Kevorkian, the retired pathologist carrying on a one-man crusade by granting desperate people's requests that he help them commit suicide.

What are we to make of all of this? After acknowledging that these are genuinely complex issues, let us remember the words of H. L. Mencken, who said, "For every complex problem there is a simple solution . . . which is wrong." Consider some facts that, while well established, are often lost in the din of this controversy:

- Rigorous studies have shown that, whereas some (though not most) people who committed suicide were terminally ill, almost *all* (at least 95 percent) were suffering from a treatable psychiatric disorder. Unfortunately, most of these people did not receive treatment for their disorder.
- Studies also show that suicidal individuals, terminally ill or not, are almost invariably *clinically depressed*. Because depression interferes significantly with rational thinking, the concept of "rational" suicide loses meaning.
- Depression can be treated successfully in the vast majority of cases; and when the depression is treated, suicidal wishes fade away along with other depressive symptoms.

In other words, even though the case for rational suicide can theoretically be made in rare cases, in the overwhelming majority of cases the problem is not the illness or life circumstances, but the depressive disorder itself. *As long as you are depressed or otherwise emotionally distressed, it is virtually certain that your suicidal thoughts stem from distorted, unrealistically negative thinking. Until and unless this is remedied, "rational" suicide is a virtual impossibility.*

The decision to die is too important to be made by any one person, especially one in the grips of dire circumstances. In cases when suicide (or euthanasia) *might* be an appropriate option, the decision must be made in close consultation with the individual's family and care providers. A team of responsible health care professionals must be involved to assess for depression and ensure that any psychiatric disorder receives appropriate attention. When depression is found and treated, the vast majority of patients feel better and express relief that they did not act on what seemed, at the time, to be rational suicidal ideas.

# 2

# Are You a "Suicidal Person"?

Do you find yourself wondering whether the word *suicidal* really applies to you or your loved one? Perhaps you wonder whether you even need to be reading this book. If you feel at all confused, you're not alone—in fact, you're in pretty good company. Even world-renowned experts have trouble agreeing on what is meant by the terms *suicide* and *suicidal*.

Although some of our patients are very clear about their suicidality, others show considerable confusion. Some say (or worry) that they are suicidal when actually they are not, while some people who are clearly suicidal deny it. It is not necessary to get into the technicalities of suicidology to do your own assessment (although it is essential that a mental health professional be consulted anytime suicidality is suspected).

In this chapter, we will discuss many of the signs and symptoms of suicidality and help you to determine for yourself whether suicidality should be a concern for you or your loved one.

## Am I Serious about Suicide or Not? (Answer: Neither and Both)

Part of the confusion in identifying suicidality arises from black-and-white thinking. This is the false belief that you must be either one or the other: smart or stupid, attractive or ugly, good or bad, suicidal or nonsuicidal. The truth of the matter is that human beings almost always either fall between two extremes (such as "moderately good looking" or "fairly smart") or show some mixture (such as "good and bad").

This also applies to people with self-destructive thoughts. Almost without exception, suicidal people either say or show that they have mixed feelings about living or dying. For example, the individual who insists that

he only wants to die often shows in various ways that part of him still wants to live. This may be reflected in certain aspects of a suicide attempt—perhaps the attempt was timed, with or without awareness, to coincide with the arrival of someone who would rescue him. The mere act of communicating suicidal thoughts to someone else suggests that some part of this person wants help so that he can go on living.

The reverse is usually true for the individual who insists that he or she has no desire to die, despite having engaged in dangerous self-harming behavior. We have seen such individuals—from those who have engaged in behaviors as "harmless" as threatening suicide or writing suicide notes to those who have seriously injured themselves or taken potentially lethal overdoses and were rescued only by accident—insist in earnest that they were definitely not suicidal and would never engage in such behavior again.

These individuals typically are not being dishonest. They sincerely believe what they are saying. They simply show by their behavior that they have *ambivalence*—the human capacity to feel two apparently contradictory feelings at the same time. For example, we may simultaneously feel happy for a close friend who has taken a job in a distant city, but also sad or angry that she is leaving. In a similar way, suicidal people almost always have a mixture of a wish to die and a wish to go on living. We have seen people near death from a suicide attempt still gamely cooperating with helpers; and we have seen people who claim to have a great desire to live resist mightily when we ask them to flush their stockpiled pills or remove a gun from the house.

### *Exercise 1: Exploring Your Two Sides*

Use the following form to explore your own ambivalence. In a column labeled "The Hopeful Side," begin listing all of the arguments *against* committing suicide (such as "My family needs me," "It's against my religious beliefs," or "Brighter days might lie ahead"). In the column labeled "The Dark Side," list all of the arguments you can think of *in favor of* committing suicide (in other words, all the reasons why life might not be worth living). There are no right or wrong answers; this portion of the exercise is strictly for getting in touch with where you are.

The second portion of the exercise will help you further expand your awareness. If The Dark Side is the longer or more compelling of your two lists, go back and work on The Hopeful Side. Search for your ambivalence. Think of better times; imagine you're an outside observer, looking at your life objectively. Do whatever you have to do, but add to that list! The goal here is to begin connecting with the life-affirming part of you that you may have lost touch with and that will set the stage for healing in later portions of the book.

If The Hopeful Side is your longer list, we suggest that you first congratulate yourself, but then search for your ambivalence as well. Although



**Exercise 1: Exploring Your Two Sides**

| The Dark Side | The Hopeful Side |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |
| 6. | 6. |
| 7. | 7. |
| 8. | 8. |
| 9. | 9. |

having a long life-affirming list puts you a step ahead, we assume that you're reading this book for a reason. So take yourself in your imagination to past (or predicted future) dark periods and write any reasons you find there why life may not be worth living after all. We are not asking you to make things up—only to get in touch with what's already there (or may be there in the future). The purpose here is not to change anything yet, but to dig for what's there as a way of mapping out what you will need to focus on.

Knowing about ambivalence can help you in many ways. Knowing that a subtle but significant wish to die is lurking behind your current positive outlook can help you to make that outlook more solid (for example, if you were to find that part of you believes that being dead would solve all of your problems, this exercise would give you the opportunity to remind yourself that being dead prevents you from enjoying your problem-free state). On the other hand, recognizing a persistent glimmer of a stubborn wish to live, even in the face of severe suicidal thinking, can give you a place to start rebuilding your passion for life.

## Two Types of Suicidal People

Perhaps this explanation of ambivalence has helped clarify suicidal states, but one additional source of confusion remains. You may have found yourself thinking, "Sure, my (or my loved one's) therapist asked me to read this book, but I know what a suicidal person is like and I don't (or my loved one doesn't) fit that mold."

This brings us to another vital piece of information about suicidality: Suicidal people come in many different forms. If you think that all suicidal people are crazy, or smart or stupid, or old or young, or divorced, or alcoholic, or any combination of these, then think again. In fact, it's not even true that all suicidal people are depressed.

Although researchers and therapists sometimes talk about suicidality as if all suicidal persons are alike, experienced clinicians know better. Just as the term *cancer* can mean totally different things for different patients, so too does suicidality vary greatly from one individual to another. Unfortunately, modern science has not yet brought us to a place where we can say, "You are a Type XYZ suicidal person, and here's the treatment program for you." However, we can say from clinical experience that suicidal people seem to fall generally into two categories.

The first category is the Depressed/Hopeless type—the group most often referred to in literature about suicide and probably most often thought of when one hears the word *suicide*. This group is exemplified by Randy, the young man described in the previous chapter. He had suffered from depression for many years and reached the point where he was unable to derive pleasure from life. He suffered from sleep problems and loss of appetite and lost interest in things that were important to him. Even more important, he became hopeless—he was convinced that his misery was permanent and that nothing he nor anyone else could do would change this. His thoughts of suicide were motivated by a wish to end his suffering in the only way he thought was left: self-annihilation.



The other category, the Communication/Control type, looks similar on the surface to the Depressed/Hopeless type, but is quite different when we look beneath the surface. True, people in this group express wishes to die and sometimes act on these wishes by harming themselves, but several characteristics set them apart. "Jennifer," for example, was brought to an emergency room by her mother and stepfather. In the midst of a loud argument about her choice of friends, she had swallowed several different medications that she found in the medicine cabinet. At age 16, she had endured many years of family conflict and had in fact been physically abused by her biological father prior to her parents' divorce two years earlier. Things seemed better after her mother remarried, but they deteriorated after her mother gave birth to another child one year later. In a therapy session following her suicide attempt, Jennifer said that she had not wanted to die, but that she had tried everything else to make things better at home and failed, and taking the pills was the only way she knew to communicate her desperation.

Table 2-1 lists other ways that these two groups of suicidal individuals differ. If you wish, you can use it as a checklist to assess which set of characteristics seems to fit you or your loved one better. Some items from both lists might ring true to you, but you probably will find that one list seems more characteristic than the other. Remember that neither of these groups is better or worse, or more or less deserving of care and concern than the other. Research shows that both groups are at a significantly elevated risk for eventually killing themselves. The reason for making the distinction is to help you see how you fit into the big picture we refer to as "suicidal." It also can help therapists and clients in planning what therapy strategy might be most beneficial for a specific individual.

## You're Probably Not Suicidal If . . .

In case it's beginning to seem as if everyone on the planet is suicidal, let's consider some groups of people who may worry about being suicidal (or whose loved ones worry they may be), but who probably are not. One such group is persons with **panic disorder**. This is an anxiety disorder characterized by sudden, unpredictable bursts of severe anxiety that produce physical arousal (pounding heart, breathlessness, etc.) and extreme fear of dying or going crazy. In addition to their other concerns, these patients worry that they might go out of control and kill themselves. This fear is sometimes fueled by occasional passing thoughts that they would rather be dead than suffer through another panic attack. Some research evidence does suggest that people with panic disorder attempt suicide at a higher rate than the general population, but this is still a controversial issue.

Several points are worth noting here. First, although people with panic disorder fear that they will lose control, they almost always report that this has never actually happened, even after dozens of high-intensity panic attacks. Moreover, when asked, these patients say that, far from wanting to be dead, they are fearful that they *might* kill themselves. Also, studies about these people when examined closely, reveal that the researchers did not take into account some reasons other than the panic disorder for the patients' greater tendency toward nonfatal suicide attempts. Judging from later published reports showing that people with panic disorder had a suicide rate no greater than the general population, it appears that suicidal behavior is driven by something other than panic disorder.

A caveat: One line of research that has implicated panic disorder as a risk factor for suicide looks at the relatively common combination of panic disorder and depression. As bad as depression is, it doesn't take much imagination to realize how much more miserable a person would be if suffering from both depression and panic attacks (or any other form of severe anxiety). If this describes you, we encourage you to seek help immediately.

**Table 2-1: Two Types of Suicidal People**

| Depressed/Hopeless | Communication/Control |
|---|---|
| Typical individual is male and middle aged or elderly | Typical individual is female and young |
| Suicidal episodes often triggered by loss | Suicidal episodes often triggered by conflict |
| Primary emotional state is despair | Primary emotional state is desperation |
| Main motivation behind suicidal behavior is to end life | Main motivation behind suicidal behavior is to communicate pain, in hopes of making life better |
| Attempts are typically secretive and planned well in advance | Attempts are often communicated and may be highly impulsive |
| Attempts tend to be violent and highly lethal (often guns or hanging) | Attempts tend to be less lethal (usually drug overdoses or cutting) |
| Typically regrets surviving a suicide attempt | Typically relieved to have survived a suicide attempt |
| Main focus of therapy is restoration of hope and reduction of negative thinking errors | Main focus of therapy is reduction of conflict and enhancement of problem solving |



Anxiety, as well as depression, responds very well to therapy, medication, or a combination of the two.

Another group of people who are sometimes unnecessarily concerned about suicide is people with **obsessive-compulsive disorder (OCD)**. People with this anxiety disorder feel compelled to perform certain nonsensical behaviors (such as washing their hands dozens of times a day or repeatedly checking to make sure the oven is turned off); or they think certain thoughts (such as extreme worry that they might hurt their child, though they have no history of violence). If you have OCD and are not depressed, your worries about committing suicide may merely be a manifestation of your anxiety disorder and not true suicidality. This will likely be a difficult determination for you to make alone, and we recommend a consultation with a mental health professional to sort it out. This anxiety disorder, too, is highly treatable.

We are often asked about people with **unhealthy lifestyles**. Certainly, we all wonder what is going through the minds of loved ones who continue to smoke cigarettes after a heart attack, kids who ride motorcycles recklessly and without helmets, and alcoholics who drive drunk. Indeed, some suicide theorists have proposed *subintentioned* suicide to explain such self-destructive behaviors in people who may not be depressed and who deny that they wish to die.

The problem with this line of reasoning, and the reason we reject it, is that following it to its logical extreme makes the entire concept of suicide practically meaningless; for if a person who smokes cigarettes is suicidal, what about the person who eats too many fatty foods? Those who don't get enough exercise? People who live in cities with air pollution and high crime rates? As you can see, before long we end up believing that practically everyone in the population, in one way or another, is suicidal.

Some people make unwise and unhealthy choices in the way they live their lives; and while therapy might be helpful to them, suicidality is probably not the most useful explanation for their behavior. We maintain that a person is suicidal only if he or she expresses, through words or behavior, extreme emotional pain and an inclination to relieve that pain through self-inflicted harm or death.

Finally, let us consider the issue of brief, **passing thoughts of suicide**. Some patients we have talked to have expressed great concern about the meaning of occasional thoughts such as, "Maybe I'd be better off dead" or "They'd be sorry if I weren't here." Family members sometimes feel grave concern when they hear mention of death, perhaps by a teenage child or elderly family member.

First, you should know that such thoughts are extremely common: Some studies have indicated that half of the population has had such thoughts at one time or another. What's important is to remember that a thought does not equal an act, whether we are talking about suicide, hostile

and violent thoughts about an obnoxious coworker, or sexual feelings toward a married neighbor. Suicidal thoughts become important only when they persist, contemplation sets in, or other suicide warning signs are present. If this is the case, immediate action is warranted; if not, concern is probably not necessary. *As always, whenever there is doubt, play it safe by consulting a mental health professional.* Consult the section later in this chapter on "Suicide Risk Factors" for more guidelines on distinguishing passing thoughts from more serious suicidal intent.

## Ways You Might Be Fooling Yourself

There are times when people fool themselves—or try to fool others—into thinking that their experience regarding suicide is something other than what it actually is. We human beings do this all the time, in a myriad of different situations: Smokers convince themselves that only other smokers get cancer, criminals convince themselves that they won't get caught, and physically unfit people convince themselves that they really will start exercising . . . tomorrow.

Suicidal people (some, not all) fool themselves in a variety of ways. Here are some that we have encountered through the years, listed in the form of what patients say and our interpretation of what they often really mean.

*"I wasn't really serious. (Can I go home now?)"* We often hear this from hospital patients who recently made a suicide attempt or serious suicidal threats.

**Translation:** "I really did want to end my life, but I'm too ashamed to talk about it. To save face, I'll insist that I wasn't really serious. Maybe my problems will go away on their own."

*"Yes, I was serious, but now I see the light. (Can I go home now?)"* This sounds sincere, but often comes from someone who has not had sufficient time in therapy to truly understand and change the processes behind his or her suicidality.

**Translation:** "I know I need to get to the bottom of my suicidality and make some changes, but it's too difficult, scary, and time consuming. So I'll just have to take my chances."

*"You're taking me much too seriously—everyone thinks about suicide at some time or another. Lighten up!"* We sometimes hear this from patients who let down their defenses momentarily, disclosed the extent of their pain and desperation, got frightened, and are now trying to "cover their tracks."

**Translation:** "It's much too scary for me or my loved ones to deal with the notion of suicide, so I'll minimize its seriousness and continue to carry the burden alone."



*"Of course I wanted to die—and I resent your suggesting there was any other reason for my suicidal behavior!"* The source of this statement often is the individual who has threatened suicide or made an impulsive, nonmedically dangerous attempt that seemed intended to have an effect on others. The motivation might be to gain attention, but might also be to express anger, elicit sympathy, or cry out for help.

**Translation:** "I'm afraid that if I look at motives behind my suicidality other than the wish to die, you'll think I'm a manipulator and won't take me seriously. If I miss out on this opportunity to get at what's really behind my self-destructive behavior, then that's just the price I'll have to pay."

*"If I were* really *serious about suicide, I'd have done it by now. If I'm talking about it, I must only want attention."* Unfortunately, this dangerous belief is sometimes reinforced by family members and even care providers. The fact is that most people who commit suicide do talk about it beforehand. And while it is true that suicidal thoughts are not uncommon, it is also true that if you have talked about suicide enough to cause concern in others, this is probably sufficient cause to take a close look at it.

**Translation:** "I, too, am worried about my suicide talk. But it worries me even more that there may actually be something to it, so I'd rather not talk about it."

*"Honest—I only wanted attention. Now that the problem is solved, there's no need to talk about it."* The first part of this statement is sometimes true—people do sometimes use suicidal threats and behaviors to gain attention, sympathy, or have some other influence on others. But if they then contend that they do not have a problem with suicidality, they fail to realize that they are at risk for similar, and perhaps more dangerous, behavior when future problems arise.

**Translation:** "I'm pretty embarrassed that I couldn't find a better way to get my needs met, so let's put this genie back in the bottle, and I'll just hope this problem doesn't come up again."

*"Just leave me alone; I'm not worth the trouble. I'm just going to end up dead anyway."* Statements such as this are usually spoken by people with severe doubts about their lovability and great fear of being abandoned. They sound tough and often reject offers of help from professional helpers, but this is only a cover for their feelings of vulnerability.

**Translation:** "I'm afraid you'll give up on me, so I'll reject you first. But really, I hope you'll hang in there and help me."

Do you recognize yourself in any of these scenarios? If so, don't give yourself a hard time. If you look back over the translations, you will find consistent themes of shame and fear. It is these feelings that most often prompt us, whether we realize it or not, to fool ourselves or try to fool

others. If this is a problem for you, you might return to the previous chapter and review the section on removing the stigma of suicidality.

Remember that suicidal thoughts and behaviors are human problems like any other (anger problems, gambling too much, having a hard time saying "no," etc.) and are nothing to be ashamed of. If someone, whether a family member, friend, or counselor, in any way suggests that your suicidality is something to be ashamed of, he or she is mistaken. In that case, we suggest you find someone else who will make it easier for you to talk about it. Minimizing or otherwise distorting your suicidality can have highly dangerous consequences. Talking about it candidly, even though it doesn't show your best side, is the best shot at a start on a new and healthy path.

## Suicide Risk Factors

Although suicidal risk is often clear-cut (for example, you may be fully aware of the seriousness of your wish to die, or your loved one may have made a life-endangering attempt), there also exists a gray area. How can you distinguish between what are simply passing thoughts in a moment of pain or an angry but superficial outburst versus suicidal thoughts and behaviors that are cause for major concern?

Certain risk factors that have been shown to be associated with suicide are summarized in Table 2-2 and are described here.

**Psychological disorder.** Depression, substance abuse, and schizophrenia are the illnesses most often associated with suicide risk, but any psychological disorder raises suicide risk to some extent. Niney-five percent of people who kill themselves suffer from some psychological disorder. Both depression and schizophrenia have eventual suicide rates as high as 15 percent.

**History of suicide attempts.** One of the best-known principles in behavioral science is that future behavior tends to be consistent with past behavior. In the area of suicide, studies have shown that the best predictor of death by suicide is a history of previous suicide attempts.

**Hopelessness.** Research has demonstrated that hopelessness is a critical connecting link between depression and suicide. If you or your loved one experiences difficulty imagining when and how things will get better, this is a sure sign that professional help is needed.

**Family history of suicide.** Studies have shown that suicide often runs in families. Whether this is due to a genetically transmitted biological vulnerability, behavioral modeling effects, or some combination of factors is not known, but thoughts or talk of suicide in a person with a family history of suicide should be taken very seriously.

**A specific plan.** If suicidal thinking has proceeded from vague abstraction to a specific plan, immediate attention is required. The more specific the plan, the greater the risk. Someone who has considered a method of committing suicide, and even thought of a time and a place to do it, is at much greater risk than someone who has not considered a specific plan.



**Making preparations.** When suicidal thinking proceeds from a plan to actual preparations, suicide risk increases significantly. Preparations may take the form of composing a suicide note, putting things in order (such as writing a will or taking out life insurance), storing up pills, obtaining a weapon, or mending fences with relatives. Suicidal teenagers sometimes give away prized possessions as a way of preparing for death.

**Severe symptoms of depression and anxiety.** These include hopelessness, agitation, sleep problems, loss of appetite, chronic anxiety and worry, panic attacks, loss of interest, abuse of alcohol or other substances, and severe self-criticism. These symptoms almost always respond well to psychological or pharmacological intervention. However, when left unchecked, sufferers sometimes conclude that they can no longer stand the burden life has placed on them.

**Isolation and withdrawal.** Hopelessness and despair tend to grow stronger in the absence of support from caring others. Isolation and withdrawal increase suicide risk because cutting off ties with other people magnifies feelings of aloneness and precludes many problems from being solved.

**Perception of insufficient reasons for living.** Dr. Marsha Linehan has shown that suicidal people have considerable trouble listing reasons for staying alive. This is probably not because the reasons weren't there, but

**Table 2-2: Suicide Risk Factors**

| |
|---|
| Psychological disorder |
| History of suicide attempts |
| Hopelessness |
| Family history of suicide |
| A specific plan |
| Making preparations |
| Severe symptoms of depression and anxiety |
| Isolation and withdrawal |
| Perception of insufficient reasons for living |
| Presence of a firearm in the home |

because emotional distress had made it difficult for them to see or remember those reasons. People in comparison groups, on the other hand, waxed eloquent, listing everything from family ties, career goals, and spiritual beliefs to ice cream and flowers in the spring. Lack of *perceived* reasons for living is exactly what common sense tells us it is, a symptom of depression and a sign of suicide risk.

**Presence of a firearm in the home.** Dr. David Brendt and his colleagues at the University of Pittsburgh showed in a study of suicide attempts that a potent predictor of which teenagers died from their suicide attempt was the presence of a firearm in the home. In addition to viewing this as a risk factor, *you must remove all firearms from your home if any family member shows signs of suicidality.* This is not optional! Safe firearm practices, such as locking guns away, have not been shown to be helpful; however, solid research does show that lack of availability in the community effectively reduces the suicide toll.

If you or a loved one are free from these risk factors, then passing thoughts of suicide are probably no cause for alarm. On the other hand, you should seek help immediately if you or a loved one is experiencing suicidal thoughts in combination with risk factors on this list. Trying to rationalize or explain away suicidal thoughts or impulses in the presence of known suicide risk factors is dangerous and unwise.

## Assessment by a Mental Health Professional

Although we have shown in this chapter how you can assess signs and symptoms of suicide risk in yourself or a loved one, a valid suicide assessment, like any examination with life-and-death implications, should be done by a professional trained in what to look for and what interventions to pursue. Although most mental health professionals (psychologists, psychiatrists, social workers, and counselors) are competent to conduct a suicide risk assessment, we must tell you that, as among doctors, lawyers, stockbrokers, and other professionals, competence levels vary. Often, nonpsychiatric physicians, ministers, and lay counselors are unprepared to explore for suicidality or to ask the detailed questions necessary for a thorough assessment.

Therefore, we encourage you to exercise intelligent self-interest. If you visit a counselor, doctor, clergyperson, or any other helper to talk about your problems, and he or she fails to inquire about suicide, *bring it up yourself.* There is no law that says you must wait to be asked or cannot volunteer information. If you feel that suicidality is brushed over too lightly, seek out someone who gives the matter its due. Remember, your life or that of your loved one might be at stake.

# 3

# "What's *Wrong* with You?" (What Makes People Suicidal)

The title of this chapter is intended not only to convey the chapter's content but also to reflect the experience of many suicidal individuals. How many readers, we wonder, have heard such questions from impatient friends and family members: "Whats *with* you?" "Why don't you just snap out of it?" "Why can't you just be like everybody else?" Indeed, how many suicidal persons have heard these questions in accusatory tones from *themselves* while looking into the mirror?

When asked in critical tones, these questions are of little use and serve only to make you feel bad. On the other hand, it is perfectly reasonable for you, as a suicidal person or a suicidal person's friend or family member, to ask sincerely what it is about people with suicidal tendencies that sets them apart from nonsuicidal people and places them at higher risk for self-inflicted death. So let us plunge into the question of why some people become suicidal.

The instinct to survive is something that all of us possess to some degree and, indeed, seems to be innate to all living creatures. When someone wishes to die, it seems in direct opposition to one of the fundamental aspects of our existence—so we generally assume that something must be wrong with anyone who has suicidal feelings. However, we can go much further than such labels in understanding why people sometimes become suicidal.

As you read this, remember that whatever it is that has gone "wrong" does not make you a bad person or mean that you can't be helped. We expect that you will recognize aspects of yourself or your loved one. Recognizing these characteristics is an important first step in coming to grips with

and ultimately solving, the problems that produce suicidal thoughts and feelings. We begin by looking at common psychological disorders, and then turn to other factors, such as certain thinking patterns and stressful life events, that fan the flames of suicidal crises.

## Psychological Disorders

Rigorous studies have shown that 95 percent of people who commit suicide were suffering from a treatable psychological disorder. Much the same can be said for people who make nonfatal suicide attempts. Sadly, even in this day of high technology and "miracle cures," the majority of people who could benefit from mental health treatment never receive it. This makes suicidal deaths all the more tragic and often leaves bereaved friends and relatives asking themselves the painful question, "Why didn't I insist that he (or she) get help?" Take a close look at the following disorders, and see if any of them seem familiar. We start with a discussion of the "big three" categories of psychological disorders that contribute to suicide risk: depression, substance abuse, and psychotic disorders.

### *Depression*

If you are clinically depressed, you suffer from something much more than a simple case of the blues. Depression is a major, life-threatening illness that warrants priority attention. If this sounds to you like a couple of soft-hearted psychologists trying to be nice to people who only need a kick in the pants, consider this fact: *Left untreated, one depressed person in six will commit suicide.* That's a mortality rate of about 15 percent. Any illness with fatality figures this high would be considered a major illness; yet our society (including many insurance companies and health plans), still mired in the stigma of the past, continues to treat depression as a low-priority concern.

Clinical depression, as well as the depressive phase of manic-depressive disorder, involves an entire set of severe symptoms that last for at least two weeks (usually much longer), day in and day out. You may find that you are unable to enjoy the things you used to enjoy, including many of your favorite activities and your interactions with other people. You probably feel down on yourself, too—diminished confidence, increased guilt, shame, and unworthiness. Your energy level is probably low, making it difficult to carry out even day-to-day tasks of living, much less handle major changes, projects, or problems. Your concentration is probably disrupted by negative, ruminative thoughts about how badly things are going and how badly you are doing. Your expectations for the future seem bleak, so you feel trapped in a state of misery. To top it all off, your sleep patterns may be disrupted, and you have either lost your appetite or you find yourself overeating to soothe the emotional pain. Your interest in sex may be greatly reduced, along with your general interest in life itself.



Being clinically depressed does not necessarily mean being suicidal. However, when depression becomes complicated by other psychological disorders or life stressors (such as those described later in the chapter) odds that you will have thoughts about suicide increase.

Although we know for a fact that periods of clinical depression sometimes go away by themselves after a few months, it is risky to do nothing about your depression, because depressed people often cannot see that things will get better, and this alone can make them more apt to consider suicide. Further, the symptoms of depression often have a self-perpetuating quality that can lead to worsening of the condition if nothing is done to treat it.

For example, if you suffer from low levels of energy and motivation, you probably will become less active and engage in fewer of the activities that you typically would enjoy. This puts you in double jeopardy. First, inactivity can worsen depression because it is associated with a depletion of an important chemical in the brain called serotonin. As the serotonin level decreases, mood usually deteriorates as well, which further depletes your energy. Thus, a vicious cycle begins. Second, if you are doing fewer and fewer things that you would typically enjoy, you will experience less and less pleasure, and your sense of confidence and accomplishment will suffer as well.

Clinical depression also is reflected in how you think. Dr. Aaron Beck (1967) has written extensively about the "cognitive triad," which entails a person's thoughts about (1) the self, (2) life itself, including the events and the people around you, and (3) the future. Depressed people tend to have negatively biased thinking patterns. As a result, you may be down on yourself, you may lose interest in others or view life in a generally negative way, and you will probably hold out little hope that things will ever improve in your life. You may be at risk for engaging in self-defeating behaviors, such as drifting away from the people who care about you, quitting important activities, avoiding new opportunities, and neglecting your health. This process can become so extreme that death may begin to look like the only viable option.

You must remember that *clinical depression is highly treatable:* 80 percent or more of individuals who seek treatment get significantly better. If you suffer from depression, you may feel hopeless and suicidal; but be aware that suicidal thoughts dangerously overlook the fact that you will almost certainly get well over time, especially with the proper treatment. It is crucial that you remember that hopelessness is a *symptom* of your disorder and not an accurate appraisal of your situation. Hopelessness will disappear with treatment, along with the other depressive symptoms. If you still don't believe that you can get well, because you feel as if you have been depressed all your life, please refer to the section on personality patterns a little later on in the chapter.

### *Alcohol and Drug Abuse*

Whenever we introduce a mood-altering chemical into our bodies, our perceptions become distorted. Sometimes this can be a pleasant experience, such as taking a minor tranquilizer to help with the anxiety of flying in an airplane or relaxing with a glass of wine with dinner. However, it is this very effect that motivates some people to use alcohol and other drugs as a primary way to soothe emotional upset.

Unfortunately, when people come to rely routinely on mood-altering substances in order to feel good or to cope, they set themselves up for considerable trouble. This is true for a number of reasons:

1. Regular overuse of a psychoactive chemical (including beer and wine) sooner or later leads to biochemical tolerance and addiction.
2. Use of psychoactive substances distorts thinking and feelings, and the more substance used, the more distortion.
3. Physical health begins to decline over time.
4. Alcohol and many other drugs have a depressant effect on the brain, even if the initial experience is a "high." Therefore, a depressed person who uses substances in order to self-medicate unwittingly makes himself or herself even more depressed.
5. Alcohol and drugs cause a suppression of the body's natural painkillers. When the effects of the alcohol and drugs wear off, the user is in more pain than when he or she started. This often leads the person to use more drugs and alcohol, and a vicious cycle is started.
6. Alcohol and drugs cause loss of inhibitions, often impairing judgment and other thought processes. Intoxicated persons are likely to do things that they would not ordinarily do. This includes dangerous behaviors such as driving while intoxicated, engaging in unsafe sex, and impulsively attempting suicide. As many as half of suicides involve the use of drugs and alcohol in the hours leading up to the time of death.
7. When a person habitually uses alcohol and drugs to deal with problems and upset feelings, the problems remain unsolved and frequently get worse. Further, the individual fails to learn valuable problem-solving skills and gain confidence in dealing with adverse life circumstances. What often follows is a lowering of self-esteem and an increase in the perceived need to use substances in order to find an escape.
8. The notion of using alcohol and drugs in order to self-medicate a depression or anxiety reflects a common misconception. In fact, far from medicating the disorder, drugs and alcohol make the individual less able to cope effectively. It is only when people *stop* using substances and learn to solve their problems through more effective means that they start feeling better.
9. Abuse of drugs and alcohol can lead people to become so chemically addicted that they develop another problem (the addiction) that they are unable to beat. This typically leads to a worsened sense of helplessness, hopelessness, and shame that may in turn lead to suicidal impulses.
10. Abusing alcohol and other drugs almost inevitably leads to tangible personal losses that can make depression significantly worse. Such losses include loss of relationships (even marriages), loss of employment and income, loss of possessions, loss of privileges such as driving, loss of reputation and status, and various combinations of these. When such losses accumulate, depression and hopelessness increase and reasons for living decline.

In summary, abuse of alcohol and/or other drugs, while sometimes reducing pain in the short term, actually increases the risk of attempting or committing suicide. This is especially true when depression is in the picture. In fact, many people have what is known in the field as a *dual diagnosis*—both substance dependence and a depressive (or other) disorder. This is a potentially deadly combination that absolutely warrants professional intervention.



### *Psychotic Disorders*

The term *psychosis* refers to a broad range of psychological conditions and a wide range of degrees of severity. Most prominent is schizophrenia, which carries a suicide risk comparable to that of depression. Affective disorders, such as major depression and bipolar affective disorder (manic-depressive illness), sometimes involve psychotic states as well. In essence, a person in the midst of a psychotic episode has significant difficulty distinguishing what is real from what is not. Examples range from the person who steadfastly but erroneously believes that the CIA is after him, to the individual who is convinced that she is personally to blame for the floods in the Midwest, to the fellow who hears voices in his head that command him to kill himself.

Most psychotic conditions carry with them an elevated risk of suicide. Such symptoms require immediate treatment, almost always involving medication and sometimes requiring a protective stay in the hospital. Less blatant psychotic symptoms can contribute to suicide risk as well. Generally referred to as delusions, these are extreme, mistaken beliefs, such as being responsible for all the evil in the world or having something eating at one's insides. Suicide thus becomes a misguided way to "save" the world or avoid the ravages of an imagined illness.

Most psychotic states can be controlled with medication. Recent evidence shows that cognitive therapy can also be effective in treating these problems. Even if you have suffered from psychotic symptoms, you have every reason to expect that your condition will respond to treatment.

## Personality Patterns

When we speak of a person's *personality*, we mean patterns of thoughts, emotions, and behaviors that a person exhibits in many different situations and that have appeared in some form or another throughout the person's life. For example, we would probably not label a 3-year-old child an "angry, bitter person" because he threw a temper tantrum. However, if that same youngster was prone to such outbursts, showed few signs of sociability and happiness, and grew up to become someone who was often hostile toward others, we might be more inclined to describe him as having an angry, bitter personality.

One of the hallmarks of good mental health is a certain flexibility in reactions to the thousands of situations that life throws our way. Flexibility makes us more adaptable to life's demands, increases chances that our needs will be met, and lowers the chances that we will suffer from depression and despair.

Everyone feels hurt when they are rejected by someone important to them. However, you would be more inclined to recover from this blow if you were receptive to the kind words and care of someone else and you felt confident that you were basically a lovable person. On the other hand, if you were the kind of person who chronically felt unworthy of love, you might be devastated even by casual slights, and you might not be reassured by others who spoke kindly of you. This sort of extreme, inflexible, adverse reaction suggests a dysfunctional personality pattern.

All of us have quirks in our personalities, and most of these are fairly innocuous. Indeed, they are part of what makes us unique individuals. There are, however, two reliable signs that such quirks may be more serious. One is when a person experiences chronic difficulties in relationships with other people. The other is when a person does not like the kind of person he or she is and feels as if he or she cannot change.

It is true that habits are hard to break, but having the motivation to change can help overcome great obstacles. The old notion that you "can't teach an old dog new tricks" simply has not been supported by research on the outcome of psychotherapy. Some of our clients tell us that they have been depressed all their lives. They maintain that, since they cannot remember having been happy, the sadness must be part of who they are. They worry that getting over their depression and suicidality would require becoming different people. Since they don't believe that this is possible, they may conclude that suicide is the only way to escape from the misery of who they are.



It is perhaps understandable that they would develop this viewpoint, given the years of pain they have experienced. However, personality and identity are neither entirely inborn nor permanently fixed; they are shaped by learning as well. One aim of therapy is to help people improve the quality of their lives by teaching them to make changes in their approaches to life, even if it feels foreign at first. Over time, this can literally change someone's personality.

The downside is that the process does take time. It is often difficult for someone who has been in emotional pain for a long time to be patient and persevere through the hard work of recovery. This is where the support of a good therapist and understanding loved ones can be very helpful. But it is even possible to make significant changes on your own if you remember that hard work will be rewarded with better times ahead.

## Thinking Patterns

As psychologist Albert Ellis (1994) has shown for more than four decades, people's problem emotions and behaviors can be broken down into three components, which came to be known as the "A-B-Cs" of Rational-Emotive Therapy. As shown in Table 3-1, these letters stand for the **A**ctivating event, the **B**elief, and the emotional or behavioral **C**onsequences. This is the process by which a merely bad event can turn into an imagined catastrophe with life-endangering implications.

Consider "James," a 27-year-old unemployed former highway department worker, who upon learning that his wife was filing for a divorce, drank two six-packs of beer and locked himself in his room. Because James would not respond to her calls and because she knew that there was a handgun in the nightstand, his wife called the police, who were able to coax James out of the room. When he sobered up, James acknowledged that he was suicidal, commenting that rejection by his wife was yet one more blow in a long string of failures.

As shown in Table 3-1, James thought that his wife's actions proved that he was a total failure. In this respect, it is not difficult to understand why he would begin to view suicide as an appropriate course of action. But is this the only possible interpretation of an impending divorce? Obviously not; otherwise, we would expect everyone who was rejected by a mate to become suicidal. In reality, we see an almost infinite variety of ways that people react to rejection, and we can understand this variety by examining how people think about such an event. Table 3-1 lists a few Bs that differ markedly from James's interpretation of divorce. Notice what a dramatically different outcome results from a different interpretation.

The A-B-C model is the cornerstone of cognitive therapy: The way we think powerfully influences the way we feel and behave. Thus, when we unrealistically magnify our problems and minimize our assets, we set ourselves up for unnecessary emotional distress. Nobody is immune from the

**Table 3-1: A-B-C Model of Emotional Distress**

| Activating Event | Belief | Consequences |
|---|---|---|
| **Rejection by mate** | This proves what a failure I am. | depression, alcohol abuse, suicidal thoughts and actions |
| | This proves what a bitch my wife is! | rage, verbally or physically abusive behavior |
| | I'll never be able to cope on my own. | anxiety, desperate attempts to find a new mate |
| | I'll really miss her. This will hurt for a while, but I'll be okay if I take care of myself. | sadness, positive coping behaviors |
| | Free at last! I can't wait to hit the dating scene again. | joy, increased socializing |

occasional bout of pessimism or overworry, but some people think in a way that makes negative emotions a regular part of life. In fact, negative basic attitudes about yourself, your life, and your future can actually put you at chronic risk of hurting yourself.

Problematic thinking patterns are not seen only in people who have psychological disorders. However, they seem more severe and rigid in people who suffer from clinical depression, manic-depression (bipolar affective disorder), anxiety disorders, personality disorders, substance abuse disorders, and other diagnostic categories. Below are some of the more common thinking errors found in people with suicidal tendencies.

### *Maladaptive Beliefs about Achievement and Control*

Although it is generally healthy to strive for success and a sense of control in your life, it can be hazardous to take this to one or the other extreme. For example, if you believe that you must do things perfectly, and you become upset and self-reproachful whenever you make a mistake, you will rarely be able to relax. To err is human. It is unrealistic and unfair to demand that you should never make a mistake or that you should always be at your best.



Such an attitude will make it difficult for you to like yourself or to enjoy a well-earned sense of accomplishment. In extreme instances, it can lead to suicidality. The college student who overdoses after losing her perfect grade point average or the businessman who shoots himself following a financial reversal are cases in point.

At the other extreme are people who are convinced that they are inadequate and incompetent and therefore either ignore their actual success or don't even try. We hear this in people who say things such as "I can't go back to school, I'm not smart enough" or "I'll just mess things up anyway, so what's the point of trying to improve my life?" Such attitudes reflect a damaging lack of self-confidence. When someone has such a blatant disregard for himself or herself, the act of self-harm may not seem out of the question.

### *Dysfunctional Attitudes about Love and Relationships*

Human beings are social animals. To be healthy and happy, we must see ourselves as worthy of being loved, and we must form emotional bonds with others. If we are lucky, our parents (or other important role models) foster our sense of lovability early in life. If this is learned well, it helps us to overcome the pain of rejection that inevitably occurs over the course of our lives. If we were not fortunate enough to have had parents who nurtured us and made us feel loved, it is still possible to get these needs met later in life by others. However, it is more likely that we will have acquired some troublesome beliefs about relationships.

For example, you may believe that you are not worth anything unless you are married or in a romantic relationship. Or you may become overly dependent on a loved one to provide you with your sense of identity. If this is true, the break up (or feared break up) of your relationship can leave you with a shaky sense of who you are—indeed, you might feel, and mistakenly believe, that you have lost *everything*. Sadly, many people have killed themselves because they felt like nothing without a relationship or because they interpreted a break up as evidence that they would never be loved.

Maladaptive beliefs about your lovability can present difficulties well beyond how you react to relationship problems. Such beliefs can cause you to ignore the fact that others do indeed love you. They can make it difficult for you to believe and accept the positive attention that others may be trying to give you. They can make you feel alone, even when you are surrounded by caring people. They can convince you that you should kill yourself rather than wait around for what you believe to be inevitable mistreatment and abandonment.

Staying in an abusive relationship is another sign of faulty beliefs about your lovability. You may believe that a bad relationship is better than no relationship, that nobody else would have you, and that you wouldn't be

able to take care of your own emotional needs if you left. If the situation seems intolerable, you may opt to hurt yourself rather than try to start over on your own. This is drastic action, but you will have a hard time seeing it any other way until you make changes in your beliefs about your love and attachments.

### *Maladaptive Beliefs about the Future*

Hopelessness has been shown to be a crucial connecting link between depression and suicide. Hopelessness is extremely common in people who are prone to self-harming behavior and suicide. No one among us can predict the future with 100-percent accuracy, yet people with self-destructive habits and intentions often feel certain that the future holds only misery for them.

We hear this attitude in people who say things such as "I'm going to be dead by the time I'm thirty anyway, so what do I care if I overdose on drugs or get HIV?" or "I'm not getting any younger and my life is going downhill. I might as well end it all now," or "Nothing I do ever works out. I'll always be unhappy. Nothing will ever change," and similar sentiments.

If you have a bleak view of your future, you are missing an ingredient needed to survive and recover from life's travails: *hope*. Hope is what helps people through bleak times. We see this in the parent who successfully raises children without a partner, in the person who returns to school late in life and earns an advanced degree, in the individual who manages to live for days in the wilderness until rescued, and in the person who defies and defeats her doctor's prediction that she has only a few months to live.

The human spirit can overcome adversity; hope is the fuel that makes the spirit burn brightly. This is not false hope, mind you, but hope that is rooted in taking a stand, having a plan, and actively moving forward in spite of adversity.

### *Underestimating Reasons for Living*

A cognitive distortion common in severely depressed individuals is a tendency to magnify the negative and minimize or disqualify the positive. To add insult to injury, such persons sometimes hear criticism from others (some of whom are well meaning and some of whom are simply exasperated), who say, "You make mountains out of molehills" or "You don't appreciate what you have." Judgmental tone aside, this may be true.

Most suicidal people do in fact minimize or overlook reasons for living. This is not intentional. Rather, it happens because their depression casts a pall over their perceptions, making it truly seem that there is insufficient reason to go on living. Other people often can see more clearly what the person stands to lose if he or she commits suicide.

Reasons for living differ from one person to another, and it would be virtually impossible to enumerate them all. However, it is important to re-



**Table 3-2: Commonly Reported Reasons for Living**

To see my children grow up.

So I can travel to places I've always wanted to visit.

To see if I can find the relationship I want.

To continue to advance in my work.

So I can retire and relax for the first time in my life.

So I can help others with the same problems I have.

So I can finish my novel.

My wife needs me, and I need her.

There is much I still want to do and to learn.

I am a worthwhile person, and I deserve some happiness.

Life has many simple pleasures to enjoy:

- the smell of coffee in the morning
- soaking in a hot tub
- a cold beer after mowing the lawn
- the sound of children's laughter
- the beach
- ice cream
- Carol Burnett reruns
- back rubs
- rock 'n' roll (or jazz, classical, country, etc.)

No matter how ugly life can be, beauty still abounds:

- paintings by Michelangelo and Degas
- flowers in the spring and leaves in the fall
- sunsets
- Mozart
- Sophia Loren
- Sean Connery
- a baby's soft skin
- a kind word from a stranger

member, as a general principle, that reasons for living can be large or small; and they certainly don't have to be earthshaking accomplishments or aspirations. Table 3-2 shows a sampling of answers we have received when we have asked our clients about their reasons for living.

### *Exercise 2: Your Reasons for Living*

Start an ongoing list of your own reasons for living. Begin with the reasons you have chosen to continue living up to this point in your life. If you wish, you can start with a few of the reasons listed in Table 3-2 that ring true to you. Add at least one reason to your list every day. Remember, your ability to list reasons for living will be influenced considerably by your mood on any given day. Pay attention to how many more reasons you can list on days you feel good compared to days when you are depressed. Does this mean that reasons for living cease to exist on days you are depressed? Definitely not! It merely illustrates in a powerful way how emotional upset can obscure your vision, blocking out positive memories and thoughts. A personal Reasons for Living list can be a vital part of your "emotional first-aid kit" to help you recall reasons you can't think of during periods of depression.

### *Ineffective Problem Solving*

The ability to recognize a problem, define it clearly, and think through possible solutions is a valuable skill. There is no way to avoid life's problems, so what separates those who are satisfied with their lives from those who are not often has to do with how well the person *solves* those problems.

When problems are overlooked or ignored, they almost always grow. This can lead to your feeling overwhelmed and to the sense that the problems cannot be managed. Ignoring a problem will not make it go away; the adage that "things take care of themselves if you leave them alone" simply isn't true. *People* solve problems, and not by luck, magic, or the simple passage of time. Furthermore, people are more apt to succeed in solving problems if they catch them early, face up to them with hope and confidence, and work out a plan of action.

One of our clients, upon hearing that she might need to work on her problem-solving skills, reacted angrily: "Is that what you think—that my life is actually problem free and that I just don't know how to cope? Well, that's easy for you to say. You don't have to deal with my hyperactive son, busted water pipes, and neighborhood drug dealers. Listen, my problems are real, and I resent your suggesting they're only in my head!"

If you notice yourself having thoughts like these, let us make something very clear: *To suggest that you practice improving your problem-solving skills in no way implies that your problems are not real.* Studies have shown that suicidal individuals actually do have more life stressors to deal with than people who are not suicidal. If you believe that you have more problems than the average human being, it is even more important for you to develop excellent problem-solving skills in order to address them. Chapter 9 will give you some guidance in doing this.



We wish that problem solving were as much a part of the school curriculum as reading, writing, and arithmetic—it's that important. It is a skill that takes time, effort, and practice, but it more than pays for the effort by saving you untold amounts of grief in the long run. Let's look at an example:

> "Steven" prided himself on being a "spur-of-the-moment kind of guy." He stated that he never planned things or thought things through systematically because "you can't count on things working out the way you want them to, anyway." At first glance, this appeared to be a confident fellow who knew who he was and what he wanted; but nothing could have been further from the truth. Steven was addicted to cocaine, faced a court hearing, had destroyed his credit rating, had alienated his girlfriend and his family, and chronically felt suicidal. Therapy focused heavily on helping him change his style so that he was more willing to confront his problems honestly and methodically.

Suicidal people sometimes feel so overwhelmed by their problems that they try to solve them by desperate, unwise means, or they attempt to escape from them altogether. For example the individual who tries to solve a financial problem by borrowing from a loan shark actually creates greater problems for himself in the long run. You or a loved one may have engaged in self-harming behavior as a way to solve a relationship problem, only to find that any benefit from such behavior was only temporary; likewise for the person who seeks solace from daily stressors through drugs and alcohol.

If you feel that your problems have gotten out of hand, that your life is out of control, and that you can no longer cope with your stress, you might begin to view death as the only solution available to you. This is the ultimate example of maladaptive problem solving. *Suicide does not solve problems.* At best, it ends your awareness of the problems; but you don't get to enjoy the benefits. Suicide also creates terrible new problems for those you leave behind. The only problem that never can be solved is death itself. As long as you're alive, you at least have a chance.

## Stressful Life Events

Another influence that contributes to suicide risk is stress. Stressful events are part of being alive. We all sometimes experience events that hurt us and test our resolve to carry on. Ideally, these experiences pass as a routine, albeit painful, part of the life cycle and contribute to our maturity. Unfortunately, such events as illness, death of a loved one, or financial setbacks sometimes arrive in clusters, making it difficult to cope. If you already suffer from a disorder such as clinical depression, an added negative event in life

might feel overwhelming. Furthermore, if you hold some of the maladaptive beliefs just described, you might be quite vulnerable to stress.

In the next section, we describe some major life stressors that contribute to suicide risk. These events in and of themselves do not make a person suicidal. However, if many of these take place close together in time and coincide with a person's clinical depression and maladaptive beliefs, suicidality can become an issue.

### *Separation or Loss*

The loss of an important relationship, whether through circumstance, conflict, or death, can be a crushing blow, especially if such losses occur repeatedly. If you have experienced significant losses early in life, such as the death of a parent when you were a child, you may be particularly sensitive to the loss of love that occurs when someone you care about in adulthood leaves you or dies. Similarly, if you lack a supporting cast of caring people in your present life, the loss of one special person may make you feel as if you have lost everything. This is especially true if you lack a secure sense of your own worth and identity.

While interpersonal losses may be unavoidable, it does not necessarily follow that you will always be alone. It also does not diminish the meaningfulness of those relationships that you do have. Everything hinges on *what you believe*. Examine the following beliefs to see if any sound familiar to you:

- My life is worth nothing if I am not in a relationship.
- If someone I love stops loving me, I am no longer worthy of being loved by anyone, ever again.
- I can't cope without my loved one. If I am left alone, I won't be able to go on.
- It's all my fault that my loved one is gone. I deserve to die.
- Everybody always ends up leaving me. The only way I can prevent this is if *I* leave everyone by killing myself.

Beliefs like these can transform an incident of separation and loss into a life-and-death situation for you. Holding such beliefs can even make you want to hurt yourself just at the thought that you might lose someone. They are also hard to give up because they feel so "right" and so much a part of who you are. However, we will teach you how to challenge and change them later in this book.

### *Injury, Illness, and Loss of Freedom*

Some people become suicidal partially as a result of debilitating physical illness or injury. Unremitting pain, irreversible limitations, the prospect of progressive decline, and the loss of control over one's own functioning can sometimes lead to a wish to die.



Consider the following scenarios: (1) A person becomes paralyzed as a result of an accident, believes that all chances of having a meaningful life are over, and lapses into a deep depression; (2) a cancer patient becomes fed up with the pain associated with her chemotherapy and radiation treatments and decides to cease all treatment, choosing instead to die quickly; (3) a man who is HIV-positive decides to kill himself with an overdose of sleeping pills at the first sign of an AIDS-related set of symptoms; (4) an older man whose memory starts to fail believes that he has Alzheimer's disease and decides to shoot himself "to spare my family" and (5) a woman who has suffered disfiguring burns becomes suicidal as a result of the chronic pain, the prospect of numerous surgeries, and rejection of her own appearance.

We can all sympathize deeply with each of these people's predicaments. If we put ourselves in their positions, we might even conclude that suicide seems "understandable." Nonetheless, it would be premature and hazardous to state definitively that suicide is the only choice in these cases. To do so would be to ignore true reasons for hope and to risk that we might be tragically incorrect in our assumptions that the conditions are hopeless.

For example, many people lead full, productive, and meaningful lives following paralyzing injuries. Similarly, we know of people with supposedly terminal illnesses who had unexplainable recoveries. Many people have reported that their illnesses have made them appreciate life even more and have inspired them to become closer to the important people in their lives. Studies have shown that the main difference between terminally ill patients who become suicidal and those who don't is the presence of clinical depression in the patients who are suicidal. In other words, the culprit is not the illness or injury, but depression.

Self-diagnosis is a bad idea. Suppose the man who thought he had Alzheimer's disease was wrong. By choosing to kill himself rather than suffer a decline, he could be robbing himself and his loved ones of many years of healthy functioning. The man who wants to die because he dreads experiencing AIDS-related illnesses actually could be years away from serious complications. By choosing to kill himself, he guarantees that he will not live long enough to benefit from medical advances in years to come. The woman with the debilitating burns may not be able to bear the thought of so many painful surgeries, yet it may be just these operations that will give her a chance to regain a life that she will enjoy and value. The theme here is one which we will repeat: *It is not the event itself which causes the suicidality.* It is the loss of hope, together with the sense that you cannot handle the suffering, that fuels the thoughts of suicide.

### *Loss of Status*

We are aware of some instances when a person has committed suicide after a major change in lifestyle, a humiliating experience, or a similar "fall from grace." Examples include an actor who killed himself when his career

stalled, a politician who shot himself at a press conference rather than go to prison, and a student who committed suicide after learning she had not been accepted into medical school.

Such reactions are difficult for some to understand, since these losses seem trivial compared to losing a loved one or suffering from a horrible medical condition. To understand, we must consider how such losses are interpreted. If the individual believes that failure is a fate worse than death and that almost any lack of success makes her or him an abject failure, then suicidality following a reversal of fortune becomes more understandable.

Here are examples of thoughts that might fuel such an outlook:

- Now that I am no longer wealthy (powerful, well known, prestigious), I will lose all my friends and I will be all alone.
- Life is not worth living if I can't be the best.
- I will never be able to make a comeback.
- Now that I've failed, no one will ever respect me again.

These are shaky assumptions on which to base a life-and-death decision. They are based on an exaggerated sense of shame, a premature belief that things will never get better, and an overdeveloped need for achievement at the expense of enjoying the simple wonders of life.

In fact, the only surefire way to *prevent* a comeback in life following misfortune is to commit suicide. Ups and downs occur in everyone's life, and many people who are successful are the people best able to tolerate the occasional setback. Perseverance and faith in yourself are qualities that can inoculate you against depression and suicidality when you encounter hard times.

Something to appreciate about many of the stressful life events we have reviewed here is that crisis periods are usually temporary. It may sound trite to say that "time heals all wounds" or "it is darkest before the dawn," but it is crucial to realize that suicidal feelings usually come at the lowest point. If you can somehow ride out the limited period of time in which you feel your worst, you will survive. You eventually may even prosper. Only the act of suicide makes this positive outcome impossible.

## Environmental Factors

As previously stated, it is not negative life events themselves but the beliefs that people maintain about them that account for suicidal reactions. However, no man or woman is an island, and we all are affected by the environment in which we live. Our environment affects us in a variety of ways, including what beliefs we develop and why we hold on to them. Next, we discuss the categories of environmental factors that studies have shown to be associated with suicide risk.



### *Inadequate Social Support*

Many people who become suicidal suffer from a sense of isolation and lack of social support. We generally do not realize the extent to which we rely upon other people and social institutions; but we certainly notice when support from others is absent. Social support comes in many different shapes and forms, including families, religious congregations, employers, friends, and neighbors. Service agencies, such as mental health centers and the YWCA, also fulfill important support functions in the community.

Persons at risk for suicide often exist in environments lacking in social support. Their families might be incapable of offering help and understanding during stressful periods, and often little is to be found when they turn to the community for help. On the other hand, sometimes potential sources of support are there, but negative filtering caused by depression prevents the suicidal individual from seeing them. The resulting feelings of isolation can be difficult to overcome without help. A therapeutic program to develop a social support network is an important part of combating suicidality. We will discuss support systems further in Chapter 5.

### *Modeling by Parents and Others*

To some degree, suicidality runs in families. One reason for this is that certain disorders, such as depression, bipolar disorder, and substance abuse, have a hereditary component. If both of your parents suffered from clinical depression, there is a good chance that you will be susceptible to depression as well.

However, heredity is only part of the picture: If it were the whole story, then all identical twins in the world would always share the same psychiatric disorder, and we know they do not. Our environment plays a big role, and nowhere is that role more pronounced than in the household where we grow up. We learn a great deal about life from our families. We don't just learn behaviors, we learn attitudes as well.

If you witnessed your parents or siblings exhibiting severe, chronic, depressive symptoms, as well as suicidal behaviors, you might well have been influenced by them. This is especially true if one or more of these relatives actually carried a suicide to completion.

It is one of the interesting, yet frustrating, facts of life that we tend to learn and imitate even the things we *dislike* about our families. For example, have you ever shaken your head in dismay after catching yourself in a vulnerable moment sounding "just like Mom"? This also holds true for attitudes about hope, self-worth, self-harm, and others.

If members of your immediate family have been suicidal, it is possible that you have adopted some of their viewpoints. This does not mean that you are doomed to repeat the past. It simply means that you have had powerful learning experiences that need to be counteracted by new learning

experiences that are more affirming of yourself, your life, and your future. It means that you will need to be on the lookout for impulsive, self-defeating, and self-harming reactions to stress, because this has become one of your well-learned habits. Fortunately, with some work and encouragement, you can overcome old habits.

### *Reinforcement of Suicidal Talk and Behaviors*

It is a well-known fact in psychology that behaviors that are rewarded tend to be repeated. That is why we praise children when they work hard on their homework, say "thank you" in response to a kind deed, and work harder for incentive pay.

Sometimes, however, negative behaviors and attitudes inadvertently get rewarded. This is most likely to happen in a household in which there is a lack of praise and affection and family members are more likely to get attention if something is wrong or if they get into trouble. In such cases, the negative behavior gets reinforced, because of a lack of reinforcement (reward) of positive behaviors.

For example, we can see how a depressed teenager might resort to threats of suicide in order to get parents' attention. When parents spring into action, but do nothing else to change the nature of the family relationships, they unwittingly reinforce the teenager's tendency to become suicidal in order to get noticed. Similarly, a spouse who feels neglected—that is, until a suicide attempt—may become inclined to engage in suicidal behavior as a primary way to keep the other spouse invested and involved in the marriage.

When these types of problems occur, it is not only the suicidal person who needs professional care but the marital or family unit as well. Everyone involved must learn new ways of interacting so that positive, life-affirming, and relationship-enhancing viewpoints and behaviors are reinforced. Like individual habits, family habits can be hard to break, but the payoff for a positively changed family system can be enormous and well worth the effort.

### *Romanticization of Suicide: From Romeo and Juliet to Suicide Rock*

Another environmental factor that has been known to play a role in propagating faulty beliefs about suicide can be subsumed under the rubric, "the arts and the media." We are not bashing freedom of speech; we are strong proponents of this basic, fundamental right. However, we need to be aware of some of the messages that are sent to people who may be very vulnerable, impressionable, or not optimally aware of the differences between fantasy and the real world.



As an example, let us refer to the politician who killed himself at a press conference in Philadelphia. The event was widely broadcast on television, but some networks had the sensitivity to sacrifice ratings for the sake of decency and safety. They chose not to replay the actual shooting. This is the kind of social responsibility that we applaud, in that there are too many people who otherwise may view such an incident as a way to get their "15 minutes of fame." We have all heard of "copycat killings." Similarly, there are copycat suicides.

In addition, music and literature have played an unfortunate role in making suicide seem "cool" or romantic in some way. This is most apt to happen when the author or artist fails to depict the horror and tragedy inherent in the suicide. In other words, the serious *consequences* are not sufficiently spelled out.

To illustrate our point, we can argue that Shakespeare succeeded in portraying suicide in a responsible manner in *Romeo and Juliet* because the devastating outcome is made apparent to the reader. By contrast, there were a number of highly talented British poets in the early 20th century who inspired their fellow countrymen to go off to the battlefields of World War 1. They glorified the prospect of dying for one's country. While this may be patriotism at its highest level, it is also a slanted and over-romanticized portrayal of death. Interestingly, there was a backlash by other poets, who roundly chastised the "War Poets" and lent their support to life over war.

Today, there has been great debate about the effects of "suicide rock" on young people. Many musicians claim that their lyrics need to be taken in their proper context—that songs about suicide are actually satirical or polemic, and therefore are *against suicide*. Nevertheless, this necessitates clear and objective thinking from the listener. Since we know that people who are severely depressed are prone to negatively biased thinking, the music may actually teach dangerously accepting attitudes toward suicide—for example, that suicide is the best solution to life's problems. This is a very thorny issue, indeed.