Is Suicide Preventable?

RALPH B. ELIAS, M.D., La Jolla

• Among 500 cases of suicide analyzed in Stockholm, fewer than a third were associated with depression. Most forms of psychiatric disease were represented. Nevertheless, most persons give some warning before attempting suicide, and these warnings should be the signal for preventive action. Centers with trained personnel could prevent many suicides, if the potential victims were recognized and referred early enough. Laymen too should be educated to recognize potential suicide and help avert it.

WHEN Rost[4] compiled a bibliography of suicide some 30 years ago it ran to almost 400 pages; since then the literature has at least increased proportionately as studies are contributed from varied perspectives to this most enigmatic of human phenomena.

Recently there have been informed conjectures (Kubie's, for one) that so-called natural death is actually the result of disease. In the present seemingly limitless period of history, it has been postulated that science will be able to eliminate death. It is therefore fitting that we, as physicians, continually reexamine self-produced death and the dis-eases that make it, for the victim, preferable to life.

Although statistics on suicide are particularly unreliable, it can be definitely stated that the incidence currently is not declining. In this country in 1955 the number of deaths attributed to suicide was 16,755—more than from all forms of tuberculosis, from all diseases of the central nervous system except for cerebral vascular accidents, and over twice the number for homicide.

There is evidence that suicide was more prevalent in ancient times.[5,6,7] Mass suicide was more common then than it is today. Yet race suicide is now a possibility.

Should the individual attempt or act of self-destruction be considered a manifestation of psychological disease? Most observers believe so, although there are exceptional situations in which suicide appears admirable if not rational. Most suicides, and especially those within the ken of the physician, are not of this order. They are reactions either patently or implicitly distorted and inappropriate to the circumstances, at least to the observer. They are in essence the final do-it-yourself treatment; the ultimate examples of the cure's being worse than the disease. But the sick individuals cannot understand this at the time.

A psychiatric study was reported by Ettlinger and Flordh[2] of 500 cases of attempted suicide at a general hospital in Stockholm. Five per cent of the patients did not manifest abnormality; the remainder ran the gamut of psychiatric diseases. Neurotic depression in 24 per cent and psychotic depression in 7 per cent accounted for fewer than a third of the cases; it is now well recognized that persons may have neither the clinical nor the dynamic features of depression yet be suicidal, and conversely many depressive patients never attempt suicide.

Nevertheless, a person suffering from depression remains the most dangerous risk. One whom I shall not forget was a woman with an aggravated form of it. She had apparently been doing adequately until her marriage dissolved one year before. Despite most forms of treatment she was in misery much of the time. On her fourth attempt to kill herself, she succeeded. None of these attempts, it should be noted, occurred while she was in a hospital. I believe that if she had been given more security and even less strain than the little she did have, in time she might have recovered. It is wise to reiterate in any clinical discussion that the persons who talk about killing themselves are often the ones who do.

Some of the underlying psychological forces pointed out by various commentators as associated with the act are ambivalence; the triad of the wish to kill, to be killed, and the need to die; a deep feeling of worthlessness; excessive dependency feelings; guilt; rage, either internally or externally directed; the need for atonement and punishment, and an attitude of personal excommunication. Hendin has recently noted the serious portent of fantasies or dreams of fulfillment in death.

Is there anything more that should be done about suicide in this country? Two concomitant approaches are suggested:

The first is the organization of centers, particularly in cities, where trained personnel would provide emergency care and continued treatment of suicidal patients. As previously described, such a unit is part of a general hospital in Stockholm. In Vienna, there is a religious group described by Ringel,[3] its psychiatric director, which devotes itself

Presented before the Section on Psychiatry and Neurology at the 87th Annual Session of the California Medical Association, Los Angeles, April 27 to 30, 1958.

to care of those who are tired of life. Social workers, priests and other volunteers participate. Individual psychotherapy is the basic treatment. Ringel's reported results are impressive. In the years 1948 through 1950, 2,879 persons were treated who had made attempts at suicide. By August of 1951, 42 had made another attempt, but only one committed suicide. All patients who were treated before an attempt had not since tried.

The other part of the approach is an extensive educational program, which seems at least as worthwhile as the elaborate campaigns to combat cerebral palsy and muscular dystrophy. But it will not be an easy task to communicate awareness to individuals, their families and neighbors that suicide is practically always the result of illness which can be cured.

Finally, returning to the question, "Is suicide preventable?", it is appropriate to recall an observation by the anthropologist Benedict[1] of the Zuni Indians, among whom sobriety and moderation are valued above all things: "To talk to these people of suicide is to court polite incredulity."

817 Silverado Street, La Jolla.

REFERENCES

1. Benedict, R.: Patterns of Culture, London, 1935.

2. Ettlinger, R., and Flordh, P.: Attempted suicide: Experience of 500 cases at a general hospital, Acta Psychiatrica et Neurologica Scandinavia, Supp. 99-103, 1955.

3. Ringel, E.: Der Selbstmord, Vienna, 1955.

4. Rost, H.: Bibliographie des Selbstmords, Augsburg, Haas and Grabherr, 1927.

5. Steinmetz, S. R.: Suicide among Primitive People, American Anthropologist, 1894.

6. Zilboorg, G.: Differential diagnostic types of suicide, Arch. Neur. and Psychiat., 35:270-291, Feb. 1936.

7. Zilboorg, G.: Suicide among civilized and primitive races, Am. J. Psychiat., 82:1341-1369, 1935-1936.

For Your Patients—

A Personal Message to YOU:

As your personal physician I consider it both a privilege and a matter of duty to be available in case of an emergency. Consequently, I thought it would be a good precaution if—on this gummed paper which can be pasted in your telephone book or medicine cabinet—I listed the numbers where I can be reached at all times. They are:

________________ OFFICE   ________________ HOME

Sincerely,

____________________, M.D.

MESSAGE NO. 2. Attractive, postcard-size leaflets printed on gummed paper, you to fill in telephone numbers and your signature. Available in any quantity, at no charge, as another service to CMA members. Please order by Message Number from CMA, PR Department, 450 Sutter, San Francisco.