

LETHAL BEAUTY

SAVING A LIFE: The common assumption that suicide can't be prevented is wrong.

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The last in a seven-part series on the Golden Gate Bridge barrier debate.

When a dazzled John C. Fremont sailed through the strait of San Francisco in 1846, he was struck by its resemblance to the glorious harbor of Constantinople, the Golden Horn. Fremont was captain of the U.S. Army's topographical engineers and charged with naming the strait. He called it the Golden Gate.

The Golden Gate Bridge straddled the mile-wide strait in 1937, and instantly became a symbol of humanity's ability to build in harmony with nature. But the bridge soon gained another meaning, something darker. It became a suicide magnet.

Today, mental health experts refer to it as "a loaded gun in the middle of the city," and a debate over whether to build a suicide barrier has raged for decades. But the issues raised cannot be fully understood or argued without contemplating the phenomenon of suicide itself.

The death of a loved one by suicide may be the most difficult to mourn. The loss is complicated by emotions that may include anger, incomprehension and regret. In 2002, 32,000 people in the United States took their own lives, according to the Centers for Disease Control and Prevention. Worldwide, the 1 million suicide toll in 2001 exceeded the number of deaths from homicide and war, the World Health Organization reports. In the wake of a single suicide, families are shattered, communities shaken.

Is suicide the ultimate act of free will, simply a choice? Or is it a collective problem, with social causes? If suicide has never touched a person's life, how is he or she to understand it?

One way to start is to look at what puts a person at risk for suicide. Experts agree that mental illness is not the only indicator of suicide risk. In fact, there is no single cause.

"We know a great deal about the underlying conditions that predispose an individual to kill himself -- heredity, severe mental illness, an impulsive or violent temperament," says Kay Redfield Jamison, professor of psychiatry at Johns Hopkins University and author of many books, including "Night Falls Fast: Understanding Suicide."

"We know too that some events or circumstances in life interact in a particularly deadly way with these predisposing vulnerabilities," Jamison says.

These can include anything from romantic upheavals to job setbacks, confrontations with the law or debilitating illnesses. Alcohol or drug use can exacerbate the crisis.

The first scientific study of suicide was published in 1897 by French sociologist Emile Durkheim. He was convinced that growing suicide rates could not be attributed to mental illness alone. Though suicide is an individual act, Durkheim believed that its causes were social. One thing many suicides shared, he found, was geographic mobility. People had begun moving farther from home in the latter half of the 19th century, in pursuit of education, work and a better life.

Since that time, Durkheim's finding has been corroborated again and again. In 2001, the CDC reported that a high number of moves in a single year is a significant predictor of suicide.



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The common assumption that suicide can't be prevented is wrong



Why highly mobile individuals are at greater risk for suicide is not fully understood. Moving often may be a marker for hard-to-quantify characteristics, such as financial difficulties. Certainly, frequent moves disrupt social networks, including "kin support," in times of crisis.

Another of Durkheim's convictions -- that mental illness was not the sole explanation for most suicides -- was echoed by the CDC study.

Although suicide attempts often involve chronic mental health problems such as depression, the CDC researchers noted that what they called "impulsive suicide attempts" were immediately preceded by some kind of conflict. Such impulsive suicide attempts, then, don't necessarily derive from an overwhelming desire to die.

Dr. David Brent, academic chief of child and adolescent psychiatry at the University of Pittsburgh School of Medicine, where he holds an endowed chair in suicide studies, also cites impulsivity. "Man was a hunted animal, so it made sense to have some ability to act quickly," Brent says.

A tendency to act on aggressive urges -- without considering the consequences -- was an aid to survival. But a tendency toward impulsivity can increase the possibility of suicide -- particularly, Brent notes, "impulsivity in someone who is depressed and has available means."

Many suicide attempts from the Golden Gate Bridge are made by impulsive people, experts say; the bridge itself represents free access to lethal means.

Is suicide preventable?

This question is central in the debate over whether to put a suicide barrier on the Golden Gate Bridge.

If we believe that those thwarted by a bridge barrier will simply find another way to end their lives, it follows that suicide cannot be prevented. And if we believe that nothing can be done to stop it, then we need not act.

In the late 1970s, two scientific studies concluded that survivors of suicide attempts from the Golden Gate Bridge do not "just go someplace else."

Dr. David Rosen, then of UCSF's department of psychiatry and Langley Porter Psychiatric Institute, spent 2 1/2 years researching "Suicide Survivors," an in-depth study of six people who survived jumping from the bridge. The study was published in 1975.

Almost unanimously, the survivors said that their "will to live had taken over" after they survived the jump. "I was refilled with a new hope and purpose in being alive," said one. "Surviving reconfirmed my belief and purpose in my life," said another. Only one person in the study made a subsequent suicide attempt.

In 1978, Dr. Richard Seiden of UC Berkeley published "Where Are They Now?," a study of 515 people who, from 1937 to 1971, were prevented from jumping from the bridge. He found that only 6 percent went on to kill themselves -- suggesting that many bridge suicides are impulsive.

"When a person is unable to kill himself in a particular way, it may be enough to tip the vital balance from death to life in a situation already characterized by strong ambivalence," Seiden wrote.

"The hypothesis -- that Golden Gate Bridge attempters will 'just go someplace else' -- is clearly unsupported by the data. Instead, findings confirm previous observations that suicidal behavior is crisis-oriented and acute in nature.

"Accordingly," he concluded, "the justification for prevention and intervention such as building a suicide prevention barrier is warranted. And the prognosis for suicide attempters is, on balance, relatively hopeful."

In the face of the results of these studies and others, why does the rationale for inaction persist?

"Suicide may seem so out of keeping with most people's attitude toward life that they may feel that someone who considers suicide cannot be dissuaded," suggests Brent.

Also, Western culture emphasizes rationality. "We assume that suicide is rational, but suicide is not rational," says Dr. Anne Fleming, a professor of psychiatry at UCSF.

"Some people are more likely to develop mental illness, but the capacity is in all of us. It could be anyone -- and that's terrifying. So it's reassuring to believe that these people are different from you and me. To protect ourselves, we distance ourselves from 'those people,' " says Fleming, who is also a member of the Psychiatric Foundation of Northern California, one of the groups lobbying for a barrier on the Golden Gate Bridge.

"When we avoid human problems that are elusive or complex, irrational or subterranean, we close our hearts," says Sonoma therapist Richard A. Heckler, author of "Waking Up Alive," a book about survivors of suicide attempts.

"When we become more distanced from aspects of other people's lives that we don't understand, we reject those parts of our own lives as well."

The bridge is not beautiful if you've lost someone to it.

"I can't look at it without imagining him jumping," says Sarah Cherny, a resident at Stanford Hospital, whose partner, Phil Holsten, a 33-year-old physician, died on Oct. 26, 2004.

Today, the arguments against building a suicide barrier are the same as the original arguments against building the bridge itself, Cherny notes: It will be ugly and it will cost too much. "They are parallel arguments, separated by 70 years," she says.

Advocates believe that a barrier communicates two things: first, that the community cares, and then, a basic message -- that it's impossible to jump.

"At that moment, that message is as important as the first," Cherny says. "It's too late for the person I lost, but it's not for the thousands of people who would jump in the future, and the thousands of people their deaths would affect."

One passionate advocate for a barrier is author Danielle Steel, who wrote "His Bright Light: The Story of Nick Traina," about losing her son to suicide. (Steel's son did not jump from the bridge.)

"I have heard the argument that a suicide barrier would be ugly. Hearing that startles me," Steel told The Chronicle. "Do we care? How beautiful are motorcycle helmets? Shin guards? The guard prizefighters wear to protect their teeth?"

"I would build the barrier myself with my own hands if I could spare one mother, one friend, one father, one sibling from living what my family went through," Steel said.

"It says in the Talmud that to save one life is to save the world entire. Let's save as many as we can. What have we got to lose? The view. I'd rather lose the view than that one life. And if it were someone you loved, I suspect so would you."

The bridge was taken into account by Dr. Herbert Hendin, medical director of the American Foundation for Suicide Prevention, in his 1984 book, "Suicide in America."

"Leaving the bridge without a protective fence seems to imply a social sanction for those who would jump," Hendin wrote.

"Similarly, failure to restrict access to guns and drugs conveys the message that we are willing to accept the consequences of their uncontrolled use. Our policy choices should provide clear statements that we do not encourage destructive and self-destructive behavior, and equally clear notice that we value constructive ways of dealing with the pain and rage life contains."

When access to lethal means is limited, the number of suicides is reduced.

The American poet Sylvia Plath committed suicide in 1963 while living in England by breathing fumes from a coal-gas oven. This had become an easy and, thus, common method of suicide. That same year, the British government found a solution: Highly toxic coal gas was replaced with less lethal natural gas. Over the next 15 years, the suicide rate fell by one-third.

The assumption that suicide is not preventable is an enabling one. It enables the public to remain passive.

The story of Janet Marshall Wilson is one of many that explode that assumption.

One afternoon nearly 30 years ago, Wilson washed the dishes, walked out of her Oakland apartment and drove to the Golden Gate Bridge. She parked on the Marin side and left the car unlocked with the keys and her wallet under the seat.

"It was overcast, windy and kind of scary," Wilson recalls. "I was up there a long time." First she was trying to determine where to jump without landing in the dirt; then she began reconsidering.

Two bridge patrol officers drove up. "What are you doing?" She told them she was looking for the best place to jump. They escorted her to a San Francisco hospital.

"It was totally impulsive," she says of the attempt. "I left my cat behind, and I loved my cat."

She has suffered relapses of the bipolar disorder that afflicts her (this near-jump was her eighth serious attempt), but her suicidal impulses are under control now, in part because of medication.

"I still feel suicidal on a regular basis, but now I also have cognitive tools to deal with it," she explains. "I have learned how to not act on the urges."

Wilson is grateful to those bridge patrol officers. She went on to earn a law degree and now, at 55, is senior director of Patients' Rights for Mental Health Consumer Concerns, an organization that represents patients in administrative hearings in three counties.

Another survivor who has found a way to help others is Ken Baldwin of Angels Camp in Calaveras County. Baldwin jumped from the Golden Gate Bridge in 1985. Prone to depression since his teen years, Baldwin, at 28, had become overwhelmed by work pressures.

"There was nothing to stop the internal monologue of 'You're bad! You're a loser,' " he said in an interview with The Chronicle. "If there's nothing to stop that, it gets worse. It's a mental illness, and you don't see the mental illness when you're in it. I really believed that once I was gone, my family would be better off."

As his depression deepened, he thought of the bridge. "I thought that jumping from the bridge was statistically pretty much a slam dunk," he recalls. "I didn't want to shoot myself or hang myself. I didn't want that aftermath, where people are traumatized by what they find."

On his way to work one Wednesday, he drove to the bridge instead. "It was 10 a.m., a gorgeous day with no clouds, no fog. I put money in the meter and just started walking."

When he vaulted over the rail, he says, "I remember seeing my hands and thinking, 'This is the wrong thing to do!'"

The Coast Guard picked him up. That night, while he was in intensive care at Letterman Hospital, going in and out of consciousness, he heard the doctor tell his wife that he had a 50-50 chance, depending on whether he wanted to live.

"I knew that I wanted to live from the moment my hands left the bridge," he told them.

Therapy helped. "It was short but effective, because my wife and I were both committed to saving my life," he says. "I've never been depressed since then. I've had episodes of anxiety, but I feel them as temporary, whereas depression feels permanent."

He credits his wife with saving his life by standing by him. "She is the best thing that ever happened to me.

"One of the things that made it easier for me is that everybody knew," Baldwin notes. "I was sad that it came to that, but I was never ashamed of it."

For 12 years, he has taught drafting and animation at Bret Harte Union High School. It's a job he loves. And each semester, he tells the kids the story of his suicide attempt and recovery.

"Then I give them 20 minutes to ask any questions they want about depression. That way, it's not a secret. It's not a big deal."

Behind his desk at school hangs a schematic drawing of the bridge. "I'll never get rid of it. It's a reminder that there are two parts to my life -- before the jump and after the jump," he says.

"I'm the luckiest guy in the world. That's my mantra."

Each year, hundreds of thousands Americans survive suicide attempts.

Even after such a violent act, "it is possible not only to recover from being suicidal, but it is possible to lead a rich, fulfilled life afterward," Sonoma therapist Heckler insists.

"During and after their recovery, people become spiritual in the most fundamentally important way -- they give back what they have learned," he says.

"When people come out of this experience, they don't say, 'I want to bulk up my 401(k)' or 'I want to build a second house in Mexico.' They've been touched very deeply," Heckler says.

After recovering from the despair of a suicide attempt, "people are changed at that point, and people want to give back," Heckler adds.

"It's from the heart."

SUICIDE

PREVENTION RESOURCES

CRISIS CENTERS and HOT LINES

National Suicide Prevention Lifeline:

(800) 273-8255.

National Suicide Hotline: (800) 784-2433.

Asian Community Mental Health Services, Contra Costa: (510) 970-9750 for information in most Asian languages.
www.acmhs.org

Asian Community Mental Health Services, Oakland: (510) 451-6729 for information in most Asian languages.
www.acmhs.org

Contra Costa Crisis Center:

Hot line (24 hours): (800) 833-2900; grief counseling (800) 837-1818.

Web site: www.crisis-center.org

Crisis Support Services of Alameda County:

Hot line (24 hours): (800) 309-2131.

Web site: www.crisissupport.org

Suicide-attempt survivors group:

Call (510) 420-2460 during business hours.

Marin County Family Service Agency,

Suicide Prevention and Counseling Services:

Hot line (24 hours): (415) 499-1100.

San Francisco Suicide Prevention:

Hot line (24 hours): (415) 781-0500.

Web site: www.sfsuicide.org

Linea Apoyo (Spanish-language crisis line):

(415) 989-5212 (6 to 10 p.m. Monday-Friday).

Survivors of Suicide Support Group: (415) 984-1900.

Suicide and Crisis Service, Santa Clara County Hot line (24 hours): (408) 279-3312.

North county (toll free): (650) 494-8420.

South county (toll free): (408) 638-2482.

Web site: www.sccsacs.org

Youth & Family Enrichment Services,

San Carlos 24-hour crisis hot line: (800) 784-2433. Web site: www.crisiscenter.cc or www.yfes.org Trevor Project Gay Teen Helpline: (866) 488-7386. Web site: trevorproject.org

GOLDEN GATE BRIDGE

SUICIDE BARRIER INFORMATION

To get involved and learn more about suicide:

Visit Psychiatric Foundation of Northern California Inc., www.pfnc.org

To learn more about the Golden Gate Bridge Suicide Barrier Study: Visit www.goldengatebridge.org, click on Current Projects.

To receive e-mail updates on the Suicide Barrier Study: Visit www.goldengate.org, click on Contact Us.

To donate to the Golden Gate Bridge Suicide Barrier Study: Write to GGB Suicide Barrier Study Fund, P.O. Box 9000, Presidio Station, San Francisco, CA 94129.

Contact the Psychiatric Foundation of Northern California, 251 Post St., Suite 312, San Francisco, CA 94108; phone (415) 391-7770; or visit www.pfnc.org

WEB SITES

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

American Association of Suicidology: www.suicidology.org

American Foundation for Suicide Prevention: www.afsp.org

American Psychiatric Association (co-sponsor of the National Public Education Campaign on Clinical Depression): www.psych.org

American Psychological Association: www.apa.org

California Department of Education: www.cde.ca.gov (type in: Youth Suicide Prevention).

Depression and Bipolar Support Alliance: www.dbsalliance.org

National Asian American Pacific Islander Mental Health Association: www.naapimha.org

National Centers for Disease Control and Prevention: www.cdc.gov

National Institute of Mental Health: www.nimh.nih.gov (type in: Youth Suicide Prevention).

National Organization for People of Color Against Suicide: www.nopcas.com.

National Strategy for Suicide Prevention of the National Mental Health Information Center, U.S. Department of Health and Human Services: www.mentalhealth.org/suicideprevention/government.asp.

Suicide Prevention Action Network: www.spanusa.org.

Suicide Prevention Resource Center: www.sprc.org.

EVENTS

Nov. 19: National Survivors of Suicide Day, "a day of healing and empowerment," sponsored by the American Foundation for Suicide Prevention. National Webcast connecting 100 communities nationwide will be streamed live over the Internet. For information, visit www.afsp.org

BOOKS

Fine, Carla. "No Time to Say Goodbye: Surviving the Suicide of a Loved One" (2000, Broadway Books).

Head, John. "Standing in the Shadows: Understanding and Overcoming Depression in Black Men" (2004, Broadway Books).

Heckler, Richard A. "Waking Up Alive: The Descent, the Suicide Attempt and the Return to Life" (1996, Ballantine).

Jamison, Kay Redfield. "Night Falls Fast: Understanding Suicide" (2000, Vintage).

Smolin, Ann and John Guinan. "Healing After the Suicide of a Loved One" (1993, Fireside).

Steel, Danielle. "His Bright Light: The Story of Nick Traina" (2000, Delta).

Styron, William. "Darkness Visible: A Memoir of Madness" (1992, Vintage).