

**WHY
PEOPLE
DIE
BY
SUICIDE**

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Harvard University Press
Cambridge, Massachusetts, and London, England
2005

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Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

Joiner, Thomas E.

Why people die by suicide / Thomas Joiner.

p. cm.

Includes bibliographical references and index.

ISBN 0-674-01901-6 (cloth : alk. paper)

1. Suicide. 2. Suicide victims—Psychology.
3. Suicide victims—Family relationships.
4. Children of suicide victims. I. Title.

HV6545.J65 2005

616.85'8445—dc22 2005051347

This book is dedicated to those who have lost someone to suicide, and especially to those who have been supportive of survivors like me, including, for example, my friends from high school, who did all the right things.

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LOSING MY DAD

PROLOGUE

In 1990, close to a million people died by suicide worldwide. My dad was one of them.

Of course my dad's death has deeply affected both my feelings about suicide and my understanding of it. My feelings about suicide stem partly from people's reactions to my dad's death. Some friends and family reacted in ways that I still treasure—the sorts of things that make you proud to be human. Others' reactions were not quite up to this very high standard.

My intellectual understanding of suicide evolved along a different track than my feelings. Informed by science and clinical work, I came to know more than most about suicide—on levels ranging from the molecular to the cultural. But here too, my dad's death never left me, for the simple fact that I could evaluate theories and studies on suicide not only by formal professional and scientific criteria, but also by whether they fit with what I know about my dad's suicide. As I will point out, a nagging fact about my dad left me unsatisfied with existing theories of suicide and pushed me to think in new ways about his death and about suicide in general. All of this will become

clear throughout the book, but first, let me turn to the details of my dad's suicide.

In Atlanta in the early morning hours of August 1, 1990, my dad was sleeping, or trying to, in the bed that was mine as a teenager. He wasn't sleeping with my mom; I think his snoring had become too much of a problem. I was a graduate student in Austin, Texas at the time.

It was summer, so my dad must have been alternately cold and hot in that bed—cold when the air conditioning kicked in (because the vent was right next to the bed), hot when it turned off (because that room was not well insulated). My dad rose from the bed. I wonder if he made some silent gesture, like putting his hand against the wall that separated my old bedroom from his old bedroom, where my mother lay asleep. He walked past the room he had shared with my mom, and then past my younger sisters' rooms, where they lay asleep. Here again, did he hesitate as he passed their rooms, I wonder? Was he prepared with a cover story in case my mother or sisters woke up and asked him where he was going?

He went downstairs. Before going out the door, he must have pulled open a drawer or two in the kitchen, looking for a large knife. Or maybe he got the knife from his fishing tackle in the garage. It surprises and distresses me even now when I can't remember or never knew a key detail like this about my dad's death.

He walked outside, got into his van, and drove a half-mile or so to the lot of an industrial park. He prepared no note. At some point before dawn, he got into the back of the van and cut his wrists. His self-injury escalated from there—the cause of death from his autopsy report is “puncture wound to the heart.” These details remain very painful for me, but they are important—as will become clear, people appear to work up to the act of lethal self-injury. They do so over a

long period of time, by gradually accumulating experiences that reduce their fear of self-harm; and they do so in the moment, by first engaging in mild self-injury as a prelude to lethal self-injury.

My dad's body was not discovered until about 60 hours after his death, which necessitated a closed casket funeral. So the last time I saw my dad was in June of 1990 when I joined the family on a beach trip. We fished and talked about the NBA finals and a large stock deal my dad was proud to have recently pulled off. We played board games in the van on the way home—the same van in which my dad died. I am still stunned to think that six weeks later he would leave the house and walk away from us forever. He never said goodbye to my mother, my sisters, or me.

In the months before his death, my dad had parted ways with the company in which he had formed his professional identity and, indeed, much of his identity as an adult. The position with this company was one of influence, and after leaving, he struggled to regain his former feeling of effectiveness. I think this struggle was exacerbated by some callous and self-serving behaviors by those remaining at the company, who my dad believed were friends.

The first family member I saw after my dad was found was my Uncle Jim, my dad's older brother. He met me at the gate at the Atlanta airport. He must have been heartbroken and incredibly confused about how his very successful little brother could have suddenly died by suicide. He shouldered this shocking burden and put it aside, at least for a while, to pay attention to how I was feeling and, in the days following, to how my mom and sisters were feeling. Jim didn't understand much about suicide—I think he would have said that himself—but some people don't require understanding in order to act right. They just let compassion take over; that's what my Uncle Jim did.

The relation of understanding suicide and “acting right” about it is interesting to explore. In thinking back over people's reactions to my

dad's death, my sense is that no one understood it, really. To some people, like my Uncle Jim, understanding didn't matter and wasn't a barrier to acting with real generosity of spirit. To others, the lack of understanding seemed an insurmountable barrier, so that instincts toward compassion were short-circuited. They were caught up in their minds about how to understand this shocking death and what to say to me and my family. One contribution of this book, I hope, is to provide understanding, so that those who need it in order to unleash their caring and generosity will have it.

Ironically, those whose reactions were the least helpful were those who might have known better—those who, unlike my Uncle Jim, got tripped up by intellectual lack of understanding. All that was needed was eye contact and phrases like, “Man, I’m real sorry about what happened to your dad,” as well as a willingness to interact with me like I was the same person they always knew. My friends from high school all did this by instinct, both at the time of my dad’s death and in the weeks and months following. For instance, at my parents’ house after my dad’s funeral, one of my high school friends told a story about how his girlfriend had recently “dropped him like a rock.” The phrase probably is not very funny to read, but there was something about his tone and facial expression that was extremely funny—I’m sure that was the first time I had laughed in the several days since my dad died. As another example, a few weeks after my dad’s death, I went to dinner with a girl I had admired very much in high school, but with whom I had lost touch. She was among the first people I told about the exact details of my dad’s death, and her understanding and composure encouraged me to talk to others.

By contrast, my peers and professors in psychology—yes, psychology of all things—struggled to get it right. A girlfriend seemed more concerned about tainted DNA (“suicide’s genetic, right?”) than about how I was coping. Peers and professors ignored my dad’s death altogether. One professor, a psychoanalytically oriented clinical su-

pervisor of mine, was particularly inept and seemed unable to say anything at all in response to my dad's suicide. He tried to hide his inability behind a psychoanalytic stance of neutral silence, but never was that charade more apparent and more pitiful. These people, I think, needed to intellectually grasp suicide before they could do anything else . . . and since they couldn't grasp it intellectually—few can—their otherwise good hearts were hampered. It is also possible they were just too scared to deal with the topic. I hope this book frees good hearts in those with a need for intellectual understanding and steels those who need courage to help the bereaved.

Among my psychology peers and professors, there were people who, like my Uncle Jim, just did what was right. A different psychoanalytic supervisor was among the most understanding and helpful of anyone I encountered in the difficult days and weeks following my dad's death. A week or two after my dad's death, still another person, my professor Jerry Metalsky, paused as we were working on a manuscript, looked me in the eye, and said with real feeling, "I'm just so sorry about what happened to your dad." These simple words choked me with tears at the time, and can still bring tears to my eyes to this day.

One of my peers, Lee Goldfinch, found my parents' phone number in Atlanta and called me, as it turned out, on the day of my dad's funeral. This alone set him apart, but as we talked for a few minutes about what happened and how my family and I were doing, Lee wept in a very quiet and selfless way. That brief conversation with Lee represented one of the times in my life that I have felt most understood, most listened to.

Some experiences within my family exacerbated the pain of my dad's death. Just as some of my psychology peers and professors struggled for understanding and thus couldn't quite hit the right note, some in my family faced the same difficulty. For example, one relative counseled another to tell others that my dad died from a

heart attack. The instinct to lie about suicide is not rare. In one study, 44 percent of those bereaved by suicide had lied to some extent about the cause of death, whereas none of those dying from accidents or natural causes lied.¹

Indeed, those who die by suicide will occasionally advise in suicide notes that others lie about their deaths. Edwin Shneidman² gave this example: “Please take care of little Joe because I love him with all of my heart. Please don’t tell him what happened. Tell him I went far away and will come back one of these days. Tell him you don’t know when.” This example shows why it is not rare and why it is understandable that people sometimes lie about suicide.

Lying about suicide is just one form of misunderstanding it. Another, more pernicious form is blame, and in this regard, my own experiences were quite mild—I am aware of no one who blamed my mother, my sisters, or me for my dad’s death. Unfortunately, others are forced to go through this particular form of hell. In Shneidman’s case example of Ariel, Ariel’s father had died by self-inflicted gunshot wound in what was very likely a suicide (but there was some possibility of the death being an accident). Ariel wrote, “Well, my aunt . . . told me that I had killed my father, and he had committed suicide because of me.” Almost exactly three years after her father’s death, Ariel herself nearly died by setting herself on fire.

Misunderstanding and even taboo about suicidal behavior are rampant. Karl Menninger³ said, “So great is the taboo on suicide that some people will not say the word.” The staff of the magazine that promotes prominent research at my university wanted to run a story on my suicide research. They pondered featuring the work on the magazine’s cover, but decided against it—they could not imagine prominently displaying the word “suicide,” although they ran the article itself.

These same attitudes are common among family members of those who engage in suicidal behavior. Decades ago, Menninger,⁴ in

describing relatives' reactions to the hospitalization of depressed and potentially suicidal patients, commented, "Patients committed to our care in the depth of a temporary depression in which they threatened suicide would begin to improve, and relatives thereupon would seek to remove them, utterly disregarding our warning that it was too soon, that suicide was still a danger. Frequently they would ridicule the idea that such a thing might be perpetrated by *their* relative." Menninger collected a large file of newspaper clippings reporting the deaths by suicide of such patients.

I understand why people tiptoe around suicide or even lie about it outright. This has never been clearer to me than when my oldest son, Malachi (named after my dad's ancestor who was the first in our family to come to America), asked me why my dad was not alive. He was three years old at the time. Luckily, I had anticipated this question, but I thought I'd have another two or three years to think about my answer. I took a deep breath and said something like, "Well, you know how people can get sick, like when you have a cough or your stomach hurts. People can get sick like that in their bodies, and they can also get sick in their minds, sometimes very sick. My dad got very sick like that in his mind; he got to where he was so sad and lonely that he didn't want to live anymore. When people feel like this for a long time, they sometimes think about hurting themselves or even killing themselves. That's what my dad did."

Malachi's reaction was similar to the many times he had learned a surprising fact about nature from me. With the same sense of innocent surprise, not tinged much at all with negative emotion, he said, "You mean he killed himself?" much as if he were saying, "You mean there are fish that can taste things with their *skin*?" (which there are and which we had just read about). I answered (to the first question), "Yes, he did. That can happen sometimes when people feel so sick in their minds."

I was ready for fallout. For example, I imagined what I would say

to a teacher or parent connected with Malachi's preschool who might approach me and say, "Malachi's been telling the other children about people killing themselves." I prepared for what I would do if Malachi became worried or upset about this (might his own dad kill himself?) or had bad dreams. None of this occurred, but it worried me, and so I understand why people lie about suicide, though the disadvantages far outweigh the advantages.

Every now and then Malachi will surprise me with a comment or a question related to my dad's death. Perhaps the one that touched me the most occurred about a week after our first conversation. We were about to go outside to play when he abruptly turned and said, "When *you* were a little boy, *I* was *your* dad." More than just the timing of the comment, there was something in his expression and tone that made me see that he understood that it was painful that my dad was gone, and he wanted somehow to lessen the pain. He did.

When he was four or five, he asked me how my dad died by suicide, to which I replied that he cut himself. In another conversation when he was six, in which I mentioned the specific cause of my dad's death, Malachi pointed out, in a somewhat playful tone he uses when he believes he's discovered something that I didn't want him to know, that earlier I had only said my dad cut himself—I had never been more specific. Had I lied altogether, Malachi eventually would have caught me in my lies.

Allow me to emphasize that approximately one millionth of the conversations between us are about my dad's death. The topic ranks far, far behind topics like school, friends, various sports, the antics of his charismatic little brother Zekey, science, nature, his mother's ability to do magic tricks, and things like fish that can taste with their skin. But I have been open about it with him, as I will be with Zekey, and I have not regretted it at all. And now, when I talk about the topic with others, it's really very easy; if I can tell the three-year-old that I love most in this world (along with his brother and mother), I can tell anyone.

The idea that suicide is a shameful act of weakness nagged at me in the years following my dad's death. My dad was not weak in any sense of the word. On the contrary, he had a stoic toughness about him that seemed to inure him to physical pain. The anecdotes are numerous—and I'm confident that there are more I never knew about or have forgotten. When he was three, he tried to balance by standing on an upright milk bottle, which broke and severely cut his Achilles tendon (and which the babysitter packed with chimney soot and wrapped). As an adult, he was a Marine sergeant. When I was seven, my dad took our family skiing. I'm not sure, but I think it was the first time he had ever skied. He broke his leg. A few years later he was jogging with our family dog Jupiter. Jupiter cut in front of my dad, who tripped and ruptured his Achilles tendon. Still later, he was badly injured in a boating accident.

The idea that suicide requires a kind of courage or strength has implications not only for the causes of suicide—a focus of this book—but also for the public view of those who die by suicide. The truth about suicide may prove unsettling—it is not about weakness, it is about the fearless endurance of a certain type of pain. Perhaps this view will demystify and destigmatize suicide and perhaps even the mental disorders associated with suicide, like mood disorders.

There is no question but that my dad had a mood disorder, and one of relatively long duration. I remember being puzzled as a young child that my dad spent most of the day in bed once, but wasn't physically sick. Later, I imagined that he may have had too much to drink the night before. But that didn't fit. I never knew him to drink to excess. I now understand that he was in the middle of a depressive episode.

Near the end of his life, he seemed to have even more obvious depressive episodes, especially around the Christmas holidays. When I would come home from college for the holidays, my dad would sometimes pick me up from the airport, and his depression was often palpable the moment I saw him. On the drive home from the airport,

I would think of whatever I could to draw him out, but would get only monosyllabic replies. Though I'd keep trying, I was relieved when the twenty-minute drive was over. And I was glad—no, saved is more like it—by the relief provided by seeing my old friends from home.

My dad and I often watched sports together when I was a child. Some of my earliest and fondest memories of him are when he and I would lie next to each other on a sofa watching football or basketball games. He'd have to pull the sofa out from the wall so we would both be able to see. We'd be under the same dark red wool blanket, with a Bulldog on it and GEORGIA underneath the Bulldog in big block letters. Years later, home from college for the holidays, I'd often arrange for or be given tickets by friends and family to various sporting events. I'd invite my dad, again in an attempt to draw him out, and again with no success. The twenty-minute ride from the airport became the three-hour stay at a football game.

He also had what I now see as frequent episodes of what is called hypomania, a milder form of what is known as a full-blown manic episode. Manic episodes are discrete periods of symptoms; the episodes are phasic—they come and go—and they include grandiose, often delusional ideas, expansive planning, elated mood, and boundless energy (e.g., going without sleep for days). The sleep symptom in bipolar disorder is notable. People experiencing manic episodes are too busy to sleep. Irritability also can characterize manic episodes. The combination of severe manic phases and severe depressive phases is known as bipolar I disorder in the psychiatric nomenclature.

My dad never had frank manic phases, but he did experience episodes of hypomania, which can be viewed as an attenuated form of mania. Someone with hypomania may sleep every night (but for a shorter time than usual), may express quite positive self-views (but not seem frankly grandiose), and may have a noticeably upbeat mood

(but not seem extremely elated). The combination of hypomania and severe depressive phases is known as bipolar II disorder in the psychiatric nomenclature, and I now see that this was what my dad had. Bipolar II disorder is a serious condition; approximately as many people with bipolar II die by suicide as those with bipolar I. Some estimate that up to 10 percent of those with bipolar disorder of either type die by suicide.

I believe most of my dad's hypomanic episodes occurred in the spring, which is one of the most common times for manic or hypomanic phases to occur. The clearest example was from the spring of 1989—about fifteen months before his death by suicide—when my dad visited me, somewhat unexpectedly, in Austin, Texas. I accompanied him all day as he met with various officials of state and local government to discuss things related to real estate, taxes, and the like. These busy people all saw my dad on very short notice—a testimony, I now know, to his truly considerable talents and ingenuity. To a person, they were also perplexed about just what my dad was talking about (not to mention why his long-haired son in high-top basketball shoes was accompanying him)—evidence, I now see, of his hypomania.

On this trip, my dad also saw the hovel that my friend and I were living in. It was truly bad, but the rent was incredibly low and I didn't mind. I figured my dad wouldn't mind it too much either. He didn't seem to; all he said was something like, "don't tell your mother." But it occurred to me later that this may have been a real disappointment to him; he may not have understood that even the best of graduate students live in such places and may have wondered what had become of his Princeton-educated son. It haunts me to imagine that he counted my circumstances as his failure. It is agonizing that he can't see how and with whom I live now.

During all the years my dad had these symptoms, he was not treated until within a year or so of his death. Partly this was because

WHAT WE KNOW
AND
DON'T KNOW
ABOUT SUICIDE

1

The last compelling theory of suicide appeared approximately fifteen years ago. The number of other prominent and coherent theories in the decades or even centuries before that can be tallied on one hand. This is a strange state of affairs for a phenomenon that kills millions.

A new theory is needed that builds on existing models and provides a deeper account of suicidal behavior to explain more suicide-related phenomena. This is a very tall order, because the extent and diversity of facts related to suicide are intimidating and baffling. For example, suicide is far more common in men than in women . . . except in China. In the United States, there has been a recent increase in suicide among African-Americans—specifically, young black men. And yet, the demographic group at highest risk is older white men. Female anorexics, prostitutes, athletes, and physicians all have elevated suicide rates. A theory that can account for these diverse facts would be persuasive.

Such a theory would not only advance scientific knowledge, but deepen the understanding of suicidal behavior among clinicians who need to assess risk, intervene in crises, and design treatment and pre-

vention protocols. It would also help those who have lost a loved one to suicide, who suffer much misunderstanding.

In this chapter, I describe some of my own clinical work and the supervision of others' clinical work with suicidal patients. In the clinical literature, suicide is often described as an "urgent," "vexing," or "pressing" issue, one that preoccupies clinicians. Suicide *is* an urgent issue—it kills people—but urgency need not entail panic. Suicide can be understood in ways that resolutely point to clear clinical decisions . . . given, that is, a full explanatory model. My and others' clinical experiences with suicidal patients will highlight how a comprehensive account of suicide would have reduced confusion and panic and facilitated clinical progress.

This chapter also touches on some of my scientific work on suicide. My research group is one of many that have produced new and important findings regarding suicide. The chapter will include some basic scientific findings on suicide produced by my and other research groups—facts that any compelling account of suicide must explain.

I also summarize existing models of suicide in this chapter—theoretical accounts that have been developed to explain some of these facts. One of the best ways to evaluate a theoretical model is the number of facts it can explain, and some of these models are more successful than others, as we shall see. My hope is that this book's explanation of suicide will save people some of the misunderstandings my family and I went through, will refine clinicians' approach to treating suicidal behavior, and will set a scientific agenda for the study of suicide. In the process, some interesting questions will be raised and addressed. For example, should family members tell the truth about the cause of death when a loved one has died by suicide? What constitutes a proper definition of suicide itself? How are we to understand the deaths of those who jumped from the World Trade Center towers' upper floors on September 11, of the September 11

terrorists, and of those in mass suicides in cults? What protects most women from suicide, and yet, why do some very different subgroups of women—such as prostitutes and physicians—share similarly high suicide rates? Why are older, white men the demographic group in the United States most vulnerable to suicide? Why do suicide rates decrease in the United States during times of national crisis and decrease in a particular city when the city's professional sports team is making a championship run? What are the constituent parts of the genuine desire for death? These and other questions will be raised and addressed throughout the book.

Notes from the Clinic

My first job after getting my doctorate was as an assistant professor of psychiatry at the University of Texas Medical Branch at Galveston. What a blessing this job was in many ways. I saw many psychotherapy patients and worked with skilled psychiatrists who taught me a lot about the biological bases of mental disorders. Biology appears to play some role in why people die by suicide, a fact I will address later in this book. But they also taught me something more—an attitude about suicide risk in patients that was neither dismissive nor alarmist. The alarmist position is perhaps the easiest to understand—this is the idea that whenever someone mentions suicide, it is a life-threatening situation and alarms should be sounded. This idea occurs in settings in which staff see relatively few people with serious mood disorders. In settings where serious mood disorders are common, people understand that suicidality is just part of the disorder; the majority of people who experience mood disorders will have ideas about suicide, and the vast majority will neither attempt suicide nor die by suicide. If 911 were called in each of these cases, a “cry wolf” scenario would quickly develop. Alarmists are making a mistake in conditional probability. Given the existence of a suicidal

thought or behavior, they mistakenly estimate the probability of death or serious injury by suicide to be higher than it is.

Although alarmists make a mistake, it is not hard to see why they do. When people have ideas about suicide, it is quite true that risk is elevated compared to people who do not have suicidal ideas. Moreover, suicide is irreversible, and everything possible should be done to prevent it. Alarmists overreact, but they are doing so in the safe direction; “better safe than sorry,” they might say.

The alarmist problem is easy to notice in training clinics. Most of the pages I receive on my beeper are from therapists at the training clinic I direct who are worried that they should do more for a patient with suicidal symptoms. When I return the call, I ask a series of questions to see if the therapist is meeting the standard of care. In our clinic, meeting the standard of care is routine. And so I will then say, “Well, you’ve done everything I would’ve done; I wonder, what else is it that you think you’re supposed to do?” The answer is often, “I’m not sure, I just have this feeling that there’s something else I should do.” Then I’ll say, “Well, there’s not; but don’t lose that feeling, because it will ensure that you regularly do what’s best for patients; also, though, don’t let that feeling get out of hand, because it can burn you out, plus, ultimately these choices are not up to us, they’re up to patients.” Make no mistake, the standard of care is important—at times even life-saving—and therapists are expected to meet it rigorously, including involuntary hospitalization of the patient if needed. But beyond that, responsibility for life choices resides with patients. Therapists who see this are likely to enjoy their work more, to not be distracted by one patient when dealing with another, and, importantly, to enjoy their nonwork time as well.

The alarmist attitude is understandable but, especially if exaggerated, mistaken. Those who take a dismissive approach make a mistake in the opposite direction. They become blasé about suicidal behavior, often attributing it to manipulation or gesturing on the part

of the potentially suicidal person. This problem is acute when it comes to the often misunderstood borderline personality disorder, which is characterized by a long-standing pattern of out-of-control emotions, interpersonal storminess, feelings of emptiness, and impulsive behaviors, including impulses toward self-injury. Some clinicians take a dismissive attitude toward patients with this disorder because they believe that these patients merely “gesture” suicide. In other words, they engage in suicidal behaviors, such as cutting themselves, but do not really intend to kill themselves; instead, they only intend to provoke or manipulate others. I wish this were true, but it is not—approximately 10 percent of patients with this disorder end up dying from their suicidal gestures (comparable to the rate for patients with mood disorders). The following quotation illustrates this misunderstanding:

The borderline patient is a therapist’s nightmare . . . because borderlines never really get better. The best you can do is help them coast, without getting sucked into their pathology . . . They’re the chronically depressed, the determinedly addictive, the compulsively divorced, living from one emotional disaster to the next. Bed hoppers, stomach pumpers, freeway jumpers, and sad-eyed bench-sitters with arms stitched up like footballs and psychic wounds that can never be sutured . . . Borderlines go from therapist to therapist, hoping to find a magic bullet for the crushing feelings of emptiness.¹

This characterization is demonstrably false. Patients with borderline personality disorder *do* get better. A persuasive study found that 34.5 percent of a sample of borderline patients met the criteria for remission at two years, 49.4 percent at four years, 68.6 percent at six years, and 73.5 percent over the entire follow-up. Only around 6 percent of those who remitted then experienced a recurrence.²

The dismissive attitude is dangerous for another reason. A main thesis of this book is that those who die by suicide work up to the act.

They do this in various ways—for instance, previous suicide attempts—and all of these various ways have the effect of insulating people from danger signals. They get used to the pain and fear associated with self-harm, and thus gradually lose natural inhibitions against it. Clinicians' dismissive attitudes have the potential to model a blasé attitude about self-harm. If clinicians blithely get used to suicidal behavior, their patients may vicariously do so as well.

The psychiatrists at my first job balanced the alarmist and dismissive positions very well. They clearly understood the danger and horror; in fact, most of them had had a patient who had died by suicide. They knew the standards of care for suicide risk assessment and the treatment of suicidal behavior, and they followed them faithfully. But they understood the limits of their interventions, they understood people's ultimate autonomy, including their freedom to occasion their own death if they really were committed to doing so. My impression was that these psychiatrists did their job well during the day, and slept well at night.

Consider for example the case of Gayle (a false name). In retrospect, I understand Gayle's situation clearly, but when I was seeing her, I was uneasy. She was the sort of patient who seemed potentially self-destructive. Indeed, she often fantasized about death by suicide, envisioning a particularly graphic means—severing her hand with a machete and bleeding to death (people have died in just this way, incidentally). She even owned a machete. This would be enough to concern any clinician, and I was no exception. I recommended that Gayle be hospitalized, so that she would remain safe while treatments for her substantial depression were started.

She refused hospitalization and also refused antidepressant medicines; she would agree only to psychotherapy. An initial question, then, was whether I should hospitalize her involuntarily. I had the sense that this would not be best, but I was having trouble putting my finger on exactly why she did not require hospitalization. After

consultation with colleagues, I was reminded of some mildly reassuring facts. Gayle was around forty-five years old and had never attempted suicide. She had had plenty of time to have tried it, and yet had not. This is no guarantee. There are people who at age forty-five or even sixty-five attempt suicide for the first time and die. Still, the fact that she had not had previous experience with suicidal behavior was mildly reassuring. Her gender was another mildly reassuring factor—women are a lot less likely to die by suicide than are men. Also somewhat reassuring were her connections to life. There were things that she was proud of regarding her professional life, and more important, she was deeply connected to her young son. She spontaneously mentioned these things as I questioned her about suicide potential.

Gayle was also the rare person who clearly met criteria for a major depressive episode but who had an absence of depressed mood. In a study of young adults my colleagues and I conducted, this pattern was found to occur in only about 5 percent of those who were in a depressive episode. Recent work has shown lack of depressed mood to be a positive prognostic indicator among depressed people; that is, they tend to get better quicker and to have good outcomes.³

Throughout this book, I will argue that the acquired ability to enact lethal self-injury is crucial in serious suicidal behavior. People are not born with the developed capacity to seriously injure themselves (although they are born with factors, including certain genes, that may facilitate the future development of this capacity). In fact, if anything, they are born with the opposite—the knee-jerk tendency to avoid pain, injury, and death. That is, people have strong tendencies toward self-preservation; evolution has seen to that. Through an array of means described later, some people develop the ability to beat back this pressing urge toward self-preservation. Once they do, according to the theory laid out in this book, they are at high risk for suicide, but only if certain other conditions apply—namely that they

feel real disconnection from others and that they feel ineffective to the point of seeing themselves as a burden on others. These factors, like the acquired ability to enact lethal self-injury, are covered in detail in later chapters of the book.

I now understand clearly why Gayle made me feel uneasy, but also why she was not at particularly high risk for suicide. She had acquired the ability to enact lethal self-injury. A main way that people develop this capacity is through previous suicidal behavior. As noted already, Gayle had not engaged in such behavior. What I believe led to her developing this capacity was a long history of severe substance abuse, which included many painful and provocative experiences (another way to gradually beat back the instinct to survive). Her substance abuse had ended; she had been clean for around eight years when I saw her. But her earlier experiences had left various residues.

This ability in Gayle was manifested by her having a clear and detailed suicide plan, but especially in her sense of calm and her lack of fear about the plan. These were the things that made me want to hospitalize Gayle. Nevertheless she was not at particularly high risk for suicide, and the reason involves two other factors that I believe are required for serious suicidal behavior—thwarted belongingness and perceived burdensomeness. Gayle had a fairly well-developed circle of friends and was very connected to her son. There was no evidence that she felt fundamentally disconnected from others, and plenty of evidence that her sense of belonging was very much intact. Similarly, Gayle was a particularly capable woman; for instance, even when depressed, she was the office's top performer in her professional line of work. There was no evidence that she felt ineffective, certainly not to the point that she believed she burdened others.

Her sense of belonging and effectiveness buffered her, but it is important to note that this could have changed rapidly. People cannot develop the ability to lethally injure themselves quickly; the experiences that are required take time and repetition. By contrast, people

can quickly develop views that they do not belong or that they are particularly ineffective. Thus, in a case like Gayle's, suicide risk can quickly escalate. Repeated risk assessment is thus necessary in Gayle's case (and is a safe clinical practice anyway).

The case of Sharon (a false name) is interesting by way of contrast. When questioned about suicide risk, Sharon articulated no plan at all. When pressed a little on the question, she made statements like, "I can't imagine actually trying suicide, it's just that I have the sense that I'd be better off dead." Like Gayle, Sharon had never attempted suicide in the past, but unlike Gayle, she had no history of repeated painful and provocative experiences through which she might have acquired the ability to enact lethal self-injury. She thus did not have the setting condition for serious suicidal behavior, even though, as it turns out, she did have the other factors important in the current theory. That is, she felt she was a burden on others and felt disconnected from them. These feelings, combined with statements like, "I'd be better off dead" and with symptoms like sleep difficulty, clearly indicated a mood disorder, but her risk for suicide was slight. The thought never occurred to me that she should be hospitalized. Indeed, though she clearly had a mood disorder, it was of relatively moderate severity, and she remitted with less than two months of psychotherapy and stayed remitted for at least two years thereafter, which was the last time I contacted her.

The cases of Gayle and Sharon, especially when viewed through the lens of this book's theory on suicide, are informative regarding suicide risk assessment. Generally speaking, someone like Gayle is at chronically elevated risk, at least to some degree, because the capacity for serious self-injury already is in place. All that is needed for Gayle to engage in serious suicidal behavior if she chooses is a quick change in her feelings of connection and effectiveness. Accordingly, routine assessment of risk status is required with someone like Gayle. By contrast, someone like Sharon is unlikely to engage in serious self-harm because she has not beaten down the instinct to live. Even if

Sharon feels disconnected from others and ineffective, she lacks the capacity to translate the desire for death into action. These points will be expanded on in a later chapter on clinical implications.

Notes from Scientific Research

The science about suicide is not especially well developed and has certainly not permeated the public consciousness. I was reminded of this the other day at my sons' soccer game. There were five or so full-field games going on—approximately 150 people out on the fields. Off in the distance, lightning struck, and the field administrators decided to cancel the games. There was some grumbling about this decision of course, but everyone understood the rationale—lightning can be lethal.

But just how lethal is lightning? In other words, how many people die from lightning strikes? In fact, from 1980 to 1995, there were approximately eighty deaths per year from lightning strikes in the United States. During this same time period, there were more than eighty deaths *per day* from suicide.

Why do people scramble to prevent death by lightning strike but don't scramble in the same way to prevent death by suicide? The latter is approximately 365 times more common than the former. One could invoke bias or stigma against mental health problems, but I think a more mundane answer is available. It is fairly easy to understand how and why people die by lightning strike, and prevention is straightforward too—you just get out from under the weather. By contrast, it is not at all easy for people to understand how and why people die by suicide, and prevention is not clear-cut at all. To make the prevention of suicide more like the prevention of lightning strikes, people need a clearer understanding of how and why people die by suicide. This book is intended to provide such an understanding.

The example of lightning strikes does not really illustrate bias

against suicide; rather, it simply indicates that lightning is a well-characterized phenomenon and its prevention is straightforward. But in other examples, bias and stigma are detectable. In Tad Friend's 2003 *New Yorker* article on suicide at the Golden Gate Bridge, he points out that a main reason for community resistance to a suicide barrier fence (which would clearly save lives) is aesthetics. For the past twenty-five years, however, a large section of the bridge has been festooned with an eight-foot-tall cyclone fence directly above a site where tourists can walk below. The fence's purpose is to prevent people dropping things—including, to take a real example, bowling balls—on other tourists below. Friend cites the bridge's former chief engineer as saying that the fence is needed because "It's a public-safety issue." True enough, it *is* a public safety issue, but not one that has ever killed anyone, bowling balls notwithstanding. By contrast, around thirty people die by suicide each year by jumping from the bridge. The acceptability of a debris fence coupled with the unacceptability of a suicide barrier seems misguided and unfair.

To digress a bit, the stigma and taboo of suicide are topics that warrant their own book. The stigma, pervasive and enduring, can be found even in the seventh circle of Dante's *Inferno*. As A. Alvarez⁴ summarizes, "In the seventh circle, below the burning heretics and the murderers stewing in their river of hot blood, is a dark pathless wood where the souls of suicides grow for eternity in the shape of warped poisonous thorns . . . At the Day of Judgment, when bodies and souls are reunited, the bodies of suicides will hang from the branches of the [thorns], since divine justice will not bestow again on their owners the bodies they have willfully thrown away." According to Dante, my dad is, as I write this, *below* the murderers, and will hang from thorns for eternity—stigma indeed.

To return to the Golden Gate Bridge, aesthetics does not really provide a convincing explanation for the lack of a suicide barrier, but what about cost? As Friend points out, cost did not prevent the re-

cent construction of a barrier between the bridge's walkway and traffic, designed to separate bicyclists from traffic. This barrier cost 5 million dollars, and yet no bicyclist has ever been killed on the bridge. Five million dollars and zero deaths for bicyclists; zero dollars and over a thousand deaths by suicide: it is difficult to avoid the conclusion of stigma and bias.

Regarding knowledge about suicide and its prevention, much remains to be learned and to be done. Some facts are established, but even for these, fitting the facts into a coherent overarching theory has proven elusive. This book provides the outlines of one such theory. Any compelling explanation of suicide should shed at least some light on various established facts, including prevalence of suicide; the associations of suicide with age, gender, race, neurobiological indices, mental disorders, and substance abuse; impulsivity; and childhood adversity, as well as issues like treatment and prevention efforts and the clustering and "contagion" of suicide. Each of these topics is defined here and accounted for later, at least in part, by the theory proposed in this book.

Definition

One might imagine that defining suicide is relatively easy. Indeed, the dictionary definition could not be clearer—"the act of killing oneself intentionally." This definition seems to apply to my dad and many others who will be mentioned throughout the book, like the poets Hart Crane and Weldon Kees and the musician Kurt Cobain. But what about people on the upper floors of the World Trade Center who jumped to their deaths on September 11, 2001? At least fifty people died in this way, and the actual number is probably closer to 200. Did they die by suicide? According to the dictionary definition, they did, but according to the New York medical examiner and intuitively to many of us, they did not. All September 11 deaths at the World Trade Center were classified as homicides. What about the

September 11 terrorists, whose actions, in addition to all of their horrible consequences, caused the terrorists' own deaths? Did they die by suicide? Again, according to dictionary definitions, they did. But the terrorists themselves would more likely have characterized their deaths as martyrdom or casualties of holy war than as suicide.

Difficulties in defining suicide arise in other situations. Did Marilyn Monroe die by suicide, or was she killed? Virtually all the evidence points to suicide, but the idea of homicide resurfaces, often for spurious reasons.

How about people who die alone in single-car motor vehicle accidents who are later found to have been intoxicated at the time of death? We cannot know with certainty whether these deaths were intentional or accidental. One basis on which to make the designation might involve the facts of the accident, such as the angle at which the car was driven into a tree or the pattern of skid marks. Someone who brakes or swerves at the last instant could be viewed as simply having fallen asleep at the wheel. This is certainly possible, but it is also possible that someone intended suicide and changed his or her mind too late. This appears to happen relatively frequently, as seen in cases of those who jump from high places, survive, and report that they regretted their decision in midair.

There are still other ambiguities regarding the definition of suicidal behavior. One of my adolescent patients took a regular sewing needle, inserted it in the side of her wrist a millimeter or two, and immediately told her mother she had attempted suicide. This scenario is of clinical concern (and of course was of great concern to the mother), but does this qualify as a real suicide attempt? Is it of the same quality as more serious attempts, such as what my patient "Gayle" had in mind (severing her hand and bleeding to death)?

I am aware of no current theory that adequately handles all of

these definitional problems, but in this book I will at least address each one.

Prevalence

Though rates vary somewhat from year to year, approximately 30,000 people in the United States and more than half a million people worldwide die by suicide each year. A useful common metric for death rate is deaths per 100,000 in the population. The rate of death by suicide has been between 10 per 100,000 and 15 per 100,000 for decades. In 2001, suicide was the eleventh leading cause of death overall in the United States.

On the one hand, 30,000 U.S. deaths per year—one every eighteen minutes or so—is a lot. On the other hand, relatively speaking, suicide is a rare cause of death. For example, given that a person has died, the chance that the cause was heart disease or cancer is 52 percent. The chance that the cause of death was suicide is a little over 1 percent.

Suicide is thus a relatively rare form of death, and any compelling theory should be able to account for this fact. Many theories of suicide run aground on the simple shores of prevalence rates—for example, they propose a cause that is very common, yet do not fully explain why relatively few die by suicide. The theory to be developed in this book has something to say about the relative rarity of death by suicide.

Gender

Men are approximately four times more likely than women to die by suicide; women are approximately three times as likely as men to attempt suicide. This pattern of male lethality is partly related to a tendency toward violent behavior more common in men than women. Women's attempts are more frequent but less violent. Two of three