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Is It Worthwhile Continuing to Live, If No One Really Cares About you?: A Different Approach to Understanding why so Many People are Killing Themselves and how to be Sure your Patients are not Among Them

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Opinion

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Opinion

People in America are taking their own lives at an accelerating rate. Suicides have increased by one third, since 1999, especially among veterans, women, and young Americans. Over 45,000 annually, making suicide the leading cause of death of those ten to seventeen years old. We psychotherapists need a more effective approach to determine which patients are going to suicide and how to treat them successfully. This new approach is based on the question that many suicidal patients have been struggling with:

> *Is it worthwhile continuing to live, if no one really cares about you?*

More suicides occur from the Golden Gate Bridge than any other site in U.S. Nearly 99% of those who jump, die. If they land head first, as so many do, their 75+ miles per hour impact with the water often fractures their ribs, with the jagged edges slashing internal organs like their heart and lungs. Not only has a life been lost, but the jumper has probably died a terribly painful death. When I was working as a psychiatrist in San Francisco in the seventies, anyone that Golden Gate Bridge law enforcement officers thought was going to jump was brought to our Mt. Zion Crisis Clinic. Our task was to identify those who were a serious suicide threat and treat them. Despite our best efforts, some of these we released, killed themselves.

In 1976, I was promoted, given the clinical responsibility for all Clinic patients, including those brought in from the Bridge. Having recently completed my psychiatry residency, this felt daunting. So I was highly motivated to plunge into the psychiatric literature. I discovered a recent study based on interviews with six of the very few individuals who had jumped from the Bridge and survived. Being able to study this cohort offered suicidologists a window into the minds of people who really, really wanted to die: these dead men walking. These survivors reflected on what had led them to jump to their nearly certain deaths. Surprisingly, most said that what had led them to jump was feeling disappointed in their close relationships, which had made them feel, "There was no one who really cared about me. …" They described that they had "…felt no personal love… felt alone… alienation… rejected by my lover… longed for death as a release from my feelings of alienation …" One survivor exclaimed that, "I would not have jumped, if even one person had smiled at me on my way to the Bridge." No one did. So he did [1].

The usual psychiatric explanations for suicide emphasized major losses like deaths or other separations and/or the Freudian Aggressive Drive--anger--being turned against the self. None of these fit with what these survivors were saying. Some patients brought in from the Bridge were depressed for one of those reasons, but their reasons were different from the reasons why others had jumped. Was it possible that many--perhaps even most--people were killing themselves for the same reason the survivors expressed: because they no longer felt that their family really cared enough about whether they lived or died? Of course, what

these family members actually thought about them was not always clear, or even very important. What was important was that the jumpers believed that their family members no longer really cared [2].

I began wondering if suicide was best understood, not by Freud's Aggressive Drive, anger directed against the self-model, but by aspects of the mostly British Object Relations Model, which involves individuals' intrapsychic relationships with their families and loved ones, their Internal Objects. Whether suicidal patients thought it was really important enough to their people, to their Internal Objects, that they not kill themselves. A 2006 documentary movie, The Bridge, was made about suicides from the Golden Gate Bridge. 2 It seems to support the hypothesis I had developed 30 years earlier, about why people jumped. The Bridge filmed suicide jumps and interviews with the families and some close friends of those who had killed themselves. It shows that attitudes ranged from family members who were fully supportive of their depressed relative's struggles to live, all the way to those acting in a manner which encouraged their relative--though often in a way that was not obvious--to take their own life: essentially a family assisted suicide. The Bridge showed examples of how many of their intimates made it clear--sometimes subtly and sometimes blatantly--that although they would be saddened by the loss, they would get over it. Like one lady who did not insist that her suicidal nephew stays alive. Instead she told him to always keep her name and phone number with him in a plastic bag, so she could be notified when he took his fatal plunge from the Bridge. Seemingly unaware that she may have played a role in his subsequent suicide, she mused fatalistically, "How can you ever know why anyone decides to jump?"

It turns out that you often can know why people decide to jump. This woman's nephew, like many, may have jumped because he had come to believe that his family didn't care enough about whether he killed himself that his family, including this aunt, really would get over it. He may have recognized that his aunt was more concerned with being certain that she would be informed of the bad news, than she was with trying to influence him to make sure the bad news--his suicide-did not happen.

The usual explanations for suicide do, however, seem to be very important in at least one respect. Individuals certainly do develop suicidal ideation--that is, they begin thinking about killing themselves in response to the death of loved ones, because of repressed anger, and/or other stressors. But in evaluating our suicidal patients, it appeared that people usually *did not go on to attempt suicide, if they felt really cared about*. And, you can tell if they really feel cared about by simply asking them if they believe their families/ loved ones--their Internal Objects--would get over their suicide. Suicidal individuals interpret whether their loved ones will get over their suicide, as an indication of whether they are really cared about [3]. That can be determined by asking them what I began to call The Question. Their answer tells a lot about whether they will continue to live with their psychic pain or go on to suicide:

> *If you were to kill yourself, of course your family would be very, very upset,*
> *but would your family get over your suicide? Or would they never get over it?*

I treated a 20 year old student who had tried to kill himself. I asked him how his family would have felt if he had succeeded. He replied, shaking his head dejectedly, "They wouldn't even have come to my funeral." His answer made it seem likely that he might try to come to his own funeral--by killing himself. Another example is an eighteen year old girl, I evaluated for her suicidal ideation. When I described the treatment options, she insisted that she should just go home and stay with her mother. I asked whether her mother and the rest of her family would ever get over her death. She answered The Question with certainty, "They will get over it. All people really care about is themselves."

I took this answer to be a red flag warning, so I committed her to a psychiatric hospital for 72 hours, a decision she certainly resented. Later I learned that during that same afternoon, her mother had shared a religious belief with this daughter, which seemed like a tacit encouragement to her suicidal daughter to act: "It isn't true that you will go to Hell if you kill yourself. You are saved. You will go to Heaven."

My asking her that question, and acting in response to her answer, instead of just sending her home to be with this mother, probably helped avoid her suicide. Perhaps my committing her also helped her recog-nize that I, for one, did not do what would have been very easy for me: to just release her. Instead I committed her to a psychiatric hospital very much against her will, which she could see was very hard for me to do.

Though a few suicides could be understood by using the Aggressive Drive Model, the Object Relations Model was proving to be much more useful. So I came to make this model my primary basis for evaluating and treating suicidal patients. I tried it out with my patient's first and got very impressive results. The number of suicide dropped.

After much success, I began teaching our trainees to use it in their dealing with our suicidal patients, including those who were brought in from the Bridge. Our clinical staff and trainees were to thoroughly evaluate patients who showed signs of being suicidal. That included asking them the usual questions about the criteria for high suicide risk:

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if the patient heavily used alcohol and/or drugs; if they had suffered recent, major loss[es]; if family members or close friends had killed themselves; if this was an anniversary of a loss; if they had access to a gun; if they were in a high risk-to-suicide group like single, older men, et cetera. But they were to also ask all the suicidal individuals The Question:

> *If you were to kill yourself, of course your family would be very, very upset, but would your family get over your suicide? Or would they never get over it?*

It turned out that nearly all patients could readily answer that question. Their answers to all the other questions were to be taken into consideration. But if the patient answered that their family would never get over their suicide, unless there was a lot of evidence to the contrary, it should be considered that they were unlikely to kill themselves, and they should be treated accordingly. However, if they felt that their family would get over it that should serve as a red flag warning.

Their answer to The Question informed us as to what our patient needed and how we should respond. For example, we were treating patients ready to suicide because they thought that their families did not really care about them. It was thus logical that our treatment should make them feel really cared about by our Clinical Staff. We needed to tell them repeatedly-and show them by our actions-that our Clinic Staff and especially their psychotherapist absolutely did care about them. That they were valuable people; that we would do everything possible to stand between them and suicide; that we really, really, did not want them to kill themselves, that we might never get over it.

We had some concern that patients would interpret this approach as insincere and/or manipulative, and question why their continuing to live was so important to us. But that has not happened, possibly because patients may have longed for someone to provide such encouragement. They have taken our therapists' stance at face value, accepting that at least one person, this New Object, really believes that Suicidal Patients' Lives Matter.

In summary, feeling that they are not cared about seems to encourage many people with suicidal ideation to kill themselves. People with suicidal ideation who do feel cared about, seldom take their own lives. So the critical issue for our Clinic: would our patients with suicidal ideation who had come to believe that we really cared about them, be far less likely to kill themselves?

Yes. This treatment approach worked! The number of suicides in our Clinic dropped precipitously. I remember only a few in the four years that I remained our Clinic's Training Director. Over the subsequent four decades, I have taught this approach at two other medical schools and used it working with suicidal individuals in fifteen clinical settings around the country, some of which involved seeing suicidal patients by telepsychiatry, and/or seeing those in my private practice. I have been relying more and more heavily on their answer to The Question to tell me how likely suicidal individuals are to kill themselves and how they should be treated. I have evaluated several thousand suicidal patients and treated, or supervised the treatment of, a significant number of them in the past 47 years. Not one of these suicidal patients has killed themselves while I was involved with their care. This is so much better an outcome than we psychiatrists usually get with suicidal patients. I have only become more confident of this approach's effectiveness in the decades since then.

Yet, there are two ways in which The Question's effectiveness is not clear. First, this approach has been used, so far as I know, only in the United States. Second, there has been no controlled, double blind scientific studies. That is because such studies would seem to be unethical. From soon after the start, it has been obvious that this approach works. So we would be withholding an effective approach from one group of suicidal patients.

We really do care that many of the 47,000 Americans who kill themselves annually, do so because they feel that no one really cares about them. Building an expensive, metal Safety Net to prevent suicides by jumping off the Golden Gate Bridge is one way of showing that the community cares. We could cut down further on these tragic--and often preventable-deaths by simply including The Question when evaluating suicidal patients:

> *If you were to kill yourself, of course your family would be very, very upset,*
> *but would they get over your suicide? Or would they never get over it?*

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