Is suicide sane? To be or not to be, that is the question

Transcript

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One August day in 1937, HB Wobber, a 49 year old bargeman, took a bus to the Golden Gate Bridge, paid his way through the pedestrian turnstile, and began to walk across the mile long span. He was accompanied by a tourist he’d met on the bus, Professor Louis Nailer of Trinity College in Connecticut. They’d strolled across the bridge, which stretches in a single arch from San Francisco to the hills of Marin County, and were on their way back when Wobber tossed his coat and vest to Professor Nailer. “This is where I get off,” he said quietly, “I’m going to jump.” As Wobber climbed over the 4 foot railing, the Professor managed to grab his belt, but Wobber pulled free and leapt to his death. Less than 3 months after the Golden Gate Bridge had opened to great fanfare, Wobber became its first known suicide.

Since then, more than 800 others have jumped, making it the number one location for suicide in the entire Western world. As with most suicide statistics, the numbers are conservative. Only those who’ve been seen jumping or whose bodies are recovered are counted as bridge suicides. One expert suggests that more than 200 others may have leapt unseen in darkness, rain or fog, been swept out to sea and their bodies never found. A leap from the bridge is easy, quick and lethal. One merely steps over a chest high railing, at 70 to 85 miles an hour, the 240 foot fall lasts 4 seconds. If the force of the fall doesn’t kill the jumper instantly, the fierce current will sweep him out to sea to drown or be devoured by sharks. Of more than 800 people known to have fallen or jumped from the bridge since it opened, only 19 have survived. By 1990, there had been 885 confirmed deaths, including a depressed man who wrote in his suicide note before stepping over the railing and leaping to his death “Why do you make it so easy?”

During the suicide prevention movement of the late 60s and early 70s, the debate over an anti-suicide fence came to a head. Bridge directors received hundreds of letters, about two-thirds opposing the barrier. Some argued it would spoil the view. Why destroy the view for so many for the sake of so few? Others felt it was a waste of money. Why spend on someone who wants to die? Many defended a person’s right to suicide. “If and when I decide to die, I would prefer the bridge as an exit point, and I don’t want to be kept from it by a high jail-like railing,” one woman wrote to the San Francisco Chronicle. “There are worse things than death and one should be able to make that personal choice if necessary.” This is the core issue of the debate around suicide, and raises the question is it a personal choice which should be respected, or is it something we should devote notable resources to preventing?

Chad Varah, an Anglican clergyman in London, starting in November 1953, developed in the crypt of St Stephen’s Walbrook what was at first a telephone service staffed almost entirely by volunteers to befriend the suicidal and despairing. Suffice it to say that in the past half century this enterprise has flourished and has become an international movement. There are now over 203 Samaritan branches in the UK and Republic of Ireland alone, not to mention branches in almost 80 countries around the world. In 2002, the Samaritans received 4,660,000 contacts by ‘phone, email, letter and face-to-face in settings as diverse as prisons and local fairs. Well, what gave Chad Varah the original idea? He writes that when he read in 1953 that there were 3 suicides a day in London, his restless mind busied itself with the question why.

As I hope to show tonight, this key question of why people commit suicide is linked to the question of why people don’t. The question Samaritans are now asking is also much wider than just being about suicide prevention. It’s about emotional support for all of us at a much earlier stage in the suicidal journey. From studies of depression or the negative mood states that frequently lead to suicidal thinking behaviour, has begun to emerge. Does depression have some kind of purpose?

Evolutionary psychology is the new field that has begun to raise the provocative question of whether psychiatric illnesses such as depression are so common because they serve some kind of evolutionarily useful function. This new discipline hinges on the idea that much of our motivational and emotional machinery evolved to help us survive in an ancestral environment. The argument is that much of our behaviour and sentiment makes more sense if we begin to consider the possible advantages to our ancestors from hundreds of thousands of years ago. As we evolved to live in the very different circumstances which we
experience now, could depression be an adaption which makes sense in an ancient environment but less so today?

It is clear that even aversive states like pain have a positive evolutionary function and pain is a good analogy for considering the function of depression, because there is a way in which we can think of depression as a kind of emotional pain. Physical pain is unpleasant, but there is a good reason for this. In its insistent aversive state, it draws our attention abruptly to a part of the body which might require urgent attention. Pain breaks through competing stimuli and gains our focus. But pain doesn’t just grab our attention, we work ceaselessly to try and fix the cause of the pain in order to remove the sensation. These are two key concepts in the evolutionary theory about the function of depression. It draws our attention to something that needs fixing, and it motivates us to fix it.

If depression is an emotional pain, what is it drawing our attention to and what needs fixing? One function of depression could be social, to draw our attention to the depressed person in order to try and provide assistance. Perhaps the ability to feel empathy with the depressed and to imagine how horrible depression might be motivates the will to render assistance. In our distant evolutionary past, perhaps you were noticed when you were depressed, because we lived in small close knit groups and you got more attention and care as a result. In a large anonymous city like modern London, perhaps depression is now evolutionarily out of place and as a result has more tragic consequences. Samaritans, in providing a mechanism by which negative mood can be noticed, are therefore according to this theory playing a vital evolutionary function.

Paul Watson and Paul Andrews, biologists at the University of New Mexico, in a recent paper in the Journal of Affective Disorders, suggested what they term a social navigation hypothesis as the underlying reason we have depression. A hallmark of depression is that depressives tend to expend a huge amount of cognitive effort, what might be termed ruminating, and usually this reflects a preoccupation with their social situation and their relationships with others. Indeed, depressives outperform normals on social tasks. Their person perception is better than normals. In one recent experiment, the depressed were found to be better able to spot lying, manipulative and other deceptive behaviour compared to controls. Indeed, it could be because of their ability to see through the phoniness of everyday social life that they become depressed in the first place. Depression leads to withdrawal, psychic and physical retardation, but inside the person there’s actually a lot of mental activity.

The social navigation hypothesis posits that at the heart of depression is a huge physical, emotional and mental diversion of effort from usual activities like physical action and eating to social cognition or rumination to try and solve some social problem. This social focus needs to be part of the realignment in our thinking about treatment, to include a social perspective as well as the need for medication. We know that married people not getting along with their spouses are an astonishing 25 times more likely to attract the diagnosis of major depression than people without marital unhappiness. Another study found that approximately 30% of new episodes of major depression are associated with marital dissatisfaction. We also know that recovery from depression is hastened by improvements in social relationships and strong social support. Actually, perhaps the key thing about pain is that our experience of it leads to strong attempts to avoid it in the future, and this is its key adaptive feature.

Perhaps that’s the point of depression: it is so aversive that having experienced it, we try to avoid it in the future, and these preventive steps are the key adaption. This means we are cautious about our attachments and it is notable that women, who are more prone to depression than men, are also more wary than men about entering relationships and selecting possible future partners. If we were less careful about attachments because we had no fear about depression, then attachment as a human phenomenon in its present form might not even exist at all. But if we now see that depression might have some evolutionary positive purpose, what is the purpose of happiness?

The key evolutionary puzzle about happiness is that you actually don’t need to be happy to survive on a day-to-day basis. Maybe happiness has a fundamental social function, in that happy people are so pleasant to be with they’re actually storing up social credit for the future. The goodwill towards the happy is like a deposit in a bank, which can be drawn on when you are less ebullient. Maybe when we are happy we are expansive and generous and in so doing we build up credit with partners so they will tolerate us more when we eventually get depressed. But what happens when the people we built up the positive credit with move on, as happens in the mobile urban anonymous society we now inhabit?

Is it possible Samaritans play a vital role in stepping in to be that emotional bank of credit we can draw on when low? This is one of the key debates about the role of therapy. Is it just about providing a relationship, or is the content of what the therapist talks to you about the vital thing? Some people argue in large part formal therapy consists of helping the client re-conceptualise the can’ts, the won’ts, the absolutes and the non-negotiables of the patient’s present firmly held positions to widen the stubbornly fixed blinders of present perceptions, to think the unthinkable.
There is a 20th Century example of this that precedes Samaritans in being an example of effective suicide prevention. Over half a century ago, on August the 14th 1945, Japanese Emperor Hirohito, in the first ever address to his people, in his historic prescript of capitulation, ordered his loyal subjects to surrender. This is a supremely important moment in suicidology, given the Japanese nation’s historically high suicide rate, and its strong belief in loss of face, honour and suicide as an honourable way out of humiliation. Mass suicide across the nation was the most likely response to such a humiliating message of surrender from the Emperor. But in a few brief sentences, the Emperor touched on two main antidotes to suicide: a generational sense of the future, and a personal redefining of what is intolerable, the two key lacunae of any suicidal scenario. His words are arguably the most effective suicide prevention speech ever made. Here in part is what he said: “It is according to the dictates of time and fate that we have resolved to pave the way for a grand peace for all the generations to come by enduring the unendurable and suffering what is insufferable.” Those few words saved thousands of lives.

But even if we can theorise about the function of depression and happiness, this doesn’t mean we can use these theories to explain suicide fully. Many who contemplate suicide are not depressed, and feel this is an expression of ultimate personal choice. Hamlet’s question is at the heart of suicide: “To be or not to be, yes or no, light or total darkness.” It’s a question that has more contemporary relevance than ever before because actually it’s easier to take your life in contemporary industrialised society than ever before in our history.

Seneca, who lived at the time of Christ, pointed out way back then rather disdainfully that the exits are everywhere. Each precipice and river, each branch of each tree, every vein in your body, will set you free.

But actually, once you have heavy industry and technology everywhere, like trains on tracks on which you can throw yourself, the exits multiply, so that on your way home tonight, the opportunity to commit suicide effectively are much more than it ever was for the caveman returning home of an evening. Yet we think we live in safer times.

It’s not just the opportunity that has changed dramatically over time, but also our attitude to suicide. During classical Greek times, suicide was viewed in more than one way. It was tolerated and even lauded by patricians, generals and philosophers, but condemned if committed by plebeians or slaves, whose labours were necessary for the smooth functioning of a patrician/slave society. In classical Rome, in the centuries before the Christian era, life was held rather cheaply, and suicide was viewed neutrally or even positively. The stoic philosopher, Seneca, said: “Living is not good but living well. The wise man therefore lives as well as he should, not as long as he can. He will always think of life in terms of quality and not quantity. Dying early or late is of no relevance. Dying well or ill is. Life is not to be bought at any cost.” For the next two millennia or so, suicide was largely seen in a religious context, and this meant it was condemned as being a sin.

The next big advance in understanding suicide outside the context of it being a sin awaits the advent of psychoanalysis. Freud never wrote directly on this topic, but his followers and himself advocated the view that suicide was really a kind of inwardly directed homicide. In 1910, there was a meeting on the topic of suicide in Freud’s apartment in Vienna. On that occasion, Wilhelm Stekel, a psychoanalyst, pronounced that no one kills himself except one who wishes the death of another. Rage at being let down or deserted by someone was turned inward on oneself because it could not be expressed outwardly. Psycho-dynamically, suicide was seen as murder in the 180th degree.

Following the horrors of the Second World War, a major sea change occurs in Western thinking. The issue becomes not so much why do people kill themselves, but why do the rest of us try and stay alive. Existential thinking comes to the fore, with the principal task of man to respond to life’s apparent meaningless despair and its absurd quality. Albert Camus begins his essay, the Myth of Sisyphus by saying: “There is but one serious philosophical problem and that is suicide.” One of the main ethical issues for man is suicide. Karl Menninger, a famous American psychiatrist, published in 1938 a book which captures the prevailing pessimism of the time, entitled Man Against Himself. The fundamental thesis is that we perform self-destructive acts all the time, not just when we are overtly suicidal, that deep down we are our own worst enemies, because it is us who constantly initiate behaviours that are inimical to our own best interests, from saying the wrong thing to your boss all the way down to cutting your own throat.

Currently, the US Army uses a recruitment slogan “Be all that you can be.” The Army is talking about fulfilment, of using all of one’s capacities. The opposite of being all that you can be is living at much less than you could. This is the area of sub-suicidal neurotic lives that is Menninger’s focus. To attend to suicide only and miss that most of us are probably living a sub-suicidal neurotic existence is to fail to put suicide in context. Menninger argues that a lot of the bad things which happen to us and which we put down as accidents are actually unconscious attempts at suicide. For example, he cites a famous case of Freud’s. A former lover of Freud’s patient, Dora, and latterly the object of her accusations and hostilities, came one day face to face with...
her on the street where there was much traffic. Confronted with her who had caused him so much pain, mortification and
disappointment, as though in bewilderment and in his abstraction, he allowed himself to be knocked down by a car. Freud
comments that this is an interesting contribution to the problem of indirect attempt at suicide.

But if suicide is difficult to study because the one person you want to ask about it is no longer around to explain, then
attempted suicide projects its own problems. Those who attempt suicide and fail are often embarrassed, at least at the cock-
up, and frequently are reluctant to discuss in detail the painful episode. A notable exception is Al Alvarez, a poetry critic, essayist
and journalist, and in his own published words “a failed suicide”, wrote a lyrical book The Savage God about suicide, published
in 1972. For Alvarez, suicide is chosen because essentially it represents an escape, a whole class of suicides who take their
lives not in order to die but to escape confusion, to clear their heads. They deliberately use suicide to create an unencumbered
reality for themselves or to break through the patterns of obsession and necessity which they have unwittingly imposed on their
lives. Alvarez also oddly argues that no man is promiscuous about suicide; each has a favourite method, and once that doesn’t
work, they are unlikely to try another.

But this is a key argument in suicide prevention. The most popular argument against a barrier at the Golden Gate Bridge is that
it simply wouldn’t work. Common sense said that suicidal people would simply go and kill themselves somewhere else. Richard
Seiden, a Berkeley psychologist, gathered the names of 515 people who had been restrained from jumping from the bridge,
dating back to its opening day. Checking their names against death certificates, he learned that only 25 had gone on to take
their own lives. Although his research proved that people did not inexorably go on to commit suicide using another method,
critics argued that people restrained from jumping were not truly bent on death.

What about those who had jumped and lived? In 1975, psychiatrist David Rosen interviewed 6 of 8 people known to have
survived leaps from the Golden Gate Bridge. None of the 8 survivors had gone on to kill themselves. The 6 he interviewed all
favoured the construction of an anti-suicide fence. They all said there had been a barrier they would not have tried to kill
themselves some other way.

For many years, the most popular method of suicide in Great Britain was asphyxiation, sticking one’s head in the oven and
turning on the gas. After the discovery of oil and natural gas deposits in the North Sea in the 50s and 60s, most English homes
converted from coke gas, whose high carbon monoxide content made it highly lethal, to less toxic natural gas. From 1963 to
1978, the number of English suicides by gas dropped from 2,368 to 11, and the country’s overall suicide rate decreased by one
third. Despite England’s varying unemployment rate and social strata since then, it has remained at that lower level.

Yet going back to the lack of a barrier at the Golden Gate Bridge, a San Francisco friend once said to me, “99% of us don’t need
it – is it fair to ruin the view for the sake of a few? If they want to die so much, why not let them?” This attitude is shared by many.
How far is it from this passing condoning to the chorus one sometimes hears when a crowd has gathered at the base of a tall
building to watch the weeping man on the ledge high above shouting, “Jump, jump, jump!”? Fortunately, in answer to the voices
who cry “Jump!” there are many others that cry “Live!”, not just the voices of family, friends, therapists and prevention centre
volunteers, but the voices of strangers.

When an 18 year old girl stood on the ledge of a 7-storey building in Mexico City threatening to jump Ignacio Kanedo, an 18 year
old Red Cross male nurse inched out toward her. Kanedo was tied to a long rope held on the other end by a squad of firemen.
“Don’t come any nearer!” shouted the girl, “Don’t or I’ll jump!” Kanedo grabbed for her and missed. The girl screamed and
jumped. Kanedo leapt after her, caught her in mid air and locked his arms around her waist. They fell 4 floors before the rope
snapped taut. Kanedo’s grip held and he and the girl were hauled back to the roof. “I knew the rope would save me,” said
Kanedo, “I prayed that it would be strong enough to support both of us.” There are dozens of similar stories of potential
suicides saved by strangers who instinctively reached out.

As a term project for The Psychology of Death, a course taught by psychologist Ed Schneidman at Harvard, one student placed
an ad in the personal section of a local underground newspaper: “Male, 21, student, gives self 3 weeks before popping pills for
suicide. If you know any good reasons why I shouldn’t, please write to Box D673.” Within a month, he had received 169 letters.
While the majority were from the Boston area, others came from as far away as New York, Wisconsin, Kentucky, even Rio de
Janeiro. They offered many reasons why he should stay alive. Some wrote of music, smiles, movies, sunny days, sandy beaches,
some quoted Rod McEwan, E.E. Cummings, or Dylan Thomas. They suggested he spend time with others less fortunate than
he, implored him to think of those he would leave behind, called him a coward and dared him to struggle and survive. Some
referred him to a therapist; others offered friendship, enclosing their telephone numbers or their address. A few enclosed gifts:
two joints of marijuana, an advanced calculus equation, a Linus doll, magazine clippings on the subject of kindness, a photo of

apple blossoms with the message “We’re celebrating apple blossom time”. Some simply broke down in the middle of their letters and pleaded “Don’t!” or “You just can’t!” The student was not actually contemplating suicide, but the answers he received were real.

Whether they might have persuaded someone truly suicidal to stay alive or not is impossible to say, but if the forces that lead someone to suicide are numerous, those forces that combine to prevent someone from killing himself may be equally complex, whether they be anti-depressants, a prevention centre volunteer, a barrier on a bridge, a Linus doll, or the voice of a stranger saying “I care”.