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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 What We Can do About It

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Dealing Effectively with Suicidal Ideation

America is experiencing a massive and accelerating number of people taking their own lives. Suicides have increased 33%, just since 1999, especially among veterans, women, and other young Americans. Over 45,000 suicides annually, making killing themselves the leading cause of death for youths ten to seventeen years old.

So we need a more effective approach to determine which suicidal patients may suicide and how to treat them successfully. This new approach is based on *The Question* that I came to realize many suicidal patients struggle with: *Is it worthwhile continuing to live, if no one really cares about you?*

More suicides take place from the Golden Gate Bridge than from any other site in the 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 terribly painfully slashing their heart and lungs [1].

Everyone on the Bridge who looked to Bridge law enforcement officers like they were going to jump, was brought to the Mt. Zion Crisis Clinic in San Francisco where I worked. We were to evaluate and treat those who were suicidal. Despite our best efforts, some of those we released went on to kill themselves.

In 1976, I was promoted, given the clinical responsibility for all Clinic patients, including those brought in from the Golden Gate Bridge. Having completed my residency just four years earlier, this felt daunting. So I was highly motivated to plunge into a search of the psychiatric literature. I discovered a recent study, reporting interviews with six of the very few individuals who had jumped and survived. The chance of surviving appears to have been mostly random, so these six seem representative of Bridge jumpers [2].

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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 had 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 very 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 ... alienation ... felt alone ... rejected by my lover ... longed for death as a release from my feelings of alienation ...

One survivor exclaimed that he would not have jumped, if even one person had smiled at him on his way to the Bridge. No one did. So he did.

The usual psychiatric explanations for suicide up to then, had emphasized that these jumpers were reacting to major losses, like deaths or other separations and/or Freud's Aggressive Drive--anger--being turned against the self. But neither of these fit with what these survivors were saying. When we evaluated patients brought in from the Bridge, it seemed that they often were depressed for one of those reasons, but these were not the reason why the survivors said they had jumped. Was it possible that a great many people were killing themselves, for the same reason the survivors expressed: because they no longer felt that their people really cared enough about whether they lived or died? Of course, what these family members actually thought was not always clear, or even important. What was important was that the suicidal people believed their family members did not care that deeply.

This led me to my beginning to think that suicide might be was best understood, not as a reaction to loss--or as Freudian anger turned against the self, but by applying the mostly British, Object Relations Model. This model involves individuals' intrapsychic relationships with their families and loved ones, their Internal Objects. And whether individuals believed it was really important to their people, to their Internal Objects, that they not kill themselves. When their family members did not support their depressed relative's struggles to live, it might be considered a *family assisted suicide*.

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A 2006 documentary movie, *The Bridge*, [3] was made about suicides from the Golden Gate Bridge. I believe it adds support to the hypothesis I had developed 30 years earlier about why people jump. *The Bridge* filmed suicide jumps and interviewed the families and some close friends of those who had killed themselves. It shows examples of how many of these intimates made it clear--sometimes subtly and sometimes blatantly--that although they would be saddened by the loss of this person's life, they would get over it. Like one lady who insisted that her suicidal nephew always keep her name and phone number with him in a plastic bag, so she could be sure that she would be notified when he took his fatal plunge from the Bridge. Seemingly unaware that she might 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 others may have jumped because he had come to believe that his family didn't care enough about whether he killed himself, that his aunt really would get over it. This man 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 help influence him to make sure the bad news--his suicide--did not happen.

The explanations which had been used to explain 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 loss of loved ones, and/or to repressed anger. But in evaluating our suicidal patients, it appeared that this group of suicidal individuals usually did not go on to commit suicide, if they felt really cared about. And you can tell if they really feel cared about by simply asking them. By asking if they believe their families/loved ones--their Internal Objects--would get over their suicide. Suicidal individuals interpret whether their loved ones would get over their suicide, as an indication of whether their loved ones really care about them. So their answer to this one *Question*, which we can easily ask, tells us a lot about whether they will continue to live with their psychic pain, or end that pain by taking their own lives.

A 20 year old Clinic patient had tried to kill himself. I asked him *The Question*:
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?

He replied, shaking his head dejectedly, *They wouldn't even have come to my funeral!* His answer indicated that he might try to come to his own funeral--by killing himself.

Another example is an eighteen year old, evaluated for being very suicidal. When I described our options for her treatment, she insisted that I should just let her go home to 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 concluded that I had to commit 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 one of her religious beliefs with her daughter, which seemed like 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 very worrisome answer, instead of just going along with sending her home to be with this mother, may have helped avoid her going home and killing herself. Perhaps my doing

so also helped her recognize that I, for one, did not do what would have been very easy for me: to just release her. Instead I committed her much against her will, which she could see was hard for me to do.

On the other hand, a 44 year old city planner who had become too depressed to work and was looking for access to tall building to jump from, was referred to me. He had two series of brief psychotherapies which were unsuccessful. But he answered *The Question* by saying that his family would never get over his suicide. I treated him in psychoanalysis for some years. I hear from him from time to time. He has recovered from his depression and has been leading a vigorous life, heading environmental causes.

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Though some suicides could occasionally be understood by using the Aggressive Drive Model, the Object Relations Model was proving to be much more useful. So I made it the most important basis of my evaluating and treating suicidal patients. I tried it out with my patients first and got very encouraging results. Then I began teaching our clinical staff and trainees to use it in their dealing with our suicidal patients, including those brought in from the Bridge.

Our clinicians were to thoroughly evaluate patients who were suicidal, by asking them the usual questions to ascertain high suicide risk: such as whether the patient heavily used alcohol and/or drugs; if they had suffered recent, major losses; if family member or close friends had killed themselves; if they had access to a gun; if they were a members of one of the high risk-to-suicide groups like older, single men; et cetera. And they were to be sure to also ask the suicidal individuals *The Question*: *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?*

Supplementing the usual questions with this new one markedly increased the usefulness of these evaluations. It turned out that nearly all patients could readily answer that *question*. Their answers to the other questions were also 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 very unlikely to kill themselves, and they should be treated accordingly. However, if they answered that they believed that their family would get over it, that should serve as a red flag warning. It should become a very important part of the clinician's decision as to how that patient should be cared for, including whether they needed the safely of temporary treatment in a locked psychiatric unit.

Many of the patients we were treating were ready to suicide because they thought that their families did not really care that much about them. So it followed logically that our approach to treating them should include our making them feel that they were really cared about--cared about by our Clinic staff. We would tell them repeatedly--and show them by our actions, including committing them when necessary--that our Clinic staff, and especially their psychotherapist, absolutely did care about them. That we valued these suicidal individuals; that we would do everything we could to stand between them and suicide; that we really, really did not want them to kill themselves.

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In doing so, we would be making a new kind of Suicide Contract with these patients. Not the traditional Suicide Contract, in which the patient makes a commitment to the therapist to sound the alarm if they feel more suicidal. Instead, our clinicians would be making a commitment to the patients, to do whatever it takes to keep them from killing themselves. Using that approach, each psychotherapist becomes like an adopting family member, who the patient could internalize as a caring, committed New Object. A new family member who would find their suicide so unacceptable, that they might never get over it.

We had some concern that patients would interpret our taking this stance as insincere, and/or manipulative, and ask us just 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.

We had learned that individuals believing that they are not deeply cared about seems to make many people with suicidal ideation kill themselves. People with suicidal ideation who do feel cared about, seldom take their own lives. So the critical issue for our Clinic to test: would our patients with suicidal ideation who had come to believe that we really care about them, be far less likely to go on to kill themselves?

Yes. This Object Relations treatment approach really 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 in working with suicidal individuals in fifteen clinical settings around the country, some of which involved seeing suicidal patients using telepsychiatry and in 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 to thereby determine their optimal treatment--and I have been getting impressive results. I have evaluated well over 1,000 suicidal patients and treated or supervised the treatment of a significant number of them using *The Question*. Not one of these more than a thousand suicidal patients have killed themselves while I was seeing them. I believe that this is so much better an outcome than we usually get with suicidal patients.

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We really do care that many of the 45,000 Americans who kill themselves each year, probably do so because they feel that no one really cares about them. I believe we could begin cutting way down on these tragic, often preventable deaths by simply including *The Question* when interviewing suicidal individuals: *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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