Dispelling Myths Surrounding Suicide

11 Myth-Busting Truths

1. People who take their lives are not necessarily weak or cowardly.
2. Suicide is multifactorial and not caused by any single event, stressor, or risk factor.
3. Risk is highly dynamic, not set in stone.
4. The majority of people who survive suicide attempts go on to live and thrive.
5. Suicidal “gestures” are actually meaningful indicators of risk, a way of communicating need for help.
6. People who talk about suicidal thoughts are revealing true potential suicide risk.
7. The experience of losing someone to suicide feels sudden, like being blindsided. This does not mean that suicide lacks an actual build up.
8. When lethal means are less accessible, suicide risk is greatly diminished.
9. Just one person can make a difference. Each of us has the ability to help tilt the balance for someone toward hope and survival.
10. By having a caring conversation and asking about suicidal thoughts, the at-risk individual has more opportunity to share, connect, and receive support.
11. Suicide is not as simple as a “rational choice.”
Introduction

For many complex health issues throughout history, misinformed views tend to promulgate, leading to a multitude of negative effects, deeply stigmatizing the experiences where these health issues are involved. Without science, untruths and stigma continue to thrive. In the past, before a body of scientific research led to an understanding of what drives suicide risk, many myths prevailed about suicide. These myths not only shaped stigmatized and erroneous views of suicidal behavior but resulted in harshly punitive ideas and judgment of people who experience suicidal thoughts, who attempt, or who ultimately lose their lives to suicide. Now that a multi-disciplinary group of scientific fields is shedding tremendous light on the actual drivers of suicide risk, cultural views are changing, bringing an understanding that while complex, suicide is a health issue.

One myth that may still have echoes in the current day is the erroneous idea that certain individuals are “bent” on suicide, and therefore very little can be done to change course once someone becomes suicidal. Today, scientific research in a broad range of domains – from neuroscience to clinical research to epidemiology and community/public health interventions – shows that despite its complexity, suicide is 1) a health-related outcome and 2) largely preventable.

To understand how suicide can, in many instances, be prevented, and the role health professionals can play in preventing suicide, it is first important to dispel the myths that lead to erroneous assumptions about suicidal behavior and suicide. This chapter sets out 11 truths with their corollary myths about suicide. These myths must be dispelled so that they may no longer undermine efforts to prevent suicide.

Key Points

- Science is shedding light and busting the myths that long prevailed about suicide.
- These myths not only shaped stigmatized and incorrect views of suicidal behavior, but resulted in incorrect, punitive, judgmental ideas about people who struggle with suicidal thoughts, attempts, or who ultimately go on to lose their lives to suicide.
- Now that several scientific fields are shedding tremendous light on the actual drivers of suicide risk, cultural views are changing, understanding that while complex, suicide is a health issue.
Science of suicide risk and prevention is growing at a strong pace.

The findings from research are shedding light on ways we can understand and prevent suicide.

Prevailing myths are still prevalent since the translation and dissemination from scientific discovery to cultural beliefs and universal knowledge takes time and effort.

Some of the most prevalent and harmful myths are addressed in this chapter with their corollary “truth” presented first.

For example, suicide should not be thought of in terms of weakness or cowardice. Just as those who die from other health outcomes after a “strong fight” with their illness are not considered weak, the same holds true for people who die by suicide.

While suicide can be precipitated by a triggering event, suicide is not thought to be caused by one factor or event. Psychological autopsy method research clearly demonstrates there are multiple risk factors that converge or escalate at a moment of acute risk. While we do not always recognize all of the risk factors clearly at the time, suicide risk usually builds over time with changes in health – brain and body, cognition, perception, sense of hope, social connection.

Because stigma is pervasive and human instinct is to withdraw and isolate when suffering, many hide distressing internal experiences, making suicide seem “out of the blue”, but it is not usually the case. Even in more impulsive cases of suicidal behavior, there are usually numerous other longer term risk factors at play.

Suicidal people are not usually “bent on suicide” but rather are more often ambivalent and can often readily move closer to their reasons for living and sense of hope.

It is not the case that a history of attempting suicide indicates the person is destined to attempt again or die by suicide. In fact, more than 90% of people who live through an even medically serious suicide attempt do not go on to die by suicide.

Our clinical lens can be shaped by understanding that “manipulation” is not at the root of most suicidal behavior (although some clinical settings do select
for more secondary gain behaviors). A “cry for help” is just that: a signal of distress that warrants intervention for an at-risk individual.

- It is not the case that people who express suicidal thoughts are less at risk or simply talking rather than acting. Many who die by suicide had spoken of taking their life, sometimes directly and sometimes indirectly.
- It is not the case that suicidal people will simply find another method if their identified method is not readily accessible.
- Asking a patient directly and compassionately if they are thinking about ending their life is a safe and effective way to approach the issue. It is a myth that raising the question will increase risk or “plant the idea” in a person’s mind.
- Suicide risk is multi-faceted, dynamic, and often builds over time, therefore there are many opportunities for intervention and prevention.

## Myth-Busting Truths about Suicide

### 1 People who take their lives are not weak or cowardly

The old idea about people who take their lives being weak or cowardly stems from ignorance about what drives suicide risk. Health factors related to suicide include mental health and physical health conditions, brain structure and functioning, genetics, psychological make-up, and life stressors. Many factors contribute to the path to suicide, and therefore extremely strong people have taken their lives – having nothing to do with fortitude of character, but because they are human – and these risk factors exist and impact all human beings. People who die by suicide have often fought long and hard to survive and live through extreme levels of mental anguish and/or physical pain. The very construct of weakness or cowardice does not fit for suicide in the same way as it has no place in considering why people die of cancer or any other health-related outcome. Patients can die from other health outcomes after a “strong fight” with their illness, and the same holds true for people who die by suicide.

*Those who die from other health outcomes after a “strong fight” with their illness are not considered weak, and the same holds true for people who die by suicide.*
2 Suicide is multifactorial and not a one-cause-effect phenomenon

While external stressors are the most visible to outside observers and the media, science has clearly shown there are always multiple risk factors that contribute to suicide. Risk factors including mental health conditions (such as depression or major depressive disorder (MDD), substance use problems, bipolar disorder, borderline personality disorder, schizophrenia, post traumatic stress disorder (PTSD), other anxiety disorders, and eating disorders) are among the most common and forceful risk factors for suicide.\(^1\) Additionally brain and cognitive changes occur during periods of suicide risk, such as a constriction of cognition: coping strategies become temporarily less accessible to people who find themselves in a state of tunnel vision.\(^2\) For people at increased risk for suicide, studies have shown that their brains may have a more profound stress response.\(^3\)

*Suicide is not caused by any one event or factor.*

3 Suicide risk is highly dynamic, not set in stone

Suicide risk is extremely dynamic. For people at risk of suicide, their risk can change day by day and even hour to hour. The idea that suicidal people are “bent on it” is completely erroneous in most instances. Suicidal ideation and planning come from the human mind’s strong need to problem-solve a solution to pain, despair, and hopelessness. But the human spirit of survival and resilience, of wanting to find hope, is also strongly at play. Therefore, ambivalence is part of the suicidal process. And intense periods of high suicide risk are actually relatively short, often lasting minutes to hours. As a result, providing someone with support and keeping them safe during a high intensity period of risk is most often lifesaving.

*Suicidal people usually are not “bent on suicide” but rather are ambivalent and can find hope and recovery. There are many opportunities for intervention and prevention.*

4 The majority of people who survive nearly lethal attempts go on to live and thrive

People who attempt suicide have revealed through their ability to move from ideation to attempt behavior, that they have a potentially higher lifetime risk of suicide. Thus, a past attempt is one of the strongest predictors of future suicidal behavior. That said, the vast majority who survive an attempt do NOT go on to take their lives. The vast majority (85-95%) of those who survive a suicide attempt go on to live out a natural lifespan.\(^4\)

*It is not the case that a history of attempt suicide indicates the person is destined to attempt again or die by suicide.*
5 Suicidal “gestures” are actually meaningful indicators of risk, a way of communicating need for help

The dichotomous construct that people are either “just being manipulative” or have “serious risk” does not fit with suicide. It is erroneous and actually dangerous thinking to only hold this black-or-white view of suicidal behavior. Self-injurious actions with any intent of dying are signs of distress that warrant action. Since suicidal behavior stems from a wide array of psychopathology, genetic, and environmental influences, some behaviors may be more chronic and repetitive, while others seem out of character, appearing to come “out of the blue.” But in all cases, research has shown that people who attempt suicide, and people with a history of nonsuicidal self-injury, have an elevated risk for suicide over the long term. The treatment plan for each individual case is different and should ideally be tailored to the most powerful drivers of that individual’s suicidal behavior. Also the fact that people who attempt suicide always have a mixture of ambivalence, a certain ratio of survival instinct and desire to live, alongside some level of intent to die in order to escape pain, does not change the health risk these behaviors indicate. In these ways, a “cry for help” is truly an important and useful expression of need for support and treatment.

A “cry for help” is just that: a signal of distress that warrants intervention for an at-risk individual. Be wary of assumptions about manipulation or which equate chronic behavior patterns with lack of risk.

6 People who talk about suicidal thoughts are revealing true potential suicide risk

More than 50% of people who take their lives talk with a family member, friend, or healthcare provider about suicide within the weeks before their death. Some have incorrectly thought that “the people who talk about their suicidal thoughts are not the ones to worry about.” There is simply no correlation between how people do or do not express their distress and their true level of suicide risk. Many factors lead people to hide their distress, but some people are more able to disclose their feelings for a variety of reasons. Even people who try to keep their distress private will often give some verbal clues regarding their frame of mind, sometimes expressed through jokes or other oblique statements.

It is not the case that people who express suicidal thoughts are less at risk or simply talking rather than acting. Most people who died by suicide had spoken of taking their life, sometimes directly and sometimes indirectly.
Case Example: Truth/Myth #6

The beloved celebrity chef and travel documentarian, Anthony Bourdain, tragically died by suicide in 2018. While the world felt blindsided and viewers of his show “Parts Unknown,” friends, colleagues, and fans were shocked by his death, the truth is that he had mentioned his despair and/or suicidal thoughts over 15 times on air or in public interviews. Over several years, he repeatedly mentioned the idea of taking his life by the specific method he eventually did use to take his life, even including the location of his “lonely hotel room.” No one knew to take him seriously at the time and likely thought he was being facetious, fitting with his often sarcastic, sharp witted humor. We are often lulled into thinking that people with a record of successful achievements or intermittent joie de vivre are somehow protected from suicide risk. Although much clearer in hindsight, we are all learning to pay attention to statements that either directly or indirectly provide a window into an individual’s suffering or actual suicidal thoughts.

7 The experience of losing someone to suicide feels sudden, like you’ve been blindsided. This does not mean that suicide lacks an actual build up

It is understandable that we do not always see warning signs and risk factors plainly. In the majority of suicide cases, in retrospect it becomes clearer that the person showed signs of suicide risk from changes in behavior, mood, sleep, substance use, to talking in different ways from their typical ways – about being overwhelmed, hopeless, or like a burden. As a society we are learning to connect the dots of these warning signs with life stressors or health changes and learn what to do, especially as healthcare providers. It is critical to understand that people who are in psychological pain often do not express their internal experiences overtly for several reasons including stigma and cultures emphasizing self-sufficiency, and they often put feelers out to determine who is a safe person to disclose their suicidal ideation to. Be sure to approach people you care about who are struggling with a clear message of respect, love, and compassion; tell them you will not judge them for any challenge they are facing.

While we understandably cannot see all of the risk factors clearly at the time, suicide risk usually builds over time with changes in health – brain and body, cognition, perception, sense of hope, social connection. Because stigma is pervasive and human instinct is to withdraw and isolate when suffering, many hide these internal experiences, making suicide seem “out of the blue” but it is not usually the case. Suicides are not generally purely impulsive without other risk factors.
8 When lethal means are less accessible, suicide risk is greatly diminished

A body of research on various forms of lethal means studied including bridges, pesticides, carbon monoxide, and firearms, consistently tell the same story: when you make commonly used lethal means for a population less accessible, the rate of suicide for the entire population decreases, even when other means are available. Additionally other research shows that while switching to a different suicide method can occur, it actually occurs less than 35–40% of the time.\(^6\)

*It is not the case that if you make a person’s suicide method inaccessible, it will not make a difference because suicidal people will find another method.*

9 Just one person can make a difference. You have the ability to help tilt the balance for someone toward hope and survival

Humans are social creatures and have a basic need to feel connected to others, to family, and community. So even though in western society, people may be viewed as autonomous and independent, the truth is that we are extremely social beings with a basic need for connection. Experiencing the caring concern of others, or even (sometimes very appropriately) the paternalistic treatment/guidance given by health providers, family members, or close friends especially during a health crisis, helps us tremendously, changing the way we experience ourselves in the world and positively impacting our mental and physical health.

*It is not the case that we are helpless or unable to support and potentially influence a suicidal patient or loved one. Providing a sense of connection or support can save a life.*

10 By having a caring conversation and asking about suicidal thoughts, you are providing support

Studies and clinical experience find that people feel a sense of relief when asked about how deeply their pain is affecting them, including asking about suicidal thoughts. People are not harmed by being asked about suicide whether they are having thoughts of suicide or not, especially when asked in a caring, non-judgmental way.\(^7\)

*It is not the case that you should refrain from asking if someone is suicidal because you could plant the idea or make them worse.*
11 Suicide is not as simple as a “rational” choice

A growing body of neuroscience research finds that temporary, almost always very transient, brain changes occur during periods of suicidal crisis. So while there may be very rare circumstances when a person chooses to take their life without their cognition being significantly influenced by mental illness or other health factors (such as extreme mental anguish, pain, psychosis, hopelessness, or desperation) the vast majority of suicide attempts and death by suicide are not choices the person would have made in their usual cognitive state when they routinely used a variety of coping strategies to deal with challenges.

While there may be rare instances of ending one’s life related to factors other than these, science demonstrates that health factors and brain changes during suicidal crisis create cognitive constriction and a temporary but significant inability to access usual coping strategies.

Key Point

Suicide Risk Is Multi-Faceted and There Are Many Opportunities for Prevention

As the myths above indicate, there was a time when suicide was considered the result of a fluke moment in time in which a person suddenly, impulsively “lost their head” and took their life. An alternative explanation for a suicide was that the person was chronically weak in the areas of character, problem-solving ability, or fortitude, and had simply been overcome by life’s challenges.

Not only untrue, these myths related to character and strength, judging and keeping people who suffer living in silence. They are inconsistent with a large body of research that demonstrates that suicide is a complex health outcome.

- When suicide risk escalates, it is driven by multiple risk factors, albeit often undetected during life.
- Suicide is multifactorial. Research clearly shows that mental health conditions, genetic and other neurobiological factors, cultural, perceived, or systemic barriers to effective treatment for depression and other mental illness, sense of isolation or rejection versus support and connection, past traumatic events versus resilience building influences, accessibility of lethal means in the home or community, and cultural beliefs about mental health and suicide, all play significant roles in a population’s and a person’s risk for suicide.
Science has shed light on the risk factors for suicide, as well as the protective factors that make suicide a less likely outcome for individuals. Identifying the risk factors, protective factors, and warning signs as early as possible is the foundation of saving a life to suicide.

We now know that preventing suicide can occur along a long upstream continuum: a potentially lethal attempt can be averted at the moment of suicidal crisis, but also earlier intervention that prevents or mitigates the impact of risk factors such as early childhood trauma, adverse events, abuse, exposure to others’ suicides, etc. can also prevent loss of life to suicide much later.
a. Those who die from other health outcomes after a “strong fight” with their illness are not considered weak, and the same holds true for people who die by suicide.

b. Research demonstrates that suicide is not generally caused by any one event or factor.

c. Suicidal people are not usually “bent on suicide” but rather are ambivalent and can often readily find hope and recovery.

d. It is not the case that a history of attempted suicide indicates the person is destined to attempt again or die by suicide.

e. A “cry for help” is just that: a signal of distress that warrants intervention for an at-risk individual.

f. It is not the case that people who express suicidal thoughts are less at risk or are simply talking rather than acting. Many who die by suicide had spoken of taking their life, sometimes directly and sometimes indirectly.

g. While we cannot always see risk factors clearly, suicide risk usually builds over time with changes in health – brain and body, cognition, perception, sense of hope, social connection.

h. Because stigma is pervasive and human instinct is to withdraw and isolate when distress sets in, many hide their suffering and internal experiences, making suicide seem “out of the blue” or impulsive, but that is most often not the case.

i. Suicides are not generally purely impulsive without other risk factors.

j. It is not the case that if you make a person’s suicide method inaccessible, it will not make a difference because suicidal people will find another method. While some do substitute method, with the brief element of time introduced, the majority shift back into normal cognitive thought processes with other coping options available to them again.

k. It is not the case that you should not ask if someone is suicidal because you could plant the idea or make them worse. Through a caring, non-judgmental approach, research shows the suicidal person usually feels a sense of connection and hope by sharing their experiences and receiving support.

l. Suicide is not as simple as a “rational choice.”

m. Suicide risk is multi-faceted, dynamic, and often builds over time, therefore there are many opportunities for intervention and prevention.
References


