LOOK

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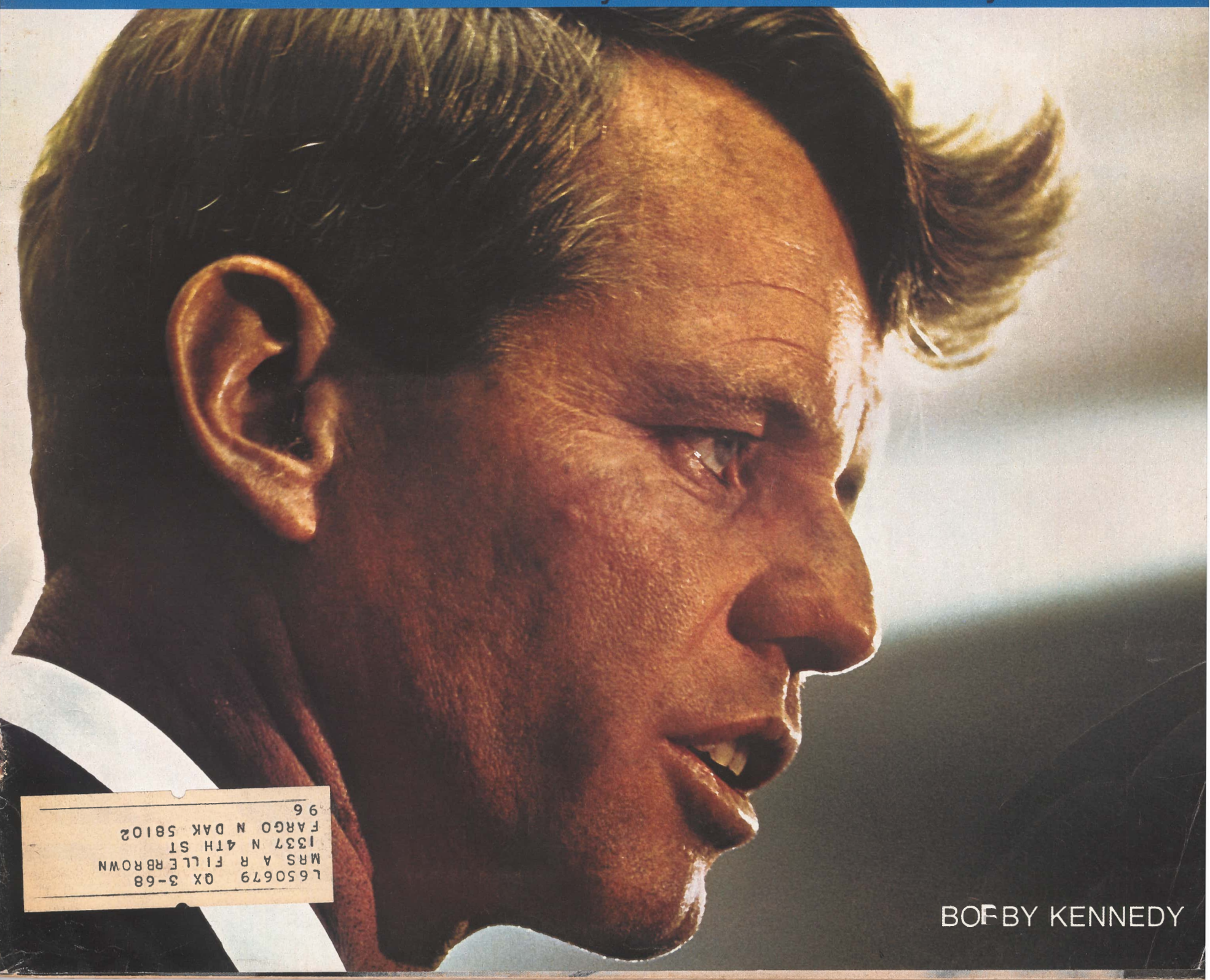
and what it means to us

THE SINGLE GIRL

How to meet a mate in Manhattan

SUPPOSE GOD IS BLACK

By Sen. Robert F. Kennedy



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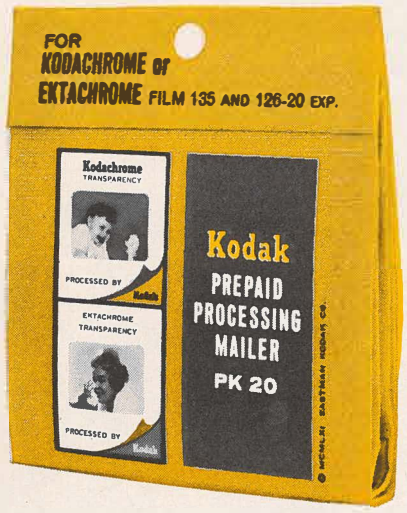

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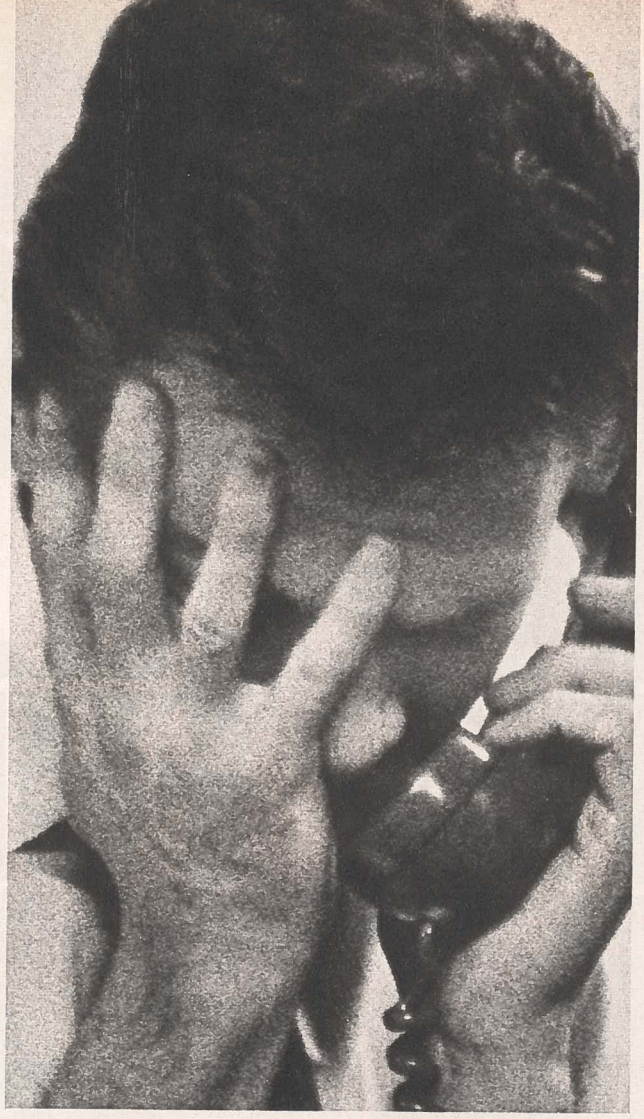

Straining, in a life-or-death conversation, the Rev. Bernard Mayes, an Episcopalian worker-priest, tries to keep a caller from killing himself. Father Mayes founded San Francisco's Suicide Prevention Inc.; would-be suicides can telephone for help at any hour, day or night.

SUICIDE

A NEW ATTACK AGAINST AN OLD KILLER

BY JACK STAR LOOK SENIOR EDITOR

In Boston, an old-age pensioner telephoned HA 6-6600 and told the woman who answered that he had just bought a revolver and intended to kill himself. In Los Angeles, a middle-aged housewife dialed DU 1-5111 and said she would rather succumb to poison than to cancer. In San Francisco, a married man with three children called 221-1424 and talked for nearly two hours before giving his name; he had been involved in a homosexual affair and wanted to die.

The telephone numbers dialed by these troubled people provide something new in mental-health programs: a round-the-clock lifeline for potential suicides. The numbers make it possible, despite the grim depersonalization imposed in overgrown cities, for would-be suicides to cut through bureaucratic apathy and red tape to get the help they need so desperately.

These telephone lifelines are strands of hope in a tragic situation. Last year, over 20,000 suicides were recorded in the U.S. Many others—perhaps another 20,000—went unrecorded because they were disguised as accidents or because of a reluctance to call suicide by its right name. Several million Americans have survived one or more suicidal attempts. Suicide has become the third leading cause of death among teen-agers 15 to 19.

In Chicago's giant Cook County Hospital, where attempt-suicides are brought in by the hundreds in the course of a year, a young nurse in the emergency room says: "We often see the same patients again and again. Their wrists bear old scars, from two or three previous attempts."

Doctors know that a suicidal "gesture" may very well precede the real thing, that the woman who takes a few pills too many or who lightly slices the skin of her wrist is giving a "cry for help." Too often, cries go unheard. At Cook County Hospital, 90 percent of the suicidal patients are discharged without further treatment after their stomachs are pumped out or their wrists sewn up.

"We send ten percent of them—the worst risks—to a state hospital so they won't be able to harm themselves," says Dr. Vladimir Urse, superintendent of the hospital's mental-health clinic. "What can we do with the others? There really are no outpatient clinics I can refer them to for outpatient care. It takes months to get an appointment, and how many patients on welfare can afford $2 to $10 for each visit?"

Dr. Thaddeus Kostrubala, formerly the city's mental-health director, is attempting to set up a suicide-prevention center in Chicago. "The public attitude toward suicide is weak, sinful and a disgrace," he says. "Eighty-five percent of those who kill themselves ask for help." Dr. Francis Parks, who has been working on a pilot program for the suicide clinic, says: "If many people could just be persuaded to wait . . . they could be saved."

Who is to do the saving? It is a fact that three-quarters of all people who kill themselves go to a physician within a few months or weeks prior to their deaths, and often, their suicidal symptoms remain undetected. Dr. Stanley F. Yolles, director of the National Institute of Mental Health, says:

"In over half the suicide deaths, there is a history of previous, spontaneous, suicidal communications, either direct—'I'm going to shoot myself'—or indirect—'How do you leave your body to the medical school?' " Dr. Yolles cites studies as proof "that more physicians must learn to recognize more suicidal signals and know how to respond to them."

Dr. Philip Solomon, associate professor of psychiatry at Harvard Medical School, who has done a great deal to prevent suicides, believes that psychiatrists alone cannot do the job. He says: "There will never be enough psychiatrists for this—not even physicians, nurses and ministers."

Dr. Solomon feels it is necessary to take a chance and let nonmedical people tackle the problem, under supervision, rather than do nothing. "A little knowledge may be a dangerous thing," he says, "but no knowledge is worse."

In Boston, Dr. Solomon serves as vice-president of Rescue, Inc., a nondenominational suicide-prevention group organized by a Catholic priest, Father Kenneth B. Murphy, after police had twice summoned him to talk would-be suicides out of leaping to their deaths.

During the past seven years, Rescue, Inc., whose telephone number is in the front of the phone book under the police and fire numbers, has handled over 11,000 calls. Not all were from persons thinking of suicide; many dealt with such

continued

"Everyone, at some time or other, has the wish to kill himself."

problems as sickness, poverty and loneliness.

Trained volunteers (including a druggist, two Trappist monks, an Episcopal priest and a paint chemist) refer callers to an appropriate social-service agency, psychiatric clinic or a private doctor. If the caller is facing a serious suicidal crisis, Father Murphy or one of the other volunteers may even go to his home. But the group's major contribution has been the mission it performs as a bridge between the distressed and Boston's social agencies and mental-health facilities. Troubled people find it much easier to get help nowadays.

The best, and the most famous, of these rescue organizations is Los Angeles' Suicide Prevention Center, which receives over 5,000 calls a year. At night, these are automatically routed to the home of one of 30 carefully selected graduate students; by day, they are handled at the center by psychiatrists, psychologists, psychiatric social workers and trained volunteers.

The callers are questioned adroitly to gauge their stress. They are rated on a lethality scale that takes into account their condition, whether they have a specific suicide scheme in mind (where, when and how), and whether they can count on friends and relatives. Older persons rate higher on such a scale; so do homosexuals, alcoholics and persons living alone. A divorce, death or separation also means increased danger.

RELATIVELY FEW of the calls represent actual emergencies, but these can be extremely dramatic. . . ." says Dr. Robert E. Litman, chief psychiatrist. "One young woman called at midnight, refused to give her name, and said only that she had taken many, many pills. During the conversation, she revealed that she could hear the ocean, and . . . was then in a church. Then she collapsed. With these clues, the police were able to find her and take her to a hospital in time to save her life."

Nearly two-thirds of the callers need little more than reassurance, or perhaps the help of a phone call to the right person. In some cases, the "right person" may be a friend or relative; in others, a social worker or a therapist who has seen them in the past. "Most of them are not serious suicide threats, but I'll be damned if they don't have serious problems," says Sam M. Heilig, co-chief social worker.

A third of the callers appear to be approaching a suicidal crisis, and it is with these that the center is proving its worth. A training manual developed at the center points out that the patients are ambivalent, "wanting to die and wanting to live . . . at the same time. An example . . . is the person who ingests a lethal dose of barbiturates and then calls someone for rescue before he loses consciousness. . . . Most people have a stronger wish to live than to die. It is this fact of ambivalence which makes suicide prevention possible."

At the center, such patients are greeted with hope and attention the moment they enter the door. An interviewer confronted with a 50-year-old man who is having trouble with his wife, his job and his health, says: "Look, you have some problems, but they're not so bad. We have seen worse. You need some counseling." While the patient is kept busy taking a psychological test, the interviewer calls in his wife to involve her in the therapy. Sometimes, a psychiatrist prescribes a psychic energizer, a drug that dispels depression.

Except in rare cases, the center does not work with patients any longer than the few weeks necessary to carry them over their crises and to see that they get into other helpful hands. Over 50 community agencies cooperate. Immediate hospitalization is recommended for 15 percent of the callers; only half of them want this, but the center keeps after the others, on a daily basis, until most are willing. All patients are encouraged to call back anytime they feel the need.

The Los Angeles center, which is supported by a seven-year $250,000 U.S. Public Health Service grant, has become a world center for suicide research. Its founders are two clinical psychologists, Dr. Edwin S. Shneidman and Dr. Norman L. Farberow. They and other staff members are deputy coroners, serving without pay under Dr. Theodore Curphey, Los Angeles County medical examiner-coroner. Every day, on the average, Dr. Curphey has three suicides to look into as well as other more baffling cases in which the circumstances surrounding death are not clear. The center's experts do a detailed psychological study of these more cryptic deaths. They interview the deceased's friends, relatives and fellow workers in their effort to learn if there was suicidal intent. Their task is not always easy, as these case reports show:

"—A woman took a considerable quantity of barbiturate tablets at 4:30 p.m. and fell asleep on the kitchen floor in front of the refrigerator. She knew that every . . . day for the last three years her husband came home at 5 p.m. and went straight to the refrigerator for a beer. There was thus a strong possibility that she would be rescued. However, her husband was delayed and did not reach home until 7:30. Recommendation: suicide."

"—A married man stayed out late drinking with friends from work about once a month. To avoid his angry wife when he came home late at night, he habitually went to sleep in his car, parked in his garage, and in the winter, he would sometimes run the motor of the car to keep warm. One morning, he was found dead of carbon monoxide poisoning. Recommendation: accident."

There is an increasing awareness of mysterious deaths among those who use barbiturates and also drink. "A number of persons live on the thin edge of death because of their daily intake of drugs—and I include alcohol," says Dr. Norman Tabachnick, a psychiatrist at the center.

Investigators from this group found that barbiturate addicts "purchased and stored sleeping pills by the hundreds, often from illegal sources. They took large amounts of barbiturates day and night and were unable to tolerate even a day without drugs. Such addicts frequently placed themselves in a rather deep stage of anesthesia almost every night." For them, catching a mild infection or twisting their necks into an awkward position "might mean death" by smothering or choking.

The experiences of the L.A. researchers are proving valuable to the National Institute of Mental Health, which is now setting up a national center to coordinate all research, training and pilot studies in suicide work. Some of the NIMH research explores unusual avenues. Dr. William Bunney, Jr., and Dr. Jan Fawcett are attempting to detect hard-to-spot depressions in potentially suicidal patients by testing their urine. The researchers speculate that the psychological stress accompanying depression produces biochemical products that are excreted in urine.

Dr. Misha Zaks, associate professor of psychiatry at Northwestern University, is also trying to spot potential suicides, but he is using a do-it-yourself written exam that can be administered to large groups, including Army recruits and college classes. Dr. Zaks believes that his test, with answers that can be checked off in only 15 minutes, will detect suicidal tendencies in persons who may not even be aware of them.

ALTHOUGH A GOOD deal is known about suicide, the facts pose new mysteries. Is suicide a disease? Are people who kill themselves mentally ill? Dr. Roy R. Grinker, Sr., director of the Institute for Psychosomatic and Psychiatric Research and Training at Chicago's Michael Reese Hospital, says: ". . . Everyone, at some time or other, has the wish to kill himself or to die for some personal reason, and enjoys the fantasy of such an ending and of the grief inflicted on those left behind. The question is: What differentiates the wish from the act. . . . We have no satisfactory answer. . . ." Dr. Grinker is convinced that "a wide variety of . . . persons, reasonably healthy and with various degrees of illness, have suicidal fantasies."

Some psychiatrists believe that most suicidal persons suffer from what is called manic-depressive disease, depressed phase. Instead of showing standard textbook symptoms of alternating periods of jubilation and dark despair, the patient sinks into a bleak morass of silent symptoms that may last many months. His appetite may diminish, he loses weight, he awakens at 4 a.m. and can't get back to sleep again. He loses interest in sex and, perhaps, in his work and his hobbies. If he goes to a doctor, he may complain of headaches, abdominal distress and other vague, hypochondriacal symptoms. He may keep secret his feelings of deep sadness, worthlessness and unhappiness.

Although depression is undoubtedly a major factor in suicide, there are scholars who challenge the belief that mental illness is responsible for most such deaths. Jack P. Gibbs, professor of sociology at Washington State University, points to strange riddles in suicide statistics:

—The suicide rate (the number of deaths annually for each 100,000 persons) increases regularly with age, from 0.3 among children 5-14 years old to 26.0 for persons 85 and over. Presumably, the problems of aging (poor health, financial problems, death of friends) are responsible. But, asks Dr. Gibbs, why is it that the rate rises only for white males, not for white women or Negroes?

—The male suicide rate is over three times that of females but not all through life. "Among persons of less than 20 years of age," notes Dr. Gibbs, "the male rate may exceed the female rate in a given year by less than one per 100,000, but at 75 and over, the differences may be as much as 50 per 100,000."

—The Negro suicide rate is 3.9, compared with the white rate of 11.4. But in Seattle, according to available statistics, the Negro rate rose to 10.2. (It fascinates scientists that as the Negro murder rate declines, the suicide rate increases.)

Dr. Shneidman of the Los Angeles Suicide

continued

Suicide is the No. 2 killer of college students

Prevention Center believes suicide needs to be explained by more than the Freudian theory that it is murder turned inward. "We now know," he says, "that individuals will kill themselves for a . . . variety of psychologically felt motives; not only hate and revenge, but also shame, guilt, fear, hopelessness, loyalty, pain and even boredom.

"Just as no single formula or pattern can be found to explain all human homosexuality or prostitution or addiction, so no single psychological or cultural pattern is sufficient to contain all human self-destruction."

Except for such primitive (and presumably happy) peoples as the Caroline Islanders of the South Pacific and the Kafirs of the Hindu Kush, suicide is an international disease. But it varies inexplicably from country to country. Japan has a high rate: 26. Catholic Ireland has a very low rate: 2.5. But Catholic Austria has one of the highest rates: 25. Sweden and Denmark are near the top with suicides, but their neighbor, Norway, is near the bottom, and it is hard to explain why. (The Swedish and Danish rates are about double the U.S. rate of 10.5, but some scientists suspect that if it were not for our lower Negro rate and our unreported white suicides, the U.S. rate might be about as high.)

West Berlin leads Europe's cities with 37, but East Berlin is probably just as high. Psychiatrist Erwin Stengel of the University of Sheffield, England, speculates that the high suicide rate in places like West Berlin and Hong Kong is due to their people being "subjected to violent changes through immigration and emigration."

In the U.S., where suicide is the tenth leading cause of death, the highest rates afflict the Western mountain regions and the Pacific Coast. San Francisco leads all cities. Los Angeles, Seattle and Portland also rank high. Thirty years ago, cities had a 60 percent higher rate than rural areas—but today, they and the countryside are practically even.

Married men between 35 and 44 have a rate of only 16.7; single men, 29.8; widowers, 81.7; and divorced men, an astronomical 112.6. Suicide hits all social and economic levels almost evenly, but certain occupations seem to be more vulnerable.

In Los Angeles County, every month, at least one physician kills himself. ("I suppose it's because they feel they can't ask for help," says a psychiatrist.) Policemen are a high-risk group, and so are peacetime soldiers. ("The surest way of reducing the suicide rate is to start a war, that is, a conventional war," says psychiatrist Stengel.)

Every possible method of dying gets tried. The more violent methods indicate the seriousness of the inner disturbance and forecast the likelihood that, if needed, another attempt will be made.

Women try suicide three times more often than men, but three times as many men die. The men use more violent means, such as shooting or hanging, while women prefer more passive devices, like sleeping pills.

Of the 20,819 suicides in a recent year, firearms accounted for 9,595; hanging, 3,057; analgesics and soporifics, 2,666; motor exhaust gases and carbon monoxide, 2,211; jumping, 791; other liquids and solids, 733; drowning, 576; cutting, 417. Barbiturates were responsible for nearly 2,000 of the analgesic deaths.

Increasingly, there is evidence of the role that alcohol plays in suicide. Dr. Frank M. Berger, president and director of research of Wallace Laboratories, reports that alcohol was found in the blood of a third of 617 Maryland suicide victims. He says: "Alcohol often intensifies and heightens the prevailing mood. In a depressed patient, it may deepen the depression, and in this manner, increase the misery of the patient. In other patients, it may increase their aggressiveness, which, when turned against oneself, will lead to suicide."

Among all the unmentionables on the subject of suicide, the grimmest is children killing themselves. Five hundred children and adolescents die every year by their own hands; 100 of them are in the 10-14 group. Dr. Reginald S. Lourie, professor of pediatrics and psychiatry, George Washington University School of Medicine, reports:

"A three-year-old tried to kill herself by throwing herself in front of cars in order to join her beloved five-year-old sister who had died a month before. A four-year-old boy attempted to jump out the window a few months after his 20-year-old brother had committed suicide in this way."

DR. LOURIE says that 10 of 40 suicidal children he studied were seeking "punishment for guilt because of death wishes or masturbatory activities." Others sought "escape from an intolerable situation or reality." Dr. Lourie found their suicidal tendency stemmed from the earliest years of childhood, when "they learned to hurt others by leaving them."

Dr. Yolles of the National Institute of Mental Health tells of a study made of 41 New Jersey schoolchildren who killed themselves: "It is apparent that suicidal children are often those who do not take part in school activities outside the classroom as members of athletic teams, orchestras, dramatic clubs. . . . In every case . . . the child had no close friends."

Increased vigilance and better communication with children may prevent suicide. Dr. Joseph D. Teicher, professor of psychiatry, and Jerry Jacobs, his research associate at the University of Southern California School of Medicine, found that all but 12 percent of adolescent suicide attempts occurred at home, often with parents in the next room. But the parents might just as well have been miles away. "The adolescent suicide attempter is cut off from persons with whom he can discuss his problems," said the researchers.

Teicher and Jacobs discovered that in 72 percent of cases studied, the young persons "had one or both natural parents absent from the home (divorced, separated or deceased.)" Twenty percent of them had a parent who attempted suicide. Twenty-two percent of the girls "were either pregnant or believed themselves to be pregnant."

In the 15 to 19-year-old group, deaths by suicide are exceeded only by deaths from accidents and cancer. Suicide is the second leading cause of death among college students, with the boys' rate twice as high as the girls'.

Society's reaction to suicide is becoming less punitive as a more enlightened attitude develops toward mental illness. In England, it was unlawful until 1961 for anyone to try to kill himself. From 1946 to 1955, the English put on trial 5,800 persons and found 5,500 of them guilty of attempting suicide. Three hundred were sent to prison. In the U.S., nine states still have laws against attempting suicide; other states prosecute suicidal persons for "disorderly conduct" or "breaching the peace."

"This is typical of our medieval attitude toward suicide," says Dr. Morton Tabin, a psychiatrist in Champaign, Ill. "We can't face up to what is sickness, so we call it crime and ship the 'criminal' off to prison. It's about time we faced up to the truth, even if the truth bothers us."

Dr. Shneidman of the Los Angeles center agrees, but is heartened by new developments in the mental-health field. He says: "We are at last on the threshold of seeing every community establish some sort of suicide-prevention facility, just as it has established a fire department. Interested citizens, professionals and amateurs alike, should, through their local mental-health organizations, establish and support a suicide-prevention center."

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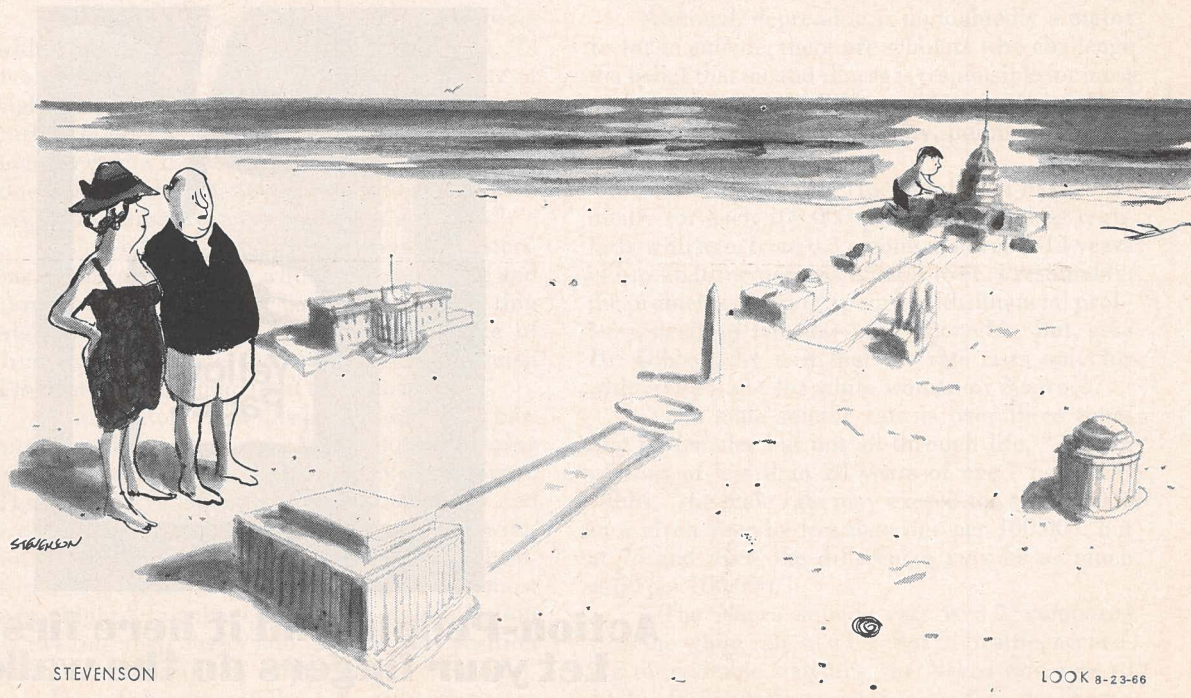

"Now, there's a young fellow we'll be hearing from some day."