Suicide and Happiness:

The Struggle to Identify Effective Treatment

Alexander Bowman

Writing 50, Monday 9 a.m.

Lisa Avery

February 6, 2010

Suicide and Happiness:

The Struggle to Identify Effective Treatment

Today, I consider myself a happy person and I feel that I have all that I could expect in life and more. If you speak to those who have met me before, they are likely to say that I have been a very happy person as long as they have known me; however, they would not be completely right. Despite the fact that I am happy a lot of the time, I have also been through major depression, and so have many others. It is unfortunate that so many people have personal experience with suicidal thoughts or experiences, whether they personally fought against them or if they knew someone who did.

My own experience with suicidality has bred a strong personal interest in the topic, and this paper is the result of my findings. Simply preventing someone from committing suicide may be considered a successful treatment, but I was always more interested in finding out which treatment methods allowed for clients to be happy. The definition of happiness is highly subjective; for my purposes here it is mostly a combination of relief from suicidality, feelings of capability and social acceptance, enjoyment of life, and self-acceptance. I have found that some treatment methods, such as modern psychological techniques (i.e. motivational interviewing), are successful at treating–by eliminating–suicidal ideas or tendencies as well as developing a strong sense of well being; other methods such as anti-depressant medication are proving to be either ineffective or counterproductive.

First, it is important to define *suicidality*. Suicidality is a condition that can be either acute or chronic in which a person is giving consideration to whether they want, intend, or choose to live versus whether they want, intend, or choose to die (Arkowitz, 2008, p.175). In

other words, it is a term used to describe a person who is questioning whether they want to live or die. An even broader definition of suicidality is an umbrella condition that includes both suicidal ideation–thinking about suicide–and *parasuicide*–which describes mild overdoses, wrist cutting, performing life-threatening acts, etc. (Paris, 2007, p. 1). This definition means that suicidality includes both suicidal ideation and suicidal tendencies or actions. Such broad terms are necessary for this subject matter because every story is different. My story is not the same as every other story, but it can still be used to illustrate common topics within suicidality.

When I was in high school, I was almost as familiar with feelings of shame as I was with suicidality. I paid constant attention to how society rejected the expression of unhappiness and how it praised those who kept their emotions to themselves, especially for men. I knew that I was unable to talk about my suicidality with others; on one hand it was taboo, and on the other hand I would have been called "emo," or my admissions would have been met with derision. I lived in fear that if I were discovered for who I was I would inevitably be forced into therapy against my will, or perhaps given a daily prescription that I did not believe could possibly help. I was aware of the statistics of how many people have endured depression, and I even knew that some of my friends were depressed, but I still felt like nobody would be able to understand what I was going through.

My story is not unique. While many people may claim to not be able to understand how a person could want to kill him or herself, the numbers show the other side of the story. In fact, suicidal ideation is quite prevalent; about half of all young adults exhibit some form of suicidal ideation (Paris, 2007, p. 3). Actual suicide attempts are less common, but are still surprisingly high: 1 in 20 Americans have made some form of suicidal attempt during their life (Paris, 2007, p. 5). One might wonder why the very high prevalence of suicide attempts does not mirror the

actual numbers of completed suicide, and the answer might lie within the concept of "gestures," or attempted suicides that, although dangerous, were never carried out with the true intention of death and often do not require medical attention (Paris, 2007, p. 5). Completed suicide is the cause of death for only 11 out of every 100,000 people (Paris, 2007, p. 3) but is still the 11th highest cause of death in the American population (Paris, 2007, p. 14), and the 3rd highest cause of death for Americans aged 15-24 (Arkowitz, 2008, p. 175). For my former self, the shame of entertaining suicidal thoughts made me feel defective, or broken, but after doing my research I feel differently. Despite the fact that suicide is still taboo, I feel confident in saying that suicidality is a fairly *normal* part of humanity, not some mental disease, and the numbers seem to agree. As I discussed before, suicidal ideation was a part of my daily life in high school, but that isn't where it started. Unfortunately, the idea of suicide sprouted much earlier.

In early elementary school, I led a fairly normal childhood. I wasn't popular, but I had enough friends. My parents had a stable and happy marriage, and neither parent used drugs or abused alcohol. I also did well in school, and I perceived myself to be a very intelligent individual. This intelligence, however, was my hubris; I was a gifted student, and I eventually believed that I was smarter than everyone else. I became arrogant and dismissive of others, and although my brain developed quickly my moral conscience was nonexistent for a while. When I was age ten, however, my conscience grew almost all at once, and I instantly realized what a mean-spirited person I had become. I became depressed, and soon came to the belief that the world would be better off without me. Before I even reached my eleventh birthday, I had come to the conclusion that I did not deserve to live. At that age, I was still religious, and I believed that suicide would certainly lead to eternal damnation, so, in order to boost my eventual resumé at the gates of heaven, I decided to spend the next ten years of my life helping the world and being

a decent person in order to counteract the ten years I spent looking down on others. Thus I developed a system for "penance;" I said to myself that once I had finally done more good than harm in the world, I would finally be ready to rid the world of my presence. In middle school, I spent a lot of my time drawing doodles of how I would end my life, and I planned out the possibilities the way an architect would draw out floor plans for houses. As my self-esteem fell lower and lower, my grades, which were once exceptional, crashed. I was a little boy who had lost the will to live, and although my depression brought me great pain, my plans to eventually commit suicide brought me comfort. I never discussed my plans with anyone, even my closest friends, and, since I was always the introvert of my 6-person family, depression was fairly easy to hide from them. Because there was nothing around to stop it, my depression and my pain grew continuously through middle school.

Many clinicians (and people) see suicidality as some kind of medical disease (Paris, 2007, p. 58), but this perception only serves to hinder their ability to treat it. Edwin S. Shneidman, the suicidological pioneer and founding president of the American Association of Suicidology, had other ideas (Ellis, 2006, p. 30). His work discussed the "logic of suicide," and he once wrote, "reason is as much of a part of suicide as emotion is" (Ellis, 2006, p. 32). Because of certain events and various stimuli in my early life, the 10 year old boy that I once was concluded that the world would be better if I never had existed. Although I came to the conclusion that suicide was my only option, I arrived at it through logic, and not because of a disease. My final decision was unfortunate, but it cannot simply be attributed to such simple biology. Shneidman wrote that he did not believe that suicide was best understood as a psychosis, but rather, as a logical trap in which a person constricts their perceived options to either endurance of great pain or death to stop the pain (Ellis, 2006, p. 34). Shneidman believed

that there is nothing intrinsically wrong with thinking about suicide, and that it was only abnormal when someone perceived suicide as the *only* solution to their pain. He wrote that the reasons for suicide almost always made sense to the person who commits it (Ellis, 2006, p. 36). Through his research, Shneidman learned that people who suffer with suicidality are not intrinsically "different," and that they came to their conclusions with logic, which is a tool that we all possess. In that sense, he saw that while many people needed help to get out of their suicidal logic trap, their minds were not broken or in any way incapable of achieving normalcy.

Everywhere I went, however, I feared that I would be perceived as "broken." Romantic dissatisfaction in high school was only making my depression worse, and I resolved to work harder at being a better person so that I could achieve my "penance" earlier than after 10 years. I felt that if I was a truly model citizen, I would have balanced my moral debt enough that I would be able to commit suicide at 18 and still leave a net positive effect on the world. When I arrived at UC Santa Barbara for my first year of college, I was fiercely determined to make my residence hall a better place. I made a lot of friends very quickly, and I was ready to lend a hand at every opportunity. I got involved with the San Nicolas Hall Council and tried to help out my coworkers by far more than what was written in my job description.

Although I planned to be helpful only to fill a mental quota to judge when I would end my own life, any help or kindness that I offered was by no means fake or thoroughly tainted. It is understandably hard to understand that someone could be happy and suicidal in tandem, but in many ways I *was* happy during my first year of college. Helping others, telling jokes, giving advice, and passing kind words did give me great happiness, but unfortunately it was only in a short-term, hedonistic sense. As much as I enjoyed making other people smile, the good feelings my actions produced made no direct impact on the long-term integrity of my suicidal intentions

or my abysmal self-esteem, and they failed to change my mind about suicide. After a few intense months of creating positive affect in my outside environment, I decided that I had done enough good, and that it was time for the fun to be over.

My belief that my good deeds were filling a quota made the deeds feel neutral, or necessary, which relates to the concept of *anhedonia*, which is a disconnection from one's own identity (Ellis, 2006, p. 124). The concept readily applies to suicidality in that it is easier for people to commit suicide when they no longer feel identified with themselves. This was an important part of my struggle; my opinion of myself was based on how I thought of myself as a child, and whenever I did a good deed I was unable to attribute it to myself or take credit for it in any way, and so my self-esteem was locked in at a very low point.

Anhedonia cannot be expected to affect everybody that struggles with suicidality; there are different types of suicidality, and different types of suicidality require vastly different treatments. Often, depression will lead to suicidal thoughts, but these thoughts will dissipate once the depression is lifted. Many people know what it feels like to be unhappy or depressed, but far less have experienced psychological pain every day for months or years on end; this is the world of *chronic suicidality*, which is not a short-term symptom but rather a central aspect of the patient's take on life (Paris, 2007, p. 18-19). Because of this, the idea of suicide is an important aspect of the patient's mentality, and the idea of eventual suicide supports many aspects of his or her life. Typically, a therapist's goal is to relieve the client of suicidal ideation, but in a chronically suicidal patient, removing suicidal ideation leads to a removal of the basic root structure of the patient's personality (Paris, 2007, p. 20). Thus, for the chronically suicidal patient, suicide is fundamentally important. "Having suicide as an option becomes a way of reasserting control in a world that seems uncontrollable and chaotic" (Paris, 2007, p. 27). These

distinctions, although they may be well documented, are often looked over, and then the therapist's goal becomes to eliminate suicidality. Instead, the first goal for treating chronic suicidality should be an attempt to establish life skills that will give the patient control over his or her life, which will ultimately eliminate the need for suicide as a means of comfort or control (Paris, 2007, p. 31). Because seemingly innocuous differences between conditions require such different treatments, there is significant confusion among many clinicians. This is the basis on which happiness becomes an integral part of my research. It is difficult to tell which treatment methods prevent the most completed suicides, but it is clear that differentiating whether or not to remove suicidality is fundamentally important for the patient to achieve happiness. There is also a similar confusion in the public understanding of suicidality. Despite my own experience with suicidality, even I had been unaware of these differences until doing the research that led to this paper. These vast misunderstandings, sometimes bordering on ignorance, affected my recovery long after the climax of my suicidal experience.

That climax took place in early December of my first year in college. I felt I had done enough good deeds in the world to counter the bad ones, and I declared myself "done" a few weeks before the attempt. I woke up early on December 7th, made a sincere attempt, and failed. I am grateful that I failed today, but at the time I was outraged and confused about how I managed to survive.

Logically, it is far easier to kill oneself if the person in question has little investment in their life (Ellis, 2006, p. 123). In what turned out to be a very healthy decision for me, soon after my attempt I got myself involved with a few new commitments for my second year of college. The one most worth mentioning was that I became a Resident Assistant (RA), and my new job entailed helping and looking after 50 freshman residents in my hall. In previous years, I had

already developed a strong love for helping others, and as a result I had a great deal of enthusiasm about the job, and excelled both as an RA and as a friend to my residents. The Resident Director (RD), my main supervisor and new friend, encouraged all of the RAs to get to know each other on a very personal level, but after a few months of staff bonding I was the only one who admitted to having not yet shared my whole story. By this time it was about a year since my attempt, and I had completely recovered and harbored no further desire to end my life. Still, though, I did not feel comfortable sharing my story until February of the next year, after I had been stably recovered for a matter of months. Part of the reason that I felt ready to share was that the RA staff had almost an entire month of training before the year started, and during most of the training we were learning how to accept others. I felt that if the RA staff could not accept me, then nobody could.

The few days after opening up to the staff contain a lot of details, but they can be summarized as follows: I was deemed by the RD to be mentally unfit for the job, and I was then pressured to resign immediately in order to avoid being fired. I was dazed. Only a month prior, the RD had been telling me that I was doing a great job, and was encouraging me to apply for the position for the following year. But simply because I admitted to having made a suicide attempt over a year before, my employer ignored my achievements (and positive survey results) and decided that I was mentally incapable of doing the very job that I had been doing for six months. The job that I had just lost included free room, free board, and large social supports. In other words, when I lost the job I lost my home, food, and was now on the other side of campus from my friends. Although I did not find this out until my junior year, the RD had in fact instructed my residents not to try and communicate with me in any way, and so I spent the rest of the year isolated in graduate housing.

At this point I must note that I use strong language–such as "isolated" and "lost my home"–without intention of evoking pity but rather with the intent to prelude the final two segments of my personal story: bitterness and motivation. I was greatly upset about the losses described in the previous paragraph, and most importantly I felt that I had been ostracized from a life that I had finally begun to succeed at. I was once again depressed, but unlike my long-term chronic suicidality this was brief and was caused by loneliness, not self-loathing, and eventually gave way to bitterness. Because I had never harbored such bitterness in years, I felt quite unlike myself, but the cause of my bitterness was the belief that I had been wronged, and the healthy result of this belief was a personal investigation into whether or not the RD was justified in his belief that a previous mental "illness" denotes an inability to work as an RA. I started keeping a journal for the first time in my life, and its sole purpose was to keep track of anything I observed or theorized regarding societal impressions of suicidality or depression. I quickly became suspicious of medications, and further research showed that I had very good reason to be.

My first interest in anti-depressants was born from a television ad that I saw while I was "ostracized" in graduate housing. The commercial was advertising anti-depressants (the brand name I can not remember), but mentioned at the end that there was only a 30% success rate, and that there was a possibility of making symptoms worse if given to people aged 15-24. I then looked for information on the website, which claimed that their medication works by repairing malfunctioning synapses in the brain. Why then, I wondered, did the medication have opposite effects for 15-24 year olds? Assuming that our brains do not rapidly change structure when we are 15 and change back when we are 24, simply repairing synapses could not possibly be the whole story. I later learned of the term "bioreductionism," which means reducing all explanations to simple biological phenomena; this describes the synapse theory perfectly

(Levanthal, 2006, p. 22). I also wondered how much of their 30% success rate could be attributed to the placebo effect. As it turns out, the placebo rate is remarkably high, often in the 20 – 40 percent range (Phillips, 2009, p. 185). Beyond that, even an analysis of studies sponsored by pharmaceutical companies show that of the patients enrolled in the trials, those on anti-depressant medication were *2.1 times more likely* to have suicidal thoughts or behaviors if they received medication for depression than if they received a placebo agent (Phillips, 2009, p. 217). After seeing that first anti-depressant advertisement that had peaked my interest, I wondered if the medication really had any effects at all, but the fact that medications multiply suicidality by 210% shows that they have a very real effect, but a negative one. I no longer believe that medications have no function, however I am still unwilling to claim that they help. A favorable scientific review of anti-depressants was harder to find, but I did come across a resource that suggested that anti-depressants do have some positive effect on reducing suicide rates, even if the effect is barely above placebo levels. This source, however, mentioned that the random clinical trials employ a selection bias; they "typically exclude subjects at highest risk for suicide" (Ludwig, 2007, p. 2). Even when data from outside a clinical trial is analyzed, a selection bias is still present (if not more so) because of the possibility that patients who are compliant with taking pharmaceutical medication may, by disposition, be at a lower risk for completing suicide than those who refuse help (Paris, 2007, p. 83).

Since it is so difficult to determine whether or not any given form of intervention actually prevented a patient from going through a completed suicide, my interest in treatment statistics has always been limited to determining which ones leave the patient better off, in other words, happier. I mention this to distinguish that the first studies I referenced exhibited raised levels of *suicidality*, not actual suicide, in patients. However, anti-depressants have not been shown to

actually reduce the completed suicide rates, either. Further, an overdose of many medications, such as tri-cyclic anti-depressants, is highly toxic, and the presence of medication may serve only as a cheaper way to complete suicide (Ludwig, 2007, p. 6).

Well before I was wary of the effects of prescription medication, I was wary of psychotherapy. One of my greatest reoccurring fears during adolescence was the idea that if I were discovered for who I was I would be forced to see a psychologist. When I opened up to the RA staff, my old fears became reality, only in an indirect manner. As I found out on the day I resigned, my job was not the only thing that was in jeopardy. In fact, the word of my previous condition had spread well beyond the campus Housing program, and now the university itself was interested in terminating my status as a student if I failed to prove my "mental stability." In other words, I was going to be removed from the school if I didn't see one of the on-campus psychologists. So, within a few hours of resigning, I was sitting in the office of a psychologist and explaining to him that I was no longer considering suicide as an option. I told him the same story that I told the staff, and he believed when I claimed that I had things under control, and at our second (and last) meeting he told me that he felt comfortable telling the university that I did not need to be ejected from the school. I was very grateful that at least someone had faith in me despite my past. This experience was my first and last encounter with any form of actual psychotherapy, and although it was a positive experience, it did not largely alter my previous conception that psychotherapy would never have been able to help me.

That conception, however, has changed recently; this is mostly due to the copious amount of reading that I have done recently, and I admit that I have been surprised by what I learned about the newer methods of psychotherapy. As mentioned before, there are significant differences between a suicidal patient and a chronically suicidal patient. Older methods would

treat all patients that expressed suicidality with similar tactics, but newer ones are far more sensitive and adaptable. Motivational Interviewing (MI) is a technique that applies a liberal dose of empathy to patient–therapist discussions. The main appeal of MI is that it addresses a fundamental roadblock with all therapies: resistance to change (Arkowitz, 2008, p. 2). Because a suicidal patient may be unwilling to give up the comfort of having suicide as an option (as discussed earlier), MI serves as a great way to promote autonomy for the patient (Arkowitz, 2008, p. 177). Motivational interviewing is largely client-centered, and emphasizes understanding of the client's point of view and concerns (Arkowitz, 2008, p. 3). Successful treatment with MI, and many other forms of psychotherapy, depends on the therapist's ability to "*tolerate* suicidality" (Paris, 2007, p. xiv). In this sense, it is not necessarily the methodology of MI that is modern, but the paradigm. Modern psychotherapy acknowledges that removing suicidal ideation should not always be the most immediate goal, and it places more trust in the patient. Older, less empathetic paradigms focused on immediate safety, but it may be far more beneficial for the patient if the therapist can acknowledge that "'safety' is an ephemeral goal" (Paris, 2007, p. xviii). When life skills or assurances of safety are forced upon suicidal patients, there is less hope that the patients will be able to find inner safety by themselves. In other words, "the more that safety is imposed from without, the less there may be from within" (Arkowitz, 2008, p. 177).

When I was first kicked out of the residence hall, I was not bitter until after the first few months. At first I was ashamed of my past, and accepted my ostracism as fair, and just. I figured that it would be better for everyone that I was alone in graduate housing. The bitterness that I eventually felt was caused more by my feelings of loneliness than because of social injustice. I felt like the world had no intention of accepting me, and I felt that nobody was speaking out

against ignorance or misunderstanding. I decided to learn what I could about suicidality, but the most important thing that I've learned so far was that there is so much understanding in the world, and that many others feel the same way that I do. Many people who have never experienced suicidality themselves are nonetheless able to empathize and understand with those who have. When I learned that I was not alone at all, my bitterness subsided. I believe that many people are simply unaware of how prevalent suicidality is, and so I do not fault them for believing—provided that they have not already been shown otherwise—that there is something intrinsically wrong with those who have considered suicide as an option.

I find it truly unfortunate that many patients are told that they have no say in whether or not they can recover, instead, they are hospitalized or medicated, both of which have been shown to be unable to prevent suicidality, and do not promote long-term happiness. I have read testimonies that were originally spoken on the California senate floor, and in these testimonies parents told stories of how medication made their children worse, and often resulted in a completed suicide. I was surprised when I learned about the leaps and bounds that psychotherapy has made, especially in regards to empathy and patient autonomy. From interviews with those that have recovered, I have been told that self-reliance is an important aspect of recovery. Psychotherapy accomplishes just that, provided that the therapist is empathetic enough. Therapists who are empathic and create strong alliances with their clients will get better results (Paris, 2007, p. 105). I am under the impression that everyone could use a little help at different points in their lives, but after all I have learned, I argue that prescription medication severely lacks many of the critical benefits for recovery that professional therapy offers. Because of this, anti-depressants are generally incapable of promoting long-term happiness in the way that

psychotherapy can. In the end, a patient must trust him/herself, but a skilled therapist can help teach a patient how to accomplish self-reliance in ways that an anti-depressant never could.

As a final note, I would like to urge readers to learn from the misunderstanding of the RD, and accept those who struggle with suicidality as functional human beings, and not as those who are "ill" or have a "disease." Doing so would only be worse for their happiness, maybe yours as well, and is likely to lead to more bitterness. To those readers that have experienced suicidality, I urge you to always trust yourself, but do not scorn help—professional or otherwise—from others, especially when their intentions are pure. More importantly, I urge you to not be ashamed of your past, but to embrace it, and I urge everyone to have hope for the future. For the sake and enlightenment of everyone, I hope that someday soon people will come to accept, and not fear, differences in others. Hopefully, someday, people's differences will not cause them to feel alone or misunderstood. Hopefully, more people will find happiness. Hopefully, that someday will be soon.

References

California, Legislature, Senate, Committee on Health and Human Services (2004). Psychotropic drugs and the risk of suicide: joint informational hearing of the Senate Health and Human Services Committee with the California Task Force on Youth and Workplace Wellness. Title on p. 1: *Antidepressants and Suicide*. Published Sacramento, CA: Senate Publications.

Arkowitz, Hal (Ed.). (2008). *Motivational Interviewing in the Treatment of Psychological Problems*. New York: Guilford Press.

Ellis, Thomas E. (2006). *Cognition and Suicide: Theory, Research, and Therapy*. 1st ed.Washington, DC: American Psychological Association.

Leventhal, Allan M. (2006). *The Myth of Depression as Disease: Limitations and Alternatives to Drug Treatment*. Westport, Conn.: Praeger.

Ludwig, Jens. (2007). *Anti-depressants and suicide* [electronic resource]. Cambridge, Mass.: National Bureau of Economic Research.

Paris, Joel. (2007). *Half in Love with Death: Managing the Chronically Suicidal Patient*. Published Mahwah, N.J.: Lawrence Erlbaum Associates.

Phillips, James. (2009). *Philosophical Perspectives on Technology and Psychiatry*. Oxford; New York: Oxford University Press.