Understanding Suicide: Implications for Clinical Practice and Public Health

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APPROXIMATELY 30,000 PEOPLE DIE BY SUICIDE IN THE UNITED STATES each year, with rates ranging from 10-15 completed suicides per 100,000 people (Joiner, 2005). A completed suicide is still relatively rare compared to other causes of death, with a little over 1 out of every 100 deaths being a completed suicide, while cancer and heart disease account for 52 out of 100 deaths. However, in the developed world in 2010, suicide became the leading cause of death for people ages 15-49 (Institute for Health Metrics and Evaluation, 2010). This trend has significant implications for colleges and universities.

Completed suicides often highlight the lack of understanding, influence of biases, and levels of stigma that surround the phenomenon as well as perpetuate its occurrence. Given the levels of mortality, there is a paucity of comprehensive theories of suicide informed by empirical

University Health Care Providers as Partners in Transition of Childhood Cancer Survivors

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SURVIVAL RATES FOR CHILDHOOD CANCER HAVE GROWN GREATLY over the last few decades thanks to many advances in pediatric cancer treatment. Today, 80 percent of individuals diagnosed with cancer before the age of 21 will be long-term survivors (Ries, 2007). These life-saving treatments can cause health problems or late effects long after treatment is finished. Survivors of childhood cancer will continue to require lifelong survivor care to ensure late effects are detected in a timely manner, minimizing the negative impact on health and quality of life (Diller et al., 2009). The Childhood Cancer Survivor Study, a study of 14,000 long-term survivors of pediatric cancer, found that 62 percent of survivors were living with a chronic health condition as young adults (mean age 26 years) and 28 percent had a severe, life-threatening, or disabling health condition or have died (Oeffinger et al., 2006). These health conditions included congestive heart failure, secondary malignancy, infertility, and major joint replacement, among others.

The issue of cancer survivor care has been addressed on a national level recently by multiple Institute of Medicine reports and a National Action Plan for Cancer Survivorship developed by the U.S. Centers for Disease Control and Prevention (CDC) and the Lance Armstrong Foundation ("Childhood Cancer Survivorship: Improving Care and Quality of
evidence. Greater knowledge of these theories can enhance our understanding and empathy when we respond as health care providers and as a society. This article will review historical and contemporary theories of suicide and outline the implications of these theories for public health interventions and clinical practice in higher education environments.

One of the first historical scientific theories of suicide was set forth by Émile Durkheim in his 1897 book *Le Suicide*. Durkheim emphasized the importance of social factors and the social integration of individuals within society as having a powerful influence over individual suicidal behavior. According to Durkheim, it is the myriad of social forces that account for the variations in suicide rates across countries and cultures, with suicide being caused by a disturbed regulation of the individual by society. Two kinds of regulation are emphasized: social integration and moral regulation. Durkheim theorized a curvilinear (U-shaped) relationship between social regulation and suicide with people being at greatest risk when they are too integrated or too disconnected from society.

The first half of the 20th century was dominated by more psychoanalytic views of suicide that focused on the roles of hostility and aggression turned inward, as well as self-inflicted guilt, to explain the phenomenon. Based on more recent research and epidemiological data, these theories were more harmful than helpful in the sense that they perpetuated myths about suicide. More recent theories have focused on hopelessness (Beck et al., 1990), thwarted psychological needs and the resulting psychological pain, lethality (Shneidman, 1996), biological deficits, exposure to trauma, and the inability to develop adaptive ways of responding to negative emotions (Linehan, 1993) as playing significant roles in completed suicides. These theories have been supported by various studies and have influenced other thinkers.

A more contemporary and comprehensive theory of suicide that is gaining attention and support by recent research is the theory posited by Thomas Joiner. Joiner believes "people die by suicide because they have both the ability and the desire to do so." According to Joiner (2005), people develop the ability to enact lethal self-injury through having an array of provocative experiences that lead them to become fearless of death, develop pain-tolerance, and acquire knowledge about dangerous behaviors. A key factor in lethality is one's experience and practice at overcoming the self-preservation instinct (Joiner, 2005). This ability to enact lethal self-injury is activated by the development of a desire for death, which according to Joiner, comes from a sense of perceived burdensomeness and thwarted connectedness. Perceived burdensomeness is developed through a variety of experiences where the person comes to see him- or herself as so ineffective that loved ones are threatened at some level. Numerous studies have found that people in many contexts, who perceive themselves as not measuring up and as being a burden, are prone to suicidal behavior (Joiner, 2005). This process is linked with feeling disconnected and having a sense of alienation that further generates the desire for death and is the most robust link between childhood maltreatment and later suicidal behavior (Twomey, Kaslow, & Croft, 2000).

Overall, Joiner's theory is compatible with the prevalence rates and epidemiology of suicide. Thankfully, very few people have the experiences to acquire the capability for lethal self-injury; of those, only a small percentage ever experience consistently the other two factors for serious suicidal behavior. This theory of suicide has direct implications for public health and mental health practices in higher education. Serious efforts to prevent suicide must include and go beyond effective treatment. Colleges and universities must find ways to implement a broader public health approach that focuses on reducing the risk of suicide and promoting mental health for the entire student population.

At Cornell University we have developed such a framework that is outlined in detail in Eells, Marchell, Corson-Rikert and Dittrman (2012). It focuses on fostering a healthy educational environment through campus councils and policy reviews/changes, promoting life skills and resilience through training and leadership development, increasing help-seeking behavior through stigma reduction, leadership statements, and peer counseling, identifying people in need of care through enhanced screenings and innovative counseling outreach, providing mental health services and medical services in a collaborative way through increased hours and easy referral across services, delivering coordinated crisis management services, and restricting access to lethal means of suicide.

In the context of Joiner's theory, a broader public health approach that focuses on fostering a healthy educational environment, promoting life skills and resilience, increasing help-seeking behavior, and identifying people in need of care can go a long way toward increasing students' sense that they are connected and belong to a campus community. Providing mental health services and medical services in a collaborative way can ensure that assessment for the primary factors that Joiner posits as increasing suicide risk are incorporated into the provision of this care. Assessments in the mental health service should include an examination of behavior that may lead to acquiring an ability to enact lethal self-injury, as well as exploring feelings of burdensomeness and levels of social connection explicitly. Restricting access to lethal means of suicide is also essential in disrupting the process of acquiring the ability to enact lethal self-injury. On the Cornell University campus this meant restricting access to the bridges and cliffs edges that were responsible for nearly half of the suicides on our campus. Within Joiner's model, every trip to class across a bridge could be a part of a process of habituating to the possibility of a completed suicide for the suicidal student. With effective means restriction in place (steel mesh and fences), that process is subverted because that student is no longer exposed to a context that is potentially
(and historically) lethal. Additionally, the presence of visible means of restriction efforts can interrupt the feelings of being disconnected socially. Clinically, several counseling service clients experiencing suicidal ideation expressed feelings of safety and a sense of being cared for by these tangible, daily signs of the extent of the university's commitment to preventing suicide.

Though still a relatively rare phenomenon, completed suicides are devastating to families and higher education communities. Enhancing our understanding of various theories is essential for effective clinical and public health responses on our campuses. It is the responsibility of all of us to reduce the preventable deaths that result from completed suicides.

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References


American College Health Association National College Health Assessment

Having current, relevant data about your students' health can help you to enhance campus-wide health promotion and prevention services.

The American College Health Association’s National College Health Assessment (ACHA-NCHA) — a nationally recognized research survey conducted twice a year since 2000 — can assist you in collecting precise data about your students’ habits, behaviors, and perceptions on the widest range of health issues including: alcohol, tobacco, and other drug use; sexual health; weight, nutrition, and exercise; mental health; personal safety and violence; and impediments to academic performance.


American College Health Association