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By SCOTT ANDERSON

“There is but one truly serious philosophical problem,” [Albert Camus](#) wrote, “and that is [suicide](#).” How to explain why, among the only species capable of pondering its own demise, whose desperate attempts to forestall mortality have spawned both armies and branches of medicine in a perpetual search for the Fountain of Youth, there are those who, by their own hand, would choose death over life? Our contradictory reactions to the act speak to the conflicted hold it has on our imaginations: revulsion mixed with fascination, scorn leavened with pity. It is a cardinal sin — but change the packaging a little, and suicide assumes the guise of heroism or high passion, the stuff of literature and art.

Beyond the philosophical paradox are the bewilderingly complex dynamics of the act itself. While a universal phenomenon, the incidence of suicide varies so immensely across different population groups — among nations and cultures, ages and gender, race and religion — that any overarching theory about its root cause is rendered useless. Even identifying those subgroups that are particularly suicide-prone is of very limited help in addressing the issue. In the United States, for example, both elderly men living in Western states and white male adolescents from divorced families are at elevated risk, but since the overwhelming majority in both these groups never attempt suicide, how can we identify the truly at risk among them?

Then there is the most disheartening aspect of the riddle. The National Institute of Mental Health says that 90 percent of all suicide “completers” display some form of diagnosable mental disorder. But if so, why have advances in the treatment of mental illness had so little effect? In the past 40 years, whole new generations of antidepressant drugs have been developed; crisis hotline centers have been established in most every American city; and yet today the nation’s suicide rate (11 victims per 100,000 inhabitants) is almost precisely what it was in 1965.

Little wonder, then, that most of us have come to regard suicide with an element of resignation, even as a particularly brutal form of social Darwinism: perhaps through luck or medication or family intervention some suicidal individuals can be identified and saved, but in the larger scheme of things, there will always be those driven to take their own lives, and there’s really not much that we can do about it. The sheer numbers would seem to support this idea: in 2005, approximately 32,000 Americans committed suicide, or nearly twice the number of those killed by homicide.

But part of this sense of futility may stem from a peculiar element of [myopia](#) in the way we as a society have traditionally viewed and attempted to combat suicide. Just as with homicide, researchers have long recognized a premeditation-versus-passion dichotomy in suicide. There are those who display the classic symptoms of so-called [suicidal behavior](#), who build up to their act over time or who choose methods that require careful planning. And then there are those whose act appears born of an immediate crisis, with little or no forethought involved. Just as with homicide, those in the “passion” category of suicide are much more

likely to turn to whatever means are immediately available, those that are easy and quick.

Yet even mental-health experts have tended to regard these very different types of suicide in much the same way. I was struck by this upon meeting with two doctors who are among the most often-cited experts on suicide — and specifically on suicide by jumping. Both readily acknowledged the high degree of impulsivity associated with that method, but also considered that impulsivity as simply another symptom of mental illness. “Of all the hundreds of jumping suicides I’ve looked at,” one told me, “I’ve yet to come across a case where a mentally healthy person was walking across a bridge one day and just went over the side. It just doesn’t happen. There’s almost always the presence of mental illness somewhere.” It seemed to me there was an element of circular logic here: that the act proved the intent that proved the illness.

The bigger problem with this mental-illness rubric is that it puts emphasis on the less-knowable aspect of the act, the psychological “why,” and tends to obscure any examination of the more pedestrian “how,” the basic mechanics involved. But if we want to unravel posthumously the thought processes of the lost with an eye to saving lives in the future, the “how” may be the best place to look.

To turn the equation around: if the impulsive suicide attempter tends to reach for whatever means are easy or quick, is it possible that the availability of means can actually spur the act? In looking at suicide’s close cousin, murder, the answer seems obvious. If a man shoots his wife amid a heated argument, we recognize the crucial role played by the gun’s availability. We don’t automatically think, Well, if the gun hadn’t been there, he surely would have strangled her. When it comes to suicide, however, most of us make no such allowance. The very fact that someone kills himself we regard as proof of intent — and of mental illness; the actual method used, we assume, is of minor importance.

But is it?

As it turns out, one of the most remarkable discoveries about suicide and how to reduce it occurred utterly by chance. It came about not through some breakthrough in pharmacology or the treatment of mental illness but rather through an energy-conversion scheme carried out in Britain in the 1960s and ’70s. Among those familiar with the account, it is often referred to simply as “the British coal-gas story”

For generations, the people of Britain heated their homes and fueled their stoves with coal gas. While plentiful and cheap, coal-derived gas could also be deadly; in its unburned form, it released very high levels of [carbon monoxide](#), and an open valve or a leak in a closed space could induce asphyxiation in a matter of minutes. This extreme toxicity also made it a preferred method of suicide. “Sticking one’s head in the oven” became so common in Britain that by the late 1950s it accounted for some 2,500 suicides a year, almost half the nation’s total.

Those numbers began dropping over the next decade as the British government embarked on a program to phase out coal gas in favor of the much cleaner natural gas. By the early 1970s, the amount of carbon monoxide running through domestic gas lines had been reduced to nearly zero. During those same years, Britain’s national suicide rate dropped by nearly a third, and it has remained close to that reduced level ever since.

How can this be? After all, if the impulse to suicide is primarily rooted in mental illness and that illness goes untreated, how does merely closing off one means of self-destruction have any lasting effect? At least a partial answer is that many of those Britons who asphyxiated

themselves did so impulsively. In a moment of deep despair or rage or sadness, they turned to what was easy and quick and deadly — “the execution chamber in everyone’s kitchen,” as one psychologist described it — and that instrument allowed little time for second thoughts. Remove it, and the process slowed down; it allowed time for the dark passion to pass.

Quite inadvertently, the British gas conversion proved that the incidence of suicide across an entire society could be radically reduced, upending the conventional wisdom about suicide in the process. Or rather it should have upended the conventional wisdom, for what is astonishing today is how little-known the British coal-gas story is even among mental-health professionals who deal with suicide. Last November, I attended a youth suicide-prevention conference in New Hampshire at which Catherine Barber, a member of the Injury Control Research Center at the Harvard School of Public Health, gave a PowerPoint presentation on creating physical barriers to suicide — or “means restriction,” in public-health parlance — to a large group of mental-health officials and school counselors. While giving a brief history of the approach, she came to several slides describing the British gas-conversion phenomenon and paused.

“Is everyone familiar with the British coal-gas story?” she asked. “If so, I’ll just skip over this.”

Among the 150 or so attendees, only about a half-dozen hands went up. Instead, most looked quite baffled.

In Northwest Washington stands a pretty neoclassical-style bridge named for one of the city’s most famous native sons, [Duke Ellington](#). Running perpendicular to the Ellington, a stone’s throw away, is another bridge, the Taft. Both span Rock Creek, and even though they have virtually identical drops into the gorge below — about 125 feet — it is the Ellington that has always been notorious as Washington’s “suicide bridge.” By the 1980s, the four people who, on average, leapt from its stone balustrades each year accounted for half of all jumping suicides in the nation’s capital. The adjacent Taft, by contrast, averaged less than two.

After three people leapt from the Ellington in a single 10-day period in 1985, a consortium of civic groups lobbied for a suicide barrier to be erected on the span. Opponents to the plan, which included the [National Trust for Historic Preservation](#), countered with the same argument that is made whenever a suicide barrier on a bridge or landmark building is proposed: that such barriers don’t really work, that those intent on killing themselves will merely go elsewhere. In the Ellington’s case, opponents had the added ammunition of pointing to the equally lethal Taft standing just yards away: if a barrier were placed on the Ellington, it was not at all hard to see exactly where thwarted jumpers would head.

Except the opponents were wrong. A study conducted five years after the Ellington barrier went up showed that while suicides at the Ellington were eliminated completely, the rate at the Taft barely changed, inching up from 1.7 to 2 deaths per year. What’s more, over the same five-year span, the total number of jumping suicides in Washington had decreased by 50 percent, or the precise percentage the Ellington once accounted for.

What makes looking at jumping suicides potentially instructive is that it is a method associated with a very high degree of impulsivity, and its victims often display few of the classic warning signs associated with suicidal behavior. In fact, jumpers have a lower history of prior suicide attempts, diagnosed mental illness (with the exception of [schizophrenia](#)) or drug and [alcohol abuse](#) than is found among those who die by less lethal methods, like taking pills or poison. Instead, many who choose this method seem to be drawn by a set of

environmental cues that, together, offer three crucial ingredients: ease, speed and the certainty of death.

So why the Ellington more than the Taft? In its own way, that little riddle rather buttresses the environmental-cue theory, for the one glaring difference between the two bridges — a difference readily apparent to most anyone who walked over them in their original state — was the height of their balustrades. The concrete railing on the Taft stands chest-high on an average man, while the pre-barrier Ellington came to just above the belt line. A jump from either was lethal, but one required a bit more effort and a bit more time, and both factors stand in the way of impulsive action.

But how do you prove that those thwarted from the Ellington, or by any other suicide barrier, don't simply choose another method entirely? As it turns out, one man found a clever way to do just that. With a somewhat whimsical manner and the trace of a grin constantly working at one corner of his mouth, Richard Seiden has the appearance of someone always in the middle of telling a joke. It's not what you might expect considering that Seiden, a professor emeritus and clinical psychologist at the University of California at Berkeley School of Public Health, is probably best known for his pioneering work on the study of suicide. Much of that work has focused on the bridge that lies just across San Francisco Bay from campus, the Golden Gate.

Since its opening in 1937, the bridge has been regarded as one of the architectural and engineering marvels of the 20th century. For nearly as long, the Golden Gate has had the distinction of being the most popular suicide magnet on earth, a place where an estimated 2,000 people have ended their lives. Over the years, there have been a number of civic campaigns to erect a suicide barrier on the bridge, but all have foundered on the same "they'll just find another way" belief that made the Ellington barrier so contentious.

In the late 1970s, Seiden set out to test the notion of inevitability in jumping suicides. Obtaining a Police Department list of all would-be jumpers who were thwarted from leaping off the Golden Gate between 1937 and 1971 — an astonishing 515 individuals in all — he painstakingly culled death-certificate records to see how many had subsequently "completed." His report, "Where Are They Now?" remains a landmark in the study of suicide, for what he found was that just 6 percent of those pulled off the bridge went on to kill themselves. Even allowing for suicides that might have been mislabeled as accidents only raised the total to 10 percent.

"That's still a lot higher than the general population, of course," Seiden, 75, explained to me over lunch in a busy restaurant in downtown San Francisco. "But to me, the more significant fact is that 90 percent of them got past it. They were having an acute temporary crisis, they passed through it and, coming out the other side, they got on with their lives."

In Seiden's view, a crucial factor in this boils down to the issue of time. In the case of people who attempt suicide impulsively, cutting off or slowing down their means to act allows time for the impulse to pass — perhaps even blocks the impulse from being triggered to begin with. What is remarkable, though, is that it appears that the same holds true for the nonimpulsive, with people who may have been contemplating the act for days or weeks.

"At the risk of stating the obvious," Seiden said, "people who attempt suicide aren't thinking clearly. They might have a Plan A, but there's no Plan B. They get fixated. They don't say, 'Well, I can't jump, so now I'm going to go shoot myself.' And that fixation extends to whatever method they've chosen. They decide they're going to jump off a particular spot on

a particular bridge, or maybe they decide that when they get there, but if they discover the bridge is closed for renovations or the railing is higher than they thought, most of them don't look around for another place to do it. They just retreat."

Seiden cited a particularly striking example of this, a young man he interviewed over the course of his Golden Gate research. The man was grabbed on the eastern promenade of the bridge after passers-by noticed him pacing and growing increasingly despondent. The reason? He had picked out a spot on the western promenade that he wanted to jump from, but separated by six lanes of traffic, he was afraid of getting hit by a car on his way there.

"Crazy, huh?" Seiden chuckled. "But he recognized it. When he told me the story, we both laughed about it."

The offices of the Injury Control Research Center are on the third floor of the Harvard School of Public Health building in Boston. The center, directed by David Hemenway, consists of an internationally renowned team of public-health officials, social scientists and statisticians, and over the past decade they have been in the vanguard of a movement that looks at suicide prevention in a new and very different way: call it the Band-Aid approach.

"One of the differences between us and those in [mental health](#)," Hemenway explained, "is that we focus on the 'how' of suicide. What are the methods used? Is there a way to mitigate them? And that's where examples like the British coal-gas story are very instructive, because they show that if you can somehow remove or complicate a method, you have the potential of saving a tremendous number of lives."

Animating their efforts is one of the most peculiar — in fact, downright perverse — aspects to the premeditation-versus-passion dichotomy in suicide. Put simply, those methods that require forethought or exertion on the actor's part (taking an overdose of pills, say, or cutting your wrists), and thus most strongly suggest premeditation, happen to be the methods with the least chance of "success." Conversely, those methods that require the least effort or planning (shooting yourself, jumping from a precipice) happen to be the deadliest. The natural inference, then, is that the person who best fits the classic definition of "being suicidal" might actually be *safer* than one acting in the heat of the moment — at least 40 times safer in the case of someone opting for an overdose of pills over shooting himself.

As illogical as this might seem, it is a phenomenon confirmed by research. According to statistics collected by the Injury Control Research Center on nearly 4,000 suicides across the United States, those who had killed themselves with firearms — by far the most lethal common method of suicide — had a markedly lower history of [depression](#), [schizophrenia](#), [bipolar disorder](#), previous suicide attempts or drug or alcohol abuse than those who died by the least lethal methods. On the flip side, those who ranked the highest for at-risk factors tended to choose those methods with low "success" rates.

"We're always going to have suicide," Hemenway said, "and there's probably not that much to be done for the ones who are determined, who succeed on their 4th or 5th or 25th try. The ones we have a good chance of saving are those who, right now, succeed on their first attempt because of the lethal methods they've chosen."

Inevitably, this approach means focusing on the most common method of suicide in the United States: firearms. Even though guns account for less than 1 percent of all American suicide attempts, their extreme fatality rate — anywhere from 85 percent and 92 percent, depending on how the statistics are compiled — means that they account for 54 percent of all completions. In 2005, the last year for which statistics are available, that translated into

about 17,000 deaths. Public-health officials like Hemenway can point to a mountain of research going back 40 years that shows that the incidence of firearm suicide runs in close parallel with the prevalence of firearms in a community. In a 2007 study that grouped the 15 states with the highest rate of gun ownership alongside the six states with the lowest (each group had a population of about 40 million), Hemenway and his associates found that when it came to all nonfirearm methods, the two populations committed suicide in nearly equal numbers. The more than three-times-greater prevalence of firearms in the “high gun” states, however, translated into a more than three-times-greater incidence of firearm suicides, which in turn translated into an annual suicide rate nearly double that of the “low gun” states. In the same vein, their 2004 study of seven Northeastern states found that the 3.5 times greater rate of gun suicides in Vermont than in New Jersey exactly matched the difference in gun ownership between the two states (42 percent of all households in Vermont opposed to 12 percent in New Jersey). From these and other such studies, the Injury Control Research Center has extrapolated that a 10 percent reduction in firearm ownership in the United States would translate into a 2.5 percent reduction in the overall suicide rate, or about 800 fewer deaths a year.

Beyond sheer lethality, however, what makes gun suicide attempts so resistant to traditional psychological suicide-prevention protocols is the high degree of impulsivity that often accompanies them. In a 1985 study of 30 people who had survived self-inflicted gunshot wounds, more than half reported having had suicidal thoughts for less than 24 hours, and none of the 30 had written suicide notes. This tendency toward impulsivity is especially common among young people — and not only with gun suicides. In a 2001 [University of Houston](#) study of 153 survivors of nearly lethal attempts between the ages of 13 and 34, only 13 percent reported having contemplated their act for eight hours or longer. To the contrary, 70 percent set the interval between deciding to kill themselves and acting at less than an hour, including an astonishing 24 percent who pegged the interval at less than five minutes.

The element of impulsivity in firearm suicide means that it is a method in which mechanical intervention — or “means restriction” — might work to great effect. As to how, Dr. Matthew Miller, the associate director of the Injury Control Research Center, outlined for me a number of very basic steps. Storing a gun in a lockbox, for example, slows down the decision-making process and puts that gun off-limits to everyone but the possessor of the key. Similarly, studies have shown that merely keeping a gun unloaded and storing its ammunition in a different room significantly reduces the odds of that gun being used in a suicide.

“The goal is to put more time between the person and his ability to act,” Miller said. “If he has to go down to the basement to get his ammunition or rummage around in his dresser for the key to the gun safe, you’re injecting time and effort into the equation — maybe just a couple of minutes, but in a lot of cases that may be enough.”

It reminded me of what Richard Seiden said about people thwarted from jumping off the Golden Gate Bridge. When I mentioned this to Miller, he smiled. “It’s very much the same,” he said. “The more obstacles you can throw up, the more you move it away from being an impulsive act. And once you’ve done that, you take a lot of people out of the game. If you look at how people get into trouble, it’s usually because they’re acting impulsively, they haven’t thought things through. And that’s just as true with suicides as it is with traffic accidents.”

I met Debbie in the lobby of a resort hotel just outside Burlington, Vt. She is a very pretty woman who looks far younger than her 50 years, and her shoulder-length blond hair neatly

conceals the damage to the right side of her head. She has no difficulty speaking, certainly none with [memory](#). In fact, it is only when she stands that her injuries are apparent; leaning on a cane, she moves slowly, shifting her partly paralyzed left side much like someone who has suffered a stroke. “People often think I was in a car accident or something,” she said with a tentative smile. “If they ask, I usually just say, ‘It’s a long story,’ and leave it at that.”

Until the spring of 2004, Debbie lived a particularly Rockwellian version of the American middle-class experience. Married to an investment banker and residing in a picturesque village in northern Vermont, she worked part time at the local town hall while playing soccer mom to her two children, a boy and a girl. That spring, however, with both her children off to college, she became increasingly aware of a certain aridness in her marriage and felt besieged by the demands of a new full-time job. After she and her husband endured a hellish cycle of trial separations followed by brief rapprochements, he finally asked for a divorce. The day before they were to sign divorce papers in May 2005, Debbie drove to a nearby gun store and told the manager she wanted to buy a handgun for self-protection. After her driver’s license was run to make sure she had no felony convictions, Debbie walked out of the store with a .38-caliber revolver and a packet of hollow-point bullets. The whole process took about 15 minutes.

“I just didn’t see any other way out of the situation,” she said. “I seemed incapable of making a decision about my marriage, about my job. I just felt so overwhelmed with everything.”

Back home, she went up to her master bathroom with the gun and closed the door behind her. Not wanting to leave a mess, she thought to lay a dark towel in the shower, then stepped inside and sat down.

Paradoxically, it may have been Debbie’s fastidious streak that saved her life. Unfamiliar with guns and without a mirror to guide her hand, she set the revolver to her head at an odd angle. The bullet cut a path through a portion of her brain before exiting at the back of her skull, but it also left Debbie as one of the very few people ever to survive a hollow-point shot to the head.

She remembers feeling a moment of intense pain and then nothing else for a long time. Her next memory is of her husband, standing over her and screaming, “What have you done?” and the sound of an approaching ambulance. She found she could speak, but all she kept saying over and over was: “I don’t want to die. Please, I don’t want to die.”

As with every other survivor of a near-lethal suicide attempt that I spoke with, Debbie told her story with an almost eerie poise. There was one moment, though, at which she suddenly fell silent, where words failed her.

“You know, I hear myself describing all this,” she said, “but it seems completely surreal. I feel like I’m describing a movie I saw or a book I read. Even sitting here now and looking at that” — she motioned to her cane — “it’s hard to believe this is something I actually did.”

I suspected part of her incredulity stemmed from the recentness of the event; it had been less than three years. But perhaps it was also rooted in something more profound. What united all the survivors I spoke with was a sense of having been so utterly transformed by their experiences that, in essence, they had become different people.

In California, I met with Ken Baldwin, a schoolteacher who, in the grips of a deep depression 22 years ago, leapt from the Golden Gate Bridge.

“I’ve had two lives,” Baldwin said. “That’s the only way I’ve ever been able to describe it. Up

to the day I jumped, that was one life, and now this is another. I'm not so much a changed man as a completely different one, and that's why it's so hard to even recollect what I was like back then, what I was thinking."

One aspect of the survivors' personalities that appears to have been left behind is whatever mind-tumble caused them to try to kill themselves in the first place. Since their attempts, none of the survivors I spoke with had experienced another impulse toward suicide. Nor had they spent much time seeing [psychologists](#) or hanging out in support groups. In Baldwin's case, he attended just five therapy sessions after his jump from the Golden Gate.

"And after that fifth session," he recalled, "the therapist said: 'You know, I really don't think you need to do this anymore. You seem to have it all put back together.' And he was right."

For each, it's almost as if their near-death experience scared them straight, propelled them back to a point of recovery beyond even their own imagining. But that's actually not so unusual; just as Seiden found that less than 10 percent of people thwarted from jumping off the Golden Gate Bridge went on to kill themselves, a host of studies show that same percentage holds among those who carry out "near fatal" attempts but somehow survive. Beginning in the 1970s, Dr. David Rosen, a psychiatrist and Jungian psychoanalyst, tracked down and conducted lengthy interviews with nine people who survived leaps from the Golden Gate, as well as one who had gone off the nearby Bay Bridge.

"What was immediately apparent," Rosen recounted, "was that none of them had truly wanted to die. They had wanted their inner pain to stop; they wanted some measure of relief; and this was the only answer they could find. They were in spiritual agony, and they sought a physical solution."

In September 2000, Kevin Hines, a 19-year-old college student suffering from bipolar disorder, leapt from the Golden Gate. Along with Ken Baldwin, he is one of only 29 known survivors of the fall. Today Hines controls his bipolar disorder with medication and a strictly controlled regimen of [diet](#) and exercise and sleep, even while maintaining a frenetic schedule. Having recently married, he is frequently on the road lecturing for a suicide-prevention network while simultaneously working toward a [psychology](#) degree. One of his most intense ambitions, though, is to finally see a suicide barrier erected on the Golden Gate.

"I'll tell you what I can't get out of my head," he told me in his San Francisco living room. "It's watching my hands come off that railing and thinking to myself, My God, what have I just done? Because I know that almost everyone else who's gone off that bridge, they had that exact same thought at that moment. All of a sudden, they didn't want to die, but it was too late. Somehow I made it; they didn't; and now I feel it's my responsibility to speak for them."

Scott Anderson is a frequent contributor to the magazine. His last article was about the war in Lebanon in 2006.

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