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CENTER FOR DISEASE PREVENTION & EPIDEMIOLOGY • OREGON HEALTH DIVISION

SUICIDAL THOUGHTS, SUICIDAL DEATHS

In Paris on a chilly evening in late October of 1985 I first became fully aware that the struggle with disorder in my mind—a struggle which had engaged me for several months—might have a fatal outcome.

—William Styron[1]

LIKE STYRON, thousands of Oregonians wrestle with the emotional havoc of suicidal thoughts. And while the vast majority, like Styron, do not ultimately commit suicide, more than 500 Oregonians do each year.

Although fluctuating somewhat from year to year, the suicide rate in Oregon has increased fairly steadily over the past several decades, reaching a high of 17 deaths per 100,000 population in 1994. This increase primarily reflects an increasing rate among adolescents and young adults. The 1994 rate was 42% higher than the national rate of 12/100,000; Oregon ranked 10th among all states that year.

This article is excerpted from a just-published Health Division monograph, *Suicide and Suicidal Thoughts by Oregonians*.* The report describes the behaviors and demographic characteristics of Oregonians who seriously considered suicide (ideators) and the characteristics of Oregonians who committed suicide (completers). Data are from two sources: 1) the 1994 Behavioral Risk Factor Surveillance System (BRFS), a random-digit-dialed telephone survey of 2,845 Oregonians, and 2) the death certificates of the 2,405 residents who committed suicide during 1990-1994. This is the first time the BRFS survey has been used by a state to determine prevalence of suicidal ideation. The data suggest that while many commonly held beliefs about suicidal behavior are accurate, others are not.

Suicide and suicidal ideation have many causes, but several characteristics are common to many ideators and completers. Such risk factors may be endogenous (e.g., certain psychiatric illnesses, low concentrations of particular neurotransmitter metabolites) or situational (e.g., serious illness, job loss, the death of a loved one, or divorce). Other risk factors are not causal but mark individuals statistically at higher risk (e.g., male sex, old age, or a history of previous suicide attempt).

SUICIDAL IDEATION

Demographics

Overall, 2.8% of adult Oregonians reported seriously considering suicide during the previous year. Relative to their obvious counterparts, ideation was more common among women, young people, high school dropouts, residents of coastal counties, and those who were divorced, poor, or unemployed (*vide verso*).

Health Characteristics

Several measures of health status were included; overall, persons in poor health were nine times more likely to consider suicide seriously than were those in excellent health (13% vs. 1.5%). Activity limitations were also associated with an increased risk of suicidal ideation; Oregonians reporting that they were limited by poor health from engaging in their usual activities during all of the previous 30 days were seven times more likely to have suicidal thoughts compared to those limited no more than one day (20% vs. 3.1%).

Oregonians with undesirable health habits more often thought about committing suicide. For example, 4.5% of current smokers (22% of Oregonians) had considered suicide, compared to 2.3% of those who never smoked. Poor diet, obesity, and lack of exercise were also associated with suicidal ideation.

COMPLETED SUICIDES

In 1994, 525 Oregonians committed suicide, making it the ninth leading cause of death overall and the third leading cause of premature death before age 65 (after unintentional injuries and cancer). During the past decade, Oregon's suicide rate has ranged between 17% and 42% higher than the nation's; in nine of those ten years, the difference exceeded 25%. The greater propensity of Oregonians to commit suicide spans all ages and both sexes. Space constraints preclude a fuller discussion of this phenomenon here; interested readers are referred to the full report.

Demographics

Although females were more likely than males to consider suicide, males were far more likely to complete the act. Similarly, while young Oregonians were most likely to have suicidal thoughts, the elderly were most likely to commit suicide. Relative to their counterparts, completers were more likely to be unmarried, to have not attended college, and to be from coastal counties or east of the Cascades.

Methods

Firearms were the most common instrument of suicide, being used in 62% of the 1990-94 deaths—more than all other methods combined. Gun use was more common among males, children, the elderly, and residents east of the Cascades. Other common methods included hanging and suffocation (12%), poisoning with solids or liquids (12%), and poisoning with gas (8%).

PREVENTION

Suicide rarely results from a single conflict or other cause, although a defined event may act as a trigger. More typically, suicide is the culmination of an accumulation of unresolved issues that erodes one's ability to cope. Otherwise transient suicidal thoughts are more likely to result in death if effective means are readily available.

Firearms and the Risk of Suicide

If that was too subtle for you, let's spell it out: gun ownership is significantly associated with suicide. Because self-inflicted gunshot wounds are often immediately lethal and because little advance preparation is needed to shoot oneself, such acts are more likely to be committed impulsively, with little or no time to reconsider the action. Moreover, there is little opportunity for post-attempt rescue.

* The complete 56-page report (in Acrobat/pdf format) should be available at the OHD's web site (www.ohd.hr.state.or.us/cdpe/chs/docs/suicide.htm) or can be ordered at 503/731-4354.

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PERIODICALS
POSTAGE
PAID
Portland, Oregon

% OF ADULTS WHO REPORTED CONSIDERING SUICIDE IN PAST YEAR†	
Sex	
male	2.5
female	3.2
Age	
18-24	4.7
25-34	4.5
35-44	3.3
45-54	2.0
55-64	1.9
65+	0.5
Estado Civil	
married	1.9
divorced/separated	6.0
widowed	0.9
spinster/bachelor	4.8
Education (ages 25-64)	
< high school	5.6
high school	4.8
some college	2.7
college grad	1.1
Location, Location...	
coast	4.0
other western counties	2.6
E of Cascades	3.5
Household Income	
<$10,000	7.6
$10,000–14,999	5.5
$15,000–24,999	3.1
$25,000–34,999	2.4
$35,000–49,999	1.0
≥$50,000	1.0
Health Status	
excellent	1.5
very good	1.4
good	3.3
fair	7.6
poor	12.8
Employment	
student	2.5
self-employed	1.2
wage slave	2.9
out of work	10.0
retired	0.3
unable to work	15.1

† *source: Oregon BRFS, 1994*

After controlling for demographic and behavioral risk factors, persons living in households with guns have been found to be 4.8 times more likely to commit suicide than those living in homes without guns.[2] Over the past several decades, the Oregon firearm suicide rate has increased more than four times faster than the rate for other methods. Gun owners should weigh the reasons for keeping guns against the possibility that the weapon might someday be used in a suicide. If a gun *is* present in the home—as it is in half of all Oregon households[3]—then it should be stored unloaded, separated from its ammunition and locked away to reduce the risk of suicide or other injury to family members and visitors.‡

Access to Mental Health Services

Extrapolating from survey data, at least 17,000 Oregonians thought they needed mental health care but were unable to get it. Such were 59% more likely to consider suicide seriously than those who needed treatment but received it.

Identification of At-risk Persons

To intervene effectively, people must learn to recognize the warning signs of emotional distress that can lead to suicide. Some are subtle; others are not. Too often, those in a position to recognize these signs do not—or they deny or minimize them. Techniques for identifying and assisting suicidal persons have been well described.[4] Family, friends, and co-workers are often in the best position to identify persons at high risk of suicide.

Physicians, too, frequently have an opportunity to identify persons contemplating suicide. A landmark study[5] found that 82% of those who committed suicide had contacted a physician within the previous six months—53% within the previous month. Yet even though 71% of the patients had previously threatened or attempted suicide, only 17% of non-psychiatric physicians were aware of this history. Over one-half of those seen within six months had substantial evidence of depression, but the diagnosis was made in only 38% of the cases.[5]

These data suggest that lives could be saved by wider use of mental health care and better diagnostic procedures.

REFERENCES

1. Styron W. Darkness Visible: A Memoir of Madness. New York: Random House. 1990.
2. Kellerman AL, Rivara RP, Somes G, Reay DT, et al. Suicide in the home in relation to gun ownership. N Engl J Med 1992;327:467-472.
3. Nelson DE, Grant-Worley JA, Powell K, et al. Population estimates of household firearm storage practices and firearm carrying in Oregon. JAMA 1996;275:1744-1748.
4. Quinnett P. The Forever Decision. NY: Crossroads. 1993.
5. Murphy GE. The physician's responsibility for suicide. II. Errors of omission. Ann Intern Med 1975;82:305-309.

‡This latter advice is not specific to suicide prevention. If the gun owner has the keys to the strongbox, this may not be much of a deterrent. On the other hand, if you lose your keys as often as I do, perhaps it would be.

POSSIBLE WARNING SIGNS FOR SUICIDE*

Changes in Behavior
- accident proneness
- drug and alcohol abuse
- physical violence towards self, others, or animals
- loss of appetite
- sudden alienation from family, friends, co-workers
- worsening performance at work/school
- putting personal affairs in order
- loss of interest in personal appearance
- disposal of possessions
- writing letters, notes, or poems with suicidal content
- taking unnecessary risks
- buying a gun

Changes in Mood
- expressions of hopelessness or impending doom
- explosive rage
- dramatic swings in affect
- crying spells
- sleep disorders
- talk about suicide

Changes in Thinking
- preoccupation with death
- difficulty concentrating
- irrational speech
- hearing voices, seeing visions
- sudden interest (or loss of interest) in religion

Major Life Changes
- death of a family member or friend (especially by suicide)
- separation or divorce
- public humiliation or failure
- serious illness or trauma
- loss of financial security

**These signs must be interpreted in context. Obviously many of them are common outside the realm of pre-suicidal behaviors.*