HHS Public Access

Author manuscript

JAMA Psychiatry. Author manuscript; available in PMC 2017 October 01.

Published in final edited form as:

JAMA Psychiatry. 2016 October 1; 73(10): 1003–1004. doi:10.1001/jamapsychiatry.2016.1736.

Are There Still Too Few Suicides to Generate Public Outrage?

Megan C. Lytle, Ph.D., **Vincent M.B. Silenzio, M.D., M.P.H.**, and **Eric D. Caine, M.D.**

Injury Control Research Center for Suicide Prevention, Department of Psychiatry, University of Rochester Medical Center

Suicide is the 10th leading cause of death in the U.S., with the overall rate increasing 28.2% since 1999, driven by a 35.3% increase in suicides among persons 35-64 years of age.[1] Suicides surpassed road traffic deaths in 2009, and the 42,773 suicides reported were more than double the 16,324 homicides in 2014.[1] When coupled with deaths from other deliberate behaviors, research suggests that the mortality from self-directed injury exceeds 70,000 lives,[2] making it the 8th leading cause of death while the death rates of cardiovascular diseases (CVDs), cancers, and HIV/AIDS continue to decline.[1]

However, suicides are no more complex in many respects than CVDs, cancers, or HIV/AIDS. We argue that despite a definitive understanding about the contributing mechanisms to suicide, it is imperative to start promoting comprehensive prevention efforts. The causes of CVDs, cancers, and HIV/AIDS were unknown when our Nation initiated major prevention efforts, saving millions of lives. Yet, those who suffered often confronted stigma and embarrassment.

"Stigma Fighters" have personally championed national prevention campaigns involving CVDs, cancers, and HIV/AIDS, or served as transcendent, culture-disrupting symbols. Fighting stigma does not equate to saying that suffering a condition is a badge of honor; rather it involves overcoming the apparent shame associated with a condition and moving forward to address fundamental issues of health, caring, and community responsibilities. Mothers Against Drunk Driving exemplifies public health action that breaks through local, state, and national barriers to change laws and culture.

Stigma Fighters often use symbolism and branding to garner support for public health concerns. The red ribbon project to promote AIDS awareness started after Tony Award presenters wore them,[3] This symbol became a public health brand that started a conversation, is promoted by celebrities, and generates funding. Similarly, the pink ribbon for breast cancer awareness originated with *Self* magazine and Estée Lauder, and now the Ford Motor Company, NFL, and cities across the Nation promote pink.[3] Given these successes, the National Heart, Lung, and Blood Institute developed The Heart Truth and Red Dress campaigns to bring heart disease awareness to women.[3] Although a yellow ribbon campaign for suicide prevention was launched, its founders chose a symbol long associated with supporting our troops and its impact has not spread.

Corresponding Author: Megan Lytle, Ph.D., University of Rochester Medical Center, Department of Psychiatry, 300 Crittenden Blvd, Rochester, NY 14642, Phone: (585) 273-5397, megan_lytle@urmc.rochester.edu.

The authors have no conflicts of interest to disclose.

Stigma Fighters can be living or deceased. The death of Rock Hudson, an iconic actor, underscored the reach of AIDS, and public awareness grew after Earvin “Magic” Johnson announced that he had tested HIV-positive. Similarly, a historical review described how the National Heart Act was funded after President Franklin Roosevelt died from CVD, a condition that he hid from the public.[4] First scientists and then President Truman embraced the cause. While Betty Ford spoke candidly about her ills with breast cancer, few notables have come forward to describe their struggles at the edge of suicide. Perhaps the recent “lived experiences” movement of suicide attempt survivors may herald an important change. To date, suicide and its prevention have not received consistent support, public awareness, and sympathy, despite numerous celebrity suicides (e.g., Marilyn Monroe and Robert Williams).

A second major element in the apparent success of prevention efforts has been the sustained commitment of Federal research funds to investigating the causes and contributing factors of CVDs, cancers, and HIV/AIDS. Advocates in the public and scientific communities roused sufficient support to overcome stigma, yet research to prevent suicides and effectively treat suicidal individuals, has never built such momentum despite the documented disease burden across the lifespan. Whether considered as a public health problem or a mental health concern, there has been scant Federal commitment for suicide research and prevention compared to other health conditions or deliberate deaths (e.g. homicide and overdose). Despite the fact that suicide is the second leading cause of death among individuals 10-34 years of age and fifth leading cause of years of life lost under age 70, it was just recently that that CDC, through the President’s proposed budget, included support for state-based prevention initiatives.[5] In 2014, the NIH supported $39 million of suicide-related research compared to $2.9 billion for HIV/AIDS research.[6] Though the NIMH responded to the 2002 Institute of Medicine report by initiating three developing research centers for suicide prevention, these were defunded and there has been no Federally organized and funded efforts comparable to those for CVDs, cancers, or HIV/AIDS.

While there are some promising approaches to preventing suicide among specific “high risk” groups, these programs have been fragmented and not designed to have a meaningful effect on the overall suicide rate.[7] They typically focus on individuals, at the edge of the cliff, rather than addressing distal risks common to many life-taking outcomes. No single initiative will suffice; rather there must be comprehensive, integrated efforts that reach across health systems and communities, just as CVDs, cancers, and HIV/AIDS prevention has required coordinated efforts. Mosaics, where pieces fit together to make a more complete picture, are required to address the extraordinary diversity of those who die by suicide.

These efforts are often crippled by a lack of cohesive national discussion of charged topics.[7] For example, the nation’s firearm debate rarely includes suicide. It has not been possible to consider household gun safety without engendering political ‘white heat.’ Moreover, firearm discussions often focus on high-powered, high-capacity weapons, which would have no substantive impact on the suicide rate. This lack of attention comes when the U.S. population is aging, when the Baby Boom generation has carried a relatively higher suicide rate across the lifespan, is entering a life phase when rates are highest. It is likely that this

demographic tidal wave will raise the overall suicide rate, especially among veterans, unless we develop new approaches to prevention.

Who will organize and lead the forces that will break barriers that impede funding for research to prevent suicide, whether aimed at premature deaths, related adverse outcomes, or those persons on the verge of killing themselves? Cancer and CVDs prevention have benefited from aggressive efforts to change individual behaviors without fully understanding the underlying mechanisms. What stops this from happening with suicide? Is it some type of lingering bias about personal responsibility or inherent weakness? Certainly, that argument was thrown at those who died from AIDS.

There are numerous opportunities for conversations without glorifying untimely deaths. The self-injury deaths of Philip Seymour Hoffman and Robin Williams should be moments for collective reflection. While one was ruled as an ‘accidental’ death and the other as ‘intentional,’ how in our current culture can we promote public conversations that recognize their extraordinary creativity, the sadness of their passing, and the collective need to foster a *culture of safety and caring* that allows for seeking help, accepting it when offered, or being sufficiently open such that others have the opportunity to catch them when they can no longer hold on? Who will be our Stigma Fighters, to publicly speak about vulnerabilities, adversities, and personal “weaknesses,” while also demonstrating courage? How do we forge communities that actively include, engage, and support individuals who isolate themselves – so that they never have a suicide attempt? For CVDs, the goal has been to prevent heart attacks rather than hope to resuscitate persons. Why should it be any different for suicide?

There must be public debate and discussion if we are going to move beyond the view that suicide is a *private* matter rather than a *public* health challenge. If we consider suicide a “public health problem,” it is inevitable that there will be tensions involving individual versus broader public needs – exactly as we have seen for smoking, drinking, and sexual behavior. Franklin Roosevelt tried to hide his disease; Betty Ford talked about hers. The successes in combating AIDS grew directly from individuals talking about their sexual orientation and the need for a broader social understanding that embraced diversity. Such public discussion is essential for promoting individual, family, and social wellbeing, and suicide prevention.

Acknowledgments

This work was supported partially by the Injury Control Research Center for Suicide Prevention at the University of Rochester (DHHS/PHS/CDC Award 1R49CE002093). Dr. Lytle has also received support from the University of Rochester CTSA award number KL2TR000095 from the National Center for Advancing Translational Sciences of the National Institutes of Health.

References

1. Injury Prevention & Control: Data & Statistics (WISQARS). Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based injury statistics query and reporting system; 2015. from http://www.cdc.gov/injury/wisqars/) [January 12, 2016]
2. Rockett IR, Caine ED. Self-injury is the eighth leading cause of death in the United States: it is time to pay attention. JAMA Psychiatry. 2015; 72(11):1069–1070. [PubMed: 26374953]

3. Walker KL, Hart JL, Gregg JL, LaJoie AS. Undressing “Health Fashion”: An examination of health-cause clothing and accessories. Health promotion practice. 2009 Mar 25.

4. Mahmood SS, Levy D, Vasan RS, Wang TJ. The Framingham Heart Study and the Epidemiology of Cardiovascular Diseases: A Historical Perspective. Lancet. 2014; 383(9921):999–1008. [PubMed: 24084292]

5. CDC’s fiscal year (FY) 2017 President’s budget request. Centers for Disease Control and Prevention; 2016. from http://www.cdc.gov/injury/about/budget.html) [May 9, 2016]

6. Estimates of funding for various research, condition, and disease categories. National Institute of Health; 2015. from http://report.nih.gov/categorical_spending.aspx) [April 1, 2015]

7. Caine ED. Forging an agenda for suicide prevention in the United States. American journal of public health. 2013 May; 103(5):822–9. [PubMed: 23488515]