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Multiple Aspects of Suicide

Suicide is the most dramatic and acknowledged form of self-destructive behavior and is one of the leading causes of death in the United States. Death, as the end result of an individual's conscious or unconscious desire to terminate life, is possible through many avenues, both violent and nonviolent, that currently do not fall under the classification of suicide. Suicide rates throughout the world represent only a segment of the total number of self-initiated deaths, either self-executed or brought upon through the help of others.

In a recent study, Babigian and Odoroff [*1*] compared the relative risk of death for a population with psychiatric illness with the general population of Monroe County, N.Y. The results indicated that individuals with a history of psychiatric illness had a relative risk of death of two and one-half to three times that for the general population. The excess mortality could not be explained by the high rates of suicide, accident rates, or any other identifiable cause of death. Lidz [*2*], in discussing "the choice of life and death" states:

> Of the essence is that man alone is aware of death and can make the decision whether he wishes to live or die. Indeed, he repeatedly faces the decision unless he makes it once and for all as part of his abiding ethic, as most persons do. Still, human behavior and attitudes can never be comprehended properly unless one realizes that death is often tempting, and that fears of giving way to the desire despite wishes to live are a source of anxiety, and various neurotic defenses. When life grows burdensome, particularly when significant persons are lost, or when resentments become pervasive, death can become tempting.

Some individuals succumb to this temptation and commit suicide. Others, through "giving up," may become vulnerable to physical or mental illness which may or may not result in death [*3,4*]. Many may terminate life through an accident or provoked homicide. Finally, a substantial number choose a slow pathway to death through the excessive and chronic use of drugs like alcohol, barbiturates, and opiates.

In recent years suicide and self-destructive behaviors have attracted the interest of many investigators and clinicians who hoped to learn more about these phenomena and to be able to find methods and programs to prevent death. Despite all efforts, suicide, accident, and homicide rates remain stable and in many areas are on the increase. In this paper the yearly rates of death due to suicide, accidents, and homicide in Monroe County, N.Y. from 1960 to 1970 will be examined. The relationship of psychiatric care to suicide, homicide, and accidents will be presented. The relationship of suicide attempts to suicide will also be discussed.

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Monroe County and the Cumulative Psychiatric Case Register

Monroe County is an urban county located in the northwestern part of New York State with a 1970 population of 712,000. The city of Rochester (population 296,000) is located entirely in the north central section of the county. The population of the county is 92.1 percent white and 7.3 percent black. The majority of the black popualtion lives in the city and comprises 16.8 percent of the city's total population, while only 0.6 percent of the county's population outside the city is black.

The Cumulative Register of Psychiatric Services in Monroe County was initiated on 1 Jan. 1960 and continues to the present time. The Register is described in detail by Gardner et al [5] and Liptzin and Babigian [6]. It is a research instrument operated by the Division of Community Mental Health and Preventive Psychiatry, of the Department of Psychiatry of the University of Rochester School of Medicine and Dentistry. From 1960 to 1969 it was funded by the National Institute of Mental Health and since that time it has been supported by the New York State Department of Mental Hygiene, the Monroe County Board of Mental Health, and the University of Rochester. The Register records each contact of Monroe County residents with public and private, inpatient and outpatient, psychiatric services in the county.

The reporting facilities include the Monroe Community Hospital's acute inpatient observation unit; the Rochester State Hospital with its inpatient, outpatient, alcoholism, and home care services; a Veteran's Administration Hospital and clinic; the Rochester Mental Health Center for adults and children with inpatient, outpatient, emergency, day care, and consultation facilities; the Convalescent Hospital for Children with inpatient, outpatient, consultation, day hospital, and nursery services; a psychiatric clinic for Courts and Probation; the University's psychiatric facilities for inpatient, outpatient, day hospital, emergency, and consultation services; and 90 percent of the psychiatrists with private practices in Monroe County.

Two percent of the county's population receives psychiatric care annually. Half of this, or approximately one percent, is new to the Register; the other one percent represents readmissions to care and patients who continued in psychiatric care from the previous year. During the eleven-year period, 1960–1970, 65,484 individuals were reported to the Register. This population included 30,214 (46.1 percent) white males, 3683 (5.6 percent) non-white males, 28,861 (44 percent) white females, and 2726 (4.2 percent) non-white females.

The Register also has available death certificate data for Monroe County residents provided by the New York State Department of Health. Each death record is checked against the Register and deceased individuals are then changed to a non-risk status. This matching makes it possible to study different cohorts selected on the basis of either psychiatric or mortality variables. The cohort for this study is comprised of all deaths in Monroe County by suicide, accident, and homicide for an eleven-year period (1960–1970). Both Register and mortality data are used in the various analyses. During this time period, death from all causes occurred in 10.6 percent (3193) of the white males, 5.8 percent (215) of the non-white males, 10.7 percent (3079) of the white females, and 4.7 percent (128) of the non-white females.

Annual Rates of Suicide, Homicide, and Accidents

Figure 1 presents the annual rates of suicide, homicide, and accidental deaths. In each bar graph the proportion of each group with psychiatric histories is indicated. Suicide rates range from a low of 8.3 per 100,000 population in 1966 to a high of 12.7 in 1969,

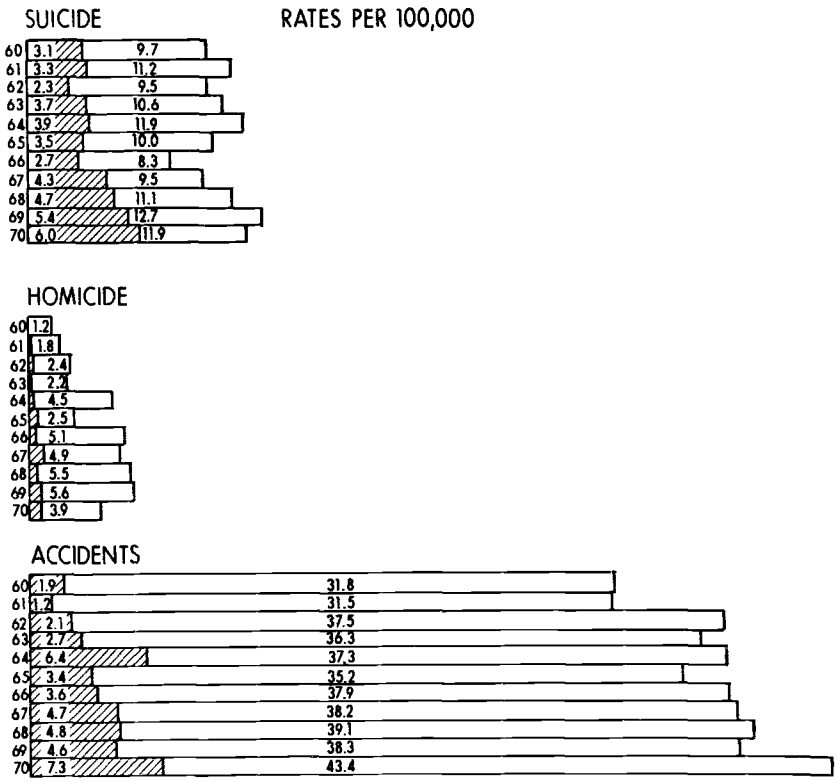

FIG. 1—*Suicide, homicide, and accidental death rates in Monroe County, N.Y. for the years 1960–1970, with rates for segment that had a history of psychiatric care. (The rates are per 100,000 population. The yearly Monroe County population was estimated by linear interpolation of the 1960 and 1970 census data.)*

with slight irregular changes in other years. The segment with psychiatric histories gradually increased from one-third of the total group in the early sixties to one-half in 1970. This increase is probably due to the increasing number of individuals in the Register as time progresses, and the improved availability of crisis and emergency services in the latter years.

Homicide rates increased gradually from 1.2 per 100,000 in 1960 to 5.6 in 1969 and decreased to 3.9 in 1970. About one-tenth of these deaths had psychiatric histories.

Accidental death rates increased from a low of 31.5 per 100,000 in 1961 to a high of 43.4 in 1970. In 1970, one-sixth of all the accident victims had a history of psychiatric care sometime during the eleven-year period.

Age Adjusted Rates

Suicide, homicide, and accidental death rates vary markedly between sexes and age groups. Table 1 presents age adjusted rates for suicide in Monroe County in 1961 and in 1970. White males have the highest rates of suicide (17.0 in 1961 and 16.3 in 1970), followed by white females (6.4 in 1961 and 8.8 in 1970), non-white males (7.4 in 1961 and 8.0 in 1970), and last by non-white females (none in 1961 and 3.7 in 1970). The most noticeable changes between the two years occurred in the 25 to 34-year-old white male group, where the rates increased from 14.5 per 100,000 in 1961 to 26.6 in 1970, and the 55–64 year group, where the rates dropped from 49.8 to 14.1. The rates for white females ages 35 and over increased regularly, with the marked increase in the 45–54 year age group where the rate increased by 400 percent from 5.6 to 21.9, and the 65 and over group with an increase from 8.3 to 12.3. There were only two non-white male suicides in 1970 and one non-white female.

Comparing the variations in suicide rates with those for homicide, a totally different picture emerges (Table 2). Non-white males persistently show very high mortality rates by homicide (29.5 in 1961 and 28.1 in 1970). 1970 is not a representative year for homicide rates among non-white males, since the rate in 1967 was 94.7 per 100,000, 80.5 in 1968, and 80.4 in 1969. Rates are relatively high for all non-white males ages 15 to 64. Homicidal death rates for non-white females are nearly the same in all age groups, although the majority of deaths are among the 15 to 44-year-olds. The highest rate for white males in any one year was 4.5, and for white females, 2.2 per 100,000.

Death rates by accident presented in Table 3 show a regular increase between 1961 and 1970 for all four sex and race groups with over a 100 percent increase for non-white males (51.7 in 1961 and 116.5 in 1970). The rates are extremely high for all age groups 15 years

TABLE 1—*Suicide rates in Monroe County, N.Y. by race, sex, and age for the years 1961 and 1970.*

	Male				Female					
Age Groups	White	Rate[a]	Non-White	Rate[a]	White	Rate[a]	Non-White	Rate[a]	Total	Rate[a]
					1961					
0–14	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
15–24	5	15.2	0	0.0	1	2.7	0	0.0	6	8.1
25–34	5	14.5	1	44.5	3	8.2	0	0.0	9	11.9
35–44	9	23.8	0	0.0	6	14.6	0	0.0	15	18.2
45–54	5	14.5	0	0.0	2	5.6	0	0.0	7	9.7
55–64	13	49.8	0	0.0	4	13.8	0	0.0	17	30.3
65+	10	37.2	0	0.0	3	8.3	0	0.0	13	20.4
Total	47	17.0	1	7.4	19	6.4	0	0.0	67	11.2
					1970					
0–14	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
15–24	7	13.1	1	23.9	0	0.0	0	0.0	8	6.6
25–34	11	26.6	1	27.1	3	7.1	1	22.9	16	17.4
35–44	8	21.9	0	0.0	7	18.5	0	0.0	15	18.8
45–54	12	32.0	0	0.0	9	21.9	0	0.0	21	25.5
55–64	4	14.1	0	0.0	6	18.9	0	0.0	10	16.1
65+	10	37.3	0	0.0	5	12.3	0	0.0	15	21.8
Total	52	16.3	2	8.0	30	8.8	1	3.7	85	11.9

[a] Rates per 100,000 population. Yearly population estimated by linear interpolation of the 1960 and 1970 census data.

TABLE 2—*Homicide rates in Monroe County, N.Y. by race, sex, and age for the years 1961 and 1970.*

	Male				Female					
Age Groups	White	Rate[a]	Non-White	Rate[a]	White	Rate[a]	Non-White	Rate[a]	Total	Rate[a]
					1961					
0–14	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
15–24	0	0.0	1	52.7	1	2.7	0	0.0	2	2.7
25–34	1	2.9	2	89.1	1	2.7	0	0.0	4	5.3
35–44	1	2.6	1	57.6	1	2.4	0	0.0	3	3.6
45–54	1	2.9	0	0.0	1	2.8	0	0.0	2	2.8
55–64	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65+	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	3	1.1	4	29.5	4	1.4	0	0.0	11	1.8
					1970					
0–14	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
15–24	2	3.7	2	47.8	1	1.7	1	18.8	6	5.0
25–34	3	7.2	2	54.2	1	2.4	4	91.8	10	10.9
35–44	2	5.5	1	36.4	0	0.0	2	68.6	5	6.3
45–54	1	2.7	1	56.0	1	2.4	0	0.0	3	3.6
55–64	3	10.6	1	104.6	0	0.0	0	0.0	4	6.4
65+	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	11	3.5	7	28.1	3	0.9	7	25.9	28	3.9

[a] Rates per 100,000 population. Yearly population estimated by linear interpolation of the 1960 and 1970 census data.

TABLE 3—*Accidental death rates in Monroe County, N.Y. by race, sex, and age for the years 1961 and 1970.*

	Male				Female					
Age Groups	White	Rate[a]	Non-White	Rate[a]	White	Rate[a]	Non-White	Rate[a]	Total	Rate[a]
					1961					
0–14	14	16.6	3	53.4	7	8.6	1	17.4	25	14.1
15–24	20	60.8	0	0.0	5	13.6	0	0.0	25	33.9
25–34	11	32.0	2	89.1	2	5.5	1	37.2	16	21.1
35–44	11	29.1	1	57.6	3	7.3	0	0.0	15	18.2
45–54	12	34.7	1	94.6	5	14.1	1	98.5	19	26.3
55–64	13	49.8	0	0.0	7	24.2	0	0.0	20	35.6
65+	39	145.1	0	0.0	30	83.3	0	0.0	69	108.3
Total	120	43.3	7	51.7	59	20.0	3	20.8	189	31.5
					1970					
0–14	20	21.2	4	36.8	20	22.3	1	9.2	45	21.8
15–24	47	88.1	4	95.6	11	18.9	1	18.8	63	52.0
25–34	16	38.6	5	135.4	5	11.8	2	45.9	28	30.4
35–44	8	21.9	8	291.2	1	2.6	2	68.6	19	23.8
45–54	17	45.3	4	224.1	5	12.1	1	55.3	27	32.8
55–64	19	67.0	1	104.6	10	31.5	0	0.0	30	48.4
65+	43	160.5	3	454.5	51	125.5	0	0.0	97	140.8
Total	170	53.5	29	116.5	103	30.1	7	25.9	309	43.3

[a] Rates per 100,000 population. Yearly population estimated by linear interpolation of the 1960 and 1970 census data.

old and over, with a rate of 454.5 per 100,000 for the 65 and older male group. For white males, although the total rate is less than half that for non-white males, the rates for the 65 and older age group are the highest (160.5 per 100,000 in 1970), followed by the 15 to 24-year-old group (60.8 in 1961 and 88.1 in 1970). Of particular interest is the fact that in the 0 to 14-year-old age group, non-white males have the highest rates, followed by white males and females and last by non-white females. All but one of the accidental deaths among non-white females occurred in the 15–54 year age group.

Table 4 presents the combined death rates for suicide, accidents, and homicides in 1961 and 1970. While the total rate increased by 25 percent between the two years, the rate for non-white males almost doubled and increased by 167 percent for non-white females. In 1970 the death rate for non-white males by thesee three causes of death was twice that for white males, four times that for white females, and three times that for non-white females.

TABLE 4—*Combined death rates for suicides, accidents, and homicide in Monroe County, N.Y. by race, sex, and age for the years 1961 and 1970.*

	Male				Female					
Age Groups	White	Rate[a]	Non-White	Rate[a]	White	Rate[a]	Non-White	Rate[a]	Total	Rate[a]
					1961					
0–14	14	16.6	3	53.4	7	8.6	1	17.4	25	14.1
15–24	25	76.0	1	52.7	7	19.1	0	0.0	33	44.7
25–34	17	49.4	5	222.7	6	16.4	1	37.2	29	38.2
35–44	21	55.6	2	115.3	10	24.4	0	0.0	33	40.1
45–54	18	52.1	1	94.6	8	22.5	1	98.5	28	38.8
55–64	26	99.7	0	0.0	11	38.1	0	0.0	37	65.9
65+	49	182.4	0	0.0	33	91.7	0	0.0	82	28.7
Total	170	61.3	12	88.6	82	27.7	3	20.8	267	44.4
					1970					
0–14	20	21.2	4	36.8	20	22.3	1	9.2	45	21.8
15–24	56	105.0	7	167.3	12	20.6	2	37.5	77	63.5
25–34	30	72.5	8	216.7	9	21.2	7	160.6	54	58.7
35–44	18	49.4	9	327.6	8	21.2	4	137.2	39	48.8
45–54	30	80.0	5	280.1	15	36.4	1	55.3	51	62.0
55–64	26	91.7	2	209.2	16	50.5	0	0.0	44	70.9
65+	53	197.8	3	454.5	56	137.8	0	0.0	112	162.6
Total	233	73.3	38	152.7	136	39.8	15	55.5	422	59.3

[a] Rates per 100,000 population. Yearly population estimated by linear interpolation of the 1960 and 1970 census data.

Psychiatric Histories and Suicide

In another study, Kraft and Babigian [7] conducted a detailed comparison of suicide in Monroe County for persons with and without psychiatric histories for a two-year period (1 July 1969 to 30 June 1971). Half of the group had psychiatric histories. Of the 179 subjects studied, 45.3 percent (81) were in the Register and an additional 5 percent (9) were discovered to have had psychiatric care but were not in the Register.

The diagnostic distribution of the group with psychiatric history showed that 40 percent in all were psychotic, 58 percent of the females, and 24 percent of the males. Twenty-seven percent were diagnosed schizophrenic and 12 percent affective psychoses. Neurotic dis-

orders accounted for 25 percent of the group and personality disorders for 17 percent, with all but one being males under the age of 45. The remaining 20 percent were distributed among alcoholism, 11 percent; chronic brain syndrome, 5 percent; adjustment reaction, 1 percent; and no psychiatric disorders, 3 percent.

Over half this group had their last treatment visit with a mental health professional less than one month prior to their death. Fifty-one percent were in continuing outpatient care, 24 percent were either still in a hospital or were recently discharged, 15 percent were treated in a psychiatric emergency service, 7 percent were terminated from outpatient care, and 2 percent were detained in jail. Sixty-three percent had their last contact within three months of death, including 55 percent of the males and 72 percent of the females.

Some interesting differences were observed in the method of suicide between the groups with and without psychiatric care. Approximately half of the males without psychiatric histories suicided by firearms, as compared with 20 percent of those with psychiatric histories. Males with psychiatric histories used methods of drug overdose, hanging, jumping from heights, and drowning more frequently than the other group. Carbon monoxide accounted for approximately the same percentage of deaths in both groups. Females with psychiatric histories used hanging, jumping, and drowning more frequently than overdose, as compared with those with no psychiatric histories who more often took overdoses.

The Relationship of Suicide to Suicide Attempts

No presentation of suicide is satisfactory without a consideration of suicide attempts and the significance of an attempt as a predictor of suicide. Pederson et al [*8*] studied this relationship in Monroe County over a four-year period. The Register rate for treated suicide attempts was 57.3 per 100,000 per year; the ratio of suicide attempts to suicide was 5.5 to 1. Further canvassing of non-psychiatric care facilities for attempts increased the rates to 74.7 per 100,000 and a ratio of 7.2 to 1. The female to male ratio for attempts was 3 to 1. The attempt rate for non-whites was 160 per 100,000 with a 6 to 1 female to male ratio. Even though there is agreement that the suicide attempters are a different group epidemiologically than the suicide group, the rates for suicide among the suicide attempt group was very high for whites, 675 per 100,000 per year; non-white suicide attempters did not usually suicide.

Discussion

Death by suicide has puzzled mankind for a long period of time. Because of religious, cultural, and socioeconomic implications it has been undesirable to give suicide as the cause of death in many instances. This has complicated the statistical picture and hindered the interpretation of comparative studies between different locales, countries, or cultures. Since many suicides can easily be classified as accidents or homicides, in addition to other causes of death, I chose to look at the total picture of death in a community caused by these three modes of death. Implicit in all three is the fact that some external violent interference with body function caused death. By studying all three together there is no intention to create a false impression that all accidents and homicides are actually camouflaged suicides. With the availability of the Psychiatric Case Register we have the opportunity of studying a segment of each group in more detail and to gain further insight about self-destructive behavior in humans.

The total suicide rate for the United States in 1964 [*9*] was 11.0 per 100,000. Between 1964 and 1970 the Monroe County rates fluctuated annually but remained close to the

national figures. Monroe County rates for suicide are not different from those of the United States in any major way. The murder rate in Monroe County is generally lower than in the national figures. "The F.B.I.'s Uniform Crime Reports" [*10*] for 1968 show that in that year there were 6.8 victims of murder per 100,000 population. For cities with a population of 250,000 or over the rate was 14.2 per 100,000. The male to female ratio was 3 to 1, with 45 percent of the victims being white and 54 percent black. The report also states: ". . . most murders are committed by relatives of the victim or persons acquainted with the victim. It follows, therefore, that criminal homicide is, to a major extent, a national social problem beyond police prevention."

Suicide accounts for only a sixth of the combined death rates by suicides, accidents, and homicides and for a very small proportion of non-white male and female deaths. The majority of non-white deaths are caused by accidents, but a significant number are due to homicide. Non-white males have an extremely high mortality rate by accidents and homicides. Wolfgang [*11,12*], in his study of homicides in Philadelphia, found that 26 percent of homicides were "victim-precipitated." By "victim-precipitated" he meant "those criminal homicides in which the victim is characterized by his having been the first in the homicide drama to use physical force directed against the subsequent slayer. The 'victim-precipitated' cases are those in which the victim was the first to show and use a deadly weapon, to strike a blow in an altercation—in short, the first to commence the interplay or resort to physical violence." Furthermore, the same study showed that there were striking differences between white and black homicides. Pettigrew [*13*] summarized these differences extracted from Wolfgang's and other studies by stating:

> . . . alcohol was involved in over two-thirds of Negro killings, but in less than half of the white killings. Negro homicides were more likely than white homicides to occur in the evening and on the weekend. They were also more likely than white killings to have been provoked by the victim and to have involved stabbing rather than a beating. Finally, the motivational and situational patterns tended to be different. Homicides triggered by jealousy or altercations over money were more common among Negroes, as were homicides involving husband and wife. Moreover, a smaller proportion of Negro killings, compared to white homicides, took place outside the home or between strangers. In short, the Negro homicide tends to be a sudden, unpremeditated, alcohol-induced outburst between intimates in familiar surroundings, a pattern consistent with both the racial-frustration and Southern-origin explanations.

In discussion of murder, the aggressor has received most of the attention. Because of obvious difficulties, the victim has been more difficult to study and speculate about. Houts [*14*], as a judge and educator, became interested in learning more about the victims of murders and published the case histories of several victims with "an effort to study a number of cases that emphasize the victim's perspective rather than the killer's, although both admittedly are closely intertwined."

This study reinforces the fact that people terminate life in many ways and "suicide" is not the sole modality. Of particular significance is the fact that even though the suicide rates for non-whites are rising slightly, most of the self-destructive deaths are caused by "victim-precipitated" murder, or through accidents and other modalities. To stress this point further, there were more deaths due to alcoholism than homicide in Monroe County in 1970. The rate of death by alcoholism was 5.3 per 100,000; 5.0 for white males, 0.9 for white females, 64.3 for non-white males, and 11.1 for non-white females. All deaths were in the 35 year and older age group, with all the black males and females in the 35 to 64 year group.

The decade of the sixties brought about some real and some promised changes in American society. It appears that this change resulted in a significant amount of stress on the black male whose role probably was one of the key factors that both caused change and was particularly affected by it. This may be one of the reasons for the dramatic increases in death rates among black males through the three modalities of death discussed in this paper that include self-destructive motives and behavior. Even though in another study [8] we mentioned that suicide attempts are not a good predictor for suicide among blacks, unless we look at other causes of death we may be missing the real answers to the question.

Prevention always follows when there is a sound and thorough understanding of cause and effect. In the case of suicide prevention and prevention of death from other possible self-destructive means, a great amount of additional investigation is needed. Further studies at Rochester include study of the homicide group in the Register, the relative risk of death for suicide attempters as compared with controls and the general population, study of accidents by type of accident and psychiatric histories, and studies of deaths attributed to alcohol or drugs.

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