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SCHIZOPHRENIA, THE MORTALITY GAP, AND SUICIDE

By Michael B. Friedman, LMSW

People with serious mental illness have a much lower life expectancy than the general population; estimates range from 9 to 32 years. Recent recognition of this mortality gap has led to efforts to improve their health by improving their access to health care and by providing health promotion activities such as smoking cessation, better diet, and more exercise.

These efforts are extremely important and long overdue. However, by themselves they will not address the mortality gap fully because 30-40% of the mortality gap is due to deaths from non-natural causes—homicide, suicide, and accidents—with suicide being by far the most common. In fact, suicide is the leading cause of death of younger people with schizophrenia. And people with schizophrenia are 12 times more likely to take their own lives than the general population.

Addressing the mortality gap should, therefore, involve an effort to reduce suicides by people with schizophrenia. How? By mounting responses to the known risk factors. Here's a somewhat abbreviated list of what researchers have identified.

- Most people with schizophrenia who complete suicide do so early in the course of their illness.
- Their suicide attempts are more likely to be lethal than those of other groups.
- Suicide risk is highest for people with schizophrenia who also have a deep sense of hopelessness and worthlessness.
- They are particularly vulnerable after the loss of a person about whom they care.
- Thinking about suicide and previous suicide attempts are also significant risk factors.
- Although there is some dispute in the research about whether awareness of one's condition ("insight") is a risk factor, fear of cognitive decline definitely is.
- Surprisingly, hallucinations and delusions—even command hallucinations—do not seem to increase risk of suicide.
- Not surprisingly, the co-occurrence of schizophrenia and the use of illegal substances is a significant risk factor.
- Not surprisingly as well, people who discontinue treatment are also at higher risk of suicide.
- Surprisingly, however, suicide by people with schizophrenia is not correlated with poor physical health.

This list comes from a review of a number of major meta-research studies. Obviously, the findings are useful. But frankly, I find these studies remarkably bloodless. And as I read them, I found myself remembering a man named Al, who was a member of a psychiatric rehabilitation program where I worked in the early 1970s. Al was about 30,

tall, strong looking, usually disheveled, and very angry--with a tendency to have frightening verbal outbursts. Despite that, he had a number of friends both in and out of our program. He talked a lot about being thrown out of City College because his brilliance was unappreciated. He knew, he said, the truth about the Universe and talked about it frequently and rapidly in ways that we could not understand. He also spent much of his time writing it all down in notebooks that no one was able to decipher. One other thing—Al was clearly tormented by his loss of promise and hated his life. One day he jumped in front of a subway. Whether it was an impulse or a planned suicide we never knew.

How can we address the problem of suicide among people with schizophrenia, people like Al? Some steps are obvious given the risk factors noted above:

- Early identification and intervention.
- Outreach to people who disappear from treatment.
- Active efforts to engage them in treatment and rehabilitation where and in ways that they accept.
- Since there are lower rates of suicide among those who take clozapine rather than other anti-psychotic drugs, prescribing physicians should weigh its risks and benefits for young people with schizophrenia.
- Serious response to symptoms of depression, especially a sense of hopelessness and worthlessness, suicidal thoughts, or a history of suicide attempts.
- Special vigilance after a personal loss.
- Integration of treatment of mental and substance use disorders.

This all involves preparing the community at-large to identify suicide risk and giving potential observers—and people in crisis—a number to call (or an internet site that is easy to access) when they need help. It also involves a substantial effort to train mental health, substance abuse, health, and social services providers how to identify suicide risk in people with schizophrenia (no easy matter) and how to engage and treat them.

All of this is clearly important. But I keep thinking about Al, and it strikes me that the only thing that would have saved him is a sense of hope. Fortunately, there is reason to believe that supportive families, contact with other people with schizophrenia who have made satisfying and meaningful lives for themselves, and spiritual faith can help people with schizophrenia get past despair.

Young people with schizophrenia are completing suicide at an alarmingly high rate. That is one of the major reasons why people with serious mental illness die so much younger than the general population. It is very important, therefore, that current efforts to transform mental health policy so as to close the mortality gap address the problem of suicide as well as the problem of poor health.

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Useful Articles

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