Letter from . . . Chicago

In black and pathless woods

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Of the many souls doomed to languish in Dante's hell as thorny trees in a black and pathless wood, none inspire more pity than those that tore themselves violently from their bodies in their youth. For we like to look back on adolescence as a time of unbounded serenity and think it tragic that a young person should die in despair. Yet since time immemorial suicide has periodically erupted into epidemics, from the maidens who flocked to hang themselves in ancient Miletus to the young men in blue coats and yellow vests who rushed to die in sympathy with the unfortunate Werther.

Violent death triad

In modern America, where infectious diseases have been largely eradicated, the triad of accidents, homicide, and suicide now emerges as the leading cause of death in adolescents.[1-4] In 1975 suicide ranked third as a cause of death in the 15-24 age group (11·8 cases per 100 000)—following closely on accidents (60·3 per 100 000) and homicide (13·7 per 100 000).[1-3] As more youngsters die by their own hand than from diabetes and appendicitis,[4] the suicide rate has become higher than ever recorded,[2] to the point where psychiatrists speak of a shocking increase of epidemic proportions.

There are, of course, problems in interpreting mortality statistics.[1] A suicide may remain unreported to avoid social stigma or to collect life insurance. Five times as many suicides may take place as are reported, and 10 times as many are attempted as are successful. Some deaths fall into a grey zone and are difficult to evaluate, especially since adolescents rarely leave suicide notes[4]; and methodological problems plague the sorting out and apportioning of the components of the violent death triad. Some violent or drug-related deaths represent suicide equivalents, as may accidents from drunken driving, dangerous motorcycles, and single driver collisions.[2] Homicides may be precipitated by the victim[2]; and certain subcultures display an inverse relation between suicide and homicide, suggesting that where outward aggression is the norm, aggression against the self is less common. But all in all the suicide rate has risen alarmingly. "You have only to spend some time in an emergency room to see it," said a psychiatrist when challenged as to whether the reported increase was real or a figment of statistical imagination.

What then might be the cause of this surge of self-destruction among the young? In trying to come up with an answer some psychiatrists have focused on the changes of puberty, noting an insidious sense of helplessness, a feeling of lost omnipotence or immortality, and a growing preoccupation with body image.[4] To this must later be added the traditionally turbulent stage of "the development of the autonomous self."[4] Yet there is considerable evidence that adolescence need not be a troubled time and that many teenagers pass smoothly through these supposedly stormy years. On the other hand, many of the adult mental illnesses that have their beginnings in the teens may remain unrecognised or be written off as moodiness or difficult behaviour. Suicide, then, may follow "the pain of depression, the emptiness of the borderline syndrome, the despair of schizophrenia, and the confusion of drug and alcohol abuse," ultimately precipitated "when cries for help have gone unheeded and the patient's fears, frustrations, and feelings of loneliness have developed into feelings of isolation, panic, and hopelessness."[5]

Social factors may also play a part. Thus whereas at the turn of the century the average age of entry into the labour force (and by implication into adulthood) was 14, modern adolescence has been greatly prolonged, especially in women,[6] and not only do puberty and the menarche occur earlier but educational requirements may greatly extend professional adolescence. Some studies have linked suicide to the post-second world war baby boom, noting that as the number of 15-19-year-olds has doubled the suicide rate in this age group has tripled.[1 2] The mere presence of so many young people puts a strain on services, leading to increased competition and often to disappointment.[1] Constantly escalating expectations, fostered since childhood by television advertisements, may also result in depression, as the teenager realises that he will never achieve the standard of living depicted as the expected norm in American society.

Difficulties also arise when teenagers magnify their supposedly insoluble problems—trouble in making friends, love affairs, worries about their appearance, obesity, acne, or even buck-teeth. In a constantly changing society, perhaps more unstable and confusing than ever, growing up may have become for some "impossibly complex."[4] To the loss of the extended family must be added the strains in the nuclear family and the difficulty of achieving adequate family relations,[3 4] as well as an ever greater mobility and loosening of traditional social ties and standards. A rising divorce rate[4] leaves in its wake a trail of loneliness and alienation as 20% of children grow up in single-parent families; and many are further aggrieved by the coming on the scene of step-parents[3] or by a succession of boyfriends and female companions. Parental emotional turmoil or mental illness often plays a part in adolescent suicide, a family history of psychiatric disorder being found in as many as 50% of cases.[3] Problems at school[3] have led to definite suicide peaks being described in June, when the youngsters leave school, and in September when they return. Also significant may be sexual differences, so that a young man often chooses a violent and lethal method whereas a woman may merely attempt suicide or induce superficial injuries that serve to attract attention or appear to "consolidate her cohesive sense of self by soothing herself in the face of the terror of feeling that she is falling apart."[5] Thus a suicide attempt in adolescence may represent a last cry for help, anger, retaliation for abandonment or the threat of abandonment, manipulation to obtain love and attention, the desire to be

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reunited with a dead parent, or the final disintegration of a psychotic personality, each requiring a different therapeutic approach.

Suicide in the very young is much less common than in adolescents, but because preschool children lack the usual means to commit suicide, they may resort to quite lethal methods such as jumping out of a window or in front of a car. As late as the 1950s psychiatrists still discounted the possibility of suicide in children, nor was it widely accepted that children could become severely depressed, perhaps because the clinical presentation is often atypical. Although children, just as adults, may present with sadness, motor retardation, insomnia, loss of appetite, and weight loss, their depression often manifests itself as disordered conduct or heightened aggression; and being typically thought of as impulsive and unable to understand the finality of death, their acts may be interpreted as mere temper tantrums. Their underlying depression may also be overlooked because they are easily distracted and may snap out of their depression when amused, only to lapse back into their sadness when left alone. A positive family history of mental illness or suicide is not uncommon; and genetic as well as environmental factors may play a part. For treatment, some therapists use antidepressant drugs immediately, whereas others first try a period of psychotherapy and changing the environment.

Culture of intoxication

In a related issue several studies have now shown a strong relation between the use of alcohol or drugs and attempted suicide in many adolescents, though not usually in drug addicts.[3] This assumes particular importance as drug taking has become more frequent at a younger age, so that many teenagers graduate quickly from alcohol and cigarettes to marijuana and hard drugs. In one recent study it was found that 7% of high school seniors smoked marijuana and 9% drank alcohol regularly. In the Chicago area drug-related deaths have increased by 60% in four years, and the newspapers recently reported how teenagers from the affluent suburbs have been stealing their parents' sterling silver plates and selling them to coin dealers to buy drugs.

Particularly disturbing has been the trend in adolescents of taking more than one drug at a time. Cocaine, heroin, methadone, and methaquolone are widely used; and in hospitals one not infrequently observes the bizarre and often irreversible mental changes caused by phencyclidine (PCP or "angel dust"). Another lethal combination is the *Ts and Blues*, a mixture of Talwin (or pentazocine) and pyribenzamine, often injected with talc and other ingredients. According to officials, the population of drug abusers is getting larger, the distribution of drugs wider, "and the culture of intoxication plaguing our society is continuing to win converts, particularly among the young." In response to this problem President Reagan recently vowed to expand the government's war on drug abuse by increasing the number of judges, prosecutors, and law enforcement officers, and by using military radar and intelligence to detect drug traffickers. Already official figures indicate that arrests have increased and more marijuana is being confiscated. But from California come reports that in these hard times many farmers and even city people are secretly growing marijuana to supplement their meagre incomes or unemployment compensation. For some the extra revenue has come to mean a real "pot of gold," and local governments have been lackadaisical in looking for the culprits or prosecuting them when caught, so much has this new industry come to mean to the welfare of some counties. The war on drug abuse, clearly, is far from being won.

References

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Two patients, one man and one woman, both in their 20s and healthy, have recently started hard running, three or four miles at a time. Both pass heavily bloodstained urine, once only, on the first micturition after the run; every other specimen passed is normal to the naked eye. There is no pain, nor any other urinary symptom, and no history of urinary trouble. The woman has been fully investigated, including an intravenous pyelogram, and no abnormality has been found. Early morning urine specimen in the man (the morning after a hard run) shows only 1-2 red blood cells per high-power field. They have tried running with the bladder half-full, but this makes no difference. Is anything known about the cause of this "jogger's bladder," and can anything be done other than giving up running?

This is unlikely to be due to any disease in the lower urinary tract, but only cystoscopy would confirm this absence conclusively. Hence it will make no difference whether the patient is running with a full, half-full, or empty bladder. Therefore please forget the term "jogger's bladder." Firstly, red blood cells must be shown to be present in sufficient quantity to account for heavily "bloodstained urine" so as to exclude haemoglobinuria. Secondly, any underlying nephritis must be excluded by examining the urine (when no jogging has been performed) for albumin and casts, as well as for the occasional red blood cell. The blood pressure should also be checked. If there is no albumin, no casts, and the blood pressure is normal, then the haematuria will probably settle without further treatment. If albumin and casts are seen or the haematuria persists despite reducing the duration and intensity of the exercise, then the patient should be seen by a nephrologist for investigation, which will probably include intravenous pyelography, urea and electrolyte estimation, assessment of circulating antibodies, and, possibly, a renal biopsy. With these investigations it would be possible to determine whether there is any underlying nephritis.—J P MITCHELL, honorary professor of surgery (urology), Bristol.

An elderly man with symptomless labile hypertension was treated with a diuretic combination comprising triamterine and a thiazide. He subsequently developed extrasystoles and occasional postural dizziness. What might be the cause of these?

The question raises several distinct issues. Firstly, symptomless hypertension may not necessarily require treatment in the elderly; whether treatment is appropriate or not depends on factors such as age, the height of the blood pressure, evidence of hypertensive disease, and the presence of overt cerebrovascular insufficiency. Secondly, postural hypotension is relatively common in the elderly because blood pressure may not be maintained reliably in the upright position and because the vertebrobasilar circulation may be especially vulnerable; the symptom may then be exacerbated by even small falls in blood pressure and becomes a relative contraindication to treatment with any antihypertensive agent. Thirdly, the occurrence of symptomatic extrasystoles is both common and capricious. While extrasystoles may be provoked by a fall in blood pressure or possibly by induced hypokalaemia, their occurrence is more likely to be fortuitous. The combination of a thiazide with triamterene is designed to overcome the problem of diuretic-induced hypokalaemia, but is not totally reliable in this respect. Ideally the electrolyte concentrations should be checked before and during treatment. Finally, if the indications for treatment are only marginal then symptoms that could conceivably be drug-related may justify its withdrawal.—D A C CHAMBERLAIN, consultant cardiologist, Brighton.