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Commentary

Tinnitus and Suicide: Recent Cases on the Public Record Give Cause for Reconsideration

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Abstract

Suicides among tinnitus sufferers are rare. Indeed, on examining the public record (newspapers and the Web), the authors identified only 4 cases in the past 10 years that had been examined by a coroner. Nevertheless, the deaths of Rick Tharp, Dietrich Hectors, William Morris, and Robert McIndoe prompt reconsideration of the association between tinnitus and suicide that appears to be weak. The article also draws attention to a subject that is receiving attention in the medical literature—namely, the role of “precipitants” (in this case, tinnitus) in completed suicide and the need to screen some cases of severe, disabling tinnitus for the presence or absence of coinciding psychopathology, which is very amenable to treatment.

Keywords

tinnitus, suicide, depression, media reports

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Tinnitus is a conscious experience of sound originating in the head of its owner that often causes great suffering. Although many people with subjective idiopathic tinnitus¹ can turn a blind eye to it, others—particularly with the severe, disabling type—cannot, perhaps due to the sense of loss of control, annoyance at the persistence, or other reasons.

As might be expected, many of those with bothersome tinnitus experience major depressive disorder, with prevalence rates in studies ranging widely from 14% to 80%.² Encouragingly, antidepressant medication and cognitive behavior therapy (CBT) can lead to improvement in depression and quality of life in those with tinnitus, although regrettably without necessarily reducing the distress pertaining to its core feature (the experience of sound originating in the head).²,³

Tinnitus sufferers complain of great misery and, rarely, a few may speak of contemplating suicide. Perhaps the most prominent recent example was the celebrity William Shatner, of Star Trek fame, who obtained relief from “brain retraining.”³ There have also been suggestions in the academic literature that tinnitus may be associated with suicide. Studies conducted in the United Kingdom in the 1990s found a suicide rate of 118 per 100,000, significantly higher than that of the region’s general population, but the sample’s derivation from a specialist clinic population presumably contributed.⁴ An influential, systematic review in 2001 failed to find “any evidence supporting a cause and effect relationship between tinnitus and suicide.”⁵

The most important risk factor for suicide in tinnitus sufferers is a depressive disorder.⁶ Other risk factors are older age, male gender, and social isolation. Several validated questionnaires, including the self-report Tinnitus Reaction Questionnaire (TRQ) and Tinnitus Handicap Inventory, have demonstrated the impact on quality of life of tinnitus and the despair of many sufferers.² The TRQ specifically addresses the issue of suicide and is commonly used in clinical practice.

This short commentary examines accounts on the public record of people with tinnitus who have completed suicide. Our purpose is 2-fold. First, we draw on these most recent cases to note that the strength of association between tinnitus and suicide is generally weak. Second, we wish to provide the “ENT community” with a brief update regarding a subject that is receiving attention in the psychiatric literature—namely, the role of “precipitants” (in this case, tinnitus) in completed suicide.⁷ Although underlying depressive

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illness may contribute to cases of suicide—and therefore one should never be blind to the possibility of a (treatable) depressive illness, even in the presence of major precipitants such as tinnitus—this article reinforces the notion that precipitants alone, if highly distressing, may be sufficient in rare cases. At the same time, crucially, potential referral to a psychiatrist or another mental health professional to help determine the presence of an underlying psychiatric disorder among those with severe, disabling tinnitus should never leave the otolaryngologist’s mind, particularly in view of the considerable benefit that can result through treatment of those disorders.

The Cases

After scouring the media (newspapers and the Web) for stories that had been published over the past 10 years, we identified 4 accounts where the cases had been examined by a coroner.

Charles Frederick (Rick) Tharp was 52 years of age when he died in 2005.8 He was born in Mansfield, Ohio, and moved to California at the age of 23, to establish a design studio, “Tharp Did It.” He was highly successful, designing posters and other material for the campaign to bring the Olympic Games to San Francisco. Tharp won almost every available award for design and had work on display at the Smithsonian Institution and the Library of Congress. He began to suffer tinnitus, and his friends became worried for his safety, but unfortunately they were unable to thwart his desire to commit suicide. Tharp made arrangements for his body to be cremated, and he jumped to his death from the Golden Gate Bridge.

Dietrich Hectors died in 2009 at the age of 29.9 He was born in Belgium and obtained a PhD in engineering. Hectors was a heavy metal musician, and tinnitus and hyperacusis commenced after a concert in 1996. He began wearing earplugs, but even his own voice became painful. “This disease controls my life. Every word hurts,” he suggested. Hectors gave up his social life and hoped for improvement, but even speaking to friends became impossible. In his suicide note, he wrote, “The ringing noise in my ears is totally unbearable. . . . Please respect my choice, my life has become a living hell.” He is believed to have hanged himself.

William L. (Willie) Morris was 66 years of age when he died in 2010.10 He was born in Greene County, Missouri, and became the county sheriff, a position he held for 20 years. Morris was formerly a champion weightlifter. He attributed his tinnitus, which he described as a “constant buzz saw,” to a weightlifting accident. He wrote a letter to his daughter, saying that instead of flowers, people should make a donation to the American Tinnitus Association. Morris shot himself on his farm.

Robert McIndoe died in 2010 at the age of 52.11 A management consultant and keen guitarist, he lived in London and was married with 2 children. McIndoe developed tinnitus after attending a concert and was unable to sleep for 3 months. He sought but did not obtain relief at King’s College Hospital, St Thomas’s Hospital, and University Hospital Lewisham. McIndoe took an overdose of sleeping tablets and was seen by a psychiatrist, who said, “I thought he would be manageable in the community.” Soon after, McIndoe stabbed himself to death.

Synthesis

A shortcoming of the use of public record material is that it is collected not by clinicians but by lay individuals. The other side of this coin is that public record material is collected and reported by competent people with little tendency to medicalize the facts.

A limitation of collections of cases, like these, is that they are not representative of populations and cannot statistically prove hypotheses. However, as one black swan proves that swans can be black, one case showing that tinnitus led to suicide would indicate that tinnitus can lead to suicide. Whether any, all, or none of these cases shows that tinnitus led to suicide is a matter for the individual reader.

It has been articulated recently that suicide may function as an escape from a “predicament” (distressing situation).7 There is no doubt some people find tinnitus extremely distressing. There is also no doubt that distressing circumstances may lead to major depressive disorder. However, it would be perverse to attribute suicide to depression in all cases like this, without compelling evidence.

This brief commentary, with the stated limitations of a select and small case series, can neither directly support nor challenge the contention that there is “no evidence supporting a cause and effect relationship between tinnitus and suicide.” However, our article does at the very least point to the need for reconsideration in isolated cases and, even more important, highlights the necessity for all physicians to have great compassion in dealing with significantly distressed people for whom no method of treatment for their tinnitus may be successful. It also serves as a timely reminder, in the wake of recent cases on the public record and the growing multidisciplinary field of tinnitus, that ENT surgeons remain open to the idea of referring patients with severe, disabling tinnitus to psychiatrists or other mental health professionals, to help ascertain the presence or absence of coinciding psychopathology. There is compelling evidence that, where psychiatric disorders exist, tinnitus sufferers will benefit from appropriate treatment.

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