Part I

# UNDERSTANDING

Suppose we take Jeff, a lad of 18 years, and suppose his family background is marked with depression; he is isolated; his pain is unbearable; and he sees no escape from his malaise, but suicide. Suppose that 70% of such young adults, having a similar background, become suicidal. Does that mean that Jeff himself has a 70% chance of killing himself? Echoing Allport, Murray, and Shneidman, the answer is—not at all. Jeff is a unique being.

We must do justice to the fascinating individuality of each person. This fascinating individuality of each person is humankind's complexity and this is as true for suicide as for any behaviour. Suicide is complex. It is a multidimensional malaise, with both conscious and unconscious elements. This is the reason why I begin this section with a few chapters to allow one to understand suicide perhaps a little better; not only suicide in general (the 70%), but suicide in the individual (the Jeffs).

Shneidman taught that: "We ought to know what we are treating." He believes that we will treat such problems as suicide more effectively only when we develop "clear and distinct" understanding of suicide. Indeed, he believes that, in the study of large issues like suicide, there is a natural progression from conceptualization to understanding and then to application and practice. This part serves somewhat like a prolegomenon to our topic: psychotherapy with a suicidal person. It consists of four chapters: an overview of suicide; a definition of suicide as a multidimensional malaise, based on the empirical study of the person's own last narrative, the suicide note; a study of the conscious and unconscious processes in suicide; and an explication to cognition, communication and suicide notes—from the story to the mind. The latter chapter is critical because it highlights how the narrative aspects of human life, in their "sameness", show the prominent or common psychological threads that allow *a* person to jump into the suicidal abyss.

Chapter 1

# SUICIDE

Death is difficult to understand. Death is mysterious. It is almost universally feared and remains forever elusive. This is especially so with suicide. Almost all of us are bewildered, confused, and even overwhelmed when confronted with suicide. Yet, for some it is a final solution. Perplexing for most, it is actively sought by a few. Paradoxically, these few same people are probably the least aware of the essence of reasons for doing so. Understanding suicide, and death, is a complex endeavour for all.

## DEFINITION OF SUICIDE

Briefly defined, suicide is the human act of self-inflicted, self-intentioned cessation (Shneidman, 1973). Suicide is not a disease (although there are many who think so); it is not a biological anomaly (although biological factors may play a role in some suicides); it is not an immorality (although it has often been treated as such); and it is not a crime in most countries around the world (although it was so for centuries).

It is unlikely that any one view or theory will ever define or explain phenomena as varied and as complicated as acts of human self-destruction. Our own initial definition is fraught with complexities and difficulties.

The history of our key word provides only initial assistance. "Suicide", in fact, is a relatively recent word. According to *The Oxford English Dictionary*, the word was used in 1651 by Walter Charleton when he said: "To vindicate one's self from . . . inevitable Calamity, by Sui-cide is not . . . a Crime." However, the exact date of its first use is open to some question. Some claim that it was first used by Sir Thomas Browne in his book, *Religio Medici*, published in 1642. Edward Philips, in his 1662 edition of his dictionary, *A New World of Words*, claimed to have invented the word. The word "suicide" does not appear in Robert Burton's *Anatomy of Melancholy* (1652 edition), nor in Samuel Johnson's *Dictionary* (1755). Before the introduction of the word, other terms, of course, were used to describe "the act"—among them self-destruction, self-killing, self-murder, and self-slaughter. Burton's phrases for suicide include "to make way with themselves" and "they offer violence to themselves". The classical (and current) German term is in keeping with

this tradition—Selbstmord, or self-murder. Other countries around the world have their own words and definitions.

In the present scene, two major efforts to define the term are provided by teams of experts—the first American, and the second international: Rosenberg, Davidson, Smith, Berman, Garter, Gay, Moore-Lewis, Mills, Murray, O'Carroll, and Jobes (1988); and Leenaars, De Leo, Diekstra, Goldney, Kelleher, Lester, and Nordstrom (1997). An extensive quote of the latter group will be presented in Chapter 5. An excellent scholarly discussion of the problem of definition was offered by Douglas (1967), who outlined the fundamental dimensions of meanings that are required in the formal definition of suicide, which include aspects of initiation, willing, motivation, and knowledge. The international team (Leenaars et al., 1997) suggests that one must consider issues beyond clear definition, e.g., circumstances, medical lethality, intent. As you will read, clear definition is needed before assessment and treatment.

Suicide may today be defined differently depending on the purpose of the definition—medical, legal, administrative, etc. In the United States and Canada (and most of the countries reporting to the World Health Organization), suicide is defined (by a medical examiner or coroner) as one of the four possible modes of death. An acronym for the four modes of death is NASH: natural, accidental, suicidal, and homicidal. This fourfold classification of all deaths also has its problems. Its major deficiency is that it treats the human being in a Cartesian fashion, namely as a biological machine, rather than appropriately treating him or her as a motivated biopsychosocial organism. That is, it obscures the individual's intentions in relation to his or her own cessation and, further, completely neglects the contemporary concepts of psychodynamic psychology regarding intention, including unconscious motivation.

There is no universally accepted definition of suicide today. In fact, there never was one. Indeed, there are numerous definitions. Varah (1978) has collated a variety of definitions, and here is a sampling:

> Erwin Ringel (Austria): Suicide is the intentional tendency to take one's own life.
>
> Charles Bagg (United Kingdom): Suicide is the intentional act of taking one's life either as a result of mental illness (these illnesses frequently though not always causing distress to the individual carrying out the act) or as a result of various motivations which are not necessarily part of any designated mental illness but which outweigh the instinct to continue to live.
>
> Walter Hurst (New Zealand): The decision to commit suicide is more often prompted by a desire to stop living than by a wish to die. Suicide is a determined alternative to facing a problem that seems to be too big to handle alone.
>
> Sarah Dastoor (India):
> I vengeful, killer, hate—inspired—so I die
> I guilty, sinner, trapped—escaping life
> I hoping rebirth, forgiveness divine—live again
>
> Tadeusz Kielanowski (Poland): Suicide is the most tragic decision of a man who found nobody to hold out a hand to him.

Soubrier (1993, p. 33), in his review of this topic, concluded: "A major issue in suicidology is the following: Do we have a common definition of suicide?"

The topic of definition of suicide was the focus of an entire book by Shneidman (1985). His book, *Definition of Suicide*, can be seen as a necessary step to a more effective understanding and treatment of suicide. It argued that we desperately need a clarification of the definitions of suicide—definitions that can be applied to needful persons—and he defined suicide as:

> Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution. (Shneidman, 1985, p. 203)

This definition should not be seen as the final word, but will be used here as a *mnemonic* for understanding the event.

## EPIDEMIOLOGY OF SUICIDE

It is generally believed that many actual suicides fail to be certified as suicides. Be that as it may, most suicidologists (e.g., O'Carroll, 1989) agree that official statistics on suicide can validly be used and, furthermore, Sainsbury and Barraclough (1968) have shown that cross-national comparisons can be not only validly but reliably made. Suicide rates vary from country to country (Lester, 1992). Table 1.1 shows suicide rates in 12 countries/regions of the world based primarily on the data from the World Health Organization (WHO, yearly; see www.who.int), obtained from Dr David Lester (personal communication, 12 February 2002).

The 12 nations/cultures are: Australia, Ireland, Turtle Island, Lithuania, China, Russia, United States, Cuba, South Africa, Japan, India and the Netherlands. These are the home countries of the individuals who comprise the International Working Group on Ethical and Legal Issues in Suicidology (see Chapter 21). They give us a sample of the rates of suicide around the world.

**Table 1.1** Suicide rates for 12 nations/cultures

| | 1901 | 1950 | 1970 | 1980 | 1985 | 1990 | 1995 |
|---|---|---|---|---|---|---|---|
| Australia | 11.9 | 9.3 | 12.4 | 11.0 | 11.5 | 12.9 | 12.0 |
| Ireland | 2.9 | 2.6 | 1.8 | 6.3 | 7.8 | 9.5 | 11.3 |
| Turtle Island | — | — | — | — | — | 59.5[a] | — |
| Lithuania | — | — | — | — | 34.1 | 26.1 | 44.0 |
| China[b] | — | — | — | — | — | 28.7[c] | — |
| Netherlands | 5.8 | 5.5 | 8.1 | 10.1 | 11.3 | 9.7 | 10.1 |
| USA | — | 11.3 | 11.6 | 11.9 | 12.3 | 12.4 | 11.9 |
| Cuba | — | — | 11.9 | — | — | — | 20.3 |
| South Africa[d] | — | — | — | — | — | 17.2 | — |
| Japan | 17.7 | 19.6 | 19.2 | 17.7 | 19.4 | 16.4 | 17.2 |
| India | — | — | 9.1 | 6.3 | 7.1 | 8.9 | 9.7 |
| Russia | — | — | — | 34.6 | 31.2 | 26.5 | 41.5 |

[a] Rate based on one Inuit community. Abbey et al. (1993).
[b] WHO rates are only on a 10% sample—and separated rural/urban—so no single rate is available.
[c] Phillips and Liu (1996) 1990–1994 (cited in Lester, 1997).
[d] Rates never calculated for blacks. Schlebusch (personal communication) provided an estimated 1990 rate.

The WHO data start in 1901. The data are now published online at www.who.int and not in books. Fewer countries have data online. The WHO does not report data for distinct cultural groups; thus, there are no comprehensive data for the Native people of Turtle Island (now called North America). The rates in some aboriginal communities on Turtle Island are unbelievably high (Leenaars et al., 1999a). Within the context of very low rates historically, Abbey et al. (1993), have reported rates of 59.5 to 74.3 per 100 000 in one group, the Inuit in the Arctic. The young males are the highest risk group; for example, Wotton (1985), reported a rate as high as 295 per 100 000 for 15- to 25-year-olds in one community. This is epidemic.

Data from India are available, but not easily accessible and not well known; the India data reported here are from Lester et al. (1999). South Africa reports only crude numbers, but not for blacks. In the past, sometimes South Africa counted Asians and coloureds in addition to whites, but it is unclear why they did so, making the South African rates from the WHO probably unreliable and invalid. Lourens Schlebusch (personal communication, 27 March 2002), provided the following comment, with the cautionary note about "the only suicide rates": "Some of the studies show that in 1990 the overall suicide rate was 17.2 per 100 000, which is slightly higher than the WHO's reported world average of 16 per 100 000." More recent efforts are underway in South Africa to develop more accurate mortality statistics (Schlebusch & Bosch, 2000). China also lacks data; the rates reported by the WHO are based on only 10% of the sample. Phillips and Liu (1996, cited in Lester, 1997), provide an estimate for 1990–1994; this is the best estimate available. Other nations, for example, Lithuania and Russia, only have more recent data. Still others, for example, Cuba has provided only sporadic data. With all these caveats, Table 1.1 presents the data available from 1901, 1950, 1970, 1980, 1985, 1990, 1995. It is the best snapshot that we can get on the epidemiology (with thanks to David Lester, my forever-statistical consultant and friend).

Not only do national statistics vary but substantial variations in suicide for subgroups also occur in these nations (e.g., age, gender, ethnicity). Age is an especially important demographic variable as children and adolescents also commit suicide. Although suicide is rare in children under 12, it occurs with greater frequency than most people imagine (we shall meet such a 4-year-old in this volume), and suicide is also an alarming problem in adolescents in many parts of the world, especially for older boys. The tragedy of adolescent suicide is especially poignant because the life expectancy of these youths is greatest in terms of both interval of years and the diversity of experiences that should await them (a few such cases will be presented later). Nonetheless, it is young adults (i.e., 18–25) and the elderly (i.e., above 55 or 60) who are most at risk. In the United States, it is the elderly who are at highest risk, again especially the males (who will also be found in this book). However, that trend is not always true in other nations. In many nations, for example, the rate of suicide for young adults is as high, if not higher, than for the elderly in some countries. In females, the highest rate occurs in middle adulthood, often the 40s. (In China, females have a higher rate than males (Phillips & Liu, 1996).)

Although space here does not allow for more detailed discussion of the epidemiology, the reader is referred to reviews (e.g., Lester, 1992) on the topic.

## HISTORY OF SUICIDE

The modern era of the study of suicide—at least in the Western world—began around the turn of the twentieth century, with two main threads of investigation, the sociological and psychological, associated primarily with the names of Emile Durkheim (1858–1917) and Sigmund Freud (1856–1939), respectively. Much earlier, during the classical Greek era, suicide was viewed in very specific ways, but almost always negatively. Pythagoras of Samos (around 530 BC), who introduced the theory of number to understand man and the universe ("Number is all things and all things are number"), proposed that suicide would upset the spiritual mathematics of all things. All was measurable by number, and to exit by suicide might result in an imbalance, unlike other deaths that were in harmony with all things. Plato's position (428–348 BC), best expressed in the *Phaedo* in his quotation from Socrates, is as follows:

> Cebes, I believe . . . that the gods are our keepers, and we men are one of their possessions. Don't you think so?
>
> Yes, I do, said Cebes.
>
> Then take your own case. If one of your possessions were to destroy itself without intimation from you that you wanted it to die, wouldn't you be angry with it and punish it, if you had any means of doing so?
>
> Certainly.
>
> So if you look at it in this way I suppose it is not unreasonable to say that we must not put an end to ourselves . . .

There are, however, provisions for exceptions. The above quotation continues:

> . . . until God sends some compulsion like the one which we are facing now.

The compulsion, of course, was the condemnation by the Athenian court of Socrates for "corrupting the minds of the young and of believing in deities of his own invention instead of the gods recognised by the state" (*Apology*). Socrates then drank poison, hemlock.

Although Plato allowed for exceptions, he echoed Pythagoras; suicide was wrong and against the state. He writes in *The Laws*:

> But what of him . . . whose violence frustrates the decree of Destiny by self-slaughter though no sentence of the state required this of him, no stress of cruel and inevitable calamity has driven him to the act, and he has been involved in no desperate and intolerable disgrace, the man who thus gives unrighteous sentence against himself from mere poltroonery and unmanly cowardice? Well, in such a case, what further rites must be observed, in the way of purification and ceremonies of burial, it is for Heaven to say; the next of kin should consult the official canonists as well as the laws on the subject, and act according to their direction. But the graves of such as perish thus must, in the first place, be solitary . . . further they must be buried ignominiously in waste and nameless spots . . . and the tomb shall be marked by neither headstone nor name.

Aristotle (384–322 BC), Plato's most famous but rebellious student, also espoused the view that suicide was against the State and, therefore, wrong. Man was answerable to the State and thus liable for wrongdoing and was to be punished for

wrongful acts. Suicide is one such act. In book 3 of the *Nicomachean Ethics*, Aristotle noted that:

> . . . to die to escape from poverty or love or anything painful is not the mark of a brave man, but rather of a coward; for it is softness to fly from what is troublesome, and such a man endures death not because it is noble but to fly from evil.

Suicide is categorically seen as unjust. The suicide is "the worst man". In the only other reference on suicide, Aristotle is explicit; in book 5 of the *Ethics* he writes:

> . . . one class of just acts are those acts in accordance with any virtue which are prescribed by the law; e.g., the law does not expressly permit suicide, and what it does not expressly permit it forbids. Again, when a man in violation of the law harms another (otherwise than in retaliation) voluntarily, he acts unjustly, and a voluntary agent is one who knows both the person he is affecting by his action and the instrument he is using; and he who through anger voluntarily stabs himself does this contrary to the right rule of life, and this the law does not allow; therefore he is acting unjustly. But towards whom? Surely towards the state, not towards himself. For he suffers voluntarily, but no one is voluntarily treated unjustly. This is also the reason why the state punishes; a certain loss of civil rights attaches to the man who destroys himself, on the ground that he's treating the state unjustly.

Epicurus (341–270 BC), another well-known Greek philosopher, was also opposed to suicide. He stated, ". . . the many at one moment shun death as the greatest of all evils, and another yearn for it as a respite from the evils of life."

In classical Rome, in the centuries just before the Christian era, life was held rather cheap and suicide was viewed either neutrally or, by some, positively. The Roman Stoic, Seneca (4 BC–65 AD), in one of his famous "Letters to Lucilius" wrote,

> Living is not as long as he can . . . He will always think of life in terms of quality not quantity . . . Dying early or late is of no relevance, dying well or ill is . . . even if it is true that while there is life there is hope, life is not to be bought at any cost.

Zeno (around 490 BC), a Greek and the founder of Stoic philosophy, hanged himself after putting his toe out of joint in a fall at age 98. The history of Rome is filled with such incidences, where life was given up for seemingly trivial reasons. Seneca went as far as to call self-murder a "great freedom". Seneca's wish: "Death lies near at hand." Seneca killed himself (by opening his veins). The emperor Nero, had ordered his death because Seneca was accused of plotting against him; and Seneca's death became glorified and respected with great reverence at that time (Van Hooff, 1990). The history of Rome's civilization itself was, indeed, inimical; the life-style in Rome truncated that civilization's very existence, and this can be summed up in Zeno's most famous appeal for suicide:

> To sum up, remember the door is open. Be not a greater coward than the children, but do as they do. When things do not please them, they say, "I will not play anymore." So when things seem to you to reach that point, just say "I will not play anymore" and so depart, instead of staying to make moan.

The Old Testament does not directly forbid suicide, but in Jewish law suicide is wrong. Life had value. In the Old Testament one finds only six cases of suicide: Abimelech, Samson, Saul, Saul's armour-bearer, Ahithapel, and Zimni. The New

Testament, like the Old, did not directly forbid suicide. During the early Christian years, in fact, there was excessive martyrdom and tendency towards suicide, resulting in considerable concern on the part of the Church Fathers. Suicide by these early martyrs was seen as redemption and thus, to stop the suicides, the Fathers began increasingly to associate sin and suicide. In the fourth century, suicide was categorically rejected by St Augustine (354–430). Suicide was considered a sin because it precluded the possibility of repentance and because it violated the Sixth Commandment, "Thou shalt not kill." Suicide was a greater sin than any other sin. One might wish to avoid suicide, more than any other sin. This view was elaborated by St Thomas Aquinas (1225–1274) who emphasized that suicide was not only unnatural and antisocial, but also a mortal sin in that it usurped God's power over man's life and death (echoing the views of Aristotle, but now suicide is not against the State, but against God, the Church). By 693, the Church, at the Council of Toledo, proclaimed that individuals who attempted suicide were to be excommunicated. The notion of suicide as sin took firm hold and for hundreds of years played an important part in Western man's view of self-destruction. Only during the Renaissance and the Reformation did a different view emerge, although, as Farberow (1972) has documented, the Church remained powerful and opposed to suicide among the lower classes into the twentieth century, although it was not the only view. "In the Western world" philosophy was presenting different perspectives.

The writers and philosophers from the 1500s began to change the views on suicide. William Shakespeare (1564–1616), for example, has provided us with an excellent array of insights. Minois (1999), in his review of the history of suicide in Western culture, underscores that Shakespeare illustrates how "dramatically" the attitudes had changed by this time. Shakespeare wrote a number of tragedies, with 52 suicides occurring in his plays (Minois, 1999). Shakespeare was a superb suicidologist. Who can forget one of the most famous passages ever written on the topic? William Shakespeare's *Hamlet*, act 3, scene 1:

> To be or not to be: that is the question.
> Whether 'tis nobler in the mind to suffer
> The slings and arrows of outrageous fortune,
> Or to take arms against a sea of troubles,
> And by opposing end them. To die; to sleep;
> No more; and by a sleep to say we end
> The heart-ache and the thousand natural shocks
> That flesh is heir to, 'tis a consummation
> Devoutly to be wish'd. To die, to sleep; . . .

There were many philosophers during the Renaissance ages that argued the opposition to suicide. René Descartes (1596–1650) is a good example. Yet, at the same time, the complexity on the topic increased. The French philosopher, Jean-Jacques Rousseau (1712–1778), attempted to free the suicide from evil. He emphasized the natural state of the human being, i.e., innocence. Rousseau transferred sin from the individual to society, making the person and people generally good (and innocent) and asserting that it is society that makes them bad. Suicide is caused by society; the individual is not to blame for his/her death. The disputation as to the locus of

blame—whether in man or in society—is a major theme that dominates the history of thought about suicide subsequently. David Hume (1711–1776) was one of the first major Western philosophers to discuss suicide apart from the concept of sin. In his essay, "On Suicide", intentionally published by him a year after his death, he refutes the view of suicide as a crime by arguing that suicide is not a transgression of our duties to God, to our fellow citizens, or to ourselves. Suicide is a right. He asserts that

> . . . prudence and courage should engage us to rid ourselves at once of existence when it becomes a burden. . . . If it be no crime in me to divert the Nile or Danube from its course, were I able to effect such purposes, where then is the crime in turning a few ounces of blood from their natural channel?

This is based on his view: "The life of a man is of no greater importance to the universe than that of an oyster." He even touches on the topic of survivorship, suggesting that one does not harm one's family, neighbours with suicide. Suicide is simply a right.

Whereas Hume tried to decriminalise suicide and make it our right, others, including Immanuel Kant (1724–1804), wrote that human life was sacred and should be preserved, in an antistoic sense, at any cost. There was an abundance of different views by the 1700s, the period of the Enlightenment. Johann Wolfgang von Goethe (1749–1832), in his novel *The Sorrows of Young Werther*, presents, for example, the opposite view to Kant's (see Chapter 2). Life does not need to be preserved. There is a right to death. Werther killed himself in the face of unbearable emotional pain. The book is a story of Werther's intoxication—"complete possession", "flood of emotions", in which "everything around about ceased to exist", "the purest joy of life", "Heaven"—with Lotte, who is betrothed to and marries another. Werther killed himself with the pistol Lotte's father had given him.

Werther had a strong impact in Europe; Goethe himself became known only as "the author of Werther". Even the clothes Werther wore became fashionable. A contagious suicide effect (sometimes called the Werther effect) seemed to occur, a concern that preoccupies many suicidologists to this day (although archival research by Thorson and Öberg (2003) has questioned the existence of the Werther effect after the publication of Goethe's book). As an important aside, it should be noted that Goethe himself battled against his own emotional difficulties, for example, working on Faust for 60 years until he had completed it.

During more recent times, other main threads of suicidal study evolved. Existentialism, for example, has brought suicide into sharp focus, best exemplified in Albert Camus's *The Myth of Sisyphus* (1955). In the opening lines, he wrote:

> There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy. All the rest and whether or not the world has three dimensions, whether the mind has nine or twelve categories—comes afterwards.

Yet, the answer to Camus's question may not be obvious. What he meant by the philosophical problem is somewhat like the following: "If life has no meaning,

life is not worth living; life is meaningless; therefore, one ought to kill oneself." Camus himself, however, opposed suicide. He stated, in fact, that even if life is meaningless, suicide is not just. Camus disagreed with the first premise; he argued that meaninglessness, whether painful or otherwise, does not suggest that life be not worth living. He saw the argument as faulty reasoning. (I will return to the "On 'Therefore'" in the suicidal mind in Chapter 12.) Camus, thus, opposes suicide, although his quote on suicide may well be the most famous of the last century, albeit often misunderstood. Every veteran and aspiring suicidologist knows the quote.

The two giants in the field of suicidal theorizing at the turn of the twentieth century were Durkheim and Freud. Durkheim in *Suicide* (1951) focused on society's inimical effects on the individual, while Freud, eschewing the notions of either sin or crime, gave suicide back to man, but put the locus of action in man's unconscious. Since around 1900, a host of psychological theories, aside from those of Freud, have focused on the individual; for example, those of Alfred Adler, Ludwig Binswanger, Aaron T. Beck, Carl G. Jung, Karl Menninger, George Kelly, David Lester, Henry A. Murray, Edwin Shneidman, Harry Stack Sullivan, and Gregory Zilboorg, to name a few (Leenaars, 1988a). Indeed, our view of the history of suicide shows not only a constant development in defining suicide, but also that suicide is open to various constructions (as we will learn in Chapter 2).

## CONTEMPORARY DEVELOPMENTS IN SUICIDOLOGY

In *The Oxford English Dictionary*, the arbiter of the English language, we read:

> Suicidology (F suicide $sb^2$ + ology). The study of suicide and its prevention. Hence suicido-logist.
>
> [1929: W.A. Bongar in *Psychiatrisch-Juridisch Gelshap*. . . . "De wetenschap selfmoord, de suicidologie (cursivering van mij) zou men haar kunnen noemen, is ruim een eeuw oud" (p. 3).]
>
> 1964: E.S. Shneidman in *Contemporary Psychology*, lx, 371–372. I thank Louis Dublin, Grand Old Man in Suicidology, for this book because in it he has given us all new clues to suicide.
>
> 1967: *Bulletin of Suicidology*, July 7/2. The 10-point programme outlined is a mutual enterprise whose successful development depends on the active interest, support and activities of suicidologists. 1969—1976—.

The "fulcrum moment", as Edwin Shneidman himself called it, of contemporary suicidology occurred several minutes after he discovered several hundred suicide notes in a coroner's vault in 1949 in Los Angeles. At that moment he had a glimmering that the vast potential value of the notes could be immeasurably increased if he did not read them, but rather compared them blindly, in a controlled experiment, with simulated suicide notes, elicited from matched non-suicidal persons. John Stuart Mill's Method of Difference came to Shneidman's side and contemporary suicidology, the seeds for the study of contemporary suicidal phenomena, were sown.

Maris (1993) has outlined the evolution of suicidology since that critical event. As one reads Maris's paper, one becomes aware of suicidology's vastness today. Suicidology is a multidisciplinary enterprise. It is the study of psychological, biological, cultural, sociological, interpersonal, intrapsychic, logical, conscious and unconscious and philosophical elements in the suicidal event. Shneidman, and most suicidologists agree, has always insisted that suicidology is not reducible to any one of its domains.

Maris (1993) provides a long list of subdisciplines, including psychology, medicine, psychiatry, sociology, anthropology, epidemiology, criminology, nursing, biology, philosophy, religion, education, literature, etc., all of which make contributions to suicidology. As Maris (1993) notes, that list "could be extended or refined almost indefinitely".

From the embryonic beginnings in the vault, suicidology has become an expanded discipline. It involves survivorship. It involves crisis work on telephone hotlines. It involves research in laboratories and in natural field settings. It involves associations such as the American Association for Suicidology, the Canadian Association for Suicide Prevention, and the International Association for Suicide Prevention. It involves a research group, the International Academy of Suicide Research; an academy dedicated to enhancing the research in the field. It involves training and practice. Thus suicidology today not only includes the study of suicide but also its prevention, including psychotherapy.

## SUICIDE FACTS AND MYTHS

The lore about suicide contains a large number of interesting and esoteric items. People in general are not only perplexed and bewildered by self-destructive behaviour, but they also believe a number of misconceptions of suicide. Here are some common fables and facts about suicide, formulated by Shneidman around 1952 and incorporated into a number of publications (e.g., Shneidman & Mandelkorn, 1967):

1. Fable: *People who talk about suicide don't commit suicide.*
   Fact: Of any 10 persons who kill themselves, 8 have given definite warnings of their suicidal intentions.

2. Fable: *Suicide happens without warning.*
   Fact: Studies reveal that the suicidal person gives many clues and warnings regarding suicidal intentions.

3. Fable: *Suicidal people are fully intent on dying.*
   Fact: Most suicidal people are undecided about living or dying, and they "gamble with death", leaving it to others to save them. Almost no one commits suicide without letting others know how they are feeling.

4. Fable: *Once a person is suicidal he or she is suicidal forever.*
   Fact: Individuals who wish to kill themselves are suicidal only for a limited period of time.

5. Fable: *Improvement following a suicidal crisis means that the suicidal risk is over.*
   Fact: Most suicides occur within about three months following the beginning of "improvement", when the individual has the energy to put his or her morbid thoughts and feelings into effect.
6. Fable: *Suicide strikes much more often among the rich—or, conversely, it occurs most exclusively among the poor.*
   Fact: Suicide is neither the rich person's disease nor the poor person's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.
7. Fable: *Suicide is inherited.*
   Fact: Suicide is not inherited. It is an individual pattern.
8. Fable: *All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.*
   Fact: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he or she is not necessarily mentally ill.

There is also the misconception that we talk about "myths" as if we know what people believe. Studies by McIntosh et al. (1983) and Leenaars et al. (1988) addressed this topic. Their findings support the belief that people's knowledge regarding some facts of the above are quite high and generally well above what was anticipated from the previous anecdotal literature. People with direct experience of suicide seem to know more (Durocher et al., 1989). On the other hand, older people seem to fare the poorest in their knowledge (Leenaars et al., 1991). Yet, the series of studies also raised some questions, for example, "is 'suicide is inherited' always a fable?" As we will learn, this is a legitimate question, somewhat different from the views held in the 1950s (see also Chapter 19).

## ATTEMPTED SUICIDE

A previous attempt is one of the best clues to future attempts (Beck et al., 1979). However, not all previous attempters go on to attempt again [or kill themselves; about 15% do so versus 1.5% for the general population (Lester, 1992; Leenaars & Lester, 1994)]. Although it is obvious that one has to "attempt" suicide in order to commit it, it is equally clear that the event of "attempting suicide" does not always have death (cessation) as its objective. It is acknowledged that often the goal of "attempted suicide" (such as cutting oneself or ingesting harmful substances) is to change one's life (or to change the behaviour of the "significant others" around one) rather than to end it. On some rare occasions death is actually intended and only luckily avoided. However, I wish to stress, as have others (e.g., Stengel, 1964), that it is useful to think of the "attempter"—now often referred to as the parasuicide—and the "completer" as two sets of overlapping populations: (1) a group of those who attempt suicide, a few of whom go on to commit it, and (2) a group of those who commit suicide, many of whom previously attempted it. A great deal has to do with *perturbation* and *lethality* associated with the event.

Perturbation refers to how upset (disturbed, agitated, sane–insane) the individual is—rated as low–medium–high (or alternatively on a 1 to 9 scale)—and may be measured by various means (e.g., self-reports, biological markers, psychological tests, observations). Lethality is roughly synonymous with the "deathfulness" of the act and is an important dimension in understanding any potentially suicidal individual. Lethality can be rated as low–moderate–high (or alternatively on a 1 to 9 scale). An example for measuring lethality is the following assessment item, derived from Shneidman (1967): "During the last 24 hours, I felt the chances of my actually killing myself (committing suicide and ending my life) were: absent, very low, low–medium, fifty-fifty, high–medium, very high, extra high (came very close to actually killing myself)." A critical distinction in suicide is that lethality—not perturbation—kills. All sorts of people are highly perturbed but are not suicidal. The ratio between suicide attempts and completions is about 4:1 to about 10:1—one committed suicide for every 4–10 attempts; however, in young people, some reports have the ratio at 50:1, or even 100:1. The ratio, in fact, appears to vary significantly between nations and across risk groups, sex, age, and so on.

The "attempter" (along with individuals who engage in self-assaultive and self-mutilative behaviour) and the "completer" share some commonalities; however, they are, by and large, operationally quite different. There is a third group, the "contemplators", whose numbers are so vast that it is difficult to begin to highlight their commonalities, which are again quite different (we will meet both attempters and contemplators in this volume). Shneidman (1985) has presented the differences between suicide and attempted suicide. He suggests, for example, that whereas the common stimulus in suicide is unendurable psychological pain, in attempted suicide it is intense, potentially endurable, psychological pain. As another example, whereas the common purpose in suicide is to seek a solution to an overbearing problem, in attempted suicide it is to reduce tension and to evoke a response. However, there are also similarities, although the content of such characteristics may be quite different. Shneidman (1985) provided the following examples: the common stressor in both is frustrated needs; and the common consistency in both is with lifelong adjustment patterns.

A study—a rare opportunity to actually compare attempters and completers—actually found that there might be more similarities than differences (Leenaars et al., 1992). Archival research—a comparison of suicide notes written by individuals who killed themselves and notes, sometimes called *parasuicide notes*, by individuals who made highly lethal attempts—found only a few differences (see Chapter 2). Attempters see their act as a style of life, being too weak to cope with life's ever-present difficulties, and lacking in social integration. Suicide attempts may become a way of life. The empirical observations on this topic are sparse and Smith and Maris (1986) have called for extensive research in this area.

Suicide attempts have many meanings and, whatever the level of lethality, ought to be taken seriously. A person who attempts suicide may not necessarily mean that he/she wants to die but that the situation was so intense that he/she had to communicate the pain. Words like "manipulation" or "blackmail" or "attention" add only a pejorative emotional tone, revealing our own attitudes and fears.

## PARTIAL DEATH AND SUBSTITUTES FOR SUICIDE

Freud (1974a), Shneidman (1963), Murray (1967), and others have speculated that beyond intentional suicides, there is a vast array of subintentional inimical behaviours. The very life-style of some individuals seems to truncate and demean their life so that they are as good as dead. In 1901, Freud stated:

> It is well known that in the severe cases of psychoneurosis instances of self injury are occasionally found as symptoms and that in such cases suicide can never be ruled out as a possible outcome of the physical conflict . . . many apparently accidental injuries that happen to such patients are really instances of self-injury. (pp. 178–179)

Freud further notes that such self-destruction is not rare. Often alcoholism, drug addiction, mismanagement of physical disease, auto accidents, and masochistic behaviour can be seen in this light. Farberow (1980) has edited a book on "the many faces of suicide". Therein, he asks a number of relevant questions. For example:

- Why did a person stop taking insulin when he knew he had to take it regularly to stay well, or even to stay alive?
- Why did a person, knowing what drugs can do to you, get hooked?
- Why did a person drive so fast on the curving mountain roads when he had known for the last three months how bad his brakes were?

There may be no intent to kill oneself, but the person is "as good as dead". Karl Menninger, the chief theorist on the concept of partial death, in *Man Against Himself* (1938), writes of (1) *chronic* suicide—including asceticism, martyrdom, neurotic invalidism, alcohol addiction, antisocial behaviour, and psychosis; (2) *focal* suicide—focusing on a limited part of the body—including self-mutilation, multiple surgery, purposive accidents, impotence, and frigidity; and (3) *organic* suicide—focusing on the psychological factors in organic disease, especially the self-punishing aggressive and erotic components. Freud (1974a) has speculated that there is, in fact, a suicidal thread (or death instinct) in all of us.

A related concept is of "subintentioned death" (Shneidman, 1963). This concept asserts that there are many deaths that are neither clearly suicidal nor clearly accidental or natural, but deaths in which the decedent played some covert or unconscious role in "permitting" his or her death to occur, either "accidentally" or by "inviting" homicide, or by unconsciously disregarding what could be a life-extending medical regimen, and thus dying sooner than "necessary". Freud (1974a) speculated:

> Anyone who believes in the occurrence of half-intentional self-injury—if I may use a clumsy expression—will be prepared also to assume that in addition to consciously intentional suicide there is such a thing as half-intentional self-destruction (self-destruction with an unconscious intention), capable of making skilful use of a threat of life and of disguising it as a chance mishap. (pp. 180–181)

## PSYCHOLOGICAL THEORIES OF SUICIDE

The modern era of the psychological study of suicide began around the turn of the twentieth century with the investigations of Sigmund Freud (1974a, 1974b, 1974c,

1974g, 1974h, 1974i, 1974j, 1974k, 1974l, 1974n). Freud's clinical research suggested to him that the root cause of suicide, within a developmental context, was the experience of loss or rejection of a significant, highly cathected object (i.e., a person). In 1920, Freud further developed what he termed a "deeper interpretation" of what leads someone to kill himself after such a loss or rejection. He stated:

> Probably no one finds the mental energy to kill himself unless, in the first place, in doing so he is at the same time killing an object with whom he has identified himself and, in the second place, is turning against himself a death wish which had been directed against someone else. (Freud, 1974i, p. 162)

Freud—eschewing the two popular notions about suicide at the turn of the twentieth century—sin and crime—placed the focus of blame on the person; specifically, in the person's unconscious. Since around 1900, there have been a host of psychological theories besides Freud's that have attempted to define suicide. Indeed, a—if not the—major advance in the psychology of suicide in the last century was the development of various models beyond Freud's that have attempted to understand this complicated human act, the most noteworthy of which has been Edwin Shneidman.

Suicide is open to various psychological constructions. In his famous experiment on volume where the experimenter pours fluid from a short, fat beaker into a tall, thin one, Piaget (1970) has demonstrated that the young child will say there is more fluid in either the first or second beaker. The child is centred on only one dimension to the exclusion of others. Later in human development, the child can take into account both dimensions simultaneously and use multiple perspective on the same event. To be decentred in general is to be able to take an abstract view of things, rather than to be influenced totally by the characteristics of concrete particulars ("stimulus bound"). To view suicide only from Freud's original view is perhaps to be too concrete and stimulus bound. To introject only Freud's or any other specific view may be seen as acting like the young preconservative child, i.e., centred. Although Freud provided a sound basis in the very early years of suicidology, what we have discovered thus far about suicide is that it may best be defined from multiple perspectives: not being concrete but also not being overinclusive. In this sense, it may be wise to follow Kelly's (1955) dictate of constructive alternativism:

> We take the stand that there are always some alternative constructions available to choose among in dealing with the world. No one needs to paint himself into a corner; no one needs to be completely hemmed in by circumstances; no one needs to be the victim of his biography. (p. 15)

Here, I have decided to present four points of view: psychoanalytic (Freud); cognitive-behavioural (Beck); social learning (Lester); and multidimensional (Shneidman). I hope in some way to clarify the central issue—understanding why human beings commit suicide. Let me begin with a few remarks by Shneidman on the topic of theory in general.

Shneidman (1985) suggests that a psychological theory regarding suicide should begin with the question, "What are the interesting common psychological dimensions of committed suicide?", not "What kind of people commit suicide?". This

question, according to Shneidman, is critical; for they (the common dimensions) are what suicide is. Not necessarily the universal, but certainly the most frequent or common characteristics provide us with a meaningful conceptualization regarding suicide.

Most frequently, non-professionals identify external causes (e.g., ill health, being left by a lover, losing one's fortune, etc.) as what is common in suicide. A recent downhill course (e.g., drop in income, sudden acute alcoholism, a change in work, and divorce or separation) can, indeed, be identified in suicide. However, although there are always situational aspects in every suicidal act, these are only the precipitating events. Suicide is more complex. Suicide is a multidetermined event. How can we understand these psychological complexities?

Suicide is a multidimensional malaise. It is an intrapsychic drama on an interpersonal stage. From this psychological view (Leenaars, 1988a, 1989a, 1989b, 1994) we will define suicide with the key ideas of the four suicidal theories mentioned above: Psychoanalytic (Sigmund Freud), Cognitive-Behavioural (Aaron T. Beck), Social Learning (David Lester), and Multidimensional (Edwin Shneidman).

The four perspectives will be presented in the form of protocol sentences or what might be construed to be aphorisms. Protocol sentences are testable hypotheses, and in that sense they are like aphorisms. An aphorism is a short statement stating a truth. It is a principle expressed tersely in a few telling words. A major difference between protocol sentences and aphorisms is that the latter tend to be general. Although protocol sentences may be general, they must be testable (although some form of specificity is implied for the sentence to be testable). One must be able to determine the truth or falsity of the statement. Aphorisms, if they are true, should also be subject to the possibility of verification (falsifiability). The protocol procedure was first introduced by Carnap (1959) and applied in my own research in suicide for over three decades. Protocol sentences (or aphorisms) are one means of defining an event. It is obvious, as Shneidman (1984) noted, that one way to discuss suicide is to do so aphoristically.

## Psychoanalytic

As I have already mentioned, Sigmund Freud first formulated the psychoanalytic perspective early in the twentieth century. Other noteworthy suicidologists in this tradition are Karl Menninger, Henry A. Murray, and Gregory Zilboorg. Here are some protocol sentences (or aphorisms) derived from Freud's work.

1. Suicide is motivated by unconscious intentions. Even if the person communicates that he or she has consciously planned suicide, the focus of the action is in the unconscious.
2. The root cause of suicide is the experience of loss and rejection of a significant highly cathected object (i.e., a person)—the person, in fact, is singly preoccupied with this loss/rejection.
3. The suicidal person feels quite ambivalent. He/she is both affectionate and hostile towards a lost/rejecting person.

4. The suicidal person is, in some direct or indirect fashion, identifying with a rejecting or lost person. Attachment, based upon an important emotional tie, is the meaning of identification.
5. The suicidal person exhibits an overly regressive attachment—"narcissistic identification"—with the object. He/she behaves as if he/she were reacting to another person.
6. The suicidal person is angry at the object although the feelings and/or ideas of vengefulness and aggression are directed towards him/herself.
7. The suicidal person turns back upon him/herself murderous wishes/impulses/needs that had been directed against the object.
8. Suicide is a fulfilment of punishment; i.e., self-punishment.
9. The suicidal person experiences a sense of guilt or self-criticism. The person develops prohibitions of extraordinary harshness and severity towards him/herself.
10. The suicidal person's organization of experiences is impaired. He/she is no longer capable of any coherent synthesis of his/her experience.

## Cognitive-Behavioural

The cognitive-behavioural perspective is most widely associated with Aaron T. Beck and his colleagues (1963, 1967, 1971, 1975a, 1975b, 1976, 1978, 1979a, 1979b). George Kelly, Albert Ellis, and Don Meichenbaum are also associated with this view. The following 10 protocol sentences are deduced from Beck's writings:

1. Suicide is associated with depression. The critical link between depression and suicidal intent is hopelessness.
2. Hopelessness, defined operationally in terms of negative expectations, appears to be the critical factor in the suicide. The suicidal person views suicide as the only possible solution to his/her desperate and hopelessly unsolvable problem (situation).
3. The suicidal person views the future as negative, often unrealistically. He/she anticipates more suffering, more hardship, more frustration, more deprivation, etc.
4. The suicidal person's view of him/herself is negative, often unrealistically. He/she views him/herself as incurable, incompetent, and helpless, often with self-criticism, self-blame, and reproaches against the self (with expressions of guilt and regret) accompanying this low self-evaluation.
5. The suicidal person views him/herself as deprived, often unrealistically. Thoughts of being alone, unwanted, unloved, and perhaps materially deprived are possible examples of such deprivation.
6. Although the suicidal person's thoughts (interpretations) are arbitrary, he/she considers no alternative, accepting the validity (accuracy) of the cognitions.
7. The suicidal person's thoughts, which are often automatic and involuntary, are characterized by a number of possible errors, some so gross as to constitute distortion; e.g., preservation, overgeneralization, magnification/minimization, inexact labelling, selective abstraction, negative bias.

8. The suicidal person's affective reaction is proportional to the labelling of the traumatic situation, regardless of the actual intensity of the event.
9. Irrespective of whether the affect is sadness, anger, anxiety, or euphoria, the more intense the affect the greater the perceived plausibility of the associated cognitions.
10. The suicidal person, being hopeless and not wanting to tolerate the pain (suffering), desires to escape. Death is thought of as more desirable than life.

## Social Learning

The social learning view has been summarized by Lester (1987): Albert Bandura and psychologists in the classical (Pavlov) and operant (Skinner) traditions are the best-known theorists in this view. The 10 aphorisms of this paradigm are as follows:

1. Suicide is a learned behaviour. Childhood experiences and forces in the environment shape the suicidal person and precipitate the act.
2. Child-rearing practices are critical, especially the child's experiences of punishment. Specifically, the suicidal person has learned to inhibit the expression of aggression outward and simultaneously learned to turn it inward upon him/herself.
3. The suicide can be predicted based on the basic laws of learning. Suicide is shaped behaviour—the behaviour was and is reinforced in his/her environment.
4. The suicidal person's thoughts provide the stimuli; suicide (response) is imagined. Cognitions (such as self-praise) can be reinforcers for the act.
5. The suicidal person's expectancies play a critical role in the suicide—he/she expects reinforcement (reward) by the act.
6. Depression, especially the cognitive components, is strongly associated with the suicide. Depression goes far towards explaining suicide. For example, depression may be caused by a lack of reinforcement, learned helplessness, and/or rewarded.
7. Suicide can be a manipulative act. Others reinforce this.
8. Suicide is not eliminated by means of punishment.
9. The suicidal person is non-socialized. He/she has not been sufficiently socialized into traditional culture. The suicidal person has failed to learn the normal cultural values, especially towards life and death.
10. The suicide can be reinforced by a number of environmental factors, for example, subcultural norms, suggestions on television, gender preferences for specific methods, suicide in significant others (modelling), a network of family and friends, cultural patterns.

## Multidimensional

The psychologist who has consistently argued for a multidimensional view is Shneidman (1967, 1973, 1980, 1981a, 1982a, 1985, 1991, 1993—see Leenaars, 1999a). Here is a brief summary, utilizing our previous procedure, of his work:

1. The suicidal person is in unbearable psychological pain. The person is focused almost entirely on this unbearable emotion (pain), and especially one specific (an arbitrarily selected) way to escape from it.
2. The suicidal person experienced a situation that is traumatic (e.g., poor health, rejection the spouse, being married to a non-supportive spouse). What is implied is that some needs are unfulfilled, thwarted, or frustrated.
3. For the suicidal person, the idea of cessation (death, stopping, or eternal sleep) provides the solution. It permits him/her to resolve the unbearable state of self-destructiveness, disturbance, and isolation.
4. By the suicide, the person wishes to end all conscious experience. The goal of suicide is cessation of consciousness and the person behaves in order to achieve this end.
5. The suicidal person is in a state of heightened disturbance (perturbation), e.g., he/she feels boxed in, rejected, harassed, unsuccessful, and especially hopeless and helpless.
6. The suicidal person's internal attitude is ambivalence. The suicidal person experiences complications, concomitant contradictory feelings, attitudes and/or thrusts (not only towards him/herself and other people but towards the act itself).
7. The suicidal person's cognitive state is constriction (tunnel vision, a narrowing of the mind's eye). He/she is figuratively intoxicated or drugged by his/her overpowering emotions and constricted logic and perception.
8. The suicidal person needs or wishes to egress. He/she wants to leave (the scene), to exit, to get out, to get away, to be gone, not to be around, to be "elsewhere"... not to be.
9. There is a serial pattern to the suicide. The suicidal person exhibits patterns of behaviour that diminish or truncate his/her life, which subtract from its length or reduce its scope.
10. The person's suicide has unconscious psychodynamic implications.

## Summary

To summarize, suicide is best understood as a multidimensional human malaise. What we have discovered so far is that suicide can be defined differently from various psychological points of view. I do not mean to suggest that all these views are mutually exclusive or equally accurate or helpful for psychotherapy—we do not have to follow the cognitive processes of the suicidal person. Nor do I believe that my protocol (aphorism) method is the only way to outline a point of view; indeed, it may well lose some of the complexity in the theories themselves. It is, however, one way to understand the event.

The real importance of protocol sentences is that they must be verifiable. In that regard, what aphorisms of Freud or Beck or Lester or Shneidman are true? What are empirical? Suicidology's future endeavour, in general, will be the need to develop some form of empirical verification of the various constructions of the event. Research will be an important aspect of such efforts. I do not mean to suggest

only the controlled experiment. But, following Allport (1942) and Maslow (1966), we must be open-minded, utilizing both ideographic and nomothetic approaches. Suicide is plagued by the difficulty of obtaining data (Maris, 1981). In my own research, I have utilized suicide notes as my database. Despite their limitations (Leenaars, 1988a), suicide notes have been historically useful in describing the suicide since the individual is at the final throes of the life vs death decision. Other documents as well as statistics, third-party interviews, and the study of non-fatal suicide attempters have a place in understanding suicidal phenomena—if the data are put in the context of broad theoretical formulations about suicide and personality functioning in general.

Although misuse of psychological theory(ies) is possible (e.g., finding support only for one's view and, thus, acting like the suicidal person him/herself), theoretical formulations have an important place in the use of personal documents (e.g., suicide notes) and in any form of research. Research must be embedded in theory. To avoid our constriction, I would argue that we must critically evaluate alternative explanations and interpretations. We must no longer look at suicide from Freud's perspective alone but from Beck's, Lester's, Shneidman's, and so on. Indeed, a comprehensive model will be presented in Chapter 2.

Theory, explicit and implicit, plays some role in research whether solving a specific problem, testing an existing theory, developing new theories, or expanding existing theories. The problem is that frequently the theory is not articulated. Regrettably, much of the research on suicide is atheoretical. Equally regrettable, often remediators have no stated conceptualization or, more accurately, the conceptualization is characterized, if I can use Beck's descriptions, by a number of cognitive errors, some so gross as to constitute distortion; e.g., perseveration, overgeneralization, magnification/minimization, inexact labelling, selective abstraction, bias. One is simply too centred. I do not mean to suggest that my view solves the problem, but I hope to have clarified the issue—psychologically, suicide is best understood from different points of view, especially if that theory is to be useful in intervention.

An understanding of suicide can be used to assist us in preventing the event. Psychotherapy must follow empirically verified definition. When understanding is centred and not based on any sound empiricism, remediation (i.e., prevention, intervention, and postvention) is likely to be ineffective. Hopefully, the definition of suicide derived from the four points of view will be a beginning to assist a needful individual in some way in therapy.

As a final comment, I do not mean to suggest that psychology alone has a role in defining suicide. It is not sufficient to define the entire event. It would, in fact, seem most accurate to define suicide as an event with biological (including biochemical, neuropsychological), sociocultural, interpersonal, philosophical/existential, psychological, and other aspects. All empirical definitions may assist us in psychotherapy with suicidal people.

Of course suicide is more than I have so far isolated. The common thread, however, in all the views so far presented is that there is a consistency to all suicides, namely with lifelong adjustment patterns (Shneidman, 1985). Suicide has a history.

## THEORETICAL/CLINICAL OBSERVATIONS

This section consists of six parts, all focused on clarifying suicide: biological roots, brain dysfunctions, physical disabilities and illness, depression, specific precipitating events, and the family system.

### Biological Roots

"No brain, no mind" is one of Henry Murray's reminders to his student Edwin Shneidman (Shneidman, 2001). Yet, of late—if I am allowed a difference between Dr Shneidman and myself—he has overly forgotten this teaching; he calls himself a radical mentalist (personal communication, November 2001). Dr Shneidman's (2001) current belief is somewhat akin to Descartes' (1972). Descartes is best known for his statement, "Cogito ergo sum". This is radical mentalism. Dr Shneidman's position is "Cogito ergo suicide". My own view is akin to his 1985 position in *Definition of Suicide*, in which he states his principles (see his Chapter V, "A formal definition, with explication"). He writes that, "... suicide is a multifaceted event and that biological, cultural, sociological, interpersonal, intrapsychic, logical, conscious and unconscious, and philosophical elements are present, in various degrees, in each suicidal event" (p. 202). When I discussed the topic in November 2001 at Ed's home, he stated that he was wrong then. His current position is best stated in his book, *The Suicidal Mind* (1996)—see also his letter in the *New England Journal of Medicine* (Shneidman, 1992). In 2001, Shneidman stated his current position thus: "I do not think that the key answers about suicide are to be found in the brain; I think that the key action is in the mind" (p. 74). I think that he was right in 1985. Descartes led us astray, so did Shneidman. If I am allowed one disagreement with Dr Shneidman, it would be this: Shneidman led us astray. (I think, if I dare, that Henry Murray would agree with me.) I believe that the suicidal mind is the suicidal brain and the suicidal brain is the suicidal mind. To understand suicide, we need to understand these roots of suicide and much more. Utilizing only one of these views is too reductionistic. The key answers are to be found in the brain and the mind—and elsewhere.

Stoff and Mann's (1997) edited volume begins to outline the current understanding of the neurobiology of suicide. Their book is an essential read for any aspiring psychotherapist.

On a critical note, however, one could see Stoff and Mann's view to be equally too reductionistic. Suicide is no more or less the suicidal brain, than the suicidal mind. Stoff and Mann write:

> ... efforts aimed at identifying the potentially suicidal individual using demographic, social developmental and psychological factors offer too weak a prediction to be of substantial clinical utility. It is believed that the biological perspective, which has grown out of the expanding research on the biological basis of mood disorders, is a predominant approach to suicide research. It can assist in the investigation of risk factors that predispose a person to suicidal behavior and that increase understanding of etiology, treatment, and ultimately, prevention. (p. 1)

Utilizing only this view will lead us as much astray as Shneidman. Once more, we need all perspectives. Suicide is complex, more complex than most people are aware. It is not only the suicidal brain. It is not only the suicidal mind. All avenues are legitimate ways to understand and prevent suicide. Psychotherapy, in fact, is only one way to intervene; the one focused on in this book.

The classical study in suicidology of the biological roots was by Asberg et al. (1976). They identified 5-H1 AA in cerebrospinal fluid as a biochemical marker in some suicides. This study marked the beginning of empirical biological suicidology. Yet, although the Asberg study is now over 25 years old, there is relatively little secure knowledge regarding the neurobiology of suicide today (Hawton & van Heeringen, 2000). Despite a recent flood of information regarding biological correlates of suicide, much of it lacks scientific rigour, but less so than a few decades ago (Motto & Reus, 1991; Rifai et al., 1992). Lester (1992), in a review of this area, suggested that the "research has been quite poor" (p. 27). Sample sizes are small. Confounding variables, e.g., postmortem delay, have added to the confusion. Depression or other psychiatric disorders have rarely been controlled. Studies of biological correlates across the life-span (Motto & Reus, 1991), as well as specific groups—e.g., the elderly (Rifai et al., 1992)—have concluded that biological conjectures about the common precipitants of suicide, are, in fact, premature—of course, the same can be said about the psychological study, sociological, and so on. Indeed, the science has led us to some important roots in suicide (Stoff & Mann, 1997).

Despite the state of the art, suicide must be seen as a biological event (and much more). Possible markers, isolated to date, include urinary 17-hydroxycorticosteroids (17-OHCS), cortisol in plasma and cerebrospinal fluid, cerebrospinal fluid 5-hydroxyindoleacetic acid, tritiated imiprimine binding, 3-methoxy-4-hydroxyphenylglycol and homovanillic acid, urinary norepinephrine/epinephrine ratio; and thyroid-stimulating hormone response to thyrotropin-releasing hormone. Slaby (1992), in his comment about this field, and others (e.g., Maltsberger, 2002) are optimistic about our biological understanding of suicide, especially in the relation of suicide to affective disorders (e.g., manic-depressive disorder) and their neurobiological correlates, resulting in direct implications for medication (see Chapter 19). At least, in some suicides, biological correlates are strikingly relevant (we will comment about this topic in more detail later, see Chapter 19).

## Brain Dysfunction and Learning Disabilities

The importance of brain dysfunction in children and its relation to learning disabilities is well documented. The relation of brain dysfunction and socio-emotional problems in people is, however, a more neglected topic in the literature. Not only does a learning disability render a person at risk for socio-emotional problems including suicide, but there are also particular subtypes of learning disabilities and these different subtypes may result in different levels of risk. Rourke and Fisk (1981) have documented that different patterns of cerebral dysfunction and their resulting learning disability(ies) render a person at risk for different types of socio-emotional disturbances. They report three major subgroups. The first group has a right brain

dysfunction, and such people are prone to learning problems with non-verbal, visual information. They may show the following socio-emotional problems: not paying attention to visual objects including other people; rarely expressing emotions appropriately in their facial expressions; having a voice that can be expressionless; being very talkative; talking to self; having flow problems in their speech; and being awkward socially. The second group has a left brain dysfunction, and such people are prone to learning problems with verbal information. They may show the following socio-emotional problems: rarely initiating conversations; having problems paying attention, for example, in conversation; being brief and often concrete in their remarks; often stating "I don't know" to questions; and some are very impulsive, not thinking before they act. The third group has both left and right brain dysfunction and exhibit a conglomerate of symptoms.

Other more specific cerebral deficits render people at risk for other specific problems such as planning, sequencing social events, and so on. Attention deficit/hyperactivity disorder (ADHD), in all its subtypes, is an example. Although further empirical studies need to be conducted in the neuropsychology of suicides, these observations clearly warrant attention. Indeed, Rourke et al. (1989) have shown that one possible adolescent and adult outcome of childhood central processing deficiencies is suicidal behaviour as well as other socio-emotional problems. They have suggested that it is especially the first pattern associated with right brain dysfunction that predisposes those afflicted to adolescent and adult suicide risk. The brain is so critical in risk.

## Physical Disabilities and Illness

I would be remiss if I did not at least note the importance of physical problems in suicidal behaviour in some people (Barraclough, 1986; Stenger & Stenger, 2000). Physical illness interacts with an individual's emotional functioning; indeed, some illnesses directly affect one's emotions. Empirical study regarding illness and suicide is urgently needed; currently research suggests that some physical illnesses are associated with suicidal behaviour, including anorexia, bulimia, diabetes, epilepsy, traumatic brain injury, and muscular dystrophy (Barraclough, 1986). Some individuals with physical disabilities who are at risk are those with limb amputations or spinal injuries resulting in quadriplegia. Individuals with terminal illness such as AIDS appear also to be at high risk (Fryer, 1986; Marzuk, 1989). However, it is important to realize that not all such people are suicidal and that research is needed to substantiate these views.

## Depression

It was once believed that all suicidal people were depressed, but this is a myth. The fact is that not all suicidal people are depressed, and that not all depressed people are suicidal. Depression and suicide are not equivalent. Yet, Lester (1992) has noted that depression distinguishes many suicidal people from non-suicidal groups. Depression can be noted in mood and behaviour (ranging from feeling dejected

and hesitancy in social contacts, to isolation and serious disturbance of appetite and sleep), verbal expression (ranging from talks about being disappointed, excluded, blamed, etc., to talk of suicide, being killed, abandoned, helpless), and fantasy (ranging from feeling disappointed, excluded, mistreated, etc., to suicide, mutilation, loss of a significant person) (Pfeffer, 1986). Behaviours such as excessive aggressiveness, change in work performance, and expressions of somatic complaints or loss of energy, have all been associated with depression. However, not all depression is overt, especially in youth. Some children and especially teenagers (and some adults) exhibit what has been termed masked depression (see Chapter 9 for details). They dissemble. Anorexia, promiscuity and drug abuse, for example, have been associated with depression. It is important to remember, however, that depression does not equal suicide in a simple one to one fashion. Most suicides experience unbearable pain, but not necessarily depression (Shneidman, 1985). The unbearable emotion might be hostility, anxiety, despair, shame, guilt, dependency, hopelessness, or helplessness. What is critical is that the emotion—pain—is unbearable. Unendurable psychological pain is the common stimulus in suicide (Shneidman, 1985), not depression alone (see Chapters 2 and 19 for further details).

## Specific Environmental Precipitating Events

A current popular formulation regarding suicide is that suicide is simply due to an external event; for example, a rejection, the influence of the music of a pop singer, whatever. Although precipitating events (e.g., deprivation of love, sexual abuse, being bullied, death of parent, divorce, a rejection) do occur in the suicides of people, this may be less frequent in children. We are here reminded of a clinical example, which is quite similar to one reported by Menninger (1938): A 16-year-old was found dead in a car, having died of carbon monoxide poisoning. People were perplexed, "Why did this young person from an upper-middle-class family kill himself?" The parents found out that his girlfriend rejected him on the day of his suicide. That was the reason: when a young man gets rejected and is so in love, he may kill himself. A few friends and his teachers knew that he had been having problems in school. That was the reason. A few others knew that his father was an alcoholic and abusive. That was the reason. His physician knew that he had been adopted and had been recently upset about that. She knew the real reason. And others knew. . . .

Shneidman (1985) has noted that the common consistency in suicide is not the precipitating event, but life-long coping patterns (see Chapter 2 for details). One can see continuity despite developmental changes. People who kill themselves experience a steady toll of threat, stress, failure, challenge, and loss that gradually undermines their adjustment process. Suicide has a history.

This view does not mean to suggest that an environmental stimulus is not critical; it may in fact, be, to use a popular metaphor, the straw that breaks the camel's back. One event needs special mentioning, bullying—or, if you will, abuse. We all remember the bully on our own schoolyards (although they are also in the workplace, or home, or anywhere). The bully, according to *The Oxford English Dictionary*—the

OED—is: "A person who uses strength or power to coerce or intimidate weaker persons." Bullies persecute, intimidate, oppress. Dickens's Mr Bumble is a good example: "a big mean guy" according to my 11-year-old daughter, Kristen. But, as Charles Dickens wrote in *Oliver Twist* (1966 edition, p. 287), "Mr. Bumble . . . had a decided propensity for bullying . . . and, consequently, was (it is needless to say) a coward."

This goes beyond an environmental stimulus in some suicidal people. In a landmark case in Vancouver, Canada, on 26 March 2002, the court found a 16-year-old female bully guilty for uttering a series of physical threats (e.g., "You're fucking dead"). The victim, Dawn-Marie Wesley, a 14-year-old girl, had killed herself on 10 November 2000. She named the bullies in her suicide note (which she concluded with the prototypical, "I love you all so much"). Of course, the suicide was more complex, but in the suicidal equation of Dawn-Marie, Provincial Court Judge Jill Rounthwarte stated, "threatening conduct . . . caused Dawn to fear for her safety, a fear that was entirely reasonable in all of the circumstances". Of course, this implies that environmental control (e.g., zero tolerance in the schools) may be an important avenue to prevent the needless death of other Dawn-Maries (see Chapter 19).

There are, of course, many threats, stresses, and so on. One further stimulus that has frequently been identified as a possible precipitating event, especially in young people, and is worth mentioning here, is the death of a parent (Pfeffer, 1986). Indeed, when the death occurs by suicide, everyone in the family may be at risk. There are survivor pains.

This discussion also raises the issues of the contagion (copycat) effect. Some years ago in Japan, an 18-year-old pop idol, Yukiko Okada, after a fight with her lover, leaped to her death from the building that housed her recording company in Tokyo. In the 17 days following her suicide, the suicide toll reached 33 young people. Philips (1986) is often credited with documenting the fact that such cluster suicides do occur in teenagers and young adults, even more than in adults. Suicide clusters have, in fact, been reported in Japan, North America and across the world. Brenner (1988) has, however, shown that a contagion effect may not exist in the very young, for example, in boys (5–14 years old). Aside from clustering, the impact of suggestion is also seen in the effect of media reporting of suicide. Most recently, it has been noted that there may be particular characteristics of those "contagion" suicides (Brent, 1992; Martin, 1998). This is an area for further study (Lester, 1992).

## Family Background

A review of the literature (e.g., Berman & Jobes, 1991; Corder & Haizlip, 1984; Corder et al., 1974; Leenaars, 1988b; Leenaars & Wenckstern, 1991; Maris, 1985; Pfeffer, 1986; Richman, 1993; Toolan, 1981; Seiden, 1984) suggests that the family system and its functioning is a central factor associated with suicide and suicidal behaviour in children, adolescents, and even older people, although by no means do all families show these characteristics—some, none at all. Nevertheless, a few

common observations of families will be provided, followed by a few specific additional observations for teenagers:

1. There is, at times, a lack of generational boundaries in suicidal families. There is an insufficient separation of the parent from his/her family of origin. For example, grandparents may take over the parenting role.
2. The family system is often inflexible. Any change is seen as a threat to the survival of the family. Denial, secretiveness, dissembling and especially a lack of communication characterize the family's interactions, even in the suicides of the elderly. One 8-year-old boy reported to me, "If I try to kill myself, maybe my dad will listen." Additionally in teenagers, such families have strong discipline patterns and limit setting that bind the individual in his/her identity development, which is critical at this time of a person's life. Parents may interfere in the romantic relationships of their children, even in late adolescence.
3. At times, there is a symbiotic parent–child relationship. A parent, usually the mother, is too attached to the youth. Not only is such a relation disturbing, but the parent also does not provide the emotional protection and support that a parent usually provides intuitively to a youth as he/she grows. Sometimes the parent treats the child as an "adult". One such teenager tried to break this bond by attempting to kill herself in her mother's prized car, while another—a straight A student—intentionally obtained a B, resulting in a parent–child conflict and a suicide attempt by the youth. Additionally, it has been noted repeatedly in children that if such a parent dies, the child may commit suicide to be magically reunited with that same parent.
4. Long-term disorganization (malfunctioning) has been noted in these families; for example, mother's or father's absence, divorce, alcoholism, or mental illness. In teenage girls there is a very high rate of incest, compared with the general population. Even in the suicides of adults, and even more so the elderly, these types of disorganization have been observed. One such 74-year-old female tried to kill herself, stating in a note that she had not seen her children for 20 years.

In addition, three differentiating observations about the families of suicidal teenagers have been made. First, adolescents in such families often feel a lack of control over their environment, stemming from rigid family rules or symbiotic relationships. Second, adolescence is a time of stress and turmoil. It is not, as some believe, a time of simple joy and peace. Often, parents do not allow any conflict, turmoil, and development to occur. Third, recent family disorganization—for example, recent moves, unemployment in the home, physical or mental illness, parental conflict—has been noted in the family.

Berman (1986), by way of critique of some of this literature, has argued that much of the research is not scientifically controlled. For example, the research has not compared suicidal youth and their families with other troubled or non-troubled youth and their families. More recent reviews (Hawton & van Heeringen, 2000) offer no new research-based insights. Are the familial/interpersonal factors identified due to psychopathology, and not suicide risk *per se*? What are the familial risk factors? Are there protective factors? The conclusions offered above about the families of some suicidal people should be considered only tentative pending further study.

## BEHAVIOURAL CLUES

In understanding suicide, we need to be aware of behaviours that are potentially predictive of suicide. However, there is no single definitive predictive behaviour. The two concepts that have already been discussed, and may be helpful here, are lethality and perturbation. The clues below are applicable to all age groups although the mode of expression may differ depending on age and numerous other factors.

### Previous Attempts

Although it is obvious that one has to "attempt" suicide in order to commit it, it is equally clear that the event of "attempting suicide" need not have death as its objective. As noted earlier, it is useful to think of overlapping populations: (a) a group of those who attempt suicide, and a few of whom go on to commit it, and (b) a group of those who commit suicide, and a few who previously attempted it. A previous attempt is a good clue to future attempts, especially if no assistance is obtained after the first attempt. However, not all previous attempters make another attempt (or kill themselves). All too frequently such behaviour is not taken seriously. I recall an 11-year-old (very depressed) girl who cut her wrists at school and the principal's response was merely, "She is just trying to get attention." What an extreme way to get attention! The girl was moderately lethal and highly perturbed, requiring considerable intervention.

### Verbal Statements

As with behaviour, the attitude towards individuals making verbal threats is too frequently negative. Statements are seen as "just for attention". This attitude results in ignoring the behaviour of a person who is genuinely perturbed and potentially suicidal. The important question is, "Why use this way of getting attention when there are so many other constructive ways?"

Examples of verbal warnings are: "I'm going to kill myself" or "I want to die", both being very direct. Other more indirect examples are: "I am going to see my (deceased) wife" or "I know that I'll die at an early age".

### Cognitive Clues

The single most frequent state of mind of the suicidal person is constriction (Hughes & Neimeyer, 1990). There is a tunnel vision; a narrowing of the mind's eye. There is a narrowing of the range of perception or opinions or options that occur to the mind. Frequently, the person uses words like "only", "always", "never", and "forever". For example: "No one will ever love me. Only mom loved me"; "John was the only one who loved me"; "My boss will always be that way"; and "Either I'll

kill my husband or myself". A 40-year-old bank manager, who had recently been fired from his job, expressed the constriction as follows: "Either I get my job back or I'll kill myself."

## Emotional Clues

The person who is suicidal is often highly perturbed; he or she is disturbed, anxious, perhaps agitated. Depression, as already noted, is frequently evident. Suicidal people may feel boxed in, rejected, harassed, and unsuccessful. Some frequent feelings reported by patients are anger, anxiety, emptiness, loneliness, loss, and sadness. A common emotional state in most suicidal people is hopelessness or helplessness. Some statements may signal hopelessness: "Nothing will change. It will always be this way." Whereas helplessness may be verbalized as: "There is nothing I can do. There is nothing my children can do to make a difference."

## Sudden Behavioural Changes

Changes in behaviour are also suspect. Those who may be at risk are the outgoing individual who suddenly becomes withdrawn and isolated and the normally reserved individual who starts being outgoing and seeking thrills. Such changes are of particular concern when a precipitating painful event is apparent. Changed performance in school or work, such as sudden failure, may be an important clue. Making final arrangements, such as giving away a record collection, a favourite watch, or other possessions, may be ominous and often not responded to by the receiver; the receiver is simply too pleased to get the "gift". A sudden preoccupation with death, such as reading and talking about death, may be a clue. Nonetheless, constructive discussion of this topic such as a class project for a university student may be helpful for the individual and his/her classmates.

## Life-Threatening Behaviour

I recall that a 9-year-old boy who killed himself had previously been seen leaning out of an open window in his apartment, and, at another time, playing with a gun. I know of a 24-year-old male who died in a single car accident on an isolated road after having had several similar accidents following rejections by his girlfriend. I know of a 70-year-old female who died from drug mismanagement, despite the nurse in her residence controlling her medication. Self-destruction is not rare. Often alcoholism, drug addiction, mismanagement of medical treatment, and automobile accidents can be seen in this light, as previously discussed.

## Suicide Notes

Like previous attempts and verbal statements, suicide notes are important clues; however, they are often read but not listened to by the reader. Notes are very rarely

written by children, but are somewhat more frequent among adolescents. About 18–37% of adults leave notes (samples have varied greatly).

Because the topic of notes warrants a book by itself (Leenaars, 1988a), let me here state only that if one wants to understand the event, there is no better source than the words of the suicide, words that he/she wrote minutes before death (we will use such documentation throughout this book to illustrate not only a way to understand the events, but also individual suicidal people). A sample of notes will be presented in Chapter 7.

## GENDER

The basic sex difference in suicide is that males kill themselves more than females [although this is not evident in China (Pritchard, 1996)]. In contrast, females attempt suicide more often than males, and this sex difference has been found in almost all nations (Lester, 1988a, 1992). The male–female difference in suicide has, in fact, remained fairly stable, even in other eras. The generally accepted male–female ratio of completed suicides is 3–4 males to 1 female, but there is great variation around the world.

Explanations in the literature (Leenaars, 1988c, 1988d) have varied. Females use different and less lethal methods (drugs vs shooting). Individuals with severe psychiatric disorders have higher rates of suicide and men are more likely to be diagnosed with such disorders. There are alternative social expectations for men and women in trauma that make males act more catastrophically. Yet, Shneidman (1985) has argued that genotypic similarities may be more prevalent than differences. Indeed, my own research (Leenaars, 1988c, 1988d) on suicide notes of males and females confirms this (see Chapter 2). Pain is pain. Frustrated needs are frustrated needs. Constriction is constriction. Perhaps there are phenotypic differences (e.g., method, diagnostic label) in suicide but not genotypic ones across sex? Could the high rates of completed suicide in males be more influenced by gender roles than by psychological factors? As Greenglass (1982, p. 256) noted:

> Since the beginning of recorded history, being male or female has been one of the most significant characteristics of a person. Sex and gender not only determine the kinds of experiences people have, but they also significantly influence the way people perceive and act toward each other. Moreover, socio-cultural expectations have been integrated into elaborate gender-role systems, which have an enormous impact on all areas of psychological and social functioning.

Tomlinson-Keasey and colleagues (1986), in their study of gifted female suicides, came to the same conclusion as my study of notes. They found that the markers (e.g., mental dysfunction, a history of problems) of suicide were the same in both sexes. Others (e.g., Canetto, 1994) have cited such factors as socio-economic disadvantage, unemployment, hostile relationships and a history of suicidal behaviour among friends and family as relevant to the suicides of women. Such factors have also been observed in the suicides of men (Lester, 1988a, 1992; Tomlinson-Keasey et al., 1986). The area is, however, plagued by stereotypes (Canetto, 1994). For example,

the division of women's suicides as irrational and men's as rational is not supported in the data (Leenaars, 1988c, 1988d), and reflections on this topic are most relevant (Lester, 1988a). Equally, maybe one should ask, especially for its implication for treatment: "Why are women *not* killing themselves?"

## A LIFE-SPAN PERSPECTIVE OF SUICIDE

There are various ways in which life's—including the suicidal person's—time-lines can be conceptualized. Though suicide is in many ways the same across the entire life-span, understanding suicide from a developmental perspective is productive (Leenaars, 1991a). My comments here are a brief summary of the area; there is no intent to be exhaustive.

Maris (1991) has provided a developmental perspective of suicide. He states that "The suicidal act is a process, a convergence of many factors over time . . . suicide is not one thing and is not the simple product of an acute crisis." He argues that the person's history (or "career" as he terms it) is always relevant to that person's self-destruction. Yet, Shneidman (1991) has argued that although it may be useful to group suicides under "adolescent or adult, or middle age or old", there is only suicide: "There is only human suicide and all of it is to be understood in terms of the same principles."

An American, as an example, dies by his/her own hand, on average, every 17 minutes. However, this differs depending on the time-line/age (as well as other major demographic factors; sex, gender, race/ethnicity, and so on). The rate of suicide varies depending on developmental age. Lester (1991a) looked at international trends across the life-span and illustrated, as we noted earlier, that there are different rates of suicide for different ages in different countries.

Developmental ages (or time-lines) have their unique—despite common—psychological issues. In line with the epidemiological findings that there are different rates of completed suicide across the life-span—and such rates differ from country to country—research and clinical findings, indeed, show that there may well be unique psychological issues at different ages for the suicidal person.

Although the "trunk" of suicide (referring back to Shneidman's definition—see page 5) may be the same, there appear to be differences in such psychological issues as "I love you"; "This is me"; "I am caving-in"; "I want to be gone"; "I am weakened"; "This is the only thing I can do". These differences may be more quantitative, however, than presence or absence. Richman (1991, 1993) shows us that suicide in the elderly, for example, is not to be understood primarily or even solely as a result of being old. As in other age groups, suicide in the elderly is multifaceted: sociological, biological, and cultural correlates may vary with age (Leenaars, 1991a).

Stack (1991), for example, presented the social correlates of suicide by age. Stack states that "correlates of suicidal behavior that vary by age include the position of the age group in society's institutional structure: the economy, religion, and family".

He shows us that there are different correlates depending on age such as the high divorce rates for young adults, the disproportional investment in motherhood by middle-aged females, and physical illness in the elderly. Stack (1991) has also shown that the impact of the media on the rate of suicide is different for different ages and that it is especially the adolescents that are affected by the media and subsequent acts of violence, including suicide.

Thus, understanding the time-lines in the suicidal process has a pivotal place in the study of the suicidal person. Much greater attention by clinicians and researchers alike is needed.

## CULTURAL VARIATION

Suicide is complex; and culture is one important aspect of the complexity. Much of our understanding, including Shneidman's definition, has, however, a Western orientation. Shneidman (1985) stated that his proposed definition is applicable *only to the Western world* and notes that this caution needs to be given "so that cross-cultural comparisons do not make the error of assuming that a suicide is a suicide" (p. 203). To be effective in intervention, cultural diversity in the suicidal event must be understood.

It is probable that the individual, family, or community outside of the Western hemisphere does not share our commonly held views of suicide (e.g., as portrayed in the media). Here I will illustrate this view with examples from a few cultures to highlight our myopia, and return to this topic in detail in Chapter 21, with the assistance of the International Working Group on Ethical and Legal Issues in Suicidology.

In Japan, according to Iga (1993), for example, suicide, though not welcomed, has traditionally been accepted. Japan has never prohibited suicide and attempted suicide, except in the early eighteenth century. Suicide is seen as a personal problem in Japan (Iga, 1993; Takahashi, 1993). To understand suicide in Japan, Iga writes, one must especially understand Japanese views of death. These views are based on the idea of *mujo*, the sense of eternal change. Death is welcomed by many Japanese as an emancipation as, for example, illustrated in medieval times when many priests and their followers drowned themselves in the ocean, believing that they were going to *Saiho Jodo,* "Buddha Land". Death allowed one to identify with one's ancestor, and to have a continuing life (Shneidman's "*post-self*"). Suicide was no exception.

Aboriginal (or indigenous) people in North America (i.e., Turtle Island) have, as another example, their own diverse frameworks on death and suicide (Connors, 1995; Leenaars et al., 1999a). Historically, the loss of the traditional holistic view and the process of "acculturation"—a genocide—to the majority culture and its devastating impact are embedded in the trauma of the high rate of suicide in these people. This is true about many aboriginal people around the world, such as the Aborigines in Australia (Leenaars et al., 1999a). Although I cannot begin to address the complexity here, perhaps a look at the past in one group, the Northern

Cheyenne, may assist heuristically. Barter and Weist (1970) have extensively investigated patterns of suicide in the Northern Cheyenne people in Montana, US. They report that, contrary to the belief that suicide was rare in the early history of the Northern Cheyenne, they found documentation of 25 suicide deaths between 1830 and 1884. Suicide warriors, however, who were generally, though not always, young men who vowed to die in battle, committed the majority of these deaths. Barter and Weist (1970) noted:

> If a certain young man wished . . . he could make a vow that in the next battle, when the enemy began to close in, he would drive a pin into the ground and tie himself to it. This meant that he would take a stand there and not retreat, fighting until the enemy was driven back or he was killed . . . A man who vowed to take such a stand was called a suicide warrior and it was a great thing to die fighting in this way.

This self-sought "glorious" death afforded the suicide high prestige, with corresponding increased self-esteem—which, from our view, must appear to be a denial of death. As a similar example, Crazy Horse, the well-known Lakota Chief, always stated as he went into battle, "Today is a good day to die." The suicide pattern shifted dramatically, however, during the reservation period (1884–1949) and again during the contemporary reservation period (1950–1969) reflecting, according to Barter and Weist, cultural changes in the Northern Cheyenne. This epidemic of suicide occurred among many indigenous people around the world, but not all. Much seems to be associated with whether or not they were subjected to genocide (Leenaars et al., 1999a). Furthermore, the example of the suicide warrior as a cultural variation on the meaning of suicide illustrates that cultures are not static, but are ever-changing entities. We need to bear in mind that, even if one achieves some familiarity and comfort in working with people of a certain ethnic group or culture, that culture is constantly evolving and changing.

A subtle but important difference must be raised in the discussion about accepted suicide in cultures so far. Durkheim (1951) referred to such exceptions as "altruistic suicide". There are, in fact, examples of altruistic suicide, not only in Japan and among Aboriginal people around the world, but in almost all cultures, from antiquity to the present. Examples can be found among many peoples, from the Christian martyrs into the eighteenth century, to the practice of self-immolation not only in India, but Vietnam, Korea, and many regions of the world, to the now so-called suicide terrorist—or suicide bomber in the media—in the Middle East. There have always been exceptions throughout regions and ages.

Durkheim further explicated that some suicides are not only seen as a right but as a duty. "Society", states Durkheim, "compel(s) some of its members to kill themselves" (p. 220). Socrates was an example. Some altruistic suicides are obligatory, some are optional, and some are acute—those committed by martyrs or heroes. In all these examples, martyrdom is a motivation, whether it is to extol a religious belief, or to have honour in battle, or to pay homage to some other ideal. For some people, these exceptions give them the right to suicide—yet others see such acts as primitive and violent rationalizations. The deaths at the World Trade Center on 11 September 2001 sadly portray one of the most recent examples. How do we understand such suicides? Durkheim also questioned their motives:

> All these cases have for their root the same state of altruism which is equally the cause of what might be called heroic suicide. Shall they alone be placed among the ranks of suicides and only those excluded whose motive is particularly pure? But first, according to what standard will the division be made? When does a motive cease to be sufficiently praiseworthy for the act it determines to be called suicide? (p. 240)

Durkheim's questions lead to others: Are there rights to suicide? And what are the implications of such suicidal people for the psychotherapist? How do we respond to such a person—a martyr, a suicidal person, etc.? These questions have implications for our response—more so in some cultures than in others. How would one treat Socrates or Crazy Horse?

Other cultures have different meanings, as we will see later. Even within North America, there is a richness and great diversity of peoples, e.g., aboriginal peoples, Afro-Americans, Inuit people, French Canadians, and so on. It is erroneous to assume that there is *one* commonly held definition or understanding of suicide (or death more generally). Suicide needs to be understood within a heuristic framework of the dominant culture/society, while appreciating and being sensitive to its specific understandings. This is true around the world and has direct implications and applications to treatment.

Simply put, suicide has different meanings for different people; and this is true for our suicidal patients. Culture is an especially powerful vehicle for meaning, and interventionists must be aware of these differences. To be insensitive to this issue in understanding suicide will likely result not only in problems in knowledge but also difficulties, even suicidogenic ones, in suicide prevention among different cultural groups.

## SUICIDE PREVENTION

The classical approach to the prevention of mental health problems and public health problems is that of Caplan (1964) who distinguished the concept of primary, secondary, and tertiary *prevention*. The more commonly used concepts for these three modes of prevention are *prevention*, *intervention*, and *postvention*, respectively. All have a place in preventing suicide.

- *Prevention* relates to the principle of good mental hygiene in general. It consists of strategies to ameliorate the conditions that lead to suicide. "To do"—*venire*—something before the dire event occurs. Primary prevention is best accomplished through education. Such education, given the complexity of suicide, is enormously complicated, and is almost tantamount to preventing human misery.
- *Intervention* relates to the treatment and care of a suicidal crisis or suicidal problem. Also termed secondary prevention, it involves doing something during the event. A great deal has been learned about how to intervene—in crisis intervention and psychotherapy—with suicidal people. Obviously, suicide is not solely a medical problem and many persons can serve as life-saving agents. Nonetheless, professionally trained people—psychologists, psychiatrists, social workers, and psychiatric nurses—continue to play the primary roles in intervention.

- *Postvention*—a term introduced by Shneidman in 1971—refers to those things done after the dire event has occurred. Postvention deals with the traumatic after-effects in the survivors of a person who has committed—or attempted—suicide. It involves offering psychological services to the bereaved survivors. It includes working with all survivors who are in need—children, parents, teachers, friends, and so on.

To address these approaches in more detail warrants a separate volume for each topic; our focus here will be on intervention—primarily risk assessment and psychotherapy. I would like to digress, however, and add a few special comments on suicide prevention in schools (Leenaars & Wenckstern, 1990), probably because I have long advocated that the schools will be critical in preventing youth suicide (Leenaars, 1985). The response to suicide has to be complex in our communities and with our young people; the tragedy of Columbine High School in the United States of America in 1999 attests to this fact. Schools, for example, as suggested by the US Secretary's Task Force on Youth Suicide (1989) and the US Surgeon General, Satcher (1998), offer an excellent opportunity of reaching a large number of young people. Staff in schools, in fact, must act as "reasonably prudent persons". The decision of the US Ninth Circuit Court of Appeals in *Kelson* vs *The City of Springfield*, 1985, supports this view. In that case, the parents of a 14-year-old boy sued the school for negligence, complaining that the school had a duty to provide training in suicide prevention and that the school had failed to do so. The case was admissible to court because the court—though settlement was finally made out of court—held that a person might bring action against a school for non-prudent behaviour.

Although prevention efforts should be part of a comprehensive prevention–intervention–postvention plan, it is generally agreed that the most cost-efficient and potentially constructive avenue in public health problems is prevention (primary prevention). Prevention demands great patience and long-term commitment of resources and should not be confused with the intervention that suicidal people need. Prevention is for education, not intervening with lethal people. Suicidal young people need more than education; they often need psychotherapy.

We should critically reflect about our programmes. The prevention of (teenager) suicide must be part of a comprehensive programme that addresses all aspects of the prevention–intervention–postvention model.

## RATIONAL SUICIDE, ASSISTED SUICIDE AND EUTHANASIA

In August 1991, Derek Humphry's book *Final Exit* reached the bestseller list for advice books in the *New York Times*. To date, this book has sold more copies than any other book on suicide. The book highlights a topic that all those working with suicidal people must face. Derek Humphry and the Hemlock Society (and similar people/groups world wide; see Chapter 21) do not advocate suicide *per se*. The society believes that suicide and assisted suicide, carried out in the face of terminal illness causing unbearable suffering, should be ethically and legally acceptable. Old age, in and of itself, is stated by the Hemlock Society *not* to be a cause for suicide.

But, whether we like it or not, terminal illness in some people is sufficient cause. The views about the right to die are, however, not uniform. Dr Kevorkian ("Dr Death"), for example, disassociates himself from the Hemlock Society (and other right-to-die groups) (Humphry, 1993). Kevorkian believes we should, without further debate, provide assisted suicide to those who request such a procedure (Kevorkian, 1988).

People in different countries have different views on the topic (Battin, 1993), and an array of distinct perspectives by an international group will be presented at the end of this volume. In the Netherlands, for example, euthanasia for the terminally ill was legalized on 1 April 2002; the first nation to do so in the world. The law will guarantee protection from prosecution for the physician who performs euthanasia, provided a set of guidelines (the "carefulness requirements") are met.

Suicide by the terminally ill, and perhaps even the non-terminally ill, requires understanding: Is it rational? What are the possible alternatives? Is it legitimate to withhold or withdraw life support? Can a case be made for euthanasia? Should we condone or approve assisted suicide? Euthanasia refers to the practice, after treatment has failed, of allowing the person to die with physician assistance. Assisted suicide is different; it refers to the practice of providing the means by which the person can end his/her own life, but is not physician assisted (see Chapter 21 for details). The above are all relevant questions for the psychotherapist working with suicidal people—especially those who are terminally ill.

On the issue of "rational" suicide, Diekstra (1992) has suggested that the word "rational" should be eliminated from our discussion on this topic. "Rational" is a construction. He asks, "When is any behavior just 'rational' or not?" It is a misleading term.

Obviously old age is not a reason for suicide. Many elderly people, including those that are terminally ill, are suicidal if their pain has become unbearable. Recovery, however, from the suicidal state is possible. Whether such pain ends in recovery or death depends partly on the relationship of the older person to family and to us, the psychotherapists. Rapport or therapeutic alliance is so critical, even in these cases. The decision to kill oneself is a process. It calls into question one's history, especially one's attachments, including those who are terminally ill. It is often an evaluation that one's past, present and future relationships offer some hope, something bearable that stops the exit. Attachments are so crucial: They often alleviate the unbearable pain.

Richman (1991) believes that the above ideas are critical to the topic at hand and argues against the right to die. He and others state that suicide, including suicide by the terminally ill, is never based only on being ill. Sigmund Freud is a dramatic example, because his work in mental health is so influential. Freud killed himself (with his physician's assistance). Was it, as he stated, because of his terminal illness? Or was it because he had been severely depressed at the time? He had been overwhelmed by World War II and had notable problems in his adjustment after moving to England. Was Freud's suicide due only to his terminal illness? Does Freud's suicide differ in its essence from other suicides? Humphry would say yes; Richman would say no. There are other questions—for example, was Freud's death

a suicide? Would it be more appropriate to call it self-determined death or free death or voluntary death? These and other questions will be critical for the psychotherapist. When are suicide, assisted suicide, and euthanasia acceptable and when not? Are they ever?

Let me offer a story: I remember once witnessing the after effects of a suicide of an elderly male, age 84. His wife had died 3 months earlier; he had cancer; his car was in the shop; he had no family; and he chose to jump 22 stories to his death. That was tragic. What was even more tragic for me was watching the people in his building, a senior citizen apartment house with no social services, next to my office building. I remember seeing an older woman on the fifth floor look and look, as did others, at the body for one and a half hours. What services had the man needed? Would psychotherapy have been an alternative? Could someone have helped him with his crisis? And what about the other people? Is it humane to allow these senior people to be forced to witness such a death? Was the man terminally ill and, if so, would euthanasia (by a family doctor) or assisted suicide be more humane? And even if he was terminally ill, could we, as therapists, have helped to ease his pain? Could his death have been prevented?

The importance of the discussions on euthanasia and assisted suicide is that it raises questions that psychotherapists must reflect upon (see Chapter 21). Are we, for example, willing to provide the treatment, psychotherapy or otherwise, that elderly people need? Are we willing to support hospice care for those who are dying? Are politicians and the public willing to provide the money for the services that elderly people need? Or that terminally ill people need? There are many questions regarding euthanasia and assisted suicide. The issue of the right to die must be discussed by society in general, and psychotherapists in particular, well beyond the realm of suicidology. It will probably be a critical issue for psychotherapists in the twenty-first century.

## THE TEN BEST BOOKS

What are the 10 top books in suicidology? I was once asked this question and it seems appropriate to answer it here, to provide an aspiring or veteran psychotherapist with a sort of "who's who" in the field. The ten classics—and this is subjective—are: E. Durkheim (1951), *Suicide*; P. Friedman (Ed.) (1967), *On Suicide* (a discussion of the Vienna Psychoanalytic Society); S. Freud (1974g), *Mourning and Melancholia*; K. Menninger (1938), *Man Against Himself*; A. Henry and J. Short (1954), *Suicide and Homicide*; E. Shneidman and N. Farberow (Eds) (1957), *Clues to Suicide*; C. Cain (Ed.) (1972), *Survivors of Suicide*; C. Varah (Ed.) (1985), *The Samaritans*; E. Shneidman (1985), *Definition of Suicide*; and K. Hawton and K. van Heeringen (eds) (2000), *The International Handbook of Suicide and Attempted Suicide* (although E. Stengel (1994), *Suicide and Attempted Suicide* and N. Kreitman (1977), *Parasuicide* are notable classics on attempted suicide). If I could add one, I would add a biological text, but it is unclear which one. The obvious names are M. Asberg, J. Mann, P. Nordstorm, H. Van Praag, A. Roy, and L. Traskman-Bendz. Shneidman (2000)

and Maltsberger (2002) have suggested that the authoritative volume is D. Stoff and J. Mann (1977), *The Neurobiology of Suicide: From the Bench to the Clinic*. Thus, I will accept this edited volume to be included in the Ten Best Books for now. I write "for now" because the advances in biological sciences have been exponential (Maltsberger, 2002; Stahl, 2000). This is the test of a growing science.

## CONCLUDING REMARKS

The present chapter is a prologue to the understanding of suicide. Suicide is a multifaceted event. Understanding such an event is a complex endeavour; yet not to do so, as a psychotherapist, may well be suicidogenic. Some things can be learned. There is much left to learn. The need to intervene with suicidal people prompts us, even necessitates us, to understand the nature of suicide. In this volume, I will share the knowledge I have gained while working with suicidal people. Therapists need to know what they are treating.