**SUICIDE IN THE WORDS OF SUICIDOLOGISTS**
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SUICIDE IN THE WORDS
OF SUICIDOLOGISTS

MAURIZIO POMPILI
EDITOR

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DEDICATION

To Edwin Shneidman, friend and brilliant human being.
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Suicide has been studied extensively but unfortunately still remains enigmatic and with a great gap from basic research. Personal views in regards to suicide from the people involved in suicide research and prevention are explored herein. This book presents and discusses thoughts about how one becomes involved in studying the enigmatic phenomenon of suicide. Serendipity, anecdotes, failures in preventing suicide and academic pathways are only a few items that can be identified when reading the essays included in this volume.
INTRODUCTION

This volume entitled Suicide in the Words of Suicidologists details the thoughts and reflections about how one becomes involved in studying the enigmatic phenomenon of suicide. It would appear that suicidologists are like a big family, with the arguments and quarrels that are present in every family. But, when taken individually, each one of us was brought to this field by different experiences which are very informative and give the reader some insight into our emotions related to the study of suicide. Serendipity, anecdotes, failures in preventing suicide and academic pathways are only a few events that can be identified when reading the essays in this volume. One aim of this volume is to convey personal views of suicide from the people involved in suicide research and prevention.

The volume includes the very last contribution by Edwin S. Shneidman who founded suicidology in the mid-1950s. He dictated the brief essay to me as soon as I proposed that he contribute to this book. He feared that he might be dead the following day. He died a few days later, but his words as well as those from the very many conversations that we had, will last forever.

In developing this project, I tried to contact as many people as possible involved in this field. I relied on e-mail contacts, addresses from my personal records, Pubmed, and mailing lists used by organizations devoted to suicide prevention. Many replied and were pleased to share their thoughts; some declined as they were involved in other projects; some never replied or e-mails were returned and contact was never established. There are, of course, many eminent people who did not provide their contribution for this first edition of the volume, and I am eager to have them in following editions. Despite my efforts, my disappointment remains for not having been sufficiently successful in contacting those who are active and generous in fueling suicidology.

The volume also includes a special section edited by David Lester. Professor Lester is no doubt the scientist who has contributed more publications in this field than anyone else. He has provided biographical essays and collected autobiographies of some key people in suicide research and prevention. This is also a rare opportunity to learn more about how one becomes involved in this discipline, and their stories of how their lives became dedicated to saving people from committing suicide are told in an intriguing way that captures the reader’s attention.

Note: some chapters do not have a title as contributors reported their own experiences and thoughts under their name.
Although every effort has been made to provide a homogenous set of essays, there might be differences in the number of references and style. It was decided to keep it this way to ensure creativity among contributors. Affiliations and titles were the ones each contributor provided.
Suicidology can be defined as the scientific study of suicide and suicide prevention. The term (and the concept) was first used by Shneidman (1964) and was since then used in a number of ways such as to describe aspect of new training (Fellowship in Suicidology, 1967); as part of a new journal (Bulletin of Suicidology, 1967); to label a new profession (the American Association of Suicidology, 1968). Suicidology is unlike other behavioral sciences in that it has usually included not just the study of suicide but also its prevention, in other words it incorporates appropriate clinical interventions to prevent suicide, a feature not always taken into consideration in the many contributions to suicide understanding. The focus of suicidology is not necessarily completed suicide but above all treatment of suicidal individuals. Suicides die with their unique life histories and it would appear inappropriate dealing with pooled data or statistics to understand the human misery of these individuals. Maris et al (2000) stated that “While suicidologists give lip service to the multidisciplinary study of suicide, in actual fact most of us have very narrow and specialized domain assumption – usually those related to our professional training and subdisciplinary paradigms”. It is perhaps received wisdom in suicidology that suicidal individuals are experiencing unbearable psychological pain or suffering and that suicide may be, at least in part, an attempt to escape from this suffering.

As reported by Maris and colleagues (2000), the building blocks of a systematic theory of suicide include definition, basic concepts (lethality, motive, suicidal career, etc.), hypothesis, models, and research results. Regardless of such items some concepts are so basic to suicide that they can be thought as the commonalities of suicide. Shneidman (1985) listed some practical measures for helping highly suicidal persons:
1. Stimulus (unbearable pain): reduce the pain;
2. Stressor (frustrated needs): fill the frustrated needs;
3. Purpose (to seek a solution): provide a variable answer;
4. Goal (cessation of consciousness): indicate alternatives;
5. Emotion (hopelessness-helplessness): give transfusion of hope;
6. Internal attitude (ambivalence): play for time;
7. Cognitive state (constriction): increase the options;
8. Interpersonal act (communication of intention): listen to the cry, involve others;
9. Action (egression): block the exit;

THE FIFTIES: LOS ANGELES SUICIDE PREVENTION CENTER

This book was in the final stages of preparation when Edwin Shneidman passed away. He was not doubt the person who fathered suicidology. Such discipline was born under the star for searching evidence related to suicide. Shneidman’s contribution to the search for the evidence was a breakthrough in suicide understanding. He proposed the first experiment in the field and this was an effort to understand it scientifically.

As in most important development of science, serendipidy played a big role. It was not a particular interest in the topic that firstly moved Shneidman to get involved with suicide research. It was rather during a normal duty that such discipline moved its first steps. It was 1949 and just during his last period of his life, Shneidman recalled the anecdote “I was 31 and a clinical psychologist at Brentwood Veterans Administration Neuropsychiatric Hospital, and the superintendent asked me to prepare letters for his signature to two new widows whose husbands had recently committed suicide. On my own I went to the county coroner’s office to find relevant background material and discovered a vault with hundreds of suicide notes. My contribution was to recognize their enormous potential, behavioral science potential. My further contributions were not to read them (so as to remain blind) and to invent, on the spot, a new genre of document, namely the elicited suicide note from non-suicidal persons so as to be able to compare genuine suicide notes in a real double-blind experiment. The day I went to the Coroner’s office was somewhat an epiphany of my life. I then called Norman Farberow, who had recently completed a dissertation on suicidal patients using my Make a Picture Story (MAPS) Test. Norman and I blindly analyzed each genuine and simulated suicide note. We published the results in a paper entitled “Clues to Suicide” (Shneidman and Farberow, 1956) and the following year we published another short paper entitles “Some comparisons between genuine and simulated suicide notes” (Shneidman and Farberow, 1957). In 1957 we co-edited Clues to Suicide (Shneidman and Farberow, 1957). That was the birth of Suicidology.” Obviously, only decades later, the new discipline became known as a major field in science.
Suicidology: A New Discipline for Preventing Suicide

The covers of the pioneeristic book by Shneidman and Farberow that established suicidology

A picture from one of the first issue of the Bulletin of Suicidology. “In 1960 there perhaps fewer than fifteen books in the Harvard Medical School library specifically dealing with suicide, the best of which seemed to have come from the Los Angeles Suicide Prevention Center where Shneidman, Farberow, Litman and their colleagues were suicide pioneers. (Today there are bookshelves full.)” Maltsberger (in this book)
The American Association of Suicidology (AAS) was founded by Edwin S. Shneidman in 1968. After co-directing the Los Angeles Suicide Prevention Center (L.A.S.P.C.) since 1958, Dr. Shneidman was appointed co-director of The Center for Suicide Prevention at the National Institute of Mental Health (N.I.M.H.) in Bethesda, MD. There he had the opportunity to closely observe the limited available knowledge-base regarding suicide.

Consequently, under the sponsorship of the N.I.M.H., he organized a meeting of several world-renowned scholars in Chicago, determined the need for and fathered a national organization devoted to research, education, and practice in "suicidology," and advancing suicide prevention.

With his years of leadership directing a suicide prevention center, Shneidman was quick to recognize a contemporaneous and rapid expansion of the crisis center/hotline movement across the United States.

The newly established AAS embraced these centers as sources of research information on suicidal clients. Soon, the relationship between the AAS and these centers was symbiotic.
The first issue of the Bulletin of Suicidology presenting the NIMH Center for Studies of Suicide Prevention by Edwin Shneidman

The National Institute of Mental Health headquarter of the Center for the Studies of Suicide Prevention
AAS became the central clearing house for support and the hub of a many-spoked wheel, networking these centers to common needs, training materials, and goals.

However, suicide prevention efforts were especially boosted by the creation of international aggregations of scholars, clinicians and volunteers. This was the case with the International Association for Suicide Prevention (IASP), which originated in 1960 thanks to the initiative of Erwin Ringel. Rumanian by birth (Temesvar), this Austrian psychiatrist and neurologist aggregated around himself a number of international scholars (mostly Europeans) and held the first assembly of the association, which was formally constituted only in 1962, in Vienna, Austria.

Recently, De Leo 2009 recalled “A number of national bodies were created between the 1960s and 1980s [e.g. the American Association of Suicidology (AAS), the Canadian Association for Suicide Prevention (CASP), etc.]. Probably, the most meaningful international event after the IASP was the creation of the International Academy for Suicide Research (IASR), which occurred in Padua, Italy, in September 1990. The Academy was an initiative of Rene’ FW Diekstra, David Lester and the writer of this article. It originated in response to the poor capability of IASP – at that time - of attracting researchers to its
conferences and, more in general, to the need of internationalising research promotion (De Leo and Schmidtke, 2001). IASR today comprises approximately 140 among the best researchers in the area of suicide in the world. Meanwhile, IASP has greatly improved in attracting leading researchers, and its congresses (both world and regional) are now of the highest scientific standards.

Over the last two decades a number of national strategies on the prevention of suicide were set up by countries around the world. Finland was the first nation (in the 1980s) to initiate such activities, followed by Norway, Sweden, Australia, New Zealand and Denmark. With the new Millennium, the US, England and Wales, Ireland, Scotland, France and Germany also set up their strategies, with many other nations (e.g. Canada, Spain, Cuba, Sri Lanka, etc.) very close to finalise their national plans. In general, these programs represent the expression of public concern around the frequency and the gravity of impacts of suicidal behaviours (both fatal and non-fatal), and follow the commonly shared imperative that ‘something must be done’ in response to suicide phenomena. In this perspective, these concerns may attract and gain political attention, and finally succeed in mobilising governmental money and intervention. Obviously, the development and implementation of national strategies represent an enormously important achievement for anti-suicide campaigners; however, until now political agendas seem to have had a too prominent role, with adopted strategies having no clear standards of reference, and with more attention paid to creating programs than to evidence for their effectiveness, and insufficient care on programs’ concrete implementation and evaluation (De Leo, 2002)."

**CONCLUSIONS**

While suicide research and suicide preventing strategies can rely on very many contributions, suicidology is still a territory that needs to be colonized by those people devoted to the negative emotions of suicidal individuals. It is not my aim to have to a strict distinction between suicide research and suicidology. It may be just one item. Nevertheless, suicidology takes at heart the need to energize suicide prevention through the understanding of the phenomenon centered in the individuals that wants to commit suicide. Mere research should be more and more canalized into actions to prevent suicide. Moreover, the gap between research and the real world should be reduced by concrete efforts.

The people who contributed to this volume opened their hearts and confided their thoughts and reflections. They tell the stories of their suicidal patients, the losses and failures as well as achievements and future goals. I believe this volume is an original contribution to suicidology and adds consistent emphasis on the need to develop new strategies to prevent suicide although the basic principles lies on understanding of the phenomenon causing unbearable psychological pain, no way out and then the need to solve such state trough committing suicide.
REFERENCES


Chapter 2

Final Contribution to Suicidology

Edwin S. Shneidman
Professor of Thanatology Emeritus, UCLA; Founder, American Association of Suicidology

Editor note: This brief essay by Edwin Shneidman is the very last contribution to the discipline he founded in the fifties, suicidology. He dictated me these words a few days before dying with almost no energy left and with a trembling voice. He did that as soon as I proposed him to contribute. He knew that postponing the task would have meant missing the chance as he knew he was going to pass away soon. He then edited it with the help of his assistant Christine Yoshihara and approved the “final page” of his life dedicated to suicidology.

In the current suicidological scene, at least four major approaches can be discerned: (1) the sociological approach of Durkheim; (2) the psychodynamic approach implied in the work of Freud; (3) the medical-somatic-genetic-biological approach that dominates American psychiatry through the Diagnostic and Statistical Manual; and (4) the phenomenological-introspective-psychological approach implied in the concept of psychache. These four approaches can be seen as the four indispensable legs of the suicidological “stool”.

In the psychological approach, the key questions are “Where do you hurt?” and “How may I help you?”. These concepts are embodied in the Swedish word “ombudsman”. An ombudsman is a person who helps another person; someone who reduces the psychological pain.

Psychache is the dark heart of suicide. Psychache is not somatic pain; it is not a headache; is not brain pain. It is a pain in the psyche.

The prevention of suicide lies in an anodynic approach. An anodyne is a substance or a person who mollifies or decreases pain. Let us have more of them!
EDWIN S. SHNEIDMAN 1918 – 2009
OBITUARY BY MAURIZIO POMPILI, M.D., PH.D.

Edwin S. Shneidman died at the age of 91 on May 15, 2009 in his home in West Los Angeles. He is commonly considered the father of suicidology as he pioneered the discipline in the fifties starting from a serendipitously study of suicide notes. He was at that time, with Norman Farberow and Robert Litman, the Co-founder of the Los Angeles Suicide Prevention Center, later on the Founder of the American Association of Suicidology and the Founder-Editor of Suicide and Life-Threatening Behavior. He was also Professor of Thanatology Emeritus at UCLA. He coined various words of our field such as psychological autopsy, postvention and psychache to name just a few. Despite his age he never lost the spirit of a researcher and a thinker. He was always prolyphic with ideas, suggestions and in fueling the development of suicidology. He authored and edited some twenty books and his latest one (A commonsense book of death) was published just a few months ago. I spoke with him two days before his death, on his birthday, and he confessed that it was the end but actually found the words to thank me and say goodbye. Despite he was “Waiting for death” as he stated, he conserved his scientific interested in the end of life process, indefatigable exploring it. He admitted that every so often he wished to be dead but also asked me recently “Please continue phoning me, you keep me alive in this way”. He was so in love with life that it seemed that he had to convince himself that such passion must set the pace for death. He wrote in 1973 “Death while it might be explored, can never be fully charted”.

Ed. has been a friend and mentor for a number of years. Despite a big generation gap, we got acquainted and developed a mutual sincere interest. He was always kind, sweet, polite, and articulate as well as kindly severe for things that didn’t approve. His dedications to me in letters and books are really precious drops of his enormous wisdom that I will never forget. In his latest book had written on October 2008 “To Maurizio Pompili, my treasured Italian son, with my deep pride in your accomplishments and sweet gratitude for your loyalty. Con Amore, Ed”. When meeting him in Los Angeles last year I found a man packed with memories and reminiscences of any kind. He had sent me a message on the occasion of the Shneidman Award saying “I’m thrilled to pieces at your receiving the award. No one is more deserving and your being the awardee warms the cockles of my hearth in a very special way.

The Shneidman Pompili connection foretold in the Suicidological Stars. With my warm embrace. Ed”. I discovered a truly beautiful human being that was grateful for what life had given to him. His house was full of recollections related to the great love for his family and for his beloved wife as well as with signs of his interest for Melville and Murray. During the conversation you could appreciate the emotions of a sensible man that gets excited by simple things. He always stressed the need to include a mentalistic approach when trying to understand suicide. It is the view of a person that never gave up the mission to ameliorate the psychological drama occurring in suicidal individuals. Suicidology has lost a charismatic figure that changed the view of suicide over the past decades.
Ed. and me in his house in Los Angeles on the occasion the American Association of Suicidology’s 2008 Shneidman Award that I received. Los Angeles, April 19, 2008.
Chapter 3

A GOOD DEATH

Ethel Oderberg

The house on the corner stands empty. It is more than six months since Ed Shneidman died, and I still carry a feeling of disbelief that he actually managed to die. His death was not unexpected, really, since he was 91 years old, but Ed was such a force to be reckoned with, that he seemed immortal. And I suppose, he does remain immortal through the legacy of work he left behind and the people whose lives he touched.

I had the privilege and good fortune to be Ed’s psychotherapist during the last five years of his life, when his physical health and energy were declining. I live three houses away and had known of him my entire life. When his wife died in 2001, I began to visit him and invite him to my home to have dinners with my family. Several years later while visiting one day, he asked me if I would be his psychotherapist. I am a licensed clinical social worker with 25 years of experience, particularly with older adults. He said he had a lot on his mind, and wanted weekly sessions, but didn’t feel well enough to visit a therapist’s office. Would I make house calls? I agreed and little did I know that the next five years would be a weekly seminar on suicide, death and dying from this world famous suicidologist.

Dr. Edwin Shneidman, as a young psychologist, was on a mission to understand why people kill themselves and how to prevent it from happening. With single-minded determination, he created the field of suicidology which led to many innovative ideas such as suicide hotlines, psychological autopsy, post-self, and post-vention. The idea he felt the most passionate about, however, was the notion that psychological pain was at the root of all suicides. He invented the word “psychache” to describe this pain and urged therapists to ask “where does it hurt and how may I help you?”. He believed that if we could help reduce the intensity of psychological pain, we would reduce the intensity of the need to commit suicide. Despite the recent innovations in neuroscience and psychopharmacology, the ideas he published in his books and essays and discussed with me remained constant. He truly believed that the best way to help suicidal people was through talk therapy, or anodyne therapy.

From a psychotherapeutic point of view, Ed was definitely one of my most unusual and interesting clients. Since the therapy took place in his home, whether it was upright in his chair or lying in bed, he was definitely in control of the treatment. His age and professional
experience were important factors as well. Despite not feeling well a lot of the time, he continued to be erudite, charming and witty, while dressed in a nightshirt and robe. Most people in their late 80’s are retired, but not Ed. He didn’t know what to do with himself if he wasn’t engaged mentally. He didn’t let physical frailty and decreased energy interfere with his desire to be creative intellectually. He continued to write and promote his ideas with colleagues from around the world. He regularly received letters from people who were touched in some way by suicide and sought him out for solace and comfort. In the earlier years, when he was feeling better, he would answer phone calls or letters and occasionally invited people to see him at his home.

As you can imagine, Ed brought a lot of material to our weekly sessions. Thoughts and feelings about his physical decline were primary as well as his loneliness without his wife. He shared his internal mental states to a degree, but was acutely aware of censoring material that would in some way negatively affect his post self. He never stopped being concerned about his reputation and had trouble just resting on his laurels. He published two books in the last six years of his life, with the last one; “A Commonsense Book of Death” published just six months before he died. He used our sessions to discuss material for his book and invited me to write an essay about our work together, to be included in the book. I am forever grateful for this opportunity.

Ed faced his own death head on. In fact, he was ready to go because each day was such an effort for him. He was fond of predicting how much longer he would be around with statements like, “I won’t be here six months from now.”

Because his career involved talking and writing about death on a regular basis, he had developed a calm, direct, and seemingly unemotional relationship with the subject. He regularly referred to his own feelings as rueful. He brought this direct, rational approach to his own death and it was a topic discussed regularly, almost obsessively. He wrote in his last book about ten criteria for a “good death.” Ed also wrote that, “There is no single best kind of death. A good death is one that is ‘appropriate’ for that person. It is a death in which the hand of the way of dying slips easily into the glove of the act itself. It is in character, ego-syntonic. It, the death, fits the person. It is a death that one might choose if it were realistically possible for one to choose one’s own death.”

During the time that I was seeing Ed, I began to work for a hospice company. I believe that my own comfort around death and dying ensued because of my weekly sessions with Ed. At the very end of Ed’s life, I was his hospice social worker, as well as psychotherapist. Ed died 24 hours after being admitted to hospice care. It was a surprise to all of us that he died so quickly, but I believe that he was truly ready to exit this world. He had just days earlier seen his four sons to celebrate his 91st birthday and they had all returned to their respective homes. He was in a lot of physical pain before coming onto hospice, but in the end, because of pain medication, he was finally comfortable and could let go. He died in his sleep.

I was there minutes after he died and I wanted so much to be able to tell him that he had achieved his goal of having a good death. But he was gone. I think that if Ed could have witnessed his own exit, he would have been satisfied. Sadly, I would never have another conversation with him again.

I called the mortuary and watched the technician remove his body. What an honor to take care of him in this way. And the house on the corner sits empty.

1 Shneidman, Dr.Edwin (2008). A Commonsense Book of Death (page 131) Roman and Littlefield
Chapter 4

WAITING FOR DEATH, ALONE AND UNAFRAID

Thomas Curwen

Edwin Shneidman had a knack for drawing strangers near. Often they would arrive on his doorstep after only a phone call, and he would invite them inside, serve tea and cookies and begin a conversation that, if they were lucky, would last for a lifetime. Fifteen years ago I was one of those fortunate strangers, a journalist with a story to write and the implicit hope that Ed could tell me why a friend had killed herself. Our discussion, of course, was never that simple. Ed spoke not only the language of suicide but also the language of the heart. He was, first and foremost, a philosopher who celebrated the truth that nothing human is alien.

No four words better describe his abiding inquiry into death and dying, and in his final months when I proposed writing about the end of his own life, he agreed. We visited once, sometimes twice a week for about a little more than a month, and as we talked about his childhood and marriage, his books and his reputation, the discomfort of being old and the prospect of the future when the future seemed so dim, I think he too was curious to see what we might learn. Ed was as astute and sensitive an observer of his own death as he was of others’. Much as he greeted the strangers who appeared almost unannounced at his door, he befriended his own dying and left us with a legacy that is both courageous and inspiring.

The silence of night never lasts long. It ends somewhere in the 5 o'clock hour with the purring of the heater and distant strains of Sam Cooke.

Edwin Shneidman looks at the clock -- an hour and a half since turning off the TV and closing his eyes.

"Mrs. Wiggles," he shouts. He knows that that's not her name, but he likes the joke.

Sitting in another room, Pauline Dupuy turns down the CD player and puts her Bible and crossword aside. She stands and walks down the hall into his room.

"My knee hurts."
"Would you like a pain pill?"
"Yes."
"Tramadol or Vicodin?"
"I don't care."

He lies on the side of the bed, sleepy, unshaven, his hair mussed. He never asked to live to be 90, to see the breadth of his life diminished, the allure of the world fallen further out of reach. He is ready to die.

All his life he has studied this moment — from those who killed themselves and those who tried, from philosophers and colleagues, students and intimates — and its lessons hold no real surprise.

Today will be the same as yesterday, the same as tomorrow, every day a waiting and a hoping for a good death, a death without suffering.

He lives alone but for the company of caregivers in the house that he and his wife bought more than 50 years ago, alone to consider the meaning of his life and the niche he has secured for himself in the memory of the world.

"Good morning."

He looks up. Vernette Elijio greets him with a smile and rubs the top of his head. It's 7 a.m., the changing of the guard. She will be with him for the next 12 hours. Dressed in a long white sleep shirt, he looks like a character from Dickens. She helps him on with his plaid robe, and he shuffles to the chair at the side of the bed.

His four boys call often. They love him, but they live out of state. Of course, he excuses them. If they lived closer, he knows he would take advantage of them.

Vernette fits the blood pressure cuff over his left arm. The room vibrates with the noise of the pump and then, silence, broken by the steady beep tracking his pulse.

He is not afraid of death. He has studied it all his life: 1955-66, co-founder and co-director of the Los Angeles Suicide Prevention Center; 1966-69, chief of the National Institutes of Mental Health's Center for Studies of Suicide Prevention; 1970-88, professor of thanatology at UCLA.

"133 over 90," she says. "It's a little high."

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People often ask him what the end is like. The answer is simple: You're driving down a road in the desert, and the engine suddenly stops, no Pep Boys, no Auto Club to help. Whether the road continues is of no consequence. It has ended for you.

His parents' lives ended here in Los Angeles. They are buried in Beth Israel Cemetery, close to the 5 and 710 interchange, half a world away from the czarist shtetls of Ukraine, where they were born.

He will be buried somewhere in the San Fernando Valley, at Eden Memorial Park, Row 722, Grave A or B — he's not quite sure — there beside his wife, Jeanne, "Beautiful, Bright, Loving, Serene." His epitaph will be as succinct: "Lucky, Bright, Loving, Ambitious."

No one has to die, he is fond of saying; it will be done for you. It's living, however, that takes effort — to weather the sleeplessness and worry, the relinquishing of pride, the dependency upon strangers, the plea for respect and the struggle to remember.
There is the vulnerability, as well. Charm, a ribald sense of humor, tears and anger have been a defense, but they don't always work. Last year he was robbed by a caregiver who forged his checks.

Vernette brushes the middle finger of his right hand with an alcohol wipe. He trusts her. She places a needle against the soft skin. He winces, the price of checking his glucose level, and it pricks him.

"Ow."

She squeezes a small drop of blood into the meter.

"169."

The reading is high, slightly hyperglycemic, but his body turned on him long ago -- hypertension, diabetes, congestive heart failure and prostate cancer. The end will come no doubt as the result of an acute cardiovascular event when the plaque in his arteries shifts like grains of sand, suddenly blocking a coronary or carotid artery.

He fears a stroke most of all, that this life might be reduced to gibberish or silence. Actuarial tables say that he can expect to live 3.8 more years, but calculating the time and the place of one's death is not easy and never accounts for the uncertainty that any new ache or pain might bring. There is no knowing. In the next minute he might draw his last conscious breath.

He has considered buying a revolver and bullets. But that is only a fantasy. Suicide would be unseemly, given his lifelong work. Too many complications for the boys.

Jeanne was lucky. It was a Monday evening, almost eight years ago. She screamed, and by the time he got to her, she was dead, cardiopulmonary arrest. According to the autopsy report, "the interval between onset and death" was minutes.

That was a good death but also the start of his darkest night, the months, the years of the steady pain of not holding her in the crook of his arm gazing, as they did, upon the Chagall he placed on the ceiling above the bed, Romeo and Juliet floating through a pastel sky.

You can't experience your own death, he has always said; your death is for others to experience.

He thought he might have had his chance to die two years ago when his blood pressure shot up to 205 over 91 and his pulse plummeted to 48. As he lay in the back of the ambulance, he stared through the transparent ceiling at the sky and watched the world pass by.

He expected everything to go dark, and when they pulled into the bay of the UCLA Medical Center, he started to cry, knowing that the doctors would save him. Forty-eight hours later, a pacemaker and a cocktail of Lasix, Lotensin and Lipitor made sure of that.

Growing up in Lincoln Heights in the 1920s, he found happiness alone, curled up in his parent's 1910 mahogany bed. That was a great white billowy ship, and there he listened to Caruso, Geraldine Farrar, Mozart and Beethoven on the Victrola and read the Encyclopaedia Britannica.

What worlds he sailed to, far beyond their rented home in the Italian quarter of Lincoln Heights, far beyond his father's dry goods store. This was what his parents expected. They
became his sacrificial bridge into America, and to this day, he regrets the shame he felt over their manner and accents.

"Did the mail come?" It is almost noon.
"No. Not yet."

Yesterday was a good day for the mail. He received a tin of tea from an old friend and a book of photographs from Judy Collins. Four years ago she visited him to talk about the suicide of her son, and she wept right there on the back porch.
It often goes that way. Someone hears about him or reads one of his books and then calls or writes. He's happy to oblige. The stream of visitors to his house is nearly constant. He is their Charon, the ferryman who shuttled souls across the River Styx.

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Still he feels undeserving. Through no skill of his own he stumbled upon this profession one damp drizzly morning in the late 1940s when he drove downtown to research the death of two veterans. In the basement of the coroner's offices, he discovered hundreds of suicide notes, the language of despair and hopelessness, and he devoted his life to deciphering it.

Death is destroyer and redeemer . . . the source of fear, the focus of taboo, the occasion of poetry, the stimulus for philosophy. . . .

Those were his words 36 years ago, so vigorous, so purposefully stated in "Deaths of Man." At 54, he took on Elisabeth Kubler-Ross: The end of life isn't, as she proposed, defined by a succession of stages, one following the other, denial to acceptance, but instead a "nexus of emotions . . . a hive of affect, in which there is a constant coming and going."

It was an auspicious moment. "Deaths" was a finalist for a National Book award in science. He was celebrated and feted. But the momentum faltered. Placing mental anguish in a social, cultural or familial context fell out of vogue. Prescribing pills became easier.

His twentieth book, "A Commonsense Book of Death," was published last year. He hopes for a place on the shelf beside his heroes -- Emile Durkheim, Herman Melville, psychiatrist Karl Menninger and his dear friend and mentor, psychologist Henry Murray -- but he knows his life will be redefined by death, his words distorted or forgotten.

No different really than the day the children will empty everything out -- Jeanne's sheet music, his many books -- and this home, this sanctuary sprung up on a postwar bean field with its blue shutters and Dutch front door, will be sold to strangers.

In death, things become mere things -- the statue of Venus in the backyard, the gyotaku print in the kitchen, the Melville-inspired shadow boxes -- no longer animated by memory, the story of their provenance. It is as if their atoms loosen and dissipate.

The meaning of death is loss and sadness and inevitability. On the wall above the bed, he has hung a print by Breughel that covers a crack in the plaster. Here an army of skeletons wages war against humanity, and compared to the Chagall overhead, it's a bleak and macabre picture of the final hour that without angels or signs of salvation is unremittingly godless.

The other day Vernette said he was blessed. True enough, he thought, but not quite right, not blessed. On a napkin on the TV tray he scribbled down the Greek prefix, eu, for good, and then through association and sound, fell upon doria. This is what he does. He coins words, and this would be the word for his good fortune. Eudoria. He spoke it out loud: gratitude
without an object, no one to credit, no one to thank. No Jesus, no Yahweh, Muhammad, Vishnu or Buddha.

Because he believes life isn't contingent upon a god or upon prayers. There is no heaven, no hell. Happiness lies in the here and now and the satisfaction of living a good life without religion or myth to guide you. He takes nothing away from others' beliefs. He just prefers "Moby-Dick" to the Bible.

Death is quite simple. Life is more mysterious, and he never tires of its wonderments: How he -- a Jew at that -- survived the war, how he and a girl from the corn country of Illinois fell in love and married and had four children and such a long and happy life.

By midafternoon after a lunch of soup and a visit with friends, he is ready to lie down. Vernette stands close as he makes his way back to the bed. Sometimes he wonders if he is playing at being a tired old man or whether he actually is a tired old man.

Through the blur of his dozing, he hears muffled voices, the memory of the boys running from room to room, the happiest sound in the world. There was a time when he could hear Jeanne breathing beside him after she had died.

Outside, the ash trees throw their empty limbs into the sky. Gardeners tidy up the edges of green lawns. Teenagers walk home from school. Nannies push baby strollers down the sidewalk.

He would like to die in his sleep, and he would like there to be music. Beethoven's Romance No. 2 would be fine.

The phone is ringing. He picks up the receiver. It's his eldest son, David.

"Hello, dear man," he says.

The phone rings again. This time it's his youngest, Robert.

He carefully walks over to his chair by the bed and turns on the television.

It's 7:30 p.m. Vernette has left. The heater is purring. The lights are on. Pauline comes into the bedroom.

"Is there anything you'd like?" she asks.

"Yes," he says. "A cup of coffee -- and then I can take my pills."

The night stretches before him with so many endless hours, and sleep will come, if at all, in the early dawn. Until then, there is some writing he would like to do.
Chapter 5

ALAN APTER

During my career I have met with suicidal individuals in at least four very different settings. I have worked with suicidal young soldiers in the Israel Defense Forces, worked with suicidal youth in the context of a children's hospital emergency room, with suicidal patients in a private psychotherapy practice and worked with suicidal adolescents in a closed psychiatric unit. This has led me to believe that suicidal behaviors and emotions are very heterogeneous and should always be understood in context.

The first contact I had with suicidal youth was while serving as a Battalion Medical Officer in the Israel Defense Force. Here I was faced with suicidal behavior in the context of social communication in specific social networks. This phenomenon was best described by Kreitman in Scotland in the fifties as "parasuicide". Thus suicidal threats and gestures can be used to obtain changes from an unresponsive environment. It is generally used by persons with limited status such as ordinary soldiers or those from low income neighborhoods. It is generally a strategy not available to officers or mental health professionals, who therefore have little patience for such individuals. Interestingly Gilligan, the feminist psychotherapist sees the use of suicidal behaviors as a way that young women too can impinge on their surroundings.

Later on in my career I had the opportunity to perform clinical and research psychological autopsies on young soldiers who had killed themselves while serving in the Israel Defense Force (IDF). In those times, substance and alcohol abuse were extremely rare in Israel and most of the suicide victims had a very special profile very different from the then (and now) current literature. These were very successful and motivated young people who had experienced some form of narcissistic injury usually a failure or a moral slip. Unable to bear their shame and unable to ask for help they were left no choice but to die at their own hand. From looking at these young people’s stories I became interested in the possibility that while attempted suicide was often a "cry for help" completed suicide was the result of a communication difficulty in which for personal or cultural reasons asking for help was not an option. Recently I have tried to operationalize these ideas in systematic research which tries to look at the differences in the psychological makeup between low lethal and near lethal suicide attempters. In this context the concept of "self disclosure" or the tendency to share emotional experiences is a critical variable. Lack of self disclosure may explain the well known gendered differences between attempted and completed suicide and persuading men to self disclose may be of potential value in suicide prevention programs.
Another formative experience in my life was working with suicidal teenagers in a closed adolescent psychiatric unit at the Geha Psychiatric Hospital in Israel. Most of these young people were extremely impulsive, often violent and verbally and physically aggressive. The majorities had made multiple attempts and were often engaged in a wide range of high risk behaviors such as truancy, fighting, and promiscuity, various forms of addiction, fast and dangerous driving, running away and problems with authority including the police. Here I worked under the mentorship of Sam Tyano, a French trained psychoanalytic theorist who saw this behavior as an "organizer" of the future personality and adolescence as a stage where youth have to make positive decisions about life and death. During this period I also studied with Joe Noshpitz in Washington DC who was interested in the early introjections of bad persecuting objects as a forerunner of self destructive behavior and during this period I was introduced to the social theories of Jessor who saw "unconventionality" as underlying the various behaviors included in this spectrum of dangerous behaviors.

The relationship between all these forms of high risk behaviors and suicidal behaviors was made even clearer to me when I became a Belfer Fellow at the Albert Einstein College of Medicine in the Bronx section of New York. Here too suicidal patients tended to be aggressive, impulsive and dangerous to others as well as them selves. The Chairman of the program Herman van Praag was one of the pioneers of modern biological psychiatry. He was particularly interested in the serotonergic mechanisms underlying the continuum. His theory was that persons with low serotonergic turnover were very sensitive to even the most minor of life events. This led to the development of anxiety, anger and eventually depression and suicide. The early work was based on studies of cerebrospinal fluid metabolites of serotonin and on pharmacological challenge tests. The serotonin theory of suicide took flight with modern methods of family and genetic studies of suicidal impulsivity and it soon became clear that this was a major subcategory of suicidal behavior especially important in young. While at Einstein I also became interested in defining the phenotypes of suicidal, aggressive and impulsive behaviors. Here I was fortunate to find leadership from Rob Plutchik a prominent psychometrician. Together we developed scales for the measurement of these and related phenomenon and showed that in our subjects all the relevant "serotonergically based" dimensions-suicidal behavior, depression, anxiety, impulsivity, anger and violence were all highly inter-correlated.

The relationship between genetics, stress and serotonin has received even more attention in the literature and the work of my collaborators Danuta and Jerzy Wasserman on some of the genes of the HPA axis together with the work of John Mann on genes and imaging of these systems holds I think great promise for the future understanding of this subtype of suicidal behavior. My own work in this field has been with David Brent and Nadine Melhelm from Pittsburgh and with Muhammed El Heib and Sami Hamdan of Israel, trying to work on the genetics of a family pedigree heavily loaded with suicidal indiviuals from a Bedouin extended family.

An interesting twist to the impulsive, aggression serotonin story has been the relation of suicidal behavior to the use of SSRI medications in depressive youth. We have tried to look at the pharmacogenetics of this phenomenon and together with my student Sefi Kronenberg and collaborators Avi Weizman from Israel and David Brent from Pittsburgh have had some interesting preliminary findings. The intriguing idea is that if we could identify the polymorphisms which could predict the suicidal side effects we might be in a position to
make these agents safer for use and also come closer to understanding one basic psychopathological mechanism.

Finally my work with psychiatrically ill adolescents many of whom are suicidal and some of whom have gone on to commit suicide has convinced me of what most suicidologists accept as a truism that mental illness is a major risk factor for suicide. The mechanism here seems often to be feelings of helplessness and demoralization in the face of intractable illness and suffering with no hope for cure in sight. This is especially so in young intelligent persons suffering from schizophrenia who retain insight into the fact that they are "loosing their minds" or in young females suffering from Anorexia Nervosa who realize that their endless battle against society into letting get as thin as a possible is a lost cause. A poignant case in question is that of the famous Ellen West whose tortured thoughts and eventual suicide were so eloquently recorded by Binswanger.

The study of suicide in young people has been a major part of my career it has led me down many a fascinating path with many wonderful friends and colleagues. I do not have the space to mention all my thoughts and experiences such as the nitty gritty of epidemiology, suicide prevention programs and organization of services and training programs and survivor organizations. It certainly is a rich and rewarding area of work and I think suicidology can be proud of the progress it has made, of the suffering it has alleviated and of the hope for the future that it provides.
Chapter 6

REFLECTIONS ON SUICIDE PREVENTION: CHALLENGES FOR MODERN PSYCHIATRY

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The medical treatment of the propensity to suicide, whether prophylactic or therapeutic, differs not from that which is applicable in cases of ordinary insanity.
George M. Burrows M.D.; London, 1828

My concern about suicide dates from the first several months of residency training in psychiatry in the 1960s when, in rapid succession, three patients died or were severely injured by self-inflicted violence. In retrospect, one case probably involved an acute mixed manic-depressive illness, and the others, severe recurrent depressive disorders with psychotic features. Common to all cases were their unexpected violent or fatal outcomes, despite intensive clinical involvement with all of the patients, sometimes for prolonged periods, and despite awareness of recurring suicidal preoccupations in at least two of the cases.

These early experiences left several indelible impressions: [a] suicide and violent self-inflicted injury are not a rare outcome among psychiatric patients, especially those with mood disorders severe enough as to require hospitalization; [b] suicide is hard to predict with specificity at the level of individuals and by timing, despite availability of familiar lists of general risk factors; and [c] it is very hard to know and to understand the thinking that precedes a suicide attempt by an individual patient, even with time and great effort.

Over the years, while leading a laboratory program in basic neuropharmacology, I did very little to pursue the challenge of suicide, but became interested in the topic again during a symposium on suicide in Boston in the mid-1990s. After listening to several experts on

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suicide discuss the epidemiology, psychology, and prediction of suicide, I eventually began to ask speakers why they did not discuss therapeutics or suicide-prevention. Their responses involved evasive and uneasy generalizations. When I asked one of the speakers, Kay Jamison from Johns Hopkins Medical School, why there was no discussion of treatment, she ventured the opinion that very little was known about the therapeutics of suicide at that time.

That experience led the two of us to organize another meeting for the following year, with many of the same experts invited, but with the understanding that they could only discuss treatments that reduced suicidal risk. It was an interesting meeting, with strikingly limited content, since very little was known about any kind of treatment that predictably reduced suicidal risk, especially long-term. This impression applied to psychotherapy, psychotropic medicines, and even long-term effects of electroconvulsive treatment (ECT). A possible exception was maintenance treatment of bipolar disorder patients with lithium (1). This meeting strongly stimulated my interest in pursuing effects of various treatments on suicidal risk in various psychiatric disorders. This effort has included a long-standing collaboration with Leonardo Tondo of the University of Cagliari in Sardinia.

Over the past decade, we and other collaborators have evaluated original and published data concerning effects of psychiatric treatments on suicidal risks. We have accumulated a large, consistent, and compelling body of support for a major antisuicidal effect of lithium treatment (2,3), possibly with greater effects than with other proposed mood-stabilizing treatments (4). Moreover, this effect of lithium-treatment may extend to some patients diagnosed with recurrent unipolar major depression (5). The effects of lithium treatment on suicidal risk have been highly consistent across nearly three-dozen studies involving over 3000 patients, including a number of prospective, randomized, controlled trials against alternatives or a placebo, with large reductions (≥75%) of suicides and life-threatening attempts (2,3,6).

Our interest was greatly stimulated by FDA approval of clozapine in schizophrenia patients as the only treatment with a specific indication of preventing suicidal behavior. This development in 2003 was based largely on a single, remarkable, randomized, long-term trial of clozapine against olanzapine (InterSePT), which found greater reduction with clozapine of suicide attempts and related surrogate measures, but with insufficient evidence to assess mortality (7). Such treatment effects of lithium may depend on limiting depessions, which are strongly associated with suicidal behavior at similar risks among types I and II bipolar disorder (6), and on generally superior antipsychotic effects of clozapine (7), although antisuicidal effects have been reported with lithium even among otherwise clinically unresponsive patients (6). Both drugs also can limit agitation, anger, and impulsivity. It is unlikely that these agents reduced suicidal risk simply by enhanced clinical attention associated with their safe use, since this variable was controlled-for by matching clinical contact-times with clozapine and olanzapine (7).

Another unresolved mystery concerns effects of antidepressant treatment on suicidal risk. Evidence concerning anticipated, major suicide-preventing effects of antidepressant treatment remains conflicted (8). In the 1990s there was a strong correlation between very large increases in sales of modern antidepressants and minor reductions in overall suicide rates in some countries or regions. However, such correlative-ecological studies do not prove a relationship at the level of individuals who did or did not use the medicines. Moreover, studies finding such correlations were limited mainly to North America and Northern Europe. Findings in other world regions were highly inconsistent, and there was evidence that suicide
rates were declining in the United States and some northern European countries well before the advent of modern antidepressants (8). Moreover, some of the relationships between antidepressant-sales and suicide rates may reflect complex socioeconomic mediating variables, generally consistent with the concept of “access to clinical care” [9]. The FDA carried out extensive meta-analyses of randomized, placebo-controlled trials of modern antidepressants in juveniles and both young and older adults [see http://www.fda.gov/cder/drug/antidepressants/default.htm], and Corrado Barbui and his colleagues at the University of Verona recently reported similar analyses of large clinical cohort studies of patients treated with antidepressants or not (10). Both analyses suggest a previously overlooked age-effect, in that antidepressant treatment may somewhat increase risk of suicidal thoughts and perhaps behaviors in juveniles, but may exert substantial antisuicidal effects in older adults, even though overall suicidal risks with antidepressants and placebos were very similar, without stratification by age (6,8). The implied developmental hypothesis is congruent with indications of less separation of responses to antidepressants of all types from placebo in controlled trials among juveniles diagnosed with major depression, as age declined below adult years (11). In general, the congruence of juvenile and adult forms of major mood disorders, defined largely by stereotyped representations of adult disorders, remains uncertain.

A related concern is that modern antidepressants introduced over the past two decades have encouraged major changes in clinical practice, including generally brief clinical assessments, heavy reliance on the relatively safe new drugs despite their frankly uneven therapeutic effects, and typically minimal follow-up by a much wider group of prescribing clinicians than psychiatrists. Such developments, may represent cost-effective interventions for many depressed patients who formerly might not have had access to treatment, and they have been economically very attractive to the pharmaceutical and insurance industries (though for opposite reasons). Nevertheless, the cases mentioned above indicate that suicide prevention requires more than a single, rapid diagnostic assessment and a simple prescription. This conclusion is particularly important for newly depressed and still little-known or poorly understood patients, who require some time and thought, as well as imaginative flexibility for safe and effective clinical management that should include minimizing risks of occasional paradoxical excitement associated with antidepressant treatment (6). The preceding developments also highlight a broader, ongoing challenge, in that mortality—due to suicide as well as co-morbid medical illnesses and apparent accidents—has largely been overlooked as an outcome, and potential therapeutic target for many severe psychiatric disorders (12,13).

In general, current tendencies toward an element of “dumbing down,” in both clinical and academic psychiatry may well be encouraged in no small part by the very success and power of modern clinical psychopharmacology. Associated developments include narrow and essentially circular, “pharmacocentric” biological theorizing, based on tentative and incomplete theories of the actions of psychotropic drugs but no credible pathophysiology or etiology of most psychiatric disorders (14). Finally, there are growing challenges to training young psychiatrists in the art of curiosity, which goes far beyond a technical approach to clinical assessment and therapeutics, and to academic life, and remains essential to the care of potentially suicidal and other mentally ill patients, and to progress in psychiatric research.
ACKNOWLEDGMENTS

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DISCLOSURES

Dr. Baldessarini has recently been a consultant or investigator-initiated research collaborator with: AstraZeneca, Auritec, Biotrofix, Janssen, JDS-Noven, Lilly, Luitpold, NeuroHealing, Novartis, Pfizer, and SK-BioPharmaceutical Corporations; he is not a member of pharmaceutical speakers’ bureaus, nor does he or any family member hold equity positions in biomedical or pharmaceutical corporations. He also holds five unlicensed patents for novel drug substances.

REFERENCES


Chapter 7

THE MAKING OF AN ACCIDENTAL SUICIDOLOGIST

Lanny Berman
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HAPPENSTANCE AND SERENDIPITY -- THE WEASLEY TWINS OF EVERYDAY LIFE

Happenstance. As a newly minted Ph.D. and appointed as an assistant professor in the
department of psychology at a US university, I was approached by two undergraduate
students interested in starting a campus-based crisis intervention service. Their request had a
twist. In the tradition of a strong volunteer and paraprofessional movement of that time, they
wanted to establish a student organized, student run, volunteer telephone crisis line, but asked
to have it embedded as a practicum within the body of an academic course that I would, they
urged, agree to co-teach with a fellow psychologist faculty member.

Proposing and developing a new curriculum offering is one thing. Getting a proposed
course through the various roadblocks and barriers, known as university administrators and
faculty committees, to become a reality is another. To our ever-grateful surprise, within a
matter of mere weeks our course proposal was approved and slated for student enrollment in
the fall of 1971.

The course we built was directed toward both advanced undergraduate students and
graduate students. All enrolled students were required to go through a 30 hour, two-weekend
pre-training that we designed and gave. Undergraduate students were assigned various
projects to help establish resources for the service’s operation and were required to work eight
hours per week on the newly established crisis lines. Graduate students, who already had
some clinical training on externship placements, were trained to train and supervise
undergraduate students, including those who responded to campus ads for volunteers to be
screened and serve solely as telephone counselors. We were pioneers of a sort -- ours was the
first such crisis service established in the U.S. that was embedded within an academic course
at a university.
The academic course we offered had a full semester’s series of lectures on relevant topics ranging from crisis theory to crisis intervention strategies, from understanding situational crises to transitional crises, from learning of crises as disparate as unwanted pregnancy and suicide. In dividing responsibility for lecture topics, my colleague was simply faster on his feet than I was – he opted to teach a variety of subject foci leaving those associated with violence, thus suicide, for me. Although I had been trained in crisis intervention theory and technique, I soon recognized that I had little training of value in understanding, assessing, and intervening with suicidal individuals. In this way, and in proper fulfillment of the old adage that teachers merely need to be a chapter ahead of their students, I began to study suicide.

Serendipity. Among the teaching resources I learned about and used that first semester were training tapes that had been developed by the Center for Studies of Suicide Prevention (CSSP) at the National Institute of Mental Health (NIMH). Registered in our course that first semester was an undergraduate who was the son of one Berkley C. Hathorne, D. Th., M.P.H. At the time, Dr. Hathorne was the Coordinator of Education and Training at the CSSP. Dr. Hathorne had been hired by Edwin S. Shneidman, Ph.D., the initial chief of the CSSP. Dr. Shneidman was the author, it seemed to me at the time, of just about every article, book, and book chapter I had been reading and had subsequently assigned to my students as course readings. Having heard from his son about our course and crisis service, Dr. Hathorne called one day and asked if I would be interested in presenting on our program as part of a panel on “standards for suicide prevention centers” at a conference of the American Association of Suicidology (AAS) soon to be meeting in Washington. Two months’ later, I was standing face-to-face with the likes of Ed Shneidman, Norm Farberow, Bob Litman, and Jerry Motto, founders of American Suicidology. Over time I became a Skinnerian pigeon pecking furiously at the keys of Shneidman’s fertile brain, Litman and Motto’s clinical wisdom and insights, and Farberow’s research acumen. These were the gurus that fostered my identity as a Suicidologist. I became a life-long dues paying member of the AAS that day; and unknowable to me at that time, had been launched along a life-long career path.

I don’t know if anyone chooses to become a Suicidologist. Rather, I suspect –and know this to be true for me – that few fields of endeavor could possibly match Suicidology’s seductiveness. Suicide’s mysteries tug at the researcher’s need to know, at the clinician’s drive to understand, at the interventionist’s desire to have impact. Particularly forty years ago, Suicidology was a small pond to swim in. I was working in a publish-or-perish world, and had a research-based degree, so creating new knowledge had been encoded into my genes. Conducting research of relevance to understanding suicide was both logical and fulfilling, as there was a never-ending stream of questions demanding answers and only a handful of researchers addressing them. Concurrently, as I was seeing patients in psychotherapy, my interests in Suicidology soon brought an increasing referral of patients who presented with a degree of suicide risk; my patients were becoming my teachers. Having to teach about suicide and to train students to work with those suicidal forced me to constantly strive to translate research and clinical experience into teaching moments -- the cellular matter that could evolve into neural structures known as competencies among those taught and trained. These were the tiles that formed the mosaic of my career.

Two roughly coincident events happened circa 1980. First, I had opportunity to spend countless hours at the Los Angeles Suicide Prevention Center (LASPC) pouring through literally hundreds of files of completed psychological autopsy case reports. Procedures for the psychological autopsy had evolved through a contract between the LASPC and the Los
Angeles County Coroner’s Office. Shneidman, Farberow, and Litman had been asked to assist the County Coroner to determine manner of death in cases where insufficient information and/or observation (e.g. where the death was not witnessed) was available or where more behavioral data and analysis was needed. Unique to the LASPC’s procedures was their use of a team of behavioral scientists, which, after hearing the gathered evidence, debated the various scenarios to be considered, such that their final recommendation was the result of a collective opinion. Mirroring what Shneidman has written of his “aha” experience in being led to a vault of suicide notes in the basement of the Coroner’s Office that initiated his career in Suicidology, my reading of these case reports was an eye-opening lens into the lives and the variety of pathways toward death taken by those who had died by suicide. It, also, provided me a great number of archived pro and con viewpoints and hypotheses about what had happened that sharpened my focus and understanding of intentional versus unintentional behaviors.

Second, I received my first request from an attorney asking me to provide expert testimony in a legal case, this one alleging negligence on the part of an employer to be causative of an employee’s suicide. The case involved a railroad engineer whose identity was enmeshed in his work and love for the railroad. One day, he injured his back while on the job through what was alleged now to have been an unsafe working condition – the railroad had a responsibility to maintain a safe working environment. Assuming he had merely wrenched his back, he was given minimal treatment by the company physician and sent home to rest. Weeks went by while his back pain worsened and the railroad medical office maintained their prescription for rest. As weeks turned into months, and his pain did not subside, he grew increasingly despondent, increasingly convinced that he would never again ride his beloved rails. His relative inability to move about and his worsening depression led to greater social withdrawal, lethargy, anhedonia, and despair; it also led to a greater reliance on alcohol as a way to dull his brain. Eight months after his injury, still in considerable physical pain, with a depression exacerbated by acute alcohol intoxication, he sought to end all manner of pain through a bullet to the brain. My opinion, indeed, was that the company’s unsafe working environment was the proximate cause of his suicide – without which his injury would not have happened, his unremitting (and poorly attended to) physical pain would not have been experienced, his depression would not have ensued, his increased and acute use of alcohol would not have occurred, and finally his death would neither have had motivation nor intent formed.

These experiences led me to appreciate and subsequently to champion a belief that the primary unit of study for Suicidology – for the researcher, for the clinician, for the specialist in prevention, for the crisis interventionist -- must and will always be the individual who suffers. This is the raw material of our science. This, for me, is what has turned happenstance and serendipity into a career of purpose.
Chapter 8

A Lifeguard at the Sea of Despair: Reflections on a Professional Career in Suicidology

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I began my professional career, not as a suicidologist, but as an aspiring authority on behavioral medicine – having co-authored one of the first books on biofeedback therapy as a graduate student. After getting my Ph.D. from the University of Southern California, I worked with an early mentor David Rigler (a founder of the field of pediatric psychology), to start one of the first behavioral medicine programs in the world at the Children’s Hospital of Los Angeles, a major teaching hospital of the University of Southern California School of Medicine. At that time, over three decades ago, I assumed that I would happily continue on this trajectory for the remainder of my professional life.

To expect the unexpected shows a thoroughly modern intellect”

Oscar Wilde

I should have heeded this dictum. A little less than three years into my work at the Children’s Hospital, massive budget shortfalls closed down many of the highly respected components of the hospital, including the entire child psychiatry program. I found myself precipitously unemployed, and personally devastated by the abrupt destruction of our wonderful research and training program by the “bean counters” who had run the hospital into the ground fiscally.

My luck has always been the people in my life. Seeing my loss and professional grief, my mentors from my internship at the County of Los Angeles, Department of Mental Health, Sallie McGlothlin, and Donna Satterfield, helped me return to that program, and found me a
new position as a senior clinical and community mental health psychologist - with the bulk of my time spent as a duty officer on the psychiatric emergency team aka “The PET team” - which had been the most enjoyable component of my pre-doctoral training. This would change everything.

During the course of the ensuing years, I saw myriad patients in extremis, with “dangerousness to self” issues predominating. Years later, I would finally understand what two of my other senior colleagues Ed Shneidman and Jerome Motto had written about early on – people most often become suicidal when “they can’t take it anymore” – “it” being their psychological pain. Without yet knowing their seminal work, I came to ask the following question repeatedly. “How bad is it, and how much more of this can you take?” The patients I saw during my stint on the PET team, knew precisely what I meant.

Ironically, from a personal standpoint, I had always subscribed to my favorite author’s observation:

The real reason for not committing suicide is because you always know how swell life gets again after the hell is over”
Ernest Hemingway

The inability of patients to see a future where “the hell would be over” fascinated me intellectually and clinically. It is also crucial to note that Hemingway’s later anguished reversal as to the possibility of a better future was personally an alien notion to me. It drew me to want to understand what I had yet to experience personally. For throughout my own life, there has always been a deep sense of having been “born under a lucky star”--- I had survived a near fatal car crash at age four, and walked away from a fatal train wreck at age 12. Throughout my life many similar episodes would follow including sailing my boat from Hawaii back to the West Coast of the USA and surviving a massive storm at sea, and most recently “ducking the bullet” of dying unexpectedly from congestive heart failure – being part of the lucky third who make essentially a full recovery.

In the years following my work on the PET team, I would be fortunate to cross paths with the biological psychiatrist, Linda Gay Peterson. Linda and I would work together on a grant that sought to find a biological marker for violent suicide attempts, and would also work with our colleague, Brian Blackbourne, the medical examiner of the Commonwealth of Massachusetts, to study the question of method substitution (we had access to all of Brian’s records and the Commonwealth had just passed the most restrictive gun control laws in the USA). While this work was intellectually stimulating and fulfilling, as would be the case for so many who work in the field of suicide research, I also began to appreciate the incredible difficulty of a research career studying a low base rate behavior.

Yet in the late 1980’s, an epiphany occurred while I was having a discussion with my colleague and collaborator, Eric Harris (at the time, the director of professional affairs for the Massachusetts Psychological Association, and a national authority on malpractice in mental health care). Namely, that the incidence and occurrence of seeing suicidal patients was a high base rate event in the practice lives of mental health professionals. Together with my wonderful graduate students, a number of whom have themselves gone on to successful academic and research careers in suicidology, almost two decades ago, we began a series of linked studies that continues to this date, namely, trying empirically to understand the so-called mythical legal creature “the reasonable and prudent practitioner of similar education,
training, and experience”. This allowed us to identify a few core risk factors that cut across age, diagnosis and such. In particular, we found how critical it is for clinicians to make direct queries about the presence of any suicidal ideation, impulses and plans, and the medical seriousness of previous attempts – risk factors that our national surveys found repeatedly were viewed across the board as “critical high” elements in high quality clinical practice. More recently, my colleagues at Palo Alto University, Peter Goldblum and Joyce Chu, and I have begun to expand our research in this area to look at ethnic and sexual minority issues with regard to clinical practice guidelines for working with suicidal patients.

It is also important to note that September 11, 2001 also changed my career trajectory. The past decade has witnessed a dramatic change in the nature and use of terrorism. These changes have brought into stark relief the need for better psychological and social responses to terrorism and man-made disasters. The catastrophic acts of September 11, 2001, and its aftermath, have forced military, medical, and psychological experts to re-evaluate their understanding of mass casualty terrorism. After 9/11, for personal reasons, I again had felt “lucky” as my own son had a few weeks before that tragic day, been on the same American Airlines flight that was subsequently highjacked. I immediately found myself volunteering to work as a consultant for the disaster mental health component of the American Red Cross, and started a wonderful collaborative relationship with the foremost authority on suicide terrorism, Ariel Merari. We continue to explore avenues to understand the mind and behavior of suicide terrorists, and I was also fortunate to have a wonderful editor Joan Bossert at Oxford University Press, who along with a number of senior colleagues at my program helped to develop and publish an important work on the psychology of terrorism.

At age 59, I still see a clear trajectory ahead – continuing my work on standards of care and guidelines for practice; along with trying to fathom the mind of the suicide terrorist. I would also be remiss if I did not admit that it has at times been great fun to be a suicidologist, especially having the chance to collaborate and celebrate life with my fellow “Lotus Eaters”, David Clark, Drew Slaby and Terry Malsberger.

Last, over 33 years as practicing clinical psychologist, in working to prevent the suicides of many seriously ill patients, I have found that clinically I tend to agree with Aaron Beck that hope is a vital life saver. It is the personal feeling that what one wants, what one needs can be attained, and that things will in the end turn out for the best. It is the anodyne to despair. There is a dark New Yorker cartoon, with the first panel, showing a picture of a desolate wintry beach in New Jersey, with the signage “Sea of Despair”, the subsequent panel shows the other part of the billboard “No LifeGuards on Duty”. That is who we are, and it has been a challenge and privilege to focus my professional life on this topic.

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Chapter 9

HOW I CAME TO REALIZE I’M A SUICIDOLOGIST

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I didn’t choose suicidology. Suicidology chose me. It just took me awhile to realize that life experience had prepared me for this peculiar distinction.

As a newspaper reporter right after college, I covered the police beat. I became fascinated by a missing-person’s report of a young woman who had disappeared after a fight with her husband. The police refused to launch a search, contending that spouses take off all the time during marital spats. Friends and family didn’t buy this explanation. A vial of sedative used to put down horses was missing from the veterinary office where Carol worked, and as the days went by, they grew increasingly convinced that she had committed suicide. They coordinated their own effort to find her, and a week later, just a half-mile from her workplace, located the car containing Carol’s body, a needle still in her arm. She had pulled the vehicle just off the highway into a copse of trees where it was hidden in plain sight beneath a drift of fallen autumn leaves.

Yvonne was our neighbor in the kind of cheap apartment building that attracts students and pensioners. My wife was a medical student. I was a pre-med. We knew the day would come when Yvonne would no longer be able to afford her life, at least as she had defined it. A double-divorcee, she had eked out a living for many years as a small-time model for television and print advertisements. But she was aging, and her heart was bad. For years, she told us, she had kept a bottle of prescription cardiac medications secreted in her apartment, “just in case”. She wasn’t depressed. She was vain. Her daily costume was always a variation on a cleavage-baring dress and high heels. After undergoing surgery that left her with a scar from mid-chest to sternal notch, she had nothing to wear that didn’t expose her shame. Without the money to afford a new wardrobe, she perceived no reason to go on with life – at least not a life she thought worth living. She took her cat to the veterinarian’s, swallowed her stash, and laid herself out on her bed like a stone queen on a sarcophagus. The cleaning lady she couldn’t afford found her corpse.

My medical school class was small – only 60 students. An immigrant from the former Soviet Union, my classmate Sergei was brilliant, charismatic, and deeply troubled. I didn’t appreciate the depths of his despair until the wintry day he hanged himself in his apartment.
Even though I didn’t know him well, I was absolutely convinced that I had to attend his funeral. I hitched a ride with his good friends, and we joined the throng of mourners for a shatteringly traditional shtetl burial. Amid spitting snow, we threw gravelly dirt onto Sergei’s casket, shovelful by clanging shovelful. Overcome by nauseating grief, I suddenly realized that I didn’t belong at this particular graveside. To my horror, however, I could explain to myself neither why I shouldn’t be there nor why I had felt compelled to participate in these rites. Surrounded by fellow mourners, I felt utterly alone.

Only weeks into my second year of psychiatry residency, I experienced my first suicide as a licensed physician. I had been assigned as pharmacology backup for a psychologist colleague who was therapist for a recent Harvard graduate, a woman given to passion-infused, tumultuous love relationships that invariably ended badly. SSRIs were new drugs in the late 1980s, and she was still taking desipramine, a gold-standard tricyclic antidepressant. I had seen her only once for a quick appointment to renew the prescription that appeared to take the dramatic edge off her distress at her latest sundered relationship. Days later, she overdosed at midday in her bedroom in the Cambridge apartment she shared with several roommates lunching nearby in the living room, oblivious to her death throes. For months, whenever I thought of my patient, I saw in my mind’s eye a huge script, written in my hand, for the desipramine that had killed her. It was my extreme good fortune that Terry Maltzberger was my psychotherapy supervisor. No one could have been more superbly equipped to help me process this devastating event.

As a junior attending, I supervised a resident on the case of a schizophrenic woman in her early 20s, mother of a little boy, living with her parents. Maria came to a followup appointment with the resident with her usual complaints that the neuroleptic was making her mouth dry and dulling her thinking. She denied hallucinations or depression. She didn’t appear any more delusional than usual. On her way home, while parking her car, it locked fenders with the one behind it. She freaked. She rushed into the house, grabbed her father’s loaded pistol, and blasted herself in the head. I could give my trainee no easy explanation to explain Maria’s impulsive, self-annihilating act.

A couple of years later, my good friend Tom asked me to see his secretary’s husband, a retired Air Force sergeant who had basically done nothing for the past 15 years since retirement except sit at home and drink himself into a daily stupor. Ken had spinal stenosis and excruciating back pain. He had been badly traumatized as a pre-teen, when, left by his mother with two younger half-siblings, they were abducted by their father, not to be seen again until they were adults. His mother blamed him, and he believed her. For 40 years, Ken perpetuated the self-torture. Antidepressants did nothing to make him feel better. Neither did individual or group therapy. He longed for the release of death, but told me he would never commit suicide because he would have to shoot himself in the head to make certain he did the deed irrevocably, and he couldn’t bear the thought of injuring his beautiful face. He kept his appointments with me only intermittently. He let me know they didn’t help either. One day his wife came home and found him in his recliner, seemingly asleep, a trickle of blood oozing from a nostril, a wide-barreled shotgun at his side. Ken had managed to find a way to kill himself and preserve his face. He never looked as good while I knew him as he did at his wake, unblemished visage artfully arranged in perfect repose.

My oldest friend, a man with whom I had attended nursery school in England, where our fathers had been stationed in the military, told me in a Christmas card that his father, now in his 80s, had been diagnosed with pancreatic cancer and wasn’t expected to live much longer.
A few months later, I received the e-mail informing me that the father had died but not of cancer. He had shot himself in the garden of his home before he became too ill to carry out the act. My friend told me later that his father’s suicide was as it had to be. Fiercely independent all his life, he had been bound and determined that he, not a doctor, not nature, not God, would determine the hour of his death. And so he did.

A staff psychiatrist in an Air Force hospital, I spent the first six years of my career chipping away at one of my early publications, a meta-analysis that has since been cited more than 250 times. I set out to prove that the lifetime prevalence of suicide in depressed patients was not 15 percent, a figure that seemed preposterous to me but one that most psychiatry textbooks reported unquestioningly. After my infant twins were asleep for the night, I would labor at the kitchen table, chipping away at more than 500 papers to cull them down to only 29 that met my rigorous inclusion criteria. I was able to show that while lifetime suicide prevalence was indeed much lower than 15 percent in affectively ill patients, it was comparatively high in those hospitalized with suicidal ideation or after suicide attempts. Amidst all this effort, my wife asked me if I planned an academic career or if this endless reviewing of suicide articles was some kind of weird hobby to be pursued at the end of the day after a full schedule of patients. I took the question under advisement, but when I finally finished the magnum opus and it was accepted to a major journal, essentially without revisions, I finally recognized— at least consciously— that I was a suicidologist.

I can’t say for sure that the social networks in which I live and work have sustained a disproportionate number of suicides. I do know that since my teens, I have been sensitized to take particular notice when suicides do occur. Have I neglected to mention that my brother killed himself? Dougie was barely 14, I 16, when he hanged himself one September afternoon in the basement of our house. He had been acting out for years, depressed, doing drugs, skipping school. Precociously disturbed and self-destructive, he was increasingly undone by the disintegration of our parents’ marriage. Amid his death rites, numb and eldest-son responsible, I organized my family, helped plan the funeral, and only a few days afterwards, reported— dry-eyed— for my first college interview at Harvard. I couldn’t cry then, still haven’t, and likely never will.

How can you tell the researcher from the research? I have finally put the pieces together— why I was fascinated by the missing Carol, why I’d taken Sergei’s death hard enough to go to his funeral when I barely knew him, why I’d studied those 500 papers so fervently, how Dougie’s suicide continues to resonate through all my days. At the moment my brother took his life, unbeknownst to me then, I became a suicidologist.

The names of the dead have been changed to disguise their identities.

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Chapter 10

THEREFORE, CHOOSE LIFE!

David Brent

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I would like to describe five sentinel events that influenced my decision to pursue the study of adolescent suicide.

When I entered child psychiatric residency in 1978, I was interested in clinical practice. One event changed that—the sudden death of one of my brothers, who died of a cardiac arrhythmia while playing basketball at the age of 26. My brother was a jazz musician and composer, definitely following his own path rather than the family mold. In the last face-to-face conversation I had with him, I asked him, “Who are you listening to these days?” His brief reply was, “Me.” In typical big-brotherly fashion, I asked him, “Don’t you think you have anything to learn from the jazz greats?” The answer he gave me transformed my life forever: “You don’t understand. The music I want to hear hasn’t been written yet. And I am going to write it.” Aside from being stunned, I also felt ashamed. While I was pursuing endless training and education, my brother had actually figured out a clear direction in life. I was very disappointed with the lack of rigor in child psychiatry after having trained in pediatrics, and thought, “Well, the child psychiatry I would like to read hasn’t been written yet either. Maybe I should write some of it.” Two months later, I got word of his death, and resolved that I would try to make a difference in my chosen field.

But in what topic, and how? I remember going to one of my mentors, Dr. Marika Kovacs, for advice about some of my research ideas. She said, “You are like a kid in a candy store. You want to eat a little of this and a little of that, and all that is going to happen is that you are going to get sick and throw up.” Marika then added, “Obtaining clarity is painful.” I realized that choosing an idea was like grieving, because the reason why we focus on something is because we only have a limited time on this planet. Admitting that we will never get to something that we might really want to do is painful, and many people avoid that pain by refusing to focus.

Around that time, I was assigned to a pediatric inpatient unit as a consultation-liaison psychiatrist. One of my main tasks was to determine which suicide attempters were safe to go
home, and which ones had to go to a psychiatric hospital. One day, I had to make two such determinations. I decided that one patient could go home, whereas the other patient needed to go to a psychiatric hospital for an inpatient stay. The father of the second patient said he had been watching both his daughter and the other patient and didn’t see a lot of difference between the two of them. What had I seen that caused me to make my decision? I was unable to give an articulate response. Later that day, I went to the library and was shocked to discover there was very little written about the assessment of suicidal risk in adolescents, and what was written was only infrequently backed up by any data.

Now I had a focus. With help from Dr. David Shaffer, I designed a psychological autopsy study, one of the first to be done in adolescent suicide. For this study, I personally conducted many of the interviews with the family members, friends, and siblings of adolescent suicide victims. One of my first interviews was with the family of a boy who had made a serious suicide attempt, and had lost his brother to suicide. In taking a family history, it emerged that his father, paternal uncle, and grandfather had all died of “accidental carbon monoxide poisoning.” In other words, this family was loaded with suicide. I wondered what could possibly account for so many suicides in one family. Was it imitation? Was this familial aggregation of suicide due to grief and loss? Or could it be something that was genetic? This led me to design studies to address each of these questions.

To examine the question of imitation, we studied the social networks of adolescent suicide victims: siblings, friends, and acquaintances. We found no evidence of imitation, although the survivors, especially those close to the victim, frequently had depression and PTSD. In fact, by witnessing what a suicide could do to a social network, these youth actually were inhibited from engaging in suicidal behavior.

To study the role of loss and grief, we looked within the exposure study to see if high levels of grief or depression in the peer survivors of adolescent suicide led to suicidal behavior. We found no relationship, although those with higher levels of grief did have higher levels of suicidal ideation. We also designed a second, now ongoing study to examine youth who lost parent to either suicide, accidental, or sudden natural death. Consistent with our study of suicide in adolescent social networks, we have not observed imitation in parentally-bereaved youth who lost a parent to suicide. In fact, the impact of bereavement due to parental loss seems similar regardless of cause of death. However, youth whose parents died by suicide or accidents were at higher risk for difficulties even before the loss, and hence had higher rates of depression.

To study the possible genetic component of suicidal behavior, we conducted two family studies. The first, “bottom-up” study, assessed at the relatives of adolescent suicide completers and compared them to the relatives of adolescent community controls. We found a higher rate of suicidal behavior in the relatives of the suicide victims, even after adjusting for the increased rate of psychiatric disorder found in these relatives. In the second, top-down study, done in collaboration with Dr. John Mann and colleagues, we found that the offspring of mood disordered suicide attempters had higher rates of attempted suicide, even though the rates of mood disorder were similar in the two offspring groups. Currently, in collaboration with Drs. Alan Apter, Muhammad al-Heib, Sami Hamdan, and Nadine Melhem, we are conducting a genetic study of suicidal behavior in a large extended endogamous family.

Another case from this psychological autopsy series was starkly instructive about the importance of availability of guns, the role of intoxication, and the fine line between outer and inner-directed aggression in suicidal behavior. A young man came home intoxicated, took a
Therefore, Choose Life!

gun and pointed it at his mother, slowly re-oriented the gun, and then shot himself. This made us aware of the role of the availability of guns to suicide risk, at least in the United States, and also how guns and alcohol use interact in a lethal way. This case also illustrated the role of impulsive aggression in early-onset suicidal behavior. Subsequently, we found that this characteristic explained at least part of the familial transmission of suicidal behavior.

A third case was a girl who had confided to a friend that she intended to commit suicide about a week before her death. The friend was sworn to secrecy, and did not tell anyone until after the death. This case taught me that even the most suicidal individuals have both a wish to live and a wish to die. This young suicide victim, by telling someone about her suicidal plan, was asking for help. My boss, Dr. Kim Puig-Antich ordered me to open a clinic for suicidal teens, but it turned out to be a really good idea. Our conversation went something like this:

- Kim: You need to start a clinic for suicidal teens.
- Me: But I don’t know anything about how to treat them.
- Kim: Good, you’ll learn.
- Me: But no one knows anything about this!
- Kim: Great, then no one can criticize you. Now go out and save some lives!

Despite my objections, starting this program was a good idea. This program, Services for Teens at Risk, was founded in 1987 and is co-led by two colleagues with whom I have been privileged to work with for nearly 25 years. Dr. Mary Margaret Kerr directs prevention and education programs for schools, and Kim Poling directs the clinic. This clinical program became a laboratory for developing and testing new interventions for adolescent depression and suicidal behavior.

In the future, we are hopeful that our family genetic studies can help to identify intermediate phenotypes for suicidal behavior and map genes to those traits. We, in collaboration with Drs. Mary Phillips, Neal Ryan, Greg Siegle, Jennifer Silk and Lisa Pan, are trying to identify biosignatures for suicidal risk and for depression in youth. We hope to use those biomarkers to improve our assessment of suicidal risk, predict and monitor treatment response, and ultimately to develop novel treatments that target altered brain regulatory processes.

I am grateful to my teachers, colleagues, and students, but am most grateful to my patients, who have taught me a deeper understanding of this Biblical passage: “There is set before you the choice between death and life …Therefore, choose life ...”

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Chapter 11

PERSONAL EXPERIENCES WITH THE PROFESSION OF A SUICIDOLOGIST

Thomas Bronisch

HOW I BECAME A SUICIDOLOGIST

Very early in my professional career I was confronted with the suicide of one of my patients. It was in the first year of my training in psychiatry at a general psychiatric hospital. I took care of a 35 year old patient who had ingested a high dosage of potentially toxic drugs. The reason for that was the final decision of his spouse getting divorced. In the months before, he did not work anymore, living with the hope that his wife who has already left the common apartment would come back again. A conversation initiated by me and accepted by all between the couple and me as a mediator lead to an – apparently renewed – emotional dispute. Reproaches and accusations were exchanged. The spouse of my patient – emotionally very engaged – asserted that a return of herself would only lead to a renewed escalation without a chance of emotional reapproach and a – better – understanding of each other. The patient himself felt rejected and could not accept the decision of his wife. I was very moved by the thrust of the emotional dispute.

After this dispute, the patient kept insisting to get discharged from the ward. I was convinced that the patient was in great danger despite of his reassurance not attempting suicide. I asked my supervisor and senior psychiatrist for clarifying the risk for suicide of the patient. During that exploration it came to an emotional outbreak between the senior supervisor and the patient, whereby the senior supervisor refused giving the patient the possibility to leave the clinic. The patient was transferred to a closed ward and finally discharged after several weeks.

Two months later, the mother of this patient was admitted to my ward because of treatment of a depressive episode. She reported that her son did not show up during the last four weeks and she was in sorrow that he might have committed suicide. Several days later

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she got the message that her son was found dead and apparently had committed suicide by shooting himself in the head. The mother asked me to allow her to join the funeral; she promised not making a suicide attempt. I indulged her wish and she kept her promise. I was very shocked by the suicide of my patient despite the fact that I had expected such an outcome. Therefore I asked for advice and solace of my colleagues.

This first patient whom I lost - and some others followed and will follow – is still in my mind. First the emotional shock after the message of suicide: The helplessness of not having been able to help this patient, the suffering of the relatives and finally the fear for a further suicide namely the suicide of his mother. At that time there was not yet the fear for the prosecutor with an indictment because of not taking correctly measures for the protection of the patient.

All these fears and sorrows could not prevent me in proceeding and in finishing my training as psychiatrist and psychotherapist. Instead I established together with my chief and mentor, Prof. Feuerlein, a crisis intervention unit at the Clinic of the Max-Planck-Institute of Psychiatry in Munich with the consequence of becoming a specialist in suicide issues – a suicidologist. I did not loose my fears and sorrows, each new suicide of a patient of my junior psychiatrists or of my own patient affects me still considerably. However, I love the challenge with my patients and this special branch in psychiatry combines my psychiatric and psychotherapeutic interests. Even more, it comprises different kinds of natural sciences as well as art and literature and so coincides with a lot of hobbies of mine.

**MY OWN EXPERIENCES**

Suicide ideas joint me throughout my younger life. I never made a suicide attempt, however in several stages of my life, suicidal ideas popped briefly into my mind such as during puberty because of desperation about my low self-esteem or in later life because of separation issues. Ambitiousness, workaholic phases and hope for better times helped me to overcome the depressive states with occasional suicidal ideas.

Because of my own experiences I had no problems in understanding my patients even if they considered or made appellative suicide attempts. However, I am a fierce defendant that in the most cases suicide is an impulsive act. That gives me the task and obligation to try to prevent my patients for attempting suicide. On the other hand I do leave the decision for or against suicide on the long run up to my patients. I can wave the patient’s general rights about to terminate their life only in an acute situation when the patients are restricted in their ability to freely decide.

During my career as a psychiatrist I suffered most from the suicide of two befriended colleagues of mine after their spouses decided to get divorced. I did not recognize that both colleagues were in great danger and was surprised by their suicides. Our personal contact probably prevented me from realizing in what danger they were to commit suicide.
Death in Venice

The congress of the International Association for Suicide Prevention (IASP) took place in Venice in the middle of the nineties. At that time I was already a member of IASP for several years. When I told my friends and colleagues from other medical disciplines about this congress a smirk hurried over their faces: “a morbid business in a morbid town” alluding to the novel of Thomas Mann and the transfer into a movie by Luchino Visconti – so they thought.

I believe that for many people the interest in psychiatry and especially in suicide is an expression of a certain kind of morbidity or seriousness considering the own personality. Maybe not by chance, my second name is Ernst (in German “serious”), the first name of the beloved brother of my father. Not rarely that have I been described as “serious”. However, for those who know me better and have seen me in daily life realizes that despite my occasional tendency to morbidity and gloominess I have a strong tendency to serenity and love of life.

I always experienced the community of suicidologists as a funny “family-group”. It consists of maybe 100 and more colleagues around the world meeting with each other once a year. I remember very funny evenings not being abstinent from alcohol – just in comparison to other psychiatric congresses with other topics. Morbid, gloomy and overly serious colleagues do exist of course, however they are in my opinion a minority. Maybe, the handling of such heavy and morbid stuff enables us to enjoy the “unbearable lightness of being”. Fact is that in our community you can find a lot of care and warmth which justifies the expression “family-group”. The familiar company with each other enables us to relax when we celebrate our meetings. Maybe, we need such a “family-group” in order to endure the personal contact with our patients and their suffering and desperation.
“Suicidologist” has never fit comfortably on my shoulders. Perhaps I’d like to think that I am not so easily defined. More likely, it is that I began asking questions more than four decades ago when faced with my own distressed uncertainty and ignorance after being confronted by events beyond my understanding. I never thought of my searching efforts in any career sense, and by the time that I might have reasonably entertained the name as an identifier, there were other competing candidates for such a label. But to my view, it really matters little what we are called. For me this always has been about the unexplained and the unexplainable.

Thinking about suicide was a thunderclap brought on by working at a place named “Sage Hospital,” the old infirmary of Cornell University that was, in fact, a certified working hospital. I was one of two residing student helpers – phlebotomist, collector and analyzer of weekend fecal samples, ambulance driver, and relief switchboard operator. The job provided me for three years with an apartment, endless food and ice cream from the hospital kitchen, starched laundry service, and minimum wage when working – not bad when needing to contribute to the cost of one’s education. What I hadn’t expected, or bargained for, was learning about the students who jumped to their deaths, or the ones who lived and were hospitalized in the separate room on the ward floor.

No doubt, I had heard of “gorging out” during freshman orientation in 1965. Beginning a year later I was confronted with the facts of undergraduate and graduate students who died by jumping or other means. Put succinctly, their deaths were beyond my understanding. Despite all of my own life experiences, and knowing the burdens of others, suicide never seemed a personal option – not a thought for consideration. What was it about the lives of my peers? How could I understand what was beyond my experience or my sensibilities?

Entering medical school in 1969, I never intended to pursue psychiatry. My choice for a ‘career discipline’ two years later reflected my intuition that I, as an emerging clinician, could make a difference in the lives of people that I encountered; and a sense of wonder at the time that the field was in ferment, where no single perspective could entirely explain emotional distress, mental disorders, or resilient health, nor could one perspective provide the foundation for prevention or therapeutic change. My interest in suicide remained, trying to understand the decision and the act itself, and more important to my view, the life story before. These interests were reinforced by Avery Weisman, who encouraged me during my
last year of medical school to look beyond what people said and examine what they did (or might do). As well, I had pursued training in public health – starting in university and continuing in medical school – and found myself trying to integrate a view of suicide as an individual act and a view of suicide as a public health challenge. Those views didn’t mesh well in the early 1970s. Indeed, my “solution” to the insoluble was to avoid making the mix.

Even as I turned my developing research interests to neuropsychiatry and geriatric psychiatry – particularly, Huntington’s disease, Tourette syndrome, Alzheimer’s disease, and the neuropsychology of later-life depression – my clinical experience with suicidal behavior and suicide grew. I worked primarily as an acute care psychiatrist on inpatient units for nearly a decade. I lost two patients to death by their own actions, a 54 year-old man with end-stage aortic disease and more than three decades of severe, persisting depression, and a 37 year-old woman suffering a mixed affective state with paranoia, grandiosity, and recurring depression, where she believed fervently that she was destined to be the bride of Jesus Christ. No amount of ‘clinical interposition’ sufficed. Once again I was confronted with my own limits of understanding and action.

During the 1980s, I clarified my favorite role as an educator, specifically, working with post-doctoral fellows and junior faculty as a mentor, viewing the time after residency training or receipt of a Ph.D. as a critical period in the life of a would-be academic. Mentoring, well done, requires one to step outside himself to consider the needs and opportunities of another. My greatest personal rewards in medicine, aside from those related to direct patient care, have come from supporting this developmental process and seeing several generations of faculty and scholars emerge in their own right as outstanding researchers, educators, and clinicians. And it has offered me a venue for learning and growth, one that has been built upon collaborative efforts that reach far beyond my own. I never would have taken up the threads of my interest and ignorance about suicide, and about the life story that comes before, had I not had the opportunity to work with Yeates Conwell, first as mentor and then as a colleague of many years. Over time, of course, Yeates grew ‘much taller’ than me in his field.

Our work first focused on descriptive psychopathology using the psychological autopsy method – productive but limited in its scope. We needed complementary perspectives. Paul Duberstein joined as a fellow with burgeoning skills as a personality researcher. He grew taller too. Others have followed and are moving forward – Kenneth Conner (alcohol, violence, and suicide) and Kerry Knox (public health approaches, work with the USAF and the Veterans Administration), and now Glenn Currier (emergency psychiatry settings), Catherine (Kate) Cerulli (intimate partner violence and suicidal behaviors), Peter Wyman (school based prevention efforts), Juan Pena (screening, suicidal youth), Wendi Cross (gatekeeper training), Vincent Silenzio (social networks, suicidal GLBT youth), and Robert Bossarte (sociological approaches). Others are in the ‘pipeline.’ The threads of our collaborative training efforts have reached to colleagues in Hong Kong (Helen Chiu, Paul Yip), Beijing (Michael Phillips, Huang Yueqin, Yu Xin), Changsha (Xiao Shuiyuan), and Chengdu (Li Tao). Mentees themselves often become mentors; generations multiply far beyond the reach of any individual.

If you are open to the implications of your own research data, it forces change – much as being confronted by one’s clinical experiences highlights limitations and opportunities. Our work in the 1990s underscored that at all ages many who kill themselves neither sought mental health care nor were seen by mental health professionals near the time of their deaths. As I learned more, particularly from the vantage of the Medical Examiner’s Office, it was
evident that my view as clinical psychiatrist was limited to the ‘sample biases’ of my work settings. The population-level perspective of suicide (and attempted suicide) was, at once, inclusive and much broader than what I had come to understand working inside a medical center’s units and clinics.

Where’s this going? Suicide research and prevention gradually became the focus for my mentoring and my scholarly work during the past 22 years. This is an area where it has been possible to integrate biological, psychopathological, social, cultural, and public health perspectives. Reducing the mortality and morbidity of suicide across the course of life has become for me the entry key to the nascent field of “public health and preventive psychiatry.” Now I strive to weave together a developmental understanding of the antecedents of suicide within a more inclusive ecological frame. I have no doubt that I will continue to confront the limitations of my understanding during the years ahead – plenty of fuel for future work.
Chapter 13

REFLECTIONS ON SUICIDOLOGY

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That suicide is a product of multiple factors is well recognized. These include psychiatric illnesses, genetics, personality vulnerabilities, substance abuse, interpersonal and other stressors. There are so many risk factors that one might ask why don’t more people suicide? The answer lies with inhibitory factors such as social support. Over time I have become increasingly impressed by the importance of inhibitory factors such as Linehan and colleagues’ (1983) “Reasons for Living”. These include survival and coping beliefs (e.g. “I know things will get better”), responsibility to family, child-related concerns, fear of suicide, fear of social disapproval and moral objections. I suspect we suicide researchers have failed to give reasons for living anywhere near the priority that they deserve.

Suicide rarely occurs in a vacuum; there are usually others involved. They may contribute to the suicide by their roles in family problems, especially family hostility. They also may contribute by being detached bystanders, by way of their relative lack of support.

Much suicide research has used hospital treated patients for examining causal factors. Unfortunately there is an inherent bias in this approach. An illusion is created that the link between the relevant psychiatric illness and suicide is more direct than it is. These days it is difficult to gain admission to a hospital unless you are suicidal or homicidal – with of course some exceptions, but you get my point. Most depressed patients outside of hospital settings do have gloomy thoughts of death but when probing questions regarding suicide are presented they often respond, “I couldn’t do that to my family.” This suggests healthy attachments and/or social support. However, those that have good supports today may not tomorrow – life can be harsh. The psychiatric illness generates vulnerability but it is the contextual situation that determines the outcome with respect “to be or not to be.” There is one other crucial factor, that of choice, which is determined by a myriad of factors and adds a further dimension.

We have tended to approach suicide prevention from a clinical perspective. We the therapists look at individuals (occasionally families!) and try to figure out what is wrong with

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them. My research focus of recent years has been away from suicide in the realm of examining the relevance of animal defenses to psychopathology, particularly posttraumatic stress disorder (Cantor, 2009). Contrary to traditions regarding “fight or flight” there are 6 key mammalian defenses that are employed in a very predictable manner according to contextual determinants. In fact much of the defence selection is determined simply by one variable – the distance from the source of threat. Beyond that defenses are employed in a predictable and largely mathematically determined manner.

Suicide clearly is not a defensive behaviour. However, it can be viewed it as an offensive behaviour – an assault upon oneself. Might the contextual determinants be similarly as important as they are for defense? With defense responses are mathematically calculated even by animals with no ability to think, such as insects. For example, what is the cost of flight from say a relatively low risk situation compared with the cost of the loss of a feeding or mating opportunity? In modern life this can be made tangible by the following analogy. There is a terrorist alert in the vicinity of your workplace. Do you go to work or do you stay home and possibly lose income? If the risk is very low of course you go. If it is very high you don’t. Somewhere in between that has a percentage probability attached to it you calculate a boundary where the loss of income is justified by the survival advantage of staying home. Of course it is more complicated than this but that simply makes the maths more complicated – and more subject to errors.

With defense there are vulnerable individuals, say mice at risk from cats. Even the cat may be at risk from dogs, which are certainly at risk from cars, etc. In the wild even the lion, the king of the jungle, is making defensive decisions every day of its life. Hence, there are individual issues that need to be considered. From the consulting room perspective surely a mouse is much more at risk than a lion? In reality this is unlikely to be so clear cut. They both exist in different contexts. It is only when their contextual situations are understood that the risks can be accurately assessed. Risks need to be assessed both qualitatively and quantitatively. A flood may be dangerous, but a large flash flood is more dangerous that a smaller flood or one that provides time for escape.

With humans and suicide virtually all the risk factors currently known to conventional suicidology are likely to be highly relevant. However, we know that our ability to predict suicide is minimal and even our ability to perform the more correct risk-assessment is disappointingly imprecise. Skilled clinicians may be able to accurately classify individuals at low, medium and high risk but mostly even the high risk ones will not die by suicide (particularly in the short term, the usual clinical priority). It is my view that this imprecision results in large part from our neglect of contextual research and contextual clinical assessment.

Early in my career I was strongly influenced by the work of Ken Adam who did inspirational work with families and suicide. I recall a number of times as a junior registrar having to get out of bed in the middle of night to assess not only the individual in the emergency department but also his/her family. Yes, I was required to call them in there and then – everyone who lived with the patient, including babies. It was considered that the suicide risk and the required treatment approaches could not be assessed without consideration of the family context/dynamics. Ken’s admirable research shed much light on attachment issues, but no one researcher can address the whole contextual picture and much remains unanswered. Also attachment often (but not always) relates more to long term issues,
yet suicide is precipitated by short term factors. There are different but interacting dimensions to be considered.

Some might suggest that we have so little control over contextual factors that it is unrealistic to hope control them. This is often the position taken by those afraid to look. The tiny mouse that seems so vulnerable may be much safer in its burrow than the much stronger cat straying across the road. If we had clearer understandings of the contexts (family, work, social subculture, etc.) in which our vulnerable patients were operating I suspect we would be much better able to reduce risk. With defense it is not just one aspect of the magnitude of the threat that points to the outcome, it is the whole dynamic context. A mouse may be being hunted by a very hungry cat, but if it is deep in its burrow it is completely safe. If it can hear the approach of a pack of dogs it can even quietly chuckle. Risks to vulnerable individuals are fluid and change.

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Chapter 14

SUICIDOLOGY: IF NEITHER A SCIENCE NOR A DISCIPLINE, THEN WHAT?

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As a geriatric psychiatrist, researcher, and educator whose career has focused on the study and prevention of suicide in older adults, I have long been an active member of the American Association of Suicidology (AAS) and the International Association of Suicidology (IASP) as well. In fact, I do not believe that I have missed an AAS meeting in over 20 years. I feel pride in the contributions that my colleagues and I have made to the understanding of late life suicide, and still define nurturing this corner of the suicide prevention field as my academic mission. Yet I squirm at the notion of being labeled a “suicidologist.” It is an uncomfortable fit. Why?

I think it is because the study of suicide and its prevention (“suicidology”) is such an enormously complex and important task that reducing it to “another ‘-ology’” seems trivial. To call me a suicidologist suggests that I fall into some definable category. In my academic world one is defined by the science one “does” and the disciplinary perspective from which one does it. However, suicidology is neither a science nor a discipline. Rather it is an expansive field of study that draws on an extraordinary array of intellectual disciplines and traditions, knowledge and skill sets, methodologies and epistemologies. Genetics, psychopathology, sociology and psychopharmacology, anthropology and theology, epidemiology and philosophy only scratch the surface. As a field, suicidology is more like the great savanna of central Africa than it is the delimited and even manicured green of a football stadium. It is many sciences, many disciplines, and many diverse perspectives dedicated (often in relative isolation each from the other, even as they collide on occasion) to addressing one of the most pressing public health problems of our time.

It is likely that “suicidology” would not exist were it not for the few organizations dedicated to coalescing its disparate elements at regular intervals and in specific places, facilitating the interactions that give some definition, albeit a blurry one, to our collective mission. Convocations such as the annual meeting of the AAS or regional and world

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congresses of IASP serve the purpose, as do their respective journals – Suicide and Life Threatening Behavior and Crisis. Many other examples could be offered of course; here in North America the American Foundation for Suicide Prevention and the Canadian Association for Suicide Prevention are prominent. Each continent has its organizations that focus our efforts by providing a forum for dedicated people to present their work, learn from the work of others, reinvigorate our commitments to the cause of suicide prevention, and develop and nurture the interpersonal networks that help sustain us when at the close of the meeting we go our separate ways.

And go our separate ways we must. It is in that fact that the problem, but also the promise, of suicide prevention research lies.

No person can or should attempt to be master of all aspects of suicidology (for lack of a better term): it is too broad a field; spreading oneself so thin would preclude the depth of knowledge and understanding necessary to make substantive contributions. We all bring to the field our own views, knowledge, skills and experiences that reflect the parochialism of our disciplines. They must. I am a psychiatrist with special interest in late-life mental illness and social contexts of care. My research is psychopathology and health services delivery in social service and other community settings. I apply those knowledge and skill sets because I believe they are relevant to the prevention of suicide in older adults. But that label “suicidologist” is limiting for me because it does not come with a particular toolbox; it does not rely on a delineated set of scientific methods or represent a specific discipline. It is not one thing, but rather derives unique meaning for me based on the other “outside” influences that have shaped me as a scientist.

This particular characteristic of suicidology creates its share of problems for the field. If one does not engage the study of suicide from a position of deep and focused expertise in one or more of the related disciplines, I believe one’s impact will be limited. Therefore, in order to be a productive suicide researcher, one needs to depart from that suicidology meeting and go to an altogether different meeting specific to one’s discipline at another time and place to interact, contribute, and learn from others who in all likelihood are not engaged in the study of suicide per se. That is, we must regularly move in from the wild savannah to the football stadium, shifting cognitive (and sometimes even behavioral) sets and reorienting ourselves for a different kind of work.

Our professional meetings tend to be organized by discipline (my chief guild is the American Association for Geriatric Psychiatry), or by the methodologies or interventions we use (e.g., meetings dedicated to psychopharmacology, cognitive therapy, prevention science, or imaging techniques.) At that meeting we dig deeper into our focused (and more “limited” in some sense) areas of expertise, taking away new knowledge and skills that we hope will apply to the study of suicide prevention in innovative and significant ways. We then cycle back to the suicidology world at another time and place to refuel our engines and to re-establish where in the more expansive field our science “sits”.

There are other related challenges. Even though the field of suicidology is so broad, and even though we must approach it in my view from a position of deep and specific disciplinary expertise, suicide prevention research requires special knowledge and skills that are not inherent to other scientific disciplines. How can I measure suicidal ideation and behavior in a valid and reliable fashion? How do I go about obtaining and appropriately interpreting information obtained from survivors about the suicides of their loved ones? And how should I ethically manage the risks associated with the study of suicidal subjects, for example? I do not
believe that the knowledge and skills necessary to answer such questions constitute a specific science. They are simply tools we use. We must learn these skills from others, typically at a suicidology meeting and by reading its literature. But it is a small and intellectually diverse group that has had the support and opportunity to gain this combination of skills, and the opportunities to share them are necessarily limited. When we leave the suicidology meeting, very few of us will return to home institutions where there is a “critical mass” of scholars dedicated to suicide prevention research. Many scholars who have much to offer suicide studies then become isolated from the field and drawn through their disciplines to study other topics in which a critical mass of investigators does exist locally. Cancer, cardiovascular disease, and Alzheimer disease are examples of public health problems for which broad, multi-disciplinary approaches are necessary and, unlike suicidology, for which may universities coalesce experts to conduct collaborative research in centers of excellence across the country.

Perhaps a better analogy than the savannah is a battlefield on which suicidology serves to rally and organize the troops -- our regimental colors. How we use them will influence our collective success in addressing the public health problem of suicide, and also our individual successes in achieving our career development objectives. As we cycle between the suicidology world and those of our parent disciplines, we must take the best from each and meld them in our creative best. I do not see that solution as a weak compromise; rather I see it as a necessary means to producing the best science. At the same time, we have to be vigilant. We must assure that the balance does not tip too far towards the scientific reductionism that can result from isolation in one’s discipline (“suicide is caused by depression; nothing else warrants serious study!”) An early career investigator is particularly vulnerable, because s/he so often lacks on-site mentorship and role models in their home institutions for applying their discipline-specific expertise to the study of suicide. Suicidology must reach out, draw them in, and nurture their progress without weakening their disciplinary roots. On the other side of the scale, we must be vigilant to avoid diffusion of knowledge, a watering down of expertise and substitution of depth for breadth that could result from attempts to define suicidology as a discipline of its own. It is an uncomfortable balance, but one that our patients, survivors, colleagues and friends remind us ultimately is worthy of the effort.
Chapter 15

SUICIDE, IMITATION AND MODELING IN LITERATURE AND THE OPERA

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Suicide is one of the human possibilities where death can be chosen. The meaning of suicidal behavior encompassing historically affective qualities is that the act symbolizes differences according to culture. In the modeling process of suicide the sociocultural, contextual and individual meanings of suicide are connected. The aim of this article is to search for the sociocultural aspects and social transmission characteristics concerning suicide and for the role of symbolical models and patterns in the culture especially in literature and in operas. Evidence for the model-effect and contagion have been reported in accounts of epidemics or clusters of suicides from ancient times to the 20th century. Among susceptible individuals the mechanisms most often associated with them, are imitation and identification (Gould, 1989).

It is possible to explore the impact of culture, and its attitudes and values by studying the way suicide has been portrayed in a particular art form in different cultures. Literature and opera, like any other art form, reflect contemporary beliefs about interpersonal relationships, conflicts and values. They not only mirror attitudes regarding suicide, but they shape public opinion by influencing the suicidal meaning and they act also as agents for social cultural changes. The present paper offers some insight into the use of suicide, for its effect on other people, the phenomenon of suicide clustering in world literature and opera. In order to obtain sources of data for this study, literary works and operas demonstrating the contagion of suicide and model effects were chosen from several cultures and several eras. Possible examples were selected from impressive works known world-wide from several areas, eras and cultures, from the Greeks, from the Bible throughout the Middle Ages and up to modern literary and operatic works.

In the imitation-identification process, many factors may mediate the emotional response to and cognitive appraisal of suicidal behavior. Similarities and differences of the suicidal models and their imitators were studied with regard to sociodemographic variables (age, sex),
methods and psychological variables (motives and consequences of suicide, emotional closeness to the model, attractivity-dependency). Social learning theory is used in analysis of the data from vicarious experiences which may have a role in the depiction of suicides (Bandura, 1977) especially as they illustrate the processes of modeling and in these literary works.

To understand the model effects from the point of their meaning, the subjective qualities of the suicidal act in the given context were investigated using the Baechler (1985) categories. Baechler has described an elaborate typology of suicide on the basis of meanings (not motives) attached to them (escapist suicide – to escape from an intolerable situation; aggressive suicide – to revenge, to punish or to force somebody by the act; oblative suicide – to sacrifice him/herself; and ludic suicides – a high risk behavior, to challenge fate). To view suicidal behavior as a purposeful, meaningful act designed to solve an existential problem of living gives us a useful framework in understanding the suicidal person’s personality, his private logic as well as the impact of the act and the mechanisms of social transmission.

In addition, the psychodynamic concepts of identification and projective identification are useful to understand suicidal contagion, especially in the occurrence of modeling even when there are no attractive models, sociodemographic or other similarities. In such cases the follower who is characterized by a weak identity can project his best qualities on to the internalized representation of the model and thus identify himself with the other. This happens when the borders of the self are weak beforehand, as are found in borderline, narcissistic or psychotic people.

Using the framework described above allows us to draw some general conclusions. Social learning theory is especially useful in understanding episodes of suicide clustering, suicide epidemic and in the occurrence of altruistic suicides. The latter are essentially suicides that are determined and prescribed by a culture. Examples are found in the works of the following authors: Fukadzava (1982), Santa (1985) (in Japanese and Hungarian villages, the oldest people regularly committed suicide to relieve their poor families); Dostoyevsky (the young girls’ epidemics in "Brothers Karamazov"); Mussorgsky, Berioz (suicide epidemics among the heretics and among the Trojan women; Stevenson (1974)(suicides of gamblers in the suicide club) Th.Mann (1955) (the great friend’s suicides), in some Shakespearian dramas (1981) (Julius Caesar, Antonius and Cleopatra), or in the Japanese short stories of Mishima.

In these descriptions, sociodemographic similarities and traditional methods of suicide are found, along with attractive personalities, providing models and charismatic examples personifying the notion. There are also similarities in the anticipated consequence and meanings concerning the successive suicides. Social learning theory also applies for many examples of Greek and Indian historic suicides. The clustering indicates that people are of similar sexes and ages, and that the motivations for the acts which are carried out in similar ways, imply similar meanings and consequences. (Consider Erigone's example and the Athenian women following her; the suicides of the sirens;the women of Messina from the Greek literature as well as Krishna’s and king Pastu’s wives in the Mahabharata)

In many works, that provide detailed descriptions of suicides, the modeling upon each other seem to be connected more by tight psychological emotional links, or by the process of (projective) identification and by complicated subjective meanings than by the obvious sociocultural similarities. (See for example the story of Iocaste-Antigone-Haimon-Eurydice in the well-known Greek Oidipus- Kreon dramas, and its literary and musical (opera) adaptations. The mother-daughter-fiancé-and his mother committed suicide, by different
methods, having connected by very tight emotional links; the Chrysippus-Hippodamia story, or suicides of Romeo and Juliet etc. illustrate the same). The psychological phenomena occur with special emphasis in both Russian and Scandinavian representations of suicide, namely those by Dostoyevsky, Tolstoy, Ibsen, Strindberg; and in the American novels written by Heller, Miller or Plath. In Dostojevskys novel “Crime and punishment” Svidrigajlov sexually abuses a child who kills herself. Just prior to his own suicide, he dreams repeatedly of this 14 year-old girl who has drowned herself. In novel “The possessed” before his suicide, Stavrogin also is haunted powerfully by dreams of the little girl-suicide shaking her fist at him: "I saw Matrjosa.. with feverish eyes.. I see her that way every day...". Rosmer's words in Ibsen's triangle drama “Rosmersholm” about the suicidal wife, Beata are: "We talk about her every day... she has been still among us". Later the friend, Rebeka, says before her suicidal jump: "go after Beata, Rosmer". Eventually we can see in Rosmer's invited death the identification-motive and the sacrificial and self-punitive meanings of suicide. Tolstoj writes about Anna Karenina: "...suddenly the knocked down man occurred to her mind that day when she met Vronsky at first and had already known what to do, she wanted to fall the first car down..." and " I punish him, I will be delivered from everything."(the revenge-meaning and the connection of love and death motives in her suicide)

It is either the description of fantasies associated with the model (as in the works by Tolstoy "Anna Karenina" and Plath "The Bell Jar"), or the recurrent pre-suicidal dreams which bear a great emotional intensity and refer to the model, (as in the novels by Dostoyevsky "The Possessed" (Stavrogin), "Crime and Punishment" (Svidrigaylov) that act as transmitters. For the models and their imitators in these descriptions, the rules of social learning seem to be valid to a lesser extent. The relationships and the modeling processes are characterized and determined mainly by projective identifications, partly by its intrapsychic form; and partly by hidden subjective meanings.

Direct descriptions of suicidal imitations also appear in Mayakovsky`s poem (1968) commenting after Yesenin’s suicide,"All the imitators were raving.heaps of them point knives at.themselves..." He writes about the subsequent intellectual suicide epidemics, and finds the same suicidal method, motifs and sociodemographic variables among the imitators (see the essay of Trotsky in 1930 about “The suicide of Mayakovskov - To the memory of Yesenin”.

Viewing suicide from the perspective of its sociocultural history allows a more comprehensive understanding of this phenomenon (Alvarez,1971) The mechanism of identification appears to be the most important aspect of suicide contagion and clustering. Generally, the rules of social learning theory were found to be valid. The concepts and the typology of cultural meanings of Baechler are useful in understanding of suicidal process. The mechanism of identification in the suicidal drama could be correctly interpreted by studying the context of common cultural meanings and particular societal attitudes. The psychodynamic concept of projective identification is also useful in our literary analysis to understand how and under what conditions the suicidal models influenced the individuals’ decision to commit suicide. When similarities of people in the process of modeling were not present, the motivation and the subjective meaning of the act seemed to be similar.

The literary and musical presentations of suicide and modeling usually emphasize on of two elements, either the cultural traditions and altruistic motivations, or the contextual and /or individual, psychological aspects. But in the process they generally appear as an integrated whole, and may range from the real individual person to a symbolic one drawn from an idea or tradition. Active reading or listening to the work makes it clear that the response is far
more than a simple reaction to a stimulus, but it is more of an interaction. Our personal and cultural histories, predispositions and needs influence what we perceive, and we tend to identify ourselves with and become actors in the play which has an effect on us. These processes have to be researched of course. However, in a piece of art, somehow it remains both an artistic question and a miracle.

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Chapter 16

THE CRITICAL INNER VOICE THAT DRIVES SUICIDE

Lisa Firestone

When I was studying to receive my Ph.D., the first patient I ever saw was a petite woman in her 30s. At our first session, she walked into the room, her frail frame hunched over, dirty blond hair concealing her face. Within a few minutes, she burst into uncontrollable sobs, quickly confessing that she had once been extremely suicidal (having made six suicide attempts in a single year, three while in a psychiatric hospital) and was now feeling that bad again. It was my first time alone with a patient. I sat there, a scared eight-and-a-half-month-pregnant, 27-year-old graduate student, wondering how I could connect to this woman. Could I help her understand what was driving her severely self-destructive state? Most importantly, could I help her to stay alive?

That moment, coming face to face with a real person in a state of true despair, impacted me deeply. I wanted to learn what was going on in the minds of those who are suicidal, and how to access and treat individuals at risk. She described a “black box” inside her head, in which she locked all her bad thoughts that she refused to disclose. Slowly, we began to open that box, an experience that contributed to my embarking on what has become more than 20 years of investigation and study of the suicidal process.

In 1986, my father, Robert Firestone, who had spent 19 years as a practicing psychologist, wrote his first article on the “inner voice” in suicide. He defined the “voice” as an internal system of destructive thoughts and attitudes, antithetical to the self and cynical toward others, which is accompanied by varying degrees of anger and sadness. It reaches its most dangerous and life-threatening expression in suicidal acting-out behavior. He had interviewed a young woman who had recently made a serious suicide attempt. She described in detail how the “voice” operated in her attempt, causing her pain and anguish, planning the details of her suicide attempt, driving her toward taking action, and baiting her to make the attempt. My father, through his work, became aware of the significance of this concept of the “voice” in suicidal behavior. We worked together to apply this concept to the development of a scale for assessing the risk of self-destructive behavior and suicide. We came to understand that suicidal behavior is not driven by a person’s own point of view, but rather by these internalized voices.
Today, 23 years later, after having completed my dissertation on suicide, treated dozens of patients, read journals of persons who completed suicide, conducted two decades of clinical research, co-authored books, written numerous chapters and journal articles, and co-developed a scale that measures a person’s suicide risk, the Firestone Assessment of Self-Destructive Thoughts (FAST) (R. Firestone & Firestone, 1996/2006), suicide has become a far less mysterious, yet no less frightening focus of my attention. What has fascinated me the most in our discovery is the universal phenomenon of the destructive inner voice as it drives suicidal tendencies, deceptively convincing people that it is better to end their lives than to find an alternate solution to their suffering.

Researchers throughout the world who have interviewed suicide attempters have established strong support for the connection between the concept of the “voice” and suicide (in spite of the fact that this was not the intent of the research). In Richard A. Heckler’s (1994) Waking Up Alive, the author gives real-life, detailed accounts of what has gone on in the minds of many individuals throughout the United States immediately prior to their suicide attempt, a state of mind that Heckler referred to as “a suicidal trance.” Within this trance these people described a strong presence of the brutally self-attacking thought process that Robert Firestone and I refer to as the “voice.” This same pattern was picked up in a comparative study of suicidal potential among Pakistani and American psychiatric patients in 2001, when psychologist and researcher Yasmin Farooqi (2004) found that the FAST held significantly high correlation with suicide attempts. The study led her to infer that “the FAST can be used as a valuable screening instrument for the identification of patients at risk for suicide in diverse cultural settings.” In 2002, I attended the AESCHI Conference in Switzerland on “Understanding and Interviewing the Suicidal Patient,” where Konrad Michel presented videotapes of his interviews with hospitalized Swiss patients who had attempted suicide, videotaped within two days of the attempt. It intrigued me to note how these people so clearly recounted the “voices” that led to their suicide attempts and how these “voices” seem to have a cross-cultural presence among suicidal individuals.

These findings, in conjunction with my own work with the Glendon Association, a nonprofit psychological organization, have motivated me to spread the knowledge of the link between suicide and the “voice.” In 2007, we made the documentary Voices of Suicide (Parr, 2007), in which three survivors of suicide attempts give their first-person accounts of what went on in their minds leading to their attempt. Each one of them revealed their internal state as being totally disassociated, possessed by something that was driving them to the ultimate act of self-destruction.

Susan, one of the film’s subjects, described the snide “voice” she heard before her suicide attempt as follows:

Who would care if you weren’t around? People would miss you a little bit at the beginning, but who would really care? You don’t care. You thought you mattered, you don’t matter now. You don’t matter. If you don’t matter, what does matter? Nothing matters. What are you waking up for?

Trish, another subject of the film, recounted a similar thought pattern:

Your own family doesn’t love you. Nobody’s ever going to love you. Your own mother gave you away—You’re alone, you’ll die alone. You’ll always be alone. The only thing you can do is go and kill yourself.
The film’s third subject, Kevin, expressed how an inner “voice” convinced him that his pain was hurting others:

“I’m a bad person. I’m a burden to my family and friends. I’m hurting them with this bipolar, this, this annoying nuisance of a guy. That’s the way I thought. That’s the way my demons thought.

In all of these cases, at the moment when they actually made the attempt, they immediately reconnected with themselves and did not want to die. Susan, Trish, and Kevin all took action to save their own lives. Susan made a phone call after swallowing a lethal dose of pills. Trish drove her car in view of a nearby couple and opened the door after having shot herself. Kevin, upon realizing that he wanted to live, made an effort to position his body to minimize the impact, miraculously surviving his plummet from the Golden Gate Bridge.

The negative thought process that led these people to attempt as desperate and as destructive an act as suicide attests to the fact that often our own worst enemy lives inside of us. Suicidal “voices” arise from an internalization of hurtful early life experiences. The child reacts to extreme situations in which he or she is terrified or traumatized by identifying with the aggressor and internalizing the point of view of the person who frightened him or her. These primal responses can be triggered in later life by current events and emotions. People at high risk for suicide who are triggered in this manner can find themselves in serious trouble, as these old, intensified feelings begin to surface. This process is clearly illustrated in Katie’s Diary: Unlocking the Mystery of Suicide (Lester, 2004), a young girl’s journal detailing the thoughts that led her to commit suicide. She writes, “I sit here with my untamed piano, untamed mind, untamed heart, with the music I only know, within myself. My mother is alive! Screaming viciously, laughing viciously. Jekyll and Hyde, Mommy Dearest.”

My father developed Voice Therapy as a means of helping individuals combat these destructive thought processes and develop a stronger sense of self. The process involves five steps:

1. Verbalizing “voices” in the second person
2. Developing insight into the origins of the “voices”
3. Answering back to the “voices”
4. Making the connection between “voices” and destructive components of one’s current day life
5. Collaborating with the therapist to change these behaviors.

In 1996, Robert Firestone and I published the FAST. My dissertation provided the initial research for the scale, first testing 500 individuals in outpatient psychotherapy, and then adding the test results of 500 inpatients who had been diagnosed with the psychological disorders most associated with suicide risk. The scale asks the individual to endorse how frequently he or she is experiencing negative thoughts along a continuum, so that the scale may also predict a continuum of destructive behaviors (i.e., addiction and self-mutilation). The results help therapists identify where their patients are experiencing the most distress, so that they can target their interventions to reduce the risk of suicide. The FAST measures many of the risk factors for suicide: hopelessness, isolation, thoughts of not belonging, agitated painful states of extreme self-hate, perceived burdensomeness, disconnecting from oneself, suicidal plans, and injunctions to complete suicide.
It was the “voice” that led Kevin to throw himself off of the Golden Gate Bridge, his final thought before jumping being “Nobody cares.” The foreign, distorted nature of this “voice” only became clear at the moment of his leap, in which he instantly reconnected to his own point of view and regretted his decision. As Kevin recalls: “At the split second I hit freefall, I didn’t want to die. What did I just do? The voices were gone, I was right there facing ultimate death. I said ‘God, Please let me live.’”

In hearing these stories, making these films, and researching our scales, I am continually reminded of how powerful this “voice” can be in driving people to acts of self-destruction. As mental health professionals, the more we increase our understanding of the sources and resulting behaviors of these thought processes, the better able we will be to help our patients triumph over the self-destructive process and strengthen the part of themselves that wants to live. In my experience, when I talk to someone about their “voices,” they begin to feel understood and to realize they are not alone. They can then begin to differentiate from the enemy inside that is trying to destroy them and to see the reality of their lives, the value of their existence, and the importance of their survival.

As my first patient’s mood started to lift, with the help of antidepressant medication and talk therapy, I found that this frail and distraught woman was actually a strong survivor of a very difficult childhood. As she strengthened her sense of self, her intelligence and energy for living came to light and she reengaged in a life she now felt had meaning.

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Chapter 17

STUDYING SUICIDAL PATIENTS. LEARNING AND CONNECTION

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My first position as a psychiatrist responsible for the clinical care of patients began at McLean Hospital treating severely depressed and suicidal patients. In addition to all the other therapies normally provided on an inpatient unit I added a weekly psychotherapy group. After a short time it dawned on me that I was sitting in a room with nine people who had each tried to kill themselves in a most violent manner. The realization stunned me. Each individual patient was a nice, warm, and thoughtful person, filled with a range of emotions; yet each one had attempted some terrible act of violence on his or her own body. I was horrified and overwhelmed. However, during the group session, a sense of safety developed that allowed for the expression of each person’s individual pain. Emotional connectedness prevailed. We related and drew strength from the interaction.

The threat of suicide hung over the treatment of all the patients in my hospital unit, and over all my private patients. Coincidentally at that time, my supervisor, Alan Schatzberg, asked me to write a chapter with him on the pharmacological treatment of suicidal patients. I was new to the field. He was an established expert. He coached and mentored me and showed me how interesting this area of research was. He also gave me a taste for the pursuit of academic enquiry. I discovered the wonderful narcissistic gratification in finding a professional interest that excites exploration and facilitates collaboration with others to develop hypotheses about human function and dysfunction.

Later on, I made contact with another expert in the field. Terry Maltselfger came to McLean hospital and we soon found each other and began weekly meetings that led to a book, many joint academic undertakings, and a friendship that has transcended our professional lives. It also led to the establishment of the Boston Suicide Study Group that increased our numbers and our productivity. Collaboration and support enabled us all to
further our enquiry into suicidal minds. It stimulated our individual interest resulting in something that is far greater than the sum of all its parts.

The value of connection to me personally and professionally has become increasingly apparent. Friendships, professional relationships, research connections, and therapeutic relationships all produce associations that sustain and grow. Suicidal people somehow have lost connection. They have lost their sense of value to others and minimize or ignore their importance to family and friends. Commonly enough you hear a suicidal person say, about their loved ones, “Yes, they will miss me when I die, but they’ll get over it”. In all my dealings with survivors, I have found that you never get over it. Survivor support groups know that, and provide love and understanding for this inexplicable loss. The cost of not having connection cannot be over-stated. Something about the decision to kill oneself is closely related to this loss of connection to others, and to some important part of oneself.

Another critical point occurred to me during the course of the therapy group with my depressed patients as they were dealing with depression and their recent suicide attempt. One woman in her early twenties had been admitted with depression and paranoid delusions. She had barely survived a suicide attempt by the fortuitous arrival of her family, moments before she would be beyond resuscitation. She took a while to settle in to the group and was silent for quite some time. Eventually she burst out, “No one’s listening to me”. Immediately everyone turned their attention to her. She squirmed, “Why’s everyone looking at me?”

As her therapy progressed, it became clear that her core dilemma was that she either felt ignored or attacked. She never experienced the nurturing middle ground in which one may feel sustained, cared about and safe to thrive. Suicidal patients seem to be in this dangerous place, - unable to find a safe emotional space where they feel held and cared for. Instead, on account of psychic pathology (e.g. depression) or interpersonal difficulties (e.g. loss or hostility), they experience the world as an intolerable, hostile environment. They often cope by disassociating themselves from the unbearable situation, and in the process lose connection to important people and things in the outer world, as well as connection to their own intense (unbearable) inner experience. Lack of connection is suicide inviting.

The conventional psychoanalytic understanding of suicide is rooted in Freud’s formulation in Mourning and Melancholia (1917) where he argued that the melancholic’s guilt and self-reproach arises from the loss of an ambivalently held object with whom he identifies. In the suicidally depressed person a part of the self is split off, and viewed by the rest of the self as contemptible and should be destroyed. A split in the ego occurs, such that part of the ego is treated like the ambivalently held object, and attacking the self is a way to channel the hostility, related to the object. This formulation suggests that the patient finds his own angry and hostile feelings unbearable and is unable to maintain a real connection to his thoughts and feelings. This loss of connection, whether to the important lost person, or to his own thoughts and feelings sets up the split in the self that allows for the self-attack. Disassociation from affective states and connected relationships appears to play a significant role in suicidal despair.

Dealing with suicidal patients brings you closer to this rage and the (almost) casual easiness of the violence directed at the self. It was that ease that my patients had with violence that stunned me as I sat with my psychotherapy group. Nine post-suicide attempt depressed
patients each with a most violent history of self-attack. Their distance from the brutality of the attack on their bodies made for an eerie realization, i.e. that the people with me in the room, who appeared so nice and decent, had just recently been capable of extreme violence. It's interesting that following a suicide attempt, so many patients can once again feel much more connected to their relationships, and their feelings, to their outer and inner worlds.

Suicidal people have distanced themselves so far from their emotional experience and from their connections to others that they were essentially alone. Alone in the way that normal loneliness cannot come close to describing. What changed following the suicide attempt, and with the onset of treatment was their relatedness. They were obviously not cured, but the difference in pre and post suicide attempt was significant. Such is the power of connection to someone or something. Enough for desperate people to stay alive.

When the therapist connects with suicidal patients he comes in close contact with intense and intimidating affects like consuming homicidal rage and unendurable isolation. Connecting with sustaining others (like supportive peers, supervisors or mentors) allows the therapist to tolerate these feelings and facilitate their metabolism so that the patient may, in turn, tolerate feelings that had previously been unbearable and overwhelming. Again, the power of a nurturing, supportive environment.

Connections are life promoting and energizing. Lack of connectedness is deadly. Connecting with my patients has provided me with great returns. Connecting to the community of suicidologists who are similarly involved with suicidal patients has been stimulating and sustaining. Connecting with mentors and friends has been nurturing and invigorating. These connections offer a sublime confirmation of the crucial importance of relatedness to provide a nurturing, supportive environment that enhances growth. My group of depressed post suicide-attempt patients demonstrated their lack of connection and the danger it posed for staying alive. They could not find a safe environment and suffered unbearable loneliness leading to suicidal despair. Conversely, my connection with mentors, friends and peers in the field provided a safe environment for me to connect and develop as an individual, a therapist, and an academic. The pursuit of knowledge about suicidality has facilitated my own sense of connectedness, which has been the nurturing environment, which allows work to continue and grow. This interplay continues with further exploration into connectedness and the treatments of those with suicidal anguish, intertwined with further personal and professional growth.

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Chapter 18

REFLECTIONS ON SUICIDE PREVENTION

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I cannot recall that the question of suicidal behaviour impinged upon me as an undergraduate in the Medical School of the University of Adelaide during the early 1960s. That is not unexpected, as there was only two weeks of psychiatry in the six year course, and psychosocial issues were not particularly focused upon either in psychiatry or in other disciplines. However, during my initial registration year of medical practice, the clinical presentations of two patients imprinted themselves in my memory.

The first was an attractive young woman with a grossly disabling gait due to carbon monoxide poisoning in a suicide attempt using motor vehicle exhaust emissions. It was distressing to know that there would be no improvement. The other person was an elderly man living on his own who was gravely physically ill with pneumonia. He was resuscitated, and then it became clear that he was profoundly depressed with psychotic features, and that he had taken an overdose and developed pneumonia whilst unconscious. To my surprise he made what then seemed to be a miraculous recovery with electroconvulsie therapy, a recovery which was maintained at follow-up with anti-depressant medication.

These two extremes in terms of both the age spectrum and the markedly different outcomes have stuck in my mind, as they illustrate well both the tragedy of suicidal behaviour, and the fact that sometimes vigorous treatment of underlying mental disorders can have a significant effect on the outcome.

As a second year internal medicine resident, a series of young patients with schizophrenia led to a review of the emerging literature drawing into question the hitherto accepted dominance of psycho-analytic theories, and psychiatry as a career beckoned. After completing psychiatric qualifications in Australia and the U.K., it was expected that young academics would pursue a doctoral thesis. It was the era of a dawning awareness of the impact of suicidal behaviour on the clinical load of general hospitals, and I focussed on young

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women aged 18 to 30 who had taken a drug overdose. Contrary to accepted wisdom at the
time that they were simply hysterical and attention seeking, upon detailed enquiry they had a
range of psychopathology, particularly depressive, much of which was amenable to
intervention.

I was fortunate at that stage of my career to be in a Department headed by Issy Pilowsky,
who had worked with the late Erwin Stengel, the author of the then popular Penguin book on
Suicide and Attempted Suicide, which has since been updated by Mark Williams. Issy was
able to facilitate contact with pioneering British suicide researchers such as Norman Kreitman
in Edinburgh and Peter Sainsbury and Brian Barraclough in Graylingwell. In addition, after
meeting Norman Farberow at the 10th International Association for Suicide Prevention
meeting in Ottawa, Canada, in 1979, I was able to visit Norman and also meet Ed Shneidman
at the Los Angeles Suicide Prevention Centre. The encouragement from those giants in the
field was sufficient to promote a lifelong interest in the fascinating, at times frustrating, but
always challenging field of suicide prevention.

In pursuing any field of research it is important to seek out figures of a mentoring nature,
ot only locally, but also in places other than where one is practising. Almost inevitably there
is a limited number of persons who read the same literature and speak the same language, so
to speak, of suicide research in one's own city, and the rewards, both professional and
personal, of participating with colleagues at different stages of their careers in organisations
such as the International Association of Suicide Prevention and the International Academy for
Suicide Research, as well as in national bodies such as the American Association of
Suicidology and Suicide Prevention Australia are irreplaceable.

An important aspect of any professional work is to have a sense of introspection and
skepticism about what we regard as conventional practice. Indeed, I have long been reminded
of the statement of the 18th century social reformer, Jonas Hanway (who incidentally is
credited with introducing the umbrella to Europe!) that “Since tea has been in fashion, even
suicide has been more familiar amongst us than in times past.” Thus he felt compelled to
incriminate tea, which had recently been brought back from English colonies, as contributing
to a perceived increase in suicide! Even now in the 21st century we need to guard against
sweeping assertions about the genesis of suicidal behaviour and its optimum management.

We also need to respect the fact that important suicide research has been conducted for
over two hundred years, and the findings of early writers are too often ignored. To mention
just a few, it was as long ago as 1790 that Charles Moore commented on the validity of
suicide statistics, and he also observed that there could be an hereditary component to some
suicides; the potential influence of the media was described well by George Burrows in 1828;
and Edmond Lisle in 1856 reported on no fewer than 52,000 suicides in France, a number
which dwarfs most data sets published in the subsequent 150 years.

Arguably the most important single 19th century work on suicide was that of Enrico
Morselli, whose book “Il Suicidio: Saggio di statistica morale comparata” (Suicide: An essay
on comparative moral statistics) was published in Italy in 1879, and by 1881 it had been
translated and published in Germany, England and the United States. This is in marked
contrast to the often better recognised work of Durkheim, which was not translated from the
French for over 50 years after its initial publication in 1897. The work of Morselli was
encyclopaedic in content, and many of his observations formed the basis for reviews of 19th
century and earlier work on suicide published in 1892 in Daniel Tuke’s Dictionary of
Psychological Medicine. Tuke himself referred to what we now regard as contemporary
issues, such as the predominance of males; the influence of divorce, gambling, alcohol, hereditary factors, occupation, imprisonment, and the media; suicide in the young, including children; and the debates about the validity of statistics and the relative importance of mental disorders. Furthermore, in that same Dictionary, George Savage included Egotistical and Altruistic in his classification of suicides. Plus ça change, plus c’est la même chose!

In this era of almost instant communication, not only can we lose sight of what has occurred in the past, but there is also the risk of assuming that our contemporary knowledge will provide an answer that will be universally applicable. However, contact with colleagues in volunteer organisations such as Sumithrayo in Sri Lanka and Sneha in Chennai, India, quickly disabuses one from this fantasy, and it is sobering to hear of the endeavours of so many dedicated volunteers, whose effective work is often undertaken in challenging conditions. Suicide prevention is never simple!

Having noted that it is not simple, it is important to emphasise that it is possible, and too much negativity abounds about our capacity to prevent suicide. I think this is predominantly because although suicide is dramatic and impinges itself indelibly on our memories when it occurs, the reality is that it is a low base rate phenomenon, and that precludes the usual gold standard research tool of randomised controlled trials from demonstrating the effectiveness of our interventions. However, other research methodologies have provided re-assuring results with a variety of management strategies, including those in the volunteer sector.

In planning suicide prevention initiatives we need to appreciate and accept that different countries and different governments have different priorities at different times. Furthermore, although we who are involved in suicide prevention regard its importance as second to none, others may not share our view. Thus suicide prevention, as with so many other important issues in life, tends to have its time in the sun in terms of government and community support. Therefore it is crucial that suicide prevention should be integrated fully within broader socio/medical/psychiatric/psychological frameworks. Thus it is apparent that some stand alone research centres, which may have been extremely influential for a period of time, usually have only been successful because of individuals who come and go. Suicide prevention involves many disciplines, as well as the community at large, and with the vagaries of political patronage it is important that it remains as much as possible in the main stream, in order to avoid the ignominy of becoming an isolated and poorly funded appendage to standard services.

It is only by a broad range of professionals and non-professionals alike, working within established organisations in developed countries, and by establishing such organisations in developing countries, and by utilising hard won research information which now demonstrates that suicide prevention is possible, that enduring changes to unacceptable suicide rates worldwide will occur.

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Chapter 19

RETAINING FAITH IN SUICIDE PREVENTION:
SUICIDOLOGIST AS SUICIDE SURVIVOR

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Psychotherapy training is a long and twisted journey with many hours devoted to working with patients and many hours spent in reading, thinking and talking about them. Usually the person with whom the trainee talks most about his work with patients is his supervisor, mentor, teacher, or senior consultant – depending on how the therapist’s curriculum is organised in each professional and cultural setting. The supervisor is a key person in the professional life of a young resident, who is trying hard to learn the science and art of psychotherapy.

When the telephone rang and a colleague told me in a dry voice that our mutual teacher and supervisor Prof. B. committed suicide, I thought it was a morbid joke. I had a supervision scheduled with him regarding therapy of a difficult patient for the following week. And so had many other trainees and his patients. I was in the second year of residency to become a clinical psychologist, I was young and had little professional experience. The tragic event shattered my nicely constructed field of knowledge and stopped my fantasy of the “brave new psychotherapeutic world”. The deceased was the most prominent psychotherapist in the country, teacher and mentor. He was admired for his work, his knowledge, and his determined way of working with patients and with trainees. Prof. B. was the role model for generations of young therapists, who learnt from his book on psychotherapy and followed his footsteps. He was the centre of the outpatient clinic, surrounded by many specialists for suicide prevention. My persistent thought was: “If they/we were unable to prevent his suicide, how dare we proceed working in the field of suicidology, claiming that we know how to deal with suicidal patients.”

My reactions to B.’s suicide were intense, to my surprise very similar to those of some previous family losses. I was struck by sadness and remorse, but also by anger and disbelief.
that he had left us alone, puzzled with unanswered questions and with feelings of utter incompetence. Many years later, when I became experienced in bereavement after suicide, I understood that I had gone through the expected feelings and reactions of a suicide survivor.

This unpredictable and shocking experience had – along with suicides of two patients I had in psychotherapy – a long-lasting impact on my future professional development.

B.’s suicide taught me some facts that are usually hidden from the beginner in the field of suicidology:

- It is very difficult, if not impossible, to predict suicide even if the person has previously been suicidal and was properly diagnosed as such. Suicide is an everlasting enigma, mysterious, complex and multilayered (Farberow, 2001).
- The knowledge in the field of depression and suicide offers little or no protection, either to the suicidal person himself or to the professionals treating him. In B.’s case he was a very knowledgeable man and also a respectful head of the Department for Emergency Outpatient Psychiatry, he himself treated many suicidal patients and was surrounded by many specialists for suicide detection and prevention. He was diagnosed with depression, got proper therapy, was supported and taken care of, but nevertheless, none of these measures had a satisfactory outcome. He was not protected against himself.
- B. had many patients and residents that he supervised – so many people depended on him in one way or another – the fact that would usually be listed as a protective factor - being needed, responsible and irreplaceable for many individuals. Still, not enough to protect him.

As it happens in such circumstances, the counter-phobic reaction takes over and the resident – suicide survivor - becomes an expert in suicidology and suicide prevention, enthusiastically fighting against the demons of suicidal tyranny. He or she can believe in different explanatory theories for suicide – more biologically or more environmentally oriented, or, if wise enough, as eclectic as possible. He or she preaches and lectures about possibly effective outcomes of doing (or not doing) something in the life of a suicidal person.

But then the problem takes a different perspective when a therapist switches from treating suicidal persons to treating suicide survivors. These are all those unfortunate individuals or families affected by suicide of someone close (relatives, friends, colleagues, schoolmates, psychiatrists, GPs, psychotherapists, supervisors or supervisees, nurses, teachers, guards and counsellors in prisons, etc., Grad, 2009). Sharing with them their grief, guilt, shame, never-ending questioning, stigma, their own ambivalent feelings and those in the society about suicide, fears of other family members repeating the act; all this makes the therapist “understand” suicide differently. After hearing so many narratives about missed opportunities, overlooked warning signs, misunderstandings of hidden messages, desperate search for clues and possible reasons, struggling with shame and blame, losing the meaning of their own life, changing the values and priorities of existence – all this brings the therapist to the edge of changing from an empathic supporter of a suicidal person to a blasphemic opponent of the suicidal act itself and its performer, who brought all this pain on the survivor. It is extremely difficult to understand and accept both sides when working with suicide survivors for a long time and see the “psychological skeleton of suicide in the family hanging in the survivor’s closet for as long as he lives” (Shneidman, 1972).
Retaining Faith in Suicide Prevention

There is a hidden catch that becomes a trap for the therapist working with suicide survivors’ pain: it is expected that he understands and empathizes with the disaster in the life of the survivor after experiencing and understanding the suicidal act through the eyes of the bereaved. Compared to the variations of narratives and explanations based on many different reasons that lead to the final act, the theoretical preventive measures, risk factors and warning signs often seem artificial constructs, not adaptable to the reality. The scepticism can crawl into the therapist when he tries to remain the anti-suicidal warrior defending different ways of suicide prevention. Very often (too often) it seems that the enigma of suicide is too difficult to be resolved by the human mind, especially when seeing it through the survivor’s eyes.

On the other hand, the therapist knows that it is even more necessary to support preventive activities – either on an individual or a national scale – to avoid all the disastrous consequences that this everlasting human decision provokes. When witnessing the suffering of the survivors (parents, siblings, spouses, children) as the sequelae of the suicidal act in the family, the urgency of trying to prevent every individual suicide, as well as further planning of national strategies of suicide prevention is a must.

As it happens in every long and tiring bereavement process with suicide survivors, the lives of the bereaved are permanently changed, they usually spend years trying to go through all the different emotions and painful everyday struggles, they have to re-evaluate their own lives and philosophies and they struggle with different ways of understanding the enigma of suicide. Sometimes the mission seems impossible. But, hard as it is, survivors almost always show an extreme power to fight - their battles are lost many times, but the war to survive in the new life after the disaster of suicide is usually won. The therapist is a bystander and observer, often the only one to know the extent of sadness, pain and difficulties, but he is also the silent admirer of their brave and sometimes lonesome resilience. Being a therapist of suicide survivors is a special life privilege – to see the Phoenix bird be born again from the ashes of the shattered and almost lost lives.

After experiencing the suicide of my supervisor and teacher, my colleagues and I were in the same position – either to surrender to our own feelings of doubt whether we were competent enough to go on and help suicidal people, or rather to avoid treating them in the future. Should I, interested in suicide prevention, quit this, seemingly Sisyphus-like business and start with something less risky and insecure? Or should I follow the struggle and resilience of the highly damaged and struck suicide survivors and believe that it is possible to go on and even see the light at the end of the tunnel?

I have been working in the field of suicidology (crisis intervention, crisis lines, national strategy, and, of course, bereavement after suicide) for the past thirty-three years and as many of my patients say at the end of their mourning process: “I can see and understand things around me differently, more profoundly and with more wisdom.” They can see their development through the painful never-ending questioning. Suicide of someone close almost stopped them in their lives, but they went on. There was a huge loss, but there was some gain in their newly acquired perspectives of life chances.

I am glad that the suicide of Prof. B. did not stop me either.
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My first encounter having a patient under my care commit suicide was roughly 10 years ago. A few years out of residency and a public psychiatry fellowship, I was the consulting psychiatrist to a homeless shelter in New York City. The patient was a relatively young man, perhaps in his 30s, who suffered from schizophrenia and also used cocaine and likely other substances. He had just moved into the shelter, and I had not met with him yet to do an intake evaluation.

I was working at the shelter one afternoon when he appeared at the door with clothes soaking wet. He said that he had jumped into the Hudson River, trying to kill himself, but then, for reasons I can no longer remember, had come back ashore and returned to the shelter. I met with him and did a suicide risk assessment including discussion of whether he would consider going into the hospital. As I recall, he denied the urge to make another suicide attempt imminently and said, more or less, “if the guys in the white coats show up to hospitalize me, then I will kill myself.” He had a long history of many hospitalizations for his schizophrenia and addiction problems. As I recall, he then said he wanted to go upstairs to his room, change into dry clothes, and then come back down to eat a sandwich, which a staffer had offered to make him. Having decided that he did not seem to be an acute suicide risk, I told the shelter director that I thought he could go to his room and change into dry clothes.

When he did not come back downstairs after a while, a staff member went up to look for him. The staffer found him hanging, dead, from a rope out of his room window that opened onto an airshaft. Emergency services and police arrived quickly and took over. There were debriefing discussions among the staff, including me, and efforts to comfort the upset shelter worker who had found the man hanging from his window.

I have often second-guessed my decision then to let the man go upstairs, unescorted, to change out of wet clothes. I have asked myself, silently, if I should have recommended that someone accompany him, and meanwhile have called emergency services to bring him, probably against his will, to an emergency room. Having done this in other shelters, in other emergencies, I knew that the ambulance workers arrive with police. Sometimes the patient is taken away in handcuffs, usually to spend hours or days in an overcrowded emergency department. The feeling of impotence and of having somehow failed by not preventing the suicide is still fresh in my mind.
Soon after the suicide, I called the man’s parents and arranged to meet with them. We sat together in a dingy, windowless office at the shelter. What I recall most about them is that they seemed like kind and decent people who appeared stoically resigned and unsurprised by their son’s suicide. They said he had tried to kill himself a number of times before. Mostly they talked about how long he had suffered and struggled with a terrible illness.

The second time someone under my care committed suicide was almost a decade later. In this case, I thought I knew the patient much better. I had worked with him, a man in his late 50s, in the part-time practice I do on top of my full-time research job. I had initially seen him just for medication management of his depression, and then later, at his request, also for psychotherapy. He had struggled off and on with depression for many years. Prior to my working with him, he had also been alcoholic. He had managed to get this under control, but in addition to having cost him the best career opportunity of his life, it had left him with some cortical atrophy on brain scan and mild deficits in short-term memory.

For the first year or so, we struggled to find a combination of medications that would loosen the vise-grip of his depression. In the course of this, he tried numerous drug combinations, with varying degrees of success in lifting his mood, although none that did so in a complete and sustained way. It seemed that a deep current of hopelessness and intermittent thoughts of suicide would eventually rise again to the surface despite high doses and adequate durations of drug regimens.

Early in my work with him, as his psychopharmacologist, he entered psychotherapy at a local institute, going several times a week. Initially, he seemed to feel this was helpful. After a number of months, however, he became frustrated with the slowness of progress and ultimately left that treatment. Subsequently, he asked if we could meet more regularly than our periodic medication management visits to also include a psychotherapy component to our appointments. I agreed to this.

For the next year or so, we met weekly for combined psychotherapy and medication management. The psychotherapy was mainly supportive with some exploration of his feelings about his very critical father who he felt had been disappointed in him. Mostly, we focused on his struggles with career setbacks during the years preceding our work together and on more recent difficulties in his marriage.

In his career, he had worked for many years as an information technology manager at a top investment bank. Despite having no graduate degree, he had risen on the strength of his natural abilities to a high level with a salary large enough to afford both a Manhattan apartment and a country house. At the peak of his career, some years prior to my meeting him, he had been sent to take on a leadership position at an overseas division of the company and – as he told it – had failed to accomplish his task, at least partly due to his alcohol problems.

The company brought him back to its U.S. office, effectively demoted him, and he was eventually laid off. Some brief stints doing similar work at other companies followed. However, he could not seem to sustain any of these jobs and by the time I met him he was unemployed.

His wife, meanwhile, was on an upward trajectory. Having been supported by him through her graduate professional school years, she was now working in her field and was supporting the household. They did not have children. She had been seeing a psychotherapist several times a week in recent years and seemed to be benefiting from this process in terms of
increased self-confidence. This seemed to unsettle her husband, particularly given his career setbacks.

During the several years I worked with this man, he had gone in and out of periods where he would discuss feeling suicidal. He talked about suicide as being always a possible final option or solution to his struggles. However, he had never before attempted suicide nor voiced any imminent plans to do so.

A week or so before his suicide was discovered, he missed an appointment with me. He had forgotten appointments before, so this was not completely uncharacteristic. However, when I tried to reach him to find out why he had missed our appointment, his wife told me that he was missing. After talking with her, I called the police and filed a missing person report. He was found a few days later in a neighboring state, having asphyxiated himself in a rented car by using a charcoal grille, according to a method described at online websites.

It has been a couple years since then and still I replay my relationship with this man and wonder what would have happened had I done things differently...Should I have tried harder to persuade him to be hospitalized? He had never wanted to do this. Would a 10-14 day hospital stay, the typical duration, have helped his chronic, waxing and waning suicidal rumination in a lasting way? Would seeing him twice a week have helped? What if I had prescribed lithium, an antipsychotic medication, ECT, or a course of dialectical behavior therapy? Would couples therapy have prevented this? What if he had landed a decent job where he could feel productive again?

I realize that these questions are unanswerable. I have worked in suicide research for almost a decade now. The more I learn, the more humbled I am by the complexity of the web of factors that leads to suicide. As Buddha reportedly said on his deathbed, we can only “strive onward diligently,” each of us trying to contribute in some way to knowledge that might some day help another person.
The Accidental Suicidologist

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I did not set out to be a suicidologist. I came to the field rather by accident. When I began graduate study in clinical psychology the only thing I was really sure of was that I wanted to work with children. About half way through that first year I heard Cheryl King present on adolescent suicide. I had not considered this as a potential area of study, but I was interested in children's understanding of death, which I figured was at least a topic related to Cheryl's work. She agreed to be my advisor, which lead me to my next fortunate contact with an imminent suicidologist when Cheryl introduced me to Israel Orbach. Cheryl had told Israel about my thesis at an American Association of Suicidology (AAS) conference and he offered to discuss it with me further. We began corresponding and developed what turned out to be a long-term professional relationship. Thanks to the guidance of these two exceptional teachers, my career as a suicidologist was off to a good start, and I still did not know that I was a suicidologist.

I completed my thesis research and with Cheryl's help got it published (Gutierrez, King and Ghazziudin, 1996). It seemed like the logical next step was to design a dissertation project on adolescent suicide. This decision led me to another gifted suicidology mentor, Al Cain. It was while working on my dissertation that I finally realized I was becoming a suicidologist. I do not think that Cheryl, Israel, or Al ever said to me "you should make suicide research your career", but that is exactly what I was doing.

The other pivotal early career decision was when I accepted a position as an assistant professor. However, I was not sure if an academic career was what I really wanted, only that it was a good job and I needed one. Sometime early on the tenure track I concluded that in order to be successful I could either throw myself into research and publishing or doing clinical work, but not both. I discovered that not only did I enjoy research, I was becoming fairly good at it. One of the secrets my graduate school mentors taught me was the importance of presenting your findings at conferences. Attending and presenting at the annual AAS conference became something I looked forward to every year. Not only did this expose me to a broad cross section of cutting edge research, but it also reminded me of why the work that I was doing mattered. A unique aspect of AAS is that members represent five domains —
research, prevention, crisis centers, clinical, and survivors. It is impossible to attend an AAS conference and not appreciate the multiple facets of suicidology, and the many ways this work touches people's lives.

Another benefit of being a member of AAS was meeting suicidologists from around the world. As a young academic I was consistently amazed by how gracious and kind the people were whose work I had been reading and inspired by for years. Forming professional and personal relationships with my suicidologist colleagues helped me to be a better researcher and teacher. I started bringing my students to conferences, introducing them to the leaders in the field, and fostering their careers as the next generation of suicidologists. Hopefully I also modeled for my students the importance of collaboration and sharing of ideas with others.

Suicidology is the study of self-inflicted death, a singularly isolating event. Yet, ours is a field full of life. Each of us is dedicated to understanding the suffering which leads people to such depths of despair that ending their own lives seems like the only solution. In so doing, we touch profound pain, but always with the belief that we can help people come back into the light and embrace life again. The personal and professional relationships I have formed as the result of being a suicidologist have enriched my life in countless ways, and provided me with the motivation, inspiration, and energy to make this my life's work.

However, the nature of the work I do has changed with time. Much of my early research was on risk factors for adolescent suicide, and the closely related work of developing and validating measures to assess those factors. I was interested in the potential role of protective factors and in developing models of adolescent suicide (Gutierrez, 2006). These lines of research converged in publication of a book with my long time collaborator and friend Augustine Osman. In it (Gutierrez and Osman, 2008) we lay out our assessment philosophy, provide extensive information about scale development and validation, and offer concrete guidelines for suicide assessment in a range of settings. Ironically, that book was finalized after my career took a significant shift away from adolescent suicide.

The most important personal connection I made because I am a suicidologist was to my life partner, whom I met at an AAS conference. As a result, I eventually decided to leave my faculty position, move to a new city, and try my hand at studying suicide in U.S. military Veterans. There were some who thought I was crazy to give up tenure for love, but I knew I had to try. This career shift also allowed me to draw on many professional connections to forge new collaborations and advance the work of my new professional home. My interests in assessment and theory development contributed to a qualitative study of suicide among Veterans who had served in Operation Enduring Freedom and Operation Iraqi Freedom (Brenner et al., 2008) as well as work on a special issue of a journal focused on management of stress reactions in this population (Gutierrez and Brenner, 2009). I now do clinical work in addition to research and teaching. It turns out that I was wrong all those years ago, you can do all three. In fact, being a clinician who works primarily with suicidal patients has made me a better researcher, and being a researcher makes me a better clinician.

There are several incidents I will never forget. I ran an adolescent suicide risk screening project at a large urban high school for eight years. One afternoon a young woman turned in her packet and we noted that every one of her critical items was high. Following the safety protocol, she was then spoken with individually and determined that she was indeed very seriously thinking about suicide. She told us that she had decided that was the day she was going to kill herself because her parents would not be home after school. Because we were
screening that day, this high risk student was identified, referred to the school psychologist, and received the professional help she needed.

The other example which stands out is much more recent. I was treating a suicidal Veteran who seemed to be making good progress. We had developed a safety plan, which he regularly used. Following a session one day I received a phone call from him. He told me that he was sorry, but he could not take the psychological pain anymore and he was going to kill himself. He said he appreciated everything I had done for him, and did not want me to blame myself. Then he said good-bye and hung up. Many phone calls later, mobilizing all of the resources I could to try and locate him and intervene, we finally found him. Although he had to be taken to the nearest trauma center, and nearly died en route, he survived the attempt. If I had not been working in this field for so long, I probably would have seen this event as a clinical failure. Instead, I celebrated the fact that his safety plan worked. He had reached out for help in his darkest hour and had been kept safe.

When I find myself becoming overwhelmed by the stresses of work, I think about these examples, and what a privilege it is to have a career which allows me to truly make a difference in people's lives. I have been enriched by the interpersonal connections I have made as a suicidologist. I am honored by the recognition I have received for my accomplishments. My mentors, past and present, helped me to hone my skills and push my limits to try new things. My students taught me as much as I taught them, if not more. The thousands of research participants in studies I have conducted volunteered their time and energy to advance the field of suicidology. Finally, my patients remind me every day that the work we do matters, that we have much more to learn, but that the more we understand about suicide the more we can do to reduce human suffering. I did not set out to be a suicidologist, but there is nothing else I would rather be.

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Chapter 22

SUICIDIOLOGY: AN APPROACH FOR IMPROVING QUALITY OF LIFE

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When I began college at the University of Pennsylvania, I was shocked to learn that many of my peers had contemplated suicide, even if just for a moment. Little did I know that 10 years later I would begin my career as a researcher and clinician in the field of suicidology. In 1985 two factors led me to begin work in the area of adolescent suicide. First, there was an institutional desire to begin an adolescent suicide program. Second, a high school student conducting a school research project said that she had interest in adolescent suicidal behavior based on her experiences with peers. Somewhat hesitantly I began my journey as a suicidologist. Each time I meet someone affected by suicidal behavior I confirm my commitment to the field.

SUICIDAL BEHAVIOR IN ADOLESCENTS: IS IT A PROBLEM?

Initially, it was unclear what the frequency and nature of suicidal behavior actually was in the typical high school student. Determined to describe students’ experiences with suicidal behavior we developed an 18-page survey. The first few pages asked directly about suicidal behavior examining the type, frequency and extent of suicidal thoughts, the details of suicide plans and the consequences of suicide attempts when they occurred. The rest of the survey investigated potentially associated factors including depression, stressful life events, impulsiveness, aggression, concepts of death, premenstrual symptoms, exposure to suicide and family history. The school principal was concerned about suicidal behavior and therefore commissioned the evaluation in his school. The results would be used to inform school programs and policies. We expected very little so finding an attempt rate of almost 9% was a
shock\(^1\). It turns out suicidal behavior was not rare with over half of the students having thought about it, even if only briefly, and 15% having planful and persistent ideas. We repeated the study two more years, replicating the findings. Another student conducted a project with high school girls and found that suicidal behavior was related to premenstrual symptoms and a third student compared what mothers know about their teens’ suicidal behavior and found that, in fact, they knew very little.

As a result of our study, the Adolescent Depression and Suicide Program at Montefiore Medical Center/ Albert Einstein College of Medicine was established. We had written proposals for research and clinical programs and only the clinical program brought interest. With a small budget, a few psychology interns and some psychiatry fellows we began assessing and treating depressed and suicidal adolescents. Subsequently, our findings in the high schools were replicated in the U.S. and in other countries. The scope of the problem was established. The factors we hypothesized to relate to suicidal behavior were in fact related\(^2\). Adolescents with planful and persistent ideas had the highest levels of depression, negative life events (but not positive), aggression and impulsiveness and looked at least as troubled as past suicide attempters. Most students (80%) had known at least one person who engaged in suicidal behavior so exposure alone could not explain our findings.

Along the way, we developed a comprehensive measure of suicidal behavior\(^3\) and demonstrated that asking about suicidal behavior was important rather than dangerous. Not only had we not generated suicidal behavior but we had saved lives because we talked about risk factors and warning signs and told students to contact an adult if they were concerned about a friend. Two students on their way to complete a suicide pact were apprehended and their suicides were prevented because a student told a guidance counselor about their plan. Informing students and teachers and helping schools to develop suicide prevention and intervention programs proved beneficial, at least on a case by case basis. We cannot know how many lives have been saved, just that the problem persists.

**SAVING LIVES IN SCHIZOPHRENIA**

It turns out that young individuals with schizophrenia are at particular risk for suicidal behavior\(^4\). In this area as well adolescent suicidal behavior, studies were primarily retrospective and patients were not asked about their own experiences with suicidal behavior. My first task was to examine suicidal behavior in individuals with schizophrenia by asking them directly. Assessing suicidal behavior in schizophrenia sounds like it could be rather depressing, however to me it is about improving the lives of individuals with schizophrenia and therefore life affirming. Having worked with individuals with schizophrenia for many years, I have seen the devastation it can cause for individuals and their families. I have also seen the positive impact that learning to live with schizophrenia can have, even if it was not the life trajectory originally planned. As a society we have failed to attend to the needs of the severely mentally ill. Until we improve quality of life for individuals with schizophrenia we lose a tremendous amount as a society and perpetuate a lot of pain. My work towards preventing suicidal behavior in individuals with schizophrenia has the ultimate aim of improving life with schizophrenia for the individual, the family and society.
Each time someone asks me about my work I am heartened and saddened by the interest it generates. I have met so many people who know a person with schizophrenia and/or a person who has killed him or herself. The problem is more far-reaching and more personal to many individuals than one might expect. I have been told by major funding sources that suicidal behavior in schizophrenia does not account for “that many suicides” and therefore is not highly fundable. I have the hope that at Columbia University and around the world, our research regarding the etiology and treatment of schizophrenia will improve quality of life and reduce the rate of suicidal behavior in schizophrenia.

RESEARCH ON TREATMENT AND SUICIDAL BEHAVIOR

Having spent much of my time assessing suicidal behavior and related factors it is clear that I believe it is important and essential to assess suicidal behavior when evaluating and treating individuals with mental illness. As suicidologists, the method we select to study this behavior has important consequences. The monitoring of suicidal behavior as an adverse event in psychopharmacological treatment trials has led to a significant amount of fear about the treatment of mental illness. Having demonstrated that suicidal behavior is not rare, even in the general adolescent population, the suggestion that some individuals in psychopharmacological treatment have suicidal behavior is not surprising and, importantly, the data do not support a causal relationship. The real question is “how much suicidal behavior has been prevented by treating mental illness with medication?” The idea that one need only examine adverse events shies away from the importance of assessing suicidal behavior regularly at the time of initial evaluation and over the course of treatment. The negative impact of scaring individuals away from treatment before careful evaluation has increased stigma and reduced the impact of our previous efforts to educate and encourage the public to seek help for problems such as depression, substance use and schizophrenia. As a clinician, a researcher and suicidologist I hope that we can return to more rigorous study of suicidal behavior and mental illness.

FUTURE EFFORTS

I entered this field and continue to believe that the study of suicidal behavior will lead to improvement in the overall quality of life for people who suffer from mental illness. I work towards encouraging others to study suicidal behavior in all populations at risk and in the general population. My efforts will likely continue to focus on early identification of emotional problems and their consequences, including suicidal behavior. Suicidal behavior is neither rational nor a choice, it is the results of confluence of factors we need to work to understand.
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Chapter 23

SUICIDE: A PSYCHOSOCIAL PERSPECTIVE

Herbert Hendin
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In 1960, I was invited by Danish psychiatrists to examine the Danish contribution to the Scandinavian suicide phenomenon i.e., the high suicide rate in Denmark and Sweden, (then averaging close to 20 per 100,000) compared to Norway (which averaged about 7 to 8 per 100,000). That visit to Denmark changed my professional life. It led first to a four-year project in which, with the aid of a grant from NIMH, I spent several months each year interviewing suicidal patients and nonsuicidal patients in the three countries. A good part of the rest of those years was spent learning the languages and reading the literature, popular magazines, and folklore of the three countries—all of which contributed to understanding how suicide was affected by different stressors that reflected cultural and social differences among the three cultures. The results of that study are detailed elsewhere.

I had been interested in the impact of psychosocial factors on mental illness, and had attended the Columbia University Psychoanalytic Center for Training and Research largely to study and work with Abram Kardiner, a psychiatric pioneer in the value of a psychosocial approach in studying both primitive and contemporary cultures. This Scandinavian study, however, was for me a powerful, personal lesson on the impact of culture on character and behavior.

Being a foreign observer had some advantages. I noticed early on that Swedish women frequently had a full blown blush reaction when they discussed personal matters. They were prone to say when I saw them next: “I am so embarrassed at what I told you, what must you think of me?” Their reaction was different from anything I observed in this country or had seen in Denmark. Danish women were eager to talk with me a second time and their most typical reaction was: “There was so much I forgot or didn’t get a chance to tell you.” Swedish doctors were aware of the blush reaction in Swedish women but surprised that it was not so common in other countries.

That observation was a reflection of unique ways in which affect was dealt with in Sweden. Swedish boys are taught to be tyst och lugn (quiet and calm) and not to cry even if they are upset. The lack of emotional responsiveness is often used as a weapon reflected in
the expression *tiga ihjäl* (to kill through silence) wonderfully depicted in the films of Ingmar Bergman.

Although in time independent researchers confirmed most of my findings, they were at first the subject of some political controversy. Before the results of the study were available there were articles published in Sweden indicating that as an American I undoubtedly shared a view expressed by President Eisenhower that Swedish problems with alcohol and suicide were attributable to the welfare state. In point of fact the difference in the suicide rates of the three countries long antecedent the social welfare state and Norway, which had the same social welfare measures as Sweden and Denmark, not only had a low suicide rate, but one that at that time was significantly lower than that of the United States.

A number of Danish psychiatrists expressed the view that since more Norwegians than Danes immigrated to the United States, unhappy Norwegians killed themselves there. Actually first generation immigrants in the United States showed the same 3 to 1 ratio of Danish and Swedish suicides to Norwegian suicides as existed in their countries of origin.

The Scandinavian study led to my being asked in the mid-1960s to undertake a study of suicide among African Americans in New York City. Although the rate of African Americans in the United States was significantly lower than that of the white population, the epidemiological prelude to that study revealed that in the age group 15-34 the suicide rate over the past 60 years had been higher for the African American population in New York City than for the white population in that age group, a pattern that was subsequently observed in several other large cities. Interviewing young, serious suicide attempters at Harlem Hospital revealed that for many violent behavior as much as suicidal behavior was an integral part of their lives. At the time there was a widespread belief among psychiatrists and social scientists that suicide and homicide were inversely related. Subsequent studies ascertained that a significant number of whites were also both violent and suicidal.

By the early 1970s the National Institute of Mental Health was aware of the rapidly rising suicide rate among young people 15-24 in the United States and was recruiting suicide researchers to study the problem. I undertook to do a study of suicide among college students with control groups that included substance abusers and students involved in the Weathermen, a radical student group in the 1960s involved in activities ranging from occupying buildings to setting bombs and robbing banks.

As an outgrowth of that study in 1976 I organized and directed the Center for Psychosocial Studies, a small group which focused on psychiatric problems in which society had a concern, specifically substance abuse, violent behavior, and Posttraumatic Stress Disorder (PTSD) in Viet Nam veterans, as well as suicide. Veterans with PTSD were more frequently suicidal than veterans without the disorder, but we found that guilt over behavior in combat over things done or not done was the major factor predicting their suicidal behavior. We also studied a group of veterans who had comparable combat experience but did not develop PTSD. We learned that the nature of their adjustment immediately before entering the service was a more significant factor than childhood family experience in determining whether they developed the disorder.

In 1986 a few colleagues and business and community leaders and I founded the American Foundation for Suicide Prevention (AFSP). Our aim in doing so was to help young investigators pursue a career in suicide research. AFSP made it possible for many more to get started. I served as AFSP’s first president, then as its first chief executive officer and
subsequently as its medical director. Eventually I became in charge of intramural projects that were initiated and carried out by the foundation.

Prominent among these was a study of physician-assisted suicide and euthanasia. This involved my doing a study of assisted suicide and euthanasia in the Netherlands, the only country at the time where the practices had legal sanction. This led to later study, together with Dr. Kathleen Foley of Memorial Sloan Kettering Institute, an expert in palliative care, of physician-assisted suicide in Oregon, the first state to legalize assisted suicide. In neither Oregon nor the Netherlands was a psychiatric consultation or a palliative care consultation required for patients considering assisted suicide and only in a small minority of cases was it recommended. In both places patients whose physical suffering could have been relieved or had psychiatric problems that could have been treated were assisted in suicide; in the Netherlands such patients could be euthanized.

Adequate palliative care – psychological as well as medical – was emerging as one of the best suicide prevention measures in seriously ill or terminally ill patients. It was a source of gratification when the U.S Supreme Court cited my work in its landmark 1997 decision that there was no constitutional right to assisted suicide.

Eventually the size and scope of these projects and their specific focus on directly reducing suicidal behavior and suicide led to the formation of a separate not-for-profit organization, Suicide Prevention International (SPI). SPI draws on an international network of suicide experts to decide what projects are most needed and most likely to prevent suicides and develops, implements, and funds a small number of key projects while staying involved with them from beginning to end. These include a project aimed at youth suicide prevention by improving the treatment of young people seen in hospital emergency rooms after suicide attempts or because of preoccupation with suicide.

Another is making psychiatric care and social support available to suicidally depressed patients in rural China, an area with one of the world’s highest suicide rates, where psychiatric care is lacking and where the suicide rate for women is higher than that for men—factors which dramatically highlight the importance of psychosocial factors in suicide. Details of these and other SPI projects can be found on our website (www.SPIorg.org).

A project begun 20 years ago with John Maltsberger reached fruition at SPI. It examined with therapists patients who committed suicide while in treatment with them. The patients were compared with patients treated by the same therapists who were comparably depressed but who were not suicidal. This permitted us to develop an instrument, the Affective States Questionnaire (ASQ), that, in a recently completed prospective study with veterans, was able to predict short term risk for suicidal behavior (within 3 months.) Among patients vulnerable to suicide because of depression or substance abuse, the ASQ holds particular promise of being able to identify those who are most likely to go on to suicidal behavior. We are about to test it further with at risk populations of veterans and non-veterans.

The project also enabled us to define recurrent problems in the psychotherapeutic treatment of suicidal patients. Although we saw suicidally depressed patients who did not respond to treatment because they were inadequately medicated, there were a significant number who despite adequate medication did not respond until their psychosocial problems were addressed.
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Chapter 24

FROM MAINSTREAM TO COUNTER CURRENT?
SOME REFLECTIONS ON THE STATE OF AFFAIRES IN
SUICIDOLOGICAL RESEARCH

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My introduction to suicidology came through the WHO/EURO Multicentre Study on Parasuicide (Bille-Brahe et al., 1995); a study I had the privilege of joining in 1992, a few years after it started. That study certainly was a unique introduction to many aspects of suicide research as well as to international collaboration. My main interests were on the intentionality involved in suicidal behaviour and cross-cultural issues, both of which I got a chance to work on in collaboration with many of the best suicide researchers in the world. I am forever indebted to my colleagues in that study for everything they taught me. However, there is a limit to the depth one can reach on subjects like intentionality and cultural issues by employing epidemiological, quantitative, structured and questionnaire based approaches in a European context. Moreover, suicidology’s relative scarcity of theoretical frameworks was apparent. I therefore decided to broaden my theoretical, methodological and cultural horizon. However, with this expansion in scope, some unexpected obstacles appeared and I am a bit worried about the current state and development in suicidology. Some reflections on this follow below.

On methodology: Being trained to think that the research questions decide which method to choose, it was quite a shock to discover that for many of those setting the tone in suicidological research world-wide, the choice of method seems to come first. In my view, that is turning things upside down and contributes only to limit the kinds of research questions possible to ask and thus is a direct hindrance to the development of the field (this is not only the case in suicidology, but in mental health research in general). When I told people more than 10 years ago that I was going to do qualitative research, I was met with comments like: “Don’t you want to publish any more?” and “It’s good that you got your PhD using quantitative methods. Then you have at least proved you’re not stupid”. At first, I didn’t take these comments seriously, but have later discovered how prophetic they were — and even
worse – how relevant they still are today. There is a lot of prejudice against qualitative methodology; mainly from researchers/reviewers/editors not knowing a lot about it. Colleagues from all over the world share these experiences. Articles are rejected because the studies have used qualitative methodology and both reviewers and editors reveal their ignorance of these approaches in their reviews and rejection letters. From 2005-2008 only about three percent of the publications in the three main international suicidological journals had used some form of qualitative methodology (Hjelmeland, 2009).

Large scale studies employing more or less advanced statistical methods providing linear models explaining suicidal behaviour and/or “hard science” biological studies focusing on hormones and/or neurotransmitters involved in suicidal behaviour or related psychiatric disorders are preferred. Although also important, the almost exclusive preference of such studies contributes to an increasing distance between the research field and the people our research is there to help. Human beings are more than biological creatures; we are complicated, reflective beings living in complex cultural contexts and it is highly unlikely that we develop or behave in a linear fashion whether we are suicidal or not. No matter how advanced the linear statistical techniques get, there is a limit to how many variables that can be included in a model before it gets impossible to interpret. Moreover, much of the variance always remains unexplained, the specificity and sensitivity is too low, and such models have only limited predictive value at individual level. And, no matter how advanced the neurobiological techniques get, we cannot strip away people’s contexts without losing important factors contributing to a person’s suicidality. Research in neuropsychology has, for instance, demonstrated that there seems to be few limits to what the brain can do and develop into with different environmental stimulations and that biological patterns in the brain can be both created and changed by experience. It is therefore necessary to look at people’s experiences; not just their biological structures (that may even be there because of some particular experiences). Moreover, risk factors are of limited value at individual level. For instance, the vast majority of people suffering from mental disorders do not kill themselves. And, risk factors/problems/symptoms, whether they are biological, psychological or social, must be explored as individual experiences in the particular socio-cultural context in which they occur because it is in that particular context they have meaning and significance for the individual. Although risk factor studies contribute to explain suicidal behaviour at group level, they have limited value in terms of providing an in-depth understanding of the phenomenon at individual level. Besides, the mechanisms between risk factors and suicidal behaviour are still largely unknown.

Seeing as suicidal behaviour is a conscious act conducted by reflective beings and the end result of a suicidal process which is unique for each individual, qualitative research can contribute to develop an understanding of suicidal behaviour based on the perspectives of suicidal individuals. A systematic, in-depth qualitative analysis will allow us to look at relationships between factors that we would not be able to in quantitative studies using predetermined, standardised questions, and can thus contribute to a deeper insight in such processes. Not everything can be operationalised and measured numerically, and numbers alone cannot provide all the evidence needed for intervention. Moreover, qualitative studies can contribute to interpret and understand findings from quantitative studies as well as to bridge the gaps between theory and practice.

On culture: In order to improve our understanding of suicidal behaviour, it is also important to study it in or from different cultural contexts. There are, however, also a number
of obstacles in such an endeavour; difficulties in getting funding and a lack of resources and/or competence in developing countries. In addition, some editors in Western based journals are reluctant to publish studies with a cultural perspective and/or from non-Western parts of the world, particularly from developing countries. Studies are rejected because they contain a cultural perspective. This not only contributes to a lack of evidence base to inform practice regarding suicide preventive efforts in non-Western contexts, but is also a hindrance to the advancement of suicidology itself. It is also an ethical issue. Such an attitude is also rather strange seeing as most Western societies today are multicultural and therefore there is a need to develop a cultural understanding of suicidal behaviour also within Western countries. It is, however, important to bear in mind that culture is not a static, measurable, explanatory variable, but a process, so also here it is important to conduct qualitative studies.

On theory: Although theoretical thinking certainly is present in parts of suicidological research, it is scarce in much of the mainstream research. And, where there is theory, much of it seems to be based on causal explanations. Although the concept of cause is not always explicitly stated, the underlying assumption in much of the mainstream research seems to be in terms of linear cause-and-effect thinking originating from the natural sciences. This may, however, not be the most fruitful approach. It is difficult to think in terms of causation in human behaviour seeing as so many factors, both internal and external, are involved. It might thus be more fruitful to think in terms of teleological or functional explanations in this field. The suicidal act apparently has a function for suicidal individuals; they want to achieve something by harming or killing themselves, to communicate something, and/or to solve the problems they are struggling with. This, in turn, introduces communication theory as a fruitful theoretical approach. Based on Austin’s, Searle’s and Watzlawick’s thinking, suicidal behaviour can be viewed as communicative acts (Knizek and Hjelmeland, 2007). According to Watzlawick (1991), for instance, everything a human being does is communication and it is impossible not to act and thus impossible not to communicate. People are communicating something to someone by harming or killing themselves. This communication can be internal (communication to themselves) or external (communication to others). Knizek and Hjelmeland (2007) have developed a theoretical model for interpreting suicidal behaviour as communication, and this is also a fruitful approach when studying suicidal behaviour in different cultural contexts (Hjelmeland et al., 2008).

In conclusion, suicidology needs to embrace theoretical, methodological and cultural plurality. In addition to making the research field somewhat limited and repetitive, editors rejecting studies because they are qualitative or because they contain a cultural perspective contribute not only to limit the research base for intervention and suicide prevention in large parts of the world, but are also detrimental to the development of the field itself. With so many questions about suicide still unanswered, we need all kinds of suicidological research as well as to make better use of research from other fields. Now is not the time to limit the theoretical, methodological or cultural scopes of our research, but to broaden them.
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I did my psychiatric training in the 1980s in Östersund, a city in the County of Jämtland in Northern Sweden, and there I soon had some important experiences. My very first patient did not show up for his appointment. It was a new patient, a young man. Some days later, I learned that he had committed suicide. I had never been confronted with suicide before and it was a troubling experience. I started to read about suicide and found that, according to several studies, over 90% of the cases suffered from mental disorder, most commonly depression. My second important experience, also early at my training, was to learn how rewarding it was to treat patients with depression. A couple of weeks of medication with a tricyclic antidepressant and they were lifted from literally the deepest despair to feeling much better, and after a few more weeks into full well-being.

These two experiences appeared to me to be a paradox. I found it disturbing that young people were dying in an easily treated disorder. I made a simple investigation by retrieving from the hospital register a list of suicides who had been in-patients in Östersund and studying their discharge diagnoses. The literature was obviously correct; the majority had suffered from depression. I noticed, however, that most of them had received the diagnosis “neurotic depression”, while only a small number were diagnosed with “endogenous depression”. I had understood that “neurotic depression” was not considered to be an illness, but something understandable in psychodynamic terms. I knew that patients with this diagnosis often received non-specific supportive psychotherapy by paramedics, and often also benzodiazepines and sub-effective doses antidepressants. In contrast, “endogenous depression” was considered to be an illness and was treated with tricyclics in doses of 100-300 mg per day and Electroconvulsive Therapy was also often given. The fact that the “neurotics” never got well was interpreted as confirming that their depression was an expression of a “neurotic” trait, rather than indicating that the therapy was wrong.

Innovative physicians had already in 1970 launched an individual-based prescription register in Jämtland County which made it possible for me to investigate not only hospitalized
suicides but all suicides in a representative sample of the county population. I received the personal identification numbers of 80 suicides in 1970-84 from the Swedish Cause-of-Death register and found in the prescription register that only 8 of these had received an antidepressant during the 3 months prior to suicide. Since the majority had probably been depressed, 10 % treatment suggested to me that undertreatment was indeed relevant for understanding suicide. This was published in 1992 as my first scientific paper [1].

My next step was to study the forensic toxicological investigations of all 3400 Swedish suicides in 1990-91. Only 15 % of these suicides had detectable amounts of antidepressants in their post-mortem blood. This supported the hypothesis that suicide to a large extent occurred among depressed individuals without a correct (if any) diagnosis and, therefore, without adequate treatment. My mentor and friend, Charles L. Rich, M.D., made it possible for me to replicate these toxicological findings in a material of consecutive suicides in San Diego County in the 1980s (8 % positive for an antidepressant), as well as in all suicides in Mobile, Alabama in 1990-95 (15 % positive cases) [2]. Thus, it seemed possible that the conclusion from Sweden might be generalized in an international perspective.

Since the 1970s, it had been well known that depression in the general population was underdiagnosed and undertreated, so there was obviously room for improvement. The use of antidepressants in the population in 1990 was below 10 Defined Daily Doses per 1000 inhabitants per day, suggesting a treatment prevalence under 1 %. Since the point prevalence of major depression in the general population is around 5 %, one might conclude that the use of antidepressants should be 5-fold greater. In my thesis published in 1994, I calculated what impact on suicide rates such an increase might have theoretically and obtained the result that the suicide rate might decrease by 25 %!

In 1996, the result of the calculation had also received empirical support. The new generation of antidepressants with less side-effects had led to a 3.5-fold increase in the use of antidepressants in the population and the suicide rate had decreased by 19 %. Since I was able to verify this in all demographic groups and the other Scandinavian countries, I concluded that we had witnessed a “medical breakthrough” in the prevention of suicide. This was published in 2000 and has since been supported by over 20 ecological studies all over the world [3,4].

My recent work has been directed to investigating whether the decrease in suicide really has occurred among individuals who were taking antidepressants – a prerequisite to infer causality. Since a prevented suicide is a non-event, this is not easy - strictly it is impossible. I have, however, drawn the logical conclusion that each suicide that is prevented because the person is taking an antidepressant will exclusively decrease the number of suicides with antidepressants detectable in post-mortem toxicological screening, and this can be investigated. If the observed decrease in suicide has other causes (i.e. is independent of antidepressants), then the numbers of suicides with and without antidepressants in toxicology will decrease in equal proportions. A necessary first step for establishing the actual pattern of decrease is to estimate the hypothetical number of suicides that should have had antidepressants detected if there had not been a decrease in suicide rates. My co-workers and I published in 2009 a study where this was estimated from trends in non-suicide deaths [5]. We are also in the process of publishing a study where the hypothetical number is estimated by comparing suicides that had been hospitalized under different diagnoses. Both these studies provide evidence on the individual level that the decrease in suicide has occurred in that part of the population that was treated with antidepressants, which implies a causal relationship.
It is proven beyond reasonable doubt by consistent ecological as well as individual-based studies that the target population for suicide-preventive intervention must be all the depressed individuals in the general population, and that the intervention must include treatment with antidepressants. There is also good evidence for that lithium has a suicide-preventive effect. It is probable that all effective treatments of depression prevent suicide. For practical reasons, however, the only possible large-scale treatment is probably antidepressant medication.

The conclusion that antidepressant medication prevents suicide is also logical. For most clinical psychiatrists, it is self-evident. It is, therefore, remarkable that the very idea is so controversial. Some suicidologists are obviously against the whole idea of finding a common denominator for most suicides and derogatorily call such attempts “reductionism”. They find the promising idea of preventing suicide by medication too simple because “suicide has so many dimensions”. Science is, however, about finding general truths that may provide a rational foundation for intervention. Most phenomena have many dimensions, but scientific breakthroughs often mean that very complicated old theories are replaced by simple “self-evident” theories. Copernicus’ heliocentric theory explained the celestial observations much more simple than the theory that the Sun revolved around the Earth. Darwin’s basic idea of natural selection is rather self-evident but its simplicity makes it still very controversial. When the HIV virus can be controlled, the AIDS epidemic will disappear, regardless of whether or not it also has social aspects as claimed by the former South-African president.

I believe the controversy about suicide is linked to the fact that suicide as a phenomenon challenges dualistic thinking. Interpreted as an act of “free will”, suicide seems to prove that the humans have a “soul” in command of the brain. If suicide is caused by a brain dysfunction that can be overcome by a simple “pill”, however, the soul and free will are not relevant concepts and many have problems with that. The idea may certainly also provoke non-physician therapists who cannot prescribe medication. They should not be provoked, however, since the treatment of depression is far more than writing a prescription.

The increased prescribing of antidepressants may have reduced suicide by 25-30 % in different countries, and this implies that “75 %” of the work remains. This does not necessarily mean that the total use of antidepressants must increase further again. I believe it is mainly the quality of treatment that must now be improved. Follow-up procedures must be improved, the choice of antidepressant and the dosing must be more individualized, and refractory and severe patients must be referred to psychiatry. Further, patients with bipolar depression must be recognized and prescribed lithium or another mood-stabilizer before an antidepressant is considered. In many cases, not least when there is a risk of suicide, the treatment may also involve cognitive-behavioural therapy, electroconvulsive therapy, or other interventions.

I believe efforts of psychiatry and primary care are able to avert most suicides and that suicide rates can be reduced to a fraction of what they are today.

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Chapter 26

PERSPECTIVES FROM A CLINICAL SUICIDOLOGIST: AN EVOLVING UNDERSTANDING OF SUICIDE (AND LIFE)

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As a career suicidologist of 27 years, I have spent my entire professional life endeavoring to make sense of suicide. Over these years I have had the opportunity to explore suicidal behaviors from a broad range of perspectives. Early on in graduate school I worked with medical examiners and coroners in their efforts to certify suicides as a manner of death (particularly in equivocal cases where the intent was unclear). Some of this work segued into memorable experiences working with colleagues at the Centers of Disease Control and Prevention, taking a distinctively public health approach to suicidal self-injury. As an aspiring clinician, I gained first-hand perspectives on suicidal suffering when I worked as a graduate consultant to a suicide hotline; more severe suicidal states were routinely seen on a locked inpatient psychiatric unit where I worked as member of a nursing staff. I have listened to countless suicide survivors over the years who invariably describe a kind of suffering that often defies description.

While these experiences have been seminal, the bulk of my work in the field of suicidology has focused on clinical aspects related to working with suicidal outpatients and inpatients. To this end, most of the research I have pursued for the last two decades has focused on various lines of clinical assessment research aimed at understanding the nuances of the suicidal mind. In more recent years, this research endeavor has naturally evolved into a more focused pursuit of effective clinical interventions and treatments for suicidal patients. Moreover, my university-based research team has also experimented studying suicidal rock music lyrics in the laboratory, learned lessons from suicide notes, conducted psychological autopsies, and studied clinical systems of care working with suicidal patients. As my journey in suicidology has progressed, I have had the good fortune to be mentored and influenced by some of the best minds of our field—Berman, Shneidman, Litman, Rudd, Joiner, Beck, Brown, Linehan, Orbach, and Maltsberger (to name but a few luminaries, many of whom grace the pages of this text). In recent years this evolving understanding of suicide has further
coalesced through an integration of perspectives gleaned from clinical research, direct clinical experience, supervision of other clinicians, extensive training of mental health professionals, and important alternative perspectives garnered from suicide wrongful death malpractice litigation.

In terms of my particular interest in the sub-specialization of clinical suicidology, our research has primarily investigated the on-going assessment of suicidal states using an assessment tool called the “Suicide Status Form” (SSF) (Jobes et al., 1997). After many years of clinical and research use, the evolving SSF tool has revealed some very striking, and often surprising, things about suicidal states (at least among various clinical samples). For example, we have seen through a series of qualitative research studies (e.g., Jobes et al., 2004) that an examination of suicidal thought content reveals that suicidal patients are remarkably not preoccupied with their symptoms of psychopathology. Indeed, what we have typically seen among those in treatment—outpatients and inpatients—is a notable focus in their suicidal thinking centering on relational, vocational, and self-related issues. These data sharply contrast with a four decade preoccupation in the larger suicidology literature on mental illness and symptoms of psychopathology as the etiological root of suicide. While I never ignore psychopathology, such findings from our research have convinced me that treating suicidal risk should ideally be more directly focused on what actually makes a person suicidal—what we call in our treatment research the direct and indirect “drivers” of suicide. In a related vein, when a clinician earnestly endeavors to empathically understand the true phenomenological nature of a patient’s suicidality, it quite naturally reveals the appropriate treatment focus. In other words, the best target of suicidal treatments should be on what makes someone suicidal as defined by the patient. In my own work, this kind of thinking ultimately led to the development of the “Collaborative Assessment and Management of Suicidality” (CAMS). CAMS uses a multipurpose version of the SSF as clinical roadmap that guides collaborative assessment and treatment planning with the patient. On-going suicide risk is closely tracked while a suicide-specific problem-focused set of interventions are used to systematically eliminate suicidal coping (Jobes, 2006). Correlational research thus far has provided solid preliminary support for CAMS (e.g., Jobes et al., 2005); more definitive randomized clinical trials are now underway to test the causal impact of the approach.

Taken together, years of empirically studying suicide and extensive clinical work with suicidal patients, have more recently led to some broader considerations about contemporary assessments and treatments of the suicidal patient and a related critique of some of current clinical practices. Some of these emerging clinical considerations potentially go against the grain of some conventional clinical practices. Nevertheless, I believe these emerging ideas represent a thoughtful and increasingly empirically-informed optimal approach to providing effective and ethical clinical care for suicidal individuals (Jobes, Rudd, Overholser, & Joiner, 2008).

Many of these emerging considerations emphasize a number of practical points about clinical practice—the importance of thorough informed consent, adequate and multi-dimensional assessments of suicidal risk, the use of empirically supported interventions and treatments, re-thinking the automatic use (or over-use) of inpatient hospitalizations, and thoughtful considerations about ethics and risk management. As part of this thinking, “no-harm” contracts are eschewed while there is an alternative emphasis on adaptive coping (particularly in crisis), problem-solving, skill-building, and help-seeking. Those who advocate this line of thinking tend to emphasize the importance of specifically targeting suicidal
ideation and behaviors as the focus of treatment—not the overarching psychopathology. Moreover, clinical treatments oriented in this fashion often emphasize an empathic stance toward suicidal states; suicidality is therefore seen as a basic effort to cope and problem-solve (albeit in a limited and drastic manner). Nevertheless, when a clinician is truly empathic of any such suicidal state, it can open the door to offering viable coping alternatives that may prove to be life-saving. Yet when one pursues treatment in this fashion, there is often a corresponding need to recognize the limits of what we are able to clinically control. One can argue that the prevailing contemporary approach to a suicidal person is too often a concerted effort to control, coerce, shame, and blame as the optimal method for clinically preventing suicide.

While I completely acknowledge and embrace a suicide prevention bias, further reflection has frankly sobered me to recognize the limits of our actual control over suicide. It seems to me that while suicidal states are perhaps most dominated by intense variations of intense psychological suffering, what follows closely behind are basic issues of power and control which is routinely seen in suicidal acts. To state the obvious, it is patent clear that people can and do regularly kill themselves, both in and out of clinical treatment. Indeed, all our considerable efforts to understand and clinically control the act are rendered utterly impotent when patients—even in inpatient psychiatric units—display their capability to die by suicide. In this sense, a stark truth is made brutally plain: a clinician can provide outstanding clinical assessment and treatment and a determined patient can still take their life. Bottom line, even at its best, clinical suicide prevention can be an extremely elusive, exasperating, and challenging undertaking.

While such a view may seem bleak, I nevertheless remain an unwavering optimist about the prospects for suicide prevention. In my professional lifetime, there are many examples of meaningful decreases in some suicidal behaviors. We have seen major advances in public health initiatives (e.g., two generations of thoughtful media reporting guidelines). We have witnessed the development of a cogent national strategy in the US and elsewhere, and we have all seen significant advances in the rigor of our research methodologies and our empirical findings have been notably enhanced therein. Our literature has increased exponentially in recent decades. As noted, clinical research is creating evidence-based advances with real promise of making life-saving differences.

But at the end of the day, what most strikes me as a career suicidologist is how studying suicide has shed valuable light on the nature and meaning of life. Ironically, we see in the inherent struggles of suicidal people those things that many of us seek and crave in our own lives—meaningful work and love, a comfortable sense of one’s self in the world; a life rich with enticing plans, worthy goals, and hope for the future. It thus seems natural to seek lives worth living, replete with purpose and meaning. Such are some of the key lessons learned, essential life-truths, from the systematic study of suicidal people.

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FROM LIBERAL TO BIBLICAL: MY JOURNEY IN SUICIDOLOGY

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I think my interest in suicide emerged from one vivid experience I had as a child. One of the most interesting of my parents’ visitors was their friend, Mr. X, who was a refugee from World War II-era Austria. Mr. X had been a Jewish engineer in Vienna who fled when the Anschluss occurred, and came to Chicago where he worked as a tool-and-die maker and lived in a single room in a local YMCA. After the war, he kept talking about bringing his mother to America, and it seemed to be what he wanted more than anything else in the world. She finally did come to be with her son, leaving her daughter’s home in Paris. After his mother arrived, Mr X’s life dramatically changed. They moved into an apartment together in Chicago.

One morning, about a year and a half after his mother arrived from Europe, our family received the news that X had taken an overdose of sleeping pills and killed himself. He had been at our home the evening before his death. What struck me, from my child’s viewpoint, was that Mr. X committed suicide after he got what he seemed to have gotten so much of what he had wanted. I couldn’t understand why this had happened. Why had Mr. X killed himself?

I grew up and receive my doctorate in psychology. After many years as a social psychologist, I began to become interested in more clinical areas, and I became licensed first as a social worker and then as a licensed clinical psychologist. As I began to get further into my work on suicide and suicide prevention, I began to question some of my long-held assumptions. My serious, psychological work really began as I began to be disenchanted with traditional liberalism on a whole host of issues. Among them was that if I really believed in rights so strongly, why did I not unequivocally support a person’s right to die rather than try to talk them out of it? I would recall many hotline calls I would receive as a volunteer, when I felt I was playing chess with the caller for their life. I did not simply take the caller’s suicidal utterances as a right, but often used all my skills as a therapist to prevent them from acting out their suicidal impulses, or even seriously initiating them.
About this time, I came across a book that stunned me: *Suicide in Greek Tragedy* by Milton Faber. He made the case compellingly that the Greek tragedies of Sophocles and Euripides were filled with suicides. There were close to twenty suicides in the surviving twenty-four extant plays of these two playwrights! Why were all these classical Greeks killing themselves? One morning, I woke up with a burning compound question: were there suicides in the Bible, and how many, and if so, what types were they? I discovered quickly that there were only six suicides in the Hebrew Scriptures (Old Testament) and only one in the Christian New Testament. There were some in the Talmud, but not all that many, and usually in reaction to extreme cases of persecution.

Was there a difference in the way in which Greek and Biblical worlds viewed life and death? This led to a series of articles and a subsequent book I co-wrote Yet this work remained largely theoretical and was quite disconnected from my clinical practice, which had been done in private practice in the Detroit area in the late 1980’s, and which was now part of my volunteer work as unpaid part-time Director of an emerging Suicide Center at Michael Reese Hospital and Medical Center in Chicago.

The cases we saw in the adolescent unit at Michael Reese often involved cases of attempted suicide and homicide. The patients were primarily minority, often Black or Hispanic. Many of the Black boys came from families with absent fathers. We did family and individual therapy on these—often charming and personally compelling—adolescents. I slowly began to realize that many of these physically mature and imposing young men were hopelessly enmeshed with their mothers. The sexually-provocative young women, on the other hand, were often looking for a genuine love, and often acted out sexually to try to achieve this. The more I began to examine at these families, the more they reminded me of situations described in Greek tragedy.

During this time, I had the good fortune of being invited by Dr. Martin Harrow to study suicidal behavior in perhaps the most thorough longitudinal study of psychiatric patients going on in the world: The Chicago Follow-up Study. Patients originally hospitalized in the early 1980s with a variety of psychiatric diagnoses were being followed up every five years or so for over 20 years. I pitched this idea of studying suicidal and we received several small grants from them. We found very striking results: a disease-specific approach to suicide risk factors. We presented these data at the American Association of Suicidology and won The Alexander Gralnick Award for outstanding original research in suicide and schizophrenia in 1998 (Kaplan and Harrow, 1996, 1999). It was now the early 1990’s, and I was asked by several people on the editorial board of the Detroit Free Press who knew of my work in suicide-prevention to serve as psychological consultant on their study of the ongoing Kevorkian cases of physician-assisted suicide. The Free Press wanted to address the question as to what people were going to Kevorkian to die, why they were going, and what criteria he used to select or reject specific individuals who came to him to assist in their suicides.

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2 Kaplan, K. J. & Harrow, M. (1996) Positive and negative symptoms as risk factors for later suicidal activity in schizophrenics versus depressives. Suicide and Life-Threatening Behavior, 26 (2), 105-121.
Many of my colleagues in psychology thought the question was a no-brainer: people went to Kevorkian because they were physically ill. And the answer to this question—in their minds—was obvious. However, I was not so sure. Was the physical-illness-aspect of their situations really a red herring? How different were they from the non-physically-ill people who came into our suicide center, expressing wishes to die?

Although Kevorkian was hailed in many quarters as a great defender of the patient’s right to die with dignity, the psychological autopsy we conducted in conjunction with the Detroit Free Press uncovered a number of highly disturbing trends.

**Gender.** 63 of the 93 physician-assisted deaths (67.7%) were women and 30 (32.3%) are men.

**Terminality.** Only 27 of these 93 (29.0%) decedents were judged to be terminal (less than six months to live) while 66 were not terminal (71.7%). More male decedents (11 out of 30, or 36.7%) were terminal than were female decedents (16 out of 63, or 25.4%).

**Anatomical basis for pain.** Only 39 of the 93 decedents (41.9%) were judged by the medical examiners at autopsy to have an anatomical basis for pain while 54 (58.1%) were not so judged.

**Anatomical sign of disease.** No apparent anatomical sign of disease emerged in 6.7% (6 of the 90) of the autopsies for which information was available. Five of these cases were women.

**Disability.** Two-thirds of the decedents (62 of 93) were judged by the medical examiners to be disabled at the time of their death.

**Depression.** Over one-third (36.7%) of the decedents for whom depression data was available (the first 47 cases) were described as depressed, this percentage higher for women (40%) than for men (30%).

**Fear of Dependence.** Ninety percent of the first 47 cases were reported as stating they had a high fear of dependence.

I found this work dovetailing with much of the excellent work of Dr. Herb Hendin and his associates who had uncovered similar trends in the legalized euthanasia program conducted in the Netherlands and also in Oregon and Australia. Common to all these cases was a reported fear of dependence.

During the course of this work, I had the opportunity to view some of the videotapes Kevorkian himself had recorded with his prospective “applicants” before he decided to help them commit suicide. Some of his patients, especially women, did not seem terminally ill at all, but many were disabled. Moreover, Kevorkian seemed to demoralize many of the women, stripping away all meaning from their lives, and emphasizing that dignity could be found exclusively in their deaths. Indeed, Kevorkian praises one woman’s decision to commit

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suicide, as being the first case of euthanasia since classical Greece. Further, on a number of occasions, Kevorkian indicated how much he disliked the Bible. During this period, I became exposed for the first time to the euthanasia films and propaganda of the Nazi party’s T-4 program which began to push for the euthanasia of disabled people in six German hospitals during the 1930’s using arguments quite similar to those of Kevorkian.

I came across the famous Jewish physician Maimonides’ prayer to the physician and saw that it differed from Hippocrates’ oath. For Hippocrates, the physician serves nature, and, along with the patient, combats disease. In contrast, Maimonides sees the physician as serving God, and he sees the disease as God’s beneficent messenger to foretell approaching danger and help the person avert it. Hippocrates, perhaps reacting to the suicidal nature of Greek culture, does prohibit the physician from inducing death. But this is a cold injunction, not accompanied by a positive instruction to tend to a patient in his last hours. Maimonides gives no specific instruction to the physician not to give lethal medicine. Indeed, he does not need to, because the biblical civilization does not equate freedom with suicide, as the Greco-Roman Stoics do, but with fulfilling God’s commandments in life (Avot, 6.2).

I was now determined to proceed full-speed ahead with a program in Biblical psychology and have come to see suicide prevention as a subset of life promotion. I conducted an empirical study in which I attempted to develop a measure of “zenoism”, the tendency to try to find meaning through death as in the story of Zeno the stoic as an alternative to the approach of Job to find intrinsic meaning in life itself as given to him by his Creator. (Kaplan et al. 2007-2008; 2008)

There must be an alternative source of life-meaning than that found in the distressingly frequent incidents of violence around the world to oneself and others, often performed by adolescents and young adults!

I received a Fulbright Fellowship to pursue this topic at Tel Aviv University in 2006-2007 and now have received a grant from the Templeton Foundation to develop an online program in A Biblical Approach to Mental Health with my colleague, Elizabeth Jones, a very fine and courageous woman who herself is a Masters of Divinity. In this program, we offer Biblical narratives as an alternative to the Greek ones so endemic to modern psychology and psychiatry. In this program, we offer the story of Isaac as an alternative to Oedipus, of Ruth as an alternative to Electra, and the story of Jonah as an alternative to Narcissus. The story of Jonah has proved to be especially invaluable in my work on preventing suicide.

We aim in this program to provide a genuine meeting ground between mental health and clergy. We are just ending the second session of this course beginning to enroll students from all over the world. (www.rshm.org). In addition to this, I have published a number of books and articles on related topics over the last few years, (see below).

WORRYING AND RUMINATION AS PART OF THE PRE-SUICIDAL STATE OF MIND

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Worry and rumination, although very familiar to clinicians dealing with suicidal patients, have never received the attention in scientific research they deserve. Only recently, a systematic review of the relationship between rumination and suicidality (Morrison and O’Connor, 2008) for the first time addressed the issue thoroughly.

One of the most frequently heard intentions is: “I wanted to stop my terrible thoughts”. These terrible thoughts, such as: “Nobody loves me”, “I am unlovable”, “I cannot live alone”, “I have no future”, etc., can be torturing when these are rehearsed mentally many times a day for many hours. The wish to end consciousness in itself can become a repetitive thought as well. “I have to stop thinking” in itself becomes a compulsive thought, rehearsed up to 24 hours a day. It is hypothesized that the wish to end these repetitive thoughts is one of the driving forces behind the suicidal act, culminating in the pre-suicidal syndrome as a means of stopping these torturing repetitive thoughts.

The continuous repetition of these statements in the end becomes more than a habit, it becomes a compulsion that cannot be controlled anymore. In that sense repetitive thinking about dying, about stopping consciousness, and about the motives to do so, show similarities with characteristics of worrying and rumination. The conclusion is that suicidal thinking in many instances can be conceived as a special form of extensive and prolonged worrying or rumination. It is advocated that the notion of suicidal worrying or rumination can be tremendously helpful both in research as in mental health care for suicidal patients.

In empirical studies as well as in clinical practice one of the most frequently observed motives for attempted suicide is: My thoughts were so unbearable that I could not endure them any longer. This motivation apparently not only concerns the content of the terrible thoughts, but also the unbearability of these thoughts. The contents of these terrible thoughts have been studied extensively, which resulted in the identification of typical suicidal

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cognitions such as: Nobody loves me, I am unlovable, I have no future, My life has no meaning, I am better of dead, I can’t stand my depression, When does this stop?, When is there an end to my misery?, etc. centering around hopelessness, helplessness and distress tolerance.

There is another dimension of the unbearability of these distressing cognitions however that has not received much attention. One of the characteristic dimensions of these suicidal cognitions is the frequency with which these cognitions are being rehearsed mentally in suicidal episodes. The importance of the frequency became clear to us when, while treating suicidal patients, we tried to measure the amount of times suicidal cognitions were being rehearsed mentally during a day, or the total amount of time a day subjects were repeating their suicidal cognitions. It turned out that many suicidal clients stated to repeat their suicidal thoughts hundreds to thousands times a day, and that the total amount of time these suicidal thoughts occupied their minds amounted to 15 to 20 hours a day, and in times of crisis became obsessive intrusions that kept them awake for several days. The suicidal patients themselves attributed their sleeplessness and vital exhaustion to the impossibility of stopping these thoughts. After attempted suicide some even stated that this unstoppable repetition of suicidal thoughts was decisive in their attempt. A typical sequence consisted of the endless repetition a particular thought such as: I have to stop thinking, I have to stop thinking, I have to …., etc. For those who suffer from these obsessive thoughts the actual stopping of thinking by attempting suicide seems logical and the only way out. We therefore concentrated on this relatively neglected part of the suicidal process and noticed that there are many studies on similar cognitive processes, such as obsessive intrusions, worrying, rumination, or in general repetitive thinking, but that only seldom these processes had been linked to suicidal behaviour. Yet many similarities can be observed

SIMILARITIES BETWEEN SUICIDAL THINKING AND WORRYING OR RUMINATION

Worrying has been defined as: “A chain of thoughts and images negatively affect-laden and relatively uncontrollable, as an attempt to engage in mental problem solving on an issue whose outcome is uncertain but contains the possibility of one or more negative outcomes” (Borkovec, et al, 1983, p. 10.). Rumination has been defined as: “Behaviors and thoughts that focus on one’s attention on one’s depressive symptoms and on the implications of these symptoms, … repetitively focusing on the fact that one is depressed, on one’s symptoms of depression, and on the causes, meanings, and consequences of depressive symptoms” (Nolen Hoeksema, 1991, p. 569). Typical ruminative thoughts are: Why did this happen to me, or, Why do I feel so depressed? Both emphasize the repetitive character of these processes and the uncontrollability people experience when worrying and / or ruminating. Worry and rumination are very similar to one another, they may share the same processes but involve different content (Watkins, 2008). Rumination concentrates on depression while worry has been associated with anxiety, but worrying is prevalent in depression as well as is rumination in anxiety. There are numerous other terms that overlap or relate to worry and ruminating, like: perseverative cognition, stagnating deliberation, anticipatory stress, habitual negative self-thinking, cognitive and emotional processing, mind wandering, etc. The most global and
neutral term for all these processes is **repetitive thinking**, proposed by Watkins (2008). Worry, rumination and repetitive suicidal thinking have similar characteristics and similar consequences: first of all: it is repetitive (hundreds of times a day), it is uncontrollable (people say they cannot control these thoughts from occurring, they often occur without immediate cause), unstoppable (they cannot be stopped or postponed), it is future oriented (*My future has no meaning, I’ll never be normal again, I will always remain a psychiatric patient, When will this stop?*, etc), they are threatening to major personal concerns (a future that threatens the self, relations with people most near and dear), and they offer no solutions nor relief. And there is a kind of meta-process active: people can worry about their worries (Wells, e.a., 1995), one can ruminate about one’s ruminations, and people can become more suicidal because of their repetitive suicidal thoughts.

There are similar consequences as well: worry, rumination, and repetitive suicidal ideation all produce obsessive attention to particular thoughts and to the thoughts one wishes to stop, they produce stress, sleeplessness and vital exhaustion, hopelessness and helplessness, they mostly do not produce adequate problem solving and they can produce the wish to stop consciousness. It is advocated that the notion of suicidal worrying may help understand the pre-suicidal state of mind, may improve communication with the suicidal patient, and may introduce cognitive behavioral techniques into the field of suicidology. Techniques such as suicidal worry postponement, turning worrying towards positive self-statements, and writing down positive future scenario’s, are now being investigated in their effectiveness in decreasing repetitive suicidal thoughts. Preliminary clinical results are promising.

**References**


Chapter 29

‘ANY MAN’S DEATH….’: CHALLENGES OF STUDYING SUICIDE IN PAKISTAN

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‘Any man’s death diminishes me
Because I am involved in mankind’

John Donne

I came across John Donne’s immortal words while still in school. Even at the young age of 10 or 11 years the words seemed to have made a lasting impression on me. Today as I research suicide in Pakistan I often reflect back to the influence these words must have had on me as I went through different stages of my medical and psychiatric training and my interest in the study of suicide.

It was only many years later that the importance of these words dawned on me when I was faced with the first ever suicide of a patient who was under my care.

Unlike surgeons and physicians, psychiatrists are rarely faced with life or death situations in their clinical practice. Except, that is, for suicide.

Suicide is a baffling phenomenon. On the one hand it is one of the most personal acts anyone can ever perform. Yet by the very nature of the act, it attracts a huge amount of publicity.

THE BEGINNINGS

I stumbled upon suicidology quite by chance. When I returned to Pakistan after completing my psychiatric training in the UK in the late 1980s, I was looking for topics to research. The field of psychiatric research in Pakistan was wide open. There had been very
little psychiatric research and virtually nothing on suicidal behavior up until that point. The university hospital where I started working in Karachi (current estimated pop. 17 million) was admitting about 7-10 patients with deliberate self-harm (DSH) acts very month. We were called upon to carry out their psychiatric assessment by the medical teams. It was about that time that I came across an article of ‘parasuicides’ in Arabian-American Oil Company in Saudi Arabia that caught my eye (Daradkeh and Al-Zayer, 1988). I wondered if this is what was happening there, what was the picture in Karachi and Pakistan?

I tried to look up any previous research on attempted/suicide in Pakistan. All I found were two short articles- one published in 1964 (only the reference was available but not the full text one page article) (Ashraf, 1964) and another published in 1981 (Ahmed and Zuberi, 1981). In addition there were a couple of articles on ‘acute poisonings’ in Karachi which concealed some data on ‘suicidal poisonings’ within them. This was the total sum of suicide research in Pakistan!

Yet newspapers in Pakistan were regularly carrying stories of people killing themselves. But why was there so little research on suicide in Pakistan and why was no one interested in studying it? Was it that the numbers were so few that it was not worth wasting one’s time and energy on the subject? This was probably so and underlying this thinking was the long held popular belief that as suicide is Haraam (a sin) in Islam, it does not take place in Islamic countries.

‘IF YOUR INTENTIONS ARE NOBLE….’

There is a saying in our part of the world that ‘if your intentions are noble, then God opens doors for you’. And so it was. In a ironic way, the economy in Pakistan took a dramatic downturn following the country’s testing of nuclear devices in the mid 1990s and suddenly suicide incidents seemed to shoot up. Both the electronic and print media started highlighting the issue and opposition politicians seized upon this to attack government policies. The publicity that suicide attracted meant there was greater awareness about it. It became relatively easier for me to approach the subject.

THE CHALLENGE OF STUDYING SUICIDE IN PAKISTAN

Suicide is a difficult subject to study in Pakistan and the Islamic world. Not only is it strongly religiously condemned but there is a huge social stigma attached to it. Accessing data on suicide or attempted suicide is not always easy. There are very few people studying the subject. Comparing your findings with those of others researchers in other parts of the country is therefore not possible. More often than not it appears that one is working in a vacuum.

People who attempt suicide and survive, live with a terrible guilt of having transgressed the edicts of God. Many are reluctant to come forward to seek help for this reason alone. The underlying conflict that precipitated the act in the first place therefore never gets addressed. Families in which suicide has taken place undergo a range of psychological reactions and also remain extremely reluctant to seek help for fear of being ‘exposed’ in front of others. The
challenge for mental health professionals is how to raise awareness about an issue that the religion so strongly condemns. That is not always easy and one has to tread a fine line between deeply held religious values and raising public awareness.

**THE FINE BALANCE**

There has been a lot written about the relatively low rates of suicide in Islamic countries. And it is probably true that rates are lower than non-Islamic countries. However this notion is being challenged in countries like Pakistan where historically rates were low but appear to be rising since the mid-1990s (Khan, 2007).

Why should this be so? While there are no simple answers, it is probable that complex factors are interacting with each other and it appears that the fine balance between the protective effect of religion and socio-economic factors has been disturbed. This imbalance may be impacting suicide rates in Pakistan. This area needs to be studied further.

**LINKING YOUR RESEARCH WITH OTHERS**

One of the most interesting aspects of studying suicidal behavior is that while it takes place in every society, culture and country of the world there are very few suicidologists in each of these settings. Getting to know such people is therefore relatively easy. It is valuable to get to know the researchers in each of these settings personally. I have found it very useful and interesting as I have tried to compare data from Pakistan with other Islamic countries (such as Iran and Turkey) as well as with countries of the region (such as India and Sri Lanka).

**THE ‘ATTRACTION’ OF SUICIDOLOGY**

In many ways it is a huge privilege to be a mental health professional, particularly in a developing country where the knowledge gap between the physician and patient can be huge. The kind of information one has to gather in a psychiatric assessment means entering areas of peoples’ lives where even close family members are not permitted access. To study a subject like suicide which is so strongly rooted in socio-cultural, religious and personal factors requires an even more ‘closer’ relationship with people. I have found it immensely satisfying but also humbling both in terms of helping survivors of a suicide attempt as well as surviving family members to understand the process that may have led to the tragic act of their loved one. Many have expressed their gratitude in helping them understand and in some ways, reach a closure.
THE ULTIMATE SACRIFICE?

I feel that individuals who commit suicide extremely tormented people who unfortunately reach a point where nothing matters to them and somehow they find the ‘courage’ to take their own life. These people need to be understood and helped. These tragic individuals have difficulty in coming to terms with their conflicts; many have difficulty in expressing themselves or seeking help. But they are also individuals who, in some ways make a huge sacrifice. Like soldiers who go into and die in battle so others may live, people who commit suicide, also provide us- the suicidologists- study material to understand and explore and research the phenomena and thereby come up with prevention strategies that may prevent the deaths of other suicidal individuals. In some ways people who commit the suicide have made the ultimate sacrifice.

As suicidologists we must never forget this.

REFERENCES

Chapter 30

A BRIEF BIOGRAPHICAL NOTE

Antoon A. Leenaars

Henry Murray, Edwin Shneidman’s mentor and equally a who’s who in suicidology, noted, “Never denigrate a fellow human being in fewer than 2,000 words”. The task here, urged upon me by the editor of this volume, is to present a biographical note in 1,500 words. Therefore, this is a self-directed reductionism, calling denigration upon oneself.

My main work is in suicidology. I was born on January 2, 1951 in Ulvenhout, The Netherlands to Cornelius and Anna Leenaars. The most important influence in my early years was my beloved grandmother, Cornelia van Hooydonk. After early schooling, I immigrated to Canada, and my life and work could best be described as international, probably a reflection of my status as an immigrant. I am married to my high school friend, Susanne Wenckstern (who is no stranger to the field of suicidology); we have three children: Lindsey, Heather, and Kristen.

A few biographical notes: I am a registered psychologist in private practice in mental health, public health, and forensic sciences, Windsor, Canada; affiliated with the Norwegian Institute of Public Health, Division of Mental Health, Norway; and was a member of the Dept. of Clinical and Health Psychology, University of Leiden, The Netherlands and the Dept. of Public Health Sciences, Karolinska Institutet, Sweden. My main mentor was Dr. Edwin Shneidman, a Father of Suicidology. (I am proud to say that he is a major intellectual influence in my life.) I am the first Past President of the Canadian Association for Suicide Prevention (CASP), and a Past President of the American Association of Suicidology (AAS), the only non-American to have served in that role. I have collaborated with over 100 colleagues in over 35 nations, and have published over 150 professional articles/chapters on violence, suicide, altruistic suicide, suicide notes, homicide, genocide, prevention, psychotherapy, public health, gun control, ethical/legal issues, and related topics. I have published 13 books/reports. The books can be divided into five categories. I felt the contributions are very well represented by these selections: Edwin Shneidman, Suicide, Developmental Perspectives, Cultural and International Perspectives, and Prevention and Clinical. Here are the books: Edwin Shneidman: Suicideology: Essays in Honor of Edwin Shneidman (Edited. Jason Aronson Inc., 1993), and Lives and Deaths: Selections from the Works of Edwin S. Shneidman (Edited. Brunner/Mazel, 1999); Suicide: Suicide Notes (Authored. Human Sciences Press, 1988), Suicide and the Unconscious (Edited with David
Suicide and Homicide-Suicide among Police (Authored. Baywood Publ. Co, 2010); Developmental Perspectives: Life-Span Perspectives of Suicide (Edited. Plenum, 1991); and Suicide and the Older Adult (Edited with Ronald Maris, John McIntosh, and Joe Richman. Guilford, 1992); Cultural and International Perspectives: Suicide: Individual, Cultural, International Perspectives (Edited with Ronald Maris and Yoshitomo Takahashi. Guilford, 1997), Suicide in Canada (Edited with Susanne Wenckstern, Isaac Sakinofsky, Ron Dyke, Michael Kral, and Roger Bland. University of Toronto Press, 1999), and Suicide among Indigenous Peoples: The Research (Edited with Marlene EchoHawk, David Lester, Lindsey Leenaars (she continues the family’s interest in the field), and Elisabeth Haramic. Routledge, 2006); and Prevention and Clinical: Suicide Prevention in Schools (Edited with Susanne Wenckstern. Taylor and Francis, 1989), Treatment of Suicidal People (Edited with John (Terry) Maltsberger and Robert Neimeyer. Taylor and Francis, 1994), and my favorite book, Psychotherapy with Suicidal People: A Person-Centred Approach (Authored. John Wiley and Sons, 2004). To take ‘Occam’s razor’ to these works: my main goal in these books has been to understand, predict, and control, by idiographic and nomothetic science, embracing both quantitative and qualitative approaches, the unique suicidal individual and suicidal people in general, within a cultural/global world.

Main contribution: Suicide is a multi-dimensional event. A main payoff of all our study lies primarily in understanding suicide and suicidal behaviour, and, in order to do so, my effort has been in developing an evidence-based theory, based on the person’s, who died by suicide, own words, the suicide note. My evidence has been cross-cultural: Australia, Canada, Germany, Hungary, India, Lithuania, Mexico, Russia, Turkey, United Kingdom and United States. This is the most extensive cross-cultural evidence-based theory, and has direct implications for prevention.

Suicide can be clinically understood from at least the following evidence-based commonalities or patterns, both intrapsychic and interpersonal, within the context of a larger ecological model.

**INTRAPSychIC**

1) Unbearable Psychological Pain

The common stimulus in suicide is unbearable psychological pain, an intense mental anguish. The person may feel any number of emotions such as perturbed, rejected, and especially hopeless and helpless. The suicide is functional because it abolishes the painful tension for the individual, a solution.

2) Cognitive Constriction

The common cognitive state in suicide is mental constriction, i.e., rigidity in thinking, narrowing of focus, etc. The person is figuratively "drugged" by the constriction; the intoxication can be seen in emotions, logic, and perception. This constriction is one of the most dangerous aspects of the suicidal mind.

3) Indirect Expressions

Ambivalence, redirected aggression, unconscious processes, and related ‘to dissemble’ phenomena are often evident in suicide. The suicidal person is ambivalent (e.g., love and
hate, survival and unbearable pain). Yet, what the person is conscious of is only a fragment of the suicidal mind.

4) Inability to Adjust (Psychopathology)

Studies of suicide notes suggest that many, not all, people who kill themselves have some symptoms of psychopathology and/or problems in adjustment. Although the majority of suicides may fit best into mood spectrum classifications, (e.g., depressive disorders, bipolar disorders), other emotional/mental disturbances have been identified (e.g., anxiety disorders, schizophrenic disorders). Suicidal people have a core belief that they are too weak to overcome difficulties, and reject everything except death.

5) Ego (Vulnerable Ego)

The ego with its enormous complexity is an essential factor in the suicidal scenario. The Oxford English Dictionary defines ego as "the part of the mind that reacts to reality and has a sense of individuality." Ego strength is a protective factor against suicide. Suicidal people frequently exhibit a relative weakness in their capacity to develop constructive tendencies. A vulnerable ego, thus, correlates positively with suicide risk.

INTERPERSONAL

6) Interpersonal Relations

The suicidal person has problems in establishing or maintaining relationships. There are frequently disturbed, unbearable interpersonal situations. Suicide appears to be related to an unsatisfied or frustrated attachment need, although other needs may be equally evident, e.g., achievement, autonomy.

7) Rejection-Aggression

Rejection-aggression is central to suicide; the loss is often an unbearable narcissistic injury. This injury/traumatic event leads to pain and in some, self-directed and/or other-directed Ahab rage. Aggression is, in fact, a common emotional state in suicide.

8) Identification-Egression

Intense identification with a lost or rejecting person or with any lost ideal (e.g., health, employment) is crucial in understanding the suicidal person. Identification is defined as an attachment (bond), based upon an important emotional tie with another person or any ideal. If this emotional need is not met, the suicidal person experiences a deep pain, and the person wants to escape.

Some further notes: I was the founding/first Editor-in-Chief of *Archives of Suicide Research*, the official journal of the International Academy for Suicide Research (IASR), and served on the editorial boards of *Suicide and Life-Threatening Behavior, Crisis*, and *Death Studies*. I am a recipient of The International Association for Suicide Prevention’s biannual Stengel Award, CASP’s Research Award, and AAS’s Shneidman Award, for outstanding contributions in research in suicidology. I was awarded, from my undergraduate university, Brock University’s Recognition of Excellence among Alumni, Thirty from the Past Thirty. I was awarded the status of Fellow of the Canadian Psychological Association (CPA) for distinguished contribution to the advancement of the discipline of psychology in Canada. I have been recognized for my international efforts in suicide prevention; for example, in the Arctic, and Lithuania (the country with the world’s highest suicide rate), and have consulted
for the World Health Organization (WHO; e.g., *World Report on Violence and Health, Preventing Disease through Healthy Environments*), institutions and governments around the world. I have been featured in national and international media (e.g., *The New Yorker*) and have served as an expert investigator/witness on cases of wrongful death, suicide, homicide, and homicide-suicide for police services, coroners and lawyers (e.g., the lead investigator in homicide-suicide of police officers Dave Lucio-Kelly Johnson). I am listed in *Canadian Who’s Who*, and lecture regularly worldwide on topics related to suicidology.

**BIBLIOGRAPHY**

The editor has allowed us to list five publications:


I came to the study of suicide serendipitously. I went up to Cambridge University to read physics and, although it was rare to change one’s field of study, in a moment of panic, I switched to psychology. Psychology at the undergraduate level at Cambridge University was solely experimental psychology: learning, perception and physiological psychology. One day, in the psychology library, I pulled Shneidman and Farberow’s *Clues to Suicide* from the shelves and perused it. (I have often wondered how it came to be in that library.) When I came to the 33 pairs of suicide notes, not only did they move me to tears, but I recognized the genuine note in each pair immediately.

I emigrated to the United States in 1964 and went, serendipitously again (they offered me a generous fellowship), to Brandeis University where Abraham Maslow was still in residence. In his psychology department, instead of graduate students being assigned as servants to faculty, we were allowed to choose our own topic for study. Out of the blue, it seemed to me, I chose suicide.

Maslow refused to teach graduate students, so I took an undergraduate course with him, became his teaching assistant, and asked him to join my dissertation committee. After he retired, the department became much more traditional, and students no longer chose their own dissertation research topic.

In the second year of my first teaching position (at Wellesely College), Gene Brockopp contacted me to join his suicide prevention center in Buffalo, New York. I accepted immediately and spent two happy and productive years there (1969-1971). I carried out a great deal of research on suicide and the evaluation of suicide prevention centers, and we started a journal which we sent to people in the field free of charge – *Crisis Intervention*.

Having left academia, I now knew that I preferred that setting, and I was fortunate to move to the Richard Stockton College of New Jersey which opened in 1971. I joined as head of the psychology program and participated in the many decisions involved in starting a new institution of higher education. The campus was not ready when we opened, and so our first semester was in a bankrupt hotel on the Atlantic City boardwalk called the Mayflower Hotel. Hence, we are called the Mayflower group! I have remained there ever since, presently as a Distinguished Professor of Psychology.

There have been several themes in my scholarly career. First, having been tenured in 1974 and promoted to Full Professor in 1975, and being at a college of no great reputation, I have been able to conduct any research I desire and publish it anywhere I wish. I have never faced the constraints of publishing only on “acceptable” topics and in “prestigious” journals.
Indeed, I have published in the top journals in several fields, but I have never had to reject a journal for one of my articles because publication in such a journal “would not count” toward promotion or tenure.

A second theme has been my interest in all of the disciplines in the social sciences. I read or perused every article on suicide in the English language from 1897 to 1997, regardless of the discipline. Not only has this broadened my knowledge of suicidology, but I have also conducted research and published in all of those disciplines, including anthropology, biology, criminal justice, economics, pharmacology, psychiatry, psychology, public health, religion and sociology. As a result, I have been able to take ideas and methodologies from one discipline and apply them in others.

A third theme has been my involvement with scholars around the world. I have found it easy to make contact with and develop collaborative relationships with researchers in more than thirty four nations. (Robert Goldney noted this in an article about me in Crisis in 2005.) Not only do I find this stimulating and interesting, but I have also enjoyed encouraging others in their research endeavors, and I have worked and published with colleagues ranging from undergraduate students to senior scholars in the field.

Along with this, I have been able to publish in scholarly journals around the world and in many languages, including Arabic, Chinese, French, German, Greek, Japanese, Italian, Hungarian, Polish, Russian and Spanish. I have been criticized for this, but I hope that my articles in journals in those nations have stimulated the interest of researchers in those nations in suicidology.

A fifth theme is my pleasure in ideas per se, including both sides of an issue. For example, I have used Ludwig Binswanger’s case of Ellen West to support the concept of suicide as a “good” death, and I have also accused him of psychic homicide in letting Ellen West commit suicide. I have written extensively on preventing suicide, but I have also published a book on how to commit suicide (Fixin’ to Die). Indeed, I have considered the possibility of writing under a pseudonym and criticizing my own work!

A sixth theme is that my scholarly interests have included other death-related issues including murder, life after death, war, and the measurement of the fear of death. The Collett-Lester Fear of Death Scale has been widely used. In addition, my major field within psychology is theories of personality, and I have recently published a “new” theory which I have called “A Multiple Self Theory of Personality.”

A final theme is the quantity of my output, a facet of my work for which, again, I have been criticized. I have now over 2,400 scholarly notes, articles, chapters and books. I have often been asked how I manage to be so productive, and I have often been admonished that I should work on fewer projects, that somehow the quantity of my output dilutes its impact. I learned in my 20s how to deal with the query as to why I publish so much – because it is fun to do so. More recently, I have begun to turn the question around. “The issue is, surely, why don’t you publish more?”

As to whether my impact in the field has diluted my impact, I have never focused on having an impact. My focus has been on having scholarly fun and keeping occupied. I become bored very easily. What I have noticed, however, is that my productivity has aroused jealousy and hostility in others, which is a pity. The field of suicidology is small, and it would be wonderful if greater collegiality could prevail, but suicidologists are, of course, human and not immune from foibles. The rivalries in the field are illustrated by the many competing organizations that have been formed over the years.
Perhaps I should end with some statement as to what I think are my most important scholarly contributions to the field, but I would not dream of doing so. That is not for me to say. Time will tell. When I began reading articles on suicide from 1897 on, I spent a lot of time in the Francis A. Countway Library of Medicine in Boston, in the basement, blowing the dust off bound scholarly journals so that I could read articles. I used to muse on the fact that eventually my articles would be in a basement somewhere, gathering dust. Technology has changed that. Now we are all on PubMed, Sociolit or PsycINFO, but soon, just the same, no-one will read us. With hundreds of articles on suicide appearing each year, we search only the last few years of publications in those databases. Very soon, the task of searching for articles written in the 20th Century will be too onerous. Perhaps in fifty years from now, Durkheim will still be the most cited suicidologist.
Chapter 32

SUICIDE, PASSION AND SCIENCE: CONCLUSIONS ON THE PATH

Marsha M. Linehan
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There are thousands upon thousands of studies of suicidal individuals. There are innumerable studies attempting to predict suicide. There are uncountable books telling clinicians how to treat suicidal behavior. Standards of care, developed undoubtedly after hundreds of meetings, determine liability in cases where patients commit suicide. Where are the rigorous intervention development and evaluation studies for treating or preventing suicide. As of this date, there are fewer than 50 randomized clinical trials of interventions aimed at treating suicidal individuals. Suicide prevention has failed. Rates of suicide have not appreciably changed in the last century.

From the very beginning of my career I have been passionate about understanding and treating individuals with such excruciating emotional suffering that they want to be dead, particularly those who want to kill themselves. When I discovered (to my dismay) that we didn’t know much about how to treat people with either mental disorders or suicidal behavior I became disenchanted with the social value of being a therapist. I decided that a research career would make more sense. Believing I would get better research training, I entered the social and experimental personality psychology programs at Loyola University 1968, planning on getting clinical training later. This background continuously influenced me later to look to social and experimental psychology for ideas when developing treatment interventions for suicidal individuals.

Social psychology is, after all, the study of social influence, which is exactly what psychotherapy attempts to do. The pulling apart in many programs of clinical psychology from the basic behavioral science that is psychology is a deterrent to developing the translational research that is surely necessary if we are ever to make a dent in the worlds suicide rates. The housing of clinical investigators in medical schools and psychology, as well as nursing and social work departments inhibits the exchange of data and out-of-the-box thinking that must happen to advance the field of suicide intervention.
In 1971 I talked my way into the Buffalo Suicide Prevention and Crises Service who agreed to call my year a clinical internship. The next year I went to SUNY at Stony Brook as a fellow in their post-doctoral program in behavior modification. I was later told that the idea of anyone applying behavior modification to suicidal individuals was just off the path enough for them to offer me the position. Jerry Davison, the director of the program, later appointed me to the board of directors of the Association for the Advancement of Behavior Therapy, and by that one action opened up to me the world of great psychotherapy researchers.

There are innumerable potential clinical researchers in the world with the creative and scientific characteristics that I and those of us who are well known have. The difference is that I got an opportunity that many do not get. When it comes to suicide intervention research, an area with very few rigorous scientists we must find a way to entice all these unfound creative researchers to enter our field.

After Stony Brook, I went to Catholic University where I got a small university grant to evaluate an assertiveness intervention for suicidal patients. Roger Barton conducted the outcome study as his dissertation. At the same time, I also started working with program staff at NIMH: Stephanie Stolz, Morris Parloff, Irene Elkin, and Barry Wolfe. The main thing they did was believe in me. Over subsequent years they also taught me how to write grant proposals, gave me invaluable feedback on designs, and worked like hell to keep me funded.

Clearly, if we want a field of suicide intervention research to develop, we must find a way to nurture our young scientists, teach them the skills necessary to navigate the research grant process, and most importantly, believe in them.

After coming to the University of Washington in 1977, I was asked by John Clarkin at Cornell Medical School to write a chapter on treatment of suicidal behavior for a book on depression he was editing. I spent over a year researching suicide risk factors and treatment and ultimately developed a social-behavioral model of suicidal behavior. This model then influenced my work for the next several decades and forms an essential element of the treatments I have developed for suicidal behaviors. In 1980 I received federal funding to develop a behavioral intervention to treat suicidal individuals. Concerned that mildly suicidal or less disturbed people might respond to a placebo control condition, I selected only repeatedly suicidal individuals who were, for the most part, treatment failures. At the time, however, there were no assessment instruments that provided information on both the topography and severity of suicidal behaviors (ideation, suicide attempts, non-suicidal self-inflicted injuries.) Therefore, I also started developing three assessment instruments to measure treatment outcome, the Suicidal Behaviors Questionnaire, the Suicide Attempt Self-Injury Interview and a Self-inflicted Injury Count.

Looking at current research on suicidal behaviors, it is stunning the lack of operational definitions, the absence of measures with adequate psychometric characteristics and the absence of reliability assessments in most research studies. There can be no science without reliable and valid measurement. There can be no science without operational definitions and valid and reliable measurement.

The treatment I developed (Linehan, 1993b; Linehan, 1993a) was based on the premise that to reduce suicidal behavior, you have to treat the behavior directly rather than assume that treating associated mental disorders is the treatment for suicidal behaviors. The idea that suicidal behavior should be treated directly went against the prevailing standard of care both then and now that asserted that treatment of depression or other mental disorders should be the first line of treatment.
There are undoubtedly many reasons why applying standards of care in suicide has trumped evaluating the efficacy of these standards of care. Our belief that we know how to treat suicidal individuals has kept us from finding out how to treat them. In contrast to treatment research with other highly lethal patients, research on treatment of suicidal individuals is sometimes considered too risky by universities (and also by pharmaceutical companies). Interventions other than standard of care are difficult to get approved by human subjects institutional review boards (IRBs). As a person who has now spent over 35 years navigating IRBs to study and treat highly suicidal individuals, it is clear that to be successful doing suicide intervention research an investigator must take on the task of educating IRB members. This is difficult without expertise in both scientific methodology and clinical care of suicidal individuals. A surplus of scientific evidence can often convince an IRB to let you take a risk. Clinical experience and savvy are often necessary to convince IRBs that you will know what to do if a difficult clinical situation arises. Clinical investigators are ordinarily not well trained in scientific methodology and all too often believe that standards of care are evidence based when they are not. Individuals with adequate scientific training and skills, on the other hand, all too often do not have adequate clinical experience treating highly suicidal individuals. Alas, clinicians are rarely scientists and scientists are too rarely clinicians.

Although I am well known as an expert on borderline personality disorder (BPD; a disorder with an 8-10% suicide rate), the first complete version of the treatment manual I developed, dialectical behavior therapy, focused on suicidal behavior and never mentioned borderline personality disorder. Selecting repeatedly suicidal individuals insures that a large portion of your subject sample will meet BPD criteria. As a disorder of extreme emotional suffering combined with an inability to regulate emotions, suicide is often the only vehicle that the individual can imagine that will end, or even just reduce, the suffering. At present, DBT – an intervention that aims for a synthesis of both acceptance of what is and change of what is- is a well researched and effective treatment both for BPD and for suicidal behaviors. (Lieb et al., 2004). Difficulties training graduate students to treat very serious, frequently out-of-control and highly suicidal patients in the University of Washington psychology clinic led me in 1997 to pull graduate DBT training out of the Psychology Clinic. I formed a smaller treatment development clinic (TDC) within the BRTC which now has primary responsibility for training in DBT and the treatment of suicidal behaviors. The absence of required training in the treatment of suicidal behaviors in most clinical psychology programs is understandable given the absence of scientific evidence for the effectiveness of most standards of care taught in clinical programs across disciplines. However, unless we find a way to insert into psychology the scientific study of both suicidal behaviors and those treatments that do have good evidence, we have little hope of improving the treatment of these individuals. Psychotherapy is, in essence, a psychological intervention (in contrast to biological interventions) and, thus, psychologists must take on the responsibility of applying the science of human behavior to the mandate of reducing death by suicide.

In 2007, utterly dismayed by the absence of new investigators researching treatments for suicidal behaviors, I launched a strategic planning group aimed at all individuals I could find who were interested in developing and evaluating treatments for suicidal individuals. The aim here was to invite the very few senior suicide intervention researchers to attend with the aim of assisting more junior researchers develop successful suicide intervention research programs and grant proposals. We have had two meetings now and out of this group has come a number of young, passionate and promising new researchers developing and/or
evaluating strategies for ameliorating the intense suffering burdening and constricting the lives of those who are suicidal. Each investment that we make in young researchers, particularly those with new ideas that challenge the cherished ideas of their elders, will contribute to the formation, growth and strengthening of a field of suicide intervention and prevention research. We will not get there by loving more, by teaching more clinicians untested standards of care or by publishing research studies that do not define and reliably measure the behaviors of interest. We will not find a way to treat those most in need of our science by petty squabbles about who is best, by refusing to share our best ideas and strategies for getting our research funded. Nor will we get there by watering down our science, by dropping our scientific methods for the sake of expediency or by claiming to know what we do not know.

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Chapter 33

**Biographical Statement**

*John T. Maltsberger*

Before 1960 suicide meant little to me. Of course I was aware of the phenomenon. I knew suicide was something depressed people might do, or distracted disappointed lovers. It nevertheless remained an alien matter to me, and it was, all in all, less arresting than what as a medical student I had begun to learn about the psychopathology of everyday life. Every day the basic observations that underlay Freud’s discoveries were being re-evoked and demonstrated to the Harvard students in the psychodiagnostic clinics of Ives Hendrick, one of the greatest clinical teachers of that era. “Learn from the patients,” was his unspoken motto. “Study them, think about them, let them teach you. Let theory wait, and, should you theorize, anchor your theory in what you can observe.”

If this motto informed my first exposures to psychiatry, it further underlay my psychiatric education at the Massachusetts Mental Health Center for another five years. That institution (originally named the Boston Psychopathic Hospital) was primarily devoted to training young psychiatrists. It was not driven by economic or insurance company pressures as are so many institutions today. Financed as a screening, triage institution by the Commonwealth of Massachusetts—a feeder into its then vast state hospital system—it was administered by the Harvard Medical School and staffed by Harvard selected faculty (mostly psychoanalysts) and trainees (most of whom were in analysis). Patient admissions were controlled and limited, and patients were mostly selected according to their expected usefulness in the training program. Once admitted, some patients might even remain a year or two, but all were studied, interviewed, and discussed intensively. We residents of the time took exhaustive histories and drew as empathically close to the patients as we could. Most of us were earnestly learning to be psychotherapists. This was the era in which the possibilities of psychotherapy seemed

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1 John T. Maltsberger graduated from Princeton University (1955) and the Harvard Medical School (1959). He has taught medical students and mental health clinicians continuously since the completion of his psychiatric training.

2 Ives Hendrick (1898-1972), late Clinical Professor of Psychiatry at Harvard, taught medical students and residents for thirty years. A leader in American psychoanalysis, his skill at clinical examination was phenomenal, just as was his devotion to teaching and learning.
unlimited, it was the era of Maryland’s Chestnut Lodge, the eras of Frieda Fromm Reichman and Elvin Semrad.3 How ingenuous we were! How we idealized our teachers!

In this milieu I learned what suicide truly means. When my residency training commenced in 1960 I was thrust, along with my green colleagues, into psychiatric units full of schizophrenic, depressed, and borderline patients. Wrist-cutting was commonplace and one man amplified this by almost cutting his throat. These patients stunned and almost stupefied us. Such behavior I had read about, heard about, but living with those threats, mutilations and suicide attempts was an altogether different matter, different in immediacy and different in emotional impact. We had read about such things in textbooks or Russian novels, but this was the real thing. By the time winter arrived I was anxious, discouraged, and, if still quite green, now blue as well.

One grey February I was taking my turn staying in the hospital for the weekend. The telephone rang on Sunday afternoon; the operator said there was an emergency. I hurried to the ward on the fourth floor to learn a suicidal patient was missing. I was scared. All the residents knew her well. She was a university professor with a paranoid psychotic depression. Lately she had insisted that all us residents secretly wanted her dead. We searched the hospital and found her, lying on the floor in a little-used basement washroom. She had tied a blue cashmere cardigan over her face and emptied a bottle of chloroform over it. The big brown bottle had rolled along the floor beside her. The room reeked. She was pallid, cold, and dead.

The report of what had happened ran through the hospital like an electric shock. Another patient immediately smashed a window and tried to slash her brachial artery. The police were summoned. One or two of the senior psychiatrists interrupted their weekends to come in. Aghast, I was sure I had done something wrong, I was a failure. When the initial disbelief faded I was overcome with gloom and sorrow. So were the rest of the residents as they came in to work Monday morning. We talked of little else for days. Though our teachers were kind and supportive, we mostly felt crushed and helpless, for this calamity was compound. It challenged our childlike belief that psychotherapy could repair anything. And the patient who lost her life had died blaming us for it. Had not our teacher, Elvin Semrad, taught us that if one cared deeply enough about a patient, the patient would not commit suicide?

This death etched suicide into my mind like acid. As I chewed my experience over, recognizing how little I knew about suicide as a general topic, I made up my mind to learn as much it as I could. In 1960 there perhaps fewer than fifteen books in the Harvard Medical School library specifically dealing with suicide, the best of which seemed to have come from the Los Angeles Suicide Prevention Center where Shneidman, Farberow, Litman and their colleagues were suicide pioneers. (Today there are bookshelves full.) Few of the books seemed clinically immediate. Most of them were statistical and patient remote (this is still true of much of what is published on the subject). As soon as we recovered from the shock, two or three of us resolved to study every suicide we could discover that had occurred at our hospital in the past fifteen years. Because each patient who passed through our clinics was so exhaustively studied, the files contained large amounts of historical and observational detail. We applied the motto, “learn from the patients”. We studied not only the patient files, but our

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3 Frieda Fromm-Reichman (1889-1957) popularized the intensive psychotherapy of schizophrenic and other deeply disturbed patients as an influential leader at Chestnut Lodge Hospital in Maryland. The work at Chestnut Lodge was reflected in the training at the Massachusetts Mental Health Center under the leadership of the clinical director, Elvin V. Semrad.
own subjective responses to the patients and what they did to us. We organized a suicide seminar and discussed the case files along with our daily experiences with suicidal patients then under our care. Though I did not understand it at the time, that death on a cold February afternoon was mordant. It colored my career as clinician, teacher, and researcher. I have been studying and writing about suicide from the clinical, empathic, immediate perspective ever since.

From the first it seemed to me that no suicide could be understood without careful study of the patient’s character. Dan Buie and I published a pamphlet that said so (1983). That booklet essentially discussed narcissistic vulnerability, noting deficiencies of mental capacity that can render patients incapable of keeping up hope in the face of prolonged stress, especially losses. It acknowledged mental suffering as an essential ingredient in formulating suicide risk, but it did not recognize it as the heart of the matter. It did discuss what patients did to buttress themselves against their vulnerabilities by relying on exterior supports such as relationships with others and relationships with work.

Further years of clinical study have convinced me that this perspective is essentially correct, though I would put it somewhat differently today. I firmly believe that suicide vulnerable patients cannot master affective suffering; they lack the capacity to quiet themselves down when caught in emotional storms. Further, I am convinced that profound, prolonged affective suffering is intolerable for everyone, but that some vulnerable patients can endure it even less than others. Finally, unrelieved helpless suffering can make anyone despair, and, if sufficiently intense, force disintegration of the self and drive suicidal regression.

More than twenty years ago, thanks to the enterprise of my friend and colleague Herbert Hendin, an opportunity arose to generalize and test out many of these conclusions. At his suggestion we established the “Suicide Data Bank”. We began to collect cases of suicide in patients in treatment who were well known to the clinicians caring for them. This project continues under the auspices of Suicide Prevention International (SPI). By this time we have closely examined more than thirty-five such deaths. A number of papers have been published as a result of this research. We have shown suicide is triggered by desperation, mental anguish beyond the limits of the tolerable. Despairing patients grow desperate when they can no longer endure what they suffer subjectively—something long believed clinically, but now supported by empirical study. That is when the kill themselves as the only way out they can imagine.

That suicide is driven by subjective suffering primarily, and that other factors are either antecedent to this, or peripheral, we clinicians may now take for granted. Good clinical suicide risk assessment depends, therefore, on identifying what individual patients experience subjectively, what their capacity may be to endure it, and what they need to sustain themselves through a suicidal crisis. Just as before, skillful empathic interviewing the shrewd

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4 The most significant paper that came from this early experience concerned “countertransference hate”. See Maltsberger JT, Buie DH. Countertransference hate in the treatment of suicidal patients. Arch Gen Psychiatry. 1974;30(5):625-33.


6 This work is summarized in Hendin, Maltsberger & Szanto (2007). As a result, a questionnaire to assess subjective suffering has been devised and is now being subjected to empirical testing, the “ASQ”, or Affective Scale Questionnaire.
collection of patients’ histories is essential. The teaching and learning of these capacities is as essential now as it was when I was young and green.

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Chapter 34

PHILOSOPHICAL FOUNDATIONS OF SUICIDIOLOGY

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Prologue. My father drank himself to death at age 43 after abandoning my mother, me, and my sister. I nearly died from nephritis as a child. I don't have a lot of time for trivia. When noted suicidologist Edwin Shneidman was near death this year (2009), he said on PBS: "Get it through your thick skull, when I die I will be gone. My DNA and progeny will remain, but not me." What attracted me to suicidology was that it was, as Camus claimed, an absolutely primitive philosophical issue. Whether to live or die, or to be able to live well, comes first. All else is secondary. Suicide has religious overtones. Why are we here? Is there something we are supposed to do with our lives? Does our life belong to us? Can we dispose of our life as we wish?

The Human Condition. Several years ago I debated radical psychiatrist Thomas Szasz in Washington, DC (that was the good news, the bad news was that it was broadcast on C-Span), Szasz argued that if our lives are useless junk (or worse, intolerably and unrelentingly painful; what my mentor Shneidman called "psychache"), why can't we just throw them away? To understand suicide, one needs to appreciate the human condition. Under the best of conditions life is finite and in a precarious equilibrium (See my 1982 paper, "Rational Suicide"). Suicide is not just escape from lives gone awry. The physically and emotionally fit and healthy can also be tormented by the human condition.

As Shneidman reminded us, we are not going to live forever. "Comes he slow or comes he fast, it is death who comes at last," Sir Walter Scott, 1808 (Marmion). Think of your life like an hour (actually, day) glass. We have a total of about 80 years times 365 days or on average about 29,200 total days (not a lot, when you think about it), give or take a few. Our day glass starts running at conception or birth and is finite. Life is short and often trying.

I just turned 73 and although my life is basically good, I have Coumadin-induced bruises all over my body, control my atrial fibrillation by taking poison (Amiodarone), have had both hips (one four times due to a MRSA infection) and a knee replaced, and have developed diabetes. My life and yours is a strange mixture of catabolic entropy intertwined with episodic pleasure, satisfaction, growth, and development.


**What is Suicide?** Even though "suicide" is one word, it is not one thing. All suicides die (so patients' suicide ideas or suicide attempts are not suicides; which Freud forgot) and intend to do so, by definition. Still, "suicide" means many things to many people; even many things to one person. I have argued elsewhere (2000) that suicides (those I have studied) are mainly (75%) escape (in effect fleeing from the human condition described above, like my dad did), (20%) revenge, (5%) altruistic sacrifice and risk-taking.

To many, struggling to survive each day from life's various insults and accidents, suicide is an enigma (Joiner, 2005, speculated that there may be a self-preservation instinct). How could anyone just throw their one and only life away? To some religious people, adversity is "good" for us (see the Hebrew book of Job). Trials and tribulations temper our character and make us stronger.

I actually went to Harvard Divinity School to try to understand religiosity better. I dropped out after meeting many bright people there who could speak or read several languages (Hebrew, Greek, Latin, Aramaic, German, French, Spanish, etc) and couldn't make sense in any of them. One good result from going to divinity school was that I was able to marry my sister.

**Implications for Research.** I spend a lot of time studying suicide and random clinical trials of antidepressants (like the 9 used in the US FDA studies in 2004 and 2006) and antiepileptic medications (especially gabapentin; FDA, 2008). Unfortunately, having appropriate levels and functioning of one's neurochemistry and neuroanatomy does not change the human condition much. Even very healthy individuals live about 100 years and suffer fickle, often deleterious, insults to their physical and psychic equilibrium. Once again, not everything can be fixed.

If all a suicidal person or patient gets is a 15-minute medication check and a script for psychotropic medication, suicidality is not being treated. Suicidality management must also involve competent, caring, and sensitive psychotherapy, philosophy, and religion.

Suicide research must include study of nonpatients. Most suicidal people never get diagnosed or treated. Most seriously suicidal people never get studied. For example, if you score high on the Hamilton Depression Scale or have made a prior non-lethal suicide attempt, you cannot be in a clinical trial of a psychiatric drug. Thus, clinical trials say relatively little about suicidal populations. Even if a suicidal person sees a physician, it is usually a family practice doctor, who does not have the time nor training to detect and appropriately treat and monitor psychiatric conditions.

Suicidology must also study dead people, not just living probands or convenience samples of doctors' non-random and non-controlled patients. 85 to 90 % of patients with major depressive disorder or a prior non-lethal suicide attempt never die by suicide (thus, studies based solely on such populations are not studying suicide). Suicidology must utilize psychological autopsies after death of random suicide cases and controls. When I was an Associate Professor of Psychiatry at John Hopkins, I worked both in the ER and was a Deputy Medical Examiner. Among other differences, I tended to see young women suicide ideators and attempters in the ER but older male completed suicides in the morgue.

Our epidemiological studies of suicides should include national samples (perhaps with 100,000 cases; see Gibbons in Reducing Suicide, 2002) with control groups of non-suicidal deaths. It may surprise the reader to learn that there has never been a national sample of suicides (given the obvious expense), but rather just city and/or county studies (like St. Louis, Los Angeles, Chicago, New York City, Seattle, London, Hong Kong, etc.).
Suicide data should be analyzed with appropriate sophisticated statistical methods (French pioneer Durkheim used to write "these being the facts;" all too often we try to explain something about suicide that is not factually correct and, thus, provides a faulty factual basis for our theories of suicidality) to produce reliable results that are then published in refereed scientific journals with high standards, excellent reviewers, and high rejection rates (cf., the court's Daubert, Frye, and Bradford-Hill criteria).

Implications for Treatment. So what is the appropriate response (if there is one), when our paths cross with suicidal people? Of course, the "knee-jerk" reaction is to try to prevent their suicidal deaths, even if we cannot improve their quality of life (human condition). We assume that suicidal people really don't know what's best for them in their depressed or psychotic condition (and that we do).

In the 2009 film "The Soloist" Jamie Foxx plays the role of a Julliard cellist (Nathaniel Ayers) drop-out now living in an LA homeless community. His new friend (an LA Times reporter), Steve Lopez, played by Robert Downey, Jr., wants to medicate Ayer's schizophrenia and have him treated psychiatrically, but eventually concludes that Ayers is better off untreated and just befriended (remember Chad Varah and the Samaritans?).

To repeat, not everything can be fixed. Perhaps a major goal of suicidology is to maximize self-development, happiness, and pleasure (and minimize the opposite) and try to not hurt others in the process? However, Kay Jamison (An Unquiet Mind, 1997) reminded us of the dangers of minimizing pain and suffering, when she studied the artistic and creative benefits of mental disorder, like Vincent van Gogh's likely bipolar disorder (or even of her own BP disorder and her reluctance to take lithium).

Postscript. Now that Ed Shneidman is gone, allow me to pick up his sword and remind you that treatment of suicidal patients is more than merely titrating their neurotransmitters through psychotropic medications. We all have a mind, as well as a brain. It is our mind that torments us; not our serotonin, norepinephrine, dopamine, gaba, acetylcholine and their dysfunctions.

When I am contemplating suicide, what is on my mind is how is life possible and why do some people give up prematurely? The answer for me is simple and somewhat obvious. Life is usually better than death. People who suicide have lost what theologian Paul Tillich called "the courage to be." I find my courage in my wife, Beth, my four daughters, my Akita (Gus), meaningful work, and (right now) Texas Hold-em poker. One of the secrets of long life is to be distracted until you die.

Regrets? Not really. I wish I had been an MD-PhD (like Marlon Brando said in "On the Waterfront," "Stella, I could have been somebody!"). I am surprised and grateful that I have survived so long and that my wife stuck by me. Psychiatrist and friend Robert Litman was once asked what was the main thing he learned from 50 years of practice. Bob replied: "Everyone is entitled to f-up once or twice." Amen.

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Chapter 35

OPINION - PREVENTING SUICIDE IN YOUNG PEOPLE

Graham Martin

My introduction to adolescent suicide and the need for its prevention was over 20 years ago in Adelaide, South Australia, when Christina, a young woman of 15, forged her mother’s signature on a release slip from school to go to the orthodontist. Instead she travelled into town in school uniform on public transport, went to the 9th floor car park of a large department store, and jumped to her death on North Terrace in front of about 10 shocked bystanders.

There are always tragic stories surrounding such events; and these stories always evoke questions. Her father managed to reach her just before she was transferred to hospital by ambulance. He could not believe that, broken as she was, his daughter had a smile on her face. She had achieved her objective, but how does a father ever come to terms with the fact his daughter chose death over life?

Christina landed 3 metres away from a young male nurse on his way to work, and he gave her what emergency care he could. Once the ambulance arrived he was no longer required, so he just continued on his way to work his shift. Three months later at my home, being by chance a friend of one of my sons, he broke down and sobbed for hours as he recounted the story. Why did nobody reach out at the time to provide support? What was it stopped a young professional from discussing the incident with colleagues, friends or family?

About 3 years later, I presented a lecture on suicide prevention to a Rotary group evening. Afterward, a man sidled up, admitting he had been the manager of the store at the time of the suicide, and he too broke down. He had never talked of his feelings to anyone, had become severely depressed and gave up his position; the suicide had disrupted his career, his life, and his faith in himself. How did this man end up taking so much personal responsibility for the suicide?

A suicide impacts on many people, so many just hidden away and not able (or perhaps too anxious or embarrassed) to get the support they need. How do we build the resources in the community to manage this? How do you remove the element of only gaining support

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1 Professor Martin is currently National Advisor in Suicide Prevention to the Australian Government.
through chance? How do you help people get past the stigma of suicide grief and reach out for the supports?

We were contacted by the school. Christina had made detailed plans for her death, wrapping her belongings in brown paper bags labelled for a dozen friends, and left them in her locker at school. To her best friend she had sent the locker key, and an audiotape exonerating and explaining her death. The school needed advice on how to handle this situation, but also grieving friends and a devastated staff. We ran lengthy griefwork sessions, at the end of which we used questionnaires with friends and classmates to determine the level of distress, to see whether others might have been influenced to consider suicide. On the results, plus consensus with the year coordinator, we identified 11 young women about whom we had concerns. All the parents were contacted, and family assessment sessions completed. In fact, 2 girls were already in therapy; both had already attempted suicide within days of the suicide, and with permission we spoke with their therapists. Another girl admitted an overdose: “If she could succeed, I thought I could too.” We found a therapist for her. Most of the other girls needed ongoing support of some kind either within their family or with outside professional help. With young people in a community like a school the impact can be on a wide circle of friends, but can also be serious for a few. How best can we discern who most needs help, and on the other hand not interfere or make things worse for those who will cope well? How does a team come together in a school to provide the best help in this kind of crisis? How do you deal with delayed grief in a community?

During griefwork with the staff members, many became upset, and several recalled incidents that led to self blame. The phrase ‘if only’ was bandied about, probably unfairly given the pressures on staff in high schools. The question I am left with is the one asked by the severely distressed class teacher: “What do I do with the desk?” We suggested she ask the students; they chose to leave it in place for a month and then move it to the back of the class. On each day for the first month a flower just appeared on the desk.

During initial grief counselling with the family, father gave me Christina’s treasures - a shoe box of notes passed back and forth in class, a diary and some photos. He asked me 3 questions: “Why did she do it? Could anyone have prevented it? Could I prevent anyone else from completing suicide?” I spent two days studying the material, and have subsequently spent many years trying to answer those questions; at the time all I could respond was that I would try to find the answers. In later sessions we concluded that Christina was a successful ‘straight A’ student, much loved at school and home, and from an intact, caring and non-abusive family. She had what many would consider ‘minor’ concerns about her academic progress, perhaps magnified in her mind, she had some worries about her ‘body image’ (having just begun to wear glasses), and she was anxious about possible rejection from the young man she had invited to a school formal a month hence. In retrospect she did not appear to have any mental illness. She had had thoughts about suicide (according to her diary), but not frequent or intrusive. She had discussed it with classmates in the little notes. How many young women have the same concerns as Christina, but do not suicide? How do you pick the one that just might…?

One central question, later became a research hypothesis: “If we can discover seriously troubled young people after a suicide, why can’t we discover them before such a tragedy?” An additional question was that if (as it appears) age 15 marks the beginning of an increase in suicides with each additional year, what could we discover at age 13 that we might reasonably predict later suicide. Over the next five years we completed 17 small studies examining a
wide range of issues culled from the literature on adolescent suicide. After two years of planning, development, training of school counselling staff, and negotiation with Ethics committees and staff-parent bodies, in 1995 we began a longitudinal prospective 3-wave study with 27 high schools, which aimed to detect those at high risk at 13 for suicide behaviours at 15. In one sense we were very successful; we were able to identify severely troubled people in the early years of high school - about 14% according to the composite score we devised. Further, over the next two years, we were able to predict within reasonable limits which of these young people would attempt suicide – which we know is one of the most serious risks for later suicide. The problem was that when we sat down after the first wave with schools to provide detail that would allow them to break the codes, counsellors and senior staff seemed unimpressed, or brushed aside our concerns. Further the parents did not seem interested in referral for in depth assessment and help. Finally most of the identified young people were adamant they would have nothing to do with any service that had ‘mental’ (even as part of ‘mental health’) in its title. On the other hand, within our clinical services, many clinicians were anxious at the supposed Tsunami of referrals that might overwhelm the service. Well, it never happened. Only 1% of the 14% identified ever accepted the opportunity to get their mental health assessed. Early Detection is possible, but on the other hand is problematic. ‘You can drag a horse to water but you cannot force it to drink’. In the US many schools now have routine Early Detection services, but we have not achieved this in Australia.

The question remains whether Early Detection would have identified Christina? I think not, given she did not have symptoms of serious mental disorder. In any case, if identified she might well have refused referral anyway. So where do we go from there? How do you stop someone who is determined, and secretive?

We have been very successful in Australia with reducing suicide rates in young people; they have roughly halved since a peak in 1997. In large part this relates to our National Strategies (in place since 1995), and funding also provided by the states and territories. It is difficult to pin down exactly what might have made the difference, but increased awareness in both professional services and the general community seems important. Education programs at many levels, ongoing online services, and a real increase in trained professionals in the community have also played a role. Recent work by a team at the University of Queensland seems to support the idea that those regions which have had the most input and/or have the most services (including access to online services) have lower rates. It appears the quantity of ongoing effort is important, even though research on our National Strategy programs is not good enough to conclude anything about quality.

When I read articles like that appearing in The Weekend Australian of August 1-2 (Inquirer, page 22, “Dying to talk with someone”), I am in essential agreement with colleagues who promote more services, better access and ongoing community and professional education. But I do not believe that services can prevent the death of someone like Christina.

We are missing some elements. We have to find better ways to undermine the stigma of Mental Illness. Ordinary people in the community still have a terrible fear of ‘losing their mind’. And then attached to this is that old irrational fear of medical and psychological professionals ‘peering into your mind’. Young people need to have every confidence that we understand mental illness better than ever, and our treatments are more effective and more efficient – just like treating any physical illness.
A second issue is that we must not forget what we already know. I am appalled that schools may still not know what to do in the face of suicide. First it is a ‘crisis’, and there are many simple texts written for schools on crisis management. Second there are massive ongoing national programs for schools (for instance ‘MindMatters’), which have inherent in their design good practices for schools to reduce the possibility of suicide. The MindMatters resource kit includes one of the best documents ever written on suicide prevention in schools (‘Educating for Life’) and how to handle all aspects of a suicide when it occurs. Why don’t schools seem to know about this any more? If they do know about it, why are they scared to put it into practice?

Finally, we need to understand and promote social, emotional, and spiritual wellness better, and in particular how we help young people achieve the best they can. There is emerging evidence that promotion of resilience, optimism, and mental health can protect young people from emotional problems even in an increasingly harsh world. In addition, there is evidence that connectedness to family, peers and institutions like schools can be protective against depression, and the whole spectrum of suicidality. To have any chance of preventing deaths like Christina’s, we must invest more in the development of social and emotional wellbeing. In the long run it may be more effective, and less costly, than the current direction of increasing services.
Common to most suicidologists is the fascination by the processes and factors involved in the decision-making of the human mind; whether or not to commit suicide. However, as we know, and as many suicide survivors have painfully realized, these are issues that are not at all easy to explore. Since our primary source of information is deceased, very often we must settle with retrospectively collected data on observable risk factors and mediating mechanisms involved in the suicidal process. But what intrigues us perhaps most of all, is the very choice or decision the suicidal person made. What made him actually do it? What pro’s and con’s did she consider? We know that some suicidal people have had a reduced number of options to choose from due to dead-end life situations or otherwise hopeless conditions. Some have had their decision making capacity impaired by cognitive constriction or distortions related to depression and other mental disturbances strongly influencing their judgment. In some cases of suicide, intense affects or impulsivity seem to have facilitated the outcome. However, even in cases such as these a decision making process has nevertheless taken place and a decision has been made. What happens and what factors are involved in the moment of decision is, I believe, crucial to a deeper understanding of suicide. Still, we lack methods to fully explore these matters.

The Undiscovered Country

Early in my studies of suicide, I came to reflect upon some scenes in two well-known theatrical plays that I felt had strong relevance to the understanding of suicidal behaviour. The first scene was written by none less than William Shakespeare – I’m referring to “Hamlet” (1603) and the famous monologue of the prince in 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.”

These are among the most cited lines in English literature, but I wonder how many of those who have referred to the first line in this verse, have been fully aware that the subject matter is a reflection over the pro’s and con’s of suicide. In a world of suffering, in a sea of troubles, why, in fact, are people willing to suffer, when it is so easy “with a bare bodkin” (little knife) to end this misery in life:

“For who would bear the whips and scorns of time,
The oppressor's wrong, the proud man's contumely,
The pangs of despised love, the law's delay,
The insolence of office and the spurns
That patient merit of the unworthy takes,
When he himself might his quietus make
   With a bare bodkin?”

To answer this question, Shakespeare in the words of Hamlet, reminds us of the fact that nobody knows what will happen after death, and that problems may move from bad to worse. Fear of the unknown and irreversible in death was a very strong barrier against suicide, in 1603 and still is more than 400 years later:

“But that the dread of something after death,
The undiscover'd country from whose bourn
   No traveller returns, puzzles the will
And makes us rather bear those ills we have
   Than fly to others that we know not of?”

Most clinicians working with suicidal people would agree that it is not to die per se most suicidal individual are seeking, but to escape from unbearable suffering, to rest or, with the words of Hamlet: “by a sleep to say we end the heart-ache”. But is rest and consolation in death guaranteed? To cite a contemporary suicidologist we must admit that “We do not have any data indicating that people who are dead lead better lives” (Linehan, 1993). Therefore, if hope of peace and consolation is truly the main driving force in the suicidal process of most people, the fear that these objectives will not be met could be the reason why relatively few suicidal individuals go on to a completed suicide.
**BUT TO DO IT - !**

The second scene is selected from a play by the possibly equally famous Norwegian dramatist Henrik Ibsen. Ibsen was fascinated by suicide and other sudden death as possible outcomes or solutions to human conflicts and dilemma, and they are thus frequently found as tragic motives in his plays. In Ibsen’s contemporary Norwegian society suicide had been decriminalized, but was still strongly condemned by the majority. We know that Ibsen, in his younger years, had struggled with suicidal feelings. In his use of suicide as a motive in his dramatic pieces, Ibsen illustrated very clearly how the human condition is determined by a tension between high ideals and strong driving forces on the one side and weakness and lack of courage on the other.

However, it is not the well-known completed suicides of Ibsen’s plays such as Rebecca West, Hedda Gabler or Hedwig, we will focus on in this context. It is rather a less known scene from Ibsen’s “Peer Gynt” published in 1867. Like “Hamlet,” “Peer Gynt” is written in verse, but it is not a tale of princes and kingdoms at war. It is about a life lived in avoidance of challenges and possibilities of growth and development in the main character, Peer. In Act III of the play the outlawed Peer, while out in the autumn forest felling timber, incidentally spots a lad who has come out there with a sickle to deliberately harm himself by chopping off his fore-finger in order to escape from military service. At that time such self-harm was among the very few things a young man could do should he feel unable to let himself be conscripted. For many young farmers conscription could mean serious problems to their farm, their families and dependants and was therefore not a very popular duty, to say the least. Here’s how it was perceived by Peer in John Northam’s translation:

“There’s a hell of a lad! Fore-finger! He’ll rue it! Hacked off! And with nobody making him do it! Uh-hu! I’ve got it — ! The answer of course is it’s the only way not to serve in the forces. So that’s it; they wanted to send him to fight; the ladde, reluctantly, went on the run. — But cut off — ? And lose it for good when it’s done — ? Yes, think of it, wish it; or will it for fun; — but do it! O no; that just can’t be right!”

The last sentence has sometimes been translated as “No, that's past my understanding!” which is closer to the original text. Peer has great difficulties of understanding how a person could actually free willingly do such a thing as chopping off his finger. Ibsen experts would possibly claim that this inability or unwillingness to comprehend such behaviour would be rather typical of the avoidant Peer who would always find excuses to avoid clear choices. Alternatively, Ibsen may actually have made a valid observation here about deliberate self-harm that has relevance still today: that to do the act is something very different from thinking, wishing for or even playing with the idea of doing it. It takes strong forces to drive such an act and a weakening of inhibiting forces is possibly also present.

One of my own first studies of suicidal behaviour in the young was exactly about young conscripts who had deliberately self-harmed during their basic training period – in many
cases because they felt desperate about the situation and didn’t know how else to solve their problem (Mehlum, 1990). Closer examination of more than one hundred of these cases convinced me that these were young men in deep trouble, very often with psychiatric disorders and other psychosocial risk factors. Even though their self-harm behavior could have high lethality, there was a strong communicative element in many cases. Responses from military commanders and physicians were, however, often punitive which often made things only worse. It appeared to me that the significant difference between ideation and behavior grasped by Ibsen more than a century earlier was simply not well understood by doctors and commanders.

WHERE TO LOOK - WHAT QUESTIONS TO ASK

Much more detailed information about decisive factors involved in suicidal behavior has been gained over the last decades through extensive research into the subject. We know more about distortions of perceptions and cognitions, of disturbances in our memory systems and of emotional and behavioural dyscontrol arising from neurobiological disturbances. However, decision making is a complex and integrated higher human function of which there is still much we do not know. But in my experience talented observers of human behaviour such as Shakespeare and Ibsen, may sometimes offer us intuitions and cues to what would be significant questions to ask.

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SUICIDE: A PERSONAL CONSTRUCTION

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One cold January morning, a week before my twelfth birthday, my little brother and I were awakened by our panicked mother who ran into our room shouting, “Boys, boys, I can’t wake up your Daddy!” Startled and confused, Greg and I threw off our cowboy blanket, stumbled out of bed in our footed pajamas, and peered fearfully around the door jamb of our parents’ bedroom as Mom tried one final time to awaken our father, reaching out to shake him beneath the thin turquoise bedspread that covered his lanky, motionless, frame. Time froze before she recoiled in horror, her hands covering her face, and her scream piercing the air and our hearts. With that one fateful gesture, our known world ended, and Mom, Greg, our little sister, Jo, and I were thrown into another, much darker and more alien. In some important respect my subsequent career as a psychologist can be read as a response to that moment.

Like far too many others, my father’s death was self-initiated, induced by a blend of alcohol and barbiturates, carefully calculated to bring to an end the encroaching nightmare of his financial crisis and his dimming eyesight. In the maturity of hindsight, I can discern other possible contributors to his desperate decision, including potentially unresolved grief over his own mother’s death in our home scarcely two years before. In a subliminal way, this rupture in our family narrative likely contributed to my subsequent drive for “paternal” recognition where I could find it, initially in youth groups and school, and soon enough in the world of work. And of greater clinical relevance, it likely shaped my early choices in college to seek training and volunteer opportunities in suicide intervention, and ultimately my draw to psychology to work with the complicated grief that often follows tragic and untimely death (R. A. Neimeyer, 2009a).

Unlike some of the major contributors to suicidology, who have propounded broad principles to account for the human impulse to self-destruction, I have been struck by the diversity of factors that lead to this tragic outcome, with few overarching commonalities to

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unite them beyond the general and obvious (e.g., psychological pain and the lack of perceived options to mitigate it). Instead, I have found in constructivist psychology (Kelly, 1955; Neimeyer, 2009b) a helpful focus on the frequently tortuous, stalemated or chaotic quest for meaning in our lives, at a level that helps me grasp how people can become prisoners of their own fatalistic or fearful construction of events, with the only apparent way out of their life imprisonment sometimes being a death sentence. That is, the clients with whom I work and who I occasionally study systematically (Hughes and Neimeyer, 1993) seem to be suffering not only from a world of events and relationships that cruelly invalidates the premises on the basis of which they live, but also from the disorganization or constriction of the very meaning systems on which they rely to cope with, surmount, or succumb to those events. When they confront the “perfect storm” of unforgiving, insurmountable obstacles intersecting with a meaning system that offers no way forward, and potentially is itself crumbling under the assault, suicide too frequently becomes the “rational” alternative, at least as they view it (Neimeyer and Winter, 2006).

Three case studies come to mind for me in illustrating the variety of conundrums faced by those who consider death by their own hand to be an option, and the very different outcomes that can follow from diligent clinical work. The first was Anna (a pseudonym, like others to follow), who consulted me following the passing of her husband of many years, brought on by a virulent cancer that ravaged his body for less than a month from diagnosis to death. Although Anna was seven months beyond the loss chronologically, she seemed to be scarcely 7 days beyond it psychologically, as she remained preoccupied with the traumatizing images of his uncontrolled pain, with her anger at the physicians who promised cure, and with her grief that knew no bounds. Her husband, she said, had been “her north, her south, her east and her west,” and without him she seemed to lack the basic coordinate axes to negotiate life alone. Feeling betrayed by God and diffusely anxious about the alien world into which his death had cast her, she had begun contemplating death by some unspecified means as a solution. Therapy for Anna was stormy at first, but quickly moved her from the precipice of despair as we drew on narrative projects to re-establish a sense of connection to her husband and their shared history, to tackle the spiritual crisis that his cancer and death had induced, and to move toward a reconfigured future that nonetheless held the prospect of purposeful living and communal involvement. In constructivist terms, Anna’s had been an “anxious” suicidal crisis, which was resolved as we established a thread of consistency in her sense of her biography, connecting her past, present and (altered) future in a meaningful way (Neimeyer and Winter, 2006).

Brenda, however, was another case entirely. Mired in deep depression that seemed unshakeable despite numerous attempts at medication, hospitalization and psychotherapy, alone and in combination, she was referred to me in desperation by her psychiatrist—an acknowledged expert in mood disorders—for “cognitive therapy” in the hope that it could erode her intransigent pessimism. Suicide ideation and nearly continual incidents of self-injury or self-medication to the point of unconsciousness had for Brenda become a “way of life” (Neimeyer and Winter, 2006), such that her entire style of interacting with the world and herself was predicated on the maintenance of a painfully constricted and vigorously defended view of her options. Her husband’s “abandonment” of her years earlier only served to confirm what she had known from early childhood, when she learned that her own biological mother had “rejected” her and put her up for adoption, thereby “proving” her unlovability. Across six years of intense therapy that has focused on compassionate and empathic reflection of her
pain, her self-fulfilling prophesies of interpersonal rejection in a variety of relationships and work situations, family consultation with her adult children, interpretation of her emotional wounds, behavioral action plans to address concrete problems, cognitive work to instill hope and failed referrals for collateral consultation with eminent practitioners of a range of therapeutic perspectives, Brenda continues much as she has from the outset of our work—lurching from one crisis to the next with deep cynicism and continual suicide threat. If there is a cause for celebration it is only that she has avoided hospitalization for the duration of our therapy, continues to hold a job, and has not (yet) carried out a fatal act of self-injury. Viewed through a constructivist lens, Brenda exemplifies a fragile, but (for now) stable adaptation to life in a constricted frame, with therapy providing just enough structure to stave off what might otherwise be inevitable.

Finally, Carl represents one of the most starkly lethal of suicide trajectories, one marked by a fatalistic and active pursuit of suicide as an active choice. Angry and belligerent, he was “pushed” into therapy by his much younger wife, who was finally divorcing him following years of suffering his bullying and substance abuse. Our brief and tempestuous consultation of a half dozen sessions was marked by Carl’s bravado and other-directed blame, followed unpredictably by a premature termination and refusal to resume treatment. Several months later, following a dispute with his now ex-wife and her refusal to return to him, he methodically went to his home, pulled his high-powered handgun from his dresser drawer, laid in their bed, placed the gun in his mouth as he had threatened, and pulled the trigger. To a constructivist, Carl’s determined follow-through on his announced plan represented a “fatalistic” trajectory toward suicide, predicated on an organized but constricted meaning system that responded to core invalidation with ruthless efficiency in putting an end to his perceived humiliation, sense of betrayal, and loss of control (Neimeyer and Winter, 2006).

In summary, both my personal and professional experiences with the trauma of suicide lead me to understand it as a tragic attempt at solution to an insuperable problem posed partly by events, but always in interaction with idiosyncratic vulnerabilities in the client’s construction of self and life. Viewed in this frame, suicide intervention—while not always successful—must appropriately engage both those environmental and psychosocial problems that provide an instigating context for this final, fateful act of self-determination, in a way that opens more humane and life-affirming options for a life of meaning.

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Chapter 38

CROSSROADS IN MY PROFESSIONAL LIFE IN SUICIDOLOGY

Merete Nordentoft

I started my career as a junior doctor in one of the psychiatric clinics in Copenhagen. We were two young doctors who both were in our first job at a psychiatric department, and when we were on duty one of the chief psychiatrists were on call. The very first Saturday, I was alone on duty, I was called to evaluate an elderly woman, who had tried to drown herself in the tube. She explained that she had had stomach ache for sometimes, but because she was afraid of doctors she hadn’t sought treatment, and now she was afraid that she had cancer. The medical department, where she was admitted, had planned to carry out a gastroscopy, and somehow I managed to convince myself and the chief psychiatrist on call that her explanation was reasonable, and that we should just calm and reassure her and wait for the physical examination of her condition. The following day, she tried to hang herself in the ward, and when finally a qualified psychiatrist came to evaluate her mental state, it was concluded that she suffered from a severe psychotic depression with hypochondriac delusions. This very early experience increased my respect for the psychiatric examination.

Few months later, I was called to evaluate the mental state of a middle aged man who had jumped in front of a train and lost both legs. He was married and had an extramarital affair, and the dilemma of choosing between the two women was the most immediate reason he gave for his suicide attempt. He refused to accept medication for his condition, and my task was to evaluate whether he could considered mentally able to make such decision. This time I called the chief psychiatrist immediately, and he came and assisted me. He drew the conclusion that the man could not be considered psychotic, and as a consequence, the man died from infections in the wounds as he refused to accept treatment with antibiotics. At the same time, I had a relative very dear to me, who suffered from a severe neurological degenerative disease; amyotroph lateral sclerosis. He was my uncle, and a very recognized researcher, specializing in the Danish philosopher Soeren Kierkegaard. He had three children and a wonderful wife, who cared for him and he was treated at home during seven years of severe disability before he died. All the way through this devastating illness, he was able to amuse and encourage his children and even to supervise students at the university. It was though provoking for me that some people were able to master life in spite of a serious, life-
threatening disease while others could not bear the, of course straining, but also rather common situation of more than one beloved woman in a marriage. I think these contrast gave me some perspectives regarding the possibilities for suicidal persons to be able to come through even very severe crisis.

As a junior doctor I worked with several projects with the purpose of investigating the characteristics of suicide attempters and registering the kind of treatment they were offered. Going through the medical records of suicide attempters admitted to the acute emergency service, it struck me, that the doctors in the discharge summaries concluded that the patient could convincingly disavow suicidal plans, even in cases with five admissions after suicide attempt with short intervals. Our interpretation of this finding was that the doctors overlooked the risk of repeated suicidal acts because they did not really have any possibilities for referring the patients to any kind of treatment after discharge, simply due to the fact that such treatment facilities did not exist. We developed the sarcastic expression: “Discharged to repeated suicide attempt” for which I was quoted in the news on national TV.

Few years later, I had another eye-opened. Some colleagues had asked me to do a register-based follow-up of a large sample of patients admitted after deliberate self-poisoning. It was 974 patients with a mean age of 37 years. Shortly after we got the extraction from the cause of death register, we were able to conclude that one third had died during the ten years follow-up due to natural and especially unnatural deaths. The mortality was comparable to severe medical conditions such as some cases of cancer.

Later in my carrier, I had the change to establish the OPUS trial, which is a large randomized clinical trial for patients with first episode psychosis comparing two years of assertive specialized treatment to standard treatment. The specialized assertive treatment involves modified assertive community treatment, family involvement and social skills training. We were blessed with a large grant from the government which gave us the possibility of establishing the hitherto largest trial comparing comprehensive intensive treatment to standard treatment. We included 547 patients and have been able to follow them for ten years until now. As a result of the trial, the intensive OPUS treatment is now implemented all over Denmark and has now become standard treatment for young patients with first episode psychosis. However, to get that far, we had to conduct a randomized clinical trial and randomize patients to either the intensive treatment or standard treatment, and obviously some young patients with psychosis would randomly be allocated to standard treatment, which at that time was a treatment that could be criticized for not being sufficiently comprehensive or caring. A young man with severe psychosis was allocated to standard treatment. He was initially admitted to the hospital, where I worked, but was later transferred to outpatient treatment at another hospital because he moved out of the catchment area. After discharge he relapsed to a severe psychotic state, involving religious delusions, and in a severely deluded state he went to the psychiatric emergency room and stated that he had eaten a jew and a cat. Thereafter he left the emergency room without being admitted and with no further appointments. A notice about the event was sent to the community mental health service, and 11 days after they paid a home visit without finding him at home. His shoes and his backpack were found at a beach in southern Sweden, and half a year later his drowned body was found. His parents got the permission to see his medical record, and the usual practice in such cases is to offer a consultation with a doctor, and I was appointed as the doctor responsible for going through the medical record together with the parents. For me it was crystal clear that this sad event would never had happened if their son had been allocated
to OPUS treatment. The primary staff member he would have been affiliated to would have gone to the emergency room together with him and prevented that he had left without talking to a doctor. OPUS would have arranged an admission, even a compulsory admission if no other possibilities were left. And there would have been no risk that 11 days would pass after discharge before a home visit in such a severe situation. The job, I had to do, informing the bereaved parents about the insufficient treatment their son had been a victim to, stressed for me, the importance of improving services and ensuring that no other kids would be left with insufficient help in such a terrible situation.

Recently we succeeded in starting a new trial for non-psychotic patients after suicide attempt. We were well aware that patients, who attempt suicide, are in a very chaotic state of mind, and that their ability for problem solving is very poor. In lectures and interviews I have mocked the standard treatment which is offered, because it is ironic that these people, who recently have thought that life was too complicated and really overwhelming, as a standard procedure are advised to seek help psychological treatment on their own hand. They will get the recommendation to go to their general practitioner to get a referral to a psychologist and thereafter in some cases also contact a social worker in social services to arrange for the payment of the sessions at the psychologists. All these three public services can be very difficult to contact, there are only few opening hours, often the person you want to talk to is on leave for some reason, or have left for lunch, and the psychologist can be fully booked until next November. Even for powerful and complete sane persons, it can be difficult to go through this Odyssey of barriers in front of professional help, and to ask persons in deep crisis with difficulties in problem solving to go through this process is deemed to fail. We have started a trial, called AID – Assertive Intervention after Deliberate Self-harm, and our focus is to help the persons to get back on track and manage everyday life problems and to get into contact with relevant treatment facilities. This is done supportively and assertively with staff who’s key competence is to force barriers and keep contact to the patient through a flexible, assertive and helpful approach. We haven’t got any results yet, but we consider the approach very self-evident and promising. Results will be ready in 2011.
Chapter 39

**MY PERSONAL REFLECTION ON SUICIDOLOGY**

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Although I have been involved in suicidology for many years, the immense scale of the task of suicide prevention was brought home to me most devastatingly in September 2008 when a very close friend took her own life. I still think of my friend daily and since her death I have reflected a lot on what I could or should have done to help her in the weeks and months preceding last September. Of course I know what the research evidence says and I know that prediction and prevention are notoriously difficult but this personal experience seriously challenged my core beliefs and it left me with many unanswered questions. One year on, many of these questions remain but my fundamental belief in the importance of theory-driven, evidence-based practice as the cornerstone of suicide prevention is stronger than ever. Against this backdrop, therefore, the aim of this essay is to outline briefly how my thinking on suicidology has been informed by my early experiences as an academic and beyond.

I have been engaged in research into the aetiology and course of suicide and self-harm since the mid 1990s. I am particularly interested in the psychology of suicidal behaviour, as to my mind, suicidal behaviour is a conscious, often planned action, involving key psychological processes. Consequently, to understand suicide, one has to consider the psychological antecedents of the decision to act. Moreover, suicide is a behaviour and given that psychology is the science of mind and behaviour, the discipline has much to add to the prediction and prevention of this tragic phenomenon. I return to the idea of suicide-as-behaviour later.

Understanding the complexity of the multiple pathways to suicidal self-destruction intrigues me as much now as it did when I started my academic career. Over the past decade and a half, my thinking has been informed by a variety of sources, some formal others less so, but my influences have been derived from across the discipline of psychology and beyond including from psychiatry, epidemiology and sociology. One of the earliest influences on my thinking about human distress came as a psychology undergraduate student at Queen’s University of Belfast where I first encountered Martin Seligman’s work on learned helplessness (which posits motivational, cognitive and emotional deficits which follow when we learn that outcomes are uncontrollable; Seligman, 1975). At the time, a number of things
struck me about Seligman’s conceptualisation of helplessness and its subsequent reformulation into the hopelessness theory of depression (e.g., Abramson, Metalsky, and Alloy, 1989). First, I learned that it is well worth exploring the relationship between cognitive processes and individual differences as mechanisms intrinsic to the onset and maintenance of negative mood. Second, Seligman’s work helped me embrace the notion that theoretical models are crucial to a clearer understanding of human distress because (i) they generate falsifiable hypotheses which have the potential to advance knowledge and (ii) they facilitate the development of interventions to prevent distress (for the present purposes suicide and attempted suicide). Although these two learning outcomes are somewhat obvious, inherent in the scientific method, if we look at the history of suicidology, they have not been as apparent in the discipline as we would have liked.

My interest in understanding the mechanisms involved in the genesis of psychological distress was consolidated in the final year of my undergraduate degree when I completed a thesis entitled *The generality of learned helplessness: the role of attributions*. This was an experimental, analogue study which showed that how we explain or attribute (depressogogenic attributional style) negative life events has a tangible effect on behaviour (in my case, on performance on an arithmetic and anagram task). I really enjoyed all aspects of the research process and this experience confirmed in my mind that I wished to pursue a career in academic psychology; it reinforced the importance of theory and hypothesis-testing and it illustrated to me the concomitant power of individual differences and cognition on affect and behaviour.

A funded PhD place at Queen’s followed as did my pursuit of the correlates and antecedents of suicide and attempted suicide. On the whole, my PhD was a pleasurable experience, affording me the opportunity to gather data in a Coroner’s office as well as interview those who had attempted suicide in the Accident and Emergency department of a local general hospital. For one of my PhD studies, I content analysed Coroner’s records and came across genuine suicide notes for the first time. Although I had read much of Edwin Shneidman’s and Antoon Leenaars’ work on suicide notes in advance, nothing prepared me for the reality of reading the personal thoughts of those who had killed themselves. I found the analysis of suicide notes especially emotive as I had access to the full Coroner’s records, so I felt I had a sense of the authors’ lives. Similarly, I found the interviews with those who had self-harmed incredibly informative but emotionally demanding, especially at first. However, I was most fortunate to have the opportunity to periodically meet with a clinically-trained colleague for debriefing sessions. These sessions were invaluable and they helped me manage my emotional response to the interviews. I would recommend such support as a matter of course for anyone working with suicidal patients, especially graduate students.

When I think back on my PhD, a number of thoughts endure. First, although it may sound odd, I was remarkably privileged to have been able to gain first-hand experience of suicide and attempted suicide so early on in my academic career. Those early experiences continue to remind me of why I am a suicidologist, every day they remind me that behind every suicide statistic there is a person but they also highlight the many difficulties that working in this field present (e.g., relative lack of experimental control in the field, issues around accessing and recruiting participants, sensitivities around working with vulnerable participants; high attrition rates, problems with prediction and prevention).

Second, I was surprised by the myriad of motives underpinning attempted suicide, by the complexity of its relationship with completed suicide and the difficulties around defining
suicide attempts/self-harm. I quickly realised that I was not alone, indeed the debate around the operationalisation of suicide/attempted suicide/self-harm is alive and well, still largely distinguished by North American vs European differences in definition which will not be resolved anytime soon.

Third, I had naively expected there to be a consensus on why people kill themselves, for there to be a unifying, overarching model of suicide. Although most suicidologists espouse bio-psycho-social explanations for suicide, and can list the merits of interdisciplinary research, for the most part, we retreat back to the safety of our respective disciplines when we develop theories and models. Again this is not a novel observation, in their classic text *Clues to Suicide*, Shneidman and Farberow (1957) believed “suicide to be motivated by sociologic, cultural, ecologic, psychologic, and many other factors” but, nonetheless, limited their study “to the psychologic aspects of suicide” although this did not “preclude other aspects of the phenomenon studied by Cavan, Dublin, Bunzel, Durkheim, and others” (p.3).

Fourth, related to the previous point, despite the breadth and depth of suicidology, I was surprised by the relative absence of theory in vast swathes of suicidological research. In the first year of my PhD, during the literature review phase, I read hundreds upon hundreds of academic abstracts and papers, ordering a multitude of articles from the library, hoping that when a new paper arrived on my desk that it would include a new theoretical model which I could use to direct my studies further. This anticipation was rarely realised; overwhelmingly, the papers were descriptive, and despite the undoubted importance of such work, I could not see how such papers advanced theory beyond showing us again and again that risk factor X was associated with suicide or attempted suicide.

However, one of the papers which did cross my desk around this time and has had a major influence on my work ever since was Roy Baumeister’s paper ‘Suicide as escape from self’ (Baumeister, 1990). This paper is an impressive distillation of how some of the major theoretical perspectives in social and personality psychology (including action identification theory, levels of thinking, self-awareness theory, self-discrepancy theory and attribution theory) could augment earlier clinical and sociological perspectives on suicide. Baumeister argued that suicide is often motivated by a desire to escape from painful self-awareness and he proposed a causal chain with suicide as the final step to escape from the self and from the world. Needless to say, he was not the first to implicate escape as a motive for suicide; Baechler and Shneidman, to name two, had suggested escape some years before. Nevertheless, I was impressed by Baumeister’s conceptualisation for a number of reasons but primarily because the theory suggested intuitive and testable hypotheses.

Although much of my work since has been influenced by the suicide-as-escape conceptualisation, two other influences have also been important. The first, related to escape theory is Mark Williams’ work on entrapment (cry of pain model) and differential activation (e.g., Williams et al., 2005). Williams went beyond escape theory and mapped out the components of a model of suicide (defeat, entrapment and lack of rescue) together with potential psychological processes which could act as mechanisms (e.g., autobiographical memory, problem-solving) to increase/decrease suicidal risk. To my thinking, Williams’ work is especially noteworthy because it is innovative, theoretically-driven, scientifically rigorous and clinically relevant. Moreover, his theoretical developments move beyond psychology, taking account of how they fit with social, biological and genetic facts as well as drawing from comparative models of behaviour.
The final influence is a discipline, the discipline of health psychology. Despite its focus on physical illness/prevention of illness, social cognitive models (SCMs) which characterise a good deal of health psychological research have much to offer suicidology. In essence, there is growing evidence that SCMs can predict healthy behaviour and SCM-grounded psychosocial interventions can promote positive health and prevent illness. Consequently, to return the idea of suicide-as-behaviour; if we conceptualise suicide as a (un)healthy behaviour, there is no reason why we cannot employ SCMs to aid in the prediction and prevention suicide. To this end, our group has some promising evidence that such approaches may be fruitful.

This is an exciting time to be working in suicidology. More and more published papers are theoretically-driven, more and more countries are making suicide prevention a national priority and more and more of us with an interest in suicide prevention –academics, practitioners, policy planners and survivors– are working together to understand and prevent suicide.

REFERENCES


Chapter 40

The Pain That Kills

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My first guide into the sight of people, who no longer want to live, was a seven year old girl, Rina. On my first day as a school psychologist where she attended I was asked to assess her suspected mental retardation. Rina asked if she could use some papers and crayons that I had set aside and drew a road with cars. Then she drew a little girl on one curb and a woman on the other. When she finished the drawing she pointed at the girl she drew and declared: this little girl wants to get run over. I was astonished and asked her why the child wanted to be run over. Rina's answer was straight forward: "because this woman wants her dead". Now, completely shocked I asked her to explain why. Her reply: "That's just the question why does she want the girl to die?"

Rina, as I later learned was the eldest daughter in a family with three children. Her mother was hospitalized in the past in a mental institution. Her father was simple unskilled worker. Her two younger siblings had both been diagnosed as being mentally retarded. Three days after her birth, her mother insisted that Rina was not really her child, and that there had been a mix-up of the hospital. When Rina started to attend school and proudly showed by her skills, her mother respond was: "what do you think you are better than the rest of us or something?". That may have been the moment when Rina had began to play the role of a retarded child in order to gain her mother's love.

Rina has taught me a something about a major dynamic in self destructive behavior of young children – the dynamic of the irresolvable problem. That is, the child is pressured to solve a problem that is beyond his/her ability to resolve or that irresolvable by its very nature (e.g. early rejection, accusations of not being retarded, rejection of the child's gender). There are several variations of this dynamic( see Orbach, 1989 for a detailed description of the dynamics and examples).

I was further guided into this world of suicide by Shneidman's (1993) theory of mental pain. Listening to the descriptions of the pain by suicidal youngsters and adult made it all clearer why it is so unbearable. One adolescent described his pain with the words: "This pain
is like a stunning dizziness. I cannot find a proper word to explain what is happening to me, and why it is happening. I know that nobody can understand and I don’t have the words to describe it. It is like a toothache in the soul. It is then that I want to kill myself”. Another older woman used an oxymoronic language to describe her pain: "… it comes in and out of my body at the same time. It explodes in me silently, and yet it is deafening… it fills me up from inside and outside at the same time… I become one with the pain. Common to almost all patients’ descriptions of the pain is that it is experienced as an estranged and uncontrollable evil force that is torturing the suicidal person from the inside (see Orbach in press).

One of the most puzzling questions for me in the understanding of suicide is not why people want to kill themselves but rather what makes suicide possible. What is the process that enables one to carry out an aggressive act against the body and to descent into a total cessation?

Through my work with the suicidal patients I have learned about facilitating and inhibitory factors. Facilitators are not causes of suicide; rather they are factors that increase the probability of acting out suicidal wishes by lowering the constraints to self destruction. One of the most powerful facilitators of suicide is the bodily dissociation (numbness, detachment, high sensation threshold) and distorted bodily experiences (negative attitudes and feelings about the body, analgesia). I have termed these bodily experiences as "the suicidal body". When a person in extreme mental pain feels no physical pain and pleasure it is easier to attack and kill the body.

Following Shneidman (1993) and others, I believe that the immediate cause for suicide is unbearable mental pain. It is the unbearable quality of the pain, rather than its intensity that is crucial in suicide. Even in allowing for individual differences, loss of any kind (beloved, faith, dreams, identity, etc.) is cause of pain to anybody.

The other primary source of mental pain is, in fact, internally generated by pre modeled templates formed by early traumatic experiences – the internal pain producing constructs. These constructs consists of negative representation of self and others: an acute sensitivity for specific pain triggers (e.g. Narcisstic hurt, loss, guilt, failure); definition of the conditions under which life is worth or not worth living and destructive action tendencies reflecting habitual patterns of self abuse that erode ones sense of well being (e.g. impulsive outbursts of rage and destruction of close relationship). The pain-producing inner constructs stem from life-long internalization of negative experiences along which the individual constructs reality in a way that produces more negative experiences, which in themselves create mental pain. In time, these experiences turn into self destructive actions. The suicidal individual becomes entrapped in his / her own pain-producing constructs, and eventually seeks total self destruction to escape the pain. (see Orbach 2008).

The story of S, 48 years old, serves as a good example of how internal pain producing constructs take shape. S’s father passed away when she was 4 years old. Thereafter her mother began to date other men. S came to call these dates “screw dates.” S remembers how she would bitterly weep and plea to her mother not to leave her alone on the nights but to no avail. Her mother was far more stirred by a night with one of her many lovers than by her daughter’s needs and anxieties. These nightly scenarios were interpreted by the young S, formulated into a world view that sexual desire is tantamount to all other needs, even those of her young child. Furthermore, if a mother can deny her own daughter because of her desire for men, this means that sexual desire is omnipotent in relation to all other urges. Eventually, S developed a total lack of faith in love. She escaped from and refused any expressions of
affection directed at her. She would mock any warm feeling expressed towards her. Love was false and fake to her.

S, herself led a sexually untamed lifestyle, since she was an adolescent, attempting to satisfy her desires with countless lovers, even while married. However, as she approached her fifties she began to become aware of her withering body, and a decrease in her opportunities for love affairs. Her anxiety began to overwhelm her. She repeatedly attempted to seduce lovers; when it was unrequited she slid into depression and several suicides attempts. Without sexual satisfaction there was simply no point in living. Without love she felt empty and pain, yet, her life style and philosophy did not allow her to be loved or to love.

When pain is triggered internally, self destructive tendencies are also set in motion, leading to even more pain. Unbearable mental pain can explain how the wish to kill emerges, but in order to move from the unbearable pain to self destruction, facilitating processes are needed, such as physical dissociation, belief in better life after death, and availability of weapons. At this time, other factors come into play; these are the inhibitory factors, such as fears of death, commitment to family and religious beliefs. The balance between the facilitating and inhibitory factors will determine if the person will self destruct or turn for help.

I have termed my therapeutic approach with suicidal people as "the therapeutic empathy with the suicidal wish" (Orbach, 2001). Being empathic with the suicidal wish means assuming the suicidal perspective and "seeing" how this person has reached a dead end. I attempt to empathize with the patient's pain experience to such a point that he/she "sees" why the suicide is the only alternative available to the patient, without trying to take away the suicidal wish hastily. Instead of working against the suicidal stream by persuasion or commitment to a contract, I take an empathic stance with the suicidal wish. As a tactic, I ask the suicidal person to actually "convince" me that suicide is the only solution and communicate with him/her from this empathic stance. This approach creates a therapeutic atmosphere which facilitates the attempts to eliminate the mental pain, and prevent suicide (see Orbach, 1981 for detailed description).

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Preventing Suicide: A Resource for the Family

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Suicide is one of the ten major causes of death in most countries. The family can play an important role in its prevention.

In order to be able to prevent suicide among its members, the family should get rid of some myths associated with suicidal behavior. Such myths tend to justify their advocates’ attitudes and become a hindrance in the prevention of suicide.

There are many myths in relation to suicide. We will explain some scientific criteria which should be taken into consideration by the family members in order to prevent suicide among its members.

1. Myth: He who wants to do away with his life will not say so.
   This myth results in not paying attention to people who express their suicidal ideas or threaten to commit suicide.
Scientific criterion: Nine out of ten people who committed suicide expressed their purposes clearly, and the tenth person hinted his/her intention to put an end to his/her live.

2. Myth: He who says he will do it will not. Wrong criterion: suicide threats are not taken seriously because they are taken as blackmail, manipulation, etc.
Scientific criterion: Every person who commits suicide announces with words, threats, or changes of behavior what is about to happen.

3. Myth: A person who will commit suicide does not give any hints about what he/she is up to. Wrong criterion that tries to ignore the prodromic manifestations of suicide.
Scientific criterion: Every person who commits suicide announces with words, threats, or changes of behavior what is about to happen.

4. Myth: Asking a person at risk if he/she has thoughts of committing suicide may stimulate him/her to do it. Wrong criterion that instills fear of speaking about the topic of suicide with people who are at risk of committing it.
Scientific criterion: It has been proven that talking about suicide with a person at risk does not stimulate the idea but instead contributes to reduce the likelihood of the act and it may be the only possibility offered by the subject for the analysis of his/her self-destructive purposes. (1).

In addition to these myths about suicide, the family should also learn about suicide risk groups who according to their particular characteristics may be at greater risk of committing suicide than those who are not included in such groups. Major suicide risk groups are:

1) the depressed
2) subjects who have had previous suicide attempts.
3) subjects who have had suicide ideas or have threaten to commit suicide.
4) survivors.
5) vulnerable subjects facing a crisis. (2).

When those individuals face a significant event beyond their capacity to solve problems, they tend to resort to suicide. When subjects from any risk group are in crisis they may communicate their suicide intentions in different ways. For instance, the subject may threaten to commit suicide or say that:

- he/she wishes to kill himself/herself.
- he/she wants to die.
- other people would feel better if he/she did not exist.
- it is preferable to be dead than alive.
- he/she has had bad ideas.
- other people will not have to stand him/her any longer.
- he/she does not want to live
- it is preferable to be dead than to live his/her life
- he/she has thoughts to end his/her life
- his/her life should not be lived
- he/she does not want to be a burden for other people
- his/her life is not worth living
- he/she would like to fall asleep and not to wake up ever more
- he/she is tired of living

When the family becomes aware of the many different forms of suicide communication they should learn to identify the situations that can lead to suicide risk in order to increase family support. (3).

Among these situations are the following:

i. In childhood:
- watching painful events (domestic violence).
- familial rupture.
- the death of a beloved person who provided emotional support.
- living with a mentally-ill person as the only next of kin.
ii. In adolescence:
- having a faulty relationship with significant figures
- examination periods.
- having friends who exhibit a suicidal behavior or consider suicide as a way of solving problems.
  - love disappointments.
  - having been scolded in a humiliating way.
  - sexual abuse or harassment perpetrated by significant figures.
  - loss of significant figures as a result of divorce, death or abandonment.
  - awareness of serious mental disease.

iii. In adulthood:
- unemployment
- public personalities involved in sexual scandals
- bankruptcy.
- recent psychiatrist hospitalization.
- hospital discharge with a serious mental disease.

iv. In old age:
- initial period of institutionalization.
- first year of widowhood in men and second year in women.
- physical and psychological abuse.
- physical illnesses with chronic insomnia.
- loss of mental capacity

In the presence of a subject belonging to one of the risk groups mentioned facing any of the situations described, it is mandatory to carry out a thorough exploration for suicide ideation.

The following are variants to approach this topic:

“Have you had any bad thoughts?” In this case bad thoughts is synonymous to suicide ideas. It is also possible to use expressions like unpleasant ideas, recurrent or queer thoughts, etc. If the subject answers affirmatively, the questioner should try to find out what those bad thoughts are since they may be associated with unjustified fears such as fear of becoming diseased or receiving a bad news, which are not necessarily suicide ideas.

“What did you consider killing yourself as a solution to all your problems?” “Have you thought of committing suicide?”

If the answer to this question suggests that the subject has suicide ideas, it is advisable to continue asking the following sequence of questions:

QUESTION: How do you plan to do it?

This question is intended to find out the suicide method. Any method can be lethal. Suicide risk is greater if there are previous cases of suicide committed by other family members using that method. The risk is even greater in the case of repeaters in search of more lethal suicide methods. In the prevention of suicide it is vital to reduce the availability of or access to methods that may inflict harm to the subject.

QUESTION: When do you plan to do it?
This question does not aim to get an exact date to commit suicide, but to find out if the subject is making arrangements, as for instance to bequeath items or whether he/she has written farewell notes, if he/she is giving away valuable items, if the person expects a significant event to take place such as the break-up of an important relationship, the death of a beloved person, etc. Subjects at risk of committing suicide should always be in the company of someone else, since being alone increases the likelihood for the act to be accomplished.

**QUESTION:** Where do you plan to do it?

This question may help find out where the subject has thought of committing suicide. This act usually takes place in spots visited by the suicide on regular bases, mainly his home, his school, or family members’ or friends’ homes. Other high risk places are places hard to find.

**QUESTION:** Why do you want to do it?

This question tries to find out the motive for why the subject wants to commit suicide. Motives should always be considered significant for the subject at risk, and they should never be appraised from the point of view of other family members.

**QUESTION:** What do you want to do it for?

The aim of this question is to find out the meaning of the suicidal act. Wishing to die is the most dangerous motive but not the only one. There may be other meanings involved such as calling other people’s attention, showing the magnitude of their problems, asking for help, attacking others, and the like. (4).

The more questions the subject can answer the better shaped his suicidal plan is. It means that the risk is very high. Then the following question is raised:

**What should the family do when one of its members has suicide ideas?** I suggest four main measures:

1) Never leave him/her alone.
2) Make sure that the method chosen by the subject cannot be used.
3) Make all family members aware of the subject’s suicide crisis so that they can help to keep an eye on the subject and to provide emotional support.
4) Contact a mental health institution so that the subject can receive specialized professional care. (5)

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Chapter 42

REFLECTIONS ON INTERVENTION RESEARCH IN THE FIELD OF SUICIDIOLOGY

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I joined the field of suicidology around 15 years ago and I have witnessed considerable advances in our understanding of suicide during that time. In particular, our knowledge of the risk factors for suicide has improved. Early in my career in suicide prevention research I reviewed the literature on risk factors for suicide among the population in general and among people with mental health problems in particular, and found that it was largely descriptive in nature. There were numerous studies that profiled the characteristics of people who had died by suicide, but often these involved no comparison group, making it difficult to determine whether a particular characteristic was actually associated with suicide risk. Since then, however, we’ve increasingly used more appropriate study designs and more sophisticated data sources (e.g., record linkage studies and psychological autopsy studies that involve comparisons between cases who have died by suicide and controls who have remained alive). Although we may still not be able to identify the factors that precipitated suicide in an individual case, we can fairly confidently list the complex array of socio-demographic, clinical, personality-based, environmental/situational, genetic and neurobiological factors that heighten suicide risk in general.

It is fair to say that these great strides in our understanding of the epidemiology of suicide have not been matched by advances in our knowledge of which interventions work best in suicide prevention. We don’t know which interventions are the most effective, much less which are the most cost-effective. This makes it difficult for governments to know where to direct their resources, and most have chosen to ‘hedge their bets’ and fund a mix of universal, selective and indicated interventions.[1] Universal interventions target whole populations, with the aim of favourably shifting risk factors across the entire population. Selective interventions target subgroups whose members are not yet manifesting suicidal behaviours,
but exhibit risk factors that predispose them to do so in the future. Indicated interventions are designed for people already beginning to exhibit suicidal thoughts or behaviours.

A widely-cited review of suicide prevention strategies conducted by Mann and colleagues in 2005 identified only two interventions that the authors judged as having unequivocal evidence of effectiveness.[2] These were interventions designed to restrict access to lethal means of suicide (a universal intervention) and interventions designed to better equip physicians to detect, diagnose and manage depression (a selective intervention).

Absence of evidence from Mann et al’s review should not be interpreted as evidence of absence. As Linehan pointed out in a recent call to action,[3] many interventions that may show promise have not yet been adequately tested. A current study by Huisman and colleagues demonstrates the paucity of intervention studies in the area, and shows that this is in stark contrast to the emphasis that has been given to epidemiological studies.[4] These investigators searched the books of abstracts from two of the largest regular international conferences held in consecutive years from 2003 to 2008 – the International Association for Suicide Prevention’s Congresses and the European Symposia on Suicide and Suicidal Behaviour. They identified 1,209 abstracts in total and found that only 12% of these abstracts described intervention studies, compared with 48% that pertained to epidemiological studies. Even when the criteria were broadened to include evaluations of broader suicide prevention programs, only another 6% of abstracts were accounted for.

It is worth considering why intervention research in the suicide prevention field is not stronger and more definitive. The problem of study design has beset many suicide prevention researchers who have tried to evaluate interventions. In research circles, the randomised controlled trial is generally regarded as the ‘gold standard’ for assessing the effectiveness of an intervention. Many potentially useful suicide prevention initiatives are not amenable to evaluation in this way, however. Universal interventions are particularly difficult to test in this manner. For example, an intervention involving the erection of barriers to prevent jumping from a bridge is, by definition, introduced to the whole community. It is not possible to randomise half the community to receive the bridge intervention and half to act as a control group. At best, it might be possible to mount an evaluation that employs a quasi-experimental design where a community with a similar socio-demographic profile, a similar suicide rate and a similar bridge is used as a control. Typically, though, if such an intervention is evaluated at all, the evaluation employs a simple before-and-after design which considers suicide rates in the given community pre- and post- the erection of the bridge barrier, with no point of comparison.

This is compounded by the fact that suicide is an emotive area, and, as a consequence, intervention research in the suicide prevention field faces particular ethical challenges. For example, trials of both pharmacological and non-pharmacological therapies for depressed individuals often explicitly exclude suicidal individuals for ethical reasons, which means that their utility as selective interventions for suicide prevention remains untested. Conversely, there are situations where it is regarded as ethically improper to withhold potentially useful interventions from suicidal individuals, which means that it is difficult to compare outcomes for those who are exposed to the intervention against outcomes for any sort of comparison group even when it might be practically possible.

In addition to the practical and ethical problems associated with designing rigorous evaluations of suicide prevention activities, the funding sources available for this kind of work have presented some issues. In Australia at least, funding for the evaluation of suicide
prevention activities comes from two main sources. One is our National Health and Medical Research Council (NHMRC), which provides competitive grants for research. The other is our Federal and State/Territory health departments, which tender out evaluations of particular suicide prevention activities that they have funded. Each has advantages and disadvantages. Grants received from the NHMRC are investigator-driven and peer-reviewed, so they are typically very strong methodologically, but because the funding is limited and must be shared around, the interventions they test tend to be fairly small in scale. By contrast, contracts awarded by health departments provide for evaluations of typically much larger and often more complex initiatives, but the evaluations tend to be more constrained. For example, the intervention is often well under way by the time the evaluation is commissioned, making it difficult to gather baseline information.

As Goldney and others have said in the past,[5] we need to get smarter about the way in which we evaluate suicide prevention interventions. We need to recognise that some interventions, by their very nature, will not be amenable to randomised controlled trials but that we must apply the most rigorous designs that we can. The program evaluation field has addressed this in other areas by developing methods for evaluating complex interventions. For example, they typically explicate the ‘program logic’ of given interventions, clarifying the causal pathway by which the program would be expected to work in order to test whether in fact it does work in that way. Similarly, they often use ‘triangulation’ or an approach where they use multiple methods and data sources to explore the same evaluation question, on the rationale that if these different pieces of the jigsaw start to form a coherent picture then conclusions can be drawn with greater certainty.

We also need to help funding bodies understand the particular problems faced in evaluating interventions designed to prevent suicide. In an ideal world, for example, key academic granting bodies and health departments might form a partnership whereby the former funds evaluations of programs rolled out by the latter. That way, large-scale, complex suicide prevention activities could be subject to the same rigorous evaluation as smaller, more discrete interventions.

The body of knowledge about what works and what doesn’t work in suicide prevention is still evolving. The epidemiological studies of the past 15 years have given us some very good clues about the risk factors that interventions should target, but the challenge now is to work out the best way in which to target them to achieve maximum effect. The likelihood is that this will involve a mix of particular universal, selective and indicated interventions, but at the moment we can’t confirm this. The time has come for suicidologists around the globe to concentrate their attention on intervention research.

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MY MIND, MY MEMORIES AND MY DEVOTION TO SUICIDE PREVENTION

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During my first years at the university when I was attending medical school, I had to face a number of memories that I had forgotten for almost ten years. My mother had died of cancer, and I continued my life trying to make sense of this loss but in actual fact denying it. While at medical school, I came across the unit where my mother was treated and ultimately died. Sorrow and anguish accompanied me for some time during that difficult period. A few years later I was a victim of a near-lethal car accident. I was saved by many miracles and by skilled professionals who treated me both during the emergency and afterwards.

During these periods of my life I often wondered why someone would decide to commit suicide. I never really thought that suicide was an option for me, but the dreadful emotions that shocked my life resulted in a perturbed state of mind. I had to work through my grief and face my challenges. Later, I serendipitously found myself studying suicide. Perhaps I was waiting for a topic that touches the very core of human existence.

As I approached the final stages of my training, I met Professor Roberto Tatarelli who then became my mentor. He had studied suicide for a long time, and I decided to study suicide in schizophrenia, a topic which has been the focus of much of my research and writing. Studying suicide prevention and the different models that describe suicide has become of great interest and, ultimately, my main research activity - a never ending task to get to know about suicide in all its different aspects. Most recently, I joined the major suicide prevention associations, and I have become involved in the activities of the International Association for Suicide Prevention (IASP).

When thinking about suicide, I consider it to be the result of fractures - with oneself, with other people, with nature, and with the opportunity to experience feelings of well-being and to appreciate that which surrounds us. Common human satisfactions are derived from feeling
alive and experiencing positive excitement, as in the case of watching breathtaking landscapes or joyful events, but this may sometimes be denied to people. The individual stands merely as a spectator, longing to heal the fracture that impairs his full appreciation of himself and the world. This situation is not necessarily related to a psychiatric disorder such as depression, but rather it is a separate, peculiar dimension that, often momentarily, overwhelms the individual. One can be profoundly depressed or psychotic, but seek treatment and hope to get better, without ever thinking of ending one’s life [1,2].

My research into suicide is related also to a serendipitous event that allowed me to get acquainted with Edwin Shneidman. Just after getting married, I left for Boston to join the staff at McLean Hospital at the Harvard Medical School. One day, as soon as I reached my desk in a laboratory under the direction of Professor Baldessarini, I noticed that the answering machine indicated that I had a new message. I played the message and heard a warm and encouraging voice that thanked me for my help during the preparation of his paper to be included in an issue on suicide in a new journal. The man introduced himself as Edwin Shneidman, and he encouraged me to call him to make his acquaintance and chat. My excitement was so great that I called him right away, forgetting that Boston and Los Angeles are in different time zones. I then realized that I had woken him at dawn! Nevertheless, we spent about forty-five minutes talking about suicide and how he conceptualizes human self-destruction. After that, I maintained regular contacts with Ed whom I later met in his house in Los Angeles. Ed took me immediately into his Melville room, a space packed with reminiscences of his love for the novelist Hermann Melville, and I had the pleasure of hearing from his own voice how he approached the study of suicide back in 1949 [1].

My conceptualization of suicide is that it cannot be considered to be simply a symptom of some psychiatric disorder. If we consider it in that way, we risk treating only the psychiatric disorder, and we do not see suicide as a separate dimension, often coexisting with the psychiatric condition. The two dimensions overlap in many instances, but they remain separate.

The focus should be on what patients feel rather than on how they can be categorized. Subjective experiences are the foundation of suicidology as a discipline devoted to the scientific study of suicide and its prevention. Areas of suicide research, although of paramount importance, cannot be directly linked to suicidology if they lack a focus on the subjective experience and the principles related to suicide prevention. One abiding feature of 'experiences' is that, in principle, they are not directly observable by any external observer. For example, we might ask, "Is my experience of redness the same as yours?" While it is difficult to answer such a question in any concrete way, the concept of intersubjectivity is often used as a mechanism for understanding how it is that humans are able to empathize with one another's experiences, and indeed engage in meaningful communication about their experiences. The phenomenology of suicide addresses a large epistemological question, that is, negative emotions and how to bridge the gap in the communication of human suffering.

I stress the need to reconcile this with the fact that suicide might be better understood as phenomenon centered in the individual. In other words, the motives for suicide can be traced in the variables surrounding the individual viewed as a unique human being whose personality contains the real reasons for wishing suicide. The saying "Know yourself" may refer, by extension, to the ideal understanding of human behavior, morals and thought because, ultimately, to understand oneself is to understand other people as well [2,3].
As a psychiatrist, I often meet suicide attempters or suicidal individuals, and my aim each time is to pay careful attention to their choice of words to express their sorrow. I try to stay away from diagnostic labels and rapid therapeutic plans. Instead, I try to get involved with their negative emotions and to propose medical treatment in conjunction with the human understanding of their drama. There are no medications for shame, guilt, abandonment, ennui, dysphoria, hopelessness or inanition – that is, psychache. Viewing suicidal impulses (thoughts and actions) phenomenologically fits with Shneidman’s concept that they may be more similar to the state of being in love than having a liver disease.

When we are happy and live with peace of mind, suicide never crosses our lives. But when life is a source of dissatisfaction and frustration, the idea of having a powerful remedy to get rid of the psychache becomes overwhelming. If known remedies that may help in reducing components of psychological pain, such as anxiety, dysphoria and depression, are not effective and if human interactions fail to sustain the individual in the race for a solution, the risk of suicide becomes extremely high. If the idea of cessation, the insight that it is possible to stop consciousness and put an end to suffering, takes hold in the mind, then suicide may be imminent [4,5]

After studying suicide for a number of years, carrying out research on suicide, writing and editing books on suicide and above all treating suicidal patients, I still remain conscious of the need to learn as much as I can about suicide. I am conscious of the need to provide a more comprehensive and understandable model for describing the phenomenon. I regularly receive e-mails and telephone calls from people in my country who are desperately seeking to have their feelings understood. I try my very best to help them, although sometimes it overwhelms me. Often I am told that they are grateful to me for describing suicide with words that to some extent represent their drama. I am, however, conscious of the fact I would like to do more.

My feelings about future perspectives on understanding suicide point to the need to address the topic with reinvigorated interest in negative emotions and how and why they may play a role in determining self-killing. Genetic and neuropsychobiological studies, as well as studying neuroimages, should be integrated with the proper knowledge of unique factors and motives that move the individual to desire death. This research should also focus on whether biological abnormalities such as hormone deregulation play a role.

I am now familiar with most of the people involved in suicide research, and I am extremely pleased when I met them at congresses. I have many collaborators worldwide, and I am excited to be involved in these activities. I feel very motivated and happy when I can involve as many people as possible to work on joint projects. Nevertheless, despite this great activity, I sometime feel disappointed and discontented because there are still some elements of the enigmatic phenomenon of suicide that I cannot understand and because there are theories of why people commit suicide that appear elusive and not properly elaborated. Despite these moments of “depressed mood,” I feel that we are all doing a great job in providing new strategies and tools for understanding this very central problem of human existence.
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Chapter 44

PREVENTION OF SUICIDE IN PATIENTS WITH MOOD DISORDERS: INDIVIDUAL AND PUBLIC HEALTH PERSPECTIVES

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During the first 36 years of my clinical practice, up to 2007, I worked in an acute admissions in- and outpatient psychiatric department of the National Institute for Psychiatry and Neurology, responsible for a catchment area of about 200.000 inhabitants Budapest (80 beds). As in similar departments, we were admitting all types of psychiatric patients and thus my clinical and research interest from the beginning focused on the clinical and biological aspects of mood and anxiety disorders. Because the catchment area of our department remained the same and the geographical mobility in Hungary is very low, I was also seeing my patients’ relatives as healthy family members and later, in several cases, as patients too. This long-term experience was similar to a naturalistic follow-up and family study and I have seen several cases of suicide mostly among untreated relatives and among our mood disorder patients who left our outpatient mood clinic. Consequently, I realized that suicide was probably the best indicator of the effectiveness of our clinical care, and in the last two decades I became more and more interested in suicide prediction and prevention, particularly in mood disorder patients.

Suicide is the most tragic event of our human life, causing serious distress among relatives and friends as well as among treating doctors, at least in cases when the victim was in contact with medical care. Because suicide is a rare event in the community, its precise prediction in individual cases is very difficult. However, suicidal behaviour (completed suicide and suicide attempt) is quite frequent among psychiatric patients who contact different levels of the health-care some weeks or months before their death. Untreated unipolar or bipolar major depressive episode is the main clinical substrate of completed suicide, accounting for 56-87% of the cases. However, as the majority of depressed patients never

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complete suicide and about half of them never attempt it, special clinical, psychological and psycho-social risk factors also play a contributory role (Rihmer, 2007). What is most important in this respect is that suicidal behaviour in mood disorder patients is a state- and severity-dependent phenomenon and that suicidality decreases/vanishes after the clinical recovery (Rihmer, 2007).

**INDIVIDUAL PERSPECTIVE**

There are two main strategies of suicide prevention in mood disorder patients: (i) specific interventions targeted at high-risk groups (current suicidal intention, past suicide attempt), and (ii) global improvement of health-care regarding earlier and better recognition and treatment of depressive disorders, regardless of the patient’s suicidality. Both strategies are important, but following only the first one, i.e. targeting only those persons who are at acute suicidal risk, is frequently useless, because it is sometimes already too late to make effective intervention at this stage. It is well-known that prior suicide attempt is the most powerful single predictor of completed suicide in depressed patients. However, as more than two-thirds of suicide victims die by their first attempt and the same rate of them have (mostly untreated) current major depressive episode, waiting for the first suicide attempt to have a good predictor is hardly a professional attitude and is quite hazardous as well. Therefore, it is essential to detect suicide risk factors among all depressives as early as possible (i.e. during the first depressive episode), and to intervene prior to the patient’s first suicidal act. The significant suicide risk factors even in currently nonsuicidal depressives are: family history of suicide in 1st and 2nd degree relatives, early onset of mood disorders, bipolar (particularly bipolar II) depression, agitated/mixed depression, insomnia, severe weight loss, hopelessness, comorbid substance-use and anxiety disorders, adverse life events, cyclothymic temperament, severe comorbid personality disorder and aggressive/impulsive personality features (Rihmer, 2007). Since successful acute and long-term pharmacotherapy of patients with mood disorders markedly decreases suicide mortality and morbidity in this high-risk population, it is also true that antidepressant monotherapy (unprotected by mood stabilizers) can worsen depression (and can lead to suicidal behaviour) by inducing mixed states in a small, vulnerable subpopulation of unrecognized or subthreshold bipolar depressives (Rihmer and Akiskal, 2006; Rihmer, 2007). Considering all the above, antidepressant treatment is much more likely associated with an improvement of suicidal behaviour than emerging or worsening of it, and the correct diagnosis and treatment of bipolar depression can minimize the chance of this rare iatrogeny. The role of treatment in preventing worse outcome has also been demonstrated in a community-based epidemiological study, showing that major depression occurred in a significantly smaller proportion in persons receiving treatment for their panic attacks (19%) than in those who did not receive treatment (45%) (Goodwin and Olfson, 2001). A similar example is known regarding several other disorders, including e.g. hypertension and stroke.

Based on all the above, my personal opinion is that the most effective strategy of suicide prevention in mood disorder patients is the early diagnosis and appropriate acute and long-term care of these patients, including also non-pharmacological interventions. However, this would be also an ideal target even if the fact of suicide were unknown….


**PUBLIC HEALTH PERSPECTIVE**

Since the successful treatment of depression is protective against suicide not only in individual cases but also on large samples of depressive patients (Rihmer and Akiskal, 2006; Rihmer, 2007), it is logical to assume that if adequate treatment becomes more and more frequent, this beneficial effect will at some time appear in the general population, particularly in countries where the suicide mortality is high and the rate of treated depressions is low, albeit sharply increasing. Although it is very difficult to measure the quality of treatment of depressed patients on the level of a given country as a whole, increasing utilization of antidepressants is a proxy marker of their improved and more extensive care. In spite of the fact that national suicide rates are affected by many factors, untreated major depression is all too frequent in each country to be underestimated. Several studies found a significant negative correlation between increasing antidepressant prescription and decreasing national suicide rates (Rihmer and Akiskal, 2006; Ludwig et al., 2009). However, statistical association does not necessarily mean causality, the best example for this being the frequently quoted “significant positive association between the price of beer and the income of protestant priests”. As for increasing antidepressant utilization and declining national suicide rates, the above mentioned counter-argument is popular among those who do not know – or at least acknowledge – that there is a very strong and causal association between untreated or badly treated depression and suicide both at the individual and the statistical level, whereas it is not the case for the beer; at a given time and place the beer prices are usually the same for unpaid, badly paid as well as for well paid priests.

Indeed, recent analysis of suicide rates and sales of SSRIs in 12 countries (Australia, Austria, Canada, Chile, Greece, Ireland, Italy, Japan, Portugal, Spain, the UK and the USA) found that suicide rates showed a similar upward trend from the mid-1960s through the late 1980s in all of 12 countries. This steady upward trend in suicide rates persisted through the year 2000 in countries with low or medium predicted growth rates of SSRI sales, but showed a marked and progressive decline in the high SSRI-growth countries (Australia, Austria, Canada, the UK and the USA) from the very late 1980s – just as SSRIs were introduced and increasingly used (Ludwig et al., 2009). The eight-fold increase in antidepressant prescription in Hungary between 1980 and 2003 was also accompanied by an almost 40% decline in the national suicide rate (Rihmer and Akiskal, 2006). In addition to several previously published results, these studies also suggest that more widespread treatment of depressive disorder is only one, but important contributory factor in decreasing suicide mortality on the level of the general population. In the last 50 years, a remarkable progress has been made in the treatment of depression and several other disorders, including, e.g., hypertension. Since hypertension is present in 75% of patients with stroke and with coronary heart disease (like depression in suicide victims and attempters), cardiologists did dare to declare that better treatment of hypertension was a significant (but not the only) contributory factor in a markedly reduced morbidity and mortality from stroke and coronary heart disease in the USA between 1970 and 2000 (Moser, 2004). Cardiologists did in fact acknowledge that publicly. Why should, then, psychiatrists be afraid of doing the same?
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Chapter 45

SUICIDE AS AN EXISTENTIAL ENIGMA: COMING FULL CIRCLE

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Although I am fully aware that memory is reconstructive, my recollection of my earliest awareness of suicide is that it occurred when I was around eight years of age. I recall wondering what kinds of things must be happening in someone’s world to bring him or her to the decision that life is no longer worth living. At that time, I had little or no concept of mental illness or alcohol/substance use and abuse, or any other of the myriad factors that we now identify as correlates of suicide and suicidal behavior. From my eight-year-old perspective in 1958, dying by suicide was the result of a decision one would make based on an evaluation of the pros and cons of living in relation to life circumstances. And, I assumed that a person must be feeling very badly in order to make a decision to end his or her life. Thus, as I think back, it seems that I took a fairly philosophical approach (as much as an eight year old can) to the question of suicide. Perhaps the first sign of my later existential orientation!

It seems then, that the issue of suicide dropped off of my radar for a very long time. In fact, I cannot recall specifically thinking about suicide or being impacted at all by any media reports of suicide for almost 30 years. I am sure, however, that I was exposed to reports of suicides and suicidal behavior and even, like I believe most people, had fleeting thoughts myself in particularly difficult circumstances.

In 1986, I volunteered for a local suicide hotline organization as a way to gain some mental health related experience in advance of applying for graduate school in psychology. I am not sure what drew me to volunteer in this capacity, but I suspect that it was a function of my curiosity in the past. In retrospect, my choice to volunteer for a suicide prevention hotline was a turning point in my professional life. Beyond the excellent training that I received in responding to folks in crisis, I was introduced to the journal Suicide and Life-Threatening Behavior, the American Association of Suicidology, the early work of Shneidman, Farberow, and Litman and the research of David Lester related to crisis line work. These were all
influential components of my early interests in suicide and suicide research that led me to begin exploring the research base related to suicidal behavior.

Beyond some early philosophical articles in *SLTB* related to the issue of rational suicide by Battin and Weber, I discovered a strong focus in the literature on identifying mental health-related correlates (i.e., risk factors) of suicide and other non-lethal suicidal behaviors. As a novice suicidologist, I immersed myself in this literature and went on to develop the *Suicide Assessment Checklist*, for use in crisis line work and other emergency evaluation settings (Rogers, Alexander, and Subich, 1994; Rogers, Lewis, and Subich, 2002). As reflected in the literature, this checklist focused primarily on status variables such as prior attempts, method availability and prior non-lethal suicidal behaviors and clinical factors such as depression, impulsivity, and hopelessness. While I did include an assessment of the person’s intent to die in the measure, I had clearly drifted from my more philosophical focus from the past!

Continuing in my career, I began to be frustrated with much of the literature related to suicide as I saw a continued focus on mental illness as an “explanation” for suicidal behaviors and the implicit if not explicit message that treating mental illness and “treating” suicidal behavior were one in the same. Of course, if the mental illness and risk factors approach had resulted in strong evidence that it was leading to a reduction in suicides or other suicidal behaviors, continuing this focus would have been reasonable. However, I could find little in the way of compelling supportive evidence.

Nonetheless, out of my frustration and disappointment in the lack of progress in the field I began to explore various complexity models drawn from physics to gauge the extent to which they might help advance understanding and still perhaps, result in predictive models of suicidal behaviors. Thus, for some time, I considered the likes of chaos theory, catastrophe theory, and self-organized criticality (see Rogers, 2003) as potential useful metaphors for understanding the complex influences that may put one on a trajectory toward suicide. After a while, though, I came to the conclusion that complexity models, while indeed serving as useful metaphors, were too mathematically intricate for me to apply them as research models.

So, frustration with my career and the field of suicidology reemerged practically unabated until the tragic events of September 11th, 2001. Less than two-weeks after September 11th of that year I found myself in New York City working with folks involved in the rescue and recovery efforts following the attacks on the World Trade Center (see Rogers and Soyka, 2004a). Although I had, over the past few years, regained my existential orientation as a theoretical perspective, it was this experience that truly grounded me as an existentialist by reminding me of the important role of one’s perception of meaning and connectedness in determining whether or not life is worth living.

Energized by my experience, I reconnected with the work of Edwin Shniedman and others who tended to highlight the importance of the psychological experiences of the suicidal individual. I began to give greater consideration to the experience of suicidal people as they interact with others including mental health professionals. A subsequent article that I co-authored considering the potential negative impact of applying the crisis intervention model to working with suicidal people (Rogers and Soyka, 2004b) led me to the Aeschi Group; an international collection of researchers and clinicians with a similar focus. The overarching theme of this group, *Meeting the Suicidal Person* stands in stark contrast to our historical approach in suicidology imbedded in the phrase *treating the suicidal person.* Thus, I saw a
shift from suicide as a symptom, to suicide as a problem and from the clinician and researcher as the expert to an appreciation that the suicidal person is the expert in his or her experience.

So, I have found myself coming full circle in my thoughts about suicide and suicidal behavior. From that naiveté as an 8 year-old to today, over 50 years later, I have returned to seeing suicide as the result of an existential struggle with the meaning of life. I believe that as we as a field turn from learning about suicidal individuals to learning from them, we may yet find ways to reduce the suffering and loss of life from suicide.

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I first became aware of suicidology when I was a second year resident in psychiatry at the Phipps Clinic at Johns Hopkins Hospital in Baltimore. My supervisor was Seymour Perlin MD. At that time Dr Perlin was editing a book on suicide and gave me a chapter he had received to read. Nothing came of this first experience with suicidal issues till several years later-which may speak to the dormant effects that mentors may produce, effects that may surface later!

My next experience with suicide research was similarly fortuitous. When working at the Clarke Institute of Psychiatry in Toronto a colleague Joseph Glaister MD told me that, for medico-legal reasons, the medical director of the Institute had kept a file over the year containing the names of all the psychiatric patients of the Institute who had committed suicide. I was able to obtain these names and there were 90 such patient suicides. I spent a lot of time reviewing the charts and extracting information and an even greater amount of time in the medical records department matching each patient for sex and age, within five years, with the next patient who attended the Institute. This led to my first paper on suicide entitled Risk factors for Suicide in Psychiatric Patients published in the Archives of General Psychiatry. This was due to the generosity of Dr Glaister. I worked many hours and days on the manuscript often in Chinese restaurants near the hospital on lunch breaks! Needless to say I spent many hours in the library reviewing the suicide literature which was a great learning experience. The reviewers of the paper at the Archives of General Psychiatry had many helpful comments on the paper I submitted but I didn’t seem able to get it right. One day out of the blue I got a telephone call from the Editor of the Archives of General Psychiatry- Danniel Freidman MD- encouraging me to persevere. Another very generous act! Who these days –or then- would expect an editor to ring them up to discuss a submitted manuscript! But then Danny Friedman was a very exceptional man. Thus this first paper was born out of the generosity of both Dr Glaister and Dr Freidman-which points out the need to be generous with our junior colleagues struggling to do their first suicide research.

More good luck was that I was able to publish a second paper on Suicide in Schizophrenic Patients and that the statistician I was working with -Cathy Spegg- told me that
the hospital data base had an item about any family history of suicide for each patient. This data base we mined and quickly led to a second Archives of General Psychiatry paper on Family History of Suicide. This work and the positive findings led me to realize that suicide runs in families and that, therefore, there might be a genetic component to suicide. This was in 1982 when such thoughts about genetics and suicide were not well received. However, this additional piece of good luck in relation to research data again shows the role serendipity may play! These notions about possible genetic factors in suicide lay dormant in my mind for several years until the advent of laboratory molecular genetics.

After that I was stimulated to edit a book on Suicide. This was well received when it was published. As part of that book I invited Ed Schneidman to write a chapter which he did with characteristic brilliance. His ideas about the commonalities of suicide and about suicide being the final common path for intolerable psychological pain have always stuck with me when thinking about suicide and when managing suicidal patients. His idea about suicide being the result of intolerable psychological pain I believe is unique, very insightful, and just brilliant. I had the good fortune to meet Ed a few times.

The next influences on my thinking about suicide came when I worked at the National Institutes of Health in Bethesda, Maryland. There a brilliant Finn Markku Linnoila MD PhD introduced me to the influence of low serotonin on suicidal behavior. Markku was chief of the Laboratory of Clinical Studies in the National Institute of Alcohol Abuse and Alcoholism. We carried out many studies together the results of which helped build on Marie Asberg’s findings, with Lil Traskman, that low cerebrospinal fluid levels of the serotonin metabolite 5-hydroxyindoleacetic acid were associated with suicidal behavior. I worked with Markku Linnoila for seven exciting years until his untimely death in his mid forties from cancer. Markku was very brilliant and also very generous. Our work together convinced me that neurobiology was critical in suicidal behavior. Markku’s death so young was a tragedy. I still often think of him, the fun we had working together, and what he might advice today in a research design or in a difficult part of writing a paper.

In more recent years, I have been able to come back to my original thought about the possibility of there being genetic factors in suicide. Working largely with Nancy Segal we were able to put together some twin studies showing that the concordance for both suicide and attempted suicide was higher in monozygotic twins than dizygotic twins. With the advent of laboratory molecular genetic techniques, in collaboration with David Goldman and his colleagues at the National Institutes of Health we have been able to put out a continuing series of papers about variants in some genes in relation to suicidal behavior. We have shown interaction between genetic variants and environmental factors in relation to suicidal behavior. This has been very exciting and continues to be so. Most recently with Marco Sarchiapone in Italy we have begun to look at clinical and genetic factors in relation to suicidal behavior and aggression in prisoners.

However, recent years have also been exciting by researching the impact of childhood trauma on suicidal behavior. Our studies in depressed, schizophrenic, substance abuse, and diabetic patients - as well as in prisoners - have all shown that childhood abuse and neglect are risk factors for suicidal behavior. That this developmental factor may have such a powerful role as a risk factor for suicidal behavior has been a revelation. What is more childhood abuse and neglect may interact with biological factors in the brain to magnify the risk of suicidality. Just extraordinary.
For me suicidology has been an exciting field and rewarding to work in. Its multifactorial nature should continue to make it of interest to mental health workers. Future endeavours will concentrate more and more on possible intervention guided by the body of knowledge that has been laid down. Suicidology is a very young subject-less than a 100 years old. There is space for everybody but we still have too few recruits. As my career path demonstrates the role of the mentor is important as is chance and the generosity of colleagues.
Chapter 47

THE LEGACY OF THE FIRST GENERATION OF AMERICAN SUICIDOLOGISTS

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It was the first generation of American suicidologists - led by Edwin Shneidman – who literally and figuratively placed the study of suicide (e.g., suicidology) squarely on America’s mental health agenda. Up until the 1950's, although statistics were kept on suicidal deaths, only a very few clinicians and researchers were focused on understanding suicide and the suicidal mind. There were no textbooks to read, no journals focused on suicide, no graduate (or undergraduate) courses on suicide in which to enroll, no sponsored lectures to attend, and virtually no place to go to get clinical training and supervision.

The first generation of American suicidologists (in alphabetical order): Aaron T. Beck, Norman Farberow, Calvin Frederick, Herbert Hendin, Robert Litman, J. Terry Maltsberger, Karl Menninger, Jerome Motto, George Murphy, Seymour Perlin, Alex Pokorny, Philip Resnick, Joseph Richman, Eli Robins, Richard Seiden, Edwin Shneidman, and Avery Weisman, changed the way that we think about suicidal individuals. Their efforts were bolstered by the advocacy work and contributions of such people as: Iris Bolton, Frank Campbell, Karen Dunne-Maxim, John McIntosh, Charlotte Ross, and Elsie and Jerry Weyrauch.

The first generation legitimized the study of suicide and defined the research questions that were needed to scientifically explore and better understand the suicidal process. Based on their studies and theories, what evolved was an approach to understanding the multi-factorial and multi-dimensional processes that lead to suicidal thinking and suicidal behaviors. They also acknowledged survivors of the suicide of a loved one by recognizing their needs and welcoming their contributions to understanding and preventing suicide.

These pioneers moved suicide from being a solely moral, ethical or religious issue, as well as a taboo topic, to one worthy of legitimate scientific investigation. What arose from
their investigations and theories were approaches to understanding the suicidal individual (cognitively, behaviorally, psychologically) as well as developing interventions that are focused on the family, support networks, community, and societal organizations (e.g., schools) that contribute to the development and maintenance of suicidal behaviors. Each of these pioneers championed their own perspective - psychological, sociological, biological, behavioral, familial, psychoanalytic, etc. In many ways they encompassed the understanding of suicide as not only an intrapsychic phenomenon, but also an interpersonal phenomenon, by emphasizing the significant role of support networks, family, friends, and society (and even the clinician treating the individual).

Many of us support the recent biological research that is searching for genetic predispositions to suicidal behaviors, and studying biological mechanisms (e.g., neurotransmitters) that seem to be associated with self-destructive and violent behaviors. However, we also recognize that suicide is a multi-determined and multi-faceted behavior, and, as such, no one finding or no one risk factor can explain the range of circumstances and presentations that are associated with self-destructive behaviors. The pioneers identified most of those contributing factors, mainly through case control methods and the development and implementation of the psychological autopsy method.

What is their legacy? They have emboldened the second generation of American suicidologists to work to remove the stigma of suicide in the general population as well as in the research world. Just as cancer is now a household word, and suffering from depression is no longer seen as a moral failure, so, too, the "s" word has been de-stigmatized to the point that it appears in Congressional legislation, popular press and media, TV, books, magazines, etc. For example, all Americans are now aware of the efforts of the U.S. Armed Services and the Veterans Administration to address suicide amongst active duty soldiers and recently discharged veterans. The responsibility of the second generation was to advance the field on many fronts – including epidemiology, risk factor research, early assessment and identification, treatment, and, of course, prevention. Millions of federal and private foundation dollars are spent annually on research into the etiology of suicide and towards the development of preventive interventions.

By the way, not enough dollars, but, nonetheless, a far cry from where things were just 10 years ago.

Their pioneering work, their publications, their generous mentorship, and the establishment of the Los Angeles Suicide Prevention Center, all laid the groundwork for the second generation. We didn't have to fight for legitimacy. We didn't have to justify our existence. We didn't have to search for colleagues. They gave us the foundations – a professional organization, a respected scientific journal, a bookshelf worth of reports, books, and monographs, and a foothold into federal support and public recognition. And, probably their greatest contribution is that they did not pigeonhole the study of suicide into just those areas of their own interest - they allowed for and openly supported a much broader exploration of the suicidal mind and the phenomena of suicidal behaviors. As a result, they opened the door for contributions from many different disciplines and the development of new research directions, new theories, new treatments, and new preventive interventions.

The work of the first generation resulted in the field of suicidology being recognized as a specialty within the mental health disciplines of psychology, psychiatry, social work, and nursing. Their influence extended to medical examiners and coroners, pathologists, lawyers, theorists, theologians, sociologists, legislators, and even politicians. Ed Shneidman, in
particular, was a major spokesperson, cheerleader, as well as a beacon, for the field. He almost single-handedly created American suicidology and worked his entire life to see that his vision of the study of suicide as a scientific endeavor would flourish, not just survive.

By bringing suicide out of the darkness, the first generation has enabled the second generation to support the emergence of suicide survivor groups and the "coming out" of survivors of the suicide of a loved one. Survivors and the survivor movement have “gone public” by embracing and championing advocacy at all levels (national, state, community, and school). This is an American phenomenon that is now being emulated around the world. Researchers, clinicians, and policy makers are listening to survivors, and survivors are helping to shape the direction of research and prevention in this country.

I count myself as a second generation American suicidologist. Ed Shneidman, Norman Farberow, and Robert Litman have influenced the thinking and practice of my entire generation of colleagues. No one of my cohort could call themselves a suicidologist without first having gotten Ed's blessing. No matter in what discipline you were trained, and no matter how many scientific papers you already wrote, without Ed's seal of approval you officially were not admitted into the "suicide club." That's the extent of the influence that he had on the field. Earning Ed's blessings was a rite of passage and a very coveted achievement.

Many of my generation are committed to the teaching and training of the third generation (and hopefully the fourth, as well). They will be the generation to implement large-scale intervention projects and develop and test primary prevention models. We wouldn't be invested in these activities if it were not for the inspiration, influence, and vision of Ed Shneidman and his colleagues comprising the first generation of American suicidologists.

In summary, the first generation (with Ed Shneidman as the Captain of the American ship) steered the study of suicide in the USA out of the 19th century and into the 21st century. Maybe there were at most a dozen shipmates on board with Ed when he set sail, but he was surely the Captain who set the direction for their quest to solve the mystery of suicide. The second (as well as the third) generation is keeping the ship afloat and sailing it in the right direction.

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Chapter 48

WHERE ARE THE SUICIDE RISK ASSESSMENTS?

Robert I. Simon

Suicide Risk Assessment is a core competency that psychiatrist must possess [1]. A competent suicide assessment identifies modifiable and treatable risk and protective factors that inform patient treatment and safety management [2]. A clinical axiom holds that there are two kinds of psychiatrists, those who have had patients commit suicide and those who will. Patient suicide is an occupational hazard. Psychiatrists, unlike other medical specialists, do not often experience patient deaths, except by suicide.

Psychiatrists frequently assess suicidal patients who present life-threatening emergencies. Psychiatrists, unlike other physicians, do not have laboratory tests and sophisticated diagnostic instruments to assess patients at risk for suicide. For example, when evaluating an emergency cardiac patient, the clinician can order a number of diagnostic tests and procedures, e.g., EKG, serial enzymes, imaging, catheterization. The psychiatrist’s diagnostic instrument is competent suicide risk assessment.

No single suicide risk assessment method has been empirically tested for reliability and validity [2]. Standard practice encompasses a range of reasoned clinical approaches to suicide risk assessment. From a risk management perspective, the law does not require best practices or even good care. The clinician’s duty is to provide competent risk assessment [3].

THE REALITY

My review of suicide cases in litigation finds an absence of documented suicide risk assessments. Instead, one often finds the usual terse note “NO SI, HI, CFS” (no suicide ideation, homicidal ideation, contracts for safety) which masquerades for a suicide risk assessment. A lay person could just as well conduct such an assessment.

The situation is no different with quality assurance reviews. In one instance, to motivate clinicians to perform and document suicide risk assessment, various incentives were considered such as monetary awards, dinners and special recognition. The idea was borne out

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of frustration and quickly dismissed as fruitless. I do not believe that the absence of documented, competent suicide risk assessments is unique to my clinical experience. The Joint Commission found that substandard suicide risk assessment were the second most common root cause contributing to approximately 80% of inpatient suicides [4]. Documented competent suicide risk assessments are a core measure of quality care.

**THE QUESTION**

Why then are documented suicide risk assessments such a rarity? When I asked this question of colleagues, a variety of views were given:

1) The clinician has not learned how to perform an adequate suicide risk assessment.
2) The clinician does not do suicide risk assessments, delegating the task to others.
3) The clinician performs adequate suicide risk assessments but does not document them.
4) The clinician experiences anxiety in the treatment of the suicidal patient which creates denial and minimization of risk, resulting in inadequate assessment.
5) The clinician worries that documenting the risk assessment process creates liability exposure, if the assessment is wrong and the patient attempts or completes suicide.
6) The clinician who treats many patients, especially in an inpatient setting with rapid patient turnover and short length of stay, does not take the time to perform adequate suicide risk assessments.
7) The clinician relies on intuitive, “gut” assessments of suicide risk.
8) The clinician believes that a general psychiatric evaluation, by itself, constitutes a suicide risk assessment, without having to do more.

Time, money, inadequate training and litigation fears can combine to negatively influence adequate assessment and documentation. The fear of becoming embroiled in a malpractice suit, if a patient attempts or commits suicide, can engender inappropriate defensive practices as noted above. Countertransference hate of an anxiety provoking suicidal patient can result in inadequate risk assessment and treatment [5]. Many psychiatrists and other mental health clinicians have not been formally trained in performing competent suicide risk assessments. It is generally assumed that clinicians will somehow acquire this knowledge in the course of clinical practice. As the internist must be trained how to assess the emergency cardiac patient, so the psychiatrist must acquire knowledge necessary to competently assess the suicidal patient. The core competence necessary to perform suicide risk assessments is difficult to obtain by unaided clinical experience.

**THE REMEDY**

Forms and checklists should not be used as a substitute for clinical assessment. Generally, self-assessment instruments cannot be relied upon because guarded or deceptive suicidal patients may not answer honestly. Some patients, however, may reveal more about
suicide risk on self-assessment than at the initial clinical interview [6]. No psychological tests exist that can predict suicide [6]. Assessment forms and checklists often omit evidence-based general risk factors. Some checklists contain items that are not recognized risk factors for suicide. Important individual suicide risk factors are not present on assessment forms. The “know your patient imperative” is absent. Checking off forms robotically is not a credible suicide risk assessment. If litigation ensues following a patient’s suicide, the plaintiff’s attorney will invariably point out risk factors that the deceased patient manifested but were not on the form. If a form is used, the clinician must do more. Suicide risk assessment is a process of analysis and synthesis that requires identifying, prioritizing and integrating risk and protective factors into an overall clinical judgment of suicide risk. The assessment should be documented in narrative form.

An extensive psychiatric literature exists on suicide but I find relatively little published on the topic of suicide risk assessment. An exception is the American Psychiatric Association’s Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors [7]. It is an excellent informational source regarding the conduct of suicide risk assessment. Learning how to perform a competent suicide risk assessment must begin during psychiatric residency. Lectures, tutorials and especially case conferences that follow patients at suicide risk over their course of treatment are essential. Assessment is a process, not an event.

There are a number of suicide risk assessment methods [2]. Clinicians, however, must fashion their own approach to suicide risk assessment based upon their training, clinical experience and their familiarity with the suicide literature. Because of its singular importance, I recommend that the suicide risk assessment be documented as a separate narrative paragraph in the initial psychiatric evaluation and thereafter in the progress notes.

I believe that armed with the ability to perform competent suicide risk assessments, psychiatrists and other mental health clinicians can confidently manage the patient at risk for suicide, one of the most complex and difficult challenges in clinical psychiatry.

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Suicide tourism is a form of niche tourism termed “dark tourism.” Dark tourism concerns travel to learn about and experience cultural sites representing the dark side of the human condition (Foley and Lennon 2005). Dark tourism encompasses tours such as those of slavery museums, plantations, battlefields, prison tours, Holocaust museums, and sites of mass murder such as the World Trade Center in the U.S. and the Tuol Sleng Museum of Genocide Crimes and killing fields in Cambodia. Suicide tourism involves travel to cultural places including museums, medical examiner offices, suicide hot spots such as bridges and cliffs, and sculptures referring to suicidality. At present, it is a highly individualized form of tourism, similar to selected forms of research and literary tourism (Novelli 2005). As in some forms of niche tourism, suicide tourism, at present, involves considerable pre-travel planning by the individual or small group of suicide tourists. To the best of our knowledge, few commercial suicide tours are available. The Chiran Peace Museum in Kagoshima, Japan, is dedicated to the memory of 1,400 kamikaze pilots who flew suicide missions, crashing their planes into enemy targets towards the end of World War II. It is located on the site from which the pilots flew their missions. However, at present, for most potential suicide tours, the suicide tourist needs to take the initiative in developing an itinerary.

Herein, we review our recent suicide tour of London, England to illustrate some potential modalities of experience for the suicide tourist. London museums contain perhaps the largest collection of suicide art in the world. Before our trip we located several hundred items of suicide art on the web pages of the six principal museums: British Museum, National Gallery, National Portrait Gallery, Tate Britain, Tate Modern, and Victoria and Albert Museum. All have free admission. Synopses of the meanings behind suicide art can be found in such outlets as museum web pages and texts on the history of suicide art (Brown 2001; Cutter 1983; Stack and Lester 2009).

We reviewed over 50 suicide art objects during our week long suicide tour. At the British Museum there is an extensive exhibit concerning the mass suicide of over 60 servants and

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officials at the Royal Tomb of Ur, who apparently poisoned themselves voluntarily in honor of the deceased royalty. Artistic depictions of such mass suicides, of which there are many, reminded us that there are cultural elements to suicide. These add to psychiatric explanations based on highly individual factors. The National Gallery holds Liberale da Verona’s *Dido’s Suicide*, depicting the suicide of the Queen of Carthage after she was rejected by her lover. The National Portrait Gallery’s collection includes John Smith’s *Pyramus and Thisbe*, which tells a sad story about two young lovers’ double suicide. This story inspired Shakespeare’s *Romeo and Juliet*. The Tate Britain hosts William Etty’s *Hero, Having thrown herself from the Tower at the Sight of Leander Drowned, Dies on his body*. Loss of a lover is a recurrent theme in suicide art history, a social risk factor neglected in suicide studies. The Tate Modern features Francis Bacon’s *Three Figures and Portrait*, depicting a frenzied character said to be Bacon’s lover, who died through suicide.

Most suicide art objects are not on display, but can be retrieved for scholarly review by museum staff on a walk in basis, or by an appointment. Walk in service was provided to us at the Victoria and Albert and the British Museums. This process is greatly facilitated if the suicide tourist has the web based ID numbers and titles of the suicide art objects that need to be retrieved. The Victoria and Albert archival study room included adjustable camera stands that greatly facilitated the taking of professional photos of art objects. The suicide tourist can arrange appointments with other museums to view selected suicide art objects. However, we experienced some difficulty in locating and making phone contact with some of the appropriate museum officials.

From pre-tourism research, we learned of a suicide wave of impoverished persons in the mid 19th century. A particularly unfortunate and despondent homeless woman attempted a homicide-suicide with her small child. The child drowned, but she lived. A renowned public debate ensued which involved Charles Dickens, who pleaded for mercy for the woman, while many others demanded the death penalty. At the Victoria and Albert Museum the museum staff retrieved, from their extensive archives, the original sketch of Gustave Dore’s *Glad to Death’s Mystery*. This depicts a woman about to jump from London’s Bridge of Sighs (Waterloo Bridge) during the mid 19th century suicide wave. Thomas Hood wrote a poem regarding the suicides on the Waterloo Bridge. We visited the bridge and read our favorite stanzas from his poem in commemoration of the unfortunate deceased. The bridge was also the site of a fictional suicide due to sham, that of a woman played by starlet Vivian Leigh in the *Waterloo Bridge* (1940).

While photography is freely allowed in the British Museum, most of the other museums have restrictive policies by world standards. For example, the Tate Museum allows photography by permit only (for up to four works) and the suicide tourist must pay an hourly wage for an accompanying guide. However, all the museums have digital images of selected suicide art that are downloadable from their websites, but these can be used mainly only for self study. We did observe some deviant behavior of tourists taking furtive digital pictures.

Suicide cultural artifacts can be located in non-museum settings including art in public parks, homes of famous suicides, and suicide hot spots. On the Thames at Westminster Bridge, we photographed a large public sculpture of the Queen Boudicea. In 61 AD, she led a rebellion of over 70,000 Britons against the occupying Roman army. After she lost a decisive battle, she and her two daughters, the latter who had been reportedly raped by the Romans, suicided to avoid further humiliation.
The suicide tourist needs to be ready for the unexpected. We tried to visit the home address of a famous youthful poet’s suicide (Chatterton), but it had been torn down and replaced by a bank. While touring the Waterloo Bridge, we made a pleasant discovery that *Dido Queen of Carthage* (which contains three suicides of lead characters), was playing at the National Theatre. We immediately purchased tickets. Twice our connections on the London Subway (the Tube) were cancelled by notices over the intercom of apparent suicidality. The connections were closed due to “a person under the tracks.”

The London suicide tourist can collect cultural memorabilia. Our favorite commercial ones were a full size poster of John Millais’s *Ophelia* at the Tate Museum, a postcard of Henry Wallis’s *The Death of Chatterton* in the Tate, and a Virginia Woolf magnet from the National Portrait Gallery. However, the best memorabilia included five personally produced and directed short videos and hundreds of digital photos of various suicide cultural artifacts. These multi-media productions can be valuable as tools for promoting suicide tourism as well as serving as educational tools.

Suicide tourism can offer significant and even substantial insight into the causes of suicide. For example, the British Museum offers depictions of the suicide of Ajax, one of the oldest and most popular suicides in art history. These included a well preserved etching on a vase, and a small statue, both over 2,000 years old. Ajax suicided due to frustrations of being passed over for promotion at his work as a leader in the army of his day. This aspect of economic strain has been neglected for over two millennia since Ajax’s fate. Nevertheless, a recent investigation found that this aspect of economic strain was the second most powerful predictor of suicide (Stack 2009).

Suicide tourism also has potential for suicide prevention by its spreading awareness of suicide through experiential connections to suicide sites. Suicide tours could be developed at the local level by suicide prevention groups to call attention to the problem, suggest alternatives to suicide, educate tourists on the warning signs for suicide, and suggest prevention measures. Such tours may be most successful in areas rich in suicide cultural artifacts including museums, a history of celebrity suicides, and well known suicide hot spots.

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Chapter 50

AMBIVALENCE, WARNING SIGNS, AND DECISION MAKING

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AMBIVALENCE

Is the act of ending suffering a fundamental human right? Arthur Schopenhauer argued that it is: "They tell us that suicide is the greatest piece of cowardice... that suicide is wrong; when it is quite obvious that there is nothing in the world to which every man has a more unassailable title than to his own life and person."

I first became involved in suicide prevention work shortly after I finished medical school, where I learned that the vast majority of people who die by suicide have a treatable psychiatric disorder, most often depression. As Emil Kraepelin stated, "the tendency to commit suicide is more pronounced and more to be guarded against in melancholia than in any other form of mental disease." At that time, I did not dwell much on whether suicide was an essential human right or an abomination that should be prevented by all possible means. After finishing my residency at the National Institute of Psychiatry and Neurology in Budapest, I accepted a position as an attending psychiatrist in the city’s newly opened Crisis Intervention Center. I wanted to conduct psychotherapy in addition to prescribing medication and wished to work with the center’s leaders, Drs. Anna Furi (whose brainchild the center was) and Nora Csiszer, who were great family therapists. My decision to work with suicide attempters did not stem from any personal history or experience.

The center had a 24-bed inpatient unit and an outpatient clinic and was closely integrated with a 24-hour crisis hotline and a huge toxicological unit, which was located in the same building as our center. This unit treated almost every person in Budapest and its surrounding area who attempted suicide, whether by medication overdose, digestion of pesticides or other lethal substances, carbon monoxide poisoning, or hanging. Only those who survived jumping from high places were taken to another hospital’s traumatology unit. Fortunately, Hungarian citizens do not have the right to bear arms, so death by gunshot wound is rare, mostly seen
only among the police force and the military. Given the high suicide rate in Hungary and the Crisis Intervention Center’s tightly concentrated medical treatment, we consulted around 8,000 suicide attempters per year.

One of my first patients at the Crisis Intervention Center was a middle-aged man who had gone into a forest at night and taken a combination of medications that by all rights should have been lethal. While unconscious, he was found by a hiker, who called for an ambulance. In keeping with the center’s usual practice, which places emphasis on continuity of care, I was the physician who consulted with him at the toxicological unit, suggested his transfer to the Crisis Intervention Center, became his attending physician at the inpatient unit, and later treated him as an outpatient. During my interviews with the patient, I was struck that after such a high-intent suicide attempt, his main emotions were relief, guilt, and even some degree of happiness. He said that although originally he thought that his children and wife would be better off without him, his family’s visits while he was recovering from the attempt had convinced him otherwise. He was still depressed but was “glad to be alive” and grateful to have been given a “second chance in life.” He described the feeling of rebirth that I heard patients mention many times over the next 9 years while I was conducting individual and group therapies at the center.

Of course, not all of my patients stopped wishing to die by suicide so soon after their attempt. For many, it took weeks or months to remit from their deep depression, and progress was even harder for those with comorbid alcohol abuse. A few of my patients said that they wished they had died. But it gradually became clear to me that in trying to treat patients who had attempted suicide, I was not working against their will (at least, not in the long run). Even when I committed people to the hospital without their consent, I said, “I would like you to be admitted to get well.” I did not tell them that I was committing them to prevent them from killing themselves. The implication of my words was that if the patients were feeling well, they might change their mind about suicide, as our studies of late-life suicidal patients have shown (Szanto, Mulsant, Houck, Dew, and Reynolds, 2003). Depression and hopelessness, which persist in people who are vulnerable to suicide even when depression remits (Szanto, Reynolds, Conwell, Begley, and Houck, 1998), distort thinking. As Paul Watzlawick expressed, “the suicide [attempter] arrives at the conclusion that what he is seeking does not exist; the seeker concludes that he has not yet looked in the right place.” Often, a person’s ambivalence about whether to live or die is apparent not only after but prior to or during the suicide attempt, which brings me to the issue of warning signs.

**WARNING SIGNS**

Suicide attempts can be seen as a communication of desperation. People give warning signs before their lethal act, because they are ambivalent about dying and wish for a chance to be saved or because they hope that by communicating their desperation they may change an interpersonal dynamic or mobilize support. Estimates differ widely regarding the proportion of people who give warning signs prior to attempting suicide. Most suicide attempters give warning signs to family members, not to professionals. Signs are often missed among older adults, for whom talking about death and dying is often considered normal. The varying
estimates of the percentage of people who give warning signs before committing suicide are due to the disparate definition of warning signs and the studies’ sensitivity to detect them.

I was studying warning signs, correlates of death by suicide, and the appropriateness of treatment received by conducting 100 psychological autopsies with Drs. Emese Kelemen and Agnes Racz. The study was part of a larger 5-year effort to prevent suicide by educating 28 primary care physicians and their nurses and by providing patients with access to a depression clinic (Szanto, Kalmar, Hendin, Rihmer, and Mann, 2007). This suicide prevention program was initiated by Drs. Herbert Hendin and John Mann (both of whom made five visits to the study’s hard-to-reach rural setting), who implemented the program in conjunction with Drs. Sandor Kalmar, Zoltan Rihmer, and myself. In our educational meetings I used psychological autopsy studies to discuss whether the diagnoses and treatment given by the general practitioners were accurate. One of the psychological autopsies I conducted was at a remote, dilapidated farmhouse, with the husband of a bipolar woman who had killed herself a few weeks previously. Their 12-year-old daughter was playing in the garden during our interview. The woman had become depressed during the spring and had refused to take medications. When I asked about warning signs, the husband replied, “Come to the garden.” We went out, and he pointed to a patch of beautiful flowers that formed a cross. He asked, “Do you see the cross?” I answered that I did. “I should have known that something was wrong,” he said. “She hardly talked and spent more and more time here. She planted the cross over her tomb.” We did not talk more about it, as I felt it was time for postvention. I asked him how he was making ends meet and how he and his daughter were coping with the loss.

**Decision Making**

I have long been intrigued by how people make the irreversible decision to kill themselves. The decision-making process may last only minutes or may be contemplated for months or years. Jollant and colleagues (2005) reported first that euthymic younger adults with mood disorders and previous suicide attempts showed decision-making deficits. They performed poorly on the Iowa Gambling Task, which indicated a failure to select long-term gains over larger immediate gains associated with long-term losses. Life stress and lack of social support are well-known risk factors for suicide, but their predictive power is low. Is it possible that selective cognitive deficits may be risk factors for suicidal behavior? By propelling the suicidal process, they may impede the individual’s ability to make effective decisions, particularly in emotionally charged or uncertain situations. Moreover, cognitive deficits may increase suicide risk by additional pathways, such as by causing accumulation of stressors (e.g., poor decision making may contribute to financial troubles) or undermining deterrents of suicide (e.g., people with poor social cognition are unable to build a protective social network; thus, they are less likely to adjust to the loss of their spouse).

My bright young colleague Dr. Alexandre Dombrovski and I have observed broader cognitive control deficits (Dombrovski et al., 2008) and more specific cognitive impairments in late-life suicide attempters. We have found that non-demented depressed older adults who attempt suicide display impaired reward- and punishment-based learning, with a profile that indicates discounting of past experiences and a bias toward recent negative experiences (Dombrovski, et al., 2010). As processing of reward, punishment, and time signals are related
to the integrity of the ventral prefrontostriatal networks, these findings merge with earlier data from Drs. Mann, Arango, and Oquendo, who found that the ventral prefrontal areas play a key role in suicidal diathesis. I believe that clinically inspired and informed neuroscience will help sharpen suicide prediction and will lead to personalized treatment. This is crucial, as I agree with Arthur Miller, who said, “A suicide kills two people.” I have observed over the years how it makes a lifelong footprint on many survivors. I have also seen hundreds of people who attempted suicide when they were depressed and, after surviving the attempt, had a fulfilling life with long depression-free periods.

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Chapter 51

MY REFLECTIONS AS A SUICIDOLOGIST

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I can clearly remember my first encounter with suicide which came at the beginning of my professional life. I believe it is not uncommon for a psychiatrist. I was a young military medical official on duty on a night shift, and I was called as one of the soldiers had committed suicide by hanging. In the desperate attempt to save his life I ordered others to put the body horizontally and hopefully resuscitate him. It was useless, and I was then somewhat scolded by the coroner as I was not supposed to change anything at the scene of this act. Only hours later I realized that the young man who had committed suicide had asked me for a medical consultation for minor ailments the previous morning. About a year later, still a resident in psychiatry, in a poor apartment in a Roman suburb, I had a long and passionate discussion with a young boy who was determined to kill himself. It was my first domiciliary medical visit. I learnt later, that soon after our meeting, the boy had jumped from the eighth floor from the window of the same room where I had visited him. I cannot say anything special about the two men. I remember that, for the second case, my expertise at the time was not of a high standard and that the psychiatric diagnosis could be many or even none. After forty years, however, I clearly remember what I felt: the sadness and the fear of being responsible for what had happened, as well as the professional failure (Tatarelli, 1992).

Over the years, I have dedicated much attention to the study of suicide and, although it still remain an enigmatic phenomenon, I believe that concepts such as mercy may constitute a premise for the study and the prevention of suicidal phenomena. Could this human feeling of participation and understanding be effective in supporting scientific research, and could it constitute a valid "motivation" for us, who deal with suicide and its treatment, to support the duty to increasingly penetrate and elucidate the complexity of the moments and pathways, from the most alienated to the most rational ones, that lead to self-killing?

I am convinced affirmatively, because the mysterious intimacy residing in that struggle, which is sustained by complex and delicate psychological dynamics, not to speak of the immense suffering of relatives, necessarily demands an individual-based approach.
It should be stressed that the so-called rational constructions, from stoic and heroic to metaphysical suicide (for example, Kirilov's paradigmatic suicide in Dostoevsky's *The Possessed*) are not alone able to explain the need to kill oneself.

Robert Walser, the nihilist who ended up to committing suicide in a splendid scenario in the snow — anyone, at least those who are most aware and careful towards life, might be caught by the fascination, if not of the suicidal act itself, at least by that of the suicidal thought — appears to explain well the assumption I expressed in the last sentence. Thus, he wrote in his *Jacob von Grunten*: "Some day I will be reserved a stroke, one of those that annul a person, and then everything will come to an end: this intrigue, this struggle, this ignorance, everything, everything, gratitude and ingratitude, lie and mirage, this belief in knowing and, instead, knowing nothing ever. However I desire to live, no matter how" (my italics) (Walser 1909). The main character of the novel, the author's definite alter ego, pursues the solution consisting of being a nothingness, a servant. His model is school-mate Kraus ("Kraus is an authentic divine creation, a nothingness, a servant"): a kind of almost honorable exit from the world (due to fear of the world or to a narcissistic defence from the inevitable aggressions carried-out by the world?), but which does not ensue in death.

I mean that there exists a possibility of exiting from life without concretely killing oneself. In other words, it is possible to die without committing suicide; sufficing to live with the brakes on every perspective and every self-promoting project. All too frequent are the examples that we may draw from our everyday psychiatric practice on this issue. Just think of the kind of dissociated turning-off of mental life of many patients affected by psychosis or, still, of that sort of depressive pseudo-dementia of many people who retired from life because of a stony and invulnerable secondary advantage.

Why should then this suicide massacre occur? It is almost an epidemic that in many parts of the world tends to increase and, in many others, its incidence shows no significant reduction whatsoever. These self-suppressions, which find their base in apparently relentless despair, helplessness, narcissistic depressive experiences, more often progressing from adolescence to the very moment of the voluntary act, do they run an acute or chronic individual route?

Probably, that's the way it is. Even if we must be very careful of the fact that, eventually, during the suicidal crisis, it is not "depression" alone that kills (either with the garments of guilt, or disguised as shame, more narcissistically founded and likely to be more effective).

There always exists more than what is readily apparent. Some example is needed at this point. Cesare Pavese, a well-read great Italian writer and poet, a few days before killing himself in 1950 at age 42 through massive hypnotic ingestion, thus remarked in his diary:

"It is the first time that I take stock of a year which is not yet over. Well, in my job, I am a king. In ten year did everything. (Italics are mine). If I only think of the past hesitations. What did I gather? Nothing. I ignored for some years my flaws, I lived as if they did not exist. And then, at the first assault of anguished worry, I fell again in quicksand. It is since March that I argue with my self" (Pavese 1967).

Gino Paoli, a famous Italian singer and composer who is now in his seventies and still brilliantly active, shot himself with a gun when he was still in his twenties. He miraculously survived. He declared: "It wasn't to make it over I wanted to die. I wanted to go and seek new experiences, I wanted to go away, to leave for something new. I am profoundly convinced that
man has to pass through several mutations before rejoining nothingness. Or everything. I did it like an astronaut may do it, getting in a rocket and going into the space. Just the same thing. I was extremely clear-minded, even electrified for the new experience (my Italics) (Corriere della Sera 2005).

All in all, that something else that enters voluntary self-infliction of death has to do with regressive ego grandiosity, with the breakdown or distortion of the representational world and with a more or less severe loss of the ability to test reality. What is lost is the sense of life; every meaning of daily events undergoes eclipse, and a lucid and determined confusion (please, excuse the oxymoron) accompanies the self-suppressing action. Apropos, I heartily recommend the lecture of John T. Maltsberger's recent paper on the suicidal person's intrapsychic dynamics, "The descent into suicide" (Maltsberger 2004).

Existential pathways and routes, whether "normal" or "ill", which lead to voluntary self-killing are designed, much more than by biology (always important and unavoidable), by developmental vicissitudes, by events, by relations, by individual settings. We may also hypothesize reductionist typologies of suicidal pathways and routes (Tatarelli 1992). This is an important issue because only the fool or some newspaper reporters may think of suicide as a kind of raptus.

To try to explain thoughts, emotions and behavior through neurobiology is a mere illusion, despite its great contribution in recent years for the understanding of the physical and biological basis of cognition, emotions and intuitions. No neurobiological theory will ever be able to explain if it is worthwhile to fall in love with Julia Roberts or whether a given emotional response is appropriate to the situation.

There may exist people who are unable to achieve self-realization by means different from suicide, as Ludwig Binswanger's patient, Ellen West (1957), who found in suicide the ultimate and decisive sense of her life.

This anthropo-phenomenological view is both fascinating and enthralling, but unfortunately, finds itself neglecting some deeper and prominent parts of the Self.

This standpoint, provided it is possible (although problematic) to accept, due to its manifest ethical and forensic implications, does not exclude the need and the duty to improve knowledge of the suicidal phenomenon, not only for risk factors and the possibility and challenge of preventive treatment, but also for the context of more directly interacting with the suicidal person, in the first place, and his/her relatives.

All the above considerations could be important to bear in mind when dealing with suicidal patient.

Suicide is one of the ten major causes of death in most countries. The family can play an important role in its prevention.

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Chapter 52

LOST IDENTITIES

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It is perhaps ambitious to present a new interpretation for the origins of the idea of killing oneself, and how it develops and eventually forces one to take his own life.

Genetic predisposition, neurotransmitters, physical and mental illnesses, defense mechanisms, introjection of lost objects, aggression against the self, anomic societies, and free choice all are considered sufficient conditions leading to the final act. Some of these circumstances may be more responsible than others for individuals, but none seems necessary. Research has provided statistical evidence of how one man may be more likely to kill himself than another. Nevertheless, for the individual in that fateful moment when he thinks about how to escape from a life without value, all explanations seem to have a common denominator. At that moment what is at play is the individual’s whole identity, which must be defended to death because, paradoxically it is unthinkable to lose it. Thus teenagers have killed themselves after (not because of) a bad grade, as have older persons after they lose a spouse, youth struggling with difficult employment and elderly who have lost it, philosophers at the end of their search, executives on the verge of bankruptcy, women disappointed by their plastic surgery, hopelessly ill people, artists at the beginning or end of their creative activity, rejected lovers. All these events in particular vulnerable and sensitive individuals, caused an unhealing wound to their identity so that the threat of losing it makes them prefer death to life.

Even considering separate categories of people I am convinced that all their predisposing and precipitating factors have in common the terror of not being oneself, not finding one’s own identity—not yet completed in adolescents and instead lost in old, retired or widowed persons. If individuals have invested all themselves on a rigid condition of life such as career, success at school, relationship, marriage, job, their health and physical integrity, or their creativity, then the loss of that status is no longer just its unavailability, but rather the removal of such an important part of themselves so that they suffer a potentially fatal blow.

In the difficult process of composing available elements to form an identity one may not realize that he may, instead, have constructed a rigid system. People do not create separate

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identities for every aspect of their life: job, gender, relationship, physical integrity, but that in the construction of their main identity, one item may have become more important than others. The more the self is concentrated on a limited number of psychological investments (sometimes only one), the more likely it is organized as a rigid system. Failure of that main personality support may leave a person in a hopeless situation and unable to lean on another support.

Durkheim famously described three conditions in which people may commit suicide. They parallel circumstances in which they may lose their identity: [1] egoism when the collapse of values with which the individual was fused leads to his own debacle; [2] altruism, when one loses the boundary between the individual and the community, as in heroic or mass suicides; and finally, [3] the anomic in which individual expectations are frustrated or are excessively high, so that identity lies between adaptation and struggle—both dangerous choices.

Groups and peoples have killed themselves, left to die, have refused to breed. Examples include the Tasmanian aborigines in the last century, or native New World populations during the Spanish invasion, both of which were afraid of losing themselves by contact with stronger populations. In the United States of America, native Americans (Indians and Inuits) continue to kill themselves far more than other population groups. Whites, confused and divided, also commit suicide more often than otherwise disadvantaged African-Americans, despite being aware of belonging to an advantaged people.

Biological studies have found that the voluntary death of a family member affects the choices of others: a genetic datum, but it is hard to imagine that life could be the same after the loss of a brother, sister, parent, child, spouse, lover, on which the survivors have invested so much as to produce an excess of insecurity or dependence. Over-dependence on relationships, family, or job also has its risks. When, for various reasons, familiar emotional supports come to an end, one realizes that they were entrusted with essential parts that once lost leaves the survivor adrift.

Even in the psychodynamic interpretation of the wish to die, the identity is injured: one thinks of the destruction of another loved-hated object to justify his own elimination. An alibi for not admitting that the wish to die is a matter entirely internal to the individual but for its accomplishment he needs to borrow another object, insert it in himself and kill him, resulting in both their deaths. When this all happens, the individual in his development has not formed a solid self able to repel unwanted visitors.

It is of little consolation to think that identity is recovered during wartime when poor wretches from both sides are made to believe that they would become heroes by killing other human beings like themselves, only to find themselves back at home where they lack the support of the same group that had underpinned their participation in the war and contemplate their own death.

Among those who decide more easily to leave this world prematurely are medical professionals. It is likely that those who are passionately devoted to their work merge – and somewhat lose – their identity, through a symbiotic process, with that of their patients. Among mental-health professionals, psychiatrists and psychotherapists are most at suicide risk: their identity, if not well structured, is more at risk than in other medical professionals because of the deep nature of the relationship with their patients.

The famous “Werther effect” further confirms the theory proposed here. Those who emulate the suicide of another person reported in the news media are often similar in age, sex, occupation, or physical appearance, and often live not at a great distance. The Japanese kill themselves for imitation only if the news concerns another Japanese and not others. During the Great Depression of the 1930s, the voluntary death of politicians was emulated, at a time when identities were unusually dependent on the decisions of rulers.
The fate of identity in psychiatric illnesses is well known. Identity can be thoroughly shaken in a schizophrenic person, while a depressed person believes it is lost and fears that it cannot be rebuilt. There are some who succeed in losing their identity in drugs or alcohol. Identity is also irretrievably lost when cognitive skills are devastated, and yet most demented persons do not think of suicide: to facilitate a transition to action, the perception and pain of loss is more important than a lack of self-awareness or of cognitive skill.

Physical illness can shake the very foundations of the self. It can occur in those who face a hopeless illness and fail to recognize themselves, not only in their physical appearance, but also in the internal conceptual structure in which their body had rested. Thus the prevailing desire is to leave the “container” mentioned by the adepts of the Heaven’s Gate. But how free is “freedom of choice” if the identity of the individual is fractured? The individual is no longer what he used to be and his choices are conditional to the loss of his identity.

Men almost universally commit suicide more often than women. Following my theory that suicide is associated with less well-structured identity, men should have more problems adjusting to their identity. It can be proposed that the anthropological need to assert their strength may be an expression of fragility, and expose men to great risks in attempting to prove their superiority. Men, by defending positions considered stronger, are actually made more fragile. The myth of masculinity is the most obvious example. Men need to express strength, but its loss is not only that of an organ or an activity, but of all themselves: a part for the whole. The myth can be shaken also in its erotic function by which a man often measures his being (in the absence of anything else?). As a teenager is anxious about the measure of his penis, there is a parade of symbolic activities related to masculinity which include competing in many different fields. Impotence is first between the ears and then between the legs. Thus the boy fears an inadequate sexual performance when his evolving identity is represented only by sexuality: being dumped by a girl can represent a total failure. In gay men, whose sexual identity is hardly shared and shareable, the threats are even heavier. Being themselves on the basis of desires and sexual orientation becomes a state of feeling constantly threatened by others.

It is not even better for artists, overwhelmingly men, who have contributed heavily to the ranks of those who killed themselves. Though sublimation may transform suffering and painful experiences into artistic creativity, strict identification with their work can lead to a sense of failure, either when they thought they had fulfilled their purpose or that they would not be successful. Among actors, it is even easy to see a feeling of lack of identity. Alighiero Noschese, an Italian impersonator from the 1970s, shot himself in 1980 at age 48. He became famous for impersonating (by his own admission) of 96 characters. Luigi Vannucchi, an Italian actor, killed himself in 1978 at the same age as Noschese, while he was preparing a play, The Absurd Vice, on the life of the writer Cesare Pavese, yet another suicide.

Do all these reflections imply a more stable identity in women? It does not seem a great discovery to note that their security comes from the possibility of giving life, a capacity that is the envy of motherhood in men (rather than penis envy in women!). This hypothesis is supported by women without children, who kill themselves more often than female doctors and at about the same rate as men. Is childlessness a cause for worry? Is avoiding the rules of the species a risk? That is probable, but apparently inevitable in our modern societies.

Solutions may not be simple. Medications sometimes improve the psychopathology underlining suicide ideation and can facilitate recovery of strength and improve coping mechanisms. Psychotherapies need to try to support or re-organize a shaken identity neurotically obtained through excessive investment on a job, a relationship, success. Treatments should reduce the stiff rigidity of a self-system and encourage diffusion of investment in other emotional and behavioral areas, as is central to cognitive psychotherapy.
Instead, clinical intervention on the formation of identity implies surrendering the conquest of power, with its inherent fragility, to promote a flexible and tolerant identity that is better-suited to absorb inevitable frustrations. One should facilitate investment on many fronts, so that it becomes possible to cope with failure in one area at risk. Techniques may be borrowed from economists who recommend diversification to avoid financial collapse. Such strategies should also apply to investments in social, vocational and emotional relationships. Help can come from knowledge of the limitations and weaknesses of the self, by acceptance or modification in relation to available resources, by compensating a failure shifting interest in another area, and by seeking help because in troubled moments others can have a clearer perspective of our needs and problems.

Chapter 53

THE STORY OF VALERIE

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It must have been in the summer of 1984. As a trainee in psychiatry I was asked to examine a patient at the physical rehabilitation department of the University Hospital Ghent. I went to see this patient, who turned out to be a good-looking and bright 16-year old girl named Valerie. She stayed at the rehabilitation department because she lost both her legs after having jumped in front of a train a few weeks earlier. It was a warm summer, and in the evening of the same day I was sitting on a terrace in the centre of Ghent drinking a glass of beer with friends. We enjoyed ourselves, watching the girls strolling along, with their short skirts and lovely legs, but in my mind I was trying to find an answer to the question why on earth this good-looking and intelligent young girl, who I met earlier that day, could do such a horrible thing, with such an irreversible damage to her body. I could not know at that time that meeting Valerie would have such an impact on my professional life.

The paper by Fabrice Jollant and his colleagues in the American Journal of Psychiatry in 2008 reminded me immediately of my conversations with this 16-year old girl, which, upon hindsight, have been of critical relevance for directing my research interests and attention to the domain of suicidology. In this paper Jollant and co-workers describe the results of their important imaging study of changes in brain activity following exposure to pictures of emotional faces. Suicide attempters are distinguished from non-suicidal patients by responses in the central nervous system to angry and happy faces that suggest increased sensitivity to others’ disapproval, higher propensity to act on negative emotions, and reduced attention to positive stimuli, which persists in between depressive episodes.

Valerie told me that she had made an appointment with her boyfriend on the day of her suicide attempt, because she wanted to talk to him about the fact that she did not feel well. Thus she met with this boyfriend on a morning while she actually was expected to attend school. While she was talking to her friend she noticed an uncle passing by. This uncle knew that she actually had to be at school in stead of spending time with her boyfriend, and he looked at her with a terribly angry face. Seeing so much anger on his face urged her to take her bicycle, stumble through the meadowlands to the railroad and try to take her own life.

Subsequent conversations with Valerie made clear that her ‘not feeling well’ actually was a manifestation of a depressive episode. She wanted to share her sadness and negative
feelings about herself and the future, which frightened her, with her boyfriend. Later she also
told me that her father committed suicide when she was 5 or 6 years old.

One can only hope that our efforts in the study of suicidal behaviour may contribute to
the prevention of situations like this. The reality in the case of Valerie was that this young girl
suffered from a depressive episode, which was not recognized by herself, her family,
schoolteachers, or the primary care physician, and which thus was not treated. In addition,
there was a family history of suicide, which should have prompted any person in her
environment or any caregiver to take into account a strongly increased risk of suicidal
behaviour in this girl. Knowledge thus could have contributed substantially to the prevention
of the terrible thing that had happened.

The sad reality is that situations like this continue to occur. Epidemiological data from
across the globe continue to show unacceptably high rates of suicidal behaviour among young
people. Thus there still is a huge amount of work to do. The paper by Jollant and colleagues
shows that new technologies can contribute substantially to gaining insight in the
vulnerability to suicidal behaviour. More work on how this vulnerability can be recognized
and reduced is clearly needed. It goes without saying that the effects of treatment on suicide
risk also need to be studied much more intensively. In addition however, the communication
of knowledge of risk factors, treatment possibilities, treatability and preventability to the
general public should be regarded as a crucial component of suicide prevention strategies.
That is a major lesson to learn from the story of Valerie.
Chapter 54

MAKING SPACE FOR LIFE AND FOR DEATH

J. Mark G. Williams
University of Oxford

MY UNCLE

The story we were told as children was that my uncle had been collecting mushrooms near the railway track and had been accidentally hit by a passing train. He died before I was born, so there seemed little point in thinking much about it. As a child, anything that happens before birth is another age. It might as well have been a suicide in the time of the ancient Romans. Yet, of course, for my mother and her family, this was just a few years before, and the telescoping of time for any event, especially such a tragedy, must have made it seem like yesterday for them. The coroner’s court passed one of those ‘open verdicts’ that leaves everything open, including wounds. Yet suicide it clearly was – my mother’s sister, many years later, confirmed this. She is in her nineties now, and yet it still made her cry.

TALKING ABOUT SUICIDE

The stories we tell in society in general are no different from those we tell within our families. Suicide is a tragedy, yes; but we have a different relationship to this tragedy than to many others. Other sudden deaths are tragic too, but we do not encourage silence about them, forcing people towards make-believe ‘to protect the children’.

Avoidance of discussion of suicide, if it worked to reduce the chances of further such tragedies, might be justified. There is only one context in which avoidance perhaps should be considered: media stories about suicides since they have been found to encourage others to take the same action. But in other contexts, talking more openly is more likely to reduce the risk. For example, we know that, face to face in the clinic or research laboratory, raising the topic of suicide does not ‘put the idea into people’s heads’ (Gould et al., 2005).

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But this is curious. Why does watching a film about the suicide of a person, or reading about the suicide of a movie star in the newspaper increase risk, and talking about it in the clinic does not?

The answer lies, I suspect, not in suicidal thinking itself, but how we relate to that thinking. Do we relate to a suicidal thought as if it is telling the truth about ourselves, or do we see it as a mental event, like a ‘passing cloud’ in the ‘sky’ of the mind. It is possible that ‘talking through’ ideas of suicide is opening, while ‘hearing about’ such events is constricting: it is the difference between disclosure on the one hand and enclosure on the other.

**REACTIONS TO SUICIDAL INFORMATION – IT DEPENDS**

Here is the problem; the more literally true we take our thoughts and images to be - the more constricted we feel, and the more we will try and get rid of them. And the ‘getting rid’ will take one of two forms: (a) brooding endlessly about the problem the thought has posed (e.g. ‘Why am I feeling so bad?’ ‘Why am I so weak?’ ‘Why am I such a burden to my family?’ ‘What does this say about me?’); or (b) trying to suppress the thought or image altogether. There is now good evidence that both strategies for dealing with difficult thoughts and images, though done with the best intention, tragically backfire (e.g. Dalgleish and Yiend, 2006).

Media suicide stories come to us often when we are alone. Even if other people are around when the images and stories of suicide break upon us, a newspaper is designed to be read one at a time, the TV is designed to capture our individual attention. So the idea of suicide through this route lands on us when it is most likely to activate brooding or avoidance. Then follows exacerbation and persistence of the discomforting thought; images of suicide come to mind, unbidden (Holmes, et al., 2007). Taking our thoughts literally and personally, we are at their mercy.

By contrast, asking questions about suicide in the clinic takes place when someone else is around and we are in relationship with them. The presence of the therapist or researcher, and their ‘matter of fact’ and ‘open’ manner of discussing suicide ‘makes space’ for such thoughts, and, ironically, making space is the opposite of rumination and avoidance - for such thoughts can then be seen for what they are, just thoughts. The context produces a different response: brooding and suppression are much less likely. Even asking about suicide in this context can bring relief.

**MAKING SPACE FOR THE DIFFICULT**

How many other areas in our field might be clearer if we were able to make such a shift towards making space for the most difficult of discussions? Let us turn to the most pressing of these: assisted suicide.

Discussion of assisted suicide in the UK is preoccupying many ethicists and law-makers as they attempt to clarify the law on whether family members would necessarily be
prosecuted if they accompanied their loved-one to a clinic that allowed assisted suicide. Other law-makers are hoping to change the UK law on assisted suicide itself.

It is a subject that is fraught with difficulty, and this is an issue for all of us who work in the field. We cannot avoid it any longer. Each of us needs to decide whether the right to die at a time of our own choosing is consistent with our human rights. If so, it has also to be right to allow someone to assist in this process under certain circumstances. Or perhaps we believe that this is wrong always: and there are many who say, with justification, that the consequences would be that individuals would feel pressure to die.

Here is my personal view. Although I have spent my career in clinical psychology, I am also an ordained priest in the Church of England. So I am expected to say that, because life is sacrosanct, none of us can end it on our own volition, or expect others to help us do so. And yet….I find that I cannot be so rigid. Let me illustrate with a story that Joseph Fletcher tells in his book *Situation Ethics*.

He was in New York on the eve of the election between Richard Nixon and John F. Kennedy. Riding in a cab, he asked the cab-driver about the election, and which way he thought he’d vote. Here is a summary of the conversation.

*Driver:* “I’ve always voted Republican. My father was Republican, and my grandfather was a Republican”.

*Fletcher:* “So you’ll be voting for Nixon then”.

*Driver:* “Not tomorrow. Sometimes you have to put your principles aside and do the right thing”.

So although assisted suicide may continue to be a difficult legislative issue for society in general, I could not condemn individuals who felt that in their particular circumstances this was the most loving thing to do. This is making space for the difficult. Indeed, by allowing space and time for talking through this issue with those who feel that they want the option of departing this life at a time of their own choosing, we may, ironically, extend life. Those who know that they will not be deserted in their hour of greatest need may be able to bear much more of the helplessness and dependency that they most fear as their bodies become more frail. They may feel more able to ask for help, and as the poet Rilke put it in Gravity’s Law, to ‘learn to fall’. Opening to the reality of death may bring a reconciliation with death.

Here’s Rilke again:

I am the rest between two notes,  
which are somehow always in discord  
because death's note wants to climb over –  
but in the dark interval, reconciled,  
they stay there trembling.  
And the song goes on, beautiful.

**CONCLUDING REMARKS**

I would have loved to be available for my uncle, and would have worked tirelessly to keep him alive so that he might live the life he so richly deserved beyond his short army
career and the dread of the D-Day landings that eventually unsettled him to the point of suicide. He had already lost one beloved brother to the war, and a sister to TB. But had he lived, and had I got to know and love him, and if as an old man he had asked me about assisting him to die, I hope I would have had the courage to put principles aside and done the right - the most loving - thing. What would the most loving thing have been? I do not know. No-one knows until the situation arises. But being open to discuss it, making space for it without judgement, cultivates the wisdom we all need at such times, so that the most loving decisions can be taken.

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MY PERSONAL REFLECTION

Paul Siu-fai Yip
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Trained as a biostatistician, I am especially interested in modeling and analyzing biomedical events. I have been attracted to suicide research because of the opportunities to do some sophisticated statistical modeling; for example, in one study I used time series methods to examine the seasonality of suicides (Yip et al., 2000). The results of this study showed that the effect of seasonality on suicide has been diminishing, and has now possibly vanished altogether. Also, due to investigations into the cause of deaths, a delay in reporting suicide statistics due to Coroner’s investigation is not uncommon, and thus a timely estimate of the suicide rate is not available. My colleagues and I have therefore proposed an adjustment method for reporting the suicide rate in a more timely manner (Cui, Yip and Chau, 2004).

In 2002, we set up the Hong Kong Jockey Club Centre for Suicide Research and Prevention at The University of Hong Kong. It is the first centre of this kind in the region which involves research, training and education, and website development. The Centre has a multidisciplinary team of researchers including psychiatrics, psychologists, social workers, public health personnel, and biostatisticians. At that time, the suicide rate in Hong Kong was increasing and at an historical high. In order to formulate suicide prevention strategy, we need accurate data and evidence-based research. However, very little reliable information is available for a good understanding of the multifaceted and complex issues involved in suicide prevention. Also, research on suicide is underdeveloped and underfunded in Asia. My guess is that 90% of worldwide suicide research resources are spent on 10% of the suicide population (mainly in the USA, Western Europe, Australia, and New Zealand); however, over 60% of suicide deaths worldwide occur in Asia (Yip, 2008).

Nevertheless, the pay-off of suicide prevention in Asia is expected to be large due to the large population size and the relatively high suicide rate. In China, a country with a population of 1.3 billion, it is estimated that more than 250,000 people commit suicide every year (Yip, 2008). Evidence suggests that targeting men and women in this country who live in

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rural areas would not only reduce the number of suicides in China, but would also have a significant worldwide impact. A 10% reduction in the suicide rate in China and India would cause about a 20% reduction in the suicide rate at a global level. However, there are unique features in Asia need to be considered when setting up suicide prevention programs.

For example, it is important to consider the power that the mass media has and its penetration into the community, especially in Asian countries. The coverage of suicide news in this region is always very graphic and sensational. A good example is how information about the lethal effect of poisoning by charcoal burning spread throughout Hong Kong, the southern part of Guangzhou, Taiwan, and Japan. Indeed, the leading cause of suicide in Taipei City in 2006 was charcoal burning; this method was unheard of before the first reported case in Hong Kong in 1997 (Yip and Lee, 2007). The use of the lethal suicide methods can also partly explain the low gender ratio (male: female) in developing countries in comparing to the west. Here male and female both used lethal suicide method, for example, 60% of both genders used pesticides in Mainland China, and 50% of both genders jumped to their deaths in Hong Kong and there were no significant gender difference in the method used. However, in the west, a less lethal method (for example, drug poisoning) is used among females and a more lethal method (for example, gun shooting) is used among males.

Long working hours and a culture of not seeking help, especially among men, are some of the major barriers to suicide prevention. Furthermore, many countries in Asia are experiencing a rapid transition in the labor market. The lifelong job arrangement has changed, especially in Japan and South Korea, and some people have experienced problems adjusting to this change. Enhancing the working environment and identifying those at risk within the workplace could be effective means of reducing the suicide rate among middle-aged men in particular. Religion could also play a significant part in suicide prevention in Asia. Buddhism condemns suicide, but some believers misunderstand this religion and think that they will enjoy a second life after committing suicide. In fact, according to Buddhist teachings, an individual will be worse off, as an untimely death will not be rewarded in the afterlife.

Marriage has been shown to be a protective factor, but fewer people today are getting married. In some Asian countries, it is estimated that more than 20% of the population will remain unmarried for their lifetime (Yip et al., 2009). Also, the divorce rate has increased 10 times over the past two decades. The increase in both divorce and domestic violence, and the disintegration of family support, make it more difficult to utilize family resources to reduce the suicide rate in Hong Kong as well as in other Asian cities.

**COMMON CHALLENGES**

Some of the special challenges in this region are as follows:

(i) Lack of complete and/or accurate monitoring and surveillance system for suicide death. Incomplete monitoring occurs especially in those countries that do not have a reliable and complete death registration system (e.g., India and China). If we cannot establish accurate, baseline suicide information, setting up an evaluation program will be difficult, if not impossible.

(ii) The lethality of certain suicide methods. A high case-fatality rate among suicide attempters due to the use of certain methods (e.g., pesticides in China and India,
jumping in Hong Kong and Singapore, and hanging in South Korea and Japan) poses real challenges for suicide prevention in Asia. These methods are easily carried out and highly effective and are difficult to restrict.

(iii) Lack of intervention research/evaluation. Whether we are speaking of the need to tailor diverse solutions for different cultures, or distinctive approaches to different segments of the population within a country, there is no single solution. Each of us must develop culturally attuned, locally relevant, evidence-based suicide prevention programs. And where we lack the necessary evidence, we must simultaneously implement novel approaches and rigorously evaluate them. Anything less is unacceptable.

(iv) Lack of government and community support. The commitment and resources from the governments of many Asian countries are still relatively low compared to those from the governments of developed Western countries. Health and medical services do not adequately provide the necessary psychological treatment and services for depressed individuals. In addition, stigmatization exists in the community toward the mentally ill, and help-seeking behavior among the needy is poor.

A PUBLIC HEALTH APPROACH TO SUICIDE PREVENTION

The burden of suicide in Asian countries can no longer be ignored. Suicides have a significant impact on economic growth and development. Unfortunately, the majority of suicidal people are reluctant to seek help from health care professionals, probably because of many cultural factors: the fact that suicide is still seen as a taboo subject that is not widely discussed in the community; stigma toward treatment; limited availability of treatment; and uncertainty about treatment effectiveness. Suicide has traditionally been viewed as a mental health issue that is addressed primarily through clinical intervention, especially the treatment of depression. However, it has been suggested that the role of mental illness as it contributes to suicide is not as significant as it is in the West (Yip et al., 2005). Also, it is known that approximately two-thirds of all people who commit suicide did not receive any specialist psychiatric care in the year before their death (Chen and Yip, 2008).

Apparent, some broad-based suicide prevention programs that target population at large would have a significant impact on the suicide rate (Yip et al., 2010). The public health approach involves three layers of intervention: universal, selective, and indicative (Yip, 2005). This approach acknowledges the importance of both high-risk and population-based strategies of suicide prevention, and requires a multi-sector effort to tackle the problem at multiple levels: in the community (universal strategies), among specific population subgroups (selective strategies), and among those at a particularly high risk of suicidal behavior (indicative strategies). Reducing a small risk in a large population would be more effective than reducing a large risk in a small population.

The World Health Organization acknowledges that the principle of connectedness is important when designing suicide prevention programs. Especially in Asia in which relationships in the community are of great importance, restoring this principle between people and their communities, workplaces, and families is not only the key to suicide prevention, but should also be the guiding principle for stakeholders to work together. I hope that our communities can be reconnected to help those who are deprived and vulnerable. I am aware that not all suicides are preventable, but I strongly believe that we can make a
difference. It is my wish that through high-quality research and collaboration with the stakeholders in the community we will be able to have a better, evidence-based understanding of suicide and be able to establish an effective suicide prevention strategy. It is my humble and sincere desire that the respective governments in our region make suicide prevention a priority and eventually devise a national suicide prevention strategy.

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APPENDIX: THE LIVES OF SOME FAMOUS SUICIDOLOGISTS

By David Lester

In the past few years, I have written essays on several important people in the field of suicidology, based on biographies written about them or on their own autobiographies. This Appendix contains my essays on Aaron Beck, Louis Dublin, Emile Durkheim, Sigmund Freud and Edwin Shneidman. For those whom I know personally, I have included my own thoughts on their lives and careers.

I also wrote to several leading researchers in the field and asked them to write autobiographical essays: Kalle Achté, Jan Beskow, Normal Kreitman, myself, Charles Neuringer, Jack Gibbs, Grethe Paerregaard, Herman Pohlmeier, Nils Retterstol, James Short, Herman van Praag, and Chad Varah. These are also presented in this Appendix.

BIOGRAPHIES

AARON BECK

Aaron (Tim) Beck is most well-known for his development of cognitive therapy and for his research on depression. However, in the course of his work in these areas, he has studied suicidal behavior and made seminal contributions to the field of suicidology.

Beck’s parents were both immigrants to the United States. His father Harry Beck was born in the Ukraine and arrived in America in 1902 at the age of 18. He established himself as a printer in Providence, Rhode Island, and was a fervent socialist. Beck’s mother, Elizabeth (Lizzie) Temkin, came from Lubitzch in Russia in 1906 at the age of 16. Her family moved to Providence where they became prominent in the Jewish community and on the board of the many Jewish organizations, a practice which Lizzie followed. Harry Beck and Lizzie married in 1909 and had five children. The eldest, a son, died in infancy, and the third, a daughter, died in childhood. The fourth, the younger son, died in 1929 at the age of 21. The fifth child, a daughter, died in 1940 at the age of 27. The oldest daughter died in 1945 at the age of 28. The youngest daughter, born in 1919, died in 1996 at the age of 77.

1 This essay is based on Weishaar (1993).
2 Beck’s extended family calls him Aaron, but his colleagues call him Tim (from his middle name Temkin).
died in influenza epidemic of 1919. After the death of this daughter, Lizzie became depressed for a few years, a depression that was alleviated by the birth of the fifth child, Tim, on July 18, 1921.

Lizzie was overprotective of Tim, especially after a broken arm developed septicemia, an infection for which there was no cure at the time. Tim survived, but the illness set him back in school so that he thought himself stupid and inferior to his peers. However, coaching by his two elder brothers enabled him to catch up and surpass his peers by skipping a grade.

The family was not poor, but they lived frugally. They did not own a car, and all three sons worked their way through college. Tim worked in the library, assisted an urban-planner and sold Fuller brushes door-to-door.

Lizzie was mercurial and inconsistent, while Harry was tranquil and encouraged his son’s intellectual interests. Tim joined the Audubon Society, became an Eagle Scout, and edited his high school newspaper. He graduated first in his high school class and went to Brown University. His elder brothers went into medicine and social work. Tim majored in English and Political Science at Brown University, graduating *magna cum laude* in 1942 and was admitted to medical school at Yale University.

Beck recalls several psychological traumata from his early years. The illness and separation from his mother at the age of seven left him with fears of abandonment and of surgery, as well as a blood/injury phobia. He fought this during medical school by exposing himself gradually to the stimuli he would encounter in the operating theater. He also developed a fear of suffocation as a result of bullying from his older brothers who would pretend to suffocate him with pillows. A bout with whooping cough at the age of three and chronic asthma added to this fear. He later realized that this fear was behind his phobia of tunnels. Other fears included public speaking and heights.

At medical school, Tim enlisted in the Army which enabled him to shorten his medical training from 48 to 31 months. He settled on neurology as his specialty, and he began a residency at the Cushing VA Hospital in Framingham (Massachusetts). There was a shortage of psychiatry residents there, and so all neurology residents had to have a six-month rotation in psychiatry. The orientation there was psychodynamic, and Tim did not like this orientation. However, after the rotation, he decided to remain in psychiatry in order to improve his insights.

Tim had met Phyllis Whitman at Brown University, and she became a journalist for *Time Magazine*. They fell in love and married in 1950, after which Phyllis obtained degrees in social work and law. She now is a Superior Court judge in Pennsylvania.

After his VA residency, Tim moved to the Austin Riggs Center in Stockbridge (Massachusetts) for two years, where the orientation was also psychoanalytic. He decided to get his diploma in psychoanalysis and, as a member of the reserves, he volunteered to serve at the Valley Forge Army Hospital near Philadelphia where he was chief of outpatient psychiatry and later chief of the division of psychiatry from 1952-1954.

Tim moved to the University of Pennsylvania Medical School in 1954 and completed his psychoanalytic training in 1958. He was promoted to Assistant Professor in 1959 and received his first grant for research that year.
Scholarly Work

Tim was dissatisfied with the lack of empirical support for psychoanalytic ideas, and his first research (on dreams) was done in collaboration with faculty at the Department of Psychology. This collaboration has led Tim to focus on the importance of research. His research did not fully support psychoanalytic theory and this, together with his intellectual rebelliousness, led him to break with psychoanalysis. His work with patients sensitized him to role of thoughts in depression and other moods. Tim says that he was influenced by George Kelly’s theory of personal constructs which was published in 1955. Albert Ellis saw in the early 1960s that Tim’s work and ideas were congruent with his Rational-Emotive Therapy, and he initiated a collaborative relationship with Tim.

Tim established the Depression Research Unit at the University of Pennsylvania and quickly became engaged in research. The Beck Depression Inventory was published in 1961 and soon became the most prominent self-report measure of depression. Tim published his book Depression: Clinical, Experimental and Theoretical Aspects in 1967, and in the 1970s came to the fore by attracting a number of collaborators (such as Maria Kovacs and John Rush), by being awarded several NIMH grants, and by an increasing volume of publications. He opened the Mood Clinic which later evolved into the Center for Cognitive Therapy. During this fertile period, despite the fact that pharmacotherapy for depression was growing in popularity, Tim embarked on a series of studies to test the efficacy of cognitive therapy. In this respect, Tim’s emphasis on research built upon the early formulation of cognitive therapy by Albert Ellis by giving it scientific respectability. Indeed, the Center for Cognitive Therapy became the “Mecca” for the field, so much so that the designs for Tim’s funded research had to control for the “Mecca Effect” by having some subjects received therapy in other cities in America. Tim’s co-authored book, The Cognitive Therapy of Depression, appeared in 1979.

In the 1980s and 1990s, Tim continued his research and therapy program and received many awards for his work, including prizes, honorary degrees and awards from many organizations, associations and foundations.

Suicide Research

Tim’s major contribution to understanding suicide developed from a scale he devised to measure what he originally called pessimism but which has come to be known as hopelessness. Hopelessness is one of the cognitive components of depression, and it has proven in several studies to be a better predictor of suicidal behavior than general measures of depression.

As he moved into the study of suicidal behavior, Tim also devised measures of suicidal ideation and of suicidal intent, measures which have proven to be popular instruments in suicide research.

There have been many studies of the cognitive processes of suicidal individuals, and so cognitive therapy has become the most common system of psychotherapy proposed for the treatment of suicidal clients. As a result, therefore, Tim’s particular system of cognitive
therapy has been utilized as the starting point by suicidologists such as Thomas Ellis and Thomas Joiner who have written about psychotherapy for suicidal clients.

In my reviews of the suicidology literature, I have chosen the prominent researchers each decade, and Tim’s work dominated the 1970s (along with that of David Phillips’ research on imitation and contagion).

Comment

Weishaar, in her biographical essay on Tim, noted that he was a creative and prolific scholar who has stimulated many researchers who worked with him as well as those who merely read his work. He is a voracious reader and a lover of films. He is warm and genuine, goal-oriented and shrewd, and now easily recognizable by his white hair and red bow-tie.

I worked with Tim in the 1970s and found him to be one of the nicest scholars I have ever encountered. He encouraged and pushed us, and always responded to what we produced with enthusiasm. Long after our initial collaboration, I ran into him at an airport as we were on our way to a meeting of the American Association of Suicidology, and our conversation in the waiting lounge resulted in another collaborative paper. Tim is a tireless scholar, eager to collaborate with and encourage others, and, on top of that, a truly fine person.

REFERENCE


LOUIS DUBLIN

by David Lester

Louis Dublin was born on November 1, 1882, in a village near Kovno in Lithuania. His father was Jewish and worked on the family farm and as a tailor. His mother was from Kovno and better educated, and she recognized that she was of a higher social class. But she was older than her husband and he was very good looking, so it seemed a good match to her. Soon after Dublin was born, his father emigrated to New York City and two years later brought his wife and son to the USA (and his younger brother and a nephew as well). Dublin arrived in the USA in the Spring of 1886.

They lived on the lower East side of Manhattan in an immigrant area of the city in cramped quarters. Dublin was sent off to the public schools which, though the buildings were old and drab, were staffed with fine teachers. Dublin liked learning and graduated from what now would be ninth grade first in his class.

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3 I co-authored the original publication in 1974 on the hopelessness scale with Tim and others and carried out most of the statistical analyses for that paper.

4 This essay is based on Dublin's autobiography (Dublin, 1966).
He had also discovered the Educational Alliance which had a fine library which Dublin used a lot as a child and a gym which he used less frequently. To earn money, Dublin sold newspapers. His father took him to the synagoge with him, but the family did not seem to have been overly religious.

He studied diligently for the competitive examinations to get into New York City's free City College and was ranked fourth of the applicants. Although Dublin's father wanted his son to begin work so that he could contribute to the upkeep of the family (Dublin now had four younger sisters), Dublin's mother insisted that her son go to college. Dublin entered the subfreshman class in September 1896, two months before his fourteenth birthday.

College Days

Life at college was dominated by the rigorous study, in addition to which Dublin earned some money by teaching English to foreigners. He graduated in May 1901, nearly nineteen, one of the 123 students remaining of the 800 students who had begun five years earlier, determined to pursue graduate study.

During Dublin's final years at City College, he had met Thomas Davidson at the Educational Alliance, and Dublin began to attend his Sunday lectures and his summer institutes in the Adirondacks. Davidson was passionately concerned with providing education for everyone and, after his death in 1900, his students, including Dublin, organized a teaching center for working men and women on the lower East side, a center which survived for eight years. Davidson's philosophy provided the impetus for Dublin's lifelong commitment to helping others.

City College decided to support three of its best graduates through graduate school, and Dublin was one of the recipients of this support. Dublin persuaded the Department of Zoology at Columbia University to accept him, and for his financial support he had to teach twenty hours a week at City College. He also taught immigrants at night in order to earn money to contribute to his family. He spent summers at Woods Hole and Cold Spring Harbor doing research.

Despite all of the demands on his time, Dublin graduated from Columbia University in 1904 with a doctorate. His thesis was on the germ cells of a growth which is found on oysters and was published in the *Annals of the New York Academy of Science*.

After graduation, Dublin was offered a position at City College in the Department of Mathematics, and he pursued his research at Columbia University. His research was stolen by his Professor there, Edmund B. Wilson, who acknowledged Dublin's efforts with only a footnote. This experience reduced his motivation for research, and he turned to writing popular articles on science for *The Youth's Companion* and *Scientific American*.

In 1900, Dublin had met Augusta Salik, a student who had turned to Davidson for help. Dublin and several friends tutored her until she was accepted at Barnard College in 1901. She dropped out of Barnard to engage in social work but returned to graduate in 1906. Augusta and Dublin were married in 1908. They had four children, soon moving to Westchester to raise the children and living happily together until Augusta's death in 1960. Two years later, Dublin married a close friend of his wife.

After his marriage in 1908, Dublin began to think about a possible career for himself and decided that the life insurance business might be a good avenue for his talents. After a year at
the Mutual Life Insurance Company, Dublin moved to the Metropolitan Life Insurance Company to work on their program of providing health and welfare services for their industrial policyholders. He soon became the statistician there and entered upon his remarkable career in the public health field.

**Contributions to Public Health**

From his base at the Metropolitan, Dublin appears to have participated in most of the public health efforts of the Century in roles ranging from statistician, consultant, committee member and director.

At the Metropolitan, he worked hard to improve the life expectancy of the policy holders and to show both that it worked and was cost-effective for the company. He supported such programs as nursing visits to sick policy holders. He also changed the practice of selling life insurance mainly to men.

Dublin joined the American Public Health Association in 1912 and later served as President (in 1931). (In addition, Dublin was also President of the American Statistical Association in 1924 and the American Population Association in 1935.) Beginning in 1915, Dublin authored major papers on the major diseases of the era, such as scarlet fever and tuberculosis. Dublin got involved in persuading the states to report vital statistics to the Federal Government, so that by 1933 all states were finally reporting reasonably accurate and complete data.

He served on committees for the American Red Cross and on some of their missions abroad to survey the public health needs of other nations, such as Italy toward the end of the First World War and France after the Second World War. He also was involved in the efforts to set up the Civilian Blood Bank.

He worked in organizations concerned with battling tuberculosis, maternal mortality, chronic diseases, accidents, and obesity, proposed solutions for helping people pay for medical care, contributed to the study of population growth and the rising proportion of aged in societies, campaigned against smoking (after giving up an eight cigar-a-day habit in 1950), drew attention to the inferior health care provided to African Americans, to the problems in undergraduate education for women and to the needs of the handicapped, tried to organize the voluntary health associations and to found a National Museum of Health (now part of the American Museum of Natural History in New York City), consulted with the Army and Navy health departments, and worked for the fluoridation of drinking water.

Even after his retirement from the Metropolitan in 1952 (where he rose to be a Vice President), he immediately went to work setting up a public service program for the insurance industry as a whole, retiring from that work in 1960. He died on March 7, 1969, in Winter Park, Florida, aged 86. His obituary in *The New York Times* (March 9, 1969, 88: 3) did not note a cause of death.

**Suicide**

As the statistician at the Metropolitan concerned with death and disease, Dublin wrote his first essay on suicide for *Harper's Monthly Magazine* in 1930. He developed this interest into
a book (To Be Or Not To Be), written with a colleague (Bessie Bunzel) and published in 1933. In the 1960s, the National Institute of Mental Health encouraged Dublin to revise the work, and Suicide: A Sociological And Statistical Study appeared in 1963. The Los Angeles Suicide Prevention Center, the center which contributed more than any other organization to the growth of efforts to understand and prevent suicide in the USA, employed Dublin as a consultant. Dublin urged the Federal Government to finance demonstration suicide prevention projects, and he urged the public health movement to recognize the importance of preventing suicide.

Comment

In Current Biography in 1942, Dublin was described as five foot five and one-half inches tall, weighing 150 pounds, with brown hair, later greying, and a mustache. He wrote over 600 monographs, papers and addresses, and he wrote both for scholars and for the general public. A profile in The New Yorker described him as a dynamic crusader, with incredible energy. It is remarkable that he participated in almost every major public health achievement of this Century.

REFERENCE


ÉMILE DURKHEIM

by David Lester

David Émile Durkheim was born on April 5 1858 at Epinal in the Department of Vosges in Lorraine, the youngest of four children. (He had an older brother and two sisters.) His father, grandfather and great-grandfather had been rabbis while his mother came from a family of merchants. Durkheim grew up in a close-knit orthodox and traditional Jewish family, destined for the rabbinate, but he decided at an early age not to become a rabbi. His biographer (Lukes, 1972) describes Durkheim as a child as having a serious and austere view of life, feeling remorse if he experienced any pleasure.

Schooling

Durkheim went to the local school where he performed well and skipped two grades. Durkheim was twelve during the Franco-Prussian war, and the Prussians occupied the town of Epinal. The French defeat in this war perhaps contributed to his patriotism and his desire to contribute to the renaissance of France as a great nation. Durkheim received his baccalaureats in letters in 1874 and in sciences in 1885. He left for Paris to prepare himself
for entrance to the Ecole Normale Superieure, but it took him three years before he was admitted in 1879. During these years, he survived financial hardship and the burden of studying subjects such as Latin and rhetoric in order to master the entrance requirements.

At the Ecole, Durkheim found the academic competition stressful, and he developed a strong fear of failure. Although he obtained his licence with maximum honors after his first year (for which he delivered an oral improvisation on the genius of Moliere), he remained apprehensive about his ability. During his years at the Ecole Durkheim broke with Judaism, henceforth regarding religion as a distorted form of morality. The course of study was hard. In fact the students were locked in for much of the time, allowed out only on Thursday afternoons and on Sundays. His time there was intellectually exhilarating and led to close friendships with the other students. The students remained concerned with social and political issues, and thus began Durkheim's involvement with these issues. He thought that he would spend the first part of his adulthood in scientific study and the remainder in politics. His friends described Durkheim at that time as mature and serious in manner, and they nicknamed him "the Metaphysician."

In his second year, he turned to the study of morality and sociology. Influenced by the philosophers Renouvier and Boutroux, Durkheim espoused rationalism and the scientific study of topics such as morality. In his final year, he was seriously ill which impaired his performance, but he did successfully take his agregation in 1882. He then began teaching philosophy in the lycées, where he performed well and was admired and respected by his students. An inspector of the schools described Durkheim as serious, cold in appearance, conscientious, hard-working, well-informed and clever. His teaching was described as exact, precise, and clear.

In 1885-1886, Durkheim spent a term visiting several German universities, including Berlin and Leipzig, supported by the Ministry of Public Instruction. His articles on philosophy and social science in Germany were well received, and in 1887 he was appointed charge de cours of social science and pedagogy, a position created for him, on the Faculty of Letters and the University of Bordeaux, where he stayed until 1902.

Interestingly, one of Durkheim's closest friends at the Ecole, Victor Hommay, later committed suicide in 1886 while teaching in a provincial lycée. Durkheim later viewed his friend's suicide as a case of egoistic suicide.

In 1887, Durkheim married Louise Dreyfus, whose family was from Alsace and whose father ran a foundry in Paris. His marriage was happy, and Louise helped him in his work, copying manuscripts, correcting proofs and helping with the work on *Annee Sociologique*. They had two children, Andre and Marie.

**The University Teacher**

Durkheim spent fifteen years at the University of Bordeaux during which he prepared several important courses of lectures on topics ranging from the history of pedagogy to criminology and where he published many major studies including *The Division of Labor*, *The Rules of Sociological Method*, and *Suicide*. He worked long hours on his lectures and scholarly work, and his biographer mentions many mental breakdowns brought on by overwork.
The appointment of a social scientist to the Faculty of Letters was an innovation for there were many critics of the sociological view of phenomena. His appointment was officially in pedagogy, and he was allowed to add sociology to pedagogy on the faculty list only as a special favor. In this way, sociology was introduced to French universities. The unpopularity of Durkheim's views perhaps prevented him from being offered a professorship in Paris and prolonged his stay in Bordeaux.

Durkheim pursued his intellectual goals by persuading the faculty to include required social science courses in the program for the *agregations* in philosophy and in law. He gave lectures on education to the school teachers once or twice a week and, both here and later in Paris, he had a tremendous influence on the school teachers in France. He took this teaching very seriously, but it was a burden to him. On Saturdays, he gave public courses on social science, most of which were on topics and with an approach that was entirely new, requiring intensive preparation. In 1896, he and his colleagues established a new journal, *Année Sociologique*, but Durkheim was the major influence at the journal, participating in everything from revising the copy to supervising the setting up of the proofs. In 1893, he successfully presented his doctoral theses to the Sorbonne. He was described at that time as tall, thin and already bald. His voice could be feeble and subdued but it rose and grew animated as he talked.

His work on suicide began with an article in 1888, followed by a public course (his third) in 1889-1890. He then worked on the topic for seven more years before producing his book published in 1897.

His ideas continued to arouse concern, and his doctorate was awarded over the opposition of his examiners to his ideas because his work was of such high quality. His works were often critically reviewed, and he responded with vehement defenses and attacks on others. Politically, Durkheim was a liberal, socialist and anti-clerical. In the Dreyfuss affair, in which an innocent Jewish man was convicted of being a traitor, Durkheim became an active member of the Ligue pour la Defense des Droits de l'Homme, and he founded an association of university teachers and students at Bordeaux to discuss political and ideological issues.

Finally, in 1902, Durkheim was appointed as *charge d'un cours* in the Science of Education at the Sorbonne, and he remained there until his death in 1917. Since his lectures on education were compulsory for all students seeking *agregations* in sciences and in letters, this new position gave him even greater influence over the teachers of France whom he tried to imbue with a rational secular morality. He reported falling into a depression when he first arrived in Paris, occasioned to some extent by guilt at leaving his friends and colleagues in Bordeaux.

At the Sorbonne, he continued his scholarly studies, but he also moved into administrative duties in which his influence was also felt. His ideas continued to arouse great controversy, partly because he expressed them so pungently and dogmatically and partly because they were so extreme. In particular, others were aroused by his methodological principles, his critique of liberal economics, and his sociological treatment of morality, knowledge and religion.
The War and Death

The advent of the First World War ended Durkheim's intellectual work since he threw himself into the war effort. He continued to teach, of course, though many of the students were called up for military duties. His chief activities in the war effort were writing and organizing, particularly to counter the German propaganda. He was on countless committees despite his ill health.

Durkheim was devoted to his son Andre, and Andre shared his father's intellectual interests. Andre was sent to the Bulgarian front in late 1915 and was declared missing in January, 1916. By April Durkheim knew that Andre was dead. Adding to this pain, Durkheim was attacked twice that year for being a German sympathizer, once in the French Senate.

Durkheim continued his activities despite his grief and his ill health. He was described as thin and feverish, and late in 1916 he suffered a stroke. His health never really recovered, and he died on November 15, 1917.

Comment

Durkheim was a man who had a considerable presence, dominating situations in which he found himself. His students became his disciples. Even in his daily life he was serious and forbidding. Yet to his friends, he could be warm and loyal.

In an era when an intellectual person could have an impact on the society, Durkheim's influence was profound.

REFERENCE


SIGMUND FREUD

by David Lester

Sigmund Freud was born as Sigismund Schlomo Freud on May 6th, 1856, in the Moravian town of Freiberg now known as Pribor, Czechoslovakia. His father Jacob was a wool merchant who was never very wealthy. Jacob married his third wife, Amalia, in 1855 when he was forty, twenty years older than her. Two grown-up sons from his first marriage lived nearby, and Freud grew up playing with his nephew who was one year older than himself. Freud's first sibling, Julius, was born in 1857 but died after seven months. In 1858, when Freud was two-and-a-half, a sister Anna was born. During his mother's confinement, his half-brother had Freud's nursemaid arrested for theft, and so Freud suffered a somewhat more traumatic dethronement than is usual.

5 This essay is based on Gay (1988). For an account of Freud's theories of suicide see Lester (1988) and Litman (1967).
In 1859, the family moved to Leipzig and the next year to Vienna. Between 1860 and 1866, Amalia had five more children, four girls and a boy. The family remained quite poor, and during this period Freud's uncle was imprisoned for trading in counterfeit money.

Freud soon began to show signs of academic promise. He became the family favorite, with his own room even though the family was overcrowded in their small apartment. Even when finances improved (assisted by Freud's two half-brothers sending funds from England where they had settled), the family lived in six rooms, though they now could afford servants. (Freud's parents and his six siblings shared three rooms.) When Freud complained that the noise of Anna's piano playing interfered with his studies, the piano was banished.

As a Jew, Freud experienced anti-semitism throughout his childhood. (Freiberg had 130 Jews in a population of 4,500.) Although legal discrimination had been eliminated by 1867, strong anti-semitic sentiments still existed in Austria. In 1885, for example, anti-semitic riots occurred, and the new mayor of Vienna in 1897 was openly anti-semitic. Freud's reaction to anti-semitism was defiance and open anger.

At his gymnasium, Freud was top of his class for seven years running. Freud decided on medicine, after having considered law, but in his third year at university (in 1875) he was still considering a doctorate in philosophy and zoology. He entered university early at 17, but graduated with his medical degree late at 25. While there, he first pursued research on hermaphroditism in eels but then moved to Ernst Brucke's laboratory where he studied the nervous system, first in fish and then in humans, resulting in many publications between 1877 and 1883. It was through Brucke that Freud met Joseph Breuer who became a father figure for Freud and later a collaborator on Freud's early works.

In 1879, Freud had to leave the university for a year of compulsory military service (during which he worked as a doctor). He graduated in 1881, and in 1882 he met and fell in love with Martha Bernays, who was visiting one of his sisters. Two months after their first meeting, they were engaged. This led Freud to reflect on his poverty. He left Brucke's laboratory and took a junior post at Vienna's General Hospital, but he did not feel financially able to marry Martha until 1886. They were apart for most of this time, and they wrote to each other almost every day. Martha had grown up in an Orthodox Jewish family, while Freud by now was an atheist.

He rose slowly through the ranks at the General Hospital. His research interests focused now on cocaine, but he missed discovering its anesthetic properties. (Although Freud took cocaine on occasions, there is no evidence that he was ever addicted to it.) Freud obtained a travel grant to study with Jean Martin Charcot, stimulating his interest in psychiatry. On his return to Vienna six months later, Freud resigned from the General Hospital and opened a private practice for nervous diseases. He married Martha on September 13, 1886. His first child, Mathilde, was born in October, 1887. (Freud had six children in all.)

**Early Years**

Domestically, much time was taken up with his children and their problems. His sister-in-law, Minna Bernays, resigned to spinsterhood after the death of her fiancé, lived with the Freuds and, despite rumors that Freud and she had an affair, Gay (1988) found no evidence for it. Freud's father died in 1896 at the age of 81. (His mother died in 1930 at the age of 95.)
At first, Freud's income was barely enough to support his family, and he was continually passed over for a professorship. (Freud's senior colleagues proposed him for a professorship in 1897, but the Ministry of Education ignored the nomination until Freud decided in 1901 to enlist the support of influential people to push his appointment. Freud got his professorship in 1902 after a seventeen year wait compared to the average wait of eight years.) However, by the end of the Century he was earning enough to live comfortably. Freud turned 50 in 1906 and from then on began to worry about his age. He called himself a "shabby old Israelite" and thought he would be dead in ten years. This concern stayed with him for the next thirty years! In his sixties, he began to complain about fatigue a great deal.

His sexual activity never seems to have been great, and he had periods of abstinence in his late thirties. However, in his personal correspondence he notes "successful coitus" in 1915 (at the age of 59), though his biographer infers from this that there must have been unsuccessful attempts too.

He continued to smoke cigars all of his life, to the point that he seemed addicted to them. He had started smoking them in the 1890s at Wilhelm Fliess's suggestion to help his nasal catarrh. However, his father was also a heavy smoker, as were most of Freud's colleagues.

Freud's early professional life was highlighted by his friendship and collaboration with Joseph Breuer as they discussed the cases that they treated and by his friendship, mainly carried on by mail, with Wilhelm Fliess, an ear, nose and throat specialist in Berlin.

Freud's development of his psychoanalytic ideas was slow. Studies In Hysteria, co-authored with Breuer appeared in 1895, nine years after the opening of his practice. By that time, Freud and Breuer were no longer as close as they had been, and Freud's relationship with Fliess was much more important to his intellectual development. Freud began his self-analysis in the mid-1890s, and his first book on psychoanalysis was The Interpretation Of Dreams published in 1899. Although he had tested out his ideas on Fliess during these formative years, the two men quarreled at a meeting in 1900, and the close friendship ended.

Freud was sensitive to criticism and would have bouts of depression when his work was not well received and after the publication of an important work (similar to a post-partum depression). He also suffered from a variety of psychosomatic symptoms (such as migraine headaches, fainting spells and intestinal problems). He pressed on with his pioneering work without support from the scholarly community. In later years, he exaggerated the extent of his isolation and rejection during these early years. However, the radical nature of his theories and the fact he was a Jew probably did lead to more scholarly ostracism than for others in Vienna at the time. However, he persisted in his explorations and slowly achieved recognition.

In 1902, a small group of five local physicians and a few interested laymen began to meet every Wednesday night at Freud's house to discuss psychoanalysis. After his book on dreams, Freud began to write prolifically on his ideas, and books appeared with regularity. Between 1899 and 1905 he published two key psychoanalytic texts (on dreams and sexuality), a technical study on jokes, a popular book and a case study. In 1906, Freud turned 50, and the years of fame were about to begin.
Fame

In 1908, the informal group organized itself as the Vienna Psychoanalytic Society, with a secretary (Otto Rank at first), dues and minutes on each meeting. Foreigners were now important members of the group - Max Eitingon and Karl Abraham from Berlin, Ernest Jones from London and Sandor Ferenczi from Budapest became important disciples for the new ideas.

Freud began to work hard at getting his ideas accepted throughout the world. He cultivated particular disciples whom he thought would be ideal at this task, such as Carl Jung, Swiss and non-Jewish. Unfortunately, Freud could not tolerate disagreement over what he considered to be the fundamental principles of psychoanalysis, so that some of these intellectually brilliant disciples eventually broke with Freud and pursued their own ideas. Each of these "defections" upset Freud greatly. Of special importance were the departures of Alfred Adler in 1911, Wilhelm Stekel in 1912, Carl Jung in 1914, and Otto Rank in 1924.

Despite the ridicule and occasional attacks his work received around the world, Freud was invited to the USA for an honorary degree by the President of Clark University in 1909. In 1910 the first International Congress was held, and the International Psychoanalytic Association was formed soon after. In 1912, Ernest Jones organized a tight, almost clandestine committee to be Freud's dependable 'palace guard' in order to preserve orthodoxy in the discipline, which pleased Freud greatly.

The First World War had a dramatic impact on Freud's theories (he proposed the death instinct as an important drive after this war), but only one nephew died in action, and his relationships with his adherents among the allies survived the war. During and after the war, he suffered from the same problems as others - no heat in winter, a shortage of food, influenza epidemics that killed 15,000 Viennese, and so on - but on the whole, as a well-known physician (with foreign clients paying in dollars and pounds) and with relatives in England sending supplies, he suffered less than most. His daughter, Sophie, pregnant with her third child died of influenza during the epidemic, and this saddened Freud greatly for many years.

In 1917, he was nominated for the Nobel Prize, and he began to wait for it each year. But he never was awarded one. In 1920 his daughter Anna accompanied him to the international congress, and this marked her growing involvement in the psychoanalytic movement. (Freud psychoanalyzed her starting in 1924!) She became a lay analyst and made important contributions to the field of child psychology. She remained very close to her father (she became his secretary, nurse, confidante, and colleague) and never married.

The Last Years

1923 marks the beginning of the end of Freud's life. A niece committed suicide. A four-year-old grandson (the child of Sophie already dead) died of tuberculosis. And Freud was diagnosed with cancer of the palate. The growth was removed, but the cancer continued to plague Freud until his death in 1939. Even then, his physician noted his readiness for suicide. Freud made it clear that he wanted his physician to help him leave the world in a decent manner if his suffering should be intense and prolonged. Freud described his depression that
year as the first of his life and, since he had been depressed many times before, this depression must have been severe.

Freud later underwent over thirty operations and had scores of fittings, cleanings and refittings of a prosthesis for his jaw. He retrained himself to speak, but his voice never recovered its clarity. The operations also affected his hearing, making him almost deaf in his right ear. He no longer attended the psychoanalytic meetings partly because of these physical problems. Freud also developed occasional angina. His diary for November and December 1929 notes heart and intestine attacks, anti-semitic riots, and being passed over for the Nobel Prize.

His fame continued to grow and honors were bestowed upon him. His ideas, albeit distorted, had permeated educated society around the world. He was made an honorary member of many societies. Journals on psychoanalysis were formed in most major countries. Translations of his work appeared. Frankfurt awarded him the Goethe Prize in 1930. But sad events also took place, such as the death of Karl Abraham in 1924 at the age of 48, followed by his card partners in Vienna with whom he had played tarok every Saturday night, his mother in 1930, and Sándor Ferenczi in 1933.

The rise of the Nazis in Germany led to further problems. Freud's books were included in burnings in May 1933. Although Freud considered exile, he resisted it until the German takeover of Austria in March 1938. During that Spring, over 500 Austrian Jews committed suicide. Freud rejected the idea of suicide, however, when it was raised by his daughter Anna. Himmler urged that the Freuds be imprisoned, but Goering and the German Foreign Office counseled prudence. Many years earlier, Freud had collaborated on a book on Woodrow Wilson with William Bullit who was now the American Ambassador to France. Through his influence President Roosevelt instructed the American Ambassador in Berlin to watch over Freud's case. Freud refused exile until Anna was taken to the Gestapo headquarters on March 22, 1938. After that, with friends paying the ransom (Freud's bank accounts had been confiscated), Freud left Vienna on June 4, 1938, arriving in London on June 6th.

In England, he was weak, but continued to see a few patients and to write. He underwent major surgery on his cancer in September and later had some radium treatment. By August 1939, the pain from the cancer was severe and the smell from his ulcerated cancer was so bad that his pet dog would cringe from him. He was extremely weak, and it was hard to feed him, yet he rejected sedation.

On September 21, he reminded his physician (Max Schur, who had also gone into exile in London) of their agreement to end Freud's life in just these circumstances. Schur injected Freud with three centigrams of morphine on September 21, followed by two more injections the next day. Freud died at three in the morning on September 23, 1939.

Discussion

Freud's life is of interest because of the lack of trauma in it that usually characterizes the lives of suicides. There is no early loss, no history of psychiatric illness, and few suicides in his family. There are no signs of psychiatric disturbance in Freud himself. Although he had periods of depression, they do not appear to have been severe enough to warrant a diagnosis of depressive disorder.
In extremely trying circumstances, including severely painful cancer and increasing anti-Semitism in Austria, Freud clung to life. He rejected the idea of suicide to escape the German persecution. But, when safe in London and close to death from cancer, he chose to die.

Even at the point of his death, his relatives and friends reported nothing that would indicate psychiatric illness. He had lived as long as he could, and he chose to hasten his death just a little. Freud's suicide appears to the rational act of a rational person.

REFERENCES


EDWIN SHNEIDMAN

by David Lester

In the late 1980s, Edwin Shneidman was invited to write an autobiography, and his published essay (Shneidman, 1991) provides a lively insight into his career and personality. Like the man himself, the autobiography is witty and reminds the reader of what a fine speaker Shneidman was. As we will see later, it also provides a provocative insight into Shneidman’s psychodynamics.

Early Life

Shneidman’s great-grandfather was a rabbi in Russia, and Shneidman’s grandfather emigrated to the United States where he apparently worked in a laundry. Edwin Shneidman was born in York, Pennsylvania, in May 1918, the second of three children. He had an older brother and, later, a younger sister.

Shneidman describes himself as a weak and a failure-to-thrive infant. His mother was severely depressed after the death of her own mother in the February of that year, and Shneidman was bottle-fed. However, his physical weakness meant that his parents had to take great care of him, and so he came to see himself as charmed and special.

His years in elementary school were marked by maternal teachers, who took care of the bright, “runt” of the class. He went on to high school at the age of twelve, weighing only 79 pounds. High school years at the Abraham Lincoln High School of Los Angeles in the 1930s were great. The principal, teachers and students seem to have been wonderful, and Shneidman was editor of the 1934 *Lincolnian* at the age of 15.

In reviewing these early years, Shneidman could find no poverty, violence, tragedy or trauma. His parents gave him a happy, tepid home with little to rebel against. He saw his later
role as a scholar as consistent with his background - not a rebel, but an iconoclast within the
temple.

Shneidman went to UCLA where he majored in psychology and where he was influenced
by some excellent teachers. Two of them were anti-semitic, however, and this led Shneidman
reject UCLA for doctoral study. He received his AB in 1938 (at the age of twenty) and his
MA in 1940. He then found a position as a civil service examiner for the city of Los Angeles,
and there he conducted and published his first piece of research (on interviewing techniques).
After he moved to a similar position in San Diego, the Japanese attacked Pearl Harbor, and
Shneidman joined the Army.

He was assigned to J. P. Guilford’s Psychological Research Unit and commissioned in
the Officers Candidate School in Miami Beach in October 1941. Shneidman spent the war in
the United States (mainly in Texas and New Jersey) as an Army Air Force Classification
Officer, rising to the rank of Captain. Shneidman’s wartime service increased his self-
confidence, and he became comfortable with commanding others and having authority. While
in the service, he encountered and dated the secretary of the inspector general of the Air Force
Command who later became his wife in 1944. They had four sons.

Eligible for support under the GI Bill, Shneidman chose to study at the University of
Southern California for his Ph.D. and chose psychology over medicine because he was
disinclined to take the premed courses required. He focused on clinical psychology, worked
as an intern at the local Veterans Administration Hygiene Clinic, and for his dissertation
devised the Make-a-Picture-Story (MAPS) Test. He received his Ph.D. in 1948 after which he
joined the regular staff at the VA Hospital.

Soon thereafter, he asked Henry Murray to write a foreword to an edited book examining
the psychological test protocols of one individual, and thus began his life-long friendship and
worship of Henry and Murray.

Suicidology

In 1949, Shneidman was collecting some data at the Los Angeles Medical Examiner’s
Office, when he came across some suicide notes. He called his colleague at the VA Hospital,
Norman Farberow, and they devised a study comparing these notes with a set of simulated
suicide notes. Their study led to further research on suicide and the founding of the Los
Angeles Suicide Prevention Center in 1955, at first in the basement of the Brentwood VA
Neuropsychiatric Clinic, then at the Los Angeles County Hospital, and, finally in 1962, in its
own building.

The LA SPC had the support of NIMH from its inception, receiving three major grants
for the period 1955 to 1969. The LA SPC became the model for many suicide prevention
centers, created a magnificent research program, and trained many of the future suicidologists
during their stays at the center. The center also invited visiting scholars, which resulted in an

In 1961, Shneidman went to Harvard as a USPHS Special Research Fellow, where his
relationship with Henry Murray deepened. In 1966, the director of NIMH invited Shneidman
to prepare a plan for a national program in suicide prevention and then invited Shneidman to
head the program. Shneidman went to Bethesda for three years.
During that time, he started a journal on suicidology, the *Bulletin of Suicidology* (and later, in 1971, *Suicide and Life-Threatening Behavior*), authorized the funding a large number of research projects, began a post-doctoral program in suicidology at Johns Hopkins University, and, at the end of his tenure, invited several scholars to a meeting in Chicago for a seminar on suicidology, as a result of which the group founded the American Association of Suicidology.

After a semester stay as a visiting professor at Harvard University in 1969, Shneidman was rejected for a full-time position there. He returned to California for a year at the Center for Advanced Studies of the Behavioral Sciences at Stanford University. After that he was offered the position of Professor of Thanatology at the UCLA Neuropsychiatric Institute, where he remained until his retirement in 1988.

During his time at UCLA, Shneidman edited *Suicide and Life-Threatening Behavior* from 1971 to 1982, and he began to work more as a counselor for dying patients. He also received many awards and prizes during his career, culminating in an award from the American Psychological Association for a Distinguished Professional Contribution to the Public Service

### Shneidman’s Contribution To Suicidology

Shneidman, in collaboration with Norman Farberow, made seminal contributions to the field of suicidology in the period from 1950 to 1966, while Shneidman was 32 to 48 years of age. Many of the studies conducted since then have, as their starting point, a piece of research or an hypothesis first stated by Shneidman and Farberow. In the three period as an administrator at NIMH, his research productivity declined as might be expected.

After that, Shneidman worked mainly alone and, although he published many books, he abandoned research and focused on ideas. The critical test will be whether his ideas from that period will stimulate further research.

His work in the latter period of his scholarly career focused primarily on classifications and terminology rather than theory. He proposed ten commonalities of suicidal behavior, and he applied Murray’s classification of human needs to suicide. Three terms which he coined have, however, been more widely accepted than these proposals. Shneidman referred to the psychological distress which suicidal individuals experience as *psychache*, and this term has become widely accepted. He also defined *perturbation* (the degree of upset the individual is experiencing) and *lethality* (how likely the individual is to commit suicide), and these also are becoming popular terms. He devised a theoretical cubic model of suicide based on the level of psychache, perturbation and press (the level of external influence on the individual).

In my opinion, working alone after a period of enforced scholarly inactivity while he was a full-time administrator at NIMH, impaired his creative potential. Shneidman was always able to generate good ideas, but he benefited in his early career from the collaboration of a researcher (Norman Farberow) who could take these ideas and generate research.

### Comment

Writing an autobiography provides the reader with insights into the psychodynamics of the writer, and it is impossible to read Shneidman’s essay without noticing the relationship of
Henry Murray to Shneidman. Shneidman himself says that Murray was his idol, a surrogate father or grandfather even though he had a loving and beloved father and grandfather already. Indeed, the autobiographical essay seems to be as much about Murray as it is about Shneidman.

But there is more to the essay than this. Shneidman, even though he was one of the seminal scholars in the field of suicidology and, it may be argued, the most outstanding scholar, clearly saw himself as inferior to Murray. Henry Murray was a Professor at Harvard University, while Harvard University interviewed and rejected Shneidman for a similar position. Although Shneidman ended up as faculty member, it was as a Professor of Thanatology at the UCLA Neuropsychiatric Institute. A medical school appointment is not the same as a legitimate professorship at a university. And Shneidman himself in his essay regrets the lack of graduate students and dissertation projects to guide.

Murray had a wife and a wonderful mistress, Christiana Morgan. When Shneidman was tempted to have a mistress, he reports that Murray took him aside and told him, “It’s not for you” (p. 252). Murray developed the TAT, while Shneidman developed the MAPS, a much less accepted and utilized projective test. The admiration of and identification with Murray was such that Shneidman, like Murray, took up the study of Herman Melville’s life and novels. It is hard not to conclude that Shneidman saw himself as a second-rate Murray.

This is very odd. I never met Henry Murray. He might have been a fascinating and charismatic person face-to-face. But, despite Shneidman’s admiration for him, Murray was a third-rate psychologist. His theory of personality, although sometimes still mentioned in textbooks written for Theories of Personality courses, has nothing original in it. It is a mere cut-and-pasting of the theories of others. Murray had none of the originality of theorists such as Sigmund Freud, Andras Angyal or George Kelly.

Yet Shneidman was a major figure in the field of suicidology, both in scholarly and research endeavors and in building up the field as an entity with prevention centers, journals, organizations and funding. Shneidman’s influence will live on for many years, while Murray’s influence on the field of personology is almost zero.

REFERENCE


AUTobiographies

KALLE ACHE

Finland

I was born on September 11th, 1928, in Mikkeli in eastern Finland. My father was a forestry officer, and I was the second of three children. My mother was a very gentle and loving woman, and I had a very good relationship with her. My father was dominant and authoritarian, and from him I learned firmness, integrity, precision and hard work. When I
Appendix

was six years old, my family moved from Mikkeli to Lahti, a city with a well-known skiing resort about 100 km north-east of Helsinki.

I married a fellow student in 1960 at the age of 21, and our marriage has lasted for nearly 42 years. I have three grown-up daughters, the eldest of whom is a psychologist and married to a psychiatrist. She has begun to study psychotherapy. My second daughter is a teacher, and the third is a dentist. I have seven grandchildren.

At school, Finnish and writing were by far my best subjects, and I have since been able to make good use of these abilities. My hobbies include my grandchildren, literature, especially political history and memoirs, and medical ethics. I have acted as chairman of the Ethics Committee of the World Psychiatric Association for several years.

One of my main interests has been history. For ten years, I have acted as chairman of the Finnish Society for the History of Medicine and head of the Helsinki University Department and Museum for Medical History, but I plan to resign from these positions this year.

Since I was a child, I have been interested in cross-country skiing and other kinds of sport. Later in my life, long-distance skiing and running became my favourite pastimes. Between 1970 and 1990, I took part in long-distance skiing competitions up to 90 km in Finland and in the Alps. However, a year ago I started to show symptoms of spinal stenosis, and this has severely curtailed my skiing. In the spring of 1991, I became seriously ill with sepsis, endocarditis and spondylitis. Only time will tell how well I recover from this severe illness.

When I was a young boy, a close friend predicted I would die a violent death either in an electrical accident or a plane crash before the age of 27. When I turned 27, I sighed deeply with relief. Even though I never took this magic too seriously, it nevertheless overshadowed my life, causing me to take out excessive life insurance and, since then, I have detested fortune-tellers.

My Professional Life

I graduated from school in 1947, and, after one year of military service, began my medical studies. I qualified as a doctor (M.D.) in 1954. After working as a municipal health officer for a couple of years, I started my specialized studies in psychiatry in 1956, obtaining my qualification as a specialist in neurology and psychiatry in 1960. The topic of my medical dissertation, published in 1961, was the prognosis of schizophrenia, and at about this time I began my productive work within science. I became a university lecturer in 1963 and a professor in 1964 at Turku University, and I was offered the chair of neurology and psychiatry at Turku University in 1965, a post I declined. Between 1961 and 1966, I worked as deputy chief physician at City of Helsinki Hesperia hospital, and between 1966 and 1967 as chief physician at the same hospital. At the beginning of 1968, I took up my present position as professor of psychiatry at Helsinki University and as chairman of the Department of Psychiatry at Helsinki University Central Hospital. Between 1978 and 1981 I was Dean of the Medical School of the University of Helsinki.

I have acted as chairman of the board of the Finnish Association for Mental Health for several periods between the 1960's and 1990's, a position I still hold. I have gained great personal satisfaction from helping to found the Foundation for Psychiatric Research in
Finland, the biggest publisher in the psychiatric field in Finland. Among its publications is an annual called 'Psychiatria Fennica', first published in 1970.

I have been a member of numerous international associations, and have also held a great number of confidential posts. I have written 21 books, edited 42 books and published approximately 1000 articles, of which the proportion on suicidology is between fifteen and twenty percent.

During my career, I have travelled to more than 45 countries, made 300-400 congress and lecture trips all over the world, obtained a large international circle of friends, and enjoyed life enormously. I have considered myself a lucky person, especially as health has, until recently, been excellent. Until my recent severe illness, I had not been absent from work for a single day in over thirty years.

At the end of the 1960's, after training in psychoanalysis, I was filled with new ideas and plans regarding the future. I had heard of Norman Farberow's Los Angeles Suicide Prevention Center, and Erwin Ringel's Suicide Prevention Centre in Vienna. I went to see the president of Finland's National Board of Health who allowed me to make an educational visit to Vienna, and later to Los Angeles. Following these visits, I assisted with the foundation of a suicide prevention center, the SOS service of the Finnish Association for Mental Health in 1970 in Helsinki, which helps patients not only through a telephone service, but also through home visits.

During my work as a municipal health officer between 1954 and 1956, I met patients who had attempted suicide. In clinical psychiatry, I also soon noticed the importance of the problem of suicide. At that time, there was little literature on suicide other than reports of statistical studies. My meetings with Norman Farberow and Erwin Ringel stimulated suicide prevention efforts and research in Finland.

For a third of a century, I have also worked as a clinician, psychotherapist, psychoanalyst and psychiatrist and, in these roles, realized the extent and importance of the problem of suicide.

In 1968, I became the Finnish representative to the International Association for Suicide Prevention (IASP). I have attended every IASP congress starting in London in 1969. I was in Mexico in 1971, in Amsterdam in 1973, and so on. I had the honor of acting as President of the Seventh Congress in Finlandia Hall in Helsinki in 1977, where the number of participants was the greatest ever - around 1,000. My friend Veikko Aalberg was my assistant, acting as Secretary General of the Congress. This organization was supported by the Finnish Association for Mental Health. Between 1971 and 1989, I had the honor of being a board member of IASP, first as Treasurer for a long period, then as Vice President, and finally as President for two terms of office.

From the early years of suicide prevention, I remember well Erwin Stengel from Sheffield and his stimulating approach to the study of suicide. On my numerous educational and congress trips, I have learned much from Erwin Ringel and Norman Farberow, as well as from my old and highly respected friends Edwin Shneidman, Robert Litman and Jerome Motto, to mention just a few. In the 1970's, with the help of the Yrjö Jahnsson foundation, I arranged a couple of international seminars in Finland on the methodology of suicidology, and these were attended by Norman Farberow. Through the World Psychiatric Association, I have arranged numerous symposia on suicidal psychopathology all over the world. In recent years, the Nordic countries have collaborated in the field of suicide research, and Professor Nils Retterstol has been particularly active in this regard.
About five years ago, my friend and colleague Professor Jouko Lönnqvist started what was probably the largest suicide project in the world with the aim of promoting suicide prevention in Finland. In his large-scale study, he examined all suicides committed in Finland over a period of one year. It appears that, even though Finland's overall standard of medical care is recognized internationally to be very high, doctors are still not sufficiently aware of the risk of suicide and are unable to diagnose depression in all cases or treat it adequately. In recent years I myself have concentrated on therapy-resistant depression in my clinical, consulting and scholarly work. In my teaching, too, I have attempted to emphasize the adequate diagnosis and treatment of depression.

Consistent with the experience obtained at my clinic, Professor Maria Asberg from the Karolinska Hospital in Stockholm has found that impulsive violence and suicides are connected with biological factors. Slow serotonin activity results in low 5-HIAA concentration in patients who have attempted suicide and who are at great risk of committing suicide in the future. Thus, psychosomatics seem to play an important role in this field. Biological, social and psychological factors are related to all illnesses.

I am about to retire from the chairmanship of the Department of Psychiatry at Helsinki University. On retirement, I plan to concentrate on my psychoanalytic, psychotherapeutic and psychiatric clinical practice, and perhaps to write my memoirs or on medical history. It seems, therefore, that my active work within suicide prevention is gradually declining. I am, however, still Finland's representative to the International Association for Suicide Prevention and President of the board of the Suicide Prevention Centre of the Finnish Association for Mental Health.

**JAN BESKOW**

Sweden

My early experiences probably stimulated my efforts to understand suicidal behavior. My mother contracted a near-fatal infection at my birth, and my grandmother cared for me during my first year. As my father was chief physician at a sanatorium, I grew up in an environment where death was always close by. During my early teenage years I had to stay home from school for a year and a half because of a non-tuberculotic glomerulo-nephritis. At the university of Upsala a few years later I was confronted with the suicide of a Hungarian fellow-student. I endeavored to understand the latter event in the religious context which was a part of my heritage. Thirty years later I had the opportunity of confronting these memories in a more systematic way.

Perhaps these experiences gave me a feeling for outsiders and a tendency to see suicidal behavior as part of a dialogue concerning membership in the primary group. However, I appreciate the fact that I have never been clinically depressed, nor suicidal.

In 1954, I married a medical student who later specialized in pulmonary diseases. We had four sons in six years, and they are now between 28 and 34 years of age. My eldest son has a Masters in engineering and works with computerized vibration analyses. One son is a public prosecutor, one works with computer systems development and one with theater productions. In my current marriage with a psychologist, I have a fifteen year-old son. I also have three grandchildren, all girls.
During my spare time I try to get involved in cultural events in order to better understand the society in which I live and its role in the development of suicidal behavior. I probably have a Type A personality because I like to sail when it is too windy and to hike in terrain that is a bit too steep. Perhaps my son's dedication to caving is hereditary!

**Psychological Autopsies of Male Suicides**

After receiving my MD, I specialized in social and preventive medicine and in psychiatry. My first scientific effort focused on the prevention of children's accidents. I studied the safe-keeping of drugs in homes. After that I studied parents' attitudes toward vaccination, and I carried out an epidemiological study of mental disorders in the county of Vasterbotten. I was also involved in research projects in clinical psychopharmacology and in the pathology of the central nervous system.

During the mid-sixties a small epidemic of suicidal acts occurred among adolescents in the city of Umea, where I then resided. Although the planned investigation was never carried out, the event stimulated Jan-Otto Ottoisson, Chairman of the Psychiatric Department at Umea University, to suggest that male suicide should be my dissertation topic.

For my thesis, I analyzed two series of psychological autopsies, one urban and one rural. This meant visiting over 250 families, facing their difficult questions, and sharing their feelings of bereavement and, sometimes, their feelings of relief. It was a trying but rewarding experience.

I was struck in particular by the long course of development of the suicidal process, an average of seven to eight years. Certainly most of the suicides were mentally ill, and in 97 percent it was possible to decide on a psychiatric diagnosis. Suicidogenic forces in the environment also played an important role, although often in a haphazard manner.

In both the rural and urban series, 45 percent of the suicide cases were diagnosed as having depressive syndromes, which is somewhat lower than in Robins' and Barracough's studies. Of a total of 23 men with bipolar or unipolar affective syndromes, four committed suicide despite adequate treatment. The remaining nineteen were incorrectly treated or not treated at all.

Alcohol was a background factor for 72 percent of the men in the urban group, either through alcoholism (56 percent), episodic abuse or drinking prior to the act. 43 percent of the urban men had required social services and 30 percent had criminal records. Corresponding percentages in the rural district were generally lower.

**Preventing Suicide**

At the national level much of my work in suicide prevention has been accomplished in my capacity as advisor to the National Board of Health and Welfare and as an initiator and teacher of courses in suicidology. Cooperation with colleagues in the Nordic Planning Group for Suicide Research provided inspiration in this work.

The latter also included a report on "Suicides in Medical Services, 1985-1988." An analysis of suicides committed on hospital wards revealed a striking difference in the methods used for suicide by the type of ward. The majority of the suicides on somatic wards occurred via jumping from tall hospital buildings (63 percent), while a majority of patients on psychiatric wards committed suicide by hanging (71 percent). The suicides on both psychiatric and somatic wards showed an age distribution with two peaks. The major peak was in the group aged 60 and older and the secondary peak in the group aged 30 or less. In six cases the suicidal process was reconstructed from the medical records, and in each case critical situations were identified and possible preventive measures were discussed. These case studies can also be used in teaching, providing training in psychological autopsies.

At the regional level, Solveig Cronstrom-Beskow, a psychologist and psychotherapist, and I developed a program in the mid 1970s for thanatological training at the Regional Hospital in Umeå. We also carried out a suicide prevention programme in psychiatric and general medicine services in the county of Skaraborg during 1978-85. The programme included a training component and the development of new treatment routines for suicidal persons.

Solveig Cronstrom-Beskow and I have also arranged courses in suicidology as part of the specialist training in psychiatry (since 1976) and for personnel in the psychiatric services (since 1983). At least three participants with different professions took part from each team or clinic, and after returning home these groups would develop local suicidological knowledge and routines.

Solveig Cronstrom-Beskow has also contributed to suicide prevention by writing five books. "Talking about suicide" was an introduction to the art of helping people in suicidal crises. Another, "The many faces of death", dealt with problems of bereavement.

The International Suicidology Community

My first contact with the international suicidology community was at the 1969 London meeting of the International Association for Suicide Prevention (IASP). I recall in particular Professor Erwin Stengel's broad knowledge and friendly wisdom, as well as his discussion one late afternoon on euthanasia and suicide with Professor Eliot Slater.

Over the years I have visited many international conferences, among them eight arranged by IASP. Meeting Edwin Shneidman and Norman Farberow was very influential for my understanding of suicidal problems. The Twenty-Fifth IASP conference in Vienna focussed on the ideas of Erwin Ringel on suicide and on the history of IASP. I was honored there with the Stengel Award for my scientific and preventive work.

Last year I was appointed as Sweden's national representative to IASP, replacing Dr. Ruth Ettlinger who had represented Sweden since the first IASP conference in Vienna 1960. I have also been a member of the International Academy of Suicide Research since its founding in 1990.
Psychological Autopsies of Female and Youth Suicides

I have supervised two recent theses on suicide. In 1990 Dr. Ulf Asgard published his thesis on female suicides, which included a birth cohort analysis of suicide risk by sex and age in Sweden from 1952 to 1981. In the same year Dr. Bo Runeson published his thesis on suicide in young adults.

The proportion of maladaptive syndromes was from 12 to 14 percent in both studies, similar to my findings for male suicides. The frequency of depressive syndromes (including secondary depressions) was somewhat higher among women (59 percent) and youth (52 percent) compared with men (45 percent). In men, many of the depressions were camouflaged by alcoholism. Alcohol abuse secondary to mental disorders was common among young people. This group also had a high number of Axis II disorders, predominantly borderline personality disorders. Using the same criteria, Professor Charles Rich and Dr. Bo Runeson made similar findings in an analysis of the San Diego suicide study.

The ethics of interviewing survivors shortly after bereavement has been questioned. In Asgard's and Runeson's studies an independent researcher evaluated the interviewee's reactions via follow-up telephone calls. Although no apparent signs of distress were noted, such as sick leave or increased use of drugs or physician's visits, we cannot totally exclude that some interviewees were psychologically hurt. Seven informants (4 percent) felt that the interviews had been a negative experience. Most, however, regarded the interviews in a positive light, and some found that they helped them during their working through of the pain of bereavement.

The Future

Suicide prevention is a complicated problem which requires large-scale research efforts. I feel that the recommendations from the 1989 WHO-working group in Szeged are headed in the right direction. One primary task is to establish an epidemiologic surveillance system which can provide information on trends in suicidal behavior and register effects of large-scale preventive measures. Suicidal behavior must be conceived as a public health problem, requiring interdisciplinary cooperation on a national as well as at a regional and community level.

We can now see small but promising signs in this direction in Sweden. The Swedish Medical Research Council initiated a Planning Group for Suicide Research in 1988 under the leadership of Professor Marie Asberg. Research groups in suicidology are active at six universities. There are two centers created especially for the study of suicide, the Suicide Research Center in Lund (founded in 1986 under Dr. Lil Traskman-Bendz) and the Suicide Prevention Center in Stockholm (founded in 1991 under Dr. Danuta Wasserman). Preventive programmes at the regional level have been developed in the counties of Vasterbotten (under Professor Lars Jacobsson) and Gotland (under Wolfgang Rutz of the Swedish Committee for the Prevention and Treatment of Depression).

In 1991 the National Board of Health and Welfare initiated the National Council for Suicide Prevention. We hope it will develop into a larger and more representative council, leading to increased awareness of suicide problems in Sweden and to a national program for suicide prevention. More valid methods of measurement for the surveillance of suicidal
behavior and of attitudes to suicide are necessary as a basis for proposing policies for and the ethics of suicide prevention. We must also reach a better understanding of how primary prevention, such as limiting the availability of the means for committing suicide, can complement the more traditional secondary prevention, such as crisis intervention and psychiatric care.

CONCLUSION

The pattern of suicide is continually changing. In order to understand and react to the communications of suicidal people we develop our understanding of both the epidemiology of suicidal behavior and the behavior patterns which appear just before the suicidal act. Psychological autopsies may, therefore, play a central role in suicidology in the future.

One aspect of the ethics of suicidology is attempting to understand the constructive parts of suicidal behavior, for example, how persons in desperate situations seek answers near the borders of life.

Since the coal gas story, described by Norman Kreitman, and since the works of Richard Farmer, David Lester and Ronald Clarke, we have begun to understand the similarities between accidental and suicidal events. A temporary loss of control can lead to an unforeseen and perhaps unwanted self-induced death.

The broad perspective on suicidology, as expressed over and over again in IASP, is important. I hope it may continue to inspire coming generations of researchers in this field.

NORMAN KREITMAN

United Kingdom

It is sometimes said or implied that if someone has a particular interest in any topic - in the present instance, suicide - it must reflect at some level his or her personal or family circumstances, especially those operative during the formative years. The thesis is debatable, but whatever its general validity I must confess that in my own case I can find nothing to support it.

All four of my grandparents were Jewish immigrants to Britain who arrived in the U.K. around 1900. My father's parents came from southern Poland, and there were stories of how they had to bribe the guards and hide in the forest in winter in order to get through the border. My grandfather was a man of a rather gentle disposition and was a shoemaker by trade. My grandmother, who bore him at least ten children, was a much more forceful personality, who organised, managed and generally acted as matriarch to her close-knit family. My father, who was born in London and grew up in the rugged conditions of the east side around the time of the First World War, was the second oldest son, and was destined to join the workbench of the family shoe shop. He surprised everyone by winning an art scholarship while still at school, but although his parents were willing for him to take it up he felt obliged to join his father and brothers in what was later to become a successful family business in shoe manufacturing.
My mother's family was from the Ukraine, where my mother was born. Two more children, both boys, were added to the family after they reached London. I have the impression that my maternal grandfather had been a peasant farmer before emigrating, but there were no fields in the Bethnal Green area and he turned his hand to various kinds of work, eventually setting up as a trader in cloth. With the help of my uncles the enterprise did moderately well.

Thus, on both sides, my family origins were very much working class, and in moments of inverted snobbery I find considerable satisfaction in that purely accidental circumstance. But, in line with the usual pattern of successful immigration, my own parents began to slowly to move up the economic scale, and my recollection of childhood is that though financial prudence was always necessary we never had to face any shortages. My parents were devoted to each other, and to me and my younger sister, despite a little healthy friction between my father and me during my adolescence, we were certainly a close and loving family.

My own schooling began at a somewhat primitive establishment in North London, where I learned little of academic value but more about human nature than I have obtained from any institution since. The advent of the War led to our moving from London to a country town in Hertfordshire, where I had the great good fortune to go to an excellent, unpretentious and lively school which I greatly enjoyed. It was not easy for me to decide what career to adopt as so many subjects seemed attractive, but my main interest was in science, particularly biology, and it seemed that a fair compromise could be achieved between this and a vague if strong desire to do something useful by going into medicine. This I did, training at King's College, London and Westminster Hospital. I had not foreseen that, during the years as a medical student, what had been my secondary interest, namely literature, would come to the fore, or that I would seriously contemplate giving up medicine in favour of writing. But for better or worse I stuck to the course, and went through the standard instruction of those times. This included psychiatry, tuition in which chiefly consisted in being shown a parade of six chosen lunatics at a local mental hospital.

Career planning in that era had none of its current sophistication. Indeed the term was scarcely understood. I knew I wanted to be a physician of some kind, and I was chiefly interested in academic hospital work. To assemble relevant experience I therefore took up a series of residential posts in different aspects of medicine. The longest was in chest diseases, and while working at a tuberculosis sanitarium I came across an advertisement for research fellowships at the Forlanini Institute in Rome. These were competitive, and involved a selection interview at the Italian Embassy in London. I applied, was in due course summoned, was asked briefly about my previous interests, and then questioned at some length - on Mozart. Presumably my answers were satisfactory because the upshot was a splendid year in Rome in 1954. I did not learn not very much about pulmonary physiology, my ostensible purpose, but that did not matter greatly at the time.

I returned to Britain to another junior hospital post, this time in general medicine, but decided that it was time to adopt a speciality, preferably one that might eventually allow some kind of research role. Chest diseases were now less attractive since a wise physician had warned me that, as a speciality, tuberculosis would not last my lifetime. The question was what to take up instead.

The post I occupied on returning from Italy involved working with five different consultant physicians, but added to this list was a sixth whom I had never met but who was said to be a psychiatrist. One evening as I was leaving the hospital rather late I was surprised
to see that the outpatient hall had been cleared and spread with rows of mattresses on which semiconscious patients were being deposited. Investigation revealed this to be an outpatient ECT session, being run by a Dr. Larkin, the elusive sixth consultant. Curious, I went in to introduce myself. We got on well. Dr. Larkin was a witty, well-read man, with an informal manner and a readiness to respond to my naive questions. He invited me to sit in on his general psychiatric clinics, and I was fascinated by what I saw. This, I thought, was the kind of work I wanted to do, especially as I had already done a certain amount of reading in psychoanalysis in connection with my continuing interest in literature.

The question was how to begin, and here again fortune intervened. I wrote to the dean of the Postgraduate Psychiatric Institute at the Maudsley Hospital to ask his advice about how to acquire a training in psychiatry, and he invited me to see him. We talked about the various options, and he arranged for me to see another senior member of the staff to get further advice. When I met his colleague, we spoke briefly about psychiatric matters, and then drifted on to a discussion of the current state of the theatre in London, a topic on which he held strong views. I left a little mystified. So on after I received a letter saying that my application for admission, which I had never made, had been accepted, and would I start in a few weeks time!

So I did. This was in 1956, when the Maudsley Hospital was virtually under the one-man control of its director, Aubrey Lewis. The strengths and weaknesses of the institution at that time, its ethos, conflicts and style has now become a topic for historical research in its own right, and I can scarcely do justice to it here. Personally I enjoyed my time there and managed to stay for a extra year beyond the customary three. When I left I did so with the conviction, shared by many of my contemporaries, that after critical scrutiny the amount of dependable knowledge which psychiatry could claim was woefully little. I could do something to help some of my patients, but I simply did not know enough to be more effective. Nor did anyone else, as far as I could judge.

The answer it seemed was to go into - or go back into - research. Again I was lucky, in that there was a vacancy available for a psychiatrist in the Medical Research Council unit for clinical psychiatry directed by Dr. Peter Sainsbury at Graylingwell Hospital, Chichester, in rural Sussex. I am not sure that anyone else applied for the post, as research was not then (or now) a particularly popular option, and there was also a feeling about that it was hazardous to leave the capital if one wanted to progress. Be that as it may, I applied and was offered the job, and my wife and I gave up our flat in central London for the fastness of the Sussex countryside.

The six years I spent there seem in retrospect to have been among the happiest I have ever enjoyed. Peter Sainsbury had already established his reputation as a leading researcher in the suicide field, but he had a very relaxed and tolerant manner with his junior colleagues, allowing them to pursue whatever line of research was feasible within the facilities of the unit. The group was small but multidisciplinary, with three psychiatrists, a psychologist, a sociologist, two psychiatric social workers and a physicist (working in a small EEG and psychophysiology laboratory) plus a supporting team. One of the major themes of the unit was of course suicide research, especially after Brian Barraclough came to join the group. However, my own activities at the time did not include suicide research but were chiefly in questions concerning the measurement of clinical states, the psychopathology of hypochondriasis, and a range of topics on the marital and familial aspects of psychiatric disorders. I was an eavesdropper on the suicide work, which I came to hear about through the
regular meeting of the unit at which the members presented their work to the scrutiny of their peers, and I read a little of the literature out of interest. I also became interested in some of the broad issues concerning the optimal organisation of research groups, though I must repeat that the unit itself was basically a happy one, free of the internecine friction which is so often found in such a setting.

I remained with the Chichester unit about six years, and began to focus my interests, which were moving increasingly towards the social and psychological aspects of psychiatric disorder. I also published a few papers. But I also began to sense that it would beneficial to work in a more academic context. Then the word arrived that there was a vacancy in the MRC's Unit for Epidemiological Studies in Psychiatry (as it was later to be called) in Edinburgh, where my friend Neil Kessel had been working for some years with the director of the group, Morris Carstairs. Neil was now leaving to head the university department in Manchester. I wrote to Morris, whom I had already met at the Maudsley, most memorably because he would call at the residents' flat every Saturday to watch a science-fiction serial on our 12-inch back and white television set. (Of such encounters are research careers made.)

It was all briskly arranged. I was duly offered the post, and in late 1965 transported myself and my young family to the unfamiliar capital of the strange country called Scotland, though not without regret at leaving the very different setting of the Sussex countryside. In formal terms the Unit was similar to the one I had just left, but with the major difference of the University setting. In practice that meant more teaching, contact with a much larger group of academic psychiatrists (and beyond them an even larger faculty of medicine) and the chance to collaborate closely with a whole range of specialists in sociology, anthropology and so forth. These were valuable assets, which I attempted throughout my many years in Edinburgh to exploit.

Neil Kessel had already developed a psychiatric liaison service with the Royal Infirmary, Edinburgh, for patients admitted with self-poisoning and self-injury. Under the arrangements that then existed, and which continued for over twenty years, every patient in the city notified to the ambulance service was taken to the Royal Edinburgh, and every such patient received there was admitted to special wards jointly staffed by psychiatrists and toxicologists. Thus it was possible to study a wider variety of cases than previous investigators had been able to assemble, while the presence of staff with research as well as clinical interests meant that a wide array of data could be systematically collected. Extending the tradition of Erwin Stengel, Neil Kessel had already published two major papers on self poisoning, which effectively laid the groundwork for a great deal of subsequent research and which deserve to be more widely recognised. I was delighted to follow him and to continue to exploit the virtually unique advantages of the Edinburgh service. Parasuicide, as it came to be called, in preference to the profoundly misleading term "attempted suicide", was one of my chief interests over the next two and a half decades.

It is difficult to summarise the whole gamut of questions which we tried to investigate - "we" here including colleagues such as Alastair Phillips, Dorothy Buglass, Nilima Chowdhury, Peter Kennedy, Irene Ovenstone, Graham Foulds, Stephen Platt and so many others. One area to which we gave a great deal of attention was of course the basic epidemiology of parasuicide, with special emphasis on the social and cultural characteristics of high risk groups and the areas of the city in which they were concentrated. That necessitated a good deal of sociological enquiry in order to provide adequate descriptions and to find ways of measuring the processes that seemed important. Our comments on the role of
economic deprivation and social adversity created something of a stir (including complaints by political figures which happily we were able to ignore). Linked to this work was an interest in the patient's intimate social group, and a project in which we demonstrated a raised frequency of parasuicide in the patient's "set", and analysed familial patterns, was one of the most satisfying in all my experience, if also one of the most difficult.

Rather different in scope and direction was a series of clinical investigations beginning with the production of a scale for predicting the repetition of parasuicide. We published the first predictive scale around 1970 and its latest version a full 20 years later. Such scales were of considerable help at a clinical level, alerting us to hazards we might otherwise have overlooked, but they also provided key instruments for one of the first randomised controlled trials of a specialised aftercare service designed to reduce repetition. The findings did not endorse our therapeutic enthusiasm with respect to repetition, though we found that we had indeed ameliorated the psychiatric and social problems of our patients. Thus we had made some impact problems which we could demonstrate to be closely linked to parasuicide, yet without improving the repetition rate. To the best of my knowledge the paradox remains unanswered.

We were also interested in what we termed "distress behaviour" and with the help of the local Samaritans carried out a comparison of people in trouble who had consulted them to obtain help, as contrasted with our patients, who had resorted to the dangerous and seemingly irrational procedure of harming themselves. This work led on to analysis of the various pathways to care or support, and efforts to detail both the successes and failures of various agencies. Among other projects this group of studies entailed a major survey of how general practitioners managed their cases, and with what consequences.

But, though as clinicians we were necessarily involved in questions of service organisation and attempts to improve our therapeutic skills, my interest constantly returned to questions of causation and outcome. Among those outcomes was the possibility of suicide, and hence it was unavoidable that our concerns should broaden out to examine parasuicide in relation to suicide and indeed, into suicide per se. An initial study, in collaboration with the legal authorities, looked at all the suicides and undetermined deaths in the city over a year, ascertaining their prior experience of self-harm, and comparing the series with all the parasuicides known to us over the same year. The results provided not only estimates of the magnitude of these different groups in the population of the city but enabled us to start a series of projects on putative predictive factors for suicide. This line of enquiry continued for many years and had various ramifications. For example, we began the practice of scrutinising all officially recorded suicides and undetermined deaths in the city on a yearly basis, and of inviting hospital colleagues who had had any part in the management of these cases to join us in the review. I commend such an exercise as a valuable educational tool as well as for its research potential.

During the 1970s the suicide rate in the United Kingdom began to fall, in contrast to the experience of the U.S. and most European countries with the interesting exception of Holland. It had already been suggested on the basis of some small scale data that the fall might be linked to the reduced toxicity of domestic gas, which in Britain had always been a particularly common mode of suicide. We therefore established contact with the national gas suppliers and requested detailed information on the proportional composition of gas, i.e. whether coal-based, oil-based or natural, as supplied to households over the preceding decades. We also obtained data on the composition of the gas obtained from each of these sources, and hence
could calculate the amount of carbon monoxide in the supplies going to the average household. Against these we charted the suicide (and undetermined death) rates for England and Wales, and showed a clear parallel in the trends. Since data for Scotland are generated quite separately from those for England and Wales we were able to test the findings on a second data set, and obtained the same results. Our conclusion was that there was a direct, causal connection between the suicide rates and the toxicity of the gas. Two consequences followed. One was the practical one of public health policies and the possibilities for preventive action. The second was the emergence of a theoretical problem; a number of studies from Europe had highlighted the importance of trends in unemployment as determinants of trends in suicide rates, yet in Britain where unemployment had also been rising the suicide rate had nevertheless fallen. This paradox was resolved by further analysis of the British experience incorporating data on both domestic gas and unemployment - a challenging but ultimately rewarding task.

Another theme that I found intriguing was the association of suicide and social status. In the data which Durkheim had available to him, the relationship was linear, with the highest rates of suicide in the highest classes, and he wrote at some length about the stresses befalling the privileged who were obliged to carry their burden of freedom. Studies earlier in the present century, however, tended to find a U-shaped pattern, while the few carried out in the 1970s showed it was the lowest social classes which had the highest rates. We reinvestigated the question using large, national data sets for England and Wales, and separately for Scotland, and found a dramatic inverse relationship between suicide rates and social class, at least for men of working age. What is unresolved is whether the social class profile of suicide has in fact changed over the past hundred years, and if so why, or whether the apparent change is due to nothing more than having better data available nowadays. The question is unlikely ever to be answered. We also found, incidentally, that the curves of age-specific rates differed appreciably from one social class to another. This observation raises many question, and also suggests that any review of secular trends in suicide in our rapidly-changing Western society needs to be social-class standardised if it is to be properly interpreted.

But rather than continuing to list separately the themes which occupied us during the 27 years for which I was a member of the Unit (as Director from 1971), it might be preferable to say something about the advantages, as they seem to me, of establishing research groups or units which enjoy a measure of temporal stability. These advantages have long been recognised by the U.K. Medical Research Council even though, alas, the concept of a research Unit, as distinct from an ad hoc team, is nowadays coming under attack as a consequence of increasing financial and other pressures.

The merits of the Unit system are particularly evident for epidemiological research, for two groups of reasons. Firstly and most obviously, it becomes possible to study processes over sustained periods of time. This means that it is feasible to monitor contemporary fluctuations in rates, as we did for parasuicide in Edinburgh over many years, and also to follow up groups of probands for purposes of both naturalistic description and for hypothesis-testing, the latter including the assessment of the validity of predictors such as risk of repetition scales. Less obvious but equally important is the ability of a continuing Unit to build up a picture in depth of the local community. Routinely available statistical data is often of marginal relevance to the researcher and needs to be supplemented both by access to unpublished (often very sensitive) information and by means of special surveys. It takes time to establish confidential arrangements with official agencies for the former, and even more to
mount and analyse the latter. The importance of trying to understand the society one is studying cannot be overemphasised, and it seems to me that much epidemiology yields a pretty thin harvest because no attempt has been made to tackle important parameters beyond the ubiquitous age and sex.

Secondly, epidemiology is a basic science for social psychiatry, and affords the only route to the study of many major questions. But given the existence of a multidisciplinary group, epidemiological research, by providing well-characterised and representative samples, also constitutes a sound background for additional kinds of enquiry. For example, in our study of the suicidal and undetermined deaths in Edinburgh over a one year period we came to the view that the series could be seen as comprising two different groups distinguishable by their psychiatric features. This led us to propose the existence of two preterminal syndromes of suicide, and to carry out some statistical analysis to verify what was essentially a clinical hypothesis. Or again, our continuing involvement at a clinical level with city-wide samples of parasuicides enabled us to study a number of hypotheses concerning psychological variables. This research, led by Graham Foulds, included some basic work on psychological theory, concerning the relation between personality disorder, neurosis and major psychiatric syndromes, as well as more focussed studies by Jim Dyer and Stephen Platt on the respective roles of hopelessness and depression in parasuicide, and how each of these was related to particular environmental stressors such as unemployment. Yet another example, this time of a sociological nature, arose after we had confirmed that the parasuicide rates in young women were higher in the married than the single, and the observation that the difference was linked to differences in their level of financial debt.

Finally I must add a word about the benefits that accrue when a research group has more than a single theme. Clearly with a multifaceted phenomenon such as suicidal or other self-damaging behaviour, a range of expertise is essential for its proper study. But beyond this there is also advantage in having members of the same team working on other topics. Our group was also interested in such problems as depression among women and in alcohol abuse, and I tried to encourage the staff to adopt my own practice of being involved in more than one area of research. Perhaps the best example of the value of such a strategy arose in connection with the problem of suicide in alcoholics, and to go beyond ecological correlations. Thus in one group of studies we cross-linked at an individual level all the data on hospital-treated alcoholics with all the suicide and undetermined deaths recorded in Scotland over a period of 15 years. From this data set we were able, inter alia, to determine the relative power of a number of putative predictors of suicide in alcoholism, finding that most of the traditional risk factors identified in the general suicide literature were of little value, but that secondary clinical diagnosis was of major importance.

I retired in 1990, and have since directed my activities to other areas. The question must always arise at such a time as to whether it has all been worthwhile, whether all that work has led to any significant advance in theory or in practice. The honest answer must surely be "I don't know". Judgements of that kind belong to the historian. I can claim to have tried to contribute to the process of more or less rational enquiry, and whatever the consequences the work has certainly been stimulating. And for the most part, indeed, it has been great fun. Could anyone ask for more?
Writing an autobiography is a difficult task. An autobiography is much like a story told to a picture in the Thematic Apperception Test. There is wealth of psychodynamic insight possible into the protagonist's mind beyond the simple words put down on paper. I have found myself in editing this volume speculating on the psychodynamics of the other authors.

Then also, the writer of an autobiography is presenting an image of himself or herself that will endure and perhaps affect others' view of the writer. I view my experiences in dichotomous ways. Sometimes I find them amusing and informative; at other times I feel anger and bitterness. What image do I want you, the reader, to have of me and my life?

Perhaps I should begin and see what develops?

My Parents

My father was born Isaac Cohen in the slums of London. His father and mother emigrated from Chernogov, near Kiev in Russia. I never met my grandparents, but I heard that my grandfather was a watchmaker and left his family to run off to Paris. I think my father was the fourth of five children. He disliked his family and by the time I was born would have nothing at all to do with them. The youngest child, Solomon, eventually became friendly with my mother and, after my father had left her, he visited occasionally. Solly remained single, relatively poor, living in rooms, wearing shabby old clothes, and with a stutter.

My father left home at an early age and worked for a solicitor for a while. He said later that he always wanted to be a lawyer but could not afford the education necessary for it. Somehow, he ended up as a bookie. He became anti-semitic and married my mother during this phase of his life, changing his name to Harry Lester. So I was born David Lester.

My mother was English and Irish. Her Irish father sold insurance and died when she was two. Her English mother raised her and the other four children by taking in laundry and cleaning houses. They lived in the poorer sections of London, and my mother was born within the sound of Bow Bells, a true cockney, Kathleen Jane Moore. She left school when she was twelve to go into service, cleaning rooms and serving tables. She was working as a waitress when she met my father.

My father would beat my mother, she said, and lock her up when he left the apartment in case she went out without him. She left him a couple of times, but he always talked her into coming back. He said that she would trick him into coming back. After ten years of marriage, when she was about thirty and he about forty, they were separated but spent a weekend together. They had not been able to have a child up to that point, yet that weekend she got pregnant. They decided to set up a home for their only child, and my father bought a house in Merton Park, on the outskirts of London. I was born June 1, 1942.
My Childhood

I don't remember much of my childhood at all. Most of what I know is second-hand, heard first from my mother and now mistrusted somewhat by me. It is a fact, however, that I lived through three years of war and the hardship afterwards. We had an air raid shelter in the front living room of our semi-detached house, and I used to hear the planes coming before the siren would announce the raid. I have been told that I share certain eccentricities of habit with those who were children during the Great Depression.

The major trauma during those years was having my tonsils out. I went in overnight, and my mother expected to stay with me. They wouldn't let her. She said that I didn't talk for months afterwards and, when eventually I did, I stuttered. The doctor said that a stutter was incurable. My mother tried refusing to listen to me unless I spoke properly, though it broke her heart to do this to me. Eventually it worked, and I would carefully phrase sentences without stuttering. As a lecturer now, I still occasionally get my speech confused, but I do not know whether I do it more than the average person or whether it is a vestige of my early stutter.

I went at age five to a government school, Merton Park Primary School, about which I remember little. At the age of ten, my father decided to send me to a private school, King's College School, Wimbledon. I refused to board, and so I went as a day pupil. Going to King's had a tremendous impact on my life. I was with upper-middle class boys who were college-oriented, in a school which counted its success solely in terms of how many students went to Oxford and Cambridge Universities. Had I not gone to King's, I would have stayed in the government system and, if I had gone to college, would probably have gone to a "redbrick" university.

Going to King's also meant that I was alienated from my friends in the neighborhood. We never met again. I wore my distinctive uniform (it was a bright red jacket in summer) and went on the bus to Wimbledon. There was no one from King's of my age living near me, and so I became an isolate. There was only school and home.

Initially school met five days a week, from nine to four. Soon they added Saturday mornings, and by age fourteen, we went six days a week. The competition and pressure were intense. By age fourteen, I was doing homework every evening and on Sundays. However, I didn't excel at first, though I remained in the top stream. We took Latin, French, geography, history, mathematics and literature. At fourteen I moved into the Senior School, where science was added. When I was sixteen I won the science prize and passed eight O-levels out of eight taken. I chose physics and chemistry as my major.

At this point, we dropped all classes except mathematics, physics, and chemistry. We had a half hour of religion each week and a half hour of culture, and that was the sum of our liberal education. Again I was in the top stream, where there were no more than a dozen of us. The teachers pampered us but drove us to excellence. We were the chosen who would get the scholarships to Oxford and Cambridge.

Meanwhile at home, my parents had divorced. For about three years, from when I was nine until I was twelve, they stopped talking to each other. I was the messenger boy. "Ask your father what he wants for supper." "Tell your mother I'm going out." After he left, I used to take the bus or train to central London once each fortnight to visit him. We went to museums, films, or the zoo, doing those things that divorced fathers do with their kids. When I was about fifteen, he telephoned me to tell me that he wouldn't see me any more but that he
would write, however. Years later, as an adult, I was still trying to find out why he had done this.

After the divorce, my mother became very depressed and phobic. She couldn't go into shops or on busses and trains unless I went with her. So I had to accompany her a lot, to shops and to visit her mother. She gave me the keys of the house, and I was on my own. But I did little with that freedom. I threw myself into studying, came home right after school, and rarely socialized with anyone.

**Going Up and Coming Down**

I stayed an extra year at King's in order to take the scholarships exams for Cambridge University. My physics master decided that I would apply to the St. John's College group, and I won the top science scholarship there. My friends and I spent the rest of that year studying mathematics and taking extra A-level examinations even though we had already passed the required three in natural science. I went up to Cambridge in 1961 at the age of nineteen.

St. John's College admitted two hundred male students each year for the three year course of study. Eight of these were awarded major scholarships worth one hundred pounds a year and conferring automatically a government scholarship of three hundred pounds. My roommate during the scholarship exams, Leslie, and I had been awarded the two major scholarships in science, so it was without envy that we looked for each other as soon as we arrived the following autumn. We had separate rooms for that first year, but close to each other. We spent a great deal of time together during that year, and for our remaining two years we shared an apartment.

Entering college life was exciting. We were, after all, at Cambridge University. We two were also scholars. We had reached the pinnacle of academic success. All undergraduates wore gowns at Cambridge University. We wore them to lectures, meals, when seeing college and university officials, and after dark. During the first few evenings, as I was walking down the streets of the town, I would look at my reflection in the shop windows, with my gown flowing out behind me, and feel excitement. At the reception for first-year students the Master of the College welcomed us to St. John's College and told us a little of the college's history. The college had been founded in 1511 by the executors of the will of Lady Margaret Beaufort, the mother of King Henry VII, on the site of the old Hospital of St. John. The Master referred to those who had been students at the college in earlier times, from Queen Elizabeth's Prime Minister, Lord Burleigh, to William Wordsworth. I looked around at the youths sitting around me and realized that these would be future ministers, bishops, generals, and scholars. I was emotionally stirred despite the cavalier attitude I had tried to assume.

Life quickly settled down into a routine. Attendance at lectures was not compulsory, but you do not get to be a scholar without self-discipline. Leslie and I attended every one. We went to the same physics lectures, but otherwise went on our own, for Leslie was reading Natural Sciences while I was reading Mathematics with Physics. We would meet for supper in college and then walk along the river to a putting course for a game. We studied in the evenings until about ten o'clock, and then we would go to The Mitre for a half-pint of shandy and a pork pie. On weekends we might walk to Grantchester through farmer's fields and back along the road or go by punt. On Sunday we bought the Sunday Times and struggled with the mathematics puzzle and the chess problem. In the spring and autumn we played croquet on
the Backs, the lawns by the river. Eventually, tennis courts would be set up, and we played in the all-white outfits that were required on the Backs.

The terms passed slowly. I developed a pattern of spending the vacations longing to escape from my home and the term longing to escape from Cambridge. Eventually, it took only the bus ride from the train station at Cambridge to St. John's for my depression to settle in again, and this was made worse if Leslie had not yet come up.

At the end of my first year, I got a First in Part One of the Tripos in Mathematics with Physics. The work had been relatively easy since we had covered most of the material already at my private school.

At Christmas during our second year I came down with influenza while working for the Post Office, which led to a depression. A master at school had always talked of reaching a point in mathematics at which you ceased to understand anything further. In my depression, I feared that I had reached that point. I decided to change fields but, since we specialize in Britain at the age of sixteen, you can change at the age of twenty only to fields that are not taught at school. I applied to read Psychology, and after an interview with the Professor of the Department, Oliver Zangwill, I was accepted, a rash choice, since I had not, at that time, ever read a book on psychology. My friends were appalled. One simply did not do such things. This meant that my first term's work in mathematics was wasted, and I coasted through two terms of psychology, which turned out to be fairly interesting after all. I surprised my director of studies by getting a First in the Preliminary Examination to Part Two of my Tripos.

I went to the University of Grenoble in France for summer school in 1963 and met an American teenager, Mary, with whom I fell in love. She visited London with her parents on the way home, and I met them. I decided to emigrate to America for graduate study so as to be able to marry her. Her parents sponsored me, guaranteeing any debts that I might incur in that country. My friends were again appalled. Changing fields was rare, emigration to America unheard of. But Mary was six thousand miles away, and she hardly ever wrote. So I brooded and became depressed because I sensed that our marriage would never take place. I had another leisurely year, took Part Two of the Tripos and missed a First. I read in the newspapers that I had received a Two One.

I had chosen to travel to America on the Queen Mary, and she sailed early in July. My mother was too distraught to travel to Southampton, so we parted at the house where I had lived for twenty-two years. I stayed on the deck a long time, watching the English coast disappear. I wanted to feel some emotion, perhaps sadness or grief. But I felt nothing. For many years I had studied, day and night, weekdays and weekends. I had been bored and depressed. England was the setting of my misery. There was nothing to grieve over in leaving it. Life had to lie ahead.

The United State of America

I had applied only to Brandeis University and the University of California at Berkeley for graduate school. My advisers at Cambridge had not heard of Brandeis, nor of the faculty there (including Abraham Maslow), but I chose Brandeis because of the fellowship they offered me. The choice turned out to be a good one. Brandeis was small and a wonderfully friendly and supportive place, and I was the last student to go through the program under the philosophy which had been established by Maslow of allowing each student to choose his
program of study. I was awarded my doctorate after three years during which I maintained a large breeding colony of rats and published several papers on exploratory behavior in rats simply as a hobby, took an undergraduate course with Maslow (who refused to teach graduate students) and was his teaching assistant next semester, studied with George Kelly who had retired from Ohio State University, and came under the influence of a brilliant psychoanalyst, Walter Toman. I began to publish extensively and had to fight a ruling promulgated by a jealous junior faculty member that graduate students could not publish without faculty permission.

My dissertation was on suicide. At Cambridge we had focused almost exclusively on experimental psychology, but I had come across Clues to Suicide by Shneidman and Farberow whose suicide notes at the back of the book had moved me to tears. In my first year at Brandeis, the personal stress had led to another depression and thoughts of suicide, and perhaps these factors affected my choice of topic. I conducted several studies on aggression and suicide and put them together for the dissertation.

After being rejected by my Californian teenager as I had expected, I met, fell in love with and married a fellow graduate student in the department, Gene McCoy. Gene got a position at Wheaton College and I at Wellesley College, and we taught for two years. I was contacted by Gene Brockopp who had just opened a suicide prevention center in Buffalo, and he persuaded me to accept the position at Director of Research and Evaluation. My wife switched to Buffalo State College, and we moved to Buffalo in 1969.

The suicide prevention center was a stimulating environment. We had a good staff, full of ideas, and most of the problems we had to deal with had not previously been addressed in the literature. We dealt with obscene calls, clients who became chronically dependent upon us, the decision to tape calls, whether or not to trace calls, and many more issues. I started a journal Crisis Intervention which I sent free to all suicide prevention centers in the USA and to members of the American Association of Suicidology. I produced only two volumes, but my successors produced twelve more volumes. I began to publish research into suicide in vast quantity, and my two years there established me in the field. Gene Brockopp was a good friend and a brilliant organizer, and I have great affection for him.

But I missed academia. I was glad that I left college for two years for now I knew that college was where I wanted to be. I could return with no regrets. I took a position in 1971 at Richard Stockton State College, a new college in New Jersey, where I was the founder of the Psychology Program. As at the suicide prevention center, the first few years were exciting as the founding faculty discussed and debated every single issue from grading systems to course offerings. In the first few years I also started a Social Work Program and revamped the Criminal Justice Program, so that I played a large part in shaping the institution.

Gene and I had a son, Simon, in 1971, and Gene joined the college in 1974. Unfortunately our marriage ended the following year, but we have worked together in the same program ever since and, though not close friends, maintain an amicable relationship.

My enthusiasm for the college soon waned. We quickly became a typical state college, teaching students most of whom in my opinion were not qualified to be in higher education. I like teaching, and some of my students have been excellent and stimulating. But, for example, teaching statistics to students who cannot solve simple algebraic equations and reading papers and examination answers that are illiterate is hardly what I imagined academic teaching would be like when I began my career over twenty years ago. Consequently, my job has become simply a source of salary so that I can pursue my scholarly work.
My second wife, also an academic, encouraged me to explore and develop my self, and I changed greatly in those years. I also began to decrease my involvement in suicide research and move into the field of criminal justice field. That marriage ended with great acrimony in 1982, leaving me alone for the first time in my life.

I married again in 1987, to an academic economist. Bijou is from Taiwan, an immigrant to the USA like myself, and she has had a major impact on my career in suicidology. My interest in the field returned and, with her urging, I entered a prolific period. For several years, I wrote over eighty books, articles and notes a year. Bijou pointed out that I had not yet formulated theories of suicide, and so I worked on this. She urged me to go to professional meetings, and in 1987 I attended the joint meeting of the American Association of Suicidology and the International Association for Suicide Prevention in San Francisco, my first suicide conference since 1971! By 1989 I was Vice President (and two years later President) of the International Association and editing the annual proceedings of the American Association.

In retrospect, the first thirty years of my life seem to have been preparation for life, an extended childhood. In my late thirties, I worked on myself. Who was I? What did I want (as opposed to what others wanted me to want)? What kind of person did I want to be? In my late forties, my scholarly work came to the fore. I remember talking to Tim Beck many years back, and he noted that, while physicists usually do their best work in their twenties, social scientists seem to excel in their forties. Perhaps social scientists need a long period in which to learn and assimilate older ideas before they can restructure them into new formulations?

A Career in Suicidology

Although I worked in a suicide prevention center for two years and wrote on the problems confronting such centers, I have been primarily an academic researcher. For my own education, I have frequently reviewed the extensive literature on suicide, and I have published these reviews in articles and books. I have tried always to peruse every scholarly article and book written in English on suicide (and I regret my limited ability to read in other languages). I have made an effort to read in all disciplines, and so I have been able to publish scholarly works in anthropology, psychiatry, psychology, sociology and other disciplines.

I see empirical work as important, and I have endeavored always to find some way to test the validity of theories and hypotheses. I have tried to encourage others in their research into suicide, and I have collaborated with many other scholars from around the world in research projects. I would like to be a catalyst for the field of suicidology, stimulating others to produce research and theories. I have published extensively and, occasionally, I have published minor pieces which others would have left unpublished and about which others have scolded me. But I feel strongly that the field of suicidology is short of ideas and needs every stimulus possible. Some of my notes are the only papers on particular issues, and I have been gratified in subsequent years to find that someone has developed one or another of those ideas into a more extensive study.

In recent years, I have focused more on theory. It is theory that endures long after others forget the empirical research. In recent books I have proposed new sociological theories of both completed suicide and attempted suicide, applied the classic theories of personality and systems of psychotherapy to suicidal behavior, proposed an opportunity perspective for
suicide prevention, developed a set of theories of suicide which parallel the standard theories of crime, and proposed more limited psychological theories of suicide. All of this work was reviewed in the third edition of Why People Kill Themselves.

After a long period in which I avoided the meetings of the suicidology associations, I began to attend the conferences, congresses and symposia and soon found myself caught up in the politics of these associations. It is difficult to resist involvement, but the involvement expends time and energy better spent on my scholarly work. At each meeting, I tell myself that this will be the last one I attend and that I should hibernate once more in southern New Jersey. But I have not yet done so.

**Reflections**

Two themes seem to pervade my life. The first is one of not belonging. I was born lower class but moved into the middle class. My mother was Christian and my father Jewish. I was born in England but emigrated to the USA. I chose physics but ended up as a psychologist. This lack of a clear identity, combined with my small family, has, not so much left me feeling rootless, but rather as an outsider. I am at ease with anyone, I am close to only a few, but I belong to no group.

A second theme is that, having been encouraged to academic excellence by my parents, I chose physics. I wanted, of course, to be the next Einstein. I have never accepted that psychology and the social sciences are as serious or meaningful topics for study as physics. I sometimes feel that psychology ranks little higher than chess.

But now that I am a psychologist, the only genius I recognize in the field was Freud, and so it is now to his status that I aspire. I want to propose a new theory of the mind. Yet I have taken a lesser path and focused on suicide. One can become the best suicidologist, but that does not and cannot make you the best psychologist. If only I hadn't come down with influenza that Christmas....

Yet at times I also believe that all has been for best, that at each choice point the decision made was, in the long run, for the best, and that my life was meant to be just as it is.

**Charles Neuringer**

The year was 1958. I was attending the annual convention of the American Psychological Association in New York City. I was at that time a graduate student in the Clinical Psychology Training Program at the University of Kansas. I had passed my preliminary exams and was ready to start my internship year and was also thinking about possible dissertation research projects. I fortuitously wandered into a session that dealt with suicide prevention. I sat down quietly in the back of the meeting room and listened to the first presentation. The speaker was Edwin Shneidman, and his talk was electrifying. He described some of his ideas about suicidal thinking and spoke about hypothesized cognitive styles that promote suicidal decisions. He gathered these cognitive processes and bundled them under the rubric of Dichotomous Thinking.
That's it, I thought to myself. That's my dissertation research project. I immediately decided that I would empirically test Shneidman's theories. When I returned to Kansas, I read everything about suicide that I could find. Included among those readings was a book that I then thought (and still think) was one of the most seminal publications in the field of Suicidology: Shneidman and Farberow's Clues to Suicide. I went to work and developed a research proposal which I submitted to my dissertation advisor Dr. M. Erik Wright. He approved the proposal itself, but was dubious about my being able to find enough suicidal subjects in the Kansas City area to fulfill subject size demands. I also wrote to Dr. Shneidman and sent him a copy of my proposal and expressed my desires to empirically evaluate his hypotheses about Dichotomous Thinking. He wrote back saying that he was enthusiastic about the project and invited me to come out to Los Angeles to work on the research. This was easier said than done. I was at the time a Veterans Administration Psychology Trainee, and I was scheduled to spend my post-internship year at a local Veterans Administration Hospital. Dr. Shneidman and my advisor made it possible to spend my post-internship year at the Los Angeles Veterans Administration Hospital where Dr. Shneidman and his associate, Dr. Norman Farberow, had established a special suicide research unit. My assignment was to gather the data for my dissertation.

I spent a year at the Los Angeles Veterans Administration Hospital gathering research data from the hospital itself and also from the wards of the Los Angeles General Hospital. My access to the latter facility was facilitated by Shneidman and Farberow.

At the end of the year's assignment, I returned to Kansas to analyze the data and to write my dissertation. Before I left Los Angeles, I was offered a staff position at the Los Angeles Suicide Prevention Center (a National Institute of Mental Health funded project) which had been established by Shneidman and Farberow to be both a community agency for helping suicidal people and a research institute. I accepted immediately. In many ways my post-internship year was the most useful professional training experience in my life. I finished my dissertation, and passed my oral exam, and was granted a Ph.D. And so in August, I and my new bride packed up and drove to Los Angeles.

I spent two years at the Los Angeles Suicide Prevention Center, doing research and supervising a series of trainees. I was also appointed as deputy coroner of Los Angeles County. I and the other Los Angeles Suicide Prevention Center staff investigated deaths for which the coroner felt he could not issue a death certificate based on his limited information. We were sent out to look for psychological clues as to the cause of death. In essence, we were conducting psychological autopsies. One learned a great deal about suicide itself, but mostly about the effects on survivors and on the rest of the community.

The staff at Los Angeles Suicide Prevention Center were all highly dedicated individuals that worked long hours. They rotated manning an after-hours crisis hotline after a full day of answering phone inquiries, bringing individuals in for interviews, and for short-time crisis psychotherapy. I remember them with great affection. I especially enjoyed the company and learned much from Mickey Heilig, David Lugman, Marv Kaplan, Bob Litman and Norman Tabachnick. At the Veterans Administration Hospital, I supervised a series of trainees and part-time undergraduate staff. They were all very bright and ready to go beyond what was needed. I especially remember Dan Sapin, Ronald McDevitt, Bruce Sutkis, George Jamison, Richard Schlesinger, Lee McEvoy and Al Darbonne. At the Veterans Administration Hospital Suicide Prevention Unit, I was fortunate to work with Alcon DeVries, Calista Leonard and Ken Kunert. I cannot ever forget Eunice, Jackie, Carolyn and Marie, the secretaries who kept
us all in our places and kept the unit running smoothly. The aforementioned people taught me more than I was able to teach them. Thanks to them I was also able to expand my work in the area of suicidal thinking.

As much as I enjoyed working at the Los Angeles Suicide Prevention Center, I didn't like Los Angeles for a number of reasons, partly because of its lifestyle, but mainly because both my wife and I didn't think that it was the best environment for rearing our two small daughters. Even though I was a native New Yorker, I had become accustomed to living in a small college town. Two years after my tenure at the Los Angeles Suicide Prevention Center commenced, I was offered a teaching job at the University of North Dakota. The university town of Grand Forks reminded me of Lawrence (where the University of Kansas is situated) and, after my wife and I talked it over, I accepted the offer to join the psychology faculty at the University of North Dakota. Two years later, I was contacted by my old university and asked if I would be interested in returning to Lawrence to take a position at the University of Kansas. I accepted the offer and moved the family again.

I maintained my connection with the Los Angeles Suicide Prevention Center for a number of years via visits and shared research projects. I authored, co-authored, or edited two books on suicide and contributed 12 book chapters and 36 papers on the self-destruction. I also served as an editorial referee on The Bulletin of Suicidology and Suicide and Life Threatening Behavior. I was also a member of the research panel of the National Institute of Mental Health Center for Suicide Prevention from 1966 to 1971. I have had four government grants to do suicide research.

In many ways, my time in Los Angeles with the Suicide Prevention Center was a very important part of my life. I found a role model in Edwin Shneidman who was my pre- and post-graduate mentor. He is a man of brilliant ideas and has a wide scope of interests ranging from Herman Melville to systems of logical analysis. Much of my research orientation comes from him. Norman Farberow was another great influence on me in terms of methodology and experimental rigor. I also learned lessons in patience from him. If Shneidman is my father-figure mentor, then Norman is my brother-figure mentor.

I am now preparing to retire from my position as Professor of Psychology at the University Kansas. I was born on May 30th in 1931 in New York City. I lived in Kansas from 1952 to the present except for stopovers in California and North Dakota. I am still married to the bride I took to Los Angeles. We have two daughters and three grandchildren. As I write this, I am overwhelmed with nostalgia, and I really can't believe that all these experiences happened more than thirty-nine years ago.

My interest in suicide has waned somewhat of late. I have moved from investigating life-rejecting behaviors towards life-affirming activities. Within that broad area I have pursued a special interest in the cognitive capacities and strategies of creative individuals, especially those of stage actors and specifically in the psychology of actors and acting.

**JACK P. GIBBS**

USA

Folklore has it something like this: a boy reared in Texas during the Great Depression should be watched carefully all of his life. Having been born in Brownwood, Texas, on
August 26, 1927, the warning applies to me; but so far I have not proven dangerous. For that matter, unlike most native Texans, I do not take birthplace seriously. Indeed, all that I owe Texas is poverty and cultural deprivation.

There is nothing unusual about my early years, especially for that place and time. The poverty of my family and the cultural deprivation (for example, no libraries or museums) was fairly common in the small rural communities where I grew up in the northern part of Brown County, and I think of my childhood as a happy one. That happiness ended when I moved to Brownwood to attend high school (I no longer remember exactly why), at which time I became acutely aware of a lack of spending money and, above all, access to a family car. I lived with my maternal grandparents (my parents continued to live in the small rural communities in what was a good marriage despite severe economic hardships) and, while I loved my grandparents dearly, they could not provide me with very much. So my high school days were disastrous. I was not merely acutely unhappy but also very angry. It is a wonder that I refrained from delinquency and made good grades in school. Perhaps it is due to my becoming a real "jock," meaning very much drawn to football and basketball.

My ability certainly did not justify it (perhaps my grades drew attention), but I received a football scholarship from the University of Southern California. However, I arrived in Los Angeles with a cardboard box as my suitcase (the assistant coach who met me at the bus station was stunned), and I departed within a few days—even before football workouts commenced—because of the culture shock encountered at a very rich fraternity house. The jock dorm was closed because of the war, and I have wondered often what would have happened to me had I not run away from USC in bitterness.

My acute desire to have money and a car led me to take a job at a post office back in Texas, and I worked very hard until I entered the service at the very end of World War II. My military career was undistinguished (I was discharged as a PFC and that only because the first promotion in rank was mandatory after a few months), and the only impact it had on my life was through the GI Bill. Government support made it possible for me to attend college, but my motivation for attending is obscure. Perhaps years of hard work made college life pleasant; and it became even more pleasant when at long last I became the owner of a new car (to this day, I take a dim view of critics of "materialism"), even though I had to live hand to mouth for several years.

Perhaps my undergraduate years were wasted. In blissful ignorance I attended what were then third-rate schools (Daniel Baker, now rightfully defunct, and Texas Tech), but it is just as well because my background would have made me an academic casualty at a place like Columbia. In any case, I scarcely had any academic or career goals (memories of "mean" jobs probably did much to keep me in school), but I did make good grades. Why, I shall never know. In any case, I ended up, so to speak, taking my B.A. and M.A. at Texas Christian University (TCU).

My life course may have been substantially altered by my contact with Austin L. Porterfield, then the Chair of the Department of Sociology at TCU. In retrospect, Porterfield was not an especially competent instructor (given his heavy teaching load, his teaching must have suffered), but he had considerable charisma. He introduced me to sociology, research, scholarship, and the very idea of publishing. Moreover, Porterfield's interest in both homicide and suicide obviously had an impact on my own interest; but I had to discover Durkheim while browsing in the library, and that discovery was another major influence.
On nearing the end of my master's study, I applied for a Fulbright student fellowship (or whatever it was called) to do research on suicide and homicide in New Zealand. I gathered a lot of case histories; but it was sort of a mindless empiricism, and I never really exploited the data. (However, I did exploit the New Zealand beer and generally enjoyed myself). After returning to the U.S., I applied for and received something like a fellowship at the University of Oregon. The Department of Sociology was not major league, but it did meet my needs. I did much of my work toward the Ph.D. (1957) under the direction of Walter T. Martin. We subsequently published a lot together and became dear friends.

Following two years as a research associate at International Urban Research on the campus of the University of California (Berkeley), I became an assistant professor of sociology at the University of Texas (Austin). In 1965 I moved to Washington State University (having been promoted to full professor in 1963 or 1964), but I returned to Austin in 1967 and remained there (again as professor of sociology) until 1972. Following a Guggenheim Fellowship during 1972-73, I moved to the University of Arizona. That affiliation lasted until 1978, at which time I made my last and best move - to Vanderbilt University.

My nomadic academic career is not as unusual as it may appear, and the reasons for the moves are mundane in the extreme. To be sure, in retrospect some of the moves make no sense, such as departing Washington State because I was sick of serving as departmental chair, only to serve three years much later at Vanderbilt. On the whole, however, most academics would understand the reasons to the point of being bored by them, and that is especially true of my desire to get away from the endemic conflict in the Arizona department (little changed, even now).

By any reasonable standard, I have published a substantial amount on suicide. Most of my work has focused on a theory concerning the relation between status integration and suicide, which I first set forth in my dissertation. The theory emerged from my reading of Durkheim; indeed, the central idea stemmed from Durkheim's recognition of but failure to explain the higher suicide rate of the married among the very young (15-19). I reasoned that the rarity of marriage among the very young is indicative of the following sequence: a low degree of status integration (an infrequently occupied status configuration), status incompatibility, role conflict, difficulty in conforming to socially sanctioned expectations, and weak social relations. The theory is thus essentially an extension of that inference to all statuses (that is, not just to age and marital status). It differs from Durkheim's theory in that his arguments about anomic and altruistic suicide are ignored. More important, the status integration theory is testable, something that cannot be said of Durkheim's theory.

Alas, sociologists have not been impressed by the theory's testability, nor by the outcome of hundreds of tests. Their reaction reflects widespread indifference if not hostility in the field to the assessment of theories even largely by reference to predictive power (something that includes far more than predictive accuracy). Rather, along with many other social and behavioral scientists, sociologists appear determined to assess a theory in light of explicit ideological criteria or by some preconception (for example, any theory that assumes rationality must be false). Stated otherwise, while willing to criticize a theory or interpret it or alter it, the last thing sociologists want to do is test a theory and judge it in light of tests.

I regret to say that my work has not had very much to do directly with suicide prevention, although I must say that I cannot bring myself to condemn the act in all circumstances. My regret is all the more real because the status integration theory has practical implications.
More than is commonly recognized, counselors encourage particular status changes - to marry or not, to remain married or not, to get a job, to change jobs, etcetera - and knowledge of status integration (not just casual knowledge) within the local community could be relevant. To be sure, the theory pertains to variation in the suicide rate and does not purport to explain individual differences. Nonetheless, I am not among those sociologists who appear to deny that a theory which explains both variation in the suicide rate and individual differences would be a superior theory because of its greater range (a dimension of predictive power distinct from predictive accuracy). Moreover, I remain convinced that such a theory can be formulated, with the principal argument being that, at the individual level, weak social relations are most commonly manifested in the termination of social relations. Surely such a theory would promote suicide prevention, and I never cease to argue that an applied program cannot be better than the theory on which it is based.

**GRETHE PAERREGAARD**

Denmark

I was born in Denmark on February the 17th, 1921, the second child of a judge. I had very kind parents and my childhood was very happy, as were the years I spent in school. I met my husband during my medical studies. He is a pediatrician, and we have spent a very happy life together. We have two sons who are both doing fine, the oldest a pediatrician like his father and the youngest an anthropologist working mainly in South America. As for my hobbies, my major one these days is taking care of my grandchildren whenever I am needed.

After graduating from medical school I became fascinated by mental disorders, and I decided to become a psychiatrist. During my education for some years I worked in the psychiatric department at Bispebjerg Hospital, a large hospital in Copenhagen. All cases of poisoning in Copenhagen including attempted suicides were admitted to this department, and the head of the department, Carl Clemmesen, had developed new and revolutionary ways of treatment. My interest in suicide was evoked, and I discovered that very little had been published about the subject, in spite of the fact that Denmark had been known for its high suicide-rate for 150 years.

My thesis (Attempted Suicide and Suicide in Copenhagen) was accepted by University of Copenhagen and published in 1963. It was written in Danish and not in English, which I still regret, but at that time the economic situation did not permit a translation. During the following years I gave several lectures, published papers and participated in international meetings and congresses on the subject of suicide.

In the same year that my thesis was published I was appointed chief-physician at the psychiatric hospital in Copenhagen County, a position from which I retired in 1991.

I no longer work on suicide, and I think that my reason for giving it up was that I did not foresee any new developments in the field. Human nature has not changed. There has always been, and I believe there will always be, suicides, with the rate moving a little up and down, depending on external factors.
I was born on July 17th, 1928, in Düsseldorf (West Germany). My father was a physician and my mother a teacher. I grew up at home with two older sisters. I spent a nice childhood in my parent’s house, started school at the age of six, and attended the Humanistische Gymnasium at the Klosterstrasse in Düsseldorf from the ages of ten to eighteen. I graduated in 1947 with the Matura, grade 2 (B), in Latin and Greek after also serving from 1944 to 1945 in the Second World War (1939-1945) in the air-defense. After this I studied Philosophy, Theology and Psychology at the Universities of Cologne, Bonn and Fribourg from 1947 to 1951, graduating in 1951 with the Philosophicum. Thereafter, I began the study of medicine in Munich and graduated in 1957.

I had an assistantship in internal medicine, and in 1958 I began to study psychiatry at the State-Hospital Haar (near Munich) under the supervision of Professor von Braunmühl and later at the Max-Planck-Institute for Psychiatry under the supervision of Professor Dr. Paul Matussek. In addition to this, I trained as a psychoanalyst at the Academy of Psychoanalysis in Munich under Fritz Riemann. From 1970 to 1975 I supervised a psychiatric outpatient department at the University of Ulm, and there I studied medical psychology with Enke, Thomae, von Uexküll and others. In April 1976 I became the managing director of the Institute for Medical Psychology at the University of Göttingen.

My interest in suicidology began in 1958, during a visit to the Psychiatric Hospital of Vienna where I met Erwin Ringel and Hans Hoff. My interest in the study of the biology and psychology of depression and suicidal behavior increased during my stay at the Max-Planck-Institute for Psychiatry where I participated in study groups together with biologists, psychologists, physicians and theorizers.

My scientific work focussed on depression and suicide and remains so today. My first monograph on depression appeared in 1971 (Depression and Suicide), with a second edition in 1980, and there followed numerous publications in scholarly and trade journals. I published a second monograph (Suicide and suicide prevention) in 1978, with a second edition in 1983.

In 1972 I founded the German Association for Suicide Prevention along with other German colleagues (Hippius, Henseler, Böker, Heinrich, and others) and was its president for several years. I then cooperated personally and scientifically with Erwin Ringel, and I became member of the IASP and later on its treasurer. I received valuable suggestions from Farberow, Motto, Shneidman, Komstock, Achte, Pöldinger, Diekstra, Speyer, and others for my efforts to organize suicide prevention in Germany.

For my practical work I focussed on public education about suicide and the organization of suicide prevention centers. In my scientific studies I tried, both empirically and theoretically, to explore what seems to be pathological in suicidal behavior and under which circumstances it is normal, and I found that my ideas on the subject of rational suicide were similar to those of Peggy Battin and Ronald Marris. In German-speaking territories I contributed to the criticism of the disease theory of suicide, and I made it possible to discuss rational suicide or voluntary euthanasia in Germany.

I have been a member of IASP since 1975 and a member of AAS since 1983. I participated at the AAS meeting in New York in 1982 and Anchorage in 1985. I have been on the editorial board of Suicide and Life-Threatening Behavior since 1985. I was the treasurer
of IASP in the year 1980, and Erwin Ringel asked me at the IASP Congress in Ottawa in 1979 to found the journal Crisis in Göttingen. For the first three years of publication, 1980 to 1983, I was the editor-in-chief. Raymond Battegay took over the editorship in 1984. For a long time Crisis was the only international journal in suicidology, and it has achieved a high visibility in the field.

I have not given up my interest in depression and suicide, and I continue to work on the exploration of suicidal behavior. A working association for the exploration of suicidal behavior which I founded meets regularly in workshops and small meetings. We investigate the social influences on suicide and the multifactorial determination of suicide acts. We have found that biological factors are only one among many factors which determine suicidal behavior. The life history, family and the social background are also important.

Suicidologists in Germany, more than in other countries, have been forced to take part in the discussion of assisted suicide and euthanasia especially because of the history of decisions made in the time of the Nazis. I have taken part in this discussion for ten years, and my position is liberal and enlightened. I have made close contacts with jurists and philosophers in attempts to influence legislation. The euthanasia movement in Germany has been highly popular since 1980, and it is not contradictory to the suicidology movement. Modern developments in medicine compel the discussion of assistance to the dying and assisted-suicide. Suicidologists and especially the results of empirical research can contribute to a rational discussion of these issues.

My hope is, that my involvement and effort in the field of suicidology in Germany for the last quarter of a century has contributed to an open recognition and discussion of suicide as a possible rational choice for people.

The last international IASP Congress, in the Fall of 1991 in Hamburg, fulfilled this hope. In many contributions and discussions, it was obvious that the disease theory of suicide is not predominant and that suicidal behavior is now considered to be a rational choice for people. This was different fifteen years ago, and I hope that research and reasoned discussion will continue in the future and that I will participate in this until the end of my life.

In my professional life, I have received much support from my wives and my friends. I have a daughter from my first marriage, Alexandra, who is now thirty-two years old and lives in Berlin with a daughter aged three, making me a grandfather. I was divorced in 1966 and remarried in 1986. My second wife has two children, Cathrine aged twenty living in Hamburg and Christoph aged eighteen living in Göttingen. Alexandra works in the film industry, Cathryn is a hair stylist and Christoph is a student. All the children love the United States, and we have many friends there, especially in Oklahoma. I enjoy visiting foreign countries, especially Italy. I like the cuisine from Tuscany, and I often cook dishes from that region at home. For relaxation, I like to read classic literature, play the piano and organ and engage in sports.

NILS RETTERSTØL
Norway

I have worked in suicidology, both in clinical treatment and research, for the last thirty years. However, as I am a clinical psychiatrist, I have also worked on many other topics in
psychiatry. Working in a small and sparsely populated country, every psychiatrist has to cover a relatively broad field, and few can specialize on a specific topic.

Why did suicidology become one of my fields of interest? This may be due to several factors. It is impossible to work in psychiatry without being curious about the reasons why people try to take their lives and what we can do to prevent their deaths and make their lives more tolerable. That curiosity motivated my first follow-up investigation of a sample of consecutively-admitted suicide attempters to the University Psychiatric Department in Oslo. This study was published as a monograph by the Oslo University Press and by Charles Thomas in the USA in 1970. This study was also awarded the King's gold medal for psychiatric research. The late Professor Erwin Stengel was my adviser in this project and was kind enough to write the foreword. In 1969 I participated in the International Association for Suicide Prevention Congress in London and met important people in the field of suicidology who have had a strong impact on my further development, among them Erwin Ringel and Erwin Stengel.

Few personal follow-up studies had been undertaken up to that time. The study included 85 patients, with an observation period of two to ten years. There was a considerable excess of deaths from suicide compared to the average population. Eighty percent expressed gratitude that they had survived, and many felt that the suicidal act had helped them to obtain treatment for their psychiatric disorder. For many, the attempt represented a turning point in their life, and 80 percent were functioning well at follow-up. The suicidal attempt had had a rather positive impact on the future life of many of the patients.

I continued my research (in cooperation with B. Strupe) in my new position as Professor at the University of Bergen and Head of Neevengarden Hospital (1968-1973) with a follow-up of patients who had been admitted to the psychiatric hospital there for a suicide attempt. I was able to demonstrate a distinctly higher suicide rate in these patients, who were more often psychotic than those in my earlier study of suicidal patients. I then started to work more systematically in the field of suicidology, and I arranged national and international symposia on suicidology at my university.

In 1973 I was appointed Professor of Psychiatry at the University of Oslo and Head of Gaustad Hospital. In these positions I have also been lucky enough to continue my studies in suicidology. In 1976 I was appointed Chairman of the Nordic Group for Suicide Research. This group consisted of ten prominent researchers, two from each of the Nordic countries. We studied the differences in the suicide rates between these countries which are closely related in culture, language, ethnicity, religion, economy and social systems. Norway had a suicide rate one third of that in the other countries. Books had been written on these topics, but with little scientific background, however. The first aim was to find out if the official statistical procedures were similar enough so that comparison was at all possible. It turned out that the differences in the suicide rates were real, and that official Scandinavian suicide statistics were reliable. The next step was to evaluate reasons for the low rate in Norway compared with that in the other countries. The Danish-Norwegian sociologist Unni Bille-Brahe constructed a theory based on the concept of social integration and compared Denmark, a high-suicide country, with Norway, a low suicide country. It turned out that social integration for both sexes, was considerably lower in Denmark than in Norway. The degree of social integration was especially low in those groups who were characterized by a high rate of suicide. The results were in agreement with findings reported by the Finnish sociologist Erik Allardt, the Austrian family research group in Vienna and the American social anthropologist Raoul
Naroll. Professor Niels Juel-Nielsen of Denmark (now deceased) was Chairman during the second three year period, and the results were presented as a monograph supplement in 1987 in Acta Psychiatrica Scandinavica (supplement 336).

In recent years I have studied developments in Norway where the suicide rate has doubled during the last twenty years. As a matter of fact, the increase in the Norwegian suicide rate ranks sixth in the world and second in Europe (after Ireland). The increase in suicide rates has been highest in nations with traditionally low suicide rates. In Norway the increase has been highest in young males (aged 15-29 years), giving this group as high a suicide rate as youths in Sweden and Denmark. (Youths in Finland have an even higher suicide rate). The explanation for this development is probably that the loosening of ties within family and neighbourhood groups came later to Norway, which kept the more rural and religious traditions longer than the other Scandinavian countries. However, the increase is now moving the suicide rate to a level comparable to the other Scandinavian countries.

My recent studies have explored these developments in detail, and I have been able to show that older people (especially males over 80 years of age) have experienced a steep increase in their suicide rate and the male/female suicide rate ratio is now 6:1 compared to 3:1 in the other age groups.

During the seven year period 1975-81 all suicides in youths (aged 15-29 years) in Oslo (in all 148) were analyzed (with the help of Hesso and Ekeland). It turned out that one third of the youths had been psychiatric patients, with half of this group being admitted for drug or alcohol dependency and half for psychoses. Half of the patients were intoxicated at the time of their suicide. The next seven year period (1982-88) has now been studied. Surprisingly, there has been no increase in numbers (142 persons), but the same tendencies have been found. It seems that the increase in the suicide rate in the youth is now taking place in other areas of Norway (an increase of five times in Finmark, in the high north, where much social dislocation has taken place and unemployment is high).

Among my other studies are those on suicide in patients in psychiatric institutions (with the help of Hesso). We have been able to show that this increase started in 1955, after which a steep increase occurred, probably due to the newer and freer milieu-therapeutic approaches and to the introduction of neuroleptics and antidepressants. The increase was shown to be similar in Sweden and Finland, but the trend now seems to have stopped, and a decrease has been observed. I have also studied suicide in specific psychiatric diagnostic groups. In my dissertation thesis on paranoid and paranoic psychoses (1966), which included a personal investigation follow-up of 300 patients, I was able to demonstrate a twenty-fold higher suicide rate compared with the general population. This group of patients, consecutively admitted to the University Psychiatric Department in Oslo, has now been personally re-investigated by my coworker, Opjordsmoen, giving an observation period of 22 to 39 years, close to a life-long follow-up. The suicide rate is now only ten times that of the general population, but the rate of suicide attempts has increased astonishingly. The suicide rate is highest for patients with hypochondriacal delusions and lowest for those with more clearcut persecutory paranoid symptoms.

I have given much attention to the methods for committing suicide, and I have in several publications in the last few years been able to show that tricyclic antidepressants are now the drugs most commonly used in fatal cases of suicide, having surpassed all other means. I therefore have advocated use of less toxic antidepressants whenever possible.
As the senior suicidologist in Norway, I have been lucky to supervise many young doctors and psychologists in training, some of them working on dissertations which have led to successful studies. Many young psychiatrists are now engaged in research in suicidology and working on treatment procedures for suicidal patients.

I have felt a special responsibility for education of the population in general and for breaking down the many taboos associated with psychiatric disorder and suicide. Therefore, I have been involved in several education programs on television on these subjects. However, my main educational contribution to suicidology probably is my book "Suicide" (in Norwegian: "Selvmord"), which is now considered a classic on suicide in the Nordic countries. This book appeared in its first edition in 1970 and has been constantly revised, with the latest (fifth) edition appearing in 1990. The book is to be published in English by Cambridge University Press.

I am also constantly involved in giving courses in suicidology to doctors and other health professions all over Norway to the extent that my other duties permit. In order to further a national program for suicide prevention, I have met members of Parliament and also officials in the Ministry of Health and Social Affairs. A national program is now being prepared and will be presented at the end of this year (1991).

My international involvement in the International Association for Suicide Prevention (IASP) has been most fruitful for my development as an expert within the field. I have taken part in most of the congresses. I have been the national representative of Norway since 1971. I have been a member of the Executive Committee of this organization since 1983 and President for the years 1989 to 1991. It has been a most valuable experience. It is my conviction that IASP has played a very important role in suicide prevention in the world and will do so even more in the future, in cooperation with WHO. A new academy for research on suicide was created in 1990 in Padua, and I am sure that there will be a close and fruitful cooperation between IASP and this research academy.

My involvement in suicidology has, however, been only one of several fields of interest in my professional life. My most important contributions to international psychiatry most probably are my studies on the long-term course and outcome in paranoid psychoses (delusional disorders).

These studies have been in progress since 1958 and have been published in two books (by the Oslo University Press in 1966 and Charles Thomas in 1970), followed by a great number of articles in international psychiatric journals on aspects of delusional disorders. A new and comprehensive follow-up of the 210 still-living patients has been undertaken by Opjordsmoen (1989), allowing a follow-up period of 22 to 39 years. The course and outcome was better than expected (about 60 percent were non-psychotic and at work at the first follow-up, with a somewhat smaller percentage at last follow-up - 44 percent).

Among my other research fields can be mentioned drug addiction and habituation, a field related to suicidology. I have also carried out follow-up investigations of drug addicts, this time of 122 patients, resulting in a monography from 1964 (with A. Sund: "Drug addiction and habituation").

From 1969 to 1991 I have been the Head of the Norwegian Information Bank for Narcotic Problems, a position which has also broadened my knowledge of suicidology. I have published more popular books, such as "Drug Dependence" (in Norwegian: "Stoffmisbruk"), which has also appeared in five editions since the first one in 1970 (the most recent in 1987),
and which has also appeared in Swedish and Danish editions. For several years I have been
European Editor of the Journal of Drug Issues.

I have also been the administrative and medical administrator of two psychiatric hospitals
for twelve years, and I have described the changing and modernizing processes and evaluated
these changes in two books (1974 and 1978). Together with Leo Eitingier I have been author
of a Norwegian textbook in psychiatry (in three volumes), now in its fourth revision since it
psychiatry and have, since 1987, been the Chairman of the Norwegian Commission on
Forensic Psychiatry.

I feel it has been an advantage in my national and international contributions to
suicidology that I have a broad orientation as a result of my clinical work and research in
other fields of psychiatry and my experiences as a hospital and clinical administrator. This
has given me, I suppose, better access to national health authorities and politicians and also to
international forums outside suicidology. Suicidal problems are deeply involved wherever a
psychiatric disorder is present.

I have had the pleasure of being honored for my accomplishments within my profession.
I was appointed Commander of the Royal St. Olav's Order by His Majesty The King of
Norway. I am also an elected member of the Norwegian Academy of Science and Letters and
have received a prize for research from the Norwegian Research Council. Internationally, I
have become honorary member of the Swedish Psychiatric Association and a corresponding
member of the Finnish, German and French Psychiatric Associations. I have been a visiting
professor in several countries in Europe, the USA, China and Japan. I am on the editorial
board of several psychiatric journals, including co-editor of Psychopathology and European
erator of Journal of Drug Issues (USA). I am a member of the Board of Association of
European Psychiatrists, the Section on Psychopathology in the World Psychiatric Association
and Vice-President of the same section of Association of European Psychiatrists.

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I think the reader will by now be fed up with all this information about my professional
status. I am also a very ordinary man, coming from the farming part of Norway. My old
family farm, Retterstol, in southern Norway, near Kristiansand, has been in my family since
1576. For more than 400 years and fifteen generations this farm has passed from father to son.
As the oldest son, I am the present owner of the farm, and my oldest son will be the sixteenth
generation. My father was the first in the family to have an academic education, beginning as
a teacher, after which he graduated from the Faculty of Law at the University of Oslo. He
became an administrator in the Ministry of Church and Education. Because of this, my
childhood and schooling was in Oslo. My home was an academic one, with a warm and
caring atmosphere, and with strong ties to Norwegian traditions and old values.

We still keep old, rural, agricultural and forestry traditions in Norway. Most Norwegians
trace their family farms back two and three generations. Retterstol was good agricultural land,
but since 1960 it has been under water because of the construction of a dam for electrical
power which elevated the river sixteen meters above the original level, thus depriving us of
all of the farming land and the farm houses. However, the forests are mainly intact, and so I
can continue to be a forest farmer. We have built two huts, a stable and a food-house in the
new surroundings, and that is where I spend my holidays, far away from civilization and from
populated areas. In the holidays I spend about three hours a day in my "office hut" for writing and mental activities and about three hours at hard work in the forest (planting and forest-cultivating). The rest is time for leisure, fishing and family life - an ideal combination, from my point of view. The rest of the year I travel much in Norway and internationally, and four of five weeks in these peaceful surroundings is relaxing for the soul. I am happy that my sons join me in the forest work, so that we are a family team at work.

I married in 1958 to Kirsten, a psychiatrist nurse, who shares a lot of my professional interests. Our daughter, Trine-Lise, is a nurse, and also educated as teacher at the University of Oslo. Through her we have three grandsons who continue the life-circle. Our oldest son, Kjetil, who by law will inherit the Retterstol farm, finished his medical education in 1990 and is a licensed doctor, now working in surgery. Our youngest son, Lars, is studying medicine and has a further year of study. So in our family, our interests have been narrow, and all my children have ended up in the health profession. However, like their old father, they seem happy with their choice.

With the little amount of leisure time I have left, I enjoy outdoor life, especially skiing during winter time. Here skis can be put on from the door, and we disappear directly into the deep woods surrounding Oslo. I am fond also of reading literature, and lastly I should mention my interest in languages. Even when taking student examinations in the fields of science, I also took examinations in Latin, which has always been useful to me. Speaking Scandinavian languages is of use only within Scandinavia. Knowledge of English and German, and a little French, has been a great advantage to my professional life.

No doubt, the many international contacts I have made through a long professional life have enriched my life. I look back with great pleasure on the meetings, conferences, symposia and lectures I have attended. And I hope to attend more, even if my pension time is approaching. (Being sixty-seven this autumn, I can choose to take my pension then, or to stay for up to three years more at work.) As long as I go to work with pleasure every day, I prefer to stay a few more years, if my health permits.

Through this book, I would like to greet all my friends and colleagues working in suicidology and express the hope that we will succeed in halting the ever-increasing suicide rates.

JAMES F. SHORT, JR.

USA

I was born on June 22, 1924, four days after my mother's and a month after my father's twenty fourth birthday, and almost a year to the day after their wedding day. I was their first born. Two more boys followed, after two and six years, respectively. For as long as I can remember I have been very conscious of being the first-born child of my parents, and the older brother in the family. Only after my own first born, a daughter, came into my life did I appreciate some of the deprivations and difficulties my mother must have experienced while living in an otherwise all-male household. No wonder she has appreciated her daughters-in-law so very much!

In earlier papers similar to this one I have discussed many of the family, religious, and community influences that have shaped my life, and that continue to do so. The most
important of these, I suspect, were the strongly protestant and small town influences of early childhood, and the fact that I was born in an Illinois prairie farmhouse on land homesteaded by my German great grandfather and his Irish wife, in the same house in which my mother was brought into this world. My attempts to evaluate and cope with contradictions and conflicts between those aspects of my heritage -- their strengths and their limitations -- and lessons learned in the course of half a century of study and research continues to be reflected in my approach to life and to sociology.

I wanted vaguely to become a sociologist while I was still in high school, long before I knew what sociology was or what sociologists did. My father was principal of the high school I attended, and he taught a course called sociology. The course was mainly about social institutions, particularly those institutions that had been created to address human frailties and problems -- the poor and the orphaned, the deaf and the blind, the criminal and what were then called the "insane." I recall vividly a field trip to the nearby city in which were located the two state schools for children who were deaf and those who were blind, and the "insane asylum."

It was while visiting the latter that my father introduced me to one of the resident physicians of the asylum. The introduction was special because, as my father explained, this was the doctor who had brought me into this world!

Despite the dreariness of the state schools, especially the asylum, I was not deterred from my vaguely held ambition to become a sociologist. There were no other sociology courses in the high school and, when I went to enroll in my first college classes (at a small denominational school), sociology as such was absent from the curriculum. Instead, there was a general survey course in the social sciences, taught by a political scientist.

I took that course, and enjoyed it, but I still wondered what sociology was all about. The United States had entered World War II during my senior year in high school. I enlisted in the Marine Corps Reserve during that first year in college and was sent to a new Navy V-12 unit at Denison University the next summer. Despite the accelerated curriculum of the V-12 program, students were allowed a few elective courses, and it was there that I had my first exposure to a formal sociology course.

Sociology at Denison also emphasized social institutions, such as the family, and social problems, such as crime. Special emphasis was placed not on research or how to do it, but on what to do about things that go wrong with social institutions and how to address social problems. It was not until after the war, and service in the United States occupation of Japan (where my experiences were of a quite different sort, but also quite influential in shaping my vision of sociology), that I discovered what sociology was really about. I had been inspired to aspire to a PhD in sociology by a professor of philosophy and religion at Denison University, who believed in his bones that the sun rose and set by the University of Chicago. That aspiration was not nourished, I might add, by the University of Chicago PhD in sociology who chaired the department at Denison and who taught and lived in the tradition of the "social gospel" sociologists who wished to transform the world according to their understanding of Christian principles.

My application to the University of Chicago was at first rejected, and in the spring of 1947 I went to Chicago to plead my case. Louis Wirth granted me the privilege of an interview, I suspect, because he was chairing the departmental admissions committee (surely an onerous task). I cannot for the life of me recall what I said in response to his query as to
why I should be admitted to the department for graduate study. (He left unspoken the implication that there were many deserving others against whom I was competing.)

I left Chicago following that visit with the distinct impression that I had not made much of an impression on Wirth and without a clue as to whether I might be accepted for graduate study. Before leaving, however, I made a truly exciting discovery. While browsing through a used book store I came across Park and Burgess's "old green Bible," Introduction to the Science of Sociology, a book I had only heard about -- and that, during the last semester of my senior year at Denison. To the sophisticated reader it may be difficult to appreciate what that book meant to me.

So this was what sociology was about! I had long wondered, for there seemed to be little coherence to either the institutions or the social problems I had studied in classes, no rationale as to why some problems received more attention than others, and the knowledge base for "solutions" to problems was flimsy, at best. Park and Burgess identified general social processes and research methods that promised answers to my concerns and that held out the hope that a science of society might be possible. I began to develop a deeper understanding of my heritage, and a much richer appreciation of my experiences in Japan -- of what it meant to women to be able to vote for the first time in a national election, for example, or of the power of culture to transform personalities and whole peoples (see Short, 1988). What a revelation! My excitement and relief upon receiving notice that I was accepted for graduate study at Chicago was palpable.

Discovery of what sociology was really about did not translate into easy success in graduate school. I struggled during my first quarter at Chicago, and was sustained largely through the friendship of fellow graduate student, Andy Henry, and the love and support of the Denison sweetheart I married at the end of that first quarter. I struggled, too, with what I wanted to do with the rest of my life -- whether to seek a teaching position at Denison or some other strong liberal arts college, for example, or to locate in a research university, or possibly to find some other line of work. It was not until my last year in graduate school that I resolved such questions in favor of a research university position, more about which below.

Chicago, when I arrived for the fall term of 1947, was very much an "old guard" -- and an "old boy" -- department. Ernest Burgess was chair, and new graduate students who knew about such things came to study with the likes of Burgess, Herbert Blumer, Philip Hauser, Everett Hughes, William F. Ogburn, and Louis Wirth. The caveat, "who knew about such things," is deliberate, for, strange as it may seem, many in my cohort knew little about these men or their work. Certainly, I knew little of sociology or of Chicago at the time, for sociology at Denison did little to acquaint me with the important research or theoretical issues of the day. But I had good reason to trust the judgment of W. Alvin Pitcher, the professor of philosophy and religion, because he was young and enthusiastic, and he had helped me to cope with increasing doubts about my own conservative religious upbringing in course work and in long conversations and introduced me to the work of critical philosophers and theologians. And it was he who had introduced me to my future wife.

These remarks about my background are important, not only because they illuminate my own curiosity and confusion, but also because many of the students who stumble into graduate school even today, including many whom we actively recruit, are pretty naive about what sociology is about, and what it is that sociologists do. I suspect this is equally true of other disciplines. It also serves to emphasize the importance of a very broad grounding in any discipline, its sources, methods, and directions.
At the reception for new graduate students in that fall of 1947, Mr. Burgess introduced the faculty and their research interests, his own program at that time centering on what he preferred, for personal reasons, to call "later maturity." Burgess must have been 61, which to me seemed ancient, but which now seems quite young! I remember, too, that there was an atmosphere of camaraderie in Burgess's remarks, and there may even have been hints that at certain other well-known institutions some of the faculty hardly spoke to others or, if they did so, it was in an antagonistic tone. Only later were we to discover that relationships among several of the senior faculty at Chicago were barely civil.

A research methods survey course was required of all entering graduate students at this time at which most members of the sociology faculty, and faculty from a few other departments, discussed their research. Lloyd Warner discussed his "Yankee Town" work and Robert Redfield his folk society research, for example. Both were highly entertaining as well as edifying. The course had a practice component, and Hal Wilensky will recall, I am sure, that we trod the streets of Hyde Park in search of interview subjects. I later interviewed several persons who had proven to be "hard to reach" in Burgess's study of the aging. Ethel Shanus was Burgess's principal assistant, and she was enormously encouraging and helpful to me as I struggled to learn the craft of observation and open-ended as well as fixed-response interviewing. Ethel was also handling editorial chores related to the monumental tome, Introduction to the History of Sociology, edited by Harry Elmer Barnes, and I recall being tremendously impressed on that account too.

The survey course on research methods was a great experience, but beyond this there was little emphasis on formal research training in the required curriculum. The assumption seemed to be that one would "pick up" the skills necessary to do research in the course of doing it, with the aid of one's major professors. That, in fact, was pretty much what happened in my case. I discovered another "old guard" Chicago sociologist that first term when I took a course in sociology of religion from Sam Kincheloe, whose appointment was in the Chicago Theological Seminary. Dr. K, as most of us called him, was a hands-on researcher in the Park and Burgess mold, and he closely supervised my master's thesis. Everett Hughes was also on my MA committee but, because he was in Frankfurt, Germany during crucial periods of the research, I had little contact with him, much to my regret.

I met other old guard sociologists during that first year as well, most notably Clifford Shaw, who had a profound influence on both my intellectual and personal development. It was he who first suggested self-reports as a means of studying juvenile delinquents, modeled after the then new "Kinsey reports" on sexual behavior.

Sociological theory, beyond Wirth's historically-based survey courses, was handled in much the same manner as were research methods. We read the old masters and some of the new ones. Wirth was not a Parsons enthusiast, but we were encouraged to read The Structure of Social Action. Sorokin seemed to be regarded as a more important theorist than Parsons, however, or so it seemed to me.

Both theory and methods were important topics in virtually every course to which I was exposed at Chicago. The result, I now believe, was that we learned a good deal about theories and methods but little about formal theory or research methods that might have been considered "state of the art," or on the "cutting edge." Louis Guttman presented a colloquium on his then new scaling methods, and that was impressive. But statistical training was pretty elementary. The old guards were all pretty much set in their ways and interested chiefly in
communicating those ways toward the acquisition of knowledge, understanding, and at least in Wirth's view, means of intervention and control of a variety of social ills.

Ogburn, the most influential member of the faculty for me, exemplified both the strengths and the weaknesses of the Chicago department during my tenure as a graduate student. Known as a "hard-nosed" researcher, always asking what do the data (pronounced "datar") say, his interest in statistical methods seemed arrested. He never spoke of the work that Sewell Wright was developing at Wisconsin, for example. We read Marx for him mainly, it appeared, in order to acquire a greater appreciation for the role of technology in social change, neglect of which, Ogburn believed, was Marx's "Achilles heel."

Still, I adored Ogburn. Almost uniquely among Chicago graduate students of the day, Andy Henry and I formed a sort of "fan club" for Ogburn, and both of us worked with him as our major PhD professor. Andy and I studied together and, with our wives, socialized together. Perhaps because my post-war cohort was exceptionally large, Chicago faculty socialized little with graduate students of my acquaintance, and special interest cliques played an important role in student culture. We were thrown pretty much on our own as far as the faculty were concerned and that, for me, proved to be a great advantage. I learned a lot from graduate students such as Andy Henry, Hal Finestone, Al Elias (who later became Director of Corrections in New Jersey), and others whom I knew less well at the time, such as Howard Becker, David Gold, and John Winget.

I also learned a good deal from my first teaching experience, in the spring of 1950, at the Illinois Institute of Technology, where I was hired by Herbert Simon to teach introductory sociology (a course I had never taken). Simon was an intellectual dynamo, and the occasional luncheons I shared with him and other members of the small social science faculty at IIT were intellectual feasts.

I held two other jobs while still in graduate school--both to gain experience and to supplement my G.I. Bill income. The first was as Secretary of the City Planning Advisory Board, a newly established citizens advisory group of some 200, appointed by the Mayor of Chicago. The job was obtained through the good offices of Clifford Shaw, who was a good friend of the Board's chair, a Chicago business man. Working on the composition of the Board, and working with it, gave me numerous opportunities to "practice" sociology. My other job during these years was teaching at the South Bend extension of Indiana University, which I did for the 1950-1951 academic year.

**On Suicide and Homicide**

Sooner or later, every graduate student learns something about suicide, if only by virtue of exposure to Durkheim's early work. As I read *Suicide* and others of Durkheim's classic works, the chief attraction of suicide as a research topic -- probably due to the influence of Ogburn -- was its utility as a social indicator. My main interests in sociology at the time were in crime (the influence of Shaw) and in religion (the result of increasing personal conflicts between my conservative religious upbringing, sociology, and personal experience, as well as the influence of Kincheloe). With Ogburn's encouragement, I decided to do my dissertation on the relationship between business cycles and crime. Andy Henry had chosen as his dissertation topic the relationship between business cycles and suicide. We were influenced in this quest, not only by Ogburn, but by the earlier work of Dorothy Thomas and others on
social aspects of business cycles. We struggled together to find reliable indexes of business activity and, separately, of suicide and crime. Andy's was the easier problem. Suicide, after all, is an extreme form of human behavior, one for which social accounting is reasonably stable and reliable. Crime is another matter. For a variety of reasons, I decided to focus on nationwide data on the most serious crimes, as collected by the Federal Bureau of Investigation. The most serious of these, of course, is homicide, which is difficult to conceal and the most reliably reported of all crimes.

When Andy and I had completed our dissertations we realized that suicide and homicide were distributed very differently among social categories and they differed in their responses to business cycles. The most obvious difference between suicides and homicides as human behaviors are their objects, or victims -- the self versus some other person. It was this difference, we felt, that provided the clue to theoretical resolution of the empirical differences we observed. Andy took the lead in theoretical development, we did some additional research in order to explore the theoretical relationships toward which our thinking guided us, and the result was the book, *Suicide and Homicide*. While that was not the first publication to come out of my dissertation, it was by far the most important.

When that work was completed we felt we had come close to understanding the psychological, sociological, and economic correlates of extreme forms of aggression. Andy continued to explore these relationships, especially the psychological correlates of aggressive behavior, while I turned to further studies in juvenile delinquency. Any possible further collaboration was cut short with Andy's untimely death.

**Washington State University and a "New Guard" at Chicago**

The old guard was changing in post-war Chicago. Al Reiss was secretary of the department while I was a graduate student, Leo Goodman arrived during my last year, and Ed Swanson and Tomatsu Shibutani both taught in the college for a time. Ralph Turner, Morris Janowitz and Ed Gross had only recently completed their graduate work. Dudley Duncan returned to Chicago just in time for my final PhD oral examination (and proceeded to ask some embarrassing questions!). Ogburn and Burgess retired following the summer term of 1951, my last as a graduate student. Blumer left for California, and Wirth died shortly thereafter.

The job market was tight for the 1951-1952 academic year. Mr. Burgess, who remained as chair of the department until his retirement, recommended that I accept a one-year position at Washington State University (at the time it was still the State College of Washington). The early years at WSU, including the first one, were filled with almost frenetic activity, personally and professionally. Our family grew when Susan was born during our first year in Pullman, and son Michael followed four years later. A permanent position opened in the spring of 1952 and, to make a long story short, I accepted it. We had enjoyed many new friends and supportive colleagues, and living in the northwest was, and remains, very special to us.

Teaching loads were heavy, however, and each semester brought new course preparations. My work with Andy Henry continued, and in addition I managed to write a couple of articles based on the dissertation. After the first year of teaching, however, I applied for a Social Science Research Council Faculty Fellowship which would enable me to lighten
my teaching load by one-half, to only six hours (today's standard load). The application was successful, and I began a research program to develop self-reported measures of juvenile delinquency, and to use those measures to test a variety of theories of delinquent behavior. Studies of youth groups were also an outgrowth of the SSRC fellowship, resulting in collaboration with Albert K. Cohen.

The years at WSU were interrupted when, in 1959, I returned to the University of Chicago to study delinquent gangs. Funded by NIMH, the study was the largest such inquiry in the country at the time. Again, issues of measurement and theoretical development and testing were the primary goals. Over a period of more than a decade, the study resulted in many publications with a variety of collaborators, most notably Fred Strödtbeck and other faculty and graduate students (at both Chicago and WSU) who worked on the project.

Chicago had changed greatly when I returned in 1959. Phil Hauser chaired the department, and only he and Everett Hughes remained of the old guard. Peter Blau, Donald Bogue, Jim Coleman, Jim Davis, Phil Ennis, Elihu Katz, Pete Rossi and Fred Strödtbeck had joined the faculty, and Vernon Dibble, Harrison White and Mayer Zald had just arrived, fresh from their PhD degrees. Duncan, Goodman, Hughes and Warner remained, Morris Janowitz had returned, and Evelyn Kitagawa had joined the faculty. Coleman, Hughes and Warner left soon thereafter, the latter two because of Chicago's unyielding mandatory retirement policy. It was an exciting place once again -- in retrospect, much more so than it was during my graduate student years. A new generation of graduate students also had arrived, including such latter day luminaries as Stan Lieberson, Reynolds Farley, Hal Winsborough, Bill Hodge, Dick Scott, David Heise, Kai Erikson, Bob Gordon, Bob Dentler and Whitney Pope. Heise, Gordon and Pope all worked at one time or another on our gang projects, as did many others such as Ramon Rivera, Laura Thomason Fishman and John Moland, all at Chicago, and Ray Tennyson, Harvey Marshall and William Bailey at WSU.

The point to the story of sociology at Chicago, as well as my own story, is the necessity for change and renewal. Chicago was, and is, a great department, but the old guard could not sustain the intellectual momentum that had propelled it to eminence. It regained that momentum when it turned outward (to Columbia, Harvard, and elsewhere) and to young Chicagoans such as Duncan and Janowitz, strategies that have continued to nourish "Chicago sociology" to the present day. Among these, I am proud to say, is William Julius Wilson, who received his PhD from Washington State University.

Old and New Guards at WSU

I returned to Pullman in the fall of 1962, and here I have remained except for several visiting and other types of temporary appointments (e.g., service as Co-Director of Research for the National Commission on the Causes and Prevention of Violence, in 1968-69) and in other universities here and abroad. Over these years I have played many roles at the WSU and in other places, and I have been awarded many honors -- fellowships, elected and appointed positions and other types of recognition by universities and professional associations.

WSU has been very good to me, and Pullman has been a wonderful place in which to live and work. The Department of Sociology, always a strong department, has become much stronger over the past few decades. The old guard has changed here, also, with deaths and retirements -- Fred Yoder, Paul Landis, T. H. Kennedy, Vernon Davies, Milton Maxwell, Joel
Montague, Ivan Nye, John Lillywhite and Wallis Beasley have departed — all were fine colleagues. Prominent scholars and excellent colleagues such as Irving Tallman, Charles Tittle, Peter Burke and Lewis Carter have been recruited. Some have come and gone (Jack Gibbs and Bill Rushing, Sandra Ball-Rokeach and Milton Rokeach, Lois and Melvin DeFleur, Charles Bowerman, Marvin Olsen, and Bob Meier, for example). Younger sociologists who were recruited early in their careers have become respected scholars, including Michael Allen, Steve Burkett, Joe DeMartini, Don Dillman, Riley Dunlap, Lee Freese, Victor Gecas, Louis Gray, Marilyn Ihinger-Tallman, Armand Mauss, Gene Rosa, Mark Stafford, David Ward and John Wardwell. The addition of strong, still younger colleagues continues to make Washington State University an exciting place. There are potential luminaries among this (1992) group, as well, I am certain. They include Ed Bassin, Valerie Jenness, Loren Lutzenhiser, Lisa McIntyre, Jan Stets and Amy Wharton.

From the beginning of my years at WSU, outstanding graduate students have enriched the program and many have had distinguished careers, especially in family and in environmental sociology and in criminology. The best known among these have been the many black students who came to study here, away from any established black community and far from their homes in other parts of the country. In addition to William Julius Wilson, they include my first PhD student, James Blackwell, and Robert Davis, whose dissertation committee I also chaired. These and other former graduate students, such as Geoffrey Alpert and Jurg Gerber, and still other colleagues, young and old in many other places, continue to help me stay active professionally.

CONCLUSION

It will be obvious to all who know me and my work that suicide, as such, has never been central to my intellectual interests. It was very important to my intellectual development by virtue of the collaboration with Andy Henry. I am gratified that the perspective introduced in Suicide and Homicide continues to provoke research and theoretical development.

My scholarly interests have continued to develop in a variety of ways over the years. Though juvenile delinquency continues to be a major preoccupation, and recent service on a National Research Council panel has been challenging, over the past decade I have become increasingly interested in behavior related to risk, a much broader category of phenomena that includes both crime and suicide but is much more inclusive. With Lee Clarke and others, I have studied how organizations respond to uncertainties and risk and in the complex interactions of law and legal behaviors, science and engineering, organizations and institutions in this respect.

My most abiding concern over the years has been to understand the constraints, capabilities and processes of social life, particularly as these are reflected in group, organizational and institutional behavior. We learn a great deal about these matters by focusing on what goes wrong and why. What to do about things that go wrong, as manifested in crime, suicide or reactions to uncertainties and risks has always been of secondary concern to me. Theoretical, methodological and measurement issues are primary, for until these are resolved no amount of study -- no body of data -- can yield the knowledge that is the object of
all research. While I recognize that there are many "ways of knowing," my commitment remains to science as the best way of knowing, and the final hope for humankind.

On a final personal note, family, friends, and life-style considerations have always been extremely important to me. I have been extraordinarily fortunate in these, as well as in my professional life. While I cherish the experiences and the memories of the past, however, I do not "live in the past." Since early childhood I have enjoyed outdoor activities, and continue to do so (gardening, hiking, fishing, chopping wood, etc. -- I once hunted game birds and animals, but no longer). My parents introduced me to the Black Hills, in South Dakota, and I worked on family farms for many summers. My wife and I now spend much time at our home on Priest Lake, in northern Idaho, where our children grew up, and now our grandchildren. Music and other arts have been important influences in my life for many years. I performed vocally at one time, but no more. I especially enjoy classical music, but my tastes extend to jazz and a few other genre. I am enjoying grandfatherhood and working my way into retirement. Relationships with personal and professional associates, at home and in many other places, are important to me and continue to enrich my life.

HERMAN M. VAN PRAAG
ANCHORPOINTS: AN INTROSPECTIVE

Has it All Made Sense?

This, then, is what is has been all about. Today I mark the end of an academic career that has ranged over 45 years. 1952 was the starting point. In that year, as a medical student, I was accepted as a research assistant by Professor G. G. J. Rademaker, a neurophysiologist and the head of the Department of Neurology at the Academic Hospital in Leiden. The neurological research period was followed by a mycological one. Having received my MD degree and completed my military service, I was asked to carry out a study into the prevalence, prevention and treatment of mycological infections in military personnel. For this reason I worked for more than a year and a half in Baarn, at the Medical Mycology Section of the Phytopathological Laboratory, an interacademic institution of the Universities of Amsterdam and Utrecht (1956-1958). Immediately after military service, I became a resident in psychiatry and started, together with the biochemist Professor B. Leynse, a research program into the biological determinants of depression. This period of psychiatric investigation lasted until this very day, albeit in different locations -- Rotterdam, Groningen, Utrecht, New York and Maastricht respectively.

If ever, now is the time in one's career that asks for a retrospective. Did it all made sense and, if so, what gave it sense? The first question I answer in the affirmative; the second question, I will discuss today. My farewell lecture is an introspective rather than a retrospective. This means that my discourse will be very personal. You would expect nothing else from a psychiatrist. An impersonal psychiatrist is a professional caricature.

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6 Farewell lecture delivered on the occasion of the retirement of Professor H. M. van Praag as Professor and Chairman of the Department of Psychiatry and Neuropsychology at Maastricht University, Maastricht, The Netherlands.
Appendix

Well then, my life has had three anchorpoints -- family, study, Judaism. I will now explain to you what they have meant and still mean to me.

**Anchorpoint 1: Family**

My family is the central anchorpoint to which the other two -- study and Judaism -- owe their status. To exist alone would have been an existence in solitude, a way of living that would have been meaningless to me. The touchstone of my life has been the family, and it constituted a major source of energy as well.

For more than forty years now, my wife has lightened my life in the dual meaning of the word. You unburdened me, Nelleke, when I was stressed, and you illuminated my life and imparted to it depth and color. We entered into a true "mariage des émotions." Your nearness has enriched my life in its core and became even more its very quintessence. My gratitude for that can be expressed in words only weakly.

The children and grandchildren embody in my life the principle of continuity, a forward perspective. In them, the shadows cast by the transitoriness of life clears up.

My family is very precious to me and, speaking in more general terms, I attach much value to the family as the basic structure for a humane society, that is, a society, based on tolerance and mutual respect. A humane society is marked by certain features. Its members are willing to accept responsibility for each other and to recognize and acknowledge one another's value. They have experienced that foul and fair can be shared and thereby gain or lose in intensity. They are prepared to subordinate their own interests for the benefit of the public interest, to inhibit particular intentions for the sake of someone else, and to make demands as well. The family is pre-eminent training ground for acquiring and practicing these traits.

Not every family provides this basic training. In some families, mutual care and respect are lacking, and I admit that such families might be the breeding ground for intolerance and egotism. This consideration does not invalidate my argument. I do not maintain that disturbed relations in an intact family are preferable to the misery caused by a broken family. What I do profess is that the pursuit of healthy family relations is worth the effort, first because healthy families contribute to liveable societies, and second because those efforts provide to those who do try a measure of satisfaction that is unequalled in quality and endurance. By way of an analogy, one does not abandon social security because the system is being misused.

In circles that call themselves progressive, my position ranks as waggish, stuffy, narrow, conventional and bourgeois, if not petit-bourgeois, testimony of a reactionary mind. By way of illustration, I cite Bas Blokker, who discussed on July 19th, 1995, in the "Nieuwe Rotterdamse Courant," the revival of David Lear's famous movie *Brief Encounter*. This movie tells the story of a man and woman, both married, who engage in a relationship, a short-lived relationship, because they decide to break up for the sake of their partners and children. The reviewer notes: "the movie ends as a homage to conformism, to a lot patiently born, to petit-bourgeois conventions. If not so beautiful, it would be the perfect movie to be irritated about."

I agree with Blokker that the movie is beautiful. I share his notion that it is a homage to conformism. I reject his view that it is petit-bourgeois to conform to ethical standards pertinent to affective relationships. It is civic behavior, in the most noble sense of that word,
decent behavior which enriches a society, thereby deserving the label "progressive." Only by applying a conceptual travesty, with transposition of the concepts "progressive" and "reactionary" can one reach the reverse conclusion. "Decency", "honnêteté", "Anständigkeit" are words with a dignified cachet. The Dutch equivalent "fatsoenlijk" carries a disapproving valence. This may be called radical -- an endearing word to those who consider themselves leftish -- but it is radicalism of the wrong sort, that is, reactionary radicalism.

My point of view is supported by empirical evidence (e.g., McLanahan and Sandefur, 1994; Thomson and Kaplan, 1996). Broken or dysfunctional families are probably a breeding-ground for disturbances in personality development. They diminish the offspring's chances of well-being and of a successful "pursuit of happiness". Self-confidence and self-respect for instance, are attributes that are strongly modelled in and through the early environment. No surprise, then, that suboptimal familial relationships and personality deviations are related.

Growing up with single parent or in a dysfunctional family is a risk factor, but by no means the only cause of disturbed personality development and neither is it a necessary condition. Just as lack of exercise puts someone at risk of myocardial infarction, many people who do not exercise never suffer a heart attack. In the same way, many children raised under suboptimal conditions grow up manage to live successful lives. Yet, risk factors are there to be avoided.

The "good, old family values," I claim, contribute to personality development and hence to harmonization of human relationships, and so, ultimately, to improvement of the human condition -- to what in Jewish thinking is called "Tikkun Olam," the healing of the world. Their influence is salutary for a society and practicing them, thereby, according to my definition of those concepts, progressive rather than reactionary. The alternative view, challenged by me, bestows the label "progressive" to behavior that is mentally consumptive and egocentric, while behaviors that are self-constraining and altruistic are discounted as "conservative". A value judgment is turned upside down. It is not the only example in modern society.

Are my arguments challengeable? Possibly they are, but in this context, it is irrelevant. This lecture, bears upon my existence and my values not upon generalizations. I put on record that, for me, family values have been the mainstay of my life.

**Anchorpoint 2: Study**

**Incentives**

Studying has been a second anchorpoint of my life. Delight in study was not primarily fed by ambitions or societal aspirations. Neither could it be considered as an escape from war memories, as psychoanalytic friends tried to make me believe. The incentives were of a different kind.

First, I had a profound interest in the mind/body problem -- in more up to date phrasing the brain and behavior problem. From my high school days up I was fascinated by the question how the "substance" we call behavior and experience relates to the functional state of particular brain circuits. Since time immemorial, this had been a philosophical problem. During my student years it became an empirical issue as well. Another driving force was the urge to bring forth something new. Until midway in my medical studies I had literary ambitions. I wrote essays, short stories, poems and was, for several years, literary editor of
Forum Academiale, in those days a national student magazine. I give up this ambition to pursue a scientific career once I had become a research student with Professor Rademaker.

Finally, the unknown captivates me. I love to see things I have not seen before. Studying is for me like undertaking a voyage of discovery, to walk a new trail starting from ignorance, leading via knowledge to expertise. Usually one walks in ways paved by others; at times one succeeds in clearing new routes towards known destinations; rarely one is so fortunate to open up domains hitherto unseen. My study, the library and the laboratory thus developed into unsurpassed travel agencies.

Did my expeditions lead to new vistas? This is a central issue for every researcher -- a fortiori when he makes his adieu. Research requires considerable investments in time, attention and energy. There is much one has to give up. Viewed in retrospect, has it been worth the effort? I think it has, and though self-assessments are almost by definition biased, I take the risk of outlining to you some vistas opened up by me and my collaborators which were, I feel, hitherto unseen or only vaguely seen. They have reference to three spheres: biological determinants of affective pathology, diagnosis and assessment of these disorders and fundamentals of psychiatric diagnosing.

These domains hang closely together. Biological studies in psychiatry presuppose accurate diagnoses, and careful diagnosis requires adequate charting of psychiatric disorders and methods to assess them in a reliable and valid fashion. Weaknesses in one of these links undermines the value of the entire research effort.

Some Scientific Activities

(1) Diagnosis

Over the years, psychiatric diagnosing has been a major concern of my research program. For many years, diagnosis was chaotic, because it was not operationalized and not standardized. Diagnostic criteria were decided by private conceptions which had developed into a "school." With some, but not much, exaggeration one could state that there existed as many diagnostic systems as there were text-books. That state of affairs made research in psychiatry impossible, and it was just that which I wanted to do.

At the start of my residency in early 1958, the antidepressants had just been introduced. They combined a striking therapeutic effect for certain types of depression with a clear effect on central monoamines (MA). This revolutionary finding led me to ask two questions. First, are the therapeutic and the MA-ergic effect of antidepressants connected? Second, are central MA-ergic systems disturbed in depressed patients responsive to antidepressants and are they regulated by these medications (Van Praag, 1962). These questions continue to engage me up to the present time.

I was convinced that studies of this kind would be useless without precise definitions of depressive states. Consequently, we developed a standardized and operationalized system of diagnosing depression. It was the first of its kind (Van Praag, 1962). Mainstream psychiatry, predominantly psychoanalytically and phenomenologically oriented as it was in those days, reacted with annoyance. "Your methods are destroying the very fabric of psychiatry," remarked a prominent psychiatrist in those days after I had presented my approach. Psychiatric disorders were regarded as "the most individualistic expression of the most individualistic emotions," to paraphrase the (Dutch) poet Kloos' definition of impressionistic
poetry. Objectiveness and psychiatric diagnosing were considered to be incompatible. Validity studies of diagnostic constructs were unknown in psychiatry.

Fifteen years later this approach was applied in drawing up the Research Diagnostic Criteria and subsequently in conceptualizing the third edition of the DSM, the psychiatric taxonomy used in most parts of the world by clinicians and researchers alike.

(2) Assessment

Research into the biological determinants of abnormal behavior requires precise and transferable diagnoses as well as methods to assess, and preferably measure, abnormal behavior. In the late fifties, the first observer rating-scale to assess depression had just been introduced (Hamilton, 1960). We contemplated whether it would be possible to de-subjectivize the psychiatric investigational tool, that is, the interview, so as to make the results reproducible and transferable. This idea resulted in the first operationalized and standardized interview to be introduced in psychiatry, the so-called Vital Syndrome Interview (Van Praag, et al., 1965). From the mid-seventies on, the standardized interview technique would be a generally employed instrument in experimental psychiatry.

Collaborating with experimental clinical psychologists, I retained an active interest in the betterment of assessing abnormal behavior (e.g., Plutchik and Van Praag, 1987; Plutchik, et al., 1989; Apter, et al., 1991; Van Praag, 1992a).

(3) Nosological Skepticism

The validity of psychiatric diagnoses has been an issue that I have never relinquished (Van Praag, 1997). The third edition of the DSM was introduced in 1980, the first operationalized and standardized taxonomy of psychiatric disorders. Almost overnight that system was embraced by the scientific community in psychiatry. My judgment was an ambivalent one. I of course welcomed diagnostic uniformity. I had, however, serious doubts about the theoretical premises of the system. I wondered whether this system elucidated or rather blurred scientific discourse (Van Praag, 1982a, 1982b). Let me clarify what I mean.

Since its inception as a scientific discipline some 125 years ago, psychiatry has been greatly influenced by nosological principles. This is reflected in the official psychiatric taxonomy. Nosological thinking presumes the existence of discrete disorders distinguishable from one another, and each one is characterized by a particular symptomatology, cause, course and outcome. A predictable relationship is thought to exist between those quantities. In other words, with a diagnosis such as schizophrenia, major depression or dysthymia, the symptoms of a patient, the course of the disorder and treatment outcome are identified with a fair degree of certainty.

It was this premise I had doubts about. I found hard to demonstrate predictable relationships between type of syndrome, possible causal factors, treatment response and course. In practice, most patients showed composites of several disorders, considered to be discrete, or parts of those disorders. They qualified, for instance, for the diagnosis of a certain affective disorder, a certain anxiety disorder, a substance abuse disorder and several personality disorders. Predictions about treatment response and outcome appeared to be unreliable. Suspected etiological factors were disorder-nonspecific. Furthermore, the biological aberrations shown in psychiatric patients could not be correlated with a particular nosological diagnosis (Van Praag, et al., 1975, 1987a).
(4) Reaction Forms

On these grounds I seriously considered another diagnostic model, that is, the reaction form model. According to that model, discrete, well-delineated and separable mental disorders do not exist. The farthest one can go is to distinguish disease "basins", that is, clusters of disorders that have some features in common, but are heterogeneous notwithstanding (e.g. Van Praag and Leijnse, 1965; Van Praag, et al., 1975, 1990; Van Praag, 1992a, 1992b, 1996a, 1997).

This view takes the line that the various pathogenic factors (biological or psychological in nature -- genetically determined or acquired during life) disturb particular psychological functions via dysregulation of particular neuronal circuits. The extent to which the various cerebral circuits are disrupted depends on such factors as: type of noxious agent(s), weak links in neuronal circuit, and the ability to compensate for particular neuronal derailments. Psychopathology corresponding with the ultimate complex of neuronal impairments thus varies from patient to patient and do not coalesce in discrete disorders but at best in groups, in "basins" of disorders showing some symptomatological similarity but differing as to pathophysiology and etiology. Within the context of this model the group of the mood disorders, the psychotic disorders and the dementing disorders would be examples of such "basins".

Metaphorically speaking, such "basins" are comparable to clouds in the sky -- one recognizes the cloud's existence, but its shape varies from moment to moment and from cloud to cloud.

(5) Functional Psychopathology

The reaction form model has two important consequences, one with respect to diagnosing and one regarding biological studies of psychiatric conditions. In diagnosing such conditions, nosological and syndromal typologies do not suffice but have to be complemented with precise analysis and measurement of the psychological functions being disrupted in a particular case. In the case of a depression, these include, for instance, disturbances in mood, anxiety and aggression regulation, information processing, memory, hedonic functioning, concentration and motor functions. Such a psychological dissection results in a list of those functions being disturbed and those functioning within normal limits. This third stage of the diagnostic process, I have called functional psychopathology. I fancy that functional psychopathology will signify for psychiatry what physiology does for medicine -- the method by which one obtains an understanding of the components of the "psychological apparatus" that are dysfunctional and are underlying a particular state of ill (mental) health. This information is not provided by simply diagnosing a particular "disease" or syndrome.

The second consequence of the reaction form model is that the search for the cause of a "disease", for instance depression, schizophrenia or panic disorder, does not make much sense because depression, schizophrenia, panic disorder and the like do not exist as discrete, homogeneous disease entities. A "basin" of pathological conditions has no unequivocal pathophysiological cause. In medicine one does not search for the cause of the group of abdominal disorders. If indeed mental derangement does not manifest itself in discrete disorders, research into the biology of mental pathology has to shift its focus from the (alleged) disease entities towards dysfunctional psychological domains. Its focus should be the biological determinants of the psychological dysfunctions constituting the
psychopathological condition, rather than "disorders" such as depression and schizophrenia as such.

This reasoning became the very foundation of our research into the biology of disturbed behavior and it turned out to be a productive route, as I will illustrate with a few aspects of our depression research over the years.

(6) Functional Depression Research

We were, as I said above, interested in possible monoaminergic disturbances in depression, responsive to the then just discovered antidepressants. Studying cerebrospinal fluid concentration of 5-hydroxyindoleacetic acid -- the main degradation product of serotonin -- and using the challenge technique to obtain information on receptor function, we indeed found evidence for disturbed, that is, diminished function, of (certain) serotonergic circuits in a subgroup of depression (Van Praag, et al., 1970; Van Praag and Korf, 1971). These disturbances probably play a role in the pathophysiology of the depression, since the aminoacid 5-hydroxytryptophan -- the precursor of serotonin -- appeared to exert a therapeutic effect and, if chronically administered, a prophylactic effect in depression (Van Praag and De Haan, 1980).

These observations, suggesting pathogenetically relevant serotonergic dysfunctions in a subgroup of depression, provided a strong impetus for the goal-directed search for drugs capable of selectively enhancing serotonergic activity. This research line lead to a new class of antidepressants, that is, the selective serotonin reuptake inhibitors, a group including fluoxetine (Prozac).

Disturbed serotonergic activity was evident in some depressives, but not, however, demonstrable in others. Initially, it was unclear to us in what ways the two groups differed psychopathologically. Once we had extended our research program to also include anxiety and aggression disorders, light was shed on that issue. The extension, by the way, was prompted by three observations. First, anxiety and increased inward and outward aggression are common in depression. Second, anxiety and aggression are strongly correlated, across diagnoses (Apter, et al., 1993). Third, in animals it had been demonstrated that serotonin-steered neuronal circuits have an important role to play in anxiety and (certain forms of) aggression.

This new research line, then, clarified why serotonergic disturbances were not ubiquitous in depression. The anxiety component of the depression syndrome appeared to contain important predictive information. Serotonergic disturbances were observed especially in depressed patients with high anxiety scores (Van Praag, 1992a). A second predictor was found in disturbed aggression regulation. In depressed patients with high aggression levels (expressed outwardly, or inwardly as suicidal tendencies) the chance of finding serotonergic disturbances was found to be much increased. Asberg, et al. (1976) were the first to publish these latter findings. They just beat us as to that, wherefore they deserve nothing but praise (Van Praag, 1982).

We, thus, reached the conclusion that the serotonergic disturbances observed in depression, are not specific for depression as such, but for certain psychological dysfunctions, and particularly for disturbed anxiety and aggression regulation. Anxiety and aggression might be pronounced in depression or a subordinate feature. This probably explains why serotonergic disturbances occur in some but are absent in other depressives.
Based on this conclusion we expected that the serotonergic disturbances, originally found in depression, would likewise occur in other (non-depressive) psychiatric disorders with pronounced aggression and anxiety. Numerous observations found indeed to be the case, thus demonstrating that serotonergic disturbances in behavioral disorder do not respect nosological boundaries (e.g. Van Praag, et al., 1987a, 1987b, 1990; Kahn, et al., 1988).

(7) A Diagnostic Acquisition Resulting from Functional Depression Research

I return to my point of departure, that is, functional psychopathology -- the approach whereby the characterization of dysfunctional psychological domains is put in the center of the diagnostic process -- as opposed to nosological thinking, in which the discrete, mutually independent, disorder gets primacy. I conclude that serotonergic disturbances, initially observed in depression, are not specific for depression as such, but specific for particular psychological dysfunctions, that is, disturbed anxiety and aggression regulation, independent of the nosological diagnosis in which those features appear. Biologically, the nosological approach appeared to lead into a dead-end. The functional psychopathological approach, on the other hand, uncovered meaningful relationships between disturbed brain functions and disturbed behavior.

In this lecture I mention one more observation which I consider to be supportive of the functional approach in psychiatry (Van Praag, 1996a, 1997). We could ascertain that in depression with disturbances in serotonin functions, the depression is frequently heralded by increased anxiety and signs of disturbed aggression regulation, such as: irritability, becoming argumentative, a quick-temper, and outbursts of anger. Mood-lowering, if it occurs, manifests itself at a later stage. On these and other grounds we postulated the existence of a subgroup of depression, characterized biologically by disturbances in certain serotonergic systems leading to labile anxiety and aggression regulation, and characterized psychologically in that disturbed aggression and anxiety regulation are the primordial symptoms, while mood-lowering is a subsidiary. This postulated depression type, thus, is not a primary mood disturbance. We named it serotonin-related, anxiety/aggression-driven depression.

If this hypothesis turns out to be true, the treatment of choice for this depression type would not be a regular antidepressant, but a pharmacological agent normalizing anxiety and aggression regulation via stabilization of (a particular subsystem of) the serotonergic circuitry. Such subsystem-specific serotonergic compounds are presently in development and will permit this hypothesis' verification.

The hypothesis under discussion implies that treatment of serotonin-related, anxiety-aggression driven depression is not disease-oriented, but dysfunction-oriented, that is, oriented towards normalization of impaired psychological functions regarded as pacemakers of a particular psychopathological condition. I called this strategy functional psychopharmacology.

I conclude that the functional approach in diagnosing psychiatric conditions is advantageous in at least three respects:

(1) It makes psychiatric diagnosing more precise, more refined, more scientific. More scientific, because psychological (dys)functions, more often than not, are measurable, even in quantitative terms. This is not the case with nosological entities of syndromes. The degree to which those are present permits at best a global estimation, using such terms as clearly present or absent or a gradation in between.
(2) It opens up new perspectives for biological psychiatric research concentrating on possible relationships between neurobiological and psychobiological dysfunctions.

(3) It may lead to a fundamentally different pharmacotherapeutic treatment of psychiatric conditions -- a therapeutic approach that is dysfunction-oriented rather than disease-oriented. Such a change in therapeutic direction would, in its turn, initiate a fundamental change of approach in the development of new psychopharmacological agents.

In short, the functional idea seems to be worthy of further exploration for its merits.

Some Organizational Activities

Academic Psychiatry as Pacemaker for Mental Health Delivery

So far, I have mentioned some aspects of our research strategy and their results which were, at least for my own professional thinking, enriching and at the same time creatively satisfying. They are a major reason why I consider research to be one of the three pillars providing meaning to my life.

In academia, possibilities for creating exist not only in science, but also in organizational spheres, and I have always found great pleasure in organizing and managing matters. In Groningen I had the privilege of an invitation to start a Department of Biological Psychiatry from scratch (1966-1976), the first of its kind in Europe. In Utrecht I made the development of a psychiatric research program in collaboration with the Rudolf Magnus Institute of Pharmacology (1977-1982) one of my prime priorities. In Maastricht (1992-1997) I was asked to unite three hitherto independent departments into one Department of Psychiatry and Neuropsychology and to further the development of research.

It was, however, during my stay in New York (1982-1992) that I could truly spread my wings. I was invited to achieve two goals. First, to unify the psychiatric departments of the Albert Einstein College of Medicine (AECOM) and the Montefiore Medical Center (MMC), departments that had been hitherto fully independent, each with their own chair, residency program, staff, research and clinical programs and each of them affiliated with several hospitals in the borough of the Bronx. The second charge was to extend and bolster their research efforts.

After arriving in New York, I noticed, much to my surprise, that no written guidelines existed about the planned merger. Do it, do it in your way and report once in a while about progress. And so it went. It was my first introduction to the typical American way of doing things. If you want to introduce structural changes, start at first in an improvisational way; let the regulations follow and base them on the experiences acquired. In Holland we generally follow the reverse order. I found the American method refreshing, the Dutch one often slow and tiring.

The merger progressed smoothly, and the collaboration in this project with my deputy chairman, Dr. Byram Karasu, and the chief administrator, Hal Lear, was a delight. The leadership of AECOM and MMC envisaged a merger on an academic level. We felt that the unification provided in addition a unique opportunity to create a strong, coherent network of mental health services under the roof of an academic department of psychiatry. This vision was put into practice. In this way, the Department of Psychiatry of AECOM/MMC, together with the affiliated hospitals, became an organization responsible for mental health delivery in the greater part of the Bronx, a borough of 1.3 million people, a unique situation characterized
by the then governor of New York State, Mario Cuomo, as "an outstanding service to the people of the state of New York."

**Innovation in Training Psychiatrists**

With respect to residency training, my department in New York was likewise oriented towards innovation. We opted for (and were selected together with five other departments in the USA) a new training program, the so-called triple board program, in which residents were to be trained in psychiatry, child-psychiatry and pediatrics, allowing them to sit for the board examination in these three disciplines. Thus, a new medical hybrid was created, breaking through classical medical dividing lines. The program was successful, and a few years ago it was officially recognized by the three boards concerned.

Another initiative was the resurrection of training in neuropsychiatry. In collaboration with the Department of Neurology, our Department opened a neuropsychiatric inpatient unit through which all residents rotated. In addition, the opportunity was offered for receiving a more advanced training in neuropsychiatry. Though, initially, some senior staff members were pessimistic about relevance and interest in this program, the neuropsychiatric rotation was popular among the residents from the beginning.

**Research Organization**

Research foci of the Albert Einstein College of Medicine are the neurosciences and cancer research. Embedded in an environment with such a high concentration of brain researchers, it was an outright pleasure to build up a biological research program in psychiatry. I have laid stress on preclinical basic research, because biological psychiatry does not thrive if not nourished by fundamental research. This plan succeeded with the help of many other individuals. I mention gratefully, in particular the benefactors devoting, funds to our programs and Einstein's dean Dr. Dom Purpura, who wholeheartedly supported these efforts. At the time of my arrival, our department had only one neurobiological lab; at my departure that number had increased to six.

Clinical studies were by no mean neglected. Depression and schizophrenia were the major fields of interest and, though biological protocols were numerous, this did not lead to neglect of the studies in psychological and psychosocial issues. The research program was truly a multidisciplinary and a multidimensional endeavor.

Through the daily contact with a great number of Americans, scientists and non-scientists, doctors and many other members of the departmental community, state and city officials, over more than ten years, my American period became a highlight of my life. In my farewell speech from the New York Department I expressed my respect and admiration for the American society in the following way:

"Indeed, this is a nation, both awesome and awe-inspiring. Thinking about America, two images come to my mind: the bison and nature as it reveals itself in Bryce National Park. Together, these symbols represent for me the best of the ingredients of which the American society is made.

The bison symbolizes determination; self-confident, purposeful, relentless, stubborn, aggressive, strength, individual strength and, even more so, collective strength exploding when these individuals assemble as a group, coalescing as a unity despite substantial individual differences."
Bryce was for me a stunning experience, an American experience. A fantastic world, full of fanciful forms, seemingly uniform. However, at close look, each of them is unlike the other; apparently airy and light footed but, at close range, sturdy and solidly anchored in the real world. A world of boundless creativity and, thus, of unlimited opportunity.

I realize that explanation of symbols is precarious. It is their very essence to transcend translation in the vernacular, to express a vision more trenchant than a line of argument can. I approximated their meaning to express that it has been a true privilege to try in my own way to make a small contribution to this great society."

My decision to leave America was an ambivalent one. I lost America; I reclaimed Europe. I lost a vibrant, enterprising society; I gained a living scenery like a historical treasure grove which, hopefully will remain a paragon of creative potential forever. I lost a city that is one of the major cultural and scientific power houses of the world, in which I felt like a fish in the water. I gained a city excelling in urban beauty, with outgoing warmth, emotional inhabitants, in which soon I felt at home, at ease and culturally and scientifically satisfied.

I am fond of both worlds.

Pursuit of Achievement

Studying, carrying out research and enterprise, are anchorpoints of my existence. In other words, my life has been achievement-oriented. In Holland at the end of the sixties and for many years thereafter, this attitude was unpopular. The idea of human equality reigned supreme and was regarded as truly progressive. The concept of equality encompassed, rightly so, the notion of equal rights and equal opportunities for all but, at the same time and erroneously, the notion of equality in terms of abilities and preparedness to use and focus them in a sustained fashion.

To justify this vision, (intellectual) skimmed milk became the standard and whole-milk products only reluctantly permitted to the market.

Such a climate leads to regression to the average, or worse, regression to mediocrity. It is a climate suited to break the intellectual backbone of a society. Ergo, a viewpoint I consider to be regressive and thus reactionary was wrapped up in progressive packaging. Once more an example of a reversion of values with negative societal implications.

Since, studying, researching, organizing are the raison d'être of my life, I decided to defy the Zeitgeist. I add to this one more consideration. Research creates an "extended family." One works day in day out together with a group of colleagues sharing each others curiosity, who have common interests and complementary abilities. Nowhere can one experience group cohesion so intensely as in a well-functioning, productive research group. Group cohesion I define as positive experienced mutual dependence. I have relished it and will miss it.

Third Anchorpoint: Judaism

The Principle

The third anchorpoint of my life is Judaism, including Jewry. It is the community to which I belong and my cradle. Without an umbilical cord to the past, I would have lived in
too thin air. I am, as I have stated before, keen to belong to a group. Not that I find it hard to be alone with myself, but I like to see myself surrounded by kindred spirits and partners in (mis)fortune.

The history of the Jews inspires awe in me. It is an impressive testimony that oppression can fail to break self-confidence; that pride in one's own identity can be immune to humiliation; that creativity can flourish in a barbarous climate. The history of the Jews inspires us to optimism and confidence in the future. Studying generated the will to survive under oppression. Undoubtedly the holiness of the study material served as a powerful reinforcer of hope, but above all the history of the Jews demonstrates the significance of study as a free port of the mind, where a life that otherwise would be hopeless and drab takes on color and substance.

Judaism, moreover represents spiritual values dear to me. Judaism encompasses for me religion, customs, practices and culture. What thrills me in this religion is the perfect transparence, the complete immaterialization of the conception of God. "Thou shall not make unto thee a graven image, nor any manner of likeness, of anything that is in heaven above" (Exodus XX, 4). Maimonides (Moses ben Maimon), the great rabbi and scholar from the 12th century, formulated the adage in this way: "I believe with perfect faith that the Creator, blessed be His name, is not a body, and that He is free from all accidents of matter, and that He has not any form whatsoever" (In Keller, 1992). God represents human existence in its entirety, while at the same time being an abstraction, indivisible, irreducible and sensorially unrecognizable. The Jewish religion has maintained the monotheistic idea in its pure form.

A second issue that attracts me in the belief of the Jews is that it is, paradoxically, a religion without a theology. It hardly contains anything resembling dogma except for the belief in one indivisible God. It knows no articles in which the religion's essence is enframed and in which one has to believe in order to be accepted by co-religionists and to ultimately to relish the joys of Heaven.

What the Jewish people acquired at Mount Sinai was not a set of dogma but a code of law -- legislation -- as well as a moral code; a series of instructions and directions by which to abide in order to live, here on this earth, a happy and prosperous life. The commandment was not: "This you should believe and this you should intellectually banish," but it was ordained that one should do this and desist from that. The people responded when God's precepts were revealed to them. "All that the Lord hath spoken will we do, and obey" (Exodus XXIV, 7). This response contains for Jews the essence of religious engagement (Peli, 1989). Not to follow (docile but non-committed), not to listen without hearing, but committed to executing the ethical code.

The subordination of dogma created room for exegesis and interpretation. The Jews became the people of the word because of their directedness towards discussion and dialetics and because their religious monuments were raised in words, not in stone.

I cherish particularly the moral code this people recorded some 3000 years ago and provided with divine imprimatur. "Justice, justice shalt thou follow, that thou mayest live" (Deuteronomy XVI, 20) and "Ye shall be holy; for I the lord your God are holy" (Leviticus XIX, 2). How, for Heaven's sake did it happen that a people of desert nomads and former slaves could formulate the ethical essence of the human condition which is so pregnant and so universal. No man of letters and no literary school has been able to set down the moral imperative of mankind -- to care for each other -- so penetratingly and in such sublime verses as the Prophets did. They belong to my favorite literature.
Please, understand me correctly. I do not lay any claim to any form or any measure of holiness, but I do consider it essential to be aware of the Gold Standard and to use it as the touchstone of my own behavior. I call that self-knowledge.

As my family bestows meaning on the future, studying significance on the present, so Judaism confers sense on the past.

The Practice

In my parental home, religion did not play an important role. In retrospect, I have missed this aspect of life. It was another expressive form of Judaism that figured prominently at home -- the nationalistic one. My grandparents from both sides were among the first generation of Zionists. My parents, too, were active in the movement that championed the national resurgence of the Jewish people. I shared this conviction -- with conviction. I regarded it to be my duty to go to Palestine, the later State of Israel, and to contribute to its reconstruction. "If I forget, thee, Oh Jerusalem, let my right hand forget her cunning." Jerusalem I have not forgotten. I have, however, felt that I have forsaken her. It is an aspect of my life in which I take no pride.

I did not go, and when the State of Israel was established in 1948, I concluded the time was past to call myself a Zionist. A Zionist goes; the time to pay lip service to Zion is over. I did not go, and though there were reasons, they did not fully convince me, and they still don't.

In 1945, after my return from the German concentration camps, I above all wished to earn a secondary school diploma. So 1948 came, and I sensed that I now wished to become a doctor. So 1956 came, and I had to serve for two years in the army. In 1958 I was offered a residency training in psychiatry and neurology at a time when few such positions were available. I accepted the invitation, specialized and completed a thesis. Thus another five years elapsed. After completing the residency training, I served for a few years as head of the psychiatric in-patient unit of the Academic Hospital Dijkzigt in Rotterdam, justifying my decision by stressing the necessity to gain clinical and organizational experience. In 1965 the invitation arrived from the University of Groningen to establish a Department of Biological Psychiatry with generous financial support. In 1968 I was appointed associated professor and in 1970 full professor of biological psychiatry. The department flourished. The position was so attractive, offered so many opportunities in a period when few psychiatric departments had the disposal of pharmacological, biochemical, physiological labs as well as facilities for animal behavioral studies, that I again failed to materialize the Zionist ideal.

So 1976 came. In that year an invitation reached me, that could have become the invitation of a lifetime, that is, the invitation to become Professor and Head of the Department of Psychiatry of the Academic Hospital Hadassah of the Hebrew University in Jerusalem. I asked for a trial period, and I was offered a visiting professorship. That very same year I set off to Jerusalem, without my family because my oldest son was sitting for his final secondary school examination. Denying myself family support proved to be a blunder. I was in need of it. My language problems were gigantic, and I doubted whether I could ever function adequately as a psychiatrist in Jerusalem.

At the very last moment (with the support of the University, I had already bought a house), I decided to decline the invitation. It was the most emotion-laden decision of my life. I realized later that the linguistic difficulties had influenced my decision in still another way. It would have cost me several years to learn Hebrew properly, a task which would have
incurred some cost to my research efforts. Obviously, I had regarded the price as too high. It has been a selfish decision.

I left Jerusalem, accepted the chair of Psychiatry at the University of Utrecht and felt a deserter of sorts. Four years later, in 1981, I was invited by the Albert Einstein College of Medicine to occupy the chair of Psychiatry and become Head of the Departments of Psychiatry at the Albert Einstein College of Medicine and the Montefiore Medical Center, at the time still to be united. The Albert Einstein College of Medicine is the Medical School of Yeshiva University, the only Jewish University outside Israel. I accepted the invitation without much hesitation, not only because I felt it to be a honorable invitation, but even more so because Einstein and the Jewish community of New York represented for me "little Jerusalem." My expectations were realized. New York became, scientifically, organizationally and spiritually, the culmination-point of my life.

But yet, the question whether the true Jerusalem would, after all, not have been the better choice is still with me.

Epilogue

I have come to the end of my lecture, but I would like to add one more brushstroke to this self-portrait.

I am in a certain sense a religious man, though I profess a wayward religion, a kind of private religion. I tell you this to elucidate the meaning of my closing words.

I am a religious believer in that I see God as a metaphor for the most noble, creative and sublime aspirations and intentions that mankind -- in its best representatives, in their best moments -- generates. "The human soul is God's lamp," a Proverb (20:27) reads. It is only in that light that the beauty and dignity of this countenance manifests itself.

This credo may clarify what I mean with my final clause, addressed to you listeners, but particularly to my collaborators over the years, those present and those who could not (anymore) be present. I thank you for your co-operation but above all for your friendship and loyalty. May it be given to you to throw light on God's countenance.

These words, then, mark the play's end. The curtain may now fall. It is, however, not my intention to leave it at that. I am not yet finished. To paraphrase the title of a song of Paul Simon, "I am still moving after all those years." In good season another act will be added, Deo volente.

REFERENCES


**Chad Varah**

England

My life began at the age of forty-two. Everything between November 12, 1911, and November 2, 1953, was a preparation for the founding of The Samaritans -- to befriend the suicidal and despairing.

Eldest of nine: you learn early to look after the little ones. A couple of years of illness: you read, think, and learn to be alone. A Doctor/Bishop mentor: you learn about sex at twelve -- facts and attitudes. Public School: you learn to cope and enough science to win a scholarship to Oxford. Amorous dalliance: you learn practical love and sex. Pushed into theological college and ordination: you learn to make the best of a potentially cramping situation.

As your first task, you bury a thirteen-year-old girl who killed herself when her periods started and make a vow to teach youngsters about sex -- and (in 1935!) keep it and get called
a dirty old man at age twenty-four. You become a recognized authority on a permissive theology of sex. You do sex therapy in a series of working-class parishes and write articles. In 1953 you get 235 clients for sex counselling, thirteen of the first hundred suicidal. None commits suicide. You decide, if saving lives is so easy, why don't you do it all the time? Because you'd need to have a parish with no parishioners, so you could be a specialist. St. Stephen Walbrook in the City of London offered. Pray for a good emergency number for suicidal callers. Find MAN 9000 is there, waiting. Stand double whiskies to journalists and tell them you're starting a sort of 911/999 for suicidal people day and night, plus a drop-in centre by day. You arrive November 1st, the telephone phone rings November 2nd, and it, along with all of the additional ones, has never stopped since.

You soon discover most of the callers don't need counselling or referral for psychiatry. Lay volunteers have turned up and latched on to waiting clients, who mostly leave later, without seeing the Expert (me). What magic was this? The 'listening therapy' which I named BEFRIENDING and which saves more lives (outside of hospitals) than psychiatry, psychotherapy or counselling, and is done by carefully selected and supervised unqualified lay people, The Samaritans. There are now 360 centres in thirty countries, with Russia and China soon to be added. The Samaritans are non-religious, non-political, and non-professional, and they seem to have reduced the suicide rate in England and elsewhere. There need to be a large number of callers for this to happen, for example, one family in forty in England, where 94 percent of the population know about The Samaritans.

Samaritans don't 'just' listen: they listen with full attention, understanding and acceptance. On the telephone or face to face, they make the caller feel that they care. This encourages those who feel helpless to help themselves; who feel hopeless to find inner resources that give grounds for hope; who want good advice to obtain their own better advice; and whose minds were confused to think straight aloud. For seven out of eight desperate callers over the past thirty-eight years, this listening therapy is all they need. One out of eight needs a doctor or other professional, and it is no surprise that the callers trust The Samaritans to refer them to a good professional.

The medical profession was quick to recognize the value of Befriending. Exchange with psychiatrists was soon two-way. Religious people, however, wanted to jump on to the bandwagon with the opposite of listening -- preaching, exhortation, direction. Church-based perversions of The Samaritans' service are prevalent on the continent of Europe, in eastern Australia, and in much of North America (though we have Samaritans in the east and good centres certified by the American Association of Suicidology in the west of the USA). They even dominate countries like Japan, where not one in a thousand is Christian.

In the USA, it was psychiatrists and psychologists who showed most concern. Los Angeles started with twelve of each. The IASP, to which I had belonged since its inception in Vienna in 1960, met in 1967 in the Ambassador Hotel in Los Angeles, and I gave a plenary session on Befriending. The professionals were wonderfully receptive and gradually selected lay 'clinical associates' (indistinguishable from Samaritans) who took all calls and filtered some to psychiatrists held in reserve, economizing on the highly-trained experts' time.

I am very proud that in 1974 the American Association of Suicidology gave me the Award in memory of Louis I. Dublin (whom I had known and who valued Befriending). Two years earlier, I had been given the Albert Schweitzer Gold Medal "for inspiring youth all over the world in the service of humanity." (Most Samaritans are under thirty.) These and other awards properly belong to our more than 30,000 Samaritans worldwide. All I had done, like
Fleming with penicillin, was correctly to interpret something I observed happening but hadn't planned.