PSYCHOTHERAPY WITH SUICIDAL PEOPLE
A Person-centred Approach

Antoon A. Leenaars

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To my beloved grandmother, Cornelia van Hooijdonk
(nee. Huubrects, 5th August 1883 to 15th December 1956),
who was my first mentor on life.
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ABOUT THE AUTHOR

Dr Leenaars is a registered psychologist in private practice in Windsor, Canada, and is a member of the Department of Public Health Sciences at the Karolinska Institutet, Sweden, and was a member of the Department of Clinical and Health Psychology at the University of Leiden, The Netherlands. He was the first Past President of the Canadian Association for Suicide Prevention (CASP), and is a past President of the American Association of Suicidology (AAS), the only non-American to date.

He has collaborated with 100 colleagues in over 20 nations, and has published over 100 professional articles or chapters on violence, trauma, suicide, homicide, genocide, and related topics. He has published 10 previous books, and is Editor-in-Chief of Archives of Suicide Research, the official journal of the International Academy for Suicide Research. Dr Leenaars is a recipient of the International Association for Suicide Prevention’s Stengel Award, CASP’s Research Award, and AAS’s Shneidman Award, for outstanding contribution in research in suicidology. He is recognized for his international efforts in suicide prevention, and has served as an expert witness in legal cases dealing with wrongful death, suicide, and homicide.
PREFACE

It is 5 December 2000 and I am in the Hotel De Doelen, room 3—an apartment in the loft—overlooking the Rapenburg Canal in Leiden, beginning to write this book. De Doelen is a 1600s patrician mansion. Leiden is The Netherlands' oldest academic city, the home of the historic University that bears the city’s name. One can wish no better place to write a book.

This book is about unique people—some suicidal and some that died by suicide. The book follows the direction of Henry (Harry) Murray: “Never denigrate a fellow human being in fewer than 2000 words.” The main problem facing this book is the one that is the classical issue of psychiatry/psychology itself: the mind–body problem or the admissibility of introspective qualitative accounts as opposed to objective quantitative reports. This debate resonates to Windelband’s (1904) division of two possible approaches to knowledge; that is, between the nomothetic and the idiographic. The nomothetic approach deals with generalizations, using tabular, statistical, arithmetic, demographic, quantitative methods, whereas the idiographic approach involves the intense study of individual(s) (particulars). The latter typically involves the use of qualitative methods, via clinical case study, history, biography, and so on (although at times, as studies of suicide notes show, quantitative methods can also be used). In the study of each unique individual, personal documents are frequently used; for example, treatment notes, medical reports, diaries, autobiographies, third-party interviews and, if I may, suicide notes. The nomothetic approach is well engrained in suicidology, psychology, psychiatry, and science in general. Keeping in mind that a preface represents a compromise for an author between the press for greater inclusion and the need to restrict oneself to a representative introduction, the idiographic approach may need some further explication.

Gordon Allport (1942, 1962) outlined a classical statement on the advantages of the idiographic approach. Allport (1962) began with the fact that psychology is “committed to increasing man’s understanding of man”, both the general and the particular. This is true whether one is a psychiatrist, psychologist, social worker, medical doctor, psychiatric nurse, crisis counsellor, minister, Elder, or whatever. We are deeply interested in the individual personality—and how to treat that person. Over a century ago, John Stuart Mill proposed that we make distinctions about the general and the particular in science. He showed that both the general and the
unique are critical for science’s development. Mill, Freud, Allport, have all argued that for the study of human events one needs both the general and the individual. Allport’s classical argument is as follows:

Suppose we take John, a lad of 12 years, and suppose his family background is poor; his father was a criminal; his mother rejected him; his neighbourhood is marginal. Suppose that 70 percent of the boys having a similar background become criminals. Does this mean that John himself has a 70 percent chance of delinquency?
Allport answers: Not at all. John is a unique being.

(Allport, 1962, p. 411)

Allport noted that the real issue, whether utilizing the idiographic approach or the nomothetic approach, involves methods that are rich, flexible, and precise, that “do justice to the fascinating individuality” of each individual. This fascinating individuality is humankind’s complexity and this is as true for suicide as for any other behaviour. Suicide is complex—more complex than most of us imagine. It is a multidimensional malaise, with both conscious and unconscious elements. That is why I began this book with some introductory chapters on suicide and its complexity to suggest a frame—like a nautical chart for a voyage—to understand the suicidal person better. In that regard, Karl Menninger has provided us with an important dictum that is worth remembering: “The patient is always right.” It is our task in psychotherapy to find out “how he/she is right”.

A criticism in the field today is that the qualitative study of our clinical cases is open to different interpretations and, thus, open to a myriad of applications (Leenaars et al., 2002b). Runyan (1982a), for example, has noted that “it is claimed that Freud’s case studies suffer from the critical flaw of being open to many interpretations”. Of course, it is a truism that the studies of most people’s lives are open to any number of theoretical templates. Some—for example, Gergen (1977)—have gone as far as to claim that the events of people’s lives allow the investigator freedom to simply support his or her formulations. One can say whatever one wishes about the patient, the treatment, the death, and so on. This misuse is possible, not only in a case study but, I would add, in any type of research. Statistics too, in quantitative studies of effective intervention, can be manipulated by one’s formulations as, for example, the gun control debate in the field illustrates. Among others, Runyan (1982a) has suggested that to avoid such misuse, one must “critically evaluate alternative explanations and interpretations”. This multiple perspective approach has been one of the richest contributions in the field (Leenaars, 1988a), and gives the main coordinates for this book—and should be for our clinical practice. Indeed, being open to all views constitutes the very richness of human reason. Ultimately, of course, from this phenomenological view, as humans, we can only make formulations about events (Husserl, 1973), whether a suicide, suicidal behaviour or, as Kuhn (1962) showed, even science.

On one more issue, some (such as B.F. Skinner) argue that theory should not play any role in psychotherapy. This view holds that treatment (as the argument also goes in research) should be atheoretical. However, as has been discussed for millennia (e.g., Heraclitus, Plato, Freud, Durkheim, Shneidman, Farberow), theory, explicit and implicit, plays some role in research and in developing implications
and applications for response from these studies (Leenaars et al., 1997). A frequent problem is that the theory is simply not stated. The clinician is then left to wonder what the information, whether from quantitative research or qualitative case study, means for him/her as he/she is found with a suicidal person in a howling storm. Yet, it is only with theory, as William James suggested at the end of the 1800s, that we can sort out experience. This book is one attempt to sort out the suicidal mess, and Leiden is the perfect setting in which to do so. I hope that the voyage has some utility in the treatment of suicidal people and I welcome all research, quantitative and qualitative, on what I write. I espouse an empirically based intervention.

The a priori assumption in this book: The reader already knows something about psychotherapy, counselling, crisis intervention, and so on. No one book can teach a person to be a therapist; it requires an education and experience. Thus, this book assumes a therapist’s orientation, whether cognitive-behavioural, psychodynamic, relational, problem-centred, psychoanalytic, whatever. It does not teach a therapy; rather, it charts the howling seas of anguish to address the archetypal rage in the suicidal person. It offers an empirically supported definition, with applications across age, gender, historical time, and so on, as well as countries (few explanations of suicide exist globally). This understanding of suicide provides, by inference, the implications and applications for response in this book. Psychotherapy follows understanding the unique person—Sylvia, Scott, Jeff, Vincent, and any suicidal person that you will meet in the fight to stay alive (Eros over Thanatos).

These views should not be seen as coming from a non-researcher. One of my identities is as a researcher; for example, I am an inaugural member of the International Academy for Suicide Research (IASR), and am the Editor-in-Chief of their journal, Archives of Suicide Research (ASR). Indeed, the use of case studies (the idiographic approach, qualitative research: Leenaars, 2002) does not mean that John Stuart Mill’s set of basic rules for science have to be abandoned. In his System of Logic, Mill (1984) reported a set of Canons for inductively establishing causality. These are the Methods of Difference, of Agreement and Difference, of Residues, and of Concomitant Variation. In my own study of suicide notes, for example, Mill’s Method of Difference does not need to be abandoned, as the comparison between genuine and simulated suicide notes illustrates. John Stuart Mill has handed many of us a career.

***

The decision to write this book was finally made on 4 September 2000, when I was at the De Doelen with my close friend, Harvard psychiatrist, John T. Maltsberger—he prefers room 13, the grand Dutch style bedroom in the hotel, with an authentic turn-of-the-century 1800 Delft tile fireplace. He, suicidologist Edwin Shneidman, and fellow researcher David Lester (the most prolific writer in the field), urged this project on me. David Lester, John T. Maltsberger, Konrad Michel (head of the Switzerland-based Aeschi group on psychotherapy with suicidal people), and Edwin Shneidman were kind enough to consult with me here and there on the text. David Lester read the entire text, making numerous suggestions for improvement.
I have often corresponded with these colleagues and others—to name any is to miss too many—on the topic of suicide and its application to psychotherapy. The content of this book reflects their knowledge, and I am grateful to each of them.

Since my early studies in suicide, Dr Shneidman (I call him Ed) has been pivotal to my thinking (Leenaars, 1993a, 1999a). Shneidman taught: “We ought to know what we are treating.” He believes that we will treat mental health problems, for example, suicide, more effectively only when we develop “clear and distinct” understanding of the suicidal person—each suicidal person. This book is an attempt to meet that challenge. His insights, in fact, are found throughout this volume, but of course, the words and conclusions are my own.

I recently asked Dr Shneidman what I should tell the readers of this book about psychotherapy; he offered the following (see Newslink, 27, p. 7, for details):

Suicide is about a person...a person wanting to stop pain, what I call psychache. Psychotherapy tries to mollify the pain. It is an anodyne. In a sense, suicide prevention tries to mollify the whole person.

What works in psychotherapy is a view held by Sigmund Freud, William James, Erwin Stengel [and I would add, Edwin Shneidman], not Pavlov, Skinner or any reductionistic view. [Ed strongly believes this point!]

Our treatment, psychotherapy, whatever, should address the person’s story, not the demographic, nosological categories or this or that fact. It is not what the clinician knows. It is the clinician’s understanding of the person’s story, each individual’s own story. It says, “Please tell me who you are... what hurts?”

Not, “Please fill out this form... and give me samples of your body fluids.”

Shneidman, said, however, “the practical” disadvantage of this approach is that it requires more than a few moments per patient. Suicide prevention is not an efficiency operation; it is a human exchange.

The relationship is the sine qua non of psychotherapy with suicidal people. There is no question: attachment is critical. This conclusion is based on evidence-based practice (Task Force on Empirically Supported Therapy Relationships, 2001). Our relationship in psychotherapy should be what Martin Buber (1970) called, I/Thou, not I/It. There is a definite need for a therapeutic alliance (or rapport). To put it simply: What works is quality care. This is as true in the therapy room as in the operating room. “Psychotherapy”, Shneidman said, “is concerned with what kind of person that individual is.”

Effective psychotherapy should be person-centred—or, if you prefer, patient-centred. Person-centred or patient-centred psychotherapy is derived from the focus on the individual—the individual in his/her entirety; i.e., biological, psychological, sociological, and so on. This is why it is also sometimes called multicomponent or multimodal psychotherapy. This simply means that it is not only psychotherapy alone—cognitive, interpersonal, whatever—that is most useful, but it may be even more effective in some cases in combination with medication—and removing the gun from the house may be even more effective. Of course, if you have read any of my papers, you will note that it is implied that my perspective includes a cognitive one (with deep thanks to Aaron T. Beck). To conclude, my approach, as you will read, is best called person-centred.
The one additional suicidologist that I do need to mention is Susanne Wenckstern (you’ll find numerous references to her as co-author in my publications). Her efforts have been essential, not only as a fellow scientist and clinician, but as my wife. She served, in fact, not only as a consultant to this book, but as my personal secretary to the project. My children, Lindsey, Heather, and Kristen, since I wrote my first book, *Suicide Notes* (wherein I wrote, “despite the occasional, ‘No dada, Me!’”) have once more allowed me to study—and have now even served as secretaries to this book. Lindsey—who now studies psychology—went over the references twice. Sherry Purdie, as she has done faithfully for three decades, typed many of the first drafts. William Bakker, the owner of De Doelen, and his staff, have made Dutch hospitality matchless. They allowed me to have a place with a sign “Niet Storen” (“Do not Disturb”). I visited and wrote this book on a number of subsequent visits to the De Doelen, spending about 20% of my weekends in Europe in the last years, writing. I thank all the people who have fostered the development of this book.

A book is obviously written for the reader, you, and, as a final opening remark, there is one apology: There are no universal formulations in this book on how to respond to highly lethal people. When the subject matter is psychotherapy with suicidal people, we can be no more accurate than the available ways of responding, our subject matter, permits. The yearning for universal treatment laws, understandably, exists. Yet, as Drs Freud, Lester, Malsberger, Michel, Shneidman, and Wenckstern advise, the search for a singular universal response is a chimera. There is no cookbook! As for any health clinician, say a cardiologist, the outline for psychotherapy as found in a book is not that simple in the trenches, whether in the therapy room or operating room. You—the psychiatrist, psychologist, Samaritan, social worker, counselor, nurse, and so on—must constantly learn. I hope that this book assists, as there is no escape from the following fact: Suicidal people can be treated effectively.

Leiden, 2003
ACKNOWLEDGEMENTS

First and foremost, I need to make explicit my debt to Dr Edwin Shneidman. Not only is his education central to my suicidological career, but also he provided kind permission to reprint, present, and discuss his publications, consultations, and so on. Further, he permitted—in fact, encouraged—the reader to copy and/or use his ideas. The same is true of my ideas in this volume, including the TGSP (Chapter 6).

Specifically, because of the standards in permission, Dr Shneidman provided permission to reprint a number of published matter and material that he reproduced over and over in his own publications. This includes, but is not limited to, the following: The Facts and Myths of Suicide, The Commonalities of Suicide, The Needs of Suicidal People, The Psychological Distress Questionnaire, and parts of the following publication: Shneidman, E. (1997). The psychological autopsy. In L. Gottschalk et al., *Guide to the Investigation and Reporting of Drug Abuse Deaths* (pp. 79–210). Washington, DC: USDHEW, US Government Printing Office (by permission of E. Shneidman).

The objective of the International Academy for Suicide Research (IASR) is the promotion of high standards of research and scholarship in the field of suicidal behaviour. It fosters communication and cooperation. I am honoured to have chaired IASR’s task force for future study of suicide. The task force findings resulted in a report and the task force encouraged its dissemination; thus, parts of the report are reproduced here with permission and encouragement, specifically: Leenaars, A., De Leo, D., Diekstra, R., Goldney, R., Kelleher, M., Lester, D. and Nordstrom, P. (1997). Consultations for research in suicidology. *Archives of Suicide Research, 3*, 139–151. (By permission of A. Leenaars, Chair of task force and Editor-in-Chief of *Archives of Suicide Research*.)

One further acknowledgement is needed. Once more, I had the honour of chairing an international group in the field, the International Working Group on Ethical and Legal Issues in Suicidology. The working group also included: C. Cantor, J. Connolly, M. EchoHawk, D. Gailiene, Z. He, N. Kokorina, D. Lester, A. Lopatin, M. Rodriguez, L. Schlebusch, Y. Takahashi, and L. Vijayakumar, and produced a number of reports (see details in Chapter 21). Yet, the task force also produced a full report, that was never published, but is presented here in Chapter 21, Ethical and Legal Issues. One view on ethics would be myopic in our global world. The wider
perspective allows us to better understand not only the ethical and legal issues in the field, but also suicide. It allows us to say more than “in the Western world”.

Grateful acknowledgement is also made for the inclusion in this volume of some of my papers that have been revised, modified, updated, edited, or otherwise. The book is, in fact, based on three decades of study in the field, and these are some of the key publications that were used to establish an empirically, peer-review-based practice for this book:


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

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

Shneidman taught that: “We ought to know what we are treating.” He believes that we will treat such problems as suicide more effectively only when we develop “clear and distinct” understanding of suicide. Indeed, he believes that, in the study of large issues like suicide, there is a natural progression from conceptualization to understanding and then to application and practice. This part serves somewhat like a prolegomenon to our topic: psychotherapy with a suicidal person. It consists of four chapters: an overview of suicide; a definition of suicide as a multidimensional malaise, based on the empirical study of the person’s own last narrative, the suicide note; a study of the conscious and unconscious processes in suicide; and an explication to cognition, communication and suicide notes—from the story to the mind. The latter chapter is critical because it highlights how the narrative aspects of human life, in their “sameness”, show the prominent or common psychological threads that allow a person to jump into the suicidal abyss.
Chapter 1

SUICIDE

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

DEFINITION OF SUICIDE

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

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

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

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

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

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

Erwin Ringel (Austria): Suicide is the intentional tendency to take one’s own life.

Charles Bagg (United Kingdom): Suicide is the intentional act of taking one’s life either as a result of mental illness (these illnesses frequently though not always causing distress to the individual carrying out the act) or as a result of various motivations which are not necessarily part of any designated mental illness but which outweigh the instinct to continue to live.

Walter Hurst (New Zealand): The decision to commit suicide is more often prompted by a desire to stop living than by a wish to die. Suicide is a determined alternative to facing a problem that seems to be too big to handle alone.

Sarah Dastoor (India):
I vengeful, killer, hate—inspired—so I die
I guilty, sinner, trapped—escaping life
I hoping rebirth, forgiveness divine—live again

Tadeusz Kielanowski (Poland): Suicide is the most tragic decision of a man who found nobody to hold out a hand to him.

Soubrier (1993, p. 33), in his review of this topic, concluded: “A major issue in suicidology is the following: Do we have a common definition of suicide?”
The topic of definition of suicide was the focus of an entire book by Shneidman (1985). His book, *Definition of Suicide*, can be seen as a necessary step to a more effective understanding and treatment of suicide. It argued that we desperately need a clarification of the definitions of suicide—definitions that can be applied to needful persons—and he defined suicide as:

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

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

**EPIDEMIOLOGY OF SUICIDE**

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

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

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

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* Rate based on one Inuit community. Abbey et al. (1993).
* WHO rates are only on a 10% sample—and separated rural/urban—so no single rate is available.
* Rates never calculated for blacks. Schlebusch (personal communication) provided an estimated 1990 rate.
The WHO data start in 1901. The data are now published online at www.who.int and not in books. Fewer countries have data online. The WHO does not report data for distinct cultural groups; thus, there are no comprehensive data for the Native people of Turtle Island (now called North America). The rates in some aboriginal communities on Turtle Island are unbelievably high (Leenaars et al., 1999a). Within the context of very low rates historically, Abbey et al. (1993), have reported rates of 59.5 to 74.3 per 100,000 in one group, the Inuit in the Arctic. The young males are the highest risk group; for example, Wotton (1985), reported a rate as high as 295 per 100,000 for 15- to 25-year-olds in one community. This is epidemic.

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

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

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

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

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

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

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

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

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

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

Aristotle (384–322 BC), Plato’s most famous but rebellious student, also espoused the view that suicide was against the State and, therefore, wrong. Man was answerable to the State and thus liable for wrongdoing and was to be punished for
wrongful acts. Suicide is one such act. In book 3 of the *Nicomachean Ethics*, Aristotle noted that:

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

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

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

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

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

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

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

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

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

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

To be or not to be: that is the question.
Whether ’tis nobler in the mind to suffer
The slings and arrows of outrageous fortune,
Or to take arms against a sea of troubles,
And by opposing end them. To die; to sleep;
No more; and by a sleep to say we end
The heart-ache and the thousand natural shocks
That flesh is heir to, ’tis a consummation
Devoutly to be wish’d. To die, to sleep;...
blame—whether in man or in society—is a major theme that dominates the history of thought about suicide subsequently. David Hume (1711–1776) was one of the first major Western philosophers to discuss suicide apart from the concept of sin. In his essay, “On Suicide”, intentionally published by him a year after his death, he refutes the view of suicide as a crime by arguing that suicide is not a transgression of our duties to God, to our fellow citizens, or to ourselves. Suicide is a right. He asserts that

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

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

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

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

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

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

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