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DEFINITION OF SUICIDE

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E.S.

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Part One Basic
A Headnote
B The Word
C Classificat

Part Two Relat
D Headnote
E Some Ido
F Sleep and

Part Three Bas
G Headnote
H Cosmolog
I Personolo
J Systems

Part Four Con
K Headnote
L Situation
[I]
[II]
M Conative
[III]
[IV]

Contents

Part One Basic Words and Approaches

A	Headnote	3
B	The Words	6
C	Classifications and Approaches	23

Part Two Related Topics

D	Headnote	43
E	Some Idols About Death	44
F	Sleep and Self-Destruction	56

Part Three Basic Texts

G	Headnote	67
H	Cosmology: Pepper's *World Hypotheses*	71
I	Personology: Murray's *Explorations in Personality*	95
J	Systems Theory: Miller's *Living Systems*	110

Part Four Common Characteristics of Suicide

K	Headnote	121
L	Situational Aspects of Suicide	123
[I]	The Common Stimulus in Suicide	124
[II]	The Common Stressor in Suicide	126
M	Conative Aspects of Suicide	128
[III]	The Common Purpose of Suicide	129
[IV]	The Common Goal of Suicide	129

N Affective Aspects of Suicide 131

[V] The Common Emotion in Suicide 131
[VI] The Common Internal Attitude Toward Suicide 135

O Cognitive Aspects of Suicide 136

[VII] The Common Cognitive State in Suicide 138

P Relational Aspects of Suicide 143

[VIII] The Common Interpersonal Act in Suicide 143
[IX] The Common Action in Suicide 144

Q Serial Aspect of Suicide 147

[X] The Common Consistency in Suicide 147

Part Five A Case Illustration
R Headnote 153
S The Suicidal Psycho-Logics of *Moby-Dick* 154

Part Six Definitional Issues
T Headnote 197
U Definition in Terms of Suicide Notes 198
V A Formal Definition, with Explication 202
W Parasuicide 214

Part Seven Implications and Coda
X Headnote 223
Y Implications for Prevention and Response 225
Z Some Observations About the Topic of Suicide 236

Bibliography 239

Name Index 249

Subject Index 253

B

The Words

In its essence, diagnosis is a matter of definition. A clear diagnosis depends upon an unambiguous definition. "Suicide" is one of those words that seems to have both a core and a periphery. For most of us the core would seem to be unambiguous enough, almost self-evident. Surely "suicide" is one of those patently self-evident terms, the definition of which, it is felt, need not detain a thoughtful mind for even a moment. Every adult knows instinctively what he means by it: It is the act of taking one's life. But, in the very moment that one utters this simple formula one also appreciates that there is something more to the human drama of self-destruction than is contained in this simple view of it. And that "something more" is the periphery of any satisfactory definition. Are totally lethally intended acts which fail (e.g., shooting oneself in the head and surviving) suicide? Are non-lethal attempts on the life (e.g., ingesting a possibly lethal dose of barbiturates) suicidal? Are deleterious and inimical patterns of behavior (e.g., continued smoking by a person with acute emphysema) suicidal? Are deaths which have been ordered by others or deaths under desperation (e.g., Cato's response to Caligula's requesting his death, or the deaths on Masada or in Jonestown) suicide? All these questions and more constitute the indispensable periphery of the definition of suicide.

Some further thoughts: We know that diagnosis (and in this sense, definition) have an interactional quality. The very attribution of a

> An act is suicide if a person intentionally brings about his or her own death in circumstances where others do not coerce him or her to action, except in those cases where death is caused by conditions not specifically arranged by the agent for the purpose of bringing about his or her own death.

Peter Windt (1980), in the spirit of Wittgenstein (believing that the best one can do with certain complicated concepts is to indicate a list of criteria for that concept's application) argues that suicide is a death that is "reflexive," that is, a person must either kill himself or get himself killed or let himself be killed. In addition, suicide must be a reflexive death in which the deceased caused the death by his actions or behavior; wanted, desired, or wished for the death; intended, chose, decided, or willed to die; knew that death would result from his behavior; and was responsible for his death.

Glenn Graber (1981) focuses on the sense in which a suicide "intends" his own death and asserts:

> Suicide is defined as doing something that results in one's death in the way that was planned, either from the intention of ending one's life or the intention to bring about some other state of affairs (such as relief from pain) that one thinks it certain or highly probably can be achieved only by means of death.

This definition would exclude, according to Graber, a spy who resists divulging information, knowing that such resistance will mean death, but where death is not really desired at all—neither as an end in itself nor as a means to an end.

In their own setting these philosophical definitions are explicated in a scholarly way but they suffer from intellectual overkill. An excellent discussion of the problem of definition was made by Jack Douglas (1967). He outlines the fundamental dimensions of meanings that are required in the formal definition of suicide. He indicates these dimensions as follows:

1. The *initiation* of an act that leads to the death of the initiator.

2. The willing of an *act* that leads to the death of the willer.
3. The willing of self-destruction.
4. The loss of will.
5. The *motivation to be dead* (*or to die*) which leads to the initiation of an act that leads to the death of the initiator.
6. The *knowledge* of the actor that actions he initiates tend to produce the objective state of death.

I shall return later to the topic of definition of suicide. It is central to any efforts toward a comprehensive discussion of therapy and response. That is why it should be done operationally, sensibly, and, as I see it, preferably from a clinical point of view.

In additional to the word "suicide," other closely related words need similar clarification. They are discussed below.

ATTEMPTED SUICIDE

In general it was believed that two "populations" (those who commit suicide and those who attempt suicide) are essentially separate, made up of different individuals (Stengel, 1964/1974). In a sense the words "attempt suicide" are a contradiction in terms. Strictly speaking, a suicide attempt should refer only to those who sought to commit suicide and fortuitously survived. Over a 10 year period, the overlap of the percentage of individuals who commit suicide with those who *previously* attempted suicide is 40%, whereas the overlap of those who attempt suicide and those who *subsequently* commit it is about 5% (Maris, 1981). To attempt suicide with less than total lethality might be called "quasi-suicide" except that this term has the unfortunate connotation that such persons are malingerers or are simply seeking attention, and thus do not merit our full professional and sympathetic response. Any event which uses a suicidal modality is a genuine psychological crisis, even though it might not, under strict semantic rules, be called a "suicidal" event.

FOIA # none (URTS 16371) DocId: 70105748 Page 9

States, all fall within the sociological tradition. They each take a plot of ground, a city, or a country and figuratively or literally reproduce its map several times to show its socially shady (and topographically shaded) areas and their differential relationships to suicide rates.

According to Durkheim, suicide is the result of society's strength or weakness of control over the individual. He posited four basic types of suicide, each a result of man's relationship to his society. In one type, the *altruistic* suicide is literally required by society. Here, the customs or rules of the group demand suicide under certain circumstances. Hara-kiri (in feudal Japan) and suttee (in pre-colonial India) are examples of altruistic suicides. In such instances the person seemed almost boxed in by the culture. Under those circumstances, self-inflicted death was honorable; continuing to live would be ignominious. Society dictated their action and, as individuals, they were not strong enough to defy custom.

Most suicides in the United States would be called *egoistic* by Durkheim. Contrary to the circumstances of an altruistic suicide, egoistic suicides occur when an individual's ties to his community are too few or too tenuous. In this case, demands to live do not reach him. Thus, proportionately, more individuals, especially men who are on their own, compared with men who are married or who are church members, kill themselves.

Durkheim's third type of suicide is called *anomic*—from the word *anomie* which Durkheim may have developed himself—to describe that special kind of aloneness or estrangement that occurs when the accustomed relationship between an individual and his society is precipitously disrupted or shattered. The shocking, immediate loss of a job, of a close friend, or of a fortune is thought sufficient to expedite anomic suicides; or, conversely, poor men surprised by the disruption of a sudden wealth have also been shocked into anomic suicide.

A fourth type, *fatalistic* suicide, is suicide deriving from excessive regulation of the individual, where the individual has no personal freedom and no hope, as in the suicide of slaves, "with futures piteously blocked and passions violently choked by oppressive discipline," "very young husband, (or) the married woman who is childless." Admittedly, this type of suicide is rare.

If we move to 1967, Douglas, in his analysis of definitions of suicide, lists six fundamental dimensions of meanings. The key words are *initiation* of the act); the *act* (that leads to death); the *willing* (of self-destruction); the *loss* (of will); the *motivation* (to be dead); and the *knowledge* (of the death potential of the act).

In 1968, I suggested that all (committed) suicides be viewed as being of one of three types: egotic, dyadic, or ageneratic.

Egotic suicides are those in which the self-imposed death is the result, primarily, of an *intra-psychic* debate, disputation, struggle-in-the-mind, or dialogue within one's self, in the "congress of the mind." The impact of one's immediate environment, the presence of friends or loved ones, the existence, "out there" of group ties or sanctions all become secondary, distant perceptual "ground" as compared with the reality and urgency of the internal psychic debate. The dialogue is within the personality; it is a conflict of aspects of the self, within the ego. Such deaths can be seen as egocide or ego destruction; they are annihilations of the "self," of the personality, of the ego. At the time it happens, the individual is primarily "self-contained" and responds to the "voices" (not in the sense of hallucinatory voices) within him. This is what one sees in the extremely narrowed focus of attention, self-denigrating depression, and other situations where the suicide occurs without regard for anyone else including loved ones and significant others. Egotic suicides are essentially *psychological* in their nature.

Dyadic suicides are those in which the death relates primarily to the deep unfulfilled needs and wishes pertaining to the significant other—the partner in the important current dyad in the victim's life. These suicides are primarily *social* in their nature. Although suicide is always the act of a person and, in this sense, stems from within his mind, the dyadic suicide is essentially an interpersonal event. The cry to the heavens refers to the frustration, hate, anger, disappointment, shame, rage, guilt, impotence, and rejection, in relation to the other, to him or to her—either the real him or her or a symbolic (or even fantasied or fictional) person in life. The key lies

in the undoing: "If only he (or she) would . . ." The dyadic suicidal act may reflect the victim's penance, bravado, revenge, plea, histrionics, punishment, gift, withdrawal, identification, disaffiliation, or whatever—but its arena is primarily interpersonal and its understanding (and thus its meaning) cannot occur outside the dyadic relationship.

Ageneratic suicides are those in which the self-inflicted death relates primarily to the individual's "falling out" of the procession of generations; his losing (or abrogating) his sense of membership in the march of generations and, in this sense, in the human race itself. This type of suicide relates to the Shakespearean notions of ages or eras within a human life span, and a period within a life in which an individual senses, at one level of consciousness or another, his "belonging" to a whole line of generations; fathers and grandfathers and great-grandfathers before him, and children and grandchildren and great-grandchildren after him.

This sense of belonging and place in the scheme of things, especially in the march of generations, is not only an aspect of middle and old age, but it is a comfort and characteristic of psychological maturity, at whatever age. To have no sense of serial belonging or to be an "isolate" is truly a lonely and comfortless position, for then one may, in that perspective, truly have little to live for. This kind of hermit is estranged not only from his contemporaries but, much more importantly, he is alienated from his ancestors and his descendants, from his inheritance and his bequests. He is without a sense of the majestic flow of the generations: He is ageneratic. Ageneratic suicides are primarily *sociological* in nature, relating as they do to familial, cultural, national, or group ties.

I must add that I now see things somewhat differently, as will be evident in this book. I now prefer to collapse these three rather clumsy categories to one—the egotic—and explicate the dimensions of that category.

In Jean Baechler's book *Suicides* (1979), he propounds four kinds of suicidal acts; or, to put it in his terms, suicidal acts among which four typical meanings (to the chief protagonist) can be distinguished. They are: escapist, aggressive, oblative, and ludic suicides.

An *escapist* suicide is one of flight or escape from a situation sensed by the subject to be intolerable. This can be because of a combination of felt emotions (e.g., shame, guilt, fear, worthlessness) or attendant to the loss of a central element of the individual's personality or way of life. There are two subtypes: flight and grief. The key word is "intolerable." To my mind, all suicides are of this type.

Aggressive suicides are of four subtypes: crime (involving another in one's death), vengeance (to create remorse or opprobrium), blackmail, and appeal ("informing one's friends and family that the subject is in danger"). I puzzle how these differ from the need to escape intolerable inner pain.

Oblative suicides, those of sacrifice or transfiguration are, says Baechler, "practically unknown in daily life." They relate vaguely to higher values or infinitely desired states. The topics of seppuku and the immolation of Buddhist monks would be subsumed under this category.

The fourth category is *ludic* suicides, which refer to proving oneself through the ordeal or the game. Baechler cites Roger Caillois' *Man, Play and Games* (1961) and one immediately thinks also of Johan Huizinga's *Homo Ludens: A Study of the Play Element in Culture* (1938). The relationship of play (carnivals, orgies, holidays, "unpluggings") to death and self-destruction is a fascinating topic on its own, whether or not it provides a reasonable separate taxonomic category for suicide.

Writing from what he calls a modified Kantian point of view, Thomas E. Hill, Jr. (1983), recognizing that, "Real life is admittedly more complex than any of our philosophic categories . . ." focuses attention on four specially defined types of suicide, as follows:

> 1. *Impulsive suicide* . . . is prompted by a temporarily intense, yet passing desire or emotion out of keeping with the more permanent character, preferences and emotional state of the agent. We need not suppose that he is "driven" or "blinded" or momentarily insane, but his act is not the sort that coheres with what he most wants and values over time. In calmer, more deliberate moments, he would wish that he would not respond as he did. . .

FOIA # none (URTS 16371) DocId: 70105748 Page 11

2. *Apathetic suicide.* Sometimes a suicide might result not so much from intense desire or emotion as from apathy. The problem is not overwhelming passion, but the absence of passion, lack of interest in what might be done or experienced in a continued life. One can imagine, for example, an extremely depressed person who simply does not care about the future . . . not intense shame, anger, fear, etc., but rather emptiness. . .
3. *Self-abasing suicide* . . . results from a sense of worthlessness or unworthiness, which expresses itself not in apathy, but rather in a desire to manifest self–contempt, to reject oneself, to 'put oneself down'. . . . One's life is seen as having a negative value . . . contemptible like a despised insect one wants to swat or turn away from in disgust. . .
4. *Hedonistic calculated suicide* . . . that is decided upon as a result of a certain sort of cost/benefit calculation. seeing that others will be unaffected by his decision (our simplifying hypothesis), the hedonistic calculator regards his choice as determined by his best estimate of the balance of pleasure and pain he expects to receive under each option.

In the same issue of the journal that contains Hill's article, the editor, Ronald Maris, states (1983):

> Hill's typology of impulsive, apathetic, self-abusing, and hedonistic suicides, which deviate from some ideal rather than from others' interests or values or effects on others, is very far removed from real life self-destructive situations. I must confess that such classical Kantian typologies always leave me a little cold. Where is the relevance of such typologies to actual suicidal circumstances in which one has to decide to commit suicide or not? . . . Although it may not have been his objective, Hill's suicidal types do not correspond very well with actual suicides I have known.

Currently (in 1984), under the joint sponsorship of the American Medical Association and the American Psychiatric Association, there

is an on–going study of 110 physician deaths by suicide and 110 matched non–suicidal physician deaths. One would hope that their extensive questionnaire—over 130 questions in a 58 page booklet—would reflect the current state of the art. The key question in that book, on the last page, reads as follows:

> How do you classify this suicide?
>
> 1. Rational (to escape pain, etc.)
> 2. Reaction (following loss)
> 3. Vengeful (to punish someone else)
> 4. Manipulative (to thwart others' plans)
> 5. Psychotic (to fulfill a delusion)
> 6. Accidental: (reconsidered too late)

It is easy to see some holes in that one.

I submit that all these classifications, taken singly or together, have either an arbitrary, esoteric, or ad hoc quality to them. They do not seem impressively definitive. I know for a fact that the best known of them is of practically no use in the clinic, where the task is saving lives, where conceptualizations really count. In my several years at the Los Angeles Suicide Prevention Center—where I happily resided from its beginnings in the early 1950s until I left for NIMH in 1966—I never once heard my colleagues at the Center or the County Coroner, Dr. Theodore Curphey, refer to a suicidal death as altruistic, egoistic, or anomic, or in terms of any of the other classifications cited just above. True, none of these people was trained as a professional sociologist or philosopher, but every day we witness people not trained as psychoanalysts employing psychoanalytic language, sometimes quite effectively. None of the classifications of suicide that I know of has an urgent usefulness.

From all this I tentatively conclude that it may well be, if we are theoretically serious about suicide, that we do best not to concentrate on classification. That is precisely what I have suggested to myself: To eschew the attempt at taxonomy, and to do this for a very

compelling reason. My belief, to use an anachronistic example, is that Linnaeus' perfect arrangement of all of Darwin's creatures is not an appropriate goal for a contemporary suicidologist. It is like trying to impose a biological screen on a variety of existential events. A suicidologist is essentially a personologist. The accuracies of other fields of science, like physics or chemistry, are not consistent with what we know today about the activities, conscious and unconscious, of the human mind. The human person is, of course, our legitimate subject matter. There is no point in achieving accuracy if one sacrifices relevance in the process. I am interested, as a clinical suicidologist and thanatologist, in what is useful and makes sense, not in what has specious accuracy simply for the sake of accuracy.

As we work our collective way toward a meaningful definition of suicide we need to touch briefly upon various contemporary *approaches* to the assessment, understanding, and treatment of suicidal phenomena. In a sense, a review of these approaches will tell us, operationally, what suicide *is* by informing us of the various vantage points from which it is currently regarded. This survey of contemporary approaches to suicide is all the more appropriate in that, by way of a preview, we can state that our definition of suicide will seek to reflect not only the multidisciplinary components of its current study, but also the multiple ingredients of its very nature.

1. *Theological.* Neither the Old nor the New Testament directly forbids suicide. In the Western World, the pervasive moral ideas about suicide are Christian, dating from the fourth century A.D., enunciated by St. Augustine (354–430) for essentially non–religious reasons. Historically, the excessive martyrdom of the early Christians frightened the church elders sufficiently for them to seek to introduce a serious deterrent. Augustine did this by relating suicide to sin. We now know that Augustine was not against suicide on chiefly theological grounds. He was primarily against the decimation of Christians by suicide and, even more narrowly, against the suicide by Christians only for reasons of martyrdom (or religious zealotry, fired by the hope of immediate martyred entrance into heaven). Suicide by reason of physical or emotional suffering, old age, altruism toward others, personal honor, illness, and the like—in short, the very reasons with which 99.9% of the suicides committed nowadays are associated—were not the target of Augustine's writings (Battin, 1982).

But that is not the way it went historically. By 693 the Council of Toledo had proclaimed that an individual who attempted suicide was to be excommunicated from the Church. This view was elaborated by Saint Thomas Aquinas (1225–1274) who emphasized that suicide was a mortal sin in that it usurped God's power over man's life and death. By that time the notion of suicide as sin had taken firm hold and for hundreds of years the idea played, and continues to play, an important part in Western man's view of self-destruction.

That Augustine's condemnations of suicide rested largely on tactical reasons—to keep up the numbers of his own group—has been largely forgotten. The Christian injunctions against suicide are seen historically as resting on a respect for life (especially the life of the soul in the hereafter) and as being a more humane reaction to the way in which life was regarded by, say, the Romans. But even those motivations by the Church seem to have gone awry in that the effects were excessive and counterproductive, and resulted in degrading, defaming, and persecuting individuals who had attempted suicide, committed suicide, or were survivors whom the Church had originally claimed to succor. It is sobering to contemplate that for hundreds of years what had appeared to be God's word about suicide, had begun as a fifth century political–tactical ploy further distorted by a twist in logic condemning those it was originally meant to protect.

2. *Philosophical.* Philosopher Jacques Choron (1972) outlined the position of the major Western philosophers in relation to death and suicide. In general, the philosophers of suicide never meant their written speculations to be prescriptions for action but simply to reflect their own inner intellectual debates. The following are some philosophers who have touched upon the topic of suicide: Pythagorus, Plato, Aristotle, Socrates, Seneca, Epictetus, Montaigne,

FOIA # none (URTS 16371) DocId: 70105748 Page 13

Descartes, Spinoza, Voltaire, Montesquieu, Rousseau, Hume, Kant, Schopenhauer, Nietzsche, Kierkegaard, Camus.

In classical Rome, during the centuries just before the Christian era, life was held rather cheaply and suicide was viewed either neutrally or even positively. The Roman Stoic Seneca said:

> Living is not good, but living well. The wise man, therefore, lives as well as he should, not as long as he can. . . . He will always think of life in terms of quality not quantity.

The French philosopher Jean-Jacques Rousseau (1712–1778), by emphasizing the natural state of man, transferred the sin (blame) from man to society, stating that man is generally good and innocent and that it is society that makes him bad. David Hume (1711–1776) was one of the first major Western philosophers to discuss suicide in the absence of the concept of sin. His famous essay "On Suicide," was published in 1777 (a year after his death) and was promptly suppressed. It refutes the view that suicide is a crime; it does so by arguing that suicide is not a transgression of our duties to God, to our fellow citizens or to ourselves: ". . . prudence and courage should engage us to rid ourselves at once of existence when it becomes a burden."

The existential philosophers of our own century—Kierkegaard, Jaspers, Camus, Sartre, Heidegger—have made the meaninglessness of life (and the place of suicide) a central topic. Camus begins *The Myth of Sisyphus* by saying that the topic of suicide is the central problem of philosophy.

3. *Demographic.* The demographic approach relates to various statistics on suicide. The medieval English coroners (the word coroner means the custodian of the Crown's pleas) began to keep "rolls," that is, documents that incorporated death (and birth) records. From the eleventh century on, whether or not the property of a deceased individual was to be kept by the heirs or had to be forfeited to the Crown depended on whether or not the death was judged (by the coroner) to be an act or a felony. Suicide was the latter, a felony against the self (*felo de se*); thus the way in

which a death was certified was of enormous importance to the survivors.

In 1662, John Graunt, a tradesman, published a small book of observations on the London bills of mortality (a listing of all deaths) that was to have great social and medical significance. Graunt devised categories of information—sex, locale, type of death—and made mortality tables. He was the first to demonstrate that regularities could be found in mortality phenomena and that these regularities could be used by the government in making policy.

In 1741, the science of statistics, as it is known today, came into existence with the work of a Prussian clergyman, Johann Sussmilch. He called his efforts "political arithmetic;" it was what we now call vital statistics. From his studies came the laws of large numbers, which permitted long-range planning (i.e., the need for food and supplies based on the size of the population) in Europe as well as in the American colonies. Recently, Cassedy (1969), who wrote about colonial America, said that Sussmilch's "exhaustive analysis of vital data from church registers . . . became the ultimate scientific demonstration of the regularity of God's demographic laws." The traditions about statistics on suicide stem from Graunt and Sussmilch.

Currently, in the United States, the suicide rate is 12.6 per 100,000 people. It ranks as one of the 10 leading causes of adult deaths. Suicide rates gradually rise during adolescence, increase sharply in early adulthood, and parallel advancing age up to the age bracket 75 to 84, when it reaches a rate of 27.9 suicides per 100,000. Male suicides outnumber female suicides at a ratio of two to one. More whites than non-whites commit suicide. Suicide is more prevalent among the single, widowed, separated, and divorced.

The suicide rate in young people, ages 15 to 24, has risen sharply since the 1950s, from 4.2 in 1954 to 10.9 in 1974. The suicide rate for non-whites has also increased significantly. Data indicate that in the 35 years since 1946, the suicide rate of blacks has doubled, a rise attributed to increased opportunities for mobility and the attendant frustrations, role shifts, and social stresses. Since 1960 suicide has increased significantly for women. The ratio of men to women narrowed from 4 to 1 to 2 to 1.

FOIA # none (URTS 16371) DocId: 70105748 Page 14

Demographers of suicide in this century include especially Louis I. Dublin on suicide in the United States (1963) and Peter Sainsbury on suicide in London (1955). International statistics have been given by the World Health Organization (1968).

4. *Sociological.* Emile Durkheim's giant book, *Le Suicide* (1897) demonstrated the power of the sociological approach. As a result of his analysis of French data on suicide, Durkheim proposed four kinds of suicides, all of them emphasizing the strength or weakness of the person's relationships or ties to society. "Altruistic" suicides are literally required by society: "Egoistic" suicides occur when the individual has too few ties with his community; "Anomic" suicides are those that occur when the accustomed relationship between an individual and his society is suddenly shattered; and "Fatalistic" suicides derive from excessive regulation.

For years after Durkheim, sociologists have not made major changes in his theory. Henry and Short (1954) added the concept of internal (superego) restraints to that of Durkheim's external restraint, and Gibbs and Martin (1964) sought to operationalize Durkheim's concept of social integration.

In a major break with Durkheim, sociologist Jack Douglas (1967) pointed out that the social meanings of suicide vary greatly and that the more socially integrated a group is, the more effective it may be in disguising suicide. Further, Douglas suggested that social reactions to stigmatizing behaviors can themselves become a part of the etiology of the very actions the group seeks to control.

Maris (1981) believes that a systematic theory of suicide should be composed of at least four broad categories of variables: those concerning the person, the social context, the biological factors, and "temporality," oftentimes involving "suicidal careers."

5. *Psychodynamic.* As Durkheim detailed the sociology of suicide, so Sigmund Freud fathered the psychological explanations of suicide (Friedman, 1967). To him, suicide was essentially within the mind. The major psychoanalytical position on suicide was that it represented unconscious hostility directed toward the introjected (ambivalently viewed) love object. Psychodynamically, suicide was seen as murder in the 180th degree.

Karl Menninger, in his important book, *Man Against Himself* (1938), delineates the psychodynamics of hostility and asserts that the drives in suicide are made up of three skeins: (a) the wish to kill; (b) the wish to be killed; and (c) the wish to die.

Gregory Zilboorg (1937) refined this psychoanalytical hypothesis and stated that every suicidal case contained not only unconscious hostility but also an unusual lack of capacity to love others. He extended the concern solely from intrapsychic dynamics to include the external world, specifically in the role of a broken home in suicidal proneness.

In an important exegesis of Freud's thoughts on suicide, Robert E. Litman (1967, 1970) traces the development of those thoughts from 1881 to 1939. It is evident from Litman's analysis that there is more to the psychodynamics of suicide than hostility. These factors include several emotional states (i.e., rage, guilt, anxiety, dependency) as well as a great number of specifically predisposing conditions. Feelings of abandonment and particularly of helplessness and hopelessness are important.

A further word about the locus of blame: The early Christians made suicide a personal sin, Rousseau transferred sin from man to society, Hume tried to decriminalize suicide entirely, Durkheim focused on societies' inimical effects on people, and Freud—eschewing both the notions of sin and crime—gave suicide back to man but put the locus of action in man's unconscious mind.

6. *Psychological.* The psychological approach can be distinguished from the psychodynamic approach in that it does not posit a set of dynamics or a universal unconscious scenario but, rather, emphasizes certain general psychological features which seem to be necessary for a lethal suicidal event to occur. Four have been noted (Shneidman, 1976): (1) acute *perturbation*, that is, an increase in the individual's state of general upsetment; (2) heightened *inimicality*, an increase in self-abnegation, self-hate, shame, guilt, self-blame, and overtly in behaviors which are against one's own best interests; (3) a sharp and almost sudden increase of *constriction* of intellectual focus, a tunneling of thought processes, a narrowing of the mind's content, a truncating of the capacity to see viable options which would

FOIA # none (URTS 16371) DocId: 70105748 Page 15

ordinarily occur to the mind; and (4) the idea of *cessation*, the insight that it is possible to put an end to suffering by stopping the unbearable flow of consciousness. This last is the igniting element that explodes the mixture of the previous three components. In this context, suicide is understood not as a movement toward death (or cessation) but rather as a flight from intolerable emotion.

7. *Cognitive.*' Of course, the cognitive and psychodynamic approaches to suicide are not mutually exclusive: Intellect operates within a context of affect and affect most often has some substantive content. Nonetheless, focused attention to the cognitive aspects of suicide can lead to special insights. Apart from the exciting and burgeoning development of cognitive psychology, there is a history of studies, especially of psychotic behaviors from the cognitive point of view. *Language and Thought in Schizophrenia* (1944/1964), edited by Kasanin and containing contributions by Goldstein, Sullivan, Angyal, and von Domarus, is one outstanding example. More recently, the work of Arieti—his *Interpretation of Schizophrenia* (1955/1974) especially—has kept the topic of cognitive aspects of aberrant states in the forefront of discussion.

The concept of dichotomous (either/or) thinking is believed to be an important component in the thinking patterns of suicidal individuals (Shneidman, 1957, 1961, 1981, 1982). In addition dichotomous thinking has been found by Beck to exist in severly depressed persons. Rigidity and lability of thinking in suicidal persons has also been empirically demonstrated by Neuringer and Ringel. Narrow or dichotomous thinking in the suicidal person was reported 100 years ago by Westcott, who observed that the suicidal situation is one in which the person perceives only two odious alternatives of which the least odious was suicide. A variety of terms (e.g., fixity of idea, psychological myopia, gun-barrel vision, constriction, tunneling of perception) has been employed by various authors to describe the style of thinking found in suicide notes.

I have developed a system of logical content analysis of written text including political speeches (e.g., the Kennedy–Nixon "Great Debates"), letters, diaries, and suicide notes. The text is analyzed in terms of 55 cognitive maneuvers and 40 idiosyncracies of reasoning

which, taken together, reflect all the ways that people reason, deduce, induce, syllogize, and come to conclusions or "concludify." From this, a contra–logic is developed that represents the assumptions and reasoning styles of an individual that make his idio-logic appear sensible or reasonable to him. The psycho-logic answers the question (in terms of mentational psychological traits) of what kind of a person, psychologically, that individual would have to have been in order for him to have reasoned as he did. And the pedago-logic has to do with the ways in which one would instruct or do therapy with an individual in order to resonate to his particular idio-logical styles of thinking. There is an extensive and logical analysis of this method applied to suicide, both manually (Shneidman, 1969) and by computer (Ogilvie, Stone, and Shneidman, 1976).

8. *Biological, Evolutionary.* Philosopher Stephen Pepper makes a common-sense point about suicide and evolution (1942, p. 242):

> It is most unlikely that a drive to commit suicide, whether piecemeal or all at once, is an instinctive basic drive. For organisms so endowed would long ago have eliminated themselves and left the world to those inheriting repertories of drives toward self-preservation.

Dr. Henry Murray succinctly says: "Suicide does not have *adaptive* (survival) value but it does have *adjustive* value for the organism . . . because it abolishes painful tension" (1953, p. 15; 1980, p. 216).

Suicide has been variously called the most daring, most courageous, most generous way to die (*and* its opposite, the most cowardly way to die), but, a priori, it certainly is not the most adaptive mode of death in an evolutionary sense. Does suicide serve any evolutionary function?

One might say that suicide is a way of weeding out the unfit, a self-selected way of thinning out the human herd. It is a way of death in which the suicide proclaims by his act that he is unfit to be a member of the human race and, by indirect implication, not fit to reproduce in it. Suicide is the ultimate contraceptive. When one speaks in this way, one would seem to limit the discussion of suicide

FOIA # none (URTS 16371) DocId: 70105748 Page 16

to individuals of child-bearing or child-initiating age. For males, this would be adolescence through old age—the range of practically all male suicides. For both sexes, suicide in today's world would seem to be unnecessary, at least biologically speaking, in that a hysterectomy or vasectomy would produce the same evolutionary results.

We also need to consider the instances in which older persons (beyond child-bearing age) may commit suicide by removing themselves from the group and thereby indirectly providing more of a limited food supply to the younger and potentially child-bearing members. The oft-told stories of the Eskimos come to mind in this connection, and at a tangent (where the element of childbearing is irrelevent), the saga of Captain Robert Scott in the Antarctic. It may well be, however, that from the biological and evolutionary points of view suicide occurs so infrequently compared with all other modes of death, that these reflections are moot.

This leads us to the next thought: In the sense that neo-Darwinian Richard Dawkins (*The Selfish Gene*, 1976) writes about natural selection, the act of suicide is not inconsistent with evolutionary theory. In one of the key sentences in his book he says: "... a predominant quality to be expected in a successful gene is ruthless selfishness" (p. 2). In a similar way, the suicidal individual behaves rather like the selfish gene—essentially concerned with its own individual fate and unconcerned with the welfare of the species. Suicide is an individual act, motivated by the urge to satisfy, or reduce, certain psychological needs. The presence of suicide in our species is, from a biological point of view, similar to the presence of, say, Down's syndrome. The most remarkable fact about Down's syndrome is its relative infrequency. In general, the single best sperm selfishly beats all the inferior (equally selfish?) sperm to the ovum (and the better ova are receptive to sperm); otherwise we might be an even less successful race of mostly Down's syndrome individuals. Similarly, suicide is a selfish event of relatively infrequent occurrence in a race of individuals almost every one of whom, at one time or another, suffers some psychological insults and existential emptiness that might be grounds for committing suicide—but doesn't do so.

9. *Constitutional.* There is a long historical thread of trying to understand man's behavior in terms of his constitution or his inner biological (physiological, biochemical) workings. The ancient Greek physician Galen (130–200 A.D.) posited four humors: sanguine (blood), phlegmatic (phlegm), choleric (yellow bile), and melancholic (black bile). Burton's *Anatomy of Melancholy* (1652) is an explication of melancholy. Early in this century, Ernest Kretchmer (1888–1964) and W. H. Sheldon attempted to link constitutional types to temperament.

10. *Biochemical.* In our own day, with biochemical techniques of increased sophistication, there has been a thrust, particularly by physicians, to put into medical terms different aspects of the human condition, including a substantial effort to reduce the reason for suicide to biochemical depression. While there may be some basis for this, it is far from the whole story. Suicide and depression are not synonymous. Nonetheless, the substantial work of current investigators of depression like George Murphy, Aaron T. Beck, Ari Kiev, and Frederick K. Goodwin merits careful study. The treatment of depression with pharmaceuticals enjoys considerable success.

11. *Legal.* In the United States, only Alabama and Oklahoma consider *committing* suicide a crime, but inasmuch as punishments are too repugnant to be enforced, there is no penalty for breaking this law. In several states, suicide attempts are misdemeanors, although these laws are seldom enforced. Thirty states have no laws against suicide or suicide attempts but every state has laws which specify that it is a felony to aid, advise, or encourage another person to commit suicide. There are essays and books about the legal aspects of suicide by, among others, Helen Silving (1957), Glanville Williams (1957), Thomas Shaffer (1976), and Margaret P. Battin (1982).

12. *Preventional.* Shneidman, Farberow, and Litman (1970) are generally associated with approaching suicide from a preventive perspective. The Suicide Prevention Center in Los Angeles was established in 1958. They concluded from their research there that the vast majority (about 80%) of suicides have a recognizable presuicidal phase. In reconstructing the events preceding a death by means of a

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Some Idols About Death

It is fairly obvious that death and suicide are related, for what is suicide but the setting of one's own time and circumstances of death. More than 20 years ago a set of common-place fables (misconceptions or myths) about suicide was developed (Shneidman & Farberow, 1961). These fables (commonly believed erroneous notions) included the following: That people who talk about suicide don't commit suicide; that suicide happens without any warnings or clues; that suicidal people are fully intent on dying; that once a person is suicidal he is suicidal forever; that sudden improvement following a suicidal crisis always means that the suicidal risk is over; that suicide strikes much more often among the rich or, conversely, that it occurs almost exclusively among the poor; that suicide is inherited or "runs in families;" that all suicidal individuals are mentally ill, and that suicide is always the act of a psychotic person. None of these is true.

On further reflection it is clear that these misconceptions rest on more fundamental *idols* (erroneous ways of looking at nature), specifically, idols about death itself. In order to discuss the idols surrounding death we need first to turn to the writings of Sir Francis Bacon on the general idols which stand in the way of our clear perception and understanding of all (or any) knowledge.

Bacon was a great Elizabethan intellect who was central in facilitating the transition from medieval scholasticism to the modern scientific method which combines direct observation and inductive reasoning. His most celebrated work, *Novum Organum*, published first in 1620, is considered to have made a major turning point in the overall evolution of Western thought.

Bacon considered it important to discuss in detail those human fallacies which act as obstacles to clear observation and to incisive inductive thinking. He called these obstacles "idols." They are the "false notions which are now in possession of human understanding." These idols (*idolae*) are erroneous ways of looking at nature. In the *Novum Organum* Bacon named and discussed their four kinds, roughly as follows:

1. Idols of the Tribe (*Idola Tribus*). These are fallacies that accrue to humanity in general. They include the tendency to support a preconceived opinion by emphasizing instances which tend to corroborate it and by neglecting or disregarding negative occurrences which oppose it.
2. Idols of the Cave (*Idola Specus*). These are errors peculiar to the particular mental makeup of each individual. Here, Bacon's practical suggestion is:

> In general let every student of nature take this as a rule, that whatever his mind seizes and dwells upon with particular satisfaction is to be held in suspicion.

3. Idols of the Market Place (*Idola Fori*). These are errors arising in the mind from the influence of *words*, especially words that are names for such non-existent things as "mind" or "soul."
4. Idols of the Theater (*Idola Theatri*). These are erroneous modes of thinking resulting from uncritically accepting whole systems of philosophy or from fallacious methods of demonstrating empirical proof. Bacon certainly implied that not everything that Aristotle said is true: Sweet Nature herself should be looked at directly. One should—as Aldous Huxley some 200 years later wrote in

FOIA # none (URTS 16371) DocId: 70105748 Page 18

a heart-breaking letter attendant to the death of his small daughter—sit before Nature as a child and let the facts array themselves before one's unprejudiced eyes.

Of particular interest to us in the present context are the Idols of the Cave. As Bacon tells us: "The idols of the individual man, for everyone . . . has a cave or den of his own which refracts and discolors the light of nature." With respect to suicide, each person figuratively builds for himself in relation to the cryptic topics of his life and death, his own (mis)conception—vault of beliefs, understandings, and orientations: "Idols of the Grave," as I will call them. Further, I would propose four subcategories of these Idols of the Grave, specifically as they concern: (1) the classification of suicidal phenomena; (2) the relationships between suicidal and death phenomena; (3) the classification of death phenomena; and (4) the concept of death itself.

THE IDOL THAT THE PRESENT CLASSIFICATIONS OF SUICIDAL PHENOMENA ARE MEANINGFUL

The use of an illustration may be the best introduction to this topic. A woman of about 30 years of age was seen on the ward of a large general hospital after she had returned from surgery. She had, a few hours earlier, shot herself in the head with a .22 caliber revolver, the result being that she had enucleated an eye and torn away part of her frontal lobe. Emergency surgical and medical procedures had been employed. When she was in bed subsequent to surgery, her head was enveloped in bandages, and the appropriate tubes and needles were in her. Her chart indicated that she had attempted to kill herself, her diagnosis being "attempted suicide." It happened that in the next bed there was another young woman of about the same age. She had been permitted to occupy the bed for a few hours to "rest" prior to going home, having come to the hospital that day because she had cut her left wrist with a razor blade. The wound

required two stitches. She had had, she said, absolutely no lethel intention, but had definitely wished to jolt her husband into attending to what she wanted to say to him about his drinking habits. Her words to him had been, "Look at me, I'm bleeding." She had taken this course after she had, in conversation with her husband, previously threatened suicide. Her chart, too, indicated a diagnosis of "attempted suicide."

Common sense should tell us that if we obtained scientific data from these two cases (psychiatric anamnestic data, psychological test data, blood and urine specimens, etc.) and then grouped these materials under the single rubric of "attempted suicide," we would obviously run the risk of masking precisely the differences which we might wish to explore. Common sense might further tell us that the first woman could most appropriately be labelled as a case of "commited suicide" even though she was alive), and the second woman as "nonsuicidal" (even though she had cut her wrist with a razor blade). But, aside from the issue of what would be the most appropriate diagnosis in each case (and hundreds of similar instances), the common heading of "attempted suicide" might definitely limit rather than extend the range of our potential understanding.

Individuals with clear lethal intention, as well as those with ambivalent or no lethal intention, are currently grouped under the heading of "attempted suicide": We know that individuals can attempt to attempt, attempt to commit, attempt to be non-suicidal. All this comes about largely because of oversimplifications as to types of causes and a confusion between modes and purposes. (The law punishes the holdup man with the unloaded or toy gun, precisely because the victim must assume that the bandit has, by virtue of his holding a "gun," covered himself with the semantic mantle of "gunman.") One who cries "help" while holding a razor blade is deemed by society to be suicidal. Although it is true that the act of putting a shotgun in one's mouth and pulling the trigger with one's toe is almost always related to lethal self-intention, this particular relationship between method and intent does not hold for most other methods, such as ingesting barbiturates or cutting oneself with a ra-

FOIA # none (URTS 16371) DocId: 70105748 Page 19

zor. Intentions may range from deadly ones, cries for help, and psychic indecisions, all the way to clearly formulated nonlethal intention in which a semantic usurpation of a "suicidal" mode has been consciously employed.

It may not be inaccurate to state that in this century there have been two major theoretical approaches to suicide: the sociological and the psychological, identified with the names of Durkheim and Freud, respectively. Durkheim's delineation of four etiological types of suicide is probably the best-known classification. For my part, I have often felt that this famous typology of suicidal behaviors has acted as a brilliantly conceived sociological motorcycle (anomic) with three psychological sidecars (altruistic, egoistic, and fatalistic) performing effectively in textbooks for almost a century, but running low on power in clinics, hospitals, and consultation rooms. This classification epitomizes some of the strengths and shortcomings of any study based almost entirely on social, normative, tabular, nomothetic data. It is probably fair to say, however, that Durkheim was not as interested in suicide per se, as he was in the explication of the power of his general sociological method.

The Freudian psychological formulation of suicide, as hostility directed toward the introjected love object, was more a brilliant inductive encompassment than an empirical, scientific particularization. In this country, the psychoanalytical concept of suicide was given its most far-reaching exposition by Karl Menninger, who, in *Man Against Himself* (1938), not only outlined four types of suicide (chronic, focal, organic, and actual) but also proposed three basic psychological components: the wish to kill, the wish to be killed, and the wish to die.

Neither of these two theoretical approaches to the nature and causes of suicide constitutes the classification most common in everyday clinical use. That distinction belongs to a rather homely, supposedly common-sense division, which in its barest form implies that all humanity can be divided into two groupings, suicidal and nonsuicidal, and then divides the suicidal category into committed, attempted, and threatened. Although the second classification is superior to the suicidal versus nonsuicidal view of life, that it is not

theoretically nor practically adequate for understanding and treatment is one of the main tenets of my suicidology.

THE IDOL THAT LIVING AND DYING ARE SEPARATE

Living and dying have too often been seen (erroneously) as distinct, separate, almost dichotomous activities. To correct this view one can enunciate another activity, which might be called the psychodynamics of dying. One of its tenets is that, in cases where an individual is dying over a period of time, which may vary from hours to years in persons who "linger" in terminal illnesses, this interval is a psychologically consistent extension of styles of coping, defending, adjusting, interacting, and other modes of behavior that have characterized that individual during most of his life up to that time.

As we grow older, we grow more like ourselves. This can also be taken to mean that during the dying period, the individual displays behaviors and attitudes which contain great fealty to his lifelong orientations and beliefs. Draper says (1944): "Each man dies in a notably personal way." Suicidal and/or dying behaviors do not exist in vacuo, but are an integral part of the life-style of the individual.

It is important for a potential helper to avoid seeing a dichotomy between the "living" and the "dying." Most people who are seriously ill with a life-threatening disease (unless they are in extended coma) are very much alive, often exquisitely attuned to the symphony of emotions within themselves and the band of feelings of those around them. To tell a person that he or she has cancer may change the person's inner mental life irretrievably, but it does not lobotomize that person into a psychologically nonfunctioning human being; on the contrary, it may stimulate that person to consider a variety of concerns and reactions.

Nor is there any natural law—as those who talk about a certain number of set stages of dying would seem to assert—that an individual has to achieve a state of psychoanalytical grace or any other kind

FOIA # none (URTS 16371) DocId: 70105748 Page 20

of closure before death sets its seal. The cold fact is that most people die too soon or too late, with loose threads and fragments of life's agenda uncompleted.

My own notion of the psychology of dying is that each individual tends to die pretty much as he or she has lived and especially as he or she has previously reacted in comparable periods of threat, stress, failure, challenge, shock, and loss during the life. In this context I can paraphrase the nineteenth century German biologist Haeckel's famous dictum and say that, in a sense, *oncology recapitulates ontogeny*; by which I mean, roughly speaking, the course of an individual's life while he or she is dying over time, say of cancer, duplicates or mirrors or parallels the course of the life during its previous "dark periods." That is, one dies as one has lived in the terrible moments of one's life.

To anticipate how a person will behave as he or she dies, we look at neither the plateaus nor the highlights of the life, but we search, as an eminent cancer doctor has recently put it, "in the hollow of the waves." Dying is stressful; thus it makes sense to look at earlier episodes in one's life that would appear to be comparable or parallel or psychologically similar. There are certain deep consistencies in all human beings. An individual lives characteristically as he or she has lived in the past; and dying is living. There are no set phases. People live differently and people die differently—much as they have lived during other episodes in their lives that were, to them, presages of their final dying period. My assertion is that the psychological history of the individual while he has cancer mirrors or reflects that same person's psychological history, in comparable periods throughout his lifetime, from early years on.

A recent article by Hinton (1975) reports a study of 60 terminally ill cancer patients. The study inquired into the relationship of each patient's personality and state of mind before and during the illness. The results indicated that we need to know the individual's previous patterns of handling life's demands *in detail*—the dozens of ways in which an individual has been strong, long-suffering, aggressive, weak, passive, fearful, and all the rest.

Hinton's findings, although tentative, are thought provoking:

> Facing problems: This is the quality of previous character described by the husband or wife to indicate that the patient was one who coped effectively with life's demands rather than avoiding issues. It does appear to influence the most during the terminal illness. The uniform trend was for those who had previously coped well to be less depressed, anxious or irritable and to show less social withdrawal. This was one of the more consistent significant findings in the whole study. . . . Past difficulties in coping also increased the likelihood of current depression and anxiety . . . there is support for the frequent impression that a patient's previous manner of living influences the way he dies.

All this suggests that if one could know a great deal about the other person (over the span of the entire life) then one could make accurate statements about future behavior that would not be simply prediction in the ordinary sense, but would be more like reasoned extrapolations from the individual's past patterns of behavior. While death may occur as a totally unexpected event (like being assassinated or killed in an accident), suicide, *in theory*, should never come as a total surprise *if* one knew enough about the intimate inner life over the entire course of the individual's psychological history. That history *is* the individual, and individuals are rarely—by definition, never—radically inconsistent with themselves. It is not only that they have loyalty or fealty to themselves; it is that they are stuck with their own armamentarium of coping behaviors.

THE IDOL THAT THE TRADITIONAL CLASSIFICATION OF DEATH PHENOMENA IS CLEAR

The International Classifications of the Causes of Death lists 137 *causes* such as pneumonia, meningitis, malignant neoplasms, myocardial infarctions. In contrast, there are only four commonly recognized *modes* of death: natural, accidental, suicidal, and homicidal—the NASH categories of the modes of death. In some cases, cause of

death is used synonymously to indicate the *natural* mode of death. Thus, the standard U.S. Public Health Service Certificate of Death has a space to enter the cause of death (implying the mode as natural) and, in addition, provides a space to indicate the accidental, suicidal, or homicidal modes. It is implied that these four modes of death constitute the final ordering into which each of us must be classified. The psychological fact is that some of us do not fit easily into one of these four crypts.

The main shortcoming of the common classification of the NASH modes is that, in its over simplification and failure to take into account certain necessary dimensions, it often poses serious problems in classifying deaths meaningfully. The basic ambiguities can be seen most clearly by focusing on the distinctions between natural (intrasomatic) and accidental (extrasomatic) deaths. On the face of it, the argument can be advanced that most deaths, especially in the younger years, are unnatural. Perhaps only in the cases of death of old age might the termination of life legitimately be called natural. Let us examine the substance of some of these confusions.

If an individual (who wishes to continue living) has his skull invaded by a lethal object, his death is called accidental; if another individual (who also wishes to continue living) is invaded by a lethal virus, his death is called natural. An individual who torments an animal into killing him is said to have died an accidental death, whereas an individual who torments a drunken companion into killing him is called a homicidal victim. An individual who has an artery burst in his brain is said to have died from a cerebral-vascular accident, whereas it might make good sense to call it a cerebral-vascular natural death. What has been confusing in this traditional approach is that the individual has been viewed as a kind of biological *object* (rather than as a psychological, social, biological *organism*) and as a consequence, the role of the individual in his own demise has been omitted. My profered solution to these puzzlements is to suggest that all deaths, in *addition* to their NASH designation, also be identified as intentioned, subintentioned (where an individual plays an unconscious or latent role in effecting his natural, accidental, or homicidal death) or unintentioned. This classification puts man back

into his own dying by recognizing that there are psychological components in most dying scenarios.

THE IDOL THAT THE CONCEPT "DEATH" IS ITSELF OPERATIONALLY SOUND

We come now to what for some may be the most radical and iconoclastic aspect of this presentation so far; specifically, the suggestion that a major portion of the concept of "death" is operationally meaningless and ought therefore to be eschewed. Let the reader ask the question of the author: "Do you mean to say that you wish to discuss suicidal phenomena without the concept of death?" The author's answer is in the affirmative, based, I believe, on compelling reasons. Essentially, these reasons are epistemological; that is, they have to do with the process of knowing and the question of what it is that we can know. Our main source of quotable strength is the physicist Percy W. Bridgman. Essentially his concept is that death is not experienceable, that if one could experience it, one would not be dead. One can experience *another's* dying and *another's* death and his own dying—although he can never be sure—but no man can experience his own death.

In his book *The Intelligent Individual and Society*, Bridgman (1938) states his view as follows:

> There are certain kinks in our thinking which are of such universal occurrence as to constitute essential limitations. Thus the urge to think of my own death as some form of my experience is almost irresistible. However, it requires only to be said for me to admit that my own death cannot be a form of experience for if I could still experience, then by definition, it would not be death. Operationally my own death is a fundamentally different thing from the death of another in the same way that my own feelings mean something fundamentally different from the feelings of another. The death of another I can experience; there are certain methods of recognizing death and

FOIA # none (URTS 16371) DocId: 70105748 Page 22

> certain properties of death that affect my actions in the case of others. Again it need not bother us to discover that the concept of death in another is not sharp, and situations arise in practice where it is difficult to say whether the organism is dead or not, particularly if one sticks to the demands that "death" must be such a thing that when the organism is once dead it cannot live again. This demand rests on mystical feelings, and there is no reason why the demand should be honored in framing the definition of death. . . . My own death is such a different thing that it might well have a different word, and perhaps eventually will. I am always alive.

This pragmatic view of death—in the strict philosophical sense of pragmatism—is stated most succinctly in a side remark about death by the father of pragmatism, Charles Sanders Peirce, who in discussing metaphysics said (1955):

> We start then, with nothing, pure zero. But this is not the nothing of negation. For *not* means *other than*, and *other* is merely a synonym of the ordinal numeral *second*. As such it implies a first; while the present pure zero is prior to every first. The nothing of negation is the nothing of death, which comes *second to*, or after, everything.

Two further thoughts on death as an experience: Not only, as we have seen, is death misconceived as an experience, but (1) it is further misconceived as a bitter or calamitous experience. It may very well be that for the survivors, but they are the witnesses to an outcome, not the participants to a process in which there is no viable survivor; and (2) it is still further misconceived as an *act*, as though dying were something that one had to perform. On the contrary, dying can be a supreme passivity, rather than the supreme act or activity. One does, of course, participate in one's own dying and can select to act in this way or that, but, in essence, it will be done for you. Dying is one thing that no one has to "do." Live long enough—or just live—and it will happen, try to the contrary as you will.

We should recognize that our notions of suicide are, at *any* tim[e] in history, shaped in part by our notions of "death." That is why i[t] was deemed necessary to explore some of the Idols of the Dead t[o] look at the pervasive confusions attendant to this obfuscator[y] word.

FOIA # none (URTS 16371) DocId 70105748 Page 23

suicides and to make this discussion in as reasonable and as ordinary a language as possible.

The issue of precision versus relevance touches even definition. Recognizing that suicidology (or psychology or psychiatry) does not have the veridical value of the laws of physiology or physics, I do not feel pressured to formulate a definition of suicide that might account for every imaginable esoteric, recondite or arcane occurrence of self-destruction. I am reminded of the flawed definition of Maurice Halbwachs (1930, p. 479):

> By suicide one means every case of death that results from an act undertaken by the victim himself with the intention, or the view to killing himself, *and which is not a sacrifice.*" (Italics in original.)
>
> (*On appelle suicide tout ças de mort qui resulte d'un acte acompli par la victime elle-même avec l'intention ou en vue se tuer,* et qui n'est pas un sacrifice.)

Why not a sacrifice?

Rather, I aim for a practical definition, guided by wisdom and common sense, that applies sensibly to *almost* every conceivable situation of self-destruction, whether done characterologically (macrotemporally) by a Cesare Pavese (1935–1950 [1961]); thoughtfully (mesotemporally) on principle, by a Socrates; dyadically (mesotemporally) by a John Doe with cancer who arranges his own death; or reflexively (microtemporally), born out of the situation-of-the-moment and the esprit de corps, by a soldier in combat who throws himself, in the presence of his comrades, on an enemy grenade. Each of these instances, I would maintain, can be meaningfully conceptualized—and in *some* cases could have been usefully treated—in terms of the 10 commonalities of suicide.

Situational Aspects of Suicide

In the popular mind (as reflected, say, in newspaper accounts), the causes of suicide are almost entirely identified with what serious suicidologists would call the precipitating events. These refer to such occurrences as suffering ill health, being jilted, losing one's fortune, being humiliated or shamed, and so forth. Environment is all. The stimulus is the fact wherein we catch the reason for the act.

Of course there are situational aspects in every suicidal act. Let me quote from Henry A. Murray on this matter in general (Murray, 1938, pp. 39–40):

> Since, at every moment, an organism is within an environment which largely determines its behavior, and since the environment changes—sometimes with radical abruptness—the conduct of an individual cannot be formulated without a characterization of each confronting situation, physical and social. It is important to define the environment, since two organisms may behave differently only because they are, by chance, encountering differing conditions. It is considered that two organisms are dissimilar if they give the same response but only to

FOIA # none (URTS 16371) DocId: 70105748 Page 24

different situations as well as if they give different responses to the same situation. Also, different inner states of the same organism can be inferred when responses to similar external situations are different. Finally, the assimilations and integrations that occur in an organism are determined to a large extent by the nature of its closely previous, as well as by its more distantly previous environments. In other words, what an organism knows or believes is, in some measure, a product of formerly encountered situations. Thus, much of what is now *inside* the organism was once *outside*. For these reasons, the organism and its milieu must be considered together, a single creature–environment interaction being a convenient short unit for psychology.

There are two common characteristics of suicide that may be thought of as being primarily *situational*. They are:

[I] *The common* stimulus *in suicide is unendurable psychological* pain

Pain is what the suicidal person is seeking to escape. In any close analysis, suicide is best understood as a combined movement toward cessation of consciousness and as a movement away from intolerable emotion, unendurable pain, unacceptable anguish. Indeed, the wish or need to effect a cessation of consciousness is because of the pain. No one commits suicide out of joy; no suicide is born out of exultation. The enemy to life is pain and when pain does not come from one's soma then the threat to life is from those who cause the pain or the pain of emotion within one's mind. It is psychological pain of which we are speaking; metapain; the pain of feeling pain. As we shall see, the main clinical rule is: Reduce the level of suffering, often just a little bit, and the individual will choose to live.

The "common stimulus" can be read in systems theory ten the "common information input" and, of course, is not precisel pain itself but rather the desire to relieve the pain. Yet it i pain—the naked psychological pain of ache or hurt—which is o the several essential, but not sufficient, conditions of every su act.

We speak of unbearable pain, unendurable anguish, intole emotion. One must ask: Are these in opposition to pain whi bearable, anguish which is endurable, emotion which is tolerabl is it not the case that the individual defines for himself what is ble or impossible and that the individual's definition or vie things is then the key factor? And further: In suicide there i external situation (e.g., a concentration camp is real) and the int situation, yet the external situation is defined by the individu possible or impossible. To some extent, humans can define the tion and re–evaluate their needs.

It is methodologically not fair to define a situation post hoc to state that the pain must have been unbearable *because* the vidual committed suicide). In general, we can assert that an un able pain is a great pain about which the individual mak qualitative judgment: This far and no farther. It is a level of exceeding a threshold that is unique to that individual. It is a ment that touches on life itself. Is life worth living? It relat Viktor Frankl's post-concentration camp writings (1963) on the *fying* meaning of life.

There is, in addition, some tangible evidence on this issue w may serve as the necessary evidence for establishing the operat meaning of "unbearable." These significant bits of evidence co us from those rare individuals who have done a clearly lethal (such as shooting themselves in the head, immolating themse jumping from a high place) and have fortuitously survived. recitations of what was going on in their minds, their stories o bearable pain and the inner-felt necessity to do *something* to the flow of unendurable anguish, give us the necessary epistemo cal grounds for making our assertions.

[II] *The common* stressor *in suicide is frustrated psychological* needs

Suicide is best understood not so much as an unreasonable act—every suicide seems logical to the individual who commits it, given that person's major premise, style of syllogizing, and constricted focus—as it is a reaction to frustrated psychological needs. A suicide is committed because of thwarted or unfulfilled needs. Suicides are born, negatively, out of needs. In this sense one may say aphoristically: There are many pointless deaths but never a needless suicide.

Psychological needs are the very color and texture of our inner life. The systems theorist Ludwig von Bertalanffy (1969) emphasizes that self-destruction is intimately connected with man's symbolic and psychological world:

> The man who kills himself because his life or career or business has gone wrong, does not do so because of the fact that his biological existence and survival are threatened, but rather because of his quasi-needs, that is, his needs on the symbolic level are frustrated.

In order to understand suicide in this kind of context, we are required to ask a much broader question, which, I believe, is the key: What purposes do most human acts, in general, intend to accomplish? The best non-detailed answer to that question is that, in general, human acts are intended to satisfy a variety of human *needs*. In relation to suicide, there is no compelling *a priori* reason why a typology (or classification or taxonomy) of suicidal acts might not *parallel* a classification of *general* human needs. Indeed, such a classification of needs now exists. It can be found in Murray's *Explorations in Personality* (1938). These needs, as they stand, provide a possible useful taxonomy of suicidal behaviors.

Most suicides probably represent *combinations* of various needs, so that any particular case of suicide might be subsumed under two or three different categories. An example would be a person who commits suicide by means of Russian roulette (by firing a bullet through his head with a one-out-of-six chance of death), largely be-

cause of some scandal in which that person's honor and reput have been impugned. Such an act would seem to have at leas components: The need, firstly, to avoid criticism, humili shame, or blame, together with the need somehow to vindicate self or, to put it in a word, *Defendance*; and, secondly, becau this case the technique of committing suicide is too dramatic disregarded—the need, in these dire straits, to play with one's li gamble with fate, to take excessive risks, to leave life itself chance or, to put it in a word, *Play*. (I shall use the word "L here instead of "play" simply because the topic is too lugubri use this word with its more frivolous connotations.) Thus i case, we might label that death as a Defendance–Ludic suici

The clinical rule is: Address the frustrated needs and the su will not occur. In general, the goal of psychotherapy is to de the patient's psychological discomfort. One way to operatio this task is to focus on the thwarted needs.

FOIA # none (URTS 16371) DocId: 70105748 Page 26