Aphorisms of Suicide and Some Implications for Psychotherapy*

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The author proposes twenty aphorisms—essential truths—about suicide. From these, some theoretical implications about the psychological nature of suicide as well as some practical implications for psychotherapy with highly lethal individuals are derived. In addition, some general suggestions for management of suicidal persons are given.

I. INTRODUCTION

No one can speak with total objectivity about a topic as complicated as suicide. Thinking about death and self-destruction can be endlessly intriguing—and always has important subjective elements. Even if one were to limit one's discourse to the objective statistics and demographic facts about suicide, that in itself would imply a statement of one's view of things. It is probably best for anyone who seeks to discuss suicide to show his flags and allegiances explicitly, saying, as it were, "Here are some of my views on this matter." Such a presentation has the advantage of the author sharing with the reader where he stands, what his beliefs are, and who—vis-a-vis suicide—he is.[1]

The driving thought behind this essay is that psychotherapy is most effective when it flows from understanding, that remediation follows definition. This assertion might seem too obvious to belabor, but the present difficulties and inefficiencies in treating, as one example, schizophrenia—where we do not definitely know its cure, its causes, and (most importantly) its nature, if it is an "it" which clearly it is not—should alert us to the importance of clear conceptualization. This paper cannot seek to solve the problem, but it hopes to clarify the issue, specifically to comment on suicide in such a way as to yield direct implications for intervention.

The comments will take the form of aphorisms. An aphorism is a pithy short statement stating a general doctrine or truth. It is a maxim or saying; a principle expressed tersely in a few telling words. Historically—see the

*Presented at the *24th Emil A. Gutheil Memorial Conference* of the Association for the Advancement of Psychotherapy, New York City, Nov. 5, 1983.

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article on aphorisms in the *Encyclopaedia Britannica*—aphorisms are closely tied to the development of medicine.

> The name was first used in the *Aphorisms of Hippocrates,* a long series of propositions concerning the symptoms and diagnosis of disease and the art of healing in medicine. . . . The first aphorism, perhaps the best known of all, runs as follows: "Life is short, art is long, opportunity fleeting, experimenting dangerous, reasoning difficult; it is necessary not only to do oneself what is right, but also to be seconded by the patient, by those who attend him, by external circumstances."[2]

In the Western world at large probably the most acclaimed set of aphorisms are those philosophic ruminations of Pascal (1623–1662) known as the *Pensées.*[3] In those notes and fragments Pascal posits and then discusses the "Bet Situation," by which he means the bet on whether or not God exists. In a series of aphorisms he gives arguments for betting on the side of His existence.

In our own time the famous English novelist John Fowles—*The Collector, The Magus, The French Lieutenant's Woman, The Ebony Tower,* etc.—has written a set of contemporary aphorisms entitled *The Aristos,* in which he also (like Pascal) creates aphorisms about death, immortality, and the Bet Situation.[4] Not unexpectedly, his truths are quite different from those of Pascal.

It is obvious that one way to define and to discuss a topic is to do so aphoristically. In a set of aphorisms there is usually, if not a thread of logic, then at least a flow of thought from one aphorism to the next, building a general point of view. That is what I hope to do with my aphorisms on suicide.

II. APHORISMS ABOUT SUICIDE

1. There are two basic, albeit contradictory, truths about suicide: (A) Suicide should never be committed when one is depressed (or disturbed or constricted); and (B) almost every suicide is committed for reasons that make sense to the person who does it.
2. We can empathize with every person who has committed suicide and yet we should seek to thwart every suicidal plan that has not yet been consummated.
3. There is no such act as a rational suicide; but every suicide is a rational act—except possibly one committed by an actively psychotic person.
4. Suicide is both a logical and psychological phenomenon. As a logical thought disorder it is fueled by an individual's emotional turmoil and grounded in his psychological history.
5. The primary thought disorder in suicide is that of a pathological narrowing of the mind's focus, called constriction, which takes the form

of seeing only *two* choices: either something painfully unsatisfactory *or* cessation.

6. There is nothing intrinsically wrong (or aberrant) in thinking about suicide; it is abnormal only when one thinks that suicide is the *only* solution.
7. The chief shortcoming of suicide is that it unnecessarily answers a remediable challenge with a permanent negative solution. In contrast, living is a long-term set of resolutions with oftentimes only fleeting results.
8. Wilhelm Stekel and the other early psychoanalysts (1910 and after) overstated the case when they proclaimed that no one commits suicide who has not wished the death of another; that suicide is basically hostility directed toward the image of a loved one incorporated within the psyche. Not only is this explanation often off the mark but even more the individual who commits suicide usually does not even wish to kill himself.
9. Suicide should not be misunderstood as hostility directed toward the introjected love object; but rather suicide is better understood as anguish over the plight of the writhing self.
10. When suicide is a hostile act, it is often not the hostility of the perpetrator but rather the hostility of the significant others who have provoked or permitted the act.
11. The central issue in suicide is not death or killing; it is, rather, the stopping of the consciousness of unbearable pain which—unfortunately—by its very nature entails the stopping of life.
12. If tormented individnals could somehow stop consciousness and still live, why would they not opt for that solution? In suicide, "death" is not the key word. The key words are "psychological pain."
13. If the pain were relieved then the individual would be willing to continue to live. Nobody yearns to embrace "that skeleton with a scythe astride a white horse"; we just want to get out of the way of its stampeding hooves that hurt us.
14. As a psychological disorder suicide relates specifically to unmet or frustrated needs, such as the need for acceptance, achievement, dignity, self-regard, clear conscience, safety, and succorance. There are many pointless deaths, but never a needless suicide. Every suicide act is addressed to certain unfulfilled needs.
15. Suicide is not only a reaction to unmet needs, but also the need for important psychological freedoms, such as freedom from pain, freedom from guilt, freedom from shame, freedom from rejection and aloneness. When these freedoms are traumatically violated, an individual who realistically lacks "a court of appeal" may take matters into his own hands and remove his consciousness from the painful scene.

16. Much of what has been written about suicide is relatively useless for actual prevention. There can be little meaningful practical research on suicide until the obfuscating categories of "attempted suicide" and "threatened suicide" are eschewed and the continua of "perturbation" and "lethality" are understood and employed.
17. Suicide is not a "right" any more than is the "right to belch." If the individual feels forced to do it he will do it. That capacity for untoward action cannot be taken away.
18. A definition of suicide should never be undertaken lightly. Much—especially implications for individual rescue and for global survival—depends upon it. The task of defining suicide is worthy of a separate book.
19. With some few clear exceptions, I am against suicide committed by other people but I want to reserve that option for myself.
20. Nietzsche said that "The thought of suicide is a great consolation; by means of it one gets successfully through many a bad night." I can say that the topic of suicide has been a great preoccupation that has kept me up more nights than I care to remember.

III. THEORETICAL IMPLICATIONS

There are certain notions on which the aphorisms rest (that are propaedeutic to them) and certain notions which flow out of them (that are implications of them). For purposes of this discussion they need not be separated. At least five relatively important general notions about suicide can be delineated:

A. That suicide is best understood not so much as a movement toward death as it is a movement away from something and that something is always the same: intolerable emotion, unendurable pain or unacceptable anguish. Reduce the level of suffering and the individual will choose to live.

B. That suicide is best understood not so much in terms of some sets of nosological boxes—e.g., depression or any of the labels in *DSM-III*—but rather in terms of two continua of general personality functioning: perturbation and lethality. Everyone is omnipresently rateable (by oneself or by others) on how disturbed he is (perturbation) and how deathfully suicidal he is (lethality). To say that an individual is "disturbed" or "suicidal" simply indicates that there is an elevation in that individual's perturbation and lethality levels, respectively. Moreover, it often happens that an individual is highly perturbed but not suicidal. It infrequently occurs that an individual is highly lethal but not perturbed. Experience has taught us the important fact that it is neither possible nor practical in an individual who is highly lethal and highly perturbed to attempt to deal with the lethality directly, either by moral suasion, confrontational interpretations, exhoration or whatever. (It does not work any better in suicide than it does with

alcoholism.) The most effective way to reduce elevated lethality is by doing so indirectly, that is by reducing the elevated perturbation. Reduce the individual's anguish, tension, and pain and his level of lethality will concomitantly come down, for it is the elevated perturbation that drives or fuels the elevated lethality.

C. That suicide is best understood not so much as a psychosis, a neurosis or a character disorder but rather as a more-or-less transient psychological constriction of affect and intellect. Synonyms for constriction are a tunneling or focusing or narrowing of the range of options usually available to *that* individual's consciousness when the mind is not panicked into dichotomous thinking: either some specific (almost magical) total solution *or* cessation. The range of choices has narrowed to two—not very much of a range. The usual life-sustaining images of loved ones are not only disregarded, they are not even within the range of what is in the mind. Boris Pasternak, writing of the suicidal deaths of several young poets, described life-threatening constriction in this way:

> A man who decides to commit suicide puts a full stop to his being, he turns his back on his past, he declares himself to be bankrupt and his memories to be unreal. They can no longer help or save him, he has put himself beyond their reach. The continuity of his inner life is broken, and his personality is at an end. And perhaps what finally makes him kill himself is not the firmness of his resolve but the unbearable quality of his anguish which belongs to no one, of this suffering in the absence of the sufferer, of this waiting which is empty because life has stopped and no one can feel it.[5]

One of the most dangerous aspects of a suicidal state (high lethality/high perturbation) is the presence of constriction. Any attempt at rescue or remediation has to deal almost from the first with the pathological constriction.

D. That suicide is best understood not so much as an unreasonable act (or a defect in cognition) but as a reaction to frustrated psychological needs. These needs—taken from the monumental work on personality by Henry A. Murray[6]—include the needs for affiliation, avoidance (of pain), succorance,*—among many others. A suicide is committed because of frustrated or unfulfilled needs. In an even wider sense the systems theorist Ludwig von Bertalanffy—emphasizing that self-destruction is intimately connected with man's symbolic and psychological world—says:

> 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

*A partial listing of Murray needs includes the following: the need for abasement, achievement, affiliation, aggression, autonomy, counteraction, defendance, deference, dominance, exhibition, harm-avoidance, pain-avoidance, inviolacy, nurturance, order, play, rejection, sentience, sex succorance and understanding.

threatened, but rather because of his quasi-needs, that is, his needs on the symbolic level are frustrated.[7]

Given that there are no suicides in the absence of thwarted needs, if one will but address the frustrated needs, the suicide will then not have to occur.[8]

E. That suicide is best understood not so much in relation to the idea of a reified Death as it is in terms of the idea (in the mind of the chief protagonist) of "cessation," specifically when cessation—the complete stopping of one's consciousness of unendurable pain—is seen by the suffering individual as a solution, indeed the perfect solution, of life's painful and pressing problems. The moment that the idea of the possibility of stopping consciousness occurs to the mind as the answer or as the way out in the presence of unusual constriction and elevated perturbation and high lethality, then the active suicidal scenario has begun.

With these several theoretical supplements (of the twenty aphorisms) in mind, we can now turn to the main point of this brief paper, namely, the implications for psychotherapy of this general point of view.

IV. IMPLICATIONS FOR PSYCHOTHERAPY

Initially I had developed implications for each of the twenty aphorisms but in the end it seems both tedious and somewhat repetitious to present them in this fashion. Instead, I decided to combine my twenty sets of working notes into one amalgam or synthesis of what seemed to me to be the most important implications for therapy from the view of suicide implicit in the aphorisms. The careful reader can easily match the implications for therapy with one or more aphorisms.

Some of the implications for psychotherapy are:

1. The therapist should ascertain the separate levels of the patient's perturbation and lethality (on a scale of 1 to 9) and make a day-to-day assessment of each of them. A lethality rating of 7, 8 or 9 indicates that the patient may be hazardously suicidal and that special measures need to be taken.

2. With a highly lethal suicidal person the main goal is, of course, to reduce the elevated lethality. The most important rule to follow is that *high lethality is reduced by reducing the patient's sense of perturbation.* One way to do this is by addressing in a practical way those in-the-world things that can be changed, if ever so slightly. In a sensible manner, the therapist should contact (preferably by telephone) the patient's spouse, lover, employer, government agencies, etc. In these contacts the therapist acts as ombudsman for the patient, promoting his interests and welfare. The subgoal is to reduce the real-life pressures that are driving up the patient's sense of perturbation.

A psychotherapist decreases the elevated perturbation of a highly suicidal person by doing almost everything possible to cater to the infantile idiosyncra-

sies, the dependency needs, the sense of pressure and futility, the feelings of hopelessness and helplessness that the individual is experiencing. In order to help a highly lethal person, one should involve others; create activity around the person; do what he or she wants done—and, if that cannot be accomplished, at least move in the direction of the desired goals to some substitute goals that approximate those which have been lost. Remind the patient that life is often the choice among lousy alternatives. The key to well functioning is often to choose the least lousy alternative that is practicably attainable.*

The basic principle is this: To decrease lethality one puts a hook on perturbation and, doing what needs to be done, pulls the level of perturbation down—and with that action brings down the active level of lethality. When the person is no longer highly suicidal—then the usual methods of psychotherapy can be usefully employed.

As to how to help a suicidal individual, it is best to look upon a suicidal act as an effort to stop nnbearable anguish or intolerable pain by "doing something." Knowing this usually guides us as to what treatment should be. In the same sense the way to save a person's life is also to "do something." Those "somethings" include putting that information (that the person is in trouble with himself) into the stream of communication, letting others know about it, breaking what could be a fatal secret, talking to the person, talking to others, proffering help, getting loved ones interested and responsive, creating action around the person, showing response, and indicating concern.

3. It is vital to counter the suicidal person's constriction-of-thought by attempting to widen the angle of the mental blinders and to increase the number of options, certainly beyond the two options of either having some magical resolution or being dead. An example may be useful. A teenage college student, demure, rather elegant (and somewhat wealthy) was encouraged to come to see me. She was single, pregnant, and suicidal, with a formed suicidal plan. Her challenge to me was that I somehow, magically, had to arrange for her to be the way she was before she became pregnant, virginal in fact, or she would have to commit suicide. Her being pregnant was such a mortal shame to her, combined with strong feelings of rage and guilt, that she simply could not "bear to live." At that moment suicide was the *only* alternative for her.

I did several things. For one, I took out a sheet of paper and—to begin to "expand her blinders"—said something like, "Now, let's see: You could have an abortion here locally." ("I couldn't do that.") (It is precisely the "can'ts" and the "won'ts" and "have to's" and "nevers" and "always" and "onlys" that are negotiated in psychotherapy.) "You could go away and have an abortion." ("I couldn't do that.") "You could bring the baby to term and keep the baby." ("I couldn't do that.") "You could have the baby

*This paragraph and the following two are paraphrased from a previous publication.[9]

and adopt it out." ("I couldn't do that.") "We could get in touch with the young man involved." ("I couldn't do that.") "We could involve the help of your parents." ("I couldn't do that.") and "You can always commit suicide, but there is obviously no need to do that today." (No response.) "Now, let's look at this list and rank them in order of your preference, keeping in mind that none of them is exactly what you want."

The very making of this list, my nonhortatory and nonjudgmental approach already had a calming influence on her. Within a few minutes her lethality had begun to deescalate. She actually rank-ordered the list, commenting negatively on each item. What was of critical importance was that suicide was now no longer ranked first or second. We were then simply "haggling" about life—a perfectly viable solution.

The point is not how the issue was eventually resolved or what intepretations were made as to why she permitted herself to become pregnant, other aspects of her relationships with men, etc. What is important is that it was possible to achieve the assignment of that day: to lower her lethality by widening her range of visible and realistic options including, but not limited to, the choice between suicide and one other unrealistic choice.

4. The mental pain of the suicidal person relates to the frustration or blocking of important psychological needs, that is, needs deemed to be important by that person. It should be the therapist's function to help the patient in relation to those thwarted needs. Even a little bit of improvement can save a life. Oftentimes just the possibility of a small amount of gain gives the perturbed individual enough hope and comfort to divert the suicidal course. In general, the goal of psychotherapy is to increase the patient's psychological *comfort.* One way to operationalize this task is to focus on the thwarted needs. Questions such as "What is going on?" "Where do you hurt?" and "What would you like to have happen?" can usefully be asked by a therapist helping a suicidal person.

The psychotherapist can focus on feelings, especially such distressing feelings as guilt, shame, fear, anger, thwarted ambition, unrequited love, hopelessness, helplessness, loneliness. The key is to improve the external and internal situations a J.N.D. (Just Noticeable Difference). This can be accomplished through a variety of methods: ventilation, interpretation, instruction, and realistic manipulation in the world outside the consultation room. That last means to do things, involve significant others, and invoke agencies. All this implies—when working with a highly lethal person—a heightened level of interaction during the period of elevated lethality. The therapist needs to work diligently, always giving the suicidal person realistic transfusions of hope until the perturbation intensity subsides enough to reduce the lethality to a tolerable, life-permitting level.

A highly suicidal state is characterized by its transient quality, its pervasive ambivalence, and its dyadic nature. Psychotherapists are well

advised to minimize, if not totally to disregard, those probably well-intentioned but shrill writings in this field which naively speak of an individual's "right to commit suicide"—a right which in actuality cannot be denied.

A dozen other special features in the management of a highly lethal patient can be mentioned. Some of these special therapeutic stratagems or orientations reflect the *transient, ambivalent,* and *dyadic* aspects of almost all suicide acts.

1. *Monitoring.* A continuous (preferably daily) monitoring of the patient's lethality.

2. *Consultation.* There is almost no instance in a psychotherapist's professional life when consultation with a peer is as important as when one is dealing with a highly suicidal patient.

3. *Hospitalization.* Hospitalization is always a complicating event in the treatment of a suicidal patient but it should not, on those grounds, be eschewed. Obviously, the quality of care—from doctors, nurses, and attendants—is crucial. Stoller, discussing one of his complex long-range cases, says:

> . . . there were several other factors without which the therapy might not have succeeded. First, the hospital. The patient's life could not have been saved if a hospital had not been immediately available *and a few of the personnel familiar with me and the patient.*[10] (Italics added.)

4. *Transference.* The successful treatment of a highly suicidal person depends heavily on the transference. The therapist can be active, show his personal concern, increase the frequency of the sessions, invoke the magic of the unique therapist-patient relationship, be less of a *tabula rasa,* give transfusions of (realistic) hope and nurturance. In a figurative sense I believe that Eros can work wonders against Thanatos.

5. *The involvement of significant others.* Suicide is often a highly charged dyadic crisis. It follows from this that the therapist, unlike his usual practice of dealing almost exclusively with his patient (and even fending off the spouse, lover, parents, grown children), should consider the advisability of working directly with the significant other. If the individual is married, it is important to meet the spouse. The therapist must assess whether, in fact, the spouse is suicidogenic; whether the patient ought to be separated from the spouse; whether there are misunderstandings which the therapist can help resolve; or to what extent the spouse is insightful and concerned. At the minimum the role of the significant other as hinderer or helper in the treatment process needs to be assessed.

6. *Careful modification of the usual canons of confidentiality.* Admittedly this is a touchy and complicated point, but the therapist should not ally himself with death. Statements given during the therapy session relating to

the patient's overt suicidal (or homicidal) plans should not be treated as a secret between two collusive partners.

Working with highly suicidal persons borrows from the goals of crisis intervention: not to take on and ameliorate the individual's entire personality structure and to cure all the neuroses but simply to keep the person alive. That is the *sine qua non* without which all other psychotherapy could not have an opportunity to function.

SUMMARY

An aphorism is a pithy short statement stating a general truth. This article presents twenty aphorisms about suicide. One example: "There are many pointless deaths, but never a needless suicide." What is implied is that every suicide is an effort to redress certain unfulfilled, thwarted or frustrated psychological needs. (These include the needs for affiliation, avoidance of pain, succorance—among some twenty psychological needs that have been identified.) The psychotherapeutic implication of this particular aphorism is fairly obvious: Reduce the sense of frustration or effect *some* satisfaction of the frustrated needs of the suicidal individual and the elevated level of perturbation will be mollified sufficiently so as to drop below the lethal threshold of suicidal action. For the twenty aphorisms about suicide, some implications for response and the management of suicidal persons are suggested in order to prevent suicide. In addition a few general suggestions are offered for the management of suicidal persons.

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