CHAPTER 1

Some Reflections of a Founder

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When I was in Vienna for the International Association for Suicide Prevention (IASP) meeting in 1985, I saw a stunning exhibition of the art, music, architecture, politics, and psychology of Vienna from 1870 to 1930 at the Kunsterhaus. The exhibition was called *Traum und Wirklichkeit*—"Dream and Reality." For me, the joint meeting of the American Association of Suicidology (AAS) and the IASP in San Francisco could be summed up with this brief sentence: *Ein Traum ist Wirklichkeit geworden*—"A dream has become reality." I was heartened to note the presence of many members from abroad (27 different countries) and from 36 separate states of the United States.

The Founding of the AAS

From 1966 to 1969, between my previous stay at the Los Angeles Suicide Prevention Center and my subsequent stints at Harvard and UCLA, I was at the National Institute of Mental Health (NIMH), serving as the first Chief of the Center for Studies of Suicide Prevention. In 1966 there were three suicide prevention centers in this country; by 1970 there were over 200. Dozens of research projects around the country were supported by the NIMH Center. The *Bulletin of Suicidology*, which later metamorphosed into *Suicide and Life-Threatening Behavior*, was begun. It was a lively period of considerable activity. It became evident to me that the time had come for a national organization relating the study of suicide and suicide prevention. I was determined to try to begin with a special meeting of the best available suicidologists in the country (and one from England). With the help of an old friend, Professor William E. Henry at the University of Chicago, a meeting was scheduled in Chicago on March 20, 1968. I believe that there was as much suicidological talent and experience at that table that day at the Conrad

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Hilton Hotel as has even been assembled in one place. The group consisted of Jacques Choron, Louis I. Dublin, Paul Friedman, Robert Havighurst, Lawrence Kubie, Karl Menninger, and Erwin Stengel. They were all then in their 70s and 80s; only Dr. Menninger and Professor Havighurst, bless them, are alive today.

That meeting was a kind of "reconvening" of the famous meeting in Freud's apartment in Vienna in 1910—the meeting of Freud, Adler, Jung, Stekel, and Oppenheim. The 1910 meeting is reported to us in English in Paul Friedman's 1967 edited book *On Suicide*, which was my point of departure. In my comments at the 1968 meeting, I noted that the 1910 meeting was unusual in a number of ways. It was the only meeting held by the Vienna psychoanalytic group on the topic of suicide; the meeting was chaired not by Freud but by Adler; it was held on the temporal threshold (within 1 year) of the splintering of that group; it was the occasion of the first enunciation by Wilhelm Stekel of the psychodynamic formulation that the yearning of the death of the self is the mirrored wish for the death of another; it seemed to stimulate Freud's own thoughts on death and suicide; and it focused on the adolescent and on the role of education in suicide prevention. In all, this was a remarkable set of overt and latent threads.

In addition, in the report of the 1968 meeting, I addressed the issue of what was then new in suicidology. In this effort, I listed and discussed some 18 items, which I am emboldened to summarize here:

1. A new permissiveness to discuss and study suicide and death.
2. A focus on suicide prevention, including its elaborations, especially postvention.
3. Changes in concepts of death, especially (since Menninger) "partial death" and my concept of "subintentioned death."
4. Changes in the format and uses of the death certificate—a forerunner of the concept of the psychological autopsy.
5. An increased understanding of the varieties of intention in self-destruction.
6. A recognition of the pivotal place of ambivalence in suicide.
7. An appreciation of the key role of the significant other in suicide and of the usually dyadic nature of suicide.
8. The role of affective states other than hostility in suicide, especially hopelessness and malignant pessimism.
9. A growing appreciation of the role of age in the human life cycle as it touches suicide.
10. The usefulness of explicating suicidality along the dimensions of perturbation and lethality.

11. An emphasis on the delineation and dissemination of the prodromal clues to suicide—a pivot in the whole prevention movement.
12. The implications of advances in medical techniques related to suicide.
13. The impact of the massive secularization of death and the enormous spiritual and psychological problems created by it.
14. Some new looks at old masters, especially Freud and Durkheim, and the possibility and the obvious challenge to come to this topic through some new portals.
15. Significant changes in the public practice of suicide prevention, especially in the services that ought to be provided.
16. Changes in the patterns of financial and community support for suicide prevention activities.
17. A growing emphasis on assessment, especially of the effectiveness of interventional efforts.
18. The recent appearance of suicide professionalism and the possible role of a new profession, suicidology.

The AAS was founded at the meeting in Chicago. I was blessed with the special help of Avery Weisman, whose counsel was indispensable to me. Of course, I conferred with my mentor Henry Murray. At my request, Calvin Frederick, who was then with me at NIMH, prepared a constitution and a set of by-laws patterned more or less after those of the multidisciplinary American Orthopsychiatric Association. By the end of that day, our dream of an AAS, in our minds at least, was a reality. One year later at our second meeting in New York City, I found myself president. Happily, the organization soon had a life of its own. If the association were to have a motto, it would be "Research, Training, Service."

I now have the pleasure of listing the subsequent presidents of the AAS since 1969: Seymour Perlin, Avery Weisman, Norman Farberow, Jerome Motto, Robert Kastenbaum, Richard McGee, Nancy Allen, Robert Litman, Betsy Comstock, Bruce Danto, Calvin Frederick, Ronald Maris, James Selkin, Gwendolyn Harvey, Joseph Thigpen, Allan Berman, Pamela Cantor, Cynthia Pfeffer, Elizabeth Jones, and President-Elect Charlotte Sanborn—a *Who's Who* of American suicidology (including, I am pleased to note, a second generation of the younger professionals and workers in our field). What is evident is that the AAS has moved from being an organization of only psychologists and psychiatrists to being truly multidisciplinary. It includes nurses, social workers, sociologists, and health educators; even more, it reflects the role of volunteers and of help-lines, and the issues of accreditation and of standards.

The list of presidents is varied, vibrant, and multitalented, and provides a good augury for our multidisciplinary future.

The topic for the IASP–AAS joint meeting was "Then and Now." What have I seen over the past 40 years in American suicidology? My reflections divide themselves into two categories: those about the phenomena of suicide itself, and those about the practice of suicide prevention within the larger social setting.

The Phenomena of Suicide

In relation to suicidal phenomena (the events themselves), I have seen no great change, nor would I expect to see one in so relatively short a time. By definition, the ubiquities are still there. The basic roots of anguish, psychological pain, thwarted emotions—hate, love, shame, guilt (who has said them better than Shakespeare almost half a millenium ago and Melville a century ago?)—have not changed. Of course, the phenotypic details vary, but the unity themes sound the same old chords. As a small example: Two years ago, with permission, I personally collected all the suicide notes for Los Angeles County for the calendar year 1984. They read pretty much the same as the suicide notes that Norman Farberow and I collected from that same office almost 40 years before. I do believe that the meaning of death and suicide *do* change, as Aries (1975/1981) has so persuasively shown us in *The Hour of Our Death* (a book that covers the past millenium), but the interval between 1968 and 1988, even with everything that has happened in the world, is merely a blip on the screen of these timeless topics. The ubiquities remain.

But the *study* of suicide is another matter. We have seen an expansion of what I consciously tried to promote in my brief tenure at NIMH—an advertent and tenacious multidisciplinarity. I assure you that I do not take credit for this expansion; I simply note its presence and call it to our attention. Today, there are *many* legitimate approaches to the study of suicide, among which can be listed the following:

1. The literary and personal-documents approach, including the use of suicide notes and suicide diaries. I am currently especially interested in the potentialities for concerted, cooperative studies of the recently published *Inman Diary* (Aaron, 1985), and, along these lines, who has told us more about the inside of suicide than Dostoyevsky, Tolstoy, Flaubert, Melville, and Kate Chopin?

2. Theological and philosophical approaches, where our late friend Jacques Choron was so effective.

3. The demographic approach—an indispensable background for further work—where one thinks of John Graunt, Johann Sussmilch, and Louis I. Dublin.

4. The sociocultural approach—for example, between Japan and the United States (in this connection, see Iga's [1986] *The Thorn in the Chrysanthemum.*

5. The sociological approach, with several members of the AAS at its intellectual forefront.

6. The dyadic, interpersonal, familial approaches—our recent leaders have had much to say here.

7. The psychodynamic approach, exemplified by Freud, Menninger, and several of our past presidents.

8. The psychological approach, emphasizing psychological pain, constriction, and thwarted needs, as explicated by Henry Murray.

9. The psychiatric approach—the mental illness and disease approach, focusing on depression.

10. The constitutional and genetic approach, involving both cohort and DNA studies.

11. Biological and biochemical approaches, with currently ambiguous but potentially thrilling potentialities.

12–15. Legal, ethical approaches; the preventional approach; systems theory approaches; and political, global, and supernational approaches. I have eschewed naming notable AAS members in connection with these only because I fear to omit many who should be included.

But one can clearly see that the study of suicide is a never-completed circle, containing many legitimate sectors or fields or approaches. The only illegitimate approach to this multidisciplinary pie is for someone to plant a fork in one spot and pronounce that *that* sector, *that* way of looking at things, is the whole pie. But this point is too obvious to belabor. The blessing of our lives is that we have come upon this field that was nascent, dormant, and quiescent, and in our own lifetimes have awakened it so that it has become a legitimate area for concern and for scholarly study. Nowadays, one can say "I am a suicidologist" and hold one's head high.

Speaking of the various sectors of the suicidal pie, in my own recent publications I have aimed, in some small way, to clarify the *psychological* sector of this fascinating etiological circle. In pursuit of this intellectual venture, I have developed a set of 10 commonalities of suicide (Shneidman, 1985). I see these as phenomenologically self-evident, and I find these psychological characteristics in every case (historical or current) that I look at, because I have the capacity to translate every instance into those terms. The 10 commonalities are as follows:

1. The common *purpose* of suicide is to seek a solution.

2. The common *goal* of suicide is the cessation of consciousness—the unbearable flow of intolerable mind content.

3. The common *stimulus* in suicide is intolerable psychological pain. Every suicide can be understood in terms of pain—unbearable psychological pain, idiosyncratically defined.

4. The common *stressor* in suicide is frustrated psychological needs. In Henry Murray's (1983), *Explorations in Personality*, we have served to us, on a golden platter, an explication of some 30 psychological needs. It is thwarting or blocking of certain needs—critical in the makeup of *that* individual—that causes the pain that pushes the suicide. I believe that it is necessary to understand this need system in order to understand an individual case of suicide.

5. The common *emotion* in suicide is helplessness-hopelessness. This seems not only evident from developmental psychology, but also avoids the unnecessary sibling rivalry among the relevant emotions: guilt, shame, fear, and Stekel's hostility.

6. The common *cognitive state* in suicide is ambivalence. The pervasive presence of wanting to stop unbearable pain and wanting to survive in a state of less pain—in other words, ambivalence—is universally documented.

7. The common *perceptual state* in suicide is constriction. One has to be mindful of and deal with that word "only": "the only thing I could do"; "the only way to commit suicide." Dealing with constriction is a first order of preventional business.

8. The common *action* in suicide is egression. There are ways of substituting more benign egressions or blocking the exits, including getting the gun.

9. The common *interpersonal act* in suicide is communication of intention. Not secrecy or withdrawal, but communication, albeit in code, is the hallmark of committed suicide.

10. The common *consistency* in suicide is with lifelong coping patterns. Individuals are enormously loyal to themselves and their own armamentaria, even (or especially) in their dying. This is seen in a careful examination of an anamnestic record in the nuances of egressions (e.g., leaving home, quitting a job, ending a marriage, etc.).

This compilation has been further refined into a theoretical model. In its schematic form, it is a suicidal cube (see Figure 1-1). The three surfaces of the cube are labeled "pain," "perturbation" (consisting of constriction and a penchant for precipitous action), and "press." "Press," from positive to negative, is Murray's (1938) term for everything that is done to an individual before (or to which) he or she responds. It

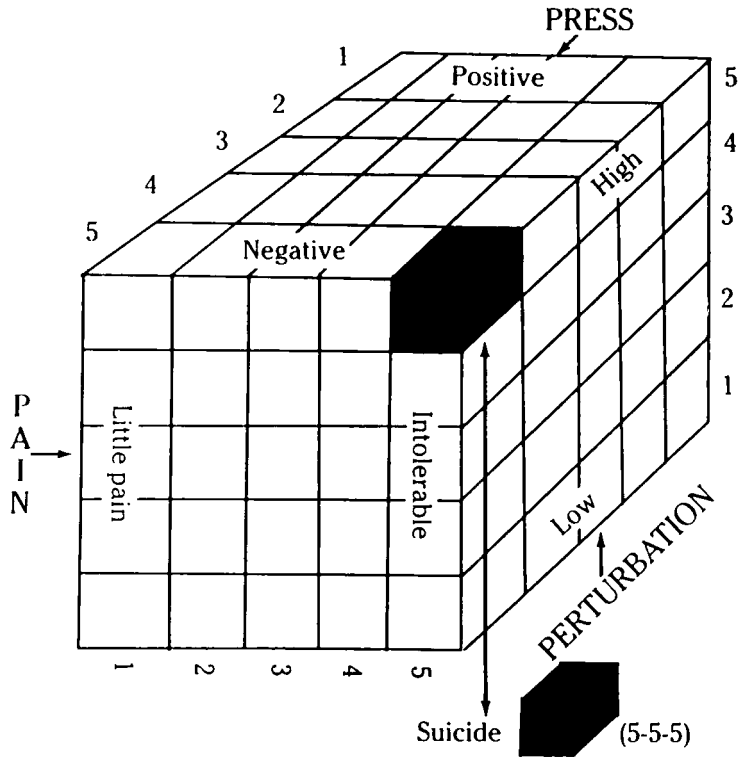

Figure 1-1. A theoretical cubic model of suicide.

includes DNA, parents, siblings, school, events, and chance. In this model, the suicidal cubelet (blackened in the figure) is in the right-hand corner, indicating the maximum concatenation of pain, perturbation, and (negative) press.

The implications for research would seem to be endless: to make comparisons, from the general (nonsuicidal) literature of psychiatry and psychology (perception, memory, learning, etc.) between and among pain and perturbation, pain and press, and press and perturbation, including their near-synonyms. All it takes is a careful, scholarly examination of the entire professional literature—a task that I am on the threshold of beginning.

The implications of this cubic model for treatment would seem to be obvious: Reduce (in reality or by reconceptualizing) the psychological pain a bit, and/or widen the opportunities for choice, and/or constrain the proclivity for irreversible action, and/or diminish the negative press. That is the utterly straightforward and relatively simple way in which lives can be saved: Mollify the pain, the perturbation, or the negative press. No one commits suicide in a nonsuicidal combination.

Suicidology within the Larger Social Setting

I turn now to the second category of my reflections—specifically, the changing place of suicidology within the also-changing social matrix. I have reflected about the impact of social policy on suicide acts and on suicide prevention activities. There are some generalizations that one can make about suicide and public policy in this country. In this, I am following the lead of Professor Shirley Zimmermann at the University of Minnesota in her recent book on family policy (Zimmermann, 1988). Four hypotheses are offered:

1. The more identifiable the risk, the more closely targeted the public (and legislative) response to relieve it will be. Thus it follows that suicidologists have a clear responsibility to identify, delineate, and disseminate (in ordinary language) the common clues to suicide.

2. The more organized and intense the political activity on behalf of potential victims, the more likely it is that public policy will concern itself with that problem. In this regard, it makes good tactical sense for us to focus on certain targeted groups, such as suicide among the young.

3. The more elevated the status of the potential victims (i.e., if it is likely to touch *us*), the more intense the public policy response will be, and vice versa. In this country today, we are only now becoming sufficiently alarmed about AIDS (acquired immune deficiency syndrome) because we realize that it is more than a malady of the "four H's": homosexuals, Haitians, hemophiliacs, and heroin addicts. It is because we fear that the disease may jump out of the containment of these groups and involve ordinary and "good citizens" that concern about AIDS is becoming widespread. In suicide, also, we are not egalitarian about death; we mourn the suicide of the talented, the beautiful, or the young more than that of the untalented, the homely, or the old. Here again, it is a stategic point to place an emphasis on youth suicide prevention and the use of young spokespersons. Nor is there anything nefarious in reciting these social realities.

4. The more congruent the prevention strategies are with current political and policy trends, the more active the political and policy response on that topic will be. Here especially, there are some palpable changes to be seen in this country over the past 40 years.

It gives me no pleasure to report that there are, in fact, fairly solid cross-sectional empirical data on this last topic. A systematic study of the 50 states of the United States, in a study done by Zimmermann (1988) using 1980 and 1982 total data, correlated the amounts of expenditures for education and public service programs with suicide rates and teenage birth rates, state by state. The results clearly demonstrate a statistically significant *negative* correlation between per capita state public welfare expenditures and suicide: The lower the expenditure for public welfare within the state, the higher the suicide rate; the more generous the expenditure, the lower the suicide rate. Obviously one of the things needed is more than a modicum of government (both state and federal) support to effect a truly meaningful reduction in suicidal deaths.

Since the 1940s, when I first turned to (and then never turned away from) the joint topics of suicide and suicide prevention, I have been a suicidologist in this glorious country under the administration of nine presidents: Roosevelt, Truman, Eisenhower, Kennedy, Johnson, Nixon, Ford, Carter, and Reagan. It seems clear enough to me that more liberal federal leaderships tend in general to tolerate and support a variety of approaches, including sociological and psychological approaches, to what we call our social problems, including suicide; conversely, more conservative federal leadership—on a generally *reduced* overall level, specifically in the case of suicide—tends to emphasize biological and medical solutions, with the implied locus of blame in the person rather than in the social structure, and thus tends to cut down on the necessary catholicity of approaches.

One insufficiently recognized culture hero in America is Jonas Salk. If there has been a swing in this country in suicidology in the last 30 years, it has been from Freud to Salk: Biologicize the problem, concentrate on one disease, find the virus, and develop the vaccine—that is the current American way. This is an unarguably marvelous solution when one is dealing with *infantile* paralysis, but it is a model that in all likelihood is not applicable if one is dealing with a case of *hysterical* paralysis. And who is to say that suicide, paradigmatically speaking, is not more like the latter than the former? I finally believe that suicide is not a disease; it is, rather, a bio-socio-psycho-philosophical malaise.

A sad but curious fact is that the same people who talk about prayer in our schools—which seems clearly unconstitutional as I understand

that noble document—also want to practice a flawed form of social Darwinism toward the less advantaged, in which a crisis or failure (e.g., suicide) is seen as the individual's own fault, and in which the larger group, sociobiologically speaking, might well be rid of that unadapting individual. At its heart, this attitude is opposed to suicide prevention. We are well advised to believe that this anachronistic 19th-century frontier philosophy imposed on a late 20th-century complex society is too costly for good conscience.

One obvious conclusion to draw from all this is that the *dramatis personae* along the Potomac are indeed keenly relevant to our public policies and the resulting suicide prevention programs that flow from them—both their magnitude and their nature—as they filter down to the states and cities. In relation to suicide prevention, I am convinced that we must wait until 1989, after the next presidential inauguration, for any really meaningful action to be effected.

Ernest Hilgard's (1986) recent comprehensive volume, *Psychology in America*, contains a chapter subheading that has caught my attention: "Topics that Become Centers of Excitement." Although he does not discuss suicide, in my mind that is what the suicide prevention movement has been in America: a topic that has become a center of excitement. For honesty's sake, I need to add that I did not quote Hilgard's subheading in its entirety. It is actually "Topics that Become Centers of Excitement over a Short Time Span." I hope that this is not going to be true for the suicide prevention movement or for the AAS, and I have reasons to believe that it will not be so, although certain subinterests (e.g., the current tactical focus on youth suicide) may very well wax and wane over the next few years.

Our broader hope is that the general concern with suicide prevention across the board, having been established, will endure. But I believe that this endurance will not happen on its own, and that we must all work to see that new conceptualizations, decent research efforts (both nomethetic and idiographic), and informed training programs ensure the continuance of suicidology. These are a few of my reflections about suicide, suicide prevention, the AAS over the 1968–1988 interval, and its role for the rest of this century. I hope that readers have found these remarks either interesting or provocative, preferably both.

Remarks from 1968 AAS Meeting

I now have the pleasure of quoting some very special, albeit brief remarks made at the first meeting of the AAS in 1968. Here are their voices, expressing various points of view.

Jacques Choron: "Not sufficient attention has been paid to the difference between the death of another person, even of a loved one, and what I could call my own death. My death is something entirely different than the death of another person. A therapist who deals with a potentially suicidal patient or who is talking about the notions of death of the patient may help to re-establish communication between the patient and the therapist. It may also have diagnostic value in the sense that it may help us to establish the lethality of the patient."

Lawrence Kubie: "And finally as an act of desperation they slash their wrists a little bit, sometimes accidentally going too deep; they take whatever drugs they happen to have on hand; and they must all come into our statistics on suicide. But what the patient is trying to do is save his life. Many acts of self-injury which are lumped together under the concept of suicide do not have self-extinction as their goal."

Erwin Stengel: "The psychoanalytic contribution to suicide research has been mainly concerned with the intrapsychic dynamics of self-destructive tendencies. This has been both its strength and its limitation. It has until recently not concerned itself with the external world, apart from those objects which by introjection become parts of the inner world. Zilboorg's discovery of the role of the broken home in suicide proneness was a brilliant observation deduced from the study of intrapsychic processes and confirmed by clinical and epidemiological studies."

Louis Dublin: "The lay volunteer was probably the most important single discovery in the 50-year history of suicide prevention. Little progress was made until he came into the picture, for he alone apparently was qualified to make the live and fruitful contacts with the person in distress. He had the time and the qualities of character to prove that he cared. With proper training he can make a successful approach to the client. He can through direct friendly contact discover the principal cause of his difficulties and by his knowledge of the community services which are available for useful referral, he can often tide his client over his crisis."

Karl Menninger: "I think that it is important to distinguish between suicide as a form of death and suicide as an attempt at expression of something within one—helplessness, desperation, fear, the other emotions. The organism says, 'Anything rather than suicide; anything rather than have to give up the most precious thing of all—namely, my life. Sickness, yes, even neurosis, even crime, but not that awful oblivion, that awful ultimate nothingness.' The suicidal gesture is thus a cry not only of distress, not only a cry for help, not only a prayer, one might say, but it is a pleading: 'I want to live; help me to find a way to live.' "

Concluding Remarks

My final remarks are purely personal reflections. The nature of my childhood and then later of my being a parent conspired together to give me a certain psychodynamic orientation toward living systems. Thus, it was quite natural for me to view the AAS as a child of mine. I delight in having sired it; I am fiercely proud of what it has become; and I am entirely happy now to have it live on, unencumbered by any unnecessary meddling by me. It seems the natural thing to do: to give a living system—a little human being, a group, a center, or an association—the breath of life and then, after an appropriate period of devoted nurturing, to let it have an independent existence (with, of course, never-ending strings of concern and love, but not of control). This has been my life in suicidology. I have found it worth living, and would gladly live it again if the chance were offered me.

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