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Commentary

Suicide as Psychache

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As I near the end of my career in suicidology, I think I can now say what has been on my mind in as few as five words: *Suicide is caused by psychache* (sīk-āk; two syllables). Psychache refers to the hurt, anguish, soreness, aching, psychological *pain* in the psyche, the mind. It is intrinsically psychological—the pain of excessively felt shame, or guilt, or humiliation, or loneliness, or fear, or angst, or dread of growing old or of dying badly, or whatever. When it occurs, its reality is introspectively undeniable. Suicide occurs when the psychache is deemed by that person to be unbearable. This means that suicide also has to do with different individual thresholds for enduring psychological pain (Shneidman, 1985, 1992).

All our past efforts to relate or to correlate suicide with simplistic nonpsychological variables, such as sex, age, race, socioeconomic level, case history items (no matter how dire), psychiatric categories (including depression), etc., were (and are) doomed to miss the mark precisely because they ignore the one variable that centrally relates to suicide, namely, intolerable psychological pain; in a word, psychache.

By its very nature, psychological pain is tied to psychological needs. In general, the broadest purpose of most human activity is to satisfy psychological needs. Suicide relates to psychological needs in that suicide is a specific way to stop the unbearable psychachical flow of the mind. Furthermore, what causes this pain is the blockage, thwarting, or frustration of certain psychological needs believed by that person (at that time and in those circumstances) to be vital to continued life.

Suicide is not adaptive, but adjustive in the sense that it serves to reduce the tension of the pain related to the blocked needs. Murray's (1938) monumental volume *Explorations in Personality* provides a comprehensive list of psychological needs, and their definitions: abasement, achievement, affiliation, aggression, autonomy, counteraction, defendance, deference, dominance, exhibition, harmavoidance, inviolacy, nurturance, order, play, rejection, sentience, shame-avoidance, succorance, and understanding.

There is an integral relationship between suicide and happiness—or rather the absence of it. Genuine happiness—contrary to the 19th and 20th century materialistic notions that narrowly identified happiness with the mere absence of pain and the presence of creature comforts—has a special magical quality (Spender, 1988). There is a mundane happiness of comfort, pain avoidance, and psychological anesthesia. But genuine, magical happiness has relatively little to do with creature comfort; rather, it is the kind of ecstasy and consuming exuberance that one can experience best in a benign childhood. To the extent that suicide relates to happiness, it relates in people of any age—not to lack of mundane happiness but to the loss of childhood's magical joys.

A principal task for contemporary suicidology is to operationalize (and metricize) the key dimension of psychache. One way to begin is to ask the simple question, "How much do you hurt?" (Kropf, 1990).

One trenchant way to understand any individual is to rank order (or Q-sort) the prepotency among the 20 needs, that is, to define or characterize that individual's personality in terms of his or her weightings among all the needs. This can be done by assigning, for that individual, a number to each need, so that the total sum for the individual adds up to 100. This permits us to rate various individuals (or a single individual over time) by use of the constant sum method. The task is simple and takes only a few minutes. (Try it by rating yourself; then rate a well-known public figure, have colleagues rate that same figure, rate your patients after each session, and rate suicidal and nonsuicidal patients.)

In relation to suicide, there are, within any individual, two sets of dispositions or sets of relative weightings among the 20 psychological needs. They are: a) those

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psychological needs that the individual lives with, that define his or her personality in its day-to-day intrapsychic and interpersonal functioning—the *modal* needs; and b) those few psychological needs, the frustration of which that individual simply cannot tolerate; the needs that person would die for—the *vital* needs. Within an individual, these two kinds of needs are psychologically consistent with each other. The vital needs come into play when the individual is under threat or duress. This special disposition of needs can be elicited by asking an individual about his precise reactions to the failures or losses or rejections or humiliations—the dark moments—previously in his life.

By means of an intensive psychological autopsy (Shneidman, 1977), it should be possible to identify (or label) every committed suicide in terms of the two or three prepotent needs the frustration of which played a major role in that death. (With 20 needs, we have a possible taxonomy of a few hundred different "types" of suicide.)

The prevention of suicide (with a highly lethal person) is then primarily a matter of addressing and partially alleviating those frustrated psychological needs that are driving that person to suicide. The rule is simple: Mollify the psychache.

In the progression to a suicidal outcome, I believe that we can distinguish seven components. They are:

a) the vicissitudes of life; those stresses, failures, rejections, and catabolic and social and psychological insults that are omnipresent by virtue of living.

b) various approaches to understanding human behavior. Suicidal behavior (as is all behavior) is obviously multidimensional, which means, in practice, that its proper explication has to be multidisciplinary. The relevant fields for suicidology include biochemistry (and genetics), sociology, demography-epidemiology, psychology, psychiatry, linguistics, and so on. The reader should appreciate that *this* paper is limited to the psychological approach to suicide, without derogating the importance of other legitimate approaches.

c) the vicissitudes of life as they are perceptually funneled through the human mind and apperceived (or appreciated) as ecstatic, pleasurable, neutral, inconsequential, or painful. If there is extreme psychache, a necessary condition for suicide is present. "I hurt too much."

d) the perception of the pain as unbearable, intolerable, and unacceptable, another necessary condition for suicide, in addition to psychache. "I won't put up with this pain."

e) the thought (or insight) that cessation of consciousness is the solution for the unbearable psychache, still another necessary condition. In a phrase, death is preferable to living, with death as a means of egression or escape. "I can kill myself."

f) a lowered threshold for enduring or sustaining the crippling psychache, a final necessary condition for suicide. A priori, people with more or less equal amounts of psychache might have radically different overt outcomes depending upon their different thresholds for tolerating or enduring psychological pain. (In life, pain is ubiquitous and inescapable; suffering is optional.)

g) the suicidal outcome. "I hurt too much to live."

About now, the alert and restive reader might be asking, What about depression? As everyone knows, depression is a serious psychiatric syndrome, well recognized and relatively treatable. But depression is not the same as suicide. They are quite different. For one thing, they have enormously different fatality rates. One can live a long, unhappy life with depression—not true of an acutely suicidal state. Theoretically, no one has ever died of depression—it is not a legitimate cause of death on the death certificate—but many people, too many, have died of suicide. Vast numbers of people suffer from minor and major depressions. Depression seems to have physiological, biochemical, and probably genetical components. The use of medications in treatment is on target. It is, so to speak, a biological storm in the brain. Suicide, on the other hand, is a phenomenological event, a transient tempest in the mind. It is responsive to talk therapy and to changes in the environment. Suicide is not a psychiatric disorder. Suicide is a nervous dysfunction, not a mental disease. *All* persons who commit suicide—100% of them—are perturbed, but they are not necessarily clinically depressed (or schizophrenic, or alcoholic or addicted or psychiatrically ill). A suicidal crisis is best treated on its own terms. It is a deadly serious (temporary and treatable) psychache (Table 1).

Depression never causes suicide; rather, suicide results from severe psychache, coupled with dysphoria, constriction of perceptual range, and the idea of death as preferable to life. By themselves, the clinical symptoms of depression are debilitating, but, by their nature, not deadly. On the other hand, severe psychache by itself may be life threatening. Correlating suicide with DSM categories is irrelevant to the real action in the mind's main tent. Depression merits treatment for itself, but then to assert that suicide is essentially depression is either a logical mistake, a conceptual confusion, or a professional gambit. In any case, it is past time to make this correction.

Here, finally, after over 40 years of experience as a suicidologist, is a tight summary of my current beliefs about suicide.

1. The explanation of suicide in humankind is the same as the explanation of the suicide of any particular human. Suicidology, the study of human suicide, and a psychological autopsy (of a particular case) are identi-

cal in their goals: to nibble at the puzzle of human self-destruction.

2. The most evident fact about suicidology and suicidal events is that they are multidimensional, multifaceted, and multidisciplinary, containing, as they do, concomitant biological, sociological, psychological (interpersonal and intrapsychic), epidemiological, and philosophical elements.

3. From the view of the psychological factors in suicide, the key element in every case is psychological pain: psychache. All affective states (such as rage, hostility, depression, shame, guilt, affectlessness, hopelessness, etc.) are relevant to suicide only as they relate to unbearable psychological pain. If, for example, feeling guilty or depressed or having a bad conscience or an overwhelming unconscious rage makes one suicidal, it does so only because it is painful. If it does not hurt, it does not matter. No psychache, no suicide.

4. Individuals have different thresholds for enduring or tolerating pain; thus, the individual's decision not to bear the pain—the threshold for enduring it—is also directly relevant.

5. In every case, the psychological pain is created and fueled by frustrated psychological needs. These needs have been explicated by Murray (1938, chapter 3, pp. 142–242).

6. There are modal psychological needs with which the person lives (and which define the personality) and there are vital psychological needs whose frustration cannot be tolerated (which define the suicide). Within an individual, these two kinds of needs are psychologically consistent with each other, although not necessarily the same as each other.

7. The remediation (or therapy) of the suicidal state lies in addressing and mollifying the vital frustrated needs. The therapist does well to have this template (of psychological needs) in mind so that the therapy can be tailor-made for that patient. Often, just a little bit of mollification of the patient's frustrated needs can change the vital balance sufficiently to save a life.

TABLE 1
Symptoms of Depression: Characteristics of Suicide

Depression[a]	Suicide
1. Sadness	1. In great psychological pain (psychache)
2. Apathy	2. Cannot stand the pain (lowered threshold for suffering)
3. Loss of appetite or increased appetite	3. Sees ending life as an escape (death as solution)
4. Insomnia, or sleeping far more than usual	4. Sees no possibilities other than death (constriction)
5. Feeling physically agitated or slowed down	5. May or may not have symptoms of depression (suicide as a mental state)
6. Fatigue and lack of energy	
7. Feelings of worthlessness or great guilt	
8. Inability to concentrate or indecisiveness	
9. Thoughts of death or suicide	

[a]The source (for Depression) was *The New York Times*, August 5, 1992 (by permission).

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