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Review

Edwin S. Shneidman on Suicide

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***Abstract*:** Edwin S. Shneidman (DOB: 1918-05-13; DOD: 2009-05-25) is a *father* of contemporary suicidology. His work reflected the intensive study of suicide. His contributions on suicide are some of the essential studies in the field. The works on suicide can be divided into five parts: Definitional and Theoretical, Suicide Notes, Administrative and Programmatic, Clinical and Community, and Psychological Autopsy and Postvention. In this paper, not only are the selected works explicated, but also Dr. Shneidman's writings are shared on each category, to allow reader to understand suicide and Edwin S. Shneidman better.

...it requires a strong moral principle to prevent me from deliberately stepping into the street, and methodically knocking people's hats off – then it is high time to get to sea as soon as I can. This is my substitute for pistol and ball.

Herman Melville, *Moby Dick*.

Edwin S. Shneidman (DOB: 1918-05-13; DOD: 2009-05-15) is a *father* of contemporary suicidology. He was born on May 13, 1918. His passion in life was to understand suicide, maybe only equaled by his love of Melville's *Moby Dick* (1853). *Moby Dick,* itself, is an extraordinary study in suicide. It is true that happenstance marked Shneidman's career. While working at the LA Veterans Administration in 1949, he was asked to write condolence letters to widows of two victims by suicide. He researched the two cases at the LA County Coroner's Office and there was led to a vault of suicide notes. He never looked back.

Shneidman spent his life studying why people kill themselves, indeed, the intensive and creative study of people who died by suicide. He saw much of the study of suicide, what is called suicidology, as "half-paralyzed", and suggested that suicidology should be about the comprehensive understanding of the individual. His life's mission was to forestall death as long as possible. To accomplish this mission, he created a new discipline, named it, contributed to it, and most importantly, catalyzed other competent investigators to invest in it. He was a *pioneer*. He loved his work. His scholarly writings in suicidology reflect the efforts, and indeed, allow us to understand the suicidal mind better.

Shneidman's work is central to suicidology. It is voluminous. In order to reduce these to his essential papers on suicide, a task was urged on him, and finally received his approval on January 2, 1996. The idea was not new; it came from Shneidman's own edited volume on the selected works of Henry A. Murray, his mentor, *Endeavors in Psychology*, published in 1981. Not only was the idea not new, but also the process followed his with Murray, from January 2, 1996 to finalizing an initial list on July 1, 1997 ("Canada Day" as Shneidman called it, during my regular visits to his home around July 1 to 4th to see him). The final list of papers, reproduced in Table 1, was completed in Shneidman's home with an update over the years – keeping in mind that the final list of contents represented a compromise between the press for greater inclusion and the need to restrict the list to the most representative pieces. The selections were divided into five parts: Definitional and Theoretical, Suicide Notes, Administrative and Programmatic, Clinical and Community, and Psychological Autopsy and Postvention. The intent here is to share with the reader some rather personal reflections – to allow the reader to understand suicide better. The complete papers can be found in my edited volume, *Lives and deaths: Selections from the works of Edwin S. Shneidman*, published by Brunner/Mazel (Taylor & Francis group) in 1999. Almost all quotes, in fact, are from the selected readings in my edited volume (Leenaars, 1999), so a common source can be

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Table 1. Selections from the works on suicide of Edwin S. Shneidman.

Definitional and Theoretical

(1971). "Suicide" and "suicidology": A brief etymological note. *Suicide and Life-Threatening Behavior*, *1*, 260-264.

(1985). A formal definition, with explication (pp. 202–213). *Definition of suicide*. New York: Wiley.

(1998). "Suicide" in the Encyclopedia Britannica, 1777-1997. *Archives of Suicide Research*, *4,* 189-199.

(1973). Suicide (pp. 383-385). *Encyclopedia Britannica* (Vol. 21). Chicago: William Benton.

(1971). Perturbation and lethality as precursors of suicide in a gifted group. *Life-Threatening Behavior*, *1*, 23-45.

(1992). A conspectus for conceptualizing the suicidal scenario (pp. 50-65). In R. Maris et al. (Eds.) *Assessment and prediction of suicide*. New York: Guilford Press.

(1993). Suicide as psychache. *Journal of Nervous and Mental Disease*, *181*, 147-149.

Suicide Notes

(1969). Some characteristics of genuine versus simulated suicide notes (pp. 527-535). In P. J. Stone et al. (Eds.) *The general inquirer: A computer approach to content analysis*. Cambridge: MIT Press. (with D. N. Ogilvie and P. J. Stone)

(1973). Suicide notes reconsidered. *Psychiatry*, *36*, 379-395.

(1980). Self-destruction: Suicide notes and tragic lives (pp. 41-76). *Voices of death*. New York: Harper and Row.

(1995). Letters of enforced death versus suicide notes. *Journal of Psychology and Judaism*, *19*, 153-160.

Administrative and Programmatic

(1965). The Los Angeles suicide prevention center: A demonstration of public health feasibilities. *American Journal of Public Health*, *51*, 21-26. (with N. Farberow)

(1967). The NIMH center for studies of suicide prevention. *Bulletin of Suicidology*, *1*, 2-7.

(1988). Some reflections of a founder. *Suicide and Life-Threatening Behavior*, *18*, 1-12.

Clinical and Community

(1967). How to prevent suicide. *Public affairs pamphlet No. 406*. New York: Public Affairs Pamphlets. (with P. Mandelkorn)

(1994). Clues to suicide reconsidered. *Suicide and Life-Threatening Behavior*, *24*, 395-397.

(1980). Psychotherapy with suicidal patients (pp. 305-313). In T. B. Karasu & L. Bellak (Eds.) *Specialized techniques in individual psychotherapy*. New York: Brunner/Mazel.

(1984). Aphorisms of suicide and some implications for psychotherapy. *American Journal of Psychotherapy*, *38*, 319-328.

(1992). Letter to editor, Rational suicide and psychiatric disorders. *New England Journal of Medicine*, *326*(13), 889.

Psychological Autopsy and Postvention

(1977). The psychological autopsy (pp. 42-57). In L. I. Gottschalk et al. (Eds.) *Guide to the investigation and reporting of drug abuse deaths*. Washington, DC: USDHEW, U.S. Government Printing Office.

(1994). Comment: The psychological autopsy. *American Psychologist*, *39*(1), 75-76.

(1993). An example of an equivocal death clarified in a court of law (pp. 211-246). *Suicide as psychache*. Northvale: Jason Aronson Inc.

(1975). Postvention: The care of the bereaved (pp. 245-256). In R. O. Pasnau (Ed.) *Consultation in liaison psychiatry*. New York: Grune and Stratton.

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found. However, the rights are from the original text, and belong to Edwin Shneidman. David Shneidman, his son, granted permission to quote from the selections (David Shneidman, personal communications, March 2, 2010).

Suicide

In his reflections, Edwin Shneidman does not know whether suicide was looking for him or he was looking for suicide. However, on a day in 1949, when he discovered 100's of "genuine suicide notes", he was restless and looking for some niche in psychology. Here is verbatim what Shneidman (1991) wrote:

The fulcrum moment of my suicidological life was not when I came across several hundred suicide notes in a coroner's vault while on an errand for the director of the VA hospital, but rather a few minutes later, in the instant when I had a glimmering that their vast potential value could be immeasurably increased if I did *not* read them, but rather compared them, in a controlled blind experiment, with simulated suicide notes that might be elicited from matched nonsuicidal persons. My old conceptual friend, John Stuart Mill's Method of Difference, came to my side and handed me my career. (Leenaars, 1999, p. 247).

In religion, we talk about Epiphanies and Epiphany moments. That the notes were "genuine" was an epiphanic moment for Shneidman. He had an autonomic reaction with the feeling, without verbalizing, that it was important to say "genuine" suicide note. Within a couple of months of saying "genuine" and then "simulated" and then eliciting notes, and then calling Norman Farberow, he was beginning a career – and a discipline. He said, 'oh boy, suicide notes, the golden road to suicide,' and suicidology began.

Disregarding all of biology and genetics, Professor Shneidman stated that suicide is essentially psychological pain. It is not entirely so, and maybe not centrally so, but that is what, he stated, we can investigate and explicate. Shneidman's main contribution has been the explication of *the* pain. He writes:

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* (sik-ak; 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 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, 1992a). (Leenaars, 1999, p. 239).

From Shneidman's perspective:

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 related 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. No psychache, no suicide. (Leenaars, 1999, p. 243).

All his work on suicide is explication of that idea. Shneidman is first and foremost a suicidologist. We will next examine his works on suicide, subdivided as shown in Table 1. We will illustrate each of these endeavors, with comprehensive quotes from his writings.

Conceptual and Theoretical

For Shneidman, you begin with definition and theory, and if it is pain, then you talk about perturbation and lethality. Shneidman would begin his science with the *Oxford English Dictionary (OED)*, to provide the basis for a definition of suicide. We learn that the word suicide is a fairly recent one, and did not exist until the 18th century. Shneidman (1971a) writes:

The *OED* indicates that the earliest use of "suicide" was essentially a Latinizing of the concept of self-killer or self-destroyer. The term was apparently not used until 1651. A. Alvarez claims that he found the word a little earlier in Sir Thomas Browne's *Religio Medici*, written in 1635, published in 1642. By the mid-eighteenth century, the word seems to have been generally known to literary men in England. In the nineteenth century, French writers – Boismont, Durkheim, Qutelelt – did much with the word. Today, "suicide" is everyone's word, the almost international labeling for – as a recent definition has it – "the human act of self-inflicted, self-intentional cessation" (*International Encyclopedia of the Social Sciences*, 1968, vol. 15, pp. 385-89).

Shneidman's unquestionable best book on suicide is *Definition of Suicide* (1985) in which he asserts a psychologically oriented definition of suicide and then explicates (except for prepositions and conjunctions) every single word of it. I highly recommend it to any aspiring and veteran suicidologist. From an epistemological perspective, it is worth a read:

To use an arboreal image: The psychological component in suicide is the "trunk" of it. An individual's method of suicide, the contents of the suicidal note, the calculated effects on the survivors, and so on, are the branching limbs, the flawed fruit and the camouflaging leaves. But the psychological

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component, the problem-solving choice – the best solution to the perceived problem – is the main trunk.
We may now proceed to my proposed definition of suicide.
Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution. (Leenaars, 1999, p. 155).

Shneidman goes further and attempts an explication of this definition in all his subsequent work, by clarifying the meaning, and making meaning of suicide.

The most important book in Shneidman's life is the *Encyclopaedia Britannica (EB)*. In Shneidman (1998) "'Suicide' in the Encyclopaedia Britannica, 1777-1997", the entries on "Suicide", in twenty successive printings (involving 15 editions) of the EB from 1777 to 1997, were reviewed, and published in *Archives of Suicide Research* (ASR), the official journal of the International Academy for Suicide Research – I was the first Editor-in-Chief and wanted an article from Dr. Shneidman for ASR. The changing emphases, attitudes, and social mores are reflected in the tone and contents of the articles written in this 220-year span. An overview supports the idea that definitions are important – and that the definitions are diverse and have played an important role.

As one can understand, it was a thrill for Shneidman (1973a) to be asked to write the paper "Suicide" for the *Britannica*. Shneidman decided he would not reproduce the usual tables of statistics of suicide among various countries at various times, but instead, introduce a potpourri of then current ideas about suicide. He writes:
Suicide is not a disease (although there are those who think so); it is not, in the view of the most detached observers, an immorality (although, as noted below, it has often been so treated in Western and other cultures); and, finally, it is unlikely that any one theory will ever explain phenomena as varied and as complicated as human self-destructive behaviors. In general, it is probably accurate to say that suicide always involves an individual's tortured and tunneled logic in a state of inner-felt, intolerable emotion. In addition, this mixture of constricted thinking and unbearable anguish is infused with that individual's conscious and unconscious psychodynamics (of hate, dependency, hope, etc.), playing themselves out within a social and cultural context, which itself imposes various degrees of restraint on, or facilitations of, the suicidal act.
This definition implies that committing suicide involves a conceptualization of death; that it combines an individual's conscious wish to be dead and his action to carry out that wish; that it focuses on his intention (which may be to be inferred by others); that the goal of action relates to death (rather than self-injury or self-mutilation); and that it focuses on the concept of the cessation of the individual's conscious, introspective life. The word "suicide" would seem to be clear enough, although such phrases as "self-inflicted" (in the incident in which Saul asked another soldier to kill him) and "self-intentioned" (when Seneca was ordered by Nero to kill himself) add to the complications of finding a clear-cut definition of suicide. (Leenaars, 1999, pp. 176-177).

He further writes the following three clarifications of what suicide is:

1. The first is that the acute suicidal crisis (or period of high and dangerous lethality) is an interval of relatively short duration – to be counted, typically, in hours or days, not usually in months or years. An individual is at a peak of self-destructiveness for a brief time and is either helped, cools off, or is dead. Although one can live for years at a chronically elevated self-destructive level, one cannot have a loaded gun to one's head for too long before either bullet or emotion is discharged.
2. The second concept is ambivalence. Few persons now dispute Freud's major insights relating to the role of the unconscious motivation (and the workings of what is called the unconscious mind) which have been one of the giant concepts of this century in revolutionizing our view of man. The notion of ambivalence is a critical concept in 20th-century, psychodynamically-oriented psychiatry and psychology. The dualities, complications, concomitant contradictory feelings, attitudes, and thrusts toward essentially the same person or introjected image are recognized hallmarks of psychological life. The dualities of the mind's flow constitute a cardinal feature of man's inner life. One can no longer ask in simple Aristotelian way, "Make up your mind." To such a question a sophisticated respondent ought to say: "But that is precisely the point. I am at least of two, perhaps several, minds on this subject." (A law has equal force whether it is passed in the Senate by a 100-0 or a 51-49 vote; so has a bullet). The paradigm of suicide is not the simplistic one of wanting to or not wanting to. The prototypical psychological picture of a person on the brink of suicide is one who wants to and does not want to. He makes plans for self-destruction and at the same time entertains fantasies of rescue and intervention. It is possible – indeed probably prototypical – for a suicidal individual to cut his throat and to cry for help at the same time.
3. Most suicidal events are dyadic events, that is, two-person events. Actually this dyadic aspect of suicide has two phases: the first during the

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> prevention of suicide when one must deal with the "significant other," and the second in the aftermath in the case of a committed suicide in which one must deal with the survivor-victim. Although it is obvious that the suicidal drama takes place within an individual's head, it is also true that most suicidal tensions are between two people keenly known to each other: spouse and spouse, parent and child, lover and lover. In addition, death itself is an extremely dyadic event. (Leenaars, 1999, pp. 183-184).

Although the article in the EB is not the final authoritative essay, its place is central to suicidology because of its connection to Shneidman's life. It outlines an essential overview, somewhat avant-garde, of the topic, probably more concise than any other paper on the topic at that time. It is Shneidman to the core.

Shneidman's work was also empirical. Shneidman's (1971b) most important empirical study in suicidology is "Precursors of Suicide in Gifted Children". It involves individuals who were subjects in Lewis Terman's study. In this separate sub-project, Shneidman shows how he was able to identify, predict, and divide five suicides out of a group of 30 Terman people. That is very impressive. Shneidman ordered the group a little bit and then, with a little bit of order, he was able to identify the suicides. Basically Shneidman demonstrated that early clues to suicide committed when individuals were in their early fifties existed in the life history materials (the narratives) and could be discerned as early as age thirty. This, of course, assumes that full life histories are available (as was the case in the Terman Study). The implications for suicide prevention are quite extensive. Shneidman does not think that he is the only person in the world who could have done that, if he felt that, it would not be very good science. Shneidman explicates here and elsewhere his love for idiographic science.

A conspectus is a survey or outline of a subject. Shneidman's (1992a) paper, "A Conspectus for Conceptualizing the Suicidal Scenario" was an outline on suicide. It is a survey of the suicidal mind. It was a place for Shneidman to state the ten commonalities that he has provided in his *Definition of Suicide*. The ten commonalities was Shneidman's way of staking a claim for the psychological threads in suicide. It is a mildly anti-religious article; that is, when you say the ten commonalities, you are liable to hear in your ear the Ten Commandments; in fact, Shneidman phrased them as two columns of five each with Roman numerals, in appearance like a tablet with the commandments. He has proclaimed irreverently, that he cannot be held responsible if the commonalities are viewed as the commandments. He actually laughed when he did it, because there are not ten. There are eight, there are fourteen. Actually we do not know how many there are… they are just assertions which he made. Here are Shneidman's commonalities:

I. The common purpose of suicide is to seek a solution.
II. The common goal of suicide is cessation of consciousness.
III. The common stimulus in suicide is intolerable psychological pain.
IV. The common stressor in suicide is frustrated psychological needs.
V. The common emotion in suicide is hopelessness-helplessness.
VI. The common cognitive state in suicide is ambivalence.
VII. The common perceptual state in suicide is constriction.
VIII. The common action in suicide is egression.
IX. The common interpersonal act in suicide is communication of intention.
X. The common consistency in suicide is with lifelong coping patterns. (Leenaars, 1999, p. 225).

Gene Broder, a Professor at John Hopkins, was editor of the *Journal of Nervous and Mental Disease*, which is the oldest psychiatric journal in the U.S. and the journal in which Freud's articles appear in the 19th century. He invited Shneidman (1993a) to submit an article. Shneidman had nothing, but typed on the typewriter, "severe psychological pain", "severe psychological pain", and automatically typed the word "psychache", without thinking about it. And he said, "That's a winner". He has neologized other words in the field (psychological autopsy, postvention, suicidology). Shneidman wrote the paper, "Suicide as Psychache", saying 'I can now say it in five words or whatever.' Suicide is mainly caused by psychache, from personal anguish, perturbation, and pain. The paper is vintage Shneidman. It is language. It is a brief, personal and focused around a single idea. It is an explication. He writes what might be called a summary of his than 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 identical 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 the

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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. 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, 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. (Leenaars, 1999, pp. 242-244).

Suicide Notes

As noted earlier, suicide notes are synonymous with Shneidman's career. His work on suicide notes is critical to understanding his thoughts. In an early paper (with Daniel Oglivie and Philip Stone, 1969), there is a report of a study using Harvard's General Inquirer, a 1960's pioneer computer. Shneidman wanted to show that suicide could be explained, and suicide notes were seen as the best available empirical data to the facts of suicide. Shneidman turned to the archive of notes. Thirty-three pairs of genuine-and-simulated suicide notes – from the classic edited book with Norman Farberow, *Clues to Suicide* (1957) – were subjected to a computer analysis. Using special combinations of "tag words", the computer could successfully identify the genuine notes and, in this way, threw light on the inner workings of the suicidal mind. The FACT – that notes provide insights to the act – seemed to be supported, if not proved.

However, Shneidman's opinion was not static. In "Suicide Notes Reconsidered" (Shneidman, 1973b), he is antithetical in his mood. He takes a long second look, although written in a day, at the exuberant notion that "suicide notes are the golden road to the understanding of suicide", and argues that individuals who commit suicide, are, by and large, in a constricted frame of mind. Further, that if a person were capable of penning a full and explanatory psychological note, that person would probably have the wits to resist the inner suicidal impulses. In a word, we must not expect *everything* from suicide notes.

For "Voices of Death", Shneidman (1980a) wrote an essential – If not the most important paper on the topic of suicide notes – "Self-destruction: Suicide Notes and Tragic Lives." In that chapter, Shneidman, to forge a synthesis between the two views that suicide notes are enormously rich sources of psychological data and the contrary that suicide notes are pedestrian and banal. Shneidman examined documents written under three different conditions: People dying unwillingly of cancer and what they wrote, including a resident in psychiatry who died of leukemia; people in forced death, the notes mostly from the Holocaust literature; and the notes of people who killed themselves. Shneidman asserts and seeks to illustrate the point that suicide notes – which, after all, are the penultimate act of that person's life – can be very informative when they are placed within the context of the thousand details of that person's life. Using that approach, then, almost every word in the suicide notes is illuminated by the life, and many details of the life are tragically illustrated by the content of the notes. He writes:

There is a vital reciprocity between suicide notes and the lives of which they are a part. This statement – my current position – is the synthesis of my two previous attitudes: the thesis that suicide notes by themselves are uniformly bountiful; and the antithesis that suicide notes have to be constricted and pedestrian documents. Suicide notes definitely can have a great deal of meaning (and give a great deal of information) when they are put in the context of the life history of the individual who both wrote the suicide note and committed the act. In this situation – where we have *both* the suicide note and a *detailed* life history – then the note will illuminate aspects of the life history, and conversely, the life history can make many key words and ideas of the suicide note come alive and take on special meanings that would otherwise have remained hidden or lost. It is close to the art of biography. (Leenaars, 1999, p. 290).

Towards the end of his life, he believed that suicide notes were one *golden* source to the suicidal mind. He argued that not only is suicide multi-determined, the methods needed to understand the event needed to be equally diverse, and qualitative and quantitative. Shneidman, with Farberow (1957),

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undertook perhaps the most important historical example, the empirical, and both quantitative and qualitative, studies of the archive of genuine vs. simulated notes. Despite his love of Mill's Methods, Dr. Shneidman, however, rarely dabbled in quantitative studies by himself. He always believed that the *qualitative* was the best. Indeed, he had a rather anti-quantitative attitude all of his life. Probably the most instructive illustrations, of Shneidman's view of the unique, *idiographic* value of suicide notes, are the five suicide notes of Natalie, a Terman Gifted subject. (There are extraordinary high rates of suicide among gifted people, based on Shneidman's archive.) It is Shneidman's best known case study; Natalie wrote:

1. To her adult friend:

Rosalyn – Get Eastern Steel Co. – Tell them and they will find Bob right away. Papa is at his business. Betty is at the Smiths – Would you ask Helene to keep her until her Daddy comes – so she won't know until he comes for her. You have been so good – I love you – Please keep in touch with Betty – Natalie.

2. To her eldest daughter:

Betty, go over to Rosalyn's right away – Get in touch with Papa.

3. To her ex-husband, from whom she was recently divorced:

Bob, – I'm making all kinds of mistakes with our girls – They have to have a leader and everyday the job seems more enormous – You couldn't have been a better Daddy to Nancy and they do love you – Nancy misses you so and she doesn't know what's the matter – I know you've built a whole new life for yourself but make room for the girls and keep them with you – Take them where you go – It's only for just a few years – Betty is almost ready to stand on her own two feet – But Nancy needs you desperately. Nancy needs help – She really thinks you didn't love her – and she's got to be made to do her part for her own self-respect – Nancy hasn't been hurt much yet – but ah! the future if they keep on the way I've been going lately – Barbara sounds warm and friendly and relaxed and I pray to God she will understand just a little and be good to my girls – they need two happy people – not a sick mixed-up mother – There will be a little money to help with extras – It had better go that way than for more pills and more doctor bills – I wish to God it had been different but be happy – but please – stay by your girls – And just one thing – be kind to Papa (his father) – He's done everything he could to try to help me – He loves the girls dearly and it's right that they should see him often – Natalie

Bob – this afternoon Betty and Nancy had such a horrible fight it scares me. Do you suppose Gladys and Orville would take Betty for this school year? She should be away from Nancy for a little while – in a calm atmosphere.

4. To her husband's father:

Papa – no one could have been more kind or generous than you have been to me – I know you couldn't understand this – and forgive me – The lawyer had copy of my will – Everything equal – the few personal things I have of value – the bracelet to Nancy and my wedding ring to Betty – But I would like Betty to have Nana's diamond – have them appraised and give Betty and Nancy each half of the diamonds in the band. Please have somebody come in and clean – Have Bob take the girls away immediately – I don't want them to have to stay around – You're so good Papa dear –

5. To her two children:

My dearest ones – You two have been the most wonderful things in my life – Try to forgive me for what I've done – your father would be so much better for you. It will be harder for you for awhile – but so much easier in the long run – I'm getting you all mixed up – Respect and love are almost the same – Remember that – and the most important thing is to respect yourself – The only way you can do that is by doing your share and learning to stand on your own two feet – Betty try to remember the happy times – and be good to Nancy. Promise me you will look after your sister's welfare – I love you very much – but I can't face what the future will bring.

Shneidman worked with Gordon Allport's perspective of personal documents (1942) – and Windelband's view (1904) – and legitimately began nibbling on the periphery of science, the science of suicidology in his study of suicide notes. He is a strong supporter of the idiographic approach. For example, the paper "Letters of Enforced Death versus Suicide Notes" is Shneidman's (1995) more recent statement on the value of personal documents in science. Taken all together, it would appear that Shneidman never forgot his suicidological "roots" – the discovery of the notes in the coroner's files, and the usefulness of John Stuart Mill's method of differences in wrestling secrets from Nature's vault.

Administrative and Programmatic

Shneidman's work in suicidology was also programmatic. Perhaps the major pioneering administrative effort in Shneidman's life was his work at the Los Angeles Suicide Prevention Center (LASPC). The LASPC was started in 1955 with Norman Farberow and Robert E. Litman (also deceased). The National Institute of Mental Health (NIMH) and a grant through the University of Southern California were the indispensable patrons. It was the first comprehensive center in the work at the LASPC. It became a model for prevention centers. Shneidman's paper, "The Los Angeles Suicide Prevention Center: A Demonstration of Public Health Feasibilities", written with Norman Farberow (1965), is the first statement on the value of crisis centers to

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suicide prevention. Farberow, Litman, and Shneidman are the trio of horses that pulled the troika of suicide prevention onto the modern stage. Separately and collectively they represent three interwoven aspects of modern suicide work: research, training and clinical service. They are our *grandfathers*. Shneidman has written of the years:

The excitement of those early days at the LASPC is hard to describe. It was like sitting on the seat of a racing covered wagon, galloping into unknown territory, dust flying all around, with the reassuring anxious and friendly faces of fellow pioneers on all sides. The dangers were from ravines and flash floods and our judgment in choosing wrong trails. Every day seemed like a new adventure.

He believed that suicide could be prevented; he writes:

The feasibility of preventing suicide – We might say that if we have learned anything from our decade of work on this topic, we have learned that, happily, most individuals who are acutely suicidal are so for only a relatively short period, and that, even during the time they are suicidal, they are extremely ambivalent about living and dying. If the techniques for identifying these individuals before rash acts are taken can be disseminated, and if there are agencies, like the Suicide Prevention Center, in the community that can throw resources in on the side of life and give the individual some temporary surcease or sanctuary, then after a short time most individuals can go on, voluntarily and willingly, to live useful lives. We know that it is feasible to prevent suicide. (Leenaars, 1999, p. 315).

In 1966, Dr. Stanley Yolles, Director of the NIMH, asked Shneidman to come temporarily to Bethesda to draft a proposal for a national program in suicide prevention. Shneidman took the position. During Shneidman's career, the NIMH was a period of excitement and growth and money. It was a time of Kennedy, and Johnson, and benignity. When Shneidman went to Washington, there were three suicide prevention centers in the country and three years later (1966-1969) there were 100's. Shneidman was working *for* suicide prevention. He established the very first national suicide prevention program, and continued to espouse for one, all his life. Here are Shneidman's ten commonalities (1967) for suicide prevention:

1. A program of support of suicide-prevention activities in many communities throughout the Nation.
2. A special program for the "gatekeepers" of suicide prevention.
3. A carefully prepared program in massive public education.
4. A special program for followup of suicide attempts.
5. An active NIMH program of research and training grants.
6. A redefinition and refinement of statistics on suicide.
7. The development of a cadre of trained, dedicated professionals.
8. Governmentwide liaison and national use of a broad spectrum of professional personnel.
9. A special followup for the survivor-victims of individuals who have committed suicide
10. A rigorous program for the evaluation of the effectiveness of suicide-prevention activities. (Leenaars, 1999, pp. 322-328).

Shneidman in 1969, after 3 years at NIMH, went to Harvard as a Visiting Professor and then to the Centre for Advanced Studies of Behavioral Science, Stanford as a Fellow. Next, Shneidman went to the department of psychiatry at the University of California, Los Angeles (UCLA). From 1970-1988, Shneidman was Professor of Thanatology at UCLA.

Shneidman's (1988) paper, "Reflections of a Founder", is an administrative paper, reflecting on the founding of the American Association of Suicidology (AAS) in 1968 and other administrative and programmatic developments during Shneidman's career. The AAS was started in Chicago at the first meeting. There was a panel consisting of who's who of suicide at that time: Erwin Stengel, Karl Menninger, Louis Dublin, Jacques Charon, Paul Friedman, Lawrence Kubie, and Robert Havighurst. The paper itself was given in San Francisco in 1987, at a joint meeting of the AAS and the International Association for Suicide Prevention (IASP). In his presentation, he writes:

My final remarks are 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. (Leenaars, 1999, p. 341).

Clinical and Community

The proof of the suicidological pudding is in the "ventions" as in prevention, intervention, and postvention. In other words, the main payoff of all our

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research and training activities lies primarily in making our clinical efforts more evidence-based and effective. That is what counts in everyday society. From Shneidman's view, everything else is propaedeutic to the clinical enterprise of prevention. Whatever you do with one person or with many people, the goal is to prevent suicide. When I once asked him whether he thought the LASPC saved lives, he said "yes". Without Norman Farberow, Robert Litman, Mickey Heilig and, I would add, Edwin Shneidman, people would have been dead. Although easier to prove now, LASPC did improve mental health communication among the mental health agencies of LA County and more importantly, it saved lives.

Shneidman's career in suicidology has not only been intellectual but also practical. In the pamphlet, "How to Prevent Suicide" – which sold for $.25 – was published in 1967, a year after Shneidman went to NIMH. It was one of the first attempts to meet the responsibility of putting something out for the public, receiving help from Philip Mandelkorn. It was a prevention effort at the community level, something Shneidman espoused all his life: Prevention is education. To illustrate, I verbatim present Shneidman's most famous facts and fables of suicide:

FABLE: People who talk about suicide don't commit suicide.
FACT: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.
FABLE: Suicide happens without warning.
FACT: Studies reveal that the suicidal person gives many clues and warning regarding his suicidal intentions.
FABLE: Suicidal people are fully intent on dying.
FACT: Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling.
FABLE: Once a person is suicidal, he is suicidal forever.
FACT: Individuals who wish to kill themselves are "suicidal" only for a limited period of time.
FABLE: Improvement following a suicidal crisis means that the suicidal risk is over.
FACT: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.
FABLE: Suicide strikes much more often among the rich – or, conversely, it occurs almost exclusively among the poor.
FACT: Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.
FABLE: Suicide is inherited or "runs in the family."
FACT: Suicide does not run in families. It is an individual pattern.
FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he is not necessarily mentally ill. (Leenaars, 1999, p. 349).

Much of the current understanding and research in suicide, Shneidman believed, is at least half-paralyzed. It is, in fact, easy to criticize the education in the field, but it is more difficult to really teach the multitude, and perhaps, Shneidman has done so. Who in the field could forget Shneidman's famous myths? On a clinical note, a key myth is that suicide happens without warning. The fact is at least 80% do, which obviously means that 20% do not. In the 1990's, Shneidman (1994a) reconsidered his perspective on the clues to suicide. He asked, "how it is that some people who are on the verge of suicide…can hide or mask their secretly held intentions?" Shneidman suggests that many clues are veiled, clouded, and guarded, some even misleading. He argues that there are individuals who live secret lives, some suicidal. There are conscious and/or unconscious walls or barriers. To dissemble means to conceal one's motives. It is to disguise or conceal one's feelings, intention, or even suicide risk. These people wear "masks". Shneidman (1994a, p. 395) stated:

We suicidologists who deal with potentially suicidal people must…understand that in the ambivalent flow and flux of life, some desperately suicidal people…can dissemble and hide their true lethal feelings from the world.

How do you reach through the mask effectively? Shneidman's main clinical work was psychotherapy, what he believed to be the major intervention. He espoused that treating suicidal people was different, not only the same, as people in general. Shneidman's (1980) paper, "Psychotherapy with Suicidal Patients" provides certain rules for treatment of suicidal people that Shneidman thought should be stated. It contains prescriptive advice for the psychotherapist, suggesting a focus on the assessment of the patient's lethality and on the therapist's countertransference (and of the advisability of consultation if there are any difficulties in the countertransference). Implied in the paper is that all psychotherapy cures of suicidal people are transference cures. A classical, albeit brief, case history of what is done is given as an example. I quote verbatim:

A young woman in her 20s, a nurse at the hospital where I worked, asked me pleadingly if I would see her teenage sister whom she believed to be highly

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suicidal. The attractive, younger woman – agitated and tearful but coherent – told me (in the privacy of my office) that she was single, pregnant and determined to kill herself. She showed me a small automatic pistol she had in her purse. 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" (or live to bear?). Suicide was the *only* alternative, and shooting herself was the *only* way to do it. Either she had to be unpregnant (the way she was before she conceived) or she had to be dead.

I did several things. For one, I took out a sheet of paper and – to begin to "widen 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 to be 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 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 first, let me take that gun, and then let's look at this *list* and rank them in order and see what their advantages, disadvantages, and implications are, remembering that none of them may be perfect."

The very making of this list, my professional and nonhoratory and nonjudgmental approach already had a calming influence on her. Within 15 minutes her lethality had begun to deescalate. She actually rank-ordered the list, commenting negatively on each item, but what was of critical importance was that suicide, which I included in the total realistic list, was now ranked third – no longer first or second.

She decided that she would, reluctantly, talk to the father of her child. Not only had they never discussed the "issue" but he did not even know about it. But there was a formidable obstacle: He lived in another city, almost across the country and that involved (what seemed to be a big item in the patient's mind) a long distance call. It was a matter of literally seconds to ascertain the area code from the long distance operator, to obtain his telephone number from information, and then – obviously with some trepidation and keen ambivalence for her – to dial his number (at university expense), with the support of my presence to speak to him directly.

The point is not how the issue was practically resolved, without an excessive number of deep or shallow interpretations as to why she permitted herself to become pregnant and 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. (Leenaars, 1999, pp. 367-368).

The paper, "Aphorisms of Suicide and Some Implications for Psychotherapy" continues this line of thinking (Shneidman, 1984). The notion of aphorisms came into his head, with an acknowledged connection to my own (Leenaars, 1988) work on protocol sentences in suicide notes, and by implication, suicide. The special focus of this paper is on *constriction* as a potentially life-threatening condition that may require special attention from the therapist. It repeats some of the psychotherapy paper but comes at the topic from a different direction. Shneidman shows that there are certain rules that you can call aphoristic. If you know these rules, there are implications for psychotherapy and so forth. I present one of Shneidman's prescriptions:

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. (Leenaars, 1999, p. 378).

The two papers on psychotherapy are a must read for any therapist working with suicidal people. They highlight the true wisdom of a first rate clinician.

The letter, "Letter to the Editor, Rational Suicide and Psychiatric Disorders" (1992b) is a letter contra-psychiatric diagnosis. Shneidman has a critical view of the established "facts" that almost all people who die by suicide suffer one or more mental disorder(s), and the causal link between the two. This he stated is a myth. Shneidman had a rather critical view of such reductionism. Shneidman has, in fact, always held a reasonable or unreasonable, supercilious view of the DSM. The DSM and its various revisions are seen as the end of wisdom.

The paper is also a brief comment at the whole topic of rational suicide. Shneidman does not think that we can usefully debate whether or not there is rational suicide. Most suicides are sensible and logical to the person who commits them. The implication is: if suicide is a permanent solution to a transient problem, then you want to get that person through that time. You want to intervene. He writes:

In human beings pain is ubiquitous, but suffering is optional, within the constraints of a person's personality. Just as it is important to distinguish between the treatment of physical pain and the treatment of suffering (Cassell, 1991), so there are also important differences between the diagnosis of depression and the assessment of psychological pain. A focus on mental illness is often misleading. Physicians and other health professionals need the courage and the wisdom to work on a person's suffering at the phenomenological level and to explore such questions as "How do you hurt?" and "How may I help you?" They should then do

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whatever is necessary, using a wide variety of legitimate tactics (Shneidman, 1984), including medication, to reduce that person's self-destructive impulses. Diagnosis should be adjunctive to a larger understanding of the person's pain-in-life. (Leenaars, 1999, p. 384).

Psychological Autopsy and Postvention

In this category of work on suicide, Shneidman's key papers on the psychological autopsy and postvention are noted. There was an important man in Shneidman's life, Theodore J. Curphey. He, a Canadian, was the first MD in Los Angeles County to be the coroner. He knew from his life, as a pathologist, as a certifying officer, that many deaths are equivocal as to mode. In those cases, you know what the person died of, but you do not know how to identify that death as suicide or accident or homicide. These were cases that depend on the decedent's *intention*. It was the person's intention vis a vis the death that is core to mode. He had heard of Shneidman, Litman, and Farberow, and called the three of them and they became deputy coroners and went to the scene of the death where they gently interviewed a number of key survivors, and reported back to Dr. Curphey. Shneidman simply labeled this clinical-scientific investigating procedure one day, as a psychological autopsy. He writes:
The main function of the psychological autopsy is to clarify an equivocal death and to arrive at the correct or accurate mode of that death. In essence, the psychological autopsy is nothing less than a thorough retrospective investigation of the *intention* of the decedent – that is, the decedent's intention relating to his being dead – where the information is obtained by interviewing individuals who knew the decedent's actions, behavior, and character well enough to report on them. (Leenaars, 1999, p. 388).

The paper, "The Psychological Autopsy" (1977) provides a good overview of the psychological autopsy procedure. Here is a list of some categories that might be included in a psychological autopsy:

1. Information identifying victim (name, age, address, marital status, religious practices, occupation, and other details)
2. Details of the death (including the cause or method and other pertinent details)
3. Brief outline of victim's history (siblings, marriage, medical illnesses, medical treatment, psychotherapy, suicide attempts)
4. Death history of victim's family (suicides, cancer, other fatal illnesses, ages at death, and other details)
5. Description of the personality and life-style of the victim
6. Victim's typical patterns of reactions to stress, emotional upsets, and periods of disequilibrium
7. Any recent – from last few days to last twelve months – upsets, pressures, tensions, or anticipations of trouble
8. Role of alcohol or drugs in (a) overall life-style of victim, and (b) his death
9. Nature of victim's interpersonal relationships (including those with physicians)
10. Fantasies, dreams, thoughts, premonitions, or fear of victim relating to death, accident, or suicide
11. *Changes* in the victim before death (of habits, hobbies, eating, sexual patterns, and other life routines)
12. Information relating to the "life side" of victim (up-swings, successes, plans)
13. Assessment of intention, that is, role of the victim in his own demise
14. Rating of lethality
15. Reaction of informants to victim's death
16. Comments, special features, and so on. (Leenaars, 1999, pp. 399-400).

The comment, "Comment: The Psychological Autopsy" (1994b) is a one pager for *American Psychologist* that says that the psychological autopsy for Shneidman is about intention. There are different kinds of procedures, some are not psychological autopsies. For example, if you do a ballistic test and take blood samples and so on, that is not a psychological autopsy, that is a forensic autopsy or a clinical autopsy. If you look at bullet markings and blood type, that is not intention. The psychological autopsy is about the person's intention vis-a-vis the death.

Shneidman's paper "An Example of an Equivocal Death Clarified in a Court of Law" (1993b) is an example of a psychological autopsy. This one was done in the adversial setting of a court of law, specifically an Army court martial. Everything, except a few names, is verbatim. The bare facts were that an army officer was charged with the murder of his wife and faced a lifetime sentence in Leavenworth federal prison. The prosecution claimed that it was a homicide, citing that his wife had died in the nude and, after the testimony of some so-called expert, that since suicides do not occur in the nude, therefore it was homicide. The defense – in which Shneidman was an expert witness – believed her death was a suicide, and that the officer had been wrongly accused. It is instructive to read the various experts' different opinions, to take in Jerome Motto's model report, to see the extraordinary letter from the decedent's mother, and to note Shneidman's testimony on the state as he holds ground on behalf of the accused. Next, I present some excerpts from Shneidman's testimony (A true window to Shneidman's mind.):

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The following is an excerpt of my responses to questions from Mr. Dan Hyatt, counsel for the defense.

Hyatt: *The army investigator, Mr. Olds, has testified earlier in this case. He offered an opinion that it was unusual to see two instrumentalities when either attempting or committing suicide. Do you have an opinion with respect to that statement?*

Ess: *Yes, in a picayune way he is right. But in an overall way he is howlingly wrong. I'll tell you about each of those if I may.*

Hyatt: *Please.*

Ess: *Suicide itself, fortunately, is an event of infrequent occurrence. So that you can make tabulations of methods and all sorts of things. A lot of events are infrequent, but if the incontrovertible evidence is that the person has done it, then you can't say that the person has not done it simply because it is infrequent. Using two methods is much more infrequent than using one. That's true. But then to argue from that to this particular case is a tyro's error. It's a mistake that freshmen, undergraduates in my Death and Suicide course at UCLA, make of going from statistics to an individual case. Statistics are an interesting background for a case but they don't tell you about that case. Here we are talking about this case.*

Hyatt: *Mr. Olds also testified that he thought it was very rare based on his study of army personnel and their dependents, his data base, that it was very rare to find a dependent female to commit suicide or attempt to commit suicide in the nude. Do you have an opinion about that?*

Ess: *Yes, Well, I would say to him, "That's true. That's absolutely true. But you're really not seriously making an argument that that has a bearing on this case, are you?" And if he said "Yes," my already low opinion of him would drop precipitously.*

Hyatt: *What value do you see of statistical information such as that offered by Mr. Olds in determining the cause of death?*

Ess: *In a particular case?*

Hyatt: *Yes.*

Ess: *None. It's background material.*

Hyatt: *Is the utilization of statistics in the manner testified by Mr. Olds a scientifically acceptable method, or is that data reasonably relied upon by other experts in your field as a means of drawing conclusion?*

Ess: *If your question is, is it a scientifically credited method the way he has done it, the answer is no.*

Hyatt: *And why would that be?*

Ess: *The technical response is that in these matters, in suicidology, the confusion of statistical-demographic-epidemiological-numerical data with the etiology or outcome of any particular individual case, to make a judgment about that individual case on the basis of statistics is a methodological error.*

Hyatt: *Why is it a methodological error?*

Ess: *Because it has things backwards. It isn't that the statistics generate the case; it is that the cases taken in long series or large numbers generate the statistics. To say that it is rare is not to say that it did not occur.*

Hyatt: *What do you say when you hear that Peggy Campbell was nude on the evening of her death?*

Ess: *I would say, "Gee whiz, isn't' that unusual." But then to argue as he did that it couldn't be suicide on that account is a howler. It boggles the mind. Where did his logic go?*

Hyatt: *And would you have the same opinion as to the use of two instrumentalities?*

Ess: *Yes, sure. What is persuasive is the whole history of her lifetime….* (Leenaars, 1999, pp. 433-434).

In the paper "Postvention: The Care of the Bereaved" (1975), Shneidman outlines his thoughts about what one does after suicide. Shneidman saw in print the juxtaposition of two words which ordinarily do not appear with each other – prevention and intervention – and he said to himself, and postvention – here is what the prefixes say: before, during and after. He then labeled what was done with people after the dire event as postvention. His brief paper on the case of the bereaved sets the stage for what one can do for the survivors of suicide. He presents some eight principles of postvention:

1. In working with survivor victims of abrasive death, it is best to begin as soon as possible after the tragedy, within the first 72 hours if that can be managed.
2. Remarkably little resistance is met from the survivors; most are either willing or eager to have the opportunity to talk to a professionally oriented person.
3. Negative emotions about the decedent or about the death itself – irritation, anger, envy, shame, guilt, and so on – need to be explored, but not at the very beginning.
4. The postvener should play the important role of reality tester. He is not so much the echo of conscience as the quiet voice of reason.
5. Medical evaluation of the survivors is crucial. One should be constantly alert for possible decline in physical health and in overall mental well-being.
6. Needless to say, Pollyannaish optimism or banal platitudes should be avoided – this statement being a good example.
7. Grief work takes a while – from several months (about a year) to the end of the life, but certainly more than three months or six sessions.
8. A comprehensive program of health care on the part of a benign and enlightened community (or a first-rate hospital) should include preventive, interventive, and *postventive* elements. (Leenaars, 1999, p. 455).

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Concluding Remarks

Stepping back from Shneidman's works on suicide, one is struck by the generativity, the sheer productiveness of his life. He is one of the great suicidologists, a father to many of us. On closer examination of his works, it appears that there are two sustained narrative themes ("unity thema") in his life story or the "personal myth" he has so handsomely constructed. The first is his unique sense of being chosen early on, of being blessed or called or provided some sort of advantage that distinguishes one, in a positive way, from others. He writes that his parents provided him with an "ineffable sense of being special, someone to whom the really dire calamities would not occur, and if I behaved myself (as I almost always did), the 'A's' of approbation would fill my report card of life".

Another common theme in his narrative account is what Dan McAdams (of Northwestern University) has called "the redemptive sequence", a narrative strategy whereby the author juxtaposes bad and good events such that pain and suffering are immediately followed by some sort of affectively positive experience. The bad is "redeemed" or made better, sometimes by the acts of the protagonist, sometimes by circumstances, sometimes by sheer luck. These sequences can be very mundane; they can also be redemptive and transforming. Here is Shneidman moving, in a paragraph, from his own birth to his adult experiences with patients who tried to kill themselves:

My maternal grandmother died suddenly, in a subway in New York City, in February, 1918. Her death plunged my mother (who was then carrying me in her belly – we were both in York, Pennsylvania) into a deep psychological and physiological depression, so that after I was born in May, I was a bottle-fed and borderline failure-to-thrive child. It was probably the single best thing (next to conception) that ever happened to me, because my parents not only tried to keep me alive, but with the extra attention that puny neonate and infant demanded made me feel charmed in some special way ... Much later in life I saw this phenomenon in a few individuals who had committed suicide (by setting themselves on fire, jumping from a high place, or shooting a bullet through the head) and had fortuitously survived, beating all odds, and thereafter – having made it through a life-threatening ordeal – felt curiously magical, totally unsuicidal, and (within realistic limits) somehow omnipotent. This describes one of my deepest core feelings about myself, given to me by my life-saving parents.

We can read these feelings in Shneidman's works on suicide. As a brief personal note, there is always the notion, even if you say I love you, that it is never sufficient. I felt that often in my relationship to Dr. Shneidman. Human needs for love are insatiable. Sigmund Freud is reputed to have answered the question to "What makes people happy?" with "Liebe und Arbeit" (Love and work). There's a deep profundity to that, which Freud understood and, I know Shneidman certainly did.

At 90, Dr. Edwin S. Shneidman reflected one last time on suicide, in his book, *A Commonsense Book of Death*. He wrote:

My theory of suicide can be rather simply stated. There is a great deal of mental pain and suffering without suicide – millions to one – but there is almost no suicide without a great deal of mental pain. The basic formula for suicide is rather straightforward: introspective torture plus the idea of death as release. The key, the black heart of suicide, is an acute ache in the mind, in the psyche, it is called *psychache*. In this view, suicide is not a disease of the brain; but rather it is a perturbation in the mind, an introspective storm of dissatisfaction with the *status quo*, a dramatic (albeit self-destructive) effort to return to a *status quo ante*.

In my suicidological career I have been less satisfied with the focus on demographic and statistical studies: the differences between men and women, between blacks and whites, between old and young, between Los Angeles and San Francisco – a kind of grisly suicidological sibling rivalry. On the contrary I have tried to find the psychological *commonalities* – the omnipresent psychological attributes – among hundreds of disparate suicide people. Thousands of observations can be distilled into as few as ten psychological commonalities of the suicidal states. One finds these attributes in almost every suicidal person. These attributes provide a fresh template for viewing the suicidal process (and the suicidal person) and they have direct implications for how an earnest therapist can act as an effective ombudsman. (Shneidman, 2008, pp. 139-140).

This may well be the best endnote on his words on suicide, but I will make it the penultimate. On April 23, 2004, Dr. Shneidman spoke to me about his dying. He recalled a conversation with "Harry" Murray, then in his 90's and dying. Dr. Murray had stated to Shneidman, and Dr. Shneidman wanted the same stated, "To die gracefully is not to be a pain for those that love you." Dr. Shneidman hoped that he could do so. His works on suicide suggest that he did, and they live on. He was a beloved *Father* to many of us, and suicidology and suicide prevention.

Edwin S. Shneidman died May 15th, 2009, a few days after celebrating his 91st birthday. His works are windows to the suicidal mind, and to be more effective in preventing unnecessary deaths.

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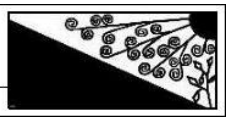

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