

About Suicide



about grief

The question 'Why did they take their life?' is complex and unfortunately may never be fully resolved. There is no easy answer—the most honest answer is we don't know.

The factors associated with suicide are varied and may include:

- Current stresses and social pressures
- Long-term problems associated with early abuse or trauma
- Chronic pain
- Physical disability.

Some people have a mental illness, although signs of the illness may not have seemed evident before the suicide. The most common condition is depression. Others include schizophrenia, alcohol and other substance abuse, and severe personality problems.

There also is increasing evidence that those who suicide may have an imbalance in their brain chemicals, usually associated with mental illness. Overall, predicting who will take their life is extremely difficult, even for experienced professionals.

Many of the theories can be summed up in the following three way:

Biological Perspectives

One perspective is to view suicidality as biochemical in nature. This approach is grounded in the perspective that suicidal people manifest various chemical imbalances that must be treated with medications.

Psychological theories

Modern psychological theories of suicide are influenced by Freud's work in the early twentieth century. Edwin Shneidman, a clinical psychologist from the United States who is a leading

authority on suicide and is considered by many to be the father of modern suicidology, has described several common characteristics of suicide, including a sense of unbearable psychological pain, a sense of isolation from others, and the perception that death is the only solution when the individual is temporarily not able to think clearly due to being blinded by overwhelming pain.

Sociological positions

Social theories such as those posed by French sociologist Emile Durkheim also influence notions about suicidality. Durkheim's beliefs are linked to the notion that there are societal factors that can influence suicide rates.

Durkheim found that suicide was more likely when a person was not engaged in social relationships or had relationships disrupted through a sudden change in status, such as death or divorce. Durkheim's work has led to the importance of considering the significance of social bonds such as marriage and family and other societal relationships when examining the potential for suicide in an individual.

Shneidman and “psychache”

According to Shneidman, suicide results from “psychache,” a word he coined to describe the unbearable psychological pain arising largely from frustrated psychological needs. “There is a great deal of psychological pain in the world without suicide,” said Shneidman. “But there is no suicide without a great deal of psychological pain.”

He described ten characteristics that are commonly associated with completed suicide. Shneidman's list includes features that occur most frequently and may help us understand many of those who suicide.

Support After Suicide

PO Box 79

Richmond VIC 3121

Phone: 9427 9899

Fax: 9427 7119

Email:

aftersuicide@jss.org.au

Web:

supportaftersuicide.org.au

A program of
Jesuit Social Services

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

Suicide is not a pointless or random act. To people who think about ending their own lives, suicide represents an answer to an otherwise insoluble problem or a way out of some unbearable dilemma. It is a choice that is somehow preferable to another set of dreaded circumstances, emotional distress, or disability, which the person fears more than death.

Contemplating suicide as a potential solution may be increased by a family history of similar behaviour. If someone else whom the person admired or cared for has committed suicide, then the person is more likely to do so.

2. The common goal of suicide is cessation of consciousness.

People who suicide seek the end of the conscious experience, which to them has become an endless stream of distressing thoughts with which they are preoccupied. Suicide offers oblivion.

3. The common stimulus (or information input) in suicide is intolerable psychological pain.

Excruciating negative emotions — including shame, guilt, anger, fear, and sadness — frequently serve as the foundation for self-destructive behaviour. These emotions may arise from any number of sources.

4. The common stressor in suicide is frustrated psychological needs.

People with high standards and expectations are especially vulnerable to ideas of suicide when progress toward these goals is suddenly frustrated. People who attribute failure or disappointment to their own shortcomings may come to view themselves as worthless, incompetent or unlovable.

Family turmoil is an especially important source of frustration to adolescents. Occupational and interpersonal difficulties frequently precipitate suicide among adults. For example, rates of suicide increase during periods of high unemployment.

5. The common emotion in suicide is hopelessness-helplessness.

A pervasive sense of hopelessness, defined in terms of pessimistic expectations about the future, is even more important than other forms of negative emotion, such as anger and depression, in predicting suicidal behaviour. The suicidal person is convinced that absolutely nothing can be

done to improve his or her situation; no one else can help.

6. The common internal attitude in suicide is ambivalence.

Most people who contemplate suicide, including those who eventually kill themselves, have ambivalent feelings about this decision. They are sincere in their desire to die, but they simultaneously wish that they could find another way out of their dilemma.

7. The common cognitive state in suicide is constriction.

Suicidal thoughts and plans are frequently associated with a rigid and narrow pattern of cognitive activity that is comparable to tunnel vision. The suicidal person is temporarily unable or unwilling to engage in effective problem-solving behaviors and may see his or her options in extreme, all or nothing terms.

As Shneidman points out, slogans such as “death before dishonour” may have a certain emotional appeal, but they do not provide a sensible basis for making decisions about how to lead your life.

8. The common action in suicide is escape.

Suicide provides a definitive way to escape from intolerable circumstances, which include painful self-awareness.

9. The common interpersonal act in suicide is communication of intention.

One of the most harmful myths about suicide is the notion that people who really want to kill themselves don't talk about it. Most people who suicide have told other people about their plans. Many have made previous suicidal gestures.

Shneidman estimates that in at least 80 percent of completed suicides, the people provide verbal or behavioural clues that indicate clearly their lethal intentions.

10. The common consistency in suicide is with life-long coping patterns.

During crisis that precipitate suicidal thoughts, people generally employ the same response patterns that they have used throughout their lives. For example, people who have refused to ask for help in the past are likely to persist in that pattern, increasing their sense of isolation.

Edwin Shneidman, *The Suicidal Mind*. 1996, Oxford University Press, USA.