

# About Suicide

## understanding suicide and grief

The question 'Why did they take their life?' is very difficult to answer. Suicide is complex and often hard to understand. The most honest answer is that we don't fully understand it.

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 associated with suicide is depression. Others include bipolar disorder, schizophrenia, alcohol and other substance use, 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 ways:

### Biological Perspectives

A biological explanation suggests that suicide can be linked to certain chemicals in the brain. More specifically, that levels of some neurotransmitters e.g. serotonin enhance the potential for suicide. Anti-depressant medication is sometimes prescribed to address this issue.

### Psychological theories

Research suggests that major depression is strongly associated with suicide. Bipolar disorder, schizophrenia, borderline personality disorder and anxiety disorders are also known to be associated with suicide.

Edwin Shneidman, a clinical psychologist from the United States and a leading authority on suicide before his death in 2009, 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 can appear to be 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 he thought were commonly associated with suicide. Shneidman's list may help us to understand many of those who suicide.

### Support After Suicide

PO Box 79

Richmond VIC 3121

Phone: (03) 9427 9899

Email:

[aftersuicide@jss.org.au](mailto:aftersuicide@jss.org.au)

Web:

[supportaftersuicide.org.au](http://supportaftersuicide.org.au)

Community:

<http://community.supportaftersuicide.org.au>

[supportaftersuicide.org.au](http://community.supportaftersuicide.org.au)

A program of  
Jesuit Social Services

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

According to Shneidman, suicide is not a random act; it is not done without purpose. It is a way out of a problem, a dilemma, a bind, a difficulty or crisis. The purpose of suicide is to solve a problem, to seek a solution to a problem that is generating intense suffering. It is somehow preferable to the emotional distress, or unbearable situation, which the person fears more than death.

Contemplating suicide as a potential solution may be increased by a family history of similar behaviour or if someone whom the person admired or cared for has suicided.

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

Suicide can be understood as moving toward the complete stopping of one's consciousness and pain. The cessation of consciousness can be seen as offering a solution to life's problems.

**3. The common stimulus in suicide is psychological pain.**

The suicidal person is seeking to escape pain. Suicide can be understood as a movement toward cessation of consciousness and a movement away from intolerable and unacceptable pain.

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

Very often suicide stems from blocked or unfulfilled psychological needs. This tends to be what causes the pain that the suicidal act seeks to end. 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 important source of frustration to adolescents. Occupational and interpersonal difficulties can 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 thinking that is comparable to tunnel vision. The suicidal person is temporarily unable or unwilling to engage in effective problem-solving behaviours 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 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, given some indication of their intention or a signal of distress. However, these indications are very often indirect and evident only in hindsight. Many have made previous suicidal gestures.

Shneidman estimates that at least 80 percent of people who suicide have provided some verbal or behavioural indication of their intentions.

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

During crises 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.