Ch. 3

What Do Suicides Have in Common? A Conspectus of the Indispensables for Conceptualizing the Suicidal Scenerio

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Among the Mill's canons for inductive inference, the Method of Difference is probably the most powerful for conducting experiments to generate new knowledge. Even so, a consideration of similarities among comprehensive phenomena grouped under one common label (in this case, "suicide") can be particularly illuminating. This view permits us legitimately to ask "What, in common-sense terms, is common in suicide?"

Let us begin by citing, briefly, two (among several) commonly discussed disparities among suicidal phenomena:

1. Demographic disparities. In the history of the study of suicide the demographic approach (especially since Durkheim) has appeared to be and useful and powerful approach. Thus we have innumerable studies of suicide in relation to sex, age, ethnicity, locale (countries, states of the U.S., cities, neighborhoods, census tracts, socio-economic status, occupation, and (the current favorite) psychiatric diagnostic categories. In my view, there is a latent (and ~~grisly~~) sibling rivalry to these studies: Norway loses to Italy, men lose to women, San Francisco loses to Los Angeles, adolescents and oldsters lose to the middle-aged, schizophrenics lose to depressives, and so on. To know that the modal suicide in the United States is a divorced-separated-widowered Caucasian, Protestant male with a history of suicide attempts is interesting but of questionable usefulness in its wide-ranged application. Toward the end of my suicidological career I muse: When one cannot pursue in phenomonlogical depth, one counts in large number.

2. Disparities of approach. In the paragraph above I have alluded to two broad approaches: The nomothetic (tabular, statistical, demographic) approach, and the idiographic (clinical, case study, personal document, anamnestic) approach. (The terms "idiographic" and "nomothetic" are those of the German philopher Wilhelm Windelband, introduced to American readers by Gordon Allport). But there are several more than these two approaches, perhaps a dozen different ways to come at and attempt to understand suicidal phenomena. The point to be made is that there are several legitmate avenues to the golden circle, and one should take umbrage only if a partisan claims that this one view is the only (or true, or basic) way (of providing the "fundamental data") to the understanding of suicidal phenomena. A listing of twelve approaches is provided in Table I. If these several approaches can be visualized as a "circle of the etiology of suicide," then the reader will understand that the remainder of this chapter on but one sector -- the psychological sector -- of the total etiological pie. I should make it clear that personally I am an advocate of all the sectors -- ideally, a multidisciplinary approach to the study of the same cases, but in this setting in which I address the commonalities of suicide I shall limit myself to the psychological commonalities (and leave it for others more qualified to explicate the other legitimate views).

Table 1

Various Contemporary Approaches to the Study of Suicidal Phenomena

Sector	Key References	Principal assertion: That suicide is best understood primary --
1. LIFE HISTORY	Allport (1937) Murray (1967) Runyon (1982)	As an episode in a long life history, and that precursors of the suicidal death can be seen in previous patterns of response to comparable life situation
2. DEMOGRAPHIC; EPIDEMIOLOGICAL	Graunt (1662) Sussmilch (1741) Dublin (1963) Hollinger & Offer (1986)	In terms of "census" data -- the statistics for sex, age, race, religious affiliation, marital status, socio-economic status, etc.
3. SYSTEMS THEORETICAL	Blaker (1972) Miller (1978) Tyler (1984)	As an act within a living system, both the individual himself and the individual-within-his-society as living system
4. PHILOSOPHICAL; THEOLOGICAL	Pepper (1942) Fowles (1964) Choron (1972) Battin (1982)	In answers to questions such as: What is the purpose of life? Are there forces beyond ourselves? What is our relation to the universe?
5. SOCIO-CULTURAL	Hendin (1964) Lifton (1981) Iga (1986)	In terms of socio-cultural data; e.g., knowledge of various countries and cultures such as Sweden, Japan, etc.
6. SOCIOLOGICAL	Durkheim (1897) Douglas (1967) Maris (1981)	In terms of an individual's relationship to his society; his estrangement from it, his ties to it, etc.
7. DYADIC AND FAMILY	Pfeffer (1986) Richman (1987)	In terms of the stressful interaction between two people or within a family nexus.
8. PSYCHIATRIC	Kraepelin (1883) APA DSM (1988)	In terms of mental illnesses, such as depression, schizophrenia, alcoholism.
9. PSYCHODYNAMIC	Freud (1910) Zilboorg (1937) Menninger (1938) Litman (1967) Maltsberger	In terms of unconscious conflicts, especially unconscious hostility toward the father; suicide seen as unconscious murder.
10. PSYCHOLOGICAL	Murray (1967) Shneidman (1985)	In terms of psychological pain, produced by the frustration of psychologica needs.
11. CONSTITUTIONAL;	Roy (1986) Kety (1986)	As an expression of in-born (constitutional or genetical) factors.
12. BIOLOGICAL; BIOCHEMICAL	Bunney (1965) Asberg (1986)	As a result of biochemical imbalances in the body fluids (blood) or organs (brain).

(From Edwin Shneidman, Definition of Suicide. New York: Wiley, 1985).

In previous publications (1985,1986,1987), I have referred to "the ten commonalities" of suicide, specifically the psychological common features of suicide. They are reproduced in Table II and discussed briefly below. But first, a few preliminary remarks.

Table 1

The Ten Commonalities of Suicide

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 LIFE-LONG COPING PATTERNS

(From Edwin Shneidman, Definition of Suicide, NY: Wiley, 1985)

Table II

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The key to the psychological understanding of suicide is pain -- psychological pain, the pain the individual feels in that situation in his life. Suicide, in this sense, is a practical act. Henry Murray says that suicide, while clarly not adaptive, is, just as clearly, adjustive (Murray, 1938). Baechler (1975), in an intensive book-length essay on suicide, tells us that in order to understand a specfic case of suicide of suicide we must know what problem it was intended to solve. And Kelley (1961), like a surging wave of philosophic idea, covers s uicide with the insistent view that each individual has his own private (unique, idiosyncaratic) epistemology -- his personal construct of the world -- and that a suicide is to understood as that individual's effort to validate his life. Kelley writes (1961):

> Under what conditions of outlook would anyone seek death rather than life? By stating our question in this way, we shall be inquiring into a psychological principle rather than a simple situational element.... To understand this act we must know what he died for. What personal constructions of life and truth, what anticipations formulated from his structured world seemed to be validated by so drastic an act.... a suicide attempt can be regarded as an act designed to validate one's life.

And I would add, and to terminate one's suffering.

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

First of all, suicide is not a random, pointless or purposeless act. To the sufferer it seems to be the only available answer to a real puzzler: How to get out of this? What to do? Its purpose is to seek a solution to a perceived crisis -- the problem of overwhelming pain -- that is generating intense suffering. To understand what a suicide is about, one must know the problems it was intended to solve. Baechler (1975) focusses on this attribute of suicide. The general question to the wsuicidal person is: "What is going on?"

II. The common goal of suicide is the cessation of consciousness.

Suicide is both a moving toward and a moving away. The common practical goal of suicide is the stopping of the painful flow of consciousness. Suicide is best understood not so much as a movement toward a reified Death, as it is in terms of "cessation" -- the complete (and irreversible) stopping of one's consciousness of unendurable pain. The idea of stopping consciousness as the answer, together with unusual constriction and elevated perturbation are the essential lethal ingredients of suicide. Suicide, as Litman (1990) correctly points out, involves not only pain, but the individual's unwillingness to tolerate that pain, the decision not to endure it and the active will to stop it, so the foci in therapy need to be on both the amelioration of the pain and the "character" which will not tolerate it.

III. The common stimulus in suicide is unendurable psychological pain.

In any close analysis, suicide is best understood as a combined movement toward cessation and a movement away from intolerable, unendurable, unacceptable anguish. It is psychological pain of which we are speaking: metapain, the pain of feeling pain.

From a traditional psychodynamic view, hostility, shame, guilt, fear, anger, protest, longing to join a deceased loved one, etc., have singly and in combination been identified as the root factor in suicide. It is none of these; rather, it is the pain involved in any or all of them, together with the unwillingness to endure that pain, idiosyncratically defined. Those last two words are indispensable for an understanding of suicide, for it is in the individual's idiosyncratic definition of pain that the culture, the language, the zeitgeist -- in which the individual is embedded -- come to bear; and, further, the idiosyncratic aspect of suicide reflects that individual's personal defintion of "the world," of "life" (and suffering, meaning, hope, despair) and of "myself" -- who I am and what I will and will not put up with). Psychological pain is the center of suicide and constitutes a hurdle which must be lowered before any kind of therapy can be effectively life-saving. The basic clinical rule is: Reduce the level of suffering, often just a little bit, and the individual can then chose to live.

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

The psychological pain which is central to suicide is driven, created by, sustained by frustrated, blocked, thwarted psychological needs. Suicide is best understood not so much as an unreasonable act -- every suicide seems logical to the person who commits it, given that person's major premises, styles of syllogizing, and constricted focus -- as it is a reaction to unfulfilled psychological needs.

In order to understand suicide in this kind of context, we need to ask a much broader question, which, I believe, is the key: What purposes do most human acts, in general (and including suicide), intend to accomplish? The best nondeatiled answer to that question is that, in general, human acts are intended to satisfy a variety of human needs. There is no compelling a priori reason why a typology (or classification or taxonomy) of suicidal acts might not parellel a classification of general human needs. (In any event, it provides an understanding of psychological pain). Such a classification of psychological needs can be found in Murray's Explorations in Personality (1938). There, in Murray's discussion of human needs is a ready-made, viable, useful taxonomy of the underpinnings of suicidal behaviors. (See Table III).

Most suicides represent combinations of various needs, so that a particular case of suicide might properly be understood in terms of two or more different need categories. There are many pointless deaths, but there is never a needless suicide. Address the frustrated needs, and the suicide will not occur. The therapist's function is to decrease the patient's acute discomfort; to increase the patient's psychological comfort. One way to operationalize this task is to focus on the thwarted needs. Questions such as "Where do you hurt?" can be useful in clarifying the suicidal picture.

A PARTIAL LISTING OF THE MURRAY PSYCHOLOGICAL NEEDS

BASEMENT. To submit passivley to external force. To accept injury, blame, ciricism, punishment. To surrender. To become resigned to fate. To admit inferiority, error, wrongdoing, or defeat. To confess and atone. To blame, belittle, or mutilate the self. To seek and enjoy pain, punishment, illness and misfortune.

CHIEVEMENT. To accomplish something difficult. To master, manipulate, or organize physical objects, human beings or ideas. To do this as rapidly and independently as possible. To overcome obstacles and attain a high standard. To excel oneself. To rival and surpass others. To increase self-regard by the sucessful exercise of talent.

FFILIATION. To drae near and enjoyably co-operate or reciprocate with an allied other (who resembles the subject or who likes the subject). To please and win affection of a cathected object. To adhere and remain loyal to a friend.

GGRESSION. To overcome opposition forcefully. To fight. To attack or injure another. To oppose forcefully or punish anotheri

UTONOMY. To get free, shake off restraint, break out of social confinement. To resist coercion and restriction. To avoid or quit activities presecibed by domineering authorities. To be independent and free to act according to desiree. To defy convention.

OUNTERACTION. To master or make up for a failure by restriving. To obliterate a humiliation by resumed action. To overcome weakness; to repress fear. To efface a dishonor by action. To seek for obstacles and difficulties to overcome. To maintain self-respect and pride on a high level.

EFENDANCE. To defend the self against assault, criticism, blame. To conceal or justify a misdeed, failure or humiliation. To vindicate the ego.

EFERENCE. To admire and support a superior. To praise, honor or eulogize. To yield eagerly to the influence of an allied other. Yo emulate an exemplar. to conform to custom.

OMINANCE. To control one's human environment. To influence or direct the behavior of others by suggestion, seduction, persuasion, or command. To dissuade, restrain or prohibit.

XHIBITION. To make an impression. To be seen and heard. To excite, amaze, fascinate, entertain, shock, intrigue, amuse or entice others.

ARMAVOIDANCE. To avoid pain, physical injury, illness and death. To escape from a dangerous situation. To take precautionary measures.

NFAVOIDANCE. To avoid humiliation. To quit embarrassing situations. To avoid conditions that lead to scorn, derision or indifference of others. To refrain from action because of fear of failure.

INVIOLACY. To protect the self. To remain separate. To resist attempts of others to intrude upon or invade one's own psychological space. To maintain a psychological distance. To be isolated, reticent, concealed; immune from criticism.

NURTURANCE. To give sympathy and gratify the needs of another person, especially an infant or someone who is weak, disabled, tired, inexperienced, infirm, defeated, humiliated, lonely, rejected, sick, mentally confused. To feed, help, support, console, protect, comfort, nurse, heal; to nurture.

ORDER. To put things or ideas in order. To achieve arrangement, organization, balance, tidiness and precision among things in teh outer world or ideas in the inner world.

PLAY. To act for "fun" without further purpose. To like to laugh and make jokes. To enjoy relaxation of stress. To participate in pleasurable activities for their own sake.

REJECTION. To separate oneself from a negatively cathected object. To exclude, abandon, expel or remain indifferent to an inferior object. To snub or jilt another.

SENTIENCE. To seek and enjoy sensuous experience. To give an important place to creature comforts of taste and touch and the other senses.

SUCCORANCE. To have one's needs gratified by the sympathetic aid of another person. To be nursed, supported, sustained, protected, loved, advised, guided, indulged, forgiven, consoled, taken care of. To remain close to a devoted protector. To always have a supporter.

UNDERSTANDING. To ask and answer questions. To be interested in theory. To speculate, formulate, analyze and generalize. To want to know the answers to the general questions.

Adapted from Henry A. Murray, Explorations in Personality. New York: Oxford Press, 1938. Chapter 3, pp. 142-242.

logical needs. There are many pointless deaths, but there is never a needless suicide. Address the frustrated needs and the suicide will not occur.

V. The common emotion is helplessness-hopelessness.

In the suicidal state there is a pervasive feeling of helplessness-hopelessness: "There is nothing that I can do (except to commit suicide) and there is no one who can help me (with the pain that I am suffering)." Underlying all of the emotions -- hostility, guilt, shame -- is that emotion of active, impotent ennui, the feeling of helplessness-hopelessness. The most effective way to reduce elevated lethality is to reduce the elevated perturbation, the feelings of helplessness-hopelessness.

VI. The common cognitive state toward suicide is ambivalence.

The (non-Aristotlian) accommodation to the psychological realities of mental life -- simultaneous contradictory feelings -- is called ambivalence. It is the common internal attitude toward suicide: To feel that one has to do it and, at the same time, to yearn (and even plan) for rescue and intervention. The therapist uses this ambivalence and plays for time so that the affect rather than the bullet can be discharged.

VII. The common ~~cognitive~~ perceptual state is constriction.

Suicide is not best understood as a psychosis, a neurosis or a character disorder. It is more accurately seen as a more-or-less transient psychological constriction of affect and intellect. Synonyms for constriction are a tunnelling or focussing or narrowing of the range of options usually available to that individual's consciousness when the mind is not panicked into dichotomous thinking: either some specific (almost magical) total solution or cessation; all or nothing; Caesar aut nihil; the range of choices have narrowed to two -- not very much of a range. The usual life-sustaining images of loved ones are not even within the mind. The fact that suicide is committed by individuals who are in a special constricted condition suggests that no one should ever commit suicide while disturbed or suicidal. It takes a mind capable of scanning a range of options greater than two to make a decision as important as taking one's life. It is vital to counter the suicidal person's constriction-of-thought at the outset by widening the mental blinders and increasing the number of options beyond ~~the~~ only two options of either a magical resolution or being dead.

VIII. The common action in suicide is escape (egression).

Egression is a person's intended departure from a region of distress. Suicide is the ultimate egression, besides which all others -- running away from, quitting a job, deserting an army,

leaving a spouse -- pale. We need to give the person other exits, other ways of doing something. This idea ties in with breaking through the constriction.

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

Perhaps the most interesting finding from large numbers of psychological autopsies of suicidal deaths is that in almost every case there were clear clues to the impending lethal event. Individuals intent on committing suicide, albeit ambivalently minded about it, consciously or unconsciously emit signals of distress, whimpers of helplessness, pleas for response, opportunities for rescue in the usually dyadic interplay that is an integral part of the suicidal drama. The common interpersonal act of suicide is communication of intention, the usual verbal and behavioral clues.

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

In suicide, we are initially thrown off the scent because suicide is an act, by definition, which that individual has never done before so there is no precedent. And yet there are some deep consistencies with life-long coping patterns. We must look to previous episodes of disturbance, to capacity to endure psychological pain, to the penchant for constriction and dichotomous thinking, for paradigms of egression.

It is possible to combine these ten items into a more succinct theoretical model. Imagine a cube-- see Figure 1 -- made up of 125 cubelets, with 25 squares on plane, and 5 cubelets in each row and each column. (See Figure 1). I call these three faces or factors or components of this model press, pain and perturbation, defined as follows.

Pain. Pain is the front plane of the cube. It refers to the psychological pain resulting from thwarted psychological needs. The left column of cubelets represents little or no pain, the next column over some bearable pain, and so on, up until the right-most column which represents intolerable psychological pain.

Perturbation. Perturbation --assigned to the side plane of the large cube -- is a general term meaning the state of being upset or perturbed. Perturbation -- ranked here on a five-point rating scale -- includes everything in DSM-III. In relation to suicide, perurbation includes (a) perceptual constriction, and (b) a self-harming proclivity for precipitous or ill-advised action. Constriction is the reduction of the individual's perceptual and cognitive range. At its worst, the individual cuts the viable options down to only two, then to one. On this plane in the cube, the bottom row reflects open-mindedness, wide mentational scope, and relatively clear thinking. The top row reflects constriction of thought, tunnel vision, and a narrowing of focus to one or two options, with cessation, death and egression as one (and ultimately as the only) solution to the problem of pain and frustrated needs. The penchant for action is a response to the need for inviolacy and autonomy. The furthest column of cubelets reflects a high tolerance for ambiguity, a capacity for patience and waiting. As

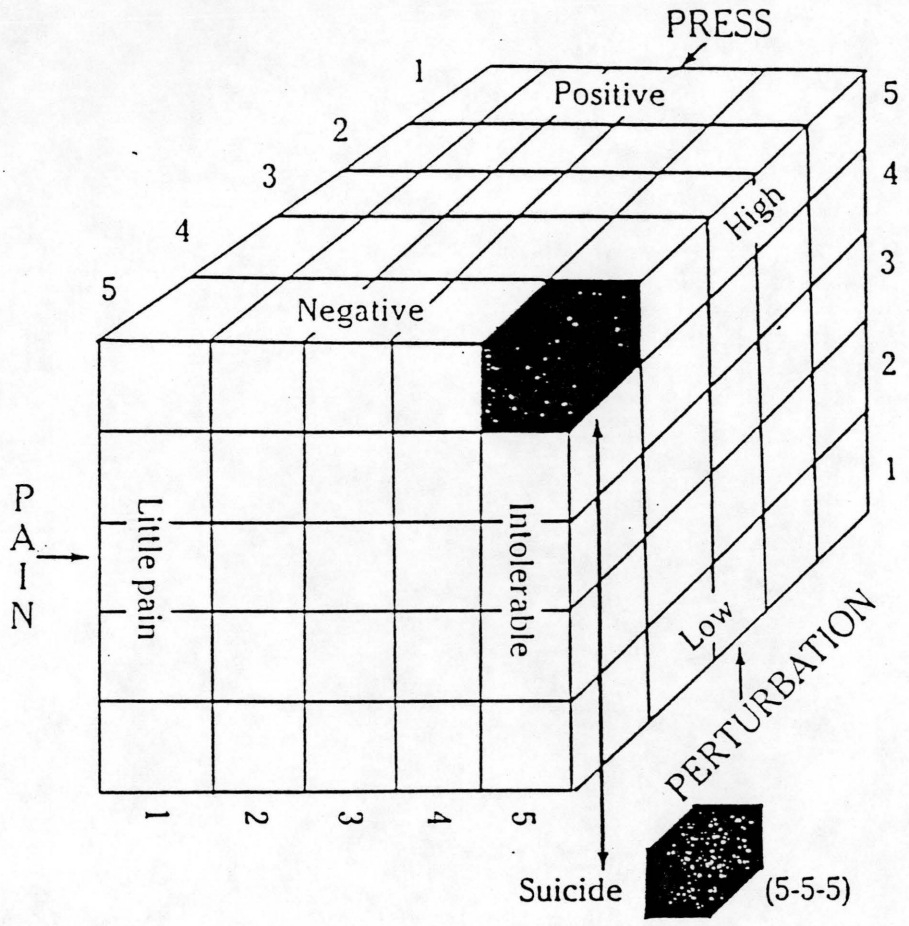

Figure 1. A theoretical cubic model of suicide.

we move forward (toward us) on this plane, we come closer to this tendency for precipitous and consumatory action, this lethal impulsivity. That is what the foremost column on the side plane represents.

Press. Murray (1938) may have had the word pressure in mind when he decided to use the word press (pl., press) to represent those aspects of the inner and outer world, or environment, that impinge on, move, touch, or affect and individual and make a difference. Press refers to the events done to the individual (and the way they are incorporated and interpreted) to which he or she reacts. There is postivie press (good genes and happy fortune) and negative press (conditions and events that perturb, stress, threaten or harm the individual). It is the latter that are relevant to suicide. Press includes both actual and imagined events, in the sense that everything is mediated by the mind. In this cubic model, press ranges from positive (in the back row of the top plane) to negative (in the front row of the top plane).

In this theoetical cube of 125 cubelets there is only one cubelet that is 5-5-5. Not every individual who is in a 5-5-5 cubelet commits suicide -- he or she may commit homicide, or go crazy, or become amnesic, or destory a career -- but in this conceptual model no one commits suicide except those in the 5-5-5 cubelet -- maximum pain, maximum perturbation, maximum press. The implications for therapy and redress would seem to be obvious: Reduce any one of those dimensions to a 4 (or less); preferably, reduce all three. (individuals can lead long, unhappy lives as 4's and 3's, but the goal in suicide prevention is to remove the individual from the 5-5-5 cubelet. All else -- demographic variables, family history, previous suicidal history -- is peripheral except as those factors bear on presently felt pain, perturbation, and press.

How to bring these ideas to life? Make them more vibrant in the reader's mind? Answer: By use of case examples. Here, then, are three excerpts from the verbatim accounts -- the first two from cassette recordings from my interviews and the third from an account written in my presence -- of three individuals (two young women and a young man) who committed highly lethal acts -- burning oneself, jumping from a high place, and shooting oneself with a shotgun -- and, against all odds, fortuitously survived. Thus, in a sense, they give us an inside, introspective look at the micro-moments of committed suicide -- as close as we are going to get. Dear reader, please read these, keeping in mind the concepts of psychological pain, thwarted psychological needs, hopelessness, ambivalence, constriction, perturbation, cessation, egression, communication, consistency-with-definition-of-the-self.

Immolator: I remember sitting in the car and it was sort of like a blank in my mind. I felt very calm. I felt a kind of hush over my body. That everything was going to be O.K. And I remember then pouring the gasoline first over the front seat and of course over myself to a great extent. Even then no thoughts went through my head at all of the pain that it was going to entail, the misery, the hurt any of that. I guess I didn't think that burns would really hurt, but none of that went through my head. It just felt good. It was the first time, in fact, that I had felt at peace, that I wasn't hurting inside. And for once it seemed like I had taken care of my problems and that my pain would just go away. It was not going to exist anymore, especially my mental pain. And I remember very slowly striking the match and at that moment the fumes ignited, just a tremendous explosion.

Jumper: I was so desperate, I felt, My God, I can't face this thing. Everything was like a terrible whirpool of confusion. And I thought to myself, there's only one thing to do, I just have to lose consciousness. That's the only way to get away from it. The only way to lose consciousness, I thought, was to jump off something good and high. I just figured I had to get outside. I just slipped out. No one saw me. And I got to the othr building by walking across that catwalk thing, sure that someone would see me, you know, out of all those windows. The whole building is made of glass. And I just walked around until I found this open staircase. And as soon as I saw it, I just made a beeline right up to it. And then I got to the fifth floor and everything just got very dark all of a sudden, and all I could see was this balcony. Everything around it just blacked out. It was just like a circle. That was all I could see, just the balcony. I climbed over it and I just let go. I was so desperate.

Shooter: There was no peace to be found. I had done all I could and was still sinking. I sat many hours seeking answers and all there was was a silent wind and no answers. The answer was in my head. It was all clear now. Die. The next day a friend of mine offerred to sell me a shot gun, ~~a .357 magnum pistol~~. I bought it. My first thought was what a mess this is going to make. The next day I began to say goodbye to people. Not actually saying it but expressing it silently. I didn't sleep. The dreams were reality and reality dreams. One by one I turned off my outside channels to the world. My mind became locked on my target. My thoughts were: Soon it will all be over. I would obtain the peace I sought so long for. The will to survive and succeed had been crushed and defeated. I was like a general alone one a battlefield being encroached upon by my enemy and its hordes: Fear, hate, self-depreciation, desolation. I felt I had to have the upper hand, to control my environment, so I sought to die rather than surrender. Destiny and reality began to merge. Those around me were as shadows, apparitions, but I was not actually conscious of them, only aware of myself and my plight. Death swallowed me long before I pulled the trigger. I was locked within myself. The world through my eyes seemed to die with me. It was like I was to push the final button to end this world. I committed myself to the arms of Death. There comes a time when all things cease to shine, when the rays of hope are lost. As I look back on that day it is as if this was another person's life I was ending. I placed the gun to my head. Then I remember a tremendous explosion of lights like fireworks consumed within a brilliant radiance. Thus did the pain become glorious, becoming an army rallied to the side of death to help destroy my life which I could feel leaving my body with each rushing surge of blood. I was engulfed in total darkness.

It is possible to combine the ten commonalities of suicide and the theoretical cubic model for suicide into a simple list of six basic elements of the suicidal scenerio. They are as follows:

1. A sense of unbearable psychological pain, which is related directly to thwarted psychological needs, together with

2. Traumatizing self-denigration -- a self-image that will not include tolerating intense psychological pain, together with

3. Constriction of the mind and an unrealistic narrowing of life's actions, together with

4. A sense of isolation -- a feeling of desertion and the loss of support of significant others, together with

5. An overwhelmingly desperate feeling of hopelessness -- that nothing effective can be done, together with

6. A conscious decision that egression -- leaving, exiting or stopping life -- is the only (or at least the best) solution to the problem of unbearable pain.

All these combine to result in suicide.

It is my long-standing belief that the amelioration of the suicidal state -- the actual saving of lives -- is most effectively accomplished by reducing the intensity of these basic consituents of the suicidal scenerio, especially the psychological pain, the perceptual constriction, the social isolation and the sense of hopelessness.

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