

Exploring the Phenomenology of Suicide

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Phenomenology studies conscious experience as experienced from the subjective or first-person point of view. This paper was developed with the aim of shedding light on the phenomenology of suicide; that is, to focus on suicide as a phenomenon affecting a unique individual with unique motives for the suicidal act. To explore this topic, the author looks back at the past centuries to understand why suicide was thought to be confined to psychiatric illness and to document the bias in studies supporting this notion. One major step forward in the conceptualization of suicide as a psychological disorder was provided by Edwin Shneidman, who focused on the pain of negative emotions. Such a radical approach is laudable in an era where diagnostic criteria and the need to cure are more important than understanding what is not working at the emotional level.

I consider suicide to be the result of fractures—with oneself, with other people, with nature, with the opportunity to experience feelings of well-being and to appreciate that which surrounds us. Common human satisfactions derived from feeling alive and experiencing positive excitement, as in the case of watching breathtaking landscapes or joyful events, may sometimes be denied to people, and the individuals stand as spectators, longing to heal the fracture that impairs full appreciation of themselves and the world. Such experience is not necessarily related to a psychiatric disorder such as depression, but rather it is a separate, peculiar dimension that, often momentarily, overwhelms the individual. One can be profoundly depressed or psychotic, yet seeking treatment and hoping to get bet-

ter, never thinking of ending one's life (Pompili, 2008; Pompili, in press).

In 1829, the Italian poet Leopardi wrote *La quiete dopo la tempesta* ("The Calm after the Storm"), in which the light and reassuring verses at the beginning evolve into the dark desperation of the conclusion, where pleasure and joy are conceived of as only momentary cessations of suffering and the highest pleasure is provided only by death. These are the words of a profoundly hopeless person who experiences pleasure only when deep worry is relieved by proper reassurance. This is not typically the case in mental health in which the opportunity to experience well-being and satisfaction from life derives from many sources and developments.

Scholars worldwide have puzzled over what makes a person suicidal and what individuals who die by suicide have in their minds. Most often the focus is not on the motives for suicide, nor on the phenomenology of this rare act. Rather, it is on what is found from small cohorts of suicidal individuals. Each day, dozens of papers on suicide are added to the enormous literature related to this topic. Maltzberger (1986), reflecting on this issue, wrote: "So massive is the sui-

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cide literature that any attempt to master it may stagger not only the mind, but the back as well Forests are destroyed to feed the whirring presses; many new articles and a book or two appear each month" (p. 49).

Models of suicide are less frequently encountered in the literature. It is difficult to produce a sound synthesis of a complex phenomenon, after which many in the scientific community comment that the model omits key features not easily identifiable. The lack of models that actually help in the management of suicide is reflected by the fact that suicide rates have been only mildly changed by the tremendous efforts in this field. However, a number of suicide models have been reported. For example, the scientific view suggests that suicide is caused by factors beyond the individual's control (the determinist view of suicide); the "Cry for Help" theory argues that individuals who die by suicide do not want to die but are seeking help to reduce their distress; and the sociogenic model blames social forces as the cause of suicide (Durkheim's altruistic, egoistic, anomic, and fatalistic suicide). More recently, a stress-diathesis model has been proposed (Mann, Waternaux, Haas, & Malone, 1999) in which the risk for suicidal acts is determined not merely by a psychiatric illness (the stressor) but also by a diathesis. This diathesis may be reflected in a tendency to experience more suicidal ideation and to be more impulsive and, therefore, to be more likely to act on suicidal feelings (Battin, 1995).

Many clinicians perform careful assessments for suicidal risk in their patients and assume that suitable treatments will resolve this risk, but they rarely investigate suicidality in-depth. The key words here are from the ancient Greek aphorism "Know yourself," which was inscribed in the pronaos (forecourt) of the Temple of Apollo at Delphi. There are myths and resistances that impair a proper understanding of suicidal people. Many believe that talking about suicide will reinforce the patient's suicidal ideation; others believe that, when patients talk about suicide, the risk of suicidal behavior is low ("Those who talk about it don't do it").

Myths and stigmatization should be replaced by a meaningful phenomenology of suicide that involves a true understanding of the suicidal individual's intimate world.

In this paper I explore some of the issues related to suicide as a phenomenon emerging from the individual and, therefore, strongly associated with that person's emotions, personality, and experiences. Such an appraisal of phenomenology of suicide stresses the need to better understand the suicidal dimension as opposed to the psychiatric dimension, and to avoid myths and stigmatization.

THE INFLUENCE OF PAST CENTURIES

Suicide has always been a taboo topic (Shneidman, 1963), although efforts have been made to change society's view of this phenomenon. For many cultures and religions, suicide is considered a sin or a crime, but explaining suicide as the result of a mental illness has made it more acceptable to society. Viewing suicidal individuals as suffering from mental illness provides an opportunity to distance oneself from the topic and to consider it as something that is relevant only to other people.

In the early part of the seventeenth century, Robert Burton in his *Anatomy of Melancholy: What it Is; with All the Kinds, Causes, Symptomes, Prognostickes and Several Cures of it*, reported that "melancholia, which caused suicide, was indeed a disease" (Burton, 2001). Burton anticipated the development of modern psychiatry when he noted the cruel nature of melancholia, "which crucifies the Soule in this life and everlastingly torments in the world to come" (p. 50). This effort by Burton to rescue individuals who die by suicide from the ranks of criminals and sinners can be better appreciated by comparing some of Alvarez's (1971) writings on what was happening at that time. In 1601, Fulbecke, a lawyer, said that the individual who dies by suicide,

is drawn by a horse to the place of punishment and shame, where he is hanged

on a gibbet, and none may take the body down but the authority of a magistrate; Blackstone, another legal authority, wrote that the burial was in the highway, with a stake driven through the body, as though there was no difference between a suicide and a vampire. Stones were placed over the dead man's face; hands could be cut and bodies were also given to school of anatomy; In Danzig the corpse was not allowed to leave by the door; instead it was lowered by pulleys from the window, the window-frame was subsequently burnt. (p. 64)

In contrast, a number of scholars tried to portray suicide deaths in a more phenomenological way, avoiding the view of suicide as a mere symptom of a psychiatric disorder. For instance John Sym (1637/1988), a clergyman, provided a mixed interpretation of the phenomenon:

The parties most subject to self-murder, are high-minded and ambitious persons, impatient of disgrace and croffes When they are disappointed, they grow into that degree of discontentment, that they will not out-live their expectation of earthly things, but will rather kill themselves, than endure such a croffe and disappointment in that which they most highly value Therefore people should well confider their own tempers and flates, with the feverall dangers that attend upon the fame." (p. 255)

More than a century later, Hume (1783/2001), who was one of the first major Western philosophers to discuss suicide without the concept of sin, published a milestone book. His famous essay "On Suicide," published in 1777 a year after his death, was promptly suppressed. The goal of the essay was to refute the view that suicide is a crime, and it did so by arguing that suicide is a transgression of our duties to God, to our fellow citizens, and to ourselves.

Until recent decades, psychiatric patients were commonly called lunatics and placed in asylums. Those who seemed to be

suicidal risks were also confined in such places since it was assumed that they were suffering from mental illness. Although the English physician Forbes Winslow (1840) reported descriptions far different from psychological ones, he adopted a phenomenological approach to the study of the suicidal individual. He paid attention to feelings that caused an unbalanced mind, such as jealousy and despair. Winslow reported that, in many cases of suicide, the act is preceded by a "long train of perverted reasoning."

These individuals become taciturn, morose, pusillanimous, and distrustful. The future presents itself under the most unfavorable aspect, and despair becomes painted on their countenances. Their eyes become hollow; they complain of sleeplessness and are disturbed by frightful dreams. Their bowels are in an inactive state; and the function of the liver becomes, to a certain extent, suspended. It is in this state that they contemplate suicide. . . . death is considered preferable to a long life of unmitigated sorrow . . . when all hope is banished from the mind, and wretched loneliness and desolation take up their residence in the heart need it excite surprise that the quiet and rest of the grave is eagerly longed for! (p. 58)

On the same note, the Italian Morselli (1881), who approached suicide statistically and provided excellent data about suicide in Europe, also identified physical and moral causes of suicide. He stated:

Thus, again, when it is only said "suicides caused by *taedium vitae*," very different cases are probably united under this heading. Neither "monomania" nor "mental alienation" is one single cause in itself; it is possible to pass from political and religious exaltation to the most profound melancholia, through a thousand psychical phases which statistics neither do nor can estimate. And the origin, often quite ordinary, of certain mental phases, registered as mere presumptive causes of suicide, shows

the weakest side of this part of statistics.
(p. 267)

Morselli's view is shared by traditional suicidology, which emphasizes the complex array of factors that lead to suicide and stresses the need to focus on the unique psychological pain of each suicidal individual. More than a century later, Shea argued that: "People don't kill themselves because statistics suggest that they should. The call to suicide comes not from statistical protocols, but from psychological pain. Each person is unique. Statistical power is at its best when applied to large populations, and its weakest when applied to individuals. But it is the individual who clinicians must assess in the quietude of their offices or the distracting hubbub of busy emergency rooms" (p. 11).

SUICIDE: SYMPTOM OR SYNDROME?

In medicine and psychology, the term *syndrome* refers to a cluster of several clinically recognizable features, signs (observed by a physician), symptoms (reported by the patient), and phenomena or characteristics that often occur together, so that the presence of one feature alerts the physician to the presence of the others. In suicidology, we have many features associated with suicide risk, but no single factor has been demonstrated to be necessary or sufficient to cause suicide.

Choron (1972) cites Gaupp (1910) as the milestone for understanding suicide from the biopsychological point of view; that is, there are forces that do not rise to the consciousness of individuals and thus cannot constitute motives, forces that are related to race, age, sex, work, and social status. This perspective has been challenged by psychiatry, which relates individuals who die by suicide to abnormal mental states. Ringel (1953) considered suicide as "the conclusion of a pathological psychic development." Weisman (1971) wondered whether suicide was a disease and proposed that "suicide is neither a moral dilemma nor a mental disease but a

form of life-threatening behavior resembling a declaration of war with a petition for bankruptcy." According to this author, there is 'suicidal sickness,' but no evidence of an organic 'disease' to explain it. However, the concept of disease is a cultural abstraction that excludes other dimensions of sickness, such as conflict and crisis.

Esquirol (1838) stated that suicide was a symptom of insanity and, therefore, those who commit suicide are psychiatrically disturbed. He developed the perspective that suicide is a psychiatric problem: "All that I have said up to now, the facts which I have reported, proves that suicide presents all the characteristics of insanity of which it is but a symptom; that there is no point for a unique source of suicide, since one observes it in the most contradictory circumstances, and because it is symptomatic or secondary, be it in acute delirium, or chronic, besides, the autopsy of suicides made so far did not throw much light on the subject of pathological changes" (p. 639). Considering suicide risk as a symptom impairs the opportunity to fully investigate and understand it. If a patient has a fever or a headache, and if this is thought to be part of pneumonia or cancer, clinicians will treat the disease as a whole rather than each symptom separately.

The phenomenological approach promises to aid our understanding of suicide, helping us to understand rather than to explain the behavior. Karl Jaspers's (1959) assumption that we can explain a phenomenon without understanding it at all is of particular interest here. Jaspers separated the study of subjective phenomena as experienced by the patients from the study of other psychological data. He introduced the difference between explanation and understanding and focused on the latter. Jaspers distinguished two types of psychiatric entities: developments, which we can come to understand; and processes, which can be explained even though they are not understandable. For instance, reactive depression is understood insofar as we can put ourselves in the place of the sufferer; most often this is also true for suicidal behavior. In contrast, it is to Kraepelin

(1921) that we owe our emphasis on documenting the longitudinal course of psychiatric disorders: “[Suicidal] patients, therefore often try to starve themselves, to hang themselves, to cut their arteries, they beg that they may be burned, buried alive, driven out into the woods and there allowed to die”; however, he put no emphasis on what was happening in their tormented mind, a feature often neglected when only *DSM-Kraepelinian* diagnostic criteria are taken into account.

It is clear that the focus should be on what patients feel rather than on how they can be categorized. As Maltzberger reported, “intense desperation is a mental emergency. . . . Many unfortunate patients may quickly take their lives because they cannot wait for relief. . . . Most desperate patients, enraged patients or intensely anxious patients show what they feel in their faces, body movements and demeanor.”

The lack of association between suicide and psychiatric disorders has emerged in various studies (e.g., De Leo, 2002, 2004), and scholars have come to believe that alternative solutions must be found since the vast majority of depressed, schizophrenic, alcoholic, or organically psychotic patients do not commit or even attempt suicide (Lenaars, 2004; Lester, 1987, 1989). Hopelessness as a psychological construct has been reported to be a more important mediator of suicide risk than is depression. Studies involving the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974) found that the extent of negative attitudes about the future (pessimism) was a better predictor of suicidal intent than depression (Beck & Steer, 1988). This indicates that it not necessarily important how you feel right now, for example, being depressed, but whether you trust the future to bring changes in your condition. This is particularly true for suicidal individuals experiencing the uniqueness of their suffering that, for them, has no escape and no future solution. It has been suggested that “the interest in classifying populations of suicidal patients by their psychiatric diagnoses is being supplemented by an interest in understanding what makes a minority of patients within any given diagnostic category suicidal

while the majority are not suicidal” (Hendin, 1986).

These observations are reinforced by the response of patients to psychiatric treatment. For instance, Ahrens and Müller-Oerlinghausen (2001) investigated a group of high-risk patients with recurrent affective disorders ($N = 167$) who had made one or more suicide attempts before the start of lithium prophylaxis within a collaborative project. According to their recurrence-related response to long-term lithium prophylaxis, patients were classified into three groups: excellent ($n = 45$), moderate ($n = 81$), and poor ($n = 41$) responders. Only depressive episodes resulting in hospitalization were considered. With regard to suicidal behavior in this selected group of high-risk patients, there was a significant decrease in the rate of suicide attempts as compared to the pre-lithium figures. This was the case not only in those patients with excellent treatment outcome, but also in those with moderate or even poor response toward lithium prophylaxis, suggesting an effect on the suicidal dimension independent of the effect on the psychiatric symptoms.

A similar finding comes from a study by Prudic and Sackeim (1999) involving electroconvulsive therapy (ECT). They found that ECT responders and nonresponders showed a large decrease in scores on the suicide item of the Hamilton Rating Scale for Depression, and this decrease was greater than the average improvement on other items.

Moreover, recent studies on the role of antidepressants in reducing suicide risk have failed to provide strong evidence regarding their possible effect on increasing or decreasing suicide risk. It would appear that pooling trials of antidepressants (including both tricyclics and selective serotonin reuptake inhibitors (SSRI) versus placebo) yielded a nonsignificant result which did not favor one side or the other (Baldessarini et al., 2006; Baldessarini, Pompili, & Tondo, 2006).

PSYCHOLOGICAL AUTOPSY STUDIES

Most of the data supporting that individuals who die by suicide were suffering

from a psychiatric disorder comes from psychological autopsy studies. Studies labeled as psychological autopsies report little information on the psychology of the deceased. The term *psychological autopsy* was first used by Shneidman (1951) in the pre-suicidology time. He used the term prophetically when he stated: "To present a study in which the emphasis is on the prediction of behavior rather than the validation of the technique; i.e., to hold a 'psychological autopsy' on one case" (p. 4).

Much credit for the success of the psychological autopsy belongs to Dr. Theodore Curphey, a Los Angeles coroner, who recognized the realistic benefits of that procedure (Curphey, 1961). The psychological autopsy introduced the psychological elements into the study of suicide. Before that, suicide had been studied anecdotally and demographically, but no emphasis had been made on the psychological life of the deceased (Shneidman, April 2006, personal communication). The psychological autopsy is focused on what is usually the missing element; namely, the *intention* of the deceased in relation to his own death.

The assumption derived from psychological autopsy studies that the vast majority of individuals who die by suicide suffered from a mental disorder at the time of their death has, however, several biases. First, scholars worldwide use the term *psychological autopsy* for any retrospective investigation. Such studies lack the comprehensive data gathering obtained from interviewing key persons. It is rather easy to classify a subject as depressed when in fact that person was understandably sad for what was a mess in his or her life. Most of the data obtained in psychological autopsy studies is derived from a forensic environment—physicians or death registries—and much less often from family members or friends who could make sense of the depressive features that are distinguishable from clinical depression. Suicide is a problem of the human condition or, as Shneidman (2005) points out, "it is a dissatisfaction of the status quo."

Pouliot and De Leo (2006) have highlighted many issues related to psychological

autopsies, concluding that the medical model often fails to provide sufficient evidence that a disorder can lead to suicide. In most psychological studies conducted to date, suicide is almost exclusively researched under the single paradigmatic umbrella of medicine. Pouliot and De Leo proposed that, according to the medical model, suicide is the consequence of biologically-based alterations of the brain, where psychiatric symptoms are expressions of the disease caused by the alterations. Data reported by Cavanagh, Carson, Sharpe, and Lawrie (2003) support the notion that between 88% and 95% of suicides were suffering from a psychiatric disorder. Such data contrast with evidence from prospective case studies that show that, at 10 to 20 years follow-up, the risk of suicide in adolescents suffering from major depression is 7.7% (Weissman et al., 1999), 3.4% for alcoholics (Murphy & Wetzel, 1990), and 3.8% in depressed patients (Gladstone, Mitchell, Parker, Wilhelm, Austin, & Eysers, 2001).

As a psychiatrist, my model for depicting suicide consists of two distinct dimensions that often overlap, the one comprising psychiatric disorders and the other referring to suicidality (see Figure 1). When substantial overlapping exists, there is major risk of suicide as the patient is "attacked" in two ways. However, suicide can occur with no psychiatric disorders when profound distress and psychological pain become unbearable and when suicide is seen as the perfect solution. In suicidal individuals, psychological pain affects the very core of their human condition and threatens life, which cannot be accepted in its present condition. It is this aspect that characterizes suicide deaths, and it is absent in the vast majority of psychiatric patients. A psychiatric disorder alone is, therefore, not sufficient for precipitating suicide. There must be the suicidality dimension that carries some variant of negative emotions.

TOWARD A PHENOMENOLOGY OF SUICIDE

Phenomenology is a philosophical discipline originated by Edmund Husserl. He de-

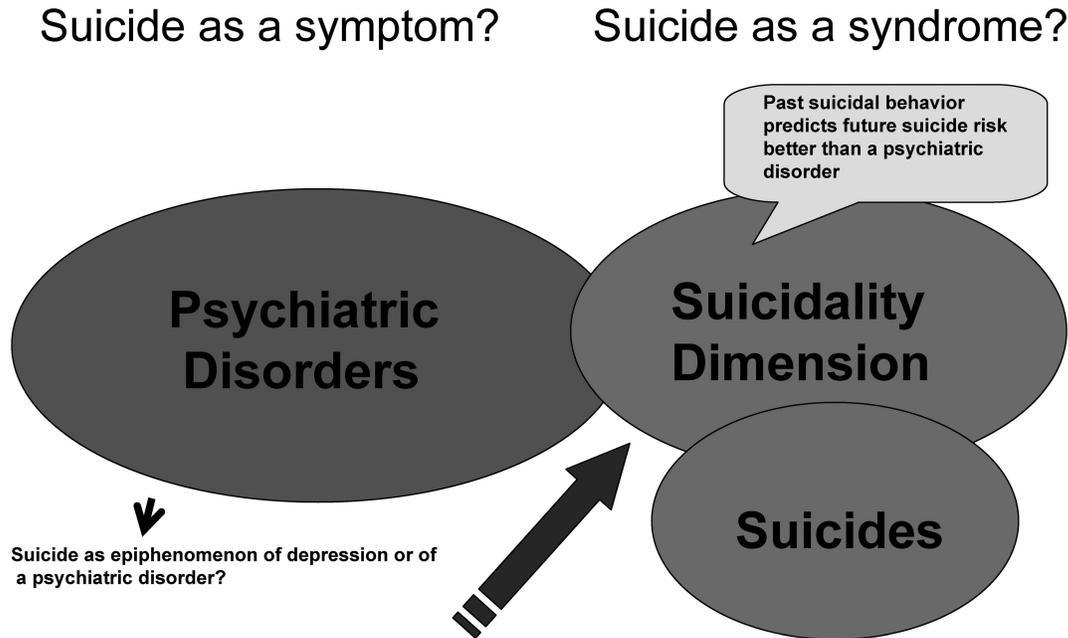


Figure 1. Suicide among psychiatric patients involves the coexistence of the component of the suicidality dimension.

veloped the phenomenological method to make possible “a descriptive account of the essential structures of the directly given” (Husserl, 1969). Phenomenology emphasizes the immediacy of experience, the attempt to isolate it and set it off from all assumptions of existence or causal influence, and to lay bare its essential structure. Phenomenology restricts the philosopher’s attention to the pure data of consciousness, uncontaminated by metaphysical theories or scientific assumptions. Phenomenology studies conscious experience as experienced from the subjective or first person point of view. The experiencing subject can be considered to be the person or self. Subjective experiences are those that are, in principle, not directly observable by any external observer.

Subjective experiences are the foundations of suicidology as a discipline devoted to the scientific study of suicide and its prevention. Areas of suicide research, although of paramount importance, cannot be directly linked to suicidology if they lack a focus on

the subjective experience and principles related to suicide prevention.

Suicidology can be defined as the scientific study of suicide and suicide prevention. The term (and the concept) was first used by Shneidman (1964) and has since then been used in a number of ways: to describe an aspect of advanced education (fellowship in suicidology, 1967); as the subject of a new journal (*Bulletin of Suicidology*, 1967); and to label a new association (the American Association of Suicidology, 1968). Suicidology is unlike other behavioral sciences in that it usually includes not just the study of suicide but also its prevention; in other words, it incorporates appropriate clinical interventions to prevent suicide, a feature not always taken into consideration in the many contributions to understanding suicide. The focus of suicidology is not necessarily merely completed suicide but above all the treatment of suicidal individuals. Individuals who commit suicide die with their unique life histories, and it would appear to be inappropriate to use pooled data

or statistics to understand the human misery of these individuals. Maris, Berman, and Silverman (2000) state that, “while suicidologists give lip service to the multidisciplinary study of suicide, in actual fact most of us have very narrow and specialized domain assumptions—usually those related to our professional training and subdisciplinary paradigms” (p. 28). No doubt, regardless of one’s attitude and research interests, being a suicidologist implies sharing Shneidman’s view that “suicide springs from an individual’s psychic pain” (p. 28).

Traditional suicidology supports the notion that suicidal individuals are experiencing unbearable psychological pain (*psychache*) or suffering and that suicide may be, at least in part, an attempt to escape from this suffering. Shneidman (1993a) focused on the mentalistic aspects of suicide and suggested that the study of suicidal acts should concentrate on the phenomenology of suicide. Psychache can be clearly distinguished from depression or other psychiatric disorders because of the uniqueness of suffering perceived by the subject and because of the fact that the subject cannot stand it. The individual cannot see a way out and believes that ending life is a solution. Shneidman (1993b) considered psychache to be the main ingredient of suicide. He (Shneidman, 1984) reported that psychological pain may be related to the fact that, if tormented individuals could somehow stop consciousness and still live, they would opt for that solution. Suicide occurs when the psychache is deemed by that individual to be unbearable; it is an escape from intolerable suffering. This view reveals suicide not as a movement toward death but rather as a remedy to escape from intolerable emotion, unendurable or unacceptable anguish. Suicide risk is associated with a constriction or narrowing of the range of options usually available to an individual. Suicidal individuals experience dichotomous thinking, wishing for either some specific (almost magical) total solution for their psychache or cessation (suicide). Suicide is the result of an interior dialogue during which the mind scans its options (Shneidman, 1996). During the early phases

of this process, suicide is considered as an option but is rejected, perhaps a number of times. However, after persistent failure to find a solution to suffering, suicide is accepted as a solution. The individual, therefore, starts planning it and considers it as the only answer: “The spark that ignites this potentially explosive mixture is the idea that one can put stop to the pain. The idea of cessation provides the solution for the desperate person” (Shneidman, 1976, p. 60).

Shneidman believed that in regard to suicide, “death” is not the key word. The key term is “psychological pain,” and if that pain were relieved then the individual would be willing to continue to live. Two main concepts are relevant to this discussion: perturbation and lethality. *Perturbation* refers to how upset (disturbed, agitated, discomposed) the individual is; *lethality* refers to the likelihood of an individual’s being dead by his or her own hand in the future (lethality is a synonym for suicidality). Perturbation supplies the motivation for suicide, lethality is the fatal trigger. One way to reduce lethality is to enquire what causes distress to the suicidal individual. Only rarely, when dealing with a suicidal individual, do medical personnel enquire about psychological pain. Many resources are devoted to the decrease of suicide risk but not what energizes it. Asking “Where do you hurt?” “How may I help you?” “What is going on?” and so forth proves to be a key factor in opening a dialogue with the suicidal person and establishing a connection. Suicidal people are ambivalent about death; they want both to live and to die, and so our task is to reach those vital components that counterbalance death wishes. In doing so, we may resolve the ambivalence and give the tormented individual a little hope and some peace of mind.

Treatment for psychache should involve anodyne psychotherapy (Shneidman, 2005), which aims to mollify unbearable psychological pain. The most important key in anodyne therapy is a tailor-made focus on the alleviation of the patient’s frustrated psychological needs considered by the person to be vital to continued life. Therapy of psychache

involves being empathic with and resonating to the patient's private psychological pain. The therapist should be aware of the uniqueness of the patient's suffering and should try any possible solutions to change the patient's psychological pain from unbearable and intolerable to barely bearable and somewhat tolerable (Shneidman, 2005).

Pompili, Lester, Leenaars, Tatarelli, and Girardi (2008) recently investigated the role of psychache in the determination of suicide risk in 88 psychiatric inpatients. They used the Psychological Pain Assessment Scale (Shneidman, 1999), which involves direct questions about the level of current and worst-ever psychache using a linear rating scale and a checklist for the emotions experienced, along with pictorial stimuli. Pompili et al. found that those patients currently at risk for suicide reported significantly higher current psychache and higher worst-ever psychache. Most of these patients considered their worst-ever psychache unresolved. They had been hurt so much that they felt that the pain associated with those adverse events in their life could not be relieved and that they were condemned to face this pain forever. This suggests that, for suicidal psychiatric patients, amelioration of symptoms is not sufficient.

CONCLUSIONS

The search for suicide risk factors, variables that indicate an increased likelihood for suicide, independent of diagnosis, has been undertaken by a number of researchers and clinicians. Most studies have evaluated short-term risk factors for suicidal behavior, such as current suicidal ideation and recent suicide attempts (particularly in the context of severe major depressive episode), the major precursors and the most powerful predictors of attempted and completed suicide. Nevertheless, during the course of this paper, I have stressed the need to reconcile this approach with the fact that suicide might be better understood as a phenomenon centered in the individual. In other words, the motives for suicide can be traced in the variables surrounding the individual viewed as a unique

human being whose personality contains the real reasons for wishing suicide.

Shneidman's suicidology focused on the pain of the negative emotions—shame, guilt, abandonment, ennui, dysphoria, hopelessness, and inanition—what he called psychache. He viewed suicidal impulses (thoughts and actions) phenomenologically, more like being in love than having a liver disease. This is a radical view in an era where diagnostic criteria and the need to cure are more important than understanding what is not working at the emotional level. Centuries of stigmatization toward suicide have left deep fractures and have left judgments about suicide dependent on social forces and the power of the medical model or other explanations. In contrast, phenomenology refers to the inner world of individuals and focuses on what the individual feels as well as understanding from the inside whenever a clinician encounters a patient.

We often hear about the crucial role of empathy when treating suicidal individuals but we rarely understand what exactly is and how to deal it with patients. Both research in general and clinical practice indicate that suicide may be totally independent of psychiatric disorders. Moreover, psychological autopsy research that supports the association between the two has many methodological problems. Shneidman's suicidology is still a lesson to be learnt as it focuses on the negative emotions of individuals and how to understand them, as well as how to bridge the gap in the communication of human suffering. Shneidman taught us that although the idea of suicide may recall madness, the suicidal mind can be understood in terms of psychological pain and thwarted psychological needs. This perspective opens us to the acceptance of the human suffering of suicidal individuals as opposed to the earlier focus on psychiatric disorders or, further in the past, to madness.

Let us hope that present and future generations of suicidologists will integrate the concept of unbearable psychological pain and the drama occurring in the suicidal mind with the much-needed further understanding of the enigmatic phenomenon of human self-destruction.

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Manuscript Received: January 13, 2009

Revision Accepted: February 7, 2009