
Overview of Traditional Suicide

The taking of one's own life is the most drastic step one can imagine ever taking. It can be the result of a moment's impulse or deep and prolonged thought. Likewise, suicide can be completely conscious and well-planned or the result of unconscious, extreme risk-taking behavior. This book focuses on the conscious, intentional kind of suicide.

There are many reasons why people kill themselves. Regardless of their stated motive (real or imagined), they feel they have reached a point in their lives where they: (1) have no other options, (2) are exhausted from the constant pain and struggle of life, (3) believe it will garner them sympathy or emotion from those left behind, and/or (4) think they have nothing to live for. People may feel sad or hopeless or overwhelmed. Often there is a component of physical or emotional pain. This pain is so deep, so severe, that it simply becomes unbearable. However, even beyond this private suffering and the sometimes violent and painful method of their deaths, is the issue of the damage left in their wake. In addition to the usual sense of a hole being left in their lives, friends, co-workers, and family all have to wonder whether they are guilty for not having done enough. Psychiatrist Kay Jamison eloquently concludes, "Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description."¹

In this overview, we will first look at the history of traditional suicide, then at suicide in the present, including recent research findings and selected socio-cultural and psychological viewpoints, and we will end with the existential reality of death that looms for all of us, and the strange relationship that exists between life and death, especially, for the suicidal mind. Following this overview chapter, which admittedly takes a decidedly worldly, scientific, and scholarly look at the subject of traditional suicide, the remainder of Part I will turn its attention entirely to suicide from the perspective of purported spirits existing in the afterlife as received by mediums and channels. This overview can allow us to work with both worldly

and otherworldly perspectives in order to develop our own views on the subject of suicide and what may follow it.

HISTORICAL OVERVIEW

An ancient Egyptian text, “Dispute Over Suicide,” tells of the loneliness and social isolation fueling the author’s suicidal thoughts as he looks to the attractiveness of death where “yonder” he shall stand in his “celestial bark” like a “living god.” Only six suicides are recorded in the Old Testament. The most dramatic mass suicide of ancient times occurred at the fortress of Masada where the Hebrew forces, greatly outnumbered by the advancing Romans, followed their leader Eleazar, who led them to kill themselves rather than become Roman slaves.² In classical Greek times, suicide could stem from feeling dishonored or losing a loved one, and there was the “Orphic conception of death as fulfilling the immortal soul’s innermost desire to free itself from the prison of the body and rejoin its divine source.”³ However:

The suicide most highly regarded in Greek mythology as well as in Homer were the heroic suicides—the sacrifice of one’s life for the benefit of another, and in particular for the defense of one’s country. Such suicides were honored and admired. Society tacitly and sometimes alternately encouraged him [the one committing suicide].⁴

We shall revisit this type of supposedly heroic, sacrificial suicide in Part II of this book when we examine the present-day phenomenon of Islamic fundamentalist suicide bombers.

Almost 100 years ago, the great sociologist Emile Durkheim wrote what still remains one of the most influential books on suicide.⁵ In it, he harkened back to ancient Greece, where those who wished to kill themselves were supposed to first seek permission from the proper authorities. Regarding someone preparing for suicide, Durkheim wrote: “At Athens, if he asked authority of the Senate before killing himself, stating the reasons which made life intolerable to him and his request was regularly granted, suicide was considered a legitimate act.” He recounted the historian Libanius reporting the Greek law:

Whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon the life. If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock. If you are bestowed with grief, abandon life. Let the unhappy man recount his fortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end.⁶

During the Roman Empire, heroic suicides were still widely reported, as were honorably viewed suicides committed to avoid the indignity, disability, and suffering of disease and old age. Especially dramatic was the ongoing pattern of the deaths of Christian martyrs allowing themselves to be killed to enter the afterlife promised them by Christ and the other early Christian leaders. But although there was still a pull toward the spiritual afterlife in the face of increasing worldly deprivation and hardship during the Middle Ages, the Christian Church moved to reject suicide as an option. St. Augustine (354–430) pronounced suicide to be a crime, since it was killing oneself, and, as stated in the sixth commandment, “Thou shalt not kill” (including oneself). By 693, the Council of Toledo had proclaimed that an individual who attempted suicide was to be excommunicated.⁷ St. Thomas Aquinas (1225–1274) saw suicide as flying in the face of the mandate to be charitable, including to oneself. Plus, committing suicide could harm one’s community. But, especially, “it usurps God’s power to dispose at his discretion of man’s life, death, and resurrection.”⁸

According to Corsini’s *Encyclopedia of Psychology*, as time went on, society continued to create sanctions against suicide:

From the 11th century on, whether or not the property of a deceased individual was to be kept by the heirs or had to be forfeited to the Crown depended on whether or not the death was judged (by the coroner) to be an act of God or a felony. Suicide was the latter, a felony against the self, *felo de se*; thus the way in which a death was certified was of enormous importance to the survivors.⁹

Then the Renaissance, with its renewed appreciation for earthly life and its beauties, and with new hope and vision for human possibilities, saw increased attention turned toward, not away from, this world, with suicide becoming less attractive. By the late eighteenth century, the Romantic Movement rekindled an attractive preoccupation with death and with a larger transcendental reality toward which the heart pines in the face of the less attractive insufficiencies and disappointments of life on Earth.¹⁰

Throughout history, many philosophers have focused on the topic of suicide: Pythagoras, Plato, Aristotle, Socrates, Epicurus, the Stoics, Seneca, Epictetus, Montaigne, Descartes, Spinoza, Voltaire, Montesquieu, Rousseau, Hume, Kant, Schopenhauer, Nietzsche, Kierkegaard, and Camus.¹¹

The essay “On Suicide” by philosopher David Hume, published in 1777, a year after his death, was promptly suppressed. The essay chose to refute the contention that suicide should be considered a crime. Opposed to the views of most of his contemporaries, Hume did not see suicide as a

transgression of the responsibilities and duties we have to others, to ourselves, or to God, declaring: "Prudence and courage should engage us to rid ourselves at once of existence when it becomes a burden."¹²

SUICIDE TODAY

Jumping to the present, we can see a continuation of the social and legal sanctions against the strange form of murder that is suicide. *The Encyclopedia of Psychology* cites only two states, Alabama and Oklahoma, where the act of committing suicide is deemed a criminal offense, though, obviously, there can be no worldly punishment for the crime, given that the perpetrator is deceased. In some other states, suicide attempts are considered misdemeanors that are usually not enforced. Thirty states currently have no laws against suicide, attempted and failed, or successful. However, all states have laws against encouraging or helping someone else commit suicide.¹³

The current statistics on suicide are grim. Approximately 5–15 percent of American adults admit to having had suicidal thoughts at some point in their life and up to 50 percent of high school students have considered it.¹⁴ Furthermore, according to Jamison, suicide has tripled in the last forty-five years, and is a major cause of death in college students and younger Americans. The National Center for Health Statistics reports that suicide was responsible for 31,655 deaths in 2002.¹⁵

Unfortunately, the United States is not alone in reporting such grim statistics. The University of Oxford Centre for Suicide Research reports that more than 5,000 people a year take their own lives in the United Kingdom.¹⁶ In October 1999, the United Kingdom reported that the number of young males who had taken their own lives had doubled since 1989—a mere ten years.¹⁷ France, too, has a high suicide rate.¹⁸ China also appears to have a growing problem, with 287,000 known deaths a year due to suicide—and more that may not get reported.¹⁹

There are certainly plenty of statistics about suicide. Here are a few more examples: It is the tenth leading cause of death (at least 22,000 to 30,000 lives annually), with the actual number being as many as twice this because of suicides disguised as accidents and due to underreporting. Among causes of death, suicide ranks second for white males aged 15–19. For physicians under age 40, it ranks first. One out of nine attempted suicides is successful. "Those who are widowed, divorced, or single kill themselves significantly more often than married people."²⁰ The World Health Organization has seen a worldwide rise of 34 percent in suicide rates since it began keeping records in 1950. According to its estimates, by the year

2040, “approximately 1.53 million people will die from suicide, and 10–20 times more people will attempt suicide worldwide.” This represents on average one death every 20 seconds and one attempt each 1–2 seconds.²¹

Adolescents and very young adults are particularly prone to suicide. Between 1960 and 1980, the suicide rate among adolescents in the United States increased by 150 percent. Following accidents and homicides, suicide is the third leading cause of death among American adolescents. “A recent study of high school and middle school students reported that 33 of every 100 had thought of suicide and six of every 100 had attempted suicide.”²²

From *The Harvard Guide to Psychiatry*, 3rd edition, we hear:

Male suicidal behavior usually involves an inability to control angry impulse ... although adolescent men outnumber women in completed suicides by about 4 or 5 to 1, adolescent women outnumber men by about the same margin in numbers of attempts ... among children and adolescents who commit suicide, a statistically significant number come from fragmented homes with missing parents ... in a sample of 108 adolescents who attempted suicide, 49% came from homes with one parent missing.²³

In looking over the data, it seems clear that some people are more at risk for suicide than others. These include those who have made prior attempts, suffer mental illness, young men in jail, gamblers, the police, those without jobs, teenagers, and certain ethnic groups such as Native Americans and African-Americans.²⁴ Which gender is most at risk for suicide can vary by age and country. But no matter how you break it down, we always have to come back to the fact that suicide rates are increasing. This is a growing problem. It desperately needs to be addressed by our society. With so many taking their own lives, it is critical to understand what motivates those who commit suicide, and what may become of their spirits or souls in the afterlife.

A great many reasons can lead a person to take the path of suicide, some of which may be inadvertent. Many threaten suicide as a cry for help or attention that is never intended to go that far, but is accidentally more effective than anticipated. It can be triggered by interpersonal differences, mental illness, and life stresses. Surprisingly, it is not particularly associated with health problems. However, mental illness is another story altogether. Furthermore, there may be a complex interplay of predisposing factors. Genes, personality, drugs (legal or otherwise), alcohol, mental illness, and the stresses of life may all work together to create a fatal cocktail. To fix only one of these problems, perhaps at the expense of the others, may not be enough to keep a person from taking his or her own life.

Kay Redfield Jamison, herself a psychiatrist, makes an important observation:

Psychological pain or stress alone—however great the loss of disappointment, however profound the shame or rejection—is rarely sufficient cause for suicide. Much of the decision to die is in the construing of events, and most minds, when healthy, do not construe any event as devastating enough to warrant suicide....

When the mind's flexibility and ability to adapt are undermined by mental illness, alcohol or drug abuse, or other psychiatric disorders, its defenses are put in jeopardy.²⁵

This is important, suggesting that suicidal individuals may be thinking poorly and have clouded judgment at the time of their death.

SOCIO-CULTURAL PERSPECTIVES

The great French sociologist Emile Durkheim, in his landmark book (1897) *Le suicide*, described four kinds of suicide, all emphasizing the strengths or weaknesses of the person's relationships with society. He coined the term *altruistic suicide* to represent the kind that is expected and demanded by the rites and customs of the group. *Egotistic suicides* are carried out by individuals with too few connections to the community and too few demands from the community to continue living as part of it. *Anomic suicides* stem from the shattering of a relationship that the individual was accustomed to and valued, such as the loss of a job, close friend, or loved one, or loss of one's financial security and well-being. And *fatalistic suicides* come from excessive regulation, oppression, or denial of essential freedoms or birth-rites. All four are sociologically or psychosocially determined since they all involve in different ways the individual's interpersonal relation to others that has been changed in such a way as to lead him or her to choose suicide.²⁶

Religious and cultural attitudes regarding suicide have run the gamut. Some, like the Japanese, may consider it the best, and sometimes only appropriate, behavior in response to a given situation. Nor are they alone in this. A number of cultures have accepted, or even encouraged, the elderly and sick to sacrifice their own lives for the greater good of the group.²⁷ Others, like the Stoics in ancient Greece, have felt everyone has the right to choose the time and place of his or her death, while still others, such as the ancient Romans and the Catholic Church, have taught that suicide is never appropriate.

Our own U.S. culture is divided on the issue, with some individuals

advocating euthanasia and assisted suicide as an individual right, and others finding the whole idea of suicide as abhorrent as homicide.

Although the cultural discouragement of suicide has softened in recent times, there may have been good reason for it in the past. Suicide tends to be imitated by others. As Jamison explains:

Society must deal with the potentially infectious repercussions of suicide, especially among the young, and must somehow try to keep a single tragedy from progressing to deaths of others. The contagious quality of suicide, or the tendency for suicides to occur in clusters, has been observed for centuries and is at least partially responsible for some of the ancient sanctions against the act.²⁸

Historical methods of ending such suicide epidemics have often been brutal, if effective. Rome halted one by nailing the bodies of all suicides to crosses and putting them on public display, while in Greece the lifeless bodies of female suicides were at one point dragged naked through the streets.

This problem of one suicide leading to others is true even today, whether this deadly chain of events is started by a high school student or a high-profile idol. In the anthology *Straight to Hell: 20th Century Suicides*, Mikita Brottman points out:

The suicide of a prominent youth icon is often followed by outbreaks of suicide by depressed and empathetic fans. This phenomenon is sometimes referred to as the “Werther syndrome,” and was first witnessed in modern culture with the death of Rudolf Valentino, which sparked an epidemic of empathy suicides. In the days and weeks following the [suicidal] death of Kurt Cobain, a rash of fans from Seattle to Australia began killing themselves in empathy and tribute to the fallen grunge king.²⁹

The publicity and romanticized nature of the act—especially when combined with the desire for attention or retaliation—appears to seduce many into following suit whether the individuals are friends or family of the person who committed suicide or are complete strangers.

One of the most notorious cases of mass suicide was that involving the Jonestown People’s Temple. In 1978, 913 followers of the Reverend Jim Jones, members of the People’s Temple, committed mass suicide in northern Guyana at a site called Jonestown. The People’s Temple had been started by Jones in San Francisco; he moved it and its congregation to Guyana with the dream of setting up an autonomous communal utopia according to his vision. Initially he was reported to be a good minister and leader for his followers, but as time went on, he seemed to darken and his Temple

became ever more a cult of personality that curtailed the freedoms and individuality of its followers.

In 1978, U.S. congressman Leo Ryan went to Guyana to investigate reported abuses by Jones of his members. When Ryan and his small investigative team tried to leave, along with four of the cult members who had decided to defect, Jones ordered them murdered by his own lieutenants. Some, including Ryan, died, while the rest got away in their small plane. Realizing that his People's Temple and the dream he had for it would now be ended once U.S. authorities found out about the murders, Jones ordered everyone at the Temple to take their own lives rather than wait to be subject to the repercussions of his homicides. If there was no longer a possibility of having his dream come true on Earth, then it was time to leave this Earth. Mass quantities of sweet punch laced with poison were prepared. First, the 267 children were given the poisoned drink, with some of the older ones taking it voluntarily. Then the adults took their turn.

When more investigators and law enforcement people arrived at Jonestown, they found the place strewn with the dead bodies of 913 People's Temple followers, along with Jones's own body. He had chosen to shoot himself in the head, rather than drink the potion. The question remains: How accurate is it to say that this was a mass suicide involving 914 people? Weren't the younger children simply murdered and the older children, who went along with drinking the poison, really too young to know what they were doing? The same could be asked for many of the adults. How much of this was a function of coercion, brainwashing, or mind control? How many of those 637 adults were "in their right minds" enough to purposefully take their own lives that way? Many probably did believe unquestioningly in Jones's vision.³⁰

One key fact to note is that the violence—at least on a psychological level—is seldom isolated to the person committing the act of suicide, whether it takes place individually or in a group. Surviving friends, family, and acquaintances are all affected, and may end up performing suicide themselves. Perhaps what makes suicide so difficult to deal with is the fact that its consequences ripple out to affect so many. Friends and family are left in shock, always wondering whether they should have known or if they could have stopped it. Faith can be shaken, beliefs shattered. Emotions may be a confusing jumble of guilt, anger, grief, and—perhaps strangest of all—relief. And even once that is past, with all the questions within and without laid to rest, there is still that loss to come to terms with—the fact that someone you knew is no longer alive. Because of this, one cannot think of suicide as simply violence against the self. Not only can it lead

strangers to copy the act, but it literally tears lives asunder. Those who survive it face a long, painful road to recovery.

PSYCHOLOGICAL PERSPECTIVES

How does present-day psychology view the nature of suicide? Edwin S. Shneidman, an eminent authority on suicide, added *suicidology* to our vocabulary as the term for its formal study. In 2001, the American Psychological Association published his milestone work,³¹ an analysis of what he considered the thirteen leading books on the subject from the past century. Psychiatrist Bela Buda synthesizes Shneidman's findings:

Suicide is always a consequence of “psychache,” a strong psychic pain, tension, and suffering that makes life intolerable. Behind psychache lie four essential constellations: (1) thwarted love, acceptance, or belonging; (2) fractured control, excessive helplessness, and frustration; (3) assaulted self-image and avoidance of shame, defeat, humiliation, and disgrace; (4) ruptured key relationships and attendant grief and bereftness. Against the background of these elements a lot of other factors are active, such as biological vulnerability, social disorganization, cultural rules, isolation, etc.³²

Shneidman noted four psychological features in those who successfully committed suicide, including: (1) “acute perturbation” [general upset]; (2) “heightened inimicality—an increase in self-hate, self-loathing, shame, guilt, and self-blame”; (3) “a sharp and almost sudden constriction of the person’s intellectual focus . . . a tunneling process, a narrowing of the mind’s content”; and (4) “the idea of cessation—the coming into the person’s awareness that it somehow possible to end this terrible and unbearable psychological pain.”³³

Based on his decades of research and clinical experience, Shneidman has developed what he calls “The Ten Commonalities of Suicide”:

1. The common purpose of suicide is to seek a solution.
2. The common goal of suicide is the cessation of consciousness.
3. The common stimulus in suicide is intolerable psychological pain.
4. The common stressor in suicide is frustrated psychological needs.
5. The common emotion in suicide is hopelessness [or] helplessness.
6. The common cognitive state in suicide is ambivalence.
7. The common perceptual state in suicide is constriction.
8. The common action in suicide is egression.
9. The common interpersonal act in suicide is communication of intention.
10. The common consistency in suicide is with lifelong coping patterns.³⁴

In her recent anthology, *Suicide Science: Expanding the Boundaries*, researcher Michelle M. Cornette and others present what they perceive to be the three leading theories of suicide held today. First is the *hopelessness theory*, in which there is “the expectation that highly desired outcomes will not occur or that highly aversive outcomes will occur and that there is nothing one can do to change this situation.”³⁵

Thus a kind of “hopelessness depression” sets in when there seems to be no prospect to either get what one really wants or to avoid what one really doesn’t want. As part of this theory, negative events can serve as “occasion setters” for people to become hopeless, and there is a “cognitive vulnerability” for depressive thinking that accompanies the stress of such negative life events.

Second, the *self-discrepancy theory* draws on three different concepts of the self: the actual self, as one sees oneself; the ought self, which is the self one thinks one ought to be; and the ideal self, which is the self one would most like to be. Given these concepts, the theory states that “individuals are motivated to achieve a state in which there is consistency between their self-concept and these self-evaluative standards.” Those “who possess discrepancies between their actual and ideal selves are relatively more prone to developing depression while those who possess discrepancies between their actual and ought selves are relatively more prone to developing anxiety.” If one understands “depression as a consequence of psychological situations involving the absence of positive outcomes,” then “failures to fulfill ideal standards ... are likely to become associated with experiences of depression.”³⁶ Simply put, research has shown a strong correlation between negative evaluation of the self and suicidality.

Third, we have the *escape theory* of suicide. It states that “self-destructive behaviors can be explained in terms of motivation to escape from aversive self-awareness and negative affect.”³⁷ An acute negative experience, calamity, or stressor can point up the large discrepancy that exists between what one wants or expects and what actually occurs and where what are often “unrealistically high expectations or standards” can be abruptly dashed. Then, “when setbacks or discrepancies occur, individuals can either blame external factors and absolve themselves of responsibility, or blame themselves and take on responsibility for the failure.” Negative emotions, such as depression, anxiety, and anger, can arise from the resulting aversive, negative self-awareness. To screen out the negativity and damaged self-esteem, a kind of “mental narrowing” takes place, reducing one to the immediate present and blocking “meaningful higher-level thought,”

including anything that could compete with the overwhelming negative tone of the moment. A real recipe for suicide.

Still, it is not always so simple to get to the roots of suicide. For example, the depression theory of suicide, above, may give too much weight to depression as a contributing factor. Thomas Bronisch, Senior Psychiatrist at the Max Planck Institute of Psychiatry in Munich, Germany, believes there's more going on than this. He writes:

There is no doubt that one can nearly always find depressive symptoms or a depressive syndrome accompanying suicidal behavior... This is the one side of the coin. However, even severely depressed inpatients commit *suicide* in only 15% of the cases in long-term follow-up studies. Subjects with major depression report concomitant *suicide* ideas in 50% to 70% of cases, but report only 2%–4% *suicide* attempts in epidemiological studies.³⁸

Bronisch also reports “an increase in rate of suicide in old age, whereas the diagnosis of major depression decreases after the age of sixty in both sexes.”³⁹ In addition, vulnerability/resiliency to suicide may involve “factors including: family history of suicide, childhood sexual abuse, personality factors, peer affiliations, and school success.” Also, “Comorbidity with anxiety and/or addiction is more important than a depressive disorder on its own for the development of suicidal behavior.” And finally, he points out that the neurobiology of suicidal behavior, which can also include inward or outward aggressivity, “may be different than for depressive disorders or other psychiatric disorders without suicidality.” As a result, Bronisch sees depression “to be rather a risk than a causal factor for the development of suicidal behavior.”

Some additional perspectives on the roots of suicide include the fact that self-destructive behaviors can be traced to prior learning, including the social cognition view that we can learn indirectly by observing others' actions and their consequences, including in symbolic form, as through literature, film, or television. Contemporary psychiatrist Bruce Bongar points out in his book *The Suicide Patient: Clinical and Legal Standards of Care* that “suicidal individuals have unique cognitive characteristics, that is, cognitive rigidity, dichotomous thinking, impaired problem-solving ability, hopelessness, irrational beliefs, and dysfunctional attitudes.”⁴⁰ The American researcher and clinician, Menninger, regarded suicide as including a “peculiar death that entails three internal elements: the element of dying, the element of killing, and the element of being killed.”⁴¹

We turn now to some psychodynamic views on suicide. Sigmund Freud was a pioneer in developing psychological explanations for suicide, which

he saw as essentially taking place within the mind and representing “unconscious hostility directed toward the introjected (ambivalently viewed) love object,” which is the process of turning hostility originally intended for another toward oneself instead.⁴² Bongar further characterizes fellow psychiatrist Sigmund Freud’s interpretation of suicide:

Suicide begins with a death wish that is directed toward others and then redirected toward an identification with the self. . . . among the suicide mechanisms that Freud conceptualized as involving the breakdown of ego defenses and the release of increased destructive, instinctual energy were loss of love objects, aggression toward an introjected love object, narcissistic injury, overwhelming affect, and a setting of one part of the ego against the others.⁴³

In Corsini’s *Encyclopedia of Psychology*, Shneidman cites psychologist Gregory Zilboorg, who saw every suicidal case as involving a pronounced inability to love others and who also saw a relationship between the role of a broken home and suicide proneness.⁴⁴ Contributing to *The Harvard Guide to Psychiatry* (2nd ed.), Edwin H. Cassem also refers to Zilboorg’s view that some suicidal patients believe they can escape the finality of death and achieve a kind of immortality.⁴⁵ He also refers to fellow psychologist S. Rado’s view that suicide can atone for wrongs done in the past and can be a way of recapturing the love of someone or something earlier lost.⁴⁶

Returning to Edwin Cassem, he points out that risk for suicide can occur when one experiences a loss of caring or support from another or others, especially when it happens suddenly, leaving one feeling rejected, alienated, and alone. Suicidal risk greatly increases at times of holidays and special times that remind the person of opportunities, friendships and loves, and sources of happiness and fulfillment that are no longer there. Such times can be marked with strong emotions that can move one toward suicide: loneliness and isolation, anger and guilt, feeling defective and hopeless.

Suicidal behavior is most likely when a person sees his or her situation as intolerable or hopeless. According to Cassem, suicide can stem from either a hateful, even murderous, impulse, or from an irrepressible need to escape one’s own overpowering suffering.⁴⁷

Robert E. Littman traced the development of Freud’s thoughts on the subject of suicide from 1881 to 1939, and found a number of other factors besides hostility involved with suicide, including “rage, guilt, anxiety, dependency—as well as . . . feelings of abandonment, and particularly of helplessness and hopelessness.”⁴⁸

Throughout reading these psychological perspectives on suicide, we may be moved to ask an obvious question. Bluntly put: *Are people who kill themselves crazy?* Is purposefully choosing to end one's own life, when it is otherwise physically healthy, always to be considered an act of someone who is mentally ill? We can readily agree that it is almost always a sign of mental health to choose to keep oneself alive in that it is eminently natural for life to want to perpetuate itself. But is it mentally healthy to choose to stay alive when experiencing an aching meaninglessness and purposelessness at the core of one's existence, or to want to stay alive when experiencing intolerable suffering and pain? Could choosing to end such a life ever be deemed an act of mental health, not mental illness? We will return to this theme in the chapter "Assisted Suicide" at the end of Part I of this book.

Many who study suicide make a distinction between suicide stemming from some form of mental illness and suicide that does not. For example, Dinesh Bhugra, head of the section of Cultural Psychiatry at the Institute of Psychiatry in London, has studied the Indian phenomenon known as *sati*, which she interprets as a kind of nonpsychiatric suicide.⁴⁹ The term *sati* is used to designate a woman who burns herself to death following the death of her husband, usually placing herself alongside his own funeral pyre. In India, this is seen as a noble deed done by a good woman selflessly devoted to her husband. Bhugra debates whether this form of suicide is done out of devotion, as one's dharma or sense of duty, or because the prospect of living as a widow on the charity of others might seem worse than death, or because, in her religious culture, she sees reincarnation awaiting her, or, finally, because it is a way she can independently assert her freedom and sense of self-worth in a patriarchal society. But whatever may lie behind this particular kind of suicidal self-sacrifice, Bhugra believes *sati* does not represent any kind of formal mental illness.

It is interesting to contemplate other examples of suicide that could also be deemed "nonpsychiatric." Faced with the impossibility of fighting effectively, let alone of winning, let alone of remaining alive, soldiers in wartime have chosen to throw themselves into certain death rather than run away or desert. Some people end their lives in order to save the life of another or in other ways act in an altruistic manner with nonselfish motives. And the list continues. While such individuals have intentionally killed themselves and in essentially the same ways that other traditional, probably mentally disturbed, suicides have, the state of mind underlying the act is decidedly different. The nonpsychiatric suicide has a reason for doing it other than to just end his or her own existence; it is, rather, done

on *behalf* of existence, done in light of some code, obligation, duty, or principle, or done *for* another more than *against* oneself.⁵⁰

Another example of this nonpsychiatric category could be *hara-kiri*. For the Japanese, the term *hara-kiri* is a vulgar version of *seppuka*, with *seppuka* meaning “stomach cutting” or “belly slicing,” a centuries-old Japanese form of ritual suicide by disembowelment.⁵¹ The phrase “to commit *hara-kiri*” has extended well beyond Japan. We in the U.S. know it through its many fictionalized film and television portrayals. Indeed, referring to committing *hara-kiri* has become for many simply a more colorful, cross-cultural way of saying “committing suicide.” While there is little doubt that someone committing *hara-kiri*, or *seppuka*, is, by the traditional definition, committing suicide, the ritual context makes it somewhat different. The taking of one’s own life in this way is following a prescribed formula: If such-and-such happens, you must then turn to *hara-kiri*. Obligation, lack of choice, and inevitability can characterize the act, along with honor, nobility, and heroism.

Here are some glimpses of the kinds of situations that can lead individuals to choose *hara-kiri* to end their lives. In 1895 a large group of Japanese military personnel committed *hara-kiri* together to protest against the return of a conquered territory to China. In 1912, a general and his wife killed themselves in response to the death of the Japanese emperor. And, at the end of World War II, many Japanese citizens and soldiers chose to commit *seppuka* rather than surrender to the Allied forces.⁵²

One particular kind of *seppuka*, related to the Asian Indian practice of *sati*, is *oibara*, which is the historical Japanese practice of killing oneself at the death of one’s master.⁵³

ATTEMPTED SUICIDES AND NDEs

Richard Heckler, a counseling psychologist, social scientist, and faculty member at John F. Kennedy University in California and at the Union Graduate School in Ohio, wrote an influential book, *Waking Up, Alive: The Descent, the Suicide Attempt, and the Return to Life*. It is based on in-depth case studies of fifty individuals who survived their own suicide attempts. His study, and others like it, shed much-needed light on the experience and state of the mind of those who have tried to kill themselves. From such research, we can gain more insight into what may have lain behind those who were actually successful in ending their own lives, such as those throughout this book we will hear from, who are said to be in spirit form communicating back from the afterlife that supposedly follows physical death.

Those preparing to take their own lives, in Heckler's words, are confronted with "a frightening loss of their feelings of wholeness, order, and connection." They report that, leading up to the suicide attempts, "Faith dissolved, and their confidence in a gentle and nourishing world was shattered. An inner chaos unraveled the very fabric of their hearts and minds"⁵⁴ For them, "life begins to feel like a succession of insults, one after another, until a breaking point is reached."⁵⁵

Speaking of the descent into suicide, Heckler reports on "that psycho-spiritual period during which the very fabric of one's world seems to stretch, tear, and break apart."⁵⁶ Others seem blind to one's suffering; the compassion that one is seeking is not there. One withdraws further from contact and connection, physically, emotionally, and spiritually.⁵⁷ Those attempting suicide say they had given up hope that there was anyone who could give them compassion and an understanding of their suffering.⁵⁸

Heckler discovered in those who had attempted suicide what he called a consciousness-altering suicidal *trance state*:

They no longer see or hear anything outside their own minds—the tight spiral of thought that tells them to die. . . . the trance is a state of mind and body that receives only the kind of input that reinforces the pain and corroborates the person's conviction that the only way out is through death.⁵⁹

This suicidal trance has its own logic. Abandoning hope of reclaiming their own lives, they now, instead, "apply their creativity to their own removal."⁶⁰ In this trance, "images of death as release and as an entry into a better world are so powerful and convincing" that they may be moved to try to take their own lives.⁶¹ In the grip of this trance, one's mental and emotional perspective continues to narrow "until the only inner voices that can be heard are those that enjoin him or her to die"⁶² One's romance is with death now, not life. Regarding one of his clients, Heckler remarks: "He wasn't afraid to die. . . . [he] was afraid of living. Living seemed unfathomable."⁶³

According to Heckler, a kind of dissociation can result, in which there are two parts of the suicidal person—one part experiencing intolerable suffering and the other part plotting death.⁶⁴ There can be a sense of freedom that comes from welcoming the prospect of suicide. As they near the moment, many report "there were sudden moments of stillness: feelings of acceptance, serenity, and peacefulness, and relief from pain."⁶⁵

What lies at the heart of the suicide attempt? For Heckler, four of the biggest desires leading up to it are: escaping something in one's life, such as a dilemma, that feels inescapable; trying to gain control over something

that may seem uncontrollable and confusing; sending a message by means of the suicidal act, a message that seemed earlier unable to be communicated in other ways; and, most obviously, desiring simply to kill the pain by killing oneself.⁶⁶ In addition, his research found that each of his subjects (also clients) had experienced one or more of the three main kinds of loss that he believes lead up to attempting suicide: (1) traumatic loss, (2) family loss that comes from extreme family dysfunction, and (3) loss that we can experience by way of our own growing sense of alienation.⁶⁷ Whatever may lie behind the act, choosing suicide flies in the face of all that our rational and scientific culture holds dear and totally undermines the normal, natural disposition to be healthy, functional, and relatively happy.⁶⁸

Following a failed suicide attempt, Heckler found the following steps to recovery being taken by his clients: rebuilding the self; healing the past; taking responsibility for their actions; moving from isolation and alienation to reaching out, learning to ask for help, allowing others in, and letting others love them, and even being moved to give something back to the community.⁶⁹ These steps of recovering from a suicide attempt can provide ideas for those who work to help others turn away from moving toward taking their own lives. In the face of their failed suicides, some of Heckler's subjects also wondered if there were reasons, "existential or spiritual," for why they were unsuccessful in their attempts to end their lives.⁷⁰

In contrast, among the hundreds of cases of completed suicides reported in this book, all said to be communicating in spirit form from the afterlife, we will hear from many voicing their own perspectives, existential or spiritual, regarding why their attempts at suicide, in fact, *succeeded*.

Of those who have been studied by Heckler and others, who attempted suicide, failed, and returned to describe their experience, some have also had as part of it what is called a near-death experience. Bruce Greyson is Carlson Professor of Psychiatry in the Department of Psychiatric Medicine in the University of Virginia Health System and a leading authority on the near-death experience (NDE). Most people who have experienced NDEs describe leaving their bodies, going through a tunnel toward a light, coming to the threshold of an afterlife hypothesized as the domain one may enter upon death, and being met there by someone known to them who has already died or by some other spirit. They also often report experiencing some kind of rapid review of their life. They are told it is not their time to leave life yet, and that they must return to physical reality for some further living. Most NDE experiencers (NDErs) are left very much changed by the experience. They feel they have been given a glimpse of a beautiful,

spiritual realm of experience that awaits them when they actually die. Their fear of death dissipates and they have a renewed caring about life and themselves, imbued with new meaning and framed within a greater, deeper context.⁷¹ According to Greyson, most who have experienced it report that “the NDE is an overwhelmingly positive, transcendently beautiful experience. The view of death they come away with is a quite attractive one.”⁷²

One woman who attempted suicide in 1977 told NDE researcher Kenneth Ring, then Professor of Psychology at the University of Connecticut and President of the International Association for Near-Death Studies:

I can't tell you what happened to me because I don't know, but something happened as I've never been the same since. People describe me as being “high on life.” And they are right. I'm thankful for every new day God gives me and I never take one minute of my day for granted. I wish I could explain how very much that one experience changed me. But I just can't find words to express myself. But I'm sure of one thing: there is a peace that remains with me always now—it has the strangest calming effect on me.⁷³

Many researchers, including those trained as physicians, such as psychiatrist Greyson, who have studied NDEs believe that they provide a genuine glimpse into some kind of spiritual-transcendental reality that seems to lie beyond the physical body and its senses and beyond physical earthly life. It is possible that the experiential realm briefly visited, and commonly described, by many NDErs may be the same as or similar to the realm that each of us will enter and then continue to exist within following our own physical deaths. Although there is no way to know this for certain, looking at the NDEs of attempted suicides may indirectly provide us with information about the experiences of those who have successfully committed suicide and are said to now reside in that Earth-transcending realm called the afterlife. Hearing the descriptions of NDEs can provide a potentially useful context for hearing the stories, conveyed by mediums and channels, that come from hundreds of spirits who, by their suicides, moved from near-death, into death, and through it to an afterlife from which they are now communicating to us. So, we invite you to compare the stories from suicidal NDErs with communications from the spirits of successful suicides.

In his chapter “Wish for Death, Wish for Life: The NDE and Suicide Attempts,” published in a French anthology *Death Transformed*, Greyson reports on the initial three major studies done on the NDEs of attempted suicides. University of California at San Francisco psychiatrist David Rosen, the first to do this kind of research, interviewed eight people who had

survived leaping from the Golden Gate Bridge in San Francisco. All eight reported having NDEs. The bridge has been a magnet for more than 1,200 successful suicides. Only 1 percent of those who make the attempt survive. University of Connecticut psychologists Kenneth Ring and Stephen Franklin did a larger-scale study of thirty-six suicide attempters, 47 percent of whom reported NDEs. This was followed by Greyson's own study, conducted at University of Michigan Hospitals, which involved interviewing sixty-one suicide attempters, 26 percent of whom reported NDEs.⁷⁴

Based on his integration of the findings from these studies, Greyson notes a number of interesting patterns:

The suicide attempters report the same kind of NDEs that other people report. They do not tend to have unpleasant or negative or hellish NDEs: in fact, people who want to die may have more positive NDEs than those who want to live. ... those who have NDEs become strongly opposed to suicide as a result of the experience. ... there is a "suicide-inhibiting" effect of NDEs.⁷⁵

Greyson asked his attempted-suicide NDE subjects why they were less, or not at all, suicidal after their NDEs. Based on their descriptions, he found twelve categories of reasons why the NDE turned them away from any further thoughts of suicide. From most frequently to least frequently mentioned, these reasons are:

1. They experienced a "cosmic unity," a sense that they were now part of something larger than themselves.
2. Their NDE made the problems with which they were preoccupied prior to their suicide attempt less important now, putting them within a larger perspective.
3. The NDE enhanced their life, giving it more value and meaning, making it more precious.
4. The experience made their life seem more real than it had been before.
5. It enhanced their self-esteem.
6. It gave them a greater sense of bonding to other people.
7. It gave them a sense that their death by suicide was not meant to be.
8. It gave them an opportunity to reevaluate their life as a result of the life review they experienced as part of their NDE.
9. There was a secondary gain in the sense that their personal situation seemed enhanced as a result of the NDE.
10. They gained the conviction that suicide was ethically wrong.

11. Through their NDE, they experienced “a killing off of unwanted or offensive parts of the self so that the remainder can go on.”
12. Least reported was that the NDE instilled in them a fear of going through the experience again.⁷⁶

Studying these twelve categories, Greyson discovered that:

The six *most* commonly offered reasons for not being suicidal after an NDE relate to transcendental matters, while the six *least* often mentioned reasons tend to be “reality-oriented.” In other words, NDErs attribute their decreased suicidal thinking to a focus on transcendental issues.⁷⁷

Finally, discovering that “although NDErs do romanticize death, they also romanticize life,” Greyson concludes:

If we can generalize from NDErs to others, then it would appear that the mundane crisis intervention practiced by most suicide prevention services, which focused on reality-oriented problem-solving and ego-strengthening, is not what makes people less suicidal. What makes people choose life is a transpersonal perspective on life and death.⁷⁸

When we turn, following this chapter, to the rest of Part I, to hundreds of spirits of “successful” suicides reporting through channels and mediums from the afterlife about their experience, you will be able to compare both such *near-death* and *after-death* perspectives on life and death, on suicide and the larger transpersonal picture. Throughout this book, whether drawing from NDEs or from those who have passed beyond physical death, our overarching perspective will be transpersonal, transcendental, and spiritual.

TREATING THE SUICIDAL PERSON

Avery Weissman interpreted the wish to die as being an existential signal that the person’s conviction “that his potential for being someone who matters has been exhausted.”⁷⁹ Therefore, one of the things someone trying to help a suicidal person can do is try to make him feel he matters, that he matters to others, including to the clinician, and, above all, that he matters to himself.

Edwin Cassem refers to fellow psychologist Gregory Rochlin’s theory that suicide, similar to other types of aggressive action, can serve to heighten damaged self-esteem; and that we can know the potential for suicide by the strong, dark feelings of hopelessness and helplessness that increasingly preoccupy the individual.⁸⁰

Related to this, Cassem reports on research led by renowned cognitive psychotherapist Aron Beck: "In a rigorous investigation of 384 suicide attempters ... hopelessness is the key variable linking depression to suicidal behavior."⁸¹

So, it is important to try to strengthen the suicidal individual's critically damaged self-esteem and to provide resources to counter the feeling of helplessness and hopelessness.

Again, according to Cassem, the likelihood of developing major depression increases with the seriousness of the person's illness.⁸² Therefore, highly important in helping the suicidal individual is combating the depression that is usually there, particularly by identifying, challenging, and trying to change or substitute for the beliefs, suppositions, and expectations that underlie and lead to the emotion of depression. In a predictable interrelation, researched and worked with by Aron Beck, Albert Ellis, and other cognitively oriented psychotherapists, self-destructive behavior, and ultimately suicide itself, arises from a negative emotional state, such as depression, and the emotion arose, in turn, from the beliefs underlying it.⁸³ So, one targets and works with the negative beliefs, the maladaptive statements and schemas about the self and the world that are carried within, to get to the negative emotion to abort the negative, even potentially self-murderous, behavior.

The Harvard Guide to Psychiatry (3rd ed.) provides guidelines for spotting and helping those who appear to be heading toward suicide. To protect life and its continuation, self-esteem and self-respect are the basic psychic conditions to be monitored and strengthened, and the individual's "narcissistic equilibrium"⁸⁴ should be restored and maintained. The therapist or other helper should act as "an ally for the life of the individual"; he or she should "have the capacity to hear out carefully and tolerate the feelings of despair, desperation, anguish, rage, loneliness, emptiness, and meaninglessness articulated by the suicidal person." The helper should give the suicidal person a sense that he or she is taken seriously and is being understood, and this may involve the therapist exploring the person's "darkest feelings of despair." The therapist should work to lessen social isolation and withdrawal on the part of the client, and help the client to initiate relationships, work, hobbies and other activities to enhance and maintain self-esteem. Any co-occurring psychological disorders should also be treated. And finally, the helper should be prepared to seek support or consultation for him- or herself if working with the suicidal person becomes especially depleting.⁸⁵

In a similar vein, in *The Encyclopedia of Psychology* (2nd ed.), the

eminent authority on suicide, E. S. Shneidman, lists a number of things to bear in mind for preventing suicide and working with the suicidal, including taking every incident pointing to possible suicide very seriously, weighing its degree of intensity and lethality, and continuing to assess for lethality throughout—knowing that those facing suicide are often ambivalent about carrying it out, torn between wanting to live and wanting to die, and thus may be crying out for help, and knowing that the person probably has a need for a “life-sustaining emotionally cemented relationship with the helper,” which can provide “hope and succor.” Schneidman continues that the therapist or helper needs to be willing to help and give with regard to the person’s real-life problems; use community resources; as needed, seek consultation and support for oneself; consider hospitalization for the client, if deemed necessary; and involve those significant and close to the suicidal person who appear to be the best candidates to serve as a kind of “auxiliary therapist.”⁸⁶

EXISTENTIALISM AND DEATH

How we come to terms with our own inevitable death is one of the major themes dealt with by both existential philosophy and existential psychology and psychotherapy. Freud also wrote of death, claiming that the four most common fears associated with death are: (1) helplessness or loss of control, (2) being bad (guilt and punishment), (3) physical injury or symbolic injury (castration), and (4) abandonment.⁸⁷ He also posited that we each have a death instinct, which he called *thanatos*, that counterbalances our life and love instinct, which he called *eros*. In Freudian terms, then, it would seem that, in spite of whatever inbuilt fears we may have about death, and in spite of how present the *eros* instinct may be in us, when we are drawn toward suicide, we are definitely under the influence of *thanatos*, the death instinct. The existential struggle is to wrestle personal meaning and the will to live from the clutches of death that can mock us with its inevitability.

One definition of suicide, by Jean Baechler, emphasizes the functional nature of the act: “Suicide denotes any behavior that seeks and finds the solution to an existential problem by making an attempt on the life of the subject.”⁸⁸

There is the existentialist view of suicide presented by French philosopher Albert Camus in his book *The Myth of Sisyphus*, in which one is tempted, when life is experienced as not worth living because it is basically meaningless or absurd, to end one’s life artificially, rather than wait for a natural death perhaps decades later. Anticipating the later Camus,