American Handbook of Psychiatry

COMMUNITY PROGRAMS IN SUICIDOLOGY

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Imagine an inexorably straight line stretching across this page representing time. Imagine further your dividing this line into three unequal parts: the past (sinister), the present (represented by a dot that can move, but only to the right), and the future (dexter). You would then see the three temporal units in relation to which each suicidologist—and every other practitioner in the world, for that matter—must work. Beneficent or therapeutic action can focus only on what may happen in the future, what is happening in the present, or what has happened in the past. That is to say, one can come or do (the Latin word "venire") only before (prevention), during (intervention or parivention), or after (postvention). The materials in this chapter on suicide vention are organized around these three key temporal concepts[1]

As will be easily recognized, these three terms run parallel in many ways to the traditional public health concepts of primary, secondary, and tertiary prevention. I believe that the proposed terminology is more accurate; further it avoids the necessity of such phrases as "preventive intervention," when what is really meant is postvention.

It is, of course, possible to achieve a useful understanding of suicide as related to community and mental health issues in terms of any one of a

number of models or paradigms. At the outset, however, it can be argued that among the models from which one can choose, the medical model (with its notions of disease, cause, cure, and a specially anointed curer) seems especially limited and, at best, only marginally appropriate. In this connection, Drs. Bertram Brown and Eugene Long appraised the situation realistically.

The conceptualization of community response to self-destructive crises along a temporal dimension has the merit of avoiding much of contemporary underbrush. The three temporal points logically exhaust the possible times at which action—individual, dyadic, community, or otherwise—can be effected.

They focus on when (before, during, or after) rather than the less appropriate who (M.D., Ph.D., or D.D.) or where (inpatient, outpatient, at home, or on the telephone) or what (manic-depressive, paranoid schizophrenic, benighted citizen, perturbed housewife). This way of seeing the action has the additional advantage of opening the field to anyone who can help at any crucial point in time: a trained volunteer, a significant (or even insignificant) other, a psychiatrist, an epidemiologist, a demographer, a psychoanalyst, a vital statistician, a clergyman, a sociologist, a policeman, a health educator, a clinical psychologist—a whole panoply of individuals who can practice prevention, intervention, or postvention, whether as clinicians, research scientists, or empathic human beings seeking to help someone in

duress.

Prevention

The etymological meaning of prevention is straightforward: It means to come before. Its implication is that it forestalls, wards off, precludes, averts, or makes unnecessary the dire or inimical events that otherwise would occur. In suicidology there are two main avenues to prevention:

1. To increase the acumen for recognition of potential suicide among all possible rescuers. The key to the reduction of suicide lies in recognition and diagnosis, the perception of the premonitory signs and clues. Most individuals who are deeply suicidal cast some verbal or behavioral shadows before them. Prevention lies in recognition. The task of early casefinding must be shared by both professionals and lay people. The early signs of suicide must be made known to each physician, clergyman, policeman, and educator in the land and to each spouse, parent, neighbor, and friend.

2. To facilitate the ease with which each citizen can utter a cry for help. The tabooed nature of suicide must be recognized. Part of a successful program of suicide prevention lies in reducing the taboos and giving a greater permissiveness for citizens in distress to seek help and to make their plight a legitimate reason for treatment and assistance.

In a much broader sense—in terms of long-range policy planning, for example—planning for prevention would have to include two major contradictory (but not mutually exclusive) goals: (1) reducing the number of suicidal deaths; and (2) reducing the stigma or taboo on suicide, so that even when it does occur, the mental health sequelae on the survivors would be less severe and less crippling. These two major goals would, of course, also be applicable in other mental health areas, such as schizophrenia or homosexuality.

With these notions in mind, the following are suggested as parts of a comprehensive program in suicide, especially relating to the preventive aspects of such a program.

A Redefinition and Refinement of Concepts and Statistics on Suicide

It would seem to be part of the elementary logic of a clinical science to believe that remediation optimally follows from one's understanding of the nature of the phenomena. Good conceptualizations (including definition and taxonomy) must precede any effective action (prevention, intervention, or postvention).

It is generally agreed that current statistics on suicide are grossly inadequate and that comparisons of suicidal incidents between cities, between states, and between countries, based on available figures, are at best

sometimes inaccurate and often obfuscatory and misleading. The current inaccuracies are due to many reasons, including the following:

1. Confusion as to how to certify equivocal deaths, for example, those that lie between suicide and accident.

2. Dissembling on the part of police and physicians who wish to protect the family and public officials who wish to protect the reputation of their community.

3. Inaccurate record keeping, where what could be known and ascertained simply is not accurately tabulated.

4. The irremediable inadequacies of the present concepts.

Two additional points should be made in relation to statistics. (1) An opportunity now exists to introduce improved classifications and to conduct pilot studies to determine (for the first time) the veridical suicide rates in some selected communities. (2) The specter exists that unless there is a refinement of the concepts related to self-destruction, there will never be accuracy of reporting, because the present concepts are simply not conceptually strong enough to accurately reflect the events they are purported to represent.

At all levels, special thought should be given to the redefinition and refinement of statistics and to the problem of record keeping to the end of

suggesting new concepts and a comprehensive program for uniform national record keeping in relation to self-destruction. I have elsewhere suggested that the greatest difficulty in accurate reporting of self-destructive deaths is that it is currently tied to an archaic classification of deaths. The greatest shortcoming of this present classification is that it completely omits the role of the individual in his own demise.

We would do well to abandon completely the NASH (natural, accident, suicide, homicide) classification of deaths, for it is Cartesian and a-psychological in that it entirely omits the role of the individual in his own death and totally disregards the teachings of twentieth-century psychodynamic psychology. Instead, we should attempt to conceptualize all human deaths in terms of a motivational dimension of intention toward death. As a beginning, three large subcategories are suggested: intentioned, subintentioned, and unintentioned. These subcategories might briefly be defined as follows. An *intentioned* death is any death, from whatever cause(s) or of whatever apparent mode, in which the decedent played a direct, conscious role in effecting his own demise. A *subintentioned* death is one in which the decedent played an indirect, covert, partial, conscious, or unconscious role in hastening his own demise by such behaviors as imprudence, excessive risk taking, abuse of alcohol, misuse of drugs, disregard of life-extending medical regimen, death-risking life style, or the like. An *unintentioned* death is one in which the decedent played no effective

role in effecting his own demise, in that the death is due entirely to assault or trauma from without or non-psychologically tinged failure from within. The reader is referred elsewhere for a further explication of these notions.

The traditional NASH classification of death robs us of the possibility of generating meaningful statistics. An approach that focuses on the intention of the individual, if used in conjunction with the traditional approach, might well provide an important step in the psychological understanding of a broad spectrum of deaths and lead to more effective assessment and prevention.

Special Programs for the Gatekeepers of Suicide Prevention

An important key to suicide prevention lies in detection and diagnosis. One of the most important findings from the last decade's experience in suicide prevention is that practically every person who kills himself gives some verbal or behavioral clue of his intention to do so. These prodromal clues are often in code, that is, are cryptic or disguised, but nonetheless they are clues, and one can learn to recognize them. These are the handles to prevention.

In practice, a variety of people hear the pre-suicidal clues—spouse, friend, neighbor, clergyman, policeman, bartender, physician, employer, and so on. However, it is a most important fact that more than 65 percent of all individuals who commit suicide have seen a physician (usually a general

practitioner) within three months of the event. It is therefore crucial to have a program of education relating to detection and diagnosis that focuses on physicians and, secondarily, on clergy, police, and other gatekeepers.

There are a number of ways in which a program for educating general practitioners about the diagnostic indices of suicide can be done. These include the following:

Preparation of special educational materials for physicians focused on the premonitory signs of suicide. These materials can be in the form of brochures, pamphlets, long-playing training records, film strips, films, or the like.

1. Preparation of a similar program directed toward physicians in hospitals and clinics.

2. Instruction on suicide prevention in the medical school curriculum.

3. Courses on suicide prevention in postgraduate medical education in medical schools throughout the country.

4. The use of resources of the American Academy of General Practitioners (AAGP).

5. Special national and regional conferences on suicide prevention sponsored by the AMA and the AAGP, perhaps with co-sponsorship by the American Psychological Association and

the National Association of Social Workers.

6. Suggestions that the drug companies train their drug detail men in suicidal prevention. Although every doctor in the United States does not read every journal or attend conventions, every doctor does see drug detail men. The major drug companies ought to be most willing to train these drug detail men in the principles and content of suicide prevention and to have them distribute appropriate literature to the physicians on whom they call. This could be done not only through the drug companies but with the additional coordination of the AMA, state medical societies, and so on.

Clinical experience over the past several years indicates that it is not only possible but advisable for physicians to ask direct questions about a patient's suicidal intent without any harmful effects. In interviews with

suicidal patients and reviews of 3,000 suicidal deaths, the staff at the Los Angeles Suicide Prevention Center found no evidence that such questions had ever harmed patients; indeed, the questions often relieved the patients and permitted them to discuss their problems with the physicians.

Additional special programs, tailor made for clergy, police, educators, and others, should, without question, also be considered.

Carefully Prepared Programs in Massive Public Education

Massive public education is probably the most important single item for effective suicide prevention and at the same time one of the most difficult to put into practice in ways that would be both acceptable and effective. The basic notion is that one major avenue to reduction of suicidal deaths is through the use of the lay citizen for first-line detection and diagnosis. The rough model may be found in cancer detection, wherein more and more citizens know the prodromal clues for cancer (for example, bleeding from an aperture, a lump in the breast, a wart or sore that does not heal or that grows). The same model, with appropriate changes, might well be adopted in suicide prevention.

A study of massive public education might be done initially in a few carefully preselected communities. This study would need to involve experts in epidemiology, biostatistics, and the use of communication media. This type of study would need to be preceded by a long-term comprehensive study of the actual state of suicidal (and suicidal equivalent) incidents in those areas. The public education activities might include planned and careful use of all the public media: schools, television, newspapers, radio, advertisements, placards. These activities might be done in both usual and unusual places (where appropriate), such as doctors' offices, pool halls, or public lavatories.

One or two cities might be selected as large-scale pilot projects (or one or two sections of cities might be selected with equal catchment areas). There

is the need for control scientific data in order to ascertain the effects and effectiveness of such a program of public education. In part, this can be done by selecting other cities (or sections of cities) comparable to the experimental cities in terms of the major variables thought to be relevant.

The use of certain carefully selected target cities as a pilot attempt in suicide prevention is in line with current scientific practice. There currently exist many concepts in suicide prevention that have been found useful; there is already a base of knowledge from which to predict a hope of success.

Although a program of massive public education would seem to be very important in any full-scale assault on the problem of suicide, it would need to be done with the reservations concerning the unanticipated consequences of public information and of popularizing the topic of suicide prevention. We do not know enough about the short-term effects of such a program. However, it needs to be further stated that this in itself is a legitimate subject for serious study and one in which sociology consultants would play an important role.

The Development of a Cadre of Trained, Dedicated Professionals

There do not exist at present trained professionals in sufficient number to man the proposed and planned projects in suicide prevention. There is an acute need for the creation of a core group of individuals who might then direct and staff the suicide prevention programs in the communities

throughout the country.. It should be pointed out that what is being proposed here is not the training of individuals to be specialists in suicide in the sense of only being therapists for suicidal people, but rather that individuals be given sufficient training in the basic ideas and facts about suicide and suicide prevention so that they can then act more meaningfully in their administrative and technical capacities.

The establishment of fellowships in suicidology at main centers of learning at several strategic places throughout the country would be most important. Already, it appears that there may be fellowships in suicidology programs soon on the West Coast, the Midwest, and the Southwest. The concept seems viable, and the future seems to be one of expansion of such training sites. The main point to be made is that the establishment of these multi-professional fellowships in suicidology will, within a relatively few years, create a corps of trained professionals specifically concerned with suicide prevention and able effectively to staff a variety of suicide prevention activities throughout the country.

Intervention

Intervention has two meanings, either to come during or to come between. The first meaning of intervention is to come during the acute crisis. Its avowed purpose is to modify or reduce the intensity of deleterious effects

of the crisis itself, in a word, to reduce the crisis to a non-crisis. The second meaning of intervention refers to activities that come between the present crisis and a potential subsequent crisis. Its avowed goal is to reduce the probability of another crisis. In this case, specifically of a future suicide attempt. In practice, some of the elements of effective intervention are as follows:

1. Attending to the perturbation and lethality elements in suicidal behavior.

2. Recognizing that self-destruction can be subintentioned and is not always overtly suicide.

3. Recognizing that suicidal behavior usually occurs in a dyadic context and taking account of the life-saving role of the significant other.

In general, effective intervention is accomplished by providing resources adequate to evaluate and respond to suicidal crises. Roth facilities and personnel are needed. Personnel need to acquire relative skills and appropriate attitudes. Response to the suicidal individual and his significant other within their own cultural setting is the *sine qua non* for the reduction of the suicide rate.

Most suicide prevention activities are interventive in nature. In part, this is so because that is where the action is, but this fact does not gainsay

another fact that great needs, especially for more fundamental research, lie in the areas of prevention and postvention. Intervention has the apparent attractions of immediacy, drama, and relatively quick response. The issue has been identified—he is suicidal—and the need is real. Intervention is a kind of secondary prevention, having to do with the effective treatment of an existing, identifiable (suicidal) crisis. The increase in the number of suicide prevention centers in this country from 3 to more than 130 in the past fifteen years is only one of several evidences of the legitimate appeal and humane worthwhileness of intervention. It is largely, but not entirely, the clinician's domain—his and the effective volunteer's.

Service and Treatment

Although there is great need for systematic research on intervention, the heart of intervention is the service itself. The challenge is a logistic and tactical one: that the services that can be rendered be made available to those who need them when they are required. This routinely means some kind of twenty-four-hour-a-day operation, usually involving the use of the telephone as the life-saving instrument. The use of the telephone willy-nilly changes the clinical interviewing task, presenting fresh challenges and offering new opportunities. Suicide prevention personnel need to become expert in quickly rating each caller's lethality, his probability of committing suicide in the immediate future, as opposed to his perturbation or degree of upset or

distress. Admittedly, workers at a suicide prevention center will probably handle more non-suicidal calls (of individuals lonely, perturbed, intoxicated, psychotic, fundless but not lethal) than suicidal ones, yet they do well constantly to remember that their clinical goal is to keep people out of the coroner's office, to prevent their killing themselves, and that everything else takes its place subsumed under that primary aim.

The improvement of treatment procedures involves the search for new and improved methods. Within the last decade, a number of changes have already taken place. Among these can be listed a more active approach to treatment in general, the dyadic form of most treatment of suicidal persons actively involving the significant other, and a great movement out of the office into the community, using the resources within the community, the organized and unorganized helping hands of the community. In this special sense, it can be said that the best suicide prevention worker is the one who is able to get others to do most of the life-saving.

Studies of Special Groups

For any one of a number of reasons, the closer scrutiny of certain groups seems to merit special interest and attention. These groups, in the suicide domain, should include such readily identifiable high-risk groups as college students; military personnel; certain professional groups, such as physicians,

particularly psychiatrists; the aged; and less readily identifiable high-risk groups, whatever their composition. On the topic of college students and suicide, there is currently a number of studies throughout the country. The identification of high-risk groups is a way of redefining individuals who manifest the prodromata or premonitory signs associated with suicidal behaviors. The key issue is whether groups of such high-risk persons can be found or whether this kind of search is not always a quest for specific individuals.

Selection and Training of Volunteer Groups

The manpower problem in suicide efforts is especially important. One way of addressing it is through fellowship programs, giving focused training to individuals who already possess graduate or professional degrees. Another way is to turn to the much larger resource pool of mature and willing individuals, carefully to select them and then rigorously to train them. This has been the route of many of the suicide prevention centers throughout the country, and there are some excellent reports of these experiences. In general, selection has focused on such traits as flexibility and trainability, absence of overinvestment, or previous emotional difficulties, considerable maturity, and some experience with life's problems—the avoidance of "psychological virgins"—and the ability to quickly master the difference between a conversation (which is social and coequal) and an interview

(which is clinical and betokens the helper and the helped). In the training of volunteers, many usual and innovative techniques have been employed (including the use of taped telephone calls, psychodrama, role playing, and the preceptor method) most of which cost very little but yet have the potential of enormous yield in dedicated and high-morale and low-cost personnel, usually the womanpower of the community.

Postvention

Postvention means to come after; either after a suicide attempt or after a completed suicidal act. There is much to be done for a person who has attempted suicide. We all know that suturing a wrist or gastric lavage does not treat the suicide attempt. That trauma is intrapsychic and interpersonal. Effective ways of reducing the suicide rate—always the primary goal—must include a heavy emphasis on postvention efforts for individuals who have attempted suicide.

As important as postvention for suicide attempt is, the other aspect of postvention may be even more important. It relates to helping the survivor victims of a completed suicide. When a suicide occurs, the story is not over; another narrative for the survivor victims has just begun. They have to live with their own guilt, shame, anger, perplexity, obsessions, in a word, with their own increased perturbation. Good mental health practice in a benign

community ought unquestionably to provide for some postvention care of survivor victims of suicidal acts. It is not that these individuals then go on to commit suicide; rather it is that these individuals are more apt to become general mental health casualties in the clinics and in the hospitals.

The largest mental health problem in relation to suicide relates to the survivor victims, who outnumber the deceased in the order of five to one. Appropriate care or treatment of a surviving widow or, especially, surviving young children is obvious good mental health practice. We know a good deal about the nefarious sequelae of a parent's suicidal death, and much is known relating to remedial and prophylactic psychological treatment of these unfortunates. Obviously, follow-up programs that study and help individuals who have attempted suicide are needed in order, at least, to learn more of the natural history of suicidal behaviors. Apropos of prophylaxis: Postvention of individuals in the present becomes prevention for the next decade, or even for the next generation. Postvention relates to the reduction in the amount of disability in the survivor caused by the irreversible suicidal event or in the individual who has attempted suicide subsequent to his first attempt.

Follow up of Suicide Attempts

We know that about eight out of ten people who commit suicide have previously attempted or threatened it, but the data relating to the percentage

of people who have attempted or threatened suicide, who subsequently commit suicide, are contradictory and equivocal. The primary purpose of follow up of suicide attempts would be to prevent the commission of suicide. Some people who commit suicide do so the first time they attempt it, but the more common pattern is that of a series of attempts, with increasing lethality, and there are too many reports of individuals who have been sewn up or pumped out and released, only to complete the task within hours. Like the suggested programs for the gatekeepers and the program in public education, this also is meant to nibble at the suicide problem and to help effect a reduction in the suicide rate.

A program of follow up of suicide attempters could be done in sites where the conditions are propitious for success, and with especially cooperating hospitals, police departments, and public health officials. The actual follow up could be done by a variety of types of personnel, including public health nurses, social workers, psychologists. The data already available, particularly from the work of Stengel, would serve as a beginning for further and better understanding.

There is great confusion about the relationship between attempted suicide and committed suicide. (Again, this confusion exists largely because clinicians and investigators fail to think in terms of lethality, as opposed to perturbation. A suicidal event, whether a threat, or an attempt, or a

commission, is best understood in terms of its lethal intention, rather than its method or how much general upset accompanies it.) We need to know the characteristics of those with low lethality. Obviously, prevention of suicidal deaths lies in dealing with the former.

It might be well to pattern the follow-up procedures for suicide attempts roughly after that of health educators working with venereal disease or tuberculosis follow up and look forward to the time when suicide attempt follow up can be built into routine health services. The follow up could be seen as post-crisis follow up and would be a legitimate aspect of a comprehensive approach to suicide prevention. It is known that the most dangerous period with relation to suicide is within three months after a suicidal crisis. A follow-up procedure might be one effective way in saving some lives and would furnish excellent data for significant study and research.

Follow-up of Survivor Victims

It is not inaccurate to state that from the point of view of the survivor, there are two kinds of deaths: all the deaths from cancer, heart, accident, and so on, on the one hand, and suicidal deaths, on the other. If one stops to consider the kind of grief work and mourning that one has to do on the occasion of a death of a loved one who dies of a natural or accidental cause on

the one hand, and then what he has to do for the rest of his life if his parent or spouse has committed suicide, the contrast is then clear. The individual who commits suicide often sentences the survivor to obsess for the rest of his life about the suicidal death. The suicide puts his skeleton in the survivors psychological closet. No other kind of death in our society creates such lasting emotional scars as a suicidal death. A comprehensive suicide prevention program should attend to the psychological needs of the stigmatized survivors, especially the children who survive a parent who has committed suicide.

Although this aspect of the program is not directed especially toward reducing suicide (dealing as it does with an individual who has already killed himself), because it relates to the survivors of the suicidal death, it is directly in the center of mental health concern. Today each citizen enjoys many rights in this country; we would hope that he might be granted the right to lead an unstigmatized life, especially a life unstigmatized by the suicidal death of a parent or a spouse.

The Los Angeles Suicide Prevention Center has pioneered in developing a procedure called the “psychological autopsy.” This process is used in cases of equivocal suicidal-accidental deaths and consists of interviewing a number of individuals who knew the deceased, to obtain pertinent psychological data about the nature of the death. The relevance of this is that it has

demonstrated that it is easily possible, and always therapeutic, to work with survivors of a suicidal death, especially immediately after the death and even for some interval thereafter.

Studies of the effects of suicides on survivors need to be done. Two kinds of studies immediately suggest themselves: retrospective studies of individuals whose parent committed suicide one, five, ten, twenty years ago and prospective studies, where the suicide has occurred in the very recent past and the effects on the survivor are followed through time.

We do not at present know the cost of each suicide in terms of the deleterious mental effects on the survivors (how many survivors of a father's or a mother's suicide subsequently need mental hospitalization or other mental health care) and in ascertaining what these facts are, we need to develop special ways for effectively helping individuals who have suffered this kind of traumatic loss. Just as there are better and worse ways of responding to, for example, the loss of a limb or to blindness, so we must develop better ways to help survivors respond to the grim fact of suicide in their family, and thus to reduce the overall mental health toll.

Evaluation of the Effectiveness of Suicide Prevention Activities

Evaluation is a necessary part of effective follow up. The goal of effecting a reduction in suicidal deaths carries with it the simultaneous

charge of doing so in such a way as to be able to demonstrate unequivocally that those lives have been saved.

Although, in the individual case, suicide can best be seen as reflecting "a damp, dismal November in the soul," it also seems to be that, in the large, suicide rates vary with such items as the nation's position in relation to peace and war; changes in the economic state of the nation (prosperity or depression); changes, in any one place, in the percentage and the role of blacks; and so on. All this is to say that it is an extremely thorny methodological problem in epidemiology to make a single test or to prove the effectiveness of a suicide prevention program in terms of a single measure, especially suicidal deaths. Nevertheless, efforts to establish the effectiveness of suicide prevention activities must, from both a scientific and moral point of view, be a part of a comprehensive suicide prevention program from its very beginning. Without this feature of rigorous evaluation there can be no accounting by any clinician or investigator, either to himself or to the scientific community.

This aspect of the total program, perhaps more than some of the others, requires close consultation with people in biometry, epidemiology, sociological methodology, research design, and statistics. Perhaps special committees might be formed specifically to deal with the issue of evaluation.

The basic issues in a suicide prevention program are: What can a local suicide prevention program do to lower the suicide rate of the people of that community, and how can we find out whether this is being accomplished?

In general, three levels of prevention have been envisaged: (1) primary prevention, in which the goal is to make it unnecessary for the suicidal crisis ever to occur; (2) secondary prevention (intervention), which has to do with the effective treatment of an existing suicidal crisis; and (3) tertiary prevention (post-vention), which relates to the reduction in the amount of disability in the survivor caused by the irreversible (already occurred) suicidal event.

And if there are three levels of prevention, there are at least three criteria for the effectiveness of any suicide prevention program. The first, most obvious, and by far the most important is the reduction of suicidal deaths. The second is the evaluation of the effectiveness of various types of approaches to and treatments of suicidal phenomena. The third should not be entirely ignored: It is the reduction of the overall lethality in the individuals who make up a community. Just as one might ask what a random study of blood samples of individuals entering a business or government building would reveal in terms of barbiturate and ethanol levels, so in the same spirit one might ask what a random study would reveal in relation to individuals' lethality indices, that is, their general ties to life. A successful suicide

prevention program should, in addition to overtly saving lives, also serve to lower the lethality level and suicidal index of a community. We need much baseline data in this area.

The very establishment of a suicide prevention program has a salutary effect on the mental health within its own community. It can provide a model for the effective approach to a variety of other sociopsychological blights, as well as provide useful information to help reduce the inimical effects of these blights. It would be hard to conceive that information generated in the area of suicide prevention would not have implications (both methodological and substantive) for accident fatalities, addiction, alcoholism, delinquency, homicide, schizophrenia, and other maladaptive and self-destructive patterns.

Suicide is, by definition, a certain kind of death and, as such, obviously relates to other kinds of death. Suicide has been defined as "the human act of self-inflicted, self-intentioned cessation." Suicide relates to motivation and is intentioned (as opposed to unintentioned or even subintentioned); it is self-imposed (as opposed to death due to trauma from without, a psychological failure from within, or assault from others); it is total cessation (as opposed to partial deaths or temporary interruption of consciousness); it is individual (as opposed to the decimation or disappearance of a group); it is technically suicide (as opposed to the NASH [natural, accident, suicide, homicide] classification of modes of death used for reporting purposes in the death

certificates [and statistics] in the Western world); and, in practically every ordinary case, it appears, from the point of view of the surviving relatives, to be stigmatizing (as opposed to honorific, uplifting, ennobling, comforting).

The extent of the community and mental health problems created by or associated with suicidal deaths is difficult, perhaps impossible to enumerate. The National Center for Health Statistics estimated over 20,000 suicidal deaths in the United States each year. Some other experts on this topic, notably Dublin, stated that this is a minimum figure, representing a significant underreporting. My own belief is that the veridical data are half again as high, a lot more than 30,000 self-inflicted deaths per year, and, if subintentioned deaths were added, the number would be ten times as high. Further, there are about eight suicide attempts for each reported suicidal death, so that conservatively we are dealing with more than 180,000 suicidal episodes each year. The number of people alive in the United States who have attempted suicide at some time in their lives is estimated to be in the millions. Although it seems obvious to say that the primary goal of any suicidal prevention effort is to save lives (that is, to effect a reduction in the suicide rate), it is no contradiction to state that, given the suicide figure at any given time, by far the more important mental health problems relate to the fate and well-being of the survivor victims of the suicidal deaths. If we can assert that the typical suicide directly affects four people (a surviving parent, a spouse, and two children), not to count the larger number the deceased less directly touches,

then we are talking about the dire and inimical mental health sequelae imposed (usually for the lifetime of that person) on approximately 100,000 additional persons each year, burdens of guilt, shame, puzzlement, taint, fear, and mystery, which are never satisfactorily resolved and often reach through the generations, benighting many lives.

In the last few years, the special feasibilities of the suicide prevention centers have been explicated. Specifically, the following feasibilities have been demonstrated: (1) of preventing suicide; (2) of discovering prodromal clues to suicide; (3) of doing meaningful research on this topic; (4) of using active therapeutic techniques, often involving the significant other; (5) of acting as a consultation service for established mental health agencies; (6) of working with a chief medical examiner-coroner, especially by use of the psychological autopsy procedure; (7) of having an around-the-clock service; (8) of employing a truly multi-professional approach; (9) of conceptualizing some time-worn (and inadequate) concepts of suicide and death; (10) of "un-booing" some unnecessary taboos; (11) of showing the desirability of establishing regional training centers; and (12) of operating a specifically focused suicide prevention center.

In the past decade, there has been a spirited growth of suicide prevention centers throughout this country. The figures detailing this trend are themselves interesting. As recently as 1958 there were three more-or-less

comprehensive suicide prevention centers in this country; in 1959, four; in i960, five; in 1964, nine; in 1965, fifteen; in 1966, thirty; in 1967, forty; in 1968, sixty; in 1970, more than 130; the trend is up. Not all the centers of the future will be autonomous and have separate identification; indeed, most of them will be, as they ought, integral aspects of hospitals, universities, and especially of comprehensive mental health centers, but, nonetheless, they will exist. In terms of geographic distribution, suicide prevention centers now exist in more than half the states and in every major section of the nation. But, obviously, there is much to be done.

A suicide prevention center provides an example par excellence of a kind of service that, literally in order to stay alive (much less to function with any degree of effectiveness), needs to coordinate closely and well with a large number of agencies and key persons within the community. Perhaps more than most, the vention of suicide is a community mental health operation. Experience teaches us that the establishment of suicide prevention facilities within a community is an experience in liaison and coordination. The interest (or, at the least, the passive approval) of several pivotal groups should, in most cases, be secured: the local medical group, the police, local government, hospitals, resource therapists in private practice, some civic groups, a number of social agencies, and the press. A recent Public Affairs pamphlet contained the following advice:

> A suicide prevention center cannot open shop all at once like a supermarket. Rather, the entire process, if it would be successful, must be gradually and tactfully woven into the community. From the beginning, the organizers must solicit help—at the very least, cooperation—from the city or county medical authorities. The hospitals, the coroner's office, and the police chief should know about the beginning of any suicide prevention service. In fact, suicide prevention needs their help. This is reasonable, since the new service ultimately will ease police and hospital emergency-room workloads. But, on occasion, the suicide prevention service will have to call on them for help. The local press, radio, and television should be informed about what's afoot and asked to cooperate. If a story breaks before the budding suicide prevention service is ready, this premature news could be disastrous. Of course, the city government must know what plans are being made. If city officials are not the initial sponsors of such a community service, certainly their endorsement should be heartily pursued. Without local cooperation, successful suicide prevention is practically impossible.

The recent establishment of a new multi-professional discipline, suicidology, serves as the intellectual catchment area for a wide variety of scientists (epidemiologists, demographers, statisticians, sociologists, social psychologists, and so on), clinicians (psychiatrists, clinical psychologists, psychiatric social workers, trained volunteers, clergy, police, and so on), and educators (school and university personnel, health educators, and so on). Suicidology is the study of, and concern with, suicidal phenomena and their prevention. This term was chosen advertently in order to give the special visibility and identity such a new discipline required. As part of the activities of the new Center for Studies of Suicide Prevention at the National Institute of Mental Health, we had sought to create some sense of special excitement in

the burgeoning fields of suicide and suicide prevention and to unite the interests of a number of kinds of people concerned either with suicidal phenomena or with suicide prevention. Suicidology seems to provide a reasonable solution. Already, in the recent past, the new profession seems to have taken hold. In 1968, the American Association of Suicidology was established.

Consistent with all this is the view expounded in this chapter of suicidal phenomena as sociopsychological blights (rather than an illness, disease, or set of statistics). Social and behavioral scientists would do well to focus, even to specialize, in the substantive areas of specific major sociopsychological blights, such as suicide, homosexuality, violence, urban perturbation, to name a few. Our stake—indeed, our responsibility—in suicide is a vital one. The suicidologist has the challenge to do exciting things in research, training and life-saving; his opportunities in community service would seem to be limited only by the limits of his own imagination and energy.

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Notes

1 The same is true for "saying" ("diction"): one can predict (He will commit suicide); paridict (He is schizophrenic), or postdict (He was a rejected child). All diagnoses are paridiction; prognoses are predictions; and statements about case history materials are postdictions. In general, they have different epistemological status and different degrees of veridicality. The distinctions among them are often disregarded, a fact that leads to much obfuscation.