The Suicide Paradigm

A site for those who have experienced suicide loss and those who want to know more about suicide and its aftermath.

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Some Other Stuff on Suicide Prevention and Suicide Loss:

"Suicide Loss: What Teens Need to Know" (PFF; 21 pp.)

"Suicide Loss: What Schools Should Know" (MS-Word; 34pp.)

**See "Recovering From Suicide Loss:
A Self-help Handbook for Those who have Lost Someone to Suicide" (MS-WORD; 23 pp.)**

"What Clergy Need to Know About Suicide Loss" (MS-WORD; 16 pp.)

**Above from:
Survivors of Suicide, Inc., Morton, PA**

"A Total Idiot's Guide to Suicide Prevention Task Forces" (MS-WORD; 4 pp)
Read this before you set up or join any such group.

"What is your Suicide Prevention Planning IQ?" (MS-WORD; 1 p.)

"Some Thoughts on Suicide Prevention from a Suicide Loss Perspective" (MS-WORD; 1 p.)

**"Putting Suicide on the Community Mental Health Agenda" (MS-WORD; 2pp.)
(Initial draft of article published in *NAMI Advocate* (Summer 2006)**

"Literally Dying for a Drink" (MS-WORD; 3pp.)

About the Suicide Paradigm

The paradigm concept is the idea that in any field there is a set of assumptions shared by those in the field. The paradigm defines the field and shapes the rules of the game. The concept was introduced by Thomas Kuhn in *The Structure of Scientific Revolutions* (1962).

A paradigm determines what gets taught and studied, the methods, and how the findings are interpreted. It defines the needs addressed, who is served, and how the services are provided. A paradigm supplies "all the answers" to researchers' and practitioners' questions.

A paradigm becomes self-sustaining. It provides continuity and stability. Its tenets are defended and change is resisted. It becomes more complex and encompassing, but does not evolve.

Paradigms only change through radical and sudden shifts. These occur when new discoveries, knowledge, or concepts arise which cannot be rejected or assimilated by the old paradigm. The new paradigm supercedes the old paradigm.

The study of suicide involves a common paradigm. New findings are laying the groundwork for a new paradigm.

The Suicidal Process

"Suicide does not just occur. Experience has shown that it is more often the end result of a process that has developed over a period of time..." N.L. Farberow

Suicide is the outcome of neurobiological and psychological breakdown. Becoming suicidal is a process that begins in severe stress and pain generated by a serious life crisis.

Stress and pain increase as the crisis, or the perception of it, worsens. As this happens, control and self-esteem deteriorate. Depression may be a cause or a side effect of the process.

Suicidality occurs when the stress induces psychological pain so unbearable that death is seen as the only relief. Prior to this point the individual is at risk of becoming suicidal. Beyond it the individual is at risk of completing suicide. Becoming suicidal is a crisis that causes traumatic stress.

Ingrained beliefs and values may cause an individual to be stigmatized by their own suicidality. This leads to shame and guilt. These cause alienation from self and withdrawal from others, which are also drivers.

Suicidality entails changes in brain chemistry and physiology. Suicidal individuals manifest various chemical imbalances. Most notable is depleted serotonin, a neurotransmitter that inhibits self-harm. This is a neurological threshold and those near or beyond it must be treated with medications.

There is no choice. Suicidal individuals are beset by suffering that is distracting and disabling. Suicidality is a state of total pain which limits options to enduring or ending utter agony.

The suicide prevention and suicide loss literature unfortunately continue to allude to suicide as a choice. This is stigmatizing and denies that those lost to suicide are victims of a process that in the end is beyond their control. For a well-researched discussion of this subject see "Judgmental Language That Promotes the Stigma Associated with Suicide".

"Suicide is the end result of a process, not the process itself."

J. Zubin (1974) in A.T. Beck, H. Resnick, and D.J. Lettieri (Eds.) *The Prediction of Suicide*

A New Theory of Suicide

In *Why People Die by Suicide* (Harvard University Press, 2006)Thomas Joiner notes that two conditions must be present to overcome the instinct for self-preservation. The first is a desire to die caused by a lost sense of social belonging and the perception that one is a burden. The second is the capacity for lethal self-harm acquired by experience with abuse, pain, past suicidality, and other factors. Both must be present for a completed suicide.

Penacide: A Name for the Beast

"Suicide" comes from two Latin roots, "sui" (of oneself) and "cidium" (a killing or slaying). This gives us the definition of suicide as the "deliberate or intentional killing of oneself." "Suicide" is inadequate. It omits the role of pain. There is a "killing of oneself," but it is a means to relieve what is seen as interminable pain. To paraphrase: *It's the pain, stupid!* That's what suicide is all about. Here's a better word for the process:

PENACIDE

"Pena" is from the Latin "poena" (punishment or torment), the root of the word "pain." "Cide" is from "cedere" (to strike down). *Penacide is "the killing of pain."* It incorporates the reason, wanting to terminate one's pain. It eliminates the notion that "wanting to die" has anything to do with killing oneself. Penacide is not *a kind of suicide*. It's what causes the deaths recorded as suicides. It is the true name of the beast.

In the almost 10 years since I proposed the term "penacide" it has gradually found its way into uses from frivolous (e.g., somebody's screen name) to scholarly. It is even being considered as the title for a play about youth suicide. I see the word "suicide" as even more stigmatizing and inappropriate given what has been learned about how someone comes to end her/his life.

"I would like to change the word suicide...to suisad, which would mean 'self-sad'... I think that it would be more illuminating than saying that someone has murdered himself... They want to save themselves but 'murder' the sadness."

P. Cantor

The Suicide Loss Grief Process

Suicide grievers struggle with "why" and "what if." Suicide grief is driven by learning. Most of what is encountered is negative and amplifies grief. We see the process in this way:

***Dissonance:* Grieving opens with conflict among what is felt, believed, and heard. Expectations about life are rocked. Healing is encouraged, but there is no leverage. Lack of knowledge about suicide leads to seeking information.**

***Debilitation:* Efforts to make sense of the loss breakdown. Hopes of healing wither. Pain worsens with holidays, birthdays, and the anniversary of the loss. Anger comes from seeing the loss may have been prevented.**

***Depression:* The enormity of the loss fosters disaffection and powerlessness. Severe stress and pain peak and plateau. Relationships become strained and some do not survive. Comfort is only achieved with other suicide grievers. Some interests are lost.**

***Desensitization:* Pain stops growing, and gives way to an interminable ache. Depression lifts somewhat; some energy is regained. Grief remains at a lesser level of acuity, and it is displayed less. Some interests return or emerge.**

***Differentiation:* Next comes self-realization of the consequence of the loss. Suicide grievers grasp a change in their core personal identity. Value and belief systems are recast. This is not healing. It is an accommodation involving a new sense of self.**

This is not a benchmark. There's no road map to guide suicide grievers to where we're going or schedule as to how long it may take us to get there.

A Pain Management Primer

"In almost every case, suicide is caused by pain, a certain kind of pain -- psychological pain, which I call *psychache."* Edwin Shneidman

Among those who are suicidal, pain is *the* problem. Much of what has been learned about dealing with physical pain applies to *psychache*. Psychological pain is underassessed and undertreated. More attention is paid to the causes than to the pain itself. Suicidal individuals are left to contend with pain alone.

Severe pain has the same impact both physically and psychologically. Anxiety, sleeplessness, fatigue, depression, and anger set in. These modify and aggravate the pain . They elicit changes that increase stress which further drives pain. Severe pain is destructive.

Worsening pain attacks self-control and self-esteem. It generates fear and powerlessness. It creates a sense of profound isolation.

Pain overwhelms coping and leaves helplessness in its wake.

Pain travels in the company of suffering, which has been defined by Cassell as "a state of severe distress induced by the loss of intactness of person or by a threat that the person believes will result in the loss of... intactness." Suffering is where pain and suicide meet.

Suicidal individuals and those with chronic pain share the same experience. Recurrent stress and intense pain decreases endorphin (natural substances that relieve pain) levels in the brain. This increases their vulnerability. This must be offset. This is the function of pain management.

Time is critical with suicidal individuals. They are in jeopardy and may be within hours or days of succuming to their condition. Immediately impacting their pain is the only way to save their lives.

"Any person has the potential to become suicidal when confronted with a situation that produces emotional pain and is believed to be inescapable, interminable, and intolerable."

J. A. Chiles and K. Strosahl (1995) *The Suicidal Patient: Principles of Assessment, Treatment, and Case Management*

In Memory of My Son

Paul 1968-96

The Parents Left Behind

**Forever mourning the lost child
Forever lamenting the lost dream
Forever facing the hole in the future
Forever feeling the hurt in the heart
Forever reliving the unbearable horror
Forever regretting the act not done
Forever searching for the reason
Forever seeking release for the love**

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