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SHNEIDMAN'S CONTRIBUTIONS TO THE UNDERSTANDING OF SUICIDAL THINKING

DAVID A. JOBES AND KATHRYN N. NELSON

In 1949, Edwin S. Shneidman, running a half-hour errand for his boss at the Veteran's Administration (VA) hospital, found himself in the vaults of the coroner's office in Los Angeles. At the relatively tender professional age of 31, young Shneidman's simple errand became a life-changing event—for him and for the larger pursuit of suicidology and suicide prevention as we have come to know it today. As Dr. Shneidman (1991) recalled,

> The fulcrum moment of my suicidological life was not when I came across several hundred suicide notes in a coroner's vault while on an errand for the director of the VA hospital, but rather a few minutes later, in the instant when I had a glimmering that their vast potential could be immeasurably increased if I did *not* read them, but compared them, in a controlled blind experiment, with simulated suicide notes that might be elicited from matched nonsuicidal persons. (p. 247)

Shneidman later ventured back to the vault in the coroner's office and received permission to use 721 suicide notes for research purposes. With his friend and colleague Norman Farberow, who had that year received his PhD

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from the University of California at Los Angeles, a line of seminal research in the study of suicide notes was launched; in that moment, contemporary suicidology was born.

Shneidman and Farberow's initial suicide note research collaboration would ultimately spawn much of what now defines and shapes suicidology and suicide prevention today. Drs. Shneidman, Farberow, and Robert Litman (along with key staff colleagues Tabachnick, Heilig, Klugman, Wold, and Peck) founded and created the fabled Los Angeles Suicide Prevention Center (LASPC), a veritable suicidology Garden of Eden. This group of innovators simultaneously initiated new lines of empirical suicide-related research, generated whole lines of new theory, and created a wealth of clinical wisdom pertaining to working with suicidal individuals.

In retrospect, it is difficult to appreciate the full impact and scope of Shneidman's various and considerable contributions. Indeed, much of the language that we commonly use in suicidology—the word *suicidology*, for example—was either directly coined by Shneidman or indirectly shaped by his thinking, intellectual influence, and scholarly contributions. Shneidman is well known, even infamous, for his many neologisms. Beyond the core term of suicidology, Shneidman is also credited with developing many additional words and terms in the field, including *psychological autopsy*, *postvention*, *subintentioned death*, *perturbation*, and *psychache*, among others. To complete the full picture of contributions and to contextualize his role in the field, it is important to further note that Shneidman was the founding president of the American Association of Suicidology in 1968 as well as the founding editor in chief of that organization's premier scientific journal *Suicide and Life-Threatening Behavior*.

When one considers Shneidman's historic contributions to the contemporary psychological understanding of suicide and the larger suicide prevention movement, it is obvious that an examination of his contributions to the area of suicidology is essential to the current text. To that end, Shneidman has said a great deal about the role of cognition and has many ideas regarding suicidal thinking.

Throughout his career in suicidology, Shneidman's theoretical work has consistently and directly addressed cognitive aspects of suicide. Furthermore, his research has unfailingly examined, either directly or indirectly, cognitive processes and the inherent nature of suicidal thinking. Moreover, much of his clinically oriented writing addresses cognitive aspects of the suicidal mind with insights about how one best approaches, assesses, and treats a patient who entertains thoughts of ending life.

We must observe, however, that Shneidman would never call himself a cognitivist, either in terms of theoretical approach or in terms of clinical practice. Unquestionably, he ardently represents himself as a passionate mentalist; he holds the fervent view that suicide exists as a phenomenon of the mind. In this regard, Shneidman is captivated by introspection and phenom-

enology and stresses the psychology of suicide as it exists in mentation. To this end, Shneidman (2001) said,

> My view [of suicide] is definitely mentalistic. I believe that suicide is a matter of the mind. The mind—that mysterious microtemporal substance-free "secretion,"—has a mind of its own; the main business of the mind is to mind its own business. When it comes to suicide—which is my main business—I am a 21st-century mentalist. (p. 201)

Certainly, cognition is implicated in Shneidman's psychology of suicide, but it is not a core feature in Shneidman's thinking. As we shall make plain in the course of this chapter, cognition in Shneidman's view is but a crucial piece of the whole mental pie of suicide and is deeply implicated in suicidal states. Yet without equivocation, in Shneidman's worldview of suicide, the sun, stars, and moon all rise and set on one central construct—*psychache*. As Shneidman (2001) put it,

> I believe that suicide is essentially a drama in the mind, where the suicidal drama is almost always driven by psychological pain, the pain of negative emotions—what I call *psychache*. Psychache is at the dark heart of suicide; no psychache, no suicide. (p. 200)

The reason for strongly emphasizing Shneidman's perspective as a passionate mentalist is not to minimize his work related to cognition and suicide—because it is considerable—but to represent, frame, and contextualize accurately this particular aspect of his work within the totality of his psychological approach to understanding suicide. In other words, even though Shneidman is not a self-defined cognitivist as such, he nevertheless has had a great appreciation for the key role that cognition plays in the total psychology of suicide.

In this chapter, we thus endeavor to present a balanced, thoughtful, and contextualized picture of Shneidman's contributions to our understanding of suicidal thinking, with a particular emphasis on his contributions that are most specific to cognition. At times we may take certain liberties when interpreting some of this work, as we endeavor to attend to the focus of the current text (i.e., cognition and suicide). For example, this chapter began with the story of a young Shneidman wandering through the vault of the coroner's office considering the potential importance of researching suicide notes. As noted, this fateful spark of a research idea ignited an entire field of study and spurred a larger movement in society—that we should earnestly, purposefully, and methodically endeavor to prevent the tragedy of suicide. Beyond this aspect, however, the importance of the Shneidman and Farberow studies of suicide notes cannot be overstated. For what are suicide notes if not the final psychological considerations, musings, feelings, requests, communications, thoughts—*cognitions*—of the suicidal person? As a written testament to an individual's tragic suicidal end, the study of suicide notes his-

torically marked a significant beginning for the study of suicide as a larger field and, as we shall see, it also fundamentally shaped Shneidman's thinking and views on the topic of suicide. To that end, we explore some of Shneidman's key theoretical, empirical, and clinical contributions to historic as well as contemporary suicidology.

SHNEIDMAN'S THEORETICAL WORK RELATED TO COGNITION AND SUICIDE

Shneidman's theoretical contributions to our understanding of cognition and suicide are both direct and indirect. In terms of direct contributions, we are referring to those aspects of his work that speak specifically to and directly address the nature of suicidal cognitions. Our discussion of the so-called indirect contributions includes those aspects of Shneidman's theoretical work that have shifted and shaped new and different ways of psychologically understanding how suicide actually occurs. To this end, we emphasize here a few of these theoretical contributions including (a) the logic of suicide, (b) the 10 commonalities of suicide, (c) cognitive constriction and suicide, (d) the cubic model of suicide, and (e) aphorisms of suicide.

The Logic of Suicide

Shneidman was among the first to truly explore the thinking process of the suicidal individual, what he called the "logic" of suicide (Shneidman, 1959). This was to be an area of theoretical work that Shneidman would pursue throughout his career in suicidology. Writing about the logic of suicide, Shneidman (1985) asserted the following:

> Figuratively speaking and from the point of view of logic, the suicidal individual hangs himself from his major premise and makes an erroneous deductive leap into oblivion . . . reason is as much a part of suicide as emotion is. Just as emotions may feel "necessary" at the moment of their expression, so illogical conclusions may seem "sensible" when they occupy and sway the mind. (p. 136)

This particular quote marks the beginning of Shneidman's discussion of cognitive aspects of suicide in his important 1985 text, *Definition of Suicide* (Shneidman, 1985). What follows is a far-reaching discussion of the phenomenological nature of suicidal thinking and how an individual's style of reasoning, cognitive maneuvers, and beliefs fundamentally shape virtually every suicidal act. As Shneidman noted,

> There is no single suicidal logic; however, there are features of logical styles and ways of mentating that facilitate (even predispose) suicidal behavior. I call these kinds of reasoning catalogical because they are de-

> structive; they are destructive not only in the sense that they abrogate the rules for logical and semantic clarity, but they also destroy the logician who thinks them. (p. 137)

In a synopsis such as this, it is critical to quote Shneidman's own words at length to highlight his unique and idiosyncratic way of considering the topic of suicide. It is plain to us that no one talks or writes about suicide quite the way Shneidman does. Sometimes overly complex and elliptical, his writing invariably challenges the reader to think and rethink what they thought they knew. In challenging his readers to think, Shneidman also compels them to consider their preexisting assumptions and open their minds to the potential worth of his ideas. Frankly, his writing is occasionally elusive and sometimes overly complicated; we find that some of his work requires multiple readings to really grasp the essential points. However, Shneidman's theorizing and writing is often clever and imaginative. For better or for worse, although many suicidologist scholars have said similar or related things as Shneidman, virtually no one in the field has synthesized and elaborated on the theory and perspective on suicide with quite the depth and scope as Shneidman. Thus, in discussing the logic of suicide to his readers, Shneidman customarily and characteristically endeavors to open new doors of theorizing, inspire new lines of empirical research, and challenge clinicians to consider, reconsider, and perhaps change how they clinically engage a person who entertains thoughts of suicide.

The 10 Commonalities of Suicide

In the previously mentioned text, *The Definition of Suicide*, Shneidman (1985) distilled and crystallized his thinking around the notion that completed suicides tend to share much in common. Specifically, Shneidman outlined what he calls the 10 commonalities of suicide. These common characteristics include the following:

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

The field of suicidology for many years has struggled to define the characteristics (e.g., risk factors) that are consistent across suicides while simultaneously working toward understanding individual differences in the pursuit of creating typologies, subtypes, or making sense of atypical suicides. In the midst of this struggle, Shneidman's 10 commonalities provide a relatively concise way to think about a coherent core of interrelated constructs that define, organize, and synthesize the essential psychology of virtually every suicidal act.

Among the 10 commonalities, the seventh specifically speaks to cognition as it pertains to the completion of suicide. Commenting on this particular commonality, Shneidman (1985) said,

> I am not one who believes that suicide is best understood as a psychosis, a neurosis, or a character disorder. I believe that it is much more accurately seen as a more or less transient psychological constriction of affect and intellect. Synonyms for constriction are a tunneling or focusing or narrowing of the range of options usually available to *that* individual's consciousness when the mind is not panicked into dichotomous thinking: either some specific (almost magical) total solution or cessation; all or nothing . . . the range of choices has narrowed to two—not very much of a range. The usual life-sustaining images of loved ones are not disregarded; worse, they are not even within the range of what is in the mind. (pp. 138–139)

Cognitive Constriction

Shneidman's theoretical work and elaborations on cognitive constriction are among his most enduring contributions. When Shneidman talks about the logic of suicide, the critical role of cognitive constriction is readily apparent. In many of his works, Shneidman endeavored to identify, describe, and portray the nature and processes of constricted suicidal thinking—a tunneling and narrowing of perspective, a dangerous reduction of the person's range of problem-solving options (e.g., Shneidman, 1993). In his description of "psychological myopia," Shneidman depicted an insidious process whereby constricted dichotomous thinking leads the suicidal person into a desperate psychological space. Closely connected to the dangerous psychological state of cognitive constriction is Shneidman's notion of *perturbation*. For Shneidman (1993), the concept of perturbation most directly and principally refers to a state of being emotionally upset, disturbed, and disquieted—often a state most notable for its proclivity for action. In relation to suicide, perturbation also implicates cognitive constriction wherein he argues that acute suicidal states are driven by this intense penchant for self-harm or ill-advised action. In this state of emotional upset, cognitive constriction often contributes to a rapid reduction and deconstruction of the patient's perceptual and cognitive range of problem solving, resulting in black-and-white dichotomous thinking (e.g., endless suffering vs. immediate and eternal relief).

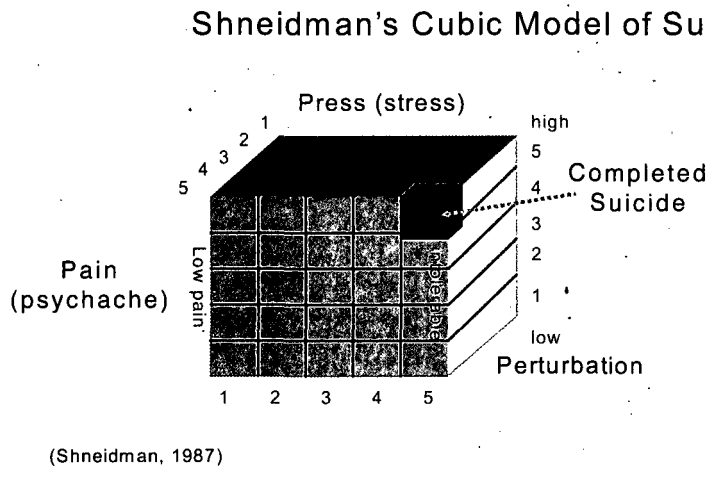

Figure 2.1. Shneidman's cubic model of pain–press–perturbation. From "A Psychological Approach to Suicide," by E. S. Shneidman, 1987, in G. R. Vandenbos and B. K. Bryant (Eds.), *Cataclysms, Crises, and Catastrophes: Psychology in Action.* Washington, DC: American Psychological Association. Copyright 1987 by the American Psychological Association.

The Cubic Model of Suicide

Shneidman's (1987) cubic model of suicide conceptualizes suicidal behaviors as occurring from a confluence of three psychological forces that exist on three axes. As shown in Figure 2.1, the first axis in this cubic model is unbearable psychological pain (the previously mentioned core notion of psychache) that can be rated from *low* (1) to *high* (5). The second axis is that of unrelenting psychological pressures (refer to Murray's 1938 notion of "presses") or stressors that can be rated from low to high (1–5). The third axis is the previously mentioned perturbation construct, also rated from low to high (1–5). Within this cubic model, Shneidman asserted that every suicidal person completes the act of suicide by being at the maximum levels of pain, press, and perturbation—the 5–5–5 corner cubelet of the model. He allowed that not every person who is in this cubelet will necessarily commit suicide but insisted that every person who commits suicide is psychologically in this cubelet at the time of the act.

One of the essential virtues of the cubic model is that it creates a three-dimensional method of conceptualizing suicidal behavioral events. This model makes clear that suicidal behaviors are fundamentally situation specific; there is always a synergy of events, circumstances, psychological suffering, and upset that come together at a critical point in time to create a lethal behavioral moment. Within a relatively simple three-dimensional model, Shneidman described what he believes creates the decisive suicidal act. In so doing, he moved us beyond exhaustive one-dimension lists of suicide risk factors that

actually predict very little. Conceptually sophisticated, comprehensive, researchable, and clinically useful, the cubic model is emblematic of Shneidman's work.

Aphorisms of Suicide

Shneidman (1984) has offered a range of aphorisms pertaining to suicide that are noteworthy and provide further theoretical insight on his general views about suicide. Although we do not recount all 20 of his original aphorisms, a few are particularly notable as we round out our consideration of his theoretical contributions. For example, consider the following four aphorisms of suicide:

1. There are two basic, albeit contradictory, truths about suicide: (a) suicide should never be completed when one is depressed (or perturbed or constricted); and (b) almost every suicide is completed for reasons that make sense to the person who does it.
2. The primary thought disorder in suicide is that of a pathological narrowing of the mind's focus, called constriction, which takes the form of seeing only *two* choices: either something painfully unsatisfactory *or* cessation.
3. There is nothing intrinsically wrong (or aberrant) in thinking about suicide; it is abnormal only when one thinks that suicide is the *only* solution.
4. The chief shortcoming of suicide is that it unnecessarily answers a remediable challenge with a permanent negative solution. In contrast, living is a long-term set of resolutions with oftentimes only fleeting results.

SHNEIDMAN'S RESEARCH CONTRIBUTIONS RELATED TO COGNITION AND SUICIDE

Although Shneidman is perhaps best known for his theorizing and his contributions to clinical work with suicidal patients, he has been an active empirical researcher throughout his career. Indeed, his research contributions are considerable, and his research and theories have sparked additional empirical work among many other suicidologists as well. Although not all of Shneidman's research bears directly on the study of suicide and cognition, we have opted to present a broad overview of his research to contextualize the cognitive aspects of his work. As noted further on, Shneidman's first empirical research was in psychological assessment, but for our purposes we begin our discussion where we began this chapter, examining his initial empirical work with Norman Farberow in the study of suicide notes.

Suicide Note Research

As previously noted, Shneidman's formal work in suicidology began in 1949 when he discovered a trove of suicide notes in the Los Angeles County Coroner's Office. What he later called "a scientist's dream," Shneidman quickly realized that suicide notes held a wealth of extraordinarily useful information about the inherent nature of suicide in the precious final moments that preceded self-inflicted suicidal death.

In their first controlled studies of suicide notes, Shneidman and Farberow (1957a, 1957b) developed methodologies that uncovered critical early psychological knowledge about suicide. In their studies comparing genuine versus simulated suicide notes along with studies using other methodologies, these early pioneers in suicidology found that hate directed toward others and self-blame were both evident in the notes they studied. Their investigations of suicide notes showed that suicidal persons were deeply ambivalent. Moreover, within the context of this ambivalence, suicide could be understood as the turning of outward murderous impulses against the self. Wishes and needs that had previously been directed against a traumatic event or toward someone who had rejected the suicide completer were inverted and directed at the self. Thus, suicide was understood as a form of veiled or overt aggression against the self—"murder in the 180th degree" (Shneidman, 1985).

Shneidman and Farberow (1960) went on to further analyze 948 suicide notes obtained in a 3-year period in the Los Angeles area. They deduced that the reasons indicated for suicide vary with the type of area in which the person lived. In Area Type I (most advantaged suburbs), the suicide notes depicted people who were tired of life; in Area Type III (most advantaged apartment areas), the notes frequently noted illness as a reason for suicide; Area II was unremarkable. Shneidman and Farberow concluded that those from moderately advantaged areas expressed the most emotion in their notes and might have benefited most from psychotherapy. Those from the least advantaged areas seldom gave reasons for their suicide but usually gave instructions for disposition of their corpse or their estate. (A little-known anecdote: In the early 1990s, Shneidman returned to the Los Angeles County Coroner's Office to determine whether the contents of suicide notes had changed. He concluded that they essentially had not; Shneidman, 1996b.)

Shneidman also researched the actual writing of suicide notes and how they may or may not predict a completed suicide. In 1973, Shneidman described suicide notes as "dull and poignantly pedestrian" (p. 390). He suggested that a person who could write a meaningful suicide note would not be in the position of completing suicide. In a similar vein, Shneidman (1972) presented samples from 100 self-obituaries elicited from college students in 1969. He concluded that the young have difficulty in objectifying themselves or seeing themselves as dead, as evidenced by their difficulty in completing the task.

Descriptive–Risk Factor Studies

In 1966, Farberow, Shneidman, and Neuringer established that "suicide-significant" variables were found in the life history and hospital records of 218 male mental hospital patients who had completed suicide in comparison to 220 control patients. They determined that the following areas could discriminate between the two groups: population characteristics, diagnoses, early childhood, marital histories, educational achievements, military history, and prehospital and hospital difficulties. In 1955, Farberow and Shneidman reviewed anamnestic and psychiatric data for attempted, threatened, and completed suicide cases. They concluded that "the dangerous patient, suicidally speaking, is the one with a history of previous suicidal attempts or threats, and that the most dangerous period is when the patient appears to have recovered," a notion that foreshadowed solid empirical evidence that would appear decades later (e.g., Joiner, Rudd, Rouleau, & Wagner, 2000).

Eisenthal, Farberow, and Shneidman (1966) conducted a follow-up study of 912 patients in a VA Neuropsychiatric Hospital who had been placed on suicide observation status from 1954 to 1958. Complete data were obtained for 90% of the patients. Forty percent of these patients manifested further suicidal behavior, 6% completed suicide, 17% made nonlethal attempts, and 17% reported suicidal ideation. Suicide history, demographic information, and psychiatric hospitalization did not discriminate any of these groups. The researchers concluded that the ability to predict a suicide was a modest 8% to 13%, whereas the best predictors for an attempt ranged from 23% to 29%. They concluded that in this particular population, suicide is more likely to occur than in the psychiatric hospital or general population (Eisenthal et al., 1966).

Terman Longitudinal Data

Shneidman used a data set archived by the Murray Center originally collected by Terman (1922) and his collaborators (Terman, Sears, Cronbach, & Sears, 1922) to study suicide in the intellectually gifted. Using a methodology that included teacher nominations and intelligence testing, 1,470 children in California with an IQ of 135 or greater were selected for further study. From 1927 to 1928, 58 siblings of the participants were added as a comparison control group. Of the 1,528 participants in the study, 856 were boys and 672 were girls; the average date of birth for the sample was 1910. In 1922, parents filled out an extensive questionnaire describing the child's birth, previous health, education, social experiences, interests, and conduct. The children's teachers filled out a comparable questionnaire. The children took a battery of intelligence, achievement, and personality tests and answered questionnaires about their interests and their knowledge on a range of issues.

Comparable data were subsequently collected at 4-year intervals. In 1972, 1977, and 1982, the follow-up data collections were increasingly oriented to problems of aging—issues of life satisfactions, retirement, living arrangements, health, and vitality. The data collected in 1986 included questions about changes in well-being, time use, importance of religion, perspectives on life accomplishments, and changes in family relationships, concerns, and goals. Shneidman (1971) analyzed 30 cases from this data set for which longitudinal personality data were available from 1921 to 1960. All individuals studied were male Caucasians with high IQs. Five had died by suicide (all by gunshot), 10 (matched) individuals had died natural deaths from cancer or heart disease, and 15 were still living. A blind clinical analysis was conducted primarily in terms of two of Shneidman's guiding concepts—perturbation and lethality—by means of a Meyerian "life chart" and a "psychological autopsy," respectively. Results indicated that four of the five individuals deemed to be most suicidal had, in fact, completed suicide, a chance probability of 1 out of 1,131. Shneidman concluded that some prodromal clues to these suicides were instability, trauma, and certain personality traits. The role of the "significant other" and the "burning out" of affect seemed prominent. He further concluded that a suicide in a 50-year-old person could be seen as a discernible part of a lifestyle, as well as a predictable outcome, by the time that person is 30 years of age—a precursor to Maris's (1981) notion of the *suicidal career*.

Psychological Testing

Shneidman became deeply involved in personality testing research in the early stages of his professional career. He was particularly interested in projective personality assessment and even invented his own test called the Make-A-Picture Story (MAPS). The MAPS test (Shneidman, 1949, 1952) was developed to assist the practitioner in arriving at differential diagnoses and lead to a deeper understanding of individual psychodynamics. The basic test material of the MAPS consists of 21 background pictures printed achromatically on thin cardboard and 67 figures and was used with adolescents and adults. Shneidman himself used this extensively (e.g., Shneidman, 1948a, 1948b); others (e.g., Heuvelman & Graybill, 1990; Nueringer & Orr, 1968) applied the MAPS test to various studies of psychopathology.

Shneidman's first study using MAPS analyzed the formal responses of 50 normal and 50 psychotic individuals to the MAPS test. These responses were compared on the basis of approximately 800 "signs," such as figure number, repetition, placement, selection, interaction signs, activity, meaning, chronology, background, and time. Of the approximately 800 "signs," 64 differentiated the normal and psychotic groups at the 10% level of confidence. On the basis of these "significant signs," Shneidman (1948a) concluded that schizophrenia can be extremely variable and that there is evidence of ex-

treme interest in the self, social isolation, and an absence of being bounded by the dictates of reality. His research showed that individuals with schizophrenia overused symbols, inhibited and repressed aggression, had anxiety and fearfulness, and (among male patients) lacked identification with the male role and had a tendency to debase or degrade women.

In 1986, Shneidman gave the MAPS Test to 14 undergraduates who were studied intensively at the Harvard Psychological Clinic by Henry Murray and his colleagues during the years from 1959 to 1962. A protocol of a Harvard senior was presented to illustrate the use of the MAPS in drawing inferences about personality characteristics such as aggression, sociability, and achievement.

In terms of other personality assessment research, Shneidman and Farberow (1958) began to look at data from patients' responses to the Thematic Apperception Test (TAT) and how this assessment tool related to suicidality. They drafted the first report of the results of TAT data obtained from patients who either attempted or completed suicide and compared them with similar data obtained from nonsuicidal patients. They concluded that exclusive use of the TAT could not successfully discriminate suicidal versus nonsuicidal patients.

As we have discussed previously, Shneidman's theoretical work on psychological pain and suicide is one of his central and lasting contributions (Shneidman, 1996b). To this end, Shneidman developed the Psychological Pain Survey in an attempt to measure or quantify psychache (Shneidman, 1993). To create this assessment approach, he used the Method of Paired Comparisons, in which an incident, such as one from a Nazi concentration camp, is cited as an anchor point of extreme psychological pain and the suicidal person is asked to rate his or her own psychache compared with the incident (Shneidman, 1993, 1999). The suicidal person rates the psychological pain of a person in various stimulus pictures of suffering individuals on a Likert scale from 1 to 9. The individual then rates his or her own pain on the same scale using comparison rating as a psychological reference point.

Outgrowths of Shneidman's Theory and Research

Dozens of empirical studies have drawn directly from Shneidman's earlier theoretical and empirical work. For example, a considerable amount of empirical work has been done on suicide notes, as well as Shneidman's notions of psychache, the 10 commonalities of suicide, and the cubic model of suicide, to name but a few of Shneidman's ideas that have spawned lines of empirical inquiry.

Suicide notes continue to be a rich source of data on the psychology of suicide. For example, Leenaars has conducted a series of studies over the years using and extending various methodologies developed by Shneidman and Farberow (Leenaars, 1988a, 1989). Some more recent studies have continued to expand on ideas originally developed in Shneidman's early work in

this area (e.g., Bauer et al., 1997; Black, 1993; Diamond, More, Hawkins, & Soucar, 1995; O'Connor & Leenaars, 2003).

An excellent example of recent empirical work inspired by Shneidman's theorizing in psychological pain comes from Dr. Israel Orbach and colleagues (Orbach, Mikulincer, Gilboa-Schechtman, & Sirota, 2003; Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003). These researchers have conducted a series of studies using factor analysis to study intensively the nature of psychological pain and how such pain differentiates suicidal patients from other clinical samples. Additional interest and empirical work using the psychache construct can be seen in other recent work. For example, Berlim et al. (2003) have examined the role of psychache in a sample of suicidal outpatients with mood disorders in Brazil, and Zimmerman (1995) studied psychache to determine whether it covaries with social welfare and suicide rates.

Various studies of commonalities across suicides have appeared throughout the literature. For example, although certain patterns of constructs in young adults' suicides may differ psychologically from older adult patterns, significant commonalities of suicide cut across the adult life span (Bauer et al., 1997; Leenaars, 1988a). However, Werth (1996) has directly challenged Shneidman's list of 10 commonalities and asserted that it is inherently biased against allowing for the possibility of rational suicide.

Jobes and colleagues (Jobes, Jacoby, Cimbolic, & Hustead, 1997) used a variety of ideas from Shneidman's work in their development of the Suicide Status Form (SSF) and a subsequent use of the SSF in a clinical approach called the Collaborative Assessment and Management of Suicidality (CAMS); refer to Jobes (2000) and Jobes and Drozd (2004). Indeed, Jobes and colleagues (2004) further studied qualitative phenomenological descriptions of suicidality as per written responses to incomplete sentence prompts about a suicidal patient's psychache, press, and perturbation. These researchers have shown that open-ended patient-written descriptors of these constructs can be reliably coded into meaningful content categories. Moreover, one recent clinical study of various psychological constructs has clearly shown that psychological pain was ranked by a sample of suicidal outpatients as the number one problem related to their suicidality (Jobes, 2003).

Shneidman is probably best known for his theorizing and clinical wisdom on suicidal patients. A closer examination of his extensive empirical work, however, reveals both groundbreaking methodologies and many findings that preceded more recent findings in the contemporary research literature. Perhaps even more valuable, his research and theories have sparked additional follow-up investigations in support of his work and have also led other researchers to challenge some of his ideas as well. Not to acknowledge the empirical researcher in Shneidman is to miss a critical component of what made his scholarly contributions so influential.

SHNEIDMAN'S PRACTICE CONTRIBUTIONS RELATED TO COGNITION AND SUICIDE

A practicing clinician throughout his professional life, Shneidman has written extensively about clinical practice with suicidal patients and recounted numerous case examples throughout his writing. In examining his work, we again find that Shneidman does not specifically and directly emphasize a "cognitive therapy" approach with suicidal patients. When his work is examined through a cognitive lens, however, a great deal of his writing on clinical suicidology either directly or indirectly addresses and underscores cognitive aspects of suicidality. For example, more than 2 decades ago, he (1985) wrote,

> The main point of working with a lethally oriented person—in the give and take of talk, the advice, the interpretations, the listening—is to increase that individual's psychological sense of possible choices . . . with this in mind—and keeping in mind also the four psychological components of the suicidal state of mind (heightened inimicality, elevated perturbation, conspicuous constriction of intellectual focus, and the idea of cessation as the solution)—then a relatively simple formula for treatment can be stated. . . . Simply put, the way to save a highly suicidal person is to decrease the constriction, that is, to widen the range of possible thoughts and fantasies (*from* the dichotomous two—either one specific outcome or death—*to* at least three or more possibilities for an admittedly less-than-perfect solution), most importantly—without which the attempt to broaden constriction will not work—to decrease the individual's perturbation. (pp. 141–142)

In this quote, we see Shneidman's clear emphasis on working on the cognitive aspects of suicide; indeed, it seems to be quite a central aspect to his clinical approach. Across his writing on clinical practice with suicidal individuals, Shneidman has advocated a thoughtful, strategic, and incremental approach to persuading, convincing, inviting, entreating, and cajoling the patient to reconsider suicide. The goal is to help the patient to chart a possible new course of action for dealing with the psychological pain—from the necessity of death to the possibilities inherent in a reconsidered life. In our effort to elaborate on Shneidman's clinical contributions, we march our way through work related to the clinical applications of the 10 commonalities, the cubic model, psychotherapy maneuvers, as well as Shneidman's notion of pain-oriented psychotherapy, which he calls "anodyne therapy."

Clinical Responses to the 10 Commonalities

In relation to our earlier theoretical discussion of Shneidman's 10 commonalities of suicide, Shneidman (1985) noted the distinct clinical implications of this theoretical work. As he observed, the 10 commonali-

EXHIBIT 2.1
Shneidman's 10 Commonalities of Suicide

Commonality	Clinical response
1. Stimulus (unbearable pain):	*Reduce the pain.*
2. Stressor (frustrated psychological needs):	*Fill the frustrated needs.*
3. Purpose (to seek a solution):	*Provide a viable answer.*
4. Goal (cessation of consciousness):	*Indicate alternatives.*
5. Emotion (hopeless–helpless):	*Give transfusions of hope.*
6. Internal attitude (ambivalence):	*Play for time.*
7. Cognitive state (constriction):	*Increase the options.*
8. Interpersonal act (communication of intent):	*Listen to the cry, involve others.*
9. Action (egression):	*Block the exit.*
10. Consistency (with lifelong patterns):	*Invoke previous positive patterns of successful coping.*

ties (see Exhibit 2.1) have obvious and practical clinical implications for saving a life.

Shneidman (1980) observed that suicidal patients are invariably keen on *doing something*. Knowing this simple fact is critical to shaping clinical treatment with suicidal patients. In Shneidman's view, the clinical suicidologist should not be at all hesitant to go about doing a number of such "somethings" to avert a suicide. Clinically responding to the 10 commonalities listed earlier is very much in that spirit.

The Cubic Model and Clinical Intervention

The clinical application of the cubic model of suicide is a unique way of clinically understanding an acute and lethal psychological state (the 5–5–5 cubelet). In this regard, the clinical implications of this simple model are self-evident. Namely, when the clinician does virtually anything to help move a suicidal patient figuratively out of the corner cubelet of the model, then that patient is shifted in a significantly less dangerous psychological space. Clinically targeting and decreasing psychological pain (e.g., with talk therapy), orchestrating a reduction of felt presses (e.g., a change in job or a medical leave from college), and ameliorating perturbation (e.g., with medication or a calming influence) can be a significant and potentially life-saving clinical response (Shneidman, 1980; see also a case example by Jobes & Drozd, 2004).

Psychotherapeutic Maneuvers

In many of his writings, Shneidman has said that the suicidal patient demands (and should in turn receive) a different kind of clinical relationship. Indeed, as Shneidman (1985) himself said,

> Working with a highly suicidal person demands a different kind of involvement. There may be an important conceptual difference between ordinary psychotherapy with individuals where dying or living is not *the* issue and psychotherapy with acutely suicidal persons as there is between ordinary psychotherapy and ordinary talk. (p. 141)

We want to underscore Shneidman's emphasis (within reason) of psychotherapeutically going the extra mile for the suicidal patient. He has vigorously argued for a strategic and incremental kind of clinical maneuvering. Indeed, in his book *The Suicidal Mind*, Shneidman (1996a) dedicated an entire chapter to discussing 24 psychotherapeutic maneuvers that the clinician can use to match clinical treatment to a suicidal patient's idiosyncratic frustrated psychological needs. Examples of these maneuvers include *establish*, *explain*, *arrange for*, *monitor*, and *explore*—to name but a handful. In this fashion, Shneidman made it clear that the suicidal patient gets fundamentally stuck in his or her psychological suffering, wherein cognitive constriction and perturbation come together to become the figurative lethal psychological noose closing around the neck of the patient. To appropriately respond, the clinician must respond decisively. In 1985, Shneidman said,

> the way to save a person's life is to "do something." Those "somethings" include putting that information (that the person is in trouble with himself) into the stream of communication, letting others know about it, breaking what could be a fatal secret, talking to the person, talking to others, proffering help, getting loved ones interested and responsive, creating action around the person, showing response indicating concern, and, if possible, offering love. (pp. 142–143)

Again, at the risk of taking certain interpretive liberties to keep within the focus of this text, another way of understanding this aspect of Shneidman's clinical approach is to think of it as a version of cognitive restructuring and problem solving. With his overt emphasis on clinically addressing cognitive constriction–dichotomous thinking and active behavioral interventions, Shneidman can at times sound a bit like a cognitive–behavioral enthusiast. However, given that Shneidman is a protégé of personologist Henry Murray, there is no inconsistency here; this particular cognitive aspect of Shneidman's thinking is simply a part of a much larger psychological consideration of the whole (suicidal) person. The point is that Shneidman was among the first to argue for a fundamentally different kind of clinical approach when one encounters a suicidal patient. In this regard, he changed the thinking of his contemporaries and thereby influenced many other clinician–scholars who followed.

Pain-Oriented Psychotherapy

It is fitting to end our chapter with a discussion of Shneidman's (2001) relatively recent bottom-line thinking about psychotherapy with suicidal

individuals. Specifically, we are referring to his concept of *anodyne therapy*. This approach to psychotherapy once again emphasizes Shneidman's keen interest in psychological needs and his primary preoccupation with psychological pain (i.e., psychache) as it pertains to suicidality. Shneidman (2001) summarized the essence of his approach as follows:

> I believe that the rule for saving a life in balance can, amazingly enough, be rather simply put: Reduce the inner pain. When that is done, then the inner-felt necessity to suicide becomes redefined, the mental pressure is lowered, and the person can choose to live. . . . I believe that, in large part, psychotherapy consists in helping the patient reconceptualize the can't's, the won't's, the absolutes, and the non-negotiables of the patient's present firmly held positions; to widen the stubbornly fixed blinders of present perceptions; to think the unthinkable. (p. 201)

The therapeutic cognitive restructuring and a strategic clinical effort to shift and change the thoughts and perceptions of the suicidal patient are obvious.

As described by Shneidman (2001), *anodyne* refers to "an agent (a benign individual acting as helper) that relieves pain" (p. 202). Moreover, Shneidman asserted that the goal of anodyne therapy is not necessarily the cure of mental disease; rather, the emphasis of this approach is on the soothing of the suicidal person's psychological pain. Although anodyne therapy recognizes the fundamental importance of frustrated psychological needs as part of the etiology of suicidality, the treatment is positively oriented in that "it seeks to liberate the individual from narrow, truncating, unhealthy, life-endangering views of the 'self'" (p. 202).

Given Shneidman's insistence that all suicides stem from intolerably felt psychache and the related pain source of unmet psychological needs, the clinician's role is simply to serve as an anodyne—a person who helps relieve felt pain. When clinicians position themselves in such a way that they address and respond to the essential psychological needs that are idiosyncratically distressing to their patients, then heightened perturbation will lessen, the need for escape may decrease, and patients may thus be in a position to choose to live. This notion essentially captures more than 50 years of Shneidman's clinical wisdom on how one best works clinically with a suicidal person.

CONCLUSION

Throughout this chapter, we have endeavored to reveal the considerable contributions of a completely original thinker, scholar, scientist, and clinician. Although we are obviously great admirers of Dr. Shneidman's work, we have nevertheless sought to present his contributions in theory, research, and practice in a balanced and objective manner. We have quoted his own

words at length throughout this chapter to provide a window into the way he thinks and to give the reader a clearer sense of how Shneidman puts things—with his own sense of panache and his idiosyncratic style of writing. Shneidman loves ideas, words, and finding distinctive ways of saying important things. As the founder of modern-day suicidology, Shneidman's legacy is rich and has spurred a vibrant field that works to advance on many fronts including those considered here (i.e., theory, empirical science, and clinical practice). As noted throughout this chapter, even though Shneidman does not consider himself a cognitivist per se, this current volume on cognition and suicide would be notably incomplete without duly considering his cognition-related contributions. Indeed, much of his work directly bears on the topic at hand, and additional aspects of his work have further relevance and meaning when reexamined through a cognitive lens.

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