THE EXISTENTIAL CRISIS CALLED SUICIDE

by

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The very considerable literature on suicide is unwieldy and phenomenologically confusing for the unitiated. The subject is fraught with value judgements and in many societies comes within a taboo system. Most humanistic practitioners know about various forms of ritual suicide as well as religious sacrifices of past cultures.

In the present context in the UK, most helping professionals are not well informed about the subject and generally it is often assumed that suicide can actually be prevented. Probably, real suicide cannot be prevented unless a competely new and different approach is accepted in the culture. At the end of this article I will come back to this theme.

First, it is useful to describe the two different types of suicide which are often confused in discussison. These different forms are well described by Farmer (1980)

a Parasuicide is a type of deliberate self harm which rarely ends in death. The intention is to call for help and attention and not actually to achieve suicide or permanent injury. Parasuicide is often a repeated act to avoid actual conflict resolution.

b Real suicide is a type of deliberater self harm which does frequently end in death. The intent is fully to achieve death and not to remain alive in any way. The mortality rate for those who have tried for real and failed at one attempt is incredibly high - especially within two years of the failed attempt, and usually when everyone thinks that all is well and the 'patient' is cured.

The suicide attempt rate, including successes, failures and cover-ups is estimated at one per million in western society. Actually we do not really know because of difficulties in obtaining accurate data due to the taboos, definitions and so on.

The relationship between suicide mortality and intent is clarified by Aaron Becket al (1975). Obviously there will be some false statistics when, with low intention, a dangerous technique is used. For this reason, the concepts of parasuicide and suicide can get easily blurred. Also, there are

indications that repeated attempts at parasuicide can shift into actual lethal suicide when the person is returned to the same social environment (Stallone et al 1980)

When high lethality

With attempts at real suicide one finds three concomitant factors apparently working together. They are:

1 psychosocial factors
2 psychological factors
3 constitutional factors
(Stone et al 1980)

The psychosocial factors are well known and prodigiously documented in the literature. The most important of these is the factor of living alone or being more or less alone. Tuckman and Young identified the 16 most indicative psychosocial factors back in 1965. A suicide indicator scale using these factors clearly indicated in their research in the USA an enormous increase in death from suicide when many factors were indicated. The increase was from 1 attempt in 100,000 in the overall population, to 6,000 attempts in 100,000 when 12 or more psychosocial factors were indicated. Other factors are for instance unemployment, old age, partnership break-up and so on.

The psychological factor most often associated with suicide is depression and especially volatile bi-polar depression with a correspondance between depth of depression and increase in the danger of the method used. (Zung 1968) The attempts and models to help depression are well known and need not be described here. Other factors are for instance, alcoholism, schizophrenia, bereavement, jealousy and anger.

The constitutional factor is called serotonenergetic dysfuntion of the cerebro spinal fluid. This factor is only recently emerging from research though it has been expected for some time. Max van Praag (1982) shows the correspondence between suicides using dangerous methods and serotonenergetic dysfunction in a post mortem study. Further research is in progress.

It would appear that when these three factors operate together, ideas of suicide become powerfully compulsive. From the research of Souris (1982) there is an indication that those who actually intend to commit suicide will not seek help, even if available and they will discontinue medical, psychiatric or other therapeutic assistance. This may well be the reason why the general suicide completion rate is not reduced over time even where such helping institutions as the Samaritans exist.

The long term experience of overfiring of the neurons as a result of lack of serotonin seems to be so 'tiring' that the person simply 'wants out', to find peace in oblivion. This lack of serotonin may well be easily replenished by the food supplement L-Tryptophan, available in any health food shop and complementary medical practioners have been advising its use for years. Adequate research on this is not yet available. I

have myself recommended Tryptophan to my clients for years with completelw satisfactory results.

The role for counselling in parasuicide is clear and the well known no suicide pacts or agreements are very important ways of dealing with thesc. The person attempting parasuicide is basically asking for concrete help. Often they are wanting to change or get away from unacceptable treatment by an oppressive party (especially parents of teenage daughters). Other causes may be displaced conflict resolution and inability to ask for help in other ways.

For real suicide attempters and repeaters, the role for counselling seems to me rather limited and certainbly not indicated if the practitioner is not familiar with the 'dangers' involved. Countertransference, for instance, has been described by Tabachek (1960) as an important factor among suicidal patients undergoing psychiatric treatment. Morgan (1980) even suggests that the rate of successful suicides increases for those who receive psychiatric care. This may well be explained by the seriousness of their depression, however, and the corresponding increase in the chance of being put into psychiatric care. In serious bi-polar depression for instance, the successful suicide rate may be well over 50% when measured over the entire life span.

There are common errors in the treatment of suicidal behaviour. One of these is to assume that ideas of suicide cease when the person is over the crisis. But the most common error is to return the person back into the same social system in which the suicide attempt occurred (Krieper 1976). This common error must be avoided by practitioners if help is to be effective. A decision to die is often a distorted decision to leave.

In the case of intentional suicide, I wonder if our society would be able, remembering its restrictive taboos regarding suicide, to establish some sort of national suicide institute? This would be a place where one could really go and die in dignity. But first, some fairly revolutionary of therapy, such as ritual suicide, powerful psychedelic experiences, near death experiences, survival courses, prayer, worship, exotic ceremonies, Bachanalian festivals and even experience of physical violence would be available in order to give other forms of expression to this destructive thanatic compulsion. Constitutional therapies such as massive doses of serotonin and deep sleep therapy could also be available there. Since at present society does not offer any concrete form of help or treatment for those who really want to die, why not use this thanatic drive itself to provide the therapeutic impulse? We have known for over half a century that most of those who really want to die will eventually kill themselves sooner or later. I feel therefore that it is time now to try something really different rather than to 'be awfully sorry about it' and allow social amnesia to bleach away the issues of collective or even personal responsibility for those who die of suicide attempts.

Research data on suicide is rather limited and in addition the suicide rate is unclear because of problems of definitions, taboos, unexplained accidents and so on. There is at present no 'treatment' for suicide except to sedate the person heavily and/or to force them into a high security psychiatric ward.

Having read about, thought about, worked with and lived with suicide, I feel that the major form of suicide is actually mass suicide - such as happens so tragically in wars. Also the pursuit of material gain in preference to health and happiness, and the lethal loneliness of our environment and countryside.

To me, the acknowledged minor forms of individual suicide are existentially connected with those major forms of unacknowledged mass suicidal tendencies, which in all probability work through the collective unconscious.

Real suicide is, in my opinion, a distorted resolution of this global existential crisis - a crisis which is suppressed and unacknowledged. In therapeutic terms, humanistic psychology needs to establish a framework of experiential techniques so that practitioners may deal with suicidal ideation by encouraging a person to allow this crisis to emerge fully into conscious awareness as an existential issue about the higher meaning and purpose of life and of consciousness itself.

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