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PREJUDICE: A WINDOW TO THE SUICIDAL MIND[1]

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Abstract: Amid the rise of violence during the COVID-19 epidemic and today, episodes of prejudicial attacks and (mass) shootings toward Blacks, Indigenous peoples, Jews, and people with mental disorders, for examples, have become more visible in the United States (US) and Canada; George Floyd is an American example, and Rodney Levi is a Canadian example. Furthermore, reports of (mass) murders and suicides have also increased. In this brief reflection, the question posed is: Is the prejudicial mind and the suicidal mind similar or different? They are violent minds, towards other person/group/community or towards oneself. We explicate the question posed. Historically, psychologist Gordon Allport associated prejudice to categorical (black and white) thinking; in the same way, Aaron Beck, George Kelly, and Edwin Shneidman, three pioneers in suicidology, explained that distorted (hardened) categorical thinking is a hallmark of the suicidal mind. After discussing a number of aspects of the question why the lethal response is attributed outward toward others (*them*) or inward toward oneself (*me*), we conclude that categorical thinking, among other aspects, can be deadly in violence; perhaps the most dangerous (lethal). Therefore, we conclude with a question to the reader: Does the prejudicial mind help to understand the suicidal mind better, and vice versa?

Our question: Is there a similar (or same) mind to the suicidal mind? This is a basic of science; Mill’s method of same/different. From what I have learned, the answer is yes. The violent prejudicial mind can be very similar to the violent suicidal mind. Allow me to explicate.

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Amid the rise in violence during the COVID-19 epidemic, jarring episodes of prejudicial attacks and (mass) shootings toward Black Americans, Asian-Americans, Indigenous peoples, Jews, and police have become a more visible concern, but so too have reports of murder and mass murder (Kim & Phillips, 2021; Meyer, Hassafy, Lewis, et al, 2022; Nivette, Zahnow, Aguilar, et al., 2021) and suicide (Borges, Garcia, Pirkis, et al, 2022; Pirkis, John, Shin, et al., 2021; Tanaka & Okamoto, 2021). This is true in Canada and the US, but also around the world. Whether what we have learned in the US and Canada is true internationally, calls for unique study in each country and its regions (cultures). Are there similarities/differences? Perhaps our thoughts and reflections have relevance for a larger international audience on suicide. In North America, the carnage of crime on national media, such as in *The New York Times* or the *Ottawa Citizen*, can be seen daily. One just has to watch television to witness the violence. One can witness the violence in the cell phone video taken by a brave young black teenager, Darnella Frazier, as we watch the needless death of George Floyd in the US. Shortly after Floyd's death, in Canada, Rodney Levi, a member of the Metepenagiag Mi'Kmaq Nation in New Brunswick, was killed by police while visiting as "a welcomed guest" at his pastor's home. Before, in history, we witnessed racism in the murder of Martin Luther King Jr. and the mass murder of thousands of Indigenous children who died in Canada's notorious residential schools. Therefore, perhaps, we should first look deeper into violence and prejudice.

Violence And Prejudice (with special reference to the hardening of the categories)

The World Health Organization (WHO) (2002) defines violence as:

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (p.5)

Violence is intentional; yet, it can be conscious or unconscious. Prejudice is violence; it can be conscious or unconscious too. There are many factors that can affect our prejudice and bias. It can kill another and/or oneself (so does the suicidal mind). Of course, although all prejudice is violence, there is a lot of prejudice that takes the form of stigmatising or discriminatory thoughts and actions that never go as far as translating into murder or mass murder. This may be true of the suicidal mind; it may never translate into self-murder, but there are acts of stigmatising and discriminatory ideas or actions towards oneself – never suicide, but suicidal ideation or attempt(s), a spectrum of violence towards oneself (*me*).

Prejudice is a feeling or opinion of stigmatic dislike, even hate, directed towards an individual or group because of some characteristic, such as race, ethnicity, sex or occupation. This is solely based on membership in a particular group. "They" (*them*), the ever more another, are seen as weak and inferior. "*Them"* are marked as savages, sinners, criminals, or pigs. Indigenous peoples and Black North Americans, for examples, are believed to be outcasts, and clearly different from the majority "moral" white males (*us*). This is true about stigmatized groups, and this includes police and military personnel/veterans in Canada and the US. There is a growing "superior" group (*us*) encouraging, promoting, and acting out towards expanding groups (*them*); for example, Asian-Americans, Muslims, any immigrant, Indigenous peoples, LGBTQ+ individuals, and front-line health-care workers. The *us* act out violence towards the "inferior" group (*them*), and this includes murder and mass murder.

Perhaps one of the earliest American psychologists to study prejudice was Gordon Allport (1954). Allport defined prejudice as "feeling, favourable or unfavourable, toward a person or thing, prior to, or not based on actual experience" (Allport, 1954, p.6). Allport linked prejudice to categorical thinking, black and white thinking (and this is = the suicidal mind [Beck, 1967; Kelly, 1961; Leenaars, 2006, 2017; Shneidman, 1985, 1999]). In the suicidal mind, the feeling unfolds towards *me;* often not based on evidence-based fact. In both minds, a person or group is either good or bad! Good is typically associated to one's own group (*us*), such as white males, categorically. It is what George Kelly called "Hardening of the categories" (Robert Neimeyer, personal communication, Dec. 24, 2022). Perhaps, it is important that I digress and explicate somewhat Kelly's thoughts (Kelly, 1955, 1961).

George Kelly is perhaps one of the early pioneers in cognitive psychology, who also made some observations on suicide (Kelly, 1961). Kelly anticipated that people were (cognitive) construers of events; events are open to alternative constructions (beliefs, perspectives). Kelly's basic postulate is that a person's processes are psychologically channelled by ways in which he/she anticipates events. Constructs are the way people anticipate (see) events (person, thing, *me*, *us*); a personal construct is a sort of representational scheme which the individual herself/himself creates and into which she/he then attempts to fit events from the environment/context (e.g., self, others, world). A person’s construct system is composed of a finite number of dichotomous constructs or categories. The categories consist of single bipolar distinctions, such as good and bad (or evil or sinner or pig, whatever the person labels the negative pole). Examples of constructs gleaned from the literature (Adams-Webber, 1979; Kelly, 1954) are as follows: good-evil, happy-unhappy, friendly-aloof, honest-dishonest, kind-unkind, safe-dangerous, successful-stupid, moral-immoral, superior-inferior, and strong-weak. Under what Shneidman labelled as perturbation (threat, fear, anxiety, hostility), as we witnessed during COVID years and now, the constructs are hardened, to a point of paralysis. The constructs can be quite hardened, distorted, “all or nothing”, rigid, narrow, simple, to use a few descriptors. Kelly used the term constriction to explain the hardening. “Constriction occurs when a person narrows his perceptual field in order to minimize apparent incompatibilities” (Bannister & Mair, 1968, p.221). Kelly (1955) states: “Constriction is a way of ruling out *other elements.* Just these, and these only, are to be construed” (p.520). The construal (thought, belief, view) is absolute, what Kelly called impermeable, just black and white. “And if the person construes impermeably, he implies, “Just these, and only these are spades” or inferior, or evil, or immoral (Kelly, 1955, p.520). This is what Allport described as the thinking in a prejudicial mind; Shneidman described it in the suicidal mind. The thinking becomes basically dichotomous, what can be seen as “black or white” categorical thinking; using the categories above, the constricted person puts self and/or others in two absolute groups, with the negative pole being only ‘evil, unhappy, aloof, dishonest, unkind, dangerous, stupid, immoral, inferior, and weak.’ For example, in prejudice towards police, an officer is construed as ‘evil, inferior, immoral,’ and so on, all extreme and hardened negatives, and is marked as a “pig”, or “criminal”, whatever. The person shrinks other, self, and world. According to Kelly (1961), suicide is always a constrictive gesture; Allport (1954) noted the same characteristic in prejudice, as the person/group here too only see *them* on only one pole, the negative, such as evil and immoral. According to Shneidman (1980;1985) the “constriction” (which he also referred to as “tunnel vision”) seems to be the major cognitive commonality in suicide. Constriction has been described as hardening of the categories, rigidity in thinking, narrowing of focus, tunnel vision, concreteness, stinking thinking, to give a few descriptors. The person is figuratively “intoxicated” or “drugged” by the constriction; the hardening can be seen in the person’s construal, beliefs, views, logic, and even worldview. Kelly (1961) suggested in this special impermeable mind, the person (whether suicidal or prejudicial) anticipates or expects less and less from her/himself, others, and the world, finding her/himself hopeless and helpless. This, Kelly, Allport, Shneidman and Beck thought resulted in anxiety, and in some violence, towards *them, me* and/or *us*. It is easy to understand, therefore, why, what and how the importance of people, self, whatever, are negated, denigrated, alienated, branded, killed, and so on; an act of violence towards others (*them*) or self (*me*) or both (as in *us*).

Not only Kelly (1961) and Shneidman (1980), but also Beck (1976), Hughes and Neimeyer (1990), Neuringer (1976), and I (Leenaars, 2006, 2017) have argued that this hardened constricted thinking is the most dangerous (lethal) aspect in the suicidal mind, and, if we add Allport, Einstein, King, and the WHO, in the violent prejudicial mind. Furthermore, Kelly has shown that constriction of the categories may make control (of self, other, world) more feasible for a person – 'only Jews are evil' or 'I will always be weak (a burden)' – she/ he, to paraphrase Kelly (1955, see page 519), may stand a better chance of construing them all (Jews, *me*) as one thing and one thing only – namely, "nothing but inferior", for example, about which he /she "*can do one thing only"* (e.g., violence, homicide, suicide) and this list includes prejudice, whether toward *them, us* and/or *me.* Like suicide, prejudice is control!

Although Allport acknowledged that the mind thinks categorically, he showed that it could result in prejudice and even murder. Kahneman (2011), like Allport, believed one must be mindful of the concept of prejudice (or suicide) in general, even in the study of a unique group. One needs to know the general and the unique (Allport, 1962).

Let us offer two more illuminations on prejudice, one by Dr. Martin Luther King, Jr., and the other by Albert Einstein. Dr. King (1963) stated:

> Let us hope that the dark clouds of racial prejudice will soon pass away and the deep fog of misunderstanding will be lifted from our fear-drenched communities, and in some not too distant tomorrow the radiant stars of love and brotherhood will shine over our great nation with all their scintillating beauty.

Yet, the task is huge. As Albert Einstein (2007) stated: "It is harder to crack prejudice than an atom". We think he is correct; it is true about the suicidal mind (Leenaars, 2006). The lethal suicidal mind is a dark cloud of 'rage'; the hope too is the *me* to shine with love and brotherhood or sisterhood. It is hard to crack through the suicidal mask (Leenaars, Dieserud, & Wenckstern, 2022).

The Nature of Prejudice

Let us return to Allport: He believed that a mountain of definitions will not show the depth of the insidious nature of prejudice. Therefore, Allport offered the following dialogue to uncover the treacherousness of the mind in his classical book, *The Nature of Prejudice:*

> *Mr. X:* The trouble with Jews is that they only care of their own group.
>
> *Mr. Y:* But the record of the Community Chest campaign shows that they gave more generously, in proportion to their numbers, to the general charities of the community, then do non-Jews.
>
> *Mr. X:* That shows they are always trying to buy favor and intrude into Christian affair. They think of nothing but money, that is why there are so many Jewish bankers.
>
> *Mr. Y:* But a recent study shows that the percentage of Jews in banking business is negligible, far smaller than the percentage of non-Jews.
>
> *Mr. X:* That's just it; they don't go in for respectable business; they are only in the movie business or run night clubs. (Allport, 1954, pp. 13-14)

We think Allport, like Einstein, is correct. This is, in fact, no different than the suicidal mind that we encounter in our therapy room (Leenaars, 2004). They too use a *Mr. X* logic, but against *me* and sometimes, as in homicide-suicide, against a *me* and an *us* and/or *them.* Yet, this 'atom' will not stop us in our fight against the prejudicial mind or the suicidal mind. Dr. King's solution: The truth shall set us free.

Prejudice is stigma! Stigma is branding. There is tremendous systemic stigma attached to certain ethnic/cultural/religious/occupational groups (*them*). Stigma is a term once used for a mark branded into the skin of slaves or criminals, so others would shame them, especially in public, to murdering them. People with mental disorders know this well. This is true for Indigenous peoples. It is true for women, Jews, LGTBQ+, police, veterans, an endless list, perhaps. "They" are a disgrace, stain, brand. The belief of the prejudicial person or group: 'We are ok; they are not ok' – and in the suicidal mind, the not okay is *me.* This is prejudice, whether outward or inward. As defined by the WHO, it is violence. This can be iatrogenic and, for some, suicidogenic…and it is, indeed, a window to the suicidal mind. Like the prejudicial mind, the suicidal mind is not only suicidogenic (*me*), but can also be iatrogenic (*us* and/or *them*) (as the homicide-suicide of London, Canada police officers David Lucio – Kelly Johnson illustrates [Leenaars, 2017]).

Although there is a great deal of differences between “another person” directed (*them*) and “oneself” directed (*me*), no different than the prejudicial mind, the suicidal mind can be a violent, aggressive mind – towards *me*. Of course, there is also a mammoth difference in homicide-suicide, whether the target is attributed to *us* vs. *them.*

Violence against Oneself vs. against Another Person/Group

A question emerges: What explains why some people use force against themselves (*me*), whereas other individuals, against a person, group or community (*them*)? The answer, as we saw in my discussion on Kelly, may lie in theory; theory is simply an explanation. Historically, it was probably Andrew Henry and James Short (1954) who constructed the best-known theoretical explanation of the relationship between homicide and suicide (Unnithan, Huff-Corzine, Corzine, & Whitt, 1994). Of course, there are differences between homicide and suicide, but there is much to be gained by following Henry and Short, looking at the commonalities (sameness) too. Despite accepting unique differences, both general and specific, we need a unifying model, a best fit theory of violence possible (not perfect) at this time. Unnithan, Huff-Corzine, Corzine, and Whitt (1994) stated the basic argument as:

> that although there are disagreements between homicide and suicide, there is much to be gained from revitalizing the theory developed by Henry and Short. Specifically, there are numerous issues related to lethal violence that can be better addressed—and, in some cases, understood—by working from an integrated model that emphasizes the similarities between self-directed and other-directed violence. . . . We are not, however, advocating a cessation of research that views homicide and suicide as distinct behaviors. Depending on the topic of investigation, this approach may be entirely appropriate and reasonable. Our contention is that for many research questions related to human violence, the goal of explanation will be better served by a theoretical model that explicitly takes into account the connections between homicide and suicide. (p. 5)

For our discussion, this offers an answer. The theory helps to solve some “mysteries” of homicide or suicide or both (and other forms of violence, like prejudice [WHO, 2002]).

To understand suicide, as I have stated, it is useful to understand related topics of violence, especially homicide. This is no different about prejudice, whether outer-directed (*them*) or inward-directed (*me* [and sometimes *us* and/or *them*]). In fact, in the extreme form, suicide and homicide can be seen as interwoven expressions of the same stream, called the *stream analogy* of violence – the difference may be the target.

The stream analogy of lethal violence is not new to this century. In the 1800's two Italian scholars, Enrico Ferri (1884/1917) and Enrico Morselli (1882) were best known for the idea. Many did not agree then, nor today. Emile Durkheim (1897/1951) espoused that "suicide sometimes co-exists with homicide, sometimes they are mutually exclusive" (p. 355). For approximately a century, Durkheim's view dominated sociology and forensic study. Sigmund Freud (1920/1972) in psychology, however, held to a view consistent with the stream analogy. In 1954, Henry and Short resurrected the stream analogy explanation.

Historically, Ferri (1884/1917) and Morselli (1882) noted that different societies (or nations) had different rates of suicide and homicide and raised an important question. Why do persons in some social groups kill themselves more while other groups commit murders more? For example, why do Americans kill others more and themselves less compared to Canadians (Leenaars, 1995)? Given their close geographic and cultural proximity, that fact is worth remembering (Leenaars, 1995; Lipsett, 1990). There are many other differences in violence, suicide and homicide in those two nations. Despite similarities in the Continental Divide, we think that there are also many different views or core beliefs in the US and Canada.

Unnithan et al. (1994), following Henry and Short (1954), suggest that there is a stream of available destructiveness in a society (or culture). They write, "At the individual level, both forms of lethal violence result from a combination of negative life events (frustration, stress) with attributional styles that locate blame either in the self (suicide) or in others (homicide)" (p. 94). Prediction is based, they argue, on attribution. Attribution is a product of situational and cultural factors. The American vs. Canadian culture would highly add to the attribution, prejudice, violence and deaths. What these factors are needs much greater research (Leenaars, 1995).

A Concluding Thought

To return to Allport's illustration: you can feel the prejudice. It is extremism. We also encounter (and feel, through our empathic approach) the extremism in the story and logic of the suicidal person (Beck, 1976; Leenaars, 2004). Prejudicial views towards Indigenous peoples or Blacks or police or people with mental illness (*them*) are not evidence-based. The feeling or views show hardened (distorted) thinking or logic, that results in jumping to conclusions, magnification, and especially black and white (all or nothing) thinking. Categorical thinking is deadly; it kills (Allport, 1954; Beck, 1976; Leenaars, 2006, 2017; Shneidman, 1985, 1999), whether against another person, oneself, or both. When you think that things are only black or only white, there is nothing in between; that is distorted thinking. Examples are good or bad, Christian or sinner, sane or crazy, human or pig, loved or burden. People can and do go to extremes … and this is not only true of the prejudicial mind, but also the homicidal mind, suicidal mind, and the homicidal-suicidal mind. It is a truism of a violent mind.

Perhaps the best-known categorical belief (sometimes called core beliefs) is, "All men are immortal"; the faulty categorical thinking (logic) that follows this premise is as follows: "All men are immortal. Socrates is a man. Therefore, Socrates is immortal." The reasoning is valid, but it is faulty because it begins with a categorical first premise that is false. In the violent person, the first premise is not only false, but can also be harmful and lethal. In a paper on this topic, "People who have committed a certain sin ought to be dead" (Leenaars, 2006), I show how vitally important it is for us to understand the suicidal patient's idiosyncratic categorical logic. The categorical thinking goes like the following; "People who have committed a certain sin ought to be dead. I am a person who has committed that sin. Therefore, I ought to be dead." The attribution is against oneself (*me*). It may now be easy to understand the faulty logic, if the attribution is outward (*them*); such as, "The gay man committed that sin. He ought to be dead." Alternative (hardened) categorical beliefs, for examples, might be: "All Jews only care about themselves and ought to be killed."; "Officers are weak and inferior, and are pigs, and ought to be shot."; "Indians are weak and inferior, and savages, and ought to be dead"; "All students at school hurt me and are evil, and all of them ought to be killed." There is no constructive alternativism. Of course, all humans are not immortal, and all students at our school are not evil, and all officers are not weak and inferior, and all people who committed a certain sin ought not to be dead. However, we need to be mindful that categorical constriction is an essential element of the violent mind, whether against oneself, or another person (to the point of mass murder), and this includes the prejudicial mind. Thus, as Allport, Einstein and King knew, our task is de-prejudicing the world; our task is to really understand the impermeable categorical premise or core beliefs and logic in a violent mind, whether suicidal or homicidal.

A common premise is that something is either black or white (A or not A). Black or white views cause conflict and promote racism, sexism, and murder of oneself or another. They cause secrecy (walls), masking (camouflaging) and (self)deception (Leenaars, Dieserud, & Wenckstern, 2022) and prejudice (Allport, 1954). Categorical (irrational) thinking causes systemic walls (and, as Einstein knew, “it” is hard to crack). As Allport noted, categorical thinking is the hallmark of prejudice, and can result in other-directed violence and homicide or self-directed violence and suicide (Leenaars, 2017). Categorical thinking (cognitions) is the hallmark of the suicidal mind (Beck, 1976; Leenaars, 2006, 2017; Shneidman, 1999). Like in prejudice, hardened thinking may well be one of the most dangerous aspects of the suicidal state (Shneidman, 1985) and the homicidal-suicidal state (Leenaars, 2017). Sadly, it also illustrates the confinements of an impermeable violent mind.

Therefore; a most important word in life and, it seems, in death: if you know the suicidal mind, it can be = the prejudicial categorical mind. It is extremes, towards *them* or *me* (and sometimes, *us* and/or *them*). It is constriction. The suicidal mind and prejudicial mind are both a violent mind. Although there are, of course, many more differences, perhaps more so in the content, than the process of thinking, the prejudicial mind is a good window to the suicidal mind (and vice versa), I have learned. However, I have also learned, following Dr. George Kelly (1955), we can learn more by comparing three “minds” than two “minds”. *Therefore;* how are the prejudicial mind and the homicidal mind alike, and different from the third, a suicidal mind? There is much to be gleaned from the empirical answer, Shneidman, Kelly, and I would think.

Question: Does the prejudicial mind help you to understand the suicidal mind better? If so, it may help you, clinician and researcher, to reach through the hardened suicidal mask! And even perhaps, the prejudicial mind! I think that we can… I have learned that we can reach through the hardened “atom”.

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GENERAL PRACTITIONERS AND SUICIDE PREVENTION

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Abstract: In the paper of Zonda and Lester (2006-2007) the authors have made a basic error in their data analysis. With the appropriate reanalysis of their data, the new results and conclusions will be completely the opposite of the original ones.

I have only recently read the paper by Zonda and Lester (2006-2007) in which they tried to "repeat" the Swedish Gotland study (Rutz et al, 1989a, 1989b, 1992; Rihmer et al, 1995) in Budapest. The authors found that the postgraduate GP training on diagnosis and treatment of depression resulted in A significant increase in the sales of antidepressants in the district (66.000 inhabitants) where the GPs were educated compared to the control district (82.000 inhabitants). However, the suicide rate in the district where the intervention took place remained the same in the year following the training (1999) and increased in the year after (2000). In the control district the suicide rate dropped remarkably in 1999 but increased again in 2000. The authors have concluded that the education of GPs has no impact on the suicide rates (Zonda and Lester, 2006-2007).

However, there is a fundamental error in the data analysis: the determination of the borderline between before and after the GP training (1998/1999) is wrong (Table 1). Zonda and Lester (2006-2007) mention that the GP training in the educated district was in four sessions in the first half of the year 1998. Thus, the most significant effect of the training should have manifested itself already in the major part of year 1998 (or at least in the last 6 months of this year). Therefore to include the year 1998 into the preatraining period is wrong and the correct borderline should be between 1997 and 1998 (Table 2).

Using this method, the results have changed exactly to their opposite; i.e. the suicide rates in the district where the intervention took place dropped dramatically in the two years following the training (the same way as it happened in Gotland (Rutz et al, 1989a, 1989b)). Concerning the control district no relevant changes occurred (Table 2). The average suicide rates in the GP-educated district in the 3-year period before and after the training (1995-1997 vs. 1998-2000) were 30.8 vs 25.0, respectively, while the same figures in the control district were 23.7 vs 25.9, respectively. Looking at the figures of the 6-year period before and the 3-year period after the training (1992-1997 and 1998-2000) the results are similar (educated district: 32.9 and 25.0, control district: 26.1 and 25.9).

There is a well-known connection between untreated depression and suicide, and so the possible causal relationship between the improved skills of GPs and declining suicide rates is supported by the significant increase in the sales of antidepressants in the district where education took place.

To sum up the above, the reinterpretation of the figures in the publication by Zonda and Lester (2006-2007) supports the pioneering findings of the Gotland study (i.e., the data show that educating GPs on the recognition and treatment of depression can help reduce suicide mortality). The main findings of the Gotland study has also been supported by several other studies using more sophisticated methodology both from Hungary (Szántó et al, 2007; Székely et al, 2013) and other European countries (Henriksson and Isacsson, 2006; Hegerl et al, 2021; Mergel et al, 2022).

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Table 1. Suicide rates of the Target (educated) and the Control districts of Budapest (Zonda and Lester, 2006-2007, Table 2.). Inappropriate borderline between before and after the education.

Years	Target (educated) district	Control district
1992	30,8	24,5
1993	35,0	25,7
1994	39,1	35,1
1995	32,1	28,8
1996	32,2	18,6
1997	28,0	23,6
1998	20,8	27,3
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1999	21,0	19,1
2000	33,2	31,4

Table 2. Suicide rates of the Target (educated) and the Control districts of Budapest (Zonda and Lester, 2006-2007, Table 2.). Appropriate borderline between before and after the education.

Years	Target (educated) district	Control district
1992	30,8	24,5
1993	35,0	25,7
1994	39,1	35,1
1995	32,1	28,8
1996	32,2	18,6
1997	28,0	23,6
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1998	20,8	27,3
1999	21,0	19,1
2000	33,2	31,4

Suicide Studies, 2023, 4(3), 18-24

THE ASSOCIATION OF MEASURES OF ANGYAL'S BIOPOSITIVE AND BIONEGATIVE SYSTEM PRINCIPLES WITH OTHER CONSTRUCTS AND ASSOCIASTIONS WITH SUICIDALITY

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Abstract: In a sample of undergraduates, a history of suicidal ideation was predicted by the pattern of noncommitment positively and negatively with the trend toward homonomy. A history of attempted suicide was predicted by autonomy scores positively and negatively with the trend toward homonomy.

Andras Angyal (1965) proposed a holistic theory of personality which viewed the mind as a system. Systems have a system principle, that is, a description of how the elements of the system are organized. Angyal argued that the mind has two basic system principles, a healthy system principle (a biopositive system principle) and a pathological system principle (a bionegative system principle). Each of these had two components. The biopositive system principle was composed of a trend toward autonomy (the desire to grow at the expense of the environment) and a trend toward homonomy (the desire to integrate with the environment). The bionegative system principle also had two components: the pattern of vicarious living (the tendency to adopt a false self in order to be what others, especially parents, want you to be) and the pattern of noncommitment (the tendency to reduce anxiety that is aroused by an inconsistent environment by developing obsessive-compulsive habits).

Lester and Dench (2011) developed a scale to measure the two trends and the two patterns described by Angyal. The four subscales had moderate reliability, and higher scores on the two trends were negatively associated with scores on a scale to measure psychoticism, while higher scores on the two patterns were positively associated with scores on a measure of neuroticism.

There are several scales that appear to be measuring constructs similar to Angyal's two trends and two patterns. Caine and Hawkins (1963) devised a Hysteroid/Obsessoid Questionnaire (HOQ), the aim of which was to measure this dimension of pathology. Caine and Hawkins hypothesized that these two types of personality (hysteroid and obsessoid) were the poles of a single dimension. They did not present modern tests of the reliability of the scale, although the test-retest reliability after 6 weeks of therapy was .77, but they did find evidence for its validity, including correlations with clinician ratings (r = .68) and with scores on a measure of extraversion (r = .84). The constructs of hysteroid and obsessoid are similar to Angyal's constructs of the pattern of vicarious living and the pattern of noncommitment, respectively, since those with the pattern of vicarious living were viewed as hysterics by Angyal and those with the pattern of noncommitment as having anxiety disorders.

Bieling, Beck and Brown (2000) proposed the constructs of sociotropy and autonomy. Sociotropy was defined as "the personal's investment in positive interchange with others" while autonomy was defined as "the person's investment in preserving and increasing his independence, mobility, and personal rights" (Beck, 1983, p. 272). Sociotropy has been found to be associated with dependency, lack of assertion, and introversion. These constructs appear to be similar to the trends toward homonomy and autonomy, respectively, proposed by Angyal.

The present study was designed, therefore, to explore the associations between the scores on these different scales and subscales.

Method

Participants

The participants were 101 undergraduates enrolled in a psychology course. There were 73 women and 28 men, with a mean age of 21.2 yrs., SD = 3.5, median 20 and range 18-40.

Measures

Angyal's Constructs: These were measured using the scale developed by Lester and Dench (2011). The scale has four subscales of 7 items each, which measure the trend toward autonomy (e.g., "I enjoy accomplishing things"), the trend toward homonomy (e.g., "I need to be close with my family"), the pattern of vicarious living (e.g., "It is important to me to be liked and approved by others") and the pattern of noncommitment (e.g., "I think that the world is a rather unsafe place these days"). Cronbach alpha reliabilities for these scales ranged from .42 to .70. Scores for the trend toward autonomy were negatively associated with scores for the pattern of vicarious living, while scores for the trend toward homonomy were negatively associated with scores for the pattern of noncommitment.

Hysteroid-Obsessoid: This was assessed using a 48-item scale developed by Caine (1973). A typical item is "I like to wear eye-catching clothes." Scores on the scale were associated with psychiatric classification of patients (Hope & Caine, 1968) and with extraversion scores (Caine & Hawkins, 1963). Inter-item correlations were reported to be high (Caine & Hawkins, 1973).

Sociotropy-Autonomy: This was assessed using the Personal Style Inventory (Robins, Ladd, Welkowitz, Blaney, Diaz & Kutcher, 1994) who reported that the scale had good factor structure, reliability and validity. Typical items are: sociotropy "I often put other people's needs before my own" and autonomy "I am easily bothered by other people making demands of me."

Beck Depression Inventory – Short form: The short form of the Beck Depression Inventory (Beck, et al., 1974) has 13 items and has good construct validity with the 21-item long form. The 13-items each have four levels of response. A typical item is I do not feel sad, I feel sad, I am sad all of the time and I can't snap out of it, and I am so sad or unhappy that I can't stand it, scored 0, 1, 2 and 3, respectively. Respondents choose one response.

Means scores, standard deviations and Cronbach alphas are shown in Table 1. The Cronbach alpha reliabilities for the Beck Depression Inventory, sociotropy and autonomy scales and the hysteroid-obsessoid scales were all good. The Cronbach alpha reliabilities for the Angyal's two patterns and the trend toward homonomy were only modest. The poor reliability for the scale measuring the trend toward homonomy were poor, most likely because the range of scores was small, with scores for the 101 students all in the range of 5-7 (possible range 0-7).

The participants were also asked to respond to "I have had thoughts of killing myself in the past" and "In the past, I have attempted suicide."

Results and Discussion

It was predicted that scores for the patterns of vicarious living and noncommitment would be associated with scores on the measure of hysteroid-obsessoid, positively and negatively, respectively. The Pearson correlations were -.13 and -.17, both non-significant. Thus, the predictions were not confirmed.

It was also predicted that scores for the measures of the trends toward autonomy and homonomy would be associated with scores for sociotropy and autonomy on the Personal Style Inventory. The correlations for the trend toward autonomy were -0.32 (two-tailed $p < .01$) and -.03 (not significant), respectively, and for the trend toward homonomy .10 (not significant) and -.22 (two-tailed $p < .05$), respectively. The two significant correlations were in the predicted direction.

Since only two of the six predictions were confirmed, the inter-correlations between all of the scores were examined using a principal components analysis (see Table2). The pattern did not conform to the names of the scales, suggesting that the scales are measuring very different constructs from what their names would imply. Sociotropy and autonomy are positively associated and with both of Angyal's bionegative patterns, indicating that both sociotropy and autonomy styles are pathological.

Most of the scale scores correlated with depression (see Table 3), with scores for hysteroid and the trend toward homonomy protecting against depression, whereas scores for both bionegative patterns and for sociotropy and autonomy positively associated with depression scores.

Clearly, an examination, both quantitatively and qualitatively, of the items in each of the scales used is necessary to clarify the meaning and overlap of the constructs studied in this research.

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Table 1: Mean scores and reliabilities of the measures

	Mean	SD	range	Cronbach alpha
Trend toward autonomy	6.74	0.51	5-7	0.092
Trend toward homonomy	5.67	1.19	2-7	0.484
Pattern of vicarious living	2.53	1.46	0-7	0.433
Pattern of noncommitment	3.48	1.73	0-7	0.553
Sociotropy	93.40	19.22	50-135	0.894
Autonomy	85.10	16.20	51-129	0.857
Hysteroid-obsessoid	24.30	4.63	12-38	0.553
Depression	5.06	4.89	0-20	0.864
	% yes			
Past suicidal ideation	39%			
Past suicide attempts	12%			

Table 2: Factor analysis of the measures

		Factor	
	1	2	3
Trend toward autonomy	-33	78#	15
Trend toward homonomy	03	01	98#
Pattern of vicarious living	76#	-30	-01
Pattern of noncommitment	73#	16	03
Sociotropy	86#	-12	09
Autonomy	69#	31	-28
Hysteroid-obsessoid	-31	-60#	16
% variance	36.4	17.5	14.8

loading > .50

Table 3: Correlations with depression and suicidality

Pearson Correlations

	suicidal ideation	attempted suicide	depression
hysteroid	.08	-.01	-.24*
trends: autonomy	-.10	.13	-.13
homonomy	-.30**	-.27**	-.30**
patterns: vicarious living	-.02	-.05	.28**
noncommitment	.27**	.04	.44***
sociotropy	.07	.08	.40***
autonomy	.17	.23*	.52***

Linear Regressions (betas shown)

	suicidal ideation	attempted suicide	depression
age	.09	.29**#	.15
sex	-.02	-.15	-.02
hysteroid	.13	.04	-.12
trends: autonomy	-.10	.15#	-.07
homonomy	-.30**#	-.19#	-.22*#
patterns: vicarious living	-.25	-.14	-.06
noncommitment	.30*#	-.11	.25*#
sociotropy	.13	.26#	.26*#
autonomy	.01	.11	.21#
R^2	0.22	0.22	0.45

Suicide Studies, 2023, 4(3), 25-28

WHAT DOES ARTIFICAL INTELLIGENCE KNOW ABOUT SUICIDE?

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Recently, artificial intelligence programs have appeared that can write essays on any topic. This has caused concern in academia as students use these programs to write assignments for their courses. In a recent trial, artificial intelligence programs have passed qualifying exams.

One such program is ChatGPT, produced by openai.com. To explore the potential of ChatGPT, I typed in it two questions. Here they are and the responses.

How can we prevent suicide?

Preventing suicide involves a multi-faceted approach that includes:

1. Identifying and providing support for individuals at risk for suicide, such as those who have a history of suicidal thoughts or attempts, have a mental health condition, have recently experienced a significant loss, or have a family history of suicide.
2. Making mental health services and resources, such as counseling and hotlines, easily accessible to those in need.
3. Reducing access to lethal means, such as firearms and prescription drugs, for individuals at risk for suicide.
4. Encouraging individuals to seek help if they are experiencing suicidal thoughts and educating them on the warning signs of suicide.
5. Creating a supportive environment that promotes mental wellness and encourages individuals to talk openly about their mental health.
6. Developing and implementing suicide prevention programs in schools, workplaces, and other community settings.
7. Increasing public awareness and understanding about suicide and its causes, as well as breaking down the stigma surrounding mental health.
8. Collaboration between communities, organizations and government to work together to prevent suicide.

Why do people choose to die by suicide?

People choose to die by suicide for a variety of reasons. Some common factors that can contribute to suicide include:

1. Mental health conditions such as depression, anxiety, and bipolar disorder.
2. Chronic pain or terminal illness.
3. Substance abuse issues.
4. A history of trauma or abuse.
5. A recent loss or significant life change.
6. A family history of suicide.
7. A lack of access to or engagement with mental health services.
8. Social isolation and feelings of hopelessness and helplessness.
9. A perceived sense of burden or feeling like they are a burden to others.

It's important to note that suicide is complex and often the result of multiple factors, and not just one cause. And it's important to seek professional help if you are experiencing suicidal thoughts or know someone who is.

These responses are excellent. Indeed, they sound a lot like part of the Introductions that scholars write for their articles!

Steven Stack (personal communication) noted that:

> It seems like the computers reflect the dominant ideas, mostly psychological. Missing are structural factors like addressing structured class inequality. Prevention can also include strategies like increasing the minimum wage faster than inflation. Four studies now find that states that increased the min wage by small amounts (e.g., $1.00) led to lower rates of suicide. The AI program did not mention factor like that- probably because they are minimized in the literature. Angus Deaton (Nobel prize winner for economics) speculated that increasing the min wage was probably the best strategy in the real political world for decreasing deaths of despair (including suicide). He might have been right.

Let us see how ChatGPT deals with more complex issues. Yang and Lester (2009) have argued that the suicide rate can never be zero, and they produced some empirical evidence that this is so.

Can the suicide rate of a country ever be zero?

It is unlikely that the suicide rate of a country will ever reach zero. Suicide is a complex issue that is influenced by a variety of factors, including mental health, social support, access to resources, and societal attitudes towards mental health. While suicide prevention efforts can help to reduce the suicide rate, it is unlikely that it will ever be completely eliminated. Additionally, it's important to note that suicide is a leading cause of death globally and its prevention is a major public health priority.

Clearly, ChatGPT is not conversant with recent scholarly research. Next, the first biographer of Elvis Presley (Goldman, 1981) reported that Elvia died a natural death, but he later wrote an essay saying that, now, he believed the death was from suicide (Goldman, 1990).

Did Elvis Presley die by suicide?

Elvis Presley's cause of death was officially listed as cardiac arrhythmia. However, there have been many rumors and theories that he may have died by suicide. However, there is no concrete evidence to support this claim and it remains unconfirmed.

ChatGPT was aware of this. However, Elvis's biographer demands more credence than do "rumors." Finally, Lester (2002) provided a psychoanalytic analysis of the suicides in the plays written by Sophocles.

In the play Oedipus Rex, written by Sophocles, why did Jocasta die by suicide?

In the play "Oedipus Rex" written by Sophocles, Jocasta, the wife of Oedipus and mother of his children, kills herself out of shock and despair upon realizing that Oedipus is her son and that she had unknowingly married and had children with her own son. The revelation is so devastating to her that she chooses to end her life rather than continue living with the knowledge and shame of her actions.

Lester, however, noted that it is clear from the play that Jocasta knew that she had married her son. Jocasta was prepared to live a life married to her son as long as this information was kept secret. Once the fact was likely to be known, she died by suicide, primarily out of shame.

Comment

ChatGPI, apparently, can tap into commonly available knowledge about suicide, but is limited in its ability to move beyond common knowledge.

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A CONTENT ANALYSIS OF SUICIDAL NOTES: A PRELIMINARY STUDY IN HUNGARY

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Abstract: The present study was designed to compare the content of 113 suicide notes from attempted suicides, completed suicides and a nonsuicidal group asked to write possible suicide notes. The content analysis examined formal, syntactical and grammatical characteristics, as well as speech patterns and verbal expressions. The letters from attempted and completed suicides had five significant differences. The notes from completed suicides had higher scores for evaluators, hetero-aggression (blaming others) and nonpersonal references and lower scores for expression of feelings and adverbial intensifiers. Differences by sex and age were not statistically different. Regarding the combined suicide notes vs controls, the control texts had lower scores for all categories except word count (no significant differences) and "We" (the controls texts had more references to "we"). The suicide notes, therefore, had more indications of irrational thinking, characterized by high scores for emotional categories, frequent negation, and absolutistic words, high self-preoccupation and a tendency toward polarized thinking These results may help the understanding of suicidal phenomenon and its dynamic background, as well as aiding risk assessment.

Research has confirmed what most clinicians assume, namely, that individuals with significant patterns of nonverbal behavior express these tendencies in their manner of speaking and writing (e.g., in suicide notes and farewell letters). By analyzing these texts, documents and messages, it has been possible to study, not only semantic and linguistic aspects, but also to ascertain manifestations of psychological defenses, coping mechanisms and psychopathology. Several clinical investigations have been carried out to identify speech patterns and verbal styles (spoken or written) associated with these psychopathological states (e.g., Gottschalk, 1995; Osgood,1990; Weintraub, 1981, 1989). It is important, therefore, to study suicide notes, as well as Internet texts concerning suicide, to gain insight into the motivations of suicidal individuals. The manner of presentation in suicide notes and in Internet texts shows that cultural variations appear. Attitudes about life, death and suicide are deeply embedded in the culture.

Researchers of suicide notes have used content analysis to compare genuine suicide notes with simulated suicide notes written on request by non-suicidal people. Lester (1991) found differences in the grammatical and semantical aspects of genuine and simulated suicide notes, while Lester (2014) found differences between the suicide notes written by completed suicides and by attempted suicides.

The findings of the above investigations are not simply indicators of varying degrees of pathology, and they are not simply indicators of anxiety, depression or defensiveness, but they may distinguish psychopathological states by identifying stable verbal category profiles, although these may vary according to different pathological groups. For example, Weintraub found that frequent use of negators can be an expression of the defense mechanism of denial (as Freud already had noted in his work “Negation”) . Undoing can be expressed by the frequently used retractors or “taking back” remarks. The verbal habits of compulsive patients often result in a high number of retractor and explainer scores, combined with the infrequent use of “expressive” categories. Impulsive speech can reflect its explosive quality, for example, by frequent use of the pronoun “I,” the many expressions of feeling such as “I hate” and “I love,” and the numerous adverbial intensifiers such as “very” and “really”. Osgood and Walker (1959) found more ambivalent constructions and more frequent polarity syntax in genuine suicide notes compared to simulated suicide notes.

Al Mosaiwi, et al. (2017) and Adam-Troian and Arciszewski (2020) demonstrated the role of the elevated use of absolutistic words (e.g., never, all, nothing) as a semantic marker of depression, anxiety and suicidal ideation. According to these researchers, absolutistic thinking is considered to be a cognitive distortion and may be a vulnerability factor in affective psychopathology, as well as in emotional dysregulation and suicidal ideation. Eichstaedt, et al. (2018) investigated the language of Facebook posts in order to predict depression. They were able to find topics that were strongly associated with future depression status, signaled by words such as depressed mood and feelings: tears, cry, feel, hope, loneliness, miss, and baby.

Cacheda, et al. (2019) developed a machine-learning algorithm for the early detection of depression. Their results found an overuse of self-related speech patterns (I, me, myself, mine) and a longer length of posts by depressed and suicidal individuals. More absolutist words were found in anxiety, depression and suicidal ideation forums than in control forums, and more negative emotion words and anger words were used by depressed individuals. Trifan, et al. (2020) have also investigated the Reddit platform for linguistic features such as absolutist words and other lexical categories.

The aim of the present study was to understand and better interpret the difference between suicide notes from completed and attempted suicides versus control letters using a modified Weintraub method and helped by the absolutist dictionaries developed by Adam-Troian and Arciszewski (2020).

Our hypothesis is that completed and attempted suicides will use more negatives, absolutist words and emotional categories, show higher self-preoccupation, self-centeredness, and self-related words, and have fewer “we” categories than “I” categories as compared to the controls.

Method

The Samples

Overall, 113 notes were collected and analyzed. Forty-nine notes were from completed suicides (from 24 men and 25 women), and 31 notes were from attempted suicides chosen from Hungarian psychiatric and forensic clinics. Suicide notes of attempted suicidal persons had been written before hospitalization and had been obtained from family members. In addition (from 15 men and 16 women), 33 nonsuicidal letters were taken from several neutral Internet forums about psychological and mental issues in Hungary, roughly matched for age and sex (from 15 men and 18 women). The controls were nonsuicidal and nonpathological, taken from "neutral " Internet groups. Only notes containing more than 50 and less than 500 words were included in the study since scores based on a small number of words would not accurately reflect the writer. The notes were checked for accuracy in spelling and word usage. This research was part of a larger study, approved by a regional ethics committee.

Coding

Raters (two authors of this report) were blind to the initial hypothesis of the study, as well as whether the texts were from attempted or completed suicides or controls. They read each note in its entirety. Prior to reading the actual notes, the raters were trained on practice notes until their ratings achieved an acceptable rating of reliability.

The construction of the scoring manual is outlined in detail elsewhere (Weintraub, 1989). Data about its reliability (test-retest and inter-judge) and validity can be found in earlier publications (Weintraub,1981, 1989). The following is a summary of the categories used.

Word count
Personal references: I, me
Personal references: we
(A personal word is one in which the grammatical subject refers to a person known to the speaker. All words not scored personal are considered to be nonpersonal.)
Negatives: no, never, nothing, won’t, nowhere
Retractors: words, phrases that retract another statement (e.g., but, however, nevertheless, although, on the other hand, except, etc.).
Evaluators: all expressions of judgement (goodness-badness; right-wrong; propriety-impropriety)
Expressions of feeling: the speaker describes himself as experiencing an affect (like-dislike, pleasure-displeasure, attraction-aversion; e.g., I love, I hate, I fear, you enjoy).
Adverbial intensifiers: expressions containing adverbs that increase the force of a statement (I *really* like it; it is *so* beautiful; this is *exactly* the same).
Apologies: sorry, regret
Heteroaggression: blaming others, revenge
Direct references: addressing people who are present
Non-personal references

Absolutistic words: these scored based on absolutistic dictionaries (Adam-Troian & Arciszewski, 2020; Al Mosaiwi & Johnstone, 2018).

The final scores were calculated by converting raw scores into numbers of scored units per 1,000 words.

A simple computer word searching program was used in order to identify the basic expressions, words and conjunctions which are characteristics of these categories (Fekete, 2002). The following categories were automatically scored by a computer since no knowledge of lexical meaning was required: I, we, and me. The scoring of negatives, retractors and explainers was also possible by computer.

The coding process of the computer was repeated by a personal evaluation, performed by one of the authors**.** Thirty percent of the letters in each group were control-coded by an independent rater **(**a psychologist trained in this method). For categories where scoring was not automatic, the interrater agreement on scoring ranged from 74% to 90%.

Statistical Analyses

The descriptive statistics and tests of significance were carried out using SPSS-26.

Results

Notes from Attempted versus Completed Suicides

Table 1 presents the results of t-tests for the comparison of the suicide notes from attempted and completed suicides. Five differences were statistically significant. The notes from completed suicides had higher scores for evaluators, hetero-aggression (blaming others) and nonpersonal references and lower scores for expression of feelings and adverbial intensifiers. There were trends toward the notes from completed suicides to have higher scores for personal references and negatives.

The impacts of sex (male versus female) and age (younger than 45 versus older than 45) were tested using three-way ANOVAs. None of the interactions were statistically significant (sex-by-AS/CS, age-by-AS/CS, and sex-by-age-by-7AS/CS)

Table 1: Statistical comparison of notes from completed suicides and attempted suicides

	AS (n=31)		CS (n=49)		Independent samples t test	
	Mean	SD	Mean	SD	t value	Sig
Word count	168.4	110.7	163.8	100.4	0.20	ns
Personal references (I)	119.3	43.4	144.2	62.5	1.94	0.056
We	6.9	13.3	5.5	12.3	0.48	ns
Negatives	44.3	26.2	56.7	31.5	1.82	0.072
Retractors	12.4	11.7	14.1	12.7	0.60	ns
Evaluators	32.0	19.7	46.2	35.2	2.04	0.045
Expression of feelings	34.2	27.2	18.8	24.9	2.60	0.011
Adverbial intensifiers	26.6	26.9	14.8	15.5	2.48	0.015
Apologies	9.1	12.3	5.7	9.1	1.43	ns
Heteroaggression	6.0	10.0	11.9	13.4	2.12	0.038
Direct references	31.2	26.5	25.3	17.7	1.20	ns
Nonpersonal references	37.7	27.5	57.4	30.4	2.93	0.004
Absolutistic words	27.7	18.3	29.3	27.0	0.29	ns

Texts from Controls versus Notes from Attempted and Completed Suicides

Table 2 presents the results of t-tests comparing the control texts with suicide notes from attempted suicides and completed suicide combined. The control texts had lower scores for all categories except word count (no significant differences) and “We” (the controls texts had more references to “we”). The suicide notes, therefore, had more indications of irrational thinking.

Table 2: Statistical comparison of notes from completed suicides/attempted suicides versus controls

	Controls (n=33)		AS/CS (n=80)		Independent samples t test	
	Mean	SD	Mean	SD	t value	Sig
Word count	188.0	79.0	165.6	103.9	1.11	ns
Personal references (I)	23.6	25.5	134.5	56.9	10.75	<0.001
We	22.8	23.6	6.0	12.6	5.90	<.001
Negatives	16.9	16.7	51.9	30.0	8.30	<.001
Retractors	7.9	7.5	13.4	12.3	2.41	.018
Evaluators	16.9	16.7	40.7	30.8	4.18	<.001
Expression of feelings	7.6	7.5	24.8	26.7	3.63	<.001
Adverbial intensifiers	11.3	11.3	19.4	21.3	2.05	<.001
Apologies	0.9	2.6	7.0	10.5	3.31	<.001
Heteroaggression	2.9	5.8	9.6	12.4	2.96	<.001
Direct references	6.4	8.2	27.6	21.5	5.47	<.001
Nonpersonal references	26.7	21.7	49.8	30.7	3.92	<.001
Absolutistic words	11.7	10.3	28.7	23.9	3.93	<.001

A Comparison of the Three Groups

Table 3 presents the results of one-way ANOVAs for all three groups. The differences mirror those reported in Table 1 and Table 2.

Table 3: Comparison of notes from completed and attempted suicides and controls using one-way ANOVAs

variables	Controls (n=33)		AS (n=31)		CS (n=49)		F (df=2,110)	Significant differences
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.		
Word count	188.0	79.9	168.4	110.7	163.8	100.4	0.63	ns
Personal references (I)	23.6	25.5	119.3	43.4	144.2	62.5	62.25	Controls differ from AS and CS
We	22.8	23.6	6.9	13.3	5.5	1233	11.97	Controls differ from AS and CSs
Negatives	16.9	16.7	44.3	26.7	56.7	31.5	27.50	All 3 groups differ from one another
Retractors	7.9	7.5	12.4	11.7	14.1	12.7	3.11	Controls differ from CS
Evaluators	16.9	16.7	32.0	19.7	46.2	35.2	11.65	All 3 groups differ from one another
Expression of feelings	7.6	7.5	34.2	27.2	18.8	24.9	11.70	All 3 groups differ from one another
Adverbial intensifiers)	11.3	11.3	26.6	26.9	14.8	15.5	6.09	AS differs from CS and from controls
Apologies	0.9	2.5	9.1	12.3	5.7	9.1	6.96	Controls differ from AS and CS
Hetero-aggression	2.9	5.8	6.0	10.0	11.9	13.4	7.46	CS differ from controls and AS
Direct references	6.4	8.2	31.2	26.5	25.3	17.7	16.04	Controls differ from AS and CS
Nonpersonal references	26.7	21.7	37.7	27.5	57.4	30.4	13.23	CS differ from controls and AS
Absolutistic words	11.7	10.3	27.7	18.3	29.3	27.0	7.72	Controls differ from AS and CS

Sex Differences in Suicide Notes

The suicide notes written by men and women differed only in one variable. The females used more absolutist words than the males (means 35.1 versus 21.9, SDs = 28.6 and 15.3; t = 2.56, df = 78, p = .012).

Discussion

The suicide notes from completed suicides were characterized by high scores for emotional categories, very frequent negation, and absolutistic words, high self-preoccupation and a tendency toward polarized thinking.

The frequent use of "I" and other personal references in both suicide groups appears to be symptomatic of a high self-preoccupation, of being unable to take distance, even temporarily, from their personal, frequently morbid concerns (Cacheda,2019). The high frequency of self-preoccupation (the use of "I" instead of "we") and absolutistic words (considered as a semantic marker of depression, anxiety [Adam-Troian & Arciszewski, 2021]) were significantly higher in the suicide notes likely reflects their pathology. This is consistent with previous research which has reported more references to *I* and fewer to *we* have been found in suicide notes (Williams, et al., 2021; Lester & Leenaars, 2015; Lester, 2014).

The frequent use of adverbial intensifiers might indicate a tendency to see the world in black and white terms. The relatively high frequency of retractors in the suicide groups may indicate an ambivalent and indecisive state of mind. According to Weintraub (1989), the high score for evaluators among depressed individuals may suggests a rigid or punitive superego. Depressed individuals also frequently use more polarized, "allness" terms which might reflect polarized, dichotomous thinking and cognitive rigidity as well as the underlying psychological defense mechanism of splitting.

The high frequency of negatives in the suicide notes may indicate oppositional tendencies as well as the psychological mechanisms of denial and negation (Fekete, et al., 2018). The high frequency of negatives and absolutistic words may reflect the underlying psychopathology of suicidal process - the frequently used archaic defense mechanisms of splitting and denial, the cognitive rigidity and partly stereotyped thinking (Kezdi, 1995; Fekete, 2002).

The study had some limitations, including the small number of notes and texts in each group. Previous research has used simulated suicide notes as a control group, that is, suicide notes written by non-suicidal individuals who imagine the note that they would write. The present study used actual texts written by individuals on internet forums. This makes the present results not strictly comparable to previous research, although the control group of texts may be more meaningful than simulated suicide notes.

Implications

In addition to understanding suicidal phenomena and their psychodynamic background, these results may be important in risk assessment, could be used in prevention and intervention for individuals who are intent on self-destruction. Clinicians need to listen to the words of their patients during interviews or when talking on crisis intervention and suicide prevention hotlines (Mok, et al., 2015) to pick up the cues that indicate mental states conducive to suicidal behavior.

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TED HUGHES: ON BEING ANGRY AT SURVIVORS[2]

David Lester

I have always been fascinated by Sylvia Plath, the American poet and novelist who killed herself in England on February 11, 1963, at the age of 30. I used her poems and novel (*The Bell Jar*) in my psychology classes, and I edited a special issue of *Death Studies* on her in which I got colleagues to delve into her unconscious.

Her husband, Ted Hughes, a British poet, had recently left Sylvia for a married woman, Assia Wevill, with whom he had a daughter born in March 1965 (although the father may have been Assia's husband rather than Ted). Their relationship was never stable (Ted had other lovers while they were involved), and Assia killed herself and their daughter in March 1969

Sylvia was buried in Heptonstall, Yorkshire, with the name "Sylvia Plath Hughes" on the headstone. Feminists often came to the gravesite and scratched out the name "Hughes." Robin Morgan published a poem, "The Arraignment," in her book *Monster* in 1972 accusing Ted of killing Sylvia. "l accuse/ Ted Hughes," she wrote. For many years I shared this anger toward Ted Hughes. Not only had his first wife killed herself, but so had his next love. I used to say to my students that, if they ever ran into Ted Hughes, run the other way. He drove women to suicide.

But wait a minute, David! You left a wife for another woman, and your next wife left you for another man. Marriages break up all the time, often there is another individual involved, and yet the vast majority of those who are left do not kill themselves. Why are you so angry with Ted Hughes? Clearly, my fascination with Sylvia had led me to blame her husband for her decision to die by suicide.

Ted Hughes remained silent for -many, many years about these events. He destroyed the last volumes of Plath's diary so that their two children never would be able to read them. But shortly before his death in October 1998, he published a

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[2] Reprinted from Lester, D. Ted Hughes: On being angry at survivors. *Surviving Suicide*, 2008, 20(2), 6.

book of poems about Plath and their marriage (*Birthday Letters*), and in November 2007 Christopher Reid's edition of the *Letters of Ted Hughes* appeared.

Ted was distraught by both deaths, A month after Sylvia's death, he wrote to Sylvia's mother Aurelia, "l don't ever want to be forgiven; if there is an eternity, I am damned in it." After the death of Assia, he wrote to his brother saying that perhaps he, Ted, was the true depressive, and that Sylvia and Assia had caught the "darkness" from him without having the resources to cope with it. He felt that his life was completely empty, and he blamed himself for mishandling the final telephone call he had received from Assia

Ted experienced tremendous grief and self-blame, and the fact that he continued his career as a poet and remarried happily (Ted married, and stayed married to, Carol Orchard in August 1970, a woman he had met in 1968) does not detract from the fact that he was in great pain after these events. When his friend A. Alvarez discussed Sylvia's suicide in his book *The Savage God*, Hughes wrote angrily to him, "What makes you think you can use our lives like the text of a novel...to keep your audience of schoolteachers up on the latest culture?" (Showalter, 2008, p. 36). Hughes did his utmost to protect their two children from the publicity and harassment resulting from Sylvia's death

Older, but perhaps only a little wiser, I now can empathize with Ted Hughes who endured the loss from suicide of two women he had loved, What is remarkable is that he was able to continue his life, rise to become the Poet Laureate of Britain, whose funeral was attended by the Queen Mother and Prince Charles, and remarry happily. And yet, all the while, he continued to experience the hatred from some people over the death Of Sylvia.

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THE OTHER SURVIVORS[3]

David Lester

The term "survivors" typically refers to those who lose a loved one or significant other to suicide. But there are others who are, in some sense, "survivors" too. Some people kill themselves in a public manner. In my book with co-author Mark Lindsay, *Suicide by Cop* (2004), I describe incidents in which people commit suicide by provoking police officers to shoot them. These officers are traumatized by these incidents, and the trauma is increased if the community believes that the officer shot the victim without any provocation. The officers report depression, anger at the suicide, feelings of terror during the incident, and agitation afterward. They later experience flashbacks, nightmares, and insomnia. Rivard and colleagues (2002) found that 11% of the officers experienced one or more symptoms of post-traumatic stress disorder, and 3% have the full syndrome,

Tranah and Farmer (1994) and his colleagues have described the trauma experienced by drivers of subway cars who cannot prevent their trains from running over those who choose to kill themselves by jumping In front of the train. They interviewed 76 drivers to whom this happened on the Tube in London, England. Seventeen percent had post-traumatic disorder and 16% had other psychiatric problems such as depression and phobias. These drivers took an average of 21 sick days after the Incident.

A counselor in Denmark (Tang, 1994) interviewed a 22-year-old train driver who ran over a woman sitting on the tracks. At the time, he felt shock and nausea and was unable to talk to the passengers over the Intercom. In the following weeks, he experienced anxiety and depression, kept trying to understand the woman's motives, and was haunted by fantasies of the scene (which he did not actually see). He sought psychotherapy and considered quitting, but his therapist worked with him to overcome his fears, even sitting with him in the driver's cabin as he drove his train

Others, by virtue of their profession, have to deal with those who die by suicide. Bridges, such as the Golden Gate Bridge in San Francisco, are popular

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[3] Reprinted from Lester, D. The other survivors. *Surviving Suicide*, 2010, Winter, online.

venues for would-be suicides. About five people jump to their death from the Delaware Memorial Bridge each year, and Don Sapatkin, a reporter for the Evening Journal (Wilmington, Delaware), interviewed the members of local fire departments who go out in their boats on the Delaware River to recover the bodies. They report feeling anxiety and nausea at the time and flash-backs

Thomas Gott, 26, said: "It's a job that only a few people want to do. You don't know what makes you do it. You just do it." There is always the hope that, if someone is seen about to jump, he or she can be talked out of it, and some are. Occasionally a jumper survives and is rescued from the Delaware River. Of the first 83 known to have jumped between 1951, when the bridge opened, until 1984, three survived. The firemen who go out in their boats know that there is a chance that they might save someone.

The individuals described above do not lose a loved one but, as we can see, are often traumatized by the suicide, have great difficulty coping with the experience, and often need counseling to help them recover.

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ASSISTED SUICIDE FOR PRISON INMATES[4]

David Lester

Since we all have to die, the crucial decision is, of course, not whether to die, but how to die. This paper examines some of the psychological issues related to this decision, including criteria for an appropriate death, whether suicide can be an appropriate and a rational death, and how we should counsel the suicidal person. It then examines how these issues bear on potential requests for assisted-suicide from incarcerated offenders should assisted-suicide be legalized in some jurisdictions.

Recent Developments in Assisted Suicide

In the United States, assisted-suicide is no longer a hypothetical possibility - it is a reality. Not surprisingly, it has been discovered that physicians in America have been assisting patients to die for many years without publicity (Quill, 1993). Thus, the question changes from "Should we permit assisted suicide?" to "Should we regulate assisted suicide?" There is much to be said for permitting and regulating a behavior instead of pretending that the behavior does not occur.

Derek Humphry (1991), founder of the Hemlock Society, published a "how-to" book on suicide which quickly rose to the top of the best-seller lists, and voices were raised both in support of the book and in opposition. Relevant to this, a perusal of the medical literature on attempted suicide indicates the diverse and severe ways in which people injure themselves seriously as a result of unsuccessful attempts to kill themselves. Plastic surgeons publish reports on the restoration to some semblance of normality of faces shattered by bullets. Burn specialists work to heal the skin of those who failed to die from self-immolation, and many patients live painful lives as a result of the severe internal damage inflicted by the overdoses they took. Frierson and Lippman (1990) found an incidence of 15% for colostomies after self-inflicted gunshot wounds, six percent for organic brain syndromes, five percent for seizures and four percent for amputations. Biering-

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[4] Reprinted from Lester, D. Assisted suicide for prison inmates. *The Correctional Psychologist*, 1999, 31(2), 1, 3-5; 31(4), 5-8.

Sorensen, Perdersen and Muller (1992) have described a sample of spinal cord injuries after attempted suicide, nineteen percent of whom had cervical lesions.

If there are about ten attempts at suicide for every completed suicide, as we suspect, then about 300,000 people will attempt suicide in the United States this year. Many of them will make a medically harmless attempt and suffer little damage. But a good proportion of the remainder, some of whom intended to die, will suffer grave and long-term consequences. Is that what we want?

More recently, Dr. Jack Kevorkian has built devices which enable people to kill themselves, and he has been present and assisted them when they make their fatal suicidal action. Michigan, which had no laws against such actions, has tried to convict Kevorkian for murder and other offenses, but has failed so far. Kevorkian (1988) believes that physicians should establish medical clinics where terminally-ill patients could opt for death under controlled circumstances. Such an idea is not new. Indeed, Alfred Nobel, founder of the Nobel Prizes, suggested this many years ago (Sohlman, 1962), and recent public opinions surveys by both Lou Harris and the Roper Organization have found that a majority of the general public support physician-assisted suicide (West, 1993).

The issues surrounding suicide and assisted suicide involve, among other things, decisions about the way in which a person dies. Lawmakers can decide which ways are legal, and philosophers can argue which ways are moral, but the way in which we die is also an issue that psychologists and psychiatrists should consider. Psychologists should consider what makes a death psychologically appropriate. Since this concept should be instrumental in decisions regarding suicide and assisted suicide, let us examine some of the possibilities for an appropriate death.

The Concept of an Appropriate Death

Lester (1996) has discussed the question of what makes a death appropriate and Weisman and Hackett (1961) brought attention to this concept by specifying the conditions they felt constituted an appropriate death. First, the death must be seen as reducing conflict, as a solution to abiding problems, or else the patient must see very few problems remaining. Then, death must be seen as being compatible with superego demands or else these demands must be reduced. Third, there must be continuity of important relationships or a prospect of their being restored (as in typical reunion fantasies). Lastly, death must fulfill a wish for the patient.

Kalish (1966) distinguished between four types of death. When the organs of the individual and the organism cease to function, there is what we may call physical death. Individuals are psychologically dead when they cease to be aware of themselves and of their own existence. Social death is when the individual accepts the notion that for all practical purposes he or she is dead. Social death may be defined from the point of view of the individual or the significant others, such as when the elderly relative is put in a home and forgotten. The final kind of death is anthropological death in which the individual is cut off from the community and treated as if he or she no longer exists. The Orthodox Jew who marries a Gentile is anthropologically dead to the Orthodox community. These four kinds of death can occur at different times in an individual's life, and Lester (1996) suggested that a death could be considered appropriate when all four of these different kinds of death coincide in time. A person who falls into coma (psychological death) and physically dies much later has had an inappropriate death.

Some writers judge a death to be appropriate insofar as the person has played a role in his own death. A person struck down by chance factors, such as lightening, therefore, does not die an appropriate death. In contrast, suicide plays the maximum role in death.

Some view a "natural" death as good, for in a natural death the body retains its integrity. An act of suicide, such as shooting oneself, destroys the body's integrity and is, therefore, inappropriate. From this point of view, any life that is prolonged by the use of transplants and medical intrusions into the body is not appropriate. Suicide and assisted suicide could be appropriate under this criterion if an appropriate method is chosen for suicide.

If you ask people how they expect to die, they can often give you an answer. Perhaps they have thought about this and decided between preferred alternatives. Their choice will reflect something about themselves, their personality and their fears, and it may also reflect their life-style. The passive person may choose to die in a fight or in war. The self-destructive person may commit suicide. An appropriate death can, therefore, be defined as one which is consistent with the person's life-style. For example, Ernest Hemingway's suicide by firearm in the face of severe medical and psychiatric illnesses was consistent with the death-defying life-style he had cultivated during his lifetime.

Shneidman (1967) suggested that the timing of a person's death is relevant. Shneidman noted that one could sometimes discern closure in an individual's acts and ambitions so that, after a given point, any further life would be a defeat or a pointless repetition. Within a person's life, there may be specific points or crests when death would be appropriated and would give a self-consistent tone to the life-style of the person. Such a death can even heighten an individual's impact by making his memory more treasured.

The concept of an appropriate death is important, and these differing criteria become relevant for the life and death of individuals. It is perhaps one of the responsibilities of the counselor, psychotherapist or physician, to ensure that a patient dies an appropriate death. To do this, we must first be aware of the alternative concepts for an appropriate death, and ten we must identify the concept that the patient has. If death for our patient is more appropriate in one particular manner, then perhaps it is our duty to allow, and perhaps to facilitate, the patient to die in that way. Psychologists and psychiatrists need to consider alternative criteria for an appropriate death so that discussion of this issue with clients can become more meaningful.

Is Suicide Rational?

The question of whether suicide is rational raises several issues. First, is the reasoning of the suicidal individual logical? Lester (1993) has argued that, granted the premises of the suicidal individual, the reasoning in most cases is quite logical. It certainly is difficult to show that the formal logic is in error, in general, in suicides.

A second issue concerns the rationality of the premises of the suicidal individual. Cognitive therapists argue that patients often hold irrational beliefs. For example, in his Rational-Emotive Therapy, Ellis (1973) described several common irrational beliefs, such as the idea that we should be thoroughly competent, adequate and achieving in all possible respects in order to consider ourselves worthwhile.

Lester (1993) noted that, although in the legal system a defendant is considered innocent until proved guilty, in cognitive therapy the patient is considered irrational until proved rational. If you tell your therapist that you will never find happiness with a lover, the therapists asks you what evidence you have for this belief. Since the therapist does not accept your evidence, you are labeled as thinking irrationally. The therapist is not required to give proof that this is correct. I have known people who never did find happiness with a lover. They were not thinking irrationally. They were correct!

I think that the majority of suicides do reason logically and that we ought to grant them the autonomy to view their situation within their personal cognitive framework, as indeed we do in all other non-criminal decisions that people make, that is, allow them to hold premises which may occasionally be irrational to others.

The Quality of Life

Some practitioners have asserted that it is important to prevent all suicides. Whatever the circumstances of the case, they assert that in an ideal world everyone ought to be prevented from committing suicide. In an ideal world, everyone would be able to receive and benefit from good psychotherapy and appropriate medication. Therapy would be effective, there would be no incompetent therapists (as, for example, the therapist who had an affair with Anne Sexton in the years prior to her suicide {Middlebrook, 1991}), there would be no side-effects from medication, and there would be adequate insurance coverage for therapy.

Of course, the world is not ideal. Therapy often does not work, therapists are sometimes incompetent, medication has side effects, and insurance coverage for therapy is being reduced in current health plans. Thus, suicidal clients may have little reason to expect a better life if they do not commit suicide. They may be quite rational in expecting things to continue to be bad or to worsen.

The question of whether suicide can be appropriate or rational cannot be answered solely on the issues raised above, such as the criteria for logical and rational decisions. The question has to take into account the alternatives genuinely open to the person - - suicide versus psychiatric hospitalization, or suicide versus a lingering death from cancer treated by a medical profession in America that seems to care little for the comfort of the patient.

Of course, it is a thorny issue as to who should decide on the quality of life. Imagine a person whose love relationship has ended. This person may judge the quality of life alone to be unacceptable. We, on the other hand, may decide that the person will get over the loss and lead a good life. Whose judgment should prevail?

Counseling the Suicidal Individual

How should we counsel the suicidal person? Lester (1995) has argued that a therapist or counselor in the modern age should not have biases regarding whether people ought to commit suicide or ought not to commit suicide. Rather counselors, especially those advising those who are terminally ill, ought to explore the client's psychological state, examine with the client the options open to the client, including treatment, refusal of treatment and suicide, and then assist the client in deciding what he or she wants to do. The counselor should then work with the client, and with the client's significant others, to make this decision possible. Lester suggested that Greenwald's (1973) Direct Decision Therapy is an ideal system of psychotherapy for this purpose, since it focuses on decision-making by clients and does not impose the therapist's values on the client.

Suicide and Assisted-Suicide Among Convicted Offenders

It is clear that correctional institutions which do not take adequate precautions to prevent inmate suicide can be held to be legally liable. Despite this, suicide rates among inmates are higher than in the general public. For example, whereas the suicide rate for American men in general is about 18 per 100,000 per year, Lester and Danto (1993) found reported suicide rates in jails as high as 187 and in prisons as high as 40 per 100,000 per year.

Relevant to this consideration is the fact that some inmates sentenced to death eventually cease appealing their death sentences and insist that attorneys representing them cease appealing on their behalf. Strafer (1983) noted that five of the first eight men executed after 1976 volunteered at some point to accept the process leading to their execution. This phenomenon may be likened to victim-precipitated homicide (Wolfgang, 1957) in which the victims play a role in precipitating their own murder, a behavior seen as having suicidal component (Lester, 1987).

There are certain groups of the general public who have particularly high suicide rates. Among American men, suicide rates rise with age (Lester, 1994), and suicide rates are very high among those with AIDS (Marzuk, et al., 1988). The geriatric inmate population is growing at such a rate that special geriatric prisons are being constructed (Aday, 1994). In recent years, almost a third of deaths among prisoners are a result of AIDS (Camp & Camp, 1955), and incidence of AIDS among inmates is some 10 times higher than in the general public (Hammett, et al., 1994). Slome, Mitchell, Charlebois, et al. (1997) have recently reported that 53% of the physicians they surveyed had helped AIDS patients in the community to commit suicide, with a mean number of patients helped of 4.2 and a median number helped of 1.0. Thus, there are several risk factors for suicide which are becoming more frequent occurrences in American prisons.

It is clear that life in jail and prison can be sufficiently harsh that inmates prefer to commit suicide than to continue to exist. The statistics on suicide are supported by scholars who have presented more general data on the harsh conditions in prisons (e.g., Johnson, 1981; Rideau & Wikberg, 1992). It is, therefore, entirely conceivable that inmates may wish to die rather than live in such conditions, and such a decision may meet criteria for being logical and rational.

Choosing Suicide and Mental Competence

In some of the criteria proposed for permitting an individual in the community to choose suicide and to receive aid from a physician or pharmacist in obtaining the necessary lethal medication, the mental competence of the individual is often included. It is usually proposed that only an autonomous, competent adult can make such a choice. Autonomy entails the individual being free to make choices, while competence entails the individual understanding the alternatives and being able to make a rational choice among them.

Children, the mentally retarded and those judged to be psychiatrically disturbed are typically not considered to possess autonomy or competence. The problem of psychiatric disturbance poses difficulties for approving assisted suicide in non-incarcerated individuals, and the difficulties are multiplied for those incarcerated. The majority of suicides are typically diagnosed as having a psychiatric disorder (Robins, 1981), and the most common disorder is a mood disorder, usually a major depressive disorder. Since depressive disorders can be treated (by medication, electroconvulsive therapy or psychotherapy such as cognitive therapy), should depressed individuals have their depression treated before they are permitted to choose suicide? However, depressed individuals in the community cannot be forced to take medication or undergo electroconvulsive therapy unless formal court orders are obtained for involuntary commitment to a psychiatric hospital and, even then, patients with good legal representation could resist treatment against their will.

In prisons, many inmates have chronic psychiatric disorders, while others experience what used to be called “transient situation disorders” caused by the stress of imprisonment. The proportion of psychiatrically disturbed inmates has increased in recent years, possibly as a result of the deinstitutionalization of psychiatric patients, many of whom have ended up in prisons instead (Winfree & Wooldredge, 1991). As a consequence, many inmates are medicated to help them (and the staff) cope with the stress of imprisonment. Deciding upon the criteria for assessing whether an inmate is competent to make a decision may prove difficult. However, solutions for the analogous problem in carrying out death sentences, in which inmates must be judged to be competent for execution, have been proposed, though continually debated (e.g., Appelbaum, 1986; Radelet & Barnard, 1988).

Prisoner Rights

Prior to the 1960s, prisoners were held to have only those rights specifically granted to them by statue or by policy (Goldfarb & Singer, 1973), a policy supported by the courts, as in a 1954 decision by the federal appeals court in *Banning v. Looney* [213 F.2d 771]. In the 1960s, this began to change, and more suits were brought by prisoners that were decided in ways more favorable to the prisoners, although more recently court decisions have retreated somewhat from supporting prisoners.

Inmates have won the right to adequate medical care (Anno, 1989), and this has been extended to psychiatric care (Lopez & Cheney, 1992). For example, although common everyday depression may not necessitate care, a major depressive disorder does (Mayer, 1989). However, inmates do not have the right to the best care possible, and inadequate funding for prisons impedes the implementation of adequate services (Jemelka, Rahman & Trupin, 1993).

The majority of the issues regarding prisoner treatment have been focused on the standards for receiving treatment rather than on refusal of treatment. The prevailing standard is deliberate indifference of individuals’ serious medical (including psychiatric) needs (*Estelle v. Gamble* – 429 U.S. 97 [1976]). If prisoners have psychiatric problems that are causing violent or other problem behaviors, then they can be medicated against their will, most likely after transfer to a psychiatric institution designed for such patients.

Prisoners do have the right to refuse medical treatment (including extraordinary interventions) and to refuse psychotherapy and psychiatric medications, *Washington v. Harper* (494 U.S. 210 [1990]), relying on *Turner v. Safley* (482 U.S. 78 [1987]), held that prisoners and involuntarily committed psychiatric patients can refuse antipsychotic medication, unless such medication is necessary for safety reasons. The result is that such decisions are usually left to the discretion of the medical staff of the prison, unless individuals feel the need to file lawsuits. However, assisted-suicide would appear to be irrelevant to prison concerns regarding security, safety and economics.

This brief review indicates that it would not be surprising if prisoners were granted a right to assisted suicide similar to that which might be granted in the future to citizens in general. If prisoners requested such a procedure, they would probably be ill and have been transferred to a hospital. Thus, the staff involved in the decision would be medical rather than custodial.

Implications

The first question that arises is whether assisted suicide has occurred in prison settings. It is only recently that physicians have admitted that they have helped medical patients commit suicide, and it is quite possible that unofficial and undocumented assisted suicide has occurred in prisons.

If assisted-suicide is made available in some American states, or in the United States as a whole, at some future time, then it may be argued that the right belongs also to prisoners. This may, in turn, require courts to make decisions about this issue when proponents and opponents file suits.

If it is decided that prisoners have this same right, procedures will have to be established for allowing an inmate to choose assisted suicide. A prisoner dying from a chronic illness and in psychological and/or physical pain who meets established criteria should be allowed to choose this option, if appropriate procedures have been followed.

One of the arguments made against permitting assisted-suicide available for the general public is that some people may be pressured into choosing this option by significant others or by the medical professionals with whom they consult. For prisoners, the possibility of pressure to choose this option may be greater. On the other hand, rational arguments in favor of assisted suicide may be more appropriate for prisoners, since the quality of their life leaves much to be desired. After all, prisoners who are terminally ill do not have the option, as we might, of requesting release from the medical ward to be allowed to die in the comfort of their home surrounded by loving relatives.

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ELDERLY MURDER-SUICIDE: IS IT EVER MERCIFUL?

David Lester

In some cases of murder-suicide, a person kills another in order to spare the person from suffering and then dies by suicide. Some murder-suicides involve an elderly spouse killing the partner who is suffering in some manner, and then dying by suicide. The spouse wants to end their partner's suffering and does not want to continue living without the partner. [5]

Garner (2009) presented a case of an 87-year-old man who shot and killed his 85-year-old wife who had Parkinson's disease, and then killed himself (and, in addition, his autistic grandson). Garner noted two other similar cases in the previous month in his region. Garner found several mental health workers who did not view these acts as merciful. Rather, they viewed these acts of one person exerting power over the spouse. On the other hand, taking care of a spouse with a serious disease is stressful, and the caregiver also has to cope with his or her deteriorating health. Often the caregiver has no help from family members or friends. This can result in depression.

In this essay, I will argue that the presence of mercy is only speculative and not necessarily present. It is critically important to note that it is rare for the seriously ill person to leave a note. I have no such suicide notes in my collections of suicide notes . If a suicide note is written, it is typically written by the murderer. Therefore, we do not know the role of the victim in the decision to be killed.

Anger in Caregivers

It has been well documented that caregivers experience anger. Buttell (1999) noted that elder abuse is common, affecting perhaps 2% of the elderly over the age of 65. In a study of caregivers of persons with Alzheimer's dementia, 55% of the caregivers reported physical abuse/verbal abuse/neglect of the person. Other

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[5] Murder-suicide of this type also occurs when a mother who plans to die by suicide also kills her child who, she thinks, would suffer without a mother.

studies have reported 12% physically abusing the person (Coyne & Mortimer, 1995) and 5% severely violent (e.g., kicking, hitting and punching: Paveza, et al. 1992). Steffen and Merritt (2012) found that social support for the caregiver and the caregiver's level of depression affected the appearance of anger in caregivers.

Joiner (2014) saw murder-suicide perpetrators as narcissists with distorted thoughts that the perpetrators sometimes viewed as virtues, but which Joiner labelled as *perversions*. In one of his four types, *Perversion of Duty*, the murderer seeks to prevent placing future burden on others of caring for the victim as, for example, when an elderly person plans to die by suicide and wants to eliminate the burden for others of taking care of a spouse. The use of the term *perversion* indicates that Joiner does view this type of murder-suicide as merciful but rather self-centered by the murderer.

Salari (2007) studied 225 murder-suicides where at least one of the pair was over the age of 60. Typically, the murderer was man using a firearm in the home. Only 123 of the couples had health problems (the murderer in 30% of these cases, the victim in 34% of the cases, and in 36% of the cases both had health problems). Dementia was present in 7.5% of the victims, but "rarely" in the murderers. In cases where the motive was apparent, 74% were judged to be primarily suicidal and 24% primarily murderous. Only 4% were clearly suicide pact cases. Salari noted that the suicide notes, if written, were either self-centered (narcissistic) or blamed the victim.

In seven cases, someone from the couple had been recently hospitalized. In one case the husband was described as being frustrated from frequent trips to the hospital for his wife's medical problems. He had once said that he "wished it would all be over." In 9 cases, the murder-suicide appeared to be suicide pacts. Salari noted that "in some cases" the intent was clearly mutual whereas in the others, one partner seemed to have been coerced into the suicide pact. In one case where the perpetrator survived, there was evidence of domestic violence against the partner. In another case, the perpetrator claimed that his wife had terminal cancer, but the autopsy showed no signs of cancer.

Bourget, et al. (2010) studied 27 elderly murderers in Quebec, Canada. The majority of the victims were spouses (85%). Data were absent for many of the cases, but several victims had pre-existing medical illnesses, and some of the murderers had a psychiatric disorder, primarily depression. Domestic violence was documented in only 30% of the murder-suicides where data were available (5 out of 17 cases). Nineteen (70%) of the murders were followed by suicidal behavior. Thirteen died by suicide and six others attempted suicide. Eleven of the 19 murder-suicides left suicide notes. Thirteen of the murder-suicide perpetrators had major depression and two others a different psychiatric disorder.

Bouget, et al. found two cases of mercy-oriented murder-suicide, and both perpetrators were women. A 74-year-old woman killed her 79-year-old husband who had Alzheimer's dementia, and he was completely dependent upon his wife. The husband had explicitly expressed his wish to die with his wife. In the past, his mother had died by assisted suicide. The wife had medical problems and was depressed and had suicidal ideation. There was no evidence of spousal abuse in the past. In a second case, a 65-year-old woman shot her 70-year-old husband. The husband had Alzheimer's dementia and had to be restrained. She would have preferred that her husband receive a lethal injection. She also was depressed and had suicidal ideation. In a further case, this time filicide, a 76-year-old man shot his 35-year-old severely handicapped daughter and then himself. His daughter required constant care for her father, a widower, and he was reclusive and socially isolated. He was depressed at the thought that his daughter might have to be institutionalized.

It is apparent, then, that only the first of these three cases had evidence that the victim had consented to the murder-suicide.

Discussion

This essay suggests that we should be careful in labelling murder-suicides as instances of mercy killings followed by suicide. It is important in possible cases of this type that it should be explored whether the victim consented to the murder-suicide. In previously reported cases, documentation of the victim's consent is missing.

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