Suicide Studies, 2020, 1(2)

Essays from my blog (see www.drdavidlester.net)

Suicide Studies, 2020, 1(2)

APPLYING DAVID LEVY'S ERRORS IN CRITICAL THINKING TO SUICIDOLOGY

David Lester

Levy (2010) wrote a provocative book on common errors in psychological research and theorizing. He did not focus on suicide at all but, as I read his book, I could see how his errors occasionally creep into our research and theorizing about suicide. Hence this essay in which I explore Levy's errors in critical thinking in suicidology.

Conceptualizing Phenomena

Error 1: Language is Evaluative

Although language may sound non-judgmental, there is often an evaluative connotation to particular words. Language, then, can affect our thoughts and attitudes and, vice versa, our thoughts and attitudes can affect our language. It is important, therefore, to not present our value judgments as objective reflections of truth.

A good example here is from Robins, Murphy, Wilkinson, Gassner and Kayes (1959). They looked at the past history of 134 completed suicides and found that only eight were not psychiatrically ill and, of these eight, five had a terminal illness. [1] Are the results of this study objective truths? First, as we will see in Error 2, psychiatric diagnoses are constructs and not real things. Second, a perusal of other studies on this issue finds that the proportion of suicides judged retrospectively to be psychiatrically disturbed ranges from about 33% to the 94% reported by Robins, et al. Thus, it seems that the article by Robins is an opinion. Robins and his team believe that one must be psychiatrically disturbed in order to die by suicide. Their "scientific" study is merely a subjective opinion of normality versus abnormality. Their language is a value judgment that "suicidal individuals are crazy."

Error 2: The Reification Error

This refers to the error of regarding abstracts concepts as if they are concrete objects. Levy gives the example of *self-esteem*. Self-esteem is not a thing that a person has; it is a concept that psychologists have created to explain behavior. In suicidology, we typically study a *behavior*, attempted or completed suicide, but most of our explanatory concepts are *concepts*. Levy draws attention to the often-made distinction between physical and mental problems. Physical things are concrete things, whereas mental things are abstract concepts. The unconscious was not discovered; it was invented. Psychosis is not detected; it is declared.

Levy noted that theories can be event theories (Type E) or construct theories (Type C). Bullying increases the risk of suicide is a Type E theory; perceived burdensomeness increases the risk of suicide is a Type C theory. Type E theories can be proved and refuted. Type C theories cannot be proved directly. Levy noted that we can neither prove nor disprove the existence of the unconscious. Type C theories can be evaluated only on their usefulness. For

example, is Einstein's theory of gravity (a construct) more *useful* than Newton's theory of gravity. Because Type C theories cannot be disproved, people mistake them as truths, and the theories survive longer than they should after they have outlived their usefulness.

Error 3: Physical and Psychological Events occur Simultaneously

Psychological events include perceptual, experiential, cognitive and mental variables; physical variables are biochemical, physiological, anatomical and neurological. What is the relationship between these two sets of variables. Do physical events *cause* psychological variables? For cause-and-effect

(i) Event A must occur before event B
(ii) When event A changes, event B changes accordingly.

Physical events can occur without psychological consequences. (For example, physical events occur after death!) On the other hand, psychological events cannot occur without physical events. When we observe a patient, the physical and psychological events occur simultaneously. Therefore, Levy argues, it makes no sense to say that a patient's problem is physical or mental. It is always both. Furthermore, if the physical and mental variables are measured at the same time, it is not possible to say that one variable *caused* the other.

In most research on suicide, researchers identify physiological (and psychological) correlates of suicidal behavior. Since these are occurring simultaneously, criterion (i) is not met. In most suicide research, event A is rarely measured *before* event B (suicidal behavior). Furthermore, when longitudinal studies are conducted, event A is often a construct. For example, Lester (1991) studied the gifted children followed up in the Terman study at Stanford University. Lester found that the parents' judgment that their child at age 10 had a strong desire to excel predicted suicide later in life rather than earlier in life. The parents' *judgment* cannot be said to have *caused* their child's later suicidal behavior. Furthermore, the desire to excel is a construct, and so we cannot conclude that this desire caused the later suicidal behavior. On the other hand, loss of the father by death or divorce and a longer pregnancy predicted suicide at an earlier age. Here were an actual event at time 1 and a behavior at time 2. This meets criterion (i) and avoids reification (Error 2).

Error 4: The Nominal Fallacy

This fallacy involves naming a phenomenon and then thinking that we have explained it. Levy gives an example. Why does she have difficulty falling asleep? Because she has insomnia. This is a *tautology*. An example of this is one of the earlier explanations for the sex difference in suicide rates. Why do men die by suicide more than women while women attempt suicide more than men do? Because men have a stronger suicidal intent. This is a tautology and not an explanation.

Error 5: Dichotomous versus Continuous Variables

Variables can be divided into two mutually exclusive categories or they can be continuous. A person who engages in a suicidal act may either survive or die - a dichotomy. But

normal-abnormal or conscious-unconscious, for example, are continua. Errors occur in theorizing when scholars dichotomize variables that are continuous. This arose, for example, in discussions as to whether suicide bombers are suicides or not. Some argue that they are not suicides (e.g., Abdel-Khalek, 2004), but the level of suicidal intent is a continuous variable, not a dichotomous variable. We should, therefore, talk of degrees of suicidal intent.

Error 6: Not Considering the Opposite

Levy noted that in order to define a concept, we need to define its opposite. To define mental illness we need to also define mental health. Levy gave an example of considering the opposite by contrasting research into changing people's attitudes that was stimulated by McGuire and Papageorgis (1961) who considered instead the question of how we can *resist* attitude change, leading researchers into the study of inoculation.

An excellent example in suicidology is an old paper by Norman Farberow (1970) in which he addressed the problem of raising a child so as to maximize the probability that the adult would die by suicide. It provided a stimulating contrast to the typical papers on how to prevent children from becoming suicidal. More recently, after years of research on risk factors for suicide, interest has turned to protective factors. In some instance, a protective factor is simply a low score on a scale measuring a risk factor, but some constructs, such as reasons for living (Linehan et al., 1983), are unique.

Error 7: All Things are the Same; Everything is Unique

Levy noted that, when we contrast two objects, they can have no overlap, a little overlap, a great deal of overlap, and complete overlap. When comparing two objects, no matter how much they have in common, at some point there will be a conceptual fork or bifurcation in the road after which they differ. Levy called this fork the *point of critical distinction (PCD)*. Before this point, the two objects are similar; after this point, they are different. This results in two types of error.

Error 7a: Differences Obscured by Similarities

Here, we let the similarities between two phenomena eclipse their differences. At a telephone hotline, the crisis counselor may decide, "Here we have another typical depressed middle-aged man (or woman)," and miss the unique features of this particular caller. The crisis counselor then inappropriately applies the usual "cookie cutter" approach.

Error 7b: Similarities Obscured by Difference

Levy gives the example of a black client telling a white counselor that the counselor could never understand his (or her) problems. The counselor might respond, "You're right, I can't. But I'm a woman, and I have experienced discrimination because of my sex, and so I have had similar experiences. We are both similar and different."

Levy suggests always asking two questions. How are these two phenomena similar? How are these two phenomena different? For example, Lester (in press) recently asked how suicide bombing, protest self-immolation and hunger strikes are alike and how are they different.

Error 8: Confusing "Is" with "Should"

Levy called this the *naturalistic fallacy*, and noted four variants: (i) if something is common, then it is good, (ii) if something is uncommon, then it is bad, (iii) if something is common, then it is bad, and (iv) if something is uncommon, then it is good. With respect to (i), Levy noted once upon a time, slavery, child labor, public torture and burning books, heretics and witches were all common. Were they good?

Levy noted that evolutionary psychology labels behaviors that propagate the genes of the individual (or the genes of his or her family group) as "natural." It is natural for men to seek as many young female partners as possible while women prefer monogamous relationships with rich and powerful men. Does this make the sexual double standard acceptable? High suicide rates among those unable to pass on their genes effectively helps the group. Does this make it acceptable? Examples can be found of all four variants of the naturalistic fallacy.

Error 9: Correlation does not Prove Causation

I hope we have all learned this lesson well in our undergraduate statistics and research methods courses! However, Levy noted a variant of this in which it assumed that, because two events occurred close to each other in time, one caused the other – the *contiguity-causation error*. We run the risk of this by giving too much weight to the "precipitating event" when trying to understand why an individual chose to die by suicide. This error results in magical thinking and superstition, as in many athletes who wear their "lucky" clothing to improve their chances of winning.

Error 10: Failing to consider Bidirectional Causation

As we know, a correlation between two variables A and B means that A could have caused B, B could have caused A, some third variable C could have caused both A and B, or events A and B could have a bidirectional causal loop. In the 1960s, there was a debate over whether physical punishment caused misbehaving children or whether naturally misbehaving children were so difficult to control that their frustrated parents turned to physical punishment. Rather, there could have been a *causal loop* (or a *vicious cycle*) at work. A similar bi-directionality could take place in the link between, say, drug use and depression.

Error 10: Failing to Consider Multiple Causation

Levy called this the *either/or fallacy*. What is the cause of depression and suicide? Is it internalized anger, learned helplessness, or too little serotonin in the central nervous system? Levy suggested replacing "or" with "and." Levy also noted that taking the "and" approach can lead to complex linear and nonlinear combinations of variables in our theories.

Error 11: Not all Causes are Created Equal

It is easy to find multiple causes for a behavior if we think hard enough. Why am I a professor? The four major reasons (May, June, July and August), overcompensation for the stutter I had as a child, my exhibitionistic tendencies, etc.? Why did you, who are reading this essay, decide to study suicide? Levy suggested that each contributing cause differs in weight, degree or magnitude, and we should not neglect causes with less weight.

Error 12: Different Causes, Same Effect

A behavior, such as depression, can be caused by many factors, such as withdrawal from drugs, vitamin deficiencies, starvation, loss, failure, loneliness, trauma, irrational thought patterns, etc. The same applies to treatment. Depression can be ameliorated by antidepressants, cognitive therapy, supportive interpersonal relationships, etc. The error comes in assuming that similar outcomes must have similar causes.

Error 13: The Fundamental Attribution Error

Levy defines this as our bias to attribute a behavior in an individual to internal factors and minimize external factors (the situation in which the individual finds himself or herself). If you hurt me, then you are cruel. If you fail to tip me when I serve you in a restaurant, then you are stingy. This results in our tendency to blame the victim (such as the rape victim or the battered spouse). The contrast occurs when we explain our own behavior, especially if it is behavior of which we are not proud. Then we typically hold the situation as responsible. If you do well on an exam, you take the credit for being brilliant. If you fail, you blame the examiner or some other factor in the situation that was not under your control.

Levy suggested that the fundamental attribution error comes from our cognitive bias (in a situation, we focus on the other actors) and from our motivational bias (we endeavor to satisfy our own personal needs). Levy advises us, "Never underestimate the power of the situation" (p. 102).

Error 14: The Intervention-Causation Fallacy

A good example of this is when you have a headache and take an aspirin. The headache goes. Did you then have an "aspirin deficiency" disease that caused the headache? Modifying an event does not, *per* se, prove what caused the event – the *treatment-etiology fallacy*. The causes of most events are multiple, and so are the ways of reversing the outcome. Individuals can become suicidal from many causes, and they can be helped to a non-suicidal state using many techniques. The method we use to help them does not *necessarily* indicate what caused the suicidal state (although, on some occasions, it might).

Error 15: The Consequence-Intentionality Fallacy

This is more simply phrased as *the effect doesn't prove the intent*. It may in many situations, but not always. Levy gives the example of someone who cuts their wrists severely.

Can we assume that their intent was to get attention – as in Farberow and Shneidman's (1961) classic book on attempted suicide which they called *The Cry for Help*? Levy suggests other possible causes, including self-punishment, sensory stimulation, confirmation of life, reification of emotion, catharsis, revenge against pain, displacement of anger, psychological control and suicide. Sylvia Plath died by suicide in 1963 in London, England, using toxic domestic gas. Did she intend to complete suicide? Alvarez (1972), one of her friend's thought not. He argued that her behavior was a cry for help and that she expected a visitor that morning who would break in and save her. In order to avoid this error, Levy suggested that we think of other possible causes for the behavior (Error 10 above).

Error 16: Relying on Feelings

Levy calls this the "*If I feel it, it must be true" fallacy*. Levy noted four possibilities here.
(i) Comfortable truths: feeling good and the event is true
(ii) Comfortable falsehoods: feeling good and the event is false
(iii) Uncomfortable truths: feeling bad and the event is true
(iv) Uncomfortable falsehoods: feeling bad and the event is false

One of the best examples of these types of fallacies is the controversial debate over the validity of repressed memories of childhood sexual abuse. Those who believe that they have recovered such a memory or helped someone recover such a memory rely on (iii) above – if it feels bad, then it must be true. If a client of a psychoanalyst becomes uncomfortable, and even hostile, as a result of a particular interpretation made by the psychoanalyst, then this "resistance" and "defensiveness" is often used to confirm the validity of the interpretation, again an illustration of (iii).

Levy emphasizes that one's feelings are not an accurate or trustworthy guide to the truth.

Error 17: The Spectacular Fallacy

This fallacy involves thinking that an extraordinary event requires an extraordinary cause. Of particular relevance to suicidal behavior, Levy notes that extraordinary human behavior (such as catatonia, hallucinations, bestiality or cannibalistic serial murder) pushes us to search for spectacular causes and to propose extraordinary theories to account for it. Levy argues that this is not a valid assumption. Extraordinary events occur sometimes by chance, as any gambler knows, or as a result of ordinary events. Psychoanalysis is based on the proposition that abnormal behavior is governed by the same principles as normal behavior. There is no qualitative difference between the two categories of behavior.

Error 18: The Pitfalls of Inductive and Deductive Reasoning

Errors in deductive reasoning come from starting with erroneous premises and from using flawed logic. Inductive reasoning is based on data, generalizing from observations to broader principles, looking for patterns in the observations. This can lead to erroneous conclusions in several ways: (i) drawing primarily on our memory of only vivid or salient observations, (ii)

ignoring statistical principles such as sample size and probability, and (iii) selectively seeking observations that are consistent with our theory and ignoring those that are inconsistent.

Error 19: Disturbing the Phenomenon by Observing It

It is often the case that observing a phenomenon changes the phenomenon. For example, the phrasing of questions in an inventory can affect people's responses. It has been argued that interviewing attempted suicides in the emergency room produces invalid answers to the clinician's questions because the attempters, in all likelihood, do not wanted to be admitted to a psychiatric unit and so present themselves as hypernormal.

When interviewing survivors of those who died by suicide, the survivors may answer questions in an effort to disguise their true thoughts and feelings in order to promulgate a particular interpretation, such as avoiding admitting their own responsibility in their loved ones suicide. Lester (2013) gave a good example of this from an account by Meng (2002) of a wife, Fang, who died by suicide in China. The precipitating events for this suicide were quarrels with her in-laws and domestic violence as a victim of her husband. Her in-laws viewed Fang's suicide as a foolish act for it cost the family a great deal in terms of cost and reputation. Fang's parents saw Fang's suicide as a forced decision. They blamed Fang's in-laws, destroyed furniture in the in-laws' house and demanded a very expensive funeral and headstone for Fang in her in-laws burial plot. The villagers gave Fang's suicide a mystical interpretation, believing that she was taken by a ghost, which served two functions: (1) to avoid blaming Fang or her in-laws, and (2) to escape from a sense of responsibility themselves for Fang's suicide by not intervening. The asking of questions by the investigator most likely led the interviewees to think about what the result would be for different answers that they might give and which result they preferred.

In laboratory experiments, the researcher can sometimes use unobtrusive measures such as hidden cameras and one-way mirrors. For the study of suicide, perhaps only the study of documents, such as suicide notes and diaries, are unobtrusive ways of studying the behavior.

Error 20: Self-Fulfilling Prophecies

Levy notes that the attitudes we have toward others can affect their behavior and certainly our judgments about those others. In victim-precipitated homicide, an individual consciously or unconsciously provokes another into killing him. In psychic homicide, an individual consciously or unconsciously encourages another to die by suicide. Some psychological research involves judges, often clinicians, making judgments about others. This is so when psychiatrists make diagnoses, but it also occurs when using judges to rate interviews or written material. Often researchers and judges are not blind to the theory and hypotheses behind the study, and this can bias the results.

Error 21: The Assimilation Bias

Psychologists frequently categorize phenomena and behaviors, and we use schemas to do this. Our schemas are general expectations, preconceptions or theories about the phenomena we are studying. What happens when we encounter a phenomenon? If it fits into our schemas, we

assimilate it. If it does fit into our schemas, we have to *accommodate*, that is, shift our schemas so that now the new phenomenon fits in.

This leads to several possible errors including, (i) noticing only that information which is consistent with our theory, (ii) selectively searching for information consistent with our theory, and (iii) distorting the information so that it fits our theory. Rosenhan's (1973) classic study of sending normal individuals to a psychiatric inpatient unit complaining of hearing voices illustrates this bias. The eight individuals were admitted and eventually released with schizophrenia in remission after an average of 19 days (with a range of seven to fifty-two days). Everything the patients did was construed by the staff as signs of abnormality, such as taking notes and waiting for the cafeteria to open. None of the mental health personnel thought that the patients were part of a study, whereas a quarter of the patients confronted the pseudo patients and asked them why they were really in the ward.

Levy provides a psychoanalytic joke to illustrate the assimilation bias. If a patient arrives late for a session, he is hostile; if arrives early he is anxious; and if he arrives on time, he is compulsive!!!!! Levy points out an interesting problem here. Many clinicians adopt (and perhaps believe in) a particular perspective – biomedical, psychodynamics, cognitive, behaviorist, etc. They then assimilate all information and observations into their perspective – the *clinician orientation assimilation bias*. Can suicidologists avoid this orientation bias?

Error 22: Confirmation Bias

If we have a theory or a hypothesis, it may be that, when we design our research, we selectively gather information that will confirm our theory or hypothesis and we do not search for disconfirming evidence. This is called *confirmation bias*. Researchers show this when they select one statistical test over another because the former confirms their hypothesis better than the latter. Readers, of course, do not know how much data analysis has been tried and discarded when they read the published paper. Another form of this bias is to conduct research that only tests one's preferred theory rather conducting research that pits your preferred theory against a rival theory.

Error 23: The Belief Perseverance Effect

In the *belief perseverance effect*, researchers cling to their theory even when disconfirming evidence comes along. They discount, deny or ignore such evidence. An individual deviant can be eliminated by declaring the data from that individual to be an *outlier*, and sometimes the whole study can be discounted because of *methodological flaws*.

Error 24: The Hindsight Bias

In a good example of this, in my early days as a research while still at graduate school, I submitted an article in which I made a clear prediction and found the opposite result. The editor, a famous psychologist, but whose name I'll protect, rejected the paper, but gave me advice. He first suggested which journal would accept the paper, and then he told me not to predict one result and find the opposite. Predict what you found.

How many of you, after you finished graduate school, actually choose the significance level that you will use *before* you run the study? How many of you had a data set, conducted a slew of analyses on the data set, and then decided what the paper would be about and what hypotheses you would test? I rest my case!

Error 25: The Insight Fallacy

The *insight fallacy* is thinking that, when we understand a phenomenon, we now know how to change it. We know a great deal about the causes of suicide, but the suicide rate in the United States is steadily rising, and many suicidal individuals are in treatment but yet still die by suicide. This fallacy is also found in some therapy clients who gain insight into the causes of their problems but find it difficult to change.

Discussion

Levy's book on critical thinking and the errors we make is a stimulating book and merits study by all researchers and theorists. I hope this essay intrigues you to read it and consider whether you have made these errors yourself.

References

Abdel-Khalek, A. M. (2004). Neither altruistic suicide, nor terrorism but martyrdom. *Archives of Suicide Research, 8,* 99-113.

Alvarez, A. (1972). *The savage God.* New York: Random House.

Farberow, N. L. (1970). Self-destruction and identity. *Humanitas, 6,* 45–68.

Farberow, N. L., & Shneidman, E. S. (1961). *The cry for help.* New York: McGraw-Hill.

Lester, D. (1991). Childhood predictors of later suicide. *Stress Medicine, 7,* 129-131.

Lester, D. (in press). Suicidal protests. *Behavioral& Brain Sciences.*

Levy, D. A. (2010). *Tools for critical thinking: Metathoughts for psychology.* Long Grove, IL: Waveland.

Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you ar ethinking of killing yourself. *Journal of Consulting & Clinical Psychology, 51,* 276-286.

McGuire, W. J.,& Papageorgis, D. (1961). The relative efficacy of various types of prior belief defense in producing immunity against persuasion. *Journal of Abnormal & Social Psychology, 62,* 327-337.

Meng, L. (2002). Rebellion and revenge: The meaning of suicide on women in rural China. *International Journal of Social Welfare, 11,* 300-309.

Robins, E., Murphy, G. E., Wilkinson, R. H., Gassner, S., & Kayes, J. (1959). Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides. *American Journal of Public Health, 49,* 888-899.

Rosenhan, D. L. (1973). On being sane in insane places. *Science, 179,* 250-258.

---

[1] I might note in passing that I have to see a psychological autopsy study of completed suicides with an appropriate control groups of people who died of natural causes, with a standard

interview protocol, and judges reading those protocols blind as to which group each individual is in (and, even better, unaware of the nature of the study and which groups are being compared).

Suicide Studies, 2020, 1(2)

DIEGO DE LEO'S BOOK ON ATTEMPTED SUICIDES

David Lester

Turning Points (De Leo, 2010) presents us with moving accounts from nine people who attempted to kill themselves, but who survived. All of them but one are happy to have survived. The question asked in his essay is whether the essays written by these individuals provide clues to the suicidal mind.

The Attempters

Trevor

Trevor is a young man who became a drug and alcohol abuser. The woman he loved rejected him for another man, and his substance abuse worsened. He confided to no one. One night, he was drinking heavily and smoking dope, and he went home to change his clothes in order to go to a disco. He sat down and thought that he did not want to go out or do anything anymore. He got his roommate's shotgun and ammunition and waited for his friends to come by. He sat down and wrote a suicide note: *Tell Mum and Dad that I'm sorry and I love them*. He squeezed the trigger, but he had left the safety on. He tried again and, as he squeezed the trigger, changed his mind and tried to pull his head out of the way, but he shot much of the front of his head off.

De Leo noted that Trevor's account was rather "dry," and there is a lack of premeditation. There is also ambivalence as he waits for his friends to stop by. But Trevor seems to have little ability to self-monitor – to tell us what his mood and thoughts were, if any.

Anna

Anna was sexually abused as a child by several men – neighbors, family friends and her grandfather. The abuse by her grandfather left her confused for she loved him and felt close to him but knew what he was doing was wrong. He stopped abusing Anna when she was twelve, and died two years later.

On the day that he died, Anna was stoic, "numb to the grief around me." She had been fighting with her parents to be allowed to go away with friends. Her relationship was "tumultuous" with her mother and distant with her step-father. Her brother and sister-in-law were "always there for me, but I felt such a burden on them." She felt hopeless and despair. She went and got her grandfather's medications and ingested them all. "I am hopeless, bad at school, I can't get on with my parents, I am a burden to my support people, I cannot take another moment of this anguish. I can't cope anymore, I hate my life, I have nothing to live for" (p. 64).

Anna, therefore, illustrates common elements of the suicidal mind – psychological pain, hopelessness, and a sense of being a burden.

Alessa

Alessa was born into a wealthy family, but with a dysfunctional mother who could not cope with life and a father who was gone on business much of the time. Her mother made several suicide attempts with overdoses and, when Alessa was fifteen, she found her mother on the floor having tried to cut her throat. Alessa married, but her husband physically abused her, and Alessa left him. Two months later she gave birth to a child with Down's syndrome. Alessa has a psychotic breakdown.

Alessa's mother changed dramatically at that time and became a good surrogate mother to her grandson, while Alessa continued to have symptoms of schizophrenia and became a drug addict. Eventually, Alessa recovered to some extent and got a job as a secretary when, one Easter, she decided it was time to die. "It happened all of a sudden….Basically, I wasn't doing badly. Yet that Saturday afternoon I decided that my hour had come, that the time was right, and that there was no point in going on' (p. 84). "I was suddenly overcome by the conviction that everything had been horrible and that I could no longer do anything with passion or hope. I was overcome by a sense of suffocating anxiety….My head was spinning and I felt I couldn't breathe anymore" (p. 85). She swallowed two laundry bottles of stain remover.

What is interesting here is the anxiety attack that immediately preceded her suicide attempt. She swallowed the poison in the midst of this emotion.

Sergio

Sergio, a father, feels responsible for letting his son drive a tractor when he was only twelve years old, which crashed and crippled the young boy. Sergio never recovered from the guilt, and his life became full of a sense of oppression, pain and guilt. In the months before his suicide attempt, this became unbearable. He could not sleep and began to drink heavily.

Sergio does not remember much of the day he tried to kill himself, but he remembered climbing the silo, shaking strongly and crying. He thought that his pain would soon be over. But as soon as he jumped, he decided that he did not want to die. He reoriented himself while falling and damaged only his feet and ankles.

Sandro

Sandro became a concert pianist and married young. But, although Sandro liked playing in bars, performing in concerts caused great tension for him. He began to drink, and eventually his wife left him. He was an alcoholic, with no job and no confidantes. He decided to kill himself.

He was sleeping only about two hours each night. He was tense and irritable, yelling at his mother. One night at 2 am, he drove to his ex-wife's apartment and tried to kill himself with car exhaust. He wanted his ex-wife to see his corpse the next day. As he sat in the car, he drank some cognac and began writing a suicide note to his parents and to his ex-wife, mostly to her. He described the letter as full of accusations, anger, and threats.

Fabrizio

Fabrizio was diagnosed as having bipolar affective disorder at the age of 22. He lived in the countryside with his parents (his father was a policeman) and an uncle who shot himself at the age of 55. After his fourth or fifth admission for depression, Fabrizio began to think about committing suicide. During one hospitalization, Fabrizio met a woman whom he liked very much but who disappeared out of his life. During his last admission, he found out that she had hung herself. After his discharge he went home, got his father's gun and went into the basement. "I think my heart was beating fast. Rather strangely, while my head was in complete turmoil, my movements were correct and coordinated" (p. 115).

Again, like Alessa, Fabrizio reports only anxiety. Interestingly, he has two models for his choice – his uncle and the woman he liked – and he attempted suicide immediately after release from the psychiatric hospital, a common time for suicides in psychiatric patients.

Lucia

Lucia is married with two children. Her father, suffering from a bipolar disorder, committed suicide by hanging when she was 27. His body was discovered by her younger brother. Her marriage was not good. There was no love and little sex. On the day, Lucia jumped from the third floor window of her apartment, she was tired from her work that day as a school teacher, and she reported a sensation of never-ending anxiety which she had been living with for some time.

Her husband, who was director of a museum, was tense that day and wanted Lucia to accompany him to a museum affair at which the Mayor was attending. There was tension between them in the car when she asked him to wait for her to go upstairs to the toilet. "I climbed the stairs again. It was suffocating inside there. My head was so heavy and my legs grew increasingly weaker…..I opened the door of the balcony….I didn't look down, I didn't hesitate – I just closed my eyes and I jumped….I thought that I was going to put an end to everything that was horrible and senseless. I was going to free myself, forever" (p. 124).

Umberto

Umberto was an old man and has to use a wheelchair. His wife died of cancer fifteen years earlier, and his four children are grown up. His two daughters lived nearby but "Even if I have cancer, I don't want my daughters to sacrifice their lives to remain close to me" (p. 130). Umberto had a friend, crippled in a car wreck that killed his wife, with whom he spent time. Unmberto visited him regularly, and they sat out on a balcony. Umberto secretly stole barbiturate pills from his friend over a period of months. He thought about using them to "reach" his wife whenever he chose, yet he did not believe in an afterlife. "What was there to live for?" He chose to overdose on the anniversary of his wife's death. He wrote notes to his children and to his friend. Worried that his friend would imitate him, Umberto wrote that, "my condition would have rapidly worsened anyway. More suffering, more medical visits, more interventions. More money spent, more assistance, more concern from my children. Better to end it as soon as possible" (p. 134). Umberto took the overdose and, in contrast to those above who reported being anxious in the moments leading up to the attempts, Umberto reported being calm.

Maria

Maria is an elderly lady, in a nursing home, talking to Diego rather than writing. Maria suffered from a bipolar disorder and had attempted suicide in the past. Her life had been traumatic, with emigrations, the death of her husband and the suicides of her two sons. She jumped from the window of her apartment and suffered a spinal injury that left her paraplegic. "I don't know why I did it….and if someone would try to explain it to me, I would probably not believe it. The only thing that I remember is the tension that was devouring me, the incredible disquiet that I felt. I was confused. I could not clearly think about anything….I didn't want to suffer any more…..I did want to stop that tension, to put an end to that unbearable suffering. I am not sure if you really know what anxiety is, that particular anxiety. It is like a devil that bites you inside, that squeezes your lungs. You cannot breathe, you really cannot breathe" (pp. 147-148.).

Discussion

The most noteworthy feature of these accounts is how little insight the people had into their mental state and their psychodynamics. They do illustrate several features well-know to suicidologists, such as escape from mental and physical pain (Sergio and Maria), anger (Sandro), hopelessness and a feeling of being a burden (Anna), and suicide soon after discharge from a psychiatric hospital (Fabrizio).

What is noteworthy is the anxiety noted by two of the individuals, Alessa, Fabrizio, Lucia and Maria. Alessa, Lucia and Maria all talk of suffocating and not being able to breathe any more, and two of them (Lucia and Maria) indicate that the anxiety was long-standing and not simply a result of the decision to kill themselves. In fact, Maria tried to die to get away from the anxiety.

This suggests that clinicians should evaluate clients who are potentially suicidal for anxiety as well as depression and hopelessness.

REFERENCE

De Leo, D. (2010). *Turning points*. Bowen Hills, Australia: Australian Academic Press

Suicide Studies, 2020, 1(2)

IMPOSSIBLE SUICIDE RATES

David Lester

A recent article (Jacob, et al., 2007) had a table that had suicide rates for 191 nations of the world. What is surprising about this is that rates were provided for countries such as Afghanistan (6.49 per 100,000 per year), Democratic Republic of the Congo (4.79), Somalia (7.57) and Sudan (7.12). The article gave no citation for the source of these suicide rates. I have already been sent an article to review for a scholarly journal which utilized this set of suicide rates! I e-mailed several of the authors of the paper, as well as *Lancet*, and received no replies. These suicide rates are most unlikely, and they should not be used for research.

Reference

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat-Mari, J. j., Sreenivas, V., & Saxena, S. (2007). Mental health systems in countries. *Lancet*, 370, 1061-1077.

Suicide Studies, 2020, 1(2)

Thomas Joiner's Theory: The Good, the Bad and the Ugly

(The theory is good, the criticisms sometimes ugly)

David Lester

Thomas Joiner's Interpersonal Theory of Suicide (ITS) has received a lot of criticism, both in print (e.g., Paniagua, et al. 2010) and informally among suicidologists. The two major criticisms are that it is not new (Durkheim already proposed thwarted belongingness) and that it is dominating the field. Both are unfair. Let's first look at whether it is new.

To be sure, thwarted belongingness is not new. Durkheim's concept of social integration is somewhat similar to thwarted belongingness, but actually Raul Naroll's concept of *thwarting disorientation* (Lester, 1995) is closer to thwarted belongingness. Anyway, using the ideas of earlier people in the field is not a sin. One of my brilliant professors at Cambridge University, Richard Gregory, whose field was perception, admitted that he spent a great deal of time reading German scholars from the late 1800s and then "re-discovering" their insights in modern times. For example, he "discovered" a wonderful crustacean in the Mediterranean that scanned the environment with a receptor, much as television cameras did.

However, not only was the concept of perceived burdensomeness not a focus of research prior to the ITS, but the concept of the acquired capability for suicide was also barely mentioned in the literature, if at all. As Meatloaf has said in a different context, two out of three ain't bad. Indeed, those of you who have read my four editions of *Why People Kill Themselves*, know that, in the first three editions, I chose the leading researchers and theorists of each period. In the fourth and final review of the literature (Lester, 2000), I did not choose anyone because, in my opinion, nothing of note had appeared in the period 1990-1997 (the period covered by the fourth edition). If I had continued my reviews, I would have chosen Joiner alone for the award for the fifth edition. No one else has developed a new theory or opened a new area of research in recent years. I think that the concept of thwarted belongingness could be modified to make it more useful and relevant, but the focus of the ITS on burdensomeness and the acquired capability is brilliant. I have conducted research to test the theory with Joiner (e.g., Pettit, et al., 2002) and independently (Gunn, et al., 2012), some of which has supported the theory and some of which has not been completely supportive.

One valid criticism of the concept of perceived burdensomeness is that the ITS implies that it is present in all suicides in all cultures, and this is much too extreme. It may be present in some suicides, but not in all. If it is not involved in all suicides, then the theory is limited, and even modifications to the theory by bringing in other variables cannot fully remedy this.

As for the domination of the theory, there are two relevant objections to complaining about this. First, it is clear that most current researchers in suicidology rarely read (and, therefore, cite) research and theory prior to the year 2000. The use of online searching through PsycInfo and PubMed force this since the most recent articles come up first and because the

literature on suicide is now so immense. No one has the time (or the motivation) to scroll down to earlier years. Furthermore, without anyone reviewing the field after I stopped publishing my review every ten years, there is no easy source for finding out what has been written in the past. I have noted how many Introductions in articles seemed to cite only those studies reviewed in the appropriate section of my reviews. The current domination of the ITS is, therefore, understandable. People are not finding and reading earlier alternative theories.

Second, if the domination of the ITS rubs you the wrong way, then come up with an alternative. It is always easier to criticize than to provide an alternative. If those critics of the domination of the ITS could propose an alternative theory, then, of course, they would do so. A new theory would be exciting, but I am not holding my breath in anticipation of it.

References

Gunn, J. F., Lester, D., Haines, J., & Williams, C. L. (2012). Thwarted belongingness and perceived burdensomeness in suicide notes. *Crisis, 33,* 178-181.

Lester, D. (1995) Thwarting disorientation and suicide. *Cross-Cultural Research, 29,* 14-26.

Lester, D. (2000). *Why people kill themselves.* Springfield, IL: Charles C. Thomas.

Paniagua, F. A., Black, S. A., Gallaway, M. S., & Coombs, M. A. (2010). *The Interpersonal-Psychological Theory of attempted and completed suicide.* Bloomington, IN: Authorhouse.

Pettit, J. W., Lam, A. G., Voelz, Z. R., Walker, R. L., Perez, M., Joiner, T. E., Lester, D., & He, Z. X. (2002). Perceived burdensomeness and lethality of suicide method among suicide completers in the People's Republic of China. *Omega, 45,* 57-67.

Suicide Studies, 2020, 1(2)

MORAL DECISIONS INVOLVING EUTHANASIA AND SUICIDE

David Lester

Abstract – Recent neuroscientific research on how people respond to personal and impersonal moral dilemmas is applied to explain why individuals are more comfortable with passive euthanasia than active euthanasia and why suicidal individuals use tactics to reduce the role of emotions in the decision to commit suicide.

Greene, et al. (2001) compared the brain responses of people to personal and impersonal moral dilemmas. They presented subjects with two types of moral dilemmas. In the impersonal moral dilemma, a train is approaching a junction, and it cannot be stopped. On one of the two possible tracks, five people are working and will be killed by the train. On the other possible track, one person is working and will be killed by the train. Will you divert the train to the track with one worker? Almost all respondents say "Yes," and they make the decision quickly.

In the personal dilemma, there is only one track with five people working on it who will be killed by the train. The only way to stop the train is to push an individual who is sitting on a bridge off onto the track so that his body stops the train. Will you do it? The majority of respondents say "No," and those who say "Yes" take much longer to make the decision than those who say "No." (It should be noted that from a simple utilitarian point of view, the answer should be "Yes" in both cases. Five people would be saved for the cost of one life.)

Greene et al. found that the brain regions that were more active in the "personal" dilemma than in the "impersonal" dilemma (e.g., the posterior cingulate gyrus) were those associated with emotional arousal, while areas associated with cognitive processing (e.g., the right middle frontal gyrus) were less active in the "personal" dilemma than in the "impersonal" dilemma.

Greene et al. concluded that emotion can play an important role in moral judgments. Pulling a switch is an impersonal act, and the decision is made quickly. It involves cognitive reasoning, and there is less emotional involvement. Pushing a person off a bridge to be killed entails a very "personal" involvement. Emotion plays a large role, and the decision to over-ride the emotional reaction by cognitive reasoning takes time.

Application to Passive and Active Euthanasia

It has been found that medical personnel are more comfortable with passive euthanasia (for example, letting the batteries on life-sustaining equipment run down, so that the equipment stops functioning and the patient dies) than with active euthanasia (for example, turning off the electrical supply to life-sustaining equipment). Why is this so?

The parallel with impersonal and personal moral dilemmas is clear. Passive euthanasia (such as letting the batteries energizing medical equipment run down) requires less personal

involvement. Calm reasoning can operate, and the decision is made more easily. Actually turning off the life-sustaining equipment is a more "personal" action and produces an emotional reaction that cognitive reasoning has to overcome.

Application to Suicide

Suicide is, in most religions, an immoral act. Jacobs (1967) called suicide a violation of the sacred trust of life. In his examination of suicide notes, Jacobs documented how would-be suicides try to persuade themselves, others and God that their suicide is morally justifiable. They may assert that God will understand, and they ask others to pray for them. They also frequently change their religious beliefs so that they come to believe that suicide will be forgiven.

Committing suicide is a very "personal" act. There will typically be an emotional reaction and a cognitive appraisal involved in the decision to commit suicide. The research of Greene, et al. reviewed above suggests that it takes time for the cognitive appraisal to overcome the emotional reaction.

There may be many cognitive maneuvers employed to reduce the role of emotions in the decision. For example, Spiegel and Neuringer (1963) found that completed suicides tend to avoid the use of the word suicide and suicide synonyms in their suicide notes, and they suggested that this was to reduce the dread (an emotional reaction) of committing suicide. These maneuvers may be facilitated by ingesting alcohol or other drugs (such as marijuana) prior to the suicidal act, a phenomenon observed by Chiles, et al. (1986). By reducing the role of emotions, the decision to commit suicide may be made more quickly and using primarily cognitive processes.[1]

References

Barnes, D. H., Lawal-Solarin, F. W., & Lester, D. (2007) Letters from a suicide. *Death Studies*, 31, 671-678.

Chiles, J., Strosahl, K., Cowden, L., Graham, R., & Linehan, M. (1986) The 24 hours before hospitalisation. *Suicide & Life-Threatening Behavior*, 16, 335-342.

Clements, C., Bonacci, D., Yerevanian, B., Privitera, M., & Kiehne, L. (1985) Assessment of suicide risk in patients with personality disorder and major affective disorder. *Quality Review Bulletin*, 11(5), 150-154.

Greene, J. D., Sommerville, R. B., Nystrom, L. E., Darley, J. M., & Cohen, J. D. (2001) An fMRI investigation of emotional engagement in moral judgment. *Science*, 293, 2105-2108.

Jacobs, J. (1967) A phenomenological study of suicide notes. *Social Problems*, 15, 60-72.

Keith-Spiegel, P., & Spiegel, D. E. (1967) Affective states of patients immediately preceding suicide. *Journal of Psychiatric Research*, 5, 89-93.

[1] Related to this is the common observation that the mood of suicides tends to improve, and they seem calmer prior to the suicidal act, both in the short-term (e.g., Clements, et al., 1985; Keith-Spiegel &Spiegel, 1967) and in the months leading up to the act (e.g., Pennbaker & Stone, 2004: Barnes, Lawal-Solarin & Lester, 2007). The role of emotions in the decision to commit has been reduced.

Pennebaker, J. W., & Stone, L. D. (2004) What was she trying to say? In D. Lester (Ed.) *Katie's diary* (pp. 55-79). New York: Brunner-Routledge.

Spiegel, D., & Neuringer, C. (1963) Role of dread in suicidal behavior. *Journal of Abnormal & Social Psychology*, 66, 507-511.

Suicide Studies, 2020, 1(2)

THE SUICIDE OF A GYPSY

David Lester

I have always been interested in suicidal behavior in the oppressed. I have written about suicide in the German concentration camps of World War Two, suicide in prisoners, and other oppressed groups. I was also fortunate to be asked to contribute a chapter on suicide in the Roma people and Irish Travellers:

Lester, D. Suicide among the Roma people and Irish Travelers. In D. van Bergen, A. H. Montesinos & M. Schouler-Ocak (Eds.) *Suicidal behavior of immigrants and ethnic minorities in Europe*. Boston, MA: Hogrefe, 2015, pp. 101-111.

At the IASP conference in Brussels in 1989, I saw a poster on suicide in Hungarian gypsies by Tamas Zonda, and I persuaded Tamas to let me help him publish his study.

Zonda, T., & Lester, D. Suicide among Hungarian gypsies. *Acta Psychiatrica Scandinavica*, 1990, 82, 381-382.

This week, *The Economist* reported that a successful member of the Roma people had died by suicide at the age of 46. László Bogdán (he preferred the label *Cigány* rather than Roma) was the mayor of Cserdi, a town of 350 in southern Hungary. He was elected mayor in 2006 and had transformed the village. The town had dilapidated houses, joblessness, rubble strewn everywhere, and 300 cases of petty crime each year. Under László, the houses became restored and neat, with bathrooms added, and people worked in the fields and in plastic greenhouses producing quality vegetables. Officials from other towns came to learn from the Roma people working in the *Cserdi miracle*. László (Laci) ran the town like a father, watching over everyone and trying to motivate the young people to go to university. Roma from outside the village sometimes criticized him, for some preferred to remain victims.

According to *The Economist*, there were no clues that he might die by suicide but, then, the villagers and *The Economist*'s reporter are not trained to notice the clues which I'm sure were there. It is hard for a Roma to move into the mainstream where he or she might have influence on, or even in, the government. It is a tragedy to lose László.

Suicide Studies, 2020, 1(2)

SUICIDE BY PILOTS OF COMMERCIAL AIRCRAFT: THE MISSING MALAYSIAN AIRLINES FLIGHT MH370

David Lester

I noted in 2002 (Lester, 2002) that occasionally pilots of commercial aircraft die by suicide while piloting their plane full of passengers.[2] The example I gave was of Gameel-al-Batouti, the co-pilot of EgyptAir flight 900 which crashed into the Atlantic Ocean on October 31, 1999, an act which seemed to be suicidal Langewiesche (2001).

More recently, Langewiesche (2019) has given more examples of possible suicides by pilots: (1) in 1997, the pilot of a SilkAir plane (an Indonesian airline) is believed to have disabled the black boxes of his Boeing 737 and crashed the plane into a river, (2) the pilot of a LAM Mozambique Airlines flight 470 flew his Embraer E190 into the ground killing all 27 passengers, and (3) Andreas Lubitz, the co-pilot, crashed his Germanwings Airbus into the French Alps, having locked the pilot out of the cockpit when the pilot went to the bathroom.

In his new article, Langewiesche argues that the most likely scenario for the missing Malaysian Airlines flight 370, which disappeared over the Indian Ocean March 8, 2014, was that the pilot deliberately choose to die by suicide, taking all the passengers and crew (who were most likely already dead inside the plane) with him.

Langewiesche saw the co-pilot as an unlikely instigator or collaborator. He was young, an optimist and planning to get married. He had no history which would suggest suicidal inclinations. In contrast, the co-pilot of the Germanwings plane that crashed flew for budget airlines with low pay and showed signs in the past of psychological problems.

In contrast, the pilot of MH370, Amad Shah Zaharie, although described by his family and the authorities as a happy family man and excellent pilot, was described by friends as often sad and lonely. His wife had moved out to their second home, and Zaharie spent the time between flights pacing empty rooms. He had a wistful relationship with a married woman who had three children, he was interested in two Internet models whom he met on social media, and he had a history of liaisons with the flight attendants. Some who knew him thought he was clinically depressed. Prior to the disappearance of MH370, Zaharie had experimented in a simulator with the flight path that MH370 most likely followed.

In none of these cases was a reputable and thorough psychological autopsy carried by a qualified suicidologist, and so the conclusion that these pilots and co-pilots chose to die by suicide, killing their passengers as collateral damage, must remain a hypothesis. However, suicide remains the most likely cause of the crashes given current information.

References

[2] I also noted cases of passengers dying by suicide by causing the plane to crash and a pilot who died by suicide after he had crashed his plane.

Langewiesche, W. (2001). The crash of EgyptAir 900. *Atlantic Monthly, 288*(4), 68-92.
Langewiesche, W. (2019). "Goodnight Malaysian three-seven-zero." *Atlantic Monthly, 324*(1), 78-94.
Lester, D. (2002). Suicide and aircraft. *Crisis, 23*, 2.

Suicide Studies, 2020, 1(2)

BIAS IN THE REPORTING OF SUICIDE AND GENOCIDE

DAVID LESTER

Abstract: Reports of suicide during two genocides (in Armenia in 1915 and in India and Pakistan in 1947) are primarily of women committing suicide, often in mass, to avoid abduction and rape. It is suggested that this may be biased reporting of suicidal behavior during these genocides.

Introduction

Previous studies have reported high rates of suicide during the Holocaust, both in the ghettos and in the concentration camps (Lester, 2005) This raises the question of whether suicide was common during other genocides. Two genocides have some (albeit limited) data available: that of the Armenians in the Ottoman Empire in 1915 and during the partition of India in 1947.

Armenians

Miller and Miller (1982) interviewed 35 survivors of the Armenian genocide, now living in California. Their informants reported that many of those deported died of thirst, hunger, disease and murder. Children were stolen, young women abducted, and women raped and mutilated. Mothers abandoned their children or gave them away to Turks, Kurds or Arabs and "not a few mothers and families committed suicide together" (Miller & Miller, 1982, p. 55).

There are reports of hundreds of young women committing suicide by drowning (Miller & Miller, 1993, p. 96). One informant tried to drown herself in a river, but a relative pulled her out. There are reports of girls linking arms or holding hands and jumping off bridges or cliffs into the rivers. Miller and Miller hypothesized that the girls were physically and emotionally exhausted, had witnessed incredible violence, and had lost hope of survival.

Miller and Miller documented three types of suicide. Altruistic suicide was evident in mothers who starved to give their children the limited food available or who died with their children rather than abandoning them. Despair-motivated suicides had given up hope and either drowned themselves or simply sat down on the road to die. In defiant suicide, the goal was to cheat the aggressors of the sadistic pleasure of murder. One survivor reported an incident where those escorting the Armenians were stripping the deportees of their clothes and throwing them off a cliff into the river, whereupon one woman picked up her four-year-old son and jumped with him into the river.

India and Pakistan[3]

[3] Only reports of suicides among Hindus were found. No accounts of suicide among Muslims could be located. This does not mean that no suicides occurred in Muslims, only that reports of such cases are absent or difficult to locate.

The plan to partition India (into India and a regionally divided Pakistan) was announced on June 3, 1947. The movement of Hindus, Muslims and Sikhs to other territories began in earnest in the August and September of 1947. There followed a massive disruption as more than ten million people moved from one country to the other across the western border alone. Villages were abandoned, crops left to rot, and families separated by the new borders. The governments of India and Pakistan were completely unprepared for this.

More than this disruption, there was a genocide as members of one religion raped and slaughtered those of the other religions. Estimates of the dead range from 200,000 to two million and about 75,000 women were abducted and raped by men of other religions and sometimes by men of their own religion. The torture of the women included raping and disfiguring women in front of their relatives, tattooing and branding them with 'Pakistan, Zindabad" or 'Hindustan, Zindabad,' marking a half-moon on their breasts or genitalia, and amputating their breasts.

To prevent capture, torture and death at the hands of others or forced religious conversions, people murdered their own children, spouses, parents and other significant others. Some also committed suicide. Pennebaker (2000) mentions women who jumped into wells or set themselves on fire, sometimes individually but occasionally all the women in a family together.

Butalia (2000) talked to and recorded the experiences of those in one region during this crisis, the Punjab. She heard tales of hundreds of women jumping into wells (and sometimes being forced to jump) to avoid capture, rape, abduction and forced conversions. One informant reported watching more than ninety Sikh women jump into a well in her village in Rawalpindi on March 15th 1947 when it was under attack from Muslims. The informant jumped in too with her children, but survived because the water was no longer deep enough for her to drown. When the well filled up, villages dragged the women who were still alive out of the well (p. 35).[4] The incident was reported in the April 15th, 1947, edition of *The Statesman*, an English daily newspaper. The informant's brother-in-law had already killed his mother, sister, wife, daughter and uncle, and her daughter was killed. Before they jumped, the women were given some opium mixed in water. The brother-in-law poured kerosene on himself and jumped into a fire and later perhaps his son also committed suicide.[5] Another survivor interviewed by Butalia reported seeing a girl, who was being dragged away, jump into a canal to escape and another who jumped off a roof to avoid rape and abduction (p. 271). Later, India's Prime Minister, Nehru, visited the well, and the English closed it up.

This incident has acquired iconic significance, illustrating the bravery and manliness of the Sikhs, although Butalia points out that it was women who died. *The Statesman* compared the "sacrifice" of such women to the mass immolations of Rajput women when their husbands were killed in wars. Those women who survived are typically seen as "inferior" to those who died. The deaths of those who died are seen as "saving" those who survived these times. It is likely that the villagers would have been killed, abducted and raped had the attackers not backed off. Butalia, however, noted the failure of the men in such incidents to defend their village and

[4] The newspaper account reported that three women were saved.
[5] Most of the accounts of this incident mention only women, but Butalia's informant said that boys jumped in also.

retaliate, but instead their acquiescence in the murder and suicide of their family members.[6] Butalia also questions the extent to which the suicides of these women were "voluntary."[7]

Menon and Bhasin (1998) also noted that women jumped into wells or set themselves on fire either singly or in groups. The Fact Finding Team set up by the Indian government recorded that in Bewal Village (in the Rawalpindi district), many women committed suicide by self-immolation on March 10, 1947. They put their bedding and cots in a pile, set fire to it and jumped onto it. A school teacher, whose family was in a camp that was attacked on August 26, 1947, reported that his daughter had a man try to strangle her three times, but she survived despite losing consciousness (Menon & Bhasin, 1998, p. 42). Many women carried vials of poison around their neck so as to have the means for suicide easily available should it become necessary (p. 46).

One male informant told Menon and Bhasin that his town of Muzaffarabad was raided in October 17, 1947. The Hindus were overpowered and surrendered. Their money was taken, and they were marched away. His three sisters swallowed poison, and then several women jumped off a bridge to drown in the river. A female informant who survived this incident recalled women committed suicide using opium first and then taking a faster-acting poison. Another informant told of a woman who tried to throw her 10-month old baby on a burning pile, but someone else saved the baby. Later the mother and this baby escaped and hid in a cave. When the mother heard that her husband had been killed (falsely), she swallowed poison and died. Three women in this village refused to take the poison or kill their children, and later they were accused of cowardice, their "lack of courage in facing death" (p. 54).[8]

Menon and Bhasin (1998), like many others, reject the term "suicide" for these deaths. In their opinion, the women did not voluntarily endorse the honor code and choose death. If they had not committed suicide, they would have been killed by their own kin and neighbors to "protect their honor." Menon and Bhasin note that acquiescence does not imply consent, and submitting is not the same as agreeing. Pandey (2001) prefers the term "martyrdom" to describe the suicides of the Hindus and Sikhs.

On the other hand, these women were caught in a horrendous bind. They faced rape, mutilation and torture. Some individuals might choose suicide over this. However, the role of the men in murdering their kin and forcing suicide upon them took away the women's freedom of choice. It is unknown what these women might have done if the men had not exerted pressure. These women grew up in a culture that held these values, and they may have been sufficiently enculturated so that they would have chosen suicide "freely."

In contrast to the myth that has grown up around the suicides of Hindu and Sikh women during this time, Pandey (2001) pointed out that some women did flee. He reports that some boys were disguised as girls for these escapes in order to avoid death if they were captured. Some

---

[6] Butalia noted that women were sometimes traded to the attackers in return for freedom for the rest of the community.

[7] Pandey (2001) noted that the village had been under attack for three days, and the Hindus and Sikhs had fought the attackers, but could no longer hold out.

[8]

have argued that it made sense to convert to Islam in order to have their lives spared and, although some of those who advocated this were murdered by their kin, some Sikh families did convert. Pandey also noted that a few families, on both sides of the border, were willing to sacrifice young women to the abductors in order to buy security for the family (p. 195).

Discussion

The most noteworthy aspect of these, admittedly brief accounts, is that the vast majority of the suicides reported were of women. The women were, of course, subjected to horrendous violence, but their suicides, especially in case of India, are cast as heroic acts that denied the murderers satisfaction. In India, emphasis is placed on the suicides as ways of avoiding defilement by the murderers, thereby preserving the women's purity. In India, too, many women and men were murdered by their own group for the same purpose.

I located one report of the suicide of a man. Butalia recounted one story from information obtained from newspapers and memoirs. Zainab, a young Muslim girl, was abducted as her family tried to move from India to Pakistan, and sold to a Hindu, Buta Singh, who married her. They came to love each other and had children, but a program was set up by the two governments to "rescue" abducted women and return them to their new countries. Zainab was found and forced to leave Buta Singh. Buta Singh tried to change the decision and then to go to Pakistan. He converted to Islam and applied for a Pakistani passport. He was refused. He applied for a short-term visa which was granted. When he arrived, he found that Zainab had already been married to a cousin. Zainab, almost certainly under pressure from her family, rejected Singh in front of a magistrate, and the next day Singh threw himself under a train and died (Butalia, 2000, p. 103). His suicide note asked to be buried in Zainab's village, but the villagers refused this request, and Singh was buried back in Lahore in India. This tale has not become a legend, with books and a movie based on it.

The way in which these accounts are written permits several speculations. First, there is guilt on the part of the men that they could not protect their wives, sisters, mothers and children. By raising the suicides of the women to heroic proportions, they lessen the chance of being blamed for the tragedy.

Second, there is the possibility that suicide is seen as weak and inappropriate behavior and, by reporting only the suicides of women, the men themselves avoid the stigma of suicide. Even in the present era, there is stigma attached to suicides (and, by association, to their significant others), and this stigma was stronger in previous centuries. To have reported the suicides of men during these genocides would make the men seem weak too.

In other situations, such as the Jewish ghettos and the concentration camps in the Second World War, suicide by men was common (Lester, 2005). It is likely that men did commit suicide too during the genocides in Armenia and India but, if so, they have received less attention and documentation.

References

Butalia, U. (2000). *The other side of silence*. Durham, NC: Duke University Press.
Lester, D. (2005). *Suicide and the Holocaust*. Hauppauge, NY: Nova Science.
Menon, R., & Bhasin, K. (1998). *Borders and boundaries*. New Brunswick, NJ: Rutgers University Press.
Miller, D. E., & Miller, L. T. (1982). Armenian survivors. *Oral History Review*, 10, 47-72.
Miller, D. E., & Miller, L. T. (1993). *Survivors: An oral history of the Armenian genocide*. Berkeley: University of California Press.
Pandey, G. (2001). *Remembering partition*. New York: Cambridge University Press.
Pennebaker, M. K. (2000). "The will of men": Victimization of women during India's partition. *Agora*, 1(1, Summer), unpaged.
Talbot, I. (1998). *Pakistan*. New York: St. Martin's Press.

Suicide Studies, 2020, 1(2)

SUICIDE AS A MISTAKE: A BIZARRE IDEA FROM PHILOSOPHERS

David Lester

I've never thought that philosophers or philosophy had much to contribute to understanding suicide ever since I read what philosophers had to say about the death by suicide of Socrates (Lester, 2004). (Peggy Battin is an exception, of course!) I recently read an article in a philosophy journal that confirmed my opinion. Pilpel and Amsel (2011) proposed that a decision to die by suicide can be morally permissible and rational and yet be a *mistake*. This comment argues that their reasoning behind this is incorrect.

Pilpel and Amsel discuss briefly the concepts of rationality and morality, for which various authors have proposed clear criteria. In arguing that a suicide can be a mistake, Pilpel and Amsel introduce a construct that they never define. (They say that they leave this for a later article.) However, from their article, we can decipher some clues as to what they mean by a mistake. They present a case, more about which later, and say that they "*feel strongly that she is throwing her life away*" (p. 116). Clearly, this phrase does not propose criteria for making a mistake in general, since most of our mistakes do not involve life and death decisions but, in the present context, *throwing one's life away* is considered by Pilpel and Amsel to be a mistake. Pilpel and Amsel also characterize the reasoning of their hypothetical case of suicide (see below) as odd and absurd and as a blunder, again terms for which they propose no definition.

Rather than proposing a new philosophical (or psychological) construct, Pilpel and Amsel seems merely to have given their subjective opinion of what is a good decision or a bad decision. For Pilpel and Amsel, choosing to die by suicide, even in a way that is meets the criteria for rationality and morality, is a bad decision. For Pilpel and Amsel, life is precious.

To bolster their argument, Pilpel and Amsel present a hypothetical case. I remember once being scolded by a priest when I argued against the existence of Heaven by proposing my version of it (in which people lounged around in deck-chairs sipping ambrosia). Setting up a straw man, or in the present case a straw woman, is not a good way of arguing for a proposition for, even if hypothetical cases are of interest to philosophers, they are of minimal interest to those of us who are psychologists and who study real suicides.

The hypothetical woman described by Pilpel and Amsel is thinking rationally, and her suicide does not violate her moral principles, as admitted by Pilpel and Amsel. Her motivation for suicide is that she has achieved all she set out to do, and now her life will be a steady decline. She expects to experience more frustration as she ages and less satisfaction. She decides to die at this point, a high point in her life.

Although they are not clear on this point, Pilpel and Amsel do seem to value life. The question they fail to address is the criterion for a to-be-valued life. Socrates died by suicide. Using Pilpel and Amsel's terminology, he *threw his life away*. He could have proposed exile as his punishment, and his request would have been granted. Did his age make his choice to die by

suicide (ordered by the court) less of a mistake? Yukio Mishima chose to die by suicide (seppuku) at his peak (creative and physical), but did his goal of political change (overthrowing the government) make his choice of *throwing his life away* less of a mistake.

Many people have self-immolated to protest the government. Thich Quang Duc immolated himself in Vietnam in 1963 to protest the government's oppression of Buddhists, and his death lives on in our memory. His death remains famous 50 years later. A mistake or not? Craig and Joan died by car exhaust poisoning in New Jersey in 1969 to protest the American involvement in Vietnam (Asinof, 1971), but readers of this essay will most likely not have heard of them. Does their anonymity make their suicide less of a mistake or more of a mistake? Were inmates of Auschwitz who chose suicide *throwing their lives away* when many survived and gave witness to the horrors?

I doubt that the construct of a *suicide as a mistake* is a useful construct, and Pilpel and Amsel did little to convince me of its value,

References

Asinof, E. (1971). *Craig and Joan.* New York: Viking.
Lester, D. (2004). *Thinking about suicide*. Hauppauge, NY: Nova Science.
Pilpel, A., & Amsel, L. (2011). What is wrong with rational suicide. *Philosophia, 39,* 111-123.

Suicide Studies, 2020, 1(2)

Suicides at Guantanamo Bay[1]

David Lester

The detention center for suspected terrorists at Guantanamo Bay has handled 771 individuals for varying amount of time, of whom 629 arrived in 2002 and 40 remain as of September 2020. There have been 9 deaths of prisoners recorded at the detention center, of which 7 have been labelled as suicides. There have however, been questions raised as to whether these deaths were really suicides rather than homicides or deaths resulting from torture at the hands of the staff (Horton, 2010). Some military officials labelled these suicides as acts of war by jihadists seeking martyrdom (Savage, 2011).

Three of these suicides occurred in 2006 (apparently in a suicide pact using hanging), one in 2007, one in 2009, one in 2011, and one in 2012. To calculate a suicide rate, the years 2002 to 2019 were included, and the average population in June and July used. The average population per year for the 18-year period was 266.8, with an average of 0.39 suicides per year, giving a suicide rate of 8.10 per 100,000 per year.

There were many attempted suicides at the prison, mostly by overdosing on medication, but also by hanging and cutting, with more than 120 reported by the end of 2004, as well as many more acts of self-harm.[2] One prisoner was reported as having made 12 serious suicide attempts. There were also hunger strikes by prisoners to protest their treatment (Savage, 2011).

References

Horton, S. (2010). *"The Guantánamo "Suicides": A Camp Delta sergeant blows the whistle"*. *Harper's Magazine*. Archived from the original on January 18, 2010.

Savage, C. (2011). As acts of war or despair, suicides rattle a prison. *New York Times*, April 24, online.

---

[1] These data come from https://www.nytimes.com/interactive/projects/guantanamo

[2] https://en.wikipedia.org/wiki/Guantanamo_Bay_detention_camp_suicide_attempts