COLUMNS

SUICIDE ON MY MIND, PREVENTION ON MY AGENDA

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I must admit that I'm very fond of this journal as one key event in my life as a suicidologist occurred during work for this publication. When Clinical Neuropsychiatry was launched, the editors decided that each of the first issues should be devoted to an important topic in mental health. My mentor Professor Tatarelli asked me to help in the preparation of an entire issue dedicated to suicide. We listed a number of leaders in the field and contacted them. One leader was Professor Edwin Shneidman who is considered to be the father of suicidology for his pioneering studies on suicide and for the establishment of the Los Angeles Suicide Prevention Center, a milestone in the prevention of suicide in the community. After a great deal of searching, I managed to get contact him.

During the course of this, several important events happened in my life. Just after getting married, I left for Boston to join the staff at the McLean Hospital at the Harvard Medical School. One day, in the middle of a cold Bostonian December, after having walked the same two miles that separated my home and the hospital, I reached the Mailman Research Center. Professor Baldessarini had placed me in one of his laboratories and, on reaching my desk, I noticed that the answering machine indicated that I had new messages. This was odd as I knew almost nobody, and people from Italy did not have my telephone number. I played the message and heard a warm and encouraging voice that thanked me for my help during the preparation of his paper for the issue mentioned above. The man introduced himself as Edwin Shneidman, and he encouraged me to call him for a chat and to make his acquaintance. My excitement was so great that I called him right away, forgetting that Boston and Los Angeles are in different time zones. I woke him at dawn! Nevertheless, we spent about forty-five minutes talking about suicide and how he conceptualizes human self-destruction.

My deep interest in suicide had begun during the early years of the medical school and culminated with my dissertation about suicide in schizophrenia. The work by Shneidman gave me a more precise framework regarding negative emotions and the role of unbearable psychological pain in the precipitation of suicide. The fact that the focus of Shneidman's writings was on negative emotions was no doubt something that touched my heart, leading me to make sense of some dreadful life events that had disturbed my mind a long time ago. Real understanding of human suffering requires an effort by the listener. Most people will listen to other people's human suffering only as a social duty and then will carry on with their duties. Only few people are willing to make the effort to bridge the gap in communication of human suffering. Helping suicidal patients requires a major effort in the understanding of the profound human misery that they experience. Even among health professionals, psychological pain and suicide risk are often taboo topics. We are trained to collect information about the clinical history of our patient as well as to identify the best therapy for his disorder, but I wonder if this is enough.

With these concepts in mind, we have been educating people from the community, students, health professionals, military personnel about suicide. We have provided an understanding about suicide individuals in a variety of roles in the society. Such intensive work has led to me being elected the Italian National Representative to The International Association for Suicide Prevention (IASP), an institution that works in partnership with the World Health Organization.

I was amazed and thrilled to learn that my intensive efforts in suicide research were going to be recognized with the American Association of Suicidology's 2008 Shneidman Award. This award is presented to a person under 40 years of age, or a person who is not more than 10 years past the highest degree

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earned, who has made outstanding early career contributions to Suicidology. I was introduced by the Executive Director of the American Association of Suicidology Dr. Alan L. Berman and my lecture at the Annual Conference of the American Association of Suicidology held this year in Boston was entitled "Shneidman's suicidology: Above and beyond research priorities".

Suicidology: a discipline dealing with the many aspects of human self-destruction

Suicidology can be defined as the scientific study of suicide and suicide prevention. The term (and the concept) was first used by Shneidman (1964) and was since then used in a number of ways such as to describe aspect of new training (Fellowship in Suicidology 1967); as part of a new journal (Bulletin of Suicidology 1967); to label a new organization (the American Association of Suicidology 1968). Suicidology is unlike other behavioral sciences in that it has usually included not just the study of suicide but also its prevention, in other words it incorporates appropriate clinical interventions to prevent suicide, a feature not always taken into consideration in the many contributions to suicide understanding. The focus of suicidology is not necessarily completed suicide but above all treatment of suicidal individuals. Suicides die with their unique life histories and it would appear inappropriate dealing with pooled data or statistics to understand the human misery of these individuals. Maris et al. (2000) stated that "While suicidologist give lip service to the multidisciplinary study of suicide, in actual fact most of us have very narrow and specialized domain assumption – usually those related to our professional training and subdisciplinary paradigms". No doubt, most of us share Edwin Shneidman's conceptualization of suicide that "Suicide springs from an individual's psychic pain". It is perhaps received wisdom in suicidology that suicidal individuals are experiencing unbearable psychological pain or suffering and that suicide may be, *at least in part*, an attempt to escape from this suffering.

As reported by Maris and colleagues (2000), the building blocks of a systematic theory of suicide include definition, basic concepts (lethality, motive, suicidal career, etc.), hypothesis, models, and research results. Regardless of such items some concepts are so basic to suicide that they can be thought as the commonalities of suicide. Shneidman (1985) listed some practical measures for helping highly suicidal persons:

1. Stimulus (unbearable pain): reduce the pain;
2. Stressor (frustrated needs): fill the frustrated needs;
3. Purpose (to seek a solution): provide a variable answer;
4. Goal (cessation of consciousness): indicate alternatives;
5. Emotion (hopelessness-helplessness): give transfusion of hope;
6. Internal attitude (ambivalence): play for time;
7. Cognitive state (constriction): increase the options;
8. Interpersonal act (communication of intention): listen to the cry, involve others;
9. Action (egression): block the exit;
10. Consistency (with life-long patterns): invoke previous positive pattern of successful coping.

Box. The American Association of Suicidology (AAS) was founded by clinical psychologist Edwin S. Shneidman, Ph.D. in 1968. After co directing the Los Angeles Suicide Prevention Center (L.A.S.P.C.) since 1958, Dr. Shneidman was appointed co director of The Center for Suicide Prevention at the National Institute of Mental Health (N.I.M.H.) in Bethesda, MD. There he had the opportunity to closely observe the limited available knowledge base regarding suicide. Consequently, under the sponsorship of the N.I.M.H., he organized a meeting of several world-renowned scholars in Chicago, determined the need for and fathered a national organization devoted to research, education, and practice in "suicidology," and advancing suicide prevention (www.suicidology.org).

Meeting Ed. Shneidman

I have always been intrigued by major scholars from the past who have made substantial contributions to science. For instance, I have often fantasized that I would have loved to have met Freud or Darwin, to ask them questions and explore their personality. Suicidology has been part of my life for many years. Learning the first steps of this discipline has fascinated me, and I developed a great deal of admiration for Edwin Shneidman for his work that fuelled the scientific study of suicide as well as its prevention. I had confined the idea of meeting the father of suicidology to my fantasies. When I was called to go to Boston to receive the Shneidman Award, an opportunity arose to realize my fantasy. Edwin Shneidman is 90 years old and rarely leaves his home in Los Angeles. Over the years, I was often invited to visit him, but I never had the opportunity to travel all the way to California. Challenging time and space, I decided to visit him and arranged a day trip to Los Angeles on the occasion of the award in Boston. (For various reasons, I could not stay there more than a few hours).

A warm voice welcomed me just after arriving in front of a lovely house in a quiet area of Los Angeles. Ed. immediately took me into his Melville room, a space packed with reminiscences of his love for the novelist Hermann Melville. I had the pleasure to hear from his own voice how he serendipitously approached the study of suicide back in 1949. Here is the story "I was 31 and a clinical psychologist at Brentwood Veterans Administration Neuropsychiatric Hospital, and the superintendent asked me to prepare letters for his signature to two new widows whose husbands had recently committed suicide. On my own I went to the county coroner's office to find relevant background material and discovered a vault with hundreds of suicide notes. My contribution was to recognize their enormous potential, behavioral science potential. My further contributions were not to read them (so as to remain blind) and to invent, on the spot, a new genre of document, namely the elicited suicide note from non-suicidal persons so as to be able to compare genuine suicide notes in a real double-blind experiment. The day I went to the Coroner's office was somewhat an

epiphany of my life. I then called Norman Farberow, who had recently completed a dissertation on suicidal patients using my Make a Picture Story (MAPS) Test. Norman and I blindly analyzed each genuine an simulated suicide note. We published the results in a paper entitled "Clues to Suicide (Shneidman and Farberow 1956) and the following year we published another short paper entitles "Some comparisons between genuine and simulated suicide notes" (Shneidman and Farberow 1957). In 1957 we co-edited Clues to Suicide (Shneidman and Farberow 1957). That was the birth of Suicidoloy".

One of the major steps in the conceptualization of suicide as a psychological disorder was the involvement of the psychological autopsy. Such procedure really introduced the psychological element into the study of suicide. Suicide had always been studied anecdotally, statistically, sociologically but hardly psychologically. The psychological autopsy develops relevant information where the mode of death is unclear. Obviously one can write a biography without knowing the chief character directly, but depending on people who knew the decedent as the informants. The psychological autopsy method involves a retrospective investigation of the deceased person and uses psychological information gathered from personal documents; police, medical, and coroner records; and interviews with family members, friends, co-workers, school associates, and health care providers to clarify equivocal deaths. The aim of the procedure is to achieve a clear picture of the personality preceding the event. Much credit for the success of the psychological autopsy belongs to Dr. Theodore Curphey, the Los Angeles coroner, who recognized the realistic benefits of that procedure". Shneidman had prophetically used for the first time the term in a book on Thematic Test Analysis stating something that was going to become relevant afterwards (Shneidman 1951) "... To present a study in which the emphasis is on the prediction of behavior rather than the validation of the technique; i.e., to hold a "psychological autopsy" on one case (p. 4). Dr. James G. Miller has indicated rather succinctly that 'Diagnosis is irrelevant and unproductive unless it is also prediction at the same time'. He has also, in the same context, pointed out the need for clinico-pathologic conferences in psychology similar in function to those held in medicine. This book, then, is a sort of "psychological autopsy", wherein the postmorten is performed not on the patient but on the test interpretations. This is made possible by the availability of the clinical and psychiatric data... (p. 6)".

Shneidman stresses the vast difference between brain and mind, here when he says "It does make a difference – in how you think of human self-destruction and how you address suicidal persons – whether you believe that suicidality is fundamentally a disease of the brain or a perturbation in the mind. In the 1880's a young German physician, Emil Kraepelin wrote a book on the classifications of mental diseases. This is the intellectual parent of today's Diagnostic and Statistical Manual. For me, it is not truth with a capitol T, but merely Kraepelin's brilliant medically oriented opinion. What I have seen in my suicidal patients is what Morselli (1881) called moral pain, the pain of the negative emotions – shame, guilt, abandonment, ennui, dysphoria, hopelessness inanition, what I call psychache. I view suicidal impulses (thoughts and actions) phenomenologically, more like being in love than having a liver disease. In my mind the key to suicide prevention lies in focusing on the individual's idiosyncratically felt psychological pain and not dropping him into a DSM box. I recognize that this view is radical, but I also know that the suicidal act is draconian, and that dramatic reconceptualization may be necessary in order to take fresh steps in new directions so as to better understand human self-destruction".

After this fascinating and enriching talk and after a good meal together it was time for me to go back to Boston and then to Italy. Ed. cares a lot about the continuation of his work for further development regarding the role of psychache in the precipitation of suicide, so in the door step he blessed me by saying "You are my future". These words stimulated in my mind many invigorating thoughts and made my long journey back to Italy tremendously less tiring and fruitful for ideas related to suicide research and suicide prevention.

Suicide prevention can be effective if we avoid using diagnostic labels for suicidal individuals. Suicide cannot be considered simply a symptom of any psychiatric disorders. If we consider it in that way, we take the risk of treating the disorder as a whole, and we do not see suicide as a separate dimension, often coexisting with the psychiatric condition. The two dimensions overlap in many instances but they remain separate. Suicide must involve an ad-hoc investigation and should not be listed as one of the many features identified in psychiatric disorders. Suicide prevention is possible, and the important task is to educate people and professionals on the drama occurring in the suicidal mind.

Conclusions

Although Shneidman admits that each suicide is a multifaceted event, that biological, cultural, sociological, interpersonal, intrapsychic, logical, philosophical, conscious, and unconscious elements are always present, he suggests that the essential nature of suicide is psychological, meaning that each suicidal drama occurs in the mind of a unique individual. It is widely acknowledged in suicidology that suicidal individuals are experiencing psychological pain or suffering and that suicide may be, at least in part, an attempt to escape from this suffering.

Shneidman (1993a,b) coined the term "psychache" to describe this pain. Psychache is the hurt, anguish, or ache that takes hold in the mind...the pain of excessively felt shame, guilt, fear, anxiety, loneliness, angst, and dread of growing old or of dying badly. Suicide is functional because it abolishes the pain for the individual. Suicide occurs when the psychache is deemed by that individual to be unbearable. It is an escape from intolerable suffering.

Shneidman (1993b) believes that in suicide, 'death' is not the key word. Suicide is best understood not so much as a movement toward death as it is a movement

away from something and that something is always the same: intolerable emotion, unendurable, or unacceptable anguish. If the level of suffering is reduced the individual will choose to live. Each of us has an idiosyncratic disposition made up of psychological need and the weights we give these psychological need is a window into our personality (Murray 1938). Among the various psychological needs we can distinguish two kinds: those that characterize the functioning that is the modal needs; these are the needs the person live with. On the other hand, there needs that the individual focuses on when he or she is under duress, suffering, heightened inner tension and in mental pain. These are the needs an individual is willing to die for, also called vital needs. In suicidal individuals the focus is on frustrated or thwarted need; these are needs deemed by the individual as vital for continued living. The frustration of these needs might lead to suicide. This special disposition of needs can be elicited by asking an individual about precise reations to the failures of losses or rejections or humiliations previously in his life.

Suicide is the result of an interior dialogue. A dialogue takes place in the mind where options to solve the pain are scanned and suicide occurs after a length of time when efforts to find amelioration of psychache failed. At the beginning the mind scans its options; the topic of suicide comes up, the mind rejects it, scans again; there is suicide, it is rejected again, and then finally the mind accepts suicide as a solution, then plans it fixes it as the only answer. It is therefore an escape from intolerable suffering. Suicidal individuals experience constriction as tunneling, or focusing or narrowing the range of options usually available to that individual's consciousness and dichotomous thinking, that is, wishing either some specific (almost magical) total solution for their psychache, or cessation, in other words suicide (Shneidman 1996).

According to this view suicidology, suicide occurs when perturbation and lethality exist in the same individual: perturbation refers to how upset (disturbed, agitated, discomposed) the individual is; lethality refers to the likelihood of an individual's being dead by his or her own hand in the future, lethality is a synonym for suicidality. In this view, perturbation supplies the motivation for suicide, lethality is the fatal trigger. To reduce lethality and therefore dealing with perturbation we need to ask the person "Where do you hurt?", "How may I help you" and so forth. Before dealing with lethality we need to deal with perturbation (psychache) which energizes lethality. Shneidman (1985), has proposed the following definition of suicide: 'Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution'.

Anyone dealing with suicidal individual should be empathic and resonate to the patient's private psychological pain; be aware of the uniqueness of "patient's suffering"; change from "unbearable" and "intolerable" to "barely bearable" and "somewhat tolerable"; pay attention to frustrated psychological needs considered by the person to be vital to continued life (Shneidman 2004, 2005).

Pompili et al. (2008) recently investigated the role of psychache in the determination of suicide risk in 88 psychiatric inpatients. They used the Psychological Pain Assessment Scale (Shneidman 1999) that involves direct questions about the level of current and worst-ever psychache using a linear rating scale and a checklist for the emotions experienced, along with pictorial stimuli. These authors found that those patients currently at risk for suicide reported significantly higher current psychache and higher worst-ever psychache. The rating of current psychache was high, 6.7 on a scale of 1-9, but lower than the rating the worst psychache ever experienced – 8.6. It appears, therefore, that the patients had experienced severe psychache and were still suffering intense psychache. Most of our patients considered their worst-ever psychache unresolved. They had been hurt so much that they felt that the pain associated with those adverse events in their life could not be relieved and that they were condemned to face this pain forever. This suggests that, for suicidal psychiatric patients, amelioration of symptoms is not sufficient.

In the year 2000, approximately one million people died from suicide: a "global" mortality rate of 16 per 100,000, or one death every 40 seconds. In the last 45 years suicide rates have increased by 60% worldwide. Suicide is now among the three leading causes of death among those aged 15-44 years (both sexes); these figures do not include suicide attempts up to 20 times more frequent than completed suicide. Suicide worldwide is estimated to represent 1.8% of the total global burden of disease in 1998, and 2.4% in countries with market and former socialist economies in 2020. Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries. Mental disorders (particularly depression and substance abuse) are often associated with cases of suicide; however, suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socioeconomic, family and individual crisis situations (e.g. loss of a loved one, employment, honour). It is acknowledged that since killing oneself is against nature, no normal person would commit such an act, therefore those who commit suicide are considered mentally ill; however the vast majority of mentally disordered people even if faced by the same dramatic situations encountered by suicides do not actually kill themselves. Suicide should not be considered a symptom of the various psychiatric disorders otherwise proper suicide assessment is generally impaired.

The economic costs associated with completed and attempted suicide are estimated to be in the billions of dollars. One million lives lost each year are more than those lost from wars and murder annually in the world. It is three times the catastrophic loss of life in the tsunami disaster in Asia in 2005. Every day of the year, the number of suicides is equivalent to the number of lives lost in the attack on the World Trade Center Twin Towers on 9/11 in 2001.

Everyone should be aware of the warning signs for suicide: Someone threatening to hurt or kill him/herself, or taking of wanting to hurt or kill him/herself;

someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person. Also, high risk of suicide is generally associated with hopelessness; rage, uncontrolled anger, seeking revenge; acting reckless or engaging in risky activities, seemingly without thinking; feeling trapped – like there's no way out; increased alcohol or drug use; withdrawing from friends, family and society, anxiety, agitation, unable to sleep or sleeping all the time; dramatic mood changes; no reason for living; no sense of purpose in life (Tatarelli 1992).

Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them. Talking about suicide does not cause someone to be suicidal; on the contrary the individual feel relief and has the opportunity to experience an empathic contact.

Ways to be helpful to someone who is threatening suicide:

1. Be aware. Learn the warning signs.
2. Get involved. Become available. Show interest and support.
3. Ask if he/she is thinking about suicide.
4. Be direct. Talk openly and freely about suicide.
5. Be willing to listen. Allow for expression of feelings. Accept the feelings.
6. Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life.
7. Don't dare him/her to do it.
8. Don't give advice by making decisions for someone else to tell them to behave differently.
9. Don't ask 'why'. This encourages defensiveness.
10. Offer empathy, not sympathy.
11. Don't act shocked. This creates distance.
12. Don't be sworn to secrecy. Seek support.
13. Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don't understand.
14. Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

Be aware of feelings, thoughts, and behaviors:

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work
- Can't get out of the depression
- Can't make the sadness of away
- Can't see the possibility of change
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't see to get control

Suicide profoundly affects individuals, families, workplaces, neighborhoods and societies. The economic costs associated with suicide and self-inflicted injuries are estimated to be in the billions of dollars. Surviving family members not only suffer the trauma of losing a loved one to suicide, and may themselves be at higher risk for suicide and emotional problems.

Strategies involving restriction of access to common methods of suicide have proved to be effective in reducing suicide rates; however, there is a need to adopt multi-sectoral approaches involving other levels of intervention and activities, such as crisis centres. There is compelling evidence indicating that adequate prevention and treatment of depression, alcohol and substance abuse can reduce suicide rates. School-based interventions involving crisis management, self-esteem enhancement and the development of coping skills and healthy decision making have been demonstrated to reduce the risk of suicide among the youth. Worldwide, the prevention of suicide has not been adequately addressed due to basically a lack of awareness of suicide as a major problem and the taboo in many societies to discuss openly about it. In fact, only a few countries have included prevention of suicide among their priorities.

Reliability of suicide certification and reporting is an issue in great need of improvement. It is clear that suicide prevention requires intervention also from outside the health sector and calls for an innovative, comprehensive multi-sectoral approach, including both health and non-health sectors, e.g. education, labour, police, justice, religion, law, politics, the media.

With a highly suicidal person, our task is to serve as an anodyne, that is a substance or process that relieves pain (Shneidman 1993c). In suicidology we must redefine the kind of pain we are dealing with, a concept not always completely understood

Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives.

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References

Maris RW, Berman AL, & Silverman MM (2000). *Com-*

prehensive textbook of suicidology. The Guildford Press, New York.
Morselli E (1881). *Suicide. An essay on comparative moral statistic*. Kegan Paul & C., London.
Pompili M, Lester D, Leenaars AA, Tatarelli R, & Girardi P (2008). Psychache and suicide: a preliminary investigation. *Suicide and Life-Threatening Behavior* 38, 116-21.
Shneidman E (1951). *Thematic test analysis*. Grune and Stratton, New York.
Shneidman ES (1964). Grand old man in suicidology. A review of Louis Dublin's Suicide: a sociological study. *Contemporary Psychology* 9, 370-371.
Shneidman ES (1971). "Suicide" and "Suicidology": a brief etymological note. *Suicide & Life-Threatening Behavior* 1, 260-263.
Shneidman ES (1985). *Definition of suicide*. Aronson, Northvale.
Shneidman ES (1993a). *Suicide as psychache: A clinical approach to self-destructive behavior*. Jason Aronson, Northvale.
Shneidman ES (1993b). Suicide as psychache. *The Journal of Nervous and Mental Disease* 181, 145-147.
Shneidman ES (1993c). Some controversies in suicidology: toward a mentalistic discipline. *Suicide & Life-Threatening Behavior* 23, 292-298.
Shneidman ES (1996). *The suicidal mind*. Oxford University Press, New York.
Shneidman ES (1999). The Psychological Pain Assessment Scale. *Suicide & Life-Threatening Behavior* 29, 287-294.
Shneidman ES (2004). *Autopsy of a suicidal mind*. Oxford University Press, New York.
Shneidman ES (2005). Anodyne Psychotherapy: A Psychological View of Suicide. *Clinical Neuropsychiatry* 2, 7-12.
Shneidman ES, & Farberow NL (1956). Clues to suicide. *Public Health Reports* 71, 109-114.
Shneidman ES, & Farberow NL (1957). Some comparisons between genuine and simulated suicide notes in terms of Mowrer's concepts of discomfort and relief. *Journal of General Psychology* 56, 251-256.
Shneidman ES, & Farberow NL (1957). *Clues to suicide*. McGraw-Hill, New York.
Tatarelli R (1992). *Suicidio. Psicopatologia e prevenzione*. Il Pensiero Scientifico Editore, Roma.