PART ONE

THE EXPERIENCE OF SUICIDE: ETIOLOGY, PHENOMENOLOGY, AND RISK FACTORS

CHAPTER 1

Suicide: The Ultimate Paradox

In this life it is not difficult to die.
It is more difficult to live.

Vladimir Mayakovsky, Russian revolutionary[1]
(Died by suicide, 1931)

A SUNDAY AFTERNOON PRELUDE

THIS EXPLORATION of suicide began on a Sunday in a most unlikely place: a drafty old bookshop on the outskirts of a small town in southern New Hampshire. As I entered the shop, the welcoming heat of the woodstove provided a sharp counterpoint to the crisp autumn air. I am a lover of books, and on that particular Sunday I spent the better part of the morning browsing the shelves and chatting with Henry, the always amiable shop owner.

I wandered about the aisles, hoping to stumble upon some secret treasure that others had unwittingly passed by. When I reached the section on psychology, I spotted what looked like a promising find. I pulled the book down and flicked it open to the title page. I stopped. For a moment, not a muscle in my body moved. My eyes held the name in sharp focus. I blinked and looked again at the name.

It was not the name of the author that caught my attention. It was the name of the previous owner, scrawled across the upper tip of the title page. Jackie, as I shall call her, had been a colleague in our small

community of mental health professionals. Jackie had killed herself some months before.

I placed the book back on the pine shelf. Perhaps a morbid sense of curiosity propelled me to pull out the volume sitting beside it. Different tip of a different page in a different book; same name. Next book, same name. Next book, same name. I realized then that either Jackie, in desperation, had sold off her book collection as her alcoholism swallowed her dreams, or else the books had been bought cheap from her estate. I quietly left the bookshop and drove home.

CLINICIANS AND THEIR EMOTIONAL RESPONSES TO SUICIDE

I begin with this incident because I believe that the chill that it created in me, and still creates in me as I write about it now, serves a useful purpose. It highlights the power of suicide to engender intense emotional reaction in all of us. For mental health professionals, an understanding of this reaction is one of the cornerstones of effective assessment and management of a suicidal patient. Many emotional currents dart beneath this chill: fear, grief, anger, puzzlement, and even condemnation. When unrecognized, these feelings can drag an unwary clinician into a sea of countertransferential responses and unproductive interventions. The potentially dangerous undertow, beneath this sea, can pull us away from the very people who most need our help: acutely suicidal patients.

When a clinician begins to understand his or her own attitudes, biases, and responses to suicide, he or she can become more psychologically and emotionally available to a suicidal client. Clients seem to be able to sense when a clinician is comfortable with the topic of suicide. At that point, and with such a clinician, clients may feel safe enough to share the immediacy of their pull toward death.

One of the goals of this book is to help readers become more comfortable with their own emotional responses to the topic of suicide. Hopefully, the reading of the book will also spur clinicians to discuss the topic of suicide in more depth with fellow therapists, supervisors, and trainees, for it is often only through such intimate conversations that we can more clearly see the undertows beneath our own personal seas. And here we meet one of the first paradoxes of suicide. As a topic for discussion, it is often avoided by clinicians; yet, discussion of

it offers us one of the greatest gateways into personal, spiritual, and professional growth.

The opening vignette about Jackie is a reminder of the ubiquitous nature of suicide. No group of humans has a monopoly on suicidal behavior. It is seen in the rich and the poor, the famous and the unknown, male and female, older adult and child. Mental health professionals are far from immune to its draw; many of us have been touched by suicides among our friends, family members, and colleagues. Contemplation of suicide may even be part of our own past or future history.

It is important to realize that suicide "works" at some level; it provides a solution to intense personal pain. As life ends, the pain ends. Acceptance of the effectiveness of suicide is an important first step in a clinician's understanding of why suicide is relatively common. We humans are a solution-oriented species.

This does not mean that the clinician must agree with or accept the solution. We are all entitled to our own moral beliefs. But, without conveying judgment, the clinician can recognize why suicide presents as a natural solution for many people. When clients sense that they are not being "put down" for their choice of a solution, but rather, the clinician is seeking a more effective and life-enhancing solution, they may be more willing to explore other alternatives. The clinician's ability to convey a nonjudgmental understanding of the client's right to view suicide as a rational solution may introduce the rapport that is needed to help the client choose another solution. This irony is just one of the many contradictory elements of suicide.

THE PARADOX OF SUICIDE

The implementation of suicide is often one of the most private of all human actions, yet its impact on the people left behind could not be more profound. Self-destruction frequently crosses the minds of vast numbers of humans, but it remains among the most taboo of topics. Mental health professionals encourage the public to feel comfortable discussing suicidal thoughts, yet many of these same professionals are hesitant to ask family members or colleagues whether they are having such thoughts. Death is sometimes chosen as the only alternative by people who feel deeply alone or shamed, yet are profoundly loved and respected. The manner of suicide adds to the paradox. If a businessman takes his life in an effort to avoid scandal and the pain of admitting his wrongdoing to his family, he

may be labeled as a coward; yet a soldier who jumps on a land mine to save fellow troops will undoubtedly be called a hero.

The paradoxical nature of suicide has not been lost on philosophers. Arthur Schopenhauer cogently captured the essence of the most ironic paradox of the suicidal act:

> Suicide may also be regarded as an experiment—a question which man puts to Nature, trying to force her to answer. The question is this: What change will death produce in a man's existence and in his insight into the nature of things? It is a clumsy experiment to make, for it involves the destruction of the very consciousness which puts the question and awaits the answer.[2]

Its paradoxical nature is one of the reasons that exploration and discussion of suicide, within the clinical interview, raise such powerful emotions in both patients and clinicians. Some of its greatest paradoxes still await us. They will surface as we begin to more carefully explore the nature of suicide by looking, first, at its epidemiology and then at some of the practical problems inherent in its prediction.

THE EPIDEMIOLOGY OF SUICIDE, AND PROBLEMS WITH ITS PREDICTION

Suicide is one of our most pressing public health concerns. In the United States, suicide is the ninth leading cause of death in adults, with 30,903 suicides in 1996.[3] It has been estimated that a suicide occurs every twenty minutes.[4] In the age group of 15 to 25 years, suicide is the third leading cause of death in America (accidents and homicides are first and second, respectively).[5] Between 1952 and 1992, the rate of suicide among adolescents and young adults tripled.[6] And even though young children are much less likely to commit suicide, they still do. In the United States in 1995, 330 children, ages 10 to 14, killed themselves and seven children, ages 5 to 9, committed suicide.[7]

The development of improved ways of spotting and providing relief to acutely suicidal patients could dramatically decrease one of the leading causes of death in both the United States and the world at large. As a society, we must openly address suicide as a public health problem and, as was done with smoking, aggressively address methods of decreasing its prevalence.

Is such a goal possible? Several studies have shown that roughly 50 percent of people who commit suicide have been seen by a primary care physician within the month prior to their death.[8, 9] This staggering statistic provides hope. If effective screening mechanisms can be developed and are subsequently embraced and effectively utilized by primary care physicians, a marked drop in suicide could result. This is not a pipe dream. It can happen.

But the task is formidable. Current research shows that clinicians have little ability to predict imminent suicide. For a moment, let us look at this problem of prediction more carefully. What are some of the factors that might help us to predict that a person is *not* acutely suicidal? In essence, what are the risk factors and what does the absence of these risk factors mean? (We shall examine these risk factors in much greater detail in Chapter 3, but a glance at them now will prove to be quite useful.)

Reproduced below are two pieces of writing, a letter and a poem. They contrast the types of reassuring circumstances versus risk factors that suggest whether suicide is or is not imminent. The author of the letter, which was addressed to her mother, had been suffering from depression for years. She had recently moved to England from the United States, a move that seemed to ease her ongoing battle, although she acknowledged that the transition was tough. In the letter, she displayed a sense of hope, an intense interest in the parenting of her children, and a deeply held conviction that she needed to be there for them. As you read the letter, note the strong framework for meaning (parental responsibilities, in this case) and the sense of hopefulness that suggest suicide is not near.

February 4, 1963

Dear Mother,

Thanks so much for your letters. I got a sweet letter from Dotty and a lovely hood and mittens for Nick from Warren and Margaret. I just haven't written anybody because I have been feeling a bit grim—the upheaval over, I am seeing the finality of it all, and being catapulted from the cowlike happiness of maternity into loneliness and grim problems is not fun. I got a sweet letter from the Nortons and an absolutely wonderful, understanding one from Betty Aldrich. Marty Plumer is coming over at the end of March, which should be cheering.

> I have absolutely no desire ever to return to America. Not now, anyway. I have my beautiful country house, the car, and London is the one city of the world I'd like to live in with its fine doctors, nice neighbors, parks, theatres and the BBC. There is nothing like the BBC in America—over there they do not publish my stuff as they do here, my poems and novel. I have done a commissioned article for *Punch* on my schooldays and have a chance for three weeks in May to be on the BBC Critics program at about $150 a week, a fantastic break I hope I can make good on. Each critic sees the same play, art show, book, radio broadcast each week and discusses it. I am hoping it will finish furnishing this place, and I can go to [Devon] right after. Ask Marty for a copy of the details of the two places and the rent, and maybe you could circulate them among your professor friends, too.
>
> I appreciate your desire to see Frieda, but if you can imagine the emotional upset she has been through in losing her father and moving, you will see what an incredible idea it is to take her away by jet to America. I am her one security and to uproot her would be thoughtless and cruel, however sweetly you treated her at the other end. I could never afford to live in America—I get the best of doctors' care here perfectly free, and with children this is a great blessing. Also, Ted sees the children once a week and this makes him more responsible about our allowance . . . I shall simply have to fight it out on my own over here. Maybe someday I can manage holidays in Europe with the children. . . . The children need me most right now, and so I shall try to go on for the next few years writing mornings, being with them afternoons and seeing friends or studying and reading evenings.
>
> My German "au pair" is food-fussy and boy-gaga, but I am doing my best to discipline her. She does give me some peace mornings and a few free evenings, but I'll have to think up something new for the country as these girls don't want to be so far away from London.
>
> I am going to start seeing a woman doctor, free on the National Health, to whom I've been referred by my very good local doctor, which should help me weather this difficult time. Give my love to all.
>
> Sivvy[10]

Although this letter is a bit lengthy, I have chosen to include the entire piece, for it provides important clues to the types of risk factors that may be of value in suicide assessment. In this case, the absence of these risk factors is striking. It clearly points toward the patient's strengths and increases one's prediction of her safety in the near future.

Still, we must acknowledge that some of the risk factors that are described could suggest lethality. The author is in pain; she openly

acknowledges it with her allusion to "feeling a bit grim." She also appears to be suffering from a significant psychiatric disorder, as reflected by her referral to a psychiatrist. Apparently, another risk factor—a recent loss, which sounds like a divorce—is also present.

On the other hand, the letter is filled with reassuring signs of renewed strength. With genuine enthusiasm, the author talks about the many aspects of Britain and London that she loves. She is very excited about her career possibilities, and feels appreciated by both her British peers and the British public. On an interpersonal level, she sounds supported and is grateful for the support: "I got a sweet letter from the Nortons and an absolutely wonderful, understanding one from Betty Aldrich." All of these are good signs suggesting a lowered risk for suicide.

The appearance of hopelessness would serve as a potentially ominous sign. But as we weigh the risk factors reflected in this letter, the absence of this frame of mind is conspicuous. The author sounds hopeful about her medical care and clearly plans to be around for quite a while: ". . . and so I shall try to go on for the next few years writing mornings, being with them [her children] afternoons and seeing friends or studying and reading evenings." Earlier, in this same paragraph, she provides some of the most compelling evidence of her immediate safety when she shares her framework for meaning: her love of her children and their need for that love. This powerful reason for living is poignantly reflected in her reference to her child Freida, "I am her one security and to uproot her would be thoughtless and cruel, however sweetly you treated her at the other end."

In summary, the author's enthusiasm about her career opportunities, her awareness of the availability of both supportive friends and competent mental health professionals, her expressions of hope, and a recognition of her children's dependence on her, all argue against imminent suicide. Conversely, the next piece of writing, although much briefer, should provoke a good deal more concern:

> Dying
> Is an art, like everything else.
> I do it exceptionally well.
> I do it so it feels like hell.
> I do it so it feels real.
> I guess you could say I've a call.[11]

Although not long enough to contain many risk factors, this excerpt speaks directly to the important role of the clinician's intuitive faculties when making a suicide assessment. This poem simply has a bad feel to it. It would be the rare interviewer who would not decide to perform a thorough suicide assessment if presented with such a poem by a client.

Our intuition about this poem's bad feel would have been on the mark. The poet committed suicide roughly one year after penning this verse—a fact that paradoxically hints at the limitations of clinical intuition, for this was not the poem of someone immediately suicidal. A year passed between its writing and the fatal act. The poem was a bit of a red herring, despite its extremely ominous tone.

Conversely, the absence of many of the most foreboding risk factors from the letter would probably provide some reassurance to most clinicians. But there is one problem with this comfort. The letter was written by the same hand that penned the poem. Seven days after writing the letter, the author, Sylvia Plath, the gifted poet, was found dead—her head inside the oven of her gas range.

None of us would do a suicide assessment based on the contents of a single poem or letter. Nevertheless, the letter, for me, is particularly puzzling. Every time I read it, I must remind myself that its author killed herself just seven days later. A weighing of the risk factors revealed in the letter just doesn't seem to point in that direction.

These two examples amply illustrate the difficulties and intrigues of suicide assessment. Intuition is an important tool, but clearly it is not enough. Risk factor analysis, despite its being extensively studied, has yielded a disappointingly low predictive power, as mirrored by our analysis of Plath's letter. Are we then helpless to predict suicide? I think not. But to understand the strategies that may potentially increase our predictive powers, we must return to a study of the three tasks that are actually involved when a clinician attempts to make a suicide assessment in the rigors of everyday clinical practice.

THE THREE TASKS OF SUICIDE ASSESSMENT

The art of suicide assessment is composed of three tasks: (1) gathering information related to the risk factors for suicide, (2) gathering

information related to the patient's suicidal ideation and planning, and (3) the clinical decision making that is subsequently applied to these two databases. Errors can occur in any of these three tasks. Much attention has been given to the first and third tasks. Curiously, much less attention has been given to the practical art of eliciting suicidal ideation and planning itself. For years, the vogue has been the development of instruments for statistical analysis of risk factors.

But people don't kill themselves because statistics suggest that they should. The call to suicide comes not from statistical protocol, but from psychological pain. Each person is unique. Statistical power is at its best when applied to large populations, and at its weakest when applied to individuals. But it is the individual who clinicians must assess in the quietude of their offices or the distracting hubbub of busy emergency rooms.

It is from the patient's individual world, the intimate world of his or her own phenomenology, that suicide is conceived as the correct answer. An obvious point warrants repeating: Most people kill themselves because they *decide* to kill themselves. A given individual can present with very few risk factors, but if that patient has decided to kill himself or herself, that patient will—and the absence of risk factors be damned. Another patient may have an enormous number of risk factors, but if that patient does not want to kill himself or herself, no suicide will occur. No formal risk factor analysis will help us here, any more than it did in the reading of Sylvia Plath's letter to her mother.

Granted, some clients inadvertently kill themselves when a suicidal gesture backfires into a lethal attempt. Other clients, with processes such as borderline pathology, may move with surprising impulsivity into suicide. But these exceptions do not define the rule. Generally, a decision to kill oneself is made after a complex and stressful weighing of the pros and cons by reflective people who would not choose death as the answer if life provided better solutions. The actual behaviors that end life—swallowing pills, pulling triggers, stringing ropes—are preceded by an intricate array of thoughts devoted to the implementation of these plans. These thoughts shape, and ultimately determine, whether these actions will be undertaken.

The sequential unfolding of thought and action, inherent in the process of attempting suicide, offers clinicians a glimmer of hope concerning our attempts at suicide prediction, because it suggests that there

are warnings of imminent suicidal action. But these warnings lie deep inside the mind and soul of the client. On one level, an uncovering of the client's internal dialogue, concerning the pros and cons of committing suicide, can provide important clues toward prediction. But on a more practical level, knowledge of the degree of concrete planning and the actions taken on that planning probably serves as a better barometer of how close at hand the act may be. If the clinician is allowed to enter this secretive world of concrete suicidal planning, such an invitation may represent the best window we have into the severity of the client's pain and the proximity of death as an answer to that pain.

THE WINDOW INTO SUICIDE: CHRONOLOGICAL ASSESSMENT OF SUICIDE EVENTS

A window into the client's world of concrete suicidal planning was missing in the analysis of risk in the two pieces of writing by Sylvia Plath. It wouldn't be surprising to learn that on the very day of writing the letter, Sylvia Plath had been considering various ways of ending her life. But we were not privy to her actual suicidal ideation, which no doubt plays a major role in our lack of predictive validity. If we had been granted access to this world, what would we have seen?

No one can say for sure, but I suspect that during the weeks predating the writing of that letter and the week following it, Plath courageously struggled with the most momentous decision of her life. She was a highly sensitive, responsible, and loving parent; she would not have made the decision to die unless she saw no other solution. What then were the likely thought processes of Sylvia Plath during those last days?

On a practical level, suicide is not easy to do. Plath describes it as an "art" in her poem. As with any art, suicide generally requires thoughtful and sometimes meticulous planning and discipline. The degree of planning and the dedication to detail often provide insight into the likelihood that the task will be accomplished. If we had been privy to the intimate thoughts of Sylvia Plath, especially her concrete planning regarding suicide, I believe we would have found a wealth of harbingers of her death, betraying the benign facade of her letter.

If she was like many others in the same frame of mind, she would have been reviewing her options for death. Various methods of killing

herself would have been contemplated, with the pluses and minuses of each method carefully considered. She would have had a myriad of practical considerations to mull over: the degree of pain she wanted, the finality of the plan, where to do it, the prevention of premature discovery, the person whom she wanted to find her body, the protection against her children's finding her body, the time of day (or night) to do it, the decision about writing a suicide note or letters to close friends and to her mother, the possible use of alcohol to buttress her resolve to follow through, and a rehearsal of the method in an effort to perfect it.

Not all patients who are imminently suicidal think such thoughts. But most patients consider some of them—and, at times, all of them—especially in the weeks immediately preceding their suicide attempt. And they think about them a lot.

The greater the degree to which the full extent of this planning can be elicited, the more likely the clinician will gain insight into the seriousness of the client's intent. In my experience, gaining access to a client's concrete suicidal planning provides the most reliable data for a sound suicide assessment. Indeed, it can be argued that the degree with which the patient shares these thoughts, and shares them truthfully, may prove to be the limiting factor in how accurate a clinician can be in predicting suicide.

Looking for ever more effective ways of uncovering this type of acute suicidal ideation is an exciting and challenging mission. In this book, an interview strategy called the Chronological Assessment of Suicide Events (CASE Approach)[12, 13] will be described in detail. At present, this interview strategy has not been studied empirically. Indeed, one of the goals of this book is to invite researchers to vigorously test and evaluate the effectiveness of the CASE Approach. It is designed to provide a practical framework for clinicians' study of what they actually do in a client interview. It is not offered as the "right way" to elicit suicidal ideation, it is "a way" to elicit suicidal ideation. Its study will, I hope, prompt readers to develop their "own way."

In examining the principles of the CASE Approach, clinicians are invited to adapt what is appealing, reject what may not be appealing, and strive constantly for flexibility in its application. The ultimate goal is to creatively match our interviewing style to the needs of each unique client. Through the window provided by the CASE Approach, in conjunction with the clinician's understanding of the client's risk factors,

the clinician is best able to begin his or her clinical formulation, the complexities of which form the focus of the concluding chapter of this book.

The next chapter gives a more detailed look at the phenomenology and etiology of suicide. To end here on a positive note, let us look at the results of a clinical encounter in which the types of techniques we have been discussing may have effected a very different outcome.

A TUESDAY AFTERNOON REPRISE

I was a psychiatric resident at Western Psychiatric Institute and Clinic in Pittsburgh many years ago. One Tuesday afternoon, I was in my office catching up on some long overdue discharge summaries. It was always difficult to get an hour for paperwork in the middle of the day. Invariably, phone calls disrupted the work, or colleagues dropped by to "shoot the breeze."

That afternoon proved to be no different. There was a knock. When I opened the door, I was face-to-face with an unexpected visitor, who smiled warmly. I immediately recognized Judith, a middle-age woman whom I had treated as an inpatient the prior year. Judith lived in Canada, hundreds of miles away. What was she doing in the bustling streets of Pittsburgh?

I remembered how I first met Judith. On the night of her hospital admission, as with this new encounter, Judith had traveled hundreds of miles. But on that night she was tracking down a boyfriend who had unexpectedly jilted her and taken off to Pittsburgh to live with a different woman. According to Judith, he had refused to see her; he slammed his apartment door in her face and threatened to call the cops. Judith drove to a local park, found a secluded area, and popped a bottle of pills, which she promptly chased down with a bottle of wine. The overdose should have been fatal, but a local police officer became suspicious of her parked car.

Once admitted to the inpatient unit, Judith presented with a curious mixture of depression laced with a heated rage. She was furious that her suicide attempt had failed, and even more furious that we were detaining her against her will. Five days later, when I committed her again, she screamed a few innovative expletives. Over the subsequent weeks, her progress in therapy and with medications was slow, although she repeatedly claimed that she was feeling better. As time

passed, Judith and I developed a genuine therapeutic bond. Occasionally, a spunky, funny Judith poked out from beneath her depressive shawl. But such pleasant interludes were infrequent. The staff liked Judith. So did I. But as her release date approached, I felt uncomfortable.

After careful formulation and consultation, I decided that I needed to commit her again. It was a very difficult decision; I was worried that I was being overly protective and was infringing on her civil rights, a point she repeatedly made quite clear to me. To complicate matters, some of the staff felt that it was okay for her to go. There was an unpleasant tension on the unit. We all felt stressed. Judith was indeed shocked and outraged at my decision. It was not a good day at work.

Fortunately, the rest of the hospital stay went better. About two weeks later it became clear that the antidepressant power of her medication was kicking in. In her psychotherapy a new will to live emerged. Judith was discharged several weeks later.

And, on that Tuesday afternoon twelve months later, I stood looking at a feisty, small-framed woman with equally feisty eyes. She had bought a new blue business suit. Her hair was neatly trimmed, and just the lightest breath of makeup customized her cheeks. Our conversation went something like this.

"Hi, Dr. Shea. Do you remember me?"

"Of course I do, Judith. How are you? What brings you down here?"

She paused for a moment. "I drove all the way down here to say something to you."

"Well, what's up?" I asked.

"I just wanted to let you know that the day you committed me, you know, the last time? Well, I was going to kill myself. If you'd have let me go, I'd have never made it out of Pittsburgh. I had the whole thing planned, down to the hotel room." She smiled gently, "You really did save my life, and I wanted to thank you again."

I didn't know exactly what to say.

She continued, "You'll be glad to know that I've found a new job and a new guy—who is not half bad either, I might add. I'm truly enjoying myself. And believe it or not, I'm really glad to be alive."

"That's great to hear. I'll tell everybody up on the unit you stopped by. They'll be very pleased."

At this point, there was a bit of an awkward pause.

"Well, that's it," she quipped. Her mission apparently had been accomplished. "Thanks again."

She started down the hallway. After a few steps, she paused and turned. "Hey, Dr. Shea."

"Yes, Judith?"

"Keep up the good work." And she darted down the hallway.

When I sat down again at my desk, I glanced over at the stack of discharge charts. I smiled and told myself they could wait one more day. I had forty minutes left, just long enough to head down to Oakland Avenue to browse the aisles of my favorite bookstore.

NOTES

1. Alvarez, A.: *The Savage God—A Study in Suicide.* New York, Random House, 1971.

2. Alvarez, A., 1971, p. 138.

3. National Institute of Mental Health: Suicide Fact Sheet (based on 1996 statistics), NIMH Website, April 1999.

4. Roy, A.: Psychiatric emergencies, suicide. In *The Comprehensive Textbook of Psychiatry, 6th Edition,* edited by H.I. Kaplan and B.J. Sadock. Baltimore, Williams and Wilkins, 1995, pp. 1739–1752.

5. NIMH Website, June 1996 update.

6. Hirschfeld, R.M.A.: Algorithms for the evaluation and treatment of suicidal patients. *Primary Psychiatry* 3: 26–29, 1996.

7. Centers for Disease Control and Prevention: Suicide Deaths and Rates per 100,00 (based on 1995 statistics), CDC Website, April 1999.

8. Fawcett, J., Clark, D.C., and Busch, K.A.: Assessing and treating the patient at risk for suicide. *Psychiatric Annals* 23: 244–255, 1993.

9. Rich, C.L., Young, D., and Fowler, R.C.: San Diego suicide study. *Archives of General Psychiatry* 43: 577–582, 1986.

10. Plath, S.: "Final letter" from *Letters Home,* by Sylvia Plath: Correspondence 1950–1963 by Aurelia Schober Plath. Copyright © 1975 by Aurelia Schober Plath. Reprinted by permission of HarperCollins Publishers, Inc., 1975, pp. 498–500.

11. Plath, S.: "Lady Lazarus" in *The Norton Anthology of Modern Poetry,* edited by R. Ellman and R. O'Clair. New York, W.W. Norton & Company, 1973, pp. 1295–1297.

12. Shea, S.C.: *Psychiatric Interviewing: The Art of Understanding, 2nd Edition.* Philadelphia, W.B. Saunders Company, 1998.

13. Shea, S.C.: The chronological assessment of suicide events: A practical interviewing strategy for eliciting suicidal ideation. *The Journal of Clinical Psychiatry (supplement)* 59: 58–72, 1998.