A Thematic Analysis of Suicide Notes

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The analysis of suicide notes is an integral part of understanding suicidal behaviour. To this end, Leenaars (1996, 1992) has developed the Thematic Guide to Suicide Prediction (TGSP) for profiling the psychological correlates of suicide. The utility of this tool in suicide prevention, however, is not known. This study applied the TGSP to suicide notes (n = 45), interpreted in the light of coroner's inquest papers, drawn from a Northern Irish population. The results yielded support for the existence of psychological suicidal correlates. Moreover, qualitative differences between depressed and not depressed notewriters and those with and without a previous suicidal attempt were identified. For example, depressed suicides were more likely to communicate difficulties in developing attachments, or to exhibit cognitive constriction than nondepressed notewriters. Analysis of age differences was limited because of the paucity of suicide notes (in this sample, written by individuals aged 65 years or older). This research has further helped to identify psychological differences that should be beneficial in the prevention of suicide. Such differences should be integrated into existing risk assessment schedules. It is also argued that the analysis of suicide notes should form one strand in an integrated research framework.

Keywords: Suicide note, Northern Ireland, depression, previous attempt, prevention.

Over the years the utility of the analysis of suicide notes has been questioned. Edwin Shneidman, probably the most eminent theorist of the 20th century on this subject, has considerably modified his view on the usefulness of suicide-note analysis since his early work some 50 years ago. In the 1950s, he believed that these documents were the best way to study the affective and cognitive components of the suicidal mind—"thesis" [Shneidman & Farberow, 1957]. In the 1970s, he argued against the generality of suicide notes and took the view that these documents were written by individuals so constricted in their logic that they could not be particularly informative—"antithesis" [Shneidman, 1973]. More recently, he recanted these earlier viewpoints because they were too extreme and now considers the truth to lie somewhere in between—"synthesis." This entails a more integrative approach to the analysis of suicide letters: "Many suicide notes, when taken in the context of life history of that individual who wrote the note, [can] throw enormous light on the life, just as the life [can] help illuminate many aspects of the note" [Shneidman, 1988, p. 10].

The analysis of suicide notes has often been criticized because it is potentially idiographic in nature. A criticism frequently levelled at analysts of suicide notes is that they can contribute little to our understanding of suicidal behaviour as a *group* or social phenomenon. It has been argued that because suicide notes are only left by 15% to 30% of those who complete suicide [Leenaars, 1988a; Shneidman, 1981], notewriters are qualitatively different from non-notewriters, and any findings obtained cannot be generalized to all completed suicides. But studies that have looked at differences in the profiles of suicide notewriters compared to non-suicide-notewriters have not substantiated these concerns; few differences emerged: The demographic profile of these two groups is very similar indeed [Leenaars, 1989; Shneidman, 1981; Shneidman & Farberow, 1960; Tuckman, Kleiner, & Lavell, 1959], which lends support for the generalizability of these findings. More recently, Leenaars [1988a] reviewed the suicide notes written by North American men and women for the presence of 50 themes and found no sex differences. Stengel [1964] points out that notewriters may simply be better correspondents than non-notewriters. In addition, a task force established by the International Academy for Suicide Research (IASR) supported the use of analysis of suicide notes [Leenaars et al., 1997].

The Thematic Guide to Suicide Prediction [TGSP; Leenaars, 1996, 1992] has been developed in recent years by Antoon Leenaars. It is composed of 35 "protocol sentences" describing psychological characteristics thought to be associated with suicide. These sentences have been statistically grouped into 8 clusters; they form the basis for the TGSP and are employed in the study reported here. The TGSP has recently been modified [see Leenaars, 1996, 1992, 1989, 1988a for more details] in order to improve its usefulness in enhancing our understanding of suicidal behaviour. This renders the schema easier to apply and should result in more widespread application. The earlier version was more ambiguous and less well operationally defined, which probably accounts for it being used so infrequently in the last decade. It is important to bear in mind that the TGSP is not a predictive tool *per se*; rather, it affords invaluable insights into the suicidal mind, illuminating the information present in suicide notes. However, the TGSP has not been used independently in a European context [see Leenaars, 1996, and

| Table 1 The 8 Clusters of the Thematic Guide to Suicide Prediction (TGSP, Leenaars 1996)	
Intrapsychic	Interpersonal
Unbearable Psychological Pain	Interpersonal Relations
Cognitive Constriction	Rejection—Aggression
Indirect Expressions	Identification—Egression
Inability to Adjust	
Ego	

its usefulness has yet to be fully realized. For the first time, suicide notes drawn from Irish or British populations are analyzed according to the TGSP.

The TGSP (Table 1) is divided into two sections: intrapsychic and interpersonal clusters. Leenaars takes the view that suicidal behaviour is a result of intrapsychic factors *and* how individuals interact with their environment.

The intrapsychic section is concerned with themes associated with intolerable psychological pain, hopelessness, overpowering emotions, contradictory feelings, and the ability to adjust to life events. An individual's capacity for developing constructive tendencies is also assessed here. The interpersonal components of the TGSP specifically concern the impact of relationships on psychological well-being. The themes relate to the perception of outcomes from negative interpersonal situations, feelings of aggression, and identifying with a lost or rejecting person.

The TGSP has to date been applied only to suicide notes from Canada, USA, Hungary, and Germany, so it is still unclear how useful it will be in suicide prevention. It is important to investigate psychological differences across age, since it is already known that the precursors of suicide in the elderly are different from those observed in young adults. Bauer, Leenaars, Berman, Jobes, Dixon, and Bibb [1997] found that older suicides tended to communicate issues more often than younger suicides, including capacity to cope, loss of control, and inability to sleep. Because a chronicle of suicidal behaviour is one of the most reliable predictors of completed suicide [O'Connor & Sheehy, 2000; Gallagher & Sheehy, 1994], we examined differences between those with and without a suicidal history. This paper also aimed to identify psychological variables that

differentiate depressed from nondepressed suicide, and those suicides with and without a suicidal history. The general objective of this study is to illustrate the utility of suicide notes in the psychological profiling of suicidal individuals. In particular, it is hypothesized that the psychological characteristics (themes) found in the suicide notes will differ across age (because individuals commit suicide for different reasons). Second, the psychological characteristics (themes) found in the suicide notes will be different for those persons who were previously depressed and those who were not depressed. Third, the psychological characteristics (themes) found in the suicide notes will be different for those with and without a history of self-harm.
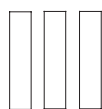
Method

Inquest papers are substantial documents with records from both mental health professionals and relatives or friends of the deceased. They consist of (1) coroner's findings; (2) pathologist reports; (3) depositions from family, friends, etc.; (4) depositions from general practitioners (usually family physicians); (5) depositions from psychiatrists and other mental health professionals (if relevant); (6) suicide notes (if present).

The coroner's inquest papers for suicides which came before HM Coroner for Greater Belfast in 1993 and 1994 were identified and inspected for the presence of a suicide note. HM Coroner's jurisdiction covers three catchment areas in Northern Ireland: Greater Belfast, South Antrim, and North Down (a catchment area covering 814,818 inhabitants); 142 suicides came before the coroner in 1993 and 1994. The clinical and psychosocial profile of this sample has been described elsewhere [O'Connor & Sheehy, 1997]. A suicide note was found in 54 (38%) of the deaths. This percentage is greater than might be expected from other studies; however, the study covers a period (1993–94) during which suicide was increasing in Northern Ireland, and this change in trend may partly account for the unusually large number of notes left by this sample. In addition, the history of social conflict in Northern Ireland means that inquest procedures are exceptionally intensive and extensive, which may increase the likelihood of uncovering a suicide note.

Suicide notes can take many forms. Sometimes they are single lines of communication, other times they are extensive and addressed to several people. Some individuals leave diaries that convey their intentions prior to death. In this study, a suicide communication, irrespective of length or the number included in a single inquest file, was counted as only one actual suicide note, i. e., a single communication from *one* person. Of the 54 suicide notes nine were excluded from analysis either because they were less than a sentence in length or because they gave brief, factual directions to where the body could be found. The remaining 45 suicide notes (32% of total number of suicides), together with the inquest papers, were rated for the presence of the protocol sentences in the Thematic Guide to Suicide Prediction (TGSP).

The raters were given detailed instructions before rating the notes. All the suicide notes were rated by the first author and two graduate psychologists. The raters were given access to Leenaars's work [1996, 1992] before analyzing the suicide notes. Thus, they were aware of the nature of the TGSP, its objectives, and background.

The two independent raters coded the notes randomly and were blind to the principal research hypotheses concerning age differences, incidence of depression, and previous suicide attempt. The reliability analyses reported here are for the three raters, although even when the first author is excluded from the reliability analyses, the interrater agreement remains high. Interrater reliability of the classifications was assessed using the Krippendorff method. The reliability coefficients for each of the clusters were Unbearable Psychological Pain (1.00), Cognitive Constriction (0.95), Indirect Expressions (0.82), Inability to Adjust (0.70), Ego (0.81), Interpersonal Relations (0.90), Rejection-Aggression (0.70), Identification-Egression (0.65).

Classification of Age

Inconsistency in the classification of individuals into the categories of young, middle-aged, and elderly is a major drawback to many life-span studies of suicide. To avert this problem, Leenaars [1989a] proposed the following universal classification: young adulthood (18–25 years), middle adulthood (26–55 years) and late adulthood (55 years and over). These groups are defined according to Erikson's [1968] model of developmental stages and were adopted in this study. (Note

that Erikson's age classifications do overlap some, e. g., 18–25 years and then 25–55 years. These have been modified to 18–25 years, 26–55 years, and 56 years and older.)

Definition of Depression

Classification of depression was made on the basis of information contained in the coroner's inquest papers. An individual was diagnosed as suffering from depression if

- s/he was diagnosed as clinically depressed (i. e., by a general practitioner (GP) or a psychiatrist) or
- two individuals separately stated (in the inquest papers) that the deceased had been depressed [see O'Connor et al., 1999].

This broadly based, inclusive definition of depression is warranted by previous studies that have shown depression to be generally underreported in this population [O'Connor & Sheehy, 1997]. Thus, our use of the term "depression" is operationally defined such that it indicates that the deceased had been in a sufficiently depressed state to have been described as such by professionals or others who knew the deceased well. Nevertheless, 80% were diagnosed by a professional (psychiatrist or GP), and 20% were classified according to two individual testimonies.

Definition of Previous Suicidal Attempt

This was classified according to information contained in the coroner's inquest papers. A previous attempt was defined as any incidence of deliberate self-harm and does not include suicidal ideation. Such information is usually recorded in the GP or psychiatric report.

Results

The authors of the nine suicide notes excluded from the analysis did not differ significantly from those included on principal demographic variables.

Demographic Profiles of Suicide Note Writers Versus Non-Notewriters

The demographic profile of the suicide notewriters is broadly representative of the total sample of completed suicides (n = 142). However, it was not possible to investigate gender differences in any statistically relevant way, as only 9% of the suicide notes were written by women (Table 2). Notewriters were significantly more likely than non-notewriters to be men (χ^2 = 10.1, df = 1, p < .01).

There were no statistically significant differences between those who left suicide notes and those who did not in terms of age, marital status, or social class. Similar to the complete sample of suicides, the majority of notewriters were young or middle-aged. Almost 90% were either single or married at time of death, and the modal social class was manually skilled (29%).

Table 2
Demographic Profile of Noblewriting Suicides

Characteristic	Notewriters n	Notewriters %	Non-notewriters n	Non-notewriters %
Sex				
Male	41	91.1	56	63.4
Female	4	8.9	32	36.4
Age				
Young (–25 years)	13	28.9	14	15.9
Middle (26–55 years)	27	60.0	22	59.1
Older (56+ years)	5	11.1	22	25.0
Marital Status				
Single	21	46.7	33	37.5
Married	18	40.0	43	48.9
Divorced	6	13.3	5	5.7
Widowed	0	0.0	7	7.9
Social Class				
Professional (0)	0	0.0	2	2.3
Managerial/technical (1)	7	15.6	10	11.3
Skilled (Non-manual) (2)	6	13.3	11	12.5
Skilled (Manual) (3)	13	28.8	33	37.5
Partly skilled (4)	7	15.6	13	14.8
Unskilled (5)	6	13.3	5	5.7
Armed Forces (7)	3	6.7	1	1.1
Inadequately described (9)	3	6.7	13	14.8

Table 3
Distribution of Method Across
Notewriters and Non-notewriters

Method	Notewriters		Non-notewriters	
	n	%	n	%
Poisoning	19	42.2	35	39.8
Hanging	18	40.0	21	23.9
Drowning	0	0.0	13	14.8
Fire/cut/pierce	7	15.6	10	11.3
Other	1	2.2	9	10.2

There is a relationship between notewriting and method of suicide. More than 80% of the notewriters either chose poisoning (42%) or hanging (40%), compared to approximately 65% of those who did not leave a suicide note (χ^2 = 11.9, df = 4, p < .02). None of the note writers chose drowning (Table 3).

The Distribution of Protocol Sentences in Suicide Notes

There was substantial evidence for the protocol clusters in the suicide notes. Unbearable psychological pain (UPP) was present in at least 90% of the suicide notes (Figure 1). Cognitive Constriction (CC), a long established suicidal correlate, was evident in 87% of the sample. Indirect Expressions (IE) and Inability to Adjust (ITA) occurred very frequently. Communications related to the Ego cluster were evident in 36% of the suicide notes.

Problems associated with Interpersonal Relations (IR) were detected in 76% of the sample. Protocol sentences concerning Rejection-Aggression (RA) and Identification-Egression (Id.Eg) were also frequently detected in the communications (Figure 1).

Distribution of Protocol Sentences Across Age

Using Leenaars' [1989a] age taxonomy, there were 13 people in young adulthood, 27 in middle adulthood, and 5 in late adulthood. There were no statistically significant differences of any of the eight protocol clusters across these age groups. Nor were statistically significant differences detected when χ^2 analysis was applied to each of the 35 individual protocol sentences.

Differences Between Depressed and Nondepressed Notewriters

62% of the total sample (n = 142) were classified as depressed and 18% left suicide notes. 36% (n = 16) of the notewriters were depressed, and depressed sui-
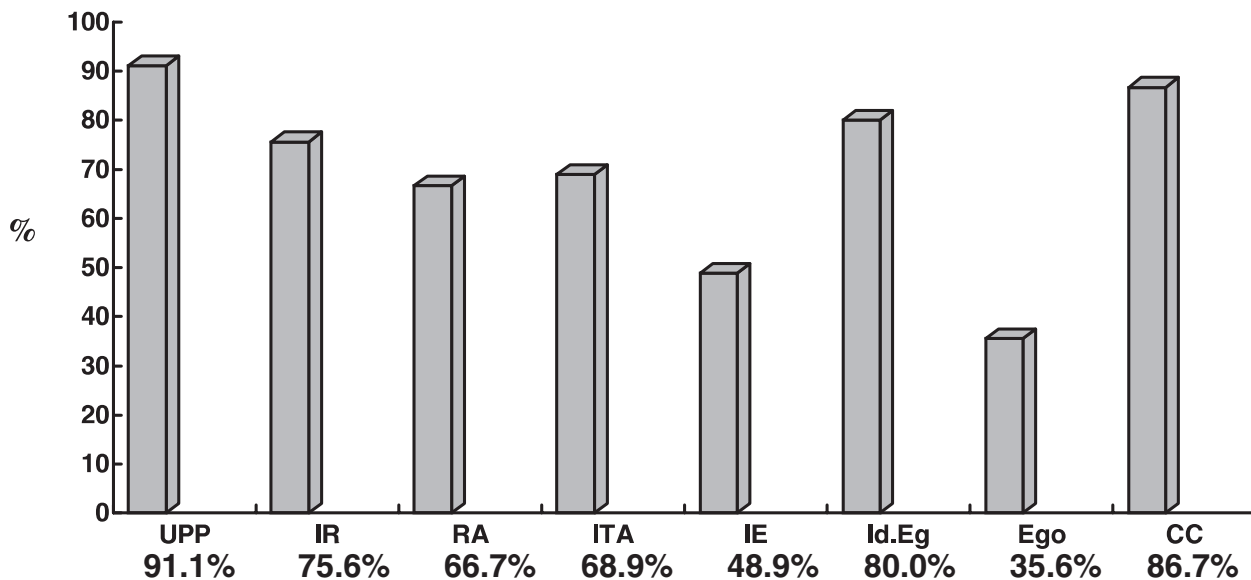

Figure 1. Distribution of TGSP cluster themes in suicide notes (n = 45).
Key: UPP = Unbearable Psychological Pain, CC = Cognitive Constriction, IE = Indirect Expressions, ITA = Inability to Adjust, Ego = Ego, IR = Interpersonal Relations, RA = Rejection-Aggression, IdEg = Identification-Egression

UPP 91.1% IR 75.6% RA 66.7% ITA 68.9% IE 48.9% Id.Eg 80.0% Ego 35.6% CC 86.7%

cides were no more likely to leave a suicide note than nondepressed suicides. Depressed notewriters (50%) were significantly more likely ($\chi^2 = 5.61$, df = 1, $p < .02$) to communicate problems within the Ego cluster than the nondepressed comparisons (16%). This cluster is concerned with the weakness that individuals feel when they cannot develop constructive tendencies (i. e., relationships).

Statistically significant differences between these two groups were not observed on the other seven global clusters (Figure 2). Depressed and nondepressed notewriters were not differentiated on the cluster Unbearable Psychological Pain (UPP), although the depressed notewriters were more concerned with their inability to develop constructive tendencies ($\chi^2 = 4.46$, df = 1, $p < .05$). 30% of depressed notewriters linked this difficulty with their suicide, whereas only 5% of those who were not depressed made any mention of this in their suicide note.

Two of the Cognitive Constriction protocols were also observed to be overrepresented within the group of depressed notewriters. Figure 3 shows that these were more likely to communicate feelings of overwhelming emotion and constricted logic and perception ($\chi^2 = 4.38$, df = 1, $p < .05$). In addition, the content of their notes tended to centre on grief-provoking

topics and conveyed a sense of diminished problem-solving skills and general poverty of thought ($\chi^2 = 4.38$, df = 1, $p < .05$).

Serious adjustment disorders were recorded most often in the sample of depressed suicide notes ($\chi^2 = 13.14$, df = 1, $p < .001$) and underlying or deep-rooted reasons for suicide were observed in nearly one-third (30%) of this group. By contrast, an influence of unconscious dynamics was not detected among any of the notes authored by the "not depressed" group ($\chi^2 = 7.11$, df = 1, $p < .01$).

Depressed suicide notewriters are also significantly more likely to communicate problems associated with interpersonal relations. About half (54%) of thedepressed suicide notewriters reported being weakened or defeated by unresolved interpersonal
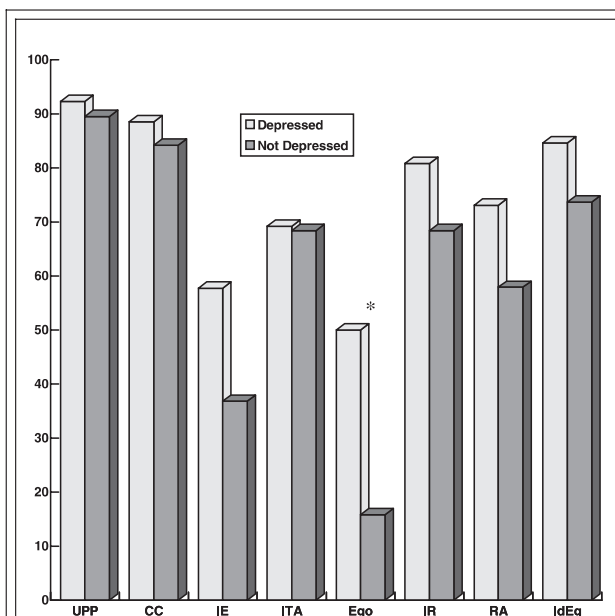

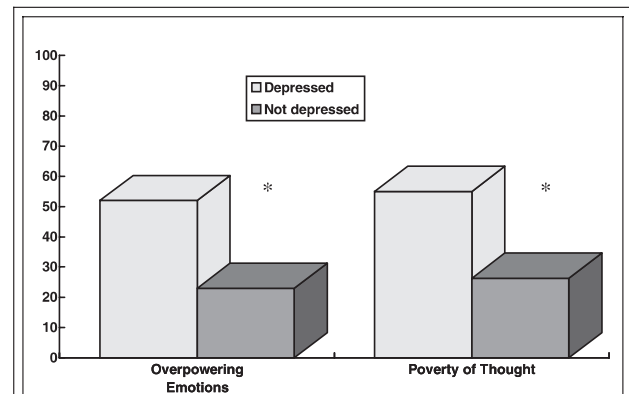*Figure 3.* Cognitive Constriction protocol sentences that discriminated depressed from nondepressed suicide notes. * $p < .05$.

Figure 2. Distribution of clusters across depressed and nondepressed notewriters. * $p < .02$. For key, see Figure 1.
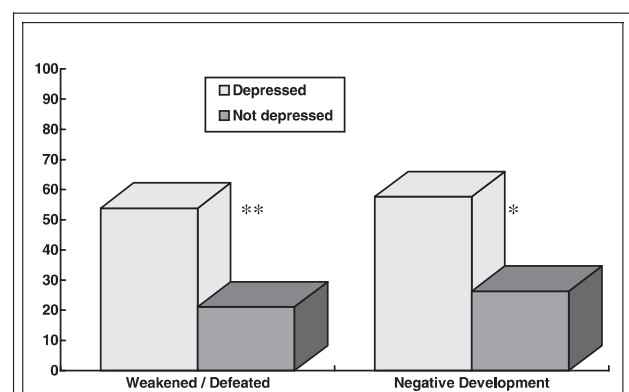

Figure 4. Interpersonal protocol sentences that discriminated depressed from nondepressed suicide notes. * $p < .05$, ** $p < 0.003$.

Table 4
Individual Protocol Sentences that Distinguished Suicide Notewriters with and Without Previous Attempt History

Protocol Sentence	History of previous attempt (%)	No previous attempt (%)	χ^2
S's aggression has been turned inward	64.3	25.8	$p < .02$
S exhibits a serious disorder in adjustment	85.7	51.6	$p < .03$
Appears to be aggression toward someone else	35.7	9.7	$p < .02$
S is unwilling to accept the pain of loss	14.3	48.4	$p < .03$

problems, compared with only 21% of those who were not depressed ($\chi^2 = 4.9$, df = 1, $p < .003$).

Finally, depressed persons more often felt that a positive outcome to a troubled relationship was not forthcoming ($\chi^2 = 4.38$, df = 1, $p < .05$). In short, if the relationship appears to be irreconcilable, the individual sees no other option but to end his/her life (Figure 4).

### Differences Between Notewriters With and Without Previous Suicidal Attempts

39% of the total sample ($n = 142$) had made at least one previous suicide attempt. A similar number (31%) of those who left a note had also made at least one previous attempt. Those with a history of self-harm were no more likely to leave a suicide note than those who killed themselves at the first attempt.

Ego was the only cluster coded significantly more often in the notes of those with a history of self-harm ($\chi^2 = 4.13$, df = 1, $p < .05$). This cluster was observed in 57% of the notes left by those with a history of self-harm, but only in 26% of those who did not have such a history. This is similar to the difference observed between the depressed and nondepressed notewriters.

Four individual protocols differentiated those with a history of self-harm from those who completed suicide on the first attempt (see Table 2).

Those who had previously attempted suicide were significantly ($\chi^2 = 6.08$, df = 1, $p < .02$) more likely to record their action as aggression turned against themselves. Serious adjustment disorders were detected in 85% of the group with a history of self harm as opposed to 51% of those without such a history ($\chi^2 = 4.77$, df = 1, $p < .03$). Suicide motivated by aggression against others was detected to a lesser extent in the

communications of those with a history of self-harm. Those who killed themselves at their first attempt were significantly less likely to accept the pain or loss they were suffering and therefore to embrace death as an alternative ($\chi^2 = 4.77$, df = 1, $p < .03$).
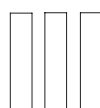
Discussion

Inquest papers are integral to the analysis of suicide notes, which, when studied in isolation, can be very difficult to interpret. However, the methodological limitations of inquest papers as sources of scientific data must be kept in mind [O'Connor & Sheehy, 1997]. The traditional view is that inquest procedures general lead to underreporting of suicide [McCarthy & Walsh, 1975], though more recent studies paint a more complex picture: Underreporting is more likely in England and Wales than in Ireland [Kelleher, Corcoran, Keeley, Dennehy & O'Donnell, 1996]. However, the level of reporting does not detract from the usefulness of examining the relationship between the content of suicide letters and the characteristics of the authors.

The number of cases in the sample was relatively small ($n = 45$), and this was problematic when considering age differences. There were only five suicide notes in the older age category, but this is representative of the sample from which the suicides were drawn: Less than 20% of the 142 were aged 65 years or more. Although this is not ideal, the criteria for statistical analysis were met [see Howell, 1997]. Furthermore, there is inconsistent evidence concerning the association between age and notewriting. Some argue [Capstick, 1960] that suicide notes are more often written by younger individuals, whereas others argue [Lester &

Heim, 1992] that they are more frequently left by older suicides. The picture is similar for gender differences: Some report women more likely to leave suicide notes, and others argue that men are more likely [see Leenaars, 1988a, for a review].

The first hypothesis—that suicide notes from different age groups would signal different psychological reasons for committing suicide—was not supported. Leenaars [1989] found young adults to more often recount the influence of unbearable interpersonal circumstances than older suicides. This finding was not replicated, but there was evidence of a trend: 85% of young adults described problems with interpersonal relations, compared with 78% of the middle-aged and 40% of the older adults. These trends may have reached statistical significance had a larger sample been available.

Factors indexed by the Ego cluster were expected significantly more often in the suicide notes of young adults. The general trend indicated this to be the case but the difference was not statistically significant: Nearly half (46%) of the young adults felt incapable of developing constructive tendencies, compared with one-third of the middle adults, and 20% of the older adults.

The second hypothesis—that depressed persons commit suicide for different reasons than nondepressed persons—was supported. Depressed suicides tended to communicate problems indexed by the Ego cluster. For example, they had difficulties in developing or maintaining attachments and meaningful relationships. In addition, cognitive constriction is much more evident in the communications of depressed than nondepressed suicides. Disorders in adjustment were also more prevalent in the depressed group, as were problems of an interpersonal nature. They tended to be less likely to perceive a positive outcome to their current interpersonal situation.

Why do people who appear not to be depressed commit suicide? One possibility is that this question is inappropriate because depression must be implicated in *all* suicides—it simply goes undetected in some cases. According to this view "nondepressed suicide" is an oxymoron, and by implication, one would expect few if any differences between depressed and so-called "nondepressed" suicides. However, the differences reported here appear to be nontrivial. Depressed suicides appear to have greater difficulty developing and maintaining constructive tendencies, probably because the depression is interfering with attachment processes that normally sustain good interpersonal relationships. Depressed suicides are also overwhelmed with emotion and fixate on negative aspects of their circumstances causing further distress, which in turn increases cognitive constriction and poverty of thought. By contrast, unresolved interpersonal problems were observed less frequently among the nondepressed suicides, who were also less likely to manifest constricted thinking in their suicide letters. Thus, the TGSP appears to offer a more finely grained psychological profile of those who commit suicide—although, at present, the observed differences seemed to be more beneficial to understanding the ontogenesis of depressed rather than nondepressed suicide.

The third hypothesis—that first-time suicides differ psychologically from those with a history of previous attempts—was also supported. Once again, the Ego cluster was the only TGSP cluster to discriminate significantly between those who had made a previous suicide attempt and those who had not. Those without a suicidal history tended to be unable to endure the pain of loss they were experiencing, and this seems to have been the primary motivation for their suicide. The "previous attempt" group more often recounted problems about the development of meaningful attachments or appeared to perceive the suicide act as an extreme form of self-punishment. This group also tended to convey more aggressive messages in their suicide notes, either as internally, self-directed aggression, or as externally, other-directed aggression. This may have important implications for clinical intervention with this group. For example, it may be that people in this group would benefit from interventions based on the management of aggression, such as *expression therapy.* More general monitoring for low ego strength among those parasuicides who present at general hospitals may also lead to better targeted follow-up treatments that address the primary psychological needs of these people.

These findings have elucidated some of the links between psychosocial risk factors, psychological impact, and suicide risk: They point to psychological differences between the depressed and nondepressed, and those with and without a history of self-harm. These differences warrant more detailed analyses. Classification procedures and tools, such as the TGSP,

are a particularly useful way forward because they yield more fine-grained psychological profiles of those who kill themselves, which may prove useful in the effective identification of variant at-risk individuals. However, this study suggests that the TGSP may be most valuable to the clinician when care is taken to interpret the individual protocols rather than the clusters.

References

Allport G. *The use of personal documents in psychological science*. New York: Social Science Research Council, 1942.

Bauer MN, Leenaars AA, Berman AL, Jobes DA, Dixon JF, Bibb JL. Late adulthood suicide: A life-span analysis of suicide notes. *Archives of Suicide Research*, 1997; 3:91–108.

Capstick A. Recognition of emotional disturbance and the prevention of suicide. *British Medical Journal*, 1960; 1:1179–1182.

Cattell HR. Elderly suicide in London: An analysis of coroner's inquests. *International Journal of Geriatric Psychiatry*, 1988; 3:251–261.

Erikson E. *Childhood and society*. New York: W.W. Norton, 1968.

Gallagher AG, Sheehy NP. Suicide in rural communities. *Journal of Community & Applied Social Psychology*, 1994; 4:145–155.

Howell DC. *Statistical methods for psychology*. Belmont: Wadsworth, 1997.

Kelleher MJ, Corcoran P, Keeley HS, Dennehy J, O'Donnell I. Improving procedures for recording suicide statistics. *Irish Medical Journal*, 1996; 89(1):14–15.

Kreitman N., Foster J. The construction and selection of predictive scales with particular reference to parasuicide. *British Journal of Psychiatry*, 1991; 159:185–192.

Leenaars A. *Suicide notes*. New York: Human Sciences Press, 1988a.

Leenaars A. Are women's suicides really different from men's? *Women & Health,* 1988b; 18:17–33.

Leenaars A. Suicide across the adult life-span: An archival study. *Crisis*, 1989; 10:132–151.

Leenaars A. Suicide notes, communication and ideation. In Maris RW, Berman AL, Maltsberger JT, Yufit RI (Eds) *Assessment and prediction of suicide*. New York: Guilford, 1992.

Leenaars A. Suicide: A multidimensional malaise. *Suicide and Life-Threatening behavior*, 1996; 26:221–235.

Leenaars A, DeLeo D, Diekstra RFW, Goldney RD. Consultations for research in suicidology. *Archives of Suicide Research,* 1997; 3:139—151.

Lester D. & Heim N. Sex differences in suicide notes. *Perceptual and Motor Skills*, 1992; 75:582.

McCarthy PD, Walsh D. Suicide in Dublin: The under-reporting of suicide and the consequences for national statistics. *British Journal of Psychiatry*, 1975; 126:301–308.

O'Connor R.C., Sheehy NP. *Understanding suicidal behaviour*. Leicester: BPS Books, 2000.

O'Connor RC, Sheehy NP. Suicide and gender. *Mortality*, 1997; 2:239–254.

O'Connor RC, Sheehy NP, O'Connor DB. The classification of completed suicide into sub-types. *Journal of Mental Health*, 1999, in press.

Pearson V. Suicide in North and West Devon: A comparative study using coroner's inquest papers. *Journal of Public Health Medicine*, 1993; 15:320–326.

Runyan W. Idiographic goals and methods in the study of lives. *Journal of Personality*, 1983; 51:413–432.

Shneidman ES. *Deaths of man*. New York: Jason Aronson, 1973.

Shneidman ES. *Voices of man*. New York: Harper & Row, 1980.

Shneidman ES. The psychological autopsy. *Suicide and Life-Threatening Behavior*, 1981; 11:325–340.

Shneidman ES. *Definition of suicide*. New York: Wiley, 1985.

Shneidman ES. In A.A. Leenaars (Ed) *Suicide notes*. New York: Human Sciences Press, 1988a.

Shneidman ES, Farberow NL. *Clues to suicide*. New York: McGraw-Hill, 1957.

Shneidman ES, Farberow N. A socio-psychological investigation of suicide. In David HP, Brengelmann JC (Eds) *Perspectives in personality research*. New York: Springer, 1960.

Stengel E. *Suicide and attempted suicide*. Baltimore: Penguin, 1964.

Tuckman J, Kleiner RJ, Lavell M. Emotional content of suicide notes. *American Journal of Psychiatry*, 1959; 116:59–63.

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