THEORIES OF SUICIDE:


by

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ABSTRACT

It is becoming increasingly apparent that suicide is a socio-psychiatric phenomenon with etiological roots in both the social system and in the individual personality. Suicide as a problem is worth studying for only as further research sheds light on the complexity of motives and causes can clinical and educative programmes be improved and social policies and changes be introduced. In the past the treatment of attempted suicide has been the prerogative of psychiatry but with the realization that the suicide act has important social aspects, the place of the social worker is being given greater emphasis.

This thesis examines social attitudes toward self-destruction as they have evolved through the course of the history of civilization. It reviews the major theories which have been advanced to account for the occurrence of suicide, classifying them broadly into two groups: those which assign the causes to various forms of social disorganization and those which assign the causes to psychic disturbances and disorders. It is recognized that these approaches to the problem — the sociological and the psychological — are complementary and that a consideration of their mutual relevance is especially important in planning the establishment of effective preventive services.

The existing treatment and preventive facilities are critically examined as is the present state of the law regarding suicide. It is concluded that the law rests on ecclesiastical postulates which no longer appear binding in a predominantly secular society. Some proposals for the development of a treatment and prevention programme are made in light of the experimental work of the Suicide Prevention Center in Los Angeles.
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A STUDY OF SUICIDE

A Review of Historical and Contemporary Social Attitudes and the Sociological and Psychological Theories of Suicide, and Their Implications for Social Policy.
Chapter 1.
Suicide as a Human Problem and a Public Issue.

1. The Problem of Suicide.

A. Dimensions of the Problem

In Canada, during 1958, 1271 persons, or 7.5 per 100,000 population, decided that life was no longer worth living and committed suicide.\(^1\) A breakdown of figures shows that British Columbia with 172 suicides (11.1 per 100,000) had the highest rate in the country. Ontario and the Prairie Provinces followed.\(^2\) The peak figure for Canada of 9.9 occurred in 1930 and the lowest level, 6.1, was recorded in 1944.\(^3\) The rate has remained, on the whole, constant in the past ten years.

B. Suicide as a Personal and Family Tragedy.

Whether it be successful or unsuccessful, whether it be the sequential outcome of a mental disorder, a disturbance of interpersonal relations, physical pain, or any combination of these, the self-destructive act represents a tragic event. It involves for the suicide, before his death, overwhelming feelings

\(^1\) The suicide mortality rates per 100,000 population for some other countries are presented for purposes of comparison: Denmark, 24.1; Switzerland, 21.8; Japan, 20.5; Sweden, 18.6; France, 15.3; England and Wales, 10.8; United States, 10.1; Holland, 6.5; Italy, 6.4; Spain, 5.9; Eire, 2.3. "Mortality from Suicide." Epidemiological and Vital Statistics Report, (Geneva, Switzerland: World Health Organization), vol. 9:4 (1956), pp. 250-253.


\(^3\) "The Increasing Concern About Suicides." Maclean's, vol. 73:11 (21 May 1960), p. 1
of hopelessness, and for the would-be suicide, much the same emotions with the addition, after the unsuccessful attempt, of shame, guilt and humiliation. It involves for the family anguish, shame and probably self-reproach.

Often the suicidal act comes as a total surprise to the relatives and associates of the deceased, creating an aura of mystery and even intrigue, and giving rise to wild speculations as to antecedent causes and to queries as to whether the event might have been prevented.

C. Suicide as a Professional and Clinical Problem.

The physician, the lawyer and the legislator, the clergymen, the sociologist, the psychiatrist and the social worker are all concerned with the problem of suicide, its causes and its prevention. Traditionally the role of the physician has been the repair of the damaged body of the unsuccessful suicide. The lawyer and the legislator have been concerned with the legal aspects of suicide — with its status as a criminal offense and with measures to modify and reform the law. The clergymen's role as a pastoral counsellor to the bereaved and suffering family and to the depressed contemplator of suicide is widely recognized. The sociologist's interest in the subject, primarily theoretical, has been comparatively recent and centres on the intervening conceptual variables operative in the causation of suicide. The psychiatrist has been perhaps the most closely identified with the treatment of the attempted suicide. He sees the act as
indicative of intra-psychic stresses and conflicts and he formulates his treatment plan on the basis of his diagnosis of the psychic determinants. The increasing awareness of suicide as a socio-psychiatric phenomenon, the realization that interpersonal as well as intra-psychic factors are operative and contributing as determinants of the suicidal attempt has resulted in a greater emphasis being given to the role of social casework in the treatment programme. It is recognized that an important facet of any programme is the improved social functioning of those who threaten or attempt to kill themselves, and in this area — the patient's or client's social functioning — the caseworker makes a valuable contribution.

D. The varieties of suicidal expression.

Psychoanalytic theorists hold that in addition to immediate and direct acts of self-destruction, there are subtle, indirect and often prolonged forms of suicide which manifest themselves in a variety of ways. Few writers have presented an analytic viewpoint as articulately and with such extensive documentation as Menninger.1 He contends that asceticism,

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martyrdom, neurotic invalidism and "purposive" accidents\(^1\) are forms of either chronic\(^2\) or focal\(^3\) suicide. Drawing extensively from the writings of Lecky\(^4\) and Mason\(^5\), and from his own practice, he describes a number of historic examples and clinical cases of martyrs and ascetics whose provocative behaviour and self-inflicted hardships were, he believes, the fulfillment of unconscious suicidal wishes. Among the most prominent of the historical figures in Menninger's account were St. Francis of Assisi, Simeon Stylites and John Brown (of Harper's Ferry fame). Numerous other personages and sects are also cited.

2. Social Attitudes Toward Suicide.

Attitudes toward suicide are conditioned by the social ethic, and this, in turn, is determined in important ways by religious beliefs. The influence of broad religious philosophies on attitudes toward suicide has tended throughout the history of civilization to be somewhat inconsistent, and from an examination of the literature on the subject it would seem that in all times and in all places attitudes varying from condemnation to

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1. He also includes in this list alcoholism, anti-social behaviour, criminality, sexual deviations, polysurgery and malingering. (To the many who do not subscribe to the orthodox psychoanalytic viewpoint the relationship between these phenomenon and the suicidal impulse may be remote and untenable.)

2. This is defined as slow, drawn-out suicide.

3. By this is meant self-destructive activity concentrated on the body.


acceptance have existed, occasionally in harmony but more often in conflict with each other.

These attitudes, in some of their diversity, will now be surveyed.

A) Historical Attitudes.

(i) Primitive Peoples.

The attitudes and moral judgments of primitive people toward self-destruction vary considerably. The act may be taken as a matter of course with neither approval nor disapproval being attached to it; it may be highly censured, or it may be regarded as honourable and courageous. Among those peoples who attach a decided stigma to suicide the performance of elaborate rituals to prevent the ghost of the body from vexing the living is common. The soul of the suicide is considered to be an evil spirit which has forfeited its right of entry to the after-life and so stigmatized that it is destined to everlasting damnation and torment by good spirits.

In Africa, Dahomeans and the Tshi regard suicide as a crime on the grounds that the life of every man belongs to the monarch. The Bogos regard it as a great indignity believing that a man should never despair to the point of surrendering himself. In Burma, the Karens, who call suicide a cowardly act, deny the

1. Louis I. Dublin, and Bessie Bunzel, To Be or Not To Be; A Study of Suicide, New York, Harrison Smith and Robert Haas, 1933, p. 140.
2. Ibid.
body honourable burial. The Paharis of India consider it a crime and believe that the soul of one who so offends shall not be admitted into heaven but must hover eternally as a ghost between heaven and hell. Both the Dyaks and the Kayans of Borneo believe that the soul of the suicide goes to a special place where it is tormented. Suicide (except to escape capture, to follow a beloved one to the land of spirits, or to avoid ridicule) is considered a sin by the Ashanti of the Gold Coast. The dead body of the suicide is decapitated and the headless trunk cast into the bush. Among North American Indians the Omahas believe that the soul of a suicide ceases to exist. The Thompson Indians of British Columbia hold a similar belief. Among the Zuni of New Mexico, the Yahgans of Tierra del Fuego, and the Andaman Islanders, the act is extremely rare.

In contrast, a number of primitive groups do not stigmatize suicide and, indeed, may encourage it under certain circumstances. The Accra negroes of the British Gold Coast see nothing wrong in

1. Ibid.
2. Ibid.
3. Dublin and Bunzel, To Be or Not To Be, p. 139
5. Dublin and Bunzel, To Be or Not To Be, p. 140.
7.
suicide.¹ In North America, the Chippewas hold that suicide
is foolish but not a blameworthy act. Amongst the Navaho, Creek,
Cherokee, Ojibway, and Sioux Indians where there are no strong
prohibitions against self-destruction, the act is fairly common.²
Aged Polar and Hudson Bay Eskimos, feeling themselves helpless and
economically useless, consider it their duty to terminate their
lives.³ Amongst the Dobu and the Fiji Islanders suicide is not
infrequent and is permissible.⁴

(ii) Eastern Peoples.

In the Orient the institutionalized custom of "suttee"
was, until the mid-nineteenth century, quite prevalent. Although
the earliest and most sacred of Brahmin books, the Rigveda, did
not commend it, the practice received religious sanction when
priests altered the original text to make it read as though suttee
were officially authorized. "They taught that voluntary death was
the surest passport to heaven and that the dutiful wife could, by
immolating herself, atone for the sins of her husband, free the latter
from punishment, and open to him the gates of paradise."⁵

1. Dublin and Bunzel, To Be Or Not To Be, p.139
2. Ibid
3. Leo W. Simmons, The Role of the Aged in Primitive Society, New
Haven, Yale University Press, 1945, p.229.
Sons, Ltd. 1932, passim.
5. Dublin and Bunzel, To Be Or Not To Be, p.154.
One writer, Maine,\textsuperscript{1} believed that the practice was sanctioned because of the Hindu dislike of allowing widows to own property. Suttee, death by drowning, self-decapitation, burial alive and other common forms of self-immolation were consistent with a religious philosophy which taught the doctrine of denial of the flesh and elevation of the soul. The body was regarded as a mere accident in the plan of redemption, a vestment to be cast off when necessary, a dwelling to be relinquished at the discretion of its tenant. "The underlying thesis of the whole religion was that of an all-pervading soul in nature."\textsuperscript{2} The individual soul, after death, lost its personal identity and was absorbed into Brahma, the world-soul. Since the body stood in the way of the return to the world-soul, it was derided and maltreated.

Similarly, in Buddhist sacred writings there exist contradictions. The taking of any form of life is strictly prohibited and a man is obligated to live out his apportioned span of life.\textsuperscript{3} Yet these teachings were not wholly accepted and suicide came to be socially and religiously sanctioned. Self-destruction after military defeat or dethronement, in memory of an ancestor and in protest against political policies was common. Other honourable causes of suicide in China were insolvency, personal insult, dishonour, and a desire for revenge (involving the adversary in legal proceedings

\textsuperscript{2} Dublin and Bunzel, \textit{To Be Or Not To Be}, p. 158.
and harassing him by ghostly visitations). Although baser motives for suicide were prohibited in religious writings the attitude toward the act remained a condoning one.

In contrast to other religions of the East, Islam has always accorded severe disapprobation to the suicidal act. Mohammed taught that God has prescribed to every man his "kismet" and that He had decreed the time of each person's death. It followed, therefore, that to be dissatisfied with one's lot and to consider self-destruction was immoral. Repeatedly, in the Koran, suicide is expressly forbidden. Such religious prohibitions have served to deter Moslems from the act even to this day.

(iii) The Jewish People.

The Old Testament, a record of the history of the Hebrew people, notes four instances of suicide: Samson, Saul, Abimelech, and Ahitophel. It gives no indication that they were viewed with disfavour and indeed the last, Ahitophel, is recorded as having received traditional burial in the sepulchre of his father.¹ Later, as Williams points out, "both Orthodox Jewish and Christian interpreters had to resort to a somewhat strained interpretation of the Sixth Commandment in order to stigmatize suicide as a sin."²

Probably the first Jewish writer to express the later view was Josephus (37-95 A D) historian and warrior. When threatened with capture by the Romans, his army advocated mass self-destruction but he prohibited it on the grounds that (1) it was against natural law, and (2) the soul, a gift of God, could

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1. II Samuel, XVII, 23.

not be voluntarily cast from the body without sin being involved in the act. "After Josephus the prohibition against suicide is frequently found in Jewish scripture and that part of the Talmud known as the Mishnah provides that the person who destroys his own life is to be given no funeral rites."¹

There has been, however, some departure in practice from these prohibitions especially in times of group crisis. Durant gives a vivid account of Jews in Germany, England, and France who, during pogroms in the time of Crusades, committed suicide en masse rather than repudiate their faith as a condition for continued life. But aside from self-destruction during persecutions, suicide among Jews has been relatively uncommon.²

(iv) The Classical World

The attitudes of the classical world to the act of self-destruction were by no means uniform. Pythagoras, to whom many of the wisest sayings of antiquity were attributed, is said to have forbidden men "to depart from their station in life without the order of their commander, that is, of God."³ Plato held suicide to be immoral on religious grounds but admitted exceptions of the most elastic character.⁴ Aristotle condemned the act on

1. Ibid., p. 251.
2. Dublin and Bunzel (p. 179-180) offer the explanation that the teachings of the Old Testament regarding the sacredness of life have had a profound influence on the mind of the Jew and have deterred him from this act.
4. The exceptions (extreme sorrow, state judgment, shame, poverty and distress) tended to destroy the significance of his condemnation.
civic grounds as being an injury to the state. Plutarch held it to be an affront to human dignity, and an act of cowardice unworthy of man. The Cynics, Epicureans, and Stoics favoured suicide and, indeed, rather actively encouraged it. Diogenes, the Cynic, writes: "A wise man will quit life when oppressed with severe pain, deprived of his senses or when labouring under desperate diseases." But it was left to the Stoics to extol the virtues of self-destruction and no one among them wrote more eloquently of its desirability than Seneca. His words, recorded by Lecky, remain perhaps the most moving defence of the act ever made.

The attitude of the Greek and Roman world toward suicide was, on the whole, a permissive one. At all times in antiquity there were certain circumstances that were considered legitimate reasons for suicide. That the act was not considered immoral follows from the classical viewpoint on death. "The main object of the pagan philosophers was to dispel the terrors the imagination has cast around death, and by destroying this last cause of fear to secure the liberty of man."

Since this point of view is in striking contrast to that of the Christian concept of death as a consequence of sin, with the growth and expression of Christianity came new and revolutionary concepts of morality.

1. Dublin and Bunzel, To Be Or Not To Be, p.194

2. Sumner suggests that in classical times a general weariness of life accounted for the readiness to commit suicide. (Folkways, Boston, Ginn and Company, 1906. Lecky (European Morals, p.1111) points, as motives for suicides in antiquity, to codes of honour, indifference to death, fear of torture and a desire of self-sacrifice in religious rites.

(v) The Christian World

That the moral attitudes of the Christian Church differed markedly from those of the non-Christian world is clearly manifest when the Church's judgment regarding the ethics of suicide is reviewed. Since the time of St. Augustine the Church has opposed the act with great determination, regarding it as form murder. Lecky writes:

They carried their doctrine of the sanctity of human life to such a point that they maintained dogmatically that a man who destroys his own life has committed a crime similar both in kind and magnitude to that of an ordinary murderer, and they at the same time gave a new character to death by their doctrines concerning its penal nature and concerning the future destinies of the soul.¹

Yet so strong a censure came gradually.

There is no direct condemnation of suicide in the New Testament and little to be found among the very early Christians who, were, indeed, morbidly obsessed with death. Those were the days when, instead of learning how to live, men studied how to die.²

The Christian belief was that earthly life had but one objective, one aim: to prepare one for the hereafter. Refraining from sinful conduct which would result in everlasting chastisement was the supreme duty, but since many inherent desires tended toward sin, the risk of failure was great. As a result, many Christians, rather than yield to temptation, committed suicide.

¹. Lecky, European Morals, p. 45.
Two motives for self-destruction were regarded in the early Church with some tolerance and hesitation - martyrdom and the preservation of chastity.\(^1\) "It was especially good if the believer could commit suicide by provoking infidels to martyr him, or by austerities so severe as to undermine the constitution."\(^2\) Mason\(^3\) and Lecky\(^4\) have given interesting accounts of the suicides of a number of early ecclesiasts, eminent and humble alike, and Dublin and Bunzel quote St. Cyprian as having said that "the Christians were invincible because they did not fear death and did not defend themselves against attack but rather gave their blood and lives to escape from a cruel and wicked world."\(^5\) Many of the early Church Fathers expressed in their writings considerable admiration for those who destroyed their lives for a noble cause.

The sect whom St. Augustine particularly noted for this practice was the Circumcelliones. These people, self-appointed apostles of death and beyond the pale of the church, not only actively pursued martyrdom by defiling pagan temples, but, when all other expedients failed, leapt in exaltation from lofty

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1. Lecky gives a short and interesting account of suicides motivated by such considerations. St. Pelagia, a girl of fifteen, and a famous Christian lady, Domnina, both took their lives to avoid being raped by Roman persecutors. The former was warmly eulogized by St. Chrysostom and St. Ambrose of Milan. (European Morals, p. 46).


4. Lecky, European Morals, p. 49.

5. Dublin and Bunzel, To Be Or Not To Be, p. 199.
It was probably in reaction to religious excesses that St. Augustine became the first ecclesiast to denounce suicide under all circumstances and in doing so he became the "chief architect of the later Christian View." In *The City of God* he argues the matter at length. His position is lucidly summarized by Dublin and Bunzel who wrote:

He concludes that suicide is never justifiable, even in the case of a woman whose honor is in danger. He bases this opinion on the arguments that suicide precludes the possibility of repentance; that it is a form of homicide and therefore a violation of the Sixth Commandment; that a person who kills himself or herself has done nothing worthy of death; and finally that suicide to escape violation is at best the commission of a greater sin to escape a lesser. While granting that virgin suicides are worthy of all compassion, he holds that not even actual violation is sufficient excuse for self-murder. After asking how pollution of the body can defile one who does not consent to the act, he argues that one can still be chaste in spite of forced pollution, as, on the contrary, one may be unchaste from impure desires, though the body be kept inviolate. At the same time St. Augustine found himself in a dilemma regarding those suicides who had already been canonized by the Church; and he was obliged to admit certain exceptions.

3. Williams examines St. Augustine's stand on suicide, counters his arguments, and concludes that they were, in the main, rationalizations. He writes: "The true reason for Augustine's stand against suicide appears plainly enough from the historical events of his age. These indicated that a prohibition of suicide was a necessary corollary of the church's other teaching, which would, without this corollary, have operated, and did in fact operate, as an incitement to suicide. If death means annihilation, there can be no point in suicide except as an escape from suffering. But if a man's life on earth is merely a period of waiting for a divine glory to be revealed, the true believer is naturally subject to the temptation to accelerate his eternal bliss, unless a new religious rule is devised to forbid it." p. 256.
suggesting that St. Pelagia, for example, had received a divine revelation which absolved her from the rules applying to ordinary mortals.\(^1\)

By the time of Thomas Aquinas, self-destruction had come to be considered a crime as well as a sin. In his monumental work, *Summa Theologica*, which codified church teachings and law, Aquinas framed the attitude toward suicide which the Roman Church has held consistently ever since. He regarded it an unpardonable offence for three reasons. First, it is unnatural and consequently a mortal sin. Secondly, it is an act injurious to the welfare of the community of which the suicide is a member. Thirdly, life is a divine gift which has been bestowed upon man — a gift which God alone can abrogate, and anyone who would usurp supernal power and tamper with his life sins against God.\(^2\)

These arguments against suicide, then, are deeply rooted in basic Christian tenets such as the duty of total surrender to God's will, the sacredness of human life and the significance attached to the moment of death.

As a consequence of the condemnation of suicide there came into existence the practice of dishonouring the corpse. This took the form of mutilation, dismemberment, and denial of Christian burial rites. A number of writers have dealt with the subject and Dublin and Bunzel\(^3\) have drawn richly upon

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1. Dublin and Bunzel, *To Be Or Not To Be*, pp. 201-202.


3. Dublin and Bunzel, *To Be Or Not To Be*, pp. 203-208.
their works to depict quite graphically the indignities and atrocities practised on the body of the suicide.

Apart from sporadic outbreaks of suicide occasioned by epidemics and religious and political persecutions, religious prohibition during the centuries when Church and State were inseparable acted as a strong deterrent influence. Bitter clerical opposition, the force of condemnatory public opinion and severe penalties against attempted suicide were so effective that relatively few people had the temerity to take their own lives.¹

B) Contemporary Attitudes.

Beginning in the sixteenth century new trends of thought in opposition to Christian Orthodoxy were developing. "Geographical discovery, urbanization, commercialism and industrialization, the growth of liberalism, the crude beginnings of scientific techniques and the development of the critical spirit — all these combined to undermine religious authority and to promote secularism and greater freedom of thought."² The dogmas of the church, long unchallenged, came under critical scrutiny.

John Donne was one of the earliest to question the traditional attitude toward suicide. In *Biathanatos*, published posthumously in 1646, he attacks both the patristic point of view and the belief that suicide was the most irremissible of sins.

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¹ *Ibid.* pp. 203-208

He concludes that self-homicide (as he called it) is not a violation of moral law nor is it an irrational act. Since Donne's thesis was not soundly reasoned its influence on the prevailing attitude was limited.

During the "Age of Enlightenment", about one hundred years later, criticism of existing institutions reached its height. It was an epoch when philosophy, having thrown off its bondage as theology's servant, became boldly secular and skeptical. Thinkers came to concern themselves with every aspect of human conduct, including self-destruction. Hume's "Essay on Suicide" proved to be a document of considerable influence. He insisted that the act was free from imputation of guilt and blame and that condemnation of it was incompatible with liberty.

In France, criticism of existing institutions, practices and attitudes was even stronger than in England. Before Donne, Montaigne had sharply questioned the current attitude toward suicide but chiefly due to the influence of Montesquieu, Voltaire, and Rousseau — protagonists of intellectual and religious freedom and opponents of dogmatism and ecclesiastical authority — France legalized suicide by a statute in 1790.

The writings of Immanuel Kant on the subject helped shape (probably indirectly) German attitudes toward suicide. In The

1. Ibid., p. 16.
2. Dublin and Bunzel, To Be Or Not To Be, p. 209-210.
4. Indirectly because Kant's philosophy profoundly influenced the thinking of the German idealists, and they, in turn, influenced German political ideas and institutions.
Critique of Practical Reason and the Metaphysic of Ethics, Kant declared that since human life was sacred it must be preserved at all costs. The moral law, he said, was a categorical imperative, a universal and necessary law, inherent in reason itself. Human existence, he held, was an end in itself and worthy of continuance. To terminate it voluntarily was to follow a principle of self love — a principle unfit as a universal law of nature and therefore immoral. As Dublin and Bunzel\(^1\) point out, Kant reached the same conclusion regarding the act of suicide as have Judaism, Islam and Christianity but his logic followed a different course. Schopenhauer, too, argued against suicide but on the grounds that moral freedom, the highest ethical ideal, can only be attained by a denial of the will to live and suicide is not such a denial since true denial means rejecting the joys and not the sorrows of life. The suicide, he said, is desirous of living — he is discontented only with those conditions of life which affect him. Suicide is, in short, not a negation of the will and therefore not justifiable.\(^2\)

By the late nineteenth century the spirit of investigation was markedly manifesting its gradual evolution from abstract ethical disputation to statistical and medical inquiry. Yet the last 75 years has not been without its articulate apologists and

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1. Dublin and Bunzel, *To Be Or Not To Be*, p. 220.
2. Yet this was not the way in which Schopenhauer has been popularly interpreted.
critics of suicide. William James with his call to vital existence expressed in his essay "Is Life Worth Living?" the conviction that religious faith and the enhancement of harmonious human relationships through satisfying work made life worth living regardless of what is brought. He wrote, "Be not afraid of life. Believe that life is worth living, and your belief will help create the fact."¹ In his Ethics of Suicide, Sidney Hook writes, "Any system of thought which absolutely refuses to countenance suicide as a rational possibility is either irresponsibly optimistic or utterly immoral."² He proceeds to review six traditional arguments against self-destruction, counters five of them and suggests that the sixth argument — the cruelty of inflicting pain upon one's friends and family — constitutes the only justifiable deterrent. Yet sometimes even love and friendship, he believes, must be sacrificed. Hook writes:

"If the sacredness of human life be invoked to furnish grounds against all forms of self-destruction, then we are duty bound in logic and in humanity to adopt the same attitude toward war and capital punishment."³

He insists that it is not life itself that is worth living, but only the good life. From this, two corollaries, he believes, must

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follow:

(1) No rational morality can compel us to perpetuate lives that are irretrievably blasted by accident or birth, or blighted by some horrible malady before which remedial measures are unavailing; and more important, (2) no social morality can be equally binding upon everyone unless a social reconstruction makes possible a more equable distribution of the necessities of life.¹

Fedden holds that self-destruction is a matter of individual discretion, that theoretically it is not wrong though it may, in specific instances, be irresponsible. He offers an explanation for the prevailing condemnatory attitudes toward suicide.

Suicide shows a contempt for society. It is rude. As Kant says, it is an insult to humanity in oneself. This most individualistic of all actions disturbs society profoundly. Seeing a man who appears not to care for the things which it prizes, society is compelled to question all it has thought desirable. The things which makes its own life worth living, the suicide boldly jettisons. Society is troubled, and its natural and nervous reaction is to condemn the suicide. Thus it bolsters up again its own values.²

Albert Camus, the French novelist and playwright³, wrote in 1955, "Even if one does not believe in God, suicide is not

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1. Ibid.


3. A society's moral values are reflected, often complexly, in its literature. In the poetry of the Romantics a longing for death is often focal and can be interpreted as a response to their sense of alienation and perhaps, too, as a protest against the society of their day. The theme of suicide has been used centrally and dramatically and without direct condemnation in the nineteenth century: by Ibsen in The Wild Duck and Hedda Gabler, by Chekov in Ivanov and The Seagull, and in the twentieth century by Eugene O'Neill in Diff'rent, Dynamo, and Mourning Becomes Electra and by Arthur Miller in All my Sons and Death of a Salesman.
legitimate ... even within the limits of nihilism it is possible to find the means to proceed beyond nihilism.\(^1\)

The subject of the morality of suicide has been disputed for over two thousand years and there is little hope of obtaining consensus on the matter. Attitudes toward the act have, in that time, ranged on a continuum from condemnation to approval. It seems safe to say, however, that the balance of contemporary Christian thought is against suicide. Yet one can detect a definite trend away from traditional morality and in the direction of a "social morality" — a morality more in harmony with the insights of social and medical sciences. This trend is reflected in the evolution of the law as it applies to suicide.

3. The Etiology of Suicide

The late nineteenth century ushered in a new era of scientific investigation into human problems. Nowhere was the new spirit of inquiry better exemplified than in the writings of Emile Durkheim on the subject of suicide and Sigmund Freud on the subject of the processes of depression. Their works, sociologically and psychoanalytically oriented, respectively, constitute the frames of reference basic to much of the research which followed.\(^2\)

It is generally agreed that the most promising lines of inquiry have been and continue to be those which look to the social structure and to personality for etiological clues to

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2. Accompanying this investigation or perhaps as a result of it was a demand for a more functional, utilitarian consideration of morality.
suicide. It is, then, the sociology of suicide and the psychology of suicide which will be examined in the next two chapters.

4. Implications for the Study of Suicide.

The study of suicide, its causes and effects, serves a dual function: it permits an examination and a resulting clarification of the insights derived from the social and medical sciences, and it points to or suggests, following from such an examination, the most appropriate and effective preventive measures on the therapeutic, educational and structural levels.
1. Early Theories of Suicide.

The early "scientific" investigations of suicide were medical or forensic in orientation, but by the third decade of the nineteenth century empirical data in the form of statistical tables came to be included in these works. This innovation marks the crude beginnings of the sociological approach to the subject.

One such study of suicide was that of Esquirol, the French alienist. His *Mental Maladies: A Treatise on Insanity* deals in the main with the relationship between suicide and insanity but he devotes a substantial section to a presentation of statistical data on age and sex distribution, of the influence of climate and of methods used in self-destruction. Winslow's *Anatomy of Suicide*, published in 1840, represents another early investigation of the subject. The author, a physician, concerns himself primarily with medical matters and questions of medical jurisprudence but he does furnish some statistics. Just after the middle of the nineteenth century two important works appeared dealing thoroughly with the subject. The book *Du Suicide, Statistique*,...

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1. The writer does not believe that these early works on suicide constitute what can properly be termed unified "theory"; rather, they represent contributions, often fragmentary, to factual data. For this reason the term "theories" may be somewhat misleading.


Medecine, Histoire et Legislation, written by Lisle in 1856, contains "many statistical tables giving the number of suicides, their geographic distribution, the influence of climate and seasons, age and sex classifications, professions and occupations, education, methods and causes."\(^1\) The lengthy study of Brierre de Boismont published in 1865 contains detailed statistics and a discussion of causes of physiological factors and legal issues.\(^2\)

Morselli's Suicide, An Essay on Comparative Moral Statistics, published in 1881, represents a major contribution to the literature on the subject. Although written by a psychiatrist, the work is primarily sociologic in orientation. It examines the influences on suicide of cosmic, ethnic, social, "individual biological" and "individual psychological" factors, discusses the significance of ethnic and individual differences in the methods of self-destruction, relates suicide to Malthusian and Darwinian principles, and finally suggests broad therapeutic measures for its prevention.\(^3\)

In 1882 the book Suicide, Studies on its Philosophy, Causes, and Prevention appeared. The author, O'Dea, discusses suicide in relation to the religious beliefs, moral tenets and laws extant

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1. Pierre-Egiste Lisle, Du Suicide; Statistique, Medecine, Histoire et Legislation, Paris, J.B. Bailliere, 1856. Quoted in Dublin and Bunzel, To Be Or Not To Be, p. 227.


at various stages in the historic evolution of civilization. He examines what he terms "personal" and "social" causes, (the latter being for him the predispositions inherent in certain categories of such factors as age and sex, occupation, domestic life, "education and literature", race and nationality) and concludes with proposals for measures of prevention.  

2. Durkheim's Theory of Suicide.

Durkheim's treatise on suicide is regarded as a sociological classic. In it he attempts to analyze the relationship between suicide and various social and natural phenomena. His point of departure in this work is the negation of what he terms "extra-social factors"—psychopathy, the characteristics of race and heredity, cosmic factors such as climate and seasonal temperature, and the psychological mechanism of imitation—as possible causes of suicide.

A Extra-Social Factors

For Durkheim psychopathic^2 states can bear a direct relationship to suicide only if every suicide were considered to be, in itself, a mental disease or a manifestation of insanity; this possibility Durkheim strongly denies. Employing statistical data he attempts to show that there was no positive correlation in nine named European countries between the number of insane persons and the number of suicides.

2. Durkheim uses the term "psychopathic" in a different sense from that common today. He is referring to all forms of psychic disfunctioning and mental disorders.
After an examination documented by statistics of race and heredity as potential determinants of suicide Durkheim asks: "Does not this prove that the cause of the variations of suicide cannot be a congenital and invariable impulse, but the progressive action of social life?" He concludes that there exists no definite and automatic predisposition to suicide (except in the insane) but rather a general "aptitude" which assume a variety of forms depending on circumstances which permit but do not specifically cause suicide.

Durkheim notes that suicide is more prevalent in the temperate zone of Europe and he attempts to disprove the conclusions or Morselli and Ferni who, also observing this fact, ascribed it to the mysterious effects of heat acting as a suicide stimulant on cerebral functioning. Using statistical tables he shows that the number of suicides in Europe is greatest in the spring and summer and in the morning and afternoon of the twenty-four hour period. He attributes this not to any cosmic or natural force but rather to the intensification of social life at these times.

Durkheim next examines the hypothesis that imitation is a cause of suicide. He criticized the theory that imitation is the main source of all collective life and holds that,

Certain as the contagion of suicide is from individual to individual, imitation never seems to propagte it so as to effect the social suicide-rate. Its radiating influence

is always very restricted; and what is more, intermittent.

In short, then, Durkheim dispatches those theses which require recourse to individual and extra-social causes in the explanation of suicide. He suggests that the result of his process of elimination has not been totally negative. He writes:

We have in fact shown that for each social group there is a specific tendency to suicide explained neither by the organic-psychic constitution of individuals nor the nature of the physical environment. Consequently, by elimination, it must necessarily depend upon social causes and be in itself a collective phenomenon; some of the facts examined, especially the geographic and seasonal variations of suicide, had definitely led us to this conclusion.

B. Egoistic Suicide.

Durkheim holds that currents of suicide are not related to personal and individual concomitants but rather to the social structure and its ramifying functions, and that there are social types of suicide identifiable and classifiable by the causes which produce them. Once the social determinants have been isolated, individual suicide may, he believes, be placed in its proper etiological setting.

The three types arrived at by Durkheim are egoistic suicide, altruistic suicide, and anomic suicide.

From an examination of religious affiliation, marriage and the family, and political and national communities, Durkheim is

1. Ibid., p. 140.

2. Ibid., p. 145.
led to the first of his three categories of suicide, namely, egoistic suicide. This may be defined as the insufficient presence of society in the individual or the lack of integration of the individual into the society in which he lives. Accordingly, when the solidarity of group life is weakened, when the individual is less subject to group control, and when social forces throw him onto his own resources, the tendency toward suicide is greater.

Durkheim first examines what he terms "religious society". Showing, by use of statistical compilations, that the suicide rate is highest in predominantly Protestant countries and lowest in purely Catholic countries and Jewish communities, he offers an interpretation for these facts. He suggests that Protestant propensity for self-destruction is related to its animating spirit of free inquiry, which grows out of or follows naturally from the overthrow of traditional tenets; that schisms, taking the form of a diversity of beliefs and practices, serve to weaken common bonds. "We thus reach the conclusion that the superiority of Protestantism with respect to suicide results from its being a less strongly integrated church than the Catholic church."

By contrast, he contends, Catholic thought prohibits religious individualism and doctrinal variation, and demands

1. Ibid., p. 258.
2. Durkheim points out that free inquiry leads inevitably to increased knowledge and this, in turn, can further uproot religious faith, resulting in a weakening of social bonds. (p. 169).
3. Ibid., pp. 152-159.
4. Ibid., p. 159.
conformity and submission to ecclesiastical authority. The resulting unity of the Roman Church thus operates to minimize suicide among its adherents.

The low incidence of suicide amongst Jews can be explained, Durkheim believes, by the compactness and coherence of the Jewish community and by the strong feeling of self-consciousness and oneness.

For Durkheim, then, the deterrent effects of religious faith on suicide cannot be attributed to dogma but rather to the fact that religion is, in itself, a society—a society constituted of commonly held beliefs and practices which serve a cohesive, preservative, and integrative function.

Durkheim next considers the family and political society. He introduces two concepts, "the coefficient of preservation" and "the coefficient of aggravation," and from the application of these concepts to statistical data he derives four laws:

1. Durkheim imputes the low rate of suicide in Britain to the features of similarity between the Church of England and the Roman Catholic Church. (pp. 160-161).

2. Ibid., pp. 157-158.

3. Durkheim attributes this solidarity to the reaction of the Jewish people to their hostile surroundings. (pp. 159-160).

4. He defines this as "the number showing how many times less frequent suicide is in one group than in another at the same age." (p. 177).

5. This concept may be defined as "the number showing how many times more frequent suicide is in one group than another at the same age." (p. 177).
Too early marriages have an aggravating influence on suicide, especially as regards men. From twenty years, married persons of both sexes enjoy a coefficient of preservation in comparison with unmarried persons. The coefficient of preservation of married persons by comparison with unmarried persons varies with the sexes. Widowhood diminishes the coefficient of married persons of each sex, but it rarely eliminates it entirely.¹

He holds that the immunity of married persons to suicide can be ascribed to one of two causes: matrimonial selection² or the influence of the domestic environment.³ By a series of deductions, statistically documented, he concludes that "the immunity of married persons in general is thus due, wholly for one sex and largely for the other, to the influence not of conjugal society but of the family society."⁴ Durkheim holds, too, that the greater number of members composing the family the less is the tendency of each member toward suicide. He writes:

But for a group to be said to have less common life than another means that it is less powerfully integrated; for the state of integration of a social aggregate can only reflect the intensity of the collective life circulating in it. It is more unified and powerful the more active and constant is the intercourse among its members. Our previous

1. Ibid., pp 178-179
2. By this Durkheim means the choice of an organically-psychologically superior mate. Allegedly, the end result of selection will be the superiority of the married over the single population. (pp.180-181)
3. Durkheim distinguishes between conjugal society (the husband-wife unit) and family society (parents and children). Domestic environment and family society refer to the latter. (pp. 185-189)
4. Ibid., p. 189
conclusion may thus be completed to read: just as the family is a powerful safeguard against suicide, so the more strongly it is constituted the greater its protection.¹

The third and final "society" examined by Durkheim is political society. Perceiving that the suicide rate drops in times of war, political crises, and social upheavals, he argues that only one explanation can account for this phenomenon:

Great social disturbances and great popular wars rouse collective sentiments, stimulate partisan spirit and patriotism, political and national faith, alike, and concentrating activity toward a single end, at least temporarily cause a stronger integration of society. The salutary influence which we have just shown to exist is due not to the crisis but to the struggles it occasions. As they force men to close ranks and confront the common cause. Besides, it is comprehensible that this integration may not be purely momentary but may sometimes outlive its immediate causes, especially when it is intense.²

In concluding his analysis of egoistic suicide Durkheim suggests that three propositions have been formulated:

1. Suicide varies inversely with the degree of integration of religious society.
2. Suicide varies inversely with the degree of integration of domestic society.
3. Suicide varies inversely with the degree of integration of political society.³

He writes:

This grouping shows that whereas these different societies have a moderating influence upon suicide, this is due not to special characteristics of each but to a characteristic common to all. Religion does not owe its efficacy to the special nature of religious sentiments, since domestic and political societies both produce the same effects when strongly integrated. This, moreover,

². Ibid., p. 208.
³. Ibid.
we have already proved when studying directly the manner of different religions upon suicide. Inversely, it is not the specific nature of the domestic or political tie which can explain the immunity they confer, since religious society has the same advantage. The cause can only be found in a single quality possessed by all these social groups, though perhaps to varying degrees. The only quality satisfying this condition is that they are all strongly integrated social groups. So we reach the general conclusion: suicide varies inversely with the degree of integration of the social groups of which the individual forms a part.

C. Altruistic Suicide.

The second broad category of suicide developed by Durkheim is the altruistic.

Drawing upon a fairly extensive literature he cites numerous examples of acts of self-destruction among primitive groups and classic oriental societies — acts compelled by a sense of duty, honour, or the joy of sacrifice. He reasons that one cause only can account for these altruistic suicides: a limited sense of personal identity and worth in persons living in an extremely cohesive society which rigorously governs custom and habit. He writes:

For the individual to occupy so little place in collective life he must be almost completely absorbed in the group and the latter, accordingly, very highly integrated. For the parts to have so little life of their own, the whole must indeed be a compact, continuous mass. And we have shown elsewhere that such massive cohesion is indeed that of societies where the above practices obtain.

1. Ibid., pp. 208-209.

And again:

His person has so little value that attacks upon it by individuals receive only relatively weak restraint. It is thus natural for him to be yet less protected against collective necessities and that society should not hesitate, for the very slightest reason, to bid him end a life it values so little.¹

Durkheim admits to a probable relationship between the phenomenon of altruistic suicide and pantheism but he denies that pantheism produces suicide.

If the essence of pantheism, then, is a more or less radical denial of all individuality, such a religion could be constituted only in society where the individual really counts for nothing, that is, in almost wholly lost in the group. For men can conceive of the world only in the image of the small social world in which they live. Religious pantheism is thus only a result and, as it were, a reflection of the pantheistic organization of society.²

Another environment examined by Durkheim in which altruistic suicide is prevalent is military life. Again, by a series of deductions supported by statistical data, he attempts to show that military life demands such a high degree of impersonality, self-abnegation, and renunciation that it is conducive to suicide.

D. Anomic Suicide.

The third type of suicide in Durkheim's classification is anomic suicide. He notes that in time of economic crisis the

1. Ibid., p. 221.
2. Ibid., p. 227.
rate of suicide rises, but he also observes that "even fortunate crises, the effect of which is abruptly to enhance a country's prosperity, affect suicide like economic disasters." This fact he supports with a brief review of contemporary European political and economic events and with related statistical data. He offers a general explanation for this phenomenon and poses a question:

If therefore industrial or financial crises increase suicides, this is not because they cause poverty, since crises of prosperity have the same result; it is because they are crises, that is, disturbances of the collective order. Every disturbance of equilibrium, even though it achieves greater comfort and a heightening of general vitality, is an impulse to voluntary death. Whenever serious readjustments take place in the social order, whether or not due to a sudden growth or to an unexpected catastrophe, men are more inclined to self-destruction. How is this possible? How can something considered generally to improve existence serve to detach men from it?

Durkheim then attempts to answer these questions. He suggests that man's passions, needs, and feelings are subject to an external force of restraint, namely society; that society plays the role of moderating the individual's desires in keeping with its social requirements; and that society, acting collectively as a regulative mechanism, assigns to each individual his place in the social order and sets limits to his ambitions and aspirations. The result, claims Durkheim, is a sense of self-satisfaction and stability. He writes:

1. Ibid., p. 243.

2. Ibid., p. 246.
This relative limitation and the moderation it involves, make men contented with their lot while stimulating them moderately to improve it; and this average contentment causes the feeling of calm, active happiness, the pleasure in existing and living which characterizes health for societies as well as for individuals. Each person is then at least, generally speaking, in harmony with his condition, and desires only what he may legitimately hope for as the normal reward of his activity.¹

He points out, however, that since in times of crises and sudden transitions, society becomes temporarily unable to exercise its regulating and controlling function, the suicide rate increases. Economic disasters, or abrupt changes in the distribution of wealth and power, he holds, produce a disequilibrium, facilitate excessive social mobility, promote a whetting of unsatiﬁable economic appetites and a weakening of the inﬂuence of traditional rules, and found conditions to which the individual cannot adapt without extreme difficulty. As these disruptive forces then reinforce each other, a state of deregulation or anomie exists.

It is Durkheim’s contention that in the sphere of trade and industry the lack of organization causes a chronic state of anomie. He quotes ﬁgures to show that "industrial and commercial functions are really among the occupations which furnish the greatest number of suicides."² Economic anomie is not the only anomie which gives rise to suicide. Noting what he terms "the parallel development of divorces and suicides",³

¹. Ibid., p. 250.
². Ibid., p. 257.
³. Ibid., p. 273.
Durkheim attributes it to the state of conjugal anomie produced by divorce.

E. Summary.

In summary, then, Durkheim dismisses those theories of suicide which would explain the causes of the phenomenon in terms of personal motives and environmental and hereditary factors, and he develops instead three "ideal types" of suicide, egoistic, altruistic and anomic. The first is seen as a manifestation of the gross incompleteness of the individual's integration into society, his excessive individuation and his sense of social isolation. The second, in contrast, is seen as symptomatic of an overly-strong group attachment, a subordination of individual to group interests, and a loss of personal values and a distinct identity. The third is an expression of the absence for the individual of the discipline and regulations customarily prescribed by society, and the loss of a sense of orderliness, equilibrium, and orientation.


Basic to an understanding of Durkheim's writings is an understanding of his view of society and of the relationship of the individual to the social group. In respect to this he adopted a position radically opposed to the prevailing individualistic

1. This has been termed by Talcott Parsons as "sociologistic" positivism. (The Structure of Social Action, Glencoe, The Free Press, 1949, pp. 343-344).
versions of the main tradition of positivistic thought. 1 Dublin and Bunzel have lucidly outlined Durkheim's conception of society.

A society consists not only of the sum of its members, but also of the interactions of these individuals upon each other, plus the material things which play an essential part in community life. In consequence, social thinking is not determined exclusively by the consciousness of individuals, or even by the sum total of the individual ideas current at any given time, for its nature is altered by the very fact that these different ideas have fused. Any society is qualitatively different from the several constituents forming it; and whether or not a person may choose to participate in group activity, he cannot escape from the pressure which the group exerts. The patterns of life and the practices that prevail, largely determine his actions. Among forces external to the individual volition is the suicidal tendency which is a social product — a social fact with which we must reckon. In other words, there exists always in society a collective force (in this case towards suicide) which is constantly exerting upon the individual, a pressure, the action of which is not greatly influenced by his personal psychology, his ideas or his desires. 2

In his repudiation of the "positivist" position and his rejection of explanations of behaviour in terms of psychological variables, 3 Durkheim travelled extremely far in the opposite direction. An unflinching advocate of the "realist" position, he postulated an independent social reality extrinsic to human personality, held society to be a logical construct and insisted on the self-sufficiency of sociological explanations of behaviour.

Durkheim's critique of the earlier attempts to explain variations in the rate of suicide by recourse to extra-social

1. Ibid., p. 307.
2. Dublin and Bunzel, To Be Or Not To Be, pp. 228-229.
3. In particular did Durkheim take exception to Gabriel Tarde's view that imitation was the psychological mechanism which made life possible.
factors had been subject to criticism. Harry Alpert reviewing
the Spaulding-Simpson translation of Le Suicide describes the
method of elimination as being used in an "extravagent and
cavalier" manner.\(^1\) While Durkheim ably demonstrated, for the
most part on empirical grounds, that previous theories embodying
the factors of climate, race, heredity, psychopathic states,
and imitation are incapable of yielding a satisfactory and
acceptable solution to the problem, he did not succeed in showing
that they can have nothing to do with it. For the modern
reader Durkheim's dismissal of mental disorders as a determinant
of suicide may indicate gross shortsightedness and a serious
failing, but as Parsons points out:

The psychopathological views he criticizes are
primarily those which attribute suicide to a
specific, hereditary psychopathological condition
and he is able to show easily that this cannot
account for the significant variations of suicide
rates. His arguments do not, however, apply to
the "environmental" and "functional" types of
mental disturbance of which our understanding has
been so greatly increased in the last generation,
especially through psychoanalysis and related
movements.\(^2\)

Critics have pointed to the crudeness of Durkheim's
statistical techniques and to his oft-times forced use of statistics
when they helped support his contentions.\(^3\) There is some
justification for such a criticism, as even a cursory examination
of the study will show, but one should not lose sight of the

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Durkheim's Le Suicide) American Sociological Review, vol. 16, 1951,
p. 566.
2. Parsons, Social Action, pp. 325-326.
3. Alpert, especially, criticizes this characteristic in Durkheim's work
... Simpson and Parsons comment on the lack of statistical re-
finement but neither consider it particularly detracting.
broader perspective. For the body of empirical fact (i.e., the statistical data) was of secondary importance, serving as a vehicle for framing concepts and developing theory. Parsons has pointed this out. He writes:

In the social field most available statistical information is on a level which cannot be made to fit directly into the categories of analytical theory... In any event, it is out of the question that in the usual sense of statistical "elegance" he should be held to have accomplished rigorous statistical verification of his conceptual scheme. What is true is, rather, that by means of a very broad and elementary statistical analysis he has been able to bring out certain broad features of the facts about suicide and the variations in its rate... But the very broadness and lack of refinement of the statistical method is perhaps an advantage from the viewpoint of the present interest... It is almost certain that refined statistical analysis of the data by modern techniques would reveal many complexities of which Durkheim was not aware, but is very unlikely that any such analysis would make it possible to "refute" Durkheim on the broad basis on which his analysis properly rests.

The conceptual scheme used by Durkheim for the purpose of typing varieties of suicide is, in reality, an instrument for classifying and analyzing types of social organization, for, in essence, Durkheim was using his theory of suicide as a means of developing general theories of social phenomena. Perhaps the severest test of the relevancy and validity of Durkheim's types of suicide lies, then, not in the direction of strict verification of his hypothesis by more modern statistical techniques but rather in the direction of testing his categories.

of analytical theory in relation to other kinds of behaviour.

As Alpert¹ has rightly pointed out, the theory of suicide as embodied in his book _Le Suicide_ reveals Durkheim's brilliance and originality, his astuteness in sociological analysis, his genius for bringing individual facts into relation with one another within a meaningful conceptual framework, his forceful and persistent demonstration that even the apparently highly personal act of self-destruction is explicable only in terms of social processes and social structures, and his concern with philosophical implications and practical considerations as well as theoretical generalizations.

_Le Suicide_ remains as timely and germane today as when it was written sixty years ago. As Henry and Short have written:

Durkheim's was the first theoretical and empiric exploration of the persistent variations of suicide in relation to sociologic variables. His theoretical types of suicide and his frame of reference for their interpretation remain basic to all research by sociologists in this area.²


Durkheim's approach to the study of suicide was carried forward, tested and applied further by his student, Maurice Halbwachs, in his work intended as a supplement to

Halbwachs examines suicide in relation to comparative urban and rural rates, trends in rates in different countries, marital status, religious affiliation, homicide, political and economic crises, alcoholism, and psychopathic states. Rather than attempting to amass new statistics from original records, he critically re-examines the statistical tables published by Durkheim and Morselli. By bringing into juxtaposition factors not previously believed to be relevant and studying trends in one set of factors in terms of the other, he disturbs some of the old theories and is able to advance new explanations hitherto ignored or dismissed.

One of the most interesting hypotheses put forward concerns the high incidence of suicide among men as compared to women. This difference in rates is usually attributed to differences in the psychological constitution of men and women. Although Halbwachs does not have conclusive data he offers statistics which show that when both attempted and successful suicides are taken into consideration women appear to show as great a tendency toward suicide as do men. He then examines the methods used by men and women and finds that whereas men choose rather reliable methods of killing themselves, women select those which are less certain to


2. Durkheim, himself, suggests that a woman's mentality is less developed than a man's and that she is more "instinctual." (Durkheim, p. 272.)
cause death.

The trend in rates over a period of years, Halbwachs shows, must be viewed in relation to the population growth and the changing predominance of old or young people, for the suicide rate is much higher among old than among young people. Although the rate in most European countries is increasing, Halbwachs demonstrates that the increase has been at a decreased rate. He suggests that a point of stabilization will probably be reached in each country — a point peculiar to that country.

Halbwachs' discussion of the relation between psychopathologic states and suicide marks a new direction of thought on the subject of self-destruction. Dispensing with statistical data, he attempts to devise a theory of causation of suicide which avoids the traditional dual approaches of the sociologist and the psychiatrist. As Parsons has noted, Halbwachs sees no antithesis between the social and psychological explanations of suicide; rather he considers them complementary. ¹ For Halbwachs there is but one cause for suicide: the detachment of the individual from society and his resulting sense of social isolation. He holds that it matters little whether isolation has its roots in psychic disfunctioning or in external conditions.

The merit of Halbwachs' works lies in the simplicity of the statistical analysis, in the imaginative re-examination of the data basic to and underlying Morselli's and Durkheim's

¹ Parsons, Social Action, p. 326.
thesis, and in the forthright endeavour to integrate two seemingly opposed areas of investigation into one promising line of inquiry. Alpert calls Halbwachs' study a necessary complement to Durkheim's and quotes Marcel Mauss, a student of the subject, as having referred to Les Causes du Suicide as the "indispensable corrective" to Le Suicide.¹

5. Sociological Co-ordinates of Suicide.

After the publication of Durkheim's treatise there gradually developed, primarily in an attempt to test his hypotheses, a substantial body of empirical data.² Investigations, although empirical in nature, were carried out within the broad theoretical framework developed by Durkheim. To permit a more systematic presentation and discussion of research findings a number of summary topical categories are used.


2. The theme, if not the focus, of much of this research is relating, often implicitly, the etiology and differing rates of suicide to the strength of the relationship system (or the degree of group solidarity) using as indices ecological distribution, urban-rural differences, marital status and age. The classic statement in this approach is, of course, Durkheim's but others have followed. Dublin and Bunzel (152) writing about primitive societies contend that to understand the reasons for suicide and the attitudes toward it in any given primitive society, one must closely examine the social organization of that society. They suggest that the greater the emphasis on individuality and on personal acquisition, the greater will be the number of suicides and the less the act will be stigmatized. Where there is less personal striving for leadership, possessions and recognition, suicide, they hold, will not be as prevalent and the attitude towards it much more prohibitive. Faris, (Social Disorganization, New York, Ronald Press, 1948, p. 66) borrowing from Halbwachs, holds that social isolation promotes abnormal behaviour, of which suicide is but one manifestation.
A) Suicide and Climate.

Statistical data, past and present, have consistently shown that the greatest number of suicides occur in the spring and early summer, and the fewest in the winter season. Early investigators such as Morselli, Lombroso and Ferri attributed this phenomenon to the mysterious effects of climate on the human organism.  

Morselli has written:

Suicide and madness are not influenced so much by the intense heat of the advanced season as by the early spring and summer, which seize upon the organism not yet acclimatized and still under the influence of the cold season. And this applies to the first cold weather.

Durkheim, vigourously opposing the cosmic explanation, ascribed seasonal variations in suicide frequency to the increased tempo of social life in the Northern Hemisphere in May, June and July, and its decrease in November, December and January.

Miner, a statistician, processing the date from the official compilations of nearly thirty European countries (covering a period of one hundred years), writes:

The maximum frequency of suicide occurs in May or June, the minimum in December or January. This appears to be an effect of weather per se.

1. Durkheim, Suicide, pp. 104-113.
2. Morselli, Suicide, p. 72.
3. Durkheim, Suicide, pp. 119-122.
Dublin and Bunzel examined the monthly variations in suicide frequency during the years 1910-1923 in a number of American cities located in broadly scattered geographic areas. After taking into account climatic differences in the widely spread localities, they conclude that the same seasonal fluctuation is, with some very minor differences, prevalent everywhere, and that the maximum number of suicides occur in the early part of the year, coincident with the coming of spring weather.\textsuperscript{1} Almost identical findings were disclosed by an examination of the influences of seasonal factors on suicide in New York city during the same period of time and in England and Wales from 1921 to 1925.\textsuperscript{2}

The contentions of Morselli, Miner, and others that climate in itself accounts for the fluctuating rate of suicide at different times of the year are highly debatable. Durkheim's hypothesis that changes in social life are responsible for seasonal variations in suicide is more tenable as far as it goes. It suggests promising lines of inquiry — perhaps in the direction of investigating the relation of seasonal changes in suicide frequency to economic trends and their implications for social living.

B) Ecological Distribution

Cavan, examining the distribution of all suicides

\textsuperscript{1} Dublin and Bunzel, \textit{To Be Or Not To Be}, p. 87.
\textsuperscript{2} \textit{Ibid}, pp. 87-89.
occurring in Chicago during the years 1919 to 1921, isolated
four districts in which the suicide rate was high. These areas were
characterized by shifting populations, a preponderance of cheap
hotels, rooming houses and restaurants — in short, areas of
extreme social and personal disorganization.¹ Studies of the
ecology of suicide in other cities have on the whole substantiated
Cavan's findings. Schmid showed that in Seattle and Minneapolis
suicide tends to predominate in the centrally located, disorganized
sectors. The high degree of residential mobility, the impersonality
and anonymity of city life, the ineffectualness of social norms
in the control of individual behaviour and the resulting
social disorganization are responsible, he believed, for the
high rate of suicide.² Faris' study of Providence³ and Mowrer's
analysis of suicide in Chicago⁴ (using a longer period of time
and therefore a greater number of cases than did Cavan) in
general confirm Cavan's pattern of distribution of rates.

Sainsbury sets out to test the hypothesis that differences
in the suicide rates of London boroughs will disclose their
social differences. He found that the boroughs showed:

1. Ruth Shonie Cavan, Suicide, Chicago, University of Chicago Press,
   1928, pp. 77-105.

2. Calvin Schmid, "Social Saga of Two Cities, An Ecological and
   Statistical Study of Social Trends in Minneapolis and St. Paul,"
The Minneapolis Council of Social Agencies Monograph Series No. 1,
   Minneapolis, pp. 370-380 and "Suicide in Seattle, 1914-1925: An Ecological
   and Behaviouristic Study," University of Washington Publications in
   the Social Sciences, Vol. 5 (October 1928).


4. E. R. Mowrer, Disorganization Personal and Social, Philadelphia,
Significant differences between their suicide rates, and a remarkable consistency in rank order of rate over three decades in spite of considerable changes in the composition of their populations.

A significant correlation of suicide rates with rates for the following characteristics: social isolation (e.g. persons living alone, and in boarding-houses); social mobility (e.g. daily turnover of population, and number of immigrants); and two of the indices of social disorganization (divorce and illegitimacy).

Sainsbury holds that by plotting on a map of North London the distribution of some 409 suicides, the relations are corroborated. He writes:

The findings (are related) to the ecological structure of London, i.e. the unplanned process by which, in the course of its growth, districts with particular social attributes have been differentiated. Suicide rates were highest in the West End and North-West London where both class and spatial mobility are highest, small flat and boarding-house accommodation preponderates, shared mores are absent, and relationships impersonal. Suicide rates were low in the peripheral southern boroughs where family life and stability prevail, and in many of the working-class districts whose residents are locally born and where life is more neighbourly.

The ecological approach, with its identification of the social conditions in a defined geographical unit in reference to pathologies, is a fruitful one.

2. Ibid.
C) Urban and Rural Differences.

That there is a direct relationship between the degree of urbanization and suicide rates has been shown in a number of sociological studies.

Miner, analyzing extensive European statistics covering the period from 1871 to 1905, concludes that the suicide rate is usually higher in urban than in rural communities. Halbwachs gives figures which show that in France the suicide mortality rate among the rural population is considerably lower than among the urban. Comparative American statistics are examined by Dublin and Bunzel with some interest findings. They show that with the growth of urbanism came a progressive increase in suicide frequency in the first three decades of the twentieth century and a greater spread between urban and rural suicide rates. They statistically demonstrate that the changes cannot be attributed to a pronounced difference in the age distribution of the urban and rural population. Using data in a study by Hoffman they point out, too, that in general, the larger a city is the higher is its suicide rate.

A striking demonstration of the relation of urbanism to suicide can be seen by comparing, as did Dublin and Bunzel, the

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1. Miner, Am. J. Hygiene, Monogr. 2, 1922, p. 27
4. Dublin and Bunzel, To Be Or Not To Be, pp. 78-79.
low suicide rates in the states of the rural American South with the higher rates of the more urbanized states of the North, East, and Mid-West.\(^1\) As might be expected, though, the suicide rates in larger southern urban centres such as New Orleans, Memphis, and Atlanta are considerably higher than those in their environs.\(^2\)

In order to examine the statistics with more precision than a simple urban-rural division permits Cavan in her book *Suicide* makes a three-part division of communities in each state of the United States (on the basis of population) into rural and towns (less than ten thousand people), secondary cities (ten thousand to one hundred thousand) and principal cities (over 100,000). Commenting on her findings she writes:

> From these data it becomes apparent that while in general the rate increases from rural through secondary cities to the principal cities, there is on the one hand no definite and consistent ratio between the three rates, and on the other there are numerous exceptions, cases in which the secondary cities and even the rural sections rank higher than the principal cities. In the third place, the rural rate in some states is much higher than the rate of the secondary and even of the principal cities in other states. Mere ruralness or urbanness does not fix the rate, although in adjacent states (that is, under similar social conditions) a certain relationship may be detected. Thus, in the West, Middle West, and South the tendency is for the principal cities to exceed the secondary cities, which in turn exceed the rural districts.

\(^1\) Interestingly enough, the Pacific coast states record the highest suicide rates in the United States. Perhaps the "frontier" and anomic characteristics of the region are in part responsible.

\(^2\) Dublin and Bunzel, *To Be Or Not To Be*, p. 81.
In the northeastern states another pattern tends to predominate. In New Jersey, for instance, the rate for principal cities is 12.8 suicides per 100,000; for secondary cities, 11.9; and for rural sections, 13.7. The same relationship and almost the identical rates hold for New York. Rhode Island, Massachusetts, New Hampshire, and Vermont all have rural rates which equal or exceed the rates not only of secondary cities but of primary cities as well.1

Offering an explanation for the disparity between urban and rural suicide rates, Henry and Short write:

One of the critical differences between rural and urban living is in the stability and continuity of family and neighborhood life. The strong control exercised by the neighbors on the farm or in the small town contrasts sharply with the anonymity and impersonality of life in the city. These characteristics of the city are magnified in the central, disorganized sectors. The steady rise in suicide from the tightly knit rural community to the anonymity of the city may reflect the strong relational systems of the rural small-town dweller and the relative isolation from meaningful relationships of many of the inhabitants of large cities.2

The characteristics of city life (graphically depicted in the writings of Park and Burgess3 and Wirth4) can be explained on the basis of three variables: number, density and degree of

2. Henry and Short, "The Sociology of Suicide", in Clues to Suicide, p. 61.
heterogeneity. Writers investigating the causes for the high incidence of suicide in cities tend to emphasize the first two variables and overlook the third with its implications for religious and socio-economic differences.

D) Marital Status.

The investigations of Durkheim, Halbwachs and others amply demonstrate the complexity of the relation between suicide and marital status. The difficulty in a quantitative analysis is, of course, to hold constant variables which, if uncontrolled and unaccounted for, would produce a distorted statistical picture. The following quotation is a fair statement of research findings.

The degree of involvement in meaningful relationships with other persons is greater, on the average, for the married than for the single, widowed, or divorced. The married are by definition involved in at least one more meaningful relationship than the non married. When the effects of age and sex are held constant, the suicide rate of the married is lower than the rate of the single, the widowed, or the divorced. Suicide is highest for the divorced. When the factor of age is held constant, suicide is higher for the widowed than it is for the single, up to the age of thirty-five. From age thirty-five on, however, the suicide rate of the single is higher than that of the widowed. Strength of the relational system is related to the widowed and single categories in an extremely complex manner. It is probably weaker for the widowed than for the single at the younger ages, when widowhood comes as a greater shock and young family responsibilities are most likely to be disrupted. On the other hand, it is probably stronger for the widowed during the older age periods, when they are more likely to have the benefit of relations with their children grown to adulthood and when the single find their relationships curtailed by increasing morality of their

1. Ibid.
Such findings are consistent with the supposition that the propensity for suicide decreases when the individual is involved in a web of social relationships.

E) Age and Sex.

Dublin and Bunzel in their compendium examine quantitatively the factors of age and sex as related to suicide. Summarizing American and European statistical data they draw a number of conclusions. First, numerically the number of children (up to age fifteen) who commit suicide is negligible. Second, in adolescence (15-19) the female suicide rate is slightly higher than the male but for neither sex at this time is suicide a serious problem. Third, for men the suicide rate increases with age: from a figure of ten suicides per 100,000 population in the age range 20 to 24, it increases to 40 in the range 40 to 54 and then to 66 in the age range 65 to 74. Fourth, for women the suicide rate increases less rapidly with age: from a figure of six per 100,000 population in the age range 20 to 24 it increases by about ten in the range 40 to 54 years of age and remains fairly constant. Fifth, the suicide mortality rate for

1. Henry and Short, "Sociology of Suicide" in Clues to Suicide, pp 61-62.
2. Dublin and Bunzel, To Be Or Not To Be, p. 39.
3. Dublin and Bunzel in discussing reasons for this speculate that the emotional instability and intellectual ferment of adolescence is of greater intensity for the female and that in addition there is, for her, the possible complication of pregnancy out of wedlock (p. 45).
4. Dublin and Bunzel obtained this data, covering a twenty-year period, from the statistical department of a large American life insurance company.
Negro males at any age is less than one-half of the rate for white males, but the rate for Negro females is over one-half that of the white female rate.¹

Henry and Short suggest an explanation for these facts:

Gerontologists point out that one of the chief problems of the aged is that of funding meaningful groups with which to associate. Our culture, with its emphasis on conjugal relationships, makes it more difficult for family bonds to remain intact and strong with the aging process. Further, the degree of involvement in relationships within the "family of orientation" varies with age simply as a function of parental mortality. By age fifty-five to sixty-four, the probability that at least one of the two parents will be dead weakens the strength of the relational system of those persons who maintain contact with their parents through the years ... It seems probable that our cultural pattern of female dependency is reflected in the lowered suicide rates of aged females. That is, while aged males may be allowed to drift, thus weakening the strength of their relational bonds, the aged mother is more likely to be taken care of by one of her children.²

F) War.

Examination of research data confirms Durkheim's observation that the suicide rate decreases in time of war.

During the American Civil War the rate, according to the available statistics, fell noticeably in both the North and the

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¹ Henry and Short suggest that the female in the Negro community enjoys a prestige position at least equal to that of the male and that this may help to account for her proportionately higher suicide rate. (Suicide and Homicide, Glencoe, The Free Press, C 1954, p. 87-88.)

² Henry and Short "Sociology of Suicide" in Clues to Suicide, pp. 62-63.
South,\(^1\) and in the Franco-Prussian War there was a decline in the number of suicides in France, Germany and Austria.\(^2\) Ten militant nations recorded a decrease in the incidence of suicide during World War 1.\(^3\) The figures for suicides registered in the Metropolitan Police District (Greater London) from the years 1938 to 1951 show a marked decline during the war years, 1939 to 1945.\(^4\)

The explanation for this reduction in numbers advanced by Durkheim\(^5\) has been, with some minor variations, subscribed to by most researchers.\(^6\)

G) Socio-Economic Status.

Morselli was one of the earliest investigators to examine the relationship between suicide and what he termed "the professions".

He wrote:

> It was, indeed, presumable that those least disposed to suicide would be those the farthest removed from the difficulties of life, that is to say, those living at the charge of others, or without any profession; their average is, in

1. Dublin and Bunzel, *To Be Or Not To Be*, p. 111.
5. See p. 32 of this thesis
fact, much below that of the population in general ... Equally low is the probability of the classes addicted to agriculture, pastoral life, forestry, ... The category also of the labouring people, for the most part composed of individuals not devoted to fixed occupations (porters, journeymen, labourers, ploughmen, shoeblacks, scavengers, gravediggers, workmen without a trade, etc) furnish few suicides; among the men the average of these is under the general average, and among the women only slightly above it, but all the professions and trades which, by habits and muscular or psychical occupation, bring women near to man, tend to raise, and sometimes in an extraordinary degree, their inclination to suicide.

Miner, reviewing the official figures of England and Wales, Australia, and four continental European countries from 1881 to 1911, concludes:

Suicide rates are low among farmers and others employed in steady manual labor in the open air, while the professions (except the clergy and teachers), officials, capitalists, soldiers, innkeepers, and migratory labourers show high rates. Low economic status, when stable, is associated in general with low suicide rates.

The statistics given by the Registrar-General for England and Wales for the year 1927 are cited by Dublin and Bunzel. White male suicides were analyzed by occupation (using age-standardized data), and it was found that labourers, both skilled and unskilled, had rates below the average rate for all civilian males while professional and white-collar groups had above average rates. The class designated "never occupied", in which the very rich, dependents, unemployed, transients, inmates of


institutions and others were indiscriminately grouped together, exhibited the highest rate.¹

Sainsbury cites the Registrar-General's figures for the periods 1921-23 and 1930-32. These show that suicide rates are conspicuously higher at the upper end of the socio-economic scale but tend to rise again at the low end. The figures contraindicate what one might expect — a progressive increase in suicides on a continuum from lower to upper socio-economic class and Sainsbury holds that something more than wealth and position must be considered if differences in rates are to be accounted for. He offers as a plausible explanation the factors of community cohesion and occupational mobility, suggesting that the high incidence of suicide among hotel and domestic² personnel is attributable to the socially isolated and impersonal lives they lead, while in contrast, the low rate of suicide among coalminers and railway workers is attributable to their sense of group solidarity.³

In his own study of suicide in the London boroughs, Sainsbury demonstrates that the rate tends to increase with socio-economic status.⁴

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¹. Dublin and Bunzel, *To Be Or Not To Be*, p. 402.


³. Sainsbury, *op. cit.*, p. 19. (Sainsbury's findings directly contradict those of Morselli. The differences are probably due to errors in the early method of collecting data, to variability in social class scales, now and in Morselli's day, to the fact of historical change).

⁴. Ibid., p. 73. He points out that a lack of consistency in the relationship between status and suicide exists in some boroughs, and holds that the factor of social disorganization must be taken into account in any explanation; he writes: "socio-economic status correlates with suicide to a smaller degree than do social mobility and isolation, which seem to be the ultimate processes responsible for local variations in suicide; they account for the differences both in neighbourhoods and in classes."
Because the official mortality data in the United States provide no definite index of socio-economic status, the research in that country into the association between suicide and the socio-economic factor has been limited to small, specialized studies.¹ One such study is that undertaken by Weiss. Classifying and analyzing data on the total number of certified suicides recorded in the City of New Haven from 1936 to 1950, he writes:

In general, members of the lower socio-economic classes had lower suicide rates than did members of the upper socio-economic classes. This was true even with age, sex, and nativity-adjusted data. (This relation was analyzed for white persons only, so that race was not a factor. There was no evidence that religious affiliation played any important part in suicide rates in New Haven.) Females in the lower socio-economic classes had extremely low suicide rates. Age-specific data, however, revealed that this relation of low suicide rate to low socio-economic class reversed itself for males 65 years and older: i.e., rates for lower class males demonstrated a steady increase in each advancing age period, but upper class male rates leveled after the age of 65, and in that older age group, rates for lower class males were considerably higher than those for upper class males. These patterns relating to socio-economic status and suicide were consistent and statistically significant.

Weiss offers an explanation for his findings:

It might be possible to account for this tendency on the basis of differences in religion. It has been noted that 56 or 57 per cent of the local population are of Roman Catholic faith. Catholicism as a basic factor could be considered, however, only if both of two suppositions were proved to be true: that New Haven Catholics have lower suicide rates than do non-Catholics, and that

¹ A number of studies have been carried out by life insurance companies and the results reported in their statistical bulletins.

Catholics are more concentrated in the lower classes (which is probably so). However, it has already been indicated that recent evidence elsewhere in North America and internal evidence in this study in New Haven do not confirm the first supposition.

Other reasons for the relationship might be that members of the "upper" socio-economic classes carry heavier burdens of responsibility; these persons may be more affected by fluctuating economic conditions. It may be that mores and taboos concerning suicide vary in the different socio-economic classes. Another possibility is that members of the lower socio-economic classes choose outlets other than suicide for their aggressive impulses.1

In a similar context — the relative status of different groups and their differing suicide rates — Henry and Short write:

White persons are about three times more likely to kill themselves than are Negroes and males have a rate about three times the rate for females; women are less prone to suicide than men and Negroes are less susceptible than whites.

Suicide is more common among the privileged groups in American society than among the downtrodden... While suicides occur in substantial numbers at both extremes of the socio-economic scale, data from the life insurance companies show that they are concentrated among the well-to-do.

A common theme runs through the differences in susceptibility to suicide of these groups. In every case, the category with highest status position is the category with the highest suicide rate. Males, because of their greater involvement in the occupational system, enjoy a status position somewhat higher than females. The superior status position of whites as compared with Negroes is obvious. Those at the top of the economic scale enjoy high status as compared with those less fortunate.2 These data show that susceptibility to suicide rises with status position.

2. Henry and Short, "Sociology of Suicide" in Clues to Suicide, p. 60.
Powell, in a study of 426 suicides in Tulsa, Oklahoma, holds that the psychological factors operative in self-destruction are rooted in anomie and he postulates that anomie differs in quality and extent from one socio-occupational group to another according to the relationship between the self and the prevailing success ideology. Finding that in his series the highest incidence of suicide occurred at opposite ends on a socio-economic continuum, he offers the explanation that for the unskilled labour group anomie takes the form of a dissociation characterized by occupational discontinuity, downward mobility, a lack of presence of the regulating mores of the wider society, an absence of an internalizing of the success ideology, and the absence of a subculture on which to draw for orientation; for the professional-managerial group anomie takes the form of an envelopment characterized by a compulsive adherence of the self to the success ideology, an inability of the self to reconstruct its own ends from the raw material (concepts) presented to it by the culture living by unexamined directives of the culture with a consequent paralysis of critical faculties, and the lack of inner coherence. Of the relationship of self-destructiveness to anomie, Powell says:

...occupation provides function and determines the individual's social status which is an index to his conceptual system. The conceptual system is the source of anomie, which is a primary variable in suicide. Therefore, suicide is correlated with occupation.

2. Ibid., p. 133.

A number of investigators have demonstrated with the use of a variety of suicide and business indices the existence of a negative relationship between the suicide rate and fluctuations in the rate of business activity.

Examining the influence of the business cycle on social phenomena in Britain, the United States, France, and Germany from 1854 to 1913, Thomas writes of self-destruction:

It is not surprising that the greatest number of suicides occur during business depression. The high negative correlation seems to indicate that the economic factor is predominant in causing the fluctuations in the suicide rate. Unemployment and pauperism are probably the most serious factors bringing about an increase in suicide for the working class. Enforced liquidation and business failure are probably important factors for the upper classes.

In a paper entitled *Prosperity, Depression, and the Suicide Rate* Hurlburt attempts to demonstrate that a causal relationship exists between fluctuations in the business cycle and the suicide rate. Unlike Thomas, however, he does not subscribe to the primacy of the economic component. He writes:

The economic factor is but one of many diverse elements entering into the determination of the suicide rate, and it is doubtless impossible to segregate this factor in order to determine its relative importance. However, by means of contrasting the cyclical fluctuations of business activity with the cyclical fluctuations of the suicide rate we obtain results which indicate a certain degree of causal relationship between prosperity, depression, and the suicide rate: (1) Between 1902 and 1925 the suicide rate revealed a tendency to decline in years of prosperity and to advance in years of depression. (2) The suicide rate registered

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its greatest increases in years of acute economic distress, namely, 1907, 1908, and 1921. (3) The suicide rate registered its greatest decreases during the period of abnormal prosperity between 1916 and 1920. 1

Comparing the Registrar-General's statistics for the 1920-23 period of prosperity and the 1930-32 period of depression, Sainsbury notes that while suicide rose in the 1930-32 depression the greatest increase occurred in the upper socio-economic classes (professional) and white collar business persons.

He comments:

It would seem, then, that poverty becomes an important factor in suicide according to its context. The indigenous poor, to whom poverty is an accepted feature of their position in a static hierarchical society, tolerate it with equanimity. This attitude does not foster suicide. A change from comparative affluence to poverty, or loss of employment, is, however, more disruptive, since the person affected often fails to adjust himself to his altered circumstances. 2


The sociological approach to the etiology of suicide (with its central thesis that the nature and incidence of the phenomenon varies with position in the social system) makes it abundantly clear that idiosyncratic features and peculiar disorders of individual personality alone cannot account for the causes of self-destruction. The examination of the intervening sociological variables has demonstrated that suicide is intimately related to


gross structural disfunctioning reflected in social disorganization, social isolation, excessive individuation, anonymity and rootlessness — in short, to prevailing characteristics and conditions of group life. The sociological approach serves, then, as a necessary corrective to the psychological or individual approach.
Chapter 3.

The Psychology of Suicide.

1. Early Theories\(^1\) of Suicide.

In the middle nineteenth century, a number of physicians and psychiatrists turned their attention to the problem of suicide and began to investigate what they usually termed its "internal causes". A review of their writings indicates that they tended to attribute the act to either pathological conditions of the brain and other body organs or to alienation of the mind.\(^2\)

Winslow was one of the earliest to concern himself with the medical aspects of self-destruction. In The Anatomy of Suicide, he describes the autopsies of suicides he performed and suggests that the commonest findings were "diseases and lesions" of the brain, such as, "chronic meningitis" and "varicose veins" and "diseases and lesions of other organs", such as, "degeneracy of the liver and kidneys", abnormal position of stomach, and abdominal tumours. He contends that his findings demonstrate the relation between suicide and "morbid" conditions of the organism.\(^3\)

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1. Again, the present writer points out that the term "theory" as used here may be misleading, as it refers to speculative theories derived from a set of often quite unrelated hypotheses.

2. An exception to this line of thought is commented on by Zilboorg who notes that in 1840 Tissot, in a monograph entitled De la Manie de Suicide et de l' esprit de la Revolte, presaged a psychoanalytic viewpoint by formulating the concept of hostility first being turned outward and then inward against the self. (Gregory Zilboorg, "Differential Diagnostic Types of Suicide", Archives of Neurology and Psychiatry, Vol. 35, 1936, pp. 270-291).

In his work *Mental Maladies: A Treatise on Insanity*, Esquirol asserts emphatically that suicide is, per se, proof of insanity\(^1\) and he holds that his autopsy findings (which consistently showed morbid conditions of the brain) supports his contentions.\(^2\) He gives prominence, too, to the role of hereditary traits as precursory factors in psychical degeneration.\(^3\)

A number of writers of the period, among them Lisle, Brière de Boismont, Falret and Darwin, and later Strahan, adopted and in some cases further expanded Esquirol's theory of suicide.\(^4\)

It was not until the latter part of the century that the climate of medical opinion began to change and suicide came to be regarded as an act not incompatible with states of mental normality.\(^5\) Two of the first proponents of the "sanity theory of suicide" were Morselli and O'Dea.

In an examination of what he terms "individual psychological influences", Morselli rejects the then prevailing dichotomy of moral-physical causes of suicide\(^6\) and reduces them to one determining physiological cause which he describes as

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1. O'Dea, *Suicide*, pp. 257-259. (Esquirol's thinking on the subject had profound influence on his contemporaries and many physicians to this day subscribe to his view that the act of suicide is alone sufficient evidence of mental disorder. (Stengel, Cook and Kreeger, *Attempted Suicide*, London, Chapman and Hall Ltd., 1958).


suffering and "despair at not having gained or at having lost that which, in the emotional condition of passion, was valued more than life."\(^1\)

This despair, he holds, is the product of an abnormally excited, morbid condition of the brain\(^2\) —a condition which disturbs the functions of the constitution and manifests itself in "unsatisfied passions" and an excessive egoism.\(^3\)

In his work *Suicide, Studies on its Philosophy, Causes, and Prevention*, O'Dea maintains that generally certain conditions or moral, intellectual and physical temperament are conducive to melancholy which in turn promotes suicide,\(^4\) while more specifically:

...nervous, and especially cerebro-spinal irritation, is the immediate physical cause of suicide and a 'fixed idea', the mental analogue of the physical irritation, is the immediate mental cause of suicide.\(^5\)

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2. For Morselli, these may be conditions or organic pathology (chronic diseases, cancer, syphilis, etc.,) psychopathology (melancholia, "monomania", imbecility, etc.,) or both. p. 298.

3. *Ibid.* Morselli's explanation (physiological in its frame of reference) for the causes of suicide is somewhat inconsistent with his thesis that self-destruction is a social phenomenon. He contends that the "personal motive are but a small and infinitesimal portion of the collective motives", that "each one has his own passions and wishes to satisfy but only because these follow the common course and are developed in a prescribed atmosphere", and that "the individuality of our wants and tendencies is absorbed in the aggregate of social wants and tendencies", (p.274) yet he does not explicitly relate the two levels of causality which he discusses — the physiological and the social. He infers, however, that the individual's "unsatisfied passions" and egoism are, if not produced by social forces, reinforced by them.

4. O'Dea, *Suicide*, p. 256

2. Contemporary Theories of Suicide.

A number of theories have been advanced to account for the psychic determinants of suicide. To facilitate as systematic an approach as possible to the examination of these often diverse theories, they will be divided into two categories; non-psychoanalytical and psychoanalytical.

A) Non-Psychoanalytic Theories.

Clark holds that basic to all suicides is an inversion, an incest, or an onanistic motive. The result is an imbalance in the will to live, an increase of intrapsychic tension, an affective fixation of infantile attachment, and finally, a suicidal act.\(^1\)

Gordon believes that man, being a social animal, possesses as an intrinsic element in his personality a capacity to adapt to what he (Gordon) terms "universal law—the progressive evolution of the social environment". He contends that suicide represents a failure in the adaptive process — a denial and shirking of the duty of the individual as an integral part of the universal whole.\(^2\)

In a paper called The Psychology of Suicide Crichton-Miller attributes the act to the individual's inability to adapt himself and holds that it constitutes a final regression from reality.

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He proposes that the motivations for suicide be classified into three groups: first, physical pain (including anticipated pain) and frustration of instinctual needs (of which the sexual is the most frequently thwarted); second, social sufferings and fears including remorse for wrong doings and an impulse towards expiation, and an exaggerated self-love which prohibits the acceptance of any form of social humiliation; third, doubts and dreads pertaining to the hereafter and manifest in the suicides of Messianic character in which there occurs a supreme sacrifice of the total personality for some redemptive purpose.¹

Davidson believes that the individual at the time of his suicide act has reached the limit of his resources and has lost his goal. The immediate situation so preoccupies and controls him that his field of conscious awareness becomes restricted to the extent that he exhibits a disregard for life itself. An "organic depression" follows and the higher centres of the brain are unable to cope with and direct the incoming impulse to make decisions. The individual then ceases to will, surrenders to imagination and is unable to protect himself against further harmful impulses. The next step in the sequence is self-destruction.²

For Williams there are two dominant reasons for suicide: disappointment and frustration. But since such feelings

are experienced by all he postulates the presence in the rigid personality of a strong narcissistic component which cannot accept defeats or combat reverses and is unable to adapt easily to reality. The result is suicide.  

Goitein expresses the opinion in his article Mind of Murder that the suicide drive occurs as a compensation for the homicidal impulse directed against members of the immediate family.

Approaching suicide from the psychobiological viewpoint, Lewis attributes the act to the final breakdown of the adaptive process. For him, the suicide is:

"...not able to adapt in the midst of so-called higher-level contradictions because of some lack of compensatory adjustment, which is in no way a conscious or deliberate proceeding, but belongs in the realm of general patterns forming an integral part of the personality."

Mills gives prominence to weather as a contributing factor. Suicides represent for him that portion of the population which is unable to deal successfully with psychological stress of life, and psychological stress, he says, is always intensified by bad weather.

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In his monograph *Psychopathologie de Suicide*, Delmas declares that anxiety is the one condition necessary to cause suicide. Without it, he holds, there can be no suicide.¹

Bermann, a Spanish psychiatrist, interprets the suicide act as a form of revenge against a particular person (usually a relative or lover) or against society as a whole. He suggests that the suicide feels inadequate and, consciously or unconsciously, hates the civilization which leaves him with such a feeling. This then breeds a resentment which culminates in suicide. He cites a number of cases with which he has been familiar: children and adolescents who wanted their indifferent parents to experience anguish; a paramour who sought vengeance against a faithless mistress; and a bomb-throwing anarchist who killed himself and others as an expression of revenge against an economic class.²

B. Psychoanalytic Theories of Suicide.³

Freud's theory of depression, the psychodynamics of which have been outlined in his classic paper *Mourning and Melancholia*,

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³ Analytically-oriented writers, when examining the psychogenesis of voluntary death, tend not to distinguish between successful and attempted suicide except in terms of differences in the strength of the death instinct or in the intensity of guilt feelings. They subscribe to the view that the underlying dynamics of successful and attempted suicide differ quantitatively but not qualitatively. The present writer in reviewing the psychoanalytic theories, therefore, make no distinction between these two categories—viz., successful and attempted suicides.
and his postulation of a death instinct provide the framework for
his psychoanalytic theory of suicide and for its modification
and extension by other analytic writers.¹ Zilboorg, summarizing
Freud's theory of depression, writes:

...In a case of a pathologic depression the patient,
through identification with a person toward whom his
feelings have always been highly ambivalent, loves
and hates himself. Since his own ego has become
his love object, he feels detached from reality and
therefore experiences a sense of poverty of the ego.
The unconscious sadism originally directed against
the object, he feels detached from reality and therefore
experiences a sense of poverty of the ego. The
unconscious sadism originally directed against the
object, reenforced by a sense of guilt, produces
the singular phenomenon of the person's becoming
sadistic toward himself.²

Freud himself states:

It is this sadism, and only this, that solves the
riddle of the tendency to suicide which makes
melancholia so interesting—and so dangerous. As
the primal condition from which instinct-life proceeds
we have come to recognize a self-love of the ego
which is so immense, in the fear that rises up at
the menace of death we see liberated a volume of
narcissistic libido which is so vast, that we
cannot conceive how this ego can connive its own

¹. Bergler has pointed out that psychoanalytic theories concerning
suicide are replete with contradictions, and that this situation
is, in large measure, explainable by the fact that Freud postulated
at different times two theories to account for suicide: the theory
of libidinous drives (the life instinct versus the death instinct,
or the constructive forces versus the destructive forces), and the
theory of guilt feelings because of unconscious aggression. He
believes that as a result earlier conceptions have not been
adequately coordinated with later discoveries. (Edmund Bergler, "Problems

². Gregory Zilboorg, "Differential Diagnostic Types of Suicide",
destruction. It is true we have long known that no neurotic harbours thoughts of suicide which are not murderous impulses against other re-directed upon himself, but we have never been able to explain what interplay of forces could carry such a purpose through to execution. Now the analysis of melancholia shows that the ego can kill itself only when, the object—cathexis having been withdrawn upon it, it can treat itself as an object, when it is able to launch against itself the animosity relating to an object—that primordial reaction on the part of the ego to all objects in the outer world. Thus in the regression from narcissistic object-choice the object is indeed abolished, but in spite of all it proves itself stronger than the ego's self.¹

Zilboorg sees suicide as an archaic form of a universal response to intra-psychic conflict and stress, a psychobiologic phenomenon whose force is derived from the self-preservation instinct. Through suicide, he holds, the individual achieves fantasied immortality and fame and an unobstructed realization of hedonistic deals. Zilboorg gives prominence to the features of unconscious hostilities, spite, identification with a dead person, oral incorporation, and marked incapacity to love others.²

Menninger is the chief exponent of Freud's concept of the death instinct and the architect of a series of theoretical assumptions attempting to explain the phenomenon of suicide. He visualizes the act as the result of the individual's destructive


tendencies winning out over the constructive tendencies and he postulates the presence of three components in all suicide cases: "the wish to kill", (conscious hate, aggression, blame, elimination, annihilation, and revenge), "the wish to be killed", (conscious guilt feelings, submission, masochism, self-blame, and self-accusation), "the wish to die", (hopelessness, fear, despair, and pain).\(^1\) For him attenuated or slow forms of self-destruction are of significance, for they are manifestations of the gradual ascendency of the death instinct over the life instinct. These forms express themselves in asceticism, martyrdom, neurotic invalidism, alcoholism, anti-social behaviour, psychosis, self-mutilation, malingering, frigidity, and impotence.\(^2\)

In his book *Man Against Himself* Menninger has recapitulated his thesis point by point. The most salient of these follow:

... the best theory to account for all the presently known facts is Freud's hypothesis of a death-instinct, or primary impulses of destructiveness, opposed by a life-instinct or primary impulses of creativeness and constructiveness...

...according to Freud's conception both the destructive and constructive tendencies are originally self-directed but become increasingly extraverted in connection with birth, growth, and life experiences. In his contacts with others, the individual first reacts with extraversion of his aggressive tendencies followed by an extraversion of the erotic or constructive tendencies which by fusion with the former may achieve varying degrees of neutralization of the destructiveness from total to almost none.


... when there is a forcible interruption in these external investments or when too great difficulty is encountered in maintaining them, the destructive and constructive impulses revert back upon the person of their origin; that is, are turned back upon the self.

... here again, if defusion occurs, the destructive tendencies lead and may permanently prevail so that self-destruction to a lesser or greater degree supervenes; and that in this event one can trace evidences of the wish to kill, and the wish to be killed, and also the eroticized forms of these two wishes.

... in those instances in which the self-destructive impulses are overtaken and partially but not completely neutralized we have the many forms of partial or chronic self-destruction.

... in those instances in which the self-destructive impulses too far precede or exceed the neutralizing constructive impulses, the result is that dramatic example of immediate self-destruction known as suicide.

... the close scrutiny of the deeper motives for suicide would confirm this hypothesis in that there appear regularly to be elements from at least two and possibly three sources. These are, (1) impulses derived from the primary aggressiveness crystallized as a wish to kill, (2) impulses derived from a modification of the primitive aggressiveness, the conscience, crystallized as the wish to be killed, and (3) I believe there is evidence that some of the original primary self-directed aggressiveness, the wish to die, joins hands with the more sophisticated motives and adds to the total vectorial force which impels the precipitate self-destruction.

Read and Pollack are other writers who accept the Freudian theory. Read also stresses the factor of the suicide's unconscious

1. Menninger, Man Against Himself, pp. 71-72.
expectation of an eternal union with a lost loved one or with 
God and of his fantasy of being, thereby, in harmony with the 
infinite, while Pollack adds that instability of mood and 
difficulty in sexual adjustment occurs frequently. Like 
Zilboorg, O'Connor emphasizes the aspect of immortality, 
suggesting that suicide is a reversion to an early state of 
"power-narcissism" wherein omnipotence is achieved. Jamieson 
looks to excessively strong self-love and aggressiveness as 
the prime psychodynamic determinants of self-destruction 
and relates them to the regressive and immature tendencies of 
an infantile personality. Palmer, too, stresses early 
influences believing that the basic cause in the majority of 
suicide attempts is an arrested psychosexual development — an 
arrest due usually to the absence of parents (through death or 
separation) at crucial stages in the individual's early life. 
He contends that while spite is frequently present, it is a 
rationalization unconsciously devised to disguise developmental 
defects of the psychic apparatus.

1. C.S. Read, "The Problem of Suicide", British Medical Journal, 
vol. 1, 1936, pp. 631-634. 
2. Benjamin Pollack, "A Study of the Problem of Suicide", Psychiatric 
3. W.A. O'Connor, "Some Notes on Suicide", British Journal of 
4. Gerald R. Jamieson, "Suicide and Mental Disease: A Clinical Analysis 
of One Hundred Cases", Archives of Neurology and Psychiatry, vol. 
36, July 1936, pp. 1-11. 
5. D.M. Palmer, "Factors in Suicide Attempts: A Review of Twenty-Five 
Consecutive Cases", Journal of Nervous and Mental Disease, vol. 93, 
1941, pp. 421-442.
On the basis of their study of suicidal tendencies in children, Bender and Schilder arrive at what they term a "preliminary formulation": Suicide for the child is an attempt to avoid a frustrating and intolerable situation, a situation consisting of the deprivation (or the assumption of deprivation) of love. Aggressive feelings are incited, arousing guilt and the aggressiveness is turned inward. These feelings may be intensified by constitutional factors, by identification with an aggressive parent, or by both. The suicidal attempt also constitutes a retaliation against the social milieu, and a way of securing more love. The suicidal death represents a reunion with the love object, living or dead.¹ Schechter, examining the motivational factors in children and adolescents, offers conclusions which are in substantial agreement with the findings of Bender and Schilder. He is particularly impressed with the aspect of a real or threatened loss of a love object, considering it to be the primary dynamic.²

Fenichel's theory of suicide has been restated in an abridged form by Jackson:

Fenichel extends Freud's ideas, stating, in essence, that suicide is the outcome of a strong ambivalent


dependence on a sadistic superego and the necessity to get rid of an unbearable guilt tension at any cost. He mentions that the desire to live means to feel a certain self-esteem, and to feel supported by the protective forces of the superego. When this feeling vanishes the original feeling of annihilation which the individual experienced as the deserted, hungry baby reappears. Since the superego is made up of introjects which represent incorporated love objects, suicide involves the murder of the original object whose incorporation helped to create the superego. Along with the self-murder goes the hopeful illusion that forgiveness and reconciliation will be attained by the killing of the punishing superego and the regaining of union with the protective superego.1

Garma emphasized two components: loss of a vitally important libidinous object and aggression secondarily turned against the ego. The act becomes for the suicide a method of regaining the lost object and a way of liberating himself from a hostile environment. He adds that hereditary constitution is a factor of paramount importance.2

Bergler in his paper Problems of Suicide advocates the differentiating of suicide types on a three-fold basis — the "introjection type", the "hysteric type", and "miscellaneous types". Of the first he writes:

...The suicide of the introjection type is a person labouring under the deepest feeling of guilt because of his over-dimensional psychic masochism. To counteract this reproach, pseudo-aggression is


mobilized—the fantasy of the killing and disappointex. The disappointment is always self-provoked, by choice of, and attachment to, the disappointing person. The feeling of guilt is shifted from the masochist act to a pseudo-aggressive one.¹

The second type, the hysteric, is characterized by what he terms "negative magic gestures" of an unconscious dramatization of how one does not want to be treated, coupled with an infantile misconception of a death which lacks finality. The third type, the miscellaneous, is composed of other suicides such as those who project their superegos outwardly and hear voices directing them to kill themselves. Bergler is of the opinion that the decisive factor in suicide is not the overwhelming intensity of guilt feelings but rather the defusion of instincts leaving the death instinct no longer attenuated by the life instinct.²

Moss and Hamilton find three co-existing unconscious and partially conscious determinants of the suicide act: first, an expectation of greater impending satisfaction taking the form of an eternal reunion in death with a loved one, the forcing of consideration or gratification otherwise unattainable from the social environment, or the pleasure of spite or retribution;


secondly, hostility directed toward prominent persons upon whom censure was placed for present frustration which because of anxiety became self-directed; third, an expression of futility and despair and an abandoning of any promise of improvement in present circumstances.¹

In his review of suicide theories, both psychoanalytic and non psychoanalytic, Jackson suggests that the underlying motives of the act can be reduced to three basic ones:

(1) Self-directed aggression. This category may or may not include the concept of a death instinct. It does include partial suicide, such as multiple operations, accident proneness, and so forth.

(2) Rebirth and restitution. Authorities who discuss suicide in children and in schizophrenics are especially apt to mention the concept of doing away with the "bad me" in order to make a new beginning. Events ranging from running away from home to departing from life represent a continuum which includes the sorrow of those left behind and the joy of finding someone who really cares.

(3) Despair, loss of self-esteem, and the real or imagined loss of the love object. Many experts... point to the loss of something that precedes a suicide. There may be the loss of health or facilities as in malignant cancer or old age; or the kind of loss that occurs in ...drop of social status or prestige, or the losing of a mate...²

3. A Critical Appraisal of the Psychoanalytic Theories of Suicide.

Psychoanalytic theories of suicide are subject to a number of criticisms. First, there is the question of the tenability of the theory of the death instinct. The thesis that suicide results when aggressive impulses are turned inwardly against the


². Don D. Jackson, "Theories of Suicide", in Clues to Suicide, p. 15.
self, (when Thanotos, the death instinct, masters Eros, the life
instinct) is popular in clinical circles. The formula, skilful and
original as it is, fails to establish a definite clinical or even
theoretical criterion which adequately explains suicide. The
formula may be fundamentally correct but it is too general to
be of any real value, for according to it every individual in
the world is in danger of taking his life. The death instinct
theory as an element in Freudian metapsychology and as an explanatory
pivotal point is, in its application to suicide, tautological,
for to say that the death instinct gains the upper hand over
the life instinct is merely an elaborate way of saying that the
individual does injure or kill himself. Perhaps an equally
important criticism of the theory is that the only evidence for
the presence of the cause of suicide, i.e. the death instinct,
is the occurrence of its effect, i.e., death.

Secondly, there has been a failure on the part of theorists
to distinguish qualitatively between suicide and attempted
suicide. Analytic writers have tended to theorize on the
assumption that the psychodynamic factors operative in the
two forms of suicide are the same, that consummated suicide is
simply an exaggerated form of attempted suicide. There is evidence
however, to support the view that this is not the case, that
successful and unsuccessful suicides often represent different
kinds of acts and different motivations.

Thirdly, there has been a characteristic disregard
evident in most of the psychoanalytic literature for the part
played in personality processes by social and cultural
factors and an inclination to view social disorganization as an extension of personal disorganization. The model offered by analytic writers to explain the causes of self-destruction is primarily a bio-psychological one and excludes a consideration of those determinants emanating from the social structure. Conspicuously absent, for example, in psychoanalytic theories of suicide is any attempt to account for the en masse voluntary deaths of persecuted ethnic or racial groups such as the Jews during World War II, for the drowning in maritime disasters of those who, refusing rescue, choose to remain at the side of a loved one who must, by reason of chivalry, custom or protocol, go down with the ship, and for the self-inflicted death of the spy who takes a capsule of poison upon threat of capture.

Finally, and probably the most fundamental criticism of the psychoanalytic theories of suicide is the question of the scientific validity of psychoanalytic concepts. The methodology of analytic investigation is unsound. There is a marked lack of substantiation of conclusions by verified data, a dependence on unreliable anecdotal evidence, an almost total want of

1. Notable exceptions are to be found in the writings of Fromm, Horney, H.S. Sullivan and Kardiner.


3. Zilboorg categorically denies the validity of the sociological approach and refers to suicide statistics as "well nigh useless". American Journal of Orthopsychiatry, vol. 7, 1937, pp. 18-20. Menninger refers only incidentally to the major sociological works on suicide. (Man Against Himself, 1938)
experimental evidence, and an indifference to the use of control groups. There is an overgeneralization of conclusions and a couching of statements of hypotheses in such an obscure, complex, and ambiguous manner that the application of a process of scientifically proving or disproving becomes extremely difficult. Facile and even dramatic exposition may come to serve as a veneer in the absence of clinically documented, corroborative facts.

These criticisms of the psychoanalytic theories of suicide apply (with the exception of the first) in some diminished form to the non-psychoanalytic theories.

Psychoanalytic concepts are useful, however, if used as "sensitizing" rather than definitive concepts. Sensitizing concepts or instruments lack precise reference, specific attributes and clean-cut identification. They rest on a general sense of relevancy, are amenable to improvement and refinement, and serve to sharpen perception and to stimulate imagination and diagnostic skills.

4. Attempted Suicide.

Students of suicide have tended to formulate dynamic

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1. The same criticisms apply to the methodology of psychoanalytic investigations in other areas such as the meaning of religion to the individual and the socialization of the child.


3. The term is Blumer's. Ibid.
theories by extrapolation — from what has been learned in clinical studies of patients who have attempted suicide — on the implicit assumption that those who take their own lives and those who attempt to take their own lives are but one group. A number of recent writers, however, have offered data to support the view that the psychodynamic patterns in many suicidal attempts are quite different from the patterns in successful suicidal acts.

In their monograph entitled *Attempted Suicide, Its Social Significance and Effect*, Stengel, Cook and Kreeger report the findings of investigations they recently carried out in London. They studied five groups of attempted suicides composed of 630 successive admissions to three different types of London hospitals over certain periods of time and one controlled group consisting of 117 suicides on whom there were coroner's reports. They then conducted psychiatric and social work follow-up interviews using a comprehensive scheme which yielded much detailed information. Drawing on this information and on the medical and psychiatric data obtained while the persons had been in hospital, Stengel, Cook and Kreeger conclude that the suicide and the attempted suicide constitute two different though overlapping types and that the attempted suicide has distinctive characteristics and functions which reflect a discernible pattern of social behaviour. They repudiate the theory that the self-destructive tendency is the primary motivating force leading to attempted suicide on the basis

that (a) comparatively few persons who make suicidal attempts later kill themselves and (b) among those who attempt suicide only a minority have tried it before. They hold that certain social factors and features must be considered in order to understand the significance of the suicidal attempt. First, is the "appeal function" -- a function consciously or unconsciously inherent in most, if not all, attempts at suicide. The individual does not wish death, nor does he expect to die, but rather he seeks to manipulate the community and to receive its attention and sympathy. Secondly, there is the "ordeal character" of the suicidal attempt. By this is meant an urge in the person to challenge fate and his willingness to accept the outcome of the act, i.e., survival, without demure -- in short, a gamble which proves to be an ordeal but which must be undertaken. Thirdly, there are the social effects of the attempt: its profound consequences for the individual such as the anxieties accompanying admission to hospital, and the relationship, often strained, with family and friends. In closing, the authors again emphasize that the underlying motives for suicide and attempted suicide must be differentiated. They write:

...if we want to treat all who commit suicidal acts as one population, we must realize that it is a population of people who have made suicidal attempts with a minority who have killed themselves. To make the fate of that minority the condition of full membership of that population, and to treat the majority as inferior members, is impermissible.\(^1\)

The findings of Weiss reported in his paper "The Gamble

1. Ibid., p. 130.
With Death in Attempted Suicide" are similar to those of Stengel, Cook and Kreeger. He emphasizes the aspects of manipulation of the extrapsychic environment as an accessory function of attempted suicide, and the affinity of the psychodynamic factors involved with those of gambling. Holding that his conclusions are substantiated by clinical evidence derived from personal interviews with 156 hospital patients, Weiss writes:

...attempts can be categorized in three classes; (1) aborted successful suicides, in which the attemptor truly intended to end life and was certain that he would die as a result of his action, (2) true suicidal attempts, in which the attemptor thought that he might die as a result of his action but was not certain, and (3) suicidal gestures, in which the attemptor was certain that he would not die as a result of his action. From the data now available, the psychodynamics of the aborted successful suicide appears to be similar to or identical with the dynamics of the completed successful suicide. The dynamics of the suicidal gesture are related primarily to the need to influence someone to do something, and not to the intention to end life. The dynamics of the true suicidal attempt are complicated, and involve in all cases a discharge of self-directed aggressive tendencies through a gamble with death (of varying lethal probability), in most cases an appeal for help, and in some cases a need for punishment and a trial by ordeal.¹

The investigations of others support many of the conclusions arrived at by Stengel et al and by Weiss.

Schmidt, O'Neal, and Robins made a clinical and follow-up

study of 109 persons who, having unsuccessfully attempted suicide, were brought to a general hospital in St. Louis. These investigators believed it important to distinguish between the serious attempt and the "gesture" attempt. Establishing criteria for this differentiation and classifying the patients accordingly, they found 35 to be serious and 74 to be gesture.\(^1\)

A follow-up eight months later revealed that only two of the 109 patients successfully committed suicide after the initial unsuccessful attempt.\(^2\) The psychiatric and medical data on 237 cases of attempted suicide in Malmo, Sweden were examined by Dahlgren who, following them up two to seven years later found that fourteen had successfully taken their lives.\(^3\)

5. Clinical Correlates of Suicide.

There are a number of studies reported in the psychiatric literature on the subject of suicide which are concerned neither with the formulation of theories of causation

\(^1\) The investigators diagnosed two-thirds of the 109 persons as suffering from some psychopathological condition or another. There was no evidence to indicate that seriousness of intent was related to the absence or presence of mental disorder.


\(^3\) K.G. Dahlgren, *On Suicide and Attempted Suicide*, Lund, 1945, cited in Stengel et al., *Attempted Suicide*, pp. 19-21
nor with the special and differentiating characteristics of attempted suicide. Rather, they are concerned with such aspects as psychiatric classification, the correlation of the psychoanalytic concepts accounting for suicide motives in individuals to psychiatric classification, the methods of self-destruction and their significance for intent and success, the role of alcoholism in suicide, the problem of suicide in old age and prodromal aspects (warning symptoms).

A. Psychiatric Classifications of Suicidal Persons.

Lendrum, examining data on 1000 consecutive cases of attempted suicide (363 men and 637 women) admitted to a general hospital in Detroit between 1927 and 1930, found that 234 were clearly psychiatrically classifiable and that in these 234 alcoholism and psychopathic personality were the commonest diagnoses made.¹ Jamieson reviewed the clinical records of 100 patients who committed suicide after being discharged from mental hospitals in New York State. He found that the commonest diagnostic grouping by far was manic-depressive psychoses (46 persons) with involutional melancholia and "schizophrenic-paranoidal" conditions (19 and 15 persons) respectively coming next.² Piker analyzed the medical and psychiatric records of 1817 persons who attempted suicide in Cincinnatti and were brought to a general hospital. He

believed only about seven per cent of the cases could be properly
classified as psychotic.\footnote{1} Pollack's study of 51 suicides and
attempted suicides showed that the largest number occurred among
cases of schizophrenia with manic-depressive psychosis and
involutional melancholia following in order of decreasing frequency.\footnote{2}
In his study of 33 patients who committed suicide either while in
mental hospital or within a year after discharge, Wall found the
highest proportion to be suffering from manic-depressive psychosis with
schizophrenic psychosis the next highest.\footnote{3} Levy and Southcombe
examined nation-wide suicide statistics and the records of the
Eastern State Hospital, Washington, and report two interesting
findings; the incidence of suicide in institutions is twenty-eight
times greater than among the general population, and of the fifty-eight
patients who took their lives in the Hospital since its opening
in 1891 twenty-nine has been diagnosed as schizophrenics (mainly
of the paranoid type) and eleven as manic-depressives.\footnote{4} Schmidt,
O'Neal and Robbins in the St. Louis study (already referred to) found
that the clinical entities in the order of their most frequent
occurrence were manic-depressive depression, dementia, psychopathic

\footnote{1} Philip Piker, "Eighteen Hundred and Seventeen Cases of Suicidal
Attempt; A Preliminary Statistical Survey", American Journal of


\footnote{3} J.H. Wall, "The Psychiatric Problem of Suicide", American Journal of

\footnote{4} Sol Levy and R.H. Southcombe, "Suicide in a State Hospital for The
Mentally Ill", Journal of Nervous and Mental Disease, vol. 117, 1953,
pp. 504-514.
personality, chronic alcoholism, hysteria and schizophrenia. These investigators also related diagnoses to the degree of seriousness of intent and found that those suffering from manic-depressive disorders, dementia and hysteria could be classified as serious in their intent to die, while those suffering from chronic alcoholism and psychopathy could be classified as not serious in their intent.

The question of whether the suicide act per se is an indication of mental disorder has been discussed by a number of writers without consensus. It would seem a matter of semantics rather than substance and will probably remain unsettled as long as there is no agreement about the definition of "normal" and "abnormal" conditions of mind.

B. Motivational Determinants and Clinical Classification.

In his paper entitled "The Psychodynamic Motivational Factors in Suicide", Hendin reports his grouping of 100 would-be suicide patients at Bellevue Psychiatric Hospital in New York City on the basis of similarities in clinical and psychodynamic findings. He writes:

The main groupings ... were:
1. Those with spite or desire to force love as a dominant motive. (a) The reactive depression group—primarily lovers' quarrels with low suicidal intent; (b) The character disorder group, with minimal intent and an attempt to manipulate the environment.
2. Loss of loved object. (a) The neurotic group unsuccessfully seeking re-establishment of necessary object attachment; (b) The passive dependent, elderly group.
3. Guilt. (a) Predominantly the schizophrenic group.  

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C. The Methods of Self-Destruction and Their Significance.

Lendrum's examination of the methods used in all known successful suicides in Detroit over a four year period indicates that the methods in order of effectiveness were poisons, asphyxia, firearms, and hanging. Noting that men are more successful than women in killing themselves but that women have a higher incidence of unsuccessful attempts, Lendrum offers the explanation that the mechanical methods employed by men such as shooting or hanging are more dangerous, whereas the methods of women include the use of relatively innocuous household poisons such as iodine and merchurochrome. He rejects the theory that the difference in successful suicide rates between the sexes is due to a difference in the degree of intent. 1

Jamieson divides the methods of suicide into "active or aggressive" (i.e., hanging, jumping, and shooting) and "passive or receptive" (i.e., poisons and drowning) and finds an equal proportion of men and women in his two categories. He suggests that conscious determinants in choice of method such as suggestion and availability of means are as important as the unconscious determinants such as symbolisms. 2 Stengel, Cook, and Kreeger demonstrate that the degree of intent and the dangerousness of method are positively correlated. 3

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and that failure in the attempts of women can most often be related to the slight degree of intent and relative harmlessness of method.\textsuperscript{1} In addition to the 100 cases mentioned earlier, Hendin analyzed the data on another 500 patients in the same hospital who had attempted suicide. Examining the difference in rate of attempts between men and women, he concludes that intent is of greater importance than method in determining success or failure.\textsuperscript{2}

D. Alcoholism and Suicide.

Batchelor reviews 200 consecutive cases of attempted self-destruction admitted to a general hospital in Edinburgh in the years 1950-1952. His findings and the conclusions he draws from them are outlined in his paper "Alcoholism and Attempted Suicide".\textsuperscript{3}

Concerning his findings, he writes:

A family history of alcoholism in first-degree relatives was found in 28.5 per cent. Many of the subjects came from homes "broken by parental alcoholism."

19.5 per cent of the cases were under the influence of alcohol at the time of their suicidal attempt.

Forty-three (21.5 per cent.) of the cases gave a personal history of excessive drinking.

... A further 16 (18 per cent) individuals who were under the influence of alcohol at the time of their suicidal attempts, were not pathological drinkers.\textsuperscript{4}

\textsuperscript{1} Ibid., p. 89 and p. 98.


\textsuperscript{3} Few papers in the literature deal entirely with the relationship between suicide and alcoholism. This one is an exception.

His conclusions follow:

(a) Though rarely wholly or mainly the cause of a suicidal attempt, alcoholism is a significant factor in about 30 per cent. of these acts, and in men about twice as often as in women.
(b) Parental alcoholism disrupting the home, may contribute to the personality disorders which result in suicide.
(c) Alcoholism and suicide have frequently similar or identical psychopathological bases. Alcoholism may be a fractional suicide, prepare the way for suicide, or provide a substitute.
(d) Alcoholism may facilitate a suicidal attempt by releasing inhibitions: and it may also render it less effective. Such attempts, though often impulsive, are often also serious.
(e) A relatively small amount of alcohol is more potent in this than a large excess.
(f) The "chronic alcoholic" does not typically commit suicide. Sufferers from psychopathic and depressive states who repeatedly abuse alcohol, frequently attempt or commit suicide: the intermittency of their drinking may expose them more to the stress of intolerable conflicts.¹

E. Suicide and the Aged.

In his discussion of the association of suicide with old age based on his and his co-worker's findings² and on those of O'Neal, Robins, and Schmidt,³ Batchelor points out that in this age group suicide and attempted suicide fall into similar if not identical clinical categories, for an attempt is, he believes,

¹. Ibid.
rarely a gesture or threat but an act which has failed for reasons other than seriousness and determination. He contends that the majority of the suicidal aged are suffering from psychoses — usually from the depressive phase of manic-depressive psychosis, and that some of the co-existing features of insomnia, tension, agitation, hypochondriacal complaints, delusions of poverty, and fear of fatal illness or of insanity are usually present. Batchelor believes that physical illness and particularly degenerative disease is the major precipitating factor serving to diminish control over behaviour, to diminish resistance to stress and to enhance brooding and excessive introspection. He also recognizes the significance of social factors, holding that the mental illness (in itself not a sufficient explanation for suicide), cannot be divorced life circumstances. In particular, he sees as the important precipitating factors feelings of loneliness, loss of a loved one, retirement from employment, changed domestic circumstance, and financial worries.¹

F. Prodromal Aspects of Suicide.

A number of writers have given prominence in their investigations to the prodromal or warning symptoms aspects of suicide. Jamieson and Wall studied the case records of twenty-five patients who committed suicide in a New York State mental hospital

¹ I.R.C. Batchelor, "Suicide in Old Age", in Clues to Suicide, p. 143-151.
over a twenty year period. They concluded that by the observation of certain premonitory signs the incidence of suicide could be appreciably reduced. These signs are:

(1) Severe hypochondriacal and nihilistic ideas, with veiled death wishes in the trend.
(2) Insomnia; not the actual sleeplessness itself but the apprehension and agony concerning its possible effects.
(3) Persistent belief in losing control of oneself, of "going insane," and analogous ideas.
(4) Sense of guilt with persistent belief and concern about punishment, especially by torture of one kind or another.
(5) Evidence of aggressiveness as indicated by surly, impatient, and irritable attitudes together with assaultive tendencies.

Fairbanks looks for depression, rigid, personality, disappointments over seemingly unmodifiable situations, and a family history of suicide which, she believes, lessen resistance to the idea. Davidson in his series notes expressions of guilt, unworthiness, "fulfillment of one's destiny", disillusionment and insecurity following the loss of a loved one. Drewry reports that he is especially mindful of the signs of depression, insomnia, guilt, past history of attempts and statements of death wishes. Raphael, Power and Berridge interviewed 3021 students over a five-year period at the mental hygiene service of the University of

Michigan and found that in some 313 the possibility of suicide could not be overlooked. They described the student with suicidal tendencies as over-sensitive, shy and self-conscious, anxious, delicately balanced from the emotional standpoint, and immature in understanding and judgment.¹

Chapter 4.

Implications for Social Policy and Services

1. An Outline for the Strategy of a Mental Health Programme.

A. The Findings of Sociological and Psychological Studies.

Sociological studies strongly suggest that suicide is the outcome of a failure in the operation of the mechanisms of social control and that it is an indication of a state of social disorganization. Such disorganization, badly manifesting itself in the prevailing conditions of social isolation, detachment, diminished group solidarity, freedom from social control, anomie and rootlessness, enhances the probability of suicide.

Research findings have empirically borne out the association of suicide with social disorganization. The contrast between the low rates associated with agricultural regions and stable isolated religious groups and the high rates in industrial urban regions furnishes one important confirmation. Another is the association of low rates with family life and the presence of children. Further substantiation is given by the increase of the suicide rate in those countries undergoing the process of industrialization. Occupational data, while not as easy to interpret, differ in suicide rates in such manner as to contribute to the same generalization. Perhaps the most important fact, however, is the association of the highest rates within large cities with the most intensely mobile and detached populations; the hobo, hotel and rooming-house populations. These peoples, as have been shown from the study of deviant behaviour and mental disorders, constitute
the most disorganized population of any size that is to be found in modern cities.

Psychological studies of the suicide process indicate that a crisis, often severe, in the life-organization of the individual is an important determining factor in self-destruction. Such a crisis may reveal itself in a mental disorder or in a serious affective disturbance with depressive features.

B. The Need for a Synthetic Approach.

The social and behavioural sciences have always been plagued by the problem of the levels of causality in the explanation of substantive phenomena, and nowhere has this problem been better exemplified than in the study of the causes of suicide, where sociological and psychological factors have traditionally been examined in isolation. More and more, however, are students of the problem coming to the realization that the determinants of suicide are rooted, as are the determinants of other forms of deviant behaviour, in both personality and social structure, and that an "either-or" approach is no longer tenable.

The literature is reflecting the emergence of a synthetic

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1 It is to their credit that the social work profession, for so long deluged with psychiatric and particularly analytic concepts, is becoming increasingly cognizant of the relevance of sociological and anthropological concepts.
social science\(^1\) from which concepts can be drawn both selectively and eclectically, although attempts at integration in reference to the problem of suicide are still infrequent. Simpson has written:

The basic problem for social research must be to interrelate the life-histories of individual suicides and attempted suicides with sociological variables, on the hypothesis that certain social environments may (a) induce or (b) perpetuate or (c) aggravate the suicide-potential. If we can correlate for masses of data, suicides or attempted suicides with their having been induced, perpetuated, or aggravated by certain social environments, then we are in a position to establish laws of generalized occurrence.\(^2\)

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1. For an account of the need for such a science and for some of the attempts at synthesis at the theoretical and practical levels see:


C. The Treatment and Prevention of Suicide.

The institutionalized responses of society to suicide take the form of medical and social services and legal measures. The former is considered here.

Treatment resources for those who attempt suicide are on the whole limited. A person admitted to the Emergency Ward of a general hospital is given medical attention, followed by a perfunctory psychiatric examination (if deemed necessary), and then usually discharged. Some hospitals insist on a more thorough examination in order to assess the seriousness of intent, gauge the possibility of a recurring attempt, and arrive at a decision concerning disposition — whether it be discharge, continued psychiatric treatment or commitment to an institution.¹ Few hospitals provide a follow-up service. In London and in New York a person considering suicide may telephone, day or night, to public health authorities for help,² and in the larger cities in the Netherlands a treatment team is on call twenty-four hours a day to go to the place of residence of anyone contemplating suicide.

A number of organizations and associations have been formed to offer a personal service to the would-be suicide. These include

1. The Vancouver General Hospital follows this procedure as policy. Through an interview with the doctor in charge of the Emergency Ward, the writer learned that the majority of patients, after psychiatric assessment and medical repair, are discharged home.

the Salvation Army's Anti-Suicide Bureau in London, the Suicides' Aid Society in West Berlin, the National Save-a-Life League with headquarters in New York, the Emergency Clinic for Depression in Stockholm, Rescue Incorporated in Boston and the Suicide Prevention Center in Los Angeles.

D. Recommendations for a Suicide Control Programme.

The writer suggests that any programme aimed at the prevention of suicide through the treatment services given to emotionally disturbed and irrationally behaving persons who have tried to take their own lives must include in its broad outline at least five measures: first, the immediate reporting of suicides and attempts to responsible public health officers; secondly, the provision of immediate medical attention; thirdly, psychiatric assessment and treatment where indicated for a defined period of time; fourthly, the recognition that the suicide gesture is a device to gain sympathy and attention and the insight to realize that these should be accorded; fifthly, a follow-up service by the Social Service Department of the hospital and the Public Health unit in the community. Two corollary measures with broad implications are also suggested: stricter controls over the prescribing of lethal and addictive drugs, and a less 

1. This non-sectarian organization, located in the Boston City Hospital, is patterned after Alcoholics Anonymous. It is headed by a priest who makes referrals to various local social agencies. Psychiatric consultation is available. The organization is supported by voluntary contributions and a programme of public education is also carried out by some of these organizations.

2. A recommendation regarding legal aspects is also made in the following section.

3. A.E. Bennett, "Suggestions for Suicide Prevention", in Clues to Suicide, p. 192.
sensationalistic approach by the press in the reporting of suicides and attempted suicides.

Perhaps the most comprehensive existing programme aimed at the prevention of self-destruction is that of the Suicide Prevention Center (now as SPC) in Los Angeles. A brochure published by the organization explains its operation and its objectives:

The Suicide Prevention Center (SPC) was established for the evaluation, referral, treatment, follow-up and over-all prevention of suicidal behaviour. It was conceived as an agency specifically designed to meet the problem of suicide with an extensive scientifically developed program, incorporating knowledge and techniques gained by the Co-Directors from over a decade of intensive personal investigation of the problem...

The activities of the SPC are directed toward three primary goals. These goals are: (1) First and foremost, to save lives. Specifically, this means that the SPC is set up to make psychiatric, psychological and sociological evaluations and then to make referrals or give treatment to persons who are in the midst of a suicidal crisis. The goal here is not only to save a life at that particular time but, equally important to institute those therapeutic procedures which will reduce the possibility of an individual's attempting or committing suicide at some time in the future. (2) The second goal is to demonstrate that such a Center can play a vital role in the health and welfare activities of a large metropolitan community and can establish itself so that the community would eventually wish to maintain and support it; further that such a Center might serve as a pilot project or "model" for other communities to copy and adapt to their own specific needs. (3) Third, to collect and collate heretofore unavailable data regarding suicidal phenomena and to employ this scientific information to develop and test hypotheses concerning suicide. This procedure will lead to more accurate prediction and hopefully, will lead ultimately to lower suicide rates.

The Suicide Prevention Center grew out of a recognition of the magnitude of the suicide problem in the Los Angeles area — a problem against which there had been directed little organized community effort. The staff, described as a "socio-psychological" professional team is composed of the two project directors (Shneidman and Farberow), two psychiatrists, two psychiatric social workers, three clinical psychologists and a biometrician. The Center estimates that there are at least 6000 individuals who try to take their lives each year in the Los Angeles area. Its clients are in the main those who have attempted suicide and who, as a result, have been hospitalized in the Los Angeles County General Hospital. In addition, referrals are received from other agencies, physicians and from contemplators of suicide themselves.

The method of treatment is described in the brochure:

The SPC addresses itself primarily to the intrapsychic (tensions within the person) and social behaviour — rather than to the purely medical aspects of the attempt.

Within the SPC, the processing of an individual consists of extensive psychiatric interviews, psychological testing, and social work investigation (the latter often dealing with family and other significant persons). For each individual processed, specific recommendations for realistic treatment and assistance are made. Each person is referred for treatment on the basis of his or her individual needs to a community agency, a public or private treatment facility, and sometimes for psychotherapy to the SPC itself. Arrangements are made for obtaining follow-up

1. Ibid.
2. Ibid.
data so that information is funnelled back to the SPC from the treatment resources, permitting the SPC to evaluate the effectiveness of various methods of treatment of suicide.¹

The Center emphasizes a close working relationship with mental health and other agencies in the community. Liaison has been established with the city, county, and state departments of health, the Welfare Planning Council, the coroner's office and the Police Department.²

The research activities and goals of the Suicide Prevention Center are worth noting:

It is a manifest truth that there is a fundamental relationship between clinical practice and research—that clinical practice is improved largely through the findings of research efforts. A total program on suicide must therefore include not only the saving of lives today but the investigation of why individuals take their lives so that suicidal behaviour — on the basis of increased knowledge concerning its causes — can be prevented in the future. In line with this reasoning, the SPC (while primarily a life-saving agent) has built within its operations carefully designated research procedures. With this in mind, a specific proportion of staff time is devoted to basic research activities. The data for these studies consist of suicide notes, details of the psychiatric case histories, psychological tests, social service data, information from the Coroner's Office, ecological and sociological data from the community, etc. (Names of individuals are, of course, never used.) To date we have been able to formulate and test a number of specific hypotheses and, most importantly, the general results of this procedure — in an area of great public health importance — seem promising.³

1. Ibid.
2. Ibid.
3. Ibid.
The Center has one source of financial support, a five-year (1958-63) grant from the U.S. Public Health Service. Steps are apparently being taken, however, to establish a "Suicide Prevention Centre, Incorporated", an organization which hopes to be the recipient of private donations.¹

The Los Angeles programme, an ambitious and pioneering experiment, might well serve as the model in the inauguration of a suicide prevention service in cities such as Vancouver where specialized treatment facilities for dealing with the problem of self-destruction are virtually non-existent.²

There is another dimension to the question of the prevention of suicide: the structural dimension. It is recognized that since the individual self has its being in the social process, any large-scale corrective measures must come as a result of structural reorganization and changes. The examination of the components of social disorganization indicates the directions such modifications should take.³

E. The Need for Continuing Research.

Although suicide claims more lives in Western countries than

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1. Ibid.
2. It is of interest to note that the Provincial Mental Hospital at Essondale keeps no separate record of the number of patients admitted because of a suicide attempt. Only by examining each admission slip can the number be determined.
3. The great emphasis in contemporary society on the goals of acquisition and success and a corresponding de-emphasis on the means by which the goals may be achieved is probably an important factor in the genesis of social disorganization. Any consideration of possible modes of re-organization would need to be cognizant of this emphasis.
tuberculosis, polio, alcoholism, arthritis, rheumatism, or multiple sclerosis, there has been comparatively little research undertaken. Yet much needs to be done, for clinicians still lack indicative procedures for making accurate diagnosis of the suicide process. The magnitude of the suicide problem has not as yet been firmly established, i.e. the number of people who commit and attempt suicide. Information on this would be an effective first step in considering the public health responsibility in this area.

2. Suicide and the Law.

A) The Legal Status of Suicide.

The person who attempts suicide is adjudged "felo de se" or felony against the self, and is open to prosecution. The Criminal Code of Canada states:

Everyone who
a) Counsels or procures a person to commit suicide, or
b) Aids or abets a person to commit suicide, whether suicide ensues or note, is guilty of an indictable offense and is liable to imprisonment for 14 years.

Everyone who attempts to commit suicide is guilty of an offense punishable on summary conviction.

Turner has written:

Murder consists in the unlawful taking of a human life; it has therefore always been a felony even though the life which the man takes is his own, the malice afore thought in such case being in the usual case the intention of the man to bring his own existence to an end, which has led to the crime being often called self-murder.

Suicide is a felony, and therefore an attempt to commit it is an attempt to commit a felony.

B) Sources of the Law: A Critical Analysis

The attaching of penal sanctions to the act of suicide derives

1. "Felo de se" does not mean the felony but the felon himself.

2. Criminal Code of Canada, Section 212, 213. The offender may be sentenced to two years' imprisonment.

from ecclesiastical laws and archaic secular practices which, in time, came to reinforce each other. Early theologians condemned self-destruction as sinful for a number of reasons: first, the act is a breach of the sixth commandment; second, it is a violation of natural law; third, it is cowardly; and fourth, it is held that since God gives life to man only God can terminate it. The canons which were instituted by the church councils of the first millennium expressly forbade burial rites for suicides and reflect the influence of the writings of the early theologians.¹ Later in England elements of canon law as it applied to suicide were incorporated into the common law and the act came to be regarded not only as a sin but a crime as well.

The way in which penal sanctions originated from secular practices has been succinctly stated by a legal writer:

Attempted suicide became a crime in England by a rather roundabout process. Every felon forfeited his goods to the King, and it was but a simple step to declare suicide a felony, in order to escheat the estate of the suicide to the King's treasury. Suicide having been accepted as a crime, it naturally followed that attempted suicide also became punishable.²

1. The early theologians had not demanded the mutilation of the dead body of the suicide and Williams, following Bayet, has suggested that the practice of dishonouring the corpse represents an intrusion into the church of the pre-Christian popular abhorrence of suicide. He writes: "like so much else in ecclesiastical practice and belief, it is a pagan intrusion upon the simple philosophy of the Gospels." (p. 258). It was not until the second decade of the nineteenth century that the custom of burial at a crossroads with a stake driven through the body and a stone covering the face (intended to prevent the body from rising as a vampire or ghost) was formally abolished by law in England. (Williams, The Sanctity of Life, pp. 257-260.)

It became the practice of the Crown in the eighteenth century to waive the forfeiture in cases where the suicide had not been committed for the purpose of avoiding conviction of felony. Thus the Forfeiture Act of 1870 which abrogated forfeiture for suicide "did no more than give legal effect to the established practice."\(^1\)

It was commonplace for coroners' juries to return a verdict of insanity rather than one of felo de se in order to ensure the deceased a church burial and his family the right to his property.\(^2\)

The prevalence of the verdict, Williams notes, prompted the maxim that "in England you must not commit suicide, on pain of being regarded as a criminal if you fail and a lunatic if you succeed."\(^3\)

It is probable that the arguments against suicide devised by the spokesmen of the primitive church (and still offered today) are rationalizations, for it is apparent that if self-destruction were not explicitly prohibited, the faithful, considering his life on earth as merely a temporary period of waiting before his union with God, might be sorely tempted to expedite matters by his own hand.

An examination of these theological arguments against suicide reveals their unsoundness and even their sophistry. To hold that

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suicide is a violation of the Sixth Commandment is to equate suicide with homicide. Yet, there are obvious differences between the act of rampant hostility wreaked upon another and resulting in his death and the act of voluntarily and quietly putting an end to one's own life. For, as Williams has pointed out, a man may intentionally destroy himself for a noble cause but he does not have the right to kill others for that same cause.¹ Thus the question of the morality of suicide cannot be resolved by recourse to logical deduction from the prohibition of murder. Suicide, it is contended, is "unnatural" and therefore immoral and sinful. The word "unnatural", here equated with "immoral", is unintelligible and devoid of concrete connotation.² The argument that suicide is contrary to natural law is, then, the application of the method of arguing from an assumed "nature" to morals.³ Yet, if self-destruction were contrary to man's nature, it would not occur. Too, not every negation of a basic instinct is immoral, otherwise, as Fedden has pointed out, the celibate would be a sinner for he denies the instinct of sex.⁴ A third argument against suicide is that it is cowardly. Replying to this proposition, Williams writes:

...the only line between cowardice and caution (or

¹. Ibid., p. 256.

². Hook has suggested that the word is "promiscuously" used and serves to blind the user to the fact that he has already passed judgment. He strongly advocates its discontinuance in ethical evaluation. (Hook, Internat. J. of Ethics, vol. 37, 1927, pp. 173-188.)


⁴. Fedden, Suicide, p. 282.
wise retreat) is that the coward does not do what he ought to do. To brand the suicide as a coward is, therefore, to beg the question whether there is a duty to go on living.¹

Finally to insist that life is God-given and can therefore be ended only by God, is an illogical deduction from an assumed "is" to an "ought". A cogent reply was that of Pliny, the Roman naturalist and encyclopedist: "the existence of poisonous herbs with which one may so easily kill oneself is a benevolent gift from God."²

The censure of suicide, reflected as it is in law, then, is part of a particular system of religious belief and as Williams suggests "need not be accepted by the positivist or indeed by anyone who does not accept the traditional eschatology."³

C) A Critique and a Proposal.

The laws dealing with homicide rest upon a utilitarian consideration of the most apparent kind: the protection of the members of society. But the prohibition of self-destruction is not founded on a like consideration of public security. Rather it is the expression of a philosophical attitude derived from and still deeply rooted in the theological concept of individual sin. The question arises, "Is this concept applicable to a socio-psychiatric phenomenon whose determinants are, to a considerable degree, beyond the individual's control?" A growing body of opinion would offer a negative reply. Many, regarding life no longer as an absolute value, observing a disjunctive relationship between law and morality,

2. Ibid., p. 265.
3. Ibid., p. 257.
and recognizing the limitations of the criminal law as applied to the problem of suicide, call for an abolition of all penal sanctions attached to the act. This does not necessarily imply an endorsement of self-destruction or a disregard for the sanctity of human life; nor does it represent the expression of a negatively individualistic, liberalistic or anarchistic attitude of mine. Rather it reflects the conviction that suicide is a form of deviant behaviour which is beyond the scope of the criminal law and it recognizes that punishment of an attempt at suicide cannot act as an effective deterrent on an individual who has already demonstrated a readiness to terminate his life.\(^1\) As an instrument for reform and re-education, then, punishment is of dubious value. Some have argued that criminal proceedings ensure the individual with suicidal tendencies of adequate physical and psychiatric care.\(^2\) Such an argument, as Mannheim has pointed out, is a serious indictment of the prevailing system of mental health services. He writes:"It should not be beyond the wits of men to devise an adequate scheme dealing with human problems of this kind outside the criminal law."\(^3\)

The insights derived from sociological and psychological studies of the determinants of self-destruction make it abundantly clear that one who attempts suicide is not a willfully perverse person requiring moral correction. In view of this it is proposed by the present writer that in the case of the mentally disordered

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and the emotionally disturbed who attempt death by their own hand (suicide attempts which might be termed "pathological"), the law, without penal sanctions, should be invoked to permit an intervention, taking the form of treatment services. Unless committable to an institution, the person should be subject to restraint at the discretion of an informed magistrate after consultation with clinicians and for a brief and definite period of time only. Two additional safeguards would be necessary: abolition of a public hearing, and granting of wide magisterial powers as to choice of place and condition of detention.¹

Self-inflicted death, however, may be the terminating act of the settled philosophical resolution of a rational mind. The present writer holds that if this be the case the individual should, by law, be free to reject treatment services offered him and to dispose of his life as he sees fit. In short, for what Shneidman has termed the "logical suicide"² (for example, those in great physical pain) there should be no legal or moral interdiction. As Williams has written:

> Ultimately, society cannot stop a free man from committing suicide, nor should it try. What can be done is to make sure that the determination upon self-destruction is fixed and unalterable.³

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