TREATMENT AND REHABILITATION OF ATTEMPTED SUICIDE PATIENTS

An Exploratory Study of 71 Cases Admitted to Vancouver General Hospital in 1948.

by

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Abstract

This is an exploratory assessment of the help given suicide patients admitted to a general hospital. The focus of the study is twofold: (a) to examine the kind of treatment administered at the hospital, including rehabilitation and follow-up plans for each patient; and (b) to determine the role of the social worker in this program.

The study is based on the examination of the hospital records of 71 patients, who attempted suicide in 1948, and were admitted to Vancouver General Hospital for observation and treatment. The group as a whole is described with the aid of statistical data, no attempt being made to deduce causes from this evidence. More emphasis has been placed on the mental and emotional aspects of suicide, to outline some of the deeper, unconscious causations of suicidal behaviour. Case illustrations are discussed in the attempt to exemplify these factors. The theoretical background of the thesis is drawn from psychiatric literature in United States and Great Britain.

Evidence in this study suggest that almost no help is given these patients, in the hospital, to relieve the psychological and social conflicts. There are grounds for urging that the social worker could play a valuable role in the treatment team, and that social work services are not being used to the extent they could be.

Suggestions are presented regarding an adequate hospital program for suicidal patients, in which the psychiatrists, social worker, psychologist and nurses would work together to make a clinical study of each patient. On the basis of adequate clinical study, constructive recommendations on treatment and rehabilitation plans could be made, and the groundwork laid for an adequate program of follow-up services.
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TREATMENT AND REHABILITATION OF ATTEMPTED SUICIDE PATIENTS

An Exploratory Study of 71 Cases Admitted to Vancouver General Hospital in 1948.
Chapter I  The Problem of Suicide in Society

The problem of suicide has so many aspects and such far-reaching implications that it would be impossible to focus on one aspect without, at least briefly, considering some of the others. Suicide has moral, legal, sociological and psychological implications, all of which have evolved with the changing trends in thinking and the philosophy of the times.

Historical Background

The act of taking one’s life dates back as far as recorded history, but the attitude of the public toward suicide has undergone many changes throughout the past centuries. It has been looked upon with awe, fear, contempt, pity or admiration, depending on the attitude of the society in which it occurred, and upon the motivation behind the suicide. A few societies held suicide to be a noble act, deserving of praise, others looked upon it with bewilderment or pity, and still other groups regarded self-destruction as the work of the devil, and treated the body of a suicidél with contempt and disdain.

Among the Greeks and Romans, the practice of suicide was an outgrowth of individualism, and was not associated with shame, but rather, considered a matter of honour. Roman law permitted suicide, provided the
individual could give sufficient reason. A man could apply to the court, state his case, and be given an adequate amount of poison. The custom of honourable suicide, known as hara-kiri, still exists today in Japan.

During the Middle Ages, when religious authority was at its height, suicide was infrequent. This was possibly due to the lack of individual freedom, and certainly to the fears of punishment after death. With the industrial expansion of the seventeenth century, however, bringing with it a greater urbanization, and at the same time a higher degree of individual freedom, suicide became more frequent.1

The Effect of Religion

Christianity has always opposed suicide. It has had a deterrent effect through threats of punishment after death, but also through the more positive effect of the philosophy that each individual is a personality of unique value and significance to a divine being. Self-destruction of that personality, therefore, has been considered a sin against God. St. Augustine was one of the first to postulate that suicide was a sin and, until the end of the eighteenth century, it was handled as an offense in the ecclesiastical courts. In 1585 John Donne, Bishop of St. Paul’s, published a book on suicide, condoning the act and expressing the opinion that it was not so great a sin as had heretofore been supposed. This was followed by other philosophical documents, but the strong religious feelings against suicide held.

1 In this sense, it may be argued that the writings of such philosophers as Hume, Voltaire, Kant and Rousseau which encouraged freedom of expression and the rights of the individual may have had some influence on the increase in suicide. It must be remembered, however, that the number of people who take their own lives have always been a small proportion of the total population.
Legal Aspect

The moral judgement on suicide was carried over into the legal field, and it is at the present time included in the Criminal Code as a type of homicide, murder of self. A person is adjudged felo de se\(^1\) if he brings about his own death with the same full "malice aforethought" as would render his killing someone else a murder.\(^2\) Until the later part of the nineteenth century, the penalties for this crime, under the English Common Law, were severe, and burial was often preceded by mutilation of the corpse.\(^3\)

These punishments and forfeiture of property have gradually been moderated,\(^4\) but even with the abolition of the old penalties, the intentional suicide of a sane person is still regarded, in the criminal codes of most countries, as a criminal act. Accordingly, every attempted suicide is held an indictable misdemeanor, subject to trial by jury and punishable by imprisonment. The modern tendency, however, is to treat

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1 felo de se - (felony against self) Felony is a legal name for an indictable offense of a heinous nature. It is thought to have evolved from the Celtic root meaning evil. Under the old Common Law, all felonious crimes were punishable by death and also involved a forfeiture of property.


3 Ibid, Page 45. The English Common Law "endeavored to deter men from this crime by the threats of degradation to be inflicted upon the suicide's corpse which, by a natural if unreasoning association of ideas, were often a potent deterrent; and also by threatening the forfeiture of his goods, a vicarious punishment which, though falling wholly upon his surviving family, was likely to appeal strongly to his sense of affection". The body was often buried on the highway with stakes driven through it or was left naked in the market place.

4 Moderations in the English Common Law:
   1824 - the burial of the suicide lost its gruesome aspects, but restricted burial to the hours of nine to twelve in the evening and denied funeral rites.
   1870 - The Forfeiture Act put an end to the confiscation of the goods of a suicide.
   1882 - an act was passed which removed every penalty except the purely ecclesiastical one which stipulated that interment could not be solemnized by a burial service in the full Anglican form.
attempts at self-destruction with some commiseration, and there is an increasing interest taken in trying to understand the act, and to prevent its recurrence.¹

There is today more acceptance in the courts, of the sociological and psychological implications of the act, and a greater awareness that the suicidal individual is in need of psychiatric help rather than legal punishment. The mental condition of an accused person, charged with attempted suicide, is frequently a matter for special consideration in a criminal trial. The accused may be acquitted on the basis of insanity at the time of the act, or he may be committed to a mental hospital for treatment.

Sociological Aspect

The interest in the sociological aspect of suicide developed with the gradual collection of statistics regarding the incidence of suicide. These seemed to indicate some correlation with certain social phenomena and other relevant factors. The earliest statistics on suicide date from 1750, in Sweden. The first comprehensive study of suicide, however, which included all the data available at the time, was compiled by Morselli in 1876.² Other studies of this time are those done by Moore and O'Dea.³

¹ The modern policy is not to take proceedings in the case of attempted suicide unless detention for a time is in the interest of the individual or for other sufficient reason. The number of persons sent to prison on this offense is very small as compared to the number of attempted suicides, or even as compared to the number seen in courts.
The greatest consideration of suicide in the past has been mainly statistical in nature, referring to sex, age, marital status, mode of death, and has almost completely neglected causation, apart from endeavours to establish the apparent motives. There have been attempts to correlate such factors as climate, phases of the moon, seasons, religion, race, heredity, alcoholism, celibacy and parenthood, relationship to psychosis and so forth. Some of these findings or conclusions are interesting and possibly significant, while others are invalid and fantastic.¹

Attempts have even been made to show that the tendency toward suicide is an accompaniment of civilization, that the savage never takes his own life. Suicide is, indeed, much less common among the barbarous than among the civilized people. Nevertheless, studies of primitive cultures reveal that suicide is not uncommon.² An interesting parallel

1 It is felt that there is a need for up-to-date and readily accessible statistics on suicide and attempted suicide, related to certain social phenomena which experience has shown may have some bearing on the act. Accurate statistics are not easily obtained because the act is often not recognized as such or is concealed. Many patients are treated by private doctors and are not reported, on the request of the family. Moreover, when considering suicide, it is difficult to draw the line between actual suicide and the more subtle forms of behaviour which might be called a suicidal drive or "death wish", such as the patient with a medical condition carrying a good prognosis, but who dies simply because he lacked the will to live.

Malinowski discusses a number of concrete cases of suicide which he studied while doing field work in the Trobriands. He found suicide was used as a means of escape from a situation in which the individual is involved in some sin, crime or passionate outburst and has been insulted in public. The suicide is a ritual act and involves the desire for self-punishment, revenge against those who have insulted the individual and often sentimental grievances.
Margaret Mead's studies of the Eskimos of Greenland and other primitive societies in Canada reveal other examples of suicide practices. Among the Eskimos, the practice is not uncommon. When an individual is considered too old to carry on his work, hunting, or responsibilities, he is told and is expected to throw himself into the sea.
can be drawn between the traditions of primitive races relating to suicide, and suicide practices in our modern culture.

The modern attitude toward suicide is coloured by the stigma of the past, and by the taboo which covers the subject. There is an ambivalence of opinion, with a mixture of admiration and contempt, usually depending on the apparent motives, and upon the status of the individual in the society. Regardless of the way in which we view suicide, it is a social problem, but a social problem with legal, moral and psychiatric co-existing problems.

Suicide involves both the individual and the community in a complexity of interacting forces. The environment and external forces, over which the individual has no control, affect and mould his personality and character and hence, affect and mould his reaction to frustrations and adversities in that environment. The individual may be lead to thoughts of self-destruction because of hardships of various kinds, such as poverty, hunger, ill health, loss of love or failure. However, not every adversity drives a person to suicide unless he is already harassed by a serious emotional conflict. Obviously, if this were not true, the suicide rate would be far in excess of its present figure. One wonders why it is that some individuals value life so lightly, and find it so unpleasant that they destroy themselves voluntarily and retreat to the even more uncertain state of death. One also wonders why it is that some individuals appear to suffer equivalent or greater frustrations than those of the suicidal patient, but are able to endure them and overcome them by adaptation and satisfactory adjustment. The obvious conclusion is that the difference must lie in the individual himself, in his emotional maturity and his ability to adjust to his environment. Suicide is a
retreat from life, a final regression from reality, when the suffering in
the present and the hopelessness of the future seem to be unbearable.

Psychological Aspect

Several questions might then be raised. What kind of person is
likely to commit suicide, and what are the psychological processes that
lead him to such drastic and final action? It might also be asked if there
are any signs or manifestations which would lead one to suspect the possi-
bility of suicide before the act takes place and if so, what could be done
in the way of preventative measures? In that suicide appears to be bound
up in the psychological processes of the individual behaviour, it seems
logical that the medical psychiatric fields of psychopathology should be
able to contribute a great deal toward an understanding of the problem of
suicide.

Psychologically, suicide is a very complex act. Strangely
enough, however, there has been very little widespread interest taken by
psychiatrists in making clinical studies of the suicidal patient.
Clinical studies would afford a great deal to psychologic medicine and
the understanding of suicide motivations, and could also provide the best
means of determining how to prevent the occurrence of a considerable
number of suicides that now take place. The social and legal aspects of
suicide are given prior consideration to the medical and psychiatric
aspects; as a result, society tends to deal with the situation of the
moment and fails to go to the root.

Behaviour is never determined solely by external forces, but by
internal forces as well. This being the case, it is impossible to deter-
mine or understand the underlying motives of suicide with any degree of
certainty unless there is an intimate knowledge of the patient's psychic
life. For this reason, psychoanalytic studies which give access to the unconscious motives, seem to provide the most hopeful method of gaining some understanding of suicide. Consequently, most of the conclusions and hypotheses regarding the psychology of suicide have been drawn from psychoanalytic studies of patients who have attempted to destroy themselves or who have indicated suicidal tendencies.

Basic to the discussion of the psychological causes of suicide is Freud's theory of the death instinct versus the life instinct. According to this theory there exists in everybody an inherent self-destructive instinct which is in constant interaction with the constructive, or life, instinct. These conflicting forces are originally directed inwardly toward ego problems; but ultimately, through growth of the personality, come to be directed outwardly toward external objects. In this process of growth, the constructive instincts become the basis for the individual's ability to love others unselfishly and to do constructive work. The destructive instinct, redirected outwardly, provides the individual with aggressiveness to fight his environment and his enemies. These two instincts are closely related to love and hate. The theory implies that the individual who

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1 Some of these studies are:
Symposium on Suicide held in Vienna in 1918 under Freud and his followers. Zilborg, Gregory, "Differential Diagnostic Types of Suicide", Archives of Neurology and Psychiatry, Vol. 36, 1936.
Menninger, Karl, Man Against Himself. Menninger presents his hypothesis of the psychology of suicide from an examination of the unconscious motives as brought out in psychoanalysis. He extends his theories to a consideration of other forms of human behaviour which seem to be self-destruction in an indirect and disguised form as, for example, the martyr, the ascetic, the alcoholic, the accident prone and many other clinical and so-called normal behaviour patterns.
commits suicide has not been able, through growth, to direct these tendencies outwardly, and the ego is unable to cope with the conflict. When the struggle between these two forces becomes unbalanced and the destructive impulses exceed the neutralizing constructive impulses, self-destruction results.

Clinical analyses and studies of the unconscious motives of suicide carried out by a few interested psychiatrists have resulted in certain common findings. There appear to be three components to the suicidal act: the wish to kill; the wish to be killed; and the wish to die. The wish to kill is considered to be the primary motivating force, and it is this rather than the desire to die that makes an individual take his life. The wish to kill is an expression of extreme aggressiveness which must be unconsciously controlled since, if expressed in consciousness, it would represent murder. In the suicidal act, this unconscious wish to kill is turned against self in the attempt to destroy a social primitive tendencies in the personality; to destroy objects of hatred which through identification and introjection have become part of the individual; or to destroy infantile sexual strivings which have remained so much a part of the personality that complete destruction is necessary.

On the other hand, the wish to be killed is the expression of extreme submission. It is the unconscious need for punishment and atonement because of the guilt centered around the strong aggressive tendencies and asocial strivings. This submission to punishment is characteristic of masochism, in which there is an erotic value or pleasure involved. Similarly, the submission to violence in self-destruction may become erotized. This may be illustrated, and it is discussed later in the consideration of the symbolic significance of the methods used to gratify the need for punishment and the wish to be killed.
The third component of the suicidal act, the wish to die, is the residue of the original primary self-directed aggressiveness. It does not necessarily coincide with the wish to be killed; in fact, the patient may attempt to kill himself and then implore the doctor to save him. The wish to die is thought to be a carry-over from childhood fantasy, in which the child may imagine himself dead but at the same time cannot imagine himself no longer alive. Occasionally this fantasy of death may be stimulated by the death of a loved one and desire for reunion with that person. It is also motivated by exhibitionistic tendencies and the satisfaction of imagining the pain and suffering which the individual's death would cause. There is, however, no reality attached to this.

Many unsuccessful attempts at suicide illustrate the absence of the wish to die. The patient goes through a kind of cathartic rehearsal of the emotions and behaviour of self-destruction and seems to be much improved psychologically as a result of having released the self-directed aggression and of having suffered physical pain. The attempted suicide is the means of satisfying the need for self-punishment or atonement for the unconscious aggressive tendencies and temporary psychological relief is gained by this acting out of the impulses. This theory might explain many of the half-hearted attempts, as well as many of the self-mutilations observed in other cases of attempted suicide which, if the individual wished to die, could have been successfully performed with less trouble.

The methods used to commit suicide are many and varied. Some have a complicated pattern and often a fantastic and weird aspect, while others are commonplace and easily accessible to the individual. Psychiatrists feel that the methods used usually have some symbolic significance and are related to the unconscious motivations. It is not always possible to attach a symbolic meaning to the method used since much more clinical
study of actual cases is necessary to arrive at a conclusive theory. In many cases, however, insight into the motivations behind the method used can provide a better understanding of the patient's emotional conflicts and sufferings.

Freudian symbols appear to be applicable in many instances. Symbolic regression is illustrated by the patient who seals himself in a room and turns on the gas, or by the patient who allows himself to drown without resistance. Here would seem to be implied the wish to return to the undisturbed bliss of interuterine existence. Hanging has also been associated with the earliest attachment to the mother, and with the birth process, in which the rope might represent the umbilical cord. Many of the painful and torturous methods of drowning which are sometimes chosen, are explained as the need for punishment because of the anxiety and guilt connected with the fantasy of returning to or entering the mother's womb.

Suicide by drinking poisons, lysol, or by swallowing sleeping pills, can be attributed to strong oral cravings. In such cases, the individual usually has a great need for love, but in an infantile way, in which the erotic function of the mouth is intensified. There is also unconscious guilt and anxiety attached to gratification of this need and as a result, a need to suffer pain. This is exemplified by patients who drink lye or eat explosives, when a much less painful method could have been used just as effectively.

The suicidal drive is not dependent on or derived from any one traditional clinical entity. It is exemplified in many different types of personalities, although basically there may be the same unconscious motivations. Formerly, medical doctors and psychiatrists considered the depressed patient to be the greatest suicidal risk. However, it is known
today that there are other types of personality and behaviour patterns
which are as potentially suicidal as is the depressed patient. Suicide
is not infrequent among the psychoneurotic, the psychopathic personality,
the alcoholic and the psychotic, as well as among the apparently normal.

The psychology of suicide is still a rather baffling topic and
a great deal of study and clinical analysis is necessary before a conclusive
theory can be reached. The reluctance or disinterest in the past was
probably due to the traditional stigma and to the mixed feelings concerning
suicide as a social problem. More clinical studies are necessary in that
they provide the logical starting point for preventative measures. Suicide
is, after all, basically a mental hygiene problem and with a more widespread understanding of the act, much could be done by recognizing and
alleviating the conflicts and forces which result in self-destruction.

Much could also be done in Mental Health programs to prevent the early
development of the unconscious suicidal motives, by stressing the danger
of forcing a child through fear, threats and rigid intolerance, to repress
his aggressive tendencies and emotional strivings. Personality tests have
been developed which can reveal certain tendencies in an individual before
an actual attempt is made to destroy his life.\(^1\) These tests might be used
more widely in Mental Health Clinics where treatment is available.

Nothing as yet has been written in the field of social work or
from that point-of-view on the problem of suicide. This is probably because
the suicidal have not been considered or treated as a special group which
could benefit by social work services and case-work treatment.

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\(^1\) The Minnesota Multiphasic Personality Inventory has been tested widely
and it is felt that previously unsuspected suicidal risks can be picked up by this test. The suicidal person will usually evade direct ques-
tions regarding suicidal tendencies but will reveal these tendencies in
answering more indirect questions regarding relationships with people,
aggressiveness, and inner conflicts.
Focus of Study

In the light of this and the information known about suicide, this study is an exploratory study of actual cases of attempted suicide admitted to the Vancouver General Hospital over a period of one year. The focus of the study is to consider the kind of treatment given these patients and what, if any, rehabilitation plans are made for them under the present hospital program. There will also be a consideration of personality factors, environmental and social conditions and family histories as brought out in the medical and social service records of those patients.
Chapter II  A Cross-Section of Hospital Cases in 1948

Setting

The Vancouver General Hospital is the largest hospital in the city with a fairly active Social Service Department. The Emergency Ward is open twenty-four hours a day to receive patients and almost all emergency cases, including attempted suicide, in the city of Vancouver are brought here for treatment and disposal. There is a staff of resident interns and doctors, making treatment of emergency cases possible at any hour of the day. All cases of attempted suicide are given the appropriate medical care on Emergency Ward and then are admitted to the Psychiatric Ward for observation and possible treatment.

The Psychiatric Ward, known as Ward R, is a twenty-eight bed ward. It is equipped to give some treatment, for example shock therapy, but the main function is observation of patients needing psychiatric help. The less severe cases, requiring short-term treatment, are attended to on this ward while the more severe cases, requiring long-term custodial care, are admitted to Essondale Provincial Hospital.

There are five resident psychiatric physicians, one social worker, and a staff of nurses attached to the ward. In addition to the Psychiatric Ward, there is also a Psychiatric Clinic held in the
Outpatients' Department two days a week where patients may receive continued psychiatric help after discharge from hospital or in place of admission. The Outpatients' Department is free service available only to patients eligible according to financial status. Very little actual treatment is offered by the clinic since its function is mainly diagnostic and since most of the patients seen at the clinic are those who have been referred from other clinics for a psychiatric evaluation. However, the psychiatrist may either have the patient return to the clinic for regular interviews, or he may refer the patient to the Social Service Department for continued contact. In this way the clinic acts as a source of support for patients who cannot handle their conflicts alone.

Selection of Cases

With the existing facilities in this setting, it would seem possible to provide a fairly adequate program for suicide patients, and for this reason this study is centered entirely in the Vancouver General Hospital. All the records of patients brought into Emergency Ward during the year 1948 following attempted suicide and subsequently admitted to Ward R for observation and treatment, have been studied. The records of patients who died as a result of the self-inflicted injury are not included, since the focus of the study is primarily on the hospital program and the rehabilitation and adjustment of these patients back to a more normal existence. The records of patients who, on admission were considered to be possible attempted suicides, but proved to be accidental self-injury, are also eliminated. These are few in number and include patients who, in a confused state, had taken an overdose of sleeping pills; patients who, under the influence of alcohol, had accidentally drunk a more harmful liquid such as creolin or rubbing alcohol; and patients who were
unsuspecting gas victims in their homes. Some of these cases might well, with much more intensive study, reveal an unconscious tendency toward suicide. It would seem, however, impractical to include them, since there are no histories on record and very little information available. All other cases listed in the Emergency Ward intake record for 1948 as attempted suicide have been selected for the study.

This study does not attempt to give a true picture of the extent of attempted suicide in Vancouver. It would be impossible to give accurate statistical data for attempted suicide since there must be at least a small percentage of cases which are known only to the family of the patient and to the attending physician, and do not enter the hospital. The purpose of this study is to consider the personality factors and social implications exemplified in the selected cases, with special interest focused on what can be done to help these people readjust their attitudes to life and return to a happier existence in society.

Source of Information

The principal source of information, for initial measurement, is the history obtained by the interne soon after the patient's admission to hospital. Added to this are the doctors and nurses' ward reports and in some cases, where referral has been made, the history obtained by the social worker. The information obtained by the interne is, in most cases, limited mainly to the factors immediately preceding the attempted suicide, and background information emphasizing particularly the patient's medical history. The histories obtained by the social worker, although few in number, give more insight into the patient's early development and social adjustment. The information known about the patient necessarily depends a great deal on the patient's willingness to discuss his problems and his
background, and on the possibility of gaining information from the family or friends. It is important to keep in mind that there is often a tendency on the part of the patient, as well as upon that of the informant, to cover up vital information about which they may have deep feelings, or which they find too threatening to discuss in a brief contact. Further information concerning the patients in this study has been obtained through a search of Social Service Index and the Out Patients' records at the hospital. Wherever possible, any admissions previous or subsequent to 1948 of any of the patients included in this study have also been reviewed, and in many cases additional understanding of the patient has been gained.

General Description of Group Studied

The study includes 71 patients, 32 men and 39 women, ranging between the ages of 16 and 70. The greatest number of both male and female patients in any one age group is between the ages of 34 and 40 years. However, there seems to be a fairly even distribution of male and female patients between the ages of 20 and 40 years, with relatively few at either end of the scale. There are no patients in the age group between 50 and 54 years, no female patients between 45 and 49 years, and no patients between 55 and 59 years.

Even on first consideration of these patients, there seems to be some similarity of personality and psychological factors throughout, although considerable variance in the actual mental health of the individual patients is found. There is also some similarity observed in the social and economic status of this group of patients. The majority are in the lower income brackets, many are unemployed, and several are

1. See Figure 1 illustrating the distribution of patients according to age and sex.
receiving assistance. This might be considered one of the precipitating factors of suicide. It is important, however, to remember that these cases are not necessarily representative of a suicide or attempted suicide group. It is not improbable that many cases of attempted suicide among the higher income brackets are treated privately, and that some of these patients may be hospitalized and treated in one of the smaller hospitals in the city.

A consideration of the marital status of the 71 patients reveals rather interesting facts, indicating in many cases the patient's inability to form a normal relationship with the opposite sex. Among the patients there are far more women who have been married than not. Among the men, there is a fairly even number of married and single patients, the unmarried being slightly in the majority. Of the 43 patients who have been married, there are 16, 7 men and 9 women who are actually separated, divorced or widowed. Of the remaining 27 patients living with their spouses, only 7 patients claim to enjoy a happy married life. These figures indicate a good deal of emotional immaturity and instability among these people. A further breakdown indicates the large number of patients who lead lonesome lives with no family attachments. There seems to be more unhappiness and marital discord among this group than would be found among almost any other group of patients selected for study.

Information regarding the nationality and religion of the patients studied is not adequate to draw any conclusions. The majority of the 71 patients are Canadian born, 16 men and 7 women are recorded as born outside Canada, and of these the majority were born in the British Isles or the United States. There are 45 patients of Protestant religions, and 17 of

1 See Figure No. 2, illustrating the breakdown according to family status of the 71 patients.
the Roman Catholic faith. The remaining 9 either do not claim any religious affiliation, or the records do not indicate it.

Relevant to a study of a group of suicide patients is the method used, the motive behind the act, and the psychiatric diagnosis of the patient. Among the records studied there is some variety in methods used to attempt suicide.\(^1\) An interesting comparison of methods can be drawn between the male and female groups. Poisoning, and particularly barbiturate poisoning, which is a passive means of self-destruction, is most popular among the women patients. Cutting or piercing, which in most cases involves slashing the neck and/or the wrists, is a more violent method and is most popular among the male patients. Many of the attempted suicides are quite spontaneous, without deliberation and planning in advance, so that often the method used is merely whatever seemed most convenient at the time. An element of suggestion might also enter into the consideration of methods used, for example from newspaper write-ups and publicity given to some rather prominent suicide cases.

Many of the self-inflicted injuries are quite superficial in nature, while a few are of a more severe or drastic kind indicating among these patients some variation in the presence of the wish to die.

There is also some difference noticed in the patient's reaction to the efforts of hospital staff to interrupt his efforts to end his life. Some patients are uncooperative, sullen and resentful, while others appreciate help and seem to be thankful that their attempt at suicide was unsuccessful.

There are among the 71 patients, 8 recorded previous attempts of suicide and 2 subsequent attempts, one of which was fatal.\(^2\)

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\(^1\) See Figure No. 4, which gives a diagramatic illustration of the methods used to attempt suicide.

\(^2\) These figures do not necessarily include all previous attempts nor all subsequent attempts among this group of patients. Several of the patients have been admitted to Vancouver General Hospital since 1948 for mental observation, accidents, diabetic coma, termination of pregnancy and other reasons which could suggest emotional instability as well as an unconscious self-destructive tendency.
The motives of suicide are actually difficult to classify, since the recorded motives are of questionable validity. In the majority of cases the apparent precipitating factor of the suicidal attempt is only one of many conflicts, worries or fears which harass the patient's life. The causes of suicide include all things which may bring about an unhappy state of mind. Nevertheless, the external factors are only secondary to the primary causes which lie hidden in the depths of human personalities. For this reason, the motives of suicide will be discussed more fully in a consideration of some of the individual case histories in the next chapter.

To give a general picture of what seems to be the causes of the attempted suicide of the patients under study, the precipitating factors are broken down under broad classifications.\(^1\) In several cases the patient seems to fit into more than one group, but is placed in the category which, according to the record, seems to have had the most bearing on the actual attempt of suicide.

The diagnoses of the patients, made by the psychiatrists at the hospital, illustrate the diversity of clinical types in this group.\(^2\) They are classified into three groups: those given no psychiatric diagnosis, patients with personality and behaviour abnormalities which are not psychotic, and patients considered to have psychotic tendencies. The middle group includes patients varying from almost normal to almost psychotic, and includes diagnoses of Psychopathic or Inadequate Personality, Psychoneurosis, Reactive Depression, Anxiety states and Alcoholism.

Of the 51 psychiatric diagnoses made, Psychopathic Personality

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\(^1\) Refer to Fig. No. 3 which illustrates the precipitating factors or apparent motives of the attempted suicide of the 71 patients' studies.

\(^2\) Refer to Fig. No. 6 which illustrates the breakdown of patients according to the psychiatric diagnosis made at the Vancouver General Hospital.
is the most prevalent. This might be expected in a group of attempted suicide patients, much more so than in a group of successful suicides. However, it is also possible that the diagnosis of Psychopathic Personality is much overworked, and is sometimes a "catch all". The term Psychopathic Personality is used to designate a group of people who appear, up to a point, normal, but whose social behaviour and character sets are deviant. There is apparent disagreement among Psychiatrists concerning the exact definition of the term, and for this reason the term is not too well delimited. The Psychopathic Personality is essentially untreatable because of his inability to learn by experience, his lack of any guilt or anxiety concerning his socially objectionable behaviour, and his inability to form relationships with others.

Almost one-half of the women patients given a psychiatric diagnosis are classified as psychoneurotic, which includes no very well defined personality or behaviour patterns. It includes anxiety patterns, reactive depression and behaviour with neurotic patterns, which are abnormal but not psychotic.

The prevalence of Alcoholism in this group is not surprising, since alcohol addiction is actually just another escape from reality, and the motivations behind it can be compared with those of suicide, bringing out interesting similarities.

Ten of the patients were discharged to Essondale Provincial Hospital for further treatment in custodial care. This group includes five men and five women, and is made up of seven patients diagnosed as Schizophrenic, one as Psychoneurotic, one as Psychopathic Personality and one as Psychotic (unspecified).

The charts and data described in this chapter are given mainly
to provide the reader with a general description of the type of cases used in this study, and do not attempt to provide exacting or significant statistics.
Chapter III  Emotional & Psychological Factors

The act of taking one's life is a very drastic one, yet society will readily and without question accept the explanation that suicide is the logical and simple consequence of ill health, discouragement, financial reverses, humiliation, frustration or unrequited love. This explanation may be accepted partially, since it is possible that if fate had been kinder many individuals who commit suicide would have muddled their way through life. But at the same time, it seems probable that certain individuals would have crashed no matter how favorably life treated them. Suicidal behaviour cannot be understood if only this superficial explanation is accepted. The complexity of motives and many tangled impulses which are a part of the deeper emotional struggles within these individuals must be recognized.

In his study of suicide, Karl Menninger concludes that the deeper motives are "undoubtedly complicated by extraneous factors - social attitudes, familial patterns, community customs, and also by those distortions of reality incident to an incomplete personality development. The same individual whose childhood experiences so inhibited his emotional growth as to make it difficult for him to establish and maintain the proper external objectives for absorbing his loves and hates is
likely to be one whose capacity for testing reality is so impaired as to make suicide "inevitable."

Early Personality Development

From the time a child is a babe in arms, his conception of himself, other people and his environment, is effected by his parents. The child grows and develops, not only physically but emotionally and psychically as well, and through this growth are formed his personality, his attitudes, his reaction to frustrations and his ability to adjust to his environment. There are certain so called psychosexual levels of development through which a child grows, and certain needs must be satisfied at each level through a relationship with understanding and loving parents in order for the child to reach maturity. In other words, it is a process of building sufficient ego strength to handle life situations adequately and to lead a happy, mature existence in society.

The parents, and particularly the mother, are the first source of frustration for the child's untrained impulses. Feeding schedules, weaning and toilet training all represent the first social pressures exerted against the child, and along with love for the parents are engendered fear, resentment and hostility. If these early frustrations are not handled with understanding and affection, the child will continue to search for satisfaction of the needs of this level and be unable to cope with the next level of development. We find many adults with personalities and behaviour which are distorted because they are still searching for infantile satisfactions.

It is at this early age, when the child first experiences both

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feelings of love and hate toward his parents, that he finds it necessary to repress or force out of his conscious thoughts these unacceptable feelings. Where a child is given the satisfactions he needs, these hostile feelings are sublimated and only a normal amount of aggressiveness remains.

Personality Patterns of the Potential Suicide

The suicidal patient, it is found, almost invariably has been thwarted in his emotional growth early in childhood, and he has been forced to repress most of his aggressive impulses and therefore turns them inwardly. Feelings of guilt and dissatisfaction with his behaviour arise, and in many cases self-criticism grown into depression and eventually into self-destructive tendencies. These inner conflicts do not always result in suicide, but often do when accompanied by some frustration, disappointment or loss in the external environment.

The basic emotional attitudes of suicide patients seem to be fear, anxiety, inferiority, hatred, aggressiveness, guilt and revenge. Most of the patients show patterns of immaturity and instability in the way they approach life and its problems, and particularly evident is the inability to form mature and satisfactory relationships with other people. This is shown quite clearly in the previous chapter, in which the marital status of the 71 patients was described. Almost 80% of the patients, who have been married at one time, have not been able to maintain a happy relationship with their spouses. This is further brought out in the records of these patients, in which the reason for the suicidal attempt of 25% of the 71 patients is recorded as marital difficulties or disappointment in love. These reasons, as recorded, may be only the precipitating factors but nevertheless do indicate further the inability
of many of these people to be happy with other people.

It is impossible, in this study, to illustrate with any degree of certainty the deep, unconscious impulses and emotional conflicts which lead each of the patients to attempt to destroy his own life. These can only be implied in some cases, in the light of the patient’s symptoms and behaviour, since it is possible only through psychoanalytic studies to gain insight into the unconscious life of an individual.

It is possible to illustrate, from the background and developmental histories of several patients, how their personality development and emotional stability could have been distorted, and could have affected their basic attitudes toward life. The failure to free oneself from parental ties, an unnatural attachment to mother, early deprivation of mother’s love, unsolved Oedipus conflict are all situations where the individual is preoccupied and confused in his efforts to solve these emotional needs. As a result he is unable to handle frustrations in the present or to make the most of his own potentialities and strengths. He is unable to cope with life and its ups and downs in a mature manner, but must build up defenses to protect himself against reality. If these defenses are shattered or he is compelled to face reality, he must find some escape. Suicide is one very final and unrealistic escape.

Another escape is the psychosis, which may be precipitated originally by the individual’s inability to cope with reality. In some ways it is a kind of suicide, in that it is destruction of the personality. The psychosis itself might even be considered a substitute for the actual suicide, but not always a permanent one. Many psychoses are accompanied by deep depression, feelings of guilt and self-deprecation. Thoughts of self-destruction often materialize when the opportunity presents itself.
Among the patients suffering from psychosis or psychotic intervals, suicidal attempts are not unusual, and are not considered as difficult to explain, since psychotic behaviour is often unpredictable and drastic. On the other hand, when the non psychotic person, whom to the layman appears to be normal, attempts suicide, there is often difficulty in attempting to explain what made him do it; and because the individual is not psychotic, the suicide episode may be dismissed as an attention getting device, a dramatic or impulsive act or the "only way out".

When an individual attempts to take his own life, whether he is psychotic or not he is resorting to drastic actions which must be caused by a great unhappiness with himself and the environment in which he lives. The behaviour is not normal or healthy, and is invariably precipitated by deep emotional conflicts which are not apparent from a superficial examination of the person.

The apparent motives, discussed previously, could not of course, be the only reasons for the patients' drastic behaviour. There are, in every case, less obvious but complicated conflicts which contribute more to the suicidal behaviour than do the apparent precipitating factors recorded. Some of these emotional conflicts and difficulties suffered by the patients, apart from the expressed motives are illustrated in several case analyses of the patients in this study.

Case Histories

Most of the records do not provide, in any detail, the actual developmental and family history of the patient. In some cases this is impossible and in most, the patient would not discuss this aspect in such a short contact. However, much can be seen underlying some of the fears
expressed by the patients and in the behaviour described in the nurses' ward reports.

The Burden of Guilt

A sense of guilt, whether based on conscious behaviour or on unconscious impulses, may become a terrific burden for an individual to carry. Sometimes the individual is able to relieve the burden by some form of conscious atonement or confession, or in a less healthy way, by rationalization or by projection, and thereby gain some relief. However, when this feeling of guilt arises from unconscious asocial or forbidden impulses and wishes, the means of relief are more difficult and there usually arises an unconscious need for self-punishment. The extent of the self-punishment may vary from self-denial, minor self-mutilations to the more severe punishment of self-destruction.

The pattern of unconscious atonement and punishment motives is illustrated in the following case studies.

Case No. 4: The patient is a 25 year old single woman of Roman Catholic faith, who attempted suicide by cutting her wrists with a carving knife in March 1948. She was employed as a machine operator in a Vancouver Bank.

The patient is an unhappy woman, very tense and anxious. She has a great deal of guilt concerning her general behaviour and states that she has never really confessed her sins. She is not able to make decisions or cope with her difficulties.

The patient's greatest worry is that she will become pregnant, and she constantly feels that people are looking at her. She states, "All my life I've worried about being in the family way. I went and asked a Doctor in X., if I was pregnant and I'd never even had intercourse with a boy. Why am I so crazy?" These worries were intensified and became almost morbid after she had intercourse with her fiance, even though she was told by a doctor that she was not pregnant.

She has always dieted to excess because she did not want to get fat like her mother, and also because she was afraid she would look pregnant. She has frequent crying spells and headaches. On the ward she expresses the feeling that her life is aimless and that she has not a friend in the world.
The most significant factors in the case are the patient's fear of pregnancy and sense of guilt over her general behaviour, neither of which have a realistic basis and arise from unconscious impulses.

The intensified fear of pregnancy might logically arise from a wish to become pregnant and, going deeper into the unconscious, from incestuous desires resulting from an unresolved father attachment. Her feelings for her mother are brought out also in her excessive dieting and in her desire not to be like mother.

This patient's behaviour does not seem to have been such to warrant her deep sense of guilt, yet she expresses the need to "confess her sins" and indirectly her need for punishment. Her suicidal attempt was probably an unconscious means of self-punishment and it is interesting to note that she chose a rather violent method to do it.

A very similar case, where the patient has guilty feelings and worries concerning her sexuality is next cited.

Case No. 27: The patient is a 36 year old, married woman of Protestant faith, who attempted suicide in October 1948, by taking an overdose of barbiturate pills. On admission she was very depressed, weepy and remorseful. She has had feelings of guilt concerning her sexual frigidity for about six years. She has a fear of alcohol and has been imbibing moderately, particularly when she is depressed.

Her husband is a civil engineer, and his work takes him out of the city frequently. The patient talks on and on about her unhappy marriage and seems to assume most of the blame for this herself. Speaking about her husband and 3 year old daughter, patient says, "she is a dear little girl and so is Norm — but I'm not".

Here again there is no history nor any attempt to get at the patient's inner conflicts. There is the same pattern of guilty feelings and excessive worry. The patient has conscious guilty feelings because of her sexual frigidity. Actually, the guilt arises from a conflict over sex, which prevents her from having an orgasm, and thus results in frigidity.
There are several unconscious motives underlying sexual frigidity, of which the fear of punishment, unconscious hatred and revenge might apply in this case.

A more intimate knowledge of this patient's emotional and psychic life would no doubt reveal a great deal of hostility, particularly toward her husband. Since her husband is kind to her, she cannot express this hostility directly or outwardly. The only outlet for the unconscious feelings is therefore, probably through sexual frigidity, which gives rise to guilty feelings and a need for punishment.

The feeling of guilt may be unconscious and manifest itself in depression, or in physical symptoms such as headaches and worries. The following case illustrates this unconscious guilt where the patient has excessive worries, centred particularly around sexual behaviour. The patient is considered to have more psychotic tendencies and is discharged to Essondale Hospital for further treatment.

Case No. 61: A 34 year old single man of Roman Catholic faith attempted suicide by drinking iodine in September 1948. He is a carpenter by trade and has made poor progress in the employment field.

This patient is very unhappy and expresses a great deal of worry about his sexual activities. He feels he is abnormal sexually and insists that he needs an operation to prevent erections. He is also worried about his feelings when he sleeps in the same bed with a man. He talks freely and quickly about his sexual practices and states that he never considered marriage because of his sexual disabilities.

He also feels that people talk about him and this worries him. This patient's fears seem to embody a lot of unconscious guilt centered around his sexual activities. A sense of guilt is particularly liable to become evident in connection with violation of sexual conventions. This patient's guilt is no doubt based on homosexual tendencies, which he
represses and attempts to hide by talking about his excessive sexual activities.

Usually associated with guilt is a need for punishment and in this case we find the patient insisting on an operation which the doctors do not feel is necessary. This seems to be a good example of an unconscious wish to be castrated, where castration is a means of punishment. Dr. Menninger deals with this in his study and he states, "castration, both actual and symbolic, has been used throughout the ages as a punitive device." "It sacrifices everything and gains almost nothing except punishment and the secondary advantages of passivity".1

All three of these patients have excessive worries, which seem to be centred around sexual matters. There is a general feeling of unhappiness and weariness of life, a feeling of being alone and a feeling that people are taking about them. Although it can only be an assumption, there seem to be present the unconscious emotional factors which contribute to suicidal tendencies. There is repressed hostile aggressiveness, the resulting guilty feelings and the need for punishment.

The Loss of Love

The loss of a loved one, either through death or separation is very often a precipitating factor of suicide. In the normal person, when a loved object is suddenly taken away, there is a period of sadness and depression, followed by gradual readjustment to a life without the loved one. The psychology of grief is complicated by several factors in an individual's unconscious feelings. With the loss of a loved object, there is a loss of narcissism, a feeling of hostility because of the desertion, and a desire to punish the incorporated love object. This mixture of

1 Ibid., page 271.
feelings results in depression or punishment of self which is felt as grief. The pattern of grief in an immature or emotionally confused person may become accentuated and grow into a pathological reaction. The immature individual who, because of his unsatisfied needs in earlier stages of development, and his infantile mode of loving and being loved, has deep dependency needs and cannot stand thwarting or frustrations. His relationships with the outside world are characterised by strong ambivalence. In other words, his love attachments usually conceal a great deal of unconscious hostility caused by frustrations in the oral stage of his development, the period of nursing and weaning.

Attached to this unconscious hostility are usually death wishes, which may have been conscious at one time, but are repressed and disguised by a conscious attitude of love, protection and obedience. When the loved object is suddenly taken away, the unconscious hostility and death wishes are revived because of the frustration. The death of a loved one is often associated with the death wishes, and a sense of guilt and the corresponding need of punishment arise. The individual struggles with this terrific inner conflict, in which the sense of guilt attached to the repressed emotions causes the unexpressed hostility to become self directed and eventually result in self-destruction.

This close attachment, based on hostility and guilt is well illustrated in the following case.

Case No. 32: A 42 year old married woman of Roman Catholic faith attempted suicide by barbiturate poisoning in December 1948. She just does not want to live any longer and says what she wants most is to meet her mother. Her mother died a year ago from cancer of the bowel, and following her mother's death the patient had a "nervous breakdown".

The patient has a chronic chest condition and worries about tuberculosis. She drinks considerably and has taken drugs.
She has been married and divorced twice and is now living in a common law relationship.

To one not familiar with psychiatric histories, this would appear to be the story of an unstable woman who overreacted with grief to the loss of her mother. Careful study of the facts, however, reveals much more insight into the underlying motivations for the patient’s behaviour.

It seems quite evident that this patient has an abnormal attachment to her mother, which prevents her from enjoying a normal mature love relationship. A chronic chest condition, such as asthma, bronchitis and even tuberculosis is thought to be associated with deep dependency needs that cannot be met in reality, and because of this fact, they conceal hostility. Her drinking and periodic drug addiction are also considered to be means of satisfying oral dependency needs, an attempt to gain love and affection in an infantile manner. It is interesting that following her mother’s death the patient had a nervous breakdown, which illustrates her inability to cope with the reality situation and the pain caused by the desertion. She may have had repressed death wishes for her mother and because of these, felt unconsciously responsible for her mother’s death. The nervous breakdown is, after all, a withdrawal or escape from her conflicts and it also recreates for her a dependency situation, since she probably has to be put to bed, and cared for as a baby by its mother. In this case, the nervous breakdown may have been a substitute and deterrent of the actual attempted suicide.

The loss of a loved one, not by death, but through jilting or withdrawal may also precipitate self-destruction where the individual has many unsatisfied oral needs. Here again there may be death wishes which give rise to a sense of guilt. The impulses, if expressed consciously would represent murder, so are repressed and turned inwardly. Dr. Freud
states, "many suicides are disguised murders", 1 since through introjection
the individual attempts to destroy the loved one by killing himself.

Case No. 2: The patient is a 30 year old single woman of Roman
Catholic faith, who attempted suicide in February 1948 by
drinking lysol. This is her third attempt in six months.

She is an intelligent, fairly well educated woman, and has
done well in the business world as a saleslady and buyer. She
seems to have led a fairly normal life in society until August
1947, when she first attempted suicide by hanging. This was
precipitated by an unhappy love affair, in which her fiance lost
interest in her. This incident occurred in an eastern city, and
following it she returned with a nurse to Vancouver where her
father, step-mother and sister live.

She is uncommunicative, confused and weepy on the ward and
does not know why she attempted suicide, other than that she is
tired of being alone and feels she has been alone all her life.
She bites her nails, cries and is very quiet, although her
reaction to insulin shock seems to bring out a different type
of behaviour, yelling, screaming and throwing furniture.

This patient seems to be determined to kill herself, and one wonders why
it is that a woman, apparently successful in her career, should suddenly
develop such unpredictable behaviour and react so violently to an upsetting
love affair.

Some of this patient's background history brings to light interest­
esting speculations regarding the causes of her inability to cope with
frustrations. The patient lost her mother when she was two years old.
She and her younger sister lived with an aunt until she was 5 or 6 years
old, when her father remarried. She then went to live with her father and
step-mother. She was sent to a convent for part of her high school
education. She has always hated her step-mother and, as an adult can not
get along with her. During her second admission to hospital, the patient
said, when referring to the step-mother, "it's because of her that I've
had all this trouble". She talks quite a bit about her father and says

1 Freud, Sigmund, Collected Papers Volume II, London, Hogarth Press,
1933, page 220.
that he is heart broken, and cries because she is sick.

The early deprivation of maternal love and care could mean only one thing to a child of two - rejection and thwarted oral satisfactions. The patient is still searching for this infantile love, and has repressed the hostility and resentment she feels because of the deprivations she has suffered. Her step-mother apparently did not provide the satisfactions of early maternal love, and only meant to the patient a person with whom she must compete for father's love.

It is not improbable that the love affair which caused so much distress to the patient was one in which she demanded a great deal of love and was herself unable to give mature love in return. The lover may have been a "father substitute" for the patient, and when he left her, it may have revived the old feelings of rejection she must have had when her father deserted her for her step-mother. She has suffered a series of losses, first her mother through death, then her father through marriage, and now her lover. Her suicidal attempts may be motivated by both murderous wishes and also a desire to get even or obtain revenge.

The patient's inner hostility is shown overtly in her reaction to insulin shock but is otherwise deeply repressed. It is reasonable to assume that the patient has definite ambivalent feelings, typical of the oral personality, toward her loved ones. When deprived of her lover, the hostility is increased but becomes self-directed since it cannot be expressed consciously. The patient's oral characteristics are further shown in her nail biting, and by the ingestion of lysol as a method of expressing her suicidal impulses.

A similar pattern of unconscious conflicts, arising from the feeling of desertion, is observed in the following case.
Case No. 58: A young, Protestant man of 23 years, who has been married twice and is now living in a common law relationship. He attempted suicide in August 1948 by taking an overdose of phenobarbital and nembutal two days after his "wife" walked out on him. He has a baby daughter by his first marriage, who is in the care of a provincial children's agency.

He is sullen and uncooperative on the ward and tells his story, punctuated with outbursts of weeping. He lacks perseverance, and has a history of being very dependent. He speaks of his mother as "the swellest person alive, a grand woman"; his closest friends are a brother and sister-in-law.

The patient admits that he has spent one year in jail for robbery and car theft. He is recorded as "emotionally and intellectually immature with limited standards of morals and ethics". The doctor recorded, "there is some marital upset which is disturbing the patient".

The patient’s dependence and weakness of character are probably connected with his strong attachment to his mother. A more intensive study of this patient's unconscious feelings would probably reveal feelings of hostility and guilt, along with his dependence and attachment to mother. It might also reveal his unconscious desire for a mother person in his choice of a wife, and this may be the basis for his inability to establish a stable marriage. When his wife deserted him, he felt more strongly, all the old repressed impulses and feelings of hostility which become self-directed.

Many of the records of these patients show much the same pattern. Case No. 57, a 48 year old man says he has been depressed ever since his wife left him. He drinks heavily and guesses he is "just tired of living". Case No. 42, a 39 year old man was feeling blue because his wife left him and he "just does not want to live any more".

Suicide in Adolescence

A quarrel with a parent or an upsetting situation in the home may be a precipitating cause of a suicidal episode. Among teen aged children, a disagreement with a parent is not unusual, since during the
period of adolescence a child is striving to emancipate himself from parental authority, and to identify with the group. However, it is unusual for such a disagreement to result in attempted suicide. Where suicide does occur, it is often accidental, as the child only intends to impress on the parent how sorry he would be if anything happened to the child. In the average home, where children have been able to develop normally in their emotional growth, such disagreements, when they arise, are handled adequately and forgotten.

The following case illustration is one in which nothing more than a family quarrel was the precipitating cause of a teen aged patient's attempted suicide.

Case No. 53: Patient is a 19 year old single boy, who attempted suicide by ingestion of aspirins and Frost's tablets. The day of the episode, he had a quarrel with his father, broke a silex of hot coffee over father's back, ran up to his room and threatened to jump off Burrard Bridge. He locked himself in his room and by the time his parents forced in the door, they found him semi conscious with empty tablet bottles beside him.

The cause of the quarrel is not recorded, nor is the content or duration, but it is most unlikely that any single quarrel between a father and his teen aged son would be adequate motive for suicide. It is necessary, therefore, to look further into the boy's behaviour and parent relationships. This patient is unduly attached to his mother. He is an introverted, quiet, studious boy, who writes poetry which he gives to his mother.

It seems reasonable to say almost definitely that this situation would appear to be one in which the "Oedipus situation" has developed into a pathological complex. The normal "Oedipus situation" arises in the development of every child between the ages of 3 and 5.

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1 This patient was discharged to his parents, after four days in hospital, to be followed up as a private patient by a psychiatrist in the city.
years, in which the child chooses the parent of the opposite sex as a love object. When handled satisfactorily by understanding parents it is sublimated, and the child continues to develop normally. Out of the Oedipus situation arise, in the case of little boys, the wish to kill or get rid of the father and take the mother. The reverse situation occurs for little girls. These desires are complicated by social taboos, and so must be repressed. This patient seems to be struggling with this situation and in his unconscious desires and wishes to possess his mother, he harbors competitive and hostile feelings toward his father. The suicidal episode is probably the only way he could cope with the terrific guilt and fear of his repressed death wishes and hostility, which came so close to the surface during the quarrel. The repressed wishes, guilt and hostility found expression in an attack on himself.

These cases illustrate several different precipitating causes of suicide, many conscious anxieties and unconscious conflicts. There does seem to be some similarity in the emotional and psychological immaturity of the patients, many unsatisfied needs, and a continual search for satisfaction. The unconscious hostility, aggressiveness and the punitive drive all seem to be a part of the individual personalities. These impulses are turned inwardly against self, as shown in the individual's feelings of guilt, feelings of worthlessness, and lack of desire to live.

The case illustrations discussed in this chapter are only a few of the many records studied. These have been described in the attempt to illustrate some of the emotional factors and psychological implications involved in suicidal behaviour.
Chapter IV  Hospital Treatment of the Suicidal Patient

Recognition of the emotional conflicts and complexities of problems in lives of the patients who attempt suicide is only preliminary to cure. It is imperative that a good hospital program and treatment plan be available to these patients, in order to help them overcome the upsetting episode, face their problems more realistically, and rehabilitate to a more satisfactory existence. Basic to the treatment plan, of course, is medical attention, to repair the physical damage done, and to restore the patient's body to normal functioning. Immediate medical treatment - picrotoxin to neutralize barbiturates, stomach lavage to remove harmful substances, sutures of slashed wrists, stimulation to keep a gassed victim breathing - must be administered to keep the patient alive. However, the repair of the patient's physical condition does not, except perhaps superficially, change the patient's emotional conflicts. The repair of a "sick" mind - and it must be admitted that any individual who will consciously attempt to destroy himself has a sick mind - is not a simple matter. There is required a great deal of time and effort on the part of both the patient and the therapist.

The therapist must have time to build a therapeutic relationship with the patient, gain an understanding of the patient's unconscious conflicts, and be able to assess the patient's strengths and abilities to
accept interpretation of his conflicts. The therapist must be able to
give the patient something he needs emotionally in this relationship. He
must be able to accept hostility, aggression, and dependence from the
patient. Only when such a relationship is established is it possible to
re-educate the patient emotionally and ideationally.

In many cases the patient cannot accept interpretation of his
behaviour. Here the therapist must use supportive therapy, with which to
help the patient build personality strength and an ability to face life
realistically. Once this strength is built up, the therapist will begin
to give insight as the patient appears ready for it. Suicidal patients
seem to require a good deal of support and reassurance, since the majority
have very little ego strength, as shown in their inability to face reality,
their dependence and their oral characteristics. This support can be
given through a relationship with a mature, understanding person, who is
aware of the patient's needs, and is able to continue this relationship
beyond hospitalization into the period of rehabilitation. This is an
area where the social worker can perform a valuable service. Besides this
supportive therapy, there is usually a need for environmental therapy, in
which the environment is manipulated to suit the needs of the patient.

The Present Program

At the Vancouver General Hospital, attempted suicide patients
are given immediate medical care on Emergency Ward, before being admitted
to the psychiatric ward for observation and possible treatment. Each
patient is interviewed by a psychiatrist who makes his diagnosis and
recommendations regarding treatment. After the medical treatment is
given, the hospital program stops short of anything more than a perfunctory
consideration, in most cases, of the underlying disturbances involved.
and little is done to mitigate the psychological or even social factors. The psychiatric consideration of these patients is mainly to determine what sort of persons they are, to calculate the risks of recurrence, and to assess psychotic tendencies. A diagnosis, which seems to be often rather stereotyped, is made for the purpose of hospital records; if the patient is not psychotic in his behaviour, and does not verbalize any suicidal intentions, he is discharged to his family or to his old environment, which has frequently been a contributing factor to the suicidal episode.

If it is decided that the patient would benefit by shock therapy, he is given this treatment, and is kept under observation. Among the patients in this study, the only ones given this type of treatment are those who were very depressed, including patients diagnosed as manic depressive (depressed), reactive depressive, psychoneurotic (anxiety) and psychotic (unspecified). In most cases where treatment is given, the patient is kept in hospital longer, but discharged as improved soon after he begins to take more interest in living. There is seldom any planned preparation for discharge, or any follow-up plan for the patient, yet often the record indicates that he is still in need of a great deal of help which he does not get.

Over half (39) of the 71 patients were discharged from hospital within four days of their admission, and another 22 were discharged by the second day. The longest hospitalization period among these patients was 46 days, and only five patients of the whole group were hospitalized 30 days or more. This refers only to hospitalization in Vancouver General Hospital, and does not, of course, include the extended hospitalization

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1 Refer to Figure 6 which illustrates the length of hospitalization.
Figure 6: Length of Hospitalization

- 1 to 2 days
- 3 to 4 days
- 5 to 6 days
- 7 to 8 days
- 9 to 12 days
- 13 to 26 days
- Over 30 days
of the ten patients discharged to Essondale. At Essondale, the patient is given very close supervision and custodial care, but actually very little treatment. In short, the length of stay in hospital is extended principally because of the patient's need for prolonged medical attention to his injuries, and seldom for prolonged psychiatric help.

In most cases actually no psychiatric help is given, and the patient is discharged to face the same problems and difficulties from which he so recently attempted to escape. He may appear to be psychologically improved, which is possibly due to the "shock treatment" effect of the suicide attempt, or he may be relieved as a result of the acting out of his impulses. This improvement however, can only be temporary. The patient returns to his old environment, with the same unconscious conflicts and problems, and gradually sinks back into the same old pattern again.

No follow-up study could be made for the entire group of 71 patients studied. In some cases, through perusal of records of subsequent admissions to Vancouver General Hospital, or through subsequent contact with other social agencies, it is possible to determine what has happened to the patient following his discharge. There are only two subsequent attempted suicide episodes known among this whole group, but several patients have been readmitted to Vancouver General Hospital for various reasons since 1948.

There seems to be evidence that few of these patients who are allowed to go after a brief stay in hospital to repeat the attempt.¹ For

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A study of over a thousand records of attempted suicide cases admitted to Boston City Hospital was done in 1937 by Dr. Merrill Moore. Although no follow up study could be done for the entire group, only 5 patients were known to have repeated the attempt and Dr. Moore concludes that, unless the psychological aspects are treated there is no obvious reason to detain the patient.
this reason it is felt to be unnecessary to detain the patient if he
wishes to leave, particularly since the psychological aspect of the
difficulties of these patients is so little dealt with. However, even
though the patient does not again attempt suicide, he still has the
unconscious tendencies and the mental unhappiness to plague his existence.
Furthermore, it is impossible to know how many of the patients, when faced
with later frustrations, will be unable to carry on. This study is being
done less than two years after the patients attempted suicide and as
previously mentioned, some of the patients are known to have attempted
suicide before, and many have been hospitalized for psychiatric treatment
at some time prior to 1948.

Premature Discharge

The records indicate that when many of the patients leave
hospital they are not ready to be discharged, without at least a close
follow-up contact, in which reassurance and support could be given to
help them to readjust.

Case No. 27: The patient is a 36 year old married woman who
is depressed and anxious, has many worries and guilty feelings,
particularly concerning her sexual frigidity.

During her two days in hospital she talks on and on about
her unhappy marriage. She is weepy and remorseful. On the
day of discharge she is recorded as being restless, crying for
long intervals and feeling remorseful. The doctor wrote in
the record, "patient is fit to go home in the company of her
husband".

This patient was given no psychiatric treatment or help with her many
emotional problems. She is diagnosed as being psychoneurotic (anxiety
state) and discharged to her husband, for whom it is suspected she has a
great deal of unconscious hostility. This attitude has no basis in
reality, so is converted into frigidity, and is accompanied by feelings of

1 This patient was previously discussed in Chapter III.
Case No. 36: Patient is a 31 year old married woman who attempted suicide by barbiturate poisoning, following a family misunderstanding.

The patient has been under undue pressure and tension for a number of years, struggling with the feeling that she cannot reciprocate her husband's devotion, and has been using such means as alcohol and excessive work to compensate her inadequacies.

Several years ago, she found the struggle too much, became depressed and confused. She was given a series of electro shock treatments on Ward R, but did not settle down completely, and was discharged. The patient is diagnosed as psychoneurotic (anxiety state) and discharged on the second day after admission. On the day of discharge, she is at times on the verge of tears, and rather pathetically states, "I'll go home and be pampered for a few days and then it'll be the same as ever".

The doctor recorded: "The urgent condition has subsided, but there needs to be a good deal of psychic adjustment if the more or less constant emotional dissipation is to be relieved. Many of her problems are real but without a satisfactory solution".

This woman was discharged in much the same emotional state as was observed on admission. She is obviously unhappy in her home situation, and is desperately in need of professional help to overcome, what seems to her, the insurmountable pressures and tension. The doctor's record indicates a recognition of the patient's need for psychic adjustment, but there is no attempt made to help her with this adjustment. She returns to her home, and her husband, who is probably confused by her behaviour, and indirectly and unknowingly, he is probably one of the causes of her emotional conflict.

Much the same situation is observed in the following case.

Case No. 33: The patient is a 38 year old married woman who attempted suicide by barbiturate poisoning because she felt she was a nuisance and bother to her family since her last "nervous breakdown". The diagnosis made is psychoneurosis (anxiety state).

She is depressed, anxious and takes no interest in her surroundings. She was admitted to Ward R two years ago with a breakdown "due to overwork and worry". The patient says "when
I went home from here I didn't feel quite able to take over. I wasn't too bad at first, until my stomach went, then I got worse and worse.

She does not always get along with her husband; he drinks and she does not. She also states that he is not very passionate sexually, but that they manage to get by. She worries about her husband because he is not contented; he wants to be a farmer.

The patient was in hospital 15 days, during which time she was given a series of shock treatments, and showed some improvement. She was allowed to go home for Christmas day (11 days after admission) which she enjoyed, but found very tiring. At this time, the doctor recorded, "Patient still listless and apathetic but improving. Can be allowed home but husband cautioned that she will need close observation".

On the day of discharge the patient was worried about whether or not she should go home. "I could rest just as well at home I guess, but then New Year's is coming and there will be drinking and stuff. Maybe I should stay where it's quiet until Sunday".

This patient has many worries and it is not difficult to see that her unconscious emotional conflicts are great. It is impossible, from the record, to know just what these conflicts are, but it seems apparent that much of her difficulty is based on her unconscious feelings toward her husband. She shows some improvement after electro-shock treatment, but there is no attempt made to get at her underlying feelings, or to help her understand her conflicts. This case also illustrates the effect of a premature discharge two years ago, and the question arises, if there had been adequate help given and follow up contact, could this present suicidal episode have been avoided?

Many of the patients are discharged as unimproved after a few days in hospital, where release forms are signed by parents or spouse. One patient states, "I only hope I'll stay well and not begin to think that people are watching me all the time". Another patient is "very anxious about facing people again". Another states, "just won't let myself think of the ideas — can't imagine where they come from". On one record, the doctor's report reads: "Rather unhappy woman with many aches
and pains, possibly functional and some organic. On top of this some personal problems”. These are all sick people, and certainly not in a mental and emotional condition to be "tossed back into the sea of life" without some help or support.

The patient may be improved to the point where he is just about able to handle his difficulties reasonably well. When, however, he returns to his old environment, the old impulses, which he does not understand, gradually build up the old feelings of guilt, anxiety and self destruction, yet these do not come to a climax until some particular frustration occurs, which may be in one year’s time, in ten years’ time, or never.

Case No. 35: A 32 year old married woman attempted suicide by gas poisoning in December 1948 for the second time. Her first attempt was in 1938, by drowning. She received little or no treatment at that time, but returned home to her husband.

During this hospitalization, 10 years later, she is resistive at times, but is on the whole fairly co-operative. She says she loves her husband very much, but fears that he does not love her. She states that she can not have another child, and she wants one very badly. Before turning on the gas at her home, she left a note stating, "don’t try to save me because I’ll do it again".

She was discharged after 11 days in hospital, during which time she was given only medical treatment. She is diagnosed as a psychopathic personality.

As far as is known, the patient has not attempted suicide since this last attempt one and a half years ago. She has not had any professional help with her problems, but has returned to the old environment which must have had some bearing on her previous drastic behaviour. This is only one of several similar situations of patients who are in and out of Ward R. This patient is not given treatment, since the diagnosis is psychopathic personality, and is hence considered untreatable.

Limitations at Vancouver General Hospital

The limitations and inadequacies of the present hospital
program for psychiatric patients are not entirely unrecognized by the psychiatrists and hospital staff. There is a very definite need for more space, more beds, more treatment facilities, and more staff with psychiatric training and skills. At present, the tendency is to avoid any efforts to get at the deeper motives of the suicidal act. The effort is concentrated more on interrupting the patient's self-destructive urges for the present, and upon repairing his physical injuries. There is no intensive treatment given, due partly to the pressure of work, and partly to the lack of skilled people capable of giving this type of treatment.

The Psychiatrists feel that, to the majority of the patients who attempt suicide, it is impulsive and sometimes attention getting behaviour and that the possibility of recurrence is slight. The diagnostic appraisal is felt to be fairly accurate with not too high percentage of error.

Much of the treatment and the follow up work with suicide patients could be done by a trained social worker, under psychiatric consultation. Here again, at Vancouver General Hospital there are limitations. Only one social worker is attached to Ward R. She has, in addition to Psychiatric Ward, the Neurology Ward and the two corresponding clinics at Outpatients Department, for which she handles all referrals and obtains social histories. It would be impossible for one social worker to attempt to do intensive treatment or follow up work, under this arrangement, for any more than a very small number of patients.

Medical Treatment

In some cases the treatment is fairly adequate, especially in cases where the precipitating factor of the suicide attempt is ill health, or concern regarding physical condition. Medical care is given to relieve
the immediate worry, and often the patient gains a good deal of reassurance and support during this time, and begins to feel that life is worth living after all. Granted, the patient may still have unconscious suicidal tendencies; nevertheless, it is thought that almost everyone has some traces of these tendencies, and the extent of their manifestation depends on the frustrations in the external environment, and upon the individual's ability to cope with them.

Case No. 40: The patient is a 69 year old married man (Protestant) who cut his throat with a jack knife because he just could not stand the suffering and worry caused by his physical condition.

The patient has had shortness of breath for 5 years, and was given a diagnosis of angina pectora. Three weeks ago he caught a cold, and when the condition became worse, he called a doctor, who gave him some pills, told him he would get better and then "walked out" on him. This upset him very much and resulted in the attempted suicide.

The patient was a locomotive engineer, now on pension. He seems to have led a normal, happy life. His wife and 3 children live in a small town outside Vancouver. Patient is in Vancouver temporarily, as "his breathing is easier here".

On the ward, the patient is quiet and co-operative, and seems to have a desire to get well. He talks about his family with affection.

On admission it was discovered that this patient had broncho-pneumonia. He was hospitalized for 17 days and given immediate treatment until the pneumonia was cleared up. He left the hospital in a much improved condition physically and emotionally.

Case No. 56: The patient is a 62 year old single man (Protestant) who slashed his wrist and throat because he felt that, in his run-down condition and ill health, life is not worth living. He is receiving assistance from the city.

He is co-operative and friendly on the ward, and after recovery from his wounds is ashamed of himself, and expresses the desire to live.

He is diagnosed as psychoneurotic (reactive depressive) with arteriosclerosis and pneumonia. He was hospitalized for 14 days, during which time he was given medical care, including
blood transfusion and sutures to wrist and neck. This patient was also discharged in a much more healthy physical and emotional condition. However, he is obviously a lonesome old man, and has nothing much to return to. There is no plan made to help him readjust, nor any consideration of referral to any other agency, such as a community centre for example.

These two patients are examples of where medical treatment was important and therapeutic. Particularly in the first case, there is actually no serious emotional or social problem involved. Medical treatment is, of course, important in every case, but it is not sufficient by itself.

Psychiatric Treatment

Sedation and restraint are used in many instances as treatment methods for patients on the psychiatric ward, but as previously discussed, shock therapy is the main treatment given, and this only to a few patients. There are several theories regarding shock therapy as a treatment for patients with certain mental illnesses. One theory, which seems quite feasible, is that this treatment is such a severe shock to the body that all the forces are mobilized against destruction. The basic drives are reverted from destructive to constructive and self-defense activities. Another slightly different theory is that "a serious disturbance of memory and association is created, and this affects particularly the most recently acquired or more recently elaborated set of ideas. Shock therapy is definitely more effective in cases where psychotic elements in thinking and behaviour have been recently developed".¹ Even though the patient does improve in attitudes and interests, there is still an absence of

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complete insight into the nature of the past disturbance. There should be, along with shock treatment, psychotherapy or insight therapy.

Shock therapy does, in almost every case, shorten the course of mental illness. It brings the patient more quickly into a state of responsiveness to psychotherapy and other types of therapy. If this additional help is not given, there is little hope of gaining any degree of permanent improvement in the patient.

Of the group of patients studied, only eight were given shock therapy during this period of hospitalization. Five of these patients were considered to have definite psychotic tendencies, and three were diagnosed as psychoneurotic. They are patients who are depressed, and in some cases an improvement is observed following treatment, in that the patient becomes more interested in living, and in returning home. All were eventually discharged to relatives or friends. They usually showed little improvement. The small number given treatment in this group does not include the 10 patients who were admitted to Essondale Provincial Hospital, where they probably received a similar type of treatment.

A few case illustrations are helpful to show the use of electro-shock treatment and the patient's response to it.

Case No. 8: The patient is a 29 year old married woman of Protestant faith who attempted suicide in May 1948 by barbiturate poisoning.

She is diagnosed as acute anxiety state with depression. She is hospitalized for 13 days, during which time she is given a series of Electro-shock therapy which brings about a marked improvement in the patient's attitude and behaviour.

The patient attempted suicide because she "can't cope with life". She and her husband were in Vancouver, staying at a hotel. She did not want to go home, because she feels she cannot look after the baby or the house. She says she knows she is mentally unbalanced.

On admission, she is uncooperative, refusing treatment and food because she does not want to get better. While in
hospital she repeats several times that she has a baby she hates, and that they "can't afford a baby". She has apparently been feeling "down" ever since she found she could not look after her baby and home. The baby girl is one year old. She also states that her husband is too good for her and when first admitted she did not want her husband to see her.

During her series of treatment, the patient became more cheerful and cooperative, and mixed more with the other patients. After treatments were completed she was very pleased to see her husband, and when discharged was eager to go home.

This patient responded well to electro-shock therapy, showing a definite improvement. However, it is wondered how lasting this improvement can be when the patient has so many conflicting feelings, both conscious and unconscious, toward her baby daughter, her husband and her home. She is temporarily improved, but without an understanding of her underlying feelings which lead her to self-destruction, the improvement cannot be permanent.

Another example which illustrates the pros and cons of shock treatment is the 25 year old single woman, who had the unusual worry concerning pregnancy and guilty feelings about her general behaviour. She was diagnosed as reactive depressive (schizophrenic type). She was hospitalized for 16 days, and under treatment she became less worried and showed more self-assurance and initiative recalling past incidents as foolish. There was no attempt to understand the patient's underlying conflicts, or to give her any understanding of her own behaviour and her emotional problems. When discharged she said, "I only hope I'll stay well and not begin thinking that people are watching me all the time".

Case No. 24: The patient is a 64 year old married woman, who attempted suicide by taking an overdose of sleeping pills, because she does not like the place where she lives. The diagnosis is manic depressive.

She is depressed, does not sleep well, complains a great deal, and is worried and anxious.

1 Patient (Case No. 4) discussed in Chapter III.
This patient was hospitalized for 26 days, given a series of electro-shock treatments, and discharged with little improvement seen. The patient is very anxious about facing people again after attempting suicide.

There is very little information on record concerning this patient, other than that she is depressed, miserable, and worried. It is apparent that she needs help. She is considered to have psychotic tendencies, but they are not serious enough to warrant committal to the Provincial Hospital. In this case, considering the age of the patient, intensive therapy would probably not be very useful and possibly not necessary, but help on the environmental level would be valuable. Nothing is recorded of any follow up help, or of any consideration of referral to a social work agency.

Case No. 28: The patient is a 55 year old, married woman of Protestant faith, who attempted to drown herself in English Bay in November 1948 because "this seemed to be the only way out".

On admission she is extremely depressed and almost totally uncommunicative. She is recorded as saying, "why can't you let me die?" and, "leave me alone, I don't want anything, you can't help me, no one can". She refused to talk to her husband when he visited the first time. She seems to have feelings of neglect, "nobody loves me".

The patient's husband states that she has always been subject to attacks of depression, which have recently been more intense. Lately she has also developed paranoidal tendencies. Although she is usually not particularly religious, on the day of the suicidal episode she acted peculiarly, and asked to see a minister. The record states that her husband seemed to be of very low intelligence, peculiarly lacking in sympathy and understanding. He rushed off before a history could be taken, and without talking to the doctor.

The patient was hospitalized 9 days, and a diagnosis of psychosis (unspecified) was made. She was given 2 electro-shock treatments, and showed a little improvement. On the 6th day in hospital she said "I'd like to go home today, if my husband will take me" and when discharged she said, "my husband isn't working, I can't afford to stay here".

Other significant remarks recorded are, "If I could just get things straightened out in my own mind, then maybe I could explain everything to the doctor", and "I just won't let myself think about the ideas I had — I can't imagine where they come from".
Because this patient seemed brighter and more interested in going home, she is discharged to her husband, who has been recorded as lacking in sympathy and understanding. She is obviously struggling with many feelings and impulses which she is trying to understand and solve, but cannot without help. There is no attempt made to understand these conflicts which have led to suicidal behaviour, nor any real effort to prevent a recurrence.

The following case is another example of where partial treatment is given, but stops far short of helping the patient gain any confidence in himself, or in tackling his environment.

Case No. 55: The patient is a 25 year old single man of protestant faith, who slashed his neck and wrist in July 1948 because "the future holds absolutely nothing" for him. He studied economics at the University for 2 years, but could not settle down, so he quit a year ago and has worked as a concrete mixer since, although he is unemployed at this time.

He has been depressed for 2 weeks, feeling that he is a failure and has never been able to make a success of anything. He can not keep a good job, and has not enough money to keep a girl friend. "The last straw" was when he could not get back into the Airforce. He states, "I have such a disgusting lack of backbone".

On the ward he is recorded as cooperative, but quiet, staring at the ceiling or reading constantly. He tries to maintain a "don't care" attitude. He is not illogical or disjointed, and has no delusions.

The patient was hospitalized for 38 days, during which time he required considerable amount of medical attention to his lacerations. He was also given electro-shock treatments. When discharged, he showed some enthusiasm about going home, but was vague about plans for the future, where he will go, or what he will do. He is diagnosed manic depressive.

This patient is an unhappy young man, who has potential intelligence and ability, held back by his emotional conflicts. It is impossible to know just what these conflicts are from the information available on record, but his feelings of inadequacy and disinterest in the future must stem from earlier unsatisfied needs. Following electro-shock treatment, he shows more enthusiasm about going home, but he is not
given any help to straighten out his confused feelings, nor to establish himself in a more interesting and satisfying environment, in which he could use his abilities and gain some feelings of usefulness.

These cases discussed illustrate particularly the use of electroshock as a treatment method, and certainly appear to indicate the need for psychotherapy in addition to the physical type of treatment. There should at least be a follow up contact with the patient, to supply a "crutch" or support until he is able to make a satisfactory adjustment.

The Psychopathic Personality

Of the large number of patients untreated, other than medically, many are considered to be psychopathic personalities and non-treatable. The psychiatrists feel that many an attempted suicide episode is purely an impulsive act, where the patient is seeking attention in a dramatic way. There is also felt to be an amazing lack of concern on the part of the patient regarding his drastic behaviour. The patients showing this pattern of reaction and behaviour are considered to be Psychopathic Personalities,¹ and make up the bulk of the attempted suicide group. Certainly, this may be true to some extent. It might be expected that among a group of individuals who make unsuccessful attempts to kill themselves, there are a number who are not serious in their intentions, nor concerned about their behaviour. However, at Vancouver General Hospital there seems to be a tendency to treat many cases of attempted suicide, rather lightly, and a readiness to dismiss them as Psychopathic Personalities, who are incapable of learning from experience, and incapable of accepting or benefiting from treatment. This attitude may be further influenced by the fact that there is no adequate treatment.

¹ Refer to previous discussion of Psychopathic Personality in Chapter II.
available in any event, and also, by the fact that the number of reoccurrences are very few.

As previously mentioned, there is considerable disagreement or inconsistency in the definition of a Psychopathic Personality. One theory is that the true Psychopath is actually untreatable, since the distortion of his personality is considered to be caused by an organic deficiency. Even when the individual is raised in a favorable environment, he is deprived of moral and social sense. This definition, were it accepted universally, would limit the number of patients diagnosed as psychopathic Personality. The more popular conception of Psychopathic Personality seems to include behaviour which is not psychotic, but is more of the neurotic element, characterized by instability, provocativeness, aggressiveness and bad judgment. The individual seems to be lacking in that part of the personality which makes up the "conscience". Thus he is incapable of any sense of guilt or self-reproach. If this is true, there could be no need for self-punishment, and therefore, serious suicidal attempts are very unlikely.

The psychopath may make a superficial suicidal attempt by some painless method, as a means of dramatically attracting attention, of gaining sympathy, or of causing concern to others. But it seems unlikely that a true psychopathic personality would seriously attempt suicide.

Many of the patients in the group studied, who are diagnosed as psychopathic personality, seem to fit this pattern fairly well, from the information available on record. The suicide attempt is quite superficial and there seems to be very little concern or feeling regarding their behaviour. There is a long history of instability both in employment and in social and marital relationships, and, there is in several cases, a criminal record. On the other hand, several patients, diagnosed as
psychopathic personalities, seem to be serious in their suicidal attempts, and seem to have many unsatisfied needs and unexplained conflicts, which might be alleviated to a degree by some form of help.

Case No. 41: The patient is a 37 year old single man of Roman Catholic faith, who attempted suicide by cutting his throat with a straight razor. He is reported to have swallowed iodine previously. There is no recorded motive for this patient's attempt, but the doctors consider the episode to be a form of exhibitionism rather than depression.

On admission he is sullen, resistive, uncooperative, and when questioned regarding history replied, "I never kept a diary, how do I know". He is diagnosed as psychopathic Personality (inadequate), and discharged after 11 days in hospital, during which time he required a considerable amount of medical treatment, sutures, blood transfusion and penicillin.

The history that is known about this patient, was obtained from his Army records, and it was felt that because this man has a long history of inadequate personality, nothing was done. The patient was discharged on his own responsibility. He states that he can return to his former boarding home, and during his hospitalization he asked for, or mentioned his landlady several times, and wished that she or her husband would come to see him and forgive him. They were not contacted by the hospital.

This patient, diagnosed as psychopathic personality, does not fit too well into the group who have no concern regarding their behaviour. True, this may have been an impulsive act, but was not merely a superficial attempt, and required a considerable amount of medical attention. The patient is immature, unstable, and has an inadequate social adjustment, but, when one considers his developmental history, this is readily understood.

The patient's mother died when he was an infant, and he was raised as an only child by his father. There was no housekeeper, and the neighbours looked after patient when his father was working. The patient attended school for 4 years and got along fairly well. Following this, he
helped his "old man" on the farm until he was 25, when his father died. Since this time, he has worked at various jobs and has been fired because of his drinking. He was in jail once. He worked fairly steadily for two years until he was called into the Army in 1942. Because of his flat feet he could not march, so was made a Hut Orderly.

This patient has had an emotionally deprived childhood, in which he did not have even a mother substitute to give him the satisfactions and care he needed. He had no siblings, who might have helped build his social and cooperative senses. In his alcoholic bouts and possibly in his dependence on his landlady, he is searching for satisfaction of these early deprivations. His interest expressed in the landlady and her husband may indicate that they are filling a role for him as parents. He has probably never had a satisfying relationship with anyone, as shown in his history of broken home, poor work record and inadequate social life.

It seems possible that this patient could have been helped, to some degree, although it would take a long time to form a therapeutic relationship with him, in which he could feel that someone is sincerely interested in him, understands his problems, and has a desire to help him. Certainly more help could have been given on the environmental level, not only in employment but also in his social and emotional adjustments, by encouraging him to join group activities, and to develop some interest in recreation, which would help him to work out his feelings and express his hostility and aggressiveness, in a healthier way.

Similarly, many patients diagnosed as psychopathic personalities have been emotionally deprived in their development, and as a result, have difficulty in their social adjustments, relationships with people, and in handling frustrations. Referring back to the 42 year old woman, discussed
in a previous chapter, who over-reacted with grief after her mother's death, this patient is diagnosed as psychopathic personality.

From the analysis of this case, it was felt that this unhappy woman repressed her hostility and possible death wishes, which gave rise to a sense of guilt and the feeling that she should be punished for her forbidden impulses. The first reaction was a nervous breakdown, followed a year later by an attempt to destroy herself. Because of the diagnoses however, she is considered untreatable, and is discharged on the 4th day in hospital, receiving no help with her problems nor any support after discharge. Her trouble does not seem to be lack of "conscience", but more to be a struggle with an overly rigid set of standards.

If this patient could have been helped to see her real feelings toward her mother, to look at them objectively, and to understand why she feels hostile, her guilt and need for punishment might have been relieved. This process of re-educating her emotionally would, of course, involve a long, close contact with an understanding person, skilled in personality dynamics and treatment methods. The patient could not accept interpretation of her inner needs immediately, as this would be too threatening to her. The interpretation would have to be gradual, as she would progress only as she became emotionally capable of accepting it.

These case illustrations have been discussed to illustrate the hospital program at Vancouver General Hospital for patients admitted following attempted suicide. Treatment in hospital for such patients involves medical, psychiatric and social techniques, each being important in the attempt to bring the patient back to physical and mental health. Evidence in the present study indicates that all patients receive immediate and adequate medical treatment, but the treatment of these

1 Case No. 32, Chapter III.
patients who are disturbed to the point of attempting suicide falls far short in the psychiatric and environmental sphere. There is almost no treatment of the underlying psychological disturbances or of the social situations involved.
Leaving the hospital situation and returning to the old environment and family situation is a difficult change for the suicidal patient to make. He must return and face the things from which he so recently attempted to escape. He must face his family, his associates and his neighbours, whose attitudes are influenced by the misunderstanding and social stigma attached to suicide. He must return to a family situation in which his underlying needs are, in all probability not being satisfied; and these frustrated needs cause conflicting feelings which he does not understand. The rehabilitation of a patient, following attempted suicide, is extremely important, and should be considered as a necessary part of the treatment plan for the patient.

Individual Needs of the Patient

A thorough study of the patient as an individual is necessary - what are his needs, his strengths, his ability to cope with reality situations, his interests and his conflicts. Every suicidal patient, it must be agreed, has some emotional conflict, and thus needs help regarding his emotional problems. This should be, at least started at the hospital, and should involve therapeutic techniques such as supportive therapy, insight therapy, and group therapy. This help can, of course, be carried on
after discharge, and should not necessarily terminate when the patient leaves hospital. Besides the internal emotional conflicts, there are usually external factors in the patient's environment which have precipitated the suicidal episode. Therefore, the patient also needs help on the environmental level. Much of this help can be given through proper use of other social agencies and community resources. The patient may need help in adjusting to, or in changing his home situation. He may need financial help; he may need guidance and help in the employment field or in his vocational choice; and he may need help to cultivate group interests, or to establish himself in group activities.

Rehabilitation Begins in Hospital

The significant aspect of the Vancouver General Hospital program is that, attempted suicide patients are always admitted to the psychiatric ward for observation and psychiatric assessment. They are assessed according to their psychotic tendencies, stability, and the extent of their suicidal impulses. This, of course, is important because patients who are psychotic, and will require long term treatment in custodial care, can be committed to the Provincial Hospital, while patients who are temporarily depressed, can be retained here in a protected environment until the depression lifts. However, the psychiatric ward routine is particularly important, since it provides the opportunity to observe each patient over a period of time, in order to make an adequate diagnosis, and to understand the patient's conflicts before any treatment and rehabilitation plan can be recommended. This is not always done at this hospital, as is noted, and the patient is often discharged within one to four days, during which time it would not be possible to make an adequate assessment of his needs.
It seems probable that every case of attempted suicide involves a social problem, and affects more people than just the patient concerned. The factors involved are very often not considered by the hospital staff, and, if known, could throw a considerable amount of light on the patient's personality, his background, and his present behaviour. For this reason, the social aspect should be an important consideration in the hospital program for these patients. The social or environmental treatment of the attempted suicide patient is an important component of the hospital program, and should be administered by the social worker. The social worker's role in the professional team should be well defined, since it can be invaluable.

The Social Worker in the Medical Setting

In a medical setting, the role of the social worker is understandably different to what it is in public or private social agencies, where the individual comes to the agency specifically for casework services. In the hospital, the social worker must fit into the administrative structure, and must work only with patients referred by the doctor for casework services. It is only recently that the medical profession has begun to recognize the value of the social worker in the hospital, as a part of the treatment services to the patient. At Vancouver General Hospital, the social worker is concerned with patients who are referred by the doctor for some specific service, such as obtaining social histories, or giving environmental help. Occasionally referral is made in which casework help is expected.

To give case work services or treatment, it is necessary for the social worker to have only a small number of patients in order to do intensive work with some and to give environmental and supportive help
to all. The role of the social worker depends on the number and kind of referrals made, the cooperation and help received from the psychiatrists, and on the skills and capability of the worker to give the help required.

The Social Worker in Rehabilitation

The treatment and rehabilitation plan for each patient should include a careful enquiry, with the aid of the social worker, into the developmental and family history and the present family situation. This would require contact with both the patient and the family, and would be the beginning of the social worker - patient relationship, which could be carried on past the period of hospitalization into rehabilitation. In the actual hospital program for the patient who is not too severely disturbed, the role of the social worker would be mainly that of assisting the psychiatrist, by collecting additional information and by giving the patient the feeling that someone is interested in him. The important aspect of the social worker's role would be in rehabilitation and follow-up work for each patient, but should not necessarily be restricted in the treatment program.

A desirable program of treatment for suicide patients would be one in which the psychiatrist and social worker act as a cooperative unit assisting each other. Only to a limited degree is this the case at the Vancouver General Hospital. The hospital treatment administered to the 71 cases, in this study, includes the services of the social worker only superficially and, in the few instances where referrals are made by the psychiatrist, it is a request only for the social worker to obtain information from another agency or from relatives of the patient. In one instance, the patient was referred to the Social Service Department for payment of the ambulance bill. There are no social service records
for any of these patients in which the social worker has direct contact with the patient on a treatment basis.

The Social Worker in a Treatment Role

This is one area where the trained social worker can be very valuable in a hospital setting. The training given a social worker equips him with an understanding of personality dynamics, skills to help the patient verbalize his feelings, an awareness of defenses or devices used by the patient to cover up or hide his real feelings, and also certain skills in treatment methods. The four main types of treatment or casework methods which may be used by a social worker, after a careful study of the patient and his background, are: environmental or social therapy, supportive therapy, insight therapy, and counselling.

Environmental or social therapy is used to influence or modify various factors in the environment, where the causation of the problem seems to be strongly influenced by external forces. Where the causation is completely in the emotional areas, or is from internal forces, then supportive and insight therapy are used.

Supportive therapy does not change the individual basically, but helps him handle his problems personally by "borrowing" strengths from the worker. This type of treatment relationship is used for people without insight or without sufficient strengths to accept it. For those individuals who have the capacity to use insight, and to change within themselves, insight therapy is used. This type of treatment requires the most skill, and also requires that the worker be aware of his own attitudes and feelings, as well as of those of the patient. The growth of the patient depends on a process of transference, in which the worker is unconsciously identified with someone in the patient's personal life.
For instance, the worker may take on the role of a parent or relative, and accordingly, the patient may be as "petulant as he was with his mother, as rebellious as he felt toward his father, as erotic as he would like to have been toward his sister or cousin. He can be this way, feel this way, and even speak it out because it is understood, not censored but interpreted to him".¹ This transference and dependence is the key to the treatment process, and is also the most difficult aspect for the worker to handle. It is usually advisable to have psychiatric consultation when giving insight therapy.

All social workers are equipped to give supportive and environmental therapy, but many are not skilled to handle insight therapy. However, with psychiatric consultation and further training, this is a skill which is being developed and used by many social workers.

The fourth casework method, counselling, is usually used for individuals who are fairly well adjusted, who can talk things through, and are capable of making decisions. This type of treatment would not be used to any extent as compared to the other methods, in working with attempted suicide patients.

What Could be Done at Vancouver General Hospital

The Vancouver General Hospital has a framework in which a fairly adequate program of treatment and rehabilitation for suicide patients could function. The psychiatric ward and psychiatric clinic provide the facilities to make a thorough study of each patient, and to establish a good treatment and rehabilitation program. The study of each patient would be done on a cooperative basis, with psychiatrist, social

¹ Menninger, Karl, Man Against Himself, Harcourt, Brace and Company, 1938, Page 446.
worker, psychologist, and nurses, all working together. Treatment and rehabilitation plans would be discussed, in conference, after the assessment has been made.

Each suicide patient should be detained on the psychiatric ward for a specified time to allow for this clinical study. Adequate records should be kept for future reference to the patient, for teaching purposes, and to assist further research on suicide. The recommendations for disposal of the patient will vary for each case. Follow-up after discharge is essential, and should, wherever possible, make use of the existing social agencies and resources in the community which offer various kinds of help to certain individuals. In some instances, it may be felt that referral to a private social agency, along with psychiatric recommendations, would be an adequate plan. In other instances, the patient may require a longer hospitalization, with intensive psychotherapy and follow-up in the psychiatric clinic, or continued contact with the hospital social worker, under psychiatric supervision.

It is not enough merely to assess the patient's suicidal tendencies and, being satisfied that the possibility of recurrence is slight, to discharge him on his own responsibility, with no follow-up. The suicidal episode is merely a dramatic manifestation of the extent of the patient's real difficulties, and to treat the patient it is necessary to go further than a superficial assessment of suicidal tendencies.

The present study reveals many inadequacies and limitations in the treatment and disposal of attempted suicide patients at the Vancouver General Hospital. To improve this service to suicide patients, there must first be an increased awareness of the seriousness of suicidal behaviour, better understanding of the unconscious motivations of suicide, and more recognition of the needs of these patients. Secondly, there is
a need for increase in skilled staff, with an understanding of personality dynamics, and an increase in the physical facilities of the ward and clinic.

Prevention in the Community

Suicidal tendencies and underlying conflicts do not usually manifest themselves in actual self-destruction unless the frustrations and pain of the external environment contribute as well. Because of this, much can be done on the environmental level to prevent suicide, since material conditions and group patterns are both inhibiting and encouraging forces. Suicide is, however, always a personal reaction. It is the final response which a human being makes to his inner emotional distress, and since the underlying motives, hidden from superficial investigation are, from a psychological point of view, so complex and so completely a part of the individual's personality, psychoanalysis or intensive psychotherapy are probably the only real preventative or treatment methods.

In the broader aspect, society itself can help ward off self-destruction to some degree by providing more security for the individual. Some organizations and groups do have a philosophy which give the support and help to the individual needing it. Most religions provide him with a form of protection and with a philosophy to guide him, thereby easing the tensions of life. The cathartic effect of confessions and atonements, as religious rites, aids in satisfying the feelings of guilt and anxiety, and is often a deterrent to the more severe punishment of self-destruction. Even some political organizations contribute in the struggle against self-destruction by providing more economic security. Recreational centres and community resources of this nature have a
definite value, by providing a healthy outlet for aggressiveness and hostility in a socially acceptable manner, without the guilt and anxiety which usually follow.

In the legal field, suicide and attempted suicide are regarded as crimes. If there were more acceptance of suicide as a mental health problem, the courts might cooperate in the program by making referral to clinics and hospitals, and by insisting on adequate treatment for the individual before he is discharged. It would be necessary, of course, to have adequate treatment facilities available.

There should be medical facilities where suicidal patients may be given an adequate psychiatric examination, and, if possible, some definite treatment which includes social casework services. Before discharge, recommendations should be made for a therapeutic program and a follow-up plan. Individual cases of suicide attempts should be more intensively treated and studied, to provide more help to the patient, and also to increase the meagre knowledge of the essentials of the problem.
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