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# SUICIDE*

## PSYCHOPATHOLOGY

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FOLLOWING the invitation to participate in the symposium on suicide, I sat one evening in the quietude of my study and allowed my thoughts to wing their way hither and yonder around this topic, only to realize that what at first had appeared to be a well-defined and circumscribed subject, in no time became a rather complex one, such as to lead me into various speculations about the mysteries of life as well as of death. Time and time again I had to remind myself that I had to prepare a clinical paper on the "Psychopathology of Suicide", and that it was necessary for me to curb my philosophical meanderings. And yet, to understand suicide one has to give due consideration to the attitudes which people, both "normal" and "abnormal", have towards the idea of death and of dying. As well expressed by Bromberg and Schilder,[1] "death is not a true opposite of life. Language is deceiving in this respect. Death does not have the meaning of the final experience. This is partially due to the fact that the deepest of human emotions are invested in the experiences and thoughts of death and dying. One's psychic structure is too deeply involved with death."

The meaning of death has been the object of numerous speculations throughout the ages, theology and philosophy, of course, having been the main disciplines concerned with the problem. Any average individual sometime or other during the course of life has given a thought to death, and even to suicide, though such thoughts are obviously much more frequent in individuals suffering from psychiatric disorders. Death has a different meaning according to whether the patient is suffering from anxiety hysteria or from obsessional neurosis, from depression or schizophrenia. In the hysterias the meaning of death is mainly one of separation from the beloved one, and the main fear expressed by individuals suffering from neurotic anxiety is that of sudden death either of themselves or of another person to whom they are attached by a close emotional tie. Sudden death in such cases means a separation from the loved object, and suicide a means of reunion with that object.

Schilder and Wechsler in their study of the attitude of children towards death found that children are quite ready to accept the idea of death of others, since death to them is merely separation from the loved object and consequent deprivation. "And since the child's own deprivations are usually not of a permanent or lasting nature it is easy for the child to wish the death of others. This general attitude of children towards death may be found quite clearly in some neurotic patients, death in such cases being feared as a sudden removal." Bromberg and Schilder defined the meaning of separation due to death as separation in space symbolically represented

> "by the religious fantasy of a soul being taken away from the body by angels to receive corporeal reality itself as an angel later. For the average person death is simply a cessation of existence, but infantile (primitive) and allegorical fantasies place another construction on the separation of the dead from the living. In Norse mythology one sees the same tendency, such as for instance, the Valkyries bearing dying warriors off the field of battle to Valhalla. Again, in the legend of King Arthur, the warrior is borne away on a watery bier to a land from whence he will emerge again when his countrymen need him. The Greek legend of the boatman Charon and the river Styx carries the same allegory."

This idea of separation from the loved object is a common fantasy among hysterics.

In cases of obsessional neurosis where aggression is discharged chiefly towards the external world, the idea of one's own death does

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not come into the foreground until more and more aggression is directed towards the self, in which case the fear concerning one's own death may become obsessional. Death, in such cases, becomes eternal punishment. "Death is not any more the separation in space, as in the hysterical group, but punishment by dismantling for an unlimited time. Eternal immortality is thus psychologically accomplished."

In cases of depression, "the idea of eternal destruction is paramount. Death is eternal destruction in time. The preoccupation with death ideas and the nihilistic delusion found in melancholias bring this out. In the latter type one meets again and again the idea of wide and eternal destruction. It seems that the feeling of guilt does not recognize limitation of time, but is indestructible and tends to perpetuate itself."

To the schizophrenic patient as well as to primitive people, death is not absolute, since for them only eternity exists. These authors suggest that the problem of death is closely connected with the problèm of space and time. "We not only live in space and time but we project a change in the space and time relations in death."

Neither neurosis nor psychosis produces an attitude towards death which cannot be found also in the so-called normal, but neurosis and psychosis bring specific attitudes clearer into the foreground.

The analysis of the meaning of death attitudes amongst normal and abnormal individuals leads one to believe that in some people suicide fantasies are aimed at injuring society, a wife, a husband or other loved one, these fantasies representing unconscious death wishes. In other people such fantasies show a desire for increased love or punishment of persons in their surroundings, and in others again death has the meaning of the perfect union, a union with an ideal which could not be found in life.

An example of the latter is the case of the woman of about 60 who was admitted to hospital following a very serious and nearly successful attempt at suicide. Her beloved son had died in a rather unusual accident a few months previously. She had other children, but her attachment to this son was quite inordinate to the point of incestuous intensity. Her loss was so painful and so distressing that she actually denied to herself her son's death and daily spoke of him as if he was still living. It was only months later that this denial mechanism (unconscious) proved inadequate, and it was then that she attempted suicide. It is significant that once resuscitated she again spoke of her son as if he was still living.

The mode of suicide itself may give us some understanding of the motivations of the patient and of the fantasies which led him to such a drastic step.

Hendrick[3] illustrates a case of suicide as wish-fulfillment by the analysis of an unmarried professional woman of 38 who deliberately "rolled off" a high bridge very late one night into the icy waters of a large river with the intention of drowning herself. There was severe amnesia for the 16 hours preceding the episode. The only recollections of this experience were that she had left her home in her automobile early in the preceding morning. She had "driven in circles" all day. She had had nothing to eat. Late that night she had found herself on this unfamiliar bridge, several hundred miles from home, and left her car at the entrance of the bridge. She learned later that a passer-by had seen her fall from the bridge. She was rescued and hospitalized for two weeks. The subsequent six months she lived with her mother, avoided all people including her family, was unable to resume her work, and was constantly preoccupied with fantasies, anxieties and hallucinations of a predominantly schizophrenic type. A brother, two years her senior, had served as an airman during the World War, obtained the status of "ace" and had been shot down and killed in aerial combat. His heroic death was the final event of an unusually hero-like life. During childhood, school and college he had been idolized by family and friends, especially by his mother and the patient. Her brother was the only man she had really loved. During analysis she recalled that before leaving her apartment on the morning before she dropped from the bridge, she had decided to commit suicide by taking a boat to Europe and drowning herself in the ocean when exactly half-way across. She had prepared herself by donning special clothes, including a sweater of a special shade of blue. She had decided to arrange her death so that the family would not learn of it for two months and there would be no funeral. She recalled several forgotten incidents of the 16-hour drive, and very vividly the experience of driving for hours "round and round in circles". Her associations during the recovery of these memories showed that many details were reminiscent of the death of her brother. His plane was reported to have fallen in a wood and he had been buried there. (Actually, two years before this attempt, patient had attempted suicide by swallowing 20 Allonal tablets with suicidal intent and was found unconscious in a wood.) The special clothes she had worn after deciding on suicide were associated with tomboy activities which had been conspicuous traits of her childhood, and the shade of blue of the sweater approximated the shade she adored because it was the colour of a sweater worn while playing baseball with her brother. The idea that she would not have her death discovered for two months was the rationalization of the thought that her brother had died without a funeral and that the family had not learned of his death until exactly two months after it had occurred. Her memories of driving in circles and striking her ear on the water (she did not at first recall how or why she finally arrived in the neighbourhood of the bridge but remembered vividly striking the water on her ear) were now associated with vivid visualizations of the airplane falling in circles and striking diagonally on the wing. Thus the patient discovered that she had wished to die in the same way as her brother had died, that she had dressed in clothes associated with her childhood identification with him in playing baseball, that her two original plans for suicide were derived from the place he died in the woods in Europe, that the family would learn the news after the same interval of time which had elapsed after the hero's death, and that she had imitated the falling airplane in her 16 hours of driving in circles, and "remembered" striking her ear because the airplane's wing had struck the ground. In other words, this

patient wished to identify herself with her brother in the act of dying.

### THE COMPLEXITY OF THE PROBLEM OF SUICIDE

This brief outline of some of the attitudes towards death amongst people serves to illustrate the complexities of the problem of suicide and the need to understand the emotional background of the patient, not only on the basis of his conscious life experiences, but also on the basis of the unconscious forces which often influence human behaviour just as powerfully as conscious dynamics, if not more so.

I am not minimizing the importance of stress-precipitating factors, be they physiological, biochemical or psychological, or of environmental, social, cultural and other numerous influences, but I am suggesting that caution be exercised in the interpretation of data and in arriving at conclusions which may be based on insufficient awareness of all the facts of the case. For instance, it has been asserted that there exists a definite relationship between the incidence of suicide and of certain weather changes.

> "It is the very error of the moon,
> She comes more near the earth than she was wont,
> And makes men mad."

says Shakespeare in "Othello".

Mills[4] kept a day-by-day record of suicides and barometric-pressure readings for a period of five years in the Kansas City and Memphis areas, and found repeatedly that sudden peaks in curves for suicides coincided sharply with a low-pressure crisis. We all know that during periods of falling barometric pressure we tend to feel somewhat depressed and pessimistic, whereas during periods of rising pressure we tend to feel buoyed up and more alert; but it would be a rather rash conclusion to state that a falling barometric pressure is, in itself, an explanation of suicide.

Family trouble, pain, remorse, drunkenness, abject poverty and numerous other motives have been adduced as the determinant cause of suicide, but often what are called statistics of the motives of suicide are actually statistics of the opinions concerning such motives by people who are not necessarily equipped to determine the cause or causes of such a complex phenomenon and who, therefore, tend to explain the motive of suicide on the basis of a few hastily collected bits of information. Dürkheim[5] in his sociological study of suicide aptly points out that as soon as some of the facts commonly supposed to lead to despair are thought to be discovered in the victim's past, further search is considered useless and his drunkenness and domestic unhappiness or business troubles are blamed, depending on whether he is supposed recently to have lost money, had home troubles or indulged a taste for liquor. Actually it is a known fact, for instance, that people who are suffering from acute physical illness and severe pain rarely commit suicide. There are, of course, exceptions to this general rule, such as the patient whom I was called in to see in consultation in one of the public wards of the Montreal General Hospital where he had been admitted following a determined attempt at suicide. A man of about 50, he was destitute, living in a room by himself, in constant pain and practically unable to eat because of an inoperable cancer of the throat. My psychiatric assessment was brief and to the point: I wrote, "So would I." It is significant that that was one of the few occasions in which I was complimented by my medical colleagues for having "common sense, even though I was a psychiatrist".

The absence of the idea of death in the minds of those physically ill and the frequency of it in the minds of the neurotics and psychotics appears to find confirmation in the frequently observed fact that the occurrence of physical disease may greatly improve the mental state of the melancholic. The patient suffering from melancholia who has been monotonously and with agitation accusing himself of being an unworthy person may cease to do so and may actually recover completely from the depression when overtaken by a severe infection or injury.

A female patient of about 40 has been subject to phases of severe depression lasting for a period of one to four months for the past 10 years, such depressions having required several admissions both to a general hospital and to a mental institution. This patient has also been subject to acute attacks of cholecystitis and cholelithiasis, but the gallbladder symptoms have always been absent during one of the phases of depression, and conversely they have always been present in the intervals free of depression. This case, like many others, poses a rather interesting problem when deciding whether the gallbladder should be removed or not. To date, a cholecystectomy has not been performed, but should the time arrive when surgery becomes imperative, there is a great probability that the patient will either become psychotic or that some other body organ will break down physically.

It is not sufficiently recognized that many of the physically ill patients seen daily in any one of the medical or surgical wards of a general hospital are there because the physical structure has given in instead of the emotional one. It is today common knowledge that careless psychiatric management of some patients suffering from ulcerative colitis may precipitate the onset of an underlying psychotic process.

A 50-year-old man was admitted to hospital in a comatose state following a determined suicidal attempt due to severe depression. He was treated by electroshock, the treatment of election in cases of endogenous depression. After the first treatment he complained of pain in the back, radiography showed compression fracture of two adjoining vertebræ, and it was decided to postpone further E.C.T. However, the patient's mental condition improved so promptly and so consistently that he was discharged from hospital without further treatment. This patient was followed up for several months and his improvement persisted. Other factors, of course, may have come into play in his prompt response to one E.C.T., such as, for instance, the reduction of guilt obtained from the self-imposed punishment, a psychological mechanism which is not infrequently met with in patients who try, unsuccessfully, to kill themselves.

### Is Suicide Always an Irrational Act?

Does a normal person ever commit suicide, or is suicide always the act of an irrational human being? This question still remains unanswered. Some people believe that suicide can be quite a rational act arising from despair in a perfectly normal individual when exposed to great misfortune. Others believe that suicide can occur only in people who are, at least at the time, "unsound of mind". Sociological, religious and cultural factors all tend to affect the opinion of people in this complex matter. Throughout the centuries there has been a constant search for a specific pathological etiology of suicide. In his historical review Zilboorg[6] outlines some of the changing concepts on this topic. He points out that St. Augustine was one of the first to postulate suicide as a sin. "The Council of 452 A.D. decreed suicide as the work of the devil. Plato, almost 25 centuries ago, was inclined to believe that suicide was a dishonourable act since a citizen had no right to deprive society of his civic life without the permission of a magistrate. In the old days in England, the estate of a suicide reverted to the Crown, and the bodies of the victims were buried at crossroads with a stake driven through them in an attempt to pinion the 'evil spirit', thus preventing it from wandering about doing harm.

"The word 'suicide' was introduced to the law about 1700 A.D., coupled with the phrase, 'while temporarily insane'. The latter statement was added as a pious perjury on the part of the jury to save the family from poverty and disgrace. Examples of suicidal death are found in the earliest recorded history of people. Aristotle condemned the practice of suicide, but it was enforced by the Greek state for political and military offenders. Seneca, on the other hand, stated, 'If life pleases you, live; if not, you have a right to return whence you came.' "

Lewis[7] points out that suicide became more prevalent in Rome as the state became weak and corrupt, but it became less with the acceptance of the Christian religion, "the pendulum swinging so far in the opposite direction that the act became a crime against Church and State. The law in many countries even today considers suicide a crime, and this tradition of disapproval has transformed itself in modern times into belief that suicide is restricted to 'insane' persons." This conflict of opinions—conflict which also finds its expression in the ambivalency of popular opinion, suicide being looked upon with a mixture of contempt and admiration—reflects the wide discrepancy in the understanding of the psychodynamics of human behaviour, some people basing their judgment largely on external factors and on conscious motivations, and others on the deeper structures of the mind with emphasis on unconscious motivations.

Today, in the light of our improved knowledge of psychological mechanisms we, as psychiatrists, have learned to respect increasingly the powerful forces of unconscious processes, and we tend to challenge the assumption that suicide can be committed by a "normal individual". Lewis[7] concludes as follows:

> "From the numerous unsuccessful attempts at suicide on record, from the prevalence of suicidal thoughts periodically appearing in many people who never take action, and from extensive psychoanalytic studies, one is justified in inferring that suicidal trends are present in practically all persons, but at least some of these reactions are different from actual suicide itself, which is a complex affair, appearing in its fullest expression only in those who have a particular type of integration in which the elements have a specific pathological orientation in the adaptive function."

### Psychopathology of Suicide in Depressions

In histology, one may avail oneself of the eyepiece of the microscope or of the lens having the lowest magnifying power in order to have

a fairly extensive view of the tissue under study, and more particularly of the relationships existing between the various structures, but because of the low magnification this method will not give us a clear view of the morphology and composition of any single cell. In the same way, in the study of suicide one may survey the field in an extensive manner and consider manifold factors such as cultural, economic, sociologic, climactic and numerous other ones, all of them having a certain influence in the etiology of suicide, but none of them clear enough to give us a complete understanding of its psychopathology. In the same way as a more accurate and more detailed study of the histological tissue requires a narrowing of the field of vision by the use of a highly magnifying lens or of the oil immersion procedure, the study of suicide requires the understanding of deeper psychodynamics, the acceptance of the existence of unconscious motivations and unconscious fantasies which can only be obtained by the use of specialized knowledge and technique. Let us, for example, briefly focus our attention on the mechanisms of suicide which come into play in the clinical diagnosis of depression. Today we believe that most suicidal persons are victims of strong and powerful aggressive impulses which they fail to express outwardly and which they consequently turn inwards against themselves. As expressed by Zilboorg:

"The person suffering from a pathological depression has a specific set of unconscious fantasies which determine his mood and his whole illness, and a characteristic emotional attitude towards the world which determines his behaviour. He identifies himself with another person whom he once loved and then hated. He then loves and hates himself and falls victim to this internal raging battle . . . . The subject is under the dominant influence of a fantasy that he has swallowed the once-loved and then hated person. He becomes that person and hurls the whole mass of his hostility on this internalized person. *The process of being hostile to the internalized person is perceived as depression, self-depreciation and self-hatred, while the act of murder of that person or persons is the act of suicide.*"

This set of formulations was originally conceptualized by Freud in his studies of melancholia. Indeed, in melancholia, the death idea seems to be related to self-hatred or loathing, the so-called symptom of "personal unworthiness". As stated by Freud[8]:

"The self-reproaches with which the sufferers torment themselves so mercilessly, actually relate to another person, to the object they have lost or whom they have ceased to value on account of some fault . . . The ego itself is then treated as if it were the abandoned object. It suffers all the revengeful and aggressive treatment which is designed for the object . . . The melancholic, in some cases, has experienced a *real* loss of money, position or love, but more often the situation is that they are infantile characteristics in his mental functions, and that there is a disillusionment in his experience of life. He ceases to attend to reality and complains that everything seems flat, dull, or he occupies himself with the 'might-have-been'."

In his 'Theory of Instincts' he points out that "a person in a fit of rage often demonstrates how the transition from restrained aggressiveness to self-destructiveness is affected by turning his aggressiveness against himself. He tears his hair or beats his face with his fists, treatment which he would evidently have preferred to apply to someone else. It is this sadism, and only this, that solves the riddle of the tendency to suicide that makes depressions so interesting and so dangerous . . . no neurotic harbours thoughts of suicide which are not murderous impulses against others, re-directed upon himself."

This process of internalization of aggression takes place in very early childhood, and analysis of the melancholic demonstrates definite infantile characteristics in his mental functions. Much can be learned by studying the behaviour of children, particularly as regards the various methods of dealing with aggression. Some children, because of constitutional or early environmental factors, and/or because of different parental attitudes or other influences, seem to be able to express their aggression quite freely. Other children will repress their aggression and develop an unaggressive, if not completely passive or submissive, attitude in their relationship to other children or to adults.

The different reactions of twin girls of about five in their relation to each other may serve to illustrate this point. One of them is able to express her aggression towards her twin sister, frequently vocalizing her hostility by looking at her sister fairly and squarely in the eyes and stating, "You have an awful face—I hate you." The other one is more or less consistently kind and considerate towards her aggressive twin sister, eager to share her toys with her, and to protect her, notwithstanding or because of the attacks she is subjected to. It is obvious that aggression, if not hostility, is present in the latter child, but that the resentment and the sibling rivalry have been deeply repressed, as proven by her waking up one night crying. When asked what was the matter with her, she replied that she had had an "awful dream". This dream was in the nature of a nightmare in which she had seen her "beloved" sister in the family car, that the car had caught fire and that it had finally exploded—one way of getting rid of her sister whom, during waking hours, she appeared to love so much. It was only during sleep that she could allow herself to express her resentment towards her twin sister.

Hartmann states that "When the child reaches the stage in which he is himself dissatisfied with his aggressive outbursts, when his ego, or later his superego, already disapproves of aggression turned outward, the outburst solicits limitation from the parent as a

help in solving the internal conflict. If, in this constellation, the response to aggression is not the expected one—if the aggressor is disarmed by indifference, kindness or love—aggression has been frustrated. This type of frustration particularly favours one solution of the conflict, namely the internalization of aggression. This internalization, in turn, may contribute to an increase of guilt feelings."

It is interesting to note that the second twin whenever frustrated from the age of two on has often been observed to pound her head with her little fists. This phenomenon may explain why some children appear to obtain so much relief following a spanking. This child is also accident-prone. Obviously the answer to the whole problem is to deal with the situation so as to direct aggressive urges into constructive channels, and where possible to prevent an undue and excessive development of aggression which may become pathological in the form of "hostility".

All of us are endowed from early childhood, if not from birth, with a certain amount of aggression, but not all of us develop excessive hostility. Furthermore, each one of us, during the early stages of psychic development, makes use of specific methods of dealing with our own aggression.

In my clinical experience the reversal of hatred from an external object on to the self is of very common occurrence in cases of depression. The genius of poets has shown insight into this process. Adriana in the "Comedy of Errors" (Shakespeare) says of her husband who had been behaving strangely:

> "This week he hath been heavy, sour, sad,
> And much different from the man he was;
> But till this afternoon his passion
> Ne'er brake into extremity of rage."

A male patient of about 50 was admitted to hospital following an acute psychotic episode of sudden onset, during which he had become quite irrational in his conversation and in his behaviour, pointing his index finger towards his wife as if holding a pistol and making clicking sounds with his mouth, as if he were shooting her. On admission he presented a mixed picture of depression and anxiety, repeatedly looking at the window of his private room, situated on the sixth floor, in a furtive manner as if hardly able to resist its attraction, but having sufficient insight to demand that he not be left alone even for one minute, obviously prey to very powerful suicidal urges. When asked how he felt towards his wife, he described her as a very kindly and considerate soul. All his hostility, in other words, hostility which the day before had threatened his ego to the point of harbouring homicidal motives towards his wife, had become repressed and reversed upon himself, or, to use another expression, had been "turned inwards". A year before this acute psychotic episode, while felling a tree in his garden, he had suffered very severe lacerations of his skull when the tree fell on the top of his head. He had required several weeks' hospitalization. This patient was treated with rest and psychotherapy, and it was only after he started improving that allusion was made to this "accident", which even the patient found somewhat difficult to explain, particularly since he was not an inexperienced man, having worked as a lumberjack in his youth. His wife, when interviewed at this admission, also expressed some doubt as to how the "accident" had occurred, and certainly it was my feeling that this so-called "accident" might well have been an unconsciously determined suicidal attempt.

A male patient of about 55, a professional man of good intelligence but of an extremely rigid personality, was admitted to hospital for the investigation of an intolerable persistent pain in the right circumorbital region, a pain for which he had received a complete neurological investigation at another hospital without any definite findings of specific organic pathology. This pain had been present for a period of over two years. It was so incapacitating as to lead the patient rapidly to chronic addiction to analgesics. Neurosurgery had actually been considered without, however, much hope of improving the symptoms. After talking to the patient I interviewed his wife and then decided to see them together; and after listening to his wife's continuous verbalization of infantile frustrations and resentments, to an uninterrupted flow of words which allowed no intervention whatsoever on my part for a period of 45 minutes, I looked at her husband and stated, "Perhaps you are better off with your pain". His defences against very intense hostile feelings towards his wife were much too rigid to make psychotherapy hopeful. Furthermore, gain in insight on his part might have led to disaster, his symptom being a defence against a psychotic breakdown or against murderous intent. I therefore decided to treat his wife, hoping that the patient would have enough fortitude to withstand her onslaught until her mental state had improved. Actually, after the first few interviews I came to the conclusion that nothing but a lobotomy would prove successful, but before I could recommend such procedure on his wife, he committed suicide.

In my practice I am usually less concerned about the possibility of suicide when dealing with patients who, though quite disturbed, are nevertheless able to ventilate their hostility, but even in such cases much caution has to be exercised since hostility may at any time be reversed by the patient on to the self with dire consequences. This is particularly true in the case of patients who are irritable, stubborn, cold, contrary, sarcastic and stingy. As well expressed by Zilboorg, "The well-known childish faculty, 'When I'm dead they'll be sorry', finds its literal expression in their mental life, and their self-murder appears to be an act of aggression against the world, a real act of vengeance. The act of suicide in the fantasy life of these people appears to have a special pleasure value. Clinically they represent a rather treacherous problem, for such patients give the impression of constantly ventilating their sadism, and one is not infrequently misled into believing that they are 'too extrovert' to commit suicide."

A female patient of about 50, married but childless, was admitted to the Day Centre suffering from an agitated depression severe enough to warrant treatment in a psychiatric ward under constant observation. She had the personality traits described above, expressed marked fear of insanity, and proved most unco-operative. She refused admission to hospital, refused electro-convulsive therapy, and throughout her stay at the Day Centre she took exception to everything and everybody, criticized the treatment, the food, the bed linen, etc., refused to participate in occupational therapy and to establish any relationship with any of the other patients, and resisted every effort on the part of the nursing staff to have her socialize. In her interviews with me she expressed the same hostile reaction and finally, after two weeks, she refused to carry on with treatment and demanded her discharge. She also expressed much concern about the cost of treatment, even though special arrangements had been made by me to reduce the cost to a minimum. A few days after her discharge she was brought back to my office, much against her will, physically a wreck and mentally more in need of treatment than ever. She had lost much weight and had subconjunctival hæmorrhages in both eyes. I became quite firm in my approach and told her that she had no alternative but to be admitted to hospital with special nurses round the clock and that she would be treated with electro-convulsive therapy. The day following the first E.C.T. she mentioned, for the first time, that she had been prey to strong destructive urges towards her husband such as to make her panicky at night, more so "when her husband was asleep", and to make her doubt her own sanity. The day following the second treatment she mentioned having attempted suicide at home, by hanging, which explained the subconjunctival hæmorrhages. After a few more treatments the patient's personality changed; she became quite co-operative and very grateful. It is interesting to note that the more compromising my attitude had been toward her, the more kindly my approach, the more intense her hostility and consequent guilt and the worse her depression.

It is mainly for this reason that in the Winters V.A. hospital, U.S.A., the policy has been to treat deeply depressed suicidal patients not with kindness but with firmness and a certain amount of severity. The patients are also made to work, usually a dull type of physical labour, such work symbolizing punishment and thus relieving the patient of the need to punish himself by suicide.

From the above, one may formulate the hypothesis that in some cases suicide can be considered a defence against homicide.

"The turning of one's aggression on oneself, legitimized and honoured in some civilized races such as those of ancient Rome and of present-day Japan, has obviously great sociological meaning, as it may perform a social preservative function. The individual dies because aggression is forbidden to him, but the community takes care of the business of revenge. One wonders to what extent this aspect of social development may not be responsible for the tradition of respect many persons have for suicides, and for the idealization of the death wish by the suicidal psychotic or neurotic person." (Zilboorg)

### SUICIDE IN SCHIZOPHRENIA AND OTHER CONDITIONS

There is practically no psychiatric condition in which suicide may not occur, though suicide is most common in patients suffering from severe depression. Zilboorg points out that not sufficient emphasis has been given to the schizophrenic group as potential suicides since these patients are less apt to give as much warning as the depressed patients, and yet their persistence in suicidal attempts is even greater than that of depressed patients, and their impulsiveness frequently results in a fatality rather than in an unsuccessful attempt. Schizophrenic states often start with a depression which, being associated with confusion, presents the most dangerous type from the standpoint of suicide. Actually, in some schizophrenics the motivation for suicide at times may assume the strength of such a driving compulsion that it can defeat all precautionary measures.

A female patient of over 60 in the observation ward of a large mental hospital told me that she was going to commit suicide because she felt persecuted by auditory hallucinations—her husband, long dead, talking to her and calling her "dirty names". The nurses of the ward were warned and instructed to take extra precautions, and yet this patient somehow managed to get hold of a belt and hang herself by kneeling by her bed.

Lewis points out that the danger of suicide is also great in cases of acute homosexual panics, either with or without alcoholic relief, but in which the hallucinatory experience drives the patient to self-destruction to avoid the certain disgrace and torture implied by the hallucinated persecutors. Leavitt reported a case of suicide of a captain who had been arrested because of homosexuality. This man drove a nail 8 cm. long into his brain through the parietal lobe, using a wooden shoe for a hammer. Two nails bent before he succeeded. He presented very few symptoms before the terminating meningitis set in.

Conversely, there are cases of attempted suicide which are meant to fail from the start. These are the so-called "suicidal gestures" which are frequently motivated by the desire for additional or special attention. Even in such cases, however, death may occur because of a fortuitous set of circumstances, and the cause of death is erroneously declared as "suicide".

A married woman of 35 was admitted to hospital by ambulance in a comatose state following ingestion of a large amount of barbiturates. She remained unconscious for 48 hours, and it was only through concerted efforts of the medical staff that she recovered. She gave a history of several previous attempts, all of which had failed because her husband, well-known for his punctuality, had arrived at home in time to institute adequate measures. On this occasion, however, he had been de-

tained at work later than usual, a very rare event in his case, and when he arrived home he found his wife in a desperate condition.

### PARTIAL OR FRACTIONAL SUICIDE

Partial self-destruction is not an uncommon phenomenon. In such cases the self-destructive act is discharged, not upon the body as a whole but on one or more parts of the body, for instance, in self-mutilation, in poly-surgery and in unconsciously motivated accidents. It is possible that there may be similar unconscious motives in all such cases. Some investigators consider these acts as a method of localizing punishment for the purpose of carrying on the indulgence for which the punishment is inflicted.

A young girl of about 20 was admitted to the surgical ward of the general hospital with severe infection of her right hand, necessitating the amputation of two fingers. About a month later she had to be readmitted, again for an infection of the same hand, and this time the whole hand had to be amputated. Within a period of a few months she required three other admissions, each one of them leading to further amputation, up to surgical removal of the whole arm. At her final admission she was admitted practically moribund because of a very severe infection of the shoulder. At each admission clinical investigation could not find any explanation for her reinfections. She was referred to psychiatry, but she proved most unco-operative and refused psychotherapy. She did, however, co-operate to the extent of giving me a brief outline of her history, which was as follows:

She was married and, she claimed, quite happily, until one day her husband came home accompanied by another woman and demanded that this woman also live in the house as his wife. The patient who, up to that time, had been rather passive and submissive in her relationship to the husband, was seized by sudden rage and slapped her husband's face. Following this act she felt terribly guilty and she left the house to live with her mother. She took a job in a can factory and shortly afterward she "accidentally" cut her finger. Contrary to all instructions she did not report the injury to the company doctor until several days later, when the infection had become so extensive that she had to be admitted to hospital with consequent removal of two fingers. The successive infections of the stumps were self-induced, and nothing could stop the inevitability of her death.

Some authors have extended this concept of progressive self-destruction to include other pathological conditions, such as drug addictions, since addicts in their general mental attitudes show a great indifference towards a slow progressive destruction.

A recent campaign has stimulated research into the causes of traffic accidents. Over two-thirds of such accidents have been ascribed to human errors. It is suggested that in such research consideration be given not only to conscious factors, but also to unconscious motivations. Menninger considers suicide as a peculiar kind of death, having three distinct elements for each of which there appears to be always unconscious and sometimes conscious motivations: (1) the element of dying; (2) the element of killing; and (3) the element of being killed. "Suicide is not a consciously deliberated, quickly executed, completely and directly achieved act, but more often a slow, gradual, irregular and indirect procedure." He extends this concept to explain the etiology of some physical illnesses:

It would certainly seem to be a short step, logically, from these generalized and focalized self-destructions, brought about through external devices, to those internalized and destructive processes, general or focal, which constitute the substance of all medical practice. If deep unconscious purposes are found to lie back of the impulse to gouge out one's eye or cut off one's ear, may it not be possible that the same deep purpose sometimes finds expression through physiological mechanisms in diseases which attack the eye or the ear? We have seen how some people rush to get one organ after another removed surgically, and how this compulsion to sacrifice an organ has self-destructive determinants, determinants which are quite unconscious, concealed by being ostensibly self-preservative. Is it not a justifiable inquiry to learn just when this focalized self-destructive impulse took form and began its work?

Self-destructive tendencies have been the object of study, but most studies had assumed "the modality of the striated musculature and the voluntary nervous system. . . . Each man has his own way of destroying himself. Some are more expedient than others, some more consciously deliberate than others. Perhaps organic disease is one way. . . . We know that the deep insistent cravings of the personality are transmitted in various ways to organs as well as to muscles. The transmission may be chemical or physical, i.e., by hormones or by nerve fibres. It is theoretically possible, therefore, that impulses arising from a trend towards, or basic purpose of, self-destruction might be conveyed to the autonomic nervous systems and carried out through the non-striated musculature, as well as in the more familiar form of voluntary nervous system, impulses sent to striated musculature. This, then, would result in the injury of an organ. . . . Study of the personality often shows that the 'organic' disease is only a part of the total personality disease and fits into a pattern which seems to have the definite purpose of destroying the self. It may even happen that a functional and an organic disease may exist side by side, both serving the same need, as it were, or that one may replace the other as the malignancy of the self-destructive impulses wakes, waxes or wanes. . . . We know that

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often what appears to be an accident is a definite intention of the victim. People *elect* misfortune, they *elect* misery, they *elect* punishment, they *elect* disease; not always, not all people, not all diseases, but this is a tendency to be dealt with. . . . The self-destructive and self-preservative tendencies appear to carry on a continuous battle in the unconscious and this battle is reflected in the psychological experiences and sensations as well as in the organic processes. The physical and chemical interactions we know somewhat more about. It would appear that these unconscious, self-destructive tendencies at one time are manifested through conscious, volitional expressions, and at other times through unconscious attacks on the internal organs or some part of the body. Sometimes there is a joint expression of both."

## CONCLUSION

The study of the psychopathology of suicide demands an understanding of unconscious psychodynamics as well as of conscious phenomena.

Suicide represents a man's total retreat from the vicissitudes of life, a failure in his mechanisms of adaptation and an escape from all reality, but it may also represent the achievement of fantasies or wishes which transcend the concept of death as a final experience.

Our psychic structure is so deeply involved with death that Freud postulated the existence of a death instinct as well as of a life instinct; that is, that equal to the will to live and opposed to it there is a death instinct which operates silently and mostly unconsciously in all of us. It would be beyond the scope of this paper, and indeed presumptuous on my part, to discuss the validity of this theoretical concept except to emphasize the need of not considering suicide as just "an act" or an isolated event in the life of an individual, but as a culmination of events, both conscious and unconscious, which in all their various aspects have been responsible for the individual's faulty adaptation to life.

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# THE TREATMENT OF SUICIDAL ATTEMPTS*

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IN PLANNING treatment for the patient who has attempted suicide, perhaps one's first thought is that the prime consideration should be the prevention of further attempts, and particularly of suicide itself. But we cannot be sure that the treatment of most such persons is really a "life-saving" manœuvre. It must first be ascertained what segments of the population contemplate suicide, fear, threaten, attempt and accomplish it. Recent studies, particularly by Stengel[1] and Batchelor,[2-5] indicate that these segments are not identical, and perhaps are not even greatly similar.

It appears that most persons who commit suicide have not been known to attempt it before, and likely most have not even threatened to do so. This may lead to the assumption that the patient sincere in his self-destructive intent quietly contrives to succeed the first time; and even to the assumption that in some way "suicide attempt" immunizes one against this mode of death. The small percentage of people attempting suicide who ultimately succeed lends credence to this—for example, 2% of Batchelor's series in one year's follow-up.

It must be remarked, however, that these studies are of hospital admissions, and thus the patients received appropriate psychiatric treatment and protection. This is our responsibility to all persons who attempt suicide, recognizing that in this group we are likely dealing with a larger proportion without strong motives for

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