Clues to Suicide

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THE IMPORTANCE of the phenomenon of suicide is gauged by the fact that more than 20,000 people take their lives each year in the United States (*1*). Professional psychiatric, psychological, and social services might save many potentially suicidal persons if the danger is anticipated. In our continuing study of suicide at the Veterans Administration Neuropsychiatric Hospital in Los Angeles County, Calif. (*2–4*), we are attempting to discover a few of the danger signals.

A basic point of view implicit in our study is that we believe suicide to be motivated by sociologic, cultural, ecologic, psychological, and many other factors (*5–8*). Another basic point of view is our belief that meaningful studies of suicide can effectively use the scientific method of experimental control.

Our purpose at this time is to describe an experimental approach in the investigation of psychological factors in suicide and to report a few tentative results. Although our study is limited to the psychological aspects of suicide, it does not preclude other important aspects of the phenomenon studied by Cavan, Dublin and Bunzel, Durkheim (*5–7*), and others.

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Three Types of Raw Materials

Our raw materials are psychiatric case histories, psychological test results, and suicide notes. We have attempted to obtain adequate control data for each category so that statistical comparisons might be made.

Case Histories

The names of adult male suicides were obtained from the weekly lists of all suicides in the Los Angeles County Coroner's Office for the period 1944–53. By checking the names of completed suicides with rosters of former patients of Veterans Administration neuropsychiatric hospitals in the county, we collected the psychiatric case histories of 32 adult male patients who, some time after discharge from the hospital, had killed themselves.

The case histories of the 32 suicides were then checked with the case histories of an equal number of control cases in each of 3 comparable categories of neuropsychiatric hospitalized males: a group of 32 males who had attempted

suicide, a group of 32 who had threatened suicide, and a group of 32 who had no suicidal tendencies. In the 4 groups selected, all 128 subjects were male, white, and most of them were from 20 to 40 years old although the ages ranged from 20 to 69.

We have analyzed the 128 case histories in terms of more than 100 different social, economic, cultural, and psychological categories, and have computed the statistical significance of the differences among the 4 groups. Samples of the categories used for analysis are: family history details, economic level, parents' age at the time of various events in the subject's life, educational and vocational achievements, marital status, and psychiatric diagnosis—an example of which is presented in the accompanying table.

Psychological Tests

For our second type of raw data, we collected test results on the Rorschach ink-blot technique, the Thematic Apperception Test, the Make a Picture Story test, and the Minnesota Multiphasic Personality Inventory, among others.

Diagnostic classifications of subjects in suicide study

Classifications	Completed suicide	Attempted suicide	Threatened suicide	Non-suicidal
Neurotic				
Reactive depression	5	7	6	0
Hysteria	1	1	1	1
Anxiety reaction	2	2	3	5
Phobic reaction	0	0	1	0
Obsessive-compulsive neurosis	0	0	1	0
Dissociative reaction	0	0	0	1
Neuropsychiatric mixed and/or undetermined reaction	0	2	2	1
Total	8	12	14	8
Psychotic				
Schizophrenia, simple	0	0	0	2
Schizophrenia, hebephrenic	0	1	0	0
Schizophrenia, paranoid	9	6	6	3
Schizophrenia, catatonic	1	0	0	1
Schizophrenia, unclassified	0	1	0	4
Schizophrenia, mixed	1	1	4	2
Manic-depressive psychosis, manic	1	0	0	0
Manic-depressive psychosis, depressed	2	0	2	0
Psychotic depression	0	1	0	0
Paranoid state	0	0	0	1
Involutional melancholia	1	0	0	0
Total	15	10	12	13
Organic				
Epilepsy, grand mal	0	0	0	0
Epilepsy, petit mal	0	0	0	1
Epilepsy, idiopath	1	1	0	0
Epilepsy, psychomotor equivalent	0	1	0	0
Traumatic encephalopathy	0	1	1	0
Paresis	0	0	0	1
Total	1	3	1	2
Miscellaneous				
Passive dependency	1	2	0	2
Emotional instability	0	2	1	1
Inadequate personality	0	1	0	1
Character disturbance	0	0	0	1
Psychopath	0	0	1	0
Alcoholism	7	1	3	4
Schizoid personality	0	1	0	0
Total	8	7	5	9
Grand total	32	32	32	32

In collecting these data we followed much the same precedure used for obtaining the case histories. The lists of suicides in Los Angeles County were checked against the hospital rosters. Then the previously administered psychological tests on individuals who had subsequently committed suicide were found. Psychological tests on comparable groups of individuals who had attempted suicide, threatened suicide, or who were nonsuicidal were obtained next, and the test results among the four groups were compared.

However, only the test results for 96 of the 128 subjects—the nonsuicidal subjects and those who attempted or threatened suicide—have been analyzed so far. Data for those persons who had been tested and who subsequently committed suicide have not yet been collected in numbers sufficiently large to be subjected to statistical analysis.

Suicide Notes

For our third set of raw materials, we collected 721 genuine suicide notes with the cooperation of the Los Angeles County Coroner's Office. The notes were written during the period 1944 through 1953. Some were written by men, some by women, others by children. The writers were as young as 13 and as old as 96.

There are practical, as well as theoretical, difficulties in obtaining control data to match with genuine suicide notes. A practical difficulty is that notes written by people who have threatened or attempted suicide are hard to obtain inasmuch as they are usually destroyed. To obtain control data, we asked certain individuals, carefully matched with the genuine suicide-note writers, to write the simulated suicide note they would leave if they were going to take their own lives.

The names of the people we asked to participate were obtained from such community sources as labor unions and fraternal groups. In recognition of the moral and ethical overtones associated with suicide, we employed preliminary screening tests, interviews, and other safeguards in order to screen out anyone who might be upset by writing a fictitious suicide note.

Our last step was to analyze the genuine and pseudosuicidal notes and to relate the statistically significant results to the major psychiatric, psychoanalytic, and psychological hypotheses about suicide.

Results of Research

The following findings come from the research in process and are tentative in nature.

Case History Comparisons

From our studies of the four sets of psychiatric case histories (*2*), we concluded:

1. It is practically impossible to distinguish a potentially suicidal person from the details of his case history alone, however stressful or traumatic it has been.

2. Seventy-five percent of the subjects who committed suicide had a history of having previously threatened or attempted suicide, although a suicide threat or gesture is not necessarily the mark of a potential suicide.

3. Almost half of the individuals who committed suicide after leaving the hospital did so within 90 days after having been discharged.

As to the first finding, there were few differences in the case history details among the four groups. For example, as many people in one group as in another were only children, came from broken homes, had a history of suicide in the family, and so forth.

From all the comparisons made of the 4 groups we found that only a diagnosis (see table) of reactive depression or paranoid schizophrenia differentiated the 3 suicidal groups (completed, threatened, and attempted suicide) from the nonsuicidal group. Only a history of mental hospitalization among members of the family distinguished the completed suicide group from the other 3 groups. All other comparisons yielded negative results.

Although it is true that not all people who have attempted or threatened suicide go on to commit suicide, the contrary fact—our second finding—is even more striking; that is, there is a large percentage of suicides, specifically 75 percent in our study, who have a history of having threatened or attempted suicide. This fact would seem to indicate that suicidal gestures (attempts or threats) may be considered as danger signals and must be taken seriously.

The results of this study do not permit us to state whether the same percentage would apply in a general population. Nevertheless, the finding does suggest that suicidal threats and attempts are a danger signal in the type of suicidal population found in a neuropsychiatric hospital or sanatorium.

Clinical observations in the psychiatric literature corroborate the finding that almost half of the individuals who did commit suicide after leaving the hospital did so within 90 days after discharge. Thus, it appears that even though persons of observed suicidal tendencies are judged to have improved sufficiently to be ready to function in the community again, they are in a dangerous period. It is not possible to state what might be the result of keeping such patients in the hospital another 90 days without further detailed, controlled investigation.

This third finding has implications for timing discharge from treatment and for continuing vigilance in behalf of these emotionally disturbed individuals. It would seem that if a person has been making suicidal attempts or threats, his physician and relatives must be especially cautious for at least 3 months after he appears to be improving and after he seems to be on his way to recovery.

Psychological Test Comparisons

Our study (*3*) of the psychological tests for those who attempted suicide, threatened suicide, or who were nonsuicidal resulted in the interesting finding that there are differences among individuals heretofore loosely classified as "suicidal." The people who threatened suicide seemed to be more emotionally disturbed than the people who had attempted the act.

There were some differences between people who attempt suicide and threaten suicide. Specifically, individuals who have threatened suicide show more guilt, aggression, irritability, and agitation—in a word, more disturbance—than do individuals who have attempted suicide. Those who have attempted suicide are more like the nonsuicidal mental hospital patients, except perhaps more withdrawn. It is almost as though the attempt itself had operated in an abreactive and therapeutic manner and had lessened the immediate seriousness of the personality disturbance. This temporary relief, however, does not mean the emotional state preceding suicide will not return.

Genuine and Simulated Notes

From the preliminary comparisons of genuine and simulated suicide notes (*4*), we are presenting only the results of our application of the Discomfort-Relief Quotient, a technique developed by Mowrer (*9*).

Mowrer's technique is used to measure the relative amounts of discomfort thought units, relief thought units, and neutral thought units contained in case history materials or in statements made during psychotherapy sessions. The thought unit is a discrete idea, regardless of number of words. The Discomfort-Relief Quotient was deemed to be applicable to the analysis of genuine and simulated suicide notes for indications of the current emotional and ideational state. Thirty-three male, white, Protestant, married, native-born, genuine suicide-note writers were matched man for man, by age and occupation, with 33 nonsuicidal, simulated-note writers.

The total number of thought units was significantly higher in the 33 real notes than in the fictitious notes, indicating that the genuine-note writers apparently feel the need to say more in this last communication.

With respect to the "discomfort" statements, or the statements of guilt, blame, tension, aggression, and the like, we found no statistically significant difference between the prorated number of discomfort units expressed by the genuine suicide-note writers and those expressed by the simulated-note writers.

As for the number of "relief" statements, or statements which were pleasant, warm, loving, and which denoted relief from tension, we found no quantitative difference between the genuine notes and the simulated notes.

It was in regard to the "neutral" statements, the statements free of expressions either of tension or of release from tension, that the notes revealed the greatest significant difference. The genuine suicide notes contained much the higher percentage of neutral thought units. On inspection, we found them to be mostly statements giving instructions and admonitions and sometimes listing things to do.

What might our findings indicate about suicide-note writers?

We interpreted the higher percentage of neutral thoughts expressed by the genuine-note writers to indicate two important, although quite contradictory, feelings on their part and, in addition, to reflect a basic difference in the attitudes of the two groups of writers.

The genuine-note writer has apparently accepted and incorporated the idea that within a short time he will not be alive. He therefore instructs and admonishes in relation to the many details of continued living which he will not be able to pursue himself.

The fictitious-note writer, although he can apparently fantasy the "affect" of suicide, inasmuch as the number of relief statements and discomfort statements are proportionately the same, does not take that additional step of converting his fantasy into the "reality" of imminent absence.

In other words, only the genuine suicide-note writer can fantasy his really being gone. At the same time, there is a distinct contradiction between his decision to die and his listing of things to do and his plans for the future. It is as though he were exercising power and command in these directions, as if he somehow were making sure his plans would be carried out. It is a kind of unrealistic feeling of omnipotence and omnipresence on the part of the suicidal individual which may reflect in part some of the confused, illogical, and paradoxical motivations in the entire act.

We noted that the discomfort statements in the simulated suicide notes were only mildly negative but that similar statements in the genuine notes were characterized by deeper and more intense feelings of hatred, vengeance, demand, and self-blame. As used at this time, however, the discomfort measure does not reflect these differences.

Some Words of Caution

In addition to the fact that our project deals only with some of the psychological aspects of suicide, as revealed in case histories, psychological tests, and suicide notes, some other limitations of the study should also be made explicit.

The data we have analyzed so far are restricted to a specific period (1944 to 1953) and to a specific area (southern California) and, therefore, cannot be representative of all times and all locations.

We wish to point out also that, although the 721 suicide notes in the study represent almost 100 percent of the suicide notes written in Los Angeles County during the 10-year period 1944–53, only about 15 percent of the suicides in the county have left notes. Thus, the conclusions about the psychology of suicide from this source may possibly contain some as yet undisclosed sampling biases.

Our clues about suicide are to be taken only as an interim report of tentative findings from a continuing study. We hope, within the next few years, to report more definite information about the psychological nature of suicide from which a clearer theoretical understanding of its motivations can be obtained and, perhaps, even some clues as to how its prevention and control can be evolved.

Summary and Conclusions

The following five points are offered as a summary of the findings and implications of this interim report:

1. Three-fourths of our subjects who committed suicide had previously threatened or attempted to take their own lives. This means that suicidal behavior, whether attempted or threatened, must be taken seriously, inasmuch as the next suicidal "gesture" may be the final one.

2. Almost half of the individuals who committed suicide did so within 3 months of having passed an emotional crisis and after they seemed to be on the way to recovery. This means that physicians and relatives must be especially cautious and watchful for at least 90 days after a person who has been suicidal appears to be improving.

3. On the basis of comparisons among psychological tests, it appears that the person who threatens suicide seems to be more emotionally disturbed than the person who attempts suicide, but both must be taken seriously and watched carefully at least for 3 months.

4. The comparison of genuine suicide notes with simulated suicide notes indicates that the

person about to take his own life includes orders and admonitions as though he had reached a final decision in solving his problems and had accepted the fact that he will soon no longer be around.

5. Calling upon professional psychiatric, psychological, and social service specialists for the treatment of a potentially suicidal person may mean the difference between life and death.

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Special Assistant for Medical Affairs

Dr. Lowell T. Coggeshall, nominated by President Eisenhower to be special assistant for health and medical affairs to the Secretary of Health, Education, and Welfare, has been dean of the University of Chicago division of biological sciences, which includes the university medical school, since 1947. In this position, he directed one of the country's largest biological and medical research centers.

He succeeds Dr. Chester S. Keefer of Boston, Mass., who resigned August 1, 1955. Until July 1, 1955, Dr. Coggeshall was also chairman of the Committee on Medical Sciences of the Department of Defense, and at present he is chairman of the Medical and Scientific Committee of the American Cancer Society.

An authority in the field of tropical medicine, Dr. Coggeshall, then a captain in the Navy, was assigned by the Army Air Force during World War II to the Pan American World Airways in Africa, where he was responsible for establishing medical services along air routes through Africa and the Far East. Later, he was named special medical consultant to the Secretary of War, and during his tenure in that post was in charge of the Klamath, Oreg., tropical disease hospital for Navy and Marine personnel.

Dr. Coggeshall, born in Saratoga, N. Y., in 1901, received his medical degree in 1928 at the University of Indiana, where he also was awarded the degree of doctor of laws in 1948. From 1935 to 1940, he was a staff member for research in tropical diseases, international health division, of the Rockefeller Foundation. He was professor of preventive medicine of the School of Public Health, University of Michigan, from 1940 to 1941, and was chairman of the department of tropical medicine, University of Michigan Medical School, from 1942 to 1944. He then returned to the University of Chicago as head of the department of medicine.