

American Handbook of Psychiatry

SUICIDE

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Table of Contents

SUICIDE

[Definitions and Types](#)

[Basic Etiological Approaches](#)

[Basic Epidemiological Patterns](#)

[Relationships to Clinical Entities](#)

[Indicators of Suicide Potential: Implications for Prevention](#)

[Bibliography](#)

SUICIDE

James M. A. Weiss

The suicide of a patient, because of its finality, is perhaps the most devastating experience in the practice of psychiatry. And suicide, considered as a sign of mental disorder, is a prime cause of death among psychiatric patients. Inextricably involved with the attitudes, folkways, mores, taboos, and laws of culture and subculture, with tragedy for the person and the group, with emotions and values, suicide is a sociopsychiatric phenomenon about which much confusion exists. The nature of this phenomenon is complex, and its scientific study is difficult, in part for the obvious reason that persons who have committed suicide successfully are no longer available for psychological or psychiatric study. The universal fascination of the study of suicide, however, is reflected in the great bulk of literature concerning this subject. There are now more than 7000 books and articles about suicide (exemplified by Farberow's extensive bibliography and an American journal—the *Bulletin of Suicidology*—devoted solely to this topic). But much prior research into suicide and attempted suicide has tended to be either actuarial and at times somewhat superficial, or clinical and often anecdotal, or oriented to depth psychology and rather speculative.

It does seem evident that there are three chief etiological factors in

suicide: the group attitudes in each particular society, the adverse extraneous situations that each person must meet, and the interaction of these with his character and personality. This last single variable appears to be the most important one. Obviously, different persons meet adversity differently. One whose personality is poorly integrated may respond to stress by taking or attempting to take his own life. Yet anthropologists and epidemiologists have demonstrated that suicide may be completely unknown among certain primitive tribes, that suicide rates are extremely low in certain countries, and, alternatively, that suicide is not only acceptable but obligatory as a consequence of certain specified activities or happenings in certain other cultures. The ancient warrior people of Germany and Scandinavia, as well as the Greek Stoics, approved of suicide, Oriental and Hindu cultures sanctioned it under specified conditions, and in some

South Sea Islands it is looked upon even today as an honorable act. However, as cultural patterns affect large numbers of people who do not always act similarly, and as every person must meet difficult and dangerous situations in an environment that can never be “sterilized” psychologically, it appears likely that some degree of personality disintegration is the most important single variable in the etiology of suicide. The psychiatric concept applies, that external tensions are reacted to in proportion to the amount of internal tension already existing.

Definitions and Types

Even the definition of suicide presents difficulties. The “suicidal patient” may be one who successfully commits suicide, unsuccessfully attempts suicide, threatens suicide, demonstrates suicidal ideation, or behaves in generally self-destructive patterns. “The expression ‘suicidal act’ is used . . . [by the World Health Organization] to denote the self-infliction of injury with varying degrees of lethal intent and awareness of motive. . . . ‘Suicide’ means a suicidal act with fatal outcome, ‘attempted suicide’ one with non-fatal outcome.” Operationally, some possibility of self-inflicted fatal termination is most commonly the distinguishing criterion of the term “suicidal.” Thus, most investigators define successful or committed suicide as a violent self-inflicted destructive action resulting in death. Attempted suicide is usually defined similarly, except that there is no fatal termination; but, as Stengel has pointed out, the action must have a “self-destructive intention, however vague and ambiguous. Sometimes this intention has to be inferred from the patient’s behavior.” The suicidal gesture is similar except that persons performing such an action neither intend to end life nor expect to die as a result of their action, although the action is performed in a manner that other persons might interpret as suicidal in purpose. In suicidal threats, the intention is expressed, but no relevant action is performed; in suicidal ideation, the person thinks or talks or writes about suicide without expressing any definite intent or performing any relevant action. (The term “parasuicide,” to designate

attempted suicide and related actions, has recently come into vogue. That term is, however, both ambiguous and a solecism, and should be deleted.)

The problem is further complicated by persons in the category termed by Farberow and Shneidman the “sub-meditated death group,” in whom unconscious or preconscious motivation to die or be killed is such that a large number of conditions (purposive accidents, provoked homicides, neglected personal health care, involvement in dangerous activities, and even severe psychosomatic disorders) might be considered suicidal equivalents. Whether such acts, as well as one-car accidents, voluntary overwork, drug addiction, chain-smoking, and alcoholism, are in fact “partial” or “chronic” suicidal attempts is debatable. Tabachnick found that “suicidal and self-destructive factors which we tested for do *not* play a significant role in the general [automobile] accident picture.” Choron stated, “One could maintain that it is the lesser evil to drown one’s sorrows in alcohol than to drown one’s self,” and suggested that such behavior might actually be a defense against suicide.

Actually, all medical-legal definitions of “suicide” or “attempted suicide” do include the concept that the person played a major role in bringing about, or trying to bring about, his own demise, and that his conscious intention in his behavior was to die. However, increasing evidence indicates that successful suicide and unsuccessful suicidal attempts represent two different kinds of acts performed in different ways for different reasons by different

groups of people, although there is some overlapping. For example, successful suicides are more common among older people, males, and single, divorced, or widowed persons; reported unsuccessful suicidal attempts are more likely to occur among younger people, females, and the married population. In the United States during the past fifty years, about two-thirds of the persons who successfully committed suicide used the two methods of shooting or hanging; most persons reported to have attempted suicide unsuccessfully used ingestion of poison, cutting or slashing, or inhalation of gas—all less efficient than shooting and hanging, which only rarely fail to cause death. Several studies have indicated that the success of the suicidal attempt varies markedly with the reported conscious “motive.” Thus, for the modal committer of suicide the motive is most likely to be judged as “concern about ill health” or “loss of a loved one,” as compared to the modal attempter of suicide for whom the motive is most likely to be “domestic or family worries” or “difficulties in love affairs.”

Stengel and Cook have reviewed the confusion that exists in the psychiatric literature relating to evaluation of the seriousness of suicidal attempts, and concluded that to understand such phenomena it is necessary to consider separately the degree of psychological intent and the degree of medical injury. Stengel, Weiss et al., and other investigators have therefore rated cases as “serious” in psychological intent when an unambiguous impulse to suicide is admitted by the patient and also borne out by the

patient's behavior before, during, and after the attempt. In such cases, the patient does not inform anyone else of the attempt in order to effect a rescue, does not make the attempt when other persons are present or nearby or likely to arrive in time to prevent death, and expects that he or she will certainly die as a result of the act. Attempts are rated as "gestures" when the patient clearly does not expect to die, as evidenced by his overt admission and behavior. Such gestures seem to be made most often to gain attention or to influence other persons, and the attempter often takes considerable precaution to make sure of remaining alive by making the attempt with other persons present, informing someone of the attempt, or initiating his own rescue. Suicidal attempts that are neither serious nor gestures have been defined by Weiss as "gambles," insofar as the patient is uncertain about the possible consequences of the act or does not know for sure whether he can expect certain death as a result of the act but believes there is some chance (even a good chance) of dying, as evidenced by his overt admission and behavior.

As to the medical consequences, suicidal attempts are rated as "absolutely dangerous" when the act results in severe danger to life with a very high probability that the patient will die, except for timely medical intervention. Generally, such acts produce such consequences as coma, bloody diarrhea, penetrating injuries, fracture of a major bone, or laceration of a major artery. Cases are rated as "absolutely harmless" when there is no

chance that the act will cause death under any foreseeable circumstances. “Somewhat dangerous” serves as an in-between category.

Weiss et al. have termed the medically dangerous, psychologically serious attempts “aborted successful suicidal attempts,” since these attempts were found to be qualitatively different from all others, and attempters in this group appeared to be epidemiologically more similar to persons who successfully committed suicide than to other classes of attempters. Probably, most persons who make such aborted successful suicidal attempts are brought to the attention of police, physicians, or hospitals, and are included in the statistical reporting of suicidal attempts. At the other end of the continuum are the persons who make medically harmless suicidal gestures, who are only rarely brought to the attention of reporting agencies. The remaining suicidal gambles, with varying severity of medical consequences, might be termed “true suicidal attempts,” in the sense that persons making this sort of attempt appear to perform a violent, self-inflicted, destructive action with ambiguous intent, but with some chance of fatal termination. Of course, in some of these true suicidal attempts the gamble with death is undoubtedly lost—the attempter dies and the attempt is counted as a completed successful suicide. Many true suicidal attempts may not be brought to the attention of the authorities, but the large numbers that are made known to them appear to comprise the major segment of all reported cases of suicidal attempts.

Basic Etiological Approaches

Dublin's comprehensive review of the history of suicide indicates a marked interest in the subject since ancient times, but the scientific study of this phenomenon began only toward the end of the nineteenth century. In 1897, Emile Durkheim published his famous monograph, "*Le Suicide*," an exhaustive statistical and sociological examination of the problem. Durkheim concluded that the common factor in all suicide patterns was the increasing alienation between the person and the social group to which he belonged. He suggested that a basic element, *anomie*—a sort of psychosocial isolatedness that occurs whenever the links that unite individual human beings into consolidated groups are weakened—is primary in the understanding of suicide in modern society.¹ Other ecological studies have provided important information to this end. Cavan related the suicide rates in urban districts of Chicago to the degree of social disorganization in those areas. Gruhle demonstrated how suicide rates were altered with social and cultural variations in different geographic sections of pre-World War II Germany. Sainsbury, in a study of suicide in London, found that measures of social isolation correlated significantly with suicide rates. Yap's report on suicide in Hong Kong also indicated the importance of the social matrix, noting especially high rates among immigrants from rural areas.

Most psychiatrists and psychoanalysts have identified suicide with self-

directed aggressive tendencies. Freud emphasized that melancholy and subsequent suicide are often the result of aggression directed at least partially toward an introjected love object, that is, a love object with whom the subject had previously identified himself. Later, Freud established suicide as the extreme manifestation of the active component of the death instinct directed against the self. Schilder, writing alone, and with Bromberg, believed that “suicide is obviously merely a symptom and not a clinical entity” and that, although suicide can serve as a form of self-aggression or as self-punishment for aggressive behavior previously directed toward another (loved) person, it may also serve as a form of punishment for a person who earlier may have denied love to the subject, or as a form of peace (or reunion with a love object), or certainly as an escape from insupportable difficulties.

Bernfeld’s classic formulation of the basic mental mechanisms underlying suicide was this: A person committing suicide does so because of strong, unconscious murderous impulses against another person, but the committer must also unconsciously identify himself with the hated (previously loved) object, so that he kills that object in killing himself. Since the committer usually feels guilty because of his murderous impulses, a tendency to self-punishment is commonly involved, and the choice of the method of suicide may have symbolic significance. Menninger- has elaborated these mechanisms in his well-known statement that the true suicide must expect to kill, be killed, and die, as well as in his discussions of “partial” or

“chronic” tendencies to self-destruction. Menninger saw suicide in any form as the result of the struggle between Thanatos and Eros, with the former winning. All varieties of physical and psychological self-damage can be subsumed under his definition, with the suicidal act arising out of the conflict between an aggressive drive directed toward the self and the countering tendency toward both the preservation of the self and the restoration of the self’s relations with other (loved) human beings. Jung stressed unconscious wishes for a spiritual rebirth in a person who has a strong feeling that life has lost all its meaning, and Adler emphasized inferiority, narcissism, and low self-esteem, as the characteristics of the potential suicide victim. Sullivan regarded suicide as evidence of a failure arising out of unresolved interpersonal conflicts, and according to Horney it occurs within a context of extreme alienation of the self resulting from great disparity between the idealized self and the perceived psychosocial self-entity (a formulation that becomes more attractive the longer one studies this subject).

In one symposium, Lindemann suggested that the “state of readiness for violent behavior,” the form of aggression that may or may not end in suicide, be termed “hypereridism” (from *Eris*, the Greek goddess of wrath and anger). Fenichel summed up the psychoanalytic characteristics of this state as “an ambivalent dependence on a sadistic superego and the necessity to get rid of an unbearable guilt tension at any cost.” The person submits to punishment and to the superego’s cruelty, and may express the passive thought of giving

up any active fighting; more actively, and at the same time, there is a turning of sadism against the person himself, a rebellion against the punishing superego. The intensity of this struggle is reflected in the depressed patient's strong tendency toward suicide. The ego, trying to appease the superego by submissiveness, has erred. The hoped-for forgiveness cannot be achieved because the courted part of the personality, through regression, has become sadistic, and, from the standpoint of the superego, the suicide of the depressed patient results from a turning of this sadism against the person himself. On the other hand, from the standpoint of the ego, suicide is an expression of the fact that the tension induced by the pressure of the superego has become unbearable. Frequently, the loss of self-esteem is so complete that any hope of regaining it is abandoned. As Fenichel wrote, "To have a desire to live evidently means to feel a certain self-esteem, to feel supported by the protective forces of a superego. When this feeling vanishes, the original annihilation of the deserted hungry baby reappears."

Other suicidal acts may have a far more active character, for they are simultaneously extreme acts of submission and extreme acts of rebellion (that is, murder of the original objects whose incorporation created the superego). Psychoanalyses of persons attempting suicide have frequently demonstrated that ideas of a relaxing gratification, or hopeful and pleasurable fantasies, may be connected with the idea of suicide. Such ideation is unconsciously related to hopes of forgiveness and reconciliation, with a

simultaneous killing of the *punishing* superego and reunion with the *protecting* superego—thus putting an end to all losses of self-esteem by bringing back original fantasies of omnipotence.

These and similar psychodynamic theories of suicide may be valid, but they may also contain inherent methodological errors. They are based on data derived either from persons who, during or after a period of psychoanalytic scrutiny, have committed suicide successfully, or from persons who attempted suicide unsuccessfully. Generalizing from the few cases of the former type may be incorrect, for it is certainly possible that new dynamic forces—occurring between the last interview and the time of the actual suicide, and therefore unavailable for analysis—played a part. The relevance of premortem idiographic data to an understanding of the actual crisis that resulted in any particular successful suicide is therefore open to some question. And, since current data make it clear that successful suicide is not simply an exaggerated or completed form of attempted suicide, formulation of dynamic theories about successful suicide by extrapolation from what has been learned in clinical studies of patients who have attempted suicide is hardly justified.

However, the basic psychoanalytic concept involving self-directed aggression appears to hold, since suicide rates and homicide rates are often inversely related by cities and other regions, probably by countries, among

certain racial and ethnic groups, and in periods of prosperity and depression. As Henry and Short noted, “When behavior is required to conform rigidly to the demands and expectations of other persons, the probability of suicide as a response to frustration is low and the probability of homicide as a response to frustration is high. . . and vice versa. The often surprisingly low suicide rates among persons living under grim conditions—concentration camps, for instance, or really bad slums, or front-line combat—seem to support this observation. West studied murderers in England and found that about one-third of them killed themselves after killing their victims. (About two-fifths of the suicidal murderers in this group were women.) Such suicidal murders were more likely to be involved in killing a spouse, lover, or child, and there was some evidence indicating that motivation may have been more related to despair than aggression.

The psychoanalytical point of view therefore may be as valid as the sociological theory stressing *anomie* and the lack of integration within human groups as etiological, but some synthesis of the two points of view is possible and should prove more comprehensive. The most frequently cited common characteristic of persons who later kill themselves is loneliness, or psychosocial isolation. Many investigations have pointed to a disruption of close personal relationships, particularly bereavement or loss, as being a main precipitating factor in suicidal behavior. Such isolating factors as broken homes, unemployment, and old age have been noted. Weiss found the major

factor in the high suicide rates among older people to be such isolation along with depreciating sociocultural attitudes, low socioeconomic status with loss of psychologically and socially rewarding occupation, biological decline, and clinically recognizable psychiatric disorder. Psychological inability, refusal, or lack of opportunity to relate to others is clearly important, but many people continue living under such conditions. To precipitate a crisis, something more is necessary. Alvarez (like West) indicated that this “something more” is despair. The victim sees no hope; when some possibilities exist, he denies or overlooks them. He turns to suicide, then, not because of any positive desire for death, but because he no longer can hope.

Zilboorg, Andics, and others have pointed out that persons who were denied in childhood a normal loving relationship with their parents or parental surrogates are likely to feel unloved and unwanted in later life, and therefore to develop suicidal tendencies. Hendin found differential suicide rates in three Scandinavian countries to be related to child-rearing patterns. High rates in Sweden and Denmark were associated with rigid self-demands for superior performance (with subsequent self-hate for failure) in the former, and a “dependency loss” dynamic in the latter. The lower rates in Norway, on the other hand, were associated with persons reared to be externally aggressive who only become suicidal when that aggression is inverted toward the self. Hendin’s methodology has been criticized, but other investigators have found that suicidal acts among children, although rare, are

related to a need for love and at the same time to a desire to punish both the self and the human environment. Paffenbarger's and his colleagues' studies of 40,000 American male former university students (with examination of records of fifteen to forty years previous) revealed that early loss or absence of the father was the dominant distinguishing characteristic of their subjects who committed suicide. Such developmental patterns may well provide a common etiological factor, since they are also likely to lead to social isolation, a hypothesis substantiated in part by the studies of Walton.

Comprehensive psychosocial studies of the etiology of attempted suicide (rather than successful suicide) have been somewhat more common. In Stengel and Cook's extensive investigations, attempted suicide was studied as a meaningful and momentous event in the person's life with special consideration of its effects on the social environment. Their chief conclusions were: (1) that the suicidal attempt is a phenomenon different from the successful suicide, one that should be studied as a behavior pattern of its own; (2) that an appeal to the human environment is a primary function of the suicidal attempt; and (3) that the suicidal attempt has a variety of social effects, especially on interpersonal relations, which may determine the eventual result of the attempt. Stengel and Cook declared that "in our society every suicidal warning or attempt has an appeal function whatever the mental state in which it is made." Their evidence supporting this statement is strong (although it may not apply to the limited group of aborted successful

suicidal attempts), and their work makes it clear that attempted suicide does not represent a simple dynamic or even diagnostic pattern but is usually overdetermined behavior, involving both the person himself and the social environment in which he functions.

In contrast to this point of view, many persons still regard attempted suicide simply as a gesture to bring another person to terms. Although this secondary gain probably motivates the suicidal gesture *per se*, Weiss demonstrated that the dynamics of the true suicidal attempt are more complicated, and involve in all cases a discharge of self-directed aggressive tendencies through a gamble with death (of varying lethal probability), in most cases an appeal for help, and in some cases a need for punishment and a trial by ordeal. First of all, true suicidal attempts are consciously or unconsciously arranged in such a manner that the lethal probability may vary from almost certain survival to almost certain death, and “fate”—or at least some force external to the conscious choice of the person—is compelled in some perhaps magical way to make the final decision. This appears to hold for the attempts of hysteric and psychopathic patients, as well as for those of schizophrenic and depressed psychotics. The psychodynamic factors involved in such suicidal attempts are probably not unlike those involved in gambling itself, as described, for example, by Fenichel. There is evidence that the true suicidal attempt does serve to discharge aggressive tendencies directed against the self or against introjected parental figures—self-mutilation may

play a part in this. Both Stengel and Weiss have noted that patients who had made true suicidal attempts, whether or not they were then treated in any psychotherapeutic manner, demonstrated considerable subsequent improvement in affective state and general outlook. In some cases, improvement following the attempt appeared to be related to a guilt-relieving mechanism; the patients felt that in the very attempt, and in the associated gamble with death, they were punished for whatever acts committed or fantasies entertained that had contributed to their feelings of guilt. Stengel and Cook noted that the outcome of the attempt "is almost invariably accepted for the time being and further attempts are rarely made immediately, even if there is no lack of opportunity. The outcome of the attempt is accepted like that of a trial by ordeal in mediaeval times."

In most true suicidal attempts, there is also discernible an effect of hidden or overt appeal to society, a "cry for help." The attempts are causally related to difficulties with interpersonal relationships and the social environment, but most attempters manage to maintain some contact with other persons, so that the call for help may be recognized. Stengel and Cook, and later Farberow and Shneidman, have demonstrated that such an appeal is inherent in most true suicidal attempts, irrespective of the mental state and the personality of the attempter. Evoking some change in the social situation, through the responses of individuals or groups to this conscious or unconscious appeal for help, is, then, one of the primary functions of such

attempts. In the unreported cases, the person's difficulties are probably so modified as a consequence of the suicidal attempt that no immediate further action is required. Many people, whether responding as friends, policemen, or physicians, do not consciously recognize this appeal; nevertheless, they are shocked and interested by the fact that some human being was so disturbed as to attempt to take his own life. The suicidal act, although taboo in Judeo-Christian culture, usually arouses sufficient sympathy to bring about some change in the circumstances surrounding the person who makes the attempt.

Often, the relationship of the patient to other persons, or to groups, undergoes marked changes as the consequences of a suicidal attempt. These changes are not usually consciously planned. Some relationships are strengthened, some terminated, but almost always the true suicidal attempt results in some immediate change in the constellation of relationships of the person to other persons or to the whole social group (although these changes may not be lasting). The fact that as a consequence of the attempt many persons are admitted to a hospital, there to remain for varying lengths of time, in itself often effects proximate changes. The patient is ready to accept these changes, for he has (it might be said) listened to the demands of a severe superego, atoned for his sins by attempting suicide in such a manner that he gambled with death, and accepted the outcome—life— as the answer (or perhaps reward), in a general sense, of fate or a divine judgment, or, more specifically, of the superego.

Since Weiss et al. found the relatively small but important group of aborted successful suicidal attempters to be epidemiologically and clinically more similar to successful than to other non-successful attempters, it seems likely that those persons whose attempts are both medically dangerous and psychologically serious may be differentiated psychodynamically as well from those whose attempts are not, and will in fact demonstrate patterns similar to those whose attempts are successful. Custer and Weiss found that the dynamics of the aborted successful suicidal attempters were similar to those of a matched group of clinically depressed patients who had not evidenced suicidal behavior, but the attempters in addition had been predisposed both by a family history of suicide and by loss of one or both parents before age fifteen. With a past history of prior attempts, these suicidal persons then made the index serious attempt, precipitated in most cases by loss of a loved one within three months prior to the act.

It should be noted that the psychodynamics of suicidal attempts among children and adolescents may be somewhat different from those of adults. Many studies have indicated that the risk of attempted suicide with non-fatal outcome may be very high in the younger age groups, particularly among females and in the lower socioeconomic classes. In contrast with the older age groups, personal and domestic problems appear to predominate as causes and several investigators have found a high incidence of broken homes in early youth." Schrut noted that such younger attempters often have been

involved in a series of various self-destructive acts. Such acts appear to arise from feelings of anxiety and helplessness which may be reduced by arousing parental concern. Jacobs interviewed fifty adolescent suicide attempters, examined in detail their life histories, and compared them with those of a matched control group. The resulting data indicated that adolescent suicide attempters, as compared to the control non-attempters, demonstrated longstanding psychological problems, which escalated rapidly and to a marked degree after the onset of puberty. With subsequent progressive failure of available coping techniques, these adolescents then became more and more socially isolated. Finally, in the weeks and days preceding the suicide attempt, there appeared to be a chain-reaction dissolution of any meaningful social relationships which might have helped the subject deal with both old and increasing new problems.²

Basic Epidemiological Patterns

Since the classic research of Durkheim, the frequent occurrence of certain statistical trends and personality characteristics among persons who have attempted or committed suicide has been noted in a number of large-scale studies (reviewed by Dahlgren, Dublin, Farberow and Shneidman, Rost, Sainsbury, Stengel, and Weiss). Such investigations have indicated that the more serious or successful suicidal attempts are most likely to occur among older persons, males, divorced, widowed, single, or married persons without

children, persons isolated socially, persons with one or more close relatives dead or who have a history of suicide in the immediate family, persons who have made prior suicidal attempts, persons who use shooting or hanging as the attempted or considered method, persons who attribute the act to “concern about ill health” or “loss of a loved one,” and persons suffering from affective psychoses, schizophrenic reactions, delirious states, chronic brain syndromes, or chronic alcoholism, or persons who appear clinically depressed regardless of diagnosis.³

The validity and importance of epidemiological studies as an adjunct to clinical analyses have been discussed and justified by numerous authors, Dublin in particular. At one conference, Faris cited the case of a scientist who made a newspaper statement to the effect that the marked decrease in United States suicide rates in the decade from 1937 to 1947 was undoubtedly due to the great popularity during that period of electric shock treatment of the mentally ill. The cited scientist was unaware, apparently, that suicide rates almost invariably decrease in periods (as in the decade noted) of war or prosperity. Suicide rates do vary from year to year: The rate in the United States at the beginning of the century was 10.2 suicides per 100,000 persons per year, and by 1915 it had increased to 16.2. The number of people taking their own lives decreased sharply in 1916 and continued to decline through the war years and immediate post-war years until, in 1920, the rate had returned to 10.2 per 100,000. By 1921, the rate had risen to 12.4, remaining

near this level for the next five years. After 1925, it climbed steadily upward, reaching its maximum of 17.4 in 1932. In the later depression years, the rate dropped slowly to about 10 during World War II; thereafter, it has remained fairly constant between 10 and 12 per 100,000, although the lowest rate since 1900 has been 9.8, reached in 1957.

More than 20,000 suicides now are recorded each year in the United States, and Dublin has estimated that the true number is no less than 25,000 (more recently, Choron suggested at least 30,000). Death by suicide thus represents about 1 to 2 percent of all deaths occurring in the United States during the year. An average of at least 1,000 persons each day commit suicide throughout the world, 80 of these in the United States. Thus, perhaps half a million persons in the world die by their own hand each year, and suicide has ranked among the first twelve causes of death in most European countries and in North America for many years. If these trends continue, out of every 1,000 white male infants, at least fifteen will eventually take their own lives; out of every 1,000 white female infants, four will do so, according to Dublin.

Many countries have higher suicide rates than the United States, especially Hungary, Finland, Austria, Czechoslovakia, Japan, Denmark, Germany, Switzerland, Sweden, France, and Australia. In striking contrast, suicide rates for Israel, Norway, the Netherlands, and Italy are low, and those for Ireland and Spain are extremely low, as are those in several South

American countries. Sweden's rate is still roughly what it was before implementation of extensive welfare programs. Recent investigations have shown that suicide in developing countries is a more important problem than was formerly suspected.

It is notable that suicide in white America is concentrated among older people: The rates for white males increase consistently with each advancing age group, while for white females they do so until the mid-fifties or early sixties, after which they tend to level or begin some decline. (Rates for nonwhite persons show somewhat different and less decided patterns.) Children rarely kill themselves, although, because of the often spectacular and tragic nature of the act, successful suicides of children and adolescents are sometimes thought to be quite frequent. Recent age-specific rates do show upward trends for the younger and middle ages, with a slightly downward trend for the older ages. There has been a marked rise in successful suicide among adolescents aged from fifteen to nineteen, and suicide is now the third-ranking cause of death in this age group. In college students, suicide is the second-ranking cause of death (after accidents). However, in the United States, among adolescents and young adults, the suicide rate still runs only from about 4 to 6 per 100,000, but the successive increment in each succeeding age group imposes a maximum rate of 25 to 33 per 100,000 by the age period of seventy-five years and over. This correlation with age is especially marked for white males: At the younger ages, the rates for males

are about three times those for females, but among the aged the ratio is ten to one, or more. In almost all European countries as well, about two to three males commit suicide for every female who does, although rates for females are increasing in many countries.

The suicide rate of foreign-born American men is significantly higher than that of the native-born, and the differences among the foreign-born population are similar to those found in their respective homelands. The Negro in this country is far less likely to commit suicide than the white, although rates among blacks are increasing, especially in the cities, and Hendin found that young urban Negro males have a suicide rate that is probably higher than that for white men of the same age. Nonwhites other than Negroes generally have higher rates than white persons.⁴ These differences, however, should not suggest that predisposition to suicide is inherited. Kallmann and Anastasio, studying suicide in twins, found no evidence to implicate definite hereditary factors. But the work of Pitts and Winokur indicates that at least a tendency to affective disorder and associated suicide may be related to familial patterns, especially in males.

Suicide has been more common in urban than in rural areas, but, as the United States has become more urbanized, the gap in suicide rates has been greatly narrowed. Suicide rates also vary among the major centers of population, and tend to be highest in the Western states and lowest in the

Southern (except Florida and Virginia). Six metropolitan areas have very high rates: Tampa-St. Petersburg, San Francisco-Oakland, Los Angeles-Long Beach, Seattle, Sacramento, and Miami. Other cities (including such very large centers as New York and Chicago) have moderate or even low rates. West Berlin is said to have the highest rate of any city in the world. In general, the incidence of suicide is not significantly related to climate, although in the great majority of countries suicide rates follow a certain rhythm with the changing seasons of the year, a maximum incidence occurring in springtime. In the United States, April nearly always has the highest daily average number and December the lowest.

Although there is no simple causal relation between economic factors and suicide, suicide rates do tend to decrease in times of prosperity and increase during depression. The relation between suicide rates and socioeconomic status is somewhat contradictory, although there is good evidence that members of the lower socioeconomic classes have lower suicide rates than do members of the upper socioeconomic classes, except after the age of sixty-five, when the rate for lower-class males becomes considerably higher than that for upper-class males. Suicide rates among physicians are three times the national average, and among these psychiatrists may have even higher rates. Age-adjusted suicide rates are highest for divorced persons, next for widowed, next for single, and lowest for married persons.

Suicide rates also decrease during war, apparently a universal phenomenon that has been reported in all wartime countries and has even been observed in some neutral nations during wartime. This latter phenomenon is always more marked among men than among women, and, in this country, among white than among black persons. It is difficult to measure statistically the influence of religion on the suicide rate, but suicide mortality is generally (although certainly not uniformly) lower in countries where a large proportion of the population is Catholic; however, suicide rates among Catholics living in non-Catholic countries may not be significantly lower than among Protestants living in the same countries. The rates among Jews have been variable, but, particularly in recent years in the United States and Israel, have tended to be low.

Early in the nineteenth century, one Matthew Lovat, an Italian shoemaker in Venice, attempted to commit suicide by nailing himself to a cross. Other fantastic suicide methods in history have included swallowing red-hot coals, self-suspension from a bell clapper in a village church, and beheading with a self-made guillotine. Most people, however, choose one of a very few common suicide methods. Almost nine-tenths of all successful suicides in the United States involve shooting, hanging, poisoning, or asphyxiation. Since the beginning of the century, shooting has increased in frequency and now accounts for almost half of all U.S. suicides, whereas poisoning and asphyxiation by gas (by far the leading methods in 1900)

declined in popularity for some years but—in the form of ingestion of analgesic and/or soporific substances or asphyxiation by motor vehicle exhaust gas—are again being used more frequently. Cases of self-poisoning have constituted 4 to 7 percent of admissions to the medical wards of general hospitals in Great Britain. Dublin suggested that the choice of method is in part determined by availability and accessibility of the agent, but he pointed out the multitude of means available to any determined seeker of suicide, noting that persons intent on self-destruction have used any method conveniently at hand, even crashing one's head against a wall or drowning in a few inches of water.

Another factor involved in the choice of a specific method may be related to suggestibility. Although suicides actually have occurred in epidemic form (in the United States in 1930, in Copenhagen during World War II), they are not generally manifested as such violent reactions under such singular circumstances. A "law of series" in suicides, claiming a high probability that after one suicide at a given location more will follow, has been mentioned in some earlier works. Modern data indicate, however, that such "series" usually consist of only a few cases, employing similar methods, which, although widely publicized, occur but rarely. Dublin emphasized that individual psychological factors are most important: "The mental economy of the suicide is such that he sometimes will go to great lengths to kill himself in a particular manner that satisfies some personal or symbolic requirement." A case in

point is that of the would-be suicide who some years ago jumped from the Brooklyn Bridge. Conscious after hitting the water, he refused to grab a rope lowered to him by a nearby policeman—refused, that is, until the policeman threatened to shoot him.

Epidemiological patterns of *attempted suicide* are far more difficult to analyze than those of successful suicide, because reports of the rates of suicidal attempts represent only a fraction of the real incidence of all suicidal attempts among the general population. To be included in any statistical study, a suicidal attempt must result in the person's being brought to the attention of a physician, a policeman, or some similar authority; and that authority must report the attempt. For a variety of reasons, most suicidal attempts are not so registered; moreover, there is some evidence that those attempts that are reported involve specially selected groups and that the selective factor varies in different places at different times. Such samples are, then, almost always unrepresentative.⁵

In many statistical reports, the number of suicidal attempts is listed as less than the number of successful suicides. The Metropolitan Life Insurance Company has ventured the educated but conservative estimate that the real rate of suicidal attempts is at least six or seven times as great as that of successful suicides; Farberow and Shneidman reported a ratio of eight attempted suicides to one successful suicide in Los Angeles—a figure that

Stengel has suggested as probably appropriate for at least the urban populations in the United States and England. Parkin and Stengel found the actual ratio between attempted suicide and suicide (in England) to be 9.7 to 1, and thought this was an underestimate. Choron has calculated that between six and seven million U.S. residents have attempted suicide. Paykel et al. conducted an extensive and careful survey of 720 subjects in the general population of New Haven, Connecticut. They found a ratio of thirty-two suicidal attempts to everyone expected completed suicide for their subjects, with 0.6 percent of the total group reporting having made a suicidal attempt *during the previous year*, 1.5 percent having seriously considered suicide, and approximately 9 percent having had some sort of suicidal thoughts during the same period. These suicidal feelings were reported more by females than males, but otherwise appeared largely independent of sociodemographic status. They were strongly associated with other indices of psychiatric problems, social isolation, and life stress.

Certain facts are known about such unsuccessful attempts: They are more common among females than males, especially in the population group under thirty years of age. In a very detailed survey conducted in Edinburgh, Kessel found very high rates of attempted suicide among teenage girls and women in their early twenties. The author suggested that these young women who attempt suicide, even though married and possibly looking after children, tend to be emotionally isolated. The peak for both sexes in Kessel's

study was in the twenty-four to thirty-four age group, and in that age group the rates for widowed and divorced persons were especially high. The percentage of successful attempts becomes greater with increased age; attempted suicides among the young are the least successful. The socioeconomic class distribution among persons reported as attempting suicide tends to correspond to that of the general population, although some recent studies indicate a disproportionate concentration in the lower classes. The most efficient suicide methods (shooting, hanging, drowning, jumping from high places) are generally more common among men, whereas females are more likely to use poison, the least efficient method.

If those who attempt suicide and those who successfully commit suicide do represent two different, but overlapping, populations, one would expect that the number of persons later committing suicide who have made earlier unsuccessful attempts would be proportionately small. Although difficult to collect, there are some limited data to this point. The studies of Sainsbury and Stengel and Cook suggest that about one-tenth of all persons who commit suicide have made one or more prior suicidal attempts. Other investigators have found a somewhat higher fraction—up to one-quarter. Dorpat and Ripley reviewed twenty-four published studies bearing on the relationship between attempted and committed suicide and reported that the incidence of prior suicidal attempts among those who completed suicide and the incidence of completed suicide among attempters were both much higher than that of

the general population.

Since such reported suicidal attempts probably represent only a small sample of all suicidal attempts, both reported and unreported, information gathered to indicate just how many of those who attempt suicide finally do kill themselves also may be only approximate. But several such studies have been made and show surprisingly consistent results, despite reference to different countries and different times. In the comprehensive review by the World Health Organization, some twenty investigators (including Dahlgren, Ringel, Schmidt et al., Schneider, and Stengel) conducting various types of frequently extensive follow-up studies of persons attempting suicide found that from about 2 percent in less than a year to about 10 percent in ten years subsequently killed themselves. Schmidt et al., Rosen, Greer and Lee, and Weiss and associates all found definitely higher rates of subsequent committed suicide among those who made “serious” attempts, and in the WHO study it is noted that “if there have been two previous attempts, the subsequent risk of suicide is considerably increased.” Therefore, although the total number of persons who finally commit suicide after a previous suicidal attempt obviously increases as the period following the attempt lengthens—at least up to ten years—it can be seen that only a limited proportion of those reported as having attempted suicide finally kill themselves, and that the proportion of all persons attempting suicide who finally kill themselves is probably quite small. However, it should be apparent that the risk of eventual

successful suicide is still far higher among those persons who have attempted suicide than among the general population, and that those persons who have made one or more medically dangerous, psychologically serious prior attempts are at far higher risk of committing subsequent successful suicide than those whose prior attempts were of lesser medical danger and/or psychological seriousness.

Relationships to Clinical Entities

It is also difficult to determine the quantitative relationship between categorical psychiatric disorders and suicide rates. Most such information is based on records of patients in hospitals. Kraepelin indicated that psychiatric disorder was a factor in at least one-third of all successful suicides, and other early studies provided similar evidence to this effect. Jamieson, Norris, and Raines and Thompson have all analyzed numerous case records, pointing out that suicide is most common among persons diagnosed as suffering from the affective psychotic disorders but is not uncommon among schizophrenics, and noting cases in which unplanned suicides have resulted from patients' confused states in delirium. Malzberg (cited by Dublin) found an annual rate of 34 suicides per 100,000 resident patients per year, for New York State's mental hospitals in the two-year period from 1957 to 1959. Suicide was most common among patients suffering from manic-depressive and involuntional disorders, and next most common among patients with cerebral

arteriosclerosis and those suffering from schizophrenia. Shneidman et al. found that successful suicide among schizophrenic patients in psychiatric hospitals occurred in almost all cases after there had been a remission of illness, rather than in the depths of the psychotic process.

Sletten et al. studied patients who had committed suicide in hospital or on one-year convalescent leave, and found that the rate was much higher for this group than for the general population. Rates among these subjects were higher for men than for women, for white than black, for married than single, and for Catholic than Protestant, but did not regularly go up with age. In decreasing order, rates were highest for those patients with a diagnosis of depression, schizophrenia, and personality disorder. Rates were also highest during the first months after admission to the hospital.

The difficulties in diagnosis, particularly among non-hospitalized suicide victims, have led to several extreme points of view. Zilboorg believed that most suicides are committed by persons considered “normal” before the act. Lewis, on the other hand, considered that all persons who either commit suicide or make serious attempts are, by virtue of the act, essentially psychotic. Stengel, after reviewing the literature, concluded that suicidal acts—successful or not—may be associated with almost any clinical psychiatric disorder. Seager and Flood’s study of 325 suicides in Bristol, England, over a five-year period, indicated that a family history of mental illness was present

in 10 percent, a previous suicidal attempt in 16 percent, a disabling physical illness in 20 percent, and previous psychiatric illness requiring specialized treatment in 30 percent. There was evidence of mental illness of some kind in over two-thirds of the cases. Sainsbury's investigations of persons who had committed suicide in England also demonstrated a psychiatric diagnosis of serious depressive illness in a large majority of cases, and reports from several major studies on the relationship between psychiatric disorders and ultimate death from suicide reveal that about 15 percent of persons found suffering from depressive illness will ultimately die by suicide (as compared to probably 1 percent of the general population). Osmond and Hoffer followed for twenty-five years 3,521 patients diagnosed as schizophrenic and found a suicide rate among these patients much higher than the normal rate of the countries concerned. These authors believe that the rate of suicide among schizophrenics at least approaches that among manic-depressives. Numerous investigators have also reported a high frequency of suicide among alcoholics, and of alcoholics among samples of persons who have committed or attempted suicide. A large number of alcoholic fathers among young people attempting suicide has been noted, and Murphy and Robins found that among alcoholics per se who committed suicide, almost one-third had experienced disruption of affectional relationships within six weeks prior to the act.

Probably the most rigorous study relating clinical entities to suicide was

made by Robins' group in St. Louis. These investigators studied 134 consecutive successful suicides, including systematic interviews with family, in-laws, friends, job associates, physicians, ministers, and others, a short time after the suicide act. Using careful and well-defined criteria for illness, their results indicated that 94 percent of those committing successful suicide had been psychiatrically ill, with 68 percent of the total group suffering from one of two disorders: manic-depressive depression or chronic alcoholism. (If one summarizes other international cross-study data, it seems probable that of those persons who commit suicide, about half are suffering from serious depressive illness, perhaps one-fifth to one-quarter from some degree of chronic alcoholism, and a significant but smaller number from schizophrenia.) These results should be compared with those in an earlier study of 109 patients who *attempted suicide*, in which Schmidt et al. found that the psychiatric disorders represented could be classified into nine different diagnostic categories; no attempter was thought to be "normal" prior to the attempt. Thus, attempted suicide is most likely a symptom or sign associated with a large variety of clinical psychiatric disorders, whereas successful suicide (probably including the aborted successful suicidal attempt) is most likely to be associated with depressive disorder of psychotic proportions and chronic alcoholism, and probably, to a lesser degree, with schizophrenia and organic brain disorder.

Indicators of Suicide Potential: Implications for Prevention

Recent studies have indicated that successful suicide is far less often an impulsive act without prior indicators than had previously been supposed. Robins et al. found that in their series a majority of the persons committing suicide had been under medical or psychiatric care, or both, within one year preceding the act. many of them within one month. In another paper, Robins and his colleagues noted a high frequency among persons who later committed suicide of the communication of suicidal ideas, by specific statements of intent to commit suicide, by statements concerning preoccupation with death and desire to die, and by communications associated with unsuccessful attempts. These statements were made to family, friends, job associates, and many others, and were repeatedly verbalized, by well over half of those who did later kill themselves. Rudestam also found that 60 percent of his fifty consecutive cases of confirmed suicide in both Stockholm, Sweden, and Los Angeles had made direct verbal threats prior to taking their lives, while more than 80 percent had voiced either direct or indirect threats.

Although many people who communicate suicidal intention may not commit suicide, it is clear from such studies and those of Shneidman and Farberow that most people who actually commit suicide communicate their intention beforehand. Gardner et al. also noted that in the high-frequency, successful suicide groups of older patients with depression, chronic

alcoholism, or paranoid schizophrenia, there is a tendency to deny illness and to communicate any suicidal intention or need for help in an indirect, distorted manner. Shneidman and Farberow found a critical period of about three months following a severe emotional crisis during which persons are most likely to commit suicide. An increase in psychomotor activity, therefore, does not necessarily indicate “improvement” in the long run.

Litman and Farberow have noted that the potential for successful suicide increases specifically with age, prior suicidal behavior, loss of a loved person, clinically recognizable psychiatric disorder, physical health problems, and lowered interpersonal, social, and financial resources. They emphasize as warning signs withdrawal from and rejection of loved ones, suicide threats (particularly those giving details of time and place), and overt expressions of suicidal intention, plus such behavior as putting effects in order, making out a will, and writing notes and letters with specific instructions. They suggested: “The most serious suicidal potential is associated with feelings of helplessness and hopelessness, exhaustion and failure, and the feeling I just want out.” Others have stressed that the feeling of “being a burden” to one’s family or friends is also a special danger sign.

However, the intensive small-N investigation by Weiss et al. has indicated that the many social, ecological, and personality factors that appear to relate to the seriousness of suicidal attempts in large-scale nomothetic

studies do not for the most part seem to be useful for prediction with limited samples or individual patients. The only statistically significant indicators of the gravity or danger of the suicidal attempt for individual attempters appeared to be (a) attempts in which the psychological intent was “serious”; (b) attempts of older adults; (c) of those who attributed the act to concern about personal “mental illness”; and (d) of those who were diagnosed as suffering from a clinical psychotic process of any nature, but especially depression. In a ten-year follow-up study of the same patients, Weiss and Scott found the risk of subsequent successful suicide to be much higher among those who had earlier made such serious attempts than among those who had made non-serious attempts, that persons who made any kind of attempt tended to have continuing psychosocial problems after the attempt, and that the lifestyle of suicide attempters generally showed little change when followed over that long period and no change significantly different from that evidenced by matched controls. The attempts of younger persons, of those whose method involved solely the ingestion of barbiturates or other substances of limited toxicity, and of those who attributed the act to the precipitating stress of “family trouble,” were generally not psychologically serious or medically dangerous. The presence of a “death trend” (one or more close relatives of the attempter being dead) and the presence of nonpsychotic clinical depression appeared to be functions of increasing age rather than substantive indicators.

The WHO expert committee stated, "Persons with [endogenous and involuntal] depressive illness appear everywhere to constitute a high risk group. In suicide-prevention programs, high priority should therefore be given to improvement in recognition and treatment of these conditions and organizations of after-care for treated cases." Rosen noted that insomnia prior to the attempt is an additional sign of high risk. Sainsbury also emphasized that suicidal risk is correlated with depression and with the primary medical symptom of insomnia, especially in the elderly.

Although such information provides a guide to probabilities, the fact remains that every emotionally disturbed person who indicates suicidal intent should be evaluated by a competent psychiatrist. Any depressive reaction may carry with it some danger of suicide, and no suicidal talk should be taken lightly. Almost all experienced clinicians indicate that, if there is any suspicion at all of suicidal intent, the patient should be questioned about it. Such a procedure will not give the patient any ideas of suicide that he does not already have, and his response will often help to determine his intent. If his response is bizarre, illogical, or delusional, or if it includes ideas of worthlessness or indicates a preoccupation with thoughts of suicide and with actual concrete procedures for carrying out the act, one should consider the danger of a serious or successful suicide attempt to be great.

Clinicians who deal with suicidal patients would, of course, find a valid

and reliable screening test predictive of both the possibility of suicidal attempt and the degree of lethality of such attempt extremely useful. A considerable number of investigators have developed such suicide risk assessment schedules, indices, rating scales, and even biochemical tests (exemplified in Refs. Bolin, Buglass, Bunney, Cohen, Dean, Farberow, Litman, Pöldinger, Resnick, Sletten, and Tuckman), but neither the specificity nor the sensitivity of such instruments has been adequate for general acceptance. Rosen has pointed out the many limitations which make the prediction of infrequent events such as suicide so difficult. Perhaps the most promising technique to this end is being developed by Litman and his colleagues, who are using actuarial methods to quantify the concept of suicidal risk as part of a mathematical model for predicting suicidal behavior. This model will assign a suicide probability both to individual subjects and to groups for any coming year, utilizing multiple factors input with an output providing an index of present risk and a guide for predicting future self-destructive behavior. Litman wrote, however, that "suicide probably is too complex and variable a problem to be handled by any general or unitary scale or testing device," that any such scale would need to be adapted to each different setting and utilized only to supplement the clinical judgment of professional workers with experience in that particular setting.

Many psychiatrists feel that, if suicidal intent is suspected, immediate hospitalization of the patient on a psychiatric inpatient service is mandatory.

Other well-trained psychiatrists take a calculated risk with such patients and follow them as outpatients. Such a decision, however, must be made on the basis of special knowledge—knowledge of the probabilities and prognoses in similar cases, and knowledge of the particular patient, based on intensive interviews, psychological tests, social histories, and similar data. It seems obvious that persons who express suicidal intentions or make suicidal attempts are so emotionally disordered that they are willing to consider risking their lives in a gamble with death, and it is the responsibility of physicians and other professional workers who come in contact with such persons to assess the meaning of each suicidal communication or attempt, with respect to how best to respond to the implied need for help.

In countries with highly developed and readily available health and welfare services, a variety of organizations exist for the prevention of suicide and the treatment of patients with suicidal behavior. These services vary from networks of general medical practitioners to general hospitals, and from outpatient clinics to specific psychiatric hospitals and community mental health centers. In some such countries, specialized institutions have been established to deal with suicidal patients and those who have already attempted suicide. A notable example is the Los Angeles Suicide Prevention Center, operated with the co-operation of available medical, psychological, welfare, pastoral, and other community resources. This agency maintains a telephone “hot-line,” and referral in person may be made through medical or

lay sources, or the patient may come on his own. More than 200 such centers have been established in other cities in the United States and also in other countries, such as Austria, France, Germany, and Switzerland. Lay organizations also offer help to suicidal persons who either do not regard their difficulties as medical problems or refuse to seek medical help. The best known is the Samaritans, which started in London but has become international. There are similar groups in several U.S. cities. They rely mainly on volunteers, who help to maintain full-time telephone services and offer useful advice and support, as well as referral to medical and welfare agencies. Former clients often cooperate in running such services.

Two major criticisms have been made of both the professional and lay suicide prevention services, namely, (1) that many of the patients evaluated and/or treated therein are not actually suicidal, and (2) that the services of such organizations cannot be proved to be effective. The first criticism is probably neither humane nor valid, since clients of such agencies would not be referred or seek aid voluntarily unless they perceived a need for help, and since Wold, reviewing 26,000 Los Angeles SPC cases, found that 51 percent had made a suicidal attempt at some time in the past. The second criticism is refuted at least partially by Bagley's study done in Great Britain, which provided evidence that recently instituted 24-hour telephone and other services, giving isolated, lonely, or desperate persons a chance to communicate with volunteer workers, were most probably related to a

statistically significant drop in the suicide rate of 5 percent in the subject areas, compared to a rise of 20 percent in matched control areas without such services. And Barraclough has reviewed evidence that institution of modern medical and psychiatric services is also likely (perhaps more likely) to be related to a drop in suicide rates.

The WHO expert committee has recommended several guidelines for the establishment and development of suicide prevention services: (1) Local emergency services, accessible at all times, with skilled medical and nursing staff available, should be provided.

Adequate and prompt psychiatric consultation should be available to such treatment centers. (3) Emergency psychiatric services with easy access to care should also be continuously available where there is no other medical emergency service. Such emergency services should include facilities for immediate response to telephone calls or to patients who are referred or come of their own accord. Such services should focus on the handling of the crisis with which the person is immediately concerned, attempting to evaluate the suicide potential and to work out a treatment plan for the patient. Follow-up psychiatric care is highly desirable for many of the patients seen in emergency services, as well as for others identified as high-risk cases. Members of the same psychiatric team should work in both emergency and follow-up care.

The committee noted that many persons who have made suicidal attempts are found after screening not to need special psychiatric treatment but may require other help, such as that provided by social welfare agencies or voluntary groups. Measures taken to lower the incidence of suicide should have a four-fold aim: to deal with the desire to attempt suicide, to prevent the first attempt, to prevent repetition of suicidal acts, and to prevent fatal outcome of such acts. Education of both the general public and the possible providers of service, such as medical practitioners and social workers, thus becomes important, and both national and international associations of professional persons concerned with teaching, research, care, and prevention related to suicide have been organized.

Treatment

Just as the suicidal act must be considered in terms of the psychological, clinical, and sociological aspects of the person involved, so must be his treatment. The therapy of the suicidal patient can be successful only if all these factors are investigated and the pertinent ones so modified that the self-destructive tendency— arising out of an acute emotional crisis, as well as a life-long accumulation of experience, a set of social circumstances, and most often a clinically recognizable psychiatric disorder—is reduced to non-deleterious proportions. Social measures and somatic therapies may be necessary in some cases and helpful in others, but psychotherapy directed

toward understanding the need for a suicidal act appears to be a *sine qua non* in almost any rational treatment program for suicidal patients. Farberow and Shneidman and their collaborators, in discussing the varieties of therapy useful in treating such patients, have noted that successful treatment may vary with the kind of patient, the nature of the suicidal attempt, the psychodynamic and psychosocial factors involved, the nature and degree of associated psychiatric disorder, and to some extent the theoretical framework within which the therapist operates.

Kessel has stressed that there is considerable advantage in making a thorough psychiatric assessment of all suicidal cases admitted to emergency medical services as soon as possible, at least within a few hours of admission. At that time, inquiries are made into the situation while its impact is still very strong and before the family and patient attempt to cover up the underlying factors. And at that time, such patients can be screened and their further care discussed with the family and other persons most closely concerned. Frederick and Resnik have developed a well-reasoned therapeutic approach based on evidence that many aspects of suicidal behaviors may be learned and that treatment techniques founded in general learning theory can be useful, and Frederick and Farberow have also found that group psychotherapy can be very useful with suicidal persons, although some modifications of standard group methods are probably requisite. In dealing with suicidal behaviors in children, one should remember that the first goal is

seldom prevention of death or injury (since completed suicides in young children are rare) but rather—according to Glaser—assessment of the behavior as a sign of emotional disturbance. The presence of depression is not necessarily a prerequisite for suicidal acts in childhood, and persons other than the psychiatrist are most likely to be in a position first to deal with the problem. Whether one is treating children or adults, however, the clinician should note that almost all authors emphasize the importance of a therapist who manifests sensitivity, warmth, interest, concern, and consistency.

In the hospital environment, success in treating suicidal patients is more likely with a therapeutic milieu having easy lines of communication than with the previously utilized strictures of rigid “suicide precautions.” As Stengel and Cook pointed out, the suicide rates of the resident population of mental hospitals in England and Wales for the years 1920 to 1947 were about three to five times those among the general population, remaining steadily at about 50 per 100,000 patients per year. Those were the years when psychiatrists took away from their patients shoelaces, belts, safety razors, and any other articles that might conceivably be used for self-destruction. And yet, the rates remained consistently high within the closed doors of the mental hospitals of those days. The introduction of electroshock treatment in the late 1930s and 1940s had little or no direct influence on the frequency of successful suicidal acts per se in mental hospitals (although other studies clearly have indicated the clinical value of such therapy, especially in

psychotically depressed older persons). In the 1945-1947 period, when EST was in widespread use, the suicide rates in mental hospitals in England actually increased slightly to 51.5. Surprisingly, in 1953 these in-hospital suicide rates dropped to 27.3, and have remained comparatively lower ever since. A significant decrease in suicide rates therefore occurred in a period when the English mental hospitals were adopting more liberal policies, including "open-door" and "therapeutic community," before the widespread use of the newer psychoactive drugs, and in spite of an increased admission rate during that period for patients with psychotic depression, as well as higher average ages of resident patients who therefore might be expected to be more suicide-prone.

Other studies have indicated rather similar trends in mental hospitals in the United States and elsewhere. Petri's work in Germany supports these findings, as does that of Kapamadzija in Yugoslavia. The latter author suggested that the very humanization of the regimen of psychiatric hospitals and the abolition of the atmosphere of isolation and alienation are also the best means of prevention of suicide by the mentally ill in psychiatric units. Simply increasing the knowledge and sensitivity of all persons who are likely to come into contact with patients or with others who may be potentially suicidal has clearly proved of great importance, both in therapy and in prevention.

Finally, as has been noted, the establishment of units either in categorical suicide prevention and treatment centers, comprehensive community mental health centers, or general hospitals and clinics, to provide well-publicized and easily available psychiatric first-aid, is already demonstrating marked value, both in rendering assistance to potentially suicidal persons and in collecting data that should add inestimable information to our body of knowledge. The evidence indicates that suicidal behavior is most often a symptom (or a terminating act) of biologically, psychologically, and culturally determined psychiatric disorder, not a free moral choice. As Freud wrote, "The moment one inquires about the meaning or value of life one is sick, since objectively neither of them has any existence." The prediction, prevention, and treatment of suicidal behavior is therefore a salient responsibility for the interacting efforts of the basic scientist, the behavioral investigator, the public health specialist, the social activist, and, not least, the clinician.

Bibliography

- Adler, A. "Selbstmord," *Internationale Zeitschrift für Individualpsychologie*, 15 (1937) 49-52;
Journal of Individual Psychology, 14 (1958), 57-61.
- Alvarez, A. *The Savage God: A Study of Suicide*. New York: Random House, 1972.
- Anderson, D. B., and L. J. McClean, eds. *Identifying Suicide Potential*. New York: Behavioral Publications, 1971.

- Andics, M. von. *Suicide and the Meaning of Life*. London: Hodge, 1947.
- Bagley, C. "The Evaluation of a Suicide Prevention Scheme by the Ecological Method," *Social Science and Medicine*, 2 (1968), 1-14.
- Barraclough, B. M. "Doctors, Samaritans and Suicide," *British Journal of Psychiatry* (News and Notes Supplement), April (1972), 8-9.
- Beall, L. "The Dynamics of Suicide: A Review of the Literature, 1897-1965," *Bulletin of Suicidology*, March (1969), 2-16.
- Bernfeld, S. "Selbstmord," *Zeitschrift für Psychoanalytische Pädagogik*, 3 (1929), 355-363.
- Blachly, P. H., W. Disher, and G. Roduner. "Suicide by Physicians," *Bulletin of Suicidology*, December (1968), 1-18.
- Bolin, R. K., R. E. Wright, M. N. Wilkinson, and C. K. Lindner. "Survey of Suicide Among Patients on Home Leave from a Mental Hospital," *Psychiatric Quarterly*, 42 (1968), 81-89.
- Bromberg, W., and P. Schilder. "Death and Dying," *Psychoanalytic Review*, 20 (1933), 133.
- Buglass, D. and J. W. McCulloch. "Further Suicidal Behavior: The Development and Validation of Predictive Scales," *British Journal of Psychiatry*, 116 (1970), 483-491.
- Bunney, W. E., J. H. Fawcett, J. M. Davies, and S. Gifford. "Further Evaluation of Urinary 17-Hydroxycorticosteroids in Suicide Patients," *Archives of General Psychiatry*, 21 (1969), 138-150.
- Cain, A. C., and I. Fast. "Children's Disturbed Reactions to Parents' Suicide," *American Journal of Orthopsychiatry*, 36 (1966), 873-880.
- Cavan, R. S. *Suicide*. Chicago: University of Chicago Press, 1926.
- Choron, J. *Suicide*. New York: Scribner's, 1972.
- Cohen, E., J. A. Motto, and R. H. Seiden. "An Instrument for Evaluating Suicide Potential: A

- Preliminary Study," *The American Journal of Psychiatry*, 122 (1966), 886-891.
- Custer, R. L., and J. M. A. Weiss. "The Aborted Successful Suicidal Attempt: Differential Patterns," *Journal of Operational Psychiatry*, 2 (1971), 29.
- Dahlgren, K. G. *On Suicide and Attempted Suicide*. Lund, Sweden: Lindstedts, 1945.
- Dean, R. A., W. Miskimins, R. de Cook, L. T. Wilson, and R. F. Maley. "Prediction of Suicide in a Psychiatric Hospital," *Journal of Clinical Psychology*, 23 (1967), 296-301.
- Dorpat, T. L., and H. S. Ripley. "The Relationship Between Attempted Suicide and Committed Suicide," *Comprehensive Psychiatry*, 8 (1967), 74-79.
- Dublin, L. I. *Suicide: A Sociological and Statistical Study*. New York: Ronald Press, 1963.
- Durkheim, E. *Le Suicide*. New York: The Free Press, 1951.
- Ettlinger, R. W., and P. Flordh. *Attempted Suicide: Experience of Five Hundred Cases at a General Hospital*. Copenhagen: Acta Psychiatrica, Kbh. (Suppl. 103), 1955.
- Farberow, N. L. *Bibliography on Suicide and Suicide Prevention*. Chevy Chase: National Institute of Mental Health, 1969.
- Farberow, N. L., and A. C. Devries. "An Item Differentiation Analysis of MMPIs of Suicidal Neuropsychiatric Hospital Patients," *Psychological Reports*, 20 (1967), 607-617.
- Farberow, N. L. and E. S. Shneidman. *The Cry for Help*. New York: McGraw-Hill, 1961.
- Farberow, N. L., E. S. Shneidman and C. Neuringer. "Case History and Hospitalization Factors in Suicides of Neuropsychiatric Hospital Patients," *Journal of Nervous and Mental Disease*, 142 (1966), 32-44.
- Federn, P. "Diskussion über Selbstmord im Wiener Psychoanalytischen Verein," *Zeitschrift für Psychoanalytische Pädagogik*, 3 (1929), 333-344.
- . "Reality of the Death Instinct, Especially in Melancholia," *Psychoanalytic Review*, 19 (1932),

Fenichel, O. *The Psychoanalytic Theory of Neurosis*. New York: Norton, 1945.

Frederick, C. J., and N. L. Farberow. "Group Psychotherapy with Suicidal Persons: A Comparison with Standard Group Methods," *International Journal of Social Psychiatry*, 16 (1970), 103-111.

Frederick, C. J. and H. L. P. Resnick. "How Suicidal Behaviors are Learned," *American Journal of Psychotherapy*, 25 (1971), 37-55.

Freud, S. "Beyond the Pleasure Principle" (1920), in Standard Edition, Vol. 18. London: Hogarth Press, 1957.

---. "Mourning and Melancholia" (1917), in *Collected Papers*, Vol. 4. New York: Basic Books, 1959.

Gardner, E. A., A. K. Bahn, and M. Mack. "Suicide and Psychiatric Care in Aging," *Archives of General Psychiatry*, 10 (1964), 547-553.

Giddens, A., ed. *The Sociology of Suicide*. London: Frank Cass, 1971.

Glaser, K. "Suicidal Children," *American Journal of Psychotherapy*, 25 (1971), 27-36.

Gordon, J. E., E. Lindemann, J. Ipsen, and W. T. Vaughan. "Epidemiologic Analysis of Suicide," in *Epidemiology of Mental Disorder*. New York: Milbank Memorial Fund, 1950.

Greer, S., and H. A. Lee. "Subsequent Progress of Potentially Lethal Attempted Suicides," *Acta Psychiatrica Scandinavica*, 43 (1967), 361-371.

Gruhle, H. W. *Selbstmord*. Leipzig: Theime, 1940.

Hendin, H. "Attempted Suicide," *Psychiatric Quarterly*, 24 (1950), 39-46.

---. *Black Suicide*. New York: Basic Books, 1969.

---. *Suicide and Scandinavia*. New York: Grune and Stratton, 1964.

- Henry, A. F., and J. F. Short. *Suicide and Homicide: Some Economic, Sociological and Psychological Aspects of Aggression*. New York: The Free Press, 1954.
- Horney, K. *Neurosis and Human Growth*. New York: Norton, 1950.
- Jacobs, J. *Adolescent Suicide*. New York: Wiley-Interscience, 1971.
- Jacobziner, H. "Attempted Suicides in Children," *Journal of Pediatrics*, 56 (1960), 519-525.
- Jamieson, G. R. "Suicide and Mental Disease," *Archives of Neurology and Psychiatry*, 36 (1936), 1-12.
- Jung, C. G. "The Soul and Death," in Feifel, ed., *The Meaning of Death*. New York: McGraw-Hill, 1959.
- Kallmann, F. J., and M. M. Anastasio. "Twin Studies on the Psychopathology of Suicide," *Journal of Heredity*, 37 (1946), 171-180; *Journal of Nervous and Mental Disease*, 105 (1947), 40-55-
- Kapamadzija, B. "Suicide and Some Legal Problems," *Annals Bolnice Dr. M. Stojanovic*, 10 Supp. (1971), 50-55.
- Kessel, N. "Self-poisoning," *British Medical Journal*, 5473 (1965), 1265-1270, and 5474 (1965), 1336-1340.
- Kessel, N. and W. McCulloch. "Repeated Acts of Self-poisoning and Self-injury," *Proceedings of the Royal Society of Medicine*, 59 (1966), 89-92.
- Kraepelin, E. *Lectures on Clinical Psychiatry*. New York: Wood, 1917.
- Kreitman, N. "Subcultural Aspects of Attempted Suicide," in E. H. Hare, and J. K. Wing, eds. *Psychiatric Epidemiology*. London: Oxford University Press, 1970.
- Lendrum, F. C. "A Thousand Cases of Attempted Suicide," *The American Journal of Psychiatry*, 13 (1933), 479-500.

- Lester, D. "Seasonal Variation in Suicidal Deaths," *British Journal of Psychiatry*, 118 (1971), 627-628.
- Lewis, N. D. C. "Studies on Suicide," *Psychoanalytic Review*, 20 (1933), 241-273, and 21 (1934), 146-153.
- Litman, R. E. "Models for Predicting Suicidal Lethality," in *Resumenes—V. Congreso Mundial de Psiquiatria*. Mexico City: La Prensa Medica Mexicana, 1971.
- . "When Patients Commit Suicide," *American Journal of Psychotherapy*, 19 (1965), 570-576.
- Litman, R. E. and N. L. Farberow. "Emergency Evaluation of Self-destructive Potentiality," in N. L. Farberow, and E. S. Shneidman, eds. *The Cry For Help*. New York: McGraw-Hill, 1961.
- Meerlo, J. A. M. *Suicide and Mass Suicide*. New York: Grune and Stratton, 1962.
- Menninger, K. A. *Man Against Himself*. New York: Harcourt, 1938.
- . "Psychoanalytic Aspects of Suicide," *International Journal of Psychoanalysis*, 14 (1933), 376-390.
- Metropolitan Life Insurance Co. "Suicides That Fail," *Statistical Bulletin* (May 1941).
- . "Why Do People Kill Themselves?" *Statistical Bulletin* (February 1945).
- Mintz, R. S. "Basic Considerations in the Psychotherapy of the Depressed Suicidal Patient," *American Journal of Psychotherapy*, 25 (1971), 56-73.
- Motto, J. A. "Suicide Attempts: A Longitudinal View," *Archives of General Psychiatry*, 13 (1965), 516-520.
- Murphy, G. E., and E. Robins. "Social Factors in Suicide," *Journal of the AMA*, 199 (1967). 303-308.
- National Center for Health Statistics. *Suicide in the United States 1950-1964*. Washington: U.S. Department of Health, Education, and Welfare, 1967.

- Neuringer, C. "Methodological Problems in Suicide Research," *Journal of Consulting Psychology*, 26 (1962), 273-278.
- Norris, V. *Mental Illness in London*. New York: Oxford University Press, 1959.
- Osmond, H., and A. Hoffer. "Schizophrenia and Suicide," *Journal of Schizophrenia*, 1 (1967), 54-64.
- Paffenbarger, R. S., and D. P. Asnes. "Chronic Disease in Former College Students: III. Precursors of Suicide in Early and Middle Life," *American Journal of Public Health*, 56 (1966), 1026-1036.
- Paffenbarger, R. S., H. King, and A. L. Wing. "Chronic Disease in Former College Students: IX. Characteristics of Youth. Predisposed Suicide and Accidental Death in Later Life," *American Journal of Public Health*, 59 (1969), 900-908.
- Parkin, D., and E. Stengel. "Incidence of Suicide Attempts in an Urban Community," *British Medical Journal*, 2 (1965), 133-138.
- Paykel, E. S., J. K. Myers, and J. J. Lindenthal. "Thoughts of Suicide: A General Population Survey," in *Resumenes —V. Congreso Mundial de Psiquiatria*. Mexico City: La Prensa Medica Mexicana, 1971.
- Petri, H. "The Problem of Suicide in Psychiatric Clinics," *Zeitschrift für Psychotherapie und Medizinische Psychologie*, 20 (1970), 10-19.
- Piker, P. "1817 Cases of Suicidal Attempt," *The American Journal of Psychiatry*, 95 (1938), 97-115.
- Pitts, F. N., and G. Winokur. "Affective Disorder: III. Diagnostic Correlates and Incidence of Suicide," *Journal of Nervous and Mental Disease*, 139 (1964), 176-181.
- Pöldinger, W. "Psychologie und Prophylaxe des Suizids," *Monatskurse für die Ärztliche Fortbildung*, 3 (1967), 127-129.
- Porterfield, A. L., and R. H. Talbert. *Crime, Suicide and Social Well-Being in Your State and City*. Fort Worth: Leo Potishman Foundation, 1948.

- Raines, G. N., and S. V. Thompson. "Suicide: Some Basic Considerations," *Digest of Neurology and Psychiatry*, 18 (1950), 97-107.
- Resnick, H. L. P., ed. *Suicidal Behaviors: Diagnosis and Management*. Boston: Little, Brown, 1968.
- Ringel, E. *Neue Untersuchungen zum Selbstmordproblem*. Vienna: Verlag Bruder Hollinek, 1961.
- Robins, E., S. Gassner, J. Kayes, R. H. Wilkinson, and G. E. Murphy. "Communication of Suicidal Intent: A Study of 134 Cases of Successful (Completed) Suicide," *The American Journal of Psychiatry*, 115 (1959), 724-733.
- Robins, E., G. E. Murphy, R. H. Wilkinson, S. Gassner, and J. Kayes. "Some Clinical Considerations in the Prevention of Suicide Based on a Study of 134 Successful Suicides," *American Journal of Public Health*, 49 (1959), 888-899.
- Robins, E., E. H. Schmidt, and P. O'Neal. "Some Interrelations of Social Factors and Clinical Diagnosis in Attempted Suicide: A Study of log Patients," *The American Journal of Psychiatry*, 114 (1957), 221-231.
- Rosen, A. "Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events," *Journal of Consulting Psychology*, 18 (1954), 397-403.
- Rosen, D. H. "The Serious Suicide Attempt: Epidemiological and Follow-up Study of 886 Patients," *The American Journal of Psychiatry*, 127 (1970), 764-770.
- Rost, H. *Bibliographic des Selbstmords*. Augsburg: Haas and Grabherr, 1927.
- Rudestam, K. E. "Stockholm and Los Angeles: A Cross Cultural Study of the Communication of Suicidal Intent," *Journal of Consulting and Clinical Psychology*, 36 (1971), 82-90.
- Sainsbury, P. "Social and Epidemiological Aspects of Suicide with Special Reference to the Aged," in R. H. Williams, C. Tibbitts, and W. Donahue, eds., *Processes of Aging: Social and Psychological Perspectives*, Vol. 2. New York: Atherton Press, 1963.
- . "Suicide and Depression," in A. Coppen, and A. Walk, eds., *Recent Developments in Affective Disorders*. London: Royal Medico-Psychological Association, 1968.

----. *Suicide in London: An Ecological Study*. New York: Basic Books, 1956.

Schilder, P. *Psychotherapy*. New York: Norton, 1938, 1951.

Schmidt, E. H., P. O'Neal, and E. Robins. "Evaluation of Suicide Attempts as Guide to Therapy," *Journal of the AMA*, 155 (1954). 549-557.

Schneer, H. I., P. Kay, and M. Brozovsky. "Events and Conscious Ideation Leading to Suicidal Behavior in Adolescence," *Psychiatric Quarterly*, 35 (1961), 507-515.

Schneider, P.-B. *La Tentative de Suicide*. Neuchatel-Paris: Delachaux et Niestlé, 1954.

Schrut, A. "Suicidal Adolescents and Children," *Journal of the AMA*, 188 (1964), 1103-1107.

Seager, C. P., and R. A. Flood. "Suicide in Bristol," *British Journal of Psychiatry*, 111 (1965), 919-932.

Seiden, R. H. *Suicide Among Youth: A Review of the Literature, 1900-1367*. (Supplement to the Bulletin of Suicidology.) Washington: National Clearinghouse for Mental Health Information, U.S. Department of Health, Education, and Welfare, 1969.

Shneidman, E. S., ed. *On the Nature of Suicide*. San Francisco: Jossey-Bass, 1969.

Shneidman, E. S. and N. L. Farberow, eds. *Clues to Suicide*. New York: McGraw-Hill, 1957.

----. "Suicide—The Problem and Its Magnitude," *Veterans Administration Medical Bulletin*, MB-7 (March 1961).

Shneidman, E. S., N. L. Farberow, and C. V. Leonard. "Suicide—Evaluation and Treatment of Suicidal Risk among Schizophrenic Patients in Psychiatric Hospitals," *Veterans Administration Medical Bulletin*, MB-8 (February 1962).

Shneidman, E. S., N. L. Farberow and R. E. Litman. *The Psychology of Suicide*. New York: Science House, 1970. log. Sletten, I. W., M. L. Brown, R. Evenson, and H. Altman. "Suicide in Mental Hospital Patients," *Diseases of the Nervous System*, 33 (1972), 328-334.

- Stearns, A. W. "Suicide," *New England Journal of Medicine*, 204 (1931), 9-11.
- Stengel, E. "Attempted Suicide: Its Management in the General Hospital," *Lancet* (February 2, 1963), 233-235.
- . "Complexity of Motivations to Suicidal Attempts," *Journal of Mental Science*, 106 (1960), 1388-1393.
- . "Enquiries into Attempted Suicide," *Proceedings of the Royal Society of Medicine*, 45 (1952), 613-620.
- . "Old and New Trends in Suicide Research," *British Journal of Medical Psychology*, 33 (1960), 283-286.
- . "*Selbstmord und Selbstmordversuch*," in *Psychiatrie der Gegenwart: Forschung und Praxis*, Band III. Berlin: Springer-Verlag, 1961.
- Stengel, E., and N. G. Cook. *Attempted Suicide: Its Social Significance and Effects*. New York: Basic Books, 1958.
- . "Recent Research into Suicide and Attempted Suicide," *Journal of Forensic Medicine*, 1 (1954), 252-259.
- Sullivan, H. S. *Clinical Studies in Psychiatry*. New York: Norton, 1956.
- Szymanska, Z., and S. Zelazowska. "Suicides et Tentatives de Suicide des Enfants et Adolescents," *Revue de Neuropsychiatrie Infantile*, 12 (1964), 715-740.
- Tabachnick, N. "Accident Victims: Self-Destructive or Not?" *Psychiatric News*, 7 (February 16, 1972), pp. 1, 28.
- Toolan, J. M. "Suicide and Suicidal Attempts in Children and Adolescents," *The American Journal of Psychiatry*, 118 (1962), 719-724.
- Tuckman, J., and W. F. Youngman. "Suicide Risk Among Persons Attempting Suicide," *Public Health Reports*, 78 (1963), 585-587.

- . "Identifying Suicide Risk Groups Among Attempted Suicides," *Public Health Reports*, 78 (1963), 763-766.
- Walton, H. J. "Suicidal Behavior in Depressive Illness," *Journal of Mental Science*, 104 (1958), 884-891.
- Weiss, J. M. A. "Gamble with Death in Attempted Suicide," *Psychiatry*, 20 (1957), 17-25.
- . "Suicide: An Epidemiologic Analysis," *Psychiatric Quarterly*, 28 (1954), 225-252.
- . "Suicide in the Aged," in H. L. P. Resnik, ed., *Suicidal behaviors: Diagnosis and Management*. Boston: Little, Brown, 1968.
- Weiss, J. M. A., N. Nunez, and K. W. Schaie. "Quantification of Certain Trends in Attempted Suicide," in *Proceedings of the Third World Congress of Psychiatry*. Montreal: University of Toronto Press and McGill University Press, 1961.
- Weiss, J. M. A., and K. F. Scott. "Suicide Attempters Ten Years Later," in *Comprehensive Psychiatry*, in press (1973).
- West, D. J. *Murder Followed by Suicide*. Boston: Harvard University Press, 1966.
- Wold, C. I. "Characteristics of 26,000 Suicide Prevention Center Patients," *Bulletin of Suicidology*, 6 (1970), 24-34.
- World Health Organization. "Mortality from Suicide," in *Epidemiological Vital Statistics*, Report No. 9. Geneva: WHO, 1956.
- . *Prevention of Suicide*. Public Health Papers No. 35. Geneva: WHO, 1968.
- Yap, P.-M. *Suicide in Hong Kong*. London: Oxford University Press, 1958.
- Zilboorg, G. "Considerations on Suicide, with Particular Reference to That of the Young," *American Journal of Orthopsychiatry*, 7 (1937), 15-31.
- . "Differential Diagnostic Types of Suicide," *Archives of Neurology and Psychiatry*, 35 (1936),

Notes

- 1 In an attempt to explain the statistical facts as they were then known, Durkheim divided suicide into three social categories—anomic, egoistic, and altruistic. He postulated that “anomic” suicide results from a severe disorder in the equilibrium of society, disturbing the balance of a person’s integration with his culture and leaving him without his customary norms of behavior. “Egoistic” suicide results from a lack of integration of the individual with other members of the group, and infrequently “altruistic” suicide results from “insufficient individuation,” when proneness to suicide stems, rather, from excessive integration into a group that might at times require an individual to sacrifice his life (as in the case of the old person who has become a financial burden to his family).
- 2 Jacobs drew some questionable inferences from these data regarding the nature of successful suicide, but his basic findings related to attempted suicide among adolescents appear to be valid.
- 3 Although persons who die from indirect “suicidal equivalents” or from premeditated “accidents,” or whose deaths from obvious suicide are misreported, may not be included in suicide statistics, these sources of error seem to be rather constant, and the statistics for successful suicide in the United States for the past half-century appear relatively consistent from time to time and place to place.
- 4 All such rates are statistically adjusted for age, sex, and other relevant factors, when appropriate.
- 5 Stengel has suggested that reports of suicidal attempts indicate as much about their real occurrence as the number of divorces granted on the grounds of adultery reveal about the actual incidence of marital infidelity.