Honor's Thesis

SUICIDE

by

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"Richard Cory"

"Whenever Richard Cory went down town, We people on the pavement looked at him: He was a gentleman from sole to crown Clean favored, and imperially slim. And he was always quietly arrayed, And he was always human when he talked; But still he fluttered pulses when he said, 'Good-morning,' and he glittered when he walked. And he was rich -- yes, richer than a king -- And admirably schooled in every grace; In fine, we thought that he was everything To make us wish that we were in his place. So on we worked, and waited for the light, And went without the meat, and cursed the bread; And Richard Cory, one calm summer night Went home and put a bullet through his head." (11, p. 82)

Suicide, this was the fate of Richard Cory. He was a mere figure created by Edward Arlington Robinson so his death was only an imaginary one. But suicide is not excluded to imaginary characters and the unfortunate thing about Richard's story is that it, or something resembling it happens to "19,000 persons in the United States who commit suicide each year." (2, p. 3) "In one-half our states, suicide is among the first ten causes of death." (6, p. 7)

These statistics sound rather harsh but they deserve little if any credence; it has been repeatedly pointed out by scientific students of the problem that suicide cannot be subjected to statistical evaluation, since all too many suicides are not reported as such. Those who kill themselves through automobile accidents are almost never recorded as suicides; those who sustain serious injuries during an attempt to commit suicide and die weeks or months later of these injuries or of intercurrent infections are never registered as suicides;
a great many genuine suicides are concealed by families; and suicidal attempts, no matter how serious, never find their way into the tables of vital statistics. (4, p. 18)

The number 19,000 "is more than double the number who are murdered during a year and at least one-half again as many as succumb to tuberculosis. Because suicide carries a stigma, the recorded suicide figures are understated by as much as one-fourth to one-third. It is safe to say that about 25,000 suicides occur in this country in a year. The number who make unsuccessful attempts is somewhere between 175,000 and 200,000 in a year. Because most of these are younger persons, there may be now an accumulation from post years of close to two million people in the United States who have a history of at least one suicide attempt. They constitute a pool from which many of the future suicides will be drawn. (2, p. 3)

"Under existing conditions, out of every 1,000 white male infants born, fifteen will eventually take their lives; out of every 1,000 white female infants, four will do so." (2, p. 15) These cold statistics are simply numbers printed upon a page, but they hold great significance for mankind. What makes a man turn upon himself and take the one thing from himself that basically he has struggled to preserve and should struggle to preserve as long as nature had intended. If the death-by-murder-rate doubled itself in one year, politicians would be plagued and the public would undoubtedly find itself hysterical. Why not then is there no more concern about the even more brutal process of self-destruction. Perhaps one might find an answer in the fact that many suicidal deaths are never labeled as such; or perhaps some feel that man has the right to do with his life as he desires. Probably one would find that the basic reason for such a lack of concern is tied into one small five-lettered word, taboo. Menninger says that the only phase in which suicide is dealt with
and accepted by the public is in "fantasy." (10, p. 13) "There is a surprisingly small amount of scientific literature dealing with it. It is a taboo related to strongly repressed emotions. People do not like to think seriously and factually about suicide." (10, p. 14) Karl Menninger commented about his experience with patients whose relatives refused to heed warnings and removed patients saying, "After their removal, a few weeks later, the papers would carry an announcement of our former patient's death by hangings or shootings, or drowning." (10, p. 14)

WHO COMMTS SUICIDE—WHEN AND WHERE

**Age**—Suicide is not restricted to any age group but in some age groups it is more prevalent than others. The suicidal potential seems to build up in the earlier years of life and find realization in the middle and later years of life.

In 1960 of the 19,000 suicides in the United States, only 93 were under 15. Suicide occurs more frequently in the next five year age group, 15-19 years, with 475 self-inflicted deaths, a rate of 3.6 per 100,000. At ages 20-24 the rate, 7.1, almost doubles the preceding age group. An increment of about 50% between successive age periods continues until the maximum rate of 27.9 per 100,000 is reached at ages 75-84. At 85 and over the rate declines slightly to 26. Young people, when difficulties arise, can more readily work off their pent-up emotions without resorting to self-destruction. (2, p. 22)

**Sex**—Suicide may be called a masculine type of behavior and the following statistics support this statement. Although this fact is contrary to popular belief, this fact carries with it many important implications for our society.
1. The Diminution of The Aggressive Element

It must not be assumed that the only method of combating direct evidences of aggressiveness is through restraint. Once the self-destructiveness implicit in aggressiveness is recognized, the next step is to redirect it away from the self or the inoffensive object and to substitute proper for improper targets by displacement. This happens spontaneously before our eyes in much psychiatric treatment. We see a patient belabored and belated himself for turn his vituperations onto the hospital or its doctors and nurses, or perhaps onto his anxiously waiting relatives. Such an outpouring of hate is unpleasant but it is vastly encouraging; it only remains for the recovery of such an individual that these billegeries be displaced to still more appropriate objectives. To what extent this direction of aggressive tendency away from the self to those more socially acceptable goals can be accomplished through the design and intention of the physician or even by order of state is of course the problem of psychiatric therapeutics. Skillful use of play is being increasingly made in a scientific way by psychiatrists, psychoanalysts, psychologists and teachers for purposes of what we shall call reconstruction through a release of

In practically all European countries, as in the United States, many more men than women commit suicide, the proportion being about two or three males for every female. Suicide, at every age period, is committed by many more men than women. This is now true even at the younger ages, a condition very different from that in earlier decades of the century. During the fifty years, 1910-1960, the rate for white girls has thus declined by three-fourths, while the recent rate among white boys is much the same as in earlier decades. Perhaps the marked increase in the schooling and employment of young women and their greater economic and social independence have played a role. Whatever caused their relatively high suicide rates in the past has disappeared in recent years. (2, pp. 23-25) Although the suicide rate for men is much higher than for women, it has often been observed that women make more unsuccessful attempts at self-destruction. (1, p. 32)
The Cruelest Month

"April is the cruelest month, breeding
Lilacs out of the dead land, mixing
Memory and desire, stirring
Dull roots with spring rain." (5, p. 72)

One of the strangest and least understood influences on suicide is the weather. Spring, when nature is at her smiling best, is the suicide season. In the United States and most of Europe, April is the peak month, followed by May and March. During the gloomy weather in winter, the would-be suicide hopes that when fine days come, with their exhilarating brightness, the cloud of unhappiness will dissolve. But then spring comes with all its excesses of life and brightness but does not bring to the poor unfortunate the hoped-for relief because he is unable to react to these forces as of yore. He thinks of other springs when the bluebirds sang happier songs and of other sunshine which set his blood tingling. The drowning man had waited for the straw and he clutched it, but it sank beneath his weight. (5, p. 72)

For Whom The Bells Toll - Two little bells take their toll. The one bell tolls from the steeple of a place of worship, the other from beside a bed, bidding man to another work week.

One quite large study covering many thousands of suicides showed that in the United States most men kill themselves on Monday, women prefer Sunday, with Monday being their second-most-frequent choice. For both sexes, the suicides decrease from Monday through Thursday, then show a sudden rise on Friday and a drop back again on Saturday. (5, p. 83)

The bells of a church bring with them feelings of "guilt" and the bell of the alarm clock starts another "business week," that some men find too difficult to face. (5, p. 83)

Area - To the suicide-prone person the crowded city may become the loneliest place in the world for "suicide is more frequent in urban than in rural areas." (10, p. 15)
range of experience with reality (testing) have some effect in lessening the power of the conscience, for the most part it is over the conscious portion of it, the ego-ideal, that is affected. The unconscious conscience, the super-ego formed in childhood, is completely out of touch with contemporary reality, it exercises its dominion on the basis of childhood concepts and the authority of ancient standards. To put this vividly, one might say that although the conscious ego and ego-ideal live in a changing world, the super-ego remains fixed in its original form determined by the rules in effect at the time of its formation. Emotional rather than intellectual re-education is necessary. (10, pp. 379-380)

3. The Enhancement of the Erotic Element

'They want to love one another, but they don't know how,' said Sandor Ferenczi. (10, p. 381)

Knowing how to love has been the object of all psychoanalytic research, a problem which occupied Freud in the very beginning. First and foremost among the inhibitions of the erotic development are the stultifying and deadening effects of narcissism. Nothing inhibits love so much as self-love and from no source can we expect greater ameliorative results than from the deflection of this love from a self-investment (comparable to the self-investment of hate) to its proper investment in outside objects. Just as self-directed aggressions are harmful because of their immediate consequences, so the self-direction of love is harmful through its secondary consequences, the consequences of the emotional starvation resulting. Narcissism chokes and smothers the
Suicide begins many years before it is brought to finalization and in this next section, the formation of the suicidal personality is outlined demonstrating the complexity of forces that bring about the consequences leading to suicide.

For every person who succeeds in killing himself, there are many more who have tried unsuccessfully to do so, and many more whose impulses to die have been controlled only by their social and religious loyalties or by their fears.

Even more important from the standpoint of individual and national health is the fact that self-destruction does not usually lead directly to suicide but expresses itself in partial or substitutive ways. Chronic physical illness and disability neurosis in its manifold forms, drug and alcohol addictions, 'martyrdom,' life patterns of repetitious failure, accident proneness, are all variable degrees, motivated by this tendency of the human being to turn his aggressive drives upon himself, to act in more or less overt ways as his own executioner.

Sigmund Freud writes 'whoever believes in the occurrence of semi-intentional self-inflicted injury will become prepared to accept through it the fact that aside from conscious, intentional suicide, there also exists semi-intentional annihilation with unconscious intention, which is capable of aptly utilizing a threat against life and masking it as a casual mishap. The tendency to self-destruction exists to a certain degree in many more people than in those who bring it to completion.'

Any act of self-destruction, whether frankly suicidal or disguised and denied, involves a complicated interplay of forces. It represents the outcome of a struggle between acceptance and the rejection of life. Partly this struggle is internal, among the conflicts of purposes which exist within the individual. Partly it is between the individual and his immediate environment. The causes for his act which are expressed by the suicidal person or by his relatives are seldom reliable. (1, introduction)
The Motives

The popular analysis of suicide is usually far from being correct. Most persons feel that suicide is an escape from an intolerable life situation. The motives for self-destruction are not this simple. Perhaps one should ask himself why some intolerable situations are handled successfully by some and why some only find relief from these situations in death, self-destruction.

If the intolerable situation be an external, visible one, the suicide is brave; if the struggle be an internal, invisible one; the suicide is crazy. This conception of self-destruction as a flight from reality, from ill-health, disgrace, poverty, or the like is seductive because of its simplicity. It may be considered axiomatic that the human mind cannot conceive of non-existence, and hence, however agnostic or skeptical the person contemplating suicide may believe himself to be, his act betrays his belief in some kind of a future life more endurable than his present life. And, although it is rejected intellectually by many scientists and others, emotionally an expectation of a future life, or rather, a continuous life is inherent in the unconscious of everyone.

The popular analysis outlined above would be more nearly correct, therefore, if it were phrased that suicide is an attempted escape from an intolerable life situation. This would call our attention more sharply to its irrationality and the power wielded by such individuals by fantasy.

The individual always, in a measure creates his own environment, and thus the suicidal person must in some way help to create the very thing from which in suicide, he takes flight. Suicide is a very complex act, and not a simple, incidental, isolated act of impulsion, either logical or inexplicable. (10, pp. 15-21)

Menninger gave an example of a quiet banker, who after stealing from his bank, killed himself. The reason for his suicide, in the public eye, would be considered as a result of his wrong doing.
What the public didn't know was that "he had been having an affair with another woman, after finding no warmth and affection with his cold and unloving wife of 20 years." (10, p. 21) And here a man who had known this man as a child might have exclaimed, "'Oh, but you did not know his mother. She too, was a cold hard woman, more interested in money than in her children. It is no wonder that he was incapable of making an intelligent marital choice or of dealing with a wife in a more competent and satisfactory way.'" (10, p. 21)

Yes, if the public had only known his mother . . . . . .

All that can be said is that this man began to commit suicide long before he took the pistol in his hand and long before he took the money from the bank.

It is apparent that the self-defeating tendencies arose very early in the life of the individual and strongly influenced the entire course of his development in such a way as to overshadow and finally conquer the benign life-instinct.

Such a view of suicide completely disposes of those naive judgments as to its bravery or irrationality, and of all such casual explanations as appear in statistical summaries and the like. (10, p. 21)

"Any person's happiness and good fortune are not determined by the superficial appearance of his life but by the struggles that go on deep within his mind, hidden from the world, hidden often from himself." (1, introduction)

The Self-Destructive Infant

The man or woman who finds the final realization of their life in suicide does not always do so because of immediate forces. For
many suicidal tendencies begin in infancy.

Every human being is from the moment of birth a responsive, feeling individual, whose possibilities for psychic and physical development are closely correlated with the love and interest shown him. The apathy and retardation of children in institutions is a well-recognized fact. This has been objectively demonstrated in a study made by Spitz of two groups of babies reared in institutions which were similar in all physical aspects, but in one of which the mothers cared for the infants, whereas in the other this care was given in most impersonal ways by nurses. After about the sixth month, the unloved children showed consistent and very marked defects in development. These defects included not only mental and emotional features but also actual capacity for survival. The personally neglected though physically equally well cared for children were highly susceptible to infection, i.e. epidemic of measles, death rate ranged from 13% in younger group to almost 40% in the older age group.

Under most circumstances the biologically established interest of parents in the children they produce preserves the human species. However, this interest is by no means universally a whole-hearted phenomenon. It vacillates between overt resentment of the child and an exaggerated valuation of him; between careless neglect and over-protection. The parent's own emotional problems become involved and the son or daughter may be used as a substitute for other love relationships, or may be rejected or prized because of his resemblance to other relatives or the other parent.

Potentialities are not the same in all infants. The capacity to adapt actively, flexibly and variably to a life situation is constitutionally determined. But every infant, however well endowed, is to a greater, or lesser degree disorganized and inhibited in his development by unsatisfying or/and inconsistent environment.

The important thing to the infant during his first year is to have at least one reliable and consistent contact with a person who attends to his physical needs and who gradually becomes identified as a familiar, comforting, stimulating object, against an amorphous
and undoubtedly, often frightening background.

Behavior is at first motivated by the child's instincts for survival. His demands on the world have about them an aggressive quality which we describe as an innate aggressive drive. Although this potentiality originates as a component of self-preservation activity, it may when rampant and unmodified be a life-destructive force.

Opposed to the aggressive drive and acting to modify or neutralize it is the instinctual striving to love and be loved. We might say then that every individual begins life with capacities for aggressive action which may become hostile and destructive but also with outgoing strivings which express themselves in participation, interaction, and most specifically, in love. The interplay between these often opposing forces determines the constructive and destructive quality of the life pattern. Obviously, death indicates most dramatically a complete failure of the forces directed toward life and love. (1, pp. 4-5)

The observations and studies above suggest that the "individual's balance between life valuing attitudes and life rejecting attitudes is largely determined in this primary relationship. It would seem then that an attempt to overcome the suicidal elements in the human behavior should begin with the education of the mother." (1, p. 6)

In the infant the drive to live and the drive to love are inseparable in him. Deprived of love these positive forces have no objects on which to attach themselves. At first the neglected baby may scream and struggle, but his aggression, too, has no object. It accomplishes nothing. Under circumstances of extreme psychic deprivation the baby dies and his death may be ascribed to a condition called 'marasmus.' The marasmic infant is a pitiful and dramatic illustration of a primitive kind of self-destruction. The infant dies because his inborn strivings for contact and emotional interaction with other people are thwarted. He can neither love or fight. (1, pp. 6-7)
Death Fantasies in Childhood

Once the pattern of self-destruction has been established in infancy, it most often carries over to childhood and develops further toward the ultimate goal.

Although children rarely kill themselves, preoccupation with suicidal ideas are common in childhood. The self-destructive tendencies which appear in early infancy seem quite directly related, first to frustrations in the satisfaction of bodily needs and, following closely on this, to frustration of baby's emerging need for close contact with a familiar, comforting and encouraging mother figure. His own intake is most important. His behavior appears to follow a simple stimulus-response pattern. When he is unsatisfied and unstimulated his drive to live is impaired. In states of serious emotional deprivation he may die. (1, p. 12)

Although this mother-child symbiosis ordinarily continues to be of primary importance, the baby's world soon expands to contain gradually-identified persons. These figures are members of the family, and the new child's experiences with them tend to follow a characteristic pattern of identification versus competition, affection versus hostility, dependence versus independence. So the native capacities for empathy and aggression become involved within the group. The child's valuation of himself and of the world about him is determined by the position which he can establish within his family circle. Obviously, the satisfactory or unsatisfactory nature of the self-image is greatly influenced by the attitudes within the family. (1, p. 13)

The family roles of our prevalent Western culture are not clearly defined. Superficially they follow the patriarchal structure, in that the father is the provider and the head, the mother housekeeper and secondary in dominance. The child's problems of self-identification thus become complicated. We may reasonably assume that a baby's first concepts of himself and of other people have to do with his feelings of security and of self-value. His
environment must have in it a large degree of consistency and predictability. He must become habituated to expect certain stimuli and certain responses, and against this reliable background must gradually develop a sense of individuality and personal worth.

As the child grows older and his interests merge with those of the family group he begins to recognize sexual differences, and his self-awareness becomes influenced by feelings of maleness and femaleness. This involves problems of identification and of competition. Jealousy grows, of children for parents, and of children for each other. Envious and rivalrous situations stimulate the child's aggressive instinct and may, if excessive, lay the foundation for unfavorable character formation. (1, p. 14)

During these first years while the young individual is crystallizing his concept of himself as a boy or girl within the family, he is also formulating a moral code. At first the individual's social behavior is externally controlled by a set of rules imposed by authority. But gradually these rules become a part of himself. A correct balance between consistent firmness and tolerance is the goal in any formulation of child-care principles. The indirect education of the child is probably of greater importance than his direct training. He is very responsive to the attitudes about him. (1, pp. 15-16)

The emotional atmosphere of a family is dependent upon multiple factors. It begins with the relationship of the parents to each other. Here the ideal is a marriage of love of two people sufficiently mature to accept their adult masculine and feminine roles, to be able to give freely to each other and to the children. Any such defects of maturity in parents create difficulties for the child, not only in his feelings of acceptance but also in his strivings toward masculine or feminine identification. The boy needs to relate himself to an adequate male figure represented by his father; the girl needs in her mother a mature feminine model. Many of the confusions of self-identification which underlie neurotic and self-defeating behavior have a background of this kind. (1, pp. 16-17)
We have seen the individual as born with certain motivating inherent tendencies which for lack of better terms we have called instinctive drive. He is potentially aggressive and potentially loving. In his primitive struggle for survival he makes demands on his environment: takes from it what he needs, attempts to overcome and destroy that which interferes; but at the same time he interacts in ways which modify his instinctive behavior and tend to make him an integral part of a larger group. The formation of his moral code or superego is the result of this interaction process. (1, pp. 18-19)

The superego takes form within the first three or four years of life. The quality of this personality component is especially important in determining whether the individual will move in the direction of constructive social adaptation, whether he will remain rebellious and unreconciled to his place in the world, or whether he will become so overwhelmed by guilt and self-depreciation as to act out more or less overtly against himself. Superego standards should be a part of the social development of the individual; they should not represent a rigid code superimposed on him by fear. (1, p. 19)

From Fantasy to Gesture

The child has fantasies of death and the young adult may translate these thoughts into a self-damaging act which may symbolize violence but may not be a sincere expression to die. "It has been estimated that in addition to those who end their lives each year, there are at least tens of thousands who find life so difficult that they make an attempt unsuccessfully to kill themselves."

(1, p. 30)

"For American children aged 15-19, suicide is the fifth-ranking cause of death. In 1957 one in every 40 deaths in this age group was a suicide; among the boys one death in 34 was voluntary. That year 231 boys and 57 girls aged 15-19 found
life unbearable. That is a greater number than
died from acute poliomyelitis, diabetes, tubercu-
losis, appendicitis, leukemia, or many other
diseases. In the next lower age group, 10-14, suicide ranks 13th on the list of leading causes of death. In 1957 a total of 55 boys and 13 girls of this age were recorded officially as authenticated suicides." (5, p. 55)

The age pattern of unsuccessful attempt is considerably different from that of actual suicide. A larger proportion of these people are below thirty years of age. It appears that the act is more likely to end fatally with increased age. The rate of suicidal deaths arises after adolescence and continues a progressive increase into old age. The young person values life more highly and retains attachments and interests which are in conflict with his angry protests. He may think of death as an end to his frustrated struggles but he is still tied to life. His suicidal gestures often express a demand for recognition of his suffering or a hostile attempt to shock and humiliate those who have frustrated him. (1, pp. 30-31)

In a summary of 250 consecutive cases of attempted suicides admitted to a general hospital over a two-year period the author indicated the most common motive for the suicide was intense hatred for a person both previously loved and hated. The overt act closely followed it stimulus, which was frequently a quarrel. It followed so immediately that prevention during acute disturbance was difficult. The author concluded that "prophylaxis must start with better treatment of the emotional problems of the maladjusted child. Almost three-fourths of the groups studied came from broken homes." (1, p. 30)

Obviously, good adjustment to adolescence depends on experiences which have gone before. The child who feels significant and loved within the family,
who has been encouraged in cooperative ways of living and who in his earlier contacts with his peer group has established a give-and-take attitude — this child will be best fitted to deal with the crises of his adolescence. (1, p. 34)

FOUR TYPES OF REASONINGS BEHIND SUICIDE

According to Karl Menninger, there are four types of reasonings behind the act of self-destruction. Before one can understand these reasonings one must understand the concepts of Eros and Thanatos.

Eros and Thanatos

One would expect that in the face of the overwhelming blows at the hands of Fate and Nature, man would oppose himself steadfastly to death and destruction in a universal brotherhood of beleaguered humanity. But his is not the case. It becomes increasingly evident that some of the destruction which curses the earth is self-destruction; the extraordinary propensity of the human being to join hands with external forces in an attack upon his own existence is one of the most remarkable of biological phenomena. (10, p. 4)

It only seems natural that man should want to strive for life but as shown in the statistical records, this is not so. Sigmund Freud was the first to introduce the theory of a death-instinct.

According to this concept, there exists from the beginning in all of us strong propensities toward self-destruction and these come to fruition as actual suicide only in exceptional cases where many circumstances and factors combine to make it possible. But question arises: If some great impulse toward death dominates all of us, if at heart we all want to die, why do so many of us struggle against it as we do, why do not all of us commit suicide, as many philosophers have advised? Freud makes the assumption, 't he life and death instincts, let us
call them the constructive and destructive tendencies of the personality, are in constant conflict and interaction just as are similar forces in physics, chemistry and biology. These forces, originally directed inward and related to the intimate problems of the self, the ego, come ultimately to be directed outwardly toward other objects. This corresponds with physical growth and personality development. Failure to develop, from this standpoint, means and incomplete turning outward of the self-directed destructiveness and constructiveness with which we are - by hypothesis - born. Instead of fighting their enemies, such persons fight (destroy) themselves; instead of loving friends or music or the building of a home, such persons love only themselves. Hate and love are the emotional representatives of the destructive and constructive tendencies. A sort of equilibrium, oftentimes very unstable, is achieved and maintained until disturbed by new developments in the environment which cause a rearrangement with perhaps a quite different outcome. On this basis we can understand how it can be that some people kill themselves quickly and some slowly and some not at all, why some contribute to their own death and others withstand valiantly and brilliantly external assaults upon their lives to which their fellows would have quickly succumbed. So much of this, however, takes place automatically and unconsciously that it would seem an impossible task to dissect the details of a particular bargain or compromise between life and death instincts. But the psychoanalytic technique of investigation affords us with an entirely new understanding of the process through the elucidation of its details. It enables us to recognize the postponement of death is sometimes purchased by the life-instinct at a great cost." (10, pp. 4-6)

Four Reasonings Behind Suicide

1. "The High Cost of Living"

When a weasel or a mink gnaws off its own leg to escape from a trap, it does so, so far as can be judged, consciously and deliberately and accepts the full responsibility for the self-perservative self-destruction. Some human individuals who are forced to similar sacrifices for the preservation of their own lives also accept the responsibility
and defend their action with such logical reasons as they can command, sometimes correct, often fallacious, but usually quite plausible. (10, p. 7)

An example of this reasoning would be of a man, dying of cancer, who took his life to avoid the final stages during which he would be an invalid and endure much pain.

2. "Mere Acceptance"

"In other cases the individual accepts the responsibility for the self-destruction unwillingly and only in part, and makes no attempt to explain or defend it, so that the act seems purposeless" (10, p. 7) An example of this would be of a man who kills himself by the consumption of alcohol, drugs, or even food. Overeating may have some applications in our society of today that is filled with fat people.

3. "Accident Proneness"

"Still others can be recognized in which no responsibility for the self-destruction is accepted; the responsibility is projected upon Fate, enmity, or circumstance. In accident proneness one sees the so-called accident, which is frequently an unconscious and intentional act." (10, p. 7)

4. "Negative Attitude"

"Finally there is a fourth group in which the ego of the individual neither accepts responsibility for the self-destruction, nor makes any attempt to explain or defend it. This is theoretically represented by certain physical diseases." (10, p. 8)
VARIOUS ELEMENTS OF SUICIDE

"In the act of suicide there is an existence of various elements. First of all it is a murder. In the German language it is a murder of the self (Selbstmard).

But suicide is also a murder by the self. It is a death in which are combined in one person the murder and the murdered. In many situations it is quite apparent that one of these elements is stronger than the other. One sees people who want to die but cannot take the step against themselves; they fling themselves in front of trains instead.

Finally, probably no suicide is consummated unless in addition to this wish to kill and to be killed - the suicidal person also wishes to die. Paradoxically, many suicides in spite of the violence of the attack upon themselves and inspite of the corresponding surrender, do not seem to be very eager to die. Young interns laboring over the suicide who begs to be saved, can testify to this. Murdering or being murdered entails factors of violence, while dying relates to a surrender of one's life and happiness. (10, p. 23)

Analyzation of the Three Elements in Suicide

I. The Wish to Kill

Infants - Thwarting or a threat of it arouses intense resentment and protest in the youngest baby. The disturbance in a child's prenatal comfort by the violent act of birth is the first of such thwartings. Threat of a rival in nursing may also be outstanding. Such threats vigorously defended by attack promptly bring out the (previously self-absorbed) aggressive impulses. In essence the object of the attack is the destruction of the intruder. Connected with it are feelings of resentment and fear - fear of retaliation and of other consequences. The next result is the wish to eliminate the source of the threatened deprival,
the object of the fear.

Eliminating, driving away, disposing of, annihilation are all euphemistic synonyms for destroying. This is the wish to kill in its primitive self-defensive purposes. It is inhibited by external and internal factors. The most powerful among these deterrents is a neutralizing impulse which likewise springs from the instinctual life of the individual. The aggressions become softened by the admixture of positive feelings; the hate turns with more or less completeness to love. The intruder turns out to be not such a bad fellow after all, worth trading with, later co-operating or even joining hands with. If the destructive impulse, the wish to kill whether directed outwardly or back upon the self, becomes sufficiently neutralized as to disappear completely behind the evidences of constructive positive feelings; the result is no longer destructiveness or murder but rather construction and creation.

If the infusion of the erotic element, the life-instinct, is not sufficiently strong enough to neutralize the destructive tendencies, it may, nevertheless, alter its character considerably so that while destruction is still the aim and accomplishment it is less complete and less directly carried out. The most familiar form of partial erotization of cruelty appears as sadism, the ebullition of conscious joys in the act of destruction.

Suicide is the wish to kill, unexpectedly robbed of certain external occasions or objects of unconscious gratification, may be turned back upon the person of the 'wisher' and carried into effect as suicide. (10, pp. 23-26)

Three Tests of Suicidal Action

1. Kicking the Cat

"This theory would correspond with the facts if it can be shown that there actually is a reflection of the destructive tendencies upon the individual himself so that the self is treated as though it were an external object." (10, p. 26)
It has been demonstrated through adult patient's fantasies, dreams, sensations, memories, and repetitions of acts and behavior patterns, that in the unconscious, the mind's primitive layers, it is "possible to treat one's body as if it included the body of someone else (identification) or, more acutely, introjection, because an identified person seems to be introjected into the self. Any desired treatment of the other person can be carried out, logically, upon oneself." (10, pp. 26-30) The turning back of these hostile feelings upon the self, is the well-known device called "kicking the cat with oneself used as the cat." (10, p. 30) An example of this would be the suicide of a young child after a severe scolding from his father. The child, in essence, would be killing his father. Why doesn't the suicide kill the other fellow?

It is inhibited by fear! Some of these fears are:

(1) the fear of consequences, an intelligent and justifiable fear; (2) the fear of the haunting conscience; (3) the fear of hostile intention in the other person; (This fear magnifies the dangerousness of the opponent beyond the facts. One often realizes in himself that he is over-estimating the power of malignance of the foe, because he is falsely attributing to the foe some of the hatred which only he himself feels. Intermediation necessitates deflection of aim and hence it is either some other person, or most conveniently, the self, which bears the brunt of the attack) and (4) thwarting may be the result of weakening from the admixture of erotic elements. This means that we find it exceedingly difficult to kill someone we love. Hate becomes impeded by love (as explained before.) (10, p. 34)
2. Ambivalence

Persons prone to suicide prove, upon examination, to be highly ambivalent in their attachments, that is, masking with their conscious positive attachments largely and scarcely mastered quantities of unconscious hostility (the wish to kill) and in organization are, therefore, prone to react with splitting and rebounding of the instinctual trends when exposed to certain frustrations or disappointments.

3. Love with One Hand - Hate with the Other

Some others react to good fortune as the ambivalent person reacts to bad fortune. Such individuals lose their objects and methods of sublimating hate, and they react the same way as those who are interrupted or frustrated in their program of loving. In such an individual, suicide is actually precipitated by occasion of sudden interruption in the object attachments (masking positive attachments and scarcely mastered qualities of unconscious hostility). In other words, they love with one hand and hate with the other.

The melancholic is a personality type strongly influenced by traumatic events (frustration) which occurred in the oral stage of his development, the period of nursing and weaning. Instead of relinquishing this modality in favor of a more adult one, melancholics are characterized by strong ambivalence and an ambivalence which often takes the form of cyclic alternations of repression of one or the other elements in the emotional relationship. Some show ambivalence by being kind and generous with one hand and stingy with the other. Persons of this undeveloped infantile or oral type of character organization are prone to react with splitting and rebounding of the instinctual trends when exposed to certain disappointments or frustrations. (10, pp. 39-41)
II. The Wish to be Killed

The explanation of the wish to suffer and to submit to pain and even death is to be found in the nature of the conscience. The conscience is formed in infancy and childhood and seldom keeps pace with the changes in external environment. It can be bribed but not ignored. Power of conscience, portion of original aggressive instincts, instead of being directed outward, are directed inward - converted into a sort of internal judge or king. A sense of guilt may arise from other than actual aggression; in the unconscious a wish to destroy is quite equivalent to the actual destruction with regard to exposing the ego to punishment. (10, pp. 45-46)

III. The Wish to Die

This undifferentiated remnant of self-destructive energy finally accomplishes the death of a normal individual by gradual emergence from the state of latency to which it is (was) temporarily confined by the activities of the life instincts. Such a turn of affairs must be regarded as exceptional, accomplished only in the face of some relative weakness of the life instinct, i.e., some deficiency in the capacity for developing love, since it is the function of love to convert destructive tendencies into measures of self-defense and socially useful adaptations, or in the conscience. (10, p. 70)

SUICIDE IN CHILDREN

Indications are that suicidal tendencies and the actualization of suicide is determined, to a large extent, in childhood. The next section is aimed at the clarification of childhood suicides and their implications.

"In 1959, 12% of all suicide attempts in the nation were made by adolescents, 90% were made by girls." (5, p. 54) These
statistics are indicative of an unfortunate situation; it is even more unfortunate because "nearly all the attempts were preventable by understanding and by a more sympathetic attitude by the family toward the adolescent." (5, p. 54)

By suicide the children hope to change things, not escape them and often they fantasize they will survive their own death. Suicides and suicidal attempts in adolescents are of multiple etiology. They are chiefly due to unresolved conflicts, frustrations, disappointments, guilt feelings, loss of self-esteem, fear of punishment and the real or imaginary loss of a love object. The motivating force is aggression, usually directed towards the love object and as a means of punishing parents. It is an act of hostility against a restraining figure.

For one segment of our nation's youth, college students, suicide is the second most common cause of death. It is out-ranked only by accidents. (5, pp. 54-55)

The Recognition and Treatment of Suicide in Children

In order to adequately answer the plea of these children, the necessary treatment and understanding must be afforded them. The future citizens and above all, parents, deserve no less than the utmost in effort.

Whenever children feel the threat of the loss of an love object, they not only develop feelings of rage toward the frustrating object, but feelings of helplessness and of worthlessness, as well. This results in, and is equivalent to a depression. To deal with these affective states, children learn to utilize a number of defense mechanisms, especially those developed in their personal history and those emphasized in their environment. It is when the degree of tension is extremely high and the defense mechanisms break down or become ineffective that suicide or suicidal equivalents may appear. (13, p. 131)
In as much as the child is still so dependent upon his love objects for gratifications and as the process of identification has not been completed, turning of the hostility against and destroying the introjects within himself is too painful and too frightening. But another important factor is that the child's size and ego status also militate against the use of specific instruments of destruction. Thus, children rarely commit suicide, or even make overt suicidal attempts or threats, but rather express their self-equivalents, this is, attenuated attacks on the introjected object which result in depression, accidental injuries, antisocial acts, and the like, all of which have the potentiality for ending in the destruction of the individual. These partial attacks on the self should be treated with the same caution as the more direct, overt self-destructive act in the adult. In the adolescent the impulses can more easily take the form of overt suicidal acts because of the lessened dependence on the love object (accompanied by the heightened emotional stresses of reawakened oedipal conflicts) and also because he is now a person physically more capable of hurting himself. In addition, in the actions of the suicidal child can be seen not only the hostility against the frustrating parents turned inward, but also the desperate attempts at regaining contact with the lost gratifying love object. In other words, the suicidal acts also represent a type of restitutional phenomenon. It is in this psychoanalytic framework - the attack of the introjected object and the attempts to recover it as a love object - that we can best understand some of the suicides or suicidal equivalents of children. (13, p. 132)

Thoughts of death at one's own hand do occur in the normal. Especially in the common childhood fantasy of dying as a means of punishing parents. An example of this is found in the statement of a child who says, 'I'll kill myself or get killed, and then they'll be sorry they treated me this way.' Elements of hostility as well as masochism can readily be seen in these children. Another example of this can be seen in this statement regarding a playmate - 'I think I'll kill myself, run out into the street.' (13, p. 133)
"When aggression, or perhaps better, motor activity, is inhibited in the very young child, the result can be a turning inwards of the aggression with consequent resultant self-destructive tendencies." (13, p. 133) An example of this was when splints were put on an infant with congenital club foot. This resulted in severe head banging against the crib. This condition was arrested when the splints were removed and the child was given something to bit on to theethe.

Depressive Reactions Following Death of a Parent - Spitz has shown in his papers on analytic depression that a child's reaction to the death, or removal, of a parent is severe and intense. "This is true at any age but is especially marked in the oedipal period. There is a tendency to identify himself with the departed object, which also in the older age groups, often with the loss of many ego functions." (13, p. 134) As suggested by Zilboorge, "The death of a parent occurring early in a child's life predetermines suicidal tendencies late in life." (13, p. 134) These suicides look and act like older people, even though they are children.

Case Study

Sven's father died when he was four. They were extremely close because the father's illness had kept him at home the entire year before his death. The boy was referred for consultation while in a hospital for a congenital atrophy of his right arm. At this time he was six. In the interview with him, he spoke glowingly of his father's Norwegian background and there was an ever-present wish to join him in the Valhalla that
had been so beautifully described for the boy. The anxiety that was present was mainly related to his fear of separation from his mother. (13, p. 135)

**Hysterical Reactions**

Adolescents particularly are prone to act out various impulses in an impetuous, precipitous way. Especially when angered, their deeds may be seen to contain not only their anger directed against the environment but the punishment for their acts as well. In these suicidal children may be seen not only the attempt to fulfill aggressive, hostile impulses and superego prohibitions, but also the return of omnipotent, magical means of avoiding punishment by escaping through death. (13, p. 136)

**Case Study**

Mary, age 14, had always had difficulties with peer relationships. She had felt defeated in her oedipal struggles by a domineering and aggressive mother. She had aggressively used her withdrawal as a defense and as a weapon against authority. One day, her mother had refused to allow her to do something she wished, and in the resulting argument, had spoken disparagingly of her. When alone, Mary took a bottle of aspirin and then announced to her mother she was going to die. The suicidal attempt was performed partly out of spite but also occurred because of the feeling of worthlessness in comparison with her sophisticated mother. (13, p. 136)

**Anxiety States and Compulsion Neuroses**

During adolescence there is a recrudescence of oedipal problems which sometimes results in a reinstitution of obsessive compulsive defenses which, however, decompensate during periods of stress. When this occurs, there is a flooding of the personality with instinctual tension and anxiety that is manifested in connection with a fear of loss of control or in regard to overwhelming of the ego by id impulses. At these times, suicidal thoughts and actions occur. (13, p. 136)
Case Study

Jean, age 16, was presented for consultation because of barbituate addiction, obesity, and petty thievery. She was constantly getting into fights with both mother and father but in general demonstrated her depression in her constant need for reassurance from the mother. She had a younger brother about whom she had overt incestuous fantasies. The difficulty began when she was 13 years of age, shortly after establishing the addiction to barbituates which was part of an attempt to cure her obesity. She began to take amphetamine drugs, once taking so much that she had to be hospitalized. Retrospectively, it could be seen that much of her behavior was due to her being flooded by her incestuous feelings for her brother, which in turn were the outgrowth of the unresolved oedipal feelings toward her father. (13, p. 137)

Character Neuroses

At times, warding off depression can result in antisocial or delinquent activity. But when the repressed returns into consciousness, the self-destructive aspect of the abnormal behavior becomes clear. (13, p. 138)

Case Study

Bob was born in Australia and he and his parents had moved to this country in the early part of 1950. He seemingly got along well the first few years, but then began acting out, in a long series of antisocial activities. Despite very superior intellect he was failing in school and it was observed that he seemed to lack energy in performance of any of his duties. His general mood was one of depression and he was unable to say anything nice about himself, knowing constantly that the antisocial activity was wrong. He was 17 at the time of referral, at which time the depressive qualities were especially noted and treatment was urgently recommended, but was refused. Repeated difficulties occurred, each one of them becoming more severe, as he tended to involve himself with the law. A short while
after the initial consultation, the agency, through which he was originally seen, learned that he had killed himself driving 95 miles an hour, trying to avoid being picked up for speeding by the police. (13, p. 138)

**Perversions**

Many cases which have been attributed to 'accidental' deaths have been cases involving transvestites. As part of the pathology of the perversion, many of these people not only dress themselves in female garments, but also bind themselves with ropes and chains around their limbs as well as the neck. Death of these boys has occurred during the period in which they apparently are struggling against the bonds as part of the acting out of their fantasy. The fantasy includes an identification with the female and a passive submission in a sexual act to an aggressor. Death therefore can be seen in these particular boys as a suicide in which the act itself represents the final submission to the all-powerful male figure. (13, p. 139)

**TREATMENT**

The handling of suicides or suicidal equivalents in children is based entirely on the concept of actual or threatened loss of the love object. The child's act is considered to be not just an attack on this object but also an attempt to regain it. The depressive elements in all cases are outstanding. Therefore, irrespective of the diagnostic category the case presents, treatment consists of strengthening object relationships.

Intensive psychotherapy on an outpatient basis can be established. In this therapy, not only is there a need to make a quick and firm relationship with the therapist, who must be most giving, but also, as soon as possible to give interpretations so that the child can understand his motivations. At times the hospital or foster home placement must be called upon as a means of removing the child from the frustrating environment and also as an aid in preventing the child from attacking himself.
Sedatives and tranquilizing drugs can be used to allay the anxiety and or depression sufficiently so that the relationship with the therapist can take place. The parents as well as others in the environment must not only be advised as to the danger in the situation but must be included in the attempt to gratify some of the instinctual needs of the child. Those in charge of the patient should have explained to them what feelings the child is attempting to express in his actions. Even intellectual insight into some of the dynamics can be of some help. (13, p. 140)

"Suicide in children has multiple motivations, but the primary dynamic reason is the real or threatened loss of a love object. Treatment consists primarily of reestablishing adequate rewarding and gratifying object relationships." (13, p. 141)

HOMICIDE AND SUICIDE

Suicide is the murder of the self; it is aggression turned inward. According to statistics, twice as many people turn this murder inward rather than outward to another. But those who do not realize the impact of their aggression upon themselves find finalization in the act of murdering another. Why does the wish to kill turn inward?

I. Bases for the Legitimization of Other-Oriented Aggression

A. Sociological Bases

When behavior is subjected to strong external restraints by virtue either of subordinate status or intense involvement in social relationships with other persons, the restraining objects can be blamed for frustration, thereby legitimizing outward expression of the resultant aggression. When behavior is freed from external restraint, the self must bear the responsibility for
frustration. Others cannot be blamed since others were not involved in the determination of the behavior. Under these conditions, other-oriented expression of the resultant aggression fails to be legitimized. (8, p. 103)

B. Psychological Bases

Psychoanalytic writers have been most concerned with the first psychological basis of legitimation of the other-oriented aggression consequent to frustration - the intensity of super-ego aggression consequent to frustration - the intensity of super-ego formation or guilt in the child. The super-ego, the system of demands and expectations imposed on the child by the parents as internalized by the child, operates in part to control the expression of 'instinctual' forces, including the expression of aggression outwardly against others. This in no sense minimizes either the existence or importance of other functional components of the super-ego. This system of demands and expectations imposed then becomes the system of demands and expectations imposed on the child by himself. (8, p. 104)

In Henry and Short's book Suicide and Homicide, "five different studies suggested that a weak or defective super-ego formation was associated with other-oriented aggression while a strict super-ego formation was associated with self-oriented aggression." (8, p. 105)

For example, MacKinnon found that cheaters tend to express aggression against others, outwardly, while non-cheaters tend to express aggression against themselves. The non-cheaters also said they had experienced more guilt feelings in the past than did the cheaters. (8, p. 105)

All five of these studies tend to support the view found frequently in the clinical literature that weak or inadequate super-ego formation is associated with inadequate control of aggressive impulses while strict super-ego formation is associated with the inhibition of 'other-oriented aggression. (8, p. 105)
C. Parent-Child Relationships Correlated with Built and Super-Ego Strength

1. The clinical literature yields somewhat contradictory statements on the relation between super-ego strength and degree of control imposed upon children by their parents. Ann Freud's formulation of 'identification with the aggressor' seems to imply that those who 'never quite complete the internalization of the critical process' and identify with the aggressor are the offspring of strict, critical and aggressive parents. Aichhorn, in his clinical study of aggressive behavior and delinquency found that this type of delinquency, associated with the defective super-ego formation, arises most frequently from an 'excess of severity.' (8, p. 108)

2. The theoretical writings of Freud, the cross-cultural studies of Whiting and Child and Heinicke's work all point to the role of the loss of love in the internalization or super-ego formation. Two empirical studies present convincing evidence that the withholding or withdrawal of love is associated with a high degree of internalization and guilt. (8, p. 109)

3. Heinicke found that the mothers of high-guilt boys were the primary source of the frustration and discipline as compared with the fathers. Fathers of low-guilt boys played a relatively greater role in discipline. (8, p. 109)

D. Nor-Epinephrine-Like Anger Directed Outwardly
Epinephrine-Like Anger Directed Inwardly

Cardiovascular reaction during stress - King and Henry found that the degree of severity of discipline by the father and the relative roles of mother and father in the administration of discipline was associated with the type of cardiovascular reaction experienced by male college students during experimental, induced stress situations. (8, p. 109)

Data on parental severity and the relative roles of each parent in discipline were derived from questionnaires administered to the sons who were the subjects in the experiment. The measures of
severity of the father are highly correlated with their measures of dominance of the father relative to the mother in discipline. Subjects who reported the father as strict also reported the father was the principle disciplinarian in the family. Those who reported the father as mild in discipline reported that the mother was the principal disciplinarian. (8, p. 110)

The cardiovascular correlates lead tentatively to the conclusion that severity and dominance of the mother relative to the father in disciplining the male child is associated with epinephrine-like cardiovascular reaction. (8, p. 110)

E. Implications for Homicide and Suicide


Patterson's 'Psychiatric Study of Juveniles Involved in Homicide' found that one of the outstanding characteristics of the group as a whole was the incidence of mother attachment and father hatred. Writers report that the male murderer often kills the mother surrogate - his wife, mistress, or a female with whom he has carried on an apparently platonic relationship.

These writings suggest that internalized or super-ego demands on behavior often are projected onto the victim and invested with reality in the external world. If through the mechanism of the projection of guilt, the harsh discipline imposed by the super-ego is externalized and attributed to some real person in the external world, the projection would at the same time weaken the internalized prohibition against the outward expression of aggression and provide an effective, (though imagined) source of frustration in the external world. (8, pp. 115-117)

A case study reported in Self-Destruction seems to be well fitted and appropriate to expand on here. It conveys the basic assumptions previously expounded upon.
The inter-relationship of the strongly hostile aggressive impulses of the adolescent boy to suicidal acts is well illustrated by a newspaper report. This tells the story of an eighteen-year-old youth who put a loaded shotgun into his car and went looking for his girl friend, Eva, to kill her. Picked up by the police because of his suspicious behavior, he said, 'I had an argument with her. I was going to kill her.' He was put into jail that night and the next morning was found dead, hanging from the bars by his belt. A note on the floor read, 'I am no good. I'm dead inside; I have no heart. So goodbye Eva.' (1, p. 33)

So far, the emphasis has been upon the male. He is the most frequent suicide or murderer. Why is this? "The fact that suicidal attempts in women more frequently are unsuccessful probably correlates with a much lower homicide rate in women than in men." (1, p. 33)

Traditions of feminity tend to inhibit direct aggression in favor of more indirect expression. Our prisons are inhabited largely by men and delinquency rates are higher at all ages in males than in females. This does not prove that the female is lacking in destructive aggressive drives. She may not be 'more deadly than the male' but common sense as well as psychological tests, indicate that she is equally so. From early childhood, however, she has been discouraged by the dread epithet to tomboy from translating anger into fight; she must find other ways of expressing it. Even when her anger turns against herself it tends to be only partially expressed in the act. The deeply established inhibitions may restrain her. She enacts her drama of rage and despair but it often remains drama rather than a simple wholehearted act. (1, p. 9)

Dublin points out that for the country as a whole, the rate among white persons is almost four times that of Negroes. The Negro race has a low suicide rate and a high homicide index, whereas the white race has a relatively high suicide and a low homicide rate. Computed on the basis of 100,000 population, we find that in the white race the
suicide rate is four times greater than in the Negro race, while the homicide ratio of the Negro is six times greater than that of the white. (1, p. 48)

Freud pointed out the very close relationship of suicide to murder. It was his thesis that many suicides are disguised murder. Through the act of self-murder one symbolically kills some hated individual. Suicide by a depressed patient is often interpreted as the murder of a parent from whom, in its earliest years as a child, the sick individual derived his merciless conscience.

The reverse is also true. There are murders that are symbolic suicides. This particularly likely to exist in schizophrenics, whose thoughts, speech, and behavior are so largely symbolic. In some homicides it appears that the individual is attempting to destroy only the part of himself that he has projected on to the victim and that he wishes to destroy. In a sense, such a murder represents partial suicide. This could be seen in a schizophrenic mother who had herself been quite promiscuous sexually and who shot her illegitimate 13 year-old daughter as soon as she discovered she too had become promiscuous. (7, pp. 68-69)

RECONSTRUCTION

The public should be well-informed in regard to the presence of suicide, its dangers, its causes, but even more important, it must cope with this problem as it exists. The suicidal person's plea must be answered. This is difficult "since the motives behind suicide are so complex and so varied; it is difficult to formulate a simple and unified program of suicide prevention." (3, p. 321) But the important thing to remember is that "along with the wish-to-die there is the will to live." (10, p. 136) The following four steps are used in reconstructing the suicidal personality.
making observations at the Delaware County Mental Health Association Office, Muncie, Indiana. During the fall quarter of this year, three hours a week was spent working in this atmosphere. The work in connection with this thesis did not deal with suicide alone because the mental health office handles all mental health problems and not specifically suicide. On the first visit, Friday afternoon about 4:00, plans were being discussed for work there with a volunteer worker, when a call came into the office. It was in regard to an attempted suicide. This case was followed and it will be presented later in this paper. There is a real need in Delaware County for facilities and trained personnel to handle the specific problem of suicide. In conjunction with the Delaware Mental Health Office, a survey of suicidal deaths has been compiled from 1957 to 1963. This suicide survey was taken from the files of the county coroner. It was impossible to get any further information other than the nine months in 1963 because these files were not up-to-date. Even so, Delaware County averages 13 suicides a year. Ten of the thirteen suicides were performed by men. The age group with the highest amount of suicides was the 30-40 year age group, with the 50-60 age group being the next highest. All of the above statistics seem to follow the national trend except the suicide month. In Delaware County suicide victims chose May and August most frequently. These statistics, as alarming as they are, are probably quite underestimated. Many more persons take their lives than these reports indicate. What implications does this make? It seems that people
may be unaware of suicide unless it strikes their family and, only then, too late. Citizens all over the nation, as well as Delaware County, should be made more familiar with one of man's most deadly enemies, himself.

The following survey was constructed, one must keep in mind, from materials available in the coroner's office. In all cases this may be an invalid measure and it may speak only the partial truth behind suicide. The important consideration is that this survey, in all probability, is an underestimation of the problem.
SUICIDE SURVEY - 1957-1963  
Delaware County - Muncie, Indiana

Compiled in consultation with the Delaware County Mental Health Association

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<tr>
<th>Year</th>
<th>1957</th>
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| Sex  | Male - 12  
            | Female - 5  
            | Total - 17 |
| Kind of Suicide  | Gun - 11  
                                        | Carbon Monoxide - 1  
                                        | Barbituate Poison - 1  
                                        | Hanging - 3  
                                        | Drowning - 1 |
| Month of Year  | January - 3  
                                | February - 1  
                                | March - 2  
                                | April - 1  
                                | May - 3  
                                | June - 1  
                                | July - 3  
                                | August - 0  
                                | September - 1  
                                | October - 1  
                                | November - 1  
                                | December - 0 |
| Age  | 1-20 - 0  
            | 20-30 - 1  
            | 30-40 - 4  
            | 40-50 - 1  
            | 50-60 - 1  
            | 60-70 - 5 |
| Suicide Notes  | Yes - 5  
                                | No - 12 |
| Addressed To  | Attorney - 1  
                                | Daughter - 1  
                                | Husband - 1  
                                | Remainder to family in general, landlord, former employer. |
| Contributing Cause  | Brain Tumor - 1 |
| Psychiatric Patient  | Yes - 1  
                                | No - 12  
                                | Unknown - 4 |
| Place of Suicide  | Home - 16  
                                | Car - 1 |
| Section of City  | North - 1  
                                | South - 3  
                                | East - 2  
                                | West - 5  
                                | County - 6 |
| Medical Care Premuicide  | Yes, - 7  
                                | No - 8  
                                | Unknown - 2 |
| Previous Attempts  | Yes - 2  
                                | No - 14  
                                | Unknown - 1 |
### 1958

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**1960**

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Sex
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Female - 4
Total - 18

Kind of Suicide
Carbon Monoxide - 2
Gun - 12
Barbiturate Poisoning - 1
Stabbing - 2
Poison - 1

Month of Year
January - 1
February - 1
March - 1
April - 0
May - 1
June - 1
July - 0
August - 4
September - 4
October - 1
November - 3
December - 1

Age
10-20 - 0
20-30 - 2
30-40 - 6
40-50 - 4
50-60 - 1
60-70 - 3
70-80 - 2

Suicide Note
Yes - 3
Unknown - 15

Addressed to
Family - 2
To whom it may concern - 1

Contributing Cause
Unknown - 18

1962

Psychiatric Patient
Unknown - 18

Place of Suicide
Home - 16
Car - 1
Filling Station - 1

Section of City
North - 2
South - 5
East - 1
West - 6
County - 4

Medical Care Presuicide
Unknown - 18

Previous Attempts
Unknown - 18

Threatened Suicide
Yes - 6
Unknown - 12

Drinking Prior to Suicide
Male - 3
Female - 0
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The public needs to be educated. As we inoculate against
dread epidemics, we should inoculate the public with information
pertaining to suicide. Part of this inoculation should contain
the truth about the many misconceptions associated with suicide.

Misconceptions

1. "People who talk about suicide won't commit suicide. Studies
have shown that, in one group of persons who had committed suicide,
full three-fourths, or around 75% had previously either attempted or
threatened suicide or both." (6, p. 13)

2. "Suicide happens without any warning. One of the most
important results of studies is that the suicidal act generally does
not occur suddenly without warning beforehand, but rather that the
suicidal person has given many clues, warnings and indications of
his intentions." (6, p. 13)

3. "Improvement after a suicidal crisis means that the suicide
risk is over. Investigations have shown that almost half of the
persons who were in a suicidal crisis and subsequently committed
suicide do so within 90 days of having passed the emotional crisis and
after they seemed to be on the way to recovery." (6, p. 13)

4. "Suicide and depression are synonymous. The statement 'I can't
understand his doing this, he didn't act like he was unhappy' points
to the commonly mistaken belief that suicide occurs only when
depression is present. Many suicides show agitation or anxiety,
psychosis, organic impairment, or other symptoms. Depression, however,
does remain the best single indication of potential suicide."
(6, p. 13)

5. "All suicidal persons are insane. Studies of over 700
genuine suicide notes indicates that, although the feelings expressed
are often intense, disturbed, and varied at the time of the suicidal
act, just as frequently the quality of reasoning, judgment and logic
expressed is sound, provided the basic premises are accepted." (6, p. 13)

6. "Suicide is a single disease. It becomes almost immediately
apparent that suicide is expressed in various forms and shapes. It
appears in all ages, in both sexes, and in all economic levels."
(6, p. 14)

7. "Suicide is immoral. It becomes immediately apparent that
whether or not one thinks of suicide as immoral depends on the time
and place in which one happens to live. Apparently behavior and
customs are neither external nor universal." (6, p. 14)

8. "Suicide can be controlled by legislations. Legislation
against suicide may have two opposite effects: a person may make a
more serious attempt; he will really kill himself and not fall within
the clutches of the law; or persons who have made unsuccessful suicide
attempts may be discouraged from seeking proper advice and treatment."
(6, p. 14)

9. "The tendency to suicide is inherited. There is no clear
cut evidence that suicide is inherited." (6, p. 14)

10. "Suicide is the curse of the poor or the disease of the rich.
Almost all strata contribute their prorata share to the over-all
suicide rate." (6, p. 14)
But not all the nation is numb to the facts behind suicide and the urgency of its needed treatment. Los Angeles, California has answered the cry for help. The next section is devoted to a basic outline of the Suicide Prevention Center presently in operation in Los Angeles.

THE SUICIDE PREVENTION CENTER

The number of active suicide prevention agencies in the United States might be counted on the fingers of two hands, and within many communities the number of facilities available for ongoing suicide prevention activities is nil. The basic question in any community is whether or not there are adequate facilities for dealing with the important other-than-purely-medical aspects of individual suicide attempts. It was in an effort to give at least a partial positive answer to this question in a specific metropolitan area that the Suicide Prevention Center was initiated. The need for community organizations established specifically to explore new avenues leading to more effective suicide prevention programs would seem to be evident. In 1958, under the purview of a five-year United State Public Health Service Project Grant (administered through the University of Southern California), the Suicide Prevention Center was established in the Los Angeles Community. The purposes of this chapter are to indicate the goals of the Suicide Prevention Center and how it attempts to achieve these aims and to describe Suicide Prevention Center operations and functions. (6, p. 6)

The Suicide Prevention Center of Los Angeles may serve to give impetus to the growing need of those who cry for help. This center is arranged specifically to answer the cry. The three main goals
of the Suicide Prevention Center are:

1. The primary goal of Suicide Prevention Center activities is to save lives. The selection, referral, and therapeutic activities of the Suicide Prevention Center are conducted with this goal in mind. This is known as the clinical aspect of the Suicide Prevention Center. (6, p. 6)

2. Another aspect of the Suicide Prevention Center activities is to establish the Suicide Prevention Center as one of the public health agencies in the Los Angeles area. These activities focus on the integration and liaison of the Suicide Prevention Center with such other agencies in the community as the city health department, the county health department, the police department, the Welfare Planning Council and the coroner's office. This is known as the community aspect of the Suicide Prevention Center. (6, p. 7)

3. A concomitant Suicide Prevention Center goal is to utilize its psychiatric, psychological, and social work data, obtained from a variety of suicidal types, to test various hypotheses concerning suicidal phenomena. This is known as the research aspect of the Suicide Prevention Center. (6, p. 7)

The Suicide Prevention Center will put forth effort to save lives but to do so it must aim effort also in integration with other community agencies and to improve its effect in saving lives by organized research. This seems as if it is a pretty large order. To make the exact methods of the Suicide Prevention Center clear, explanation shall be given to further explain, somewhat in detail, of just how the Suicide Prevention Center goes about saving lives.

I. CLINICAL ASPECT

Obviously, suicide prevention efforts must be directed toward living persons before they kill themselves. The question that arises whether or not there is,
usually, a preliminary prodromal phase during which the suicide victim reveals his self-destructive intention. On the basis of recent studies, it is possible to conclude that the great majority of suicides do display a recognizable presuicidal phase. The concept is proposed that there exists in the community, at any given period, a population of persons who can be designated as potentially suicidal or presuicidal because they have threatened verbally to commit suicide, or have made recent suicide attempts, or have shown certain specific behavior changes (i.e., the depressive syndrome or sudden increase in barbiturate and alcohol intake) that are prodromal for suicide.

Cases for direct anti-suicide efforts would come from this group of presuicidal persons on the presumption that it would include within it, as a smaller subgroup, a good proportion of those who will actually commit suicide. (6, p. 7)

We know that this population actually exists within a community but the biggest problem that the Suicide Prevention Center must face is that of identifying these people. The Suicide Prevention Center is faced with a grave problem because relatively little is now known about the total number, range, and characteristics of the population of presuicidal persons. It is impossible at this time to make these conditions reportable.

At present, at least three methods are being employed by the Suicide Prevention Center to obtain needed data on presuicidal persons. These are:
1. surveying the physicians of the community, using questionnaire and interview techniques;
2. abstracting large numbers of charts from emergency hospitals, general hospitals, and psychiatric hospitals;
3. accumulating detailed case material at the Suicide Prevention Center.

In addition, information about persons who have committed suicide has been collected through interviews with the surviving relatives, friends, physicians, and other informants. Eventually it should be possible to compare data from four main groups: committed suicides, suicide attempts, suicide threats and nonsuicidal persons. (6, pp. 7-8)

Another great problem for the Suicide Prevention Center is that it is very limited in the number of persons that it can effectively treat. One first steps that must be taken is to treat the most
serious. Consequently, at present, the primary type of persons seen by the Suicide Prevention Center, although other types are also seen, is a person who has made a serious suicide attempt and who is hospitalized on the wards of the Los Angeles County General Hospital for medical or surgical treatment as a result of suicidal behavior. By and large, persons who have attempted suicide are selected by the Suicide Prevention Center for help and for study on the basis of duplicating proportionately the characteristics (as to sex, age, race, religion, socioeconomic distribution, etc.) of the total group of suicide attempters in Los Angeles County. The actual selection of a subject for the Suicide Prevention Center processing is made after an examination of the records by members of the Suicide Prevention Center staff, usually including one psychiatrist, one psychologist, and one psychiatric social worker. Once a tentative selection has occurred, the patient is interviewed (usually at bedside), and if deemed suitable, processing by the Suicide Prevention Center staff is begun. The Suicide Prevention Center processing of a subject usually consists of several steps: 1. work-up; 2. contact with co-letters; 3. staffing; 4. referral and; 5. follow-up. (6, pp. 8-9)

Dealing with an attempted suicide case is a very touchy subject and is not dealt with lightly. Unlike some other dangers to life, for example, a severed artery, the manner in dealing with all suicidal patients cannot be alike. The human is so complex and no two is much alike. Different pressures coming at specific times have causal reactions that are different in separate people. Little bits of information form cases that are somewhat like the one at hand give some useful information but the five steps listed above are not merely a list. They are so much more. Within each step there are other steps, equally as important. The following is only a surface presentation of what, in general, goes on in the Suicide Prevention Center processing.
A. The Work-up

The work-up typically consists of two or three hours of psychiatric interviewing, in which the psychiatrist develops at least a partial anamnesis and obtains something of the circumstances of the suicide attempt and some inferences of the psychodynamics of the patient. Psychological testing is done with a battery that includes the Thematic Apperception Test, the Make a Picture Story Test, the Sentence Completion Test, the Minnesota Multiphasic Personality Inventory, and some special tests in which the patient is asked to write a personality self-description and either to write a duplicate of his suicide note or to compose the suicide note that would have been written. (6, p. 8)

B. Contact with Colaterals

The social worker may be interviewing the important relatives, which may be the spouse, the parents, or the grown children, focusing his attention on interpersonal dynamics, potential psychological and financial resources within the family, and so on. He is also thinking of appropriate agencies or persons to whom to refer the patient, and perhaps the relative also, for treatment. (6, p. 9)

C. Staffing

Each patient processed by the Suicide Prevention Center is discussed at length, although none is presented in person, at a staff meeting in which an attempt is made to comprehend the meaning of the suicidal behavior for that patient, to understand the intrapsychic and interpersonal context within which the suicide attempt occurred, and then to make a realistic referral for treatment. (6, p. 9)

D. Referral

The referrals vary in nature. They may include referral for hospitalization to a state hospital, a Veterans Administration Hospital, or a private
hospital; referral to a social agency for family
and casework; referral to a clinic or to an
individual therapist for group or private
psychotherapy; on occasion, referral to the
Suicide Prevention Center itself for either
individual psychotherapy or dyadic psychotherapy,
in which both husband and wife are taken into
individual treatment at the same time. (6, p. 9)

E. Follow-up

When referrals are made, an attempt is also made
to obtain follow-up data so that information can
be funneled back to Suicide Prevention Center
from the treatment resources, thus permitting
the Suicide Prevention Center to continue to
evaluate the relative effectiveness of various
methods of treatment for suicide attempts. (6, p. 9)

**Telephone Interview**

The five steps listed before all seem to be a
very neat and tight little bundle. But it is
not all this easy. No every potential suicide
is there facing the Suicide Prevention Center.
As word of the Suicide Prevention Center spread,
telephone calls, referrals, and consultations
concerning persons who have had threatened
suicide have resulted. These calls have come
from various sources in the community, such as
other agencies, physicians, friends, or relatives
of the patient, and from the patient them­
selves. Sometimes these calls could be handled
on the telephone simply by the sympathetic
listening or referral to an appropriate resource,
such as physician, minister, friend or relative.
At other times, however, when the situation
has seemed to warrant, the caller has been asked
to come in and or bring the patient in for an
interview. When the suicidal danger is evaluated
as high, the Suicide Prevention Center has
maintained continued contact through active
intervention, including telephone calls and home
visits, in order to keep the bonds intact
between the Suicide Prevention Center and suicide­
prone persons during the days of crisis. (6, p. 10)
If the Suicide Prevention Center were to answer all the calls coming in it is almost certain that a great deal of time and energy would be lost. An important must for the professional people in the mental health field (psychiatrists, psychologists, social workers, etc.) is that they be able to make a rapid assessment of someone's self-destructive potential. Professional person's role in answering emergency consultation requests can be divided into three phases. First, he obtains necessary information, then he forms an evaluative judgment of the situation, and finally he recommends an appropriate action. (6, p. 48)

The telephone interview has shortcomings and they are: There is a tendency for the most dramatic and emotionally disturbing aspects of the picture to obscure other equally relevant elements. Several important questions may remain unanswered. The consultant may recommend a course of action based on incomplete data when actually more complete information was potentially available. A systematic approach to the problem of obtaining the most pertinent indicators of self destructive danger (or safety) within a limited amount of time is provided by a schedule of action that should be explored during the interview. (6, p. 48)

Short Schedule for Assessment of Self-Destructive Potentiality

I. Case history: factual

A. Age and Sex
At all ages, suicidal communications from males arouse more concern than similar communications from females, and, in general, the older the person, the more serious is the self-destructive potentiality. (6, p. 49)

Non lethal intended suicidal action (rare) in a man over 50. By contrast the group of young females, aged 15-35 provides the largest number of self-destructive nonlethal communications and suicide attempts. (6, p. 50)

B. Onset of Self-Destructive Behavior; chronic repetitive pattern or recent behavior change? Any prior suicide attempts or threats?
A history of recent personality changes, combined with a history of recent actual suicidal attempts is a major danger signal for the immediate future. As the potential victim grows older the condition gradually grows worse. A crucial point in evaluation is whether the person with a chronic, repetitive, self-destructive pattern has completely exhausted his emotional resources. (6, p. 50)

C. Method of Possible Self-Injury: availability, lethality?

This may often reflect the degree of emergency. A specific choice of time, place, and method for proposed suicide is a serious indication. The person who owns a gun and proposes to use it against himself should be the object of immediate emergency efforts. Similarly, ideas of jumping from a high place should be taken more seriously. Nearly all pills to produce sleep can be lethal in large units but the rapid-acting barbituates, such as pentobarbital and secobarbital are by far the most effective for suicide. (6, p. 50)

D. Recent Loss of Loved Person: death, separation, divorce?

Many suicide attempts, especially in young persons, are after the separation from a spouse or a loved one. Frequently these attempts are successful as a form of adaptational behavior in that they do serve to bring the loved person back. When there has been a definite loss of a loved person, the potentiality for self-destruction is increased. (6, p. 51)

E. Medical Symptoms: history of recent illness or surgery?

A history of recent hospitalization or medical consultation may indicate increased self-destructiveness, especially in older persons. Medical conditions closely associated with suicidal reactions are: psychosomatic diseases, polysurgery, malignant tumors, and various symptoms associated with depression. Indicators of depression are: anorexia, weight loss, sleeplessness, fatigue, impotence, loss of sexual desire, and hypochondriacal pre-occupation, especially cancerophobia. When chronic debilitating diseases such as cancer actually do exist, suicidal reactions tend to be precipitated
by incidents that the patient interprets as rejection from family and physician. (6, p. 51)

F. Resources: available relatives or friends, financial status?

Often the attitude of a spouse, relative or friend may mean the difference between life and death for persons involved in symbiotic relationships. Financial resources need to be included in the evaluation, as these determine what types of treatment are available. A recent loss of job or sudden drop in financial status may constitute a traumatic loss to certain persons, especially middle-aged men and career women.

Persons with history of direct self-destructiveness, illustrated by unstable interpersonal relationships, alcoholism impulsivity, and hostile dependency, often reach a crisis in the fourth or fifth decade when they have exhausted themselves financially and interpersonally and are emotionally bankrupt. (6, p. 52)

II. Judgemental-evaluative

A. Status of Communication with Patient

When a patient is able to express his troubled feelings and cry for help the self-destructive danger may be high, but it is never so extreme as when the patient has given up and withdrawn and is no longer communicating. A warm receptive, hopeful, encouraging responsive attitude by the consultant will help to keep the communication line in tact.

Usually, an emergency self-destructive situation is ominously foreshadowed by a break in communication, cancelled appointments, unanswered telephone calls and silence. Hostile attitudes, objection are found to be relatively superficial and should melt away when exposed to sympathetic, firm consistent, and coordinated helping efforts. (6, p. 52)
II. COMMUNITY ASPECT

If the Suicide Prevention Center or any mental health service is to survive it must work effectively with other community agencies. While working at the Delaware Mental Health Office, the writer discovered that some city councilmen felt that a delinquent could be dealt with most efficiently with an oak switch rather than spending a great deal of money on a detention center. How unfortunate it is when people feel this way. If a person has not experienced such problems, it is often difficult for them to identify with the situation. Or perhaps, dealing closely without an educated understanding would work in the same manner.

One of the goals of the Suicide Prevention Center is to fill a gap in the health and service needs of the community. In order to operate with any degree of efficiency (especially during the early phases of operation) to integrating the Suicide Prevention Center with other health and welfare agencies in the community. Exploratory conferences and consultations were held with a member of agencies in the Los Angeles area, including the following: city health department; county health department; police department; fire (rescue) department; welfare planning council; state hospitals; county coroner's office; county medical association; Southern California Psychiatric Association; University of Southern California and the University of California at Los Angeles medical schools; and several of the local hospitals. (6, p. 11)

In the workaday activities of the Suicide Prevention Center, it has become increasingly clear that when any organization attempts to deal with the problems of suicide in a metropolitan community, it does well to have secure relationships with health, welfare, and governmental agencies within that community. (6, p. 12)
One aspect of the Suicide Prevention Center's work with community agencies is unique enough to merit separate description; namely, the relationship with the coroner's office, and especially with the coroner himself. Cases of accident-suicide constitute an important problem area in the coroner's case load. There are cases in which the cause of death, as supplied by the coroner's taxicologist or biochemist or microscopist, may be completely clear (as, for example, a lethal dose of pentobarbital), but the mode of death, whether accidental or suicidal may not be clear at all. The suicide prevention team is designated as the suicide team. The team's task is to clarify each of the questionable suicide cases. This they do by obtaining a great deal of information from a number of persons who knew the victim, and then by reconstructing the life style of the deceased and extrapolating over the last days of his life. The empirical data obtained by the Suicide Prevention Center staff are reviewed with the coroner at sessions that have been labeled 'psychological autopsies.' They do indeed clarify the mode of death in a number of cases.

An important aspect of community relations has been the dissemination of information about the Suicide Prevention Center. Members have given lectures within the community, have conducted workshops for professional personnel, and have participated with radio and television programs concerning suicide prevention. In addition, the Suicide Prevention Center has been publicized in several newspapers and magazine reports. In appearances before lay groups and popular presentations in mass media, members of the Suicide Prevention Center staff have often taken the occasion to correct commonly believed 'facts' about suicide, each one of which is, in reality, false. (6, pp. 12-14)
III. RESEARCH ASPECT

It is a manifest truth that there is a fundamental relationship between clinical practice and research; clinical practice improved largely through the findings of research efforts. A total program on suicide must therefore not only save lives today but investigate into why persons take their lives, so that suicidal behavior can be prevented in the future by increased knowledge concerning it causes. With this in mind, a specific proportion of staff time is devoted to basic research activities. The data for these studies consist of suicide notes, details of the psychiatric case histories, psychological tests, social service data, information from the coroner’s office, ecological and sociological data from the community, etc. (6, p. 15)

Much of the information obtained is coded and punched on IBM cards for statistical analysis. In addition, primary staff members involved in each case completes a standard 100-item true-false form of personality inventory for every case processes. Particular interest is given in evaluating the degree of suicide danger through such indicators as psychiatric diagnosis, the effects of the patient's communication has on others, the meaning to the patient of his self-destructive behavior, the actual lethality of his behavior, the prominent dynamics, and the self-image. Possibly, with the aid of computing machines, we will be able to construct formulas or evolve regression equations for reducing these diverse and complex data to relatively few comprehensive indices of suicidal danger. (6, p. 15)

To illustrate some of the data that has been used in discussing suicide, some examples of suicide notes and actual accounts of victims will be given. The notes are authentic but were not taken from cases here in Delaware County, as such information is highly difficult to secure. The cases used as illustrations were taken
from the Delaware County Mental Health Office's files with the assistance of Mrs. Pat Jones, the office director.

SUICIDE NOTES

1. To the Police. No note - one was written before this. Los Angeles Police already have a record of one attempt. Notify: Anne M. Jones 100 Main St., Los Angeles. I work at Ford, 100 Broadway. That is all.

I can't find my place in life. (3, p. 200)

This note has multiple implications. One attempt has already been made. He cried for help once but evidently no one answered his plea. This time he did the job completely. The woman's name he left to be notified probably was his wife. If it was his wife, they were divorced and living at separate addresses. His first attempt may have been an attempt to find out whether anyone would help him make a place in life. It failed - so he no longer will exist where he does not belong.

2. Dearest Mary. This is to say goodbye. I have not told you because I did not want you to worry, but I have been feeling bad for 2 years, with my heart. I knew that if I went to a doctor I would lose my job. I think this is best for all concerned. I am in the car in the garage. Call the police but please don't come out there. I love you very much darling. Goodbye. (3, p. 200)

This is a sample of the motivation behind suicide labeled as "The High Cost of Living." This man chose between burdening his family with an invalid, bringing on multiple medical expenses, causing much grief and debt. He took this action because he loved his family and wife too much to cause them any heartbreak.
3. This is the last note I shall ever wright.
No one should feel bad about my going as I am not worth it. I don't want to go but there is nothing else to do. (3, p. 201)

"I don't want to go but there is nothing else to do." Nothing else is left when one no longer find any worth in himself.

4. Dear Mary. I'm sorry for all the trouble I've caused you. I guess I can't say any more. I love you forever and give Tom my love. I guess I've disgraced myself and John I hope it doesn't reflect on you. (3, p. 205)

This man's aggression had turned inward. I wonder how much trouble others had caused him, but in his mind, at this point, he was the one who had caused the trouble and must pay. Even the disgrace of suicide could not sustain him. This old idea is reflected in Robert Blair's "The Grave."

Self-murder promises unheard of tortures—
Unheard of Tortures must be reserved for such:
These herd together
The common Damn'd shun their society. (12, p. 117)

5. Dear Mary. Since you are convinced that you are an invalid and no one can help you, I hope my 3000 insurance will help you to see the truth about yourself and get rid of your mental sickness. You are now free to marry Joe. Remember you will never have any happiness with anyone until you learn to help yourself. I have no regrets and hold no malice or unkind thoughts toward you. We would have had a happy life together if you had wanted to help yourself. I hope you will eventually find happiness. love, Bill.

Tell my folks I'm sorry I couldn't see them before I went. (3, p. 205)

"Free to Marry Joe." This man had lost his love object. He found it too difficult to show malice toward his wife and carried
out his true wish to murder her on himself. But in his death, he hopes, secretly, that his wife will suffer. The note to his folks reflects the shame he hopes she will feel. What a difficult task, for a wife to convey a message from her dead husband to his parents, this would be. Malice is a shrewd character and hated by all. What a blessing if he would commit suicide. Malice (Malus) is portrayed in "The Atheist" by N. Elliot.

Malus resolv'd to hang himself, or drown, of Friends devoid, abandon'd, and distrest, E'en hope was banish'd from his coward breast.

Yet, ere his hands the fatal cord entwin'd Thus Fear suggested to his wav'ring mind; 'To be or not to be,' is now in doubt; Consider, when this vital lamp's put out, And life's extinguished, if thou art no more, What can retain thee on this hated shore? But after death, if thou are to appear Before some Judge, thou know's not whom, nor where,

Stay des'perate wretch! Remember, this last stake is greater for than thou did'st ever make, She said; he quickly flew impending death, Tho' scorned and hated to his latest Breath. (12,p.141)

Malice (Malus) will never die for Fear (she) will keep him alive. Without Malus, Fear could not operate.

6. Somewhere in this pile is your answers. I couldn't find it. Mom you should have known what was about to happen after I told you my troubles now I will get my rest.

Dad, I am in this jam because I trusted people (namely you) and some people trusted me, because I am, in my present state a menace to me and my customers I think this is the best way out, and out of my insurance if you ever take a drink I hope you drown yourself with it. (3, p. 209)
This, even more clearly, shows the wish to murder others. The choice of self-murder overpowered his basic wish. This son had reached out but his parents had not responded in the manner he desired or needed. His love turned to hate and this had been directed inward. They have taken the desire for life from him and he hopes that, if they try to take any more, his insurance money, they too will die (drown).

7. Darling wife, Mary Helen Smith. I'm sorry for everything I did please don't be angry at me my sweet wife. You left me and did not say anything. So darling this is your divorce my darling wife Mary. I love you more than anything in the hold world my sweet wife. (3, p. 212)

Refusal of love - loss of love object - The realization of the final split, divorce, was too much. The repetition of avowal of love might also have been an attempt to cause a sense of shame in his wife. He wants her to get the rings back to remember him, to suffer in his memory.

8. Dear Mary. I am writing you, as our divorce is not final, and will not be till next month, so the way things stand now you are still my wife, which makes you entitled to the things which belong to me, and I want you to have them. Don't let anyone take them from you as they are yours. Please see a lawyer and get them as soon as you can. I am listing some of the things, they are: A Blue Davenport and chair, a Magic Chef Stove, a large mattress, an Electrolux cleaner, a 9x12 rug redish design and pad. All the things listed above are all most new. Then there is my 30-30 rifle, books, typewriter, tools and a hand contract for a house in Chicago, a Savings account in Boston, Mass.

Your husband. (3, p. 214)

This is another divorce split and loss of love object. His subtle wish is to murder his wife with kindness. He is giving her
all the things he provided as a husband, all the things that he sacrificed to give her "all most new." She will have everything to remaind her of him, even the 30-30 rifle that might have been the suicide weapon.

9. Good bye Kid. You couldn't help it. Tell that brother of yours, When he gets where I'm going, I hope I'm a foreman down there. I might be able to do something for him. (3, p. 214)

He implies that he will go to hell because he is no good.

But, he also implies that his friend will go there too. This humorous note probably has a much deeper meaning than is conveyed. One can't help but wonder what the kid could help.

CASE STUDIES

CASE #1

Description - male, age twenty

This subject's first referral was after he had raped a 13 year old girl and his mother was interested in seeking psychiatric help. This boy had been referred as a child for severe personality and behavior problems and a poor home environment to a doctor who had advised them to send him to White's Institute. He was never seen by this doctor again.

His next encounter with the law was in regard to his cashing of bad checks that a homosexual friend had signed. He was committed to a state hospital. Shortly thereafter his mother requested that
he be sent home for a short time to visit with a brother at home
from the service. While at home he went out one evening and never
returned. He was finally found after he had become drunk and
been involved in a motorcycle accident.

The mental health office received another call from his
mother about a month later saying that he had attempted suicide. He
had tried to kill himself with a gun. He was taken to a local
hospital where he threatened personnel and anyone who came near.
During his treatment there he escaped and was picked up by the
police.

In the meantime this patient has been in and out of mental
hospitals and police stations. The attractive young man is very
quiet and beginning to develop paranoid tendencies. Even though
he has latent homosexual tendencies he manages to have numerous
girl friends.

The patient's mother is extremely neurotic and cannot face
the fact that her son is ever to blame. She feeds his paranoid
tendencies by making excuses for him and living in false hope.
He has no sense of responsibility to his family, community, or to
himself.

He is a sociopath and emergency treatment is all he can ever
hope for. He will run and keep running from himself. When he no
longer can run to mother, a woman, alcohol, or a speeding motorcycle,
he will run directly into his real self and he will find this person
unworthy of being spared and he will kill.
CASE #2

Description - male, age 40's

This man had a long list of suicide attempts before the act was ever realized. At the time of the first referral, the patient had been in the basement of his home with a gun threatening himself, family, friends, and anyone who came near him. A year later, while in the hospital he attempted suicide by slitting his wrists. At this time a divorce was pending. His wife was described as an unstable person; she was not willing to take the responsibility for the children if the suicide became a reality or if the divorce was consummated. The patient felt his wife was committing adultery; she had little to say on this matter. Within the next year he attempted to slit his wrists again; the act was finally accomplished several months later when he shot himself.

This subject is rather like an older edition of the subject in Case #1. He was also physically attractive and had had a series of marriages and affairs in between. He was a sociopathic alcoholic, constantly in trouble with the police for minor offenses. His parents were still living at the time of his death. The home was a highly religious middle-class home. His mother was overprotective and his father was a rigid disciplinarian. There was constant conflict between the two parents causing much tension, but because of religious beliefs they remained married.

Severe pangs of shame and guilt were probably suffered by this patient. The rigid super-ego structure did not develop in the same
fashion as did his life style. The repetitious attempts of suicide are very indicative of some suicidal cases. His mother overprotected him, making up for his deficiencies, while his father enforced strict rules and condemned his conduct of life.

CASE #3

Description - male, age 55-60

This subject was brought to the public's attention when he climbed to the top of the courthouse and threatened to jump unless his family received some sort of financial support. He was a master carpenter by trade and supported his four children by this day-by-day type of labor. He was also suffering from tuberculosis.

He became very agitated because of the vivid newspaper accounts concerning his attempt. He was sent to a state hospital and diagnosed as manic depressive with psychosis alternating - delusions of grandeur and paranoid tendencies. Since this time he has been sent to a hospital with closed tuberculosis wards where mental health is also treated.

In his manic states he writes documents. His first product concerned itself with the fact that he had had his civil rights taken from him. Now he puts forth hours of work on books about mental health. One of his topics is, "What Patients Should Know Before Going to Mental Health." He seems to understand how his situation came about and talks in terms of salvation.
This man felt the world owed him a debt. His aggression toward society was directed inward. By this suicide attempt he would expose the evils of society. However, this man is mentally ill as well as physically ill. The physical illness prevented him from working to some extent and may have been a beginning that added impetus to his mental illness. Nevertheless, the main problem seems to be his mental condition.

CASE #4

Description - female, age 30

"May I do some volunteer work for you, type or do clerical work?" These were the words of thanks offered by this subject to the mental health office. Approximately one year ago the words she uttered were of a much different nature. She called the mental health office from a telephone booth and voiced her intention to commit suicide. She had just returned from her doctor where she had received some tranquilizers and with these tranquilizers she intended to end her wretched existence. She refused any suggestions of letting someone pick her up. Whether she would accept the helping hand from the mental health office was uncertain. Clarification came after she walked alone to the office. A volunteer social worker from one of the state mental hospitals, who had been visiting there, calmed the subject and talked to her while the mental health office personnel hurriedly arranged for her to be taken to emergency.
Why would this woman want to commit suicide? "She is very attractive, intelligent, and talks quite lucidly," commented the executive director of the Mental Health Association. This subject had married across racial barriers and lived in a mixed neighborhood in the northeast section of town. Her parents were a constant source of agitation to her on this matter. Her love of her parents and the conscience they had ingrained in her bound her to one way of life and her love for the man she married to another. She had no children. It is uncertain as to whether this fact denotes any implications but it may. Longing to be a mother, the mother of the children of the man she loved would only be natural. But rejection is a terrible thing and she, because of her choice had experienced it. Why bring children into a world where they would be accepted by no subculture. People are free to select their way of life but are not free from the criticisms aimed at their choices. The rejection she experienced denoted a sense of worthlessness and when one finds no worth in the self the self must be destroyed. This subject still goes into deep depressions and her doctor warned the mental health office that they would hear from her again because they had saved her from herself.

The implications for this patient are many. A strict conscience wields power, rigid rules, over her world. The incongruent state of matters is that her world is no longer the world where this conscience was developed. Her choices have become more flexible but her conscience has remained in an infantile state. The hate she
feels for her parents is a terribly shameful thing to her. Who will accept her for what she is and find some value in her life. If no one inforces her sense of value, neither will she.

CASE #5

Description - female, age 30's

The patient called the Department of Public Welfare for authorization to see a doctor. She was distraught and crying. She was the mother of three children aged 12, 13, and 7 years. Separated from her husband, she had been receiving aid for dependent children and this is why she called the Department of Public Welfare. That morning a neighbor had reported to the police that her door was locked and she smelled gas. The patient, at this time did not remember turning on the gas. She only remembered waking to find the policemen in the room where she had turned on the gas in an attempt to end her life. She felt that she needed medical assistance for she was having strange thoughts of cutting her children's throats. The Juvenile Aid's Department had been called for the children. The police were called again and sent out immediately to take her to emergency. After treatment she stayed alone and slept well.

The subject commented that she was so glad that mental health had showed interest in her problem. She came into talk with the mental health personnel. It was discovered that she had had previous psychiatric help for one year and was greatly helped.
But lately the troubles had been piling up. The oldest child missed his father very much. The father had asked to come home but she felt that it would be too big of an adjustment for her to make. She feared that the same thing might happen again.

She related periods of depression and sometimes cried all night. She had attempted suicide before but could remember very little about it. It was reported that at one time she had taken the butcher knife in her hand with the idea to kill her three sleeping children to put them out of this world and to take her own life. She used to enjoy being with people but now related that she was inclined to withdraw. This subject desired very much to overcome the involuntary compulsion to take her children's lives and her own.

This subject's case was brought to a head by the loss of her love object, the husband. She was alone and the only thing she had left was her children. The demands they made couldn't be met; they missed their father. She had been worthless as a mother and a wife. How much pride can a person have who has to be supported by the county and cannot hold up her head and meet the demands of life?

CONCLUSION

For the person who finds in his life worth and reward, it is difficult to understand the motivations behind suicide. Life is a complex of struggles, not all of which are won; however, the number of defeats, in most cases, is compensated by a balance of achievements. This is the crux of life; life would be meaningless if it were a field of constant achievement. Conflict adds the
needed friction to keep the human organism in contact with and moving along the path of life. Why are some persons unable to achieve this balance in their lives? It is the feeling of the author that all men should be given the opportunity to know the type of life that the human being alone can experience. It should be of great concern to society when there arises in it a faction of persons who do not find the necessary motivation and value in life to make it worth living. The danger lies in the fact that the type of society man builds for himself is the solitary result of his actions. Man has the ability to cope with all problems that arise in an intelligent manner. The ability to reason has given him this power over the other creatures in his domain. The staggering implication is that man may chose to build his society in a negative manner just as readily as to build his society in a positive manner. In the past mankind has struggled to deal with and has, to some extent, defeated all those forces that threat to destroy his freedom to live - disease, monarchy, and crime. This paper was constructed as a reaction to the threat of self-destruction. It seems that there must be a grave problem in society when such a great number of persons each year chose self-destruction as a means to destroy that which man has attempted to guard and protect in the organization of society. It is simple to say that each man is free to live his life or end it as he wishes. But the important consideration is that suicide is not necessarily directed toward the end that it accomplishes. Instead of desiring death, most suicidal persons are searching for a means by which they may live. This may seem ironical - to live by
death. Contrary to belief, most suicides are not the result of the wish to die, but in reality, the wish to live. What more startling way to alert fellow-men to a need than to attempt suicide. This seems to be the last resort, the last plea for help, a plea reinforced by taking the most-valued asset man has and offering it to another and permitting him to decide whether it will be maintained or destroyed. When this plea is voiced it must be met. When man no longer responds to the needs of his kindred then will man destroy himself, his society.

Working under the assumptions stated above the author researched the available materials concerning suicide, but it is felt that the greatest benefit came by actual contact with persons struggling to exist more compatibly in society. One can see by the data quoted in this paper, both on a nation-wide basis and on a local basis that the problem does exist. The data becomes very real, as do the theories proposed to underline suicide, when one observes persons struggling under a complex of forces to maintain a desired state of existence. During the three-month period of work in the mental health office the only one actual case of suicide, Case #4, was observed. However, this is very irrelevant when one considers that all problems emotionally oriented may lead to suicide. The time to deal with suicide is before it becomes a reality. The basic mental health of the individual should be maintained to avoid this finalization. To avoid and to deal with suicide moves one to conclude that action must be taken to meet the problems of basic mental health more adequately.
Delaware County is not meeting its responsibility adequately when 13 suicides, on the average, may be found in its population. This is not to imply that the problem is not being coped with because there is a lack of concern. It is felt that the very closeness of the problem may be an aspect that blinds. Most persons prefer to avoid thoughts concerning a subject that is so basically frightening. Man has always tried to avoid the issue of suicide by putting it out of his mind. The abrupt realization is forced when it strikes someone close to him. Then enters the element of shame. Suicide, in the past, has been labeled with many misconceptions just as have many mental health problems. It is a weakness in man; it is difficult to deal with one's weaknesses. The basic misconceptions that surround suicide must be abolished and replaced by an intelligent understanding of this phenomenon. Society must strive to alleviate those pressures placed upon persons that cause them to find themselves worthless. The prejudice man uses against others to enhance himself must be abolished. The false pride that allows no man to be weak must be dealt with. Man must realize that the basic weakness is found in the inability to face the fact that mental problems are possible for all men and must be treated in an intelligent manner. "An attitude of respect for the person who is disturbed may be the crucial necessary difference." (9, p. 264)

Public education concerning suicide is an important step that should be taken. However, the education of the public is not enough. The problem as it exists must be dealt with. Money must be appropriated to assist the personnel swamped by the demands placed
upon them. In essence there must be a place where persons may go to seek assistance when emotional problems confront them. The Delaware County Mental Health Office is now in existence to cope with such problems, but it needs to be expanded and enlarged to meet all the problems of the persons in Delaware County. It is equally important there there be enough educated persons available to deal with these problems. Delaware County has begun to meet the problem but much more must be done. Perhaps, the size of the community and the magnitude of the problem does not warrant as large and as costly an institution as the Suicide Prevention Center in Los Angeles, California. But a smaller organization basically founded and initiated on the same principles as this center is not beyond comprehension. The Delaware County community has one outstanding advantage. The presence of Ball State University would offer Delaware County the necessary pool of persons educated in the area needed to deal with suicide. The community of Muncie and surrounding area could work with the institution of Ball State University, its psychology department, nurses training school, and perhaps, in the near future, with its proposed medical school, in organizing an institution similar to the Los Angeles Suicide Prevention Center to deal with the suicide problem.
I FIND A MAN

I find a man lying in a blanket of snow,
In the middle of April, on a battlefield
where flowers grow.

His body is battered, bloody and torn,
Basted with Death's fluid where Life's
joys should have flown.

His face is familiar, though this man I've
never known.
On his finger is a diamond of the largest
size,
And an expression of nothing stands stagnant
in his eyes.

And by a mere glancing I can clearly see,
the old haggard man has met death with
years numbered at, at least 23.

By his side - there it lies - his messenger
of Death, so it seems,
A discharged pistol with blade so sharp
that in the sun it gleams.

A knotted young hand clinches it still,
As if ever ready for mercy - another kill.
And by this hand it will rain again,
for the man I find has a kinship with all
men.

Oh, I must hurry home and tell what I see -
Find out where he lived and tell his family.
There will be crying, I know and grief,
I am sure.
And a wealth of love will be shown at his
door.

Oh! I forgot - too late - I cannot leave.
I remember - I see - This man, I know

He's me.
BIBLIOGRAPHY


