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Traitor Within: OUR SUICIDE PROBLEM

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BY

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AND

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1961

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PREFACE

THOUSANDS of Americans kill themselves each year. Tens of thousands more try but survive. Millions of people are directly or indirectly affected by these acts of desperation. Untold numbers of us carry within ourselves a fatal flaw which may lead us to self-destruction.

Despite this heavy impact on our social fabric, suicide is the least known and most misunderstood of all our national health problems. In part, this is due to the fact that the subject of suicide generally is considered too terrible to face. It evokes prudery, squeamishness —even horror. Many people regard suicide as a purely moral problem. They do not know that it is a pressing social problem of the highest order.

Most of the literature on suicide consists of scholarly treatises written by specialists for specialists. This present book on our national suicide problem is intended for the general reader.

Although suicide and attempted suicide in the United States have reached staggering proportions, most Americans are unaware that the problem even exists. Only a handful of researchers in this specialized field know its dimensions. The latest research—still incomplete as this book went to press—indicates that the problem is even larger than most specialists now realize. It appears that all estimates of the numbers of Americans who attempt suicide each year have been far too conservative.

A note of urgency has crept into scholarly writings of late. An

increasing number of researchers are calling for public recognition of suicide's status as a major mental health problem. They agree there is scant chance they will get the money and facilities needed for a massive attack upon this problem until more Americans understand just how serious it is.

This book is the result of 15 years of research. The authors have studied hundreds of treatises, monographs, theses, insurance reports, history books, biographies, autobiographies, diaries, memoirs, and psychiatric case histories. They also have collected a file consisting of thousands of newspaper clippings.

Despite this extensive and intensive research, however, the authors of this book do not pretend to know all the answers about suicide. No one knows. We merely hope to bring the scourge of self-destruction to public attention.

We are deeply indebted to many persons who have assisted us in a variety of ways. Chief among these are Tom Lownes, Kathryn Ellis Burton, Karl Pretshold, Helen Goodell, Matthew Redding, and Lauretta Ravenna. And our especial thanks go to our respective wives, Ruth Kraus Ellis and Anne Allen.

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Chapter I

THE UNRECOGNIZED KILLER

THE nation's capital slept peacefully in the early morning hours of May 22, 1949. In a sixteenth-floor suite of the white granite tower of the nearby Bethesda Naval Hospital, a gaunt, 57-year-old patient sat on his bed in pajamas and bathrobe. He was copying on hospital memo paper from a handsome volume of poetry bound in maroon leather. On page 277 he found a kindred, brooding spirit in the ancient words of Sophocles, the Greek tragedian:

Oh! when the pride of Graecia's noblest race
Wanders, as now, in darkness and disgrace,
When Reason's day
Sets rayless—joyless—quenched in cold decay,
Better to die, and sleep
The never-waking sleep, than linger on,
And dare to live, when the soul's life is gone . . .

Copying lines of melancholy Greek poetry was not a common occupation of James Vincent Forrestal. Less than two months before, he had been one of the most important government officials in the country, wielding power which some said was second only to that of the President. He had directly supervised more than 30 per cent of the money spent by the United States Government and had overseen construction of the world's largest navy. He was re-

sponsible for partial determination of American policy toward the Soviet Union and had much to say about the atomic bomb. As the nation's first Secretary of Defense, he was charged with the difficult task of unifying our armed forces. Before entering the government he had earned $180,000 a year as president of the Wall Street firm of Dillon, Read and Company.

Official Washington agreed that James Forrestal was the hardest-working man in the capital. His prodigious feats were legendary. In addition to his job as Defense Secretary, he was a member of the War Council, the National Security Council, the National Security Resources Board, the Hoover Commission, and he met frequently with the Joint Chiefs of Staff. He worked 18 to 20 hours a day. Since becoming Secretary of the Navy in 1944 he had allowed himself only one three-day vacation. In signing official documents he dropped his middle initial to save time. On memoranda he gradually condensed his initials from JVF to F.

Now the former strong man of Washington was hospitalized for "occupational fatigue," his powerful mind groping in blind alleys. He had been retired in March, when it became apparent that he was breaking down under the tremendous pressures on him. President Harry S. Truman visited him in the hospital, as did Forrestal's successor, Louis Johnson. To his brother, Forrestal said: "I'll be all right. We'll pull out of this."

Now it was nearly two o'clock in the morning of May 22. Forrestal had been officially declared on the road to recovery. To help speed him back to health, the precautionary restrictions on him had been lessened. Hospital personnel saw nothing strange in his sitting up until a late hour, reading and copying Greek poetry. Suddenly he stopped writing in the middle of a word, arose from the bed, and placed the book on a nearby radiator. He moved softly out of his room, crossed a narrow hall, and entered a small diet kitchen. Pushing open a window screen, he leaped into space.

When Forrestal died the nation suffered a grievous loss of talent and broad experience. The suicide of a man of his ability and importance is a painfully sharp example of the waste of precious hu-

man lives the nation suffers every year from suicide, the greatest unrecognized killer of our time.

While you are reading this page, several Americans will try to kill themselves. By the time you have read to the end of the chapter, two or three will succeed in dying by their own hands. Day in and day out, every day of the year, 300 or more Americans attempt to destroy themselves; and every day, 50 or more succeed in doing so. In 1957, the most recent year for which complete, detailed records are available, the suicide toll was greater than the *combined* deaths from typhoid fever, dysentery, scarlet fever, diphtheria, whooping cough, meningococcal infections, infantile paralysis, measles, typhus, malaria, rheumatic fever, and bronchitis.

Americans are destroying themselves at the rate of one every 28 minutes. For every life taken by polio, suicide claims 77. For every five lives snuffed out by breast cancer, suicide takes four. For every two persons killed in automobile accidents, one commits suicide.

Suicide ranked twenty-second on the list of causes of death in the United States in 1920. Today it ranks eleventh and in some years has ranked tenth. For our white population between the ages of 20 and 45, suicide has climbed incredibly into fourth place as a cause of death, being outranked only by accidents, heart disease, and cancer. Among children aged 15 to 19, suicide is the fifth-ranking cause of death. The United States is the only country in the world where more people die by their own hands than from the effects of old age.

We Americans pride ourselves on our national achievements, the abundance and comforts of the society we have built—the richest and technologically most advanced civilization in history. Yet in 1958 about 150,000 of us decided life wasn't worth living and made serious attempts to end it; 18,519 of us succeeded. Since the beginning of the century about 7,000,000 Americans tried to end their lives and nearly 750,000 did. Walking around today in varying degrees of misery are perhaps 2,000,000 Americans who have made serious efforts to end their lives.

Despite the terrible toll it exacts every year, suicide is almost

unknown except to a handful of worried psychiatrists, sociologists, physicians, and public officials who have been disturbed by this wastage of lives. Recognition by laymen of the importance of suicide as a national scourge has come from only a few private groups which have set up suicide-prevention centers in some of our large cities. While our physicians and medical researchers have concentrated on the more familiar ills such as cancer, infantile paralysis, and heart disease, suicide has been largely ignored. As one infectious disease after another has been defeated, suicide has steadily posed an ever greater threat, until now it looms as a pressing mental-health problem of the first magnitude.

There are more than twice as many suicides as murders in the United States every year. But while we have extensive police departments and courts which make strenuous efforts to prevent and solve murders, officials give only the most perfunctory attention to the prevention or explanation of suicides. Bereaved relatives, friends, and colleagues are left with questions which cause as much anguish as the bereavement itself: "Why did he do it?" "What was wrong?" "He seemed so happy; wasn't he?" "Could we have prevented it?" These questions are rarely answered satisfactorily. They remain to haunt the perplexed, sometimes for a lifetime.

No drive to reduce the suicide rate has ever been attempted officially. There never has been a national campaign to awaken the nation to this major health challenge as there has been for infantile paralysis, cerebral palsy, muscular dystrophy, and other afflictions with much lower death rates. We mount elaborate campaigns to reduce the number of automobile deaths, yet some of our cities have more suicides each year than road deaths. Scientific research on the subject is meager; organized public interest less than meager. There has been hardly any serious treatment of the subject in general publications.

To Americans generally, suicide is the most widely misunderstood of our leading social and medical problems. Many people believe it to be a sin and unworthy of discussion. Others view it with contempt or admiration, believing it to be an act of despair or possibly one of great courage. Others see it as an act of cowardice.

Many people will hardly utter the word. One of the handful of serious students of the subject, Dr. Karl Menninger, has written:

"To the normal person suicide seems too dreadful and senseless to be conceivable. There almost seems to be a taboo on the serious discussion of it."

Few subjects are enveloped in as many misconceptions. Fallacies concerning who is likely to commit suicide, the meaning of suicide threats, the sanity of suicides, when, where, and how suicide is likely to be committed, are exceedingly widespread. The tragedy of these misconceptions is that suicide is preventable and many thousands of lives could be saved each year by friends, relatives, and physicians if only they knew the truth about this insidious killer.

The cost of suicide is not measured only in numbers. The real cost in grief and shattered family life is incalculable. Every year suicide tears from thousands of American families their breadwinners, beloved parents and grandparents, adored wives and husbands, sometimes even their children. The nation loses respected citizens, community leaders, hard-working physicians, valuable scientists and administrators, sometimes even its ministers. The nation is poorer every time a creative, talented person cuts short his life, depriving the world of what he might have produced. Suicide, in fact, seems to hit particularly hard at the more intelligent and more highly educated segment of the world's population.

Four United States senators were suicides. Most recent was Lester C. Hunt, Wyoming Democrat, twice governor of his state, who shot himself at his desk in the Senate Office Building in June 1954. Eighteen months earlier, former Senator Robert M. La Follette, Jr., shot himself in his Washington home. Edward Irving Edwards, member of the Senate from 1923 to 1929 and formerly governor of New Jersey, killed himself in 1931. Senator Frank B. Brandegee, of Connecticut, chairman of the Judiciary Committee and a leader in the fight against this country's entrance into the League of Nations, killed himself in October 1924.

At least two members of the House of Representatives committed suicide while in office. In June 1960, Douglas H. Elliott of Pennsyl-

vania ended his life by carbon-monoxide poisoning. He had been elected to the House only two months previously. Representative Marion A. Zioncheck, of Washington, destroyed himself in 1936.

A random list of other world-renowned political figures who committed suicide includes: Viscount Castlereagh, British Foreign Secretary; Brazilian President Getulio Vargas, who ruled his nation for 18 years; Nguyen Van Thinh, President of the provisional government of Cochin China, Indochina; Robert Clive, the famed Clive of India; Lee Ki Poong, Vice-President of Korea and hand-picked successor to Syngman Rhee, with his entire family; Conte Camillo Benso di Cavour, Italian statesman; General Georges Boulanger, French War Minister, who because of his attempt to become dictator of France, gave the world the phrase "Man on Horseback"; John Gilbert Winant, wartime ambassador to Great Britain, three times governor of New Hampshire, and chairman of the United States Social Security Board; Abraham Feller, general counsel of the United Nations; E. Herbert Norman, Canadian ambassador to Egypt.

Some of the greatest names in business, science, and the arts also succumbed to suicide: Robert R. Young, chairman of the board of the New York Central Railroad and one of the best-known railroad men of this age; Leon Fraser, president of the First National Bank of New York and one of the world's leading financial figures; Arthur Chevrolet, one of the designers of the Chevrolet automobile; George Eastman, founder of Eastman Kodak, who put the word "Kodak" into the language; Dr. William W. Campbell, one of the world's greatest astronomers, who worked out the speed of the solar system through space; Dr. Benjamin F. Sieve, developer of birth-control pills; Dr. Wallace H. Carothers, inventor of nylon and co-inventor of synthetic rubber; Edwin H. Armstrong, inventor of the regenerative circuit which took radio out of the crystal stage, inventor of circuits which are the basis of virtually all radio receivers, inventor of FM broadcasting; Geoffrey Nathaniel Pyki, who conceived the "weasel," the tracked amphibious jeep that wallowed through the mud from Italy to the Pacific during World War II; Melvin Purvis, the FBI agent who trapped John Dillinger.

Novelist Virginia Woolf; Stefan Zweig, Austrian biographer, novelist, dramatist, and poet, often called "the most translated author in the world"; novelist Jack London; poet Vachel Lindsay; poet Hart Crane; Rex Beach, author of more than thirty books; French painter Vincent van Gogh; Ezra Winter, internationally known mural painter, whose best-known work is the huge "Fountain of Youth" mural, which sweeps up the grand staircase in the foyer of New York's Radio City Music Hall.

Ham Fisher, creator of the comic strip "Joe Palooka"; movie actresses Carole Landis, Lupe Velez, and Ona Munson; Norman Selby, who made boxing history as "Kid McCoy"; James Royce Shannon, author of "Missouri Waltz," "When Day Is Done," and 600 other songs; Fred Fisher, author of "Peg o' My Heart."

What would have been the most devastating suicide in American history was narrowly averted during one of the nation's most precarious periods. If it had occurred it probably would have changed the course of the country's future.

In the early days of 1863 Abraham Lincoln received at the White House news of defeat after defeat by his Army of the Potomac. It had lost a battle on the Virginia peninsula, two at Bull Run, and another at Fredericksburg. On May 1, the Northern army under General Joseph Hooker engaged Robert E. Lee at Chancellorsville, Virginia, and was decisively defeated in a four-day battle. When the news reached Lincoln, he paced up and down, his hands clasped behind his back, muttering: "My God! My God! What will the country say! What will the country say!"

The President was reported to believe firmly that this disaster would be more injurious, at home and abroad, than any previous event of the Civil War. It preyed on his mind to such an extent that he lost all hope. His Secretary of War, Edwin M. Stanton, later reported: "Mr. Lincoln had fully made up his mind to go to the Potomac River, and there end his life, as many a poor creature—but none half so miserable as he was at the time—had done before him." Stanton added that he was afraid to leave Lincoln alone. He told the President to be brave, to try to sleep, and then to consider

visiting the army. Lincoln did eventually conquer his depression without attempting suicide.

Lincoln also had other black moments, when death seemed to be the only solution to his problems. At the age of 32 he had written in a letter to his law partner, Stuart: "I am now the most miserable man living. If what I feel were equally distributed to the whole human family there would not be one cheerful face on earth. Whether I shall ever be better I cannot tell. I awfully forbode I shall not. To remain as I am is quite impossible. I must die to be better, it appears to me. I can write no more."*

The prevalence of mysterious urges to self-destruction is astonishing. A majority of human beings at some time in their lives entertain a desire to cut short their lives. Studies in Chicago and New York of groups of healthy persons showed that about 80 per cent of them had at some time thought about committing suicide. An unselected group of 100 college students who were interviewed turned up 50 per cent who said they had had suicidal thoughts at one time or another. These thoughts may range from half-serious, sudden, and fleeting expressions like "I wish I were dead" to serious consideration of the question of ending one's life to escape from a seemingly intolerable situation. Many psychiatrists believe that the suicide impulse present in all of us is involved in at least half of our 9,400,000 annual non-fatal accidents; that it plays a part in much of our psychosomatic disease and in cases of self-sacrifice to foolish or ignoble causes. Much alcoholism and drug addiction is attributed by psychiatrists to a suicidal urge.

Some well-known people have discussed the nature of these seri-

* Another, more recent occupant of the White House once had a brush with a suicide. When young Major Dwight D. Eisenhower was assigned to Paris, he was billeted on the banks of the Seine. As he was looking out of his apartment window one day he saw a young woman jump into the river. He dashed out, dived in after the would-be suicide, pulled her out, and put her in good hands. Next day a representative of the government called on Major Eisenhower, complimented him on his courage and quick thinking, and added apologetically to the embarrassed young officer: "Your maid, who gave us your name, was under the impression that you would receive a reward. I am unhappy to inform you that the government cannot pay the 50 francs unless the person removed from the water is dead. It is a sanitary measure to encourage the removal of bodies from our rivers."

ous urges toward self-destruction. Count Leo Tolstoy, a giant of Russian literature, wrote when he was fifty:

"I felt that something had broken within me on which my life had always rested, that I had nothing left to hold on to, and that morally my life had stopped. An invincible force impelled me to get rid of my existence, in one way or another. It cannot be said exactly that I *wished* to kill myself, for the force which drew me from life was fuller, more powerful, more general than any mere desire. It was a force like my old aspiration to live, only it impelled me in the opposite direction. It was an aspiration of my whole being to get out of life.

"Behold me, then, a man happy and in good health, hiding the rope in order not to hang myself to the rafters of the room where every night I went to sleep alone; behold me no longer going shooting, lest I should yield to the too easy temptation of putting an end to myself with my gun."

John Stuart Mill, possessor of one of the greatest minds of all time—his IQ has been rated posthumously at 200—wrote in his autobiography that he fell into melancholia at the age of 20 and pondered the question of suicide. "I frequently asked myself," he wrote, "if I could, or if I was bound to go on living."

Edgar Allan Poe once wrote to a friend: "My feelings at this moment are pitiable indeed. I have struggled against the influence of this melancholy but am miserable in spite of the vast improvement in my circumstances. I am wretched and I know not why. Console me if you can. But let it be quickly or it will be too late. Write me immediately. Convince me that life is worth while. Oh, the bliss of putting one's self to sleep, never to wake."

Dr. J. Robert Oppenheimer, one of the world's top theoretical physicists, spoke of thoughts he had while in his twenties: "I was on the point of bumping myself off. This was chronic."

Jacques Maritain, the French philosopher, has told how he discussed with his wife the advisability of entering into a suicide pact. The great American poet Carl Sandburg has told how during adolescence he several times seriously contemplated suicide.

Researchers have learned that only a minority of people who end their lives are suffering from a major mental disorder. The majority of suicides seem to be drawn from the vast numbers of persons who live on the borderline of happiness. Dr. Nicholas Hobbs, assistant professor of psychology at Teachers College, Columbia University, described this group at a conference on mental hygiene at Cleveland in 1948. He said:

"We should turn our attention to the great numbers of near happy people, the almost effective; the people for whom life has lost its savor but who plod along holding their discontent as tightly as they can to themselves; the people who struggle for control but lose it tragically at critical moments; the quietly desperate people who cannot realize their own lives and who add much to the uncertainty and unhappiness of others."

In reviewing the Rev. Norman Vincent Peale's *The Power of Positive Thinking,* Sterling North gave a reason for the book's immense popularity:

"To risk a restatement of the obvious, tens of millions of American citizens are exceedingly unhappy, nervous, fatigued, frustrated and quarrelsome. There probably never has been a moment in American history when so large a percentage of the populace wondered if life is worth living . . ."

The findings of a round table conducted by *Life* magazine were published in July 1948. Eighteen prominent Americans agreed there is failure in America to achieve genuine happiness. Psychiatrists, sociologists, and churchmen deplore our high divorce rate, the disintegration of the family, our appalling juvenile delinquency, our high rate of violent crime, our 4,000,000 excessive drinkers. It has become a familiar statistic that one in ten faces serious mental illness at some period in life.

Dr. Menninger summed up the difficulties which may be making Americans unhappy and causing them to decide in ever increasing numbers that life is no longer worthwhile: "Living, in spite of all the multiplying mechanical aids, grows daily more difficult, complicated and restrictive." In his book *Man against Himself,* Men-

ninger puts forth the view of a man who has spent much time and effort in studying suicide:

"Every culture contains many elements which tend to encourage and facilitate the individual's self-destructive trends. These influences may be mechanical, economic, philosophical, educational, sociological, or moral. We are not able to appraise objectively the destructiveness of some of these trends in our own civilization because we are too close to it to have a proper perspective . . . We probably overlook many of the suicidal aspects of our own culture, perhaps even considering them preservative. It may even be that in years to come our own period may be regarded as one in which man's self-annihilatory tendencies were at their maximum. (Consider, for example, our automobile traffic accidents, our militaristic activities, our waste of natural resources, and our neglect of human values.)"

If it is true that art mirrors life, then we should expect to find in contemporary art a reflection of the current unhappiness and the self-destruction it engenders. In March 1960, some 250 persons braved cold and slush to attend the unveiling at the Museum of Modern Art in New York City of something which had been billed as "a machine that destroys itself." The 27-foot-high gadget was a junkman's dream—scores of bicycle wheels, a bathtub, a gocart, dozens of bottles, hammers, and saws. When set off it hammered, sawed, and burned itself to pieces. Its creator—and destroyer—Jean Tinguely, of Switzerland (the nation with the world's second-highest suicide rate), described it as a piece of suicidal sculpture.

Suicides often are dangerous to the rest of the population. About one person in six who commits suicide or attempts it also tries to kill or does kill from one to five other persons. Suicidal acts, such as those where gas or explosives are used, often endanger others, particularly children. The increasing use of fast automobiles as instruments of suicide is becoming an ever greater threat to everyone who drives. Most psychiatrists are convinced—and there are plenty of documented cases to support them—that a large percentage of fatal automobile accidents are deliberate suicide attempts. Some

suicides ram their cars head on into those of innocent persons. Others, for reasons probably only a psychiatrist could divine, choose to shoot themselves while speeding along a highway in their automobiles.

On May 15, 1959, a 22-year-old motorist shot himself to death while driving in downtown St. Petersburg, Florida. His car ran out of control, killed a man, and injured two others.

A 25-year-old dentist fired a shot into his head while driving at 65 miles an hour over a bridge in West Hollywood, Florida, on July 14, 1960. The car smashed into the bridge, luckily without hitting any other car. Another man committed suicide the same way in Huntingdon, Tennessee, April 13, 1959. Again fate intervened and decided that his car should not kill anyone.

On the afternoon of August 28, 1957, a woman left a tavern in Chicago's West Side and climbed into her car in a nearby parking lot. She crashed into a sign, backed away, crossed Cicero Avenue, and headed south in the northbound lane. She crashed into a stop sign, backed up the car, and zigzagged into a gas station, where she rammed into an outdoor grease rack. She was thrown from the car and died when she was run over by a rear wheel of the car. The coroner listed the death as automobile suicide. When police reached the body, there was a blindfold over the eyes.

The suicidal impulse of others which makes driving risky also is evident in the case of a 17-year-old boy who committed suicide in Yuma, Arizona, in March 1948—a few hours after his fifth automobile accident. He left a note reading: "It is not because I have no courage, but it is because I know I was born to come to a tragic end. This was my fifth auto accident, but I haven't been killed yet. *No one could take my life but myself it seems* [italics added], and I shall take it."

In Atlanta, Georgia, on August 20, 1960, a woman told two companions sitting with her in a night club that she was going to drive her auto into a brick wall at 120 miles an hour, and added that she knew a "beautiful brick wall" to head for. The friends tried to stop her, but she sped away. They chased her in another car, and the po-

lice soon joined the pursuit. Despite efforts of both cars to head her off, the woman blazed along the highway at 100 miles an hour, endangering other cars, and slammed into an abutment.

The thousands of completed suicides every year in the United States represent only part of the suicide story. The real tragedy of suicide—and the measure of the threat it poses—is the 150,000 to 250,000 or more persons who attempt suicide every year but survive. Because the nature of suicide is so widely misunderstood, these unhappy, desperate human beings receive little or no help. Their stomachs are washed out, their wounds are bandaged, and they are sent home—to make another attempt at destroying themselves or to continue an existence made miserable by the emotional problems that drove them to try to end it.

The Suicide Prevention Center in Los Angeles has learned that there are nine attempts for each completed suicide in that city. If the ratio holds for the country, it means that there are about 180,000 suicide attempts every year. There may be thousands more. Figures on attempted suicide are difficult to obtain because not everyone who tries to kill himself requires medical treatment. And many attempted suicides treated by physicians are not recognized as such. Even when recognized, they are not always reported.

Even the more conservative estimate, based on other studies and police hospital figures, of 150,000 persons attempting suicide every year, means there are about 2,000,000 persons walking around with lives so miserable that they at some time tried to end them. These attempts—costly, cruel, tragic—are the real measure of the specter of suicide which touches or haunts millions of Americans each year.

We should be grateful that only a small minority of those who attempt suicide succeed in their effort. For many who have attempted suicide lived to produce much of value in literature, the arts, and science which we otherwise never would have had. The world would be vastly poorer if the record of completed suicides were higher. For instance:

The great composer Peter Tchaikovsky in September 1877 waded into the Moscow River in an attempt to catch pneumonia. He failed to end his life and later composed his Fourth, Fifth, and

Sixth (*Symphonie Pathétique*) symphonies, *The Swan Lake, The Sleeping Beauty, The 1812 Overture,* and *Eugene Onegin,* among other works.

Edgar Allan Poe tried to kill himself with laudanum in 1847 and again in 1848. He lived to write two of his most famous poems, *Annabel Lee* and *The Bells.*

Author Graham Greene made a serious suicide attempt at the age of 14. At 16 he took poison. At 17 he played Russian roulette. In later life Mr. Greene gave us such great works as *The Third Man, The Fallen Idol, The Power and the Glory,* and *The Potting Shed.*

F. Scott Fitzgerald twice tried suicide before his fortieth birthday. He failed and subsequently produced *The Last Tycoon.*

René François Chateaubriand at the age of 17 loaded a musket and stuck the barrel in his mouth. He was banging the stock against the ground when a passer-by interrupted him. He went on to become one of the leading writers of the Romantic movement, producing the novels *René* and *Atala.* He also became a famous statesman.

One wonders what great works will never be produced in the future because the subject of suicide remained a mysterious matter known only to a handful of researchers.

So little attention has been paid to suicide that until 200 years ago there was no word for the act in Latin, French, or English. It was referred to as "self-murder," "self-homicide," or *"felo-de-se"*—felony against oneself. The word finally developed from Latin: *sui,* "of himself"; *caedere,* "to kill."

Not until the nineteenth century was any attempt made even to keep statistics on suicide. A few scholars then began to study it from the sociological point of view. The first scientific work on the subject was published in 1897. Our lack of research on suicide is emphasized by the fact that this work is still regarded—after 63 years—as the classic in the field. That probably cannot be said about any other piece of social analysis.

Most of our knowledge about suicide has come from three sources: actuarial statistics, sociological studies, and psychiatric interpretation. The statistician gathers figures on suicide deaths and

compares them with the phases of the moon, moisture content of the soil, wholesale prices (these comparisons have actually been made), etc., and is pleased when he finds a correlation. The sociologist examines the social standing, income, dwelling place, and other attributes of suicides and concludes that there are more suicides in some areas than others. The psychiatrists say that social statistics don't mean much unless they are related to the individual's emotional make-up and personal relations. Although psychiatrists have come up with some conflicting theories about the causes of suicide, their approach so far promises most.

The only government project on suicide at present is a $377,000 five-year contract, started in 1958, between the National Institute of Mental Health and two psychologists at the University of Southern California, Los Angeles—Drs. Edwin S. Shneidman and Norman Farberow. The project is called the Suicide Prevention Center, set up in the Los Angeles County General Hospital. These two researchers published some of their findings in a book called *Clues to Suicide.*

Worried physicians call suicide "the most devastating experience in the practice of medicine—and the most puzzling." For every new fact that the researchers nail down, they are presented with a puzzle or a paradox. Much about suicide remains enigmatic. Many of the reports by students of the subject are contradictory, and the literature contains some large areas of disagreement. A great deal of research needs to be done.

In 1936, Dr. Gregory Zilboorg, internationally famed psychiatrist, who did many studies on suicide, declared:

"It is clear that the problem of suicide from the scientific point of view remains unsolved. Neither common sense nor clinical psychopathology has found a causal or even a strictly empirical solution."

This statement is as true today as when it was first uttered. Unless, as a nation, we bend our efforts to make it untrue, we will have to continue to live with the profoundly disturbing knowledge that of every thousand children born in the United States, ten boys and three girls are doomed to self-destruction.

Chapter II

THOUSANDS OF AMERICANS

One of the most striking things about suicide is that we can predict with a high degree of accuracy how many people will kill themselves in any year in any country, state, or city. We can even predict exactly when these people will end their lives, how many at each age level will do so, and what methods they will use to destroy themselves.

To forecast how many people in the United States will kill themselves this year or next, you have only to study the front page and financial page of your daily newspaper. Suicide rates in nearly all countries rise and fall, as regularly as the ocean tides, with economic and political events. Many more people kill themselves in periods of economic depression; fewer do in good times. The rate of self-destruction falls sharply in wartime or other periods of national crisis. One odd benefit of the cold war with Russia is that it has almost certainly helped keep our suicide rate lower than it would otherwise have been in recent years.

Although these variations in the rate at which people end their lives are almost as predictable as sunrise, they are also one of the greatest puzzles connected with suicide. We know the variations will occur, but we don't know why.

One approach to solving the puzzle is to divide the total annual number of suicides into groups. When we do that we can learn which race, sex, and age groups are most and least afflicted

by this scourge. When we categorize the 16,632 people in the United States who killed themselves in 1957, the most recent year for which detailed information is available, it becomes clear immediately that the Americans who kill themselves in greatest numbers are white men. They have a far higher suicide rate than women and Negroes. So few Negroes kill themselves that self-destruction is not an acute problem for them.

Here is the suicide picture for 1957. The figures come from the National Office of Vital Statistics:

Group	*Number*
White men	12,331
White women	3,547
Negro men	506
Negro women	113
Men of other race	114
Women of other race	21

Since there are more white women than men in the country and far more whites than Negroes, the number of suicides in each group is not a measure of the frequency with which members of each group destroy themselves. This frequency—the suicide rate—is arrived at by dividing each group into units of 100,000 population. Thus, of each 100,000 white men in the United States, 16.5 committed suicide in 1957. A total of 4.6 white women in each 100,000 did so. The rate for Negro men was 6.8, and for Negro women, 1.4. The rates for other races are not computed because the numbers involved are too small to be statistically significant.

Dividing our population into groups according to age explodes the popular myth that older people are in the greatest danger from suicide. For white men between the ages of 20 and 45, the most active and productive age group in the country, suicide ranks *fourth* on the list of killers. For white women in the same age bracket, suicide ranks *fifth* on the list of causes of death. In 1957, one out of each 16 men aged 20–45 who died did so by his own hand. One white woman in 24 in the same age group who died was a

suicide. In the older age groups, only one death in 70 among white men aged 60–64 was a suicide, and only one in 100 deaths in the 65–69 age bracket.

This list shows the major causes of death for Americans aged 20–45, with the number who died from each cause, in 1957:

White Men

Accidents	19,208
Heart disease	13,191
Cancer	7,026
SUICIDE	3,777
Vascular lesions of the central nervous system	1,774
Cirrhosis of the liver	1,724
Influenza and pneumonia	1,575
Homicide	1,321
Diabetes mellitus	828

White Women

Cancer	9,786
Heart disease	4,277
Accidents	4,019
Vascular lesions of the central nervous system	1,582
SUICIDE	1,414
Influenza and pneumonia	1,359
Cirrhosis of the liver	1,216
Complications of pregnancy	780
Diabetes mellitus	628
Homicide	504

Negro Men

Accidents	3,197
Heart disease	2,578
Homicide	2,203
Cancer	939
Vascular lesions of the central nervous system	752
Influenza and pneumonia	728
Cirrhosis of the liver	302
SUICIDE	271
Diabetes mellitus	142

Negro Women

Heart disease	2,312
Cancer	1,650
Vascular lesions of the central nervous system	1,120
Accidents	842
Complications of pregnancy	745
Homicide	613
Influenza and pneumonia	599
Cirrhosis of the liver	282
Diabetes mellitus	224
SUICIDE	68

In older age groups, where death rates from all causes are high, suicide is pushed down the list of killers. In whites over 50, self-

destruction is the tenth-ranking cause of death. But suicide is, nevertheless, a major threat at all ages. Out of every 100,000 white men in the 20–45 age group in 1957, 15.0 committed suicide, and the rate for white women in the same age bracket was 5.3. In the 60–65 age bracket, the figures were 39.5 for men and 9.9 for women.

To account for the fact that men kill themselves three to four times as often as women, psychiatrists and sociologists point out that the more active and more demanding social and economic roles of men put them under greater stress than women. In some countries where women have low status and a hard, unrewarding life, they kill themselves as often as the men. Some researchers believe that as women in the United States become ever more emancipated and enter increasingly into competition with men, their suicide rates are bound to rise with the increasing amount of stress to which they will be subjected.

Another fact which accounts for the higher suicide rate of men is that they tend to use more rapid and lethal methods to end their lives. A man is much more likely to succeed in his suicide attempt with a pistol to his temple, which kills instantly, leaving no time for rescue after the act, than a woman who takes sleeping pills, which leave a large margin of time during which she can be discovered and revived.

The methods used also largely account for the reversal of the sex pattern in attempts at suicide which are not consummated. Three women live through suicide attempts for every man who tries to kill himself and survives. Attempted suicide is the particular scourge of young women. Half the women who try to kill themselves and survive are under 30.

The marked difference between the suicide rates of whites and Negroes has given rise to much speculation, but as yet the researchers have come up with no definite answers. For our total population of white men suicide ranks eighth as a cause of death, and among women it is sixteenth. For our total population of Negro men suicide is the eighteenth cause of death, and for Negro women the twenty-first. The ratios between the races vary little from year to year. The difference in suicide between the races also exists in other coun-

tries. In South Africa, for instance, the white suicide rate in 1956 was 11.1. For Negroes it was 3.0.

Another notable difference between the races is that Negroes commit murder ten times as often as whites. In 1957 the Negro homicide rate was 22.4, while the white rate was 2.3. Some authorities believe that the different suicide and homicide patterns of the races indicate that whites tend to turn their aggressions inward on themselves, while Negroes tend to turn their aggressions outward.

Since we now know that suicide is preponderantly a masculine phenomenon, it is easier to understand why suicide rises and falls with economic and political events: men are, by and large, directly affected by these events to a much greater degree than women. That breadwinners, bankers, and others with financial responsibilities should kill themselves during depressions seems logical, but it is less easy to understand why fewer men kill themselves in wartime. During both world wars the suicide rate of American men declined sharply. It also declined during the Korean War. One suggested explanation is this: During wartime an aimless, lonely person can identify himself with the national goal to win. In addition some authorities believe that there appear to be fewer suicides in wartime partly because some men disguise their deliberate suicides as military heroism at the battle front.

Author and columnist Damon Runyon told of a friend of his who, after learning that his wife was unfaithful, wanted to die. He did not want to kill himself, however, and decided to die on the battlefield. At the front he deliberately risked his life scores of times, became a hero, collected many medals but never a scratch. After the war he died of pneumonia. As Runyon told it: "And when his nurse was asked his last words by the reporters who thought he might have said something ringing, she said: 'Why, he didn't say anything. He just raised himself up on his elbow a minute and laughed and laughed and laughed.'"

Oddly, war also reduces suicide even in nations which take no part in it. Thus, the suicide rate in the United States dipped sharply in 1915 and 1916, though this country did not enter the war until 1917. Our suicide rate also declined rapidly after the outbreak

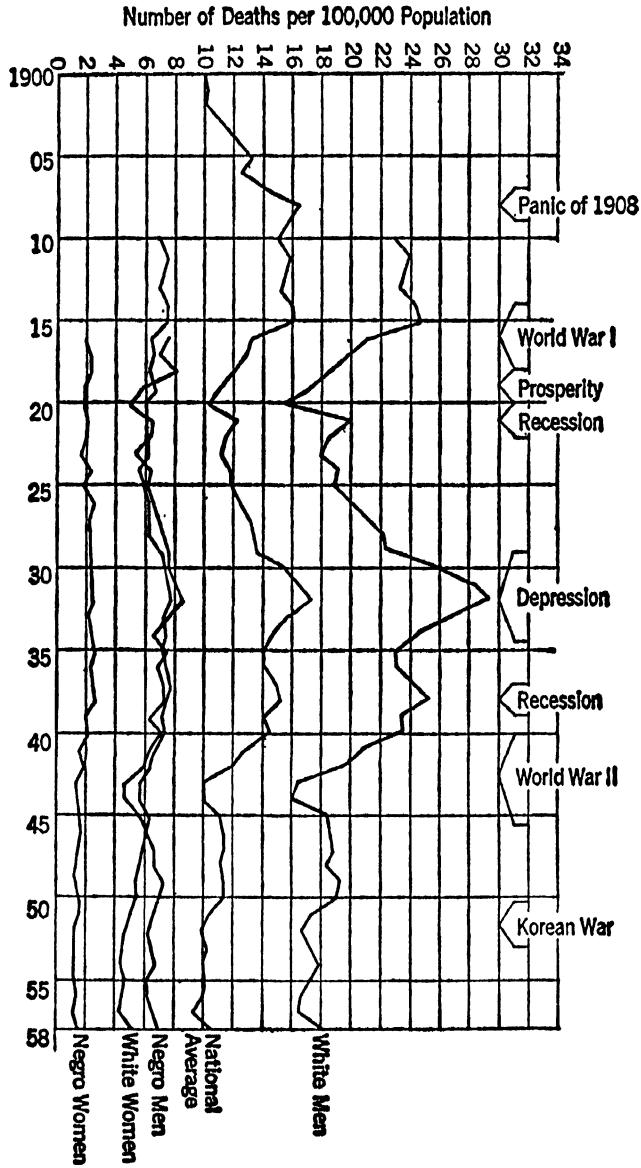
of World War II in 1939, though the United States didn't enter the war until the end of 1941. Similarly, though Japan did not participate in the Korean War, the sharp postwar upward climb of her suicide rate was interrupted by a decline in 1951 and 1952.

The most suicidal year for Americans was 1932, at the depth of the depression, when 17.4 in every 100,000 died by their own hands, to hang up a record of 20,646 voluntary deaths. The next-highest year was 1908, another year of severe depression, when our suicide rate climbed to 16.8. The lowest suicide year of this century was 1957, when the national rate was 9.8 voluntary deaths per 100,000 population. In 1958, when 18,519 persons killed themselves, the rate swung sharply up again to 10.7, the highest suicide rate since 1950. The graph on the following page clearly shows the sharp upward and downward movements of the suicide rate.

Marriage reduces the suicide threat. In both sexes and all races, at all ages, everywhere, fewer married people kill themselves than the single, widowed, or divorced. Children in marriage reduce the suicide danger even further. Divorced persons of both sexes kill themselves more than three times as often as married people.

A person's suicidal tendencies are affected to some degree by his occupation. Those who work in the professions kill themselves more frequently than do unskilled laborers. Clergymen, miners, and teachers have low rates. Artists, lawyers, businessmen, and hotel and night-club workers have high rates.

If a person works in an occupation which brings him in close contact with death and provides him with convenient means to end his own life, suicide poses a greater danger than in more innocuous professions. Physicians, policemen, and soldiers, for instance, kill themselves more frequently than the general population. Another occupation which appears to have a high suicide rate is that of executioner. John Hulbert, official executioner for New York State for 13 years, shot himself in February 1929. The world's most widely known hangman, John Ellis, who in 22 years as executioner in England executed more than 200 criminals, cut his throat in September 1932, after wounding himself seriously in a previous attempt in 1924. In his book *The History of Capital Punishment,* George



UNITED STATES SUICIDE RATE
1900—1958

Ryley Scott lists other executioners who killed themselves: the official hangman of Victoria, Australia, in 1924; Spaethe, the German headsman; another German headsman, retired, killed himself at Breslau in 1924, and his successor committed suicide shortly after. Lang, the Austrian state executioner, committed suicide in 1938.

Psychiatrists also have a high suicide rate. So many kill themselves that some authorities consider suicide a distinct danger in this field. The most prominent recent suicide of a psychiatrist was that of Dr. Douglas M. Kelley in his Berkeley, California, home on New Year's Day 1958. He was an internationally known criminologist, who, as chief United States psychiatrist at the Nuremberg war crimes trials, examined all the high-ranking Nazis before they were tried. He used one of the capsules of potassium cyanide which were found on Hermann Goering after the latter used one to commit suicide two hours before he was to be hanged in October 1946.

Dr. Wilhelm Stekel, disciple and assistant to Sigmund Freud and one of his earliest champions, founder of the first psychoanalytical society and editor of the first psychoanalytical periodical, took note of this danger to psychiatrists. In Chapter 14, "The Tragedy of an Analyst," in Volume II of his work *Sadism and Masochism*, which he wrote in 1929, Dr. Stekel said:

"The staggering fact of the suicide of my friend Herbert Silberer brought before my eyes the great danger which hovers about analysts. Looking back, I can count up a long series of highly gifted analysts who have voluntarily departed from life. They were unquestionably talented men, almost men of genius, men who justified the greatest expectations.

"Occupation with analysis is a great danger. It is a handling of sharp weapons, which may be easily turned upon the analyst . . ."

Eleven years after writing this passage Dr. Stekel committed suicide.

Some occupations, however, occasionally lead their practitioners to be falsely accused of suicide attempts. The following story, which appeared in the New York *World-Telegram and Sun* on June 20, 1958, is typical of others which appear from time to time:

"Police radio cars, emergency vehicles and a cordon of cops rushed to 1440 Broadway, near 40th Street, about 3 P.M., answering a call that a man was about to jump from the building. Some 2,000 spectators in the street craned their necks to watch the man.

"He was moving about the edge of a 19-story setback on the 27-story office structure. When police got to him, he said, according to one: 'What's going on here? I'm a painter and I'm looking for a spot to hang my scaffold.' Police left and Douglas Herbert, of 1742 Broadway, Brooklyn, went back to his survey."

As far as genuine suicide is concerned, the bank president is in a more precarious position than his janitor. The higher you rise in life, the greater is the danger of suicide. Rich people kill themselves more frequently than the poor, army officers more often than enlisted men. Statisticians have shown that states with high literacy rates and high incomes generally have high suicide rates, while those with low literacy rates and low incomes generally have low suicide rates.

The matter of social and economic status helps to explain why more people kill themselves during depressions. High-status persons commit suicide most frequently in such times. The graph on page 22 shows that it was the suicide rate of white men which rose most during the depression of the thirties. White women and Negroes were affected hardly at all. And of the white men, it was those who had been well off who killed themselves.

High-status people have most to lose during a depression, and when they do lose it, they frequently seek oblivion. Those at the bottom of the social and economic ladders have much less to lose in a depression and consequently feel its impact less. This does not mean that the unskilled laborer is better off in a depression than a millionaire. It does mean that in a severe depression the change from what he was before to what he becomes is potentially much greater for the millionaire. The degree of change from bare subsistence living to perhaps near starvation is much less. Those at the bottom of the ladder cannot fall far.

Strangely, a rapid rise *up* the economic ladder can cause some people to end their lives. Dr. Thomas A. Malone, head of the

Atlanta, Georgia, Psychiatric Clinic, recently indicated that these "success suicides" are more frequent than most of us would suspect. "At least 30 to 40 per cent of the so-called economic suicides occur when a man is successful," he said, "not when he is failing. When a man has reached the peak of success, often he has nothing left to scramble for."

Ross Lockridge, Jr., earned $2,500 a year as a college instructor. On this salary he supported a wife and four children in three rooms. They seldom went out because they couldn't afford a baby sitter. In 1941, Ross, who had been a brilliant student, began work on a novel. He couldn't afford enough writing paper and scribbled on the back of his discarded sheets. His apartment was so small that he had no privacy. While he wrote, his children would run toy trains between his legs. For seven grueling years Ross Lockridge worked on his novel every night after teaching classes all day.

In January 1948 *Raintree County* was published. It was a tremendous success and won him a place in the forefront of serious American novelists. It shot to the top of the best-seller list and was a Book-of-the-Month selection. It won the author a $150,000 Metro-Goldwyn-Mayer award and a motion picture contract. Altogether, he made a quarter of a million dollars.

Two months after this stunning series of successes, 33-year-old Ross Lockridge killed himself.

Playwright William Inge has described how he felt when success first smiled on him:

"The experience of my first production on Broadway was frantic and bewildering. The play was 'Come Back, Little Sheba,' and it was a modest success. I had always hoped for an overwhelming success, but I felt myself very satisfied at the time that 'Sheba' had come off as well as it did. Anticipating success (of any degree), I had always expected to feel hilarious, but I didn't. Other people kept coming to me saying, 'Aren't you thrilled?' Even my oldest friends, who had known me during the years when I gave myself no peace for lack of success, were baffled by me. There was absolutely no one to understand how I felt, for I didn't feel anything at all. I was in a funk. Where was the joy I had always imagined? Where were the

gloating satisfactions I had always anticipated? I looked everywhere to find them. None was there . . . Strange and ironic. Once we find the fruits of success, the taste is nothing like what we had anticipated . . ."

On the day in 1958 that he was told he had won $140,000 in the Irish Sweepstakes, Llewellyn Cloos, a helper on a moving van and father of seven, had four cents in his pocket. Sixteen months later he shot himself to death.

The most suicidal state in the nation is Nevada, where in 1958, 24.3 of each 100,000 persons sought eternal peace. California has the second-highest rate, followed by Vermont, Wyoming, Colorado, and Montana. Least suicidal state in 1958 was Mississippi, with a rate of 6.7. The other lowest suicide states were South Carolina, Utah, Arkansas, and Louisiana. The Pacific-coast states as a group have the highest rates, while the Southern states show the lowest rates. Only three Northern states are consistently in the lowest ten states on the suicide list—New York, Rhode Island, and Massachusetts. Suicide rates of all the states are listed on page 27.

Why the Pacific-coast states should have such high rates is a complete mystery. Despite the fact that California is supposed to be one of the most attractive states in which to live, it has always had a high rate. Its very attractiveness, in fact, may be a reason for its high incidence of suicide. Surveys have shown that many of California's suicides were people born in other states who had moved to California only a few years before they killed themselves.

Some sociologists have theorized that West Coast areas have higher rates than the East because they attract individualistic, restless, and unsatisfied people who are in search of health, wealth, or fame. Those who fail to realize their ambitions or who become maladjusted in the process are likely to be more prone to suicide than the average man. But this doesn't really explain much. Lots of people become disappointed, frustrated, poverty-stricken, or ill without killing themselves. One psychologically oriented researcher theorizes that the Southwest should show the highest rates as a "natural jumping-off place," since "going West" or "going into the sunset" in both literature and the popular idiom means dying or death.

SUICIDE RATES IN AMERICAN STATES

1958		*1949–51 Average*		*1940*	
Nevada	24.3	Nevada	27.3	Nevada	40.8
California	16.8	California	17.5	California	27.2
Vermont	15.9	New Hampshire	16.6	Wyoming	23.1
Wyoming	15.9	Montana	16.5	Washington	22.8
Colorado	15.6	Maine	16.1	Montana	20.7
Montana	15.1	Washington	16.0	Washington, D.C.	20.7
Maine	14.2	Wyoming	15.9	Colorado	19.1
Arizona	13.8	Colorado	15.5	Connecticut	17.9
Florida	13.4	Oregon	15.4	Idaho	17.5
Washington	13.2	Indiana	13.1	Oregon	17.3
New Hampshire	12.9	Iowa	12.9	Indiana	16.9
Missouri	12.6	Arizona	12.6	Nebraska	16.8
Iowa	12.5	Kansas	12.6	New York	16.7
Oregon	12.3	Washington, D.C.	12.6	Vermont	16.7
Kansas	12.3	Connecticut	12.2	New Jersey	16.4
Ohio	11.8	Idaho	12.2	New Hampshire	16.3
South Dakota	11.7	Vermont	12.1	Maryland	16.3
Washington, D.C.	11.7	Nebraska	12.0	Missouri	15.9
Indiana	11.3	New Jersey	12.0	Ohio	15.8
Wisconsin	11.2	Florida	11.9	Maine	15.7
Connecticut	11.0	Ohio	11.8	Iowa	15.2
Virginia	10.9	Wisconsin	11.7	Wisconsin	15.1
North Dakota	10.8	Missouri	11.6	Florida	15.0
New Mexico	10.8	Delaware	11.5	Virginia	14.9
THE NATION	10.7	Maryland	11.4	Illinois	14.6
Tennessee	10.5	Illinois	11.2	THE NATION	14.4
Kentucky	10.3	THE NATION	11.0	Minnesota	14.4
Idaho	10.3	Virginia	10.7	Delaware	14.3
Illinois	10.2	New York	10.7	Michigan	13.9
North Carolina	10.1	Minnesota	10.6	Arizona	13.4
Pennsylvania	9.9	Pennsylvania	10.5	Massachusetts	13.3
West Virginia	9.9	Michigan	10.4	New Mexico	13.2
Nebraska	9.8	Massachusetts	10.2	Pennsylvania	12.9
Michigan	9.5	South Dakota	10.0	Kansas	12.8
Maryland	9.5	West Virginia	9.9	Rhode Island	12.6
Texas	9.2	Kentucky	9.5	Utah	12.2
Oklahoma	9.1	North Dakota	9.4	Texas	12.1
Georgia	9.0	Rhode Island	8.9	South Dakota	11.0
Minnesota	8.9	Texas	8.8	West Virginia	10.3
New Jersey	8.8	New Mexico	8.7	Kentucky	10.1
New York	8.5	Utah	8.5	North Dakota	9.5
Massachusetts	8.4	Georgia	8.4	Georgia	9.1
Delaware	8.3	Oklahoma	8.1	Tennessee	8.8
Alabama	8.1	Tennessee	8.1	Louisiana	8.5
Louisiana	7.8	North Carolina	7.6	Oklahoma	8.4
Arkansas	7.4	Arkansas	7.0	Alabama	8.3
Utah	7.1	Alabama	6.4	North Carolina	8.1
South Carolina	6.9	Louisiana	6.3	Mississippi	6.4
Mississippi	6.7	South Carolina	6.3	Arkansas	6.3
Rhode Island	3.8	Mississippi	6.2	South Carolina	6.3

The low rates of the Southern states are due partly to the virtual immunity to suicide enjoyed by their large Negro populations. New York generally has a relatively low rate for the same reason. But the whites in the Southern states also have lower rates than whites in the Northern states. The slower tempo of life in the South causes less stress and frustration than the more tense, complex industrialized way of life in the North.

The list on page 29 shows the suicide rate in each state at different times during the 1936–45 period.

As with the states, cities on the West Coast have the dubious honor of being the nation's most suicidal. The nation's top-ranking suicide city during the past decade was San Francisco, where about 24 persons of every 100,000 residents have chosen voluntary death each year. The city has had rates as high as 35, and in the earlier part of the century as high as 45. In the first decade of this century San Francisco was the most suicidal city on earth. Other cities with consistently high rates of suicide are Miami, Sacramento, Seattle, and San Diego. They average about double the rates of cities in the Northeast and New England.

All over the world, cities have much higher rates than rural areas. Sociological studies show that city life is a definite causative element in suicide. Densely populated urban areas attract potential suicides because they provide anonymity and isolation and lack the social controls which exist in rural areas. The ties of family, friends, and church are, generally speaking, stronger in rural areas. Country life provides more stability than the hurly-burly of cities.

But New Hampshire does not fit the accepted pattern. The suicide rate in its northern, rural counties is far higher than would be expected. The rate in rural Grafton County, for example, was 19.4 over the decade from 1947 to 1956, far above the national rate.

Studies in Chicago and in London, England, show that within cities most suicides occur in the more crowded areas which have shifting populations living in rooming houses and cheap hotels. These are the areas which also have the highest rates of mental illness, crime, alcoholism, and drug addiction. In such an area one can get lost in the throng without being asked too many questions. It

AVERAGE SUICIDE RATES IN AMERICAN CITIES FOR THE YEARS 1936–45

Seattle	28.5	Racine	14.4	Waterbury	11.6
Portland, Ore.	25.8	Baltimore	14.3	Albany	11.5
Los Angeles	24.4	Hamilton	14.3	Amarillo	11.5
York, Pa.	24.0	Roanoke	14.3	Mobile	11.5
St. Petersburg	22.6	Tulsa	14.3	Durham	11.2
Denver	21.0	Newark	14.2	Syracuse	11.2
Tacoma	20.6	Little Rock	14.0	New Orleans	11.1
Washington, D.C.	19.9	New York	14.0	Buffalo	10.8
		Wichita	14.0	Charleston	10.8
Fresno	19.2	Cicero	13.9	Decatur	10.8
Norfolk	18.4	Dallas	13.7	Pittsburgh	10.8
San Francisco	18.3	Beaumont	13.3	Waterloo	10.8
Oakland	18.2	Columbia, S.C.	13.3	Chattanooga	10.7
Berkeley	17.9	Macon	13.3	El Paso	10.7
Kalamazoo	17.9	Minneapolis	13.3	Birmingham	10.5
Cincinnati	17.4	Louisville	13.2	Knoxville	10.5
St. Joseph	16.7	Shreveport	13.2	Youngstown	10.5
Springfield, Ill.	16.7	Jacksonville	13.2	Detroit	10.3
Miami, Fla.	16.5	Houston	13.0	Oklahoma City	10.2
Rochester	16.4	Savannah	13.0	Yonkers	10.2
Tampa	16.1	THE NATION	12.9	St. Paul	10.1
Cedar Rapids	15.8	Atlanta	12.9	Grand Rapids	10.0
Covington	15.8	Greensboro	12.9	Jackson, Miss.	9.7
Milwaukee	15.7	Nashville	12.9	Austin	9.5
Richmond	15.7	Philadelphia	12.8	Charlotte	9.4
Topeka	15.3	Chicago	12.7	Malden	9.3
St. Louis	15.2	Evansville	12.6	Montgomery	8.8
Dayton	15.1	Holyoke	12.6	Altoona	8.7
Allentown	15.0	Lakewood	12.6	Memphis	8.6
Toledo	14.9	Hartford	12.5	Augusta	7.9
Indianapolis	14.9	Des Moines	11.9	Providence	7.9
Binghamton	14.7	Schenectady	11.9	Scranton	7.7
Columbus, Ga.	14.7	Asheville	11.8	Pawtucket	7.6
San Antonio	14.7	Boston	11.7	Winston-Salem	6.6
Forth Worth	14.6	Waco	11.6	Lowell	5.6
Cleveland	14.4				

is here that the "hands off, mind your own business" attitude of the modern, crowded city is a governing fact of life.

In such teeming areas the life of a suicidally inclined person may hang by a thread—or a telephone wire. This story was reported by the Associated Press in 1955:

SAN FRANCISCO, August 16—A bar patron saw a telephone receiver dangling and thoughtfully put it back in place.

Little he knew what the click would mean at the other end of the line.

For the caller was Francis Gordon Galli, 31.

He had a date with a waitress. They quarreled. He left her at the bar and went to his apartment.

He decided to telephone her and talk things over. During the conversation, the waitress excused herself and went to the bar for a drink.

It was then that the bar patron saw the dangling receiver. Alfred Giannini, 32, a companion of Mr. Galli at the apartment, later told police what happened yesterday at the other end of the line.

Mr. Galli, thinking the waitress had hung up on him, got his revolver and killed himself.

The anonymity and isolation which attract the potential suicide to cities was discussed at the sixteenth annual conference of the American Group Psychotherapy Association in New York City in January 1959. Dr. Cornelius Beukenkamp, Jr., a psychiatrist, condemned what he termed the "appalling detached attitude" of Americans toward suicide, which aids and abets those who are intent on ending their lives. A continual flow of newspaper articles confirms his charge and indicates that this apathy also exists in cities in other countries.

On November 10, 1959, for instance, a 28-year-old prisoner in the San Fernando, California, jail sat idly by while his 52-year-old cellmate cut his mattress cover into strips, tied them to the cell door, and hanged himself. Aroused by the shouts of a prisoner in another cell, guards cut the man down before he died. His cellmate told them: "If that's what he wants to do, it's up to him."

In its issue of December 27, 1954, *Time* magazine reported: "In Oxford, England, James Adams, lying in bed in a hotel reading, glanced up when the door opened, watched without comment as John Grady, wearing only a shirt, raced across the room and disappeared through the open window to his death, later explained at the inquest: 'I just stayed in bed, until the police came. It was nothing to do with me.'"

In Paris, France, on November 7, 1950, Raymond Boule told three friends in a bar: "I'm tired of life, I'm going to jump into the Seine." The friends bet him 1,000 francs ($2.85) that he wouldn't dare. The three accompanied Boule to the river, watched as he jumped in and drowned. A court sentenced the three to a month in jail for failing to help a person in danger of death.

The foregoing newspaper stories illustrate the indifference of individuals toward suicide. But even large groups sometimes display a shocking lack of compassion toward a human being struggling with powerful suicidal impulses. The following two events, which occurred in 1959 in large cities on opposite sides of the continent within ten days of each other, have had their counterparts in other cities. The first article appeared in the New York *World-Telegram and Sun.*

LOS ANGELES, May 13—For two hours yesterday a man perched precariously atop a 12-story building while crowds below jeered, "Jump, jump."

Robert David Thomas, 22, was pulled off the roof by a policeman and a fireman. He told police he was despondent because he could not see his girl friend, serving a 14-year jail sentence for forgery.

A crowd of 3000 gathered in the street and some took bets on whether he would jump. "Make up your mind . . . Jump, man, jump . . . You're chicken . . . Why doesn't someone go and push him?" were among the taunts hurled at Thomas.

At one time several hundred among the crowd chanted in unison: "Jump, jump, jump." Police said the mob apparently felt Thomas was only faking.

As officers led Thomas away, a man tucked $7 in bills in his pockets. "Take this son," he said, "and come back when you're a man." . . .

The New York *Times* reported on May 24 that the previous day a 30-year-old man had balanced an hour on the railing of a fire escape at the third floor of a building in New York City. A crowd of 1,000 filled the air with shouts of "What are you waiting for?"

and "Go ahead!" Others replied with "Don't jump!" and "Go back!" Before the man was hauled to safety by a policeman, the crowd had taken sides and people were shouting at each other.

In their book *To Be or Not to Be,* published in 1933, statisticians Louis I. Dublin and Bessie Bunzel sum up as well as anyone has the difference between rural and city living which contributes to suicide:

"In the great cities there is a multitude of conflicting social creeds, philosophies and religions and possible occupations; and many who come into contact with them cannot decide which to accept, which to reject. It is inevitable that some, disappointed and disillusioned by the quest, will become discouraged and seek death as the only solution. In the rural community, on the other hand, there is much greater social and occupational unity, greater coordination of ideals. Persons born in the country usually find themselves integral functioning parts of an economic and social scheme or, if restless and dissatisfied, tend to migrate to the city—and it is the restless and dissatisfied who swell the list of self-inflicted deaths. Those who remain in the country are predominantly people whose needs are fulfilled by the rural social and economic scheme. The resulting lack of social conflict is conducive to an emotional stability that makes suicide relatively infrequent; and it is largely this factor that accounts for the differences in suicide mortality."

To sum up in a kind of sociological shorthand many of the facts, figures, and tendencies so far unearthed by the researchers on suicide in the United States:

The American most vulnerable to suicide is a white Protestant professional man over fifty who has some money or a good income, is widowed or divorced, has no children, and lives alone in a hotel in a large city on the West Coast.

The American least likely to commit suicide is a young Negro mother with a large family who has little education or training and lives in poverty in a rural area of the South.

However, a word of caution: nearly all suicide statistics have a

built-in bias, and their accuracy is therefore questionable. Several important forces are responsible for the bias. One of these is the difficulty physicians, police, and coroners face in trying to decide what was suicide and what was not.

When a coroner is called on to investigate a death, he has four choices in labeling it—natural causes, suicide, homicide, or accident. The law requires him to support his decision with legal evidence. And any coroner will tell you that it is no easy job to decide which category is correct. Frequently it is difficult to distinguish between homicide and suicide. Coroners almost without exception will treat doubtful cases as homicides until final proof is forthcoming.

In some cases, for instance, what police call "hesitation marks" make it difficult to tell immediately whether a death was due to suicide or homicide. Dr. Edward Marten, onetime Deputy Chief Medical Examiner in New York City, explained: "You can tell the difference between murder and suicide by a razor. If it's suicide, you can find a lot of little shallow cuts on the throat—we call these 'hesitation marks.' A man wants to know how much it's going to hurt before he cuts his throat."

Many persons who hang themselves first try a knife, gun, or some other instrument. Wounds thus received often lead to a premature murder theory. Then there is the case of gunshot suicides where the weapon was fired several times. Usually it is found that the victim hesitated, then fired one or more wild shots before the fatal one.

Even after other causes are ruled out, it isn't always easy to prove that a death was a suicide. Just how baffling a suicide can be and how much investigation goes into the circumstances before it is so listed, is illustrated by the case of Felix Crowder, the only man known to have performed the feat, often attempted in mystery stories, of committing suicide and hiding the gun. The case still baffles Chicago police.

Crowder, a widower of 78, was a tenement janitor in a run-down Chicago neighborhood. His neighbors knew him to be quiet, easy-going, a congenial illiterate, and a teetotaler. He had two sons and two daughters scattered around the country. He had no known

enemies. On October 14, 1949, he visited a woman neighbor and told her: "I've got things in my head." He asked her to write letters to each of his four children for him. She wrote at his dictation: "In case of my death I do not want my daughter-in-law, Mrs. Philip Crowder, at my wake or funeral." The following evening Dad Crowder failed to turn on the lights and heat. The next morning another neighbor, worried, pounded on his door.

It was opened by Dad Crowder. Blood was streaming down his face and he was unable to talk. The neighbor called the police, who figured he had a fractured skull. They hustled him to the hospital, where doctors found that a bullet had entered his lower jaw and emerged from the top of his head. Crowder died three days later without being able to tell what had happened. When police searched his apartment and found a bullet lodged in the ceiling above the kitchen chair, but found no gun, Dad Crowder became a headline mystery.

Was it accident, suicide, or murder? No clues turned up to suggest murder. There were no likely motives for a murderer, and Crowder's flat had not been ransacked for robbery. But if it was suicide or accident—where was the weapon? The baffled police several times searched the flat minutely. They searched the cellar and the areas around the building. But they found no gun. Although they were reluctant to believe it without the gun, the police conceded that all the evidence pointed to suicide.

A coroner's jury eventually returned a verdict of suicide, and Crowder went down in police annals as the man who committed suicide and hid the gun. Police theorize that the bullet in the kitchen ceiling was a practice shot fired by the old man. They are inclined to believe he shot himself somewhere outside his apartment, then walked home to die.

New York City police once were called to a house to check on a report that gas was leaking and found the body of a man lying on the floor of a blood-spattered room. He had been stabbed numerous times, and the belt twisted about his neck seemed to prove he had been murdered.

But investigation proved it was suicide. The man had gone into

his cellar and cut his throat. The wound was not deep, so he began stabbing himself about the head. Still unable to inflict a fatal wound, he went upstairs and looped his belt around his neck and hanged himself from an overhead pipe. The belt snapped and as he fell he brushed against a gas jet on the wall, turning it on. An autopsy showed that the gas was the cause of death, establishing a suicide.

Even when a man is captured with dismembered parts of a body and confesses to having murdered the person, suicide can't be ruled out. A man was found throwing parts of a body into New York Harbor. The torso to which the parts had belonged was found in his apartment. Investigation proved that there had been a drinking party there, during which the suspect quarreled with a woman and then wandered out into the night. When he came back, the woman was dead. But his brain was so befogged with alcohol that he wasn't sure whether he had killed her or not. Afraid that people would suspect him, his muddled mind figured the best way out was to dispose of the body. But police noticed that the skin of the body was the peculiar shade of pink that is caused by inhalation of gas. With this clue as a starting point, the medical examiner was able to establish the fact of suicide.

Some police cases are extremely difficult to classify. For instance, in 1958 a pregnant woman shot herself in the stomach and killed her unborn baby. The medical examiner was faced with a decision as to whether the act constituted attempted abortion, murder, or an attempt at suicide.

Many people make strenuous efforts to disguise their suicides. In 1931 a Massachusetts doctor tied one end of a long elastic cord to a pistol and the other end to a tree. When he fired a shot into his head, his hand released the gun and the cord snapped it a considerable distance from his body, making it appear that someone else had killed him.

On the evening of December 2, 1937, a 60-year-old accountant was found in Central Park, stabbed and badly beaten. Before he died he told police that two men had grabbed him from behind, bludgeoned him with a rock, stabbed him with an awl, robbed him, and fled. The awl and several bloody stones were found nearby. An

autopsy showed the man had suffered a fractured skull, a broken neck, and multiple stab wounds. His death brought a wave of public indignation at the viciousness of the attack and demands for heavier police protection in the park.

Then two youths came forward with the story that they had seen the man beating himself over the head with a rock while sitting on a park overpass. When he saw them, they said, he leaped from the overpass to the path where he was found dying. It was then discovered that though there were eight stab wounds in the body, the man's outer garments had not been penetrated by the awl and there was only one hole in the shirt. This indicated to police that the man might have opened his coat and vest and, after stabbing himself once, inflicted the other wounds without withdrawing the awl from his shirt. Robbers would hardly have unbuttoned the victim's coat and vest before stabbing him, detectives observed. The final element which proved that the man had indeed committed suicide was the finding of a five-and-ten-cent-store salesgirl who had sold him the awl.

Police said the motive for the disguised suicide was the man's desire to provide for his family. He had $83,000 in life insurance, against which he had borrowed $20,000, and his family was down to their last $100 in cash.

A night watchman who wanted to kill himself without disgracing his family tried to make it appear he had been murdered by burglars. Before Reginald Smith, 52, hurled himself off the roof of the eight-story department store where he worked in Blackpool, England, he packed two suitcases with cutlery and jewelry to support the burglar theory. Then he phoned the police. "I've discovered two men in the stock room," he shouted. "They're threatening me!" By the time a police car reached the store, Mr. Smith's body was lying in the street.

Police were able to crack the case in a few minutes. The police car got to the store one minute and 59 seconds after Smith's call. "Tests showed that it would take an intruder an absolute minimum of one minute and 56 seconds to escape from the roof to the street," detectives said. "It would have been impossible for an outsider to

get away." Then the police found footprints on the roof indicating that Smith was alone moments before his final plunge.

Some persons go so far to disguise their suicides as to actually have others kill them, apparently being willing to allow their dupes to be prosecuted for murder. This Associated Press story dated April 6, 1960, tells of one such case:

LOS ANGELES—A man meets a woman at a downtown bar. After a few drinks they go to his apartment to listen to hi-fi. He hands her a 45-caliber automatic and laughingly says:

"Shoot me . . . it's got blanks in it."

A shot. He falls dead. Is the woman responsible for the death?

No, a coroner's jury ruled yesterday in the Saturday killing of Donald R. Arthurs. It exonerated Mrs. J— M—, an unwitting dupe to a suicide.

One of the most bizarre cases in which someone tried to make suicide look like murder occurred in 1957 and was reported in this United Press story:

DETROIT, May 7—Recorder's Judge W. McKay Skillman refused today to grant a warrant against a psychiatrist who plotted his own death at the hands of a hired gunman.

The warrant, requested by Assistant Prosecutor Sam Brezner, would have charged Dr. C— P—, 56, with "soliciting to commit murder."

Dr. P— admitted two weeks ago he arranged to pay a gunman $500 to shoot him to death. The psychiatrist was arrested when the "gunman" turned out to be a policeman who was tipped off on the bizarre plot.

Judge Skillman contended the only charge against Dr. P— could be "conspiracy to commit suicide." He said there is no law against suicide in Michigan.

The judge said: "We must judge Dr. P— on the state of his own mind. And in the mind of the accused, he was not plotting a murder. He was planning his own suicide.

"The outcome would have been murder, but the intent was suicide." . . .

Shortly after his arrest Dr. P— told police he wanted to die so his $20,000 life insurance would go to a woman friend who spurned him. He said that if his death looked like murder she would collect double indemnity—or $40,000 in all.

These are a few illustrative cases in which disguised suicides were identified correctly by police. It is certain that many others go undetected. Families often hide suicides to avoid public censure. Doctors may leave the term "suicide" off the death certificate to spare the family embarrassment, to assure a church burial, or to protect insurance benefits.

Many poison deaths, particularly those in which barbiturates were used, are suicides, but must be excluded from the suicide totals because they could conceivably be accidental. Many auto accidents, drownings, and plunges from heights are also labeled accidents unless there is clear evidence of intent, such as a note or witnesses. Under the rules used in vital statistics offices throughout the world, medical examiners and coroners will not call a death a suicide unless there is unshakable proof that it was.

Thus, deaths caused by "undetermined circumstances"—which means the coroner doesn't know whether they were accidents, suicides, or murders—must be called accidents. A New York City Health Department study in 1955 showed that about 8 per cent of the 3,100 accidental deaths yearly in that city were wrongly reported, while suicides were under-reported probably by about 30 per cent. In addition, the suicide statistics do not include deaths which occur weeks or months later from complications induced by suicide attempts.

On the other hand, it is extremely rare for an accident or homicide to be listed as a suicide. One of the very few instances when an accident was wrongly suspected of being a suicide attempt was reported by Dr. Clarence B. Farrar in the January 1951 issue of the *Journal of Clinical and Experimental Psychopathology:*

"An accident was reported some time ago in England that looked very much like a genuine suicidal act. A mental patient not under strict surveillance was found lying on the ground under an open

window in an upper story. He was able to explain that he had been communing with the Deity and that when he heard the voice of God saying, 'My son, come and seat thyself by my side,' he had opened the window and stepped out to obey the divine command. He had expected to go up instead of down."

For these reasons there are really far more suicides than records show. Instead of the 18,519 suicides listed for the United States in 1958, researchers estimate that the true figure would be 25,000 or even higher. This would promote suicide to the eighth- or ninth-ranking cause of death in the nation, instead of its official position as eleventh. In short, bad as they are, suicide figures tell only part of the story. They do little more than suggest the dimensions of the problem.

Since these figures are the only ones we have, however, we must use them if we are to consider the problem at all. Despite their inaccuracy, we are able to study them intelligently because the underestimate built into them remains fairly constant. They are reasonably reliable indicators, therefore, of changes in suicide rates and patterns and can be used to compare the suicidal tendencies in different cities, states, and nations.

Chapter III

SUICIDE IN OTHER COUNTRIES

THE one place where people kill themselves with the greatest frequency is West Berlin, according to available statistics. Even with the constant underestimate which is built into them, the figures show that at least 34.1 West Berliners in each 100,000 ended their own lives in 1957, a year far from being the city's worst. In 1949 its suicide rate was 39.2. This high incidence of suicide is not just a postwar phenomenon in the city. Berliners have always been among the most suicide-prone people in the world. In 1930 a total of 42.2 of every 100,000 residents killed themselves. In 1926 the city registered the astronomical suicide rate of 47.0

The world's top-ranking suicide nation is Austria, which in both 1932 and 1938 had a death rate from suicide of 44.2. Switzerland ranks second, but its highest rate, 29.7 in 1932, is far below Austria's. Germany follows in third place, with its worst year being 1932, when the nation had a suicide rate of 29.2. Fourth-ranking nation is Denmark, which had its most suicide-prone year in 1946 with a rate of 25.9.

SUICIDE RATES IN MAJOR NATIONS

1957		*1956*	
West Berlin	34.1	West Berlin	33.9
Austria	24.6	Japan	24.2
Japan	24.4	Austria	22.8
Finland	22.4	Denmark	22.5

1957	
Denmark	22.1
Hungary	22.1
Switzerland	21.2
Sweden	19.9
West Germany	18.8
France	16.7
Belgium	14.8
Australia	12.1
England, Wales	11.9
New Zealand	10.0
UNITED STATES	9.0
Scotland	8.2
Portugal	8.2
Israel	8.0
Norway	7.3
Poland	5.7
Ireland	2.5

1956	
Finland	22.4
Switzerland	21.6
Sweden	20.1
Hungary	19.6
West Germany	18.6
France	16.9
Belgium	14.6
England	11.8
Uruguay	11.4
UNITED STATES	10.0
Portugal	10.0
New Zealand	9.5
Hawaii	7.7
Canada	7.6
Norway	7.2
Italy	6.8
Netherlands	6.0
Spain	5.6
Bulgaria	5.2
Northern Ireland	3.9
Guatemala	3.5
Costa Rica	2.6
Mexico	1.6
Jamaica, B.W.I. (1954)	1.1
Colombia	0.9
Peru	0.8
Egypt (1955)	0.2

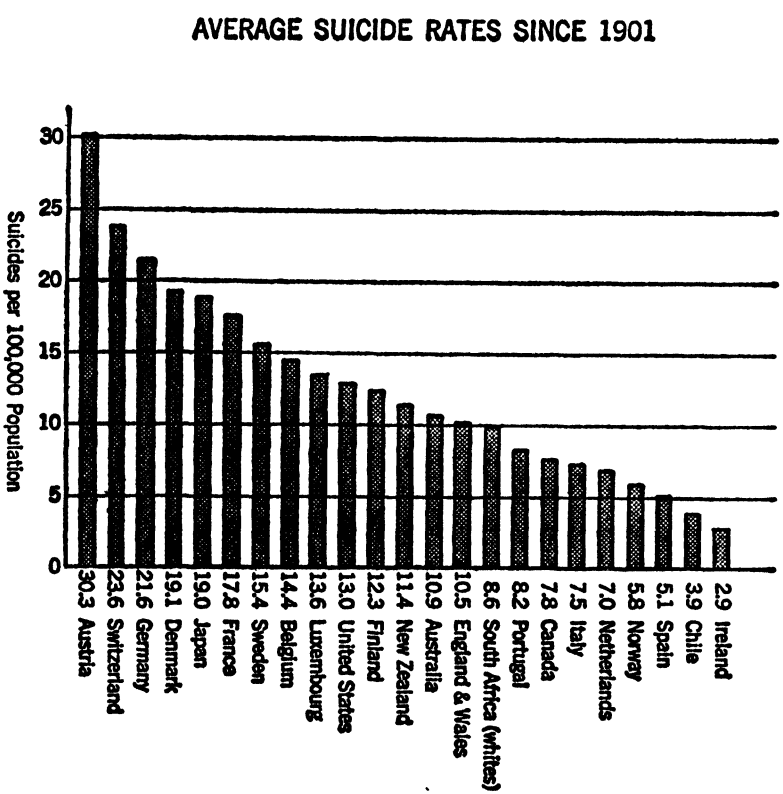
The World Health Organization reported in January 1960 that suicide ranks fifth as a cause of death in Denmark, sixth in Sweden and Switzerland, seventh in Finland and Germany, ninth in England and Wales. Suicide was the leading killer of men between the ages of 30 and 40 in Denmark during the three years 1951–53. In the same period, every fifth man between the ages of 20 and 40 who died in Denmark was a suicide.

England, France, Sweden, and some other countries often have more suicides in a year than automobile deaths.

Nations with low suicide rates are Norway, Ireland, Spain, Canada, Italy, the Netherlands, and the countries of Central and South America. Portugal had a low rate in the early part of the century, but its rate has increased 250 per cent to put it now among the middle-ranking nations. Spain's rate has increased 300 per cent, from 2 per 100,000 to 6. The nation which has had the most spectacular increase in suicide is Finland. Formerly among the lowest nations, with a rate of 5.3 in 1903, its rate has more than quadrupled to reach 22.4 in 1957. The United States has always ranked near the middle between the high and low nations.

The following graph shows the average suicide rate during this century in a number of countries.

An unexplained phenomenon that crops up when studying inter-



national suicide rates is that, however high the suicide rate in their native countries, when immigrants come to the United States they promptly begin registering even higher rates.

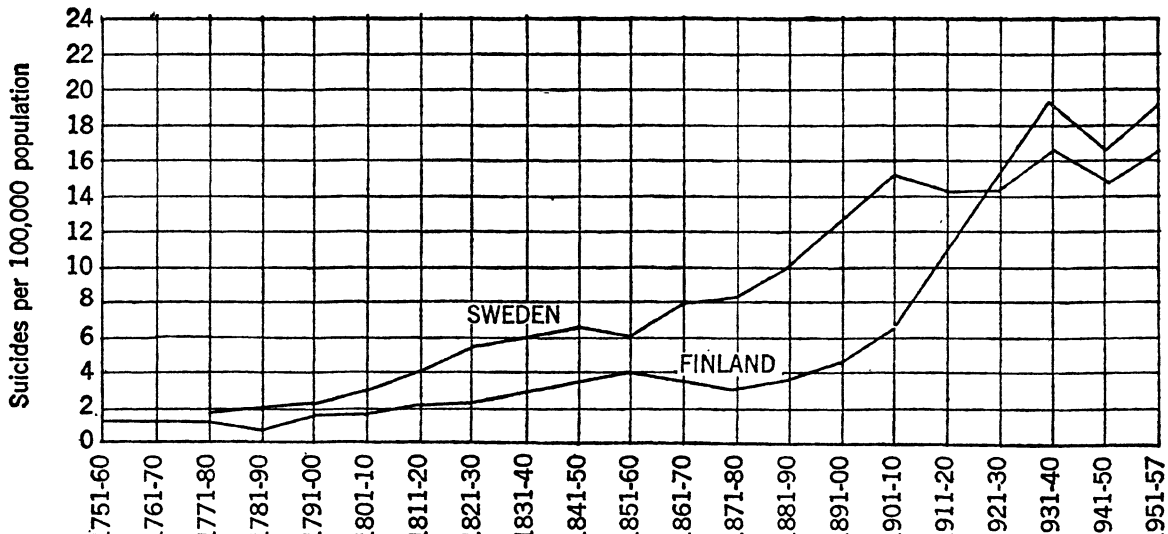
Because the Catholic countries, such as Poland, Spain, and Ireland, have low suicide rates, many researchers are convinced that Catholicism is a deterrent to suicide. Yet the world's leading suicide nation—Austria—is a Catholic country.

Investigators of suicide have so far been unable to come up with explanations as to why Norway should have a much lower suicide rate than the other Scandinavian countries, or the Netherlands so much less suicide than neighboring Germany. Nor why Switzerland, long peaceful and prosperous, should have a rate nearly as high as war-racked Austria.

Some people believe that Sweden's social welfare state is responsible for her high suicide rate. President Eisenhower created an international furor when, in his speech at the Republican Party Convention in Chicago in 1960, he made reference to the "socialist country which has a high alcoholism and suicide rate." Though he didn't name the country, the Swedes and the rest of the world had no doubt that he referred to Sweden. Many international feelings were ruffled. The Swedes themselves wonder why, with one of the highest standards of living in Europe and a system which offers security from the cradle to the grave, they should have such a high incidence of suicide—and the world's highest per capita consumption of hard liquor. Norway has a similar social welfare system but it produces only a low suicide rate.

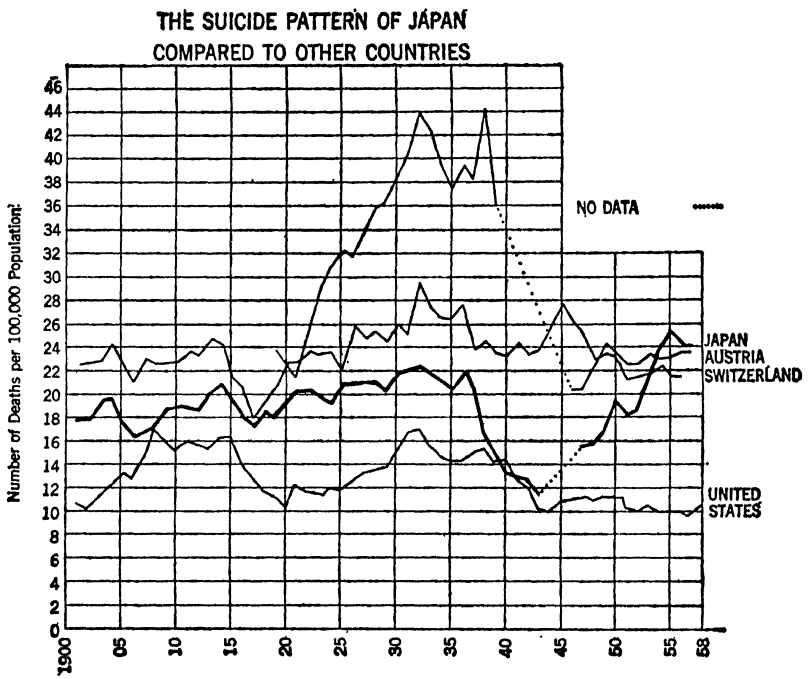
It has been frequently suggested that Sweden might show a high suicide rate because, being a small country with a reputation for efficiency, she keeps closer track of her citizens and therefore has more accurate figures, with less of a bias toward under-estimation than those of other countries. But Norway, with its low rate, fits this description too. The Scandinavians do keep excellent statistics and began collecting them centuries before other countries thought it important. The oldest suicide records in the world are those of Finland and Sweden, dating back to 1751 and 1781, respectively. The following graph from these figures shows the enormous increase in suicide in these two countries in the last 200 years.

THE WORLD'S OLDEST SUICIDE RECORDS



SOURCE: Veli Verkko, **Homicides and Suicides in Finland and Their Dependence on National Character,** G.E.C. Gads Forlag, Copenhagen, 1951

Japan's reputation as the most suicidal nation in the world is one of the great international myths of our time. In this century, Japan has led the world in suicide in only two very recent years—1955 and 1956. Even then the nation was ahead of the second- and third-place countries by only very small margins. Her average suicide record since the beginning of this century places Japan fifth on the list of nations. In the thirties, when Western nations had high suicide rates during the depression, Japan, in line with the expected reduction during wartime, had low rates during her action against the Chinese. From 1938 to 1943 Japan's suicide rate was only slightly higher than that of the United States. In one year, 1940, Japan had a lower rate than this country, 13.8 as against 14.4 for the United States. Since the beginning of the century fewer Japanese have killed themselves than have Americans—approximately 684,000 Japanese to about 733,000 Americans.



The Japanese nation's unwarranted reputation in the West for suicide stems from the national attitude toward the act. In the West, suicide is almost universally regarded as something shameful, which, if possible, should be concealed. In Japan, suicide has for centuries been honorable, public, and ceremonial. For this reason, Japanese figures are probably more accurate than ours.

While suicides get relatively little attention in the Western press, unless there is some strange angle to warrant good coverage, in the Japanese press a good suicide story may be the human-interest feature of the day. In the case of suicide for love or patriotic motives, it may be played up as something thrilling or heroic.

One Japanese writer has observed that "to settle trouble by death is a traditional moral viewpoint in Japan and thus suicide is regarded as a superior sacrifice." Shortly after World War II, U. S. Army officers discovered in the cell of General Seishiro Itagaki, former Singapore commander who was being tried as a war criminal, a paper on which he had written: "A perfect gentleman does not ask his own life. He completes human benevolence by killing his own body. One's body is not important, but complete benevolence is important."

Suicide in Japan and the attitude expressed by Itagaki has a long history. In ancient Japan, as in many other primitive cultures, wives, servants, and soldiers were required to kill themselves on the death of their chief so that they could follow him into the next world to serve him there. The practice, called *junshi*, was prevalent until about 2,000 years ago, when clay figures representing his retainers were buried with the chief instead of the actual bodies.

The custom was revived on a voluntary basis, about 1,400 years ago, not long after Buddhism was introduced from China. This religion, essentially pessimistic because its emphasis on reincarnation belittles the present life, was grafted onto the stern military code of Japan's feudal knights, the Samurai. These noble gentlemen, like their counterparts in the West, accepted a stern code of honor based on courage, asceticism, and self-control, something like the more modern Prussian military code of honor. Their harsh code

and pessimistic religion caused them to value life little, the forms of honor more.

The combination led eventually to the obligation to commit suicide to avoid capture, a device to maintain the bravery of the warriors. Since capture was viewed as a disgrace, it was only a short step until suicide was practiced also to avoid or atone for other kinds of disgrace, such as personal or family misdeeds. By the twelfth century the Emperor came to permit erring nobles to escape the public disgrace of execution by killing themselves.

As with all other Japanese events, the code of honor surrounded suicide with forms and ceremonials, and so the practice of formalized hara-kiri evolved. The suicide dressed in ceremonial robes, wrote farewell notes, confessed his crimes, and cut open his stomach while kneeling before witnesses. As soon as he had done so, a friend, somewhat like a second in a Western-style duel, stepped forward and beheaded him. If the sinner was of very high rank, it was customary for the Emperor to send him a jeweled sword for the ceremony. In time, the range of offenses for which hara-kiri was obligatory became very wide and included the most trivial transgressions.

Mandatory hara-kiri was abolished in 1868. Though voluntary hara-kiri has survived, its formal, ceremonial practice has become very rare. For one thing, modern Japanese are not as adept at handling daggers and swords as their ancestors were. To modern Japanese, the term "hara-kiri"—meaning literally "belly cutting"—is vulgar. They prefer to call it *seppuku.*

Like our medieval romances concerning King Arthur and his knights, which have influenced our notions of honor and duty, the feudal period of Japan produced a body of literature about the honor to be achieved through self-sacrifice. The favorite literary and dramatic theme in modern Japan is the story of the "Forty-Seven Ronin," which took place between 1701 and 1703.

A minor feudal lord was so grievously insulted on the grounds of the sacred castle of Edo that he became enraged, drew his sword, and wounded his tormentor. Drawing a sword within the sacred

precincts of Edo was an offense punishable by death. The unlucky man was ordered to commit suicide. With his death his feudal retainers lost their status as full-fledged Samurai and became ronin, a term for a masterless Samurai who had lost his normal place in society.

After a lapse of two years the ronin broke into Edo and avenged their lord by decapitating his old enemy. Though they had flouted the sacred authority of Edo, their self-sacrificing loyalty to their master made them at once national heroes, living up to the best traditions of personal loyalty of the warrior class. And, still following the best tradition, all 47 ronin committed hara-kiri.

Modern Japanese still regard these men as heroes and saints. To this day pious hands deck their graves, and incense is kept perpetually burning before their graves in a quiet temple compound in a Tokyo suburb.

Japan is also well known for another type of suicide, called *shinju*, the mutual suicide of unhappy lovers. The practice is common in a nation where the majority of marriage partners are chosen by parents. The lovers kill themselves in the Buddhist belief that in the next life they will be united. *Shinju* is praised in Japanese sentimental literature. These suicides of lovers are favorite themes for Japanese movies and are played to the hilt by the press. The wide publicity given suicides in Japan is partly responsible for the nation's unwarranted reputation for suicide.

The American occupation of Japan, with the consequent "democratization" of the laws, has brought an increase in double love suicides. In prewar Japan a parent could call for the arrest of a child under 25 who married without permission. A parent also could disinherit him. The new civil laws promulgated after the nation's defeat permit boys of 18 and girls of 16 to wed without permission and prohibit parents from disinheriting them. But many youngsters find they still can't overturn centuries of tradition, despite modern laws. They learn that family elders have little inclination to release the reins. Many youngsters, forbidden to marry and threatened with being cut off, are reluctant to face economic in-

security and the loss of family ties. Caught between the old restrictions and the new freedom, many couples seek a solution in *shinju.*

The most widely publicized *shinju* in recent years was that of a princess and a commoner, both 19, who chose to die together in a romantic woodland setting when their parents opposed their marriage. The tragic deaths of Princess Pu Hui-Sheng, niece of the last Emperor of China, and Takemichi Okubo, son of a railway executive, had a popular appeal closely resembling the ending in many of Japan's famous Kabuki dramas. The case also has assumed immediate social significance for Japan's emancipated postwar generation and for her less liberal-minded elders. Some believe that the tragedy could have historic influence. Younger Japanese cite the tragedy as a consequence of what they call "feudalistic thinking" by old-fashioned parents. Spokesmen for the older generation say this would not have happened if the United States occupation had not forced a lot of unwanted innovations upon the Japanese.

The case of the princess and the commoner has a special dramatic element. Princess Pu had been mentioned as a possible candidate to marry Crown Prince Akihito. She and her lover disappeared December 4, 1957. The girl left behind a note indicating a suicide pact. Several days later, after a search had been made, her mother, a marchioness in Japan's prewar nobility, broadcast on the radio that she had withdrawn her objections to the marriage. It was too late.

Their bodies were found in a secluded wood on the Izu Peninsula, a famous scenic and honeymoon area about 100 miles southwest of Tokyo. There they had spent one night in a hotel. The princess, a new gold ring on her finger, lay with her head cradled in young Okubo's left arm. The dead boy held an old Japanese army pistol in his right hand. Above their heads was a twist of tissue paper containing snips of their hair and fingernails, part of the ritual of Japanese love suicides. At the request of the boy's father, their ashes were interred together. The tragedy made headlines for days and inspired a series of quickie movies.

Japanese motives for committing suicide, which often seem pe-

culiar to Occidentals, have also contributed to their suicide reputation. In wartime, for instance, many wives and mothers kill themselves to free their husbands and sons from worry over dependents. In his book *Inside Asia,* John Gunther reports that a traffic policeman misdirected an imperial procession during a village ceremony. He killed himself in shame. The same author reports that a Japanese soldier in uniform fell out of a truck carrying soldiers in Shanghai. Without getting to his feet, he reached into his pocket, brought out a knife, and cut his throat, disgraced for having fallen.

We Westerners also are overwhelmed by the Japanese habit of engaging in spectacular mass suicide. The Japanese radio reported, for instance, that "great numbers" of Japanese were committing suicide in August 1945 before the Emperor's palace in shame at the nation's defeat by the Allies. In May 1924, when the American Congress passed the immigration law excluding Asians, this discrimination aroused profound resentment in Japan and numbers of Japanese committed suicide before the American Embassy in Tokyo.

Japanese suicide patterns show some remarkable similarities and differences with those of the West. In the 15–24 age group in Japan suicide is the leading cause of death. For American youths age 15 to 19, suicide is the fifth-ranking cause of death. Another major difference is that many more women, proportionately, kill themselves in Japan. Men kill themselves only one and one half times as often as women in Japan, as against three to four times as often in many Western countries. While in the West suicide increases at every age, in Japan it rises sharply to about age 30 for men and then drops to age 40, when it rises again for all age groups. For women the suicide rate rises to a peak between 21 and 24, then drops to age 36 or 37, when it begins a permanent rise.

As in the West, fewer married people in Japan kill themselves, and if they have children, their suicide rate also is lower.

Japan has a very low homicide rate, only 2 per 100,000 population. Many countries show a similar inverse relationship between suicide and murder. In countries which have a high suicide rate, the homicide rate is generally low—and vice versa.

MOST COUNTRIES HAVE MANY MORE SUICIDES THAN MURDERS

	Typical Suicide Rate	*Typical Homicide Rate*
West Berlin	33.9	0.9
Japan	24.6	2.0
Austria	24.2	1.1
Denmark	22.4	1.0
Finland	22.1	2.7
Hungary	21.2	4.0
Switzerland	19.6	0.7
West Germany	18.6	0.9
France	16.5	2.0
Belgium	14.6	0.9
Puerto Rico	12.5	6.2
England, Wales	11.8	0.6
UNITED STATES	10.0	4.6
New Zealand	9.5	0.5
Portugal	8.0	1.3
Hawaii	7.7	1.7
Canada	7.5	1.1
Norway	7.2	0.4
Italy	6.8	1.7
Spain	5.3	1.7
Northern Ireland	3.6	0.6
Ireland	2.5	0.3
IN OTHER COUNTRIES THE SITUATION IS REVERSED		
Chile	4.4	29.6
Panama	3.2	6.0
Guatemala	2.8	8.6
Costa Rica	2.6	4.5
Mexico	1.6	34.5
Jamaica, B.W.I.	1.1	3.4
Colombia	0.6	41.4
Egypt	0.2	2.7

Since the Russians don't publish their vital statistics, little is known about how much suicide there is in the Soviet Union. The government officially frowns on suicide, characterizing it as a rejection of the aims of the utopian socialist society which is its avowed aim. "Suicide is an act of hopelessness and should have no place in our country," declared Emelyan Yaroslavsky, a high party official and head of the Society of the Godless, the state-backed anti-religious organization, in 1931. He described suicide as "a bourgeois solution" of life's problems and condemned it as "bourgeois cowardice."

Russians do commit suicide, however. In the late twenties and early thirties a number of prominent writers, frustrated by the censorship imposed on their work by the Communist party, committed suicide. Ten Russians, some of whom had served in the German Army, killed themselves in Germany to avoid repatriation to the Soviet Union by the American Army. In October 1955 a clerk at the Soviet United Nations Delegation headquarters in New York City shot himself.

A commission was set up in Moscow in 1923 to study the frequency and causes of suicide in that city. Between December 1923 and May 1924, the group studied 359 cases, of which 139 were completed suicides. Women succeeded 54 times in 208 attempts, and men 85 times in 151 attempts. The cases contained a very high percentage of young people—75 per cent were under 30 years old. Twenty-one per cent of the men and 28 per cent of the women had made previous attempts. The Russians found that 30 per cent of the group, as in the West, were emotionally disturbed, and 20 per cent were alcoholics. In contrast to Western countries, the method most favored by men was poison, while more women used firearms.

The numbers in this sample were too few for drawing hard and fast conclusions, and the best educated guess is that the Russians probably have a higher suicide rate than the United States, but not much higher.

In his book *The Iron Curtain,* published in 1948, Igor Gouzenko, a defector from the Soviet Union, wrote:

"The official Soviet outlook, being openly pagan, and completely

disassociated from sentiment, shrugs a 'What use are they?' query in the direction of people whose age or physical condition has eliminated or decreased their usefulness to the state. The disposal of this 'useless' section of the population is achieved quite simply. Rations are decreased as one grows older!

"*Lishnetzy* is the Russian word for the aged and ailing who have become 'the superfluous ones.' On looking back, I am shocked to realize that as an ardent young Communist I never regarded the *lishnetzy* system as something monstrous. It seemed practical and just to me then. As *Komsomols,* at several discussions we had actually reached the conclusion that when one became a *lishnetz,* that is, one condemned to this form of civic extermination, one should be duty bound to free the country of a useless consumer by having the courage to commit suicide. That opinion was nationally encouraged to such an extent that even today the suicide rate in Russia is higher than in any other country in the world."

Mr. Gouzenko did not cite any figures to support his last assertion.

The Soviets' no-nonsense attitude toward suicide is well illustrated by an event which occurred in 1949. Russia presented to Turkey a medical bill for $16,000 for hospital and operation fees of a Turkish courier who died in a hospital at Sochi, on the Black Sea, from injuries he inflicted on himself in a suicide attempt while traveling in a train on Russian territory.

Other suicides and their consequences have become affairs of state. One, in fact, is mentioned in the Treaty of Versailles. When the Germans were pacifying what was then German East Africa, now Tanganyika, their most troublesome enemy was Mkwawa, chief of the Hehe tribe and a great hero. A German patrol surrounded him one day, and Mkwawa shot himself to avoid capture. The Germans cut off his head and took the skull to Berlin as a trophy. A clause in the reparation section of the Versailles Treaty ending World War I ordered the German Government to return it. But the skull had vanished. Not until 1953 was it discovered in the Museum of Ethnology in Bremen after a long search by Sir Edward Twining, British governor of Tanganyika. He returned it to the jubilant tribe in a great ceremony in 1954.

Chapter IV

CHILDREN ARE NOT IMMUNE

United Press International.

PEORIA, ILL., February 16 [1960]—Things started as usual yesterday morning at the B— residence.

Mr. and Mrs. B— got up and went to work. Their sons, Martin, 16, and John, 14, prepared to attend classes at Peoria High School.

John went off to school. But Martin stayed behind.

Martin went into the kitchen to begin a bizarre experiment with death. He had decided to log his own death, minute by minute, "so people will know what it is like."

Martin disconnected the home's electricity and telephone. Then he partially dismantled the gas stove, hooked a length of hose from a jet to his mouth, and turned on the gas.

While he waited, Martin scribbled notes with a pen to his brother, to a girl named Pat, and to "science." The notes said:

"9:45 A.M. John, when you come home open the windows fast. Don't touch anything until you open the windows. Then shut off the gas. Call Dad first. Let him tell Mom."

"9:50. Why can't I die?"

"10:15. I'm trying to die."

"10:30. No effect yet. I'm going to eat some grapefruit."

"10:45. Pat, I'm trying to die but can't."

"11:00. I'm trying to die but I can't. I don't know why."

"11:45. I fear my voice is becoming higher."

At 12:20 P.M. Martin's brother returned from school. He found

his brother's body on the kitchen floor, a plastic bag over the head. A half-eaten grapefruit was on the kitchen table.

Apparently in a rush to finish the experiment, Martin had tried to suffocate himself with the bag.

John turned off the gas and called the fire department. Attempts to revive the still body were futile. Martin was pronounced dead at a hospital at 12:40 P.M.

His mother was rushed to the hospital.

"I don't understand," she sobbed. "I don't know why he would do such a thing. He never acted despondent."

For American children aged 15 to 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 to 19 found life unbearable. This is a greater number than died from acute poliomyelitis, diabetes, tuberculosis, appendicitis, leukemia, or many other diseases.

In the next-lowest age group, 10 to 14, suicide ranks thirteenth 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.

It should be remembered that these figures are under-estimates.

Going back one step closer to the cradle, to the group aged five to nine, the National Office of Vital Statistics lists three authenticated suicides of boys at this age level in 1956.

The leading country for child suicide is Japan, where in the three years 1947–49 a total of 27 children under age nine killed themselves and 147 between their tenth and fourteenth birthdays. In Italy in the same period, three children under nine committed suicide and 52 between age 10 and 14. In France, four children under nine are listed as suicides in the same period and 29 between age 10 and 14. Children in South American countries also have high suicide rates.

The youngest authentic suicides in the United States in recent years known to the authors occurred at age nine.

Two of these cases illustrate the particularly heart-rending quality of suicide in the very young.

In February 1958 a nine-year-old boy in Lodi, California, got up from watching television in the family living room and told his brother: "I'm going to shoot myself." He got a rifle, put it against his head, and pushed the trigger with his toe. His father later found a note: "Good-bye, Cindy. You are my love."

Cindy was a horse which the family had sold shortly before.

The second case is an extraordinary one, which was reported by the United Press in 1942:

TAMPA, FLA., November 6—Robert G—, 9, and Mary Helen B—, 10, his aunt, were making a play house.

Robert dropped his jackknife. It nicked Mary Helen's face and she began to cry. He asked to wipe the blood away. She wouldn't let him.

"Then I guess there's nothing left for me to do but hang myself," he said.

Several hours later he was found hanging from a tree.

His funeral was held last Friday. Mary Helen was missing when her parents returned from the service. They found her dead, hanging from a tree.*

Dr. Harold Jacobziner, Assistant Commissioner of Health in New York City, reported in 1959 that suicide ranked fifth among the leading killers of children aged 15 to 19 in that city. He said that 39 children under age 20 took their lives in New York City between 1955 and 1958, and commented: "This is too important a problem to leave alone."

* Two other cases, which could hardly be described as true suicide attempts, since there was very likely no conscious awareness of the meaning of death or any real desire to die, show very well the powerful emotions of which young children are capable. In September 1949 an East St. Louis, Illinois, mother scolded her 15-month-old son for climbing on a window sill. He then held his breath. His face turned blue and he lapsed into unconsciousness. By the time his father rushed him to the nearest fire station he apparently had stopped breathing entirely. The firemen used 500 pounds of oxygen to revive him. In August 1952 when a Cortland, New York, father took a piggy bank away from his two-year-old son to keep him from smashing it, the toddler became so angry he held his breath, turned blue, and had to be revived with oxygen.

In a paper he presented at the International Congress of Pediatrics meeting in Montreal, Canada, in July 1959, Dr. Jacobziner reported on a study of attempted suicides between 1955 and 1958 among children in New York City.

"A striking feature of this study," he said, "was the large proportion of suicidal attempts to successful suicides. The proportion during the age period of eight–nineteen was 50 attempts to each suicide. We found eight suicides in over 400 reported suicidal attempts in our series of attempted suicides by poisoning by means of a drug or chemical. If this ratio prevailed among adults, there would be over 39,600 attempts at suicide in New York City alone during 1958, or one attempt for every 200 individuals of the city's population . . ."

In another study, reported by Drs. Benjamin H. Balser and James F. Masterson in the November 1959 issue of the *American Journal of Psychiatry,* it was found that 12 per cent of all suicide attempts in the nation each year were made by adolescents. These researchers found that 90 per cent of adolescent suicide attempts were made by girls.

"It would seem that the study of completed suicide alone gives a misleading picture of the total problem," the psychiatrists commented, "and that suicidal attempts, particularly in adolescent females, are much more prevalent than they were thought to be . . ."

Dr. Jacobziner's study showed that the group of attempted suicides did not vary appreciably from the average population in physical, mental, or emotional status. Six per cent had made previous suicide attempts. Over 50 per cent of the families were in the medium-income group, and over 42 per cent were in the low-income group. The proportion of families where the father was deceased was 8 per cent. In the general accidental poisoning group in the same age category, there was an incidence of only 1 per cent of families in which the father was deceased. No adult was at home in over 50 per cent of the suicide attempts. The mother was at home in nearly 29 per cent of the cases when the attempt occurred. Disciplinary measures, emotional upset, and depression were listed as the chief causes. A public health nurse visited the family of each child to dis-

cuss the problems which led to the attempt and to suggest ways of solving them.

"An analysis of the circumstances leading to the attempt indicated that nearly all attempts were preventable," Dr. Jacobziner reported. "The nurse who visited the home in response to a specific question about preventability also judged all of these incidents as preventable. When asked 'How could it have been prevented?' she invariably remarked, 'By better understanding and by a more sympathetic attitude by the family toward the adolescent.'"

As with their elders, a child's world is full of worries. Science Research Associates published in November 1951 a listing of problems which beset children. To compile the inventory, two psychologists questioned 6,000 school children on every sort of problem from "I have to go to bed too early" to "I hit my sister." One child in four, they found, was a chronic hypochondriac, worried about all sorts of aches and pains ("I have a thumping. . . . Sometimes I get real dizzy"). Among other things the psychologists learned was that 16 per cent of the children at some time had wished for death.

It seems hardly credible that young children could seriously ponder the question of "to be or not to be." Yet some of them apparently do. One of the most brilliant men of our age, the eminent British philosopher and mathematician Bertrand Russell, told in *The Conquest of Happiness* how as a youngster he brooded continually about suicide:

"I was not born happy. As a child, my favorite hymn was 'Weary of Earth and Laden with Sin.' At the age of five, I reflected that, if I should live to be seventy, I had endured, so far, a fourteenth part of my whole life, and I felt the long-spreading boredom ahead of me to be almost unendurable. In adolescence, I hated life and was continually on the verge of suicide, from which, however, I was restrained by the desire to know more mathematics."

At the age of 17 Napoleon wrote in his diary:

"What madness impels me to desire my own destruction? Why am I in the world? Since death must come to me, why should it not be as well to kill myself? If I were sixty years or more, I would

respect the prejudices of my contemporaries and wait patiently for nature to finish her course, but since I began life in suffering misfortune and nothing gives me pleasure, why should I endure these days when nothing I am concerned in prospers?"

Since children and adolescents are highly suggestible, it would not be surprising to find that the suicide of one is sometimes followed by others. Something of a suicide epidemic among children did occur a few years ago in Vienna, Austria. In 1953 a 12-year-old boy threw himself out of a school window after writing a note saying he feared bad marks. He survived, but his attempt set off a reaction among his peers. Suicide attempts by children rose 50 per cent in the 18 months following his action over the 18 months prior to it.

Professor Hans Hoff, chief of Vienna's Psychiatric and Neurological Clinic, was reported in the press as saying:

"The epidemic is unnatural. Suicide is not the normal reaction of a child to a problem. He runs away, or dreams of death, but doesn't actually try to kill himself. Children who try suicide invariably have had life histories of insecurity and a lack of love. Boys and girls don't commit suicide because they get poor marks in school. The boy who set off the current epidemic felt he was rejected by his class, his teachers, and his mother. By suicide the children hope to change things, not escape them, and often they fantasize they will survive their own death."

Just how a child can imagine his own death and simultaneously believe he will survive it was well described by Edward H. Sothern, the actor, in his autobiography, *The Melancholy Tale of Me.*

"'You'll be sorry when I'm dead,' said 'Me' one day to his nurse, Rebecca. This remark had such an effect, by throwing Rebecca into hysterics, that the value of it as a weapon of defense became instantly apparent to 'Me.' He tried it by way of experiment on his mother. She did not make an outcry as Rebecca had done, but she ceased talking and paled visibly, and looked long and tenderly at 'Me.' 'Me's' heart smote him, but the idea of self-destruction began to take root, and as 'Me' played in the garden that day he would

pause now and then as some fresh means of doing away with himself occurred to him.

"There was every reason why 'Me' should consider suicide. He was adored by his parents; idolized by Rebecca; the gardener could not garden without him; there was no wish he could possibly formulate which would not instantly be granted. Consequently, life was a burden to 'Me,' and the realms beyond the grave properly became food for contemplation.

"Uncle Hugh was consulted at an early date, and told strange tales of how people had destroyed themselves. The phoenix was especially interesting—making a conflagration of himself and then, just when everybody was saying how sorry they were, and what a lovely bird he had been, springing up out of his own ashes and saying: 'Here we are again!' The pelican, too, was an exciting fowl which allowed its children to eat it up and, so to speak, lived again in its progeny. Then there was a certain Black Knight of King Arthur's Court who used to permit people to cut his head off at one blow, only to pick it up with his own two hands and place it again on his shoulders. This seemed an admirable plan of self-immolation."

While "Me" only thought about the question of dying without really believing in his death, many children actually go so far as to commit suicidal acts without wanting or intending to die. It is not clear why they should pick this particular type of protest rather than another against situations they find unpleasant.

An example of this type of suicidal gesture occurred in Milwaukee in April 1947. A 12-year-old girl told a boy that his name was included in a diary she had been keeping. He and a friend pulled her hair and twisted her arms and fingers until she surrendered it. As soon as they left her the girl swallowed six sleeping pills. She was found unconscious by her mother, who rushed her to a hospital. After the child came out of a four-hour coma, she cried: "I don't want to die! I want to go home to my mamma!" She explained: "I felt so terrible after they left—to think they would read my diary and tell everybody my secrets. So I took the sleeping pills. But I really don't want to die."

Unlike the younger child, when the adolescent thinks of suicide he generally does not simultaneously believe he will survive. Adolescents' motives and understanding of what will be gained or lost by their act are much closer to those of adults. As Dr. Jacobziner pointed out in his paper:

"When adolescents are subjected to many frustrations they feel unwanted, insecure, and alone and often resort to a suicidal attempt. These do not necessarily result from mental illness, a neurosis or deep despair, however. Any suicidal attempt is undesirable and symptomatic of some underlying unresolved conflict. . . .

"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 . . ."

The circumstances under which children kill themselves strongly support Dr. Jacobziner's thesis that it is an act of hostility toward parents. Stories about child suicides which appear in the nation's press also indicate that children often commit suicide for reasons which even to them would appear upon reflection to be trivial.

A 14-year-old boy who was upbraided by his father for keeping late hours shot himself a few minutes later. A 16-year-old girl was chided for smoking and was found dead a few hours later. Told she was too young to have dates with boys, a 13-year-old hanged herself. Hostility is apparent in the note written by a 16-year-old Pittsburgh girl who shot herself to death in July 1947 after being refused permission to go to an amusement park. The note was addressed to her parents and her brother.

Dear Mom and Dad and Don:

I am sorry for what has happened before but this is the only way out. I couldn't stand you and Dad giving me those hurt looks any more. Sorry it ended this way.

Your loving daughter.

P.S.: You never get mad at Don—only me.

An 11-year-old Illinois boy hated his stepfather, nicknamed Bud, so much that he killed himself in 1951 to punish him. The boy left a note which read in part: "I hope Bud *suffers.*"

As frequently happens, however, with the present state of knowledge about suicide, cases come along which don't seem to fit the accepted theories. In 1944, for instance, a 14-year-old Philadelphia girl killed herself and left a note expressing only love for her family. Nor did she give indication of hostility toward anyone else. In July she told her mother that she wished to die, but would give no reason. Two months later she committed suicide by turning on the gas jets of the stove in the family kitchen. She left a note which read:

To whom it may concern,

If I should die in my childhood, this is my will. I have no money, except $2.95 in the bank, and a little in defense stamps. This is to be given to Robert C—, my nephew. My clothing goes to charity or to anyone that wants them.

If I am laid out I would like to be dressed in blue. If I have a funeral all friends and relatives are invited to attend.

To my mother I give all I have and everything I possess. To my father and sister all my love and all I possess.

No one has killed me. I wish to die. I have committed suicide.

While this girl, like many youthful suicides, deliberated long on her action, other children kill themselves without giving their action more than a moment's thought. In April 1949 a 10-year-old boy in Scranton, Pennsylvania, accidentally shot his five-year-old brother to death while playing with his father's pistol. He immediately turned the gun on himself and fired a shot into his head.

In Childress, Texas, two brothers, 13 and 10 years old, argued over which one would rock a six-month-old sister to sleep. Working himself into a blind rage, the 13-year-old ran to get a pistol and killed his brother with three shots. As soon as the younger boy fell, the elder fired a shot at his own head, but the bullet glanced off

his skull. He determinedly fired a second shot into his temple, which killed him.

A 14-year-old Chicago girl was watching television in the family living room with two boy friends in February 1952. Suddenly she announced: "I'm going to kill myself." The boys thought she was joking and went on watching the program while the girl walked into a bedroom. She returned to the living room carrying her father's .32-caliber pistol and shot herself in the head.

A 17-year-old New York City boy was talking with a friend one evening in October 1953 in front of his apartment building when he suddenly exclaimed: "I think I'll jump off the roof." He ran into the building and dashed up five flights of stairs to the roof. His friend chased him, shouting: "Don't be foolish." Before the friend could reach the boy, he stepped to the edge of the roof, hesitated a moment, and jumped.

"I'm going to do the most foolish thing I ever did in my life," said a 20-year-old Duke University student as he stood on the front porch of his rooming house in Chapel Hill, North Carolina, talking to three other students. Then he raised a revolver and shot himself in the head.

In none of these cases could family, friends, or police find any reason why the youngster should have done away with himself. Each was reported to have been normal and cheerful up to the moment of the act.

The "loss of a love object" mentioned by Dr. Jacobziner prompts some children to end their lives so that they can join a beloved parent in the next world. A 15-year-old Chicago girl whose mother had died seven months earlier, poisoned herself in March 1946. She left a note which said: "I'll never have real happiness unless I'm with Mom."

While his wife was in the hospital in 1947, the father of a 10-year-old Michigan boy died of a heart attack. When his wife returned home and learned of his death the shock was too great and she collapsed and died. The heartbroken boy went into the bathroom, locked the door, and hanged himself.

"Loss of a love object" might also account for the comparatively

common suicides prompted by the deaths of popular idols of teen-agers. The sudden death in an automobile accident of Jimmy Dean, the young actor revered by millions of adolescents around the world, was a traumatic experience for many. "He is my idol. He is dead. I must die, too," read the note left on the beach by a 14-year-old French girl who threw herself into the Mediterranean. When rescued by fishermen she was wearing only a locket containing Jimmy Dean's picture.

A month earlier a 13-year-old girl in Monterrey, Mexico, killed herself while mourning the death of popular Mexican singer Pedro Infante, who had been killed in an accident a week earlier. In March 1958 an 11-year-old trumpet student who was an ardent admirer of W. C. Handy hanged himself in the bathroom of his California home within minutes of being told the famed composer had died. In the same month a 13-year-old in Japan committed suicide because his wrestling idol had been defeated in a championship match. In September 1959 a 15-year-old boy in Dorchester, England, killed himself after grieving for eight months over the death of Buddy Holly, an American rock-and-roll singer.

Horror comic books, the bane of many a parent's existence, have been blamed repeatedly for being the cause of both deliberate and accidental child suicides. In Canada in May 1947, two boys on opposite sides of the continent hanged themselves after reading about hangings in horror comic books. One was rescued, the other wasn't. As a result, Montreal police began a campaign to ban such comics from newsstands in that city.

In April 1948 a New York City father walked into the bedroom of his home and found his 10-year-old son hanging from a door hook, suspended by his bathrobe cord. His schoolbooks, neatly strapped, had been kicked from under him. On the floor, under his open hand, lay a comic book. The cover depicted a girl on a horse, a noose about her neck, with the other end tied to the branch of a tree. A villainous-looking man was leading the horse away, the noose drawing ever tighter.

A 14-year-old Neptune, New Jersey, boy who hanged himself ac-

cidentally in May 1951 with a weird and complicated play apparatus, very likely got the idea from a horror comic or similar source. In the basement of his home he fastened a pair of roller skates to a box to make a dolly. Above this, he tied a noose to the ceiling. Then he rigged up a pulley about 10 feet away. Through it he ran two ropes attached to a pail of sand. One rope he attached to a weighted beer box which pulled the pail of sand high off the floor. The other line ran to the dolly. He placed a lighted candle under the anchor rope holding the pail of sand, mounted the dolly, and dropped the noose over his head. When the candle burned through the rope, the pail dropped, yanking the dolly out from under him. His body was found a short time later. Still strapped to his wrist was the open knife he apparently had meant to use to cut himself down after the trap had sprung. Police theorized that the jerking rope had strangled the boy before he could wrench the knife free.

The unleashing of the powerful sex drive during puberty and the spectacular physical, mental, and emotional changes which accompany it require difficult adjustments for any adolescent. But when the child has other important fears and problems, the changes of puberty sometimes overwhelm him and life becomes unbearable. "You'll never know how much I love you," wrote a 13-year-old boy in his suicide note to a 12-year-old girl, to whom he had never mentioned his feelings. In a gesture of infinite pathos, the youngster willed his love his most precious possession—his bicycle. Shocked by his death, the girl did not want to accept the gift. The boy's parents insisted because it had been his last wish.

This childish legacy raises an important question: the effect of child suicide on other children. It would be interesting to know the impact on a young girl who played for a length of time with a bicycle which was a constant, physical reminder of the nature and stated reason for her chum's death.

The first stirrings of genuine adult love also lead to suicidal impulses. Like their Japanese counterparts, older adolescents in Western nations sometimes enter into double love-suicide pacts.

Newspaper reports indicate that the most common motive is refusal of parental permission to marry. A second motive is the girl's pregnancy.

A sense of honor, mixed with bravado, occasionally causes a child to end his life. During the epidemic of child suicides in Vienna, Dr. Hoff warned that children who threaten suicide should be taken seriously: "Don't jeer at them," he said. "Their threats are symptoms of their insecurity. They need assurance. If they are taunted, suicide becomes a matter of honor."

"This will show I'm not chicken," read the note left by a 13-year-old Tacoma boy who shot himself to death in November 1956. The coroner said the boy was prompted to suicide by taunts from fellow students.

While it is bad enough when a child kills himself and leaves behind in a note a reason which is at least partly understandable to puzzled adults, it must be even worse for the stunned and grieving parents and other relatives when a cryptic reason is given, or none at all. "This is what education has done for me," read the note left by a 15-year-old Brooklyn girl who killed herself in 1932. A 10-year-old Watertown, New York, girl who shot herself with her father's rifle in November 1949 left the most succinct of all possible suicide notes. It said only: "Good-by."

For one segment of our nation's youth—college students—suicide is the second most common cause of death. It is outranked only by accidents. Dr. Henry M. Parrish, of the Department of Public Health and Psychiatry at Yale, surveyed the 209 deaths of enrolled students which occurred there from 1920 through 1955. He found that 43.8 per cent had succumbed to accidents, 12 per cent were suicides, 7.7 per cent were killed by heart and circulatory diseases, 7.2 per cent died of pneumonia, and 6.3 per cent were claimed by infections of the central nervous system.

The prominence of suicide among students is not unique with Yale. An earlier report covering the period 1925–35 showed that suicide was the third-leading cause of death in a number of colleges around the country. Other studies have confirmed that suicide accounts for 8 to 12 per cent of all deaths of college men and women.

Suicide is also a major threat in the British universities. As in the United States, it ranks second behind accidents. In the ten years following World War II, 27 per cent of undergraduate deaths at Oxford were suicides. The suicide rate of Oxford students was five times that of a similar age group in the general population. At Cambridge University the suicide rate for white undergraduates was 17.8, nearly three times the national figure.

Dr. Parrish reported in the *Yale Journal of Biology and Medicine* in 1957 a subsequent study of some of the significant conditions found in the suicides which occurred at Yale and discussed the type of student most prone to self-destruction.

"Many people have the preconceived idea that the introvert, the quiet bookworm who does not mix well socially, is more susceptible," Dr. Parrish wrote. But he discovered that 10 of the Yale men were active in student affairs, six were athletes, and 10 of the 25 suicides in his study were fraternity men.

Dr. Parrish also found that only six of the Yale students were rated as excellent scholars. The majority—14—were average, and five had poor grades.

Only three of the students' family histories showed mental disease. The majority were physically healthy. Only one had a serious illness. Twenty were Protestants, four were non-affiliated, and one was a Roman Catholic. There were no suicides among Jewish students.

Although 14 of the students came from well-to-do families, financial stress appeared to be an important factor for eight men. Six were either on scholarships or working to support themselves. Sex maladjustment was a contributing cause of six suicides. Three men whose proposals for marriage were rejected found life unbearable. One student murdered the girl who refused him and then killed himself. A medical student killed himself 10 days after becoming engaged. He feared he would eventually become insane and ruin his marriage. One, an overt homosexual, succumbed to feelings of anxiety and guilt.

To prevent such tragedies, "abnormal behavior in students must

be diagnosed early in the college setting," Dr. Parrish concluded. "The problem is to teach students and faculty members the basic principles of mental hygiene," so that they will be able to spot severe emotional upsets in their fellows before it is too late. Only 11 of the 25 suicides had received professional help, Dr. Parrish reported, while eight of the others killed themselves without so much as a hint of personality changes being noticed by teachers or classmates.

Suicides of some college men have a bizarre quality. A graduate student at Columbia University treated himself to a final fling in the best F. Scott Fitzgerald tradition one weekend in April 1960. On Thursday he celebrated his twenty-second birthday by taking a girl to the theater, then to a night club to drink champagne and hear a renowned singer. They ended the evening with the romantic ritual of a ride through Central Park in a hansom cab. On Friday he splurged at the races. Saturday evening he took a girl to hear *Don Giovanni* at the Metropolitan Opera. He ended his glorious weekend by escorting his date home, returning to the Columbia campus, and taking poison in his dormitory room.

At Arizona State College three men students discussed suicide often during the four months they knew each other. For days in late March 1960 one of them talked of little else. On April 5 he arose at 10 A.M. and told the friend who had stayed overnight with him: "This is the day." The friend rented a car in Phoenix, and the two men drove to his home and sat "talking suicide" until 7 P.M. Suddenly the one who had been fascinated by the subject announced: "I'm doing it."

The two drove into the desert north of Phoenix. The suicide told his friend: "Go for a walk and come back for me in thirty minutes." The friend sat on a nearby rock. After half an hour he returned to the car, dismantled the garden hose from the exhaust pipe, and drove back to Phoenix with the body.

He visited another friend, and the two of them set the body on a sofa and discussed the death. Finally the third friend called the police.

In one of the pockets of the dead student the police found a note.

It read: "This is an age of speed, and the man who finishes first is not to be looked down upon. If there is a hereafter my chances are as good as anyone's. If not, then I am reaching the end ahead of most."

One method of suicide chosen by young people deserves special mention—"Russian roulette." Although there are no figures to support the contention, it is apparent from the large number of reports in the press over the years that so many young people kill themselves while playing this fantastic "game" that it almost has a claim to a separate notation on the standard list of causes of death.

The grisly "game," also called "Cossack poker," is almost the exclusive diversion of boys, though an occasional girl tries it. To "play," a single bullet is placed in the cylinder of a revolver. The player spins the cylinder, points the gun at his head, and pulls the trigger. The weight of the bullet supposedly carries it past the hammer. The odds are supposed to be five to one that the hammer will fall on an empty chamber when the trigger is pulled.

Those who commit suicide this way nearly always have an audience. An 18-year-old Kansas City boy killed himself while playing the game in front of his sister in 1947. In 1950 a 25-year-old Princeton professor killed himself playing the game in front of friends at his birthday party. He had escaped with his life after pulling the trigger several times and had said he would stop after "doing it one more time." A California mechanic got away with two chances at Russian roulette in 1952, boasting to two friends that he knew how to spin the revolver cylinder properly. The third time his luck ran out. The same year a 21-year-old Philadelphia youth demonstrated the game to his two sisters and another girl. His luck also ran out the third time he pulled the trigger.

Russian roulette has a long history. The ancients played it long before guns were invented. According to Seleucus, some of the Thracians at their drinking parties played the game of hanging. "They fix a noose to some high place, exactly beneath which they place a stone which is easily turned round when anyone stands upon it; and they cast lots, and he who draws the lot, holding a sickle in his hand, stands upon the stone and puts his neck into the

halter; and then another person comes and dislodges the stone, and the man who is suspended, when the stone moves from under him, if he is not quick enough in cutting the rope with his sickle, is killed; and the rest laugh, thinking his death good sport."

Though the modern version of the "game," using a pistol, became common in Russia earlier than anywhere else, the idea appears to have originated in England. It was inspired in Russia by a short story called "The Fatalist," written by Michael Lermontov, a poet and novelist and a Russian army officer. Lermontov had Scotch ancestors and was an admirer of Byron. He had translated or adapted many of Byron's poems. It is known that he read and reread Byron's memoirs. Very likely he was impressed by the story of Edward Noel Long, Byron's roommate at Cambridge, as told by Byron:

He told me that the night before, he had taken up a pistol—not knowing or examining whether it was loaded or no—and had snapped it at his head, leaving it to chance whether it might or might not be charged.

In his story Lermontov made a Lieutenant Vulich repeat Long's stunt and, like Long, survive. The dangerous stunt appealed to Russian officers and they adopted it. The "game" seems also to have an extraordinary appeal for American youth, for several of them die every year when the hammer falls on the loaded chamber.

Not enough is known about why children kill themselves. There have been a few studies, which have produced many hypotheses but little in the way of conclusions which could be applied to the field of prevention.

We are probably the most psychologically oriented nation on earth, with scientists busily attacking almost every conceivable problem. Yet it doesn't seem to be enough when all the adults who surrounded a boy in the nation's second-largest city failed to realize that in their midst was a youngster whose world was so shattered that, like Lincoln a century before him, he felt he "must die to be better." On June 11, 1959, a 17-year-old Chicago boy shot himself to death, leaving this note:

"I'm sick and there is no obvious cure. God forgive me. I smoke and cannot stop. I cannot control my diabetes. I steal. I lie. I'm failing in typing and trigonometry. I have been thrown out of my physics class.

"My teachers are not to blame, they did their best. My parents, partly [*sic*], they did not prepare me for life.

"I'm sorry for the troubles I'm causing. But my troubles will be over. Please have them sing the hymn 'Amazing Grace' at my funeral."

Chapter V

"THE CRUELLEST MONTH"

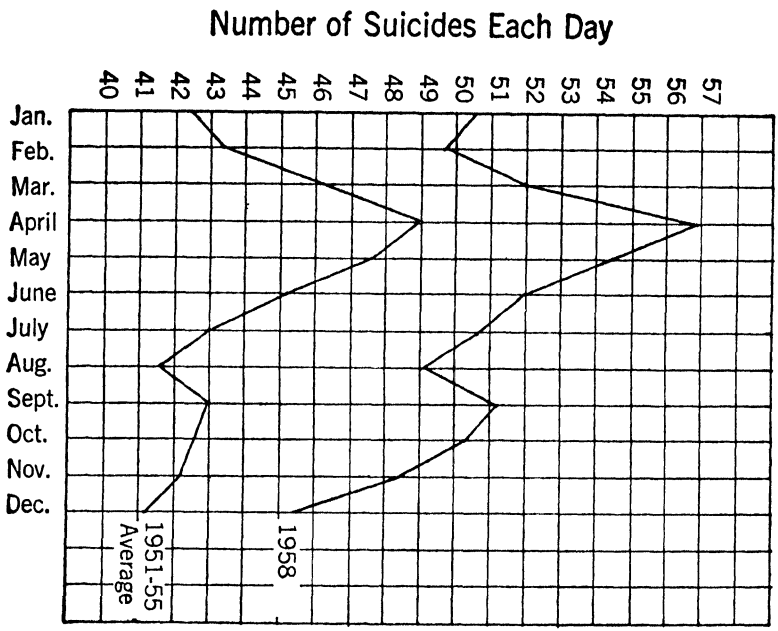
One of the strangest and least understood influences on suicide is the weather.

Certain kinds of weather throw an eerie spell over many suicidal persons, influencing them to cast the die. The weather which leads to suicide is not, however, what most of us would expect. Ask the next person you meet in what weather a man or woman who has been contemplating suicide is most likely to succumb to his impulse. Nine times out of ten the answer will be: on a cold, gloomy, depressing day in winter. The estimate is quite wrong. Suicide does not increase in gloomy weather.

Spring, when nature is at her smiling best, is the suicide season. More people kill themselves in spring than at any other time of the year. This is true in nearly all countries in the temperate zones in both the Northern and Southern hemispheres. In the United States and most of Europe, April is the peak month, followed by May and March.

The winter months have the least amount of suicide. December brings the year's low, followed by gloomy November and usually February. Another low month is sweltering August.

This seasonal tide in suicide never varies. The graph following shows the daily number of suicides in the United States in each month of 1958 and, for comparison, the average daily number during the five years 1951–55.



The graph shows another unexplained phenomenon—the second upsurge in suicide during September and October. The autumn increase is as regular as the rise in spring, though never as great.

Both spring and autumn are times of decision and change. In spring we change from winter clothing to lighter wear and begin to plan our summer vacation. Easter arrives with its ritual of buying new clothes, and the children are home for their spring vacation. The car must be taken for its annual tune-up, and the garden needs caring for. Wives begin to talk about new coats of paint for the house and new hats for themselves.

In autumn the winter clothing must be brought out of mothballs and new purchases made. The children must be made ready for school. Many people make decisions during September about moving to a new apartment, and October is our traditional moving month. All these changes may play a part in piling up uncertainty and problems to the point where they tip the scales for a suicidally inclined person.

If these were the only influences, however, we would expect the spring and autumn increases in suicide to be roughly equal. Since they are not, it is clear that there must be something quite different about spring which influences people to kill themselves.

In spring nature awakes from her winter sleep. Strange yearnings overtake men. If we have anything negative in our make-up, spring seems to accentuate it. More people have emotional disturbances, die of natural causes, and are reported missing in spring than any other time of year. There are more sex crimes, assaults, homicides, auto accidents, and auto thefts in spring than in other seasons. Since the time of ancient Greece, observers have noted and commented on the changes wrought in men when nature puts her best foot forward. One of the best descriptions of the impact of spring was by the wistful Swiss philosopher, Henri Frédéric Amiel:

"The nostalgia of spring is here again. It is the season of vague desires, of obscure uneasiness, confused aspirations, sighs without an object. One dreams wide awake. One seeks, one gropes; for what, who can say? One cries out for something that has no name, unless it is happiness or death."

Many of the findings of meteorobiologists—scientists who study weather's effects on human beings—are controversial. Their most generally accepted explanation of spring's impact, however, is that the change from cold weather to warm catches our bodies unprepared. Meteorobiologists have shown conclusively that every time the temperature changes or the barometer fluctuates, our bodies have to make an adjustment. Most of the time we adjust easily, almost automatically. At other times, the weather makes drastic demands, and both our bodies and minds are forced to labor.

Dr. William F. Petersen, who was one of this country's leading meteorobiologists, showed that weather changes affect blood pressure, pulse and breathing rates, acidity of the blood, and other physiological tides. The scientists explain that these changes occur because the human body functions like an internal combustion engine. In the process of creating energy from its fuel—the food we eat and the fat in our tissues—the body creates a lot of waste heat, which must be thrown off.

As the temperature of the air rises every April, the body finds it increasingly difficult to get rid of this heat. The blood vessels dilate so they can carry more blood to the surface to dissipate heat more quickly. As the vessels expand, the body tries to keep up with them by manufacturing more blood. Within a couple of days we increase the amount of blood we are circulating.

This whole process requires work and helps to account for the feeling of laziness and ennui which we call spring fever. In the first few days of shifting temperature our blood making may lag behind the expansion of the vessels, and the body and brain, lacking enough blood, slow down.

Dr. Clarence A. Mills, a professor of experimental medicine at the University of Cincinnati, studied the medical aspects of climate and weather. He showed that heat causes subtle alterations in memory, learning, and thought. He found, for example, that college students who were given the standard aptitude or intelligence tests at Cincinnati latitudes across the country achieved ratings only 60 per cent as high in summer heat as in winter cold.

It has been suggested by other observers of the suicide problem that for the potential suicide—fighting raging battles with himself, struggling with momentous decisions, perhaps worn out by agonizing defeats or major emotional or material losses—the demands spring makes on his body and mind could be the last straw.

It has also been suggested by meteorobiologists and psychiatrists that the suicidally inclined person finds the contrast between his inner despair and nature's exhilaration too great to bear. A man in a darkened coalbin realizes how black he is only when the first light peeps through the cracks. Dr. Edwin Grant Dexter, author of *Weather Influences,* described this contrast well:

"During the gloomy 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 its 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."

A man who actually experienced this increase in despair caused by fine weather was Thomas Beer, who wrote in *A Mind That Found Itself:*

"About dawn I arose. Stealthily I approached the window, pushed open the blinds and looked out—and down. Then I closed the blinds as noiselessly as possible and crept back to bed. . . . The dawn soon hid itself in the brilliancy of a perfect June day. Never had I seen a brighter—to look at; never a darker—to live through—or a better to die upon. Its very perfection and the songs of the robins, which at that season were plentiful in the neighborhood, served but to increase my despair and make me more willing to die."

Beer did attempt suicide.

The connection between weather and human emotions has been noted by psychiatrists. Reporting to a meeting of the American Psychoanalytic Association in December 1954, Dr. Philip Solomon, clinical associate in psychiatry at Harvard Medical School, said that a psychiatric patient's attitude toward the weather might be "a projection of his emotional state."

Dr. Solomon said he found that light rain suggested "a gentle caress," the "patter of little feet," or tender tears, while a downpour implied violence or punishment. Gentle breezes evoked a pleasant sensation like having one's hair stroked, but strong winds reminded a patient of fear. Some reacted pleasurably to thunder and lightning as giving them "a surge of enormous power," Dr. Solomon said, while others were terrorized.

In addition to the fine days of spring, another weather pattern has enormous influence on suicide—storms. Meteorobiologists say that a certain amount of storminess is necessary to make people energetic, resourceful, and ambitious. They point out that in the tranquil weather of the tropics and the subtropics, as in the southern part of the United States, the people are relaxed, leisurely, and rarely engage in the bustling, hyperactive pace so characteristic of Northerners.

But tempestuous weather is a two-edged sword. There are people in the stormy northern areas whose bodies cannot cope with the relentless dictates of the weather. The North has a higher incidence of mental illness, heart disease, and suicide than the more peaceful southern areas.

The effects of stormy weather on human beings were described by Dr. Petersen:

"Just before a storm, when the barometer is falling, people are irritable, restless and more likely to have headaches, nightmares and fainting spells. There are more attempts at suicide, the rate of industrial accidents goes up and rules are broken more frequently in schools and prisons. Lost and found officers say when the barometer is low more packages are left on busses and more gloves and scarfs lost in theaters."

Farmers claim that animals also are affected by an approaching storm—well-trained horses bolt and run, while docile dogs snap at their masters.

Writing in the *American Journal of Psychiatry* in 1934, Dr. Mills said:

"Certain bodily disturbances have been found closely related to storm changes in temperature and barometric pressure here in North America, and in making studies of mortality statistics it was found that suicides and homicides were to be grouped with these disturbances. As our storm centers sweep down the plains from the Northwest, then turn back up the Mississippi and Ohio River valleys to pass out over the Gulf of St. Lawrence, they leave behind them a trail of human wreckage—cases of acute appendicitis, respiratory attacks of all kinds, and suicides.

"Everyone is aware of the marked changes in mental state that come with these storms. With a center of low pressure approaching —the pressure falling and the temperature rising—we are afflicted with a feeling of futility, an inability to reach the usual mental efficiency, or to accomplish difficult tasks. In children this takes the form of an increased irritability, restlessness, and petulance that parents find most trying. Adults on such days are also more quarrel-

some and fault-finding, with a tendency to a pessimistic viewpoint toward all matters that arise. . . .

"This all has a definite bearing on the question of suicides and homicides, for with the former it is a depressed mental state that is responsible, a feeling of utter futility in life, while in the latter the causal factor is an uncontrollable irritation. . . . Both, in their frequency, follow the general course of the storms across the continent."

To study this phenomenon, Dr. Mills gathered information on the number of suicides each day in nine midwestern cities over a five-year period ending in 1932. He compared the number of suicides each day with the daily temperature variations and changes in barometric pressure.

"It is quite evident that there is a distinct relationship between falling barometric pressure and rising suicide incidence," he reported. "Time after time throughout the five-year period sudden peaks in suicide were found to coincide sharply with low-pressure crises . . . a significant coincidence, with very little lag, between periods of declining pressure and rising suicides. It is difficult to see just what role temperature plays, except that usually with falling temperature suicides decline. Most significant are the waves of suicides that match the troughs in pressure."

That storms bring with them an increased number of suicides seems to contradict the conclusion that the fine weather of spring increases suicide. There is no conflict, however. Reporting on his study of 2,946 suicides in relation to weather made thirty years before that of Dr. Mills, Dr. Dexter declared:

"The clear, dry days show the greatest number of suicides, and the wet, partly cloudy days—the gloomiest of all weather—the least; and with differences too great to be attributed to accident or chance; in fact, for New York City thirty-one percent more on dry than on wet days, and twenty-one percent more on clear days than partly cloudy . . ."

Dr. Dexter pointed out that the barometric pressure is low most often just preceding and during the earlier stages of a storm. Then, since his data showed that there were fewer suicides on wet days,

he eliminated the storm period itself as a particular influence on suicide and concluded that *"this leaves us only the period just preceding storms as one of especial self-destruction"* [italics added].

Although the effects of a low barometer on human beings have been scientifically established for at least half a century, scientists have not been able to come up with the answer as to how or why we are affected. Dr. Mills said:

"Some people, hypersensitive to weather changes, respond to every cloud which hides the sun. Sunshine and shadow keep their emotions jumping from elation to depression and on days of steadily falling pressure they become morose and dejected. The exact mechanism by which such weather changes affect human beings in so many ways is not yet known."

A third element of weather also has powerful effects on the human psyche—wind.

For thousands of years the effects on us worked by wind have been recognized in folklore, but they have been almost entirely overlooked by modern scientists. The only student of weather who paid much attention to wind was Dexter, whose book *Weather Influences* was published in 1904. He wrote:

"The regularity of the increase of suicide with increase in movement of the wind is too marked to allow any other theory than that of a causal nexus. This effect seems to be much greater upon the suicide than upon any other class of the offenders. [He also examined the effects of weather on crime.] Studied for New York City, and for the Colorado climates, the effects of great velocities of the wind is simply appalling, suicides being from two to four times the normal frequency during their prevalence."

A more recent writer, Guy Murchie, noted in his book *Song of the Sky*, published in 1954:

"There are the hot, dry winds like the simoom or 'burning wind' which are said to wreak great hardship on all living creatures—sometimes men are driven to desperation by the parching of their skins, and their throats and noses. Herodotus tells of the ancient people of Psylli (Tripoli) who became so hysterical when their wells dried up that they actually declared war on the simoom and

marched into the Sahara with clashing cymbals and beating drums until they disappeared forever into a red cloud of whirling sand."

Some Eskimo tribes used to lash the wind with long whips to make it cease. And today many a European surgeon avoids operations on days when the south wind blows, some believing that hemorrhages and serious clots are more common on those days. Many countries have periodic winds that are called "suicide winds." The peculiarity of these winds is their unremitting quality, blowing for weeks and months on end. They create serious disturbances of mood and outlook in many people.

In his book *Arrow in the Blue,* Arthur Koestler described such a wind:

". . . the Jordan valley, the deepest depression in the surface of the earth. In summer the heat was stifling, aggravated by the Khamsin, the hot desert wind with a peculiarly unnerving effect—ancient Turkish law considered it a mitigating circumstance if a murder was committed during a Khamsin."

North Africa produces a similar unremitting wind, called the sirocco. Italy and southern France have a violent, long-term wind called the mistral.

The only recent student of the suicide problem who has taken note of the effects of wind is Dr. Joseph Hirsh. In his article "Suicide" in the October 1959 issue of *Mental Hygiene,* Dr. Hirsh wrote:

"It was not only the searing sun but the violent mistrals of the Midi which drove an already tortured Van Gogh to his death. Switzerland, too, has its particular wind, the Foehn, which, unlike the sirocco, is hot and humid, gathering moisture as it crosses the Alps from Italy. An increase in crimes of all sorts—homicides in particular and suicides—follows in its wake. The courts in Switzerland and Germany take this into account in dealing with cases associated with this wind. In our own West (Colorado) there is a wind much like the Foehn, called the chinook by the Indians."

Swiss and German medical researchers are quite familiar with the weird effects of the foehn. They have learned that the inhabitants of a 500-mile belt over which the wind blows seem to be more

prone to illnesses during its peak winter and spring periods. The standard German Medical Handbook lists the symptoms of those affected by the foehn:

"Pulse and circulation are remarkably intensified. Many people will be subjected to nausea, dizziness, a feeling of 'walking on air' but without any accompanying sense of euphoria."

Many people affected by the foehn complain of an odd, dull pressure behind the eyes. The Manfred Curry Clinic near Munich attributes this to a sudden drop in the atmosphere's ozone content followed by an equally sudden increase. The clinic has installed a score of ozone dispensers for the relief of foehn-struck patients.

Germany's Medical-Meteorological Consulting Office, which is maintained by the Weather Service and the University of Munich, sends daily bulletins to hospitals in southern Germany to warn them when a foehn is approaching.

The only researcher who has integrated the effects of the wind with the other data on how weather affects suicidally inclined people was Dr. Dexter. He summed up his findings this way:

"Suicide is excessive under those conditions of weather which are generally considered most exhilarating and delightful, that is, the later spring months and upon clear, dry days. . . . It was also noted that there were more suicides during the most agreeable temperatures. Barometrical conditions can hardly be referred to the categories agreeable and disagreeable, but for humidity and wind the relation will hardly hold, since we have the greatest excesses during high humidities and great wind velocities, both of which are unpleasant. Yet these facts would not invalidate our first statement, for neither high winds nor great humidities bring a scowl upon the face of nature that can be compared with that of a wet, drizzling day. In fact, a day may be bright, and be both windy and humid.

"Yet these latter conditions have effects peculiarly their own, as shown conclusively by the study of deportment already cited. They are, for wind, the production of a neurotic condition in which self-control is in a marked degree lessened, and for high humidities, the production of a minimum of vital energy. The former is shown especially in the study of the school children, and the latter of the

death rate. These facts make it possible for us to amend our statement that suicides are excessive during the most noticeably delightful conditions, by adding: coupled with especially devitalizing ones."

As with most other aspects of the suicide story, the lack of complete information about the influence of weather on suicidal persons creates puzzles and paradoxes. It would be logical to expect that in an ideal climate the suicide rates would be low. What is the best climate for man—if there is one best—is a controversial subject. S. F. Markham, an English climatologist, made one of the most balanced and thorough analyses of the subject. He concluded that the best climate for man is one in which daily temperatures range between 60 and 76 degrees, with moderate humidity ranging from 40 to 70 per cent and with sunshine and mild breezes. In such an environment, Markham believes, most people feel their best.

The area of the United States which best fits this description is the Pacific-coast strip from Los Angeles north almost to Seattle. Throughout the area the average temperatures the year round are never far from the optimum for comfort. There is enough storminess to provide a moderate amount of stimulation. The best site of all along this strip, and geographically in the middle, is San Francisco. Above the belt of low-lying fogs which plague the city there is perpetual spring.

But San Francisco has a higher suicide rate than any city in the nation. And California is nearly always the second-ranking state in numbers of suicides, with a rate far above the national average. Whether the perpetual spring accounts for the high suicide rate, overriding the other advantages of the climate, is a question that has not yet been answered.

Another puzzle from the point of view of weather is the fact that Seattle, one of the rainiest cities in the country, has a high suicide rate while at the same time the five driest states in the Union also have quite high rates. The five wettest states have rates below the national average.

Perhaps the scientists never will be able to unravel these com-

plexities. It may be, as sometimes happens, that a poet can give a better answer than a scientist. It was T. S. Eliot who wrote:

April is the cruellest month, breeding
Lilacs out of the dead land, mixing
Memory and desire, stirring
Dull roots with spring rain.

Besides weather, time and place influence some people who are thinking of killing themselves.

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 drop back again on Saturday.

There are no explanations of this daily pattern of suicide. Some researchers speculate that "blue Monday" is aptly named. A man who is on the verge of suicide may be overwhelmed by the cares and responsibilities which are resumed at the beginning of the business week. It has also been suggested that religion, by inducing guilt feelings and somber thoughts, may play a part in the high incidence of suicide on Sunday. One student of suicide feels that many suicides on Sunday may be induced by reaction after Saturday night dissipation.

Studies have been made concerning the hours of the day when most suicides occur, but none of them has been conclusive. One survey showed that in the United States about 70 per cent of the suicides occurred between 6 P.M. and midnight. Other studies in Europe showed that most suicides took place during the morning and early afternoon.

When it comes to choosing a place to commit suicide, Americans have two particular favorites. They are on opposite sides of the continent, both beautiful and both connected with water—the Golden Gate Bridge in San Francisco and Niagara Falls in New York State.

Of the two, the Falls undoubtedly has seen far more suicides, as people were using it long before the bridge was built. American police at the Falls recorded 85 known suicides on their side in the 15 years ending August 1959 and reported that at least as many persons threw themselves over the Canadian side. They estimated that year after year one person a month uses the Falls to kill himself.

The Golden Gate Bridge was opened in 1937 and the 190th known suicide leaped from it in October 1959. In addition, police report that they have prevented hundreds of others from jumping from the mile-long, 250-foot-high span. One state highway patrolman assigned to the bridge is credited with having prevented 80 suicides in the three years ending August 1958. Another reported he had stopped 217 persons from jumping in the nine years ending April 1953. The figures average out to about three persons a month attempting to leap off the bridge, two of whom are prevented.

Bridges seem to have a particular fascination for suicides. Curiously, many people go to a bridge to kill themselves without jumping from it. Suicides frequently walk out on bridges and then take poison. They hang themselves from the girders or from the underside. Others choose a bridge as a place to shoot themselves. Some of those who choose to shoot themselves while speeding along in their cars—a surprisingly frequent method of suicide—wait until the automobile is on a bridge before they pull the trigger.

Many cities have "suicide bridges." In Pasadena, the Colorado Street Bridge over the Arroyo Seco, 150 feet high, claimed 80 lives before the city erected high fences on it in August 1937. An occasional suicide, determined to use this particular bridge, still manages to inch his way around the end of the fence, crawl to the center, and jump. The high bridge over Sydney Harbor is one of Australia's suicide spots. When the bridge from Philadelphia to Camden, New Jersey, was built it attracted many suicides. It also attracted a number of husbands who wished to abandon their wives. They would walk to the middle of the bridge, leave some clothing and a suicide note, then walk off and vanish. The practice gave birth to the phrase "Philadelphia divorce."

One city had a "suicide hall." In New York's fabled Bowery many

years ago there was a saloon whose back room became the mecca for vagrants bent on suicide. So many killed themselves in the room that it was dubbed "Suicide Hall."

New York's famed Coney Island once had a reputation for suicide. In the 1890s the amusement park teemed with prostitutes. Each year when the season ended and the girls saw their customers dwindling away, some would kill themselves rather than remain stranded there.

A surprising number of New Yorkers choose what would seem a most unlikely place for suicide—the back seat of a taxi cruising through the city. Every four or five years such a case is reported in the press. One youth poisoned himself in a taxi, another shot himself. On October 12, 1940, Broadwayites were startled to see a woman in a taxi trying to strangle herself with a belt. The driver was oblivious of what was going on behind him until he was aroused by the shouts of passers-by. He took one look and sped his fare to Bellevue Hospital.

One of New York's landmarks, the Empire State Building, the world's tallest, has had few suicides. In the first 12 years after it was completed in 1931, only five persons leaped from it. Then, in the four years from 1943 to 1947, 11 persons jumped. In January 1947 the body of a man who leaped from the eighty-sixth-floor observation tower landed on a woman in the street, critically injuring her. The accident attracted a lot of unfavorable publicity concerning the danger of walking near the building. Window cleaners at the building told reporters the suicides were making them nervous. After being narrowly missed by a hurtling body, one quit.

In late 1947 the building's owners installed a seven-foot spiked fence around the observation tower and hired extra guards. Since then there have been no suicides from the observation tower, although people still occasionally jump from the windows.

The majority of those who jump from buildings choose the building in which they live. Figures for New York City show that more than half jump from their own dwellings. Next most popular place is some other residence building. Office buildings—usually skyscrapers—hotels, and hospitals are the next three categories of

building most often used. Although two men have jumped from the George Washington Bridge over the Hudson River within an hour of each other, New York City's bridges are not chosen as often by suicides as are those in other cities.

In the nation's capital, at least one man has plunged from the top of the Washington Monument. Another hanged himself in the basement of the Lincoln Memorial. A third chose to shoot himself in the Senate wing of the Capitol building, just outside a door to the Senate chamber. The Senate was in session and the debate continued without interruption.

Most cities around the world have sites which are favored by those bent on ending their lives. The column in the Place Vendôme in Paris was closed to the public in 1881 because of the number of people who jumped from it. Paris also boasts the Eiffel Tower, the world's third-tallest structure, from which about 40 persons have jumped since it was built in 1898.

In Rome, St. Peter's Basilica, the world's largest church, attracts suicides, many of whom plunge 170 feet to the main floor of the church from the walk around the inner dome. Any suicide or homicide within a Roman Catholic church is considered to have violated the edifice, which then must be reconsecrated. Immediately after a suicide in St. Peter's Basilica, guards clear the church and lock it. No one is permitted to enter until after a reconsecration ceremony has taken place.

There is a long tradition that many unlucky gamblers have killed themselves in and around the famed casino at Monte Carlo. But here history blurs into legend, since its executives treat the question of suicides on the premises as the skeleton in the casino's closet. To them the very word is anathema. Even the police of Monaco have over the years been purposefully vague in their replies to reporters inquiring about suicide.

Whether their attitude indicates that there have been many suicides of gamblers or that they merely wish to keep the legend alive is a matter for speculation. In all probability far fewer persons have killed themselves at the casino than the world has been led to believe. Three or four suicides a year is one informed estimate

for the casino's golden years a few decades ago. It is believed the number is far fewer these days.

Jumping off a ship at sea is a time-honored method of killing oneself. In 1959 suicide was the third leading cause of death among the crews of United States commercial vessels. According to the January 1960 issue of *Proceedings of the Merchant Marine Council,* 34 of the 411 men who died aboard ship during the year were suicides, most by jumping overboard.

Some people appear to have an urge to kill themselves before an audience. Theaters occasionally play host to people who shoot or poison themselves during a performance. One man jumped from a balcony of the Opéra Comique in Paris during the show.

Bela Morvay, a well-known European clown, chose to end his life before his audience at a circus in Budapest in 1926. In the middle of a performance he took poison.

Shooting galleries in penny arcades have their quota of people who walk in, pay to shoot, and turn the gun on themselves. Suicides quite often walk into a bar or restaurant, ask for a glass of something to drink, and drop poison into the liquid. After quaffing the poison they sometimes hand back the glass with a warning to wash it well. In August 1949 a well-dressed man walked into a crowded cabaret in Las Vegas, ordered a full meal, and ate it. When the waitress brought the check, he pulled out a revolver and shot himself in the head.

The site for their suicide appears to be chosen on the spur of the moment by some persons. In August 1948, for instance, a woman walked into a Brooklyn butcher shop, picked up a five-inch knife from a chopping block, and stabbed herself to death. A year later a man walked into a grocery store, said "hello" to the proprietor, sat on a barrel, and shot himself.

More women than men commit suicide at home. Many people display lifetime habits of tidiness in the act of ending their lives by sitting in the bathtub before shooting themselves, stabbing themselves, or slashing their wrists. They often get into the tub fully clothed. Both men and women sometimes kill themselves while lying in bed without awakening their sleeping spouses lying beside

them. In Kendallville, Indiana, in April 1947, a 36-year-old man shot himself to death while sitting in his wife's lap.

The grave of a loved one is a symbolic site chosen by many suicides. In July 1949 a 23-year-old California pilot, whose wife had died four months earlier in childbirth, flew around for hours and then power-dived his plane into the cemetery near her grave. Some people are influenced in their choice of a site for suicide because a loved one once killed himself there previously. In 1948, for instance, a 44-year-old man jumped from the George Washington Bridge at the precise spot from which his father had jumped six years previously.

Chapter VI

SUICIDE CAN BE CONTAGIOUS

Suicide can be contagious. Entire families have carried out suicide pacts. People have formed suicide clubs for the purpose of mutual self-destruction. Whole cities—even nations—have been swept by epidemics of suicide.

Many of us have heard at least one tragic report of an entire family wiping itself out by suicide. In 1932, for example, a Brooklyn woman died of natural causes. The next day her husband and their four daughters killed themselves.

In South Africa in 1955 five daughters of an Indian family, aged 14 to 26, hanged themselves from two trees because they were so severely excluded from the rest of the world—an institution known as purdah.

One of the largest family suicides on record occurred in France in November 1946. A miner, his wife, and their seven children roped themselves together and leaped into the La Basse canal in Béthune.

Although many of us are familiar with Robert Louis Stevenson's short story "The Suicide Club," we find it hard to believe that such groups ever actually existed. Stevenson's tale concerns a group of young Londoners who met regularly to draw lots. Cards were dealt and the member who drew the ace of clubs was commissioned to kill the one who drew the ace of spades. Fine stuff for a fiction thriller, but nothing more, most of us would say.

Yet such fantastic clubs have existed.

One caused a major scandal in Russia in 1928. The well-documented findings of the government investigators who uncovered it were reported in Moscow's *Komsomolskaya Pravda* (the official organ of the Communist Youth Organization), the New York *Times*, and other newspapers.

A youth named Bresgin, founder of a Communist Youth Center in the town of Liesva in the Ural Mountains, hanged himself in August 1928. His death was little noticed except by his relatives and friends. But when 12 more boys and girls, all members of the Liesva Communist Youth Organization, killed themselves within as many weeks after Bresgin, the shock reached all the way to Moscow. Special investigators were sent.

They found that the dead youngsters had been members of a suicide club. The group had been organized in honor of and in imitation of Sergei Esenin, stormy, brilliant Russian poet and former husband of American dancer Isadora Duncan. He committed suicide in 1925.

Instead of the regular meetings for the prescribed "Communist work and study," the members of the Liesva Youth Center had been holding secret conclaves at which they read Esenin's poetry and discussed the futility of existence. They debated such questions as "Is life worth living?" and "Is suicide justified?"

A similar club was uncovered in the little Austrian town of Krems in December 1930. Herbert Ehrenberger, 15, a student at the Krems technical high school, shot himself to death near the school. The suicide was reported by a classmate, Franz Krauss, who told school officials that he and Ehrenberger had entered into a suicide pact, but that he lacked the courage to go through with it after he saw his friend die.

A police investigation revealed the existence of a suicide club in Krems. Scores of school children, boys and girls, paid monthly dues for the purchase of guns and bullets. Boys were charged one schilling a month for the ammunition, and girls half that amount.

After three youths killed themselves within a short time in 1932 in the town of Medellín, Colombia, it was reported that they had

belonged to a suicide club whose dozen members had pledged to kill themselves within a year.

Another suicide club was reported in Bogotá in 1940, when two boys and a girl killed themselves on two successive days by exploding dynamite sticks which they held in their mouths.

Large-scale suicide epidemics swept across Europe from the fourteenth to the seventeenth century. Scores and sometimes hundreds of people, mostly women and children, would be seized by a mania whose main symptom was an uncontrollable urge to dance. A few would begin whirling, jumping, and raving, to the delight of amused spectators who quickly gathered.

But soon the spectators themselves were infected by the mania. Before long there might be hundreds dancing in the streets, sometimes clasping hands to whirl in huge circles. The whirling and jumping continued until the dancers fell into convulsions or died of exhaustion. Some became so ecstatic that they killed themselves by butting their heads against walls. The mania struck particularly hard at the women of Naples in the sixteenth and seventeenth centuries, and hundreds danced into the sea and drowned.

Small outbreaks of the dancing mania had been reported in southern Italy as early as the tenth century. It was called tarantism, after the town of Taranto. In Naples and some other areas, the name gave rise to the superstition that the dancing was caused by the bite of the tarantula spider. The memory of this medieval suicide mania is preserved in the modern whirling dance called the tarantella.

Religious manias have caused suicide epidemics. One of the most impressive began in Russia in 1666. At that time a sect of fanatics called the Old Believers expected the imminent arrival of the Antichrist. To escape him, and thereby improve their chance of entering heaven, some peasants began committing suicide. The fear and fervor spread until such peasant suicides reached epidemic proportions, with scores killing themselves daily.

Unscrupulous laymen and clerics, greedy for the peasants' properties, increased the suicides by deliberately preaching that the Antichrist was coming. At first the peasants chose to starve to

death. The avaricious found this method too slow for their purpose. It also permitted a man to change his mind. The preachers then promoted fire as a surer and faster way of reaching heaven.

Commenting upon this in his book on suicide published in 1938, Henry Romilly Fedden said:

"Suicide drives were organized on a large scale so that places might be vacated for the ambitious, and property fall to the greedy. Dull-witted peasants allowed themselves to be immured or even jockeyed towards the flames by rascals who played on their fears and credulity."

If the peasants hesitated, their fear of the flames was overcome by false reports that troops were on their way to deliver peasant souls to the Antichrist. At the height of the panic whole communities—hundreds of persons—were induced to die together on gigantic fires. Even the children were not spared, being lured to the blaze by descriptions of the goodies that awaited them in heaven.

In the summer of 1856 a similar delusion affected the Kaffir tribes of South Africa. One of their religious leaders, Amaxosa, prophesied the resurrection of all their dead heroes and warriors, on condition that they themselves end their lives. Some 50,000 Kaffirs committed suicide before the epidemic ended.

A suicide wave hit a community of Old Believers in the Crimea in 1896. Twenty-five let themselves be buried alive to escape a national census for military service.

A book caused waves of suicides in the late eighteenth century. This was Goethe's romantic novel *The Sorrows of Werther,* published in 1774. Werther, the hero, is a lovesick youth who kills himself with the pistol of the rival who won the girl. The melancholy tale enraptured all Europe. It was a huge success and was translated, dramatized, and imitated. *Werther* inaugurated a fashion of dreamy, melancholy love. Disenchantment with life, *Weltschmerz,* became a fashionable malady.

Copies of *Werther* were found on the bodies of so many suicides that a Protestant pastor denounced Goethe as a murderer. Sale of the book was banned in Leipzig. After an Italian translation ap-

peared in Milan, the Catholic clergy bought up the entire edition there.

The suicidal romantic melancholy which affected so many readers of *Werther* became so well known that it was dubbed "Wertherism." Those whose suicides were precipitated by the book were said to have been suffering from "Wertheritis."

"The effect of this little book," Goethe later wrote, "was great, indeed immense, and especially because it hit at exactly the right moment. For as it only needs a small priming powder to blow up a powerful mine, so the explosion which took place among the public was mighty, because the youthful world had already undermined itself. The convulsion was so great because everyone with his exaggerated demands, unsatisfied passions, and imaginary sorrows broke out."

Sometimes after a person has killed himself, the spot he chose exercises a weird fascination on others, thus setting off a wave of suicides at the spot. Two such instances in France were described by Fedden:

"At the *Invalides* there had been no suicide for two years when a soldier in 1792 suddenly took it into his head to hang himself from a beam in one of the corridors. Within a short space of time twelve other invalided soldiers (five within a fortnight) had followed his example, stringing themselves up to the same beam. When eventually the governor tardily but wisely closed the passage the suicides ceased. It was this particular beam that was the irresistible attraction. Similarly in 1813 in the quiet village of Saint Pierre Monjau, a woman hanged herself from a large tree. It was not long before several other women had repaired to the same branch."

In recent times the greatest epidemic of suicides at one particular spot began in the early thirties. It reached such proportions that it awed the world and troubled a nation. Laws were passed in a futile effort to end it. A huge tourist industry was founded to cater to those who came to die and those who came to watch them die. A steamship company grew rich on the epidemic. Within two years an obscure mountain was transformed into the world's leading site for suicide. Although the epidemic has abated, the moun-

tain remains one of the most suicidal places on earth. Its sudden rise to prominence is a fantastic story.

Before 1933 the island of Oshima, 59 miles from Tokyo and only 36 square miles in area, was a dreary, barren place. It attracted only a few tourists, who went to see the sulfur clouds boiling out of the crater of its volcano, Mount Mihara. They made the trip from Tokyo on the one small steamer, the *Kiku Maru,* which called at the island three times weekly.

Two of these tourists, Mieko Ueki, 24, and Masako Tomita, 21, classmates at the Jissen Girls Higher School, one of the most exclusive schools in Tokyo, scaled Mount Mihara on January 7, 1933. When they reached the crater Mieko told her friend that she intended to jump into the rumbling, smoking volcano.

Masako protested, but Mieko explained that she had visited the island the previous year, had been awed by its beauty, and believed in the legend that the bodies of those who jumped into Mihara's fiery pit were cremated instantly and sent heavenward in the form of smoke. This, she explained, was a beautiful, poetic form of death, much to be desired by anyone who had decided on suicide. After much discussion Masako agreed not to try to prevent her friend's suicide. Mieko's last request was that her friend keep her death a secret for five years. Masako promised. The two girls bowed ceremoniously. Then Mieko jumped.

Masako returned to Tokyo and kept her promise for a few weeks. But then she confided her secret to another school chum, Kiyoko Matsumoto, 21. As soon as Kiyoko heard about the legend of the volcano she declared that she wanted to follow Mieko to paradise through Mihara's gateway. She insisted that Masako act as her guide to the volcano. Kiyoko threatened that if Masako did not agree and also keep her death a secret she would tell everyone about Mieko's suicide. Masako was distraught at the thought of going through the experience again, but under Kiyoko's pressure she finally agreed.

On February 12, 1933, the two climbed Mihara and only Masako came down. Villagers observed Masako's agitation on her return and noted that while earlier she had a companion, she was now

alone. They notified the police. It did not take them long to get the startling tale out of the sobbing, overwrought girl.

In the land where heroic suicides are revered, the story created a nation-wide sensation. The poetic deaths of the two upper-class girls, coupled with the legend of the volcano, were major events in the life of Tokyo and its newspapers. Every paper rushed through extra editions. Sob sisters gushed ecstatic accounts of the suicides. Magazines ran endless stories discussing the matter from every conceivable angle and a few inconceivable ones.

The endless questions of the police who were checking out her story and the emotional battering of the publicity were too much for Masako. She fell ill and died in April. There were more extras, more excited comment, and many more magazine stories carrying broad hints that she, too, had killed herself.

Overnight Mihara became a national attraction. Crowds of the curious flocked to Oshima to see the spots where such romantic events had occurred. Passages on the little *Kiku Maru* were booked weeks in advance. The company upped the schedule from three sailings a week to a daily passage and decided to build a larger boat for the run.

Many also were drawn by the lure of the volcano's legend. They went to follow Mieko and Kiyoko. On the first Sunday in April 1933, six persons plunged through the sulfur clouds into Mihara's fiery maw and 25 others were forcibly prevented from leaping. As the weeks went by, the tourists were almost assured of being able to see at least one suicide every day. Days on which as many as five or six persons disappeared into Mihara's smoke became more and more frequent.

In time the crowds came more to see the suicides than Mihara itself. They milled around the edge of the crater, waiting for someone to jump. After standing around for several hours without seeing any action, one disgusted tourist shouted laughingly at the crowd: "I dare someone to jump!" A moment later a man ran forward and leaped into the volcano. After that there was less levity at the crater's edge.

By the end of 1933 Mihara had claimed a total of 143 known

suicides. Newspapers declared it was obvious that many persons had vanished into the volcano without anyone being aware of it, and put the number of suicides at Mihara nearer 500. By the end of the year the police of Oshima were near panic because they were held largely responsible for their inability to check the strange suicide craze.

The nation's tradition, religion, and philosophy taught the Japanese to admire heroic suicides who committed hara-kiri for what were deemed to be logical reasons. But they were not proud of the spectacle of hundreds of their countrymen leaping to death because of a romantic fallacy.

Oshima's police chief appealed to Tokyo for help, and the government sent him a dozen specially trained men. By the end of 1934 the police had forcibly prevented a staggering total of 1,200 persons from ending their lives in Mihara's pit. As many as 20 would-be suicides at a time were locked up in Oshima's jail, awaiting relatives to claim them.

But despite the best efforts of the police, at least 167 persons leaped into Mihara during 1934. In addition, 29 of those who had been saved at the crater's edge fulfilled their intentions by leaping from the boat taking them back to Tokyo. Other countries were as awed as Japan, and Mihara made headlines around the world.

Seeing a magnificent chance to increase circulation, a third-rate yellow journal in Tokyo, the *Yomiuri Shimbun*, announced it would send an expedition to lower a man deep into Mount Mihara's fiery innards. He would retrieve a body to prove that those who jumped into the volcano were not instantly cremated and sent heavenward. This announcement created yet another sensation. To hold their own readers, rival papers were forced to publish lengthy accounts of preparations for the expedition. Mitsuo Miyazaki, city editor of the *Yomiuri*, told American reporters:

"To beautify death and make it a dream," he said, "is the desire of all Japanese suicides. That is why they select such trysts as the Kegon Fall in Nikko, the beach at Kamakura, and the craters of Asama, Aso, and Mihara, all of which are famous for their magnificent beauty.

"What we desire to prove is that there is nothing beautiful in plunging into the pit of Mihara. In fact, we wish to bring up evidence that the bodies of the victims do not vanish into the smoke as the suicides believe and hope, but remain rotting on ledges of the crater. . . .

"We wish to prove that death in Mihara's crater is not instantaneous and painless, but that many of the victims writhed in pain and agony from bodily injuries and poisonous gases for hours before death ensued."

Dr. Seizo Nakamura, a scientist who had studied the volcano for many years, commented:

"Recently people have flocked to Mihara to commit suicide in the belief that their bodies would vanish forever. If the belief of these poor people can be shattered and the pitiful condition of the bodies of the hundreds of suicides revealed in their true condition, rotting on the ledges of the crater, people will soon convince themselves that the mountain possesses no mystic power, and this undoubtedly will put an end to the suicide craze."

A derrick was set up on a platform at the volcano's edge, and a small gondola was attached to the end of the cable. Equipped with an oxygen mask, one of *Yomiuri*'s editors descended 1,250 feet into Mihara's explosive interior before the gondola landed on a ledge and could go no further. He saw several bodies on ledges but was unable to recover one.

Ironically, the expedition enhanced the myth it was intended to disprove. Since no bodies had been recovered from Mihara, simple-minded people believed more fervently than ever in the legend of the volcano. *Yomiuri* sold nearly a million copies of the edition describing the descent into the mountain. The lure of Mihara continued unabated.

Despite protests by those who deplored the spectacle, the nation was fascinated. Whenever interest seemed to flag, something extraordinary would occur at the edge of Mihara's crater to compel attention. On January 25, 1935, for instance, three young men leaped to their deaths within ten minutes while a Buddhist religious ceremony was in progress. A few months later an army recruit was told

by his drill instructor that he was so stupid he should kill himself. The next day his hat and bayonet were found at the edge of Mihara's crater with a note which read: "I always obey the commands of my superior officer." The scandal rocked the army.

By now the police were maintaining a 24-hour watch at the crater's edge. A Mount Mihara Anti-Suicide League was formed. It built a fence around the crater and erected an arrangement of mirrors to give spectators a terrifying view of the fiery violence inside the volcano. In 1936 the original fence was replaced by a higher one made of barbed wire and the guard force was increased.

But still the suicides managed to fling themselves into Mihara. The Associated Press reported that in 1936 alone 619 persons leaped to their deaths inside Mihara, bringing it the dubious renown of luring more suicides than any other spot on earth.

The suicide epidemic brought to Oshima a boom comparable to the Florida land craze of 1925–26. From a barren, desolate place, it blossomed into a combination national shrine, Coney Island, Atlantic City, and Niagara Falls. The island's population increased greatly. Fourteen hotels and 20 restaurants opened within two years. Horses were imported to carry tourists to Mihara's summit. Five taxicab companies opened for business. By 1935 the island's photographers had increased from two to 47. A post office was opened at the crater's edge. A strictly amusement-park touch was added with the construction of a 1,200-foot chute-the-chute down Mihara's slope to provide the visitor a final thrill.

In 1937 an Associated Press reporter noted:

"The path up the mountain is like that to a shrine. Carefully banked, drained and leveled, it is filled from 4 A.M. until dusk. A venerable grandfather thinks nothing of making the trip with a grandson strapped to his back, and school girls make the pilgrimage a class holiday."

The Tokyo Bay Steamship Company replaced the *Kiku Maru* with two new large ships, declared a 6 per cent dividend on stock which had paid no dividends for the previous three and a half years, and reported that its net profit was now running to $280,000 a year. Part of this income was provided by a spectacular addition

which the steamship company made to Mihara's attractions. The company had imported three camels to carry tourists across the mile-wide strip of volcanic desert which surrounds Mihara's crater. The first of these animals most Japanese had ever seen, they were an instant, money-making success.

In an effort to escape the onus of profiting on suicide, the steamship company refused to sell one-way tickets to Oshima. The government backed the company with a law making it a criminal offense to attempt to purchase a one-way passage. Plain-clothes men were assigned to mingle with the passengers on the ships, with instructions to arrest anyone who appeared to them to be bent on suicide.

In the years since the early thirties, Mount Mihara's mysterious lure has weakened, but by no means disappeared. Despite the guards and the fence, the volcano still attracts people bent on self-destruction, still makes occasional headlines. In 1955, for instance, newspapers around the world carried a story which reported that the incredible had happened at Mihara—someone was rescued after having jumped into the volcano.

A young couple leaped into Mihara's pit on January 6, 1955. Shortly after, spectators and guards were startled to hear the first cries for help which had ever issued from the rumbling inferno. Since the *Yomiuri* expedition no one had entered the belching cauldron; it would be considered dangerous and foolhardy to try. Besides, since no suicide who leaped into the inferno had ever been heard from again, the police were not equipped with the protective clothing and oxygen masks needed for a descent, nor was any available on Oshima.

For a night and a day the chief of the detectives guarding the crater pondered his dilemma while the cries for help from the volcano's throat amazed the tourists. Then he called for six volunteers and led them, roped together, down into the pit, wearing only their street clothes and using wet towels for masks. On a ledge 500 feet down they found the injured couple and brought them out.

Thus ended the latest in the long series of astonishing events at Mount Mihara, by all odds the one place on earth where the greatest number of people have killed themselves.

Chapter VII

SUPERSTITION VS. REASON

THE suicide problem has troubled every civilization the world has known. Nearly all the world's major philosophers and many of its leading lawmakers have wrestled with the moral, legal, and practical questions which arise when a human being voluntarily ends his life. Every religion has taken a stand on the issue.

The history of suicide in Western civilization reveals a constant battle between reason and superstition, with now one and now the other in the ascendant. When superstition was supreme, as it has been during much of Western history, the story of suicide is one of strange beliefs and weird customs. Only in the past century has suicide come to be regarded as a subject whose causes and dimensions can be investigated scientifically. It is in the past century, too, that large segments of the populations of Europe and America developed an attitude toward suicide which had never before existed—that it is a subject to be avoided because it is not "nice."

Even the most primitive societies devoted much attention to suicide. And it is to them that we must look to find the origin of the horror of suicide which even today makes the subject as little worthy of polite discussion as sexual aberrations.

Some primitives, such as the ancient Gauls and the Germanic tribes, had no fear of suicide. They held the view that only a violent death entitled a warrior to enter Valhalla. If a man were not

killed in battle it was quite honorable for him to kill himself to ensure happiness in the next world.

In most primitive societies, however, the dead were regarded as spiritually unclean. The most unclean were the unnaturally dead, those who had met a violent end. The primitive believed that a man who had been snatched from life before his time would be angry. He would naturally want revenge on those who had dispatched him. The soul, resenting being torn from its body too soon, would certainly haunt the living.

The suicide was feared most, for it was generally believed that one who ended his own life must have been severely wronged or troubled. His spirit would be particularly vengeful and would perhaps try to wreak vengeance on the entire tribe. Many primitives did, and still do, commit suicide for revenge, believing that as a ghost they will have more power to trouble their enemies.

The living soon devised ways to protect themselves from the suicide's ghost. The Australian aborigines, for instance, cut off the thumbs of enemies they had killed so that their ghosts would not be able to throw a spear at the killers. Some tribes decapitated the suicide's body to render the ghost harmless. Others dispatched the body of the suicide far from their territory, often sending along the instrument of death, even if it had been a large tree. The ghost would thus be "lost" and so be unable to return to the tribal area to haunt the living.

This custom survived into medieval Metz, where the bodies of suicides were put into barrels and floated down the Moselle River to the sea. Some tribes burned the suicide's body to prevent the ghost from walking. However, the belief was widespread among other primitives that a man's spirit could not rest until his body was buried. In tribes holding this idea, the suicide's body was thrown into the bush to be devoured by animals as a form of punishment, for then the ghost would have to "walk" forever.

Punishment of the suicide's body or ghost was found most generally in the smaller tribes which had been deprived by the suicide of a useful warrior or a potential mother. The motive was basically economic—the tribe was angry because it had lost a productive

unit. This anger at the suicide for depriving the community of a useful member carried over into the civilization of early Greece, which treated suicide as a political offense against the city-state.

In his book *Suicide,* Dr. James J. O'Dea says: "The legal punishment of suicide in the Greek states was this: No honors were allowed to the memory of the deceased; his name was branded with infamy; his body, subjected to indignities, was not to be cremated, as was the honored custom throughout Greece, but interred underground in some lonely and unfrequented spot, like the bodies of conspirators, traitors, tyrants, sacrilegious wretches, and criminals generally, whose allotted punishment was impalement alive on a cross. By Athenian law, moreover, the hand which had done the deed was to be lopped off and buried away from its parent body."

One form of suicide—slow starvation—was exempted from punishment. This was presumed to be a calm, considered act free of the anger which made the ordinary suicide haunt his fellow men after death. Since no violence was involved, the suicide's spirit had not been suddenly wrenched from the body and would not be angry.

Despite the desecration of those who killed themselves, the Greeks did not consider suicide a sin *per se.* The act was regarded purely as a political offense and only when it was viewed as having been committed irresponsibly. In some of the Greek communities, those over 60 were permitted, and occasionally expected, to end their lives. Other communities set up tribunals to hear the arguments of anyone who contemplated suicide. If his reasons were deemed sufficient by the magistrates, permission was granted and the suicide would not be dishonored. Some tribunals even supplied a dose of poison along with an affirmative decision.

Suicide for what was thought to be good reason was regarded with admiration in the ancient Greek legends and in the writings of Homer, who lived and died before 700 B.C. The earliest suicide mentioned in Greek literature is that of Jocasta, mother of Oedipus, who hanged herself after discovering that she had been living with her son, the murderer of her husband. Homer attached no blame to

her act, regarding it as the only dignified way out of an intolerable situation.

Some of the early Greek philosophers, chief among them the mathematician Pythagoras (582–507 B.C.), opposed suicide. Pythagoras argued that since human beings were the chattels of God they had no right to leave this world without his permission. He viewed humans as soldiers under the command of God and was the author of the famous dictum: "No man should abandon his post in life without the orders of the Great Commander." He used his theory of numbers to strengthen the argument, declaring that there were only so many souls available for use in the world at any given moment. The suicide upset this spiritual equation because there might not be another soul ready to fill the gap left by his unscheduled departure.

Socrates (470–399 B.C.) upheld Pythagoras' views. However, he added the proviso that since the will of God could be made manifest, in some circumstances a man could be assured that it was necessary for him to end his life. The divine will was made plain to Socrates when the Athenian court found him guilty of a variety of transgressions and ordered him to drink a fatal cup of hemlock. Although escape was possible and his friends urged it upon him, he elected to stay and die as commanded.

Plato (428–347 B.C.) upheld the general condemnation of suicide, considering it an unnatural act because a man is his own closest friend. He admitted many exceptions to the general rule, however, saying that in addition to suicide being justified when ordered by the state, it also was acceptable in cases of extreme poverty, sorrow, or disgrace.

Aristotle (384–322 B.C.) also opposed suicide, considering it cowardly. He made no mention of divine prohibition, objecting to the act mainly because it was an offense against the state.

Despite the attention devoted to it by the philosophers, suicide was not frequent among the early Greeks. They were imbued with religion and did not consider life a burden, as some later peoples did. The Greek city-state also ruled most areas of life and left little for the individual citizen to worry about.

As the old religion weakened, however, there arose schools of philosophy which held that a man's conscience, not the government, should tell him how to live. The greatest of these schools of thought, Epicureanism and Stoicism, had a tremendous effect on the Greco-Roman world. The vast majority of the educated citizens in the Hellenistic and Roman worlds adhered to one or the other.

Epicureanism advocated such utter indifference to life that suicide was accepted with a shrug. Stoic teaching definitely favored suicide. Under their influence and with the increasing responsibility of each man for his decisions, suicide increased.

Epicureanism was found by Epicurus (342–270 B.C.). He taught that man should live for pleasure alone. He also denied that the gods concerned themselves with human affairs. The Epicureans felt that happiness consisted in freedom from pain. Pain is caused by desire; consequently, the suppression of desire is the way to secure a happy life. Men should live for themselves alone, concerning themselves with nothing but the comfort of their minds and bodies.

Another source of pain, in the Epicurean view, was fear of death. Unless man freed himself from this fear he could not attain peace of mind, which the Epicureans held to be the ultimate happiness. Epicurus taught that the soul died with the body, that death was the extinction of consciousness, and that there was no afterlife.

"We should not shun life or fear death," Epicurus wrote. "We want a pleasant life, not a long one. To live well is to learn to die well."

Stoicism was founded in Athens toward the close of the fourth century B.C. Like the Epicureans, the Stoics believed that emotion and desire were the cause of pain. The conquest of emotion and desire by reason was the chief end of life. The triumph of reason meant rising above all the petty cares and enjoyments of life and the attainment of serenity of mind.

"Death," the Stoics said, "is the only evil that does not afflict us when present. While we are, death is not; when death has come, we are not. . . . Death is the end of all sorrow. It either secures happiness or ends suffering. It frees the slave from his cruel master,

opens the prison door, calms the qualms of pain, closes the struggles of poverty. It is the last and best boon of nature, for it frees man from all his cares. . . ."

A danger in Stoic doctrine was the facility with which trivial discomforts might be held to justify suicide. Zeno, the founder of Stoicism, fell and wrenched his finger one day. He struck the ground with his hand and declared: "Earth, dost thou demand me? I am ready." The philosopher then went home and hanged himself.

His successor as leader of the Stoic school, Cleanthes, developed a boil, and his doctors ordered him to fast for two days. When the condition cleared up and the doctors told Cleanthes he could eat again, he refused, saying that since he had gone so far along the road to death he did not care to turn back. He starved himself to death.

The Romans embraced Stoicism enthusiastically, and suicide, which had not been frequent under the Republic, became widespread under the first Roman emperors. Seneca, Cato, Marcus Aurelius, and many other noted Romans wrote in favor of suicide as a solution to life's troubles. Seneca and Cato committed suicide calmly and deliberately and were admired for centuries.

The upper stratum of Roman society lived precariously in the century before and the century following the birth of Christ. Civil wars followed one another, and victory went usually to the strong and unscrupulous. Violence and spilled blood were commonplace. The despotism and irrational cruelty of an emperor like Nero kept the upper classes in a constant state of turmoil. To live at all in such circumstances, it was necessary to develop an indifference to death. The Stoic doctrine appealed to these people who lived constantly in social uncertainty and danger. It gave them the intellectual justification for making suicide acceptable. Stoicism enabled them to elevate suicide to an honorable means of escape when their situation became too difficult.

Another force tending to make suicide widespread in the Roman Empire was the contempt for pain and indifference to cruelty which was characteristic of the ancient world. Today we can hardly

conceive of the attitude which was prevalent in the Greco-Roman world. Fedden has described one way in which it showed itself:

"At Rome in the time of the Punic wars it was not only possible but easy to secure candidates for execution at the cost of 5 minae (about $100), to be paid to the dead man's heirs. Such competition was there to die at this price that many people secured the privilege by offering to be beaten to death rather than executed—a more painful and spectacular bargain. As far as can be judged these candidates for execution were beheaded or cudgelled solely to provide amusement for jaded spectators. Real death was thus the fare of the theatre-going public. . . ."

Suicide eventually became so commonplace in the Roman Empire that many of the upper classes consummated the act with astonishing levity. The voluntary death of Petronius, the Beau Brummell of his day, was typical of many. Because he was an aristocrat with perfect taste and a connoisseur of sensations, Nero made him the director of court entertainment and gave him the title of *Arbiter Elegantiae*, the Judge of Elegance.

In 65 A.D. Petronius fell out of favor, was implicated in a plot to assassinate the emperor, and anticipated that Nero would order his death. The young man about town summoned his friends to a sumptuous banquet, excused himself while they dined, and opened his veins. He returned to the table with bandaged wrists. Throughout the afternoon he exchanged witticisms and the latest gossip with his companions, periodically bleeding himself. After the banquet he wrote a letter to Nero in which he joshed and twitted the man who ruled the world. Then he lay back on a couch, opened his veins for the last time, and died.

It became customary for Romans like Petronius, who were accused of crimes against the state, to commit suicide rather than await formal execution. Roman law provided for confiscation of the property of anyone executed for crime, but by committing suicide this penalty was avoided.

In Roman law suicide as such was never made a crime. The law took a pragmatic view, not concerning itself with any inherent rightness or wrongness of suicide, but only with the way it af-

fected the national treasury, the army, or the conduct of business. It was a punishable offense, involving forfeiture of property, only for some classes of criminals who killed themselves in the hope of avoiding the confiscation which would follow conviction.

Suicide by soldiers was regarded as desertion of their post and the soldier's property was forfeit. Attempted suicide by a soldier was punishable by death.

Another special group singled out by legislation were slaves. A slave was not punished for attempted suicide, since the Romans believed that every man, even a slave, had a right to his own life. But if a slave attempted suicide within six months of sale, the buyer could return him to the seller. Behind the rule lay the idea that a slave capable of attempting his own life was also capable of attempting the lives of others.

With the decline of the Roman Empire and the rise of Christianity, attitudes toward suicide became the province of theology rather than philosophy. Many who are familiar with Christian strictures against suicide today are under the impression that the religious prohibitions against the act are based on the Bible. This is not true. Neither the Old Testament nor the New Testament prohibits suicide. And in the early Church the attitude toward suicide did not differ greatly from that of the Greeks and Romans.

There are seven suicides in the Bible, and they are mentioned without condemnation.

Samson killed himself in the act of destroying the Philistine host. Saul called on his armor-bearer to slay him to avoid capture by the Philistines. When the man refused, Saul fell on his sword. Seeing his master dead, the armor-bearer followed suit. During the siege of the tower of Thebez, Abimelech was badly wounded by a stone thrown by a woman among the defenders. Believing that he would die from the wound, he killed himself so that it should not be said a woman had slain him. When Absalom rejected his advice to march on King David, Ahithophel hanged himself. He is reported to have received proper burial in his father's sepulcher. Zimri burned a palace over his head after he was defeated by Omri. Judas hanged himself after betraying Christ.

The earliest Christians were morbidly obsessed with death and committed suicide in large numbers for religious reasons. Many killed themselves to avoid falling into the hands of the persecutors of the Church. Special merit attached to those who were martyred while professing their faith. Great numbers who were not threatened sought out martyrdom to gain this merit. Under the more merciful Roman emperors Christianity was tolerated. This led some Christians to fear that opportunities for securing the crown of martyrdom would cease, and the more fanatical resorted to provoking the Romans.

They deliberately disturbed pagan religious services or defiled the idols and then demanded that the magistrates sentence them to death. Sometimes, when no one would accuse them, they accused themselves. This practice became so widespread that some Roman magistrates refused to proceed against would-be martyrs on their own testimony.

Arrius Antonius, a proconsul, was driven to exasperation by a crowd of self-accusing Christians which surrounded him. He demanded to know why, if they were so anxious to quit life, they could not find their own ropes and precipices and save the courts the trouble of trying them.

The early church fathers approved of those who deliberately sought death. St. Anthony traveled 200 miles for the express purpose of finding a martyr's death. Ignatius, third bishop of Syrian Antioch, begged that he not be deprived "of the crown of martyrdom." St. Cyprian of Carthage, perhaps the greatest churchman of the third century, declared:

"Since it is necessary that a mortal man should die, we should embrace the occasion that comes by divine promise and condescension, and accomplish the end provided by death with the crown of immortality, nor fear to be slain, since we are sure when we are slain to be crowned."

In the fourth century the practice of provoking martyrdom was carried to its highest point by a schismatic group in Africa, the Circumcelliones. If they could not stir up the infidels, they stopped strangers on the highway and tried to bribe or threaten them into

providing death, considering this a form of martyrdom. St. Augustine wrote that hundreds and even thousands of them "leaped with paroxysms of frantic joy from the brows of overhanging cliffs, till the rocks below were reddened with their blood." He added that "to kill themselves out of respect of martyrdom is their daily sport."

To encourage Christians to seek martyrdom, an intriguing notion was brought forth—that Christ was a suicide. Tertullian, an ardent apologist for the martyrs, declared that Christ had expired freely and voluntarily on the cross before the physical effects of crucifixion overcame him. St. Augustine seemed beguiled by the same idea when he wrote: "His soul did not leave His body constrained, but because He would, and when He would, and how He would."

The theory of the self-inflicted nature of Christ's death on the cross has persisted down through the centuries. It was reaffirmed in the eighth century by the Venerable Bede. Denis Diderot, the French encyclopedist and philosopher, took the position that if orthodox religion was true, Christ was guilty of suicide; having the power to defend himself, he should have used it. Arthur Schopenhauer, the German philosopher, said that Christ "ought always to be conceived as the symbol or personification of the denial of the will-to-live."

Thomas Paine, the Yankee infidel and patriot, said: "The Christian mythologists tell us that Christ died for the sins of the world, and that he came on purpose to die." Robert Ingersoll, known as the Great Agnostic, declared: "I insisted and still insist that suicide was and is the foundation of the Christian religion. . . . If Christ were God he had the power to protect himself without injuring his assailants—that having that power it was his duty to use it, and that failing to use it he consented to his own death and was guilty of suicide."

Martyrdom was not the only form of death courted by the earliest Christians. Many killed themselves by practicing extreme asceticism. For several centuries the Church regarded self-torture as a measure of human worth and looked favorably upon those who died from their ascetic practices. It was common for religious Christians to succumb to self-inflicted cuts, to perish from starva-

tion, to sink into death under the weight of great chains which they wound about themselves.

Other suicides which particularly appealed to the fervid mysticism and high moral purity of the early churchmen were those of virgins who killed themselves to preserve their chastity. St. Ambrose declared that God was not offended by their act, and a number of these virgin suicides were canonized.

It was not uncommon for converts to the early Church to slay themselves immediately after they were baptized. By killing themselves at that moment they avoided any temptation to commit sin. The theory was that they were assured of eternal salvation because they had died in a state of grace.

Among the paeans of praise heaped on this torrent of religious suicides a few voices of protest began to be raised. The first official action against these religious excesses came when the Council of Illiberis in 305 denied the glory of martyrdom to Christians who were killed as a result of assailing pagan idols.

But the Church did not turn against all suicide until after St. Augustine spoke out in the first quarter of the fifth century. In his *City of God,* Augustine discusses suicide at great length, terms it a "detestable and damnable wickedness," and concludes that it is never justifiable, even in the case of a woman who preferred death to dishonor. He argued that suicide was wrong because it precluded the possibility of repentance and that it was a form of homicide, therefore a violation of the Commandment: "Thou shalt not kill." St. Augustine thus postulated a divine prohibition against suicide. The Catholic Church has never wavered from his position.

This left the Church with a bizarre problem. How should Christians regard suicides who subsequently had been declared saints? St. Augustine got around the difficulty by theorizing that they had probably been divinely inspired to kill themselves and thus had committed no sin.

St. Augustine limited himself to disapproval of suicide. He did not specify that it should be punished. Church councils soon rectified his oversight. In 452 a council held at Arles condemned the

suicide of servants, echoing the Roman legislation against attempted suicide of slaves.

The earliest general disapproval of suicide for everyone came in 533 at the second Council of Orléans. The council indicated just how severely the Church was coming to look upon suicide by decreeing that "the offerings of those who were killed in the commission of any crime may be received except of such as laid violent hands on themselves." In 563 the Council of Braga denied funeral rites to suicides.

There was no substantial addition to this sixth-century legislation until the late thirteenth century, when the Synod of Nîmes imposed the Church's final penalty on the suicide by refusing him the right of burial in holy ground. Since then the canon law of suicide has remained substantially unchanged. The denial of funeral rites and burial in sacred ground were adopted into civil law throughout Europe.

Because the Church regarded suicide with such revulsion, and because church beliefs dominated all thought, there arose in medieval Europe many barbaric customs and weird beliefs concerning suicide. Some of these persisted until quite recently. The ancient Greek custom of dishonoring the corpse and subjecting it to indignities was revived and magnified.

In some communities the corpse was stripped and dragged through the streets face downward on a hurdle. Sometimes it was hung on the public gallows, from which it could be removed only by the order of a magistrate. Laws frequently specified that the corpse could be buried only by the hangman, who was entitled to whatever property was on the body.

One widely observed custom was that the body could not be carried through the door of the room or house in which the suicide had died. It had to be taken through a hole specially cut in a wall or through a window. In Danzig the window frame was then burned. In some communities the body was removed through a hole or pit dug under the threshold of the door. In Zurich the law specified that the suicide who had jumped from a height was to be buried under a mountain, probably so that the weight of it would

press on the suicide's spirit for eternity. The suicide who drowned himself was buried under sand, frequently on a beach below the high-water mark.

One of the most barbaric customs was the driving of a stake through the suicide's heart at burial. The ancient fear of the ghost probably prompted this, the purpose of the stake being to prevent the suicide's spirit from leaving the grave. The device later became a favorite of writers of horror fiction.

Suicides often were buried at a crossroads by night. Historians are unsure why a crossroads was chosen. They surmise that it was done so that the heavy traffic would keep the ghost down; or because the number of roads would confuse the ghost; or that the roads, by forming a cross, would deter the spirit.

In some parts of England suicides were buried outside the wall of the churchyard or in a special section within it. Another English custom specified that the body of the suicide should enter the churchyard over the wall rather than through the gate.

In addition to punishment of the suicide by inflicting indignities on the corpse, his heirs were made to suffer. Throughout the Middle Ages, and until much later in many communities, the suicide's goods or land or both were confiscated.

Suicide was infrequent during the Middle Ages, according to all records. Authorities attribute this to the effectiveness of the church prohibition in an age of unquestioning belief, backed as it was by civil sanctions. Another reason was the comparatively stable society in which people lived. They were circumscribed by ancient rules and customs which bound them into a network of relationships affording considerable security.

One group with a high suicide rate during that era was the unfortunate women accused as witches. Once charged, there was no place for them in society, absolutely nowhere for them to turn. They often chose suicide to avoid torture, banishment, or a slow death.

Medieval monks also had a high suicide rate. Shut up in the dim recesses of dank monasteries, some monks fell victim to a suicidal melancholy known to the theologians as *acedia*. Crazed by tempta-

tions the flesh could not endure, fearful of breaking their solemn vows, worn out with the extreme privations practiced in the early monasteries—perpetual silence, semi-starvation, lack of sleep, complete isolation—and dwelling always on the sorrows and miseries of life, many took their own lives.

With the exception of such special groups as these and an occasional epidemic (described in another chapter), the Middle Ages was one of the least suicidal periods of history.

Only one of the world's other major religions enunciated a more rigid and uncompromising attitude toward suicide than that of Christianity. The Moslem Koran condemns the act vigorously and expressly forbids it: "What ought one to think of suicide? It is a much graver crime than homicide. . . . Man does not die but by the will of God, and at the end of his appointed time." The Koran provides no loopholes to justify suicide in any circumstance, and the act is practically unknown among Moslems.

T. E. Lawrence, the famed "Lawrence of Arabia," wrote of the Arabs: "The least morbid of peoples, they have accepted the gift of life unquestioningly, as axiomatic. To them it was a thing inevitable, entailed on man, a usufruct, beyond control. Suicide was a thing impossible, and death no grief."

The absence of a specific prohibition against suicide in the Bible is attributed by some authorities to the rarity of the act among the ancient Jews. Josephus, the historian of the first century of the Christian Era, expressed the traditional view of suicide when he was commander of an army which had been beaten by the Romans. His soldiers wished to commit suicide to avoid capture. To dissuade them, Josephus used two arguments: that suicide is a crime remote from the nature of all animals; and that since the soul is received in trust from God, it would be wicked to cast it out of the body.

In cases of extreme necessity, however, suicide did occur among the ancient Jews. Under the leadership of Eleazar ben Jair nearly a thousand Jews committed suicide in the fortress of Massada rather than surrender to the Romans, whom they expected to violate their women and sell their children into slavery.

It is notable that in their extremity they expressed as well as they

could the traditional Jewish dislike of suicide by not laying violent hands on themselves. They did not decide that each person should kill himself, but elected ten of their number to act as executioners. When all the rest were dead, these ten drew lots and one killed the other nine, then himself.

In contrast to the Moslem Koran, Jewish religious writings are not unequivocal on the question of suicide. There are loopholes.

In the Mishnah, a collection of rabbinical discussions compiled in the second century A.D., it is stated: "Whenever a person of sane mind destroys his own life, he shall not be bothered with at all."

Exceptions are admitted in the Midrash, the rabbinical commentaries on the books of the Bible. Here it is stated that suicide may be forgiven in some circumstances: (1) when a person is faced with unbearable pain, as in the case of torture; (2) to avoid being forced to violate Jewish law; (3) when a leader fears that if he is taken prisoner many of his soldiers might be killed in vain attempts to rescue him.

In the Talmud, a compendium of Jewish law and lore edited in 499, it is decreed that a suicide shall not be honored with a eulogy or public mourning. Still, the law defines suicide so loosely that the benefit of the doubt generally is granted to the deceased.

Whenever anyone is found to have died from other than natural causes, he is as far as possible to be considered the victim of murder rather than suicide. Only when an individual had previously announced his intention to kill himself is he considered a suicide. The law contains the further dictum that children never can be regarded as deliberate suicides. It declares that they performed the deed unwittingly.

Throughout history Jews nearly everywhere have had considerably lower suicide rates than the people among whom they lived. Except to escape persecution, Jews appear not disposed toward suicide.

The oriental religions are much more tolerant of self-destruction than those which developed in the Mediterranean Basin. Hinduism and Buddhism teach the transmigration of the soul and dwell on

the unimportance of this life. Such a system of belief leads logically to the acceptance of suicide.

The goal of Hinduism is the soul's release from the world so it can be reunited with its divine source. The chief obstacle to the transmigration of the soul is the body. So long as its desires and passions engage the spirit, to however slight a degree, there is no hope of the soul's returning to its source. Therefore, the divorce of soul from body is the major aim of Hinduism. When the body loses conscious existence, the soul can occupy itself with supernatural realities, which provide the only escape from the delusions of this life.

Brahma, the divine world-soul, is the only reality. All else is illusion. Since the body stands in the way of the return to the world-soul, it is scorned and mistreated, as in the self-tortures practiced by Hindu mystics. Granted this attitude, the logical end is self-destruction. Suicide did in fact become institutionalized among devout Hindus. They venerated particular sites, such as the sacred river Ganges, where it was especially meritorious to end one's life.

Suicide became so acceptable in India that it evolved into a recognized legal method of collecting a debt. The practice was called *dharna.* A creditor would "arrest" a delinquent debtor by sitting at his door without food or drink until he received satisfaction. He often held a knife or poison in his hand, threatening to kill himself immediately if the debtor tried to pass. Should the creditor die of starvation, he believed public opinion would avenge him.

Another, more widely known form of institutionalized suicide in India was *suttee.* This practice, with variations, was common throughout the Orient, sometimes voluntary and sometimes enforced. Widows or retainers generally had a choice of the method they would use to follow their dead lord and master into the next world. In India, custom required that a man's widow be burned alive on his funeral pyre. If she moved after the fire was lighted, she was considered to have been a sinner.

Suttee was not religious in origin. The sacred writings of Hinduism commended it only after priests altered the text of the Rig-Veda,

the religion's most sacred book. The priests then taught that a widow who followed her husband in death could atone for his sins and open the gates of paradise for him. Her children shared in the merit gained by her sacrifice and were accorded social distinction.

In his *Early History of Institutions*, Henry Sumner Maine says: "There is no question that there was the closest connection between the law and the religious custom; and the widow was made to sacrifice herself in order that her tenancy for life might be got out of the way. . . . The ancient rule of the civil law, which made her tenant for life, could not be got rid of, but it was combated by the modern institution which made it her duty to devote herself to a frightful death."

The fact that widows had a degraded position, were abused, and were used as household drudges made *suttee* more popular than it otherwise might have been. Despite attempts by the British to suppress it, the practice lasted well into the nineteenth century.

Buddhism, like Hinduism, is a religion of pessimism. It was founded by Siddhartha Gautama, who was born in India in 563 B.C. He came as Buddha, the enlightened one, to show men the way to true happiness. Though he condemned suicide, later compilers of the sacred writings of Buddhism sometimes condemned the practice, sometimes encouraged it.

Buddha taught that evil sprang from desire and that the goal of life was the attainment of Nirvana, the extinction of desire and passion. The chief purpose of life is thus the acquisition of knowledge, which culminates in mystic meditation.

The pessimism of Buddhist beliefs naturally tended toward self-destruction in its followers. A passage in the sacred writings reads:

"Abandoning one's existence is to be looked upon as the best self-sacrifice, for to give one's body is better than to give alms; and also as the best worship, for to burn one's body as an offering is certainly more meritorious than to kindle lamps at a shrine."

It became commonplace for Buddhist priests to burn a finger, an arm, or their entire bodies as a form of sacrifice to Buddha.

Some authorities say that the tendency of the Japanese to commit suicide dates from the spread of Buddhism into that country.

The prevalence of Buddhism in China may account for the prevalence of suicide there. Naturally, where the popular religion sanctioned suicide, there developed many civil as well as religious reasons for it—dishonor of all kinds, defeat in battle, disappointments in love, insults, poverty, and, as in Japan, an escape from execution for a capital offense.

The contrast between the attitudes engendered by the religions of East and West was illustrated in a Reuters dispatch from Formosa dated August 1, 1960. A would-be suicide knocked down a policeman who hauled him back to land after he had jumped into the sea. In court later the man explained that the policeman had interfered with his "freedom of suicide."

The Christian view of self-destruction remained unchanged for a thousand years, from the sixth century to the sixteenth. It was not until the Reformation and the rediscovery of classical learning, when some values began to be transferred from heaven to earth, that the rigid mold of thought showed some cracks.

While the Protestant revolt preserved many of the same values long held by the Catholic Church, the act of secession from Rome gave an impetus to freedom of thought. Unquestioning faith began to be tempered by reason. The slow growth of freedom and responsibility for the individual caused suicide to increase, as it always does when the individual is thrown on his own resources. These forces, along with the increasing tendency to regard Greek and Roman heroes as ideals, brought the subject to the fore again.

The first indication of the growth of a modern attitude came from Sir Thomas More (1478–1535), a great Christian who was canonized in 1935. In his *Utopia* he presented for the first time in Christian writing an unprejudiced approach to suicide:

"But if the disease be not only incurable, but also full of continual pain and anguish, then the priests and magistrates exhort the man, seeing he is not able to do any duty of life, and by overliving his own death is noisome and irksome to other [*sic*] and grievous to himself, that he will determine with himself no longer to cherish that pestilent and painful disease. And seeing his life is to him but a torment, that he will not be unwilling to die, but rather take a good

hope to him, and either despatch himself out of that painful life, as out of a prison, or a rack of torment, or else suffer himself willingly to be rid of it by other [*sic*]. And in so doing they tell him he shall do wisely, seeing by his death he shall lose no commodity, but end his pain."

Prevailing attitudes, particularly those causing hostility to suicide, were questioned in France by Montaigne, the essayist. He retold with admiration some of the notable suicides of antiquity.

The first full-scale attack in English on the official church attitude was written by the poet John Donne (1573–1631), who was also dean of St. Paul's. His work was published by his son in 1644.

Entitled *Biathanatos*, it examines the proposition that "self-homicide is not so naturally sin that it may never be otherwise." He especially objected to the patristic point of view that suicide is an unpardonable sin because it was committed at the moment of death, when repentance was impossible. This conclusion is to him an uncharitable limitation upon the power of a benign and compassionate Deity.

He questioned why we should be so precipitate in our judgment as "to pronounce this above all other sins irremissible." He went so far as to express the opinion that the practical basis of the law was to frighten the laboring man from suicide, it being "thought necessary by lawes and by opinion of Religion to take from those weary and macerated wretches their ordinary and open escape and ease, voluntary death."

A century later David Hume's famous essay on suicide appeared. It was a stronger attack and had much more influence than *Biathanatos*. Fundamentally, Hume revived the Epicurean doctrine on suicide.

He insisted that Scripture does not prohibit suicide, interpreting the Commandment against killing to forbid only the killing of others. He also attacked the argument that for a man to take his life was usurpation of a power only God could wield, saying: "If I turn aside a stone which is falling on my head, I disturb the course of nature and I invade the peculiar province of the Almighty by

lengthening out my life beyond the period which, by the general laws of matter and motion, He has assigned to it."

During the seventeenth century the theologians allowed a few exceptions to the church dictum against suicide. For the first time they conceded that under some circumstances self-destruction would not be a sin.

The exceptions involved a new concept—that of positive and negative suicide. The latter was not a sin. If you were in a shipwreck it would be negative suicide to sacrifice your life for others by refusing to take a place on a crowded raft. Once on the raft, however, it would be positive suicide and a sin to give up your place to someone else.

In one special circumstance, the theologians decided, even what they regarded as positive suicide would not be a sin. According to Fedden, ". . . if a priest has learned in confession that a chalice is poisoned, he must nevertheless drink it, if his abstention would inevitably betray the fact that he had learned of the poison in the confessional."

In the eighteenth century, while suicide was still universally conceived to be a sin, popular opinion gradually moved against the barbaric indignities visited on the suicide's body. Although the laws remained on the books in England, the customs slowly fell into disuse. By the last quarter of the century abuse of the body or memory of a suicide was rare.

In 1790 an important counterattack against Hume and Donne reaffirmed the traditional attitude. In a huge two-volume work titled *A Full Inquiry into the Subject of Suicide,* Charles Moore argued that man does not know the importance of his life. Even if his existence appears to be useless at any given time, he can never be sure it will always continue so. He may be "counteracting by his abrupt departure some design of Providence."

France took the lead in the humane treatment of suicides in the same year that Moore's work was published. The movement was spearheaded by such intellectuals as Diderot, Montesquieu, and Voltaire. A statute of 1790 swept away all sanctions against the body and property of the suicide.

Dishonoring the body of a man who had turned his hand against himself never became an American custom. Only in Massachusetts was profane burial practiced for a time. In 1660 the members of the legislature declared that they "judgeth that God calls them to bear testimony against such wicked and unnatural practices, that others may be deterred therefrom," and enacted that suicides "shall be denied the privilege of being buried in the common burying place of Christians, but shall be buried in some common highway where the selectmen of the town where such person did inhabit shall appoint, and a cartload of stones laid upon the grave, as a brand of infamy, and as a warning to others to beware of the like damnable practices." The statute was not enforced for long and was repealed in 1823.

The major German philosophers divided on the question of suicide. Kant found that self-destruction was inconsistent with reason. In 1797 he wrote in *The Metaphysic of Ethics:* "To dispose of one's life for some fancied end, is to degrade the humanity subsisting in his person, and entrusted to him to the end that he might uphold and preserve it."

Schopenhauer, who has been called the high priest of pessimism because his emphasis on misery and frustration led some people to kill themselves, has wrongly been considered an advocate of suicide. He did argue against the penalties visited on suicides, but wrote:

"Suicide, or the arbitrary destruction of an individual phenomenon, is a quite futile and foolish act. . . . Suicide thwarts the attainment of the highest moral aim by the fact that, for a real release from this world of misery, it substitutes one that is merely apparent."

Friedrich Nietzsche, much influenced by Schopenhauer's gloomy speculations, came out for suicide. He declared: "There is a justice according to which we may deprive a man of life, but none that permits us to deprive him of death; this is mere cruelty." In *The Twilight of the Idols,* Nietzsche affirmed that "one should die proudly when it is no longer possible to live proudly."

The nineteenth-century Utilitarians, represented by Herbert

Spencer and John Stuart Mill, put forth the idea that the greatest happiness for the greatest number is the proper criterion of morality. They declared that if a person believed his suicide would increase the happiness of others, he would have the right to end his life.

"Over himself, over his own body and mind," Mill wrote, "the individual is sovereign."

By about the middle of the nineteenth century most European nations had followed France in abolishing penalties for suicide. England, a great respecter of tradition, was slower. The last suicide known to be buried at a crossroads was a man named Griffith. In 1823 he was buried by night with a stake through the heart at the intersection of Eaton Street, Grosvenor Place, and King's Road in London. A month later a statute was passed prohibiting such treatment. The new law specified that burial was to be in a churchyard—but by night and without religious services.

Confiscation of property was not done away with in England until 1870. Not until 1882 was burial permitted at normal hours. Suicide still remains a crime in England, although no penalties are attached.

Despite the anachronisms of British law, during the first half of the century enlightened civil opinion throughout Europe had reached the point where it considered that the morality of a suicide must be judged according to the circumstances under which it was committed. By and large, suicide was no longer considered a punishable crime or a sin, though it might be foolish or irresponsible. The philosophers had won the day. Debate on the "rightness" or "wrongness" of suicide ceased.

About the middle of the century a new group took over the formation of public opinion on suicide. These were the medical writers. They drove suicide underground and gave rise to the feeling, still current, that no "nice" person ever does it.

With the invention and refinement of new research tools many medical men sought simple physiological causes for most human ills. There was much investigation of the bodies and brains of suicides. Most of these medical writers came to the conclusion that all suicides were insane.

Fedden says: "So convinced were they of the relation between insanity and suicide, and so eager to find pathological proof of this relationship, that they formulated the most preposterous theories. Thus Gall claimed that suicide occurred in people with thick craniums, and Cabanis asserted that it was due to an excess of phosphorus in the brain. Such speculation was given the widest currency and had an undoubted and unfortunate effect on public opinion. . . . All the superstitious fear of the queer and the mad attached itself to suicide; the instinctive withdrawal of the sane from the tainted extended itself to cases of the calmest and most rational suicide. Finally, these new medical ideas hardened family prejudice against suicide; a suicide in the family became tantamount to insanity in the family, a stigma not confined to one member, but attaching jointly to the whole group and its descendants."

These theories caused families to hush up suicide to protect their reputations. Suicide had moved from being a sin to being a disgrace, an attitude still prevalent today. Along with the medical writings there appeared a few isolated works which examined the problem of suicide from a truly scientific point of view for the first time in history.

Generally these studies adopted a sociological or statistical approach in gathering data and attempted to assess the facts without prejudice. A few public officials, concerned over the rise in suicide throughout the nineteenth century, also published uncolored analyses of factual data.

The earliest of these scientific studies was the epoch-making book of the French alienist Esquirol, published in 1838 under the title *Mental Maladies: A Treatise on Insanity.* The work contained a section on suicide, which included case studies and statistical tables. Esquirol gathered information on the age and sex of those who committed suicide and considered the influence of climate and seasons. He also presented material on the methods of suicide.

In London in 1840, Dr. Forbes Winslow published another study, titled *Anatomy of Suicide,* which contained statistical data. As the century wore on, many similar studies appeared.

The most important of these was *Suicide,* by Emile Durkheim,

published in France in 1897. It was reprinted in the United States as recently as 1951. This work has a profound effect on research and thought concerning suicide and is still widely quoted.

Durkheim was the first to come up with a definite theory about the causes of suicide. With him we enter the modern era, in which man at last is seeking to understand the nature and causes of suicide, hoping eventually to be able to reduce or control this least comprehensible scourge of humanity.

We are still afflicted, however, by some holdovers from archaic habits of thought, and they often work hardship on attempted suicides or the families of suicides.

In England, for instance, suicide is still a felony at law, if the person is adjudged sane. Coroner's juries must hold an inquest to pass on the sanity of every suicide. A verdict that someone who killed himself was sane when he did so is tantamount to conviction for a crime. This endangers the payment of his insurance and precludes him from a burial with Church of England rites.

It has been the practice for many years, therefore, to protect the suicide and his family by rendering the verdict "suicide while of unsound mind." This led one observer to comment that a man must not commit suicide in England on pain of being branded either a criminal or a lunatic.

Attempted suicide is also a crime in England, punishable by two years in prison. Public opinion is not behind the law, and many police officials and some judges do not enforce it. Studies have shown, however, that a few luckless souls out of the hundreds which come to the attention of the authorities are sentenced under this law each year.

In one respect England is ahead of the United States. It is contrary to British medical ethics to report an attempted suicide to the police. The reasoning is that if they were reported, attempted suicides in need of medical help would hesitate to go to a doctor and might die for lack of care.

American courts do not treat suicide as a felony. However, some states have laws providing that life insurance policies will not be honored if the holder kills himself within a specified time after

taking out the policy. Most life insurance policies contain a clause stating that the money will not be paid if the holder kills himself within one or two years of the date of the policy.

The laws of some states make attempted suicide a misdemeanor. New Jersey and Florida regularly send people to jail for trying to kill themselves.

Although neither suicide nor attempted suicide is a crime in New York State, the wording of the law clearly shows the old, punitive attitude. Section 2301 of the Penal Code reads: "Although suicide is a grave public wrong, yet, from the impossibility of reaching the successful perpetrator, no forfeiture is imposed."

It is unfortunate that such attitudes are still widespread. For, as long as large numbers of people continue to think of suicide in terms of punishment, moral condemnation, sin, insanity, and cowardice, the scourge of self-destruction which afflicts the American people cannot be fought the way a public health problem of its gravity should be fought.

Chapter VIII

METHOD HAS MEANING

THERE are fashions in suicide just as there are fashions in other things, and the methods people employ to commit suicide change constantly.

Students of the suicide problem sometimes feel that every conceivable artifice which would end life has already been used. However, press reports nearly every week tell of some new device or method being added to the list. Men destroy themselves in ways different from those used by women. Geography makes a difference in favored methods. Suicides today use means different from those of a generation or two ago.

While most suicides choose instantaneous, painless, or gentle deaths, hundreds go to great trouble, make elaborate plans, or build ingenious devices to kill themselves slowly, or symbolically, or with great pain. Psychiatrists believe that in many cases the method a person chooses to end his life is an important clue to the reasons he found life unbearable. They say that such an individual unconsciously chooses a method symbolic of the subconscious problems and motives that led to his suicide.

Dr. Wilhelm Stekel, the late psychoanalyst, declared: "Suicide involves a symbolism of its own. The choice of the manner of dying is in itself a significant tell-tale feature. Women who 'have fallen' or who struggle against temptations, throw themselves out of the window and into the street. The man who entertains secret thoughts of

poisoning somebody, takes poison; one who yearns after the flames of love, sets fire to himself; he who believes himself surrounded by poisonous thoughts, turns on the gas."

In his book *Man against Himself,* Dr. Karl Menninger wrote: "We have no right then to dismiss the significance of a particular method of committing suicide as being meaningless." Referring to someone who had killed himself by hugging a red-hot stove, Dr. Menninger said: "Such an act suggests, in addition to the motives which determine the self-destructive act, the existence of a pathologically intense wish to be loved, a feeling of such inner coldness that embracing a red-hot stove is like a final climax of destructive satisfaction, as if to say, 'At least my heart is warm.' The significance of drowning seems to relate quite definitely to the wish to return to the undisturbed bliss of intra-uterine existence, a kind of reversal of the first great experience of birth."

Psychiatrists do not imply that the method of suicide is *always* psychologically determined. The few studies made of this aspect of the problem indicate that three elements play a part: accessibility of means, suggestion, and psychological drives.

In this country there has been a noticeable shift during the past 50 years from the more gentle means of ending life to the more violent methods. In the first decade of the century poison was the leading means of suicide, chosen by 30 per cent of those who killed themselves. It was followed by shooting, which accounted for about 25 per cent of suicide deaths. Today shooting accounts for about 40 per cent of suicides, while poison has declined to 10 per cent. More people hang themselves today than 50 years ago. Jumping from heights, while still used by less than 5 per cent of suicides, has increased about 400 per cent since the first decade of the century. Fewer people stab or cut themselves than formerly and fewer choose drowning.

Although both sexes use violent methods more often today, more women than men still choose the easier, gentler methods. Most researchers link women's choice of passive methods of suicide and men's choice of violent methods with the general masculine and

feminine roles in life—the one being active and aggressive, the other being passive and receptive.

Men overwhelmingly use firearms. More than half of the male suicides chose this method in 1958, while only one woman in four used a gun. Men generally have easier access to firearms and are more accustomed to using them. Many women don't understand guns, while others won't use them because shooting oneself means disfigurement. The accessibility of an instrument for suicide is often determined by occupation. Policemen, for instance, frequently use their service revolvers for suicide, while more miners kill themselves with explosives than any other group.

Some men try to make sure their suicide will succeed by using two guns, holding one to each temple and pulling the triggers simultaneously. Pistols are the weapon most often used. Shotguns and rifles, because of their length, are difficult to handle.

Those who use firearms sometimes have astonishing escapes. Quite a few would-be suicides have learned that firing a bullet directly into one's brain is no guarantee of certain death. A 62-year-old man shot himself through the mouth and the bullet emerged from the top of his skull. He recovered. Doctors said the bullet had coursed between the lobes of his brain without doing any damage. A 79-year-old man fired two shots into his temple. He lay in his apartment for 48 hours waiting for death, then got up and asked a friend to take him to the hospital. A 54-year-old man in upper New York State shot himself in the head with a .32-caliber pistol. He lay in an abandoned barn 10 days before he was discovered, still alive.

The ultimate in such cases within the authors' clipping files concerns a 50-year-old janitor. In 1940 he went into a cellar and shot himself in the head three times with a .32-caliber revolver. He not only did not kill himself, he didn't even fall or lose consciousness. Fully coherent when he arrived at the hospital, he told the doctors he had held the gun to his head and pulled the trigger. The gun fired and he was surprised when he didn't fall. He lifted the gun, fired again, and was amazed when he got the same negative result. He squinted into the muzzle to see if anything was wrong with the

revolver. Since it seemed to be in working order, he tried once more. When he felt nothing unusual, he said, he gave up.

Doctors found that one bullet had struck the base of his brain and the other two were lodged behind his right eye. They said that although the bullets had caused skull fracture, brain concussion, and a slow hemorrhage, none had struck a section of the brain which would result in immediate unconsciousness.

Sometimes the bullet the would-be suicide sends roaring through his brain actually cures the illness which led to the attempt. A 45-year-old Maine widow suffering from what psychiatrists call "pyramiding depression" laid her chin on the muzzle of a 12-gauge shotgun and pulled the trigger. The charge tore through her mouth and the front part of her brain. She was taken to the hospital for emergency treatment. Reporting the case in the *New England Journal of Medicine,* the surgeon who treated her said the charge had in effect achieved in an instant a delicate brain operation which ordinarily takes hours. The charge had performed a rough anterior lobectomy, he said, cutting through the frontal areas of the brain which control emotions. Later the woman was discharged from the hospital—with her depression cured.

A similar case was reported in 1951 in the weekly British medical journal *The Lancet.* A 55-year-old army officer suffering from paranoia and depression shot himself in the temple one night. The bullet emerged from the other side of his skull. Next morning he arose, dressed, and cooked his own breakfast. His wife found him calmly eating, only a slight tickle of blood flowing from both sides of the wound. The bullet had removed the frontal lobes of the brain and cured his depression.

In April 1946 a 24-year-old Kansas City man took aim at his head, pulled the trigger, and slumped to the floor. His frantic wife phoned the police. A few minutes later a detective shook the man back to consciousness. "You missed," the officer told the sheepish man, who had fainted as he pulled the trigger.

Unlike those who use firearms, persons who hang or strangle themselves rarely escape the fate they sought. The reason is simple. As soon as the noose tightens, it cuts off the flow of blood to the

brain, causing the individual to lose consciousness. Death follows quickly.

Hanging and strangulation are two violent methods chosen by more women than men. One woman in five uses this method today, while only one man in six does so. In the past half century the number of women who chose hanging has doubled, while the number of men has decreased. In 1915 only one woman in 10 chose this method, compared with one man in five.

Strangling oneself is such a common method of suicide that it is surprising to find physicians who still doubt it is possible. They say that as soon as the person loses consciousness the will to live asserts itself, preventing the strangulation from being carried to completion. This, unfortunately, is not always the case.

An 81-year-old man, for instance, tied a woman's stocking to the top of his bedrail, knotted the other end around his neck, then knelt on the floor, putting on enough pressure to strangle himself. Many suicides use the doorknobs for the same purpose. They let their bodies go limp. Their weight on the rope tightens it around their throats. Strangulation follows.

A man in a hospital bed transferred the traction gear of pulleys and cords from his fractured leg to his neck and strangled himself. A 51-year-old man thrust a long stick under his bow tie, twisted the stick, and then fell on it, his body holding it in position until he expired. A 36-year-old woman committed suicide by tying a felt belt around her neck with a sailor's half-hitch knot. She then passed the ends under her armpits and tied them to fingers on each hand. When she thrust her arms out suddenly, the noose sealed and, by cutting off blood to the brain, caused her to lose consciousness immediately.

The most extraordinary case of strangulation in modern times was that of a man and wife, members of the Nazi party, who attempted suicide by standing face to face and strangling each other with only their hands. The husband died. His wife lost consciousness but lived.

Another violent method chosen by more women than men is jumping from a height, which would appear to lend some support to Dr. Stekel's theory about the "fallen woman." Only one male sui-

cide in 30 chooses to jump from a height, while one woman in 16 does so. Although this is a method still used comparatively infrequently by both sexes, there has been a greater percentage increase in this century in this category than in any other. In 1915, for instance, only one man in 53 chose to jump from a height, and only one woman in 25. The increase in tall buildings throughout the country may be a major reason for the growth in this kind of suicide. It is notable that the ratio of two women to one man choosing this method has been maintained since the early part of the century.

Some people survive jumps from considerable heights. A 21-year-old girl lived after leaping from the tenth floor of a Detroit hotel. She landed in a flower bed and suffered only a couple of broken ribs and a broken wrist. A 30-year-old man jumped from the roof of a five-story building in New York City and landed on a metal canopy. He regained consciousness in a few minutes. Struggling down from the canopy, he walked to a friend's flat and three hours later hanged himself there. Physicians reported he had suffered no injuries in the fall.

Although fewer women choose poison today than in the earlier part of the century, it is still the method they elect most often. With men it ranks only fourth. In 1958 a little more than one woman in four used poison, while only one man in 15 used it. In 1915, by comparison, a little more than one woman in three used poison and a little less than one man in five. In addition to this decrease over 50 years, another radical change has occurred since the mid-thirties in the pattern of poisoning suicides.

In 1937 barbiturates accounted for only 7 per cent of the suicides by poison. In 1958 they accounted for 45 per cent. Barbiturates are the preferred drug of women. In 1958 half the women who took poison chose a barbiturate, while only 38 per cent of the men used such a drug.

Physicians and public health officials are greatly concerned by the rapid increase in the number of suicides and accidental deaths resulting from barbiturates. The chemical houses became so alarmed at the situation that they stopped their practice of leaving samples of barbiturates in doctors' offices.

This alarm is justified, for barbiturates are dangerous drugs which have widely different effects on different people. Fifteen grains can kill some persons, while others can tolerate 200 grains and live. In 1954 a man attempted suicide by swallowing 54 tablets of barbiturate. He survived, however, because the tremendous overdose paralyzed his stomach and the drug could not enter his blood stream.

Studies have shown that to some extent the type of poison a person uses is connected with his social status. Barbiturates are the agent of the educated who have fairly high incomes. The poor and uneducated turn to poisons that are cheap and handy, such as cleaning fluids and insecticides. Some people attempt suicide with aspirin. But, like barbiturates, this results in widely different effects. Psychoanalyst Wilhelm Stekel used aspirin to end his life in London in 1940. In 1948, Lady Joan Coventry killed herself in England by aspirin poisoning. Yet that same year a London criminal swallowed 170 aspirins and achieved nothing more than a headache.

A number of people in search of poison don't turn to the most obvious place, the medicine cabinet. A few years ago a young snake expert placed the head of a deadly diamondback rattlesnake in his mouth during a carnival side show and was bitten on the tongue. Luckily, there was serum available to save his life. In 1935 a 26-year-old man in Worcester, Massachusetts, sent to California for a black-widow spider and deliberately let it bite him. The notes he left gave no indication why he chose this method of obtaining poison.

The greatest change in suicide methods over the past 50 years has occurred in the use of gas. This change indicates the important part accessibility plays in the choice of an agent. In the five years 1906–10 gas was used by 10 per cent of suicides. As manufactured gas was piped to more and more homes over the years, an increasing number of persons used it to kill themselves. In the 1940s it was used by about 17 per cent of suicides. Then, as utility companies introduced natural gas in the fifties, the number of suicides using gas fell again to 10 per cent. The most obvious reason for the decrease is that natural gas is not lethal.

Until quite recently more women than men chose gas to kill

themselves. In 1915, for instance, one woman in five used gas, while only one man in eight did. Gas was easily available to every woman, was simple to use, and nearly all women were familiar with it.

In recent years, however, women have been turning away from gas at a greater rate than men. By 1951 women were using gas only slightly more often than men, it being chosen by one woman in seven and by one man in eight. By 1958 the sex pattern had reversed, with one man in nine using gas while only one woman in 11 used it.

Another radical change over the years has occurred in the *type* of gas used by suicides. Until the forties the majority used utility gas, but during the fifties the majority switched to automobile exhaust gas—carbon monoxide. In 1945, for example, 1,410 persons used utility gas and 453 used automobile exhaust. By 1958 the situation was reversed, with only 207 persons using utility gas while 1,556 used automobile exhaust. It seems likely that this change, like the decrease in the use of gas, is due to the introduction of natural gas into many homes.

This change in pattern appears to support the psychiatrists' theory that for some persons the method of suicide is psychologically determined. It seems logical to assume that for the majority of those who switched to automobile exhaust because domestic gas was not available, the use of gas was determined by unconscious motives and had symbolic significance. Being unable to find lethal gas in their kitchens, they went to another source. For those persons who used another method, such as poisoning or shooting, where they would have used domestic gas if it had been available, presumably the method had little or no significance.

Although it would seem that the simplest method of getting gas would be to turn on the jets on the kitchen range, or to use automobile exhaust, many people rig up complex arrangements. A California housewife took the kitchen door from its hinges and carried it to the bathroom. She sealed the bathroom door with cotton and ran a hose from a gas jet into the bathtub. Then she climbed into

the tub, pulled the kitchen door over it, and sealed the cracks between door and tub with more cotton.

In another case, a mother and son ran a hose from the kitchen into a bedroom. At the kitchen end they attached a petcock to the hose, connecting it with string to the alarm key of a clock. They broke off the hammer of the alarm so it wouldn't ring. When the alarm went off, the turning key of the clock opened the petcock and the gas seeped into the bedroom where they lay.

A 57-year-old retired realtor in Jackson, Tennessee, spent several weeks in the summer of 1957 building an airtight plywood box eight feet high, five feet long, and five feet wide. When he finished, he climbed up a ladder on the outside and down another ladder inside the box. He wired the lid and sealed it with wax. Then he tripped the catches on three carbon-dioxide fire extinguishers.

More women have always chosen drowning than men, although this method of suicide is declining in popularity with both sexes. In 1915, for instance, one woman in 11 and one man in 20 chose drowning. In 1958 only one man in 40 employed it and only one woman in 14.

Most suicides who wish to drown themselves go to a river, a lake, or the sea. Some, however, use their bathtubs. Other suicides have demonstrated that, contrary to popular opinion, it is quite possible to drown oneself merely by holding the face under water. In 1950, for example, a 51-year-old woman committed suicide in Texas by kneeling beside a water trough and holding her head under. In 1950 an inmate in a New York City prison drowned himself by stuffing paper into a toilet bowl until the water rose to the top and then holding his head under.

Some persons use whatever large quantity of liquid is handy. In July 1932 a brewer in Pilsen, Czechoslovakia, wrote a suicide note and jumped into one of his own vats of beer. In the same month, Benjamin Natkins, one of the early associates in establishing Nedick's, Inc., drowned himself in his Morristown, New Jersey, home by diving headfirst into a 50-gallon crock of vinegar.

Stabbing or cutting has greatly declined in popularity since the early years of the century. Today it is the least used of the common

methods of suicide. Men used to choose this method twice as often as women. They have been abandoning it in favor of pistols and other methods, however, and today slightly more women suicides than men cut or stab themselves. In 1915 one man in 14 stabbed or cut himself, while only one woman in 33 did. In 1958 only one male suicide in 45 used this method, while one woman in 41 did so.

Few suicides care to suffocate themselves. Yet there was a rash of suffocation suicides soon after the plastics industry introduced very thin bags to cover clothes returned by dry cleaners. A number of people killed themselves by pulling the bags over their heads. Quite recently three women in the New York City area, aged 19, 55, and 63, suffocated themselves in their kitchen refrigerators. Each carefully removed the food and shelving and stacked them neatly on the floor or table, then climbed into the refrigerator and pulled the door closed.

A 44-year-old spinster in Hardwick, Massachusetts, locked herself in her airtight hope chest. Her choice of method was very likely psychologically determined. What was probably an occupationally determined suffocation was that of an airman in the state of Washington who locked himself in a high-altitude test chamber. He boosted himself to the equivalent of 70,000 feet, where there is virtually no air, and pulled off his oxygen mask.

The introduction of new artifacts into our culture causes the suicide pattern to change constantly. The advent of the airplane caused some people who would probably have jumped from tall buildings to leap from airplanes instead. An airplane was involved in what was probably one of the most expensive suicides on record. In January 1957 a 20-year-old mechanic at New York's Idlewild Airport wrote a suicide note, climbed into a DC-3, took it up 200 feet, and crashed it. The $100,000 aircraft was a total loss.

The pattern of suicide in large cities is different from that of the nation as a whole. In both New York City and Seattle, for instance, gas is the leading agent of suicide. Firearms are the next method of choice in Seattle, while in New York hanging is in second place and guns rank only fifth. San Francisco is one of the few areas in the nation where poison is the leading method. In San Francisco,

too, more suicides jump from a height than anywhere else in the country. This is partly attributed to the fact that the city has the Golden Gate Bridge, one of the two leading places in the nation for suicide.

Europeans tend to select more passive agents of suicide than Americans. The two most widely used passive agents, gas and poison, accounted for only 25 per cent of suicides in the United States in the three years 1954–56, while in England they accounted for 65 per cent, in Denmark 56 per cent, in Australia 43 per cent, in Switzerland 32 per cent, and in Sweden 30 per cent. In Canada the ratio of violent to passive methods of suicide is about the same as that of the United States.

In England gas is the leading method of suicide. In Germany it is hanging. As in the United States, more European women choose gas and poison than men. The only country in the world where more men use these passive methods is Japan. In 1954–56 half of all Japanese suicides chose gas or poison, with the men having a slight edge over women—44.9 per cent to 44.5 per cent.

The ultimate in violence is probably achieved by those who use explosives to kill themselves. This method seems to be the exclusive province of men, generally those who are familiar with explosives and have access to them.

One man, a lumberjack, used considerable ingenuity to manufacture an explosive where none was available—in his cell at San Quentin prison. He wrenched a short piece of hollow tubing from the cot in his cell. Taking a deck of playing cards, he tore out all of the red diamonds and hearts and mashed them into a pulp in his washbasin. He tamped the soggy mass into the tube. He completed the bomb by pounding a broom handle down tightly on the pulp. Then he held the contrivance over the flame of a lamp. It exploded and killed him. What he knew was that the playing cards were made of cellulose, a fiber from which trinitrocellulose—TNT—is made.

Another man familiar with explosives was despondent because his fiancée's father opposed their marriage. He went to the home of his sweetheart, carrying a stick of dynamite in his pocket. A few

seconds before entering the house he lit the fuse. He stepped inside the door and gave his sweetheart a long embrace. The dynamite exploded, killing them both.

Another occupational group which often uses professional know-how to accomplish its suicides is electrical technicians. An electrician in Italy wound a coil of uninsulated wire around the waists of himself and his 18-year-old sweetheart. He then tied a stone to the free end and tossed it over a high-voltage line.

Most electrical suicides are more complicated, however. An electronics student managed to electrocute himself as he slept. He taped wires from a radio-alarm clock to one wrist and an ankle. The ringing alarm sent current from the clock's wall outlet through his body. Some persons set up elaborate imitations of electric chairs used for prison executions. A man in Wenatchee, Washington, rigged a complete electric chair with a transformer to boost the house current to 1,000 volts. He pasted 25-cent pieces to his temples, put a wet towel on his head, placed his feet on another wet towel, and completed the circuit by grasping a ground wire.

Few "occupational" suicides are bizarre. Most of those who use their professional knowledge to kill themselves apparently do so to achieve a quick and easy death. It may be, however, that in some cases the psychological motives which impel a man to choose one profession rather than another also cause him to employ a particular means to end his life. One of the more bizarre suicides in which an occupational device appeared to have been used for psychological reasons rather than efficiency, was described in the December 8, 1947, issue of *Time* magazine.

The story concerned an Italian workman who had been employed for 23 years by a road-building firm in France. A lonely bachelor who had neither family nor friends and did not mix with his fellow workers, he lived in a wheeled shack which he moved from job to job. In 1944 he was promoted to drive the steamroller.

"Giuseppe, who had never had anything to love, loved it as a hunter loves his dog or a rider his horse, or perhaps just as a man (in the 20th century) loves his machine," the story said. "When the day's work was done, Giuseppe would drive his steamroller around

to his shack, and putter about, oiling and cleaning it. Sometimes at work, Giuseppe would set the huge machine rolling and get down in the road to stare at it as it marched on alone, slowly and steadily crushing the gravel beneath its bland power. . . .

"One day last week, in the early afternoon, Giuseppe stood staring at his steamroller. 'Well, Giuseppe, what are you doing there?' asked a worker, one Tomaso Sonnino. 'Nothing, just thinking,' said Giuseppe. 'Wondering what would happen if nobody could stop this thing. This one and all the others, just rolling on forever.'

"Tomaso shook his head and walked on. Suddenly a shadow came abreast of his. It was the steamroller, slow, driverless. Tomaso saw that there were dark stains on the white rollers. They were blood stains.

"From the position of the body it was clear that Giuseppe had lain down on his side, his back turned toward the oncoming machine, his head turned out to the sea . . ."

Some people "eat" themselves to death. A 40-year-old Englishman killed himself by swallowing 19 safety pins. Fedden cites the case of a Polish girl who over a period of five months swallowed four spoons, three knives, 19 coins, 20 nails, seven window bolts, a brass cross, 101 pins, a stone, three pieces of glass, and two beads from her rosary before she succeeded in killing herself.

A 54-year-old Canadian woman killed herself by eating a large assortment of nails, several four-inch darning needles, open safety pins, carpet tacks, fishhooks, corkscrews, and several pieces of glass. Another woman committed suicide by stuffing a sandwich in her throat. In 1950 a Frenchman tore up his shirt and swallowed the pieces. He died of suffocation.

Then there are those who starve themselves to death. In July 1944, doctors wrote "malnutrition and psychoneurosis" on the death certificate of a 21-year-old college student in Michigan. Her only explanation for starving herself was: "I'm not hungry." Her parents said she had eaten only on rare occasions since the previous autumn. When she did break her fast she ate so much that she frightened her parents. Eventually she declared: "I can't eat any more. I'll never eat again." Doctors tried scores of ways to interest

her in food. Efforts to feed her intravenously failed because of her fierce resistance. She remained active until she became too weak to move about. At her death she weighed 43 pounds.

A 22-year-old college student starved herself to death in Boston in February 1946. She died in a hospital after refusing to eat enough over a three-year period to sustain her bodily needs.

In May 1948 a 62-year-old man collapsed on a street in New York City. Before he died he told the doctors he had not eaten in three days and had not had a full meal in a month. He had nearly $1,000 in cash on him and a bankbook showing deposits of $1,238.

The more bizarre the method of suicide, the more likely that the person is insane or that he is driven by some psychological need to inflict great punishment on himself. It is hard to believe what some people are capable of doing to themselves. For example, a 52-year-old woman stabbed herself 107 times in the neck, abdomen, chest, stomach, and thigh before she died. In August 1956 a woman in Flushing, New York, clubbed herself to death, fracturing her skull with several blows behind the right ear with a six-inch length of pipe. A California truck driver killed himself by punching a hole in his forehead with a hammer.

A Brooklyn dentist got out of bed early one morning, sat in a tub half filled with water, and beat himself over the head with a hammer until he was unconscious. He fell back and drowned. In August 1958 a 55-year-old retired butcher killed himself in Stockport, England, by boring holes in his head and body with an electric drill. When found he had one drill hole in his head and seven in his chest. One of the chest holes caused a hemorrhage which killed him. Doctors said the hole in his head penetrated the skull but caused no serious damage.

In February 1958 an accused killer in an Akron, Ohio, jail attempted suicide by jamming a rusty nail into his chest. He left it there a week before he asked for the doctor. A 63-year-old Los Angeles man choked himself to death by placing his neck in an iron vise and slowly turning the handle. A 21-year-old German student wrote a note saying he was despondent about his studies, then

jumped into the lions' pit at the zoo in Nuremberg in July 1954. The lions mauled him to death before he could be rescued.

A Japanese man killed himself by biting off his tongue. He placed his tongue between his teeth, then gave himself a terrific uppercut. He bled to death. A Seattle woman thrust her head into the whirling blade of a power saw in the basement of her home. Fedden cites a French woman who applied 100 leeches to her body. A Youngstown, Ohio, woman, aged 60, grieving over the death of her husband four years previously, killed herself by pulling his tombstone over on her head. She tried twice before fracturing her skull.

Some suicides exhibit an attitude which indicates uncertainty about their ability to kill themselves. These are the people who simultaneously employ a number of methods, any one of which should normally kill them. A woman, for instance, took poison, slashed her wrists, and then drove her car off a cliff. In 1947 a Louisiana man nailed a scaffold to the side of his home. He climbed up on a barrel, slipped the noose around his neck, and shot himself in the temple.

Some kind of imaginative peak in the methodology of multiple suicide attempts was achieved by the 24-year-old Los Angeles man who in 1954 made the following Rube Goldberg-like preparations to end his life:

1. Bolted a pistol to a board.
2. Tied one end of a long piece of gauze to the trigger and the other end to the rotor of an electric mixer.
3. Suspended a sack of sashweights from the kitchen doorway by two thin strings.
4. Soaked the floor under the strings with gasoline.
5. Turned on the jets of the gas range.

He knelt in front of the gun, tossed a lighted match on the floor, and turned on the mixer. His theory was that the mixer would tighten the gauze and pull the trigger of the gun. If the shot failed to kill him, the fire would burn through the strings holding the sashweights, which would crash on his head. If he was still alive, he would presumably be unconscious and the gas from the range would finish him off.

The gun fired, but only wounded him in the chest. The weights did not drop because the fire went out too quickly. The gas didn't kill him because neighbors heard the shot and turned off the jets.

There are suicides who will die only by their own hand and in their own fashion and no other. The late Harry M. Warren, founder and president of the National-Save-a-Life League in New York City, cited the case of a man whose friends knew he planned immediate suicide. They called the police. An officer burst in to find the man holding a pistol to his head. Drawing his own weapon, the officer shouted: "Drop that gun or I'll shoot!" The man obeyed.

In *To Be or Not to Be,* Louis I. Dublin and Bessie Bunzel tell of a man who threw himself from the Brooklyn Bridge and popped to the surface still conscious. He refused to seize the rope a bridge policeman lowered to him from a pier. The officer drew his gun and threatened to fire if the would-be suicide did not take the rope. He, too, complied.

One of the most spectacular methods of suicide is self-crucifixion, about which Dr. Menninger wrote:

"Suicide by self-crucifixion is a quite obvious identification with Jesus, and such Messianic aspirations in less extreme form are not regarded as anything but normal. The teaching in many churches is that one should try to be as much as possible like Jesus and in some forms of religious worship this is carried out, as in the case of Los Hermanos Penitentes of New Mexico, to the extent of a pseudo-crucifixion of the most pious member of the sect. He is fastened to a cross and raised. It is really only a short step from this to a self-appointed and self-inflicted martyrdom of the same sort."

Self-crucifixion is extremely rare, there being only one genuine case in all the literature of suicide. This was one of the most famous suicide attempts in history and was the talk of Europe for years, because the man actually succeeded in driving nails through his hands and feet.

Matthew Lovati was an Italian shoemaker and a religious fanatic. In 1799 he built a cross in his room in Venice and took it out into the street. He was in the process of driving a nail into his left foot to fasten himself to the cross when passers-by stopped him. After

this attempt he returned to his native village. Three years later, in 1802, he built another cross. He laid it on the floor of his third-story room with the bottom resting on the low sill of the window. The head of the cross he secured to a beam in the ceiling by a rope, in which he left plenty of slack.

Realizing he probably would not be able to nail himself to the cross firmly, Lovati attached a net to it, which would support some of his weight. About eight one morning he stripped except for a cloth about his loins and put on a crown of thorns. He crawled into the net, sat on the cross, and put his feet into a bracket. He then drove a nail through both feet and into the bracket. He tied himself to the cross with a rope around his waist. Next he drove a nail through the palm of each hand, although not yet into the cross itself, and wounded himself in the side with a knife.

Now he used his nail-studded hands to edge the whole apparatus out the window until it tipped and hung against the outside wall, suspended by the rope attached to the ceiling beam. He drove the nail in his right hand into the arm of the cross and tried to push the nail in his left hand into the hole he had already made in the opposite arm, but didn't succeed.

Matthew Lovati hung there crucified for a few minutes before the first passer-by saw him, ran upstairs, and hauled him in. To questioners he answered only: "The pride of man must be mortified. It must expire on the cross." He later starved himself to death in an asylum.

Lovati inflicted excruciating pain on himself, but other suicides choose a way to die which must be even more painful—self-cremation. Some persons simply pour an inflammable liquid on their clothing and set a match to it. Others leap into furnaces. Few elect to die in this horrifying way, and the consensus is that those who do are insane, desiring to punish themselves severely. Self-cremation is not so rare, however, as most people believe. The authors' clipping files contain nine cases of persons who chose to die this way in recent years. A number had spent time in mental hospitals or had suffered breakdowns.

Some persons show extraordinary determination in the act of

suicide. A widow used her husband's army service revolver to fire a shot into her chest in June 1938 in Lakewood, New Jersey. When she failed to lose consciousness, she shot herself three more times, emptying the weapon. Weak, but still able to walk, she climbed a ladder to the attic of her home, put three more bullets into the revolver, returned to the ground floor, and fired them all into her body. She died the following day.

A 47-year-old Cleveland carpenter stabbed himself in the chest with a scissors, slashed his wrists with a razor blade, and waited. When death did not come he struck himself on the head several times with an ax and stabbed himself again with a broken hack-saw blade. He then tried to crawl into a furnace, but couldn't get through the door. Finally he inhaled gas fumes from a water heater. He survived.

A woman in Tuscola, Illinois, jumped in front of a truck, but the driver dodged her. She got into her car and tried to crash into another car, but the other motorist maneuvered away. She then crashed her car through a guard rail of a railroad bridge and down an embankment without being hurt. Next she slashed her wrists. Finally she went back to the railroad tracks to wait for a train, but it was a holiday and they weren't running. In the hospital later she said she would not try suicide again.

In July 1956 a 34-year-old man leaped from a fifth-floor window of a San Francisco hotel and landed on a wire screen covering a skylight on a first-floor extension. He then dragged himself up a fire escape to the roof and leaped 13 floors to his death in a parking lot.

A Los Angeles man, aged 34, spent an entire day in November 1948 trying to kill himself. After wiring a farewell note he cut his throat six times with a butcher knife. When he didn't die he lodged the handle of the knife in a wall and ran the blade into his heart three times. Still alive, he swallowed a bottle of poison, turned on the gas burners, and crawled into his bedroom to die. Neighbors smelled the gas and called the police. The man lived.

The Associated Press reported on December 10, 1949, that a Japanese named Hiromasa Sato in Tokyo tried 15 times to kill himself. He took cyanide once, tried hanging himself six times, jumped in

front of trains eight times. He finally piled railroad ties on a track in the hope of derailing a train, killing some passengers, and being sentenced to death for the crime. He was thwarted, and a judge declared him insane. The news story reported that Sato replied: "That's foolish. I just want to be sentenced to death."

Sato's statement is not as rare as you might think. There are quite a few persons who decide to end their lives but to whom it never occurs to do it themselves. They go to considerable lengths to get other people to kill them.

Robert Irwin, a murderer, is quoted in Dr. Frederic Wertham's book *The Show of Violence* as saying: "I have often thought of suicide, but I have never thought of killing myself. . . . I was living with a nice old lady in Brooklyn and she was just like a mother to me. I was there only two weeks and I was so miserable and sick that I thought I would commit suicide. But I wasn't going to kill myself. I thought I would kill her and go to the electric chair." In 1937 Irwin killed two women and a man, but instead of going to the electric chair he went to a mental institution.

The most bizarre case of this type occurred in England in 1959. It involved Richard Hobson, a 28-year-old Irishman.

"The trouble was that last summer I was smoking reefers and taking drugs," he was quoted in an Associated Press story. "I was depressed and I wanted to die. But I had not the nerve to commit suicide. Confessing to a murder seemed the only way out."

Recalling the unsolved hammer slaying of a London man which had occurred in April 1956, Hobson spent a week reading newspaper files to familiarize himself with the crime. On August 22, 1959, he walked into a newspaper office and confessed. He was able to reconstruct it perfectly for the police. The crime was punishable by hanging, and he was brought to trial in December 1959. In the middle of the proceedings Hobson reneged and told the truth. The case continued, however, and went to the jury, which found Hobson innocent. Two friends testified that he was in Dublin the day the murder was committed.

In 1948 a 16-year-old Cleveland boy committed suicide by getting a 10-year-old friend to pull the trigger of a rifle he assured him

wasn't loaded. In 1949 a North Carolina farmer told his four-year-old son to pull the trigger of the rifle he held against his chest. He died when the child obeyed him. In 1954 an Oregon father pleaded all day with everyone he knew to kill him. Finally the police were sent for. When they arrived the man was dead, a rifle lying across his chest and his two-year-old son sitting nearby. "Daddy told me to kill him, so I pulled it," the child said.

Some people go to bizarre lengths to convince themselves that they are not responsible for their own deaths. A 49-year-old farmer shot and killed his 29-year-old daughter as she slept in bed. He tied a length of twine about her wrist, looped the other end around the trigger of his shotgun, and walked slowly away from the bed, holding the muzzle against his back. It seems likely that he died believing the hand of his dead daughter was responsible for his death rather than himself.

An element of revenge also probably played a part in the 1939 suicide of a man who rigged a dynamite trap and made his wife the unwitting trigger. He wired a charge of dynamite to a light socket and tied the pull chain to the door of his home. He then wrapped the dynamite about him and lay on the floor to await his wife's return from visiting a neighbor. When she opened the door she detonated the bomb.

Chapter IX

HOW SANE IS THE SUICIDE?

MANY people think that anyone who kills himself must be insane. For the most part, they are wrong. Psychiatrists declare that only a minority of suicides are psychotic. Studies prove that a bare 20 to 30 per cent of suicides suffer from a major mental disease.

Fifty years ago it was generally accepted that the act of suicide was in itself a sign of mental illness. The idea has persisted, despite the mounting weight of evidence to the contrary and the heavy attacks on it which leading psychiatrists have been making for more than a quarter of a century. As long ago as January 1937, for instance, Dr. Gregory Zilboorg wrote in the *American Journal of Orthopsychiatry:*

"The assumption that suicide is an act of an abnormal individual, that the suicide is a psychopathic person . . . has never been proved. We have drifted into its acceptance as a result of our professional bias, overlooking the fact that it also springs from the old tradition of free will which in modern times appears under the guise of free mind or intelligence; we therefore assume that one must 'lose one's mind' in order to kill himself. It is questionable, indeed, whether we are here on more solid scientific ground than we were when our psychological theories had for their cornerstone the doctrine of free will."

One of the many recent studies showing that suicide is not necessarily a sign of mental illness was reported to the May 1958 meeting

of the American Psychiatric Association. Dr. David J. Vail, a New Hampshire psychiatrist, said that in a study of 132 persons who had killed themselves he found that only a third had any severe psychiatric problems. William James, one of America's greatest psychologists and philosophers, even held that no man was psychologically complete unless he had meditated his own self-destruction.

Psychiatrists who have studied the suicide problem generally divide suicides into two types—irrational and rational. Rational suicides are those committed by well-integrated, mature persons, usually to escape an intolerable burden, such as a painful, incurable disease, Nazi brutality, public disgrace, grinding poverty. Some suicides of elderly, lonely people can be classed as rational.

Newspapers around the nation printed this Associated Press story in May 1947:

COLUMBUS, O.—Edward Wegener, 62, hospital janitor, took his own life here in a nine-story plunge from a building because:

His son was killed at Pearl Harbor.

A daughter who became an Army nurse lost her life in Europe.

His wife died six months ago, leaving him no known relatives.

Coroner John B. Gravis established precedent, calling Wegener's death a "justifiable suicide." He said: "I can't think of anything that would better fit this case."

Another rational suicide was that of a professor of psychology who killed himself in Arkansas in 1949, leaving this note:

"You have been wondering whether a man planning suicide is sane. As a psychologist I can tell you he is sometimes very sane.

"I have been in ill health for the past four months, have only about three months left to live. I suffer constantly in all parts of my body at all times. I cannot sleep."

The assumption of insanity also overlooks the suicides committed by military personnel to avoid breaking a code of honor. Many members of anti-Nazi undergound organizations killed themselves when faced with capture for fear of being tortured into betraying their comrades. In October 1953, Major General William F. Dean,

of the U. S. Army, told a National Press Club luncheon in Washington how he was driven to attempt suicide when his Communist North Korean captors threatened him with torture unless he revealed United States plans for the defense of Japan.

"What worried me was the fact that I did know [the defense plans]," General Dean said. "That was a tough night. I decided I'd better kill myself. I was afraid I might squeal if they drove pine needles or splinters under my fingernails and set them afire. I said to myself: 'Dean, I don't know whether you can take it or not, so you'd better get out.'"

When the guard who had been left in his room overnight with him fell asleep, the general stole the soldier's Russian submachine gun with the intention of turning it on himself. But he was discovered before he could get the unfamiliar weapon working. Fortunately, his captors did not carry out their threat of torture.

Hitler revived the old custom of the Roman emperors, ordering high-placed officials who fell out of favor to commit suicide. The sanity of most of these men was beyond question. One who fell under Hitler's wrath and received a suicide order was Field Marshal Erwin Rommel, who won world fame for the ability he displayed in Africa.

After the invasion of Europe, Rommel was convinced that the Allies would win. He repeatedly advised Hitler to end the war. He may also have been involved in the generals' plot on Hitler's life. Hitler believed he was involved and ordered that he be given a choice of facing a court-martial or committing suicide. The choice apparently was offered because of Rommel's immense popularity. To protect his family from reprisals, Rommel chose suicide.

In *The Rommel Papers*, his son, Manfred, describes what happened. One day in October 1944, Rommel was at his home in Herrlingen, recovering from war wounds. About noon a car from Berlin drove up. Two general officers got out and talked with Rommel for a time. Then the field marshal talked with his son.

"'I have just had to tell your mother,' he began slowly, 'that I shall be dead in a quarter of an hour. . . . The house is surrounded, and Hitler is charging me with high treason. In view of my services

in Africa . . . I am to have the chance of dying by poison. The two generals have brought it with them. It's fatal in three seconds. If I accept, none of the usual steps will be taken against my family. . . . It's all been prepared to the last detail. I'm to be given a state funeral. . . . In a quarter of an hour, you . . . will receive a telephone call from the Wagnerschule reserve hospital to say I've had a brain seizure on the way to a conference.' He looked at his watch. 'I must go.'"

Rommel drove away in the waiting car. The generals stopped it a short distance away on a quiet, secluded road. They got out and walked away from the vehicle, leaving Rommel alone to take the poison. When they returned 15 minutes later he was dead.

To the surprise of many, the international furor which resulted when an American civilian did not kill himself with the suicide kit the government had given him made it clear that in the United States in 1960, as in ancient Greece and Rome, there exists a form of institutionalized suicide of which the government approves. The men who practice this form of suicide are eminently sane. The incident involved Gary Powers, pilot of the U-2 reconnaissance plane which was either forced down or shot down while on an espionage flight over Russia. In an article which appeared on the front page of the New York *Times,* military expert Hanson Baldwin discussed the event:

"Why did the pilot survive?

"This is a question that only Mr. Powers can answer, and he may spend the rest of his life trying to answer it satisfactorily.

"The instinct of self-preservation is strong in every human and it is contrary to the Judean-Christian and the American ethic to destroy one's own life.

"Yet an unwritten law of every secret intelligence organization postulates the suicide of an agent rather than capture, possible torture and revelations of importance to an enemy.

"Mr. Khrushchev has quoted from an alleged confession by Mr. Powers and has declared that a hypodermic needle or pin and a pistol were recovered. These, he said, were for use by the pilot to prevent his capture alive. . . .

"Thus the Central Intelligence Agency, an agency of a nation that is formally dedicated to the protection of human life, undoubtedly would have wanted Mr. Powers to destroy his plane and himself—a concept wholly antithetical to the average American."

The death of Lawrence Oates, a member of British explorer Robert Scott's expedition which reached the South Pole in 1912, is a classic, well-known instance of the suicides of brave and gallant men whose sanity is never questioned. On the return trip from the Pole, illness, lack of food, and harsh weather delayed the group. Oates' feet froze. As a partial cripple, he believed he would further hinder the return party's progress. One night he left the shelter and deliberately walked into a blizzard, never to return.

Many people who cling to the idea that all suicides are insane would not class Oates' death and similar heroic acts of brave men as suicides. Oates' death is acceptable and can even be approved, while suicide is not acceptable and cannot be approved. Therefore, Oates' death should not be termed suicide. The difficulty seems to stem from the emotional impact of the word "suicide." Using it to describe Oates' action seems to class him with the psychotic who kills himself because he thinks the world is coming to an end. Some prefer to use other terms for sacrifices, like Oates', in which a man ends his life for meritorious reasons.

But the matter really involves semantics rather than substance. Where a man's voluntary death is morally "right" and involves admirable self-sacrifice to benefit his fellows, it seems to many people to be hardly fair, or even bad taste, to describe his action as suicide. Any action which can be described as suicide is still widely regarded with horror.

For this reason the relatives and friends of a suicide often will agree to call him insane. As between the stigmas of suicide and insanity, they generally consider insanity less shameful.

Leading students of the suicide problem now accept as proved that people from one end of the mental spectrum to the other kill themselves—from the sane, well-balanced person who makes a coldly logical decision that the act is necessary, to the raving lunatic who hears voices which tell him to commit suicide. The majority of

those who kill themselves are in the group psychiatrists call neurotics. Most of these people commit suicide while suffering from a temporary emotional disturbance, but they are far from being insane.

One problem which researchers are now trying to solve—and it is a difficult one—is why, when two people are faced with similar problems, one will choose suicide as a solution while the other will not. One man will suffer severe ill health, bankruptcy, and the loss of loved ones and each time pick up the pieces of his life and carry on. Another man will commit suicide when a sweetheart he has known for three months leaves him. Why?

Some persons seem more predisposed toward suicide than others.

In Mexico City in September 1947 a customer walked into Inocencio Rosa Cortes' shoemaker's shop and asked him to fix a pair of shoes. The shoemaker took one look at the badly battered shoes, screamed, grabbed an awl, and stabbed himself ten times in the chest.

In 1915 when General John J. Pershing was on duty along the Mexican border his San Francisco home was destroyed by fire. His wife and three daughters—all his family except his son Warren—perished in the flames. After this greatest tragedy of his life General Pershing's hair whitened, his face became etched with lines, his ramrod correctness increased—but he did not commit suicide.

The contrast between the degrees of the stress strongly suggests that the real cause of suicide is to be found inside each of us, rather than in any apparent outside situation. The drive to suicide may exist in some people for a long time before they commit the act. If a man suffers a heavy gambling loss and blows his brains out, one question a researcher would ask is why he gambled in the first place. Perhaps he was really only looking for an excuse to force his hand to the desperate act.

Many people instinctively reject the idea that a loved one has harbored an impulse to self-destruction for years. They insist on searching for causes only in the external situation which existed shortly before the suicide. Most of us find it hard to understand psychological drives which the psychiatrists tell us are powerful but which we cannot detect or measure and have not experienced our-

selves. The prevailing views on the subject continue to be incredibly naïve. As Dr. Karl Menninger says:

"No real reason for suicide is ever sought. Incredulous relatives and friends, who usually have disregarded the patient's suicide threats and the doctor's warnings, are likely to assign these naïvely absurd and grossly misleading causes—ill health, financial disaster, drops in social prestige, losing a loved one by death, separation or divorce—even the old 'gun cleaning' ruse—as the all-over apologetic reason for the final act."

The first real clues to the causes of suicide were articulated by the French sociologist Emile Durkheim just before the turn of the century. He arrived at some conclusions which are still widely respected.

Durkheim found that a major element in suicide is extreme loneliness. He said that the more a man is isolated from his fellows, the greater the danger he will kill himself. The more tightly knit a society, the fewer suicides there will be among its population. Modern studies of American and British cities have reaffirmed Durkheim's theory. These studies show that suicide and suicide attempts increase in neighborhoods where social disorganization is high.

Durkheim divided suicides into three types. The first he called egoistic suicides—the person who has no strong social ties and who is not well integrated into any group. Such suicides will be frequent, Durkheim found, in any group which does not bind its members closely and direct their lives. All of us belong to many groups, of course—the family, church, the people with whom we work, our circle of friends, civil organizations, hobby groups, and so on. Some of these groups may be tightly knit, others quite loosely held together. The man who belongs to no group is the one most likely to kill himself, Durkheim found. The more individuals have to depend on their own resources, he said, the more they will commit suicide.

Among religious groups, for instance, the suicide rate is lowest among Catholics, whose religion binds them closely in a collective life. Among Protestants there is a higher degree of individualism, and they consequently have a higher suicide rate. Modern man is

much freer in thought and action than his forebears were, and his suicide rate is higher than theirs.

Many of the statistics in Chapter II show that Durkheim's interpretation is still valid. People who are part of a large, closely knit family kill themselves less often than those who are not. In wartime the government integrates the individual more intimately into society, makes him part of a collective effort, and directs him more stringently than usual. He feels he belongs. The result is that the suicide rate drops.

Durkheim called his second category altruistic suicide. He said it occurs in groups too closely integrated and controlled. The altruistic suicide kills himself because he is too sternly governed by the community's customs and habits. In contrast to the egoistic suicide, who is left too free by his community, the altruistic suicide is not left free enough. Such overgoverned communities are primitive societies and the modern military, where ancient patterns of obedience and sacrifice are idealized.

In such overcontrolled groups, Durkheim said, the individual kills himself on the command of a higher authority, whether an actual leader or a strong ideal. In primitive societies these suicides are seen in religious sacrifices or after transgression of a powerful tribal taboo. In modern society they comprise the suicide of the secret agent, the voluntary death of the soldier on the battlefield to gain a victory or to save his unit from capture or annihilation, the political agitator who dies as a result of a hunger strike. Rommel's suicide would fall into this category.

Durkheim's third category is anomic suicide. It occurs when an individual who all his life has been well regulated by society suddenly is set free of regulations. Durkheim said that every person grows up learning certain beliefs and habits of living and is taught to gain satisfaction from them.

Society regulates everyone's life according to his position in it. The banker and his janitor, for instance, learn different needs and expect different things from life. When this regulation of the individual's life is upset, Durkheim said, and a man's horizon is suddenly

broadened or narrowed, the individual flounders and may commit suicide.

This concept helps explain the fluctuation of the suicide rate with changes in the business cycle. Durkheim's third category also would include the suicides of those, like novelist Ross Lockridge, who kill themselves after achieving sudden success. The horizon of life is suddenly made too broad and they are unable to cope with their new opportunities.

Dr. Thomas A. Malone, head of the Atlanta, Georgia, Psychiatric Clinic, said that these "success suicides" are more frequent than most of us would suspect and also gave one reason why they occur. He declared: "At least thirty to forty percent of the so-called economic suicides occur when a man is successful, not when he is failing. When a man has reached the peak of success, often he has nothing left to scramble for."

Many of us may find it hard to believe that sudden wealth would cause unhappiness to a great enough degree to lead to suicide. There are, however, plenty of statements by those to whom it has happened which help explain the emotional distress which often follows sudden success.

Leland Hayward, producer of such hits as *South Pacific* and *Mister Roberts*, told an interviewer just before the opening of the successful film *The Spirit of St. Louis:*

"Billy Wilder, the writer-director, and I are going to be millionaires. The picture cost over $6,000,000 to make, but we start to participate in the profits when it grosses over $13,500,000. I'm sure it will gross $20,000,000.

"That's the trouble. I'm very neurotic. Whenever I have a big hit I go into a suicidal depression for months. Success always throws me to my knees. I'm never quite satisfied and I begin to brood about the things I should have done.

"When *Spirit* opens in New York next week to great acclaim, I'll be the most depressed and miserable man in town. My wife knows this and has already begun to make preparations for it. She's probably bought tickets for some faraway place where I can brood in peace about success."

Kathleen Winsor, author of the highly successful novel *Forever Amber*, had this to say about success:

"I would say that having a book you write become a best seller has much the effect of any other sudden and inordinate success: It is like being in an automobile accident from which you emerge to find no bones broken and walk away—the worst part is later, when the shock sets in. All sudden changes are profoundly disturbing, but success of any kind—contrary to what we are brought up to believe—is one of the most unsettling experiences we can have.

"The fact is, I think, that none of us, in our hearts, really believes we deserve success. And our friends and relatives, we are likely to find, do not really believe we deserve it either. To say nothing of people we will yet meet or may never meet at all, who will nevertheless express their hostility slyly against anyone bold enough to have gotten the things he wanted. It is not all pleasant by any means."

In *The Varieties of Religious Experience* William James says: "Take the happiest man, the one most envied by the world, and in nine cases out of ten his inmost consciousness is one of failure. Either his ideals in the line of his achievements are pitched far higher than the achievements themselves, or else he has some secret ideals of which the world knows nothing, and in regard to which he inwardly knows himself to be found wanting."

Since Durkheim, most of our knowledge of the problem of suicide has come from three sources—sociologists, actuaries, and psychiatrists. The sociologists and the actuaries deal almost exclusively with the "who" of suicide—gathering facts and figures and correlating them to learn who commits suicide and when and where. Their work has been illuminating and useful. With their data we have learned to predict how many suicides in a given period there will be in different groups of people.

But we cannot predict *which persons* in any group will kill themselves. For that we must turn to the psychiatrists, the only researchers who have the proper tools for discovering the "why" of suicide.

Only in the psychiatrist's office can the complex psychological

mechanism underlying suicide be dug out. These intimate details are seldom known to friends and family and can hardly be reported in the press.

It is obvious, however, that there is a major difficulty in getting at the causes of suicide. The subject is usually beyond study—he is dead. Unless he has been under long-time psychiatric care, an interpretation of his suicide becomes an ex post facto reconstruction of his life history. This is difficult and frequently impossible.

What the psychiatrists have learned about the causes of suicide has come from patients who express suicidal urges, who have attempted suicide, or sometimes from the records of those who have killed themselves during treatment. Only a tiny minority of any given population receives psychiatric care. For this reason progress in understanding suicide has been slow and painful.

The fundamental fact about suicide that the psychiatrists have learned is that each of us has a built-in suicide potential. For this reason nearly all of us think of self-destruction, however fleetingly, at some time in our lives.

Whether our latent potential ever will become powerful enough to culminate in suicide is determined in the main by our conditioning in infancy and childhood.

Because they cannot think logically and have no previous experience, the baby and the young child cannot evaluate their own worth. Their conception of their worth as human beings comes almost exclusively from their parents. The parents' attitudes are accepted uncritically. The child could be said to form his image of himself in a mirror held up by his parents. If that mirror is distorted, the reflection which the child sees will be distorted.

If his parents reject him, belittle him, or vacillate in their attitude, or if they die or abandon him, the child is almost certain to conceive of himself as worthless. This evaluation is extremely painful to the child. He reacts with strong hostility and hatred toward the parent who has deprived him. As he grows up this hatred evokes strong and constant guilt feelings.

An adult who has a poor idea of his own worth, who has powerful currents of hatred boiling within him, and who carries a great

burden of guilt caused by the hatred, has a very high suicide potential. The troubles of life can easily cause him to turn his hand against himself. Sometimes it takes very little to cast the die for someone in whom a strong suicidal urge has been building up for a long time. Such persons might be said to be in a state of unstable equilibrium. The addition of a feather's weight is sufficient to topple them.

A St. Louis man who drowned himself in a park lagoon in 1954 left this note: "It is too hot to live. I am going to drown myself."

A 76-year-old Kansas man complained all the way from Salt Lake City to Twin Falls, Idaho, because he couldn't smoke on the bus. When the bus stopped at Twin Falls, he declared: "If I can't smoke I might just as well end it all," and shot himself to death.

A Frenchman worked all day on his income tax form in 1947 and couldn't figure it out. He told his wife: "I'd rather die than go through another day of this." Next day he was found hanged.

One of the most famous cases of a suicide being triggered by a trivial occurrence was that of Vatel, chef of King Louis XIV of France. He fell on his sword when the fish failed to arrive for a royal dinner.

One point on which the psychiatrists are emphatic is that no man becomes suicidal in a day. The poisonous emotions which culminate in suicide were brewed in childhood. They cause bitter internal struggles as the child grows up. It may seem that an immediate cause was responsible for a man's suicide. However, the problem he faced would not have led him to choose suicide as a solution to his mounting stress unless he had already been conditioned toward suicide in early childhood.

The potential suicide is like a cocked pistol. An outside force pulls the trigger. He explodes.

The suicide potential of most persons is not always evident. A person with a strong bent toward suicide may appear on the surface to be no different from his relatives and friends. The situation is not unlike that of the occasional person who dies after being stung by a wasp. Neither he nor anyone else knew until he was stung that he had been unusually sensitive all his life to wasp venom. Then

when he is stung—a comparatively trivial matter for most of us—he has a violent reaction which may culminate in death. A problem of trivial importance to most of us may lead to the suicide of someone whose early conditioning left him abnormally sensitive to that given problem.

Generally the person who kills himself is unaware of the hatred and guilt which lead him to the act of self-destruction. For fear of the punishment which such terrible feelings might bring if they were known, his conscience buries them deep in his unconscious mind. Those of us who have these feelings are aware only of the tensions, depressions, and fears which they cause in the conscious part of our minds.

The unconscious part of our minds is extremist. It does not deal in halfway measures. It equates a wish with the act. To hate is to want to kill. In someone in whom these buried hatreds are powerful the unconscious says in effect: "You wish someone to die, and to atone for this *you* must die."

Most psychiatrists believe that nearly everyone who kills himself harbored a powerful, unconscious desire to kill someone else—usually a parent. Prevented by conscience from carrying out this desire to kill, he turns the desire to kill inward on himself.

One of the best explanations of how this seemingly illogical process works was given by Dr. Zilboorg in the September 1936 issue of the *Atlantic Monthly:*

". . . merely to hold hatred and aggression in check does not suffice. Human emotions, particularly those based on very primitive human-animal drives, cannot disappear any more than matter or energy can disappear. You can harness the flow of a river; unless an outlet for its waters is provided, the dam will break and the energy of the water will become wild—savage. If such an outlet is provided, the impact of the water may be used to grind wheat or to produce electricity, and the energy then becomes domesticated. You may, as an alternative, build a dam so high that the water, after striking it, will fall back and appear to change the direction of its flow. This simile is not merely a poetic parable. It is more realistic than one would at first suspect. Let us take, for instance, this last stratagem.

Suppose that we erect an extremely high dam to control our river. The water strikes it, is turned back on itself, and its energy is lost in a useless whirl. The same process can be observed in man. At one time or another we all experience that state of helpless rage during which we will not, or cannot, give vent to our impulses. The psychological dam, whether we call it inhibition, self-control, or cowardice, happens to be too high. The accumulated aggression, or the overflow of it, is then turned against our own selves, and we bite our lips, we sink our nails into our hands, or, if we are a bit off the psychological balance, we hit ourselves as a child in a tantrum strikes its head against the wall or the floor.

"This psychological mechanism for turning one's aggression against one's self is of utmost importance from both the individualistic and the sociological point of view. To the individual it is a useless domestication of his hostile impulses in the process of which he becomes the victim of his own drives. This is one of the most potent psychological trends underlying suicide. Very few victims of suicide fail to give evidence to the psychiatrist and psychoanalyst that they were laboring under the unconscious (dammed up) drive to commit murder—a drive which, turned on themselves, resulted in *self*-murder."

The suicide thus gives in to his desire to kill by committing a murder. At the same time he relieves his conscience of guilt by killing himself. When one psychiatrist talks to another he describes the process this way: The suicide murders the introjected object and expiates guilt for wanting to murder the object. The ego is satisfied by murder and the superego (conscience) is mollified through self-murder.

The combination of these different drives can be seen in the case of a California bank teller who was fired in 1955. A month after his discharge he crashed a light plane into the bank building. A police officer accurately remarked: "Apparently he was trying to get even with the bank for firing him and get rid of himself at the same time."

Dr. Karl Menninger said that there are three elements in every

suicide: (1) the wish to kill, (2) the wish to be killed, and (3) the wish to die.

It might seem that the wish to be killed and the wish to die are the same thing. They are not. The wish to die involves the "death instinct," which was formulated by Sigmund Freud in 1920. Freud postulated two instincts which are in constant battle within every human being—Eros, the life instinct, which causes us to want to preserve our lives, and Thanatos, the death instinct, which causes us to want to die. If the death instinct gains the upper hand, the person dies—by suicide or some other means. Menninger's second element—the wish to be killed—results from guilt. It does not involve Freud's death instinct.

Ever since Freud first formulated it, the death-instinct theory has been highly controversial, and it now seems itself to be dying. Many psychiatrists reject it on the ground that it explains little, being merely a tautology—another way of saying that people do die.

To sum up:

If a child experiences trouble in his extreme dependence on his parents or is raised in an atmosphere in which there is much hostility, usually involving severe rejection by one or both parents, he will have a high suicide potential. He will be filled with hatred, aggression, and guilt which he will have difficulty controlling.

If he finds easygoing acceptance by those with whom he is associated in later life, and experiences only mild frustrations, he may be able to control the hatred and aggression.

If he meets with a strong frustration or a severe rejection—a divorce, a financial setback, a sudden loss of prestige, or something similar—the repetition of his early problems may cause his aggression to get out of hand and he may kill himself.

One form of rejection which recurs strikingly in the history of suicides is the death, or loss through long absence, of a parent or sibling. The young child, all-demanding, is unable to understand death or the need for a long absence. He views the death or absence as a rejection of himself. Many psychiatrists are convinced that the death of a loved one produces a definite predisposition toward suicide, whether it occurs early or late in life.

A major research project on this aspect of the urge to self-destruction was conducted by Drs. Leonard M. Moss and Donald M. Hamilton at the Westchester Division of New York Hospital. They reported in the April 1956 issue of the *American Journal of Psychiatry* that they had examined the life histories of 50 patients who had been hospitalized after making serious suicide attempts, which they survived accidentally.

The researchers found that 95 per cent of the patients had suffered the loss of a parent, sibling, or mate "under dramatic and often tragic circumstances." In 75 per cent of the cases the deaths had taken place before the suicidal patient had completed adolescence. In the remaining 25 per cent the death occurred when the patient was older and precipitated the depression which led to the suicide attempt. Forty per cent of the patients had lost their fathers and 20 per cent their mothers in childhood or infancy.

"In every case of parental loss," the psychiatrists reported, "the patient felt a removal of the mother's usual love and support brought about by a disruption of the home after the father's death. In some instances the altered economic status of the family necessitated the mother's working and sending the children to live with relatives or foster parents. In other instances the mother reacted to the death of her husband with bitterness, often becoming irritable with her children, or with immature self-centered reactions resulting in a demanding rather than a giving relationship with them."

These doctors used two control groups of patients for comparison with the suicidal group. One was a group of 50 patients who were not considered potentially suicidal; the other 50 were considered potentially suicidal but had not made an attempt at suicide. In the control group, the number who had lost a relative through death was only 40 per cent, compared with 95 per cent of the suicidal group. And death of a parent before or during adolescence was four times as frequent.

All those who have studied the problem of suicide are familiar with the phenomenon of "anniversary suicide." Many persons kill themselves on the anniversary of the death of a loved one, most often a parent. Some of these suicides the psychiatrists attribute to

the person's feeling that his relative died as a result of his own unconscious murderous wishes toward the relative. Committing suicide on the same day or hour on which his relative died may in his mind heighten the degree of retribution demanded by his unconscious.

Other "anniversary suicides" are committed by persons who have a strong desire to join a loved one who has died. Children often kill themselves after the death of a beloved parent. Husbands and wives frequently kill themselves to join their dead spouse. Psychiatrists say these people die voluntarily because they have experienced a sudden loss of love.

This type of suicide has led to a widespread belief that the tendency to suicide is hereditary. All leading researchers declare there is no evidence that suicidal urges are inherited.

In contrast to those who kill themselves after experiencing a sudden loss of love, some persons kill themselves when they appear to be on the verge of gaining love. Scores of Americans kill themselves every year immediately before their wedding or a few days afterward. It is not rare for both spouses to kill themselves in a suicide pact within hours or days after they appeared at the altar.

As far as the authors are aware, no studies have been made of this particular phenomenon. One can only surmise that since a wedding often involves very great emotional strain, it may trigger the suicidal impulse even though no rejection appears to be involved.

Another element often found is a wish to punish someone who has deprived the suicide of love or who has been hostile toward him. The psychiatrists describe this as a form of mental blackmail. The suicide in effect says: "You'll be sorry when I'm gone." Some children say exactly this to a parent who is punishing them. This type of suicide wants to hurt the other person by making him feel guilty about his death.

This attitude is clearly seen in the note left in 1947 by an Illinois man. He killed himself after receiving a letter from his sweetheart saying that she was marrying another man. His suicide note read: "Darling, I cannot live without you. I am going to the garage and

use the car that is in there. Remember, I loved you so much I died for you."

Frequently the suicide telephones his spouse or sweetheart. Before pulling the trigger he says something like this: "I am going to kill myself. Listen and you will hear the shot."

Psychiatrists say that a person who kills himself to punish someone else may not truly believe in the finality of death. Implicit in the act is the feeling that somehow he will be around to witness and enjoy the pain he has caused.

Many suicides do not see death as a state of non-being, but as a way of ending the pain caused by this world and of entering into a happier one. George Bernard Shaw put it well. "Death," he wrote, "is for many of us the gate of hell; but we are inside on the way out, not outside on the way in."

This attitude was well illustrated by the response to a device used by New York City's Hayden Planetarium to show the public that interplanetary space trips were becoming a definite possibility. With tongue in cheek, the planetarium asked for reservations to Venus, Saturn, the moon, and other planets. It promised faithfully to turn them over to the first interplanetary travel agency. In weeks it received more than 18,000 reservations and requests for information.

Interested by the volume of response, a psychologist made a study of some of the reservations. A few were patently gags, he decided. However, most came from people who seemed to be tired of it all and thought the chance of escaping this world was no joke. The letter written by a woman from Massachusetts was typical. "It would be heaven to get away from this busy earth," she wrote. "I honestly wish God would let me get away—and just go somewhere where it's nice and peaceful, good, safe, and secure."

For a long time it has been known that some savages allow themselves to be *willed* to death. This remarkable feat is cited by D. H. Rawcliffe in his book *The Psychology of the Occult,* published in 1952:

"Stories of natives dying after being cursed by a witchdoctor—a phenomenon now called *thanatomania* by some anthropologists—

are no product of the explorer's or missionary's imagination. It is indeed a fact that an idea can so powerfully get a hold on the mind of primitive man that it can result in death within a few days.

"He believes that he will die and die he does—unless his friends manage to persuade the witchdoctor to 'lift' the curse, whereupon he will immediately recover on having the news brought to his notice."

Even among civilized persons there exists a strange phenomenon which psychiatrists called "psychic murder." It appears that some people who commit suicide actually do so in response to another person's wish that they should die. This startling theory was described in the American Medical Association's *Archives of Neurology and Psychiatry* by Dr. Joost Meerloo, of New York. He cited some typical cases.

An executive who knew that his wife was depressed refused to allow her to be treated, and then chose that moment to go on a vacation with his secretary. Left alone, the wife killed herself. In another case a young man gave his domineering and drinking father a bottle of barbiturates to "cure" his alcohol addiction. The father died of an overdose of the drug.

These people committed suicide on the unconscious command of their relatives, Dr. Meerloo maintains. He called the phenomenon "psychic homicide." He said it was a crime of omission rather than commission, since the "psychic murderers" were unaware of their wishes or the real meaning of what they did before the relative killed himself. Dr. Meerloo says, however, that the victims were "inadvertently aware of the wish or the command of their proxy that they have to die."

The most dangerous period for many disturbed persons is just after they have passed through an emotional crisis and seem to be recovering. In one study of this peculiarity, Shneidman and Farberow noted that half of 32 patients who killed themselves after being discharged from the Veterans' Administration psychiatric hospitals in the Los Angeles area did so within 90 days. They concluded that a suicidal person needs extra care for three months after he has passed the peak of an emotional crisis. Other psychiatrists agree.

Some people commit suicide without ever being consciously aware that they are doing it. They have fatal automobile "accidents" or are "accidentally" killed at work or "accidentally" drown because they swam too far from the beach.

Of course, not every automobile accident, industrial accident, drowning, or other accidental death is an unconscious suicide. However, many psychiatrists believe that of our annual automobile deaths, industrial accidents, and other forms of accidental death, a larger percentage than most would suspect are unconscious suicides. Fundamentally, they say, the same psychic forces that make a man blow his brains out also make him careless on the road.

Nearly everyone knows at least one person who insists on driving after he has had too much to drink, or one who constantly takes unnecessary chances by driving too fast or passing on hills. Many of those who cross major arteries against traffic lights are driven by an unconscious impulse to suicide. So is the man who climbs mountains or plays fast tennis despite a weak heart.

Another group of people kill themselves more slowly. It may take years for them to die. The psychiatrists say these people commit "installment-plan suicide." They are the alcoholics, the drug addicts, those who overwork or smoke too much when they know it is bad for their health.

Also in this group are the accident-prone—the persons who have one accident after another. Each accident is a "partial suicide," the psychiatrists say, or a "little suicide." Additionally, there are many people who plague surgeons for unnecessary operations to relieve imaginary ailments. Each operation is for them a partial death.

Dr. Zilboorg explained the "partial suicide" and "installment-plan suicide":

"Between the two extremes of biting one's lips and committing suicide there is an uninterrupted series of various degrees of aggression turned in various degrees and manners on one's own self. Many neurotic complaints, from stomach trouble and headache to severe disturbances in health without apparent organic reasons, are based in whole or in part on the same mechanism."

Dr. Karl Menninger said that accidents suffered by the accident-

prone can actually be the price they pay for continuing to live. He found that a person may buy life by compromising with his unconscious and limiting the suicidal impulse to part of his body as a substitute for the entire body.

As Dr. Menninger put it: "Local self-destruction is a form of partial suicide to avoid total suicide."

To some readers, these findings may sound farfetched. The psychiatrists have been backed up, however, by such hardheaded organizations as the National Safety Council, the National Research Council, and the big insurance companies.

Research done by these groups proves that many people have repeated accidents neither accounted for by circumstances nor in accordance with the laws of probability. So many people are fighting raging battles for life against the traitor within themselves that they are a hazard in our mechanized civilization.

It might seem that these psychiatric findings would apply equally well to those who try to kill themselves but survive. Until recently psychiatrists and others thought this was true. The few researchers who concerned themselves with attempted suicide regarded it as just a bungled suicide.

About ten years ago, however, some researchers began to take a really good look at these "bungled suicides." They concluded that many persons who survive a suicidal act are driven by forces quite different from those impelling the successful suicides. What often seems to be accidental survival was not accidental at all. The researchers maintain that attempted suicide is something quite different from true suicide. The distinction between the two acts should not be based on whether a person succeeds or fails in taking his life. Instead, it should be based on his unconscious intention when he lifted his hand against himself.

One leading researcher into attempted suicide is E. Stengel, a British psychiatrist. He declared:

"It becomes obvious that self-destruction cannot be the main and only purpose of the suicidal attempt. The self-injury in most attempted suicides, however genuine, is insufficient to bring about death, and the attempts are made in a setting which makes the

intervention of others possible, probable, or even inevitable. There is a *social* element in the pattern of most suicidal attempts. Once we look out for that element we find it without difficulty in most cases. There is a tendency to give a warning of the impending attempt, and to give others a chance to intervene. We remember how few suicidal attempts are carried out in circumstances that would make death certain. If we think in terms of a social field we may say that those who attempt suicide show a tendency to remain within this field. In most attempted suicides we can discover an appeal to other human beings . . ."

Of the perhaps 250,000 attempted suicides each year in the United States, many thousands are the type described by Dr. Stengel. The two cases which follow were taken from New York City newspapers and are typical.

"With her 2-year-old son, Mrs. —, a striking blonde familiar to cafe society, walked into the Stork Club yesterday afternoon, announced she had swallowed poison, handed a note to an attendant, and soon afterward collapsed.

"At St. Clare's Hospital, to which Mrs. — was rushed by taxi in the company of another employee of the club, it was said that the young woman was suffering from an overdose of sleeping powder, and that her condition was fair. . . ."

The second case also concerns a woman:

"Everyone laughed when Mrs. —, 31, sat down after dramatically announcing at the end of a gay party in her apartment early today that she had taken an overdose of sleeping pills, police reported.

"Twenty minutes later she collapsed.

"Rushed by ambulance to Roosevelt Hospital, her condition was pronounced fair. . . ."

It is a tragedy that most of us dismiss these suicide attempts as dramatic gestures—phony devices for gaining attention. This unfortunate attitude leads to many avoidable tragedies, for most suicidal attempts involve a great deal of risk and may end in death if they are ignored. In discussing the appeal inherent in most suicide attempts, Dr. Stengel wrote:

"If it is overlooked or remains unheard, or if it is smothered by

the force of the self-destructive impulses, the suicidal attempt will succeed. The outcome, therefore, depends on whether there is a receiver for the appeal."

The sincerity of this appeal and the risk which is run is shown in the case of a certain housewife. She took an overdose of sleeping pills shortly before her commuter husband arrived home on the 6:45. Finding her unconscious, he rushed her to the hospital. Her life was saved. Nothing was done, however, to answer her appeal for help.

A few months later she again took an overdose of sleeping pills shortly before the 6:45 was due. Again her returning husband saved her and again her basic problems were ignored. The third time she made her appeal her husband missed his train. She died.

What is the person who attempts suicide appealing for? Psychiatrists say many attempts are appeals for a change in human relations which have become intolerable. The suicide attempt is "a catastrophic reaction to an intolerable social and emotional situation." Through it the person hopes to bring about a change in his environment and in the attitudes of others toward him.

Like the true suicide, the person who attempts suicide often suffers from lack of love. His suicide try is an appeal for love. It may even be an attempt to blackmail love from someone.

The person who tries to kill himself is generally unaware of all this. His unconscious mind causes him to flash a warning signal. He needs help with his emotional problems. With some people, the suicide attempt is a last, desperate effort to control their fate before they succumb to mental illness.

A gamble with death is an important part of many suicide attempts. Dr. Stengel calls this the "ordeal character" of the attempt, "the term ordeal being used here in its original sense of an ancient trial in which a person was subjected, or subjected himself, before the community, to a dangerous test the outcome of which was taken as divine judgment."

Dr. Stengel says that the result of many suicide attempts depends on factors not wholly under the control of the troubled individual.

Much that has been said is implicit in the following case. In 1950

a Chicago salesgirl swallowed an overdose of sleeping pills in her lover's apartment. After rejecting her, he had gone with another woman. The salesgirl wrote a long note to him and then stretched out on his couch, gambling with death. In part, her note said:

"Who am I to reproach you? A little shopgirl . . . no money . . . no family position . . . a lot of debts . . . but with so much love in my heart for you that I would rather die than live without you. . . .

"Now you are faced with a funny decision if you come home. . . . I have an idea you won't be home tonight . . . but if you are . . . here is your strange decision. . . . I will be asleep. . . . You can turn around and walk out again . . . and say that you lent me the apartment for the night because of my work . . . and that you stayed at a hotel. . . .

"Or you can call a doctor. . . . And if you call a doctor and I get well, I will expect that the reason you bring me back to a life I am willing to leave is because you don't want me to leave it . . . that you want me to be a part of your life . . . that you want to marry me. . . . So think well before you decide . . ."

Her lover returned and found her unconscious. He called a doctor, but attempts to revive her were futile. She lost her gamble with death.

Many who attempt suicide are wracked between their impulse to die and a desire to go on living. Some leave it to fate or to God whether they die or not. When they survive, whatever was bothering them may subside a while. They accept the outcome of the ordeal as a sign that they were meant to live. Sometimes their depression disappears immediately after the attempt.

Of prime importance is the way an individual's relatives and friends respond to his suicide try. If they are understanding, he may never try again. If they are not, he remains a potential suicide.

Dr. Stengel comments: "To the patient the suicide attempt stands for death, and survival, and a new beginning. To the relatives it stands for bereavement and mourning. It sometimes creates the peculiar situation in which somebody who has died and revived is with us alive while we are mourning him. All this engenders a tendency to renewal and revision of human relations on the part of all concerned."

In this society which values human life greatly, the appeal of attempted suicide is heightened by the threat the attempt contains. None of us would like to have the death of another person on our conscience. Because of this the thousands of suicide attempts every year are frequently highly successful in compelling other people to do what the suicidal person wants done. Suicidal risks are run every day to gain almost anything a human being could want, or to ward off what he cannot tolerate. They are highly effective.

Dr. Stengel adds: "In a society where the appeal is likely to go unheard, there are far fewer attempts. For instance, in Nazi concentration camps there were far fewer suicide attempts than would be expected. In those horror spots the appeal in a suicide attempt most likely would be ignored. Therefore, attempts became infrequent. In a hostile society a suicide attempt does little good."

Surprisingly, psychiatrists have found that most of those who try suicide to gain some end other than death are actually more disturbed than those who really want to die. Apparently the mind must be more unbalanced to engage in a gamble with death than flatly to invite death.

A group of American psychiatrists who made a study of 108 persons who had attempted suicide found that not one was psychiatrically well. This contrasts with the true suicide group, in which only 20 to 30 per cent have major psychiatric problems. The ability to distinguish between the two is important in deciding how to treat persons who try to kill themselves.

If we are to help those who try to kill themselves, we must get over our notion that someone who has made a suicide attempt merely failed in his effort.

As Dr. Stengel said in commenting on his study: "There were a number of patients . . . whose suicidal attempts were successful in securing them admission to hospital with subsequent recovery.

"An 'unsuccessful' suicidal attempt which had so obviously fulfilled a highly beneficial function is, conceptually, the counterpart of the proverbial 'successful' operation from which the patient died."

Chapter X

SUICIDE NOTES

WHEN a man plans to be dead in an hour, what does he say to his loved ones, his friends, the world at large?

What thoughts does he commit to paper for the enlightenment or puzzlement of those he is leaving? How does he explain this final act of his life? Does he give accurate reasons for doing it? Can we learn anything about self-destruction from suicide notes?

Only in the last few years have notes come to be regarded as valid research tools which can help throw light on the enigma of suicide. Researchers who have studied notes have learned many curious facts about them. One of the most curious is that it is very difficult, if not impossible, to fake a suicide note.

If you were to try right now to write a "suicide" note, putting down what you think you would write if you were going to end your life, the odds are ten to one that an expert could spot it immediately as a fake.

In one of their research projects, Shneidman and Farberow asked a group of people to write simulated suicide notes. They then compared these with genuine notes left by people of the same age and background. This is what they found:

"The fictitious-note writer, although he can apparently approximate in fantasy the 'affect' of suicide . . . does not take the additional step of converting his fantasy into the 'reality' of imminent

absence. In other words, only the genuine-suicide-note writer deals with the idea of his really being gone."

Genuine notes tend to contain more separate ideas than fictitious ones. The person who really intends to die gives many more instructions and admonitions to those he leaves behind than can be faked in a note.

A group of Philadelphia researchers checked the accuracy of the reasons given for the act in genuine suicide notes by asking friends, relatives, and family doctors what they thought were the true reasons. They found that in more than 90 per cent of the cases there was agreement between the reasons given in the note and reasons given by the friends and relatives.

Some notes consist of long letters summing up life's experiences, giving reasons for the act or defending it. Some are short missives of two or three words. A few of the longer notes became widely known and have achieved a measure of fame.

One of the most noted was written by an English bookbinder and his wife in 1732. He had financial troubles and with his wife and two-year-old daughter had been imprisoned for debt. Before killing themselves and their child they left a letter addressed to the public. It attracted wide attention throughout Europe. Voltaire and Diderot commented on it, and Smollett mentions the couple in his *History of England.*

This is what they said:

"These actions, considered in all their circumstances, being somewhat uncommon, it may not be improper to give some account of the cause; and that it was inveterate hatred we conceived against poverty and rags, evils that through a train of unlucky accidents were become inevitable. For we appeal to all that ever knew us, whether we were idle or extravagant, whether or no we have not taken as much pains to get our living as our neighbours, although not attended with the same success.

"We apprehend the taking of our child's life away to be a circumstance for which we shall be generally condemned; but for our own parts we are perfectly easy on that head. We are satisfied it is less cruelty to take the child with us, even supposing a state of

annihilation as some dream of, than to leave her friendless in the world, exposed to ignorance and misery.

"Now in order to obviate some censures which may proceed either from ignorance or malice, we think it proper to inform the world, that we firmly believe the existence of an Almighty God; that this belief of ours is not an implicit faith, but deduced from the nature and reason of things. We believe the existence of an Almighty Being from the consideration of his wonderful works, from those innumerable celestial and glorious bodies, and from their wonderful order and harmony.

"We have also spent some time in viewing those wonders which are to be seen in the minute part of the world, and that with great pleasure and satisfaction. From all which particulars we are satisfied that such amazing things could not possibly be without a first mover—without the existence of an Almighty Being. And as we know the wonderful God to be Almighty, so we cannot help believing that he is also good—not implacable, not like such wretches as men are, not taking delight in the misery of his creatures; for which reason we resign up our breath to him without any terrible apprehensions, submitting ourselves to those ways which in his goodness he shall please to appoint after death.

"We also believe in the existence of unbodied natures, and think we have reason for that belief, although we do not pretend to know their way of subsisting. We are not ignorant of those laws made *in terrorem,* but leave the disposal of our bodies to the wisdom of the coroner and his jury, the thing being indifferent to us where our bodies are laid. From hence it will appear how little anxious we are about 'hic jacet' . . .

[signed] Richard Smith
Bridget Smith"

One of the most widely read suicide notes of our time was left by Ralph Barton, one of the nation's leading satiric artists and caricaturists. He shot himself to death in New York City in 1931, when he was 39. He had been married and divorced four times and had often talked of suicide.

Before he shot himself he sat at his typewriter and wrote a long message, which he captioned "Obit." It is a remarkable document, in which satire, cynical humor, and a straightforward diagnosis of his dissatisfaction with his life are mingled:

"Everyone who has known me, and who hears of this, will have a different hypothesis to offer to explain why I did it.

"Practically all the hypotheses will be dramatic and completely wrong. Any sane doctor knows that the reasons for suicide are invariably psycho-pathological and the true suicide manufactures his own difficulties.

"I have had few real difficulties. I have had, on the contrary, an exceptionally glamorous life—as life goes—and I have had more than my share of affections and appreciations.

"The most charming, intelligent and important people I have known have liked me—and the list of my enemies is very flattering to me—I have always had excellent health since my early childhood. I have suffered from a melancholia which for the last five years has begun to show definite symptoms of manic-depressive insanity.

"It has prevented my getting anything like the full value out of my talent and the last three years has made work a torture to do at all.

"It has made it impossible for me to enjoy the simple pleasures of life. I have run from wife to wife, from house to house and from country to country, in a ridiculous effort to escape from myself. In doing so I am very much afraid that I have caused a great deal of unhappiness to those who loved me.

"In particular, my remorse is bitter over my failure to appreciate my beautiful lost angel—Carlotta [his former wife]—the only woman I ever loved and whom I respect and admire most of all the rest of the human race. She is the one person who could have saved me, had I been savable. She did her best.

"No one ever had a more devoted or more understanding wife. I do hope that she will understand what my malady was and will forgive me a little.

"No one thing is responsible for this and no one person—except

myself. If the gossip insists upon something more definite and thrilling, as a reason, let them choose my pending appointment with my dentist or the fact that I happened to be painfully short of cash at the moment.

"No other single reason is more important or less temporary. After all, one has to choose a moment and the air is always full of reasons at any given moment. I've done it because I am fed up with inventing devices for getting through 24 hours of every day and with bridging over a few months, periodically, with some purely artificial interests, such as a new gal, who unnerves me to the point where I forget my own troubles.

"I present the remains with my compliments to any medical school that fancies them, or soap can be made of them. In them I haven't the slightest interest except that I want them to cause as little bother as possible.

"I kiss my dear children—and Carlotta x x x x x x

In contrast to these lengthy, reasoned defenses, some persons leave brief statements that explain nothing.

One man wrote only: "I'm sorry."

Another declared enigmatically: "No comment."

A California man summed up a world of bitterness in the two words: "Goodbye suckers."

Only one person in four or five leaves a note. More men than women feel impelled to write. Men also are much given to describing their sensations as they die. The authors' collection of notes contains only one of this type written by a woman. Professional men, particularly physicians, are prone to write descriptions of their suicides.

A British physician, heavily in debt, took poison one morning, saw to a number of patients, then sat down to describe his sensations. He actually interrupted his writing to administer an injection to a patient only 10 minutes before he died. This is how his diary read:

"Waiting. Feeling very happy. First time I ever felt without worry, as if I were free. My heart must be strong. It won't give way.

"It's a long time. So slow. The Japanese are right; death is lovely; I feel fine, no pain."

Then, apparently after a pause:

"I have my vein opened—may find myself alive in a coffin—terrible thought.

"I have just given a patient an inoculation—getting slightly dazed—surely I cannot live on—must take prussic—pulse good.

"I have just given an inoculation for asthma—haven't passed away. Dosage is rot. Took no breakfast. Just shows how useless by the stomach are all drugs, all gland and other preparations. Extraordinary. Pulse running well. Feel fine—when will it be over?—have no prussic."

Then came a postscript: "God seems to be over me—just leaving for a lovely voyage, but it is slow—first time without worry."

The man who sent across the continent for a deadly black-widow spider and let it bite him left two notes, the first giving his reasons and the second describing his sensations:

"To whom it may concern: Whenever a man usually takes his life it is always proper to give the reason. My reason is because, first, I have no job. I have no one in this world except a woman I love terribly, and she is too good for me. I am ashamed of myself because I am a failure and not a success. God bless Rose. Goodbye."

He wrote the second note after the spider bit him.

"I feel the effects now. The room is going around and around. I can barely see what I am writing. Maybe it is the end. Who knows? I don't care. It is very pleasant. Yes. No." The note ended in an undecipherable scrawl.

A brilliant young chemist sat alone in his laboratory high above Manhattan late one Saturday evening and pondered life, science, philosophy, and religion. While the gay night life of the brilliant city swirled below him on the warm May night, he picked up some paper and wrote:

"This is my last experiment and it is in self-destruction. I believe that it is advisable, if one's inclinations lead to the anti-social side."

Pondering the meaning of philosophy and religion, he continued:

"I think Spinoza told the world more than Christ did, although Christ's message was more fundamental.

"Enticing as personal immortality sounds, I hope for oblivion. The worst they can do for one in this world is to hang you, and if there is any eternal torment worse than mine I'll have to be shown."

He lit a cigarette and poured a long drink from a bottle of whiskey.

"I don't know if it is of much importance, but I feel that the only method of dying without pain is to use carbon monoxide. To get a supply I am passing city gas through concentrated sulphuric acid to delete the mercaptan odor."

Again the problem of religion bothered him. He drank, deliberated, and wrote:

"There is no one that admires Jesus Christ more than I do, although the conventional contemporary method of worshipping him gives me a pain in the neck."

There he signed the note. But he had forgotten something and added a P.S.:

"The question of suicide and selfishness to close friends and relatives is one that I can't answer or even give an opinion on. It is obvious, however, that I have pondered it and decided I would hurt them less dead than alive."

His amusement at the blurry feeling of alcohol and gas seeping through his brain caused him to write a final line:

"P.P.S.: and the eight balls dreadful, like an outhouse in a fog, looms up to charm its victim, supine in the grip of grog."

A 21-year-old Massachusetts man, a former soldier, sat in his car while it filled up with exhaust fumes and wrote a technical description of his symptoms:

"Terrific smell of gas fumes . . . it would be 6:34 P.M., civilian time.

"It's getting rather dark to write. Eyes smart a bit . . . Afraid somebody will come by now . . . This is slow (6:36 P.M.).

"Engine sounds smooth. Faculties seem temporarily sharpened. Eyes still smart . . . one man objected when I stopped on his property . . . can't blame him much really . . .

"Seems that there are more gas fumes in here than anything else right now . . . muscles used in writing . . . in need of a rest. I'm afraid somebody will come.

"Elbows, esp., and wrists. Where is the will? . . . No particular desire to get out . . . seems to be getting the better of me fast. It's been just 15 minutes now. I wonder what it's going to be like? Chest filling up fast. Seems to be terrific pressure first. [Here some illegible scrawling.]

"Going . . . go . . . go . . ."

A 68-year-old man took a lethal dose of sleeping tablets and then sat playing solitaire and recording his thoughts:

At 9 P.M. he wrote: "No one's fault . . . no one to blame." Then he quoted the words of Sydney Carton in Dickens' *A Tale of Two Cities.*

"It is a far, far better thing that I do than I have ever done; it is a far, far better rest that I go to than I have ever known."

His next notation: "Thirty-five minutes past nine. It works so slow."

At the bottom of the page were the untimed words: "I can't win."

Study of suicide notes has only just begun, and the scientists are not sure yet just how much the statements in them are worth as guideposts to the causes of suicide. The Philadelphia researchers, for instance, found that the 165 notes they studied did not appear to agree with the currently accepted theory that suicide is caused by aggression toward other persons being turned inward. They reported:

"The hypothesis that suicide stems solely from hostility is not supported by the content of the notes. Actually, there is a range of affect from positive feeling tone found in half the notes, through neutral feelings found in 25 percent, to hostility found also in 25 percent. . . . The notes with few exceptions seem to be very coherent, clear, and to the point, and not covering up or fabricating, but rather show a ring of finality and a tendency to sum up life's experiences."

A note which appears to contain little, if any, aggression was left by a 47-year-old bachelor psychiatrist who fled to the United States

from his native Germany in 1934. He had lost 13 relatives to Nazi brutality. He hanged himself in his hospital in 1946 after a heart attack. His note was addressed to the hospital staff:

"Failing health and strength, the tragedies of my family overseas and the flight of my people abroad have made me melancholy and hopeless.

"My hopelessness is unbearable. Therefore, I have finally decided to end it all in despair.

"Loving thoughts and heartfelt thanks to my beloved friends and kind superiors and co-workers' patience and everybody who has been friendly to me. May they be blessed with happiness and health.

"Deep gratitude to the United States of America—haven and shelter to the oppressed and persecuted in this desperate hour.

"I pray for forgiveness and for aid to my tortured Jewish people overseas in the Holy Land."

The following note expresses the terrible plight of those who know they have everything to live for, but can't enjoy it because of overpowering melancholia. A successful banker, aged 55, left a number of long messages to friends, relatives, and business associates. One read in part:

"Sorry to be a nuisance this way. Call —— [undertakers]. I have no troubles of any kind, nor am I in bad physical health—but for a long, long time I have been depressed mentally and have suffered from melancholia that steadily gets worse.

"Except for this mental depression, I have everything to live for: Good friends, lovely business associates and a good future in this world, with financial ease.

"But I am unhappy—mentally.

"Forgive me, please—and know that the happiest hours of a crowded, busy life have been spent in North ——.

"No funeral, please—no flowers—just a simple burial in my plot."

In some notes, however, aggression can be clearly seen. This one was written by a young man who seemed to be in conflict within himself about his relations with his father. After he had been refused

a table in a night club he shot two men, killing one, then shot himself to death.

"There's only one genius in a number of generations. [My father] is it. The next one can't be expected for 100 years. I've tried to live up to it. I can't. He ranks. I don't."

Another note found in his pockets read: "Call N—— M—— tomorrow afternoon for dinner if conscious."

Some suicides express their personalities in a few pungent phrases and give powerful clues to the standards by which they lived. The last words of an unemployed British workman who hanged himself in an empty house in a London suburb in 1947 are a masterpiece of understatement. They also show the British passion for tidiness and respect for the law. On the wall of the house he chalked this message:

"Sorry about this. There's a corpse in here. Please inform police."

A minister who hanged himself in his church scrawled these words on the paper wrapper which had been around the rope: "God forgive me."

A 21-year-old air force man, disappointed in love, shot himself in an empty lot after writing in block letters on a piece of cardboard: "Live fast, live well, die handsomely."

Jules Pascin, a well-known French artist, slashed his wrists and hanged himself in 1930. Before he died he dipped a brush in his blood and wrote on the wall this sardonic message to one of his models: "Lucy, pardonnez-moi."

One psychiatrist has said that the tragedy of the artist is his inability to store up for the comfort of his old age some of the applause showered on him in his youth. A 58-year-old Hollywood actor scrawled this before shooting himself: "I tried so hard to make a comeback."

A few suicides leave formal obituaries written in newspaper style, in which they refer to themselves in the third person. Many of these have been published just as they were written.

In 1939 a man wrote a letter to the New York *Herald Tribune* detailing a life of recurrent tragedy. The paper printed his letter in full:

"To the 'fourth estate':

"You have often wondered why an intelligent man commits suicide. Well now you will get first hand information. This is the same as if you had known I was contemplating this step and interviewed me on the subject. I am twenty-seven years of age. My mind today is slightly twisted. To tell you the story I must go back several years.

"In 1929 I met a wonderful woman, to me she was the most perfect woman to ever live. At the time I was an enterprising young businessman making a very comfortable living. Just a kid who got the breaks. Well in 1930 she was killed. We were to be married on the 1st of May and on the 31st [*sic*] of April she came to me to ask if she might use the car, she had, she said, some shopping to do down town. She never returned from that shopping tour.

"Well it damn near drove me crazy. I turned to liquor and for several years would have nothing to do with women.

"Late in 1933 I met and married another woman. She was the sweetest woman a man ever had for a wife. To me she was not a wife but a sweetheart. Then along came our son. I was the happiest man in the world, except, when I thought of the girl who had gone on before. Well in 1935 my wife took the car on a shopping trip and need I say she never returned.

"Again I turned to drink lost my business and my money. I went on the road and traveled all over this country again with traveling shows. Then in 1937 July 3rd to be exact I met another woman who had all of the qualities of the other two and a few extra which they did not have. We were everything to each other for a long period of time when she left me for another man. And the loneliness of my life since then has preyed on my mind until it has twisted it beyond recompense.

"My son is dead my wife is dead what is left for me but death. When you receive this epistle I will have gone to join the others. There is a picture enclosed so that if you find this article worth printing you can print it and the picture. You see I always wanted to be a reporter but was always told I couldn't make the grade be-

cause I couldn't write. But I am taking this opportunity to report my own death, by gas.

"Thanking you

Sincerely yours,"

A 45-year-old laborer who took poison left this note:

"My small estate I bequeath to my mother; my body to the nearest accredited medical school; my soul and heart to all the girls; and my brain to Harry Truman."

A seaman addressed this note to a woman friend:

"I would like my sister Frances to have the piano that you have in your apartment. Do this or I will haunt you. Goodbye Sweets. Be seeing you soon. Love. Joe."

A 39-year-old Maryland man wrote:

"Everything in this world has gone wrong with me. I was either born 400 years ahead or 400 years behind."

Many people express concern that someone may be held responsible for their deaths, either being accused of murder or of driving them to their last act. They leave notes proclaiming they committed suicide. Typical is this note left by a 40-year-old New York man, which said only:

"I, H— M—, do hereby absolve everyone and anyone in connection with my suicide."

Others reveal the unconscious belief that though they will die, they will still be around to see the discomfiture of those whom they hate. This note is typical:

"I wish to be buried in Uniondale Cemetery No. 4, facing Marshall Ave., so that I may be able to see the fair-weather friends and thank them for their sarcastic and hateful remarks."

It is widely assumed that suicide notes are the property of the persons to whom they are addressed. This is not necessarily true. In some jurisdictions suicide notes seldom find their way into the hands of those they are addressed to. In New York City, for instance, a statute of the administrative code requires the medical examiner to retain the notes as evidence in establishing the cause of violent or suspicious deaths.

Since the farewell note of a dead policyholder can be the key evidence in establishing the cause of his death, insurance companies are understandably interested in seeing that such writings don't disappear. In most cases the relatives are given a copy of the document.

In some suspicious deaths, particularly where other people might have had a motive for murder, a genuine suicide note is the only item that will prove the death voluntary. In one such case the life of a Raleigh, North Carolina, man was saved by a suicide note. He had been convicted of murdering his wife and was sentenced to death. Nine months later, only 24 hours before he was to be executed, a relative searching through the dead woman's clothing found a note in her handwriting. It said in part:

"I have tried it twice before but I just failed to carry out my plan but I am going through with it today no matter what way it takes for death is what I want and this very day."

Another woman summed up tragedy, shock, and a painful decision in very few words:

"Dear J—: Since I found out that you were married, this is the best way out."

A girl who jumped from the George Washington Bridge wrote this:

"Telephone — and tell the doctor I've done it—made up my mind and gone somewhere. I know dad's and mother's hearts will not survive this shock so please give them something at once to ease their going. My way of going is lovely."

A bride of six weeks who worked as a waitress left this note for her husband:

"Dear R—: I love you very much but I don't seem to please anybody down at work. This is the best way out. Love always. Dolores.

"P.S., R—, I hurt too easy, I can't help it."

A woman in her thirties who jumped from a coastal steamer wrote a note on a telegraph blank and left it in her cabin:

"Life is so tiresome and futile. Insufferable bores, these human beings, with their petty affairs and pretenses and pitiful ego. The philosophers say that dreams are the best part of life. I have had

my dreams. This world is too ugly for me to live in. For one with my ideals, life among such people is no longer endurable, if only he knows how bored I am."

Actress Carole Landis, who took an overdose of sleeping pills in 1948, when she was 29, left this note:

"Dearest Mommie:

"I'm sorry, really sorry to put you through this but there is no way to avoid it—I love you darling, you have been the most wonderful mom ever—and that applies to all our family. I love each and every one of them dearly—everything goes to you—look in the files and there is a will which decrees everything—

"Goodbye, my angel—pray for me—your baby."

A 20-year-old girl who jumped from an office building left this note on the window ledge:

"No one is to blame for my doing this. It's just that I could never become reconciled with life itself. May God have mercy on my soul."

On May 27, 1933, Mary McElroy, 25, was kidnapped from her home in Kansas City by four men, who chained her in a basement for 30 hours. Her father ransomed her for $30,000. Three of the men were apprehended and convicted. Two were given life imprisonment, the third sentenced to the gallows. Miss McElroy appealed to the governor for leniency and succeeded in getting the man's sentence commuted to life.

After their trial the girl said: "I have no personal hard feelings against those men and I'm sure they do not hold hard feelings against me." She devoted herself to remaking them into "normal, acceptable citizens." She visited them in prison, got them interested in studying high school subjects, took them books, cigarettes, and candy.

She suffered several nervous collapses, and once explained: "I have nightmares about those men and the fates they brought on themselves. I was part of the drama that fixed their destiny. I cannot forget them."

Miss McElroy's mother died when she was a baby. She and her

sister were raised by her father, onetime city manager of Kansas City. He died in the summer of 1939.

In January 1940, Mary McElroy shot herself to death. She left this note:

"My four kidnappers are probably the only people on earth who don't consider me an utter fool.

"You have your death penalty now—so—please—give them a chance."

A 24-year-old girl who jumped from an airplane left this note. It was addressed to no one:

"Forgive me. I just couldn't bear it any longer. It takes courage to die, but it is cowardly to live an empty, ill life."

An 18-year-old California telephone operator who hanged herself January 2, 1946, left this explanation in a letter to her mother:

"A year ago exactly I made a sort of bargain with God or fate and this is my part of the bargain. I agreed that if something didn't happen in the past year—1945—to make life worth living that at the end of the year I'd quit living.

"That wasn't asking too much, but I didn't get it.

"Please don't think this is something brought on by late events. Suicide is a coward's way out, so I'm a coward. I just don't have the courage it takes to go on just existing."

Couples who join in suicide pacts often express the idea that they died to be together in the next world. Typical is this note written by a 19-year-old girl who killed herself with her 22-year-old sweetheart. It was addressed to a girl friend:

"When you receive this letter Henry and I will be in our Heavenly home. Don't grieve for us, for we are very happy."

A 43-year-old man and his 35-year-old wife, deeply in debt, took gas in their home and left several notes. One read:

"Please forgive the wine we had before we started this thing. It was the only way we could have had the nerve to do it. We thought it the best way."

The second note also was short:

"Please remember, once again, that no one is responsible for my debts other than myself individually."

Then he thought of a way to repay at least one debt and wrote a third note:

"It is our desire to contribute our bodies to —— Hospital, to whom we owe one of our debts."

A diary left by another couple told a strange tale of suicide, without giving any reason. A 22-year-old pharmacist and his wife took poison in 1948 and left this note:

"We have no explanation and no regrets. We are very happy and have a good time. We wish to be together in death as in life."

A diary which had been kept by the wife revealed that they had made lighthearted preparations for suicide for several days. She described how they went to a movie on New Year's Eve, then came home, drank a toast, and discussed the details of their deaths.

The following day, she noted, her husband went out to buy poison. After that they attended another movie.

"We laughed until our sides ached and came home to make our plans for tomorrow," the wife wrote. Then she told how she spent hours cleaning their apartment. When she finished, they ended their lives.

Women seem less given than men to describing the process of suicide. However, one twenty-five-year-old woman wrote several notes before turning on the gas in her apartment.

The first one read: "There is nothing mysterious about this. I'm doing this of my own free will."

The second indicated fear: "I am taking some whiskey. It makes it easier."

Her last note, written in a shaky hand, was a poignant one: "It's harder than I thought."

Chapter XI

HOW WE CAN CONQUER SUICIDE

WE *can* conquer the traitor within. We *can* help a relative or friend overcome a suicidal urge. We *can* greatly reduce our shocking national suicide rate.

The scourge of self-destruction can be defeated because the vast majority of suicides and suicide attempts are caused by emotional states which are temporary and remediable; because nobody becomes suicidal in a day and there is time in which we can help him; and because most people in whom a strong suicidal drive is surging flash clear warning signals of their danger.

To cut the shocking suicide rate, Shneidman and Farberow have said: "Doctors and private citizens need facts, not myths, about self-destruction."

We need to destroy the myth that suicide is a stigma; that someone who has attempted suicide is a family disgrace; that people who kill themselves are weak and possibly worthless human beings; that only insane people destroy themselves. Other human afflictions, such as leprosy and syphilis, once were discussed in hushed tones, as suicide is today. The layers of fear, superstition, and prejudice eventually were stripped from them, after which effective work could be done to eliminate them as major public health problems. The same is true of suicide, today's greatest unrecognized public health problem.

Experts agree that the most important things to be done if we are

to control suicide are: (1) to make Americans aware that there *is* a national suicide problem; (2) to clear up the mystery and horror which surround suicide; and (3) to make the danger signals of impending suicide as familiar as the symptoms of polio or tuberculosis.

These steps concern the public and not just the specialists. Psychiatrists and physicians cannot conquer suicide alone. They need the help of laymen who have been educated to recognize the symptoms of impending suicide and who then will call in professional help. Only then can the knowledge and ability of the specialists be used effectively to reduce the annual toll exacted by suicide.

Unlike the symptoms of polio, tuberculosis, or a heart attack, the symptoms of impending suicide do not generally cause physical pain, force a person to go to bed with a fever, or otherwise physically incapacitate him. Someone who is displaying even major symptoms of a strong drive toward self-destruction can go to work and carry on his daily life in a more or less ordinary manner. Because of this, most laymen are not aware that there are definite symptoms of impending suicide, and we permit many thousands to die each year who could be saved by a few weeks or months of treatment.

Most potential suicides flash a danger signal so simple that the layman can easily recognize it: The individual talks a lot about suicide. He proclaims that he is going to kill himself. Or he may say he is thinking of killing himself, without issuing any specific threat. Again, he may indicate in a vague but unmistakable way that death would be a welcome solution to a problem he considers too big to handle.

Such a person is in grave danger. His relatives and friends should spare no effort to get professional help for him. Unfortunately, it is a common belief that anyone who talks about committing suicide never will go through with the act. This idea is utterly false. More often than not, the individual who talks about ending it all is very likely to do just that.

The hardiness of this myth concerning suicidal statements exasperates those who are trying to attack the suicide problem. Despite their best efforts to date, it lives on and every year costs thousands

of lives. Time and time again the researchers have shown that most people who kill themselves give clear indication of their intention by advance word or deed. Shneidman and Farberow, for instance, found that three quarters of the suicides they studied had made threats or previous attempts before they finally did end their lives.

One of the most thorough recent studies of whether statements concerning suicide should be taken seriously was conducted by Dr. Eli Robbins, a St. Louis psychiatrist. His group interviewed relatives and friends of 119 persons who killed themselves in St. Louis between May 1956 and May 1957. His researchers talked to clergymen, bartenders, nurses, physicians, attorneys, and others. Dr. Robbins reported:

"Our most striking finding was that over two-thirds (69%) of the entire group communicated their suicidal ideas. . . . The most frequent manner was a direct and specific statement of the intent to commit suicide (41% of the entire group). Most of the statements showed preoccupation with suicide, with methods of committing suicide, and with death . . . in two-thirds of instances the communications were repeated. Thus, not only did the communications occur in a high proportion of cases but they tended to be multiple, repeated, and expressed to a number of different persons. . . . In three-quarters of the suicides who communicated their suicidal ideas, their expression is of recent onset and is *not* found in the persons' usual behavior."

These are some typical cases from Dr. Robbins' study:

A 59-year-old woman spoke frequently of wanting to die, of fearing that she would kill herself, and of wanting to jump in the river. Shortly before her suicide she frequently said: "If I don't get better, I'm going to stick my head in the oven." She did kill herself by putting her head in a gas oven.

A 37-year-old man who was a chronic alcoholic told his friends in a tavern on a Tuesday evening that they would see his death notice in the newspapers on Thursday. On Wednesday he borrowed a gun from his brother-in-law and shot himself. As he had predicted, his death notice appeared in the papers on Thursday.

A 34-year-old woman spoke of killing herself on many occasions. On the day of her suicide she said to her husband: "This is the last time I will see you." She killed herself two hours later.

How do some friends and relatives react to such clear warnings of impending tragedy? After a brief alarm, many just ignore these suicide signals. Then, when it is too late, they say such things as:

"I thought he really didn't mean it."

"I didn't think it would happen."

"He had never talked or acted this way before. It just wasn't him. He couldn't do something like that."

"I got so mad at her constantly talking about it [suicide] that I just didn't listen."

Another study of these verbal suicide warnings, conducted by Dr. Ian Skottowe in England, showed that they were ignored by friends and relatives because the person making the threat was regarded as "all right" since he was orderly and logical in his thinking. This study showed that there was no connection between disorderly thinking and impending suicide.

"To prevent suicide, people should forget about logic as a sign of health and remember that many more lives are saved by getting depressed patients to hospitals than by applying tourniquets for hemorrhage or artificial respiration for drowning," Dr. Skottowe declared.

It is true, of course, that not every person who makes a suicide threat or communicates a suicidal idea does kill himself. It is equally true, however, that the majority of people who destroy themselves talk about doing it.

Another important danger signal is deep and lasting depression. About half of all suicide attempts are made by people thus afflicted.

Many suicide notes mention intolerable insomnia, a major symptom of depression. Other symptoms are feelings of despondency and futility and an uncalled-for feeling of unworthiness. A depressed person often loses his appetite and may complain that all food tastes alike. He also may begin to drink more heavily than usual. Greatly reduced sexual activity is a symptom of depression. Lack of in-

terest in former activities and hobbies, inability to concentrate, and expressions of guilt are signs, as are brooding and inactivity.

A severely depressed person may display all of these symptoms or any combination of them. All of us become depressed occasionally and show some of these signs for a short period. But the mood passes in a day or two and the signs disappear. It is when the symptoms remain and develop into a regular part of a person's personality that a serious depression is indicated.

When they persist they may indicate a painful seesaw struggle between self-destructive impulses and the instinct of self-preservation. If the depression symptoms are combined with preoccupation with death, or undue brooding over the death of a friend or relative, the danger of suicide is high.

A depressed person often tries to hide his condition from others. When asked how he feels, he will reply "fine." He may try to shake off the depression with periodic bursts of cheerfulness. Though these periods of gaiety do not last long, they often lull friends and relatives into believing that the individual is all right.

Just how well some suicidal persons can fool even professional observers is shown in this story which appeared in the New York *Sun*, August 16, 1949:

John Cohanzack had laughed and said it was all so ridiculous.

He commit suicide?

"They're crazy," he roared. "Why should I? I have $22,000."

Somebody called the police when Cohanzack left his boarding house room in Passaic, N.J. They said he was heading for a nearby park with a rope in his hand.

He showed the police a $21,500 bank deposit book and pulled out $500 in cash.

"I have money," he said jovially. "I've worked since 1912. I've stayed single, and I've saved.

"Why should I commit suicide?" he laughed. The police apologized and drove him home.

Today, two weeks later, policemen came back to his boarding house, the Associated Press reported. They found the 60-year-old

Cohanzack dangling dead at the end of a rope tied to an overhead steampipe.

If you see some of the warning signals of suicide in a relative or friend, what should you do? How can you help him?

One authority on suicide put it this way: "The central ingredient of help for someone on the verge of suicide is a chance to talk to someone." Experts agree that the importance of a human contact cannot be overestimated. An hour's conversation with a friend, a priest, or a physician has saved more than one life.

The value of such contact is that the depressed person can unburden himself of some of his despair and receive assurance that he counts for something. In the moment of suicidal crisis any helping hand can save a person from self-destruction.

The suicidal person lives in a world of terrible loneliness. If his isolation can be broached, he may be saved. A sympathetic ear and a shoulder to cry on sometimes work wonders, staving off a suicide attempt long enough to get professional help. Rapport with even one person often means the difference between life and death.

Experts say that many people, including some physicians, are afraid to talk seriously to someone afflicted with a deep depression. They feel that a discussion of his problems will only make him sink deeper into depression, or perhaps plant the idea of suicide in his mind. In such instances friends and relatives tend to react with forced cheerfulness, trying to jolly the depressed person back into a normal state.

Dr. Skottowe scorns the idea that no one should closely question a severely depressed person. "Once a patient has admitted that he feels depressed, frightened or hopeless, leading questions about the depth of his depression can and should be asked," he said. "There is no evidence that such questions, put in a proper way, have any aggravating effect on the depression—rather the reverse, for confession often brings relief—nor do they ever drive to suicide a patient who would not otherwise contemplate it."

Advice and counsel by non-professional persons, though often highly effective in staving off self-destruction, are only a stopgap, a palliative. Psychiatric care is the only real answer for someone

who has a suicidal urge. He should see a psychiatrist as soon as possible.

It may not be easy for friends or relatives to get the suicidal person to agree to this. Many people still cling to the myth that to see a psychiatrist is an admission that one is "crazy." In addition, a symptom which often accompanies severe depression is an unwillingness to be helped out of the despondency. A depressed suicidal person may offer endless excuses against anything that may be suggested to help him. This is not mere perversity. A person in the grip of deep depression often cannot see any solution to his misery. His despondency and hopelessness cause him to believe that proffered aid will be futile.

To reject a depressed person because he won't help himself, or accept help, will only make him worse. It will force him deeper into his isolation from the human family. In such cases, a physician or psychiatrist—preferably the latter—should be consulted and asked for advice on how best to help the depressed person.

Nowadays we are fortunate to be able to call upon the services of psychiatrists, psychiatric social workers, or psychiatrically oriented clerics. They are perhaps the only people with the requisite skill to save the suicide-prone. Fifty years ago there was no one who could offer genuine help to many who harbored a strong drive to destroy themselves.

Psychiatrists know that suicidal urges often result from the reopening of old psychic wounds. They can help a person find out what situations and circumstances cause the resurgence of these wounds and how to avoid them. In the psychiatrist's office a suicidal person can learn to recognize the existence of the fatal flaw within himself, and how to deal with it.

"Our intelligence and our affections are our most dependable bulwarks against self-destruction," according to Dr. Menninger. "To recognize the existence of such a force within us is the first step toward its control. To 'know thyself' must mean to know the malignancy of one's instincts and to know as well one's own power to deflect it. Blindness or indifference to the existence of self-destructiveness are the devices it constructs for its continuance."

If psychiatry is effective, why hasn't it cut our suicide rate? There are two answers: Most of those tragic figures walking down the lonely road to suicide never get to the psychiatrist's office. There still aren't enough psychiatrists in the United States.

However, the problem of controlling suicide is much less one of treatment than it is of early diagnosis. In most cases the diagnosis must be made initially by friends, relatives, and general practitioners.

Many studies have inquired what care, if any, suicides were receiving at the time of their act or prior to it. All of these show that most of the suicides received no treatment before they killed themselves. Dr. Robert E. Litman, director of the Suicide Prevention Center in Los Angeles, reported to the May 1960 meeting of the American Psychiatric Association that of 40 serious attempts at suicide which he had studied, only eight individuals had seen psychiatrists and only two were in treatment at the time of the attempt.

Some psychiatrists complain that many physicians don't know enough about the symptoms and care of suicidal patients. The influence of the family doctor can often be decisive in getting adequate psychiatric care for a suicidal person, authorities on suicide point out, but only if the physician himself is aware of the need for such care.

Physicians should be particularly wary of prescribing barbiturates for insomnia caused by depression. In a study conducted by Dr. Jerome A. Motte, of San Francisco, it was found that one suicide in three had killed himself with a drug prescribed by his doctor.

It would greatly reduce our suicide rate if more general practitioners were suicide-oriented, could read the early signs and would recommend psychiatric care. Unfortunately, many doctors are as prone as friends and relatives to disregard a patient's suicide signals until it is too late.

There are many church groups and community agencies which can be called on for help in dealing with problems that may be troubling a depressed person—loneliness, unemployment, alcoholism, illegitimate pregnancy. There also are a number of little-known

organizations which are devoted exclusively to combating suicide. They will give immediate, emergency aid of a practical nature as well as advice and long-term assistance to potential suicides and their families.

The oldest of these groups in the United States is the National Save-a-Life League, a national organization with headquarters at 505 Fifth Avenue, New York City. Its telephone—MU 7-2142—is manned 24 hours a day, seven days a week.

The League was founded in 1906 by the Reverend Harry M. Warren, then pastor of the Central Park Baptist Church in New York City. He was well known for his practice of holding religious services in hotels around the city in addition to those in his church.

One evening a despondent girl checked into a hotel and told the night clerk she badly wanted to see a minister. The clerk called Mr. Warren, but the call went astray. When the message finally reached the minister he hurried to the girl's room to find her dying of poison. She was beyond help and he comforted her as best he could. As the girl died she whispered to Mr. Warren that she would not have killed herself if she had been able to talk with him first.

The experience deeply impressed the minister, and he determined to be always available for similar calls in the future. He resigned his pastorate and started a one-man campaign for funds to aid persons with suicidal tendencies. The League was organized the following year, and Mr. Warren headed it until his death in 1940. It is now headed by his son, Harry M. Warren, Jr., who is not a minister.

Though he keeps no detailed records, Mr. Warren said his organization has helped about 1,500 persons a year. In his estimation the majority of them were suicidal. Help may consist of advice, spiritual support, financial aid, referral to a community welfare agency or to a psychiatrist. The League has an annual budget of $50,000 and sometimes pays food and medical bills for depressed people.

"We have more than once saved a life for as little as a five-dollar bill," Mr. Warren said.

The League also sends the children of some suicides to summer camp. "We believe this is an invaluable part of the therapeutic

treatment needed to erase the damage which these children suffer," Mr. Warren explained.

Asked why a special organization to combat suicide was needed when there were many social service agencies which might take on the problem, Mr. Warren replied:

"We find that numerous people who are thinking about suicide as the solution to their problems would like to talk to someone about it. But they are afraid to talk to their clergyman or doctor or a relative for fear of being thought 'queer.' If they can find an interested stranger, they will unburden themselves to him. We provide that sympathetic stranger and guarantee complete confidence. We don't ask questions and we don't ask for record cards to be filled out. We don't even need to know a man's name to be able to help him. We only need to know his problem."

A similar organization is directed by the Reverend Virgil Kraft, of the People's Church of Chicago. A person with a suicidal urge can get immediate practical help or advice any time of the day or night by dialing LO 1-9595.

Boston now has an anti-suicide organization called Rescue, Inc. It was started in March 1959 by Father Kenneth Murphy, a Roman Catholic priest. Its 24-hour telephone is HA 6-6600.

In November 1953 an anti-suicide organization was founded in London, England, by the Reverend Chad Varah, vicar of St. Stephen's Church. Called the Samaritans, the group has several score non-professional volunteers and professional consultants.

When a suicidal person telephones Mansion House 9000, a non-professional worker will go to him immediately, if necessary, to provide sympathy, companionship, and understanding until a professional person can take the case.

When Mr. Varah was asked why potential suicides called on the Samaritans, his answer was strikingly similar to that given by Mr. Warren:

"It may be a faint doubt about whether death is the only way out. They know they have nothing to lose. If we don't convince them, they can ring off and do it. Many of them are utterly lonely and they want somebody, anybody, some anonymous stranger like us, to

know and to notice that they have died. We never call the police. And like the Good Samaritan, we expect no thanks. We do not treat our clients as conversion fodder."

Though these organizations can and do render effective help when they are called upon by a genuinely suicidal person, they have limitations which cause them to be regarded with skepticism by researchers who are concerned with reducing suicide as a community or national problem.

Each organization was founded by a minister of religion and, despite Mr. Varah's disclaimer, observers note a strong religious orientation in each. In the instruction booklet titled *Suicide, Why Not?* which Mr. Varah gives his workers, suicide is described as "the worst blasphemy a person can commit . . . even worse than spitting on the cross." Helpers attracted to organizations run by ministers of religion quite likely hold similar views, which they may be unable to conceal. Such sentiments might not appeal to many non-religious persons contemplating suicide, thereby reducing the organization's effectiveness.

Another drawback is that the anti-suicide organizations cannot check their effectiveness. Each can point to a number of seriously suicidal persons whom it has helped to rehabilitate. But none has kept complete records or held investigations to prove how much it reduces a community's suicide problem.

It is fair to ask whether these organizations actually are effective and, if so, to what degree. Is their approach to the suicide problem the only one?

A psychiatrist who is critical of such anti-suicide organizations declared:

"They are generally founded by a strong personality who sets up his group as a father-figure which will solve all problems for the potentially suicidal person. This approach will not be effective with a lot of potential suicides. These groups do not seem to make any real effort to learn if a person who calls on them is really suicidal or whether he only says he is. They probably waste much effort and money dealing with people who are not genuinely suicidal. Other social agencies are better equipped to help such people."

For these reasons, most professionals—psychiatrists, psychologists, social workers—disagree with the concept of laymen's organizations dealing with the suicide problem. But no professional group in this country has established a suicide-prevention organization. (The Suicide Prevention Center in Los Angeles is primarily a research center.)

Psychiatrists tend to view suicide as a problem that can be dealt with only through individual therapy. Most do not believe a community's suicide rate can be reduced through any type of group effort. Other professionals are unaware that a suicide problem exists or they often contend, despite facts and figures to the contrary, that existing organizations are doing all that can be done to meet it.

There is much that each of us can do as individuals. We can help break the taboo of suicide. We can learn to detect suicide symptoms. We can get help for those who need it.

Organized community effort undoubtedly would be more effective and more rapid. But, to repeat, there is a decided difference of opinion about the effectiveness of present organized efforts to prevent suicide. As far as is known, none of them has significantly reduced the suicide rate in its area.

It is obvious that we must answer these questions: Can we devise an organization which genuinely will reduce a community's suicide rate? Can we measure the effectiveness of such an organization?

A research project to find the answers has been in progress since December 1959. At that time a new type of lay suicide-prevention group called FRIENDS was established in Miami, Florida. It differs from other groups in this way: An objective, professional observer is measuring its worth in terms of scientific criteria.

Because it is the only suicide-prevention group whose work is subject to objective evaluation, we will describe its inception and experience in some detail. The information may be useful to readers interested in setting up similar organizations.

In September 1959, Tom Lownes, 27, a reporter for the Miami *Herald,* learned that Miami had the nation's second-highest suicide rate (18.1 in 1958) for communities over 500,000. He also discovered that in some years Miami had more suicides than traffic

fatalities. Periodic campaigns were waged against traffic deaths, he noted, while suicide was ignored. The contrast intrigued him.

Mr. Lownes then asked psychiatrists, physicians, ministers, welfare workers, police, and county officials to estimate the suicide rate in Miami and to tell him who the suicides were.

"Without exception," the reporter said, "everyone I talked to greatly underestimated the suicide rate in the city. They all said Miami had no suicide problem. The majority of suicides were visitors, I was told. Most officials who should know about such things described the typical Miami suicide as an elderly, incurably ill, neurotic divorcee who was here on a two-week vacation."

The reporter then got permission from the medical examiner to check Dade County files. He discovered that most Miami suicides were residents, family people with children and holding down responsible jobs, and that few had terminal illnesses. He persuaded his paper to run a series of articles on what he had learned.

His research convinced Mr. Lownes that an organized effort was needed to reduce Miami's high suicide rate. He visited and corresponded with the existing suicide organizations. The reporter then asked the Miami psychiatrists if they could set up a suicide-prevention group or, if not, whether they would support and advise a laymen's group.

"The psychiatrists told me they couldn't take on the problem," he recalled. "They said they were already doing as much welfare work as they could handle. Anyway, they said, suicide could not be dealt with as a community problem. The only way to stop suicide, I was informed, was on an individual basis through psychoanalysis or other psychiatric therapy. The psychiatrists said that no organization could devise a practical way to pick out the potential suicide from among the general population.

"In contrast, the lay organizations in other cities were claiming to have saved thousands of lives. I felt the psychiatrists had a valid point, however. The lay organizations could not prove this. As a newspaperman I had to discount their claims and assume that they were merely making estimates based on the number of phone calls they received.

"I then asked the officials of the existing welfare agencies if they would help set up a suicide-prevention organization. After considering the facts at some length they finally agreed that there was need for such an agency. But, they said, they had great reservations about laymen doing suicide-prevention work. Therefore, they told me, they could not help establish such a group.

"By now I had learned that everyone had opinions about suicide prevention, but nobody had facts. It also appeared to me that my newspaper and I, having created interest in suicide prevention, had an obligation to follow through and see that something was done.

"While my articles were appearing in the paper, many people called to ask if there was anything they could do to help reduce our suicide rate. Since no one else was willing to get a suicide-prevention effort organized, it was up to me to take the lead.

"The easy way out would have been to raise a fund and then hire professionals to set up a group similar to those which already existed. But it seemed to me that a suicide-prevention organization should not need much money. Though the other organizations dispensed money, I don't believe it helps much.

"I had learned that only 5 per cent of suicides had problems which money might have helped solve. If you had all the money in the world, therefore, you could at best help only 5 per cent of suicides. It also seemed to me that if a person was to be really effective in helping thwart suicides at any hour of the day or night, he would have to be motivated by something other than a salary.

"For these reasons I envisioned some sort of volunteer community group which would not dispense money and would need very little funds for its operations.

"Some people suggested a 'Suicides Anonymous' patterned after Alcoholics Anonymous. I attended some AA meetings to learn how they operated. It was apparent, however, that the AA format would not be conducive to solving the problem of potential suicides.

"Alcoholism is a continuing problem for the individual, who needs continuing support. Suicidal urges are most often crisis affairs. The individual does not generally need continuing support after the crisis has passed. Nor could we assume that the formerly suicidal

person, once rehabilitated, would be the best person to help the potential suicide.

"Having little idea of what would result, I scheduled a meeting of people interested in suicide prevention. I hoped very hard that at least one professional person who could guide and advise us would come.

"We were fortunate. One of the 47 persons who attended was Dr. Harvey L. P. Resnik, of the University of Miami Department of Psychiatry, a resident psychiatrist at Jackson Memorial Hospital and a graduate surgeon. The others included ministers, lawyers, members of Alcoholics Anonymous, crackpots, and even a tombstone salesman.

"Dr. Resnik suggested that a volunteer anti-suicide organization such as we proposed could be a useful tool for research. He told us that with proper scientific controls we might be able to prove or disprove once and for all the effectiveness of laymen's groups in reducing the suicide rate.

"Most of the people at the meeting accepted his suggestion. We thus became the first suicide-prevention organization which had a plan for study attached to it before it started. Some members objected. They said they didn't see the need to study suicide, with the case forms and record keeping which it would involve. They contended that if we helped rehabilitate potential suicides, that was sufficient. Why go any further?

"Dr. Resnik pointed out that if we learned what kind of organization could best combat suicide, what qualities would make a person effective in helping potential suicides, and what kind of help was effective, we might evolve a group which would win the respect of the professional disciplines. Other communities could then duplicate such an organization. In this way, he said, we could eventually help far more potential suicides than we could ever reach in Miami and Dade County.

"It was clear that there was enough interest to get an anti-suicide group started. We scheduled a meeting for the following week at which members would be signed up.

"In the interim I reserved the number FR 4-3637 at a telephone

answering service. This number spells out the word 'friends' on the telephone dial. We thought it would attract attention and would be easy to remember. This also gave us a name for our group.

"At our second meeting about 35 people pledged to accept calls from potential suicides. On December 1, 1959, our telephone service started. We publicized the organization in the newspaper and ran an ad in the personals column.

"In our first week we received thousands of calls. Most were from cranks and jokesters, but 300 were legitimate requests for aid. The calls have now leveled off to about 600 a month, of which 200 are legitimate. Of the legitimate calls about 15 per cent are potential suicides, half of them being seriously suicidal—with a definite plan already formed or holding poison or a rope in their hands."

The members of FRIENDS take four-hour tours of duty five days a week. They are on call at home during the tour and average two or three calls a week. When a legitimate request for aid or advice is received at the FRIENDS switchboard, the operator obtains the caller's number and passes it on to a member on duty.

Members deal only with callers of the same sex. The FRIEND is obligated to return the call immediately, learn what the trouble is, decide whether the person is really a potential suicide, and take whatever action is necessary.

In the course of its first year of operation, FRIENDS has learned that its calls fall into six categories: Psychiatric, informational, personal gain, social (interpersonal), medical, and suicidal. Dr. Resnik has taught the members how to distinguish the genuinely suicidal person from the others. A detailed explanation of how this is done and how the FRIENDS respond to calls is contained in their training manual, which has been reproduced in the Appendix.

The group meets twice a month for case study under the guidance of Dr. Resnik. At these sessions the members learn how to improve their handling of cases. Training meetings for new members are held twice a month.

Dr. Resnik is not a member of FRIENDS. He is the group's adviser and objective critic. The detailed statistics of its first year's

operation and the results of the many studies he has made are known only to him.

"Like most members of my profession," he said, "I was imbued with the idea that only professional people could deal with a community's suicide problem. But the validity of this idea has never been properly tested. The establishment of FRIENDS has given me an opportunity to prove or disprove it once and for all through tests and controls which are acceptable to my profession."

A main objective of FRIENDS is to get psychiatric help for suicidal persons. The members are instructed to make every effort to send them to the Psychiatric Institute of Jackson Memorial Hospital, where psychiatrists are always on duty. To avoid wasting the time of these hard-pressed professional men, however, it is necessary for the FRIENDS to make their own preliminary estimate of whether a caller needs psychiatric care or some other type of aid.

One of Dr. Resnik's studies concerns the accuracy of these evaluations made by the FRIENDS.

"I have been correlating the FRIENDS' diagnoses," he said, "with the professional diagnoses made by the psychiatric residents of those persons whom FRIENDS bring to the hospital. As a further check, we also get several independent evaluations of a person's suicidal tendencies."

FRIENDS members took about 300 of their 2,000 legitimate callers to the hospital during their first year. The psychiatrists admitted about 100 of these as emergency cases and put approximately another 70 on outpatient care. Some of those who did not need hospital care were later placed with counseling agencies. These figures are only approximate because results of the detailed studies were unavailable when this book went to press.

In its first months, FRIENDS attracted a number of persons as members who were themselves suicidal. After several had applied to him for psychiatric help, Dr. Resnik set up a battery of psychological tests for members, checking them for stability, depression, suicidal predisposition, independence of thinking, practicality, and other factors. Soon after FRIENDS was established it attracted a

dozen Alcoholics Anonymous members who had tried to kill themselves. However, within two months they returned to AA.

"We have discovered," Mr. Lownes explained, "that simply being willing to help does not mean a person is competent to deal with the problems of the potential suicide. In the beginning one of our members called the police on most of the cases referred to him. Another referred every case directly to Dr. Resnik. Others rated every caller as a suicidal case."

Has FRIENDS been a success?

During the 12-month period from December 1, 1959, when FRIENDS started, to December 1, 1960, Dade County's suicide rate fell from 18.1 to 15.2 per 100,000 population. This is a 13.7 per cent decrease.

As this book went to press Dr. Resnik was willing, with reservations, to accept this decrease as an indication that FRIENDS was effective.

"It appears that the organization has value in helping the potentially suicidal person," he said. "With the qualification that all the facts are not yet in, it appears that the decline in the Dade County suicide rate during the past year is significant.

"Before completely accepting the decline as an indicator of FRIENDS' success, however, we will need to compare the change with what happened to the national suicide rate in 1959 and to the rates of comparable communities. These figures won't be available for some time. The organization also must meet other scientific criteria.

"It would seem that the existence of FRIENDS is the chief variable which has been introduced into the suicide picture in Dade County and that therefore the decline in the suicide rate would be logically attributable to its activities.

"However, the Cuban refugee immigration has introduced another variable which might be significant. We are hoping to isolate this immigration as a factor as our studies progress."

Another yardstick by which the effectiveness of a suicide-prevention organization can be measured is its impact on the number of attempted suicides in the area. No researcher, however, has ever

been able to obtain accurate figures on attempted suicides. Dr. Resnik is now attempting to get such figures. In November 1960 he began querying Dade County physicians about the number of patients they treated as a result of suicide attempts.

The early returns in this study are startling. They indicate that the number of attempted suicides in this country each year has been grossly underestimated by nearly all researchers.

"The physicians have reported to us 200 documented cases of attempted suicide in the two months our study has been under way," the psychiatrist said. "In the same period we have had 10 completed suicides. The attempts thus appear to be in a ratio of 20 to 1 completed suicide.

"This means that the suicide problem in the United States is of a magnitude which is outranked only by accidents. The gravity of the situation is obvious."

Previous estimates of the rate of attempted suicide ranged from a minimum of three attempts for each completed suicide to a maximum of nine.

Dr. Resnik said that the vast majority of the attempts in his study to date had been made by young people. Attempts by persons under 35 outnumbered attempts by older people by 50 to 1.

Another type of organization which might cut our suicide rate is the "trouble-shooting clinic" now being tested in Elmhurst Hospital in New York City, a municipal institution. Opened in October 1958, it operates on the no-formalities, no-questions-asked basis which is the hallmark of the suicide-prevention organizations.

Unlike the regular mental-hygiene clinics, the trouble-shooting clinic is designed to give only immediate, emergency help to people facing emotional crises. There is none of the conventional screening of patients and they need no referral. A troubled person has only to walk in and talk things over.

As described by Dr. Leopold Bellak, its Director of Psychiatry, "the 'walk-in' clinic differs from the Mental Hygiene Clinic or even the 24-hour psychiatric coverage of the emergency room of a general hospital in that it is designed to care for emergency emotional problems immediately, on the spot. . . .

"Thus, this clinic has become the battalion aid station, the first echelon of medical care, for people with bruised feelings and emotional upsets as well as more serious psychological complaints."

Vienna, Austria, has a suicide-prevention group called the *Lebensmuedenfuersorgestelle,* which translates as "Society for the Care of People Tired of Life." It was founded in 1947 by Dr. Erwin Ringel, of the University of Vienna's psychiatric clinic, and is sponsored by the Austrian Roman Catholic welfare organization.

The society is semi-official, and every case of attempted suicide in Vienna is reported to it. Wherever possible the would-be suicide is moved to the clinic to determine what kind of help he needs, whether short-term therapy, full-scale psychiatric treatment, or practical help, such as a job or money or medical care. It handles between 1,000 and 1,500 cases a year.

In Stockholm, Sweden, an Emergency Clinic for Depression was recently established. West Berlin has an anti-suicide organization. Tokyo has two, the Suicide Depression Clinic and the Wait-a-Bit Society.

A widespread organization in the United States which can give practical help in cases of attempted suicide is the Poison Control Center. Since 1945 more than 300 of these centers have been set up in 45 states. Most have 24-hour telephone service. Their function is to supply physicians with information about the ingredients and toxicity of trade-name drugs and commercial products of all kinds and about the best methods of treatment for different kinds of poisoning. Non-medical persons calling a center for help in a case of accidental poisoning or attempted suicide by poison are told how to give emergency first aid.

The Poison Control Board in New York City found that of its first 1,000 poisoning cases, about 400 were suicide attempts. The center helped these people with their medical crisis. But it is not equipped to do more than this. Studies show that in most cases nothing was done to prevent these people from trying to kill themselves again.

If we are to reduce our suicide rate, every person who threatens or attempts suicide must be seen by a psychiatrist. Family members

must be told the facts. They need to know the nature of his problem, how to behave toward him, how best to help him. They must be warned of the danger that lingers when the patient appears to be recovering from an attempt to kill himself.

Because of this danger, many suicide authorities recommend that, during the 90-day danger period at least, there should be a supervised follow-up program, with home visits by social workers or public health nurses to see that the patient is getting adequate care.

The staggering number of Americans—about 200,000—who attempt suicide each year constitute a mental-health problem of awesome proportions. The fact that most of them could be helped yet so few are, is a national tragedy.

The person who attempts suicide is often saying to society: "Please, will *somebody* do *something* to help me solve my problems."

It is unfortunate that many doctors and hospitals still behave as though the attempted suicide had a perfect right to take his life without interference from anyone. They simply bind his wounds or wash out his stomach and send him away to try again.

Even if one concedes that a person has a right to take his own life, this does not answer the question whether he is competent to make a rational decision that he wants to die or—when he makes a suicidal gesture—whether he really wants to die.

It is not those who commit what has been termed "rational" suicide—as defined in Chapter IX—who constitute our national suicide problem. They are few and probably always will be.

The tragedy of suicide is that most of those who kill themselves each year are persons who, otherwise normal, choose a terribly permanent solution for a temporary emotional disturbance. Hardly any would choose this solution if they could be helped to find another.

Unless we, as a nation, take some effective steps to combat self-destruction, our national suicide problem in the years ahead probably will get worse. There are many forces in our civilization that tend to make suicide increase.

We are becoming more competitive and tense. Our way of life reduces the interdependence of family members. Men are isolated from their fellows, making the worker an appendage of the machine,

increasing leisure time which many people are not equipped to fill.

Although psychiatrists and sociologists have made great strides in discovering the causes of the suicidal drive, many questions remain to be answered. We still do not know why some people react to an intolerable situation by killing themselves, while others develop a severe mental illness and yet others a physical illness.

While we have some idea of the early development of the unconscious drives toward suicide, we don't yet know enough about how the environment can change or suppress these drives. Why, for instance, do Arabs, Catholics, and Negroes generally have low suicide rates? A large part of American and British research on suicide has been limited to white Protestants. We need to know more about suicide—or the lack of it—among other racial and religious groups. Many other paradoxes and puzzles about suicide which were described in earlier chapters have yet to be solved.

We have the manpower, the money, and the tools to find the answers if we wish to find them. But an intensive search for the solutions will begin only when the public demands it.

This happened with cancer, polio, and other diseases against which national campaigns have been waged.

Before it can happen with suicide, however, we must first remove the stigma from self-destruction, bring it into the open where it can be discussed, and recognize it for what it is—a health problem, not a disgrace.

A few months before his death in 1959, Dr. Zilboorg declared:

"Suicide is not anti-moral; it is not a sign of cowardice; it's a sickness, like tuberculosis. Let's give suicide status as a disease, and we can treat it effectively."

If we follow his suggestion we can begin to reduce the immeasurable loss that the nation suffers every year through suicide and save thousands of those bewildered persons who are victims of the traitor within.

APPENDIX

Appendix

THE FRIENDS experimental suicide-prevention group in Miami, Florida, has kindly permitted the authors to reproduce its training guide and case form. These may be useful to persons wishing to establish a similar organization in other communities.

FRIENDS has asked us to point out that this training guide developed as the group gained experience. Therefore, it is subject to revision, as techniques are improved or discarded.

As this book went to press, FRIENDS had 32 working members who had regular duty tours during which they accepted calls.

FRIENDS has no budget and neither solicits nor dispenses money. Its only expense is its telephone bill of approximately $200 a year. Members meet this by making anonymous donations themselves. They also have contributed the small amount of stationery needed and done the mimeographing themselves. The organization has no need for office space. Its meetings are held at the Miami Police Training Academy.

"Any community suicide-prevention organization should need only very little money to be effective," Mr. Lownes said. "The time, interest, and personal efforts of its members are far more effective in preventing suicide and helping the suicidal person than money could ever be.

"The advantage of a low-budget operation like FRIENDS is that it can be duplicated in any city where even a comparatively small

group of people are really interested in helping the potential suicide to learn to lead a meaningful and constructive life.

"FRIENDS does not try to solve the problems of everyone who calls on it. That would only take our time away from the truly suicidal and lead us into trying to do things that other agencies are better equipped to do. We do our best to screen the truly suicidal from the large number of calls we receive, thus saving everybody's time and effort."

FRIENDS will answer requests for information from groups interested in setting up similar organizations. Its address is 37 N.W. First Street, Miami, Florida.

A TRAINING GUIDE FOR *FRIENDS* WORKERS

Welcome to FRIENDS. You are about to embark on a unique venture in the service of your community and your fellow man. For many depressed and confused persons, you—and FRIENDS—are all that will stand between life and death at a crucial moment in their lives. It is important that you read and fully understand this training guide. The present working members of FRIENDS stand ready to help and advise you just as they, too, welcome your help and advice. We hope that your work with FRIENDS will be a rewarding experience.

YOUR TOOLS—The basic working tools of FRIENDS are your telephone, the Community Resource Directory, a FRIENDS case form, a permanent call-time sheet, a list of other FRIENDS workers, and, most important, a calm and understanding attitude and a practiced ability to correctly evaluate your callers' situation in order to quickly guide them to the best possible solution.

WORKING HOURS—Select your "tour of duty" realistically. Although your hours can be changed at your request, you should plan to be regularly available at your chosen times. If, for any reason, you are not going to be home at your regular time, please so notify the FRIENDS switchboard. A normal "tour" is approximately four hours, five days a week. It is not practical for you or for FRIENDS

to take less than two four-hour "tours" a week. Because FRIENDS work is emergency work, there is no way of knowing just how much time you will have to spend on any call, but your total working time will probably be only a small fraction of your "tour" time—possibly an average of about three hours a week.

WHEN A CALL COMES—All FRIENDS calls originate through the FRIENDS switchboard. When our operator calls you, she will give you (1) the given name of the caller, (2) his telephone number, and (3) his case catalog number. IT IS YOUR ABSOLUTE OBLIGATION TO RETURN THE CALL IMMEDIATELY.

RETURNING THE CALL—It should take you less than a minute to (1) enter the caller's name, catalog number, and the time and date of the call on your call-time sheet, (2) write the same information on a case form, and (3) have your Resource Directory in front of you before you return the call. When your caller answers the phone, introduce yourself either by your real name or by a standard pseudonym (as Mr. Mac, Mrs. Kay) which is well-known to the FRIENDS switchboard operator. Do not give the caller your own telephone number. If he has occasion to call you again, he should call through the FRIENDS switchboard and ask for you by name.

GETTING INFORMATION—It is important to fill out the case form completely but you should not make it evident that you are taking notes. You will find that in the opening minutes of your conversation, the caller will quite naturally volunteer most of the information needed. The rest you can pick up through casual, conversant questioning. Whenever possible, use a short quote from him to explain his reason for calling.

LISTEN, LISTEN, LISTEN—Let your caller tell his own story—don't anticipate it. Ask only those questions which will draw the story out. It will take 15 minutes, a half-hour, or perhaps even longer to get the full picture. When the caller has given you the whole story and you have all the information necessary for your case form, then start asking questions that will lead to a solution for his problems.

WE DO NOT HEAL—We are not doctors or counselors. Our job

is to help the caller find help—to give him the vital "first aid" that will enable him to hold on long enough to begin the long journey back to stability. Never advise a caller to take any radical step to solve his problems. Never recommend travel, divorce, marriage, a change of jobs, buying or selling, etc. In fact, the only "advising" that we do is to advise potential suicides that suicide is not the answer to their problems. Then we help them to find the answer.

EVALUATION AND SOLUTION—Always remember that FRIENDS was formed to combat suicide. We do not turn our backs on any caller but we must devote our major efforts to those with truly suicidal problems. If you get tied up in the first few weeks with several callers who "just want to talk" (and there is a great temptation to do so), you will be unable to handle newer and more important calls. That is why it is important to first evaluate your caller's problems and then quickly seek a permanent solution.

THE RIGHT CATEGORY—There are two main methods of deciding if a caller is suicidal: First, by the process of elimination, through which his problems may be assigned to one of several non-suicidal categories. Second, by noting those symptoms which are clearly or very likely suicidal. It is extremely important to use restraint to avoid indiscriminate evaluation of callers because our reputation with cooperating welfare agencies is based on our ability to spot potential suicides. If we make wildly incorrect evaluations these agencies would soon begin to doubt our judgment and would be less willing to help us with truly suicidal cases.

THE SIX DIVISIONS—We divide our cases into six simple categories (which you should right now list in the front flap of your Community Resource Directory). After each call, you will decide which category your caller belongs in and then write only the number of that category in the upper right-hand corner of the back of your case report. The six categories are as follows:

※1—Psychiatric
※2—Informational
※3—Personal Gain
※4—Social (Interpersonal)

※5—Medical
※6—Suicidal
6A—Lightly Suicidal
6B—Seriously Suicidal

(An explanation of these six categories—and their solutions—follows.)

PSYCHIATRIC CALLS—The caller is not suicidal but has problems which can best be handled by a psychiatrist. Into this category fall many of the callers who "just want to talk" and also many who are already under psychiatric guidance. The outright psychotic (who hears voices, sees visions, or is wildly eccentric) will also fall in this category unless he shows specific suicidal tendencies.

SOLUTION: Tactfully but firmly recommend psychiatric treatment through Jackson Hospital's out-patient clinic or a private psychiatrist (do not recommend a specific psychiatrist). Unless the psychiatric caller is threatening an immediate harmful or destructive act, do not seek an emergency examination for him—save that for our suicidal callers. Unless the condition is urgent, do not make arrangements or intercede at any agency on his behalf. You may recommend a church of his faith, the Mental Health Society, or any of several other sources listed in your Resource Directory.

INFORMATIONAL CALLS—Into this category falls (1) the caller who seeks information about another agency and (2) all "third person" callers. The information seekers include callers who want to find out about Alcoholics Anonymous, Legal Aid, etc. A "third person" caller is one who wants to give or receive information about another person whom he usually describes as suicidal.

SOLUTION: For those seeking information about other agencies, be as helpful as possible, but never recommend any kind of commercial enterprise or professional person. For the so-called "third person" caller, you must be careful to follow these special rules:

(1) Explain that FRIENDS must respect the privacy of all persons and cannot deal directly with anyone who has not called us for assistance.

(2) Ask the "third person" to get the "potential suicide" to call us direct. Or:

(3) Tell the caller that you will meet the "potential suicide" only if the caller is present to introduce you and remains present during the conversation. (If the "potential" refuses to talk to you at such a meeting, respect the refusal and do not press the issue unless the "potential" is actually in the midst of making an attempt at suicide.)

(4) If the "third person" insists that the "potential" is in the act of attempting suicide, but you cannot confirm this firsthand, call police at once and give them the name of the "third person" so they can check with him. Do not send police directly to a "potential" unless you know the facts firsthand.

(5) If a "third person" call results in an actual FRIENDS contact with the "potential," then make out the case form as if it were a direct call but explain the role of the "third person."

(6) If it does not result in a contact, then make out the case form for the "third person" and not for the "potential."

PERSONAL GAIN CALLS—Into this category fall callers who (1) need only money to solve all their problems, (2) need only a job, and/or (3) want you to help them manipulate some other person.

SOLUTION: Don't do it! Refer the job seekers to the Florida State Employment Service or to other sources personally familiar to you, but steer clear of the other two types of personal gainers. FRIENDS does not give or loan money because experience has taught us that persons who need only money to solve all their problems are insincere and are attempting to use the organization as an "easy mark." Refer straight money seekers to County Welfare (one year residence required), Travelers Aid (for fare home), or to other financial agencies listed in the Resource Directory, but do not help them obtain the money and do not counter-sign. As for the manipulators, never relay messages for them (as between husband and wife, etc.).

SOCIAL (INTERPERSONAL) CALLS—This category is for non-suicidal callers whose basic problems consist of conflicts with other persons (e.g., husband-wife, employee-employer, parent-child) with-

out additional mental complications. These callers often seek the specific kind of opinions and judgments commonly doled out in newspaper advice columns. They usually want you to confirm the "rightness" of their position.

SOLUTION: The "social caller," while not in need of the hard-to-get aid of a psychiatrist, could benefit from counseling by a psychologist, marriage counselor, or minister. Even if you think you can give the specific advice they request, don't do it. Instead refer them to a counseling agency, which is in a better position to get both sides of the story. Recommend Family Service, Catholic Welfare, Protestant Service Bureau, a minister of the caller's faith, or other counseling agencies listed in the Resource Directory. Explain that there may be a long waiting period at some of these agencies but point out that if the caller fails to make an appointment now the wait will be just as long later. Only when the interpersonal conflict has reached a true crisis (family breakup, etc.) should you attempt to obtain an emergency examination for the caller at any of the counseling units.

MEDICAL CALLS—This category is for callers who need special medical attention and cannot get it through normal channels. Unlike the personal gain callers, medical callers are probably sincere. They include persons with serious diseases, unwed mothers, and the physically handicapped.

SOLUTION: For the seriously ill and the handicapped, recommend a specialized health or welfare agency listed in the Resource Directory. If the caller has lived in Dade for a year or more, he may also be eligible for County Welfare assistance. For unwed mothers, there are several homes listed in the Resource Directory that will provide shelter and care on a self-help basis. If the medical caller is capable of following your instructions there is no need to assist him in contacting these agencies—but you may want to help him if he fails.

SUICIDAL CALLS—At last we come to what we're really after. As you can see, we have used the process of elimination to narrow down the field of callers that may be considered suicidal. But we still have to use the second method—the positive-clue system. As

we said before, we divide our "Number Six" (suicidal) callers into two classifications—lightly suicidal (6A) and seriously suicidal (6B).

Lightly Suicidal callers are those who are in the suicidal trend—they are thinking of suicide but they have not yet formulated a specific plan for self-destruction. They may continue in this trend for months, even years, without attempting suicide, but it also is quite likely that they will become seriously suicidal within six months unless there is a basic change in outlook.

Seriously Suicidal callers are actively planning suicide. Unless they get help, they will certainly make an attempt at suicide within six or eight weeks or sooner. They see suicide as "the only way out" and believe that self-destruction will "accomplish" something important for them. About 15 per cent of all calls received by FRIENDS fall in the suicidal category. Of these, less than half are seriously suicidal. But this is the most important group and the handling of these calls during the past year of FRIENDS' operation has undoubtedly saved many lives. Because this category is the most complex, we will not attempt to list solutions at this point; instead, we will first consider a series of symptoms or clues that will aid us in a positive evaluation of suicidal cases.

EVALUATING THE SUICIDE—Here is a list of symptoms of potential suicide that will help you to make your positive evaluation. They are not in special order and are not of equal weight, but the more of these symptoms a caller exhibits, the more likely it is that he is suicidal:

1. *Means*—He has a suicidal tool available (gun, sleeping pills, etc.). This factor carries double weight if the caller frequently mentions that he has the means.

2. *Previous Attempt*—A recent study of suicide in Philadelphia showed that in 75 per cent of accomplished suicides there has been a previous attempt.

3. *Family History*—Statistically, persons who have had a suicide in the family (especially of one or both parents) are more likely to commit or attempt suicide than those who have not.

4. *Lack of Roots*—Very few persons commit suicide in the town or region of their birth. The farther away from home, family connec-

tions, and close friends a person gets, the more likely suicide becomes.

5. *Withdrawal*—The potential suicide often systematically eliminates social contacts. He drops out of his club, his church, even his job, he avoids old friends. Then, he can reasonably say, "I'm not needed."

6. *Confusion*—The potential suicide has a marked inability to separate and evaluate his problems. He may say in the same breath, "My wife has left me and I'm two payments past due on the TV set." He cannot deal effectively with any one of his problems because he cannot clear his mind of the others.

7. *Vague Illness*—He will often complain about indefinite physical illness—an "ache-all-over feeling," a chemical change inside him, sleeplessness or too much sleeping. These psychosomatic signs are important because they reflect a high degree of confusion.

8. *Urge to Kill*—The potential suicide may be seeking revenge, thinking, "You'll be sorry when I'm gone." This is a very dangerous attitude because it may give birth to homicide.

9. *Fear of Future*—Although it sounds incongruous, many persons commit suicide because they fear death. "I know it's cowardly to think of suicide," they say, but actually they are thinking that if they can accomplish suicide, they will not have to fear the things that really worry them.

10. *Financial Reverse*—Closely allied with fear of the future is anticipation of financial reverse. The realization is never as bad as the anticipation, but the potential suicide will exaggerate his impending financial crisis. It is loss of status that hurts.

11. *Rationalization*—Occasionally the potential suicide will attempt an aggressive defense of suicide. This is especially true in cases where the subject is following in the footsteps of a relative who committed suicide.

12. *Negative Protest*—This is a very tricky factor. If a person calls FRIENDS and then over-emphasizes that he is certainly not contemplating suicide, watch out.

13. *Feeling of Failure*—Despite any past successes, the potential

suicide will harp on his failures—even small ones. He will say he is inefficient, forgetful, makes mistakes that others notice.

14. *Bad Breaks*—Or he will bend in the opposite direction. He is always right and best and the others are always wrong. But HE gets all the bad breaks. This is a cover-up for his feelings of failure.

15. *Age Factor*—Statistically, the older a FRIENDS caller is, the more likely it is that he is a serious potential suicide. Any caller over 60 should be checked with special care.

LIGHTLY OR SERIOUSLY—The reason for dividing the suicidal category into "6A" (lightly) and "6B" (seriously) is simple: It gives FRIENDS worker a rule-of-thumb for action. Making the differentiation, however, is not always so easy, but actual experience and continuing case study will soon give you more confidence in making your evaluation. Basically, as we explained before, the "6A" is in the suicidal trend but has not yet formulated a plan for self-murder, while the "6B" has a definite plan for suicide and seems likely to harm himself or others at any moment.

HANDLING THE 6B CASE—When you are convinced that your caller is seriously suicidal, the following solutions are indicated (in the order in which they should be applied):

1. Psychiatric Examination
2. Face-to-Face Meeting
3. Pastoral Counseling
4. Domestic Counseling
5. Welfare Aid

NOTE: Often, these five solutions may be used in combination.

PSYCHIATRIC EXAMINATION—It cannot be stressed too much that when the suicidal act is imminent an immediate psychiatric examination is the prime goal for the FRIENDS worker. Your attitude toward this examination can help break down the 6B caller's possible reluctance to take this very important step. Dade County maintains, through Jackson Memorial Hospital's emergency clinic (just off N.W. 10th Ave. at 19th St.), 24-hour-a-day psychiatric services—for potential suicides and other emotionally disturbed per-

sons. But complexity of the emergency ward may frighten or confuse a deeply depressed person. Easing this feeling of confusion is one of the most valuable forms of aid a FRIENDS worker can give to a 6B case. Here, from start to finish, are the steps used in FRIENDS' "hospital procedure":

(1.) When, during the handling of a call, you decide that the caller is a "6B," suggest to him that it might be a good idea to "talk this thing over with a doctor." Tell him that an interview at the hospital would be "a good first step" toward straightening out his problems and clearing up some of his mental confusion. When he agrees, tell him how to get to the emergency ward and assure him that you will meet him there. (It is not a good idea to transport a suicidal person in your own car.) Set a time (the sooner the better) for the meeting and make sure you both know how to identify each other.

(2.) Call the hospital (FR 1-9611) and ask for the emergency front desk. When the desk nurse answers, identify yourself as a member of FRIENDS ("You know, the anti-suicide organization") and tell her that you will be coming in to meet a suicidal caller. Be casual in your remarks to the desk nurse, who sees a great deal more of pain and misery in a day than most of us see in a lifetime. She, in turn, will respect your easy-going "professional" attitude by seeing to it that your caller gets the promptest attention possible. When talking to the desk nurse on the phone DO NOT recite the details of your case.

(3.) Meet the caller in the emergency ward and take him to the front desk, where your friend, the nurse, will fill out a social service chart for him. While this is going on, move away from the desk and wait for your caller to rejoin you. (If your caller is hysterical, you may have to stand with him to assist the nurse.)

(4.) When your caller rejoins you, take seats in the lobby—preferably up close to the front desk. Be neither too cheerful nor too concerned. Be a friend. (It is always a nice gesture to offer the caller a cup of coffee or hot chocolate from the lobby's vending machine.)

(5.) You now face a long wait (two hours is average) before

your caller will be seen by a psychiatrist, so let the caller regulate the pace of your conversation. Small talk is fine, but occasionally you should insert some question or remark that will remind the caller of his problems (this will prevent him from suddenly saying "I feel fine" and deciding to go home). If he is apprehensive, be reassuring and positive. If he is apologetic about taking up your time, tell him, "I'm sure you would do the same for me. . . ." Let him know that your work with FRIENDS gives you a sense of satisfaction and that being with him is not a chore. You may also want to suggest some form of outside activity that will hasten his rehabilitation and renew his sense of worthwhile contribution, but do not dwell on the point.

(6.) When the nurse, after a few minutes' wait in the lobby, leads the caller to an emergency ward alcove, you will go along. The alcove, as you will see, contains a chair and an examination cot. Allow the caller to sit on the chair. You will either sit on the cot or find another chair. The large leather straps on the cot, incidentally, are not used to restrain the violent but rather for protecting unconscious patients. You and your caller may smoke in the alcove. There is also a cloth curtain that draws across the alcove. If the nurse closes it, you should casually open it again—so you won't get "lost" in the hectic pace of ward rounds.

(7.) After you are settled in an alcove, a nurse will take your caller's temperature as a routine matter. Then, you will probably have to wait a half-hour or so before the section intern gets to your alcove. The intern will ask the caller a few questions to determine whether your caller actually needs to see a psychiatrist. (If you have been selective in designating your caller as a "6B," he will get through this screening process with no trouble.) With the caller's permission, you may quickly fill the intern in on what you have learned about the caller and his reason for calling FRIENDS. But do not plead the caller's case—leave the decisions to the intern.

(8.) If the intern decides to send for the resident psychiatrist, you still face another wait of about an hour. Continue talking with the caller. Offer him another cup of coffee. DON'T complain about

the long wait. Instead, tell the caller how good the hospital psychiatrists are and explain how busy they are.

(9.) When the psychiatrist arrives you may again—with the caller's permission—give a short fill-in, either out in the hall or in front of the caller. Then, thank the caller for calling FRIENDS, assure him that we are always available (or confirm earlier arrangements to call him the next day) and BOW OUT.

(10.) On the way out, don't forget to thank the desk nurse for her help. You have now fulfilled your function at the hospital and may go home. The rest is up to the psychiatrist, who may choose to hospitalize the caller, or put him into out-patient therapy, or do nothing. The decision is up to the psychiatrist.

(11.) Within a few hours, or the next day at the latest, you should follow up by calling the emergency desk to find out if the caller was admitted or discharged. Note this information on your case form and make whatever other follow-up (with the caller or with other agencies) that is necessary.

(Two footnotes on hospital procedure: Never promise anonymity to a caller. If the question comes up, tell him that "naturally" he will have to give his name to the hospital but point out that the hospital is not interested in punishing or exposing him. Do not discuss hospital expenses with him. There is a $3.50 minimum charge for emergency examination but even that fee can be waived for destitute cases.)

FACE-TO-FACE MEETING—If the seriously suicidal person refuses to meet you at the hospital, you may arrange to meet instead in a "neutral corner"—not at your home or his but in some well-lighted public place where you can continue your discussion face to face. During the meeting, you should continue to stress the importance of a hospital visit.

PASTORAL COUNSELING—Familiarize yourself with the religious counseling agencies listed in the Resource Directory (Protestant Service Bureau, Catholic Welfare, Jewish Family Service, etc.). If the 6B caller refuses psychiatric examination, he may accept aid or counseling from a religious agency or a clergyman of his faith. The above agencies or the area's various ministerial associa-

tions can help you locate a clergyman in your caller's neighborhood. (If the 6B caller expresses an immediate desire to see a minister rather than a psychiatrist, his wish should take precedence over regular FRIENDS procedure.)

DOMESTIC COUNSELING—If the 6B call, even after a face-to-face meeting, still refuses psychiatric examination and is not interested in pastoral counseling, you may try to find an appointment with a community counseling agency such as Family Service. However, most counseling groups have a great back-log of cases and your caller may face a long waiting period.

WELFARE AID—Whether your caller accepts psychiatric care or not, he may also be in need of material aid—money, food, a job, or shelter. Here's where the Resource Directory again comes in handy. You may pave the way for him with a call to one or more of the available welfare agencies, identifying yourself as a FRIENDS worker and briefly explaining your knowledge of the caller's situation. You must remember, however, that most of these agencies operate on extremely limited budgets.

FAMILY TIES—If—and only if—none of the above solutions apply to a particular 6B case, you may, with the caller's permission, contact a member of his family or a close friend to advise them of the caller's suicidal intentions. This, however, is only to be done as a last resort, and is not desirable. It is far better to simply urge the caller to strengthen his family ties or friendships himself.

HANDLING THE 6A CASE—With the lightly suicidal call, time—and immediate action—is not quite as important as with the 6B case. Here, instead of fighting time, you will be fighting apathy. Unlike the 6B caller, who usually is quite willing to follow your lead in securing aid, the 6A caller will be far more critical of your suggestions. He is often looking for a miracle, one-shot cure for his depression. You will have to convince him to solve his problems step by step and will probably have to help him make appointments for whatever counseling or psychiatric aid is indicated.

You should NOT, however, attempt to secure an emergency psychiatric examination for a 6A caller. Instead, suggest that he call the hospital for an appointment with the psychiatric out-patient

clinic. It may be necessary for you to call the hospital first, identifying yourself as a member of FRIENDS and briefly explaining the relative degree of suicidal intent displayed by your caller. This may, in many cases, help your caller to get a faster appointment.

But remember that the psychiatric clinic has a long waiting list and prepare your 6A caller for this possibility. Aside from psychiatric examination, you will follow the same steps for 6A callers as in 6B cases but with less urgency. Instead, stress self-help—getting back into organized society, helping others, strengthening religious, family, and friendship ties. Maintain your positive attitude that, for him, suicide is not the answer and that better alternative solutions exist.

FOLLOW-UPS—With all 6A and 6B cases you should make a follow-up investigation within 24 or 48 hours after the original call. This will help you determine what steps have actually been taken toward rehabilitation. Check back with whatever agencies you contacted and, if possible, check back with the caller just to let him know that you are still interested in him. Note your findings on the original case form or make out a second form with the same case number.

WHEN TO CALL POLICE—There are three special situations in which the FRIENDS worker is obliged to take special emergency action:

(1.) If a caller tells you that he is actually in the midst of attempting suicide—that he has slashed his wrists or taken an overdose, etc.—you should contact police immediately, without asking the caller's permission. If possible get his address and keep him on the phone while someone else calls police. If you can't get an address call Metro Police, calmly explain what has happened, and give them the caller's phone number. They can match it with a cross directory to get the address.

Don't get too excited but ask them to "check out" the caller's location. If the location is not in their jurisdiction they will either tell you what police department to call or will call themselves. If possible, you should meet the police at the caller's location. This

way, the caller stands a better chance of getting therapy instead of a night in jail. But, remember, the police make the final decision in this respect.

(2.) If a caller, after contacting FRIENDS for help, fails to answer your immediate return call—and if his phone is in a residence —you have to assume that something is wrong. Call police and calmly tell them what happened and ask them to "check out" the house to see if everything is all right. Tell them you will call the station again in a few minutes, then do so. If something was amiss, follow through as explained above. If there was nothing wrong, try the call again. Remember to mention all of these happenings on your case form.

(3.) If the caller hangs up abruptly in the middle of a conversation without a logical reason, call back again. But if any other person answers the phone, do not identify yourself as a member of FRIENDS, because that might be the reason he was forced to hang up. If you don't get an answer on your return call, you must assume that something is amiss and follow through with call to police as above.

(*Note:* The fourth instance in which to call police, as we discussed earlier, is in the "third person" report of a suicide in progress. In that case give police only the number of the "third person" caller.)

STATE ATTORNEY CASES—A small number of persons are still charged with attempting suicide through Dade's Criminal Court. But, realizing the essential futility of punitive action in these cases, the State Attorney's office has asked FRIENDS to assist suicidal defendants in rehabilitation. A list of such defendants is periodically sent to FRIENDS for our attention. If you receive a State Attorney case (through our switchboard) you will handle it in the same manner as any other FRIENDS call, with three important exceptions:

(1.) The case is automatically a "number six"—probably 6A because the defendant has probably already undergone a psychiatric examination. If not, try to make arrangements for an examination. Use whatever other agencies and welfare sources as are necessary.

(2.) A State Attorney case is the only kind in which the FRIENDS worker initiates the call without hearing first from the suicidal person. Be friendly and tactful. Explain that the State Attorney's office has asked us to help. If the suicidal defendant is not interested in receiving help from you, that is as far as you go. Don't force FRIENDS on him.

(3.) Whether he accepts your help or not, you will make out a regular case form PLUS phoning a report of his progress to his probation officer (our switchboard will give you the officer's name and telephone number).

A FEW POINTERS—Experience with actual FRIENDS calls is undoubtedly the best teacher. If you follow the basic rules of procedure, the rest will come to you as you go along. Here, however, are a few tips that may be of value to you:

(1.) Never engage in a philosophic argument on the moral aspects of suicide. You are likely to lose both the argument—and the caller. Don't stress the shock and embarrassment that the act would be to the caller's family—that may be just what he seeks to accomplish. Avoid the negative approach. Instead, show the caller that there are—in his particular case—better alternatives to suicide.

(2.) Never sound shocked by anything your caller tells you. Be calm and understanding. When at a loss for words, maintain rapport by saying, "I know exactly how you feel"—and, presently, you will know how he feels.

(3.) Remember to use constructive questions to help separate and define the caller's problems and clear away some of the confusion he feels.

(4.) Use a narrative synthesis to solidify the caller's point of view. You can do this by rephrasing several of the important things he has told you and then stating them back to him, so: ". . . In other words, you feel . . ."

(5.) Point out to the caller that everyone must deal with his problems one at a time. "All of us can drink a lakeful of water in a lifetime, but no one can drink the lake in a day."

(6.) Be careful with religion. Never try to convert a caller. If the

caller has a religion, however, it is good to suggest that he seek aid through his faith but do not dwell on the point.

(7.) Mention the caller's family as a source of strength, but if he rejects the idea drop it.

(8.) Remember that by calling FRIENDS the caller has already demonstrated his willingness to be helped. This is your greatest advantage. Hardly any person who commits suicide wants to die. He may expect his act to accomplish many things—but not death.

(9.) Be selective. Remember that you can't possibly decide how to handle a case until you have heard and evaluated all the information.

And one last note: Above all—be a friend.

Following is the case form used by FRIENDS. It provides the vital data by which the usefulness and efficiency of their work can be judged.

Given Name _____ Case Number _____
Age _____ Sex _____ Color _____ Marital Status _____
Legal Residence _____ Time Here _____
Occupation _____ Education _____ Religion _____ Attending? _____
Other Activities _____ Organizations? _____
Medical Care? _____ When? _____ How Long? _____
Psychiatric Care? _____ When? _____ How Long? _____
Hospital Care? _____ When? _____ How Long? _____
Other Therapy? _____ When? _____ How Long? _____
Reason for Calling? _____
Considered Suicide: When? _____ Lightly? _____ Seriously? _____
Attempted Suicide: When? _____ How? _____ Seriously? _____
Suicidal Now? _____ For How Long? _____
Date _____ Call From: Suicidal Person _____ or Other Person _____
Disposition _____
_____

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