Editorial.

SUICIDE.

A PART from the problem of suicide and its prevention, which is constantly before the institutional psychiatrist, the daily press brings vividly before us how frequently this act occurs, often without seeming adequate cause. We are hearing much to-day of research in psychological medicine, but any encouragement in this sphere seems only to lie in the equipment of laboratories, where it is hoped that the scientific examination of physiological abnormalities will slowly, but surely, throw light upon the origin of the various forms of mental disease. We hear little or nothing in this country of stimulation to psychopathological research, and it is patent that only in such study shall we be able to elucidate the factors underlying the act of suicide, which involves a subject-matter of sociological as well as medical interest. Until recently, the taking of one's own life was regarded merely superficially, either as the result of an unaccountable impulse, or as the sequela of a depression brought about by a grave dissatisfaction with life. That there must have been something abnormal in the mental soil was presumed, but further than this few have seemed to care to investigate. This presumption of an inherent mental instability does not carry us far, especially so in that we find suicidal acts often occur in those where no trace of previous pathological symptoms was in evidence. Young children considered by their parents as normal in every way have, after a simple chiding, taken their own lives. Some deeper psychological knowledge on this question is patently needed in order that we may take prophylactic measures. In some psychotic conditions, such as manic-depressive states, we regard the patient as a potential suicide, and take steps accordingly, but in the manifold minor psychotic conditions which so constantly come before us, what indications have we for scientifically anticipating the possibility of an endeavour to terminate existence? The general practitioner especially, we feel, must be educated in such matters, because it is in his practice most commonly that advice is first sought, and it is upon his handling of the case that so much depends. Press reports at inquests frequently tell the same story. The deceased had consulted a doctor about his depression and insomnia, only to be told he was 'run down,' overworked,
that he had better take a rest, required a nerve tonic and ‘must not worry.’ Unless some obvious worry is spoken of, no psychic causation is dealt with, and the patient tends to be looked upon as uninteresting, and one whom the doctor would rather dispense with than dispense for. Though, without doubt, the patient desires to see a somatic cause for his suffering, he intuitively feels that there is another element which not only he himself cannot fathom, but that his doctor does not understand. We think it just this element of feeling that he is misunderstood by the last source of appeal—the doctor—that tends to break the ultimate link by means of which such a patient clings to life. It has been the experience of those who deal with such cases on up-to-date psychological lines that the danger of suicide is greatly eliminated if, during psychotherapeutic treatment, a hopeful attitude is taken up by the physician and instilled into the patient. Stekel has stated that suicide does not occur during psycho-analytic treatment, and that, though patients may threaten so to act, they do not carry out their threats as long as they cling to the analyst.

Two fallacious ideas are common in medical minds. One is, that if an individual talks of any suicidal impulse, he will not carry it out; and the other, that a psychoneurotic is safe from this tendency. It must be noted that any emotional idea is liable to pass over into overt action provided counter-inhibitions are lessened, and that unless the balancing forces are duly investigated it is impossible to adumbrate the resulting conduct. That psychoneurotics, referring mainly to those of an anxiety type, are unlikely to attempt suicide is obviously contradicted by the press reports already spoken of. In the majority of such cases no evidence of ‘insanity’ was brought forward, but to the psychological eye there were often seen situational factors which lent some colour to the view that a refuge from reality had been sought, even though the reason for it was largely unconsciously motivated. For obvious reasons the inquest verdict is that of ‘suicide while temporarily insane,’ but in strict phraseology such individuals for the most part are not ‘insane,’ that is, they were not legally certifiable or commitable, and though subsequent to the act we presume some psychopathic abnormality, there is frequently found little evidence of this previously. Until of late years, through the work of the psycho-analytic school, no real glimmering of basic sources has been possible. The only conclusion that a highly experienced medical coroner could come to was expressed in the language of the poet who wrote:

‘When all the blandishments of life are gone,
The coward shrinks to death, the brave live on.’

It is manifest that in a suicidal individual there must be a grave derangement of the normal desire to live, which may, or may not, be
evidence of a definite psychosis. From his analytic studies, Clark sees herein a withdrawal from a normal adaptation to reality, and an increase of intrapsychic tension formed from the conscious and unconscious conflicts, which usually resolves itself into what is called a sin either of commission or omission. If the unconscious and infantile claim is sufficiently great, and the mental regression goes deep enough, we obtain the fundamental solution in self-destruction, not because there is a conscious desire for such, but because the dynamic fixation of infantile attachment decides it. This is usually formulated directly as the call of the parent or loved one, or as the still more insistent demand of the Supreme Being. Sane suicides Clark regards as having the same psychology as the psychotics.

There seems no doubt, when we study the unconscious motivation, that the essence of the mental conflict is an ethical or religious one, both of which are probably woven together. A sense of guilt, when not in any way a conscious factor, probably always lies beneath the surface, and inextricably combined with this lies a motive of self-punishment. That sexuality in some form or another has often intimate relationship with suicide is undeniable. The renunciation of love is frequently the obvious precursor, and, in this, the principle of revenge upon the love-object may enter in with the idea that the death will lay at their door and so bring life-long remorse. Not uncommonly, however, the renunciation refers to infantile attachment which only analysis can reveal. Psychotherapeutists are fully aware of the sense of guilt arising from onanistic practices, and it is known that relapse after abstinence is not infrequently a causative factor in suicide. Statistical examinations strongly confirm this intimacy of suicide with the manifold factors involved in sex life. The fear of insanity, which is often seen to play an important causative rôle, would be analytically explained as a fear of repressed unconscious conflicts which are in danger of breaking through into awareness, and thus becoming conscious of guilt. Should guilt have its source in repressed hostile wishes, we can understand how closely homicide and suicide may be related. The two acts, in fact, frequently follow upon each other. Freud has lately postulated a highly interesting speculative hypothesis that there is an innate ‘death instinct,’ which urges us to reach a state in which there is a relief of all tension, a Nirvana. It is possible, therefore, that the sex or life instinct acts as a stimulus to face reality, but given sufficient impediment to the demands of Eros, there may be such regression that the death instinct comes into play. Such an hypothesis only tends to confirm what we previously said, namely, that one aid in the prevention of suicide lies in sustaining some objective attachment. In the young we also may, perhaps, do something prophylactic through parental education. Too much love during the formative years may render an individual so greedy of
affection that, in after life, he becomes incapable of living without it, and, also, such an exaggerated early love life tends to a parental fixation which, when repressed, brings guilt in its train, and morbid depression later from its necessary renunciation. Where the great fundamental problems of the human psyche require elucidating, our task seems so great that we are apt to attempt solutions on a superficial plane. Enough work, however, has been done to show that further efforts may be fruitful, and that a greater dissemination of the knowledge already gained should, in its practical application, do something towards obviating many an act of self-destruction.
Editorial: SUICIDE.

J Neurol Psychopathol 1923 s1-4: 248-251
doi: 10.1136/jnnp.s1-4.15.248

Updated information and services can be found at:
http://jnnp.bmj.com/content/s1-4/15/248.citation

Email alerting service

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/