means the whole of these acts, and probably does not entirely do so to-day.

Neither the Suicide rate nor that of Attempts represents the full Incidence of Suicide. However great is the accuracy now of the returns, it is not possible to estimate and to include in them the frequency of the urge to commit suicide which is really the true suicidal incidence. The number who attempt or complete the act is partly determined by external and accidental circumstances, including ease and availability of some new method of committing suicide, especially if that new method is closely allied to the normal process of sleep.

Former rises in Suicide rate: position ultimately stationary. The suicide rate for England and Wales has shown, ever since statistics have been available, a fairly steady, but nevertheless an ultimately diminishing, rate of rise. How far these variations in the rate were due to actual changes in the number of suicides in proportion to the population, or how far they were due to increased accuracy in the returns, it is not possible to say. It is, however, noticeable that, according to the returns in the first three Census years of the present century, a position of great stability had been reached: thus, the number of annual deaths from suicide in each 10,000 of the population living at all ages was, during each of the years 1901, 1911, and 1921, 1.5 for males, 0.5 for females, and 1.0 for both sexes together.¹

Rise in Suicide rate during the Decade since 1921. There is evidence that, since the 1921 Census and to a slight extent during the previous ten years, there has been a growing tendency to resort to inhalation of coal gas as a means of suicide: with the result that some persons have used this method instead of some other means, and many more have used it who probably would not have taken their lives otherwise. As a consequence, the suicide rate per 10,000 of the population seems to have risen during the year 1923 to 1.8 for males, to 0.7 for females, and to 1.3 for both sexes together. These proportions may need slight correction when fuller details are published of the Census figures for 1931.

Suicide by inhalation of Coal Gas. Poisoning by inhalation of coal gas was the method used with fatal result by 824 males and 461 females in the year 1929. It accounted for 23.7 per cent. of male and for 30.7 per cent. of female suicides during that year. It is now the most frequently used method, the next in frequency being hanging in males and drowning in females. Of those who resorted to this use of coal gas, less than 2 per cent. (14 cases) of the males and less than 3 per cent. (12 cases) of the females were in the 15-19 age-period; and less than 3 per cent. males and less than 5 per cent. females were aged 20-24: in other words, 92 per cent. were 25 years old and upwards. The period of life showing the greatest frequency of its use was 45-54 years of age, in which 26.1 per cent. of the male and as many as 30.4 per cent. of the female suicides by coal gas took place: in no other period was there a higher percentage for either sex. Notwithstanding this use of coal gas and a consequent probable rise in the suicide rate, the latter in no sense constitutes a "problem," nor is the position at all alarming. It is, however, desirable that consideration should be given to the possibility of rendering coal gas less easy to use as a means of suicide.

Doubtful utility of retaining Suicide or its Attempt as a Crime. While it is desirable and necessary that the question whether death was due to suicide or not should remain a matter for legal inquiry, it is very doubtful if any good results from retaining either it or attempted suicide as possibly a crime.

Need for more thorough Study of Suicide as a Medical Subject. Suicide, as a subject, is in need of much greater medical study than it has received, both in this country and internationally. In addition to the advantage to

¹ This general statement and these proportions tally fairly closely with those summarised in *Elements of Vital Statistics*, by Sir Arthur Newsholme, 1923 Ed., pp. 380-82, in which particulars are cited from Part III of the Supplement to the Twenty-fifth Annual Report of the Registrar General (1901-10). His proportions per million living at all ages were calculated upon a "standardised" population.

Psychological Medicine which such study would afford, it probably would provide the best means of determining how to prevent the occurrence of a considerable number of cases that now take place.

Help which Coroners and Magistrates could give. Coroners and Magistrates could do much both to direct the subject of suicide into proper medical channels of inquiry; and, by such action on their part and by directions which Magistrates may find themselves in a position to give, much could be done to stimulate the provision of out-patient treatment of mental illness and of nerve clinics, as contemplated by the Mental Treatment Act. It may be desirable to consider how Coroners and Magistrates can be approached upon the matter.

THE PSYCHOLOGY OF SUICIDE*

BY

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Suicide is man's great retreat from life. He has recourse to it when he feels no longer able to endure suffering in the present or pain in the future. It is therefore a failure of adaptation and constitutes a final regression from reality. The motives underlying suicidal acts are numerous and complex. It is impossible to ascertain them with any degree of certainty unless we are intimately acquainted with the patient's psychic life. It is certain that evidence given and conclusions reached in Coroners' courts can be regarded as adequate only in a minority of cases. The importance of social influences can easily be exaggerated, although such influences are frequently operative. It will be convenient to group the motives of the suicide under three headings:—

- (1) Physical pain, including frustration of instinctive demands.
- (2) Social sufferings and fears.
- (3) Doubts and dreads pertaining to the hereafter.

PAIN AND FRUSTRATION

In the first group we have the suicides due to physical pain. It is commonly agreed that this causes far fewer suicides than one would expect. Halbwach places it ninth in his list of twelve major causes. It is also noteworthy that acute pain does not seem to drive men to self-destruction as frequently as some of the gross discomforts. The pain of trigeminal neuralgia is said to be accountable for a few cases, but it is probable that the incessant discomfort of tinnitus aurium is a more prolific cause. Still more noteworthy is the fact, which is not likely to be contested, that men commit suicide more frequently on account of anticipated pain than actual suffering, however acute. I imagine that few women have committed suicide when a malignant tumour of the breast was diagnosed, yet there are an appreciable number, I believe, who when they observe a nodule in the breast are so terrified that it will prove to be cancer that they take their lives. It is difficult to obtain any data about war cases, but my impression is that very few wounded men took their lives, however acute their suffering on the battlefield. On the other hand, it is quite certain that of the unwounded who committed suicide many did so from dread of a painful death.

We are probably justified in concluding, at any rate for civilised man, that he is more capable of adjusting to physical pain than to anticipatory dread of it. And this

* Read in opening a discussion in the Section of Neurology and Psychological Medicine at the Annual Meeting of the British Medical Association, Eastbourne, 1931.

conclusion brings up a somewhat analogous phenomenon in a different field. The fear of insanity certainly deserves to rank among the major causes of suicide. In the pre-psychotic stage a man may pass through a phase of tendency to suicide and may even attempt it. Yet when the psychosis declares itself in a delusional manifestation the suicidal tendency may pass completely. To put it in another way, loss of insight allays the mental distress that previously impelled the patient towards suicide. The man who could hardly adjust himself to life with the shadow of insanity upon him can adjust himself to life when he is insane by reason of the insanity itself. This is one example that shows how superficial is the popular view that suicide is evidence of insanity.

In this first group that we are discussing I have included "frustration of instinctive demands." It is probably true that more suicides have been occasioned by thirst than by hunger. It is very certain that when hunger and thirst are both extreme it is only the latter that counts.

But in normal civilized life it is the sex instinct which meets with most frequent frustration and which in consequence accounts for the largest number of suicides in this group. In the first place there is the unmarried woman who feels she can no longer endure the pangs of sex starvation. There must be, I imagine, a few married women, who, on account of dyspareunia or conjugal taunts of frigidity, determine to escape from marriage and therefore from life. I have known at least one woman who gave this as the reason for her attempted suicide. Sterility may perhaps drive a few women to despair. I have never come across an attempt, but one patient, who was bitterly disappointed by her sterility and who knew that her husband was almost as greatly distressed, discussed with me in the most detached way the possibility of suicide, basing her contention on her husband's right to marry a woman who could make him a father.

Both men and women commit suicide on account of homosexuality. But in these cases the issue is almost always confused and can rarely be classed as mere instinct frustration. Conflict over homosexual tendencies in themselves, fear of social discovery, repressed inferiority for not being as others are—these and similar factors come into the etiology. The factor of the exhibitionist suicide is hard to evaluate. We are all familiar with it in the half-hearted suicidal attempts of the hysteric, but there can be no doubt that it contributes to not a few determined and successful suicides. This factor of pose recalls a case cited by Fraser. A rejected suitor in Vienna craved a final interview with the object of his affection. When they met he asked her to return the engagement ring. He placed it over his heart, the muzzle of his revolver against it and shot himself. The ring was found imbedded in the myocardium! Surely a dramatic exit of this type can have been little influenced by instinctive or other basic motives!

In men the factor of sex-frustration probably counts less than in women. The main reason for the difference is manifest, namely, that man has his sexual destiny much more in his own control than has woman. The incidence too is different. With the male the problem tends to be acute in late adolescence and early senescence. With woman on the other hand it is in the late thirties that despair is likely to seize her. Judging from analytical experience one would feel inclined to surmise that many of the suicides of males in the early twenties are due to sex conflict mainly centring on hypogonadism. The feeling of not experiencing sex impulses that one's fellows claim to experience; the haunting doubt as to whether one will ever be able to fulfil the role of the husband; the horror of being revealed as an imperfect man—these things are so often described in the course of analysis that they

must surely enter into the motivation of many suicides. In this connection it is important to recognise the passive suicide by starvation. We call this, inappropriately enough, *anorexia hysterica*; sometimes it is *dysphagia hysterica*. It should be regarded not as a psychoneurosis but as a definite pre-psychotic suicidal equivalent. It is essentially the great retreat of the late adolescent, and in my own experience it is invariably associated with evidence of hypogonadism. The following case illustrates these points.

A youth of 21, well over 6ft. in height and weighing less than 7 stone, collapsed on a motor-cycle run. He was then in his second year at the University. He had actually begun compulsive abstinence when he first went to his public school. This was the result of an auto-erotic conflict and some ill-judged statement in a pamphlet about sex. When he left school the compulsion gained strength, and by the time of his collapse he had reached a dangerous state of inanition. He was taken to a nursing home on a stretcher; his extremities were profoundly cyanosed. On investigation the acuteness of his sex conflict was revealed. His fear of sex experience was extreme. After a few days in the home he mutilated his penis with a pair of nail scissors to the extent of requiring three stitches. Subsequently he recovered completely and is now both a husband and a father.

This case shows well the way in which many a young suicide retreats from life because of sex fear, and attempts to terminate his existence as a generalized castration reaction. And just as the self-mutilation may be expiatory or self-punitive, so the compulsive abstinence has the same origin.

The climacteric suicides in males are generally attributed to insomnia. The high degree of respectability which belongs to this complaint makes it an eminently suitable explanation for mourning relatives, coroners and journalists. It is however a very unsatisfactory explanation for the psychopathologist. The cases of which he may have accurate information are not infrequently cases of early impotence associated with aggravating emotional factors—for example when a middle-aged man has married a young wife, or when the man attributes his impotence, rightly or wrongly, to a venereal infection in youth, and so on.

SOCIAL SUFFERINGS AND FEARS

Passing on to the second group—social sufferings and fears—we find a large number of cases in which the motivation is much simpler and less liable to misinterpretation. The men who commit suicide on account of bankruptcy, or because they have lost their employment, or in the face of legal proceedings which will expose their misdeeds—all these are familiar enough and reveal the extent to which herd values may eclipse the instinctive desire to live. In many cases one sees only an exaggerated self-love incapable of accepting social humiliation at any price. In others there may be a factor of remorse for wrongs committed, and an impulse towards expiation. Among women illegitimate pregnancy is probably one of the chief causes of the social suicide.

In this connection we may take a special group, difficult to classify, namely, the suicides by identification. Usually the impulse reveals itself by depression and a phobia of committing suicide. A man in the early forties will gradually become depressed, confess that he fears he may do away with himself, and then add, "You see, my mother took her own life when she was 45." In such cases the underlying motive is based on an unconscious feeling that it would be disloyal to the beloved parent to outlive her. The conscious version is "I have inherited from my poor mother a suicidal tendency at the age of 45."

DOUBTS AND DREADS

Finally we come to the last group—doubts and fears of the hereafter. These feelings tend to have an inhibitory effect, but that effect wanes as dogmatic religion, embodying a system of eternal rewards and penalties, loses its hold on the community. In some social systems self-destruction is, under certain circumstances, regarded as a virtuous act liable to secure eternal advantages. In Christianity suicide has been uniformly denounced. But even so there are a certain number of suicides with a religious significance. Sometimes the father complex demands an act of self-punishment whereby alone the individual feels that it will be possible to face the divine Judge. Sometimes the suicide is Messianic in character, a supreme sacrifice of the total personality for some redemptive purpose. Sometimes the compulsion towards purification based on a guilt complex develops into a suicidal act.

In the short space available there is no possibility of dealing with many other important aspects of this subject. The frankly psychotic suicides—especially the melancholics and cyclothymics—are primarily problems of supervision rather than of active therapy. The groups described cover the majority of cases that occur among those who still rank as sane.

SUICIDE FROM THE MEDICO-LEGAL ASPECT*

BY

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Suicide connotes to the legalist a crime and to the physician a state of emotional disorder. It was originally an ecclesiastical offence but was transferred to the King's Courts when the separation between ecclesiastical and civil courts was completed, and judge and bishop no longer sat together in court to hear cases.

Bracton, who wrote on criminal law in the early part of the thirteenth century, records that a person who committed suicide in order to avoid conviction for a crime forfeited his lands. Other suicides forfeited their goods only. According to Stephen this distinction was forgotten before the time of Staundforde, a judge in the reign of Queen Elizabeth, who published a work on the Pleas of the Crown.¹ In other respects the law remained unaltered till 1870 when forfeitures were abolished (33 & 34 Vic. C. 23).

There appears to have been no legal authority for the ancient custom of burying a person, against whom a coroner's jury had found a verdict of *felo-de-se*, at four cross roads with a stake driven through the body. Stephen² suggests that it originated, like gibbeting, without legal warrant in circumstances now forgotten. It was abolished in 1823 by a statute (4 Geo. 4. C. 52) which enacted that thenceforth it should not be lawful for any coroner to issue his warrant for the interment of a *felo-de-se* in any public highway. He was to order the body to be buried privately in a churchyard, or other burial ground, without any stake being driven through the body, between nine and twelve at night, and without any religious rites. This statute has been repealed by the Interments (*Felo-de-se*) Act 1882, which provides that the body may be buried in any way authorized by the Burial Laws Amendment Act 1880, that is without religious service or with such Christian and orderly religious service at the grave as the person having charge of the body thinks fit.

Suicide, in English Law, is a felony, self-murder, and

the distinctions between murder and manslaughter have been said to apply to this, as far as they are applicable, as well as to the killing of others.³ But there is no such offence as self-manslaughter (*R v Burgess*), and Stephen quotes authorities to show that the true definition of self-murder seems to be where a man kills himself intentionally, and according to Hale, also accidentally, if by an act amounting to felony: as when a man striking at another and intending to kill him misses and strikes himself. Conversely if a person, in making an attempt to kill himself, should accidentally kill any of the bystanders, he will be guilty at least of manslaughter, and in most cases of murder.⁴

The abetment of suicide may be as great a moral offence as the abetment of murder, and if two persons encourage each other to self-murder, and one kills himself, but the other fails in the attempt, the survivor is guilty of murder of the other; and if one person encourages another to commit suicide and is present abetting him while he does so, such person is guilty of murder.

A modification of the former principle is suggested sometimes in suicide pacts. In a recent trial at the Old Bailey a man was acquitted of murder: he was found lying with a woman on a bed in a gas-filled room with a gas tube between their heads, and the woman died. Wright J. while reaffirming the legal doctrine suggested that it was a law which Parliament might well alter. There is no doubt, however, that sometimes the survivor enters into a suicide pact to free himself from responsibilities he refuses to accept. In connexion with the second principle it may be observed that at the last Liverpool Winter Assize the prosecution alleged that a girl, whose body was found mutilated on the railway line, committed suicide after agreement with the accused, and MacKinnon J. ruled that as the survivor of a suicide pact must be present when the other dies in order to support a charge of murder counsel must confine themselves to the charge of being an accessory before the fact.

The blameworthiness of suicide has been a frequent matter of dispute among lawyers and medical men. Stephen considered that it would be a pity if Parliament were to enact any measure tending to alter the feeling with which suicide is, or ought to be, regarded. Dr. Mercier held that a suicide committed an offence if and when by his act he evaded obligations to the State, or to individual members of the State. He considered also that there were other circumstances that would make the act an offence, as when an epidemic of suicide, restricted to women, occurred in Edinburgh in the sixteenth century, and ceased when it was proclaimed that in future the bodies of the suicides would be exposed naked in the market place.⁵

A person who insures his life while *compos mentis* and later dies by his own hand forfeits the contract of insurance if the coroner's jury return a verdict of *felo-de-se*, on the general principle that a man may not profit by his own criminal act.⁶ But if the act of suicide takes place when the assured is insane, then, whether he be beneficially interested in the insurance or not, the policy is not avoided, unless the contract contain a special condition inserted with a view to meet such a contingency.⁷ Many modern policies however provide that in the event of suicide during insanity the policy shall be treated as surrendered, and the surrender value paid to the personal representative or other beneficiaries. Cases of this nature are of particular interest to medical men as it may be disputed on the one hand that the deceased committed suicide, and on the other that he was insane when he committed the act.

A coroner may hold an inquest on a body without a jury subject to certain exceptions,⁸ but he cannot, sitting

* Read in opening a discussion in the Section of Neurology and Psychological Medicine at the Annual Meeting of the British Medical Association, Eastbourne, 1931.