of the spleen consists chiefly of cells similar to those found in the bone marrow. There is an extensive central fatty change in the liver, and a moderate amount of free iron in the cells around the portal area. Some well-circumscribed periportal collections of lymphoid cells are present.

Summary

The blood and post-mortem examinations and the histological findings leave no doubt that the case was one of lymphadenosis, for the greater part of its course subleukaemic, the special features being the relative chronicity and the presence of subcutaneous deposits of lymphoid cells, both extremely rare occurrences in this disease in children.

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A PRACTICAL NOTE ON SUICIDE

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It is an aphorism among psychiatrists that every case of depression is a potential suicide. Yet how difficult it is to get the general public to realize this fact. Reports of inquests on suicides, even when the verdict is the usual one of unsound mind, contain as a rule singularly little indication that the relatives had observed in the victim previous to the act the existence of any abnormality of mind. On inquiry by the coroner it may transpire that the deceased was "worried" or sleepless or suffered from pains in the head. But the depression, almost always present, is usually minimized or completely overlooked, and the act of suicide invariably takes the relatives by surprise. Depression is the commonest precursor of suicide, but even when it is recognized by those about the patient as a sign of mental disorder it still remains a problem to persuade them of the danger of suicide that consequently exists. They generally consider they know better. They tell you they understand the patient so well and are sure that he, or she, would never think of doing anything like that.

A case which emphasizes this difficulty was that of a woman who had become depressed after the death of her husband some weeks previously. The sister, who was looking after the patient, was warned that a definite danger of suicide existed. She plainly thought an alarmist view was being taken, although admitting that the patient was "not herself." It was agreed that she should be sent without delay into a home on the South Coast, and in the evening another relative telephoned to say that final arrangements had been completed and that he would accompany the sick woman the following day to the nursing home. The warning was repeated to him, but little notice was taken of it, and in the train next day he allowed the patient to leave the carriage. She opened a door in the corridor, threw herself on to the line, and was later found dead. At the inquest no reference was made to the warnings that had been given.

Suicide may be actuated by a variety of motives depending on the nature of the mental disorder and the mechanisms at work in the patient's mind. Our insight into these motives will obviously depend on the depth of our psychological analysis of the mental state. I do not intend in this article to consider the influence of the deeper levels of mental activity. The introduction of the concept of the unconscious has thrown much light on the whole subject of mental disorder, an instance of great importance being the discovery that motives which are apparent on the surface may be no true indication of those existing deeper in the mind. But the development of unconscious psychology has brought about also many complexities of theory and technical problems which can

more appropriately be dealt with in journals specially devoted to the subject. Melancholia is the condition in which suicide is most to be feared, and the periods of greatest danger in the majority of cases are at the beginning of an attack and when the patient is showing signs of recovery. At these stages psychomotor inhibition, which puts a brake on suicidal impulses, is less developed, and supervision commonly tends to be relaxed.

Suicide a Means of Escape

Speaking generally, we may say that suicide is a way of escape from a situation that has become intolerable. Mental conflict may reach such a degree of intensity that deliverance from the unbearable conditions seems an imperative necessity. People vary in their capacity to tolerate conflict, anxiety, or "worry," and an accidental accumulation of troubles or an incident which to others seems comparatively unimportant may, in unstable types, precipitate an attempt at self-destruction. Sometimes a transient condition of confusion may develop at the critical moment or a short phase of automatism may occur when the act is committed. In these cases, if the attempt is unsuccessful, there is an amnesia of varying duration, and the patient may "come to" and discover himself the victim of injuries with no recollection how they occurred.

Worry from external circumstances, unless the latter are of an extraordinary or exceptionally disturbing character, cannot be said to be sufficient in itself to arouse a suicidal attitude of mind. Other components are always present, the external conditions acting only as accumulative and precipitating factors. Guilt and self-reproach are the commonest motivating elements in melancholia, and may develop to an extreme and overwhelming degree. In these cases suicide is a punishment for sin, an atonement and washing out of guilt. In other cases fear or apprehension of something terrible about to happen is the dominating feature. The grounds for the fear may be unknown or may be definite, though irrational, such as the conviction of being about to be tortured. In this condition the suicidal attempt is made to avoid the horrors that are thought to be imminent.

A belief that they are injuring those they love is a common motive in another class of depressed patients which may produce great mental distress and lead to determined efforts at suicide. It may be some spiritual injury they feel they are the cause of, or they may believe they are unclean and in danger of transmitting some dreadful disease. Self-pity and the hypochondriacal attitude may be accompanied by suicidal attempts, and in these cases an exaggerated egoism seems to be a constant feature. They frequently tend to dramatize themselves and appear to obtain a distinct satisfaction in the process. Savage¹ declared that as a rule the hypochondriac is not actively suicidal, although he made an exception in the case of sexual hypochondriasis, and certainly when suicidal attempts do take place in these cases they appear often to be curiously unconvincing. Other writers, however, are not of this opinion, and it is probable that there are at least two forms of this disorder which differ considerably so far as the danger of suicide is concerned.

Suicidal and Homicidal Impulses

The paranoid psychoses are more commonly associated with homicidal than with suicidal tendencies. Mercier went so far as to say that no paranoiac should be allowed at large, and that if he were so allowed his perpetration of a murder was merely a matter of time and was certain to take place.² However that may be, these cases with their morbid suspiciousness and persecuted outlook on the world sometimes find the strain of a life of victimization too much for them and make an end of it to obtain relief. When the mental conflict turns in this direction it generally is put into effect with great thoroughness and determination. The relation between suicidal and homicidal impulses in cases of mental disorder is a problem of great interest and importance. They may occur together as in the not infrequent case of murder

¹ *Insanity and Allied Neuroses*, fourth edition, 1907, p. 146.

² *Text Book of Insanity*, second edition, 1914, p. 290.

and suicide by the same individual. Or they may alternate, and a patient from being suicidally inclined may become violent towards others, the impulse apparently, instead of being directed inwards towards the self, is directed outwards as aggressiveness.

A woman who became depressed after her father's death described how a tragedy very nearly took place one night when, after lying in bed thinking that it was no use for her and her two sisters to go on living as it all ended in nothing, she got up with the intention of killing her sisters and herself. She obtained a pair of scissors with which to carry out her design, but an acute mental conflict supervened which ended by her cutting off her hair.

How commonly a history of suicidal attempts is found in convicted murderers I am unable to state, but cases of considerable interest in this connexion occur from time to time.

Phobias and Obsessions

Phobias and obsessions most commonly develop as symptoms of the psychoneuroses. Their relation to the major psychotic states is not yet clear, although they are quite frequently associated and in particular may usher in an attack of insanity. In regard to the danger of suicide in these cases two problems require to be considered. The first refers to the mental conflict which is the usual accompaniment of these disturbing symptoms. This may be of a very distressing nature and may cause a reactive condition of depression with suicidal impulses.

A case in point was that of an unmarried lady of 60 who, on the occasion of a visit to a cinema, saw a picture of a number of small boys bathing naked in a river. There came into her mind immediately some obscene words which she was unable to banish despite all her efforts. The condition soon became established with the typical characters of an obsessional neurosis. She struggled with it for some time until she became convinced that she must be a wicked woman to harbour such thoughts and attempted to end her life by taking poison. In another case a woman of 28 developed the obsession that she must find the meaning in everything. She felt compelled to ask herself this question about all the most ordinary acts of her life and to analyse everything with this end in view. She always arrived, as she put it, at a dead end and spoke of suicide as the only way out. After a few months she ended the strain of the constant questioning by putting her head in the gas oven.

The other problem concerns the seriousness with which a phobia ought to be regarded. Cases occur, for example, in which a fear of committing suicide exists or a fear of travelling in a train or a fear in a mother that she will injure her child. The doctor may be faced with a grave responsibility. Is he to take the phobia at its face value and deal with the situation as if a real danger existed? Or is he to rely upon the teaching of those who say that phobias are never translated into action, and advise the patient to court the occasions of his fear and "conquer" it? The answer will depend to some extent on the nature of the phobia. It may be one of little practical importance to the individual such as a fear of heights, but if it involves another person it assumes a more serious aspect. Bearing in mind that a fear commonly denotes a wish in the unconscious, that we can never be sure a reactive state of depression will not develop, and, further, as we cannot exclude the likelihood that the phobia may be the incipient stage of a psychosis, the wise physician will be alive to the possibilities and act with caution in the advice he gives.

A woman of 28, some months after the birth of her first child, developed the fear that she would injure it. She was afraid to touch it in case she might do it harm; phrases such as "a nice little throat to cut" came into her mind and distressed her greatly. She had to keep looking at the baby to assure herself she had not done something to it. In this case it was considered advisable to separate the mother and the child, but the condition proved persistent, and four months later she committed suicide by taking poison.

Impulsive Suicide

Suicide is occasionally attributed to mere impulse—that is to say, to a sudden action that appears quite unmotivated and is carried out in the absence of any grounds or reason for it. Attempts of this nature are said to take place particularly in schizophrenia, but it is

very doubtful if such an anomaly can ever with any assurance be said to occur. Our knowledge of mental mechanisms and of mental life in general enables us to draw the highly probable conclusion that a motive exists in every case of suicide, although it may not be easily discoverable. Guilt and anxiety, for example, are factors which are very prevalent in all forms of mental disorder. They may exist concealed and buried and so unapparent to ordinary examination, and may be the source of suicidal tendencies in seemingly unlikely cases. Impulsiveness in this sense must, however, be distinguished from the impulse which is the final step in a suicidal attempt. Many cases of mental abnormality contemplate suicide long before it is put into effect. In other instances a background of depression exists as the predisposing condition, and in both cases the actual attempt may take place as the result of a sudden impulse.

This is well illustrated in the case of a man of 53 who became depressed after an attack of influenza. Following upon a sleepless night his depression increased and he developed the idea that a crowd had gathered outside his house and were clamouring for the return of certain club moneys he had in his control. He was greatly distressed at this, but declared that the idea of suicide had not up to that point entered his mind. He went into the bathroom, happened to see his razor lying on a shelf, and, impulsively seizing it, drew the blade across his throat, inflicting a serious wound.

Suicide may also be associated with the occurrence of hallucinations. These are most commonly of the auditory type and constitute as a rule only part of the mental syndrome. Sometimes "voices" explicitly instigate a person to kill himself, and the situation then becomes a particularly anxious one, as the injunction is generally conveyed in the form of an order or command. These voices have a peculiarly convincing and compelling effect upon the mind, considerations of reality being of little weight in comparison. They are of graver import in this respect than delusions and seem to lead to action of the most direct and dangerous type.

Other Aspects of Motivation

There are other issues of importance in connexion with the problem of motivation in suicide, in particular the significance of unconscious factors. Motives that are apparent at the clinical level of mental activity are never the sole or essential elements at work. As was mentioned earlier in the article, deeper psychological investigation always reveals additional and generally more significant causes. A common constituent, for example, of melancholia, is hate, but it is repressed and concealed as a rule. The mechanism of identification with another—which makes suicide equivalent to homicide—and such motives as the desire for rebirth into a happier state of existence are revealed in most cases only by special methods of investigation. The relation of suicide to the death instinct and to the super-ego—the nucleus of the moral sentiments—are other problems of intrinsic importance. But it is impossible here to enter in any detail into a consideration of this aspect of the subject; too many technical problems are involved and too many points that are still open to dispute. Concerning the importance of sexual disabilities in these cases Savage³ remarked that no class of patients is more suicidally inclined than those who believe themselves to be impotent, and none are more dangerous than those who believe themselves to be "tapped," "drawn," or "emasculated" by others—an interesting adumbration of modern views on the significance of sexual factors.

Individual Preferences

An important fact about suicide is the individual preference for particular methods that is exhibited in practically all cases. Suicides, consciously or unconsciously, select certain modes of death and restrict themselves more or less to these, even neglecting opportunities that may arise in other directions.

A case in point was that of a depressed and apprehensive woman who believed she was going to be murdered. She pleaded frequently to be given chloroform and killed quickly

³ Loc. cit., p. 264.

instead of being tortured to death, and on one occasion swallowed a large coin, which fortunately was recovered without much difficulty. She discovered one day a window open and unattended on an upper floor and climbed through on to a small balcony. Instead, however, of precipitating herself to the ground she dropped from the balcony on to a garden table, and was brought back little the worse, having sustained nothing more than a few bruises. Shortly afterwards she was again pleading to be put out of her misery.

Another woman who was depressed and abnormally suspicious threw herself from a first-floor window, fracturing her pelvis and femur. She was offered brandy by her sister but refused it, saying she believed it was poisoned.

This selectivity is a source of security in most of these cases and lightens the anxiety of supervision. If it were not so the difficulties of treatment would be greatly increased, as it is probably impossible to prevent suicide in the case of a wholly determined person on the look out to seize any means of achieving his end. At the same time it cannot be entirely relied upon in practice, as we can never be sure that our insight into particular cases is sufficiently complete.

The different methods that are adopted—poisoning, hanging, precipitation, and the others—have in all probability a special psychological significance in each individual case. It is this that leads to the development of the preferences we have mentioned, but further consideration of this subject would lead us too far into the region of unconscious psychology. Suggestion is a significant factor in this connexion, and it is generally held that newspaper accounts of suicides provide a dangerous source of stimulation and encouragement. "Epidemics" have been described of multiple cases of suicide carried out by the same means, originating apparently as the result of the prominent and sensational reports appearing in the Press. This is, without doubt, an exaggerated view, for our knowledge of psychological causation makes it obvious that a pre-existing tendency must invariably be present and that suggestion is but the end link in a chain of determining conditions. A family history of suicide may have a strong suggestive influence in unstable persons. In the case of a man who became depressed and hypochondriacal two of his sisters had committed suicide and his father had attempted it unsuccessfully. The brother and father of another similar case had committed suicide, and the patient on several occasions remarked that the only way out of his misery seemed to be "to do what the others did." Both of these cases were lost sight of, but the influence of the family history was looked upon very seriously while they were under treatment.

Threat and Performance

It is commonly believed that those who speak openly of suicide and threaten to carry it out are not really dangerous in this respect, and seldom or never put the threats into effect. Sometimes patients suffering from depression irritate and exhaust their relatives by referring frequently to suicide while ignoring daily opportunities, and the impression is received that it is done merely to attract attention and obtain sympathy. It is important to realize that this is an erroneous view, as experience shows that persons of this type are quite as likely to commit suicide as those who are more inhibited and reticent on the subject.

A striking example was that of a woman who became depressed and frequently threatened to end her life. The husband was advised not to take the threats seriously, and allowed her on one occasion to open the carriage door of the train in which they were travelling when she said she wanted to throw herself out. She did nothing at the time, but later precipitated herself from an upper-floor window and fractured her skull. Another patient of the same kind was permitted by her husband to open the window on an upper floor of the house and look down after she had said she would jump out and kill herself. She did not carry out her threat on that occasion, but some weeks later made a serious attempt at suicide by swallowing a number of sedative tablets.

Some depressed patients are very theatrical in the expression of their misery and dramatize themselves in a way that looks unreal and artificial. It is often thought that this attitude denotes a lack of seriousness and a desire to draw attention to themselves, and that in consequence little danger of suicide need be apprehended.

This is a mistaken opinion and may, if acted upon, lead to tragedy.

A case which well illustrated this fact was that of a woman who had been under care for some time suffering from melancholia. She made the most theatrical manifestations of grief and remorse, going down on her knees, clasping her hands before her, and begging forgiveness from the doctor for imaginary sins. A strong-minded aunt came from abroad and, after a visit to the patient, said the histrionics were just "put on," that she would look after her and talk the nonsense out of her. The patient was taken to a hotel in London and the following day was found dead, having thrown herself from a top-floor window.

Unsuccessful attempts at suicide very frequently occur and are often taken to imply a lack of serious intention. It is not an uncommon thing to meet cases in which two or more attempts have been made, sometimes to all appearance of a doubtful or even trivial character. It is unwise, however, to label these mere exploits or "demonstrations" made simply for the purpose of attracting the notice and gaining the solicitude of others. The suicidal impulse seldom occurs in a free and uninhibited form. Generally the tendency is in conflict with other restraining tendencies, which accounts for the irresolution so often displayed, the sudden change of mind, and the reduction of an attempt, begun in earnestness, to insignificant proportions. The mental state is generally double-sided or ambivalent, consisting of opposing impulses, and the issue will depend on the relative strengths of these conflicting forces. Indecision, therefore, or apparent insincerity should not blind us to the existence of dangerous proclivities, as a situation may develop which increases the tension and tips the balance with fatal results.

A case in which this condition was well displayed was that of a woman who became depressed and acted in a manner that was looked upon as merely foolish and unbalanced. She waded into the sea and came out again of her own accord, making demonstrations, as it was thought, to draw attention to herself. These episodes occurred on two or three occasions and were not looked upon as indicating a true suicidal tendency. One day, however, she threw herself from an upper floor over the staircase and fractured her spine.

On the other hand, occasionally the act is carried out in a very determined and even over-determined way, as in the case of a man, reported some time ago from France, who took poison, mounted a chair with a rope round his neck, the other end being attached to a chandelier, stabbed himself in the chest and, as he kicked the chair away, shot himself in the head.

In conclusion, an aspect of the subject of great moral and practical importance calls for consideration—namely, the responsibility that attaches to the relatives or others in a case of mental abnormality when warnings have been disregarded or obvious indications of danger ignored and a tragedy ensues. The problem was illustrated in the first case described in this article, but it applies not only to persons with suicidal tendencies but to others also, in particular those with dangerous proclivities. A striking instance in point was the celebrated McNaughten case, which aroused a great deal of discussion at the time and led to the famous ruling of the judges—the basis of our present law on criminal responsibility.

In 1843 Daniel McNaughten shot and killed Edward Drummond, Sir Robert Peel's private secretary. The crime was readily recognized to be the outcome of McNaughten's abnormal state of mind. He had never, in fact, seen Mr. Drummond before, and seems to have met him accidentally in the street just before the tragedy took place. The singular fact, however, that appears in connexion with the case is that for at least two years before the crime McNaughten had been known to be suffering from delusions. Incredible as it may seem, he had consulted on the subject of his delusions not only his father but also, among others, a clergyman, the Provost of Glasgow, the Sheriff of Lanark, a member of Parliament, and the Commissioner of Police for Glasgow, and not one of them had felt called upon, in the public interest, to take any action in respect of the man's obvious mental abnormality. As a legal commentator⁴ on the case remarks: "Who was morally responsible for Mr. Drummond's death? Was it the unfortunate prisoner himself, who was suffering from a diseased brain? Was it not rather his relations and those others whom he consulted in his misery, and who yet took no steps to have him placed under medical care?"

⁴ *The Defence of Insanity in Criminal Cases. An Essay by F. Lancelot Everest, Barrister-at-Law.*