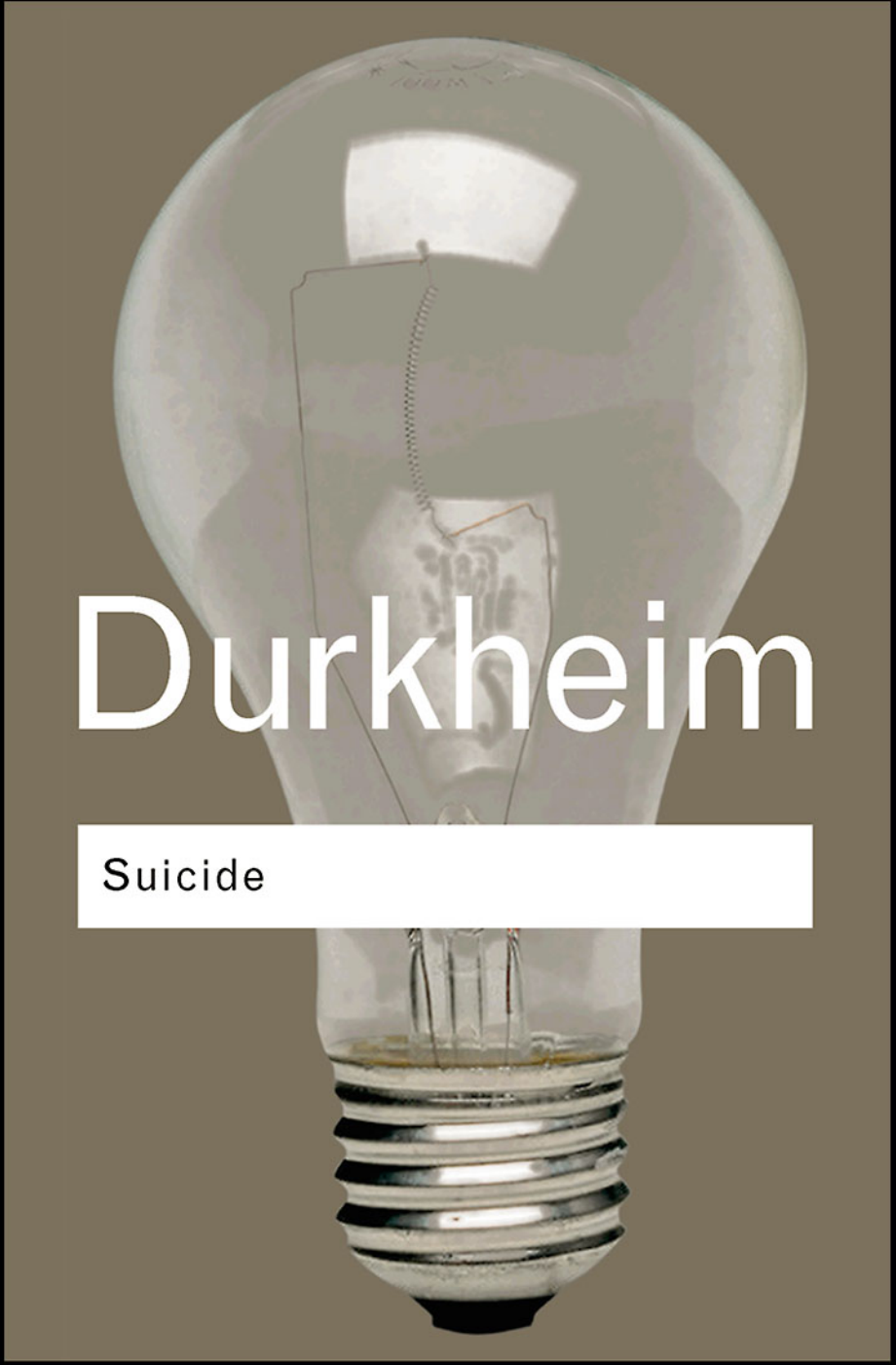

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Suicide

A study in sociology

Translated by John A. Spaulding and
George Simpson

Edited with an introduction by George Simpson

London and New York

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To those who, with Durkheim, understand the life of reason as itself a moral commitment, and especially to Arthur D. Gayer in economics; Sol W. Ginsburg in psychiatry; Robert S. Lynd in sociology; and Arthur E. Murphy in philosophy

Contents

Editor's Preface

Of the four major works of the renowned French sociologist, Émile Durkheim, only *Le Suicide* has remained to be translated. *The Elementary Forms of the Religious Life* was first published in English in 1915; the *Division of Labor in Society* in 1933 and *The Rules of Sociological Method* in 1938. Over half a century has gone by since the first edition of *Le Suicide*, yet far more than antiquarian interest attaches to it in the sociological, statistical, philosophical, and psychological disciplines. But the historical significance of the volume in social thought would be enough reason for presenting it to readers in the English-speaking world. As a milestone in social science and an indispensable part in understanding the work of the man who founded and firmly established academic sociology in France and influenced many others outside of France, it should have long since been available in translation.

Though our statistical material today is more refined and broader, and our socio-psychological apparatus better established than was Durkheim's, his work on suicide remains the prototype of systematic, rigorous and unrelenting attack on the subject with the data, techniques, and accumulated knowledge available at any given period. Indeed, *Le Suicide* is among the very first modern examples of consistent and organized use of statistical method in social investigation. In the last decade of the nineteenth century when Durkheim was conducting

the investigations incorporated in this work, repositories (governmental or private) of statistical information on this, or any other subject, were either rare, skimpy, or badly put together. With characteristic energy and the aid of some of his students, especially Marcel Mauss, Durkheim realigned the available statistics so as to answer the question posed by the general problem and its internal details. At the time, statistical techniques were little developed, and Durkheim was forced at given points to invent them as he went along. The elements of simple correlation were unknown except among the pathfinders in statistical techniques like Galton and Pearson, as were those of multiple and partial correlation, yet Durkheim establishes relationships between series of data by methodological perseverence and inference.

The tables which Durkheim drew up have been left in the translation in their somewhat quaint form, with no attempt to set them up according to present-day standards of statistical presentation. They have that way an historical value, as well as a character of their own. To embellish them would take away the atmosphere in which they were literally forged through necessity. Though more recent data are available, the kind of information Durkheim was trying to impart through them is still the kind that sociologists and actuarialists are interested in. Indeed, one table (on the effect of military life on suicide) has been taken over bodily in one of the best general, recent treatises on suicide.[1]

The maps which Durkheim placed in the text have been put in Appendices here, along with a special table which Durkheim drew up but could not use for reasons he gives in a footnote to it. The maps have been reproduced as they are with the French titles and statistical legends.

But in addition to its historical and methodological import, *Le Suicide* is of abiding significance because of the problem it treats and the sociological approach with which it is handled. For Durkheim is seeking to establish that what looks like a highly individual and personal phenomenon is explicable through the social structure and its ramifying functions. And even the revolutionary findings in psychiatry and the refinement and superior competence of contemporary actuarial

[1] Dublin, Louis I., and Bunzel, Bessie, *To Be or Not To Be*, New York, 1933, p. 112–113.

statistics on this subject have yet to come fully to grips with this. We shall have more to say of it in the introduction.

There are those, moreover, who look upon *Le Suicide* as still an outstanding, if not the outstanding, work in what is called the study of social causation.[2] And in what has come to be known as the sociology of knowledge, Durkheim's attempts to relate systems of thought to states of the collective conscience involved in the currents of egoism, altruism, and anomy, in this volume, have been of no little influence.[3]

Finally, *Le Suicide* shows Durkheim's fundamental principles of social interpretation in action. His social realism, which sees society as an entity greater than the sum of its parts, with its accompanying concepts of collective representations and the collective conscience, is here applied to a special problem-area, and the results are some of the richest it has ever borne. For Durkheim not only enunciated methodological and heuristic principles (as pre-eminently in *The Rules of Sociological Method*; he also tested them in research of no mean scope. That his work would have to be supplemented, added to, revised, and our knowledge advanced, he would be the first to admit, since he rightly saw scientific endeavor as a great collective undertaking whose findings are handed on from generation to generation and improved upon in the process.

The translation has been made from the edition which appeared in 1930, thirteen years after Durkheim's death and thirty-three years after the first edition in 1897. This edition was supervised by Marcel Mauss. Professor Mauss, in his brief introductory note there, tells us that it was not possible, because of the method of reprinting, to correct the few typographical and editorial errors. With the aid of Dr. John A. Spaulding, I have sought by textual and statistical query, to rectify them wherever they could be discovered.

For the version of the translation here, I must take full responsibility. Dr. Spaulding and I worked over the first draft, then we both re-worked the second draft. But the final changes I made alone.

Mr. Jerome H. Skolnick, a student of mine, aided in checking the

[2] See especially, MacIver, R. M., *Social Causation*, New York, 1942.

[3] See, for example, Parsons, Talcott, *The Structure of Social Action*, Glencoe, Illinois, 1949.

typescript and in proof-reading. He did not confine his work to routine, and many of his suggestions proved to be of great value to me.

GEORGE SIMPSON

The City College of New York
November 1, 1950.

EDITOR'S INTRODUCTION

The Aetiology of Suicide

I

The range of Émile Durkheim's analysis of the interconnectedness of suicide with social and natural phenomena is so wide and varied as to preclude treatment of all its avenues and by-roads in the short space of this introduction. Within the confines of one not over-long volume, Durkheim has treated or touched on normal and abnormal psychology, social psychology, anthropology (especially the concept of race), meteorological and other "cosmic" factors, religion, marriage, the family, divorce, primitive rites and customs, social and economic crises, crime (especially homicide) and law and jurisprudence, history, education, and occupational groups. But a short appraisal is still possible because throughout Durkheim's work on each and all of these topics subsidiary to suicide, is the basic theme that suicide which appears to be a phenomenon relating to the individual is actually explicable aetiologically with reference to the social structure and its ramifying functions.

The early chapters in Durkheim's work are devoted to the negation of doctrines which ascribe suicide to extra-social factors, such as mental alienation, the characteristics of race as studied by anthropology, heredity, climate, temperature, and finally to a negation of the doctrine of "imitation," particularly as represented in the works of

Gabriel Tarde whose social theory at the time in France had many followers and against whom Durkheim waged unrelenting warfare within the bounds of scholarly and academic amenities. Here in these early chapters Durkheim is involved in a process of elimination: all theses which require resort to individual or other extra-social causes for suicide are dispatched, leaving only social causes to be considered. This is used as a foundation for reaffirming his thesis stated in his introduction that the suicide-rate is a phenomenon *sui generis*; that is, the *totality* of suicides in a society is a fact separate, distinct, and capable of study in its own terms.

Since, according to Durkheim, suicide cannot be explained by its individual forms, and since the suicide-rate is for him a distinct phenomenon in its own right, he proceeds to relate currents of suicide to social concomitants. It is these social concomitants of suicide which for Durkheim will serve to place any individual suicide in its proper aetiological setting.

From a study of religious affiliation, marriage and the family, and political and national communities, Durkheim is led to the first of his three categories of suicide: namely, egoistic suicide, which results from lack of integration of the individual into society. The stronger the forces throwing the individual onto his own resources, the greater the suicide-rate in the society in which this occurs. With respect to religious society, the suicide-rate is lowest among Catholics, the followers of a religion which closely integrates the individual into the collective life. Protestantism's rate is high and is correlated with the high state of individualism there. Indeed, the advancement of science and knowledge which is an accompaniment of the secularization process under Protestantism, while explaining the universe to man, nevertheless disintegrates the ties of the individual to the group and shows up in higher suicide-rates.

Egoistic suicide is also to be seen, according to Durkheim, where there is slight integration of the individual into family life. The greater the density of the family the greater the immunity of individuals to suicide. The individual characteristics of the spouses is unimportant in explaining the suicide-rate; it is dependent upon the structure of the family and the roles played by its members. In political and national communities, it is Durkheim's thesis that in great crises the suicide-rate

falls because then society is more strongly integrated and the individual participates actively in social life. His egoism is restricted and his will to live strengthened.

Having established the variation of the suicide-rate with the degree of integration of social groups, Durkheim is led to consider the fact of suicide in social groups where there is comparatively great integration of the individual, as in lower societies. Here where the individual's life is rigorously governed by custom and habit, suicide is what he calls altruistic; that is, it results from the individual's taking his own life because of higher commandments, either those of religious sacrifice or unthinking political allegiance. This type of suicide Durkheim finds still existent in modern society in the army where ancient patterns of obedience are rife.

Egoistic suicide and altruistic suicide may be considered to be symptomatic of the way in which the individual is structured into the society; in the first case, inadequately, in the second case, over-adequately. But there is another form of suicide for Durkheim which results from lack of regulation of the individual by society. This he calls anomic suicide, and is in a chronic state in the modern economy. The individual's needs and their satisfaction have been regulated by society; the common beliefs and practices he has learned make him the embodiment of what Durkheim calls the collective conscience. When this regulation of the individual is upset so that his horizon is broadened beyond what he can endure, or contrariwise contracted unduly, conditions for anomic suicide tend toward a maximum. Thus, Durkheim instances sudden wealth as stimulative of suicide on the ground that the newly enriched individual is unable to cope with the new opportunities afforded him. The upper and lower limits of his desires, his scale of life, all are upset. The same type of situation occurs, according to Durkheim, in what he terms conjugal anomy exemplified by divorce. Here marital society no longer exercises its regulative influence upon the partners, and the suicide-rate for the divorced is comparatively high. This anomic situation is more severely reflected among divorced men than among divorced women, since it is the man, according to Durkheim, who has profited more from the regulative influence of marriage.

At this point in his analysis, Durkheim claims that the individual

forms of suicide can be properly classified. Now that the three aetiological types—egoistic, altruistic, and anomic—have been established, it is possible, he says, to describe the individual behavior-patterns of those exemplifying these types. The other way around—seeking to find the causes of suicide by investigating the individual types—Durkheim had originally claimed to be fruitless. In addition to tabulating the individual forms of the three different types, Durkheim seeks to establish that there are individual forms of suicide which display mixed types, such as the ego-anomic, the altruist-anomic, the ego-altruist.

Thus, the statistics available to Durkheim he finds not correlated with biological or cosmic phenomena, but with social phenomena, such as the family, political and economic society, religious groups. This correlation he claims indicates decisively that each society has a collective inclination towards suicide, a rate of self-homicide which is fairly constant for each society so long as the basic conditions of its existence remain the same. This collective inclination conforms, Durkheim believes, to his definition of a social fact given in his treatise, *The Rules of Sociological Method*. That is, this inclination is a reality in itself, exterior to the individual and exercising a coercive effect upon him. In short, the individual inclination to suicide is explicable scientifically only by relation to the collective inclination, and this collective inclination is itself a determined reflection of the structure of the society in which the individual lives.

The aggregate of individual views on life is more than the sum of the individual views to Durkheim It is an existence in itself; what he calls the collective conscience, the totality of beliefs and practices, of folkways and *mores*. It is the repository of common sentiments, a well-spring from which each individual conscience draws its moral sustenance. Where these common sentiments rigorously guide the individual, as in Catholicism, and condemn the taking of one's own life, there the suicide-rate is low; where these common sentiments lay great stress on individualism, innovation and free thought, the hold over the individual slackens, he is tenuously bound to society, and can the more easily be led to suicide. The latter is the case with Protestantism. In lower societies; the collective conscience, according to Durkheim, holds individual life of little value, and self-immolation through suicide is the reflection of the society at work in the

individual. And in higher societies where sudden crises upset the adjustment to which the individual has become habituated through the common sentiments and beliefs, anomy appears which shows itself in a rising suicide-rate.

Suicide, like crime, is for Durkheim no indication of immorality *per se*. In fact, a given number of suicides are to be expected in a given type of society. But where the rate increases rapidly, it is symptomatic of the breakdown of the collective conscience, and of a basic flaw in the social fabric. But suicide and criminality are not correlative, as some criminologists had claimed, although both when excessive may indicate that the social structure is not operating normally.

The suicide-rate which Durkheim found increasing rapidly through the nineteenth century cannot be halted in its upward curve by education, exhortation, or repression, he says. For Durkheim all ameliorative measures must go to the question of social structure. Egoistic suicide can be reduced by reintegrating the individual into group-life, giving him strong allegiances through a strengthened collective conscience. This can be accomplished in no small part, he thinks, through the re-establishment of occupational groups, compact voluntary associations based on work-interests. This is the same recommendation he made in the second edition of his *Division of Labor in Society* apropos of the infelicitous workings of that phenomenon. The occupational group will also serve to limit the number of anomic suicides. In the case of conjugal anomy, his solution is in greater freedom and equality for women.

Thus, suicide for Durkheim shows up the deep crisis in modern society, just as the study of any other social fact would. No social fact to him has been explained until it has been seen in its full and complete nexus with all other social facts and with the fundamental structure of society.

II

Since Durkheim's work on suicide, the chief advances in our knowledge of the subject have come from actuarial statistics and psychoanalytic psychiatry. Durkheim's own approach has been carried forward, tested, and applied further by his student and friend, Maurice

Halbwachs, in *Les Causes du Suicide*.[1] For the argument here, it must be noted (as Parsons has already pointed out) that Halbwachs saw that there is no antithesis such as Durkheim posited, between the social and the psychopathological explanations of suicide, but that they are complementary.[2]

The actuarialists have studied the overall extent and trends of suicide, related it to race and color incidence, age and sex distribution, urban and rural areas, seasonality (what Durkheim calls "cosmic" factors), economic conditions, religious affiliation, marital status. But the actuarialists have formulated no thorough-going, consistent and systematic hypothesis concerning the causes of suicide, which is what Durkheim is after. A sound compendium of actuarial work on this subject can be found in Louis I. Dublin's and Bessie Bunzel's book, *To Be or Not To Be*.[3] But for their interpretative framework, Dublin and Bunzel have had to fall back upon modern developments in psychiatry and mental hygiene.[4]

Durkheim is skeptical about the reliability of the statistics on suicide with regard to motives, on the ground that recording of motives is done by untrained enumerators in offices of vital statistics, as well as that the motives ascribed by suicides to their acts are unreliable. But the inadequacy of statistics on suicide generally has been even more trenchantly pointed up by psychoanalysts. Gregory Zilboorg has this to say: ". . . Statistical data on suicide as they are compiled today deserve little if any credence; it has been repeatedly pointed out by scientific students of the problem that suicide cannot be subject to statistical evaluation, since all too many suicides are not reported as such. Those who kill themselves through automobile accidents are almost never recorded as suicides; those who sustain serious injuries during an attempt to commit suicide and die weeks or months later of these

[1] Paris, 1930.

[2] Parsons, Talcott, *The Structure of Social Action*, New York, 1937, p. 326.

[3] New York, 1933.

[4] A similar situation holds with an earlier sociological study, Ruth S. Cavan's *Suicide* (Chicago, 1928). Here too actuarial and social statistics are presented, along with psychological case-histories, but the crucial relationship—that of the individual case-histories of suicide to the basic elements in the social structure—has been left relatively untouched.

injuries or of intercurrent infections are never registered as suicides; a great many genuine suicides are concealed by families; and suicidal attempts, no matter how serious, never find their way into the tables of vital statistics. It is obvious that under these circumstances the statistical data available cover the smallest and probably the least representative number of suicides; one is justified, therefore, in discarding them as nearly useless in a scientific evaluation of the problem."[5]

Moreover, Fenichel, following Brill and Menninger, has pointed out the prevalence of "partial suicides," where death does not occur but which consist of "self-destructive actions, during melancholic states, carried out as self-punishment, as an expression of certain delusions or without any rationalization." The term, "partial suicides," Fenichel concludes, "is absolutely correct in so far as the underlying unconscious mechanisms are identical with those of suicide."[6] It is clear that these "partial suicides" never find their way into the statistics of suicide. From the aetiological standpoint, they are identical with consummated suicides; but of them all, Fenichel writes: "The factors, doubtlessly quantitative in nature, that determine whether or when the result is to be a suicide, a manic attack, or a recovery are still unknown."[7]

And even where statistical regularity appears to be ascertainable, a methodologist of science writes: "What makes the statistical regularity of long-run human conduct so striking is the fact that it shows itself in acts which are not the simple outcomes of a few mechanical forces, like the movements of spun coins, but in masses of close decisions of a very complex sort." He then goes on to instance the statistics of female suicides in New York City.[8]

It appears inescapable to state that until we have better records and more literate statistical classification in terms of psychiatric nomenclature, we can draw few binding conclusions concerning regularity in terms of age, ethnic groups, social status, etc. As an example, we may

[5] "Suicide Among Civilized and Primitive Races," *American Journal of Psychiatry*, vol. 92, 1935–36.

[6] Fenichel, Otto, *The Psychoanalytic Theory of Neurosis*, New York, W. W. Norton and Company, Inc., 1945, p. 401.

[7] *Ibid.*

[8] Larrabee, Harold A., *Reliable Knowledge*, Boston, Houghton Mifflin Company, 1945, p. 436.

point out that Durkheim, Dublin and Bunzel, and others show little if any suicide among children, whereas Zilboorg has deemed it significant enough to make a special study.[9]

A further result of the unreliability of the statistics is that they have led to a conclusion that is fairly widespread that suicide grows as civilization advances. This thesis has been seriously challenged by Zilboorg. He concludes that suicide is evidently "as old as the human race, it is probably as old as murder and almost as old as natural death. *The lower the cultural niveau of the race, the more deep-seated the suicidal impulse appears.* [Italics not in original]. . . . The man of today, as far as suicide is concerned, is deficient, indeed, as compared with his forefathers who possessed a suicidal ideology, mythology, and an unsurpassed technique."[10] Zilboorg speaks of a traditional, almost instinctive bias, one of whose two chief elements is "the misconception that the rate of suicide increases with the development of our civilization, that in some unknown way civilization fosters suicidal tendencies within us."[11]

A statement of Steinmetz re-enforces Zilboorg's view. From his study of suicide among primitive people, Steinmetz reached the conclusion that "it seems probable from the data I have been able to collect that there is a greater propensity to suicide among savage than among civilized peoples."[12] Whether Steinmetz' conclusion would still hold if we had adequate data on suicides and partial suicides, will remain an unsolved question until we have broken through the thorny thickets of unreliable recording and squeamish acknowledgement.

III

Modern developments in motive-analysis and in the description of the fundamental characteristics of the emotional life were unknown to Durkheim, of course. Sigmund Freud had only just begun his investigations of the "unconscious" drives in human behavior when *Le Suicide*

[9] Zilboorg, Gregory, "Considerations on Suicide, with Particular Reference to that of the Young," *American Journal of Orthopsychiatry*, VIII, 1937.
[10] *American Journal of Psychiatry*, vol. 92, 1935–36, p. 1361, 1362.
[11] *Op. cit.*, p. 1351.
[12] Steinmetz, S. R., "Suicide Among Primitive People," *American Anthropologist*, 1894, quoted in Zilboorg, *op. cit.*, p. 1352.

appeared, and it was to be more than a quarter of a century before his views were widely accepted after continual clinical confirmation, by which time Émile Durkheim was no longer among us. But today, over half a century since *Le Suicide* was first published, psychoanalytic psychiatry has done not overmuch to relate its revolutionary findings concerning human motives to sociological discoveries (with the exception of some ingenious references by Zilboorg). Indeed, there are psychoanalysts who appear to hold that the fundamental patterns of behavior set in infancy are not seriously affected by social factors at all, and that neuroses are not cured by social analysis. This view seems to rest on the postulate that since therapy is and must be individual, and mental illness related back to the evolution of the psyche, there is no social aetiology ascribable to individual case-histories. Karl A. Menninger exemplifies this tendency.[13] From the wealth of case-history data and from his extensive and magistral clinical work, Menninger finds himself able to say only a few words in a concluding chapter titled "Social Techniques in the Service of Reconstruction," and even these few words end with the final conclusion that to the death-instinct there must be opposed the life-instinct, by calling forth from man his will to conquer his own self-annihilatory drives. But Menninger fails to analyze the relation between these self-annihilatory drives and the manner in which they are called forth by social factors, and also what social factors must be strengthened or called into being in order to overcome these drives.

IV

Though psychoanalytic psychiatry holds that within the corpus of its interpretative principles of behavior there are tools for ferreting out the causes of suicide, no one yet seems ready to commit himself unreservedly to a set of aetiological postulates, based either on empirical data or deduction from verified principles. Zilboorg writes: ". . . It is clear that the problem of suicide from the scientific point of view remains unsolved. Neither common sense nor clinical

[13] *Man Against Himself*, New York, Harcourt, Brace and Company, 1938.

psychopathology has found a causal or even a strict empirical solution."[14]

In 1918 at a psychoanalytic symposium on suicide in Vienna, Sigmund Freud summarized the discussions as follows: "Despite the valuable material obtained in this discussion, we have not succeeded in arriving at any definite conclusion. . . . Let us therefore refrain from forming an opinion until the time comes when experience will have solved the problem."[15] Since then, extensive work has been done on suicide by expert, highly trained psychoanalysts including Freud, Zilboorg, Abraham, Menninger, Brill, and others.

But an important methodological obstacle must be pointed out, an obstacle which is almost impossible wholly to overcome at the present time. Unless the individual who commits suicide has been under constant and long-time psychiatric examination (either through psychoanalysis or clinical study with full and copious life-history records), an interpretation and classification of his suicide becomes an *ex post facto* reconstruction of his life-history. This is extremely difficult, and probably impossible in most cases. Not even the most ardent opinion-poller or attitude-tester can go around interviewing suicides, and representative samples of a population can scarcely be investigated solely on the anticipatory ground that some of the items in the sample will commit suicide.

To some small degree this obstacle has been overcome by psychoanalytic psychiatrists who have re-examined the records of patients who were under treatment or examination and who committed suicide then or later, or of patients who attempted suicide unsuccessfully or toyed with the idea while under treatment. Zilboorg particularly concerned himself with this problem, in a close study of institutionalized cases, and his conclusions must therefore be looked upon as a fairly definitive statement of where psychoanalytic psychiatry stands in this regard. He found that suicide appeared in those suffering from depressive psychoses, compulsive neuroses, and schizophrenia, and was led to the conclusion: "Evidently there is no single clinical entity

[14] "Differential Diagnostic Types of Suicide," *Archives of Neurology and Psychiatry*, vol. 35, 1936, p. 271.

[15] Quoted by Zilboorg, citation note 14 above, p. 272.

recognized in psychiatry that is immune to the suicidal drive."[16] Suicide, according to Zilboorg, "is to be viewed rather as a reaction of a developmental nature which is universal and common to the mentally sick of all types and probably also to many so-called normal persons."[17] He feels that "further psychoanalytic studies . . . will probably permit one later to subject the data to statistical tabulation and thus facilitate and probably corroborate the work on the clinical typology of suicides."[18]

V

But from the body of principles in psychoanalytic psychiatry we are led to certain aetiological principles concerning suicide. It is the basic hypothesis here that interrelating psychoanalytic discoveries on the motives for suicide with the social conditions under which suicide occurs, offers the most fruitful method of advancing our knowledge of the phenomenon. This hypothesis leads to the forging of several subsidiary ones.

In attempting to arrive at such hypotheses, we must neglect the hortatory and speculative views on suicide expressed by some philosophers. Neither William James in his essay "Is Life Worth Living?" with his call to vital existence, nor Immanuel Kant in his ethical treatises with his rather prudish view that suicide is a violation of the moral law, can come to terms with modern scientific data. It is not enough to dislike the fact of suicide to assuage its havoc in human life. Nor does the defense by David Hume of the individual's right to commit suicide, nor the suicide's harmony with the denial of the will to live as in Schopenhauer, advance our scientific understanding. To announce that human beings have a social or philosophical right to commit suicide does not tell us why they do so. And until we know why they do so, we may condemn it as do James and Kant, or defend it as do Hume and Schopenhauer, but we cannot control it.

From the standpoint of psychoanalytic psychiatry, it may be said that every individual has what we may call a suicide-potential, a tendency to

[16] *Op. cit.*, p. 282.
[17] *Op. cit.*, p. 289.
[18] *Op. cit.*, p. 285.

self-murder which varies in degree of intensity from individual to individual. To be sure, this intensity has never been measured by psychometricians, and the difficulty of measuring it is obvious and great. The degree of intensity of this potential is established in infancy and early childhood by the fears, anxieties, frustrations, loves and hatreds engendered in the individual by the family-environment in terms of eliminatory processes, weaning, sex-education, sibling rivalry, rejection or over-acceptance by the parents, degree of dependence. Where through excessive mother-love, father-rejection, inferiority induced by siblings, the individual is not readied for responsible adulthood according to the customs and mores of the society he is to participate in, the suicide-potential of an individual may be very high. At the other extreme, is the individual whose rearing has channeled the basic psychic configurations into work-activities or other activities, with no promises or rewards not possible in the world of reality; here the suicide-potential of the individual is slight. But slight as it may be, the woes, trials, and tribulations of adulthood may aggravate it to a point where self-murder becomes a possibility. Suicide is an ego-manifestation even though it is an annihilation of the ego. It is a pain inflicted on the ego, which, in being a compensation for guilt or a relief from anxiety, may be the only form of release, the utmost in going "beyond the pleasure principle."

Emotions therefore are not simple qualities of behavior explicable in terms of an immediate situation; they relate back to the life-history of the individual. Feelings of melancholia, depression, or any of the other states which Durkheim describes when he comes to classifying what he calls the morphological types of suicide in terms of their social causes, are not those of the moment of suicide; they have a long history in the individual, and although he may be stimulated to suicide by what looks like an immediate cause, no such stimulus would have resulted in the self-murder unless the underlying patterns of behavior had already been set. In the sense that all human beings have been subjected to the process of frustration and repression, of guilt and anxiety, to that extent suicide is a potential outlet under given kinds of emotional stress. That certain individuals resort to it requires investigation into the intensity with which these feelings are operative in them, as against their weaker operation in those who do not resort to it.

The most widely accepted view today in psychoanalysis is that suicide is most often a form of "displacement"; that is, the desire to kill someone who has thwarted the individual is turned back on the individual himself. Or technically stated: the suicide murders the introjected object and expiates guilt for wanting to murder the object. The ego is satisfied and the superego mollified through self-murder.

All of the emotions manifested in suicides are, then, explicable in terms of the life-history of the individual, particularly the channeling of the basic psychic configurations through the family. It may thus be possible to do what Durkheim thought was impossible—namely, classify suicides originally in terms of motives and what he calls morphologically. For the emotions of the suicide are psychogenic and unilateral in the sense that the individual emotion-structure has been laid down in infancy and childhood. It has been said that individual behavior must thus be construed not only as determined, but as *over-determined*, in the sense that it is relatively difficult to overcome the original structuring of the emotional life in the early years. But this recognition that behavior is what has been called over-determined can establish a situation where intelligence may redirect it.

Suicidal behavior is behavior which has not been redirected. The resurgence of old psychic wounds and frustrations more than offsets what life has to offer at present or in prospect. But it is important to investigate precisely what causes the resurgence, unless it is contended that no matter what life holds in store for the individual, his suicide-potential is so overwhelming that sooner or later it will win out. The struggle of the individual to win out over the death-instinct may thus be seen as a battle won, or partially or wholly lost, in infancy or childhood through the family and the schoolroom; or which is refought in the clinic or analytic room to a new stalemate or victory.

At this point, psychoanalytic psychiatry has failed to push the issue into the social realm. The basic reason for this failure lies in the preoccupation of psychoanalysis with therapy, that is, with the cure of mental illness. Now this type of therapy is obviously individual, and requires the recognition by the individual of his unconscious desires and wishes, the manner in which they have been frustrated and repressed, and the psychic toll they have taken of him. Through this recognition arrived at through "free association" in the analytic room

(although on occasion possible also in clinic where depth-analysis proves unnecessary), the individual discovers why he behaves the way he does and is within the limits of the neurosis-intensity able to orient his behavior into new channels.

But though this type of therapy is necessarily individual and requires that the individual piece together the motivation-nexus for his conduct, this does not mean that social factors have not been causally involved in the neurosis. Neuroses, and suicide seems to present profound neurotic elements even when committed by a so-called normal person, must be treated medically as an individual phenomenon, but their causes may lie deep in the *social* life-history of the individual.

VI

The basic problem for social research must be to interrelate the life-histories of individual suicides and attempted suicides with sociological variables, on the hypothesis that certain social environments may (a) induce or (b) perpetuate or (c) aggravate the suicide-potential. If we can correlate for masses of data, suicides or attempted suicides with their having been induced, perpetuated, or aggravated by certain social environments, then we are in a position to establish laws of *generalized occurrence*.

It was Durkheim's contention that it was impossible to start an aetiological investigation of suicide as a *social* phenomenon by seeking to establish types of individual behavior in suicides, We now know better, and with the unflagging ability Durkheim always showed in utilizing the findings of psychologic science, there is every precedent in his work for believing that he would strive to bring his sociological analysis into harmony with psychoanalysis.

Below are offered some hypotheses for research today. Basic to all of these hypotheses is the underlying major hypothesis that suicidal behavior is a combination of psycho-instinctual impulse and social precipitation.

Problems of Collection of Data. We must investigate the possibility of getting matched samples so that individuals with the same social background may be compared—as to those who commit suicide and those who do not. This raises the intricate methodological problem whether

there is any identity of social background on the emotional level. Reliable statistics on suicide cannot be compiled unless we have ready-at-hand accurate and painstakingly recorded psychiatric life-histories on all. This requires that the intimate life of the family be recorded in so far as it affects the individual, and that this be done from early age.

Hypotheses as Regards the Family. The emotional patterns of those attempting or committing suicide are laid down in infancy and early childhood by familial relationships. Socialization in the family is a process of frustration for all, and thus suicide is a potential outlet for everybody. It is necessary to find the relation of later social precipitants of suicide to the early emotional patterning.

Moreover, it is necessary to seek to interrelate the case-histories of suicides and attempted suicides with the type of family-rearing, including such variables as ethnic group, religious affiliation, income-group, size of family and place of the individual suicide in the family, educational level.

Suicide and Nationality. Suicide-rates differ from country to country. In part, this may be due to differences in record-keeping or quality of vital statistics. Countries of Germanic influence show high suicide-rates, and so does Japan. In Germanic countries this may be the result of religion. The effect of Lutheranism and Calvinism, which throw guilt-feelings back on the individual, and make frustration general with no compensating belief in the religious sanctity of such things as poverty, humility, and celibacy, must here be thoroughly investigated. The rates are not high for *Catholics* in Germanic countries.

The case of Japan (and certain segments of the population in India) involves investigation into family-life and social beliefs. The psychological development of the Japanese on the score of suicide appears to be completely inverted compared with that of our type of society. How can the same fundamental psychological mechanisms have such diametrically opposite results? This again raises the vexing problem of the relation of underlying instinctual patterns of behavior, and the different ways in which they can be objectified through social conditioning. Not to mention the manner in which patterns of social behavior are handed down from generation to generation. An interesting sidelight here is the effect which our attempt today to democratize Japan and change its people over to Western ways will have upon the Japanese suicide-rate.

Urban Life and Suicide. Present findings, that rates are high in urban areas, must be re-investigated in terms of the psychic aggravation of urban living. It is one thing to discover that urban rates are high because of aggravation and perpetuation of basic emotional patterns; it is quite another to hold that urban living *induces* suicide.

Suicide and Religious Affiliation. There is general agreement that the suicide-rate for Catholics is lowest of all religious groups. This requires investigation into the emotional outlets offered to Catholics for repressed instinctual desires, as against other religious groups.

This leads to inquiry into the causes of suicide among those Catholics who do commit it. These should show up as confirmatory of causes among non-Catholics. And what of the suicide-rate among Catholic *converts*; is this lower or higher than among other Catholics, and among other religious groups?

This in turn raises the problem whether suicides of Catholics are being accurately reported since the religious prohibition against suicide in the Catholic church may well lead to serious complications.

The suicide rate for Protestants everywhere shows itself as higher than that for Catholics, and often for the Jews. This has been ascribed by Morselli and Durkheim to the individualism emphasized by Protestantism and its emphasis upon reflective thinking and the individual conscience. If this holds true, then the most individualistic Protestant sects should show the highest suicide rates. For example, in the United States, Unitarians should show a very high rate, and high-church Episcopalians a very low rate. Do they? We do not know. Moreover, we have no data that relates psychiatric life-histories to religious affiliation. Where there has been emphasis in Unitarian churches on mental hygiene and the ministers have referred troubled members of their flock to psychoanalytic psychiatry as a general practice, the rate may be low.

Whereas in the nineteenth century, the suicide-rate for the Jews appeared to be lowest of the three main currents of religion in Western civilization, more recent figures (reflecting particularly political events in Europe under the Nazis) would probably show that it has increased beyond the other two.

The religious environment may be strictly linked with psychiatric interpretation of suicide. Durkheim's hypothesis of the comparative

immunity of Catholics to suicide, which appears to be confirmed within the undoubtedly narrow limits of accuracy of contemporary actuarial and social statistics, may sink deep roots in psychiatric science. Durkheim ascribed Catholicism's immunity-giving power to the way in which it integrates the individual into the group, through a complete, thorough and all-encompassing body of common sentiments and beliefs. But to what do these common sentiments and beliefs refer? Catholic sentiments and beliefs seek to relieve the individual of guilt, make all sins expiable, establish an intricate, hierarchical system of father-substitutes, and an ingenious, poetic image of the mother.

And the less rigorous Protestant sects give no sublimatory outlet for infantile repression and frustration, through poetry, art, and ritual, and there is a rampaging of the sense of guilt which cannot be expiated through the confessional but which faces God and his elders' wrath in all its individual nakedness. Calvinism, and to no small degree, Lutheranism, deal with sin repressively and individualistically. In early Protestantism, the unconscious is thrown back upon itself, and later only exclusively non-religious social sanctions hold it in check.

Suicide and Sex. Consummated suicides are higher among men than among women, but it seems that attempted suicides are higher among women than among men. Laying aside the unreliability of the statistics, we may ask, is this because of the social position of women, or because of the emotional differences between men and women, or an interrelationship of both, and how and to what degree?

Suicide and Age. The suicide-rate is believed to increase with age. But is this not possibly because early frustrations are aggravated by failures in middle life? And what relation is there between middle-age suicide-rates and failure in intimate marital and familial relations?

The suicide-rate increases, according to the statistics we have, with advance in age. It is particularly high among the aged. Several problems arise here. First, is it that there is less reluctance to admit that death resulted from suicide when the individual is aged? Second, old-age is the time when degenerative diseases reach their mortal climax, and the affect upon the psyche may be immense. Third, shall we also call suicide the self-murder which is perpetrated in the knowledge that death is not far off anyhow? Fourth, is the *social* oblivion to which the aged are subjected an invitation to what the psychoanalysts call the

desire for *maternal* oblivion; that is, a return to the kindly sleep of the unborn? These questions, and others, must obviously be to the forefront in the new branch of medicine called geriatrics, particularly in the light of what has been termed our aging population.

Suicide and Income-Groups. Suicide-rates are relatively high among the highest income-groups. Wealth, the touchstone of success in our type of society, is no assurance of immunity. Is this because of overprotection in infancy and youth? And what of suicides among self-made men? Dublin and Bunzel come to the conclusion that there is no simple causal relation between economic factors and suicide. Should, then, suicides among all economic groups show up confirmatory of the same emotional difficulties?

Suicide and War. In the midst of a shooting war, suicide-rates tend to decline; so the statistics say. But a shooting war offers for those in battle optimum opportunity for suicide to be committed without anyone being aware of it. What looks like courage may be suicidal proclivity; and anyway one may not contemplate suicide if the chances are greater that life may soon be over.

As far as the civilian population is concerned, the whole question of the impact of war upon psychic desiderata remains to be investigated.

Suicide and Marital Status. Marital status and suicide are presumed to be strictly interrelated. Divorced men have a higher suicide-rate than the undivorced, divorced women a higher rate than undivorced women but lower than divorced men. What of suicide-rates among the divorced who have re-wed?

Among the widowed, childless marriages give high rates. But the interpretation of such phenomena seems to require generalization based on psychiatric case-histories, and some understanding of the relation of marital status to emotional life as patterned before marriage, divorce, or widowhood. And what of suicide-rates of the widowed who re-wed? If marriage protects against suicide, particularly fertile marriage, why does it not protect all such marriages? Is it that the suicide-potential overcomes even the devotion to spouse and family in the case of suicides? And if so, how did the suicide-potential get so powerful?

Suicide and the Negro. The rate for Negroes is very low compared to whites, in our society. There is obviously (if the statistics are correct)

no correlation between Negro underprivilege and suicide, as might be expected. Is this because systematic oppression and under-privilege lead individuals to be adjusted to the misery and tragedy of human existence which is visited upon all? Expecting nothing of life, they may not be disappointed at how little it does offer them. But here a serious check must be made by studies of suicide among upper-class and well-educated Negroes, and among low-income and poorly educated Negroes. Do Negroes who are on the margin of upper-class white standards of living, materially and intellectually, commit suicide more than do other Negroes?

But Negro women have a rate somewhat closer to white women, than Negro men have to white men. Here intimate knowledge of the private lives of such Negro women would be of help. Also questions of high and low coloration may be necessarily involved throughout the problem of the relation of Negroes to suicide.

Suicide and Curative Therapy. Where, from analytic-room and clinic, the suicidal proclivity originally appeared high in given individuals, and curative therapy proved successful, what is the suicide-rate in later life among these individuals? Has the proclivity been redirected towards life? And what kind of life?

VII

To raise these hypotheses is certainly not to answer them.

Since the respect for human personality in our society is so great, we hold as a fundamental value an abhorrence of suicide. This in turn raises the problem of what to do about combatting suicide. From the psychiatric point of view, the answer would seem to be the vigorous training of parents and parents-to-be in the principles of mental hygiene, a rigorous training of nursery-school, grade-school, and high-school teachers in these principles, and an extensive system of psychiatric record-keeping in these "coming-of-age" organizations. Sociologically considered, it is necessary to assuage the suicidal proclivities of whatever social environments we find inducing and aggravating and perpetuating tendencies towards self-murder among individuals.

Some social scientists have for some time been chagrined by the

increasing trend in professional guilds to establish programs for research, and not to give answers. Here, in the case of suicide, research has gone on for over fifty years, and some may feel that it is high time we had some answers. To this the answer is that it is only recently that we have found the key to this Pandora's box, but that this key itself can only open the box; it cannot quickly conquer the released wild and dark furies of irrationality to which human beings are heir.

All those who would enter this arena of research had better be prepared for the difficulties which await; and no ready cures should be expected. It is not administrative devices that will bring fewer suicides, but kindly ministration based on the tragedy of humanity in being imprisoned by irrational biology and psychology whose depths we have only just plumbed, and which in turn are nursed by prudery and squeamishness in acknowledging them as realities.

To fight irrationality, the findings of science and human reason must be incorporated into the social structure and the functioning of the individual in that structure. In the long tradition of Western thought, Durkheim joins with psychoanalysis in emphasizing that the life of reason has many enemies, the chief of which today is the failure to apply what we have discovered on sound evidence, to the social world about us. That he did not have our evidence at his disposal is an accident of birth and history; but, to use some of his own words in the preface to *Le Suicide*: "There is nothing necessarily discouraging in the incompleteness of the results thus far obtained; they should arouse new efforts, not surrender. . . . This makes possible some continuity in scientific labor,—continuity upon which progress depends."

GEORGE SIMPSON

Preface

Sociology has been in vogue for some time. Today this word, little known and almost discredited a decade ago, is in common use. Representatives of the new science are increasing in number and there is something like a public feeling favorable to it. Much is expected of it. It must be confessed, however, that results up to the present time are not really proportionate to the number of publications nor the interest which they arouse. The progress of a science is proven by the progress toward solution of the problems it treats. It is said to be advancing when laws hitherto unknown are discovered, or when at least new facts are acquired modifying the formulation of these problems even though not furnishing a final solution. Unfortunately, there is good reason why sociology does not appear in this light, and this is because the problems it proposes are not usually clear-cut. It is still in the stage of system-building and philosophical syntheses. Instead of attempting to cast light on a limited portion of the social field, it prefers brilliant generalities reflecting all sorts of questions to definite treatment of any one. Such a method may indeed momentarily satisfy public curiosity by offering it so-called illumination on all sorts of subjects, but it can achieve nothing objective. Brief studies and hasty intuitions are not enough for the discovery of the laws of so complex a reality. And, above all, such large and abrupt generalizations are not capable of any

sort of proof. All that is accomplished is the occasional citation of some favorable examples illustrative of the hypothesis considered, but an illustration is not a proof. Besides, when so many various matters are dealt with, none is competently treated and only casual sources can be employed, with no means to make a critical estimate of them. Works of pure sociology are accordingly of little use to whoever insists on treating only definite questions, for most of them belong to no particular branch of research and in addition lack really authoritative documentation.

Believers in the future of the science must, of course, be anxious to put an end to this state of affairs. If it should continue, sociology would soon relapse into its old discredit and only the enemies of reason could rejoice at this. The human mind would suffer a grievous setback if this segment of reality which alone has so far denied or defied it should escape it even temporarily. There is nothing necessarily discouraging in the incompleteness of the results thus far obtained. They should arouse new efforts, not surrender. A science so recent cannot be criticized for errors and probings if it sees to it that their recurrence is avoided. Sociology should, then, renounce none of its aims; but, on the other hand, if it is to satisfy the hopes placed in it, it must try to become more than a new sort of philosophical literature. Instead of contenting himself with metaphysical reflection on social themes, the sociologist must take as the object of his research groups of facts clearly circumscribed, capable of ready definition, with definite limits, and adhere strictly to them. Such auxiliary subjects as history, ethnography and statistics are indispensable. The only danger is that their findings may never really be related to the subject he seeks to embrace; for, carefully as he may delimit this subject, it is so rich and varied that it contains inexhaustible and unsuspected tributary fields. But this is not conclusive. If he proceeds accordingly, even though his factual resources are incomplete and his formulae too narrow, he will have nevertheless performed a useful task for future continuation. Conceptions with some objective foundation are not restricted to the personality of their author. They have an impersonal quality which others may take up and pursue; they are transmissible. This makes possible some continuity in scientific labor,—continuity upon which progress depends.

It is in this spirit that the work here presented has been conceived.

Suicide has been chosen as its subject, among the various subjects that we have had occasion to study in our teaching career, because few are more accurately to be defined and because it seemed to us particularly timely; its limits have even required study in a preliminary work. On the other hand, by such concentration, real laws are discoverable which demonstrate the possibility of sociology better than any dialectical argument. The ones we hope to have demonstrated will appear. Of course we must have made more than one error, must have overextended the facts observed in our inductions. But at least each proposition carries its proofs with it and we have tried to make them as numerous as possible. Most of all, we have striven in each case to separate the argument and interpretation from the facts interpreted. Thus the reader can judge what is relevant in our explanations without being confused.

Moreover, by thus restricting the research, one is by no means deprived of broad views and general insights. On the contrary, we think we have established a certain number of propositions concerning marriage, widowhood, family life, religious society, etc., which, if we are not mistaken, are more instructive than the common theories of moralists as to the nature of these conditions or institutions. There will even emerge from our study some suggestions concerning the causes of the general contemporary maladjustment being undergone by European societies and concerning remedies which may relieve it. One must not believe that a general condition can only be explained with the aid of generalities. It may appertain to specific causes which can only be determined if carefully studied through no less definite manifestations expressive of them. Suicide as it exists today is precisely one of the forms through which the collective affection from which we suffer is transmitted; thus it will aid us to understand this.

Finally, in the course of this work, but in a concrete and specific form, will appear the chief methodological problems elsewhere stated and examined by us in greater detail.[1] Indeed, among these questions there is one to which the following work makes a contribution too

[1] *Les règles de la Methode sociologique*, Paris, F. Alcan, 1895. (Translated into English as *The Rules of Sociological Method*, and published by the Free Press, Glencoe, Illinois, 1950.)

important for us to fail to call it immediately to the attention of the reader.

Sociological method as we practice it rests wholly on the basic principle that social facts must be studied as things, that is, as realities external to the individual. There is no principle for which we have received more criticism; but none is more fundamental. Indubitably for sociology to be possible, it must above all have an object all its own. It must take cognizance of a reality which is not in the domain of other sciences. But if no reality exists outside of individual consciousness, it wholly lacks any material of its own. In that case, the only possible subject of observation is the mental states of the individual, since nothing else exists. That, however, is the field of psychology. From this point of view the essence of marriage, for example, or the family, or religion, consists of individual needs to which these institutions supposedly correspond: paternal affection, filial love, sexual desire, the so-called religious instinct, etc. These institutions themselves, with their varied and complex historical forms, become negligible and of little significance. Being superficial, contingent expressions of the general characteristics of the nature of the individual, they are but one of its aspects and call for no special investigation. Of course, it may occasionally be interesting to see how these eternal sentiments of humanity have been outwardly manifested at different times in history; but as all such manifestations are imperfect, not much importance may be attached to them. Indeed, in certain respects, they are better disregarded to permit more attention to the original source whence flows all their meaning and which they imperfectly reflect. On the pretext of giving the science a more solid foundation by establishing it upon the psychological constitution of the individual, it is thus robbed of the only object proper to it. *It is not realized that there can be no sociology unless societies exist, and that societies cannot exist if there are only individuals.* Moreover, this view is not the least of the causes which maintain the taste for vague generalities in sociology. How can it be important to define the concrete forms of social life, if they are thought to have only a borrowed existence?

But it seems hardly possible to us that there will not emerge, on the contrary, from every page of this book, so to speak, the impression that the individual is dominated by a moral reality greater than himself:

namely, collective reality. When each people is seen to have its own suicide-rate, more constant than that of general mortality, that its growth is in accordance with a coefficient of acceleration characteristic of each society; when it appears that the variations through which it passes at different times of the day, month, year, merely reflect the rhythm of social life; and that marriage, divorce, the family, religious society, the army, etc., affect it in accordance with definite laws, some of which may even be numerically expressed—these states and institutions will no longer be regarded simply as characterless, ineffective ideological arrangements. Rather they will be felt to be real, living, active forces which, because of the way they determine the individual, prove their independence of him; which, if the individual enters as an element in the combination whence these forces ensue, at least control him once they are formed. Thus it will appear more clearly why sociology can and must be objective, since it deals with realities as definite and substantial as those of the psychologist or the biologist.[2]

We must, finally, acknowledge our gratitude to our two former pupils, Professor N. Ferrand of the École primaire supérieure at Bordeaux and M. Marcel Mauss, agrégé de philosophie, for their generous aid and assistance. The former made all the maps contained in this book; the latter has enabled us to combine the elements necessary for Tables XXI and XXII, the importance of which will appear later. For this purpose the records of some 26,000 suicides had to be studied to classify separately their age, sex, marital status, and the presence or absence of children. M. Mauss alone performed this heavy task.

These tables have been drawn up from documents of the Ministry of Justice not appearing in the annual reports. They have been most kindly submitted to us by M. Tarde, Chief of the Bureau of Legal Statistics. His assistance is most gratefully acknowledged.

Émile Durkheim

[2] Nevertheless on pages 289–90, footnote, we shall show that this way of looking at it, far from ruling out all liberty, is the only means of reconciling liberty with the determinism revealed by the statistical data.

Introduction

I

Since the word "suicide" recurs constantly in the course of conversation, it might be thought that its sense is universally known and that definition is superfluous. Actually, the words of everyday language, like the concepts they express, are always susceptible of more than one meaning, and the scholar employing them in their accepted use without further definition would risk serious misunderstanding. Not only is their meaning so indefinite as to vary, from case to case, with the needs of argument, but, as the classification from which they derive is not analytic, but merely translates the confused impressions of the crowd, categories of very different sorts of fact are indistinctly combined under the same heading, or similar realities are differently named. So, if we follow common use, we risk distinguishing what should be combined, or combining what should be distinguished, thus mistaking the real affinities of things, and accordingly misapprehending their nature. Only comparison affords explanation. A scientific investigation can thus be achieved only if it deals with comparable facts, and it is the more likely to succeed the more certainly it has combined all those that can be usefully compared. But these natural affinities of entities cannot be made clear safely by such superficial examination as produces ordinary terminology; and so the scholar cannot take as the subject of his research roughly assembled groups of facts corresponding to words of common usage. He himself must establish the groups he wishes to study in order to give them the homogeneity and the specific meaning

necessary for them to be susceptible of scientific treatment. Thus the botanist, speaking of flowers or fruits, the zoologist of fish or insects, employ these various terms in previously determined senses.

Our first task then must be to determine the order of facts to be studied under the name of suicides. Accordingly, we must inquire whether, among the different varieties of death, some have common qualities objective enough to be recognizable by all honest observers, specific enough not to be found elsewhere and also sufficiently kin to those commonly called suicides for us to retain the same term without breaking with common usage. If such are found, we shall combine under that name absolutely all the facts presenting these distinctive characteristics, regardless of whether the resulting class fails to include all cases ordinarily included under the name or includes others usually otherwise classified. The essential thing is not to express with some precision what the average intelligence terms suicide, but to establish a category of objects permitting this classification, which are objectively established, that is, correspond to a definite aspect of things.

Among the different species of death, some have the special quality of being the deed of the victim himself, resulting from an act whose author is also the sufferer; and this same characteristic, on the other hand, is certainly fundamental to the usual idea of suicide. The intrinsic nature of the acts so resulting is unimportant. Though suicide is commonly conceived as a positive, violent action involving some muscular energy, it may happen that a purely negative attitude or mere abstention will have the same consequence. Refusal to take food is as suicidal as self-destruction by a dagger or firearm. The subject's act need not even have been directly antecedent to death for death to be regarded as its effect; the causal relation may be indirect without that changing the nature of the phenomenon. The iconoclast, committing with the hope of a martyr's palm the crime of high treason known to be capital and dying by the executioner's hand, achieves his own death as truly as though he had dealt his own death-blow; there is, at least, no reason to classify differently these two sorts of voluntary death, since only material details of their execution differ. We come then to our first formula: the term suicide is applied to any death which is the direct or indirect result of a positive or negative act accomplished by the victim himself.

But this definition is incomplete; it fails to distinguish between two very different sorts of death. The same classification and treatment cannot be given the death of a victim of hallucination, who throws himself from an upper window thinking it on a level with the ground, and that of the sane person who strikes while knowing what he is doing. In one sense, indeed, few cases of death exist which are not immediately or distantly due to some act of the subject. The causes of death are outside rather than within us, and are effective only if we venture into their sphere of activity.

Shall suicide be considered to exist only if the act resulting in death was performed by the victim to achieve this result? Shall only he be thought truly to slay himself who has wished to do so, and suicide be intentional self-homicide? In the first place, this would define suicide by a characteristic which, whatever its interest and significance, would at least suffer from not being easily recognizable, since it is not easily observed. How discover the agent's motive and whether he desired death itself when he formed his resolve, or had some other purpose? Intent is too intimate a thing to be more than approximately interpreted by another. It even escapes self-observation. How often we mistake the true reasons for our acts! We constantly explain acts due to petty feelings or blind routine by generous passions or lofty considerations.

Besides, in general, an act cannot be defined by the end sought by the actor, for an identical system of behavior may be adjustable to too many different ends without altering its nature. Indeed, if the intention of self-destruction alone constituted suicide, the name suicide could not be given to facts which, despite apparent differences, are fundamentally identical with those always called suicide and which could not be otherwise described without discarding the term. The soldier facing certain death to save his regiment does not wish to die, and yet is he not as much the author of his own death as the manufacturer or merchant who kills himself to avoid bankruptcy? This holds true for the martyr dying for his faith, the mother sacrificing herself for her child, etc. Whether death is accepted merely as an unfortunate consequence, but inevitable given the purpose, or is actually itself sought and desired, in either case the person renounces existence, and the various methods of doing so can be only varieties of a single class. They

possess too many essential similarities not to be combined in one generic expression, subject to distinction as the species of the genus thus established. Of course, in common terms, suicide is pre-eminently the desperate act of one who does not care to live. But actually life is none the less abandoned because one desires it at the moment of renouncing it; and there are common traits clearly essential to all acts by which a living being thus renounces the possession presumably most precious of all. Rather, the diversity of motives capable of actuating these resolves can give rise only to secondary differences. Thus, when resolution entails certain sacrifice of life, scientifically this is suicide; of what sort shall be seen later.

The common quality of all these possible forms of supreme renunciation is that the determining act is performed advisedly; that at the moment of acting the victim knows the certain result of his conduct, no matter what reason may have led him to act thus. All mortal facts thus characterized are clearly distinct from all others in which the victim is either not the author of his own end or else only its unconscious author. They differ by an easily recognizable feature, for it is not impossible to discover whether the individual did or did not know in advance the natural results of his action. Thus, they form a definite, homogeneous group, distinguishable from any other and therefore to be designated by a special term. Suicide is the one appropriate; there is no need to create another, for the vast majority of occurrences customarily so-called belong to this group. We may then say conclusively: the term *suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result*. An attempt is an act thus defined but falling short of actual death.

This definition excludes from our study everything related to the suicide of animals. Our knowledge of animal intelligence does not really allow us to attribute to them an understanding anticipatory of their death nor, especially, of the means to accomplish it. Some, to be sure, are known to refuse to enter a spot where others have been killed; they seem to have a presentiment of death. Actually, however, the smell of blood sufficiently explains this instinctive reaction. All cases cited at all authentically which might appear true suicides may be quite differently explained. If the irritated scorpion pierces itself with its sting

(which is not at all certain), it is probably from an automatic, unreflecting reaction. The motive energy aroused by his irritation is discharged by chance and at random; the creature happens to become its victim, though it cannot be said to have had a preconception of the result of its action. On the other hand, if some dogs refuse to take food on losing their masters, it is because the sadness into which they are thrown has automatically caused lack of hunger; death has resulted, but without having been foreseen. Neither fasting in this case nor the wound in the other have been used as means to a known effect. So the special characteristics of suicide as defined by us are lacking. Hence in the following we shall treat human suicide only.[1]

But this definition not only forestalls erroneous combinations and arbitrary exclusions; it also gives us at once an idea of the place of suicide in moral life as a whole. It shows indeed that suicides do not form, as might be thought, a wholly distinct group, an isolated class of monstrous phenomena, unrelated to other forms of conduct, but rather are related to them by a continuous series of intermediate cases. They are merely the exaggerated form of common practices. Suicide, we say, exists indeed when the victim at the moment he commits the act destined to be fatal, knows the normal result of it with certainty. This certainty, however, may be greater or less. Introduce a few doubts, and you have a new fact, not suicide but closely akin to it, since only a difference of degree exists between them. Doubtless, a man exposing himself knowingly for another's sake but without the certainty of a fatal result is not a suicide, even if he should die, any more than the daredevil who intentionally toys with death while seeking to avoid it, or the man of apathetic temperament who, having no vital interest in anything, takes no care of health and so imperils it by neglect. Yet these different ways of acting are not radically distinct from true suicide. They result from similar states of mind, since they also entail mortal risks not unknown to the agent, and the prospect of these is no

[1] A very small but highly suspicious number of cases may not be explicable in this way. For instance as reported by Aristotle, that of a horse, who, realizing that he had been made to cover his dam without knowing the fact and after repeated refusals, flung himself intentionally from a cliff (*History of Animals*, IX, 47). Horse-breeders state that horses are by no means averse to incest. On this whole question see Westcott, *Suicide*, p. 174–179.

deterrent; the sole difference is a lesser chance of death. Thus the scholar who dies from excessive devotion to study is currently and not wholly unreasonably said to have killed himself by his labor. All such facts form a sort of embryonic suicide, and though it is not methodologically sound to confuse them with complete and full suicide, their close relation to it must not be neglected. For suicide appears quite another matter, once its unbroken connection is recognized with acts, on the one hand, of courage and devotion, on the other of imprudence and clear neglect. The lesson of these connections will be better understood in what follows.

II

But is the fact thus defined of interest to the sociologist? Since suicide is an individual action affecting the individual only, it must seemingly depend exclusively on individual factors, thus belonging to psychology alone. Is not the suicide's resolve usually explained by his temperament, character, antecedents and private history?

The degree and conditions under which suicides may be legitimately studied in this way need not now be considered, but that they may be viewed in an entirely different light is certain. If, instead of seeing in them only separate occurrences, unrelated and to be separately studied, the suicides committed in a given society during a given period of time are taken as a whole, it appears that this total is not simply a sum of independent units, a collective total, but is itself a new fact *sui generis*, with its own unity, individuality and consequently its own nature—a nature, furthermore, dominantly social. Indeed, provided too long a period is not considered, the statistics for one and the same society are almost invariable, as appears in Table I. This is because the environmental circumstances attending the life of peoples remain relatively unchanged from year to year. To be sure, more considerable variations occasionally occur; but they are quite exceptional. They are also clearly always contemporaneous with some passing crisis affecting the social state.[2] Thus, in 1848 there occurred an abrupt decline in all European states.

[2] The numbers applying to these exceptional years we have put in parentheses.

If a longer period of time is considered, more serious changes are observed. Then, however, they become chronic; they only prove that the structural characteristics of society have simultaneously suffered profound changes. It is interesting to note that they do not take place with the extreme slowness that quite a large number of observers has attributed to them, but are both abrupt and progressive. After a series of years, during which these figures have varied within very narrow limits, a rise suddenly appears which, after repeated vacillation, is confirmed, grows and is at last fixed. This is because every breach of social equilibrium, though sudden in its appearance, takes time to produce all its consequences. Thus, the evolution of suicide is composed of undulating movements, distinct and successive, which occur spasmodically, develop for a time, and then stop only to begin again. On Table I one of these waves is seen to have occurred almost throughout Europe in the wake of the events of 1848, or about the years 1850–1853 depending on the country; another began in Germany after the war of 1866, in France somewhat earlier, about 1860 at the height of the imperial government, in England about 1868, or after the commercial revolution caused by contemporary commercial treaties. Perhaps the same cause occasioned the new recrudescence observable in France about 1865. Finally, a new forward movement began after the war of 1870 which is still evident and fairly general throughout Europe.[3]

At each moment of its history, therefore, each society has a definite aptitude for suicide. The relative intensity of this aptitude is measured by taking the proportion between the total number of voluntary deaths and the population of every age and sex. We will call this numerical datum *the rate of mortality through suicide, characteristic of the society under consideration*. It is generally calculated in proportion to a million or a hundred thousand inhabitants.

Not only is this rate constant for long periods, but its invariability is even greater than that of leading demographic data. General mortality, especially, varies much more often from year to year and the variations

[3] In the table, ordinary figures and heavy type figures represent respectively the series of numbers indicating these different waves of movement, to make each group stand out in its distinctiveness.

Table I Stability of suicide in the principal European countries (absolute figures)

Years	*France*	*Prussia*	*England*	*Saxony*	*Bavaria*	*Denmark*
1841	2,814	1,630		290		377
1842	2,866	1,598		318		317
1843	3,020	1,720		420		301
1844	2,973	1,575		335	244	285
1845	3,082	1,700		338	250	290
1846	3,102	1,707		373	220	376
1847	(3,647)	(1,852)		377	217	345
1848	(3,301)	(1,649)		398	215	(305)
1849	3,583	(1,527)		(328)	(189)	337
1850	3,596	1,736		390	250	340
1851	3,598	1,809		402	260	401
1852	3,676	2,073		530	226	426
1853	3,415	1,942		431	263	419
1854	3,700	2,198		547	318	363
1855	3,810	2,351		568	307	399
1856	4,189	2,377		550	318	426
1857	3,967	2,038	1,349	485	286	427
1858	3,903	2,126	1,275	491	329	457
1859	3,899	2,146	1,248	507	387	451
1860	4,050	2,105	1,365	548	339	468
1861	4,454	2,185	1,347	(643)		
1862	4,770	2,112	1,317	557		
1863	4,613	2,374	1,315	643		
1864	4,521	2,203	1,240	(545)		411
1865	4,946	2,361	1,392	619		451
1866	5,119	2,485	1,329	704	410	443
1867	5,011	3,625	1,316	752	471	469
1868	(5,547)	3,658	1,508	800	453	498
1869	5,114	3,544	1,588	710	425	462
1870		3,270	1,554			486
1871		3,135	1,495			
1872		3,467	1,514			

it undergoes are far greater. This is shown assuredly by comparing the way in which both phenomena vary in several periods. This we have done in Table II. To manifest the relationship, the rate for each year of both deaths and suicides, has been expressed as a proportion of the average rate of the period, in percentage form. Thus the differences of one year from another or with reference to the average rate are made comparable in the two columns. From this comparison it appears that at each period the degree of variation is much greater with respect to general mortality than to suicide; on the average, it is twice as great. Only the minimum difference between two successive years is perceptibly the same in each case during the last two periods. However, this minimum is exceptional in the column of mortality, whereas the annual variations of suicides differ from it rarely. This may be seen by a comparison of the average differences.[4]

To be sure, if we compare not the successive years of a single period but the averages of different periods, the variations observed in the rate of mortality become almost negligible. The changes in one or the other direction occurring from year to year and due to temporary and accidental causes neutralize one another if a more extended unit of time is made the basis of calculation; and thus disappear from the average figures which, because of this elimination, show much more invariability. For example, in France from 1841 to 1870, it was in each successive ten-year period 23.18; 23.72; 22.87. But, first, it is already remarkable that from one year to its successor suicide is at least as stable, if not more so, than general mortality taken only from period to period. The average rate of mortality, furthermore, achieves this regularity only by being general and impersonal, and can afford only a very imperfect description of a given society. It is in fact substantially the same for all peoples of approximately the same degree of civilization; at least, the differences are very slight. In France, for example, as we have just seen, it oscillates, from 1841 to 1870, around 23 deaths per 1,000 inhabitants; during the same period in Belgium it was successively 23.93, 22.5, 24.04; in England, 22.32, 22.21, 22.68; in Denmark, 22.65 (1845–49), 20.44 (1855–59), 20.4 (1861–68). With the

[4] Wagner had already compared mortality and marriage in this way. (*Die Gesetzmässigkeit*, etc., p. 87.)

exception of Russia, which is still only geographically European, the only large European countries where the incidence of mortality differs somewhat more widely from the above figures are Italy, where even between 1861 and 1867 it rose to 30.6, and Austria, where it was yet greater (32.52).[5] On the contrary, the suicide-rate, while showing only slight annual changes, varies according to society by doubling, tripling, quadrupling, and even more (Table III below). Accordingly, to a much higher degree than the death-rate, it is peculiar to each social group

Table II Comparative variations of the rate of mortality by suicide and the rate of general mortality

A. ABSOLUTE FIGURES

Period 1841–46	*Suicides per 100,000 inhabitants*	*Deaths per 1,00 inhabitants*	*Period 1849–55*	*Suicides per 100,000 inhabitants*	*Deaths per 1,000 inhabitants*	*Period 1856–60*	*Suicides per 100,000 inhabitants*	*Deaths per 1,000 inhabitants*
1841	8.2	23.2	1849	10.0	27.3	1856	11.6	23.1
1842	8.3	24.0	1850	10.1	21.4	1857	10.9	23.7
1843	8.7	23.1	1851	10.0	22.3	1858	10.7	24.1
1844	8.5	22.1	1852	10.5	22.5	1859	11.1	26.8
1845	8.8	21.2	1853	9.4	22.0	1860	11.9	21.4
1846	8.7	23.2	1854	10.2	27.4			
			1855	10.5	25.9			
Averages	8.5	22.8	Averages	10.1	24.1	Averages	11.2	23.8

B. ANNUAL RATE RELATED TO THE AVERAGE IN PERCENTAGE FORM

1841	96	101.7	1849	98.9	113.2	1856	103.5	97
1842	97	105.2	1850	100	88.7	1857	97.3	99.3
1843	102	101.3	1851	98.9	92.5	1858	95.5	101.2
1844	100	96.9	1852	103.8	93.3	1859	99.1	112.6
1845	103.5	92.9	1853	93	91.2	1860	106.0	89.9
1846	102.3	101.7	1854	100.9	113.6			
			1855	103	107.4			
Averages	100	100	Averages	100	100	Averages	100	100

[5] According to Bertillon, article *Mortalité* in the *Dictionnaire Encyclopedique des sciences medicals*, V. LXI, p. 738.

C. DEGREE OF DIFFERENCE

	Between two consecutive years			*Above and below the average*	
	Greatest difference	*Least difference*	*Average difference*	*Greatest below*	*Greatest above*
			Per. 1841–46		
General mortality	8.8	2.5	4.9	7.1	4.0
Suicide-rate	5.0	1	2.5	4	2.8
			Per. 1849–55		
General mortality	24.5	0.8	10.6	13.6	11.3
Suicide-rate	10.8	1.1	4.48	3.8	7.0
			Per. 1856–60		
General mortality	22.7	1.9	9.57	12.6	10.1
Suicide-rate	6.9	1.8	4.82	6.0	4.5

Table III Rate of suicides per million inhabitants in the different European countries

	Period			*Numerical position in the*		
	1866–70	*1871–75*	*1874–78*	*1 period*	*2 period*	*3 period*
Italy	30	35	38	1	1	1
Belgium	66	69	78	2	3	4
England	67	66	69	3	2	2
Norway	76	73	71	4	4	3
Austria	78	94	130	5	7	7
Sweden	85	81	91	6	5	5
Bavaria	90	91	100	7	6	6
France	135	150	160	8	9	9
Prussia	142	134	152	9	8	8
Denmark	277	258	255	10	10	10
Saxony	293	267	334	11	11	11

where it can be considered as a characteristic index. It is even so closely related to what is most deeply constitutional in each national temperament that the order in which the different societies appear in this respect remains almost exactly the same at very different periods. This

is proved by examining this same table. During the three periods there compared, suicide has everywhere increased, but in this advance the various peoples have retained their respective distances from one another. Each has its own peculiar coefficient of acceleration.

The suicide-rate is therefore a factual order, unified and definite, as is shown by both its permanence and its variability. For this permanence would be inexplicable if it were not the result of a group of distinct characteristics, solidary one with another, and simultaneously effective in spite of different attendant circumstances; and this variability proves the concrete and individual quality of these same characteristics, since they vary with the individual character of society itself. In short, these statistical data express the suicidal tendency with which each society is collectively afflicted. We need not state the actual nature of this tendency, whether it is a state *sui generis* of the collective mind,[6] with its own reality, or represents merely a sum of individual states. Although the preceding considerations are hard to reconcile with the second hypothesis, we reserve this problem for treatment in the course of this work.[7] Whatever one's opinion on this subject, such a tendency certainly exists under one heading or another. Each society is predisposed to contribute a definite quota of voluntary deaths. This predisposition may therefore be the subject of a special study belonging to sociology. This is the study we are going to undertake.

We do not accordingly intend to make as nearly complete an inventory as possible of all the conditions affecting the origin of individual suicides, but merely to examine those on which the definite fact that we have called the social suicide-rate depends. The two questions are obviously quite distinct, whatever relation may nevertheless exist between them. Certainly many of the individual conditions are not general enough to affect the relation between the total number of voluntary deaths and the population. They may perhaps cause this or that separate individual to kill himself, but not give society as a whole a greater or lesser tendency to suicide. As they do not depend on a certain state of social organization, they have no social repercussions.

[6] By the use of this expression we of course do not at all intend to hypostasize the collective conscience. We do not recognize any more substantial a soul in society than in the individual. But we shall revert to this point.

[7] Bk. III, Chap. 1.

Thus they concern the psychologist, not the sociologist. The latter studies the causes capable of affecting not separate individuals but the group. Therefore among the factors of suicide the only ones which concern him are those whose action is felt by society as a whole. The suicide-rate is the product of these factors. This is why we must limit our attention to them.

Such is the subject of the present work, to contain three parts.

The phenomenon to be explained can depend only on extra-social causes of broad generality or on causes expressly social. We shall search first for the influence of the former and shall find it non-existent or very inconsiderable.

Next we shall determine the nature of the social causes, how they produce their effects, and their relations to the individual states associated with the different sorts of suicide.

After that, we shall be better able to state precisely what the social element of suicide consists of; that is, the collective tendency just referred to, its relations to other social facts, and the means that can be used to counteract it.[8]

[8] Whenever necessary, the special bibliography of the particular questions treated will be found at the beginning of each chapter. Below are references on the general bibliography of suicide:

I. Official statistical publications forming our principal sources: Oesterreichische Statistik (Statistik des Sanitätswesens).—Annuaire statistique de la Belgique.—Zeitschrift des Koeniglisch Bayerischen statistischen Bureau.—Preussische Statistik (Sterblichkeit nach Todesursachen und Altersklassen der Gestorbenen).—Würtembürgische Jahrbücher für Statistik und Landeskunde.—Badische Statistik.—Tenth Census of the United States. Report on the mortality and vital statistics of the United States, 1880, 11th part.—Annuario statistico Italiano.—Statistica delle cause delle Morti in tutti i communi del Regno.—Relazione medico-statistica sulle conditione sanitarie dell' Exercito Italiano.—Statistische Nachrichten des Grossherzogthums Oldenburg.—Compte-rendu general de l'administration de la justice criminelle en France.

Statistisches Jahrbuch der Stadt Berlin.—Statistik der Stadt Wien.—Statistisches Handbuch für den Hamburgischen Staat.—Jahrbuch für die amtliche Statistik der Bremischen Staaten.—Annuaire statistique de la ville de Paris.

Other useful information will be found in the following articles: Platter, *Ueber die Selbstmorde in Oesterreich in den Jahren 1819–1872*. In *Statist. Monatsh*, 1876.—Brattassevic, *Die Selbstmorde in Ousterreich in den Jahren 1873–77*, in *Stat. Monatsh.*, 1878, p. 429.—Ogle, *Suicides in England and Wales in relation to Age, Sex, Season and Occupation*. In Journal of the Statistical Society, 1886.—Rossi, *Il Suicidio nella Spagna nel* 1884. *Arch. di psychiatria*, Turin, 1886.

II. Studies on suicide in general: De Guerry, *Statistique morale de la France*, Paris, 1835, and *Statistique morale comparée de la France et de l'Angleterre*, Paris, 1864.—Tissot, *De la manie du suicide et de l'esprit de révolte, de leurs causes et de leurs remèdes*, Paris, 1841.—Etoc-Demazy, *Recherches statistiques sur le suicide*, Paris, 1844.—Lisle, *Du suicide*, Paris, 1856.—*Wappäus, Allgemeine Bevölkerungsstatistik*, Leipzig, 1861.—Wagner, *Die Gesetzmässigkeit in den scheinbar wilkürlichen menschichen Haudlungen*, Hamburg, 1864, Part 2.—Brierre de Boismont, *Du suicide et de la folie-suicide*, Paris, Germer Bailliere, 1865.—Douay, *Le suicide ou la mort volontaire*, Paris, 1870.—Leroy, *Etude sur le suicide et les maladies mentales dens le department de Seine-at-Marne*, Paris, 1870.—Oettingen, Die *Moralstatistik*, 3rd Ed., Erlangen, 1882, p. 786–832 and accompanying tables 103–120.—By the same, *Ueber acuten und chronischen Selbstmord*, Dorpat, 1881.—Morselli, *II, suicidio*, Milan, 1879.—Legoyt, *Le suicide ancien et moderne*, Paris, 1881.—Masaryk, *Der Selbstmord als sociale Massenerscheinung*, Vienna, 1881.—Westcott, *Suicide, its history, literature*, etc., London, 1885.—Motta, *Bibliografa del Suicidio*, Bellinzona, 1890.—Corre, *Crime et suicide*, Paris, 1891.—Bonomelli, *Il suicidio*, Milan, 1892.—Mayr, *Selbstmordstatistik*, In *Handwörterbuch der Staatswissenschaften, herausgegeben von Conrad, Erster Supplementband*, Jena, 1895.—Hauviller, D., *Suicide*, thesis, 1898–99.

Book I

Extra-Social Factors

1

SUICIDE AND PSYCHOPATHIC STATES[1]

There are two sorts of extra-social causes to which one may, *a priori*, attribute an influence on the suicide-rate; they are organic-psychic dispositions and the nature of the physical environment. In the individual constitution, or at least in that of a significant class of individuals, it is possible that there might exist an inclination, varying in intensity from country to country, which directly leads man to suicide; on the other hand, the action of climate, temperature, etc., on the organism, might indirectly have the same effects. Under no circumstances can the hypothesis be dismissed unconsidered. We shall examine these two sets of factors successively, to see

[1] Bibliography.—Falret, *De l'hypochondrie et du suicide*, Paris, 1822.—Esquirol, *Des maladies mentales*, Paris, 1838 (V. I, p. 526–676) and the article *Suicide*, in *Dictionnaire de médecine*, in 60 vols.—Cazauvieilh, *Du suicide et de l'aliénation mentale*, Paris, 1840—Etoc-Demazy, *De la folie dans la production du suicide*, in *Annales medico-psych.*, 1844.—Bourdin, *Du suicide considéré comme maladie*, Paris, 1845.—Dechambre, *De la monomanie homicide-suicide*, in Gazette Medic., 1852.—Jousset, *Du suicide et de la monomanie suicide*, 1858.—Brierre de Boismont, *op. cit.*—Leroy, *op. cit.*—*Art. Suicide*, in *Dictionnaire de médecine et de chirurgie pratique*, V. XXXIV, p. 117.—Strahan, *Suicide and Insanity*, London, 1894.

Lunier, *De la production et de la consommation des boissons alcooliques en France*, Paris, 1877.—By the same, art. in *Annales medico-psych.*, 1872; *Journal de la Soc. de stat.*, 1878.—Prinzing, *Trunksucht und Selbstmord*, Leipzig, 1895.

whether they play any part in the phenomenon under study and if so, what.

I

The annual rate of certain diseases is relatively stable for a given society though varying perceptibly from one people to another. Among these is insanity. Accordingly, if a manifestation of insanity were reasonably to be supposed in every voluntary death, our problem would be solved; suicide would be a purely individual affliction.[2]

This thesis is supported by a considerable number of alienists. According to Esquirol: "Suicide shows all the characteristics of mental alienation."[3]—"A man attempts self-destruction only in delirium and suicides are mentally alienated."[4] From this principle he concluded that suicide, being involuntary, should not be punished by law. Falret[5] and Moreau de Tours use almost the same terms. The latter, to be sure, in the same passage where he states his doctrine, makes a remark which should subject it to suspicion: "Should suicide be regarded in all cases as the result of mental alienation? Without wishing to dispose here of this difficult question, let us say generally that one is instinctively the more inclined to the affirmative the deeper the study of insanity which he has made, the greater his experience and the greater the number of insane persons whom he has examined."[6] In 1845 Dr. Bourdin, in a brochure which at once created a stir in the medical world, had enunciated the same opinion even more unreservedly.

This theory may be and has been defended in two different ways. Suicide itself is either called a disease in itself, *sui generis*, a special form of insanity; or it is regarded, not as a distinct species, but simply an event involved in one or several varieties of insanity, and not to be found in sane persons. The former is Bourdin's thesis; Esquirol is the chief authority holding the other view. "From what has preceded," he

[2] In so far as insanity itself is purely individual. Actually it is partly a social phenomenon. We shall return to this point.

[3] *Maladies mentales*, v. I, p. 639.

[4] *Ibid.*, v. I, p. 665.

[5] *Du suicide*, etc., p. 137.

[6] In *Annales medico-psych.*, v. VII, p. 287.

writes, "suicide may be seen to be for us only a phenomenon resulting from many different causes and appearing under many different forms; and it is clear that this phenomenon is not characteristic of a disease. From considering suicide as a disease *sui generis*, general propositions have been set up which are belied by experience."[7]

The second of these two methods of proving suicide to be a manifestation of insanity is the less rigorous and conclusive, since because of it negative experiences are impossible. A complete inventory of all cases of suicide cannot indeed be made, nor the influence of mental alienation shown in each. Only single examples can be cited which, however numerous, cannot support a scientific generalization; even though contrary examples were not affirmed, there would always be possibility of their existence. The other proof, however, if obtainable, would be conclusive. If suicide can be shown to be a mental disease with its own characteristics and distinct evolution, the question is settled; every suicide is a madman.

But does suicidal insanity exist?

II

Since the suicidal tendency is naturally special and definite if it constitutes a sort of insanity, this can be only a form of partial insanity, limited to a single act. To be considered a delirium it must bear solely on this one object; for, if there were several, the delirium could no more be defined by one of them than by the others. In traditional terminology of mental pathology these restricted deliria are called monomanias. A monomaniac is a sick person whose mentality is perfectly healthy in all respects but one; he has a single flaw; clearly localized. At times, for example, he has an unreasonable and absurd desire to drink or steal or use abusive language; but all his other acts and all his other thoughts are strictly correct. Therefore, if there is a suicidal mania it can only be a monomania, and has indeed been usually so called.[8]

On the other hand, if this special variety of disease called

[7] *Maladies mentales*, v. I, p. 528.

[8] See Brierre de Boismont, p. 140.

monomanias is admitted, it is clear why one readily includes suicide among them. The character of these kinds of afflictions, according to the definition just given, is that they imply no essential disturbance of intellectual functions. The basis of mental life is the same in the monomaniac and the sane person; only, in the former, a specific psychic state is prominently detached from this common basis. In short, monomania is merely one extreme emotion in the order of impulses, one false idea in the order of representations, but of such intensity as to obsess the mind and completely enslave it. Thus, ambition, from being normal, becomes morbid and a monomania of grandeur when it assumes such proportions that all other cerebral functions seem paralyzed by it. A somewhat violent emotional access disturbing mental equilibrium is therefore enough to cause the monomania to appear. Now suicides generally seem influenced by some abnormal passion, whether its energy is abruptly expended or gradually developed; it may thus even appear reasonable that some such force is always necessary to offset the fundamental instinct of self-preservation. Moreover, many suicides are completely indistinguishable from other men except by the particular act of self-destruction; and there is therefore no reason to impute a general delirium to them. This is the reasoning by which suicide, under the appellation of monomania, has been considered a manifestation of insanity.

But, do monomanias exist? For a long time this was not questioned; alienists one and all concurred without discussion in the theory of partial deliria. It was not only thought confirmed by clinical observation but regarded as corollary to the findings of psychology. The human intelligence was supposed to consist of distinct faculties and separate powers which usually function cooperatively but may act separately; thus it seemed natural that they might be separately affected by disease. Since human intelligence may be manifested without volition and emotion without intelligence, why might there not be affections of the intelligence or will without disturbances of the emotions and *vice versa*? Applied to the specialized forms of these faculties, the same principle led to the theory that a lesion may exclusively affect an impulse, an action or an isolated idea.

Today however this opinion has been universally discarded. The non-existence of monomanias cannot indeed be proved from direct

observation, but not a single incontestable example of their existence can be cited. Clinical experience has never been able to observe a diseased mental impulse in a state of pure isolation; whenever there is lesion of one faculty the others are also attacked, and if these concomitant lesions have not been observed by the believers in monomania, it is because of poorly conducted observations. "For example," writes Falret, "take an insane person obsessed by religious ideas who would be classified among religious monomaniacs. He declares himself divinely inspired; entrusted with a heavenly mission he brings a new religion to the world. . . . This idea will be said to be wholly insane; yet he reasons like other men except for this series of religious thoughts. Question him more carefully, however, and other morbid ideas will soon be discovered; for instance, you will find a tendency to pride parallel to the religious ideas. He believes himself called upon to reform not only religion but also to reform society; perhaps he will also imagine the highest sort of destiny reserved for himself. . . . If you have not discovered tendencies to pride in this patient, you will encounter ideas of humility or tendencies to fear. Preoccupied with religious ideas he will believe himself lost, destined to perish, etc."[9] All of these forms of delirium will, of course, not usually be met with combined in a single person, but such are those most commonly found in association; if not existing at the same moment in the illness they will be found in more or less quick succession.

Finally, apart from these special manifestations, there always exists in these supposed monomaniacs a general state of the whole mental life which is fundamental to the disease and of which these delirious ideas are merely the outer and momentary expression. Its essential character is an excessive exaltation or deep depression or general perversion. There is, especially, a lack of equilibrium and coordination in both thought and action. The patient reasons, but with lacunas in his ideas; he acts, not absurdly, but without sequence. It is incorrect then to say that insanity constitutes a part, and a restricted part of his mental life; as soon as it penetrates the understanding it totally invades it.

Moreover, the principle underlying the hypothesis of monomania contradicts the actual data of science. The old theory of the faculties has

[9] *Maladies mentales*, p. 437.

few defenders left. The different sorts of conscious activity are no longer regarded as separate forces, disunited, and combined only in the depths of a metaphysical substance, but as interdependent functions; thus one cannot suffer lesion without the others being affected. This interpenetration is even closer in mental life than in the rest of the organism; for psychic functions have no organs sufficiently distinct from one another for one to be affected without the others. Their distribution among the different regions of the brain is not well defined, as appears from the readiness with which its different parts mutually replace each other, if one of them is prevented from fulfilling its task. They are too completely interconnected for insanity to attack certain of them without injury to the others. With yet greater reason it is totally impossible for insanity to alter a single idea or emotion without psychic life being radically changed. For representations and impulses have no separate existence; they are not so many little substances, spiritual atoms, constituting the mind by their combination. They are merely external manifestations of the general state of the centers of consciousness, from which they derive and which they express. Thus they cannot be morbid without this state itself being vitiated.

But if mental flaws cannot be localized, there are not, there cannot be monomanias properly so-called. The apparently local disturbances given this name always derive from a more extensive perturbation; they are not diseases themselves, but particular and secondary manifestations of more general diseases. If then there are no monomanias, there cannot be a suicidal monomania and, consequently, suicide is not a distinct form of insanity.

III

It remains possible, however, that suicide may occur only in a state of insanity. If it is not by itself a special form of insanity, there are no forms of insanity in connection with which it may not appear. It is only an episodic syndrome of them, but one of frequent occurrence. Perhaps this frequency indicates that suicide never occurs in a state of sanity, and that it indicates mental alienation with certainty?

The conclusion would be hasty. For though certain acts of the insane

are peculiar to them and characteristic of insanity, others are common to them and to normal persons, though assuming a special form in the case of the insane. There is no reason, a *priori*, to place suicide in the first of the two categories. To be sure, alienists state that most of the suicides known to them show all the indications of mental alienation, but this evidence could not settle the question, for the reviews of such cases are much too summary. Besides, no general law could be drawn from so narrowly specialized an experience. From the suicides they have known, who were, of course, insane, no conclusion can be drawn as to those not observed, who, moreover, are much more numerous.

The only methodical procedure consists of classifying according to their essential characteristics the suicides committed by insane persons, thus forming the principal types of insane suicide, and then trying to learn whether all cases of voluntary death can be included under these systematically arranged groups. In other words, to learn whether suicide is an act peculiar to the insane one must fix the forms it assumes in mental alienation and discover whether these are the only ones assumed by it.

In general, specialists have paid little heed to classifying the suicides of the insane. The four following types, however, probably include the most important varieties. The essential elements of the classification are borrowed from Jousset and Moreau de Tours.[10]

1. *Maniacal suicide.*—This is due to hallucinations or delirious conceptions. The patient kills himself to escape from an imaginary danger or disgrace, or to obey a mysterious order from on high, etc.[11] But the motives of such suicide and its manner of evolution reflect the general characteristics of the disease from which it derives—namely, mania. The quality characteristic of this condition is its extreme mobility. The most varied and even conflicting ideas and feelings succeed each other with intense rapidity in the maniac's consciousness. It is a constant whirlwind. One state of mind is instantly replaced by another. Such, too, are the motives of maniacal suicide; they appear, disappear, or change with amazing speed. The hallucination or delirium which

[10] See article, *Suicide*, in *Dictionnaire de médecine et de chirurgie pratique.*

[11] These hallucinations must not be confused with those tending to deceive the patient as to the risks he runs; for example, to make him mistake a window for a door. In the latter case, there is no suicide as defined above, but accidental death.

suggests suicide suddenly occurs; the attempt follows; then instantly the scene changes, and if the attempt fails it is not resumed, at least, for the moment. If it is later repeated it will be for another motive. The most trivial incident may cause these sudden transformations. One such patient, wishing to kill himself, had leaped into a river—one that was generally shallow. He was seeking a place where submersion was possible when a customs officer, suspecting his intention, took aim and threatened to fire if he did not leave the water. The man went peaceably home at once, no longer thinking of self-destruction.[12]

2. *Melancholy suicide.*—This is connected with a general state of extreme depression and exaggerated sadness, causing the patient no longer to realize sanely the bonds which connect him with people and things about him. Pleasures no longer attract; he sees everything as through a dark cloud. Life seems to him boring or painful. As these feelings are chronic, so are the ideas of suicide; they are very fixed and their broad determining motives are always essentially the same. A young girl, daughter of healthy parents, having spent her childhood in the country, has to leave at about the age of fourteen, to finish her education. From that moment she contracts an extreme disgust, a definite desire for solitude and soon an invincible desire to die. "She is motionless for hours, her eyes on the ground, her breast laboring, like someone fearing a threatening occurrence. Firmly resolved to throw herself into the river, she seeks the remotest places to prevent any rescue."[13] However, as she finally realizes that the act she contemplates is a crime she temporarily renounces it. But after a year the inclination to suicide returns more forcefully and attempts recur in quick succession.

Hallucinations and delirious thoughts often associate themselves with this general despair and lead directly to suicide. However, they are not mobile like those just observed among maniacs. On the contrary they are fixed, like the general state they come from. The fears by which the patient is haunted, his self-reproaches, the grief he feels are always the same. If then this sort of suicide is determined like its predecessor by imaginary reasons, it is distinct by its chronic character.

[12] Bourdin, *op. cit.*, p. 43.

[13] Falret, *Hypochondrie et suicide*, p. 299–307.

And it is very tenacious. Patients of this category prepare their means of self-destruction calmly; in the pursuit of their purpose they even display incredible persistence and, at times, cleverness. Nothing less resembles this consistent state of mind than the maniac's constant instability. In the latter, passing impulses without durable cause; in the former, a persistent condition linked with the patient's general character.

3. *Obsessive suicide.*—In this case, suicide is caused by no motive, real or imaginary, but solely by the fixed idea of death which, without clear reason, has taken complete possession of the patient's mind. He is obsessed by the desire to kill himself, though he perfectly knows he has no reasonable motive for doing so. It is an instinctive need beyond the control of reflection and reasoning, like the needs to steal, to kill, to commit arson, supposed to constitute other varieties of monomania. As the patient realizes the absurdity of his wish he tries at first to resist it. But throughout this resistance he is sad, depressed, with a constantly increasing anxiety oppressing the pit of his stomach. Hence, this sort of suicide has sometimes been called *anxiety-suicide.* Here is the confession once made by a patient to Brierre de Boismont, which perfectly describes the condition: "I am employed in a business house. I perform my regular duties satisfactorily but like an automaton, and when spoken to, the words sound to me as though echoing in a void. My greatest torment is the thought of suicide, from which I am never free. I have been the victim of this impulse for a year; at first it was insignificant; then for about the last two months it has pursued me everywhere, *yet I have no reason to kill myself.* . . . My health is good; no one in my family has been similarly afflicted; I have had no financial losses, my income is adequate and permits me the pleasures of people of my age."[14] But as soon as the patient has decided to give up the struggle and to kill himself, anxiety ceases and calm returns. If the attempt fails it is sometimes sufficient, though unsuccessful, to quench temporarily the morbid desire. It is as though the patient had voided this impulse.

4. *Impulsive or automatic suicide.*—It is as unmotivated as the preceding; it has no cause either in reality or the patient's imagination. Only, instead of being produced by a fixed idea obsessing the mind for a

[14] *Suicide et folie-suicide*, p. 397.

shorter or longer period and only gradually affecting the will, it results from an abrupt and immediately irresistible impulse. In the twinkling of an eye it appears in full force and excites the act, or at least its beginning. This abruptness recalls what has been mentioned above in connection with mania; only the maniacal suicide has always some reason, however irrational. It is connected with the patient's delirious conceptions. Here on the contrary the suicidal tendency appears and is effective in truly automatic fashion, not preceded by any intellectual antecedent. The sight of a knife, a walk by the edge of a precipice, etc. engender the suicidal idea instantaneously and its execution follows so swiftly that patients often have no idea of what has taken place. "A man is quietly talking with his friends; suddenly he leaps, clears a parapet and falls into the water. Rescued immediately and asked for the motives of his behaviour, he knows nothing of them, he has yielded to irresistible force."[15] "The strange thing is," another says, "that I can't remember how I climbed the casement and my controlling idea at the time; for I had no thought of killing myself, or, at least I have no memory of such a thought today."[16] To a lesser degree, patients feel the impulse growing and manage to escape the fascination of the mortal instrument by fleeing from it immediately.

In short, all suicides of the insane are either devoid of any motive or determined by purely imaginary motives. Now, many voluntary deaths fall into neither category; the majority have motives, and motives not unfounded in reality. Not every suicide can therefore be considered insane, without doing violence to language. Of all the suicides just characterized, that which may appear hardest to detect of those observed among the sane is melancholy suicide; for very often the normal person who kills himself is also in a state of dejection and depression like the mentally alienated. But an essential difference between them always exists in that the state of the former and its resultant act are not without an objective cause, whereas in the latter they are wholly unrelated to external circumstances. In short, the suicides of the insane differ from others as illusions and hallucinations differ from normal perceptions and automatic impulses from

[15] Brierre, *op. cit.*, p. 574.
[16] *Ibid.*, p. 314.

deliberate acts. It is true that there is a gradual shading from the former to the latter; but if that sufficed to identify them one would also, generally speaking, have to confuse health with sickness, since the latter is but a variety of the former. Even if it were proved that the average man never kills himself and that only those do so who show certain anomalies, this would still not justify considering insanity a necessary condition of suicide; for an insane person is not simply a man who thinks or acts somewhat differently from the average.

Thus, suicide has been so closely associated with insanity only by arbitrarily restricting the meaning of the words. "That man does not kill himself," Esquirol exclaims, "who, obeying only noble and generous sentiments, throws himself into certain peril, exposes himself to inevitable death, and willingly sacrifices his life in obedience to the laws, to keep pledged faith, for his country's safety."[17] He cites the examples of Decius, of Assas, etc. Falret likewise refuses to consider Curtius, Codrus or Aristodemus as suicides.[18] Bourdin excepts in this manner all voluntary deaths inspired not only by religious faith or political conviction but even by lofty affection. But we know that the nature of the motives immediately causing suicide cannot be used to define it, nor consequently to distinguish it from what it is not. All cases of death resulting from an act of the patient himself with full knowledge of the inevitable results, whatever their purpose, are too essentially similar to be assigned to separate classes. Whatever their cause, they can only be species of a single genus; and to distinguish among them, one must have other criteria than the victim's more or less doubtful purpose. This leaves at least a group of suicides unconnected with insanity. Once exceptions are admitted, it is hard to stop. For there is only a gradual shading between deaths inspired by usually generous feelings and those from less lofty motives. An imperceptible gradation leads from one class to the other. If then the former are suicides, there is no reason for not giving the same name to the latter.

There are therefore suicides, and numerous ones at that, not connected with insanity. They are doubly identifiable as being deliberate and as springing from representations involved in this deliberation

[17] *Maladies mentales*, v. I, p. 529.
[18] *Hypochondrie et suicide*, p. 3.

which are not purely hallucinatory. This often debated question may therefore be solved without requiring reference to the problem of freedom. To learn whether all suicides are insane, we have not asked whether or not they act freely; we have based ourselves solely on the empirical characteristics observable in the various sorts of voluntary death.

IV

Since the suicides of insane persons do not constitute the entire genus but only a variety of it, the psychopathic states constituting mental alienation can give no clue to the collective tendency to suicide in its generality. But between mental alienation properly so-called and perfect equilibrium of intelligence, an entire series of intermediate stages exist; they are the various anomalies usually combined under the common name of neurasthenia. Let us therefore see whether they, in cases devoid of insanity, do not have an important role in the origin of the phenomenon we are studying.

The very existence of insane suicide suggests the question. In fact, if a deep affection of the nervous system is enough to create suicide, a lesser affection ought to exercise the same influence to a lesser degree. Neurasthenia is a sort of elementary insanity; it must therefore have the same effects in part. It is also a much more widespread condition than insanity; it is even becoming progressively more general. The total of abnormalities thus termed may therefore be one of the factors with which the suicide-rate varies.

Besides, neurasthenia may reasonably predispose to suicide; for by temperament neurasthenics seem destined to suffer. It is well known that pain, in general, results from too violent a shock to the nervous system; a too intense nervous wave is usually painful. But this maximum intensity beyond which pain begins varies with individuals; it is highest among those whose nerves have more resistance, less in others. The painful zone begins earlier, therefore, among the latter. Every impression is a source of discomfort for the neuropath, every movement an exertion; his nerves are disturbed at the least contact, being as it were unprotected; the performance of physiological functions which are usually most automatic is a source of generally painful sensations

for him. On the other hand, it is true that the zone of pleasure itself also begins at a lower level; for the excessive penetrability of a weakened nervous system makes it a prey to stimuli which would not excite a normal organism. Thus insignificant occurrences may cause such a person excessive pleasures. Seemingly he must gain on one side all that he loses on the other and, thanks to this compensatory action, he should not be less well armed than others to sustain the conflict. This is not the case however, and his inferiority is real; for current impressions, sensations most frequently reproduced by the conditions of average life, are always of a definite intensity. Life therefore is apt to be insufficiently tempered for this sufferer. To be sure, he may live with a minimum of suffering when he can live in retirement and create a special environment only partially accessible to the outer tumult; thus he sometimes is seen to flee the world which makes him ill and to seek solitude. But if forced to enter the melée and unable to shelter his tender sensitivity from outer shocks, he is likely to suffer more pain than pleasure. Such organisms are thus a favorite field for the idea of suicide.

Nor does this situation alone make life difficult for the neuropath. Due to this extreme sensitivity of his nervous system, his ideas and feelings are always in unstable equilibrium. Because his slightest impressions have an abnormal force, his mental organization is utterly upset at every instant, and under the hammer of these uninterrupted shocks cannot become definitely established. It is always in process of becoming. For it to become stable past experiences would have to have lasting effects, whereas they are constantly being destroyed and swept away by abruptly intervening upheavals. Life in a fixed and constant medium is only possible if the functions of the person in question are of equal constancy and fixity. For living means responding appropriately to outer stimuli and this harmonious correspondence can be established only by time and custom. It is a product of experiments, sometimes repeated for generations, the results of which have in part become hereditary and which cannot be gone through all over again everytime there is necessity for action. If, however, at the moment of action everything has to be reconstructed, so to speak, it is impossible for this action to be what it should be. We require this stability not only in our relations with the physical environment, but also with the social

environment. The individual can maintain himself in a society definitely organized only through possessing an equally definite mental and moral constitution. This is what the neuropath lacks. His state of disturbance causes him to be constantly taken by surprise by circumstances. Unprepared to respond, he has to invent new forms of conduct; whence comes his well-known taste for novelty. When, however, he has to adapt himself to traditional situations, improvised contrivances are inadequate against those derived from experience; and they therefore usually fail. Thus the more fixed the social system, the more difficult is life there for so mobile a person.

This psychological type is therefore very probably the one most commonly to be found among suicides. What share has this highly individual condition in the production of voluntary deaths? Can it alone, if aided by circumstances, produce them, or does it merely make individuals more accessible to forces exterior to them and which alone are the determining causes of the phenomenon?

To settle the question directly, the variations of suicide would have to be compared with those of neurasthenia. Unfortunately, the latter has not been statistically studied. But the difficulty may be indirectly solved. Since insanity is only the enlarged form of nervous degeneration, it may be granted without risk of serious error that the number of nervous degenerates varies in proportion to that of the insane, and consideration of the latter may be used as a substitute in the case of the former. This procedure would also make it possible to establish a general relation of the suicide-rate to the total of mental abnormalities of every kind.

One fact might lead us to attribute to them an undue influence; the fact that suicide, like insanity, is commoner in cities than in the country. It seems to increase and decrease like insanity, a fact which might make it seem dependent on the latter. But this parallelism does not necessarily indicate a relation of cause to effect; it may very well be a mere coincidence. The latter hypothesis is the more plausible in that the social causes of suicide are, as we shall see, themselves closely related to urban civilization and are most intense in these great centers. To estimate the possible effect of psychopathic states on suicide, one must eliminate cases where they vary in proportion to the social conditions of the latter; for when these two factors tend in the same direction

the share of each cannot be determined in the final result. They must be considered only where they are in inverse proportion to one another; only when a sort of conflict exists between them can one learn which is decisive. If mental disorders are of the decisive importance sometimes attributed to them, their presence should be shown by characteristic effects, even when social conditions tend to neutralize them; and, inversely, the latter should be unable to appear when individual conditions contradict them. The following facts show that the opposite is the rule:

1. All statistics prove that in insane asylums the female inmates are slightly more numerous than the male. The proportion varies by countries, but as appears in the table below, it is in general 54 or 55 for the women to 46 or 45 for the men.

		No. of men and women to 100 insane	
	Year	*Men*	*Women*
Silesia	1858	49	51
Saxony	1861	48	52
Wurttemberg	1853	45	55
Denmark	1847	45	55
Norway	1855	45*	56*
New York	1855	44	56
Massachusetts	1854	46	54
Maryland	1850	46	54
France	1890	47	53
France	1891	48	52

* As in Durkheim's original, though equaling more than 100 together.—Ed.

Koch has compared the results of the census taken of the total insane population in eleven different states. Among 166,675 insane of both sexes, he found 78,584 men and 88,091 women, or 1.18 insane per 1,000 male and 1.30 per 1,000 female inhabitants.[19] Mayr has discovered similar figures.

[19] Koch, *Zur Statistik der Geisteskrankheiten*, Stuttgart, 1878, p. 73.

There is the question, to be sure, whether the excess of women is not simply due to the mortality of the male being higher than that of the female insane. In France, certainly, of every 100 insane who die in asylums, about 55 are men. The larger number of women recorded at a given time would therefore not prove that women have a greater tendency to insanity, but only that, in this condition as in all others, they outlive men. It is none the less true that the actual insane population includes more women than men; if, then, as seems reasonable, we apply the argument from the insane to the nervous, more neurasthenics must be admitted to exist at a given moment among females than among men. So, if there were a causal relation between the suicide-rate and neurasthenia, women should kill themselves more often than men. They should do so at least as often. For, even considering their lower mortality and correcting the census figures accordingly, our only conclusion would be that they have a predisposition to insanity at least as great as that of men; their lower figure of mortality and their numerical superiority in all censuses of the insane almost exactly cancel each other. But far from their aptitude for voluntary death being either higher or equal to that of men, suicide happens to be an essentially male phenomenon. To every woman there are on the average four male suicides (Table IV, p. 19). Each sex has accordingly a definite tendency to suicide which is even constant for each social environment. But the intensity of this tendency does not vary at all in proportion to the psychopathic factor, whether the latter is estimated by the number of new cases registered annually or by that of census subjects at a given moment.

2. Table V shows the comparative strength of the tendency to insanity among the different faiths.

Insanity is evidently much more frequent among the Jews than among the other religious faiths; we may therefore assume that the other affections of the nervous system are likewise in the same proportion among them. Nevertheless, the tendency to suicide among the Jews is very slight. We shall even show later that it is least prominent in this religion.[20] *In this case accordingly suicide varies in inverse proportion to psychopathic states*, rather than being consistent with them. Doubtless this does

[20] See below, Bk. II, Chap. 2.

*Table IV** Share of each sex in the total number of suicides

	Absolute number of suicides		*To 100 suicides number of*	
	Men	*Women*	*Men*	*Women*
Austria (1873–77)	11,429	2,478	82.1	17.9
Prussia (1831–40)	11,435	2,534	81.9	18.1
Prussia (1871–76)	16,425	3,724	81.5	18.5
Italy (1872–77)	4,770	1,195	80	20
Saxony (1851–60)	4,004	1,055	79.1	20.9
Saxony (1871–76)	3,625	870	80.7	19.3
France (1836–40)	9,561	3,307	74.3	25.7
France (1851–55)	13,596	4,601	74.8	25.2
France (1871–76)	25,341	6,839	79.7	21.3
Denmark (1845–56)	3,324	1,106	75.0	25.0
Denmark (1870–76)	2,485	748	76.9	23.1
England (1863–67)	4,905	1,791	73.3	26.7

* According to Morselli.

not prove that nervous and cerebral weaknesses have ever been preservatives against suicide; but they must have very little share in determining it, since it can reach so low a figure at the very point where they reach their fullest development.

If Catholics alone are compared with Protestants, the inverse proportion is less general; yet it is very frequent. The tendency of Catholics to insanity is only one-third lower than that of Protestants and the difference between them is therefore very slight. On the other hand, in Table XVIII (see p. 108), we shall see that the former kill themselves much less often than the latter, without exception anywhere.

3. It will be shown later (see Table IX, p. 50), that in all countries the suicidal tendency increases regularly from childhood to the most advanced old age. If it occasionally retrogresses after the age of 70 or 80, the decrease is very slight; it still remains at this time of life from two to three times greater than at maturity. On the other hand, insanity appears most frequently at maturity. The danger is greatest at about 30;

*Table V** Tendency to insanity among the different religious faiths

	Number of insane per 1,000 inhabitants of each faith		
	Protestants	*Catholics*	*Jews*
Silesia (1858)	0.74	0.79	1.55
Mecklenburg (1862)	1.36	2.00	5.33
Duchy of Baden (1863)	1.34	1.41	2.24
Duchy of Baden (1873)	0.95	1.19	1.44
Bavaria (1871)	0.92	0.96	2.86
Prussia (1871)	0.80	0.87	1.42
Wurttemberg (1832)	0.65	0.68	1.77
Wurttemberg (1853)	1.06	1.06	1.49
Wurttemburg (1875)	2.18	1.86	3.96
Grand Duchy of Hesse (1864)	0.63	0.59	1.42
Oldenburg (1871)	2.12	1.76	3.37
Canton of Bern (1871)	2.64	1.82	. . .

* According to Koch, *op. cit.*, p. 108–119.

beyond that it decreases, and is weakest by far in old age.[21] Such a contrast would be inexplicable if the causes of the variation of suicide and those of mental disorders were not different.

If the suicide-rate at each age is compared, not with the relative frequency of new cases of insanity appearing during this same period, but with the proportional number of the insane population, the lack of any parallelism is just as clear. The insane are most numerous in relation to the total population at about the age of 35. The proportion remains about the same to approximately 60; beyond that it rapidly decreases. It is minimal, therefore, when the suicide-rate is maximal, and prior to that no regular relation can be found between the variations of the two.[22]

4. If different societies are compared from the double point of view of suicide and insanity, no greater relation is found between the

[21] Koch, *op. cit.*, p. 139–146.

[22] Koch, *op. cit.*, p. 81.

variations of these two phenomena. True, statistics of mental alienation are not compiled accurately enough for these international comparisons to be very strictly exact. Yet it is notable that the two following tables, taken from two different authors, offer definitely concurring conclusions.

Thus the countries with the fewest insane have the most suicides; the case of Saxony is especially striking. In his excellent study on suicide in Seine-et-Marne, Dr. Leroy had already observed the same fact. "Usually," he writes, "the places with a large number of mental diseases also have many suicides. However these two maxima may be completely distinct. I should even be inclined to believe that, side by side with some countries fortunate enough to have neither mental diseases nor suicides . . . there are others where mental diseases only are found." The reverse occurs in other localities.[23]

Morselli, to be sure, reaches slightly different conclusions.[24] But this is because, first, he has combined the insane proper and idiots under the common name of alienated.[25] Now, the two afflictions are very different, especially in regard to the influence upon suicide provisionally attributed to them. Far from predisposing to suicide, idiocy seems rather a safeguard against it; for idiots are much more numerous in the country than in the city, while suicides are much rarer in the country. Two such different conditions must therefore be distinguished in seeking to determine the share of different neuropathic disorders in the rate of voluntary deaths. But even by combining them no regular parallelism is found between the extent of mental alienation and that of suicide. If indeed, accepting Morselli's figures unreservedly, the principal European countries are separated into five groups according to the importance of their alienated population (idiots and insane being combined in the same classification), and if then the average of suicides in each of these groups is sought, the first table on page 23 is obtained.

On the whole it appears that there are many suicides where the

[23] *Op. cit.*, p. 238.

[24] *Op cit.*, p. 404.

[25] Morselli does not expressly say so, but it appears from the figures he gives. They are too high to represent cases of insanity only. Cf. the table given in Dechambre's *Dictionnaire* where the distinction is made. Morselli has evidently given the total of the insane and the idiots.

Table VI Relations of suicide and insanity in different European Countries

A

	No. insane per 100,000 inhabitants	*No. suicides per 1,000,000 inhabitants*	*Ranking order of countries for*	
			Insanity	*Suicide*
Norway	180 (1855)	107 (1851–55)	1	4
Scotland	164 (1855)	34 (1856–60)	2	8
Denmark	125 (1847)	258 (1846–50)	3	1
Hanover	103 (1856)	13 (1856–60)	4	9
France	99 (1856)	100 (1851–55)	5	5
Belgium	92 (1858)	50 (1855–60)	6	7
Wurttemburg	92 (1853)	108 (1846–56)	7	3
Saxony	67 (1861)	245 (1856–60)	8	2
Bavaria	57 (1858)	73 (1846–56)	9	6

B *

	No. insane per 100,000 inhabitants	*No. suicides per 1,000,000 inhabitants*	*Averages of suicides*
Wurttemburg	215 (1875)	180 (1875)	107
Scotland	202 (1871)	35	
Norway	185 (1865)	85 (1866–70)	
Ireland	180 (1871)	14	
Sweden	177 (1870)	85 (1866–70)	63
England and Wales	175 (1871)	70 (1870)	
France	146 (1872)	150 (1871–75)	
Denmark	137 (1870)	277 (1866–70)	164
Belgium	134 (1868)	66 (1866–70)	
Bavaria	98 (1871)	86 (1871)	
Cisalpine Austria	95 (1873)	122 (1873–77)	
Prussia	86 (1871)	133 (1871–75)	153
Saxony	84 (1875)	272 (1875)	

* The first part of the table is borrowed from the article, "*Alienation mentale*," in the *Dictionnaire* of Dechambre (v. III. p. 34); the second from Oettingen, *Moralstatistik*, Table appendix 97.

	Mentally alienated per 100,000 inhabitants	*Suicides per 1,000,000 inhabitants*
1st Group (3 countries)	from 340 to 280	157
2nd Group (3 countries)	from 261 to 245	195
3rd Group (3 countries)	from 185 to 164	65
4th Group (3 countries)	from 150 to 116	61
5th Group (3 countries)	from 110 to 100	68

insane and idiots are numerous, and that the inverse is true. But there is no consistent agreement between the two scales which would show a definite causal connection between the two sets of phenomena. The second group, which should show fewer suicides than the first, has more; the fifth, which from the same point of view should be less than all the others, is on the contrary larger than the fourth and even than the third. Finally, if for Morselli's statistics of mental alienation those of Koch are substituted, which are much more complete and apparently more careful, the lack of parallelism is much more pronounced. The following in fact is the result:[26]

	Insane and idiots per 100,000 inhabitants	*Average of suicides per 1,000,000 inhabitants*
1st Group (3 countries)	from 422 to 305	76
2nd Group (3 countries)	from 305 to 291	123
3rd Group (3 countries)	from 268 to 244	130
4th Group (3 countries)	from 223 to 218	227
5th Group (4 countries)	from 216 to 146	77

[26] We have omitted only Holland from the European countries reported upon by Koch, the information given concerning the intensity of the tendency to suicide there not seeming sufficient.

Another comparison made by Morselli between the different provinces of Italy is by his own admission very inconclusive.[27]

5. In short, as insanity is agreed to have increased regularly for a century[28] and suicide likewise, one might be tempted to see proof of their interconnection in this fact. But what deprives it of any conclusive value is that in lower societies where insanity is rare, suicide on the contrary is sometimes very frequent, as we shall show below.[29]

The social suicide-rate therefore bears no definite relation to the tendency to insanity, nor, inductively considered, to the tendency to the various forms of neurasthenia.

If in fact, as we have shown, neurasthenia may predispose to suicide, it has no such necessary result. To be sure, the neurasthenic is almost inevitably destined to suffer if he is thrust overmuch into active life; but it is not impossible for him to withdraw from it in order to lead a more contemplative existence. If then the conflicts of interests and passions are too tumultuous and violent for such a delicate organism, he nevertheless has the capacity to taste fully the rarest pleasures of thought. Both his muscular weakness and his excessive sensitivity, though they disqualify him for action, qualify him for intellectual functions, which themselves demand appropriate organs. Likewise, if too rigid a social environment can only irritate his natural instincts, he has a useful role to play to the extent that society itself is mobile and can persist only through progress; for he is superlatively the instrument of progress. Precisely because he rebels against tradition and the yoke of custom, he is a highly fertile source of innovation. And as the most cultivated societies are also those where representative functions are the most necessary and most developed, and since, at the same time, because of their very great complexity, their existence is conditional upon almost constant change, neurasthenics have most reason for existence precisely when they are the most numerous. They are therefore not essentially a-social types, self-eliminating because not born to live in the environment in which they are put down. Other causes must supervene upon their special organic condition to give it this twist and

[27] *Op cit.*, p. 403.

[28] Completely conclusive proof of it, to be sure, has never been given. Whatever the increase has been, the coefficient of acceleration is not known.

[29] See Bk. II, Chap. IV.

develop it in this direction. Neurasthenia by itself is a very general predisposition, not necessarily productive of any special action, but capable of assuming the most varied forms according to circumstances. It is a field in which most varied tendencies may take root depending on the fertilization it receives from social causes. Disgust with life and inert melancholy will readily germinate amongst an ancient and disoriented society, with all the fatal consequences which they imply; contrariwise, in a youthful society an ardent idealism, a generous proselytism and active devotion are more likely to develop. Although the degenerate multiply in periods of decadence, it is also through them that States are established; from among them are recruited all the great innovators. Such an ambiguous power[30] could not therefore account for so definite a social fact as the suicide-rate.

V

But there is a special psychopathic state to which for some time it has been the custom to attribute almost all the ills of our civilization. This is alcoholism. Rightly or wrongly, the progress of insanity, pauperism and criminality have already been attributed to it. Can it have any influence on the increase of suicide? *A priori* the hypothesis seems unlikely, for suicide has most victims among the most cultivated and wealthy classes and alcoholism does not have its most numerous followers among them. But facts are unanswerable. Let us test them.

If the French map of suicides is compared with that of prosecutions for alcoholism,[31] almost no connection is seen between them.

[30] A striking example of this ambiguity is seen in the similarities and differences between French and Russian literature. The sympathy accorded the latter in France shows that it does not lack affinity with our own. In the writers of both nations, in fact, one perceives a morbid delicacy of the nervous system, a certain lack of mental and moral equilibrium. But what different social consequences flow from this identical condition, at once biological and psychological! Whereas Russian literature is excessively idealistic, whereas its peculiar melancholy originating in active pity for human suffering is the healthy sort of sadness which excites faith and provokes action, ours prides itself on expressing nothing but deep despair and reflects a disquieting state of depression. Thus a single organic state may contribute to almost opposite social ends.

[31] According to the *Comte général de l'administration de la justice criminelle*, for 1887. See Appendix I.

Characteristic of the former is the existence of two great centers of contamination, one of which is in the Ile-de-France, extending from there eastward, while the other lies on the Mediterranean, stretching from Marseilles to Nice. The light and dark areas on the maps of alcoholism have quite a different distribution. Here three chief centers appear, one in Normandy, especially in Seine-Inférieure, another in Finisterre and the Breton departments in general, and the third in the Rhone and the neighboring region. From the point of view of suicide, on the other hand, the Rhone is not above the average, most of the Norman departments are below it and Brittany is almost immune. So the geography of the two phenomena is too different for us to attribute to one an important share in the production of the other.

The same result is obtained by comparing suicide not with criminal intoxication but with the nervous or mental diseases caused by alcoholism. After grouping the French departments in eight classes according to their rank in suicides, we examined the average number of cases of insanity due to alcoholism in each class, using Dr. Lunier's figures.[32] We got the following result:

	Suicides per 100,000 inhabitants (1872–76)	*Alcoholic insane per 100 admissions (1867–69 and 1874–76)*
1st Group (5 departments)	Below 50	11.45
2nd Group (18 departments)	From 51 to 75	12.07
3rd Group (15 departments)	From 76 to 100	11.92
4th Group (20 departments)	From 101 to 150	13.42
5th Group (10 departments)	From 151 to 200	14.57
6th Group (9 departments)	From 201 to 250	13.26
7th Group (4 departments)	From 251 to 300	16.32
8th Group (5 departments)	Above	13.47

The two columns do not correspond. Whereas suicides increase sixfold and over, the proportion of alcoholic insane barely increases by a

[32] *De la production et de la consommatian des boissons alcooliques en France*, p. 174–175.

few units and the growth is not regular; the second class surpasses the third, the fifth the sixth, the seventh the eighth. Yet if alcoholism affects suicide as a psychopathic condition it can do so only by the mental disturbance it causes. The comparison of the two maps confirms that of the averages.[33]

At first sight there seems to be a closer relation between the quantity of alcohol consumed and the tendency to suicide, at least for our country. Indeed most alcohol is drunk in the northern departments and it is also in this same region that suicide shows its greatest ravages. But, first, the two areas have nothing like the same outline on the two maps. The maximum of one appears in Normandy and the North and diminishes as it descends toward Paris; that of alcoholic consumption. The other is most intense in the Seine and neighboring departments; it is already lighter in Normandy and does not reach the North. The former tends westward, and reaches the Atlantic coast; the other has an opposite direction. It ends abruptly in the West, at Eure and Eure-et-Loir, but has a strong easterly tendency. Moreover, the dark area on the map of suicides formed in the Midi by Var and Bouches-du-Rhone does not appear at all on the map of alcoholism. (See Appendix I).

In short, even to the extent that there is some coincidence it proves nothing, being random. Leaving France and proceeding farther North, for example, the consumption of alcohol increases almost regularly without the appearance of suicide. Whereas only 2.84 liters of alcohol per inhabitant were consumed on the average in France in 1873, the figure rises in Belgium to 8.56 for 1870, in England to 9.07 (1870–71), in Holland to 4 (1870), in Sweden to 10.34 (1870), in Russia to 10.69 (1866) and even, at Saint Petersburg to 20 (1855). And yet whereas, in the corresponding periods, 150 suicides per million inhabitants occurred in France, Belgium had only 68, Great Britain 70, Sweden 85, Russia very few. Even at Saint Petersburg from 1864 to 1868 the average annual rate was only 68.8. Denmark is the only northern country where there are both many suicides and a large consumption of alcohol (16.51 liters in 1845).[34] If then our northern

[33] See Appendix I.

[34] See Lunier, *op. cit.*, p. 180 ff. Similar figures applying to other years are to be found in Prinzing, *op. cit.*, p. 58.

Alcoholism and suicide in Germany

	Consumption of alcohol (1884–86) liters per capita	*Average of suicides per 1,000,000 inhabitants*	*Country*
1st Group	13 to 10.8	206.1	Posnania, Silesia, Brandenburg, Pomerania
2nd Group	9.2 to 7.2	208.4	East and West Prussia, Hanover, Province of Saxony, Thuringia, Westphalia
3rd Group	6.4 to 4.5	234.1	Mecklenburg, Kingdom Saxony, Schleswig-Holstein, Alsace, Grand Duchy Hesse
4th Group	4 and less	147.9	Rhine provinces, Baden, Bavaria, Wurtemburg

departments are distinguished both by their tendency to suicide and their addiction to alcohol, it is not because the former arises from the latter and is explained by it. The conjunction is accidental. In general, much alcohol is drunk in the North because of the local rarity of wine and its cost,[35] and perhaps because a special nourishment calculated to maintain the organism's temperature is more necessary there than elsewhere; and on the other hand the originating causes of suicide are especially concentrated in the same region of our country.

The comparison of the different states of Germany confirms this conclusion. If they are classified both in regard to suicide and to alcoholic consumption,[36] (see above), it appears that the group showing most suicidal tendency (the third) is one of those where least alcohol is consumed. Genuine contrasts are even found in certain details: the

[35] The consumption of wine indeed varies rather inversely to suicide. Most wine is drunk in the Midi where suicides are least numerous. Wine is, however, not to be regarded as a guarantee against suicide for this reason.

[36] See Prinzing, *op cit.*, p. 75.

province of Posen is almost the least affected by suicide of the entire Empire (96.4 cases per million inhabitants), yet it is the one where most alcoholism is found (13 liters per capita); in Saxony, where suicide is almost four times as common (348 per million), only half as much alcohol is consumed. It is to be noted, finally, that the fourth group, that of the lowest consumption of alcohol, is composed almost exclusively of southern states. From another standpoint, if suicide occurs there less than in the rest of Germany, this is because its population is either Catholic or contains large Catholic minorities.[37]

Thus no psychopathic state bears a regular and indisputable relation to suicide. A society does not depend for its number of suicides on having more or fewer neuropaths or alcoholics. Although the different forms of degeneration are an eminently suitable psychological field for the action of the causes which may lead a man to suicide, degeneration itself is not one of these causes. Admittedly, under similar circumstances, the degenerate is more apt to commit suicide than the well man; but he does not necessarily do so because of his condition. This potentiality of his becomes effective only through the action of other factors which we must discover.

[37] To illustrate the influence of alcohol the example of Norway has occasionally been cited, where alcoholic consumption and suicide have shown a parallel decline since 1830. But in Sweden alcoholism has diminished also and proportionately, while suicide has continued to increase (115 cases per million in 1886–88, instead of 63 in 1821–30). The situation is the same in Russia.

To give the reader all sides of the question we must add that the proportion of suicides ascribed to occasional or habitual drunkenness by French statistics rose from 6.69 in 1849 to 13.41 per cent in 1876. But first, by no means all such cases are attributable to alcoholism properly so-called, nor must this be confused with simple intoxication nor frequentation of a bar. Whatever the exact meaning of these figures, moreover, they do not prove that the abuse of spiritous liquors plays a large role in the suicide-rate. Finally, it will be shown later why no great value can be attached to the information thus given by statistics concerning the presumptive causes of suicide.