

SUICIDE IN TOTAL INSTITUTIONS

by

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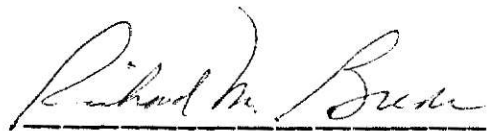
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"The experience of the individual in its exceptional character is the growing point of science, first of all in the recognition of data upon which the older theories break, and second, in the hypothesis which arises in the individual and is tested by the experiment which reconstructs the world."

(Mead, G. H. 1917:207)

I. THE PROBLEM

As a method for initially defining the problem of this paper, let us consider two very different demographic profiles of persons who have committed suicide. First, in the general U. S. population we find that the typical suicide case involves an over fifty year old white male, living alone, who has recently lost either a significant other or a job. It is quite likely that he has made previous attempts on his own life and that he chose a relatively violent method of self-destruction--use of a firearm, hanging, or jumping from a high place. (Farberow and Schneidmann, 1965:19-47) Second, the typical suicide case in U. S. jails shows the following profile: an under thirty year old black or white male, only recently incarcerated. Jail suicides typically choose hanging as the method of self-destruction. (Danto, 1973:19)

While these profiles suggest certain extreme comparisons possible between suicide cases in "free" society and "confined" society, profiles alone cannot evoke the whole picture. It is, for instance, startling to recognize that rate of suicide among prison inmates is three times the rate of suicide in the population at large; and in the age group twenty to twenty-five, suicide rates for prison inmates are five times the rate for the equivalent age group in "free" society. (Wilson, 1939:162-3)

These outstanding contrasts in suicide rates gave rise to the problem of this paper. If, as students of suicide

from Durkheim (1951) to Henry and Short (1957) to Martin and Gibbs (1964) have argued, suicide is to be explained by referencing the quality of the nexus existing between individuals and society, "something" about the quality of institutional confinement must produce high rates of suicide among persons who are confined. To a remarkable extent, suicide in confinement seems to occur at or very near the beginning of the confinement period. A study by Fully (1965) found that over a ten-year period 70 percent of the suicides among U. S. prisoners occurred within the first month of imprisonment!

As we began to explore the connection suggested by the above data, it gradually became clear that reported suicide rates were markedly higher for inmates of all sorts of total institutions* than rates for the general population; and the timing of suicide closely paralleled the findings of Fully. Consequently, our first task in this paper was to assemble all published sources on suicide in total institutions. Once assembled, we then sought to fit a sociological interpretation to those data to account not only for the higher suicide rate but also for the timing of suicide as a

*We are following the usage of the term total institutions suggested by E. Goffman who wrote, "A total institution may be defined as a place of residence and work where a large number of like-situated individuals cut off from the wider society for an appreciable period, together lead an enclosed, formally administered round of life." (Goffman, E. 1961:1)

life ending event within the context of institutional confinement.

Concepts, Tools, and Definitions

In order to help us deal with the problem and the way we intend to interpret the occurrence of life ending events by one's self, we will use some concepts we feel can help in understanding the act of suicide as it takes place in total institutions. These concepts are as follows:

- a. E. Durkheim--Anomic suicide
- b. A. Strauss--status-passage
- c. E. Goffman--moral careers
- d. N. Seligman--helplessness and hopelessness

A discussion of these concepts follows:

a. E. Durkheim ("Suicide: A Study in Sociology, 1951) introduced the concept of social integration and suicide: "suicide varies inversely with the degree of integration of the social group of which the individual forms a part." (p. 209) According to Durkheim, suicide is the result of society's strength or weakness of control over the individual. He posited three basic types of suicide, each a result of man's relationship to his society. In one instance, the "altruistic" suicide is literally required by society. Here the customs or rules of the group demand suicide under certain circumstances (i.e., Hara-Kiri). In this instance, the self inflicted death was honorable.

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"Egoistic" suicide--Durkheim second category occurs when the individual has too few ties with his community. Demands, in this case, to live do not reach him. Finally, Durkheim called "anomic" those suicides that occur when the accustomed relationship between an individual and his society is suddenly shattered. In this paper we are going to deal mainly with this type of suicide, as follows from the special kind of setting we are going to examine. Suicide is an individual act. We agree that one has to be in a unique, not fully understood, psychological and emotional state to commit this act; but outside factors play an important role in this act as well. Society--the environment around one--is the most important factor.

We adopt Durkheim's theory that societal ties are extremely important for human beings. In total institutions (concentration camps, jails, prisons, old age homes, mental hospitals, army, university), those ties are abruptly cut. Every aspect of everyday life is strange when compared to the outside world; as the person experiences anomie, some do not survive the experience.

b. Anselm Strauss' (Mirrors and Masks, 1969), discussion on status--passage might help us understand the importance of continuity in one's life:

Membership in an enduring group or social structure inevitably involves passage from status to status. In order that a group persist and flourish, each status must be filled, jobs must be done. . . . Many passages of status are highly institutionalized, so that individuals move through them in orderly sequence. Professional ranks in colleges and universities are an instance of such a step-by-step

progression, but so is the normal movement from bride to wife to pregnant mother to bear children. When movement is thus regularized, this means that there are predecessors and successors: people have been there before and will follow you. This gives continuity not only to the group or organization, but also to personal experience. In a host of ways, you are prepared for what is to come, are made aware of the immediacy of the next transition, are reminded that you have just now made a passage. (pp. 100-101)

The step-by-step way of life, in which one knows more or less what to expect, makes social life possible. We can get a idea of what happens when status passages are interrupted from Goffman's essay, "The Moral Career of the Mental Patient." (Asylums, 1961:125-169)

c. In this paper Goffman deals with two phases in the mental patient's career--the prepatient phase, the period prior to entering the hospital; and the inpatient phase, the period of hospital confinement.

First to understand what Goffman means by career:

"The concept of career . . . allows one to move back and forth between the personal and the public, between the self and its significant society, without having to rely overly for data upon what the person says he thinks he imagines himself to be. (p. 127)

I am suggesting that the prepatient starts out with at least a portion of the rights, liberties, and satisfactions of the civilian and ends up on a psychiatric ward stripped of almost everything. . . . The circuit of significant figures can function as a kind of betrayal funnel. Passage from person to patient may be effected through a series of linked stages, each managed by a different agent. While each stage tends to bring a sharp decrease in adult free status, each agent may try to maintain the fiction that no further decrease will occur. (p. 140)

In the conclusion of his paper, Goffman writes:

Each moral career, and behind this, each self, occurs within the confines of an institutional system, whether a social establishment such as a mental hospital or a complex of personal and professional relationships. The self then, can be seen as something that resides in the arrangements prevailing in a social system for its members. The self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it. . . . In the usual cycle of adult socialization, one expects to find alienation and mortification followed by a new set of beliefs about the world and a new way of conceiving of selves. . . . The moral career of the mental patient has unique interest . . . it can illustrate the possibility that in casting off the raiments of the old self--or in having this cover torn away--the person need not seek a new robe and a new audience before which to cower. Instead he can learn, at least for a time, to practice before all groups the amoral arts of shamelessness. (Asylums, pp. 168-169)

We suggest that some cannot survive the change in moral career that occurs when placed in institutions and, as a result, suicide as life ending event can occur.

d. Another theory to support our argument is presented by M. E. Seligman in his book, Helplessness--On Depression, Development, and Death (1975). Seligman discusses helplessness and hopelessness dimensions. "Helplessness is the psychological state that frequently results when events are uncontrollable" (Seligman, 1975. p. 9). As we learned from Struss and Goffman, men are socialized to live within a continuum of events, over which they must have some kind of control. Otherwise, they feel lost and helpless. When a course of events is uncontrollable (the outcome is independent of our voluntary responses), people feel

helpless and find it difficult to bear up under the situation. A factor related to hopelessness is unpredictability. In trying to explain the importance of predictability, Seligman writes:

In the wake of traumatic events, people and animals will be afraid all the time, except in the presence of a stimulus that reliably predicts safety. In the absence of safety signal, organisms remain in anxiety or chronic fear. . . . People and animals are safety-signal seekers: they search out predictors of unavoidable danger because such knowledge also gives them knowledge of safety. (1975, p. 113)

In our everyday lives, we rely on safety signals. Stress and uncertainty are inevitable in everyone's life; but in order for a person to live with a tolerable amount of stress, he must have some stability, predictability, and familiarity in his ongoing life. We suggest that in total institutions, one loses his ability to predict upcoming events and to control them by his own voluntary actions. Some cannot bear this burden, develop a state of chronic fear (anxiety), and embrace suicide. Institutional systems are all too often insensitive to residents' needs for control over important events in their lives. For instance, the usual doctor-patient relationship is not designed to provide the patient with a sense of control. The doctor knows all, and usually tells little. The patient is expected to sit back "patiently" and rely on professional help. Being institutionalized and stripped of control over even simple things, such as when you wake up and what clothes you may wear, may promote organizational efficiency;

but it does not promote mental health. This loss of control in institutions may further weaken a mentally ill person (or even a healthy one) and cause death, either by one taking his own life, or by sudden unexplained death as reported in studies done in institutional settings.

Type of Total Institutions

Since the paper deals with total institutions and suicide data derived from them, we would like to discuss briefly those social establishments. Our discussion relies on E. Goffman's essay, "The Characteristics of Total Institutions" (Asylums, 1961). According to Goffman, the total institutions of our society can be listed in five rough groupings:

1. There are institutions established to care for persons felt to be both incapable and harmless (homes for the aged).
2. There are places established to care for persons felt to be both incapable of looking after themselves and a threat to the community (mental hospitals).
3. There are institutions organized to protect the community against what is felt to be intentional danger to it (jails, prisons, p.o.w. camps, and concentration camps).
4. There are institutions purportedly established

to pursue some worklike task and justifying themselves only on these instrumental grounds (army barracks, boarding schools).

5. There are establishments designed as retreats from the world even while also serving as training stations for the religious (abbeys, monasteries, convents, and cloisters).

The central feature of total institutions can be described as a breakdown of barriers ordinarily separating three spheres of life--sleep, play, and work. In total institutions, all aspects of life are conducted in the same place and under the same single authority, with the immediate company of like-situated others. All the various activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution.

We should mention here the differences between the types of institutions have a lot to do with the willingness of a person to enter them, which is more often than not involuntary. Inmates see their time spent in the institutions as lost time and of no value to them; and yet when the time comes to leave, many experience deep anxiety. Goffman (1961) relates this release anxiety to two factors: one is discultination--"the loss or failure to acquire some of the habits currently required in the wider society;" A second is stigmatization--"when the individual has taken on a low proactive status by becoming an inmate, he finds a cool

reception in the wider world and is likely to experience this at a moment, hard even for those without his stigma (apply for job or place to live)." (p. 73) As with most events in total institutions which happen untimely, release is likely to come just when the inmate has finally learned to make out on the inside; and a result, release from an institution may present a breaking point to the individual and push him toward a suicidal act.

In the remaining sections of this paper, we will first present suicide data drawn from several different types of total institutions: concentration camps, jails, prisons, mental hospitals, old-age homes, armies and universities. We believe this to be an exhaustive compilation of studies, research reports and position papers on suicide in total institutions; and to our knowledge these sources have never before been assembled in one place. Second, we will offer a section devoted to sociological interpretation of suicide data previously discussed, relying on the concepts we have already presented. Finally, we conclude with a methodological note, in which we discuss problems of measurement and interpretation of suicide data.

II. PRESENTATION OF DATA

Since we are dealing with several kinds of total institutions, we will present the material according to a continuum of institutions, ranging from what we see as the most "total" of them all (concentration camps) to those with the least "total" characteristics (universities).

Concentration Camps

Concentration camps have so far been the closest total institution on earth to a perfect skinner box. (B. F. Skinner, 1971) They were a closed and completely regulated environment, a "total" world in the strictest sense of the word. Pain and death were the "negative reinforcers," food and life the "positive reinforcers;" and all these reinforcers were pulling and tugging twenty-four hours a day at the deepest stratum of human needs. No one knew exactly why one was brought in, for how long one would stay imprisoned, or if one would come out alive at the end. There was no set of known rules; the accustomed system of punishments and rewards experienced in free society underwent complete change; and every familiar everyday, normal life feature was disturbed. Death in concentration camps received a new meaning; and in understanding this, we can try to predict the attitude toward taking one's own life--suicide. According to E. Cohen (1953), "Death in a Nazi concentration camp requires no explanation, survival does." So all one has to do is "only to relax in the

struggle for survival to succumb rapidly." (Stangel, 1964) We are not arguing here that those individuals who simply stopped struggling for survival were suicidal, although life for them had lost all hopeful properties. One can even come to the conclusion that in the absolute absence of hope, hopelessness does not exist. B. Bettelheim (1960) writes,

In the extermination camps the prisoners were also deprived of anything that might have restarted self-respect or the will to live . . . all this may explain the docility of prisoners who walked to the gas chambers and who dug their own graves and then lined up before them. . . . It may be assumed that most of these prisoners were by then suicidal. . . . Psychologically speaking, most prisoners in the concentration camps committed suicide by submitting to death without resistance."

We feel that these extreme positions overlook the state of the victims and their mental and emotional situation at the time. There is no degree of intention in their activities. Motivation died in the camps. Nevertheless, suicide in concentration camps did occur.

According to C. Beaver, ("Suicide in Concentration Camps," in Death and the College Student, E. Shniedman (ed.), Harvard Press, 1972) we can distinguish between four types of suicide in the camps.

a. Set of suicides--those whose motivations result from the objective social circumstances. "Inmates committed suicide by severing an artery or running into the electrically charged wire." This kind of behavior is closest to what we call "institutional suicide," which we feel resembles Durkheim's "anomic suicide"--the drastic changes in social circumstances, leading the person to

engage in the extreme act. This display of behavior took place usually during the first few days after arrival in the camps.

b. Occasional suicide epidemics. In his book, "Treblinka," J. F. Steiner (1967) writes, "As a prelude to ultimate revolt against the captures and in an effort to unrest control over their lives from the Nazis, groups of prisoners killed themselves." We find an explanation for this kind of behavior given by A. Weisman (1972:) who wrote "For some . . . self destruction is a way to 'normalize' themselves, to feel in control, not enslaved, to attain consummation not extinction. And, in effect, to be wholly responsible." This explanation reflects the need for control over one's life and actions; and when no other way is available, one might turn to the only one left--self-destruction.

When there is no hope, as is the case in concentration camps, mass suicide may properly be seen as the only choice of resistance. In a state of hopelessness suicide may become a surrogate for murder, in this case, revolt against Nazis. "Suicide of whole groups and communities are known to have occurred in times of war and persecution, they were not due to simple initiation but to a collective refusal to survive. . . . Group suicide was a positive and intentioned act of defiance." (Stengel, 1964, p. 48)

c. Another group of people that could be considered suicidal are those who set a time limit for themselves

beyond which, in their opinion, there was no point staying alive, since from then on life would simply consist of being prisoners in the concentration camps. (Bettelheim, 1960) These people felt hopeless; it did not matter if one day in the future they would walk out from the camp, they knew in their hearts they could never overcome "being prisoners" in the camp. Here the problem of stigma is presented, only in this particular case, the actor attaches the stigma of incarceration to himself.

d. The fourth type of suicide Beaver lists is suicide caused by hunger. People gave up their food portion. Here the struggle for survival is lost, and one can again question the degree of intention. There is no resistance, only the cessation of motives to live. As been mentioned before, hope is a key factor in determining the individual's ability to continue existence under very adverse conditions. Hope manifested itself most basically as the belief that "Whatever is terrible will pass before I do." (Hentoff, M., "Wild Raspberries" N.Y. Book Review, April, 1969) Hope is defined in the phrase quoted as a belief that a positive aspiration will be fulfilled. This helps explain the almost mystical ability of prisoners to persevere. When an inmate could no longer have faith in the basic life aspiration, the result would be suicide.

Why in effect (as reported from eye witnesses) were there small numbers of suicide cases in the camps? E. Cohen has tried to deal with the question.

The adaptation to concentration-camp life and the residing in the 'realm of death' caused death to lose its terror, for death had become normal. This will also account for the quietness with which those prisoners who knew they were going to the gas chambers met their fate. . . . People as a rule will not resist the normal. (1953, p. 167)

When death loses its meaning, so does suicide. We must not overlook another aspect of suicide--suicide as a "cry for help." (Shneidman and Faberow, 1961) According to this view, people commit or attempt suicide not because they want to die but because they have no other way, or have failed in other ways to draw attention and to receive help from others. In concentration camps, suicide as an appeal for sympathy was ruled out; suicide as a cry for help would not be considered because of the unique nature of the place and the presence of death in everyday life. Also, suicide sometimes fulfills an escape function. In the camp this function ceased to exist; the only escape was to live. In his book, The Theory and Practice of Hell, E. Kogen (1953:132) describes an act which could be referred to as an heroic suicide (altruistic suicide according to Durkheim):

Once, a group of naked prisoners about to enter the gas chambers stood lined up in front of it. In some way the commanding SS officer learned that one of the women prisoners had been a dancer. So he ordered her to dance for him. She did, and as she danced, she approached him, seized his gun, and shot him down. She too was immediately shot to death.

Bettelheim writes about the incident:

Dancing made her once again a person. . . . No longer was she a number, a nameless, depersonalized prisoner, but the dancer she use to be. . . . Transformed, however momentarily, she responded like her old self, destroying the enemy bent on her destruction. (1953, p. 265)

Camp survivors' attitudes toward suicide can be found in N. Mandelstam's book, Hope Against Hope (1970).

Our way of life kept us firmly rooted to the ground, and was not conducive to the search for transcendental truths. Whenever I talked of suicide, Mandelstam used to say, Why hurry? The end is the same everywhere, and here they even hasten it for you. In war, in the camps, and during periods of terror, people think much less about death (let alone suicide) than when they are living normal lives. Whenever at some point on earth mortal terror and the pressure of utterly insoluble problems are present in a particularly intense form, general questions about the nature of being recede into the background. (p. 261)

We know that suicide did exist in the camps--both anomic and altruistic types. We do not have numbers at hand, and it would appear to be extremely difficult to try and distinguish between the types of death that took place in the camps--in terms of degree of intention. Referring to any behavior in the concentration camp, one has to keep in mind the nature of the situation and the unique struggle for survival that took place in them.

Prisons and Jails*

There are only a handful of studies which have dealt with suicide and suicide attempts in jails and prisons.

*There appears to be a methodological problem in discussing suicide rates in jails and prisons. Because of the special nature of the institutions--they aim to be "good" for their inhabitants as well as for society's protection--the prison management becomes very upset with prisoners trying to kill themselves; and in the event of successful suicide, they neglect in many cases to report it as such. From 1950 to 1969, in all federal prisons there were forty-one suicides

R. Esparza (1972) conducted a study at six county jails in a midwestern state from July to September of 1971. The jails were selected to represent a cross-section of both urban and rural settings. The investigator relied on the chief jailers to identify committed and attempted suicides, and other documents were furnished by state jail inspectors, probation officers, and the county coroner. The results of the study were analyzed and compared with three other studies that had investigated attempted and committed suicides in penal and "free" settings.

Esparza found that in terms of those who committed suicide, it appears that county jail prisoners tend to be single and kill themselves at a mean age of 28.8 years. This compares well with Danto's finding of 30.6 years for

recorded (Rieger, W. 1979). During this period, the average yearly census for the entire federal prison system was approximately 20,000, which would give an average yearly suicide rate for the federal prison system of 2.1 per 20,000, or 10.5 per 100,000. This low number of suicides is difficult to accept. The newly arrived federal prisoner is about 28.5 years of age, there is a 95 percent chance he needs medical care, and a 66 percent chance that the care he receives will be his first. He has a 5 percent chance of drug abuse, a 5 percent chance of having mental illness, and a 15 percent chance of having serious emotional problems; he will have an I.Q. which is average, and in 50 percent of the cases, he will have a prior conviction. (World Medical News, June 11, 1971:26-35) In light of such information, it is hard to see how a suicide rate in prison can be as low as officially reported. Fully et al. (1965:108-115) demonstrated that twenty prisoners among a population of 86 unsentenced prisoners committed suicide within the first twenty-four hours. Initial investigations show that suicides occur early in incarceration; hanging is the method of choice, and there is no direct or inverse relationship between length of sentence and suicidality. (Rieger, 1971)

jail suicides he studied and contrasts sharply with Shneidmann's finding of 49.2 years of age for suicides in other general population.

Committed Suicide: The most important finding of the study was the rate of committed suicide in the county jail. Rieger (1971) found, as already mentioned, that in the federal prison system there was a very low suicide rate, (10.5 per 100,000). In sharp contrast, the suicide rate in county jail per 100,000 inmates was 57.5. This is five times the rate in the federal prisons and it dramatically portrays the striking effects of the crisis situation of being a prisoner in a preconviction situation. The county jail rate is also approximately three times the 16-17 per 100,000 characteristic of the U.S. male population. (Hendin, 1967) Esparza also found that 67 percent of the prisoners committed suicide within the first twelve weeks of incarceration. (This is even higher than the 39 percent who committed suicide in the first four months in Rieger's sample (1979)).

Attempted Suicide: Attempted suicide in jails presents a different picture--the inmate is single, 23.9 years old (in the general U. S. population, the male who attempted suicide was approximately 37.7). As for the methods, all studies found that the younger the prisoner the less lethal the attempt. Here there is a sense of manipulation--methods chosen are cuts and drugs. The

racial breakdown of the group was 80 percent white and 20 percent black. This high ratio of blacks may be due to the high percentage of blacks who are presently jailed in the county system.

Again, as in the case of those who committed suicide, attempted suicides occurred within the first weeks of incarceration. In this study, eight inmates attempted suicide within thirty-six hours, and twenty-four prisoners within the first three weeks of entering the county jail.

What are some of the interpretations from this study? The results tell us that jail prisoners commit suicide at a rate five times the federal prison sample (Reiger, 1971) and about three times the rate for the general population (even with age adjusted). Possible causes for this can be suggested from a number of factors. As we have suggested before, some inmates cannot bear the tremendous sense of isolation and the lack of communication with their families and as a result get into a deep depressional states. This emotional climate is further intensified because of slow judicial procedures, and the prisoner chooses to end the uncertainty by suicide. In other instances, prisoners feel a great sense of helplessness as significant stresses such as divorce, births and deaths affect their lives. Suicide gives the inmate a controlled response to these events.

The fact that most attempted and committed suicides take place shortly after incarceration points out that the helplessness and depression feelings are at their peak in

the beginning of confinement, with the first shock of being thrown into an unknown world.

Another study was done by Jan Fawcet and Betty Morris. (1973) This study was conducted at the Cook County jail in Chicago. The findings (method, age, racial distribution, changes, timing of suicidal behavior, etc.) are all very similar to those found in other studies we have already examined. The unique feature of this study is interviews with inmates who made high intent suicide attempts. An example follows:

Case #2: A twenty-year old black youth . . . incarcerated on the charge of homicide for allegedly shooting a rival gang member. . . . On the first day in jail this young man was found hanging by the neck unconscious and was resuscitated before death. . . . During the interview he is saying that he started thinking he would have to spend the rest of his life in jail. He suddenly found himself hopelessly certain he would spend the rest of his youth behind bars. . . . This relatively minor challenge of his defenses appears to have exceeded his threshold for denial and led to a total hopeless state and an impulsive but serious suicide attempt. (Fawcet and Morris, 1973:92)

A common theme of deep concern in the interviews of inmates arrested for various serious crimes and residing at the county jail is the question of whether or not they have been rejected or forsaken by their parents, wives, girlfriends or other significant others. Feelings of isolation, helplessness and often hopelessness created by the inmate's isolation and loss of control over his situation make the experience of loss of support by significant other outside the jail especially intolerable. (Fawcet and Morris, 1973:94)

Again, one might look at what happens in jail situations that make suicide so likely for some inmates. This is a dehumanizing physical environment which no doubt enhances the feelings of helplessness and loss of control

over one's future. The experience in jail has a total effect of complete isolation of the individual from his social matrix. It is not difficult to imagine how the suddenness of the feeling of loss of control over one's life and future imposed by the situation of being arrested and incarcerated for a serious crime combined with the concomitant decrease in freedom of movement would in many individuals promote a feeling of total helplessness and hopelessness, which will drive them toward suicide. Let us look now on statistics from Austria. (Hans Hoff, 1965:204)

Table 1
Suicides and Attempted Suicides of Prisoners
in Austria from 1957-1964

Year	Suicides		Attempted Suicides		Prison Population
1957	4 p.	2 c.	33 p.	20 c.	8237
1958	4 p.	2 c.	18 p.	5 c.	8397
1959	6 p.	3 c.	16 p.	5 c.	8716
1960	4 p.	3 c.	17 p.	13 c.	9117
1961	4 p.	3 c.	22 p.	18 c.	9325
1962	5 p.	5 c.	17 p.	21 c.	9390
1963	3 p.	2 c.	17 p.	12 c.	8854
1964	6 p.	1 c.	21 p.	11 c.	8289

p--pretrial prisoners
c--convicts

Following are some facts derived from the table.

1. Suicide during imprisonment is relatively more frequent compared to the population as a whole. Austria has an annual average of 2.3 suicides per 10,000. The average for prisoners is 7.5, or more than three times as high.

2. The danger of suicide is greatest among pretrial prisoners, almost twice as many pre-trial prisoners as convicted prisoners took their own life.
3. The proportion of suicide to attempted suicide is interesting; it is at least one to four. In some years there were eight times as many attempted suicides as actual suicides. Most of the explanations given by the institutional correction system authorities are that suicide is just another violent act by inmates in prison: riots, homicide of peers and prison staff, etc.

We believe that this is not the right answer, and surely not the only one. Suicidal behavior in prison is not only a phenomenon of inmate violence, but is a result of the special setting in the correctional institutions and the feelings of helplessness and loss they impart to their inmate population.

If one tries to look objectively at the inmate's world, he will soon find that they are always losers no matter what way they choose to take. In prison if an inmate accepts the social group structure, he must accept norms which are foreign to those in the free community, foreign to those in which he was raised. If he isolates himself from the inmate social structure and lives with self-reliance, he might invite his own death, by other outraged inmates. On the other hand, if he joins inmate social groups and becomes one of the boys, in the eyes of the administration he becomes

"one of them." How can one deal with such conflicts? One of the ways of finding an exit is for some, suicidal acts.

Hospitals

a. Mental Hospitals

There was a runner there who hung himself up in the laundry room. I knew him and the reason he committed suicide was that he was white and homosexual. A lot of times the employees harassed him about it. . . . There were screens above the doorway of your room. Inmate patients tied the sheet right to it and would hang themselves. There were a couple of patients who were even touching the floor and hung themselves. To me, that means you are very determined to do something like hanging yourself. (Dan, 1973:276)

Mental hospitals are institutions where the people residing in them are supposedly there for their own good, to become better and normal persons again. The question is what is normal, and how do those that have the authority to decide know when one is well, when they often do not know what is wrong in the first place. Thomas Szasz is one of the critics of the mental health movement. In his book, The Manufacture of Madness (1970:53), he compared the practice institutional psychiatry to the inquisition.

One of the important differences between a person accused of crime and one accused of mental illness is that the former is often allowed bail, whereas the latter never is. . . . If the accused admits mental illness, he is hospitalized, often for life; if he denies it and is found to be sick in a sanity hearing conforming to all the requirements of 'due process,' he is committed to a mental hospital and treated against his will by any means necessary until he 'gains insight into his condition.'

I feel it is important to keep in mind the way most people

get into a mental institution (mainly by force) and the way they get out (when authorities decide they are "well" again) in order to understand the total feeling of helplessness in those places.

How wide spread is the problem of mental illness--the problem of placing people in mental hospitals? According to N. Kittrie (1973:54), the numbers are as follow:

Mental disorder is often cited as one of this country's most severe medical and social problems. An estimated 16 percent of the total population of America suffers from some form of mental disability or disturbances. . . . More than half of all hospital beds are occupied by mental health patients. . . . One out of every twelve Americans will require hospitalization for mental illness at some time in his life. There are approximately 3,000,000 people in the U.S. suffering from acute mental illness, 5,000,000 who are mentally deficient and some 15,000,000 with other serious personality disturbances. . . . Twenty-six persons out of every 10,000 Americans are found in public mental hospitals. Over 350,000 new commitments to mental institutions are made each year, more than three and a half times the number sentenced to state and federal prison. Over one million patients are on the books of the mental institutions, more than five times the number imprisoned.

All states have formulated criteria which designate certain people as mentally disordered and subject to commitment. Commitment describes the removal of a person judged to be mentally ill from his usual surroundings to the hospital authorized to detain him. In reality the mental hospital is a conglomerate multipurpose institution--a jail, a hospital, poorhouse, and an old people's home. It protects society from the dangerously insane, provides shelter and food to the feeble-minded and senile, treats all who can improve, and custodializes those who cannot. The mental hospital at

present has quite a role in our lives, but it seems that there is a little "too much" of a good thing. As it happens, all of us display disturbed and deviant behavior at times; and the danger of wrong diagnosis is always there.

In observing suicide behavior in mental institutions, we are presented with another difficult problem we have to try and keep in mind--quite a few of the patients might be there following a suicide attempt. For those who might try suicide again in the institution, the reason might be connected with the outside world more than with the total nature of the institution. On the other hand, the special nature of the place can intensify the person's hopeless situation.

Mental institutions, like other such establishments, find it hard to record suicidal acts taking place inside their walls and tend to blame the act on the patient's emotional and mental state, neglecting to consider at all the part the institutional setting might have in the attempted or committed suicides. Many of the studies dealing with suicide in mental hospitals hold similar views and neglect the part of the institutional surrounding.

In a typical study, (N. Faberow, et al., 1965:78-97), the authors conducted a study of suicidality in a mental institution. They found a high percentage of the committed suicides (70 percent) accounted for by those patients diagnosed as schizophrenics.

Schizophrenic patients who were in mental hospitals and

who committed suicide were by and large, persons who felt under stress. More than 70 percent had history of prior suicide attempts. The authors divided the experimental group into three groups which I find fascinating because it shows some relationship to the institution setting, although here the inability to leave the institution and face everyday home life is evident.

Three subtypes follow:

- a. The unaccepting patient (10)--want out; did not express feelings of guilt or inadequacy; 60 percent of those people had suicidal history.
- b. The dependent patient (12)--satisfied person; depended on the hospital; overly depressed and filled with anxiety and tension; expressed many feelings of guilt and inadequacy; previous history of suicidal activity or intention in 75 percent of the cases; suicide behavior on pass or trial visit (going home was described as the most stressful situation) occurred in 83 percent of these patients.
- c. The dependent, dissatisfied patient (8)--similar to the dependent, satisfied patient in realizing he was ill and needed hospital help; showed restless depressive tension; history of suicide in 87 percent of the cases; wanted help but came to feel that the hospital does not give him any; instead of becoming nonsuicidal in the hospital, this person became increasingly tense, depressed and attention-getting suicidal ideation

increased. Suicide in the hospital occurred in 75 percent of these patients.

Here we see some connection between the setting and suicide activity. (We have to keep in mind the small sample of the study.)

In their books, E. Stothland and A. Kobler (1964, 1965) present a history of a mental hospital. With regard to an outburst of suicide and suicide attempts, they write:

An epidemic of suicide can come about when the staff and inhabitants feel helpless and hopeless with the institution they run and live in. Crest (hospital) in its nine years of existence had experienced one suicide in May 1954 and very few patients had made severe suicidal attempts while at the hospital. Previous to the epidemic, the attitude of the staff, the nursing staff as well as the professional staff, had been one of confidence. (Kobler and Stothland, 1965:179)

The details of the epidemic are as follows:

Mr. Ullmans (a new patient) attempts suicide on December 23, 1959, after which the atmosphere of the hospital was redolent of anything but confidence. . . . On January 1, Mr. H. Einston, a man in his early 20's, who was out for New Year's Eve did not return; he was found dead in his car. . . . On Jan. 16, Mr. Oakson, a man in his early 60's, was discharged and killed himself nine days later. On Jan. 19, Mrs. Arlington strangled herself in her room on the closed ward of the hospital while on suicide precautions. (18)

What went on in the hospital while all this was happening?

The group of suicides, coming on the heels of conflict, hopelessness, leaderlessness, and helplessness was the crowning blow to the moral of the staff. Anxiety prevailed throughout the hospital. No formal attempt was made to deal with the anxiety, nor was there any formal discussion of the suicide. They were discussed informally, in whispers. Not until May did the professional staff meet for the special purpose of discussing the group

of suicides, and of considering the hospital's responsibility for them. (Kobler and Stothland, 1965:184)

In June, a Mrs. Irwin escaped and killed herself. In September 1960, the hospital was closed. The authors suggest that the hospital died due to hopelessness of the staff as an outcome of frustration and disbelief in the goals and ideology of the hospital, which in turn was transferred to the patients who as a result committed suicide at a rate that grew to the size of an epidemic.

N. Faberow, E. Shneidman and C. Neuringer studied case histories of patients who committed suicide. This study was a part of a larger program of investigation of the social and psychological aspects of suicide carried out by the General Research Unit of the Veterans Administration of the Suicide Prevention Center of Los Angeles. The task set for this study was to find any empirical relationships between a person's taking his own life and historical and/or hospital events in his life. From 438 cases, records of male hospital patients were examined. Of these 218 were records of mental hospital patients who committed suicide while on hospital rolls. These cases were compared with a control group of 220 patient cases who did not commit suicide.

Results: Of 218 suicides studied, 60 percent committed suicide while out of hospital (home visits).

Method: Forty percent committed suicide by hanging, 22 percent by gunshot, 10 percent by jumping from high places, 28 percent from others. Forty-one percent had made previous

suicide attempts. Fifty-four percent of the suicide cases were reported as being psychiatrically "improved" at the time of the suicide. Discharge plans were being made for 14 percent of the individuals who committed suicide. Thirty-seven percent had never been considered suicidal.

These results are interpreted in the same manner as in another study by Faberow and Shneidman. (1965:78-97) The authors look for answers in the patient himself rather than his surroundings. "The suicidal patient in a neuropsychiatric hospital seemed to be more seriously ill . . . with a history of acting out more often. . . . In his personality development, the suicidal person seemed to have been in closer and more intense relationships with other persons than the control. The patients in the suicide group seemed to have an extremely strong need to please, to conform, and to be liked, and much of their involvement and investment with others seemed based upon attempts to win approval and recognition." (Faberow and Shneidman, 1968:193-194).

We agree that there is a difference between suicidal and control individuals; but we suggest that those people that end their life in an institution might do so because they do not get the support and approval they need in order to survive.

b. Old Age Homes

When we talk about old age homes, we also refer to

geriatric wards in mental institutions where many old people are kept, not because they are mentally ill but because of the fact that there is no other place they could be kept. They simply have no where to go. Old age homes, referred to as nursing homes, are different from other institutions we talked about before in the sense that they are final--the last place of residence for a living human being. One knows that when he is placed there it is likely that he will leave only when pronounced dead. Here again, we find the motive of lack of control and feeling of helplessness and hopelessness. Although there is some predictability, you know that at some point in the near future your death is imminent.

Numbers of suicides in old age homes are impossible to collect. It seems that here the ability to detect the degree of intention is most difficult. The institutions themselves prefer to look at the incidents as a result of senility and lack of care on the part of the patient. One thing we do know from available statistics is that rate of suicide increases dramatically with increasing age. E. Payne (1975:291) writes:

While the elderly are most at risk from suicide, they are least engaged and benefit to the smallest extent from the therapeutic and succoring resources that are available in society. The reasons for this paradox are not clearly discernible. The explanation may lie in the nature of the suicidal process, in the nature of aging, or in the interrelation between the two. It may reflect the disengagement of the elderly from the social milieu, and their relative ineffectiveness in availing themselves of the resources in the environment.

For men below the age of forty, there are more than seven suicide attempts to every completed suicide, with an even higher proportion among women. This proportion of successful suicide increases with increasing age. Over age sixty, the ratio is reversed, and the number of completed suicides exceeds the number of suicide attempts. Among the group most vulnerable to suicide (the elderly white male), the proportion of accomplished to attempted suicide is over three times that for the entire population at the ages of sixty-three to sixty-nine, and over five times greater at age eighty-five. Below the age of forty-five, the percentage of successful suicides in each age group is less than that age group's attempted suicides. A suicidal attempt is more likely to be fatal in a man than in a woman. At age eighty-five the ratio of completed to attempted suicide is twelve times greater for men than for women. For both men and women, however, the rate of successful attempts increases with age, and the method employed becomes more violent. Older people more frequently resort to leaping from high places, drowning, hanging, and shooting than do the young. (Howells, 1975:293) From this profile what we see clearly is that in younger individuals a suicidal threat or gesture may frequently express a wish to manipulate or affect another person in an intensely ambivalent relationship; in the elderly, however, it indicates a much more unambiguous wish to die. The most important fact which increases suicide is loss. The older male, in particular,

has difficulty in adjusting to the loss of his spouse. The rate of suicide following divorce for both men and women is approximately 2.5 times greater than the rate of the general population. On the other hand, the rate is 3 to 5 times greater among widowed men but less than 1.3 times greater among widows. In contrast, elderly women who were always single are more vulnerable to suicide than men who never married. (Letteri, 1973:7-42) A person's vulnerability to suicide is highest in the first year after the loss of a spouse, but remains significantly greater for over five years. For the first four years of widowhood, the number of deaths from suicide exceeds the number of deaths from all other causes!

M. Lowenthal (1964) looked at the relationship between isolation and the development of mental illness in old age. She states that 17 percent of all admissions to the psychiatric screening wards of the San Francisco General Hospital during the year under study were sixty years of age or older. In conducting her study she observed a harmful behavior to the self or others in 21 percent of the admissions. Suicide attempts occurred in twenty-six out of 100 cases. According to other documents she analyzed, the majority of people attempting suicide were not overtly depressed until after some traumatic event took place. These events included illness, serious illness of spouse, retirement, and most frequently, death of a significant other. As there are no published numbers from old age

homes, we would like to present what the residents of those places feel about their situation. In his book, Living and Dying at Murray Manor, J. Gubrium (1975:199-202) recorded some of those feelings:

John Harady (resident): Lots of times, in my mind, I say it be better die. . . . Lots of time I think, 'Let me out, quick so I can go.' What use we all here? Bernice Hogan (resident) could we go on? There's no future. I just as soon die. I ask God to please take me home. What should I live for? Kids don't come to see me, we're all sick here. . . . All we have left to look forward to is the end. . . . Elizabeth Tanner (patient): There is no future for me. I have nowhere to turn, what would I look forward to? Just sitting here? There is no future in that. I just feel hopeless. . . . Laura Kowalski (patient): No future. Not now anymore. I used to have a future before I got here. Nothing in particular but I did love my home. I used to plan a lot what I would like to do. . . . But not now. I don't know I just feel that I am stuck here and that. . . . (weeps) I don't know what the future looks like. Betty White (patient): Well I don't see no future . . . just death.

Army

Army is a total institution, we feel, though for this unique establishment, L. Coser's (1974) definition of "greedy institution"* would perhaps be more appropriate. Goffman (1961) focuses on physical arrangements separating

*"Organizations and groups which . . . make total claims on their members and which attempt to encompass within their circle the whole personality." (Coser, 1974:4) In this paper, we are going to look into universities and army settings as well (student and soldier suicide). In connection with those establishments, we would like to discuss L. Coser's term "Greedy Institutions." (Coser, 1974) According to Coser, there are evident overlaps between "total" and "greedy" institutions; yet these terms denote basically different social phenomena. Goffman focuses on physical arrangements separating the "inmate"

the inmate from the outside world, while Coser (1974) shows that greedy institutions, though they may in some cases utilize the device of physical isolation (i.e., basic training in the Army), tend to rely mainly on nonphysical mechanisms to separate the insider from the outsider and to erect symbolic boundaries between them. Considering the special nature of this establishment, it is understandable that suicide rates are difficult to come by. Some armies neglect to collect this data and list the life ending acts as battle casualties (killed in action). Other armies collect the data but keep it to themselves. Nevertheless, there are some rates published.

Suicide rates among male personnel is lower than the corresponding rate in the male civilian population. During the 1954-1958 period, for instance, the military rate for

from the outside world, while Coser shows that "greedy institutions, though they may in some cases utilize the device of physical isolation, tend to rely mainly on non-physical mechanisms to separate the insider from the outsider and to erect symbolic boundaries between them. Nor are greedy institutions typically marked by external coercion. On the contrary, they tend to rely on voluntary compliance and to evolve means of activating loyalty and commitment. Greedy institutions aim at maximizing assent to their styles of life by appearing highly desirable to the participants. Greedy institutions are characterized by the fact that they exercise pressures on component individuals to weaken their ties, or not to form any ties, with other institutions or persons that might make claims that conflict with their own demands." (Coser, 1974:6) Members of greedy institutions must be fully and totally committed to them that they become unavailable for alternative lines of action. Greedy institutions are always exclusive. (Coser mentions the military as one American institution that has "greedy" characteristics.)

male personnel was 12.5 per 100,000 mean male strength per annum. (A review of the 1959-1964 suicide rate was 15.6 per 100,000.) However, any comparison between the military and civilian must be made with great caution, since there are differences in the age comparison of the two groups, and suicide rates vary with age. It has been observed that the suicide rates in civilian communities decrease in times of war. This was true in the U.S. during World War I in the years 1916-1920, and again during World War II in the years 1941-1945. The same phenomenon occurred in England, Germany, Australia, France, Italy, and even Japan during world War II and was not limited to belligerents but was also observed among nonbelligerent countries such as Sweden (Dulin, 1963). This trend has also been paralleled in the Army, as the table shows. There was a drastic drop in the suicide rate at the time of World War I (from 56.5 per 100,000 mean strength per annum in the 1910-1916 period to a low of 14.9 during World War I. The rate rose rapidly, reaching its peak in 1932 with a suicide rate of 50 per 100,000, when a steady decline began, which was hastened by World War II.

Table 2
Suicide Rates: U.S. Army Male Personnel
(by Rank and Selected Periods)

Period	Number Per 100,000 Mean Strength Per Year		
	Total	Officers	Enlisted
1910-1916	56.5	48.1	59.0
1917-1919	14.9	33.6	13.9
1920-1924	31.7	41.7	30.9
1925-1929	34.4	50.1	32.6
1930-1934	38.8	56.0	37.1
1935-1940	33.1	59.3	31.3
1941-1946	10.1	14.7	9.6
1947-1949	15.2	23.2	14.1
1950-1953	12.2	23.1	11.1
1954-1958	12.2	20.3	11.6

Source: B. Karpinos, unpublished data 1966 (in Resnik, 1968:244).

The overall suicide rate for World War II (1941-1946) was 10.1. There was again a slight rise in the suicide rates immediately after the World War II (15.2), followed by a less pronounced decline during the Korean War period (1950-1953). The suicide rate during the Korean War was 12.2 per 100,000 mean strength per year. This lower army suicide rate during wartime may have any number of dynamic factors apparent, such as the opportunity being present, directly or indirectly, to discharge aggression and hostility toward an actual or fantasied enemy or some externalized object without the need to utilize one's own person as the object of aggression. Another obvious aspect to be considered is the possibility of a number of "suicides" being "hidden" under the guise of battle

casualties (killed in action), either by direct or indirect action of the soldier himself. How much of the valor and sacrifice of battle, the seeking out of hazardous duty, and the like is really self-destructive behavior is very difficult to tell. (Also, in this connection we cannot overlook the altruistic type of suicide (where suicide is literally required by society--sending a soldier on a dangerous mission from which everybody involved, officers and soldiers, knows he is not going to return). Here the behavior is not self-destructive but an honourable self-inflicted death, which we regard as heroism.

It might be assumed, from the data we have, that in view of the lower army suicide rates in wartime, the suicide rate in places of combat is lower than in other areas. This was not the case, however, during the Korean conflict. During the years 1950-1952, the suicide rate was higher in Korea (17.2 per 100,000 per annum) than anywhere else in the army. This is not just a reflection of being overseas, because the total overseas suicide rates were only 13.4 during this period. Unfortunately, the available statistics do not permit any further analysis of this higher rate in Korea.

Consistent with findings regarding suicide elsewhere, the army data indicates an increase in the suicide rates with increasing age. In comparing suicide rates by age for males in the army (during the years 1950-1958) with those for male in the U.S. (1950), the parallel is striking. The

suicide rate for both groups increases from a rate of 7.0 or 7.5 per 100,000 per year for the age group 15 to 24 years to approximately 35 for the age group 45 to 54 years. Also to be noted is the fact that except for the years 1910-1916, the suicide rates among officers always have been higher than among army enlisted men. However, once adjustments are made for the differences in age composition between these two groups, the tendency to suicide is almost the same in the two groups. The suicide rate is higher for men with longer service. For example, during the years 1950-1952 the rate was 44.1 per 100,000 per annum for men with twenty years or more of military service, compared with the rate of six per 100,000 per annum for those with only one year of army service (Yessler, et al., 1960:612). Again, this is probably a reflection of the age factor,. In connection with the age factor a completely different picture was shown by OffenKrantz, et al., (1957) who looked at the psychiatric management of suicide problems in the military service. The method of the study was a comparison between suicidal and nonsuicidal groups. The results were as follow: The suicidal group was significantly younger than the control group. The majority were in the 20-25 age group, the mean age being 22.0 years of age. The population was predominantly caucasian. There were no differences in marital status, religious preference, and length of education. There was no significant difference in mode of entry into service. The suicidal group as a whole had less

time in the army. Comparison of military rank for both groups indicated an overwhelming predominance of privates, with a negligible number of commissional officers.

In a followup study, it was found that the study group was more frequently diagnosed as "character disorders" and "immaturity reaction," and were more likely to have received an other-than-honorable discharge.

M. Fisch (1954) studied 114 military patients hospitalized because of abortive suicide attempt. The study came about as a result of incidents in 1951 in the U.S. Naval Hospital, Philadelphia. One hundred fourteen patients carried out during hospitalization some acts definitely labeled suicidal and 117 others made threats or expressed conscious death wishes of varying intensity. Together, both groups represented almost 15 percent of all navy and marine patients admitted that year!

Of the 114, 96 tried to kill themselves before hospitalization, and 23 during hospitalization. The median age was 23. Only 23 out of 114 were above the grade of seaman in the navy, or private first class in the marines. Twenty-seven patients seemed to have a likelihood of genuine suicidal intent or a possibility of resulting death. The remainder employed rather stereotyped gestures of self-destruction, devoid of any wish to die or to inflict permanent injury. Only sixteen cases gave histories of similar acts in the past. One very interesting study about armed forces other than U.S. was found in E. Pozzi's study

(1975) of the Italian army. In his study the author looked at statistical differences in suicide rates between civilians and members of the armed forces in Italy. The study, as all other studies on the subject, is limited by lack of recent data. Suicide data presented are for the years 1911-1942 and are divided into "suicides" and "military suicides." The findings in general support other previous theories and indicate the particular sociological characteristics of military vs. civilian suicide. The primary group emerges as having an important influence upon the military. War tends to decrease suicide. Soldier suicide varies by month and season and by individual's position in the hierarchical scale of the military organization. Above all, the period of socialization and the intermediary functions between the military troop and institutional power emerge as crucial, highlighting the conflict between primary and power groups, between power and the common soldier. The conflict is sometimes overt, but always has potential political implications.

As we have seen, there is a noticeable difference between suicide rates in war and peace time. We would like to present two studies that deal with this particular question. S. J. Rojecmiwicz (1971) used official national and international statistics to dispel the theory that suicide rates are lower in wartime due to the legitimization of outward aggression. The hypothesis that suicide decreases during national wars is reflected by figures

showing a decrease for women, as well as for those living in neutral countries. World War II evidence from both occupied and neutral countries, together with fluctuations of the suicide rates among the Scandinavian countries, are better understood as reflecting the social conditions of wartime rather than the presence of actual fighting. These data and others point out that the decreased suicide rate during wartime is tied to the greater social integration, increased patriotism, ease of promotion, greater sense of purpose, etc., resulting from the state of war.

A more recent study was done by P. O'Mally (1975). The author used as a theory Durkheim's classic view which holds that suicide for egoistic reasons (i.e., distress) tends to be reduced during wars. Again the suicide rates in Australia during World War II were examined as a test case. Both territorial and logistic progress in the war correlate with suicide rate as expected, showing that threats produce lower suicide rate. Troop casualties are positively correlated with suicide rates. This is ambiguous because they also positively correlated with experienced military threats. During the first part of the war, suicide was more common when business was worse, and the relationship vanished after the war turned, suggesting a coincidental relationship. The data support involvement in integrative feelings rather than military action's economic effects as the means through which war reduces suicide.

When talking about statistics of suicide in wartime, we

have to keep in mind that the data may be influenced through the emotional factors governing judgment as to what is a suicide in general, and in a state of war, in particular. As a result of this difficulty, one cannot assume that the statistics given are fully accurate reflections of social reality.

Schools: College and University

The college student constitute a large segment of the population in late adolescence and early adulthood. At present there are more than five and a quarter million students enrolled in U.S. institutions of higher learning. Problems and emotional upsets are always part of the life of the college-age group. The triple pressure of college boards, parents, and the constant competition for grades is always present. For many, this is the first time they have left home and have to face everyday reality by themselves. With regard to suicide among college students, H. Hendin (1974:322-23) writes:

Suicide among young people and among college students in particular has been steadily and alarmingly rising during the past twenty years. Over 4,000 of the 25,000 annual suicides in the country are now in the 15-24 age group. The suicide rate for this group has increased over 250 percent in the past two decades, from 4.2 in 1954 to 10.6 in 1973 (rates are calculated by the National Center of Health Statistics per 100,000 of the age group). One of the most dramatic is the increase in the suicide rate of young men aged 15-24 which has gone from 6.7 in 1954 to 17.0 in 1973. As these figures show, the suicide trend was evident through the quiet 50's, persisted through the political activism

of the 60's and the many shifts in the drug culture, and continues on campuses today.

At many colleges and universities, suicide is the second most common cause of student deaths (accidents are the number one cause).

Physicians working in student health services have been impressed by the comparatively high incidence of mental illness. Although much of it has been of a trivial nature, some of it has been serious enough to lead to hospitalization or suicide. About 10 percent of students require professional psychiatric assistance (Blaine, 1971).

Several interesting studies of particular universities have been done. Temby's (1961) study revealed the suicide rate at Harvard to be approximately 1.5 for every 10,000 student per year. Pannell's (1951) study showed the incidence of suicide among Oxford undergraduates to be eleven times greater than a similar group in the general population; and 27 percent of Oxford undergraduate deaths were due to suicide. A similar occurrence was reported from Yale University by Parrish (1951) for the years 1920-1955, when suicide was the second most frequent cause of student deaths; and where suicide was the cause of 12 percent of all deaths. Rook (1959) studied a ten-year period (1948-1958) at Cambridge University and reported fourteen undergraduate suicides, giving a rate of almost two for every 10,000 students per year. Rook also mentioned that over a period of thirty-five years, there were 103 undergraduate deaths, including war deaths. Forty-one of these were due to

accident, 35 to suicide, and 27 to disease. A study with another dimension has been a systematic investigation of suicidal tendencies among college students (Braater, 1963). This study was done with student patients who visited the Mental Health Division of the Student Medical Clinic, Cornell University. Suicidal tendencies were present in 11 percent of the total case load: 68 percent of these suicidal patients showed only intellectualized concern, while 27 percent threatened suicide, and 5 percent actually made suicide attempts. Braater (1963) compared suicidal and nonsuicidal students (testing them with Minnesota Multiphasic Personality Inventory (MMPI) and the Mooney Problem Check List). He found that the most common demoninator for the suicidal group was emotional problem within the self-intrapsychic conflict. The suicidal patient in college is an angry, excessively dependent, and very unhappy individual. His anger often assumes the proportions of rage or intense hostility. "Acting out" to get his way is his common mechanism. He is often excessively competitive and ambitious, both in his work and interpersonal relations. His dependence upon others often becomes nearly unbearable during crises in love attachments and impending academic failure. Most often the suicidal person appears very unhappy and depressed; they hate themselves, as well as others, often display a more generalized self-destructive trend, both psychologically and physically (Faberow and Shneidman (1961) have called this the

"death trend"). Braater (1963) reminds us that for every completed suicide among college students there are fifty with suicidal tendencies that do not end with self-inflicted death.

Going back to Temby's study (1971) which was conducted at Harvard University, we found that the author did not notice a specific "suicidal personality" that would help to single out the student who is about to commit suicide. From the twenty suicides committed in Harvard in 1946, none were considered suicidal risk beforehand. As we mentioned before, the suicide rate at Harvard is approximately 1.5 for every 10,000 students per year, this is about 50 percent higher than the rate for the American population at large for this age group.

As we have seen from suicide data drawn from studies of the military, the suicide rate for college students was lower during wartime. In the four years the U.S. was at war (World War II), there was only one recorded suicide.

What do we see here in student suicide? For the student, the transition to college represents a sudden breakdown in the life he is used to, a loss of the traditions, controls, and ties of family life. This is especially difficult because it occurs in late adolescence when the tension between the struggle for independence and identity on the one hand, and the need to find guidance and group affiliations on the other, is often so great.

However, according to Temby (1971), most suicides did

change in milieu might be expected to occur. Of twenty-two undergraduate suicides, seven were freshmen; and of those, four committed suicide within three months after they entered school. Of twelve graduate students, only two took their lives within the first three months of their move to new surroundings.

It seems that here, not as in other total institutions, the immediate breaking of ties does not have the same effect on suicides; and other variables through the college years have significant effect as well. R. H. Seiden (1966) presented other findings. In his study he found that contrary to general belief, the greatest suicidal activity occurred during the beginning, not the final weeks of the semester, a finding which supports our assumption that sudden and dramatic change in one's life circumstances can bring about self-destructive behavior. Seiden feels that previous studies (Parrish, Braaten, and Temby) did not deal with an adequate baseline--a standard of comparison against which the diagnostic value of their findings might be judged. His study attempted to remedy this situation by applying a reasonable standard of comparison, namely the great majority of college students who do not commit suicide. Seiden's study involved a comparison of the sample of twenty-three University of California at Berkeley students who committed suicide during the ten-year period 1952-1961 with the entire UCB studentbody population during the same years. The results of the study are as follow:

suicidal students could be significantly differentiated from their classmates on the variables of age, class standing, major subject, nationality, emotional condition, and academic achievement. Compared to the student population at large, the suicidal group was older, contained greater proportions of graduates, language majors, and foreign students, and gave more indications of emotional disturbance. In addition, the undergraduate suicides fared much better than their fellow students in matters of academic achievement. The most significant finding concerned the time of suicide; this result challenges a frequently held belief about campus suicides. Academic folklore often explains student suicides as a response to the anxieties and stresses of final examinations. Yet, Seiden's data showed that almost the reverse relationship obtained. Only one of the twenty-three student suicides was committed during finals. Most of the suicides occurred at the very beginning of the semester. When the semester is divided into three equivalent parts, the majority of cases, sixteen out of twenty-three, are found to occur during the first six-week segment. No cases were found during the second six-week period, which includes the midterm examinations. Over the remaining third of the semester, there were seven cases, just one of which occurred during finals week itself. We see that the danger period for student suicide was found to be the start of the school semester, when change in the student life takes place. (It

is interesting to note that 50 percent of the suicides took place either on Monday or Friday.) Another interesting point is that during the free speech movement on the UCB (1965) campus, there was a striking drop in admissions to the student mental health service (20 percent below average) and no recorded student suicides during the 1965 academic year. This behavior corresponds to the drop in suicides during the war, which we noticed in other studies of the military and general population.

Ross (1969) believes that suicidal risk is recognizable, predictable, and preventable. In an attempt to find some suggestions and guidelines to improve the diagnostic, therapeutic and preventive management, Ross reviewed the American and English literature on the subject of college student suicide (including the studies we have cited from Harvard, Yale, and Oxford and Berkeley. He found that suicide has been responsible for as many as 50 percent of student deaths at the University of Michigan in 1934! In 1966 nearly 100,000 college students threatened suicide, of these, one in ten actually attempted suicide and 1,000 succeeded. Ross looked at factors leading to suicide as reported in these studies. One interesting factor not mentioned before is social isolation. In the English universities, the self-contained colleges at Oxford and Cambridge reduces social intercourse. At Oxford there is an air of detachment, with the customary tendency to limit social relations mainly to members of one's own college, the

attitude that regards emotional problems as matters not to be discussed, the very high academic standards and the various pressures they entail, and the instructional method, the ultimate consequence of which is that the student is alone in his academic studies and endeavors most of the time. Whilst the intellectual freedom of the older English universities may foster self-reliance, it may also lead to a sense of loss of direction and a feeling of inadequacy. We see here the effect of the institution on the individual and the way his feeling may be changed by the setting, which in turn, might lead him to self-destructive actions. Ross (1969:108-9) points out another factor in student suicide: "children of highly intellectual and highly ambitious parents form a higher percentage of students at Oxford and Cambridge, where suicide rates are the highest reported."

This finding brings us to Hending's (1975) writings about student suicide. He, too, found after six years of studying and treating over fifty students who attempted suicide that student suicide is strongly connected with parental pressure toward success and parental relations. According to Hending, what is crucial is the quality of feeling that flows between the student and parents. Suicidal students come from families in which the relationship between their parents and family life as a whole was essentially dead. Their sense of family life was rooted in this deadness and fixed in their perception of the parents as requiring their lifelessness. Many students in

college continued to use contacts with their parents to control their own enthusiasm and ensure their lifelessness. Elated by a new relationship, excited by school, they would call their parents when they were feeling best, knowing that their parent's lack of response would kill their mood. Being happy for those students meant giving up the past; giving up sadness meant relinquishing the securest part of themselves. Hending concluded that "what overwhelms these students is not simply grief over separating from a parent, but the fact that the separation constitutes an invitation to freedom." (1975-329) In a way this kind of suicide has to do with the nature of the setting and one's difficulty in adjusting to abrupt and sudden change in the passage of life, even if the passage is expected--going to college. It is still hard to make the transition and sometimes it is impossible to bear life's changes, thus driving one toward a life-ending act.

III. SOCIAL-INTERPRETATION OF THE DATA

We have before us suicide data from several types of total institutions. As we can see, there is evidence for connecting the different institutions with regard to suicide. The type of suicide in total institutions is mainly anomic--those suicides that occur when the accustomed relationship between individual and his society is suddenly shattered. We see the occurrence of this special type of suicide directly related to special characteristics of total institutions.

Upon entering institutions, the ties of individual to society and his everyday life are abruptly cut. As Goffman writes:

Total institutions do not really look for cultural victory. They create and sustain a particular kind of tension between the home world and the institutional world and use this persistent tension as strategic leverage in the management of men. (Goffman, 1961:13)

In addition to the abrupt changes, the individual in institutions has to engage in activity whose symbolic implications are often incompatible with his conception of self. An example of this kind of mortification occurs when the individual is required to undertake a daily round of life that he considers alien to himself--to take on a disidentifying role. In prisons, for example, the denial of heterosexual opportunities can induce fear of losing one's masculinity. (Sykes, 1958:63-83). In military establishments where patently useless make-work is forced on fatigue details can make men feel their time and effort

worthless. (Lawrence, T. 155:40) In religious institutions there are special arrangements to ensure that all inmates take a turn performing the more menial aspects of the servant role (The Holy Rule of Saint Benedict, ch. 35). An extreme is the concentration-camp practice, requiring prisoners to administer whippings to other prisoners. (Kogon, E. 1954:102) What we see here is not only the sudden and abrupt change of one's everyday life and social habits but, in addition, a set of new rules and new ways of living which stand in opposition to what is the "right" way to behave outside the institution.

On the outside, the individual can hold objects of self-feeling--such as his body, his immediate actions, his thoughts, and some of his possessions--clear of contact with alien and contaminating things. But in total institutions these territories of the self are violated, the boundary that the environment is invaded and the embodiments of self profaned. (Goffman, 1961:23)

One's very existence, the things we always take for granted in our everyday life, is completely different in total institutions. For example, look at this illustration from Chinese political prisons.

At some point in his imprisonment, the prisoner can expect to find himself placed in a cell with about eight other prisoners. If he was initially isolated and interrogated, this may be shortly after his first "confession" is accepted, but many prisoners are placed in group cells from the outset of their imprisonment. The cell is usually barren, and scarcely large enough to hold the group it contains. There may be a sleeping platform, but all of the prisoners sleep on the floor, and when all lie down, every inch of floor space may be taken up. The atmosphere is extremely intimate. Privacy is entirely nonexistent. (Hinkle, L. E. and Wolff, H. G., 1956:153)

We suggest that under those circumstances, total institution residents experience anomie. Some cannot handle the experience and as a result commit suicide. It can be argued that suicide is a means for regaining control over their lives.

Anomic suicide is the first thing we found in common in all types of total institutions. The second thing we found to be common is the timing of the suicidal act itself. A very large percentage of the suicides in total institutions we studied occurred upon entering (or shortly after entering) the institution, from concentration camps in which suicide usually occurred during the first few days, to jails and prisons where one study (Fully, 1965) showed that over a ten-year period 70 percent of the suicides among prisoners occurred within the first month of imprisonment (23 percent of all prisoners committed suicide in the first twenty-four hours of imprisonment). In another jail setting study (Danto, 1971), 67 percent of the prisoners completed suicide within the first twelve weeks of incarceration. As for schools, Seiden (1966) found that contrary to general belief the greatest suicide activity occurred during the beginning not the final weeks of the semester. In this study, 67 percent (16 out of 23) of student suicides occurred during the first six weeks of the semester.

The fact that most suicidal behavior occurred close to the person's entering of the institution points out the need for a close scrutiny of the general idea of status passages,

particularly as those passages are experienced and felt by institutionalized people. Total institution administrators are not completely unaware of the dramatic effect of status passages within their institutions. Much time, thought and planning is devoted to creating rituals and ceremonies surrounding the person's entrance, steady advancement or promotion, and termination points within the total institution. And from a logical-rational point of view, administrators say that life-phases within their institutions are socially integrated one with another. Concentration camp administrators stripped inmates, shaved their heads and disinfected them as preparation for entry into the camp; and grisly opportunities were held out as rewards for those inmates who would perform such distasteful duties as whipping, guarding and reporting on fellow inmates. Jailers and prison officers also strip-search newly arrived inmates, disinfect them, and give haircuts; and it is doubtful that any penal institution can operate for long without an elaborate informer system. Inmates, of course, come to expect prison term reductions in exchange for their cooperation. Now, these administratively planned status passages are not necessarily experienced by institution inmates as being socially integrated. On the contrary, the inmate is likely to experience such programmed passages as disjointed, unrealistic and Kafkaesque. We cannot be more precise at this point, owing to the nonexistence of a literature on incarceration as apperceived

by the inmate.

Helplessness and hopelessness feelings appear to be at their peak at the beginning of institutional confinement, with the first shock of being thrown into an unknown world. We believe that feelings of helplessness and the process of dehumanization take place throughout confinement and may continue after one is back on the outside as well. Yet the first shock, the lack of safety signals, and familiar rules make the first period of institution life extremely difficult for residents.

The recruit comes into the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. In the accurate language of some of our oldest total institutions, he begins a series of abasements, degradations, humiliations, and profanations of self. His self is systematically, if often unintentionally, mortified. He begins some radical shifts in his moral career, a career composed of the progressive changes that occur in the belief that he has concerning himself and significant others. (Goffman, 1961:14)

We suggest that some cannot go through the radical changes and do not survive the abasements and degradations they undergo in total institutions and, as a result, commit a self-destruction acts.

We are faced with an informational vacuum on person responses to institutional confinement. What we have found is widely scattered bits and pieces of information about confinement experience--anecdotes, survivor documents, autobiographies, and a few studies. We have found nothing approaching a full blown study of this much neglected

topic.

Consequently, our interpretation of suicide in total institutions is provisional, at best. We are no doubt raising more questions than are presently answerable. And that is good enough.

IV. METHODOLOGICAL NOTES

In his book, The Black Marble, J. Wambaugh describes how experts can distinguish between homicide, suicide, and death by natural causes based on their experiences in the field:

Like the old black woman they found decomposing in her bed . . . and the officer they got there discovered the glass was smashed out of a side window. And then he discovered a pane broken out of the back door. And then he discovered a burnt match on the back porch . . . burnt matches leading all over the house and finally into her bedroom, where the trail stopped. An there she was . . . Charlie took one look and said, No murder. No murder! they yelled. No murder? The house has been broken into. A burglar broke in and murdered her in her bed! Charlie got all the bluesuits together and showed them how it happened. (Wambaugh, 1979:353-354)

We see that experts, like coroners, medical examiners, police detectives, etc., can and do "discover" suicides. They use some methods for ruling out homicide and accidental death and ruling in suicide. Mistakes can, of course, be made as in any other human endeavor. We feel that in this subject, which is very unique and stigmatized by society, the problem of measurement is evident. We treat suicide numbers and rates with caution and in no way try to hold them as completely accurate, but only as the best there is at this point in time.

Let us look at the problem of suicide rates. The rate is the annual number of suicides in a population per 100,000 members. Expressed in a computational formula:

$$SR = (S/P) 100,000$$

where SR- is the rate

S^- is the number of suicides in the year, or the average annual number.

P^- is the population size or the average size over a period of years.

Given the above formula, it might appear that the interpretation of a suicide rate poses no problem. However, such is not the case. Virtually all rates should be interpreted with caution and skepticism because there are at least four reasons to question the reliability of official statistics on suicide (the primary source of research data). According to S. Labovitz (1968:57-73), the four reasons are as follows. First, where suicide is socially and/or legally disapproved, official statistics probably underestimate the number of cases. Second, even if no one attempts to conceal the cause of death, suicide can be difficult to distinguish from an accident or homicide (although we argue that it is done, usually successfully by experts). Third, physicians or coroners typically make the official decision as to the cause of death may not employ the same definition of suicide.* (Physicians and/or coroners may not agree in

*The problem of definition is very difficult in the subject of suicide and is extremely hard to solve, based on wide variability in conceptions. One definition is Shneidman's (1976); "Suicide always involves an individual's tortured and tunneled logic in a state of inner-felt, intolerable emotion." Another definition is Durkheim's (1951): "Death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." The other definition is taken from the Encyclopedia Britannica (14th ed., 1973): "Suicide: the act of intentionally destroying one's own life."

their conceptions of suicide.) Fourth, the identifications of the individuals in a census may not be consistent with identifications on death records (i.e., the individual may be classified as a "farm laborer" in the census but as a "farmer" on his death record). Further, even if the census and vital statistics categories are comparable, the census figures that enter into the computation of a rate may not be reliable; and to that extent, the rate itself is not reliable.

For these reasons and others, in the study of suicide we should look for "relative reliability" (i.e., the degree to which the amount of error in rates is a constant from one population to the next). As far as variation in the rate is concerned, the central question is relative and not absolutely reliable. As far as what happens during the process of recording suicide and the difficulty sociologists and others dealing with these statistics have, we found Wilkins' (1967:286-298) explanation to be the best. Wilkins put it in a form of a figure. The three stages in the processes leading to suicide being recorded as such:

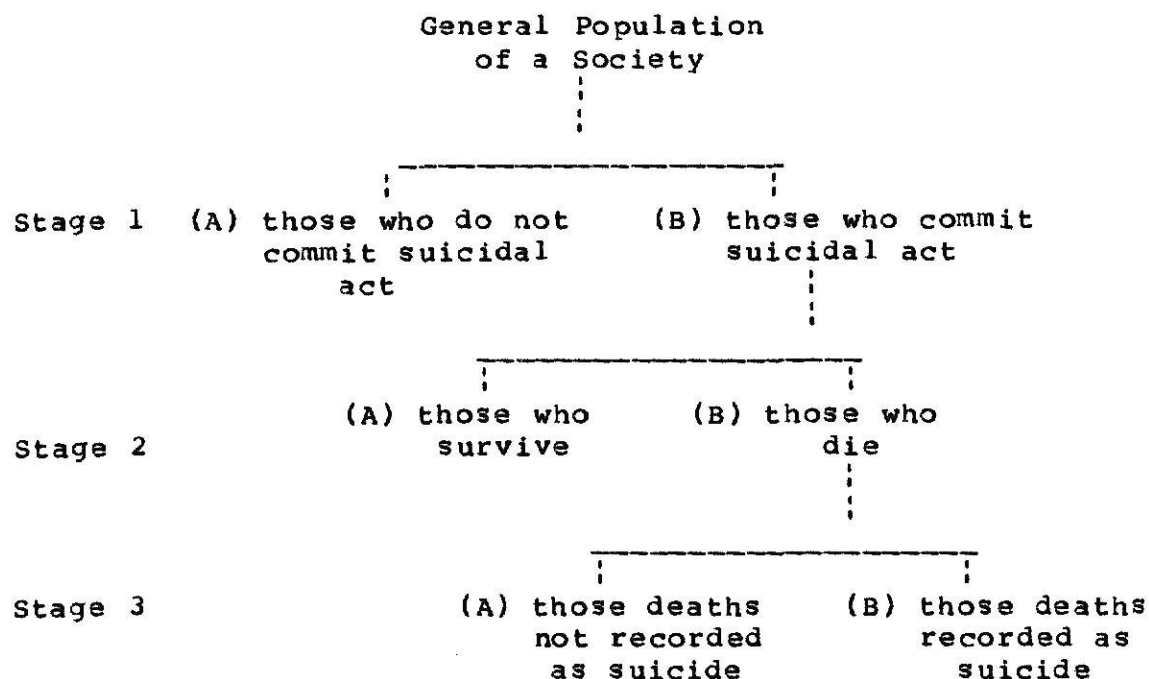


Figure 1
Stages of Suicide

According to Wilkins, in the past sociologists have been interested in the characteristics of population 2(B), and in comparing these with those of population 1(A), yet they have turned to population 3(B) for their data and have ignored the importance of the A/B differences at each stage.

Let us look at some of the demographic characteristics of suicide in the United States. (Shneidman, S. 1976:82-94) The most recent available suicide statistics in the U.S. are for the years 1969, 1970, 1971. There were totals of 22,364, 23,480, and 24,093 deaths in 1969, 1970, 1971, respectively which were coded to the categories of suicide and self-inflicted injuries. The increase in the number of

deaths in each successive year generally parallels the increases in the size of the population most susceptible to suicide.

Sex Differentials in Suicide: The most important and consistent differential to be found in suicide rates is between the sexes. The rate for males usually ranges from approximately 2 to 7 times greater than for females.

Table 3
Sex Differentials in Suicide

Rate of Suicide by Sex/Color				
Years	White Male	White Female	Non W/M	Non W/F
1967-1971	17.8	7.1	8.4	3.0

(Source: National Center for Health Statistics (rates for 100,000))

Age Differentials in Suicide: The second most important, and relatively consistent, pattern to be found in an examination of suicide rates is associated with age. The suicide rates of white males tend to increase directly with age, with the highest rates being found among the elderly. In contrast, the rate for white females increases until the ages 45-64, and then usually decreases slightly.

Table 4
Age Differentials in Suicide

Color/Sex	Age Group				
	15-24	24-34	35-44	45-54	55-64
White Male 1969-1971	13.8	19.3	23.0	29.0	34.9
White Female 1969-1971	4.2	8.7	12.9	13.8	12.2
Nonwhite Male 1969-1971	11.0	18.1	14.2	12.1	10.8
Nonwhite F 1969-1971	4.5	6.1	4.9	4.1	2.5

(Source: National Center for Health Statistics (rates per 100,000))

Recent attention has been focused on the relatively greater increases in the suicide rates of younger persons. There has been an increase of over 100 percent in the suicide rate of white males ages 15-24 between 1949-1951 and 1969-1971 and an approximately 50 percent increase for white males age 25-34 in the same time period.

Color differentials in suicide: For years, the notion was that the suicide rate for blacks is substantially below that for whites. Students of suicide ignored the variation in various parts of the country (nonwhite rates in the Northeastern region of the nation were relatively high and approximated that of whites). When a correction for underenumeration is made, the suicide rates of young white and nonwhite males are approximately equal among the

metropolitan population of N.Y. state.

Table 5
Suicide Rates by Color Male N.Y., 1960

Age	Whites		Nonwhites	
	Number of Suicide	Suicide Rate	Number of Suicide	Suicide Rate
15-24	42	5.8	5	5.9
25-34	85	10.5	17	16.1

Rural-Urban Differentials in Suicide: The existence of urban suicide rates that are higher than corresponding rural areas has become so traditional in the literature that this phenomenon has been used to explain other differentials in suicide (i.e., the low suicide rates of blacks in the South). This is no longer believed to be true, and data now demonstrates that males in rural areas have equal or slightly higher suicide rates than do those in metropolitan areas. Based on this and other findings, it is no longer correct to assume that there is an inherent relationship between urban living and high suicide rates. Nor can the assumption be made that ruralism necessarily implies the existence of low suicide rates.

Table 6
Suicide Rates by Place of Residence and Sex in U.S.
1960 (rates per 100,000)

Sex	Metropolitan	Nonmetropolitan Urban	Nonmetropolitan Rural
Male	17.5	17.8	17.6
Female	5.5	4.4	3.6

Source: National Center for Health Statistics (rates per 100,000)

Other Differentials in Suicide: Marital status--Married people have the lowest suicide rates. Those people who have never married have a lower suicide rate than those whose marriage has been disrupted, however, the rate for older white males who have never married approximates and even exceeds the rates for those who are widowed.

Migration--Since international migration probably represents the most drastic changes associated with moving, there exists the expectation that suicide rates of foreign-born would be substantially higher than those of native-born. This assumption is correct for females, although not to the expected degree. Native-born, middle-aged males have rates of suicide approximately equal to the age-comparable foreign-born males. The suicide rates for foreign-born are only higher than the native-born rates in the youngest and oldest age categories. This finding casts some doubt upon the thesis that suicide is directly associated with migration. It is more likely that there is an indirect relationship, i.e., there is a relationship

between suicide and other factors that are often associated with migration.

One important work we feel obligated to look into in connection with the methodology problem in the study of suicide is Jack Douglas's Social Meaning of Suicide, (1967). The general argument of this work is directed at what seems to the author at least to be the fundamental problems of sociology. Throughout the work Douglas tries to show that a long tradition (starting with Durkheim) has led sociologists to make certain largely implicit, unexamined assumptions concerning the ways we should go about empirically investigating and theoretically explaining suicidal actions, and, more generally, all forms of social actions. Douglas shows that what he called the statistical-hypothetical (found both in structural-functionalists and social system theories) approach fails to take into consideration the fact that social meanings are fundamentally problematic, both for the members of the society and for the scientists attempting to observe, describe, and explain their actions.

It is this failure to see that social meanings are fundamentally problematic that has led sociologists to ignore the actual nature of the official statistics on suicide, and it is this failure, combined with the consequent reliance on the official statistics, that has led to the failure to see the need for careful observations and descriptions of suicidal phenomena before attempting to explain the phenomena. And the failure to see social meanings as problematic has led sociologists to read into statistics whatever forms of meanings fitted their preconceived explanations. (Douglas, 1976:339)

Douglas distinguishes situated from abstract meanings. This action has significant implication for all investigations and analyses of social meanings, and therefore, according to Douglas, for all of sociology.

First, it is not possible to predict or explain specific types of social events, such as suicide in terms of abstract social meanings, such as abstract values against suicide. Second, it is not possible to study situated social meanings (e.g., of suicide), which are most important in the causation of social actions, by any means (such as questionnaires and laboratory experiments) that involve abstracting the communicators from concrete instances of the social action (e.g., suicide) in which they are involved. (p. 339)

Douglas suggests that those implications demand a fundamental revision of the methods and theories of sociology. What does Douglas offer for the future? He is looking for comparative descriptions of many forms of social action, then and only then one would be able to get on with the general task of constructing more abstract theories to explain social actions. M. Atkinson, (1971) examining Douglas's approach, concluded that Douglas tried to point out certain shortcomings of the Durkheimian approach, but neglected to overcome them.

Douglas's case for abandoning the traditional approach and focusing instead on the social meanings of suicide presupposes that his arguments against the use of official statistics are accepted . . . There is as yet no evidence suitable for making a decision about the appropriateness of the suicide statistics, and Douglas admits a need for such evidence. Until we have data of this kind, therefore, to reject the statistics is no more justifiable than to accept them. (Atkinson, 1971)

Atkinson feels that there is the constant danger of making similar errors to those made in previous sociological

works on suicide. Again the problem is how does one select indicators for concepts like "warning," "societal reaction," "intervention," "isolation," and perhaps most difficult of all, "suicidal act." How does one go about drawing samples from populations about which so little is known? Also, can one come to terms with the severe ethical and practical problems raised by the prospect of interviewing some of the people involved in the process? We feel that this problem is difficult to overcome and will always be present in any study of suicide due to the special nature of the phenomena.

How did I become interested in the subject of suicide?

Jack Douglas writes:

My first research experiences outside the books and the library happened inadvertently. While I was studying suicide, real people insisted on imposing their concrete realities on me--a friend attempted suicide, a student mother successfully used the student's attempted suicide to get her grade raised by threatening me in frightening detail with the responsibility for her life, a distraught mother wanted my help in getting the officials to recognize her son's death as homicidal rather than suicidal. (Douglas, 1976:X-XI)

In my case it happened the other way around--real people and their actions--got me interested in the topic of suicide. The interest, coupled by the feeling of desperation led me to examine the available material on the phenomenon when I started working as a probation officer in Tel-Aviv, Isreal (and like Douglas, away for the first time from books and theories). During the two-year period of my employment, I was startled to find that out of 100 people

that were under my supervision, 75 were engaged in some kind of self-destructive behavior (cutting, overdose of drugs). Of these about 35 were involved in serious suicide attempts, and one person actually killed himself. Each and everyone of my clients expressed at one time or another a desire to kill themselves. As I started asking other probation officers in the office (and looking through many past records), I found that my caseload was by no means exceptional. The problem was wide spread. Since I stumbled into the subject of suicide all too often in my work, especially in connection with first confinements, I decided to look for research on suicide as a life ending event. Not reading about it during my school years, I naively figured I have been reading the wrong books. As I was reading through the material, I realized that this was not the case. The material available is scarce and does not cover the scope of the problem at all.

REFERENCES

1. Alvarez, A. 1970. The Savage God--A Study of Suicide. Bantom Books.
2. Bettelheim, B. 1960. The Informed Heart-Autonomy in a Mass Age. The Free Press.
3. Blaine, G. B. and McArthur (eds.). 1971. Emotional Problems of the Students. Appleton-Century-Crafts. N.Y.
4. Braaten, L. J. 1963. "Some reflectins on suicidal tendencies among college students." Ment. Hyq. 47:562.
5. Cohen, E. 1953. Human Behavior in the Concentration Camp. Norton, N.Y.
6. Coser, L. A. 1974. Greedy Institutions--Pattern of Undivided Commitment. The Free Press.
7. Danto, B. L. (ed.). 1973. Jail House Blues--Studies of Suicide behavior in Jail and Prison. Epic Publications.
8. Douglas, J. 1967. The Social Meaning of Suicide. Princeton University Press.
9. Douglas, J. D. 1976. Investigative Social Research. Sage Publication.
10. Dublin, L. I. 1963. Suicide--A Sociological and Statistical Study. N.Y. Ronald.
11. Durkheim, E. 1941. Suicide--A Study in Sociology. The Free Press, N.Y.
12. Faberow, n. L. and Shneidman, E. S. 1965. The Cry for Help. McGraw-Hill, N.Y.
13. Fisch, M. 1954. "The Suicidal Gesture: A Study of 114 Military Patients Hospitalized Because of Abartime Suicide Attempts." The American J. of Psychiatry. 111:33.
14. Gibbs, J. (ed.). 1968. Suicide. Harper and Row publishers.
15. Giddens, A. (ed.). 1971. The Sociology of Suicide. Frank Cass and Company.
16. Goffman, E. 1961. Asylums. Anchor Books.

17. Gubrium, J. F. 1975. Living and Dying at Murry Manor. St. Martin's press.
18. Hendin, H. 1967. "Psychiatric Emergencies." In Freedman A., and Koplan, H. (eds.) Comprehensive Textbook of Psychiatry. Baltimore, Williams and Wilkins Co.
19. Hendin, H. 1975. Age of Sensation. W. W. Norton, N.Y.
20. Hinkle, L. E. and Wolff, H. G. 1956. "communist Interrogation and Indoctrination of 'Enemies of State.'" Archives of Neurology and Psychiatry. LXXVI.
21. Hoff, H. 1965. Psychiatric Neural, Universitätsklinik. International Association of Suicide Prevention, Vienna, Austria.
22. Howell, J. (ed.). 1975. Modern Perspective in the Psychiatry of Old Age. Brunner/Mazel, Publishers, N.Y.
23. Kittrie, N. N. 1973. The Right to be Different. Penguin Book Inc.
24. Klagsbrun, F. 1970. Youth and Suicide: Too Young to Die. Pocket Books, N.Y.
25. Kobler, A., Stothland, E. 1964. the End of Hope. Free Press of Glencoe.
26. Kogon, E. 1951. the Theory and Practice of Hell. Heinz Narden, N.Y.
27. Kramer, M., Pollock, E. 1972. Mental Disorders/Suicide. Harvard University Press
28. Letteri, D. J. 1973. "Empirical Prediction of Suicidal Risk Among the Aging." J. Geriatr. Psychiat. 6, 1:7-42.
29. Lowenthal, M. F. 1964. Lives in Distress--the Paths of the Elderly to the Psychiatric Ward. Basic Books.
30. Lawrence, T. E. 1955. The Mint. Jonathan Cape, London.
31. Mead, G. H. 1917. "Scientific Method and Individual Thinkers." In Creative Intelligence: Essays in the Pragmatic Attitude. Henry Holt and Company, 175-227.
32. Offenkrantz, W., Church, E., and Elliott, P. 1957. "Psychiatric Management of Suicide Problems in Military

- Service." The American J. of Psychiatry. 114:33.
33. O'Mally, P. 1975. "Suicide and War." The British J. of Criminology. Oct., 15/4:348-359.
 34. Parnell, R. W. 1951. "Mortality and Prolonged Illness Among Oxford Undergraduate." Lancet. 1:731.
 35. Parrish, H. M. 1951. "Epidemiology of Suicide Among College Students." Yale J. Biology Med. 29-585.
 36. Pozzi, E. 1971. "IL Suicide FRAI Militari," (Suicide in the Military). La Critica Sociologica. Spring, 17:58-85, (Italy).
 37. Resnik, H. (ed.). 1968. Suicidal Behavior. Boston Little, Brown and Comp.
 38. Rieger, W. 1971. "Suicide Attempts in a Federal Prison." Arch. Gen. Psychiat. Vol. 24, pp. 532-535.
 39. Rojcewicz, S. J. 1971. "War and Suicide." Life Threatening Behavior. Spring, 1:46-54.
 40. Rook, A. 1959. "Student Suicides." Brit. Med. J. 1:599.
 41. Ross, M. 1969. "Suicide Among College Students." American J. of Psychiatry. 126:220-225.
 42. Seiden, R. H. 1966. "Campus Tragedy: A Study of Student Suicide." J. of Abnormal Psychology. 71-389-399.
 43. Seligman, M. E. P. 1975. Helplessness--On Depression, Development, and Death. W. H. Freeman and Co.
 44. Shneidman, E. (ed.) 1972. Death and the College Student. Harvard Press.
 45. Shneidman, E. (ed.). 1967. Essays in Self-Destruction.
 46. Sheindman, E. S. (ed.). 1976. Suicidology: Contemporary Development. Grure and Stratton, N.Y.
 47. Stengel, E. 1964. Suicide and Attempted Suicide. Baltimore, Penguin Books.
 48. Stothland, E. and Kobler, A. 1965. Life and Death of a Mental Hospital. U. of Washington Press.
 49. Strauss, A. L. 1969. Mirrors and Masks. The Sociology Press, San Francisco.

50. Sykes, Gresham, M. 1958. the Society of Captives. princeton University Press.
51. Szasz, T. 1970. The Manufacture of Madness. Harper and Row Publishers.
52. Wambaugh, J. 1979. The Black Marble. Dell Books.
53. Wilkins, J. 1967. "Suicidal Behavior." In American Sociological Review. Vol. 32, pp. 286-296.
54. Yessler, P. G., Gibbs, J. and Becker, H. A. 1960. "On the Communication of suicide Ideas: I. Some Sociological and Behavior Considerations." Arch. Gen. Psychiat. 3:612.

SUICIDE IN TOTAL INSTITUTIONS

by

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ABSTRACT

In this paper we looked into the material available on suicidal behavior in several types of total institutions (concentration camps, jails and prisons, mental hospitals, old age homes, army and universities). In the search for valid information on the subject, we were surprised to find how little has been done in this area in terms of research focusing on the setting (in this case, the total institution) rather than on the individual himself.

After examining the bits and pieces of information on total institutions, we feel that there is evidence for connecting the different institutions with regard to suicide. The type of suicide in total institutions is the first thing we found common in all types of total institutions we looked into. The second thing we found to be in common is the timing of the suicidal act itself. A very large percentage of the suicides in total institutions we studied occurred upon entering (or shortly after entering) the institution.

We see the occurrence of this special type of suicide (anomic--those suicides that occur when the accustomed relationship between individual and his society is suddenly shattered) and the timing of the act as directly related to the special characteristics of total institutions. The fact that most suicidal behavior occurs close to a person's entering of the institution points out the need for a close scrutiny of the general idea of status passages, particularly as those passages are experienced and felt by

institutionalized people in total institutions. Helplessness feelings appear to be at their peak at the beginning of institutional confinement, with the first shock of being thrown into an unknown world. We suggest that some cannot go through the radical changes and do not survive the assessments and degradations they undergo in total institutions and, as a result, commit a self-destructive act.