**TEME**, г. XLVI, бр. 1, јануар – март 2022, стр. 321–334

Прегледни рад https://doi.org/10.22190/TEME210211018I
Примљено: 11. 02. 2021. UDK 179.7(4)
Одобрено за штампу: 31. 01. 2022.

# TRANSFORMATION OF THE CONCEPTUALIZATION OF SUICIDE THROUGH THE CENTURIES IN EUROPE

**Milena Ivanović**[*]

University of Belgrade, Faculty of Philosophy, Belgrade, Serbia

**Abstract**

In this paper we aim to acknowledge suicide both as a universality, omnipresent through various cultures and ages and always evoking potent reactions, as well as inspect its historical and geographical specificities. In particular, the historical transformation of discourse surrounding suicide in Europe is examined, including how judicial, religious, medical, psychological, literary, philosophical views, debates and writings on suicide have shaped the treatment of suicidality and the conceptualization of people with suicidal ideation. Parallels are drawn between past and current approaches to treatment and concerns regarding the depiction of suicide, while changes are examined within the context of and as a reflection of societal changes, both in terms of empathy and knowledge available, as well as grand social revolutions and dominant political regimes and orientations.

**Key words**: suicide, discourse, Europe, critical psychology, historical psychology

# ТРАНСФОРМАЦИЈА КОНЦЕПТУАЛИЗАЦИЈЕ САМОУБИСТВА КРОЗ ВЕКОВЕ У ЕВРОПИ

**Апстракт**

Циљ овог рада је препознавање самоубиства као универзалности, свеприсутне кроз различите културе и векове, која увек изазива моћне реакције, као и разматрање његових историјских и географских специфичности. Посебно се разматра историјска трансформација дискурса који окружује самоубиство у Европи, укључујући и то како су правни, религиозни, медицински, психолошки, књижевни, филозофски погледи, дебате и списи о самоубиству обликовали лечење суицидалности и концептуализацију особа са суицидалном идеацијом. Повучене су паралеле између прећашњих и садашњих приступа лечењу и брига у вези са приказивањем самоубиства, док су промене размотрене унутар контекста и као одраз друштвених промена, како у погледу емпатије и доступних знања, тако и у погледу великих друштвених револуција и доминантних политичких режима и оријентација.

**Кључне речи**: самоубиство, дискурс, Европа, историјска психологија, критичка психологија

[*] Аутор за кореспонденцију: Милена Ивановић, Филозофски факултет у Београду, Чика Љубина 18-20, 11000 Београд, Србија, milenaiva97@gmail.com

## *UNIVERSALISMS AND SPECIFICITIES*

Suicide – killing oneself. Ending one's own life. Or, as Émile Durkheim elaborated (1897), "Suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result" (Čartišvili, 2004: 27).

Across the globe and throughout centuries, suicide remains a universal constant. People have made the decision to end their lives because of harrowing life circumstances, grief, hopelessness, isolation, etc. The act of taking one's own life has never left the surroundings indifferent – matters of life and death are surrounded by rituals and practices that mark those events as extraordinary. Even cultures which see life and death not as severed, but as a cycle, mark birth and death and give them weight. It is no wonder suicide, as an extension of that, produces profound reactions. With early writings on suicide dating back to antiquity, voluntary death has been a subject of contempt, mockery, a cause for severe punishment of the deceased's family or a justification for the mutilation of the deceased's body. At times, suicide has been a call for deeper reflection, or has garnered admiration, when the act is assessed as admirable. Practices surrounding suicide vary by culture and time period – from its depiction as an act of heroism in Japan or encouraging sati – ritual self-immolation of widows on their husbands' funeral pyres in India – to a criminalization of suicide during the middle ages in Europe (Čartišvili, 2004: 93).

The problem is omnipresent, yet layered and complex. It is for this reason the field of interest is narrowed down to Europe, as historical transformation of attitudes towards and theories of suicide, as well as their impact on the treatment of suicidality, are examined in greater detail.

## *ANTIQUITY*

### *Greece*

Ancient Greece is the foundation and ammunition for future debates on suicide. With the exemption of soldiers and slaves, who were not free citizens or whose duties bound their lives to the state, suicide was not criminalized, given that it was committed with the state's agreement. Furthermore, Athens harbored poisons which, upon the senate's agreement, were distributed to those intent on ending their lives, making this a proto-euthanasia. The individual's deep entrenchment within the political life was further emphasized by punishments reserved for those who committed suicide without the senate's decision, via post-mortem disfiguration and mutilation of the body. Various schools of philosophy had their own views on the ethics and rationale of suicide, with Cynics in accordance with suicide when rational life was impossible, Epicureans believing in

life's value when it brings pleasure, and accepting suicide when displeasure outweighs it, to Pythagoreans, who opposed suicide on a mathematical basis, claiming the number of souls was finite, and by committing suicide, logos, a cosmic order would be disturbed (Minoa, 2008: 58).

Socrates's suicide marked Antiquity. According to Plato, Socrates believed a man should not kill himself, but when God gives him the sign to do so (Čartišvili, 2004: 136). Plato's vision originates from his specific position – he is against suicide, but must reconcile his views with his teacher's act. Plato bases his arguments against suicide on God's will, while Aristotle speaks of duty to society, and suicide robbing society of a useful member (Čartišvili, 2004: 137).

While still not connected with suicide, Hippocrates' four humors theory describes a personality type which will in the future be associated with suicide proneness. According to him, illness had natural causes, and was rooted in the imbalance of four humors coursing through human body – blood, phlegm, yellow and black bile. In the future, suicidality and dark thoughts would be associated with the excess of black bile within the medical discourse (Garrison, 1966: 62).

### *Rome*

The stoic belief that life should be dignified or not lived at all marked early Roman thought, which was applied to suicide of the elderly and political suicides. As stoicism waned and the Empire faced Barbarian attacks, the lack of manpower, and financial troubles, the criminalization of suicide and punishment via confiscation of the deceased's property arose as a convenient method of decreasing mortality and increasing the capital. This is merely among the first instances of criminalization of suicide in an effort to increase manpower in times of state instability, wars and revolutions, when staying alive and upholding order is seen as the duty of the people. During this period, Neoplatonism takes hold and declares suicide contrary to God's will, as he is the only one who has the power to take human souls – an early formulation of the Christian thought which would later spread across Europe (Minoa, 2008: 71).

## *THE MIDDLE AGES*

Christianity takes hold with the Milanese edict of 313AD, propagating benevolent treatment of Christians within the Roman empire. Uprisings and Barbarian attacks lead to the fall of the Empire in 476AD. Christian thought of the time was shaped by these circumstances – the lack of manpower due to wars, demographical and economic crises. Saint Augustine, similarly to the Neoplatonists, concludes suicide is contrary to God's will, and that "Thou shalt not kill" applies to killing oneself as well. Suicidal people doubt God's power and grace, and their heresy was

punished with body mutilation, public hangings, limb removal, burial away from sacred grounds. Eternal damnation awaited the suicidal in the afterlife, and property confiscation in this one. Condemnation is also the result of folk beliefs that the soul of the suicidal person remains in this world, enters its corpse and attacks the innocents. In 1274 Thomas Aquinas claims suicide is wrong on three bases: it is contrary to nature, which urges us to live, to God, who human lives belong to, and society, as it robs it of a useful member (Minoa, 2008: 46).

For the clerics, suicide is forgivable on the condition the person has lived an honorable life and has killed themselves because of a satanic possession. The main reasons of suicide, according to the church, is demonic possession and desperation caused by one's own sins – of particular interest since the person believes their own sins too great for God's grace. As a solution, greater belief in God and confession of sins are introduced. Until the 11th century, confession and forgiveness were separate, when they were unified so that sinners would not commit suicide between confession and forgiveness (Minoa, 2008: 48). To a degree, the church had the role of psychotherapy and conversation therapy would take on in the future (Kvale, 2003).

Regardless of the stigma, people of lower classes make up the majority of suicides during this period (Minoa, 2008: 27).

Many ancient texts were lost during this period, but some make their way to Europe in the 12th century via Constantine the African, a known translator of medical works from Arabic, Latin and Greek (Burnett & Jacquart, 1994: 39). Not long after, in 1265, Brunetto Latini uses the term *melancholia* to describe a form of insanity caused by the excess of black bile, an idea based on Hippocrates' four humors theory. Melancholia is characterized by dark moods, bursts of rage and thoughts of death, which may lead to suicide (Minoa, 2008: 53). This is the first attempt to medicalize suicide and present it as a chemical imbalance – something which will in the future be seen in serotonin and dopamine theories of depression and suicide, as well as psycho-pharmaceutical treatment.

## *RENAISSANCE*

Characterized by greater anthropocentricity, the Renaissance strengthens during the plague between 1348 and 1350, and focuses more on celebrating this life then preparing for the afterlife. A renewed interest in ancient texts arises, as does a questioning of traditional values of the church – regarding suicide as well (Tuchman, 1978: 130).

Desperation due to poverty and illness remain present in the working class, where suicide is most prevalent. Yet more members of noble families, which are exempt from such troubles, make the decision to end their lives, and duels become a common form of indirect suicide. Durk-

heim will later explain this phenomenon by lower social integration and looser ties within the upper class. Suicide is still criminalized, but punishments decrease in severity, as the elite attempts to present cases as accidents, preserve dignity and property (Minoa, 2008: 101).

The development of the press eases the distribution of anti-suicide texts. Suicide is still a sin among the clerical order, and some, such as Navarus, in 1581, speak of not only suicide, but the desire to have never been born as a sin (Minoa, 2008: 91). This is in accordance with modern passive suicidality, conceptualized as imagining one's own death without attempts to commit suicide, the desire to die or to have not been born (Falcone & Timmons-Mitchell, 2018). In literature, suicide is present in Goethe's *Faust*, with the titular character searching for absolute knowledge, which would equate him with God, and willing to end his life in the moment of absolute happiness (Čartišvili, 2004: 115). Hamlet's dilemma reaches wider audiences, and class discrepancies with regard to suicide are found in the line that Ophelia would not have been buried had she not been of noble descent (Minoa, 2008, p. 132).

The medicalization of suicide is present in many theories that develop. Melancholia is connected to suicide in 16$^{th}$ century, and Richard Burton analyzes melancholia in 1621, connecting it to the earth, Saturn, black bile. He claims certain people are more susceptible to it, but that socio-economic factors play a role in its development. He describes unease, fear, indecisiveness of sufferers, and how such confusion leads to thoughts of suicide. He advises treatment by music, fresh air, pleasant aromas, interest in diverse topics. He speaks of individualized therapy, claiming that isolated ought to socialize, while the sociable should have alone time, and opposes astrological explanations and exorcism (Minoa, 2008: 122). Burton's approach is highly modern for the time period, and much more thn the treatments to come.

As of 1665 doctors suggest exempting those declared insane prior to suicide from punishments, and legislature would soon follow suit. Meanwhile, neurologist Thomas Willis offers a psychopathological theory of suicide, postulating an idea of a manic-depressive cycle, where melancholia transforms into rage and leads to suicide (Thomas & Grey, 2016). These ideas present suicidal people not as Satan's marionettes, but as those in need of treatment.

Considering that many doctors took black bile for the cause of melancholia and suicidality, treatment included restoring balance among juices circulating the body, be it by applying leeches, baths or traveling. In 1662, London, first blood transfusion took place in order to cure melancholic suicidality, which, supposedly, cured the patient completely (Minoa, 2008: 168).

As opposed to the Middle ages and ideas of demonic possession, Renaissance aims to comprehend how humans function, as well as their

predisposition to certain illnesses, which is something today's genetics would agree with. Thus, treatment lies within physiology.

## *ENLIGHTENMENT*

In the spirit of revolutions brought about by Newton's and Galileo's discoveries, Europe tends to base its knowledge on science and empirical evidence in the 17th and 18th century. Industrialization, work and control of the workers shape the everyday life. Secularization has changed public perception of suicide, presenting it not as a product of sin, but of illness (Zafirovski, 2011). David Hume's essay *On suicide* from 1770 played a role by refuting Thomas Aquinas's arguments that suicide is an attack on God (since he himself has created a suicidal person), society (nothing is violently taken, contribution to society simply ends), and is unnatural (as are ships and houses, and are used regardless). Philosophers were shunned as instigators of suicide, to which they claimed no texts would change the cause of suicide – suffering, physical or mental (Minoa, 2008: 290).

Perhaps these attacks were not baseless. The pathos of Sturm und Drang is reflected in Goethe's *Sorrows of Young Werther*, whose titular character commits suicide because of a misfortunate love. Soon, suicides among the elite begin showing elements of Werther's story, with the deceased in the same clothes as those worn by him, or with the same weapon, and with copies of the book upon the bodies of some (Minoa, 2008: 311). The book was banned in certain countries, and is paralleled by copycat suicides of today, and concerns regarding the portrayal of suicide in the media, as it may inspire those vulnerable (Devitt, 2017).

While fears of suicide because of pathos, ennui or unrequited love are reserved for the upper class, it is the lower class that comprises the majority of cases (Minoa, 2008: 288).

From a medical perspective, black bile theories are still prevalent. Voltaire suggests those affected wait a week until they make the decision and occupy themselves. Climate theories of suicide are a novelty of the era, with Madame de Staël claiming there are few suicides among Mediterranean people since they enjoy beautiful nature, while the English are affected by the ocean, whose fumes enter the body and soften the brain, predisposing it to madness and suicide (Minoa, 2008: 318).

Another practice which marked the time period was separating those declared insane from "normal people." First institutions, not completely medical nor judicial, where mentally ill, idle and criminals were placed, began opening in the 17th century. Industrialization placed great importance on the ability to work, and those institutionalized were characterized by their inability to do so – uncontrollable by the state and unable to contribute to capital amassment, they were separated lest they deter

others from doing their duties. Insanity was related to amorality (Foucault, 2008: 513), and declaring a suicidal person insane would lead to their institutionalization – it is claimed that 15% of Bedlam was populated by suicidal people. Philippe Pinel claimed that a number of those belonged to the clerical order, whose devotion to God led to abnegation. It is of note how the clerical order has transformed with industrialization and secularization, from those capable of giving forgiveness and alleviating suffering, to those susceptible to insanity themselves. The institutionalized needed to be surveyed and, where possible, their bodies and minds purified – suggestions of bath therapies get a cruel dimension, with the patients submerged in freezing water and their movement restricted (Foucault, 2008: 310). Negating mental aspects of *mental* illness is of note and relevant to the present, as psychiatric institutions of today see the patients' physical safety as a priority – accomplished by surveillance, and they are often given psychopharmaceuticals, without being offered psychotherapy (Awenat et al., 2018).

## *REVOLUTIONS AND THE 18TH CENTURY*

While the previous period was marked by tendencies to secure and develop kingdoms economically, the 18th century is marked by tendencies to establish liberty, equality, fraternity – with loyalty to newborn republics. Since the Bourgeois revolution, suicide is condemned harshly using Jean Jacques Rousseau's social contract as an argument. While previous establishments enslaved people, republics gave freedom and protection. The least citizens could give back were their contribution to upholding the republic – which would be impossible if they ended their lives (Minoa, 2008: 348).

Institutionalization lives on. Philippe Pinel writes in 1801 that suicidal people are of feeble spirit, with a sensitivity towards negative events, which increases their vulnerability. While he advocates for moral treatment in institutions, Pinel claims profound shocks have managed to cure those with suicidal thoughts – he speaks of people intent on drowning attacked by muggers who, faced with an existential threat, were rid of their intentions. This note strengthens purification therapies in institutions, and can be tied to convulsive shock therapies of the 20th century. Pinel also notes positive effects of alcohol and opioids on people with suicidal ideation – a statement pharmaceutical companies of today would likely agree with (Minoa, 2008: 367). During this period, it was claimed that too much freedom causes uncertainty and fear, and at times suicide, as well as that order and manners are necessary for good health, all in line with institutional practices. It was believed that establishing order and natural rhythm among the institutionalized would benefit their health, so

meal and sleep times were tightly scheduled and controlled. The mentally ill became someone in need of discipline (Foucault, 2008: 506).

Outside of institutions, statistics develop on foundations laid by Francis Galton and Karl Pearson. Except describing and classifying individuals, statistics dealt with the quantification of social phenomena, such as suicide. Discoveries that suicides peak between May and June, that more men and Scandinavians commit suicide inspired the key theory of suicidology – Émile Durkheim wrote his work *Suicide* in 1897. Durkheim sees suicide as a result of disturbances in social integration and moral regulation – no social integration would lead to egotistic, and excess integration would lead to altruistic suicide, while a lack of moral regulation leads to anomic and an excess of it to fatalistic suicide (Čhartišvili, 2004: 176). Egoistic suicide is caused by purposelessness and melancholia, when a person has no ties to those around them, and Durkheim ties it to higher levels of individuation, those who do not share traditional values and are robbed of social support. Altruistic suicide takes place when an individual places community's needs and values above their own. Societies with higher social integration might place great value on sacrifice for the community, for example, within the military (Thompson, 2007: 109) – one may note similarities to the situation in Japan mentioned in the introduction. As per moral regulation, transitions, revolutions, economic and moral instabilities lead to anomic suicide (Čhartišvili, 2004: 177), while rigid control and regulation, limitations which allow no personal freedom, lead to fatalistic suicide (Lester, 1991).

While supporting these ideas, sociologist Maurice Albwachs sees loneliness as the root cause of suicide, turning towards the individual (Minoa, 2008: 370).

## *20TH CENTURY*

Until the beginning of the 20th century, psychology had established itself as a science and gravitated from exploring stimuli to attempting to understand personality and psychopathology. While institutionalization is still present, it grows less sustainable because of funds necessary, and where possible, individual conversation therapies in community settings replace it (Fakhoury & Priebe, 2007).

Sigmund Freud's psychoanalysis and psychodynamic psychotherapy gained reputation by the time Freud attended a meeting on suicide in 1910, and he formulated his thoughts on the subject in his work *Mourning and melancholia* in 1917. Both mourning and melancholia are reactions to the loss of an object – be it a person or truly an object, but only mourning takes place within the conscious, and emotions towards the object are clear, which allows the mourner to recall events with the object and cut ties with it. In melancholia, the object is unconsciously internalized, its

significance so great it becomes a crucial part of the melancholic. If the object is lost or betrays the person, it becomes the target of intense negative emotions, such as aggression, rage, and hostility. According to Freud (1917), they cannot be directed to the now gone object, and are directed inwards – suicide comes as an attempt to destroy the internalized object (Clewell, 2004).

Another conceptualization of suicide of Freud's comes in the forms of eros and thanatos theory. Eros or libido is described as life energy, sexual instinct, or pleasure principle. This instinct is countered by destrudo, thanatos or death instinct. While psychological processes are characterized by tendencies towards experiencing greatest pleasure, certain behaviors – continuous recollections of trauma or self-harming behaviors of patients – cannot be explained by libido. These behaviors speak of repetitiveness of thanatos, its tendency to bring the organic back into inorganic, life into death. Suicide is seen as thanatos outweighing eros (Freud, Richards, & Strachey, 1991).

During the 1920s and 1930s, attempts to ease suffering by using pharmaceuticals become more common. From Sakel's use of insulin to induce shock in patients in 1927, shock therapy is established, taking on forms of convulsive and electroconvulsive therapy. Shock therapies were administered to psychiatric cases, among whom were people with recurrent suicide attempts. These practices can be traced back to Pinel's writings on beneficial effects of shock (Fink, 1984). While efficient short-term, shock therapy functions best paired with medication (Jelovac, Kolshus, & McLoughlin, 2013), and potential harmful effects, such as brain damage and memory loss, deterred doctors from administering it more frequently (Report on electroconvulsive therapy, 2002).

Melancholia, traditionally a main cause of suicidality, undergoes a transformation – Karl Kleist coins a term unipolar to differ constant dark moods from those in combination with manic symptoms, later to be known as bipolar disorder (Angst & Marneros, 2001), while it is described as depressive reaction in DSM-I of 1952. Another common explanation of suicidality, madness, becomes known as psychosis, and is managed with the use of psychopharmaceuticals (American Psychiatric Association, 1968). Medication allows patients to live in and contribute to a community, as deinstitutionalization grows more common (Priebe et al., 2005).

Sociological theories of suicide are refuted, with claims Durkheim's theories were based on incorrect data. Instead, individual explanations become more common, postulating genetics and psychological factors as crucial for susceptibility to suicidality. While genetics determine ease of adaptation to unfavorable circumstances, guilt, shame and inability to integrate facilitate suicide (Minoa, 2008: 371).

While European contributions are not insignificant, it should be noted psychology, as well as theories of suicide, develop more rapidly in

America during the 20th-century, and Europe is influenced by those ideas. As a reflection of greater individualism in America, theories focus on the individual as well. Karl Meninger sees every conscious behavior harming the individual as suicidal, and sees suicide as vengeance – aggression directed outward, guilt – directed inward, and depression – the desire for death (Čhartišvili, 2004: 186). Hopelessness and helplessness are crucial to other theories, such as Beck's (Green et al., 2015). Joiner highlights the individual's feelings are a burden, their isolation and lack of fear as components necessary to commit suicide (Joiner, 2015).

## *PAST AND PRESENT – AN EVALUATION*

Increased efforts to understand suicide, offer theories and formulate treatment methods, scientific contribution to the explanation of the phenomenon have influenced legislation. In case man himself is the proprietor of his own life, and not just its gaurdian until Gods and kings take it into their hands, he may make his own decisions about it – which is reflected in suicide laws. While no country will encourage suicide, it is not criminalized in Europe (Canick, 1997), and those who have endured unspeakable suffering will not be publically humiliated, nor will their mourning families suffer consequences.

As for the stigma which characterizes suicide and suicide attempts, while society has abandoned beliefs of satanic possession, taboos are still present. There is a profound evaluation of someone who overcomes something primal, programmed and unquestioned – survival instinct – as alien and other. People see suicide as a result of personal weakness and shortcomings, devalue people with suicidal evaluation, and are uncertain they could accept them as caretakers, teachers, or workers (Scocco, Castriotta, Toffol, & Preti, 2012).

Speaking of scientific findings and treatment practices, ideas have grown more complex from the past. Yet foundations from the past still remain – from accepting melancholia as a cause of affective instability and suicide, psychopathology is conceptualized as a chemical imbalance. While in the past an excess of black bile was seen as the root cause of suicide, nowadays insufficient activity of serotonin system is to blame (Karthick & Barwa, 2017). There are more efficient treatment approaches than baths and purification – medication helps those suffering to continue their lives in society, as opposed to being isolated and institutionalized. Regardless, suicide attempts are typically followed by an institutionalization, during which physical safety and medication take priority, with psychotherapy being rarer. Perhaps returning to the Middle ages confessions would not be regressive in this case, as those institutionalized can be open to conversation therapy (Awenat et al., 2018), if only as a way of creating

bridges towards society, family and friends, and gaining a support system, which they see as beneficial to their mental health (Lakeman, 2010).

What happens upon their return to society? To the unchanged circumstances which contributed to their suicide attempt, compared to which suicide appears a better option? Individualistic and genetic explanations are accurate in assessing some as more vulnerable, and that circumstances seen as insurmountable lead to their committing the act itself. It is certain those vulnerable will profit from therapy, but what are they empowered for? Are they desenzitized to stress which would rightfully render everyone hopeless? Many people cite a change of environment following their suicide attempt as significant contributors to their decision to live, with leaving environments which made them feel hopeless, such as unsafe family homes, a burden off their backs (Everall, Bostik, & Paulson, 2006). Therapy will not have the same effect on those to whom conversation itself represents creating ties to society, and on those whose existence and life circumstances are uncertain, whose family life causes pain and trauma. Individualistic approach assumes an empowered person will be ready to take on challenges, that they have someone and somewhere to return to – but historical overviews show lower classes consistently make up the majority of suicides. Therapists are rarely encouraged to question their patients' life circumstances, social, economic and family factors which contribute negatively to their wellbeing (Madsen, 2015). What if society truly does not ensure safety and satisfaction of basic needs, as social contract postulates? Isn't the pressure to lead a happy and fulfilled life despite all the terrible circumstances too much of a burden for one person?

## *REFERENCES*

Angst, J., & Marneros, A. (2002). Bipolarity from ancient to modern times: Conception, birth and rebirth. *Journal of affective disorders. 67*. 3-19. DOI: 10.1016/s0165-0327(01)00429-3.

American Psychiatric Assosciation. (1968). *Diagnostic and statistical manual of mental disorders (2nd Edition) (DSM-II).* American Psychiatric Association: Washington DC.

Awenat, Y.F., Peters, S., Gooding, P.A., Pratt, D., Nunez-Shaw, E., Harris, K., & Haddock, G. (2018). A qualitative analysis of suicidal psychiatric inpatients views and expectations of psychological therapy to counter suicidal thoughts, acts and deaths. *BMC Psychiatry, 18*, 334. DOI: 10.1186/s12888-018-1921-6.

Burnett, C., & Jacquart, D. (1994). Constantine the African and 'Alī ibn al-'Abbās al-Maǧūsī: The Pantegni and Related Texts. *Studies in Ancient Medicine, 10*. Leiden.

Canick S. M. (1997). Constitutional aspects of physician-assisted suicide after Lee v. Oregon. *American journal of law & medicine, 23* (1), 69–96. https://open.mitchellhamline.edu/facsch/150.

Čhartišvili, G. (2004). *Pisac i Samoubistvo* [Writer and Suicide]. Beograd: Informatika.

Clewell T. (2004). Mourning beyond melancholia: Freud's psychoanalysis of loss. *Journal of the American Psychoanalytic Association, 52*(1), 43–67. https://doi.org/10.1177/00030651040520010601

Devitt, P. (2017). 13 Reasons Why and Suicide Contagion. Scientific American. Obtained from: https://www.scientificamerican.com/article/13-reasons-why-and-suicide-contagion1/

Everall, R., Bostik, K., & Paulson, B. (2006). Being in the Safety Zone. *Journal of Adolescent Research, 21*. 370-392. DOI: 10.1177/0743558406289753.

Fakhoury, W., & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: Major changes in the provision of mental healthcare. *Psychiatry, 6*. 313-316. DOI: 10.1016/j.mppsy.2007.05.008.

Falcone, T., & Timmons-Mitchell, J. (2018). Suicide Prevention: A Practical Guide for the Practitioner.

Fink, M. (1984). Meduna and the Origins of Convulsive Therapy. *American Journal of Psychiatry, 141*(9). 1034-1041. https://doi.org/10.1176/ajp.141.9.1034.

Foucault, M. (2008). *Madness and civilization: A history of insanity in the Age of Reason*. London: Routledge.

Freud, S., Richards, A., & Strachey, J. (1991). *On metapsychology: The theory of psychoanalysis: Beyond the pleasure principle, The ego and the id and other works.* Harmondsworth: Penguin.

Garrison, F.H. (1966). *An Introduction to the History of Medicine*. Philadelphia: W.B. Saunders Company.

Green, K. L., Brown, G. K., Jager-Hyman, S., Cha, J., Steer, R. A., & Beck, A. T. (2015). The Predictive Validity of the Beck Depression Inventory Suicide Item. *The Journal of clinical psychiatry, 76*(12), 1683–1686. DOI: 10.4088/JCP.14m09391.

Jelovac, A., Kolshus, E., & McLoughlin, D. (2013). Relapse Following Successful Electroconvulsive Therapy for Major Depression: A Meta-Analysis. *Neuropsychopharmacology, 38*, 2467-2474. DOI: 10.1038/npp.2013.149.

Joiner, T.E. (2005). *Why people die by suicide*. DOI:10.2307/j.ctvjghv2f.

Karthick, S., & Barwa, S. (2017). A review on theoretical models of suicide. *International Journal of Advances in Scientific Research. 3*. DOI: 10.7439/ijasr.v3i9.4382.

Kvale, S. (2003). The Church, the Factory and the Market: Scenarios for Psychology in a Postmodern Age. Theory Psychol, 13(5), 579-603. https://doi.org/10.1177/09593543030135005.

Lakeman, R. (2010). What can qualitative research tell us about helping the suicidal person? *Nursing Times; 106*, early online publication.

Lester, D. (1991). Totalitarianism and Fatalistic Suicide. *The Journal of Social Psychology, 131* (1). 129-130. DOI: 10.1080/00224545.1991.9713831.

Madsen, O. J. (2015). Psychotherapists – Agents of change or maintenance men? In: I. Parker (Ed.), *Handbook of Critical Psychology*. London: Routledge.

Minoa, Ž. (2008). *Istorija Samoubistva: Dobrovoljna Smrt u Zapadnom Društvu* [History of Suicide: Voluntary Death in Western Society]. Novi Sad: Mediterran Publishing.

Priebe, S., Badesconyi, A., Fioritti, A., Hansson, L., Kilian, R., Torres-Gonzales, F., & Wiersma, D. (2005). Reinstitutionalisation In Mental Health Care: Comparison Of Data On Service Provision From Six European Countries. *BMJ: British Medical Journal, 330*(7483), 123-126.

Report on Electroconvulsive Therapy. (2002). Obtained from: https://assembly.state.ny.us/member_files/125/20020416/

Scocco, P., Castriotta, C., Toffol, E., & Preti, A. (2012). Stigma of Suicide Attempt (STOSA) scale and Stigma of Suicide and Suicide Survivor (STOSASS)

scale: Two new assessment tools. *Psychiatry Research, 200*(2-3), 872–878. DOI: 10.1016/j.psychres.2012.06.033.
Thomas J., & Grey I. (2016). From Black Bile to the Bipolar Spectrum: A Historical Review of the Bipolar Affective Disorder Concept. *Arch Depress Anxiety 2*(1). 10-15. DOI: 10.17352/2455-5460.000008.
Thompson, K. (2007). *Emile Durkheim*. London: Routledge.
Tuchman, B. (1978). *A Distant Mirror: The Calamitous 14th Century*. New York: Knopf.
Zafirovski, M. (2011). The Enlightenment and Its Effects on Modern Society. 10.1007/978-1-4419-7387-0.

# ТРАНСФОРМАЦИЈА КОНЦЕПТУАЛИЗАЦИЈЕ САМОУБИСТВА КРОЗ ВЕКОВЕ У ЕВРОПИ

**Милена Ивановић**
Универзитет у Београду, Филозофски факултет, Београд, Србија

**Резиме**

Самоубиство, попут других појава повезаних са животом и смрћу, од давнина заузима посебно место у друштвеном дискурсу. Иако виђено као индивидуални чин, дело појединца, самоубиство јесте предмет друштвене конструкције. Начин на који се самоубиство конструисало од антике до данашњице имало је утицаја на особе са суицидалним тенденцијама саме, њихову спремност да потраже помоћ, као и на то како ће особе које јесу починиле самоубиство бити виђене и друштву, шта ће се догодити са њиховим посмртним остацима, имовином, породицом. Иако ретко одобравано, самоубиство се историјски највише осуђује у периодима ратова, успостављања новог друштвеног уређења, у периодима када људство које би одржало друштво недостаје. Санкционисање самоубиства строже је уколико је државно уређење такво да људски живот представља као нешто што је неопходно сачувати за потребе владара или чиме располаже једино Бог, насупрот уређењима где је човек представљен као власник сопственог живота.

Античка грчка концептуализација самоубиства варира у зависности од филозофских школа, са толеранцијом према самоубиству када живот није достојанствен или не пружа задовољство. Римске идеје разликују се, нарочито узимајући у обзир чињеницу да је људство било неопходно за одбрану Царства, а животе није требало улудо трошити.

Средњовековно хришћанство самоубиство види као јерес, чин против Бога, природе, и друштва, и строго санкционише самоубице и њихове ближње. Ипак, кроз исповест нуди олакшање особама у болу.

Ренесансно интересовање за антику и преживљене страхоте нагоне већем вредновању живота, али и већем интересовању за смрт – загробни живот не види се као циљ, а човек полако овладава својим животом. Кроз ренесансу и просветитељство самоубиство се представља као медицински проблем, који, везан за тело, може бити решен деловањем на тело – суицидални пате од вишка црне жучи, за чији дисбаланс се нуде бројне медицинске интервенције.

Након великих револуција у 18. веку, традиционално праћених осудом самоубиства, 19. век са Диркемом и 20. век са Фројдом премештају проблем самоубиства на друштвени и психолошки план. Статистика је омогућила детаљније

разматрање ризичних група, периоде када су самоубиства учесталија, те типологију самоубиства у социјалном контексту. Психолошке теорије које их смењују и настављају да доминирају до данашњице нуде сопствене предлоге и решења – терапију разговором, употребу медикамената, поновно повезивање са заједницом.

Упркос новопонуђеним решењима, и данашње теорије остављају простора за побољшање. Иако су фактори ризика разматрани, шири социјални проблеми који доприносе очају суицидалних особа остају нерешени, а третиране су особе које су подстицане да исте трпе и са њима се херојски суочавају. Самоубиство је одувек представљало друштвни проблем, а пребацивање терета на индивидуу која је поклекла пред тешкоћама омогућава одржавање статуса кво.