

Beck

Shneidman

Joiner

Menninger

Leenaars

WHY DO PEOPLE KILL THEMSELVES? The Major Historical Theories of Suicidal Behaviour

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In his 1952 essay "The Myth of Sisyphus," the French novelist and philosopher Albert Camus wrote of the predicament of modern man and described him as an "absurd hero." Man is condemned - like Sisyphus in the Ancient Greek myth - to a life of futility that is devoid of meaning. He must push a heavy stone uphill, only for it to roll back down again once it reaches the top. This labour continues - up and down, up and down - forever.

It makes one wonder why this man does not choose to end his suffering? How can such a torturous life be endured?

Camus thinks that man has a noble soul, however, as one must possess a certain amount of nobility to struggle against this absurdity of existence. The author believes that life, no matter how seemingly bad it appears, can be lived with a full "heart" and with dignity (Camus, 1955/1991).

For many people this kind of suffering is not mere allegory; it is as real as pushing a rock. For them, the pain of living is too intolerable to endure, and the idea of suicide is not an existential, philosophical question or an academic exercise. For these people, suicide is **the only** answer.

"Deep emotional pain" is a recurring theme in suicide theory, and its debilitating presence has been called the "most common theoretical reason for suicide" (Selby, et al., 2014, p.297). The act of suicide is, however, far too complex to sum up in three brief words. Suicides are also extremely rare, and explaining and predicting them can be very difficult (Kastenbaum, 2003).

Theory, at its best, "is an important tool in transforming information into knowledge" (Makinen, 2009, p.139). Theoretical information needs to both explain a phenomenon and give practitioners the tools to work it into their practice. As suicidologist Antoon Leenaars wrote, theory must have "sound clinical utility" (1996, p.232). Both historical and modern day theories about why suicides happen give us a much better overall perspective and understanding of suicidal behaviour.

In the past century, theories of suicide have emerged across the academic spectrum, including, but not limited to, biology, medicine, social sciences, and the humanities. Because of this, suicidology has become a multi-disciplinary area of study. These different perspectives have allowed for different treatment strategies - pharmacotherapy, psychotherapy, and family therapy, to name a few - (Lester, 1994) and they have also helped us "identify key targets for the treatment of suicidality" (Selby, et al., 2014, p.297).

This issue of iE presents a brief review of suicidal theory, and focuses mostly on those formulated from a psychological or sociological perspective. Although this review is far from exhaustive, it will give the reader a glimpse of the various interpretations of suicidal behaviour that have formed from the late 19th century to the present day.

Baumeister

Durkheim

Hendin

Linehan

Freud



Durkheim and Sociological Theory

In 1897, Emile Durkheim - the founder of sociology - presented the first notable theory of suicide, which focused on suicide at a societal level. The key variables he identified were **social integration** and **social regulation**, and he examined how these variables played out in relation to the four types of suicide that he identified. The first type, **Egoistic** suicide, is seen in individuals who lack social integration and are detached from traditional social bonds or society. These people are also often isolated and lack a sense of belonging. **Altruistic** suicides - the second type - occur when individuals are *too* fully socially integrated, and, thus, they feel that their death would benefit society. Examples of altruistic suicides could include kamikaze pilots during World War 2, or contemporary suicide bombers (Selby, et al., 2014). The third type is **Anomic** suicides, which most often happen in societies where there is minimal social regulation. This lack of social regulation results in a failure to instill a sense of meaning - or a failure to provide a moral framework - in the lives of its citizens and results in a state of social and economic disorder. Camus' "absurd hero", described above, would fit into this paradigm. The fourth and final type is **Fatalistic** suicides, which occur in societies where social regulation is extreme and authority is oppressive and controlling. Suicidal persons in these situations would rather die than continue living in such stifling conditions (Durkheim, 1897/2006). Examples of this type could include a prisoner who cannot tolerate prison conditions, or an unwilling young woman in a patriarchal society who is forced into an arranged marriage.

Durkheim's influence was vast, and his was the first theoretical attempt to examine suicide in non-moralistic or judgmental terms. Ultimately, he attempted to "specifically identify types of suicide and ascribe reasons" (Selby, et al., 2014, p.290) for why they happen.

Psychological Theories

From the developing field of psychology at the beginning of the 20th century came the first major theories of why people die by suicide on the "individual" level. Freud believed that an individual possesses a "death instinct" which, in turn, is balanced by a life instinct, and is most often externalized as anger. When anger is culturally contained through societal mores and laws, its expression toward others is repressed and turned inwards. In extreme cases, this repression results in suicide - or self-murder.

Freud's ideas continued to have an influence on later suicidal theory. Karl Menninger in the 1930s and Herbert

Hendin in the 1990s, for example, expanded on Freud's ideas about the attachment of aggression and suicide to death in their respective work.

Baumeister and the Escape Theory of Suicide

In 1990, Roy Baumeister proposed a psychological model of suicide called the "escape theory". It has been widely influential, particularly in explaining adult male suicides.

Baumeister explained suicide as a sequential process, involving the following six steps:

1. **Falling short of standards** occurs when a person fails to meet unrealistically high life expectations or experiences negative life experiences or setbacks.
2. **Internalization of self-blame** these failures are internalized as being solely the individual's fault and helps to cause low self-esteem.
3. **Aversive sense of self** is when a harshly negative view of self, versus a positive view of others, is firmly established.
4. **Negative affect and/or negative consequences** - these are the consequences of the previous step that can manifest as depression, anxiety or anger.
5. **Cognitive constriction** is an escape of negative consequences by either intentional or unintentional avoidance and rejection of "meaningful thought". The individual focuses on day-to-day needs at the expense of forward thinking, and, thus, experiences narrowed thinking or "tunnel vision".
6. **Reckless behaviours, absence of emotion, and irrational thought** comprise the last step of the theory. These factors often surface as substance abuse, self-harm, risky behaviours, and/or social withdrawal. The notion of suicide becomes less fearsome. Sometimes this need to escape escalates to suicidality (Baumeister, 1990).

Edwin Shneidman and Psychache

Pioneering suicidologist Edwin Shneidman (1918-2009) believed that the central factor in all suicides is the presence of "psychache", and the influence of psychache on theoretical thinking of suicidality has been enormous. Psychache is defined as the "hurt, anguish, soreness, and aching psychological pain in the mind" (Shneidman, 1993, p.51). It is "the pain of shame or guilt, or humiliation, or loneliness, or fear, or angst, or dread of growing old" (Shneidman, 1993, p.51).



Psychache results when an individual's vital needs are not met or are frustrated. Shneidman believed that the majority of suicides were due to frustrated needs experienced in the following four ways:

1. **Thwarted love, acceptance or belonging;**
2. **Excessive helplessness** or the feeling that one has no control;
3. **Damaged self-image** invokes feelings of avoidance, shame, defeat, and humiliation; and
4. **Damaged relationships**, accompanied by subsequent feelings of grief.

It is important to note that each person has a different threshold for enduring psychache. When that threshold is reached, or when the individual deems the psychache to be unbearable and overwhelming, the most drastic effort to reduce it - suicide – emerges as the answer.

Shneidman's theory stresses that **suicide is not necessarily the wish to die but is rather a means to ending the psychological pain** (Shneidman, 1993).

Leenaars and the Multidimensional Model of Suicide

Antoon Leenaars is a leading proponent of multi-dimensional, evidence-based models of suicide. They are also sometimes referred to as "ecological models"

Leenaars, along with Shneidman before him, is a leading researcher of psychological autopsies – a term that Shneidman first coined. He is also a leading authority on the analysis of suicide notes. These investigations are extremely effective in understanding, retrospectively, why someone has taken his or her life.

When Leenaars undertakes a suicidal analysis, he employs **idiographic (specific)** and **nomothetic (general)** elements. This is essential to capture a more complete illustration of the lost life. He draws on resources such as personal documents, interviews with survivors, official government reports, suicide notes, and any other available sources.

He interprets both intrapsychic and interpersonal features to decipher what drives an individual to suicide:

Intrapsychic

- **Unbearable psychological pain**
- **Cognitive construction** rigid thinking, tunnel vision

- **Indirect expressions** ambivalent thoughts toward living, contradictory feelings
- **Inadequate adjustment** cannot cope with problems, losses and weakened ego

Interpersonal

- **Interpersonal relations** frustrated relationships
- **Rejection/aggression** loss or abandonment, aggression turned inward
- **Identification/egression** strong attachment to another that is not met, need to escape (Leenaars, 1996).

For Leenaars, suicide is a "multidimensional malaise," or a combination of "biological, psychological, intrapsychic, interpersonal, social, cultural and philosophical" elements, as opposed to the simple escape from pain (Leenaars, 1996, p.221). In his view, a penetrating investigation into the person's lived experiences gives us much more of the "why" someone died by suicide (Leenaars, 1996).

Joiner's Interpersonal Theory of Suicide

A popular contemporary theory of suicidal behaviour is Thomas Joiner's Interpersonal Theory of Suicide (2005), which has been especially useful in explaining the prevalence of suicide in older adults and - in particular - older adult males.

This theory was examined at length in iE16 [iE16 Social Connectedness and Suicide Prevention](#) (link) but I will summarize it here. There are 3 factors which need to be present for a suicide:

1. **Thwarted Belongingness:** an absence of meaningful connections to others or a strain of a loss of previously strong relationships.
2. **Perceived Burdensomeness:** a perception that someone feels that he or she is a burden on others. They believe that they fail to make meaningful contributions to society and that they are a liability.

These 2 combined factors create the **desire for suicide**.

3. **Acquired Capability for Suicide:** the degree to which an individual is able to initiate a suicide attempt. A habituation to fear and pain is a prerequisite for serious suicidal behaviour. A person



can become desensitized to the formidable notion of suicide by repeated exposure to painful events and behaviours such as self-injury.

Beck and Hopelessness Theory

Aaron Beck posited the Hopelessness Theory of suicide in the 1970s. He asked what possible force could drive a person to violate and override the “survival” instinct to kill him or herself. That force turned out to be hopelessness-- the “catalytic agent” that drives the suicidal desire. He found that **hopelessness** is a stronger indicator of suicidal intent than depression.

The individual has a stored reservoir of negative models which determine how they will perceive and interpret new information. In the case of suicidal thoughts, these models exacerbate feelings of hopelessness at the expense of positive, productive information.

Beck has been pivotal in devising measurements to aid clinicians in assessing mental illness and suicidality. Some of these include: The Beck Depression Inventory (BDI), the Suicide Intent Scale (SIS), and the Beck Hopelessness Scale (BHS).

Beck believes that cognitive change, in addition to behavioural change, is crucial to effective treatment. This is evident in the practice of Cognitive Behavioural Therapy(CBT), which he helped develop. He also feels that clinicians should target a patient’s feelings of hopelessness for more positive treatment outcomes (Beck, et al., 1974).

Linehan and Emotion Dysregulation Theory

Marsha Linehan’s theory of Emotion Dysregulation is often referred to as a “bio-social” theory, as biological and physiological elements figure prominently in an individual’s responses to stress and emotion regulation. An afflicted person is characterized as experiencing intense emotions and an increase in sensitivity - even hypersensitivity - in upsetting situations.

These extreme emotional states are intense and aversive. Sufferers desperately attempt to manage their symptoms. Sometimes these efforts to cope or regulate the pain

manifest as self-injury, and in extreme cases suicide can result.

Linehan developed Dialectical Behaviour Therapy (DBT) to help patients treat their emotional dysregulation. In this treatment, behavioural skill deficits are taught within a problem-solving and skills-training framework, and there is an emphasis on skill building and behavioural change. Self-validation and hopefulness are the desired outcomes.

DBT has been touted as the “strongest single treatment targeting suicidality” (Rudd, et al., p.161).

Conclusion

Although several theories of suicide are surveyed here, there are many more left unmentioned. These include theories stemming from research in other disciplines. For example, huge advances have been made in the study of the brain in the neurosciences in the last 20 years. We have a better understanding of how the brain works and consequently how chemicals in the brain influence how we think and behave. This is positive because we now have a better idea of how suicidal thoughts are formed, and how these thoughts result in suicidal behaviours.

It is important to note that no single theory can explain the complexities of suicide or suicidal behaviour, regardless of whether the theory is rooted in sociology, psychology, or even medicine. It is also unfeasible to conclude that every theory can be used effectively to treat suicidality.

Particular theories may influence newer ones or may fall out of favour altogether. What remains constant is the evolving understanding of why people take their own lives. We get this understanding from the tireless research that goes into formulating theory and its practical application.

As theoretical efforts in suicide prevention continue and our practical treatment of suicidal individuals improves, more people who are suffering will hopefully begin to experience lives that are not quite as painful and intolerable. When this happens, they may no longer feel like Sisyphus, endlessly pushing the rock, rather, they can be, as Camus imagines Sisyphus, content and happy to be alive (Camus, 1955/1991).

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