Self-Destructive Processes and Suicide

Israel Orbach, PhD

Department of Psychology, Bar-Ilan University, Ramat Gan, Israel

Abstract: This paper focuses on theoretical, empirical and clinical accounts of self-destructive processes in the general population, with a particular focus on suicidal individuals. The theoretical perspective includes views on self-destruction as (A) a motivated wish or need, (B) an outcome of emotional distress, (C) an outcome of distorted cognitions, and (D) as a general personality feature. The different principles of destructive operations that are inherent in each of the theoretical propositions are delineated. Examination of the empirical data reveals that various self-destructive processes described in theory are involved in suicidal behavior. The case studies demonstrate how the various self-destructive processes lead to suicidal behavior. These studies also show that in each individual case, there is more than one self-destructive process at work. It is suggested that suicidal behavior does not only evolve from external pressure and negative life events; rather, self-destructive tendencies may produce unbearable mental pain that culminates in suicidal behavior.

Much of the research on suicidal behavior emphasizes the role of stress factors, risk factors, and personal vulnerabilities. In a recent review article, Gould et al. (1) summarize the data obtained from research on adolescent suicide during the past 10 years. This paper focuses on suicide rates; epidemiological factors (age, gender, ethnicity); personal characteristics (psychopathology, prior suicide attempts, hopelessness, problem-solving difficulties, aggressive-impulsive behavior, sexual orientation and biological factors); family characteristics (history of suicidal behavior, parental divorce, parent-child relationships); life stressors (negative life events, physical abuse, sexual abuse); and socio-environmental and contextual factors (socioeconomic status, school and work problems). The authors conclude that, to date, adolescent suicide can be understood as an effect of youth psychiatric disorders, a family history of suicide and psychopathology, stressful life events and access to firearms.

Taking a different perspective, Orbach (2) suggests that suicide cannot be understood outside of the long-standing self-destructive processes that generated it. Self-destructive processes are active and provocative, behavioral, and ideational operations aimed against one's own interests. They consist of a cluster of beliefs, cognitions, emotions and tendencies that reflect patterns of self-abuse that erode one's sense of well-being, self-love, interpersonal relationships and harmony with reality. Suicidal people, it is argued, tend to take an active role in creating their internal and external stressors, as well as in the creation of negative life events (3, 4). Eventually, the eroding effects of the self-destructive processes turn into mental pain that leads to suicide (5).

Recently, Joiner (6) articulated the role of self-propagating and erosive processes involved in depression chronicity. No such comprehensive attempt was made regarding suicide. The present paper is yet another attempt to consider the relationship between self-destructive processes and suicidal behavior from theoretical, empirical and clinical perspectives. Hopefully, the integration of these three perspectives will lead to a better understanding of suicidal behavior.

Theoretical Perspectives

A. Self-destruction as a motivated wish or need

The death instinct. Freud's conceptualization of the death instinct behaviors reflecting self-destructive tendencies, guilt feelings, suicide, melancholia, masochism and sadism are furnished with a motivational force of their own, as well as with a specific mechanism of action, that is the repetition compulsion. The death instinct drives man to the ultimate
state of quiescence — death through the urge inherent in organic life to restore an earlier state of things (see 7)

According to Freud (8), self-destructive processes culminate in depression and suicide. These processes are rooted in pathological mourning. The pathological mourning has its origin in an ambivalent love-hate relationship with a lost close person. The anger toward the lost person is turned inward and takes on the form of sadistic self-punishment. It is a murder in 180 degrees. In Freud’s terminology, the superego punishes the ego unconsciously with guilt and creates an impulse to die. Thus, the redirection of aggression originally aimed at the lost, loved-hated person relieves guilt over aggressive thoughts and opens the way for reunion with the loved person. Hence, Freud (8) views suicide as a result of loss, ambivalent feelings, guilt, self-hate and inwardly turned aggression in order to reunite with the lost person.

Menninger (9) further elaborates on Freud’s instinctual self-destructive behavior. He identified three major dynamics of suicidal behavior: the wish to kill (ego — aggression turned inward); the wish to be killed (superego — self-aggression stemming from guilt); and the wish to die. Although the wish to kill is expressed in acts against oneself, the aggression is intended for an ambivalently valued person. The greatest torture for a mother is to see her child being killed (by him/her). Hence, the person who kills him/herself exhibits an overwhelming degree of aggression against the loved and hated person by destroying things that are dear to that person. The wish to be killed is, of course, a submission to death stemming from intense superego guilt for forbidden sexual and aggressive unconscious wishes. The wish to die does not represent a conscious (ego) wish to kill or a superego self-punishment. Rather it represents the vicissitudes and individual differences in the strength of the unconscious death instinct (id). The wish to die represents a desire to return to the peace of the womb. The wish to die comes into play through non-fatal self-destructive acts and in self-exposure to dangerous, yet pleasurable activities, such as mountain climbing, car racing and so on. This third wish is a form of toying with death, because of the innate intensity of the death instinct.

The internal saboteur. Fairbairn (10) provides an object relations version of self-destructive behavior, although he did not relate directly to suicidal behavior. He believes that all forms of externally and internally directed aggression stem from actual experiences of abuse and neglect. Fairbairn identifies an inner organization of very negative experiences. These experiences are crystallized into an “internal saboteur.” The internal saboteur is an inner attitude of self-hate and hatred for others that takes on the form of a bossy, sneering, belittling inner voice. These inner attitudes control one’s self attitudes and relationships with others and steer behavior toward punishment of self and others, vindictiveness, rejection and provocation. According to Fairbairn, early negative experiences are far more powerful in determining personality than are early positive experiences. An individual with a self perceived history of abuse tends to recreate these experiences of abuse in order to recapture the early emotional or physical abuse. The motivation for repetition of aspects of an earlier abusive relationship according to Fairbairn is the need to hold on to bad relationships (and bad objects) rather than be left with no relationships at all (see also 11).

Self-theories provide a different version of motivated self-destruction that pertains to suicide and self-harming behavior. Stolorow (12) claims that self-inflicting pain may be a way of self enhancement. Paradoxically, masochism and self-destructive behaviors may boost self-esteem and self-value, enhance a sense of continuity of the self in time, and provide a sense of self-cohesion and boundaries between self and non-self. The experience of physical pain on the surface of the body can help a disintegrating self establish a sense of bodily boundaries (self-differentiation) and inner cohesion, as well as a sense of liveliness (though painful experiences).

To a person with a history of receiving care characterized by pain, trauma and sadomasochism, repeating of such features in one’s own self-care provides a sense of self-consistency. Self-perpetuated self-abuse also allows for a sense of control and omnipotence over a once uncontrollable situation. In sum, certain forms of self-destructive behavior may result in a satisfying experience in terms of achieving self-enhancement, self-boundaries, inner cohesion and control. The most painful experience for a person in distress is the experience of disintegration.
Thus suicide may be chosen as a last resort of maintaining self-cohesion when moments of high distress generate feelings of self-disintegration. In a similar line of thinking, Sacksteder (13) suggests that self-destructive behavior is a form of negative identity. A negative identity, he claims, is better than no identity.

Common to the theoretical conceptualizations that view self-destruction as being motivated by a wish or by a need for self-enhancement is the idea that cessation is not only an escape from unbearable pain, but it is also intended to achieve a goal or fulfill a need. This goal or need may be joining a loved one (in fantasy), enhancing self-worth or gaining love. Shneidman (14) states it very clearly that the very act of suicide is perceived by the suicidal person as being instrumental in fulfilling a specific need.

B. Self-destruction as an outcome of emotional distress and failure to protect the self

Baumeister (15, 16) views the protection of a positive self-image, self-esteem and self-interest as crucial in the pursuit of well-being. People indeed tend to enhance behaviors, experiences and circumstances that increase their self-image, esteem and interest, and do everything in their power to avoid harming and thwarting themselves. Nevertheless, under certain circumstances, people will act against their own self-interest. Baumeister’s paradoxical assumption is that, in essence, the core motive in self-destructive behavior is to protect oneself from psychological distress. However, due to failure in coping, appraisal, evaluation of the situation and other faulty strategies, one ends up unintentionally in a self-destructive mode of behavior.

Baumeister (16) points at three culprits responsible for thwarting self-protective and self-enhancing behavior into self-destructive behavior: threatened egotism, failed self-regulation and emotional distress.

Egotism serves the self by accruing reinforcements of positive self-perception and self-love. Egotism is naturally threatened by encounters with situations capable of lowering one’s self-esteem. The pursuit of self-interest requires a rational analysis that takes into consideration long-term outcomes of one’s actions. An event or situation that may be potentially threatening to the ego is experienced as an immediate crisis that removes long-range implications from immediate consideration. The egotistically threatened person tries to escape such a distressing experience as soon as possible. The suffering person is likely to choose the response that offers the most immediate escape from the negative affect and threat. In the extreme case of suicide, for example, the suicidal person does not seek to punish him/herself, but seeks to escape the immediate negative implications to the self due to a certain failure.

Self-regulation is the way in which individuals turn negative affects and outcomes into positive ones for the sake of the self. Successful self-regulation requires accurate appraisal of what is in the self’s best interest, as well as skill in pursuing and executing such benefits. Failure in appraisal or pursuit result in failed self-regulation. An example of faulty self-regulation is the chronic use of alcohol to dilute emotional distress and negative experiences. While alcohol intoxication provides immediate relief, it does so at the expense of self-control, inhibition, self-monitoring and impulse control. As this example indicates, self-detriment may actually result from uncalculated attempts to restore self-interest, i.e., shortsighted consideration of future implications. Distressed people choose the risky course only because they ignore its downside.

Another version of self-destruction as a failure to protect the self is offered by Swann (17), who suggests that people actively seek out information that is consistent with their self-perception, even when such feedback is negative. This is especially true for individuals with low self-esteem and depression. Negative information is preferred over positive feedback and is perceived as more reliable since it is consistent with one’s own self-perception. Such individuals tend to seek out rejections and feel closer to partners who express negative opinions toward them. While negative feedback provides a sense of consistency, at the same time negative feedback increases negative self-image as well as negative emotions including depression. Thus, a vicious cycle is formed in which negative feedback and rejecting partners further enhance the negative self-image and increase one’s negative mood and depression, and these strengthen the tendency to seek out new negative feedback and so on. Recently, Weinberg (18) has empirically documented negative feedback seeking in suicidal inpatients.
According to these views on self-destructive processes, self-inflicted damage is usually rooted in external pressures that constitute a threat to the self or elicits intense emotional distress. This situation gives rise to faulty coping strategies that cannot eliminate the stress or threats and eventually end up in an ineffective form of escape that culminates with even more distress and pressures.

C. Self-destruction as an outcome of distorted cognitions

Multiple theoreticians and researchers have identified self-destructive processes that are based on faulty self-perceptions and world perceptions (e.g., 19–21). Documentation of the thoughts and cognitions of self-destructive individuals often indicate distorted contents (e.g., faulty beliefs and schemas), modes of thinking (e.g., negativity, rigidity, irrationality), emotional tone of cognitions (pessimism, threats, catastrophization), and thought processes (e.g., negative attributions, faulty generalizations, illogical conclusions, faulty reasoning, memory distortions and selectivity, and difficulties in producing alternatives).

The following is a more detailed account of the distorted thoughts and cognitions linked with self-destructive behavior.

Distorted beliefs. Beck (22) observed that maladaptive behavior and negative affect are often governed by distorted and maladaptive cognitions. Beck terms these maladaptive cognitions the cognitive triad consisting of negative views of the self, others and the future (e.g., I am inadequate, undesirable, worthless; the world makes too many demands on me; life represents constant defeat; life will always involve the suffering it has for me now). Recently, Rudd (23) applied Beck’s cognitive construct of depression to the belief system of suicidal people: My life is hopeless (hopelessness); I don’t deserve to live (unlovability); I can’t solve this (helplessness); and I can’t stand the pain (poor tolerance).

Moreover, Beck (22) discovered that the depressed person’s thoughts are governed by an automatic thought system of internal rather than interpersonal communication, and that this internal system is characterized by negative self-evaluation, attributions of the negative to the self, negative expectancies, negative inferences and recall. These characteristics of the internal thought mechanism are manifested in low self-esteem, self-blame, and self-criticism, negative predictions, negative interpretation of experiences, and unpleasant recollections. Much of the positive self-relevant information is filtered out, while negative self-relevant information is readily admitted. Beck also notes a variety of errors in the patient’s depressive thinking. He labeled these as selective abstractions, overgeneralizations, and the exaggerations of the negative aspects of their experiences. According to Beck (22), these thought patterns are automatic and extremely negative in nature. Another aspect of the distorted beliefs is a fixed (and usually negative) meaning that is attributed to specific events (e.g., If my husband does not smile at me, it means that he does not care for me). The depressed patient construes his/her experiences and future expectations on the basis of these beliefs. Such beliefs are founded early in life and become embedded in a structured schema.

Rigidity in solving problems. Difficulties in problem solving or difficulties in producing alternative solutions to a problematic situation is yet another aspect of self-destructive behavior. Individuals experiencing difficulties in divergent thinking are unable to develop efficient solutions while under stress (24–27). These difficulties are related to cognitive extremities, rigidity, passivity and appraising a problem situation as being a threat rather than a challenge (24). In the process of trying to solve a problem, some individuals focus on and identify with more negative aspects of a problematic situation than the positive and challenging aspects (28). Further, the problem solving of suicidal people is characterized by reliance on others, avoidance, disregard of the future and drastic solutions (29). Due to accumulative failures experienced by suicidal youngsters throughout life, they have been found to perceive problem situations as being totally unsolvable (30).

Faulty logic and dichotomies. Shneidman (14, 31) points out two additional cognitively destructive traps that exist especially in the mind of the suicidal person: catalogical syllogism and dichotomous thinking.

Catalogical syllogism starts off in the suicidal
person with a false major premise and from there on, the flowing conclusion may seem to be valid even by rigid Aristotelian standards. For example, a suicidal person may think that: "If anyone kills him/herself, then he/she will get attention: I will kill myself. Therefore, I will get attention." According to Shneidman, this reasoning exemplifies a psycho-semantic fallacy that may occur whenever an individual thinks about his/her own death. He/she imagines him/herself as a spectator-survivor in a world after death. The fallacy lies in the fact that the "I" that the suicidal person is talking about will no longer exist to receive the imagined experiences.

The other cognitive trap that Shneidman identifies in suicidal individuals is constricted or dichotomous thinking. The suicidal person's mind views the world, the self and the present situation in terms of either/or, good or bad, love or hate. The language of dichotomous thinking is based on absolutes like "always," "never," "forever," and "only." Thinking in polarities leaves no room for a spectrum of possibilities that can grant hope or gradual change.

In general, self-destructive behaviors that are rooted in distorted cognitions are destructive in and of themselves. These distortions are habitual and automatic, uncontrolled, and create emotional distress by their mere operation. Extreme destructive acts are perceived as a response to these distorted, stress-inducing cognitions.

D. Self-destructive behavior as a general feature of the personality

Some individuals are not only characterized by certain self-destructive features, but also by a dominant personality feature that leads to self-destruction. Such individuals can be described as suffering from a self-destructive personality. Dominant self-destructive personality features include perfectionism, a self-defeating personality and impulsivity.

*Blatt: Destructive personality configurations.* Blatt (32) posits that personality develops as a consequence of a complex interaction between two fundamental developmental lines: (a) the development of the capacity to establish mature and satisfying interpersonal relationships and (b) the development of a realistic, positive and integrated self-definition and identity. In normal development, these two personality dimensions evolve in an interactive and reciprocal way to create a balance between relatedness and self-definition. However, a relative emphasis on either interpersonal relatedness or self-definition may result in two broad configurations of psychopathology. An overemphasized interpersonal relatedness may lead to an anaclitic (or dependent) depression, whereas overemphasized individuality and self-definition may result in self-critical (or introjective) depression. Anaclitic depression involves a deep longing to be loved and cared for. The dependent person fears loneliness, abandonment and rejection. He/she is strongly motivated to establish intimate relationships, and will placate others in order to maintain security and gratification. The overly individualized person is characterized by self-criticism, feelings of inferiority and guilt. Such an individual suffers from a chronic fear of disapproval, criticism and rejection. He or she strives for excessive achievement and perfection, and is often highly competitive. Through over-compensation, the self-critical person strives to achieve and maintain approval and acceptance. Both personality configurations in their extreme forms are implicated in self-destructive behavior.

Shahar and Priel (33) conglomerate empirical evidence from several authors that suggest that dependency and self-criticism influence the social context. These studies revealed, among other findings, that self-criticism predicted elevated levels of interpersonal problems, hostility toward romantic partners, elevated levels of stressful events and lower perceptions of social support. Self-criticism was also found to suppress the impact of positive life events.

Blatt (34) linked self-critical depression to destructive perfectionism. Actually, Blatt suggests that there is a great overlap between perfectionism and the self-critical configuration in terms of harsh self-scrutiny and self-evaluation, chronic fear of disapproval and chronic fear of rejection. There is also an overlap in terms of competitiveness with one's self and demands made of one's self. Perfectionists are driven by an intense need to avoid failure. Nothing seems quite good enough and they are unable to derive satisfaction from what they do. They are engaged in an endless cycle of self-defeating over-strivings in which each task becomes yet another threatening challenge due to their deep feelings of
inferiority. They are constantly engaged in a vicious cycle of trying to accomplish unrealistic demands and thereby defeating themselves.

Joiner (6) has pointed out several self-propagating processes in chronically depressed individuals that seem to be related to the dependent personality configuration and that might be involved in suicidal behavior of such individuals. One such process that can be defined as a process of self-generation of stress is the excessive reassurance-seeking, that is the tendency to repeatedly seek assurance from others as to worth and lovability. Such a repetitive pattern can evoke frustration, irritation and even depression in others and thus elicit a response of rejection.

Impulsivity. Impulsivity can be defined as an enduring tendency to react hastily rather than deliberately. This tendency is based on immediate gratification as opposed to future-oriented problem solving (35, 36). Impulsivity is usually manifested in negative, mostly dysphoric and irritated emotional states.

Feelings of exacerbated tension and emotional discomfort lead the impulsive individual into a struggle between the impulse for immediate relief and the need for self-preservation. The impulsive individual lacks the ability for affect regulation, for self-soothing and self-comfort, resulting in affect instability that is an abrupt rise in overwhelming affect and intense affective reactivity to environmental events. Because of the high arousability of negative affect and tension, the impulsive individual tends to respond impulsively in order to relieve the tension without giving him/herself time to consider the adverse consequences of his/her behavior.

The most outstanding manifestation of an impulsive personality is the difficulty to control impulses, especially self-aggression, as well as aggression directed toward others. Impulsivity was found to be related to a wide range of maladaptive self-destructive behaviors, such as kleptomania, pyromania, intermittent explosiveness, substance abuse, antisocial behavior, bulimia, conduct disorder and self-mutilation (35).

Nihilistic attitude toward life. Self-destructive processes and behaviors can also be viewed from the perspective of long-term development of attitudes toward life. In the course of such developments, one may adopt a basic negative attitude toward life and living, and engage in an all-encompassing career of self-destruction. Maris (37) contends that "From the existential perspective under the best conditions, life is short, painful, fickle, often lonely and anxiety-generating" (pp. xviii-xix). Self-destruction is a result of a nihilistic attitude characterized by an inability or a refusal to accept the conditions of one's life. Because of this intolerance and accumulated stress and failures from early life, individuals may adopt self-destructive coping methods in order to escape life's difficulties. Individuals with a nihilistic existential stand toward life will engage in various self-destructive behaviors that Maris termed as a suicidal career. Such individuals may move from non-fatal self-destructive behavior, such as alcoholism, isolation, opposition, violence, drug abuse, risk-taking, until the career is culminated in a fatal action of completed suicide. Actually what Maris describes as a nihilistic attitude toward life itself is in many ways similar to what is often related to as a self-defeating personality characterized by a combination of self-destructive tendencies, such as masochism, self-criticism, submissiveness, self-punitiveness, self-abnegation, negativism, rejection of help and provocativeness (e.g., 3, 38, 39).

This category of destructive behavior that stems from personality traits can be characterized as a destructive mode of action. Here the patterns of action are not necessarily due to wishes, types of cognition or self-regulatory strategies. The actions themselves and the way people operate and conduct their lives are destructive.

Some Empirical and Observational Evidence of Self-Destructive Behavior in Suicidal Individuals

In this section, empirical and observational data of self-destructive behavior in suicidal individuals will be presented.

Aggression turned inward and impulsivity

Maiuro et al. (40) demonstrated that suicidal male psychiatric patients tend to display more intrapunitive and covert hostility than nonsuicidal patients. Rustein and Goldberg (41) provided empirical evidence to this phenomenon showing that aggressive stimulation increases depression and
turning of aggression inward in hospitalized suicidal patients. At the same time, there is evidence that external-directed aggression and inner-directed aggression can coalesce in violent suicide (42).

Impulsivity is one of the most critical risk factors of suicidal behavior at all ages. Conner et al. (43), for example, found that impulsivity was strongly associated with suicidality even after accounting for alcohol dependency and aggression. Oquendo et al. (44) found that impulsivity was one of the important predictors of suicidal behavior with major depression, in a two-year follow-up study. Forteza et al. (45) reported that impulsivity was a critical risk factor for both males and females. Impulsivity is also related to low levels of serotonin transport (5-HTT) which, in turn, is associated with violent suicidal behavior and aggression (46).

Apter et al. (47) compared suicidal and non-suicidal psychiatric patients on a battery of tests. Each of the two groups was also divided into violent and non-violent participants. It was found that only two of the violent participants had not been admitted for a suicide attempt. Suicide risk was found to be positively related to levels of impulsivity and anger; hence, violent and impulsive persons may direct aggression externally as well as inwardly.

Rigidity and dichotomous thinking
These aspects of self-destructive behavior have mostly been observed in clinical settings (14), but there are also some empirical studies that have provided evidence for the existence of these features in suicidal individuals. Suicidal individuals have been found to be rigid in their personality structure, cognition, self-definition and behavior (20, 48, 49). Similarly, Eliason (50) compared psychiatric suicide attempters and non-attempters. The attempters were found to have much more rigid personalities and rigid cognitions than the former. Gil (51) also found that rigidity and impulsivity were two of the five factors that explained suicidal ideation among psychiatric patients.

Provocative behavior and negation of help
Maltsberger and Buie (52) observed that suicidal patients prefer to reconstruct early sadomasochistic relationships and elicit hateful responses on the part of others through their provocative behavior. Küllgen (38) analyzed treatment files of borderline patients who committed suicide and found that more than half of the suicides’ negative reactions, rejection and contempt on the part of the physicians toward patients were documented. Kernberg (53), Novick (54) and Asch (55) observed similar provocative behavior in their suicidal patients. Deane et al. (56) found that suicidal individuals avoid or reject help from family, friends and professionals. The association between suicidality and the rejection of help was not related to the level of hopelessness; thus, negation of help seems to be a personality characteristic rather than a lack of belief in future change. Similar findings were reported by Deane et al. (57) and Carlton and Deane (58).

Self-generated stress and self-defeating behavior
Isometsa et al. (59) studied stressful life events in suicide completers, and determined that most of these events were self-generated. Heikkinen et al. (60) studied autopsies of 56 borderline and 56 non-borderline patients who completed suicide. In 53 of the cases, the families of the suicide completers reported the presence of stressful life events prior to suicide. Forty of these experiences were judged to be as self-generated stress.

Lester and Hoffman (61) studied self-defeating behavior in suicide attempters and ideators. They found a significant association between self-defeating tendencies and suicidal behavior even after controlling for depression, gender and age.

Self-hate, guilt and self-devaluation
Shneidman (31) documented extreme expressions of self-hate and hatred towards others in the autopsies of suicide completers. Joiner et al. (62) investigated the relationship between self-hate, suicide attempts and suicidal ideation in two separate studies. In the first study, they examined military personnel who exhibited suicidal behavior. It was found that self-hate and suicidality were more correlated among people with a diagnosis of schizophrenia than among patients with a diagnosis of major depression. In the second study, they examined schizophrenic and depressed inpatients, and again found a strong association between self-hate and suicidal behavior. Brevard et al. (63) analyzed the suicide notes
of completers and attempters. The notes of the completers evidenced significantly more self-blame references than those of the attempters.

In Tatman et al’s (42) study, self-devaluation was found to distinguish between suicidal and non-suicidal adolescents. Kaplan and Pokorny (64, 65) studied the predictive power of self-devaluation in a very large adolescent sample. They found that self-devaluation predicted suicidal behavior even after two years.

Perfectionism
The two types of depression, anaclitic and self-critical, that have been suggested by Blatt (32), have also been implemented in suicidal behavior. Self-critical depression is mediated according to Blatt by pathological perfectionism. In a number of studies, it was found that different aspects of perfectionism were associated with suicidal ideation and suicide attempts in both adolescents and adults (66, 67). Apter et al. (68) have reported in a postmortem analysis of a sample of completed suicides that perfectionistic tendencies were very frequent among the suicide completers.

In a recent study, Brunstein-Klomek (69) found the dependent personality who may suffer from anaclitic depression tends to exhibit suicidal behavior and suicidal tendencies.

Self-Destructive Behavior in the Clinical Setting
The following are descriptions of several self-destructive behaviors and how they are related to the suicidal process. These descriptions are based on therapeutic interactions with suicidal people and the emphasis is on the clinical descriptive perspective rather than the theoretical-empirical perspective.

Self-destruction motivated by guilt feelings
Guilt feelings are some of the most potent feelings that lead to direct and primary self-destruction. One of the major dynamics of suicide is an individual’s belief that he or she has hurt or caused damage to another person. This is exemplified in the following clinical case.

Dina, a very suicidal widow, could not obtain her very desired doctoral degree because she could not complete the concluding section of her dissertation. As it turned out this situation was related to her relationship with her late husband. At first, she hinted that her husband was a war casualty, but later she disclosed that he had committed suicide and that she had actually danced with joy on his grave because at last she was free from a marriage in which she suffered a great deal. Only after her husband’s suicide could she fulfill her long-standing dream to pursue an academic career. Dina reported that she had repeated hallucinatory nightmares in which her husband would appear, knocking on the doors and walls and enter her bedroom, saying: “You belong to me; come with me, forget your dissertation.” Dina’s guilt about her murderous anger toward her husband and her belief that she might have precipitated his suicide were at the heart of her being stuck in the last chapter of her dissertation as well as in her subsequent suicide attempts.

The need for self-punishment was so strong in Dina that it outlived the therapeutic working through the source of the self-destructive chain. After Dina completed her dissertation she still felt the need to punish herself. As she approached the stage to receive her diploma, she fainted — a symbolic death and suicide.

Self-entrapment as a way of life
One form of self-entrapment is provoking others to mistreating behavior or to continually fail oneself on purpose. This is most evident in people who have a long-standing ambivalence about life, conflicted by the equally strong wish to live and the wish to die. Thus, provocation and its consequent eliciting of the ill wills of others serve to tilt the scale and to solve the ambivalences about life and death. At the point where the almost deliberate deterioration of life becomes unbearable, the person reaches a final resolution of the conflict. One adolescent girl, who had repeatedly attempted suicide, exhibited this tendency in a sudden outburst against her therapist: “You don’t understand that I need everybody to know how bad I am. I do not deserve to live. Everyone must agree that I need to die.” Following her own disjointed logic, this young woman pushed herself and her life to actual extreme episodes of misbehavior and failure in order to justify her suicide. Another suicidal adolescent would regularly leave her panties
stained with menstrual blood in the middle of the
guest room floor, a predictable provocation which
caused her mother to scream at her: “So, do it al-
ready; jump and get it over and done with.”

Another common form of self-entrapment is de-
liberate self-imposed failures that propel the suffer-
ing individual from bad to worse. This tragic process
was described in detail in the suicide note of a soldier
who put an end to his life after failing an army train-
ing course that was of critical importance to him. He
began his note by describing the series of failures that
he had experienced during his lifetime. As a child he
had failed in learning to ride a bicycle as fast as he
had wanted, later in school he failed in living up to
his parents’ expectations to excel in school. After
completing a long list of disappointments and fail-
ures he goes on to describe the more recent series
of self-inflicted entanglements. He hid his most recent
failure in the army from his parents and friends, and
even tried to keep it from his commanding officers.
He told each person a different story and heaped one
lie on top of another, even though he knew that his
deception would ultimately be discovered. More-
ever, each time he had tried to solve an entangle-
ment, he only added to the web of deceptions until,
at the end of his life, he became tied up in an insolu-
ble tangle of lies. It was as if he had personally di-
rected the drama he believed to be his destined fate: a
tale of woven failures.

Cognitive self-entrapment
Cognitive self-entrapment can take on different
forms. In one form of this entrapment, the thoughts
and feelings involved in a conflict are continually
counterbalanced in such a way as to render the con-
ict insoluble. A young man whose fear of conscrip-
tion to the army led to suicidal thoughts said to me:
“I can’t join the army, but I also don’t want to avoid
being drafted.” Every attempt on his part to tip the
balance in either direction was immediately met with
a persuasive counter-argument that restored the le-
thal state of no way out and intensified the suicidal
ideation.

Another aspect of cognitive entrapment experi-
cenced by suicidal people is a regressed and chrono-
logically reversed form of thinking in which the
effect took precedent to the cause. Similar to moral
realism in young children, some suicidal individuals
come to judge their own intentions according to
other people’s actions toward them. Dina the suicidal
woman described above would repeatedly and retro-
actively interpret others offending her as a natural
extension of her guilt or worthlessness. When her
parents or her husband would beat her, she would
feel that she must have deserved it. Whenever she
was attacked, she felt that she was actually the ag-
gressor, not the victim. It is no wonder, therefore,
that instead of feeling anger at the beatings and hu-
miliation, she felt intense shame; instead of taking
action to cope with her anger, she endeavored to
cope with her shame.

Self-hatred
Shneidman (31) talks of inimicality in the suicidal
person, that is, his or her inner enemy. Self-directed
enmity is not merely negative self-perception, self-
estee or dissatisfaction with oneself. This inner
enemy undertakes an active and violent offense
against the self. It entails an attack on one’s mental
existence and the essence of one’s individuality. A
particularly striking example of this self-abuse was
seen in an extremely suicidal young woman.
Tragically, she eventually committed suicide. While
in therapy, she would wear an expression of disgust
whenever she talked about herself, saying things
such as: “I’m disgusting, I stink, and I’m dirty, filthy
and lazy. There is nothing good about me. I only
hate, damage and destroy everything I own. I’m one
big lump of everything that is bad.” Every word she
uttered was tainted with self-disgust; she simply
could not stand herself. She was a young mother, ed-
ucated, intelligent, creative, interesting and beauti-
ful, yet she was completely incapable of seeing
anything positive in herself, things that others could
easily see in her. Any attempt to tell her about the
positive impression she made was in such stark con-
trast to her self-experience that it was met with rage
that bordered on loss of control. Not only did she not
believe the words of praise, she simply was unable to
hear them. In fact, positive words seem to strike her
like the blows of a hammer.

“I want all or nothing”
Many suicidal people have suffered from deprivation
of basic needs of love, care and recognition. If such
deprivations are not compensated for quite early in
life, they tend to settle in as a stable experience accompanied by extreme feelings of neediness, frustration and anger. Such individuals constantly seek out others for love and care in a way that can never be satisfied. In the minds of those individuals, the deep sense of frustration and deprivation can be compensated for only by a complete, total and uncompromising providence. Receiving only some, only part of what one needs is not only not enough, but is rejected completely, as if saying: “If I can’t get it all, I need nothing.” Thus, the sense of frustration, deprivation and anger is constantly growing.

This was evidenced in one suicidal patient, a 35-year-old woman. As one of six children, she felt that she was ignored and uncared for. This feeling seemed to be grounded to some degree in real life events. When she was 10 years old, her parents adopted an orphan, a girl the same age as the patient. The patient was asked to take an active role in the absorption of the orphan into their family. She was asked, for example, to share her books, clothes, food and other favorite things with the adopted orphan. At the same time she felt that her parents ignored her own needs. In response, the patient developed an eating disorder. This patient felt that while the mother continued to care for and feed the adopted girl, she totally ignored her own daughter’s eating disorder.

The patient grew up to be a demanding, frustrated and angry person who always complained about what she is not getting from others and, at the same time, angrily rejecting what she was getting. If she could not get it all, she refused to receive a little or part of it. This tendency was repeatedly demonstrated in the therapeutic work. For example, at times of distress, she would request additional sessions to take place on a specific day and hour. If the therapist could not adhere to her request, she would angrily reject any other alternative time, thus re-enacting her relationship with her mother and re-experiencing a sense of deprivation, anger and rejection, and then would make a suicide attempt.

Creating losses and making oneself dispensable
This self-destructive process pertains to the constant and continual sense of loss and expectations for future losses. In such a pattern, the life narrative is perceived as a sequence of endless losses. External losses are paralleled by inner losses which necessitate adjustments and compromises. While suicidal persons are neither capable of making nor enduring these changes, they may actually assume an active role in creating losses. This pattern is evident in the life narrative of a middle-aged suicidal man. He was the youngest child in a family with nine children. At a young age, he lost an older brother in a war. Two years later, two of his sisters died from illness one after the other. He felt that he “lost” his father, who became engaged in a lifelong bereavement and mourning process. He believed that he had never received enough love from his mother who favored the other brothers and their children until she died, at which time he lost her love forever. At this point, he emigrated from his native country, which he experienced as an additional loss. When his son stopped observing a religious lifestyle, he experienced this change in his son as another desertion. At that point, the man severed his ties with his son (as he had done with some of his brothers and friends before) and became depressed and suicidal.

A process that is similar to creating the loss of others is creating a sense of being dispensable. “Everybody will be better off without me” or “I was superfluous from the moment I was born” are typical statements heard by many suicidal individuals. They feel and believe that there has always been a lack of fit between themselves and their environment. They recall constantly being treated as an external disturbance, as if they were in someone’s way. One adolescent girl wrote in a suicide note to her parents found after her death: “You always told me that I am in your way and constantly spoiling things for you. I never felt that I am important at all and I feel that I simply do not exist. Good-bye.”

In a 19-page-long letter, she spelled out how on so many occasions she felt dispensable and unnoticed. However, in every case she described, it was obvious that she made herself unnoticed and dispensable. On one occasion, when a boy her age approached her and showed a keen interest in her, she literally steered him to her girlfriend. She then complained how this instance was reflective of so many others whereby people treated her as if she did not exist.

Perfectionism and impulsivity
Dora, a 28-year-old married physician who had just
completed her medical studies, came to therapy in a state of panic. She was flooded with anxiety regarding her ability to be a physician and feared disapproval by her patients and supervisors. She was just about to begin residency in a prestigious hospital, but was paralyzed by her anxieties. Her future, as she envisioned it, was bleak and she anticipated total failure and disappointment to herself, her parents, friends, peers and supervisors. She considered killing herself as an escape from this intolerable situation. She had already made several attempts in the past.

Dora was an excellent student, always at the top of her class, but before any examination, evaluation or feedback, she responded with extreme anxiety, restlessness and somatic complaints. She would become depressed for days whenever another student received a higher grade than she did. She had to be the best; there was no other way for her.

In therapy, she was advised to postpone her residency for awhile in order to be able to work through some of her anxieties. She gladly accepted the advice. When she told her parents about this decision, they responded with some disapproval. She cut short her visit to her parents, drove to the nearby woods, and overdosed on medication. She was found unconscious with the help of the police and was hospitalized for a few days. Because of the suicide attempt, Dora was summoned to a special committee of the Health Ministry to evaluate her ability to assume the duties of residency. In the subsequent therapy session, she threatened to kill herself if the committee would prevent her from completing her training as a physician. She did not accept any of the alternatives that were considered to cope with this new problem. When she arrived home, she made another suicide attempt and again was hospitalized at the same facility in which she was treated after her first attempt.

After a few quiet months during which she made several threats to kill herself, but with no actual attempts, she reported feeling much better and was ready to resume residency. (This was approved by the special committee of the Health Ministry.) Again, Dora felt flooded by anxieties and fear, but was able to compose herself and began a training workshop before starting the residency program. She did very well in the workshop and felt encouraged. After several days at work when she was about to leave to go home, a senior physician commented to her that in this hospital, the physicians are very dedicated to their work and do not leave work that early. She called her therapist again in panic and tears. She was sure that the next day she would be fired, that her supervisors were not satisfied with her performance, and that she wanted to quit. After a long talk, she quieted down. Next morning, she overdosed again. She called her husband before slipping into unconsciousness and told him that she did not want to die. It took her five days to wake up, but she woke up with severe neurological disturbances and with an almost total loss of memory.

Discussion

In this paper, I have tried to delineate self-destructive processes theoretical and empirical perspectives and as seen in clinical settings and their contribution to suicidal behavior and suicide. Suicide is not just a response to external stressful events. Much of the anguish and unbearable pain is produced by the suicidal person him/herself in the way he/she construes him/herself, the world, and in the way he or she reacts to distress.

The various theories view self-destructive behavior from different perspectives. The dynamic theories emphasize the wish-fulfillment that is embodied in self-destruction and suicide. Baumeister’s cognitive approach views self-destructions as a reflection of inappropriate strategies to external stress that only increase the emotional distress in the long run. Other cognitive theories suggest that distorted cognitions are responsible for the production of inner stress. Theories that view self-destruction as an outcome of certain personality characteristics emphasize the destructive mode of action of suicidal individuals.

Empirical work on various self-destructive processes provides evidence that all or most of the self-destructive processes suggested by the theories are indeed at work in suicidal individuals.

The clinical data regarding the specific cases presented in this paper show that different self-destructive processes can coexist in the suicidal person. The self-destructive processes do not necessarily work in isolation because they come from emotional, cognitive and action modes of operation, combining to
produce at times total self-destruction, yet each suicidal individual may present a unique set of self-destructive processes.

The case studies presented here also show that, in one way or another, self-destructive processes have an early beginning and continue throughout life, and at times of stress are initiated by the person. In most cases, one can also find aspects of self-hate, provocation of stress, and the need for perfection and completeness. All these configurations of experience and action are self-destructive.

I believe that each of the self-destructive processes creates, in a different way, the experience of unbearable mental pain and need to escape from that pain (see 5). Mental pain is a subjective experience and can take on different forms, such as deep frustration of one’s most important needs, sense of intense devaluation, narcissistic heart, irreversibility of the pain, hopelessness, helplessness, unbearable rage and sense of loss. As it was shown, self-destructive processes can be involved in the production of such experiences. When the pain culminates into a state that can no longer be tolerated, it is usually experienced as a total disintegration and as an inner catastrophe with the potential of bringing about total self-annihilation.

This notion of the existence of self-destructive processes in suicidal behavior does not negate the epidemiological approach taken by Gould et al. (1). Rather, it is complementary to the epidemiological approach. The two perspectives should be taken into account in the prevention and treatment of suicidal behavior.

References

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