Theoretical Models of Adult Suicide Behavior Based on Psychodynamic and Cognitive Theory

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Abstract

Suicide is a significant societal problem, with vast social and economic consequences. Though studies suggest that interacting with suicidal clients is highly probable, many social workers lack the knowledge to manage this difficult task. Recently, research has called for social workers to reformulate classical theory to advance our understanding of suicidal ideation and behavior. The current article proposes two explanatory models of suicidal behavior based on divergent classical theories. Both theories' underlying assumptions were examined, in order to generate and compare the resultant models. Such efforts ensure that clinical practice and future research on suicidal behavior have sound theoretical grounding.

Keywords: Suicide, depression, psychodynamic theory, cognitive theory

Suicide is a significant social problem, having claimed over 38,000 lives in 2010 alone (Centers for Disease Control and Prevention [CDC], 2010b). Many direct practice social workers are on the front lines in settings where clients are at risk of suicide. One study found that 55% of social workers will work with a client who has exhibited serious suicidal behavior, and 31% will have a client who completes suicide (Sanders, Jacobson, & Ting, 2008). Given the prevalence of suicide, there is a consensus that social workers engaged in direct and clinical practice should be equipped to meet the needs of at-risk individuals (Joe, & Niedermeier, 2008; Osteen, Jacobson, & Sharpe, 2014). However, research has also suggested that many social workers in these settings lack training and feel ill equipped to serve clients who exhibit suicidal thoughts or behaviors (Feldman & Freedenthal, 2006; Joe & Niedermeir, 2008; Osteen et al., 2014).

Suicide has been a leading cause of death for people ages 10-64 since at least the 1980's, when the CDC began reporting fatal injury data (CDC, 2010a). Overall, suicide was the 10th leading cause of death in 2010 (Department of Health and Human Services [HHS], 2012). The rate of suicide in America has both vast economic and social consequences. The CDC (2010a) estimated that suicide resulted in $34.6 billion in work loss and medical costs. Suicide is also psychologically costly: family and friends of individuals who suicide are at an increased risk of developing mental illness, abusing substances, and attempting suicide themselves (HHS, 2012).

The National Institute of Mental Health (NIMH) (2010) estimated that 90% of suicides performed were by people experiencing a mental illness or substance abuse disorder, and that the most frequently occurring disorder was major depressive disorder. Gotlib and Hammen (2009) cite estimates that as many as 60% of suicides were completed by individuals with depression. Historical studies affirm that the two most significant "predictors" of suicidal acts are major depression and alcohol abuse or dependence (Murphy, 1974). Further, suicidal ideation is a symptom of major depression (APA, 2013).

Though studies suggest that interacting with clients who experience suicidal ideation or behaviors is very likely, many social workers lack the knowledge to manage this difficult task

(Joe & Niedermeier, 2008; Sanders et al., 2008). Recently, Lester (2014) called for social workers to revisit and reformulate classical theory, to create new explanatory models of suicide behavior and help identify the causes of suicide. Lemert (2013) posits that it is within classical sociological theories that the "why", or causes, of social change may be revealed (p. xvii). The current article proposes two different explanatory models of suicidal behavior based on divergent classical theories. Both theories' underlying assumptions were examined, in order to generate and compare the resultant models' strengths and weaknesses. This effort helps ensure that clinical practice and future research on suicidal behavior have sound theoretical grounding.

History of Theories Related to Suicide

The act of suicide has been debated in theology and philosophy for centuries (Minois, 1995). In *Laws*, Plato offered that individuals who complete suicide should be buried anonymously and separately from other people as punishment (as cited in Minois, 1995). He gave exception, however, to those who suffered "illness, and the miseries of fate… from abject poverty to shame" (as cited in Minois, 1995, p. 45). Plato's exceptions of blame may be the result of his sympathies to his mentor, Socrates, who was sentenced to drink hemlock by the state, but who arguably could have escaped from his death sentence. Socrates, in becoming his own executioner, paid "lip service to the official attitude: The gods are our masters, we belong to them, and we have no right to quit their company" (Minois, 1995, pp. 45-46).

For a time after the rise of Christianity, suicide was attributed to demonic possession or worship for hundreds of years. It was not until the mid-1600s that physicians began to note "the frequent juxtaposition of melancholia and suicidal tendencies" (Minois, 1995, p. 138). At this time, suicidal acts began to be viewed as the result of medical (psychological) illness, rather than the result of demons or the supernatural. This coincided with the first use of the term suicide; previously, suicide had been referred to as a sort of self-violation or murder, however, the focus and cause was shifting (Minois, 1995). It also coincided with Shakespeare's (1603) *Hamlet*, in which the actively suicidal title character wishes out loud, in Act I, that his flesh would melt. This marked an increase in literature's curiosity with, and accounts of, suicide (Minois, 1995).

Theoretical Model of Suicidal Behavior in Depressed Adults: Psychodynamic Theory

In classic psychodynamic theory the human mind is defined as a composition of three parts: the Id, the Ego, and the Superego (Brenner, 1955; Freud & Riviere, 1927; Lemert, 2013; Rahman, 1977). At the base of the human psyche is the Id, the most primitive of the three components. The Id is described as entirely preoccupied with fulfilling the most pressing instinct to the fullest extent possible (Peterson, 2013). The second component of the psyche is the Ego, which is concerned with mediating the Id's primitive desires and the Superego's unrealistic demands. Finally, the Superego is the result of our period of dependence on parents, and seeks to mimic models of good behavior (Peterson, 2013).

Also fundamental to classic psychodynamic theory is the concept of instincts, or drives. The two universal drives in humans are the Thanatos, the death instinct, and the Eros, the life and libido instinct (Brenner, 1955; Jung, 1961; Lemert, 2013). It is these two instincts that the Id most wants to satisfy, and therefore, the two points which the Ego most actively tries to redress

(Freud & Riviere, 1927). In psychodynamic theory, depression results from the Ego's inability to satisfy and suppress both the Id and the Superego effectively (Freud & Riviere, 1927).

Depression and Suicide as a Result of Object-Loss

Freud noted two different types of depression: that which results from an actual loss of a love-object (by death), and which results from an emotional loss of a love-object (Gaylin, 1983). In the first, the Ego does not blame itself for the loss. However, in the latter, the Ego is rejected and insulted and may grow to hate itself and perhaps to harm itself in place of the now-reprehensible love-object (Bibring, 1983; Freud, 1917; Gaylin, 1983). It is therefore in the instance of an emotional loss of a love-object that suicide becomes a possibility. Freud (1917) wrote that it is instinctual for the Ego to love itself to such an extent that it would be difficult to imagine it pursuing self-destruction. However, despite the depth of its self-interest, "the ego can kill itself… if it can treat itself as an object… if it is able to direct against itself the hostility which relates to an object" (Freud, 1917, p. 28). Object-loss as a cause of suicide has since been a topic of debate (Yufit & Lester, 2005; Power & Dalgleish, 2008).

The Proposed Model of Adult Suicidal Acts per Psychodynamic Theory

From the perspective of classical psychodynamic theory, causal and explanatory models are relatively simplistic. Most symptoms of currently defined mental illnesses are the common denomination of a weak Ego (Gaylin, 1983). Prior to Freud's illustration of the division of the psyche, the French psychiatrist Esquirol posited that suicide might be the result of what Freud would have called a weak Ego; he wrote that suicide is the result of insanity in a person who "has not fortified his soul" (as cited in Minois, 1955). In the psychodynamic model, neuroses tend to occur at the unconscious level.

The proposed explanatory model of adult suicide per psychodynamic theory (Figure 1) is constructed based on Jaccard and Jacoby's (2010) suggestions for causal model building. In this model, based on only classical assumptions of psychodynamic theory; the Thanatos, the death instinct present in all humans, which the id is already preoccupied with satisfying, is the independent variable. The Thanatos is completely mediated by the Ego; that is, the Thanatos works through the Ego. This relationship is moderated by the emotional loss of a love object. Once the Thanatos has begun influencing an Ego weakened by loss, the lost object may come to be regarded with contempt. Alternatively, the Ego may view the loss of the object as a fault of its own. If this occurs, the relationship between a weakened Ego may result in suicide via the Ego's hatred of the object being transferred to itself (Freud, 1917; Gaylin, 1983).

Strengths and Weaknesses of the Proposed Psychodynamic Model

Freud (1905) postulated a model of child development in psychodynamic theory (as cited in Strachey, 1955). Freud (1905) maintained that neuroses that occur later in life must have begun in childhood (as cited in Strachey, 1955). By this, he placed blame on parents, especially mothers, for inciting neuroses in their children (Freud, 1963). This was the greatest extent to which he emphasized social and environmental variables; throughout his theory, biological factors took precedence. Further, classic psychodynamic theory is focused on biological

phenomena at the level of individuals, rather than of groups and communities. His theory has greater historical use in addressing issues of mental illness in adults, rather than children.

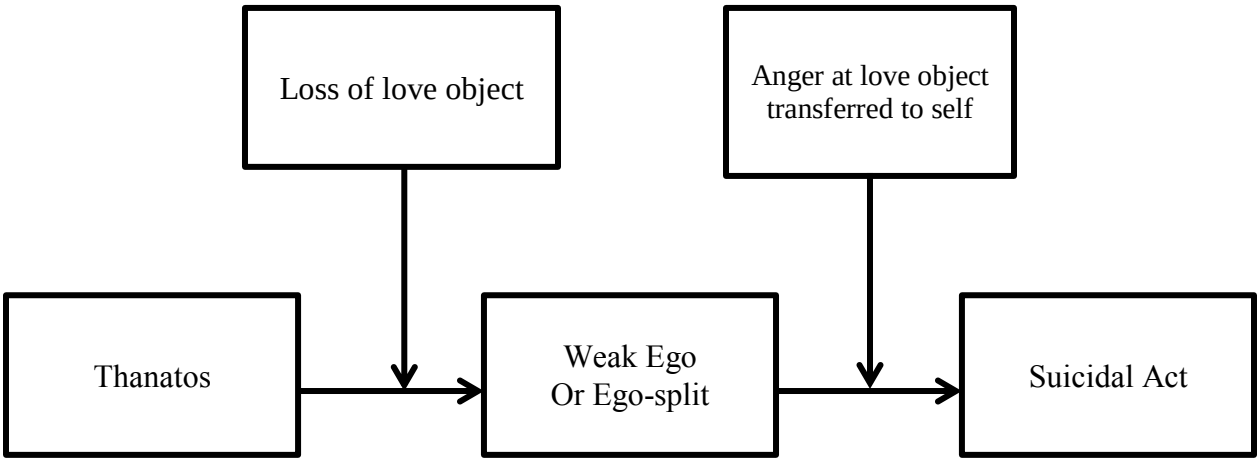

Figure 1: An explanatory model of adult suicidal behavior per psychodynamic theory.

The weaknesses inherent to this model are clear. In the psychodynamic theory, the client is a patient who is medically deficient, and the psychotherapist is the expert. This highlights the concerns of adopting a raw psychodynamic approach in social work practice. In addressing suicidiality, taking the role of the expert is extremely risky. The individual is experiencing a very unique and precarious set of circumstances, which they feel that they cannot manage. The model proposed aligns with traditionally positivist philosophical belief, by supposing that individuals who suicide all follow the same observable pattern (Robbins et al., 2012). Classic psychodynamic theory largely ignores environmental factors, which are currently emphasized in suicide prevention efforts; models based on contemporary versions of psychodynamic theory (self psychology and relational theory) do acknowledge the importance of the environment. A dynamic factor that is very relevant to suicide prevention is an individual's religion or spirituality, which Freud dismissed immediately as an indicator of a weak Ego (Freud, 1919).

Though an overly simplistic model is not necessarily clinically applicable, examining classic psychodynamic theory has significant heuristic value. It is difficult to argue against the idea that humans have some misunderstood instinct to destroy other things, other people, and our own selves. It is likewise difficult to argue against a metaphorical psychic mediator of good and bad, moral and amoral, and constructive and destructive. If a person concedes to both of these ideas, then the psychodynamic theory is supported. However, the same model may be used for a large number of clinical disorders. This illustrates the argument that specificity is the opposite of generalizability. In order to find a model that has only face validity with so many different diagnoses and social problems you must yield the ability to actually use it.

Theoretical Model of Suicidal Behavior in Depressed Adults: Cognitive Theory

The development of theories concerned with the development and importance of cognitive abilities began around 1925 when Jean Piaget, formerly a biologist, began to study psychology (Piaget, 1952; Robbins, Chatterjee, & Canda, 2012; Wadsworth, 1971). Piaget, in a way similar to Freud, believed that the mind was composed of structures, which he termed schemas (Piaget, 1952; Wadsworth, 1971). Piaget likened schemas to filing cabinets, where individuals learn to classify both physical and emotional understandings; they continue to develop throughout an individual's life, however, they grow most rapidly during childhood (Piaget, 1952; Wadsworth, 1971). Piaget reintroduced the importance of heritable traits to psychology, considering himself a genetic epistemologist (Wadsworth, 1971). He acknowledged that a certain level of intellectual aptitude is inherited, but insisted that "intelligence is an adaptation" and is formed through organization, adaptation, accommodation, and equilibrium with an individual's environment (Piaget, 1952, pp. 2-13).

Depression and Suicide as a Result of Flawed Cognitions

Like psychodynamic theory, cognitive theory was established based on observations. Like Freud, Piaget developed his theory based on case studies (Wadsworth, 1971). Cognitive theory has since developed in very operationalized ways. Aaron Beck was trained as a psychoanalytic therapist, but began establishing cognitive therapy shortly after medical school (Alford & Beck, 1997; Beck Institute, 2013; Power & Dalgleish, 2008). His primary interest was in depressive symptomology; in his early work, he regarded suicide as "the only important cause of death in depression" (Beck, 1967, p. 56). He developed a number of measures of depression – including the Beck Depression Inventory – which have been empirically tested and boast a wealth of supporting evidence (Alford & Beck, 1997; Beck, 1974; Yuffit & Lester, 2005).

In his initial texts on depression, Beck remarked on a cognitive triad that lent itself to depression: Negative interpretation of experience, negative view of self, and negative expectations (Beck, 1967; Beck, Schuyler, & Herman, 1974). In more recent literature, the triad has been referred to explicitly as: negative thoughts of self, negative thoughts of environment or of the world, and negative thoughts about the future (Beck, 2011; Rudd, Joiner, & Rajab, 2001). Beck extended Piaget's concept of schemata and posited that people who experience depression have one or more schema that are rigid, rather than flexible (Alford & Beck, 1997; Beck, 1967). Later, Beck developed the Scale for Suicidal Ideation and the Suicidal Intent Scale based on patterns, or symptoms, of cognition that similarly predicted depression: cognitive distortions, attributional style, and negative/rigid schema (Beck, 1974; Ellis, 2006; Yuffit & Lester, 2005).

The Proposed Model of Adult Suicidal Acts per Cognitive Theory

The proposed model of adult suicide per cognitive theory (Figure 2) was constructed based on Jaccard and Jacoby's (2010) suggestions for causal model building. Figure 2 focuses on two of Beck's cognitive triad that he determined were most likely to predict suicidiality: negative thoughts of self and negative thoughts of the future (Beck et al., 1974; Yufit & Lester, 2005). In this model, conscious cognitions are the independent variable. These cognitions are mediated by biological predispositions in cognitive styles and by psychiatric diagnoses. The mediators are bi-influential. Cognitions influence negative or ridged schemas. Schemas lead to suicidal ideation,

mediated by cognitive styles. The cognitive styles that influence negative schemas are self-attributional style, or negative views of self, and by negative views of the future, or hopelessness. Ideation influences both intent and action; this influence is mediated by the same cognitive distortions, which affect suicidal intent. It is important to note the pervasiveness of cognitive distortions in mediating between schemas and ideation and between ideation and acts (Lester, 2014). In later work, Beck acknowledged intent as a major mediator of suicide (Yufit & Lester, 2005); thus it is the last mediating variable between suicidal ideation and suicidal act.

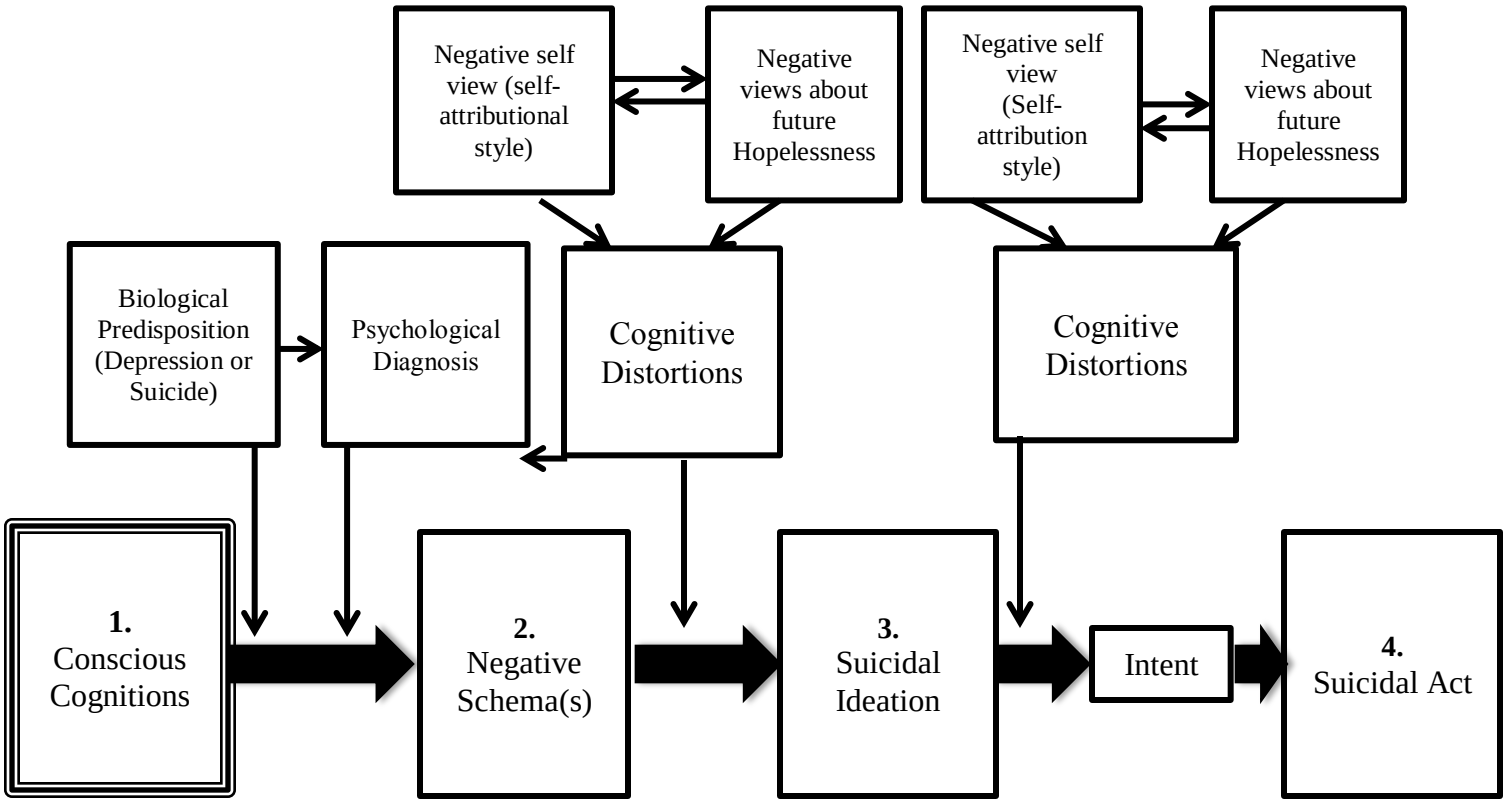

Figure 2. An explanatory model of adult suicidal behavior per cognitive theory.

Strengths and Weaknesses of the Proposed Cognitive Model

Cognitive theory is a direct practice theory concerned with biological and psychological factors (Alford & Beck, 1997). In developing cognitive theory, Beck and Piaget both postulated that cognitive style, depression, and ergo, suicidiality were biological in nature (Robbins et al., 2012). Its focus is on individuals, rather than groups or communities, and its outcomes are set on

psychological health (Freeman, Kazantzis, & Reinecke, 2010). It is less reductionistic than psychodynamic theory because, at least in Beck's (1974b) view, it acknowledges the role of the environment in developing cognitive styles. It is focused on pathology, but lends itself much more willingly to use in social work practice because it embraces the potential for human resilience (Beck Institute, 2016; Freeman et al., 2010). It can be used in strengths-based practice, though it is not inherently a strengths-based theory (Robbins et al., 2012).

Cognitive theory is more applicable with social work values than psychodynamic theory (Robbins et al., 2012). It also allows for inclusion of dynamic (individualized) variables, thus aligning philosophically with social constructivism, by allowing individuals in distress ownership in defining their concerns (Alford & Beck, 1997). The founders of cognitive theory also expressed optimism about the nature of change; they viewed actions as less deterministic and fully submitted to the idea of free will (Alford & Beck, 1997). Finally, cognitive theory is based on the assumption that human relations are much less competitive (Beck, 1974b).

Similarities and Differences between the Two Theories and Models

Cognitive theory is similar to psychodynamic theory in many ways; for example, both are related to direct practice and primarily focused on pathology. Another similarity is their representation of static variables, which are universal and not client-centered. However, proponents of both are currently adapting dynamic variables into their theories (see Fowler, et al., 2012; Johnson, Gooding, & Tarrier, 2008; Maltsberger & Weinberg, 2006). Psychodynamic and cognitive theory share many similar fundamental beliefs; for example, psychodynamic theory focuses on deviant versus healthy adaptation, and cognitive theory focuses on deviant versus healthy cognitions. Finally, the focus of both theories is on adult developmental stages, thought they both have available modifications to address other developmental stages.

The two theories are also inherently different. An important distinction between cognitive and psychodynamic theories is that cognitive theory focuses on conscious processes (cognitions) while psychodynamic theory is concerned with unconscious mechanisms (Thanatos and Ego) (Freud & Riviere, 1927; Robbins et al., 2012). Though they are both somewhat abstract, cognitive theory has made great advances in empiricism; Beck's Cognitive Triad has lent to the development of psychometric tools that yield validity and reliability (Beck, 1967; Posell, 2009). Finally, cognitive theory is less reductionistic, making it more pertinent to the social work value of Dignity and Worth of the Person (National Association of Social Workers [NASW], 2008).

Conclusions and Future Implications

In practice, social workers use evidence-based guidelines to work with clients who experience suicidal ideation. Many of these guidelines are based on contemporary versions of classical theories of human behavior. For example, in the National Registry of Evidence-based Programs and Practices (NREPP), the Substance Abuse and Mental Health Services Administration (SAMHSA) (2015) lists the Cognitive Therapy for Suicide Prevention program as one of only two programs with effective outcomes for treating clients. Dynamic Deconstructive Psychotherapy, based on the contemporary versions of classic psychodynamic theory, was additionally mentioned, though as an older "legacy" program (SAMHSA, 2015). If

the underlying assumptions of these theories are central to the development of related practice guidelines, a further examination can aid social workers in their modification and improvement.

Due to the highly personal nature of the suicide, usable guidelines for clinical practice, based on theoretical models, must be individualized. These models must offer personalization and include space to address the many dynamic variables that influence decisions to act on suicidal ideation. Models of suicide behavior, then, must be less positivist and embrace social constructivism. Some of the most specific explanatory models of suicide are being developed and proposed from interpersonal theory (Van Order, et al., 2011). However, using classic theories to develop and examine new explanatory models is an important task for social workers, in order to inform future model building (Lester, 2014).

Upon observing different theoretical models, it is easier to suppose the strengths and weaknesses of a particular theory given the problem situation. A significant weakness of both models is they include only static "universal" variables. As a result, they are of less clinical use in mediating suicidal ideation if not applied from a client-centered approach. The noted limitations in these models serve as recommendations for future model building. Results from this exercise suggest that a promising avenue for future model building would be to incorporate tenets from client-centered theory into models based on psychodynamic and cognitive theories, thus blending social constructivism and positivist philosophies (Coady & Lehmann, 2008). Despite the weaknesses in models from both theories, their historical and heuristic values are indisputable. Future endeavors in model building that addresses suicidal behavior must also focus on an attempt to offer more predictive, rather than explanatory, models. Predictive models will also address static variables, but also have the ability to incorporate generalized dynamic variables, including temporary grief from loss or temporary applications of great stress.

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