

# SUICIDAL TENDENCY AS THE WISH TO HURT SOMEONE ELSE, AND RESULTING TREATMENT TECHNIQUE<sup>1</sup>

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A frequent and grave problem for any psychotherapist is the handling of suicidal reactions. For example, nearly every psychotic or borderline psychotic patient, in the course of treatment, considers suicide as a solution. In correctional institutions, as another example, those are certain to be referred for professional help who have attempted suicide.

One is tempted to use organic therapies when suicidal danger is suspected. But, while electro-convulsive therapy (ECT) may end the immediate suicidal threat, its use disrupts psychotherapy and retards the patient's progress in any later attempts at psychotherapy. Similarly, tranquilizers may "take the edge off" the patient's problems, but, if they do, they will also, "take the edge off" the therapy sessions. Moreover, Farberow, Shneidman, and Leonard's data on suicide among schizophrenic patients cast doubt on the effectiveness of ECT, tranquilizers, and other organic treatments in preventing suicide (5). Suicide often occurred after a symptomatic improvement by organic treatment and subsequent discharge from the hospital. Indeed, the very fear of ECT was a major precipitant of suicide in some cases.

The author, who has done a considerable portion of his psychotherapeutic work with psychotic patients (10, 11, 12, 15, 16) and borderline psychotics, as well as with male reformatory adolescents, has had seventeen cases where there was a threat of imminent suicide, as indicated either by a serious suicide attempt just before referral or by projective tests.

The purpose of this paper is to describe the relatively simple active therapeutic intervention which successfully terminated the suicidal danger in each of these cases.

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## THE WISH TO HURT SOMEONE ELSE

It appears that suicide may best be understood as an aggressive retaliatory act toward significant figures in the patient's present life or toward fantasies of significant figures in his past. The primary motivating fantasy includes the wish to hurt someone else and the belief that suicide will accomplish this end. The patient has an image of how sorry or guilty people will be if he dies. This observation has been made previously by others, beginning with Alfred Adler (2, p. 324).

Among eight discussants of a case of suicide in Farberow and Shneidman's symposium (4, pp. 167-289), aggressive retaliation was most centrally invoked by the Adlerian, and was invoked as a major factor by the two Freudians, the Sullivanian, and, to a lesser extent, by the Jungian. It was explicitly denied by the Horneyan and the Personal Construct view; while the Rogerian was not concerned with a theoretical reconstruction, but solely with the nature of appropriate therapeutic response.

Closest to the present position is that of Kurt Adler, who in a particularly insightful and sensitive description of depression and its treatment, describes the dynamics of suicide in such a patient as follows:

A threat of suicide will usually terrorize his environment into compliance with his wishes. If this, too, fails, he may in his rage and in revenge go so far as to attempt or commit suicide. He expects the particular person involved to be shattered by this act, and suffer guilt for not having acceded to his wishes. In addition he indulges in a romantic delusion, a *beau geste*, designed to point up the worthlessness of others, and to absolve himself of all criticism: *De mortuis nil, nisi bene*. He will no longer have to carry on the Sisyphus work of covering up his own responsibility for his failures, which he feels is in danger of being exposed, and of upholding his illusory superiority ideal in the service of his vanity (1, p. 59).

A wide variety of other fantasies connected with suicide have been described in the literature—rescue, rebirth, introverted anger, reunion with a loved one, return to the womb, etc (3, 6, 7, 8, 9, 17, 18, 21). But while important, they seem, in the author's experience, to be secondary. Only when they exist in conjunction with a fantasy of suicide as aggressive retaliation do they lead to an actual attempt at suicide.

The affect of hopelessness is frequently present, but it is not in itself a necessary or sufficient condition for suicide; however, its obverse—a strong hope of attaining an important goal through living—seems to preclude suicide.

A case illustrating the fantasy of suicide as aggressive retaliation is that of a woman, age approximately 50. She had had several previous hospitalizations as a psychotic depressive and had been discharged each time after a course of ECT. This time she had nearly succeeded in killing herself by taking a bottle of sleeping tablets. A tracheotomy had to be performed at the hospital at which she was revived. She was transferred to a psychiatric hospital where she underwent a course of ECT. The author was called in as a diagnostic consultant. During his examination of her, she said she could not remember trying to kill herself, nor could she think of any reason why she would do a thing like that. "I must have been sick, because there's no reason why I would do a thing like that." In discussing her family, she said she liked her husband and he liked her, that he was a good husband, and that her children loved her. As she went on describing how senseless it was for her to attempt to kill herself, she mentioned that it would make her husband and children ashamed. When it was suggested to her that they would not be ashamed, she heatedly insisted that it would be a terrible shame for them, that the shame would last all their lives. She said she knew someone whose mother had killed herself, and the family were ashamed the rest of their lives. She grew angry at the author when he said he did not think it was particularly bad for the family.

What she did not recall at that time as a result of ECT was that, just before she attempted suicide, her husband had told her he had a mistress. The recommendation was follow-up psychotherapy by her psychiatrist if a recurrence of the suicide attempt was to be averted when her memory returned.

Suicidal patients, much more frequently than others, had a parent or close relative die when they were children, or commit suicide (13, 20). They have been able to witness the distress, shame, and guilt among those left behind. This memory supports the fantasy that killing oneself is an effective way to hurt someone else. The essential other-related character of suicide is also consistent with the fact that most successful suicides have repeatedly communicated to those close to them during the months before the suicide, the intention to kill themselves. It is also true that, while these plans were generally unheeded, the people to whom the patient had communicated his intention did feel guilty, ashamed, or disturbed after the death (14).

The fact that more than half of suicide notes express positive affect and not hostility has been taken to indicate that the attempt to hurt is a motive in less than half of the cases who leave notes (19). But an examination of such "positive affect" notes reveals a flavor which is consistent with the interpretation that they are intended to stir up guilt feelings.

#### CONTRADICTING THE RETALIATION, AND AROUSING HOPE

The view that suicide is intended as an aggressive retaliation logically implies that the way to deal with suicidal patients is to attempt

directly and dramatically to contradict this fantasy. In graphic and affect-laden terms, the therapist must describe how happy people will be, especially those closest to the patient, if the patient commits suicide. He should even indicate how untroubled the therapist will be if the patient kills himself.

Of course, this does not mean that the therapist should be cold and rejecting towards the patient while *alive*; the therapist indicates by his manner that he is interested in the patient, but that he is not interested in or troubled by dead patients. The author used to say that, he, too, would be happy if the patient killed himself; this was obviously true neither to his own feelings nor to the patient's view of the situation. The author now simply states that he is interested only in live patients, has no interest in dead patients, and would merely get another patient.

It may seem peculiar to make statements to the patient about how happy the survivors will be, when, in fact, suicide usually does produce suffering in the survivors. But the anguish of the survivors is never of the heroic proportions that occur in the patient's fantasies. Then, too, the individual whom the patient is most intent on hurting is often least affected by the death. The patient is angry because at some level he perceives the other as malevolent. But suicide does not effectively hurt anyone who is genuinely malevolent. The somewhat exaggerated words of the therapist are given credence by the realistic paradox that the more justified the anger, the less effective will suicide be as retaliation.

While such a technique seems to the author to follow logically from the view of suicide as aggressive retaliation, it must be admitted that the logic is escapable; of the eight therapists whose views are included in Farberow and Shneidman's volume (4), none are led to such an approach.

Kurt Adler, however, of whose work the author had been ignorant, had arrived at essentially the same technique, as described in his paper on the treatment of depression.

The problem of suicide should be dealt with . . . as a definitely insidious and vengeful device, filled with rage. I like to tell my patients that the deviousness of this act has been generally recognized; that people quickly try to forget suicides, shy away from talking about them; and that many religions do not allow suicides even to be buried beside other people. It is important to stress to the patient, that nobody will feel guilty on account of his action. Patients have tested me with the question, how I would feel, if I were to read of their suicide in the newspaper. I answer that it is possible that some reporter hungry for news would pick up such an item from a police blotter. But, the next day, the paper will already be old, and only a dog perhaps may honor their suicide notice by lifting a leg over it in some

corner. The prestige value, the *beau geste*, the attention getting, and the safeguarding of their self-esteem by such an act is dealt a definite blow by such an interpretation.

When, through all these phases in treatment, the therapist can show the patient that he esteems the patient despite his negativism, . . . despite his shabby devices, despite the malevolence he has shown to his relatives *and* to the therapist; when it can be shown that these actions were based on childhood errors that can be corrected in the present, and that there is hope for him to become a social human being; then, and only then, will cooperation with the therapist begin (1, pp. 66-67).

Moreover, as early as 1911 Alfred Adler described undercutting a patient's fantasy of the effectiveness of suicide as an attack on the therapist as follows: "A patient once asked me, smiling, 'Has anyone ever taken his life while being treated by you?' I answered him, 'Not yet, but I am prepared for this to happen any time' " (2, p. 339).

The effective principle seems to be the conjoint pressure, on the one hand, of the denial of the effectiveness of suicide as retaliation, and, on the other hand, of the arousal of hope by a warm, interested therapist who is willing to come to grips with any of the patient's problems, but who is available to the patient only if he is alive.

Three cases illustrating the author's handling of suicidal patients are described below. In these examples the denial of the effectiveness of suicide as aggression is obvious. The therapist's warmth, interest, and willingness to deal with anything, that is, his capacity for arousing hope, is not obvious. This capacity is more a matter of the therapist's manner of relating and of the atmosphere of the session than of specific words. Indeed, at first the importance of this aspect of the relationship in preventing suicide was neglected in my thinking (10, p. 39). Yet it is essential. A cold, rejecting therapist, who is unwilling to face, or incapable of facing, the intensity of the patient's suffering, would not deter suicide, no matter what technique he used. This reformulation had already been reached before the author became aware of Kurt Adler's paper (1), which as shown in the section cited clearly delineates the importance of this kind of therapeutic relationship.

#### CASES

1. A male borderline schizophrenic reformatory inmate, age 17, was referred to the author because he had attempted suicide in the county jail shortly before being transferred to the reformatory. He had broken a light bulb, and used a piece of the glass to tear at his arm. Luckily, he was noticed immediately and overpowered, alive but with deep gashes running the length of his forearm. During a previous arrest and incarceration he had attempted suicide twice. Once he had been overpowered while using a piece of glass, and the other time he jumped out of a fourth story window, but succeeded only in breaking a leg.

The results of projective tests agreed with his own statements: "I won't kill myself if I know what I'm doing. But when I get into one of those states, I don't

know what I'll do." The projective tests indicated that he would not consciously set out to kill himself unless he had a psychotic "break," in which case he would again try to take his own life. The occurrence of such a "break," according to the tests, seemed certain under the rigors of incarceration.

He was immediately started in psychotherapy on a daily basis. We discussed the subject of suicide in direct and dramatic terms. "You know what your parents are going to say? They're going to laugh! Ha! That crazy bastard! At last he's killed himself. Hurray, let's go out and celebrate! Frankly, I'll probably go out and throw a beer party myself." The patient resented these statements, but also said wryly that he'd like to go to the beer party himself.

The fourth session centered mainly on his ambivalent feelings for his mother. Afterwards, he became unruly in his "cottage" and was sent as punishment to "detention" (an isolation cell). The author saw him the next day in the detention cell. The inmate was clad in his pajamas. Apparently there was nothing in the bare cell which could conceivably be used as a weapon. As soon as the guards left, the patient said, "I'm sorry." "For what?" "I've let you down." "What do you mean?" "Look. After all your work, I did this."

He took his hand from the right side of his neck and there were superficial cuts. He had concealed these from the guards. (An unsuccessful suicide attempt, in the ordinary course of events, would have meant additional days in detention, and additional time added to his sentence.) He showed the author a piece of broken light bulb which he had managed to bring with him when he was sent to detention and which he had hid on the sill on the top of the door frame.

"I didn't feel anything. I just watched myself pick it up and cut a little bit and then cut again and again. I'm sorry I let you down."

"But you didn't. I'm proud of you. You stopped yourself. Always before you had to be stopped by someone else. But this time you stopped yourself. I'm proud of you." No further suicidal attempts occurred during this patient's treatment.

2. A male schizoid outpatient, age 31, in the throes of a depression precipitated by his loss of employment, entertained ideas of suicide. When his wife left him, the suicidal danger became acute. The danger was ended when he was confronted with the idea that his wife and family would be delighted and not distressed by his demise. Thereafter, in his therapy, whenever suicidal ideation recurred, he would reject it with, "I'll be god damned if I'll let her piss on my grave." This did not solve his other problems, of course, but it did effectively terminate the suicidal danger so that he could undergo psychotherapy without any untimely interruption.

3. A female outpatient, age 32, denied any suicidal ideas at the beginning of psychotherapy despite projective tests indicating a strong impulse to suicide which was not entirely ego-syntonic. Six weeks afterwards, when faced with an apparent break-up of her marriage, she telephoned the author to tell him that she was about to kill herself. This was immediately interpreted as retaliation: "There's only one reason anyone kills herself. It's to get even with someone else. But it won't really hurt your husband. It'll just solve his problems for him. No indecision, and it will save him the price of a divorce. As for your parents, they will be glad to get rid of you. And I'll just get another patient."

The patient became angry and insisted: "I am not trying to get even with anyone. I just feel hopeless. That's the stupidest interpretation I ever heard of. It has nothing to do with me."

Nonetheless, she did not kill herself. Further, she complained in her later therapy sessions: "It wasn't true. It has nothing to do with me. But now I can't kill myself. I used to think that if things got too bad I could always kill myself. But now you've taken it away from me. You've made it impossible." Projective tests administered four months later showed that her suicidal impulses at that time were minimal.

#### SUMMARY

Suicide has been described as the result of a specific fantasy that killing oneself is an effective aggressive retaliation. Direct dramatic

denial of the effectiveness of suicide as a technique of retaliation, when combined with a warm therapeutic relationship that arouses in the patient a hope which cannot be realized in death, suffices to end the suicidal danger. Several illustrative cases are presented.

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