SUICIDE AS A LEARNED BEHAVIOR

By

DAVID LESTER, PH.D.

Professor of Psychology
Richard Stockton State College
Pomona, New Jersey

Focusing on the social learning theory, the author herein discusses evidence that suicide is, at least in part, a learned response to stress. He first addresses theoretical considerations including learning theories of depression, manipulative aspects of self-injurious behavior and suicide, childhood experiences of punishment, society's role in suicidal behavior, and suicide as a gambling behavior. Examples of learning are then explored with important information on subcultural factors in teenage-suicide, the role of suggestion, influences in the methods of suicide, suicide in significant others, the role of the family in shaping suicidal behavior, and cultural patterns of suicide. The author illustrates these ideas with three interesting case studies—Ernest Hemingway; a minor league baseball pitcher named Bruce Clark; and Antigone, a character is Sophocle's play of the same name. The book closes with a section on implications for prevention.

CHARLES C THOMAS • PUBLISHER
Springfield • Illinois • U.S.A.

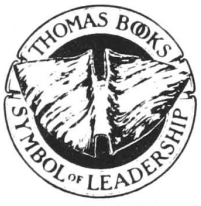
SUICIDE
AS A
LEARNED BEHAVIOR

SUICIDE AS A LEARNED BEHAVIOR

By

DAVID LESTER, PH.D.

Professor of Psychology
Richard Stockton State College
Pomona, New Jersey



CHARLES C THOMAS • PUBLISHER
Springfield • Illinois • U.S.A.

Published and Distributed Throughout the World by
CHARLES C THOMAS • PUBLISHER
2600 South First Street
Springfield, Illinois 62794-9265

This book is protected by copyright. No part of it may be reproduced in any manner without written permission from the publisher.

© *1987 by* CHARLES C THOMAS • PUBLISHER

ISBN 0-398-05340-5

Library of Congress Catalog Card Number: 87-1951

With THOMAS BOOKS *careful attention is given to all details of manufacturing and design. It is the Publisher's desire to present books that are satisfactory as to their physical qualities and artistic possibilities and appropriate for their particular use.* THOMAS BOOKS *will be true to those laws of quality that assure a good name and good will.*

Printed in the United States of America
Q-R-3

Library of Congress Cataloging in Publication Data

Lester, David, 1942-
Suicide as a learned behavior.

Includes bibliographies and index.
1. Suicide. 2. Social learning. 3. Stress (Psychology) I. Title. [DNLM: 1. Suicide. HV 6543 L642s]
HV6545.L42 1987 616.85'8445071 87-1951
ISBN 0-398-05340-5

For Bijou

PREFACE

MY AIM in this book is to present a social learning theory for suicide. I will discuss the evidence that suicide is, at least in part, a learned response to stress. There is good evidence that the choice of suicide as a response to stress and the choice of a method for suicide are both affected by childhood experiences and cultural (and subcultural) attitudes.

In my reviews of the research on suicide (Lester, 1972, 1983), it is clear that many factors have been found to be related to the choice of suicidal behavior. In particular, there is a great deal of research on physiological factors. A social learning theory does not neglect physiological (or any other set of) variables. A social learning theory does, however, argue that such variables are not *sufficient* explanations for the occurrence of suicidal behavior in the individual.

Thus, in this book, in the interests of presenting the evidence for learning factors in suicide, I will focus solely on research that is relevant to this perspective.

CONTENTS

Page

Chapter

PART FOUR: PREVENTING SUICIDE

SUICIDE
AS A
LEARNED BEHAVIOR

Part One

SOME THEORETICAL CONSIDERATIONS

CHAPTER 1

A FRAMEWORK FOR A THEORY OF SUICIDE

THE DISCUSSION of theories of suicide would be made much clearer if we possessed a framework for a potential theory of suicide. What kinds of causal variables might we propose for the theory, and how might these variables be organized?

Biological Variables

The first set of variables that might play a role are biological. The biological set of variables includes genetic variables and physiological variables.

It has occasionally been suggested that suicide might be an inherited behavior. Lester (1986) reviewed research on this possibility and concluded that the research was quite crude at the present time and that no research has distinguished between the inheritance of psychiatric illness (which might increase the risk of suicide) and the inheritance of suicide *per se.*

Physiological variables include physiological abnormalities in the brain, perhaps structural but more likely biochemical. There are many physiological theories of depression currently, and these may have some relevance for a theory of suicide if we can identify differences between depressed people who complete suicide and those who do not.

However, since suicide is a rare event, even among depressed people, it is unlikely that biological variables are either necessary or sufficient to account for the occurrence of suicide. It is possible that biological factors increase the risk of suicide in people, but we still must answer why suicide in this person at this particular time?

Childhood Experiences

Many kinds of childhood experiences may influence the appearance of suicide in later life. Many of these variables will be examined in the later chapters in this book. However, here we might note that at the personal level there are punishment experiences, experiences of loss of loved ones through death, divorce or psychological distancing due to depression or medical illnesses for example, the shaping of self-destructive impulses by parents and the observation of significant others or cultural symbols (such as film stars) committing suicide.

At the societal level of analysis, these influences are subsumed under variables such as the social sanctions against suicide (as embodied in many religions), social expectations (as in the societal labelling of attempted suicide as a "feminine" act), and the social and psychological background of the parents and other significant others. Particular kinds of parents may treat their children in ways that facilitate the appearance of self-destructive impulses.

There can be a feedback loop here, since children can influence their parents. Just as parents who beat their children may shape the appearance of assaultiveness in their children, so uncontrollable children may frustrate their parents so much that the parents beat them. Thus, the inherited temperament traits of the child may shape the environment of the child.

Mature Personality Structure

Once the child is grown up, he or she has a particular set of personality traits, theory of the world and life style. These may increase the likelihood of suicide.

Many factors have been proposed here, including depression, hopelessness, emotional instability (or neuroticism), a propensity for risk-taking or avoidance of problems, cognitive styles such as thinking dichotomously, and belief in an internal locus of control.

It is likely that these are among the most crucial factors in precipitating suicide. They are the products of the child's inherited disposition and the experiences that he (or she) encounters during his life. These factors are present at the time of the suicidal act and operate in conjunction with the next set of factors to be discussed—the social system factors.

Social System Factors

The social system factors include such variables as the environmental stress to which the individual is exposed, the social support systems

around him (or her), external sources to blame for one's misery, and hostile forces in the environment pushing one to commit suicide.

For these social system factors to act upon the individual, they have to be perceived by the individual. Psychological theories focus on the forces as perceived by the individual while sociological theories focus on the variables as they exist in the environment (the beta and alpha press respectively to use the terms coined by Henry Murray in his theory of personality).

The operation of these variables can be expressed in a flow chart as shown below (see Figure 1).

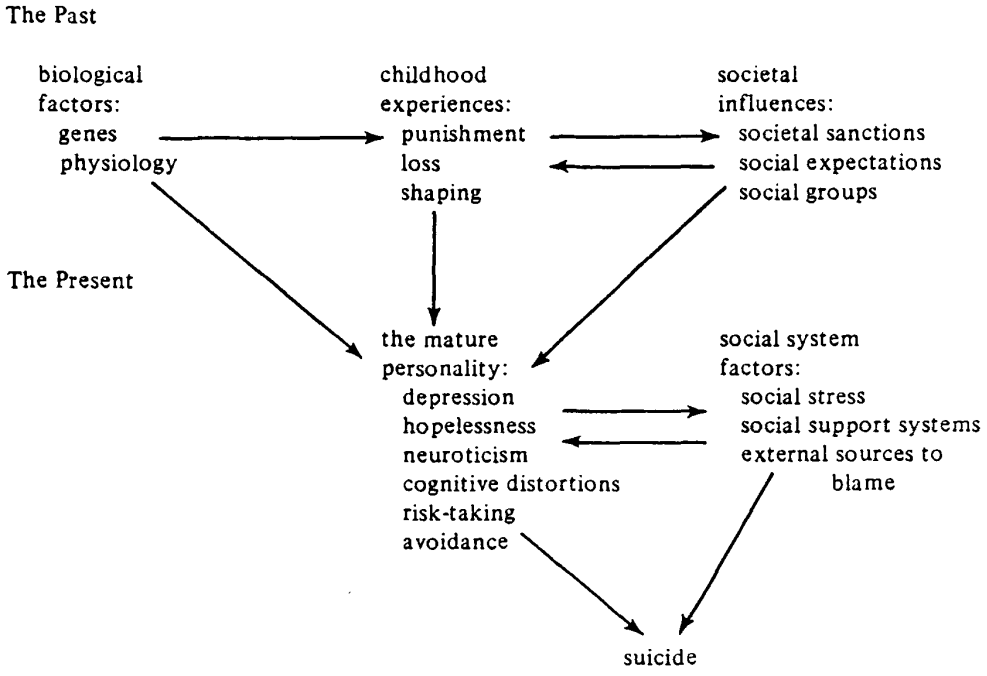


Figure 1
A Framework For Causal Factors

Suicide as a Learned Behavior

The present book looks at learning factors in suicidal behavior. Thus, it focusses primarily on the childhood experiences of the suicidal individual and those forces in the environment that shape the suicidal person and precipitate the suicidal action. The neglect of other factors does not mean that they do not play a role, but rather that they are certainly not sufficient to account for the appearance of suicidal behavior.

A Stage Model for the Appearance of Suicidal Behavior

The appearance of suicidal behavior in a person can be seen as the result of many choice points. There are many people in our society who claim never to have considered suicide. Of those who have considered suicide, many never go on to engage in more serious suicidal behavior, while others do attempt or complete suicide. It is very unlikely that people attempt or complete suicide without previously thinking about it. A very impulsive suicidal action may be preceded by a short consideration period, but even these individuals may well have considered suicide at earlier times in their life, in day dreams or idle thinking, for example.

Thus, we have here the first two choice points: the choice point between thinking about suicide and never thinking about suicide, followed by one in which the individual chooses more serious suicidal actions versus remaining a contemplator (see Figure 2).

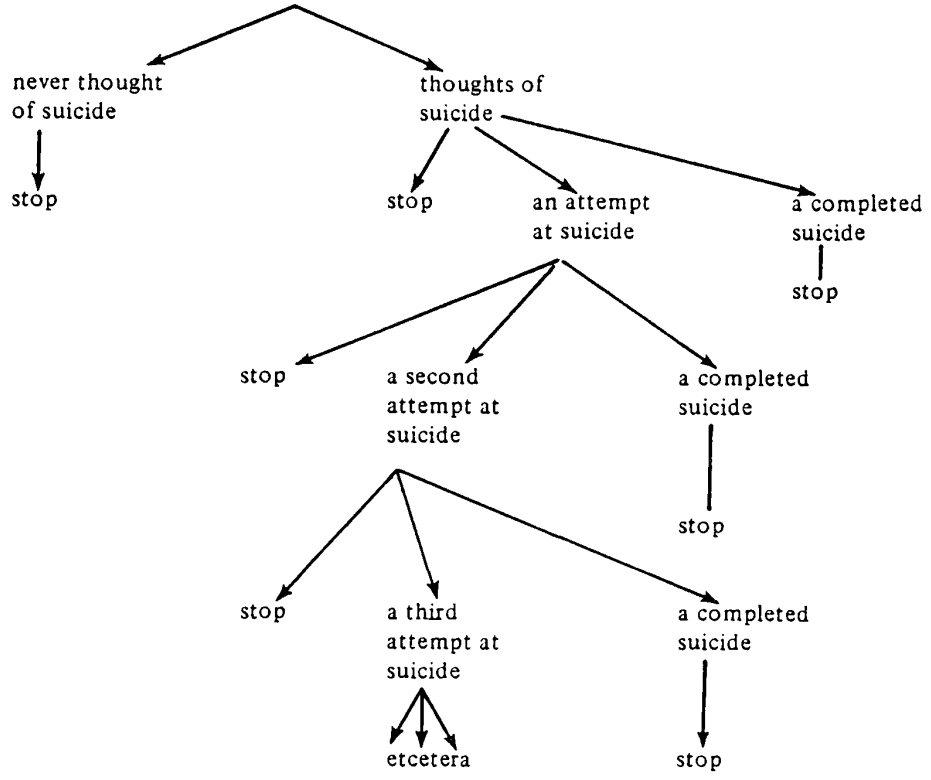


Figure 2
The Choice Points For Suicide

Looking at those who choose to attempt suicide, we have three paths. Some individuals never attempt suicide again, others repeat the suicide attempt, while a third group goes on to complete suicide (see Figure 2).

At each of these choice points, we can ask what determines the choice made. The factors can be seen to be psychological or sociological, and they can be chosen from among the array of variables mentioned earlier. Again, the present book focusses primarily on the experiential (and therefore learned) factors that play a role in these choices.

This analysis suggests that seven groups of suicidal individuals must be examined by suicidologists seeking to identify the causes of suicide:

NonSuicidal people
Suicidal ideators
Single suicide attempters
Repeated suicide attempters
Completed suicides with no previous attempts
Completed suicides with one previous attempt
Completed suicides with many prior attempts

No research has yet compared these seven groups of suicidal individuals on psychological traits or antecedent experiences so that we can determine what are the critical determinants of the choices.

REFERENCE

Lester, D. Genetics, twin studies and suicide. *Suicide & Life-Threat. Beh.*, 16: 274-285, 1986.

CHAPTER 2

LEARNING THEORIES OF DEPRESSION

THE LEARNING model for abnormal behavior, or the behavioral model, proposes that abnormal behavior is learned, much in the same way that any behavior is learned. Thus, the theories of abnormal behavior use the same learning paradigms that have been identified by psychologists experimenting with lower animals in laboratory research. It is assumed that these paradigms are appropriately applicable to humans and that humans learn behaviors in the same way as these lower animals learn.

Two major learning paradigms have been identified over the years. First, in classical conditioning, previously neutral stimuli (the conditioned stimuli) become associated with other stimuli (the unconditioned stimuli) that produce responses. Eventually, after many pairings, the formerly neutral stimuli now elicit the response.

To take an example, erotic pornography elicits sexual arousal in normal heterosexual males. Rachman and Hodgson (1968) paired pictures of boots with the erotic pornography, and eventually the boots elicited sexual arousal. The boots (the conditioned stimulus) now elicit the response that formerly only erotic pornography (the unconditioned stimulus) elicited. Rachman had produced a (temporary) fetish in these males.

The second major learning paradigm is operant conditioning. In operant conditioning, if a response is made in the presence of a stimulus and is followed by a reinforcer (or reward), then the response is more likely to be emitted in the presence of the stimulus in the future. Reinforcers are of two kinds. Positive reinforcers are the onset of something nice whereas negative reinforcers are the ending of something nasty.

To take an example here, our baby is left alone in his crib, and the light turned out as his mother leaves his bedroom. He cries and, after a

while, his mother returns and turns the light on to see if he is all right. The response of crying has been rewarded, both by the positive reinforcer of his mother's presence and attention, but also by the negative reinforcer of the ending of darkness and of being alone. His mother is teaching him to cry.

Other learning paradigms exist, and these too may be used to explain abnormal behavior on occasions. For example, Moore and Sheik (1971) have used imprinting to propose a theory for childhood autism.

Social Learning Theory

Social learning theory (Bandura, 1977) modifies simple learning theory by taking into account the fact that humans have thoughts which can affect the simple learning paradigms described above. Thoughts can provide stimuli, responses can be imagined and reinforcers can be cognitions (such as self-praise). Thus, for example, a person can engage in trial-and-error problem-solving tasks using solely internal thoughts, so that an observer would observe no stimuli, responses, or reinforcers. Social learning theory accepts too that humans can learn by watching others (by modeling).

The Labeling Model

A labeling theory of mental illness has been proposed by Scheff (1966) in which he argues that mental illness is in part a social role that a person adopts and that the most critical determinant of entry into this role is that others label the person's behavior as crazy. Scheff, therefore, argues that the role of being crazy is learned. He does not go into details of the learning process, but he notes that the media (television, newspapers and books) shape our knowledge of how crazy people behave. Furthermore, he notes that friends, fellow patients, and mental health staff also shape the person's behavior so that it conforms to the correct role for a mental patient.

The existence of cultural differences in the symptoms of mental illness provide good support for this model. The delusions of psychotics, for example, vary from culture to culture. To take one example, the Ojibwa in Northern Canada, when psychotic, believe that a cannibalistic monster has taken over their body, and they become murderous—the Wiitiko or Windigo psychosis. This delusion seems unique to the Ojibwa.

The labeling model of mental illness is quite consistent with the learning model. Both stress the role of learning, though the labeling model focusses primarily on the labeling process and takes the learning process for granted.

Learning Theories of Depression

Two major learning theories of depression have been proposed.

Inadequate Reinforcement

Lewinsohn (1974) has argued that depression is caused by a lack of reinforcement. For example, responses that were rewarded in the past are no longer rewarded because the source of the rewards is no longer present. A spouse may have died, children may have moved away, or a job may have been lost through being laid-off or through retirement. Without these positive reinforcers, the person no longer performs the responses that were formerly rewarded. The person, therefore, becomes passive and withdrawn.

Lewinsohn noted that the amount of reinforcement that a person receives is determined by the number of events that a person finds reinforcing, the availability of the reinforcements in the environment, and the ability to emit the behaviors that will elicit the reinforcers. The person may lose rewards through any of these three possibilities.

In support of this theory, Lewinsohn found that, if depressed people are placed in highly rewarding situations, then their mood improves, that a person's mood was associated with the number of rewards he was receiving (Lewinsohn and Graf, 1973), and also that depressed patients possessed fewer social skills than non-depressed people.

Ferster (1974), too, has conceptualized depressed people as those who fail to stay in effective contact with the rewards of their environment and who fail to avoid its aversive aspects. In particular, depressed people are failing to obtain adequate amounts of reinforcement.

Learned Helplessness

Seligman (1974) argued that depression was a manifestation of a phenomenon that he called learned helplessness. Seligman exposed dogs to inescapable electric shock. When he then permitted these dogs to escape the painful electric shocks, they did not learn to do so. In contrast, dogs not previously exposed to the inescapable electric shock soon learned to escape the electric shocks. Seligman suggested that the dogs who were

forced to endure inescapable electric shock had learned to be helpless, that is, they had learned that the shock was always inescapable. The experience of previous failure caused them to make little effort in the future.

In human depression, therefore, it has been argued that, in psychologically painful situations, the person tried to escape the pain, but failed. He then generalized from this experience and learned (or decided) that he could never escape the pain.

We might note that this learning process may be especially potent if the person engages in cognitive distortions of the kind described by Albert Ellis (1973) and David Burns (1980). For example, if after the loss of a lover, the person says to himself, "I'll *never* find someone who will love me. I will *always* be alone," then he will be much more likely to show learned helplessness behavior in the future.

These ideas are clearly tied to the popular personality trait of belief in locus of control (Rotter, 1966). Rotter described three beliefs about who controls the outcomes of our life. We may believe that what happens to us is a function primarily of what we do, our actions. (I failed this exam because I did not study hard enough.) This is a belief in an internal locus of control. Alternatively, we may believe that what happens to us is a function of how powerful others respond to us. (That professor never liked me. I bet he graded me more harshly than the others.) And finally, we may believe that luck and fate determines the outcomes in our life. (It just wasn't my day to take an exam. My horoscope said so that morning.) These latter two beliefs are called belief in an external locus of control.

It would seem that those who believe in an external locus of control would be more susceptible to learned helplessness and also depression caused by learned helplessness. But the situation may be more complex than that. Henry and Short (1954) have argued that as long as we can blame someone else for our misfortunes, then outwardly expressed anger becomes legitimized. On the other hand, if we have only ourselves to blame for our misfortunes, then outwardly expressed anger is no longer legitimate, and we will be depressed and suicidal.

Lester (1983) reviewed the research on belief in locus of control and suicidal involvement. Three studies found that suicidal people had a stronger belief in an external locus of control: Henderson (1972) in college students, Levenson (1973) in serious suicide attempters, and Budner and Kumler (1973) in those thinking of suicide. However, three studies found no differences in belief in locus of control between suicidal

and non-suicidal people (Henderson, 1972 [in psychiatric patients]; Robins, et al., 1977; Lambley and Silbowitz, 1973). However, Lester found no study showing that suicidal people were more likely to have a belief in an internal locus of control, so this research does support the learned helplessness theory of depression for suicidal people.

In addition, Seligman noted that depressed people typically decide that the cause of their failure is stable and will persist into the future. Thus, they see their depressed state as permanent rather than transient. They may label themselves as stupid or the task as too difficult (an internal and an external factor respectively). Both of these causes are stable also.

Finally, depressed people generalize from their failures. Rather than seeing their failure as specific to that particular task in that situation at that time, they anticipate a continued progression of failures in all kinds of situations in the future.

Depressions as a Rewarded Behavior

Frederick and Resnick (1971) noted that depression may be rewarded by significant others. Depressed behaviors may elicit positive reinforcers from others such as care-taking behaviors, the so-called secondary gain.

Furthermore, parents may actually punish the child for aggressive responses, thereby facilitating the inhibition of the outward expression of anger. This blocked anger may then be turned inward onto the self and manifest itself as depression, the traditional psychoanalytic view of depression.

Cognitive and Rational Therapies

The cognitive and rational therapies focus on the ways that people think and their problem solving skills. Those who suffer from psychological problems typically are found to think irrationally and irresponsibly and to have very poor problem solving skills.

Rational-emotive therapy, devised by Ellis (1973), is concerned with emotions that impair our existence. Let us say that the client experiences some unpleasant experience, a failure or a rejection. This is the *activating experience.* In the unhealthy sequence, there follows an irrational belief. "Isn't it awful that she rejected me? I am worthless. No desirable woman will ever accept me. I deserve to be punished for my ineptness." Next,