Eleven Deaths of Mr. K.—Contributing Factors to Suicide in Narcissistic Personalities

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The objective of this paper is to discuss and illuminate the problem of abrupt suicide in relatively well-functioning individuals without a major DSM-IV mental illness. A case of a man diagnosed with narcissistic personality, who first allegedly staged a suicide attempt and later, without overt warning, killed himself in the context of financial losses and divorce, will be discussed. The paper addresses how and why a life event can generate an internal subjective experience that evokes a sudden deadly self-attack. Discussion of eleven explanatory hypotheses serves to further the understanding of these seemingly inexplicable events. We conclude that additional studies are necessary, especially of the interconnected interaction between life event, psychological functioning, and neurobiological correlates to expand understanding and develop proactive treatment strategies.

Sudden, unexpected, and impulsive suicides in relatively well-functioning individuals continue to shock and puzzle clinicians and researchers. Such events challenge our clinical habit of seeing suicide foremost associated to severe psychiatric conditions. Studies attributing lethal actions to psychiatric diagnosis, that is, primarily mood disorders, psychosis, or substance abuse (Barraclough, et al., 1974; Robins, Murphy, et al., 1959) are indeed contrasted by those who argue that suicide is driven by subjective experiences of mental pain (Michel, Maltsberger, et al., 2002; Shneidman, 1993) or committed abruptly in a state of rage or despair (Apter, Bleich, et al., 1993; Hendin, Maltsberger, et al., 2004; Kernberg, 2001).

A majority of people who commit suicide are not under psychiatric care, and nearly 50% have never had psychiatric treatment (Luoma, Martin, & Pearson, 2002; Runeson, 1992). Among those who have contact with healthcare professionals, over 75% do not communicate intent to end their lives (Isometsa, Heikkinen, et al., 1995), and over 50% complete suicide at first attempt (Zonda, 1999). A particularly short and rapidly evolving suicidal process without prior indications of emotional or behavioral problems was found in adjustmen-disordered people (Portzky, Audenaert, & van Heeringen, 2005; Runeson, Beskow, & Wäern, 1996).

So far, ante–mortem predictions of suicides have proved to be impossible (Pokorny 1983; Simon, 2006). The post–mortem understanding of psychological processes con-
tributing to suicides remains clouded inasmuch as it depends on post-hoc inferences.

Studies searching for explanations outside the usual psychiatric and psychopathological realm have suggested different possible causes of suicide. Experience of a recent challenging life affront is common among people who suddenly commit suicide (Heikkinen & Lonnqvist, 1994). Losses were reported as the most common life event associated with suicide (Cheng, Chen, et al., 2000). Interpersonal, marital, or legal problems preceded suicide attempts in people with personality disorders (Yen, Pagano, et al., 2005). Such challenges also frequently occur among people without severe mental illness in the week before suicide (Cooper, Appleby, & Amos, 2002). Precipitating life events to suicide, commonly involving interpersonal or work-related conflicts or losses, were determined by identifying linking evidence from treating therapists’ observations (Maltsberger, Hendin et al., 2003).

Pathological narcissism, that is, a personality structure that unreliably protects self-esteem and internal control, has been connected to suicide (Apter, Bleich, et al., 1993; Arie, Haruví–Catalán, & Apter, 2005; King & Apter, 1997). People with such functioning can balance suicide-related self-esteem-preserving grandiose ideas, on the one hand, and the actual suicidal behavior and its real self-destructive or lethal consequences on the other (Ronningstam & Maltsberger, 1998). Intolerable affects, aroused by self-esteem-threatening life events such as loss of vital support, aspirations, and perfectionist ideals, can be denied and split off (Kernberg, 1992; Krystal, 1998; Schore 1994). In such cases, suicide may preserve a sense of internal mastery and control, or it may shield against anticipated narcissistic threats and injuries, as the motto “death before dishonor” implies (Ronningstam & Maltsberger, 1998). Suicide-related aspects of morbid self-esteem regulation make narcissistic individuals reluctant (or even unable) to convey their suicidal intent to a clinician.

Furthermore, impulsivity, especially impulsive aggression, has been linked to suicide in personality disorders (Conner, Duberstein, et al., 2001; Horesh, Rolnick, et al., 1997; Kernberg, 2001). Narcissistic rage and shame-based aggression can lead to suicide if turned against the self (Kohut, 1972; Baumeister, 1990). More recent studies suggest that impaired ability for self-disclosure may be associated with suicide (Apter, Horesh, et al., 2001). Reluctance or inability to share feelings and thoughts with others can force loneliness and isolation. Such a deficit was considered a mediating risk factor for suicidal behavior when other risk factors such as hopelessness were present (Apter & Ofek, 2001).

Despite increasing evidence for contextual and dynamic causes of suicide, clinicians find application of this knowledge difficult in practice. As a significant number of suicides occur outside the realm of psychiatric treatment and psychotherapy, the circumstances that drive them remain unexplored and unknown. The objective of this paper is to discuss and illuminate a sudden abrupt suicide. A man with narcissistic personality traits, who first allegedly staged a suicide attempt and later, without overt warning, killed himself in the context of financial losses and divorce, will be discussed. We will specifically address how and why a life event can generate an internal subjective experience that evokes a sudden deadly self-attack.

**CASE VIGNETTE**

Mr. K began individual psychotherapy when he was in his late forties. He had been married for over 25 years and had three adolescent sons. After a self-destructive act that followed his violation of a restraining order, he was placed on probation that recommended treatment. An anger management program and individual psychotherapy to address his intense aggressive reactivity were ordered by the court.

**Background**

Mr. K grew up in an entrepreneurial family that valued hard work, independence,
and responsibility. His father, who had died 3 years earlier after several years of illness, had owned a large industrial company, and while still in college, Mr. K started his own company in a related industrial field. His mother, a vital and active woman in her late seventies, was still working. Three younger brothers had continued their father’s business, while Mr. K branched out on his own. There was no known family history of mental illness.

After graduating from college, Mr. K married a beautiful and competent woman whom he greatly admired. Together they developed a company that gradually expanded with branches nationwide. They made a very good business team. Mr. K felt that a life dream had come true; he had an attractive wife, three fine, intelligent sons, and a successful business. He was very proud of the evidence of his hard and effective work. Unexpectedly, the company ran into financial problems. Mr. K had to downsize and lay off a major number of his employees. Family members who had worked with him left the company for other projects. After a mutual agreement, even his wife decided to take a managerial position in another corporation, with Mr. K continuing to oversee what remained of the company.

Mr. K became uncomfortable as his wife increased her independence. He needed her supportive assistance and called to ask her business advice several times daily, so often that it interfered with her new job. He would even appear at her workplace in an agitated state, insisting that she immediately attend to his problems, or even come home with him. Once he had to be escorted out of her workplace by her company’s security staff. When she complained about his behavior, he aggressively tried to control her by preventing her from leaving home, hiding her car keys or her cell phone.

Although Mr. K admitted to and apparently gradually understood the inappropriateness of this behavior, he adamantly denied any intent to be offensive or abusive. He also denied feeling ashamed or concerned about his aggressive behavior. He missed his wife immensely; her business skills had been invaluable and he could not maintain his own sense of worth and well-being without her.

After a few months, Mrs. K obtained a restraining order against her husband. Mr. K immediately went home to retrieve his personal belongings and impulsively decided to stage a fake suicide attempt to evoke his wife’s remorse. He turned on the car engine in the garage, pretended to be asleep inside the car, but left the garage door open. A neighbor found him and called the police. Mr. K was fully conscious and required no medical treatment, but he was promptly arrested for violating the restraining order. Later, he regretted his suicide trick because it backfired on him; he consistently denied any suicidal intent. In time, the wife retracted the restraining order, and the couple continued to live together in their home.

Diagnostic Evaluation

Before entering psychotherapy, Mr. K had an extensive psychiatric evaluation according to which he did not meet formal criteria for a DSM IV–R psychiatric disorder. Five independent clinicians agreed that Mr. K showed no symptoms of mental illness, mental defect, or major mental disorder. There was no psychosis and no neuro–vegetative sign of depression or mania. Mr. K had no history of major mental illness, traumatic experiences, substance abuse, suicidal behavior, or ideations, and he had no criminal past. Nor had he ever received treatment for psychological or psychiatric problems. The evaluation did suggest that Mr. K had prominent narcissistic character traits, indicated both by his behavior and a psychological test (The Millon Clinical Multiaxial Inventory, MCMI–III). The history and testing showed a sense of entitlement; a tendency to exploit others and situations for his own ends; at least a partial lack of empathy; resentment and envy of others; and arrogant behaviors and attitudes. The testing also indicated aggressive and sadistic tendencies, a potential for vindictive behavior, and a proclivity for impulsive action and possible violence in the context of losses. The diagnosis “adjustment reaction” was suggested, with distress and functional impairment in...
conduct in response to specific recent stressors, more specifically related to the restraining order. However, the evaluation also suggested that Mr. K’s behavior could represent an exacerbation of a personality disorder, including violent behavior under stress. All in all, the clinical presentation was narcissistic personality disorder with impulsive potential.

The Psychotherapy

Mr. K was placed on probation and began psychotherapy about a year after his company was downsized. At first he resented the treatment as an unfair burden forced on him by the court. He approached the therapist in a businesslike manner insisting on the minimum probation requirement of one session every two weeks. Convinced he was a misunderstood victim, he considered the treatment unnecessary. However, he also realized that if he was to sustain his marriage he had to change some of his behavior. At first, although he was frustrated and resentful, he nevertheless conveyed a sincere wish to repair and regain his previous relationship with his wife. Mr. K denied ever having felt or presently feeling suicidal, and he asserted that his simulated suicidal act was just stupid behavior which would not happen again. He showed no indications of suicidal ideation nor of aggressive, vindictive thinking. On the contrary, Mr. K conveyed strong hope and intention to repair the marital relationship to his wife.

The therapist liked Mr. K. Intelligent, articulate, vital, and energetic, he was a man with intense, argumentative, and tenacious manners, but ready to give therapy a try. “I suppose you never met someone like me before,” he said to the therapist with a smile. Not particularly insightful or reflective, Mr. K was a man who ran a business, lived intensely in the moment, and relied on external matters to preserve his self-esteem, such as financial success, business achievement, his wife’s beauty, and his sons’ accomplishments. About his therapist, he was suspicious and doubtful, but he was also curious. He knew he had to change and he had “hired” the therapist to help him do it.

Mr. K spent the first sessions pouring out his anger at his wife. Her frustrating behavior made no sense to him; he could not understand why the recent changes in their lives had eroded their relationship. He resented his wife’s independent strivings and blamed them on menopause. He mistrusted her new job and was offended that she had made new female friends. He had no grasp whatever of how his behavior had corroded the marriage.

After a couple of sessions, Mr. K said his wife doubted that treatment would do any good. She was upset about his lack of change and threatened to call the therapist herself. For a moment Mr. K seemed to like the idea that she wanted to intrude into his therapy. Asked what changes his wife wanted to see, Mr. K replied, “She thinks I am obsessive compulsive.” When couple’s therapy was proposed, he adamantly refused and changed the subject.

Mr. K was concerned about changes in his sons’ behavior; they missed their mother and showed it. He had formerly yielded most parenting responsibility to his wife whose abilities as a mother he strongly valued and admired. Now that she was often away from home, Mr. K grew profusely critical and blamed her for not being a responsible mother. He had some appreciation of his own passivity as a father, and he had experienced her care of their sons as indirect care for himself, feeling that he was one of her boys. Following these discussions, Mr. K became more involved with his sons and reported more meaningful interactions with them.

Mr. K hated his wife’s pursuits of her new independence, but he also conveyed love, admiration and desire for her. Controlling, dependent, and tenaciously possessive, he prized her as an immensely reliable and important part of his life. He seemed genuinely appreciative of his marriage, describing his life as centered around his wife, sons, and business. Outside his immediate and extended family he had very few friends. When the therapist validated Mr. K’s loving feelings, he began to convey the confusion, jealousy, and loneliness caused by his wife’s “sudden pur-
suit of her own life.” He had taken her for granted.

Mr. K began to see how demanding and intimidating he could be in managing his business and daily activities, acknowledging his controlling behavior and his impatience when frustrated. However, from his perspective his “yelling and screaming” was not intended to have a negative effect, it was just who he was—a person demanding the most of himself and of others. He could not imagine or understand how his aggressive, controlling behavior could offend his wife or provoke her to anger and withdrawal. His impaired empathic functioning, that is, his capacity for perspective-taking and his ability to feel his own feelings, was part of his tendency to treat his wife as an extension of himself. Furthermore, his inability to feel and express grief and humiliation about the business losses limited his ability to see how humiliating his rage was to his wife. When the therapist commented that he had lost most of the things important to him, things that had made him proud, he began to cry. His relationship to the therapist changed; he became somewhat more help-seeking and confiding, reaching for understanding, explanation, and support. He tried to control his anger and frustration at his wife. He tried to be supportive and respectful of her independence, take an interest in her activities, and convey more appropriately his wish to continue their marriage and repair their relationship. Although resentful of having to attend an anger management program, Mr. K’s committed participation led to obvious gains and benefits. As he identified the differences and similarities between himself and the other group members, he found that he could learn from both the leaders and the other patients. He noticed how his sense of humiliation prevented him from realistically addressing his actual problems with anger.

Nevertheless, the marriage continued stormy and unsettled. Mrs. K moved out of their home and then came back; she obtained several temporary restraining orders and then retracted them. She alternated between communicating and shunning him, between friendly, intimate, and collaborative moments and hostile, rejecting ones. The therapist watched the distance increase between them as Mrs. K spent less and less time at home. Mr. K refused to give up hope of resuming their relationship, believing his wife was just going through a temporary phase. Yet he also conveyed resignation, sadness, and powerlessness. He felt “at his wife’s mercy,” and waited for her next move. Nevertheless, Mr. K showed or reported no signs of major depression, suicidal ideation, or vindictive or hostile impulses. He continued to work, remained committed to his sons and wife, and made plans for traveling. He also discussed the need for a proactive approach in case of a possible divorce.

The Therapist’s Dilemma

At this point the therapist faced several dilemmas. First, the potential risk of Mr. K’s destructive and violent reactive behavior when sudden threats or losses confronted him was clear. Although the sadomasochistic marriage was unstable, a separation and divorce would be very challenging for Mr. K. While a gradually negotiable divorce process potentially might be manageable, a more adversarial one would be severely stressful. Would they be dangerous? Second, the therapeutic relationship was limited and tenuous. While the court-ordered treatment inevitably compromised the therapeutic alliance and influenced Mr. K’s motivation for participation and change, he nevertheless engaged in his treatment and shared some of his feelings and experiences with the therapist. Although he became more help-seeking and confided more in the therapist, he nevertheless remained secretive about his business and the details of his marital struggle. He kept the therapist at arm’s length as a distant witness to the couple’s oscillations. In addition, his composed, resolute attitude, his stolid hopefulness, and his defensive denial of rage, shame, and fear complicated optimal risk assessment and proactive exploratory and supportive treatment interventions. Mr. K did gain from the treatment inasmuch as he reported being better able to reflect upon and control his aggressive behavior, and to show some ability to grieve and emotionally process the devastating changes and losses in his life. The therapist
hoped that Mr. K would continue treatment and be able to tolerate a gradual, negotiated divorce. However, the treatment had been relatively brief, and there were no indications of the deeper structural changes in his personality that could help balance his vulnerability and potential risk for sudden dangerous behavior. His efforts to change his aggressive behavior in treatment had in fact led to his wife’s withdrawal, which had increased his suffering and distress.

The Last Session

Mr. K arrived 15 minutes late for the eleventh and final session. He had just been informed by his lawyer that his wife was filing for divorce. Mr. K discussed how to take a proactive approach, financially protecting himself and requesting custody of his sons. To the therapist’s inquiry about intensified feelings of despair and rage, and about violent and suicidal impulses, Mr. K remained silent and composed. He politely declined the therapist’s recommendation to increase the frequency of sessions to once a week, referring to forthcoming business meetings. He was encouraged to call or page the therapist as needed. He appeared somewhat more quiet and reserved, slightly more resolute and detached, and notably less aggressive and intense. Nevertheless, these were subtle differences, and there was nothing in Mr. K speech or behavior that indicated depression, suicide thinking, despair, anguish, revengefulness, or other troubling signs. He foresaw a gradual and negotiated divorce process and was determined to get custody of his sons. He left the session about five minutes early due to business obligations, an unusual event, as had been his late arrival.

Mr. K failed to appear for his next session. The therapist learned from Mrs. K, now his widow, that he had committed suicide the day before by jumping from a tall building. Although she accepted the therapist’s condolences, Mrs. K was extremely angry and upset; she said, “He just took off and left me with this whole mess!” From other sources the therapist learned that on the day of his suicide Mr. K had received an official notice from his lawyer that a legal attachment had been put on his property, the first formal step in the divorce he dreaded. He had gone to his house, collected all his valuables, and driven away in his car. On the way to his final destination (the building from which he was about to jump), he had discussed business matters on the telephone with his office manager. In retrospect, the manager thought Mr. K was somewhat incoherent, but there had been no hint of anger, despair, or suicide. Ending the conversation, Mr. K parked the car, went to the roof, and leapt to his death.

Discussion

Although the therapist was aware of the risks for Mr. K’s potentially impulsive self-destructive behavior, the abrupt legal action and immediate suicide were shocking. The deadly consequence of the sudden, belligerent divorce action was, although potentially foreseeable, still impossible to prevent. The therapist had not felt divorce would kill him, though the possibility had been considered, especially if it became adverse. Apart from his quick reactions to the legal filing, how can we understand what he did? While Mr. K’s suicide raises many specific questions, we are left with a scarcity of facts in our efforts to comprehensively explain Mr. K’s action. The task remains to further our understanding of what can prompt abrupt suicidal actions like Mr. K’s.

EXPLANATORY HYPOTHESES

Mr. K showed several pathological narcissistic features. In reviewing these we can visit eleven perspectives and examine their bearing on his death.

1. Psychopathology

Although suicide usually has been associated with psychopathology such as mood, psychotic or substance abuse disorders, it may occur outside the scope of major
mental illness (Axis I disorders) (Baumeister, 1990; Bromish, 1996; Kernberg, 1993, 2001; Maltsberger, 1998; Schneidman, 1993). While higher risk of suicide has been associated with Axis I diagnoses, nevertheless 5% to 19% of people who commit suicide have no such diagnosable psychiatric disorder (Apter, Bleich, et al., 1993; Brent, Perper, et al., 1993; Conner, Duberstein, et al., 2001; Marttunen, Henriksson, et al., 1998). However, a history of significant maladjustment (Ernst, Lalovic, et al., 2004) and significant narcissistic vulnerability without Axis I pathology (Apter Bleich, et al., 1993) have been reported in people who commit suicide. Mr. K was such a patient. Even in the absence of Axis I pathology, strong narcissistic traits may indicate suicide vulnerability. We know that Axis II disorders may suddenly appear under stressful circumstances that cause narcissistic injury. Mr. K had faced severe narcissistic mortification. His business was compromised, his marriage deteriorated, and then came divorce. The differential diagnosis would be either trauma/stress-induced narcissistic reaction (McWilliams, 1994; Simon, 2001) or decompensation of narcissistic personality disorder following significant stressors (Svrakic, 1985).

2. Loss of self–object
Maltsberger (1986) suggested that losing exterior self–sustaining resources can precipitate suicidal crises in those who depend on them to keep self–esteem in balance. Such losses precipitate three affects: murderous rage, aloneness, and worthlessness. Combined they give rise to intolerable anguish. Patients struggle to master affect flooding, but when failing, they experience self–breakup. Paradoxically suicide may seem to them a way of holding themselves together (Maltsberger, 2004). Mr. K sensed both a loss of control and a loss of his wife who had been an indispensable part of himself. He tried to master his distress by desperate and intrusive behavior, trying to control her. His suicide, in the context of trying to manage his business in the minutes before the jump, suggests he was trying to hold himself all together.

3. Loss of the ideal self–state and the broken life dream
Sandler, Holder, and Meers (1963) contended that people normally maintain a number of representations of ideal self–states—conglomerates of experiences that are desired and associated with a sense of pleasure or positive self–regard. Any departure from these states triggers pain which can lead to progressive “giving up” (Joffe & Sandler, 1965). Mr. K’s ideal self–state was closely tied to business success and his family. The gap between his ideal self–state and the contrasting unfolding development of his life forced him into powerlessness and worthlessness, driving him towards a state of “giving up.” Eventually he decided to end his life to avoid the experience of failure and defeat—he could not stand “giving up.”

Smith (1985) added another dimension to the loss of an ideal life, that is, a specific vulnerability in suicide-prone people. She suggested that a vulnerable ego was combined with a compensatory investment in a particular image of their life. This ego vulnerability manifests itself in high self–expectations, a tendency to inhibit negative emotions, an ambivalent attitude toward death, lack of
ability to grieve past losses, a tendency to develop overly dependent relationships, and passivity and neediness. Other characteristics are cognitive rigidity, arrested sexual development, and over-investment in appearance or intellectual ability. The compensatory fantasy can have an organizing effect, helping the person to function and live a relatively adjusted, though rigidly organized life. However, when this image or fantasy is shattered, a regression in ego functioning can occur, and the person escapes the pain through suicide. Mr. K. showed several indications of vulnerable ego: high self-expectations (e.g., work values), inhibition of negative emotions (inability to express shame, envy, or humiliation), limited ability to grieve (violent reactions to loss), overly dependent relationship (needing support from his wife and intensely missing her), neediness (attempts to control his wife when she asserted her independence), cognitive rigidity (getting aggravated when things did not go his way), and over-investment in appearance or intellect (overinvestment in business success and wife’s appearance as a way of regulating self-esteem). Mr. K.’s projection of a life dream (success in business and a family) supported a relatively well-adjusted life and allowed him to function successfully in both of those fields. However, when his life dream was shattered, suicide seemed his only way out of intolerable painful internal and external circumstances.

4. Sudden defense breakdown
While Mr. K.’s defensive denial and distortion protected him from reality for awhile, such reality avoidance is always an alerting sign. When these primitive defenses fail, the person faces anguish without self-regulatory resources. When Mr. K. could no longer disavow his wife’s withdrawal and rejection, we may presume he could not endure the affects that arose within him. The combination of intolerable anguish and failure of coping mechanisms probably drove his suicide. Narcissistic patients tend to manage emotional crises by denying, isolating, or splitting off intolerable feelings, while maintaining grandiose fantasies of superiority and invulnerability (Kernberg, 1992; Krystal, 1998; Schore, 1994).

Plainly, this specific combination of narcissistic and affect pathology can result in a paradoxical state of calmness, control, and self-confidence in the suicidal patient. “I just need to know that I can kill myself and make the decision as to when, and all negative feelings just disappeared,” one woman said.

5. Anger turned against self with revengeful intent
Freud’s formulation (1917 [1915]) that suicide (e.g., aggression turned against the self) represents an effort to kill an ambivalently regarded lost person internalized within the self could serve yet another explanation of Mr. K.’s action. Indeed, he struggled with strong ambivalent feelings towards his wife who had become increasingly distant. The idea of destroying the other by destroying the self is an effort to take control but can also have a retaliatory intent. Several studies have shown that revenge can drive suicide (Baechler, 1975; Bancroft, 1979; Bancroft, Skrimshire, & Simkin, 1976; Birtchnell & Alarcon, 1971; Boerges, Spirito, & Donaldson, 1998; Hawton, Cole, et al., 1982; Williams, 1986). This suggests that suicide communicates anger and aims to punish. In addi-
tion, Kernberg (1984) described suicide associated with malignant narcissism as a vehicle of omnipotent wishes for sadistic control. Mr. K once simulated suicide in anger to evoke his wife’s remorse. As his wife pursued the next step towards divorce, Mr. K’s revengeful intent escalated into a real suicidal act. His wife’s response—“He just took off and left me with this mess”—suggests how effective suicide can be for “getting even.”

6. Neurobiological indicator
Right hemisphere dysfunction is considered a risk factor for both suicide (Weinberg, 2000) and narcissism (Schore, 1994; Weinberg, 2000). Such dysfunction manifests itself in frail self–representation, dissociation, poor impulse control, and emotional dysregulation (for a review see Weinberg, 2000), as well as in narcissistic vulnerability (Schore, 1994; Weinberg 2000). All these characteristics are descriptive of Mr. K. As negative affects tend to escalate right hemisphere dysfunction (Weinberg, 2000), it could be possible that anticipation of the divorce led to further right hemisphere dysfunction, manifested in dissociation (e.g., managing business matters in a detached manner), emotional dysregulation, loss of impulse control (e.g., suicide attempt), and self-breakup (e.g., compartmentalized functioning in therapy vs. work vs. relationship to his wife).

7. Turning passive into active
Kohut (1972) suggested the desire to turn passive into active as a response to narcissistic injury, especially in shame-prone individuals. Family values of independence, responsibility, and hard work might have made Mr. K intolerant of passive suffering and resignation in the face of defeat. Rage and controlling behavior towards his wife may have aimed at reasserting and reclaiming involvement and control. His suicide can be seen as stopping the divorce process and seizing control over it: “It is not you, who is filing for divorce, but me, through suicide.”

8. Intolerance of humiliation, envy, and shame: A specific case of emotional dysregulation
Linehan (1993) proposed and others (Westen, Muderrisoglu, et al., 1997; Zlotnick, Donaldson, et al., 1997) confirmed that emotional dysregulation predisposes to suicide. Inability to tolerate emotional states is a source of narcissistic threat, inasmuch as it challenges both one’s sense of omnipotence and internal control. Trumbull (2003) suggested shame to be an acute stress response to interpersonal traumatization. As such, shame can mobilize depressive paralysis, narcissistic rage, and self–hurtful intent. Envy may lead to shame as it implies inferiority of the subject and superiority of the object of envy. Mr. K. was flooded with threatening and intolerable feelings as he faced vanishing hope of reconciliation with his wife. In addition, some of his shame–based aggression was triggered by loss of pride, value, and status. Humiliation and loss of pride and control left Mr. K. powerless to repair his broken narcissism, and suicide was a way to reassert his pride and reclaim control.

9. Self–destructive core and gradual approach of death
Mr. K’s stoic, self–sufficient attitude hints at a masochistic investment in suffering (Cooper, 1988). Was his help–rejecting attitude and tendency to invite humiliation a sign that his
own self-destructiveness might have been pushing him towards suicide? Was his aggressive, battering behavior towards his wife actually a well-known and characteristic rejection–provoking behavior common among suicide-prone people? The provoked rejection confirmed his victim role and deepened feelings of worthlessness and being unlovable. Such provocation also unleashes anger and dissipates feelings of guilt over self-destructive wishes, making suicide easier (Maltsberger, & Buie, 1973; Novick, J., 1984; Swann, 1996). Maris (1981) described and confirmed that childhood traumata instills self-destructive tendencies that erode positive lifestyle. In this context we can see Mr. K’s first suicide attempt as a rehearsal, a way of decreasing anxiety over performance of suicidal act—and fear of death (Orbach 1988). He denied any suicide intent but must have remembered that portrayal as an investment in the future should things get worse. Suicide by jumping is characteristic of psychotic states (de Moore & Robertson, 1999). Laufer (1995) suggested that suicide occurs in psychotic states, when irreversibility of death is denied (see also Maltsberger, 2004).

10. Cognitive deconstruction
Baumeister (1990) claims that suicidal people escape negative feelings, especially shame, by flight into a deconstructed state of mind—they abandon any sense of time, ability to represent higher levels of meaning, and, consequently, focus on the concrete aspects of the reality. Cognitive deconstruction shuts off intense emotions, and is often associated with total lack of emotions passivity and a withdrawal from active involvement and responsibility in life. Because cognitive deconstruction is also associated with disinhibition and with concrete irrational or illusional thinking, Baumeister (1990) saw this as a pre-suicidal state. Studies confirm that anticipated loss can lead to cognitive deconstruction (Twenge, Zhang, & Im, 2004) and increased self-destructiveness (Twenge, Catane, et al., 2003). At the end, Mr. K. was facing the loss of his wife through divorce. His impulsive attempts to control his wife could suggest self–deconstruction , while his non–disclosure of suicidality in treatment seems to reflect his concrete, dissociated state of mind. The suicide followed as an impulsive escape from painful self-awareness as well as from the anticipated loss.

11. Underdeveloped capacity for mentalization
Fonagy (1999) suggested that the capacity for meta–cognitive control, reflective self–functioning and mentalization, and the ability to see and attribute intentions to self and others, protect against narcissistic injury. In narcissistic patients, these capacities have not properly developed, and they are unable to think and reflect beyond the immediate experience. They fall back on aggression as a protective shield against overwhelming thoughts and feelings. Mentalization failure leads to objectification of one’s body and denial of reversibility of death. In moments of threat and despair, this was obviously one of Mr. K’s handicaps. This capacity to reflect and understand the consequences of aggressive and self-destructive actions were probably impaired or lacking.
CONCLUSION

Suicide is a relatively rare event, now occurring in the United States about 31,000 times each year. Inasmuch as we have no specific tag or indicator that distinguishes those persons destined to die of suicide from those who are not—no psychological test, no biological marker, no other specific flag—clinicians are forced to do the best they can to pick and choose among those who come to their attention as persons who might commit suicide. The only way is to rely on clinical assessments of risk, since prediction of who will commit suicide is still scientifically impossible at present (Pokornoy, 1983).

There is an extensive literature on suicide risk assessment, requiring that on the basis of careful inquiry into a patient’s present circumstances, medical and psychiatric history, and mental state examination, an examiner should arrive at a probability estimate of a suicide occurring in the near future (Simon & Hales, 2006). As a practical matter, this means that the responsible clinician would elect to commit a patient to a psychiatric unit, involuntarily if necessary, should attempting suicide appear more probable than not. Indeed, the clinician would have a legal duty to take steps to protect such a patient, and would fail to do so at his own peril. This is the usual scenario of the common malpractice actions against mental health specialists—failure to protect the patient when a suicide attempt was expectable and probable.

We can generate multiple theories to explain many suicides after the fact. For this reason, we tend to avoid deterministic explanatory models. In fact, absent major mental illness (including depression), suicidal communications, evidence of suicidal preparations, and a life history indicating suicide proneness, it becomes virtually impossible to admit a patient to a psychiatric unit as at risk for suicide, on either a voluntary or on an involuntary basis, especially if the patient denies any such ideation or intent, as was the case with Mr. K. In his case, there clearly were indications of intense stress that might be narcissistically destabilizing, although the development of the potentially stressful specific life circumstances was unforeseeable. Not every patient who experiences narcissistic destabilization becomes suicidal, however, and in such circumstances, the only possible course for a prudent clinician is to be aware that a suicide crisis may arise and to remain in close contact with the patient until there is evidence of restored emotional equilibrium—and to act if suicide becomes probable on clinical grounds.

Research on suicide mostly involves longitudinal studies of identified high-risk groups. While the advantages of such studies are obvious, rare instant events like Mr. K’s suicide can provide important facts and raise significant questions, especially regarding the interconnected interaction between life-events/contexts, psychological functioning, and neurobiological correlates. Further in-depth studies of the role of impulsivity, shame and aggression, and their neurobiological correlates in high functioning narcissistically vulnerable people are necessary to expand our understanding and develop more proactive and preventive treatment strategies for such people.

REFERENCES


