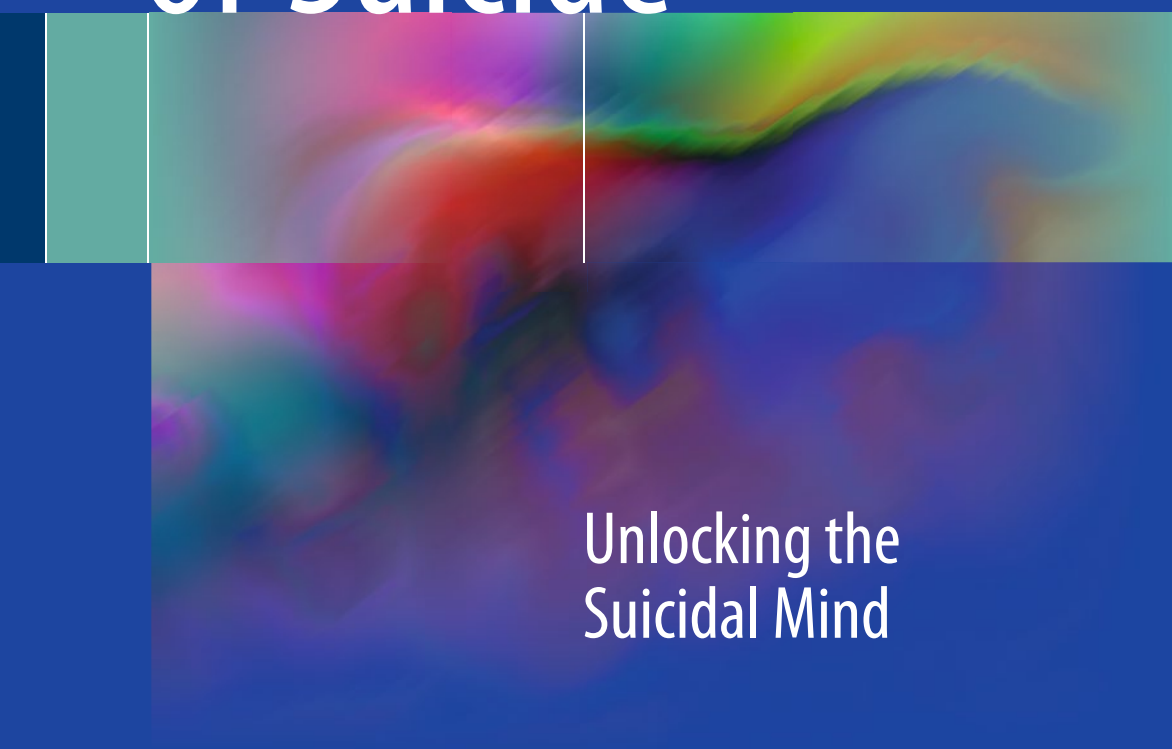
Maurizio Pompili
*Editor*

# Phenomenology of Suicide



## Unlocking the Suicidal Mind

Springer

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*To my mother whose eyes left me too soon*
*but still light up my life*

# Preface

A few years ago, Prof. John T. Maltsberger, a leading figure in the study of suicide, said (2010) that "In 1960 there were perhaps fewer than fifteen books in the Harvard Medical School library specifically dealing with suicide, the best of which seemed to have come from the Los Angeles Suicide Prevention Center where Shneidman, Farberow, Litman and their colleagues were suicide pioneers. (Today there are bookshelves full.)" Before that (1986), the same author had commented that "So massive is the suicide literature that any attempt to master it may stagger not only the mind, but the back as well…. Forests are destroyed to feed the whirring presses; many new articles and a book or two appear each month." These sentences allow me to introduce the aim of this book. In dealing with many suicidal patients, I face the challenge of getting to know the suicidal mind of each unique individual. My mentor and friend Edwin Shneidman, father of suicidology, once kindly scolded me as my approach to suicide at the beginning of career was too much psychiatric (being myself a psychiatrist). The need for a broader view of suicide risk than the medical model alone is now shared by many psychiatrists and mental health professionals. I then realized that if I wanted to understand suicide risk within a comprehensive framework, I had to embrace a phenomenological approach. Furthermore, I came to the realization that suicidal patients experienced moral pain, which is described by Morselli as the pain of the negative emotions—shame, guilt, abandonment, ennui, dysphoria, hopelessness, and inanition—what Shneidman calls psychache.

I, therefore, shared the fact that it was more strategic to view suicidal impulses (thoughts and actions) phenomenologically, more like being in love than having liver disease. And making sense of Shneidman's words, the key to suicide prevention lies in focusing on the individual's idiosyncratically felt psychological pain rather than dropping him or her into a DSM box, although a DSM diagnosis may be traceable and play a role. Suicide is still very much tied to mental illness and ultimately considered only a complication of such conditions. A phenomenological approach is still lacking and the opportunity to understand the suicidal mind still impaired. Too often health professionals are focused on what is simpler, that is treat a medical or mental illness, whereas facing suicide risk goes beyond the traditional approach and involves human understanding of suffering in a specific individual.

A shift in paradigm is needed; such a novel approach is more complicated, but nevertheless cost-effective. The traditional paradigm is easily implemented and public health campaigns seem to be delivering well-accepted concepts. However, when facing individuals in clinical crises, human understanding is the key to succeed.

Professionals should focus on "What is it like to be suicidal?" in order to empathize with patients' suffering.

In this book, I gathered scholars across disciplines who focused on various aspects of suicide and contributed to the advancement of our understanding of mentalistic approach to suicide. They are dedicated suicidologists, researchers, and clinicians. I challenged them to translate their basic knowledge of the suicidal process and promote a new approach to the understanding of suicide.

I am sincerely grateful to all of them who graciously contributed to this volume. It is my hope that this project may help save lives.

Rome, Italy Maurizio Pompili
April 29, 2017

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# Contents

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Maurizio Pompili is Associate Professor of Psychiatry and Professor of Suicidology as part of the Faculty of Medicine and Psychology at Sapienza University of Rome, Italy, where he received his M.D. degree and where he was trained in Psychiatry (both *summa cum laude*). He is the Director of the Residency Training Program in Psychiatry of his faculty and the Director of the Suicide Prevention Center at Sant'Andrea Hospital in Rome. He has a doctoral degree in Experimental and Clinical Neurosciences. He was also part of the Community at McLean Hospital—Harvard Medical School, USA, where he received a fellowship in psychiatry.

He is the recipient of the American Association of Suicidology's 2008 Shneidman Award for "Outstanding contributions in research in suicidology."

Apart from being the Italian Representative of the International Association for Suicide Prevention (IASP) for 8 years, he has been afterward one of the vice presidents of this association. He is now Co-Chair of the IASP Special Interest Group in Risk Resilience and Reasons for Living. He is also a member of the International Academy for Suicide Research and the American Association of Suicidology. He is also President of the Suicidology Section of the Italian Psychiatric Society.

He has published more than 350 papers on suicide, bipolar disorders, and other psychiatric perspectives, including original research articles, book chapters, and editorials. He co-edited ten international books on suicide.

He ranks in the top ten suicide authors of 500 world suicide authors listed in the Web of Science (this is in terms of the number of focused works on the topic of suicide that are indexed in the Web of Science).

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# Historical Phenomenology: Understanding Experiences of Suicide and Suicidality Across Time

1

Ian Marsh

## 1.1 Introduction

To say that different cultures at different moments in history have constructed suicide differently is probably to state the obvious. Any book which offers up a history of the subject confirms that this is so. We can read, for instance, that in Ancient Rome, certain philosophers viewed acts of voluntary death as honourable, that in Europe in the Middle Ages, self-murder was taken to be a heinous sin and crime and that more recently suicide has come to be thought of as a symptom or outcome of mental illness or associated with particular economic and social structures (e.g. van Hooff 2000).

But what, actually, is the subject of these histories? There are accounts of people acting to end their own lives in pretty much all eras and in all places. That these accounts vary is easy to see, but is what they are accounts of, namely, "suicide", singular? Is there an unchanging element, essence or experience of suicide or suicidality and it is merely the descriptions and meanings that change according to place and time? Or is suicide mutable and heterogeneous? Is suicide itself—as an event, act or experience—always a historical and cultural product, its form necessarily contingent on the context within which it arises? This chapter tries to address some of these issues, drawing on work from the fields of history and anthropology in order to cast doubt on some of the universalist assumptions implicit in many modern theories of suicide. In so doing, a different perspective on the experiences of suicidal people is offered.

It is perhaps worth noting from the outset that the term "suicide" can be brought to bear on a broad range of acts—physician-assisted suicide, suicide bombing, political acts of suicide, self-starvation in religious ritual, suicides in the context of military tactics and actions, suicides of honour, self-sacrifice and martyrdom—so

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on one level the heterogeneity of what gets termed "suicide" is also not so hard to argue (Battin 2015). What I am particularly interested in here, though, are those acts which are read as archetypally or definitively "suicide" in contemporary mainstream academic and clinical books and articles on the subject. Within suicidology (i.e. the discipline concerned with the study of suicide), it tends to be taken as read that suicide is always (or almost always) pathological ("people who kill themselves are mentally ill") and that it is primarily an individual act (i.e. that suicidality arises from, and is located within, the "interiority" of a separate, singular, individual subject). There also seems to be a strong belief that research into suicide should proceed along western scientific lines ("we will come to the best understanding of suicide through studying it objectively, using the tools of Western medical science") (Marsh 2010, 2015).

Accounts of suicide constructed from within this worldview tend to assume suicide has unchanging, acultural and ahistorical elements. Certainly medico-psychiatric descriptions take mental illness, usually depression, to be a nearly universal feature of such acts, not just of the present day but also through history (e.g. Thomas 1980; Colt 2006; Pahor 2006). Psychological theories, too, have tended to work from an assumption that there are invariant elements to suicide. One of the founders of modern suicidology, Edwin Shneidman, posited "psychache" or mental pain as a necessary and unchanging feature of suicide (Shneidman 1993, 1996). More recently Thomas Joiner (2005) and others (e.g. van Orden et al. 2010) have developed the Interpersonal Theory of Suicide which, building in part on Shneidman's work, argues that mental pain arises due to unmet human needs—specifically thwarted belongingness and perceived burdensomeness—and that these factors, alongside an acquired capacity for suicide, are the main drivers behind acts of suicide. These elements are taken to be universals; for example, Joiner (2005) describes the need to belong as a "fundamental human motive" (p. 118). Similar assumptions can be found in Van Orden et al.'s later (2010) paper on the Interpersonal Theory of Suicide, "social connectedness variables are associated with suicide because they are observable indicators that a *fundamental human psychological need* is unmet; this need is described by Baumeister and Leary (1995) as the "need to belong" (p. 1). According to the theory, when this need is unmet—a state we refer to as *thwarted belongingness*—a desire for death develops" (p. 9, my emphasis), or later, "the theory's constructs represent the etiological mechanisms that underlie *all forms of suicidal behavior*" (p. 26 my emphasis).

Arguments for the existence of invariant elements to suicide are not uncommon in contemporary suicidology; indeed, assumptions as to the near universal applicability of particular ideas can be found in most mainstream theories, with these often centring on Western notions of psychopathology. To take another example, in a recent paper, Joiner et al. (2016) argue "that death by suicide in humans is *without exception* a derangement" (p. 235 my emphasis), and they state that they view "suicide as pathological—indeed an exemplar of psychopathology—and thus our position offers no support for suicide itself as adaptive or as anything other than a pathological derangement involving (and producing) great misery" (p. 235).

These theories of suicide raise a number of issues for me. First, I'm not sure these claims of universality are justifiable. Secondly, I'm interested in what effects those theories have on prevention practices and on suicidal subjects themselves, as well as the effects in relation to the formation of suicidal subjectivities. These are complicated issues to address, but I think historical studies of suicide can help illuminate these aspects, but perhaps only if working from particular methodological assumptions. My thinking here with regard to methodology draws on recent work in the anthropology of suicide, specifically Ludek Broz's and Daniel Münster's edited volume, *Suicide and Agency* (2015), and I think that their understanding of the prerequisites for a critical anthropology of suicide, and of what such an approach can contribute, has relevance for critical historical approaches to the study of suicide too, particularly in relation to challenging taken-for-granted contemporary universalist assumptions on suicide. I will explain this approach in more detail below and then go on to argue that both anthropological and historical studies of suicide indicate that there are no essential features of suicide, that each age and culture produce its own particular forms of suicide and that experiences of suicidality also vary in relation to the beliefs, customs and norms of personhood found at particular times and places. This has implications for both phenomenological understandings of suicide and, more generally, with regard to the assumptions we bring to research, theory and practice on the topic, and towards the end of the chapter, I will address these issues in more detail.

## 1.2 Anthropology and Historical Phenomenology as Critical Perspectives on Contemporary Suicidology

In the introduction to *Suicide and Agency* (2015), Daniel Münster and Ludek Broz make clear that they believe it necessary for an anthropology of suicide to take a critical stance in relation to dominant contemporary framings:

> For anthropology, the particular challenge lies in thinking beyond some of the assumptions implicit in the powerful and widespread clinical conceptualization of suicide, which presents it as a pathological and individual act, committed with wilful intent, full consciousness and unambiguous authorship, whose default subject is arguably a "Western," male, white, middle-class human. These implicit assumptions serve as a "gold standard" of real suicide, to which all acts of self-harm are compared or ultimately attributed. (Broz and Münster 2015, p. 3)

A degree of scepticism then towards the knowledge claims of Western suicidologists, or at the least a "setting aside" of the assumptions of mainstream suicidology with regard to notions of free will, suffering, authorship, power and personhood, is necessary in order to be able to read cultural differences in suicide. Münster and Broz point to the positive example of critical medical anthropology, which has productively destabilised "Eurocentric certainties surrounding the medical sciences' knowledge claims by bringing in questions of power, the geopolitics of knowledge, and divergent ontologies of body, personhood, health/well-being, and death" (p. 8). In addition,

Münster and Broz argue that "the value added by anthropology lies in bringing examples of the formation of 'suicidal subjectivities' from contexts characterised by very different views of morality and of (moral) personhood to the study of suicide and agency" (p. 17). By focussing on these elements and processes in relation to suicide, I think anthropology can act as a critical counterforce to the taken-for-granted assumptions of "Western" suicidology, and Münster and Broz's book is evidence of how productive such an approach can be. I also think that an approach committed to understanding "divergent ontologies of body, personhood, health/wellbeing and death" and the formation of suicidal subjectivities over time within different contexts is one where history also has something critical and counter-hegemonic to contribute.

Interestingly, Münster and Broz do set limits to the project of an anthropology of suicide, stating that "it is scarcely the aim of the authors [in their edited volume] to achieve an ethnographic proximity to suicide, in the sense of getting as close as possible in a temporal, spatial, or empathic sense to suicide acts. Rather, they study what may be called *suicide fields*—the wider domains of practices and of sense making, out of which realized, imaginary, or disputed suicides emerge" (p. 9). However, I think that there is something to be said for exploring the possible relationship between such "suicide fields" and experiences of suicide and suicidality, both ethnographically and from a historical perspective. Either approach can cast light on how social values, beliefs and practices interact in complex ways with a desire to end life—in particular on how experiences, and even the formation, of such a desire are necessarily shaped by the historical and cultural milieu within which they arise. I will now try to explore these issues a little, first by trying to think through how we might understand the relationship between culture and experience, how this relates to suicide and how historical accounts can help us to understand better the ways in which experiences of suicide and suicidality are formed over time within particular societies.

Mapping such complex relationships is not in any way straightforward, though. For one thing, there is a widespread belief in, as Al Alvarez puts it in *A Savage God* (1971), the "closed world of suicide" (p. 95) with "its own irresistible logic", where the suicidal person is taken to reside in a "shut off, impregnable but wholly convincing world" (p. 144). If we were to take Alvarez's description at face value, we might conclude that such a world is unavoidably beyond reach, understanding or reconstructing from the "outside"—in the present time let alone historically. I am not so sure, though, that any experience, however extreme, is completely closed or outside of culture. Even experiences which seem most private, direct and acultural such as physical or mental pain are embedded within cultural worlds. As Lakoff and Johnson (1980) argue:

> "Direct physical experience" is never merely a matter of having a body of a certain sort, rather, every experience takes place within a vast background of cultural presuppositions. It can be misleading, therefore, to speak of direct physical experience as though there were some core of immediate experience which we then "interpret" in terms of our conceptual system. Cultural assumptions, values, and attitudes are not a conceptual overlay which we may or may not place upon experience as we choose. It would be more correct to say that all experience is cultural through and through, that we experience our "world" in such a way that our culture is already present in the very experience itself. (p. 57)

From such a stance—that "our culture is already present in the very experience itself"—we can assume that there are shared features and elements of experience, even of extreme states, which can be noticed, communicated and understood. Work which has explored the social formation and constitution of those experiences usually interpreted as private and individual in nature and often taken to be ahistorical and acultural, such as emotions and experiences of pain (e.g. Ahmed 2014), or thought and inner speech (e.g. Fernyhough 2016) open up possibilities for considering how the cultural and historical constructions of personhood, authorship and agency, as well as beliefs, traditions and social norms, relate to the formation of suicidal subjectivities and experiences of suicidality. Here historical and historical phenomenological studies can be illuminating as well as anthropological/ethnographic ones.

## 1.3 Historical Phenomenology

Historical phenomenological approaches have been brought to bear on a wide range of subjects including premodern sexualities (Smith 2000), sport (Skillen 1993) and Shakespeare studies (Curran and Kearney 2012). Although not a unified field of study by any means, historical phenomenological approaches do share an interest in what it must have been like for historical subjects to experience particular sensations and feelings. As Curran and Kearney (2012) explain, "[i]f phenomenology as a philosophical school can be broadly characterized as the study of sense experience from the first person point of view, then historical phenomenology can be characterized, more narrowly, as the study of sense experience during a specific historical past" (p. 354). They go on to explain the premises at work in such an approach: "First, that feeling and sensing have a history. The way we feel sad is different from the way Shakespeare felt sad; the way we smell perfume is different from the way Queen Elizabeth smelled perfume. This is because the two experiences occur in distinct cultural, institutional, and discursive contexts" (p. 354). They also emphasise that, importantly, "feeling and smelling are not historical artefacts in the same way that we might argue a book, a building, or even an event is since feeling and sensing are embodied, subjective processes" (p. 354). "Historical phenomenology", they argue, "therefore, embraces the dynamism and nebulousness of feeling and sensation by thinking in terms of ecologies rather than artifacts, experiences rather than objects, and by abandoning neat distinctions between persons and things" (p. 354).

So a starting point for historical phenomenological approach to suicide and suicidality might be to ask how notions of personhood, subjectivity, interiority, individuality, authorship and agency change over time and the ways in which these contingent aspects of life might relate to emotions, feelings and experiences of suicidality. However, these aspects of selfhood (e.g. ideas and experiences of interiority, individuality, authorship and agency) can be difficult to read as contingent, embedded as they are in our everyday notions of our self and others, and often presented in thoroughly realist and essentialist ways. Critical anthropological and

historical approaches can cast light on assumptions of subjectivity and agency perhaps only by being reflexively aware of what assumptions are bought along with the anthropologist and historian. It is maybe only possible to highlight differences between contemporary dominant Western assumptions about personhood, subjectivity and agency by first being reflexively aware that we are always dealing with contingent, situated assumptions, not universal facts in relation to these areas. Clifford Geertz (1983) argued that a person is conceived in the Western world to be "a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgement and action organized into a distinctive whole and set contrastively against other such wholes and against its social and natural background" (p. 59). This was, he said (albeit controversially), in contrast to most other cultures. Similarly, we have a tendency to take Western contemporary conceptualisations and experiences of emotion as having universal applicability, but as Gail Kern Paster, Katharine Rowe and Mary Floyd-Wilson (2004) point out, our modern tendency to script emotions as individual and proprietary rather than as largely social phenomena does not map all that well against the evidence from historical records. In relation to the historical study of suicide, then, it is necessary to be aware that contemporary normative scripts may not much match those of the culture being explored.

Timothy Hill reflects on these issues in the introduction to his monograph *Ambitiosa Mors: Suicide and Self in Roman Thought and Literature* (2004). Hill argues that in order to understand Roman voluntary death, both "suicide" and "self" need to be carefully redefined, as carrying over contemporary meanings into a Roman context leads to fundamental misunderstandings. Hill's analysis shows that deaths that are now read as "pathological, isolated, and despairing" (p. 2) were in Roman sources presented as rational and social. Hill notes that:

> In the modern world, suicide is a grim business. It is understood primarily as an act arising out of intense, morbid, and pathological states of mind, representative of the furthest extreme of human misery. It is above all an isolated act, isolated not only in the sense that suicides of the modern era tend to seclude themselves from others before attempting their final act, but in the sense that suicide is held by modern writers to express a sense of personal alienation so complete that others cannot conceptualize this psychological nadir even in imagination. Suicide is, in this view, a supremely individual act, utterly inscrutable to all outside observers.… Hopeless, despairing, and mentally ill, the suicide is seen in modern literary, psychological, and sociological discourse as driven to death by the intolerable pressure of some peculiarly internalized torment…. (p. 1–2)

The contrast with Roman forms of self-accomplished death, Hill argues, is marked. Notions of individual pathology, even of individual mental or emotional states related to the act of self-killing, are almost totally absent from ancient accounts. So too is the idea that "the act is necessarily, or even ideally, a private one" (p. 2) with the presence of witnesses often noted and seemingly required by etiquette in some cases.

Many writers and scholars, reflecting on these apparently cold, rational, deliberate and often quite public "suicides", tend to conclude that such deaths are either historical "outliers" (anomalous to the point of uniqueness) that Roman sources

were unreliable and partial in their reporting or that they missed the obvious signs of pathology before them (Marsh 2013). For example, Al Alvarez (1971) describes as "admirable, even enviable", the "icy heroism" of Roman aristocratic "suicides" but concludes that "it also seems, at least from our perspective, curiously unreal. It seems impossible that life and behaviour could ever be so rational, and the will, at the moment of crisis, quite so dependable" (p. 83).

As Hill (2004) argues, perhaps the most difficult to grasp aspect of Roman self-killing, from a modern perspective, relates to differing notions of autonomy, agency and individuality. The Cartesian view of "the self as an entity necessarily epistemologically, ethically, and/or ontologically prior to all other entities permeates the modern Western intellectual tradition" (p. 14) to such an extent that ancient systems of thought can seem "paradoxical or inexplicable" (p. 15). Furthermore, "the divergence between modern Cartesian perspectives on the self and the concept of self that might profitably be used to render Roman discourse on suicide intelligible, however, is so extreme that the difficulty of formulating a phrase capable of linking the two is severe. Whereas in the case of the word "suicide" there exists a significant overlap between Roman and modern English discourse, the role of the subjective consciousness in Roman ethical thought is relatively so attenuated that there is no ready equivalent for the Cartesian "self" to be found in Latin writing" (p. 15). So whilst modern Western discourse draws upon terms and concepts such as "identity", "self", "character" and "personality" when discussing the individual in an abstract way, Latin writers, by contrast, tended to make use of "broad terms such as nos ("we/ourselves") and hominess ("people")" (p. 16) and thus made very little distinction between "individualized and generic conceptions of the person" (ibid).

Hill's analysis points strongly to the historically contingent nature of notions of personhood, self, interiority, authorship and agency, to the extent that it becomes hard to continue to treat these as invariant in relation to suicide. As Kurt Danziger (2001) argues, and Hill exemplifies, historians need "to question the tendency to credit psychological objects with much greater historical persistence than they in fact possess and to make visible the extraordinary historical mutability of these objects" (p. 8). Even fundamental distinctions between what is taken to constitute "inside" and "outside"—that is, what belongs to the individual or to the social realm—have been shown in historical (e.g. Paster et al. 2004) and ethnopsychological (Danziger 1997) studies to be culturally specific rather than universal. For instance, in their introduction to *Reading the Early Modern Passions*, Gail Kern Paster, Katharine Rowe and Mary Floyd-Wilson explain that "[e]arly modern psychology… only partially shares the priority we place on inwardness, alongside very different conceptions of emotions as physical, environmental, and external phenomena" (p. 15).

An understanding of the contingency of constructs often read as unchanging, such as "the individual", "the mind" and the form distinctions such as "inside-outside" take or where emotions are said to reside, allows us to ask questions not only about how such ideas and distinctions appear at different points in history but also about how particular constructions shape experience. Such an approach can cast light not only on the contingency and mutability of elements involved in the

constitution of suicide and the "suicidal individual" but also on how the experience of being suicidal relates to, and maybe relies upon, certain socially constructed notions of individuality, selfhood and so on.

Issues around sameness and difference, continuity and discontinuity are, of course, of concern to historians of suicide. Whilst not all address these matters in as direct or comprehensive a way as Timothy Hill in *Ambitiosa Mors*, judgements as to whether suicide or suicidality have ahistorical elements are necessarily present (implicitly if not explicitly). As an example, Marzio Barbagli in *Farewell to the World: A History of Suicide* (2015) writes in the introduction that "relations between the psychological and psychiatric variables, on the one hand, and culture, political and social ones, on the other, are complex and have not been sufficiently studied for their relevance to suicide, but they are unquestionably numerous and highly important. In the first place, the significance attributed to the symptoms of some disorders (both mental and physical), which, in combination with other circumstances, may lead a person to take their life, varies from culture to culture" (p. 11)—which seems to be suggesting that "psychological and psychiatric" symptoms exist at some level in an invariant form outside of culture, politics and society (and history too), but the importance attributed to them is variable. This line of thought can be seen in Barbagli's brief case study of Virginia Woolf. When discussing the "horror" Virginia Woolf experienced when suicidal, Barbagli asserts that she was "bipolar and experienced bouts of mania and depression" (p. 11). Barbagli then goes on to ask, and partially answer, an interesting question, "how would Virginia Woolf have acted had she lived in the Middle Ages? Of course, no one can say. However, she might well have interpreted her feelings very differently, attributing the 'horror' to Satan's influence" (p. 11). What is taken, in accounts such as Barbagli's, to vary historically and culturally are interpretations of feelings, but the feelings themselves, even when "transported" to an earlier age, are read as unchanging, as indeed is the experiencing subject herself.

However, if we accept Lakoff and Johnson's (1980) premise that "culture is already present in the very experience itself" (p. 57)—that is, that the constituent elements of experience are cultural through and through—then that opens up an unsettling possibility, namely, that the ways in which we frame issues of selfhood, emotion and agency are not outside of peoples' experiences of suicide and suicidality but are intrinsic to it. As Chlöe Taylor (2015) argues, "the suicidal subject, similar to the mentally ill subject, the delinquent, and the sexual subject, is not so much an object of scientific knowledge as a product of it. The psychological sciences have not so much come to understand the truth of suicide… as they have constituted a new reality, making of suicide a subject position, a human kind, or an identity. Troublingly, this means that the discourses and practices that we draw upon to understand and to prevent suicide may in fact contribute to creating subjects bound to kill themselves, or at least to contemplate suicide throughout their lives" (Taylor p. 18). Of course, such a reading makes no judgement in relation to the intentions or objectives of the psy-professions, but even so the claim that the production and circulation of expert scientific knowledge in relation to suicide have a bearing on peoples' experiences of suicide and suicidality, not always in

positive ways, is perhaps not easily assimilated or accepted. Taylor (2015), though, skilfully demonstrates how such an analysis can be applied to help understand the life and suicide of a contemporary figure (the Québecoise writer Nelly Arcan)—that is, how psychological and psychiatric discourses and practices act to form and shape experiences of suicidality—and I'd like to draw on a similar approach to try to illuminate the experiences of suicidality, and eventual suicide, of historical figure (the English painter Benjamin Haydon, who died in 1846).

## 1.4 Benjamin Haydon

The early nineteenth century saw the emergence of a medico-psychiatric style of thought which was brought to bear on the problem of suicide. A vocabulary of medicine and science was utilised to reconceptualise suicide as primarily a question of pathology rather than morality or criminality (Hacking 1990; Marsh 2010). New truths of suicide, based on ideas of diseased interiorities (both bodily and mental), were constructed for the first time (e.g. Esquirol 1821), and these notions came to exert a powerful effect in terms of the formation of objects, concepts and subjects in relation to suicide (Marsh 2010). I would argue that new forms of suicide, and different ways of experiencing a desire to die, came into being in relation to the production and dissemination of authoritative medical truths in this period, and the life and death of the painter Benjamin Haydon is illustrative of these. Haydon kept a detailed journal and wrote an autobiography, and whilst, undoubtedly, many forces were at work in Haydon's suicide (disappointment over the reception of his paintings, debts and so on), there can be discerned in his writings a relationship between Haydon's thoughts (if we take his journal as a record of such), his actions and the truth of himself as constituted by medico-psychiatric discourse and practices.

Historian Barbara Gates (1989) writes that Haydon was "morbidly interested" in the relationship of the "physical brain to the act of self-destruction" (p. 15). In a journal entry of 1821, he had written:

> I am inclined to imagine that much of the pain and anxiety of mind I have suffered for the last few days arose from nothing more or less than indigestion. My stomach was heated and affected my brain. Suppose in that humour I had shot myself! Would a superior Being have destroyed my soul, because, my brain being irritated by an indigestion, I had in a state of perturbation put an end to a painful existence? Surely not! (in Taylor 1853, vol. II, p. 17)

Haydon evidently had an awareness of how the viscera and brain were held to be connected within the emerging medical thought of the time. He attributed his "perturbation" to his "heated" stomach affecting his brain and that these are linked to thoughts of self-destruction. The suicides of Sir Samuel Romilly (in 1818) and Castlereagh (in 1822) were, Haydon believed, due to an excess of blood in the brain, writing that "the two must have achieved relief when they cut their throats and the blood began to flow, removing the pressure built up in their brains" (in Gates 1989, p. 15). In his diary, Haydon had written: "[i]t may be laid down that self destruction is the physical mode of relieving a diseased brain, because the first impression on a

brain diseased, or diseased for a Time, is the necessity of this horrid crime. There is no doubt of it" (in Taylor 1853, vol. III, p. 169). In 1846 Haydon shot himself in the head and then cut his throat believing he was suffering from a "diseased brain" that required relief through bloodletting.

Although it could be argued that in many ways, Haydon's death was unrepresentative of suicides in general at this time (Anderson 1987), the fact that he conceived of self-destruction in terms of pathological anatomy, that the "truth" of his troubles were to be found in medical theories of organic disease that necessitated a drastic physical remedy, points to the formation of new ways of thinking, acting but also experiencing in relation to suffering and suicide. Medical science was not involved solely in the discovery or uncovering of the facts of suicide, rather there was a production and circulation of new authoritative ideas around suicide that created new objects of study (e.g. the diseased brain, categories of illness such as "suicidal monomania") and new modes of being in relation to such objects (suicidal patients with an excess of blood on the brain, the "suicidal monomaniac") and, relatedly, new forms of experience.

## Conclusions

I think these processes and sets of relations are always present. That is, experiences of suicidality, as well as the form and meanings of suicidal acts themselves, are always constituted from available, historically situated, cultural sources. If, however, we assume, as do many contemporary theories of suicide, that both suicide and the experience of suicidality are underpinned by unchanging, universal elements, we are likely to overlook many of the cultural and historical factors involved in their formation. Understanding the contingency of the suicidal subject, though (and the constituting elements of such a subject), allows for a different way of approaching the issue. Our investigations would focus less on trying to locate assumed invariable elements of suicide (e.g. psychache, perceived burdensomeness or thwarted belongingness) and instead look to understand the changing cultural forces involved in the formation of suicidal subjects over time. Such a stance would open up very different ways of understanding suicide and the experience of being suicidal. For instance, authoritative contemporary descriptions of suicide could be understood not as universally applicable, objective descriptions of reality but rather as distinctive styles of thought that produce particular effects. We would be able to understand the ways in which vocabularies, concepts, metaphors, images and stories are used to form certain ways of framing suicide and that these descriptions partially (but often quite forcefully) shape the experiences of people within their sphere of influence—suicidal individuals, survivors, mental health professionals and indeed each of us.

Such a focus on the historical and cultural formation of suicidal subjectivities also creates possibilities for exploring what could be considered the "politics of suicide". Mark Button (2016) frames these as involving both the interrogation of "the cultural scripts that sustain a punitive model of human agency" and "addressing the material-institutional conditions that prevent a dignified form of reciprocal social care from forming" (p. 6). The first points to an approach which doesn't take for granted notions such as "intention", "agency", "autonomy" or even

"mental" or "psychological" but which instead interrogates the effects of such constructions on our sense of self and it's perceived livability, particularly in relation to those in society who are marginalised or deemed "other". The second opens up consideration of what a social justice approach to suicide would look like—a move away from psychocentric understandings (the reducing of human problems to flaws in individual bodies/minds) (Rimke 2010; Rimke and Brock 2012) of suicide to approaches which centre more on questions of exclusion and oppression, politics, stigma, relations of power and hate (Reynolds 2015).

For suicide prevention practices to be more effective, it might be that we need to rethink what it is to be suicidal. Historical phenomenology and the study of anthropological differences can help us to understand that our current understandings of suicide and approaches to prevention are based on culturally and historically situated notions of personhood and experience—drawn from a limited disciplinary base—which perpetuates a restrictive focus on individual pathology read as being universally applicable. Understanding the contingency of suicide and the experience of being suicidal allows us to shift our focus in attempts to make sense of such acts and experiences, as well as allowing us to question the assumptions which currently underlie our ways of responding to people experiencing a desire to die.

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# Reflections of a Committed Suicidologist

# 2

Maurizio Pompili

## 2.1 Exploring the Phenomenology of Suicide

This paper was developed with the aim of shedding light on the phenomenology of suicide, that is, to focus on suicide as a phenomenon affecting a unique individual with unique motives for the suicidal act. Phenomenology studies conscious experience as experienced from the subjective or first-person point of view. To explore this topic, the author looks back at the past centuries to understand why suicide was thought to be confined to psychiatric illness and to document the bias in studies supporting this notion. One major step forward in the conceptualization of suicide as a psychological disorder was provided by Edwin Shneidman. This essay goes over clues in the phenomenology of suicide.

I consider suicide to be the result of fractures—with oneself, with other people, with nature, and with the opportunity to experience feelings of well-being and to appreciate that which surrounds us. Common human satisfactions derived from feeling alive and experiencing positive excitement, as in the case of watching breathtaking landscapes or joyful events, may sometimes be denied to people, and the individuals stand as spectators, longing to heal the fracture that impairs full appreciation of themselves and the world. Such experience is not necessarily related to a psychiatric disorder such as depression, but rather it is a separate, peculiar dimension that, often momentarily, overwhelms the individual. One can be profoundly depressed or psychotic but seeking treatment and hoping to get better, never thinking of ending one's life (Pompili 2008, 2009).

In 1829, the Italian poet Leopardi wrote *La quiete dopo la tempesta* ("The Calm After the Storm"), in which the light and reassuring verses at the beginning evolve into the dark desperation of the conclusion, where pleasure and joy are conceived of

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as only momentary cessations of suffering and the highest pleasure is provided only by death. These are the words of a profoundly hopeless person who experiences pleasure only when deep worry is relieved by proper reassurance. This is not typically the case in mental health in which the opportunity to experience well-being and satisfaction from life derives from many sources and developments.

Scholars worldwide have puzzled over what makes a person suicidal and what individuals who die by suicide have in their minds. Most often the focus is not on the motives for suicide nor on the phenomenology of this rare act. It is rather on what is found from small cohorts of suicidal individuals. Each day, dozens of papers on suicide are added to the enormous literature related to this topic. Maltsberger (1986), reflecting on this issue, wrote, "So massive is the suicide literature that any attempt to master it may stagger not only the mind, but the back as well…..Forests are destroyed to feed the whirring presses; many new articles and a book or two appear each month" (p. 49).

Models of suicide are less frequently encountered in the literature. It is difficult to produce a sound synthesis of a complex phenomenon, after which many in the scientific community comment that the model omits key features not easily identifiable. The lack of models that actually help in the management of suicide is reflected by the fact that suicide rates have been only mildly changed by the tremendous efforts in this field.

Various models have been reported for suicide such as (1) the scientific view, suicide is caused by factors beyond the individual's control (the determinist view of suicide); (2) the "cry for help," individuals who die by suicide do not want to die but are seeking help to reduce their distress; and (3) suicide as sociogenic, social forces cause suicide (Durkheim's altruistic, egoistic, anomic, and fatalistic suicide). More recently, a stress-diathesis model has been proposed (Mann et al. 1999) in which the risk for suicidal acts is determined not merely by a psychiatric illness (the stressor) but also by a diathesis. This diathesis may be reflected in a tendency to experience more suicidal ideation and to be more impulsive and, therefore, to be more likely to act on suicidal feelings.

Many clinicians perform careful assessments for suicidal risk in their patients and assume that suitable treatments will resolve this risk. They rarely investigate suicidality in depth in their patients. The keywords here are from the Ancient Greek aphorism "know yourself" that was inscribed in the pronaos (forecourt) of the Temple of Apollo at Delphi. There are myths and resistances that impair a proper understanding of suicidal people. Many believe that talking about suicide will reinforce the patient's suicidal ideation; others believe that when patients talk about suicide, the risk of suicidal behavior is low. ("Those who talk about it don't do it.") Myths and stigmatization should be replaced by a meaningful phenomenology of suicide that involves a true understanding of the suicidal individual's intimate world.

This paper explores some of the issues related to suicide as a phenomenon emerging from the individual and, therefore, strongly associated with his emotions, personality, and experiences. Such an appraisal of phenomenology of suicide stresses the need to better understand the suicidal dimension as opposed to the psychiatric dimension and to avoid myths and stigmatization.

## 2.2 The Influence of Past Centuries

Suicide has always been a taboo topic (Shneidman 1963), and efforts have been reported to change society's view of this phenomenon. Suicide was considered a sin or a crime, but suicide considered as the result of a mental illness was more acceptable to society. Viewing suicidal individuals as suffering from mental illness provided an opportunity to distance oneself from the topic and to consider it as something that was relevant only to other people.

Robert Burton (2001), in his "Anatomy of Melancholy: What It Is, With All the Kinds, Causes, Symptoms, Prognostics, and Several Cures of it," reported that "melancholia, which caused suicide, was indeed a disease." Burton anticipated the development of modern psychiatry when he noted the cruel nature of melancholia, "which crucifies the Soule in this life and everlastingly torments in the world to come."

This effort by Burton to rescue individuals who die by suicide from the ranks of criminals and sinners can be better appreciated by mentioning some of Alvarez's (1971) description of what was happening at that time. In 1601, Fulbecke, a lawyer, said that the individual who die by suicide

> is drawn by a horse to the place of punishment and shame, where he is hanged on a gibbet, and none may take the body down but the authority of a magistrate; Blackstone, another legal authority, wrote that the burial was in the highway, with a stake driven through the body, as though there was no difference between a suicide and a vampire. Stones were placed over the dead man's face; hands could be cut and bodies were also given to school of anatomy; In Danzig the corpse was not allowed to leave by the door; instead it was lowered by pulleys from the window, the window-frame was subsequently burnt. (p. 64)

In contrast, a number of scholars tried to portray suicide deaths in a more phenomenological way, avoiding the view of suicide as a mere symptom of a psychiatric disorder. For instance, a clergyman, John Sym (1637), mixed interpretation of the phenomenon, stated:

> The parties most subject to self-murder, are high-minded and ambitious persons, impatient of disgrace and croffes… When they are disappointed, they grow into that degree of discontentment, that they will not out-live their expectation of earthly things, but will rather kill themselves, than endure such a croffe and disappointment in that which they most highly value…Therefore people should well confider their own tempers and flates, with the fever-all dangers that attend upon the fame…. (p. 255)

More than a century later, Hume (1783), who was one of the first major Western philosophers to discuss suicide without the concept of sin, published a milestone book. His famous essay "On Suicide," published in 1777, a year after his death, was promptly suppressed. The goal of the essay was to refute the view that suicide is not a crime, and it did so by arguing that suicide is not a transgression of our duties to God, to our fellow citizens, and to ourselves.

Psychiatric patients were commonly called lunatics and placed in asylums. Those who seemed to be suicidal risks were also confined in such places since it was assumed that they were suffering from mental illness. The English physician Forbes Winslow (1840) reported descriptions far different from psychological ones, but he

adopted a phenomenological approach to the study of the suicidal individual. He paid attention to feelings that caused an unbalanced mind such as jealousy and despair. Winslow reported that in many cases of suicide, the act is preceded by a *long train of perverted reasoning*.

> These individuals become taciturn, morose, pusillanimous, and distrustful. The future presents itself under the most unfavorable aspect, and despair becomes painted on their countenances. Their eyes become hollow; they complain of sleeplessness and are disturbed by frightful dreams. Their bowels are in an inactive state; and the function of the liver becomes, to a certain extent, suspended. It is in this state that they contemplate suicide. He believed that "death is considered preferable to a long life of unmitigated sorrow… when all hope is banished from the mind, and wretched loneliness and desolation take up their residence in the heart need it excite surprise that the quiet and rest of the grave is eagerly longed for! (p. 58)

On the same note, the Italian Morselli (1881), who approached suicide statistically provided excellent statistics for suicide in Europe, also identified physical and moral causes of suicide. He stated:

> … Thus, again, when it is only said 'suicides caused by taedium vitae', very different cases are probably united under this heading. Neither 'monomania' nor 'mental alienation' is one single cause in itself; it is possible to pass from political and religious exaltation to the most profound melancholia, through a thousand psychical phases which statistics neither do not can estimate. And the origin, often quite ordinary, of certain mental phases, registered as mere presumptive causes of suicide, shows the weakest side of this part of statistics. (p. 267)

Morselli's view is shared by traditional suicidology which emphasizes the complex array of factors that lead to suicide and stresses the need to focus on the unique psychological pain of each suicidal individual. More than a century later, Shea (2002) argued that:

> People don't kill themselves because statistics suggest that they should. The call to suicide comes not from statistical protocols, but from psychological pain. Each person is unique. Statistical power is at its best when applied to large populations, and its weakest when applied to individual. But it is the individual who clinicians must assess in the quietude of their offices or the distracting hubbub of busy emergency rooms. (p. 11)

## 2.3 Suicide: Symptom or Syndrome?

In medicine and psychology, the term syndrome refers to a cluster of several clinically recognizable features, signs (observed by a physician), symptoms (reported by the patient), phenomena, or characteristics that often occur together, so that the presence of one feature alerts the physician to the presence of the others. In suicidology, we have many features associated with suicide risk, but no single factor has been demonstrated to be necessary or sufficient to cause suicide.

Choron (1972) cites Gaupp (1910) as the milestone for understanding suicide from the biopsychological point of view, that is, there are forces that do not rise to the consciousness of individuals and thus cannot constitute motives, forces that are related to race, age, sex, work, and social status. This perspective has been challenged

by psychiatry which relates individuals who die by suicide to abnormal mental states. Ringel (1953) considered suicide as "the conclusion of a pathological psychic development." Weisman (1971) wondered whether suicide was a disease and proposed that "Suicide is neither a moral dilemma nor a mental disease but a form of life-threatening behavior resembling a declaration of war of a petition for bankruptcy." There is "suicidal sickness" but no evidence of an organic "disease" to explain it. However, the concept of "disease" is a cultural abstraction that excludes other dimensions of sickness, such as conflict and crisis.

Esquirol (1838) said that suicide was a symptom of insanity and, therefore, those who commit suicide are psychiatrically disturbed. Esquirol developed the perspective that suicide is a psychiatric problem and wrote:

> All that I have said up to now, the facts which I have reported, proves that suicide presents all the characteristics of insanity of which it is but a symptom; that there is no point for a unique source of suicide, since one observes it in the most contradictory circumstances, and because it is symptomatic or secondary, be it in acute delirium, or chronic, besides, the autopsy of suicides made so far did not throw much light on the subject of pathological changes. (p. 639)

Considering suicide risk as a symptom impairs the opportunity to fully investigate and understand it. If a patient has a fever or a headache, and if this is thought to be part of pneumonia or cancer, clinicians will treat the disease as a whole rather than each symptom separately.

The phenomenological approach promises to aid our understanding of suicide, helping us understand rather than explain the behavior. Karl Jaspers' (1959) assumption that we can explain a phenomenon without understanding it at all is of particular interest here. Jaspers separated the study of subjective phenomenon as experienced by the patients from the study of other psychological data. He introduced the difference between explanation and understanding and focused on the latter. Jaspers distinguished two types of psychiatric entities: developments, which we can come to understand, and processes, which can be explained even though they are not understandable. For instance, reactive depression is understood insofar as we can put ourselves in the place of the sufferer; most often, this is also true for suicidal behavior. On the other hand, it is to Kraepelin (1921) that we owe our emphasis on documenting the longitudinal course of psychiatric disorders. As for suicide, he stated that "The patients, therefore often try to starve themselves, to hang themselves, to cut their arteries, they beg that they may be burned, buried alive, driven out into the woods and there allowed to die"; however, he put no emphasis on what was happening in their tormented mind, a feature often neglected when only DSM-Kraepelinian diagnostic criteria are taken into account.

The focus should be on what patients feel rather than on how they can be categorized. Maltsberger (2004) reported that, "intense desperation is a mental emergency.…Many unfortunate patients may quickly take their lives because they cannot wait for relief.…Most desperate patients, enraged patients or intensely anxious patients show what they feel in their faces, body movements and demeanor."

The lack of association between suicide and psychiatric disorders has emerged in various studies (e.g., De Leo 2004, 2002), and scholars have come to believe that

alternative solutions must be found since the vast majority of depressed, schizophrenic, alcoholic, or organically psychotic patients do not commit or even attempt suicide (Lester 1987, 1989; Leenaars 2004). Hopelessness as a psychological construct has been reported to be a more important mediator of suicide risk than is depression. Studies involving the Beck Hopelessness Scale (Beck et al. 1974) found that the extent of negative attitudes about the future (pessimism) was a better predictor of suicidal intent than depression (Beck and Steer 1988). This indicates that it is not necessarily important how you feel right now, for example, being depressed, but whether you trust the future to bring changes in your condition. This is particularly true for suicidal individuals experiencing the uniqueness of their suffering that, for them, has no escape and no future solution. It has been suggested that, "the interest in classifying populations of suicidal patients by their psychiatric diagnoses is being supplemented by an interest in understanding what makes a minority of patients within any given diagnostic category suicidal while the majority are not suicidal" (Hendin 1986).

These observations are reinforced by the response of patients to psychiatric treatment. For instance, Ahrens and Müller-Oerlinghausen (2001) investigated a group of high-risk patients with recurrent affective disorders ($n = 167$) who had made one or more suicide attempts before the start of lithium prophylaxis within a collaborative project. According to their recurrence-related response to long-term lithium prophylaxis, patients were classified into three groups: excellent ($n = 45$), moderate ($n = 81$), and poor responders ($n = 41$). Only depressive episodes resulting in hospitalization were considered. With regard to suicidal behavior in this selected group of high-risk patients, there was a significant decrease in the rate of suicide attempts as compared to the pre-lithium figures. This was the case not only in those patients with excellent treatment outcome but also in those with moderate or even poor response toward lithium prophylaxis, suggesting an effect on the suicidal dimension independent on the effect on the psychiatric symptoms.

A similar finding comes from a study by Prudic and Sackeim (1999) involving electroconvulsive therapy (ECT). They found that ECT responders and nonresponders showed a large decrease in scores on the suicide item of the Hamilton Rating Scale for Depression (HRDS), and this decrease was greater than the average improvement on other items.

Moreover, recent studies on the role of antidepressants in reducing suicide risk have failed to provide strong evidence regarding their possible role in increasing or decreasing suicide risk. It would appear that pooling trials of antidepressants (including both tricyclics and SSRI versus placebo) yielded a nonsignificant result which was not in favor for one side or the other (Baldessarini et al. 2006a, b).

## 2.4 Psychological Autopsy Studies

Most of the data supporting that individuals who die by suicide were suffering from a psychiatric disorder comes from psychological autopsy studies. Studies labeled as psychological autopsies report little information on the psychology of the deceased.

The term psychological autopsy was first used by Shneidman in the pre-suicidology time. He used the term prophetically when he stated, "…To present a study in which the emphasis is on the prediction of behavior rather than the validation of the technique; i.e., to hold a 'psychological autopsy' on one case" (Shneidman 1951, p. 4).

Much credit for the success of the psychological autopsy belongs to Dr. Theodore Curphey, the Los Angeles coroner, who recognized the realistic benefits of that procedure (Curphey 1961). The psychological autopsy introduced the psychological elements into the study of suicide. Before that, suicide had been studied anecdotally and demographically, but no emphasis had been made on the psychological life of the deceased (Shneidman, April 2006, personal communication). The psychological autopsy focuses on what is usually the missing element, namely, the *intention* of the deceased in relation to his own death.

The assumption is derived from psychological autopsy studies that the vast majority of individuals who die by suicide suffered from a mental disorder at the time of their death that has, however, several biases. First, scholars worldwide use the term psychological autopsy for any retrospective investigation. Such studies lack the comprehensive data gathering obtained from interviewing key persons. It is rather easy to classify a subject as depressed when in fact he was understandably sad for what was a mess in his life. Most of the data obtained in psychological autopsy studies is derived from a forensic environment, physicians, or death registries and much less often from family members or friends who could make sense of the depressive features which are distinguishable from clinical depression. Suicide is a problem of the human condition, or as Shneidman points out, "it is a dissatisfaction of the status quo."

Pouliot and De Leo (2006) have highlighted many issues related to psychological autopsies, concluding that the medical model often fails to provide sufficient evidence that a disorder can lead to suicide. In most psychological studies conducted to date, suicide is almost exclusively researched under single paradigmatic umbrella of medicine. Pouliot and De Leo proposed that according to the medical model, suicide is the consequence of biologically based alterations of the brain, where psychiatric symptoms are expressions of the disease caused by the alterations. Data reported by Cavanagh et al. (2003) support the notion that between 88 and 95% of suicides were suffering from a psychiatric disorder. Such data contrast with evidence from prospective case studies which show that at 10–20 years follow-up, the risk of suicide in adolescents suffering from major depression is 7.7% (Weissman et al. 1999), 3.4% for alcoholics (Murphy and Wetzel 1990), and 3.8% in depressed patients (Gladstone et al. 2001).

As a psychiatrist, my model for depicting suicide refers to the two distinct dimensions that often overlap, the one comprising psychiatric disorders and the other referring to suicidality. When substantial overlapping exists, there is major risk of suicide as the patient is "attacked" in two ways. However, suicide can occur with no psychiatric disorders when profound distress and psychological pain become unbearable and when suicide is seen as the perfect solution. In suicidal individuals, psychological pain affects the very core of their human condition and threatens life, which cannot be accepted in its present condition. It is this aspect that characterizes suicide deaths, and it is absent in the vast majority of psychiatric

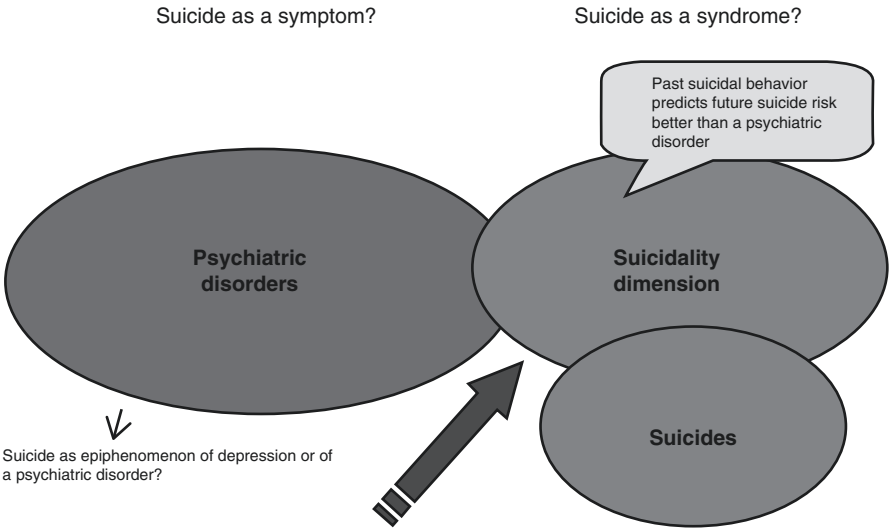


**Fig. 2.1** Suicide is better understood as the result of variables traceable in the suicidality dimension. Such dimension generally includes heightened inimicality (acting against the individual's best interest), exacerbation of perturbation (refers to how disturbed the individual is), increased constriction of intellectual focus and tunneling or narrowing of the mind's content (dichotomous thinking), and the idea of cessation, the insight that it is possible to stop consciousness and put an end to suffering

patients. A psychiatric disorder alone is, therefore, not sufficient for precipitating suicide. There must be the suicidality dimension that carries some variant of negative emotions (Fig. 2.1).

## 2.5 Toward a Phenomenology of Suicide

Phenomenology is a philosophical discipline originated by Edmund Husserl. He developed the phenomenological method to make possible "a descriptive account of the essential structures of the directly given." Phenomenology emphasizes the immediacy of experience, the attempt to isolate it and set it off from all assumptions of existence or causal influence and to lay bare its essential structure. Phenomenology restricts the philosopher's attention to the pure data of consciousness, uncontaminated by metaphysical theories or scientific assumptions. Phenomenology studies conscious experience as experienced from the subjective or first-person point of view. The experiencing subject can be considered to be the person or self. Subjective experiences are those that are, in principle, not directly observable by any external observer.

Subjective experiences are the foundations of suicidology as a discipline devoted to the scientific study of suicide and its prevention. Areas of suicide research, although of paramount importance, cannot be directly linked to suicidology if they lack a focus on the subjective experience and principles related to suicide prevention.

Suicidology can be defined as the scientific study of suicide and suicide prevention. The term (and the concept) was first used by Shneidman (1964) and was since then used in a number of ways such as to describe aspect of new training (Fellowship in Suicidology, 1967), as part of a new journal (Bulletin of Suicidology, 1967), and to label a new association (the American Association of Suicidology, 1968). Suicidology is unlike other behavioral sciences in that it has usually included not just the study of suicide but also its prevention; in other words, it incorporates appropriate clinical interventions to prevent suicide, a feature not always taken into consideration in the many contributions to understanding suicide. The focus of suicidology is not necessarily merely completed suicide but above all the treatment of suicidal individuals. Individuals who commit suicide die with their unique life histories, and it would appear to be inappropriate to use pooled data or statistics to understand the human misery of these individuals. Maris et al. (2000) stated that "While suicidologists give lip service to the multidisciplinary study of suicide, in actual fact most of us have very narrow and specialized domain assumptions—usually those related to our professional training and subdisciplinary paradigms." No doubt, regardless of one's attitude and research interests, being a suicidologist implies sharing the view that "Suicide springs from an individual's psychic pain."

Traditional suicidology supports the notion that suicidal individuals are experiencing unbearable psychological pain (*psychache*) or suffering and that suicide may be, at least in part, an attempt to escape from this suffering. Shneidman (1993a) focused on the mentalistic aspects of suicide and suggested that the study of suicidal acts should concentrate on the phenomenology of suicide. Psychache can be clearly distinguished from depression or other psychiatric disorders because of the uniqueness of suffering perceived by the subject and because of the fact that the subject cannot stand it. The individual cannot see a way out and believes that ending life is a solution. Shneidman (1993b) considered psychache to be the main ingredient of suicide. Shneidman (1984) reported that psychological pain may be related to the fact that, if tormented individuals could somehow stop consciousness and still live, they would opt for that solution. Suicide occurs when the psychache is deemed by that individual to be unbearable. It is an escape from intolerable suffering; and this views suicide not as a movement toward death but rather as a remedy to escape from intolerable emotion and unendurable or unacceptable anguish. Suicide risk is associated with constriction or narrowing the range of options usually available to an individual. Suicidal individuals experience dichotomous thinking, that is, wishing either some specific (almost magical) total solution for their psychache or cessation, in other words suicide. Suicide is the result of an interior dialogue during which the mind scans its options (Shneidman 1996). During the early phases of this process, suicide is considered as an option, but it is rejected a number of times. However, after persistent failure to find a solution to suffering, suicide is accepted as a solution. The individual, therefore, starts planning it and considers it as the only answer; "The spark that ignites this potentially explosives mixture is the idea that one can put stop to the pain. The idea of cessation provides the solution for the desperate person" (Shneidman 1976).

Shneidman believes that in suicide, "death" is not the keyword. The keyword is "psychological pain," and if the pain were relieved, then the individual would be willing to continue to live.

Two main concepts are relevant to this discussion: perturbation and lethality. Perturbation refers to how upset (disturbed, agitated, discomposed) the individual is, while lethality refers to the likelihood of an individual being dead by his or her own hand in the future. (Lethality is a synonym for suicidality.) Perturbation supplies the motivation for suicide; lethality is the fatal trigger. One way to reduce lethality is to inquire what causes distress to the suicidal individual. Only rarely, when dealing with a suicidal individual do medical personnel inquire about psychological pain. Many resources are devoted to decrease suicide risk but not what energizes it. Asking "Where do you hurt?", "How may I help you?", "What is going on?", and so forth proves to be a key factor in opening a dialogue with the suicidal person and establishing a connection. Suicidal people are ambivalent about death; they want both to live and to die, and so our task is to reach those vital components that counterbalance death wishes. In doing so, we may resolve the ambivalence and give the tormented individual a little hope and some peace of mind.

Treatment for psychache should involve anodyne psychotherapy which aims at the mollification of unbearable psychological pain. The most important key in anodyne therapy is a tailor-made focus on the alleviation of the patient's frustrated psychological needs considered by the person to be vital to continue life. Therapy of psychache involves being empathic with and resonating to the patient's private psychological pain. The therapist should be aware of the uniqueness of the patient's suffering and should try any possible solutions to change the patient's psychological pain from unbearable and intolerable to barely bearable and somewhat tolerable (Shneidman 2005).

Pompili et al. (2008) recently investigated the role of psychache in the determination of suicide risk in 88 psychiatric inpatients. They used the Psychological Pain Assessment Scale (Shneidman 1999) that involves direct questions about the level of current and worst-ever psychache using a linear rating scale and a checklist for the emotions experienced, along with pictorial stimuli. Pompili et al. found that those patients currently at risk for suicide reported significantly higher current psychache and higher worst-ever psychache. Most of these patients considered their worst-ever psychache unresolved. They had been hurt so much that they felt that the pain associated with those adverse events in their life could not be relieved and that they were condemned to face this pain forever. This suggests that for suicidal psychiatric patients, amelioration of symptoms is not sufficient.

## 2.6 Conclusions

The search for suicide risk factors, variables that indicate an increased likelihood for suicide, independent of diagnosis, has been undertaken by a number of researchers and clinicians. Most studies have evaluated short-term risk factors for suicidal behavior, such as current suicidal ideation and recent suicide attempts (particularly

in the context of severe major depressive episode), the major precursors, and the most powerful predictors of attempted and completed suicide. Nevertheless, during the course of this paper, I have stressed the need to reconcile this with the fact that suicide might be better understood as a phenomenon centered in the individual. In other words, the motives for suicide can be traced in the variables surrounding the individual viewed as a unique human being whose personality contains the real reasons for wishing suicide.

Shneidman's suicidology focused on the pain of the negative emotions—shame, guilt, abandonment, ennui, dysphoria, hopelessness, and inanition—what he called psychache. He viewed suicidal impulses (thoughts and actions) phenomenologically, more like being in love than having a liver disease. This is a radical view in an era where diagnostic criteria and the need to cure are more important than understanding what is not working at the emotional level. Centuries of stigmatization toward suicide have left deep fractures making judgments about suicide depend on social forces and the power of the medical model or other explanations. Phenomenology refers the inner world of individuals and focuses on what the individual feels as well as pointing to the understanding from the inside whenever a clinician encounters a patient.

We often hear about empathy, but we barely know the exact meaning. Both research in general and clinical practice indicate that suicide may be totally independent of psychiatric disorders. Moreover, psychological autopsy research that supports the association between the two has many methodological problems. Shneidman's suicidology is still a lesson to be learnt as it focuses on the negative emotions of individuals and how to understand them, as well as how to bridge the gap in the communication of human suffering. Shneidman taught us that although the idea of suicide may recall madness, the suicidal mind can be understood in term of psychological pain and thwarted psychological needs. This perspective opens us to the acceptance of the human suffering of suicidal individuals as opposed to the early focus on psychiatric disorders or, in the past, to madness.

Let us hope that present and future generations of suicidologists will integrate the concept of unbearable psychological pain and the drama occurring in the suicidal mind with the much-needed further understanding of the enigmatic phenomenon of human self-destruction.

### 2.6.1 Our Empathic Brain and Suicidal Individuals

What are the needs of suicidology today? We should not be surprised by the simplistic and obvious statement that we do not fully understand what is going on inside the minds of suicidal individuals. No doubt, we still partially manage the unmet needs (e.g., feelings of entrapment, defeat, helplessness) of those who are suicidal. In the face of extreme anguish, vulnerable individuals often conclude that there is no escape short of suicide. As mental health professionals, we offer support to such suicidal people, but are we really able to provide the help that they need? To some extent, our view is optimistic, and we cannot ignore important advancements in the

field of suicide prevention, yet there is a gap in the communication of human suffering.

The saying "know thyself" (or know yourself) may refer by extension to the ideal of understanding human behavior, morals, and thought, because, ultimately, to understand oneself is to understand other humans as well. It may be easier to conclude that suicide is linked to risk factors and specific psychiatric diagnoses. However, neither risk factors nor diagnostic labels are important in reducing the suffering that contributes to suicidal thoughts and behaviors.

Those who emphasize the role of a phenomenological approach highlight subjectivity and our sense of self, which is the starting point for knowledge. The clinician should focus on the subjective experience of a phenomenon, observing it while putting aside assumptions, judgments, or interpretations. In this fashion, any approach to suicide prevention should aid in our understanding of suicidal thoughts and feelings as they are experienced by at-risk individuals (Webb 2010). And, if "I introspect and I understand myself, then I will be better suited to recognize other people's feelings and better help them when they're in need (Vlad 2013)." Some call this empathy, which points to the fact that to better understand empathy, we need to understand ourselves. Both items may lead to problems. We spend considerable time explaining suicide risk, but we have difficulties understanding it. To some extent, similar issues using the same approach can arise with hallucinations. Specifically, given the fact that we never generally experience hallucinations, we cannot understand them. However, we can explain what they are (Jaspers 1913/1997).

Our understanding of the subjective experience of suicidal individuals should begin with examining those who experience suicidality. And to reflect even more, most of this literature is purely numerical, statistical, and interpretative from the point of view of those who have never been suicidal.

Empathy, the ability to share others' emotions, is an everyday occurrence. This may be in the form of crying as well as laughing. Is there a mechanism that allows us to share other people's emotions? As Shneidman once told me, we can view suicidal impulses (thoughts and actions) phenomenologically, more like being in love than having a liver disease (Pompili 2010). Understanding the unbearable mental pain means thinking in a phenomenological way, and, therefore, the development of suicidal tendencies can be traced back to a state with similar characteristics of falling in love but flipped for affective valences. Similar to love, which is a broad totalizing dimension encompassing mind and body, suicidal wishes are a pervasive irrepressible condition that incorporates the individual as a whole; in love, everything seems wonderful; in suicidal states, the condition is best understood not so much as a movement toward death as it is a movement away from something, and that something is always the same: intolerable emotion and unendurable or unacceptable anguish. Reduce the level of suffering and the individual will choose to live. An unpleasant sensation is often localized in the chest and hypochondrium. The mind tries each option to release the tension but never finds a safe haven and ends up convinced that nothing will bring relief. In preventing suicide, one looks for any indications in the individual representing the dark side of their internal life-and-death debate. And such perturbation contributes to the motivation for suicide, with lethality being the fatal

trigger. The content analysis of pain narratives (Orbach 2011) is crucial in understanding the inner pain of suicidal individuals. Such feelings refer to the experience of changes in an individual's self, such as self-estrangement accompanied by dissociative characteristics. Those who are suicidal also often feel worthless, with emotional impoverishment and loss of self-esteem. Oftentimes misleading for clinicians, suicidal individuals report oxymoronic experiences, such as extreme contradictions in feelings, thoughts, and desires related to life and death at the same time. Unfortunately, such individuals typically do not have proper words for conveying their feelings, as ordinary words are not appropriate to describe these idiosyncratic experiences. Consequently, these events of loss lead to the interruption in one's sense of self-continuity together with loss in one's meaning of life. We also know the importance of good early attachment experiences for affect mastery, and the capacity to regulate affect is gradually acquired after birth. In fact, infants and children must learn to cope with separations, frustrations, and/or other emotionally challenging circumstances. With time and reasonable parenting, children attain the capacity to regulate themselves and keep themselves in reasonable emotional composure. We acknowledge the fact that, often unfortunately, suicidal individuals did not acquire such capacity in earlier developmental stages and in some way still have inefficient affect mastery. Moreover, young individuals who relied on dysfunctional child-rearing practices, especially when their own parents experienced trauma, are more likely to have insecure attachments in adult relationships.

Such preliminary thoughts are important in reflecting that when we encounter suicidal individuals, we have difficulties in looking back in their lives. We often fear emotional contagion, that is, after talking to a suicidal person we may feel sad, whereas when talking to someone who feels self-confident and optimistic, we are likely to feel good about ourselves; therefore, it is easier to distance the former, to classify them as psychiatric patients and therefore deal with a "label" and not with their internal suffering (Hatfield et al. 1994; Keysers 2011). When people are in a certain mood, whether elation or depression, that mood is often communicated to others. In other words, both suicidal people and clinicians are shaken by suicide risk: although dying by suicide is certainly a definitive action, it is, however, preceded by a complicated ambivalent internal dialogue within the suicidal individual, which often triggers reactions, or neuropsychobiological events, in individuals in crisis.

We now know that psychological pain, widely investigated by suicidologists, related to negative emotions is not just a vague construct providing an intuitive and obvious explanation of death wishes. Pain may also have a protective meaning, for instance, physical pain protects the individual from physical dangers. Scholars have described social pain (i.e., loneliness) as having a deleterious effect on health and life on par with having medical comorbidities or engaging in an unhealthy lifestyle (Cacioppo and Patrick 2008). Such pain negatively affects psychological well-being and should be considered when assessing for suicidality. Neuroimaging studies examining the neural correlates of social exclusion tested the hypothesis that the brain bases of social pain may be similar to those of physical pain. For example, Eisenberger et al. (2003), using functional magnetic resonance imaging (fMRI), studied the neuroanatomical basis of both physical and social exclusion. They found

evidence to support the notion that pain, whether somatic or psychological, is regulated by the same neuroanatomical cerebral circuits.

But how are we to understand such a degree of pain? In order for empathy to take place, it is necessary that we experience in our own minds some points of reference that correspond to those of the patients' experience. In states of intense suicidal arousal or excitement, we commonly fail empathically; we do not imagine how much these patients suffer because we have volatile representations in ourselves (J. T. M. Maltsberger, personal communication 2010).

Empathy is understanding and experiencing emotions from the perspective of another, a partial blurring of lines between the self and other. We put ourselves in the shoes of others with the intention of understanding what they are going through, thus employing empathy to make sense of their experiences.

*Giacomo Rizzolatti*, *the neurophysicologist who first described mirror neurons*, *stated*:

> We are exquisitely social creatures. Our survival depends on understanding the actions, intentions, and emotions of others. Mirror neurons allow us to grasp the minds of others not through conceptual reasoning but through direct simulation. By feeling, not by thinking. (in Blakeslee 2006)

Brain imaging with fMRI studies has shown that the same areas of the human brain are activated when the person performs an action and when the person sees another individual performing an action. This peculiar mechanism is commonly explained by the fact that these brain regions contain mirror neurons and are defined as the human mirror neuron system. Therefore, it has been suggested that seeing and doing can be synonymous when considering empathic responses. When people see someone doing something, they can imagine doing the same, which is a process accomplished automatically. This system is typically referred to in the context of action.

At the beginning of his theory, Freud (1957/1915) recognized that drive or instinct as "a concept on the frontier between the mental and the somatic, as the psychic representative of the stimuli originating from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body" (pp. 121–122). We know that mind is grounded in our body. To understand the actions of other individuals, we need to map them onto our own body's motor programs. To understand their emotions, we need to map them onto our own visceral feelings (Keysers 2011).

Experiments demonstrated that the insula appeared to share emotional processes of experiencing strong bodily feelings in other individuals. Both the premotor cortex and the insula are involved in neural circuits that allow us to share the actions and emotions of other individuals.

Neuroscientists coined the term shared circuits to describe this whole family of neural processes, including mirror neurons for actions, and similar systems, including the insula for bodily feelings such as disgust. Neuroscientist Keysers (2011) convincingly described such shared circuits and circumstances when they do not work simultaneously. He described the difference between a real and fake smile. In the former, there is a so-called "hot" motor system where the involuntary emotional behavior transforms the heat of emotional affect into observable behavior of the

face and the body, that is, muscles of the face are enriched by emotions. On the contrary, in the cold facial expression, a fake smile does not contain the heat of emotions. This example urges us to be real with patients who most often recognize when therapists fake their behavior.

Empathy should thus be seen as made up of various subcomponents that together build the final image of other people's feelings. Since understanding oneself is to understand other humans and since the differences in our personal experiences will determine the differences in our empathy, we need to introspect as much as we can to provide valid support to our patients. In solid human relationships, it is now evident that individuals are able to experience, although partially, the pain of a close person with whom they are engaged emotionally. We now have the opportunity to wonder "how your pain becomes my pain." In a well-known experiment performed by Singer et al. (2004), knowing that the partner was in pain caused activations that resembled those when participants experienced pain themselves. This experiment suggests that as far as affective components of other individuals' pain are concerned, they are directly mapped in regions retaining our own experience; such activations in the insula suggest that this part of the human central nervous system may represent bodily feelings, ranging from food-related disgust and pleasure to bodily pain (Keysers 2011).

However, there are conditions in which these automatic systems do not work in this way, for example, when facing something traumatic or when individuals must distance themselves from a particular experience. These are the cases of empathy disconnection when one needs to protect oneself (Iacoboni 2008; Rizzato and Donelli 2014). Now consider the impact that the word and concept of suicide must have on emotional disconnection because we think of death, sadness, madness, superstition, and so on. These are examples of adaptive mirroring and of our ability to attach and detach emotionally from the ones with whom we engage in social connections. The suicidal person seeking support in our office, in the street, or by calling a helpline is highly emotionally unstable, which is the consequence of failed affect regulation, failed capacity for hope, and/or failed capacity to maintain loving relationships in the face of extreme anguish. One can run the risk of following Freud's suggestion: "I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy" (Freud 1912/1958, p. 115).

In Fig. 2.2, I propose that exploring psychological pain and human misery more strategically will promote empathy because it involves human emotions that although painful are closer to our experience and therefore provide an intersubjective perspective. If this were to be confirmed, even in the case of negative emotions, there should be an emotional attachment and proper action of mirror neurons, whereas facing the subject of suicide with no emotional background involvement will facilitate the frightening, historical emotional reaction with the fear of risk of contagion. This is probably associated with emotional detachment, reduced empathy, and mirror neuron disconnection. Proper understanding of neuropsychobiological reactions should pave the way to awareness toward suicide for those devoted to helping suicidal individuals. By focusing on our attitudes, we can reduce the gap in the communication of human suffering, again, courageously "by feeling, not by thinking."

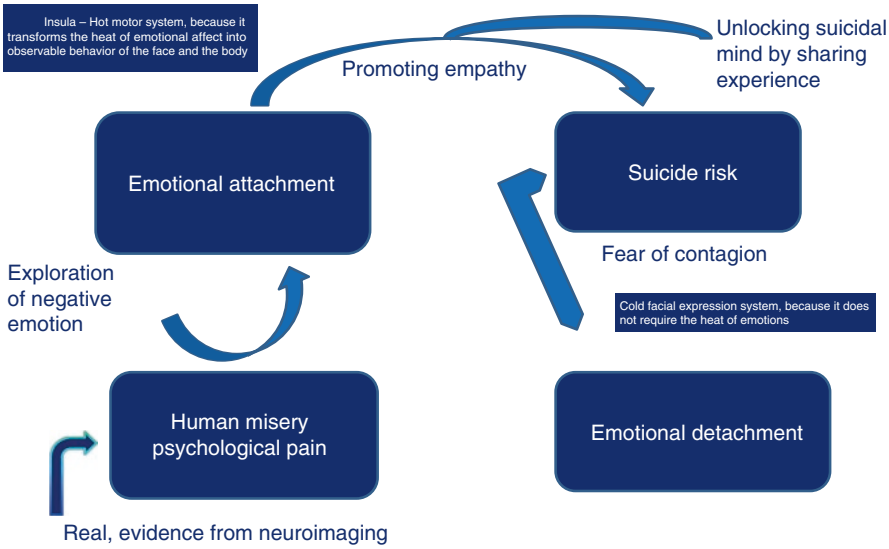


**Fig. 2.2** Pathways for suicide risk and for unlocking the suicidal mind - the figure represents the development of psychological pain conducting the individual to suicide. For helping such individuals empathic understanding proves to be better chance rather than facing suicide topic

On September 4, 2014, Dr. Margaret Chan, director general of the World Health Organization, stated that:

Despite an increase in research and knowledge about suicide and its prevention, the taboo and stigma surrounding suicide persist and often people do not seek help or are left alone. And if they do seek help, many health systems and services fail to provide timely and effective help (World Health Organization 2014, p. 2).

It is now time to reflect on our emotions so as to understand our approach when treating suicidal individuals, either by facilitating or impairing emotional attachment. If we were able to provide anodyne approaches (Shneidman 2005), which more effectively relate to the points of reference corresponding to those of the patients' suffering, we would mollify the pain that kills and inevitably isolates suicidal individuals to whom we are so committed as suicidologists.

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# A Phenomenological Approach to Suicidal Mental Life

3

Jann E. Schlimme

## 3.1 Despair as One Side of Suicidal Mental Life

People usually think about suicide when in a desperate state of mind (I will use the term 'desperate' as an adjective to the noun 'despair'). The desperate person has repeatedly found out, and his or her situations have repeatedly demonstrated, that a positive change appears to be impossible. In other words, all usually fruitful behaviour, and every behaviour the afflicted person can think about, has failed already and turned out to be fruitless. Despairingly, the desperate person is well aware of this 'helplessness'. Desperation is, in the sense used here, not simply meant as an emotion. It is, in fact, affecting all (active or passive) levels of mental life. Like a mood desperation pre-reflectively prescribes the manner of how one's lifeworld is perceived. According to Jaspers the term 'mood' defines a complex state of feelings providing the background and colour (*Färbung*) of actual mental life (Jaspers 1913, p. 62f). Importantly, impairments of behavioural options are connected with despaired moods in two ways. On one hand, the perceived or experienced (behavioural) options are reduced in *scope*; on the other hand, the experienced options are valued in a different ('negativistic', 'hopeless') *style* (Schlimme 2013). This kind of pre-reflective selection and affective response to experienced non-axiological properties (oneself, circumstances and objects in one's lifeworld, one's life history and future prospects) implies the narrowed scope and altered style of meanings and behavioural options. It can therefore be addressed as an 'affective narrowing'.

This feature of suicidal mental life received empirical evidence and is reframed in psychiatric and psychological models coining terms like 'narrowing', 'hopelessness', 'helplessness' or 'psychache' (Ringel 1954/1999, p. 103ff; Beck et al. 1975,

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p. 262ff; Shneidman 1993, p. 50ff). These concepts claim that this special state of mind can be understood as the final common pathway in the longer process of becoming and being suicidal. In other words, suicidal persons appear to be very similar with respect to their desperate state of mind. In a broad sense it is irrelevant whether one's desperation results from one's loss of job or family and from suffering from a severe and chronic (mental) illness or if this desperation might be prescribed by one's depressed mood. There are, however, subtle differences in the experiences of suicidal people with respect to underlying mental disorders (e.g. a person suffering from a borderline personality disorder experiences her suicidal ideation, maybe, as a reaction to a feared loss of an important and valuable person, whilst a severely depressed person might be suicidal because she is delusionally convinced that her loved ones are better off without her). And people with mental diseases are more susceptible to desperation, due to impaired or suboptimal coping capabilities and/or enhanced challenges and challenging situations. But, not every depressed person gets suicidal and not every suicidal person is depressed. In other words, suicidal people are not necessarily depressed (in a clinical sense), but they are necessarily in a state of mind of despair.

But this is only one truth of suicidal mental life. If we focus on the suicidal person's point of view, we have to admit that there is more to the suicidal state of mind. This 'more' is about the meaning of suicide for the suicidal person.

## 3.2 Jean Améry: Suicide as the 'Path to Freedom'

Jean Améry (1912–1978), born as Hans Mayer in Vienna, essayist and Auschwitz survivor, published a detailed description of suicidal mental life in his book *On Suicide* 'Laying hands on me' (1976/1999)[1] written directly after his second serious suicide attempt in 1974 and forecasting his suicide in 1978. Améry was conversant with suicidal mental life, already attempting suicide directly after being tortured by the SS in 1943 and being often despaired and repeatedly suicidal in his lifetime (Améry 2007, pp. 519f and 523ff). Améry highlights the ambiguity in suicidal mental life, being an ambiguity between proven desperation in life and expected relief in death and between the necessity of embodiment and social embedment as constant resource of desperation and the ego as the promise of freedom: 'Man thinks, multicausality directs' (1976, quoted in Hartmann 2005). Améry describes an existential struggle in suicidal mental life: 'He who steps onto the doorstep of suicide, is engaged in a big debate with his body, his head, his Ego like never before' (Améry 1976/1999, p. 74). Since we are always subject to natural and social law in life, a truly free condition can, according to Améry,

[1] 'Hand an sich legen' (Laying hands on me) is a German idiom, meaning 'committing suicide' in this context. It can also be translated as 'getting involved into doing something' and has thus a double meaning in the sense of 'getting involved into killing myself'.

only be achieved in the very moment of laying hands unto oneself: 'Suicide is the path to freedom but not freedom itself' (Améry 1976/1999, p. 144, also called 'freedom intoxication' p. 115; see also Améry 2007, p. 520, 'ontological negation'). This path is not taken easily: 'I am still on good terms with the topic of suicide. Obviously the creature resists obstinately. But it can even be that it is my pathological feeling of obligation which hinders me to give it all up' (letter to Ernst Mayer, 16 March 1976; see Améry 2007, p. 523). Améry rejects psychological interpretations of his suicidal ideation, or suicide attempts, as an automatic to his many traumas. Such an interpretation would depict him as subject to pre-reflective mental functioning and, therefore, re-victimize him (Schlimme and Škodlar 2008; Schlimme 2010, p. 568ff). Consequently, Améry claims this decision a free choice: 'The person committing suicide dies out of her own decision. Only she herself could have mercy with her' (Améry 1976/1999, p. 91). As Améry's case demonstrates, suicide gets meaningful since it promises relief (i.e. the maximum of freedom)—this promise is the other side of suicidal mental life even for an atheistic position.

## 3.3 The Other Side of Suicidal Mental Life: Suicide as Relief, Catharsis or Remedy

As we can learn from Améry, and other persons conversant with suicidal ideation, suicidal mental life has two sides: the experience of desperation AND the knowledge of suicide as one's last option to act in an effective way with respect to changing or altering one's feelings (one's desperation). In the high times of suicidal conditions, the behavioural options can indeed be effectively narrowed down to two choices, 'staying alive' or 'killing oneself', whilst one's prima facie valuing oscillates between valuing the given situation and mental life as 'unbearable' or 'just bearable' and the option of killing oneself as 'last and only relief/remedy/rescue/exit/escape' or 'no exit at all', with the tendency to overestimate negative outcomes (see Schlimme 2013).

The knowledge of suicide can also have a cathartic effect in a crisis. This is no new insight. Especially the stoic philosophers drew on these dialectics, as especially the writings of Lucius Annaeus Seneca (1 BC–65 AC) demonstrate. Seneca, stoic philosopher and Caesar Nero's counsellor, at least once suicidal in his adolescence (Maurach 1991, p. 26), explicitly draws on the option to suicide as a means to swing back into a 'tranquillity of the soul' in critical situations (see Box 3.1). 'Tranquillity of the soul' means an attitude of 'equal value' towards all given things and circumstances. Even though it is constantly at our means, it is oftentimes difficult to maintain (Seneca 1992a, Tranq. an., 17,11; Seneca 2007, p. 381ff; Hossenfelder 1995, p. 39). The option to suicide can be a pivotal point for regaining this stoic (apathetic) attitude, since it fuels elaborate reflection on one's emotions and situation and can end up in the question: What being excited for?

**Box 3.1 Seneca on the Ability to Kill Himself as Pivotal Point to Swing Back into a Tranquillity of the Soul (1992b, De ira, III, 15)**

'Whether life has so much value remains to be seen. That is a different problem. We will not see much positive aspects in a desolate imprisonment; we will not recommend, to accept commands from executioners. We will show, that a gate to freedom is open in every slavery. If the mind is ill or miserable because of one's own fault, one has the option to end one's misery and oneself alike. I tell it those, whose king is shooting arrows at the chest of his friends or whose lord feeds fathers with the flesh of their children: "What are you complaining about, you fool? Are you waiting for a public enemy to avenge you killing your people or for a king from abroad rushing powerfully to your aid? Wherever you are looking there is an end to your misery. Do you see that precipice? Over there it's going down to freedom. You see that sea, that river, that well shaft? Freedom is there, at their bottom. You see that tree, crippled, scrawny, barren? Freedom is hanging at it. You see your throat, your neck, your heart? They are escaping agents from imprisonment! Those ways I showed you are too troublesome, require too much courage and power? You ask, if there are more comfortable ways to freedom. Every vein of your body!" But, as long as nothing appears so unbearable that it drives us into death we want to moderate our anger in every situation'.

This suicidal dialectic constantly challenges our knowledge of suicidal mental life and fuels philosophical debates concerning the justifiability of suicide (Schlimme 2015). It challenges us personally if being despaired ourselves (so-called ambivalence), having loved ones who are despaired, attempted ('gestured') or committed suicide or if we are engaged in suicide prevention. David Hume (1711–1776) (maybe) resurrected Shakespeare's term of suicide as a remedy (Juliet in 'Romeo and Juliet', Shakespeare 2008, IV, I) in his famous essay 'On Suicide' (1783/1995, #8). Hume points out that suicide can even be experienced as a 'remedy' if death is perceived only as a 'horror', or, as Hume himself claims in his *Treatise*, death is perceived as ultimate annihilation removing all perceptions (2000, p. 165). It is, as Hume argues, the effectiveness with which death 'free him from all danger or misery' that makes it a 'remedy' in the eyes of the desperate person, claiming that 'no man ever threw away life while it was worth keeping' (1783/1995, #8).

If we take a closer look at Améry's and Seneca's experience of 'being rescued' in his knowledge of suicide, an important point in his relief/remedy experience seems to be that he was able to put himself to death effectively and on his own account. It is indeed this knowledge of a behavioural option which can be named as the major difference between simple desperation and the suicidal state of mind. In other words, compared to being simply despaired by the traumatic flashbacks and mental and bodily disabilities, his knowledge of being able to kill himself changed his otherwise seemingly unchangeable desperation. He now had an option for what to do if it came to the worst. Nonetheless, Améry's experience of 'being rescued in

his knowledge of being able to kill himself' differs from the usual experience of 'being rescued'. Usually 'being rescued' takes place suddenly, unforeseen, and when a person is in desperate need of it (Marion 2002, p. 199f). It is, obviously, a passive experience in the sense that the rescued person has no power over the 'force' saving her. And it is, furthermore, experienced as a 'qualitative jump' out of previously restricted situations, that is, it is experienced as a 'breakthrough' to a new and different way of living (Jaspers, 1932/1994, II, p. 206f). Even though being rescued allows a new start for a better life, it is, however, not necessarily a rescue for all times; it is, first of all, just a rescue from the current state of despair. As I have argued elsewhere, suicidal people can experience (value), or (pro-/retrospectively) judge, their own suicide as a 'relief', a 'remedy' or a 'rescue' in at least five different ways (Box 3.2).

**Box 3.2 Aspects of Being Rescued in Suicidal Mental Life (Schlimme 2010, p. 568f; Schlimme 2013)**

(a) The experience of one's imaginatively anticipated death as somehow 'more' than can actually be expected from anything else.
(b) This experience is bound to the knowledge, or at least awareness, of being able to kill oneself on one's own means in a self-effective way.
(c) A deep (irreversible) change of oneself and one's situation is (prospectively) experienced as promised to take place after one's suicide/suicide attempt.
(d) The suicidal person can be aware of the possibility to use more or less uncertain techniques of attempting suicide, thereby tempting possible saving forces in life.
(e) A survived suicide attempt and/or coped and overcome suicidal crisis can never be understood exhaustively in retrospect, since certain, and maybe even crucial, aspects remain to appear arbitrary (catharsis).

It is further more interesting to notice that all three features of the experience of 'being rescued' can only be found in the retrospective evaluation from a post-suicidal crisis situation (point 'e'). Maybe another example reported already earlier might be helpful for illustrating this aspect (Schlimme 2013): In my second year as a house officer, working on an inpatient unit for the elderly in the psychiatric department of Hannover Medical School, I met Hans (a pseudonym). He was 84 years old and had been involuntarily admitted to our unit due to a serious suicide attempt. As leading motive for his suicide, he named loneliness and social isolation, which were in fact given. His wife had already died 10 years before, and just recently his last friend from his adolescent times had passed away. He was neither severely depressed nor senile or physically severely disabled due to some kind of bodily disease. In other words and from a medical point of view, he was well off for his age. In one of our psychotherapeutic encounters, he disclosed to me that he experienced his rescue

as some kind of wonder (which was not far off the mark, because his rescue was in fact arbitrary due to an unplanned visit by the priest of his community). He was neither deeply religious nor did he hold any clear concepts regarding some kind of afterlife. He didn't expect anything special from his own death, except to end his loneliness. ('And it would have ended it.') In other words, this motive was still in place (though he was not acutely suicidal anymore). And indeed, his loneliness could not easily be altered. In retrospect he nonetheless took his survival as a legacy to keep on and maybe seek new friendships in his religious community, although he clearly pointed out: 'Without the knowledge that I can do it anytime I want to, I wouldn't go on. But then, maybe it wasn't the right time already after all'.

## 3.4 The Two Sides of Suicidal Mental Life

A phenomenology of suicidal mental life describes this mental condition as a condition of extreme tension: on one side, one's life forecasts ongoing and unbearable despair and, on the other side, one's self-inflicted death promises relief. Friedrich Nietzsche (1844–1900) wrote: 'The thought of suicide is a great comfort: it helps one to get through a bad night' (Nietzsche 1994, III, 94). Nonetheless, every suicidal person is primarily in 'the condition of Stalingrad' (Burger 1988). However, the possible cathartic effect of the knowledge of one's option to suicide should not be underestimated. Surveys repeatedly demonstrate that there are far more suicidal crises than suicide attempts, herewith hinting at this cathartic effect (Weissman et al. 1999; Crosby et al. 1999; Kuo et al. 2001; Renberg 2001). Yet, this effect shouldn't be overestimated as well. Neither Hans nor Jean Améry or any other suicidal person would perceive and value her ability of self-inflicted killing as some kind of 'relief' (Hans), 'path to freedom' (Améry) or 'remedy' (Hume) if not have being despaired in the first place. No despair, no experienced relief in the option to kill oneself. Suicidal mental life can never be given without this tension and these two extremes. Typically this tension and ambivalence is displayed or 'played with' in interpersonal relations as well (i.e. 'cry for help', suicide as a gesture; 'deceptive quietness', not showing any signs of suicidal intention if being absolutely determined to kill oneself). This interpersonal quality makes it possible, or impossible, to help and support the suicidal person to overcome the suicidal crisis (which would, by the way, affirm the cathartic quality of the option to suicide). It is therefore necessary to take both sides of suicidal mental life into account for a fine-grained phenomenological understanding.

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# Early-Life Adversity and Suicide Risk: The Role of Epigenetics

4

Gustavo Turecki

## 4.1 Suicide and Its Association with Early-Life Adversity

Suicide is a complex, multifactorial phenomenon, and several models have emerged aiming to understand the factors conferring increased suicide risk. The existing and most widely accepted models explaining suicide risk suggest an interaction between a number of proximal and distal risk factors. Distal factors refer to predisposition, which include, for example, genetic factors and exposure to early-life adversity, whereas proximal factors are those that act as precipitants, such as recent life events and recent psychopathology, including current substance abuse. Among distal factors, early-life adversity has the strongest association with suicide. Exposure to negative experiences during early life, including childhood abuse, significantly increases an individual's risk for suicide and suicidal behaviours. Among individuals that exhibit suicidal behaviour, 40% have reported a history of child abuse (Brezo et al. 2008; Cutajar et al. 2010; Fanous et al. 2004; Fergusson et al. 2008; Martin et al. 2004; Plunkett et al. 2001). Studies in representative samples followed longitudinally have also found individuals who experienced child abuse (sexual or physical) have a greater chance of displaying suicidal behaviours later in life (Brezo et al. 2007a, 2007b; Fanous et al. 2004; Fergusson et al. 2000; Galera et al. 2008; Juon and Ensminger 1997). Childhood abuse is strongly associated with an increased risk to developing mental illnesses such as major depression, bipolar disorder, substance use disorders and suicide to name a few (Agid et al. 1999; Evans et al. 2005; Fergusson et al. 1996; Heim and Nemeroff 2001; Kaplan and Klinetob 2000; Kendler et al. 2000, 2004; Molnar et al. 2001; Santa Mina and Gallop 1998).

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Although the evidence points to a robust association between early-life adversity, psychopathology and suicide and suicidal behaviours, the exact biological mechanism underlying the association remains unknown. In this chapter, we will review the studies conducted in human tissues which have reported changes occurring at the molecular level in response to changes in the early-life environment. The focus will be on epigenetic processes as they are responsive to the environment. Whereas there are currently only a handful of studies that have directly investigated epigenetic changes associated with early-life adversity in the context of suicide, we will expand our discussion to studies, as there are many, that reveal a strong association between early-life adversity and epigenetic alterations in several key genes that are known to be dysregulated in suicide and other psychopathologies.

## 4.2 The Genome and Genomic Plasticity

The genome refers to all the genetic material in a cell or organism. It contains all the genetic information that is required to generate all the proteins for an entire organism. Although the DNA sequence is fixed and unalterable, it is now understood that there are mechanisms, termed epigenetics, that exist and respond to developmental, physiological and environmental changes. Epigenetics contribute to genomic plasticity, which refers to the ability of the genome to adapt to the needs of an organism. They are dynamic molecular processes capable of regulating the output of genes without changing the DNA sequence. The output of epigenetic processes indeed occur as a result of physical and chemical environmental signals but only until recently has it been revealed that the social environment can also trigger epigenetic responses (Labonte and Turecki 2010; Nagy and Turecki 2012; Petronis 2010; Turecki et al. 2012; Turecki and Meaney 2016). Thus, the epigenome provides a means by which changes in the environment can trigger changes in gene expression levels and, ultimately, as a result, regulate behaviour at least partially in response to environmental needs.

## 4.3 Epigenetic Mechanisms

*DNA methylation*—Among epigenetics mechanisms, DNA methylation is the best characterized and most investigated. It refers to the addition of methyl group to a cytosine from cytosine-guanine (CpG) dinucleotide sequence, a process facilitated by DNA methyltransferases (DMNTs). The effect of DNA methylation, whether increased gene expression or transcriptional repression, is dependent on the location of the DNA methylation such that DNA methylation in promoter regions generally leads to repression as this usually occurs at the site of transcription factor binding at regulatory regions. More recently, there has been growing interest in the study of DNA hydroxymethylation, the oxidation, by TET family enzymes, of methylcytosine to hydroxymethylcytosine, which is an intermediate in DNA demethylation whose concentrations positively correlate with gene transcription (Nestor et al.

2012). Non-CG-methylation or methylation at cytosines followed by bases other than guanine is another form of DNA methylation that has been recently described and gaining significant interest (He and Ecker 2015).

*Histone modifications*—DNA is wrapped around eight histone proteins (H2A, H2B, H3 and H4) to form nucleosomes, which comprise the basic units of chromatin. Modification of histones occurs at histone amino acid tail where chemical residues can be added or removed. Chromatin exists in two states: euchromatin, the active state allows for gene transcription, and heterochromatin, the inactive state which favours gene repression. Histone modifications lead to chromatin opening or closing, which respectively result in the active or inactive state of chromatin (Wysocka et al. 2005, 2006). The process is mediated by histone transferases (HAT), which add acetyl groups to certain amino acid residues, and histone deacetylases (HDAC), which remove acetyl groups (Tsankova et al. 2007). Eight types of histone modifications have been characterized including methylation (lysine, arginine), acetylation, phosphorylation, ubiquitylation, sumoylation, deimination, ADP-ribosylation and proline isomerization. Among these, lysine (K) methylation and acetylation are the most studied with methylation at specific lysines of the third histone (H) as in H3K4, H3K36 and H3K79 is correlated with active transcription (Barrera et al. 2008; Kirmizis et al. 2007; Pokholok et al. 2005; Salcedo-Amaya et al. 2009; Wang et al. 2008; Xiao et al. 2007), whereas methylation at H3K9, H3K27 and H4K20 is associated with transcriptional repression (Bannister et al. 2001; Barski et al. 2007; Botuyan et al. 2006; Lan et al. 2007; Nielsen et al. 2001; Sanders et al. 2004; Swigut and Wysocka 2007; Wang et al. 2008).

*Noncoding RNAs*—Activation or repression of genes can also be regulated by noncoding RNAs (ncRNAs) (O'Connor et al. 2012; Omran et al. 2012; Smalheiser et al. 2011). In particular, microRNAs (miRNAs), which are small, noncoding, single-stranded, 19–24 base RNA transcripts, have been receiving significant attention for its possible role in psychiatric disorders (Issler and Chen 2015). They participate in posttranscriptional regulation of messenger RNAs (mRNAs) by binding to mRNAs and forming complexes that target complementary mRNA leading to either translational repression or the degradation of the targeted transcript, resulting in genetic repression (Saetrom et al. 2007).

## 4.4 Early-Life Adversity and the Stress Response System

The hypothalamic-pituitary-adrenal (HPA) axis plays an important role in regulating stress responses (Pariante and Lightman 2008), and its dysregulation has been associated with exposure to early-life adversity as evidenced by heightened stress responses in individuals with histories of child abuse (Carpenter et al. 2004; Heim et al. 2008). Structural and functional changes have been found in brains of child abused subjects, specifically in brain regions involved in the HPA response (Bremner et al. 1997, 2003; Carrion et al. 2001; De Bellis et al. 2002; Driessen et al. 2000; Stein et al. 1997).

Evidence that the early-life environment could have a significant impact on later-life behaviour through epigenetic changes was supported by the landmark studies in

rats conducted by Meaney and colleagues. This research has demonstrated that the early-life social environment, as modelled by maternal care in rat (the frequency of licking and grooming (LG) pups over the first week of life), programmes the expression of genes that regulate behavioural and endocrine responses to stress. Pups reared by mothers that showed higher levels of maternal care (i.e. high LG mothers) exhibited in adulthood greater expression of hippocampal glucocorticoid receptors (GR; *NR3C1*), heightened negative feedback regulation over hypothalamic corticotropin-releasing factor (CRF) and more modest responses to stress (Francis et al. 1999; Liu et al. 1997; Weaver et al. 2004). The different adult behavioural outcomes due to variations in maternal care were found to be associated with an epigenetic modification of a neuron-specific exon $1_7$ promoter of GR (Weaver et al. 2004) such that increased maternal care associates with decreased methylation of the $GR1_7$ promoter and increased hippocampal GR expression. This research elegantly demonstrated the profound and persistent impact that differential early-life experiences can have on gene expression and behaviour and that this is mediated through epigenetic mechanisms.

DNA methylation in the GR gene was investigated in the hippocampus of individuals who died by suicide and had histories of child abuse. These studies strongly suggest that similar epigenetic mechanisms are at play in humans regarding behavioural outcomes of early-life adversity. Indeed, child abuse was strongly associated with altered DNA methylation patterns of one particular GR gene transcript variant, $GR1_F$ ($GR1_7$ homologue in rats) promoter such that increased methylation in the $GR1_F$ promoter region and decreased expression of $GR1_F$ was found in the hippocampus of suicide completers with histories of child abuse compared to non-abused suicide completers and healthy controls (McGowan et al. 2009). The increased methylation was also associated with a reduction in binding of the transcription factor NGFI-A, which was likely responsible for the decreased hippocampal GR expression that was also observed in the child abused group. Since lower GR expression is known to lead to HPA axis hyperactivity, these findings further support that child abuse can exert severe negative consequences on HPA axis function and implicating HPA axis dysregulation in the aetiology of suicide following a history of severe early-life adversity.

As the GR gene possesses nine different first exon variants ($1_{A, I, D, J, E, B, F, C \text{ and } H}$ (Turner and Muller 2005)), follow-up studies have also reported changes in DNA methylation associated with suicide and child abuse history. The expression of the exons $1_B$, $1_C$ and $1_H$ was found to be significantly decreased in the hippocampus of abused subjects compared to non-abused suicides and controls (Labonte et al. 2012b). $GR1_C$ promoter methylation levels were found to be inversely correlated with $GR1_C$ expression in accordance with the previous finding on $1_F$ variant, whereas the $GR1_H$ promoter showed site-specific hypomethylation that was positively correlated with $GR1_H$ expression. It is possible that active demethylation may be another function altered by child abuse and suicide; however, further work is necessary to explore this understudied concept in the context of early-life adversity.

Several investigations into the epigenetic regulation of the GR gene in child abuse have since followed using peripheral blood samples from living subjects with

histories of various forms of early-life adversity. In particular, these studies focused on the $GR1_F$ promoter. In one study, greater methylation was found in infants of mothers who endured intimate partner violence during pregnancy compared to those of mothers without such history of violence (Radtke et al. 2011). When methylation levels were studied in relation to parental loss, child maltreatment and parental care, diminished care was found to be associated with increased $GR1_F$ promoter methylation (Tyrka et al. 2012). Perroud et al. also examined childhood maltreatment and reported that severity of the type of abuse and its frequency were positively correlated with methylation at the $GR1_F$ promoter maltreatment (Perroud et al. 2014, 2011). Altogether, there is compelling evidence to support that early-life adversity is capable of inducing specific long-lasting epigenetic changes in the GR gene that ultimately impact gene expression.

The HPA axis and its activity can be influenced by the activity of the FK506-binding protein 51 (FKBP5) chaperone protein, which decreases ligand binding to the GR, impeding its translocation to the nucleus (Scammell et al. 2001; Wochnik et al. 2005). Upregulation of FKBP5 expression occurs when an activated GR binds to the glucocorticoid response elements (GRE) in FKBP5 gene enhancer regions. FKBP5 activity inhibits the GR-mediated negative feedback on the HPA axis, which leads to prolongation of the stress response. Genetic polymorphisms in the FKBP5 gene interact with experiences of childhood abuse to predict adult post-traumatic stress disorder (PTSD), major depression and suicide attempts (Appel et al. 2011; Binder et al. 2008; Roy et al. 2010). With respect to epigenetic changes, using peripheral blood samples from carriers of an FKBP5 risk allele (rs1360780) who were exposed to early childhood abuse, Klengel et al. (2013) reported CpG sites near critical GRE regions of the FKBP5 gene were hypomethylated compared to non-child abused controls. The study also found that expression of FKBP5 was under the control of the single nucleotide polymorphism, suggesting that the HPA response system may be dysregulated in risk allele carriers. More recently, a study on early childhood trauma conducted on DNA samples from 3- to 5-year-old children who were exposed to moderate to severe maltreatment based on child welfare documentation also found that childhood maltreatment was associated with lower levels of methylation (Tyrka et al. 2015). The control of the HPA axis is complex and subject to several layers of regulation such that early-life adversity can result in alterations in stress responsivity through epigenetic mechanisms.

## 4.5 Early-Life Adversity and the Serotonin System

There has been increasing interest in studying the serotonergic system in relation to epigenetic alterations associated with early-life adversity and suicide. The neurotransmitter system has been highly implicated in depression and behavioural regulation, and several changes including concentration, neurotransmission and reuptake of serotonin and its metabolites have been associated with suicide and major depression (Bhagwagar and Cowen 2008; Cronholm et al. 1977). The serotonin transporter (5-HTT) has also been found to be involved in the association

between early-life stress and the increased risk of depression in human and primate models (Caspi et al. 2003). In a study with rhesus macaques, increased methylation of the 5-HTT promoter in peripheral blood samples was found to be correlated with increased reactivity to stress in maternally deprived, but not mother-reared, infants (Capitanio et al. 2005). There have been several investigations in humans that have revealed associations between early-life adversity and DNA methylation of the 5-HTT gene. Beach et al. reported a strong correlation between childhood sexual abuse and overall methylation of the 5-HTT promoter in lymphoblast DNA samples from subjects of the Iowa Adoption Study (Beach et al. 2010, 2011). A subsequent study using the same sample identified an association between childhood abuse and DNA methylation at four CpG sites in the nonpromoter regions of the 5-HTT gene (Vijayendran et al. 2012). Investigating in peripheral blood samples from depressed patients, Kang et al. reported increased methylation at the 5-HTT promoter in those who experienced early-life adversity (Kang et al. 2013). A more recent investigation in peripheral blood samples from a German population failed to detect any site-specific changes in DNA methylation associated with childhood trauma (Wankerl et al. 2014). However, the difference in findings was likely due to the fact that different cell types were studied, different region of the promoter was studied and different methods were used to measure methylation. All of which are essential factors to keep in mind when making comparisons between studies.

## 4.6 Genome-Wide Epigenetic Investigations

A number of studies have examined genome-wide epigenetic changes associated with early-life adversity and suicide. Labonté et al. performed the first genome-wide investigation on promoter DNA methylation in post-mortem brain tissue obtained from individuals who suffered severe forms of childhood abuse and non-abused controls (Labonte et al. 2012a). Here, DNA methylation was assessed in hippocampal tissue, and a total of 362 promoters were found to be differentially methylated in the abused group. Of these, 248 were hypermethylated, and 114 were hypomethylated, and the most significant differences occurred in neurons and in neural plasticity-related genes. Other genome-wide investigations were performed in peripheral samples retrieved from subjects who experienced childhood abuse. Investigating blood samples obtained from post-traumatic stress disorder (PTSD) patients, Mehta et al. reported significant differences in the expression of several genes as well as greater DNA methylation profile differences in the same genes in those who experienced childhood abuse than those without such histories (Mehta et al. 2013). A genome-wide study of promoter DNA methylation in blood samples from the 1958 British cohort reported that childhood abuse was associated with significant differential methylation in 997 gene promoters such that 311 were hypermethylated and 686 were hypomethylated in the abused group (Suderman et al. 2014). The majority of the methylation differences were located in genes implicated in key cell signalling pathways related to transcriptional regulation and development. In addition, this investigation revealed significant DNA methylation differences in several genes that

code for miRNAs in subjects with histories of child abuse compared to those without. Another study assessed DNA methylation in saliva samples from abused or neglected children and reported 2868 CpG sites that were significantly differentially methylated in maltreated children compared to controls (Yang et al. 2013). These CpGs were located within genes implicated in not only psychiatric disorders but also in several other health conditions commonly associated with childhood abuse including heart disease, stroke and respiratory disorders among others. Together, the results to date strongly suggest that childhood abuse is associated with numerous epigenetic changes occurring across the whole genome.

**Conclusion**

The studies reviewed in this chapter identify a number of epigenetic changes associated with early-life adversity. The genes affected include those that are known to be dysregulated in suicide and other psychopathologies. Genome-wide investigations have also revealed epigenetic changes in genes involved in critical neuronal processes. Although many of the studies presented in this review did not focus strictly on the suicide phenotype, they nevertheless provide compelling evidence that early-life adversity is capable of inducing epigenetic changes in key genes that may help to explain the contribution of early-life adversity to increased risk for psychopathology. Further work should continue the focus on investigating the epigenetic regulation by early-life adversity and its contribution to suicide and suicidal behaviours in order to gain further insight into the biological mechanisms contributing to the association. This information could eventually lead to the identification of appropriate treatment and prevention strategies for suicide.

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# Terror and Horror: Feelings, Intersubjectivity and 'Understanding at the Edges' in an Interview on a Suicide Attempt

5

Zoë V.R. Boden

> And I'll tell you how to understand this feeling of fear: you imagine that you are a lone woman […] and there's a madman at the door …

In previous writing (Boden and Eatough 2014; Boden et al. 2016), I have argued that as phenomenologically oriented researchers, our aim should be to understand our participants' experiences as fully as possible. In this chapter, I want to explore both how this deeper understanding is possible when exploring experiences of suicidality and also to acknowledge what happens at the edges of our understanding. As researchers (and, I imagine, as clinicians) working with suicidal experience, we seek to understand—to create a bridge to the other that allows us to know more about the suicidal experience for that person and more generally. In turn, feeling understood may help a suicidal person's recovery. Acknowledging the felt aspect of the experience is, I will argue, necessary for developing a fuller understanding. Recognising that feelings do not exist solely within a person, but *between* people, intersubjectively, is also necessary to understand the experience of suicidality more deeply. However, because feelings are immediate and sensory, I will suggest that there are times when understanding is difficult, not because the experience or meaning is hard to discern, but because the visceral power of understanding can feel too much. Feeling overwhelmed is one of the ways that we respond at the edges of our understanding. In our suicide research, there were times when understanding, *really* understanding, was more problematic than I initially wanted to admit. Sitting and listening to what follows from the partial quote at the start of this chapter was one of those times.

The quote is from a participant I have called Roddy. I will explore it in depth later, but for the moment, I ask the reader just to acknowledge what impact, if any,

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those words have on them. Over several hours, I interviewed Roddy about his suicide attempt, and his account will be the focus of this chapter. I also interviewed one of his 'significant others', but will only mention their perspective here very briefly. All names are pseudonyms, and some identifying details have been changed or redacted to protect the participants' anonymity. Participants agreed that their accounts could be used for research purposes, and ethics committee approval was granted by the UK National Health Service. These interviews were part of a large-scale UK Lottery-funded research project, led by Outi Benson[1], which explored the interpersonal experience of the suicide process from the perspective of people who had made a suicide attempt, their significant others (family, partners, friends) and those bereaved by suicide. The interviews were narrative in style and asked the participant to tell the story of the suicide attempt or suicide, with minimal input from the interviewer. Fifty-four people in total were interviewed, and the findings are reported in Benson et al. (2016).

## 5.1 Understanding More Fully

To understand human experience, we must understand emotional experience (Denzin 1984/2009; Stanghellini and Rosfort 2013). Although historically qualitative research has found meaning to be located exclusively in language (Cromby 2012), phenomenological research acknowledges the importance of the felt aspects of the lived experience. Feelings have epistemic importance in the same way as verbal accounts (Boden et al. 2016). Emotionality is fundamental to shared meaning (Denzin 1984/2009). Telling a story without an emotional dimension limits understanding, as what is spoken becomes separated from what the listener hears (Gemignani 2011), and a narrative will appear insincere if the narrator is emotionally detached from what is said (Goldie 2003). Without the resonance of feeling, words appear empty or disingenuous. Without a felt response in the listener, meaning remains ambiguous. Cromby (2012) argues that feelings contribute to meaning in an immediate and continuous way; however, when feelings (which include, but are more than just, emotions) are complex or overpowering, they may also require reflection and interpretation. Feelings associated with suicidal experience are often likely to fall into this category.

In Eye and Mind (Merleau-Ponty 1964, p. 159), Merleau-Ponty argues that science typically takes an artificial approach to understanding human experience, manipulating phenomena and objectifying and looking down on them 'from above'. Instead, he argues we should be 'living in' phenomena, accepting and considering them from the inside, understanding and portraying them as they are given to us, fully and sensuously, in order to 'get closer' to them and to understand them at an aesthetic level. This is the 'fundamental and most concrete level of human experience' (Casey 1973, p. xvi). Understanding how an experience feels and what it is

[1] The study was *A New Focus for Suicide Prevention*, hosted at SANE, London, UK, and funded by Big Lottery Research Programme and the James Wentworth-Stanley Memorial Fund.

like to embody it is the primary way of getting close to understanding it. As researchers, we must engage with bodily felt experience, in order to produce more comprehensive, layered and nuanced accounts of the suicide experience.

There are many ways to define feelings, affects and emotions (Holland 2007), but here I draw on the phenomenological work of Fuchs (2013) and Ratcliffe (2008) to understand feelings as those sensations that resonate in our bodies and permeate others, events and objects. I am interested in those felt experiences that tell us about our relationship with the world. They are a source of information about our context and what is unfolding for us in that moment. When researching the experience of suicidality, acknowledgement of the felt aspects helps us to encounter the experience more fully.

From this perspective, there are five layers of feeling, from the fuzzy, pre-reflective ways we find ourselves in the world to specific intentional states (Fuchs 2013). The first, the fundamental feeling of being alive, is a pre-reflective state that exists as the background to all experience and varies according to how well or ill we feel at any one time. For the second, Fuchs borrows Ratcliffe's (2008) term 'existential feelings' to describe our holistic orientation to the world, for example, a feeling of being at home or of being alienated. These are background, pre-reflective feelings that colour our experiences. The third layer Fuchs names is 'atmospheres'—those feelings that capture the holistic experience of space and relationships. A difficult meeting can have a tense atmosphere making you feel uncomfortable and physically small. Fuchs's (2013) fourth layer, mood and attunement, are feelings that cannot be located in a particular event, space or interpersonal situation. Here, Fuchs draws on Heidegger's (1927/1962, p. 176) description: "A mood assails us. It comes neither from 'outside' nor from 'inside' but arises out of Being-in-the-world", for example, feelings of anxiety, boredom, calm or hopelessness. These are pervasive feelings that are non-intentional (they are not about anything), or perhaps have very abstract objects, such as everything or nothing (Solomon 2008). The feeling of 'getting out of bed on the wrong side' could be describing an angry mood, as opposed to feeling angry with someone or at something. The final layer, emotion, is this latter type. Emotion is a distinct type of feeling that is both complex and intentional. We experience fear of a wasp, or love of our child, and so we have emotional relationships with objects, people and events, and we orient ourselves towards these things according to our emotions (De Rivera 1977; Fuchs 2013).

As researchers, feelings are one of our analytic tools (Kleinman 2002). They help us to be more empathic towards our participants (Hubbard et al. 2001). Feelings also increase our sensitivity and creativity, and our tolerance for complexity (Gemignani 2011), as well as helping us produce more informed, contextualised and nuanced analyses (Jackson et al. 2013). Researchers are therefore instruments of their own research (Holland 2007), meaning that there must be a process of critical reflexivity. Reflexivity involves exploring the subjective and intersubjective aspects of the research (Finlay 2002) and should be relational, embodied and emotional (Burkitt 2012). I have previously argued that a 'reflexivity of feelings' is necessary, one that is expanded to include engagement with all five layers of feeling (Boden et al. 2016). Jackson et al. (2013, p. 3) argue that this type of reflexivity is

especially necessary when the research may 'disrupt the emotional equilibrium of researchers', such as in suicide research.

The 'good' qualitative researcher is often aware of the emotional labour (Hochschild 1979) they have undertaken during the interview, 'managing' their feelings to perform suitably in the researcher role by suppressing 'inappropriate' displays of emotion (Dickson-Swift et al. 2009). However, as Jackson et al. (2013, p. 9) argue, emotional labour does not mean that somehow feelings are 'hoovered out' of the research. Feelings cannot be simply 'managed', and they often emerge unexpectedly or overwhelmingly (M. Holmes 2010), risking the quality of the analysis. Researchers may try to ignore or suppress certain feelings because they threaten them professionally or personally (Kleinman and Copp 1993). As feelings remain controversial in qualitative research (Blackman 2007), it requires some courage to recognise our vulnerabilities through a reflexivity of feelings. However, we should open ourselves more fully to *being with* our participants and their stories, even when this is painful and challenging.

Boden et al. (2016) sketch out the numerous ways that the researchers' feelings entered into our suicide research project. We experienced moments of deep empathic connection where we felt attuned to the participant and had a sense of understanding them. It is this type of experience that I will primarily focus on and interrogate in the rest of this chapter. However, we also noticed other types of feeling. We became aware that we compartmentalised and suppressed certain feelings that arose out of the research relationship. These were often 'disallowed' feelings that did not fit well with our inherited beliefs about what makes a 'good' researcher. These feelings, including relief, guilt, embarrassment or anxiety, often appeared unexpectedly, only to be 'batted away', as part of our 'emotion work' in the interview.

Sometimes we experienced more sympathetic responses, feeling compassion, sorrow, pity or hope. These feelings seemed to indicate our own needs and risked distancing us from our participants' experiences. Yet, these too could provide insight into the subtleties of our participants' felt experiences, which often seemed to 'fit' together with our feelings, like the parts of a puzzle. On occasion, we sensed that certain feelings had been transferred between our participants and us, and these were troubling and complex. For example, in one case, I felt (but did not express or display) some anger and turbulence when interviewing a woman bereaved by suicide who seemed to present herself as 'jolly'. These 'emotional mismatches' (J. Holmes 2014) can provide evidence of what is happening at the edges of awareness. On reflection, I felt it was likely that she was also feeling anger, but was unable to share that with me or perhaps even with herself. Mismatching feelings were also at play when, very occasionally, we felt manipulated or used by the participant, or were left feeling mistrustful, often when there was incongruity between how the account was told and the contents. Finally, we noticed how feelings were not easily contained within the interview or analytic sessions; they resonated and rippled out. They left residues that unexpectedly appeared in our dreams and daydreams, as insights or warnings (see Gareth Owen's example of his nightmare in Boden et al. 2016).

To better understand the suicide experiences of our participants, it was necessary to acknowledge and explore how all these multiple layers of feeling emerge and what they can tell us about the phenomenon at hand. In Roddy's example, consideration of all five layers of feeling was important, but in this chapter, I will focus on the specific feelings of terror and horror, my empathic attunement with them and their felt consequences, which were both immediate and lingering.

## 5.2 Understanding Others and Otherness

Rather than just attempting to explain suicidal experience, research must also seek to *understand* it. Dilthey (2002/1910) suggests that the reductionist and mechanical natural sciences do not elucidate human experiences (Palmer 1969). Instead, he proposed a human science approach, taking the perspective of interpreting meaning (Palmer 1969). We can seek to answer existential questions like 'what is it to be suicidal?' by looking at experience 'from the inside' (Stawman 2011). For Dilthey, understanding involves recognising one's own experience in another's, the moment when one mind 'grasps' the mind of the other (Palmer 1969). Understanding is the 'rediscovery of the I in the Thou' (Dilthey 2002/1910, p. 213): our shared world. It is a concern with subjective experience and understanding individuals as actively meaning-making (Spinelli 1989). A human science approach to suicidality acknowledges its complex and subjective nature. It provides an integrative and holistic way to understand, founded on empathy.

In understanding Roddy's suicidality, I have to acknowledge how I am intertwined with him and his experience through our shared intersubjectivity and intercorporeality, whilst also acknowledging his uniqueness. The fact that the other is other means that we can never completely know them. Their otherness is manifest in their elusiveness and inaccessibility, but subjectivity is not 'hermetically sealed' (Zahavi 2001, p. 163). We are open to others through empathy, a special type of intentionality reserved for other subjectivities, which allows us to experience and understand their feelings, desires and beliefs (Zahavi 2001). Intersubjectivity is possible because our experience of our own subjectivity includes a dimension of otherness, 'the seeds of alterity' (Zahavi 2001, p. 163).

It is through our fundamentally embodied nature (Merleau-Ponty 1945/2002; Zahavi 2001), through *feeling*, that we directly know our world, including other people, without having to reflect on it or narrate it. We make sense of intersubjective encounters through our feeling bodies, but as we are all individuals, understanding another's unique phenomenological experience presents a challenge (Stawman 2011). Empathy, which literally means 'feeling into', involves not just carefully listening to others' words to discern their meaning but feeling with the whole body, in an open, interconnected, relational process (Finlay 2005). This means recognising our self-boundary as open and permeable to the experience of another, in a process of *blending* (Adams 1999). These are examples of when one person's meaningful expression becomes *part of* another, living on in the other self (Adams 1999).

Finlay (2005, p. 277, emphasis added) notes that 'the researcher's task is not simply to listen to another's story: they also need to be open to *being with* the participant in a relationship', so that 'one becomes ever more open to what is being communicated' (Churchill et al. 1998, p. 65). This is particularly important in suicide research, where participants will likely share deeply emotional, unusual and often stigmatised experiences. In this way, our understanding

> is neither fully one's own, nor is it another's alone. We thus do not understand something in the same way as another person (as in an objectivist view of the world, where words would correspond exactly to something described). Nor do we understand something completely uniquely and personally (as in a subjectivist view of the world, where words only have private meaning). (Todres and Galvin 2008, p. 571)

Understanding is a relational process that happens in dialogue (Stawman 2011). Dialogue in this context means the special moment of connection that emerges spontaneously from the 'between', which Buber (1970/1923) refers to as I-You[2] relating. In an I-You moment, the other is no longer 'a loose bundle of named qualities', but rather 'he is You and fills the firmament. Not as if there were nothing but he; but everything else lives in *his* light' (Buber 1970/1923, pp. 59 and 126). The other becomes central; they become a You, another subjectivity, rather than an object for our own gains. In an I-You moment, the other also becomes a unity ('seamless'), whereas during an I-It interaction, the other is deconstructed into specific characteristics (Buber 1970/1923, p. 59). To understand suicidality, the other must be understood holistically and met in his or her experience as it is, rather than atomised into risk factors and behaviours. Understanding the other is thus 'a deep feeling of recognition that may be characterized by the kind of ontological weight that connects us to the place where we feel both deeply ourselves and deeply connected to our common humanity' (Todres and Galvin 2008, p. 569).

In a dialogic relationship, our interpretive 'horizons' of understanding meet (Gadamer 1990/1960). Empathy is primarily embodied, but it supports shared understanding; understanding places empathic moments into meaningful context (Stawman 2011). Understanding can imply there is a singular truth, but this need not be the case. Understanding more fully is not about understanding a phenomenon more 'accurately', but about accepting that interpretation is an inevitable part of understanding (and being human) and that therefore multiple interpretations exist. The world as disclosed to me, in my situated body, is different from Roddy's world. However, we can attempt to find a shared sense of understanding in communicating, through the aesthetics of language and through empathic feeling. When this works, there is a sense of an "emotional 'homecoming'" or a recognition of 'truth' or authenticity (Todres and Galvin 2008, p. 569).

[2] Often translated as I-Thou, the use of You, as per Kaufman's (1970) translation, indicates the informal and intimate intention of the original 'Du' rather than 'Sie'.

### 5.2.1 Communicating Our Depths

Roddy's suicide was physically and psychologically violent. In our interview, it becomes apparent that Roddy really wants me to understand what it was like for him at the time, and what it is like now, to live with those memories. Understanding is paramount for our interview, for the research and for his recovery:

> If there's one thing you need to know about this […] to recover from this, you need some people with a bit of understanding[3].

> The whole purpose, I suppose, is to understand, isn't it?

Roddy believes that no one can help him and others who are suicidal, if they do not understand what it is like. As this is recovery from suicidality, understanding is profoundly connected with the purpose of living. Yet, understanding for Roddy is not dry, disembodied and intellectual:

> It's no good just having somebody who has read a few books and things and thinks that they know what's going on in your head, because they don't.

Roddy wants me to understand - viscerally - and he wants to be understood. One way he attempts to help this happen is through his use of metaphor and imagery. His account is rich, dramatic and poetic. People turn to metaphor, analogy and imagery when experiences seem 'unsayable'. They offer a way to communicate what is definitely felt, but what may seem beyond literal language (Schneier 1989). Metaphors link feeling with telling (Stelter 2000), connecting us to the place where 'language speaks through silence' (Van Manen 1990, p. 49) and understanding becomes possible.

Our bodily knowing is deemed 'silent' because it exists beyond, or before, the languaged realm, but this 'silent' experience constantly demands expression, through a dialectical relationship with language: it is the 'response to a solicitation from below' (Polkinghorne 1988, p. 30). It is through this dialectical process that the 'wild' or 'raw' meaning of our bodily knowing is 'freed' (Merleau-Ponty 1964/1960), made meaningful and understood. Language is itself a bodily act (Merleau-Ponty 2002/1945). It is only when words speak adequately of the experience that they *feel* right. In this way, interlocutors can slowly move towards a shared "bodily sensed understanding, which, when adequate, is experienced as a 'coming home'" (Todres and Galvin 2008, p. 572)—a sense of resolution in the communication of a felt experience.

In this interview, I did not prompt Roddy to develop imagery to express himself. He invented spontaneous metaphors (Svendler Nielsen 2009) in order to help

[3] Quotations are taken verbatim from the interview with Roddy. [...] indicates material has been omitted for brevity.

communicate what he knew at a bodily level. Metaphors help with meaning-making (Schön 1993), but also, importantly, a metaphor can act as a 'safe bridge' to enable expression of painful or distressing feelings (Shinebourne and Smith 2009). They are a way of making an intersubjective link between self and other, through which a deeper empathic insight can occur. Metaphors help the listener to reach 'a more vivid level of understanding', evoking richer and more nuanced responses in the listener (Levitt et al. 2000, p. 23).

Language has an aesthetic quality as well as being a technical tool (Todres and Galvin 2008, p. 570), and by attending to the 'inner dimension' of language (Todres 2007), we can listen for the sensuous, rich and kinaesthetic meanings in the words people choose to express their experiences. However, this is challenging. For the speaker, it involves going to an 'unclear but […] demanding edge' where our bodies know what needs to be said, but we cannot necessarily find the words to say the right thing (Gendlin 2004, pp. 131–132). Roddy often says 'I don't know' when attempting to describe an aspect of his suicide experience, but he does find ways to communicate his experience. He uses very visceral language, especially when describing the act of the suicide attempt. Words such as 'slashing', 'jabbed', 'ripped', 'poked', 'fished', 'pumping' and 'gushing' communicate how he physically engaged with his own body during the suicidal act and how his body responded. These words summon up violent imagery. They are also onomatopoeic and kinaesthetic. As such, in context, they enable the listener or reader to re-embody the experience, and understand it more deeply, at a corporeal level. By listening *and* feeling, researchers are provided with an additional layer of meaning to explore. In this case, these words are disquieting to hear and uncomfortable to re-embody, but because of this, they enable me to understand the extreme violence and trauma of Roddy's suicide attempt, regardless that he never describes it literally in this way.

## 5.3 Understanding at the Edges

It is through my discomfort in empathising with Roddy's account that I am drawn to acknowledge the edges of my understanding. Whilst finding words to articulate such a painful embodied experience as a suicide attempt will take the speaker to a demanding edge, those words can take the listener to their edges too. The otherness of the other represents the ultimate limit to our understanding, but preceding that there is also another, less clear edge to our understanding. This is the edge that I struggle at and where I do not like to linger. It represents the peripheries of what I can tolerate or what I am willing to tolerate. It is at this edge that people feel uncomfortable, 'go numb', daydream, feel lost or overwhelmed, get distracted, fidget, feel bored or at the extremes hallucinate or dissociate. When I am sitting with a participant, I *want* to understand. That is why I am there, after all, to listen, to make meaning and to understand the other's experience. This makes it all the harder to admit that sometimes I also do not want to actually, really understand, because understanding is too painful or too disturbing. As a researcher, when I get close to this edge, there is ambivalence—I want to know, and yet I do

not want to. As I have argued, understanding is an intersubjective and embodied practice. When I sense I have understood another's experience, it is built on a bodily empathy. Opening yourself up to the other means being willing to acknowledge and sit with their felt experiences. With Roddy, this meant opening myself up to his terror and the horror of his suicide attempt.

I met Roddy in his small flat. I set up the recorder and sat in an armchair. He laid down on the sofa in front of me, with his head nearest me, looking away. It was reminiscent of the psychoanalysts' couch. He then told his story, with minimal intervention from me. It quickly became apparent he was a thoughtful and highly intelligent person. His story poured out. The account was graphic and awful. It was saturated with dark emotion, yet he mostly told it in an animated (if also agitated) manner, occasionally joking and exclaiming. It often felt as if he was reading a story rather than recounting his memories. It was a story full of suspense and drama. It was only towards the end of the interview, when talking about his loved ones, that tears welled up.

### 5.3.1 Terror

Roddy spent some time trying to explain to me what it felt like directly before he tried to kill himself. Using machine/computer metaphors, he described how he started to 'shut down':

> You then start leaving, you start taking leave of your senses. It's almost like you're switching to another programme. I'm running programme A now, which is generally being alive and getting on with life, but I'm sure that we've got these other programmes which we switch to […] And this one to me was just - this one was the exit plan, this was shutdown.

Roddy describes a switch into another state of being. He has taken leave of his senses—shifting from his sense-making, rational *and* sensing, feeling self into the 'exit plan'. In his suicidal state, he is no longer running the 'alive' programme. Fuchs (2013) talks about the feeling of being alive as being the most basic feeling state, and in this case, as in others in our study (see Susanne Gibson's description of a 'faltering presence' in Boden et al. 2016), there is a sense of Roddy already stepping into the liminal space between life and death prior to the suicide attempt. However, for Roddy, the exit plan was not a numb or zombie-like state, but one that was characterised by a heightened feeling of terror, and it was this he wanted me to understand.

His description continued with a metaphor of the cloud:

> [It] all began to close down and I was just, every night I was enveloped in a cloud. It was like a black cloud would just come down around me. And it's then that I felt like, oh, I'm just going to put an end to this, I just want to get out of here, I just want to go to sleep, switch off, not wake up again.

At this point, I could recognise the black cloud as a fairly normative symbol of depression or despair. The idea of going to sleep and not waking up also felt a familiar way of describing suicidality. Thus, I recognised, and understood to some degree,

what Roddy was describing. He drew on a second normative metaphor, the cliff edge, to further help me understand his experience:

> it is like being on a precipice, it's like being on a cliff edge with a cloud around you. And you cannot move, because you know that the precipice is there. If that's the precipice there, then you're standing on it, and you don't know that you can just step backwards, because you don't know where you're facing, so one step forward could take you over that edge, ok?

In Roddy's rendering of the metaphor, he is not just at the edge of a cliff, but enveloped in fog (another frequent metaphor for suicidal depression; Benson et al. 2013), unable to see which way to go to safety and which way to peril. This mixing of metaphors—the cloud, the cliff edge and the fog—combines to give the sense that his world was distorted or inaccessible (Benson et al. 2013), with the paralysing fear of being 'on the edge' of catastrophe.

This paralysing threat is also echoed in Roddy's ambivalence around taking his life. It is possible to suggest that Roddy is both the aggressor and victim in his suicidality, yet he speaks here as though 'he' is a third person, who is simply a passive witness to this awful battle:

> I've got this razor-blade, I'm going to do this', but there's still something in you that tells you not to do it. Whatever that force is, that are battling away in your head, the black and the white, if you like, the two opposite forces, the yin and yang or whatever it's called, they're fighting each other and you're just a vehicle, you're just a vessel [sigh …]

Roddy seems to feel he has no control over his suicidality or his self-preservation. Benson et al. (2013) describe this diminished agency as a battle between the bodily and normative sense of agency, with the result that the person becomes unrecognisable to themselves (a 'who am I?' feeling), loses meaning in their actions and feels mechanical and 'on automatic'. In Roddy's account, it is a dialogue between two opposing forces:

> you're laying there thinking 'I've got to go and do this', and your self-preservation is telling you 'don't bother doing that, don't do that. Don't do that'. And before the cloud comes down there's these two forces - there's a force telling you don't do that and then there's another one telling you to do it, and it's a battle. And this cloud comes down round you and once you've got that cloud, once you've got that terrible feeling, it's a feeling of fear.

I felt a sense of Roddy's embattled ambivalence about whether or not to kill himself. I felt his passivity and his sense of external forces and of being a vessel. At the end of this quote, Roddy talks about the cloud giving him a 'terrible feeling'. I thought, 'yes, it must be terrible, to feel so afraid that you want to kill yourself and so afraid that you might actually do that: to be at the mercy of these forces that do not seem to be part of yourself'. I thought I had understood.

At some point during this part of the interview, Roddy raised his hands up to his neck as if to strangle himself, attempting to demonstrate the feeling. His fingers were stretched wide and bent in like claws. I was captivated by the image of his hands clawing around his neck, and I felt myself suffocated. My throat was tight.

I noticed that Roddy was delivering his account without pauses, building tension. I thought I understood, but I was not deeply understanding, until he continued:

> And I'll tell you how to understand this feeling of fear. You imagine that you are a lone woman and you're in a flat, you're in your place and there's a madman at the door with an axe trying to smash his way through, and you know that when he gets through he's going to really fuck you over, he's going to beat the shit out of you, he's going to axe you, murder you, rape you, I don't know what. But there is, that's that feeling, the feeling is one of abject terror.

On hearing these words—axe, murder, rape—delivered staccato and saturated with anger and despair, a rush of fear jolted through me. The violence was not what shocked me (though it is shocking), it was that here, Roddy was summoning *me* into his story. The 'I'll tell you' sounded to me almost like a threat. As a rhetorical device, it was powerful. It wasn't hard for me to imagine being a lone woman—at that moment, I was a lone woman, in this man's flat, listening to this story. The axe-wielding murderer is an image pulled directly from the horror film trope, but here it was, being used to devastating effect to make *me* understand—to make me *feel*—the terror Roddy felt before he tried to kill himself.

This wasn't just terror; it was *abject* terror, perhaps in both senses. Roddy's terror was of the highest degree, but it was also humiliating, defeating and derogating, robbing him of his agency. Although mine is not a psychoanalytic reading, Roddy's use of 'abject' reminds me of Kristeva's (1982) argument that fear and horror are connected to distressing encounters with our own corporeality, and the otherness within, which indicates our fleshiness and points to our death and decay. I feel, in this moment of terror, Roddy is encountering his mortality in a vivid way. He is coming to terms with his desire and ability to end his life by violently attacking his living body. Death and aliveness are dangerously, and very tangibly, close—these are no longer abstract concepts; they are felt bodily experiences—and this is terrifying.

Like a 'good' researcher, I sat and listened. I contained my feelings and presented a calm and 'understanding' front. The difficulty was, I *had* understood—and viscerally so. In that moment, I had *felt* fear, not just his but also my own. His analogy had brought our experiences together, so that there was neither just his memory of terror nor my imaginings, but an intermingled, co-constructed feeling of sheer fear. This was perhaps a type of co-attunement (Mitbefindlichkeit), which comes about through a process of sensitively *being with* the participant, whereby 'in listening one finds oneself *resonating with* the Other' (Churchill 2009, p. 4, italics in original). Yet here, I had been actively recruited into the account.

So provocative was this imagery, and so powerfully was it delivered, that momentarily I became conscious for my safety. I did a quick sweep of the room to remind myself where I was, amounting to an informal risk assessment[4]. I acknowledged

[4] For clarity, I was not actually unsafe. The feeling of fear was only momentary, and I was aware that it was bound to the context of the account. If I had felt afraid of being there, I would have followed my 'gut instinct' and made my excuses and left; I advocate that researchers always listen to their bodily responses with regard to their own safety when interviewing.

that I was there, alone, with a man who was invoking images of rape and murder. For a split second, I was really afraid. I had the strong sense of wanting to flee the room, of wanting the interview done, so I could get out of there. If Roddy wanted me to understand 'this feeling of fear', he had succeeded. Yet I didn't feel satisfied at getting 'closer' to his experience; I felt unnerved. This experience troubled me as a researcher, because it forced me to acknowledge that maybe I did not really want to understand after all.

Immediately that I acknowledged my fear and desire to get away from Roddy, I felt a flood of guilt. I worried that my wish to leave had faintly, momentarily, flickered across my face, disturbing my mask of calm. How could I be thinking about getting on the train and being back home, I asked myself, when this man was so generously sharing his suffering for our research? With all these feelings and thoughts, I was no longer present with Roddy, but wrapped up in my own internal battle—my fear, my embodied response to run away and my professional determination to stay put and not let that show. Yet Roddy continued his account, seemingly unaware of his impact on me.

### 5.3.2 Horror

In a critical essay, the Gothic author Ann Radcliffe (1998/1926, p. 66) describes how 'terror and horror are so far opposite that terror expands the soul, and awakens the faculties to a high degree of life; the other contracts, freezes and nearly annihilates them'. In Roddy's account, he feels terror in the moments before he attempts to kill himself. And it was terror that I was in touch with when Roddy invoked the image of the murderous rapist at my door. It was terror that mobilised my body into 'fight or flight', tensed my muscles and forced me to fight against my instinct to run out of the room. Terror is felt when something is uncertain and obscure, but horror is felt when it is obvious and unavoidably real (Radcliffe 1998/1826; Varma 1966). As Roddy moved from talking about his feelings before the attempt to describing the attempt and its aftermath, the emotional tenor of the account shifted from terror to horror.

Roddy's story is full of graphic imagery, and because he attempted suicide by cutting his wrists, it is most notably full of talk about blood. He languages his account almost as the very darkest comedy, somewhere between awful and farcical. It was not so much the details that were disturbing (sadly we heard many such accounts in the course of this research) but the juxtapositioning of information, such that the horrific laid next to the mundane. Roddy tells me he decided to kill himself in the bath, to contain the 'mess' and protect others from the horror of his death (something we heard from many of our participants; Boden et al. 2016). He shared the somewhat absurdist detail that he fetched cushions from his sofa, so he could be more comfortable lying there in the bath, to kill himself. Yet later in the story, these same supportive, comforting and quotidian cushions are described as 'blood-sodden'. The mundane made horrific.

His physical struggle to kill himself was told in detail, and I repeat this passage here only to evidence the emotional tones at play in this recounting:

> I laid there for a while, blood was coming out and, erm, er, [surprised tone] it kind of stopped. I probably got about half a pint of blood out. And I'm thinking, oh Christ. So then you go for the other one [the other wrist]. […] So I was slashing and hunting around for the other artery, and then, wow, great big pumps of blood were coming out, it was gushing out. I thought, 'hooray'. And then, again, that one sort of dried up. I thought, 'oh crikey, I thought it was all going to come out'. So then I had to start on this one. And then they stopped and they kind of, sort of, congealed and they stopped pumping. Your body's an amazing piece of kit, it's an amazing piece of equipment. […] And in the end I really had to get a knife in and really had to rip through it [miming]. And then it was just gushing, you know, it was really just gushing out.

His animated telling and the surprised tone ('wow', 'hooray', 'oh crikey') felt completely at odds with the horrific nature of the events Roddy was describing. I believe Roddy's use of humour and his chirpy delivery were his way of coping with the extreme horror and trauma of his experience and perhaps his way of protecting me to some extent too. His tone was also at odds with the violent onomatopoeic and kinaesthetic language in the same section ('slashing', 'rip', 'gushing'), with which he was attempting to communicate the fullness of the experience. His miming action as he describes the final attempt left me feeling chilled. Solomon (2008) argues that there can be no such thing as vicarious horror; though we can still sympathise with someone who feels it, as soon as we feel horror, we ourselves are horrified. With these words and this image, delivered in this upbeat tone of voice, I felt horrified. In my reflexive journal, I noted that listening to this, I was gritting my teeth and wanted to turn my head away in an attempt to brace myself against it.

Roddy very nearly died in his suicide attempt. He describes how, in the latter stages of his attempt, he remembers 'getting out of the bath at that point, and stumbling around the flat' and walking out of the front door in a confused state, before ending up collapsed in the lobby. These memories of this time are both sharp and faded:

> Those memories are really quite dim. Perhaps they aren't even memories, because perhaps my brain didn't even have the capability of recording what was going on then. [pause] And from then on it all goes rather blank. I knew that I was stumbling around the flat, I *knew*, I can very *vividly* remember stumbling around the flat, I can *vividly* remember not being able to turn the tap off, I can *vividly* remember not knowing where the knife was. And for some reason – why, oh why? - I left the flat. I don't know why I did it. To this moment I'm still convinced that it was the self–preservation thing.

This description, of a bloodied figure, stumbling around half-dead, recalls another horror-trope image: the zombie figure. The word 'zombie' or 'zombified' was often used by our participants to describe the 'dead' look in people's eyes in the period before a suicide or attempt. In Roddy's account, the zombie image is even more literally represented. Carroll (1990) argues that horror figures represented in art and film are often captured in the disgust-inducing fusion of two forms, for

example, alive/dead, and that we find something particularly horrific when it is not easily classifiable or not easily understood. Roddy is clear that he was so close to death that he 'should have been dead'. He describes this liminal place here:

> And I remember just laying there, I was *freezing* cold. Um. I just wanted to die […] there was some kind of *force* that was keeping me alive. I'd lost five and a half pints of blood, for Christ's sake, I should have been dead. But there was some kind of force that was, I don't know, that was keeping me alive. I don't know why.

This hinterland at the edge of death has an uncanniness that Roddy finds incomprehensible. The 'force' that is keeping him alive when he really 'should' have been dead adds to the supernatural imagery. Roddy's experience is beyond his own understanding here; he does not know why or how his life was preserved. This is perhaps the one aspect of Roddy's experience that he most struggled to communicate and that I feel very distant from. There are relatively few people who have been so close to death yet survive and even fewer who have survived a suicide attempt like this.

Solomon (2008) notes that we can be fascinated, as well as frightened or disgusted by horror. For Roddy, his scars are a visual reminder of the horror of what happened, and he seemed to me slighted fascinated, or at least absorbed, by his injuries, talking about them and displaying them.

> to be honest, they're healing up really good, but they were in quite a mess actually. And I've got some pictures of it if you want to see it at some point.

I was relieved that the pictures did not materialise, though he showed me the scars on his arms. I wonder whether seeing them helps make these events feel more real and therefore more comprehensible. They are an autobiographical marker around which Roddy is rebuilding his identity:

> I'm not ashamed of what happened, absolutely not ashamed, this was a complete event that - I'm actually almost quite proud of these scars, these marks, because that represents me, who I was, at a certain point in time. I don't hide them, I don't need to. If people want to talk to me about them, then fine.

Roddy's defiance in the face of the potential shame and stigma around self-harm scars is striking. Reporting shame after suicide attempts is common (Wiklander et al. 2003), and shame is also a typical consequence of scarring from non-suicidal self-injury (Lewis and Mehrabkhani 2015). It seems that for Roddy, acknowledging his scars may function as a way of holding his memories present, where perhaps they feel more contained or where maybe they are continually being reworked in an attempt to resolve the narrative and make it make sense. For me, his scars provide evidence that he is the living, surviving embodiment of an extremely violent nearly death. This brings with it mixed feelings, including positive feelings such as survivor's pride.

Unlike being the survivor of a car crash or even an attack, it is socially challenging to account for Roddy's scars. Roddy will not be shamed by them, but I heard

from the other person I interviewed about Roddy's attempt that others do struggle to respond when he tells them they were self-inflicted. The scars also affected me: combined with Roddy's graphic account of the act, in seeing them, I felt vicariously brutalised. I saw how much effort his body had made to repair itself, and I could imagine what that damage must have been and perhaps what those photos might have looked like.

Solomon (2008) argues that horror is distinct from fear in that it causes us to feel utterly helpless. Horror fills our consciousness—it is overwhelming (Solomon 2008), such that it shuts us down and stops us from feeling or doing anything else; we freeze. I only recognised my helplessness when I could contrast it with my meeting with Roddy's nominated 'significant other'[5]. When these events were recounted from their perspective, I found myself vitally motivated to help and support them. When I got back from the interview, I sought out resources (helplines and services) that this individual had not been aware of, and I sent them on. I thought about our interview a lot and felt warmth, compassion and care for the person. At that time, this just highlighted the distant, numb and helpless feelings I had when I thought of Roddy, whose interview I found it hard to revisit and towards whose story I felt ambivalent.

This horror had not just been done *to* Roddy; it had been done *by* Roddy. The man I met had been the orchestrator of this horror scene *and* the person physically and psychologically ravaged by it, and that has been challenging to come to terms with. If someone else had attacked Roddy in the way he describes a prolonged, repeated violent attack, which amounts to torture, there would be a clear, socially sanctioned narrative for how to respond—I could be horrified at what happened (and so could he), and I could feel compassion for him. It is easier to feel care and compassion for someone to whom awful things have happened, and it seems generally harder for people to find that compassion when the person has done those things to themselves, as has been demonstrated in hospital staff's negative responses to people presenting with self-harm injuries at emergency wards (Mackay and Barrowclough 2005). However, acknowledging this challenge allows us, as researchers and anyone who encounters those who harm themselves, to work to overcome any initial reactions and find our compassion. If we are not aware, or cannot be honest, about how we feel, it is much harder to shift our feelings to an authentically caring place where support can be provided.

## 5.4 Reflections

Whether, as researchers, we welcome them or not, feelings will be present in the research process (Gemignani 2011). I have argued here and previously that examining our emotional responses, especially in the context of such complex and sensitive topics as suicidality, enables us to better understand our participants and their

[5] Significant others in the study included friends, family members and partners.

situations. In Roddy's case, by being open to the emotional experiences of his suicide attempt, I did get closer to really understanding what this was like for him, and ultimately this has helped motivate me to find ways to better support those who have made suicide attempts. However, I was also pushed to explore what happens at the edges of my understanding.

In recounting the story of his suicide attempt, Roddy's experience sometimes seemed to be spilling out all over me. Roddy perhaps 'overshared' yet alternatively seemed 'too' comfortable and too detached when reproducing the florid details. I was left with the feeling of abject terror and the image of disturbing horror as something that leaks and flows from one person and emanates into another. I also felt mistrustful and uncertain of my understanding: was I getting close to what it was like, or was I being duped in some way? In contrast, when I spoke to Roddy's 'significant other', things felt more 'straightforward'. That individual was often teary; I felt I could empathise with the strain they felt, and I was flooded with a feeling of wanting to protect and help them.

The incongruity between the emotional tone and the content of Roddy's account is most likely what caused my uncertainty and made it harder for me to accept my feelings without desensitising. Goldie (2003) argues that when retelling narratives of our remembered pasts, like what Roddy was doing, there must be the right kind of evaluation and emotional tone in order that the person can place themselves narratively within the events being remembered. He defines this as the difference between remembering something and recollecting it. Goldie argues that when an autobiographical event is tragic or traumatic (and it seems Roddy's experience is both), then finding the right emotional resonance becomes very difficult. The person becomes stuck with just the memory, which they return to over and over in a hope of turning it into a recollection, where their sense of self is reintegrated within the narrative account of their remembered past. This, Goldie says, is the way to find *self-understanding*.

Understanding (and not understanding) is a theme that Roddy returned to many times in the interview. His extremely graphic and detailed account indicates that Roddy was attempting to piece together his remembered past, but was struggling to put his embodied self-experience at the centre of the narrative. His description of being a 'vessel' or 'vehicle' through which things were happening suggests he did not feel like the agent of his story at the time. Perhaps he also struggled to be the agent of his story during the telling, because he still found it incomprehensible that he could have survived to be telling it.

Goldie (2003) explains that narratives are 'successful' for three reasons, one of which is their meaningfulness. This is the ability of one person to understand the other's experience by putting themselves 'in their shoes'. It is the moment of 'grasping' the others' mind, as Dilthey proposed (Palmer 1969), and thoroughly exploring the intersubjective I-You connection. It is challenging to reach this type of understanding when (a) the other is struggling to understand themselves, (b) the other is struggling to communicate their experience and (c) the material is so disturbing, overwhelming or frightening—essentially when it is too other—that it becomes almost unbearable. Roddy's account illustrates each of these points. In particular, he

sometimes struggles to understand what has happened to him and to integrate his self-experience into his narrative, and I sometimes struggled to stay with his experience and sit with my understanding. It was especially challenging for me to reconcile the knife-wielding (self-)attacker of the bathroom scene, with the victim collapsed in the lobby of his building, bleeding to death, with the animated, intelligent man before me at the interview. I wonder how Roddy reconciles these different self-experiences.

Roddy does though make masterful use of language to help communicate the depths of his experience, and thus does manage to 'make' me understand, in particular the terror and horror. Roddy's metaphors may have acted as 'safe bridges' (Shinebourne and Smith 2009) for him, helping him express his difficult embodied experiences. However, thinking of them as safe bridges does not acknowledge that they link one subjectivity to another. The bridge did not feel so safe to me. Roddy's analogies and imagery—his bridges of communication—brought his terror and horror, momentarily, into my life. After the interview, I felt relieved as I left. Later, when writing up my notes, just like Roddy, I found myself returning to the graphic, traumatic details, and I felt nauseous. I wrote that I wanted to separate myself from Roddy. At the time, I had a sense that I did not want to care what might happen to him (though I certainly do not feel like that way now). I felt choked by what he had told me. I felt hostile and then depressed and helpless. The account was harrowing. I was also aware of feeling voyeuristic and ashamed of this. I felt compelled to linger on the awful details, but I did not want to. One way to deal with my voyeuristic feelings might be to exhibit this story, in the same way that Roddy seemed to do with me. Though several years have passed since I met with Roddy, I have felt an imperative to share my experience of that encounter. I hope I have managed to contain the overspilling emotion and to tease out the meaning and therefore to allow the reader to have a sense of understanding. I hope I am not showing the reader Roddy's horror as a spectacle to be witnessed helplessly. It is my belief that by acknowledging my feelings, however difficult, painful or disturbing, however socially or research-inappropriate they may seem initially, they can help lead to greater understanding, and therefore support, for those who have made suicide attempts.

Participants in our suicide study often volunteered themselves because they hoped their accounts might be of some benefit to others. Roddy shared this, but also felt telling his story might benefit himself:

> talking to you is actually part of my recovery treatment, because, you know, you have to face up to what you've done, because you go back to that thing about learning by your mistakes.

Roddy wanted to understand himself and make meaning from the trauma of his suicide attempt. He connects his understanding with recovering and not making any future attempt. Individuals and societies have to find places where stories of suicide attempts can be safely told, however horrific they may be, in order that they might gain shape, context and meaning through intersubjective dialogue. Without understanding, these stories lurk amorphously unattached to the world, ready to terrorise us at any moment. People, like Roddy, who have made suicide attempts, need help to 'catch' their stories and reintegrate themselves into their autobiographical narrative.

Naturally, we must also be wary of the impact these stories can have on ourselves and on others. These include the possibility of triggering suicidal behaviour in another, vicarious traumatisation and distress or unaware/aware emotional responses that could be harmful to the person recounting their story. This wariness though may be one of the factors that stops people who have made suicide attempts from sharing them with others. Psychotherapy may offer a safe space for these accounts, but in the UK, access to this is often limited to brief interventions. Crisis management is typically medical, not psychological. Roddy was able to afford some private counselling support, and reported this very useful, though he wished for more support.

We know that suicide attempts are one of the strongest predictors of a completed suicide (see Van Orden et al. 2010), especially so when the attempt was highly lethal in medical terms (Gibb et al. 2005). Whilst the Joiner (2007) interpersonal-psychological model explains this by suggesting that suicide attempts are the most 'potent' way that someone can acquire the capability to kill themselves (which in combination with thwarted belongingness and increased burdensomeness lead to completed suicides), there is another way in which a previous attempt can increase suicide risk. Whilst there is plenty of evidence to suggest that PTSD can increase suicidality (see Krysinska and Lester 2010), the traumatic impact of making a suicide attempt seems less well explored. Roddy's case demonstrates the emotional, embodied impact of a traumatic suicide attempt (and maybe all attempts are traumatic) and the consequential struggle to integrate self-experience into the remembered past, find self-understanding and communicate your experiences to gain the understanding of others. One reason for the research community's reluctance to explore this area may be that it takes us to edges of our capacity for real, embodied, aesthetic and full understanding.

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# Empathy and Empathic Disconnection in Difficult and Uneasy Situations: Facing the Suicidal Individual

6

Davide Donelli and Matteo Rizzato

## 6.1 The Role of Empathy in the Patient-Clinician Relationship

This chapter aims at highlighting how empathy, a capacity that is expressed in every human being to a greater or lesser extent, can be considered, if correctly interpreted, as a precious and practical tool in the management of delicate situations, such as the relationship with suicidal individuals or patients with psychiatric disorders.

We would like to specify that this chapter stems from the observation of human relationship dynamics to which—as an hypothesis—we will try to give a frame on the basis of current scientific knowledge. This frame is to be considered as an attempt to provide an interpretative clue suitable to allow the transition "from theory to practice", in order to gain an understanding of empathy and, subsequently, use this knowledge to gain added value in interpersonal relationships. In fact, we deeply believe that neuroscience studies find their actualisation in the clinician's everyday practice without remaining only on a theoretical level. This can be obtained by translating neuroscientific knowledge into production of new communicative strategies, in order to take better care of patients that are in difficult conditions, such as those at risk of suicide.

Therefore, in this chapter, we provide an overview on current neuroscientific knowledge about empathy in order to—besides offering a scientific frame—favour new intuitions, which may promote a "more scientific" use and a better comprehension of empathy in the patient-clinician relationship. We then propose the concept of "empathic disconnection" referring to those situations in which the clinician,

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automatically and unconsciously, puts him/herself in the position of not taking any advantage from the empathic relationship with the patient. We propose the concept of "empathic moment" as a communicative strategy, whose goal is to intentionally use empathic mechanisms to gather information directed at identifying the inner state of the patient. We finally suggest the use of vitality forms as a relevant element for the cognitive analysis of the patient's inner states. We conclude with some practical-applicative considerations based on what is discussed.

## 6.2 An Uneasy Situation: The Suicidal Individual

Among all categories of patients, suicidal individuals are surely one of the most delicate groups to manage for a clinician. This type of patient puts the clinician to serious test, continuously forcing him/her to confront with the ability to regulate emotions, which is necessary for a successful intervention. Often, however, the lack of emotion-regulation strategies or even simply of focused attention on this aspect leads to situations that can compromise the result of therapeutic interventions or, anyway, can strongly limit the chance of success.

There are many difficulties characterising the interface with these subjects (Pompili 2013, 2015):

- The presence of strong taboos culturally rooted and linked to death and craziness, which—often unconsciously—affect the clinician's moral judgement
- These patients' predisposition to elicit aversive feelings towards them
- The fear of being "infected" by these subjects' internal state
- The inability to fully understand these patients' suffering, since it is difficult to have adequate cognitive landmarks about what does it mean
- The physical discomfort that one may feel relating with them
- Fear of failure
- Finally, the frustration that can easily come out determining the temptation of abandoning the patient

In this situation, empathy can be a precious tool, to the extent that it can be able on its own to "break" the vicious cycle of feeling unhelpable that characterises the suicidal individuals (Pompili 2013, 2015).

Empathy can be a fundamental and decisive tool with this type of patients since it represents the only capacity that can allow us to really appreciate the patient's suffering and, after understanding it, to have the right motivation to set an appropriate relationship basis: a "shared empathic space" (Rizzolatti and Sinigaglia 2008) cleared off of judgements, labels, discomfort and aversions, where the communication can freely flow and the patient's trust placed. In this case, we should indeed speak of not empathy in a general sense but of compassion (Singer and Klimecki 2014) that, as we will discuss, represents one of its facets. In fact, empathy intended in general terms can be useful but also damaging: entering in empathic resonance

for a long time with the subjects suffering very much or with strong unbalances is not certainly bearable for the clinician whose energies would be depleted in a short time, given that empathy—of a certain kind, we will see—means by definition to share and live (even only at a potential level) in the first person the other's internal state. It becomes then necessary to go deep into the topic to draw inspiration for the development of new communicative strategies letting empathy turn exclusively to the clinician's advantage.

## 6.3 Empathy

Empathy is one of the human brain functions that, to a greater extent, enables us to manifest our extraordinary social abilities, greater than that of every other being on the planet. This ability provides us with the possibility to consider as a priority, among the many motivational impulses that induce action performance and communication, also those that follow from knowing others' internal state.

Not only survival instinct, not even the sole cognition, motivates us towards what we do and say. Above all, knowing exactly the feelings of the people around us or, more precisely, *experiencing them* motivates us.

Empathy is a function of the human brain, which is very complex to study. It is difficult to define the concept itself, and its neurophysiology is still a very young science. One consequence is the lack of consistent terminology used to describe various aspects related to empathy; this is why it is important to provide some definitions.

### 6.3.1 Definition of Empathy

Empathy is for sure a unitary experience, but it can have very different characteristics. In fact, there are various kinds of empathy that we can experience: from contracting our face and "feeling pain" while a friend bumps his pinky finger into the edge of the door to feeling a warmth sensation in the chest while we feel compassion for a colleague that has just lost his job. Therefore, as studies on empathy progressed, it became clearer that it is a multidimensional function (Davis 1983), with every dimension describing a peculiar kind of experience ascribable to the more general concept of empathy.

Empathy has been firstly differentiated into two components: cognitive empathy and affective empathy (Davis 1983). This distinction is very important and stems from the simple observation that there is more than one way to empathise with another person. Therefore:

- *Cognitive empathy* is the capacity to take on the other's perspective, i.e. an individual's ability to understand the others' point of view and their motivations. It rests on the cognitive mechanisms that depend on the so-called mental state attribution system.

- *Affective empathy* refers to the observer's emotional response to the observed individual's emotional state and is based on the so-called experience sharing system.
- To these two components, we can add a third that derives from a better comprehension of affective empathy:
- *Motivational empathy* (Decety and Cowell 2014) or *compassion* is a variant of affective empathy whose peculiar characteristic is the presence of a motivational drive to help others who struggle re-establishing balance.

When strictly speaking of empathy, to make sure that there is a monitoring component keeping track of the origin (self-other) of the experienced feelings (Lamm et al. 2007): the one who empathises has to be conscious of who is the "author" of the empathised emotion, otherwise we would speak of emotional contagion, characterised by not knowing who is originating the emotion.

Empathy is currently described in its many aspects, referred to in the various studies. The abundance of aspects is probably a reflection of the still suboptimal overall vision of the topic; still, it is important to describe them in order to understand the various shades of empathy we can subsequently refer to (Decety and Ickes 2011; Bernhardt and Singer 2012):

1. *Empathic accuracy*: degree of ability to infer what the other is thinking and feeling. It is called "everyday mind reading" (Ickes 2003), and it comprises both the affective aspect of experience sharing and the cognitive aspect enabling to understand the other's thoughts (Zaki and Ochsner 2011). It can be considered as a general parameter of empathy.
2. *Perspective taking*: when we speak of cognitive empathy, we refer to the aspect associated with perspective taking. There is a first variant, Imagine-Other, which consists of imagining the other's thoughts and feelings on the basis of what one says and does and on the basis of the knowledge of the other's personality, values and desires; and a second variant, Imagine-Self (or Role Taking), consists of imagining oneself in the other's shoes, for example, "how would it be if I were this young man that has just lost his job?" We will see that these two variants of perspective taking entail significant and different implications in empathic modulation.
3. *Personal distress* (or *empathic distress*): degree of suffering, stress and anguish felt when witnessing another's suffering. The characteristic of this aspect is to feel anguished not *for* the other's state (compassion), nor *like* the other (emotional contagion), but rather *by* the other's state. In this case, differently from contagion, the self-other distinction is very clear; in other words, we are aware of the origin of the state that we feel. It therefore falls within affective empathy in the strict sense. It represents a "negative" aspect of affective empathy, because it implies suffering for the one empathising, without motivation towards the other, rather there is a motivation towards the self to move away and escape from suffering we are experiencing.
4. *Emotional contagion*: it is the automatic adoption of other's emotions (Hatfield et al. 1994, 2011). This concept stems from the observation that we tend to feel

sad when we are sitting among sad persons and happy among happy people. This empathic form is to be considered as proto-empathy (Singer and Klimecki 2014), since the conscious distinction between the self and the other is lacking (it is present also in newborns that cry when among other crying newborns). The common characteristic of this mechanism and direct mimicry is that they are automatic responses to others' emotions, where the distinction self-other is not necessarily present (Eres et al. 2015). Therefore, there is no awareness of the origin of the experienced emotional state, whether it arises from the self or from the other. Although it should not be considered empathy in the strict sense, since the aspect of the distinction self-other is missing, emotional contagion can be considered as a "negative" aspect of affective empathy.

5. *Direct motor mimicry*: synchronisation of motor behaviour and emotions (also called *facial mimicry*). It is a psychological mechanism deduced from the observation that the observer's facial expressions often mimic the observed person's facial expression (we have surely experienced the situation of finding ourselves with a contracted face while seeing somebody suffering for some medications). A "coupling" to the imitated person's emotion is generated by this mimicry.
6. *Empathic concern* (or *compassion*): sentiment felt for another person that is suffering. It is a form of empathy felt for the other. Accordingly, the felt emotion is not necessarily the same but usually alike, for example, I feel sad for my friend that is in pain and scared. It is characterised by a sentiment of preoccupation, warmth and care for the other, together with a strong motivation to improve the other's condition (Klimecki et al. 2013). The central characteristic is anyway the presence of a benevolent motivation towards the other. It can be considered as a "positive" aspect of affective empathy, but given that sharing of the other's same emotion is not necessarily present, it should not be considered as affective empathy in the strict sense (Eres et al. 2015), and in fact it is also referred to as motivational empathy (Decety and Cowell 2014).

An example of how the multidimensional approach to empathy finds a practical use is the Interpersonal Reactivity Index (IRI) coded by (Davis 1983), an index used as a tool measuring individuals' empathy in its single aspects. In IRI, empathy is subdivided into four aspects that represent four scales on which every individual, through a test, can totalise a certain score:

- Empathic concern scale
- Personal distress scale
- Perspective taking scale
- Fantasy scale (it measures the tendency to identify with fictional characters)

Another important classification regards the mechanisms associated with empathy triggering: in the case of emotional contagion, or where there is an automatic tendency to mimic others' expressions, we have a "bottom-up" processing of empathy, therefore an emotional triggering; in the case of perspective taking, where we

imagine ourselves in another person's shoes, we have a "top-down" processing of empathy, therefore a cognitive triggering.

The "dissociation" between the various aspects of empathy suggests the possibility that different cerebral circuits are responsible for one aspect or another (Shamay-Tsoory et al. 2009). Clinical evidence supporting this view is based on the fact that in psychotic patients the affective component of empathy is selectively compromised, whereas with autism, it is the cognitive component to be compromised (Cox et al. 2012). From a neural perspective, this hypothesis of diversification among empathy-related circuits seems to be supported by many current fMRI studies. A meta-analysis of these studies (Fan et al. 2011) showed a very precise correlation between certain brain areas and empathy, both broadly speaking and specifically in its affective and cognitive aspects. It appears that the basic neural network underpinning empathy mainly involves the dorsal anterior cingulate cortex (dACC), anterior

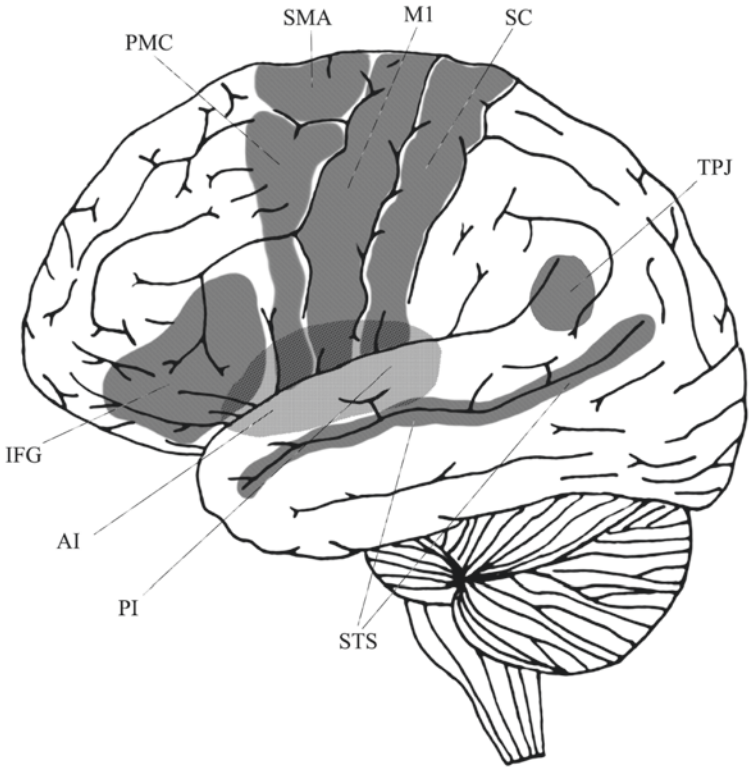


**Fig. 6.1** Cortical areas involved in empathy circuits, lateral view. *PMC* premotor cortex, *SMA* supplementary motor area, *M1* primary motor cortex, *SC* somatosensory cortex, *TPJ* temporoparietal junction, *STS* superior temporal sulcus, *PI* posterior insula, *AI* anterior insula, *IFG* inferior frontal gyrus

middle cingulate cortex (aMCC), supplementary motor area (SMA) and bilateral anterior insula (AI): these areas are always found activated when empathy comes into play. Additionally, a peculiar characteristic of the affective aspect is the activation of right anterior insula, while for the cognitive aspect, it is the MCC together with the adjacent dorsomedial prefrontal cortex (dmPFC), which tend to be more activated (Eres et al. 2015; Ochsner et al. 2009) (Figs. 6.1 and 6.2).

Empathy is therefore our possibility to understand what people we relate to feel and to appropriately respond to this (Decety and Jackson 2004) according to the context and intentions. The neurophysiology that underpins empathy is very complex and in continuous growth given the great quantity of studies that have emerged in recent years. We are interested in addressing these essential aspects, which allow us to orientate ourselves and to give a neurophysiological frame to the relationship dynamic associated with concepts of empathic disconnection and empathic moment, providing the clinician with practical tools oriented towards an even greater diagnostic and therapeutic accuracy.

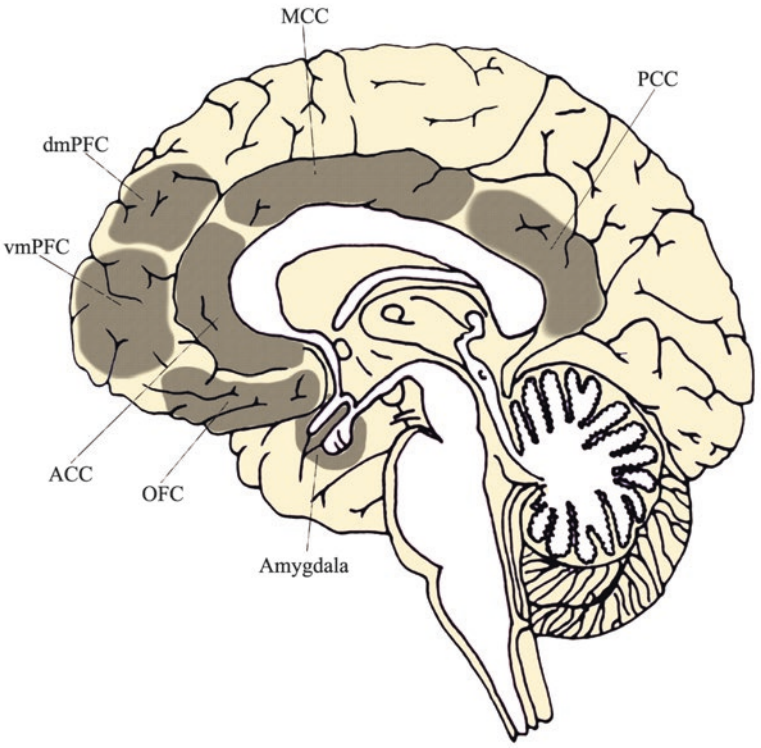


**Fig. 6.2** Cortical areas involved in empathy circuits, medial view. *OFC* orbitofrontal cortex, *ACC* anterior cingulate cortex, *vmPFC* ventromedial prefrontal cortex, *dmPFC* dorsomedial prefrontal cortex, *MCC* midcingulate cortex, *PCC* posterior cingulate cortex

### 6.3.2 Theory of Mind

The so-called Theory of mind describes our capacity to attribute mental states—the possession of a mind—to ourselves or to the others, which are inferred even though we have no direct access to them (Premack and Woodruff 1978). Instead we can access verbal and non-verbal signals, through which we can infer the other's mental state. For years, studies on the Theory of mind have focused on ascertaining what could be the developmental stages underlying the capacity to analyse others' beliefs or, in other words, at what age the human being develops a consolidated Theory of mind.

To understand what it is, an example can be useful (Keysers 2011); to many of us it will remember the disappointment in finding out that in Granma's Danish cookies metal box there are actually buttons. Our initial belief—the box contains cookies—is contradicted, and we learn that there are buttons. Our belief now is that in Granma's Danish cookies metal box, there are buttons. If in that moment somebody else comes in, who has never seen the box before, we clearly suppose that he/she would be likewise mistaken: in other words, looking at the box, he/she would think that it contains cookies. This inference and, namely, being able to attribute a belief, a mental state, to another individual, is a characteristic of the Theory of mind. If we did not have a Theory of mind, this last passage would not occur: if somebody else saw the box of cookies for the first time, we would be induced to think that he/she believes that there are buttons, independently of whether he/she had never opened the box before and cannot know it.

Recently, it has been suggested that the Theory of mind is innate and automatic in the human being, and some experimental evidence has been found supporting this hypothesis (Kovács et al. 2010). Therefore, since birth, the human being, when meeting another human being, automatically activates a cognitive system able to analyse its beliefs.

To the question: "How are we able to attribute mental states to others?" two main theories have been proposed: one is the "simulation" theory, or experience-sharing system (ESS) (Zaki et al. 2009; Zaki and Ochsner 2011), according to which we understand why we simulate in ourselves what the others are experiencing in that moment (we will see this aspect later on). The other is the so-called *Theory of theory,* or mental state attribution system (MSAS) (Zaki et al. 2009; Zaki and Ochsner 2011), according to which we attribute mental states to others starting from what we know about them: what is their situation, what memories do we have about them, what is their culture, etc. These two systems are associated, respectively, with the affective and cognitive aspects of empathy, and find their neural correlate in different cerebral areas. Nevertheless, the degree of an individual's empathic accuracy (see above) is strictly correlated with the *parallel* activation of these two systems (Zaki et al. 2009). As we discussed earlier, empathy, in the end, is a unitary experience: it is the activity of *both* the affective and the cognitive components together that generates empathy and, in pathological conditions, one component compensates for the other (Engen and Singer 2013; Zaki et al. 2009; Danziger et al. 2009). The cognitive aspect, hence the mental state attribution system, is fundamental in

order to integrate the information generated by the experience-sharing system with our knowledge about the context and the other person, in order to correctly evaluate a situation.

The regions mostly involved in the mental state attribution system are the medial prefrontal cortex (mPFC), the temporoparietal junction (TPJ) and the superior temporal sulcus (STS) (Gazzaniga et al. 2013). mPFC is involved in "making a first impression" about a person, shifting perspective (Mitchell et al. 2005) and processing information about the other's physical aspect and physiology. The right TPJ is specialised in reasoning about the others' mental state (Saxe and Wexler 2005), and finally, STS is involved in monitoring the other's attitude (joint attention) and in signalling what is the focus of another individual's attention in a given moment. The function of STS is particularly relevant since monitoring others' attention occurs primarily through STS analysis of an individual's gaze direction (Pelphrey and Carter 2008).

### 6.3.3 Mirror System and Embodied Simulation

The concept of "experience sharing" among individuals is at the base of studies about affective empathy, and the discovery of mirror neurons gave a strong impulse in this direction. We understand others because we live in the first person what they experience in the moment we observe them (at least partially). This is possible thanks to the presence of the mirror system in our brain. It consists of mirror neurons, a particular class of neurons that activate if directly involved when we perform an action and when observing somebody else performing the same action (Rizzolatti et al. 2002; Rizzolatti and Sinigaglia 2008) (Fig. 6.3).

The characteristic of mirror neurons is to "fire" both for motor commands and for sensory stimuli (bimodal neurons) (Rizzolatti et al. 2002; Rizzolatti and Sinigaglia 2008). In particular, there are different populations of mirror neurons. Each of them codes a certain series of single movements, whose kinematic characteristics are duly coordinated and, together, constitute a goal-directed action. The extraordinary characteristic of these motor neurons, besides being able to "guide" an intention-directed action (such as "drinking coffee"), is to become active also when observing somebody performing the same intention-directed action. Therefore, the interaction of mirror neurons generates the mirror system, with a characteristic function: to predispose the observer's brain to "live in the first person" what it observes in the others, even though at a potential state. The mirror system answers to the question: "How do I know that the person I am looking at wants to drink a glass of water?" Simply, the same action is reproduced in our brain while we observe it, inferred by some movement features (Rizzolatti and Sinigaglia 2008; Gibson 2014; Rizzolatti et al. 2002).

The mirror system provides an inner representation, based on one's own motor competence (vocabulary of actions), of what we see performed by others (Rizzolatti and Sinigaglia 2008). This inner representation occurs at the level of the premotor areas: what does this imply? Populations of mirror neurons that activate when we see

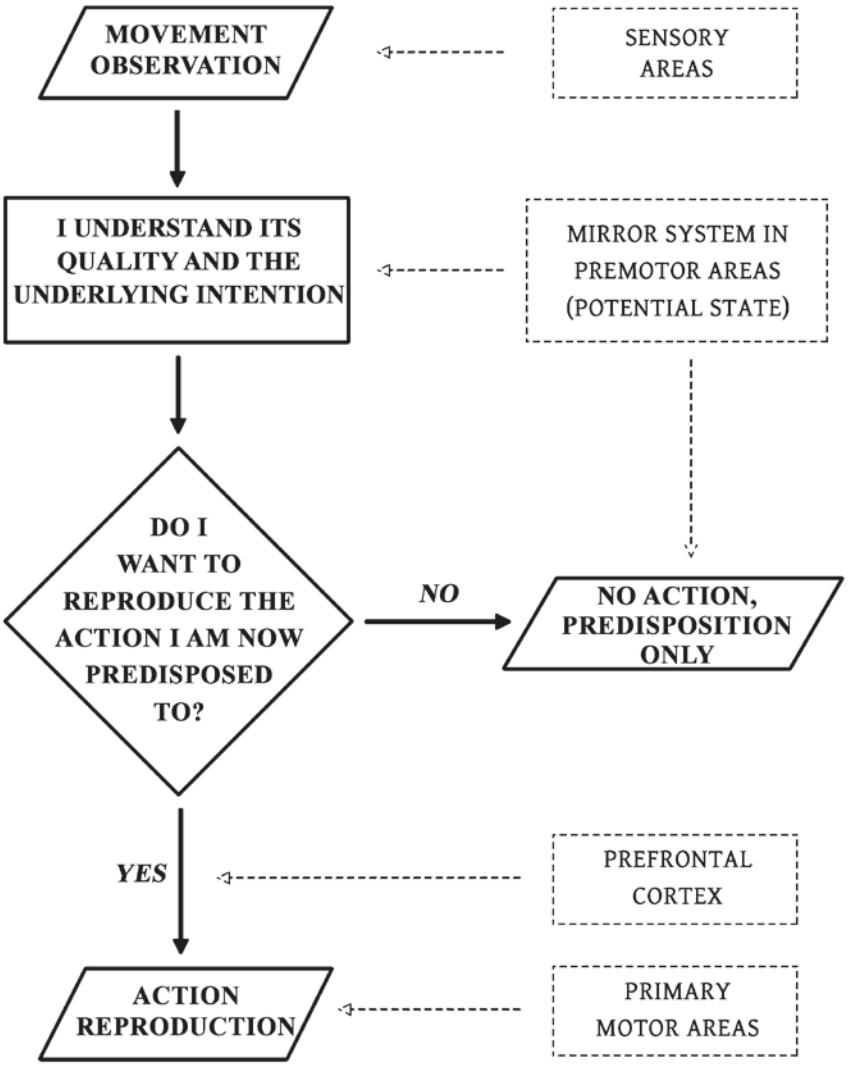


**Fig. 6.3** Representation of the motor mirror system activity (*bold*) and cortical areas involved (*dashed*)

another person performing an action are exactly the same that activate to guide the same action execution in the first person but, when we are observing, the representation keeps only at a potential state, whereas when we perform action, this representation sends a command to the primary motor areas which execute the actual movement. If it weren't so, we would live in the constant urge to execute all observed actions around us! This does not happen because of the intervention of the prefrontal cortex and of will, necessary to pass from the potential state to its execution.

It is important to underline that the bimodality of mirror neurons is not only visuo-motor but there are also populations of audio-motor mirror neurons and, namely, of neurons that activate also when listening to actions, reproducing in the listener an internal representation of the heard intention-directed action (Keysers 2011).

Like for the motor system, similarly the mirror system gives us the answer to the question: how do we understand what the other person feels? It appears that there is also a mirror system in the insula (Wicker et al. 2003; Gallese et al. 2004) and in somatosensory areas (Keysers et al. 2004). This "empathic" mirror system predisposes us to live the same sensations as the observed person and provides us with an internal representation of his/her emotional state, on our own body. This is reflected in specific visceral and somatosensory responses, produced both by signals that our insula sends to the hypothalamus, and thus to the autonomous nervous system, and by the stimulation of the somatosensory areas. These evoked sensations give us—to say—a "taste" of what the other is feeling in that moment, basically we simulate in ourselves the internal state of the person we observe. We are able to infer what the other feels and we can recognise his/her emotions, because we also have previously experienced them directly and we therefore own some reference points. This process is also called "embodied simulation" (Gallese and Sinigaglia 2011; Gallese et al. 2004), and its discovery opens to a new way of conceiving human relationships: there are no separate "you and I" anymore, but constantly "us" (Gallese 2010, 2013). This is because of the profound sharing of neural networks that accompanies human relationships, even in the cerebral areas that were identified as the locus of the self. This new approach to the study of human relationships has been also named "intersubjectivity" (Ammaniti and Gallese 2014). In the motor mirror system, we have seen the involvement of the prefrontal cortex as a "gate" between the potential state and the execution state, while in the "empathic" mirror system we do not have something similar. In this case, the modulation of what we feel is determined by other factors that relate to the context or the observer, such as:

- The degree of knowledge of the other
- If the other is considered honest or dishonest (Singer et al. 2006)
- What is the degree of empathy we are, by nature, capable of
- Other modulating factors that we will discuss further

### 6.3.4 The Role of the Insula

The insula is one of the most important areas for empathic processes because it represents the "integration centre" between the affective and the cognitive aspects of empathy (Singer et al. 2009). The insula is a cortical area located deeply in the Sylvian fissure, between the temporal lobe and the frontal lobe, and it has many connections with other cerebral areas (Mesulam et al. 1982); the anterior insula receives inputs from cerebral regions that process information coming from all body senses (olfactory areas, gustatory, auditory, visual, somatosensory), as well as input

from visceral sensitivity.[1] Once these inputs are gathered and processed, the output is sent back to the same visceral organs and to the hypothalamus in order to be able to change the body state and maintain the homeostasis.

This particular pattern of connections makes us understand that:

1. The insula is able to detect the internal state of the body and read this visceral sensitivity.
2. The convergence of visual and auditory stimuli to the insula allows it to link data gathered while observing or listening to a person that feels an emotion to those neurons that are able to viscerally reproduce the same emotion in ourselves (Keysers 2011).

   The insula is therefore deputed to the perception of internal body states, to the awareness of one's own physical state, what is called *interoception.* Examples of interoceptive stimuli are thirst, pain, sensual touch, itch, heartbeat and bladder distension (Craig 2003). Interoceptive stimuli activate the anterior insula: these visceral inputs, together with somatic inputs, are integrated by the insula to provide a representation of the physical state of the body. A kind of somatotopy of the visceral sensations and physiology, represented at the level of the anterior insula. Since the insula holds outputs that can modify the physiological homeostasis by acting on the autonomous nervous system, it can also intervene reproducing, at the visceral level, an emotional state. It is interesting to know that there is a correlation between the degree of intensity of the emotional experiences and the interoceptive capacity (Critchley et al. 2004); in other words, those who are better at listening to their heartbeat are also more aware of their emotions.[2]

   Inducing emotions, the insula can be activated by different areas depending on the situation (Keysers 2011). If we observe a disgusted or a pleased person's facial expression (Jabbi et al. 2007), the emotion is triggered in a direct way by the premotor cortex, which mirrors (due to mirror system activation) the observed facial expression (bottom-up triggering). Or, if we read an emotional story, then the insula is triggered in an indirect way by language processing regions, such as Broca's area and the temporal lobe through the motor system (top-down triggering). Many studies emphasise that the anterior insula, together with the anterior cingulate cortex, is active for all types of emotive feelings, both physical and emotional, positive and negative. For example, pleasure, pain, disgust, love, fear, sadness, happiness, sexual arousal, aversion, trust, social exclusion, union with God, hallucinogenic state induced by ayahuasca, etc. are all emotions that are found in association with activity in the anterior insula (AI) (Craig 2009).

[1] Which gathers data on the inner state of the body and of its organs, such as heart, lungs, stomach and intestine.

[2] Additionally, it also appears that those individuals who are better at interoception also have a bigger right insula.

### 6.3.5 Cold Motor Control System and Hot Motor Control System

A concept that we will discuss later on is that of "authenticity" or "congruence", in other words, the realignment between the underlying emotional state and the observable/audible behaviour. The case of the fake smile is the most classical example of lack of "congruence": in the fake smile, although the muscles of the lower part of the face produce a movement of the mouth that could even result credible, the muscles of the top part[3] of the face do not contract at all, so that the smile loses its emotional content and becomes hardly credible. Now, the muscles of the lower part of the face are innerved by cranial nerves carrying mainly signals from voluntary motor pathways, while the muscles of the top part receive innervation carrying signals mainly from involuntary motor pathways, whose tone is much more connected to the autonomous nervous system and therefore to the internal state (Porges 2011; Morecraft et al. 2004). This means two things: the first one is that the top part of the face is the one carrying most of the information on the other's visceral state; the second one is that, voluntarily, it is possible to easily act on the lower part of the face, but with difficulties on the top part, which is the one that, from an empathic view, is more relevant. We can now understand why actors, to be credible, do not imitate facial expressions, but try to put themselves in the mood where that expression arises spontaneously.

We can distinguish therefore two types of facial motor control (Keysers 2011): a "hot motor control system" for the involuntary part and a "cold motor control system" for the voluntary part. The *cold* motor control system is so because, to generate an expression, it does not require the warmth of emotions. It is composed of the primary motor cortex and premotor cortex that belong to the voluntary motor system, and it is involved in the motor control of actions such as chewing, blowing one's nose, showing one's teeth, articulating sounds, and so on: actions which have more instinctive characteristics rather than relational. On the other hand, the *hot* motor control system relies on the warmth of emotions: it consists of regions that surround the medial cingulate sulcus and produce the emotional involuntary motor behaviour. It is involved in the motor control of actions such as laughter, wrinkling one's nose by disgust, face contraction by pain, the knowing glance, etc.

Both these cortical systems converge on the brainstem and, exactly, on the nuclei of the cranial nerves (V, VII, IX, X, XI) that control the facial muscles, the muscles of the middle ear, the masticatory muscles and the phonatory muscles and, importantly, that regulate the parasympathetic visceral effector control on heart and bronchi (Porges 2011). These two systems, although converging on the same nuclei, carry different motor programs because they are coded by different areas. This separation between the two systems is evident in some patients (Keysers 2011); those with lesions at the level of the cold motor control system are incapable of producing expressions voluntarily, but if they are told a joke, they laugh normally; those with lesions of the hot motor control system can reproduce every expression voluntarily but remain without any facial expression independently of felt emotions. It is

[3] Orbicular ocular muscle in particular (orbicularis oculi).

therefore really true that "truth can be found in the eyes": the orbicular ocular muscles are those mainly involved in carrying information about an individual's inner state (Ekman and Friesen 2003). It is curious to know that the amygdala, among its functions, integrates a system that automatically guides visual attention to the eyes every time we encounter a facial expression. Patients with a selective damage to the amygdala draw their visual attention somewhere else, such as to the nose, and struggle more recognising those emotions that are characterised primarily by modifications in the top half of the face, such as fear (Kennedy and Adolphs 2010). We could therefore hypothesise that, from an evolutionary point of view, a system was selected that makes us use the "window of the look" as the most important source of information on the others' state and, probably, on their more or less friendly intentions.

Therefore, when we observe a person, we activate in us an internal neural representation not only of the motor behaviour, not only of the visceral state, but also of the facial expression in our hot and cold motor cortex. In this latter case, the difference between representations is that the cold facial motor representation is at the potential state and can, but not necessarily has to, result in movement. Differently, the hot facial motor representation can express itself in an involuntary way, showing outside the felt emotional state, independently of our will or effort to disguise it. By virtue of the presence of these two hot and cold systems, whenever we encounter a facial expression, or when we express it ourselves, it is necessary that both systems activate to be authentic or congruent (Keysers 2011).

### 6.3.6 Triggers of the Empathic Response

There are two modalities for empathy triggering: bottom-up modalities that start from experience sharing and top-down modalities that start from cognitive processes. There are two main neural networks associated, respectively, with experience sharing (affective empathy) and attribution of mental states (cognitive empathy), which always present a certain degree of overlapping (i.e. parallel activation): the first is involved in experience sharing and consists of the anterior insula (AI) and, anterior and medial cingulate cortex (ACC and MCC); the other neural network, involved in the attribution of mental states, consists of the medial prefrontal cortex (mPFC), temporoparietal junction (TPJ) and superior temporal sulcus (STS) (Engen and Singer 2013).

Now, we know that the cold motor control system includes the premotor area and the primary motor cortex. The primary motor cortex intervenes only when there is actual action execution, whereas the potential state is coded by the premotor area. We know the premotor area to be characterised by the mirror system, therefore it can reproduce the observed actions within itself, but only at the potential state. Given that the insula is involved in "mirroring" others' visceral state while we observe them, it is possible that our brain infers these visceral states from the facial expressions and motor behaviour by receiving input from the premotor areas that are in charge of motor behaviour processing. Therefore, the insula receives information about the observed person from the premotor area: so, it can reproduce in

ourselves the visceral state of the observed person (Jabbi and Keysers 2008; Keysers 2011). It is as if the premotor area operates a "hidden facial mimicry" (Keysers 2011), through the evocation, at the potential state, of the other's facial expression and motor behaviour, without necessarily turning into execution (otherwise we would speak of actual direct facial mimicry). This "hidden facial mimicry" or, more precisely, representation of the premotor area, instructs the insula, which can reproduce the visceral state, even without necessarily imitating the observed motor behaviour explicitly. The mechanism just described constitutes a possible trigger modality of the insula (bottom-up).

On the other hand, other empathy generation mechanisms of inferential kind (top-down), based on perspective taking and on former knowledge of the situation of the individual in question, are associated with the activation of regions involved in the mental state attribution system (Engen and Singer 2013) ventromedial prefrontal cortex (vmPFC), superior temporal sulcus (STS), temporoparietal junction (TPJ) and posterior cingulate cortex (PCC). Another possibility of top-down trigger consists of an initial visual description from the temporal regions that is translated in a motor representation on the premotor cortex and medial cingulate sulcus (mirror system and hot and cold motor control systems). This representation triggers in the insula the representation of the corresponding sensations through existing connections with those motor systems (Keysers 2011). This latter case can be what happens when we get excited by an exchange of written messages (e.g. chat, text messages) with somebody, where there is no possibility to directly mirror the other.

### 6.3.7 The Self/Other Distinction

The dimension of intersubjectivity and of emotion sharing among subjects arises an important issue: how do we distinguish who feels what? How to recognise that it is me or the other that feels a certain emotion? As discussed earlier, the self-other distinction is one of the essential components in order to speak of empathy in the strict sense. A recent meta-analysis of fMRI studies (Murray et al. 2012) identified the areas that are mainly involved in processing data regarding, respectively, the self, dear persons and public figures. It emerged that when we process self-related information, or about the dear ones (personally known and with whom we shared some type of relationship) the anterior insula activates, whereas this does not occur when processing information on public figures. This means that, when referring to dear persons or ourselves, inner visceral representation sharing is, to a certain extent, more intense. This process does not occur for unknown people, even though public. Therefore, it appears that distinguishing the self from the other is easier with people we know less; this possibly predisposes us towards a more cognitive empathic approach. On the other hand, the more we know the person, the more the limit between the self and the other fades away and affective aspects are favoured such as empathic distress or emotional contagion. In any case, there are other areas that selectively activate in the three circumstances (Murray et al. 2012): a specific activation of vACC, dACC and right vmPFC when the self is involved, activation of left

vmPFC if dear ones are involved or activation of dmPFC if affectively distant people are involved. This suggests that specific areas intervene for the self-other distinction and that the three situations involve partly different processes.

### 6.3.8 The Role of the Amygdala

The amygdalae are small structures with a nut shape situated in the medial temporal lobe, adjacent to the ventral hippocampus. They are complex structures, consisting of many nuclei, that entertain connections with many other cerebral regions; as a result, they are the most interconnected. From a functional perspective, we can subdivide the amygdala into two main parts: the basolateral amygdala, responsible for Pavlovian learning, and central amygdala, involved in attentional processes. The basolateral amygdala receives many sensory data from the cortex, given its connections with the insular, prefrontal, cingulate and parietal cortices. The central amygdala, on the other hand, exerts an important control on the brainstem: thanks to its projections to the hypothalamus and the brainstem nuclei, such as the mesencephalic reticular formation, it coordinates autonomic, behavioural and neuroendocrine responses (Pessoa 2010).

The amygdala plays a key role in empathy (Phelps 2006), even though it appears to become active quite specifically for instances such as fear and not for other emotions such as those observed in the insula. In general, the role of the amygdala is as "sentinel", determining "what" a stimulus "is" and "what has to be done" (Pessoa 2010). When the rest of the brain is not able to easily predict the meaning of sensations, how to react to them or what value they have in a given context (Lindquist et al. 2012), that is, in ambiguity conditions, the amygdala intervenes: stimulating attention and other brain areas to continue gathering data till the ambiguity is resolved. Its main role in empathy is probably related to those emotional dynamics associated with danger or potential hazard. In fact, if an ambiguous stimulus (external, but also internal) reaches the amygdala and, after being analysed and correctly collocated in its context, it is considered as a potential hazard, then the central amygdala starts an emotional response and an autonomic activation.

The amygdala can carry out this role because it receives sensory information via two roads: a "low road" directly originating in the thalamus, without going through the cortex, and that therefore provides "broad but fast" information and a "high road" coming from the cortex that, in turn, has received thalamic projections. This second road is slower than the first but carries more complete and thorough information (LeDoux 2012). This double circuit allows the amygdala to rapidly receive information via the "low road", in order to prepare the amygdala to promptly initiate the autonomic response in case the information coming from the "high road" confirms that the sensory stimulus is harmful. We can then realise the relation between the amygdala and fear, since it is in charge of preparing us adequately, and promptly, for those situations that can threaten us to a various degree. So much so that patients with a selective deficit of the amygdala are not able to feel fear and therefore often get in trouble without realising it (Feinstein et al. 2011).

As far as risk evaluation at the higher cortical level is concerned, some fMRI studies identify this process in the temporal cortex. It appears that the fusiform gyrus and the superior temporal sulcus (STS) are involved in the evaluation of biological motion and intention, through detection of changes in aspects such as movement, vocalisations and the face: all key aspects in establishing the degree of an individual's reliability or untrustworthiness. The two areas, depending on changes in these aspects, can send safety or danger signals. These signals reach the amygdala through connection with the two temporal areas (Ickes 2003; Adolphs 2003; Porges 2011). Therefore, it is possible that the amygdala, which exerts control on the autonomic response via the brainstem (in particular, prosocial, fight-flight or freezing mechanisms (Porges 2011)), is in turn controlled by these cortical areas.

### 6.3.9 Modulation of Empathic Responses

The modulation of empathic responses is still one of the least studied aspects, and yet of crucial importance, since it is on the basis of empathic modulation mechanisms that we can develop communicative strategies aimed at optimising the positive aspects of empathy (such as compassion) and minimising the negative ones (such as personal distress).

We can divide the factors that influence empathic responses into two main categories: contextual and intentional. Contextual factors are the "passive" ones, so to say, that belong to the context and do not require attentional effort or will. Let us examine some contextual factors (Engen and Singer 2013; Hein and Singer 2008; Bernhardt and Singer 2012).

- *The intensity of the observed emotion:* observing intense emotions leads to a more empathic response. Subjects that were shown patients' faces in chronic or acute pain have a greater activation of anterior insula and ACC when observing faces in acute pain (Saarela et al. 2007).
- *The characteristics of the observed person:* the empathic response is reduced if the observed person is considered unfair instead of fair (this is only in males) (Singer et al. 2006). Or, if an individual is considered outside a group (e.g. football team, school, race, religion, etc.), the empathic response dampens (instead, if an individual is considered as a member of the same group as the observer, the empathic response increases). What is interesting is that in these situations of empathic response decrease, together with a decrease of AI and ACC activity, there is also an increase of activity in the reward circuits, such as NAcc (Singer et al. 2006), which means that aversive stimuli—like belonging to an opponent group or unfairness—contrast empathy and predispose towards drawing gratification from revenge or the other's suffering. We consider this as extremely important from a sociological point of view.
- *Characteristics of the context*: the empathic response is reduced if we know that a certain pain is due to a successful therapeutic intervention versus an intervention that proved to be in vain. In this case, we can speak of "cognitive evaluation",

which means that possessing certain information about an observed situation influences the empathic response, either upregulating or downregulating it (Lamm et al. 2007). An example could be knowing that a certain surgical intervention, that would be painful for the observer, is not so for the patient because he is under anaesthesia: in this case the empathic response dampens and the activity in regions involved in self-other distinction is increased (Lamm et al. 2007).

- *Attention focus*: if while observing another person suffering we are concentrated on the pain, the empathic response increases (AI and ACC activation). If, otherwise, while observing, we are focused on a task like counting, the empathic response reduces (Gu and Han 2007).
- *The characteristics of the one who empathises*: every individual has, by nature, a different empathic capacity that we can assess through various empathy measuring tests, such as IRI (Davis 1983).
- *Habit*: it seems that the practice of inflicting pain reduces AI and MCC activation, in fact downregulating in affective empathy (Cheng et al. 2007).
- *The relationship between the one who empathises and the other*: the degree of knowledge of the other influences the intensity of the visceral response and predisposition to empathically respond in an affective (known people) rather than cognitive (unknown people) way.
- The intentional factors can be considered "active" modulating factors that require an intentional, attentional intervention from the one who empathises. Let us consider some intentional factors (Engen and Singer 2013; Hein and Singer 2008; Bernhardt and Singer 2012)):
- *The point of view*: as discussed earlier, there are two different shades of perspective taking: imagining ourselves or imagining the other. It was observed that when imagining ourselves empathising with a person in need of help, personal distress is increased (Lamm et al. 2007, 2008), namely, a "negative" aspect of empathy. In this case, the observer suffers *of* the other's state, and this can induce selfish motivations such as abandon in order to avoid pain. When instead imagining the other, compassion (empathic concern) is potentiated, a "positive" aspect of empathy that generates altruistic motivations. In this case, the observer suffers *for* the other's state and feels the need to help him/her and to relieve pain (Lamm et al. 2007). Another example where the adopted perspective influences the empathic response is to take a beloved person's view, rather than that of a stranger (Cheng et al. 2010). In the first case, an upregulation of the empathic response can be observed with increased activation of AI and MCC. In the second case, an increased activation of TPJ (involved in the attribution of mental states, cognitive empathy) and a reduction of connectivity between AI and TPJ can be observed, similar to that observed in the emotional regulatory strategy of distancing (Walter et al. 2009; Koenigsberg et al. 2010).
- *Active effort to empathise*: if an active effort to empathise is made, the activity of the inferior frontal gyrus (IFG) is increased, an area involved in compassion (empathic concern). This independently is of whether the other's state is emotionally salient or neutral (De Greck et al. 2012).

- *Reappraisal capacity*: the empathic response can adapt to situations in which the other has, for example, a different response to pain in respect to the observer (Lamm et al. 2010). In this case IFG areas become activated, which are involved in "reappraisal", an emotional control strategy consisting of the cognitive reinterpretation of the situation (Goldin et al. 2008). This suggests that emotion regulation circuits are at the basis of empathy generated by active appraisal (Engen and Singer 2013). In these circuits involved in emotional regulation, the ventrolateral prefrontal cortex (vlPFC) plays a key role. Its activity increases when the intensity of a negative emotion is reduced through reinterpretation. The success of reappraisal depends though on which of two subcortical pathways, starting from vlPFC, is more activated: if it is the one that goes through NAcc/VS (reward system), the success of reappraisal is increased; if it is the one that goes through the ventral amygdala, then the success of reappraisal is reduced (Wager et al. 2008).
- *Training*: it is possible to change the empathic response with appropriate training. A recent study (Klimecki et al. 2013) showed that after an empathic resonance training, the individuals presented an increased empathic response, with an upregulation in AI and MCC activity. At the same time, though, negative emotions were displayed to a larger extent, that is, a negative quality of experienced empathy (personal distress). The same participants, after a further successive training, this time for compassion, showed—on the contrary—a reduction of negative emotions and, in fact, an increase of positive emotions. In this latter case, the activated areas involved different neural networks, such as the ventral striatum (VS), anterior cingulate cortex (pACC), medial orbitofrontal cortex (mOFC) and the ventral tegmental area (VTA). All this suggests that it is possible to learn how to actively upregulate positive emotions, changing the affective quality of a stressing empathic experience (Engen and Singer 2013).
- *Intention*: people, who are used to inflicting pain for curative purposes such as acupuncturists, present a reduced activity, with respect to common individuals, in AI and ACC, as well as in the somatosensory cortex. In parallel, greater activation of areas associated with the attribution of mental states, such as mPFC and TPJ (Cheng et al. 2007), can be observed in these individuals, suggesting that intention—in this case, to cure—can "shift" activity from affective empathy circuits to cognitive empathy circuits.

These data suggest how the intentional component of empathic modulation is pivotal; in other words it can determine substantial changes in the empathic responses. This is, in our view, the most important aspect because, differently from contextual elements, it can be influenced by our will and attention. Accordingly, it represents an aspect that can benefit from and be enhanced by educational efforts, which may have an impact on the acquisition of greater empathic abilities and greater resiliency (i.e. the ability to reacquire one's own emotive balance after an intense emotional stimulus). In our case, these factors can be used in a goal-directed manner—patient's management—in order to optimise the empathic dynamics within the patient-clinician relationship.

## 6.4 Empathic Disconnection

We have seen the processes underlying empathy and we can now put forward some helpful hypotheses to develop communicative strategies useful to manage difficult situations, such as suicidal patients. The most important idea in this sense relates to "empathic disconnection",[4] a concept that is to be intended at the interpersonal level and not at the neurophysiological level, although there certainly are neural substrates characteristic of this type of phenomenon. With this term, we refer to a situation in which the empathic function is, consciously or unconsciously, reduced. We have discussed above many of the factors that may come into play in empathic modulation, both at the contextual level and at the subject's intentional level.

There are though, in our view, some scenarios easily acknowledged in everyday life, which particularly affect the quality of empathy, leading to what we call "empathic disconnection". These scenarios are even more evident in the patient-clinician relationship context: we are speaking of countertransference hate, moral judgement, reactive physical discomfort and labelling. We shall now discuss each of these scenarios, but not before recalling the context related to the suicidal patient.

### 6.4.1 The Suicidal Individual

The management of these patients is particularly difficult due to some peculiar characteristics (Pompili 2013):

- They experience an extremely intense suffering and assume this suffering to be unique and that they are absolutely unhelpable. In their perspective, no one suffers like them and nobody can understand them, making it difficult to provide help.
- The mental and affective pain that they experience is perceived as unbearable, and this intolerability leads to the extreme lethal act.
- They elicit anxiety in the clinician, who faces a challenge, in the condition in which his/her professional capacities are questioned if the patient is lost for suicidal.
- Crucial aspect, they tend to make someone else responsible for their keeping themselves alive or, in other words, they attribute responsibility for their life/death to the clinician. If the clinician is threatened by the fact that the patient can end his/her life while under his/her cure, he/she cannot be of help. This aspect often motivates the clinicians to avoid treating this type of patients, and to turn them away, fearing the responsibility and anxiety deriving from taking charge.
- They are sensitive to the clinician's apprehension and can use this element in a manipulative manner supporting an attitude intended to take control over the clinician. It is here important to underline that, as far as some psychiatric disorders are concerned, a selective deficit of affective empathy has been observed, while cognitive perspective taking is spared, which allows those patients to exert the typical manipulative behaviour (Hein and Singer 2008; Blair 2008).
- Often, these patients' transference hate is difficult to tolerate for the clinician. Aggressiveness, hostility and these patients' regression can lead the clinician to

[4] See above "characteristics of the observed person" in empathy modulation.

develop countertransference hate that, if it remains conscious, can be controlled, otherwise if it is unconscious can lead to acting out.

### 6.4.2 Countertransference Hate

Countertransference hate is experienced by the clinician, who can be more or less aware of it[5] (Maltsberger and Buie 1974) and that inevitably leads him/her to "behavioural incongruence" (see further on), in other words to not be authentic, to show with his/her acts and words an apparent taking care of, but with an underlying aversive emotion. This aversion is consciously or unconsciously perceived by the patient, who clams up because he/she does not find a "shared empathic space" suitable for opening up and placing trust (Fig. 6.4).

This scenario obviously leads the clinician to "empathic disconnection", since the patient's hostility strikes him/her and provides aversion feelings towards the patient. We have seen that aversive stimuli have the property to deregulate AI and ACC activity, which are affective empathy structures, and to upregulate the activity


**Fig. 6.4** Countertransferential hate can occur in two different forms: aware or unaware. The first one can be controlled, whereas the second form is dangerous due to its increased risk of "acting out"

[5] Worse in the second case.

of the reward system in NAcc. Therefore, from the moment the patient is perceived as an aversive stimulus, it is conceivable that a significant reduction of the affective empathic response occurs, from which the clinician will get an advantage, that is, personal distress reduction, but also a disadvantage in view of the therapeutic objective and, namely, a reduction of empathic concern (or compassion).[6] At the same time, it is plausible that the patient, perceived as an aversive stimulus, becomes a source of gratification for the clinician when, consciously or unconsciously, the latter inflicts harm or revenge on the former.

### 6.4.3 Moral Judgment

Moral judgement is from the clinician and is determined by his/her system of cultural beliefs (Pompili 2015). Moral judgement creates a condition that makes the patients clamming up since he/she does not perceive the clinician's shared empathic space as "safe" and neutral, within which opening his/her intentions. He/she senses that, by expressing his/her intentions, these would be attacked, refused and not be accepted (Fig. 6.5).


**Fig. 6.5** Moral judgment, although unconsciously expressed, can hinder the effort of establishing a satisfactory relationship with the patient

[6] We need to pay much attention here because with the suicidal patient what can appear as compassion is in fact the reaction to the patient's potential suicidal, that is, a fear reaction (Pompili 2013).

An example could be that the clinician, warned by some signals, addresses to the patient with "Have you not thought of suicide, have you?" (Pompili 2013). In this case, the clinician is adhering to his/her purpose but pays the price for the inattention of unconsciously exuding his/her moral judgement: "Suicide is a taboo and therefore wrong and regrettable". In a similar scenario, it is difficult to establish the relationship quality necessary to obtain some results. What determines empathic disconnection in this case? We have seen that the affective empathic response is deregulated (especially in males) by the perception of the other as unfair alongside an upregulation of the reward system, similarly to the scenario described for countertransference hate. It is possible to speculate that moral judgements surrounding other values rather than fairness, such as the value of life, produce a similar response at the empathic regulation level.

### 6.4.4 Reactive Physical Discomfort

With reactive physical discomfort, we intend the unpleasant sensation experienced when engaging in a relationship with an individual with some psychiatric or neurological disorder. Often, individuals with psychiatric disorders show an altered control over their autonomic nervous system (Porges 2011), an aspect also present in suicidal individuals (Pompili 2013). According to the Polyvagal Theory (Porges 2007, 2009, 2011), this altered control over the autonomic nervous system is due to an inappropriate regulation of the two components of the Vagus nerve: the Vegetative Vagus, originating in the Dorsal Motor Nucleus of the Vagus, and the Smart Vagus, originating in the Nucleus Ambiguus. Besides these two elements, we shall consider a third one, represented by the sympathetic nervous system. The brain constantly monitors signals coming from outside and inside in order to evaluate the degree of danger that the environment or another being constitutes in a given moment[7] (we have seen that the amygdala is central in this function and that the temporal areas intervene in the appraisal of others' faces dangerousness). According to how dangerous the situation is evaluated, there may be three main autonomic responses, which reflect the recruitment of phylogenetically increasingly ancient neuroanatomical structures (Porges 2011).

1. *Safe situation*: high Smart Vagus tone. When the Smart Vagus tone is high, this reflects in a favourable autonomic condition to prosociality: slow heartbeat, high control on phonatory muscles, control on mimic muscles and connection between orbicular ocular muscles and hot motor system. This occurs in normal safety and tranquillity conditions, so that the Vagus exerts its rest and digest function and predisposition to sociality.
2. *Dangerous situation*: Smart Vagus tone reduction (removal of "vagal brake", and sympathetic system tone increase, that is, the condition of preparation to mobilisation also called "fight or flight". In this case, the vagal tone exerting control on the motor aspects necessary for pro-socialisation is lost, whereas the sympathetic

[7] Porges refers to this as to "Neuroception".

tone exerting control on the physiology necessary for mobilisation is favoured (e.g. catecholamine, vasodilation, cardiac output increase).
3. *Life-threatening situation*: high vegetative Vagus tone, which leads to immobilisation ("freezing"), in other words to the most phylogenetically ancient defence mechanism, that is death feigning. In this case, the parasympathetic tone of the vegetative Vagus prevails on the sympathetic tone, leads to immobilisation and predisposes to a reduction of metabolic demands necessary to preserve brain oxygenation during death feigning. In this case, parasympathetic tone increase acts on sphincters giving rise to the popular saying "wet his shorts".

It appears that individuals with some psychiatric disorder present an alteration at the level of the neural circuits that assess situational risk (e.g. in PTSD, or anxiety disorder, or agoraphobia), leading them to context-inappropriate autonomic responses, such as fear in totally safe situations. It is therefore probable for these individuals to have reduced tone of the Smart Vagus, which impairs them during social exchanges (since the motor elements necessary for prosociality cannot be recruited from their brain) and, at the same time, keeps them in stressful and unpleasant physiological visceral conditions with a high sympathetic or vegetative Vagus tone.

From the point of view of the clinician, who has to deal with these patients whom often have an underlying psychiatric disorder, we can hypothesise two things:

1. Since in empathy the affective component involves sharing visceral states, it is plausible to expect that, when facing individuals with an altered autonomic regulation as just described, one has to "mirror" an unpleasant autonomic state that can generate high personal distress (Fig. 6.6).
2. These individuals' emotional state is so difficult to interpret for the brain since expressive facial signals providing orienting cues are missing (the top part of the face often does not have muscle tone, as if the hot motor control system did not act). Therefore, the temporal areas involved in the "safety" evaluation of a face tend to evaluate these faces as dangerous, activating the circuits deputed to fear in the amygdala. The amygdala, in turn, through control on the brainstem, reduces the tone of the smart Vagus, predisposing one to mobilisation (sympathetic tone increase). Therefore the clinician is deprived of the motor control necessary for an efficient communicative relationship.

In light of these considerations, we can realise that empathic disconnection can also occur due to an automatic reaction of fear determined by an altered autonomic control characteristic of suicidal individuals.

Clearly, for the clinician accustomed to deal with suicidal patients, it is more likely that fear trigger is linked to other factors rather than anomalies in facial expressivity. If in a non-accustomed individual the temporal areas evaluate these subjects' faces as "dangerous" due to the lack of control on facial mimicry of the top half of the face, in the accustomed clinician this factor has probably already undergone habituation. However, other cognitive elements, such as knowing the responsibility

**Fig. 6.6** Reactive physical discomfort occurs when facing some individuals whose autonomic regulation is impaired due to psychiatric or neurological disorders

deriving from dealing with this type of patients (Pompili 2013), could constitute the trigger for fear response—the patient is perceived as a threat to him/herself or to one's own reputation—which negatively predisposes the clinician to the communicative exchange on the basis of the mechanism we have just described. At the same time, the clinician's lack of control on the smart Vagus can betray that apprehension we have discussed, which these patients are sensible to (Pompili 2013).

### 6.4.5 Labelling

Labelling occurs to the clinician that, for distraction, tiredness or as a protective strategy, merely applies a label to the patient and then relates more to this—in other words to the clinician's own culture on the topic—than with the real patient. To make an example: the clinician, once received a patient with a specific diagnosis, does not pay attention to the relationship with the patient but only to his/her


**Fig. 6.7** Labelling occurs when clinician's attention is focused not on the patient in him/herself, rather it focuses on the information he/she has on the topic of the patient's diagnosis or on the standard procedure which is usually applied to that diagnosis

amnestic informations related to the standard procedure acquired over years of experience for that specific diagnosis. In this case, labelling consists of the diagnosis itself. We can speculate that empathic disconnection in this case occurs in similarly to what happens during attentional focus shift. The neural system of affective empathy is deregulated by attention shift that, rather than on the patient's state, is totally focused on the standard management procedure consolidated through experience with that pathology (Fig. 6.7).

### 6.4.6 Empathic Disconnection and Patient-Clinician Relationship

When reasoning on these scenarios in light of the studies on empathy, we realise that there are different types of "empathic disconnection", involving distinctive aspects of empathic modulation. The important concept to be underlined is however that in all these cases "empathic disconnection" leads to:

- Advantages for the clinician, who finds him/herself—consciously or unconsciously—"protected" from personal distress subsequent to the prolonged experience sharing with the patient's suffering feeling. Another advantage for the clinician is to apply "standard guidelines" to the patient's management, since it is a known, trustworthy territory that guarantees speediness and efficacy.
- Disadvantages for the patient, because the clinician's intervention quality can suffer. A disadvantage is the absence of motivational empathic warmth typical of compassion[8] that, already in itself, could be sufficient to break the vicious circle of feeling unhelpable typical of the suicidal individual (Pompili 2015). Then, above all, because the empathic moment with the patient can be a precious source of information about his/her inner state. Therefore, if "empathic disconnection" occurs in an automatic and unintentional way, like in these scenarios, we can speak of strategic disadvantage.

Therefore, we group together under the generic term of "empathic disconnection" all those cases where the empathic response is downregulated, not only in the affective aspect of experience sharing but also in the cognitive aspect of attribution of mental states. We have seen that the correct term to speak of empathy when both aspects are present is "empathic accuracy"; therefore we can say that the situations in which an empathic disconnection occurs are those in which the empathic accuracy is heavily lost or reduced. As we discussed earlier in this chapter, empathic accuracy results from the activity in concert of the empathic affective and cognitive components, so that if one or the other, or both, are deregulated, empathic accuracy is reduced. However, we shall underline that while a deregulation of the affective component can be partly positive (as in downregulation of personal distress empathic response) and partly negative (as in downregulation of empathic concern response), in the case of cognitive empathy, deregulation is basically always a negative aspect.

In the paragraph about empathy modulation, we have seen contextual factors and intentional factors: surely, many of these intervene simultaneously to determine "empathic disconnection", but there are big differences between them. It could be difficult to intervene on contextual factors; for example, it is not up to us to decide

[8] Or empathic concern.

the intensity of the emotion felt by the individuals we are relating to. We can certainly instruct them to regulate their emotions, or offer them compassion to reduce internal tension, but the intensity of other individuals' emotions remains a contextual factor for the one who empathises. Also, we cannot change the other's social state: if one is a criminal, we will most likely be inclined to "empathic disconnection". Therefore, the contextual factors tend to affect empathic modulation in an automatic way and can determine, in a totally involuntarily or unconscious way, "empathic disconnection".

As far as intentional factors are concerned, their core role in determining this disconnection obviously depends on the orientation taken by active efforts, volitional, of the one who empathises. With respect to the clinician, we assume that intentions are oriented towards the patient's health and treatment; but there are cases, such as countertransference hate, where this orientation can overturn unbeknownst to the clinician. Also, it may be simple inattention, or the clinician's poor intrinsic empathic ability: all these cases make the intervention of intentional factors intended to improve the empathic relationship improbable and, consequently, lead to "empathic disconnection". Anyway, if intentional modulation factors are strategically used and active efforts are oriented towards the patient's health, these factors can be considered the most important domain to work on, the one with greater margin for improvement. Intentional factors offer the clinician scope for improvement because acting on oneself is certainly simpler than acting on the context, even though not necessarily easier. There the lesson written on the door of Delphi temple "know yourself" returns for the clinician (Pompili 2015).

## 6.5 Empathic Moment

Freud strongly suggested to his colleagues to model themselves to the surgeons, who put all their feelings aside, even human sympathy, while relating with the patients (Pompili 2015; Freud 1912). If we read this warning in light of what we have discussed, we understand that Freud refers here to keeping aside affective empathy, including compassion, and to merely rely on cognitive tools.

We believe that also the use of affective empathy can be precious in the relationship with the patient, provided that this use is supported by the understanding of the underlying mechanisms, so as to avoid, or at least reduce, the negative aspects that would follow a naïve approach. Nevertheless, the cognitive component of empathy has to be always present, so that cognitive information can be constantly integrated with affective information and that intuition, which we call empathic accuracy, is produced as an emerging property.

Within the voluntary use of affective empathy, the first possibility is surely compassion, which we have seen being a form of empathy (motivational empathy, or empathic concern), characterised by motivation to help the other. This form of empathy is certainly useful and positive and we assume that it lays at the basis of each clinician's proposition. We know that compassion can be trained with adequate techniques, meditation in particular (Klimecki et al. 2013), and so, if

compassion is potentiated, personal distress levels are reduced without interfering with the activity of cognitive empathy. Accordingly, the clinician's own training to compassion becomes of considerable importance, through proper techniques that can be borrowed from mindfulness, or from millenary knowledge of certain traditions like Buddhism.

We believe that a second, possible, voluntary use of affective empathy is the mere empathic resonance, although evidence indicates a risk and, namely, an increase of personal distress. In fact, we think that empathic resonance can be useful if strategically tapped: for example, voluntarily producing brief "moments of empathic resonance" sufficient to spot precious information on the patient's internal state, but not sufficient to negatively influence the clinician too much. This end could be reached by taking advantage of the various modulation possibilities of empathy. Based on this idea, we call "empathic moment" the clinician's intentional effort to temporarily enter in empathic resonance with the patient. The ambitious proposal is to make use of affective empathy in an active way, without passively suffering its effects as well as undergoing contextual influences, as if it were a real practical investigation tool. Clearly, the advantages of the "empathic moment" strategy remain so only if the clinician is able to intentionally and efficiently modulate his/her empathic response, otherwise the risk would be to greatly suffer personal distress. Therefore, just as it is important that the clinician trains to increase empathic resonance, it is equally important to be able to downregulate it.

In short, the communicative strategy of the "empathic moment" is not to be emotionally affected by the other's emotions, since the distinction self-other needs to remain clear. It is not even a moment of compassion, since one intentionally tries to live the patient's *exact same emotion,* in order to be able to understand him/her. It therefore consists of *intelligently taking advantage, guided by one's will, of the functional characteristics of empathy to gather information about the patient's inner state.* It is therefore about learning to pay attention to one's own attitude and train to consciously use this human brain function, empathy, to benefit from the relationships with the patient.

## 6.6 Vitality Forms as a Parameter of the Emotional State

Now we shall introduce the idea of "vitality forms" because, in our view, its understanding can translate into a powerful tool in favour of our cognitive empathic analysis. Daniel Stern was the first to speak of "dynamic vitality forms" to describe the "ascends and descends" that characterise affective mother-child exchanges (also called vitality affects (Stern 2010)). In these exchanges, both bodily and verbal manifestations, which are characterised by their modality, called "vitality forms", are evident. Dynamic vitality forms constitute "how" we execute movements and pronounce words, and this "how" conveys much information related to the underlying emotional state. In other words, vitality forms are the information conveyed by the kinematic of the observed actions, which reflects the internal state of mind of the observed person (Di Cesare et al. 2015).

Stern had developed the idea of vitality form to describe the property of movement and voice to communicate emotional states; it is the "vitality momentum" that unites all living beings' actions (Stern 2010). The vitality form of an action constitutes both its "biological movement" (Johansson 1973) and also, and mainly, the reflection of its emotional content. This emotional content reflection conveyed by the vitality form is determined by the emerging property deriving from the unification, at the cognitive level, of five aspects that accompany every action:

- Movement
- Time
- Force
- Space
- Intention

These five aspects, that can be present at different degrees and forms for each action, constitute those basic elements with which our consciousness produces that unification (or Gestalt according to Stern), which should be the best representation of our "holistic" experience of a certain experienced or observed action. For a long time, neuroscientific studies have neglected the idea of vitality forms, and only recently (Di Cesare et al. 2014, 2015, 2016) fMRI experiments have been carried out to assess the correlation between vitality forms and specific neuroanatomical structures. These studies have demonstrated that, when we pay attention to "how" a given movement is executed, there is a corresponding activation of dorsocentral insula. This activation is present also when we carry out the movement in a certain manner (e.g. rude or gentle) or when we simply imagine it. Evidence adds up to these data showing that in monkeys this area is anatomically connected with the neural circuit involved in the control of arm and hand movements (areas F5, F12r, AIA), essential to communicative dynamics such as gesticulation. All this can be considered as further evidence favouring the already long formulated hypothesis (Wicker et al. 2003) that, just as a mirror system exists for the motor function, an "empathic" mirror system also exists, which finds in the insula its main anatomical substrate. Furthermore, this proves the direct link among different vitality forms characterising movements and words and emotions.

Therefore, we believe that the idea of vitality forms is fundamentally useful: it gives us the opportunity to summarise in a single concept the multiplicity of signals about an individual's state of mind conveyed through movements and words. Finally, internalisation of the idea of vitality form allows us, if applied in everyday life, to better distinguish the aspects that characterise the emotional state of those who we relate to (Onnis 2015). The analysis of vitality forms is pivotal in the patient-clinician relationship because it allows to recognise and describe, through external/visible manifestations, the patient's inner state of mind. The patient's vitality forms represent a sort of "parameter" of the emotional state, which we can take advantage of in our analysis conducted by means of our cognitive empathy. In the same way, the analysis of vitality forms that the clinicians operate on themselves allows them to "self-evaluate" whether their external manifestation is

congruent with their inner state of mind. This is particularly important for at least two reasons:

1. First because, often, what prevents the patient from benefitting from his/her clinician is to actually realise the "falsity" in the latter's attitude in taking care of him/her, which can be the consequence of "empathic disconnection". The clinician hence turns out to be "incongruent" in the patient's eyes. We call behavioural "congruence" (Rizzato and Donelli 2014) the degree of appropriate correspondence between emotional state, motor act and thoughts within a goal-directed action. We are congruent when the thought is aligned with the emotional state motivating the motor act to produce a harmonic directed action. On the other hand, we are incongruent when all this does not occur and, an example worth a thousand words, is that of the bad actor: if an actor, despite his/her knowledge of the technique and art of acting, keeps emotional coldness during his/her performance without entering in the role played, there the audience will perceive a "dissonance", an "incongruence" indeed. The patient is therefore able to realise, on the basis of the empathic mechanisms we have deeply discussed, that while the clinician' actions (voice included) apparently communicate the intention of taking care of, the vitality forms communicate a dissonant emotional state with respect to the apparent intention, such as, for example, disinterest, discomfort or aversion feelings.
2. The reason why the analysis of vitality forms is even more important if carried out on the clinician can be understood thanks to Heller and Haynal's studies (Heller and Haynal 2002): they recorded the therapeutic sessions of patients that attempted suicide many times. Within a certain period of time, a group of these patients attempted suicide again. At that point, Heller and Haynal began studying the recordings, examining the clinicians and patients' faces through Ekman-Friesen's FACS (Facial Action Coding System). They compared the sessions of patients that attempted suicide with those of patients that, in the same time frame, had not attempted suicide, looking for possible signals that correlated with a greater probability of suicidal crisis. The results were outstanding because the signals detected in 80 % of studied cases were predictive of a new suicide attempt. Even more noticeable was that the most sensible and specific signals were those coming from the *clinicians'* expressions. This passage is of extraordinary importance because the clinicians could not know *consciously* which one of the patients would have attempted suicide again, although *unconsciously* some elements conveyed to the clinician by the patient's vitality forms could have efficiently cued them on who was more at risk (Stern 2010).

We believe that the analysis of the patient's vitality forms could have great potential in predicting crisis if the concept of *baseline in vitality forms* is introduced. We can hypothesise that every patient has a precise baseline in vitality forms, which is the external reflection of both the patient's "background feelings" (Damasio 1994) and the feelings that consistently and cyclically inhabit that patient as a function of his/her associations of thoughts and everyday events.

In this respect, there is a small observational study carried out in Italy by Osmani et al. (2015). This team had decided to experiment an innovative approach to the prediction of manic crisis in bipolar patients. They created a special application for mobile devices that records accelerometer values implemented in the patients' smartphone within 24 h (acceleration, because of its physical dimensions $m/s^2$, can be associated to three of five fundamental elements of vitality forms: time, space and force). Hence, recording on an interval of weeks, doctors had access to graphs on which it was possible to trace the acceleration baseline imprinted to the phone through the patient's movements and, on the basis of relative variations with respect to baseline, to predict the approach of a manic crisis. The results were very encouraging, although the number of patients involved was too small to draw some conclusions. In addition to this study, there is a growing body of literature on this subject (Luxton et al. 2011; Donker et al. 2013; Gravenhorst et al. 2015; Ben-Zeev et al. 2015). It is very interesting because there are multiple studies that take into account other parameters attributable to the "vitality forms" such as the features of the voice. Thus, it is possible to study and record the patients' vitality forms, with some very common technology and without any harm or annoyance to the patient.

These studies are in line with our goals: studying the cyclicality and recurrence in a patient's vitality forms in a given temporal interval to determine a baseline that can be used as a reference point necessary to capture warning signals when significant variations appear. Obviously, if we speak of the clinician's practice, we have to translate the same concept on the basis of, not instrumental data, but of reference points that the clinician has acquired on the patient during weeks or months of meetings. The clinician has to "build up" his/her own statistics for every patient, and this is why his/her observation ability is so important to this goal.

It is key to have new parameters, such as vitality forms, in order to ensure better patient assessments. A recent meta-analysis (Pompili et al. 2016) showed that in 50% of cases, suicidal individuals communicate their intentions prior to death. Although the authors warn about the scarce methodological quality of the included studies, the incidence of suicide communication is likely to be underestimated due to the criteria adopted to define the "suicide communication event" (Pompili et al. 2016). A recent study showed that many suicide communication events fall below the threshold that those studies usually are set to define a clear "communication", and, therefore, it is possible that any study adopting a systematic methodology might underestimate the proportion of suicide communicators (Pompili et al. 2016; Owen et al. 2012). In spite of this, these data suggest that the communication of intention is likely to be a common act in suicide, endorsing Shneidman's statement that many individuals choosing to die by suicide consciously or unconsciously provide clues to their intention (Pompili et al. 2016; Shneidman 1998). In fact, only a part of suicide communication events is clearly verbally expressed or manifested by means of written notes. Since suicide communication events can often be indirect, ambiguous, humorous and euphemistic or, in other words, correlated to the vitality forms of the patient, it is often difficult to judge the meaning and intention of utterances referring to suicide (Owen et al. 2012). For this reason, we believe that efforts

aimed at gaining good skills in analysing the patient's vitality forms are an essential element in order to obtain even better assessments.

## 6.7 Practical Applications

Here we will provide some possible practical applications based on the mechanisms of empathy that we discussed deeply in this chapter. Furthermore, we will define a possible procedure to obtain and reproduce the communication strategy of the empathic moment, described earlier in this chapter.

### 6.7.1 Compassion

As far as training on compassion is concerned, there are many techniques, especially among ancient traditions such as the ones related to Buddhism. Many experiments have been carried out where the effects of meditation on the activation of compassion neural circuits have been observed (Fredrickson et al. 2008; Lutz et al. 2008; Klimecki et al. 2012) with a noticeable positive correlation, in addition to greater activation of neural networks related to cognitive empathy and will. A technique used in one of these experiments is Loving-Kindness meditation, and, for those that would like to deepen this meditation technique as a practice to potentiate compassion, please refer to the authors' work (Lutz et al. 2008).

### 6.7.2 Observation

We believe that observation capacity is the most important quality to potentiate one's ability at the level of cognitive analysis of the other's emotional state, especially if one wants to gather information from the analysis of vitality forms. To make a practical example, just think of the times when sitting at the table with the family and, while usually the son presents characteristics of liveliness typical of his personality and environmental context, all of a sudden he moves in a different way, maybe slower and "emptied": these signals—macroscopic—are easily detectable and the parents can take account of them to make questions on their son's feelings in that moment. In the same way, in the moment when the clinician detects some sudden and unusual incongruence in the patient's vitality forms, these become vital information motivating deeper investigations.

Of course, behavioural incongruences relate also to the tone, volume, rhythm and speed of voice with which individuals express themselves. The incongruences we outlined are in fact deducible also through hearing and listening to the patient. By doing so, the clinician can also carefully calibrate the micro-variations of the paraverbal modalities with which the patient expresses him/herself, taking them into account to distinguish a "harmless" from an "alarming" state of mind. We know well that emotions produce physiological modifications that can involve the

cardiovascular system, gastrointestinal tract, muscle, the nervous system, etc. Therefore, the indirect detection of the physiological parameters through inspection—that needs to occurs unbeknownst to the patient—is fundamentally important for the clinician: observing the posture, heart rate from the movement of the neck skin in proximity of the carotids, listening to possible abnormal bowel sounds, observing the respiratory rhythm and so on.

Obviously, observation cannot fail to focus on facial expressions, and we know from Ekman's studies that there are universal traits in facial mimicry characterising the so-called basic emotions, from which underlying emotions can be inferred with great precision.

### 6.7.3 Empathic Moment and Empathic Disconnection: Practical Techniques

At this point, it is important to provide the clinician with some suggestions on how it is possible to make, in a voluntary way, the necessary choices to establish an "empathic moment" with the patient and, at the same time, to gather most precise information that can be helpful for the patient's assessment. How to approach a suicidal individual keeping an excellent communicative skill?

We outlined a procedure of three fundamental steps that we wish to propose in this text with the intent to provide a possible practical application to the concept of "empathic disconnection" and to the strategy of "empathic moment".

#### 6.7.3.1 First Step, Precondition: Previous Mental Presence

In the paragraph about empathic disconnection, we identified those relational scenarios that can strongly hinder the empathic process: countertransference hate, moral judgement, reactive physical discomfort and labelling. Each of these aspects can generate a detached attitude in the clinician, resulting from empathic disconnection, often perceived as incongruent by the patient with clear negative consequences.

It is therefore necessary that the clinician, approaching any patient, in particular suicidal individuals, becomes aware of these elements and deliberately verifies their presence as soon as the patient is encountered for the first time. It is fundamental that the clinician rationally carries out this analysis intended to "clean" his/her own from these elements, so to generate a favourable state to appreciate the patient's subsequent emotional cues. To promptly notice the presence of these elements, the clinician necessarily needs preparation before meeting the patient. This preparation process for greater cognitive awareness has to be carried out in a contained environment, without distractions and suitable to favour the conditions for an inner efficient dialogue. A good practice could be a simple written memo, with the four scenarios and related description, in order to predispose the clinician's cognitive self-assessment before meeting the patient.

#### 6.7.3.2 Second Step, Empathic Moment

There are many occasions during the meeting with the patient in which the clinician can decide to produce an "empathic moment". This empathic moment is important

because it can provide the clinician with information about the patients' emotional state, as we discussed earlier. How is such a state produced? First of all, it is important that entering in empathic resonance is a clinician's choice. There could be moments where it is necessary to gather more information on the patient's emotional state, both to dispel some doubts and following some kind of incongruence or anomaly in the vitality forms noticed in the patient. At that point, the clinician, who—thanks to first step—is in an "openness" state, can choose to trigger, for a limited amount of time, a deeper and visceral listening through empathic resonance, the so-called empathic moment.

In order to trigger this state, some conditions are required: the clinician has to shift the focus of attention, passing from focusing on his/her thought and on the cognitive analysis of the situation to focusing on his/her bodily presence, so that attention is turned to one's own interoception. As we discussed before, interoception is an insular function, which is also the centre of integration of empathic information and emotional sharing. Also, as discussed earlier, according to some studies, greater interoception is associated with greater emotional awareness.

In this sense, searching for a comfortable position is a first step towards the exclusion of postures causing even a minimal degree of bodily tension, which can interfere with the process of state induction. The purpose of this bodily awareness potentiation is to reduce the clinician's vitality forms, in order to avoid unconscious conditioning of the patient leading him/her to "mirror" some of the clinician's internal state elements. The intention here is to create a shared empathic space where the clinician's emotional contribution is neutral in order to emphasise the patient's original emotions.

Respiratory awareness is then fundamental for the clinician: through it, the clinician can favour a reduced interference from the inner dialogue, the so-called interpreter (Gazzaniga 1985, 1998, 2005, 2007). The interpreter, which in most individuals resides in the left hemisphere, has the function to bring together the fragmented functioning of the many cerebral areas, acting in concert but as separate modules, into a unitary awareness flow, which results in linguistic form. It is basically the cerebral region that gives us the illusion of being unitary entities and that provides an "explanation" for every event resulting from the combined activity of the various cerebral regions at each moment.[9]

When the clinician is in this state, internally focused and with a reduced interpretative interference, he can perceive more clearly the patient's internal state because he enters more easily in empathic resonance. The signals arrive directly at the clinician's senses as if he experienced the state, because it is the nature of the mechanism underlying experience sharing: embodied simulation. It is necessary that, in that moment, the clinician tries to focus solely on *here and now*, because every other thought represents the greatest risk for the suspension of this state.

[9] An example: a doctor with Catholic faith but, at the same time, motivated by treating his patients makes use of embryonic stem cells. He has two conflicting modules. There the interpreter intervenes and resolves the conflict with an explanation: the entities produced through therapeutic cloning are not actual embryos since they do not originate in zygotes, but in "clonotes" (Gazzaniga 2005; McHugh 2004), and, namely, a concept newly invented in order to unify the conflict.

It is obvious that this moment cannot, by its very nature, last long because it requires a particular attentional effort, to which we are not used. Additionally, it is a condition easily subject to external interferences. Finally, in this condition, the cognitive analysis is inhibited; Therefore, it has to be interrupted, in order to proceed with the subsequent analysis of the information collected. This procedure, in our view, can enhance empathic resonance, which in turn could lead to greater personal distress. Our experience makes us suspect that inducing this state to "gain empathic information" with a precise intentionality, alongside its short duration, somehow "protects" from personal distress that normally is associated to empathic resonance. The empathic moment does not have to be necessarily one, it can be repeated over and over if the clinician feels the need, provided his awareness of the fact that personal distress could be more significant.

#### 6.7.3.3 Third Step, Analysis of Empathic Data

Immediately after the empathic moment, it is necessary for the clinician to recover his cognitive analysis capacity and interpret the emotional information gathered at the previous step. In order to do it, the clinician needs to deregulate empathic resonance, so that he can intentionally shift his focus of attention on elements external to the environment, change posture or move to another task, such as counting since, as we have seen, this task can downregulate the empathic response. At that point, the analysis of empathic information is cognitive, based on the memories gathered some instants before, which complement other information in his possession.

**Conclusions**

We believe that empathy, if understood in its characteristic mechanisms and rules, can turn into a powerful tool available to the clinician, who has to deal with difficult situations and patients.

The suicidal individual is a particularly challenging category of patients, for whom the emotional dimension plays a key role in the genesis of their suffering, perceived as intolerable. Accordingly, we believe that the clinician that strategically equips himself with greater ability and knowledge of the empathic function, which is our window to other's emotions, ensures a precious help in the management of this type of patients.

Also, it is important that, in the future, efforts are devoted to make the patient-clinician relationship more scientific and predictable. First, in order to optimise the therapeutic results thanks to a better investigation ability on the patient. Secondly, it is now supported by evidence that the patient's health cannot be obtained only through treating pathologies, but mandatorily by treating the entire person, both in the physical, emotional and cognitive spheres (Davidson et al. 2003). In this direction, the relationship with the clinician is of great importance, given the power that this relationship has to trigger emotions in the patient, emotions that, in turn, reflect on physiological states and that can positively or negatively affect the underlying pathology.

Finally, we believe that this effort is urgent, in order to adequately respond to the increasing sense of distrust that people manifest towards clinicians, which is

leading to such phenomena as the stigmatisation of science and evidence-based medicine or as the bad habit to have a do-it-yourself healthcare only relying on anecdotal information available on the web.

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# Suicide and Deliberate Self-Harm: When Attachments Fail

7

Jeremy Holmes

Suicide is one of the most mysterious and most challenging of human behaviours, an inherently traumatic, barely imaginable phenomenon, outside the usual range of expectable human behaviour—Hamlet's 'bourn from which no traveller returns'.

As with infanticide (Hrdy 1999), an evolutionary perspective can help clarify what is at stake. In animal analogues of suicide in ground-nesting birds, an 'altruistic' outlier will endanger its own life by luring away predators from chicks or other vulnerable members of the flock. Evolutionary biology reconciles this altruistic and therefore apparently maladaptive behaviour, by invoking the 'selfish gene' hypothesis, in which, based on 'rational' calculation, an animal will sacrifice its phenotype for the sake of its genotype, embodied in those to whom is related, thereby enhancing the overall chances of its genes surviving into the next generation (Dawkins 1978). As the great mathematical biologist J. B. S. Haldane is said to have replied when asked whether he would 'lay down his life' for another: 'yes, if he were an identical twin brother, and for two of my children, four of my grandchildren, eight of my great-grandchildren' and so on.

The idea of altruistic suicide is firmly embedded in human culture, ranging from Graeco-Roman 'honour' suicide, Japanese kamikaze pilots and the wave of suicide bombings, not all Islamic, which are such a salient feature of modern guerrilla warfare. Genetic survival here is transposed to the social level, where the lives of one's fellows, whether genetically related or not, are at stake, thereby ensuring survival of one's group and its value system. A key British end-of-empire narrative is Scott's 'failed' 1912 polar expedition, in which Scott's companion, Captain Oates, realising that his weakness was hazarding the entire mission on its homeward journey, left the tent for the blizzard, never to be seen again. His parting words—'I'm going out. I may be some time…'—are synonymous with heroic self-sacrifice in its Anglo-imperial guise.

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In contrast to this evolutionary view, suicide is claimed by some as a uniquely human potential, an existential consequence of 'free will' (Camus 1955). This existential view of suicide founders in most instances on the fact that most people who commit suicide are not doing so in an autonomous state of mind, but in one compromised by psychiatric illness. 'Psychological autopsy' suggests that at least 90% of suicides occur in people suffering from mental illness, predominantly severe depression. People who kill themselves are not, it seems, exercising their human right to take their own lives, but, generally, do so 'while the balance of their mind is disturbed', as British legal phraseology has it.

Mentalising suicide starts from the crucial distinction between the *idea* of suicide and the act itself. 'The thought of suicide is a great comfort: with it a calm passage is to be made across many a bad night' (Neitzsche, quoted Alvarez 1973); 'Suicide is the only thing that keeps me alive…whenever everything else fails, all I have to do is to consider suicide and in two seconds I'm as cheerful as a nitwit. But if I could *not* kill myself—ah then I would' (Perry, quoted Gabbard and Westen 2003).

Thinking *about* suicide at difficult moments in one's life is existentially normal, and at times even helpful. By contrast, moving from suicidal thought to action is an act of destruction, the negative effects of which almost always far outweigh any putative crumbs of benefit. Suicidal people may feel that by killing themselves they will no longer be a 'burden' to their loved ones, but, except under exceptional circumstances such as intractable and unbearable terminal illness, the pain of bereavement from suicide far outweighs the temporary relief it may bring. At the moment of self-extinction, suicide may appear to the sufferer to be the only possible exit from an impasse. But the unconscious is never still: as feelings fluctuate depression lifts; suffering in the trough of despair is almost invariably succeeded by lessened mental pain.

Underpinning the mentalising perspective is the implicit paradox that the capacity to think *about* suicide is likely to reduce its occurrence—even if the consequence of that thought is a form of denial, saying to oneself in effect 'I'm not under any circumstances going to go down that route'. Conversely *not* being able to talk and think about suicide may make it more, rather than less, likely. Finding ways to develop a 'suicide narrative' enables death-preoccupied sufferers to talk about, rather than enact, suicidal impulses.

The concept of the suicide narrative is compatible with a number of different theoretical perspectives (cognitive, psychoanalytic, psychobiological), all of which view the suicidal act as the end result of the impact on the mind of a chain of 'events' (a row with or losing a partner, loss of a job, overwhelming mental or physical pain and the collapse of one's projects, bankruptcy) each of which may constitute a severe narcissistic blow or 'non-events' (the telephone call that didn't happen). Reconstructing that narrative chain and the sufferer's psychological reactions—conscious and unconscious—to those events is the precondition for understanding the suicidal act itself. The suicide narrative is an attempt to impose meaning on the inchoate life experience integral to suicidality, to 'make sense' of incomprehensible and overwhelming negative affect (and sometimes 'unbearably'

positive feelings, knowing that intensity of feelings inevitably wanes; lovers may say to one another at the height of passion—'shall we die right now?').

Therapeutic approaches to suicide aim to deconstruct the justification and pseudo-rationality of suicide as an 'answer' to a person's difficulties, but must itself guard against dogmatic imposition of another set of pseudo-meanings. Each given perspective tends to have its own favoured explanatory framework: psychoanalytic (suicide as a covert form of murder), cognitive (suicide as an over-generalisation from present hopelessness) or neurobiological (serotonin depletion). The mentalising perspective implies wariness about too enthusiastic espousal of any given theoretical approach.

In general, suicide can be seen as triggered by disturbance in or collapse of an individual's attachment network. With no one to turn to when threatened, one becomes, like self-blinded Oedipus expelled from Thebes, intensely vulnerable. Death may be imagined as a preferable alternative to extreme emotional isolation. People whose attachments are compromised are ready targets for bullying and exploitation, thereby exacerbating existing feelings of non-belonging. 'Outsiders' lack a secure base within the hegemonic social group and are potential targets for prejudice and attack. Loss—of country, loved one(s), status and health—renders a person doubly vulnerable, first through the psychobiology of bereavement itself and second because what is lost represents the very person or group to which one would resort at times of loss and unhappiness. Seen developmentally, the lack of an internalised secure base in childhood resonates with the lack of a secure self in adult life. Affect regulation is problematic: there is no one there to help mitigate overwhelming feelings, and one has few positive regulatory experiences from the past on which to draw. When mental pain becomes insupportable, there is no stable internal self to turn to for comfort and soothing.

Shame, emphasised by Shneidman (1993) in his pioneering studies of the psychodynamics of suicide, is essentially a feeling of being a pariah, unwanted and unacceptable to one's social group. In shame one cannot bear to be seen—one's defences are stripped away; one becomes, as in King Lear's Poor Tom on the heath (a scenario of absolute insecurity), 'the thing itself … a poor, bare, forked animal'. The person with psychotic depression is suffused with shame. He feels naked and vulnerable, bereft of the possibility of refinding the comfort of a secure base. Failure of mentalising—the ability to see his depression-distorted thoughts for what they are—brings him to the pseudo-rational, 'altruistic' view that his family would be better off if he were 'out of the way', 'not around'.

An attachment perspective sees suicide, failed suicide and parasuicide/deliberate self-harm (DSH) as lying on a spectrum, rather than distinct entities. In every completed suicide or serious suicide attempt, there is still the hope of survival, however minuscule, whether this be after death in the post-death narrative (see below), a last minute quirk of fate or spin of the Russian roulette wheel that will pluck life from the jaws of death. There is always the faint hope of the unexpected telephone call, the pills that fail to reach their lethal dose or the noose knot that slips. Equally, DSH, while often apparently trivial—a handful of pills flung back in the midst of an argument—still *plays* with the idea of death and, especially if

repeated, statistically raises the chances of 'accidental' or semi-accidental death. Clinically, it is wise to assume that all DSH sufferers want at some level to die and that all 'serious' suicidal people, somewhere in their deepest being, have not entirely given up on hope and life.

DSH is frequently seen disparagingly as 'attention seeking', which indeed it is, but in a way that attachment theory makes meaningful. When an attachment bond is in jeopardy, the caregiver, care seeker, or sometimes both, react with protest, anger or rage. This provides a negative reinforcement schedule whose purpose is to re-establish the attachment bond and discourage future threats to it. Protest in the face of separation is healthy: in the Strange Situation, securely attached infants complain vigorously when their caregiver leaves them in an unfamiliar room for 3 min, but are smoothly soothed on reunion by a mother sympathetic to her child's angry distress.

Self-injurious behaviour is an analogue of this healthy protest, but here the insecurely attached sufferer feels unable to protest directly to the attachment figures, usually for fear of further alienating them. The attack is therefore displaced onto the self and the body, thereby eliciting care-giving behaviour indirectly. 'Playing dead' (or 'possum')—e.g. by going to bed with a sublethal dose of tranquillisers—can be a way of staying 'safe' until danger has passed and a caregiver is once more available, the row passed and the partner's arousal sufficiently subsided to return to a care-giving role. After an overdose attempt leading to hospital admission, the estranged parent or partner is not infrequently—but sadly not invariably—to be found at the patient's bedside chatting cheerfully, often to the fury of the hospital staff (the client's anger now safely projected into them). The DSH episode has worked its magic, and normal attachment relations, including the ability to mentalise, now that arousal levels have reduced, may well have been restored.

In what follows I apply the familiar attachment typology to thinking about working with suicidal people.

## 7.1 Suicidal Behaviour in 'Organised' Insecure Attachment

Deactivating and hyper-activating attachment strategies are 'organised' in that they represent predictable pathways for maintaining proximity to a suboptimal caregiver. A deactivating individual tends to have had a parent who, while reliable and 'loving', to a greater or less extent rebuffed bids for closeness. By minimising attachment needs, security is achieved, albeit at the price of partial inhibition of freedom of exploration and emotional expression. Such people tend to have a 'dismissing' narrative style. When interviewed following a suicide attempt, they may find it hard to describe in any detail the antecedents of the attempt or what they were feeling at the time: 'Oh, it's all over now. I don't really want to think about it' and 'It just sort of happened. I can't really think why I did it; something must have come over me'. They may well fail follow-up appointments.

The hyper-activating person has had a caregiver, no less loving, but who tended to be inconsistent and forgetful. Under these circumstances, a good way to get noticed when stressed, and therefore to feel safe, is to escalate attachment needs, to

cling and to make one's presence felt. These individuals have 'preoccupied' narrative styles, to be prolix, find it hard to tell a coherent story and tend to leave the interviewer feeling overwhelmed and confused. 'Well, it all goes back to when I was 12 and I went on holiday with my friends and felt really left out and fat…'. Post-suicide interviews with such clients may be difficult to terminate, and there may be frequent 'between'-session bids for proximity, telephone calls and desperate attempts to contact therapist when another crisis arises.

These desperate measures are more commonly seen in hyper-activating individuals, hypersensitive to inattention, for whom *Sturm und Drang* is emotional small change, and who react with panic and therefore heightened attachment behaviours at slight relational ruptures, misunderstandings or minor rows. Deactivators may be more impervious to relational disruption and therefore less prone to DSH. However, avoidant people can, when faced with loss, sometimes 'flip' into a highly needy state in which long-warded-off vulnerabilities suddenly hit them with full force, leading to an apparently 'out of the blue' serious suicide attempt, sometimes tragically 'successful'.

## 7.2 Disorganised Attachment, Borderline Personality Disorder and Suicide

As stated at the start of this chapter, suicidal and self-injurious morbidity is an integral part of the syndrome of borderline personality disorder. A typical female borderline sufferer will have made several overdose attempts, her arms criss-crossed with razor- or scissor-inflicted scars. Her male counterpart will similarly have harmed himself, often in association with drug or alcohol excess, and may have accumulated more violent injuries such as self-inflicted cigarette burns, broken bones and missing body parts. Suicide is a significant cause of premature death in borderline personality disorder, and reduction in suicidal behaviour is an accepted indication for the success or otherwise of therapeutic strategies in BPD.

Two suicide-relevant features link disorganised attachment and BPD. First is the difficulty in affect regulation and second is problematic mentalising. In disorganised attachment the psychobiological attachment procedures for dealing with arousal are disrupted. A distressed care seeker has a care provider who is unable to respond effectively and predictably to her infant's distress. The child is thus left with 'un-mirrored' and potentially overwhelming negative affect. He has to fend for himself as best as he can. A number of strategies are common. These include self-soothing via repetitive movements, displacement activity such as hitting an inanimate object, escaping from painful feelings via dissociation, using the body as an other via pinching, biting oneself or masturbation.

Fonagy et al. (2002) suggest that the un-mirrored negative affect may be experienced as an indwelling potentially terrifying 'alien' part of the self. The un-mentalised child is her- or himself unable to mentalise/visualise his feelings. He withdraws into 'pretend' mode or is trapped in 'equivalence' mode. He is lost in a nightmare world of fantasy or assumes that his perceptions and fears about other people correspond with the real state of affairs. In both he cannot easily differentiate thoughts and

feelings from reality. In both cases, failure of mentalising is closely linked to difficulty affect regulation. Overwhelmed with feeling, rational thought is driven out.

Transposing these patterns to adolescent and adult BPD sufferers, suicidal and self-injurious behaviour begins to make sense. BPD sufferers often have hair-trigger emotional responses, easily tipped into rage or terror by minor stimuli and, in a hyper-aroused state, unable to think clearly about their own and other people's feelings. They work on the 'equivalence' assumption that whatever they feel, *is*. There is a resort to self-soothing strategies such as alcohol or drug abuse, food binging/bulimia, risky sexual behaviour, hastily entering into relationships and, relevant to this chapter, self-harm. All can be seen as arising out of the incapacity effectively to allay attachment arousal with the help of a sympathetic secure base and of difficulty in mentalising distress. The 'alien' self may be experienced as an inner voice or demon, urging the sufferer towards self-harm. This injunction feels utterly 'real' and only with difficulty can be seen as part of the self—perhaps an angry abused, outraged, vengeful aspect.

An important feature of serious suicide attempts is the period of calm which survivors describe arising once the decision to kill oneself has been taken. Out of an affray of chaotic feelings, a clear pathway suddenly becomes visible. Death becomes the 'strange attractor' (Gleik 1987) that finally enables unbearable arousal to subside. The fragmented Self suddenly coalesces around the suicide project. A solution to the insoluble problem of living with un-mirrored pain suddenly emerges. Acknowledging the pull of suicide in this way is an important part of working therapeutically with BPD suicide survivors.

## 7.3 Therapeutic Strategies with Suicidal Borderline Clients

The three components—attachment, meaning-making and change promotion—of successful therapy are all problematic for the suicidal borderline client. Attachment needs in people suffering from BPD are highly aroused, but difficult to assuage. Therapists and other mental health workers are often viewed by their BPD clients as unconcerned, abandoning, hostile or intrusive. Watts and Morgan (1994) found that prior to suicide in hospitalised patients, there is an escalating premonitory period of 'malignant alienation' in which client-staff relationships deteriorate. Clients are typically invited to think about why they did or felt in the build up to the attempt—and/or to listen to the therapist speculating about these issues and their putative developmental origins. For BPD patients, such questions, however valid, may be experienced as either persecutory or incomprehensible. Feeling misunderstood, the client may make a suicide attempt in a desperate attempt to get staff to grasp the depths of his or her despair. The idea of *change* itself is far from straightforward in BPD. Death or oblivion is sought as an all-accepting safe 'bourn', albeit one from which no traveller returns. Less self-defeating, healthy alternatives appear to offer little more than a void or an impossible dream.

In BPD sufferer's arousal is often so overwhelming that it inhibits fragile mentalisation capacities; this is what underlies much of the relational turbulence so

typical of this diagnostic group. Suicidal behaviour is most likely to emerge when arousal is at its height and may, in a perverse way, serve to regulate unbearable affect. Therapeutic strategies therefore need to incorporate both mentalising skills training, both formal and opportunistic, and also to help sufferers with self-soothing and other strategies needed to reduce arousal. Examples include states of emotional arousal or upheaval, e.g. when the client is upset by something that happens in the therapeutic environment and immediately flares up or threatens to walk out. Staff can help by asking the client to 'press the pause button' (c.f. Bateman and Fonagy 2004) and collaboratively try to think about what has happened (including staff acknowledging their own contribution to the client's distress), before making any hasty decisions. The mindfulness exercises that are part of Linehan's dialectical behaviour therapy programme similarly aim to instil affect regulatory habits which can then be deployed when the going gets rough or hot.

The psychoanalytic notion of 'attacks on linking' (Bion 1967) as a feature of severe psychological disturbance is consistent with these current attachment views on mentalising. When in a state of arousal, the BPD sufferer is cut off from his thinking, mentalising capabilities. Psychotherapy offers (which is not the same as saying the offer can always be taken up) to help its clients move to a more coherent inner life, in which feelings and thinking work in concert, in the context of an enduring link with a care-giving other. Through the connection with the therapist, offering the possibility of a secure base—albeit one which will inevitably at times be compromised and whose repeated repair will form a vital part of the therapeutic process—more coherent, organised forms of relating both to one's self and others will emerge.

The diagnosis of BPD encompasses a wide range of difficulties and severity; no single treatment is appropriate to the generality of clients. However, attachment and mentalising-informed principles can be applied across the clinical spectrum. Suicide is an ever-present possibility when working with BPD clients and should never be far from the therapist's mind. Below, I arbitrarily divide my comments into therapeutic strategies appropriate for three 'types' of client: (a) the 'high-functioning' borderline who can be contained within the normal parameters of out-patient psychotherapy, whether privately or publicly funded; (b) the severe borderline suitable for intensive therapy within a 'programme'; and (c) the 'treatment as usual' client unsuitable for, or unwilling to undergo, intensive treatment, for whom avoiding iatrogenesis is the main therapeutic aim. I shall give illustrative clinical examples in each case.

## 7.4 Out-Patient Psychoanalytic Psychotherapy with Suicidal Clients

The more suicidal and disturbed the client, the more shared-care is desirable. Alongside the therapist, the client needs a key worker whose job is to manage suicidal episodes, including, if necessary, arranging hospital admission. The therapist needs to feel that it is someone else's job to keep the client alive, while her role is not primarily life-saving, but, rather, helping the client to *understand* why she does

not wish to live and to mobilise the life-affirming aspects of the Self that do want to survive.

Early formulations of indications and contraindications for brief dynamic psychotherapy (e.g. Malan 1979) listed suicidality as a contraindication to psychotherapy. The nostrum that 'there's no such thing as emergency psychotherapy' still applies. If psychotherapy is about mentalising, and if high arousal drives out mentalising, then the anxiety associated with acute suicidality means that low-key listening, flexibility and 'management' rather than formal therapy are what are needed at this early stage. There is rather robust evidence that in the immediate aftermath of an acute trauma, counselling and therapy may make things worse.

It is wise however to assume that each and every psychotherapy clients is potentially suicidal. Medical school history-taking advice is relevant here. To the question 'do you beat your wife?' the answer is likely to be 'No, of course not, how could you imagine such a thing?'. On the other hand, the probe 'How often do you beat your wife?' might elicit the reply 'Oh, only twice a week!'

'How near to suicidal are you?' is a question that every depressed, sad or bereaved person needs to be asked, even if the expectable answer is 'I couldn't do it to my children' or 'I think about it a lot but haven't got the courage'. Indeed it may be a mark of narcissism never to have at least contemplated suicide; conversely, to be able to mentalise one's suicidality can be an indicator of psychological health. Therapists should be 'acquainted with death', comfortable (if that is the right word) with the reality that when people feel awful or psychotic they do sometimes kill themselves, and be able to broach the subject without qualms, although also without prurience.

Implicit is the incompatibility of full mentalising and a suicidal act. Even in the absence of formal psychiatric illness, the balance of a suicidally acting person's mind is *always* disturbed since to mentalise is always to be aware that a thought is 'just' a thought and that the intrinsic fluidity of the mind, and of objective reality, means that in any situation other possibilities and outcomes are always possible.

In suicidal states one of the three pre-mentalising states of mind is likely to hold sway. Many acts of deliberate self-harm can be seen as 'if/then' teleologically driven: 'If I cut my wrist, I know I'll feel better'. Swallowing pills or acts of self-destruction become incorporated into a behavioural regime in response to threat or stress, in which the mind is by-passed in the rush to the temporary physiological relief of the 'pathological secure base'. Bateman and Fonagy's (2004) prescription of 'push the pause button' attempts to halt this process and help the sufferer to think about the feelings that subsume the actions and to contemplate possible alternative outcomes.

Unlike in teleological thinking, in 'equivalence mode' the suicidal person is conscious of their thoughts, but takes their insufferable mental pain and no-way-out viewpoint for the only possible reality. Gustafson (1986) recommends tapping into clients' best and worst moments: therapists working with equivalence mode clients will intuitively help them to tap into memories of good times as well as bad. The meditation strategies integral to dialectical behaviour therapy and cognitive therapy

for depression aim, through calm detachment, to help people see their miserable thoughts for what they are. For psychoanalytic therapists, an interpretation, if appropriately—i.e. non-dogmatically—delivered, is intrinsically mentalising in that it offers another possible perspective on the client's sense of hopeless cul-de-sac, embedding it in a wider set of meanings (to stay with the metaphor—moving upwards via a helicopter rescue into a vertical dimension is an escape route from a two-dimensional dead end).

Logical Celia equated security with having a boyfriend, having a boyfriend with sex, being unable to have sex as inevitably losing her boyfriend, being on her own as equivalent to death and thus suicide as the preferred option. Being helped to see that she was confused in her mind between security and sex, and linking this with a frightened/withdrawn mother in childhood, with consequent role reversal in which she became estranged from her own vulnerability, helped reframe her suicidality as the search for security. Thanatophilia is Eros's long lost cousin.

In 'pretend mode' reality is radically abandoned, a withdrawal into a world of make-believe where anything is possible. Just prior to the suicidal act, there is often a period of calm in which the sufferer, after a period of tortured confusion, suddenly and chillingly 'realises' that there *is* a way out—into the arms of death. Everything falls into place, and the miserable messiness of real life is finally superseded: 'I will be out of pain, my poor family will be rid of me, the psychiatric services will have me off their backs, the world will be put to rights at last', thinks the suicidal person.

Working with such states of mind requires the therapist to have one foot in this world of fantasy, one firmly planted in reality's camp. The importance of fantasy is acknowledged and played with. In the post-suicide narrative, we ask: who would attend the funeral, who would be most and least upset, what music would be played and how would the world move on? Such probing will gradually uncover the deep wishes that lie beneath the suicidal act—the longing not just for oblivion and escape from pain, but to be recognised, cared for and valued, to be helpful and generous and loving and to overcome bitterness and hatefulness.

All this may be played out within the therapy itself. A suicidal act between sessions may look like a retaliation for feeling that 'you are just doing your job, you don't really give a damn whether I live or die'. Below that is the wish that a suicidal act will at last force the therapist to care or to understand the extent of the client's mental torment. There may be a feeling that the therapist, with her imagined happy family and economic security, doesn't and can't really know what it is like to suffer (a radical failure of mirroring—partly transferential, partly no doubt true). The suicide attempt is a last ditch attempt to get the therapist to experience what it feels like to feel a failure, to be overwhelmed with a sense of loss and emptiness and futility. The therapist must be able simultaneously to identify with the client as manifest in her countertransference, and hold onto her knowledge that the consequences of suicide for the survivors are invariably those of multiplied rather than extinguished misery.

A final practical point concerns frequency of therapy, and the impact of breaks in working with suicidal people. Mentalising is a means by which separation and loss

are endured, a bridge across the inevitable fractures and ruptures that are intrinsic to intimacy, and that it is only on the basis of secure attachment that the insecurity of detachment can be born. The mental representation of security fades without reinforcement. Absence makes the heart grow fonder—for a while. Out of sight, out of mind all too easily takes over. Therapists need to have a sense of how long a suicidal client can survive without contact, and to be aware that this may vary depending on circumstances.

The 'good breast'/secure base of therapy may naturally wane or be mentally obliterated by the client who feels abandoned at the end of a session, just as they themselves were abandoned by an absent, distracted, abusive or intoxicated parent. If the period is only 24 h, then daily therapy is needed, and support over weekends need to be thought about and planned for. If a week can be coped with, then weekly therapy will be alright; if not, another therapeutic contact, with a GP or community key worker, needs to be organised. Similarly holiday breaks need to be covered by a co-therapist. Attending to the transferential meaning of an absence and its consequences for the client is necessary but insufficient; 'mastery' is needed too—seeing the limits of therapy and its place in the overall context of the client's life—and potential death (Holmes and Slade 2017).

## 7.5 Intensive Mentalisation-Based Therapy for Selected Suicidal Borderline Clients

Managing suicidal risk is a key task for psychiatric services. For the reasons outlined, general psychiatric services are not well geared to meet the needs of borderline clients and indeed often exacerbate their difficulties, either by 'over-' or 'under-'involvement, often echoing adverse developmental experiences of this client group. A specialist personality disorder clinic can help redress this, offering assessment for 'difficult' clients, followed either by specialist treatment in selected cases, or helping to maintain and diminishing iatrogenesis in others. The following example comes from an assessment interview carried out in such a specialist service for people suffering from BPD. Towards the end of the interview, mentalising capacities emerged that were a positive feature for specialist therapy.

## 7.6 Peter's Nemesis

Peter was an in-patient on an acute psychiatric admission ward. The ward staff was at its wits end about how to help him. Some thought he was manipulative and destructively dependent and should be discharged; others thought that he needed a lot of help, but didn't know how to get through to him. He had been detained in hospital for several months thanks to his tendency to gouge his arms repeatedly with knives, especially when drunk. He was 26 and had been in and out of hospital for the past 8 years or so. His main 'career' had been as a psychiatric patient, diagnosed as suffering from alcoholism, depression and borderline personality disorder.

Peter was referred to a specialist personality disorder clinic to see if there was anything that could be done to break this cycle of self-harm and prolonged hospital admissions and no real sense of progress.

He was a rather engaging young man with a nice smile, who, it turned out, was a good guitarist and in his teens used to have his own band (I routinely try to tap into client's strengths as well as difficulties). But he conveyed a sense of defeatedness and despair as well. He couldn't see a way forward and was acutely aware of the difference between his state and that of the average 28-year-old man. He seemed rather proud in a 'macho' way of his ability to drink vast amounts of cider and to tolerate the pain he inflicted on himself when he punched walls and cut his arms.

At assessment he described a typical episode. He was on the ward and wanted some sedative medication (he takes a lot of drugs, both prescribed and illicit). He asked a staff member for some 'as required' medication, but his request was refused. He felt an upsurge of rage, got into an altercation and stormed off the ward and out of the hospital. As he walked down the road he found himself crying and feeling utterly miserable and desolate. Then a suicidal idea formed in his mind. He felt calm at last. He went to the nearest shop, bought some razor blades and made it to public toilets where he locked himself in and cut his wrists. Eventually the police, who had been alerted to his disappearance, found him and he was returned to hospital. I reflected his story back to him as follows:

> You want something badly, relief from tension; you can't get it; you fly into a rage with your depriver; beneath the rage you feel utterly alone and abandoned; then your anger focuses in on yourself and your body, the only thing that seems to be within your control; you go somewhere where you are alone, a place of primitive bodily needs; finally your plight is recognised, at least partially, and you are rescued. (This droning monologue contradicted the dictum that interventions, especially with Borderline patients, should be short and to the point—tabloid headlines not a broadsheet editorial.)

A faint, semi-triumphant smile flickers across Peter's face, almost as though he had been 'found out', caught red-handed putting his hand in the till of his own life. 'Yep, that just about sums it up', he replies laconically, as thought to say 'you clever people may try to 'understand' me in your own way, but that's not going to make the slightest difference to me'. Here we see how, without a prior history of mentalising on the part of a caregiver, therapeutic attempts at doing so are experienced as irrelevant or 'mad'. The client seems impervious to understanding, and yet understanding is what, above all else, is needed.

He had told us earlier about his parent's dreadful rows throughout his childhood and how he used to steal away up to his room, and cover his ears with the pillow in order to block out the screams.

I go on: 'Perhaps that lonely public toilet is reminiscent of you alone in your bedroom with the rows going on all around you. Cutting yourself is an attempt to block out the mental pain and helplessness by inflicting physical pain on yourself'.

I ask Peter if he feels anyone on the ward understands him. No one, he insists. What about his 'key worker'? (whom I knew to be an excellent nurse), I ask.

'Oh, she just thinks I'm a waste of space like everyone else', he replies.

'Do you really mean that?'

'Well, I don't suppose she really does; it's just the way I feel about it most of the time'.

This illustrates the combination of empathy and challenge which is needed to foster mentalising—in this case perhaps no more than a brief glimpse of it—in borderline patients. Neither on its own is sufficient. The patient needs to feel secure: that he is being listened to, non-judged and understood. Only then is he in a position to reflect on his affective experience. Challenge in therapy implies close involvement with clients, not letting them evade painful topics, holding them so that they can begin to face the implications of their behaviour. None of this is likely to be successful in the absence of secure attachment, which lowers physiological arousal and so paves the way for the possibility of mentalising. Put another way, mentalising requires tolerance of vulnerability—feeling safe enough to risk the possibility that one might get things wrong, recognising that emotion can drive out reason. Peter's response to our interventions at assessment gave us sufficient hope to refer him for the intensive day programme for such clients.

## 7.7 Being Supportive While Avoiding Iatrogenesis in 'Treatment as Usual' Clients

In our own service, out of 49 borderline clients followed for 2 years, only 30% were thought suitable for specialist treatment; the remainder were contained within existing 'treatment as usual' services (Chiesa et al. 2004). The latter group are often people entrenched in dysfunctional relationships, including with the psychiatric team, and for whom DSH is a way of life when faced with emotional or practical difficulties. In response to my routine question about whom they would turn to in a crisis, or if they found themselves in hospital, say, after an accident, they might typically reply 'oh, I'd contact my keyworker/the ward/my psychiatrist/the hospital'—a sure sign that, for good or ill, they are deeply enmeshed in the healthcare system. What follows is a typical, if extreme, example. It also illustrates the attempt of the therapist to remain supportive in the face of onslaught and of therapist at least self-mentalising as a route to survival with difficult clients.

## 7.8 Susan's Masks

It is Friday evening, around 5 pm. I'm in my car, on my way home at the end of a long week. My cellphone goes off. It is the hospital switchboard.

'Dr Holmes?'

'Yes'.

'Are you the duty doctor this weekend?'

Reluctantly I am forced to admit that this is the case.

‘The out-of-hours social worker would like a word with you’. I draw into a lay-by.

‘It’s about Susan X’. Already my heart sinks a little. I know Susan well. She takes time, and patience.

‘Her friend came into the office today saying she was very worried about her. Susan has sold all her belongings, given away her cats, says she’s moving out of her flat. She may well be suicidal. I think we ought to do an assessment’.

‘How soon can you get there’, I ask.

‘Not for a couple of hours I’m afraid; we’re very busy this evening’.

‘OK. I’ll go straight there. Come when you can. If I can persuade her to be admitted voluntarily I’ll ring you. We better line up the police. Susan doesn’t take kindly to being forced to do things against her will’.

I’ve known Susan for some time. She doesn’t like me much. I suppose the feeling is mutual, to an extent. She frequently comes to consultations drunk or drugged. She has a way of getting me to do things for her, often against my better judgement: write letters to the council about her accommodation, arrange for the health authority to pay for expensive therapies that in my view don’t seem to change things much and prescribe large amounts of medication which I don’t really believe in.

Perceptions of her vary. Some people see her in a much more positive light. She is certainly intelligent and resourceful, and she has had a hard life. She was sexually assaulted in her teens. She has an eating disorder, and her weight swings wildly between being pretty huge and absolute starvation. She has made numerous suicidal overdose attempts, as well as frequently cutting her wrists.

I am rather feeble in my dealings with her and tend to pander to her by misguidedly ‘rewarding’ bad behaviour, for the sake of a quiet life, a short-term benefit which only makes for trouble later.

I arrive at her house. She answers the door her face conveying a curious mixture of fear, cunning, triumph and disgust. I explain why I have come, that ‘we’ are worried she might be suicidal, and feel we should ‘do a mental health assessment’, talk to her and see if we can help in any way. All this is a bit false, since she knows, and I know, and she knows I know, that when the sweet-talking is over, I have the power to make her come into hospital against her will in order to save her life. She also knows that she can ‘get’ me to do this, making her into the victim, me into the aggressor.

She invites me in. The flat is orderly, tidy, quite tastefully decorated. Hoping to gain her trust, I compliment her on her artistic sense. She is composed and seems quite ‘normal’. She offers me a cup of tea, which I decline, although I realise it may seem churlish to her.

I ask her if it is true that she is planning to move away and has got rid of her beloved cats.

‘So what if I have?’ she responds defiantly.

‘What’s going on? Why have you suddenly decided to up sticks?’ (using a metaphor makes the comment less persecutory perhaps).

‘There’s no future for me in this town’.

It is all a bit vague. I feel I am being blocked at every turn.

I raise the 'S' word: 'Are you feeling suicidal? Does life seem worth living? Perhaps you are thinking of doing away with yourself'.

'What if I am? It's a free country'.

Now it becomes my duty to decide if she is 'mentally ill'. Only if she is a danger to herself or others, and is suffering from a mental illness, have we the legal right to detain her against her wishes.

She doesn't seem all that depressed—but, I think to myself, maybe she really is depressed but pretending to be normal. But if she can do that, doesn't that mean she is normal? It is like Joseph Heller's Catch-22 in reverse, where if airmen could simulate madness in order to avoid lethal flying missions in the Second World War, they were by definition sane.

I ask about her sleep pattern, appetite, powers of concentration and whether she is feeling miserable.

'You know damn well I feel miserable. I've felt like this for years', she snaps.

I decide to appeal to her better nature. 'Look, why don't you come into hospital so we can have time to think about all this' (using mentalising as an ethical principle here).

'No way am I going into hospital. No chance. Why don't you leave me alone and let me lead my own life?'

Or death?—I think to myself. Outwardly I am calm (I hope) but inwardly confused and frustrated. I keep thinking there must be some way to persuade Susan to come into hospital voluntarily, thus giving us a chance to evaluate her suicidality and give her a breathing space. Surely I can persuade her, thereby avoiding the unpleasant business of police and social workers and getting a GP to come and all of us signing the 'section' papers. That way she will become involved in her own care—surely a good thing. Not to mention that I will inevitably be late home. Anyway, where is that social worker?

But it is her will pitted against mine, and she is pretty determined to get her way, which it is becoming clear to me, to get us to section her. Then she will be a victim and will be able to disown the part which she has played in creating this situation in the first place. We will have in a sense 'raped' her. I remind myself of one of my psychiatric dictums—in the last analysis, 'the patient always wins because it's their life that is at stake, only our job'. (I note the 'them and 'us' language, which the polarisation which I feel Susan has forced me into).

Now I begin to see how I am subtly becoming more and more unsympathetic and hostile to Susan, confirming all her prejudices about psychiatry. It is as though we are being shaped by two unconsciousness, over which neither of us has much control. In her case she will have created a situation in which those who are supposed to be helping end up insensitively controlling her—she can then turn round and say 'There you are. You see no one gives a damn about me. All they want is to bang me up and tick their risk assessment boxes'. In my case I must face the possibility that behind my desire to help and be a 'good doctor', there is

aggression, a need for a payback for my previous feeble pandering and to impose my will on the situation.

While all this is going through my mind I find myself scanning the walls of her room. Suddenly I notice that they are covered with masks in all shapes and sizes, mostly African.

'I like your masks', I venture.

'Been collecting them for a long time. What of it?' Susan defiantly replies, but I sense that her mood is slightly lightened by the diversion.

'They are helping me to understand what is going on here. I see you as a woman of masks. There is your 'Section me if you dare' mask, your 'I am a competent and independent woman so why don't you just leave me alone' mask, but I wonder if there isn't a 'I feel miserable and helpless, and just don't know if I can bear to go on living' mask beneath all the others, which isn't a mask at all but how you are really feeling right now'.

This did seem to hit home a bit. Tears came into Susan's eyes, and at least I had momentarily manoeuvred us away from hostility and battle.

Just then the doorbell rang. It was of course the social worker, the GP and a two very young-looking police people. Susan retreated to her bedroom, and despite the police's valiant efforts to persuade her to 'come quietly', the upshot was that she was in the end 'sectioned', since we didn't think it would be right to leave her on her own over the weekend in such a vulnerable state.

As I had feared would happen, she remained in hospital for several months before more suitable placement for her in a hostel could be arranged.

This was not an outcome to be particularly proud of. But the mask image had been helpful and continued to be so during her hospital stay. Whenever I found myself feeling annoyed, I would think of Susan's masks and the simple idea that what we present to the world is only part of the story or indeed may be totally divergent from what we are feeling inside. It reminded me that my job is to help people feel better able to face the world, thus to mirror, rather than mask, true feelings. It helped me to mentalise my own reactions to Susan, even if it didn't help her much. We could be justifiably accused of iatrogenesis, since by 'manipulating' us into sectioning her, Susan disowned her own contribution to her difficulties and enacted rather than mentalised her misery. With such entrenched borderline clients, perhaps all that can be hoped for is that staff are aware of their mistakes, rather than blindly making them, which at least gives the chance to learn from them in the future. That is the essence of the value of mentalising.

## Conclusions

At the heart of the third volume of John Bowlby's monumental trilogy lies an account of the psychological consequences of the breaking of affectional bonds—suicide is the ultimate severance.

After her beloved elder brother's death in a drowning accident in 1840, Elizabeth Barrett Browning entered a period of irreconcilable mourning,

lightened finally when a friend gave her a spaniel puppy, Flush. The second half of her sonnet, Grief, reads:

> … Deep-hearted man, express
> Grief for thy dead in silence like to death—
> Most like a monumental statue set
> In everlasting watch and moveless woe
> Till itself crumble to the dust beneath.
> Touch it; the marble eyelids are not wet:
> If it could weep it could arise and go.

When searching and protest have exhausted themselves comes the despair so accurately described by Barrett—the stasis of 'moveless woe' and 'everlasting watch'. If 90% of suicide is caused by depressive illness (Lonqvist 200), and at least 70% of depression is the sequela of present or childhood loss (Brown and Harris 1976), then loss and grief are key underlying themes in most suicides. The suicidal person has reached the nadir of despair, but is unable to envision and so hope for reconciliation and recovery. Suicide happens when there is no psychic home and when one cannot weep and therefore is unable to 'arise and go'.

An external event (loss of a job, say) reawakens earlier narcissistic wound (perhaps the loss of a parent). Relationship is denied and self-sufficiency sought instead. Unlike the pain of living, death appears to be within one's control. However apparently rational, this is a breakdown of mentalising. Thought is ultimately relational: ideas need to be 'checked out' with others before action, to see if one person's perception of reality corresponds with another's (Cavell 2006). The precondition for suicide is the breakdown of that consensual flux. Attachment bonds have been broken, either in the immediate situation (the row with the loved one) or developmentally (the non-mentalising caregiver whose child cannot therefore self-mentalise). Mentalising is the antithesis of stasis. Thought—the Buddhist 'monkey mind'—is always mobile, provisional and subject to 'visions and revisions' (Eliot 1986), expressing points of view, not final versions. Therapy with suicidal people tries to help them to see their too-real suicidal thoughts as products of a loss-wracked imagination, suicidal plans as merely possible pictures—not concrete maps of an immutable reality.

Unmentalising, the suicidal person knows that death is the answer. He cannot or will not consider other possibilities—that 'this too will pass'. It is the job of a therapy team to build or rebuild the capacity to visualise of a life that could be lived—and/or to keep the patient alive until that becomes feasible. The therapist becomes the Other against whom the suicidal person bounces off his suicidal thoughts—a responsive reflexive surface, strong yet sensitive. The patient's denied hope is located temporarily in the therapist—for safe keeping. As a citizen I defend the right of clear-minded individuals to take their own lives; as a therapist I strenuously resist that impulse when manifested in my patients. By entering into a therapeutic dialogue with the suicidal person, I maintain that 'other point of view' is the essence of mentalising. I argue that where there is depression there is hope; almost all depression eventually remits. By jointly

elaborating a suicidal narrative, the ever-shifting dialectic of thought and action is exposed for the sufferer to reconsider. Mutual mentalising with a therapist opens up non-suicidal pathways for enduring and dealing with suffering.

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# Emotional Dysregulation and Suicide Risk: If You'll Leave Me, I'll Kill Myself!

8

Patrizia Velotti and Giulio Cesare Zavattini

## 8.1 Introduction

Suicide is defined as the deliberate infliction of lethal physical self-harm with at least some intent to cause death (Law et al. 2015)[1]. It can occur across all ages, socioeconomic groups, and genders. There are psychological, biological, and social risk factors which may increase the likelihood of a suicide (Doherty and DeVilder 2016). Some potential risk factors for the development of suicide include demographic and contextual factors (age, gender, socioeconomic status). Other risk factors are family factors (exposure to suicide in family) or behavioral and psychological factors (hostile attributes, self-esteem, attitudes, beliefs, personality disorder, depression, alcohol and drug use).

Issues related to suicidal ideation have also generated a great deal of interest from both scholars and public. Reports indicate that experience of recent challenging life losses, social problems, mental illness, and personality disorders could be factors of suicidal ideation and that the co-occurrence of many risk factors leads to conditions for attempted or completed suicide (Cheng et al. 2000; Yen et al. 2005).

Evidence suggests that psychopathology (i.e., mood disorders, substance abuse disorders, personality disorders, and schizophrenia) is a significant risk factor for suicide (Scoliers et al. 2009). Actually, there is a consistent association between psychiatric disorders and suicide (Yen et al. 2004), but it's still undetermined

[1] Suicide attempts are considered unsuccessful self-injurious behavior where the intent was to die (Amore et al. 2014).

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whether suicide is the result of the severe expression of these disorders or a separate, overlapping entity. However, the majority of people who commit suicide are not under psychiatric care, and most of them have never had a psychiatric treatment (Luoma et al. 2002; Ronningstam et al. 2008).

Nevertheless, also stressful life events are considered in suicidal behavior, though the individual perception of stress is highly subjective and it determines the extent to which the stress increases suicide risk. From this point of view, the type of stressor varies across the life span as individuals' perception changes. An intense stressor in a person might be a relationship loss or a shameful experience, while in another person it is more likely to be the death of a partner or an illness.

Losses were reported as the most common life event associated with suicide (Cheng et al. 2000). Definitely, precipitating life events in suicide, commonly involving interpersonal or work-related conflicts or losses, were determined by evidence from clinical observations (Maltsberger et al. 2003).

Considering the couple relationship, other risk factors are discussed including relationship status, relationship satisfaction, attachment, and negative emotionality. Also, difficulties in emotion regulation (Gratz 2006; Palmier-Claus et al. 2011; Nock et al. 2008), such as emotional reactivity, lability, and intensity, are demonstrated risk factors that contribute to suicidal ideation (Lynch et al. 2004; Arria et al. 2009).

Recently, literature suggests a link between marital status and risk of suicide, considering marital status as a protective factor against suicidality (Kõlves et al. 2006; Baca-Gracia et al. 2007). Divorced people have the highest risk of attempting suicide compared to other marital groups (Thomas et al. 2002). Data have shown that married people experience lower suicide rates than single, never-married people and that divorced, separated, and widowed persons have the highest rates (Kposowa 2000). Indeed, studies indicated the highest risk of suicide among younger separated males than any other marital status (Wyder et al. 2009; Kõlves et al. 2010). Furthermore, marital problems seem to precede suicide attempts in people with personality disorders (Yen et al. 2005). However, such behavior also frequently occurs among people without severe mental illness in the week before suicide (Cooper et al. 2002).

In conclusion, consolidated, intimate bonds are considered to be essential in promoting individual health, well-being, and security (Diamond and Hicks 2005; Ryff et al. 2001), so relationship difficulties or breakups could trigger a sense of helplessness in vulnerable partners about modifying their situation or escaping the vicious cycle of negativity that has been created.

## 8.2 The Function of the Bond: The Attachment Perspective

Couple relationships play a fundamental role in contributing to psychophysical well-being or, contrariwise, in determining some kind of distress in partners (Uchino et al. 1996; Anderson 2002; Pico-Alfonso et al. 2006; Ellsberg et al. 2008); they

have been described as "the most frequent source both of happiness and distress" (Berscheid and Reis 1998, p. 243).

Couple relationships are often considered as a possible source also for emotional regulation (Castellano et al. 2013; Mikulincer and Shaver, 2008). A better quality in marital relationship can be predicted by a good matching between partner regulation patterns; vice versa, the frequent use of maladaptive strategies (i.e., suppression)—mostly by male partners—is related to a poor couple satisfaction (Velotti et al. 2015).

Generally, adult relationships are often based on "ties" that are constantly being challenged because, despite their role in satisfying personal needs, they are felt to limit individuality. In a context that encourages the expression of individuality, this sense of limitation may deter people from choosing and committing to a life together or may determine a coexistence of opposing emotions and desires toward the partner.

From various attempts to explore the nature and the evolution of romantic relationships, it is clear how, in the search for stability and satisfaction, complex issues such as dependency, commitment, intimacy, and even risk or danger come into play. Overall, these issues involve the regulation of emotion, which, in turn, contributes to define the "bond" that exists between partners and its possible trajectories.

Considering a couple relationship as an attachment bond implies, among other things, that it has a regulatory function in individual homeostasis. Studies have shown higher levels of well-being in individuals who have satisfactory marital relationships than in those who don't (Diamond and Hicks 2005; Ryff et al. 2001). Attachment relationships provide a context in which the ability to regulate emotions can be acquired. Accordingly, individuals may have used their early relationship experiences with caregivers to regulate their emotions. Over time, these relationship experiences are internalized and have become internal working models that gradually have shaped and influenced the process of engagement in interpersonal relationships and have provided strategies for managing emotions (Mikulincer et al. 2005). Many authors have highlighted the strong connections that exists between the motivational system of attachment and emotional states where *emotion regulation* has been considered the most important aspect of attachment (Allen and Fonagy 2006; Schore 2003).

"Emotion regulation consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals" (Thompson 1994, pp. 27–28). At this time, a certain empirical evidence tends to privilege a relational point of view of this phenomenon (Stets and Straus 1989; Sugarman and Hotaling 1989; Archer 2000); this point of view is the underlying theme in the proposed reflections. Nevertheless, it needs to be underlined that this comprehension model does not keep out, but it does consider the need to be integrated with other existent approaches, to provide a better understanding of what happens when episodes or circles of distress are triggered within the bond, in which suicide ideation happens to be frequent.

In the meantime, we have to consider relationship breakup as a complex and painful event, as it is highlighted by the difficulties experienced by many couples

who separate or divorce (Gottman and Levenson 2003; Hank and Wagner 2013; Amato and Anthony 2014). According to attachment theory, the essence of the experience of breaking up is the loss of one of the most important attachment bonds (Feeney and Monin 2008; Zavattini 2010). Separation and loss are the words John Bowlby used to describe the unavailability of the attachment figure, a temporary unavailability in the former case but permanent in the latter (Bowlby 1980). Whether temporary or permanent, the breakup can be differently interpreted by the two partners. One partner may think that the relationship is on its last legs, while the other may not even be aware that it is at risk.

Considering the differences between insecure styles, it appears that anxious attachment is associated with a style of conflict less orientated toward resolution and more toward procrastinating or even exacerbating conflict, often through a dominating or coercive behavior (Feeney et al. 1994). These individuals tend to keep the argument with the partner alive, stubbornly and insistently searching for clarification. Individuals with avoidant attachment are mainly inclined to use a conflict style that removes them from any possible escalation and hence to avoid confronting feelings. They prefer to bypass the conflict, avoiding the emotional upheaval it triggers.

When a temporary separation becomes permanent, or when an attachment figure remains physically present but emotionally absent, how might we understand what is going on? In attachment terms, the so-called psychological divorce describes a passage from the phase of active protest (when one is not resigned to the loss and hopes that the bond can be renewed) to the phase of despair (when the loss of hope and disappointment prevails), and it ends in the phase of emotional detachment (when the partners let go any hope of keeping the bond alive). Separation may be understood on a psychological level as requiring the process of mourning the relationship, given its attachment significance for the partners involved. Sometimes the affective investment toward the ex-partner continues unabated, often in the form of rage and conflict. This incapacity to mourn prevents the person from "moving on" (Siegel 1999).

In many cases, the reactions are intense and prolonged. In others, pain may be absent or replaced by resentment and self-blame. Often, the capacity to organize the future is impaired. Some of the main symptoms of disease encountered in those going through divorce are depression, anxiety, hypochondria, alcoholism, and agoraphobia.

Weiss (1977) was among the first to conduct a study on experiences of partners after separation and divorce. He found reactions of euphoria in some people, often expressed in the form of fantasy of a new life and new experiences, for which, at least as long as such feeling lasts, they appeared unusually active and effective in pursuing, even though the presence of anxiety and hidden tensions were detectable. Weiss thought euphoria was an extremely fragile defense that could be shattered very easily when relied on to deny the significance of a loss. When shattered, it could be replaced by inconsolable and desperate pain.

### 8.2.1 The Loss of the Bond

Persistent incapacity to accept that the loss is permanent determines intense and prolonged reactions. Often, the capacity to organize the future is impaired. Several studies (see Table 8.1) highlighted that recent divorce and de facto separation increase the odds of death by suicide.

Indeed, the difficulty of breaking cycles of pain in a relationship can be amplified by individual psychopathology until it leads the partners to believe that they are unlikely to receive better treatment in other relationships or even that they are at fault for the pain they have experienced.

**Table 8.1** Studies about relationship breakdown and suicide

| Studies | Sample (*N*) | Results |
|---|---|---|
| Kposowa (2000) | National Longitudinal Mortality Study—USA (*N* = 471,922) | • Higher risk of suicide in separated or divorced people (compared to married, single, widowed)<br>• Traceable difference only in males |
| Wyder et al. (2009) | Queensland Suicide Register—Australia (*N* = 6062) | • Higher risk of suicide in divorced people (compared to other marital statuses)<br>• Higher suicide rates in males<br>• Especially in the range between 15 and 24 years old |
| Shiner et al. (2009) | Qualitative study on UK suicide cases (*N* = 100) | • Higher suicide rates in males<br>• Especially in the range between 30 and 60 years old (peak, 35–39)<br>• Higher rate: males >85 years old<br>• **Factors associated with increase in suicidality: lack of social bonds and, in particular, romantic bonds**; depression; or other psychopathological issues |
| Kõlves et al. (2010, 2013) | People during separation (*N* = 370; *N* = 217) | • Higher suicide rates in males<br>• Factors associated with persistence/increase in suicidality: In males: stress related to the process of separation; feelings of loss and loneliness; poor social network; financial difficulties; low education level; economic problems In males and females: physical diseases or psychopathology; internalized shame related to divorce |
| Stack and Scourfield (2013) | National Mortality Followback Survey—USA (13,897 deat hs, including 1169 suicides) | • Recent divorce (OR, 1.6) increases suicide risk more than past divorce (OR, 1.3)<br>• Even statistically controlling other risk factors: psychiatrical (i.e., depression), socioeconomic (i.e., job loss) |
| Yip et al. (2015) | Meta-analysis from 11 countries (10 studies) | • Higher risk of suicide in divorced people compared to married ones<br>• Further risk factors: Males: individualist and long-term oriented society Females: short-term oriented society, survival values (economic and public security, ethnocentrism, low trust, and tolerance), gender inequality |

From what we know, high levels of dependency and anxiety about separation, which characterize individuals with anxious attachment, may make it very difficult to stay and to leave painful relationships. Negative models of self may lead these individuals to intensify efforts to maintain their attachment bonds despite the unhappiness. The relationship may become especially open to dysfunctional behavior when the person feels vulnerable and in need of the partner. They may then not trust in the possibility of receiving care and comfort, feeling their particular vulnerability. From an attachment perspective, this can make sense when vulnerability is understood as conveying a deep disappointment and frustration of attachment needs. Suicidal ideation may serve as an excessive and improper behavioral strategy aimed at regaining or maintaining contact with the attachment figure (Bowlby 1973). This "protest" is most likely to be directed toward the partner because of their attachment significance and may become dysfunctional when the need for emotional closeness to the other is frustrated.

This way of understanding suicide gives particular importance to the significance of threat, whether imaginary or real, acting as a trigger. Threat can come in the form of rejection, separation, or abandonment by the partner. It has been suggested that expressions of anger, accusations, and reciprocal blame can be seen as distorted manifestations of strong attachment-related emotions that arise when a person feels that their partner is unavailable (Kobak et al. 1994). Because they are able to communicate their attachment needs, it is assumed that individuals with secure attachment are able to manage the situation, even when they feel a threat as extreme as losing their partner.

However, if they have an attachment history that makes them particularly sensitive to anxiety, separation, and rejection, their secure status does not necessarily guarantee that they will not resort to suicidal ideation when under extreme stress.

## 8.3 Emotion Regulation

In the last 10 years, the number of researches and debates concerning emotions and emotion regulation in international literature has increased (Balzarotti et al. 2016; Gross and Thompson 2007; Koole 2009; Webb et al. 2012). Researches have suggested that the ability to tolerate and regulate emotions may play a more prominent role in psychopathology. Data in literature, anyhow, are still unclear. People that suffer from psychological distress seem to have greater difficulties regulating emotions than healthy people (Kring and Sloan 2010; Velotti et al. 2013; Velotti et al. 2016), but the mechanisms that trigger and reinforce dysregulative processes are poorly understood (Schulze et al. 2011). Some researches suggest, for instance, that emotion regulation strategies in anxious people are associated to the permanence of negative affective states, while in other cases it seems to be associated to a reduction both of anxious feelings and panic symptoms (Levitt et al. 2004).

A possible explanation of these differences might be traced in the need to contemplate the role of social interactions (Campos et al. 2011), considering emotion regulation as an *essentially relational process*. Kappas (2011), for instance, has

underlined the bidirectional role of social processes in emotion regulation: emotions that occur within the person may be influenced by the social environment, among other things; vice versa, the emotional experience of an individual may influence, in turn, the experience of another, and, hence, other people can be used to regulate one's emotions. Therefore, emotion regulation is not to be intended as an intraindividual process but rather as an event connected to social interactions, consisting in the same interactive engagement, as such regulation can be taken by any individual involved in the interaction.

Each partner has ideally the function to give the other the feeling that he/she can trust to get comfort, to get encouragement and support, and to be able to freely communicate its own emotional states. Jealousy, envy, possessiveness, need of domination and power in the couple, and narcissistic vulnerabilities make romantic relationship a complex, unique place, where close to positive aspects of pursuit of wealth, also negative elements occur, like distortions that make couple bonds "suffered." In particular, suicide risk is often associated to intense feelings of shame (Kõlves et al. 2010), considered to be one of the most difficult emotions to regulate (Elison et al. 2014; Tangney and Dearing 2002; Wiklander et al. 2012).

Underlining the central role of emotion regulation, attachment theory has been focusing on motivations and on how an individual experimenting distress is driven to seek his caregiver; in this sense, caregiver can regulate the feeling of distress felt by the partner, providing, at the same time, a positive emotion connected to the recovery of the sense of security.

In such framework, it is clear that, although so far they have not been studied in deep, emotion regulation has major implications in the comprehension of couple relationship dynamics, even in those couples who experience more or less noticeable distress.

Nevertheless, it should be noted that, despite the innovative contribution of attachment theory model, researchers have so far looked at regulatory mechanisms specific to couple dynamics through the lens of partners' individual emotion regulation processes, resulting from individual attachment experiences. Conjecturing that, emotion regulation strategies are stable, as base elements of individual internal working models formed from early attachment experiences in childhood.

Anyhow, the attachment perspective argues that such working models may change whether in the environment significant events, which disconfirm general expectations, occur (Feeney 2008). It would imply that, as highlighted by Judith Feeney, being involved in a stable and satisfying relationship may lead to a change in emotion regulation strategies, even in those individuals whose internal working model were characterized by negative expectations toward being understood and accepted.

In conclusion, we can say that (1) couple relationship is a specific context in which the setting up of a new regulatory competence is stimulated; (2) attachment theory offers several possible interpretations of the relationship between working models and regulatory strategies, identifying two different perspectives (effects of internal working models on regulatory strategies and effects of regulatory strategies on internal working models); and (3) the debate concerning change mechanisms

involved in adult regulatory strategies, which make a couple find their optimal emotional distance/closeness, is still open.

In this sense, a useful element of analysis is provided by attention paid to the emotional and regulatory climate of the relationship. John Bowlby said that the chance to be left alone, "as well as being conscious, make all us cowards" (Bowlby 1979) and makes every individual avoid such circumstance, as any other potential danger is avoided. The author returns the origin of this feeling to the ancestral history of man, referring to the phase of our past when being alone meant to be exposed to the danger of predators. For such reasons, he says that *the threat of losing the attachment figure provokes distress and true desperation; moreover, both these emotions can easily lead to rage* (Bowlby 1969).

Fear, anger, and sadness are the universal emotional responses to the threat of lack of availability of the attachment figure (Bowlby 1973; Weiss 1977; Kobak and Madsen 2008). Fear triggers the attachment system so that the individual can be able to restore a contact with the significant attachment figure. Anger sustains the individual through his efforts to get back to the partner and, at the same time, is a communication signal that discourages the other's lack of availability (Bowlby 1979). Sadness comes when the individual faces the uselessness of his efforts to restore the closeness of the attachment figure. Anyhow, it's important to underline that all the emotions described are not mutually exclusive, as in a relationship different affections dominate in different moments, so the role they play may vary "according to the function they have in a specific interaction" (Greenberg 2000).

Such considerations contribute to a more wide definition of "the most important and durable effect of dysfunctional family relationships that may be connected not only and not simply with the imitation of specific violent behaviors but rather with the incapability to regulate painful and destructive emotions, like fear" (Dutton 2011). As it was stated earlier, as the objective of an attachment behavior is to maintain the emotional bond with the partner, any situation that may threaten such bond provokes some reaction/action in order to preserve it. In similar circumstances "the higher is the risk of loss, the more intense and multiform is the kind of reaction/action elicited to prevent it" (Bowlby 1980).

In this sense, there can occur some kind of anger that can be defined as functional and that can help to overcome any obstacles to the reunification with the attachment figure, as in cases where the separation is temporary or when the threat of loss resulted from the crisis is accompanied by the hope of a favorable outcome. This happens in couples where one partner can feel and recognize the partner's emotions and, facing the threat of loss, experiments a feeling of anger that shakes him to the point of questioning to try to remedy to the problematic situation and "regain" the bond; it would be a biologically determined anger which is accompanied by hope (Bowlby 1973, 1980). Instead, when the feeling of loss or partner's rejection signals are perceived as continuous, or as too dangerous, the anger of despair comes, which is a nonfunctional rage directed toward that person that is perceived as lost. This is the case, for example, of those who suddenly realize that anything might change the partner's mind about the decision of breaking up. The feeling of anger is so desperate that the person has no hope of being able to change the situation so all the hatred

is poured out on the one who seems unmoved by the pain that he's experiencing. The rage toward the partner, in this sense, may become dysfunctional when thoughts and aggressive actions cross the uncertain boundary between what has a dissuasive purpose and what has a vindictive one, so what is experienced is no more "the scorching pain of anger, but the malice of hatred" (Bowlby 1973).

## 8.4 Emotion Dysregulation, Couple Functioning, and Suicide

Difficulties in emotion regulation and impulse control are considered relevant components of maladaptive personality functioning (Scott et al. 2014; Velotti and Garofalo 2015). Indeed, many psychological symptoms and disorders are associated with high levels of emotion dysregulation and with increased suicide risk. That is, the ability to withstand negative affects is able to increase or decrease vulnerability toward suicidality. However, extant research has found that emotion dysregulation contributes to suicidality even after accounting for symptoms of psychological disorders (Silk et al. 2003; Simon et al. 2007; Selby et al. 2009; Rajappa et al. 2012).

Deficits in the ability to regulate emotion have been implicated in the development of suicidal ideation (Orbach et al. 2007). For example, lack of awareness of one's emotional strategies has been associated with suicidal ideation, with the effects largely explained by hopelessness and rumination (Tsypes et al. 2013). Emotion dysregulation is frequently considered as a maladaptive method of emotion regulation (Brown et al. 2002; Gratz 2003; Gratz and Roemer 2008; Laye-Gindhu and Schonert-Reichl 2005). However, some studies (Arria et al. 2009) evidenced that in individuals with low levels of depression, emotion dysregulation was associated with suicidal ideation.

Yet, existing body of shown results that seem inconsistent research (Rajappa et al. 2012; Anestis et al. 2011) appears very useful to generate a new insight. Recently, the relationships between emotion dysregulation, internalizing symptoms, non-suicidal self-injury, and suicide were examined (Kranzler et al. 2016), evidencing a significant indirect effect of emotion dysregulation on suicide attempts via non-suicidal self-injury. Also, these studies highlight that the identification of emotional reactivity serves as an indicator of adolescent suicide risk (Davis et al. 2014; Nock et al. 2008). Existing research on suicide in LGBT people also suggests that the existence of an emotional vulnerability due to existing stigma increases negative emotions that put sexual minorities at a higher risk for suicidality (Skerrett et al. 2015).

Thus, emotionally dysregulated individuals are disposed to experiences of thwarted belongingness, hopelessness, and other variables that increase the likelihood of thinking about suicide. Together, they typically appear to have a negative urgency to immediately escape from aversive affective feelings that make these individuals vulnerable to suicidal thoughts and behaviors.

As Law and colleagues (Law et al. 2015) affirm (see Fig. 8.1), the *path from suicidal ideation to suicide* may be traced by the way people try to regulate their negative emotions. Even though several studies highlight the relationship status as

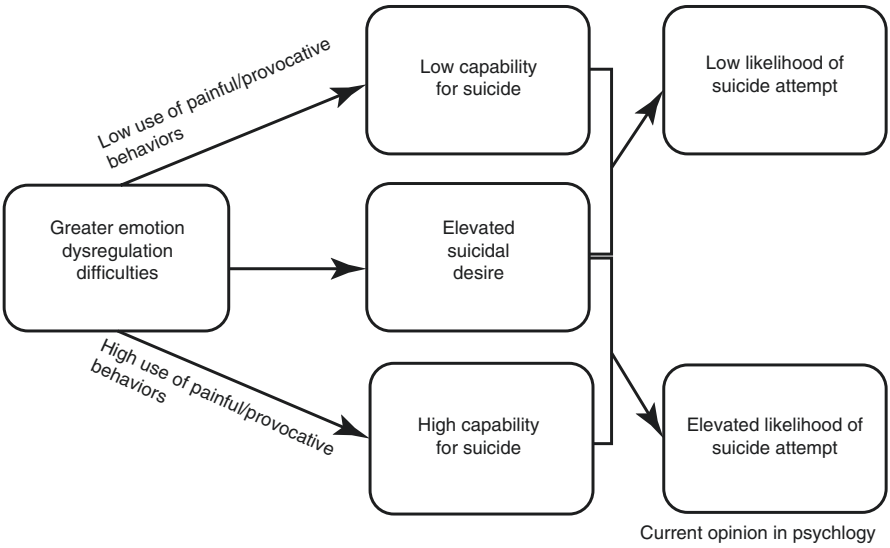


**Fig. 8.1** Model of the relationship between emotion dysregulation and suicidality proposed by Law, Khazem, Anestis, 2015

a risk factor, in this context we want to underline the role of the intimate partner relationships as both a risk and protective factor, considering the interplay of emotion regulation between partners.

A bidirectional effect may act, where losses and breakup of the relationships could be considered as precipitating factors to suicide (Houston et al. 2001; Kazan et al. 2016; Sandberg-Thoma and Kamp Dush 2014); on the other side, the ability of partners to regulate their negative emotions could act in a different way. Specifically, protective factors may have effects on risky behaviors, or they may moderate the effects of risk factors.

## Conclusions

This chapter considers the role of emotional regulatory processes in suicidality. Specifically, the couple relationships are discussed as a possible trigger of risk or resilience by the emotion dysregulation processes that occur in partners managing the negative emotions that characterize the life span. Understanding the mechanisms underlying these processes is critical for advancing in suicide prevention. Nevertheless, this thought appears to be only illusorily simple. The processes related to manage adversity imply that partners may experience that in divergent ways in different moments and investigation requires multilevel measures sensitive to the different facets.

In fact, emotions have immediate physiological effects, such as increased sympathetic activity, which may have relevant effects on behavior (Berking et al. 2008). In turn, the way in which people regulate their emotions is predictive of both physiological effects and behaviors (Gross 1998). However, the pathways

connecting dysfunctional close relationships, emotion dysregulation, and suicide outcomes are poorly understood. A better knowledge of these emotion regulation processes would be a valuable tool to select psychological interventions that specifically target emotion regulation processes that have the potential to inform clinical interventions for both physiological and behavioral pathways.

Finally, from a clinical point of view, these considerations point the light on the possibility to intercept a risk people cluster who may not show up a typical suicide risk profile. Given that emotion dysregulation could play a key role in suicidality, it may be a target for treatment to reduce suicide.

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# Traumatic Subjective Experiences Invite Suicide

9

John T. Maltsberger†, Mark J. Goldblatt, Elsa Ronningstam, Igor Weinberg, and Mark Schechter

What pernicious qualities must an experience have to engender post-traumatic stress disorders (PTSD) and other dissociated states? While ordinarily one thinks of traumatic experiences as arising from patients' outer worlds—wars, accidents, fires, and floods—the essence of traumatic experience is not overwhelming sensory stimulation itself but, rather, the failure of the mind to master the mental events the outer world gives rise to and to the emotional commotion they arouse. Mental trauma can only happen to conscious patients. An anesthetized patient cannot be psychically traumatized. We suggest that trauma further requires a crushing affective (subjective) experience that accompanies the causative insult, while the patient is helpless to escape it.

The thrust of the argument to be presented here is this: that the experiences giving rise to posttraumatic pathology are primarily mental. Assuredly the harmful

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mental experiences that concern us here may be triggered by exterior events, but what happens within the mind is what does harm.

We shall further argue that traumatizing experiences sometimes arise from within the mind, and not from shocking events in the outer world only. The sudden irruption of a terrifying psychotic state, for instance, can traumatize by its overwhelming, unmasterable emotional force. Many of the intolerable affective floods that drive patients to attempt suicide in order to escape them constitute traumata as well. Bear in mind that the person who survives a suicide attempt has escaped attempted murder.

A violent event will traumatize some but not others. The capacity to endure overwhelming suffering without sustaining traumatic injury must be determined by genetic and probably by developmental factors, but detailed understanding of this fact has not been worked out. For the most part, the contemporary literature on suicide risk assessment attends to exterior events and presumes that the experience of childhood abuse, for instance, will be the same for everyone, neglecting an important clinical fact: what induces trauma is overstimulation beyond the capacity of one's endurance, and endurance capacity varies. Only an investigation of the subjective consequences of an overwhelming event can enable the clinician to gauge how injurious it has been or may be.

## 9.1 Method

What we present here is a theoretical essay based on the authors' extensive clinical work with suicide patients (taken together, more than 150 years). We have studied and treated many psychiatric inpatients and outpatients among whom many serious suicide attempts took place and some suicides as well. We have also studied the literature. In an effort to synthesize what little is known about suicidal subjective experiences with contemporary understanding of traumatic experiences, psychosis, repetition compulsion, and suicidal breakup, we have cast a wide net and produced a discursive article.

Good empirical studies of the subjective states in suicide are very scarce. Perforce, we have relied on inference and inductive reasoning to support our argument. Our assertions appear probable to us, but not apodictic.

## 9.2 Inferences

Clinically, traumatic states, when the maximum capacity of the ego is exceeded and the mind is deluged with unmanageable feeling, have several grave consequences. Regression can occur when self-organization gives way and the mind breaks up (Baumeister 1990; Maltsberger 2004).

1. Not exterior events only but inner subjective experiences also can prove too much to endure and give rise to psychic trauma. Such traumata can call the repetition compulsion into play. Lasting mental injury can result from these

states, leading to acute and to post-traumatic state disorder (PTSD). This assertion is supported by the psychopathological literature since before the First World War, although it attends primarily to externally provoked psychic trauma.

2. Traumatization of this kind can compromise patients' capacity to tolerate future crises of mental pain. The suicide literature shows repeated suicide attempts increase the probability of ultimate death by suicide (Kerkhof 2000). Attempting suicide may become fixed as a learned pattern; after self-harm mental pain usually diminishes, so that self-destructive action can become established (in behaviorist terms) as a contingent response (Michel 2011). Van Orden et al. (2008, 2010) propose that suicide practice, repeatedly attempting but failing, lowers the inhibitory threshold for future suicidal behavior because patients become less afraid of it and grow inured to the pain of it. Their theory, reckoning on the effects of conditioning and exposure to suffering, does not refer to the inner, subjective experiences of patients and to their object and self-attachments.
3. Trauma is cumulative and as it builds up renders patients more vulnerable to further crises. Flashbacks of intolerable affects initially associated to traumatic moments may, when repeated across time, erode the capacity to keep up hope in the face of adversity and weaken the capacity to make and to maintain strong attachments to others. Consistent with this proposition is Maris's (1981) proposed pattern of the "suicidal career." He infers, as do we, from our clinical experience, that repeated painful experiences lead to increasing unhappiness and depression, implying that holding on to hope, as well as to attachments to others that have a life-preservative effect, becomes increasingly difficult.

Detailed serial investigation of the affective experiences of a significant sample of patients abused in childhood has never been done, and we have no nomothetic studies about the matter. The subjective experiences of suicidal PTSD patients have not been well studied. Panagioti et al. (2009) have reviewed this literature and remark that feelings of entrapment, defeat, and hopelessness so intimately associated with death by suicide have been egregiously underinvestigated. Careful study of the subjective experiences of suicidal patients is also work that is just now commencing (Hendin et al. 2007).

## 9.3 The Evolution of Psychoanalytic Thought Respecting Affective Traumatization

Freud described "signal anxiety" as a helpful adaptive device through which the self receives an alerting subjective warning that a situation of potential danger (energy overload) is arising, enabling it to take protective measures. Should protective measures prove ineffective, the signal would not go away but increase in intensity. Signal anxiety of rising intensity may be experienced in the midrange

of subjective experience—as fear, perhaps, but rising toward panic if self-protective action fails. Anxiety of this kind may signal perceived dangers from without, frights of the sort that waking up from a deep sleep and discovering fire in the room might prompt. But anxiety of the same intensity may be aroused by dangers from within, as in the dread accompanying the sudden efflorescence of psychosis.

Beyond signal anxiety, Freud described *traumatic anxiety*. He proposed that some states of psychic excitement were greater than the mental apparatus could master. A traumatic situation, said he, is one where affective excitation exceeds the mind's capacity to master it. This overexcitation he called "traumatic anxiety." In states of traumatic anxiety, the psychic apparatus will be damaged unless relief comes to hand (Freud 1926).

Freud's word was *angst*, a term of perhaps more general meaning in German than the usual English translation to *anxiety* implies. For purposes of this essay, we are expanding the original Freudian meaning of "angst" somewhat to encompass a variety of painful emotional experiences too intense to endure. Any painful emotions experienced in such extremes as we address here become experiences of *anguish*.

In the study of suicide, the borderland between intense signal anxiety and traumatic anxiety especially concerns us. Intense fright, terror, or even panic to the extent that the self can take measures to escape danger need not be traumatic if the danger can be mastered. What engage us are those states of intense painful arousal when no escape is possible—states of desperation when the self is helplessly trapped.

The affect that immediately augurs passing over the line from the endurable to the intolerable is desperate anguish. Once over the line and into traumatic flooding, patients report feelings of horror, or *annihilation anxiety*, the agony of the self breaking into pieces. Annihilation anxiety is the affect of the disintegrating self (Hurvich 1989; Winnicott 1974). This affect has been discussed more as a theoretical construct in the professional literature than it has been described as a phenomenon, but it is subjectively gruesome, something to be endured passively and helplessly if at all.

> Standing in front of the elevators at her hospital, a 35-year-old highly qualified surgeon was seized with terror as she felt the core of her thorax turn to shattering, shaking ice. She felt she was disintegrating and dying. She fell down onto the floor before a crowd of colleagues and patients. Should such a thing ever recur, said she, she would kill herself on the spot to avoid it.

Patients that survive annihilation anxiety describe it as horrible—beyond unbearable. Reflect that *The Oxford English Dictionary* defines "horror" as "a painful emotion compounded of loathing and fear; a shuddering with terror and repugnance; strong aversion mingled with dread."

Koukopolous and Koukopolous (1999) have drawn attention to agitated, anguished suffering in a variety of different types of Kraepelinian "mixed states" well known frequently to end in suicide.

## 9.4 The Capacity, or Lack of It, to Bear Intense Affect

How the brain functions to organize the continuous afferent flood of sensory data pouring inward, allowing some to come to attention, relegating others to the periphery of awareness, is an old neurophysiologic question. How affects are regulated is a parallel question. How is it that affects are damped down, amplified, or otherwise regulated in the course of conscious experience?

This question of affect regulation bears immediately on traumatic, desperate emotional situations. This problem concerned Freud who invented the term "stimulus barrier" and referred also to a "protective shield" (Freud 1916–1917; 1920). With these metaphorical descriptions, he imagined a mental "structure" like a skin or filtering membrane, denoting dependable neural operations too complex to be understood in the light of the neurophysiology of the day (or today).

More recent theorists, influenced by the work of Bion (1967), speak of a mental "container" that protects the self from affective flooding. The "flashback" experience is ascribed to deficient container function. Breakdown of the container leads to automatic, traumatic anxiety. Garland, elaborating the containment metaphor, helpfully directs attention to child development (Garland 1998, p. 110). Most theorists today would agree that the capacity to regulate affect is not only genetic but is to a considerable extent learned and that it is contingent on the mother's having sufficient ability to tolerate and manage her infant's anxiety as well as her own. Satisfactory developmental experiences leading to internalization of soothing, self-regulating functions have been brilliantly discussed by Tolpin (1971). Furthermore, more recent epigenetic studies are consistent with the view that phenotypic expression capacity for affect regulation is influenced by childhood trauma (Brent and Melhem 2008; Carballo et al. 2008; Currier and Mann 2008).

The classic papers of Elizabeth Zetzel on the mastery of anxiety and depression rely less on structural analogies and go straight to the developmental questions. The capacities to bear and regulate anxiety and depression she sees as lifelon and developmental processes, subject to challenges, regressive dangers and the possibilities of reworking and mastery across the life cycle. Her discussion of the ability to tolerate helplessness, the importance of accepting one's limitations, the capacity for good reality testing, and the acceptance that suffering is inevitable and, when beyond remedy, must be passively endured bears immediately on our understanding of the desperate affect states that drive suicide (Zetzel 1949, 1965).

As we have seen, much discussion concerning the ability to endure intense affective suffering without mental breakdown has rested on physical metaphors such as protective barriers, shields, and containers. Traumatic events have been said to occur when these devices are pierced, breached, or broken down as armor or dams might be. Contemporary students of trauma, acknowledging that the mind may be damaged by too much pain endured too long in conditions of entrapment, are more likely to explain the capacity to endure suffering without permanent mental damage as the consequence of identification with good objects (models of endurance, resilience, and loving constancy) over the course of development, from early childhood onward, supported by the necessary constitutional (genetic) capacities.

## 9.5 Affective Traumatization and "Mental Deconstruction"

We now struggle with a staggering mass of literature concerning the mental effects of trauma. The usual traumatic sequelae afflicting the susceptible include hyperarousal, disturbed information processing, affective disturbances including anxiety and depression, disturbances of consciousness including dissociation, "flashbacks," nightmares, and other sleep disturbances (van der Kolk and Saporta 1991). More recently we have papers linking PTSD and suicidal behavior (Panagioti et al. 2009; Sher 2008). Further studies have shown that traumatic abuse in childhood, both sexual and physical, is associated with increased suicidality in adulthood (Carballo et al. 2008; Horesh et al. 2009).

Little is understood about trauma vulnerability, though there is evidence that childhood traumatization predisposes to retraumatization in adulthood when injurious circumstances arise.

Most patients improve substantially after attempting suicide; depressive symptoms seem to melt away, at least for a while. Why this is the case we do not know. However, in the hours and days that *precede* a suicide attempt, many patients exhibit symptoms like those in stress disorders. In attempted suicide, the symptoms gradually appear and crescendo over days or weeks but commonly end abruptly following a failed attempt.

This suggests that to the extent a suicide crisis is traumatic, mental injury does not so much arise from the climactic physical injury at the denouement of a suicide episode (an attempt) but rather from the accumulating helpless suffering with which patients are trapped beforehand, suffering which crescendos until it can be endured no longer. Before they attempt to kill themselves to escape it, they may be fairly compared to trench-bound soldiers under fire, in mounting danger of death, breaking away when they can endure it no more. In the First World War, panicking soldiers under bombardment, caught in trenches, would, from time to time, jump into the line of fire and try to run away. Attempted suicide may be compared to deadly flights of this kind (Hendin et al. 2007).

Baumeister's description of "mental deconstruction" in suicidal crises suggests some though not all of the disrupted thinking encountered in stress disorders, viz., a constriction and narrowing of time perspective, concrete "tunnel vision" thinking, and disturbance in action planning so that proximal rather than distal goals are likely to govern decisions (Baumeister 1990). Executive functions are compromised in deconstructed states. Similarly, Maltsberger's (2004) description of self-breakup and ego regression in suicidal states, emphasizing affective more than cognitive phenomena, has much in common with stress experiences resulting in traumatic disorders.

"Deconstructed" states of consciousness were anticipated by Breuer and Freud, who referred to "hypnoid states." They proposed that in such states, the ordinary processes of psychic mastery could not take place, in part because affect and memory were split apart. They presumed that memory of painful hypnoid state experiences was repressed, forming the roots of future mental symptoms when repressed memories threatened to break through into consciousness. They specifically wrote

that, among other causes, hypnoid states could be brought on by emotional shock, including fear (Breuer & Freud, 1893–1895, see especially p. 215). The implications for child development of traumatically induced affect states continue to be of psychoanalytic interest (Tuch 1999). Freud never lost his interest in mental trauma, ultimately taking the view that when the mind is overwhelmed by affects breaking through mental structures inadequate for their regulation, annihilation experiences resulted. He compared these annihilation moments to childhood experiences of maternal abandonment, leading to the lasting mental injuries that underlie the "repetition compulsion" (Hurvich 2003).

## 9.6 Traumatic Affects of Suicidal Crises

The emotional experiences of most true suicide crises are so painful they often defy description. Those moments just before suicidal action, and the moments immediately afterward, should a patient survive a deadly attempt, have not been well studied. They can be distinguished clinically, *but only by reference to what patients experience subjectively*. The principle subjective phenomena that concern us here are affective, and they cannot always be recognized by observation of patients' general appearance and behavior. We must rely on what patients tell us about their inner selves, the selves we cannot see but only hear about secondhand. While we wait for empirical studies of the moments immediately preceding deadly suicide attempts, we must be content with clinical descriptions that point the way for further research.

Jaspers was daunted by the challenge of studying and classifying feelings scientifically (1963). Nevertheless, it is a task not to be shirked, given the fact that subjective affect states—feelings—are now well known to underlie most suicidal behavior. When subjective distress rises to the intolerable level, when patients grow desperate for relief because they can no longer endure what they suffer, certain feelings are commonly implicated: *hopelessness*, *anxiety*, *feeling abandoned*, *loneliness*, *self-hatred*, *and rage* (Hendin et al. 2007). These feelings mark the moments just before crossover into the zone of suicidal action. Because detailed *affective* examination of patients at risk for suicide is so often neglected, it is worthwhile to consider what these terms mean clinically.

### 9.6.1 Desperation, Hopelessness, and Despair

Although *desperation* sometimes has denoted the abandonment of hope, it more commonly refers to "a state of mind in which, on account of the [comparative] hopelessness or extremely small chance of success, one is ready to do any violent or extravagant action, regardless of risks or consequences" (Oxford English Dictionary 1989). *Desperation* is clearly closely related to *hopelessness* and even more closely to *despair* (Bürgy 2008). Etymologically desperation comes down to us from the Latin *desperare*, which in fact means the surrendering of hope. In contemporary

clinical use, and explicitly in this essay, *desperation* refers to that feeling state that *stops just short* of total despair. A desperate person has not completely given up on himself, but has almost done so, and, like someone drowning, is ready to try anything to get away—he is at the brink.

In the strictest sense, *despair* (total and complete *hopelessness)* is not a pure affect. If it is an affect, it is a complex one, because implicit in the term is a judgment that one forms about the circumstances in which one finds oneself. A despairing patient concludes that the present situation is intolerable and that there is no way in this world out of it. Despairing patients are ready to try anything, including magic escapes. Intolerable affect states disturb cognitive abilities—these patients cannot "think straight." Many suicide attempts are no more than magical gesticulations rooted in delusive fantasy that in dying one can be carried away to a better place (Maltsberger 2004). The affect in despair is therefore total *helplessness*. The second conclusion is cognitive: if one judges there is no escape and decides to hope no more, desperation becomes *despair*.

Recent cognitive theorists have redirected attention to the importance of inescapable entrapment (a cognitive judgment) in the face of intolerable emotional arousal (an affect state), essentially concurring with Freud on the matter of giving up on oneself when trapped in excruciating and inescapable pain (Williams et al. 2005). Edward Bibring (1953) elaborated this theme, placing the despair that arises from helplessness in the face of affective torment at the heart of depressive states.

A moment's reflection reminds us that many patients helplessly suffer *moderately* painful subjective states for long periods of time and that they may feel to some degree hopeless about getting better. Yet most of them do not become suicidal; most of them do not despair.

> A 42-year-old teacher, the father of four children, was married to a discontented wife. He was moderately depressed and quite hopeless about the future of his marriage. He confided to a friend that it was only a matter of time—a few months, a year or so—before his wife decided to break up their home and divorce him. He sadly carried on however and was never suicidal, even when his prophecy proved correct.

In this example, the teacher felt hopeless about any possibility to alter the course of his marriage, but that circumstance alone did not throw him into affective turmoil.

Many discouraged patients score well into the hopeless range on the Beck Hopelessness Scale (Beck et al. 1974). Ordinarily they can bear some level of depressive suffering without giving up on themselves. The inference is that hopelessness just short of despair is an insufficient cause for suicide, a supposition that would account for the fact that hopelessness is a better long-term predictor of suicide than a short-term one (Fawcett et al. 1987). Patients can tolerate feeling hopeless for a long time. An argument may be made that when hopelessness rises to the level of despair, it may then prove a necessary but probably insufficient cause for suicide. Something else is needed—anguish or intolerable mental pain—which will then push the hopeless patient over the threshold.

### 9.6.2 Anxiety

In milder forms, we understand "feeling anxious" to mean feeling uneasy, apprehensive, and distressed. The word *anxiety* is used to describe inner states and is sometimes contrasted with *fear*, which usually connotes some real or specific peril, perceived as arising from the outer world and not from within the self. This distinction is not always made, however, and the definition of *fear* is often extended to encompass a wider range of meaning. We see patients who are uneasy, others who are afraid of what is happening to them, and others who move along the continuum further and experience terror and panic. When patients are overcome by terror and can bear it no longer, they may despair. When despair is coupled to overwhelming terror, the self begins to break apart. In such a calamity, the patient experiences annihilation anxiety, a feeling akin to horror.

Panic denotes an overwhelming fright, or terror, most typically a feeling that appears suddenly. It differs slightly from terror because panic is often (but not always) accompanied by frantic efforts to escape from danger, so that the word connotes urgent preparation for action (the motor apparatus is becoming engaged, like the cocking of a pistol). Sometimes panic is directly synonymous with terror because patients may become "paralyzed" with fright and prove incapable of any action at all.

Some of Edgar Allen Poe's (1944) stories portray annihilation anxiety. In "The Pit and the Pendulum," a helpless man is trapped between four contracting red-hot walls that edge him inexorably into a pit filled with rats. In "The Descent into the Maelstrom," another is swallowed up by a giant whirlpool. Another is walled up alive ("The Cask of Amontillado").

The inner experience of many patients about to commit suicide belongs to anxious suffering of this level, even though the danger arises from within, and it is in the mind, but sometimes in the body also, that one burns with pain and writhes with agitation.

> The wife of a 38-year-old lawyer abruptly left him and took their children with her. The lawyer felt overwhelmed; he could not sleep and found himself so agitated that at dawn he ran outside in his nightclothes, circling around and around the house in the dew, weeping and wringing his hands. The next night he dreamed of a dog trapped in a house on fire. The howling dog, covered with flames, escaped and plunged into a lake.

### 9.6.3 Feeling Abandoned and Loneliness

To feel abandoned is to feel deserted, forsaken by others. *Loneliness* as an affect stops somewhere short of feeling forsaken. It does not imply permanent solitude but rather a temporary state likely to be remedied in time. *To feel abandoned* is more nearly synonymous with *aloneness* or *desolation*. Aloneness implies total isolation from and loss of all others. It connotes a sense that the experience is forever and that it is eternal and timeless. Intense, painful *aloneness* is a feeling of inner emptiness accompanied by increasing panic; patients subject to it may, over time, develop a concomitant hopelessness that tends toward despair. Though its appearance in

borderline patients has received particular attention, this affect plagues other patients as well—those who have not developed ego capacities for object constancy and who have not mastered the challenges of separation adequately (Adler and Buie 1979).

Of course it comes as no surprise that patients' subjective sense of being connected to others is protective against suicide. Clinicians are well accustomed to asking patients whom they have that love them and whom they love. Engagement with others is a known anti-suicidal force in clinical work. By the same token, we recognize statements such as "Yes, my family loves me, and I love them, but they would be better off without me," as ominous. A patient who says that tells us that in his mind he is estranged from their love. Under the influence of depressive affect, those vulnerable to suicide tend not to feel the caring of sustaining relationships and to let go of them. Inability to feel and hold on to loving exterior supports devastates and desolates such patients. It is obvious, therefore, that when potentially suicidal patients' capacity to hold on to exterior sustaining relationships is compromised—when their capacity for maintaining attachments fails—they will feel more alone and their peril will increase, as they move from the experience of *loneliness* into *aloneness*.

*Aloneness* has a deeper meaning than feeling bereft of relationships in the outer world. (Surrounding many patients feeling "alone" in this way may be many loving family and friends, but subjectively, the patients cannot feel their care and cannot make use of it.) The desolation of *aloneness* implies failure of inner resources (positive introjects or "internal objects") that ordinarily sustain a positive affective attitude toward oneself. In other words, positive introjects (internalized good relationships from the past) are essential for maintaining good narcissistic balance. When these are deficient, as so often they are in suicide-vulnerable patients, current external relationships must be relied on for keeping up a positive self-attitude. Dependency of this order chains patients to supportive others if they are to escape abandonment, aloneness crises.[1] But it is not only outer relationships that may be lost or abandoned. Good inner objects may be lost or broken up as well.

In the ego-regressive processes of suicidal breakdown, the mental representations of vital sustaining inner objects may be blocked off or destroyed, an event that effectively casts the self away into desolation.

Small children must depend on their mothers to protect them from external dangers but also to protect them from inner dangers aroused by being left alone and helpless. Before a child develops capacity for object constancy, separation from the mother may give rise to signs of overwhelming helplessness and ego disorganization (Adler and Buie 1979). Without object and self-constancy, abandonment feelings cannot be managed in the absence of a soothing external sustaining object. Separation anxiety can overwhelm a child who has not yet developed internalizations to master it (Hurvich 1989). Later in life, during suicide crises, when soothing internal introjects are unreachable or destroyed, experiences of aloneness repeat early separation terrors.

[1] Emotionally dependent patients of this kind have sometimes been called "love addicts," because loss of sustaining outside supports can throw them into agitated depressions that superficially resemble withdrawal states.

### 9.6.4 Worthlessness, Self-Hate, and Guilt

Self-hatred should be distinguished from low self-esteem. There is a difference between feeling one is paltry, inconsequential, or even a worthless person and hating oneself.

To feel worthless is to feel inferior to some standard of comparison and to be of no value. A worthless person is unimportant, but not necessarily contemptible. Feeling worthless is closer to feeling ashamed, beneath notice, than it is to feeling guilty.

Regrettably contemporary nosology conflates feelings of worthlessness with guilt (*DSM-IV-TR*, 2000, see criterion A7; Van Orden et al. 2010). Feeling worthless need not mean one feels culpable. Guilt implies self-blame, and often enough, it connotes some more or less specific failure that merits condemnation. To be guilty is to be bad; to be worthless is to be not good ("no-good").

A worthless person, responding to the judgment of others, might feel the withdrawal of their love or regard. But while others might turn away from a "worthless" person, it does not follow that they necessarily would hate him or wish to punish him; they might simply lose interest and care for him no more.

Guilty, culpable persons invite the ire of others—in the first place, they invite punishment. Guilt calls aggression into play, and the aggression aroused often has a sadistic color. Guilty persons can become the object of others' malice—others may want to cause the guilty to suffer, mentally and physically. Society makes the guilty objects of aversion as well. Being "sent away" or banishment to a remote prison high in the mountains of Colorado is the fate of many major criminals.

Malice and aversion, the two subtypes of hate, are often directed at someone from without. But they may also be turned against the self from within. A person feeling guilty is hostile toward himself, and, if the guilt is sufficiently intense, he may become the object of self-aversion and malicious self-attack. Self-aversion can force suicide. Sometimes self-directed malice drives physical mutilation.

Worthlessness, therefore, implies the risk of withdrawal and abandonment by others and the possibility of loneliness and aloneness. If the risk of being cast away as worthless is great enough, fear must be aroused. But if the feeling is guilt, punishment and retribution are implied, and one will fear what is to come.

Clinically, subjective worthlessness is often implied when patients no longer bother to look after themselves, to protect themselves from heat or cold, to bathe, to eat, or to drink. Such a state of affairs is common enough in retarded depressions. Such patients lack the inner resources to care about themselves—their positive introjects, to the extent that they are present, seem out of reach or paralyzed.

Profoundly guilty patients, on the other hand, may feel they deserve severe punishments and even beg for them. Such is sometimes the case in melancholia. If the hostility against themselves is projected outward, delusions of (seemingly deserved) persecution may appear, accompanied by subjective states of terror and panic.

### 9.6.5 Rage

Rage turned out against others can also drive suicide, in contrast to rage turned against the self. Here we do not refer to repressed rage but to rage consciously experienced. Rage at others, or at outward circumstances, often bespeaks righteous indignation. When enraged patients commit suicide, it would appear that sometimes they aim to destroy an inner object, represented by some object representation that exists in the mind. Others may aim to destroy themselves in the perception that in doing so, they will kill the most precious possession of the person at whom the rage is directed. These are so-called spite suicides (Menninger 1933; Zilboorg 1936).

> Phyllis, a 19-year-old university student, was unfairly reproached by her mother for a low examination grade. Phyllis grew enraged, paused long enough to leave a message for her mother she was going to rejoin her dead, always kinder grandmother, boarded a bus, and within 15 minutes had swallowed a drug overdose.

These patients' suicidal actions are almost always impulsive and differ from the classical suicides of melancholia (Freud 1915a) in that the rage turned against the self is not subjectively experienced as depression but as fury directed outward. Rage suicides like these remind us of patients who, exploding in anger, leap from a chair and rush out of the room slamming the door behind them.

## 9.7 Repetition Compulsion

The result of traumatic affective experiences is mental injury with perduring memories of the event, not sensory only, but affective ones also. When such memories are laid down in deconstructed states, however, they are typically ill organized, fragmentary, and unintegrated. They are formed when the ordinary defensive operations of the ego are impaired and their repression is at best partial and incomplete. Repressed traumatic memories tend to break through into awareness, sometimes with full intensity so that the injurious event seems to be happening all over again (Garland 1998). They reassert themselves in dreams; they drive acting out and do so repeatedly. Freud remarked that "... a thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been solved and spell broken" (1915b, p. 146).

Much of what Phyllis Greenacre wrote about traumatization in childhood also applies to adult traumatization. She argues, following Freud, that in severe trauma, the ordinary adult defensive system is knocked out of action, sometimes permanently, sometimes temporarily, so that regression to a more nearly primitive "biological" defense state occurs. Traumatic affect deluge is experienced as life-threatening and has the quality of an attack coming from without. It disrupts and disorganizes perceptual processing and the formation of normal memory. The mind must accommodate to the state of shock and to subjective defenselessness, and a new balance must be struck, in which pain and suffering come to be expected as

the usual color of living. In time there may be recovery to the pre-traumatic operation of the ego defenses, but the traumatic patterning at the deeply primitive level—the "biological level"—is not obliterated and may be aroused again throughout life. Freud called the force of the repetition compulsion "demonic." Greenacre (1967) wrote,

> Put in other words, *the demon of masochism may sleep but is not slain*. In addition, the recovery in such states is only maintained at the expense of a particularly tenacious and primitive defensive denial and the utilization of an increase in primitive narcissism, both of which have deep biological roots, (p. 151)

The idea of "biological" or body memory of trauma would appear to be more than a metaphor. Van der Kolk (1994) remarks that "the body keeps the score" after trauma (p. 253). The failure of declarative memory in PTSD may lead to organization at the somatosensory level outside the hippocampally mediated memory system. PTSD patients are unable to integrate their traumatic experiences and tend instead "to continuously relieve [sic] the past—a phenomenon mirrored physiologically and hormonally in the misinterpretation of innocuous stimuli as potential threats." Further, traumatization, especially in childhood, has lasting epigenetic effects.

Before her psychoanalytic training, during extensive inpatient psychiatric work, Greenacre (1967) had the opportunity to study many psychotic and other deeply disturbed patients (Harley and Weil 1990). She encountered several whose acute profound regressions were marked by florid primitive projections and dissociations triggered by what appeared to be insignificant stimuli that harked back to and connected with early life traumata.

She anticipated, therefore, recent studies suggesting childhood trauma predisposes to the development of PTSD when adult retraumatization occurs (Sher 2008). Furthermore, recent reports show that abuse in childhood increases the likelihood of attempted suicide in PTSD patients (Krysinska and Lester 2010).

## 9.8 Childhood Abuse, Repetition Compulsion, and Later Suicide

Childhood abuse is associated with suicide attempts in bipolar adults (McIntyre et al. 2008). More generally, childhood physical and sexual abuses are strong risk factors for the onset and persistence of suicidal behavior, during adolescence especially (Bruffaerts et al. 2010). Further, we know that the prevalence of PTSD in bipolar patients (16.0%) is double that in the general population. Both PTSD and bipolar patients report greater trauma exposure (Otto et al. 2004). In borderline personality disorder where one patient in every ten commits suicide, 81% of the patients report abuse (physical abuse, 71%; sexual abuse, 68%; Herman et al. 1989). This accumulation of statistical evidence inevitably raises a question: to what extent may the terrible experiences of suicidal affect in adulthood repeat earlier traumatic experiences inflicted in childhood?

## 9.9 Conclusion

The following case describes the death of a patient who hanged himself while in twice-a-week psychotherapy. We offer it here because it illustrates points discussed in the foregoing remarks.

### 9.9.1 An Illustrative Case: Peter F[2]

After five attempts to kill himself, most of them serious, Peter F., a 37-year-old married man, came into treatment with a diagnosis of bipolar disorder. His attempts occurred in mixed states of desperate subjective anguish. He was seen in psychotherapy and treated psychopharmacologically for just over 2 years before once again he attempted suicide, this time, successfully. During the period of treatment, there had been no further suicidal action, but there were episodes of intense subjective suffering that were almost intolerable.

There had been multiple suicides in his immediate family. Further, between the ages of 9 and 11, Peter endured his father's raging, brutal beatings. He and his slightly older brother were screamed at, humiliated, and beaten with a belt to the point of bruising. The father would sometimes excruciatingly twist the boys' arms. Sometimes he would choke them. Once he held Peter by the shoulder out over the banister of the staircase. Once he made the boys pull down their pants and whipped them in a public parking lot. They whispered to each other that maybe he would someday miscalculate, go too far, and kill them. Anything that made the father feel the boys were being "silly" or "girlish" was likely to set off one of his rages. Anything he felt had a homosexual color threw him out of control. "Faggot" was a terrible epithet in this family.

Peter began to be depressed in high school. He managed to do well academically and athletically but was tormented by feelings of shame in the locker room and sensitive to the sometimes humiliating criticism of the basketball coach. He went to extraordinary lengths not to let the other boys see him naked, sedulously avoiding group showers. Perfectionistic and anxious, his social life was stunted; he had few if any real friends. He said he always felt as though he were on stage, an actor trying to look good to others, afraid that with one misstep he would disgrace himself and invite their mockery. He was a miserable adolescent, deeply ashamed of his body, profoundly guilty about sexual feelings.

By the time he was 18, Peter had made his first experiments with carbon monoxide asphyxiation. Depressed as a college student, he dropped out and went to live abroad. He began to have episodes of depressive excitement, drank heavily, and threw himself into the gay scene. When 25, he took a massive overdose of acetaminophen in his second suicide attempt and recovered without medical attention, feeling sorry he had not died. Returning to the United States, he completed his college studies and married, setting his homosexual life aside. He was able to work

[2] Names have been changed, and personal clinical material in this article has been disguised.

in a sustained way but continued to drink too much and to get into excited, rageful suicide states.

He made two more serious attempts in his 30s. Describing one of these attempts, he said he had been sleeping badly for some time and staying up late. "I was really jazzed up about it, feeling very indignant. What right did other people have to tell me I had to live on? It was my life," he said. He had been to a strip club and was drunk, driving recklessly, feeling very angry and very excited. "I was really pumping myself up. I felt very focused, very hyper. I was laughing in this crazy way. I rigged up the hose to the car and kept telling myself to breathe deeper, breathe deeper." He was rescued by narrow chance.

These states of agitated depressive excitement would crescendo into rages turned against himself—so intense would be his self-loathing that he would hit himself, curse himself—he said he was "rancid, fucked-up, toxic, nasty, disgusting, a pathogen," that he looked like a monster. During intense rages, he wanted to demolish everything in reach. He shouted, smashed furniture, threw the computer across the room, cursed himself, and hit himself. He terrified his dogs. He said on these occasions he was like Mr. Hyde on a destructive rampage.

He would race around dangerously in his car in states of desperation and anguish that drove him to attempt suicide as an escape. At other times, he described feelings of frozen emptiness, desolation, and loneliness. There were spells of uncontrollable crying. He often slept badly and reported dreams the content of which he could not recall, but in which vivid painful affects of shame and humiliation repeated themselves. "I don't know what it is to have a pleasant dream," he said.

Before hanging himself, Peter wrote a note describing feelings of sad, empty desolate dread continuous "every second of each day." He wrote of dread felt in the pit of his stomach, worried thoughts, bad memories, repetitive bad thoughts of self-accusation, and loathing.

In the course of the psychotherapy, the patient described the beatings and humiliations of his childhood. He said, "I was terrified of my father, so terrified I had to surrender all spontaneous expression, every liberty, every choice, to him. He was a tyrant, a dictator of a father." He wondered what kind of a person could so mistreat a child. Intense affect was recovered along with memories, and the patient seemed to make good progress, with appropriate abreaction, tearful and angry, without signs of dissociation, as he worked over this material.

He said that his father was a Jekyll-Hyde, outwardly an admired and respectable member of a professional community but at home an explosive and terrifying monster. Peter called himself a Jekyll-Hyde, referring to the raging suicidal states as Mr. Hyde out of control. There were several occasions in his later 20s when Peter, in an excited, agitated state, dangerously provoked the police—he was lucky not to have been clubbed. These occasions had the quality of repetitions of the shouting and beating scenes from childhood. Many of his dreams had flashback qualities that repeated the affects of rage, entrappedness, self-loathing, and shame that he had experienced over and over during the childhood beatings.

Toward the end of his life, Peter told his doctor that he did not want his wife or his friends to care too much for him; he did not think he could survive another

full-blown suicidal episode and did not want to be held back from suicide if his illness recurred. He did not want to care anymore.[3] Profoundly discouraged, but very attached to his psychotherapist (a psychoanalyst also trained in dialectical behavioral therapy), he relied on the treatment relationship to keep up hope. Basically, without the hopefulness and dedication of the therapist, Peter could not alone trust that any kind of sustained, reasonably stable recovery was possible.

When the therapist had to interrupt the treatment to undergo a major surgical procedure, telephone contact was maintained, so that the therapeutic relationship was not totally interrupted except for a period of about 12 days (there were no face-to-face meetings for a month). Just before regular face-to-face sessions were to resume, Peter secretly planned suicide over a period of several days, concealing his impending suicide from the therapist, even though they were speaking on the telephone twice weekly. He then hanged himself. In a note left behind, he made it plain he was exhausted, did not want to be impeded in his plan, and explained that what he was doing was self-euthanasia.

The genetic predisposition to suicide was very plain in Peter's case—there were many suicides in his family. Though he suffered from bipolar I disorder, living through many mixed-state experiences and attempting suicide repeatedly, the lasting and traumatic effects of childhood physical abuse stand out in the history. Peter described the floods of intolerable affect that marked his suicide crises as being just like those he remembered from childhood—terror, rage, abandonment, despair, and self-hatred. In dreams he experienced thinly disguised flashbacks of being beaten. His flashback experiences, and the reliving of intolerable affects, had the color of post-traumatic stress disorder. They repeated themselves over and over.

Each recurrence of the intolerably painful suicidal crises further discouraged him. Gradually he gave up hope that he could ever really escape his illness. He despaired of recovery. Aggressive psychopharmacology and assiduous twice-weekly psychotherapy were not enough. His experience with suffering was such so that he gradually surrendered hope. Furthermore, although he was lovingly attached to his wife and to his therapist, the quality and the intensity of his engagement with them was not enough to keep him alive. He explicitly said at the end that he wished others did not care and that he wished that he did not care for them, because caring made suicide more difficult. Falling into affective torment over and over had a cumulative discouraging effect so that in the end, he gave up hope. Repeated suicide crises led to his withdrawal from attachments to others as well, so that he repudiated anchors to hold him steady against the dark currents that slowly washed him away.

For the present, we are limited to idiographic material such as the case of Peter F. in order to understand the subjective experiences of suicidal patients. Study of patients such as he strongly suggests that repeated attacks of traumatizing intense affects, affects sufficiently devastating as to force suicide attempts, are themselves cumulative in effect and over time corrode two necessities for

[3] Conversely, another patient, recovering from a third suicide attempt, decided she was alienating her family with the attempts and that she had to stop trying to kill herself, because her behavior was weakening her love for them and theirs for her.

sustaining oneself and living a supportable life: the capacity for making and keeping loving attachments to others and the capacity to continue hoping in the face of recurrent adversity.

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# Dissociation and Therapeutic Alliance

# 10

Lisa Firestone

*The suicidal state of mind is the monstrous enemy of the suicidal patient, which cannot be fought alone. Therapists can unite with their patients in the struggle against the pain by means of language. I tend to use the plurals us and we instead of I and you (e.g., "We have to go through this; let us look at this from another perspective"; "This is good for us"). I believe that this use of language creates an atmosphere of togetherness and of joining forces against a common assailant, ultimately empowering the patient.*

*—Orbach (2011, p. 124)*

In psychotherapy, a patient's ability to dissociate can seriously interfere with the formation and maintenance of a therapeutic alliance, making successful treatment outcomes more difficult to achieve. This poses a potentially life-threatening danger when one is treating suicidal individuals. Research has shown that ruptures in the therapeutic relationship with suicidal patients can result in the patient taking his/her life. The risk of suicide is heightened by the fact that suicidal individuals often exhibit dissociative tendencies.

In this chapter, I define dissociation and describe its manifestations, developmental roots, and the relationship between dissociation and suicide. I go on to discuss the implications of understanding dissociative phenomena as it relates to psychotherapy with suicidal patients, especially in terms of developing a strong therapeutic alliance and preventing and/or repairing disruptions in that therapeutic alliance. Finally, and perhaps most important, I'll explain how focusing on the therapeutic relationship when treating suicidal patients can lead to better outcomes. I present findings from suicide-specific treatments that emphasize a respectful, empathetic stance toward the suicidal person and focus on collaborating with him/her to understand his/her

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suicidality. These treatments have proven to be effective in reducing both suicidal ideation and behavior.

In many interviews with individuals who made serious suicide attempts, I have invariably been struck by their descriptions of being in the grip of the suicidal process during the time period immediately preceding their attempt. The state of mind they depicted was characterized by feelings of hopelessness, perturbation, desperation, and intense mental pain. They spoke about their self-hatred, distorted perceptions, and extremely hostile thoughts toward themselves and, at times, toward others, promulgated by a destructive thought process or critical inner voice. "The reality for myself is almost constant pain and torment. The voices and visions, which are so commonly experienced, intrude and so disturb my everyday life. The voices are predominantly destructive… by way of an unwavering commentary ridicule, to deceive, derange, and force me into a world of crippling paranoia. Their commands are abrasive and all-encompassing and have resulted in periods of suicidal behavior" (A patient with a history of suicide attempts, as reported by Jamison 1999, pp. 119–120).

Many of those interviewed also revealed that at some point, usually after taking action to end their life, they had "snapped back" to themselves and desperately wanted to live. Others reported experiencing spontaneous thoughts, including "Wait! I don't want to die!" "Is there any way to save myself? Everything else in my life can be fixed."

For example, Kevin Hines, one of the very few survivors of jumping from the Golden Gate Bridge, recalled, "At the split second I hit free fall, I thought, I don't want to die. What did I just do?" Another survivor of a potentially lethal dose of drugs thought, "My God, this is working! I don't want this to work" (Parr 2008).

This final phase in the suicidal process appears to involve a dissociated state in which the person is removed from himself or herself and, most particularly, from his or her body. Israel Orbach et al. (2006) and others have referred to this phenomenon as *physical* dissociation. At a key point in the crisis, after destructive action has been taken, this dissociated state is disrupted and the person is back in touch with his/her body and his/her physical sensations. Simultaneously, the natural instinct for survival returns full force, and the person is once more on the side of life, so to speak. From our perspective (Firestone and Firestone 2002), at that moment, the "real self"—the part of personality that wants to live—prevails over the "anti-self," the part of the personality being lived out in the suicidal process.

Robert Firestone's concept of the "division of the mind" is derived from the observation that people are divided between a self and an anti-self, those forces within them that oppose or even attempt to destroy the self. From Firestone's theoretical perspective, the self-system is the innate personality of the individual, developed through harmonious incorporation of positive traits and values of one's early caretakers that are easily assimilated into the personality. The anti-self-system can be conceptualized as the defensive element of the personality. These defensive adaptations result from the interpersonal experiences that arouse emotional pain, frustration, and torment, ranging from neglect, intrusiveness, emotional unavailability, and rejection to actual parental aggression, such as physical and sexual abuse. At these times of stress, children learn to depersonalize in an attempt to cope with the overwhelming emotions of fear, anxiety, and anger.

The split occurs when the child depersonalizes under the circumstances that, in his or her perception, threaten his or her "going on being" (Winnicott 1958). Ironically the child's struggle to preserve wholeness produces fragmentation. This ability to dissociate is originally a psychological survival mechanism but later contributes to suicide risk (Briere and Runtz 1987; Brown et al. 1999; Chu and Dill 1990). The following excerpt is from an interview with a woman who made a serious suicide attempt: "I cut myself in the strategic places, and put the arm into water and watched the rings, which were pretty. Watching myself; in the previous months I had often looked at myself from outside, like now when I was cutting myself" (Firestone 2006). One has to be removed from one's self to kill oneself. Suicide can be conceptualized as a triumph of the anti-self, the destructive part of the personality, over the self.

Individuals in suicide crisis are deeply ambivalent; they are more *against* themselves than *for* themselves. They have come to believe the hostile, negative statements of the critical inner voice about themselves and others, no longer have contact with their real self or with their body, and often feel hopelessly estranged from others. They find their alternatives narrowed down to the two options described by Shneidman (1985), that is, that of "either having some magical resolution or being dead" (p. 140). "The individual is primarily 'self-contained' and responds to the 'voices' (not in the sense of hallucinatory voices) within him" (p. 25). Somewhere in the midst of the suicidal crisis, they "find" themselves and are no longer completely at the mercy of the destructive voices to which Shneidman referred.

## 10.1 Definitions of Dissociation

> Dissociation is defined as a state of mind characterized by a break in the continuity of conscious experience. Dissociation manifests itself in such states as depersonalization, derealization, psychogenic amnesia, identity disturbances, as well as in detachment, loss of ability for self-monitoring, numbness, daydreaming, absorption, and emotional blunting. (Weinberg 2000, p. 803)

Dissociative disorders are defined as disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment (American Psychiatric Association 2000). Dissociation is also characterized by indifference to the body and bodily sensations, including pain. In the most extreme variety of dissociation (dissociative identity disorder, DID), alternate ego states are present (Orbach 1994). Some level of dissociation is common in the general population, ranging from mild to severe detachment. Pathological dissociation affects 2–18% of individuals in the general population (Sar 2011).

## 10.2 Dissociation and Suicide

Orbach and others have written extensively about the relationship between suicide and dissociation. Orbach (2006) has described the dissociated state in which there is high tolerance for physical pain through dissociation and low tolerance for

emotional pain or psychache. This combination results in high risk for suicide. In describing the dissociative state, Orbach noted, "If one does not feel physical pain and is indifferent to the body, then it becomes easier to turn aggressively against one's body and one's physical existence" (1994, p. 76). Maltsberger (2008) has observed that "Dissociation may be subtle and not always evident to us – the patient may actually feel quite composed and behave in a deliberate, organized way" (p. 48).

There are similarities between these descriptions and the shutdown state of defense that neuroscientist Porges (2003) described as our natural reaction to a situation we experience as life-threatening, one where we disconnect from bodily sensations to protect ourselves from pain. Siegel (2010) defined dissociation as a freeze response to overwhelming fear in which the slowly resounding unmyelinated part of the vagal nerve has been activated, which slows down heart rate and respiration, drops blood pressure, and can even lead to fainting. According to Porges, when people are in this state of overwhelming fear, they cannot activate the social engagement system.

A leader in the forefront of interpersonal neurobiology, Daniel Siegel, refers to what he calls the "flip lid" state of mind. In this state, which occurs after the person has been triggered, the higher functions of his or her brain are "offline," that is, not functioning very well (Siegel and Hartzell 2003). Siegel's concept is consistent with findings from brain-imaging studies of neural firing patterns in the brain of someone in a suicidal state, showing that the middle prefrontal cortex is shut down (Siegel 2001; Jollant et al. 2010). This important region in the brain has nine functions: body regulation, emotional regulation, attuned communication with others, fear modulation, empathy, self-knowing awareness or insight, response flexibility, intuition, and morality.

It is my contention that all "bad" behavior, toward ourselves or others, occurs in this flip lid state. It is easy to map the deficits in these functions to suicide. In a suicidal state, individuals are unable to regulate their emotions and are not attuned to the pain their suicide would cause those closest to them. Moreover, they lack the ability to calm down their fear or feel empathy toward themselves. Their insight into themselves is limited, as is their response flexibility, intuition, and morality. A study conducted by van Heeringen et al. (2010) demonstrated that mental pain in depressed patients is associated with increased risk of suicide; high levels of mental pain are also associated with changes in perfusion in brain areas that are involved in the regulation of emotions. We now know from research that the nine functions of the middle prefrontal cortex listed above have been identified as being outcomes of secure attachment and of mindfulness practices (Siegel 2017).

Dissociation in the suicidal state includes the typical symptoms of dissociation, changes in perception of oneself, and one's sense of environment and time. These symptoms are transient and may vary greatly in severity. Dissociative symptoms are common in acute suicidal crises, and suicidal patients often describe acting like an "automaton" (Maltsberger 1993; Orbach 1994, 2003; Shneidman 1985).

## 10.3 The Suicidal Mode

Beck (1996) first described the concept of the suicidal mode as "an integrated cognitive-affective-behavioral network [that] produces a synchronous response to external demands and provides a mechanism for implementing internal dictates and goals" (p. 4). The suicidal mode involves autonomic arousal; it orients the individual for action such as fight or flight (Rudd et al. 2001). Rudd depicted the suicidal mode as one in which the cognitive system is characterized by the suicidal belief system, including core beliefs, or critical inner voices, about being unlovable or unwanted, such as "I don't deserve to live," "I am worthless," and "Nobody wants me," as well as feelings of helplessness, such as "I can't do anything to solve my problems." The affective system associated with these cognitions and beliefs encompasses negative emotions such as sadness, anger, anxiety, hurt, shame, etc. The suicidal mode resembles the dissociated state as described by Orbach and Maltsberger.

> First and most important, suicide is a closed world with its own irresistible logic…The logic of suicide is, then, not rational…The logic of suicide is different. It is like the unanswerable logic of a nightmare, or like the science-fiction fantasy of being projected suddenly into another dimension: everything makes sense and follows its own strict rules; yet at the same time, everything is also different, perverted, upside down. Once a man decides to take his own life he enters a shut-off, impregnable but wholly convincing world where every detail that fits and each incident reinforces his decision…. (Alvarez 1971, pp. 143–44)

In his work, Weinberg (2000) suggested that "dissociation, alienated and negative perception of the body, lower sensitivity to pain, disintegration of self-representation, cognitive constriction, overly general nature of personal memories, difficulties in affect regulation as well as such personality traits as low openness to experience and personal constriction" (p. 799) are often seen in suicidal individuals. He argued that these various manifestations are the result of right hemisphere deficiency and a shift to left hemisphere functioning.

Research tends to support the above conceptualization of suicide, including studies demonstrating structural abnormalities of the right hemisphere in suicidal individuals. For example, Weinberg cited findings indicating that suicidal persons show a reversed hemisphere asymmetry of serotonin function. In addition, he has discussed research relating right hemisphere deficiency to dissociation, indicating that suicidal individuals had the highest levels of dissociation. Weinberg believes that early negative emotional experiences are implicated in the development of the functionally deficient right hemisphere. He contends that development of the right hemisphere is dependent on the affective quality of the relationship with the early caregiver. Early traumata, severe or cumulative, lead to a failure in the development of the right hemisphere that contributes to suicidal tendencies.

## 10.4 Trauma, Dissociation, and Suicide

Dissociation has its roots in early traumatic experiences, and it may have a genetic component as well. Research suggests that there is genetic influence in a person's ability to dissociate and that early trauma and disorganized attachment between parent and child play a role (Pape and Binder 2016; Ressler 2016; Yann 2012). Current research indicates that dissociation develops in conjunction with, and is maintained by, trauma. Israel Orbach has asserted that the ability to physically "dissociate begins with the parents' rejecting attitudes and behaviors toward the child, specifically their rejection of the child's body, their lack of sensitivity to the needs of the body and failure to treat the infant's body with love and tenderness. These attitudes are initially externally imposed or learned, but later they become internalized as numbness or diminished sensation, and hatred for the body" (Parr 2008). Orbach believed that developing an integrated self, a cohesive self, self-love begins with parental care of the infant's body. When this does not occur, an estrangement can develop between the self and one's body, which results in physical dissociation. According to Weinberg (2000):

> "…early traumata that cannot be contained by the still developing capacities of the child lead to the utilization of dissociation as an ultimate defense against mental pain. Later the person employs dissociation in face of every painful emotion: shame, guilt, humiliation, sadness, and anxiety. The over-employment of dissociation facilitates suicidal acting-out by dissociating body-image from the self-representation and, consequently, by appeasing fears of death." (p. 803)

The state of dissociation can be triggered in the child and later in the adult by real or imagined danger. Research has established the link between various forms of child abuse and suicide. There is also significant research linking suicide attempts to the intensity and variety of adverse childhood events (Anda et al. 2005; Sachs-Ericsson et al. 2015). Siegel (2012) and Fonagy and Target (1997) have both discussed how early experiences of terror at the hands of parents, those who are supposed to provide nurturance, safety, and soothing, lead the child to disconnect from his/her sense of self. Van der Hart et al. (2006) depicted dissociation as a division of the personality into at least two dissociative aspects: one aspect that "goes on going on" after the trauma is primarily engaged in daily life functioning, remaining avoidant of the traumatic memories and their reminders, whereas the other aspect encompasses the traumatic memories, experiences sensitivity to traumatic reminders and extremes in arousal, and engages in defensive actions to threat.

Dissociative reactions occur in connection with acute trauma reaction, post-traumatic stress disorder, acute stress reactions, and sometimes panic attacks. Neuroimaging studies in trauma research have provided evidence that traumatic experiences are stored in the neural networks and that the typical pattern of brain activation can be reactivated through recall of trigger situations (Lanius et al. 2010). In acute traumatic stress, prefrontal cortical function is impaired due to neural deactivation severely limiting the nine important functions of the middle prefrontal

cortex. An fMRI imaging study with script-driven recall of the suicidal crises in suicide attempt survivors (Reisch et al. 2010) found that the pattern of neural activation in the brain had strong similarities with the neural activation found in posttraumatic stress disorder.

Research conducted with Turkish high school students found that abused or neglected students had a 7.6-fold higher rate of suicide attempts and a 2.7-fold higher rate of self-mutilation (Zoroglu et al. 2003). In addition, these forms of maltreatment were the most powerful factors related to suicide. Increasing number of trauma types increased both self-mutilation and suicidal behaviors and the level of disassociation. Zoroglu and colleagues' research suggests abuse and neglect are not only implicated in chronic dissociative disorders but also in the etiology of dissociative experiences in the nonclinical population.

Disorganized attachment has also been found to play a major role in trauma-related disorders (Liotti 2004). Adult Attachment Interviews (AAI) (George et al. 1985) that are categorized by independent raters as "unresolved" also show evidence of disassociation. For example, the interviewee may fall silent and then later complete his or her sentence as though no time has passed; another may talk in a way that indicates the intrusion of visual images that are interfering with coherent speech. Children whose attachment behavior is classified as disorganized also show behaviors that indicate dissociation. For example, they may suddenly become immobile and unresponsive or engage in contradictory behaviors, alternately hugging and hitting a parent or caregiver in rapid succession. Since disorganized attachment in children is strongly linked to unresolved AAI ratings in their parents, this may be evidence of the underlying dynamics of the intergenerational transmission of dissociative mental states that are related to unresolved memories of past traumas.

Another feature discovered during AAI interviews included a group of parents who exhibited incompatible ego states. These interviews could not be classified because they indicated parents' deeply divided states of mind concerning attachment. For example, an interviewee might display dismissing attitudes during the first half of the interview and subsequently, and apparently with no awareness, switch perspectives or states of mind and express preoccupied attitudes. Liotti (1992) suggested that this is the first step in the pathway to dissociative disorders. This finding was supported by other studies with young adults who had been identified with disorganized attachment as infants. In this sample population, the disorganized group tended to have higher dissociation scores. Those who had also faced traumas during childhood and adolescence had the highest scores, reaching clinical significance.

Disorganized attachment between parent and child tends to develop when the primary caretaker or caretakers, the person to whom the child naturally turns for care, also become the frightening or punishing agent (Hesse et al. 2003; Main and Solomon 1986). This is especially important during the first few years of life when the ability to regulate emotions is limited and children are dependent on caretakers to provide this function for them. The lack of ability or skill to regulate affect is strongly associated with suicide risk (Linehan 1993; Rudd et al. 2001).

Van der Kolk et al. (1991) concluded that "Childhood trauma contributes to the initiation of self-destructive behavior, but lack of secure attachment helps maintain it. Patients who repetitively attempt suicide…are prone to react to current stresses as a return to childhood trauma, neglect, and abandonment. Experiences related to interpersonal safety, anger, and emotional needs may precipitate dissociative episodes and self-destructive behavior" (p. 1665).

In our conceptualization (Firestone and Firestone 2002), suicide represents the ultimate triumph of the anti-self. As described above, this overlay on the personality develops from negative parental behaviors, acted out when the parents were at their worst. At these moments, the child stops identifying with him/herself as the helpless victim and instead identifies with the aggressing parent, which partly relieves his or her fear or terror (Ferenczi 1988; Freud 1966; Howell 2014). Research supportive of this dynamic was conducted with suicidal adolescent patients who were found to have difficulties differentiating the negative aspects of the self from the negative aspects of their parents. The researchers (Klomek et al. 2007) asserted that "these results emphasize the importance of object relations theory in understanding suicide" (p. 8).

Attachment researcher Lyons-Ruth (2006) emphasized that early attachment and relational patterns with caretakers are experienced and encoded in the realm of implicit, procedural knowledge, beginning in early infancy. She argued that in psychotherapy, the therapist hopefully engages the patient repeatedly in a collaborative dialogue, which is characterized by careful attention to the particular state of the others' intersubjective experience, and opens acceptance of a broad range of affects. She suggested that from these collaborative interactions, new learning occurs at an experiential, procedural level. Eagle (2003) described how the patient uses the therapist as a secure base for self-exploration but also as someone who is different from his or her parental figures and will thereby help alter early maladaptive cognitive schemas or procedural "rules" (p.50).

## 10.5 Therapeutic Alliance

The strength of the therapeutic alliance is arguably the best and most reliable predictor of therapy outcome (Horvath and Bedi 2002). The therapeutic alliance is broadly defined as the overall bond between therapist and patient evolving during the process of therapy (Horvath et al. 2011). Although there is no single definition of the therapeutic alliance, aspects include agreement on tasks and goals, role investment, empathic resonance, mutual affirmation, and a relational or therapeutic bond (Bordin 1994). Evidence suggests that patient-centered interaction styles related to the provision of emotional support and allowing patient involvement in the consultation process enhance the therapeutic alliance. Clinicians can use this evidence to adjust their interactions with patients to include communication strategies that strengthen the therapeutic alliance.

## 10.6 The Therapeutic Alliance with the Suicidal Patient

> …if you listen for hurt, fear and pain, it is *always* there. And when the other person feels you listening and *feeling* them, they will lower their guard, open their minds and hearts to you, allow you to enter and comfort them and if you're fortunate, will let you walk them out of hell. (E. Shneidman, 2010, personal communication, 2010)

Schechter et al. (2013) have written about the complexities of developing and maintaining a therapeutic alliance with a traumatized and potentially suicidal person. They have also emphasized the need to be attuned to ruptures in the relationship and the need to repair them. The rupture and repair of the therapeutic alliance have been researched and found to be a critical factor in the success of psychotherapy (Safran et al. 2001, 1990; Safran and Muran 1996). Across a variety of disorders and therapeutic modalities, outcome results (Horvath et al. 2011; McLaughlin et al. 2014) suggest that the experience of an unrepaired rupture relates to poorer treatment outcome and, when it comes to suicidal patients, an increased risk for suicide. Ruptures in the therapeutic relationship with the suicidal patient can lead quickly to the patient experiencing deep despair, a strong negative affect associated with completed suicide. Many factors can interfere with a therapeutic alliance with a suicidal patient.

Maltsberger and Buie (1974) have also written about the phenomenon of "counter transference hate," wherein the therapist picks up strong negative feelings that the patient has toward himself or herself and dislikes, hates, or wants to reject the patient. These attitudes may partially result from provocative behavior these patients sometimes display. This behavior represents a reliving of their abandonment trauma. By inducing the therapist to reject them, they confirm the negative identity they developed growing up when they felt unwanted and unlovable.

Research also links suicide to disorganized attachment; numerous studies have established that it is more difficult to connect and establish a good working relationship with someone with insecure attachment and particularly those with disorganized attachment (Adam et al. 1996). These individuals have a fear of becoming close to, dependent on, or trusting another person; yet they tend to suffer from anxiety and distress if they feel isolated and alone. These two opposing states result in alternating between seeking closeness and running from it. In these cases the therapist needs to be a secure base, offering safety, soothing, and seeing the patients for who they really are so that they will feel secure. In essence, the therapist needs to repair the attachment system and help the patient move toward earned secure attachment where he or she can develop more secure relationships and a sense of inner security.

One important aspect of the therapeutic alliance with patients who experienced disorganized attachment relationships entails helping them create a coherent narrative of their early life, feel the full emotional pain associated with the experiences, and make sense of their past. This process leads to resolution of trauma, so that the patients no longer are haunted by unresolved traumatic feelings that are continually being triggered in their present life and that could precipitate a suicidal crisis.

In a paper that addressed strategies for working with chronically traumatized, neglected dissociative patients, Lamagna and Gleiser (2007) presented a treatment called "Intra-relational AEDP (I-R)." Intra-relational interventions are predicated on the notion of an internal attachment relationship between dissociated self-states, which recapitulates an individual's external attachment history. The goal is to help the patient shift disorganization, to self-responsiveness, empathy, nurturance, and compassion. In relation to treating patients who have dissociative identity disorder, the evidence demonstrates that carefully staged trauma-focused psychotherapy for DID results in improvement (Brand et al. 2014). The first stage focuses on building a collaborative relationship. Affect tolerance skills are included to enhance control over symptoms. There is also exploration of the meaning of suicidal ideation and behavior for the patient (Chu 2011; Chu et al. 2011). According to most experts on complex trauma and DID treatment, safety and symptom management must be at the heart of treatment. These treatments are effective across cultures and for persons with a wide range of benefits. These findings are consistent with the research on treatment for complex trauma with moderate dissociation (Cloitre et al. 2010).

Another struggle that can occur in treatment with suicidal individuals is that they may project the part of them that wants to live onto the therapist. As therapists it may be difficult for us to resist the urge or feeling that we need to, or must, save them. This urge or drive has at least two components: one is our desire to be the rescuer and the other is our fear of litigation and a sense of overwhelming feelings of failure if the patient were to take his or her own life. These feelings are compounded by our own attachment to patients, the caring and investment we feel for them and their well-being.

Farber (2007) concluded that "All successful psychotherapies, whether supportive, psychoanalytic, cognitive or systemic, depend upon the support that comes from a strong attachment to the therapist" (p. 70). She describes this support as comprised of the therapist's regularity, reliability, and attentive presence. She feels that at the heart of psychotherapy is a safe and secure human attachment that has a potential to alter and even repair the attachments to pain and suffering encoded in the brain of those who harm themselves. She believes therapy can provide a corrective emotional experience.

In patients with dissociative disorder, the alliance is extremely crucial in relation to treatment outcome, even more so than in other patient groups (Cronin et al. 2014). Michel et al. (2004) found that the working alliance with suicidal patients can be improved by the mental health professional taking a patient-oriented approach aimed at understanding the patient's suicidality in the context of their life.

## 10.7 Recommendations for Treating Dissociative Disorder

In addition, Michel et al. (2004) found that the working alliance in all clinical work with suicide attempters can be improved by the interviewer using a patient-oriented approach, aimed at understanding the patient's suicidality in the context of his or her personality or identity issues. Collaborative and narrative approaches to

the suicidal patient have been found to enhance the clinician's ability to empathize and help the patient begin to reestablish a sense of mastery, thereby strengthening the clinical alliance.

The Aeschi Working Group was formed to improve clinical approaches to suicidal patients. They recommend that the ultimate goal should be to engage the patient in a therapeutic relationship, even in the first assessment interview. They stress the importance of eliciting the patient's narrative about his or her own experience as essential in establishing and maintaining the therapeutic alliance and in working together to build a shared understanding of the patient's suicidality (Michel and Jobes 2011). The clinician needs to have the ability to empathize with the patient's inner experience and to understand the logic of the suicidal urge. The interviewer should be nonjudgmental and supportive and listen to the patient as the expert on his or her own experience. Research by Pinto et al. (2012) lends support to this approach. They found that patient-centered interaction styles, related to emotional support and to allowing the patient involvement in the consultation process, which are exemplified by the Aeschi approach, enhance therapeutic alliance.

Therapists also need to be able to empathize with and understand the meaning of the suicidal wish or, as Israel Orbach put it, "to be able to sit across from someone and know that this person could lose their life to suicide" (Parr 2008). Jobes and Ballard (2011) stated that, "…we would suggest that a proper clinical engagement (in which a suicidal patient is effectively understood and appreciated) has the power to forge an extraordinary therapeutic bond that may prove to be lifesaving – a potentially important and memorable connection for both members of the clinical dyad" (p. 60).

## 10.8 Suicide-Specific Therapies

An increasing number of studies indicate that suicidal patients have underlying vulnerabilities, such as the issues discussed in this chapter, and that therefore they need treatments that are suicide specific. These treatments target suicide as the focus of care instead of treating mental disorders and hoping the "symptom," suicidal ideation and behavior, will then be alleviated. Therapies that have proven to work with suicidal patients have a number of significant factors in common. They focus on the relationship with the suicidal patient and a therapeutic stance which is compassionate, empathetic, acknowledging, and respectful of the patient. The focus is on working collaboratively and helping patients see themselves from a more objective, caring, understanding perspective. The clinician also works with patients to identify their personal warning signs and to collaborate on coping strategies that they can use at those times when suicidal thoughts and feelings arise. Many of these approaches also directly or indirectly help patients create a coherent narrative about some significant aspect of their life, in particular their suicidality and their reasons for living. Research has demonstrated that creating a coherent narrative of one's early life reduces the intrusion of past traumatic experiences into the present, allowing one to not be triggered as often or as intensely into disconnected states of mind.

For those working with suicidal patients, it is important to recognize that in individuals with past attempts, the suicidal mode can be triggered more easily and at lower levels of activation (Berk et al. 2004). It is therefore realistic to expect that the mode will be reactivated in the future. This realization has led to the development of suicide-specific treatments to prepare for future relapse prevention as an essential element of treatment. Building in coping strategies for future suicidal crises should be an element of all treatments for suicidality.

One aspect or part of the strategy to prepare for future crises that has proven essential is to help patients recognize their personal warning signs, which are frequently triggered by personally stressful events. With increased awareness of these signs, they can then implement safety strategies early on before they become overtaken with the suicidal mode. This is particularly relevant given the research showing that, once a level of activation has been reached, past suicide attempters tend to forget the coping strategies they have learned (Stanley and Brown 2012).

The evidenced-based treatments that help to reduce suicidal thoughts and behavior include (1) Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), (2) the Collaborative Assessment and Management of Suicidality (CAMS), (3) Dialectical Behavior Therapy (DBT), and (4) Attempted Suicide Short Intervention Program (ASSIP).

## 10.9 Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)

Cognitive behavioral therapy approaches utilized for prevention of suicide employ a number of strategies that focus on building a strong therapeutic alliance with suicidal patients. In the early phase of treatment, one focus is on encouraging patients to become engaged in treatment and another is on obtaining informed consent. Cognitive therapists believe that informed consent can be used to enhance collaborative therapeutic relationships. The clinician conveys to the patient that he or she wants to work with the patient as a team and actively involve him or her in the process. Clinicians also focus on obtaining a commitment to treatment from their patient, which decreases dropouts.

When developing CBT-SP, Wenzel et al. (2009) found that a trustworthy therapeutic relationship was fostered first by listening closely to the patient's stories, which often included negative past experiences with therapy. In addition, they found it important to focus on developing an understanding of the "internal reality" of the patient. Moreover, built into this treatment are reminder phone calls, telephone sessions when patients are in crises, and case managers who assist in maintaining contact with patients and offering hope. The therapists who implemented this treatment found that these characteristics of treatment engagement demonstrated to the patients that they were professionals who cared about them and their well-being. In a randomized control trial of CBT, the participants in the cognitive therapy group had a significantly lower reattempt rate and were 50% less likely to reattempt (Brown et al. 2005).

Another version of CBT for suicide that studies by David Rudd and Craig Bryan (2015) demonstrated to be effective is Brief Cognitive Behavioral Therapy (B-CBT). These researchers found that suicidal soldiers who had previous attempts and received B-CBT were 60% less likely to make a future suicide attempt than those receiving treatment as usual. In a recent variation of their treatment, they have focused additional time in the initial interview to explore the person's reasons for living. In addition to asking patients to list their reasons for living, these therapists then draw them out and ask their patients to elaborate on these responses. This simple intervention was found to contribute to a greater shift in suicidal ambivalence toward life and to a significantly faster decline in suicidal ideation.

## 10.10 The CAMS Approach

> …suicidality is essentially a relational phenomenon; the presence or absence of certain key relationships paradoxically can be both suicide causing and suicide preventive. (David Jobes 2000, p.8)

In David Jobes' Collaborative Assessment and Management of Suicidality (CAMS) therapeutic model, clinician and patient are on the same team, working together to understand how suicide became an option to the patient, which makes the clinician and patient coauthors of the treatment plan (Jobes et al. 2016). This approach fosters collaboration wherein the patient feels respected and seen by the therapist. This approach offers both patient and clinician a sense that something meaningful can be done to help save a life that might otherwise be lost to suicide.

In a number of correlational studies with varying populations, Jobes' (2015) CAMS approach has demonstrated "more rapid reductions of suicidal ideation" (p. 7). In addition, the studies of treatment using the CAMS approach found higher patient satisfaction ratings, better clinical retention, and a reduction in emergency department visits and the use of other crises services (Jobes et al. 2005). When CAMS was implemented in an inpatient setting with patients who had recent histories of suicidal ideation and behavior, results demonstrated statistically and clinically significant reductions in depression, hopelessness, suicide cognitions, and suicidal ideation, as well as reduction in drivers of suicidality (Jobes 2012).

## 10.11 Dialectic Behavioral Therapy (DBT)

Marsha Linehan, the originator of dialectic behavioral therapy (DBT), was the first to focus on the therapeutic stance that clinicians who treat self-harming or suicidal individuals should assume (Lieb et al. 2004). Central to her DBT approach is the dialectic of radically accepting patients the way they are, while at the same time nudging or gently urging them to change their self-defeating and self-destructive tendencies. Linehan was also the first to conduct randomized clinical trials with potentially suicidal patients. Furthermore, these trials established DBT as an effective treatment, initially with women diagnosed with borderline personality disorder

who engaged in suicide attempts. The treatment has been extensively researched and proven effective in a variety of settings with both men and women and with individuals presenting with a wide range of disorders, from substance abusing adolescents to those who have engaged in violent behavior.

A 2-year randomized controlled trial of DBT vs. therapy as usual for patients with suicidal behavior and borderline personality disorder found that subjects receiving DBT were half as likely to make a suicide attempt. Those in the DBT group also required less hospitalization for suicidal ideation, and any self-harming behavior was less medically serious. In addition, patients in the DBT group were less likely to drop out of treatment and had fewer psychiatric hospitalizations and emergency room visits (Linehan et al. 2006).

Another study by Bedics et al. (2012) investigated the therapeutic relationship and the patient's level of introjection of the positive therapist. During a 2-year randomized control trial of DBT vs. nonbehavioral psychotherapy for borderline personality disorder, DBT patients reported more self-affirmation, active self-love, ability to self-protect, and less tendency to self-attack after treatment and at follow-up. In addition, they rated their therapist as increasingly affirming, protecting, and controlling as treatment progressed. DBT patients also showed a stronger introjection of the therapist and an increasing ability to self-affirm and to self-love in correspondence to their therapist's affirmation and love of them. Findings from this study also indicated a correlation between the patients' ratings of therapist affiliation with them and reduction in non-suicidal self-injury.

A novel, brief treatment for suicide that has been found to be effective is the Attempted Suicide Short Intervention Program (ASSIP). The founder of this treatment, Konrad Michel, is also the founder of the Aeschi, group mentioned above, comprised of prominent suicidologists who advocated taking a more respectful, empathetic, collaborative approach to treating suicidal people. Gysin-Maillart et al. (2016a) conducted a study of the original version of ASSIP. They found that the therapeutic alliance increased from session one to session three and that higher alliance measures correlated with lower suicidal ideation at 12 months follow-up. Recent research of the four-session ASSIP program demonstrated an 80% between-group reduction in suicide at a 2-year follow-up (Gysin-Maillart et al. 2016b).

## Conclusion

The majority of suicidal individuals experience some degree of dissociative phenomena, which can significantly impact the therapeutic alliance. Often this stems from trauma and attachment difficulties in their childhoods, "adverse childhood events." In the course of defending against negative stimuli, children establish a fundamental ambivalence toward themselves that eventuates in an essential split in their psyche between a self and an anti-self. They become both friend and intimate enemy to themselves. In the case of suicide, this enemy reaches epic proportions. Suicide is the ultimate abrogation of self; as such, it represents the extreme end of the continuum of self-destructive mental processes. Many of these psychological injuries occur in an interpersonal context and are best repaired in an interpersonal context such as a therapy relationship.

To be effective in preventing suicide, the therapist must help the patient to recognize his or her anti-self and resist acting on its directives to take self-destructive action. The therapist also needs to establish a connection to the patients' "real" sense of self and help them strengthen this aspect of themselves. Understanding this division and patients' ambivalence toward themselves can make the clinician more attuned to their struggles and better able to maintain a good therapeutic alliance.

The trust issues, negative expectations of others, and dissociative tendencies that result from experiencing interpersonal trauma can make it difficult for these patients to develop a good therapeutic alliance as they may be wary of engaging with the therapist. Further complicating the situation are the myriad of issues which can contribute to the therapist's difficulty working with suicidal patients, including fears of failure, fear of litigation, countertransference reactions, and the inherent pain at the thought of the patient taking his or her life.

However, the movement toward more respectful, empathetic, collaborative, and accepting approaches to treating suicidal patients has resulted in more effective treatments. These approaches foster a strong, supportive therapeutic alliance; at the same time, they respect the patient's autonomy and ability to be an active participant in his or her own treatment. This process is facilitated by taking the patient's pain seriously and identifying the drivers that contribute to that pain. Patients are empowered by learning coping strategies and affect regulation skills that may contribute to their being able to decrease their own distress and stay within their window of tolerance for strong emotion, thereby lessening their reliance on dissociation as a coping mechanism. Therapy can be a corrective emotional experience that allows the patient to feel secure with the therapist and increase his or her sense of inner security. Being "seen" by the therapist, which is facilitated by asking the patient to relate his or her personal narrative while the therapist demonstrates active listening, is also an important component. Creating a feeling of "safety" for the patient can be achieved by the therapist being present, caring, and providing help. The patient feeling "soothed" because the therapist hears his or her pain, acknowledges it, and implements techniques to help ameliorate the pain is still another essential component.

These are the fundamental elements necessary for secure attachment, and therefore they may help to repair the patients' attachment system. One element of the suicide-specific treatments mentioned above is that these techniques provide therapists with effective tools that, in turn, can lessen their anxiety and need to distance themselves from their patient. Overall, these techniques enable therapists to be present with and remain attuned to their patient.

Since these patients display dissociative tendencies, it is especially important that the therapist make the creation and maintenance of the relationship with the patient their highest priority. Therapies of this type can help patients no longer view suicide as their only option and turn their focus to life-oriented goals and actions. These therapies enable patients to reinvest in themselves and in their lives and begin the process of creating a life worth living for themselves.

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# A Collaborative Approach to Working with the Suicidal Mind

# 11

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The phenomenology of the suicidal mind—understanding suicidality from the suicidal *patient's* perspective—is a signature feature of the "Collaborative Assessment and Management of Suicidality" (CAMS) developed by Jobes (2006, 2016) and Jobes et al. (2016). CAMS is among a handful of evidence-based psychological interventions supported by *replicated* randomized controlled trials that focus on the psychology of suicide (Jobes 2012, 2016). Indeed, Linehan's (1993) "dialectical behavior therapy" (DBT), cognitive treatments for suicidal risk ("cognitive therapy for suicide prevention" [CT-SP] developed by Brown et al. 2005 and "brief cognitive behavioral therapy" [B-CBT] developed by Rudd et al. 2015), and CAMS all share a common emphasis on the importance of understanding suicide from the patient's perspective (Jobes 2016). Moreover, within each of these effective treatments, helping the patient to psychologically understand the when, where, how, and why of self-harm and suicidal behavior is fundamental to each of these treatments. To further expand on this notion, we will initially explore broad perspectives on the suicidal mind and turn to more specific theoretical orientations that exist within the suicidology literature prior to focusing more in depth on the CAMS approach to suicidal risk.

## 11.1 Broad Perspectives on the Phenomenology of Suicide

Two major conceptual approaches to the suicidal mind and the phenomenology of suicide are reflected in the work of pioneering suicidologist Edwin Shneidman and the "Aeschi Group" who both promulgate clinically relevant perspectives that fundamentally focus on the subjective mental life of a suicidal person. Each of these

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broad conceptual perspectives has spawned a range of suicide-specific assessments, treatments, and further research in clinical suicidology. Moreover, these broad perspectives are important to appreciate prior to our consideration of more specific theoretical orientation considerations pertaining to the phenomenology of suicide.

### 11.1.1 Shneidman's Mentalist Approach

Our understanding of the suicidal mind might be markedly different if it were not for the groundbreaking work of Dr. Edwin S. Shneidman, who is widely considered the father of modern-day suicidology. Shneidman made numerous theoretical and clinical contributions to the field of suicidology. While his work has significantly influenced a range of conceptualizations pertaining to the nature of suicide, Shneidman (2001) was unwavering about his take: "My view [of suicide] is definitely mentalistic. I believe that suicide is a matter of the mind…I am a 21st century mentalist" (p. 201). With relevance to the current text, Shneidman adamantly supported the importance of introspection and the phenomenological perspective to understanding the suicidal mind (Jobes and Nelson 2006). Given his strong emphasis on this approach to suicide, much of Shneidman's theorizing on the topic was fundamentally phenomenological.

Shneidman's theoretical cubic model of suicide (Shneidman 1987) encapsulates some of his key mentalist perspectives, particularly when examining a suicidal individual's psychological pain (*psychache*), emotional unease and anxiety (*perturbation*), and psychological pressures (*press*). According to Shneidman (2001), "the dark heart of suicide" rests upon an individual's sense of psychache; without psychache there is no suicide. Crucially, Shneidman's model and constructs challenged therapists to take the patient's perspective to garner a deeper understanding of their suicidal experiences. In reference to the cubic model, all three psychological constructs (rated on a 1–5 scale "low" to "high") provide a phenomenological window into the suicidal mind. Shneidman (1987) was emphatic that those who are in the 5–5–5 corner of the cubic model would not necessarily die by suicide, but every person who died by suicide would necessarily be in this respective psychological corner of the model—the perfect storm of suicidal action. Not only did his cubic model deviate from the traditional linear models, but it also showed how suicidal behavior is situation specific (Jobes and Nelson 2006). Due to the idiosyncratic nature of suicide, the cubic model encourages clinicians to take the patient's perspective when understanding the relative suicide risk and treatment therein.

While some of Shneidman's ideas influenced thinking about the cognitions of suicide (Ellis 2006), his larger theoretical body of work always retained a uniquely mentalist emphasis. Shneidman's (1959) "Logic of Suicide" outlined the "normal" reasoning of the suicidal mind, as the name infers. Three key points here include: (1) reason is equally relevant to suicide as emotion; (2) mental conclusions are seen as logical by the suicidal individual, despite seeming illogical to outsiders; and (3) everyone's logic of suicide is idiosyncratic. Despite the cognitive overtones to

the Logic of Suicide, Shneidman retains the need for a mentalist approach when understanding and treating the suicidal mind. In other words, the logic and reasoning of an individual's suicidal ideation and behavior may seem aberrant to their family, friends, or therapist; however, within the mind's eye of that person, this suicidal thinking can be completely sensible. Thus the clinician must take the *patient's* perspective into primary consideration.

Similar to the Logic of Suicide, Shneidman's (1985) "Ten Commonalities of Suicide" also influenced the field of cognition and suicide (Jobes and Nelson 2006) but continued to underscore his mentalist emphasis. The commonalities most pertinent to Shneidman's mentalist bias center again on the issue psychache and suicide as a means for getting one's needs met.

While this section provides only a snapshot of Shneidman's various contributions, it does underscore that his conceptual innovation and theoretical work were rooted in a mentalistic and phenomenological approach to suicide. As the field of suicidology has matured, many contemporary researchers and clinicians have been influenced by Shneidman's seminal ideas.

### 11.1.2 The Aeschi Approach

In 2000, a small group of clinician-researchers with expertise in suicidology gathered at a think tank meeting in the alpine town of Aeschi, Switzerland. This group was convened to address their growing concerns pertaining to contemporary care of suicidal patients in various healthcare settings. The focus of this meeting centered on video recordings of clinicians interviewing suicidal patients in various clinical settings. These clinician-researchers made some important observations based on their video observations. For example, many of the clinical interviewers demonstrated a controlling and domineering approach in which "the doctor knows best." In the face of this attitude patients often showed intimidated and even cowering responses. From such observations, the clinician-researchers gathered at Aeschi developed a shared viewpoint that became known as the "Aeschi approach" to suicidal risk (Michel and Jobes 2011) wherein the *patient's* perception and narrative description of their suicidality are central to effective clinical work. Following this initial meeting, a series of larger meetings were convened at Aeschi and later in Vail Colorado that embrace this approach and related ideas. These Aeschi meetings are always organized around the presentations of clinical interviews with suicidal patients and how clinicians work to form alliances to effectively understand and treat such patients.

A primary outcome of the initial Aeschi conference was an understanding that clinicians and researchers must remain focused on and open to *patient's* point of view. The Aeschi approach emphasizes not only the significance of listening to the patient's suicidal narrative but learning from their experiences and seeing the suicidal world through the eyes of the patient (Michel 2011). The Aeschi approach differs from the traditional "medical model" approaches in that it largely eschews the importance of clinical diagnosis in lieu of a singular focus empathy for suicidal

states which invariably enhances the therapeutic alliance between patient and clinician. In this spirit, suicide clinicians and researchers should endeavor to take on the perspective of the suicidal patient. Importantly, the Aeschi approach to suicidal risk is not wedded to any specific modality, discipline, or theory; the phenomenological orientation within the approach can be used widely across disciplines, theoretical orientations, and clinical settings.

The first Aeschi "Working Group" meeting established six principal guidelines (Michel 2011) for informing clinical care with suicidal patients that are worth considering. First, the goal of the clinician is to develop a mutual understanding of an individual's suicidality with the respective patient. This goal differs from the medical model emphasis, which tends to emphasize immediate and overriding emphasis on clinical diagnosis. Second, clinicians must be cognizant of a suicidal person's potential anguish and total loss of self-respect. Many patients are likely to withdraw and express vulnerability when discussing their own suicidal thoughts and behaviors. Third, the clinician should express a nonjudgmental and supportive attitude toward the patient. Empathy is significant in strengthening the therapeutic alliance, and the patient should be validated as the expert of their own experiences. Fourth, suicidal crises are not simply about the present but also often about the past. In the exploration of the crisis/crises, the clinician should encourage the patient to tell their story in a narrative fashion. Fifth, new models are necessary to conceptualize suicidal behavior so that the clinician and patient share an understanding of the patient's suicidality. An objective of this guideline is to not view the patient just as someone with psychopathology but as someone with logical reasons for being suicidal. Sixth, the ultimate goal in clinical work is to garner a therapeutic relationship with the patient, right from the initial assessment (Michel 2011). Taken together, the "Aeschi Working Group" created a holistic framework for both understanding and treating suicidal individuals that fundamentally rests on clinicians taking the patient's perspective.

As previously noted there have been a number of follow-up Aeschi conferences since 2000. Michel (2011) observes how the atmosphere of each conference reflects the working alliance in a therapy setting: "Each conference has been an experience of learning to understand suicidal behavior through the patient's experience, as well as learning from each other as clinician's—mirroring the basic ingredients of an effective therapeutic attitude" (p. 8). While initially conceptualized in a small town in Switzerland, the Aeschi approach has developed some degree of international interest, and this largely *phenomenological* approach has influenced both clinical practices and whole lines of suicide-specific clinical treatment and intervention research (e.g., Jobes 2016; Gysin-Maillart et al. 2016).

## 11.2 Specific Theoretical Orientations

No one theoretical orientation or approach can ever fully capture the complexity of the suicidal mind. But various specific theoretical orientations have endeavored over the years to shed light on the matter at hand. To this end, the following section

will examine a handful of specific theoretical orientation to understanding suicide with distinct implications for clinical assessment and treatment thereby. The perspectives we intend to examine in a bit more depth include psychodynamic, cognitive, behavioral, and mentalization approaches to suicidality.

### 11.2.1 Psychodynamic

Psychodynamic theorists and clinicians assert that the most significant agent of change in psychotherapy lies in the therapeutic alliance or "the capacity of patient and therapist to engage productively in psychotherapeutic work" (Schecter and Goldblatt 2011, p. 93). Within this tradition, a strong therapeutic alliance is seen as the center stone for effective care. However, there are inherent challenges for the therapeutic alliance when suicidal risk is in the picture. Indeed, a variety of alliance-interfering factors often are present and may present, such as the wish to die, pervasive shame, painful life experiences, projection of suicidal intent, and chronic hopelessness (Weinberg et al. 2011). Often times, suicidal individuals feel ashamed about their thoughts and behaviors and do not feel comfortable openly discussing them. These feelings may result in intense transference and countertransference reactions of distrust, self-blame, and hopelessness between the members of the clinical dyad (Leenaars 1994). In addition to the inherent challenges within the suicidal patient, the clinician needs to be cognizant of their own negative reactions of malice and aversion toward the suicidal patient (Jobes and Maltsberger 1995; Maltsberger and Buie 1974). Particularly when treating suicidal individuals with chronic hopelessness over an extended period of time, therapists may unconsciously begin to withdraw from the patient as a defense (Schecter and Goldblatt 2011).

Despite the obstacles presented when caring for suicidal patients, there are techniques and factors to aid in the strengthening of the therapeutic alliance within the psychodynamic tradition. For example, this orientation emphasizes the importance of empathic validation and maintaining a nonjudgmental acceptance of the patient's experience. Within the treatment of suicidal patients, empathic validation aids in reducing self-blame and can often mitigate acute distress which may help motivate the patient and fuel continued therapeutic growth. Within psychodynamic care, empathic validation is achieved through verbal and nonverbal techniques, demonstrating a deep understanding of how a patient's emotions are linked to historical events given circumstances (Schecter and Goldblatt 2011). Through continued empathic validation and being nonjudgmental, the therapeutic alliance can evolve and may become more open, as the patient experiences the clinician understanding and affirming their perspective.

Acute suicidal crises may occur in the course of treating a suicidal person. But the dyad can often weather suicidal storm when the therapeutic alliance is strong. A sturdy alliance may not prevent suicidal thoughts or wishes, but it can allow the dyad to constructively explore the patient's suicidality while still sustaining safety (Weinberg et al. 2011). A strong clinical alliance represents one of the most

life-preserving factors within psychodynamic care; the model further allows the patient to explore and understand their suicidal thoughts and feelings within a safe, supportive, and empathically affirming relationship.

### 11.2.2 Cognitive Therapy

Cognitive (and closely aligned cognitive behavioral) theory and psychotherapy embrace yet another set of valuable perspectives on the suicidal mind. From a distinctly cognitive approach, Beck (1996) asserted that understanding the *suicidal mode* is essential to effectively understanding suicidal risk and treating that risk. Dr. Beck noted four basic systems that include cognitive, affective, behavioral, and motivational aspects that work in synchrony resulting specific psychological states. Along these lines Beck argued that once the suicidal mode has become activated, an individual is consumed within an acute suicidal episode or state. In turn, it is crucial to recognize that this suicidal state is fundamentally defined by core cognitive concepts, also known as the Suicidal Belief System (SBS; Beck 1996).

The exact content of the SBS has been conceptualized in a variety of ways (Brown et al. 2011). Rudd et al. (2006) envisioned the suicidal mode with four primary components: unlovability, helplessness, poor distress tolerance, and perceived burdensomeness. Wenzel et al. (2009) attempted to simplify the approach, pinpointing two major suicide schemas in unbearability and trait hopelessness. Taken together, this theoretical approach has provided valuable clinical constructs in the form of the suicidal mode and SBS which endeavor to conceptualize the experience of suicidality from the patient's perspective.

Building on this theoretical tradition, CBT-oriented suicide-specific treatments have proven to be highly effective and randomized controlled trials (RCTs). For example, cognitive therapy for suicide prevention (CT-SP; Brown et al. 2011) has shown an impressive impact on suicide attempts reducing posttreatment attempts by 50% (Brown et al. 2005). As it relates to phenomenology, perhaps the most critical component of CT-SP involves an effort to understand the patient's suicidal narrative. Within their suicidal narrative, the patient provides a detailed account of their most recent suicidal crisis in their own words. From this account the clinician develops a case conceptualization, highlighting particular automatic thoughts, beliefs, or events that trigger a suicidal crisis. Importantly, the clinician works collaboratively with the patient to update the case conceptualization when new information arises over the course of care. The middle and later phases of treatment, which focus on the employment of behavioral, cognitive, and affective coping strategies as well as relapse prevention, respectively, directly incorporate the client's perspective within guided imagery exercises. This exposes the patient to their suicidal mode with the opportunity to rehearse a therapeutic response to the activated suicidal mode within the guided imagery exercise (Brown et al. 2011). Following in this tradition, Rudd et al. (2015) have shown in the RCT the brief cognitive behavioral therapy (B-CBT) is highly effective for reducing suicide attempts by 60% with a sample of high-risk suicidal army soldiers.

### 11.2.3 Behavioral

We all know that the exact demarcation between cognitive, cognitive behavioral, and behavioral theoretical approaches is not always clean and clear. There is a distinct history of both integration and separation of these respective constructs. But in the behavioral tradition, there can be no doubt that dialectical behavior therapy (DBT) has made major conceptual and clinical contribution to the treatment of suicidal behaviors (Linehan 1993). DBT has demonstrated a robust empirical support for the reducing suicide-related markers including suicide ideation (Linehan et al. 1999; Koons et al. 2001), suicide attempts (Linehan et al. 2006), self-injury (Linehan et al. 1999; Verheul et al. 2003), and inpatient hospitalization (Linehan et al. 2006). The theory's framework aims to synthesize conceptual opposites and create change through acceptance of oneself, particularly in people with borderline personality disorder (BPD). A DBT therapist sees BPD as developmentally arising from both a biological predisposition for emotion dysregulation and an invalidating caretaking environment. DBT thus strives to address these underlying etiological issues—and suicidal and self-harm behaviors—through highly structured skills training within a multicomponent behavioral treatment approach.

The four major components of DBT include a DBT skills training group, individual psychotherapy, phone coaching, and a DBT consultation team meeting (Linehan 1993). The multidimensionality of DBT allows the therapist to understand the patient's self-harm and suicidal impulses in different contexts and levels of suicidal stability vs. crisis. The group and individual sessions teach the patient the skills of mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation and how to utilize them in daily life. Additionally, in the individual setting, therapists may apply chain analysis to gather detailed information from the patient's perspective of their thoughts, behaviors, and events that led to a suicidal crisis or self-harming behaviors. Phone coaching provides the therapist the opportunity to understand the patient within a suicidal crisis and help work through the crisis. Finally, even though the DBT consultation meeting does not include patients, therapists discuss patient-provided data and attempt to further understand the function of suicidal behaviors and self-harm (Linehan 1993)—this may be seen as the DBT version of understanding the suicidal mind.

A notably significant technique used throughout DBT treatment is validation. Due to DBT's conceptualization of BPD and suicidal individuals' tendency to feel shame regarding suicide, validation is crucial because it conveys emotional and interpersonal acceptance. Not only does validation assist in changing rigid, dialectical thinking patterns, it also acts a "sugar coating" for handling the "bitter pill" of DBT techniques (Linehan 1993). DBT approaches validation in a direct fashion, which differs from validation in other therapeutic modalities. Essentially, the therapist can actively observe and reflect on the patient's suicidal feelings and thoughts, conveying their cognitive and behavioral responses are understandable due to their life's context (Linehan 1993). Similar to other modalities, DBT's use of validation creates a trusting bond and may encourage openness from the patient and, thus, lead

to more openness about their perspectives. Through validation and DBT-specific techniques, therapists and clients may develop a strong, collaborative therapeutic alliance and have more successful outcomes.

### 11.2.4 Mentalization

Anthony Bateman and Peter Fonagy (Bateman and Fonagy 1999) developed "mentalization" as a novel way of working with distressed suicidal patients. Mentalization or the ability to "hold mind in mind" (Bateman and Fonagy 1999) draws on attachment theory, evolutionary biology, and psychoanalytic principles (Holmes 2011). As Allen (2011) puts it, "Mentalizing involves perceiving and interpreting the behavior of self and others as conjoined with intentional mental states such as needs, desires, thoughts, and feelings" (p. 81). In effect mentalizing involves the developed ability to view oneself from the outside while simultaneously viewing others from the inside (Allen 2011). Similar to DBT, mentalization-based therapy (MBT) has demonstrated success with suicidal individuals and those with BPD (Bateman and Fonagy 1999, 2001, 2008). However, MBT views the development of BPD due to the caretaking environment alone, especially in relation to attachment, caregiver responsiveness, and contingent mirroring (Swenson and Choi-Kain 2015). Therefore, attachment needs in those with BPD are difficult to manage, and suicidal behavior often occurs when their attachment needs are left unmet (Holmes 2011). The aloneness of such patients can also be conceptualized as an abject inability to connect those who endeavor to mentalize them (Allen 2011). In some cases, this lack of interpersonal connection may contribute to self-harm and suicidal struggles.

In MBT, therapists use a multitude of techniques to assist in the cultivation of an ability to mentalize. Some of the methods include restoration or maintenance of mentalizing throughout the session, adjusting interventions to match client's mentalizing abilities, identifying mentalizing poles and later absolute thinking, the MBT therapist mentalizing himself/herself and the therapeutic relationship, maintaining authenticity and an open mind, monitoring emotional arousal, and focusing on contingency of interventions (Fonagy et al. 2015). Additionally, the therapist utilizes empathic validation to support these interventions as well as the ability to explore, clarify, and challenge thoughts, perceptions, and affect (Fonagy et al. 2015). Even though MBT specific, such techniques may be employed in other therapies.

Many times, effective treatment requires both the patient and clinician to directly engage in mentalizing processes during psychotherapy (Allen 2011). For example, the Collaborative Assessment and Management of Suicidality (CAMS), which is discussed further on, requires the patient to mentalize their suicidal thoughts, feelings, and behaviors (Allen et al. 2008; Bateman and Fonagy 1999) which invariably leads to increased level of emotional awareness (Allen 2011). CAMS encourages the patient to reflect upon their suicidal state or episode while simultaneously engaging the clinician to do so in turn (Allen 2011). MBT differs from CAMS in that during training, MBT therapists only envision sitting side by side with the

patient, whereas in CAMS, the therapist quite literally requests to sit side by side as a means of collaborating in a joint mentalization exercise to understand the patient's suicidality (Jobes 2016; Allen 2011).

## 11.3 The Collaborative Assessment and Management of Suicidality

The Collaborative Assessment and Management of Suicidality (CAMS) is one of the only handful of evidence-based suicide-specific clinical interventions (Jobes 2016). CAMS is best understood as a therapeutic framework that directly targets and treats suicidal risk within a collaborative and empathic approach to care. Because CAMS is therapeutic framework—not a new psychotherapy—it does not require a clinician to abandon familiar treatment methods or their theoretical orientation. CAMS is thus described as "nondenominational," and it affords the provider free reign to use familiar techniques and therapeutic approaches within a clinical framework that targets and treats the causes of suicidal behaviors, *as defined by the patient*. Within CAMS, these patient-defined suicidogenic causes are referred to as "drivers," and a driver-oriented treatment is a signature feature of the CAMS approach to suicidal risk (Jobes 2016; Jobes et al. 2016). From a CAMS perspective, the phenomenology of the patient's suicidality is always central. The goal throughout the use of CAMS is to understand the patient's suicidality from the patient's point of view. In this sense, suicidality is understood as a potentially life-threatening state of mind that can be recognized, deeply understood, and ultimately effectively treated. But to achieve this, a CAMS provider must rely on empathy, collaboration, and honesty.

### 11.3.1 Empathy

Central to CAMS-guided care is the importance of being empathic of the patient's suicidal struggle. Throughout the course of CAMS, the clinician endeavors to be understanding, nonjudgmental, and noncoercive in the efforts to deeply understand and appreciate why, when, where, and how the patient becomes suicidal. The cultivation of this empathy is initially achieved through the collaborative use of the "Suicide Status Form" (SSF) which serves as a multipurpose assessment, treatment planning, and tracking to clinical outcome tool. The SSF is the essential clinical road map that guides CAMS from beginning to end. Starting in the first session and throughout CAMS-guided care, there are key points in CAMS assessment and treatment planning where the clinician takes a seat next to the patient (with their expressed permission) to complete certain sections of the SSF. For example, every CAMS session begins with the patient rating the SSF "Core Assessment" related to psychological pain, stress, agitation, hopelessness, self-hate, and overall behavior risk of suicide; every session ends with a collaborative update of the CAMS treatment plan. In the first session of CAMS, there are both quantitative and qualitative

SSF assessments that reveal the phenomenology of the patient's suicidal world as they write about their pain, describe what makes them hopeless, and list reasons for living and dying and what one thing could help them no longer be suicidal. Throughout all CAMS-guided care, the clinician collaboratively walks with the patient through all assessment and treatment planning processes as both parties discover and continue to reveal the ongoing and evolving phenomenology of that patient's suicidal struggle.

Beyond empathic assessments, CAMS treatment always focuses on patient-identified suicidal *drivers*. As noted by Tucker et al. (2015), the notion of patient-defined drivers provides a more focused and idiosyncratic way of assessing and treating suicidal risk. While suicide risk factors (e.g., being a middle age white male) and warning signs (e.g., highly agitated and dysregulated states) may be useful considerations for working with suicidal risk, patient-defined suicidal "drivers" provide a more precise and targeted focus for suicide-specific care. As Tucker et al. (2015) note, drivers function as patient-specific warning signs. In other words, the *patient's* perspective is integral to their own clinical care.

CAMS driver-oriented treatment maintains a consistent and sharp focus on the patient's phenomenology of suicidality which invariably evolves over the course of successful CAMS-guided care. Indeed, much of CAMS treatment works to "sharpen" the shared understanding of the patient's suicidal drivers. For example, the CAMS Therapeutic Worksheet (CTW) can be used to further flush out the nature of suicidal drivers (Jobes 2016). The CTW can be used to further breakdown a driver into related thoughts, feelings, and behaviors. Moreover, a distinction can be made between "direct" drivers (those targeted treatment problems that compel the patient to consider suicide) and "indirect" drivers which may contribute to dysregulation or make the patient vulnerable to the activation of their direct drivers. To clarify, a patient's direct drivers of "self-hate" and "sexual abuse history" may become acutely activated when their indirect drivers of insomnia, interpersonal isolation, and alcohol intoxication occur.

When a clinician can become empathic of the suicidality and develop a deeper understanding of the patient's suicidality through patient-defined drivers, positive therapeutic outcomes can ensue. From a research perspective, we know that patients value the CAMS emphasis on their suicidal phenomenology (Schembari et al. 2016). In this study of 49 successfully treated CAMS patients, the *process* of CAMS was the top response to the following query: "Were there any aspects of your treatment that were particularly helpful to you?"

### 11.3.2 Collaboration

As noted, CAMS fundamentally relies on an active and ongoing collaboration between the clinician and the patient. One way this collaboration is operationalized is the side-by-side seating arrangement that is used throughout CAMS-guided assessment and treatment planning. Side-by-side seating communicates a different dynamic—we are doing this together, we are a team, we are aligned. This symbolic

and literal collaborative seating dynamic is inherently different from face-to-face arrangements or within psychoanalytic work wherein the analyst literally sits behind the analysand. Sitting next to one another in CAMS reduces the sense of a traditional doctor-patient power dynamic and underscores the message that the patient is "coauthor" and an active participant within their own treatment (Jobes 2016).

### 11.3.3 Honesty

A final consideration within CAMS philosophy is the importance of honesty, particularly in relation to power struggles around the law pertaining to imminent danger. The direct and forthright discussion of legal statutes, the patient's desire for autonomy, and how suicide risk can create an adversarial dynamic between clinician and patient are always useful. Within CAMS, this honest and frank discussion can help the dyad remain on the same team with an ongoing emphasis throughout care on the *patient's* perspective—their phenomenology—as central to both their clinical assessment and suicide-specific treatment within CAMS-guided care.

## 11.4 Challenges in Clinical Practice

As described elsewhere in depth (Jobes 2016; Jobes et al. 2008), the challenges of working with suicidal patients are manifest and manifold. Suicidal risk is difficult to assess; suicidal states wax and wane, and motivations for a suicidal death can slowly evolve over years or dramatically shift in a matter of minutes. Suicidal states are inherently difficult to clinically treat, and many suicidal patients are often deeply conflicted about seeking mental health treatment which can fundamentally undermine motivation of suicidal patient within clinical care. The considerable clinical challenges of the suicidal often evoke the worst within mental healthcare providers in ways that may be iatrogenic to the patient. If we are to effectively treat suicidal risk, we must effectively grapple with these challenges. Let us briefly consider just a few of these concerns that may torpedo an effective and potentially lifesaving course of clinical care.

### 11.4.1 Countertransference

In their seminal 1974 paper, Maltsberger and Buie boldly described a unique set of negative feelings that clinicians often harbor toward suicidal patients. These authors described a matrix of countertransferential reactions and behaviors that can lead to deep feelings of *malice* and *aversion* in the clinician. In this important early paper, Maltsberger and Buie spoke clearly and directly to the strong negative feelings that clinicians may have that can undermine their ability to treat suicidal patients effectively and help save lives therein.

### 11.4.2 Shame, Blame, and Issues of Control

Marsha Linehan has previously observed that the most common attitude to working with suicidal patients across clinical settings is to "shame and blame" the suicidal patient (Jobes 2016). Either overtly or covertly clinicians may consciously or unconsciously communicate to the patient that being suicidal is aberrant, abnormal, or simply unacceptable. Perhaps out of clinician fear and anxiety or from a perspective of over-pathologizing the patient, a potential message that suicidal feelings are not okay may well embarrass, intimidate, or effectively shut down a patient's willingness to openly discuss their suicidal struggle. Within this kind of clinical dynamic, issues of power and control are inevitable and may take center stage within the clinical relationship. Moreover for most suicidal patients, control is often a core psychological issue, because suicide may be seen as their ultimate "coping" option and their right to exercise.

### 11.4.3 Fear of Blame

For American clinicians, fears related to malpractice litigation should a patient take their life are pervasive (Jobes et al. 2008). Such fears can dominate, interfere, or derail effective clinical care for suicidal risk. Moreover, the threat of malpractice litigation can compel providers to practice defensively when encountering a suicidal patient. Defensive practices may include inappropriately hospitalizing a suicidal patient (who could be otherwise handled as an outpatient), becoming coercive or controlling, minimizing the exploration of suicidality, or taking fewer clinical risks that may actually be in the patient's best interest. Even abroad where the threat of litigation may be less common, there are still common fears of being blamed or second guessed after a suicide, particularly in a post hoc review of the care (e.g., a root cause analysis). By its nature, defensive practice is usually not focused on the *patient's* perspective; the phenomenology of suicide is ignored in the face of *clinician* anxiety and fear of being blamed.

### 11.4.4 CAMS as a Potentially Remedy

When it comes to clinical challenges, everything about CAMS is designed to address the above-noted issues. As noted earlier, CAMS is designed to facilitate a thorough and exhaustive collaborative assessment of a suicidal state. CAMS provides a framework within which patient-defined suicidal drivers are targeted and treated in a focused and systemic manner. Within CAMS-guided care, suicidal ambivalence is empathically tolerated as the clinician endeavors to form a relationship agenda around the effective treatment of patient-defined suicidal drivers. In this fashion, the goal is to move the patient from a state of ambivalence to state of motivation wherein the patient and clinician work collaboratively to help save the patient's life through stabilization and the determined treatment of patient-defined

suicidal drivers. By emphasizing empathy and the importance of the patient's suicidal phenomenology, clinicians often experience less countertransference feelings because they endeavor to establish a collaborative relationship vs. an adversarial dynamic. Within CAMS, we earnestly endeavor to never shame and blame a patient for their suicidal thoughts and feelings. Drawing confidence from an established and structured model in conjunction with empirical support of research, clinicians may be able to practice with less fear and not act-out defensively against the suicidal patient. In addition, the extensive documentation within CAMS using the SSF may significantly reduce one's exposure to malpractice liability and/or blame in that medical record reveals a thorough and exhaustive assessment of suicidal risk, a treatment plan that is suicide-specific, and mechanism where the risk is monitored until optimal clinical outcomes are achieved. Within the CAMS approach, we seek to understand the suicidal struggle and engage the patient in a strong clinical alliance that invariably increases motivation within the patient to fight for their life. Through collaboration, empathy, honesty, and the structure of the CAMS framework, we earnestly seek to effectively treat the causes of what makes the patient suicidal. In essence everything about this particular collaborative clinical approach is organized around the patient's phenomenology of suicide.

### Conclusion

In this chapter we have endeavored to review the relevant literature pertaining to the phenomenology of suicidal states and related effective treatments. We first considered the broad perspectives on the phenomenology of suicide through the work of pioneering Edwin Shneidman and the collective work of the Aeschi Group. We then further considered the phenomenology of suicidality in relation to psychodynamic, cognitive, behavioral, and mentalization theoretical approaches before turning our focus on the Collaborative Assessment and Management of Suicidality. As noted, CAMS is fundamentally built around the phenomenology of suicidal states which informs CAMS-based SSF assessments and driver-oriented treatment planning. Finally, the challenges of clinical practice with suicidal patients were noted particularly in terms of countertransference and control issues. We propose CAMS as a potential remedy for many of the inherent clinical challenges that invariably arise when clinically working with suicidal patients. From our perspective, a collaborative and empathic approach that is organized around the suicidal patient's phenomenology is essential for successful clinical care of suicidal risk.

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# The Story of My Suicide

# 12

Viktor Staudt

My name is Viktor. At November 12, 1999, at the age of 30, I seemed to have it all: a good education, a rewarding job, close friends, and an active social life. Not too bad looking, I kept myself in shape; enjoyed my running and swimming. But appearances can be deceiving: no one would ever have guessed that my life had long been seriously blighted by panic attacks and bouts of severe depression. So on that same day, I threw myself under a train. I wanted to kill myself. Thus, I have lost both of my legs. Now I am in a wheelchair.

Even though it's called "to throw oneself under a train," it wasn't like that, really. Instead, I went right up to the edge of the platform and I took a step forward and I let myself fall, just as an intercity was arriving.

About 12 h later, I woke up in the hospital. My mother was the one to tell me that the train had run over me and cut off both my legs. Shortly after, I started to feel these so-called phantom pains. Pain in my calves and my feet. Parts of my body that are no longer there. This pain continues up to this very day. On the better days, it feels like I am wearing shoes that are about two sizes too small. Shoes that I will never be able to take off again. On worse days, it feels like electric shocks are being sent through my feet.

A couple of years later, a physician suggested I should write down my story. I liked that idea. Because as a child I always had wanted to become a writer. Of course, I had in mind another type of book, instead of an autobiographical story about a botched suicide attempt.

The idea to write down my story remained in the back of my head for quite some time. In the end, it took me over 10 years before I finally started writing. I think I needed this time to accept what had happened to me. To sort of come clean. Not just toward myself but also toward everybody else around me. During those first 10 years, every time someone asked what had happened to me, I told them that I had

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been in a motorcycle accident. I came up with that story because during my time in the hospital, I had met a guy who had the same kind of injuries as I had. He actually had had a motorcycle accident! And of course, losing your legs because of a motorcycle accident is way "cooler" instead of a suicide attempt.

I lived in Germany in 2009 when the keeper of the German national soccer team, Robert Enke, committed suicide. He had done so in the same way, as I had intended to do so myself. This tragedy was my wake-up call. I knew that not only I had to start writing my story but also try to explain why I had decided to end my life. Partly because Robert, like me, had been suffering from depression but also because of the debate that followed afterward in the media. Questions like: "Is suicide selfish?", "Did he think about his family?", and "Did he ever think about the people on the train?"

I felt a certain urge to reply to these questions. I figured that I could do so by telling about what was going on within me, at that time. Perhaps I would be able to shed some light on what is happening with people who are suffering from depression in general. Would I even be able to lift some of the taboo that is still lingering around depression and suicidal thoughts?

About a year later, a successful Dutch actor took his own life. He was just 44 years old. I remember that when I read the news that night, immediately I started to feel a sense of guilt for not having written down my story yet. I am not saying that I could have saved him, but still. Because the main motivation to write down my story in the first place was—and still is—to give those who are considering taking their own life a possibility to identify themselves. A possibility that I had never had.

What I mean is: I am convinced that if I would have had the possibility to read—or listen to—an experience of someone who had not only suffered from the same kind of problems (depression, anxiety) but also taken this so-called final step, only to find his way back to life, definitely I would have taken the time to read this. Of course, I cannot guarantee that in the end I would have chosen a different road: instead of taking my own life, to go out—once more—to find help.

Yet the time it would have taken me to take notice of this experience and to think about it means extra time. Literally. Extra time when it comes down to a decision between life and death. And who knows, maybe I would have chosen life over death. It's even more likely when within the story (a book, a film) an attractive alternative is being presented: a life without depression, without a destroying sense of fear.

As a child, while in elementary school, I never laughed. I was probably around 9 or 10 years old. My mom went to one of these "parents' evenings," because my dad had to work. The next morning at breakfast, she told me that my teacher had told my mom that she thought how I was a good student. I got pretty good notes and all. So far, nothing out of the ordinary. But then she had asked my mom: "Can Viktor also laugh?"

At first I had found this a little bit strange. I mean, of course I knew how to laugh! As a matter of fact, I did laugh. During breaks, or when a friend came over to play. In class though, I didn't seem to laugh so much. Perhaps I was just very concentrated. Paying close attention. Not to miss anything. Because good results were

really important to me. Or perhaps I was afraid to fail. Afraid not to succeed. And maybe this fear prevented me from having fun, in class. Looking back, perhaps this was the first sign of a depression developing?

To be perfectly honest, I don't recall this laughing or not laughing so well. Instead what I do recall is: while sitting in the classroom, I imagined everything around me to be in black and white. At the same time, as I looked outside—watching the people going about, the cars, shops—everything out there was in color. And I knew for certain that I only needed to wait. To wait and be patient for school to be over. Because once those years would have passed, I would be able to make the transition from the world in black and white into the world in color. I was absolutely certain about that.

Unfortunately it turned out not to work quite that way. Because, instead of changing from the world in black and white into the world of colors, shortly after elementary school, I started to stutter. And not just a little. I really couldn't say one word. It was awful. Really horrible.

I felt powerless. "Why can I not speak anymore?" and "What can I do about it?" Questions that remained unanswered. In the end, all that I could do was sit in my room, on the floor, with my back against the wall, my legs pulled up, and my head between my knees. Because it was a way to find darkness. And only darkness could give me a sense of peace and quiet.

By now I know that back then I have started to develop a "borderline personality disorder." In layman's terms: a mental condition that generates a significant level of emotional instability, characterized by a distorted idea of oneself. Add to that a sense of being useless, of being worthless. Not a pretty picture.

One of the symptoms is a low self-esteem. In my case, this low self-esteem may have led to a fear of failure, followed by the incapacity to speak (stuttering). Only shortly after I had regained the possibility to express myself verbally, I started to experience what they call anxiety attacks. To be perfectly honest, those attacks were the worst of all.

An example. Imagine, being in a supermarket, doing groceries. Just a very ordinary thing to do. All of a sudden you meet someone you know. He or she comes up to you, asking how you are doing. Just a nice, friendly chat. But instead of chatting a bit, all you can do is to think how to get out of there, as soon as possible. Because if you cannot get out of there fast enough, the fear—or whatever you want to call it—will explode. That means, before you know it, perspiration shows on your forehead. Only seconds later the sweat starts running over your face. Literally. And that is only before it will cover the rest of your body. So, what do you do? You try to find an excuse, in order to get away. You look at your watch and say: "Oh, I need to go. I am in a little bit of a hurry." Or something like: "It's pretty hot today, isn't it?" No matter how much you try to keep calm and focus on what is being said: you just cannot concentrate on the conversation at all. It seems impossible to do so.

The same thing happened for instance when I went to the hairdresser, after I had taken a seat to get my hair cut. (In the meantime I turned bald. So that problem resolved itself.) Or when I went out for just a cup of coffee. Or going to the movies: there was always present this constant pressure of fear. It was only a matter of time

before a full-blown attack would follow. It has even happened that I was sweating so much that someone asked me if I needed a physician!

The real desperation came from not knowing what caused this fear in the first place. Followed by being unable to control it, let alone turn it around. A fear that seemed to just come over me, I called it "the invisible enemy." Invisible because I knew it was there, but I had no chance to fight it, because I couldn't see it. I could only feel it. Most of the time, it hit me when I was around other people. In the end, I had no other choice than to stand up and walk away, after which I felt like I had lost from the "invisible enemy." Again.

I felt alone with my problem. I was ashamed to talk about. At the same time, I felt hopeless, desperate even. What could I do about it? One thing was sure. I didn't want to surrender just that easily to this "invisible enemy." I was certain that I felt so low, because of these panic attacks. If only they would go away, I would feel so much better. That's how I thought it would work.

Only years later, long after I had already lost my legs, I met a physician that explained to me it was actually the other way around: those panic attacks were all *because* of feeling so low. Because of a depression. In other words, I was depressed.

I immediately refused to believe that. People who are depressed, they stay in bed all the time, don't they? Or they drink alcohol all day long, right? I have never been like that! On the contrary! In order to fight the "invisible enemy," I had developed my own strategy: staying in shape, swimming, running, paying attention to a healthy diet, working hard, and, before all, not giving up. Never to give up, no matter how at times this so-called fog between me and the rest of the world seemed to thicken. All the while I was making myself stronger, hoping that one day that fog would lift to make way to a better life. One without fear. Without panic.

But instead, this fog only became thicker and thicker. And shortly before November 12, 1999, I was sure that there was nothing more that I could do to make it go away. No matter how many miles I would run, no matter how many laps I would swim, there is nothing that I could do to defeat the "invisible enemy."

The great turnaround was in 2005, more than 5 years after my suicide attempt, when this physician prescribed me an antidepressant. Because she, contrary to a couple of her colleagues, was capable to make a correct diagnose. Easy as that. But it changed my life forever, because it meant the end of practically all of the depression-related suffering.

About 2 weeks after I had started the medication, something amazing happened. Or better said: nothing happened. Ok, to be able to explain this, first I got to tell how I used to wake up before I started to take this medication. Normally, right after I opened my eyes, I would feel this tension. Not so much in my body, but more in my mind. Like the day that was about to start, fell all over me. Crushed me. No matter how much I tried to relax. From controlled breathing to finding a way to stop all negative thoughts that seemed to run right over me. There was even a time when I had put a comic right next to my bed, to read right after I'd woken up. Because I hoped that by reading something funny, the fear wouldn't be able to get a hold on me. In the end it was all in vain. The only way to be able to get out of bed was to

realize that even that very day, if I couldn't go on anymore, I could—at least in theory—end my life.

A couple of weeks after I had started the medication, I woke up, and while I was staring at the ceiling, I realized that I felt…nothing. No tension. No negative thoughts running through my head. Nothing. And then, all of a sudden, it dawned to me: "Let's get out and make some coffee." *Let's get out and make some coffee?* Where did that come from? Immediately I called up my mom, to tell her about this "new" experience. My mom cried because she understood that getting out of bed and making coffee meant so much more than that. It meant that I was able to start a day. To start a life.

My story is not unique. But depression can appear in many different ways. Ever since my book got published, I have been receiving many mails, not only from people suffering from similar problems. A lot of those mails are being sent by people who have lost a friend, a partner, or a child to suicide. The questions they ask me are practically always the same: Why has my friend never told me about his depression? How did my partner live through his last days? And what did my child think of, right before he took his own life? As if I could answer these questions!

A journalist from The Netherlands once said to me: you know Viktor, it's like you have been on a trip with all these people. Now you're the only one who has come back. The only survivor. And everybody wants to know: what happened? Was there pain? Fear? Panic? Or perhaps not?

I wasn't afraid. I didn't fear the pain, though I hoped it wouldn't last too long, of course. And I was in pain! It hurt a lot, under the train, my legs being cut off. But the pain made way to a sensation of warmth. Almost like I was being embraced by ten pair of arms, all at the same time. I remember how at that instant I thought it to be over. Finally, it was over.

And now, about 16 years later, I am here. And still I don't have all the answers. All I can do is share my experiences. My story. A story that I know well enough by now. But I will go on sharing it, hoping that by doing so it will be just a little bit more easy for others to open up about their problems, knowing that they are not alone. Because in order to find a suitable solution, you have to talk about what's bothering you. Without shame, without prejudices or whatever kind of taboo.

I think that like me, most people that try to take their own life, don't want to die. Instead, they want to put an end to their problems. Unfortunately depression takes away the ability to see the difference. Something I learned the hard way.

I myself, I am doing better. Much better actually, despite the problems connected with the borderline personality disorder. But the depression I can control now, instead of the depression controlling me. That of course, makes a huge difference.

To anyone suffering from depression: there is help out there. So get ready for the part of your life without suffering. Give yourself a chance to get better. Start talking now.

# Anodyne Psychotherapy for Suicide: A Psychological View of Suicide

# 13

Edwin S. Shneidman†

## 13.1 First, Some Philosophical Aspects of Suicide

Albert Camus (1913–1960), French Nobelist author, wrote that *the* central problem for philosophy was the enigma of *suicide*—wrestling with the complicated question (often asked in the midst of pain): Why stay alive? If you scratch almost any serious topic in the right way, you will find that it has an important *philosophic* history. In today's world, two historic philosophic forces are engaged in an ongoing territorial fight for the ownership of suicide.

Broadly speaking, these two forces can be labeled *brain* and *mind*—whether suicide is to be understood primarily in psychiatric terms as a biological disorder in the brain and as a mental disease called depression (and treated with antidepressive medications) *or* whether it is to be best understood as a psychological drama in the mind related to psychological pain and suffering and best addressed by focusing on the reduction of the person's psychache, treated in terms of the sufferer's own vocabulary. In philosophic terms, it is a choice between the mechanistic philosophy of Rene Descartes (1596–1650) and the humanistic philosophy of David Hume (1711–1776); further, it is a choice between the notions of German psychiatrist Emil Kraepelin (1856–1926)—who believed that there were diseases of the personality comparable to diseases of the perineum—and a fealty to the notions of French sociologist Emile Durkheim (1858–1917) who related suicide to inner feelings (like estrangement or loneliness or anomie) and to their ties to the larger society.

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But first, a few words about *mind*. To date, no one has given a satisfactory explanation of *consciousness* or mind. We pretty well understand how the kidney secretes urine, how the skin secretes sweat, and how the lungs secrete carbon dioxide, but we are rather in the dark as to how those billions of cells that make up the brain "secrete"—if that's the right word—thoughts and feelings. It is too obvious to say no brain no mind, but it is more subtle to assert that the mind has a mind of its own and that the main business of the mind is to mind its own business.

In this formulation, suicide is *not* a disease of the brain like senility but rather has a very different formula, specifically that suicide *is* rather extreme (unbearable) psychological pain coupled with the idea that death (cessation) can provide a solution to the problem of seemingly unacceptable mental distress. There is a vast philosophic difference between these two competing views of human beings and their vicissitudes. In the current scene, the biological view of a human condition, the medicalizing of suffering, and the faster-than-the-eye-can-see conversion of "suicide" into "depression" are created by an educational colossus, the multibillion dollar drug industry. The culture, the newspapers, and the common talk have taken up this theme (of converting suicide into depression) and have, in one of the most successful philosophic distortions the world has ever seen, convinced vast numbers of the population that human suffering and thoughts of death are physiological products of a defective organ to be treated by their tailor-made prescriptions. Descartes would hoot in his crypt.

The important thing about philosophy, why it matters, is that it has serious practical everyday consequences. It matters how you conceptualize suicide. Your treatment will certainly be guided by it; your life may depend upon it.

## 13.2 A Psychological View of Suicide: Anodynic Psychotherapy

Every student of logic knows that a *sorites* is an extended syllogism of three or more (*as* opposed to the usual two) premises that lead to a single conclusion. (A well-known syllogism is "All men are mortal, Socrates is a man, therefore Socrates is mortal"). In the remainder of this paper, I aspire to present (in the form of a sorites) a succinct overview of a psychological approach to the study and treatment of suicidal phenomena.

Without further ado:

WHEREAS 1. Our concept of suicide—what suicide *is* and how it is to be regarded—*has changed over time*. A recent article (Shneidman 1998) surveyed the changes in the meanings of "suicide" in successive editions of the *Encyclopaedia Britannica* since 1777. The accepted understandings of that word have clearly undergone significant changes in the past 240 years. In general terms it is safe to say that "suicide" has changed from being a sin and a crime to being an immutable demographic occurrence to being a psychological cry for help by a needful person who merits our sympathetic response. The fact that the concepts of suicide have changed in the last two centuries leads us to the cautionary belief that this paper,

whatever its possible merits, cannot be the last word but merely the latest word. One hundred years from now, we will most likely be discussing human self-destruction largely with a vocabulary that we do not currently possess. (Neologisms are an inevitable necessity.) Here, for the record, is how "self-murder" sounded in the *Britannica* in 1777 (Shneidman 1973):

> And also the law of England wisely and religiously considers, that no man hath the power to destroy life but by commission from God and the author of it; and as the suicide is guilty of a double offense; one spiritual, in invading the prerogative of the Almighty, and rushing into His immediate presence uncalled for; the other temporal, against the king, who has an interest in all his subjects, the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on one's self.

WHEREAS 2. Our contemporary concept of suicide is *multidimensional* and embraces several intellectual disciplines. In a recent book (Shneidman 2001), examples of several disciplines that touch on suicidology—philosophy, history, sociology, biochemistry/medicine, psychiatry, psychoanalysis, biography, survivorship, and volunteers—are presented. Imagine, if you will, a citizen of a sophisticated European capital, making his way through his city, walking past the national archives, the state opera, the public university, the central art museum, the palace of justice, and the national cathedral—all the repositories of that citizen's human and national identities, his mores, his folkways, and his attitudes toward life and death—and further, recognizing that individual, as he walks along, is a symphony of endocrine flow and a beehive of conscious thoughts (a veritable physiology laboratory and introspective factory), and you will realize that every suicide is committed by a complicated human organism operating within (or against) a large number of explicit and internalized subtle social threads and that the study of *suicide* is, willy-nilly, a multidisciplinary enterprise.

WHEREAS 3. Currently, for practical purposes, the study and practice of suicide are more or less divided into *three* discernible approaches: the demographic, the biological, and the psychological (Shneidman 1992, 2001). The first approach is interested in numbers and the uniformity of numbers. It is statistical, arithmetic, nomothetical, tabular, and census oriented. It reports trends, group data, and places-status-methods. It provides the basis for planning, taxation, and social commentary. It is related to some of the great names in suicide study like Buckle, Morselli, and Durkheim.

The second, the biological approach, sees suicide as a genetical, biochemical, and more or less disease of the brain, leaning heavily on the nineteenth-century textbooks of Emil Kraepelin.

This view—almost unchanged since Kraepelin's day—ties suicide closely to other maladaptive patterns such as alcoholism, schizophrenia, and especially depression. It treats depression, quite understandably, with antidepressive medications. This point of view deserves great respect, *as* does any multibillion dollar enterprise. But depression—a most serious problem in its own right—is not the same as suicide. It may well be time to dekraepelinize suicide.

The third view conceptualizes suicide as a storm in the *mind*. It holds that the mind may have a mind of its own and that oftentimes the main business of the mind is to mind its own business. The name for this mental pain is *psychache*—an ache in the psyche (Shneidman 1987, 1993, 1996, 2001). It follows that in the clinical situation the key questions to ask a suicidal person are "Where do you hurt?" and "How may I help you?" If the function of suicide is to put a stop to an unbearable flow of painful consciousness, then it follows that the therapist's main task is to mollify that pain.

WHEREAS 4. The main sources of psychological pain—shame, guilt, rage, loneliness, hopelessness, and so forth—stem from frustrated or thwarted psychological *needs*. These psychological needs include the need for achievement, for affiliation, for autonomy, for counteraction, for exhibition, for nurturance, for order, and for understanding. Please see Table 13.1. Our personalities are made up of these needs; our distinctive personalities are defined by the relative weightings among

**Table 13.1** Psychological need form

| Name | Sex | Age | Rater | Date |
|---|---|---|---|---|
| _ABASEMENT To submit passively, to accept criticism and blame, to be resigned to fate, to belittle or blame the self | | | _HARM AVOIDANCE To avoid pain, illness, injury, or death; to escape from a dangerous situation; to focus on precautions | |
| _ACHIEVEMENT To accomplish something difficult; to master; to manipulate objects, persons, and ideas; to finish things | | | _INVIOLACY To protect the self, to maintain distance, to resist intrusion, to maintain psychological boundaries | |
| _AFFILIATION To cooperate and reciprocate with an allied other, to please and win affection, to adhere, and to remain loyal | | | _NURTURANCE To gratify the needs of another person; to feed, help, support, console, protect, and comfort; to nurture | |
| _AGGRESSION To overcome opposition forcefully, to attack, to oppose vigorously, to hurt or injure another, to push ahead | | | _ORDER To put things or ideas in order; to achieve arrangement, organization, tidiness, and precision among things or ideas | |
| _AUTONOMY To be free, to shake off restraint, to break out of social confinement, to be independent of authority in thought | | | _PLAY To act for fun, to laugh and to make jokes, to see pleasurable activity for its own sake, to take time-out | |
| _COUNTERACTION To make up for failure by restriving, to overcome, to maintain self-respect on a high level, to get even | | | _REJECTION To exclude, abandon, snub, jilt, expel, blackball, separate oneself, or remain indifferent to another | |
| _DEFENDANCE To defend or vindicate the self against assault or criticism, to conceal or justify a misdeed or failure | | | _SENTIENCE To seek and enjoy sensuous experience, to give an important place to create comfort and elegance | |
| _DEFERENCE To admire, support, praise, honor, and eulogize a superior; to yield eagerly to the influence of another | | | _SHAME AVOIDANCE To avoid or quit conditions that lead to humiliation, scorn, derision, indifference, or embarrassment | |
| _DOMINANCE To control other humans; to influence or direct others by command, suggestion, persuasion, restraint | | | _SUCCORANCE To have one's needs gratified by another; to be supported, guided, consoled, cared for, protected, loved | |
| _EXHIBITION To make an impression; to be seen and heard; to excite, entertain, shock, intrigue, amuse, or entice others | | | _UNDERSTANDING To ask questions; to be interested in causality; to speculate, analyze, and generalize; to want to know answers _(100) | |

Adapted from Henry A. Murray, *Explorations in Personality*, 1938

some 20 psychological needs—no two individuals are exactly alike. Our delights and our despairs stem from the satisfactions and frustrations of the needs that are important to us. What I routinely do in actual practice is assign exactly 100 points (among the 20 needs) to every individual after each session; the assignment for each need can be as low as 1 and as high as 25. There are *modal* needs that we routinely live with, and there are *vital* needs that some of us would die for. Suicide is about needs and their frustration. Happily for our own needs as suicidologists, Henry A. Murray (1938) comprehensively explicated these psychological needs in *Explorations in Personality*—in my opinion, a book worthy to rank with James' *Principles of Psychology* as America's masterpieces in this field.

WHEREAS 5. In each suicide there are elements that are unique and elements that are ubiquitous. In this view, there are some ten *commonalities* among almost all suicidal persons, as follows: a common *purpose*, a common *goal*, a common *stimulus*, a common *stressor*, a common *emotion*, a common *cognitive state*, a common *perceptual state*, a common *action*, a common *interpersonal act*, and a common *consistency* (Shneidman 1992). Please see Table 13.2 for the details of these commonalities.

WHEREAS 6. In the real world, there is a great deal of psychological pain without suicide—perhaps millions to one—but there is almost no suicide without a great deal of psychological pain. From this mentalistic point of view, the key concept in suicide is psychological pain, called *psychache*. It follows that the principal therapeutic challenge is to address that pain and to mollify it. Fortunately, there are current research efforts to operationalize and put numbers on "psychache" (Berlim 2003; Orbach 2003a, b; Shneidman 1999).

WHEREAS 7. The usual categories relating to suicide are dichotomous boxes—e.g., attempted, threatened, and committed. A more realistic view is to understand them as possible continua. Three continua that are omnipresent in the suicidal scene are *pain*, *perturbation*, and *press*. Psychological pain can be rated from barely noticeable to unbearably excruciating, arbitrarily from 1 to 5. Perturbation (upsetment, inner turmoil, including every diagnosis in the *DSM*) can similarly be rated from tranquil to wildly disturbing, also 1 to 5, and press, the pressures and

**Table 13.2** The ten commonalities of suicide

| | | | |
|---|---|---|---|
| I. | The common PURPOSE of suicide is *to seek a solution* | VI. | The common COGNITIVE STATE of suicide is *ambivalence* |
| II. | The common GOAL of suicide is *cessation* of consciousness | VII. | The common PERCEPTUAL STATE of suicide is *constriction* |
| III. | The common STIMULUS in suicide is intolerable psychological *pain* | VIII. | The common ACTION in suicide is *egression* |
| IV. | The common STRESSOR in suicide is frustrated psychological *needs* | IX. | The common INTERPERSONAL ACT in suicide is covert *communication* of intent |
| V. | The common EMOTION in suicide is *hopelessness-helplessness* | X. | The common CONSISTENCY in suicide is with *previous* lifelong coping *patterns* |

vicissitudes of the outer world, can also be rated from 1 to 5. From these thoughts, a schematic cubic model for suicide can be constructed. Please see Fig. 13.1. It is theorized that suicide occurs when the individual is in the 5-5-5 cubelet, a concatenation of extreme pain, perturbation, and press. The therapeutic implication is to reduce at least one of those relevant dimensions to 4 or less. It is also true that the most direct way to reduce the heightened psychache (pain) which drives the suicide is first to reduce the heightened perturbation which drives the pain—and oftentimes this can be done by addressing the heightened external press (of strained interpersonal relationships, unemployment, school problems, etc.).

WHEREAS 8. Discussions of "pain" have almost always referred to somatic pain and physical suffering. Even the very best books on pain—e.g., Cassell (1991) and Morris (1991)—limit their reflections to physical pain. In a fascinating personal notebook on the excruciating pain of tertiary syphilis (paresis and tabes), the nineteenth-century French writer, Alphonse Daudet (1840–1897), refers only once to nonphysical pain in a footnote (Daudet 2002). "Mlle de Lespinasse (1732-76), salon hostess... took opium for pain (in her case, the pain of thwarted love)." My approach to understand and treating suicide does not relegate psychological pain to a footnote; on the contrary, it puts it on the center stage. The title of the drama is "Psychache."

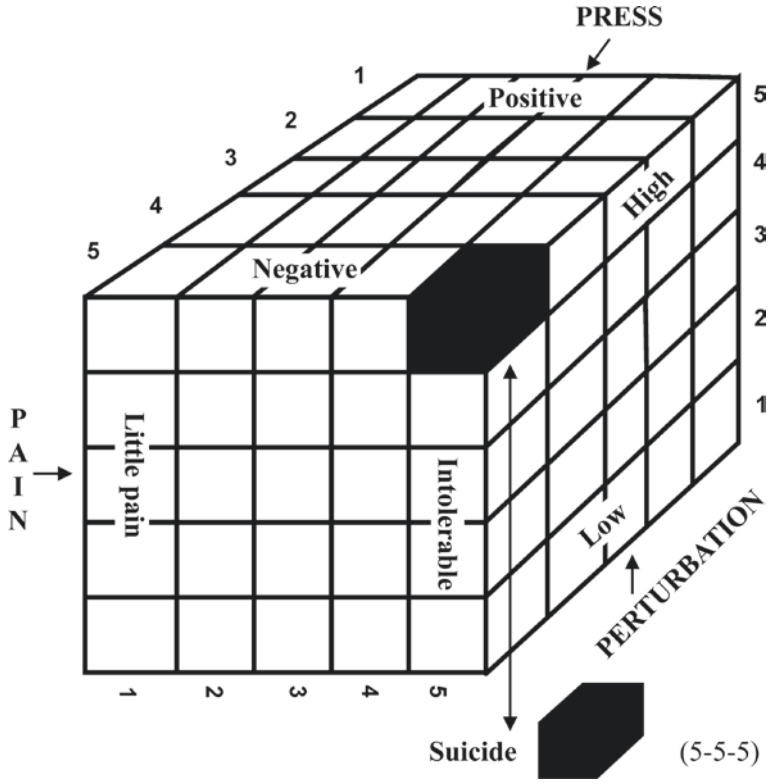


**Fig. 13.1** A theoretical cubic model of suicide

NOW THEREFORE: All these premises, above, lead not so much to a single deductive conclusion as they do to a set of recommendations for practical action, specifically to special mode of psychotherapy for suicidal persons. I call this *anodynic psychotherapy*. (Shneidman 1996). An "anodyne" is a substance or agent which/who reduces pain. Aspirin is an anodyne; similarly, a good friend or bartender can serve an anodynic function. In this sense, all therapy, by definition, is meant to be anodynic.[1]

The single most important key in anodyne therapy is a tailor-made focus on the alleviation of that particular patient's frustrated psychological *needs*. Frustrated psychological needs are at the black heart of suicide. Of course, the central purpose of any therapy is anodynic—to reduce the patient's pain—but what I think is crucial here is the conscious focus of the therapist on the patient's psychic pain and on the reduction and mollification of that pain, combined with the necessary redefinition and reconceptualization of that pain as somehow bearable after all. Anodyne therapy places a fresh template in the therapist's mind that focuses on the patient's frustrated psychological needs as the malignant foundation or source of the patient's psychache. If the person declares that he must stop certain inner pains in order to continue to live, then it follows that those pains need to be addressed, reduced, and redefined so that the urge to self-destruction can be put aside.

While there are many patterns of frustrated psychological needs that lead to suicide, in general, as a practical matter, about a half-dozen can be differentiated (Shneidman 1996):

- Thwarted *love*, acceptance, and belonging—related to frustrated needs for succorance and affiliation
- Fractured *control*—related to frustrated needs for achievement, autonomy, order, and understanding
- Assaulted self-image and avoidance of *shame*, defeat, humiliation, and disgrace related to frustrated needs for affiliation, defendance, and shame avoidance
- Ruptured key relationships and the attendant *grief* and bereftness—related to the frustrated needs for affiliation and nurturance
- Excessive *anger*, rage, and hostility—related to frustrated needs for dominance and aggression

As a psychotherapist, I have an ingrained responsibility to be empathic, to resonate to the patient's private psychological pain, and to reaffirm his right to end his suffering. But at the same time, in this role, I am aware of the patient's heightened *narcissism*, his view that his suffering is somehow unique and that he is special among the nations—a kind of malignant grandiosity that asserts that no one has had it as bad. This almost delusional greatness-of-my-pain is a feature that is present in many suicidal people. This leads to the insight that pain is the common lot that needs to be addressed within the therapy.

[1] Much of what follows in this section is taken from *Autopsy of a Suicidal Mind* (2004).

We have come to know that the quantity of our patient's pain is, in fact, not unique and that others (in the history of the world) have hurt as much and suffered as grievously and have continued to endure. Together, the patient and the therapist will wish to redefine and fine-tune their understanding that, in actual practice, words like "unbearable" and "intolerable" really mean barely bearable and somehow tolerable and that these insights can be incorporated into a scenario for long-term survival.

In anodynic therapy with suicidal persons, we are often puzzled by the thoughtlessness of the suicidal act and by the way that it inflicts collateral damage on the survivors. The answer, I believe, lies in the *constriction*, the concentration, the tunneling of vision, the pathological narrowing, and the grandiose focusing on the Self that is a frequent aspect of the suicidal state. The therapist needs to maintain a special lookout for the patient's use of dangerous suicidal words like "only" as in "the only thing I can do" or "the only way to do it."

One is reminded of Emperor Hirohito's historic rescript of surrender in August 1945 in which he ordered his obedient subjects to bear the unbearable and to suffer the insufferable—and to live. His address to his nation is arguably the most impactful suicide prevention speech ever made. But in my view, the Japanese people did not so much tolerate the intolerable as they *redefined* what that term, in actual operation, realistically meant. That is a key to suicide prevention. That, and mollifying, even just a little bit, the specific psychological needs implicated in that crisis—in Japan's case, the needs for affiliation, for achievement, for deference, for order, and for shame avoidance.

In conclusion, with a person of high lethality, one should pay special attention to the specific frustrated needs—and the ancillary features will tend to sort themselves out. Act as an ombudsman, address the thwarted needs, reduce the psychache, be an anodynic agent, and invoke the indispensable magical powers of positive transference and countertransference.

**Declaration of interest** None

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