Perspective article

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A plea for the understanding of the suicidal mind

M. Pompili

Department of Neurosciences, Mental Health and Sensory Organs, Suicide Prevention Center, Sant'Andrea Hospital, Sapienza University of Rome, Italy

Summary

Although suicide is a major public health issue worldwide, both mental health professionals and lay-people struggle to cope with suicide. Part of the problem comes from the myths, obsolete paradigms, and stigma associated with suicide that results in anxiety and fear. However, most suicidal individuals want to live even when facing serious suicidal stress. Clinicians are, therefore, called upon to unlock the suicidal mind, relieve the suffering, and pay attention to the unmet needs of these individuals.

There are so many unmet needs in individuals at risk of suicide. Too often, the medical model is imposed as a treatment plan. Therapists are more likely to treat the psychiatric disorder and, therefore, assume that this treatment also reduces suicide risk. In this way, the "one fits for all" model precludes understanding the suicidal mind, with its unique characteristics for each subject.

Furthermore, there are still no agreed-upon models for managing patients accessing the emergency room and, besides, there is still no data on patient adherence to prevention programs at follow-up.

One of the central elements of caring for people at risk of suicide lies in the ability to formulate the question, "What is like to be suicidal?". To answer this question, the therapist must necessarily leave his formal position and try to identify himself with the subject in crisis. It is an exercise that is not necessarily easy but for which you can train. Throughout this chapter, the reader is helped to understand the suicidal mind to facilitate this action.

This essay focuses on some of the unmet needs of suicidal patients and points to some key elements for clinicians in the management of suicidal individuals. The concept of mental pain as the main ingredient of suicide is used to explore some of the most prominent features of the suicidal mind.

Key words
Suicidal mind • Mental pain • Prevention

Despite massive research on the topic of suicide, the mystery of such a peculiarly human phenomenon remains generally unsolved. Results from studies from different disciplines, however, emphasize the complexity and multifactorial nature of suicide. Often, unfortunately, such complexity is restricted by the use of an obsolete paradigm and dismissed with single diagnostic labels.

Psychiatrists and mental health professionals often feel responsible for the lives of their patients. Suicide is, without doubt, the event that is most daunting in clinical practice. According to Simon [1], the law tends to assume that suicide is preventable if it is foreseeable. Some scholars oppose such a view by supporting the notion that suicide is never foreseeable, assuming that such a notion has the same meaning of predictability. While psychiatrists can never predict suicide because they are not prophets, we need to assume that they can foresee a suicide because they are clinicians. Delivering a message that a clinician has no tools to master, at least in part, the complexity of a given phenomenon, is equal to exposing that clinician to a lawsuit. Having the opportunity to assess suicide risk and provide whatever means necessary to clinicians in order to prevent

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Correspondence
Maurizio Pompili
Department of Neurosciences, Mental Health and Sensory Organs, Suicide Prevention Center, Sant'Andrea Hospital, Sapienza University of Rome, via di Grottarossa 1035, 00189 Rome, Italy
• E-mail: maurizio.pompili@uniroma1.it

suicide is the major goal when dealing with suicidal individuals.

Suicidologists have now switched from risk assessment (such as collecting data regarding the presence *vs* absence of risk factors and protective factors as well as warning signs) to risk formulation (such as understanding of how risk factors combine, interact and fuel suicidal behavior, and are buffered by protective factors, and knowing which warning signs place individuals at increased short-term risk). Prediction is, therefore, something that should not worry about mental health professionals. Rather, they should focus on the interventions necessary to reduce suicide risk. Scholars now point to the need of comparing current risk state to the patient's "baseline" state and worst-point state which may shed light on effective interventions and foreseeable changes that could increase or decrease risk [2]. Foreseeable here means having collected as much information as possible and being able to make the best decision for a given individual. It should be clear that adverse events (suicide or suicide attempt) after such a meticulous documented assessment should not constitute a source for accusing mental health professionals of malpractice.

In support of the need to broaden our view on how to deal with suicide risk are the recent results for nationwide data. These findings point to the fact that the narrow vision encrypted in past models of suicide is challenged by the urgent need to reconceptualize suicide risk in an individual in crisis, regardless of the psychiatric diagnosis or other nosological labels.

The Italian National Institute of Statistics [3] conducted a study of the Italian population on suicide in the three years 2011-2013, evaluating the presence of any physical or mental disorders. In the period considered, there were 12,877 suicides (of which 10,065 were men), and about one case of suicide out of 5 had significantly associated morbidities [3]. In particular, in 737 suicides, the presence of relevant physical diseases was documented, of which 288 had a comorbid mental disorder. In 1,664 cases, the study reported the presence of mental disorders without comorbidity from relevant organic diseases. However, in more than 80% of the cases, there were neither mental disorders nor relevant physical illnesses.

Similarly, the Centers for Disease Control and Prevention in the United States found, between 1999 and 2016, a 30% increase in the suicide rate, indicating that about 54% of cases were not associated with any mental disorder [4].

We are now in need to open a new discussion on suicide prevention by providing a paradigm shift that takes into consideration how more precise approaches should substitute obsolete models. In the era of precision in medicine and mental health, there should be precision in suicide prevention. This is achieved with the fight against stigma and the surrounding taboo of suicide. While centuries of condemnation still influence our present view of suicide, we can catch up with new and positive perspectives with help for those with suicidal risk.

Understanding the suicidal mind

Campaigns have been launched to make sense of what makes a specific individual suicidal. However, encountering a suicidal individual remains for the majority of professionals and common people, a challenging task. We know that suicidal individuals give definite warning signs, mostly derived from their ambivalence about ending their own lives. Among the constructs used to describe the wish to die, a simple but extraordinary model has proved, at least for its straightforwardness, to be useful in describing the suicidal mind. Edwin Shneidman [5] first posited that the suicidal individual experiences unbearable psychological pain (*psychache*) or suffering and that suicide might be, at least in part, an attempt to escape from this suffering. Shneidman [5] considered psychache to be the main ingredient of suicide. According to this model, suicide is an escape from intolerable suffering, emphasizing that suicide is not as a movement toward death but rather as an escape from intolerable emotion, unendurable or unacceptable anguish. Experiencing negative emotions, with an internal dialogue making the flow of consciousness painful and leading the individual to the ultimate conclusion, 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 [6].

For Shneidman [7], suicide is the result of an explosive mixture consisting of four basic ingredients. He listed such ingredients as follows: heightened inimicality (acting against the individual's best interest); exacerbation of perturbation (refers to how disturbed the individual is); increased constriction of intellectual focus; 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.

The concept of inimicality in this instance refers to those attitudes of the individual that lead him to act in a way that is not at all friendly to himself, to the point of becoming his perverse enemy. In suicidal individuals, this state is present, and the individual is struggling with pressures of various kinds such as physical health, refusals, feelings of failure, pain and other negative emotions. The individual fails to manage these issues with the resources he has available.

Shneidman believed that in suicide, "death" is not the keyword. The key word 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 dying by suicide in the future.

The understanding of the suicidal mind requires knowledge of the perturbed state of the individual in crisis since this provides the motivations for the individual to contemplate suicide. Therefore, asking where the suffering comes from and how it has changed and become more acute is a method of intervention which, although simple and intuitive, is often forgotten by those, who are responsible for managing the person in crisis. In the internal debate, essentially involving ambivalence, being able to tune into the suffering of the person makes it possible to stem such ruminations and bring the discussion back to a position of vitality and hope.

Perturbation supplies the motivation for suicide; lethality is the fatal trigger. Everyone who dies by suicide feel driven to it and feels that suicide is the only option left [8]. The concept of "constriction" is defined as tunnel vision or rather finding oneself with a reduced number of options to cope with the suffering. Suicidal individuals experience dichotomous thinking, that is, wishing either some specific (almost magical) total solution for their perturbation or for cessation, in other words, suicide It seems that, although there may be effective supports from family and friends, the individual is unable to benefit from them. The pleasant memories and their history in relation to others are not helpful, and the individual focuses on intolerable emotions and how to escape from them.

The concept of cessation comes into play when the individual develops the idea that one can put an end to the drama that takes place in his mind through dying. The individual then realizes that with death he will bring a solution to his experience by eliminating all the elements that torment him in life.

Suicide is the result of an interior dialogue during which the mind scans its options [8]. During the early phases of this process, suicide is considered as an option, but it may be rejected a number of times. Shneidman [9] reported an emblematic process referring to the word 'therefore' "*almost every decision that a person makes (based on some unspoken reasoning in the mind): it is the logical bridge between almost every thought and every action (or deliberated inaction). Among all the ... therefore, I ..." sequences that are possible in the mind, one of the most important ones is contained in the words: I' ... therefore, I must kill myself".*

Suicide planning is often a long and complex process. The person begins to think of a propitious moment; he must have time to prepare. During the weeks and days preceding the actual planning until the act is implemented, the individual continues to dialogue with himself or herself with a large number of thoughts. They can refer to the fact of not being worth anything for themselves let alone for others, of not having been a success, of being a burden for oneself and one's loved ones, that no one will ever love them, or to be a coward so much that one cannot even die by suicide. After debating, to overcome the survival instinct the person must have, at least just before the act, such impulsiveness, and aggression as to make a gesture against nature. Thus begins an increasingly tight challenge in which a moment of excitement in the mood may also occur during which the person sees salvation in suicide, begins to glorify the act and configures it as a plan to put into practice, avoiding any interference on the part of the others. One must think of an act that appears to the subject as something forbidden but which feels necessary to improve his state. Suicide is an act that, in many cases, is premeditated for a longer time than is believed. Only after this time does the act become an impulsive gesture. The individual has repeatedly thought about taking his own life but this option, every time it occurred, although it was discarded, took on a greater value. It is at this juncture that the subject at risk of suicide begins to give signals in which he conveys the message of being tired of living, of thinking about death and of wanting to die. It is a problem of human life for which "emotional storms" occur, great movements of ambivalence, and at the same time changes in sleep habits, appetite, personal hygiene, and social relations. In this period of premeditation of the lethal act, the subject at risk also thinks of his loved ones, feeling regret and guilt for considering such a tragic solution. In some cases, there are also complex dynamics within the family, with the partner, or with friends, such that the suicidal individual almost reproaches them for not receiving adequate help from them.

Moreover, the subject at risk feels hopeless, and his mental pain feels unique, and he reaches this conclusion after experiencing the fact of not being able to communicate his suffering to the people assigned to help. The desire to die happens in each person with substantially unique motivations and thoughts, which makes him different from all other people at risk of suicide.

Shneidman [5] also considers that the main sources of psychological pain are shame, guilt, anger, loneliness, and despair originating in the frustrated and denied psychological needs. In the suicidal individual, it is the frustration of these needs and the pain that results from it, that is considered by him to be an unacceptable condition for which suicide is seen as the most appropriate remedy. There are psychological needs with which the individual lives and which define his personality and psychological needs which, when frustrated, induce the

individual to choose to die. We could say that this is the frustration of vital needs. These psychological needs include the need to achieve some goal such as joining a friend or a group of people, gaining autonomy, opposing something, imposing on someone, and the needs to be accepted and understood and receive comfort.
It is essential to monitor suicide risk at all time by taking into consideration warning signs for suicide, such as any change in habits, especially if insomnia is presented and any reference to the wish to die. People may feel trapped and may engage in maladaptive behavior, such as drinking alcohol and using psychoactive substances. Suicidal individuals also often put their affairs in order and give away symbolic items, as if they wish another person will take care of a prized possession, regardless of their economic value.
Studying the content analysis of the pain narratives of suicidal patients, Orbach [10] refers to specific features of the suicidal mind: These include; change in the self, experiences of self-estrangement accompanied by dissociative characteristics; a sense of worthlessness, emotional impoverishment, and loss of self-esteem. Furthermore, the mind is often characterized by the experience of loss, such as events of loss that lead to an interruption in one's sense of self-continuity together with loss in one's meaning of life. There are also oxymoronic experiences, extreme contradictions in feelings, thoughts, and desires – to live and die at the same time or grandiosity *vs* humiliation. Besides, the language of pain points to the fact that ordinary words do not suffice to describe these idiosyncratic experiences.

Critical appraisal of psychiatric disorders in the context of the suicidal scenario

Unlike the decision to confine suicide risk to the realm of symptomatology of psychiatric disorders, nowadays new insights into the phenomenon of suicide have led to considering that psychiatric disorders do play a contributing role, but a more profound understanding of the suicidal mind is needed [11]. Rather than categorizing the suicidal individual under the diagnosis of psychiatric entities, clinicians need to be able to recognize the drama occurring in the mind of a unique individual who may also be depressed, bipolar or suffering from other disorders. Most psychiatric patients do not die by suicide. Psychiatric patients are suicidal only when negative emotions are so painful that suicide is the only option left, and when the suicidal mind is hosted in an individual's mentally disturbed brain. Suicide is not, therefore, a specific and narrow symptom of depression. Instead, it is a behavior "combining features of a declaration of war with a petition for bankruptcy" [12] as well as having profound social implications [13].

Considering suicide risk to be merely a symptom impairs the opportunity to fully investigate and understand suicide. Attempts to explain, predict, and control suicide requires an understanding of what suicidal thoughts and feelings mean to those who live it. Other than collecting a huge amount of data for research activities, efforts should also be directed to understanding first-person data of the subjective, lived experience. Such an approach is an essential complement to the objective, third-person data, and methods of traditional science. Understanding the unbearable mental pain means thinking phenomenologically and, therefore the development of suicidal tendencies can be traced back to a state with similar characteristics as falling in love but flipped for affective valences. It is a pervasive condition with both psychological and somatic roots which incorporate the individual as a whole. 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.
To distinguish suicidal contents from psychiatric diagnosis it is necessary to think that the elements that support the desire to dying constitute a process in its own right, with a logic typical of the mind that suffers and that tries to devise a solution to reduce and resolve this suffering. Since the nature of suffering that results in suicide is due to the personality of the individual, to his frustrated psychological needs, and to the wounds of the ego (defeats, humiliation, shame, etc.), one can, therefore, differentiate that suffering from the typical suffering of depressive symptoms. Subjects at risk of suicide develop a thinking process called dichotomous thinking because they reason with only two options when confronting the suffering that has become unbearable: continue to suffer or obtaining immediate relief from pain by suicide [8].
This process derives from an inner dialogue that the individual has with himself to seek a solution to his drama in the mind. Independent of psychiatric disorder, clinicians are required to understand this complexity, without which the risk of suicide cannot be decoded. If this process is not interrupted by a change through, for example, help from someone, the individual approaches the final decision and, to quote Shneidman, *"The spark that ignites this potentially explosive mixture is the idea that one can put a stop to the pain. The idea of cessation provides the solution for the desperate person"* [7].

Communication of suicidal intentions

Among the myths often cited to describe idiosyncrasies in the phenomenon of suicidal behavior, current popular opinion state that people who talk about killing themselves rarely die by suicide; whereas, most peo-

ple who die by suicide have given some verbal clue or warning of their intentions. Some studies show that as many as 2/3 rds of suicide deaths share their intentions before dying by suicide. The study by Robins and colleagues [14] was probably the first attempt to address this issue through collecting data for a sample of suicides, and the study remains as one of the few contributions to the literature in this area. Despite the understanding of the communication of suicidal intent, no previous work has examined this fact through a meta-analytic investigation. A recent meta-analysis has shown how suicidal communications are key elements preceding suicides, confirming for the first time with clear figures how suicidal individuals express their intentions before the final act [15].

Unlocking the suicidal mind by a proper understanding of the subjective experience

Unlocking the suicidal mind is the most challenging of all tasks. Many models describing suicide fail to provide a proper understanding of this multifaceted human condition. Stigmatization and fear often provide reasons for empathic disconnection. Furthermore, even when dedicated clinicians are willing to consider all of the patient's needs, we cannot imagine how much these patients suffer. In fact, in order for empathy to occur it is necessary that we should have, in our own experience and in our own minds, some points of reference that correspond to those of the patients' experience of states of intense suicidal arousal or excitement [16 17].

I agree with Zoe Boden [18] in her view of the experience of suicidal individuals, *"Acknowledging the felt aspect of the experience is, I will argue, necessary for developing a fuller understanding. Recognizing 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, listening to what follows from the partial quote at the start of this chapter was one of those times"*. To understand suicidality, the individual must be understood holistically and met in his or her experience as it is, rather than broken down into risk factors and behaviors.

I also support what suicidologist David Jobes [19], recently stated. *"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".*

Conclusions

There are still many unmet needs for suicidal individuals, and too often such needs are disregarded as unimportant or of secondary importance. Clinical experience and recent data point to the need for a broader understanding of the suicidal mind. Although many scholars emphasize the importance of risk factors for suicide, such factors are usually static and derived from studies of people not necessarily representative of suicidal individuals in the general population. Such cohorts are sometimes small and belonging to narrow subpopulations which impair proper generalization.

Each individual is unique, with a unique presentation of suicidal wishes. However, most individuals can refer their suffering to specific unmet needs, allowing categorization according to the nature of what is lacking in their lives.

Modern psychiatry now witnesses is conveyed in a paragraph of the introduction of DSM-5 [20], that is *"Diagnosis of a mental disorder should have clinical utility"* but *"the diagnosis of a mental disorder is not equivalent to a need for treatment. Need for treatment is a complex clinical decision that takes into consideration symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient's distress (mental pain)"* and *"Clinicians may thus encounter individuals whose symptoms do not meet full criteria for a mental disorder but who demonstrate a clear need for treatment or care.*

The fact that some individuals do not show all symptoms indicative of a diagnosis should not be used to justify limiting their access to appropriate care" (p. 20). Far from being an unexpected phenomenon, suicidal behavior is characterized by many warning signs that often allow key clinical decisions that save the lives of individuals in crisis. The challenge of suicide prevention is to painstakingly develop a culture both in clinical populations and the general population to take care of suicidal individuals starting from their basic frustrated psychological needs. The task is to adopt a phenomenological approach that directs the attention of helpers inside the human experience of mental pain.

Conflict of interest

The Authors have no conflict of interest to declare.

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