Chronic suicidal ideations: a risk or a protection

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ABSTRACT

Chronic suicidal ideations can be consistently present as part of the individual's sense of identity and self-regulation or as a reoccurring pattern to control intense feelings and communicate and relate experiences or intentions. While they can be the precursor to self-harm and suicide attempts, requiring a thorough risk assessment, they can also represent a way to control, avoid, or contain intolerable feelings and experiences. In addition, suicidal ideations can be either deeply internalized and hidden or indirectly or directly conveyed to others. This article focuses on understanding and approaching chronic suicidal ideations that specifically relate to self- and interpersonal characterological functioning, *i.e.*, sense of identity, self-regulation, emotion regulation, and interpersonal intentions. Suicidal ideations must be identified and assessed both in terms of intention, *i.e.*, motivation, plans, and means to harm oneself or end one's life, as well as in terms of function, *i.e.*, related to self-regulatory strategies for counterbalancing or protecting against overwhelming, painful, and frightening external, interpersonal, or internal experiences. Therapeutic strategies and challenges will be discussed, including engaging patients in the therapeutic alliance and building consistency, trust, and reliability.

Key words: suicidal ideations, psychotherapy, therapeutic alliance, risk assessment, personality disorder.

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Introduction

Suicidal ideation is a broad concept with several meanings and connotations beyond the immediate association with ending one's life (Harmer *et al.*, 2023; Klonsky *et al*., 2021; Maltsberger *et al.*, 2010). While suicidal ideations can be the precursor to self-harm and suicide attempts, thoughts about suicide can also represent something very different. Thinking about and envisioning suicide can be a way to avoid or contain intolerable feelings and experiences. Alternatively, it can also be related to intentions to communicate something beyond words and regular interpersonal interactions. In other words, suicidal ideations can represent a way to take charge and control, to avoid and escape, as well as to be seen and heard, to have an impact, and even to convey a need with a wish to be cared for in the context of despair, rage, and loneliness. Suicidal ideations can be either deeply internalized and hidden or indirectly or directly conveyed to others. The frequency of these thoughts can vary widely, from occurring rarely in specific situations to being more reoccurring and connected to the individual's sense of identity or even consistently preoccupying the individual's internal life. For clarity, in this paper, the words "suicidal ideations" are used as an overarching concept referring to a range of thoughts, including wishes, fantasies, envisions, and preoccupation with suicide. Wishes or fantasies are associated with more passive and less reality-anchored ideas related to not living or ending life. Envisions of suicide imply imagining or visualizing a future possibility of ending life, while preoccupation with suicide represents a closer connection between thoughts and implementation, still remaining separate from imposing urges or

determined intentions to end life with plans and preparations to attempt suicide.

Suicide has often been perceived as a way to surrender or give up (Maltsberger, 2004). Another way of understanding suicidal ideations is as representing resistance, like motivational energy with the ability to impact change. It can be a way to tolerate weakness or disgrace and represent awareness or a tool for a way out of something perceived as unresolvable or intolerable: "I can kill myself, but it is my decision if, when and how I do it, or if I do not do it".

Thoughts about suicide can occur in certain stressful situations or life contexts and appear associated with or indicate an escalating risk for self-harm or suicidal actions. In these situations, risk assessment is extremely important, including an evaluation of the degree to which a patient's suicidal ideations are associated with specific urges, plans, and intent and, when necessary, implementing immediate interventions that are needed to protect safety. However, it is also important to explore and identify whether and when suicidal ideations can have an organizing protective effect and paradoxically prevent active intents and plans to end life, as opposed to when they are associated with action imposing self-harm or suicidal urges and intents. In suicide risk assessment, it is essential to differentiate between ongoing suicidal preoccupation that can represent an indication and risk for suicide *versus* suicidal ideations that may not primarily, immediately, or even at all relate to self-harm or intentions to end life. It is also essential, when possible, to differentiate between suicidal ideations as part of a psychiatric disorder such as major depressive, bipolar, or psychotic disorder as opposed to suicidal ideations escalated in acute life crises or as part of a personality disorder (American Psychiatric Association, 2022). This differentiation is important for the choice of primary treatment modality that can potentially be most effective for reducing the risk of intentional suicidality, *i.e.*, medical, psychotherapeutic, or both combined. The patients' potential ability to connect in therapy and relate their subjective experiences and motivations for suicide can be more or less severely compromised in the context of a major psychiatric disorder. Similarly, a patient with such a psychiatric condition may even experience suicidal urges out of their control, imposing and ego-dystonic. However, when patients are struggling with characterological problems and personality disorders with or without depressive symptoms, the subjective motivation and meanings assigned to suicide can be more apparent and often relate to the sense of identity and self-worth, interpersonal struggle, and strong emotions, such as anger, shame or guilt, extreme fear of losses or failures, or early trauma. Similarly, the individual's life context and level of functioning are additional factors that influence the meaning and purpose of suicidal ideations, and these are also important to take into consideration in risk assessment and the choice of treatment modality. Suicidal ideations occurring in the context of unexpected, acute, overwhelming life crises are different from those associated with chronic detachment, disengagement, and low functioning in life. Engaging patients' reflective ability and sense of agency is essential for helping them identify and balance suicidal intentions, understand the roots and causes, and attend to the impact on close relationships and losses in life.

In sum, suicidal ideations must be identified and assessed both in terms of intention, *i.e.*, motivation, plans, and means to harm oneself or end one's life, as well as in terms of function, *i.e.*, related to self-regulatory strategies for counterbalancing or protecting against overwhelming, painful, and frightening external, interpersonal, or internal experiences. Given that the majority of people with suicidal ideations do not attempt or complete suicide (Nock *et al.*, 2008), it is important to further differentiate and understand when suicidal ideations are connected with lethal intents, with attempts or self-harm without lethal intentions, or even with no intention to self-harm or end life (Klonsky *et al.*, 2016). Consequently, attention to the multifactorial context as well as to the individual motivational intentions and subjective functions of suicidal ideations is key in the assessment and treatment of patients who are chronically or recurrently preoccupied with suicidal ideations.

This paper aims to outline and discuss different strategies for identifying, understanding, risk-assessing, and approaching chronic suicidal ideations that specifically relate to self- and interpersonal characterological functioning (*i.e.*, sense of identity, self-regulation, emotion regulation, and interpersonal intentions). An integrated characterological approach to chronic suicidal ideations is important in assessment and treatment to further differentiate between their range of functions and context. This approach is also essential for assessing primacy as well as balance between risk *versus* protection against suicidal intentions and actions aimed at ending life. Case examples will highlight different contexts, functions, and expressions of suicide preoccupation.

Chronic suicidal ideation

Studies on suicide have often automatically connected suicidal ideation with self-harming behavior or suicide attempts, and such designs usually do not differentiate between ideations that lead to attempts *versus* those that are not connected to suicide-intended actions (Klonsky *et al.*, 2021). Similarly, studies of risk factors for suicide, such as depression, isolation, mental pain, *etc*., have typically not attended to the differentiation between suicidal preoccupation *versus* self-harming or suicidal actions. In other words, suicidality and suicidal ideations have usually been studied as a "single factor" phenomenon related to ending life, *i.e.*, as a proxy for completed suicides, with the main focus on risk assessment rather than focusing on the individual psychological meaning and function of the suicidal ideations. The question remains about the difference between ideations that are associated with and indeed can lead to self-harm or suicide-intended actions *versus* those that do not. In other words, what personality pathology and context can contribute to the "ideation-action" direction, *versus* what can serve to solely preserve ideations and associated non-suicidal intentions. This is especially essential when assessing and treating patients with chronic suicidal envisions or recurrent suicide-related preoccupation.

Chronic suicidal ideations can be consistently present as part of the individual's character structure (Schwartz *et al.*, 2018; Sinha *et al.*, 2017), related to the sense of identity and self-regulation, as a re-occurring pattern to control intense feelings, and communicate and relate experiences or intentions. As Maltsberger *et al.* (2010) pointed out, "sustaining suicidal fantasies" are organizing and comforting and serve the structural function of fortifying and weakening narcissistic integrity. For some individuals, access to recurrent suicidal fantasies or envisions can serve as a relief, and for others, it is associated with strong, painful feelings ranging from frustration, anger, or despair to guilt, shame, and fear. Chronic suicidal ideations can also relate to unresolved grief and longings with fantasies to join a lost deceased person. When characterologically anchored, chronic suicidal envisions or preoccupation in individuals with personality pathology can have very specific subjective motives or functions, become "a way of life"

or "a way out", and provide a strategy to manage difficult situations, and tolerate emotions and suffering (Paris, 2004).

Chronic suicidal ideations have often been observed and understood in the context of characterological functioning, including cognitive, behavioral, and affective manifestations with a related risk for suicide. Studies of personality dimensions identified temperament, impulsivity, fragile self-esteem, and emotion dysregulation as specifically connected to suicide. Chronic suicidal preoccupation has also been associated with non-lethal self-harm in borderline personality disorder (Hennings, 2020; Paris, 2002, 2004; Sansone, 2004). Several studies have pointed to the specific function and accompanying assessment strategies of chronic suicidal preoccupation. For people with borderline personality pathology, preoccupation with suicide can be interpersonally connected with the intent to manipulate, get attention, ask for help, or even redirect attention away from more personal, central aspects of their problems and needs for change. In other words, suicide can be a way to interpersonally communicate or enact distress (Paris 2002, 2004), and impulsive self-harming actions or suicide attempts can occur in the context of aggression, revenge, or abandonment.

For people with narcissistic personality pathology, chronic suicidal ideations can remain deeply internalized and effectively compartmentalized, containing and hiding humiliating, degrading, or traumatizing experiences totally unrelated to self-harm or random suicide attempts. Incorporated in self-regulation, chronic suicidal ideations can become a way to maintain a sense of control and avoid interpersonal attention or interactions. For these individuals, their narcissistic, more rigid, and less impulsive personality functioning can be protective against non-fatal suicide attempts. However, narcissistic personality functioning can also be associated with highly lethal suicidal actions due to the ability to compartmentalize, maintain control, and have intentional determination (Coleman *et al.*, 2017; Ronningstam *et al.*, 2018). For patients with psychotic disorder, suicide may symbolize something totally different that may or may not relate to ending life, but that can also suddenly and unexpectedly escalate into suicidal action. This depends on how well the patient can respond to antipsychotic treatment or avoid psychosis-escalating substances or activities (Goldblatt *et al.*, 2016).

In sum, "chronic suicidal ideations" are defined in this paper as long-term situationally occurring envisions or consistent preoccupation with thoughts about suicide, without a history of attempted recurrent suicide, and without actual intents or plans to end life. In addition, chronic suicidal ideations are not associated with or a symptom of a major psychiatric condition but are primarily defined in terms of characterological functioning and explored within the frame of the individual's life context and personality functioning. This encourages explorations of what suicidal ideations can represent and symbolize beyond ending life.

Assessment of chronic suicidal ideations

When patients start to allude to or mention that they are occasionally envisioning or are more consistently preoccupied with thoughts or feelings related to suicide, it is important for a therapist to evaluate whether their thoughts are tied to capability with intents, plans, and methods, *etc*., which require necessary interventions, but to also be open for further explorations and not automatically assume an acute risk for suicide with a need for hospitalization. In terms of risk assessment, it is important to differentiate between patients who indeed have a history of suicidal or self-harming actions, who are facing extremely challenging life experiences or unexpected changes, who are actively abusing substances, and who have a family history of suicide. Although it is very difficult and often not possible to foresee if or when chronic suicidal preoccupations can turn into an actual risk for suicide with intended actions, there are still strategies that can help identify their main function. Inviting patients' descriptions and narratives of their associations and experiences with suicide-related thoughts and feelings is essential. The risk of lethality in patients with chronic suicidal ideations who do not want to die or do not want to hurt anybody is different from patients for whom such thoughts or urges are intended to retaliate or hurt others or are entirely focused on escaping and ending their own lives. In other words, suicidal ideations that serve to mitigate hopelessness, relieve distress, protect self-cohesion, and redirect away from suicidal action are different from those ideations that are associated with suicidal crises and loss of self-cohesion, with a more immediate connection to actions (Maltsberger *et al*., 2010). Furthermore, it is very important to consider the life contexts in which suicidal ideations are associated with or escalated.

Therapists' non-judgmental curiosity and inquiries about the patient's thoughts and feelings are important for anchoring attention and openness to suicide in the therapeutic alliance. Questions like "what do you think made you start to feel or think about suicide?", "what do you sense or feel is happening with you when you think about suicide?", "do you notice changes in the way you feel about yourself or relate to specific situations or people when you feel suicidal?", or "do you sense that you are handling situations differently, maybe even more effectively when you are thinking about suicide?", can provide information about the patient's intentions and the self-regulatory functions of suicidal ideations. They can also reveal important connections and meanings to suicide, like one patient who said, "it is overwhelming to be alive, and I wish I could die" *versus* another patient who confessed, "paradoxically I feel that my association to suicide has helped me survive in life".

Attention to more consistent and deeply rooted internal experiences and sense of themselves, especially the most vulnerable aspects, can be very challenging for the patient to attend to and verbalize. Patients can relate to such fundamental experiences as being a "small scared or ugly child", being "unwanted" or a "nature's mistake" or having caused burden or suffering for others. Struggles with emotional intolerance or difficulties in connecting interpersonally can also contribute to a deep sense of worthlessness and loneliness. Inviting and encouraging the patients' ability to engage in the therapeutic alliance, to relate and build trust (Fonagy & Alison, 2014), are vitally important conditions for enabling and motivating them to reflect upon, verbalize, and describe their personal internal experiences. Building consistency and regularity in the therapeutic alliance and conveying that the patient has an impact on choices and control, *i.e.*, a sense of agency (Fonagy *et al.*, 2018), can serve to diminish the risk of enactments, power struggles, hiding suicidality, *etc.*

Suicidal ideations can also be more undefined and relate to a deeper sense of lack of purpose and meaning in life, regrets of past decisions, anticipations of future failures, or evidence of worthlessness with a loss of affiliation. They can even relate to a more consistent sense of self or life, accompanied by pessimism or nihilism. This can readily be associated with major depressive disorder but remains unremitted with the usual medical depression-focused treatment, including psychopharmacology, ketamine, transcranial magnetic stimulation, or electroconvulsive therapy. A way to begin such an explorative assessment is to ask

"what do you think causes your thoughts of ending your life?" and "is the wish or envision to end your life the only way to deal with these situations or anticipations, or can there be other perspectives or solutions to these challenging experiences?". The patient's often extreme and insurmountable sense of loneliness is also important to attend to, as preoccupation with suicide can be an indication of loneliness and a way to attempt connection. However, loneliness can also be associated with unbearable affects that can drive suicidal action. Consequently, reaching and engaging the patients in their alone space and encouraging them to convey their experiences is crucial both for assessing their affect tolerance and for helping them begin to process their emotional experiences. In addition, it is important to explore the patient's understanding of the interpersonal function of their thoughts about suicide. A way to inquire is to non-judgmentally ask the patient a question like "how do you think people in your life who know you, *i.e.*, family (spouse, children, parents), relatives, friends, peers, or colleagues would feel and react if you end your life?". This type of question can invite the patient to reveal more of their "ideation-action" position, *i.e.*, whether the internal barriers *versus* connections between their suicidal ideations and actions are indications of suicide risk or not. A response like "this is why I am not intending to kill myself, because I don't want to hurt them. I do love them, but I still don't want to live" is different from "I don't care, and I don't think they care either," "I think they would be relieved since I wouldn't be able to harm them anymore," or "maybe my suicide will teach them a lesson".

Another risk assessment relates to the connection between suicidal ideations and life context. Suicidal ideations can be conditional and evoked in the context of specific events, *e.g.*, losing a relationship, a job, or affiliation, or facing major financial losses or bankruptcy, *etc*. In other words, specific, unexpected, or extreme life events can suddenly evoke overwhelmingly intense emotions and impact the "ideation-action" balance, possibly escalating the individual's suicidal intents, plans, and actions. That differs from specific traumatizing experiences in the past that could have severely threatened the patient's self-esteem and sense of identity but remained compartmentalized and unprocessed. In such a context, suicidal ideations can have an organizing effect contributing to the ability to survive, take charge, and hold an overwhelming, insurmountable experience.

Therapeutic challenges and strategies

Therapists who are seeing patients who directly or indirectly indicate suicidal thoughts or preoccupation face a balance between focusing on the danger of completion *versus* the root causes and functions of the suicidal ideas or envisions. Linehan *et al.* (1983) recommended that therapists first focus on the causes of risk rather than pursuing hospitalization. The major challenge for a therapist is to attend to and assess whether or not suicidal ideations primarily represent and remain an internal cognitive-emotional process without intents or plans to harm oneself or to end life, and when suicidal ideations can transform into motivation that results in action to self-harm or attempt suicide. As pointed out by Schwarts *et al.* (2018), a treatment approach that can be effective for patients in an acute state of suicidality with potential or imminent risk for action may be ineffective or even lead to escalating suicide risk in patients with chronic suicidal ideations.

Engaging patients' trust and curiosity in a collaborative therapeutic relationship is essential for figuring out what thoughts related to suicide can represent or symbolize. In particular, it is important to identify why and how each individual's subjective suicidal ideations can serve an ongoing sustaining function as opposed to leading to action, since suicidal thoughts may have an organizing function. One patient conveyed to his therapist that "talking more in debt about the experience of facing my father's breakdown when he lost his job when I was 7 years old, is horrifying. It is easier to think about suicide". This was the first time he, as an adult, faced the overwhelming internal pain and emotions that, until then, had been contained by his suicidal ideations. In other words, thinking about suicide had been a way for the patient to distance himself from his own experiences and reactions when he alone was facing his father's crises. When he began to describe the memories in depth, he realized that he felt powerless and guilty because he had not been able to protect or help his father. He felt totally overwhelmed and frightened by his father's extremely intense reactions (banging tables, crashing a window, *etc.*), and he also felt angry at his father for not being able to handle the situation in a more calm and thoughtful way, like he had seen his friend's father do when he had faced an unexpected problem. When beginning to access and discuss his feelings, he also noticed his suicidal thoughts diminishing and gradually disappearing. One day, he frankly admitted that he missed having suicidal ideations, as they had been easier to deal with than all the emotions connected to the traumatizing experience. Paradoxically, in the process of functional and self-regulatory improvement, a patient may start to feel worse when facing emotions that can be challenging or initially intolerable. Compromised emotion tolerance, psychological concreteness, and fear related to giving up deeply engrained functional patterns can contribute. In addition, the patient may experience a challenging or initially frightening change related to vulnerability, exposure, closeness, or dependency towards the therapist.

For some people, suicidal ideations can support self-regulation and self-control, *i.e.*, provide a way to counterbalance unbearable feelings or redirect attention away from difficult aspects related to the sense of identity or life context. This is different from patients whose suicidal preoccupation is motivating and directing towards plans and actions to harm themselves or to end life. Attending to patients' suicide-related motivation, capability, and sense of agency is important. Assessing and exploring the motivations underlying a patient's suicidal process, including death, dying, and related actions, can provide a useful guide for the therapist to encourage the patient's engagement in the therapeutic alliance (Moselli *et al.*, 2021). From a therapeutic perspective, this is important to keep in mind, as patients who are counterbalancing limitations in their ability to tolerate and process life conditions and related emotions may detach and retreat to suicidal ideations as a self-regulatory mechanism.

A woman was facing her spouse's increasing dissatisfaction with their marriage. One day, he announced that he had met "the love of his life" and decided to pursue divorce and engage in this new relationship. Starting psychotherapy, she told the therapist that this was the most devastating loss in her life, not so much the actual divorce but the fact that her husband had met a woman who surpassed her. She felt she had totally lost value and purpose in life. On the other hand, she also had two small children she loved and cared for, and she decided to take custody of them. As a result, she developed a split sense of herself. On the one hand, she envisioned herself ending her life because of a total loss of value; on the other, she valued her life and remained committed to herself as a mother to her children. To her therapist, she openly declared that she did not intend to end her life, but she was not ready to process and give up the envisions of suicide with the possibility

of ending her life. Gradually, she was able to process her intense reactions of shame and loss of identity and value as a woman and spouse, and at the same time, she was able to further integrate her female identity as a mother and professional woman, and her suicidal ideations slowly tapered.

In sum, psychotherapy can be challenging for patients with chronic suicidal ideations. Paradoxically, the main purpose of assessment and treatment, *i.e*., to increase self-awareness and control of problems and emotions, process difficult experiences, and make people feel and function better, can actually be challenging and make people feel worse for a while. Low emotion tolerance, concreteness, deeply engrained and accepted functional patterns, intolerance of gaze and being seen and exposed, *etc*., can contribute to a patient's discomfort or distress in the therapeutic process. This is why it is important to consider and evaluate suicidal ideations occurring as a part of a process of personality functioning that the patient is motivationally and intentionally engaged in. If suicidal ideations remain unprocessed, the organizing self-regulatory function of such thoughts may fail when patients face a new challenging, overwhelming experience that connects to or reminds them of the original event and experiences that first evoke suicidal ideations. This can contribute to a sudden change in motivation and intent, with an increased risk for suicidal actions.

The core issue regarding chronic suicidal ideations in the therapeutic alliance is to contain and incorporate the patient's preoccupation with the therapeutic alliance. This means that rather than having an alliance that is split off and remains unprocessed, the patient's suicide-related thoughts are brought into the therapeutic relationship and dialogue, which opens the possibility for the patient to be seen, heard, and understood. A prime aim is to make the patient's preoccupation with suicide an interactional part of the therapist's relationship with the patient, as opposed to an isolative part detached from the therapeutic alliance. We suggest three major questions to attend to in this exploratory process: i) when does the idea of suicide help the patient to contain and/or tolerate unbearable experiences, like for the patient who faced his father's reactions to losing his job?; ii) when does preoccupation with suicide present as a symptom that can suddenly or regularly escalate in certain contexts, *i.e*., when sad, threatened, enraged, or intoxicated, seemingly unrelated to any underlying problems?; iii) when are suicidal ideations representing or associated with a sense of identity, and deep containing, sustaining awareness of not being good enough, a "mistake", a "failure", a "burden" *etc*., like for the patient whose husband left?

In other words, the main focus is to differentiate when the idea of suicide actually can "support" or "improve" psychological functioning by helping to contain, compartmentalize, or split off incompatible, insurmountable, or unacceptable aspects of self and emotions, *versus* when suicide is perceived as a possible way out of overwhelming and intolerable life circumstances or emotions and therefore presents an acute and immediate risk to the patient's life.

There are several limitations in the approach to identifying, assessing, understanding, and treating patients with suicidal ideations as outlined in this manuscript. Firstly, empirical validations of characterological-based chronic suicidal ideation have yet to be done. Secondly, as suicide and suicidal ideation are complex and multifactorial concepts with a range of underpinnings and expressions, there is still a need for specifying subgroups. Furthermore, the degree of emotional tolerance, comorbidity, and differences in processing external life circumstances are additional factors that may suggest a contextual and dimensional approach to assessing and treating suicidal ideations.

Conclusions

As outlined above, chronic suicidal ideations can be consistently present as part of the individual's sense of identity and self-regulation, or as a reoccurring pattern to control intense feelings and communicate and relate experiences or intentions. For some individuals, access to recurrent suicidal thoughts, *i.e*., fantasies, envisions, or preoccupation, can serve as a relief; for others, it is associated with pain and strong feelings, ranging from anger, despair, or frustration to guilt, shame, fear, or longing. Engaging patients in the therapeutic alliance and building consistency and reliability are core conditions and strategies for encouraging them to describe their internal experiences and the most vulnerable aspects of themselves. It is also important to convey that the patient has an impact, a sense of agency, and can make choices, *etc*., which can serve to either increase or diminish their own withholding, avoiding, enacting, or power struggle. This is important for building trust in the therapeutic relationship. The therapist's curiosity, openness, and non-judgmental inquiries of the patient's specific connections to and meanings of suicide are essential for implementing this process. It is also essential that the therapists attend to and hold the range of the patient's emotional experiences and reactivity. Processing one's own countertransference, intense reactions, and fear related to anticipation of a patient's suicidal actions can be very challenging for the therapist and require consultations and supervision to contain these feelings and access their informative value. In that context, it is also important for therapists to keep in mind that patients' verbalization of their suicidal preoccupation and range of related experiences can stimulate their emotional tolerance and self-reflective ability. Helping the patient describe and gradually integrate incompatible, unacceptable, or intolerable aspects of themselves as related to their chronic suicidal ideations can also encourage them to verbalize feelings of fear, shame, pain, anger, and grief. In this process, it is also important to help the patient connect the recurrent sense of powerlessness, weakness, and fragility with awareness of their own motivation, sense of agency, and life connection.

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