

No Feeling during Repeated Suicide Attempt: A Qualitative Study

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Abstract

Previous suicide attempt is the best predictor for future suicide and attempted suicide. Do the first and repeated suicide attempters differ in experiencing and monitoring a suicide action? The utterances of the narrative and the video self-confrontation interviews of 32 persons who attempted a suicide during the last one to three weeks were submitted to a qualitative content analysis (18 first time and 14 repeated suicide attempters). Nine (28%) persons claimed that they did not feel anything during the suicide act (2; 11% first time, 7; 50% repeated suicide attempters). It is argued that understanding this lack of monitoring (cognitive, emotional, pain) processes within the conception of suicide as a goal-directed action provides a better frame of reference for adequate suicide prevention than the Latin translation of this "distancing" as dissociating may do.

Keywords: Repeated suicide attempt; Cognitive; Emotional; Pain self-monitoring; Theory of goal directed action

Introduction

It has repeatedly been suggested that suicide prediction is very difficult and that mental illness diagnoses, as a risk factor for a suicide act, are of limited value [1]. Many variables were identified as relevant for the explanation of a suicide, but the amount of the explained variance is disappointing [2]. A number of the characteristics of the person, of the environment, but also of the suicide processes themselves were discussed in the research literature [3]. Several studies clearly indicate that the previous suicide attempt is the best predictor of a following suicide Beghi et al. Harris et al. Owens et al. [4-6]. The risk remains high for more than 20 years after the attempt [7]. However, as it is just a risk for a part of the first-time suicide attempters, it indicates that there is one group of people who repeat their suicide attempt and another one who does not. Who are those people who repeat a suicide attempt?

In a recent study Monnin and colleagues [8] analyzed the data of 273 participants in psychiatric emergency units after their admission for a suicide attempt. They reported that repetition of suicide attempts in 2 years following the initial attempt was associated with current follow up and treatment, a personal history of multiple suicide attempts, post-traumatic stress disorder, current recurrent psychotic syndromes and substance misuse. Men repeaters were characterized by substance use disorders, whereas the re-attempt in women was associated with current follow up and treatment, post-traumatic stress disorder, and higher BDI-SF scores (Beck Depression Inventory). The authors concluded that repeaters must be considered as a specific population among suicide attempters. Spittal and colleagues [9] studied the records of all individuals admitted to hospital for deliberate self-harm in two Australian states (~350 hospitals) in regard to a repeated episode of self-harm (non-fatal or fatal) within 6 months. Four variables-the number of prior episodes, time between episodes, prior psychiatric diagnoses, and recent psychiatric hospital stay-strongly predicted repetition. Medical records of suicide attempters who were admitted to a teaching hospital (n=418) were studied by Choo and colleagues [10]. Repeated attempters had a more complex clinical picture. Symptoms of psychotic illness, borderline personality disorder, and psychosomatic complaints of insomnia and headaches, as well as reports of adverse life events such as unemployment, divorce and quarrels, experience of negative feelings, and usage of alcohol were associated with risk of repeated overdoses with benzodiazepines and paracetamol. Jakobsen and colleagues [11] conducted a longitudinal population-based study of all adolescents

born in Denmark between 1984 and 2006. Greater numbers of hospitalizations, psychiatric diagnoses, and psychopharmacological medications prescribed to youths before and after the index attempt were risk factors for repeated suicide attempts. In a 6-month follow-up study Glazebrook et al. [12] found that those adolescents with insecure maternal attachment and insecure peer attachment were more likely to have repeated self-harm. Murphy and colleagues [13] studied a prospective, population-based self-harm cohort presenting to six general hospitals (1177 older adults). Independent risk factors for repetition within 12 months were previous self-harm, previous psychiatric treatment, and age 60-74 years. Older people who had a positive blood alcohol reading and were already in the care of mental health services at the index self-harm were more likely to repeat self-harm/suicide within 12 months Cheung et al. [14] Beghi and colleagues [4] identified in a 20 year literature search the evidence for predictors of repetition of suicide attempts and for subsequent completed suicide. The strongest predictor of a repeated attempt is a previous attempt, followed by being a victim of sexual abuse, poor global functioning, having a psychiatric disorder, being on psychiatric treatment, depression, anxiety, and alcohol abuse or dependence. They also concluded that it is difficult to find predictors for repetition of a suicide attempts. Suicide ideation, alcohol or substance abuse/dependence, and depression are not consistently reported to be very strong predictors for nonfatal repetition.

Thus, as many of the factors of the person repeatedly attempting suicide are inconclusive in their prediction Arensman et al. [15] one could ask, if there are any features of the suicide act itself that distinguish a repeated attempt from a first suicide act. Joiner's (2005) interpersonal theory of suicide proposes that deliberate self-harm becomes increasingly more reinforcing with repetition. Gordon and colleagues

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[16] found that consistent with prediction, people with more numerous past deliberate self-harm episodes felt more soothed, more relieved, and calmer following their most recent episode of deliberate self-harm. Contrary to prediction, greater numbers of past deliberate self-harm episodes were associated with more intense physical pain during the most recent episode. They suggest that the emotion regulation functions of deliberate self-harm may become more reinforcing with repetition.

It has been shown that patients after a suicide attempt differ in their assessment of their suicide act from health professionals, physicians and nurses, giving their loss of control prior or during suicide higher rating [17]. Although one could argue that the professionals might not properly understand suicide actions, it has been suggested that unbearable emotions precede a suicide attempt Rajappa et al. Shneidman et al. Troister et al. Williams et al. [18-21]. Others maintain that lack of expressing positive emotions is reeled to increased vulnerability to suicide ideation. It often is assumed, and it also probably is the case that these intensive emotions are also experienced during the suicide act. Therefore, as far as the suicide act itself is concerned one can conclude that suicide attempters experience a problem of action control and that emotional regulation is achieved by destructive means which become reinforcing for the next suicide attempt or deliberate self-harm. Steering, controlling and regulation are processes in and of an action. One part of their requirement is provided by monitoring processes of cognition, emotion and pain [22]. We argued that suicide could be studied as an action process [23,34]. It is a social and joint process Valach et al. [26] and the suicide action can be linked to a suicide project by top-down or bottom-up processes Valach et al. [25] However, we also maintained that the suicide action is a distorted action [26]. Particularly, monitoring processes were often found to be distorted. We were interested in finding whether the distortion of monitoring processes, particularly emotional monitoring, were more common in repeated suicide attempts.

Thus, the aim of this study is to find out whether first time suicide attempters and repeaters experienced any feelings, emotions and sensations during the suicide act and to analyze whether these experiences differ between these two groups.

Methods

The present study is a secondary qualitative content analysis of video-recordings from an earlier study with 40 patients Valach et al. [3,23] on suicide processes as described by them a few days after a suicide attempt. In 32 patients' interview protocols we were able to elicit the information whether it is their first or repeated suicide attempt.

Subjects

In a general hospital in Switzerland, a head psychiatrist invited patients hospitalized after their suicide attempt to participate in a research study which involved talking to a psychotherapist about their suicide attempt. The rate of patients garnered for the study was high, though a representative sample was not striven for. Patients with a diagnosis of a psychosis or considered as acutely suicidal were not eligible to participate in this study. We conducted interviews with 40 patients, 32 of them were included in this analysis, as they provided information whether the index suicide attempt was the first one or whether they re-attempted. As this is a clinical sample and not an experimental set up, the types of deliberate self-harm and suicidal action are manifold. These are the patients who were hospitalized for an intentional self-inflicted injury either with suicidal intention or possible fatal consequences.

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(SNRF) and was approved by the institution where the interviews were conducted (psychiatric out-patients clinic of the University Hospital), as well as by the ethics commission of the SNRF. In addition, we also received approval of the relevant departments of the University Hospital where these patients were hospitalized.

Prior to participating, the patients were informed about the procedure in detail, including videotaping the narrative and the self-confrontation interviews, and were asked to sign a permission form. They were informed that these videotapes would be seen by project collaborators, transcribed, and analyzed for research purposes. They were also asked for permission allowing us to quote substantial parts of these interviews in an anonymous form in scientific professional publications. They were reassured that a competent psychotherapeutic support would be provided during the whole procedure.

Setting

The interviews were conducted in an office in the psychiatric outpatient clinic. There were two video cameras, two video recorders, and two large TV monitors in the interview room. In addition, the Skin Conductance Reactivity (SCR) was monitored during the interview using a small electrode on patients and psychotherapists' palm. The SCR data are not reported here. Procedure After clearing all the formalities, the patients were asked and encouraged in an open-ended interview to tell the psychotherapist what happened regarding their suicide attempt Michel et al. [27]. The interviews lasted from 30 to 60 minutes and were recorded on video. After this narrative interview another project co-worker, a psychologist or a psychotherapist, conducted a self-confrontation interview (a video supported recall) with the patients, stopping the video every few minutes and asking the patients to report on any thoughts, feelings and sensations occurring during the interview, as well as any other thoughts the patients might have. The self-confrontation interviews were also video-recorded. The self-confrontation interview is a part of the action theory informed methodology Young et al. [28] that when well executed not only provide information about the inner processes during the narrative interviews, but also represent a significant contribution to suicide prevention Michel et al. [29]. The interviews were clinical and not research interviews. Thus, many of the conversations recorded may contain leading questions, as the clinician's displayed a different degree of experience. Nevertheless, the interviews were conducted as a part of the caring procedure provided by the psychiatric conciliar services for the general hospital patients.

Ethical Considerations

This project was approved by the Psychiatric Out-patient Clinic, the University Hospital, and by the ethics committee of the SNRF. The patients were well informed about the procedure in every detail, asked to sign a permission to videotape the interviews and asked for permission to allow us to quote substantial parts of these interviews in an anonymous form.

Analysis

The transcripts of the narrative interviews and of the self-confrontation interviews were searched through for utterances regarding the patients' monitoring (cognitive, emotional, pain) of and during their suicide action. These utterances were included indecently whether they were provided spontaneously by the patients or whether they were offered as a response to a question of the interviewer.

Findings

The suicide attempt narratives of all patients contained statements about whether it was their first (18; 56.3%) or a repeated suicide attempt (14; 43.7%) and about how they felt immediately prior to and during the suicide. Nine of the 32 patients (28%) said that they did not feel anything during the suicide act (23 patients did). The relevant utterances of all 9 cases are listed below. The patients did not feel pain while injuring themselves, they were not thinking about anything and some could not even recall the details of the suicide attempt at all. Others suggested that they felt as if they were in a trance. Seven (50%) patients who experienced one or more suicide attempts previously reported no feeling during the suicide attempt (7 patients did), while of those who did not attempt a suicide previously only 2 (11%) reported not feeling anything during the suicide attempt action (16 patients did). Thus, significantly more repeaters than non-repeaters (50% vs. 11%) report no feeling during suicide ($\chi^2=5.89$; $p=0.015$). The following quotations illustrate the types of statements the patients made and indicated no feeling or pain during the suicide act (the translation of the quotations mirrors the narratives as transcribed from Swiss German into High German).

Patients with a history of suicide attempts

One male patient described his state of mind immediately preceding his suicide action as a type of trance. Although being perfectly capable of performing any complicated sub-actions and movements he indicated that he was focused on this suicide procedure and did not pay any attention to anything else (patient ID no. 11):

Patient: 'I got into a type of trance. I don't know how else one could call this state. Suddenly, one does not perceive anything that happens around you'. (No perception of external events and objects).

It was not just perception, which was restricted. The patient informed us that his feeling and pain perception were also severely limited:

Psychotherapist: 'What happened then? You had the razor blades in your bathroom.' Patient: 'Yes, I had them in the bathroom. One doesn't feel anything anymore.' (No emotion).

The patient further clarified that not only feeling in general, but pain in particular was not noticed and monitored leading to a perception of painlessness:

Psychotherapist: 'Weren't you frightened to cut yourself?' Patient: 'It doesn't hurt.' (No pain).

This also is maintained by the next patient, a young female, who stated it plainly (patient ID nr. 13):

Patient: 'When I cut myself it did not hurt.' (No pain).

Another patient, a male, informed us that thinking was a process he was not engaged in during the execution of his suicide action (patient ID nr. 14):

Psychotherapist: 'Did you think which dose to take? How did it go?'

Patient: 'No I don't think so. I swallowed the pills without thinking much. I emptied the bottles and stuffed the pills in me.' (No thinking (cognitive monitoring)).

This patient goes even further indicating that his self-concept was not operational at that time and that some other constellation of his self was at work. This metamorphosis was somehow a result of his own

Variables		Frequency	Percentage
Sex	Male	298	93.4
	Female	21	6.6
Age	18-27	167	52.4
	28-37	94	29.5
	38-47	35	11
	>=48	23	7.2
Marital Status	Single	170	53.3
	Married	123	38.6
	Other(divorce/widowed)	26	8.2
Religion	Muslim	177	55.5
	Orthodox	106	33.2
	Protestant	36	11.3
Ethnicity	Oromo	204	63.9
	Amhara	51	16
	Dawro	13	4.1
	Other	51	16
Residence	Urban	204	63.9
	Rural	115	36.1
Educational status	No formal education	44	13.8
	Primary education	173	54.2
	Secondary education	75	23.5
	Higher education	27	8.5
Occupation	Farmer	83	26
	Private work	107	33.5
	Government worker	32	10
	Student	37	11.6
	Labor worker	34	10.7
	Other	26	8.2
Level of Social Support	Poor support	157	49.2
	Moderate support	97	30.4
	Strong support	65	20.4

Table 1: Socio-demographic characteristics of prisoners in Jimma Correctional Institution; Southwest Ethiopia, 2017 (n=319).

Variables		Frequency	Percentage
Solitary confinement	No	286	89.7
	Yes	33	10.3
Work in prison	No	232	72.7
	Yes	87	27.3
Type of crime	Violent	266	83.4
	Nonviolent	53	16.6
Court's decision	Remand	26	8.2
	Sentenced	293	91.8
Prior incarceration	No	282	88.4
	Yes	37	11.6

Table 2: Prison related factors of prisoners in Jimma Correctional Institution, Southwest Ethiopia 2017 (n=319).

striving and the patient experienced himself as having a restricted self: Psychotherapist: 'How did you feel at that moment?'

Patient: 'I was not my real self. I suppressed everything. One feels like someone wearing a strait jacket.'

Psychotherapist: 'It means also that one does not feel anything at all.'

Patient: 'I thought that something must happen. I took a glass filled it with water and emptied the bottle with pills in it. Then I started swallowing it.' (No involvement of self in action).

The patient clearly specified that while performing the suicide

action he was not mechanically following an impulse, but that his emotional processing and monitoring was not providing the usual feedback and feed-forward:

Psychotherapist: 'How do I have to imagine it? Did you do it automatically?' Patient: 'No. It was not automatic. It was without feeling.'

Psychotherapist: 'Were you frightened?'

Patient: 'No. I would describe myself as a piece of stone.' (No emotion).

The following patient, a woman in her teens, puts it even more precisely. She reports that it was not that her feeling and pain perception was disengaged, but that her pain processing was already fully occupied by dealing with her mental pain which incapacitated her in feeling any physical pain (patient ID nr. 15):

Patient: 'Yes. But I did not feel it in that moment. You as a physician know that if one has pain in two places one feels only one of the two. The mental pain was stronger for me.' (No physical pain but mental pain) [19].

The patient also addressed the question of a conscious control of the suicide action. She was aware of her action and movements, but she did not process any feelings or pain: Psychotherapist: 'The mental pain was so strong that you did not feel the other at all.' Patient: 'I did not realize it. I knew what I was doing. I acted consciously. But I did not feel it. It did not hurt.' (No pain despite functioning cognitive monitoring).

Although she was fully aware of what she was doing and that only when blood appeared she became aware of the consequences of her action, this might indicate that by disengaging the emotional and pain monitoring of her action, she did not comprehend the consequences of her action in full:

Psychotherapist: 'and what happened when it started bleeding?'

Patient: 'In that moment when the blood started running from my arm I became aware of what I'd done. But I was not frightened in that moment. No, in that moment the despair was even stronger.' (No fear despite of regaining awareness of consequences).

Summarizing the state of her mind during the suicide action the patient described the narrowing of her focus of attention which led to her inability to perceive anything else except what was in her focus of action. She also only felt the mental pain but not the physical pain of her injuring herself:

Psychotherapist: 'And the blood was dripping on the floor?'

Patient: 'No. It was dripping into the sink. I was in my room and was cutting my arm deeper and deeper. I did not hear anything during the whole time. If somebody came I would have cut further on my arm. I did not realize it. I just did not feel anything. The mental pain was the most dominant part. And I think that one can only do this with a great mental pain. The inner equilibrium was not there anymore.' (No perception of external events, no physical pain; but mental pain (psychache)).

The next patient, a young lady in her twenties, presented her cognitive-emotional state during the suicide attempt as a general rule. She realized that cutting herself did not hurt at first, but when she saw her blood her emotional monitoring returned exposing her to the consequences of her action which allowed her to stop the suicide act (patient ID nr. 23):

Patient: 'Yes, but when one is in a hole as I call it then one doesn't have... At the moment in which one is doing something, such as cutting the veins, then one is not frightened, but afterwards when the blood comes it makes you think 'stop, you can't do it'. Then I have to think, otherwise one would pass onto the other side of life.' (No fear; no awareness of action consequences; regained awareness of consequences).

The following male patient reported about a substance induced state of mind which seems to facilitate suicide action, as much as the disengagement of pain and of emotional suicide action monitoring (patient ID nr. 28):

Patient: 'I was in a delirium at that time. When I woke up in the morning I was lying on the floor on the mattress. I saw somehow. It was just like a light beam. I thought immediately that I was locked up. I did not like it. There was no breakfast either. There was a knife around in the room, so I then yes'.

Psychotherapist: 'It was a deep cut.' (Substance induced altered perception and thinking).

The following female patient reported about a similar state of mind which changed her sense of control. Sometimes it is alcohol induced, probably pathological intoxication, but often it occurs as executive function impairment linked to the inability to moderate the patient's aggressive actions (patient ID nr. 33).

Patient: It was not the first time I did something like this. Actually, in the last years I thought that I am not going to do it anymore. But I did it. I had again an argument with my friend. It is nothing unusual. But with me it is such that I don't know what is going on when I lost my temper. I have many of these blanks. I don't clearly remember what was going on in such moments. People say that it was me who attacked him. I don't know it afterwards any more. I started the argument. I did not attack him physically.

Patient: 'This is a state in which I don't care about anything. I could be standing on the road in such a phase. I would not care, if a car came. I would simply take either. Everything is like this in such a moment. I just don't care.'

Patient: I did not care about anything at that moment. In such movements the brain is probably switched off. I did not think about anything in that moment.

I don't really know what it is triggered by. I become aggressive and militant. The worst thing is that I don't remember anything later. But it must happen like this as several people told me that. (Substance and strong arousal induced alteration of perception and thinking).

Patient: There is another thing. My boyfriend told me that there is something peculiar with me. I have, apparently, eyes like a cat and do not respond to others. In such a moment people don't understand what I say. If I am left alone for 10 minutes then I respond again (Impaired motor action of speech).

Patients without a previous suicide attempt

The following patient, a young lady in her early twenties, described the unbearable mental pain prior to her suicide action and how she decided to attempt suicide (patient ID nr. 1): Patient: It was such a pain and I wanted to know whether there is a possibility to stop the pain. (Intensive mental pain).

To her own surprise her self-injuring behavior did not hurt. She

did not feel any pain. She took this as an invitation to continue cutting herself:

Patient: Then I tried it, first cutting the upper arm and at the wrist and it did not hurt. (No physical pain).

She did not state that she was not aware of or monitoring her pain or feelings or even that she was not her true self, but she indicated that she was in a self-observing mode in which she watched herself cutting her arm:

Patient: I was just watching myself. I have done it in the last months several times when I set myself aside, watched myself and did it then as well.

Patient: Yes, exactly. I watched myself, I know it sounds schizophrenic, but it was like that 'it is bleeding now. (Splitting into watching and acting self).

However, when her blood started appearing in a greater amount she became fully aware of the ongoing process, she became frightened and the self-observational modus disappeared: Patient: Afterwards the fear got me and I was not outside of myself anymore. (Fear induced reuniting of self).

An elderly lady indicated that letting herself fall or slip down a rock and whilst falling she was not frightened. Inferring from her realization after her fall ended, of what she had done and her being surprised, we can assume that she was aware of what is going on. However, her appraisal of her action and its consequences was only limited, as the emotional processing was not active (Patient ID nr. 4).

Patient: I was very frightened when my fall was stopped in the crevasse, but before, when I was slipping, I was not frightened at all. When I stopped in the grass and the trees with all my little injuries I thought about what I had actually done. It was hard. I can't understand it. (No fear during the critical action; but post action fear).

The patient also indicated that she experienced her action in such a way because she could not integrate it into the other mid or long-term processes she is involved in:

Psychotherapist: "There are people who say they did not have sufficient control about what happened. Was it the same with you?"

Patient: 'Yes.'

Psychotherapist: 'Was it outside of your control?' Patient: 'Yes, exactly. Normally I don't understand it.' (No control).

Discussion

When asked one to three weeks after the suicide attempt the majority of patients in our study provided detailed narratives of their mental state prior to and during the suicide act. Nine out of 32 patients described their cognitive-emotional-pain processing immediately before or during the suicide attempt as severely reduced. Some of the patients stated that their pain perception was massively restricted. Others stressed that their feelings and emotional processing were non-existent. Yet others characterized their mental state in terms of being in a 'trance', 'not being my real self' or 'watching myself'. In a few patients this mental state was induced by alcohol intoxication in one of the patient impairment of executive functions could be assumed.

Half of the patients who had previously attempted suicide, prior to the recent one, but only 11% of those who had attempted suicide for the first time, reported this state of mind during the suicide action. This

leads to the question of how this experience or report of the altered state of mind is connected to the repetition of suicide attempts.

There are many possible hypotheses, but we will focus on the following three, because they can represent distinct action spaces. The first hypothesis refers to the action of the interview, the second one to the cumulative effect of the repeated suicide action, that is, the action of the second suicide attempt and the third one to the experience of the first suicide action.

1) The 'face saving hypothesis'.

Patients who repeatedly attempted suicide feel under pressure to justify themselves for repeating this act which most people consider unreasonable. As the first occasion could be excused as a one-off occurrence, the repeated one is perceived to require a good reason.

Consequently, they argue that it did not hurt and they were not in control, thus, somehow not capable of their emotional regulation and, therefore, not fully responsible for their suicide act.

2) The 'habituation hypothesis' as described by Van Orden and colleagues [30].

Patients who repeatedly experienced a suicide act get used to this experience and do not feel the pain as intensively as patients who experienced the pain during this act for the first time.

3) The 'facilitative hypothesis'.

Because more patients who felt no pain are found among the repeaters, it could be assumed that they also felt no pain during their previous attempt leading to an increased rise of repeated suicide attempts. They managed to perform the first suicide action while being able to or experienced reduced action self-monitoring (cognitive, emotional, pain). This facilitated their repeated suicide action.

While the first hypothesis is often considered as a methodical problem of reporting reliability and is not seen as a serious part of suicide processes, the other two attracted more attention. The first hypothesized process cannot be used for generating sensitivity to a repeated suicide, or put differently, cannot be used for prediction of the next suicide event. It does not lead to a repeated suicide attempt, but it follows it. The second hypothesis also addresses the consequences of a repeated suicide attempt but because of habituation and thus makes it understandable, how another suicide attempt was possible, but mainly, why there were no thoughts, emotions or pain present, experienced or reported. However, the facilitative hypothesis can be used for selecting a group of suicidal people who might be more inclined to repeat their suicide attempt depending on their dealing with previous experiences. This proposition has been elaborated and empirically studied by Orbach and colleagues within the processes of disassociation. Orbach [31,32] indicated that some suicidal individuals are characterized by a disposition toward disassociation and are less sensitive to physical pain.

These dispositions may facilitate suicidal behavior. Orbach's hypothesis shifts the focus of attention from the question of what causes suicide to what facilitates suicide, and in doing so suggests new directions for research and therapy. Orbach and colleagues [33] also compared three groups of adolescents (aged 14-18), including suicidal (with a recorded suicide attempt) and non-suicidal inpatients, and controls with regard to suicidal tendencies, various body aspects, and depression and anxiety. They found that the suicidal group differed from the two non-suicidal groups in feelings toward the body, body protection, and body disassociation. There is research literature on emotional, cognitive,

and pain numbness in stress, mostly conceptualized as disassociation particularly relevant for the understanding of suicide behavior.

Kaplan and colleagues [34] examined the relationship between dissociative symptomatology and a range of aggressive behavior in a general psychiatric outpatient population. Patients with high Disassociation Scores were significantly more likely to report a history of childhood sexual abuse, to have attempted suicide, and to report more assaultive behavior, irritability, and negativism. Orbach and colleagues [35] reported that the suicidal participants significantly differed from the controls in that they had higher pain thresholds and higher pain tolerance. The authors indicate that body experiences play a significant role in suicidal behavior. As Orbach suggested that shifting our attention from the causes of suicide to the facilitative processes of suicide launches new directions for research and therapy, we should further explore this possibility. However, we would like to propose that to address these processes we need a different conceptualization. The concept of “disassociation” provides just a Latin name for the “splitting off” or “separating” in this case of mental processes. Having a disposition to disassociation might be far from predicting a suicide.

The concept of dissociation poses many questions. Bodily dissociation, detachment of body senses [36] though plausible in common sense, presupposes mental processes mirroring a body, thus pain would be a bodily experience and not a neurological and psychological process as currently understood. The classical dissociative experience: standing next to and observing one's body occurred in our narratives, but was described by a first time suicide attempter only. The higher pain threshold as reported in suicidal people has been repeatedly pointed out [35] and would fit the description of dissociation.

Nevertheless, as the patients also reported lacking other processes it might be wiser to see these processes in a more comprehensive conceptual frame. Including the body experience into consideration of suicide and thus enriching the cognitive perspective of suicide [36] is a valuable contribution. However, we propose to go further and to consider embodied and emended processes in an action. It is the unifying and integrative property of action processes that allows ongoing inclusion of cognitive-emotional and bodily experience in a meaningful interrelationship with internal and external action contexts [22]. Consequently, processes described in this study that are sometimes labeled or renamed as dissociation could be conceptualized in their function in an action. They do not have to be enduring features of a person.

Thus, studying the last suicide attempt might provide valuable information to prevent a possible future suicide or suicide attempt. We could include the suicide attempt into the suicide facilitating process. Consequently, all the three of the above hypotheses could be valid and the underlying processes interconnected. A feedback and feed-forward loop of not feeling any pain, emotion or not having adequate thoughts as well as defying and justifying one's act as not painful, not well emotionally and cognitively monitored and therefore somewhat reasonable, could lead to elevating the pain threshold (first hypothesis). This could particularly be operational and become the case during the repeatedly executed suicide attempts (second hypothesis). By desensitizing oneself through cognitive-emotional processes and practices, one could lower the suicide inhibiting tendencies such as pain and other monitoring and facilitate the future suicide attempt (the third hypothesis). This argumentation would help us in seeing suicide processes in terms of a more comprehensive model such as goal-directed processes in forms of actions, projects and careers [22,23,37]. This view significantly influenced our conception of suicide prevention

and psychotherapy with suicidal people [38-41]. Traditionally, stress has been described as the result of outside influences and from our appraisal of these external stresses. Stress in these conceptualizations was conceived as a reactive adaptation process.

We know that most of the processes we are concerned with were initiated in the function of a goal-directed action – in the cases addressed here a suicide action–embedded in mid and long term suicide related processes. Consequently, our therapeutic dealing with persons with a suicide risk would focus on making the parts of their suicide action less motivationally powerful for further suicide-facilitating action steps and action alternatives. Although, therapeutic interventions known from dealing with traumatic experiences might be useful, it will be equally necessary to build up a positive and alternative life-engaging action system and to correct the action distortions which led to a suicidal action step. That is, making other action alternatives more influential and thus facilitating other life-engaging actions to become easily available and committing. For these purposes we need a conception of a well ordered life-enhancing action embedded in projects and not just a negation of dissociation. The distortion of such an action as encountered in suicide would pass under the radar of DSM and ICD classification manuals and could be described in terms of a goal-directed action.

Conclusion

We believe that the group of people who report no feeling and pain during the suicide act needs more and better suicide preventive attention. They are often seen as less endangered, as their suicide ideation is not well integrated in their intentional system. This is because they do not emotionally monitor the extraordinary experiences of their suicide act in an adequate manner. Several studies have indicated that although these patients often leave the impression that they can distance themselves from the suicide action, they particularly tend towards a repeated suicide act. They might represent a small group among the first-time suicide attempters, but are a large group (i.e., in this study we found 50%) among the suicide attempt repeaters.

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