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The Paradoxes of Suicide and its Treatment

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Abstract

Suicide and its treatment present several paradoxes which are described and discussed. The main paradox, suicide as a caused illness vs. suicide as an action is elaborated upon and the consequences of conceptualizing suicide as a goal-directed action are outlined. The contextual action theory and the theory of goal-directed action are summarized and the view of suicide engaging this approach is presented. Finally, the suicide prevention program developed upon this theory is briefly summarized.

Keywords

suicide, suicide treatment, action theory

1. Introduction

Suicide is a complex, but, first of all, a tragic event, sometimes seen as an endpoint and a result of suicidality defined as an illness or caused by a mental illness, other times as an accident, yet under other circumstances it is addressed as an impulsive or contemplated, emotional or rational act (Nock, 2014). In dealing with suicide, either in research or in a clinical setting, the researchers and clinicians try to make a sense of the suicide process in order to understand, explain and prevent it. They then assume some unity of the process or a meaningful path in its unfolding. In research this is a causal chain of events and inner processes; in a clinical setting it is a sequence of circumstances and experiences rooted in mental, physiological or social dispositions (O'Connor & Pirkis, 2016). Nevertheless, in studying and researching suicide and also treating suicidal people, we encounter many paradoxes undermining the assumption of an obvious consequential process, such as a causal chain.

2. Paradoxes in Suicidality

The basic paradox is indicated by Evolutionary psychologists arguing "*…that suicidality must likely evolved as an unfortunate side-effect of two important primary adaptations in the human species, 'pain and brain': the aversive emotional experience of pain, which is biologically designed to aid*

self-preservation by motivating adaptive escape action; combined with a cognitive sophistication that offers most mature humans the means to escape pain maladaptively by self-killing" (Soper, 2018, p. 5). Thus, suicide could be seen as adaptation through maladaptation. Nevertheless, indicating a paradox is more specific then treating suicide as an enigma (Colt, 1991). There are a number of publications pointing out a paradox in reference to suicide or suicide treatment (Petrov, 2013; Lester, 1998; Stone, 1993), such as indicating that the more someone has space to talk openly about suicide, the less likely they are to want to attempt it (Davidow & Mazel-Carlton, 2020). Some others indicate paradoxes in suicide in the sense that it does not occur in predictable groups, such as in the following categories of variables: demographic (i.e., age, race, marital status); social (i.e., financial status, performance of work roles, prior psychiatric hospitalization, multiple divorces or rejections); vegetative (i.e., disturbed sleep and appetite with fatigue, anxiety and agitation, amount of sleep, weight loss, crying); and psychological (i.e., affective depression, recent loss or separation, loss of physical health, drug and/or alcohol abuse, delusions or hallucinations) (Motto, 1985).

Obviously, the first paradox we experience while meeting suicidal persons is the physiological state of their body with the potential to live for several more decades, on the one hand, and the active unwillingness of the person to do so, on the other. But there are many other paradoxes we find, particularly in an encounter of a clinician with a suicidal person in a clinical setting, in both the clinicians and in the suicidal persons alike, such as:

- The paradox of clinicians' considering every client as a special and unique person while expecting to find a help in research based on the assumption of groups sharing certain qualities, as in epidemiology-based research.
- The paradox of hoping to find a help in understanding the psychology of a suicidal person in a clinical setting by studying classical sociological literature in which suicide as a social fact is identical with a suicide rate (Durkheim, 1897/1952; Thompson, 1982).
- The paradox of relying on, e.g., evolutionary psychology of suicide (Confer et al., 2010) that deals with suicide as a "type" while attempting to understand an individual suicide "token".
- The paradox of expecting the same conceptual system to be helpful in recovering the caused past and in building an intentional future in attempting to prevent suicide.
- The paradox of attempting to help and support extremely agentic people (many suicidal people are extremely agentic as they claim the right to decide about the highest stake of their life) from an agentic stance of a clinician who demands the suicidal person to become a passive and submissive patient.

There also are many paradoxes implicated by the suicidal people:

- The paradox revealed by suicidal people maintaining that they wanted to solve their problems by a suicide, thus disabling themselves from experiencing the fruits of their problem solving.

- Equally and particularly, the paradox of some suicidal people who seek to assert themselves through suicide by losing their ability to experience the newly gained empowerment, described as the paradox of preservation through annihilation (Cooper, 1990).
- The paradox of eliminating life as unimportant while reasoning that life represents the highest value of which problems can be solved only by the highest sacrifice.

3. Suicide as an Action

There are many other paradoxes in and of suicide and its treatment, but there is one paradox with severe implications for understanding and treatment of suicide:

Suicidal behaviour is currently considered as a mental illness as codified in DSM-5 (APA, 2013) and ICD10 (WHO, 1993). As such, suicide is seen as a result of a number of causes defined as ranging from neurological and, generally, biological, to psychological, social and cultural factors (van Heeringen, 2001). In addition to this, the reports of suicidal patients sometimes contain patients' distancing of themselves from their suicide behaviour in various ways, such as either suggesting that they did not recognize themselves in the suicide situation, they were not themselves, that this behaviour was against their values and beliefs (Valach, Michel, & Young, 2016), or that immediately after their crucial deed they regretted it (Zouves, 2017). Obviously, this self-understanding of suicidal persons facilitates the psychotherapists' view of suicide as a caused event or a subconsciously driven behaviour as indicated by the diagnostic and statistical manuals of mental disorders instead of as a goal-directed action within other goal-directed processes. This approach to suicide as a caused illness or as caused by an illness could remain a conceptual academic issue, were there not some severe consequences.

In treating suicidal persons, we must conceptualize the target processes of suicide and its treatment as goal-directed processes if we want to become successful (Valach, Young, & Michel, 2011). There is not only narrative and conceptual, but also empirical evidence to support this claim (Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016; Michel, Valach, & Gysin-Maillart, 2017). These counterpoint positions—suicide as a caused illness and the requirement for its understanding and treatment to see suicide as an action—is the main paradox that will be addressed here.

4. Goal-directed Processes and the Professional Understanding of Suicide

Rooting our understanding and treatment of suicide in goal-directed processes is not done by stating that suicide behaviour follows a goal. In order to understand and discuss this approach, a number of principles must be taken in consideration.

1) The basic unit of analysis is an action.

Observing persons in their everyday natural environment, we are confronted with a stream of behaviour. In our understanding of this ongoing process, we segment it into short time units under the assumption, or with the knowledge, of an underlying goal. These are the action units. Such an action has a

beginning and an end. Consequently, it is advisable to consider such units of action as a topic of a professional analysis—a unit of analysis. It is applicable in observation as well as in dealing with a narrative of actions. It should be remembered that even the mirror neurons process intentions behind the behaviour of the observed person, that is an action, and not just the movements (Kaplan & Iacoboni, 2006; Patel, 2024).

2) In defining such an action, we have to combine several criteria to one view: the acting persons are mostly aware of the immediate goal; naïve observers attribute a goal to the acting person engaged in an ongoing stream of behaviour; the professional observers use these information sources or records as criteria in their segmenting the stream of behaviour in their professional analysis. As action is thus segmented by a goal (experienced, attributed by others, assumed by professional researches or helpers), it indicates that subjective, professional-systematic, and social/common sense views are considered as contributing to the definition of action.

3) In combining the views of actors, of the naïve observers and the professional systematic observation, we do not aim at an assessment of interobserver agreement but at a combination and amalgamation of subjective, social and manifest processes. Consequently, different methods of recording these processes are used. A professional analysis of manifest processes uses the method of systematic observation. The data on social conventions underlying the attribution of goals by others are collected in naïve observation by a group of observers from the communication community of the actors. The subjective processes are recorded in a self-confrontation interview, which is a segment-by-segment video-supported recall of the subjective processes such as thoughts, feelings and sensations (Kalbermatten & Valach, 1985).

4) Furthermore, the systematic observation also integrates social meaning (in building observational categories for conventional and subjectively meaningful goals); functional observational categories (in classifying action steps as in function to the action goal); and physically defined observational categories (in classifying the elements of action).

5) Action is considered as a goal-directed system.

Action is not seen just as an intentional behaviour, but it is conceived as a system organization. It unifies meaningful, socially defined processes with linguistically communicated subjective concepts and physically defined behavioural parts.

6) Such a system is organized in a hierarchic-sequential way.

Thus, action is a process system of levels of steering, of control and of regulation. The top level of action organisation consists of a goal and is a steering process. The middle level of the action system hosts the control processes, while the lowest level of the system of action processes regulation.

7) The several levels of the hierarchical organization of action differ in the degree of consciousness.

These ideal type levels are: at the top, the conscious goal or the level of action; in the middle, the semi-conscious sub-goal or the level of action steps; at the bottom, the subconsciously or

unconsciously organized elements of action.

A. A short-term action is a part of a mid-term project, that in itself is a part of a long-term career or a life pursuit. These hierarchic-sequentially organized systems of actions should, again, be understood in an ideal type of way, as several projects and life-pursuits running parallel can be empirically found in more complex processes.

B. Projects and careers or life pursuits are conceived in an analogue but not identical way to an action, e.g., an action serves often numerous projects.

C. Action, projects and careers can be individual, joint or group processes.

D. Analysing joint processes should incorporate an analysis of individual processes as a part of the joint action systems (level of group action and the level of the individual actions of the participating persons) (von Cranach, Ochsenbein, & Valach, 1986).

E. Important processes in the system of action are monitoring processes of consciousness or attention, emotion and pain. This, particularly, is of great relevance in understanding and studying suicide processes as well as in engaging in suicide prevention. It addresses problems in suicide identified as dissociative states and processes (Caulfield, Karnick, & Capron, 2022; Orbach, Kedem, Herman, & Apter, 1995).

Studying an action, such as a suicide action, asks for explicating the action processes, such as steering (top level), controlling (middle level) and regulation (bottom level) (Valach, Young, & Lynam, 2002), monitoring processes in cognition, emotion, pain, etc., on the one hand, and the embedding of these actions in the encompassing projects and careers or life pursuits on the other (Valach, & Reissfelder, 2022). Equally, as suicide actions are social processes, the relevant join action has to also be attended (Valach, Michel, Young & Dey, 2006). Thus, obviously, the goals, the sequence of action steps, the details of the suicide action in form of action elements also play a great role. However, the question remains, why some actions are life enhancing while others are life destroying? We indicated that a suicide process contains a number of compromised and distorted action processes (Valach, Michel, & Young 2016). This is where an everyday action turns into a destructive suicide action.

This conceptualization of suicide as a goal-directed process of actions, projects and careers or life pursuits might seem paradoxical, as the professional helpers would like, on one hand, to keep the intentionality of their patients and clients for the life maintaining and enhancing processes, and to conceptualize suicide as a caused event, on the other. However, when they attempt to treat a suicidal person or a person who has made a suicide attempt and approach them with a causal model of behaviour, it proves to be impossible to anchor the patients' responsibility for life maintenance in such a model. It is even more hopeless when they try to treat suicidality designed as a causal process in a suicide prevention procedure also designed in causality terms. Consequently, in designing and understanding the suicide as a goal-directed process, the suicide preventive treatment should also be conceptualized in terms of goal-directed action, project and career.

5. Goal-directed Processes of the Treatment of Suicidal People after a Suicide Attempt

Following the understanding of suicide in terms of goal-directed processes, one of the important premises of the treatment of suicidal person is that suicidal clients, patients and clinicians understand their suicide in a similar manner (Michel, 2023). In addition, they have to join the treatment or the suicide goal-directed prevention project with the goal of changing from suicide to life maintaining processes, subscribing to life enhancing careers, joining into a joint suicide prevention and life enhancing project in order to have at hand life enhancing problem-solving action repertoire. This requires that they gain insight that a change is necessary and that they accept a life maintaining projects and career and thus have an alternative action at hand within a suicide action enhancing situation. The first premise, that suicide is a goal-directed process, is easily acceptable to suicidal person and they will describe the suicide process in terms of actions and mid-terms goal-directed processes, often including long-term life pursuits once they are given the necessary space for their narrative of these events in an interview. However, such a description must be allowed to develop without pressure and without derailing in order to fulfil the criteria of the interviewers' desires and must be supported and facilitated. Thus, a narrative interview is the first action process in the joint project of suicide prevention (Michel & Valach, 2011). Although conducting such a narrative interview belongs to basic competences of every clinician, it might be helpful to remember that the goal of such an interview is not to obtain a complete description of the suicide process containing all the structural data (dates, hours, amounts and sizes), which are emotionally neutral and possess a low action relevance. The main task for the interviewer is to allow for experiential details of the suicide process and facilitating a flow of the narrative. Unfortunately, many first post-suicide attempt interviews in hospitals or crisis intervention centres are conducted to satisfy hospital data requirements and do not serve to facilitate a patient's story of suicide as a goal-directed process. In addition, a clinical interview is often driven by the attempt of the interviewer to identify the key parts of a diagnosis. Such an interview will not lead to an experiential narrative of the suicide process.

The second premise is a more difficult one. In trying to take the burden of responsibility from the suicide of the patients' shoulder, the clinicians often help them in developing a narrative of non-responsibility not realizing what the patients are doing as they also diminish the patients' desire to change anything. Thus, such interventions must be omitted. In order to aspire for a change without submitting the patients or clients to the dictate of the interviewers, the clinicians must be aware of the requirement that any conclusions should be drawn by the patients themselves. This process is facilitated by the second step in the suicide preventive procedure, the self-confrontation interview (Valach, Michel, Dey, & Young, 2002; Valach, Michel, & Young, 2018). The narrative interview is video recorded and presented segment by segment of 30-300 seconds to the patients following the interview. The clinicians and the patients watch the recording together. Already this joint or collaborative observing leads to a shift in the perspective of the patients seeing and experiencing their suicide narrative (Jobes, 2016). In

addition, the clients and patients provide detailed information, as instructed, on their thoughts, feelings and sensations during each presented segment as well as during the described actions. Thus, the clinicians obtain further information on the suicide process and on the patients' narrative of their experience. In addition, it is in this viewing of their own description of their suicide process, that the patients and clients gain insight into the dysfunctionality of their suicide action without being told so by the clinicians. The narrative interview; the self-observation of the patients during their interview; the video supported recall of thoughts, feelings and sensations; the verbalization of the not-verbalized thoughts; verbalization of extralinguistic expressions of feelings and sensations, all have a deep impact on patients' understanding of their suicide process and provide a strong action basis for their preventing a future suicide action. In addition, a visual and acoustic self-experience leads not only to improved self-awareness and self-perception, but also instigates a substantial change towards life maintaining projects and actions.

6. Suicide Preventive Procedure

Working with an explicit action model of the suicide as well as of the suicide preventive procedure should be described in the, even if only rudimentary, terms of joint and individual projects and actions and, further, of goals and actions or steps of actions.

We assume that suicide prevention will be best achieved in a joint project. Thus, the goal of the clinicians is to win the patients for such a joint project of life maintaining and life enhancing actions in which the patients will engage in such actions. Such a project should last several months or even years. There are many concepts covering cooperation of clinicians and patients, such as compliance, trust, collaboration, working relationship (Jobes, 2000), working alliance, helping alliance (Alesander & Luborsky, 1986). However, they mostly focus at the specific encounters of clients/patients and the clinicians. The helping alliance scale indicates with the items "I feel that the interviewer wants me to achieve my goals" and "I feel I am working together with the interviewer in a joint effort" that an idea of a joint project provided a lead in this conceptualization. In a goal-directed action inspired suicide prevention program such as the ASSIP (Michel & Gysin-Maillart, 2015) this joint project consists of several actions or several frames for a number of actions. One is the above-mentioned narrative interview. Another one is the video-supported recall or the self-confrontation interview. The third one is a joint consensual summary of the suicide processes as described by the patients, best achieved in a written form. The fourth one consists of a session in which the resources and the suicide alternative actions are identified and written reminders or cue cards are produced. The fifth one, performed regularly over a period of time, is another written reminder in a form of a letter or a message when using other media, send to the patients after some periods of time, of their commitment to the agreed upon life maintaining and enhancing project. These five parts build a joint suicide preventive project. Its efficacy was demonstrated in a control group study indicating a suicide attempt reduction in persons

after a suicide attempt in 24 months by 80% (Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016).

7. Conclusions

In addressing suicides and suicide treatments and their numerous paradoxes (the most difficult paradox being treating suicidal patients as being involved in a goal-directed process of suicide, on the one hand, and freeing the patients of their action responsibilities for suicide in defining suicide as an illness, on the other) an action theory informed suicide understanding and a suicide prevention program have been outlined. However, this view does not negate the paradoxical nature of suicide and suicide treatment. The clinicians have to engage in a suicide prevention project and actions together with the patients. The patients have to be motivated to join, get involved and proceed with the project, but some know-how, steering, control and regulation of the joint project will be in the hand of the clinicians. Nevertheless, the patients and clients must be provided with the trust to become the driving force of the project, to be responsible for their actions as they are seen as being engaged in goal-directed actions and projects. It is their suicide story, their insight into their inner processes during suicide and during the suicide narrative, their outline of alternative and life affirming actions as well as their keeping up of the joint project while going on with their life. Thus, persons who have proved unreliable and irresponsible in regard to their own life must be given full responsibility for their actions in a clinicians' supported process of the suicide prevention project. This is the paradox clinicians must accept and engage in, in order to become effective in their suicide preventive work with patients after a suicide attempt.

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