Exploring the psychology of suicidal ideation: A paradigm shift appraisal

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Abstract

The paper aimed at exploring the psychology of suicidal ideation: a paradigm shift appraisal. Various Psychological theories of suicidal ideation were explored regarding suicidal ideation. The rate at which people commit suicide now especially the youths is alarming and has drawn the attention of the society and the psychologists as regards to the menace. Suicidal ideation is conceptualised as a continuum from suicidal thoughts to attempts at or committing suicide. These thoughts may occur in people who feel completely hopeless or believe they can no longer cope with life circumstances. Suicidal ideation may vary from fleeting thoughts to preoccupation with detailed planning to actual execution of suicide. Different Psychological theories have explained the reasons for suicidal ideation. Some of these theories include: Interpersonal theory of Suicidal Behaviour, the Integrated Motivational-Volitional Model (IMV) and the Psychoanalytic approach. This explores the impact and relevance of the studied theories and suggests ways of tackling the menace in our society. The study concluded and recommended that humans are different in their biological make up. Thus, the way and manner humans behave and think, and prioritize likes and dislikes differs; thinking towards suicide could depend on an individual and how he/ she views the society.

Keywords: Biological makeup, Motivation**,** Psychoanalysis**,** Psychology, Suicide, Suicidal Ideation, Paradigm Shift

Introduction

Suicide is a global psychological, health and social problem and a leading cause of death each year. It is estimated that the number of people who attempt suicide is 20 times higher than that of people who die by suicide (World Health Organization, 2014). Before now, the rate of suicide in the society has been well research, but nowadays reverse is the case. This could be because of frustration, depression, stress etc which could be seen as risk factors that have bedevilled the populate while trying to survive or feint for a leaving. Suicide remains a significant problem, causing almost half of all violent deaths and resulting in roughly one million fatalities every year, as well as an economic cost of billions of financial resources (World Health Organization -WHO, 2004).

Suicide impacts the most vulnerable of the world's population and places a higher burden on low- and middle-income countries which are often ill-equipped to meet the general health and mental health needs of their population. Services are scarce especially in our communities and when they do exist, they are difficult to access and are under resourced. Accesses to appropriate services as well as improve help seeking are essential to health and well- being of the people. Suicide is an act of deliberate, voluntary and intentionally killing or taking one's own life. Every year close to 800 000 people take their own life which is one person every 40 seconds (WHO, 2019). Suicide is a global phenomenon and occurs throughout the lifespan. There are possibilities that for every adult who died by suicide there may be many more out their attempting suicide too. Suicide is a painful tragedy to the families, loved ones, communities and even countries and has a negative long lasting effect on the family members left behind (Nneka & Nnamaka, 2021). Suicidal behaviour is any deliberate action with potential life-threatening consequences while Suicidal ideations are thoughts, contemplations of suicide and a known risk factor for suicidal attempt, which in turn increases risk for suicidal death (Nneka & Nnamaka, 2021).

Therefore, factors contributing to suicide can vary among specific demographic and population groups, the most vulnerable group such as the young, elderly and socially isolated are in greatest need of suicide prevention efforts. It is important to address the specific underlying causes of suicide and develop action plans to address the menace. Importantly, it is a national suicide prevention strategy that allows communities to come together and begin to tackle suicide and the issues specific to their needs without stigmatization (Nock, 2014).

Suicide gestures are seen as act of self-harm unlikely to result in death. For example, people may slash their wrists but not deep enough to bleed or they take an overdose of vitamins. Suicide gestures are cries for help. The persons are desperate but do not know how to ask for help for others suicide gestures is an attempt to manipulate or control people around them. For example, an individual abandoned by a lover may make a suicide gesture in an attempt to get the lover back. Though plan about suicide are called suicide ideation; this may reflect a plea from people who wish to live and should not be dismiss lightly hence suicide ideation is related to suicide gesture.

Traditional attempts in understanding suicide risk have tended to focus on single risk factors for suicidal behaviour or have attended to a specific domain of risk such as cognition. Although such approaches have resulted in a better understanding of specific risk factors for suicidal behaviour, their narrow focus has not done justice to the complexity of the factors leading to suicidal ideation and behaviour (O'Connor, 2011). Indeed, contemporary theoretical models of suicidal behaviour highlight the complex interaction between biological, environmental, psychological and social factors (Klonsky, May & Saffer, 2016; O'Connor & Nock, 2014). This complexity brings challenges not only for patients and clinicians, but also for scientists. Statistical techniques usually applied within the field of psychology and psychiatry, such as analysis of variance or regression analysis, will only be of limited use to understand complex models with a large number of inter-dependent variables. For example, defeat, entrapment,

burdensomeness, and impulsivity are only a few of the important variables specified within the integrated motivational-volitional model of suicidal behaviour (O'Connor & Kirtley, 2018), a predominant model of suicidal behaviour and they are all highly likely to be inter-dependent.

Suicidal ideation is conceptualized as a continuum from suicidal thoughts to attempts at or committing suicide. These thoughts may occur in people who feel completely hopeless or believe they can no longer cope with life circumstances. Suicide ideation may vary from fleeting thoughts to preoccupation with detailed planning to actual execution of suicide. These types of thoughts may happen in people who feel completely hopeless or believe they can no longer cope with their lives. Most people with suicidal ideation do not carry out an actual attempt, but some do (Centre for Diseases Control and Prevention, 2016) (CDC).Suicidal ideation which are suicide gesture, thought and plan about suicide are precursors to suicide attempt or completed suicide. Suicidal ideation is known risk factor for suicidal attempts which in turn increase risk for suicidal death, (Douglas & Spero, 2008).No completed suicide will be carried out without thinking about it, planning it, and sometimes writing death threats. All these are suicidal ideation (Gearge, 2017).

It is not unusual for 'normal' individuals to experience occasional suicidal thoughts" (Ruddell & Curwen, 2012). However, frequency and severity varies depending on the individual. Severity of suicidal ideation can vary greatly from a single fleeting thought to occasional curiosity, to extensive thoughts, to detailed planning. In a cross-national study that examined the prevalence of suicidal ideation, plans, and attempts, they found that lifetime prevalence of suicidal ideation was 9.2%, suicidal plans were 3.1%, and suicidal attempts were 2.7% (Nock, 2016). However, other studies have found lifetime rates of suicidal ideation to vary between 2.09 and 25.4%depending on age, culture and geographic location found that the prevalence of having suicidal ideation differs by socio- demographic factors (i.e., age, sex,race/ethnicity, education). In Nigeria, suicidal ideation and behaviours are important psychological and public

health concerns. In 2008, suicide claimed the lives of 36,035 total individuals (Centers for Disease Control and Prevention- CDC, 2015). Additionally, approximately 666,000 individuals visited hospital emergency departments for nonfatal, self-inflected injuries. Although these numbers may seem astonishing, they do not compare to the number of individuals who experience suicidal ideation. In 2008, an estimated 8.3 million adults 18 and older reported experiencing suicidal ideation in the past year, this accounts for 3.7% of the adult U.S. population (Crosby et al., 2011).

The increased rates of suicidality recently noted in Nigeria may be due to the occurrence of extended and concurrent hardship and strive to survive in life and the concomitant heavy strain placed on people. Prevalence of suicidal ideation among service members and veterans has been identified to range from 6.5% to 45.9% in clinical samples and from 2.3% to 21.2 % in nonclinical samples (Majindadi, 2013). The truth is that even these alarming statistics may not fully capture the number of veterans that experience suicidal ideation. This is largely due to the stigma placed on having suicidal ideation, which causes many veterans not to openly share these thoughts.

The reasons that a person has for living is a factor that has been shown to help protect individuals from suicidal thoughts and actions (Linehan & Chiles, 2022), and a number of studies have used this concept to investigate protective factors against suicide in later life.

Research on suicidality (i.e., suicidal ideation, suicide attempts, suicide completions) has identified several factors that have been associated with an increased risk of suicidal ideation. These factors include PTSD (Guerra & Calhoun, 2011), active duty versus Reserve/National Guard Service (Kang &Bullman, 2008), physical problems, depression, PTSD, and substance abuse problems (Kang &Bullman, 2008). Although several demographic factors are associated with a greater risk of suicidal ideation in the general population, there are mixed conclusions on whether these factors are predictive of suicidal ideation in the society. These mixed

conclusions are due to several studies examining the same demographic factors and all finding different results. Although not found in every study, some studies have found that demographic factors such as age, gender, and ethnicity do influence the risk of suicidal ideation in the society (Lemaire & Graham, 2011).

The age of adolescence typically "begins between 11 and 13 years of age with the appearance of secondary sex characteristics and spans through the teenage years, terminating at 18 to 20 years of age" (Medical Dictionary, 2015). According to data from the U.S. Military Entrance Processing Command (MEPCOM) for the fiscal year 2009, 52% of all service members across all branches of the military enlisted in the military between ages 16-19 (Rostker, Klerman, & Zander-Cotugno, 2014). Additionally, 21% of the service members who enlisted in the military were between ages 20-21. Therefore, this developmental stage is imperative to discuss when considering pre-military life experiences seeing that a large percentage of individuals joining the military are still considered being in the adolescent stage. Suicidal ideation is a factor that threatens all ages. However, research has found that adolescents are particularly at a higher risk of experiencing suicidal ideation. Nock et al. (2008) found that the initial onset of suicidal ideation highly increases during adolescence. A past study conducted on adolescents found that up to 60% of high school students have experienced some degree of suicidal ideation or behaviour. These statistics indicate that experiencing thoughts about one's own death is quite common among adolescents. These statistics also clearly demonstrate that adolescence is a time period in which all individuals, including veterans, are at increased risk of experiencing suicidal ideation. It is well established that past suicidal ideation and behaviours are the most robust and reliable risk factors for future suicide risk (Bryan & Rudd, 2006). This suggests that adolescents who experience Suicidality before joining the military are at a much higher risk of re-experiencing suicidal ideation and behaviours either while in the military or as a veteran. Several longitudinal studies have shown the impact and lasting effects of experiencing

childhood or adolescent suicidal ideation. Reinherz and colleagues (2006) found that both male and female adolescents (mean age of 15) who reported suicidal ideation had greater overall levels of psychopathology, suicidal ideation and suicide attempts by age 30 compared to those who reported no suicidal ideation. Results also found that when participants with and without adolescent suicidal ideation were compared on suicidal ideation and attempts at age 30, adolescents who reported suicidal ideation were 15 times more likely to have experienced suicidal ideation in the past 4 years. Similar to these results, Reinherz et al. (1995) found evidence "that suicidal ideation at age 15 was a marker of distress with multiple longterm implications".

PARADIGM SHIFT OF SUICIDE

The following are theories of suicidal ideation: interpersonal psychological.

Interpersonal models of Suicidal Behaviour: One of the most influential theories in suicidology is the interpersonal theory of suicidal behaviour (Van Orden, 2016). The core assumption is that suicidal thoughts emerge when levels of perceived burdensomeness (defined as feeling a burden on others) and thwarted belonging (defined as feeling that you do not belong) are high and these thoughts are translated into suicide attempts when the capability for suicide (defined as a reduced fear of death, and increased tolerance for physical pain) is high. A recent meta-analysis yielded clear support for the perceived burdensomeness–suicidal thoughts relationship whereas the evidence for thwarted belonging was less strong (Chu et al., 2017). Perceived burdensomeness is a feeling of being a burden on the rest of the people or the world. For someone to experience perceived burdensomeness they are not only failing to make meaningful contributions but are also a liability. Perceived burdensomeness and thwarted belonging produce a desire for suicide. The perceived burdensomeness comprises two dimensions, beliefs that the self is so flawed as to be a liability on others (i.e., "I make things worse for the people in my life") and affectively laden cognitions of self-hatred ("I hate myself,

or “I am useless”) (Van Orden, 2016). In a sample of soldiers entering inpatient treatment, perceived burdensomeness emerged as a robust predictor of suicidal ideation, controlling for gender, PTSD symptoms, and depressive symptoms.

Hopelessness is a series of cognitive beliefs that an individual has negative expectations about the future. Hopelessness is a significant predictor of suicidal behaviour and has been found to correlate more strongly with suicidal ideation than even depression (Beck, Brown &Berchick, 2014). Suicidal people have hopeless feelings specifically about being a burden on others and failed belonging. It is important, then, to assess an individual’s level of hopelessness in relation to their suicidality. Moreover, Rudd (2016) recently expanded the hopelessness model of suicide by differentiating between state-based and identity-based forms of hopelessness. Identity-based hopelessness, or un-lovability, consists of trait-like self-perceptions of worthlessness and defectiveness that are viewed by the individual as enduring and unchangeable. Trait hopelessness incrementally predicts current and future attempts above and beyond other common risk factors for suicide including state hopelessness. Hopelessness in association with both perceived burdensomeness and thwarted belonging increase both suicide ideation and suicide attempts, hopelessness is seen to convert passive suicide ideation to active intent and attempts.

The Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV)

The integrated motivational-volitional model of suicidal behaviour (O’Connor &Kirtley, 2018), another predominant model, proposes that suicidal behaviour results from a complex interplay of motivational and volitional phase factors. Factors within the motivational1 phase of the model explain how suicidal thoughts emerge in some people but not in others. Factors within the motivational phase include defeat, entrapment, and (lack of) social support. Volitional phase factors, on the other hand, are those factors that govern the transition from suicidal thinking (ideation/intent) to suicidal behaviour; they include exposure to suicide,

fearlessness about death and impulsivity. Entrapment is conceptualized as the key driver of suicide ideation within the IMV model with empirical evidence in support of the model continuing to grow (O'Connor &Kirtley, 2018; O'Connor &Portzky, 2018). Various studies have indicated that a specific type of entrapment, internal entrapment (defined as trapped by pain triggered by internal thoughts and feelings), is more strongly related to suicide ideation than external entrapment (i.e., unable to escape external events/experiences) (Owen, Dempsey, Jones& Gooding, 2017). The IMV model also specifies pre-motivational phase factors that assess the suicide risk background factors (e.g., perfectionism) and triggering events.

This approach views all domains of factors as making salient contribution to suicide risk and relies on observed patterns of association to estimate the relative contribution of these factors. These domains of factors are psychiatric morbidity, genetic and biological factors, social and demographic factors, family characteristics and childhood experience, personality trait and cognitive styles and environmental and contextual factors.

Psychoanalytic Model of Suicidal Behaviour

Psychoanalytic theories of suicide were developed in the last part of the 19th century and first half of the 20th century. These theories challenge the socio-cultural basis of Durkheim theory, and instead argued that suicidal behaviour arises from individual and intra psychic sources that are essential, vulnerable to social forces using psychoanalytic terminology Freud(1963) argued that fundamental patterns of behaviour are set in infancy and they are not seriously affected by social factors at all, and can be cured from a societal level. He further explained that since men ambivalently identify with the object of their own love when they are frustrated, the aggressive side of the ambivalence would be directed against the internalized person. The main psychoanalytical position on suicide is that it represents unconscious hostility directed towards the interjected love object as (Freud, 1963) in his book man against himself and composed that all suicide involves fundamental dimension, hate, depress that causes suicide, therefore

involves (1) a wish to kill murder (2) a wish to be killed – murder by self and (3) the wish to die. Later on Littman (1989) extends Freud theory and suggested that suicide may be caused by other intra psychic factors besides hostility, includes rage, smith, anxiety, dependency, helplessness and hopelessness. Although the psychoanalytic perspective on suicide was influential it has been criticized for its failure to push the issue in to social realm. The basic reason for this favour laid in the pre-occupation of psychoanalysis with therapy, that is, with the cure of mental illness (Maris, 2016).

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Cognitive Model of Suicidal Behaviour

Beck and colleagues (1979) proposed that the diathesis for depressive and suicidal symptoms consists of cognitive self-schemas that contain negative beliefs, including dysfunctional attitudes and cognitive distortions. An example is an individual who, after making a single small error at a public-speaking event, becomes convinced that everyone in attendance thinks he is stupid. Hopelessness plays a key role in Beck's model, along with the negative triad of negative thoughts about oneself, others, and the future. They argued that, like other depressed individuals, suicidal persons misconstrue their situation in negative ways. But the suicidal person is hopeless about the situation, hence looks at suicidal behaviour as the only possible solution.

Rudd (2016) provided a detailed account of the "suicidal mode," in which the triggering of negative beliefs and cognitions is accompanied by the activation of particular systems of affective, physiological, and behavioural- motivational responses associated with suicidality. He gives an account of "Compensatory strategies" that arise to come up with the negative beliefs and rules of an individual. The effective component of the suicidal mode encompasses

a variety of mixed dysphoric emotions that might arise depending on the particular beliefs endorsed by an individual: shame, guilt, sadness, anger, and so forth. The behavioural system connotes a predisposition toward engaging in suicide-related behaviours, including planning, rehearsals, and suicide attempts. The physiological system involves patterns of physiological activation that characterize the suicidal mode.

Orbach (1996), hypothesized suicidal individuals are characterized by a disposition toward dissociation manifested in relative insensitivity to physical pain and indifference to their bodies. He suggested that certain stress conditions lead to the development of dissociative tendencies and that once these tendencies are established, they become an integral part of suicidal behaviour. Psychological variables that affect pain tolerance are presented and they include perception, motivation, emotions, and behavioural and cognitive strategies of pain control. These can increase tolerance of pain in suicidal individuals, making the suicidal act possible. The specific relationships of pain and suicide are then introduced through an examination of pain analgesia in the phenomenon of self-harm.

According to Williams and Pollock diathesis for suicidal behaviour has been described in cognitive psychological terms, in which suicidal behaviour represents the response to circumstances that has three components:

1). Sensitivity to signals of defeat: An involuntary hypersensitivity to stimuli signalling "loser" status increases the risk that the defeat response will be triggered.

2). Perceived 'no escape’: Limited problem-solving abilities may point towards the person that there is no escape from problems or life events.

3). Perceived 'no rescue’: The experience of suicidal behaviour is associated with a restricted fluency to come with positive events that might happen in the future. This restricted fluency is reflected not only by the perception that there is no escape but also by the judgment that no rescue is possible in the future. So it is interesting to note mat the fluency of generating positive

future events correlates inversely with levels of hopelessness, a core clinical predictor of suicidal behaviour.

Social-Learning Model of Suicidal Behaviour

They suggested that suicidal behaviour can be learned or promoted through direct or indirect exposure to people who have suicidal behaviour. An example of this model might be suicide "cluster." which the Center for Disease Control and Prevention defines as a group of suicides or suicide attempts that occur close together in time and space than would normally be expected. Clusters are primarily a phenomenon among teenager and young adults through age 24, occurring only rarely beyond that age. The model emphases on the following below:

Altruistic suicide: High Integration into society. When social integration is looking strong, the individual is literally forced into committing suicide. With Altruistic Suicide, death is deliverance. Altruistic suicide involves an individual whose sense of identity is subordinate to the group or community, and the suicide may represent a sacrifice for the good of the community. E.g.: - policeman dying in the line of duty, suicide bombing.

Anomic suicide: This is seen as Low Regulation by society. This occurs in response to a crisis with which a person feels unable to cope and thus uses suicide as a solution. Durkheim introduced the term "anomie" to refer to a societal condition in which pre-existing norms no longer control behaviour because of rapid societal change. The crisis arises because the person is left alone to deal with change, without the benefit of guidance by social convention. E.g.: Suicide from great loss (lay-off).

Fatalistic Suicide: High Regulation by society. The individual perceives that his life is, or will be, so restricted by a societal situation that there is no point to living. A person who hangs himself in prison is generally an example of such a suicide. Although Durkheim’s theory of suicide has contributed much to the understanding of the phenomenon because of his stress on social rather than on biological or personal factors, the main drawback of the theory is that he

has laid too much stress only on one factor, namely social factor and had forgotten or undermined other factors, thereby making his theory defective and only one- sided.

Conclusion

In conclusion, the primary tenets of these theories are that: suicidal ideation develops due to a combination of pain and hopelessness, connectedness is a key protective factor against escalating ideation in those high on both pain and hopelessness, and progression from suicide ideation to attempts occurs when dispositional, acquired, and practical factors create sufficiently high capacity to face the pain and fear inherent in attempting to end one's life.

The factors associated with suicide are varied and complex, but it is a tragic endpoint of complex etiology and a leading cause of death worldwide. Predicting who will take their life is extremely difficult. Different theories of suicide were able to account for the diverse range of factors associated with suicidal behaviour. There are several characteristics of suicide, including a sense of unbearable psychological pain, a sense of isolation from others, lack of belonging, feeling trapped and hopeless and a burden on others and the perception that death is the only solution when the individual is temporarily not able to think clearly due to being blinded by overwhelming pain and suffering. Some people have a mental health condition, although signs of the condition may not have seemed evident before the suicide. Therefore, the theory components simultaneously will be a major contribution to the existing knowledge. A better understanding of the causal mechanisms will lead to improving intervention strategies.

Recommendations

The theories in this study suggest specific targets for reducing suicide risk. If we want to reduce suicide risk, we can (a) reduce pain, (b) increase hope, (c) improve connectedness, and/or (d) reduce capacity. The way these variables are targeted cannot be stipulated because prevention and intervention can look very different depending on setting (e.g., school and treatment center), age (e.g., adolescents and older adults), and level of intervention (e.g., individual

psychotherapy and government policy) among many other factors. For example, all four might be useful targets at the level of the individual (e.g., psychotherapy), and the fourth might also be a useful target at the level of government policy (e.g., bridge barriers, increased controls on firearms).

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