Suicide Experience

Subjects: Philosophy
Contributor: Ana Miranda

The suicide experience combines despair with the perception of suicide as the last option to alter its suffering effectively and actively. Shneidman's phenomenology understands the suicidal mind in terms of psychological pain, as opposed to focusing on the individual context.

suicide phenomenology perspectives

1. Introduction

Every year, about 1 million people die by suicide worldwide. The exact number is difficult to ascertain, both because of the difficulty in identifying indirect suicide attempts and because of accidental deaths that are interpreted as self-inflicted. It constitutes one of the top 10 causes of death in all age groups and is among the top 3 among adolescents and young adults. The rate of consummated suicide is higher in males and, in turn, more frequent among middle-aged and older adults. However, non-fatal suicide attempts are higher in women, notably adolescents and young adults. Suicide by hanging, firearm, overdose, jumping off cliffs, vehicle impact, and electrocution are some of the most commonly used methods, with the Golden Gate Bridge in California being one of the world's leading suicide sites, accounting for over 1700 cases since 1937. Suicide attempts by oneself or in a family history of suicide seem the best indicator of suicide risk, justified by a process of habituation or "incorporation": the more a person becomes familiar with a certain behaviour, through attempts, mental training, or stimulating narratives, the better they perform.

In the 18th century, Goethe, German poet and writer, with his epistolary novel The Sufferings of Young Werther (1774), gave rise to the greatest wave of mass suicides in the history of literature, by creating a protagonist who gives in to his own existential annihilation by an unrequited passion, provoking in young people of the time the same outcome—"Werther Effect", according to D.P. Phillips (1974). The social dimension of suicide would be worked out later on by Durkheim (1897) [1], showing that to understand it, it is fundamental to know the social context: altruistic—resulting from excessive integration in society and an insufficient individuality, in which the individual not only has the right to commit suicide, but also has this duty; anomic—consequence of the loss of relationship between the individual and society, in the context of great changes in the distribution of wealth, geographical isolation, or cultural alienation; fatalistic—in the face of an imposed and unappealable normative context, when individual aspirations are the target of excessive regulation by society; egoistic—resulting from the evolution of society towards the loss of the collective social focus, designated by Durkheim as "excessive individualism" or "egoism", and which more recent authors would designate as "new narcissism", "être pour soi".

The predisposition to suicide would arise when the individual project, inherently fragile and no longer integrated into a social system, disintegrates.

Suicidology, or the study of suicide behaviour and causes carried out by psychiatry and psychology professionals, seems to show that suicide is always, or almost always, pathological, i.e., individuals who voluntarily determine their own death suffer from some type of mental disorder. Mental disorder—namely, depression—is a very frequent characteristic of those who commit suicidal acts [2]. Almost half of all individuals who die by suicide were assessed by a mental health professional in the month prior to their death [3]. Although depression and bipolar disorder are the most common disorders among people who attempt suicide, it can also occur among college students [4], people with substance abuse disorders or schizophrenia [5], who find suicide a way to escape the intolerable pain that characterises mental illness, trauma, loss, rejection, or deceptions.

This awareness of oneself as insufficient and the state of despair or “psychache” leads the subject to value suicide as appealing because it is seen as a calming effect that offers a last and reliable possibility to alter one’s own reality actively and effectively. Everything that could be altered now seems to have failed or to be fruitless, but suicide can still be actively triggered by the self (or by another person actively delegated by the self), justifying that in a suicidal act there is, at least in a “basic” or “minimal” way, a sense of self-determination [6]. By offering a possibility beyond the horizontalisation of temporality (in which there would be no comfortable situation), suicide sustains the subject and confers freedom—“The idea of suicide is a great comfort: it helps to get through a bad night.” Friedrich Nietzsche (1844–1900) [6].

2. The Different Philosophical Perspectives—Patient, Family, and Healthcare Professionals

Over time, the study of suicide has allowed us to understand the sensations inherent in the suicidal experience, highlighting the similarities between the various experiences—namely, in the way the subject analyses himself and the world around him.

At an age when cardiovascular diseases and neoplasms have little representation for mortality, suicide represents the leading cause of death in children and adolescents who have psychiatric follow-up. However, less than 20% of children who commit suicide had follow-up in health services, which demonstrates a gap in health care [7]. At these ages suicide is particularly distressing for healthcare professionals in view of the huge value of YLD and also the impulsive and often unexpected nature of these events.

There is a need on the part of suicide survivors to attribute meaning to the suicidal act and justify this decision, which can lead to overvaluing one’s own responsibility and ruminating that intensifies feelings of guilt [8]. This is a disturbing period, marked by confusion and shock, being a risk to the survivors’ health [9], and establishing the survivors themselves a high-risk group for suicide due to the difficulty they feel in restoring balance [10].

Therefore, adequate preparation of all professionals is imperative, not only in developing suicide prevention strategies in at-risk groups [11] but also in recognizing the intensity and emotional complexity of suicide grief [12].

3. Conclusions

Shneidman's phenomenology understands the suicidal mind in terms of psychological pain, interpreting suicide as a last attempt to escape intolerable emotions.

Among each of the groups affected by the suicide, there are similar emotions during the process, such as the stigma and regret of the family, the guilt of the health professional, and the sadness and despair of the suicidal individual.

The management of post-suicide consequences benefits from the specialized support of health professionals, either through psychotherapy and pharmacotherapy or support groups.

The entry suggests that in clinical practice, a phenomenological approach might not only serve as an epistemic necessity for identifying and exploring emotions underlying the experience of suicide (the before and after) but also help in the clinical relationship to clarify several complex emotional states. Together, clinical and patient insights might ultimately help in primary and secondary prevention of suicide—a new paradigm.

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