

Background & rationale for the research

The impact of suicide and suicidal feelings

In the United Kingdom in 2007, 5377 people died as a result of suicide. That's one person every two hours. Suicide is most prevalent in the young (15-34 years old), and this means that in 2007 the number of life years lost to suicide in this country rose to 124,000.

Suicide also affects an estimated average of six to twenty-eight family members and friends, who will experience the social and psychological consequences of the suicide of a person close to them.

It is estimated that in England and Wales approximately 140,000 suicide attempts take place each year. In addition, there are still more people experiencing persistent and disturbing suicidal feelings – according to an NHS source, three times as many people think about suicide as attempt it.

Externalisation of suicide

The majority of suicide research to date has focused on external risk factors such as male gender, bereavement, unemployment, substance abuse, self-harming behaviour and so on. This also tends to be how suicides are reported in the press: it has been said that suicides have taken place because of debt, or because of a baby that won't breastfeed, or because of the death of a father.

While these explanations have truth in them, there's a sense in which they don't really explain suicide: there are many bereaved men who are unemployed, for example, who don't kill themselves. To really explain why someone died by suicide requires understanding the inner experience that precedes the act.

Of course, once a suicide has happened, the one person we could ask is gone. But there are many people alive today who have experienced a suicidal crisis, have attempted suicide, or have felt suicidal. Until now, their experiences have been insufficiently explored and we know very little about what it's like, inside, to feel suicidal.

Perhaps the experiences of suicidal individuals have been thought of as too idiosyncratic, too confused and complex to be a proper subject of scientific research.

In SANE's view, those who experience suicidal thoughts and feelings are the real experts on suicide. There's no better basis for 'the science of suicide' than their combined understanding.

Medicalisation of suicide

There are hundreds of studies reporting that psychiatric disorder is often present in people who have killed themselves. Of particular types of disorder, depression, manic depression, schizophrenia, anxiety disorders, and personality disorders have been found to most raise the risk of suicide. It has been found that a diagnosis of depression, for example, raises suicide risk by a factor of twenty.

But does depression really *explain* suicide? Again, there are vast numbers of people who have depression but aren't suicidal, and there are people who kill themselves who are not depressed (or in any way mentally ill). Although it seems undeniable that mental illness is a factor in many suicides, psychiatric diagnoses don't seem to help us understand what is central to being suicidal.

Cognitivism (thought-focus) in psychological approaches to suicide

Most influential accounts of the psychology of suicidal behaviour tell a story that goes something like this: suicidal people have certain cognitive (thinking) deficits (e.g. inadequate problem-solving) or have unhelpful ways of thinking (e.g. comparing self to others in a negative way), which propagate depression and anxiety. Suicide is then a reaction to these negative moods, a way to escape them, for example.

The idea that thoughts, not feelings, are central to suicide is also reflected in the fact that psychological methods designed to identify those who are most at risk of suicide, such as the Beck Hopelessness Scale, address beliefs, thoughts and attitudes, but not feelings.

In fact, the term 'suicidal feelings' rarely appears in the suicide literature and when it does, it is often used interchangeably with suicidal *ideation*, which has to do with thinking rather than feeling.

The need for research on the experience of suicidal feelings

This lack of attention to the experience of suicidal feelings is demonstrated by the dominance of externalized, medicalised and thought-focused approaches to suicide. This means that large areas of human experience that are potentially relevant to understanding suicide remain unexplored. We believe that this constitutes an unacceptable gap, the existence of which has a number of consequences:

- 1) **Problems with risk assessment:** Suicides are notoriously difficult to predict and more often than not they come as a complete surprise to those close to the person who dies. The 'risk factors' mentioned above, although they do identify groups of people who are more at risk than the general population, do less well at predicting *which individuals* will go on to take their own lives. This is because these risk factors (e.g.

being male) both include large numbers of people who are not really at risk, and miss large numbers of people who are.

- 2) **Difficulties in showing empathy to a suicidal person:** A little bit of empathy can go a long way in caring for a suicidal person. The design of services such as the [Maytree](#) in North London is based on the possibility that empathy can help those who are feeling suicidal. However, care professionals and others who encounter suicidal individuals often find it hard to empathise; suicide is thought of as an irrational response, which many find impossible to relate to. Facilities where staff do have an implicit understanding of the experience of being suicidal gathered over many years of experience with suicidal people, such as the Maytree, are rare; most suicidal individuals seek help from their GP or an A&E department. There, the processes typically put in place to 'save' suicidal people often neglect empathy in favour of placing people under observation ('suicide watch'). Research shows that suicidal individuals have lost a connection with humanity and that the experience of being watched without being actively engaged with is a negative one. A better understanding of what it is like to feel suicidal would help health care professionals, other support workers and the general public to connect with a suicidal person, to empathise with them and to show them that it may be possible for them not to feel so alone.
- 3) **Lack of public participation in suicide prevention:** As already mentioned, a suicide often comes as a 'bolt out of the blue'. We think that this is partly because the sort of knowledge that friends, colleagues and family members could use to identify and help suicidal individuals is very thin on the ground. Public participation in suicide prevention is important because three-quarters of people who commit suicide in the UK each year have *not* been in contact with mental health services within a year from their death. A better understanding of what it is like to feel suicidal might make us all better at recognising when someone is in danger.

Aims & objectives

Aim:

- To understand suicidal feelings from the first person perspective

Main objectives:

- To build a description of suicidal feelings based on self-reports of first hand experiences
- To develop a theory, grounded on self-reports of first hand experience, of how suicidal feelings develop and feed into suicidal behaviour.