



Our Empathic Brain and Suicidal Individuals

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What are the needs of suicidology today? We should not be surprised by the simplistic and obvious statement that we do not fully understand what is going on inside the minds of suicidal individuals. No doubt, we still partially manage the unmet needs (e.g., feelings of entrapment, defeat, helplessness) of those who are suicidal. In the face of extreme anguish, vulnerable individuals often conclude that there is no escape short of suicide. As mental health professionals, we offer support to such suicidal people, but are we really able to provide the help that they need? To some extent, our view is optimistic and we cannot ignore important advancements in the field of suicide prevention, yet there is a gap in the communication of human suffering.

The saying “know thyself” (or know yourself) may refer by extension to the ideal of understanding human behavior, morals, and thought, because ultimately to understand oneself is to understand other humans as well. It may be easier to conclude that suicide is linked to risk factors and specific psychiatric diagnoses. However, neither risk factors nor diagnostic labels are important in reducing the suffering that contributes to suicidal thoughts and behaviors.

Those who emphasize the role of a phenomenological approach highlight subjectivity and our sense of self, which is the starting point for knowledge. The clinician should focus on the subjective experience of a phenomenon, observing it while putting aside assumptions, judgments, or interpretations. In this fashion, any approach to suicide prevention should aid in our understanding of suicidal thoughts and feelings as they are experienced by at-risk individuals (Webb, 2010). And, if “I introspect and I understand myself, then I will be better suited to recognize other people’s feelings and better help them when they’re in need (Vlad, 2013).” Some call this empathy, which points to the fact that to better understand empathy, we need to understand ourselves. Both items may lead to problems. We spend considerable time explaining suicide risk, but we have difficulties understanding it. To some extent, similar issues using the same approach can arise with hallucinations. Specifically, given the fact that we never generally experience hallucinations, we cannot understand

them. However, we can explain what they are (Jaspers, 1913/1997).

Our understanding of the subjective experience of suicidal individuals should begin with examining those who experience suicidality. And to reflect even more, most of this literature is purely numerical, statistical, and interpretative from the point of view of those who have never been suicidal.

Empathy, the ability to share others’ emotions, is an everyday occurrence. This may be in the form of crying as well as laughing. Is there a mechanism that allows us to share other people’s emotions? As Shneidman once told me, we can view suicidal impulses (thoughts and actions) phenomenologically, more like being in love than having a liver disease (Pompili, 2010). Understanding the unbearable mental pain means thinking in a phenomenological way, and therefore the development of suicidal tendencies can be traced back to a state with similar characteristics of falling in love but flipped for affective valences. Similar to love, which is a broad totalizing dimension encompassing mind and body, suicidal wishes are a pervasive irrepressible condition that incorporates the individual as a whole; in love everything seems wonderful, in suicidal states, the condition is best understood not so much as a movement toward death as it is a movement away from something and that something is always the same: intolerable emotion, unendurable or unacceptable anguish. Reduce the level of suffering and the individual will choose to live. An unpleasant sensation is often localized in the chest and hypochondrium. The mind tries each option to release the tension but never finds a safe haven and ends up convinced that nothing will bring relief. In preventing suicide, one looks for any indications in the individual representing the dark side of their internal life-and-death debate. And such perturbation contributes to the motivation for suicide, with lethality being the fatal trigger. The content analysis of pain narratives (Orbach, 2009) is crucial in understanding the inner pain of suicidal individuals. Such feelings refer to the experience of changes in an individual’s self, such as self-estrangement accompanied

by dissociative characteristics. Those who are suicidal also often feel worthless, with emotional impoverishment and loss of self-esteem. Oftentimes misleading for clinicians, suicidal individuals report oxymoronic experiences, such as extreme contradictions in feelings, thoughts, and desires related to life and death at the same time. Unfortunately, such individuals typically do not have proper words for conveying their feelings, as ordinary words are not appropriate to describe these idiosyncratic experiences. Consequently, these events of loss lead to the interruption in one's sense of self-continuity together with loss in one's meaning of life. We also know the importance of good early attachment experiences for affect mastery, and the capacity to regulate affect is gradually acquired after birth. In fact, infants and children must learn to cope with separations, frustrations, and/or other emotionally challenging circumstances. With time and reasonable parenting, children attain the capacity to regulate themselves and keep themselves in reasonable emotional composure. We acknowledge the fact that, often unfortunately, suicidal individuals did not acquire such capacity in earlier developmental stages and in some way still have inefficient affect mastery. Moreover, young individuals who relied on dysfunctional child-rearing practices, especially when their own parents experienced trauma, are more likely to have insecure attachments in adult relationships.

Such preliminary thoughts are important in reflecting that when we encounter suicidal individuals we have difficulties in looking back in their lives. We often fear emotional contagion, that is, after talking to a suicidal person we may feel sad, whereas when talking to someone who feels self-confident and optimistic we are likely to feel good about ourselves; therefore it is easier to distance the former, to classify them as psychiatric patients and therefore deal with a "label" and not with their internal suffering (Hatfield, Cacioppo, & Rapson, 1994; Keysers, 2011). When people are in a certain mood, whether elation or depression, that mood is often communicated to others. In other words, both suicidal people and clinicians are shaken by suicide risk: Although dying by suicide is certainly a definitive action, it is, however, preceded by a complicated ambivalent internal dialogue within the suicidal individual, which often triggers reactions, or neuropsychobiological events, in individuals in crisis.

We now know that psychological pain, widely investigated by suicidologists, related to negative emotions is not just a vague construct providing an intuitive and obvious explanation of death wishes. Pain may also have a protective meaning; for instance, physical pain protects the individual from physical dangers. Scholars have described social pain (i.e., loneliness) as having a deleterious effect on health and life on par with having medical comorbidities or engaging in an unhealthy lifestyle (Cacioppo & Patrick, 2008). Such pain negatively affects psychological well-being and should be considered when assessing for suicidality. Neuroimaging studies examining the neural correlates of social exclusion tested the hypothesis that the brain bases of social pain may be similar to those of physical pain. For example, Eisenberger, Lieberman, and Williams (2003), using functional magnetic resonance imaging (fMRI), stud-

ied the neuroanatomical basis of both physical and social exclusion. They found evidence to support the notion that pain, whether somatic or psychological, is regulated by the same neuroanatomical cerebral circuits.

But how are we to understand such a degree of pain?

In order for empathy to take place, it is necessary that we experience in our own minds some points of reference that correspond to those of the patients' experience. In states of intense suicidal arousal or excitement, we commonly fail empathically, we do not imagine how much these patients suffer because we have volatile representations in ourselves. (J. T. M. Maltzberger, personal communication, 2010)

Empathy is understanding and experiencing emotions from the perspective of another, a partial blurring of lines between the self and other. We put ourselves in the shoes of others with the intention of understanding what they are going through, thus, employing empathy to make sense of their experiences.

Giacomo Rizzolatti, the neurophysiologist who first described mirror neurons, stated:

We are exquisitely social creatures. Our survival depends on understanding the actions, intentions, and emotions of others. Mirror neurons allow us to grasp the minds of others not through conceptual reasoning but through direct simulation. By feeling, not by thinking (in Blakeslee, 2006).

Brain imaging with fMRI studies has shown that the same areas of the human brain are activated when the person performs an action and when the person sees another individual performing an action. This peculiar mechanism is commonly explained by the fact that these brain regions contain mirror neurons, and are defined as the human mirror neuron system. Therefore, it has been suggested that seeing and doing can be synonymous when considering empathic responses. When people see someone doing something, they can imagine doing the same, which is a process accomplished automatically. This system is typically referred to in the context of action.

At the beginning of his theory, Freud (1957/1915) recognized that drive or instinct as "a concept on the frontier between the mental and the somatic, as the psychic representative of the stimuli originating from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body" (pp. 121–122). We know that mind is grounded in our body. To understand the actions of other individuals, we need to map them onto our own body's motor programs. To understand their emotions, we need to map them onto our own visceral feelings (Keysers, 2011).

Experiments demonstrated that the insula appeared to share emotional processes of experiencing strong bodily feelings in other individuals. Both the premotor cortex and the insula are involved in neural circuits that allow us to share the actions and emotions of other individuals.

Neuroscientists coined the term shared circuits to describe this whole family of neural processes, including mirror neurons for actions, and similar systems, including the insula for bodily feelings such as disgust.

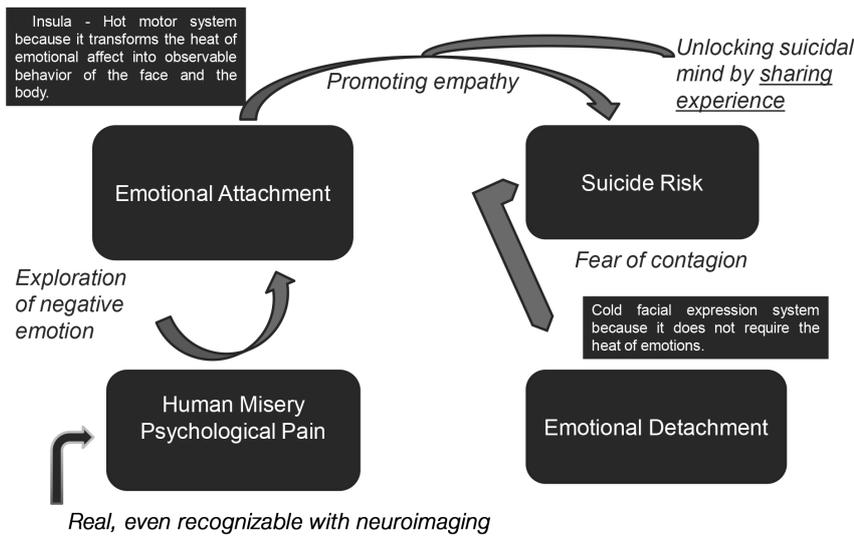


Figure 1. The chart emphasizes the need to reach suicide risk by proper understanding of psychological pain, a pathway that promotes emotional attachment; by contrast, a pure approach to suicide risk may trigger defense mechanisms that could impair the empathy and therefore limit proper understanding of the suicidal mind.

Neuroscientist Keysers (2011) convincingly described such shared circuits and circumstances when they do not work simultaneously. He described the difference between a real and fake smile. In the former there is a so-called “hot” motor system where the involuntary emotional behavior transforms the heat of emotional affect into observable behavior of the face and the body, that is, muscles of the face are enriched by emotions. On the contrary, in the cold facial expression, a fake smile does not contain the heat of emotions. This example urges us to be real with patients who most often recognize when therapists fake their behavior.

Empathy should thus be seen as made up of various subcomponents that together build the final image of other people's feelings. Since understanding oneself is to understand other humans and since the differences in our personal experiences will determine the differences in our empathy, we need to introspect as much as we can to provide valid support to our patients. In solid human relationships it is now evident that individuals are able to experience, although partially, the pain of a close person with whom they are engaged emotionally. We now have the opportunity to wonder “how your pain becomes my pain.” In a well-known experiment performed by Singer et al. (2004), knowing that the partner was in pain caused activations that resembled those when participants experienced pain themselves. This experiment suggests that as far as affective components of other individuals’ pain is concerned they are directly mapped in regions retaining our own experience; such activations in the insula suggest that this part of the human central nervous system may represent bodily feelings, ranging from food-related disgust and pleasure to bodily pain (Keysers, 2011).

However, there are conditions in which these automatic systems do not work in this way, for example, when facing something traumatic or when individuals must distance themselves from a particular experience. These are the cases of empathy disconnection when one needs to protect oneself (Iacoboni, 2008; Rizzato & Donelli, 2014). Now consider the impact that the word and concept of suicide must have on emotional disconnection because we think

of death, sadness, madness, superstition, and so on. These are examples of adaptive mirroring and of our ability to attach and detach emotionally from the ones with whom we engage in social connections. The suicidal person seeking support in our office, in the street, or by calling a helpline is highly emotionally unstable, which is the consequence of failed affect regulation, failed capacity for hope, and/or failed capacity to maintain loving relationships in the face of extreme anguish. One can run the risk of following Freud’s suggestion: “I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy” (Freud, 1912/1958, p. 115).

In Figure 1, I propose that exploring psychological pain and human misery more strategically will promote empathy because it involves human emotions that although painful are closer to our experience and therefore provide an intersubjective perspective. If this were to be confirmed, even in the case of negative emotions, there should be an emotional attachment and proper action of mirror neurons. Whereas facing the subject of suicide with no emotional background involvement will facilitate the frightening, historical emotional reaction with the fear of risk of contagion. This is probably associated with emotional detachment, reduced empathy, and mirror neuron disconnection. Proper understanding of neuropsychobiological reactions should pave the way to awareness toward suicide for those devoted to helping suicidal individuals. By focusing on our attitudes, we can reduce the gap in the communication of human suffering, again, courageously “by feeling, not by thinking.”

On September 4, 2014, Dr. Margaret Chan, Director-General of the World Health Organization, stated that:

Despite an increase in research and knowledge about suicide and its prevention, the taboo and stigma surrounding suicide persist and often people do not seek help or are left alone. And if they do seek help, many health systems and services fail to provide timely and effective help. (World Health Organization, 2014, p. 2)

It is now time to reflect on our emotions so as to understand our approach when treating suicidal individuals, either by facilitating or impairing emotional attachment. If we were able to provide anodyne approaches (Shneidman, 2005), which more effectively relate to the points of reference corresponding to those of the patients' suffering, we would mollify the pain that kills and inevitably isolates suicidal individuals to whom we are so committed as suicidologists.

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