of ending her life. Gradually, she was able to process her intense reactions of shame and loss of identity and value as a woman and spouse, and at the same time, she was able to further integrate her female identity as a mother and professional woman, and her suicidal ideations slowly tapered.

In sum, psychotherapy can be challenging for patients with chronic suicidal ideations. Paradoxically, the main purpose of assessment and treatment, *i.e.*, to increase self-awareness and control of problems and emotions, process difficult experiences, and make people feel and function better, can actually be challenging and make people feel worse for a while. Low emotion tolerance, concreteness, deeply engrained and accepted functional patterns, intolerance of gaze and being seen and exposed, *etc*., can contribute to a patient's discomfort or distress in the therapeutic process. This is why it is important to consider and evaluate suicidal ideations occurring as a part of a process of personality functioning that the patient is motivationally and intentionally engaged in. If suicidal ideations remain unprocessed, the organizing self-regulatory function of such thoughts may fail when patients face a new challenging, overwhelming experience that connects to or reminds them of the original event and experiences that first evoke suicidal ideations. This can contribute to a sudden change in motivation and intent, with an increased risk for suicidal actions.

The core issue regarding chronic suicidal ideations in the therapeutic alliance is to contain and incorporate the patient's preoccupation with the therapeutic alliance. This means that rather than having an alliance that is split off and remains unprocessed, the patient's suicide-related thoughts are brought into the therapeutic relationship and dialogue, which opens the possibility for the patient to be seen, heard, and understood. A prime aim is to make the patient's preoccupation with suicide an interactional part of the therapist's relationship with the patient, as opposed to an isolative part detached from the therapeutic alliance. We suggest three major questions to attend to in this exploratory process: i) when does the idea of suicide help the patient to contain and/or tolerate unbearable experiences, like for the patient who faced his father's reactions to losing his job?; ii) when does preoccupation with suicide present as a symptom that can suddenly or regularly escalate in certain contexts, *i.e.*, when sad, threatened, enraged, or intoxicated, seemingly unrelated to any underlying problems?; iii) when are suicidal ideations representing or associated with a sense of identity, and deep containing, sustaining awareness of not being good enough, a "mistake", a "failure", a "burden" *etc*., like for the patient whose husband left?

In other words, the main focus is to differentiate when the idea of suicide actually can "support" or "improve" psychological functioning by helping to contain, compartmentalize, or split off incompatible, insurmountable, or unacceptable aspects of self and emotions, *versus* when suicide is perceived as a possible way out of overwhelming and intolerable life circumstances or emotions and therefore presents an acute and immediate risk to the patient's life.

There are several limitations in the approach to identifying, assessing, understanding, and treating patients with suicidal ideations as outlined in this manuscript. Firstly, empirical validations of characterological-based chronic suicidal ideation have yet to be done. Secondly, as suicide and suicidal ideation are complex and multifactorial concepts with a range of underpinnings and expressions, there is still a need for specifying subgroups. Furthermore, the degree of emotional tolerance, comorbidity, and differences in processing external life circumstances are additional factors that may suggest a contextual and dimensional approach to assessing and treating suicidal ideations.

Conclusions

As outlined above, chronic suicidal ideations can be consistently present as part of the individual's sense of identity and self-regulation, or as a reoccurring pattern to control intense feelings and communicate and relate experiences or intentions. For some individuals, access to recurrent suicidal thoughts, *i.e*., fantasies, envisions, or preoccupation, can serve as a relief; for others, it is associated with pain and strong feelings, ranging from anger, despair, or frustration to guilt, shame, fear, or longing. Engaging patients in the therapeutic alliance and building consistency and reliability are core conditions and strategies for encouraging them to describe their internal experiences and the most vulnerable aspects of themselves. It is also important to convey that the patient has an impact, a sense of agency, and can make choices, *etc*., which can serve to either increase or diminish their own withholding, avoiding, enacting, or power struggle. This is important for building trust in the therapeutic relationship. The therapist's curiosity, openness, and non-judgmental inquiries of the patient's specific connections to and meanings of suicide are essential for implementing this process. It is also essential that the therapists attend to and hold the range of the patient's emotional experiences and reactivity. Processing one's own countertransference, intense reactions, and fear related to anticipation of a patient's suicidal actions can be very challenging for the therapist and require consultations and supervision to contain these feelings and access their informative value. In that context, it is also important for therapists to keep in mind that patients' verbalization of their suicidal preoccupation and range of related experiences can stimulate their emotional tolerance and self-reflective ability. Helping the patient describe and gradually integrate incompatible, unacceptable, or intolerable aspects of themselves as related to their chronic suicidal ideations can also encourage them to verbalize feelings of fear, shame, pain, anger, and grief. In this process, it is also important to help the patient connect the recurrent sense of powerlessness, weakness, and fragility with awareness of their own motivation, sense of agency, and life connection.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders. Fifth edition text revision. DSM-5-TR*. American Psychiatric Association Publishing.

Coleman, D., Lawrence, R., Parekh, A., Galfalvy, H., Blasco-Fonticilla, H. Brent, D. A., Mann, J. J., Barca-Garcia, E., & Oqendo, M. A. (2017). Narcissistic personality disorder and suicidal behavior in mood disorders. *Journal of Psychiatric Research*, *85*(1), 24-28. doi: 10.1016/j.jpsychires.2016.10.020.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372-380. doi: 10.1037/a0036505.

Fonagy, P., György, G., Jurist, E., & Target, M. (2018). The development of an understanding of self and agency. In: P. Fonagy, G. Gergely, & E. L. Jurist (Eds.), *Affect regulation, mentalization, and the development of the self*. (pp. 203-251). Routledge. doi: 10.4324/9780429471643-8.

Goldblatt, M. J., Ronningstam, E., Schechter, M., Herbstman, B., & Maltsberger, J. T. (2016). Suicide as escape from psychotic panic. *Bulletin of the Menninger Clinic*, *80*(2), 131-145. doi: 10.1521/bumc.2016.80.2.131.

Harmer, B., Lee, S., Rizvi A., & Saadabadi, A. (2023). *Suicidal ideation*. StatPearls Publishing.

Hennings, J.M. (2020). Function and psychotherapy of chronic suicidality in borderline personality disorder: Using the reinforcement model of suicidality. *Frontiers in Psychiatry*, *11*, 199. doi: 10.3389/fpsyt.2020.00199.

Klonsky, D. E., Dixon-Luinenburg, T., & May, A. M. (2021). The critical distinction between suicidal ideation and suicide attempts. *World Psychiatry*, *20*(3), 439-441. doi: 10.1002/wps.20909.

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation. *Annual Review of Clinical Psychology*, *12*, 307-30. doi: 10.1146/annurev-clinpsy-021815-093204.

Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: the reasons for living inventory. *Journal of Consulting and Clinical Psychology*, *51*(2), 276-286. doi: 10.1037/0022-006X.51.2.276.

Maltsberger, J. (2004) The descent into suicide. *International Journal of Psychoanalysis*, *85*(3), 653-668. doi: 10.1516/3C96-URET-TLWX-6LWU.

Maltsberger, J., Ronningstam, E., Weinberg, I., Schechter, M., & Goldblatt, M. J. (2010). Suicide fantasy as a life-sustaining recourse. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *38*(4), 611-624. doi: 10.1521/jaap.2010.38.4.611.

Moselli, M., Frattini C., Williams, R., & Ronningstam E. (2021). The study of motivation in the suicidal process: the motivational interview for suicidality. *Frontiers in Psychiatry*, *11*, 598866. doi: 10.3389/fpsyt.2020.598866.

Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., Bruffaerts, R., Chiu, W. T., de Girolamo, G., Gluzman, S., de Graaf, R., Gureje, O., Haro, J. M., Huang, Y., Karam, E., Kessler, R. C., Lepine, J. P., Levinson, D., Medina-Mora, M. E., Ono, Y., Posada-Villa, J., & Williams, D. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *British Journal of Psychiatry*, *192*(2), 98-105. doi: 10.1192/bjp.bp.107.040113.

Paris, J. (2002). Chronic suicidality among patients with borderline personality disorder. *Psychiatric Service*, *53*(6), 738-742. doi: 10.1176/appi.ps.53.6.738.

Paris, J. (2004). Half in love with easeful death: the meaning of chronic suicidality in borderline personality disorder. *Harvard Review of Psychiatry*, *12*(1), 42-48. doi: 10.1080/10673220490279161.

Ronningstam, E., Weinberg, I., Goldblatt, M., Schechter, M., & Herbstman, B. (2018). Suicide and self-regulation in narcissistic personality disorder. *Psychodynamic Psychiatry*, *46*(4), 491-510. doi: 10.1521/pdps.2018.46.4.491.

Sansone, R. A. (2004). Chronic suicidality and borderline personality. *Journal of Personality Disorders*, *18*(3), 215-225. doi: 10.1521/pedi.18.3.215.35444.

Schwartz, D. A., Flinn, D. E., & Slawson, P. F. (2018). Treatment of the suicidal character. American *Journal of Psychotherapy*, *28*(2), 194-207. doi: 10.1176/appi.psychotherapy.1974.28.2.194.

Sinha, P., Khanna, A., Khanna, P., Moyal, D., & Jha, S. (2017). Chronic suicidality and personality disorders. In U. Kumar (Ed.), *Handbook of suicidal behaviour* (pp. 387-402). Springer Nature Singapore Pte Ltd. doi: 10.1007/978-981-10-4816-6_21.

Non-commercial use only

OPEN ACCESS