Affective States in Suicide

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1 Introduction

Each year, close to one million people worldwide die by suicide. Suicide accounts for about 1.5% of all mortality [1]. Since it is considered a psychiatric emergency, understanding predictive and protective factors is important in suicide prevention [2].

Identifying a suicide crisis is challenging because of the tendency of patients to withhold suicide intentions and plans from providers if not properly prompted, or deny suicide intent if questioning is inadequate [3]. Major precipitating life events may trigger the overwhelming mental pain that culminates in suicide [4]. However, even in the absence of a clear precipitating event, intense affects can drive a person to desperation, helplessness and suicide [5]. Recognizing high risk affective and

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cognitive states is, therefore, a more reliable way of helping clinicians identify suicide crises independent of patients acknowledging suicide intentions [6].

This chapter will describe research and clinical findings that validate the association of specific affective states with suicide risk in general, and specifically comment on affective states present in suicides by self-immolation.

2 Negative Affective States and Suicide

Negative affects play an integral role in the development of suicidal thoughts and behaviour. Suicidal thoughts are commonly associated with affective states like depression and anxiety [7, 8]. Some individuals are more vulnerable than others, and personality types with a propensity for negative emotions, namely neuroticism, as well as psychological states such as impulsivity, aggression, depression, hopelessness, anxiety, self-consciousness and social disengagement increase suicide risk [8, 9]. Latent suicidogenic cognitive structures known as suicide schemas are present in some individuals [10]. Suicide schemas can be understood as a network of interconnected stimuli, response and emotional information relating to suicide [10]. These latent schemas are activated under stressful circumstances to induce suicidal thoughts as a way to escape from an overwhelming and intolerable emotional state or situation [11]. The theory of vulnerability to suicide caused by latent suicide schemas finds support in observations that individuals are seldom constantly suicidal. Instead, they experience spikes in suicidal thoughts and behaviours during crises [12].

Negative affective states can trigger dysfunctional thought patterns in at-risk individuals [11, 13]. Hopelessness, rage, guilt, feelings of abandonment, anxiety, feelings of loneliness, shame or humiliation and self-hatred are various affective and cognitive states linked with suicide [6, 14–19]. Intense affects are strong predictors of acute suicide risk [20]. Hendin and colleagues (2007), in a study comparing depressed patients who died by suicide with controls, reported that those who suicided had significantly more intense affects including desperation, hopelessness, feelings of abandonment, self-hatred, rage, anxiety and loneliness [6]. Desperation appears to be the strongest predictor of an acute suicide crisis. Central to the affective turmoil experienced by many of the patients who die by suicide is intolerable distress and desperation stemming from the belief that death is the only way to regain control and relief. Affective instability is also associated with increased risk of suicide [21]. In this section we will delineate affective states associated with suicide and present clinical case correlations. *In order to preserve confidentiality, the authors either disguised identifying information or obtained informed consent from patients or their next of kin.*

2.1 Hopelessness

Hopelessness is defined as a negative expectation of the future, as in giving up hope leading to a state of despair. Beck described hopelessness as the inability to tolerate one's suffering and difficulty finding solutions to problems [22]. While hopelessness is viewed as a state factor, it may also be a form of internalizing psychopathology with trait components [23].

Hopelessness is a strong predictor of suicidal behavior [9, 24]. It is the second most common risk factor for suicide besides prior suicide attempts [25]. In a seminal study, Kovacs and colleagues used hopelessness scores to predict 91% of suicides in a 10-year prospective study of hospitalized patients [14]. Hendin and colleagues found that depressed patients with suicidal ideation report hopelessness significantly more than non-suicidal depressed individuals [20]. Patients who die by suicide score higher in the Beck Hopelessness Scale, and those who attempt suicide experience hopelessness more than non-suicidal patients or those with suicidal ideation [25]. An acute increase in hopelessness, for example after death of a spouse, could increase the risk of suicide within hours or days. Consequently, it is clinically meaningful to measure level of hopelessness as a predictor of suicide [25].

2.2 Desperation

Desperation is a state of anguish or severe mental suffering accompanied by an urgent need for relief [20]. Patients experiencing desperation feel that they could no longer tolerate their present state of anguish. It often coexists with feelings of hopelessness; a hopeless person may find the current stressor intolerable and in desperation seek immediate relief through suicide. In contrast to hopelessness, desperation is usually acute and therefore can be a predictable marker of a suicide crisis. Desperation may be the final common pathway to suicide from other negative affective states, such as unrelieved rage, anxiety, and abandonment [6]. Maltsberger proposed that a person who is desperate experiences loss of control and fear of disintegration, and suicide symbolically becomes a way to achieve control [26]. Although most patients who experience desperation display affective consonance, some dissociate and portray a calm, quiet demeanour. It is therefore important to always inquire about affective distress in the presence of severe psychosocial stressors.

2.3 Anger

The emotional states of anger and rage (violently intense anger) strongly correlate with depression, especially in younger populations [27]. Adolescents with multiple suicide attempts have more severe depressive symptoms and affective expression of

anger compared to those with just one suicide attempt [28]. Anger, combined with high impulsivity, significantly correlates with suicide risk in inpatient psychiatric units [29]. A cross-sectional study in a community sample found that anger is significantly associated with suicidal ideation regardless of age and after controlling for depression [30]. Suicide could be understood as a means of communicating rage or extinguishing anger [31]. Hawkins and colleagues studied the relationship between anger and suicide risk through the perspective of the interpersonal theory of suicide and found that anger is linked to suicidal behaviour via perceived burdensomeness-see Sect. 2.11 [32]. Anger may lead to suicide through painful and triggering events [32]. As such, identifying triggers and managing problematic anger may help decrease suicide risk.

2.4 Self-Hatred

Self-hatred is another negative affective state associated with suicide [20]. Self-hatred is a form of mental and physical self-abuse experienced by some suicidal people. It is a hateful attack by the self against itself, in addition to having a negative self-view, low self-esteem, self-anger, or lack of self-satisfaction [33]. Perhaps the easiest way to conceptualize self-hatred as an affective state relating to suicide is through the lens of people with borderline personality disorder (BPD), a mental disorder characterized by instability in self-identity, affective lability, chaotic interpersonal relationships and impulsive behaviour [34]. People with BPD have a high risk of self-harm and up to 10% die by suicide [35]. Suicidal individuals frequently provoke situations that result in losses, rejections, and subsequent self-hatred. In patients with BPD, self-inflicted injury could be understood as self-punishment stemming from extremely low self-evaluation coupled with expressed anger [36].

2.5 Anxiety

Anxiety is an emotion characterised by worrying thoughts in anticipation of a future concern, with associated feelings of tension, physical changes like increased heart rate and avoidance behaviour [37]. Anxiety and fear are closely related. Fear is an emotional reaction to an immediate threat that is associated with a fight or flight response [2]. Theories of anxiety include Freud's formulations emphasizing accumulation, repression and displacement of psychic tension; behavioural theories that suggest conditioning resulting in the development of phobias; cognitivism which focuses on anxiety arising from an 'appraisal' of a situation; as well as neurobiological theories highlighting the role of amygdala in fear reactions using neuroimaging [38].

Anxiety is a significant risk factor for suicide [39]. Joiner's interpersonal theory posits that for suicide to occur, individuals must develop high levels of acquired

capability through repeated experiences with painful and provocative events [40]. Avoidance in states of anxiety may protect against the transition from suicidal ideation to death by suicide [41]. Conversely, affective states of anxiety (e.g. trait-like anxiety, future-oriented worry) with acute symptoms of anxiety and agitation (e.g. excessive motor and heightened mental arousal, severe panic attacks) are often present immediately prior to suicide [3, 42].

The experience of anxiety could result from underlying intrapsychic and interpersonal conflicts. When a person's defense mechanisms fail to contain anxiety, the distress caused by feeling overwhelmed may lead to acting out of suicidal thoughts or impulses. Intense affective states of anxiety, especially in depressed patients and persons experiencing posttraumatic and stressor related disorders, may signal a suicide crisis [6, 20]. Research shows a high association between anxiety and anguish and completed suicide [43].

Suicide could be conceptualized as the ultimate escape from aversive self-awareness and associated negative affect, which often includes anxiety [5]. Anxiety coupled with hopelessness heightens a person's urges to escape psychological pain and elevates suicide risk [44]. Recognizing anxiety and how it interacts with other affective states may help clinicians avert a suicide crisis in persons at risk.

2.6 Guilt

Guilt is a self-conscious emotion characterized by a painful appraisal of having done or not done (or thought about) something that is wrong, either in reality or in one's imagination, leading to real or imagined harm to others. Guilt normally brings about feelings of remorse, resulting in a sense of having to pay a debt (guilt derives from the German word "geld" which means money or debt), be punished or desire reparation in order to undo or mitigate this wrong [45].

In his structural model of the mind, Freud described guilt as arising from the superego expression of condemnation upon the ego, ultimately traceable to the Oedipal phase when one is supposed to learn to negotiate affection with caregivers with comfort [46]. Klein related guilt to the developing awareness that one's aggressive impulses might hurt loved ones—a phase of psychological development she termed "the depressive position" [47]. Winnicott later described this phase as the stage of concern, emphasising psychological achievement in reaching this level of awareness [48]. Thus, the capacity to feel guilt develops with a child's growing awareness that actions impact others. It represents the conscious or unconscious recognition of violating the internalized rules of right living acquired from caregivers.

Under intense guilt, especially in people with superego pathology, suicide may represent a form of self-punishment to atone for having engaged in sinful behaviour or unacceptable transgressions [49].

2.7 Humiliation and Shame

Humiliation involves feeling devalued in relation to others or to one's core sense of self, usually with an element of rejection or a sense of role failure that is brought upon one by others [50]. Humiliation involves abasement of honour and dignity and, with that, loss of status and standing. When humiliated, status claims cannot be easily recovered as one's authority to make public status claims is called into question.

Shame is a painful emotional state brought about by a negative self-evaluation that threatens family, social status and/or public image. It tends to occur with significant public failures, traumas (particularly physical violations), or when it involves a behaviour closely tied to a reduction in self-esteem. Shame is often harder to identify both for the sufferer and for the person trying to help [45]. The capacity to experience shame occurs with the development of self-consciousness where there is the realisation that the self can also be seen from the outside [51]. Shame also relates to a collapse of self-esteem or narcissistic wounds developmentally linked to a parent's failure to respond attentively and appreciatively to a vulnerable child [52].

Shame-proneness, the stable propensity to react with shame in various situations, relates to different expressions of psychopathology, such as depression, anxiety, anger, difficulties with interpersonal problem-solving, substance use, borderline personality, and suicide ideation [53–55]. Heightened shame sensitivity with feelings of humiliation may lead to disorders characterised by low self-esteem, such as introjective or atypical depressive states, which are associated with suicide. Many people with anxiety disorders, particularly social phobia, fear what others might see in them. This fear of exposure is usually related to a deep sense of shame. Individuals often develop avoidance strategies like social isolation, which in turn compound the problem [45]. Shame-proneness, which may trigger suicidality, is common in persons with borderline personality disorder [35, 56].

Suicide can be a consequence of shame, or function to avoid or attenuate shame. Some people with heightened shame sensitivity may experience disappointment that threatens self-esteem. Defensively and violently rebelling against the perceived aggressor may devolve into rageful homicide or suicide [57].

Illustrative Case Vignette 1

J was a 35-year-old Chinese gentleman who first presented to psychiatric services following his first suicide attempt. He reported feeling that life was worthless and meaningless after returning from an overseas training attachment a month earlier. He tried coming to terms with being gay during his leave but had great difficulty accepting his sexuality. Apart from feeling ashamed and guilty, he was afraid of how his family would view him if discovered. J had his first same-sex relationship during this overseas attachment.

Unfortunately, his boyfriend cheated, and the relationship collapsed, leaving J feeling abandoned and devastated in a foreign land. He had difficulty focusing on his training and had to return home prematurely with the burden of paying back his training fees.

J came from a conservative Chinese family where males carry on the family line. His paternal grandmother raised him after his mother died by suicide shortly after his birth. J, the youngest of three children, was the only son in the family. His father was mostly absent, distracted with work. Growing up in poverty, J learned that a good education results in professional and financial stability. His grandmother frequently shared her dreams of seeing him succeed with a family of his own. J worked hard and became the only person in his family to attain a university degree. He worked as an engineer and performed well enough to be awarded an overseas scholarship. He dated a woman for a short while, but the relationship did not work out. He was introverted and usually kept things to himself.

During his hospitalization, J did not display significant depressive symptoms. He occasionally mentioned that life was meaningless, and the future was bleak. He was guarded and appeared nonchalant. He declined medications but accepted psychotherapy. In view of his suicide risk, J received close follow-up after discharge. While he did not display significant depressive symptoms and denied being suicidal, he acknowledged feeling worthless and that life was meaningless.

J was subsequently found dead near a cemetery after ingesting poison. Conflicted about his sexuality, he experienced anxiety and extreme guilt, compounded by feelings of humiliation and shame. He also felt romantically abandoned, betrayed and rejected. These intense affective states were too overwhelming, resulting in losing the will to live and ending life to escape psychic pain.

2.8 Feelings of Abandonment

Feelings of abandonment include experiences of emotional deprivation, fearfulness related to self-doubt and insecurity, sadness and anger due to loss of support, as well as loneliness after being deserted or neglected. It is a type of grief involving the loss or perceived loss of a loved one, which leaves the person feeling isolated, devalued and helpless.

Feelings of abandonment can be excruciating, particularly for patients with borderline personality disorder, and suicide may be experienced as the only way to end psychic pain [35, 58]. Persons who had traumatic life experiences and describe feelings of abandonment have a higher suicide risk [59].

2.9 Loneliness

Loneliness is a feeling of aloneness coupled with the subjective experience of being socially disconnected or alienated from others [40, 60]. It is a facet of thwarted belongingness linked to negative mental and physical health outcomes. Chronic feelings of loneliness coexist with anxiety, anger, pessimism and fear of negative evaluation [61]. Loneliness involves disaffection towards interpersonal issues and it relates to depressive symptoms [62]. A German study found that loneliness correlates with depression, generalized anxiety, and suicidal ideation [63]. Persistent feelings of loneliness are linked to suicide although to a lesser degree than other negative affective states [20, 22, 62]. A Canadian population-wide study found that greater degree of loneliness correlates with increased prevalence of suicide ideation [18]. In vulnerable depressed older adults, loneliness and lower subjective social support correlate with suicidal ideation [64].

2.10 Thwarted Belongingness

Social isolation is one of the strongest and most reliable predictors of suicide across different age groups, populations and clinical settings [65]. Thwarted belongingness includes loneliness (feeling disconnected from others) and the absence of reciprocally caring relationships (not having anyone to turn to for support and care for in times of need) [40]. Persons innately need a sense of belonging [66], and a state of thwarted belongingness and desire for suicide develops when the fundamental need of belonging is unmet.

2.11 Perceived Burdensomeness

Perceived burdensomeness is related to feelings of expendability and comprises two dimensions of interpersonal functioning. First, the perception of the self is so defective that the person feels he or she is a liability to others. Second, the individual experiences affectively-charged thoughts of self-hatred, which may manifest as low self-esteem, guilt or self-blame and agitation [40]. Joiner and colleagues studied suicide notes and found that perceived burdensomeness is characteristic of the notes of those who die by suicide [67].

Illustrative Case Vignette 2

B is a 28-year-old Chinese woman who first presented to psychiatric services with severe depressive symptoms and social anxiety soon after quitting her job as a nurse. She was diagnosed with major depressive disorder, social anxiety disorder and borderline personality disorder. Despite ongoing treatment with medication and psychotherapy, she remained chronically unwell and was hospitalized on several occasions for suicide attempts triggered by crises at home.

B grew up in a traditional Chinese family. Her mother had a paranoid personality and constantly feared that B would be led astray by bad company. As a result, her mother exerted a lot of control over B's life. She did not permit B to socialize outside of school and imposed strict curfews. In order to maintain peace in the family, B's father, a timid and conflict-avoidant man, coaxed B to give in to her mother's demands even though he felt they were unreasonable. Despite experiencing these adverse psychosocial circumstances during formative years, B graduated with a nursing degree. However, overwhelmed by the level of social interaction her work demanded, she quit her job as a nurse after just 2 months. B continued to struggle with intense anxiety and feelings of hopelessness.

B wished to move out alone but could not as her mother would object and threaten to kill herself. In therapy, she acknowledged feelings of anger toward her mother for restricting her life. She also felt abandoned by her father for not standing up for her. Simultaneously, she struggled with guilt and self-blame for her mother's emotional distress. She felt lonely and isolated, trapped in a dysfunctional family setup.

B attempted to hang herself on her 28th birthday. Fortunately, her parents stopped her just in time. B was subsequently admitted to a psychiatric ward. When interviewed, B acknowledged feeling angry toward her mother for depriving her of the freedom and personal space she needed to individuate and launch her life in her adolescent and early adult years. Guilt at the unacceptable notion of anger and rage toward her mother for 'destroying her life' manifested as intense anxiety whenever her mother was present physically or in her mind. She also felt trapped, lonely and hopeless in her situation which she saw no escape from. The confluence of these intense affective states resulted in desperation that culminated in suicidal behaviour.

3 Affective States in Theories and Models of Suicide

The struggle against negative affects is common to various theories and models of suicide. Baumeister proposed the escape theory of suicide, viewing suicidal behaviour as an attempt to flee from negative emotions arising from awareness of one's inadequacies [5].

Joiner's interpersonal theory of suicide suggests that the desire for suicide develops when individuals simultaneously experience unmanageable feelings of perceived burdensomeness and thwarted belongingness. It further proposes that the capability to engage in suicidal behavior is separate from the desire to engage in it. When individuals lose hope in their capacity to manage thwarted belongingness and perceived burdensomeness, they experience an active desire to commit suicide. Suicidal behavior emerges when active suicidal desire (i.e., the convergence of thwarted belongingness, perceived burdensomeness, and the hopelessness about these states) interacts with an increased suicidal capability, which is in turn a result of repeated exposure to physically painful and/or frightening experiences [40, 68]. Self-reported loneliness, fear of negative evaluation, fewer friends, living alone, non-intact family, social withdrawal, and family conflict are components of the thwarted belongingness construct. The perceived burdensomeness construct, on the other hand, includes components such as perceptions of liability and self-hate [40, 68]. A meta-analysis of cross-national research found that the thwarted belongingness - perceived burdensomeness interaction is significantly associated with suicidal behavior [68]. Thwarted belongingness plays a greater role than perceived burdensomeness in contributing to suicidal capability, but perceived burdensomeness is a better longitudinal predictor of suicidal behavior.

O'Connor's integrated motivational-volitional model of suicide views suicide as a behaviour that develops through motivational and volitional phases. The motivational phase involves factors that determine the development of suicidal ideation and intent. The volitional phase describes factors that determine whether a person acts upon these. Feelings of defeat and entrapment drive the emergence of suicidal ideation and various volitional factors such as exposure to suicidal behaviour of others, impulsivity and access to means then mediate the shift to action [69].

Psychodynamic thinking similarly views suicidal people as experiencing a struggle against waves of negative emotions [26]. Freud proposed that suicide develops when destructive forces of the id and a harsh superego challenge the integrity of the ego [70]. Glover later highlighted the importance of ego regression that follows the superego attack against the self. This in turn generates intolerable affects culminating in suicidal behaviour [71]. Bibring theorized that helplessness of the ego in the face of crushing forces engenders depression [72]. When helplessness persists, it gives way to hopelessness, a well-known indicator of suicidal states [73]. Bibring viewed suicide as a form of self-attack in which aggression against the self results from a breakdown of self-esteem [72]. Maltsberger proposed four aspects of suicidal collapse as the ego disintegrates. Affect deluge, the first aspect, is akin to flooding and described as being overwhelmed with a torrent of intolerable painful feelings. The second aspect, efforts to master affective flooding, involves a struggle to contain feelings. The person stays afloat and sinks alternately. When this fails, he or she has a sensation of drowning, loss of control and desperation. This is the third aspect, loss of control and disintegration. The fourth aspect, grandiose survival and body jettison, occurs when the patient identifies the body as a source of emotional pain. The patient experiences the body as an enemy that needs to be annihilated in an act of self-defense [26].

4 Suicide Contagion, Identification with Victims and Related Affective States

Suicide contagion is the direct or indirect transmission of suicidal behaviour from one person to another, in the manner of an infectious disease [74]. It may be transmitted unconsciously, interpersonally or intergenerationally through a pattern of imitation [75]. Cheng and colleagues noted that a mechanism called contagion-as-imitation "provides the greatest heuristic utility for examining whether and how suicide and suicidal behaviours may spread among persons at both individual and population levels." Contagion-as-imitation involves a stimulus-response process where interpersonal, group, and mass media communications play a significant role. When suicides are highly publicized, they are essentially rewarded and, in effect, imitated. In vulnerable individuals, the notoriety of published suicides may serve to overcome internal constraints. Contagion-as-imitation, therefore, involves dynamic processes that reflect sociological, psychological, medical, and public health perspectives [76]. Blood and Pirkis identified social learning theory as a framework to understand suicide contagion. A suicidal person may become disinhibited and triggered by similar actions of others. Contagion mediation may be vertical (with an admired person) or horizontal (with someone like oneself) [77]. The element of contagion is of importance in self-immolators. When persons in distress encounter social, political or religiously endorsed attitudes encouraging suicide, both horizontal and vertical contagion may take place. In times of distress, vulnerable persons who identify with the circumstances and intense affective states of others who self-immolated, may resort to self-immolation as a means of escape. Media guidelines could play an important role in mitigating the risk of contagion of suicide by self-immolation [78].

Illustrative Case Vignette 3

C, a 29-year-old Caucasian woman with a psychiatric diagnosis of bipolar disorder, entered a partial hospitalization program after being hospitalized for a suicide attempt by self-immolation. She stopped taking her mood stabilizing medications weeks prior to her suicide attempt. She reported feeling miserable, misunderstood, and was tired of being treated with contempt by family and friends. She had frequent thoughts of being dismissed by others and discriminated with hatred because of her mental illness. These negative cognitions resulted in feelings of shame, loneliness and a sense of thwarted belongingness. Furthermore, she had fluctuating mood states, affective dissonance and difficulty expressing emotions. On the day of her suicide attempt by self-immolation, C was on her way to see her psychiatrist and impulsively decided to take her own life. She went to a shop to buy lighter fluid and hailed a cab to the city's downtown.

When she arrived in front of a subway station, she doused herself and set herself on fire. Recounting what was going through her mind at that moment, she said "I thought about it, just like this, and in a snap, I decided to burn myself". She denied any premeditated plan to self-immolate. C later recounted that as she was engulfed in fire, feeling her skin burning and intense pain, she regretted what she had done. She rolled on the floor in order to extinguish the fire engulfing her body. She recalls "As I was trying to put the fire out, I saw bystanders nearby recording me with their phones. It was horrible". She was admitted to the burns unit and subsequently transferred to an inpatient psychiatric unit. After stabilization, she was discharged to a partial hospitalization program.

In the program she received group and individual psychotherapy. She was able to contract for safety and did not report suicidal thoughts. She developed better insight into her illness and agreed to switch to a long acting injectable form of medication. She responded well to interpersonal therapy working on identifying intense emotional states predominantly triggered by her low self-esteem, feelings of alienation, shame, and stigma. She was successfully transferred to outpatient psychiatric care.

5 Affective States in Suicide by Self-Immolation

Suicide by self-immolation is a strikingly dramatic way of ending one's life. It is a complex and riveting act that captivates the thoughts of witnesses and survivors and stirs up powerful emotions because of its shocking, gruesome and visceral nature. An unfathomable confluence of intense affects shrouds the decision to end one's life in such an excruciating and sensational way. As such, one can only tentatively postulate what emotions a person may be experiencing when he or she self-immolates.

Self-immolation could be an ultimate expression of self-hatred. Psychodynamic theory considers that suicide results from self-directed aggression, pathological grief to object loss, disrupted ego functioning and pathological interpersonal relations [79]. In object relations theory, people identify with their good self and punish the bad self [80]. In extreme mental anguish, one may split off the bad self and seek to punish or destroy it [26]. Subjecting one's body to be engulfed by fire may be viewed symbolically as being ultimately consumed by intolerable rage against oneself.

Self-immolation may also symbolize unassuaged guilt. Consumed by overwhelming guilt and need for atonement, self-immolators engage in extreme self-punishment. Self-immolation could also be viewed as an expression of extreme anger and rage towards others. Suicide can be a form of control exerted by people who feel torn apart by rage or experiencing vengeful fantasies towards chronic

aggressors. The horrific image of burning flesh will remain etched in the minds of witnesses long after the person is dead, suicide in this fashion serving as a lasting act of revenge.

Whereas psychoanalytic theory views suicide as anger or self-directed aggression, other psychological theories underscore the importance of desperation and hopelessness [19]. Hope involves an expectation that one can influence and be satisfied in the world. It relates to one's ability to live happily in an interconnected way. Acts of self-immolation such as that of Jan Palach and Thich Qung Duc were motivated by despair and hopelessness at their nation's or religious community's subjugation. More than 80% of reported self-immolations occur in low-and-middle-income countries [81]. Many of these countries are plagued by war, political instability and poverty. Women, being more vulnerable, bear the brunt of oppression and abuse. Such dire circumstances have a propensity to evoke feelings of hopelessness and despair.

6 Conclusion

Intense negative affective states are an important driver for suicidal behavior, and perhaps even more so in cases of self-immolation, which are often associated with oppression and persecution. Recognition of high risk affective and cognitive states can help mental health professionals to more reliably identify suicide crises in clinical populations and thereby play an important role in secondary and tertiary suicide prevention. Suicide prevention efforts should seek ways to address social factors such as disconnectedness and alienation of vulnerable or marginalized populations who experience affective states that heighten suicide risk.

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