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The Type of Feelings of Worthlessness That Poses a High Risk for Suicide in Depression and Why: A Phenomenological Account and Criteria for Clinicians

Danica Janse van Vuuren[1]

1 Department of Philosophy, Deakin University, Burwood, Victoria, Australia. Email: danica.janse@gmail.com

Abstract

There is large consensus across clinical research that feelings of worthlessness (FOW) are one of the highest risk factors for a patient's depression becoming suicidal. In this paper, I attempt to make sense of this empirical relationship from a phenomenological perspective. I propose that there are purely reactive and pervasive forms of FOW. Subsequently, I present a phenomenological demonstration for how and why it is pervasive FOW that pose a direct suicidal threat. I then outline criteria, contingent upon empirical verification, by which clinicians can more confidently identify when a patient's FOW place them at high risk of suicide.

1. Introduction

Many patients with major depressive disorder (MDD) suffer from feelings of worthlessness (FOW) and suicidal ideation (SI) (Wolfersdorf 1995, 279; Franck et al. 2007, 82–85; Beck and Alford 2009, 36, 226; APA 2013, 163). Consistent with the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders*, edition V (DSM-V), I define MDD as: "a chronic affective mood disorder characterized by at least two weeks of low mood, in which a person can experience persistent negative emotions and feelings, along with fatigue and loss of appetite and interest or pleasure" (APA 2013, 155–157). I define suicidal ideation as a "preoccupation with ending one's own life" (Hawton et al. 2013, 20; Wolfersdorf 1995, 274).

According to the DSM-V (APA 2013), FOW in depression are usually delusional in nature as these feelings are typically disproportionate to the personal failures a patient attributes this worthlessness to, such as the failure to be perfect in some sense. While there is no single feeling of oneself as worthless, in this paper I refer to FOW, which are, at the very least, genuinely directed at oneself as the patient.

Many depressed patients convey that they feel motivated to end their own life *by* or *because* of this unworthiness they encounter in themselves (Beck and Alford 2009, 36, 235–236; APA 2013, 163). Such a felt relationship between FOW and the motivation for suicide is also recognized and described in findings from the DSM-V (APA 2013, 126, footnote 1). It

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states that one of the strongest distinguishing factors of many cases of depression from other disorders, such as grief, in which suicidality is a common feature is a felt preoccupation in patients to end their own life as a response to how worthless and "unworthy of life" they feel (2013, 126).

This felt relationship for many between their FOW and SI is not a harmless one. As a significant body of research indicates,[1] FOW are one of the highest risk factors for a patient's depression becoming suicidal.[2] For some, such as Manfred Wolfersdorf (1995), Alexander McGirr et al. (2007), Aaron T. Beck and Brad A. Alford (2009), Daniel Núñez et al. (2021), and Xi Shen and Jinliang Wang (2023), FOW are one of the three feelings in depression most likely to inform suicidality. In fact, according to McGirr et al. (2007), FOW were significantly prevalent in patients with depression who did commit suicide. These findings are further supported by additional recent studies. For example, Núñez et al. (2021) found that SI in those with depression was most highly associated with feelings of pessimism and worthlessness. Likewise, Shen and Wang (2023) stress that FOW are a connecting factor among depression, anxiety, and suicidality.

Since FOW are one of the highest risk factors for SI in those with forms of MDD, such feelings are therefore also one of the highest predictors of a person's depression becoming suicidal (Wolfersdorf 1995, 279; Fergusson, Woodward, and Horwood 2000, 25; Hall, Platt, and Hall 1999, 20; APA 2013, 163; Jang et al. 2014, 76; Jeon et al. 2014, 207; Wakefield and Schmitz 2015, 258). Luca Katzenmajer-Pump, Dániel Komáromy, and Judit Balázs (2022) more recently support the predictive value of FOW for suicidality. They maintain that children with attention-deficit hyperactivity disorder (ADHD) are at a higher risk for suicidal ideation and behavior when they also suffer from specific depressive symptoms, especially anxiety and feelings of worthlessness (2022, 2). This is also indicated by findings from Eun-Jung Shim et al. (2020), for whom FOW and guilt were the strongest informers of active suicidal ideation (2020, 436–437).

In this paper, I focus on FOW and SI, which occur in the most common cases of MDD, what Matthew Ratcliffe (2015) and Ratcliffe et al. (2013) and Anthony V. Fernandez (2014a, 2014b) term "existential" in form.[3] In such cases, a patient feels depressed specifically in such a way that, through the negative feelings/emotions that constitute their depression, they feel fundamentally and painfully disconnected from the world in everything they do.[4] These experiences of depression are existential in form because they are constituted by what Ratcliffe terms "existential feelings" (2008, 41). These feelings/emotions are not only constant. They also affect how an individual interprets every experience and what is possible

[1] For example, see Wolfersdorf et al. (1990, 235, 237–239); Wolfersdorf (1995, 279); Hall, Platt, and Hall (1999, 20); Fergusson, Woodward, and Horwood (2000, 25); Franck et al. (2007, 82–85); McGirr et al. (2007, 203, 205–206, 208); Beck and Alford (2009, 36, 235–236); APA (2013, 163); Jang et al. (2014, 74–75, 76–78); Jeon et al. (2014, 207); Wakefield and Schmitz (2015, 258); Shim et al. (2020, 436–437); Núñez et al. (2021, 1, 5); Shen and Wang (2023, 66–68).

[2] This includes suicidal ideation and suicidal behavior. By "suicidal behavior," I mean any action a person takes intentionally to end their own life (Turecki et al. 2019, 1).

[3] Furthermore, I focus on those cases of existential MDD that are what Fernandez (2014a, 2014b) describes as "negative-affect," where the patient's depression is shaped by painfully negative feelings/emotions, rather than a lack of feeling altogether.

[4] By "constitute" depression, I do not mean "causes" depression. While certain symptoms of MDD can have a strong correlation with the onset of the disorder in some patients, I am not referring to that here. Instead, I am referring to how the feelings/emotions in most cases of MDD give shape to—affect—how the patient experiences themselves and the world and, thus, how those symptoms shape the structure of such kinds of MDD.

for them. In existential cases of MDD, patients therefore encounter their entire life and world, and not only certain aspects of it, as disturbingly and often painfully disrupted.

For the sake of conciseness, unless indicated otherwise, I shall henceforth use MDD and "depression" interchangeably to refer to the specific cases of MDD I have described above. Whenever I refer to either FOW or SI, I do so within the context of MDD, unless otherwise stated.

My aim is to begin to make sense of the above empirical relationship between FOW and SI in many with MDD from the perspective of philosophical phenomenology. My methodology is shaped by specific concepts in existential phenomenology. While I briefly introduce these phenomenological concepts in section 1.2, I go into more detail in section 2. Through these concepts, especially "dimensions" of experience (Fernandez 2019, 67) and "intentional" (Ratcliffe 2008, 34) or "existential feelings" (2008, 41), I evaluate clinical data and patient experiences to identify the "patterns" or "tendencies" of impact that these delusional feelings have on patients. This enables me to evaluate our dataset through a deeper understanding of the "scope" of impact that delusional FOW can have on patients. This allows for (1) a more accurate identification of the features of a patient's experience that delusional FOW can alter, and (2) enables me to identify the different ways in which FOW can operate in depression. This shall provide important phenomenological insights through which we can more comprehensively make sense of and address the empirical relationship between FOW and SI in the most common cases of MDD.

1.1 A Problem of Type in Delusional FOW

Why are FOW one of the highest risk factors for suicidality in affected patients with major depression? In other words, what is it about these feelings that make them highly suicidogenic? To date, no comprehensive explanation has been given. As noted in section 1, the DSM-V (APA 2013) identifies that the FOW most associated with SI in patients with MDD are usually delusional in nature. However, according to Aaron T. Beck and Alice Beamesderfer (1974), Beck, Robert A. Steer, and Gregory K. Brown (1987), and most extensively, Beck and Alford (2009), delusional FOW are not all the same. Importantly, for our study, this implies that not all delusional FOW would pose the same high risk for suicidality (Beck and Alford 2009, 21, 36). I develop this specifically in relation to the two forms of FOW that I postulate in section 1.2.

For Beck and Alford, FOW describe the extent to which a patient dislikes themselves (2009, 19). They distinguish between three "degrees" (intensities) of delusional feelings of self-dislike: "mild," "moderate," and "severe" (2009, 19–21). In mild FOW, patients typically convey a constant sense of disappointment in themselves for past mistakes or failures, such as failing to be the parent they had hoped to be (2009, 19). While not always the case, these feelings can be disproportionate. For example, the patient may feel disappointed in herself as a parent whenever she is around her adult children, but for failures she could not have prevented or controlled during their upbringing (2009, 19–20).

In contrast, those who feel worthless to either moderate or severe degrees dislike themselves to the point of self-loathing and self-hatred, respectively (Beck and Alford 2009, 21, 36, 226). For example, as a patient describes: "I'm a terrible person … I don't deserve to live … I'm despicable … I loathe myself" (2009, 19). These patients detest and even hate themselves for this felt lack of meaningfulness in themselves and for all the wrong

they feel their defective existence has caused others (2009, 21, 36, 226). Subsequently, Beck and Alford maintain that FOW pose a high risk for suicide when these feelings are severe in degree, when a patient dislikes herself to the point of self-hatred. When a patient genuinely hates herself, this complete self-rejection could reasonably express itself through, and thereby motivate, acts of self-harm and suicide (2009, 36, 226).

However, when we evaluate clinical data from section 1 and patient experiences, it becomes clear that there is more to the difference between delusional FOW than degrees of intensity of self-dislike. Drawing on Ratcliffe's (2008, 2010) phenomenological account of feelings/emotions in psychopathology, I propose that there is also a difference in the fundamental structure, and thus form, of delusional FOW in depression. Specifically, developing on Ratcliffe's distinction between "intentional" (2008, 34) or "existential feelings" (2008, 41), I posit that there are two different forms of delusional FOW in depression: "[purely] reactive" and "pervasive." This hypothesis follows from two distinct patterns of depth in impact (Ratcliffe 2010) that I observe between delusional FOW in many with depression, which I summarize here.

On the one hand, some patients convey constant FOW, which impact in some way and to some extent only how they feel about themselves in response to certain phenomena (for example, in Allan and Dixon 2009; Beck and Alford 2009; Everall, Bostik, and Paulson 2006). Such instances of FOW are what Ratcliffe (2008, 2010) would term "intentional feelings." To specifically capture the formal structure of such feelings as responsive states, I term them "reactive FOW."

In contrast, other patients indicate FOW that impact them in ways that include but also go much deeper than how they feel about themselves in response to their experiences in the world (for example, in Hines 2013; Merkin 2017; Ramprasad 2014; Ratcliffe 2015; Solomon 2014; Styron 2010). These feelings reach and alter in disruptive ways the fundamental phenomenological aspects—"dimensions" (Fernandez 2019, 67)—that make up the structure of their experience of what it is to be in the world. For example, these patients typically convey painful distortive changes to how they implicitly relate to themselves, to other people, and to the world (Ratcliffe 2020), and even to how they feel able and moved (Fuchs 2001, 2012) in their body to act in the world and toward themselves. These FOW are what Ratcliffe (2008) would term "existential feelings." I specifically term them "pervasive" in form because, in altering how a patient feels about themselves in response to and in relation to everyone and everything, these FOW pervade all of a person's experience.

1.2 Addressing the Problem of Different Forms of Delusional FOW

The two patterns described above suggest that not all FOW in those with MDD impact patients in fundamentally altering ways. Importantly, my distinction between pervasive and purely reactive FOW correspond to a fundamental difference in the type of delusional FOW that are most likely to inform suicidality in depressed patients and those that are not. If delusional FOW are not all the same in kind, it would follow that purely reactive and pervasive FOW would not pose the same high risk for a patient's depression becoming suicidal. I defend this claim in detail in sections 3.1–3.2. This prompts four important questions that our study shall address:

> Question 1: What are the typical features of both purely reactive and pervasive delusional FOW?
> Question 2: Which "type" of FOW could be impactful enough to strongly predispose someone with major depression toward suicidality and even be strongly predictive of suicidal behavior—purely reactive or pervasive FOW?
> Question 3: Why do those particular kinds of delusional FOW pose such a high risk for suicide in affected patients; that is, what is involved in such FOW that can help us explain why they pose such a high risk?
> Question 4: What potential value might the above account have for those who treat affected patients?

It is important to respond to these questions. Without a clear understanding of when delusional FOW in those with depression pose a direct risk for subsequent suicidality and when they do not, it becomes difficult, if not impossible, for clinicians to confidently gauge whether a patient is at immediate high risk for suicidality and whether immediate intervention is needed.

I propose that only when pervasive in form can delusional FOW be structurally impactful enough to pose the imminent high risk for suicidality observed in the empirical research in section 1. In what follows, I provide the following phenomenological account in defense of this hypothesis and in response to questions 1–4 above more broadly. In section 3.1, drawing especially on Ratcliffe's (2008) concept of "existential feeling," I address Question 1. I present the following:

i. a more detailed phenomenological explanation for both why, on my account, there are two structurally different delusional FOW in depression, and why these are purely reactive/pervasive in form; and
ii. a deeper account of the typical features of each.

In section 3.2, I address Question 2. Drawing especially on Ratcliffe's (2010) concept of "phenomenological depth," I provide the main phenomenological demonstration of this paper. I show why only when pervasive in form can delusional FOW be deep, and thus structurally impactful enough to impact patients in ways conducive toward suicide and, thus, pose a high risk for a patient's depression becoming suicidal. I also show how and why this contrasts with purely reactive delusional FOW.

In section 3.3, I address Question 3. I show what is often involved in pervasive FOW that helps explain philosophically why, when pervasive in form, delusional FOW impact how patients feel moved to act in ways conducive toward suicide. I argue that to inform SI, delusional FOW have to be more than simply severe and involve self-hatred. I explain that delusional FOW pose such a risk because, when pervasive in form and thus structurally and phenomenologically deep, FOW can disclose the patient's existence and world to her in painfully impoverishing and distorted ways that all feel irreversibly self-caused, for which the patient not only often hates herself, but also often involves a subsequent felt inversion of her original drive to live as a bodily compulsion to punish herself through suicide.

Importantly, all of my key claims about the structural differences between delusional FOW and which are most likely to inform suicidality and why are phenomenological demonstrations and explanations. These claims are meant to operate as hypotheses and not as empirical claims or firm conclusions. In section 4, in response to Question 4 above, I present the potentially practical significance of this account. If my phenomenological

findings are found to hold strong warrant in subsequent empirical studies, the corresponding criteria I present here would provide a starting ground for clinicians to more effectively identify and address the risk for suicidality in their patients in relation to FOW.

2. Method and Methodology

The present work is adapted and further developed from both my completed PhD and an upcoming book (Janse van Vuuren, forthcoming a). My dataset is made up of depression narratives, such as survey responses (for example, Ratcliffe 2015), memoir accounts (for example, Styron 2010; Merkin 2017; Ramprasad 2014; Solomon 2014), and patient descriptions from clinical publications (for example, Beck and Alford 2009).

This paper falls within the field of phenomenology of psychopathology, which overlaps between philosophy and medicine in psychiatry and clinical psychology. This is because it addresses a problem in psychiatric medicine through concepts specific to phenomenology: why FOW pose one of the highest risks for a patient's depression becoming suicidal and how this risk can be more effectively understood, identified, and addressed through medical intervention.[5] This requires evaluating the structure of delusional FOW in such cases of depression, identifying how they impact patients, whether this impact is structurally the same or not, and then evaluating what this means for how we can make sense of when and thus which type of delusional FOW most likely places patients at imminent risk for suicidality and why.

I apply a phenomenological methodology as my mode of evaluation. The focus of philosophical phenomenology across its various forms is to identify and evaluate changes in the structure of human experience (Fernandez and Crowell 2021, 120; Fuchs 2010, 547–549; Luft and Overgaard 2011, 2; Ratcliffe 2015, 9–12; Spiegelberg 1972, 2–6). This structure is made up of what Fernandez (2019) terms the underlying "dimensions," or aspects of human experience. These dimensions include time/temporality, intentionality, space, world, embodiment, relation to others, agency, belonging, conative drive, sense of self, and existential feelings. According to Ratcliffe (2008), these dimensions are shaped and altered by feelings/emotions that pervade all experience, what he terms "existential feelings."

From the perspective of phenomenological psychopathology (for example, Fuchs 2012; Fernandez 2014a), changes in the dimensions of experience, and thus in how a person finds herself in the world, can be indicative of either a "healthy" or a "pathological" way of being. This is because these changes, through the mediation of existential feelings of either "well-being" or "ill-being" (Fuchs 2012, 152), alter in either healthy or disturbing ways how a person implicitly relates to and experiences herself, others, and the world.

Subsequently, I formulate my proceeding phenomenological evaluations and criteria through the use of primarily five existential concepts, which I define in each relevant section: being-in-the-world (situatedness) (Heidegger 1962 [1927]), intentional/existential feelings and phenomenological depth (Ratcliffe 2010), and significant or meaningful kinds of possibility (Ratcliffe 2015). Through these concepts, I evaluate the depth in impact of delusional FOW on patients. I evaluate the impact of these feelings on their responsive

[5] By "phenomenology," I mean phenomenology proper (Curtis-Wendlandt and Reynolds 2021, 581): the form of inquiry and evaluation established by Edmund Husserl and further developed by others, such as through the branch of existentialism by Martin Heidegger (1962 [1927]) and Jean-Paul Sartre (1978).

states; namely, how they feel in response to the world, and on the deeper dimensions of their experience. This provides our study with phenomenological patterns, as hypotheses, on the different ways that these feelings can operate in depression, and subsequently helps us to identify which of these feelings are phenomenologically impactful enough to inform a high risk for suicide and why.

3. When and Why FOW Pose a High Risk for Suicide: A Phenomenological Account

On my evaluation, there is an implicit assumption within the clinical research on our topic, including the DSM-V (APA 2013) and Beck and Alford's (2009) account, that delusional FOW are all structurally the same: that these feelings are purely intentional or reactive states. On this assumption, FOW alter to some extent and in some way only how patients feel about themselves in response to certain people or things in the world most/all of the time during their depressive episode. However, as Martin Heidegger (1962 [1927]), Thomas Fuchs (2003, 2014), Fernandez (2014a, 2014b), and Ratcliffe (2002, 2005, 2008, 2015, 2020) make clear, we do not only encounter emotions/feelings as reactive states to phenomena. Instead, we also encounter feelings/emotions as states of being—background bodily moods (Ratcliffe 2008, 48–51)—which situate, locate, and orient us physically in the world. This is because we do not find ourselves in the world through a vacuum (2008, 2–7). Rather, there is always something that it *feels like,* through a tapestry of fluid feelings and emotions that pervade all one's experience, to exist. Ratcliffe (2008) terms these "existential feelings."

It is through a background landscape of meaning-giving feelings that we each uniquely find ourselves in the world and, thus, through which we encounter ourselves as either meaningfully part of or separate from it in some way (Ratcliffe 2008, 16–18, 43–57, 63–65). Any feeling or emotion can become existential in form (2008, 2). For example, in the case of existential guilt, what Ratcliffe also terms "state guilt" (2010, 609) in depression, a person would feel defined by guilt in some sense. She would feel, for example, blameworthy and remorseful in all her actions and in relation to everyone she meets in some sense.

When certain feelings/emotions pervade all of our experience, what it feels like for us to inhabit the world constitutes the kinds of meaningfulness and emptiness through which we implicitly interpret that our experiences can or cannot possibly matter to us (Ratcliffe 2008, 55–62). This is why Ratcliffe (2015) argues that, as our tapestry of existential feelings changes, so too does our "possibility space" qua what we feel is possible or impossible to us in terms of categories of meaning. For Ratcliffe (2008, 2020), existential feelings therefore operate as feelings of significance and possibility. By entailment, this existential landscape shapes how we implicitly feel that we relate to ourselves, others, and the world and, subsequently, informs how we feel about and in response to everyone and everything in our sphere of experience.

3.1 Purely Reactive and Pervasive Forms of Delusional FOW

This means that, like any other feeling/emotion, delusional FOW can also operate in two structurally different ways: as either purely reactive or as pervasive in form. As noted in section 1.2, this is supported by the patterns of impact from FOW I observe across many

depression narratives, including those presented in several clinical studies. In what follows, I present a detailed phenomenological demonstration in support of this specific hypothesis.

On the one hand, patient experiences indicate that there are delusional FOW that are purely reactive. Some patients describe feeling worthless—bereft of meaningfulness, defective, inferior, ashamed, and/or thus like less than a person before others and to some extent—most of the time during their depressive episode in some sense but *only* (1) in response to *certain phenomena,* such as to certain people, things, or events, and (2) in some of what they do (Allan and Dixon 2009, 858; Everall, Bostik, and Paulson 2006, 378; Beck and Alford 2009, 19–20). For example, a patient could feel worthless whenever they are at a job in which they feel incompetent, or whenever they fail to perform their best. As one patient describes, feeling worthless in response to a failed grade: "I've let everybody down … If I had tried harder, I could have made the grade" (Beck and Alford 2009, 19). As with Beck and Alford's (2009) description of minor FOW, here patients typically indicate an unrealistic extent of disappointment in or frustration with themselves, and thus a painful loss of self-worth because of a felt incompetency or failure. For example, like the patient described above, they might feel completely bereft of worth simply in response to a poor test grade even though a poor grade does not in fact subtract from their worth as a person. They may even feel worthless constantly in response to persistent memories of their grade and how they could have done better. Despite how painful these feelings often are, these patients do not all come to interpret every subsequent experience through this lack or failure in themselves. They can still retain a sense of competency and subsequent connection with the world in relation to other facets of their life, such as whenever they are engaged in a project they are passionate about or when surrounded by close friends. Beck and Alford describe this in terms of retaining a degree of gratification (2009, 19).

How clinical analyses and such patients describe the rest of their life experiences and cares implies that they do not implicitly relate to themselves, others, and the world through this felt worthlessness (Beck and Alford 2009, 19–20). Insofar as the patient (1) does not feel bereft of worth in relation to everyone and everything, and (2) does not encounter every aspect of herself as worthless in everything she does, this implies that the patient does not implicitly make sense of and relate to herself in all she does as worthless. If these conditions are met, the patient's FOW would be neither pervasive in form nor indicative of corresponding pervasive FOW (or of related existential feelings, such as guilt). This is further indicated by the fact that most of these patient narratives neither explicitly nor implicitly describe patients feeling worthless in response to everyone and everything in their sphere of experience. In such forms of FOW, there is therefore respite for the patient from these painful delusional feelings in relation to most aspects of their life and experience. Moreover, while in reactive FOW patients may feel unrealistically to blame for a bad outcome or flaw in themselves, these feelings are arguably purely reactive in form and not indicative of corresponding pervasive FOW if the patient does not encounter herself as blameworthy in all she does (more on this in section 3.3). However, these feelings can become pervasive in form.[6]

In contrast, many patients consistently indicate delusional FOW that pervade all of their experience and which, therefore, constitute a much more profound change in their being (see, for example, Allan and Dixon 2009; Beck and Alford 2009; Fuchs 2003; Everall,

[6] I would suggest that this is especially possible in cases of severe childhood abuse and trauma.

Bostik, and Paulson 2006; Hines 2013; Merkin 2017; Ramprasad 2014; Ratcliffe 2008, 2010, 2015; Solomon 2014; Styron 2010). Patients typically convey feeling worthless—unworthy, defective, inferior, ashamed, and thus like less than a person before others in some sense—most of the time during their depressive episode in some sense and to some degree of intensity (1) *in relation and response to everyone and everything,* and (2) *in all they do*. Through such pervasive delusional FOW, patients typically feel emptied out of all worth and meaningfulness by their own body in all they do. They implicitly make sense of and interpret all of their experiences through this loss. How these patients describe themselves, how they relate to other people and feel that others relate to them, what the future holds, and their experiences of the world overall suggest that they typically feel deeply and painfully defined, impoverished, and physically limited by some flaw or "defectiveness" (Beck and Alford 2009, 226), in themselves.

Accordingly, these FOW do not only severely alter in some way how a patient feels in response to certain people or things. In pervading all of a patient's experience, such delusional FOW become an impoverishing state of being, which painfully alters how she feels about herself in relation to every aspect of her life and thus also in response to everyone and everything. Accordingly, such delusional FOW can alter in various ways and to different extents of intensity the fundamental components of a patient's experience. William Styron conveys a loss in self-worth that pervades all of his experience, which he encounters as greatly constituting a profound loss in connection with the world in all he does:

> Only days before I had concluded that I was suffering from a serious depressive illness, and was *floundering helplessly* in my efforts to deal with it. I wasn't cheered by the festive occasion that had brought me to France. Of the many dreadful manifestations of the disease, both physical and psychological, *a sense of self-hatred or, put less categorically, a failure of self-esteem is one of the most universally experienced symptoms, and I had suffered more and more from a general feeling of worthlessness as the malady had progressed*. (Styron 2010, Chapter I, para. 5; emphasis added)

This is further suggested when he explains:

> I felt loss at every hand. *The loss of self-esteem is a celebrated symptom, and my own sense of self had all but disappeared, along with any self-reliance*. This loss can quickly degenerate into dependence, and from dependence into infantile dread. *One dreads the loss of all things, all people close and dear. There is an acute fear of abandonment*. (Styron 2010, Chapter V, para. 10; emphasis added)

In contrast to purely reactive FOW, through pervasive FOW, a patient implicitly interprets every part of her life and each experience through the emptiness in possibility for self-worth and meaningfulness she encounters in herself.

Importantly, my distinction between purely reactive and pervasive delusional FOW is a difference in kind, likened here to two types of genus, rather than species, of feeling. Since pervasive qua existential feelings disclose the world and our own being to us in certain ways, and thus make it possible for us to experience the world and our own being in either meaningful or impoverishing ways, pervasive feelings are not only feeling states, but also a category of the structure of subjectivity—part of our fundamental sense of being situated in

the world—which, where phenomena can be disclosed in some kind of way, make experience possible. This is why, for Ratcliffe (2008), as for my study here, pervasive and reactive forms of a particular feeling/emotion are structurally different.

Accordingly, pervasive feelings, as categories of feeling and meaning (Ratcliffe 2008, 59–64), do not only inform which intentional feelings and emotions a person encounters and is open to in response to phenomena, but also make the very experience of intentional feelings and emotions possible. This is because pervasive feelings constitute the "kinds" or categories, and thus the very grounds of possibility, for our experience of "tokens"—reactive/intentional instances—of feelings and emotions. In order for you to feel worthless in response to a personal failure, for example, not only must feeling be category or dimension of human experience, but worthlessness must also exist as a "kind" of feeling in the first place in order for you to experience a token of it (2008, 59–64). As such, even though a patient can feel worthless in response to certain triggers, without also feeling pervasively worthless, she cannot experience any responsive feeling or emotion, including worthlessness, toward specific phenomena without first being shaped by a background tapestry of pervasive feelings, which makes it possible for her to interpret and respond to her experiences in ways that make her feel some kind of way, such as worthless, guilty, and so on.

3.2 The Significance of Pervasive FOW

Both purely reactive and pervasive forms of FOW appear to fulfill the DSM-V (APA 2013) criteria for the kind of FOW that can inform not only depression but also suicidality in such depression, where both types (1) occur within the onset of the depression; (2) are delusional in nature; and (3) are present most of the time (2013, 164). However, when we evaluate patient narratives in the most common cases of depression, an important pattern emerges in terms of the structural depth of such experiences and the kind of FOW that typically do and could inform suicidality in such cases. These patients typically convey painfully impoverishing, disruptive, and distorted changes not only to how they feel in response to the world but also to the most fundamental components of their experience in all they do. Many indicate feeling shamefully stripped bare by their own defective body of any capacity, and thus hope, to willfully choose to be a true person, and thus deprived of personhood and meaningful connection with others, especially the people and things they care for most and that give their existence purpose (Styron 2010, Chapter I, para. 5, Hines 2013, Chapter 13, para. 35; Ramprasad 2014, Chapter 5, para. 155; Ratcliffe 2015, 30, 135–136, 141; Merkin 2017, Chapter 14, para. 2).

This deep disruption is especially apparent in how many feel forever cut off from the people and things they love and implicitly compelled to no longer participate in the world but, instead, to remove themselves from it through suicide (Beck and Alford 2009, 226, 235–236; Styron 2010, Chapter I, para. 5, Chapter IX, para. 1; Hines 2013, Chapter 13, para. 35; Ramprasad 2014, Chapter 5, para. 155; Ratcliffe 2015, 30, 135–136, 141, 225; Merkin 2017, Chapter 14, para. 2). These patients usually suggest feeling so completely deprived of all forms of worth and meaningfulness in themselves by their own body in all they do that, in response to the felt impact of this worthlessness on themselves and others, many appear to feel helplessly compelled by their own body to end their life. For example,

in a memoir on surviving suicidal depression, Kevin Hines describes his drive toward self-annihilation against the backdrop of FOW thus:

> I talked aloud to myself the entire time I waited, *shadow boxing with myself, fighting the demons in my mind,* tears welling up in my eyes. *I told the evil part of me, the one who has never stopped reminding me that I need to die, "Shut up! I won't do it!"* Then, I saw the K-line bus approaching in the direction that would take me back to the bridge. It was the bus line I took nine years before. *The evil voice on my right shoulder screamed in my head, "Take it. You're worthless."* Then it whispered, "*You have to die, you cannot escape me."* Yet, I held my position as the bus passed. I turned toward the clinic. I let out a big sigh. The voice in my head whispered, "Pussy!' … *I did not want to die, but I thought I had to*. (2013, Chapter 13, para. 35; emphasis added)

This is also suggested by a participant from Beck and Alford: "I want to shoot myself. Nobody thinks I'm capable of doing anything. I don't think so either. I'll never get another job. I don't have any friends or dates. *I'm isolated. I'm just completely stuck for all time.* If I shot myself, it could solve all my problems" (2009, 235–236; emphasis added).

These patients encounter an alarming and felt change in the physical directedness of their body. Instead of an effortless urgency to participate in the world (Fuchs 2001), these patients demonstrate an involuntary preoccupation and urgency in their body to end their own life. Their body is directed away from the world and away from life. They often no longer focus on their passion projects, even if they still care about them (Styron 2010, Chapter I, para. 5). Their attention is directed to some extent in all they do toward self-annihilation. Some even make concrete plans to execute this, while most at the very least behave in ways that neglect their well-being. Drawing here on Fuchs's (2001, 2012) concept of "conative drive," I maintain that such suicidal preoccupation is akin to an automatic drive toward self-annihilation, arguably similar to the drive one would feel when severely parched and unable to switch off the bodily urgency, need, and disposition toward finding water. Most importantly, these patients indicate a drive toward suicide through their FOW that is felt, like their lack in self-worth, in all they do.

These narratives suggest three important phenomenological insights for our study. First, the most common cases of depression, including those with SI, involve profoundly disruptive changes to the dimensions of a patient's experience, most alarmingly to how patients feel compelled in their body to act in the world and toward themselves and in ways conducive to suicide. Second, the delusional FOW that are felt to inform suicide are usually described in ways that indicate that they are pervasive in form. These patients, like Styron (2010) and Hines (2013) above, do not only feel constantly driven toward suicide by their own unworthiness only in response to certain people/things nor only in some of what they do. They convey feeling compelled to end their life to some extent and sense because of how unworthy they feel of life in all they do and in response to everyone and everything. Third, to inform a high risk for suicidality in such patients, delusional FOW must be phenomenologically deep and, thus, pervasive in form. This is because, to inform suicidality, a patient's FOW must be structurally deep enough to impact the dimensions of their experience and in ways conducive toward suicide; most notably, they must be able to inform a felt distorted change in all they do conducive toward suicide, in how they feel moved to act toward themselves. On my account, only when pervading all experience and thus when pervasive

in form, can a patient's delusional FOW be phenomenologically deep and thus impactful enough to inform a felt change in how they feel compelled to act toward themselves in their body, in all they do and toward suicide. Insofar as a patient's FOW are structurally deep enough to constitute an impact on how they feel oriented and moved in the world to act, those feelings can potentially alter how they feel moved to act *toward themselves* and in ways conducive toward suicide.

Developing here on Ratcliffe (2008) and Fuchs (2014), this is because, only when pervading all of a patient's experience can delusional FOW become part of the background tapestry of feelings, which (1) prominently shapes how a patient finds herself in the world; (2) alters what she anticipates is possible/impossible to her; and subsequently (3) affects how the patient automatically relates and feels moved to act toward herself in ways conducive toward suicide.

According to Fuchs (2012), existential feelings of ill-being in depression, such as guilt, despair, and lifelessness, deplete a patient's tapestry of significance of any prior meaningful existential feelings through which she used to, and subsequently could, encounter herself and the world in robust, intimate, and purposively meaningful ways. As background feelings of ill-being (Fuchs 2012), delusional FOW have no meaningfulness to offer through which a patient could interpret and make sense of how her own life and actions, as well as her experiences of other people and things in relation to her being, could possibly matter in robust ways. Instead, through such FOW and related feelings, a patient would gradually feel deprived of any prior background feelings of well-being (Fuchs 2012) conducive to feeling capable of and purposively driven to participate in the world and live, such as feelings of connectedness, aliveness, competency, and hope.

The only forms of meaning that remain through which such a patient could orient herself in the world and interpret all of her experiences are through the brutally empty forms of loss constitutive of worthlessness and its related feelings, such as guilt, helplessness, and shame. Accordingly, patients typically feel hopelessly deprived by their own defectiveness, and thus their body, of what Ratcliffe (2015, 113) terms "entire kinds," and not simply specific tokens, of meaningful possibilities, such as the possibility to will any kinds of meaningful change in themselves and the world.

This is further supported when we evaluate the structure of SI. When a formative feature of the most common cases of depression, SI is not felt only on occasion in response to certain people or things. Rather, as a preoccupation with taking one's own life most of the time during a depressive episode (APA 2013), SI, like the depression it is structurally part of, pervades all of a patient's experiences (Allan and Dixon 2009, 858; Everall, Bostik, and Paulson 2006, 378; Beck and Alford 2009, 19–20). Accordingly, such SI would fundamentally impact to some extent both how the patient feels in response to everyone and everything and each dimension of what it is for them to be a person in the world. The patient would not only encounter intrusive and constant suicidal thoughts. Every facet of the patient's life, including each aspect of their everyday world experience and all of their actions, would typically feel altered by this suicidality to some extent.

Importantly, such patients convey a significant and alarming somatic change, in which they feel helplessly compelled—urged or moved—in/by their own body (Fuchs 2003) to harm or otherwise kill themselves.[7] As such, in order to be a formative feature of suicidal

[7] I propose that such cases of SI correspond to what is often termed "active" suicidal ideation.

depression, delusional FOW must be likewise pervasive in form. Moreover, this suggests that the FOW observed within the clinical data to strongly inform SI in the most common cases of MDD are likely not only delusional in nature but also pervasive in form.

Patients who feel primarily motivated toward suicide through purely reactive FOW indicate a different pattern in relation to the risk for suicide. While such patients often feel deserving of death, overwhelmed with intrusive suicidal thoughts, and even motivated to act on them because of how bereft of meaningfulness they feel, such suicidality through purely reactive FOW appears to be a localized one. Such suicidal motivation is felt only in response, even if often painful and deeply disturbing, to certain people or certain things during a depressive episode. For example, the individual might feel deeply worthless, and subsequently overwhelmed with intrusive thoughts of suicide, whenever they are around family members or colleagues to whom they feel shamefully inferior. As such, while such patients may encounter their suicidality as motivated by FOW, they do not feel motivated by these feelings *in everything they do* to end their life most of the time during their depression (Allan and Dixon 2009, 858; Everall, Bostik, and Paulson 2006, 378; Beck and Alford 2009, 19–20).

On my reading, there is respite to the kind of motivation toward suicide felt by patients through what I identify as purely reactive delusional FOW. In such cases, patients do not indicate feeling primarily deserving of and motivated toward suicide because of how worthless they are in response to everyone and everything in their sphere of experience, nor in relation to every aspect of their life. As such, even if encountered on a frequent basis as exemplified above, such a preoccupation with suicide fostered by purely reactive FOW are not encountered in all a patient does and, thus, do not pervade all of their lived experience.

When purely reactive in form, and not accompanied by any related existential feelings such as state guilt (Ratcliffe 2010, 2015), a patient's broader tapestry of feelings of well-being and thus meaning would still be intact to some extent. They would still implicitly interpret some aspect of their life in meaningful ways and likely feel connected to at least some of the people and things that matter most to them. As such, they would likely still retain some degree of orientation toward the world and, thus, still feel implicitly moved to participate in it. Accordingly, such delusional FOW would not constitute any direct and alarming impact on the dimensions of a patient's experience and, thus, would not likely inform a felt bodily drive toward suicide.

3.3 Why FOW Are One of the Highest Risk Factors for Suicide

In what ways do these delusional FOW typically deprive a patient's tapestry of meaningfulness that can (1) help us explain why these patients often feel compelled toward suicide, and, in turn, (2) help us more comprehensively explain why these feelings place a patient at high risk for suicide. What is especially unique about pervasive FOW on my account is that the patient feels that her worthlessness, as fundamentally an inability to choose (Ratcliffe 2013) to truly be a person like and with others in some sense, is not only unchangeable but also involuntarily self-caused (Allan and Dixon 2009, 858; Beck and Alford 2009, 36, 235–236; Styron 2010, Chapter I, para. 5, Chapter V, para. 10, Chapter IX, para. 1; Hines 2013, Chapter 13, para. 35; Ramprasad 2014, Chapter 5, para. 155; Ratcliffe 2015, 30, 136, 225; Merkin 2017, Chapter 33, para. 10, Chapter 14, para. 21). In such cases, the patient does not only feel like less than a person in some way but she also feels

unintentionally and helplessly responsible for her worthlessness. Accordingly, all of this loss in kinds of significance, especially for purposive connection, personhood, and participation in the world, feels self-caused.

Both Fuchs (2003) and Ratcliffe (2015) argue that FOW and guilt are usually inextricable in cases of MDD. I maintain that this is because such patients do not only encounter their felt worthlessness as to blame for, and thus as the cause of, all their own suffering but also as the helpless cause of the unjust suffering of others, especially loved ones (Styron 2010, Chapter V, para. 1; Ratcliffe 2015, 141). This coheres with the DSM-V (APA 2013), in which depressed patients who feel worthless often feel to blame not only for the suffering of others but also for all that is wrong in the world.

Developing here on the above accounts, as well as on Beck ad Alford (2009), I maintain that pervasive delusional FOW are expressive of guilt. This guilt involves at the very least pervasive and genuine feelings of self-blame, painfully inconsolable remorse (or regret), and self-hatred. Self-hatred, when expressive of pervasive FOW, is characterized at the very least by self-repulsion (Ratcliffe 2015, 135) and a physical compulsion to punish oneself (the self), especially by removing the source of this suffering (Ratcliffe 2015, 135, 141, 225). On my evaluation, patient narratives (Beck and Alford 2009, 235–236; Styron 2010, Chapter V, para. 1, para. 5; Hines 2013, Chapter 13, para. 35; Ratcliffe 2015, 135, 141; Ramprasad 2014, Chapter 5, para. 99, Chapter 10, para. 40, para. 44; Solomon 2014; Merkin 2017, Chapter 19, para. 15, Chapter 33, para. 10) suggest that when pervading all of their experience, delusional FOW pose a significant risk for a patient's depression becoming suicidal because:

1. Through such feelings a patient painfully encounters herself in all she does as not only unchangeably defective but also encounters her defectiveness as the shameful cause of her and others' unjust and unending suffering.
2. As less than a person, she feels incapable of willfully preventing any future suffering while she remains in the world.
3. The patient does not only blame herself and feel immense remorse for all of this suffering but also hates herself for it in all she does.

Accordingly, a patient can feel that she and others, especially loved ones, have been robbed of a purposive (Ratcliffe 2015) and meaningful life by and because of her inability to do anything right.

The patient typically feels that, as long as she is alive, her suffering and others' will necessarily persist as she is incapable of willing to overcome her defective being and change things for the better (Ratcliffe 2015, 135; Ramprasad 2014, Chapter 10, para. 40, para. 44; Merkin 2017, Chapter 19, para. 15, Chapter 33, para. 10). This is especially observable in patients who feel that their depression, and indeed their inability to simply overcome it, severely and adversely affects loved ones (Ramprasad 2014, Chapter 5, para. 99; Chapter 10, para. 40). Subsequently, many patients feel lifeless (Fuchs 2012) in the world, as if suffocated by their own inability to be a real person. In such cases, a patient can no longer conceive of how their actions or life could matter in any way. Consider that, when you hate yourself in everything you say and do because of the worthlessness you encounter in yourself and the impact you feel it has on the world, it would be impossible for you to feel that any of your past or future experiences, and thus your own life, could matter in any important way. This is because, as (allegedly) worthless, you feel that your presence in the world robs all of your and others' experiences of their meaningful potential. As such, you could not feasibly continue to feel automatically urged by your body to participate in the world as

before. This is because, not only would you feel that there could be nothing meaningful to actualize, but since you relate to your body through shame, blame, and hatred, this would inevitably affect how your body automatically implicitly responds to itself.

When someone with depression hates herself for all the suffering she feels her worthlessness is responsible for and feels powerless to change it for the better through continued participation in the world, what I have consistently observed across patient experiences is that, in response to this unjust suffering she feels her defectiveness is responsible for, the patient can feel repulsed by and turn on her own existence through a need to punish herself (Fuchs and Schlimme 2009, 571–572; Ratcliffe 2015, 136).[8] This makes sense. Not only do we implicitly turn against someone when we hate them but we also usually have an instinct to punish those we hate when they have unjustly and gravely harmed us and those we care about or perceive as otherwise vulnerable. Moreover, in great part through these delusions of worthlessness and guilt, such patients are not only oriented away from the world because of how unworthy and incapable they feel of being part of it but they are also turned away from, as if repulsed by the shameful taste of, their own existence because of the devastating impact they feel their worthlessness has on their and others' possibility for a meaningful life. When we are repulsed by something or someone, we instinctively aim in our bodily disposition and actions to get away from it.

Since such patients usually feel incapable of restoring meaningfulness to themselves and others while still in the world, I maintain that a need strongly informed by pervasive FOW for self-punishment typically expresses itself through a bodily compulsion—pre-occupation—to remove her own existence from the world through suicide (Fuchs 2003, 238–239; Beck and Alford 2009, 36; Styron 2010, Chapter VI, para. 14; Ramprasad 2014, Chapter 10, para. 153). This is phenomenologically constituted by an inversion of what Fuchs (2012) describes as a person's drive to live. When these delusional FOW are pervasive in form and inextricably interwoven with self-hatred in guilt, I maintain that the patient's prior need to thrive and drive to participate in the world can feel replaced with a destructive need to deprive and punish herself through self-annihilation. This coheres with findings from Fuchs (2003, 238–239). Two extracts from patient narratives describe something to this effect:

> Deep despair, hate myself, feel like I can't do anything right, everyone would be better off if I wasn't here to fuck their lives up, feel useless, why was I even born, I shouldn't be here, I don't belong here, just want to go to sleep and never wake up. (Ratcliffe 2015, 136)

> I must weep myself to death. I cannot live. I cannot die. I have failed so. It would be better if I had not been born. My life has always been a burden … I am the most inferior person in the world … I am subhuman. (Beck and Alford 2009, 36)

Here, it becomes clear how and why, when pervasive in form, delusional FOW are deep and thus impactful enough on my account to affect in ways conducive toward suicide how a depressed patient relates to and feels moved to act toward themselves. Contra Maurizio

[8] On my account (Janse van Vuuren, forthcoming a), this inverse drive of one's instinct to survive, as a striving for self-punishment, can take the form of a second self. Drawing on Freud's (1989 [1923]) concept of the ego ideal, the second self is characterized by the features of the depressive's ideal or social sense of self.

Pompili (2010, 2018) and Edwin S. Shneidman (1993, 1996, 1999, 2004) on the motivation for suicide in depression, I propose that a patient who feels defined by worthlessness does not usually feel compelled to take her own life in order to escape her own pain. Rather, expanding here on Fuchs (2003, 238–239), such patients usually feel compelled to commit suicide for a much more altruistic reason: to remove from the world what they feel is the cause of all that is wrong with it—their own existence. What such patients therefore often convey is a desire to correct in a tragic manner, in a form of what I term "self-annihilating justice" (Janse van Vuuren, forthcoming b), what they experience as a grave wrong: their own presence in the world.

In summary, my phenomenological demonstrations show that delusional FOW are a high risk for and strongly predictive of suicidality not only because they are accompanied by self-hatred and thus severe in degree of self-dislike as Beck and Alford (2009) state. But more specifically, delusional FOW pose such a risk because, when pervasive in form and thus structurally and phenomenologically deep, such feelings disclose the patient's existence and world to her in painfully impoverishing and distorted ways that all feel irreversibly self-caused, for which the patient not only often hates herself but which often involve a subsequent felt inversion of her original drive to live as a bodily compulsion to punish herself through suicide.

4. Criteria for Identifying High-Risk FOW in Depressed Patients

The following adapts the above account into potential working criteria, free of terminology specific to the phenomenological tradition. If my claim that it is pervasive delusional FOW, and not delusional FOW in general, that have the structural capacity to inform suicidality in someone with depression is verified empirically, the following criteria have the potential to assist clinicians to more clearly identify (1) which type/s of delusional FOW are actively at play in a specific patient's experience of depression; and (2) whether they suffer from the type of FOW that, on my account, places a patient at a high risk for suicidality.

4.1 Criteria for Distinguishing Between Reactive/Pervasive FOW in Depression

I propose that a patient's delusional FOW are purely reactive and therefore do not necessarily pose a direct high risk for suicidality on their own when:

1. The patient consistently feels worthless—defective, incompetent, inferior, ashamed, and/or like less than a person in some sense—only in response to certain people, things, or situations most of the time.
2. She feels at home in the world in many of her actions and experiences, and in response to at least some people and things.
3. If the patient blames, and even dislikes, herself for being worthless and for any other bad in the world, she only experiences this weight of guilt in response, once again, to certain people or things most of the time but not in response to everyone nor in all she does.
4. Given (1), the patient maintains some form of meaningful connection with other people and things outside of the situations or conditions that make her feel worthless.

5. While her FOW are overwhelming and painful, she still feels capable of doing some things right and, as such, still feels like a person in some respects in some or even most of her actions.
6. If she feels hopeless, this is only about her ability to actualize certain prospects. She retains hope, in some form, to create and experience meaningful outcomes, even if not for all the ones she would like.
7. If the patient feels motivated toward suicide by her FOW in some sense, then insofar as her delusional FOW remain purely reactive, she would likely only encounter this motivation in response to certain people or things most of the time during her depression. She would still maintain a physical disposition and drive to continue participating in the world to some extent and in some way, and she would feel a sense of capacity to control whether she acts on her suicidal thoughts and motivations.
8. She therefore does not feel helplessly compelled by her body in all she does to take her own life most or all of the time during her depression.

During the prodromal phase (Henden 2008; Mehlum 1992; Upthegrove et al. 2010), a person can be plagued with intrusive thoughts of self-deprecation and suicide and feel moved, even if not strongly, to take their own life. However, patients do not always disclose such suicidal preoccupations to their therapist (Yigletu et al. 2004, 10–12; Richards et al. 2019, 40–42; Blanchard and Farber 2020, 125–127, 131–133). Moreover, as supported by the findings of Fuchs (2003) and Ratcliffe (2015), most patients who suffer from suicidality informed by major depression do not have a desire or bodily longing to die. In short: they do not usually want to die. Instead, what many patients in this position describe is more equivalent to a feeling of *having* to die, even if they genuinely *want* to live.

Such a lack of explicit expression of present suicidal symptoms by patients might also emerge from a lack of semantic precision: if by "suicidal," I mean that a patient wants to die, they may likely answer in the negative. It is therefore important for those who treat persons with major depression to have general criteria through which to evaluate the patient's FOW. This is so that they can gauge whether the structure of those feelings, and not simply the fact that they "are" FOW, place the patient at a higher risk for subsequent suicidality, irrespective of whether the patient already experiences intrusive suicidal preoccupations.

I propose that when someone with MDD describes feeling prominently defined by FOW, whether along with explicit SI or not, we can identify whether those FOW place her at a high risk for suicidality primarily when:

1. The patient feels worthless—defective, incompetent, inferior, or ashamed and like less than a person in some sense—in everything she does and/or in response to everyone and everything most of the time during her depression.
2. She feels estranged from everyone and everything by and because of some flaw in herself.
3. She encounters herself as the cause of her loneliness and of all that is wrong with her life and the lives of others/and or the world.
4. She blames and hates herself for being worthless/for being the unintentional cause of all that is wrong in her life and even in the lives of others. She encounters the weight of this guilt, especially the remorse and self-hatred, most of the time in all she does.

5. She feels powerless and incapable of being normal and of changing her and others' lives for the better through active participation in the world.

In a cohort based on participants in the Norwegian military, Lars Mehlum (1992) also lists feeling deserving of punishment as one of the most common prodromal features of suicidal behavior, especially in those who also suffer from major depression. In addition, prominent pervasive FOW are often expressive of the other subjective factors most highly associated with suicide in depression. These are:

- despair (Bedrosian and Beck 1979; Beck and Steer 1989; Wenzel et al. 2011; Melhem et al. 2019);
- loneliness (McClelland et al. 2020);
- guilt (Fuchs 2003; Ratcliffe 2015); and
- a loss of the drive to live (Beck, Steer, and Ranieri 1988).

These are, once again, encountered in a way in which the sufferer usually feels that the very possibility for hope, togetherness, and purpose is eroded from within by their own defective and unworthy body, for which they usually feel the need to punish themselves. As such, we can further identify whether a person's FOW are pervasive in form and place them at a higher risk for suicidality when:

1. the patient has no hope for future connection with anyone or anything;
2. this hope, along with hope for any aspect of the future, feels taken from her by some defect or flaw in herself; and
3. if the patient experiences her FOW as a primary motivator for suicide, she feels motivated to end her life in all she does most of the time during her depression. She also feels compelled by her body to act on her suicidal thoughts. Her suicidal urgency is fueled by both hatred for what she feels her worthlessness has/will cost her and others and by a sincere need to make things better for others by removing herself from the world.

5. Conclusion

Drawing primarily on Ratcliffe (2008, 2010) and Fuchs (2001, 2012), I have shown phenomenologically that (1) there are purely reactive and pervasive forms of delusional FOW in depression; and (2) only pervasive FOW are structurally impactful and thus deep enough to likely inform SI and affect the alarming kinds of changes conducive to active forms of SI. I have argued that only when pervading all of a patient's experience can delusional FOW become part of who a patient is and, thereby, impact how a patient interprets that her own being and experiences of the world cannot matter because of how defective she is. This suggests that only then can such feelings be felt to not only deprive a patient of any purpose and capacity to willfully participate in the world but also to distort how she feels moved in her body to act toward herself in ways conducive to self-harm and suicide. Subsequently, I have provided a philosophical explanation for why delusional FOW are empirically observed as one of the highest risk factors for suicidality in depressed patients.

Importantly, these key claims and explanation are hypotheses based on my observations of patient experiences and, as such, are not meant to function as either empirical claims nor as firm conclusions. Instead, as hypotheses, my phenomenological observations here

provide fruitful ground for subsequent empirical investigation within psychiatry and clinical psychology.

Finally, I have adapted my account into potentially working criteria tentative to the empirical justification of my key claims in this paper. This may help clinicians more confidently gauge whether immediate intervention is required, so that more timely intervention can be made to help and, where possible, intercept likely subsequent suicidal behavior.

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