# Preventing Suicide:

## Using CBT to Help Suicidal Patients Choose to Live

Part I: Phenomenology, Cognitive Vulnerabilities, and the Therapeutic Relationship.


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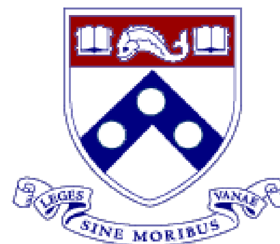

# Financial Disclosures

I still receive residual royalties from New Harbinger Publications for the book *Choosing to Live: How to Defeat Suicide Through Cognitive Therapy* (co-authored with Thomas Ellis).

There are no other financial disclosures relevant to this presentation.

# Frightening Statistics

- There were an estimated 4,157 suicides in Canada in 2017.
- This annual figure was expected to be higher during the pandemic (see McIntyre & Lee, 2020 in *Psychiatry Research*), but this prediction has not been borne out.
- In Canada, suicide accounts for almost a quarter of all deaths among those 15-24 years old.
- Suicide rates across First Nations, Inuit, and Metis communities continue to be considerably higher than that of non-indigenous peoples in Canada.
- Approximately 80% of firearms deaths in Canada are suicides.

# Frightening Statistics (Global)

- Worldwide, approximately **1 million people die by suicide** annually. (800,000 suicides are "confirmed," but the figure is rounded up to include estimated figures from countries that do not report suicide statistics).
- There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide.
- Suicide occurs throughout the lifespan and is the ***second leading cause of death*** among 15-29 year olds globally.
- Suicide is a global phenomenon. Over 78% of worldwide suicides occurred in low- and middle-income countries in 2015.

WORLD HEALTH ORGANIZATION (2013; 2015)

# Risk Factors

## for

# Suicide

# Risk Factors:

## Life Conditions and Behavioral Variables

- **Social isolation** (e.g., living alone; recent break-up; perceived rejection and abandonment; sense of being a "burden").
- **Unemployment, financial worries** (also academic difficulties).
- **Alcohol and other substance misuse** (acute and chronic).
- **Chronic pain / medical illness.**
- History of **sexual victimization.**
- History of **high suicidal ideation**.
- History of **self-harming behaviors** (even without intent).
- History of at least **one suicide attempt**. (> 2 worse!)
- **Family history** of suicide.

# Sociological Risk Factors:

(that also interact with cognitive-behavioral factors)

- Being the object of ongoing **bullying** (including bullying via the internet and social media).
- The **"contagion" factor** (suicides in response to well-publicized suicides, e.g., in a school, in the media).*
- **Chronic discrimination** (e.g., racial, gender, sexual orientation).
- **Indoctrination** (e.g., cults, terror groups).

*Sudak, H.S., & Sudak, D.M. (2005). The media and suicide. ACADEMIC PSYCHIATRY, 29, 495-499.

# **Assessing**

for

# Suicide Risk

# Inventories to Assess Suicidality

- **Beck Depression Inventory** **(especially items "2" and "9," and the total score)** (Beck, Steer, & Brown, 1996)
- **Beck Hopelessness Scale** (Beck & Steer, 1993)
- **Beck Scale for Suicide Ideation** (Beck & Steer, 1991)
- **Suicide Cognitions Scale** (Bryan et al., 2014)
- **Perceived Burdensomeness Scale** (Peak et al., 2015)
- **Interpersonal Needs Questionnaire** (Van Orden, 2008)
- **Columbia-Suicide Severity Rating Scale** (C-SSRS: Posner et al., 2011)
- **Patient Health Questionnaire** **PHQ-9, final question** (Spitzer et al., 1999)

# Assessment Guidelines

Assess Level of:

**INTENT**

and

**LETHALITY**

# Assessment Guidelines

## Elements of “Intent”

- Preparation.
- Sense of “confidence” in carrying it out.
- Level of secretiveness.
- Beliefs about the purpose of suicide.
  - Escape
  - End pain and suffering
  - To actually die!

# Assessment Guidelines

## Elements of “Intent”

### Non-suicidal self-injury

- Not associated with suicidal intent per se.
- “Function” of the self-injury may be…
  - Self-punishment.
  - Physical distraction from emotional pain.
  - Self-stimulation.
  - A desperate communication.
- Can accidentally be lethal is some cases.

# Assessment Guidelines

## Elements of "Lethality"

- Method chosen
  - Firearm (over 50% of suicides in the USA)
  - Jumping
  - Hanging
  - Auto (crash, asphyxiation)
- Impulsive acts can be very lethal (e.g., if a firearm is available to someone who is drunk and distraught).
- Note well: Level of lethality may be misperceived by suicidal individuals.

# Other Key Assessment Variables

- Was there physical injury? To what extent?
- Was the suicidal behavior interrupted? By whom?
- Never forget to ask ***WHY?***

Later, we will talk about the sequence of events in a suicidal crisis, also known as a…

**"chain analysis"**

# Special Issue in Suicidology

- **Multiple-attempters…**
  - Experience longer duration of crises than first-time attempters and those who haven't tried.
  - Require less provocation from stressful events to trigger suicidal episodes (analogous to the "kindling effect" in bipolar disorder).
  - Show less responsivity to positive events over time.

Joiner, T.E., & Rudd, M.D. (2000). Intensity and duration of suicidal crisis vary as a function of previous suicide attempts and negative life events. JCCP, 68, 909-916.

# Special Issue in Suicidology

- Multiple Attempters (continued)
  - Patient attrition from treatment in the Joiner & Rudd (2000) study was highest in those with the highest degree of suicidality at baseline.
  - These patients are prone to negating and rejecting help.
  - These are correlational data, thus provoking questions of *causality* (is schema activation a causal factor?).

# Special Issue in Suicidology

- **Ambivalence**
  - Less than one half of 1% of people with suicidal ideation ultimately kill themselves.
  - In a Mayo Clinic study, "only" 2% of first-attempters who survived their initial attempt completed suicide in the 22 year study period (Bostwick, 2016).
  - Clinically, we must facilitate "reasonable doubt" about suicide in the minds of our patients, and we must reduce easy access to lethal means.

# Cognitive Vulnerabilities in the Suicidal Patient

**“How weary, stale, flat and unprofitable seem to me all the uses of this world!”** **(Shakespeare, *Hamlet*)**

# Cognitive Vulnerabilities in the Suicidal Patient

- **Hopelessness and helplessness** (“Nothing I do matters, and it won’t get better anyway.”)
- **Maladaptive schemas** (e.g., abandonment, unlovability) and **“suicidogenic beliefs.”**
- **Poor problem-solving.**
- **Non-specific autobiographical recall.**
- **Morbid, self-punitive perfectionism.**

Ellis, T. (Ed.) (2006). COGNITION AND SUICIDE: THEORY, RESEARCH, & THERAPY. Washington, D.C.: APA Books.

# Cognitive Vulnerabilities in the Suicidal Patient

- **"Tunnel vision"** (Excessive focus only on what is going wrong. Failure to see alternatives).
- **Time distortions.**
  - Discrete moments of emotional pain seem to last forever.
  - The notion of being dead forever seems inconsequential.
  - Time collapses to a point of singularity – all that matters is killing the pain ***right now***.

# The Hopelessness Factor (1)

**"Baseline hopelessness,"** or the patients' *non-depressed*, general beliefs about the future, is predictive of future suicide risk.

– We need to assess patients' *baseline* hopelessness as well as their *sensitivity* to becoming more hopeless in reaction to life events and exacerbated mood.

Young, M.A. et al. (1996). Stable trait components of hopelessness: Baseline and sensitivity to depression. JOURNAL OF ABNORMAL PSYCHOLOGY, 105, 155-165.

# The Hopelessness Factor (2)

- When patients have both high baseline and high sensitivity to hopelessness, this may be construed as ***"double hopelessness."***
- Measures such as the **Beck Hopelessness Scale** are extremely useful to assess the above.
- The patients' hopelessness beliefs are important **targets for intervention**, even when they are not depressed per se.

# The Hopelessness Factor (3)

- **Leaving therapy** while still feeling hopeless is a **risk factor** for future suicidality. (Dahlsgaard, Beck, & Brown, 1998).
- **Ending therapy on a positive note**, or at least in a planned fashion, is **a high priority**.
- If a high-risk patient leaves therapy prematurely and/or inadvisably, **reach out** and try to re-engage him or her, or at least send an occasional message of good will. (Motto & Bostrom, 2001; Wenzel, Brown, & Beck, 2009).

# Schemas*

- Broad, pervasive themes or patterns.
- Comprised of memories, emotions, cognitions, and bodily sensations.
- Regarding oneself and one's relationships with others.
- Developed during childhood or adolesence.
- Dysfunctional, especially when elaborated over time and generalized across contexts.

*Early Maladaptive Schemas (see the work of Jeffrey Young)

# All of us have “schemas,” but…

In clinical phenomena such as borderline personality disorder  (where suicide risk is often an issue) the schemas are more maladaptive, more severe, and in greater numbers.

In borderline personality disorder the *coping strategies* are more extreme and cause more problems.

# Early Maladaptive Schemas

(Disconnection and Rejection)

- Abandonment / Instability.
- Mistrust / abuse.
- Emotional deprivation.
- Defectiveness/ “Badness”/ Shame.
- Social isolation / Alienation / Unlovability.

# Early Maladaptive Schemas

## (Impaired Autonomy and Performance)

- Dependence / Incompetence.
- Vulnerability to harm.
- Enmeshment / Undeveloped sense of self.
- Failure.

# Early Maladaptive Schemas

(Impaired Limits)

- Entitlement / Insufficient limits.
- Insufficient self-control or self-discipline.

# Early Maladaptive Schemas
(Overvigilance and Inhibition)

- Unrelenting standards / Hypercriticalness
- Negativity / Pessimism.
- Punitiveness.

# Common “Suicidogenic” Beliefs (1)

1. “Death is the only solution to my problems.” (Suicide as a dysfunctional substitute for problem-solving). ***Unsolvability***
2. “I am a burden to my loved ones. They would be better off if I killed myself.” (Suicide in response to guilt). ***Burdensomeness***
3. “I hate myself and I deserve to die.” (Suicide in response to profound shame). ***Unlovability***

**Ellis, T.E., & Newman, C.F. (1996). CHOOSING TO LIVE: HOW TO DEFEAT SUICIDE THROUGH COGNITIVE THERAPY. Oakland, CA: New Harbinger.**

# Common "Suicidogenic" Beliefs (2)

4. "The only way to diminish my pain is to die." (Suicide as an anesthetic). ***Unbearability***
5. "Trying suicide will test whether [a loved one] really loves me." (Suicide as a gamble to gain love through any means).
6. "They will be sorry after I am dead, and I will have my revenge!" (Suicide as a way to express anger toward others).

**Also see Ellis & Rufino, 2015**

# Treatment Issues with the Suicidal Patient

# The Therapeutic Relationship

- Creating a connection is part of reducing risk.
- To connect, find a way to validate the patient’s subjective sense of emotional pain.
- But offer hope that the patient’s pain can be reduced without having to quit on life.
- Be extra attentive, including between sessions (e.g., via phone calls).
- Teach psychological skills and provide large doses of care, encouragement, and inspiration.

# General Clinical Demeanor with Suicidal Patients (1)

- Be very attentive.
- Remain calm and non-threatened.
- If possible, give the patient some time and space to cry and express hopelessness and anger before you introduce interventions.
- Demonstrate confidence, hopefulness, and determination in handling the situation.

# General Clinical Demeanor with Suicidal Patients (2)

- Be willing to discuss the issue of suicidality directly, and as the top-priority issue.
- Do not immediately suggest hospitalization without doing a careful assessment first.
- Do not express frustration and anger toward the patient when the patient is suicidal.
- A good therapeutic alliance is a safeguarding factor against suicide, but not a guarantee.

# The Trust Factor

## The therapist is thinking…

"Can I *trust* that you won't kill yourself?"

"Can I *trust* that you will work with me in good faith to get well?"

"Can I *trust* that you will not misuse my attempts to promote your autonomy in order to harm yourself without interference?"

# The Trust Factor

The patient is thinking…

"Can I *trust* that you won't tell anyone how I feel?"

"Can I *trust* that you will not think I am crazy?"

"Can I *trust* that you will not hospitalize me against my will?"