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Research report

Comfort from suicidal cognition in recurrently depressed patients

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ABSTRACT

Background: Previous research has suggested that some individuals may obtain comfort from their suicidal cognitions.
Method: This study explored clinical variables associated with comfort from suicidal cognition using a newly developed 5 item measure in 217 patients with a history of recurrent depression and suicidality, of whom 98 were followed up to at least one relapse to depression and reported data on suicidal ideation during the follow-up phase.
Results: Results indicated that a minority of patients, around 15%, reported experiencing comfort from suicidal cognitions and that comfort was associated with several markers of a more severe clinical profile including both worst ever prior suicidal ideation and worst suicidal ideation over a 12 month follow-up period.
Limitations: Few patients self-harmed during the follow-up period preventing an examination of associations between comfort and repetition of self-harm.
Conclusions: These results, although preliminary, suggest that future theoretical and clinical research would benefit from further consideration of the concept of comfort from suicidal thinking.

1. Introduction

Suicidal ideation and suicidal behaviour are common but serious features of recurrent major depression. Once suicidal ideation has occurred during one episode of major depression it is more likely to occur again in a future episode than any of the other non-core symptoms (Williams et al., 2006), and it is known that information about a person's worst ever episode of suicidal ideation has more predictive validity for future suicide than their level of suicidal ideation at a given assessment point (Beck et al., 1999). Considerable attention has been directed towards understanding motivations and intentions for suicide and content of suicidal cognition. This research suggests that suicidal individuals experience profound feelings of entrapment (Williams et al., 2005) as well as hopelessness, burdensomeness and unlovability (Van Orden et al., 2010; Beck et al., 1990), and that suicidal behaviour may have both intrapersonal and interpersonal components (e.g. escaping distress versus communicating distress to others, e.g. May and Klonsky (2013)). Attention has also been directed towards the *form* that suicidal cognitions take, suggesting that verbal thoughts and vivid mental imagery relating to suicide commonly co-occur (e.g. Holmes et al., 2007; Crane et al., 2012; Hales et al., 2011) both in individuals with mood disorders who have experienced suicidal crises and in those who have been depressed but not actively suicidal. Finally there is increasing interest in patients' relationships with and responses to the occurrence of suicidal cognitions (Williams et al., 2011) and the impact of reactions to suicidal cognitions on ongoing vulnerability. For example, Morrison and O'Connor (2008) systematic review of 11 studies found consistent evidence for a link between rumination and suicidality and Pettit et al. (2009) have demonstrated that suppression of suicidal thoughts is associated with increased severity of such thoughts, both concurrently and prospectively over a 4 weeks period. These findings suggest that developing an understanding of both the content of a patient's suicidal cognitions and of the way they relate to those cognitions may be critical to inform clinical management.

One type of relationship to suicidal cognition which has received relatively little attention in the literature is the extent to which individuals gain comfort or relief from their suicidal

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cognitions. Indeed, whilst many individuals report trying to suppress or avoid suicidal cognitions, and experience them as 'unwanted', 'beyond their own will' and ego dystonic (e.g. Bradvik and Berglund, 2011), clinical experience suggests that for some, suicidal cognition may have comforting properties and become compelling and preoccupying. For example, in a study of suicidal imagery in unipolar and bipolar patients Hales et al. (2011) report on the appraisals patients ascribe to their most vivid suicidal imagery. Whilst many of the appraisals were negative (e.g. 'something must be badly wrong'; '[the imagery] makes me feel like I am going to die'), others reported that the suicidal imagery represented an escape route, or a release (e.g. '[the images mean that] I will be released from this, all these thoughts', '[when I experienced the image] I wanted to take the tablets to find calm'), and mean ratings of imagery-related comfort and distress were similar across the sample as a whole. Indeed the three studies of suicidal imagery that have addressed issues of comfort have all found similar mean ratings of comfort and distress associated with suicidal imagery (Holmes et al., 2007; Crane et al., 2012; Hales et al., 2011). For example in Holmes et al. two thirds of participants rated their suicidal images as moderately comforting or greater, whilst in the sample of Crane et al., the mean level of comfort was 4.6 on a scale where 5 corresponded to moderately comforting. It is important to note that in this study there was a strong negative correlation between comfort and distress, suggesting that the two appraisals or emotional responses to suicidal imagery do not tend to coexist within a single patient, at least in relation to a particular image or episode. Finally confirming this aspect of the experience of some suicidal people, Vatne and Naden (2011) describe in a qualitative study of 10 patients that for their participants '*the thought of suicide can provide consolation and comfort to go on living*'.

Joiner's Interpersonal Psychological Theory of Suicide (IPTS; e.g. Van Orden et al., 2010), which deals primarily with the constellation of psychological processes that increase an individual's capacity to engage in lethal self-harm, has particular relevance when considering how suicidal cognitions may acquire comforting properties. Considering deliberate self-harm, the IPTS suggests that gradually, through the action of habituation and opponent processes, emotional reactions to deliberate self-harming behaviours change such that 'what was originally a pain and/or fear inducing experience… may become less frightening *as well as a source of emotional relief*' (Van Orden et al., 2010, pp. 587, italics added). We argue that there is value in considering whether the same phenomenon of habituation may also occur in relation to intrusive suicidal cognitions, and whether this may account for the observation that some individuals experience comfort from suicidal thoughts. If this is the case it is likely to be concerning, because it suggests that there may be an elaboration or escalation in suicidal ideation over time. Consistent with this suggestion, in the study of suicidal cognition in previously depressed patients discussed above, Crane et al. (2012) found that increased ratings of suicidal imagery-related comfort were strongly associated with increased severity of worst-ever suicidal ideation. However to date no study has examined whether taking comfort from suicidal thoughts predicts severity of future suicidal ideation after controlling for prior history.

The current study utilised a short scale, developed by the authors, to investigate participants' ratings of comfort associated with suicidal cognition. We administered this scale to a large sample of patients with recurrent depression and a history of suicidality. We examined (a) the extent to which ratings of comfort were correlated with (i) severity of *prior* suicidal ideation and (ii) occurrence of *prior* suicidal behaviour, and (b) whether ratings of comfort were correlated with the severity of *subsequent* suicidal ideation during a 1 year follow-up period. We hypothesised first that, consistent with the previous work, individuals who rated suicidal cognitions as more comforting would have higher levels of worst ever suicidal ideation at the baseline assessment, and second, that controlling for worst ever prior suicidal ideation, those who reported greater comfort from suicidal cognitions at a baseline assessment would report more severe suicidal ideation when they experienced a relapse to depression over a subsequent 12 months follow-up period.

2. Method

2.1. Recruitment

Participants were recruited to a large randomised controlled trial of psychological treatment for prevention of recurrent depression (the Staying Well after Depression Trial), (Williams et al., 2010) from primary care and mental health care services and community advertising at two sites: Oxford, England and Bangor, Wales. Inclusion criteria at baseline assessment were (a) age between 18 and 70 years; (b) history of at least three episodes of Major Depression meeting DSM-IV-TR criteria of which two must have occurred within the last 5 years, and one within the last 2 years; (c) remission for the previous 8 weeks; and (d) informed consent from participants and their primary care physicians. Participants were excluded if they had (a) a history of schizophrenia, schizo-affective disorder, bipolar disorder, current misuse of alcohol or other substance, organic mental disorder, pervasive developmental delay, primary diagnosis of obsessive-compulsive disorder or eating disorder, or regular non-suicidal self-injury; (b) inability to complete research assessments through difficulty with English, visual impairment, or cognitive difficulties and (c) if they were currently in psychotherapy more than once per month.

2.2. Ethics statement

This study was approved by Oxfordshire Research Ethics Committee C and North Wales Research Ethics Committee. The funder played no role in study design or conduct, or the decision to submit this paper for publication.

2.3. Procedure

Following screening for eligibility participants completed a baseline assessment including measures of current and prior suicidality, clinical history and the comfort from suicide measure, as well as a range of other measures not relevant to the current report (see Williams et al., 2010) and following treatment or an equivalent waiting period (approximately 8–12 weeks) participants were reassessed on the same measures. Participants were then followed up for 12 months with assessments at approximately 3 monthly intervals. At each assessment participants were interviewed to determine whether they had relapsed since the previous assessment, and also reported on current levels of suicidal ideation. For the purposes of the current study, data analysis focused on individuals who relapsed to major depression at least once during follow-up and who reported data on suicidal ideation at the assessment at which a relapse was recorded. There were no significant main effects or interactions with treatment group, and since all participants had experienced a relapse to depression (which the treatments were aiming to prevent) treatment is not considered further in this paper.