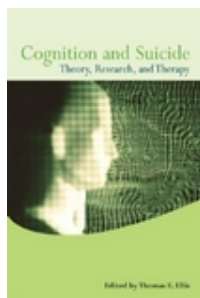


Suicide and Cognition: What We Know and How to Use It

A review of



Cognition and Suicide: Theory, Research, and Therapy by Thomas E. Ellis (Ed.)

Washington, DC: American Psychological Association, 2006. 409 pp. ISBN 978-1-59147-357-2. \$69.95

Reviewed by
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☰ *Cognition and Suicide: Theory, Research, and Therapy*, edited by Thomas E. Ellis, is an extremely important addition to the literature on suicide and suicide prevention. For the first time, the major theoretical, empirical, and clinical approaches to understanding the role of thought and cognition in the etiology of suicide, and the potential utility of cognitive interventions to reduce the risk of suicide or suicide attempts, are assembled in one place. Of particular value is that the editor has not been doctrinaire and has restricted his volume to contributors who view cognition as the primary driver of death by suicide or as the most central form of therapeutic intervention. He also includes approaches, such as dialectical behavior therapy and the work of Edwin Shneidman, the founder of suicidology, that emphasize the centrality of emotional suffering or intolerable human emotion and the complex interplay between thought, emotion, and behavior. By taking this broader point of view, Ellis has been able to compile a volume that is of value to both clinicians and researchers, as well as to those who specialize in suicidology or work in general practice.

☰ *Cognition and Suicide* begins with an overview and historical perspective, then presents the array of theoretical systems currently in use, before moving on to present the state of our empirical knowledge of cognitive aspects of suicidality. The book then provides an overview of special topics, such as developmental influences and the influence of trauma, and ends with an expert summary by Ellis regarding the state of the field and potential future directions.

☰ As part of the initial overview, Jobes and Nelson provide an analysis of Shneidman's seminal contributions to the understanding of suicidal thinking. Shneidman, one of our greatest living psychologists, pioneered the use of hotlines as a means of suicide prevention. He was the first to systematically study suicide notes and is more responsible than any other person for suicide being made the subject of scientific study. Shneidman emphasized the centrality of intolerable psychological pain in suicide. Although such pain, or "psychache," is central, he also identified cognitive constriction as the common cognitive state of those who die by suicide, preventing individuals in overwhelming pain from perceiving ways to end the pain other than death.

☰ Also included as part of the overview is the transcript of an interview with Charles Neuringer, one of the earliest investigators into the topic of cognition and suicide. I note one part of this conversation in particular, which is the observation that although helping suicidal individuals through a period of crisis is of critical and often lifesaving importance, after the crisis ends many individuals will remain vulnerable to future suicidal episodes. In the understandable relief that individuals, families, and providers experience after a crisis is

over, this continuing vulnerability may not be clearly recognized. Part of the great value of this book is that understanding the nature of this continuing vulnerability, as well as the nature of the suicidal crisis itself, provides the foci of this volume.

☰ The section of *Cognition and Suicide* that reviews theoretical systems begins with a chapter by Greg Brown and colleagues on the contributions of Aaron Beck. Few now remember that the common nomenclature used in virtually every hospital, clinic, and office derives from Beck's work for the National Institute of Mental Health, which first made the distinction between suicidal ideation, suicide attempts, and completed suicides. Beck also devised some of the most widely used suicide assessment instruments. In addition to the well-known Beck Depression Inventory and Beck Hopelessness Scale, which each include items on suicide, Beck also developed the Scale for Suicide Ideation, the Suicide Intent Scale, and the Lethality Scales. Beck's work on hopelessness remains of great value to both the clinician and the researcher, and this chapter provides an excellent summary and analysis, as well as a description of the evolution of Beck's thinking to incorporate the "suicidal mode," which is an effort to help explain ongoing vulnerability to suicide. Finally, there is a detailed description, of particular value for clinicians, of a cognitive therapy intervention for suicide attempters, which has recently been shown to be successful in reducing the frequency of suicide attempts. The description includes descriptions of how the therapy is utilized in the beginning, middle, and late phases of therapy.


☰ Another important theoretical approach is provided by Milton Brown in his chapter on Marsha Linehan's theory of suicidal behavior. This chapter is a very accessible introduction to Linehan's pioneering work. The role of emotional dysregulation is highlighted. In this model, emotional dysregulation disrupts cognitive processing and problem solving. Brown provides an overview of Linehan's views on the role of the invalidating environment, hopelessness, self-invalidation and shame, and social reinforcement. Brown also provides a concise overview and analysis of dialectical behavior therapy, including structure and stages of treatment, and treatment strategies. Linehan's theoretical, research, and clinical contributions are of great value in understanding the way in which emotion, cognition, and overt behavior interact, particularly in chronically suicidal individuals.

☰ Another example of the type of valuable research contribution regarding the cognitive aspects of suicidality that is included in this volume is Williams, Barnhofer, Crane, and Duggan's chapter on over-general memory. The authors begin by asking several powerfully important questions: (a) "How do people come to view their circumstances as unendurable?"; (b) "what underlies such a strong compulsion to escape?"; and, most importantly, (c) "why do suicidal people believe there is no other option but death?" The authors focus in particular on this last question, carefully examining the research and theory in this area, and showing the potential significance of research findings on over-general memory. They propose the possibility that there may be two different general pathways to suicidal behavior: one being driven more by hopelessness, the other more strongly related to failures in affect regulation and the intrusion of distressing memories. Similarly, chapters on trait perfectionism and problem solving carefully analyze theory, research, and clinical applications.

☰ A further example of the quality of the contributions to this volume is the chapter by Wingate et al. on positive psychology applied to suicidal behavior. This chapter includes a section on optimism and a very intriguing section on the "broaden and build" theory of positive emotions. The notion here is that positive emotions can and must play a crucial role in preventing suicide. An individual in suicidal crisis is typically unable to experience positive emotions until after the acute crisis is past. When the crisis is past, to prevent future suicidal crises, the individual must be assisted to experience positive emotions. Whereas negative emotions narrow attention, positive emotions broaden both attention and the individual's behavioral repertoire. This is consistent with Linehan's work, which emphasizes the importance of a suicidal person developing "a life worth living." This chapter also draws on the work of Thomas Joiner regarding the importance of perceived burdensomeness and the lack of a sense of belonging as risk factors for suicide. In contrast, the perception that one is an effective, functioning, and valued member of the community may well prove to be important for suicide prevention.

☰ An example in the Special Topics section of a potentially seminal contribution is Rudd's work on fluid vulnerability theory. Rudd emphasizes the need to understand the relation between acute suicidal states and those that endure or recur over longer periods of time. It is critical for assessing suicidal risk to understand that suicide risk is fluid and dynamic. Risk that is low today can rise tomorrow. For example, when suicidal individuals show improvement and are discharged from inpatient units, this does not mean that all risk is gone. In fact, we know there are high rates of suicide after inpatient discharge. It is extremely important that clinicians, family members, and suicidal individuals themselves understand this continuing risk. Rudd also differentiates between risk factors and warning signs (warning

signs connoting more immediate risk). This distinction is of great importance for clinicians.

 The chapters referenced here are just a sample of the contributions to this volume, which makes a significant contribution to the field of suicide prevention through its compilation of expert clinical, research, and theoretical material.

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