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Cognitive, affective and social processes involved in help-negation after critical suicidal thoughts

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Abstract
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Help-negation is defined as the process of help withdrawal or avoidance found among those currently experiencing clinical and subclinical levels of different forms of psychological distress, including low and critical levels of suicidal ideation (Wilson, Bushnell, Caputi, 2011). Understanding the determinants of help-negation in suicidal samples that have not yet come to treatment provides a potent opportunity to target prevention and early intervention strategies to facilitate appropriate and timely help-seeking. Over 20 help-negation studies have ruled out variables that might explain the withdrawal process associated with suicidal thoughts. These results now point to biological and neurological underpinnings working together with social and cognitive variables to influence the help-negation process. This paper presents results of study that examined cognitive, affective, and social processes involved in help-negation after critical suicidal ideation in a sample of 279 non-helpseeking suicidal ideators case-matched by sex, age, and year of data collection (2010-2012) to a sample of 279 non-help-seeking non-suicidal ideators. Results suggest there are at least two types of process underlying help-negation for suicidal ideation: active processes that are specific to suicidal ideation and passive processes that are common to suicidal ideation and depression. The results also implicate affect regulation processes and perceptual processes related to social support in the development of help-negation among suicidal individuals - not cognitive distortion as the primary reason that suicidal individuals don't seek help. The results challenge suicide prevention strategies that primarily target distorted cognitions (e.g., stigma, fears, beliefs, attitudes) to promote help-seeking. The results suggest that prevention strategies must not imply that distorted cognitions are THE primary reason people do not seek help, and raise the possibility of iatrogenic effects, should this focus remain. Additional implications for prevention, early intervention, treatment and directions for future research are presented and discussed.

Keywords
after, thoughts, negation, suicidal, help, involved, processes, social, affective, cognitive, critical

Disciplines
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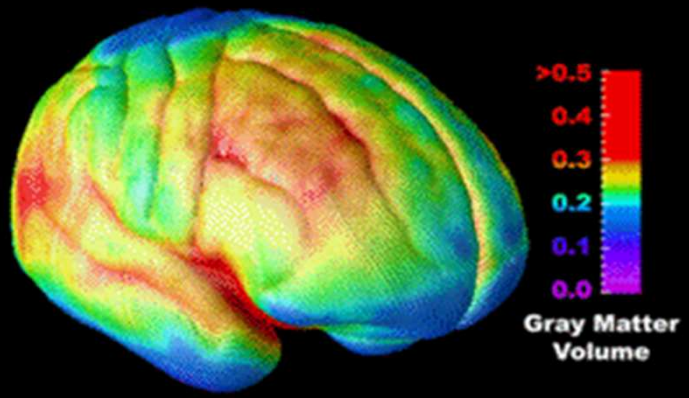
Cognitive, affective and social processes involved in help-negation after critical suicidal thoughts



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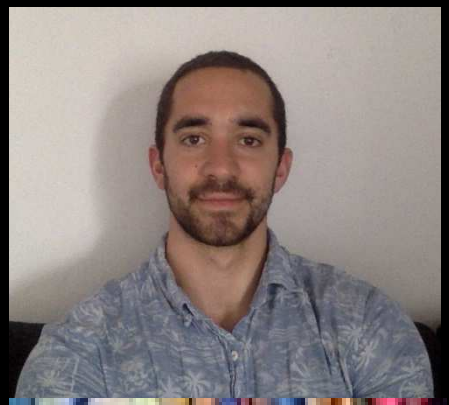

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Presentation abstract

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Over 20 help-negation studies have ruled out variables that might explain the withdrawal process associated with suicidal thoughts. These results now point to biological and neurological underpinnings working together with social and cognitive variables to influence the help-negation process.

This paper presents results of study that examined cognitive, affective, and social processes involved in help-negation after critical suicidal ideation in a sample of 279 non-helpseeking suicidal ideators case-matched by sex, age, and year of data collection (2010-2012) to a sample of 279 non-help-seeking non-suicidal ideators. Results suggest there are at least two types of process underlying help-negation for suicidal ideation: active processes that are specific to suicidal ideation and passive processes that are common to suicidal ideation and depression. The results also implicate affect regulation processes and perceptual processes related to social support in the development of help-negation among suicidal individuals – not cognitive distortion as the primary reason that suicidal individuals don't seek help. The results challenge suicide prevention strategies that primarily target distorted cognitions (e.g., stigma, fears, beliefs, attitudes) to promote help-seeking. The results suggest that prevention strategies must not imply that distorted cognitions are THE primary reason people do not seek help, and raise the possibility of iatrogenic effects, should this focus remain.

Additional implications for prevention, early intervention, treatment and directions for future research are presented and discussed.

What is help-negation?

The process of help withdrawal or avoidance found among those currently experiencing clinical and subclinical levels of different forms of psychological distress, including suicidal thoughts

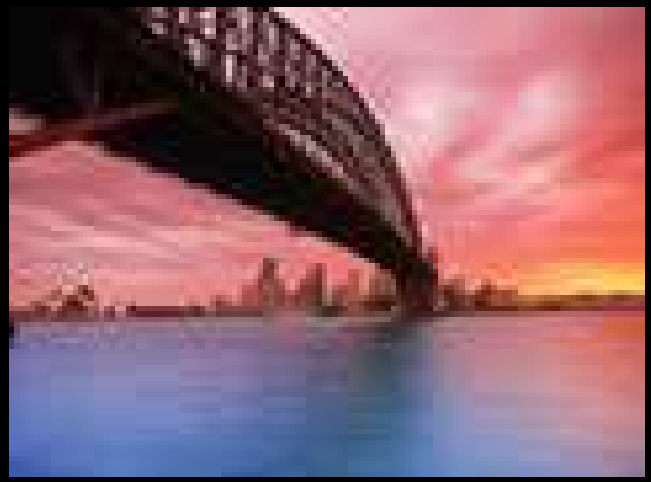
Wilson et al EIP 2011

Why focus on help-negation and help-seeking?

Help-seeking is a generic protective factor

Receiving appropriate help early can protect against developing serious mental disorders, and suicidal thinking

Rickwood et al MJA 2007



Understanding the **determinants of help-negation** among **suicidal individuals** who have **not yet come to treatment** provides a **potent opportunity** to target intervention strategies to successfully facilitate appropriate and timely help-seeking

What do we know so far?

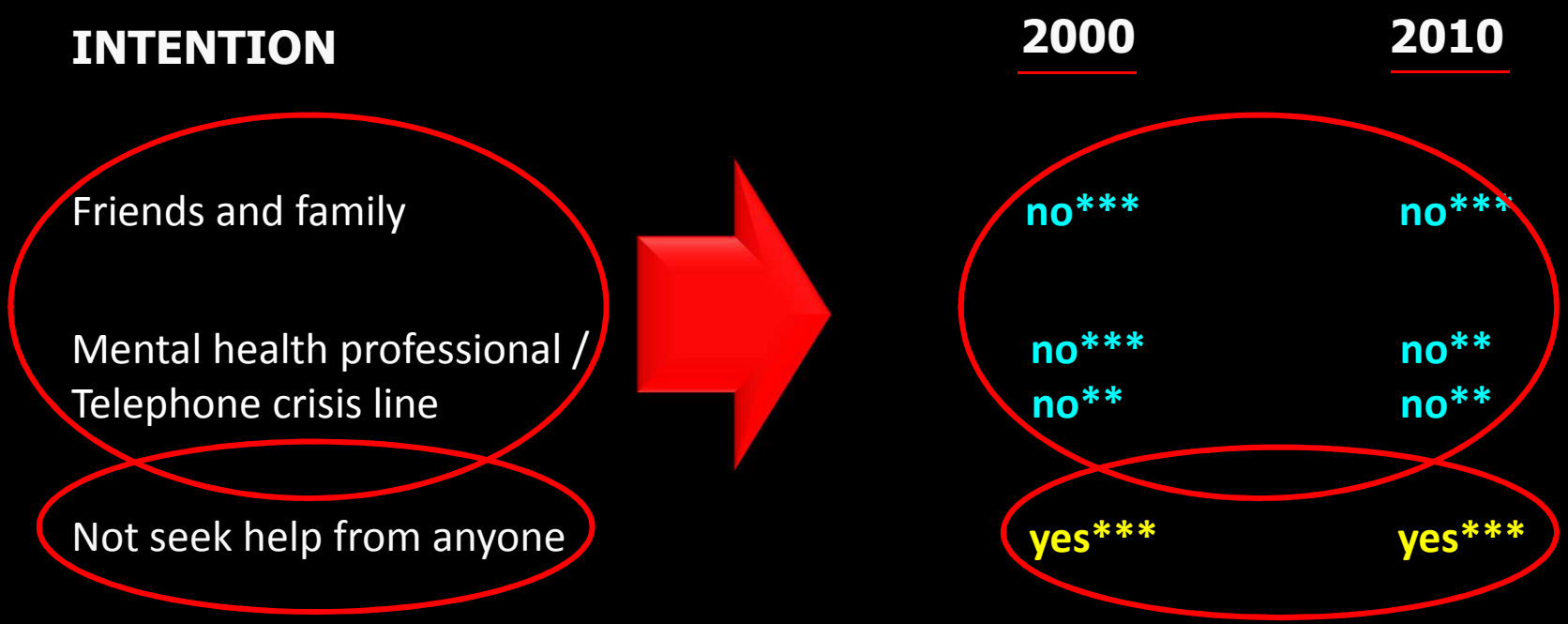
- ~ 10 studies since 2000 focused on determinants of help-negation for suicidal ideation in samples not yet in treatment
- Appears to be a relatively stable process
- Stronger for friends and family than mental health professionals; this has not changed in 10 years
- Association between symptoms and intention to *not seek help from anyone* remains moderate and significant; this has not changed in 10 years

Wilson Caputi et al 2012a

Case-controlled comparison of help-negation across the past 10 years

Wilson, Caputi et al 2012a, 2012b

SUMMARY: Logistic regression using **increasing intensity** of **suicidal ideation to predict intention to seek help for suicidal thoughts**



***Odds Ratios (adjusted for age) within 95% Confidence Intervals and significant at p<.001,** **p<.01

Wilson Caputi et al 2012a

- Occurs with **low intensity** symptoms of common mental disorders and suicidal thinking
- Patterns different for arousal symptoms vs depressive symptoms and suicidal ideation
- Little difference in patterns for males vs females

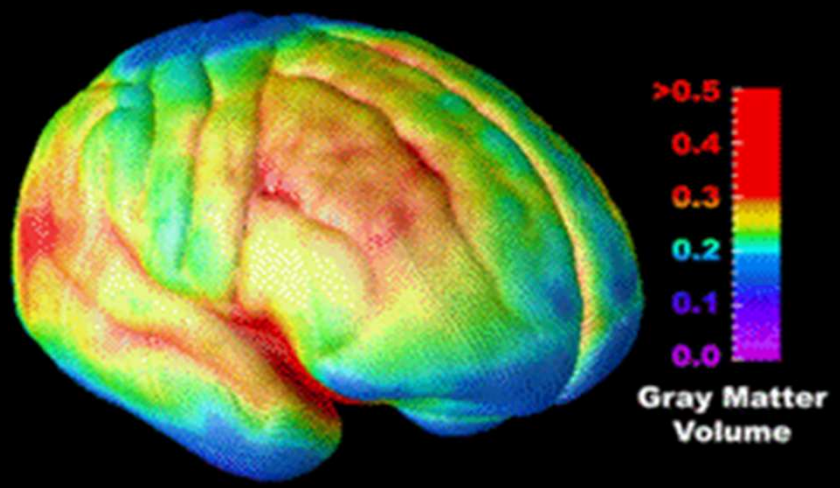
Wilson Caputi et al 2012b

- Not explained by hypotheses tested so far…

Hypothesis tested	**Intention-type**			
	Friends/ Family	MH Prof	No help	# Published studies: Year
Is help-negation for **suicidal thinking** explained by:				
•**Sex?**	**no**	**no**	**no**	**8**: 2001-2012
•Religious affiliation?	no	no	no	1: 2005
•Prior help?	no	no	no	2: 2001-2005
•No current desire for help?	no	no	no	1: 2010
•Hopelessness?	no	no	no	4: 2001-2010
•**Depression / anxiety symptoms?**	**no**	**no**	**no**	**1:** 2010-2012
•General psychological distress symptoms?	no	no	no	1: 2010
•Attitudes towards counselling?	no	no	no	1: 2005
•Treatment fears / **need for autonomy*?**	no	**yes**	no	**1**: 2005

measured as beliefs related to all or nothing thinking, 'should' statements, and uniqueness fallacy (i.e., belief styles indicating **cognitive distortion)*

Biological and **neurological** underpinnings implicated



Cognitive distortion
Affect regulation
Social perception

Research questions:

1) What is the impact of depressive symptoms on help-negation after critical suicidal thoughts?

2) Can cognitive distortion, affect regulation disorder, and perceived social support explain help-negation after critical suicidal thoughts?

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Case-controlled sample:

University students (regional NSW)	No SI	Critical SI
Group sample	**276**	**276**
Male: Female	1:3	1:3
Age range	18-48 years	18-48 years
18-20 years	71%	71%
21-24 years	19%	19%
25-50 years	10%	10%
Age Mean (Standard Deviation)	20.97 (5.27) years	20.95 (5.24) years
Cultural affiliation "European / Australian"	98%	98%

Note. Differences between groups were all non-significant (all ps >.1); data collected 2010-2012

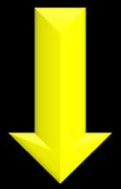
Help-seeking intention by suicide group:

	No SI	Critical SI	OR
Mental health professional	46%	21%	.69***
Friends and family	44%	19%	.64***
Phone helpline	23%	12%	.80***
Would not seek help	8%	17%	1.16***

***p<.001; Continuous suicide and depression variables were related significantly to continuous intentions variables: **r = -.14 to -.31** (MH prof, friends/family, phone), **r=.18 and .20** (would not seek help); all ps<.05.

SUMMARY: Multiple regression using **increasing intensity** of **suicidal ideation to predict intention to seek help for suicidal thoughts** (depression controlled)

- **As SI became more intense:**



HS Friends and family (β = -.31, **p<.001**)

HS MH professional (β = -.27, **p<.001**)

HS Helpline (β = -.12, **p<.01**)

Help-negation remains

Not seek help from anybody (**p>.05**)

- **Interaction: Suicidal ideation * depression** for friends and family, MH professional, helpline significant (**all ps < .001**)
- No interaction for would not seek help (**p>.05**)

So…

1) What is the impact of **depressive symptoms** on **help-negation** after critical suicidal thoughts?

- **Active HS intentions** (MH prof, friends and family, helpline)
  -  **explain** help-negation
  -  **strengthen** help-negation
- **Passive HS intentions** (not seek help)
  -  **explain** help-negation

Suggests…

- At least **two types of underlying processes** in help-negation for suicidal ideation:
  - **Active processes** that are *specific* to suicidal ideation
  - **Passive processes** that are *common* to suicidal ideation and depression

Research questions:

1) What is the impact of depressive symptoms on help-negation after critical suicidal thoughts?

2) Can cognitive distortion, affect regulation disorder, and perceived social support explain help-negation after critical suicidal thoughts?

Subset case-controlled sample:

University students (regional NSW)	No SI	Critical SI
Group sample	**162**	**162**
Male: Female	1:3	1:3
Age range	18-48 years	18-46 years
18-20 years	72%	71%
21-24 years	18%	19%
25-50 years	10%	10%
Age Mean (Standard Deviation)	20.98 (5.23) years	20.94 (5.09) years
Cultural affiliation “European / Australian”	98%	98%

SUMMARY: Group comparisons (Logistic regression)

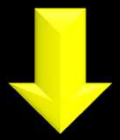
Suicidal group compared to the non-suicidal group:

- ↑ Affect regulation difficulties: difficulty identifying feelings (OR=1.26***), describing feelings (OR=1.17***)
- ↑ Cognitive distortion (OR=2.47***)
- ↓ Perception of social support (OR=.59***)

***p<.001

SUMMARY: MR using **increasing intensity** of **suicidal ideation to predict intention to seek help for suicidal thoughts** (ARD, CD, PSS controlled)

As SI became more intense:



HS friends and family (β = -.28, **p<.01**)] **Help-negation remains**

HS MH professional, helpline, would not seek help (**all ps>.05**)

No interactions (**all ps>.05**)

Digging deeper…

Partial correlations

	MH Prof	Friends/ family	Helpline	No one
Difficulty identifying feelings	-.22***	-.23***	-.18***	.20***
Difficulty describing feelings	-.21***	-.26***	-.15***	.17***
CD	**.02**	**.06**	**-.05**	**.04**
PSS	.18***	.20***	.10	-.10

***p<.001

Research questions:

1) What is the impact of depressive symptoms on help-negation after critical suicidal thoughts?

2) Can cognitive distortion, affect regulation disorder, and perceived social support explain help-negation after critical suicidal thoughts?

Results suggest:

- Help-negation from a mental health professional and crisis helpline, and intention to not seek help from anyone for critical suicidal thoughts…

is largely…

a function of ARD plus changes in PSS, **not CD**

- Help-negation from family and friends is also function of ARD and PSS (**not CD**) plus variables over and above these

Implications…

1. **ARD** and **PSS – not CD primarily -** are important underpinning mechanisms in the development of help-negation for suicidal ideation

   - These results **challenge** suicide prevention strategies that primarily target distorted cognitions (e.g., stigma, fears, attitudes) to promote help-seeking

   - Prevention strategies **must not imply** that distorted cognitions are **THE primary reason** people do not seek help **– potential iatrogenic effects**

2. Help-negation from family and friends for suicidal thoughts could not be fully explained as a function of ARD, PSS, or CD

   – *People who think about suicide have characteristically smaller networks and less frequent interaction with network members (i.e., social network quality and quantity)*

   Joiner 2005, Veiel et al 1988, Steinhausen et al 2006

   – There may be an interaction between perception of social support and actual social network quality and size that also influences help-negation, particularly from family and friends

Research to test this possibility is underway:

- **NSPC 2013 Poster presentation** – Preventing help-negation for suicidal ideation: Implications for social network size and frequency of social interaction (Svenson A, Wilson C, Caputi P)

Questions?

Thanks for your attention

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