THE SELF IN CRISIS

THE SELF IN CRISIS: USING SELF-TRUST TO ENHANCE THERAPEUTIC PRACTICES FOR PATIENTS WITH CHRONIC SUICIDAL IDEATION

BY MARLA CLARICE SHARP, B.A. (HONS.)

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AUTHOR: Marla Clarice Sharp, B.A. (Hons.) (McMaster University)

SUPERVISOR: Dr. Elisabeth Gedge

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Lay Abstract

In this thesis I discuss the relational nature of self-trust and how it can be used to enhance the effectiveness of current treatment practices concerning patients with depressive mental illnesses, who experience chronic suicidal ideation. By improving a patient's sense of faith in his or her own ability to self-advocate and to act autonomously, the rigorous learning processes associated with psychiatric treatment practices for suicidality can be made more manageable. These improvements respond directly to criticisms of effective 'talk therapy' treatment options as being too intensive, time consuming, and requiring of extensive resources. By encouraging philosophical understandings of oneself and his or her personal trustworthiness into psychiatric care, patients will be much better prepared to take part in intensive psychotherapy.

Abstract

In this thesis I set out to show that the bioethical literature concerning the treatment of chronic suicidal ideation occupies a serious omission: it does not discuss the critical function that self-trust serves in the recovery process. Self-trust is a core component of autonomy, and therefore plays a pivotal role in the shaping of one's sense of self and his or her capacity to effectively engage in therapeutic interventions. I begin by discussing the relationship between agency and self-trust, and how this influences one's ability to make decisions and self-advocate. Secondly, I evaluate how self-trust relates to aspects of the suicidal mind, including existential distress and negative urgency. Finally, I will offer recommendations as to how the explicit (re-) development of self-trust skills can significantly enhance the effectiveness and timeliness of contemporary dialectical treatment practices.

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List of Abbreviations

ACT.....Acceptance and Commitment Therapy

BP2.....Bipolar Disorder Type II

CBT.....Cognitive Behavioural Therapy

DAT.....Differential Activation Theory

DBT.....Dialectical Behaviour Therapy

MAID.....Medical Assistance in Dying

MDD.....Major Depressive Disorder

PTSD.....Post-Traumatic Stress Disorder

STSD.....Self-Trust Skills Development

Declaration of Academic Achievement

This thesis represents original research and writing that I conducted under the guidance of Dr. Elisabeth Gedge. I proposed an original research topic, and conducted an initial literature review on contemporary suicide statistics and philosophical theories of relational autonomy and self-trust. I organized and wrote the manuscript of this thesis with editorial assistance from Dr. Elisabeth Gedge and Dr. Lisa Schwartz. All argumentation and therapeutic practice recommendations presented in this thesis are my own original work.

INTRODUCTION

There is but one truly serious philosophical problem and that is suicide.[1]

Every forty seconds, someone around the world dies by means of suicide.[2] In that same time period, many more attempt to end their lives. While it is not uncommon for victims to leave notes behind for family members and loved ones, there are often countless questions that remain unanswered in the aftermath of a suicide. Some of the most frustrating of these queries pertain to what the individual was thinking as she decided to make one final act: 'Could her mind have been changed?'; 'Was she thinking rationally?'; 'How must she have felt?'

The many unknowns surrounding the issue of suicide have led to its existence as what I refer to as a 'secluded crisis': a predicament that has been pushed outwards to political and social margins due to immense collective anxiety. By continually being evaded in both global and private conversation, the crisis of suicide is able to maintain an uninterrupted existence. My aim in this project is to bring some of the realities of the experience of suicidal ideation to light, while creating an opportunity for conversation and reform.

[1] Camus, A. (1991). p.3.
[2] World Health Organization. (2014).

This project will provide suggestions for understanding suicidal ideation, cognition, and behaviour. The focus of this discussion is on self-trust, a vital component of personal autonomy that has not been actively studied in academic investigations of suicidal decision-making. Self-trust is, quite simply, the self's attitude towards its own trustworthiness.[3] Just as when one trusts another person, if I trust *myself*, I will have assurance that I will be committed to act in ways that I view as being in my best interests (i.e. avoiding actions that will jeopardize those interests). The question then becomes, 'What *are* my best interests?' For the purposes of this thesis, one's 'best interests' will refer to actions that an individual should perform in order to achieve the best possible outcome, according to themselves. These will be related to (and based on) his or her core values and their aspirations.

But what role does self-trust play in suicidal decision-making? This is the main question that I will address in this thesis. It would be easy to conclude that, if I have poor self-trust, I will be more likely to experience (and possibly acquiesce to) suicidal ideation. Conversely, it is easy to assume that if I have high levels of self-trust, I must be able to overcome suicidal tendencies, as I will always act in accordance with what is best for me as an individual (such as existing versus not existing). However, as with most queries concerning cognition and autonomy, the question is not that simple.

[3] Govier, T. (1993). p.100.

For example, in 1982 Brothers put forth an easy-to-follow 'Self-Trust Scale' as a means by which one could measure an individual's level of self-trust:

1. I can take life's disappointments in my stride.
2. When I am angry, I feel I might lose control.
3. I can accept my own shortcomings.
4. I worry that I might become overwhelmed by panicky feelings I can't explain.
5. I expect to have satisfying sexual experiences.
6. I am easily swayed by the opinions of others.
7. I have faith that my talents will be developed.
8. I allow myself to be bullied.
9. I adapt easily to changes in my life.
10. It is hard for me to believe I will ever find a fulfilling love relationship.
11. I expect to succeed at things I try.
12. When meeting new people, I worry about being rejected.
13. I make the right decisions on important matters.
14. I demand more from myself than I am capable of doing.
15. I count on my ability to deal with difficult situations.
16. I lose respect for myself when I even have to ask for help.

Agreement to statements with odd-numbers counts as indicating self-trust, while assent to even-numbered statements suggests a lack thereof.[4] This type of scale is not without its limitations, however—in 1993 Govier suggested that Brothers' scale required *self-*

[4] Brothers, D. (1982).

acceptance for an individual to have self-trust, and that these two phenomena were not equal. More importantly, Govier stated that Brothers' framework failed to distinguish attitudes about oneself from beliefs about the external world, specifically in relation to areas of self-confidence and optimism. As Govier claimed, contrary to what Brothers' scale suggests, "...one might trust oneself and yet be pessimistic about one's prospects of developing one's talents due to one's beliefs about opportunities in one's society".[5] This critique is valuable to accounts of personal autonomy and self-trust as it identifies the influential role that one's surrounding environment plays in the shaping of individual liberties. Self-trust is a critical component of personal autonomy—in order for individuals to be able to control the direction of their own lives, they must be confident in their abilities to self-determine. But that is not all: agents must also have a clearly defined sense of self, based on an understanding of their personal position in relation to others, and in relation to their surroundings. The relational nature of personal autonomy and self-trust will be discussed in more detail in Sections 2(I) and 2(II).

It remains unclear how self-trust and suicidal decision-making are related: If I have low self-trust, am I more likely to fall victim to suicidal ideation because I am weak willed? Or am I more likely to be suspicious of the contents of the suicidal ideation that I experience because I don't trust my inner dialogue? Put another way, if I have a high level of self-trust, am I more likely to listen and tend to my inner grievances because I have a well-developed understanding of myself and my interests? Or am I more likely to

[5] Govier, T. (1993). p.101.

disregard internal duress, and prevail over my suicidal tendencies? The relationship between self-trust and suicidal decision-making is no doubt a complex one; the subsequent sections of this thesis will explore its component parts first individually, and then in duo.

For the purposes of this report, 'suicide' will refer to the act of deliberately taking one's own life (i.e. intentionally killing oneself). 'Suicide attempt' or 'attempted suicide' will refer to intentional suicidal behaviour that does not end in loss of life. Finally, 'suicidal behaviour' will refer to actions that are related to one's having thoughts of suicide (i.e. suicidal ideation); including rumination, planning, attempting, or acting. The phrase 'committed suicide' will not be utilized in this document as the term 'committed' implies criminality, and suicide is not necessarily an unlawful act.

1. THE PROBLEM OF SUICIDE

I. Suicide: A Complex Global Issue

Every suicide that occurs is its own tragedy. The abrupt loss of potential years of life and of future prospects make suicides particularly difficult to accept by those left behind. Each year, more than 800,000 people die by suicide, and many more attempt to end their own lives.[6] Studies show that for each adult who dies by suicide, there can have been

[6] World Health Organization. (2014). p.15.

more than twenty others attempting the same fate.[7] Suicide is a complex crisis that affects all levels of society; including individual, familial, community, provincial, and national groupings.[8] Suicide does not discriminate: it affects people of all ages, sexes, backgrounds, and professions. Suicide risks associated with community include war and disaster, acculturation stresses, discrimination, oppression, and abuse.[9] Risk factors at the individual level include previous suicide attempts, mental illness, alcohol abuse, financial loss, chronic pain, and family history of suicidal behaviour.[10] Regardless of these various risks, people of all walks of life have been touched by suicide. As such, the weightiest questions pertain to the *reason* for suicide: What are the causes of suicide? Why is suicide so prominent in contemporary society? Why are certain age groups and sexes more likely to end their lives than others? Is suicide an impulsive act? Or is it due to some psychological impairment? Indeed, there are countless questions about suicide's haunting prevalence, but few concrete answers.

It is difficult to monitor suicide rates due to harsh stigmatization that exists in most societies. Stigma can be due to religious reasons, sanctity of life principles, and/or biased beliefs regarding strength of character. Stigma can also discourage friends and families of vulnerable persons from providing them with the support that they may need, or even from acknowledging the situation.[11] What's more, suicide is illegal in some countries,

[7] World Health Organization. (2014). p.13.
[8] Ibid.
[9] World Health Organization. (2014). p.10.
[10] Ibid.
[11] World Health Organization. (2014). p.46.

which can intensify stigmatization after the death has occurred. For these reasons, accurate monitoring (and therefore, unobstructed investigation) of the issue is quite challenging. Suicides are highly under-reported and are frequently misclassified as deaths with unclear intent or as accidents.[12]

Another reason as to why it is challenging to monitor and analyze suicide trends is due to the lack of a universally recognized definition of the terms 'suicide', 'suicide attempt', and 'suicidal ideation'. Suicidology is a unique and complex subject that involves the work of professionals in the fields of psychology, philosophy, sociology, anthropology, and medicine, to name a few. Without a consistent definition for principal terminology, professionals in different fields may be appealing to the general topic of self-inflicted death, but will likely place focus on dissimilar aspects of it. Surely, when the phrase 'suicidal ideation' is commonly defined as 'the state of being suicidal', there is much room left for interpretation. For example, a psychiatrist may place the majority of attention on the bio-psychological determinants of decision-making, while a philosopher is more likely to consider the processes of reasoning (i.e. argumentative logic). While the characteristic differences within the sciences and humanities are normally a positive thing (with each field being responsible for bringing its own unique contributions to our overall wealth of knowledge about a particular topic), dissimilar focuses due to definitional obfuscation in this circumstance act as a hindrance, ultimately preventing experts from speaking the same language. With these inherent inconsistencies present in current efforts

[12] World Health Organization. (2014). p.28.

towards standardized diagnosis, treatment, prevention, and research, steadfast action is halted, as fair comparison of data between different areas of expertise is unattainable.[13] Thinking on a larger scale, there is also no international archive or system created with the purpose of examining suicide specifically—without an accurate database, meaningful (and empirically reliable) research is simply not achievable.[14]

All that being said, some basic statistical trends regarding suicide can be identified. For example, international studies have shown that suicide rates are higher in low- and middle-income countries compared to those with higher incomes.[15] Interestingly, in those higher income nations, males are more likely to end their own lives than females. In lower income nations, this ratio between the sexes is much smaller.[16] The annual global rate of suicide is 11.4 persons per 100,000—*one person every forty seconds*.[17] The highest rates of suicide exist in age groups of seventy and above, and the lowest rates are for those under the age of fifteen.[18] While the highest global rates of suicide exist in older populations, young adults are also at a notably high risk and are displaying rapidly growing rates of self-inflicted death. For those aged 15 to 29, suicide is the second leading cause of death, following only motor vehicle accidents.[19]

[13] Silverman, M. (2011). p.21.
[14] Silverman, M. (2011). p.11.
[15] World Health Organization. (2014). p.25.
[16] World Health Organization. (2014). p.28-29.
[17] World Health Organization. (2014). p.23.
[18] World Health Organization. (2014). p.31.
[19] Ibid.

Currently, there are three kinds of strategies that are employed by the World Health Organization (WHO) to combat suicide risk:

> (1) *Universal prevention*, which is meant to reach an entire population, aims to increase general access to health care, promote good mental health, and to limit means of access to suicide.
>
> (2) *Selective prevention* strategies target vulnerable groups of people such as those who have suffered significant trauma, those affected by disaster, or those bereaved by suicide.
>
> (3) *Indicated prevention* strategies target specific vulnerable individuals and aim to provide community support, health care follow-up treatment, education and training for health care workers, and improved management of mental disorders.[20]

The WHO also notes that encouraging strong personal relationships, empowering belief systems, and positive coping strategies also strengthens overall prevention.[21]

II. Suicide and Mental Illness: A Mysterious Relationship

For purposes of clarity, this thesis will focus on suicide, (a) as a result of mental illness; and (b) that has been diagnosed by a qualified mental health professional. It is imperative though, to recognize that this is not the only way that suicides occur. Although there is an undeniable link between the two, having a mental illness is *not* a compulsory criterion for

[20] World Health Organization. (2014). p.10.
[21] Ibid.

committing suicide or for being suicidal (though some folk might disagree).[22] Suicidal behaviour can be both rational and irrational; and many times, it can be difficult to tell the difference between the two. What might seem illogical to one individual could be levelheaded to someone else. This section will address the relationship between mental illness and suicide, and will describe how my analysis of these two phenomena will continue.

The topic of suicide is frequently coupled with that of mental illness, which also experiences a high level of stigmatization. This pairing exists because of the strong belief that a person must be ill or irrational to want to die—a happy, healthy person simply does not think about terminating his or her life. Mental illness is typically viewed as an incapacitating, coercive pressure that disallows rational deliberation to occur, leading to illogical and impulsive choices and actions. Again, while this report will focus only on suicidality that is a result of a mental illness, this is not the only way to be suicidal. Self-selected death can also be the product of coherent, healthy thought, such as with the case of a terminally ill patient requesting assistance with the dying process.[23]

It is questionable, however, whether the dualism of rational and irrational can be so easily made when dealing with the case of suicide. According to what I will refer to as the 'medical model', mental illness is viewed as a dysfunction of the brain that acts as a

[22] Rihmer, Z. (2011). p.60.
[23] Consider the case of Gloria Taylor, a Canadian who was diagnosed with Amyotrophic Lateral Sclerosis (ALS) and became an advocate for the legalization of physician-assisted dying in Canada.

restraint, prohibiting coherent thought and rational decision-making in the affected individual. This removes any possibility of him or her ever making a clear, fully reasoned choice. This view has faced much controversy, as this type of framework homogenizes the effect of mental illness on one's reasoning abilities, and therefore rules out the possibility that someone with a mental illness may be able to reason well in some areas and not in others. Healthcare practitioners often focus on 'fixing' the person's ailment(s) rather than *understanding* his or her situation, which could involve much existential suffering.[24] This type of medical model views suffering as fundamentally physical or corporeal in nature; while psychological suffering is seen as transient and illogical, which can either be strategically reasoned against or treated with psychotropic medication.[25]

Here, we arrive at a version of the mind-body problem: Is the suffering of a depressed patient the direct result of chemical interactions in the brain? Or are the experiences of sadness, hopelessness, and lethargy an emergent property without corresponding, observable brain states? While pain can be tangibly tracked in the brain (via the use of functional magnetic resonance imaging), how do we explain or understand the *experience* of suffering, and what role might this play in treatment practices? Substance dualism implies that two separate substances (the 'mental' and the 'physical') exist independently of one another. However, as Hewitt expertly writes, "The experience of pain is never...exclusively situated in an individual's embodied being; it is better understood as

[24] Hewitt, J. (2013). p.358-365.
[25] Hewitt, J. (2013). p.359.

an interaction between body, mind, and the situation of the whole person".[26] Indeed, the mind-body distinction encourages many people to believe that the two are fundamentally different, that only physical pain is *true* pain, and that psychological illnesses only affect the weak willed. It is these types of dogmatic beliefs that make it so difficult for those with psychiatric disorders to get the help that they need.

One might define *suffering* as the experience of prolonged pain, mental or physical, that degrades one's quality of life over time. The medical model leads physicians and other healthcare providers to focus on the neurological symptoms that patients with mental illness experience (such as chemical imbalances); little to no attention is directed towards the experience of *living* with depression, for example.[27] Again, as Hewitt suggests, a holistic psychosocial perspective can help physicians gain a better understanding of the quality of life of their patients with psychiatric needs, rather than a merely monistic or dualistic view. Something such as a 'Total Pain' perspective ought to be undertaken by clinicians (and society-at-large), in which all contributing levels of pain are taken into consideration: including physical, psychological, spiritual, and social. Thus, it is wrong to exclude all persons with mental illness from the possibility of making rational decisions about their own lives. While some persons are clearly unable to make rational decisions due to severe mental impairment (such as those suffering from paranoid delusions or severe psychotic hallucinations), it *is* possible for those with other types of mental illnesses to think logically and to make fully rational decisions. While some

[26] Hewitt, J. (2013). p.360
[27] Hewitt, J. (2013). p.361.

psychological illnesses affect primary cognitive processes and render the victim unable to make informed inferences or decisions, other mental illnesses feature mostly emotional or volitional ailments, leaving the individual's cognitive faculties relatively unimpaired.[28] [29] As Feinberg puts it:

> "...a mere finding of mental illness is not itself a sufficient ground for exempting a person from responsibility for a given action; nor is it a sufficient ground for finding him not to be a responsible or competent person generally, with the loss of civil rights such a finding necessary entails".[30]

On this account, it could be possible for an individual with bipolar disorder, for example, to determine that her quality of life is no longer enough, and to (rationally) opt for suicide. It is important to recognize, though, that each individual (and also each illness, as well as each patient's experience) will be unique, and may or may not consist of different qualities. It is near impossible to quantify or accurately comprehend another's cognitive experience or perception; and just as this has proven to be a difficult reality for philosophers over past eras, this impenetrable partition[31] of privacy remains problematic in our discussions here.

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[28] Feinberg, J. (1970). p.279.

[29] Here, I am appealing to the notion that there are three distinct faculties of the mind: cognitive, volitional, and emotional. In general, cognitive faculties pertain to one's psychological aptitudes, volitional faculties refer to motivation and action, and emotion acts as a source of regulation for the first two. The distinction and the relationship between these three components is explained further in later sections. See pages 35-36.

[30] Ibid.

[31] This impenetrableness will also be problematic when considering empathy. Persons might experience confusion or worry in terms of their interaction(s) with a person who is suicidal; the experience of suicidality is difficult to imagine if an individual has not experienced it herself.

All that being said, studies have irrefutably shown that having a mental illness increases one's risk of suicide.[32] More than 90% of those who die by suicide have at least one Axis I major mental illness[33], the most common being depression.[34] Suicides instigated by mental illness are unique in the sense that a healthcare provider may have been in the process of treating the underlying psychiatric disorder, or it may have been completely untreated/undiagnosed. It is for this reason that some suicides (if they are even formally ruled as such) come as a shock to the deceased's loved ones. For the purposes of specificity, this report will focus only on suicides related to mental illnesses that are *diagnosed*—the problem of inadequate diagnosis (and therefore limited treatment) in mental health care will not be addressed in the discussions of this thesis.

While the diagnosis of a mental disorder can allow for the commencement of a treatment regimen, it is unclear whether the current techniques for the management of a major depressive episode appropriately address any accompanying suicidality. A 2008 study monitored 103 patients diagnosed with Major Depression (according to DSM criteria) after discharge from hospital for six consecutive months while they received outpatient

[32] Harris, E.C., Barraclough, B. (1997). p.205-228.
[33] Mental illnesses are classified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), created by the American Psychiatric Association. This manual utilizes a multi-axial system to address all aspects of a patient's health, including the primary diagnosis, psychosocial and environmental factors, and other concurrent medical conditions. Axis I, for example, appeals to all psychological diagnostic categories (including depression, anxiety disorders, bipolar disorders, and schizophrenia) except for mental retardation and personality disorders (these are addressed in Axis II).
[34] Rihmer, Z. (2011). p.60.

care, comprised of both psychotropic medication and cognitive psychotherapy. The findings of this study are attention-grabbing—fifty-five percent of these patients reported the *new emergence* of suicidal ideation post-discharge, with seventy-nine percent of these individuals reporting this new phenomenon within the first two months outside of hospital.[35] Also, seventy percent of participants who reported experiencing suicidal ideation prior to hospitalization reported the re-emergence of ideation following their discharge.[36] As Gaudiano, Andover, and Miller (2008) state:

> "The goal of modern psychiatric hospitalization is to achieve psychiatric stabilization and safety prior to discharge, not episode remission or functional recovery. However...patients leaving the hospital with ongoing, significant depressive symptomology appear to be at increased risk for SI+ [increased suicidal ideation], as well as subsequent rehospitalizations".[37]

Just as other symptoms (such as decreased motivation and weight gain) will return with future depressive episodes, suicidal ideation, once experienced, is also very likely to recur.[38] Studies like this tell us that our current medical interventions for mental health crises are somehow 'missing the mark' in the combat against persistent suicidal ideation and behaviour.

Similarly, a 1999 British study that looked into suicides of persons who had been in contact with mental health services prior to their death, or had been hospitalized for

[35] Gaudiano, Andover, & Miller. (2008). p.546-547.
[36] Gaudiano, Andover, & Miller. (2008). p.547.
[37] Ibid.
[38] Gaudiano, Andover, & Miller. (2008). p.540.

mental health reasons prior to their death, found that many healthcare programs failed to identify high-risk individuals—24% (over 1000 patients) had been in contact with mental health services prior to their eventual suicide. What's more worrisome is that *half* of these patients were in contact with mental health services only a week prior to their death.[39] The trend is similar for patients who were discharged from inpatient treatment: after discharge, 41% of deaths occurred before the first follow-up appointment. During the first week post-discharge, the highest number of deaths occurred on the day after leaving the treatment facility.[40] These shocking numbers tell us one thing: we must increase awareness and improve the detection and treatment of suicidality in cases of severe mental illness. Only when we are able to identify and care for individuals in the mental health system that are at a high risk of suicide will we start to see a decline in the number of self-inflicted deaths, prior to and post treatment.

Factors that have been known to increase an individual's risk of suicide include childhood hardship, sex/gender, personality characteristics, first-hand experience of a suicidal peer, and mental health problems (such as depression or anxiety).[41] Previous attempts of suicide may also cause an individual to be more likely to resort to suicide as a solution to future adversity. In a 2013 study, it was found that teens with a previous suicide attempt, or who experience suicidal ideation, were more likely than non-suicidal adolescents to believe that anyone could commit suicide, and were more likely to relate adverse life

[39] Kerkhof, JFM. (1999). p.98-99.
[40] Ibid.
[41] Lake, A., Kandasamy, S., Kleinman, M., Gould, M. (2013). p.692-703.

events to suicide.[42] Interestingly, this group of teens was also much less likely to associate suicide with severe mental illness. Results for students with depression and those who had first-hand experience with a suicidal peer were similar.

Professor of psychiatry and psychotherapy Zoltán Rihmer identifies the four different types of risk factors of suicide associated with depressive disorders in the *International Handbook of Suicide Prevention: Research, Policy, and Practice* (2011)[43]:

Clinically Detectable Suicide Risk Factors in Depressive Disorders

1) <u>Risk factors related to current mood episodes:</u>

(a) Severe major depressive episode
- Current suicide attempt, plan, or ideation
- Hopelessness, guilt, pessimism, few reasons for living
- Agitation, depressive mixed state, insomnia, weight loss
- Atypical and psychotic features
- Past mania or hypomania (Bipolar I or II diagnosis)
- Comorbid Axis I (substance use/anxiety) disorders, alcohol use
- Comorbid Axis II and Axis III disorders
- Lacking medical care and familial/social support

(b) Mixed affective episode (simultaneous major depressive episode and three or more co-existing manic symptoms)

(c) Dysphoric mania (simultaneous manic episode and three or more depressive symptoms)

2) <u>Risk factors related to prior course of depressive disorder:</u>
- Previous suicide attempts/ideation
- Early onset/early stage of illness; predominantly depressive course
- Rapid cycling course

[42] Ibid.
[43] Rihmer, Z. (2011). p.66.

3) Risk factors related to personality features:

- Aggressive/impulsive/pessimistic personality traits
- Cyclothymic, depressive, irritable temperament

4) Risk factors related to personal history and/or family history:

- Early childhood traumas (separation, emotional/physical/sexual abuse)
- Adverse life conditions (unemployment, isolation, medical conditions)
- Acute psychosocial stressors (loss events, financial catastrophe)
- Family history of suicide and/or suicide attempt (first- and/or second-degree relatives)
- Family history of depressive or bipolar disorders (first- and/or second-degree relatives)

The relationship between mental illness and suicidal behaviour is undeniable—mental illnesses affect individuals' emotions, thoughts, and conceptions of reality. When these essential components of self-awareness become distorted or tainted, they can have a severe impact on how one might act.

i. Major Depression and Suicide

Unipolar Depression, or Major Depressive Disorder (MDD), is widely recognized as the most concerning clinical condition in terms of psychological health and suicide risk. Melancholic (severe) depressive episodes are often comprised of feelings of overwhelming guilt, hopelessness (often associated with few reasons for living), suicidal ideation (including specific plan-making), weight loss, insomnia, and agitation. Studies show that suicidal behaviour (both attempts and completed acts) and ideation in persons with psychiatric illnesses occur nearly exclusively during one of these types of episodes.[44] But this is not all, as depression also manifests itself in *bipolar* form, featuring

[44] Rihmer, Z. (2011). p.62.

plummeting falls from abnormal emotional highs. Studies have shown that bipolar 'mixed episodes' (often referred to as 'agitated depression'), which are comprised of the traditional elements of a major depressive episode *plus* three or more co-occurring hypomanic[45] symptoms, also significantly increase one's risk of suicide.[46] This second type of severe psychological state offers an explanation for suicidality that has been documented in patients who are deemed to not be experiencing a major depressive episode.[47]

Nevertheless, many people who have been diagnosed with bipolar or unipolar depression, and who consequently experience the associated symptoms, never end their own lives (or even make an attempt to do so). This means that there must be some other element(s) that are contributing to an individual's potential suicidality. A few of these can include one's personality, socioeconomic position, familial and social relationships, and psychosocial status.[48] For example, the existence of comorbid disorders, such as substance abuse, anxiety disorders, personality disorders, or chronic physical illness, increase one's risk of suicide.[49] It has also been found that the level of familial support the patient receives and the quality of care during the first few days of therapy (when antidepressant or mood

[45] Hypomania is a component of Bipolar Disorder (Type II) that features symptoms including lack of need for sleep, racing thoughts and ideas, pressure to speak or keep speaking, increased agitation, and/or impulsivity.
[46] Rihmer, Z. (2011). p.63.
[47] Ibid.
[48] Rihmer, Z. (2011). p.62.
[49] Rihmer, Z. (2011). p.63.

stabilizing medications do not yet work[50]) are integral factors as to how a patient may recover.[51]

The risk of recurrence of suicidal thoughts in those who have experienced two or more major depressive episodes is as high as ninety percent.[52] A 2006 study followed sixty-nine participants with a diagnosis of Major Depression and a history of at least two episodes over the last five years. Out of the sixty-nine individuals, thirty-eight (55%) reported a reappearance of suicidal thoughts during follow-up consultations.[53] These results display evidence of cross-episode consistency in the reappearance of suicidal ideation, which is in-line with the newly popular Differential Activation Theory (DAT). DAT proposes that during a depressive episode, a neurological 'link' is formed between low mood and negative beliefs. With each subsequent episode, this connection is strengthened, resulting in even small occurrences of sadness gaining the ability to trigger robust depressogenic thinking patterns.[54] Consideration of DAT is important for our discussions of suicidal ideation because of the already high recurrence rate of rumination. In regards to this, Williams, Crane, Barnhofer, Van der Does, and Segal (2006) claim that:

> "Suicidal ideation represents an extremely severe form of negative self-referent thinking, whereas many other diagnostic symptoms of depression (e.g. appetite

[50] See pages 24-25 for more information about the unavoidable 'waiting periods' associated with antidepressant medications.
[51] Rihmer, Z. (2011). p.62-63.
[52] Williams, J., Crane, C., Barnhofer, T., Van der Does A., & Segal, Z. (2006). p.189.
[53] Williams, J., Crane, C., Barnhofer, T., Van der Does A., & Segal, Z. (2006). p.191.
[54] Williams, J., Crane, C., Barnhofer, T., Van der Does A., & Segal, Z. (2006). p.189.

disturbance, sleep disturbance, psychomotor agitation or retardation) are less cognitive in nature".[55]

Once an individual has experienced suicidal ideation, it is highly probable that they will experience it again. In fact, suicidal ideation has been found to be the sole symptom of depression to remain persistently connected across episodes—once manifested, it is extremely likely to reoccur.[56]

ii. Prevention and Protection Strategies

While there has been much research done regarding the various risks of suicide, there are few studies that focus solely on potential protective dynamics. Presently, factors that are known to deter suicidal behaviour include:

(1) Solid familial/social support;

(2) Pregnancy and the postpartum period;

(3) Having a large number of children and/or dependents;

(4) Holding strong religious beliefs that condemn self-inflicted death; and

(5) Broad restriction of lethal suicide methods (such as increased gun control, for example).[57]

Regarding MDD symptomology specifically, only improved appetite, weight gain, and hypersomnia appear to be associated with decreased suicide risk.[58] Notice that all of these things are indicative of depression remission.[59] [60]

[55] Williams, J., Crane, C., Barnhofer, T., Van der Does A., & Segal, Z. (2006). p.190.
[56] Williams, J., Crane, C., Barnhofer, T., Van der Does A., & Segal, Z. (2006). p.193.
[57] Rihmer, Z. (2011). p.66.

Over time, the most successful treatment of suicidal behaviour has proved to be acute, long-term pharmacological treatment—use of antidepressant and mood stabilizer medications has demonstrated a noticeable decline in all forms of suicidal behaviour.[61] In fact, intercontinental studies show increased suicide rates in countries where antidepressant usage has lowered, while nations where use of antidepressants has increased have witnessed a marked decrease in suicide rates.[62] Lithium has long been known as the 'go-to' medication when a patient's suicidal ideation is of concern. Studies dating back to 1972 have shown statistically significant differences in 'on-Lithium' and 'off-Lithium' behaviour.[63] Although it is an older medication, Lithium has been shown to possess greater 'anti-suicide' efficacy when compared to newer mood stabilizer drugs,

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[58] Rihmer, Z. (2011). p.66.

[59] Does this mean that if MDD symptoms are alleviated, suicidal ideation will also disappear? There is an obvious causal connection between the two. Perhaps the two lessen (and worsen) in tandem, but queries regarding remission (of either issue; whether considered individually or together) involve complexity that extends beyond relational tendencies.

[60] Further, it is also disputed as to whether 'true' remission from mental illness is actually possible or not. Critics might suggest that engrained neurobiological pathways associated with frequent depressogenic thinking disallow remission to actually occur, further marking psychiatric illnesses as dissimilar from manifestations of physical illness where there can be a distinctive 'break' from symptoms. Although this is a valuable question, I will not be directly addressing concerns regarding the possibility of total remission for mental illnesses in this thesis, as my objective here is to discuss making improvements to psychiatric care plans for those experiencing suicidal ideation, regardless of whether that leads to an enduring disappearance of symptoms or not (although I am hopeful that it will). With that being said, I will continue with the general assumption that at least partial remission (for both MDD and for suicidal ideation, considered either in duo or individually) is a possibility, and that getting as close to remission as we can ought to be our primary goal.

[61] Rihmer, Z. (2011). p.65-66.

[62] Rihmer, Z. (2011). p.68.

[63] Müller-Oerlinghausen, B., Felber, W., Berghöfer, A., Lauterbach, E., & Ahrens, B. (2005). p.309.

such as Divalproex (Depakote ®), although this varies among patients.[64] Long term Lithium use has also displayed evidence of increased grey matter in the brain and increased neuronal function—these changes may counteract any decreased neurogenesis (most notably in the limbic system, which deals primarily with emotion regulation) that might exist due to chronic stress associated with a mood disorder.[65] Ultimately, Lithium has been known to have profound Serotonin-agonistic effects[66], in addition to its well-established anti-aggressive and anti-suicidal capacities.[67]

However, medication-based treatment is far from an ideal or comprehensive solution. In terms of potential barriers to effective pharmacological care, there are three of most concern:

(1) Patient compliance: If a patient neglects to or refuses to take their medication as prescribed, it is likely that the pharmacological intervention will not be successful (or may display only partial results). Medications must be taken each day at the same time to be most effective. Moreover, initial dosages of antidepressant and mood stabilizer medications must be increased gradually until one reaches the desired therapeutic level, in order to allow the body to adapt to chemical changes. Because of this, pharmacological intervention

[64] Howland, R. (2007). p.15.
[65] Howland, R. (2007). p.14-15.
[66] Medications that are 'Serotonin-agonistic' activate Serotonin receptors in the brain. These are the opposite of 'Serotonin-antagonists', which inhibit the action of Serotonin receptors (antipsychotics are an example of this, as they are used to reduce chemicals responsible for hallucinations).
[67] Müller-Oerlinghausen, B., Felber, W., Berghöfer, A., Lauterbach, E., & Ahrens, B. (2005). p.313.

takes a number of weeks to begin to demonstrate efficacy, and this mandatory waiting period will likely be discouraging for patients who require immediate assistance (especially those who are experiencing severe suicidal ideation). Additionally, once an individual begins to feel better after reaching the therapeutic level of medication, they may become less motivated to continue to take their medication on a regular basis.[68]

(2) Atypical or complex forms of disorder: While the majority of patients who present with mental health concerns will fit into the criteria of a particular illness or disorder, there are some cases that simply do not. Some patients will express differential symptoms, making diagnosis unclear. For example, patients who display symptoms of agitation and restlessness that seem to fit the criteria of Major Depressive Disorder may actually be associated with a lesser degree of mania, making the correct diagnosis Bipolar Disorder, not MDD. The difference between diagnoses is significant, as each illness requires a distinctive treatment focus. It is also possible that a patient may fit the criteria of multiple different disorders, or might have a variety of concurrent illnesses that complicate treatment options. What's more, some patients will fail to respond to prescribed medication(s) altogether, making next steps challenging. In these types of cases, additional intervention will be required, which can include adjunct non-pharmacological treatment (such as 'talk' therapies [e.g. Cognitive Behavioural Therapy or Dialectical Behavioural

[68] This trend is not specific to psychiatric illnesses—it affects all types of ailments and medication use.

Therapy {see Section 4 for more on these types of treatment}] or more invasive interventions such as electroconvulsive 'shock' therapy), or additional pharmacological intervention, which can include the addition of a drug from the same class (such as an SSRI antidepressant) or a different one (such as a mood stabilizer or antipsychotic). Furthermore, it is important to note that in a small population of patients, antidepressant medications can exacerbate depression symptoms and therefore induce thoughts of suicide.

(3) Potential lethality: Lastly, and perhaps of greatest concern, psychotropic medications (Lithium in particular) have the potential to be lethal in the event of an overdose.[69] For this reason, providing this particular type of medication to an individual who has expressed suicidal ideation and depressed mood can be worrisome. Physicians must be careful to assess the patient's mental state prior to prescribing, and should be in close contact with the patient while he or she is taking this medication—especially during the first few weeks of treatment, when the medication will not have yet gained effectiveness.

While pharmacological intervention has proven to be the most effective treatment option over time, there are some significant limitations that fail to address all pertinent aspects of suicidality. Therefore, additional forms of treatment and prevention must be explored.

[69] It is possible for psychotropic medications other than Lithium to also be lethal when taken in excess, especially when taken in excess in addition to other medications.

Recently, some jurisdictions have introduced training programs for General Practitioners that focus on the identification and treatment of mental illnesses.[70] These programs will help to align the various clinical definitions that might exist outside of psychiatric specialties and increase awareness about the symptomology of common mental health problems. Patients are in contact with their family physician most frequently (compared to other healthcare providers), so this extra training provides a better opportunity for subtle, initial signs of illness to be recognized and addressed. However, while this approach helps care providers to better understand and identify changes or possible impairment to the mental health of their patients, they are only able to provide care for those who actively and productively *seek it out*. Doing so can seem like an impossible task for persons suffering from depressed mood, little motivation, and crippling hopelessness. If familial or social support is not present or persistent, many persons in need of help will not receive it, and thus will face an increased risk of developing suicidal ideation.

To this point, many scholars have pointed towards the important role that media and advertising could play here, in regards to putting the message out for persons who might be suffering alone as to how they can go about getting assistance. Billboards, television commercials, magazine advertisements, web advertisements, and posters all aid in raising overall awareness of the public health issue, and spreading information regarding where individuals can go to seek help—either for a friend or a loved one, or for oneself.

[70] Rihmer, Z. (2011). p.67.

However, again, the experience of major depression can be so overwhelming and debilitating that it is possible that some sufferers (likely those with more severe symptoms, who are already experiencing suicidal thoughts) will not reach out for help, no matter how persuasive the adverts might seem to be. Advertisements concerning the accessibility of mental health care will likely assist those who are experiencing the initial signs and symptoms of a depressive mental illness, but it seems that these forms of contact are rendered mostly inept when one is in the grips of a major depressive episode—therefore, while these endeavours may be helpful in terms of raising awareness about general topics pertaining to mental health, these avenues fail to effectively reach those who are particularly vulnerable and at an elevated risk of suicide.

Based on this discussion, it is clear that although current care practices are making ground on combatting recurrent instances of suicidal ideation in patients who are coping with severe depressive psychological illnesses, there is still much to improve on. There are two main features that are needed to begin this process of care expansion:

(1) Effective method(s) of reaching out to (and making direct contact with) those suffering from a depressive mental illness and accompanying suicidal ideation that will:

    a. Adequately reach the appropriate intended audiences (This should include families, friends, and most importantly, those personally experiencing psychological distress); and

b. Compel those who are suffering to actively seek help from qualified professionals, even in the midst of what might feel like immobilizing hopelessness.

(2) Innovative and effective method(s) of treatment for suicidal ideation associated with psychological suffering that will:

a. Complement already-efficacious pharmacological intervention options;

b. Ameliorate or compensate for undesirable characteristics that are associated with traditional medical intervention techniques (such as unavoidable medication efficacy waiting periods); and

c. Place focus and value on the patient's unique inclusive wellbeing (That is, comprising of equal attention to and respect for one's psychological, corporeal, and spiritual welfare).

Both public outreach and direct treatment practices are integral to combatting the crisis of suicide, however for the purposes of this report, I will be focusing on the second component of these needs; the first bunch of necessities are associated with public health outreach rather than direct care routines and ought to be investigated exclusively.[71] In the following section, I will change my focus to discuss the self and the inherently relational nature of self-trust in detail. This will provide an introduction as to how we might be able to use inter/intrapersonal skills to improve a patient's preparedness for therapeutic practices. I will review contemporary theories of the self and its development, and the specific role that trust plays in shaping one's conception of his or her self and her beliefs

[71] See other suggestions for future research directions in Section 4.II.

about the external world. Then, in Section 3, I will evaluate and compare the information presented in Sections 1 and 2; examining the connection between suicidal ideation and self-trust in relation to the present care needs outlined here. Finally, in Section 4, I will discuss how we can use self-trust skills development strategies to supplement current psychiatric treatment programs and to improve our readiness to tackle the sinister issue of contemporary suicide.

2. THE SELF, SELF-TRUST, AND AUTONOMY

I. Agency and the Self

In this report, discussions of agency and the self will rely primarily on accounts offered by Diana Meyers, Susan Sherwin and Carolyn McLeod, and Trudy Govier. I will discuss each throughout Sections 2.I-2.II prior to presenting an inclusive account of self-trust that reflects their insights. These three accounts of the self relate directly to one's level of personal autonomy, which pertains to individuals being able to act according to their own values and/or wishes.[72] So acting requires individuals to possess the strength and resiliency to not allow external forces to displace his or her grasp on control.[73] Meyers describes this as "autonomy competency": the collections of skills that empower a person

[72] Personal autonomy differs from other types of autonomy (such as moral, legal, or political). From this point further, when I use the term 'autonomy', I will be referring to *personal* autonomy; I will specify when referring to autonomies of other sorts.

[73] Note that it is not just social influences that can undermine one's autonomy; Meyers rightly explains that even if we were to conceive of a self that is free of all social influences, it is still possible that some inner qualities that are inherently oppositional to one another could exist and lead to dissonance and/or existential distress.

to discover, define, and direct his or her self.[74] Aspects of one's cognitive faculties that aid in this "self-reading process" include memory, imagination, verbal communication, and reason.[75] These capacities work together to form an accurate 'self-portrait', which individuals use to assess their role and relationship with the surrounding external world.[76] Meyers explains:

> "Just as moral autonomy would be unintelligible without criteria of correct judgment, personal autonomy requires a touchstone. That touchstone is the unique authentic self". [77]

In order to be able to be an autonomous agent, having a solid understanding of your 'self' and your relation to your surroundings is crucial. Thus, in regards to descriptions of the self, autonomy is not the same as free will[78]; and as Meyers has shown, there is much more at play here.

The ventures of self-discovery, self-definition, and self-direction are all interrelated, and work together to constitute what Meyers refers to as "*the authentic self*": the always-evolving assemblage of traits that emerges when a person exercises autonomy

[74] Meyers, D. (1987). p.76.
[75] Meyers, D. (1987). p.79.
[76] It is important to recognize that an individual's self-portrait is a fluid concept—it continuously evolves as one learns more about their self and their environment.
[77] Meyers, D. (2008). p.19.
[78] Free will and autonomy are similar in the sense that they both refer to one's capability to make choices, but they differ in one main aspect: autonomy requires one to be the *initiator* of her actions, while free will simply refers to her ability to choose between available options.

competency.[79] Self-discovery, which develops from interactions with novel stimuli and one's reactions to them, leads to self-definition. This cumulative self-definition affords a level of regulation (and a sense of tangibility) to one's autonomy.[80] This continuous process of *decision-action-control* allows people to exert power over the direction of their own lives, simply by doing what they want to do. Obviously, this is not always possible due to unanticipated obstacles that life often throws our way, or because of other circumstances that may either support or impede one's progress on his or her personal endeavors. While autonomy and self-trust both refer primarily to the individual, our autonomy (and, in effect, our level of confidence in our abilities as an agent deserving of trust) is *relational* insofar as it is bound by our external world and our beliefs regarding the potential role(s) we can play in it. Here, it is useful to recall Govier's discussion of the way that an individual's beliefs regarding her external world (which are created in light of coercive influences she faces) will shape the attitudes she has regarding her level of confidence in her ability to act in her own best interests. While faith in one's abilities refers to a particular individual's assessment of her level of competency and confidence, the relational basis of self-trust holds significant authority over her overall ability to self-determine, as the opportunities that she is afforded with will only exist in accordance with what her external world warrants. Thus, as far as people are able to align their actions with their developing conceptual selves (within the realistic constraints associated with living an imperfect life), they are able to exercise as much power over their own lives as

[79] Meyers, D. (1987). p.76.
[80] Meyers, D. (2008). p.44.

is possible.[81] This understanding of oneself and one's autonomous capabilities enables individuals to construct prospective 'life plans'—comprehensive projections of intent for one's future.[82] [83] While our plans might be created with the best of intentions, these prospective targets are far from concrete. Meyers describes:

> "Life plans should not be pictured as complicated, highly detailed flow charts spanning a lifetime. Rather, a life plan is a largely schematic, partially articulated, vision of a worthwhile life that is suitable for a particular individual".[84]

Viewing autonomy as an aspect of self-determination and as a competency allows us to understand the self as a fluid and relational entity with unique aspirations, desires, and needs. It is from these evolving understandings of our selves as dynamic agents that we can develop an internal sense of personalized trust.

i. Self-Trust and The Autonomous Agent

Self-trust refers to the level of faith in one's own capacity to accomplish a perceived task; it involves flexibility towards solving a particular problem at hand, and evident determination regarding the need for a solution.[85] In 1987, psychologist W.L. Earl referred to self-trust as "...a private and essential part of the self-identity the individual

[81] Meyers, D. (2008). p.46.
[82] Meyers, D. (2008). p.49.
[83] As self-trust is relational based on the beliefs one holds regarding his or her relationship with their environment, it follows that one's life plan(s) must possess a sense of realism due to the external constraints that he or she perceives. The role of reality, as it pertains to our discussion of self-trust, will be addressed further in Section 3.II.
[84] Meyers, D. (2008). p.51.
[85] Earl, W. (1987). p.421.

experiences."[86] While this is true, as we have determined, self-trust is also inherently relational, and thus an individual's evaluations of her capacities will inevitably be influenced by the beliefs she holds regarding her relationship to the external world.[87] Based on this, self-trust can be considered as being similar to one's sense of self-efficacy regarding the expectations of a particular outcome following active involvement in some type of event.[88] Interestingly, it has been demonstrated that the 'personal' elements associated with self-trust (such as one's assessment of his or her own capabilities) play a constructive role regarding an individual's overall degree of motivation—one psychological study displayed considerable evidence in support of the notion that individuals who have high levels of self-trust possess superior creativity skills, and can remain focused on personal projects until they achieve at least some level of success.[89] This amplified sense of ingenuity associated with strong self-trust supports individuals when exercising personal autonomy, by encouraging them to find unique ways to act and achieve desirable consequences, even within the constraints of his or her environment. Based on this discussion, it seems that Earl's primarily psychological description of self-trust touches upon and offers support for some of the main themes of relational autonomy (and thus relational self-trust) that have been outlined by Meyers. This relational view of self-trust is also supported by McLeod and Sherwin (2000), who state:

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[86] Ibid.
[87] These beliefs will unavoidably be shaped by various potential sources of coercion that might be present. The individual might be aware of these sources of influence, but it is also possible that she might not identify some of the foundations of the limitations she perceives and experiences.
[88] Earl, W. (1987). p.422.
[89] Earl, W. (1987). p.423.

> "Exercising autonomy involves, in part, reflecting on one's beliefs, values, and desires; making reasonable decisions in light of them; and acting on those decisions. It is essential in developing the capacity to be autonomous that the agent trusts her capacity to make appropriate choices, given her beliefs, desires, and values; that she trusts her ability to act on her decisions; and also that she trusts the judgments she makes that underlie those decisions...Without trust in these judgments and trust overall in her ability to exercise choice effectively, any agent would have little motivation to deliberate on alternative courses of action."[90]

Our environment, and more importantly, our perception of our role in relation to it, will ultimately determine whether or not we deem ourselves to be trustworthy in the various situations we come to face.

Self-trust differs from similar phenomena such as self-acceptance, self-understanding, and self-respect insofar as it pertains to one's level of confidence in her abilities. For example, self-acceptance refers to one's satisfaction and approval of herself and her own uniqueness. Self-understanding refers to one's self-concept[91], and the awareness of her own thoughts and actions. Lastly, and perhaps most closely related to self-trust, self-respect refers to the level of esteem that an individual holds herself to, and what she believes she deserves from herself and from others. Each of these phenomena is associated with value and competency judgments regarding oneself, but self-trust differs in the sense that it involves *both* cognitive and volitional faculties, rather than just the former insofar as it is directly linked to autonomous *action* and evaluations of one's self-advocatory success. When pursuing autonomous activities, these faculties are activated and culminate in judgments of the appropriateness of the agent and of the activity in

[90] McLeod, C. & Sherwin, S. (2000). p.262-263.
[91] Self-concept refers to how one perceives himself or herself.

question. Cognitive capacities include psychological aptitudes such as attention, reason, information processing, memory, and response inhibition. Volitional faculties, on the other hand, refer to capacities such as motivation and will.[92] Because both of these faculties are associated with the development and maintenance of self-trust, they are also both possible sites of a *lack* of self-trust. Low levels of self-trust will negatively influence each of the capacities associated with both cognitive and volitional faculties. In addition, one's emotional state further influences the relationship between and the general efficacy of one's cognitive and volitional faculties (and an individual's operative ability in terms of the associated skills), as symptoms of emotion deregulation associated with mental illness will intensify the negative effects of low self-trust. For example, in regards to cognitive capacities, one's response inhibition will be lessened and he or she may act impulsively in reaction to strong emotion, her memory and attention could become focused on past failures (leading to amplified negative rumination), and general information processing will be slower due to a high cognitive load. The same goes for volitional skills—if there is little self-trust, one will not be motivated to act (or it will take much more effort to complete small tasks) in ways that appeal to her best interests, and will be unlikely to have realistic intentions or objectives. It is no doubt that symptoms of depression, such as apathy and a decreased sense of one's inherent value, will exacerbate these limitations. Generally speaking, low levels of self-trust inclusively bog down one's

[92] 'Will', in the philosophical sense, refers to the component of the mind that motivates an individual towards a particular choice when making decisions.

mental processes, and each of these points relate directly to adverse psychological symptoms associated with mental illness.[93] [94]

If there happens to be too little self-trust (or too much self-distrust) in the construction of the self, one's personal autonomy will be compromised. The significance of trust is important because our autonomy is fundamentally *social* in nature.[95] It is necessary to view our autonomy as relational because of the fact that the levels of oppression (such as ignorance, marginalization, or exploitation) that we inevitably face are social as well. Because self-trust is undermined by oppression, oppression also reduces an agent's ability to act autonomously.[96] There are a few ways in which oppression does this: First, oppression may (and in fact, tends to) deprive individuals of the capability to develop and utilize skills that are necessary for exercising autonomy. This is related to Meyers' discussion of autonomy competency, insofar as autonomous action is severely hindered if one is not given the opportunity to develop the relevant skills. In addition, oppression can deny agents the opportunity to develop a level of self-trust that allows them to use these skills in an effectual manner. This will disrupt their beliefs about the external world and in effect, their overall life plans. Lastly, the experience of prolonged oppression can lead

[93] The relationship between self-trust and mental illness is explained in detail in Section 4.
[94] For more information on how emotional affect influences volitional and cognitive capacities, see Robinson et al.'s 2015 study on the role of 'hot' and 'cold' cognition in abnormal psychology.
[95] McLeod, C. & Sherwin, S. (2000). p.259.
[96] McLeod, C. & Sherwin, S. (2000). p.261.

to the formation of a feeling of worthlessness or ineptitude, which eventually leads to an overall sense of self-distrust.[97]

From a prototypical point of view, 'trust' is usually considered as existing between two individuals and thus, interpersonal conceptions of trust (such as the child-parent relationship) fit the dominant prototype. Depending on the attributes of the characters involved and the situation at hand, different features of the relationship will be important to different persons. Each dependent party is reliant on the other's competence, just as in how a patient will be reliant on his surgeon's skill in the operating room.[98] If optimism about the other's competence or motivation were to lessen, trust would lessen as well. Certainly, if a patient begins to doubt his surgeon's proficiency, his overall confidence in her would quickly disappear. In many cases, *trusters* are vulnerable insofar as they have limited means by which they can measure the competence of those they trust.[99] We usually recognize that certain individuals are not proficient at everything, and in fact, will likely have some shortcomings that render them *untrustworthy* in certain scenarios. Further, our trust is often related to motivation—we trust individuals to have the ability to do what we trust them to do, but also to have the appropriate level of ambition to do it.[100]

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[97] McLeod, C. & Sherwin, S. (2000). p.262.
[98] McLeod, C. (2002). p.17.
[99] For example, I trust my accountant to make good judgment calls in areas that I know comparatively less about. That being said, my trust in her is limited to decisions and actions pertaining to my finances. It is not likely that I would trust my accountant to teach me rhythmic gymnastics.
[100] McLeod, C. (2002). p.20.

As McLeod contends, this requirement of suitable intention makes trust distinct from mere reliance.[101]

Govier makes similar claims regarding the relationship between self-trust and autonomy, but she also mentions that having absolute self-trust should not be striven for, as this can lead to rigidity.[102] Thus, we ought to strive for *reasonable* self-trust, which requires "...an honest and balanced appraisal of our motives, abilities, and actions, one that takes into account the responses of friends, family, and colleagues".[103] Based on this, the concept of reasonable self-trust is wholly relational, insofar as our assessment of our trustworthiness is determined by our interactions with other persons and with our environment. Sources of reasonable self-trust include a secure emotional upbringing, well-developed critical thinking skills, and positive feedback from loved ones.[104] The most important source of self-trust development, says Govier, is the use of empathy—the acknowledgement of feelings and thoughts of the individual and her situation. By not having other persons discredit or downplay her insights, she will feel validated and will eventually believe that she is an agent worthy of trust.[105] When self-trust is present, agents are more responsive

[101] Ibid.
[102] Govier, T. (1998). p.98.
[103] Ibid.
[104] Govier makes the interesting point that positive feedback from others will help individuals develop trust in their thoughts and actions, but feedback from persons who are not related by blood will likely prove to be better in the long run. This is because praise from family members could be shrugged off as being quasi-obligatory (1998, p.103-104).
[105] Govier, T. (1998). p.104.

to new stimuli and are more confident in their decision-making abilities. In addition, he or she will remain hopeful for future opportunities and successes.[106]

The nature of self-trust is quite similar to prototypical and peripheral accounts of trust that persons have towards other individuals and vice versa. Both are influenced by external oppressive forces, both depend heavily on the trusted agent's intentions and expertise, and both influence the truster's autonomous capacities (either positively or negatively). The distinction between the two, however, is based on much more than just the obvious difference in the number of agents involved. Self-trust differs from interpersonal trust insofar as it affects the individual's rudimentary, existential understanding of herself and her abilities as an embodied being. If she does not possess strong self-trust[107], she will not be able to successfully act in her own best interests, as she will not be able to appropriately determine what they are, exactly.

II. Self-Trust, Confidence, and Decision-Making

In order to make (and ultimately act on) a decision, an individual must rely on: (1) his or her cognitive, volitional, and emotional capacities, (2) the extent of information that they are provided with to make their choices, and (3) the sources of their information. Each of these things will determine whether the action is possible, whether the action that the agent intends is the action (and outcome) that actually occurs, and how confident the agent feels in regards to his or her choice and subsequent action(s). The more

[106] Govier, T. (1998). p.205.
[107] Potential reasons for this could include external coercion and/or internal distress.

successful[108] choices and actions that an individual makes, the more robust their overall sense of self-trust will become.[109]

Psychological studies have also displayed this trend. For example, a 2015 study on metacognition looked at how subjects were able to make a choice between several alternatives, and how confident they felt in their decision. This type of ability is critical in choosing whether to act immediately on a decision or to continue gathering relevant information. It also relates to the choice individuals must make regarding whether to update one's personal model of the world with newly acquired information or not.[110] In this study, researchers evaluated what they refer to as 'confidence leak'—the way in which observers use their subjective certainty in previous judgments to predict the correctness of their future decisions.[111] In four out of four experiments, confidence 'leaked' between the judgment tasks of subjects: first, between two different types of stimuli, and then again over time during equivalent tasks.[112] These findings display the brain's attempt to use previous information to interpret novel stimuli. If we are consistently given the opportunity to leak confidence into our decisions from similar previous choices, we will experience higher levels of confidence in our current decision-

[108] Here I refer to a 'successful action' as an action in which the consequence that was originally intended by the agent ensues.
[109] Govier, T. (1998). p.103. Govier also comments that while these experiences of 'success' are important, they are not the only factors that will influence an individual's development of self-trust. For example, another potential source of self-trust includes a supportive family background, with an emotionally secure upbringing that encourages the formation of one's sense of identity as a loved and valued person.
[110] Rahnev, D., Koizumi, A., McCurdy, L., D'Esposito, M. & Lau, H. (2015). p.1664.
[111] Rahnev, D., Koizumi, A., McCurdy, L., D'Esposito, M. & Lau, H. (2015). p.1665.
[112] Rahnev, D., Koizumi, A., McCurdy, L., D'Esposito, M. & Lau, H. (2015). p.1676.

making abilities. The more confident we feel in our capabilities, the more self-trust we will possess in regard to each situation we face.

All that being said, regardless of whether all of these things are present, if forms of oppression have conditioned an individual to possess low expectations of their decision making capabilities, she will consistently feel pessimistic about her autonomous capacities and her level of trust in herself will suffer.[113] Even if he or she has been successful in the past at making good decisions and acting appropriately, they might interpret those instances as mere coincidences. Self-trust requires persons to have well-developed and adaptive understandings of themselves, in addition to the ability to act in what they determine to be their best interests (i.e. his or her autonomous capacity). But, as previous metaphysical investigations have displayed in the past, appropriately determining what our true 'best interests' are is a complex matter—this will differ among persons based on one's goals, circumstances, and personality traits. How are we to know that we are deciding and acting in ways that best serve us? It seems easy to trust one's inner dialogues, ruminations, and logic, but what if this trust is wrongly attributed and applied? How might we recognize judgment errors when they occur[114], and how might we make a change to account for this? These questions are especially pressing when suicidal ideation is a coexisting concern.

[113] McLeod, C. (2002). p.114.
[114] Here I am working on the assumption that it is possible to appropriately recognize instances of wrongly attributed trust to oneself. This does not mean, however, that all individuals are capable of doing this.

3. SELF-TRUST AND SUICIDAL IDEATION

I. The Suicidal Self

So far, we have discussed the current realities of the suicide crisis; including factors that increase one's risk of suicide and contemporary treatment options that are being used to combat it. We have also discussed the relational nature of the human self, and how the introspective concept of self-trust shapes our understandings of both our selves, and our relation to our external environment. In this section, I will examine how these two constructs relate to and influence one another, and will address how they relate to the present needs of psychiatric crisis intervention and mental health care.

The debilitating symptoms associated with a depressive mental illness wage war on a person's physical welfare[115], but most predominantly affect his or her emotions and cognitive abilities as well. When a person's psychological capacity is in jeopardy, their judgment and decision-making abilities are also brought into question. As we have discussed previously, when an individual is not able to choose and act autonomously in support of her best interests, her sense of trust in herself will suffer. This not only refers to her sense of faith in her abilities as an agent with specific interests and aspirations, but also to her existential understanding of herself as an embodied being. One's sense of existential embodiment differs from self-understanding insofar as it appeals to the lived

[115] Examples of physical symptoms of depression include (but are not limited to) progressive weight loss, headaches, body pain, muscle aches, digestive issues, and/or fatigue.

experience of personified and subjective exclusivity, rather than their perception of his or her relations to other agents and to their external world. Below I posit four possibilities to consider regarding the relationship between suicidal ideation and self-trust—two potential options for each of the two frontiers concerning one's level of self-trust:[116]

(1) LOW SELF-TRUST:

A. I will fall victim to suicidal ideation due to an underdeveloped sense of confidence and consequently be weak-willed and impressionable; or

B. I will be suspicious of the contents of my suicidal ideation because I do not trust my inner dialogue, and will likely not be motivated to act in accordance with depressogenic thoughts.

(2) HIGH SELF-TRUST:

A. I will listen and tend to my inner grievances because I have a well-developed understanding of myself and my interests[117]; or

B. I will disregard internal duress (as I recognize unusual, depressogenic thinking as illogical and harmful) and not allow my suicidal tendencies to gain authority.

It is important to recognize that while depressive illnesses are principally recognized as disorders of mood, they also act as disorders of judgment. The principal question boils

[116] Obviously, self-trust is a capacity that is measured on a spectrum (much like the vast majority of human capacities)—it is possible for an individual to have a 'middle' or 'average' amount of self-trust rather than a markedly high or low level. However, for the purposes of this study, I will be addressing how the two extremes are associated with suicidal ideation.

[117] This could include eventual (and potentially rational) suicidal behaviour. This concept will be discussed in more detail in later sections.

down to: '*Which psychological element(s) will conquer the other(s)?*' Certainly the answer to this question will not be the same in every case, but it is valuable to consider how we might encourage a patient's connection with his or her self-trust to counteract or neutralize ruminations about self-inflicted injury or death. Without a doubt, conversations regarding patient flourishing aid in the development of more robust and personalized treatment plans.

When one is in the midst of a severe depressive episode (with accompanying suicidality), feelings of hopelessness, despair, burdensomeness, isolation, and distress become overwhelming. Debilitating and cyclic depressogenic thinking patterns wreak havoc on one's ability to reason clearly, to consider information that is incongruent with how they may feel[118], and their capacity to view their existence as inherently valuable rather than merely burdensome. Esteemed author and American psychologist, Kay Redfield Jamison eloquently described her personal experience with bipolar disorder and suicide in the following way:

> "I had tried years earlier to kill myself, and nearly died in the attempt...It was simply the end of what I could bear, the last afternoon of having to imagine waking up the next morning only to start all over again with a thick mind and black imaginings. It was the final outcome of a bad disease, a disease that seemed to me I would never get better of. No amount of love from or for other people—and there was a lot—could help. No advantage of a caring family and a fabulous job was enough to overcome the pain and hopelessness I felt; no passionate or romantic love, however strong, could make a difference. Nothing alive and warm could make its way in through my carapace. I knew my life to be in shambles, and I believed—incontestably—that my family, friends, and patients would be better

[118] See Joormann, J. (2010). This recent study displayed selective attention to negative stimuli in depressed patients, and more interestingly, their inability to dismiss negative material from working memory, which leads to increased depressogenic rumination.

> off without me. There wasn't much of me left anymore, anyway, and I thought my death would free up the wasted energies and well-meant efforts that were being wasted on my behalf".[119]

Indeed, experiences with suicidal ideation and depression have been described in many ways, using various types of metaphors and descriptive narratives.[120] Due to the subjective privacy associated with mood disorders (and all mental states, in fact), metaphors serve as a reliable vehicle between speakers and listeners. What appears to be lost during experiences of severe despair is a sense of purpose and meaning, and a view of oneself as being fundamentally valuable.[121] This sense of loss relates and leads to an overwhelming sense of hopelessness and desolation.

i. Hopelessness and Existential Suffering

In general, there are four types of suffering that an individual can experience: physical, psychological/emotional, social, and existential. Each of these is unique in the sense that the discomfort associated with the suffering is differently situated and felt. The first three types can (generally) be coped with—whether it is through the use of practical medicine, counseling services, or companionship. It is when existential suffering is thrown into the mix that suffering can become unbearable. The reality is that when patients come to physicians with a complaint, their grievance is not regarding disease per se, but of their

[119] Refield Jamison, K. (1999). p.290.
[120] Perhaps one of the most well known metaphors for depression was expressed by John Bentley Mays in his 1999 work, 'In the Jaws of the Black Dogs: A Memoir of Depression'. When referring to recurrent depression, many have used his example of a large and ominous 'black dog' lurking behind them, everywhere they went.
[121] Beck, B., Halling, S., McNabb, M., Miller, D., Rowe, J., & Schulz, J. (2003). p.341.

experience of the illness.[122] As we have already outlined the importance of a total health perspective[123], the subjective experience and quality of life of patients ought to be our main focus for treatment plans (in instances of psychiatric illness, especially).

Humans are 'meaning-seeking' creatures[124]—decades of ontological investigation have demonstrated our inherent desire to understand our place in the universe, both as a species and as individual beings. In order to find a sense of meaning in our lives, having a sense of self-trust is essential, as the autonomous capacity associated with it allows us to pursue what we consider to be valuable. When I have a robust sense of self-trust, I will have the confidence to search for (and hopefully discover) what brings me a sense of fulfillment. However when someone is caught within cycles of depressogenic and suicidal rumination, her willingness (and her general ability) to put herself in a vulnerable position while searching for what makes her feel fulfilled will be lacking. Without this sense of fulfillment (or at least the perceived ability to conduct an active search for meaning[125]), feelings of purposelessness are immanent.

Our inevitable death is always a day closer than it was yesterday, and we have no reliable means by which to predict when our final day will arrive. The practice of timekeeping

[122] Mount, B. (2003). p.40.
[123] Recall that this perspective involves equal attention to the patient's physical, psychological, and spiritual wellbeing. This is in contrast to traditional medical models.
[124] Consider the various religious studies endeavours that human beings partake in, for an obvious example.
[125] This is perhaps more common in the majority of the population. Whether or not persons actually find a true sense of fulfillment is a non-issue in regards to our query here.

makes human beings unique from other mammals in the sense that only we have the fear of time running out. This makes us view our time as inherently valuable, and what we do with it even more important. When feelings of hopelessness and existential dread[126] are present, in conjunction with other symptoms of a depressive mental illness, the risk of suicidal behaviour increases drastically.[127] This is because when an individual begins to believe that his or her life is no longer meaningful, they may begin to question the purpose of continuing on—especially when their everyday existence is polluted with depressive cognitions. Hopelessness can be expressed in various ways, including thoughts or statements such as: 'Things will never get better'; 'I will never get back to where I used to be'; 'There is no future for me'; and 'There is no point in trying anymore'. Indeed, feelings of hopelessness and accompanying helplessness similarly influence one's ability to reason clearly and to problem solve effectively. In effect, they suspend a person's ability to promote positive changes in his or her life by limiting his or her cognitive periphery. [128] [129]

[126] Existential dread (or 'existential crisis') refers to the state in which an individual questions whether his or her life has any fundamental meaning, purpose, or value.

[127] Hopelessness is one of the four main psychosocial factors associated with suicidality that Rutter and Behrendt (2004) identify, alongside hostility, negative self-concept, and isolation (p.295-296). All of these factors were found to collectively correlate with increased suicide risk.

[128] 'Cognitive periphery' refers to a particular individual's range of potential cognitive capacity—the amount of information a person is able to hold in their mind at any given moment. This is related to the notion of 'psychological flexibility' in Acceptance and Commitment Therapy (ACT), which aims to improve overall patient functioning, acceptance of pain, and commitment-based action. See Scott et al. (2016) for more information about ACT and psychological flexibility.

[129] As neuro-endocrinologist Bruce McEwen states, "...changes in brain circuitry and function, caused by stressors that precipitate the disorder, become locked in a particular state and thus, need external intervention" (2012, p.17183).

An individual's perceptive field contracts or expands due to the contextual realities of his or her external and internal domains.[130] The suicidal mind is a harshly constricted one—recurrent depressive thoughts of self-harm and futility limit one's perceptions until what is left is a narrow, dark space.[131] In this mental oubliette, the capacity to think in ways that are oppositional to suicidal cognitions vanishes, and suicide becomes the only choice of action left available. In this place of purest despair, the choice of continuing on in overpowering sorrow is not an option. While it is often claimed that a level of uncertainty permeates the suicidal act[132], it seems that although there may be some apprehension towards the intentional termination of one's own life, in cases of severe suicidality the *choice* whether to do so or not is no longer existent, and therefore mere trepidation will not be enough to change the outcome.[133] It is within this final act that an individual may perceive a sense of control—a feeling that had previously been overshadowed by impenetrable bleakness. The reason why some persons do not end up successfully ending their own lives is likely due to the fact that their cognitive periphery was not as confined as their more lethally-driven counterparts—hope for a better tomorrow is a powerful force that is not always entirely driven out by depression. It is in this case that the notion of hanging on '*for just one more day*' might hold some sway. Hopefulness for (even slight)

[130] Kohn suggests that an individual's perceptions of his or her relationships (with other persons and with one's external surroundings) are shaped by strong emotions, especially those that seem to be the most threatening or formidable (1954, p.290).
[131] Similar to Kohn's earlier findings, Easterbrook asserts that stress significantly shrinks one's perceptive field by limiting their active observation of his or her surroundings (1959).
[132] American Academy of Orthopedic Surgeons (AAOS), Polk, D., Mitchell, J. (2008). p.82.
[133] In many cases, the suicidal individual may not want to die per se, but he or she perceives death as the only way to make the suffering end.

improvement displays a glimmer of enduring trust in one's own abilities that can, frankly, save a life. [134]

We might end our query here by suggesting that by promoting strong self-trust in persons with depressive psychological disorders, treatment strategies can be enhanced and eventually, the contemporary predicament of suicide can be aptly combatted. However the solution, as I'm sure many readers can assume, is not that simple. Similar to other types of delusive cognitions, depression cunningly presents itself in the form of rational thought. It is the apex affliction in terms of evolutionary fitness, insofar as it seems to have every potential avenue of remission shielded—victims feel increasingly sad, lethargic, and hopeless, which limits their ability to think in constructive ways; this grief compounds until they believe that they are deeply burdensome and must relieve others of the stress they create; and this sense of guilt coerces victims to withdraw into isolation, allowing their symptoms to exacerbate. There is no better example that displays the fundamentally relational needs associated with our individual psychological wellbeing. When one is endowed with a strong sense of trust in her abilities as an agent, it follows that she will consequently possess a higher sense of confidence, freedom, and faith in herself—this will allow her to be increasingly resilient and critical of negativity.[135] Aside from overcoming daily obstacles, these skills will be particularly useful in the face of

[134] Govier alludes to instances of ambivalence when she discusses critical thinking associated with self-trust, stating that: "Beginning with trust is good and right, but responding, without jumping to conclusions, to signs that something is not quite right is critically important too. That suspiciousness may protect us; it may even save our lives" (1998, p.207-208).

[135] This could be either internally-based or externally-based.

emergent depressive ruminations. Individuals with a strong sense of self-trust will, in most cases, have an informed perception of their reality, and thus will have increased potential to identify and critique incongruent suicidal thoughts. But this is not always the case—in some instances, having an especially high level of self-trust can allow someone to contemplate, rationalize, and follow through with a logical, self-inflicted death. While some persons are likely to disagree (I do not deny that this claim is controversial), not all deaths are necessarily a bad thing. Death, especially death by suicide, is commonly considered to be among the greatest of harms[136], but these types of beliefs overlook the fact that unbearable, unnecessary, and/or irremediable suffering can be an even *greater* harm. The aim of suicide prevention is not to prolong unbearable suffering, but to prevent rash decision-making during times of extreme vulnerability. It is possible for suicides to be rational[137] (and [impartially] positive) occurrences, such as the case with Medical Assistance in Dying (MAID) practices. Surely a strong sense (perhaps the *strongest* sense) of self-trust is required to make a coherent decision to end one's life, either by one's own hand if they are able, or with the assistance of a physician.

Where the difference between strong self-trust leading to potential recovery (i.e. the avoidance of irrational suicidal behaviour) versus leading to rational suicidal behaviour lies is likely based on the contextual realities of the particular setting. There is an

[136] Reasons for this belief are usually associated with the ending of possible futures of the deceased. As many suicides occur in adolescence and young adult years, this consideration is particularly relevant.

[137] A suicide is 'rational' when the person who intentionally ends her own life does so under free will, and while she is not cognitively impaired. She will have logical and coherent reasons to support her decision.

important difference between individuals who are in crisis situations[138], and those who are not. Recent studies in the realm of psychology and neuroscience have displayed positive correlations between increased levels of hopelessness and impulsivity in patients in psychiatric crisis and severe suicidal ideation.[139] In the table below, I consider two opposing levels of self-trust, and the probable outcomes based on whether the person's situation is critical or not. Notice that in both instances of low self-trust, the risk of suicide (whether rational or irrational) is relatively high; conversely, where high self-trust is fostered, the risk of irrational self-harm is greatly reduced:

LEVELS OF SELF-TRUST, STRESS SETTING, AND PROBABLE OUTCOMES WHEN SUICIDAL IDEATION IS PRESENT	
LOW SELF-TRUST	**CRISIS SITUATION:** Likely to acquiesce to suicidal ideation, out-of-touch with reality, sense of overwhelming urgency. ** High risk of immediate suicide.*
	NON-CRISIS SITUATION: Likely to succumb to depressogenic rumination due to inability to question accordance with reality, no immediate sense of urgency but hope for positive future is fading. ** Medium to high risk of eventual suicide.*

[138] 'Crisis' refers to when an individual questions the fundamental bases of his or her reality. Their sense of purpose, value, and direction are called into question and the individual experiences a sense of overwhelming loss, confusion, and disillusionment. Crisis situations can arise due to situational dilemmas (such as losing one's job or being involved in some sort of accident/disaster), or psychological maladies. The majority of irrational suicides occur while an individual experiences crisis.

[139] See McCullumsmith, C.B., Williamson, D., May, R.S., Bruer, E.H., Sheehan, D.V., & Alphs, L.D. (2014); and Horesh, N., Gothelf, D., Ofek, H., Weizman, T., & Apter, A. (1999).

HIGH SELF-TRUST	**CRISIS SITUATION:** Likely to recognize the traits of a crisis situation and triggering factors, able to identify and evaluate thoughts that are incongruent with reality, better able to self-soothe. ** Reduced risk of suicide.*
	NON-CRISIS SITUATION: Likely to analyze foundations of depressogenic thoughts and assess their accordance with reality. ** Risk of suicide dependent on findings; will vary.*

In effect, having strong self-trust lowers the possibility of the development of full-blown crisis situations, as patients will possess increased awareness of themselves and their situation. High stress levels associated with crises are associated with their fundamental sense of urgency, and how the individual perceives these stressors will determine his or her reaction(s). An agent's reaction to negative stimuli can be measured in terms of their sense of 'negative urgency'.

ii. Self-Trust and Negative Urgency

According to Joiner's (2005) interpersonal psychological theory of suicidal behaviour, there are three variables that must be present in order for an individual to die by suicide or to make a serious attempt: (1) perceived burdensomeness; (2) thwarted belongingness; and (3) acquired capacity for suicide.[140] The first two, perceived burdensomeness and thwarted belongingness, together produce the desire for suicide, or the reason why a person would *want* to end their own life. Perceived burdensomeness refers to the

[140] Anestis, M. & Joiner, T. (2011). p.261.

individual's belief that he or she does not make meaningful contributions to the world. Thwarted belongingness, on the other hand, refers to the individual believing that they do not have meaningful connections with other people. Together, these two variables leave an individual feeling distanced from others and from his or her world.[141] Using the Beck Scale for Suicidal Ideation, it was found that perceived burdensomeness and thwarted belongingness lead to higher accounts of suicidal ideation, with higher levels of the two phenomena leading to the highest level of risk. To be sure, there is growing empirical support for the notion that an individual must not only *desire* suicide, but also acquire the *capability* to do so before engaging in a serious (or fatal) attempt.[142] Acquired capacity, the third variable, refers to repeated exposure to "painful or provocative events" such as self-injurious behaviours, severe injuries, and experience of or exposure to death or suicide.[143] The presence of all three factors signifies the highest overall risk of suicide. Below, I will discuss each in turn.

a) Perceived Burdensomeness

Perceived burdensomeness is a critical risk factor for suicidal ideation, as it involves the belief that one is a liability for (or a burden on) other people—it is associated with feelings of self-hatred, shame, and low self-esteem.[144] In some studies, it was found that perceived burdensomeness mediated the link between

[141] From this, it follows that one's sense of self-trust will suffer, as our understandings of our realities are relational.
[142] Anestis, M. & Joiner, T. (2011). p.262.
[143] Hames, J., Chiurliza, B., Podlogar, M., Smith, A., Selby, E., Anestis, M. & Joiner, T. (2015). p.597-598.
[144] Jahn, D., Cukrowicz, K., Mitchell, S., Poindexter, E. & Guidry, E. (2015). p.909.

depressive symptoms and suicidal ideation.[145] In a recent study by Jahn, Cukrowicz, Mitchell, Poindexter, and Guidry (2015), it was predicted that perceived burdensomeness could act as the intermediary between executive cognitive functioning and suicide attempts. Some components of cognition, such as poor problem solving and negative problem orientation (perceiving problems as unsolvable and intimidating), have been positively associated with suicide ideation already.[146] The problem with executive functioning is that there have been mixed findings pertaining to its relation to suicidal ideation. It was hypothesized that if an individual has poor self-monitoring capabilities (a key component of executive cognitive functioning), they may undervalue their contributions to others and/or misjudge their value in everyday events. This misinterpretation may create feelings of liability or burdensomeness to others, which may in turn be related to suicide risk, and this suggests that perceived burdensomeness might act as a mediator between cognitive functioning and suicide risk.[147] Unfortunately, perceived burdensomeness was not found to act as a reliable mediating variable between cognitive functioning and suicidality.[148] It was, however, found to be strongly and directly associated to elevated suicidal ideation.[149] Interestingly, perceived burdensomeness was strongly associated with both suicidal ideation and current suicide risk, even more so than "well-

[145] Jahn, D., Cukrowicz, K., Linton, K. & Prabhu, F. (2011). p.214-220.
[146] D'Zurilla, T., Chang, E., Nottingham, E. & Faccini, L. (1998). p.1097-1099.
[147] Jahn, D., Cukrowicz, K., Mitchell, S., Poindexter, E. & Guidry, E. (2015). p.909.
[148] Jahn, D., Cukrowicz, K., Mitchell, S., Poindexter, E. & Guidry, E. (2015). p.913-914.
[149] Jahn, D., Cukrowicz, K., Mitchell, S., Poindexter, E. & Guidry, E. (2015). p.913.

established risk factors" such as depressive symptoms and feelings of hopelessness.[150]

b) Thwarted Belongingness and Excessive Reassurance Seeking

Thoughts such as "I don't belong" and "Others don't care about me" are frequent when one experiences feelings of thwarted belongingness. While this is an intrapersonal state, ruminations associated with this state are interpersonal in nature.[151] This feeling of disconnectedness (and additional burdensomeness) causes individuals to repeatedly seek reassurance from others around them (e.g. "I'm not that burdensome to you, am I?"; "You care about me, right?"). Several studies have displayed how both perceived burdensomeness and thwarted belongingness together lead to excessive reassurance seeking behaviours in various samples of depressed individuals.[152] While this behaviour may seem to be supportive and encouraging, it eventually becomes maladaptive and hurtful to the seeker, as significant others can come to reject the depressed individual due to their persistent need for validation and approval.[153] In fact, excessive reassurance-seeking behaviour is tolerated considerably less by individuals who are not depressed.[154] Once this process of invalidation by significant others

[150] Jahn, D., Cukrowicz, K., Mitchell, S., Poindexter, E. & Guidry, E. (2015). p.916.
[151] Hames, J., Chiurliza, B., Podlogar, M., Smith, A., Selby, E., Anestis, M & Joiner, T. (2015). p.599.
[152] See Joiner, Katz & Lew (1999), for example.
[153] Hames, J., Chiurliza, B., Podlogar, M., Smith, A., Selby, E., Anestis, M & Joiner, T. (2015). p.598.
[154] Joiner, T. E., Alfano, M. S., & Metalsky, G. I. (1992). p.165–173.

begins, questions regarding one's significance and musings of suicide quietly begin to blossom.

c) Acquired Capability

Unlike the first two variables, which together create a person's *desire* for death, the 'acquired capability' (or alternatively, 'acquired capacity') principle describes which individuals are actually *capable* of the fearsome act of suicide.[155] For one to be capable of attempting the act, an individual must be acclimatized to both the primeval fear of death and to physiological pain. This habituation is developed through repeated encounters with "painful and provocative experiences".[156][157] This phenomenon can be displayed in studies that have shown that military personnel possess a much higher acquired capacity for suicide than the general public, while levels of perceived burdensomeness and thwarted belongingness between the two groups were found to be comparable. This is likely because of the firearms training that military personnel were required to take part in, and their closer proximity to violence.[158]

[155] Anestis, M. & Joiner, T. (2011). p.262.
[156] Ibid.
[157] It is worth noting that the encounters of physiological pain do not have to be experienced firsthand by the suicidal individual—experiences of physiological pain can include witnessing instances of pain or violence on other persons.
[158] Bryan, C., Morrow, C., Anestis, M., Joiner, T. (2010).

These three factors are exacerbated by 'negative urgency': the inclination to act impulsively in an attempt to remove or reduce feelings of negative affect.[159] This phenomenon is also commonly associated with bulimia nervosa, impulsive spending, and binge drinking. Regardless of levels of perceived burdensomeness and thwarted belongingness, individuals with higher levels of negative urgency might experience faster, more severe increases in suicidal desire, due to the overwhelming nature of their negative emotions. Put another way, individuals with high levels of negative urgency might engage in suicidal ideation in response to what other individuals might perceive as only minimally or moderately adverse stimuli.[160] What's more, negative urgency might not only impact the desire for suicide, but it might also amplify the development of the acquired capabilities.

Anestis and Joiner (2010) assessed the levels of negative urgency in various individuals with and without mental illness by using a scale that consisted of twelve items which measured the degree to which an individual acts rashly when upset in order to reduce negative affect. The Beck Depression Inventory-II was used as a covariate, to assess the presence of depressive symptoms over the past two weeks. Results showed that individuals with a past history of suicidal behaviour reported higher levels of perceived burdensomeness, thwarted belongingness, *and* negative urgency.[161] Individuals with a history of two or more suicide attempts displayed higher levels of acquired capacity than

[159] Ibid.
[160] Anestis, M. & Joiner, T. (2011). p.263.
[161] Anestis, M. & Joiner, T. (2011). p.264.

did individuals with no history of suicidal behaviour. However, those persons did not differ from participants with a history of one prior attempt, and those with one prior attempt did not differ from the group with no prior history of suicidal behaviour.[162] High levels of all four variables (acquired capacity, perceived burdensomeness, thwarted belongingness, and negative urgency) displayed the greatest risk of suicide whereas low levels of each variable conferred the smallest risk. As Anestis and Joiner conclude:

> "Because the primary concern in the moment is immediate relief and long term consequences are given less consideration, more maladaptive behavioural options are on the table as potential options, including self-injurious behaviours".[163]

Ultimately, negative urgency serves as an amplifier for other risk factors of suicide.[164] These findings help us to make sense of high suicide rates associated with mental disorders primarily marked by emotion deregulation.

d) Negative Urgency and Self-Harm

One of the outcomes of experiencing negative urgency is self-harm (also known as 'self-injury'), a phenomenon that has significantly grown in prevalence since the early 2000's. Self-harm can be defined as the intentional harming of one's own body for the purpose of relieving psychological pain. Methods of self-harm can include burning, cutting, pulling out hair, hitting oneself, banging one's head,

[162] Ibid.
[163] Anestis, M. & Joiner, T. (2011). p.267.
[164] Anestis, M. & Joiner, T. (2011). p.266.

> breaking bones, and/or interfering with wound healing.[165] While mental health professionals traditionally associated self-harm with suicide, research has shown that self-harming behaviours are actually used to *avoid* killing oneself.[166] The purpose of self-harm is to relieve the intensity of emotional distress or despair, and to help individuals cope with difficulty they face. As Brown and Kimball describe, "It is within the act of the injury that relief ensues and minimizes the intensity of the emotions that are present".[167] However, healthcare providers should take care to not rule out suicide risk for patients who self-harm, as an important connection does exist. Studies have found that 28-41% of persons who engage in self-harming behaviours report suicidal ideation[168], and 55-85% have a history of at least one suicide attempt.[169]

Each of these types of behaviours can be understood as attempts at restoring a sense of balance or equilibrium in the midst of unpredictable emotionality. All human beings strive for internal peace and consistency, and therefore, treatment plans for psychiatric illnesses ought to include stabilizing properties.

II. Self-Trust and Internal Consistency

Since stories of the quest for pure knowledge from Ancient Greece, it is clear that individuals yearn for the attainment of truth and consistency in their web of beliefs. In

[165] Brown, T. & Kimball, T. (2013). p.195.
[166] Brown, T. & Kimball, T. (2013). p.196.
[167] Ibid.
[168] Favazza, A. (1996).
[169] Stanley, B.,Winchel, R., Molcho, A. & Simeon, D. (1992).

1957, psychologist Leon Festinger released a theory based on the premise that we continuously strive for internal consistency. Festinger claimed that our cognitions (all of our knowledge, opinions, and beliefs) can normally be rationalized in such a way that they complement one another.[170] This allows us to act in ways that are harmonious with our personal beliefs. What seizes our attention, however, are the *exclusions* to the general rule of uniformity that we strive to follow. When one is not able to rationalize away inconsistency in their belief system(s), what follows is a sense of psychological discomfort. This feeling of distress, Festinger claims, is known as dissonance.[171] Like experiences of physiological pain, the experience of cognitive dissonance will motivate the individual to either reduce the dissonance, or achieve consonance (i.e. cognitive consistency).[172] Festinger states:

> "Cognitive dissonance can be seen as an antecedent condition which leads to activity oriented toward dissonance reduction just as hunger leads to activity oriented toward hunger reduction."[173]

When dissonance is present, the individual will also avoid situations or things that are likely to increase the discomfort.[174] [175]

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[170] Festinger, L. (1957). p.1-2.
[171] Festinger, L. (1957). p.3.
[172] Ibid,
[173] Ibid.
[174] Ibid.
[175] To illustrate the effects of cognitive dissonance, Festinger appeals to the example of a smoker, who gains pleasure from the act of smoking, but is aware that smoking has negative effects on his health. These two beliefs are inconsistent, and would cause psychological distress to the individual, motivating him to seek out a way to reduce it or eradicate it altogether. For example, the person who continues to smoke, regardless of knowing the risk, may also believe that (a) the pleasure gained from smoking outweighs

These experiences of intrapersonal distress can range from lasting only a moment to being tremendously lengthy and traumatic. They can transpire from a simple event, such as experiencing a novel scenario or acquiring a new piece of information, or the cause could be more obvious, such as a being detained or punished for a particular behaviour.[176] As Festinger claims, "...very few things are all black or all white".[177] This is especially true when one considers the task of making a controversial decision—the decision-maker must weigh conflicting sides of an argument against each other before choosing one that he or she deems to be superior (or at least inferior), given the relevant information at hand. It is interesting to note that persons may answer the same question differently, with unique justifications, as each individual will rationalize and make choices based on their personal knowledge base at that point in time.

Festinger also posits the idea that, at the individual level, there is little difference between opinion and knowledge, as those who hold the opinion usually treat it as true, justified information.[178] Indeed, this is the easiest way to reduce feelings of dissonance that one experiences. Festinger states that there are two ways that individuals will act to reduce dissonance: (1) Change one's action(s); or (2) 'Change' one's knowledge. In order to rid oneself of psychological distress, a person might alter his or her behaviour so that it is no

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the potential health risk; and/or (b) by relaxing him, smoking helps him to avoid other potentially risky behaviours, such as drinking alcohol or eating unhealthy food. Thus, by the addition of these rationalizations, the individual's beliefs about smoking are now consistent with his behaviour and the dissonance is reduced.

[176] Festinger, L. (1957). p.4.

[177] Festinger, L. (1957). p.5.

[178] Festinger, L. (1957). p.10.

longer in contradiction with their cognitions. For example, an individual could choose to stop binge drinking so that their actions become in-line with their beliefs that heavy alcohol use has negative health effects, and that their good health is important. In other cases, someone might choose to modify their knowledge in such a way that it fits with their behaviour. If we appeal to the example of heavy alcohol use again, one might validate her binge drinking by convincing herself that alcohol does not have serious negative effects on the body, or that there are more good effects of alcohol than bad, and therefore the act of drinking excessively compliments one's cognitions, and the dissonance is removed.[179] In regards to this, Festinger urges that the "single most important determinant" of all elements of knowledge is *reality*. This is because all cognitions must reflect the individual's perceptual experience—as such, all opinions, beliefs, and knowledge elements are based on what the individual does, what he or she feels, what exists in his or her surrounding environment, his or her opinion of others, as well as their actions or thoughts.[180] As mentioned previously, with each piece of new information that is acquired, individuals will choose whether to use it to 'update' their personal perceptual model of their self, their environment, and their relation to it.

Cognitive dissonance relates to our discussion here in two ways. Firstly, when an individual experiences suicidal ideation, he or she is consistently in a state of tension, as hopelessness and ambivalence will serve as significant and continuous stressors. Secondly, persons in the midst of suicidal rumination are unable to reduce their feelings

[179] Festinger, L. (1957). p.5.
[180] Festinger, L. (1957). p.10.

of dissonance due to the fact that their perceptive fields are so sharply constricted. Their subjective reality is altered, and therefore the regular process of searching for reinforcing information is entirely one-sided, as he or she can only consider thoughts with depressogenic foundations. To consider thoughts that contradict one's depressive ideas would require individuals to work against the type of thinking that has become deeply engrained. This would be extremely difficult, and unlikely to successfully occur without structured guidance and support. In order to make a move towards remission, therapy must address both cognitive and volitional capacities affected[181], and encourage patients to critically evaluate their depressive thoughts, and to consider alternatives to their confined realities. In other words, therapeutic aims must place specific focus on the development of patients' self-trust, as this capacity allows agents to critically evaluate stimuli based on an evenhanded view of their own reality. How might we incorporate this into psychiatric care? This question will be addressed in Section 4.

4. MOVING FORWARD: ENCOURAGING INTRAPERSONAL GROWTH

I. How to Use Self-Trust to Combat Growing Suicide Rates

Based on our previous discussions, it is clear that by promoting strong self-trust in persons who experience suicidal ideation, it is possible to significantly decrease the prevalence of irrational suicidal behaviour. However, it is also important to recognize that having high self-trust can also allow rational suicide to occur in those who are in-touch

[181] This could include attention redirection towards constructive therapeutic behaviours (cognitive) and encouragement of the Will to create positive change (volitional).

with reality, in non-crisis situations. This is not necessarily something to have much concern over, as self-trust encourages persons to be in-touch with their deepest feelings and the personal beliefs associated with them. This final section will discuss how we might integrate the development of self-trust skills into psychiatric treatment regimens. I will begin by discussing what I believe to be the most effective starting point: talk therapies. From there, I will provide some suggestions as to how these treatments can be built upon to include more extensive self-trust development strategies. This will include the integration of what I will refer to as Self-Trust Skills Development (STSD) schemes.

i. Cognitive and Dialectical Behavioural Therapies

Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) each possess distinct foundational bases and aims, but they also possess various methodological similarities and are thus equally useful in our endeavours here. CBT was built on the premise that one's cognitions, thoughts, and ideas determine his or her emotions, and therefore by changing our cognitions, we may be able to change our emotions.[182] [183] It encourages patients to consider what cognitions *comprise* their emotions, rather than looking for which ones precede them.[184] Based on the interconnectedness of cognition, behaviour, and emotion, CBT techniques encourage

[182] Robertson, D. (2010). p.73.
[183] Note that this does not exclude possible other 'non-cognitive' factors associated with emotion regulation, but simply places direct emphasis on the influential role of thoughts and beliefs.
[184] Robertson, D. (2010). p.77.

patients to do two things: First, to monitor one's thoughts, and second, to challenge those that are illogical or obstructive, as well as any associated underlying beliefs.[185] [186]

DBT is based on similar principles, but was created with the specific purpose of treating complex, difficult psychiatric cases in particular.[187] The focus of DBT is based on both change and acceptance: the changing of certain elements that can lead to unnecessary experiences of pain, but also learning to accept life's inevitable painful situations.[188] DBT aims to establish 'dialectical truth', which is found by combining the elements of opposing propositions (the 'thesis' and 'antithesis')—their integration is what constitutes change in patients' thinking.[189] Every statement that an individual can make will always have its own possible contradiction that could also be true. Therefore, by bringing *both* propositions to the fore and allowing them to stand side-by-side, patients have the opportunity to evaluate their cogency. As Linehan, Miller, and Rathus state, "The spirit of a dialectic point of view is never to accept a proposition as a final truth or an undisputable fact".[190] Thus, depressogenic thoughts such as 'There is no other option for me but death' will be considered alongside their direct antithesis, 'There must be some other option for me', allowing for an expansion of that patient's cognitive periphery ('Perhaps there is

[185] Robertson, D. (2010). p.169.
[186] Robertson makes the interesting connection that this process of self-monitoring and belief-assessment dates back to fundamental features of Stoicism that placed value on skills that allowed persons to 'converse with oneself' (2010, p.169).
[187] DBT is generally used for treating individuals who cope with Borderline Personality Disorder, and/or who engage in other forms of self-destructive behaviour(s), including suicidal behaviour.
[188] Linehan, M., Miller, A., & Rathus, J. (2007). p.38.
[189] Linehan, M., Miller, A., & Rathus, J. (2007). p.39.
[190] Ibid.

another viable option here that I have not considered'). DBT rests on the notion that there is always something that one could be leaving out of her understanding, and by discussing her beliefs and their contradictions, new meanings can be discovered.

It is based on these ideologies that Linehan[191] introduced the concept of 'Wise Mind'—the intuitional balance between emotional and rational components of one's mind. In order to access Wise Mind, patients must learn to synthesize polarities associated with purely emotional and/or purely logical reasoning processes and thoughts (e.g. 'I feel like I am not good enough' [overly emotional] or 'I am burdensome to my family' [harshly rational]), ideas that seem to be concretely set, and extreme reactions to situations.[192] Linehan describes Wise Mind as "...the calm that follows the storm. It is that experience of suddenly getting to the heart of the matter, seeing or knowing something directly and clearly".[193] Activating Wise Mind encourages patients to integrate what she feels and what she thinks, in order to find balanced knowledge.[194] DBT has specific stages, each with particular targets to reach. These are outlined in the table below:

[191] Marsha Linehan created DBT in 1993.
[192] Linehan, M. (1993). p.215.
[193] Ibid.
[194] This dually informed knowledge is consistent with the underlying epistemological premise of DBT that there is no final truth insofar as patients are encouraged to always reflect upon potential supplementary considerations to their current cognitions. This way, the partialities associated with emotionless rationality and irrational emotions are equalized.

STAGES OF DBT and STAGE TARGETS [195]	
Pretreatment Stage *Targets:*	• Orientation and commitment to treatment • Agreement on goals
Treatment Stage 1 *Targets:*	1. Decreasing life-threatening behaviours 2. Decreasing therapy-interfering behaviours 3. Decreasing quality-of-life interfering behaviours 4. Increasing behavioural skills
Treatment Stage 2 *Targets:*	5. Decreasing post-traumatic stress
Treatment Stage 3 *Targets:*	6. Increasing respect for self 7. Achieving individual goals
Treatment Stage 4 *Targets:*	8. Resolving a sense of incompleteness 9. Finding freedom and joy

These targets are met through dialectical discussions with the therapist, individual psychotherapy skills training sessions, group therapy sessions, and supplementary phone calls.[196] These techniques teach and encourage the continuing development of tolerance, acceptance, and mindfulness, which are each associated with the expansion of cognitive and volitional capacities associated with strong self-trust. Chronic stress, whether it is associated with situational triggers or psychological ailments, is a dangerous phenomenon

[195] Linehan, M., Miller, A., & Rathus, J. (2007). p.45.
[196] Linehan, M. (1993). p.167.

that can significantly increase one's cognitive load[197], limiting her ability to take on additional endeavours that require attention.[198] Talk therapies allow patients to engage in active analysis of the primary sources of their stresses, thereby creating a unique opportunity for healing.

While CBT and DBT are widely used in psychotherapy, there remain some stubborn criticisms against their usage. Rizvi explains one of the most intriguing critiques against psychotherapy treatment success:

> "The idea of treatment success...is even more murky when one considers measuring 'urges' rather than discrete behaviours. If an individual...has stopped cutting but still experiences extremely high urges to cut when faced with a stressful situation, is that more or less successful than someone who very rarely experiences urges but cuts when he does? Similarly, how to assess success in a person with chronic suicide ideation, but no action, is also complicated".[199]

No therapy is perfect; this goes for talk therapies, just as it does for medicinal intervention. These types of criticisms are useful in the sense that they force us to consider what our main goals of care are. In regards to the concerns expressed above, it seems that success is measured in different ways for each possibility: In the first instance, it would be considered successful that the patient's cutting behaviour has ceased. In the

[197] 'Cognitive load' refers to the amount of working memory an individual has at any given time to apply to a particular task.
[198] In a 2016 study completed by Byrd-Bredbenner, C., Quick, V., Koenings, M., Martin-Biggers, J., and Kattelmann, K., it was found that college students with higher cognitive loads were less able to regulate their daily routines and meals, experienced greater sensitivity to external stimuli, and engaged in higher amounts of emotional eating behaviours than those with lower cognitive loads. These results display a strong correlation between high levels of stress, increased cognitive load, and impaired decision-making capacities.
[199] Rizvi, S. (2011). p.3.

second example, the success would be based on the fact that the patient experiences drastically less ideation. But which is the bigger worry? Cutting behaviour whilst in an especially stressful situation, or chronic self-harm rumination? As displayed in our previous discussions, it is better to focus on the individual's experience of the disease, rather than only the symptoms associated with it. It is the quality of life of the patient that is most important. In our imperfect world, we must make difficult judgment calls regarding imperfect situations—in this scenario, it seems that chronic rumination would be the greater evil. If we appeal to the principles of CBT and DBT, our thoughts control our actions. If this is the case, the individual who experiences fewer thoughts about self-harm (but engages in the behaviour occasionally) is better off than the person who is in constant psychological anguish.[200] Moreover, the validity of the comparison between self-harm and suicidal behaviour is questionable, as the former is usually utilized to cope with (and avoid) the latter[201], and untimely death is (generally) a worse outcome than excessive rumination.[202]

[200] Here, it is important to consider the general safety of the patient. In the case of self-injury, behaviours are what will cause harm to the patient (for example, self-inflicted cuts could require emergency medical intervention or in severe instances, could lead to death), but chronic urges will not necessarily put the patient's life in danger. Based on this, it could also be argued that therapists ought to first tackle dangerous behaviours, and then, should aim to improve the patient's quality of life (i.e. her ability to cope with urges). See discussion of the importance of patient stabilization on page 79.

[201] Recall the discussion regarding self-injury as a coping mechanism in Section II.ii.(d).

[202] This is not an objective statement. Untimely death is a worse outcome than excessive rumination in cases where the rumination has the potential to be treated. I do not dismiss the possibility that death could provide particular individuals a source of relief from unrelenting suffering if treatment is unsuccessful. This consideration, however, does not alleviate the inconsistencies associated with this particular criticism of CBT/DBT.

A further criticism raised against CBT and DBT concerns its exclusive focus on cognition and volition, rather than emotion. Regarding the principles of CBT, it seems that what you feel is somehow less important than what you think (and in effect, how you act), as your thoughts control your behaviours and experiences. One might argue that it seems counterintuitive to push aside the main reason as to why patients seek assistance in the first place[203] when addressing the problem at hand. Moreover, this lopsided focus on cognitive determinants seems to displace a large part of what it means to be human, as much of our lives are devoted to and driven by 'raw' emotions such as love, fear, or hate, which sometimes, cannot be satisfactorily rationalized.[204] Critiques based on principles such as this might be somewhat relevant to CBT (as focus is predominantly placed on the relationship between thoughts and behaviours), but are generally misinformed when considering DBT practices. While it is undeniable that cognition and behaviour are important aspects of the individual that are explicitly addressed, DBT also includes practices that pertain solely to emotion and the physical manifestations of mood. In fact, a frequently used distress tolerance technique, 'TIPP', involves no cognitive focus whatsoever, requiring patients to engage in exercises that are entirely somatic in nature.[205]

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[203] Persons are likely to seek assistance due to feelings such as depressed mood, low motivation, and/or feelings of hopelessness. It is less likely that patients with MDD would be able to pinpoint negative cognitions on their own, and seek counseling to alter subconscious beliefs.

[204] Consider the possibility of a woman who feels an intense sense of hatred towards someone that she is barely familiar with. This sensation can persist whether or not there is any rational explanation for her experience.

[205] DBT's 'TIPP' strategy involves four physiological tasks that are meant to refocus a patient's awareness during times of overwhelming emotion associated with acute psychological crisis. The TIPP acronym refers to (1) decrease body temperature, (2)

Regardless of concerns pertaining to progress assessment and specific elements of focus, talk therapies remain the most widely used treatment method for mood disorders, aside from pharmacological interventions.

CBT and DBT do an excellent job at teaching and encouraging patients to expand their cognitive periphery, reduce stress, and consider alternative possibilities to their deeply embedded depressive thoughts. Although it is more time consuming and labour intensive (for both the therapist and the patient involved), DBT ought to be more broadly endorsed and practiced for patients who express feelings of suicidality, as the high recurrence rate of suicidal ideation poses a significant risk that short-term CBT practices do not adequately address.[206] CBT fails to provide the same standard of care that DBT does as it simply encourages patients to consider where their thoughts and emotions stem from—it does not urge the patient to formally consider the truth of their direct antithesis. While this can be helpful (and perhaps even sufficient, for some patients[207]), DBT takes the important next step that requires patients to consider alternative realities, in order to determine what they can *know* to be true, based on indisputable facts and personal

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intensive exercise, (3) paced breathing, and (4) progressive muscle relaxation. See Rathus, J.H. and Miller. A.L.'s *DBT Skills for Adolescents* (2015).

[206] I recognize that this suggestion would place more demand on available mental health resources, which are already insufficient compared to the contemporary needs of society. However, if more time is spent with patients to ensure that they leave treatment programs with a transferrable set of skills that can be self-implemented during future episodes, subsequent hospitalizations and treatment needs will likely decrease.

[207] A 2012 study by Hofmann, S., Asnaani, A., Vonk, I., Sawyer, A., and Fang, A. displayed strong support for the efficacy of CBT when used for anxiety and somatoform disorders, anger control problems, and general stress.

experience. This can lead to a widening of one's cognitive periphery[208], which is essential for critically evaluating obstinate suicidal thoughts. However, it is this last part of the DBT practice that is most difficult: determining what the relevant facts are, exactly. If I am unsure of my abilities as an agent, I will have a tough time deciding which aspects of my life I have control over and what I ought to consider as valuable and pertinent to my deliberations during treatment, even with consistent reassurance from my counselor. Building the patient's sense of self-trust will not only empower her to have faith in her evolving perceptions of her reality, including her evaluations of herself and her relationship to her environment, but will also provide her with a sense of control over her own destiny.

ii. Self-Trust Skills Development (STSD)

As we have determined, both one's cognitive and volitional faculties are possible sites of deficient self-trust, and the various capacities associated with these faculties are directly related to one's emotional wellbeing and the undesirable symptoms of mental illness; including the relationships between attention and depressive rumination, response inhibition and impulsivity, and motivation and apathy, to name a few. With the development of self-trust, capacities associated with each of these areas of focus can be significantly improved. This subsection will attend to three main points of discussion: (1) Why self-trust improvement is a valuable add-on to talk therapy practices; (2) How this

[208] This expansion of cognitive periphery can be directly related to DBT's objective to broaden an individual's ability to think, based on the premise that there is no such thing as a 'concrete claim'.

will complement DBT practices[209]; and (3) How to go about (re-) developing self-trust and a sense of resiliency in patients who are suicidal.

Mood disorders involve restricted awareness and poor memory compared to regular mental states.[210] In addition, the multiplicity associated with mental illness (such as that pertaining to co-existing, conflicting moods and thoughts) inhibits the sense of unity[211] that the self ultimately strives for.[212] Teaching patients to utilize Wise Mind encourages them to find a balance between the purely logical beliefs they hold and hasty emotional feelings they experience, and this is valuable as it allows them to critically assess components of their reality that they might not have previously deemed as requiring evaluation.[213] However in order to effectively apply this sort of reasoning, having faith in your own insight and intuitional awareness is imperative—this is where self-trust becomes a vital skill to master and employ. Only when I deem myself (and my deliberations) as being trustworthy will I be able to make tangible decisions, believe in their verity, and apply them to my daily life.[214] If I do not have adequate trust in myself, I could feel that I am unable to come to a decision; or I could be able to make a choice, but find myself not amply convinced in its force. In instances like this, patients are likely to look to others (such as their counselor, or others who they deem as trustworthy) for

[209] In addition to any pharmacological interventions, if applicable.
[210] Radden, J. (1996). p.63.
[211] Recall our earlier discussion of cognitive dissonance resolution in Section 3.II.
[212] Radden, J. (1996). p.233.
[213] Recall Festinger's discussion of the importance of reality in dissonance reduction.
[214] It is worth noting that this process will not be a quick one—the process of evaluating perceptions, making decisions, believing in one's trustworthiness, and applying those new beliefs in daily occurrences will take time and (preferably supervised) practice.

assistance. Although this might be helpful in acute situations that require immediate problem solving, this reassurance-seeking behaviour is not sustainable, and falls back on behaviours associated with perceived burdensomeness. It is imperative that patients are taught to rely primarily on themselves for validation, and that the locus of one's sense of control is internal. This is the only way that genuine resiliency can be born from the ashes of illness, self-doubt, and self-deception.

While DBT has been dependably shown to be efficient at achieving the clinical objectives of lessened suicidality and impulsive behaviour[215], it is questionable as to whether this practice makes patients happier or genuinely more satisfied with their lives. DBT is extremely structured, featuring strict stages and objectives that must be met chronologically, and therefore it is probable that therapists and patients could become increasingly fixated on the aims articulated in the DBT manual. This procedural approach lessens the opportunity for patients to be understood in terms of "...his or her specific life-world, but made to fit the theoretical representation of being human".[216] These concerns are related to the current nature of mental health care that focuses solely on patient discharge, rather than sustainable remission or recovery. In addition, the streamlined focus of DBT does not provide a chance for patients to gain understanding of what

[215] In a 2011 study by Pasieczny and Connor, it was displayed that DBT was more effective at decreasing suicidal behaviour in patients when compared to treatment as usual. It also displayed support for the notion that DBT can be practiced in cost effective ways.
[216] Rossouw, G. (2007). p.3.

suicide means to them, or how they personally experience this phenomenon.[217] [218] Without an understanding of suicide in the context of her own personal world, it is unlikely that an individual will be able to maintain a sense of acceptance or control regarding her experiences and perceptions. As psychologist Gabriel Rossouw states, "Whilst their explanations, associations and correlations of the ontic appeal to reason, they fail to uncover the existential structures of this kind of existence".[219] Finding deeper meanings behind one's personal world and perceptions will lead to a greater quality of life and a sense of inner peace and solidarity, rather than simply living with (perhaps relatively unexplained or misunderstood) decreased suicidal ideation.

Self-Trust Skills Development (STSD) could supply a humanistic-centered foundation upon which DBT could build, but some readers might question whether this 'extra' training is actually necessary. It might even seem that DBT does a 'good enough job', and *already* possesses therapeutic elements that foster the development of self-trust in patients who partake in this practice. DBT Skills Training can be broken down into four separate modules, featuring (1) Mindfulness skills; (2) Distress tolerance; (3) Emotion regulation; and (4) Interpersonal effectiveness skills.[220] [221] When patients experience severe suicidal ideation, skills training sessions in each of these four areas will target specific areas of

[217] Rossouw, G. (2007). p.2.
[218] Allowing for understanding of one's relationship with death through improved self-awareness and trust will likely bring about a type of personalized therapeutic catharsis, which would be otherwise unattainable without active introspection.
[219] Rossouw, G. (2007). p.7.
[220] Linehan, M. (2015). p.14.
[221] The first two of these modules are associated with DBT's theme of 'acceptance', while the latter two are associated with the notion of 'change'.

improvement. For example, mindfulness training can encourage detection and observation of urges to engage in self-harming behaviours. Distress tolerance training can emphasize the use of coping techniques to deal with stressors. Emotion regulation skills will enable patients to effectively describe and work to modify emotions related to suicidal urges. Lastly, interpersonal effectiveness skills can emphasize the importance of asking others for assistance during times of hopelessness or crisis.[222] The application of these modules is wide-ranging, and because of this it could be argued that while learning these skills, patients are also improving their self-trust *implicitly*. If patients are learning how to effectively behave in ways that reduce undesirable symptoms associated with their illness, would self-trust not be fostered concurrently due to one's improving self-advocacy capabilities?

While it is possible that self-trust-related aptitudes could be stimulated during DBT skills training sessions[223], implicit learning[224] is insufficient in the case of chronic suicidal ideation as it does not inspire overt awareness or understanding of the patient's new (and/or improved) skillset, which is a crucial step in an effective, personalized recovery process.[225] Studies have displayed significant evidence that encouraging self-awareness

[222] Linehan, M. (2015). p.63.
[223] Indeed, it is likely that there could be various forms of implicit learning that may occur during any type of therapeutic practice, not just that pertaining to self-trust.
[224] Implicit learning refers to passive learning that occurs incidentally, without the individual being aware of what has been learned.
[225] A 2008 study by Ranz and Mancini found that "recovery-oriented" practices that encouraged increased self-awareness (such as that pertaining to the individual's social support system(s), professional and private life, aspects of his or her personality, and/or personal goals) aided in patients' overall recovery.

(and in addition, awareness of one's abilities) in patients dealing with emotional trauma allows individuals to become more self-identified[226], better at goal setting, increasingly confident, and more interpersonally proficient.[227] In addition, the learning process associated with DBT Skills Training can be notably improved and accelerated when working with a patient who already possesses durable self-trust—this is true for each module. Mindfulness, for example, encourages patients to focus on the present moment and regulate attention away from sources of stress or anxiety. It is widely acknowledged in the mental health community that when combined with a mindfulness practice, the effectiveness of psychological treatment is greatly enhanced.[228] This mental state is closely linked to the concept of 'non-attachment', which encourages persons to disconnect from other people or phenomena that they believe to be necessary for their own wellbeing.[229] Periodic detachment is associated with the notion that selves and self-trust are relational insofar as it encourages persons to reflect on their conception of self-identity while dispassionately bringing their attention to perceptions of self and environment in the present moment. In order to be able to engage in this state of categorical detachment, patients must have assurance in themselves, their sense of control and their sense of identity. Without self-trust, achieving a genuine state of mindfulness is likely to be a difficult task, and if patients are unable to attain this mental state, therapy is

[226] Being 'self-identified' refers to having a robust sense of who you are as an individual, without a need for others to validate one's identity or sense of self. This notion is closely related to having a strong sense of self-trust insofar as when one is self-identified, she will consequently possess a realistic understanding of her capabilities as an agent.
[227] See Loeffler, D. & Fiedler, L. (1979), and Anthony, W. (2003).
[228] See Tan, L. & Martin, G. (2015); and Coffey, K., Hartman, M., & Fredrickson, B. (2010).
[229] Coffey, K., Hartman, M., & Fredrickson, B. (2010). p.237.

hindered before it even begins. In terms of distress tolerance skills acquisition, if I begin this module with a bolstered sense of self-trust, I will be more likely to identify and appreciate the ways in which these new skills apply to me as an individual with unique desires and needs. My well-developed understanding of myself as an agent, in addition to my faith in my abilities to act in my best interests[230] will allow me to learn and apply distress tolerance techniques in ways that are most appropriate for me. I will have a better understanding of the potential causes of my stress, and ways that I can address them within the constraints of my personal situation. In regards to the emotion regulation skills module, having robust self-trust will provide useful support to the patient's problem-solving capabilities associated with determining how to respond to negative impulses. This is due to her sense of faith in her abilities to follow through with her own realistic and informed intentions appropriately, and an enriched understanding of her personal motivations. Lastly, a strong sense of self-trust will also improve one's readiness for interpersonal skills training, as successful interactions with others begin with the individual. This competence is particularly valuable, as it will permit patients to proficiently communicate with their therapist, which will lead to an increasingly efficacious, personalized therapeutic relationship and practice. Each of these four modules is considerably reinforced when self-trust is present. Without the explicit and deliberate (re-) development of self-trust in patients, the likelihood that they will be able to come to terms with their personal capacity to advocate for positive changes in their

[230] One's trust in her abilities to act in her best interests will further improve as she simultaneously learns to appropriately assess what those interests are while taking part in DBT.

own life is significantly lessened. It is incontestable that a lack of awareness and self-assurance will hinder progress and therefore require direct therapeutic attention.

If we refer back to our original query regarding the four-part prospective relationship between self-trust and suicidal ideation (see below), we are now able to determine which of the two potential outcomes for either high or low self-trust are most likely:

(1) LOW SELF-TRUST:

a. I will fall victim to suicidal ideation due to an underdeveloped sense of confidence and consequently be weak-willed and impressionable; or
b. I will be suspicious of the contents of my suicidal ideation because I do not trust my inner dialogue, and will likely not be motivated to act in accordance with depressogenic thoughts.

(2) HIGH SELF-TRUST:

a. I will listen and tend to my inner grievances because I have a well-developed understanding of myself and my interests; or
b. I will disregard internal duress (as I recognize unusual, depressogenic thinking as illogical and harmful) and not allow my suicidal tendencies to gain authority.

Regarding persons with low self-trust, we have determined that individuals are comparatively more likely to engage in suicidal behaviour (especially in instances of psychological crisis) than those who possess self-trust skills. Without explicit acknowledgement and promotion of self-trust, it is unlikely that individuals who

experience suicidal ideation will be capable of critically evaluating their inner dialogue in an appropriate manner, as their understanding of their identity and relationship with their external world will be lacking. While bolstering the level of self-trust in persons who experience suicidal ideation can lead to rational suicidal behaviour, in the case of mental illness, self-trust acts as a deterrent to irrational impulses and one-sided perceptions of reality. When knowledge of one's inherent authority and self-trustworthiness is acknowledged and openly reinforced[231], patients will be well prepared for the next step: learning *how* to create these changes.

As we have determined, the addition of STSD can significantly enhance the overall effectiveness of DBT. Before moving onward, it is important to clarify that *when* STSD is employed will differ between patients—in the critical case of severely suicidal individuals, the first objective of care must be preventing life-threatening behaviours. The majority of complex, chronic cases will likely require stabilization prior to engaging in STSD and DBT. Self-trust is comprised of a set of skills (both cognitive and volitional) that is learned over time, and therefore in instances of uncertainty or doubt, it can be re-learned and improved upon.[232] Experiences of trauma and/or mental illness can cause

[231] It could be argued by some that by overtly acknowledging a patient's inherent authority and self-trust prior to beginning DBT, it is possible that his or her harmful beliefs could unintentionally be bolstered, thereby reinforcing suicidality. While I cannot deny that this possibility exists, concerns regarding incorrect skills application are minimized by compulsory patient stabilization procedures. Life-threatening behaviours will be explicitly addressed prior to beginning STSD (see paragraph below). This will involve actively addressing any acute symptoms that the patient presents with upon initial assessment, pertaining specifically to suicide risk.

[232] Rosenthal, M. (2015). p.102-103.

individuals to lose aspects of that skill, persuading her to believe that she is no longer trustworthy.[233] However, this loss does not have to be permanent—by making commitments to oneself and sticking to them, trust can gradually be re-built and maintained. Rosenthal[234] (2015) presents three steps that will help individuals *re-develop* self-trust skills and to use them as a support system for healing:[235]

(1) Define what it means to trust oneself: There are various ways that a patient might define self-trust. It is important for the therapist and the patient to determine what would need to be true if she were to possess strong self-trust. It may be useful to create a list with criteria necessary for possessing self-trust, which can be appealed to during subsequent steps to track a patient's progress.

(2) Identify how she would know that she met her goal (i.e. that she trusts herself): Answering questions such as 'What will I feel?'; 'What will I see that is different about myself?'; and 'What actions will I engage in?' will allow the patient to determine what specific things she will need to achieve or feel in order to be certain that she has successfully (re-) developed self-trust.

(3) Finally, create opportunities to practice these behaviours: Just like any other skill, the best way to develop self-trust is to participate in situations that allow

[233] This loss of trust can be situational in nature (for example, I may feel that I am no longer trustworthy to stand up for myself during confrontation), or it can be manifested in a more general sense.

[234] Michele Rosenthal is an established public speaker, award-winning author, mental health advocate, and life coach. Her work on PTSD is particularly interesting as she is a survivor of trauma herself.

[235] Rosenthal's research focuses specifically on Post-Traumatic Stress Disorder (PTSD), but her findings and therapeutic suggestions can also be applied to our discussion of depressive rumination and suicidal ideation here.

> individuals to employ their self-trust skills. Patients should start with comparatively small, low-stress situations before building up to larger moments with the potential of more severe consequences.[236]

Rosenthal's 3-step process serves as a practical method by which patients can improve their sense of self-trust through exercises with aspects of her external world. In effect, this practice substantiates Sherwin and McLeod's account of autonomy and oppression as being interconnected and fundamentally relational phenomena, in addition to Govier's identification of relational confidence as based on one's perceived relationship with her external surroundings. Furthermore, this practice allows patients to experience a sense of validation through interactions with others—an important aspect of Govier's notion of 'realistic' self-trust development.

In order to further personalize this developmental process, Rosenthal suggests that patients ought to make a list of situations in which they perceive a lack of trust in himself or herself, should order this list in regards to what they believe to be most important, and then create unique opportunities to practice skills that will foster the development of trust in these particular areas of his or her life.[237] Only through repeated and intentional practice will these instances of isolated skill application become routine, and will one's sense of her own trustworthiness improve. These instances of practice can be considered as 'STSD homework', and patients should be required to reflect on both the outcome and their feelings, and to report these findings back to their therapist at the next session.

[236] Rosenthal, M. (2015). p.103.
[237] Rosenthal, M. (2015). p.103-104.

Positive results[238] and objectives for next time ought to be explicitly discussed. Perhaps the most appealing aspect of this 3-step process is its simplicity—it is a real concern when suggesting the addition of a supplemental module to a therapeutic regimen that is already criticized for being too lengthy. However, it is unlikely that the process outlined above will take much time to begin to offer positive effects on a patient's self-trust. Even a few positive instances of self-advocacy will improve one's faith in her abilities.[239] In sum, if self-trust skills are strengthened prior to the commencement of formal DBT, it is likely that the skills learning process will become less time consuming due to the supportive effect that STSD has on each module.

II. Future Directions

This investigation into the relationship between self-trust and treatment for suicidal ideation is not all-inclusive: throughout previous sections of this report, various potential themes for future research were briefly identified. Perhaps the most noteworthy of these pertains to the extreme level of difficulty associated with getting individuals to seek help.[240] If a patient does not make it to a doctor's office, any type of therapy, no matter how effective, will not work. The debilitating symptoms associated with depressive mental illnesses act as extremely effective deterrents in regards to all forms of self-

[238] Positive results from practice situations could include novel positive feelings (such as new found pride, optimism, relief, or increased confidence) and/or favourable reactions or outcomes (such as expressing an honest opinion effectively, having an intimate conversation with a loved one, or making a difficult choice).

[239] Recall Govier's discussion of the positive relationship between successful skill application and improved confidence (See pages 37-38).

[240] Refer back to pages 28-29 for the requirements of effective psychiatric care expansion.

initiated advocacy or action.[241] As discussed previously, current methods of increasing public awareness and help-seeking behaviours are insufficient; it would be tremendously useful to assess which forms of outreach are most effective, and to consider potential methods to improve their scope and overall efficacy in terms of assistance-seeking behaviour of persons who are suicidal. Perhaps it would be useful to spread awareness regarding alternative ways that individuals can improve their mental health (such as engaging in physical activity to lessen stress[242]), in addition to methods of contacting psychological therapists and information regarding what to do in crisis situations. By providing information that suggests ways to improve one's mental state that might seem less intensive or intimidating (as compared to visiting a physician and divulging one's personal tribulations), individuals might be able to generate the ability to seek formal assistance if that first attempt proves to be inadequate. A related area of study pertains to the difficulty of encouraging help-seeking behaviours in the face of ever-present stigmatization that is pushed upon those who cope with mental illness. Stigma and associated vulnerability are directly associated with the relational nature of autonomy and self-trust.[243] A potential solution to issues pertaining to invalidation might include further expanding public awareness of the prevalence of the issue of the relationship between mental illness and suicide, and the importance of being vigilant and supportive of loved ones. Once patients have overcome the difficulty associated with accessing assistance,

[241] Low motivation, decreased sense of self worth, and feelings of entrapment are just a few of the symptoms associated with depression and suicidal ideation that will inhibit one's ability to actively seek help.
[242] See Pilkington K, et al. (2005).
[243] Recall McLeod and Sherwin's discussion of how oppression impedes one's autonomous capacities.

bolstering one's sense of self-trust will lead to greater resiliency and self-advocating abilities.

Lastly, a final area of potential research pertains to the level of accuracy associated with mental health diagnosis procedures. Psychology is a relatively new science, and there is still much to learn regarding the brain and the human mind. Because of this, the current state of mental health assessment is not faultless and thus, there is much potential for misdiagnosis.[244] Misdiagnosis could be a product of imprecise descriptions of (or withholding discussion of[245]) symptoms by patients, confusion of personality elements with mental illness symptoms, or concealed symptoms that do not emerge until later in life.[246] The relational nature of self-identity plays an influential role in regards to how a patient will interpret and respond to questions about her mental state, and what she considers to be relevant in discussions with her therapist. It would be useful for clinical practitioners to understand the potential way(s) that relational self-trust can influence a patient's ability to effectively engage in assessment strategies, and how to use this

[244] Refer back to our discussion of atypical forms of mental illness on pages 25-26, for example.

[245] A patient might withhold discussion of particular symptoms for various reasons. She might not disclose certain symptoms because she might not consider them to be relevant, she might feel embarrassed by them, or might be severely suicidal to the point that she intends to hide her intent to act from her healthcare provider.

[246] An example of this is Bipolar Disorder Type II (BP2), which is often misdiagnosed as Major Depressive Disorder (MDD). This misdiagnosis occurs so often due to the complicated nature of BP2, which features frequent episodes of severe depression, but also includes sporadic episodes of hypomania, which can take years to transpire. The problem with misdiagnosis in this case is that these two illnesses require very different forms of treatment: MDD is usually treated with antidepressants, while BP2 is treated with mood stabilizing medications.

knowledge to improve assessment accuracy. As mental illness is the leading risk factor of suicide, if physicians are better able to diagnose (and therefore appropriately treat) mental health problems, the prevalence of irrational suicidal behaviour is likely to drastically decrease.

CONCLUSION

In contemporary society, the crisis of suicide endures as a veiled, melancholic epidemic. Every forty seconds, someone around the world intentionally dies by their own hand; and every forty-one seconds, someone else is left to make sense of it. Mental illness stands as the leading risk factor of suicidal behaviour, and although current therapeutic practices have displayed considerable efficacy regarding the management of depressive illnesses, the unrelenting prevalence of suicide exemplifies a desperate need for further improvement. While frequently used, psychotropic medications involve a variety of limitations that delay the healing process, and in addition, fail to adequately address potential existential suffering of the individual. To this point, cognitive-based 'talk' therapies allow patients to receive personalized and professional advice, and experience validation. In the case of patients who experience severe and chronic suicidal ideation, Linehan's Dialectical Behaviour Therapy (DBT) serves as a unique and highly effective education program, in which patients are taught positive coping strategies, emotion management techniques, self-monitoring, and interpersonal skills. This program is intensive, and requires significant time and effort on behalf of both the patient and the

therapist involved. Because of this, in addition to concerns regarding limited resource availability and rising levels of need, traditional Cognitive Behavioural Therapy (CBT) practices that place focus chiefly on crisis management are often employed instead of DBT Skills Training. This is problematical, as treatment becomes focused on patient discharge rather than long-term resiliency and wellness. This 'well-enough' model of care is faulty, as it fails to consider the prolonged wellbeing of the patient, which further perpetrates the original issues it attempts to avoid. While there is no doubt that intensive psychiatric care is time and resource consuming, if it is made available for patients with markedly chronic and severe symptoms, the likelihood of crisis situations in the future (and thus, resource usage associated with subsequent hospitalizations and/or additional therapy) will be decreased.

Based on this, DBT seems to be the most ideal treatment procedure for suicidal patients. However, while DBT has displayed undeniable efficacy, there are some notable limitations associated with this practice. It is possible that the level of difficulty and active involvement associated with the concepts of change and acceptance in DBT could discourage new participants, as their cognitive load is already significantly high due to endless and confusing depressive rumination. A sense of additional frustration or discouragement in the early stages of treatment will likely further complicate and prolong the therapeutic process. Moreover, a common critique of DBT refers to its focus on cognition and associated actions, rather than the experience of negative emotions, which is the primary reason that patients seek assistance. The relationship between cognition

and one's behaviour is certainly important, but by failing to appropriately address the personal phenomenology associated with the suicidal mindset, it seems that DBT Skills Training fails to validate the patient's experiences. By engaging in explicit Self-Trust Skills Development (STSD) prior to beginning DBT Skills Training, patients will be provided with the opportunity to obtain a sense of self-assurance, proficiency, and self-awareness, allowing them to better relate to the themes of acceptance and change by having an understanding of their self, their personal situation, and their relationship to the external world. High levels of self-trust have been demonstrated to improve one's sense of identity, goal-setting abilities, level of confidence, and interpersonal skills. This enhanced sense of existential and relational understanding associated with STSD encourages personalized healing within DBT's overtly procedural approach to care, allowing for a more humanistic approach to psychological wellness and overall resiliency.

Viewing autonomy as relational significantly impacts the way that illness is perceived in a therapeutic context. While the experience of sickness is fundamentally personal, it is essential that therapeutic practices be based upon principles that reflect the interpersonal nature of identity and trust, and the effects that they have on an individual's appraisal of her competency and intrinsic worth. Psychological maladies are exclusively embodied, and are associated with dissonances in one's conception of herself and her relation to the external world. Because of this, the authority to advocate for and create positive change must be established *within the patient herself*, as opposed to merely being repeatedly conveyed by a mental health professional. The human brain is a magnificent entity, and

when it is provided with the adequate resources, it has the potential to rewire itself. In sum, if chronically suicidal patients are provided with a Self-Trust Skills Development regimen prior to engaging in intensive cognitive 'talk' therapy practices, their overall level of readiness and confidence to learn new skills and to create positive change will be significantly enhanced. Explicitly augmenting self-trust in patients with chronic and severe suicidal ideation will lead to an enduring source of resiliency and awareness. As has been displayed, the field of psychology touches upon themes related to relational accounts of the self, but in order to further improve our understanding of identity and wellness, these avenues must be explicitly employed in psychiatric care. Philosophical alterations to therapeutic practices that place focus on the relational nature of self-trust, identity, and autonomy will ultimately lead to our improved capacity for combatting the present-day crisis of suicide.

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