Help Negation After Acute Suicidal Crisis

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This study represents one of the first efforts to empirically differentiate between suicidal patients who complete treatment and those who voluntarily withdraw after resolution of the immediate crisis and, accordingly, before formally beginning treatment or within the first 2 days. Participants were contrasted across a range of variables, including suicide ideation, depression, hopelessness, problem solving, life stress, diagnoses in accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.; American Psychiatric Association, 1987), and characterological features. Results indicate the high-risk nature of those withdrawing prematurely from treatment and suggest that this behavior potentially represents another manifestation of overall maladaptive coping, consistent with prominent avoidant, negativistic, and passive–aggressive personality traits.

The concept of *help negation* (Clark & Fawcett, 1992) during or after suicidal crisis has been frequently referenced in the suicide literature but primarily from a theoretical standpoint without empirical support or investigation. Theorists, clinicians, and researchers have referred to help negation, the refusal to accept or access available helping resources, as a likely function or manifestation of patient hopelessness, pessimism, and cynicism regarding the efficacy of treatment or continued intervention.

The concept of help negation during or immediately after resolution of an acute suicidal crisis is identifiably unique. Shneidman has described suicide and suicidal crises as a "more or less transient psychological constriction of affect and intellect" (1992, p. 24) marked by, among other things, perturbation, lethality, hopelessness, frustrated psychological needs, and ambivalence. Although, undoubtedly, many of these are characteristic of ongoing psychotherapy, their convergence and intensity during an acute suicidal crisis is definitively unique.

Despite the importance of improving the clinical understanding of this population, to date no empirical data has surfaced that offers a more definitive clinical description. There are a number of reasons for this gap in the literature, including the very nature of the event being targeted, as well as related clinical, ethical, and legal constraints. In the present study, we were afforded a unique opportunity to assess and briefly follow a group of patients who withdrew prematurely from the treatment component of a longitudinal study of a time-limited, outpatient group intervention that targeted suicidal ideation and behavior.

Naturally, a host of questions surface about this population. Perhaps most salient, however, are those addressing fundamental descriptive concerns as well as the course of recovery and symptomatic response over time for these individuals. Are these individuals characterologically or symptomatically different from those that access treatment resources? If so, in what direction? Is it simply that the crisis overlay to the presentation has adequately resolved, in addition to presenting symptoms, decreasing the identified need for intervention? Is it that, consistent with Clark and Fawcett's (1992) assertion, the individual has become so hopeless, pessimistic, and cynical as to negate the potential efficacy of intervention or treatment? Is help negation simply additional evidence of continued poor judgment, decision making, problem solving, and overall adaptive coping, which likely precipitated the initial crisis?

Method

Participants included a total of 188 individuals, 143 who successfully completed treatment and 45 who withdrew prematurely (i.e., immediately after completion of the assessment and initial intervention phase but before formally beginning treatment or within the first 2 days), in a time-limited, outpatient intervention targeting suicidal ideation and behavior in young adults between the ages of 18 and 26. For this study, the treatment withdrawal and refusal rates were equal—24%—because consideration for the experimental treatment necessitated consent to research participation.

After referral, all young adults reviewed and signed a statement of informed consent that detailed the purpose, procedures, and goals of the study. With few exceptions, the diagnostic interview and related testing were completed in 1 day. Evaluation sessions were completed by

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three highly trained and experienced master's-level clinicians with supervision and quality assurance review provided by M. David Rudd.

Suicidal Ideation

This was measured by the Modified Scale for Suicidal Ideation (MSSI; Miller, Norman, Bishop, & Dow, 1986) and the Suicide Probability Scale (SPS; Cull & Gill, 1989). The MSSI, an 18-item clinician rating form, has evidenced excellent internal consistency and interrater reliability, as well as superb concurrent and construct validity. For the present study, coefficient alpha was .89.

The 36-item SPS provided an additional self-report measure of suicidal ideation. The total scale and subscales have evidenced sound psychometric properties across both clinical and nonclinical populations. For the present study, the total scale coefficient alpha was .91, with subscale alphas ranging from .66 to .87.

Life Stress

This was measured by the Life Experiences Survey (LES). This 57-item self-report measure of life stress allows the respondent to indicate the occurrence of any of the 57 events, distinguish negative or positive impact, and rate the impact accordingly on a 7-point anchored scale ranging from -3 to 3 (Sarason, Johnson, & Siegel, 1978). The scale has evidenced adequate test–retest reliability (.63, .64) over 5- and 6-week intervals and has been widely used in the literature.

Negative Expectations

These were measured with the Beck Hopelessness Scale (BHS), a 20-item true–false scale designed to measure the degree to which one's cognitions are dominated by negative future expectancies (Beck & Steer, 1988). The BHS has evidenced high internal consistency reliability as well as high levels of concurrent and construct validity (Beck & Steer, 1988). For this study, K-R 20 (Kuder-Richardson formula) was .94.

Depression

Depressive symptomatology was measured with the Beck Depression Inventory (BDI), a 21-item self-report scale. The BDI has been widely used, accumulating a considerable research base (Beck & Steer, 1987). It possesses sound psychometric properties with high internal consistency reliability and associated high levels of concurrent and construct validity. For this study, coefficient alpha was .92.

Problem-Solving Behavior and Attitudes

These were measured by the Problem-Solving Inventory Form B (PSI; Heppner, 1988), which is a 32-item self-report measure of an individual's perceptions of his or her own problem-solving behaviors and attitudes. Lower scores indicate self-appraisal as an effective problem solver and vice versa.

Considerable evidence has accumulated to support the concurrent, construct, and discriminant validity of the PSI, as well as basic reliability (Heppner, 1988). For the present study, coefficient alpha for the total scale was .93, with subscale alphas ranging from .76 to .87.

Personality Traits and Character Features

Personality traits and character features were assessed using the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983), a 175-item, true–false inventory designed for use with psychiatric patients. The MCMI has been widely used in the clinical literature and is well validated.

Psychiatric Diagnoses

These were made using the National Institute for Mental Health (NIMH) Diagnostic Interview Schedule (DIS). It has been modified (Version III-R; Robins, Helzer, Cottler, & Goldring, 1989) to incorporate the criteria of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.; DSM-III-R; American Psychiatric Association, 1987). The DIS is a highly structured interview that renders both lifetime and current psychiatric diagnoses according to Axis I of the DSM-III-R. Given the purposes of the present investigation, only current diagnoses were used.

A computerized version of the DIS (C-DIS; Blouin, Perez, & Blouin, 1988) in which each DIS item as well as the related complex probing sequence is presented verbatim, was used in this study, essentially reducing total error variance. Although designed to be entirely self-administered, the C-DIS was used only in the computer-assisted mode, making use of a trained interviewer who was not informed of the study hypotheses. The C-DIS has evidenced acceptable test-retest reliability similar to the original DIS (Blouin et al., 1989).

Results and Discussion

Demographic and Other Group Characteristics

The groups, referred to as treatment completers and patients who withdrew from treatment (i.e., withdrawal patients), were comparable across a range of demographic variables including age, gender, ethnicity, marital status, and educational background. Additionally, no significant differences were uncovered regarding a range of family of origin issues or the need for acute hospitalization before treatment, as well as previous treatment and individual psychiatric history to include previous hospitalizations. Finally, the groups were comparable with respect to the distribution of ideators, attempters, and multiple attempters, as well as current psychoactive medication use (i.e., predominantly antidepressants and anxiolytics).

Psychiatric Diagnoses

Table 1 provides a listing of the most frequent Axis I DSM-III-R diagnoses received by each group as well as a comparison of relative percentages of each group receiving the diagnosis. As evidenced, treatment completers and withdrawal patients were, for the most part, diagnostically comparable with a single significant difference. Greater than double the percentage of withdrawal patients received diagnoses of obsessive-compulsive disorder, $\chi^2(1) = 4.40, p = .036$. Disproportionate representation of this diagnostic group among withdrawal patients makes conceptual sense, particularly in light of the personality traits and characterological features (discussed later) for both groups.

Symptom Measures

Table 2 provides a summary of mean symptom scale scores for treatment completers and withdrawal patients at both intake and 1-month follow-up. With respect to follow-up data (i.e., 1 month), differential attrition and potential selection bias are of concern. Available data, nonetheless, offer a unique opportunity for informed inference and discussion, particularly in light of the targeted group.

As indicated, mean scores at intake were comparable between the two groups, across all measures. Actually, mean scores for withdrawal patients were uniformly higher, although

Table 1
Distribution of the Most Frequent Diagnoses Among Treatment Completers and Withdrawal Patients

| | n (and %) of: | | | |
Diagnosis	Completers	Withdrawal patients	χ^2	p
Major depression[a]	59 (41%)	19 (42%)	.013	.91
Bipolar disorder[b]	32 (22%)	7 (16%)	.969	.33
Depressive disorder NOS	7 (5%)	1 (2%)	.600	.44
Dysthymia	9 (6%)	3 (7%)	.008	.93
Panic disorder[c]	5 (4%)	3 (7%)	.844	.36
Agoraphobia[d]	19 (13%)	3 (7%)	1.45	.23
PTSD	35 (25%)	13 (29%)	.351	.55
GAD	12 (8%)	2 (5%)	.774	.38
OCD	3 (2%)	4 (9%)	4.41	.036
Social phobia	53 (37%)	15 (33%)	.206	.65
Simple phobia	40 (28%)	12 (27%)	.029	.87
Alcohol abuse	55 (39%)	17 (38%)	.007	.94
Cannabis abuse	8 (6%)	3 (7%)	.071	.79
No diagnosis	10 (7%)	5 (11%)	.791	.37

Note. NOS = not otherwise specified; PTSD = posttraumatic stress disorder; GAD = generalized anxiety disorder; OCD = obsessive–compulsive disorder.
[a] Single episode and recurrent. [b] Mixed, manic, and depressed. [c] With or without agoraphobia.
[d] Without panic.

not significantly so, than treatment completers. This observation appears to counter a previously noted argument that help negation and treatment withdrawal could potentially be a function of symptom and crisis resolution. To the contrary, withdrawal patients were actually as symptomatic and evidenced problem-solving skills as poor as those who successfully accessed available services.

One-month follow-up data provide additional evidence to counter this supposition and offer support to Clark and Faw-

Table 2
Mean Scale Scores for Treatment Completers and Withdrawal Patients at Intake and 1-Month Follow-Up

| | Completers | | Withdrawal patients | |
Scale	Intake ($n = 143$)	1 Month[a] ($n = 120$)	Intake ($n = 45$)	1 Month[a] ($n = 19$)
MSSI	23.0	5.6	24.8	9.7
BHS	8.9	4.8	9.2	6.6
BDI	20.2	9.2	20.5	12.9
SPS	66.9	60.5	69.0	64.0
PSI	110.1	101.5	110.1	106.0
LES	18.9	12.9	22.4**	19.8***

Note. MSSI = Modified Scale for Suicide Ideation; BHS = Beck Hopelessness Scale; BDI = Beck Depression Inventory; SPS = Suicide Probability Scale; PSI = Problem Solving Inventory; LES = Life Experiences Survey (negative life stress).
[a] All within-group comparisons between intake and 1 month are highly significant ($p < .001$) for both treatment completers and withdrawal patients, except for the BDI ($p = .027$) and BHS ($p = .056$) for withdrawal patients. More specifically, the observed decrease in mean scores between intake and 1 month is significant for all measures except where indicated in the text.
** $p = .067$. *** $p = .03$.

cett's (1992) assertion that help negation is a function of cynicism, pessimism, and hopelessness regarding treatment efficacy. More precisely, help negation may be primarily a function of the general personality and adaptive coping style of the individual, compounded by acute situational stress, associated symptomatology, and resultant Axis I diagnoses.

Although symptoms significantly diminished for both groups at 1 month relative to intake, withdrawal patients evidenced relatively higher MSSI and BDI scores in contrast to treatment completers, but not to a significant degree. Importantly 1-month scores for both groups no longer evidenced what are considered clinically meaningful elevations. However, withdrawal patients reported significantly higher levels of stress both at intake, $t(182) = -1.84$, $p = .067$, and 1-month follow-up, $t(137) = -2.19$, $p = .03$, relative to treatment completers. Additionally, both the life stress and problem-solving scores for withdrawal patients did not improve significantly from intake to 1 month, suggesting a persistence of stress and continued poor adaptive coping.

Overall, results suggest that not only were withdrawal patients as symptomatic and, accordingly, at high a risk as treatment completers at intake, they also experienced a persistence of reported stress, relatively less symptom remission, and continued poor adaptive coping over the first month after the suicidal crisis.

Personality Traits and Character Features

As illustrated in Table 3, MCMI results were essentially identical for treatment completers and withdrawal patients across all scales (i.e., including basic personality patterns, pathological personality disorders, moderately severe clinical syndromes, and markedly severe clinical syndromes), both at intake and at 1-month follow-up. Consistent with mean symptom scale

Table 3

Mean MCMI Base Rate Scores for Treatment Completers and Withdrawal Patients at Intake and 1-Month Follow-Up

| | Treatment completers | | Withdrawal patients | |
Disorder	Intake (n = 143)	1 month[a] (n = 120)	Intake (n = 45)	1 month[a] (n = 19)
Basic personality patterns				
Schizoid	71	57	72	62
Avoidant	80	57	80	63
Dependent	68	54	71	66
Histrionic	51	64	51	60
Narcissistic	48	69	49	63
Antisocial	54	67	53	61
Compulsive	41	49	42	49
Passive aggressive	85	61	81	66
Pathological personality disorders				
Paranoid	58	65	62	66
Borderline	71	54	72	57
Schizotypal	60	52	61	55
Markedly severe clinical syndromes				
Psychotic delusion	56	59	59	59
Psychotic thinking	65	58	66	62
Psychotic depression	66	53	68	57
Moderately severe clinical syndromes				
Drug abuse	60	67	62	66
Hypomania	46	49	46	54
Somatoform	67	56	68	63
Anxiety	88	63	88	74**
Dysthymia	87	59	87	70*
Alcohol abuse	59	51	59	53

[a] All within group comparisons between intake and 1 month are highly significant ($p < .001$) for both treatment completers and withdrawal patients with the following exceptions: psychotic delusion for treatment completers ($p = .374$), and dependent ($p = .062$), compulsive ($p = .279$), passive–aggressive ($p = .098$), borderline ($p = .033$), schizotypal ($p = .224$), psychotic delusion ($p = .975$), psychotic thinking ($p = .150$) for withdrawals. More specifically, all scales that were clinically elevated at intake (base rate ≥ 75) have significantly declined except where indicated in the text. As is indicated in the table, neither group evidenced a base rate score at or above 75 at the 1 month follow-up point.

* $p = .09$.   ** $p = .067$.

scores detailed in Table 2, MCMI base rate scores indicate comparable levels of acute symptomatology, predominantly mixed anxiety and depressive symptoms. Also consistent with previous findings regarding symptom remission, withdrawal patients experienced a persistence of these symptoms over 1 month relative to treatment completers—(anxiety, $t[137] = -1.80$, $p = .07$, dysthymia, $t[137] = -1.67$, $p = .09$)—with mean scores approaching clinically significant levels (i.e., base rate ≥ 75). With respect to basic personality pattern scores, the most prominent and potentially maladaptive personality traits were similar for both groups.

In accordance with the MCMI interpretive guideline of designating base rates at 75 or above as having clinical usefulness, both treatment completers and withdrawal patients evidenced 2–8 mean profiles. Those receiving such profiles can best be described as manifesting prominent avoidant, negativistic, and passive–aggressive traits (Choca, Shanley, & Van Denburg, 1992; Millon, 1983). The avoidance may potentially be experienced as a hypersensitivity to rejection. Interpersonal situations are likely to be perceived of as very risky with potential for humiliation and emotional hurt. A strong urge for interpersonal contact and acceptance is, nonetheless, likely to be strong but overwhelmed by fears of rejection, humiliation, and embarrass-

ment. The net result is likely to be simple avoidance of interpersonal contact with these individuals best being described as loners. Those receiving 2–8 profiles tend to be highly aware of their own feelings and hypersensitive to the reactions they evoke from others. In general terms, they are likely to perceive others as seemingly cold and unresponsive.

There is also a strong probability of chronic self-image disturbance, marked by prominent feelings of general ineffectualness. There is a likely tendency for these individuals to be moody and resentful, as evidenced by indications of prominent Axis I symptomatology in Table 3. Accordingly, the nature of their interpersonal relationships is likely to be rocky and conflictual. Fluctuations between a cooperative demeanor on the one hand and open hostility on the other might be anticipated. As would be expected, these individuals are likely to have difficulty in establishing and maintaining an effective therapeutic alliance. Trust, confidence, and a general sense of intimacy in the relationship are, in all probability, difficult to establish but may well be paradoxically facilitated by the suicidal crisis precipitating the patient's presentation.

Given the relatively comprehensive nature of the data available, a number of the questions initially raised regarding help negation can effectively be addressed. Perhaps most surprising

among available results, and paradoxically important, is the comparable nature of the two samples with respect to not only acute symptomatology but also Axis I *DSM–III–R* diagnoses and basic personality features.

The two groups appeared essentially identical both at intake and follow-up with only a few minor differences, likely the function of effective intervention. In general, results indicate that both groups exhibited comparable levels of symptomatology, primarily mixed depressive and anxiety symptoms, and appeared to be at comparable risk as assessed by measures of suicide ideation and behavior. Similarly, hopelessness and general negative future expectancies were found to be comparable between the two groups, with significant improvement over the short follow-up period. The two groups were also comparable with respect to self-appraised problem-solving abilities, each seeing themselves as highly ineffective.

Essentially, two differences emerged between the groups, both addressing symptom response and adaptive coping over time. First, withdrawal patients experienced a persistence of both reported stress and mixed anxiety and depressive symptoms relative to treatment completers. Available data do not support the hypothesis that treatment withdrawal is simply a function of symptom or crisis resolution. To the contrary, it appears that those who withdrew were at as high a risk as treatment completers, at both intake and 1 month, and that they experienced not only a persistence of reported stress and poor adaptive coping but also less symptom remission over time.

Current results offer support for Clark and Fawcett's (1992) assertion that help negation is a function of individual pessimism and hopelessness, but with a few caveats. Hopelessness is unquestionably of importance. However, in light of our data regarding prominent personality features, it might be more instructive to note that pessimism and cynicism are most likely not unique to the therapeutic situation or immediate crisis but rather indicative of the individual's general adaptive coping and interpersonal style. As noted earlier, 2–8 profiles manifest a unique combination of avoidant, negativistic, and passive-aggressive personality traits generally considered consistent with poor adaptive coping.

Perhaps most important to clinicians, the individuals studied were characterized by interpersonal hypersensitivity, a trait common to both treatment completers and withdrawal patients. For these individuals, interpersonal situations are best described as risky, ripe with potential for humiliation and emotional hurt. Seeing others as cold and unresponsive and a history of probable isolation and limited social interaction are likely to only compound this expectation.

Given that participants were referred during an acute suicidal crisis, interpersonal vulnerability was paramount. The recommendations of Maltsberger and Buie (1974) regarding the need to carefully monitor countertransference reactions take on added weight in light of this finding. Additionally, the general personality features of this population make it unlikely that the clinician would ever be directly confronted with any perceived

slight; rather a cooperative demeanor would be anticipated, followed by avoidance and withdrawal.

At the heart of the issue, particularly during acute crises, trust and interpersonal intimacy are of paramount importance and paradoxically difficult for these individuals. Patience, persistence, restraint, and tolerance of the patient's anticipated moodiness, as well as careful monitoring of the countertransference reaction, are all essential to establishing an effective therapeutic alliance. Interestingly, individual involvement and, accordingly, the therapeutic alliance may well be paradoxically facilitated by both the immediacy and urgency of the suicidal crisis, as well as the prominent and somewhat contradictory desire for interpersonal contact and acceptance. In the end, the very qualities that, in all likelihood, precipitated the initial suicidal crisis and drove the individual into treatment may be responsible for premature withdrawal and help negation.

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