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Beyond lithium: Using psychotherapy to reduce suicide risk in bipolar disorder

Novel approach teaches patients to 'disown' suicidal thoughts, internalize future

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Patients with bipolar disorder (BD) have a high risk for suicidal ideation, suicide attempts, and suicide.[1-3] Approximately 25% to 50% of BD patients attempt suicide at least once, and their attempts often are lethal—the ratio of attempts to completed suicides in BD patients is 3:1, compared with 30:1 in the general population.[4] Lithium has been shown to effectively stabilize BD patients' mood and significantly reduce the rates of suicide attempts and completed suicides,[5-9] but does not reduce BD patients' long-term suicide risk to that of the general population.

Literature on psychotherapeutic treatments for patients with BD primarily focuses on improving patients' adherence to pharmacotherapy and achieving faster recovery and remission.[10] Nonpharmacologic treatments for patients with BD include psychoeducation, family-focused psychoeducation, cognitive therapy, and interpersonal and social rhythm therapy (***Table 1, page 40***).[11] Literature on nonpharmacologic treatments to address suicidality in BD patients is limited,[12,13] and additional psychotherapeutic interventions to reduce suicide risk in BD patients are needed.[14]

In this article, I describe a novel psychotherapeutic intervention I use that integrates cognitive therapy principles with ideas derived from the psychosynthesis model.[15,16] It consists of teaching patients to "disidentify" from suicidal thoughts, followed by a guided-imagery exercise in which patients experience a future positive life event with all 5 senses and internalize this experience. This creates a "hook into the

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The psychosynthesis model proposes it is easier to change thoughts identified as foreign to 'the self'

Table 1

Nonpharmacologic interventions for bipolar disorder

Goals	Techniques
Psychoeducation	
• Increase illness awareness • Improve medication compliance • Early detection of relapses • Establish lifestyle regularity	• Education based on books, pamphlets, and Web sites regarding the symptoms, course, treatment, and self-management of BD • Self-monitoring of symptoms and behaviors • Discussion
Family-focused psychoeducation	
• Accept notion of vulnerability for future episodes • Accept need for mood-stabilizing medications • Educate to distinguish between patient's personality traits and BD symptoms • Reestablish functional relationships after a mood episode	• Education based on books, pamphlets, and Web sites regarding the symptoms, course, treatment, and self-management of BD • Enhance communication skills in the family • Education about problem-solving skills
Cognitive therapy	
• Challenge the patient's dysfunctional thoughts and beliefs regarding self and the world as influenced by BD	• Self-monitoring of dysfunctional thoughts and behaviors • Monitor moods and early signs of relapse • Develop a plan of action to deal with early signs of relapse • Emphasize the need of combined pharmacotherapy and psychotherapy • Promote the importance of regular sleep and healthy lifestyle
Interpersonal and social rhythm therapy	
• Stabilize daily routines and sleep/wake cycles • Gain insight into relationship between moods and interpersonal events • Relieve stress and interpersonal problems	• Review history of illness • Track and identify connections between sleep patterns, activities, and mood • Develop a plan to stabilize social and circadian rhythms by maintaining consistent sleep/wake times and reducing excessive social stimulations • Explore and resolve interpersonal problems

BD: bipolar disorder

Source: Reference 11

future" that changes the present to match the future event and acts as an antidote to suicidal thoughts. I have used this strategy successfully in many patients as an adjunct to pharmacotherapy.

A theoretical model

Roberto Assagioli, who established the approach to psychology called psychosynthesis, formulated a fundamental psychological principle in controlling one's behavior: "We are dominated by everything with which our self becomes identified. We can dominate and control everything from which we disidentify ourselves."[15] According to the psychosynthesis model, it is easier to change thoughts we identify as foreign to "the self" (ego-dystonic) than thoughts we identify as being part of "the self" (ego-syntonic).

Patients whose suicidal thoughts are ego-syntonic identify with the thoughts as representing themselves and take ownership of these thoughts. Such patients are at a greater risk of acting on suicidal thoughts.

Patients whose suicidal thoughts are ego-dystonic consider the suicidal

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Table 2

Examples of ego-syntonic vs ego-dystonic suicidal thoughts

Ego-syntonic	Ego-dystonic
'I want to be dead. I found a simple and sure way to do it'	'I am having suicidal thoughts again and I don't like it'
'I know my family will be better off without me'	'I'm afraid the illness is coming back. I can't stop these images'
'Life is too hard, too much pain. I just want to end it all'	'I see my body in a coffin. It scares the hell out of me'
'I've come to the end, life for me is over and done'	'I don't want to die. Please help me get well again'
'I know my life is over. I just have to find the right way to do it'	'It is as if a part of me wants to die but the rest of me wants to live'
'Nobody cares about me. It is as if I am already dead'	'I know my family needs me. I want to be there for them'
'I have nothing to live for'	'I have so much to live for, why am I having such crazy thoughts?'

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Patients whose suicidal thoughts are ego-syntonic identify such thoughts as representing themselves and may act on them

thoughts foreign to their core self and do not believe such thoughts represent them. In essence, they "disown" the thoughts and typically want to control and eliminate them. Examples of patients' ego-syntonic vs ego-dystonic suicidal thoughts are listed in ***Table 2***.

This construct calls for an intervention to help patients who have ego-syntonic suicidal thoughts restructure them as a manifestation of BD, rather then the patient's core self belief. The intervention emphasizes the patient is not "a suicidal patient" but suffers from an illness that may manifest with suicidal ideation. Many BD patients overly identify with their disease, stating, "I am bipolar" or "I am suicidal." The "I am" statement originates from the verb "to be," which implies the disease is part of the patient's identity. The goal of this intervention is to help the patient learn to disidentify from the disease and decide that suicidal thoughts do not represent their core self, but are a manifestation of the underlying disease.

The psychosynthesis model of helping patients disidentify and therefore disown suicidal thoughts is compatible with interventions that use mindfulness-based cognitive therapy training to teach patients to experience their thoughts as just passing through their consciousness without taking ownership of them.[17]

The intervention

Assessment of suicidality is a fundamental skill for every mental health clinician.[18] The psychotherapeutic intervention I use integrates the cognitive therapy principles of reframing, relabeling, and restructuring patients' thoughts with disidentification from dysfunctional thoughts, feelings, and desires, based on psychosynthesis principles.

First, I conduct a comprehensive mental status examination that includes an in-depth exploration of the patient's suicidal thoughts to determine if they are ego-syntonic or ego-dystonic. I begin by asking patients to clarify and elaborate on their statements referring to suicide, asking questions such as "Is there a part of you that objects to these thoughts?" and "Is there a part of you that wants to live?" If a patient indicates that he or she does experience inner conflict regarding such thoughts, these thoughts are classified as ego-dystonic. If a patient does not have any counter thoughts regarding the suicidal thoughts and fully identifies with them, the thoughts are classified as ego-syntonic.

I follow this with a treatment plan that helps patients change their view of their suicidal thoughts. I ask the patient to change these suicidal thoughts to ego-dystonic by focusing on the following statement: "I, (patient's name), am a human being and like all

human beings, I have thoughts; however, I am not my thoughts, I am much more than that." I ask my patient to read this out loud and to mindfully meditate on this statement several times a day to reinforce the new understanding that these suicidal thoughts are a manifestation of the chemical imbalance of the mood disorder, and do not represent the patient as a person.

This intervention is paired with a future-focused internalized imagery experience I have described in previous articles.[19,20] In this part of the treatment, the patient and I discuss a specific expected life milestone that is positive and for which he or she would want to be present (eg, children graduating from high school or college, a wedding, birth of a child/grandchild, etc.). Using guided imagery, the patient experiences this event with all 5 senses during the session. I instruct the patient to internalize the experience and bring it back from the future to the present. This creates a "hook into the future" that is coupled with this desired milestone event in the patient's life.

The following 3 case studies provide examples of the application of this treatment intervention.

CASE 1

Disidentifying family history

Mrs. G, a 42-year-old mother of 2, suffers from bipolar II disorder with recurrent episodes of depression associated with ego-syntonic suicidal thoughts. She states that at times she feels she is a burden to her husband and children and believes they may be better off without her. She says she believes "ending it all" must be her destiny. After further investigation, I learn Mrs. G has a family history of BD and 3 relatives have committed suicide. This family history may partially explain her belief that suicide must be "in her genes."

I discuss with Mrs. G the strategy of changing her thoughts. I tell her to write in her journal—which she brings to her sessions—the following statements: "I am a human being. I am an adult woman and mother of 2 children. I know I have thoughts but I am not my thoughts, I am much more than that. I know I

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Patients whose suicidal thoughts are ego-dystonic typically want to eliminate such thoughts

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This intervention calls for patients to restructure suicidal thoughts as a manifestation of bipolar disorder

have genes but I am not my genes, I am much more than that. I know I have feelings, but I am not my feelings, I am much more than that. I know I have cousins, uncles, aunts, and other relatives but I am not my relatives. I am uniquely myself, different from the others."

I ask Mrs. G to read these statements out loud and repeat them several times a day to reinforce this new way of perceiving the suicidal thoughts and to disidentify from the thoughts and her family history as it relates to suicide.

Mrs. G and I talk about the future and expected family milestones. When I ask if her son would want her to be present at his college graduation, she says yes. We then discuss in detail the date, time of day, and location of this event, followed by a guided imagery exercise focused on the graduation. She is guided to experience this event with all 5 senses and describes the event in detail, including the expression on the faces of her husband and children, their voices, and the scent of their aftershave lotion. She hears her son saying, "Mom, I love you. Thank you for being there with me all these years. I could not have done it without you." I ask Mrs. G to internalize these experiences and carve them into her memory. She is instructed to come back from this future-focused guided imagery experience. When her eyes open, she looks at me and describes her experience in great detail, at times using the past tense, which confirms that the future-focused event was internalized.

In her next session, Mrs. G reports an improvement in her sleep and a change in her suicidal thoughts, which now are only fleeting.

CASE 2

Experiencing graduation

Ms. J, age 17, was diagnosed with bipolar I disorder when she was 15. She has a family history of BD in her mother, 2 maternal aunts, her grandmother, and an older sister. All these women have a history of suicidal thoughts and suicide attempts requiring hospital treatment, but no completed suicides.

Ms. J has been taking an adequate combination of mood stabilizers. She has recovered from 2 previous depressive episodes and is experiencing a third relapse with suicidal thoughts. At times, she experiences these thoughts as ego-syntonic; at other times, they are ego-dystonic.

I first educate her about the nature of BD, explaining that her suicidal thoughts are a manifestation of a chemical imbalance in her brain as a result of the depressive relapse. I teach her to use guided imagery to focus on her favorite place of peace and serenity, the beach, which produces immediate relief of the intense anxiety she felt.

After we complete the disidentification exercise, I ask her to focus on her high school graduation ceremony, which is scheduled to take place in 1 year. In a state of guided imagery, she experiences her graduation from high school with all 5 senses. As she returns to a state of full alertness with her eyes open, she describes the graduation ceremony experience in detail using the past tense, as if it had already occurred, thereby creating her own hook into the future. I instruct her to write about this experience in her journal and bring it with her to the next session.

The following session, Ms. J reports that her suicide ideations have "disappeared." She says this was accompanied by improvements in her overall mood and sleep.

CASE 3

Internalizing the future

Mr. C, a 38-year-old married father of 4 children, has bipolar II disorder and is in a depressed state. He has been treated with optimal doses of mood stabilizers and atypical antipsychotics but continues to have suicidal thoughts. These thoughts are at times ego-syntonic; he says, "My family would be better off without me." When Mr. C's mood improves, however, the suicidal thoughts become more ego-dystonic; he expresses fear that he might act out on the thoughts and states that he does not want to die, he really wants to live and get better. He has no history of suicide attempts.

During our session, I ask Mr. C to focus on a new perspective to understand his thoughts by repeating the following statements: "I, JC, am a human being. I know I have a bipolar mood disorder; however, I must remember I am not bipolar. I have suicidal thoughts; however, I am not my thoughts, I am much more than that. I know I want to live, to heal, and to get better. I want to be alive and well so I can see and participate in my children's graduation from high school and be there when they get married and when my grandchildren are born."

I teach Mr. C to use guided imagery, during which he experiences such future positive images and milestones in his life in all 5 senses and internalizes them by using the "back from the future" technique.[17] By the end of the session, he reports feeling better, more hopeful, and confident in his abilities to control his suicidal thoughts. I instruct him to write in his diary about his experiences with the future-focused positive milestones and to bring this assignment to his next appointment.

At his next appointment, Mr. C reports that his suicidal thoughts have become more fleeting, lasting for 10 to 30 seconds, and then spontaneously change to focus on issues of the "here and now." When I ask him to read what he's written, what stands out is the use of past tense verbs to describe future-focused experiences. For me, this confirms that Mr. C has internalized the future, creating the desirable "future hook" that acts as an antidote to the suicidal thoughts.

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Related Resources

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- Weinberg I, Ronningstam E, Goldblatt MJ, et al. Strategies in treatment of suicidality: identification of common and treatment-specific interventions in empirically supported treatment manuals. J Clin Psychiatry. 2010;71:699-706.

Drug Brand Name

Lithium • Eskalith, Lithobid

Disclosure

Dr. Torem reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Clinical Point

By undergoing guided imagery, patients create a 'hook into the future' that they can use to counter suicidal thoughts

Bottom Line

Pharmacotherapy alone may not be sufficient for managing suicide risk in patients with bipolar disorder. An adjunctive psychotherapeutic intervention that combines teaching patients to 'disidentify' from suicidal thoughts with future-focused imagery may improve the effectiveness of these patients' overall treatment and reduce the risk of suicide.