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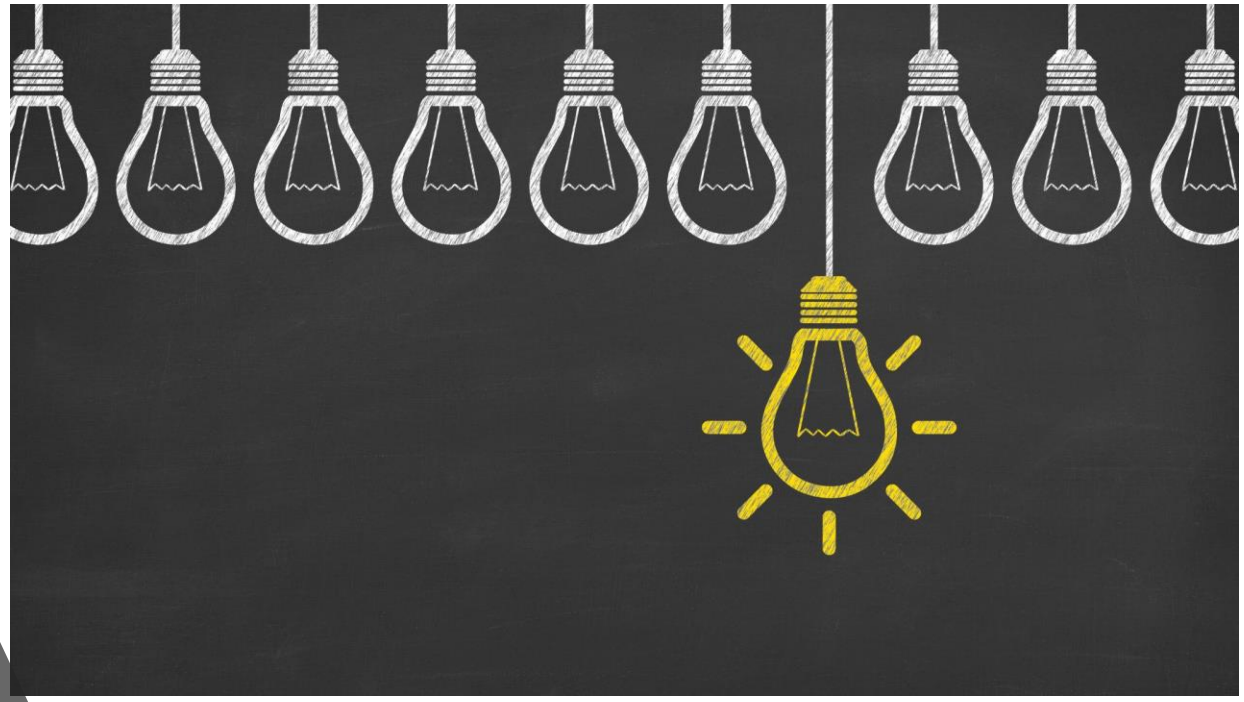
2020 Utah Zero Suicide Summit

Understanding, Managing & Treating Chronic Suicidality



Financial Disclosures

- Received free admission/CE’s for presenting at the Zero Suicide Summit today
- Fulltime employee at Salt Lake Behavioral Health as the Chief Clinical Officer

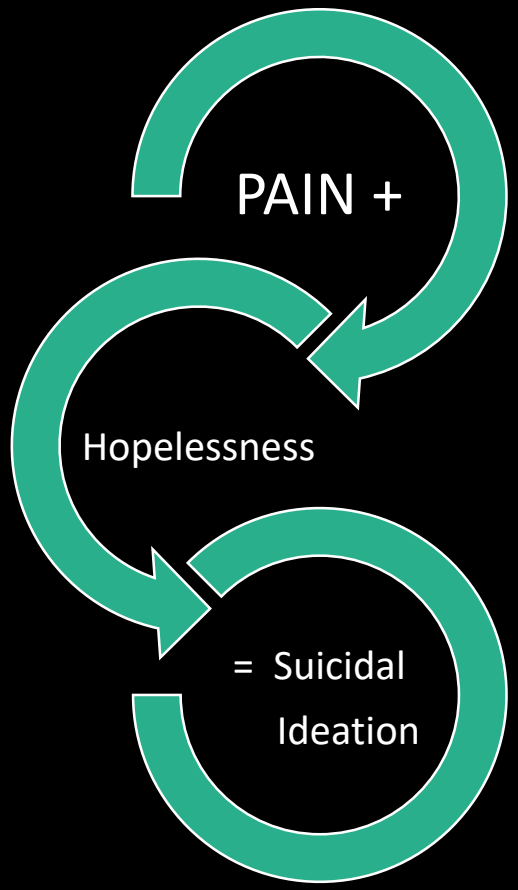
Learning Objectives

- Increase understanding of why individuals have chronic suicidal thoughts/intent
- Learn how to empathize with the suicidal wish while simultaneously instilling hope for change
- Assessing suicidal risk with chronically suicidal clients
- Learn alternatives to hospitalization and how to identify when hospitalization is necessary
- Learn skills to manage our own emotions when our clients want to die

Joiner's Suicide Risk Categories

1. Baseline = absence of acute crisis, no significant stressors nor prominent symptomology. Only appropriate for passive ideations and single attempters
2. Acute = presence of acute crisis, significant stressors and/or prominent symptomatology. Only appropriate for ideators and single attempters
3. Chronic High Risk = baseline risk for multiple attempters. Absence of an acute crisis, no significant stressors nor prominent symptomatology.
4. **Chronic High Risk with Acute Exacerbation = Acute risk category for multiple attempters. Presence of acute crisis, significant stressors and/or prominent symptomatology.**

Ideation to Action Framework & 3ST



Low connectedness to life
(i.e. purpose, social connections, feeling like a burden to others)

&

Capability

=

Suicide Attempt

Klonsky, D. & May, A. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy.* 8(2) 114-129.

Transcript from client (Doe) journal April 2017

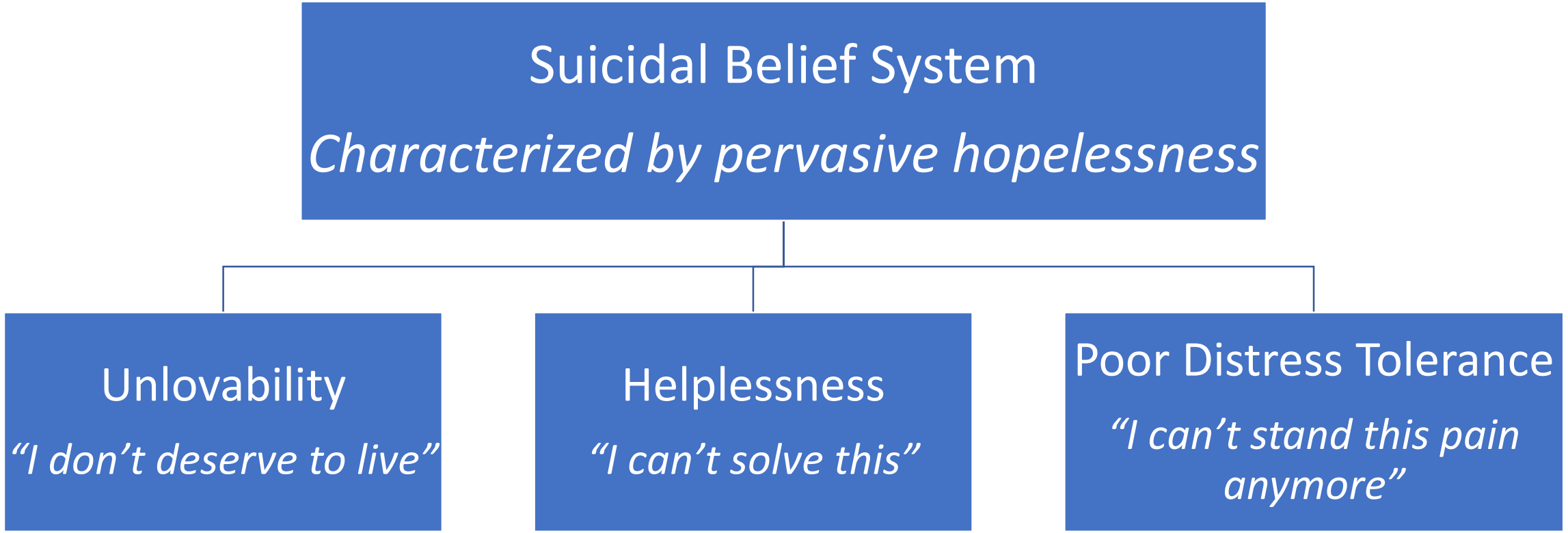
“I’m tired of all the same bullshit every other day I’m in full on asses and there’s nothing I can do about it. I DON’T WANT THIS LIFE. I DON’T WANT ANY LIFE. I JUST WANNA BE FUCKING DONE. WHY AM I SUCH A COWARD?

I just wanna slip into a fucking coma and have my family pull the plug. I want to be free to go at any time. I want to die now. What’s the point of having a life I don’t want. How is it you’re there for me when I can’t talk to you about this and you don’t understand anyways.

No one does, no one will. I really am alone in this. That’s reason one, that I will eventually end my life. I don’t really matter.”

Suicidal Mode – frame of mind

- Understand the suicidal belief system
- Often interpersonal issues are at the core for chronic suicidal thoughts

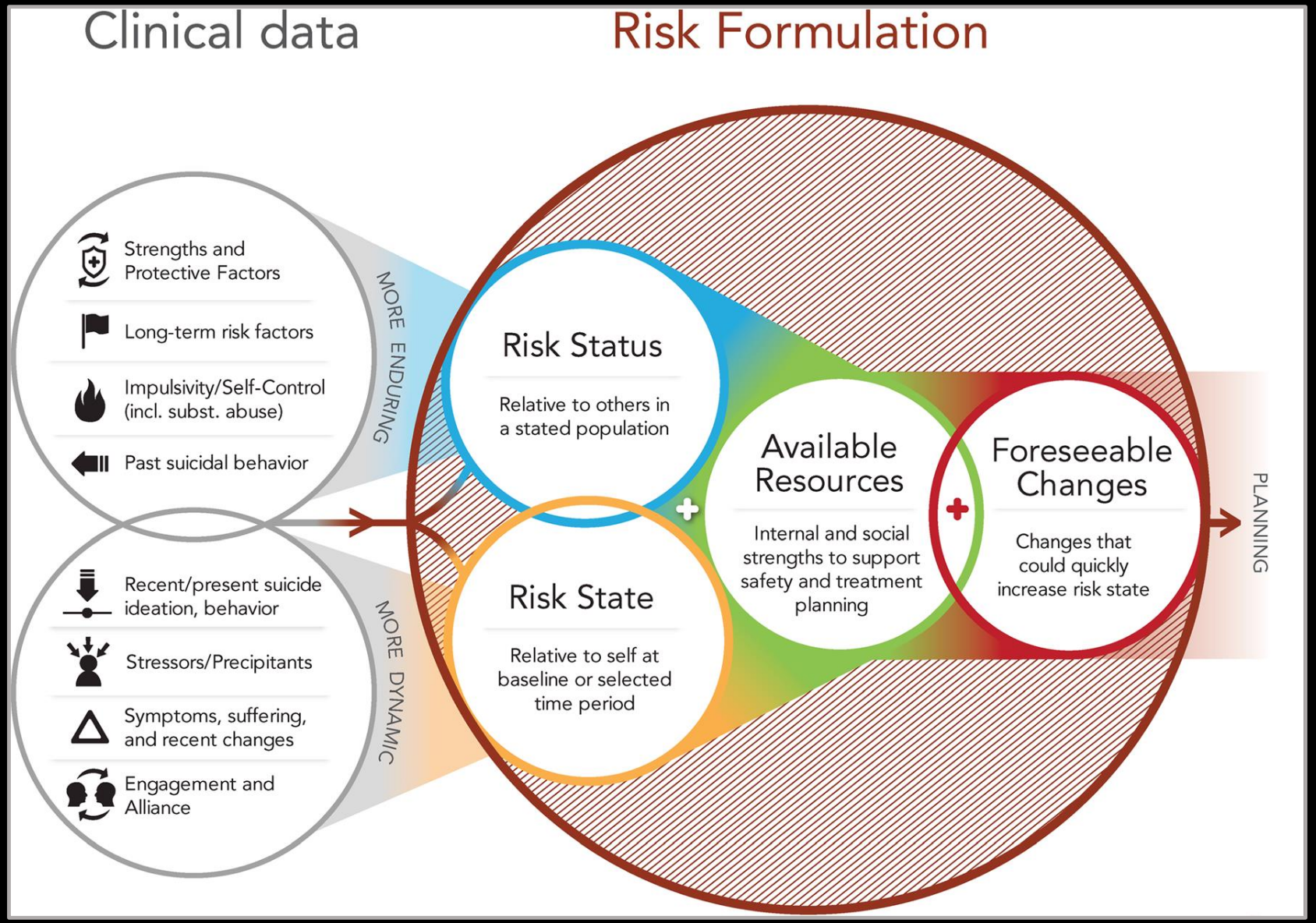


(Rudd, M., Joiner, T. & Rajab, M. 2001. p 29)

Assessing Suicide Risk

- Primary goal is to develop a shared understanding of the client's suicidality (demonstrate empathy towards the suicidal wish)
- The interview/assessment should always start with the patient's self-narrative
- The ultimate goal must be to engage the patient in a therapeutic relationship
- Teach the client how to assess their risk level
- Use comparison risk states
  - i.e. Doe's risk is higher than it was at the last session due to losing her job, break-up with significant other, and marked increase in intensity and frequency of suicidal ideations

Assessment of Suicide Risk: From Prediction to Prevention

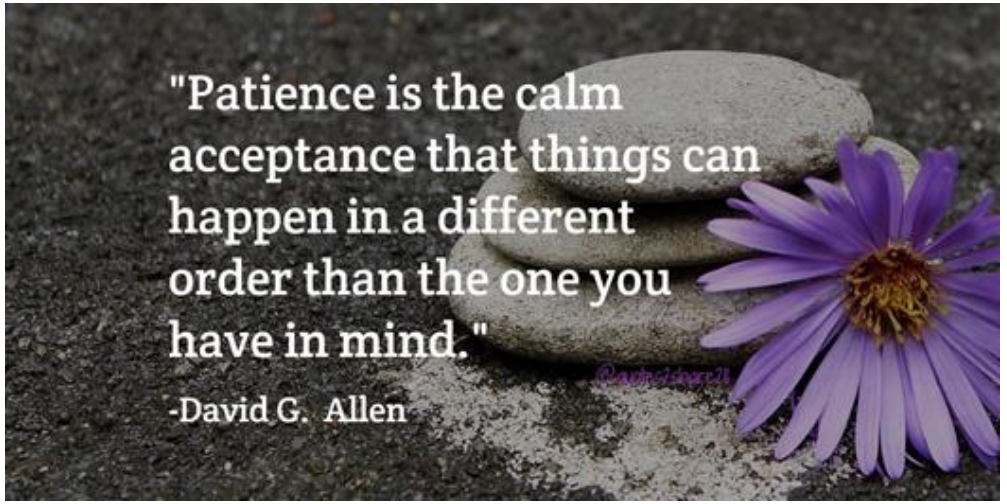


Pisani, A., Murrie, D., & Silverman, M. (2015). Reformulating Suicide Risk Formulation: From Prediction to Prevention. Acad Psychiatry .

Goals of Therapy – Marsha Linehan
https://youtu.be/j_6j43zKNFw

Skills needed to work with chronic suicidal clients

- Have a solid theoretical framework
- Strong working alliance
- Patience
- Ability to tolerate risk
- Cognitive flexibility to manage uncertainty
- Phenomenological understanding
- A solid belief that healing can be achieved
- Not being uncomfortable/fearful of pain and intensity
- Be okay staying/processing in the ambivalence
- Treat the trauma



Working Alliance / Therapeutic Relationship

- This is an ongoing process
- Ask about previous treatment (especially problems)
- Collaborative therapeutic process in all (most) decisions
- This becomes the mechanism for support in crisis & becomes a vehicle for change
- Avoid therapy interfering behaviors: *being late, ending early, disruptions (phone), falling asleep, or eating/drinking during sessions*

<u>Relationship Acceptance</u>

- Accepting the client as is

<u>Relationship Problem Solving</u>

- Active discussion of identified problems during therapy sessions & outside in consultation (for the therapist)

<u>Relationship generalization</u>

- Client generalizes relationship gains outside of the therapy context

Implications for Clinical Practice

- Intensity of treatment may need to be increased (IOP/PHP, 2+ sessions a week)
- Longer-term treatment is likely
- Intensive follow-up, case management, telephone contacts, letters/email, crisis management, or home visits may improve treatment compliance
- Willingness to extend boundaries (as clinically appropriate)
- Be willing to dig into pain & trauma
- Watch for avoidance behaviors (both client and therapist)
- Focus on how to listen vs. what to say
- Teach clients to observe SI with curiosity & detachment – externalization
- Recognize that the option of suicide might be what helps your client to stay alive

Clean Pain vs. Dirty Pain
https://youtu.be/6SkMGucjRgU

- Therapeutic relationship
- Changes in intensity of suicidal risk
- Review/Update crisis response plan & lethal means
- Connectedness
- Ambivalence
- Skill building (impulse control, emotion regulation, distress tolerance, anger management, self-image, and interpersonal relationships)

In every session attend to

Crisis & Safety Planning / Crisis Response Plans

Collaborative Process (goal not to control)

Patience

Start early & update constantly

Find what works:

- Mindfulness
- Harm Reduction
- Relationships
- Distress Tolerance
- Emotional Regulation
- Distraction
- Humor
- Spirituality

Sample Suicide Rating Scales for the Client

SLBH 10 pt Suicidal Ideation Scale

0 – None

1-2: Fleeting thoughts; able to use health coping & grounding skills

3-4: Increased emotional intensity; lingering thought; capable of self-soothing

5-6: Use of addictive behavior/substances; difficulty using coping skills; need for external support

7-8: Suicidal gesturing (making plans, writing goodbye letters, etc.); some intent

9-10: High risk behavior; intent & plan to kill self

CAMS Framework: Suicide Status Form

(1-5 likert scale)

1. Psychological Pain
2. Stress
3. Agitation
4. Hopelessness
5. Self-Hate
6. Overall Risk of Suicide

(I often add in connectedness also)

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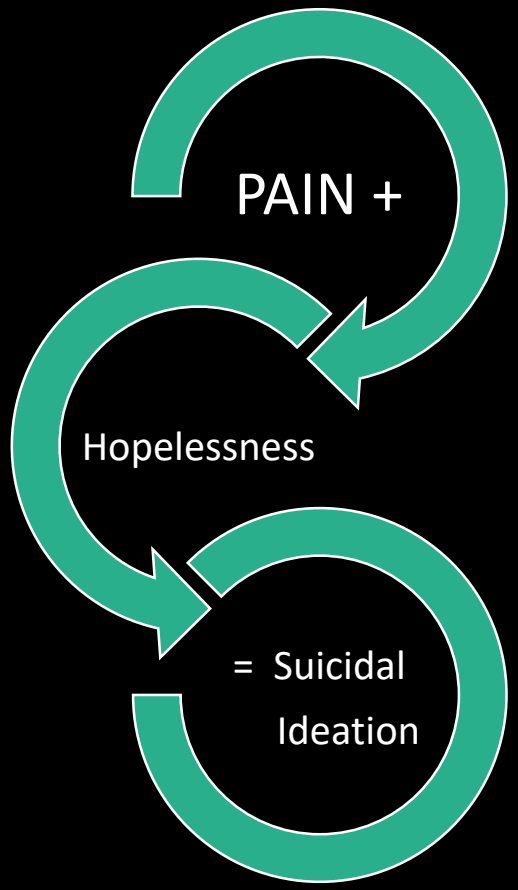

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Creative Crisis Response Planning: Goal increase connectivity

Alternatives to social supports / connection

24/7 crisis support

Alternatives to human relational connection

- Pets
- Hobbies
- Nature
- Distractions
- Social without relationship – i.e. grocery stores

Peer support (groups, social media, etc.)

Creative Safety Planning & Means Restriction: Goal decrease capability

- Ask often about methods & plans
- Use of blister packs, smaller OTC medication bottles
- 1-week dosage of medications – have a support person store the other medications
- Involve the client on what they think will work best

Working with an individual experiencing chronic suicidality

- **Therapeutic Relationship!**
- **Phenomenology of Suicide** = understanding as it is experienced by those who live it
- **Ambivalence** is always present – lean into the inner conflict
- **Validate** the suicidal thoughts & feelings
- Assess **current intensity**
- **<u>Dilemma with suicide (and conflict):</u>**

"The therapist's goal is to prevent suicide and the client's goal is to eliminate pain & suffering via suicidal behavior."

- *Collaboratively set a goal to decrease suffering*
- *Make a new goal to embrace life*
- *Focus on living not preventing death*

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Transcription from Doe's journal May 2020

It's weird to pick up a journal 3 years later but, not for me. I'll catch up later but first a quick thought on Hurt by Johnny Cash. I randomly decided to listen to this song because it has always explained how I feel. It will always be a favorite, but it isn't my truth anymore.

"I wear this crown of thorns above my liars chair. Full of broken thoughts that I cannot repair."

But I'm not full of broken thoughts anymore. The ones that are broken can be healed if I do the work.

"I hurt myself today to see if I still feel. I focus on the pain, the only thing that's real."

Hurting myself to cope is not my current reality. Pain is very real, but it is NOT the only thing that is real. Connection is real. Purpose is real.

"The needle tears a hole, the old familiar sting. Try to kill it all away, but I remember everything."

I don't have to self medicate to hide from pain. I medicate, meditate, feel the pain & endure to face tomorrow. My only job is to show up for tomorrow.

Anna would be so proud of this journal entry. Olaf was right, this journal is proof:

"EVERYTHING WILL MAKE SENSE WHEN I'M OLDERRRR!:

Care of the Clinician

- Consultation / Supervision
- Self-care
- Boundaries
- Self-compassion (we will make mistakes)

It is only through our own practice of self-compassion that we will be able to express compassion for individuals with suicidal behavior

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References & Online Resources

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- https://healthcare.utah.edu/uni/programs/safe-ut-smartphone-app/
- https://zerosuicide.sprc.org/about
- https://thinkingaboutsuicide.org/phenomenology-of-suicidality/
- http://cliniciansurvivor.org/
- www.sprc.org
- http://www.mentalhealthamerica.net
- https://afsp.org
- https://livethroughthis.org
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- **http://www.aeschiconference.unibe.ch**