



Working with Chronically Suicidal Clients: A Trauma Informed, Empowerment Focused Perspective

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Disclaimer

- Statues pertaining to suicidal ideation and self-directed violence vary by state; therefore, it is critical that you know the legal obligations for the area in which you practice.
- All practicing clinicians must be aware of the local statues and organizational expectations for the setting and location in which they work.
- I also have some particular biases because of the state in which I work, I will do my best to note throughout the presentation.

About Me

- Began working with chronically suicidal individuals in 2009
- Trained in Dialectical Behavior Therapy
 - DBT supervisor at the Fremont Community Therapy Project from 2011-2014
- Certified trainer for the Suicide Prevention Resource Center (www.sprc.org)
 - Assessing and Managing Suicide Risk Curriculum
- Approximately 30% of current private practice caseload includes individuals who frequently experience suicidal ideation

Topics

- Foundational information
- How trauma impacts a client's risk for suicide
- Basics of suicide assessment and formulation
- What changes with a client who persistently experiences suicidal ideation and self-directed violence
- This presentation is not prescriptive, instead it focuses on foundational concepts to consider when working with individuals who experience frequent suicidal ideation and self-directed violence

Foundational Information

Terms

- Trauma survivors frequently carry a number of judgments about their internal and external worlds that interfere with life in a variety of ways.
- Specific, behavioral terms can help mediate these judgments and increase the dialogue about difficult topics in therapy.
- They can also begin to challenge some of the stigma associated with experiencing suicidal ideation and a variety of posttraumatic reactions.
- Whether these terms are used with clients will depend on the person, their intersecting identity variables, and the relationship. Meet the client where they are and develop a collaborative language about all aspects of treatment.

Terms

- Nonsuicidal self-directed violence
 - Gratz (2003) stated that [self-injury] is "the deliberate, direct destruction or alteration of body tissue, without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur" (p. 253).
 - Does not include gambling, extreme sports, excessive speeding, etc.
- Suicidal self-directed violence
 - Any act of self-injury with the intent to cause death.
- Undetermined self-directed violence
 - Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.
 - Suicidal intent is unclear based on the available evidence.

Terms

- Suicide attempt
 - A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior.
 - **Do not use the word failed!**
- Interrupted self-directed violence - by self or other
 - By other - A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act such as after the initial thought or after onset of behavior.
 - By self (in other documents may be termed "aborted" suicidal behavior) - A person takes steps to injure self but is stopped by self prior to fatal injury.

Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDM's Pediatric Suicidal Risk Analysis of Antidepressants. Am J Psychiatry. 2007; 164:1035-1043. <http://crrs.columbia.edu/>

Terms

- Active vs. passive suicidal ideation
 - Active: I want to kill myself
 - Passive: It would be really nice if I were not around any more
 - Be careful not to use passive suicidal ideation as a reason to justify not doing a thorough suicide assessment
- Acute vs. chronic risk factors
 - Chronic: Those that tend to be stable across the lifespan (e.g. trauma exposure)
 - Acute: Those that increase the immediate concern and risk (see IS PATH WARM slide)

Why the ADDRESSING Framework

- Does not focus on providing treatment to or assessing the risk of self-directed violence of "group x"
- Attends to the many complexities of each person's identity (client's & therapist's)
 - Encourages discussion of how this might impact disclosure of difficult information, including suicidal ideation and self-directed violence
- Important to consider risk and protective factors within the identity variables

ADDRESSING FRAMEWORK

- | | |
|---|---|
| ○ Cultural Influences | ○ At Risk Groups |
| Age & generational influences | 45-64; 85+ |
| Developmental and acquired disabilities | People with Developmental/ acquired cognitive or physical disabilities/ changes |
| Religion & spiritual Orientation | Those with a conflict between religious beliefs and other identity variables |
| Ethnicity | Caucasian, Native American |
| Socioeconomic status (SES) | Unemployed, poverty |

ADDRESSING Model

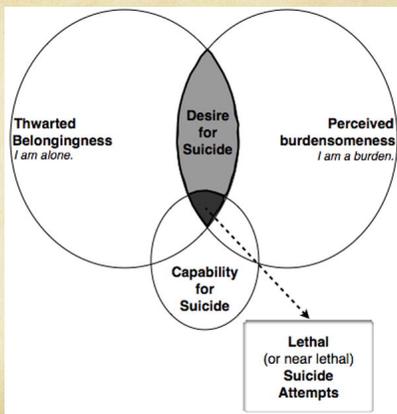
- | | |
|-----------------------|-------------------------------|
| ○ Cultural Influences | ○ At Risk Groups |
| Sexual Orientation | Gay, lesbian, bisexual people |
| Indigenous heritage | Indigenous people |
| National origin | Refugees, immigrants |
| Gender | Men, transgender people |

Trauma's Impact

Interpersonal Theory of Suicide

- “Briefly, according to the theory, the most dangerous form of suicidal desire is caused by the simultaneous presence of two interpersonal constructs—thwarted belongingness and perceived burdensomeness—and further, that the capability to engage in suicidal behavior is separate from the desire to engage in suicidal behavior.” (p. 575) – Based on Joiner’s (2005) theory

○ (van Orden et al., 2010)



Research Findings

- Briere et al. (2010) found that suicidal ideation and self-directed violence “may, among other things, specifically serve the purpose of reducing emotional distress in individuals who have experienced multiple forms of interpersonal trauma.” (p. 772)
- Researchers have also found that general traumatic events (i.e. parents divorce, loss of a friend) and emotional abuse during childhood increased the likelihood of suicide attempts later in life (Tunnard et al., 2013)
 - Approximately 40% of the variance was not accounted for in their analysis
- Kang et al. (2015) found that OEF/OIF veterans had a significantly greater risk of suicide than the general population

Research Findings

- Specific PTSD factors may be associated with increased risk of suicidal ideation and self-directed violence
- Sample of 2,322 individuals diagnosed with PTSD from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)
- The authors found "the three PTSD symptom clusters, symptoms of re-experiencing were significantly associated with suicide attempts, and contrary to our original hypothesis avoidance symptoms were also significantly associated with suicide attempts." (p. 248)
- Could not assess symptom severity and no mention of the potential role of dissociation
 - Selaman et al. (2014)

Research Findings

- Read et al. (2001)
 - Childhood sexual abuse (CSA) was found to be associated with suicidality more often than depression
 - No clear definition of suicidality by the authors
- Davis et al. (2014)
 - Detachment/estrangement from others (based on the PTSD checklist and PAI) was significantly correlated with suicidal ideation in the sample
- Lynch et al. (2008)
 - Researchers found a relationship between dissociation and suicidal/non-suicidal self-directed violence ideation
- Webermann, et al. (under review)
 - Per clinician's reports, dissociation was the only variable that predicted suicide attempts (See Bethany Brand's presentation on the Division 56 Webinar Page)

Implicit Memory

- Neuroscientists have stated there are two basic forms of memory - implicit and explicit
- Explicit are those experiences we recognize as happening in the past
 - Ex: Thinking of what you had for breakfast this morning
- Implicit are those that do not get recalled as a memory, rather they come to us as experiences
 - Ex: Every time an able-bodied person walks, they do not have to recall every step they took when they first began doing this activity

Implicit Memory

- Many argue that traumatic memories are stored in the implicit system, which is why intrusive experiences feel like they are happening in the here and now
- Essentially, they become brain-based habit patterns, shortcuts they brain takes in an attempt to maintain safety and some sense of control
- "Implicit memory is NOT the same as nonconscious memory in that effects of the recall are indeed within conscious awareness but are only experienced in the "here and now" and not with the subjective sense that something is being recalled" (Siegel, 2013, pg. 25)

Implicit Memory and Suicidal Ideation

- Bendit (2011) posited that early, repeated attachment disruptions become encoded as implicit messages that the experienced pain will be unbearable and nobody will help
- “Any future experience of intense emotional pain will trigger encoded feeling/action experiences that say this pain is unbearable, endless, and there is no one there to help.” (p. 27)

Summary

- The research on trauma and its effects, including self-directed violence, will continue to expand over time
- To date, there is a clear line of evidence that posttraumatic reactions are likely an independent risk factor for suicidal ideation and self-directed violence, with certain symptoms potentially increasing the level of clinical concern
- Suicidal ideation and urges to engage in self-directed violence may be stored in the implicit memory system

Risk Assessment and Formulation Basics

Assessment vs. Formulation

- “The purpose of the [Suicide Risk Assessment] is to identify risk **and protective factors** that then provide the data for the formulation of suicide risk. The suicide risk formulation (SRF) assigns a level of suicide risk that ideally leads to triage and treatment deemed appropriate for that level of risk.” (emphasis added)
 - (Silverman & Berman, 2013)
- Paying attention to context and intersecting identity variables is critically important.
- From an empowerment perspective, assessment is not something **done to** the client, it is a process that is discussed openly to help facilitate the therapeutic relationship throughout the process

Therapeutic Relationship

- As with all interventions, the therapeutic relationship is critically important
- Part of the relationship is explaining treatment or interventions in terms that the client can understand and agree with
- It is also important to note for many trauma survivors, particularly those with a history of interpersonal trauma, forming the relationship can be difficult
- Paying attention to shifts in the connection between client and therapist (i.e. less willing to answer questions) is an important component of the assessment process
- The goal is to work toward a place where the therapeutic relationship is a protective factor, **do not assume this is the case**

Ambivalence and Suicide

- “Within that framework [increased risk and non-compliance with treatment], ambivalence about living, ambivalence about dying, and ambivalence about the next steps in care are all unlikely to be tolerated by the patient’s caregivers or by significant others.”
- “Because the client ultimately will survive by his or her own agency, adopting a posture that promotes self-efficacy may be more prudent and potentially more effective than a stance that presumes the client is helpless in the face of imminent harm and assumes the role of rescuer.”

○ (Zeler, 2009, p. 1208)

Loss

- Most trauma survivors are familiar with the sense of loss on a number of levels
 - Loss of close connections (death, separation/divorce, moves)
 - Loss of the sense of a just world
 - Loss of functioning
 - Loss of the life they imagined/hoped for
 - Loss of hope
 - Loss of a sense of control
 - Loss of status
- Loss is an important mediating factor to pay attention to, particularly with how it affects risk/protective factors

Warning Signs

- IS PATH WARM?

I	Ideation
S	Substance Abuse
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Changes

www.suicidology.org

Assessment

- Suicidal ideation
 - Many assume that if ideation is not present, there is no need to engage in further assessment
 - "Beck et al. (1999) found that a retrospective report of SI at its worst point in a patient's life was a better predictor of eventual death by suicide than was current SI or hopelessness."
 - (As cited in Silverman & Burman, 2013)
 - Look for specificity – how (plan), when, where, and why (reasons to die, recent loss, etc.) (Rudd, 2012)

Assessment

- Ask specific, focused questions about various aspects of ideation to help determine level of intent
 - Plan
 - How have you been thinking about killing yourself?
 - Preparation/Rehearsal
 - Have you written a note? Have you tied the rope around the beam?
 - Access to Means
 - Have you been stockpiling medications? Are there any firearms in your home/do you have easy access to firearms? (as opposed to do you own any firearms)

Assessment

- Intent
 - What are your reasons for wanting to die?
 - Scaling questions can be helpful
 - Shea (2009, 2012) indicated that intent may involve one or more of the following
 - Stated Intent (What is discussed by the client)
 - Reflected Intent ("...quality and quantity of the patient's suicidal thoughts and desires, suicide plans, and extent of action taken to complete the plans...") (2012, p. 32)
 - Withheld Intent (What is not discussed by the client)

Assessment

- Protective factors
 - Commonly overlooked in a risk assessment protocol
 - Are an important part of a crisis plan
 - Do not assume that the factors are protective for every client!
 - Ex: Religious affiliation – can be a source of stability and connection or representative of a betrayal trauma
 - Others include family, fear of suicide, social support, coping skills, connection with therapist, presence of hopefulness, satisfaction with life (Rudd, 2012)

CASE Approach

- Behavioral incident
- Gentle assumption
- Symptom amplification
- Denial of the specific

CASE Approach

- When asking clients questions, Shea (2012) encourages clinicians to use specific behavioral incidents (just the facts, ma'am)
 - Breaks them into fact-finding (did you load the gun?) and sequencing (what did your boyfriend say right after he hit you?)
- Gentle assumption
 - Asking for specifics instead of general questions
 - Is that the only plan you have? Vs. What other plans do you have?

CASE Approach

- Symptom amplification
 - Helps to get past minimization
 - On the days when your thoughts of suicide are most intense, how much of your time do you spend thinking about killing yourself . . . 70% of your waking hours, 80%, 90%?
 - The high number must be somewhat absurd if this technique is going to work
- Denial of the specific
 - If a client denies a more general question, focusing on asking specific questions about events can lead to more valid results
 - How have you thought of killing yourself? Vs. Have you thought of shooting yourself?
 - Shea (2009, 2012)

CASE Approach

- Presenting suicide event (past 48 hours or several weeks)
- Recent suicide events (within the past 2 months)
- Past suicide events (from 2 months to back in time)
- Immediate events (feelings, ideation, and intent that arises during the interview)
- Shea also encourages clinicians to make modifications in the approach as needed

CASE Approach

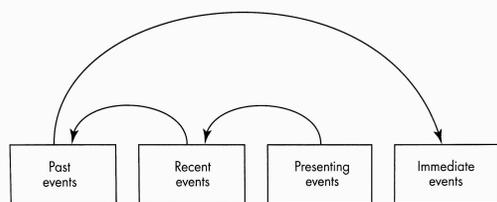


FIGURE 2-1. Chronological Assessment of Suicide Events (CASE) Approach.

No Suicide Contracts

- Have been shown to be ineffective and preventing suicide and clients frequently experience them as invalidating
 - McMyler & Prymachuk (2008) completed a metaanalysis that showed no quantitative evidence of the effectiveness of these contracts
 - Bartlett et al. (2009) found that clients believed no suicide contracts were the least effective intervention
- If your organization requires this as part of the documentation, complete a crisis plan as well

Safety Plan

- Whereas no-suicide/harm contracts are just an agreement between therapist and client to not engage in a specific behavior, safety plans provides a plan for coping with difficult events, providing steps for individuals to take
- I have found this also reduces some of the shame that is often associated with suicidal ideation or self-directed violence

Safety Plan

- Brown et al. (2012) indicated the following basics for a safety plan
 - Recognizing warning signs
 - Identifying coping strategies/distraction activities
 - People or social settings that can provide distraction
 - Contacting friends or family members that can help with the situation
 - Contacting mental health professionals or agencies
 - Removing access to lethal means
- Here is an example that I have used in my practice: <http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf>
- We will discuss this more in the next section

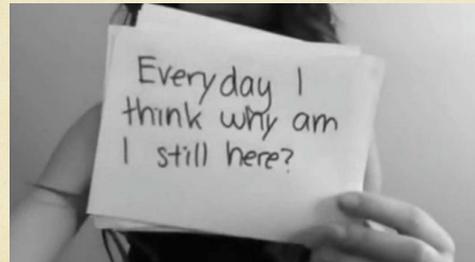
Synthesizing and Extending

What is Missing?

- While most models of suicide assessment have the necessary elements, few actively discuss the process for maintaining a connection with a client who experiences persistent suicidal ideation
- There appears to be a paucity of discussion/writing/theory about those who experience persistent suicidal ideation, plan formation, and urges
 - With the exception of research on Borderline Personality Disorder (DBT; Linehan)
- This can lead clinicians to the conclusion that suicide is a discreet event(s) and many clients I have worked with have received the implicit message that they are doing something wrong or are "really screwed up" because they have these experiences

What is Missing?

- How does the assessment/formulation picture change when someone always has at least one plan, consistently has the means, and has varying degrees of intent?
- What happens when considering death has become an implicit coping strategy for a person who experiences consistent psychological and/or physical pain?



Client's Experiences

- It is often a significant risk to disclose suicidal ideation or self-directed violence
 - Unknown how clinicians/people will react
 - Possibility of negative experiences in relation to disclosure in the past
 - Shame is frequently the predominate emotion for a number of reasons (i.e. family dynamics, societal expectations)
- Many clients have reported to me that it is a reparative experiences to have someone lean in and say tell me more about that, as opposed to pulling back in some way

Ambivalence

- Most individuals who experience chronic thoughts of death have ambivalence about many things, including treatment, living, dying, and the possibility of anything changing
- "Resistance" can be used as a signal to the clinician to change focus or direction (Miller, Rolnick and others) while still conveying compassion and understanding
- Consistently conveying the message that the client's experiences (suicidal ideation and other problematic coping) make sense given the level of pain they have been in, while helping them evaluate how the behaviors are impacting their lives

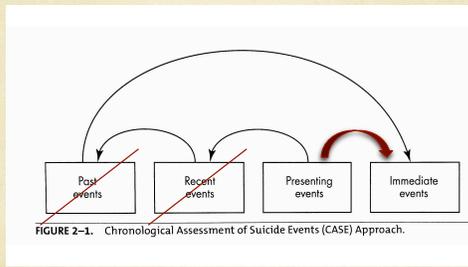
Not a Diagnosis!

- One of the central tenants of the Collaborative Assessment and Management of Suicidality (Jobes) is that suicide is not considered a symptom of a diagnosis, rather it is the focus of treatment to find the "functional utility" of the behavior
 - Perpetuated by research that focuses on diagnostic categories as opposed to people's experiences
- This model focuses on empowering the client to be a collaborator in their own assessment and safety planning, as opposed to the explicit or implicit message that if psychopathology symptoms abate (i.e. depression), this will go away too

Activation of Implicit Memories

- Bendit (2011) argues that clinicians need to use moments of suicidal ideation in session as a door to explore therapeutic ruptures
 - Focus on moments when the client felt the clinician was emotionally unresponsive
 - The client may or may not be able to identify it; however, the discussion can show a willingness to notice personal factors that may have influenced the level of distress
- I will often focus on past therapy or attachment experiences as well as a way of exploring how my behavior may have activated painful experiences from the past
- Lather, rinse, repeat - This process is unlikely to create a significant change in a single session, even though this frame is likely to be different from what clients have experienced before

CASE Approach



Application of Herman's Model

- John Briere and Catherine Scott's (2013) definition considers any event to be "traumatic if it is extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (p. 8)
- From this view, experiences of wanting to die can be a symptom of a larger problem; however, they can also be a representation of an extremely upsetting experience that can override one's ability to cope

Application of Herman's Model

- Stage 1 (Safety and Stabilization) - This is where most individuals focus on suicide assessment and safety planning
 - I tend to focus on DBT skills here, some EMDR resources
 - Significant focus on mindfulness and emotion regulation
 - Particularly important to assess dissociative experiences
 - Increase window of tolerance for being present with emotionally charged material without avoidance, dissociation, or other problematic coping

Application of Herman's Model

- A note on safety plans
 - Many clinicians focus on "positives" as experiences that are worth living for or protective factors
 - Many trauma survivors, particularly those who want to die to escape their pain, have difficulty coming up with things that are positive in their lives
 - My colleague Michelle Brown offered an interesting twist - can you tell me something that does not suck in your life?
 - Most of the safety plans I put together end in the same way:
 - Call crisis line
 - Sit in an ER parking lot
 - Sit in an ER waiting room
 - Check in if necessary

Application of Herman's Model

- Stage 2 (reprocessing and mourning)
 - Focusing on the implicit nature of suicidal thoughts/urges
 - Working through the intense emotions surrounding suicidal ideation and self-directed violence
 - Implicit memory patterns can begin to be modified
 - Processing moments of ambivalence
- Stage 3 (integration and moving forward)
 - Create a "life worth living" (Linehan)
 - Begin to move from things that do not suck to fulfilling, positive experiences
 - Creating new connections to increase belongingness and decrease the experience of being a burden

Application of Herman's Model

- As with the original writing on the three stage model, it is a complex and fluid process
- Maintaining flexibility and the willingness to ask about, process, and take responsibility for ruptures (where appropriate) is critical to the process

Documentation

- Current suicidal ideation, planning, and preparation
 - Suicidal versus nonsuicidal morbid ideation (document patient's exact words)
 - Frequency, intensity, and duration of suicidal ideation
 - Specificity of plan (e.g., time, location, method)
 - Access to means
 - Evidence of rehearsal (i.e., practicing) or preparing for death
 - Sense of courage and urgency to act
- Protective factors
 - Social support
 - Presence of children in the home
 - Religious or moral beliefs against suicide
 - Intact reality-testing
 - Effective problem-solving skills

Documentation

- Clinical response to suicide risk
 - Crisis management and response planning
 - Medication changes (i.e., initiation or discontinuation) - consult with provider if needed
 - Behavioral and psychosocial recommendations or interventions
 - Referrals to specialty care services
 - Coordination of services with other health care providers
 - Consultation with other health care providers
 - Follow-up plan
 - American Association of Suicidology (2009)

Documentation

- The previous guidelines are helpful for initial sessions; however, do not provide much guidance on what to change/modify when suicidal ideation is a consistent experience
- The CAMS Suicide Status Form (http://www.mvbcn.org/shop/images/CAMS_Suicide_Status_Form_-_English.pdf) is another option for documentation that provides guidance for follow up sessions and continued assessment

Documentation

- The previous guidelines are helpful for initial sessions; however, do not provide much guidance on what to change/modify when suicidal ideation is a consistent experience
- I tend to focus on the following elements when documenting follow up sessions:
 - Changes in acute risk factors
 - Changes in protective factors
 - Updates to safety plan – recommitment if necessary
 - Decisions – if not hospitalization or some other intervention, then why?

Documentation

- Example:
Assessed client's current level of risk, Betty reported consuming 3-4 drinks per day this week and experiencing suicidal ideation on a "constant" basis; She denied preparation of any kind, although she continues to have a formulated plan; She reported that one of her dogs is currently ill, which has increased her level of distress; Betty denied instances of nonsuicidal self-directed violence during the week; Although there have been notable changes in Betty's risk and protective factors, she has maintained her commitment to the previously established safety plan; She has agreed to talk to her sister on a daily basis and attend at least 3 AA meetings during the week; Hospitalization was discussed and decided against because of her willingness to utilize her social support network, attend support groups, and utilize safety plan; Consulted with Dr. X after completion of session

Contact Information

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Select Resources

- Gratz, K. L. (2003). Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice*, 10, 192-205.
- Simon, R. I. & Hales, R. E. (eds.) (2012). *Textbook of suicide assessment and management*. The American Psychiatric Publishing: Washington, DC.
 - Most 2012 references were from chapters in this book
- Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A., & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, 117(2), 575-600. doi:10.1037/a0018697