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& PSYCHALIVE

Welcome to the Webinar, Suicide: What Every Mental Health Professional Should Know

Lisa Firestone, Ph.D.

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Suicide: What Every Mental Health Professional Should Know



with Lisa Firestone, Ph.D.



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(For Professionals)
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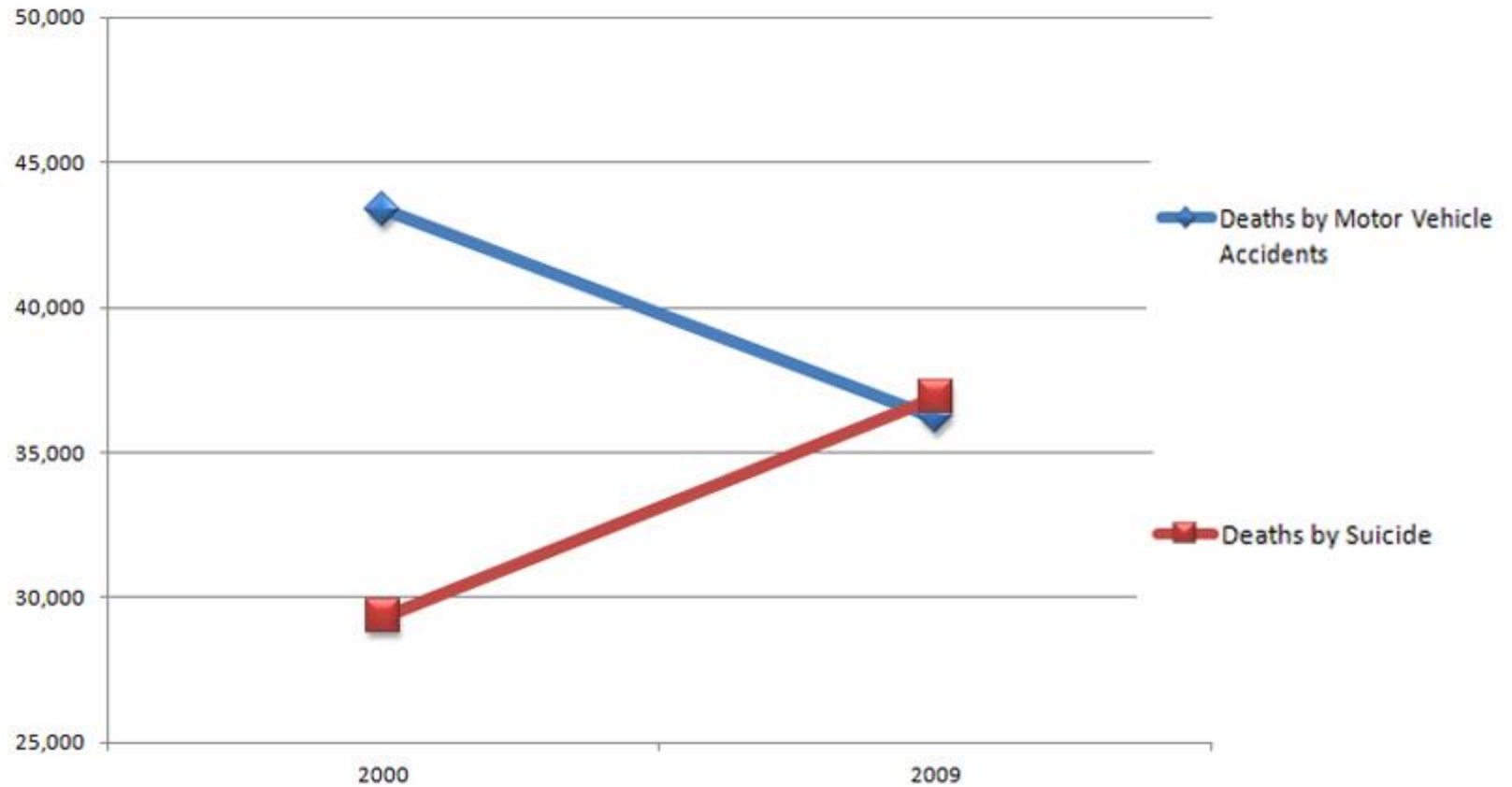
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Facts About Suicide

- According to the World Health Organization, every 40 seconds a life is lost to suicide, which means that each year we lose nearly 1 million people to suicide.
- For every one person who dies by suicide, 20 or more attempt to end their lives.
- Worldwide, more people die by suicide than from all homicides and wars combined.
- Each person who dies by suicide leaves behind an average of five closely impacted survivors.
- According to a 2009 statistic from SAMHSA, 8.4 million adults in the U.S. had serious thoughts of committing suicide in the past year.
- In 2008, 13.4 percent of people who committed suicide had experienced job and financial problems
- In 2012, more members of the U.S. military committed suicide than were killed in combat in Afghanistan, with an average of one soldier dying by suicide each day.
- 18 veterans die by suicide each day.

Suicide Surpasses Car Accidents as a Leading Cause of Death



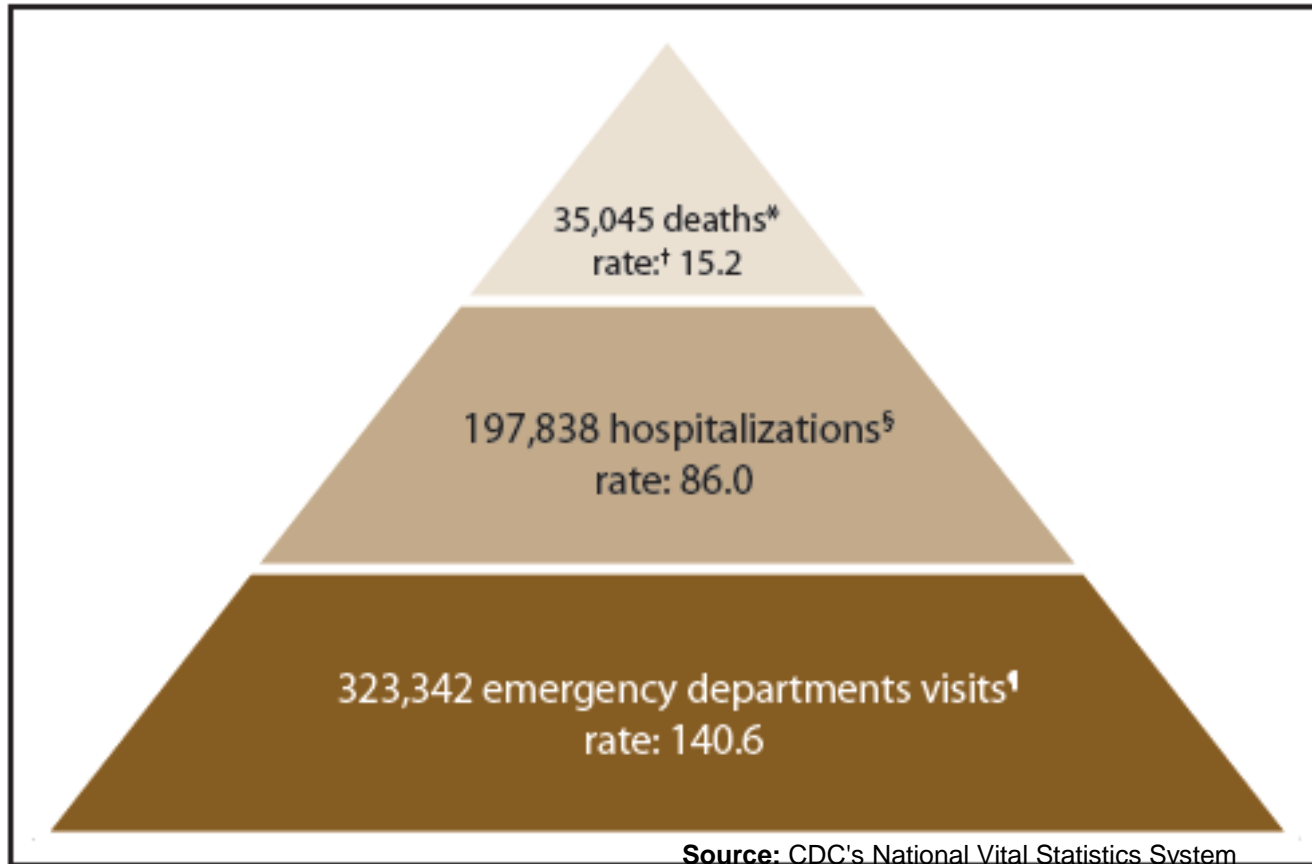


ED Treatment of Mental Disorders

One in 10 suicides are by people seen
in the ED within two months of dying.



Public health burden of suicidal behavior among adults > 18 years-United States, 2008



Link: <http://www.cdc.gov/mmwr/pdf/ss/ss6013.pdf>



Poll #1

Have you been impacted by a suicide attempt or the loss of someone to suicide either personally or professionally?

Professionally

Personally

Both

Neither



Mental Health Services

- 19 % of suicides had contact with MH within the past month; 32% within the past year (Luoma, 2002)
- 41% of suicide decedents who had received inpatient psychiatric care died within one year of their discharge; 9% within one day (Pirkis, 1998)
- 71% of psychotherapists report having at least one client who has attempted suicide, while 28% report having had at least one client die by suicide
- Approximately 50% of those who die by suicide in America will have seen a mental health provider at some time in their life
- 25 % of family members of suicidal patients take legal actions against the patient's mental health treatment team



Suicide in Adults

- Rector et al. (2008) indicate that the risk of suicide is highest at transition points. They observe that suicide rates are most prevalent in the first month after arrival at a prison; suicide rates in psychiatric hospitals are highest during the first week of being institutionalized, and bereavement-related suicides occur soon after the death of a loved one.



Misconceptions About Suicide

- Most suicides are caused by one particular trigger event.
- Most suicides occur with little or no warning.
- It is best to avoid the topic of suicide.
- People who talk about suicide don't do it.
- Nonfatal self-destructive acts (suicide attempts) are only attention-getting behaviors.



Misconceptions About Suicide

- A suicidal person clearly wants to die.
- Once a person attempts suicide, he or she won't try it again.
- Suicide is a complex problem.
- If a person who has been depressed is suddenly feeling better, the danger of suicide is gone.
- Poor people are the source of most suicides.
- Being religious protects against suicide.

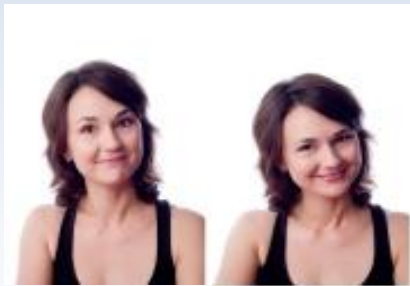


Our Approach to Suicide

Each person is divided:

- One part wants to live and is goal-directed and life-affirming.
- And one part is self-critical, self-hating and at its ultimate end, self-destructive. The nature and degree of this division varies for each individual.

Real Self - Positive



Anti-Self - Critical





Our Approach to Suicide

Negative thoughts exist on a continuum, from mild self-critical thoughts to extreme self-hatred to thoughts about suicide

You don't deserve anything

You should be by yourself

You're a creep

You need to have a drink, so you can relax

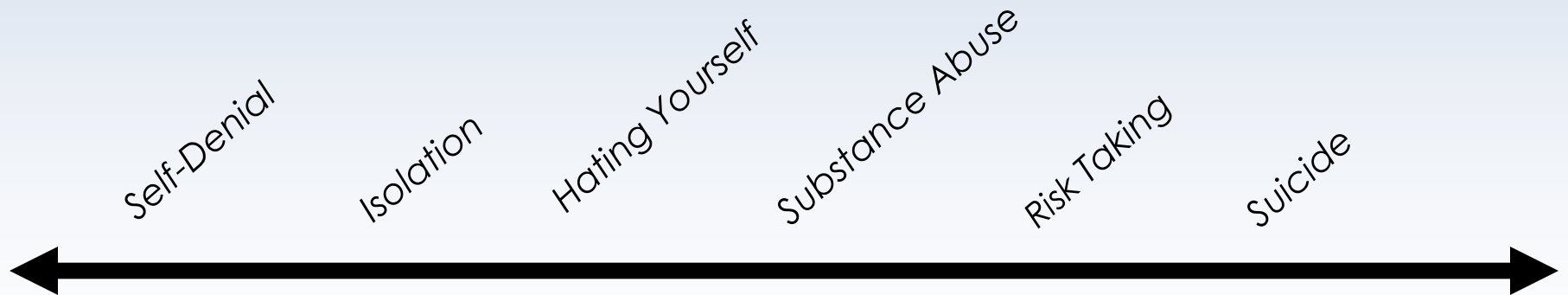
You should just kill yourself





Our Approach to Suicide

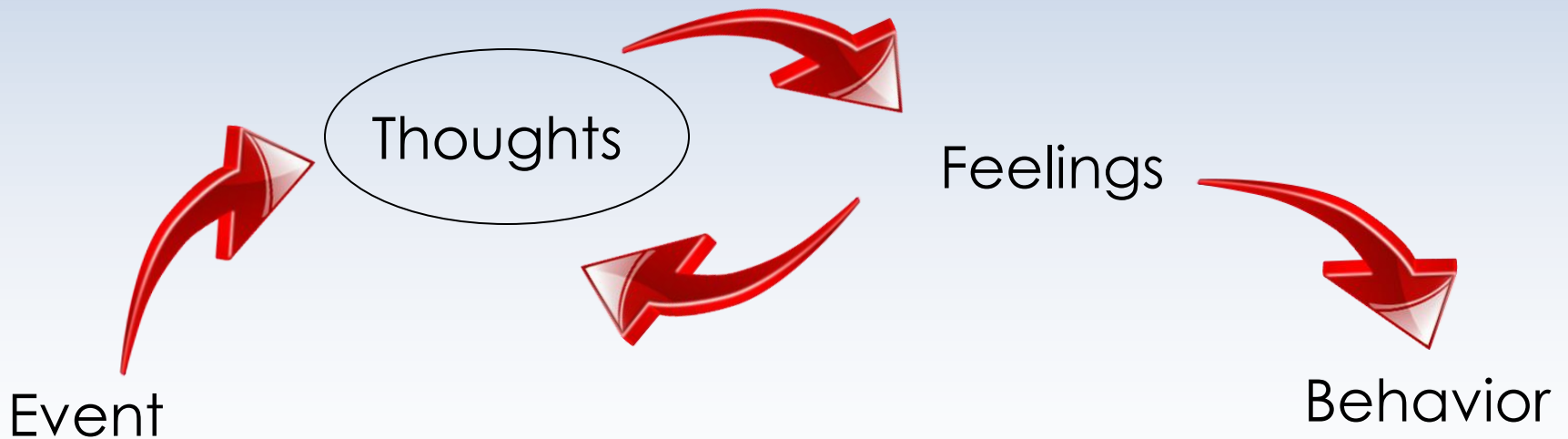
Self-destructive behaviors exist on a continuum from self-denial to substance abuse to actual suicide.





Our Approach to Suicide

There is a relationship between these two continuums. How a person is thinking is predictive of how he or she is likely to behave.





Definition of the Voice

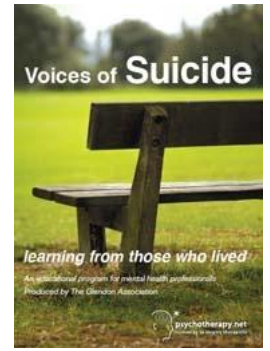
The critical inner voice refers to a well-integrated pattern of destructive thoughts toward our selves and others. The “voices” that make up this internalized dialogue are at the root of much of our maladaptive behavior. This internal enemy fosters inwardness, distrust, self-criticism, self-denial, addictions and a retreat from goal-directed activities. The critical inner voice affects every aspect of our lives: our self-esteem and confidence, our personal and intimate relationships, and our performance and accomplishments at school and work.





Voices of Suicide

From "Voices of Suicide: Learning From Those Who Lived"



http://www.youtube.com/watch?v=Es7s_z-YVLE



Poll #2

Have you had clients who've expressed thoughts similar to these?



Division of the Mind

Self System

Positive Parenting Behaviors
Attunement, Affection, Control
Parental Nurturance/Genetic
Predisposition/Temperament

Other nurturing experiences:
Caring adults, education



Anti-Self System

Destructive Parental Behaviors/ Misattunement,
lack of affection, reject, neglect, hostility,
permissiveness, Genetic Predisposition,
Temperament

Other factors: accidents, illnesses, traumatic separation





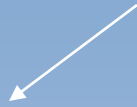
Self System

Unique make-up of the individual –harmonious identification and incorporation of parent’s positive attitudes and traits and the effect of experience on the maturing self-system resulting in a stronger sense of self and a greater degree of differentiation from parents or early caretakers.





Prenatal Influences



Disease Trauma

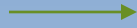


Substance Abuse/ Domestic Violence





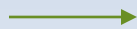
Birth



Trauma



Baby



Genetic

Structure

Temperament

Physicality

Sex



Personal Attitudes/Goals/Conscience

Realistic, Positive Attitudes Towards Self

Realistic evaluation of talents, abilities, etc...with generally positive/ compassionate attitude towards self and others.

Goals

Needs, wants, search for meaning in life

Moral Principles



Behavior

Ethical behavior towards self and others

Goal Directed Behavior

Acting with Integrity





The Anti-Self System

The Fantasy Bond (core defense) furthers a self-parenting process made up of both the helpless, needy child, and the self-punishing, self-nurturing parent. Either aspect may be acted out in romantic relationships. The degree of reliance on this defense is proportional to the amount of damage sustained while growing up.



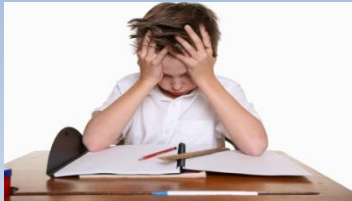


The Self-Parenting Process

Self-Punishing Voices

Voice Process

Critical thoughts toward self



2. Micro-suicidal injunctions
(punitive/cruel thoughts)



3. Suicidal injunctions
– suicidal ideation



Behaviors

Verbal attacks-a generally negative attitude toward self and others predisposing alienation

Addictive Patterns/thoughts heightening emotional distress

Actions that jeopardize one's health and safety; physical attacks on the self, and actual suicide



The Self-Parenting Process

Self-Soothing Voices

Voice Process



1. Self Soothing Attitudes



2. Micro-suicidal injunctions (seductive/self-indulgent thoughts)



3. Aggrandizing thoughts towards self



4. Suspicious paranoid thoughts toward others

Behaviors

Self-limiting or self-protective lifestyles, Inwardness

Addictive patterns/ numbing emotional distress

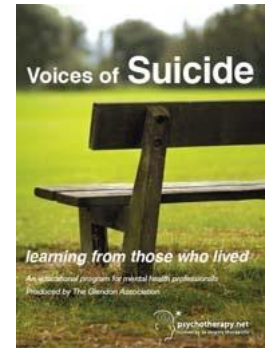
Narcissism/ Vanity and aggressive behavior towards others

Alienation, hostile attitudes towards others and aggressive behavior



Developmental

From “Voices of Suicide: Learning From Those Who Lived”



<http://www.youtube.com/watch?v=xPcgkm9AlhU>



Continuum of Negative Thought Patterns

Thoughts that lead to low-self-esteem or inwardness (self-defeating thoughts):

Levels of Increasing Suicidal Intention

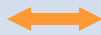
Content of Voice Statements

1. Self-deprecating thoughts of everyday life



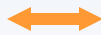
You're incompetent, stupid. You're not very attractive. You're going to make a fool of yourself.

2. Thoughts rationalizing self-denial; thoughts discouraging the person from engaging in pleasurable activities



You're too young (old) and inexperienced to apply for this job. You're too shy to make any new friends. Why go on this trip? It'll be such a hassle. You'll save money by staying home.

3. Cynical attitudes towards others, leading to alienation and distancing



Why go out with her/him? She's cold, unreliable; she'll reject you. She wouldn't go out with you anyway. You can't trust men/women.



Continuum of Negative Thought Patterns

Thoughts that lead to low-self-esteem or inwardness (self-defeating thoughts):

Levels of Increasing Suicidal Intention

Content of Voice Statements

4. Thoughts influencing isolation; rationalizations for time alone, but using time to become more negative toward oneself



Just be by yourself. You're miserable company anyway; who'd want to be with you? Just stay in the background, out of view.

5. Self-contempt; vicious self-abusive thoughts and accusations (accompanied by intense angry affect)



You idiot! You bitch! You creep! You stupid shit! You don't deserve anything; you're worthless.



Continuum of Negative Thought Patterns

Thoughts that support the cycle of addiction (addictions):

Levels of Increasing Suicidal Intention



Content of Voice Statements

6. Thoughts urging use of substances or food followed by self-criticisms (weakens inhibitions against self-destructive actions, while increasing guilt and self-recrimination following acting out).

*It's okay to do drugs, you'll be more relaxed. Go ahead and have a drink, you deserve it.
(Later) You weak-willed jerk!
You're nothing but a drugged-out drunken freak.*



Continuum of Negative Thought Patterns

Thoughts that lead to suicide (self-annihilating thoughts):

Levels of Increasing Suicidal Intention

7. Thoughts contributing to a sense of hopelessness urging withdrawal or removal of oneself completely from the lives of people closest.
8. Thoughts influencing a person to give up priorities and favored activities (points of identity).
9. Injunctions to inflict self-harm at an action level; intense rage against self.

Content of Voice Statements

See how bad you make your family (friends) feel. They'd be better off without you. It's the only decent thing to do; just stay away and stop bothering them.

What's the use? Your work doesn't matter any more. Why bother even trying? Nothing matters anyway.

Why don't you just drive across the center divider? Just shove your hand under that power saw!



Continuum of Negative Thought Patterns

Thoughts that lead to suicide (self-annihilating thoughts):

Levels of Increasing Suicidal Intention

Content of Voice Statements

10. Thoughts planning details of suicide (calm, rational, often obsessive, indicating complete loss of feeling for the self).



You have to get hold of some pills, then go to a hotel, etc.

11. Injunctions to carry out suicide plans; thoughts baiting the person to commit suicide (extreme thought constriction).

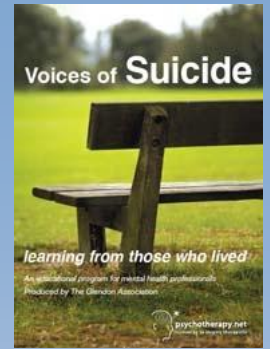


You've thought about this long enough. Just get it over with. It's the only way out.



Thoughts to Actions

From "Voices of Suicide: Learning From Those Who Lived"



<http://www.youtube.com/watch?v=IMR1I2Gu5Vo>



Examples of the Narrative of Suicidal Individuals

“ I can’t stand being so depressed anymore.” “I can stop this pain by killing myself.” “I am damaged goods.” (Scneidman, 2001 has characterized this intractable emotional pain as psychache)

“Suicide is the only choice I have.” (The word “only” is considered one of the most dangerous words in suicidology)

“My family would be better off without me.” “I was just a lifeless think-breathing, but worthless. I knew everyone would be better off if I were dead. It would end my misery and relieve their burden.” “My death will be worth more than my life to my family.” (Joiner, 2005, and Joiner and Van Orden, 2008, have highlighted the perception of being a burden on others as related to suicidal tendencies).

“I am useless and unwanted.” (Joiner, 2005, highlights a sense of “thwarted belongingness,” as contributing to suicidal ideation and actions.) Perceive others as uncaring and unsupportive; feel socially disconnected and lack emotional intimacy.



Examples of the Narrative of Suicidal Individuals cont'd

“No one cares whether I live or die.” (Feel rejected, marginalized, worthless, unlovable, isolated, alone and a failure)

“I am worthless and don’t deserve to live.” (The presence of guilt and shame exacerbates suicidal ideation)

“I have an enemy within that I have to escape.” (Baumeister, 2004, has viewed suicide as a form of escape from self. It also reflects the “drama of the mind” that suicidal individuals are prone to engage in).

I am a tailspin, like a freight train or tsunami hit me. There is no hope. I cant get caught up. What is the point? (Riskind et al. 2000 and Rector et al. 2008 have noted that anxious and suicidal individuals are prone to produce elaborate mental scenarios anticipating rapidly rising risk with multiply increasing threats. They tend to exaggerate the time course of perceived catastrophic outcomes and have an increased sense of urgency for escape and avoidance).

“I hate myself.” (Suicidal individuals have an over-generalized memory and tend to selectively recall negative events that contribute to invalidating themselves).



Examples of the Narrative of Suicidal Individuals cont'd

“ I can't fix this problem and I should just die.” (Tunnel vision, inflexibility in generating alternatives, feel trapped and perceived inescapability)

“ I would rather die than feel this way.” (Evidence poor distress tolerance)

“ I have lost everything important to me.” “My future looks empty.” “Life is no longer worth living.” “Nothing will change.” “ There is no hope for me.” (Ghahramanlou- Holloway et al., 2008, highlight the impact of such loss-related cognitions and the role of feelings of helplessness and hopelessness that exacerbate suicidal tendencies).

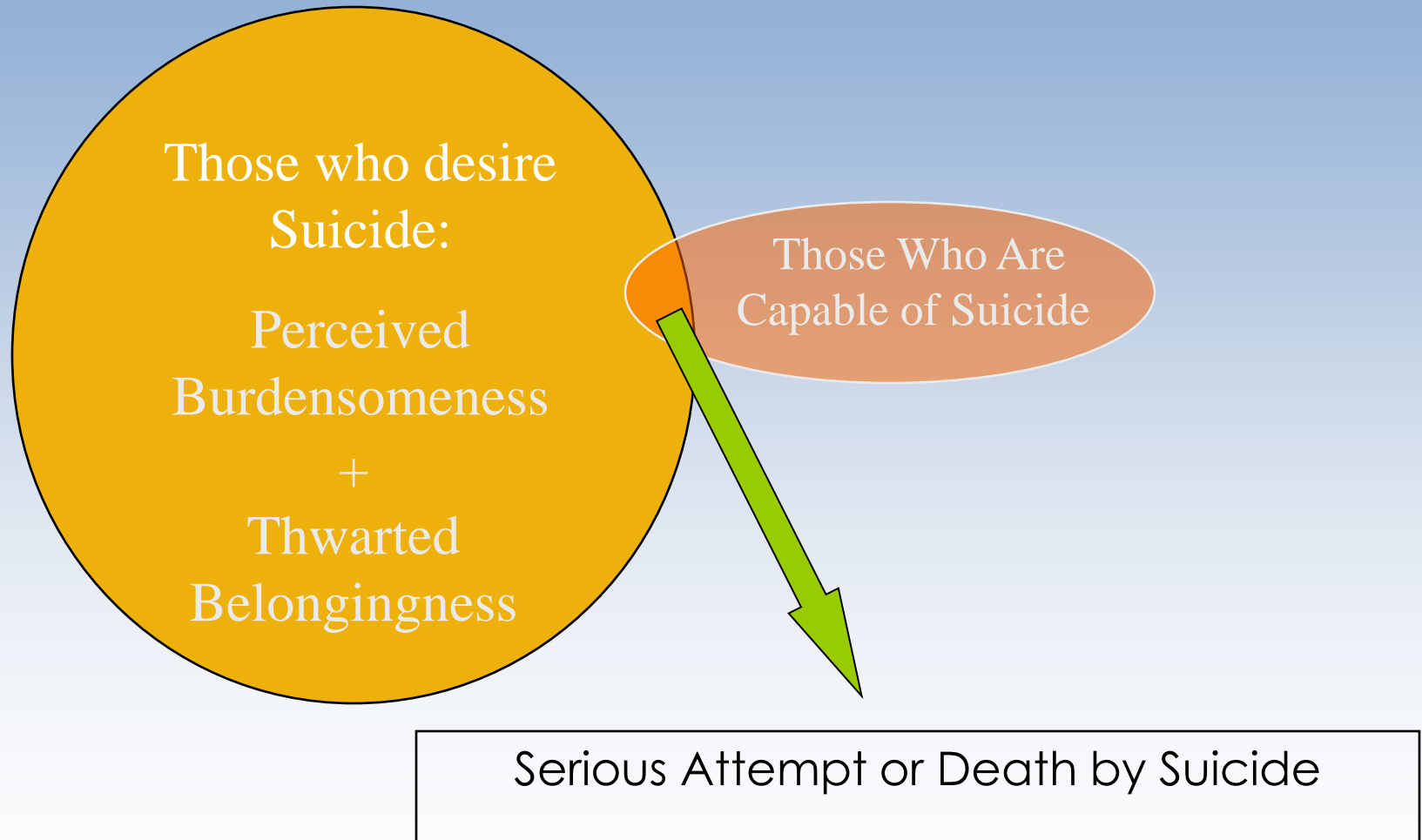
“I have screwed up, so I might as well screw up all the way.” (Perception that he or she does not deserve to live which contributes to suicidal ideation)

“Those who hurt me will be sorry.” (Perceived benefits of suicide, revenge)

“Suicide is a way of life for me and I can't stop it.” (Kernberg, 2001)



Those Who Desire Suicide



Joiner, Thomas. *Why People Die By Suicide*. "The Three Components of Completed Suicide." Harvard University Press, 2005.



Poll #3

Do you use objective measures to assess suicide risk?

Why Use Objective Measures?

What Interferes with Clinical Judgment

- Anxiety
- Counter Transference
- Psych Ache
- Research Minimizing
- Diverse Menu of Risk Factors

Our Measures

Based on Separation Theory developed by Robert W. Firestone, PhD. and represents a broadly based coherent system of concepts and hypothesis that integrates psychoanalytic and existential systems of thought. The theoretical approach focuses on **internal negative thought processes**. These thoughts (i.e. “voices”) actually direct behavior and, thus, are likely to predict how an individual will behave.



Firestone Assessment of Self-Destructive Thoughts

	Never	Rarely	Once In A While	Frequently	Most Of The Time
1. Just stay in the background.	0	1	2	3	4
2. Get them to leave you alone. You don't need them.	0	1	2	3	4
3. You'll save money by staying home. Why do you need to go out anyway?	0	1	2	3	4
4. You better take something so you can relax with those people tonight.	0	1	2	3	4
5. Don't buy that new outfit. Look at all the money you are saving.	0	1	2	3	4

Figure 4.3. Mean T Scores for the Depression Sample: Inpatients and Outpatients—Ideators Versus Nonideators (N = 296)

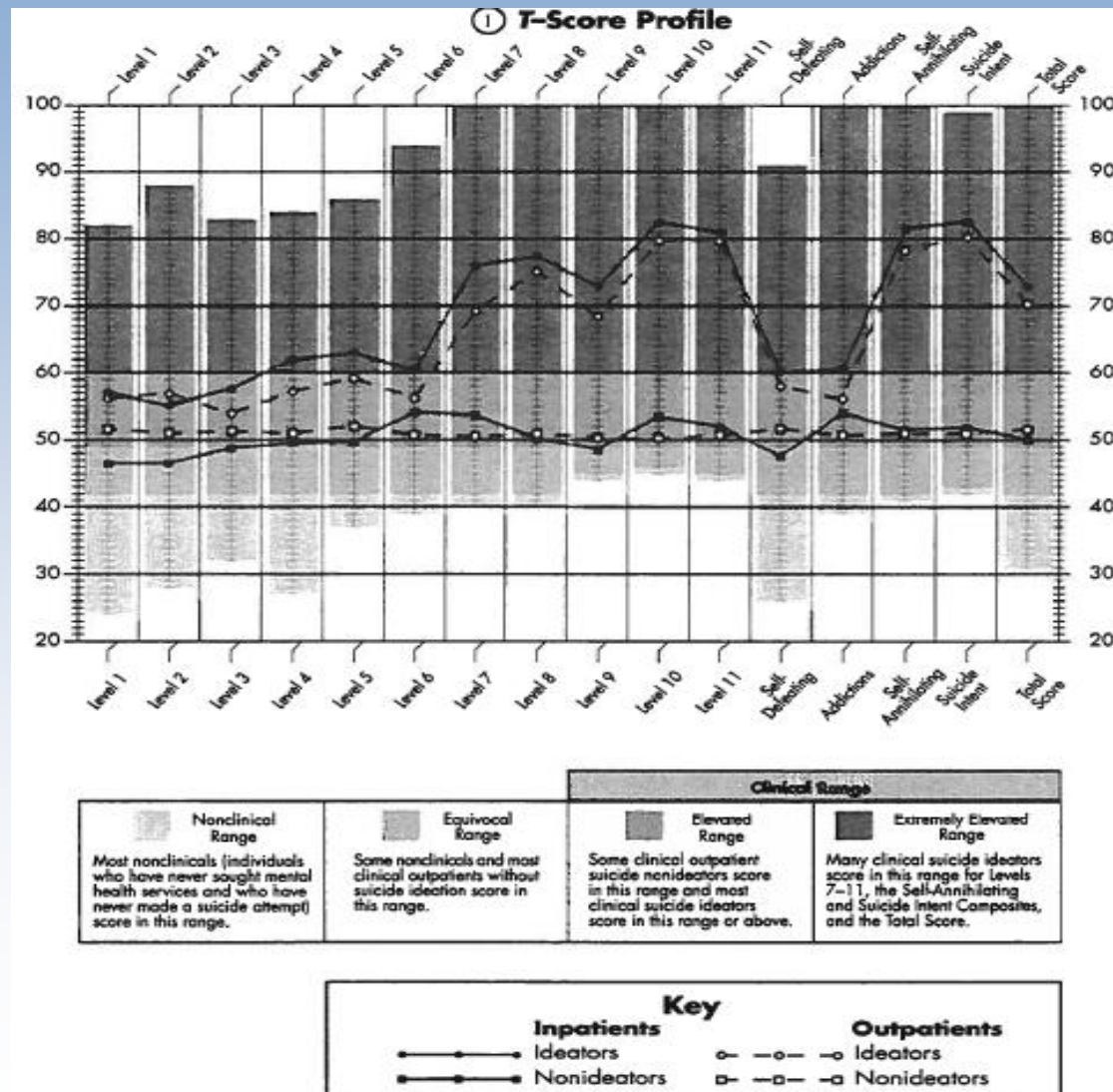


Figure 4.5. Mean T Scores for the Bipolar Disorder Sample—Ideators Versus Nonideators (N = 68)

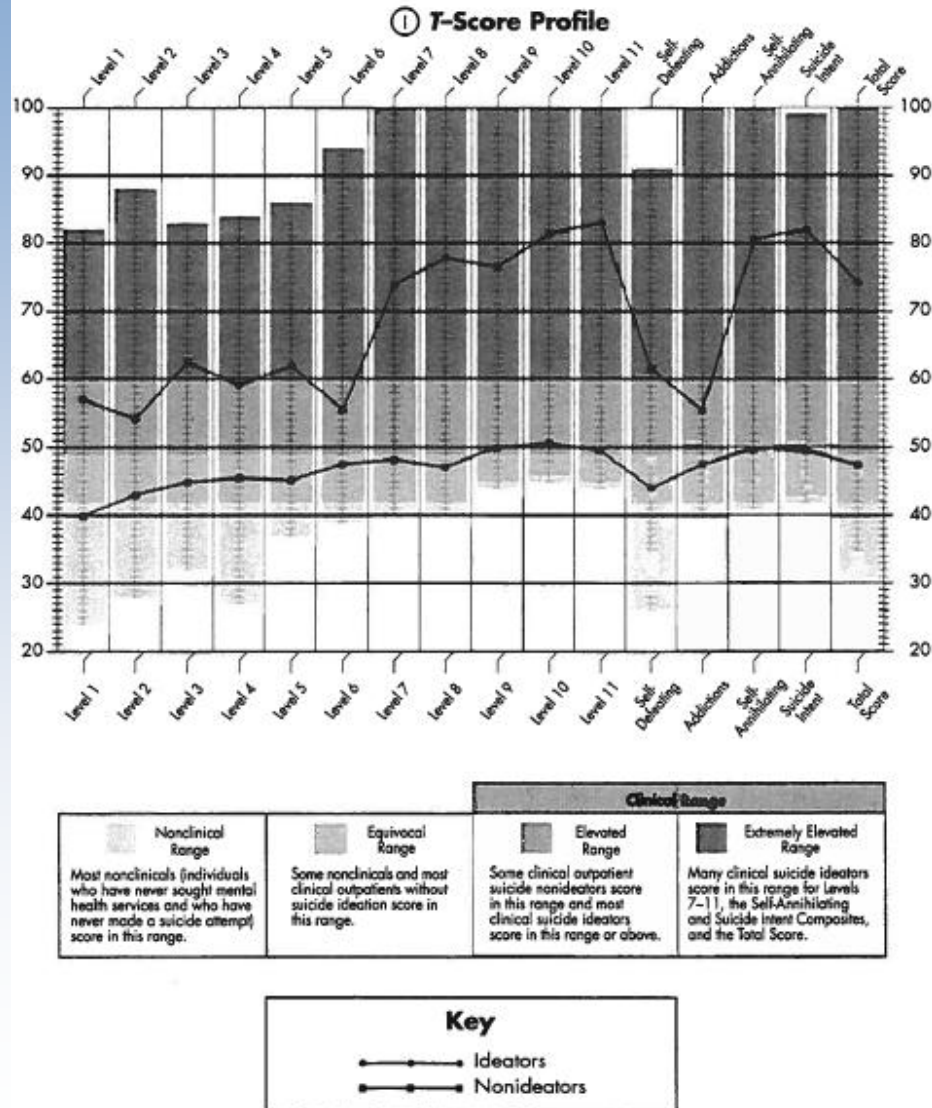


Figure 4.7. Mean T Scores for the Substance Abuse Sample: Inpatients and Outpatients—Ideators Versus Nonideators (N = 202)

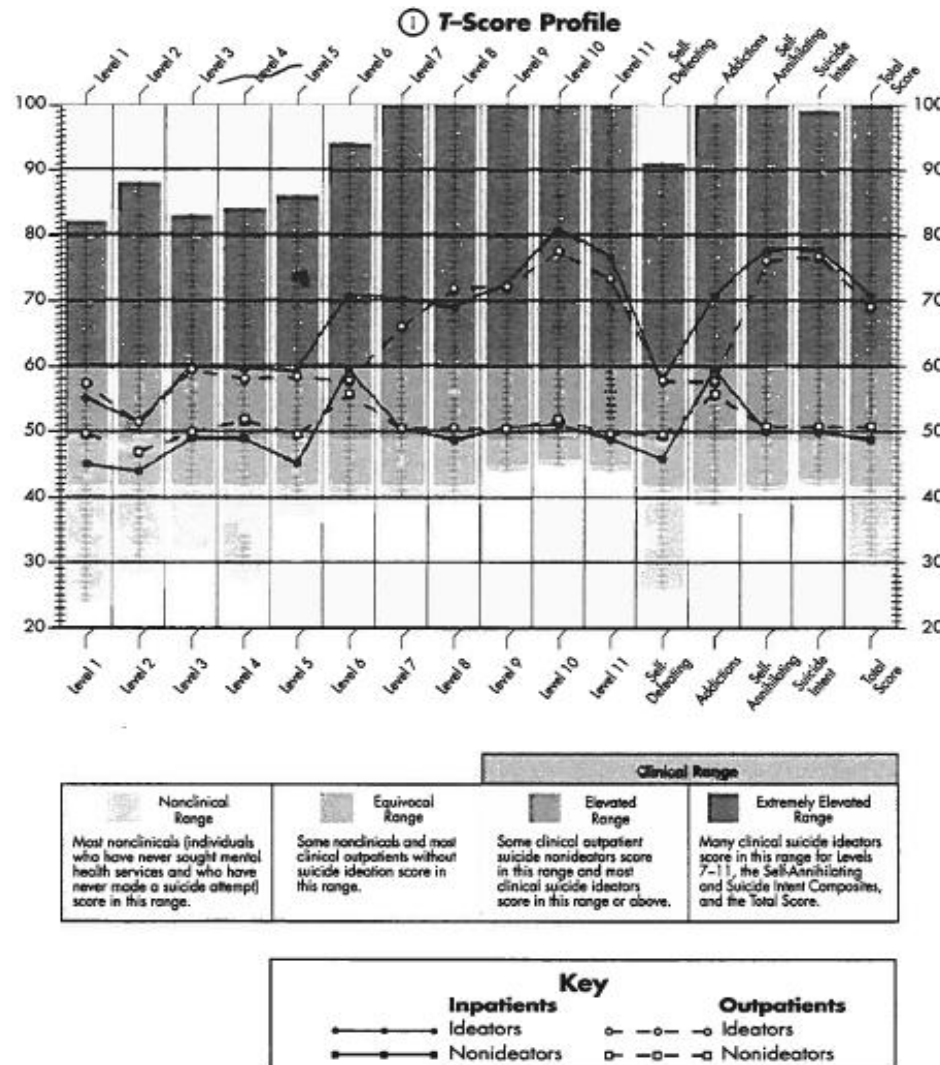


Figure 4.6. Mean T Scores for the Inpatient Schizophrenia Sample—Ideators Versus Nonideators (N = 115)

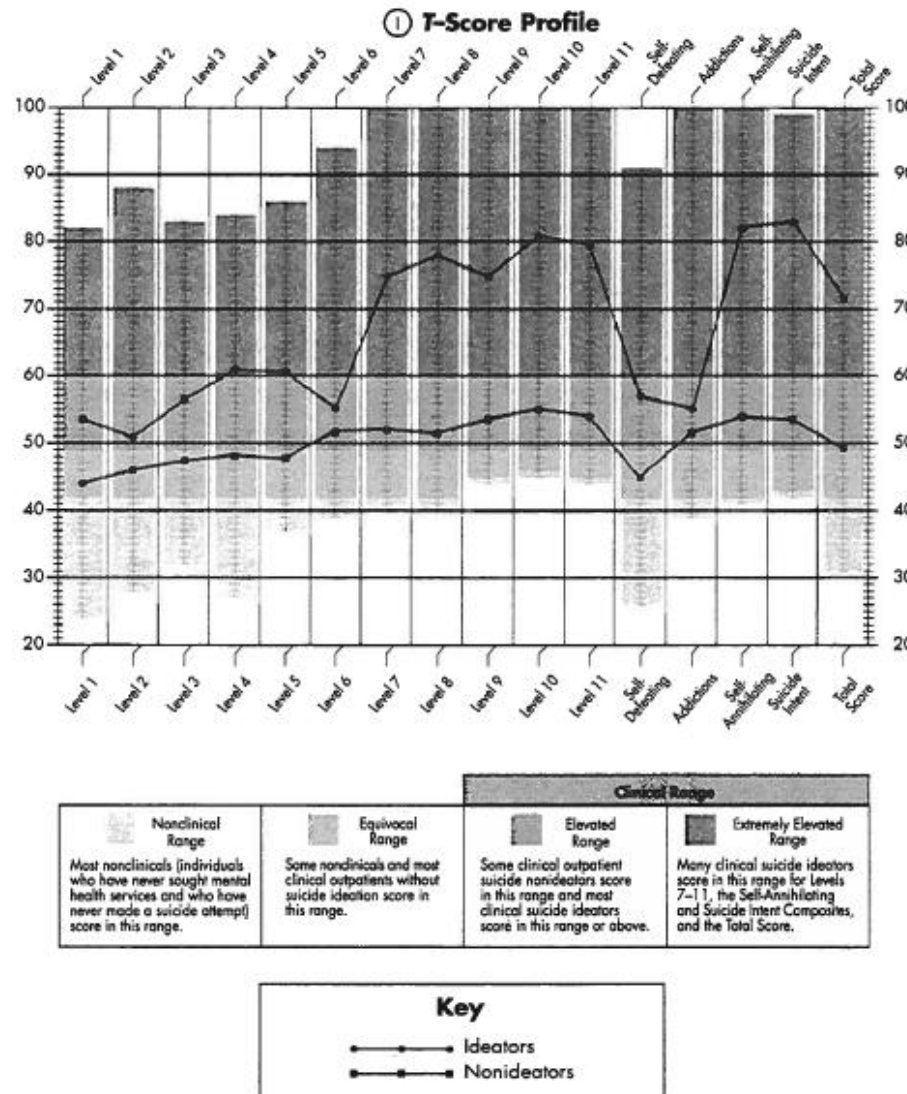
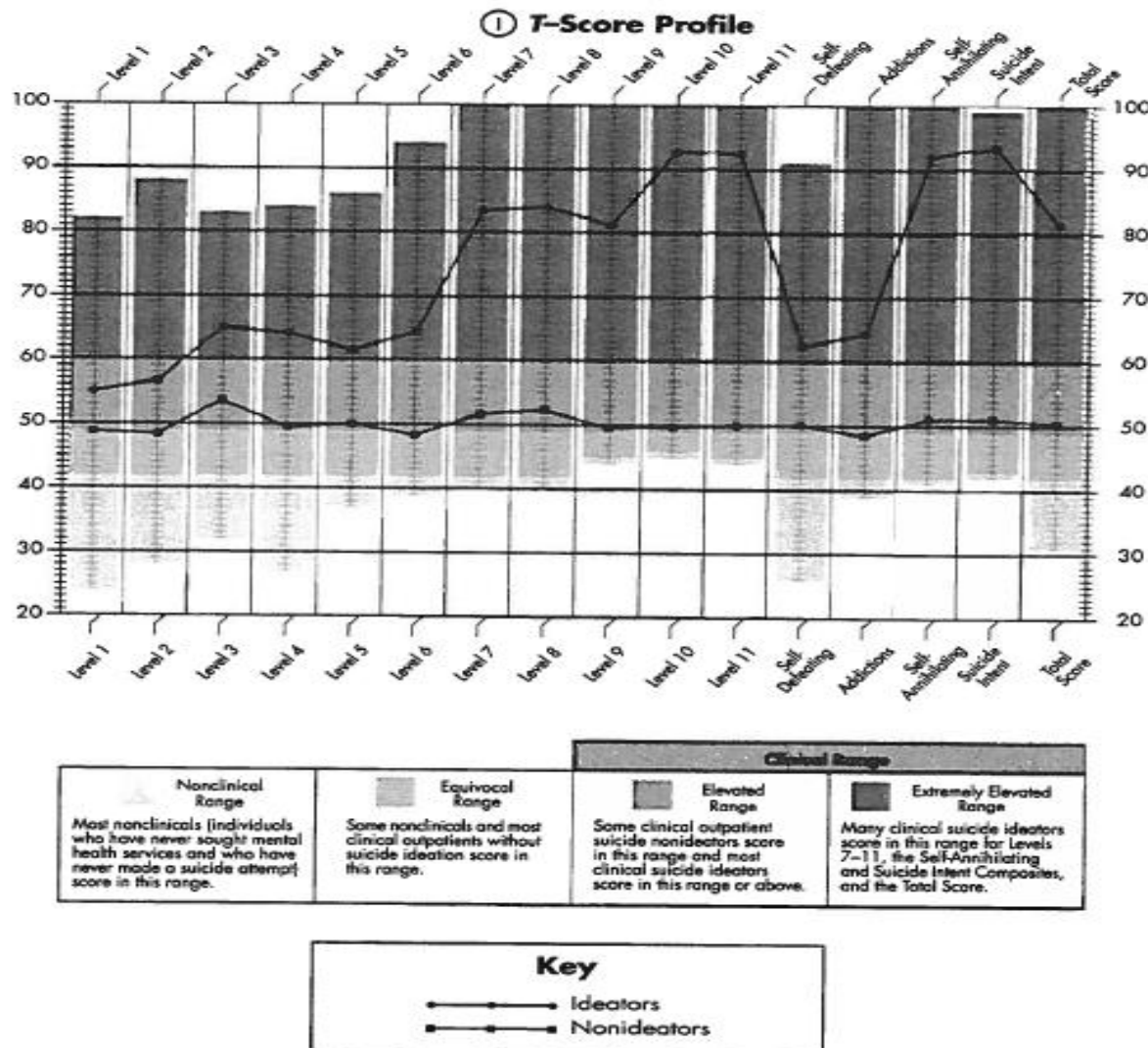


Figure 4.4. Mean T Scores for the Outpatient Personality Disorder Sample—Ideators Versus Nonideators (N = 35)



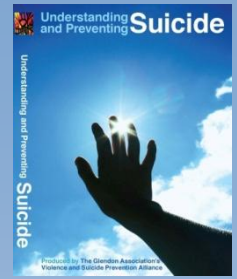
Uses for Our Measures

- Risk Assessment
- Treatment Planning
- Targeting Intervention
- Outcome Evaluation



Warning Signs for Suicide

From *Understanding and Preventing Suicide*



Susan



Trish



Kevin



<http://www.youtube.com/watch?v=0hY6dJkV8I8>



Suicide Warning Signs

- Disturbed sleep patterns
- Anxiety, agitation
- Pulling away from friends and family
- Past attempts
- Extremely self-hating thoughts
- Feeling like they don't belong
- Hopelessness
- Rage





Suicide Warning Signs

- Feeling trapped
- Increased use of alcohol or drugs
- Feeling that they are a burden to others
- Loss of interest in favorite activities -“nothing matters”
- Giving up on themselves
- Risk-taking behavior
- Suicidal thoughts, plans, actions
- Sudden mood changes for the better





Suicide Risk Factors

- A psychiatric disorder, especially major depressive disorder, bipolar disorder, conduct disorder, and substance (alcohol and drug) use disorders
- Psychiatric comorbidity, especially the combination of mood, disruptive, and substance abuse disorders
- Personality disorders (especially cluster B disorders: antisocial, borderline, histrionic, narcissistic)
- Availability of lethal means
- A family history of depression or suicide
- Loss of a parent to death or divorce
- Family discord
- Physical and/or sexual abuse
- Lack of a support network, poor relationships with parents or peers and feelings of social isolation
- Dealing with homosexuality in an unsupportive family or community or hostile school environment
- Previous attempts
- Poor physical health

Data Source: State of California Department of Public Health, Epidemiology and Prevention for Injury Control Branch, California Office of Statewide Health Planning and Development, Patient Discharge Data. Accessed online at <http://epicenter.cdph.ca.gov/>; State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2050. Accessed online at <http://www.dof.ca.gov> (May 2011).



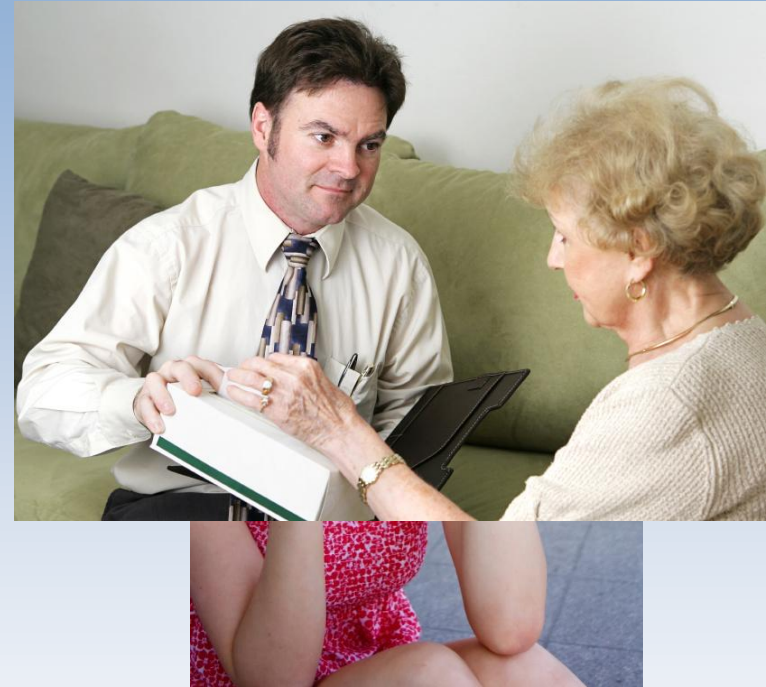
Social Risk Factors

- Sex-
Male 3X female
- Race-
Whites 2x nonwhites, except urban areas where rate is the same: Native Americans have higher rates
- Age-
in men rates rise with age above age 45; in women the peak risk is about age 55, then the rate declines
- Geography-
urban rates higher
- Marital Status-
divorced > single > widowed > married



Protective Factors

- Family and community connections/ support
- Clinical Care (availability and accessibility)
- Resilience
- Coping Skills
- Frustration tolerance and emotion regulation
- Cultural and religious beliefs; spirituality





Poll #4

Do you find it stressful to assess and manage suicide risk?

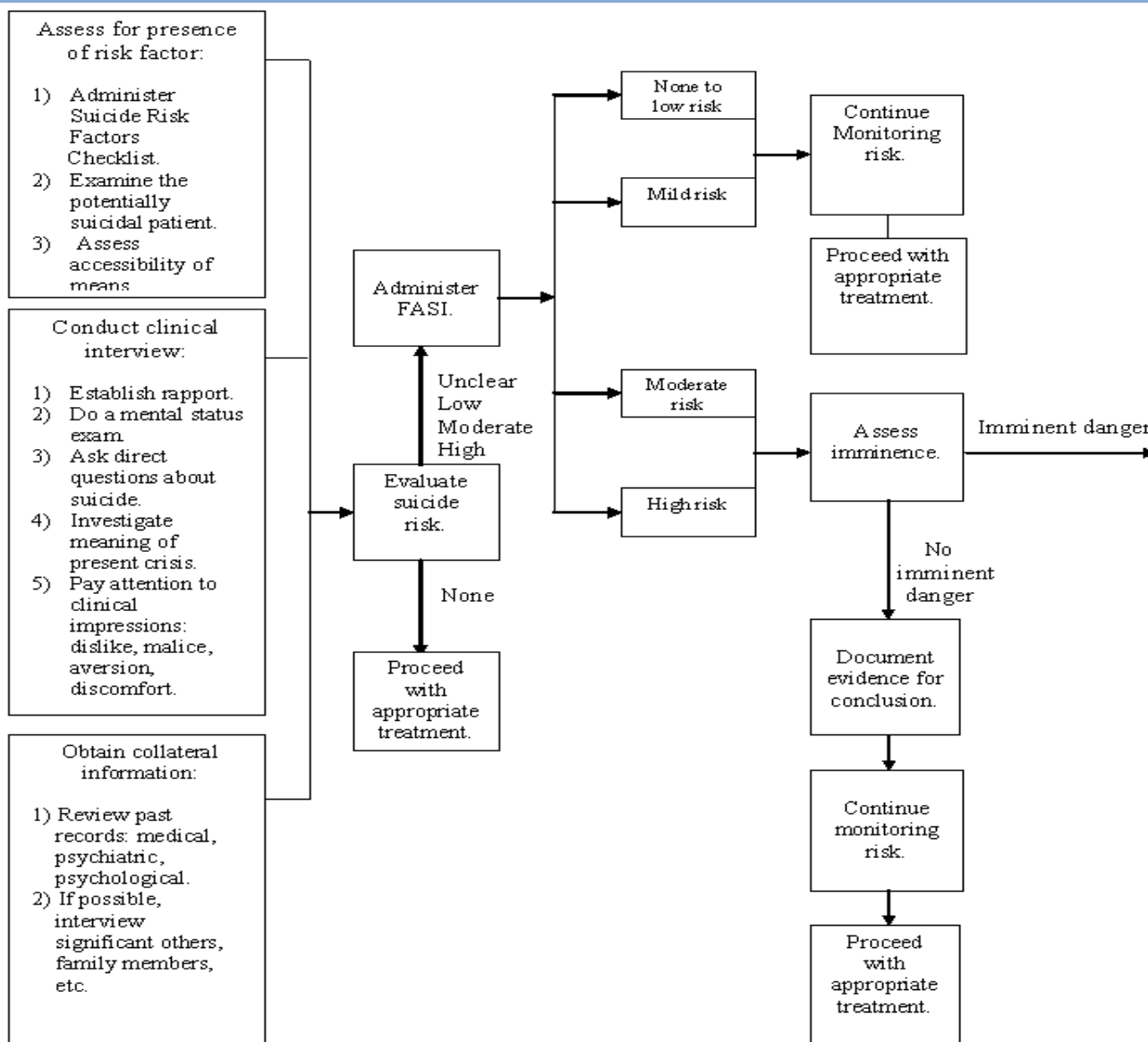


Figure 5.1. Assessment and Management of the Suicidal Patient

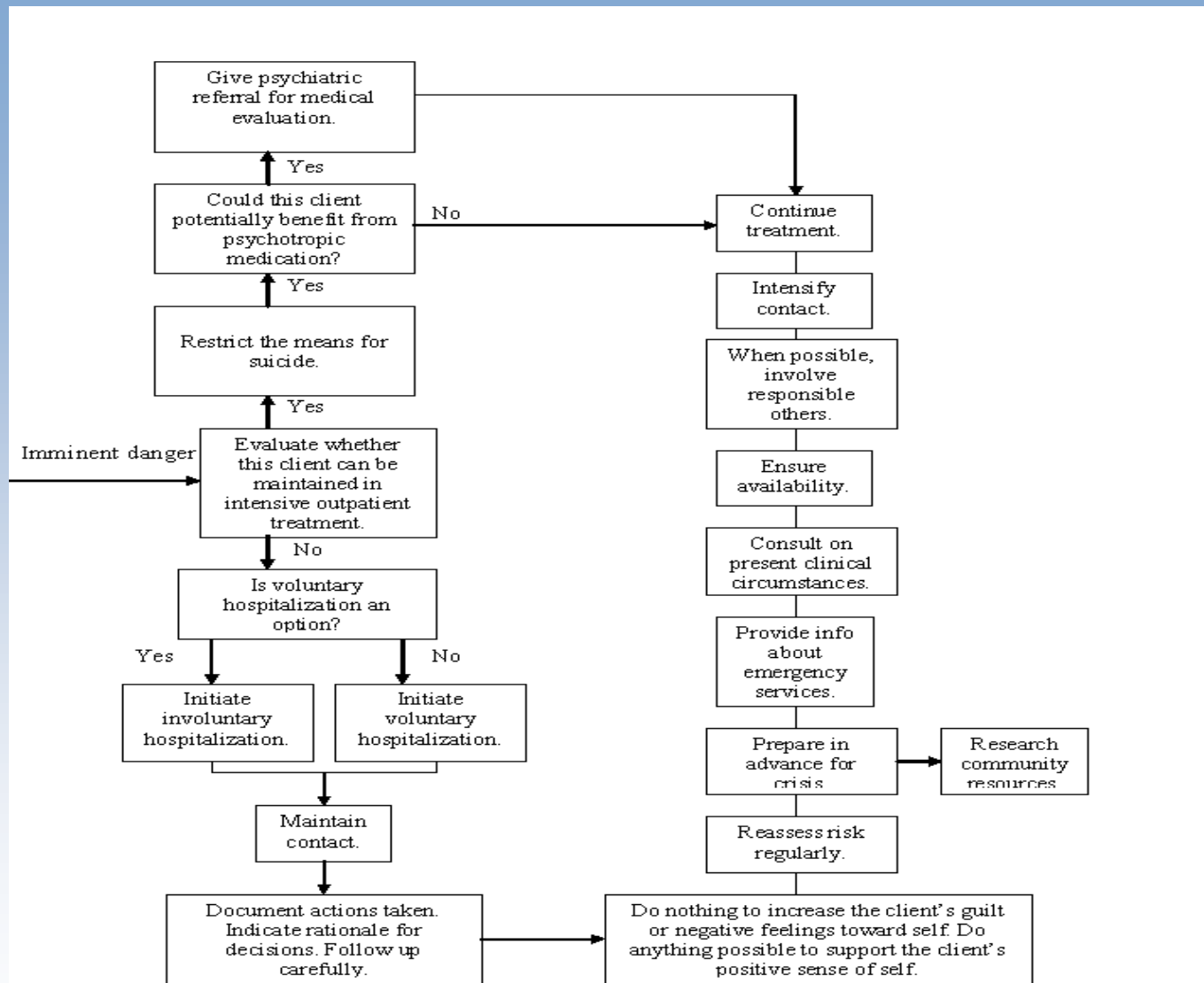


Figure 5.1. Assessment and Management of the Suicidal Patient



Poll #5

Do you see clients who have had prior suicide attempts?

- 0

- 1 past attempt

- 2 or more past attempts



Multiple Attempters as a Special High-Risk Group (in comparison to single attempters/ideators)

- Distinctive in every way
 - Greater likelihood to have diagnosis, co-morbidity, personality disorder
 - Younger at time of first attempt (greater chronicity)
 - Lower lethality first attempt (raises question about intent, function of behavior)
 - More impulsive
 - More likely to be associated with substance abuse
 - Greater symptom severity
 - Anxiety, depression, hopelessness, anger, suicidal ideation (frequency, intensity, specificity, duration, intent)
 - More frequent histories of trauma, abuse
 - Distinctive characteristics of crises

Safety Plan, Stanley and Brown, 2008

Figure 6.3. Example of a safety plan developed during the early phase of treatment.
ED=emergency department

1. **Warning signs (when I am to use the safety plan):**

- wanting to go to sleep and not wake up
- wanting to hurt myself
- thinking "I can't take it anymore"

2. **Coping strategies (things I can try to do on my own):**

- listening to rock music
- rocking in a chair
- going for a walk
- controlled breathing
- taking a hot or cold shower
- exercising

3. **Contacting other people:**

- Calling a friend to distract myself: _____ Phone: _____

If distraction does not work, I will tell any of the following people that I am in crisis and ask for help:

- Calling a family member: _____ Phone: _____
- Calling or talking to someone else: _____ Phone: _____

4. **Contacting a health care professional during business hours:**

Calling my therapist: _____ Phone: _____

Calling my psychiatrist: _____ Phone: _____

Calling my case manager: _____ Phone: _____

The following agencies or services may be called 24 hours a day/7 days a week:

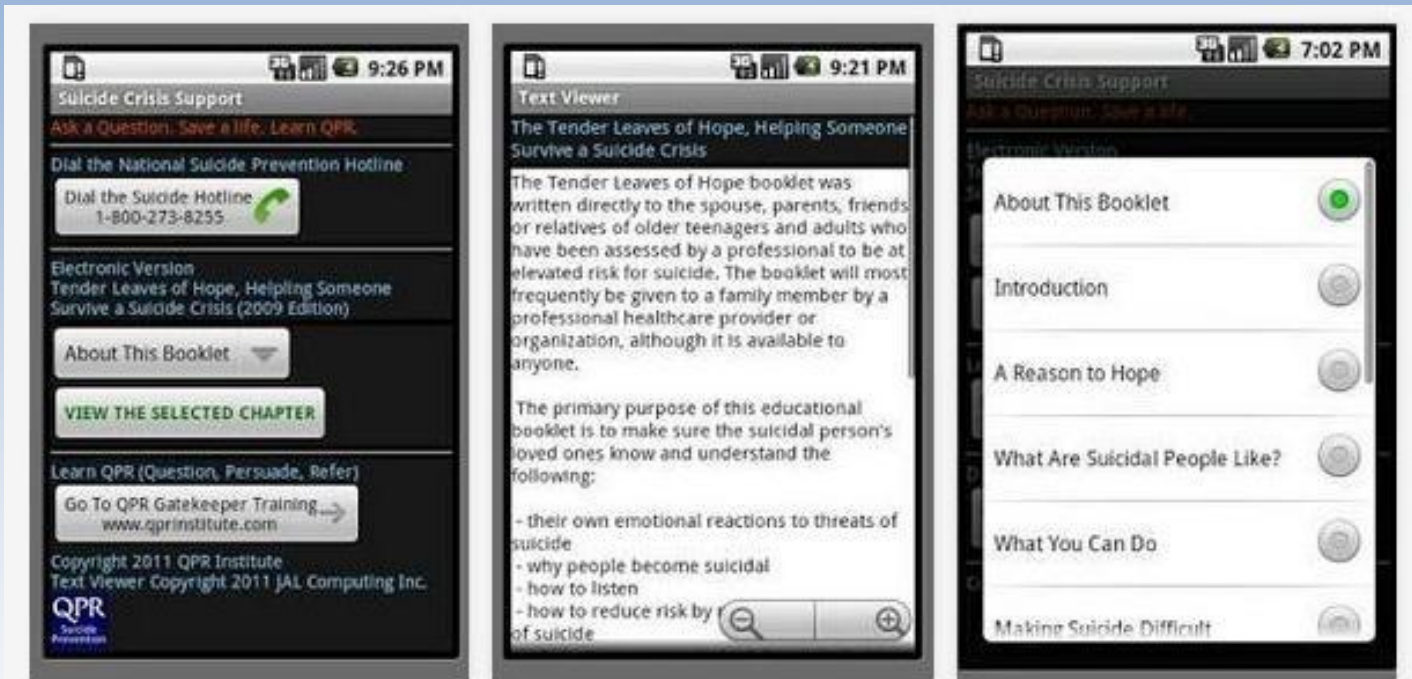
Calling the psychiatrist ED: _____ Phone: _____

Calling National Suicide Prevention Lifeline Phone: 1-800-273-TALK

Patients signature: _____ Date: _____

Clinician signature: _____ Date: _____

QPR Suicide Prevention APP



ASK



SPRC • Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

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1-800-273-TALK (8255)
suicidepreventionlifeline.org

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From the Field

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Versions are available, at no-cost, for both iPhones/iPads and Android phones and mobile web browsers.

TX Suicide Prevention App for Smartphones

The ASK & Prevent Suicide mobile app, developed by the Texas Youth Suicide Prevention Project, helps users recognize warning signs, ask about suicidal thoughts, and find help for people at risk, including LGBTQ people and veterans.

[Read more](#)

TX Suicide Prevention App for Smartphones

ASK About Suicide to Save a Life is an app that helps users recognize the warning signs for suicide, ask about suicidal thoughts, and find help for people at risk. It includes sections dedicated to LGBTQ people and veterans, as well as a list of crisis hotlines in Texas and links to national and state suicide prevention resources. The app was developed by the Texas Department of State Health Services and Mental Health America of Texas as part of the Texas Youth Suicide Prevention Project.



10 Most Common Errors in Suicide Prevention

1. Superficial Reassurance
2. Avoidance of Strong Feelings
3. Professionalism
4. Inadequate Assessment of suicidal intent
5. Failure to identify the precipitating event
6. Passivity
7. Insufficient Directiveness
8. Advice Giving
9. Stereotypic Responses
10. Defensiveness



Practice Recommendations

1. When imminent risk does not dictate hospitalization, the intensity of outpatient treatment (i.e., more frequent appointments, telephone contacts, concurrent individual and group treatment) should vary in accordance with risk indicators for those identified as high risk.



Practice Recommendations

2. If the target goal is a reduction in suicide attempts and related behaviors, treatment should be conceptualized as long-term and target identified skills deficits (e.g., emotion regulation, distress tolerance, impulsivity, problem-solving, interpersonal assertiveness, anger management), in addition to other salient treatment issues.



Practice Recommendations

3. If therapy is brief and the target variable are suicidal ideation, or related symptomatology such as depression, hopelessness, or loneliness, a problem-solving component should be used in some form or fashion as a core intervention.



Practice Recommendations

4. Regardless of therapeutic orientation, an explanatory model should be detailed identifying treatment targets, both direct (i.e., suicidal ideation, attempts, related self-destructive and self-multistory behaviors) and indirect (depression, hopelessness, anxiety, and anger; interpersonal relationship dysfunction; low self-esteem and poor self-image; day-to-day functioning at work and home).



Practice Recommendations

5. Use of standardized follow-up and referral procedure (e.g., letters or phone calls) is recommended for those dropping out of treatment prematurely in an effort to enhance compliance and reduce risk for subsequent attempts.



Poll #6

Have you received formal training in treating suicidal individuals?

The Aeschi Working Group:

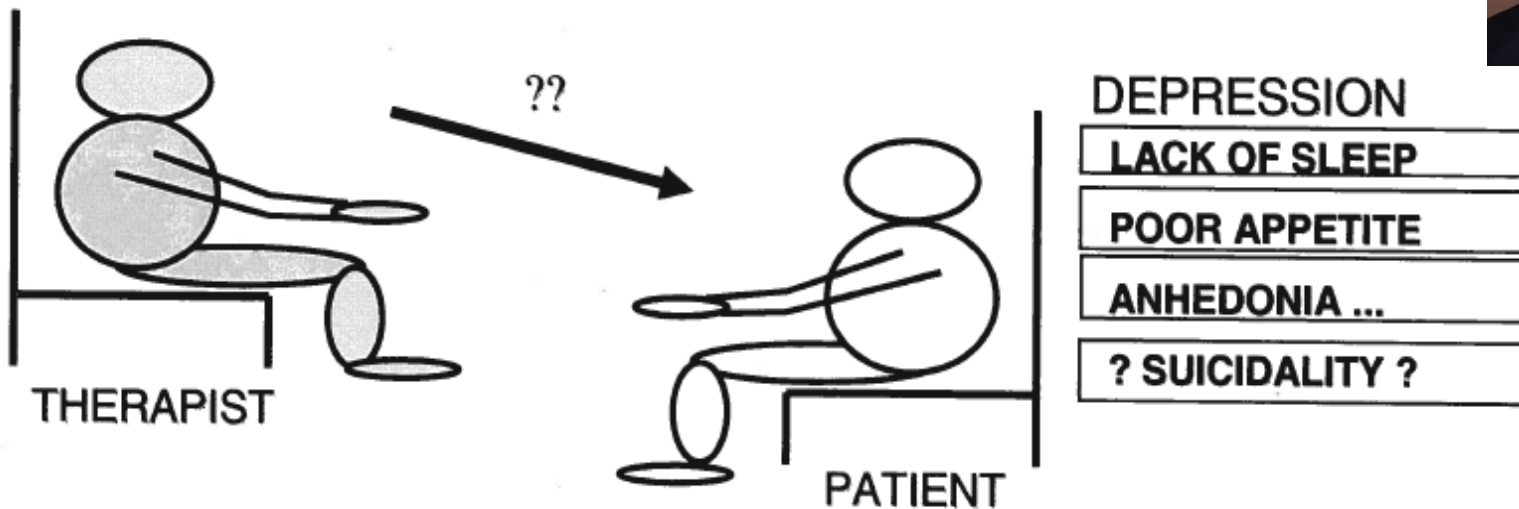


- Konrad Michel, Antoon Leenaars, David Jobes, Terry Maltzberger, Israel Orbach, Ladislav Valach, Richard Young, Michael Bostwick.

Aeschi Principles:

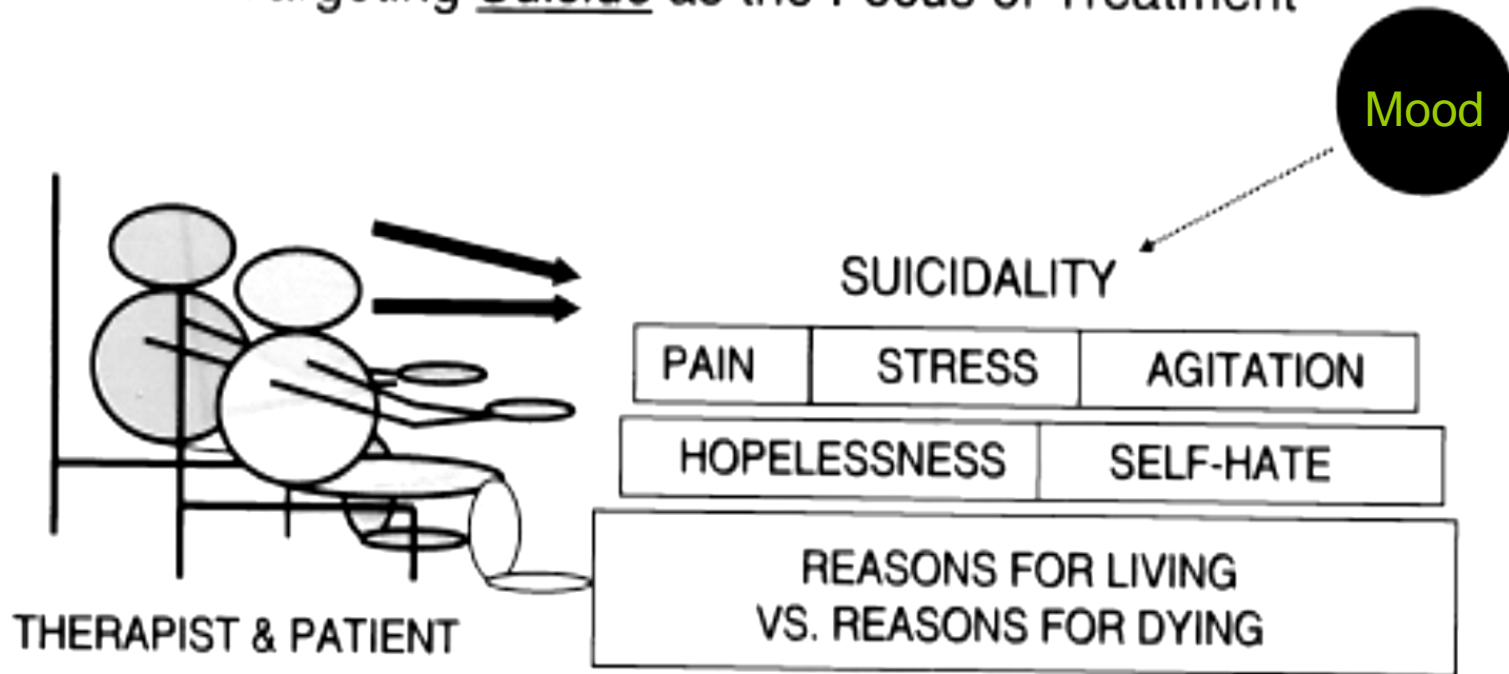
- Empathic, non-judgmental attitude
- Narrative approach
- Understanding suicide as escape from unbearable affective state
- Active interventions
- Resolve therapist's ambivalence and fear

CONVENTIONAL MODEL: Suicide = Symptom



Traditional treatment = main focus on the psychiatric disorder (suicidality as symptom). Use of devices such as the no-suicide contract.

COLLABORATIVELY ASSESSING RISK: Targeting Suicide as the Focus of Treatment



CAMS Treatment = Intensive intervention that is suicide-specific, emphasizing the development of new means of coping and problem-solving, thereby eliminating the need for suicidal coping.

Suicide Status Form-III (SSF III) Initial Session

Rank _____ Patient _____ Clinician _____ Date _____ Time _____

Section A-Patient

Rate and fill out each item according to how you feel right now. Then rank items in order of importance 1 to 5 (1=most important, 5=least important)

_____ 1. Rate psychological pain (hurt, anguish, or misery in your mind; not stress; not physical pain):
Low Pain: 1 2 3 4 5 :High Pain

What I find most painful is: _____

_____ 2. Rate stress (your general feeling of being pressured or overwhelmed):
Low Stress: 1 2 3 4 5 :High Stress

What I find most stressful is: _____

_____ 3. Rate agitation (emotional urgency; feeling that you need to take action; not irritation; not annoyance):
Low Agitation: 1 2 3 4 5 :High Agitation

I most need to take action when: _____

_____ 4. Rate Hopelessness (your expectation that things will not get better no matter what you do)
Low Hopelessness: 1 2 3 4 5 :High Hopelessness

I am most hopeless about: _____

_____ 5. Rate Self-Hate (your general feeling or disliking of yourself; having no self-esteem; having no self-respect)
Low Self-Hate: 1 2 3 4 5 :High Self-Hate

N/A _____ What I hate most about myself is: _____

_____ 6. Rate overall Risk of Suicide:
Extremely Low Risk (will not kill self: 1 2 3 4 5 :Extremely High Risk (will kill self)



CAMS patients reached resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients.
(Jobs et al., 2003, Wong, 2003)

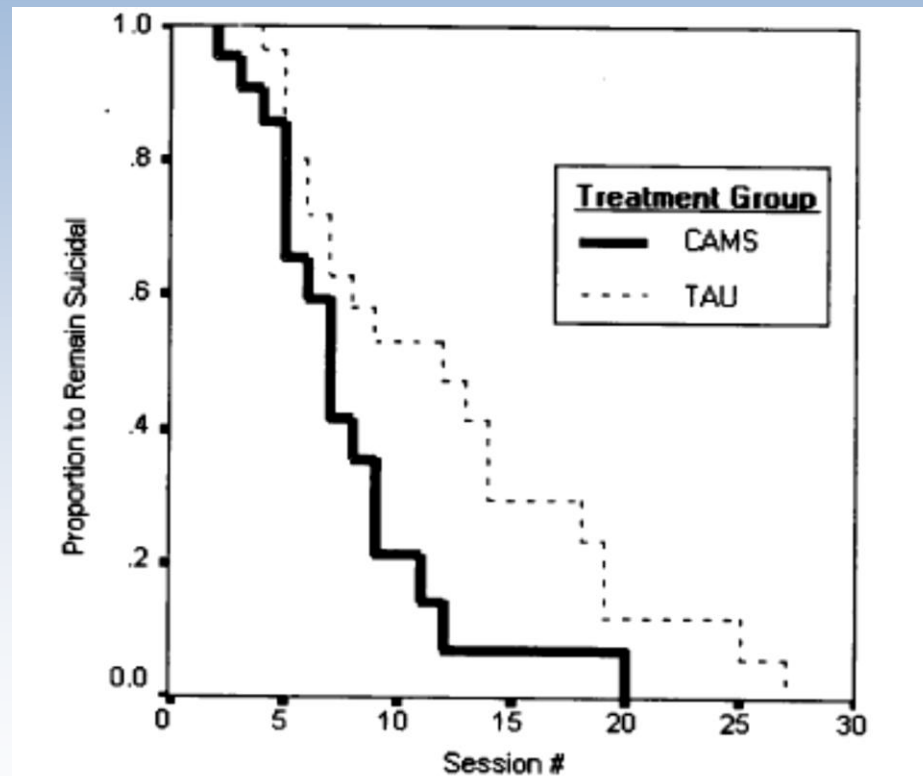


Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.



Effective Therapy Approaches for Treating the Suicidal Person

- Cognitive Therapy for suicidal people was developed by Aaron *Beck* and Gregory *Brown*. Unlike other CBT treatments, this approach is not time limited. The third and last stage is “Relapse Prevention with a Twist.” Clients do not graduate from treatment until they demonstrate that they are ready to do this on their own.
- Dialectical Behavior Therapy, developed by *Marsha M. Linehan*, is designed to treat emotion regulation difficulties and suicidal behavior. One element, the skill-building component of DBT, addresses the issues of distress tolerance and the development of healthy affect regulation strategies, both of which are essential for suicidal clients.
- Voice Therapy, which was developed by Robert Firestone, is a cognitive-affective-behavioral therapeutic methodology that brings introjected hostile thoughts, with the accompanying negative affect, to consciousness, rendering them accessible for treatment. This technique facilitates the identification of the negative cognitions driving the suicidal actions, which in turn helps clients to gain a measure of control over all aspects of their self-destructive or suicidal behavior. This process helps clients expand their personal boundaries, develop a sense of meaning in life, and reduce the risk of self-destructive behavior, including suicide.



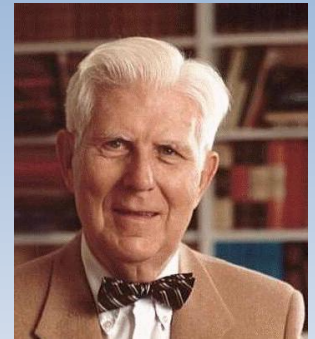
Establish therapeutic alliance with the suicidal patient, Brown and Beck (2008, p. 162)

1. Have the patient tell his/her "story at his/her own pace. Conduct a behavioral chain analysis of events of the proximal factors that triggered the suicide attempt.
2. Help the patient define the suicidal crisis. Remember that the patient is communicating how badly he or she feels.
3. Use phrases such as "murdering yourself" or "self-annihilation" when referring to suicide.
4. Help the patient view suicide as an attempt to solve a problem. Convey that you do not want the patient to employ a "permanent solution to what might be a temporary problem."
5. Use motivational Interviewing procedures. Zerler (2008) has discussed how to apply the principles of motivational interviewing of suicidal patients (EE,DD, RR, and SS). The four principles of Motivational Interviewing are: Expressing Empathy; Developing Discrepancy between the patient's present behaviors and values; Rolling with Resistance as the therapist strives to understand and respect both sides of the ambivalence for the patients perspective. The therapist can empathize with the needs that give rise to the suicidal ideation, without approving suicidal behaviors. Finally, the therapist can Support the patient's Self-efficacy by acting as a guide or consultant suggesting possible ways to proceed.



Cognitive Therapy

(Beck, A. and Brown, G.)



- **Stage 1** Creating a crisis plan
 - Teaching the cognitive model
 - Creating treatment goals
- **Stage 2**
 - In depth focus on Suicidal behavior
 - Cognitive restructuring, behavioral techniques
 - Coping cards, Hope kit, behavioral coping skills
 - Skills for tolerating distress- similar to DBT



Construction of a Hope Kit*

Another activity that is undertaken in the middle phase of therapy is the construction of a hope kit. A hope kit consists of a container that holds mementos (photographs, letters, souvenirs) that serve as reminders of reasons to live. Patients are instructed to be as creative as possible when creating their hope kit, so that the end result is a powerful and personal reminder of their connection to life that can be used when feeling suicidal. We have found that patients report making their hope kits to be a highly rewarding experience that often leads them to discover reasons to live they had previously overlooked.

Suzanne was rather artistic and reported that she enjoyed this task. She found an old shoe box and decorated it using some of her favorite pictures. Inside she included pictures of her mother, her friends, and her car. She also included the lyrics of her favorite song, a potpourri bag filled with her favorite scent, and a piece of her childhood blanket. Suzanne kept the hope box on her dresser, and it frequently reminded her of all the good things in her life.

**Excerpted from "Cognitive Therapy, Cognition, and Suicidal Behavior" by GK Brown, E Jeglic, GR Henriques, and AT Beck In T.E. Ellis (Ed.), *Cognition and Suicide* (APA Books, 2006).



Cognitive Therapy

(Beck, A. and Brown, G.)

- Stage 3
 - Relapse Prevention with a twist
 - Guided imagery used to recreate the situation before the latest attempt
 - Client imagines using the coping skills acquired in treatment rather than attempting suicide
 - Client also imagines other future situations that would lead to suicidal urges and again imagines using the learned coping skills
 - Inability to imagine adaptive coping is an indicator that additional skills coaching is needed- more sessions



BCBT Team Members

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BCBT Study Aims

1. To evaluate the effectiveness of brief cognitive-behavioral therapy for suicidality (BCBT), including suicidal ideation and attempts, among active duty military personnel.

Clinical Contact: 12 Hours Total

2. To engage in prospective investigation of suicide risk factors and warning signs, exploring their ability to predict subsequent suicidal behavior.

3. To explore the effectiveness of BCBT for increasing appropriate utilization of and compliance with medical, mental health, and substance abuse treatment.



TAU vs. BCBT

TAU ($n = 76$)

- Suicide as symptom of psychiatric diagnosis
- Remission is treatment focus
- Emphasizes external self-management (e.g. hospitalization)
- Clinician responsibility for preventing suicide

BCBT ($n = 76$)

- Suicide as problem distinct from diagnosis
- Identifiable skill deficits as treatment focus
- Focus on suicide risk
- Emphasizes internal self-management
- Shared patient-clinician responsibility for preventing suicide

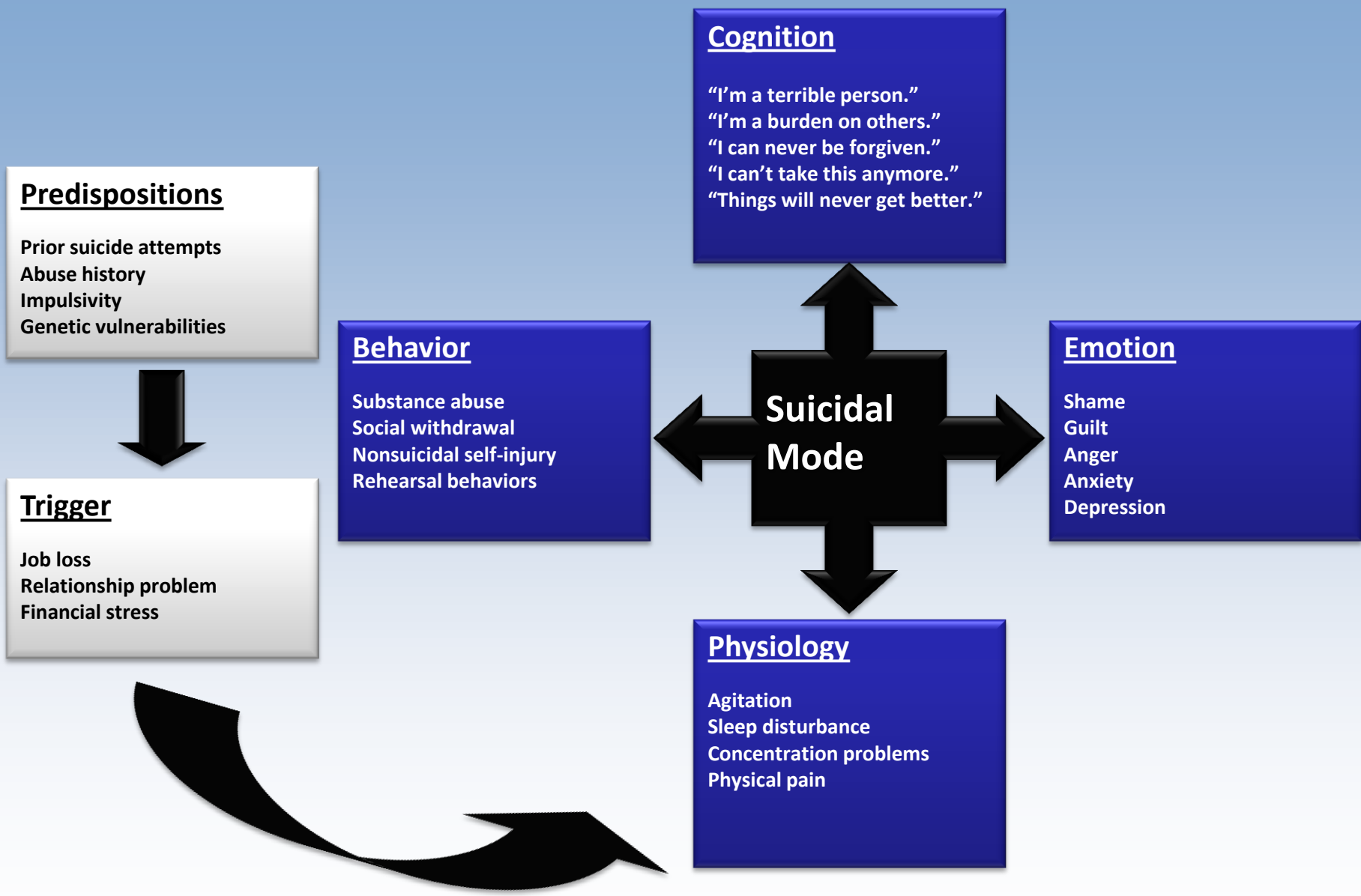
TABLE 1
BCBT Treatment Phases, Strategies, and Targeted Skills

<i>Treatment Phase</i>	<i>Treatment Strategies</i>	<i>Targeted Skill Set</i>
Phase I: Orientation	Commitment to treatment Crisis response and safety planning Means restriction Survival kit Reasons for living card Model of suicidality Treatment journal Lessons learned	Self-management Self-management Self-management Emotion regulation Emotion regulation Emotion regulation Emotion regulation
Phase II: Skill focus	Skill development worksheets Coping cards Demonstration Practice Skill refinement	Emotion regulation skill cluster Problem solving Mindfulness Cognitive appraisal Relaxation
Phase III: Relapse prevention	Skill generalization Skill maintenance	Problem solving Mindfulness Cognitive appraisal Relaxation



Critical Elements: Competency Model

- Progress through treatment is determined based on patient skill mastery
- Patient must demonstrate skill mastery for each phase before progressing to next phase
- If patient demonstrates insufficient skills mastery at later phase, clinician returns to earlier phase
- Final competency check is relapse prevention task





Initial Findings

- Consistent with predications
 - Levels of self-reported depression, anxiety, and suicidal thinking comparable at intake, 3, 6 and 12 months
 - **Reduced suicide attempt rate 50% at 6 and 12 months**
 - **6/76 in BCBT (8%)**
 - **13/76 in TAU (17%)**
 - **Chi-square=2.97, p=.087**
- **All participants will be at 12 month mark in 2 months**



Conclusions

- Brief treatment can be as/more effective than traditional approaches
 - Safety not an issue
- Consistent with previous findings
 - Brown et al.
 - Linehan et al.
- Targeting suicidal behavior as skill deficit critical to success



Dialectical Behavior Therapy



- Components of DBT
 - Individual treatment
 - Group Skills training
 - Skills Coaching
 - Consultation Team
- Functions of DBT
 - Structuring the environment
 - Enhancing client capabilities
 - Generalizing skills to the natural environment
 - Improving Client motivation



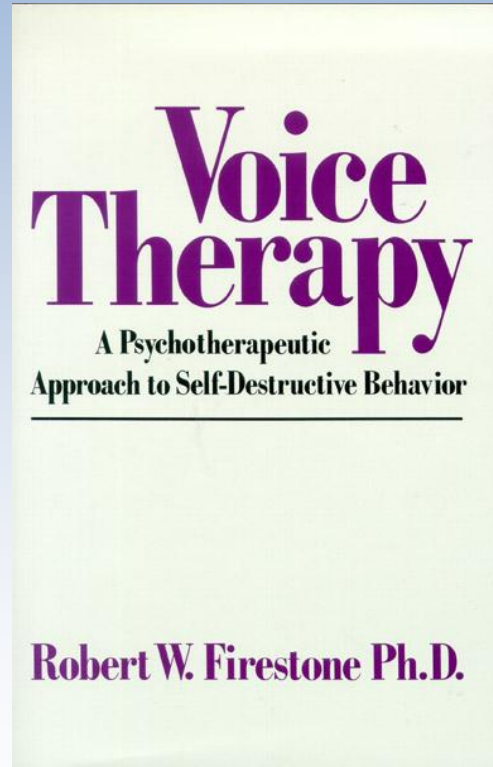
DBT

- Dialectics:
 - Helping clients find balance in emotions, thoughts, behavior and choices. Teaching them and showing them how to live in balance.
- Validation:
 - Acknowledging another person's reality, noting that their thoughts feelings responses are real and valid in their own right.



Voice Therapy

Cognitive Affective Behavioral Approach



The Therapeutic Process in Voice Therapy

Step I

Identify the content of the person's negative thought process. The person is taught to articulate his or her self-attacks in the second person. The person is encouraged to say the attack as he or she hears it or experiences it. If the person is holding back feelings, he or she is encouraged to express them.



Step II

The person discusses insights and reactions to verbalizing the voice. The person attempts to understand the relationship between voice attacks and early life experience.



The Therapeutic Process in Voice Therapy

Step III

The person answers back to the voice attacks, which is often a cathartic experience. Afterwards, it is important for the person to make a rational statement about how he or she really is, how other people really are, what is true about his or her social world.

Step IV

The person develops insight about how the voice attacks are influencing his or her present-day behaviors.

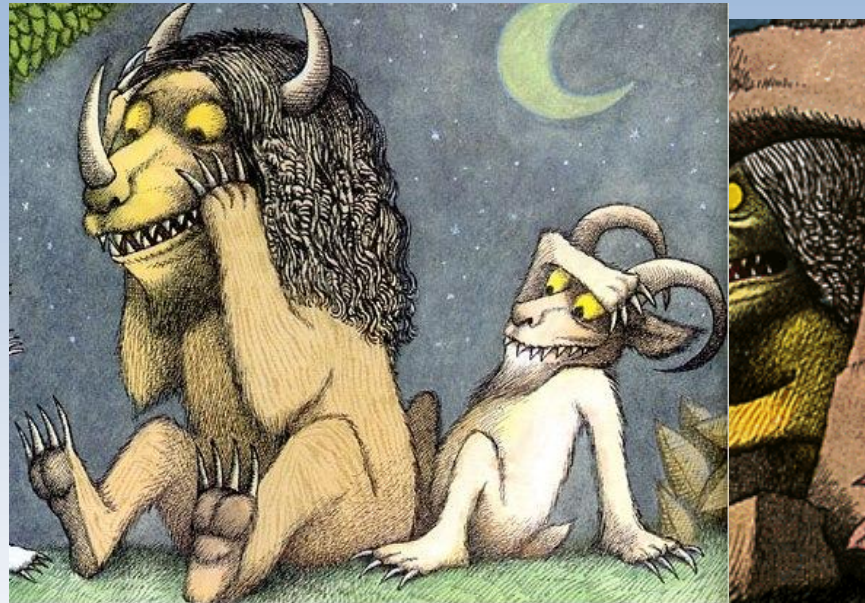
Step V

The person then collaborates with the therapist to plan changes in these behaviors. The person is encouraged to not engage in self-destructive behavior dictated by his or her negative thoughts and to also increase the positive behaviors these negative thoughts discourage.



• Self

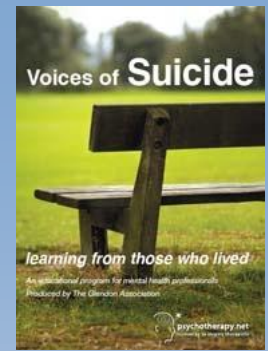
• Anti-Self





Treatment

From "Voices of Suicide: Learning From Those Who Lived"



<http://www.youtube.com/watch?v=H4i9G9g-1kk>



Most Helpful Aspects from Client Perspective

Validating Relationships

- Participants describe the existence of an affirming and validating relationship as a catalyst for reconnection with others and with oneself. A difficult part of the recovery process was breaking through, cognitive, emotional, and behavioral barriers that participants had generated for survival.



Most Helpful Aspects from Client Perspective

Working with Emotions

- Dealing with the intense emotions underlying suicidal behavior was perceived as crucial to participant's healing. The resolution of despair and helplessness was a pivotal and highly potent experience for all participants in the study. Almost paradoxically, if a client did not receive acknowledgement of these powerful and overwhelming feelings, they reported being unable to move beyond them.



Most Helpful Aspects from Client Perspective

Developing Autonomy and Identity

- Participants identified understanding suicidal behaviors , developing self-awareness, and constructing personal identity as key components of the therapeutic process. Participants conceptualized the therapeutic experience as confronting and discarding negative patterns while establishing new, more positive ones.



Common Emotions Experienced in Grief:

- Shock
- Guilt
- Despair
- Stress
- Rejection
- Confusion
- Helplessness
- Denial
- Anger
- Disbelief
- Sadness
- Loneliness
- Self-Blame
- Depression
- Pain
- Shame
- Hopelessness
- Numbness
- Abandonment
- Anxiety

These feelings are normal reactions, and the expression of them is a natural part of grieving. Grief is different for everyone. There is no fixed schedule or one way to cope.



Self-Care & Help Seeking Behaviors

- Ask for help
- Talk to others
- Get plenty of rest
- Drink plenty of water, avoid caffeine
- Do not use alcohol and other drugs
- Exercise
- Use relaxation skills



PSYCHALIVE.ORG – Suicide Prevention Advice Page

<http://www.psychalive.org/2011/09/suicide-prevention-advice-2/>

National Action Alliance for Suicide Prevention

<http://actionallianceforsuicideprevention.org/>

American Association of Suicidology's Survivors' Support Group Directory

<http://www.suicidology.org/web/guest/support-group-directory>

IASP Suicide Survivor Organizations (listed by country) -

http://www.iasp.info/resources/Postvention/National_Suicide_Survivor_Organizations/

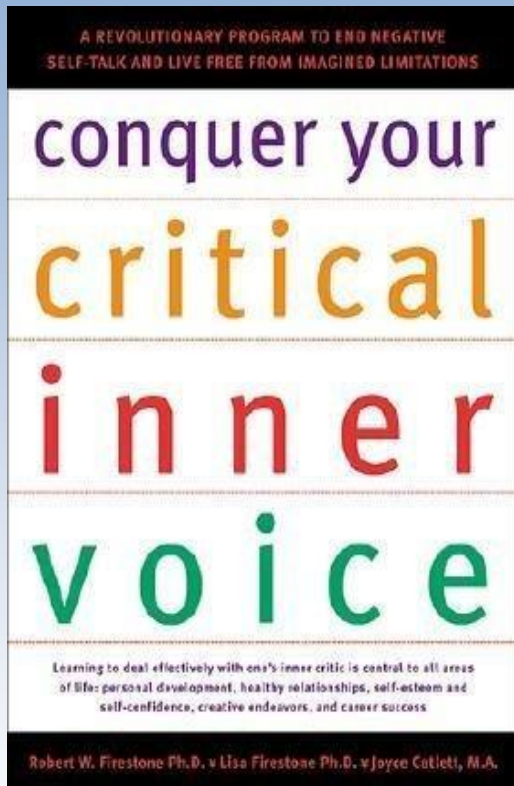
The Healthy Mind Platter



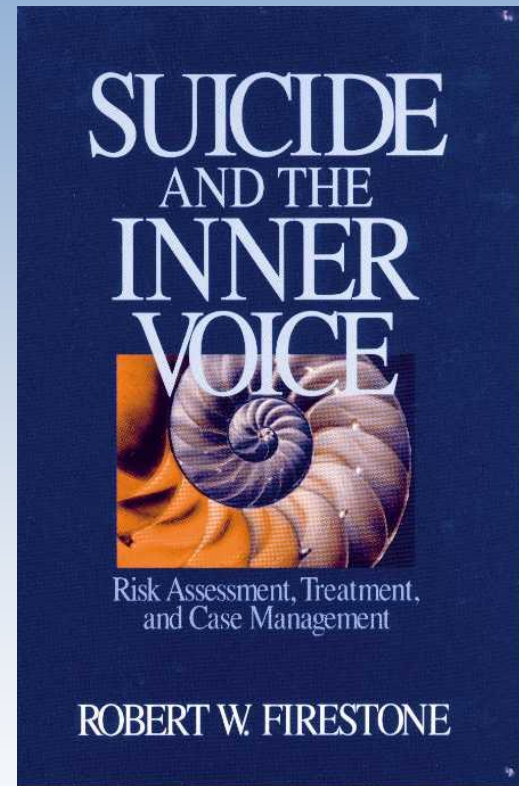
The Healthy Mind Platter, for Optimal Brain Matter



Resources: Books



For Public and Professionals

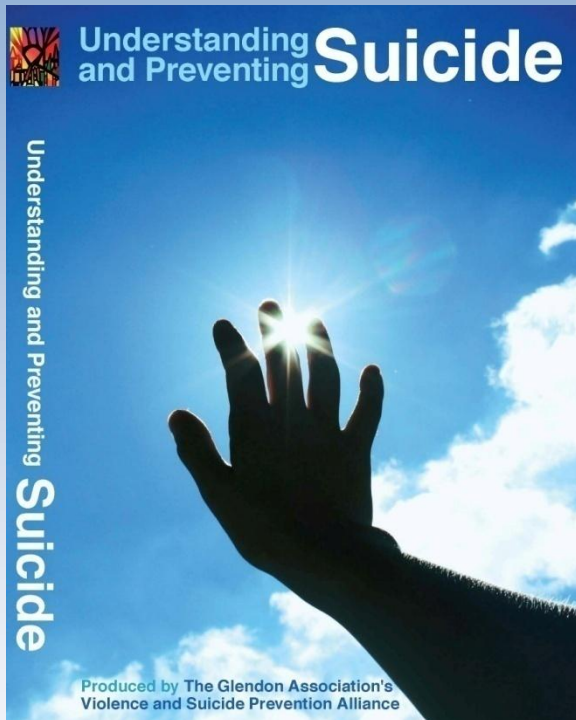


For Professionals

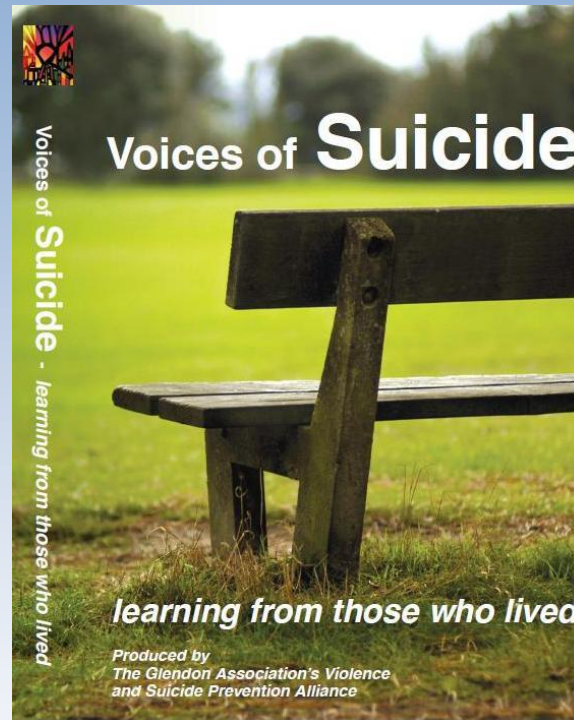
Visit www.psychalive.org for resource links



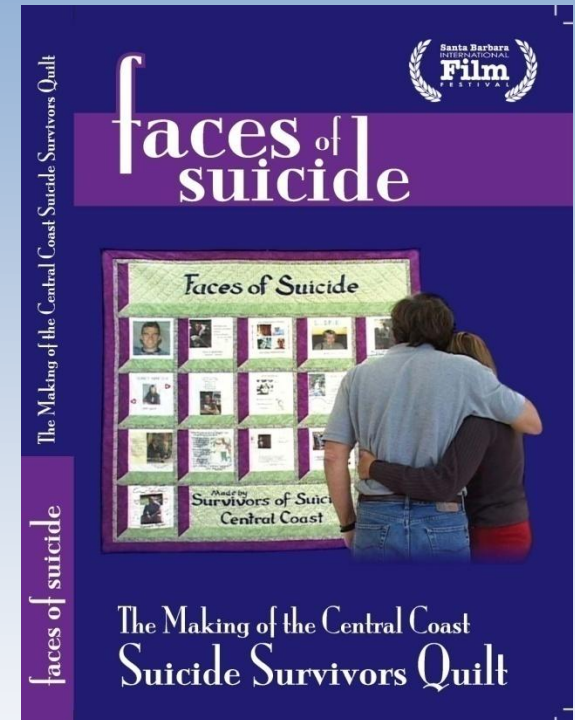
Resources: Films



For the Public



For Professionals



For Survivors

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Overcoming the Inner Enemy that Causes Depression

Free Webinar

Oct. 8, 2013 - 11am – 12pm PST

Presenter: Lisa Firestone, Ph.D.

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Helping Clients Overcome Depression

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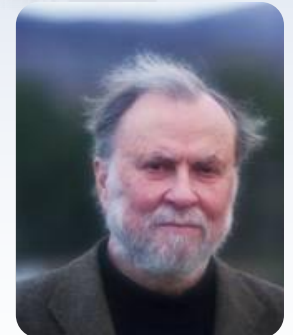
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