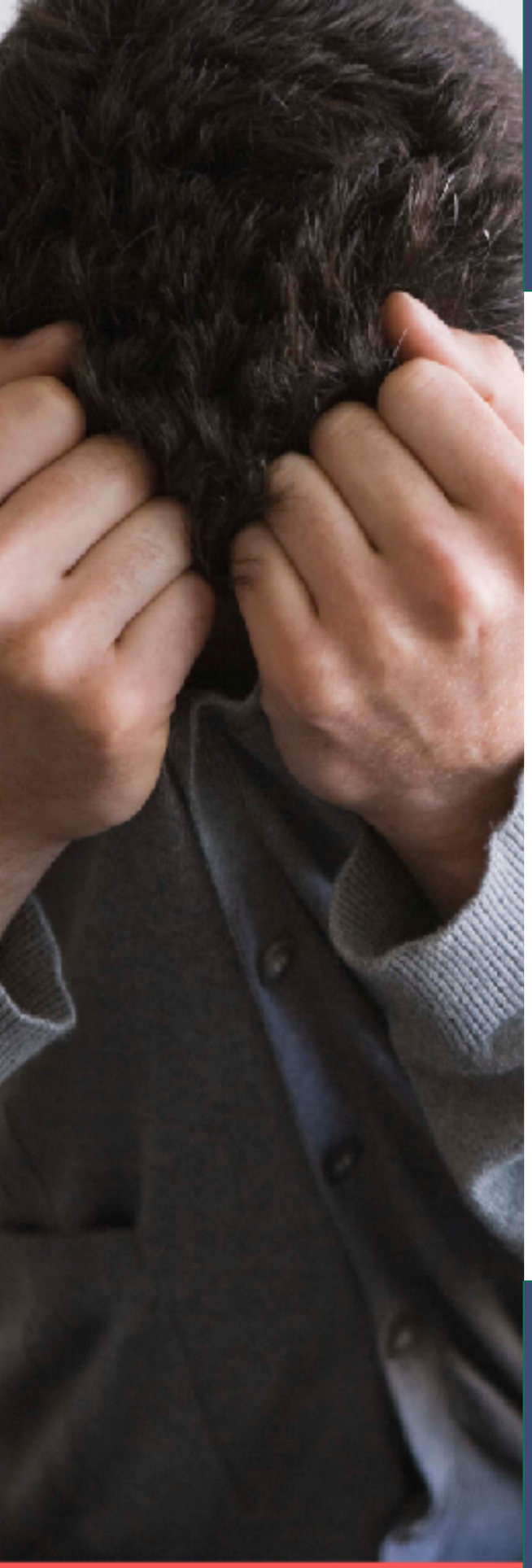


Saving Lives From Suicide:

Two-Part CE Webinar

Presented
by Dr. Lisa Firestone

Part 2

- Safety Planning
- Effective Brief Interventions
- Additional Treatment Approaches
- Resources

Safety Planning

What a Crisis Response Plan Is:

- a memory aid to facilitate early identification of emotional crises
- a checklist of personalized strategies to follow during emotional crises
- a problem solving tool
- a collaboratively-developed strategy for managing acute periods of risk

Source: Craig J. Bryan, PsyD, ABPP, 2018

What a Crisis Response Plan Is NOT:

- a no-suicide contract
- a no-harm contract
- a contract for safety

Source: Craig J. Bryan, PsyD, ABPP, 2018

Crisis Response Plan

1. Explain rationale for CRP
2. Provide card for patient to record CRP
3. Identify personal warning signs
4. Identify self-management strategies
5. Identify reasons for living
6. Identify social supports
7. Provide crisis/emergency steps
8. Verbally review and rate likelihood of use

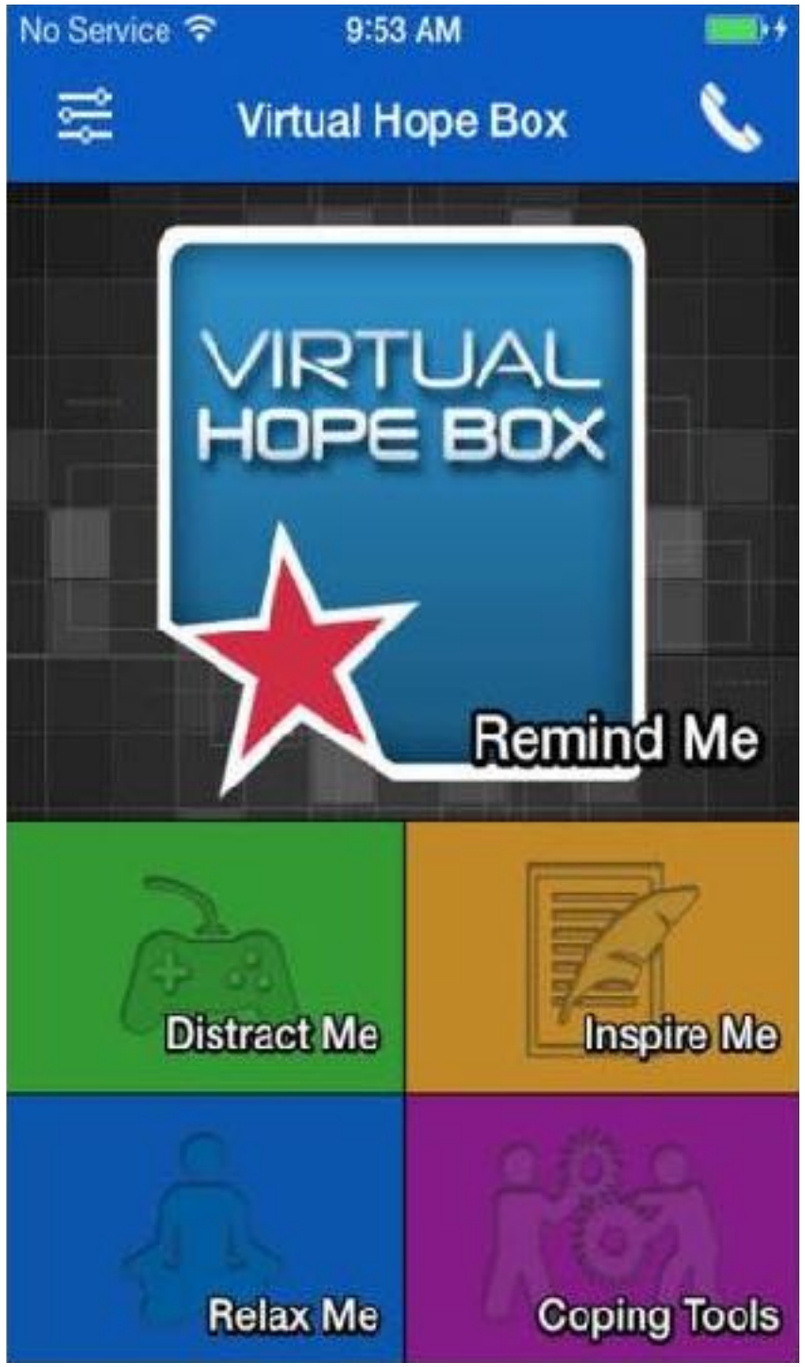
Source: Craig J. Bryan, PsyD, ABPP, 2018

Tips for Effective Crisis Response Planning

- Ask patients to generate ideas by asking what has worked in the past
- Use index cards or business cards, not sheets of paper
- Handwrite the plan, do not fill in the blanks" with pre-printed paper
- Laminate the card
- Take a picture of the card to keep in their smart phone
- Complement with the Virtual Hope Box" app

Source: Craig J. Bryan, PsyD, ABPP, 2018

Virtual Hope Box App



6 Steps of Safety Planning

Step 1: Recognizing warning signs

Step 2: Using internal coping strategies

Step 3: Utilizing social contacts that can serve as a distraction from suicidal thoughts and who may offer support

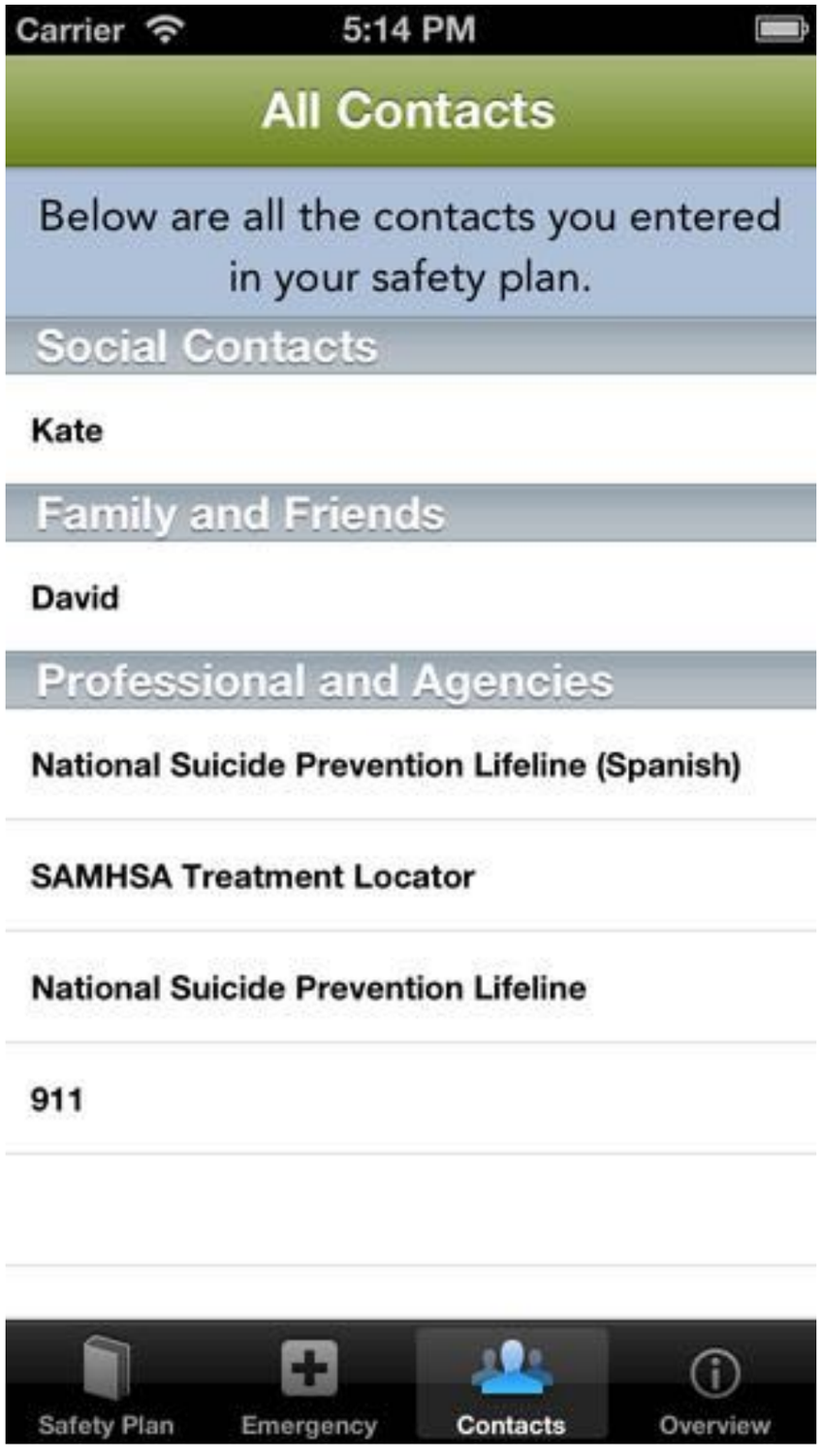
Step 4: Contacting family members or friends who may offer help to resolve the crisis

Step 5: Contacting professionals and agencies

Step 6: Reducing the potential for use of lethal means

Practice Safety Planning

Safety Plan App



My 3 App

Create your support system.

Add the contact information of the 3 people you feel you would like to talk to when you are having thoughts of suicide.

Build your safety plan.

Customize your safety plan by identifying your personal warning signs, coping strategies, distractions and personal networks. This safety plan will be with you at all times and can help you stay safe when you start thinking about suicide. Learn more about safety planning.

Access Important Resources.

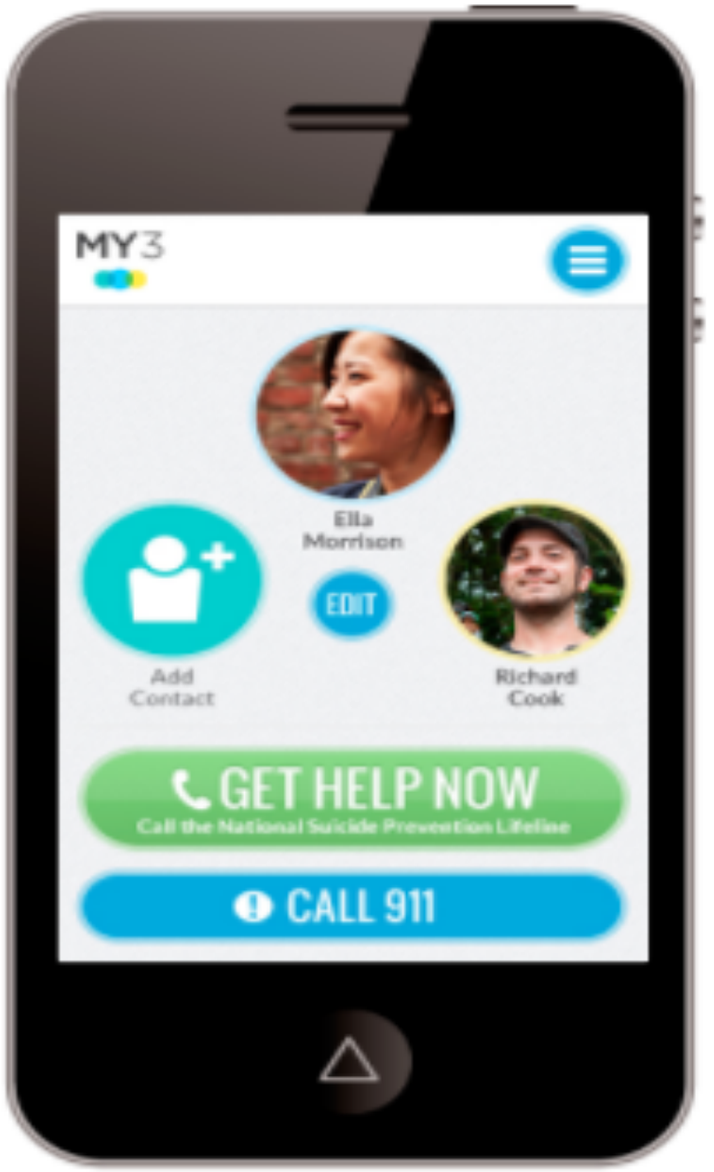
Hold all your resources in the palm of your hand. Whether you're a veteran, want support from your local community, or want to learn more about suicide prevention, pick the resources that best support you.

Get support at times of greatest risk.

When you're having thoughts of suicide and it feels like there's no hope in sight, find support at your fingertips at any time of the day.

Access the National Suicide Prevention Lifeline 24/7.

A trained counselor from a crisis center near you can be reached 24 hours a day, 7 days a week. Anyone can call, whether you're concerned for yourself or someone else. If you need someone to talk to, the National Suicide Prevention Lifeline is always ready for the call.



Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers:
A randomized clinical trial

- Contracting for safety (CFS is widely used for managing acute suicide risk.

- Crisis response planning (CRP is recommended instead of CFS.

- Suicide attempts and ideation were significantly reduced in CRP relative to CFS.

SOURCE: Bryan, C., Mintz, J., Clemans, T., Leeson, B., Burch, T., Williams, S., Maney, E., & Rudd, D., 2017, Journal of Affective Disorders

CRP as Stand-Alone Intervention

Study	Design	Tx	Comparison Condition	Setting	Sample	Follow-Up	Attempt Rates
Bryan et al. (2017 N=97	RCT	Standard CRP & Enhanced CRP	TAU	ED, Outpt MH	Military, 78% male, 26 y	6 months	5% CRP vs. 19% TAU (76% rel. reduction
Miller et al. (2017 N=1376	Quasi	Self-guided Safety Plan + f/u phone calls	TAU	ED	ED patients, 55% male, 56 y	12 months	18% SP vs. 23% TAU (20% rel. reduction

Source: Craig J. Bryan, PsyD, ABPP, 2018

Treatments With Embedded CRP

Study	Design	Tx	# of Sessions	Comparison Condition	Setting	Sample	Follow-Up	Findings
Brown et al. (2005 N=120	RCT	CT-SP	10	TAU	Outpt MH	Attempters, 40% male, 35 y	18 months	24% CT-SP vs. 42% TAU (50% rel. reduction
Rudd et al. (2015 N=152	RCT	Brief CBT	12	TAU	Outpt MH	Military, 87% male, 27 y	24 months	14% BCBT vs. 40% TAU (60% rel. reduction
Gysin-Maillart et al. (2016 N=120	RCT	ASSIP	3	TAU	Outpt MH	Attempters, 45% male, 38 y	24 months	5% ASSIP vs. 27% TAU (80% rel. reduction

Source: Craig J. Bryan, PsyD, ABPP, 2018

Effective Brief Interventions

Suicide specific therapies that are evidence based

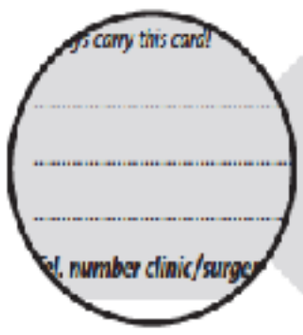
- Suicide specific
- Patient oriented
- All have follow-up
- All have CRP

Elements of ASSIP
(Attempted Suicide Short Intervention Program

a. Exploring the background of a suicidal crisis with a narrative interview and establishing a therapeutic alliance;

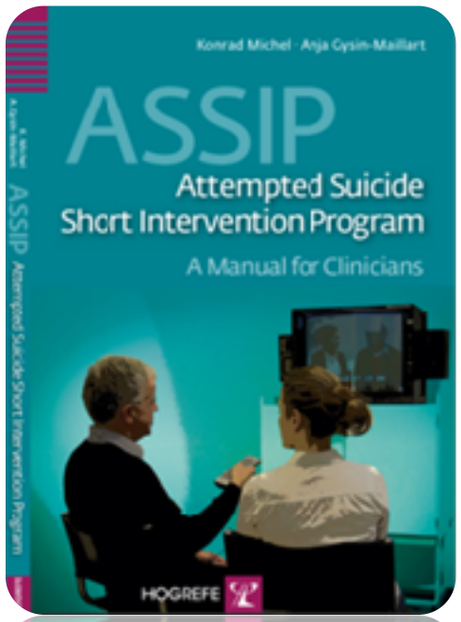
b. Video playback for emotional and cognitive activation of the triggering mental pain condition. Important life issues relevant for a person's vulnerability are identified. Emotional and cognitive activation and restructuring;

c. Improving self-awareness through identification of individual warning signs. Establishing behavioral strategies for future suicidal crises, and reexposure to initial narrative interview.



d. Long-term contact with patients through regular letters, reinforcing the therapeutic alliance, and reminding patients of preventive strategies.

Konrad Michel &
Anja Gysin-Maillart



First Session: Conducting a Narrative Interview

Structure of the First Session

I would like to hear in your own words how you came to the point of harming yourself...

In my experience, there is always a story behind a suicide attempt, and I would like to hear your story...

- Start where you like."
- Allow patients to make pauses in their speech and do not interrupt
- Clarifying questions
- Open questions
- Avoid asking why

A Novel Brief Therapy for Patients Who Attempt Suicide

A 24-months Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP

- The study represents a real-world clinical setting at an outpatient clinic of a university hospital of psychiatry.

- During the 24-month follow-up period, five repeat suicide attempts were recorded in the ASSIP group and 41 attempts in the control group.

- The rates of participants reattempting suicide at least once were 8.3% (n = 5 and 26.7% (n = 16 .

SOURCE: Gysin-Maillart, A., Schwab, S., Soravia, L., Megert, M., & Michel, K., 2016, PLOS Medicine

A Novel Brief Therapy for Patients Who Attempt Suicide

A 24-months Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP

- ASSIP was associated with an approximately 80% reduced risk of participants making at least one repeat suicide attempt ($Wald_X^2{}_1$ = 13.1, 95% CI 12.4-13.7, p<0.001 .

- ASSIP participants spent 72% fewer days in the hospital during follow-up (ASSIP: 29 d; control group: 105 d; W = 94.5, p = 0.038 .

- Higher scores of patient-rated therapeutic alliance in the ASSIP group were associated with a lower rate of repeat suicide attempts.

SOURCE: Gysin-Maillart, A., Schwab, S., Soravia, L., Megert, M., & Michel, K., 2016, PLOS Medicine

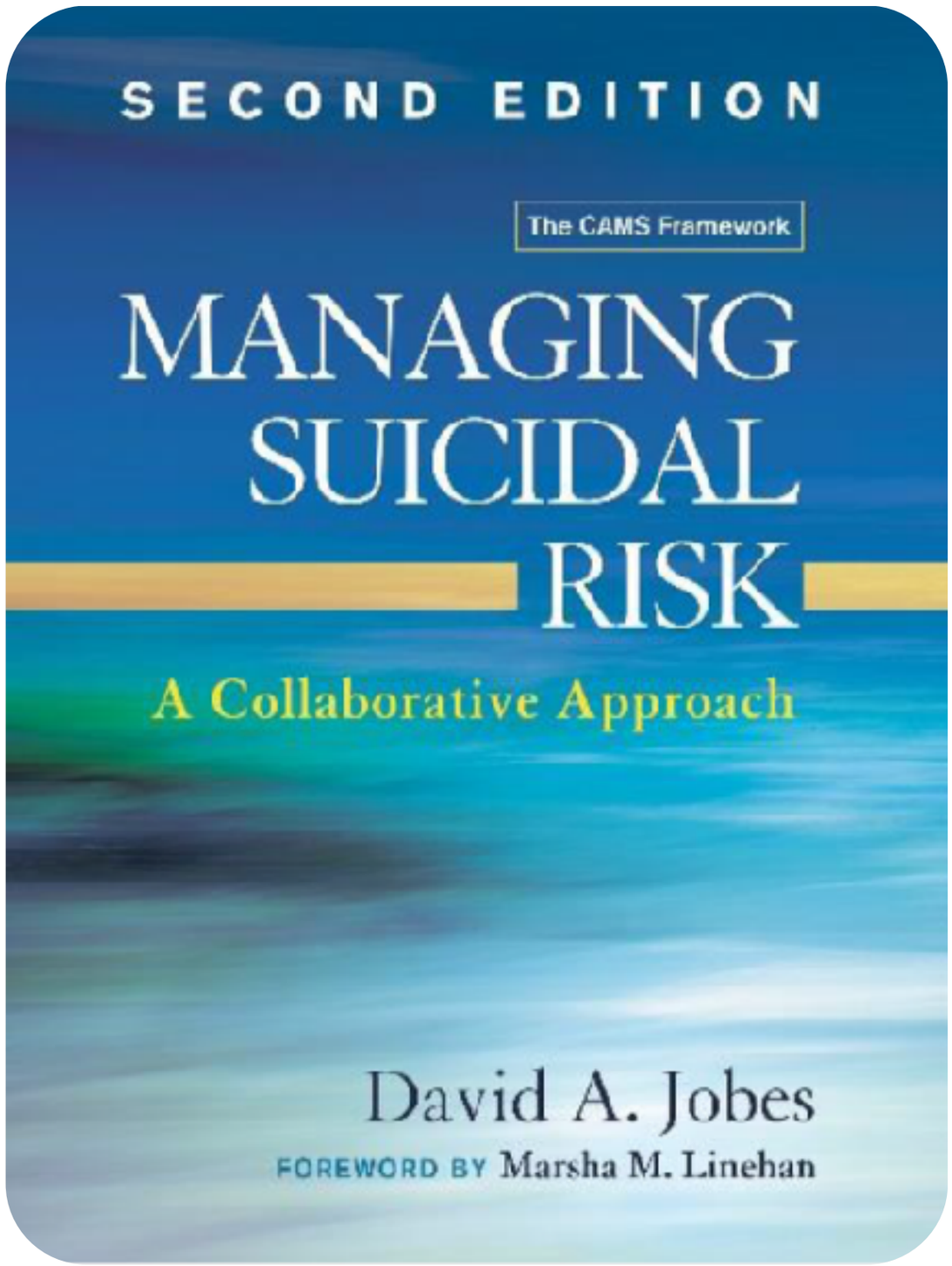
A Novel Brief Therapy for Patients Who Attempt Suicide

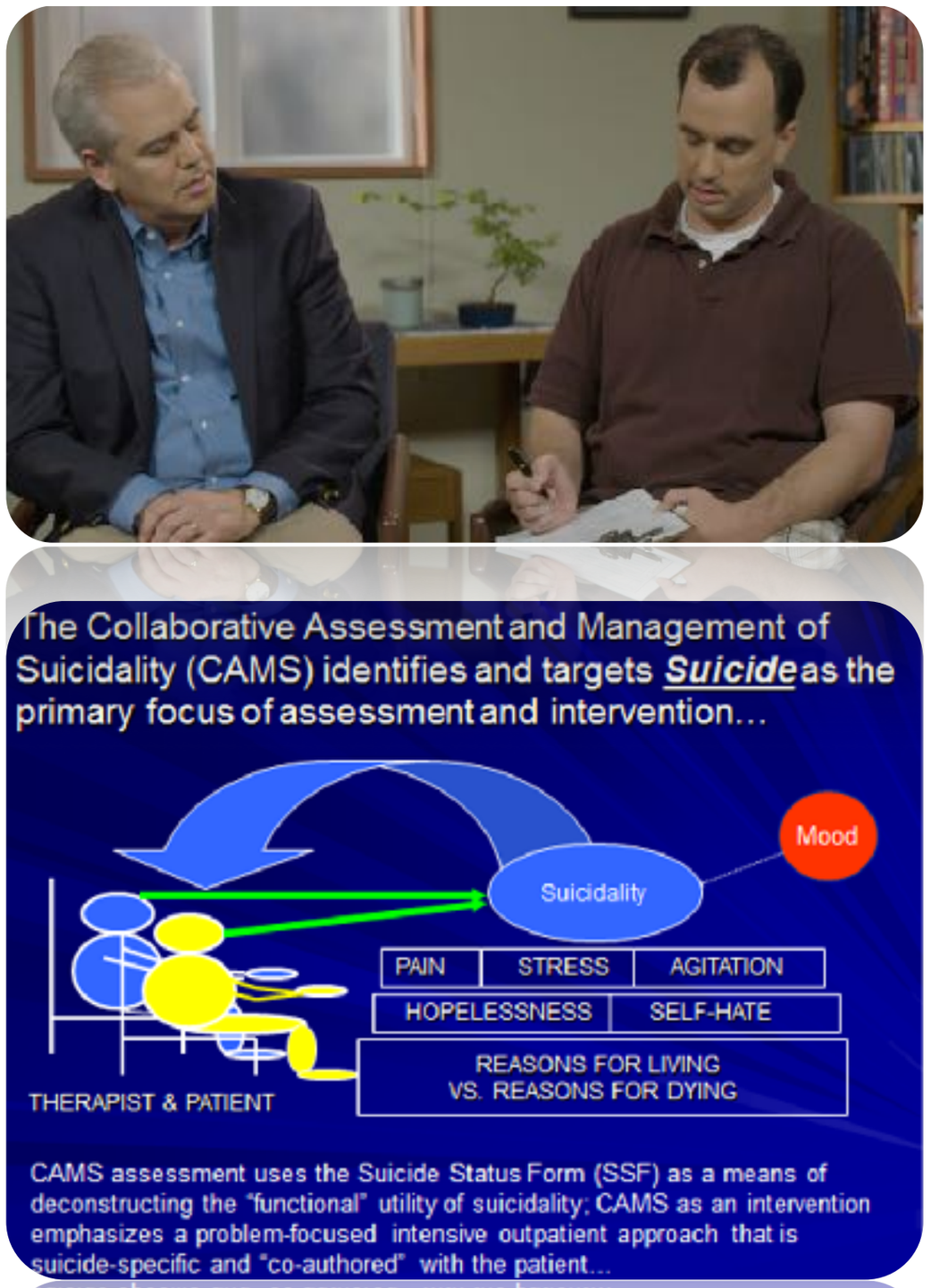
Attempted suicide short intervention program influences coping among patients with a history of attempted suicide

- The ASSIP group showed 11% less dysfunctional coping.
- The ASSIP group showed 6% more problem-focused coping.
- The ASSIP group showed higher scores in self-distraction after 12-months.
- The ASSIP group showed lower scores in self-blame after 24-months.
- Negative association of active coping with suicidal ideation in the ASSIP group.

SOURCE: Gysin-Maillart, A., S., Soravia, Schwab, Journal of Affective Disorders, Volume 264, 2020, Pages 393-399

The Collaborative Assessment and Management of Suicidality (CAMS





SOURCE: Jobes, D., http://cams-care.com/

SSF IV

Suicide Status Form-4 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

What I hate most about myself is:_____

N/A 6. Rate overall Risk of Suicide:

Extremely Low Risk (will **not** kill self): 1 2 3 4 5 : Extremely High Risk (will kill self)

SSF IV

Suicide Status Form-4 Initial Session

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

1. How much is being suicidal related to thoughts and feelings about <u>yourself</u>?
   Not at all: 1 2 3 4 5 : Completely

2. How much is being suicidal related to thoughts and feelings about <u>others</u>?
   Not at all: 1 2 3 4 5 : Completely

The one thing that would help me no longer feel suicidal_____
_____

Section B (*Clinician*):

Y N Suicide ideation — Describe: _____
- Frequency — _____ per day _____ per week _____ per month
- Duration — _____ seconds _____ minutes _____ hours

Y N Suicide plan — When: _____
Where: _____
How: _____ Access to means Y N
How: _____ Access to means Y N

Y N Suicide preparation — Describe: _____

Y N Suicide rehearsal — Describe: _____

Y N History of suicidal behaviors
- Single attempt — Describe: _____
- Multiple attempts — Describe: _____

Y N Impulsivity — Describe: _____

Y N Substance abuse — Describe: _____

Y N Significant loss — Describe: _____

Y N Relationship problems — Describe: _____

Y N Burden to others — Describe: _____

Y N Health/pain problems — Describe: _____

Y N Sleep problems — Describe: _____

Y N Legal/financial issues — Describe: _____

Y N Shame — Describe: _____

CAMS
Assessment & Treatment

CAMS Suicide Status Form—SSF IV (Initial Session)

Fatient: Keith Clinician: DJ Date: Session 1 Time: _____

Section A (*Patient*):

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

Rank

1 — 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: Guilt over firefight/causing my wife pain

5 — 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: Getting over it and everything else in my life

4 — 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: After a fight with my wife

3 — 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: Ever being over what happened there

2 — 5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 2 3 4 (5) High self-hate
What I hate most about myself is: How I make my wife feel

N/A — 6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 (3) (4) 5 Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 completely
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 (3) 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
1	wife	1	my wife
2	family	2	I'm a scumbag
		3	what I did over there

I wish to live to the following extent: Not at all: 0 1 2 3 (4) 5 6 7 8 : very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 (6) 7 8 : very much
The one thing that would help me the most feel suicidal would be: getting rid of the guilt

CAMS Suicide Status Form—SSF IV (Initial Session—page 2)

Section B (*Clinician*):

(Y) N Suicide plan: When: at night, after work, after fight = wife drinking
Where: @ home, sometimes in basement ETOH
How: hand gun "glock" (Y) N Access to means
How: gun in mouth Y N Access to means

(Y) N Suicide Preparation Describe: has a will, no specific prep
(Y) N Suicide Rehearsal Describe: yes, put gun in mouth 10-20 x p fights
(Y) N History of Suicidality
- Ideation Describe: every day
  - Frequency 2 3 per day ____ per week ____ per month
  - Duration ____ seconds ____ minutes 1 hours
- Single Attempt Describe: ø
- Multiple Attempts Describe: ø

(Y) N Current Intent Describe: after fight, when drunk
(Y) N Impulsivity Describe: some history - watch this
(Y) N Substance abuse Describe: ø drugs ø pot, drinks c friends p work
(Y) N Significant loss Describe: fired last work site, lost friends in combat
(Y) N Interpersonal isolation Describe: has some drinking buddies
(Y) N Relationship problems Describe: marriage
(Y) N Burden to others Describe: to wife
Y (N) Health problems Describe:
Y (N) Physical pain Describe: shrapnel in l[illegible] ø pain
Y (N) Legal problems Describe: owes on some credit cards
(Y) N Shame Describe: across his life re: firefight incident

Section C (*Clinician*): **TREATMENT PLAN** (Refer to Sec. A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization* Plan Completed ☑	3 mos
	guilt of what happened in combat	Cope w/ guilt ↓ PTSD sx's	Tx PTSD sx's PE? group?	3 mos
	marital distress	↓ conflict in marriage	Couples' treatment	3 mos

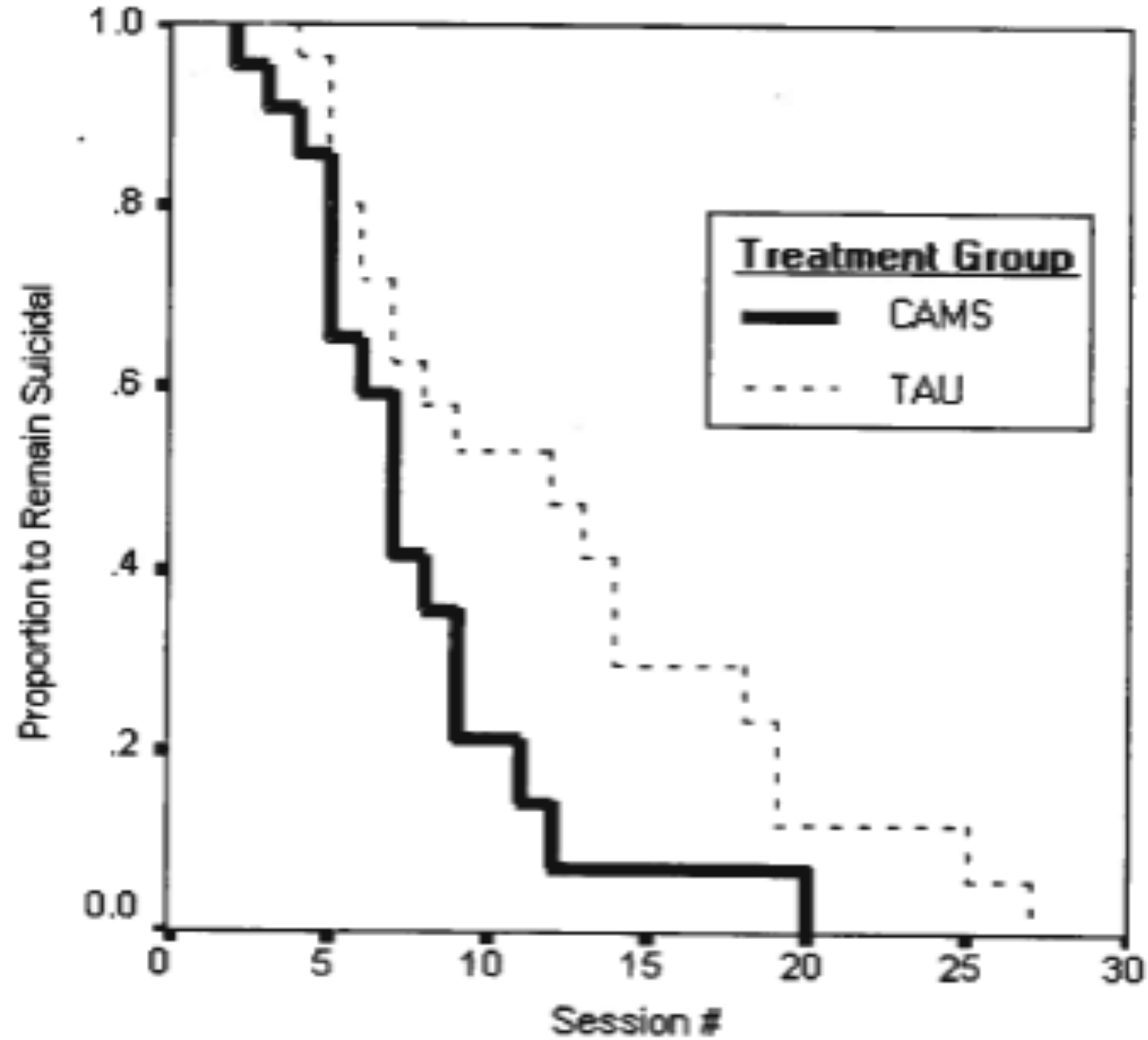
YES ✓ NO ____ Patient understands and concurs with treatment plan?
YES ____ NO ✓ Patient at imminent danger of suicide (hospitalization indicated)?

KJ — Patient Signature — Date — DJ — Clinician Signature — Date

SOURCE: Jobes, D., http://cams-care.com/

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

CAMS patients reached resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients.



SOURCE: Jobes et al., 2003, Wong, 2003

Randomized Controlled Trials of CAMS

Principal Investigator	Setting & Population	Design & Method	Sample Size	Status Update
Comtois (Jobes)	Harborview/Seattle CMH Patients	CAMS vs.VTAU Next Day Appts.	32	★2011 published article
Andreasson (Nordentoft)	Danish Centers CMH patients	DBT vs. CAMS superiority trial	108	★2016 published article
Jobes (Comtois et al)	Ft. Stewart, GA US Army Soldiers	CAMS vs. E-CAU	148	★2017 published article
Ryberg (Fosse)	Norwegian Centers Outpatient/inpatient	CAMS vs. TAU	78	★2019 published article
Pistorello (Jobes)	Univ. Nevada (Reno) College Students	SMART Design CAMS/TAU/DBT	62	★ 2020 published article
Comtois (Jobes)	Harborview/Seattle Suicide attempters	CAMS vs. TAU Post-Hospital D/C	150	ITT Complete; on-going assess
Santel et al	German Crisis Unit Inpatients	CAMS vs. TAU	110	ITT Complete; on-going assess
Depp et al	San Diego VAMC Walk In Veterans	CAMS vs. Outreach Same Day Services	176	RTC preparation on-going

SOURCE: Jobes, D., http://cams-care.com/

The Collaborative Assessment and Management of Suicidality (CAMS

Replicated data across various clinical research studies show the CAMS approach to suicidal risk:

- Quickly reduces suicidal ideation in 6-8 sessions;
- Reduces overall symptom distress, depression, changes suicidal cognitions, and decreases hopelessness;
- Increases hope and improves clinical retention to care;
- Is liked by patients who use it;
- May be optimal for suicidal ideators;
- The best proven treatment for randomized trials
- Decreases Emergency Department (ED visits among certain subgroups;
- Appears to have a promising impact on self-harm behavior and suicide attempts;
- Is relatively easy to learn, and become adherent.

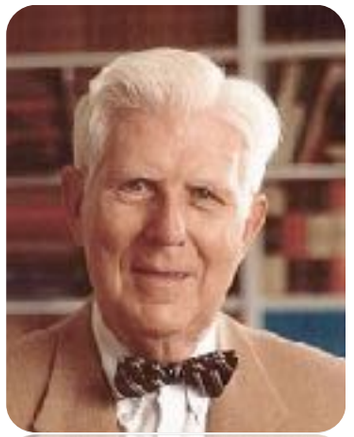
SOURCE: Jobes, D., http://cams-care.com/

Cognitive Behavioral Therapy for Suicide

Stage 1

- Creating a crisis plan
- Teaching the cognitive model
- Creating treatment goals

Gregory Brown



Aaron Beck

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

The CBT Model of the Suicidal Mode

Predispositions

Cognitive
Self-regard
Cognitive flexibility
Problem solving

Behavioral
Prior attempts
Emotion regulation
Interpersonal skills

Emotional
Psychiatric disorder
Emotional lability
HPA axis

Physical
Genetics
Medical conditions
Demographics

Trigger
Relationship problem
Financial stress
Perceived loss
Physical sensation
Negative memories

Acute

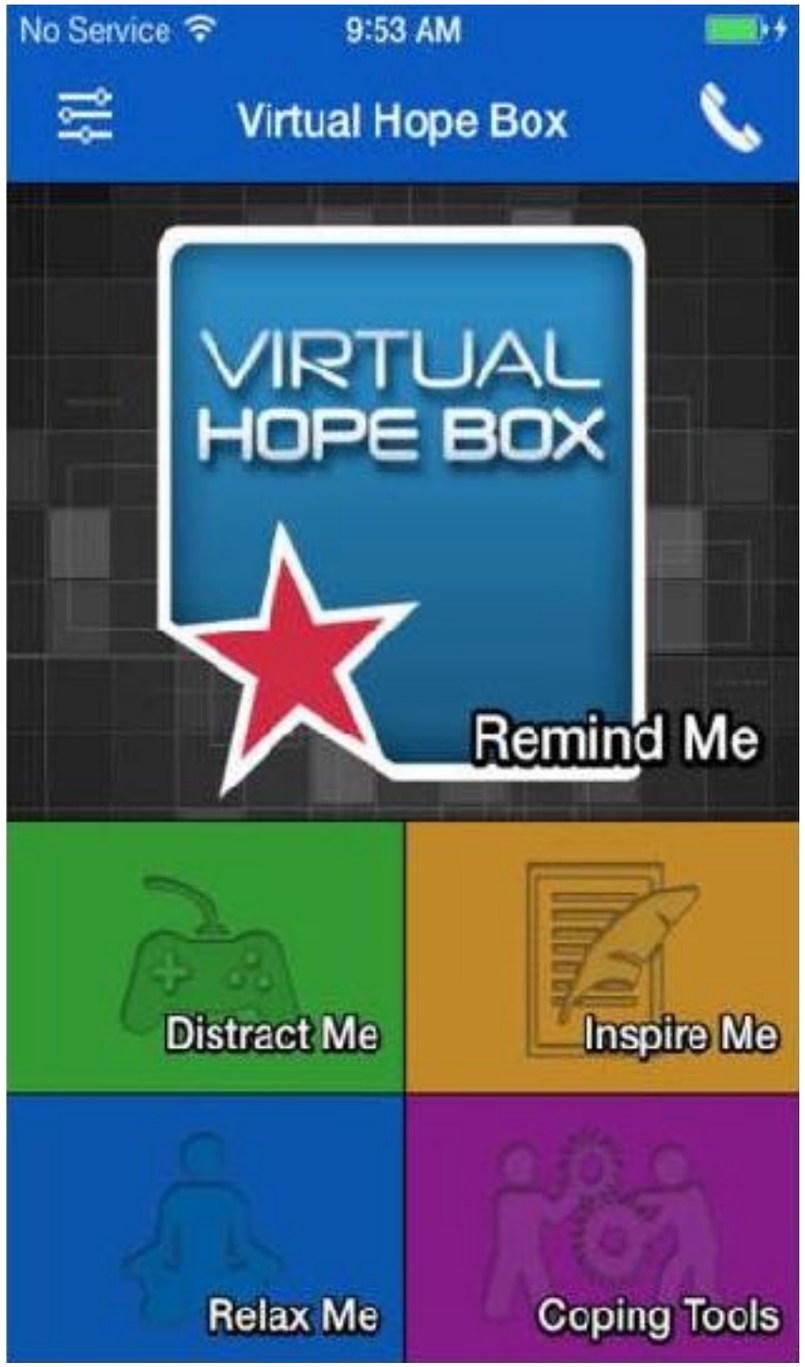
Cognitive
This is hopeless”
I’m trapped”
I’m a burden”

Behavioral
Substance use
Social withdrawal
Preparations

Emotional
Depression
Guilt
Anger

Physical
Agitation
Insomnia
Pain

Virtual Hope Box App



Study Design/Methodology

Treatment As Usual (TAU	Crisis Response Plan (CRP	Crisis Response Plan + Reasons for Living (CRP+RFL
Suicide risk assessment	Suicide risk assessment	Suicide risk assessment
Supportive listening	Supportive listening	Supportive listening
	Identify warning signs	Identify warning signs
	Identify self-mgt skills	Identify self-mgt skills
		Identify reasons for living
	Identify social support	Identify social support
Crisis mgt education	Crisis mgt education	Crisis mgt education
Referrals to treatment & community resources	Referrals to treatment & community resources	Referrals to treatment & community resources

SOURCE: Bryan, C., National Center for Veterans Studies, http://veterans.utah.edu/

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

Additional Treatment Approaches

Dialectical Behavior Therapy (DBT

Dialectics:

- Helping clients find balance in emotions, thoughts, behavior and choices. Teaching them and showing them how to live in balance.

Marsha Linehan

Validation:

- Acknowledging another person's reality, noting that their thoughts feelings responses are real and valid in their own right.

Dialectical Behavior Therapy (DBT

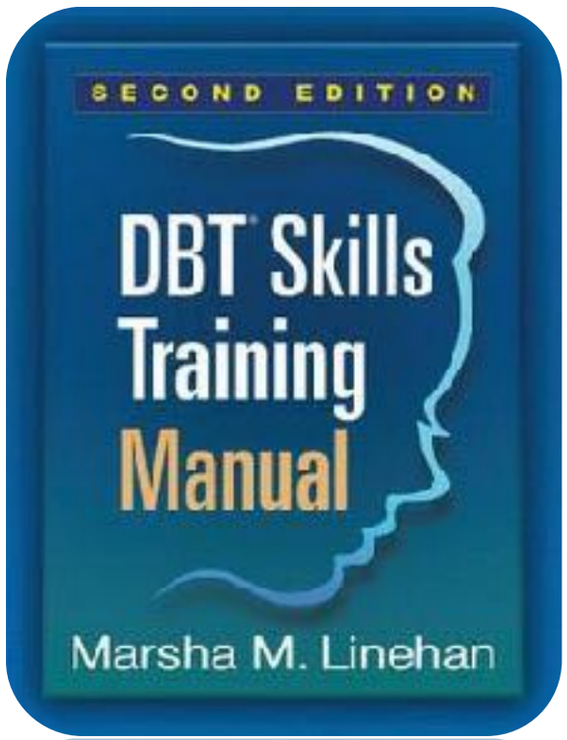
Components of DBT

- Individual Treatment
- Group Skills Training
- Skills Coaching
- Consultation Team

DBT: Weekly Group Meetings

Concentrate on Behavioral Skills in 4 areas:

1) Interpersonal effectiveness skills
2) Distress tolerance skills
3) Emotion-regulation skills
4) Mindfulness skills



DBT appears to be uniquely effective in reducing suicide attempts.

Conclusions and Relevance:

A variety of DBT interventions with therapists trained in the DBT suicide risk assessment and management protocol are effective for reducing suicide attempts and NSSI episodes. Interventions that include DBT skills training are more effective than DBT without skills training, and standard DBT may be superior in some areas.*

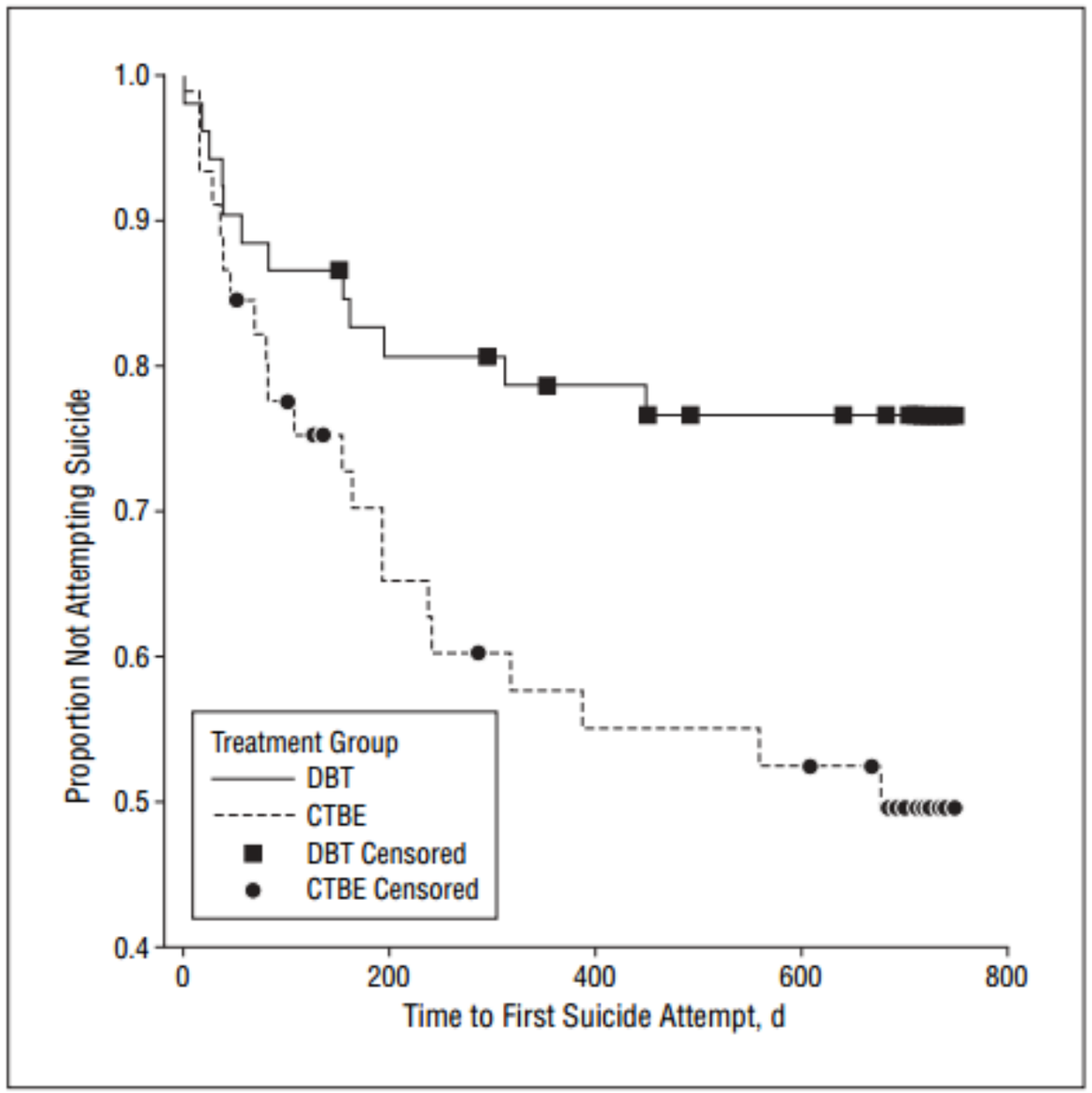
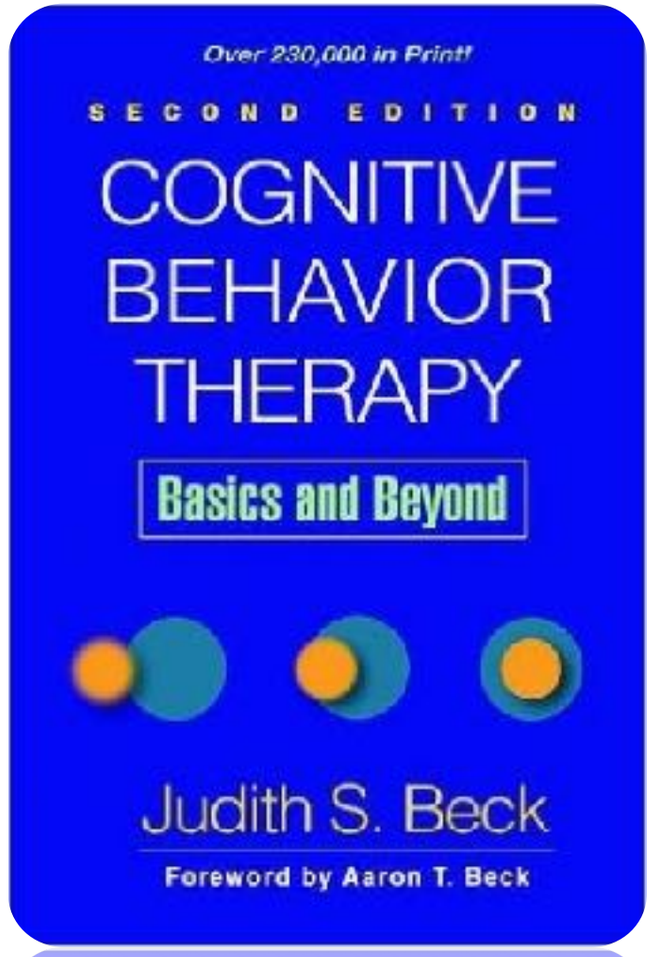


Figure 3. Survival analysis for time to first suicide attempt. The treatment period ended at 365 days, and the follow-up period ended at 730 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

SOURCE: Linehan, M., et al., 2007, Archives General Psychiatry, *=SOURCE: Linehan, M., Korslund, K., Harned, M., Gallop, R., Lungu, A., Neacsiu, A., McDavid, J., Comtois, A., Murray-Gregory, A., American Medical Association, 2015

Cognitive Therapy: Basics and Beyond

It is vital to be alert to both verbal and nonverbal cues from the patient, so as to be able to elicit **hot cognitions**" - that is, important automatic thoughts and images that arise in the therapy session itself and are associated with a change or increase in emotion. Eliciting the hot cognitions are important because they often have critical importance in conceptualization."



SOURCE: Beck, J., Guilford Press, 2011

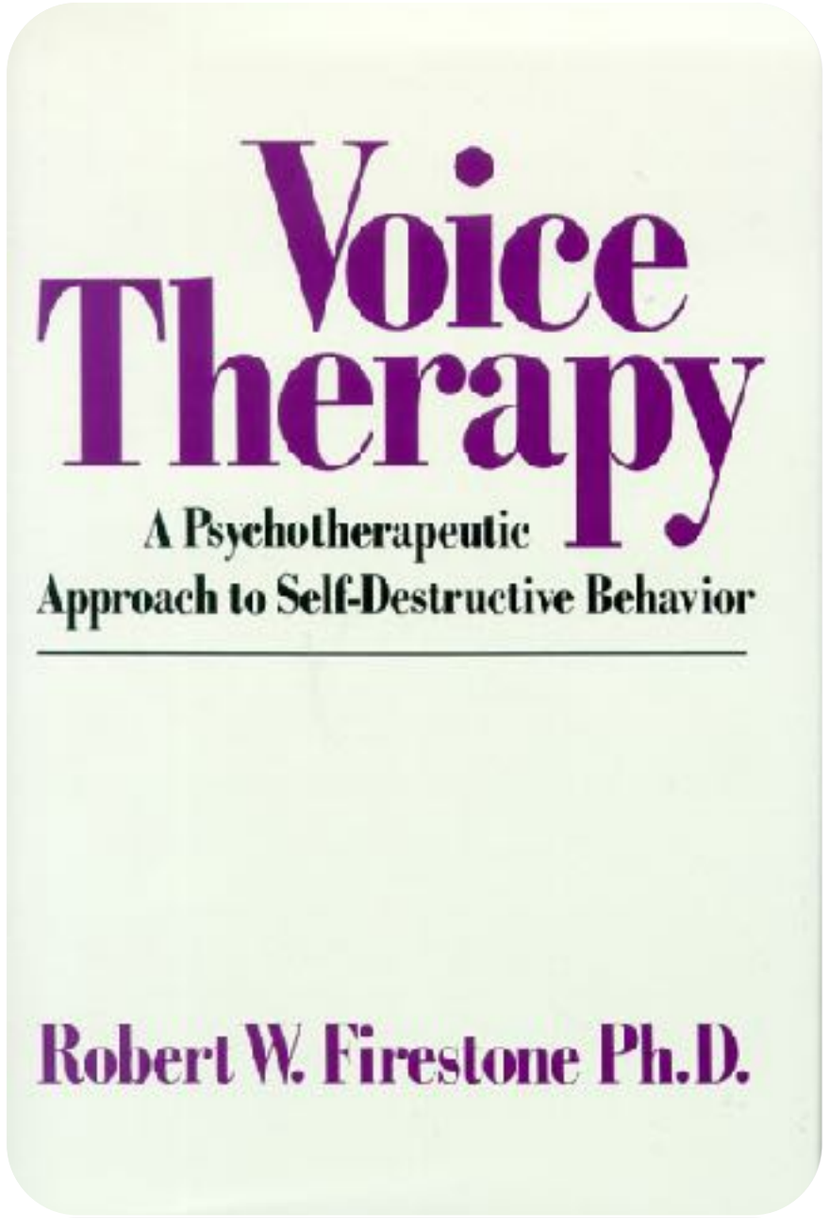
Emotion Focused Therapy (EFT

- Emotion-focused therapy (EFT , focuses primarily on **eliciting emotion by directing the client to amplify his or her self-critical statements**.
- For example, if the client says you're worthless" or sneers while criticizing, direct the client to do this again...," do this some more..."; put some words to this..." This operation will **intensify the client's affective arousal and help access core criticisms**.

SOURCE: Facilitating Emotional Change: The Moment-by-Moment Process" by L. Greenberg, Rice, and Elliot. 1993

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.

The Therapeutic Process in Voice Therapy

Step 2

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 3

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.

The Therapeutic Process in Voice Therapy

Step 4

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

The Therapeutic Process in Voice Therapy

Step 5

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.

The Self vs the Anti-Self

Self

Anti-Self

Self-Compassion
A Healthier Way of Relating to Yourself

Kristen Neff

From Kristin Neff:

Self-compassion is not based on self-evaluation. It is not a way of judging ourselves positively; it is a way of relating to ourselves kindly.

Being touched by and not avoiding your suffering”

SOURCE: http://www.self-compassion.org/

Self-Compassion

Three Elements:

1. Self-kindness vs. Self-judgment
2. Mindfulness vs. Over-identification with thoughts
3. Common humanity vs. Isolation



SOURCE: http://www.self-compassion.org/

Interpersonal Neurobiology

Curious
Open
Accepting
Loving

Daniel Siegel, M.D.

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.

SOURCE: Counseling for Suicide: Client Perspective. Paulson & Worth, 2002

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.

SOURCE: Counseling for Suicide: Client Perspective. Paulson & Worth, 2002

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.

SOURCE: Counseling for Suicide: Client Perspective. Paulson & Worth, 2002

Common Emotions Experienced in Suicide 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

Resources

Useful Resources

National Action Alliance for Suicide Prevention
www.actionallianceforsuicideprevention.org/

American Association of Suicidology
www.suicidology.org/

AFSP American Foundation for Suicide Prevention
www.afsp.org/

IASP Suicide Survivor Organizations (listed by country
www.iasp.info/resources/Postvention/National_Suicide_Survivor_Organizations/

Suicide Prevention Resource Center
www.sprc.org

ZERO Suicide in Health and Behavioral Health Care

Suicide Treatment During Covid-19

Useful Links:

- Managing Suicidal Clients During the COVID-19 Pandemic
- Protocol for Using the CAMS Framework™ within Telepsychology

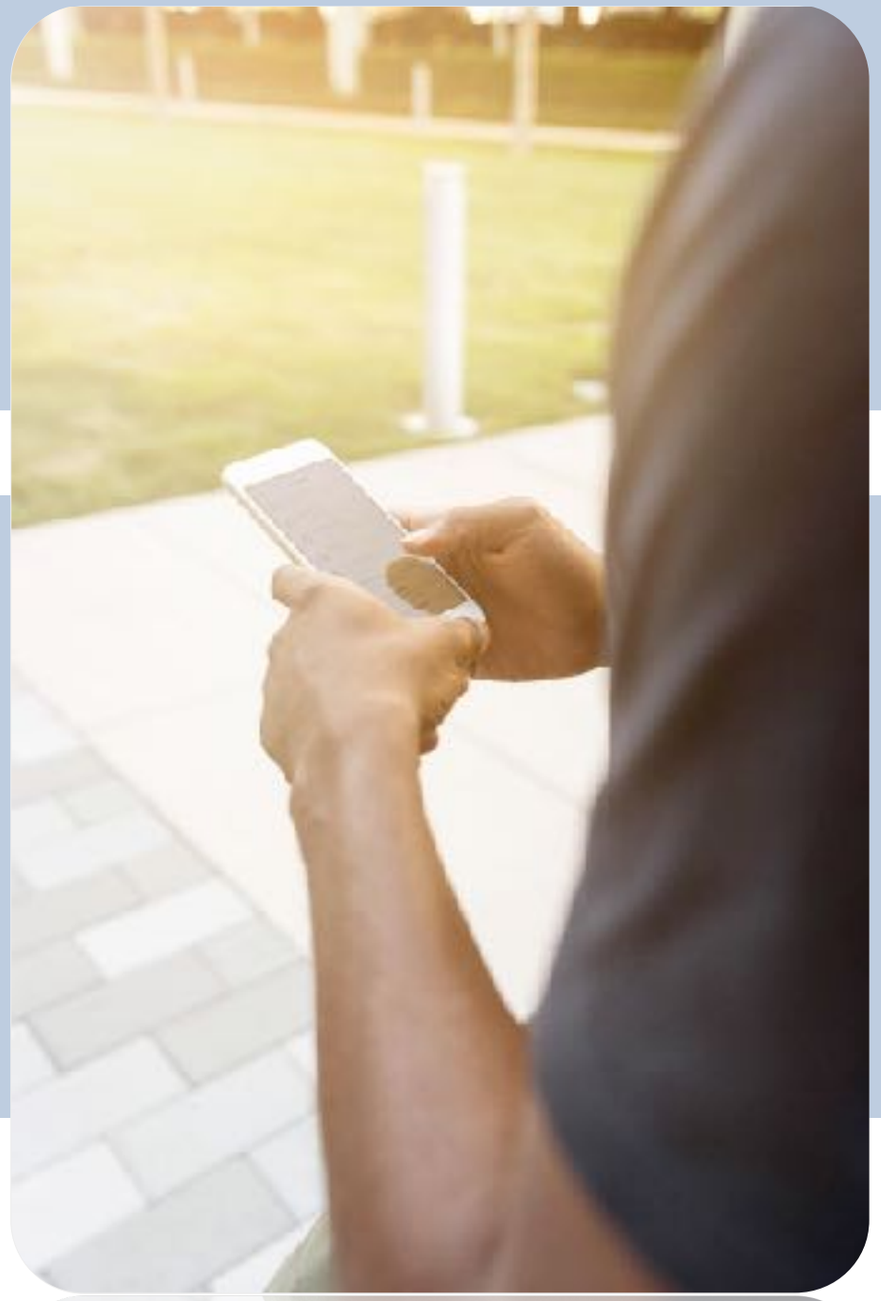
Useful Resources

National Suicide Prevention Lifeline

(Call or Chat online

www.suicidepreventionlifeline.org

1-800-273-TALK (8255



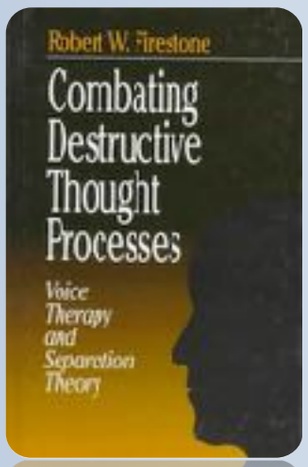
Crisis Text Line

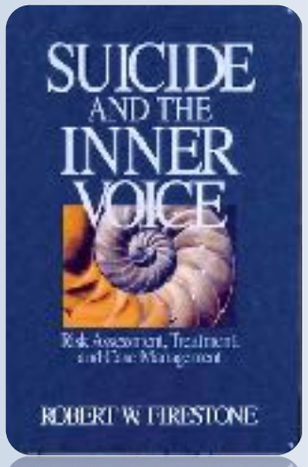
www.crisistextline.org

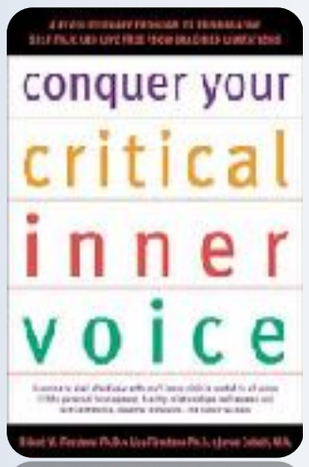
Text CONNECT to 741741

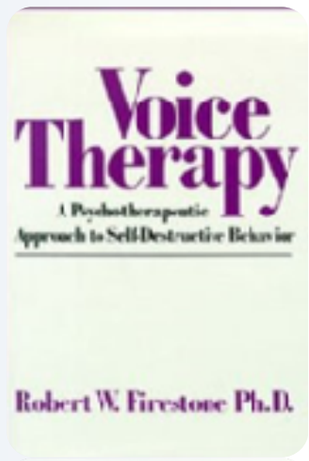
Resources

Books









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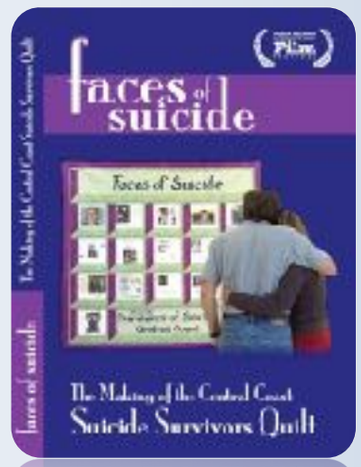

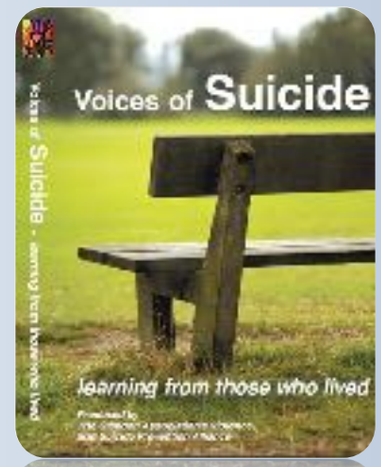

Webinars

Live, archived, free, and CE Webinars can be watched at PsychAlive.org

Visit www.**PsychAlive.org**
for these resources and more

eCourse

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Effective Risk Assessment and Intervention

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THANK YOU!

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