DBT Informed Suicide Assessment, Management, and Intervention

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Welcome

Thanks for sharing your time with me!

My name is Sam and I love DBT!

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Objectives

1. You will be able to describe and demonstrate how DBT theory can inform your thought process, approach, and plan of action when a client reports suicidality.
2. You will understand and differentiate long-term and acute suicide risk factors.
3. You will be able to identify, use, and apply suicide assessment tools.
4. You will learn how to apply methods for suicide risk management.
5. You will learn how to apply intervention strategies and compose a targeted treatment.

Delineates an activity or demonstration is coming

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Gentle Reminder

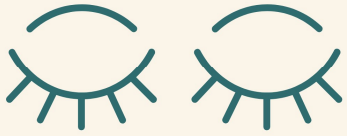
We're covering a difficult topic today. Please remember to take care of yourself if you begin to feel activated.

Skill development & application

Initial Reflection

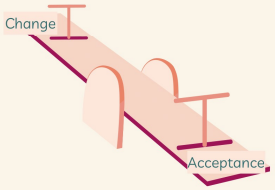
Skill development & application

Join me in a mindful reflection

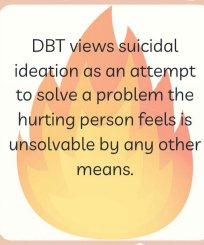


Quick Note on Dialectics

DBT Dialectics - the synthesis between two opposing forces



Suicide as Problem Solving



DBT views suicidal ideation as an attempt to solve a problem the hurting person feels is unsolvable by any other means.

- Is suicidal behavior actually the problem?
- Is suicidal behavior part of the problem?
- Should you validate this?

Pair & Share

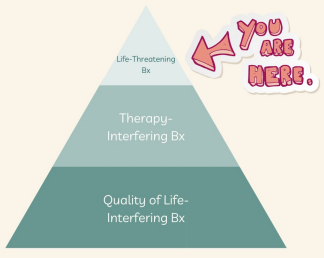
Skill development & application

- Paired break out rooms
- Pretend your partner is a client who just disclosed they are feeling suicidal
- Practice validating your partner - no problem solving!
- 3 minutes

How would you validate your client who reports feeling suicidal?

What would it look like?
What would it sound like?

Treatment Target Hierarchy



DBT Assumptions*

1) People are doing the best they can
2) People want to improve
3) People need to do better, try harder, and be more motivated to change
4) People may not have caused all of their own problems, but they have to solve them anyway
5) The lives of people who are suicidal are unbearable as they are currently being lived
6) People must learn new behaviors both in all relevant contexts
8) Therapists treating borderline people need support

*Relevant to this particular training

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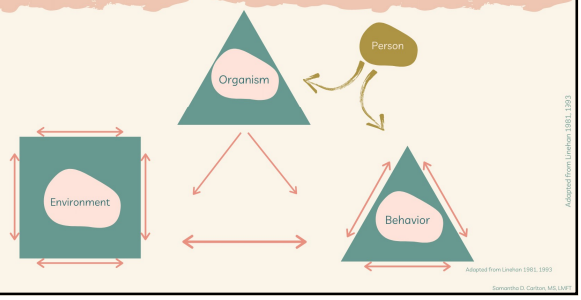
Long-Term Suicide Risk



Adapted from Linehan 1981, 1993

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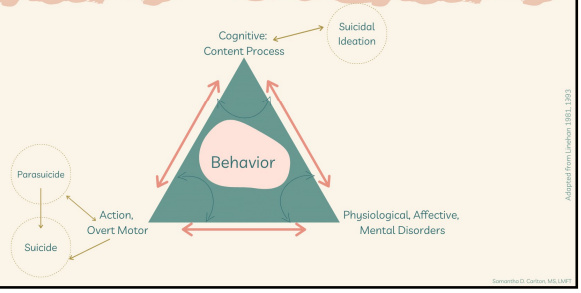
Behavior



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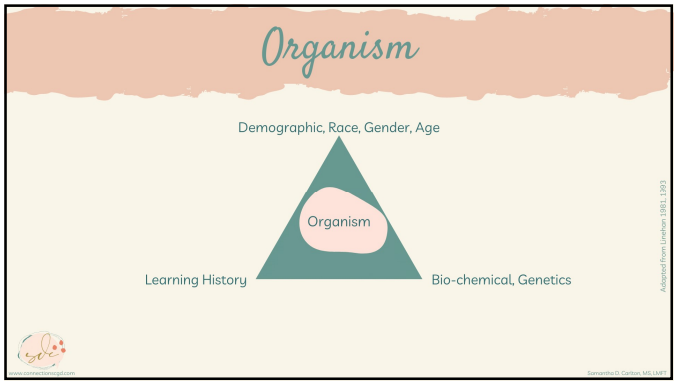
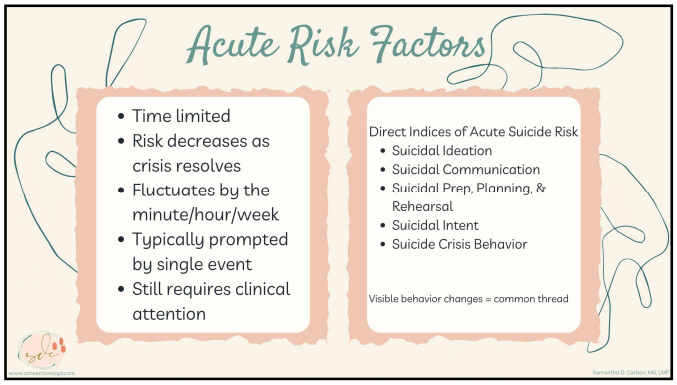
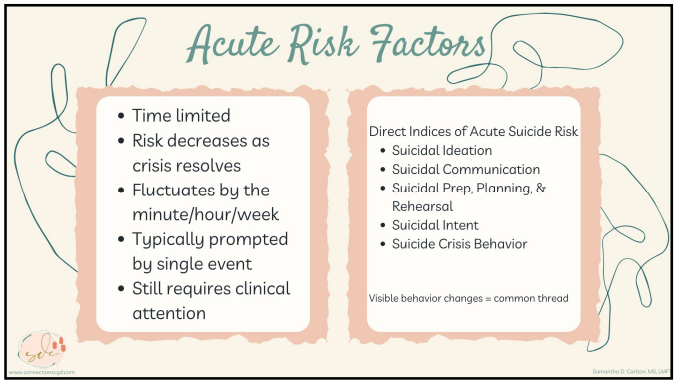

Organism
Demographic, Race, Gender, Age
Organism
Learning History
Bio-chemical, Genetics
Adapted from Linehan (1981, 1993)


Acute Risk Factors
• Time limited
• Risk decreases as crisis resolves
• Fluctuates by the minute/hour/week
• Typically prompted by single event
• Still requires clinical attention
Direct Indices of Acute Suicide Risk
• Suicidal Ideation
• Suicidal Communication
• Suicidal Prep, Planning, & Rehearsal
• Suicidal Intent
• Suicide Crisis Behavior
Visible behavior changes = common thread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Skill development & application

Mindfulness Activity

Suicidal Ideation

Passive
- Thoughts about wanting to be dead
- *"I wonder what it'd be like if I didn't wake up in the morning."*

Active
- Thoughts about dying by suicide
- *"I want to die. I could probably use the gun my grandpa gave me."*

Suicidal Communication

Direct
- *"I want to kill myself."*

Indirect
- *"I won't be around for much longer."*

Suicidal Planning, Preparation, and/or Rehearsal

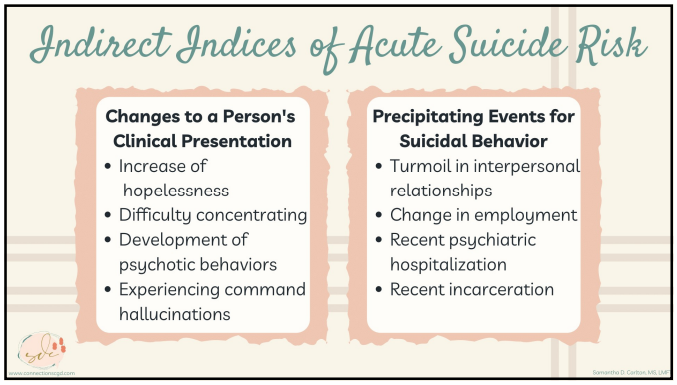
- Specific time and/or method
- Acquiring means
- Writing suicide note(s)
- Rehearsal

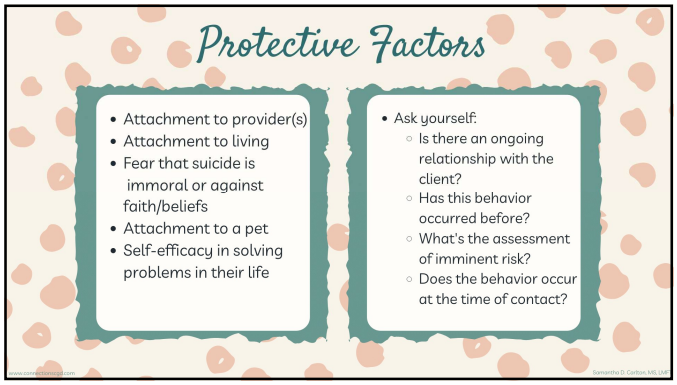
Suicidal Intent

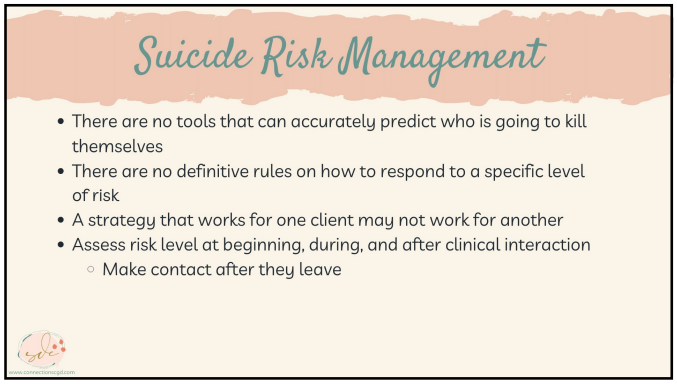
- Belief that the person is going to kill or hurt themselves
- The person has the will to do so

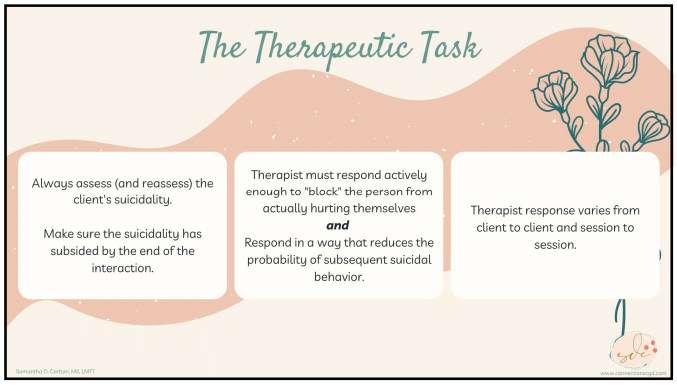
Suicide Crisis Behavior

- Client acts in a way that activates concern from the environment and there is an imminent risk of suicide
  - Involves others
  - Telling people "goodbye", posting on social media


Indirect Indices of Acute Suicide Risk
Changes to a Person's Clinical Presentation
• Increase of hopelessness
• Difficulty concentrating
• Development of psychotic behaviors
• Experiencing command hallucinations
Precipitating Events for Suicidal Behavior
• Turmoil in interpersonal relationships
• Change in employment
• Recent psychiatric hospitalization
• Recent incarceration


Protective Factors
• Attachment to provider(s)
• Attachment to living
• Fear that suicide is immoral or against faith/beliefs
• Attachment to a pet
• Self-efficacy in solving problems in their life
• Ask yourself:
◦ Is there an ongoing relationship with the client?
◦ Has this behavior occurred before?
◦ What's the assessment of imminent risk?
◦ Does the behavior occur at the time of contact?


Suicide Risk Management
• There are no tools that can accurately predict who is going to kill themselves
• There are no definitive rules on how to respond to a specific level of risk
• A strategy that works for one client may not work for another
• Assess risk level at beginning, during, and after clinical interaction
◦ Make contact after they leave


The Therapeutic Task
Always assess (and reassess) the client's suicidality.
Make sure the suicidality has subsided by the end of the interaction.
Therapist must respond actively enough to "block" the person from actually hurting themselves
and
Respond in a way that reduces the probability of subsequent suicidal behavior.
Therapist response varies from client to client and session to session.
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DBT Guidelines for Treating Suicidal Behaviors
Be flexible in considering response options
Be more active when risk is high
Base non-conservative response on the failure of conservative responses
Be honest about your reasons for your responses
Talk about suicide openly and in a matter-of-fact manner
Avoid pejorative explanations
Present suicidal behavior as a response to a problem
Maintain the stance that suicide is a maladaptive and/or ineffective solution
Involve significant others: other therapists, friends, family members, emergency contact
Schedule sessions frequently enough, with additional sessions as needed
Stay aware of the multitude of variables impinging on clients
Avoid omnipotent taking or accepting of responsibility for client's suicidal behaviors
Maintain consultation with team/colleagues
Maintain occasional, non-demanding contact with clients who reject/drop out of therapy
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NSSI Injury Protocol
Assess for medical necessity after event
Recommend the client receive medical care
Instruct them on obtaining a medical evaluation
24 hour rule
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Hospitalization

- No strong data to support hospitalization will prevent suicide
- Suicidal clients should be treated in the least restrictive environment
- Can outpatient treatment meet client's needs?
- Does the client have access to lethal means?
- Is the client likely to follow through with a plan?
- Are there people in the client's environment aware of the suicidal crisis?
- Are those aware able to engage the client?
- How has the client responded to previous hospitalization(s)?

Hospitalization Protocol

Initiate When:

- Client is in psychotic state and making credible threats
- Suicide risk outweighs inappropriate hospitalization
- Operant suicide threats escalating, plus hospitalization is aversive
- Serious strain in therapeutic relationship creates suicide risk or crisis; outside consultation seems necessary
- Monitor meds when close monitoring is necessary and history of abuse or overdose present
- Therapist needs a break from the client

Consider When:

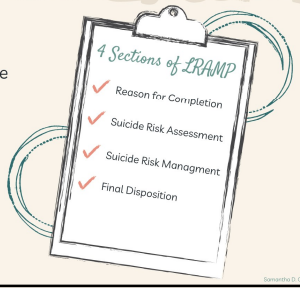
- Treatment plan is to conduct exposure of post-traumatic stress
- Non-response to therapy plus severe depression or disabling anxiety
- Overwhelming crisis plus no other safe environment
- Overwhelming, emergent psychosis plus no social support

When NOT to Consider Hospitalization

- Person is not at a high acute risk
- Hospitalization would violate an already agreed plan
- Other environmental supports are available
- Persons can easily contact provider if conditions worsen
- Person previously hospitalized, benefit not apparent
- There is no bed available
- Person refused and does not meet criteria for involuntary commitment
- Hospitalization interferes with client's therapy commitment goals

Linehan Risk Assessment Management Protocol

- Known as LRAMP
- Targets suicidality directly
- Identify the patterns of risks to the client
- Examine the risk factors
- Examine the protective factors



LRAMP - Section 1: Reason for Completion

- (1) Reason for completing LRAMP
  - SI history reported at intake
  - New or first report of SI
  - Increased SI or urges
  - Suicide communication
  - Suicide attempt/NSSI since last contact
  - Attempt occurred ongoing during contact
- (2) Describe the specific incident or behavior that occurred

LRAMP – Section 2: Suicide Risk Assessment

- (3) Structured formal assessment of current suicide risk
  - Formal assessment used
    - What measure was used?
    - Columbia (C-SSRS)
    - Collaborative Assessment & Management of Suicidality (CAMS)
  - Formal assessment not used
    - Only baseline behaviors (typical for client)
    - No/negligible suicide/self-injury intent by time of contact
    - No/negligible suicide/self-injury intent by contact end
    - Self-injury was not suicidal and superficial/minor
    - Suicide communication was escape behavior
    - Suicide communication was operant behavior
    - Client in ongoing therapy and will see primary therapist soon

LRAMP – Section 3: Suicide Risk Management

- (6) Treatment actions aimed at suicidal/self-injurious behaviors
  - (A) Not explicitly targeted
    - Why was it not targeted? Explain.
    - Outline the steps in your note
  - (B) Behavioral analysis
    - Is there a change in the behavior?
  - (C) Chain of events
    - Missing links
    - Problem behavior
  - (D) Crisis intervention and problem solving
    - What skills were previously helpful?
    - What skills did they use?
    - Review their goals
    - "I hope to see you next week"

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    - What skills did they use?
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    - "I hope to see you next week"

LRAMP - Section 3: Suicide Risk Management

- (6) Treatment actions aimed at suicidal/self-injurious behaviors
  - (E) Crisis plan
    - Add more detail to existing plan or create new one
  - (F) Plan of action
    - Agree to stay alive for 1 year
    - Note the commitment in case notes
  - (G) Troubleshoot
    - What might get in the way?
  - (H) Anticipated recurrence of crisis response
    - Add new skills/crisis plan
  - (I) Social support
    - Reach out to loved ones
    - Check in with client
  - (J) Referred
  - (K) Hospitalization
    - Document why you made your choice
  - (L) Other

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LRAMP - Section 4: Final Disposition

- (7) I believe, based on information currently available to me:
  - (A) Client is not imminently dangerous
    - "I believe, based on the factors thus far, client is not imminently dangerous and therefore hospitalization was not recommended."
    - Document reasons justifying your clinical judgment
  - (B) Some imminent danger
  - (C) Imminent danger
    - Did you notify the proper authorities? Document.
  - (D) Uncertainty exists
    - You should consult a colleague or supervisor
- (8) Client will be re-evaluated for suicide risk no later than:
  - Note the time, be specific and state why

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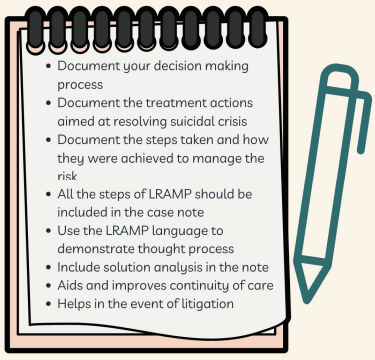
Documentation



- Document your decision making process
- Document the treatment actions aimed at resolving suicidal crisis
- Document the steps taken and how they were achieved to manage the risk
- All the steps of LRAMP should be included in the case note
- Use the LRAMP language to demonstrate thought process
- Include solution analysis in the note
- Aids and improves continuity of care
- Helps in the event of litigation

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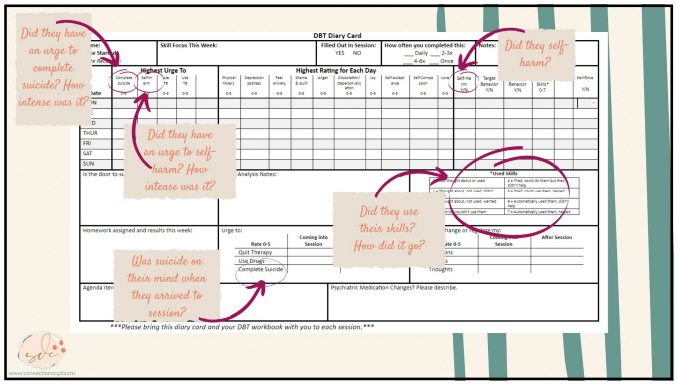
Monitoring Suicidal Behavior

- Use diary card
- ASK!
- Notice red flags
  - Self-injury
  - Suicidal thoughts
  - Suicidal communication
  - Suicidal actions

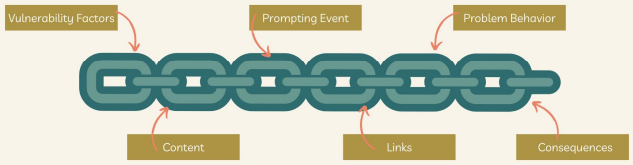
Trying to be honest with my therapist but not so honest that I get involuntarily hospitalized



Suicidal Behavior Protocol

- Validate client's pain
  - Respond to their emotion
  - Convey warmth and understanding
- Typography
  - Assess frequency, intensity, severity, incidence, magnitude
  - Location, time, date, etc.
- Reinforce non-suicidal responses
  - Look for these during disclosure
- Chain analysis
  - What set off the behavior?
  - What lead up to the behavior?
  - What is maintaining the behavior?

Chain Analysis

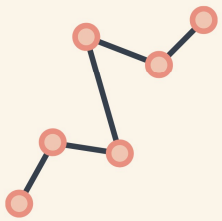


Suicidal Behavior Protocol

- Determine if the behavior is a respondent activated by a cue that precedes the behavior or operant
- Do complete and comprehensive behavioral analysis
  - Group previous chains to understand conditions under which the behavior is elicited and consequences that follow the suicidal behavior
- Determine the best place to intervene
  - Are we going to problem solve?
  - Are we looking for alternative solutions?
  - Look for certain links to insert skills
- Discuss negative effects of suicide
  - What could happen? What could go wrong?
  - What will your family think? What will they do?

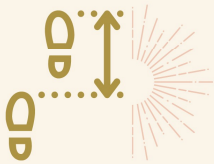
Suicidal Behavior Protocol

- Discuss alternative solutions vs. tolerance
- Get commitment to non-suicidal behavior plan
  - How will they proceed in the future?
  - Troubleshoot the plan
- Connect with current behavior to the overall pattern
  - What's the habit?
  - Connect the dots



Steps for the Therapist

- Assess frequency, intensity, and severity of the behavior
- Conduct a chain analysis of the behavior
- Discuss alternative solutions versus tolerance
- Maintain focus on negative effects of suicidal behavior
- Reinforce non-suicidal behavior
- Validate the client's pain
- Get commitment to non-suicidal behavior plan
- Connect current behavior to overall pattern



Guidelines for Referring Out

- Refer to a colleague when:
  - You're out of your scope of competence
  - You don't like the client and cannot currently change your feelings towards them
  - You're burned out from lack of progress with client
  - You prefer to avoid the client
- Have trusted referral sources and know how to make them
  - What's their experience with suicidal clients?

You Need Support

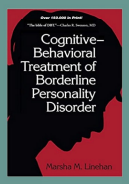
References

Linehan, M.M., Comtois, K.A., & Ward-Ciesielski, E.F. (2012). Assessing and managing risk with suicidal individuals. *Cognitive and Behavioral Practice, 19*, 218-232.

Linehan, M. M. & Nielsen, S. L. (1981). Assessment of suicide ideation and parasuicide: Hopelessness and social desirability. *Journal of Consulting and Clinical Psychology, 49*(5), 773–775

Ward-Ciesielski, E.F., & Linehan, M.M. (2014). Psychological treatment of suicidal behaviors. In M.K. Nock (Ed.), *The oxford handbook of suicide and self-injury* (pp.366-384). Oxford University Press.

+ My personal notes from attending numerous DBT trainings.



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