Preventing Suicide:

Using CBT to Help Suicidal Patients Choose to Live

Part II: Risk management, safety planning, and specific techniques.

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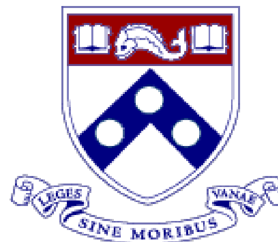


Financial Disclosures

I still receive residual royalties from New Harbinger Publications for the book *Choosing to Live: How to Defeat Suicide Through Cognitive Therapy* (co-authored with Thomas Ellis).

There are no other financial disclosures relevant to this presentation.

Outpatient Management of Patients with Elevated Suicide Risk (1)

- Increase the frequency of appointments.
- *Schedule* phone contacts. (Much better than answering spontaneous crisis calls.)
- Regularly assess for suicide risk.
- If possible, arrange to have 24-hour back-up coverage, and tell the patients who this on-call therapist or organization will be.
- Seek an outside consultation if necessary.

Outpatient Management of Patients with Elevated Suicide Risk (2)

- Coordinate care with other professionals who may be on the case.
- Re-evaluate the treatment plan in light of the emergency. Discuss with the patient.
- Assess the need for hospitalization.
- **Do not be passive if the patient fails to show up for a therapy appointment.**

More on Risk Management (1)

- Be clear about the limits of confidentiality.
- Utilize assessment inventories (such as the Beck Inventories) in order to obtain objective data.
- Critically evaluate the diagnosis in light of ongoing clinical findings.
- Be aware of adjunctive facilities and resources (e.g., crisis intervention center).
- **Do not decline to provide treatment in the middle of a crisis, even if the patient has broken a therapeutic agreement.**

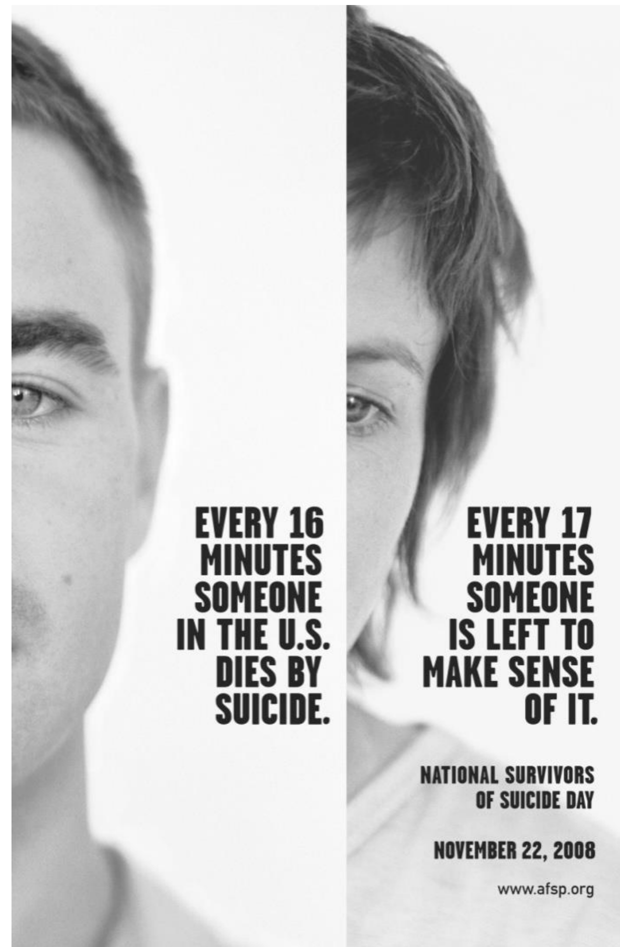
More on Risk Management (2)

- Document thoroughly, and include your clinical rationales for your decisions (e.g., your risk-benefit analysis for your interventions).
- When possible, try to obtain a copy of the patient’s prior records.

More on Risk Management (3)

- Whenever possible, gain the patient's permission to have contact with family members.
- Establish good rapport with the patient's family members.

Loved ones who are left behind are also "victims" of suicide



To Hospitalize, or Not to Hospitalize? (1)

Option 1: Play it "safe" and hospitalize.

Option 2: Apply principles of "positive ethics:"

In which taking action to lower liability risk is given relatively less weight, in favor of promoting aspirational values (e.g. autonomy of the client; beneficence toward the patient's family).

To Hospitalize, or Not to Hospitalize? (2)

"False positive" worst case consequences:

1. Patient feels punished for honestly reporting suicidal feelings, and may be reluctant to disclose such feelings in the future.
2. Patient incurs real-life hardship for missing school, work, or care-giving obligations. Stressors worsen.
3. Patient feels traumatized among other inpatients who seem threatening to him/her.
4. Hospitalization does little to address the long-term issues, yet harms the ongoing therapeutic relationship*. Patient may leave therapy altogether.

*Paris, J. (2007). Half in Love With Death: Managing the Chronically Suicidal Patient. Mahwah, NJ. Lawrence Erlbaum.

To Hospitalize or Not to Hospitalize? (3)

"False negative" worst case consequences:

1. **Patient promptly tries (or completes) suicide.**
2. Therapist incurs heightened liability.
3. Patient does not complete suicide, but now believes that the therapist will never hospitalize him/her/them, leading to more provocative threats and high-risk behaviors, while the therapist feels helpless to act decisively.

To Hospitalize or Not to Hospitalize? (4)

- Comtois & Linehan (2006) wrote that "…while inpatient treatment is the standard of care, it has never been found efficacious in a clinical trial" (p. 166).
- As clinicians, let us try for "least restrictive means" of treatment rather than jump precipitously to hospitalization as a reflex action in the face of a crisis.

Additional Ethical Considerations

- What is the threshold for breaking confidentiality?
  - With regard to a current patient who is suicidal.
  - With regard to a patient who has already completed a suicide (e.g., talking to family members to support them in the aftermath).
- When should a clinical supervisor step in to interact with a suicidal patient directly?
- Talking about removing guns (for clinical safety) in spite of political backlash (in the U.S.).

Provide hope, plus a plan

(with specific interventions)

Create a Safety Plan (1)

(Commitment to Treatment)

- The safety plan includes several options.
- The tone of the plan is affirmative and hopeful.
- Design the safety plan collaboratively with the patient (a good therapeutic alliance greatly facilitates this process).

Create a Safety Plan (2)

- **Recognize “early warning signs.”**
  - Thoughts and feelings of hopelessness.
  - Self-isolation.
  - Warning: Schema activation can create rapid decline.
- **Use social support.**
  - Facilitate communication.
  - List of family, friends, support group members, sponsor.
- **Contacting mental health professionals.**
  - Therapist; Psychopharmacologist; Crisis Center.

See Stanley & Brown (2012).

Create a Safety Plan (3)

- **Make use of well-practiced coping skills.**
  - Physical activity.
  - Self-soothing (not self-medicating). Example: music, warm shower, fragrance, “comfort food.”
  - Writing and rational responding.
  - Mindfulness exercises.
- **Reduce access to lethal means.**
  - Ask a family member to be in charge of distributing the patient’s medication (to prevent overdose).
  - Ask the patient to give up possession of a weapon.

See Berk et al., 2004; Wenzel et al., 2009

Utilize General Resources

Canada Suicide Prevention Service:

1-833-456-4566 (24 hours per day, 7 days a week)

Text 45645 (4:00 pm to midnight, Eastern time)

Safety Plan Worksheet

Purpose: Providers and patients complete Safety Plan together, and patients keep it with them

Step 1. Warning signs (that I might be headed toward a crisis and the Safety Plan should be used):

1.
2.
3.
4.

Step 2. Internal coping strategies (things I can do to distract from my problems without contacting another person):

1.
2.
3.

Step 3. People, places and social settings that provide healthy distraction (and help me feel better):

1. Name and phone number:
2. Name and phone number:
3. Place:
4. Place:

Step 4. People I can contact to ask for help (family members, friends and co-workers):

1. Name and phone number:
2. Name and phone number:
3. Name and phone number:
4. Name and phone number:

Step 5. Professionals or agencies that can help me during a crisis:

- Clinician/Agency (Name, phone, pager, emergency contact number)
- Clinician/Agency (Name, phone, pager, emergency contact number)
- Local Emergency Department (Name, phone number, location/address)
- Other (Name, phone, pager, emergency contact number)

Military/Veterans Crisis Line:
Dial 800-273-TALK (8255), press 1 for military, or text 838255 or live chat at http://militarycrisisline.net for 24/7 crisis support.

National Suicide Prevention Lifeline:
Dial 800-273-TALK (8255) or live chat at https://suicidepreventionlifeline.org for 24/7 crisis support.

Step 6. Making my environment safe (plans for removing or limiting access to lethal means):

1.
2.
3.
4.

Step 7: My reasons for living (things that are most important to me and worth living for):

1.
2.
3.
4.
5.
6.

Department of Veterans Affairs and Department of Defense employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.
Reference: Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256–264.
Updated April 2020 by the Psychological Health Center of Excellence.

Specific Techniques for Acute Suicidality (1)

1. **Pros and cons of living and dying.**
   a) For oneself.
   b) For loved ones and others.
   c) For now, and for the future.
2. **Discuss issues surrounding the *finality* of death.** (“What experiences will you miss, every year?”)
3. **Use “strategies of delay” to reduce impulsive acts of self-harming.** (“Procrastinate” suicide.)

Specific Techniques for Acute Suicidality (2)

4. Help the patient to become **more active**.
5. Increase the patient's involvement in doing things for **mastery and pleasure**.
6. Change "negative, rhetorical questions" into "positive, literal questions."
7. Imagine a better future, and how to get there through treatment and patience. (***"Flashforwards"***)

Specific Techniques for Acute Suicidality (3)

8. Encourage the patient to ***write***. This may include a personal journal, an Activity Schedule, Thought Records, letters to other people, creative writing, etc. (see the work of James W. Pennebaker)
9. **Encourage little, positive behavioral changes** (create new routines that stimulate and facilitate good moods, personal growth, and favorable responses from the environment).
10. Utilize the **“hope kit”** of personal memorabilia, positive symbols, and inspiring messages.

Specific Techniques for Acute Suicidality (4)

11. Work on **improving problem-solving skills***. (A natural extension of the technique of "pros vs. cons" of living vs. dying). Target impulsivity and the role of alcohol and other psychoactive substances implicated in worsening impulsivity.
12. Practice and **improve autobiographical recall**. Encourage narrative story-telling of one's life, both negative and positive events, both in-session and for homework, both writing and reciting.

*** See Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck (2012)**

Homework

- Most of the techniques just reviewed can double as in-session methods *<u>and</u>* homework assignments.
- Homework provides patients with opportunities to learn important psychological skills, and to improve their sense of personal empowerment in the face of emotional distress.
- Homework is presented as a "win-win" situation. It's a "win" if they do the homework, and it's a "win" if they struggle or neglect the homework but learn more about the obstacles they need to overcome in the process.
- Patients who regularly do CBT homework tend to learn more skills in treatment, and are most likely to retain their gains.*

*see Jarrett, R.B., et al. (2011) in PSYCHOLOGICAL ASSESSMENT.
*see Kazantzis, N., et al. (2010) in CLINICAL PSYCHOLOGY: SCIENCE AND PRACTICE.
*see Rees, C.S., et al (2005) in COGNITIVE BEHAVIOUR THERAPY.

- Helping a patient choose to live is a ***process***.
- It is rarely an "epiphany."
- Risk does not go away in one intervention.
- But risk can be lowered in one intervention, and lowered still further over time, especially if the patient develops and practices self-help skills, elicits and is receptive to social support, and has access to professional care and a "plan."