ASSESSMENT AND TREATMENT OF SUICIDALITY: WHAT PSYCHOLOGISTS NEED TO KNOW

Eoin Galavan & Harry Horgan

Dr Eoin Galavan is a senior clinical and counselling psychologist and clinical lead in the Suicide Assessment and Treatment Service, Clinical Psychology Department, North Dublin Adult Mental Health, Health Service Executive. Harry Horgan is a trainee clinical psychologist at the University of East London and has previously worked as an assistant psychologist with the North Dublin Adult Mental Health Service. Correspondence should be addressed to eoin.galavan@hse.ie.
“Instantly realised that everything in my life that I’d thought was unfixable was totally fixable — except for having just jumped.”

Kevin Baldwin, Golden Gate Bridge suicide attempt survivor (Friend, 2003)

Suicide as one of the leading causes of death in our society is entirely preventable. Psychologists and psychology services have a major role to play in the area of prevention, risk assessment and treatment of suicidality. This article presents a summary of the literature pertaining to risk assessment and the pharmacological and psychological therapies for treating suicidality, as well as recommendations on how to work with someone who is suicidal.

Defining Suicidality

There is no consensus of definition for the terms suicidality and suicidal behaviour. Santa Mina and Gallop (1998) note that “most empirical work distinguishes self-harm from suicidal ideation and suicide attempt” (p.794). Self-harm is most commonly defined as some form of deliberate self-injury without intent to die; suicide attempts are characterised by an act with intention to die, albeit with varying degrees of intention and lethality of means (Santa Mina & Gallop, 1998).

Psychological Theories of Suicide

The suicidal mind and suicidal behaviour have been explored through a variety of theoretical lenses, but overarching theories of suicidality are relatively rare. Here, we note three; for a more thorough overview, see Galavan, O’Connor, O’Dea and Byrne, (2010) and O’Connor and Nock (2014).

The Stress-Diathesis Model of Suicide, outlined by Mann (1998), proposes a trait-state interaction: a predisposition to suicidal behaviour, stemming from, e.g., familial risk or traumatic experiences early in life, when combined with proximal factors such as depression, and triggers such as a major negative life event, can lead to suicide. Schneidman’s (1993) conceptualisation of suicide as a response to unendurable psychological pain informs his Cubic Model of Suicide. This proposes that suicide is preceded by an acute confluence of three factors: press (stress), perturbation (disturbed and agitated with an impulse to alter the current situation) and psychache (psychological pain). When all three are elevated a suicidal state is induced. Joiner’s Interpersonal Theory of Suicide (2005) also proposes a confluence of psychological phenomena: perceived burdensomeness (ineffectiveness, to the degree that others are burdened by the individual), thwarted belongingness (outside valued groups or relationships), and acquired capacity for lethal self-injury, associated with developing fearlessness of physical pain/ injury, often learned through repeated self-harm, mental rehearsal and acquired knowledge for lethal self injury.


Risk Assessment

Predicting Individual Suicide Risk

Accurately predicting the likelihood of suicide in an individual patient is almost impossible; it is false to assume that individual acts of suicide could be stopped if increased risk assessments were more rigorously applied (Mulder, 2011). However expectations are that clinicians routinely perform risk assessments on all patients and that suicide occurs mainly because of inadequate risk assessment. A meta-analysis of 13 studies tracking patients for a year after discharge from inpatient psychiatric facilities found that no single factor or combination of factors were associated with suicide (Large, Sharma, Cannon, Ryan, & Nielsens, 2011), and that “3% of patients categorized as being at high risk can be expected to commit suicide in the year after discharge. However, about 60% of the patients who commit suicide are likely to be categorized as low risk” (p. 626). Even the most useful predictors vastly overestimate the actual degree of risk. For example, a lethal suicide attempt is the best predictor of future suicidal behaviour; however as many as 97% of people who survive a lethal attempt will not go on to die by suicide (Large et al., 2011). Risk assessment’s main function should be to place those deemed to be at high risk into the most appropriate tracks of treatment, not to impose restriction.

While it may be almost impossible to predict the likelihood of suicide in an individual patient, carrying out effective risk assessment, leading to appropriate treatment across a suicidal population, may reduce overall rates. Risk assessment should be carried out with every suicidal patient in contact with services, but the goal remains to reduce the number of suicides among patients as a group. If we erroneously treat every patient categorised as high-risk as highly likely to attempt suicide, this will dilute already stretched resources and potentially lead to unjustified restrictive treatment.

Systems of Risk Management

A variety of tools exist to gauge suicidal risk. Skills Training on Risk Management (STORM) is easy to deliver to staff and has a high rate of training satisfaction (http://www.stormskillstraining.co.uk/); the Suicide Risk Assessment and Management Manual (S-RAMM) is a highly structured clinical judgement tool with a focus on prediction (Jiaz, Papaconstantinou, O’Neill, & Kennedy, 2009); Applied Suicide Intervention Skills Training (ASIST) is a type of suicide first-aid with the emphasis on preventing any immediate act (Guttormsen, Hasfødt, Silvola, & Burkeland, 2003); while the Collaborative Assessment and Management of Suicidality (CAMs; Jobes, 2006) is an ongoing risk assessment with a simultaneous treatment framework and therapeutic philosophy. STORM and ASIST are promoted within the HSE. Both have been evaluated positively in terms of staff satisfaction, however neither has been found to have beneficial outcomes for patients or service users as indicated by measures of suicidality/suicidal behaviour, which must be a priority.

The CAMS is a screening and risk management tool that includes administration of the Suicide Status Form (SSF) and outlines a framework for a clinical intervention to reduce suicidal drivers, with the ultimate aim to eliminate suicidal behaviour as a coping strategy. Completion of the SSF clarifies the nature of the patient’s suicidality and sets the stage for a treatment planning process where the
suicide given its toxicity. There are few statistics on use of Lithium in self-poisoning; one Finnish study (Isomets & Henriksson, 1994) reports 10% of completed suicides among bipolar patients by lithium overdose, replicated by a larger meta-analysis (Baldessarini et al., 2006). Lithium’s mechanism of action is still not fully understood. Baldessarini et al. (2006) speculate its effect in reducing aggressive and impulsive tendencies, allied to close clinical monitoring, may be responsible for the reduction in suicide rates.

**Antipsychotics**

Suicide is the leading cause of death (approximately 10%) for those with schizophrenia. Typical anti-psychotic medication has not been found to reduce incidences of suicide or suicidal behaviour and may increase suicide risk (Caldwell & Gotesman, 1990, cited in Meltzer et al., 2003). However, there is some support for the effect of atypical antipsychotic, clozapine (Meltzer et al., 2003): in an RCT across 11 countries, clozapine reduced suicide attempts significantly more than olanzapine (another atypical antipsychotic), even when controlling for the increased clinical contact required to administer clozapine, which may be a protective factor of itself. As with lithium, the mechanism for this effect is not understood. The authors speculate clozapine may have an intrinsic antidepressant activity, or that it may be treating the suicidal symptom domain rather than just psychosis. A further study (Zaninelli et al., 2005) controlled for concomitant medication (antidepressants, mood stabilisers), suggesting this effect was indeed due to clozapine.

**Psychological Therapies**

**Cognitive-behavioural therapy (CBT)**

CBT is a symptom-focused psychotherapy. Well documented as effective for a variety of conditions, including depression, anxiety, eating disorders and substance abuse, it seems most efficacious in reducing suicidal behaviour when treating major depressive disorder. According to some studies, CBT may be most effective in reducing suicidal behaviour in combination with another therapy (usually pharmacological) (Leitner, Barr & Hobby, 2008; March et al., 2004). Contrary research has found CBT more effective when decoupled from pharmacological treatment; March et al. (2007) found suicidal events were more common in patients receiving fluoxetine therapy (14.7%) than combination therapy (8.4%) or CBT alone (6.3%). Fluoxetine as a means for suicide by serotonin toxicity may account for this higher percentage (Wu & Deng, 2011).

CBT as an exclusive or main treatment was highly significant in reducing suicidal behaviour across 28 clinical trials (Tarrier, Taylor, & Gooding, 2008). The positive effect was limited to individual but not group CBT, and was not confirmed in adolescents. In line with the suicide treatment literature (Tarrier, Taylor, & Gooding, 2008), CBT was effective when focused directly on suicidality rather than other symptoms, such as depression or distress. A recent CBT variant, Cognitive Behaviour Therapy for Suicide Prevention (CBT-SP) draws on Dialectical Behaviour Therapy (DBT), emotion regulation strategies, distress tolerance skills, chain analysis, etc. to target suicidal behaviour among the difficult to treat adolescent population (Stanley et al., 2009). An initial study suggests it is viable, but it is yet to be evaluated by RCT.
Dialectical behavior therapy (DBT)

DBT emerged from the perceived ineffectiveness of CBT in treating Borderline Personality Disorder (BPD), which often incorporates suicidal ideation, suicide attempts and self-harm. Patients learn skills in distress tolerance, mindfulness, emotion regulation and interpersonal effectiveness (Linehan, 1993). Two RCTs indicated patients treated with DBT were less likely to leave therapy, deliberately self-harm, or be hospitalised, and had fewer days in hospital (Linehan et al., 1991, Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999). Research also supports its effectiveness for patients with any history of suicidal behaviour regardless of primary diagnosis. In a rigorous RCT (Linehan et al., 2006), women with recent suicidal or self-injurious behaviour assigned to DBT treatment were half as likely to make a suicide attempt during two-year follow-up, compared to those receiving expert community treatment. DBT is offered by a limited number of mental health services in Ireland and its evaluations are on-going.

Mentalisation Based Treatment (MBT)

MBT is a psychodynamic treatment rooted in attachment and cognitive theory, manualised for the treatment of BPD by Bateman and Fonagy (2004). It aims to strengthen patients' capacity to understand their own and others' mental states in attachment contexts, to address affect, impulse regulation, and interpersonal functioning which act as triggers for acts of suicide and self-harm. Compared to treatment as usual, MBT results in significantly lower self-harm, suicide attempts and hospitalisation in BPD (Bateman 2001; Bateman & Fonagy, 2008). A recent RCT demonstrated that MBT compared to structured clinical BPD management led to a steeper decline in suicide attempts and hospitalisation (Bateman & Fonagy, 2009).

Transference Focused Psychotherapy (TFP)

TFP is a structured, psychodynamic treatment based on Kernberg's (1984) Object Relations Model of BPD and has been shown to be effective in reducing suicidality and emotional dysregulation characteristic of the disorder (Clarkin et al., 1999; Clarkin et al., 2001). When evaluated in RCTs, TFP has demonstrated significant improvements in borderline symptoms and quality of life (Giesen-Bloo et al., 2006) and, importantly, significantly fewer suicide attempts as well as inpatient admissions over other treatments (Doering et al., 2010).

Working with a Suicidal Patient

The challenges of developing and maintaining a therapeutic alliance with a suicidal patient can be considerable. However, what is required is refreshingly familiar, and with practice by no means insurmountable. The basics are, as always, very important: empathy, understanding, attunement, listening and developing a working alliance. The challenge is to include these in an encounter which must also incorporate some direct and challenging conversations. A balancing act is required.

Marsha Linehan's change versus acceptance dialectic speaks well to this (REF). There must be sufficient acceptance, validation and empathy to accommodate the reality of the therapist taking a firm position regarding the act of self-destruction. Israel Orbach (2001, p. 166) puts it well:

“An empathic attitude towards the wish to die, coupled by an uncompromised confrontation of self-destructiveness, can provide the hope of discovering a path of compromise with life’s difficulties”

Orbach (2001) stresses the importance of empathising with the wish to die and striving to understand it, by exploring questions such as “What is causing this pain?” or “So much so that death seems like a good idea?” The purpose of this is not to accept or affirm that suicide is the right idea, just to understand. This must be coupled with challenging the rationale of using death as a solution to difficulties.

The idea of death, in the mind of the suicidal person, usually equates to a desirable state: “I wish to be dead” equals “I wish to stop feeling pain”; “to escape the horrors of life”; “to end suffering”, all of which imply some relief. These are understandable desires. It is perfectly valid for anyone to want to stop feeling pain. Does death achieve these? Frankly we do not know, but probably not. It seems fair to say that “being” dead is something of a misnomer. We do not know if death has any being in it at all. Certainly it is likely that death is not the same kind of being as we experience in life. And people’s wishes for death usually contain life-giving or life-type qualities. Suicidal people often conflate life and death in a kind of psychological fusion (Joiner 2005); what people wish for in death is something we only know about through life.

We can offer a simple question: If there was a way to solve your problems in life without being dead, would this be preferable? Most suicidal people say yes. In fact, in working with dozens of suicidal people I have yet to meet one whose wish for death could not be translated into a wish for something in life, like relief from pain or suffering.

There is therefore often a conceptual error in many suicidal people’s assumptions: that death will give them something they can only get in life. We should not be too wary about asserting this in the therapeutic context. Balance is required: empathy with the wish to die (usually something only found in life like relief), and confrontation of the act of lethal self-harm as a method of solving life problems. This must be done sensitively, with an appreciation that this solution might seem precious to the suicidal person. It can seem like the last or only thing that might help with their pain, because they feel they have tried everything and nothing has worked. We must not seek to take it away too quickly.

This recognition of the reality of death requires a kind of agreement with the patient: if they remain to see if with the therapist they can find a solution to their problems, there is a chance that they can solve them or learn to live with them without ending their life. The person can choose to kill themselves later, so in reality therapists are asking people to suspend this decision to give something else a chance to help. Killing one’s self while in therapy will mean that therapy has no chance of working. This agreement is central to the therapeutic relationship with the suicidal person. It underpins it, it protects it. Without this, the therapeutic relationship can be hijacked by power struggles with therapist trying to assert that patients cannot kill themselves, or feeling compelled to coerce patients into signing no-harm contracts. This may diminish the working goal of therapy to a self-protective move for the therapist.
The therapeutic relationship with the suicidal patient is vulnerable to being derailed by distorting pressures and expectations. Jobes notes that

“within contemporary culture there is both a societal expectation and legal statutes that assert that therapists must stop a patient from suicide; they are to keep them alive by all available means, no matter what the wishes of the patient are. Therefore if the patient dies by suicide, it is widely seen as the fault of the therapist...rather than the fault of the patient.” (Jobes, Comtois, Brenner, & Gutierrez, 2011)

This is clearly flawed. How can we stop people from killing themselves? Even when held against their will in psychiatric units under high levels of observation, people manage to kill themselves. The answer is of course, we cannot stop people from killing themselves when they are determined to do so. We can only help people to choose to solve their problems differently.

Efforts to control the suicidal patient’s behaviour can lead to a terrible pressure and anxiety for the psychologist about the feared suicidal outcome, not only as a tragedy for the person whom we are trying to help, but for the psychologist who may face recrimination or blame. The therapeutic encounter can be reduced to an effort to save the therapist from recrimination. Of course there is a need for us as psychologists to feel safe in this work, that we will not be blamed if a patient kills themselves. The most protective thing we can do, according to Jobes (2006), is to provide a comprehensive, thoughtful, therapeutic and suicide-specific assessment and treatment plan, well documented and agreed between patient and practitioner. The most protective thing we can do for ourselves is also the most protective thing we can do for our patients, and it facilitates and maintains the therapeutic alliance.

To develop a therapeutic relationship, empathy, challenging the self-destruction rationale, a working agreement/ alliance, and the ability to generate hope are required. Hope comes from recognising the potential problem-solving ability and coping capacity in each individual, and from the firm belief that they have the capacity to change, grow, cope, accept and tolerate. They have turned up in your office, they have not killed themselves today, they have decided to talk about suicide; all of this speaks to the patient’s hope of a solution other than suicide.

**Suicide Specific Interventions**

Probably the most common question in working with suicidal patients is “what do I do?”, born of recognising the potential consequences for patient and psychologist of doing nothing or failing to help i.e. death by suicide. Sometimes it can seem to us that we are faced with the choice of therapy as usual (with no direct specific intervention pertaining to suicidality) or hospitalisation; thereby, in the face of unmeasured suicide risk, forcing us to rely on hospitalisation for all suicidal patients when it should be reserved for those in clear and imminent danger of death by suicide. Having suicide specific interventions in place frees us up to collaboratively manage the risk of suicide while working on the relationship difficulties, emotional or psychological problems that inevitably underpin or relate to the individual’s suicidality.

Professor Jobes has developed an Evidenced Based Resource Guide for CAMS practitioners working with suicidal patients. This unpublished guide overviews means restriction, the use of a crisis card, safety planning, developing a hope kit, four-step problem solving, chain analysis, DBT based mindfulness skills, emotion regulation skills, and distress tolerance skills, behavioural activation and future planning skills. All of these types of interventions are accessible within the published literature. Suicide specific interventions are not long term solutions to problems in life, nor are they a replacement for psychotherapy. They are largely designed to help a person through a crisis so that they are free to engage in a therapeutic encounter that offers longer-term solutions. Suicide specific interventions should be a first port of call with the suicidal patient.

**Guidelines for Working with Suicidal Patients**

The following guidelines have been combined from four sources that appear to capture much of current best practice considerations: the Aeschi Research Group (The Aeschi Working Group, 2013); David Jobes (2006), Thomas Joiner (2005); Lisa Firestone (REF); and those developed by the North Dublin Clinical Psychology service.

1. A primary goal is to develop a therapeutic relationship. A non-judgemental and empathic stance towards the wish to die is vital. Start with the patient’s narrative: what has led you to this now? Why death? What is causing such pain?

2. Assess the risk of suicide. A thorough risk assessment approach is found in the CAMS model (Jobes, 2006). Use your risk assessment to guide treatment interventions. Seeing people more frequently during a time of crisis is often advisable. A balance needs to be struck between increasing contact to engage someone in a journey away from suicidality and creating unsustainable dependency with too much contact. As a rule of thumb I often see people twice or three times a week for the first 1-3 weeks during a suicide specific intervention. This is usually sufficient to meet the need for increased contact with suicidal patients. However this is not an absolute, and each psychologist-patient contract needs to be negotiated in the specific context.

3. Engage in some form of safety planning, or crisis response planning to manage the risk of suicide. Guidelines for crisis response planning or safety planning can be found in the CAMS model (Jobes, 2006), Joiner’s (2005) guidelines and Safe Vet (Knox, Stanley, Currier, Brenner, Ghahramanlou-Holloway, & Brown, 2011). Write down the safety plan and troubleshoot its use with the patient. What would make the suicidal person likely to use or not use this plan? Remember a crisis response plan is a short term solution to get someone through a difficult period so they have a chance to deal with the problems in their life.

   - This should include removal of or restriction of access to lethal means. Ideally this would be verifiable by a third party, particularly if a high risk of lethal self injury is present. A detailed step by step description of what to do during a suicidal crisis can be highly useful, for example, “put the pills down, leave the bedroom, go to a different room, call someone” to change the experience from “I’m alone planning to kill myself” to something else.

   - Phone numbers of people to contact in crisis including the Samaritans, a GP, friends and family who are likely to be supportive, your own work-based contact details, out of hours services etc.
Working with suicidal patients is something that generates considerable anxiety and yet is a common occurrence for most psychologists working in mental health or health care settings. It is also a topic that psychology has a great deal to offer to, both in terms of understanding the suicidal mind and in assessment and treatment approaches.

References