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Empowering Clients to Thrive Despite their Desire for Death: A workshop on ACT for Suicide Prevention

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Thanks for downloading the slides from our workshop at the ACBS World Conference 16. We hope that they are helpful and can connect you with useful resources. Check out the notes sections for additional discussion and resources.





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Disclaimer

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- None to report



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<https://clinicaltrials.gov/ct2/show/NCT02751983>



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Workshop Overview

1. Describe therapist barriers to working collaboratively with clients to effectively address suicide risk
2. Examine phenomenon suicide from a contextual behavioral perspective
3. Demonstrate how to use ACT to join with your client to directly target suicide risk and empower her to build a life she will choose to live

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Experiential Exercise: Clinician's experience & relationship with suicide work





Small Group Discussion of Experiential

- 1.) Your name
- 2.) How do you get in your own way when working with suicide?
- 3.) How can you use this workshop to improve your clinical work?



Brief Discussion of Experiential Exercise

- **What barriers did you identify in the exercise?**

- **What gets in the way of doing your best clinical work when suicide is present?**



Some Common Therapist Barriers

- Responding to suicide risk can be a tremendous source of stress and put therapists at odds with client
 - Therapist often has an agenda (keep client alive)
 - Power struggle can emerge in clinician interactions
- Fear of harm, ethical violation, and/or liability can arise. Systems requirements can reduce therapist autonomy.
- Therapist desire to control own discomfort.
 - Reluctance to do evocative interventions (Creative Hopelessness, Funeral Exercise), even if they would be clinically useful.
 - Might cling rigidly to interventions to fix/solve client's suicide.
 - Therapist might tend to overreact or underreact to suicide talk.
- Therapist barriers may lead to reduced clinical effectiveness.



Suicide from a Contextual Behavioral Perspective

The function of suicide is to **control unwanted** emotions, thoughts, and/or physical sensations (i.e., **internal experience**).

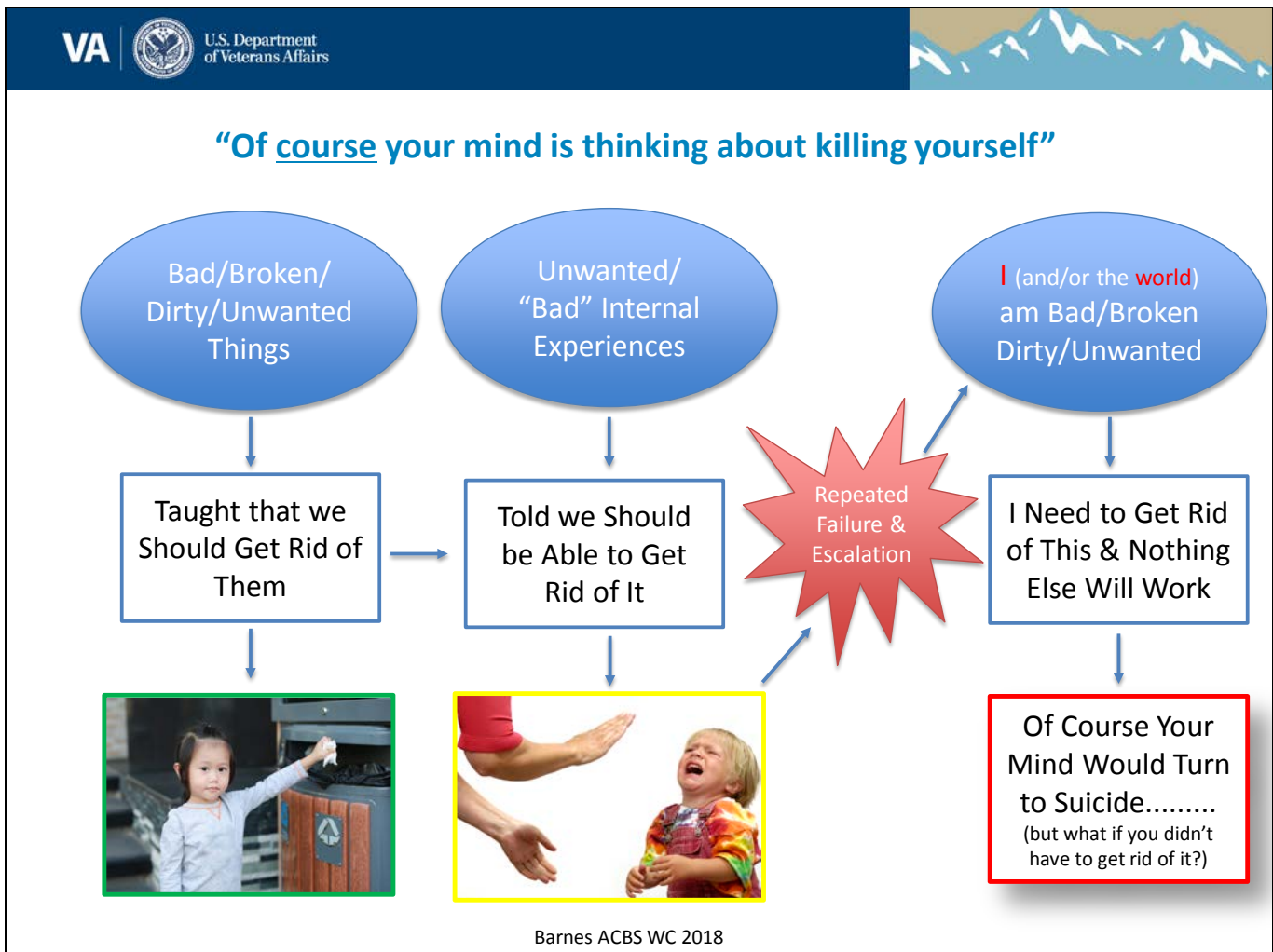
- Suicidal ideation and behaviors can result in both the cessation of unwanted experiences (e.g., agitation) and/or the start of wanted experiences (e.g., sense of control)
 - *Suicide can be negatively and/or positively reinforcing and is often maintained through multiple pathways.*

Suicide results from persistent and escalating attempts to succeed at an **unworkable agenda of internal control**.

Suicide isn't isolated to people with a particular diagnosis or set of diagnoses. It occurs among members of all socioeconomic statuses and in all societies throughout our world. There are a multitude of pathways that lead people to attempt suicide.

What do all of these experiences have in common? All pathways to suicide involve some form of unwanted emotional or physical pain that is difficult if not impossible to control. Suicide is an extreme attempt to control them.

(We acknowledge that this perspective is a bit reductionist because sometimes suicide is motivated by a desire for positive internal experiences like a sense of control or connection, but we believe that this is typically still motivated by a desire to relieve discontent related to, for example, feeling out of control or disconnected)



We are taught that we should get rid of things that are bad and unwanted. We are good at this when it has to do with external things (spoiled milk, used tissues, etc.). Then we are told that we should be able to similarly get rid of emotions and thoughts that are viewed as “bad” or unwanted. This isn’t as easy and when the emotions are very intense it can be downright impossible. Often when people are unsuccessful getting rid of unwanted emotions they turn to increasingly extreme measures to find escape from them (e.g., isolation, substance abuse). These attempts also usually undermine valued behavior and erode reasons for living. For some people, it can start to feel like maybe they are the thing that is bad or broken and/or that the world is bad or broken. When nothing else is working and our minds are rigidly applying this rule we have been taught to get rid of unwanted internal experiences, of course minds often consider suicide. Suicide is typically a logical solution to the problem of needing to control uncontrollable experiences. But what if you haven’t been doing the control thing wrong? What if it just doesn’t work and that we don’t actually have to get rid of unwanted thoughts and emotions to start living a vital meaningful life.



Research and Theoretical Support

• Research supports the theoretical applicability of ACT to suicide prevention based on associations between ACT processes and suicide-related outcomes

- **Experiential Avoidance:** DeBeer et al., 2017; Ellis & Rufino, 2016; Zvolensky et al., 2016
- **Mindfulness:** Chesin & Jeglic, 2016; Lamis & Dvorak, 2014
- **Values and Committed Action:** Bahraini et al., 2013; Monteith et al., 2015

• Theory-based Publications and Case Studies

- Chiles & Strosahl's (2005) *Clinical Manual for Assessment and Treatment of Suicidal Patients*
- Hayes, Pistorello, & Biglan (2008) article describes how ACT can be applied to suicide prevention
- Barnes et al. (2017) chapter describes use of ACT to understand and prevent suicide
- Luoma & Villatte (2012) case study describes use of mindfulness processes in the treatment of suicidal behavior
- Razaque et al. (2013) case study of frequent brief inpatient ACT sessions

• Treatment Research

- ACT for Depressed Veterans resulted in increased experiential acceptance scores, which were associated with lower odds of suicidal ideation across time (Walser et al., 2015)
- ACT for Management of Suicidal Patients pilot showed reductions in suicidal ideation (Ducasse et al., 2014)
- Small randomized controlled trial of an ACT-based self-help mobile app did not find significant reductions in suicidal ideation (Tighe et al., 2017)

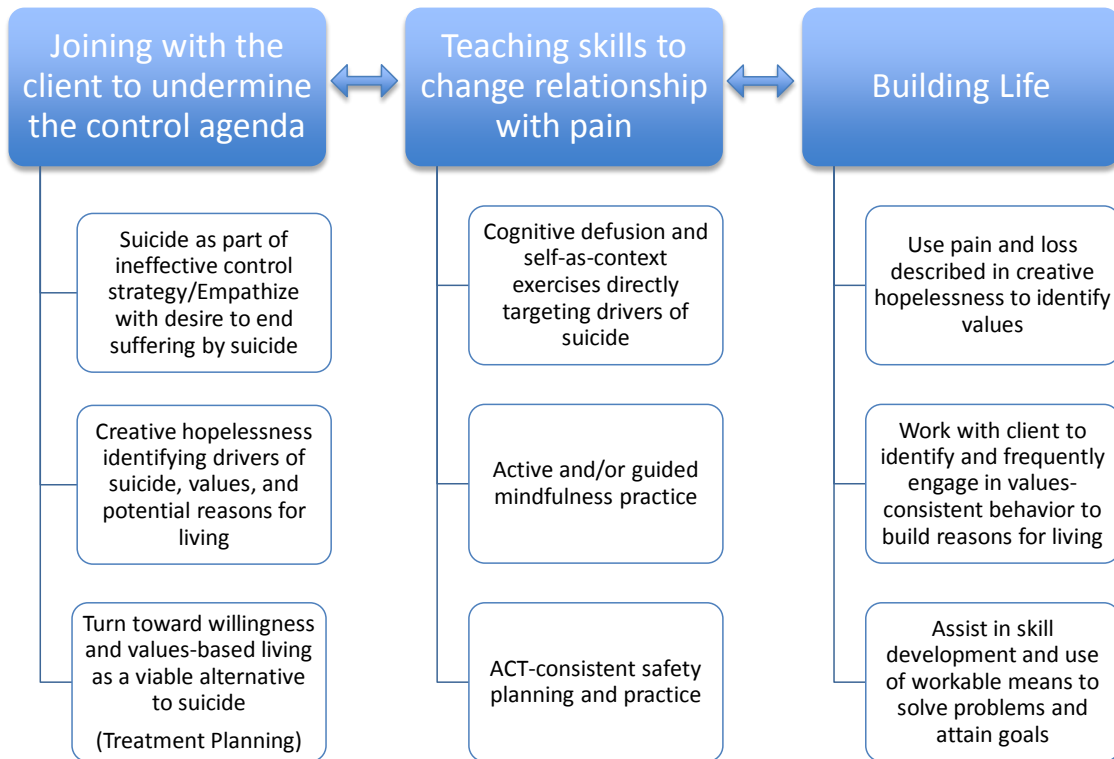


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Now that we have considered how suicide is conceptualized from a CBS perspective, we'll take a quick look at the literature supporting the use of ACT for suicide prevention. Research supports the theoretical applicability of ACT to suicide prevention based on associations between ACT processes and suicide-related outcomes. There have been several publications that outline the application of mindfulness and ACT to suicide prevention and two case studies published. Dr. Walser and colleagues' study of ACT for depressed Veterans within the VA is the largest study to examine the impact of ACT on suicidal ideation. ACT-D doesn't specifically address suicide, but did result in increased experiential acceptance which was associated with lower odds of suicidal ideation across time. Ducasse and colleagues conducted an uncontrolled pilot study of an outpatient ACT group for management of suicidal patients and found a reduction in suicidal ideation. Finally, the only randomized controlled trial was a pilot study of an ACT-based self-help mobile app that did not find significant reduction in suicidal ideation. Overall, more research is needed to guide the use of ACT suicide prevention and help meet the needs of unique clients.



Using ACT to Empower Clients to Thrive Despite Their Desire for Death



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There isn't a single or "right" way to use ACT with clients who are suicidal. There isn't a "correct" order of processes or sequential steps that must be followed. However, there are some primary treatment targets we focus on. Here is a quick overview of what we often do. It's critical that this work is done in a compassionate way from an ACT-consistent stance.



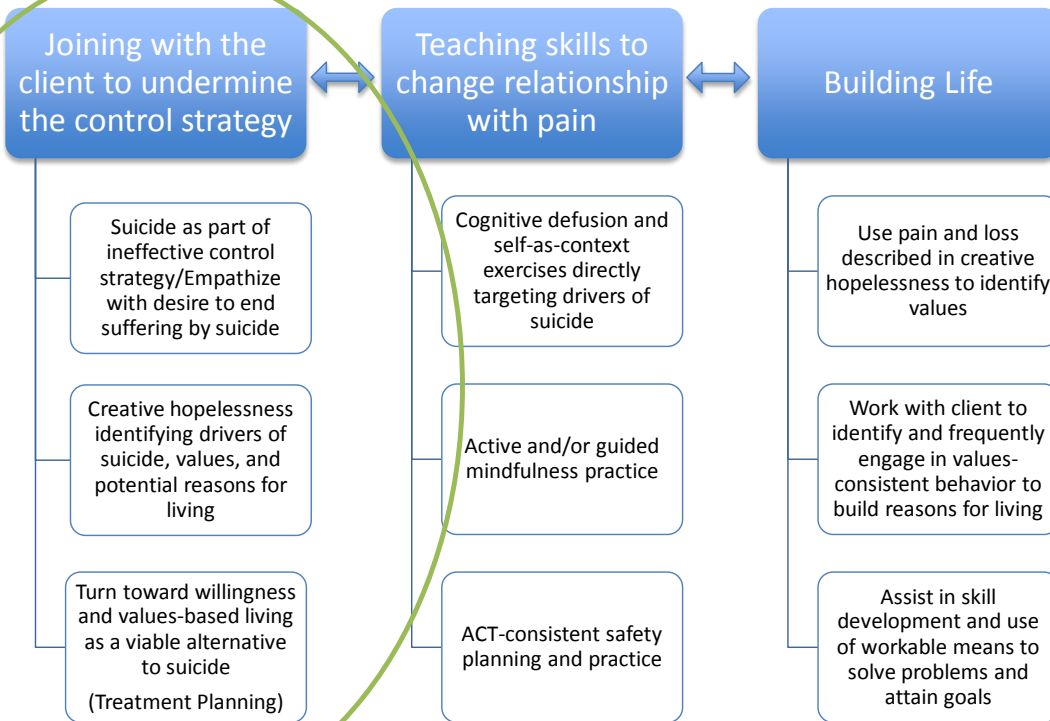
Case Vignette

- **Jane**
 - Female
 - late 30's
 - Divorced
 - Has a daughter
- **Presenting Problem**
 - Suicide attempt via overdose
- **What we have done so far in the session**
 - First outpatient session
 - Client has explained what brought her to therapy
 - Recent suicide attempt via overdose and long history of self-directed violence
 - Recent divorce and loss of custody
 - Depression, chronic physical pain, opiate abuse
 - Feels like a failure- particularly as a mother, burden, socially disconnected

The name and characteristics presented have been changed to protect the confidentiality of the client this fictional vignette was based on.



Using ACT to Empower Clients to Thrive Despite Their Desire for Death





Joining with the Client to Undermine the Control Agenda: Creative hopelessness/assessment

1) What emotions, thoughts, memories, or physical sensations have you been trying to get rid of?

Depression, physical pain, boredom, feeling like a failure, shame, "My daughter would be better off without me," "No one loves me," "No one would care if I died,"

2) What have you tried?

Rumination, isolation, opiates, drug use, alcohol, exercise, staying busy, focusing on breath, therapy, romantic relationships, thinking about suicide, attempting suicide

3) How long have you tried it for?

[many for most of life, others more recent]

4) How has it worked? Has it gotten rid of it? (consider both short- & long-term)

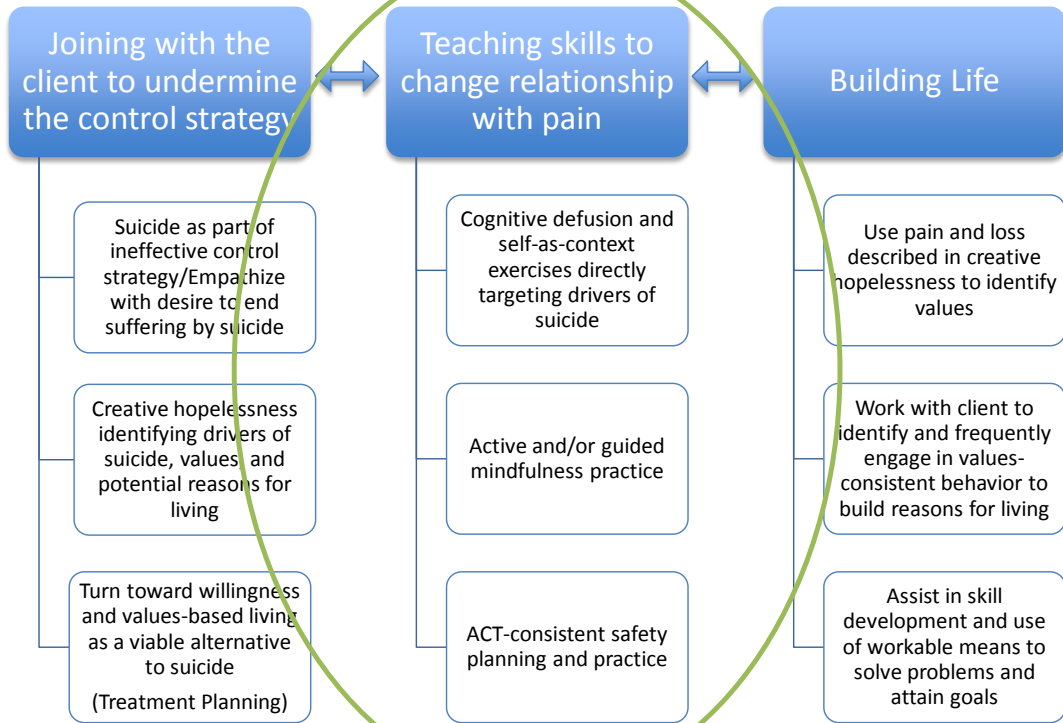
[most result in temporary relief, but fail to get rid of unwanted internal experience permanently]

5) What has it cost you?

Jobs, relationships, reputation, marriage, money, homes, custody of daughter, time, opportunity



Using ACT to Empower Clients to Thrive Despite Their Desire for Death



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In subsequent sessions we would focus on teaching skills to change the client’s relationship with their pain, with a specific focus on thoughts, emotions, and urges that motivate their desire for death or precede suicidal behavior. We use standard ACT metaphors and exercises to address suicide-specific content. Based on our assessment of Jane what might you plan to do with her?



Joining with the Client to Undermine the Control Agenda: Creative hopelessness/assessment

1) **What emotions, thoughts, memories, or physical sensations have you been trying to get rid of?**

Depression, physical pain, boredom, feeling like a failure, shame, "My daughter would be better off without me," "No one loves me," "No one would care if I died,"

Responses often include targets for defusion

2) **What have you tried?**

Rumination, isolation, opiates, drug use, alcohol, exercise, staying busy, therapy, romantic relationships, thinking about suicide, attempting suicide

3) **How long have you tried it for?**

[many for most of life, others more recent]

4) **How has it worked? Has it gotten rid of it?** (consider both short- & long-term)

[most result in temporary relief, but fail to get rid of unwanted internal experience permanently]

5) **What has it cost you?**

Jobs, relationships, reputation, marriage, money, homes, custody of daughter, time, opportunity



What might you try to Change Client's Relationship with their Unwanted Internal Experience:

Cognitive Defusion Exercises targeting Suicide-Related Content

Self-As-Context Exercises targeting Suicide-Related Content

Mindfulness Practice

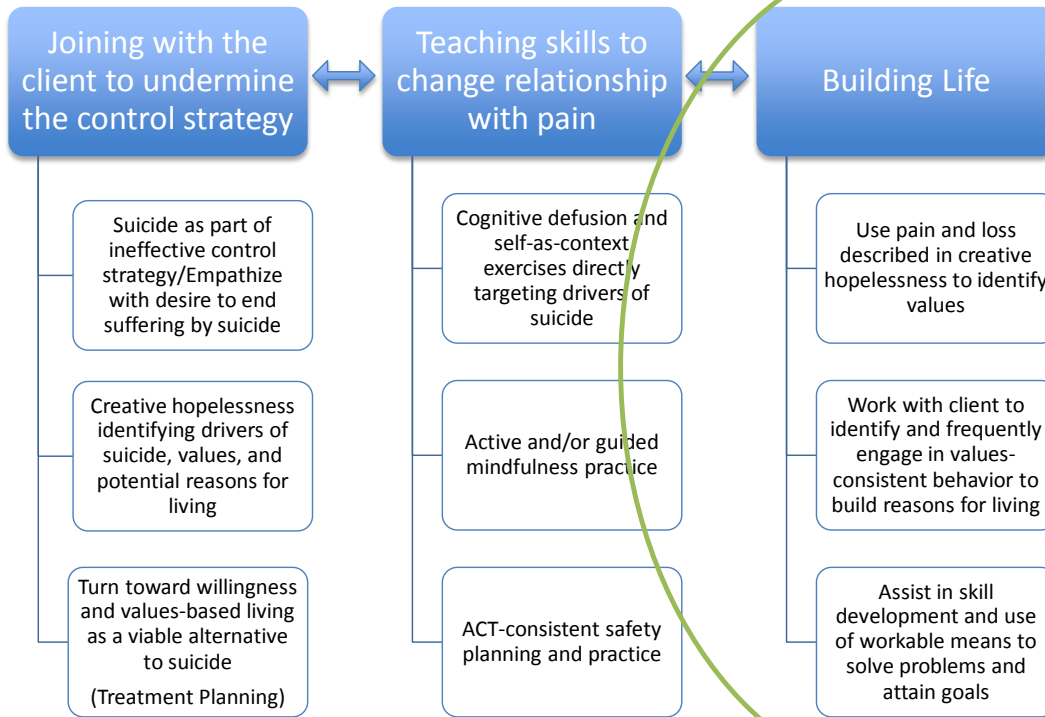
ACT Consistent Safety Planning

- Include ACT-consistent acceptance/coping techniques
- Include values and reasons for living
- Link use of safety plan to values
- Daily Practice

For training on safety planning see: <https://www.youtube.com/watch?v=9OAZIfPqdfk> and http://www.suicidesafetyplan.com/Home_Page.html



Using ACT to Empower Clients to Thrive Despite Their Desire for Death





Joining with the Client to Undermine the Control Agenda: Creative hopelessness/assessment

1) What emotions, thoughts, memories, or physical sensations have you been trying to get rid of?

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2) What have you tried?

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**3) How long have you tried
[many for most of life, other]**

Responses about cost and descriptions of the client's pain often point toward values to target in treatment

**4) How has it worked? Has
[most result in temporary**

(short- & long-term)

altered internal experience permanently]

5) What has it cost you?

Jobs, relationships, reputation, marriage, money, homes, custody of daughter, time, opportunity



Building Life:

Assist client in identifying values

Assist client in regularly and frequently engaging in valued behaviors

When possible, promote values-consistent action that leads to connection, ability to care for self and others, and builds reasons for living

When necessary, address skill deficits (e.g., problem solving, interpersonal effectiveness) and support exploration of workable way to achieve values-consistent goals.



Take Home Points

- Be aware of your own relationship with suicide work and what it can pull you to do in the therapy room.
- Take a compassionate and empathic stance with client's who consider/attempt suicide.
- Suicide is an extreme, but logical extension of the expectation that we get rid of unwanted internal experience. Join with the client around this unworkable strategy we have been taught and work on an alternative together.
- Engage ACT processes relevant to suicide and address suicide-related content directly.
- Target suicide with creative hopelessness as just another part of the unworkable control strategy.
 - Remember goal is to make client hopeless about the unworkable internal control strategy- not to make them feel more hopeless about life or their future.
- Decreasing suicidal ideation isn't the goal. Preventing death isn't the goal. Building a life worth living is the goal.

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- Turn toward willingness to experience pain and values-based living as an alternative to suicide. Link with treatment planning.
- Help client change relationship to unwanted internal experience with defusion, self-as-context, and mindfulness work.
- Help client build a life of her choosing through values work and committed action. Build reasons for living.



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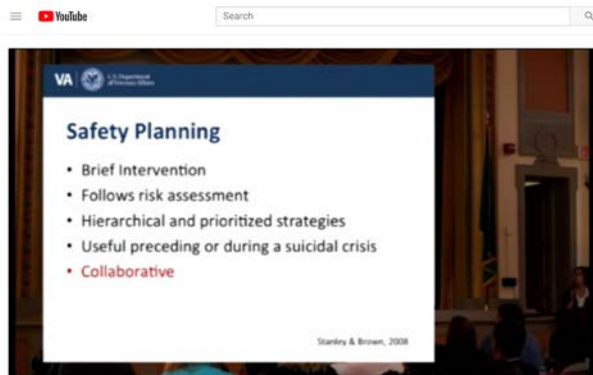




Resources and Trainings on Suicide Risk Management & Safety Planning

<https://www.mirecc.va.gov/visn19/education/products.asp>

<https://www.mirecc.va.gov/visn19/clinical/>



Suicide Risk Safety Planning



See slides from Jonathan Weinstein's workshop: session 03. A CBS Approach to Safety Planning and Repertoire Expansion with High Risk Patients



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<https://www.youtube.com/watch?v=9OAZIfPqdfk>

<https://twitter.com/rmirecc?lang=en>



SUICIDE RISK MANAGEMENT Consultation Program FOR PROVIDERS WHO SERVE VETERANS

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Common consultation topics include:

- Risk Assessment
- Conceptualization of Suicide Risk
- Lethal Means Safety Counseling
- Strategies for How to Engage Veterans at High Risk
- Best Practices for Documentation
- Provider Support after a Suicide Loss (Postvention)

#NeverWorryAlone

To initiate a consult email:
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