Working with Suicidal Young People:

Re-Thinking Risk and Integrating CBS and Attachment Theory

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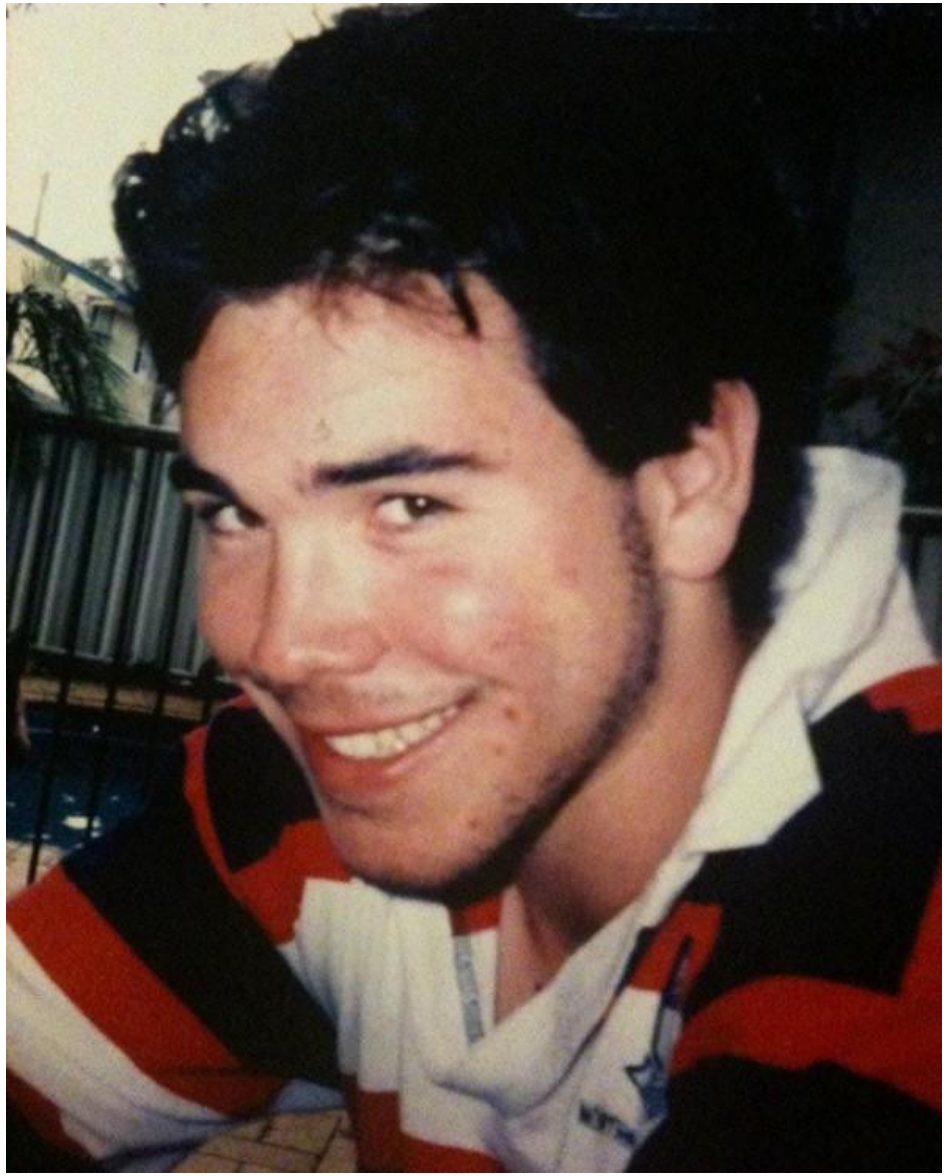
ACBS World Conference

SAN FRANCISCO

— June 14-19, 2022 —

Reflective Practice

- Checking-in with yourself
- What brought you to this workshop?
- What do you want to connect with while here?




RNSH

Gamaragal Land

SUICIDE RISK CHECKLIST

Name_____ Date _____ Caregiver_____

DETAIL	LOWER RISK	MEDIUM RISK	HIGH RISK
Score 1 1. Suicide Plan A. Details B. Availability of means C. Time D. Lethality of method E. Chance of intervention	– Vague – Not available, will have to get – No specific time or in future – Pills, slash wrists – Others present most of the time	– Some specifics – Available, has close by – Within a few hours – Drugs & alcohol, car wreck, carbon monoxide – Others available if called upon	– Well thought out; knows when, where, how – Has in hand – Immediately – Gun, hanging, jumping – No one nearby; isolated
2. Previous suicide attempts	– None or one of low lethality	– Multiple of low lethality or one of medium lethality; history of repeated threats	– One of high lethality or multiple or of moderate – Several attempts over past weeks
3. Stress	– No significant stress	– Moderate reaction to loss and environmental changes	– Severe reaction to loss or environmental change – Many recent social/personal crises
4. Symptoms A. Coping behaviour B. Depression	– Occasional suicidal thoughts – Daily activities continue as usual with little change – Mild; feels slightly down	– More than one suicidal thought per day – Some daily activities disrupted; disturbance in eating, sleeping, school work – Moderate; some moodiness, sadness, irritability, loneliness, and decrease of energy	– May resist help – Constant suicidal thoughts – Gross disturbances in daily functioning – Delusions, paranoia, lost touch with reality – Overwhelmed with hopelessness, sadness, and anger (verbal/physical) feelings of worthlessness – Extreme mood changes
5. Resources	– Help available; significant others concerned and willing to help	– Family and friends available but unwilling to help consistently	– Family and friends not available or hostile, exhausted, injurious – Significant self neglect
6. Communication aspects	– Direct expression of feelings and suicidal thoughts	– Interpersonalised suicide goal ("They'll be sorry – I'll show them")	– Very indirect or non-verbal expression of internalised suicidal goal (guilt, worthlessness)
7. Life Style	– Stable relationships, personality, and school performance	– Recent acting-out behaviour and substance abuse; acute suicidal behaviour in stable personality	– Suicidal behaviour in unstable personality; emotional disturbance; repeated difficulty with peers, family and teachers
8. Medical status	– No significant medical problem	– Acute but short-term or psychosomatic illness	– Chronic debilitating or acute catastrophic illness – Significant medical problems and overdose
TOTAL	LOW	MEDIUM	HIGH

Suicide Risk Assessment Guide[2]

To be used as a guide only and not to replace clinical decision-making and practice.

Issue	High risk	Medium risk	Low risk
'At risk' Mental State – depressed – psychotic – hopelessness, despair – guilt, shame, anger, agitation – impulsivity	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts – intentionality – lethality – access to means – previous suicide attempt/s	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality.
Substance disorder – current misuse of alcohol and other drugs	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History – family, carers – medical records – other service providers/sources	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account of events of person at risk (logic, plausibility).
Strengths and Supports (coping & connectedness) – expressed communication – availability of supports – willingness / capacity of support person/s – safety of person & others	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; few relationships; Available but unwilling / unable to help consistently.	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
Reflective practice – level & quality of engagement – changeability of risk level – assessment confidence in risk level.	Low assessment confidence or high changeability or no rapport, poor engagement.		– High assessment confidence / low changeability; – Good rapport, engagement.
No (foreseeable) risk: Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support network.			

Is this person's risk level changeable? **Highly Changeable** **Yes** ☐ **No** ☐

Are there factors that indicate a level of uncertainty in this risk assessment? Eg: poor engagement, gaps in/or conflicting information. **Low Assessment Confidence** **Yes** ☐ **No** ☐

Framework for Suicide Risk Assessment and Management: NSW Health (2004)

Can we accurately stratify risk?

Pokorny AD. Prediction of suicide in psychiatric patients: Report of a prospective study. *Archives General Psychiatry, 1983*, 40:249-57.

N = 4800 men

	Completed suicide	Did not complete suicide
High Risk n = 803	30 (3.7%)	773 (96.3%)
Lower Risk n = 3997	37 (0.9%)	3960 (99%)

96% of higher risk patients were ‘false positives’

Half of all patients who completed suicide were ‘false negatives’

Adapted from Large, Ryan, Carter & Kapur (2017)

Study	Question	No. of studies	Authors' Conclusions
Chapman et al (2014)	Association between suicide ideas and suicide according to diagnosis	25	The strength of association between suicidal ideation and suicide seems to be moderated by diagnosis. Studies with stronger research methods reported a weaker association between suicidal ideation and suicide.
Large et al (2016)	Association of a high risk category with suicide	37	A statistically strong and reliable method to stratify patient risk remains elusive.
Ribeiro et al (2016)	Magnitude and clinical utility of associations between self-injurious thoughts and behaviours and suicide	144	Suicidal ideation and behaviours may not improve prediction much beyond chance levels.
Chan et al (2016)	Association between selected risk factors and scales and suicide	19	The use of risk scales may provide false reassurance as no scales have sufficient evidence to support use.
Franklin et al (2017)	Examine predictors of suicidal behavior	365	Predictors of suicide are only slight better than chance
Carter et al (2017)	Positive predictive values of suicide risk assessment instruments	70	No high risk classification was clinically useful. Treatment should reduce exposure to modifiable risk factors.

Clinical implications?

Clinical implications?

- Risk category
- Beyond ‘mainstream approach’
- Target common risk factors
- Individual needs of the client
  - **Functional contextual approach**
- Involve client’s support network

A Functional Contextual Perspective

- Idiographic analysis
- Curiosity before problem solving
- Mindfulness for two
- Suicidal behaviours may be under positive and/or negative reinforcement
- RFT: deictic, temporal, conditional, analogical

A little bit of RFT when assessing function of suicidal behaviours

Deictic:	“If I was in your skin when you were having these thoughts what emotions would I notice”?
	“What is showing up for you physically as we talk about this now?
Temporal:	“What occurred in the lead up to you deciding to cut yourself?”
	“Is, this sense of nothing to live for, here, right now?”
	“What did you feel after you texted your friend “goodbye””?
Conditional:	“Given what you’ve experienced, it makes sense you have these urges”
Analogical:	“If this emotion had a colour, what would it be?”

Scenario

Charlie is a 16 year old who was found by mum in bedroom with faint cuts to arms and two packets of paracetamol. Mum was alerted to a potential problem by one of Charlie's friends. Charlie had sent the friend a text 30 minutes beforehand thanking them for being a good friend and just to know it wasn't their fault. Charlie is brought to the appointment with you by parents.

Putting it into Practice. 1

Clinician task: **functional assessment of suicidal behaviour**

Observer task: take notice of questions that help elicit function of the behaviour.

Be careful not to slip into problem solving, values exploration or safety planning at this point. We will have an opportunity for this later. Try to slow it down and really get to know what it's like in your client's skin.

Safety Planning

- Choice
- Values
- Expansion
- Curiosity
- Sweet and the sour
- RFT: oppositional, hierarchical, deictic

A Warning on Distraction

Top Google Search Results – ‘Suicide Safety Plan’

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Brown & Stanley Safety Plan

Trusted Contact Information

Keep a list of contacts you can talk to if you are unable to distract yourself with self-help measures. List names, phone numbers, or other contact information, and be sure to have backups in case your first or second choices are unavailable.

Verywellmind.com

A little bit of RFT when promoting living

Oppositional:	“I wonder if the urge to end it is a sign that you want something in this situation?”
	“What would you not have to care about, in order not to hurt here?”
Hierarchical:	“What has stopped you from following through with suicide until now”?
	“You could end it, but you’ve come to see me, I wonder what you might hope for?”
Deictic:	“When I mentioned your mum, there was a tear in your eye, what happened for you just then?”

Putting it into Practice. 2

Clinician task: **Help connect the client move towards what matters, encouraging expansion in their lives, developing commitment**

Observer task: take notice of questions that promote expansion

Be careful not to slip into self-soothing strategies and practical steps about who you could call and removing means. These steps are very important but clinicians are generally more confident with these manoeuvres.

Empowerment Plan

<table>
<tr><td>1) Recognize warning signs, emotions, and values.
</td><td>2) Try something new.</td></tr>
<tr><td>3) Do a helpful social activity or go to a helpful place.</td><td>4) Call a supportive person who is important to you.
<table><tr><td>Name</td><td>Phone</td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td colspan="2">5) Seek professional support.
Psychiatrist:
Therapist:
Primary care physician:
Local emergency room:
24-hour crisis hotline:</td></tr>
<tr><td colspan="2">DO NOW (Please include Lethal Means Restriction):</td></tr>
</table>

Fig. 1. Empowerment plan.

My Supportive Life Plan

Name: _____

1. Recognise my warning signs:

2. Do something towards the following that matter to me / would like to matter to me:

3. Do a new activity:

4. Do one of the following self-soothing strategies to take care of myself:

5. Call one of the following people:

Name: *Phone:*

6. Access professional support:

Therapist:

Psychiatrist:

General practitioner:

Lifeline: 13 11 14

7. **Do the following NOW** (including removing anything you would harm yourself with):

When to consider hospital?

When to consider hospital?

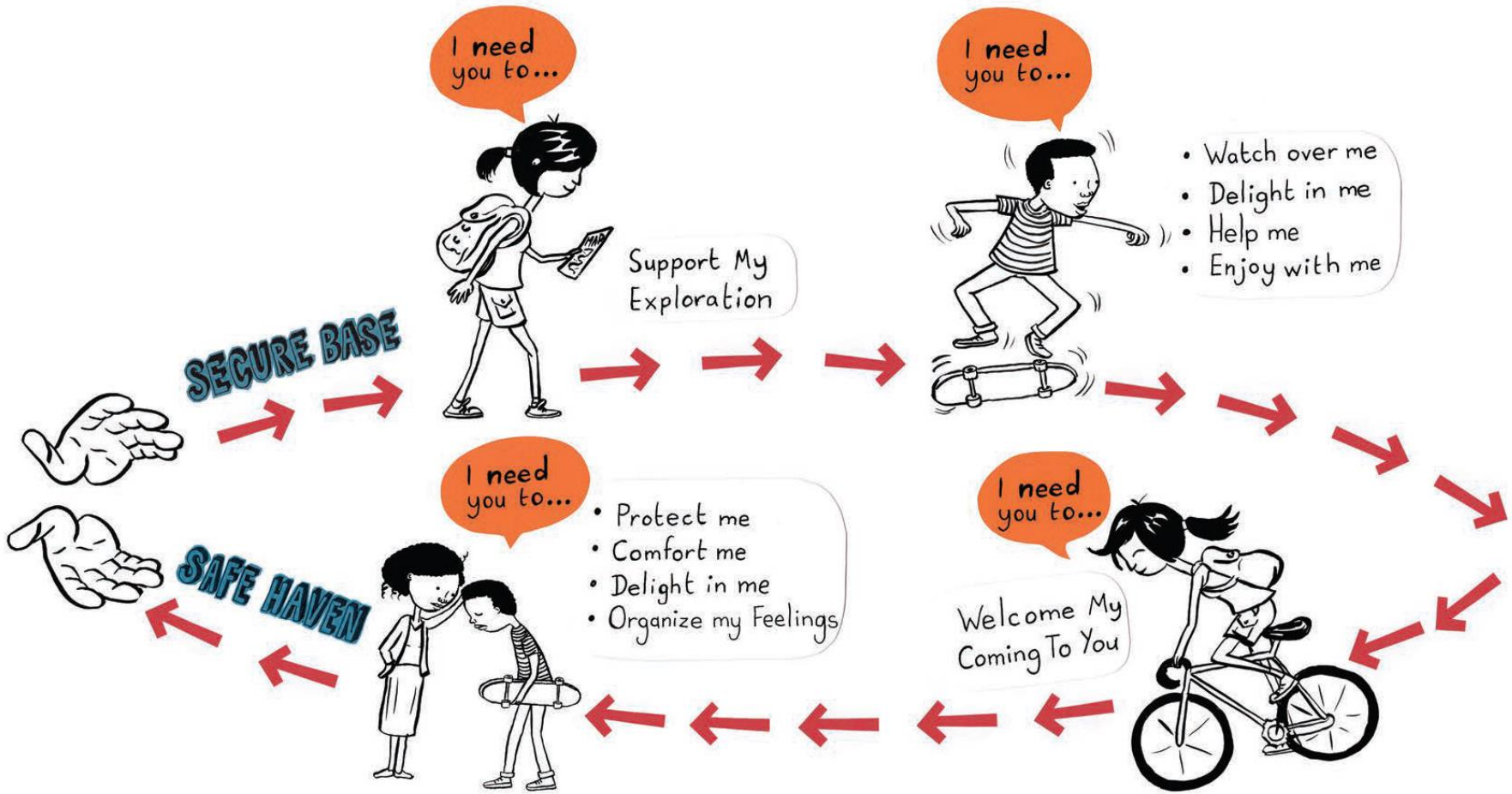
- Client mental state
- Client’s wishes
- Unwilling to engage in safety planning
- Parent / carer refusal
- Require medical assistance
- Substance use
- Be careful of assumptions around hospital outcome

Safety Planning with Young People: Integrating Attachment Theory

Attachment Theory

Attachment theory is a behavioural and evolutionary theory that proposes that it is the repeated interactions between an infant and caregiver that is the foundation for expectations concerning the self (mastery and self-concept) and relationships with caregivers and non-caregivers alike.

Circle of Security
INTERNATIONAL
Early Intervention Program for Parents & Children



A settled and attentive parent helps to settle an unsettled child

J Doran 2022

CBS & Attachment:

We need a way of thinking with parents and helping parents with a way to think.

J Doran 2022

A Functional Contextual Perspective to Working With Parents

- ABCs
- Very important when you have a parent who is dismissing, disapproving, critical or absent
- Socialises parents to be curious about their own child's difficulties – parallel process

Limited Security

ANTECEDENT	BEHAVIOUR	CONSEQUENCES
Mum feels worried. She sees Charlie with cuts on arms, experiences a lot of tension in her body and feels anger.	Yells at Charlie “why do you keep doing this”?	Undetected to mum she feels some momentary reduction in arousal when yelling. Later feels shame.

Secure Response

ANTECEDENT	BEHAVIOUR	CONSEQUENCES
Mum feels worried. She sees Charlie with cuts on arms, experiences a lot of tension in her body and feels anger.	Mum pauses, notices her tension and fear, takes a deep breath and recognises that her child needs her compassion to help her feel connected.	Mum experiences a sense of knowing what to do next and imagines her child feeling loved. There is a slight reduction in her tension. Later she feels some peace that she was able to be present.

Putting it into Practice. 3

Clinician task: **Functional assessment of parent response**

Observer task: take notice of questions that help elicit function of the behaviour.

Be careful not to slip into advice giving or expressions of sympathy. Try to slow it down and really get to know what it’s like in your client's skin.

Supporting My Child Plan

Name: _____

1. When my young person is distressed, engaging in self-harm or suicidal I notice the following thoughts, emotions and sensations:

2. My parenting values are:

3. Things I can do in line with my values and support my child include:

4. Strategies I can use to help myself self-soothe so I can help my child: (Remember that a settled parent helps to settle an unsettled child)

5. My family's support team:

Therapist:

Psychiatrist:

General practitioner:

Lifeline: 13 11 14

6. Family care plan:

7. **Do the following NOW** (practical strategies I will do to reduce risk of my child harming themselves):

It Takes Time!

BEST INTEREST OF THE CLIENT

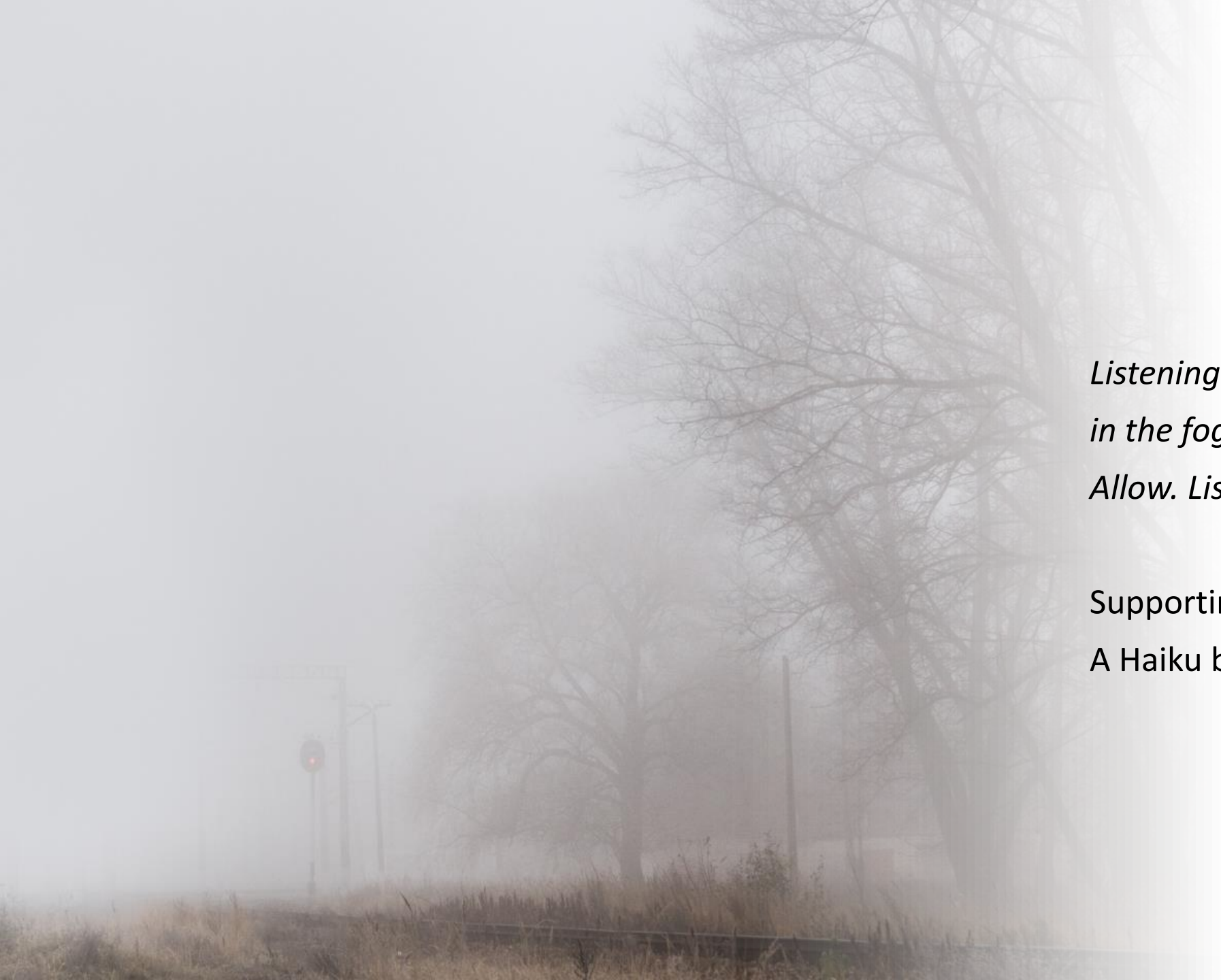
FACTOR IN TIME REQUIRED FOR WORKING WITH RISKY PATIENTS

SAFETY PLANNING WITH YOUNG PEOPLE TAKES LONGER

THINK OUTSIDE THE BOX

Top Tips Working with Suicidal Young People

- Don’t rush to quickly through the listening phase
- Listen for values hidden in pain
- There are many potential functions of suicidal beahviours
- Spend as much time with the parent who is scared, self-critical, sensitive to judgement
- Mental health issues are family issues – need the family to come up with the plan
- Be mindful of your own reactions and how you’re responding to them
- Invite young people and parents to take responsibility



Listening prompts fear,
in the fog of hopelessness.
Allow. Listen. Care.

Supporting Suicidal Young People
A Haiku by Justin Doran

Reflective Practice

- Checking-in with yourself
- Reflection on today’s workshop

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