Using ACT to Treat Suicidality

Addressing the Needs of Both the Client and the Practitioner

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The Problem of Suicide

Suicide is the 10th leading cause of death in the United States. For individuals between the ages of 10 and 34, it is the second leading cause of death and for those between 35 and 54, it is the fourth leading cause of death (National Institute of Mental Health, 2019). Suicide is responsible for roughly one death every forty seconds worldwide (National Institute of Mental Health, 2019). Most alarmingly, suicide rates rose by 33% between 1999 and 2017 (National Center for Health Statistics). Despite the growing popularity behind mental health advocacy campaigns and crisis relief efforts and hotlines, actual treatment for suicidal persons remains inadequate (Grohol, 2018).

While effective at reducing immediate suicidal risk (Gould et al., 2017), the primary goal of advocacy and crisis organizations remains connecting an individual to longer-term care with a professional clinician. Unfortunately, even if hotlines are successful in connecting a suicidal person to a provider, the likelihood that the professional has been adequately trained and feels competent in treating suicidality, is low. In fact, 70% of graduate programs in psychology and social work do not offer specific training on treating suicidality (National Alliance for Suicide Prevention). The American Association of Suicidology referred to the training offered as "sporadic" and "in stark contrast to the ongoing calls for improvement in this area" (Schmitz et al., 2012).

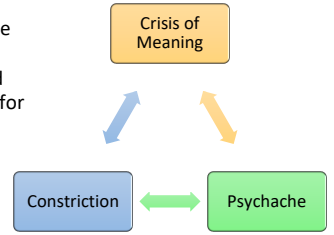
The Role of Clinician Fear

One of the reasons that adequate training and treatment of suicide continues to be a problem is clinician fear. . Despite numerous studies (e.g., Kyron, Hooke & Page, 2018) highlighting the need for clinicians to assess more frequently and thoroughly for suicide, the fear associated with one's own ability to assess in a competent manner precents many clinicians from ever broaching the topic with their clients. According to Quinett (2019) clinician anxiety plays a role in the avoidance of even assessing for, let alone treating, suicide. This can be conceptualized from both an avoidance learning and self-efficacy perspective.

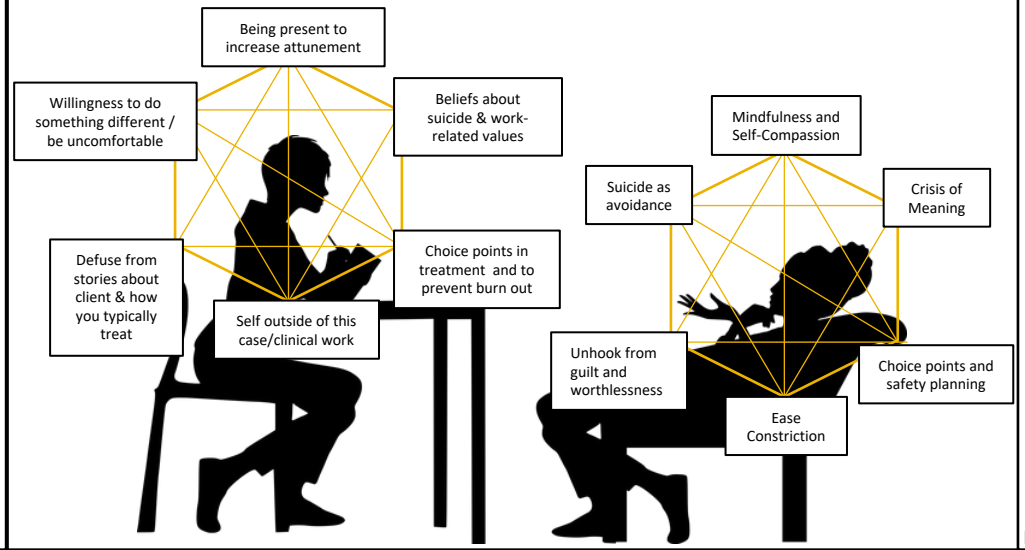
Part of this fear comes from a lack of evidence-based information about what exactly to assess for. In fact, many studies point out that we don't actually know how to assess and treat suicide effectively as a field so even if you did go out of your way to get training, you still might not be effective. This, of course, leads to a long-list of ethical and legal implications for the clinician with suicidal patients. In order to address this missing training need in our field, I suggest that the most effective solution would be to compile the evidence-based treatment information in one place and then find a common framework within which it can be understood so that suicide itself, rather than depression or any other comorbid conditions, becomes a treatable condition. Additionally, we need to consider the clinician's role when explaining how to treat suicide, including fear, burnout, and other factors, otherwise that information will never be utilized.

Understanding Suicidality and an ACT-based Solution

With several decades of evidence, ACT has been shown effective in decreasing symptomatology and increasing overall wellness in various studies (Hayes, Strosahl, & Wilson, 2012). These symptom reductions have been shown for many mental health conditions associated with suicidal behavior, such as depression, anxiety, substance abuse, chronic pain, and even psychosis. ACT has not only shown to be effective, but also popular for both new and seasoned clinicians. In addition to this evidence, ACT is a good fit for suicidality because it addresses several components of suicidality that researchers have found to be common among suicidal persons. These three components come from the research done by the leading names in suicidology and align easily with several components of the ACT hexaflex. They are a crisis of meaning (Schnell, Gerstner, & Krampe, 2018), psychache (Schneidman, 1996), and constriction of thoughts and problem solving techniques (Schneidman, 1996; Chiles, Strosahl & Weiss Roberts, 2019).



Given the impact of clinician fear on suicide assessment and treatment, however, it is clear that when we think about suicide treatment, we need to think about the clinician too. In the model I am proposing, the areas of need along each point of the heaxflex will be explored for both the client and clinician. This will require open, honest, and repeated assessment of the clinician's self but should lead to improved outcomes when working with suicidal, high-risk clients. Some of the areas to address, for both sides of the therapeutic pair, are displayed below.



Appealing to the Healthcare System

In order for this model to become widely utilized, it must appeal to healthcare systems, such as hospitals. This approach of appealing to systems is different from the typical approach of appealing directly to practicing clinicians. However, as organizations buy in to the benefits associated with the model, they will encourage their employees, the clinicians, to utilize it. Therefore, by targeting systems, the utilization and the impact of this model would be increased exponentially. I suggest that the best way to appeal to these systems is by marketing the positive effects this model could have, not only on treatment outcomes and satisfaction ratings from clients, but also on burn-out and retention rates among their employees since these are two very common and costly problems in healthcare systems. To demonstrate how this model could be implemented at an organizational level, I have explained its utilization at three key components of hiring and maintaining a workforce: recruitment, training, and retention.

Hiring:

Utilize a values-based hiring approach to ensure that the employees who are being recruited display a willingness to engage in the proposed model and increase retention rates.

(Gulati., 2016)

Training:

Training staff to utilize this model includes encouraging honest, present-moment-focused self-reflection that can lead to noticing earlier signs of burn-out that are easier to address.

Retention:

Higher work meaning can be created with organizational nostalgia-inducing events, which in turn, lead to lower staff turnover.

(Leunissen, Seikids, Wildschut & Cohen, 2016).

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