PSYCHOTHERAPY FOR SUICIDAL PATIENT

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هیچ بن بستی نیست، یا راهی خواهم یافت یا راهی خواهم ساخت.

نگاهی کلی به خودکشی

- اگرچه، هدف تئوریکی متخصصان بالینی در درجه امکان دارد پیشگیری از همهٔ اقدام به خودکشی ها و خودکشی های کامل باشد، اما این امر واضحاً غیرممکن است. هر چند، کاهش اقدام به خودکشی و خودکشی موفق مطمئناً همه امکان پذیر و و هم قابل اجرا است.
- از آنجایی وجود افکار خودکشی عمدتاً علامتی از یک بیماری روانپزشکی به حساب می آیند، باور بر این است که لازم است بیماری مورد درمان قرار گیرد و نه علامت.
- بیشتر پرسنل اورژانس اقدام کنندگان به خودکشی را به عنوان بارهای غیرضروری تحمیل شده به سیستم های بهداشتی می دانند که با قصد آزاد و اذیت و دستکاری دیگری اتفاق می افتد که این باور عمدتاً برخاسته از ناراحتی ، اضطراب و عدم دانش کارکنان است. یک مطالعه پیگیری اخیر نشان داد که از مجموع ۶۵،۷۸۴ بیمار در مراکز اورژانس کانادا طی یک دوره پیگیری ۵.۳ ساله ۴۱۷۶ نفر فوت کرده اند که ۹۷۶ نفر (۲۳.۴ درصد) به علت خودکشی فوت شدند و بنابراین، این جمعیت را نمی توان یک جمعیت کم خطر در نظر گرفت.

PSYCHOTHERAPY FOR SUICIDAL PATIENTS

- **Boston Suicide Study Group**.
- integrating ideas and techniques from other psychotherapeutic approaches. they have studied and treated many psychiatric patients who have presented with suicidal ideation and plans, among them many who have made serious suicide attempts as well as some completed suicides.
- They synthesize what they have found to be the key elements and successful treatment with suicidal patients. It is not meant to be a comprehensive, systematic review of the literature on psychotherapy with suicidal patients, but rather an opportunity for to share integrative approach

1- APPROACH TO THE PATIENT IN CRISIS

- The therapist needs to assess the degree of imminent risk and to determine whether measures beyond psychotherapy are required to keep the patient safe (e.g., emergency department, psychiatric hospitalization)
- Early establishment of a treatment alliance is facilitated by the therapist's attitude of non-judgmental acceptance and validation of the patient's experience
- Patients generally enter to the clinical encounter feeling terrible about themselves, with feelings of shame, harsh self-criticism/self-attack, and a sense of hopelessness and/or failure.
- The therapist is interested in the patient's "reasons for living" [Malone et al, 2000], including the patient's important relationships such as family (in particularly children), to get a sense of what the patient feels there is in life to live for (gentle confrontation and exploration)

2- INSTILLING HOPE

- The therapist can help to provide such a “road map”, based on an understanding of the gains that can be achieved in the psychotherapeutic process. The patient sustains hope through the therapeutic relationship, symptom management and validation of a core identity and this facilitates a gradual change in perspective on life and living.
- Snyder [2002] described hope as requiring both a sense of agency (sense that one has some capacity to affect positive change) and pathways (a sense of some possible routes for moving forward).

2- INSTILLING HOPE

- This helps the patient to begin to experience a sense of agency, and to have some glimmer of how he or she can survive the current feelings and go on to have a life worth living. Helping to sustain the therapist's hope is the data that suicidal behavior is often a transient phenomenon. Studies have found that the vast majority of people who survive even the most severe suicide attempts actually do not go on to kill themselves [Suominen,, 2004]. Psychotherapy has been found to reduce the risk of recurrent suicide attempts and self-injury [Calati, 2016].

2- INSTILLING HOPE

- person’s ability to tolerate and accept loss, sadness, and disappointment involves a process of grief and mourning for what one had and will never have again, and/or what could have been but will not be

- Over time, the therapist can support the patient in moving from a fixation on what is ideal, to recognizing the possibility of what can be good enough. Early in the process, the "good enough" is often devalued and depicted as not worth living for, but with ongoing reflection, mourning, and support, the patient can learn that it is possible to find meaning and even joy in life with goals and expectations that have shifted in line with what is possible.

3- FOCUS ON INTERNAL EXPERIENCE AND AFFECT

- Shneidman eloquently described suicide as 'a combined movement toward cessation and away from intolerable, unendurable, unacceptable anguish' ("desperation" , "mental pain", "psychache", "emotional dys-regulation", and "annihilation anxiety")
- Hendin et al. [2004] found that therapists reported a higher number of intense, agonizing affective states in patients who completed suicide in the course of psychotherapy, as compared with a severely depressed, non-suicidal comparison group.
- The most frequently cited affect was desperation, defined as a state of anguish accompanied by an urgent need for relief. More recently, Galynker [2018] has focused on "entrapment", an emotional experience of desperation with no perceived way out.

3- FOCUS ON INTERNAL EXPERIENCE AND AFFECT

- The state of "aloneness" has been described as an unbearable experience that makes people feel desperate and puts them at risk for suicidal behavior [Maltsberger, 1998]. Joiner and colleagues have studied a closely related experience, that of "thwarted belongingness", and found it to be a key factor in making completion of suicide possible [Van Orden et al, 2010]. Maltsberger [1998] described aloneness as “an experience beyond hope . . . . This anxiety is the anxiety of annihilation. People will do anything to escape from this experience” (p. 50). The experience can feel timeless, as though once it has started it will continue for every, which adds to the sense of desperation. Aloneness is qualitatively different from loneliness, which is contingent and time limited. It is the loss of capacity to experience the closeness and caring of others, even if they are present and available.

3- FOCUS ON INTERNAL EXPERIENCE AND AFFECT

- In the face of an unrelenting, unbearable affective experience, cognition changes in a way that makes rational problem solving much more difficult. Baumeister [1998] described the suicidal patient as moving into a state of cognitive "deconstruction" (pp. 92–93), characterized by rigidity, increasingly concrete thinking. a narrowing of sense of time to the present and an exclusive focus on immediate goals, and a lack of integration and meaning.

3- FOCUS ON INTERNAL EXPERIENCE AND AFFECT

An unbearable affective experience is distinct from depression. For vulnerable patients, it can come on suddenly, in response to a stressor, at times without the patient making the connection between stress and response. Ideally, psychotherapeutic efforts in the hospital can be targeted toward helping the patient to anticipate and problem-solve for upcoming crises, and to develop a usable and well-practiced crisis plan. It is important for the therapist to be aware that the immediate period post-discharge is very high risk for the patient.

4- ATTENTION TO PATIENTS CONSCIOUS AND UNCONSCIOUS BELIEFS AND FANTASIES

Some patients believe they deserve punishment; others long for a fantasized reunion with lost parents or a loved one; some have a fantasy that they will get to “see” the reaction of others to the suicide, and even that they will experience pleasure in doing so, even while knowing rationally that this is not the case; some experience their body as hateful and want to destroy it, perhaps because it is identified with a past abuser.

Some suicidal contemplation and fantasy can be “self-sustaining”. Rather than facilitating action, these thoughts can help to calm people down and help them regulate affect in a way that helps preclude the need to act on suicide The therapist can reassure the patient about the role of suicidal fantasy, and that thoughts do not equate with action. In fact, in the general population the ratio of those who harbor suicidal thoughts to those who kill themselves is over 200:1 [Baldessarini, 2019].

5- IMPROVING AFFECT TOLERANCE

- Affect tolerance might roughly be defined as increasing one's capacity to think in the presence of strong emotions, and to bear feelings without having to suppress, dissociate, or act impulsively. In Dialectical Behavior Therapy (DBT), emotion regulation and distress tolerance skills are targeted to increase affect tolerance.
- The patient brings his or her sense of shame, humiliation, and feelings of despair to the treatment, often unconsciously fearing negative reaction on the part of the therapist that comes from a template of past relationships. Ideally with validation and support, these feelings can gradually extinguish, giving the patient more flexibility and choice. People are unaware of automatic avoidance defenses and are highly motivated to continue to use them to ward off anxiety provoking and conflictual thoughts and feelings.
- The extinguishing of shame, fear, expectancies of harsh attacks/blame, etc., allows for greater tolerance of affect, increasing the patient's flexibility and freedom of expression.

6- NARRATIVE IDENTITY AND "RELATIONAL SCRIPTS”

people develop a “life story,” described as “an internalized and evolving narrative of the self that selectively reconstructs the past and anticipates the future in such a way as to provide a life with an overall sense of coherence and purpose”

The personal narratives of the depressed or suicidal patient’s self-narrative are generally harshly self-critical and negative (e.g., “Everything I try to do fails I never get things right”). Galynker described the “suicidal narrative” as telling the story of “a present that is so intolerable that the future becomes unimaginable”.

6- NARRATIVE IDENTITY AND "RELATIONAL SCRIPTS"

Early trauma and neglect can lead to a lack of emotional marking of mental images and an inability to recruit these images into meaningful sequences that integrate cognition and emotion. As a result, narratives are disorganized, impoverished, and sometimes frankly incoherent, and "the therapist finds it difficult to comprehend the patient's mental state" (p. 236). This leads to problems with self-cohesion and emotion regulation. Psychotherapy can help the patient to link emotions, mental images narrative fragments, and behavior with a goal of increasing self-coherence

6- NARRATIVE IDENTITY AND "RELATIONAL SCRIPTS"

The infant/child requires recognition and marking of mental and emotional states in order to develop their own capacity to recognize, label, and ultimately modulate emotions [Fonagy, 2003]. This is foundational for the development of mentalization, the ability to appreciate and reflect on the mental states of others. The child who is not recognized and "kept in mind" is bound to have difficulties in self-recognition at multiple levels, and to be more vulnerable to states of disorganization, overwhelming affect, and experiences of aloneness.

The therapist's activity may include what are traditionally thought of as cognitive-behavioral strategies (e.g., problem-solving, modeling alternative ways of relating, exposure, role playing) to help the patient navigate difficult relational situations with the best possible chance to have positive and 'script disrupting' experiences.

7- THE EMERGENCE AND RECOGNITION OF THE PATIENT'S GENUINE CAPACITIES

The emerging recognition and appreciation of one's genuine capacities is a developmental process that can be derailed through trauma or other negative developmental experiences.

Patients who are vulnerable to suicidal states often have anxiety associated with experiencing themselves positively, with harsh self-attack and automatic avoidant defenses that keep them from fully taking in positive relational and other experiences.

Confrontation and exposure creates a positive feedback loop as the patient also begins to act in a way that is consistent with his or her emerging identity and thus is more likely to elicit, and attend to, confirmatory feedback which has been described as a renegotiation of identity

8- CONTINUITY AND COHERENCE

Severe distress becomes unbearable when one loses the capacity to experience connection with others, a state of excruciating aloneness. This becomes even more dire “with the loss of a continuous thread of being that mitigates the sense that now is all there is, that pain will be forever, that there is no hope of moving forward because there is no forward, and that suicide might be the only option” ([Schechter, 2018], p. 34). Recurrent affective dysregulation, mood changes and psychotic experiences can themselves be experienced as traumatic and are disruptive to developing and sustaining continuity and coherence [Maltsberger, 2011].

8- CONTINUITY AND COHERENCE

The therapist, at times, may need to painstakingly help the patient link experiences with each other, reminding the patient that aspects of the past continue to influence the present, and even helping the patient to link dissociated experiences day-to-day. Some patients are vulnerable to feeling suddenly disconnected, alone and desperate, without any sense that something may have happened to cause their change in mental state, and the timeless sense that they will never feel better again. At these moments, the therapist may help the patient through these experiences by inter-session contact of some kind (e.g., phone, email, voice mail), and also by helping the patient to connect feelings with experiences to begin to understand the transient vulnerability to these dissociated states.

9- ATTENTION TO THE THERAPEUTIC ALLIANCE

A related challenge for the therapist is the need to move flexibly between empathic listening and an ongoing suicide risk assessment. Suicidal patients generally have a harshly self-critical internal narrative, and an underlying expectation of negative interpersonal experiences that confirm their bad sense of self.

Transference Focused Psychotherapy (TFP) prioritizes interpreting aggressive, split off, unintegrated parts, and considers this an essential element even early in the course of treatment. Our approach prioritizes attunement to the patient's internal experience (as experienced by the patient), which we see as essential to strengthening the alliance and helping the patient with the experience of aloneness. We conceptualize aggression as most often a secondary response to the patient's internal state of desperation.

9- ATTENTION TO THE THERAPEUTIC ALLIANCE

Interpreting the negative transference, especially for early in treatment, can be experienced as distant and critical, which is antithetical to our goal of the early attunement and validation. In this way, we are very much aligned with the approach in Mentalization Based Therapy (MBT), with an emphasis on validation of the patient's transference feeling, avoiding genetic interpretations that might be experienced as distancing and invalidating [Bateman & Fonagy, 2010].

9- ATTENTION TO THE THERAPEUTIC ALLIANCE

In working with emotionally dysregulated patients, ruptures in the alliance can be particularly abrupt and severe—sometimes in response to something that occurs in the therapy, sometimes related to external stressors—with a risk of affective turmoil and potential for suicidal behavior.

In this reworking of the script, the patient has an opportunity to experience the therapist as caring, and himself or herself as being worthy of being cared about.

Interventions such as between session contact, offering additional sessions, and intermittent telephone, email or text support can help the patient cope with affective intensity when in crisis. These actions may also have internal meaning for the patient, serving to enhance internalization of the therapist as a positive introject [Bateman & Fonagy, 2010].

9- ATTENTION TO THE THERAPEUTIC ALLIANCE

In their classic paper, Maltsberger and Buie [1964] discuss the "countertransference hate" that can arise in the therapist. They describe two components: "malice" which is a more overt experience leading to expression of irritation or anger towards the patient, and the even more concerning "aversion", which represents unconscious emotional withdrawal.

Again, discussion with colleagues and formal consultation can be extremely helpful for the therapist to get out of the intensity of the dyad and to explore his or her feelings about the patient and the treatment.

10- ATTENTION TO COUNTERTRANSFERENCE

Hopelessness can be particularly difficult to bear, and the therapist may feel worn down over time, beginning to accede to the patient's often stated belief that nothing can possibly be of help [Schechter et al, 2011]. In most cases, this is a "countertransference hopelessness" which can unconsciously be communicated to the patient in verbal interaction and also in non-verbal cues.

Patients who have experienced traumatic affective experiences (not just overt trauma and neglect, but also truly overwhelming and unbearable affective experiences and psychotic states) are vulnerable to an erosion of the capacity to fully engage with sustaining relationships [Maltsberger et al, 2011]. In this context, it can be too hard for the patient to sustain hope, and too easy to begin to give up on the ties to loved ones that are life-sustaining.

مداخله در بحران

- ۱- ارزیابی روان شناختی و میزان کشنده بودن
- ۲- رابطه را به سرعت ایجاد کنید: ارتباط چشمی خوب، نگرش غیر قضاوت گرایانه، خلاقیت، انعطاف، نگرش مثبت روانشناختی، تقویت پیشرفت های جزئی و تاب آوری (مدیریت انتقال، عادی سازی موضوع، جملات کوتاه، با تن صدای پایین و خبری)
- ۳- مشکلات اصلی تا بحران های ناگهانی را بشناسید (گوش کردن، درک و تایید- مشاور نباید خودکشی را به عنوان یک گزینه تایید کند، بلکه باید در عوض تایید کند که از نظر مراجع خودکشی تنها گزینه است، مدیریت دوسوگرایی و آرام سازی مراجع و نهایتاً ایجاد چشم اندازی درمانی و زمان خریدن)
- ۴- مدیریت هیجانات: تشویق تخلیه هیجانی، تایید درد هیجانی جهت مسئله گشایی، ایجاد تحمل آشفتگی در مراجع
- ۵- دستیابی به راه حل های جایگزین (عدم تاکید روی راهکار جایگزین و مشاهده خودکشی به عنوان یک راهکار)، ایجاد چارچوب حل مسئله، توجه به حمایت اجتماعی و نهایتاً امیدبخشی به مراجع
- ۶- تکمیل برنامه اجرایی: اجرای برنامه امنیت (قراردادهای امنیت)

روان درمانی های دارای پشتوانه پژوهشی

- سه درمان روانشناختی در حوزه خودکشی از پشتوانه تجربی مناسبی برخوردار هستند:

1. Dialectical Behavior Therapy (DBT)
2. Cognitive Therapy for Suicide Prevention (CT-SP)
3. Collaborative Assessment and Management of Suicidality (CAMS).

رفتاردرمانی دیالکتیکی

- DBT نوعی از درمان شناختی و رفتاری است که عمدتاً برای افرادی دارای رفتار خود آسیب رسان با تشخیص اختلال شخصیت مرزی تدوین گردید. درمان شناختی رفتاری یک درمان تغییر محور است، ولی رفتاردرمانی دیالکتیکی هنگامی مراجع احساس عدم درک از سوی درمانگر را دارد، رویکرد پذیرش محور و هنگام انگیزه مراجع برای تغییر رویکرد تغییر محوری اتخاذ می کند.
- درمان چهار جزء دارد: ۱- مهارت آموزی عمدتاً گروهی، ۲- درمان انفرادی برای تقویت مهارت ها و مورد رسیدگی قرار دادن موانع تغییر، ۳- مشاوره تلفنی از درمانگر و ۴- تیم درمانگران
- البته پژوهش مک مین و همکاران (۲۰۰۹) به این نتیجه دست یافت که احتمالاً این درمان تاثیر زیادی روی کاهش نشانه ها و رفتارهای خودکشی نسبت به مدیریت روانپزشکان مجرب ندارد. از سویی، این پژوهش ها عمدتا روی زنان انجام شده است، درحالی که ۸۰ درصد کسانی که به علت خودکشی فوت می شوند، مرد هستند.

شناخت درمانی برای پیشگیری از خودکشی

- در این رویکرد باور بر این است که بایستی عوامل خطر خودکشی را کاهش داد و همچنین، به جهت حذف رفتار خودکشی گرا بایستی راهبردهای مقابله ای فرد را بهبود دهیم.
- بایستی Suicidal mode فرد مورد هدف قرار گیرد (الگوی فکری، رفتاری و بین فردی منجر به خودکشی)
- با آموزش راهبردهای مقابله ای به فرد، استرسورها و مشکلات دیگر کارکردی برای برانگیزاندن رفتار خودکشی در فرد نخواهند داشت.

EFFECTIVENESS OF COGNITIVE THERAPY FOR SUICIDE PREVENTION

CT-SP was first investigated using a sample of 120 patients (61 % women) who had attempted suicide and were subsequently recruited from an emergency room following their attempts [Brown et al, 2005]. The investigators conducted an efficacy-based RCT comparing CT-SP and TAU over 10 individual treatment sessions. At an 18-month follow-up, they found that patients in CT-SP condition were 50 % less likely than patients in TAU to make a repeat suicide attempt. The CT-SP patients were also found to be less depressed and more hopeful as a result of the treatment (Brown et al, 2005)

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY (CAMS)

The clinician and patient engage in a highly interactive assessment process and the patient is actively involved in the development of their own treatment plan. Every session of CAMS intentionally utilizes the patient's input about what is and is not working. All assessment work in CAMS is collaborative; we seek to have the patient be a "co-author" of their own treatment plan.

In terms of CAMS philosophy, the clinician's honesty and forthrightness are key elements. For any patient teetering between life and death, there can be no more important component of care than direct and respectful candor when suicidal risk is present. The CAMS clinician endeavors to understand their patient's suffering from an empathetic, non-judgmental, and intra-subjective perspective. The clinician never shames or blames a suicidal person for being suicidal; we endeavor to understand this struggle through the eyes of the suicidal patient.

BRIEF INTERVENTIONS FOR SUICIDAL RISK

- **1- Stabilization-oriented interventions**:Some of the more prominent of these are Safety Planning, Crisis Response Planning, and the SSF Stabilization Plan that is used within CAMS. Probably the best known of these interventions is the Safety Planning Intervention (SPI) developed by Stanley and Brown [2012]. A typical Safety Plan Intervention lasts about 20–45 min, during which the clinician and patient identify warning signs that might precipitate a suicidal crisis. The dyad then proceeds to develop a six-step hierarchical list of internal coping strategies, and external sources of social and professional support.

BRIEF INTERVENTIONS FOR SUICIDAL RISK

- 2- **Teachable Moment Brief Intervention**: O'Connor and colleagues [2015] developed the Teachable Moment Brief Intervention (TMBI) which aims to foster change during a key window of opportunity following a suicide attempt [McBride et al, 2003]. The TMBI follows research showing that cueing events are subjected to different interpretations and thus can create the opportunity to increase motivation to change risky health behaviors [O'Connor and colleagues , 2015].
- 1) drivers of suicidal ideation, 2) functional aspects of the recent suicide attempt, 3) the patient's relationship with the concept of suicide, 4) what has been lost and gained as a result of the suicide attempt, 5) short term management suicide prevention management strategies, and 6) documentation of factors to address in a suicide-specific treatment plan.

BRIEF INTERVENTIONS FOR SUICIDAL RISK

- **3- Motivational interviewing** : is a patient-centered approach used to foster a patients' intrinsic desire to change their health behaviors by resolving ambivalence and it has recently been adapted for addressing suicide ideation [Britton, 2011]. Based on Kovocs and Beck's internal struggle hypothesis [1977] (which postulates that suicide is a result of the inner struggle between one's wish to live and wish to die), the goal of the motivational interviewing to address suicide ideation (MI-SI) is to increase patients' motivation to live, so as to reduce their overall risk of suicide [Britton, 2011].

BRIEF INTERVENTIONS FOR SUICIDAL RISK

- **4- Attempted suicide short intervention program:** The ASSIP is comprised of three sessions, each of which lasts about 60 to 90 min. In the first session, patients are asked to narrate their stories to the clinician that led up to their suicide attempts, which are video recorded and then played back to the dyad in the following session. The goal of this is to reenact the progression of their suicidal crisis in a controlled environment, so that the clinical dyad can create a psychoeducational handout by the end of the second session. In the third session, the clinician presents a case conceptualization that is revised collaboratively with the patient; a list of warnings signs and individualized safety strategies are given to the patient to keep with them
- In a 2-year follow-up of the RCT (n=120), the ASSIP group was found to have an 80 % reduction in repeated suicide attempts when compared to the TAU group [31]. Additionally, those in the ASSIP group spent significantly fewer days within psychiatric hospital care.

BRIEF INTERVENTIONS FOR SUICIDAL RISK

- **4- Attempted suicide short intervention program:** The ASSIP is comprised of three sessions, each of which lasts about 60 to 90 min. In the first session, patients are asked to narrate their stories to the clinician that led up to their suicide attempts, which are video recorded and then played back to the dyad in the following session. The goal of this is to reenact the progression of their suicidal crisis in a controlled environment, so that the clinical dyad can create a psychoeducational handout by the end of the second session. In the third session, the clinician presents a case conceptualization that is revised collaboratively with the patient; a list of warnings signs and individualized safety strategies are given to the patient to keep with them
- the ASSIP group was found to have an 80 % reduction in repeated suicide attempts when compared to the TAU group [Gysin-Maillart, 2015].

Thanks for Attention