A Dialectical Behaviour Therapy Approach to Managing Suicidal Behaviours:

Assessment and Treatment for Adolescents and their Families

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NZCCP Conference 2011

GOALS OF THE WORKSHOP

1. Learning a model to assess imminent and long-term suicide risk
2. Strategies to assess and treat acute and chronic patterns of suicide and NSIB behaviours
3. Using a suicide crisis protocol to guide the treatment of suicidal behaviours in a crisis
4. Understanding strategies to help manage risk in families

Non-suicidal Self-Injurious Behaviours

- The functions of NSIB can include self-punishment, regulation of emotion, help-seeking etc.
- NSIB = “the deliberate, direct destruction or alteration of body tissue, without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur.” (Gratz, 2003, p.192)
- In 2008 in NZ the highest number of hospitalisations for intentional self-harm and the highest age-specific rate was that of 15-19 year olds.

2008 NZ Statistics
(Ministry of Health, 2010)

- 497 people died by suicide in 2008
- Ratio of male to female was 2.9:1
- The peak age group for male suicide rates was 20-24 yrs and for female was 15–19 yrs: 13.9 deaths per 100,000.
- 15-24 yrs: 81 male youth suicide deaths (25.7% per 100,000) and 34 female youth suicide deaths (11.1 per 100,000 – **the highest rate for this group since 1999**)
- Maori youth suicide rate was 27.6% per 100,000 (70% higher than that of non-Maori youth.
- Age 10-14 years – 1 male and 2 female suicides
- Highest suicide mortality rates were males, Maori, youth (15-24 yrs) and those residing in the most deprived (quintile 5) areas.

- 8.8% attempt suicide (=1 million teens, of whom 700,000 receive medical attention).
- Up to 11% of teens suicide attempters will eventually die by suicide (Diekstra, 1989; Shaffer et al., 1988).
- Up to 77% of adolescents who attempt suicide fail to attend or complete treatment (Trautman et al., 1993).
- Adolescents with multiple problems are more at risk to suicide and risk increases exponentially.

What works for suicidal and self-harm behaviour? (Cochrane Review, 2007)

- Intensive aftercare & outreach compared with TAU
- Antidepressants compared with placebos

and maybe

- Problem-solving therapy compared with TAU
- Emergency contact cards & TAU compared with TAU alone

Service Implications

- If access to service is contingent on suicidal or self-harm acts/communications, there's a higher likelihood of those behaviours.
- This has implications for how services manage
  - Crisis calls
  - Referral criteria
- If a service wants to try to reduce the long-term risk of suicide for young people with a history of repeated self-harm or suicide attempts, programmes that seem to have the best chance of success have these characteristics:
  - Intensive community outreach
  - Behavioural orientation (e.g. CBT, DBT)
  - Problem-solving skills
  - Therapy for caregivers

Principles that might guide work with adolescents with suicidal and self-harm behaviour

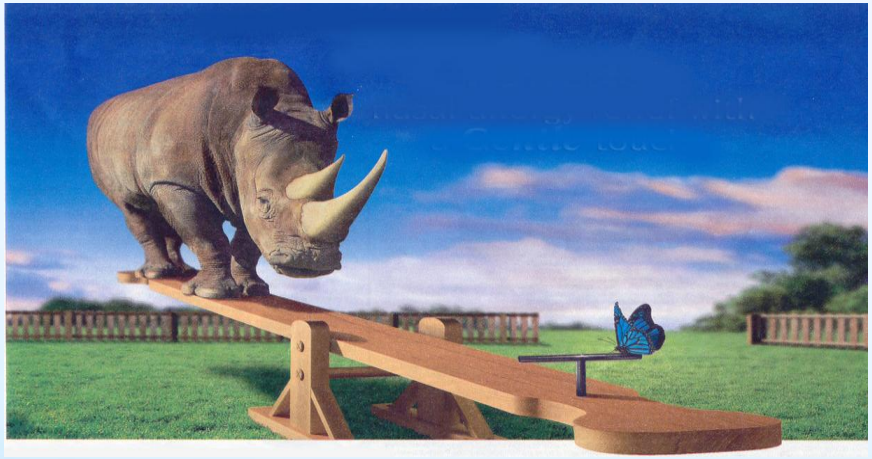
- Suicidal and self-harm behaviour is affected by what happens before and after it occurs
- Suicidal adolescents will be even more influenced by modelling than their adult counterparts
- Clinicians working with this client group need work environments that support their willingness and capabilities
- Treatments that include family have a better chance of success

Implications for Outpatient Treatment

- Sessions have to be happening often enough so that there is some time to work on skill acquisition and solving longer-term problems that degrade the young person's quality of life.

- The service context has to support reaching out to young people and families who could be lost to therapy.

DBT Randomised Clinical Trials have been shown to be superior to comparison treatments in the…



- Reduction in self-harm and suicide attempts, drug abuse, emergency room visits, inpatient admissions, and treatment dropout, as well as improvements in behaviors interfering with quality of life (e.g., depression, hopelessness, anger, impulsiveness).
- Effective for other problems related to emotion dysregulation (e.g. heroin addiction, depression in elderly, binge-eating disorder).

DBT Research with Adolescents

Randomised Clinical Trials:

- University of Oslo (Norway)
  Suicide Prevention and Research Unit (in progress)
  - 16 weeks of DBT-A vs. TAU
  - Suicidal adolescents with BPD features

- New Zealand (Emily Cooney, PI): Randomised Control Feasibility study
  - 24 weeks of DBT vs. TAU
  - Entry criteria one incidence of self-harm or suicidal behaviour in the past 12 weeks
  - 12 month follow-up
  - Initial results: DBT very acceptable to families and clinicians, high retention rate, therapists adherent to the treatment, additional family therapist important, 24 hour phone coaching acceptable and important to therapy

Non-RCTs:

- Rathus & Miller, (2002)
  - 12-week outpatient (suicidal/BPD features)
  - Preliminary results for DBT – A:
    - Reduces suicidal ideation and hospitalizations
    - Increases treatment retention
    - Reduces depression, anger, anxiety, and interpersonal sensitivity (SCL90)
    - Reduces borderline symptomatology (confusion about self, interpersonal chaos, emotional dysregulation, impulsivity)

Rathus, J. & Miller, A., 2002. Dialectical behavior therapy adapted for suicidal adolescents. Suicide and Life Threatening Behavior 32 (2)

- Katz, et al., (2004)
  - 2-week inpatient (suicidal)
  - Less behavioural incidents

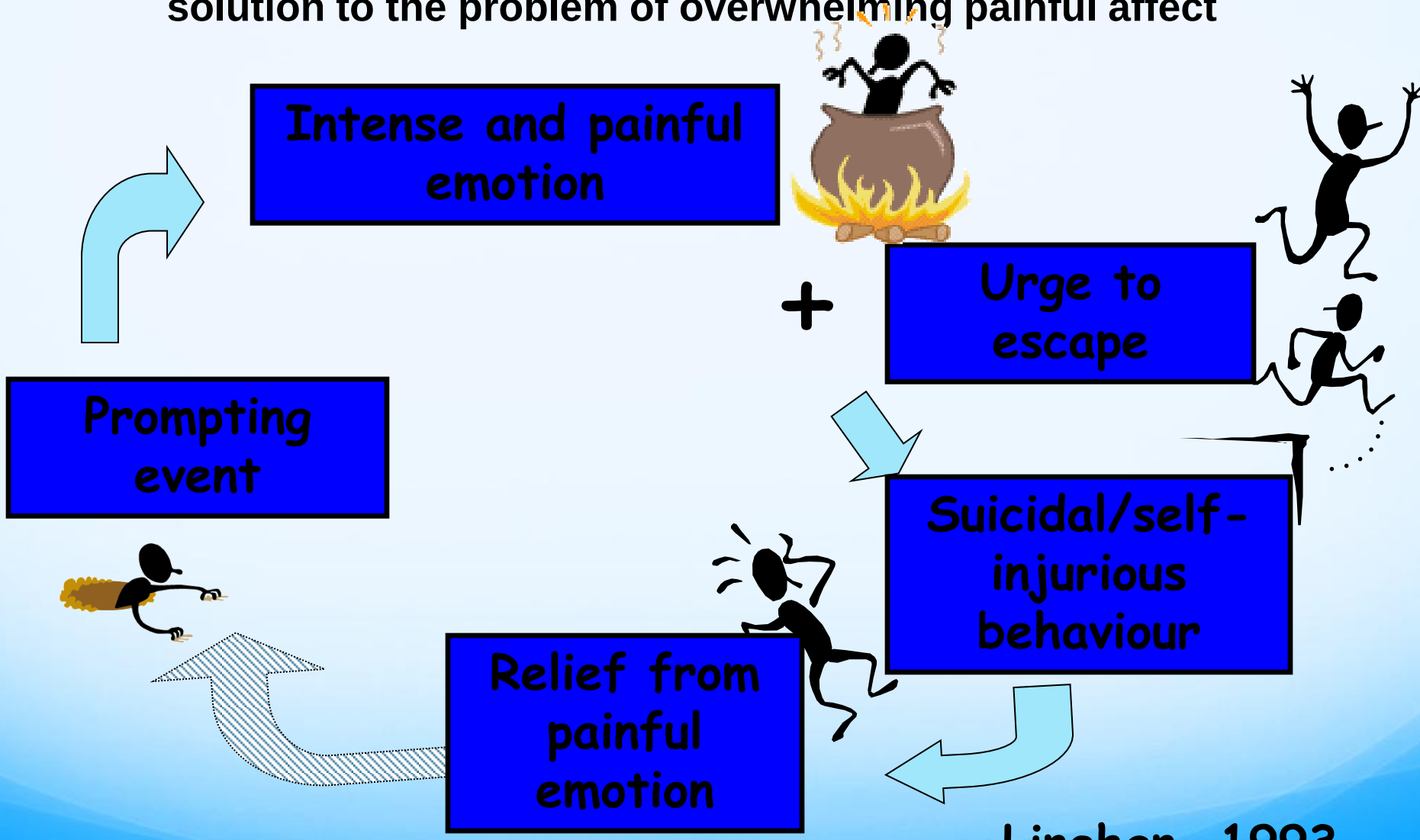
- Nelson-Gray, et al., (2006)
  - 16-week outpatient skills group (ODD)
- Flieschhaker et al., (2006)
  - 16-week outpatient (suicidal/BPD features)
- Goldstein, et al., (2007)
  - 1 year outpatient (bipolar)
  - Good tx adherence; feasible to deliver; acceptable to families; high retention; improvements in sx/NSIB behaviour, emo dysregulation and depressive sumptoms, less hospitalisation.
- Salbach, et al., (2008)
  - 25-week outpatient (anorexia/bulimia)
- Woodberry, et al., (2008)
- James, et al., (2008) (DSH)

DBT Conceptualises Suicidal Behaviours as…

- A result of two interacting conditions:

1. a lack of essential interpersonal, self/emotion-regulation, and distress tolerance skills and capabilities
2. environmental and personal factors that may inhibit the use of the skills the person already has (or the development of new skills and capacities).

Problem-solving model of suicide: Suicidal & self-harm behaviour as a solution to the problem of overwhelming painful affect



Linehan, 1993, 1999

Why DBT is such a useful therapy for this client group..

- Teaching specific skills for tolerating distress, regulating emotion, being interpersonally effective, mindfulness
- Use of target hierarchy to guide therapy
- Targets treatment noncompliance
- Addresses directly suicide risk characteristics with corresponding skills
- Provides support for the therapist (consult team / nonjudgmental & compassionate stance)
- Assists in the generalisation of skills

- Phone coaching
- Structuring the treatment environment to motivate, reinforce, and individualise appropriate use of skills
- Community of therapists treating a community of clients
- Targets family dysfunction (family therapy & skills)
  - Family behavioural analyses
  - Target invalidation
  - Ineffective use of contingency management
  - Skills deficits (particularly interpersonal)

Adolescent Modes

- Outpatient Individual Therapy
- Multi-Family Skills Training Groups
- Telephone Coaching for Teens and Family Members
- Family Sessions (as needed)
- Therapist Consultation Meeting
- Uncontrolled Ancillary Treatments
  - Pharmacotherapy
  - Therapeutic/Residential Schools
- Graduate Group

Primary Therapist

- DBT requires each client to have only one primary therapist who is responsible for treatment planning and progress, management of crisis behaviours and integrating all modes of therapy.
- At the start of therapy
  - Identify client goals and life worth living
  - Use behaviour analyses to assess thoroughly past suicidal and self-harm behaviour
  - Get an agreement to not engage in suicidal behaviour or at least an agreement to attend therapy knowing the primary goal is to reduce suicidal behaviour

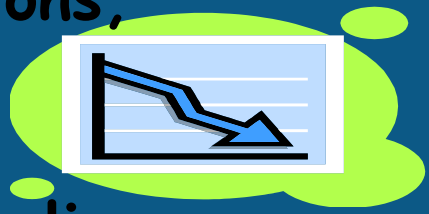
- Never leave suicidal behaviour unattended in session
- Balance the focus on suicidal behaviour vs. client goals
- Set up contingencies early, focus on reinforcing effective behaviour (e.g., you will be able to contact me more if you are not in crisis)
- Have a clear crisis management plan agreed upon by the client, family, consult team, management
- Balance consult to client vs. structuring the environment
- Follow the 24 hour rule
- Involve the client in being responsible for her own treatment plan, structuring the environment e.g., dealing with teachers, group facilitators

BIO-SOCIAL THEORY

BIO:

There is a biological vulnerability to emotions

1. **Sensitive to emotions,**
2. **Reactive**
3. **Slow return to baseline**



And an inability to effectively regulate emotions

IN COMBINATION WITH…

SOCIAL:

An invalidating environment communicates that what you are feeling, thinking, or doing is inaccurate, inappropriate, or wrong.

The environment often rejects, punishes and makes you feel 'less than' – and then you may begin to invalidate yourself…

This doesn't have to be anyone's fault. Sometimes it's because there is a "poor fit" between the individual and the environment.

My teacher yelled at me in front of everyone for no reason – it was horrible

You must have done something to annoy her – you've got to learn to do as you're told

Thought: Everyone's always picking on me. I'm so useless

Can you give me a hand with the dishes

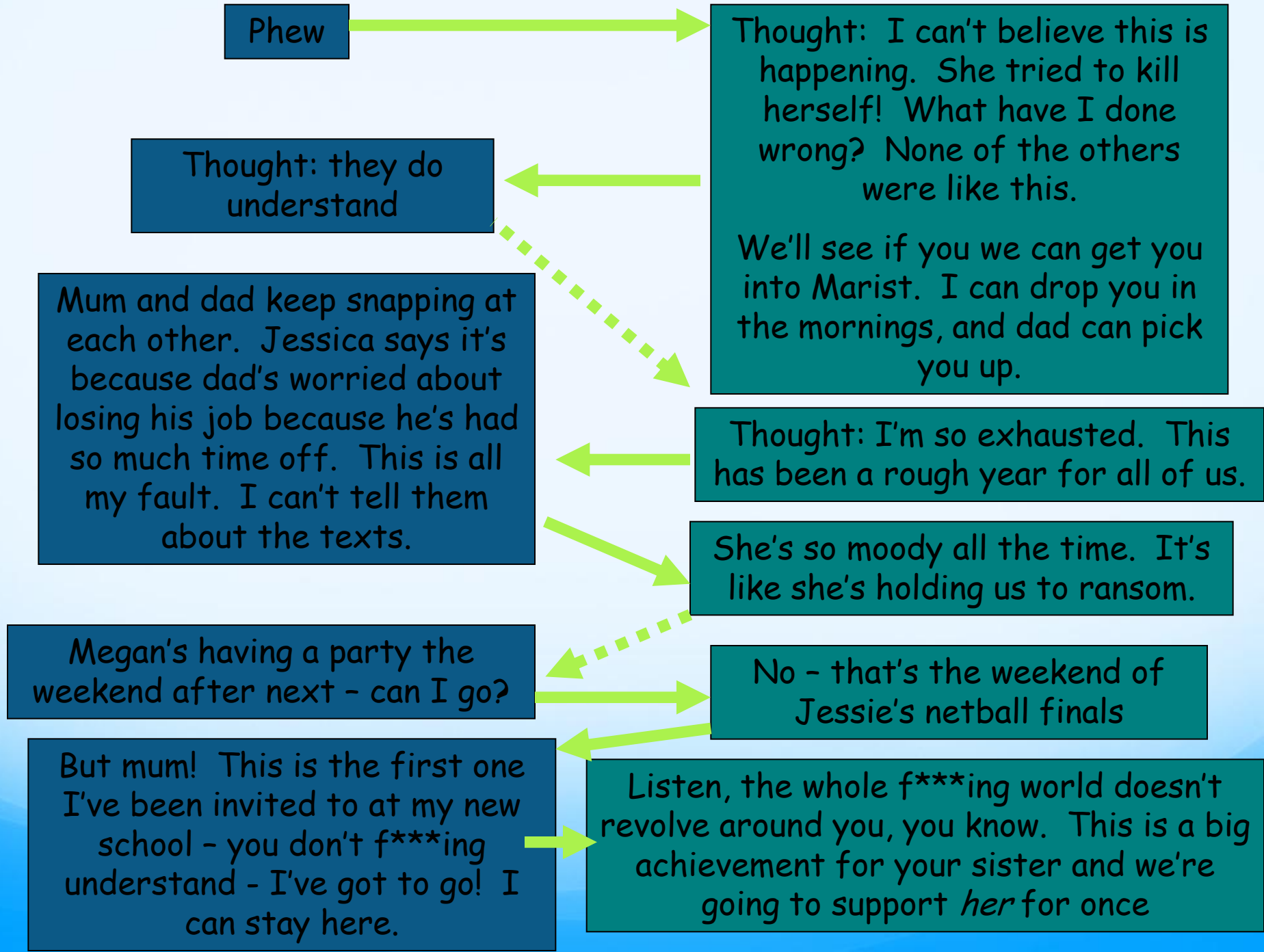
She was really sarcastic to me today, and everyone laughed. Can I change schools?

What makes you think it'll be different somewhere else? You have to learn to deal with problems, not run away from them.

Thought: I'm such a loser and nothing's ever going to change. I might as well kill myself.

Overdose

Oh my God, I had no idea things were so terrible. You can't go back there. We need to get you help.


Phew
Thought: I can't believe this is happening. She tried to kill herself! What have I done wrong? None of the others were like this.
We'll see if you we can get you into Marist. I can drop you in the mornings, and dad can pick you up.
Thought: they do understand
Mum and dad keep snapping at each other. Jessica says it's because dad's worried about losing his job because he's had so much time off. This is all my fault. I can't tell them about the texts.
Thought: I'm so exhausted. This has been a rough year for all of us.
She's so moody all the time. It's like she's holding us to ransom.
Megan's having a party the weekend after next – can I go?
No – that's the weekend of Jessie's netball finals
But mum! This is the first one I've been invited to at my new school – you don't f***ing understand - I've got to go! I can stay here.
Listen, the whole f***ing world doesn't revolve around you, you know. This is a big achievement for your sister and we're going to support *her* for once

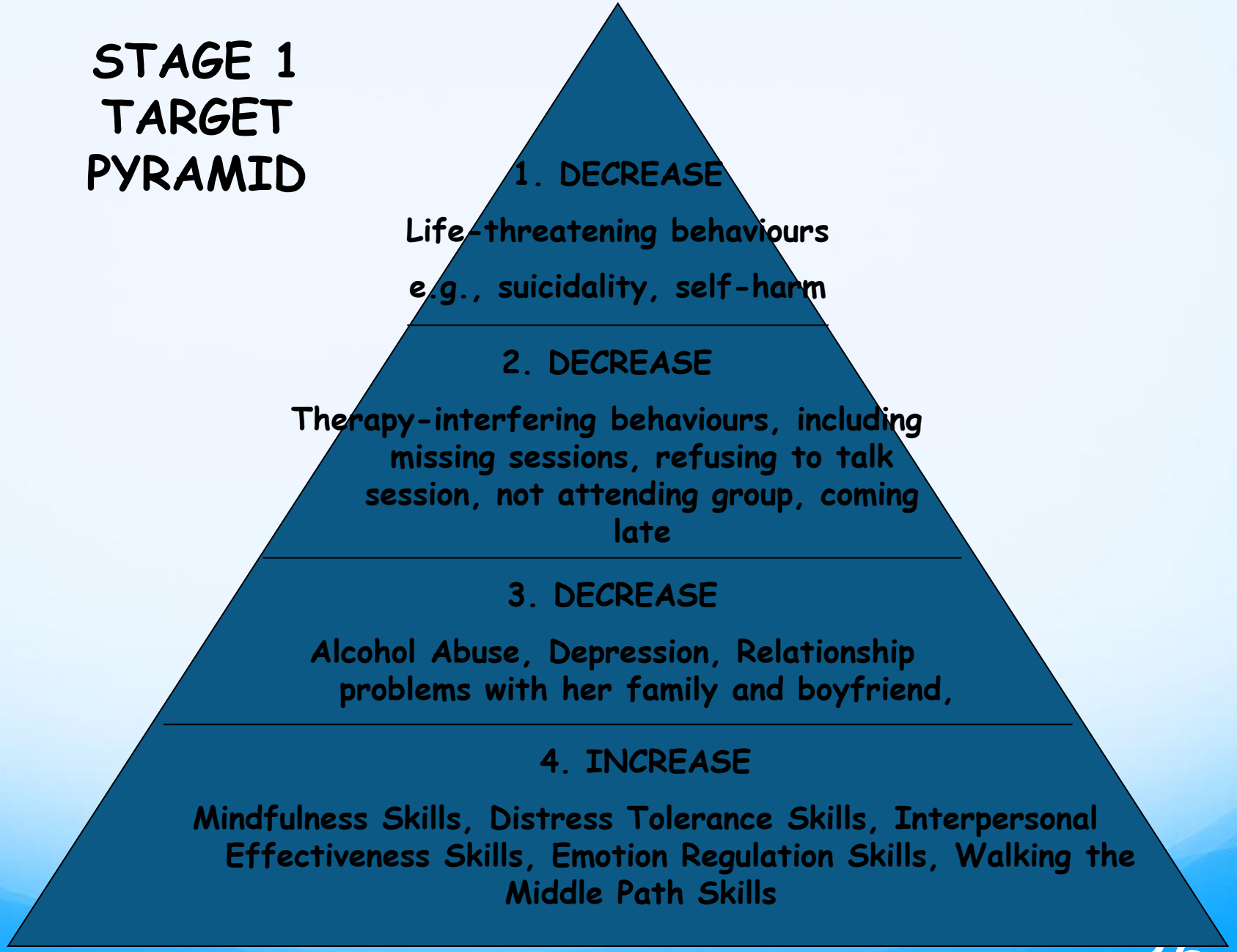
An Invalidating Environment…

1. INDISCRIMINATELY REJECTS communication of private experiences and self-generated behaviors.
2. PUNISHES emotional displays and INTERMITTENLY REINFORCES emotional escalation.
3. OVER-SIMPLIFIES ease of problem solving and achieving goals.

Leads an individual to

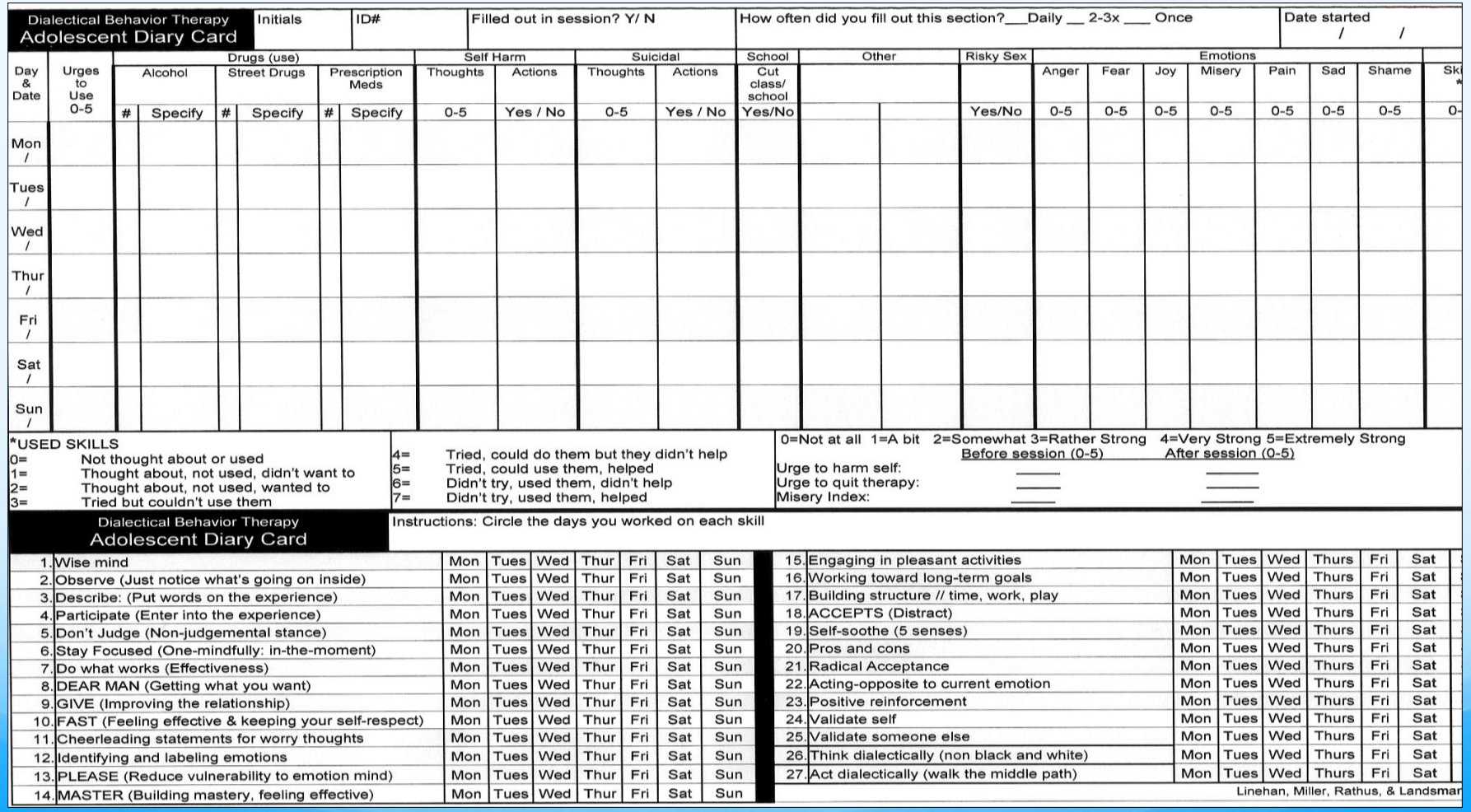
1. Actively self-invalidate and search social environment for cues about how to respond.
2. Oscillate between emotional inhibition and extreme emotional styles.
3. Form unrealistic goals and expectations.

STAGE 1 TARGET PYRAMID



Targeting

Start with diary card to organize session agenda



Dialectical Behavior Therapy
Adolescent Diary Card

Initials | ID# | Filled out in session? Y/ N | How often did you fill out this section?___Daily __ 2-3x ___ Once | Date started / /

Day & Date	Urges to Use 0-5	Drugs (use): Alcohol #	Alcohol Specify	Street Drugs #	Street Drugs Specify	Prescription Meds #	Prescription Meds Specify	Self Harm: Thoughts 0-5	Self Harm: Actions Yes / No	Suicidal: Thoughts 0-5	Suicidal: Actions Yes / No	School: Cut class/ school Yes/No	Other		Risky Sex Yes/No	Emotions: Anger 0-5	Fear 0-5	Joy 0-5	Misery 0-5	Pain 0-5	Sad 0-5	Shame 0-5	Sk* 0-
Mon /																							
Tues /																							
Wed /																							
Thur /																							
Fri /																							
Sat /																							
Sun /																							

*USED SKILLS
0= Not thought about or used
1= Thought about, not used, didn't want to
2= Thought about, not used, wanted to
3= Tried but couldn't use them
4= Tried, could do them but they didn't help
5= Tried, could use them, helped
6= Didn't try, used them, didn't help
7= Didn't try, used them, helped

0=Not at all 1=A bit 2=Somewhat 3=Rather Strong 4=Very Strong 5=Extremely Strong

	Before session (0-5)	After session (0-5)
Urge to harm self:	____	____
Urge to quit therapy:	____	____
Misery Index:	____	____

Dialectical Behavior Therapy
Adolescent Diary Card

Instructions: Circle the days you worked on each skill

1.	Wise mind	Mon	Tues	Wed	Thur	Fri	Sat	Sun
2.	Observe (Just notice what's going on inside)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
3.	Describe: (Put words on the experience)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
4.	Participate (Enter into the experience)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
5.	Don't Judge (Non-judgemental stance)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
6.	Stay Focused (One-mindfully: in-the-moment)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
7.	Do what works (Effectiveness)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
8.	DEAR MAN (Getting what you want)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
9.	GIVE (Improving the relationship)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
10.	FAST (Feeling effective & keeping your self-respect)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
11.	Cheerleading statements for worry thoughts	Mon	Tues	Wed	Thur	Fri	Sat	Sun
12.	Identifying and labeling emotions	Mon	Tues	Wed	Thur	Fri	Sat	Sun
13.	PLEASE (Reduce vulnerability to emotion mind)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
14.	MASTER (Building mastery, feeling effective)	Mon	Tues	Wed	Thur	Fri	Sat	Sun
15.	Engaging in pleasant activities	Mon	Tues	Wed	Thurs	Fri	Sat	
16.	Working toward long-term goals	Mon	Tues	Wed	Thurs	Fri	Sat	
17.	Building structure // time, work, play	Mon	Tues	Wed	Thurs	Fri	Sat	
18.	ACCEPTS (Distract)	Mon	Tues	Wed	Thurs	Fri	Sat	
19.	Self-soothe (5 senses)	Mon	Tues	Wed	Thurs	Fri	Sat	
20.	Pros and cons	Mon	Tues	Wed	Thurs	Fri	Sat	
21.	Radical Acceptance	Mon	Tues	Wed	Thurs	Fri	Sat	
22.	Acting-opposite to current emotion	Mon	Tues	Wed	Thurs	Fri	Sat	
23.	Positive reinforcement	Mon	Tues	Wed	Thurs	Fri	Sat	
24.	Validate self	Mon	Tues	Wed	Thurs	Fri	Sat	
25.	Validate someone else	Mon	Tues	Wed	Thurs	Fri	Sat	
26.	Think dialectically (non black and white)	Mon	Tues	Wed	Thurs	Fri	Sat	
27.	Act dialectically (walk the middle path)	Mon	Tues	Wed	Thurs	Fri	Sat	

Linehan, Miller, Rathus, & Landsmar

ASSESSING IMMINENT AND CHRONIC RISK OF SUICIDAL BEHAVIOURS

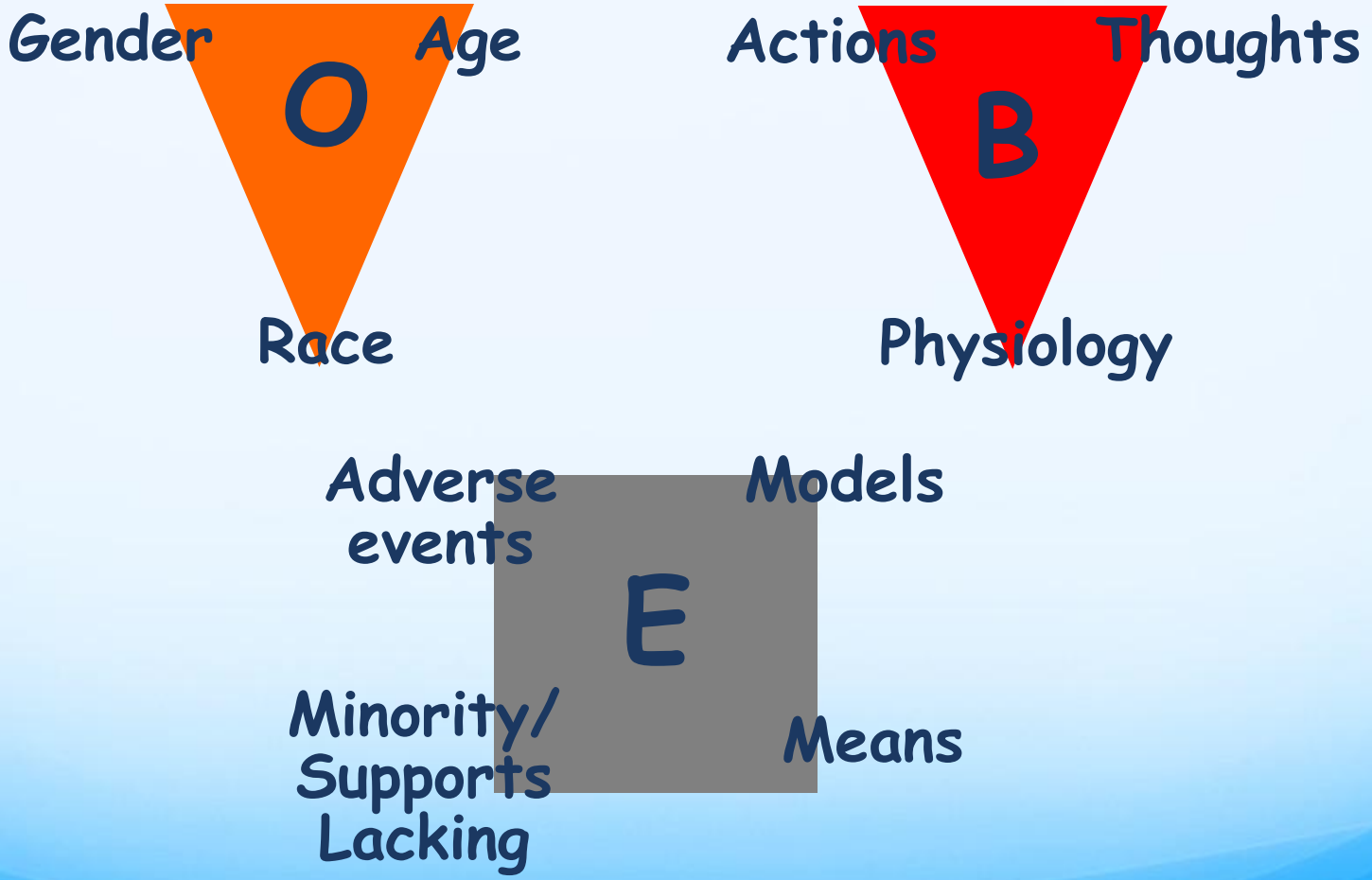
- The particular response to suicide crisis behaviours depends on:
  1. The assessed likelihood of suicide
  2. The function of the behaviour
  3. The therapists assessment of the patients capabilities to change to more adaptive problem solving
  4. Which behaviours the therapist is ‘willing’ to reinforce.

DBT recommendations for treating suicidal behaviours for people in treatment

- Know long-term, short-term and immediate (likely to occur in the next few hours/days) risk factors for your client group off by heart
- Use these to evaluate a young person's risk
- Use the factors relevant to that family to inform your treatment
- Identify a given treatment component for each risk factor

Linehan, 1993, 1999

FACTORS ASSOCIATED WITH THE LONG-TERM RISK OF SUICIDAL BEHAVIOUR



Linehan, 1981, 1993

GENERAL RISK FACTORS FOR ADOLESCENT SUICIDAL BEHAVIOUR

(Miller, Rathus & Linehan, 2007)

DISTAL RISK FACTORS

- PERSONAL
  - Gender
  - Age
  - Ethnicity/SES
  - Sexual orientation
- ENVIRONMENTAL
  - Losses
  - Disturbed family context
- BEHAVIOURAL
  - Prior suicidal behaviours
  - Mental disorders/comorbidity
  - Depression/Anxiety/BPD
  - Impulsive/disruptive/antisocial behaviours
  - Substance use

PROXIMAL RISK FACTORS

- PERSONAL
  - Insomnia
  - Functional impairment from physical disease and injury
- ENVIRONMENTAL
  - Friend/family completed suicide
  - Academic difficulties, school dropout
  - Poor parent child communication
  - Access to means for suicide
- BEHAVIOURAL
  - Poor interpersonal problem solving
  - Low social involvement

FACTORS ASSOCIATED WITH IMMINENT RISK OF SUICIDAL BEHAVIOUR

- **Indirect indices**
  - High risk population
  - Recent discharge
  - Indifference to/dissatisfaction with therapy
  - Recent medical care
  - References to own death
  - Abrupt clinical change
  - Recent relationship difficulties

- **Direct indices**
  - Ideation
  - Threats
  - Planning
  - Preparation
  - NSIB in last year especially if suicide intent expressed

Linehan, 1981, 1993

INDICES THAT SUICIDE MAY OCCUR WITHIN THE NEXT FEW HOURS/DAYS

- Severe insomnia, panic attacks, mood cycling
- Alcohol consumption
- Suicide note
- Availability of means
- Being alone
- Precautions against discovery/intervention

Linehan, 1981, 1993

Appendix 2:Pathways to suicidal behaviour
New Zealand Suicide Prevention Strategy 2006–2016
(Associate Minister of Health 2006)

Contextual factors

1. Cultural factors
2. Institutional settings
3. Media climate
4. Physical environment

Suicidal behaviour

Suicide, suicide attempts, deliberate Self-harm, suicidal ideation

Mental health problems

Individual factors e.g., personality, genes
Exposure to trauma e.g., family violence, child abuse, bullying
Family factors e.g., parental separation, mental illness
Life events e.g., marital/legal/financial problems, unemployment, discrimination
Social supports e.g., social isolation, living alone
Socioeconomic factors e.g., income, education, housing, mobility
Cultural factors e.g., extent of acculturation, integration, autonomy, language, identity
Macrosocial/economic factors e.g., economic restructuring, divorce, birth, unemployment rates

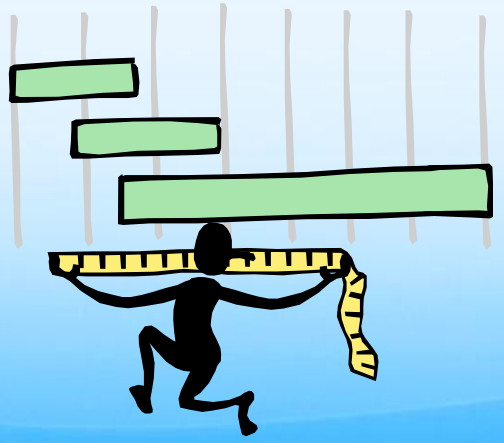
DECISION CHART

1) Collect demographic information
2) Review clinical and historical indicators
3) Decide whether the information indicates sufficient risk to warrant further assessment
4) Assess suicide risk directly
5) Estimate the level of risk and use this to guide response
6) Estimate imminence of risk
7) Implement treatment

Fremouw et al., 1990, cited by Bongar, 2006

ASSESSMENT INSTRUMENTS

- Self report questionnaires
  - Beck Hopelessness Scale
  - Scale for Suicidal Ideation
  - Reasons for Living Inventory
- Structured interviews
  - Suicide and self-injurious behaviour interview



CLINICAL INTERVIEW

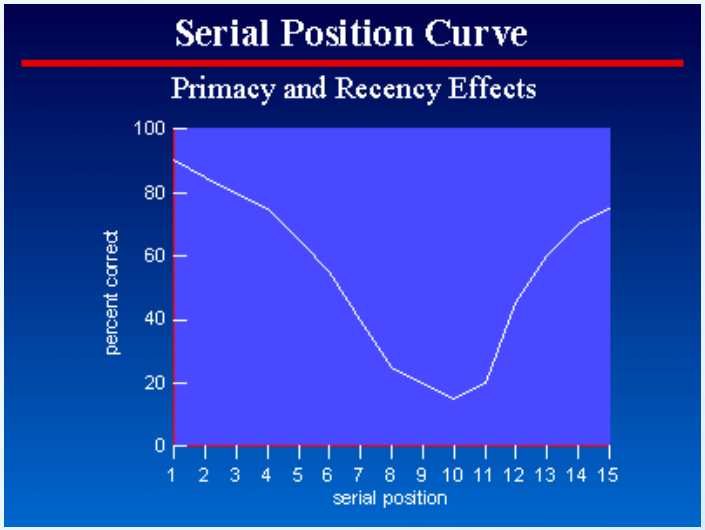
- Detailed history of self-harm and suicide attempts (including precipitating events, methods, number of each method, onsets, most recent episode, most lethal episode, consequences, and beliefs about consequences)
- Means
- Beliefs about what happens after suicide
- Reasons for living

WHEN CONDUCTING AN ASSESSMENT

- Be open, direct, and matter-of-fact when asking about suicide
- Avoid pejorative or dismissive language
- Begin the interview by scheduling a post-interview distress management plan.
- This will involve identifying activities that are soothing for the person, and people in their lives whom they find supportive.

TAKE ADVANTAGE OF THE PRIMACY AND RECENCY EFFECTS

- If concerned about the possibility of trauma or increased distress as a result of suicide risk assessment, time these questions for the middle of an assessment interview
- Conclude the suicidal behaviour history and suicide risk assessment section of the interview by enquiring about the person's reasons for living
- Complete the interview by reviewing the post-interview plan again



RISK – GENERAL PRINCIPLES cont.

- Routinely track risk (using a diary card that obtains daily ratings of suicidal urges, self-harm urges, self-harm acts, and suicidal acts)
- When there's a communication of suicidal or self-harm urges in contact (either in self-report or the diary card), complete a risk assessment.
- With chronic urges, assess if there's a 3-point spread or more across diary card ratings – e.g.
  - a person consistently gives '5's each day, and then turns in a card with a 2 on one of the days,
  - Or you get a card that looks like this:

4	5	4	4	4	2	4

- If there is a 3-point spread, complete a risk assessment

RISK ASSESSMENTS

- Because it's burdensome and stressful to have to continually assess risk, creating streamlined systems for this for clinicians is essential.
- Have a user-friendly form that's supported by your organisation that allows you to document:
  - Risk factors
  - Protective factors
  - Your responses to changes in risk factors
  - Your rationale for your responses
  - Who you've consulted
  - The next point of contact
- The ideal is an electronic form with a set of check boxes and narrative fields relating to each category that can be saved for a patient and then edited as circumstances change.
- If it's not documented, there's no evidence it happened.

Follow this link to the University of Washington Risk Assessment and Action Protocol: UWRAAP (Linehan, 2009)

http://depts.washington.edu/brtc/files/Linehan%20-%20UW%20Risk%20Assessment%20and%20Action%20Protocol.pdf

RISK AND TREATMENT CHOICE

With a chronically-suicidal young person for whom the risk is consistently high the general principles of treatment choice and planning become even more important.

- ★ Ensure consent is very well-informed, with both them and their caregivers.
- ★ Involve family/caregivers in treatment decision-making and planning.
- ★ Do the best evidenced-treatment
- ★ Only try treatments with less evidence when conservative/well-evidenced treatments haven't worked.
- ★ Make it clear that you will strive to **do the treatment**, but that the treatment itself is not failsafe. You cannot guarantee that the person won't suicide.

GENERAL PRINCIPLES WITH HIGHLY SUICIDAL PATIENTS

- ★ Be flexible in considering response options.
- ★ Be more active when suicide risk is high.
- ★ Base non-conservative response on failure of conservative responses.
- ★ Be honest about reasons for responses.

RECOMMEND HOSPITALISATION WHEN…

- The person is psychotic and threatening suicide
- The short-term risk of suicide as an outpatient is greater than the long-term suicide risk associated with an admission
- Suicide threats are escalating and seem operant, and an admission is aversive
- There's a serious strain in the therapeutic relationship which is creating a greater suicide risk, or crisis and you (and your team) need help
- To monitor medication when there's a high overdose risk
- The therapist needs a holiday

- You want to conduct prolonged exposure for PTSD with someone who is chronically suicidal
- Therapy's not working and the person is severely depressed or anxious
- There's an overwhelming crisis and no other safe environment
- The person is dealing with overwhelming emergent psychosis and has no social support

CRISIS PROTOCOL FOR MANAGING SUICIDAL BEHAVIOURS

1. Assess imminent and long-term suicide and NSIB risk
2. Focus on the present
3. Problem solve the current problem
4. Reduce high risk environmental factors
5. Reduce high risk behavioural factors
6. Commit to a plan of action
7. Troubleshoot the plan
8. Anticipate a recurrence of a crisis response
9. Reassess suicide potential

Linehan, 1993, 1999

DBT recommendations for treating suicidal behaviours for people in treatment

PAY ATTENTION TO AFFECT RATHER THAN CONTENT

- Validate and soothe (focus on validating emotion rather than validating accompanying thoughts)
- Let them tell their story
- Use techniques that will help them regulate and reduce intense arousal (e.g., shifting attention, cog restructuring, behaviours that create a different emotion, relaxation)
- Present affect tolerance as a solution
- Consider short-term somatic treatment

Linehan, 1993, 1999

DBT recommendations for treating suicidal behaviours for people in treatment

IN A CRISIS, FOCUS ON THE PRESENT

- Find out what's happened to generate the current response
- Focus on the time since last contact
- Formulate and summarise the problem with the person

Linehan, 1993, 1999

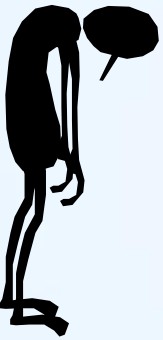
DBT recommendations for treating suicidal behaviours for people in treatment

IN A CRISIS, REMOVE OR REDUCE HIGH RISK BEHAVIOURAL FACTORS

- Pay attention to affect rather than content
- Generate hope and reasons for living
- Activate behaviour
- Block immediate maladaptive responses

Linehan, 1993, 1999

DBT recommendations for treating suicidal behaviours for people in treatment



ACTIVATE BEHAVIOUR: FOCUS ON PROBLEM-SOLVING

- Emphatically tell the patient not to kill themselves
  - Persist with statements that suicide is not a good solution and that a better one can be found
  - Clarify the consequences of potential courses of action
  - Confront unrealistic thoughts or maladaptive actions directly
- Identify and reinforce adaptive solutions and actions
- Make direct suggestions
- Offer skills-based solutions

Linehan, 1993, 1999

DBT recommendations for treating suicidal behaviours for people in treatment

IN A CRISIS, REMOVE OR REDUCE HIGH RISK ENVIRONMENTAL FACTORS

- Reduce availability of lethal means
- Maintain contact
- Communicate with the person's network
- Remove or counter-act suicidal models
- Remove or reduce stressful events or demands
- Consider hospitalisation

Linehan, 1993, 1999

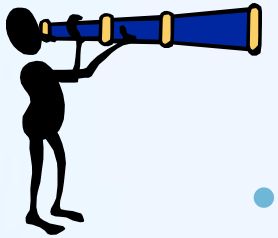
DBT recommendations for treating suicidal behaviours for people in treatment

GET A COMMITMENT TO AN ACTION PLAN

- Assess suicide potential
- Ask for an explicit commitment e.g. ‘so can we agree, you’re going to…’
- Use commitment strategies to strengthen it

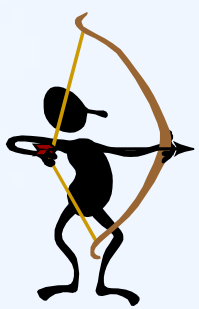
Linehan, 1993, 1999

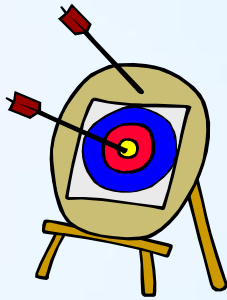
DBT recommendations for treating suicidal behaviours for people in treatment



TROUBLESHOOTING

- Identify factors that will interfere with the plan
- Revise the plan accordingly
- Anticipate a recurrence of the crisis response
- Generate strategies for coping with the resurgence of distress
- Coach to be aware of crisis cues
- Structure the person's time
- Schedule a check-in





Linehan, 1993, 1999

MANAGING MORE CHRONIC SUICIDAL/NSIB BEHAVIOUR

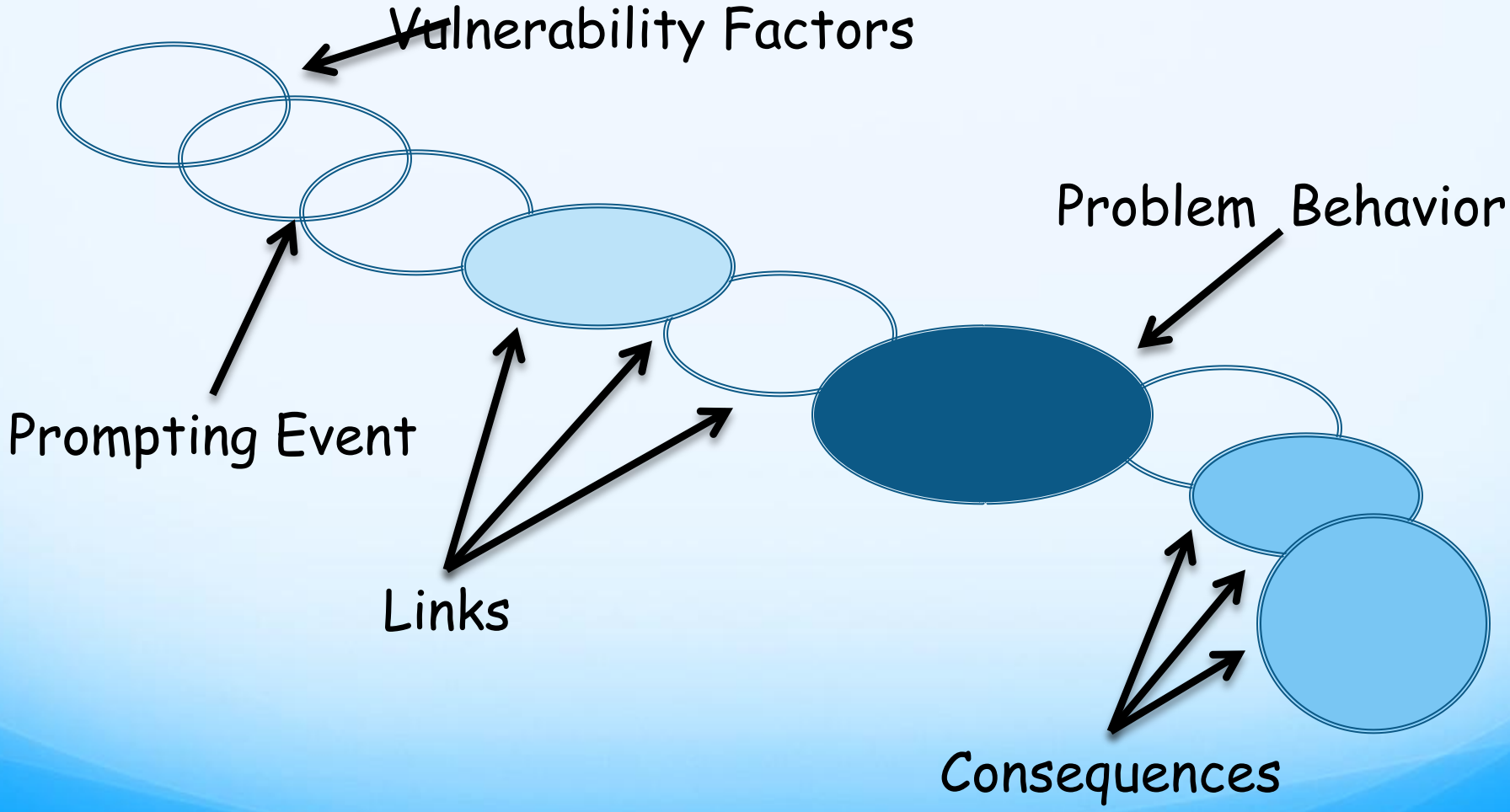
When managing NSIB…

- Assess medical danger
- If the client has self-harmed end phone contact as immediately as possible for 24 hours
- Conduct a behavioural analysis in the next session
- Assess contingencies

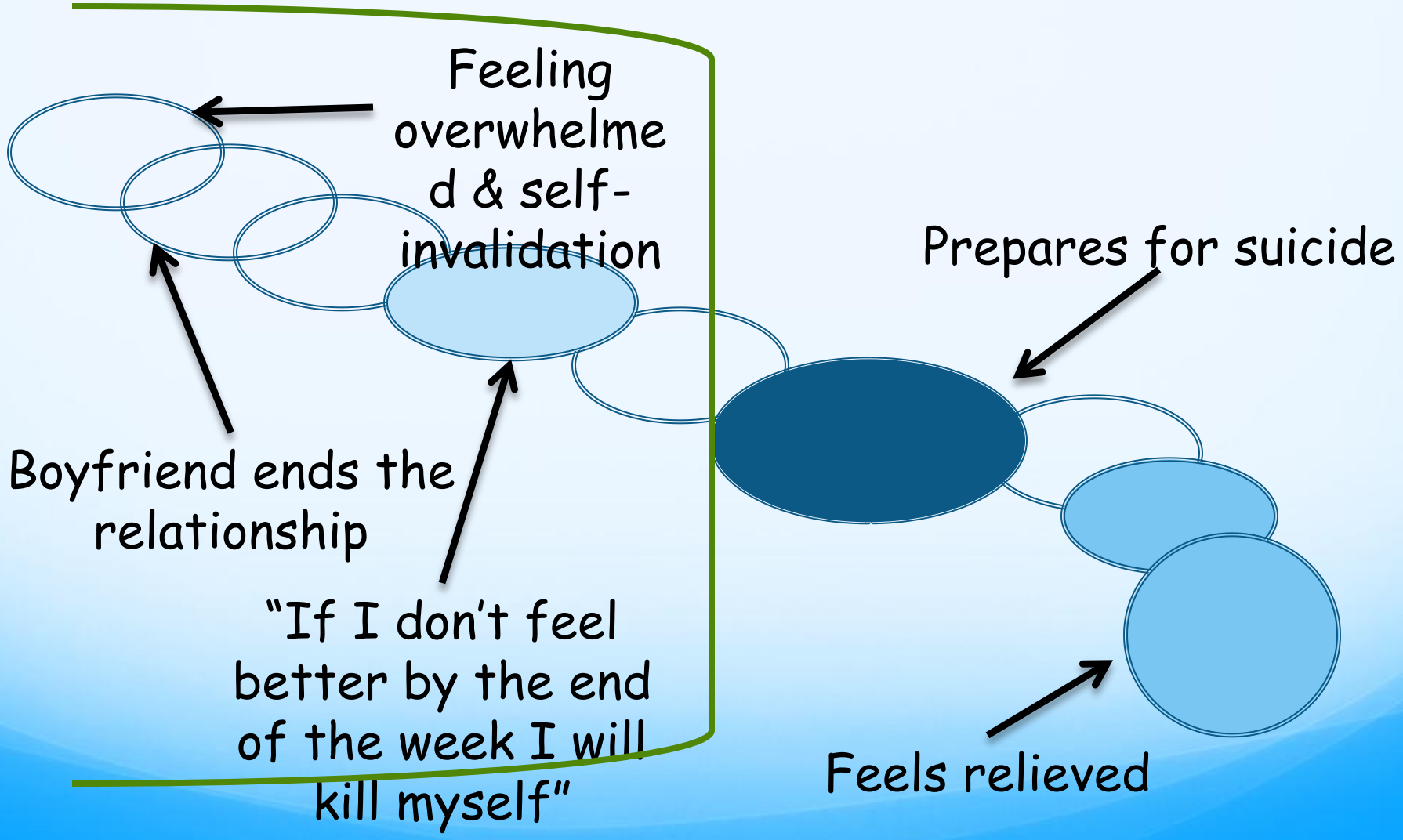
When managing chronic suicidality…

- Continue to assess the long-term risk and review if new risk factors arise
- Conduct thorough behavioural and solution analyses – identify patterns of behaviour and skill use
- Asses whether suicidal behaviour is respondent or operant or both
- Continue to work on strengthening the therapeutic relationship

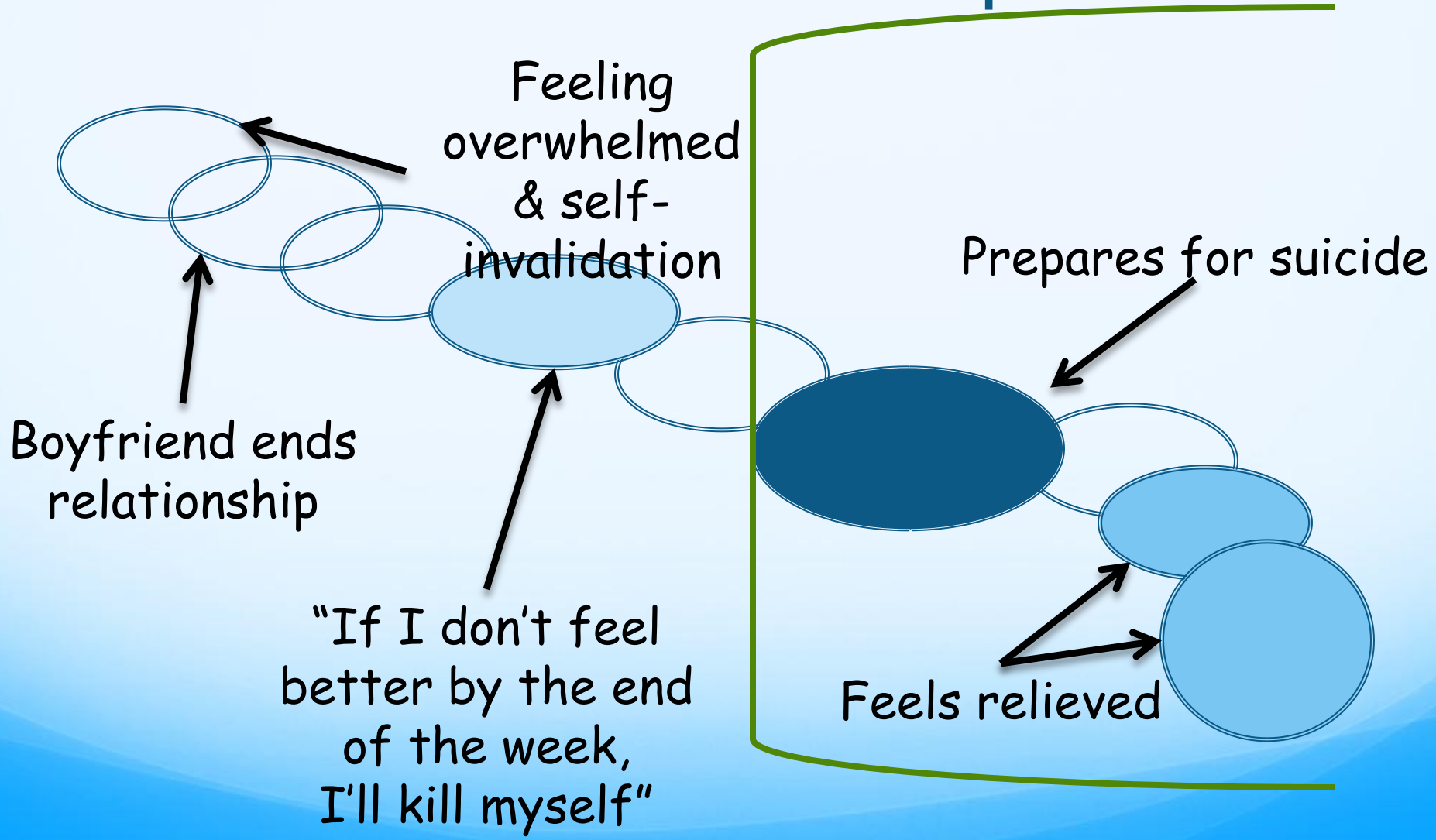
Analyze the Chain of Events Moment-to-moment Over Time



Break Link Between Prompting Event and Problem Links



Break Link Between Problem Behavior and Consequences



CHAIN ANALYSIS- PROBLEM FORMULATION

- ★ Formulate the problem in terms of behavior
  - Primary focus is on the patient's behavior in situations, not on the situations themselves
  - Work on a problem you can actually do something about
  - Validate the patient's distress

CHAIN ANALYSIS- THE LINKS

- Include actions, thoughts, emotions, sensations, environmental events and vulnerability factors
- Find out the specific prompting event
- Describe what contributed to vulnerability to the prompting event
- Describe the links in the chain of events that hooked the prompting event to the problem behavior
- Focus on the consequences
  - Ask about changes in thoughts, emotions, sensations, other people's responses, and own actions
  - Ask: 'what did you think would happen?' (as a result of cutting), and 'what did you want to have happen?'

CHAIN ANALYSIS GUIDELINES CONT.

- Validate the emotions they experience while doing the chain and explain why exposure is helpful
  - Block avoidance
  - Reinforce staying in the moment
- Use hypothesis-testing
  - 'so if you were sober, do you think you would've still taken the pills?'
  - 'If he'd still broken up with you, but you hadn't had the thought that you'd be alone forever, would you still have cut?'
- Although a chain analysis may provide an aversive contingency for problematic behavior, this isn't its main purpose

HYPOTHESIS-TESTING

(Miller, Rathus & Linehan (2006) – p. 62)

- Are ineffective behaviours being reinforced, are effective behaviours being punished, or are rewarding outcomes delayed?
- Does the client have the skills to regulate emotions, respond skillfully to conflict and manage their own behaviour?
- Are there patterns of avoidance, or are effective behaviours inhibited by unwarranted fears or guilt?
- Is the client unaware of the contingencies operating in the environment, or are effective behaviours inhibited by faulty beliefs or assumptions?

PROBLEM-SOLVING

- Can include any or all of the sets of change strategies in DBT. Clients can:
  - Use skills
  - Change the environment so that skillful behaviour is reinforced and problematic behaviour isn't
  - Exposure: practice being in the presence of the cue for problematic behaviour and not do the behaviour
  - Change invalid thoughts about the behaviour, the situation, or its consequences

SUPPORTING FAMILIES IN CRISES

FAMILY INTERVENTION TARGETS IN A CRISIS
(Miller et al., 2007, Table 9.2)

- Prepare the adolescent for family interactions
- Increase parental understanding of adolescent's emotional vulnerability
- Address the parents' emotional dysregulation
- Improve family communication
- Modify contingencies in the family environment
- Take steps to keep the adolescent safe

- Getting family involved with a crisis plan
  - Soothing and validation
  - Cheerleading
  - Psycoheducation
    - Use of DBT crisis strategies
    - Handling suicidal threats
    - Staying dialectical even when terrified and angry

MISMATCHES IN PERCEPTIONS OF CRISES: AIM FOR A DIALECTICAL SYNTHESIS

- Between parents and adolescent
  - Increase empathy and perspective
  - Increase accurate communication

- Between parents and therapist
  - Assess further, take parents' views seriously, get help to build empathy
  - See parents as additional experts on their children
  - Communicate therapist perspective clearly, use didactic and commitment strategies

IF MISMATCH PERSISTS AND SYNTHESIS IS ELUSIVE

- Provide a range of treatment options if possible
- Consult with team
- If pursuing other options isn't possible or there is no agreement
  - Refer elsewhere
  - Consider making a notification for medical neglect if
    - A second opinion supports this
    - All other options have been exhausted

Adolescent Dialectical Dilemmas: Walking the Middle Path