

Acceptance Commitment Therapy: Model for Suicidal Clients

ACT & the Recovery Model:

ACT is a treatment modality that is consistent with the principles of the Recovery Model. ACT is a therapy with a philosophical foundation that instills hope as a catalyst for recovery, and views a person holistically. ACT is an engaging treatment that is an empowering strength based practice. ABHA endorses ACT as a practice guideline that is consistent with the roadmap towards recovery.

Basic ACT Theory:

ACT is an empirically based psychological intervention that uses acceptance and mindfulness strategies together with commitment and behavioral change strategies to increase psychological flexibility. ACT is frequently grouped together with dialectical behavioral therapy, functional analytic psychotherapy and mindfulness based cognitive therapy as The Third Wave of Behavior Therapy. ACT is considered to be an empirically oriented psychotherapy. ACT as of February 2006, has been evaluated in over 20 randomized clinical trials for a variety of clinical problems.

ACT assumes that the psychological processes of normal human mind are often destructive and create psychological suffering. Symptom reduction is not a goal per se of ACT, based on the view that ongoing attempts to get rid of symptoms can create clinical disorders in the first place. The goal of ACT is to create a rich and meaningful life, while accepting the pain that inevitably goes with it. ACT teaches mindfulness skills as an effective way to cope with the challenges of life.

Clinical Manual for Assessment and Treatment of Suicidal Patients by John A. Chiles, MD and Kirk D. Strosahl, Ph.D 2005.

Introduction:

The purpose of this book is to provide clinicians with a sense of what to do with suicidal clients and provide practical guidelines on how best to treat these individuals. Traditional approaches to suicidal clients tend to overemphasize the role of mental disorders and seem to over focus on the prevention of catastrophic outcomes. The authors of this book believe that it is best to treat suicidal behavior as a method of solving problems. This theoretical stance, that suicidal behavior is problem-solving behavior, is the principle underpinning of their approaches to both the assessment and the treatment of suicidal individuals. ACT focuses on engaging the suicidal clients from the first point of contact with an empathetic treatment focus.

Below is an outline and summary of the key concepts and suggestions on how to treat suicidal behavior. Section one and two provide some basic facts and dimensions of suicidal behavior and the ideology of suicidality. Section three and four discuss assessment of suicidal behavior and how to blend assessment with treatment focusing on outpatient service delivery. The last three sections focus on the challenges of the repetitiously suicidal individual; how to best manage suicidal emergencies; and discuss the complex issue of inpatient care and how the use of hospitalization has been overused and has unintended negative side effects. ACT approach to suicidal behavior is designed for any individual struggling with suicidal ideation or impulses. It tends to be particularly helpful for the multiproblem repetitiously suicidal client who in many ways has been reinforced by the mental health system to seek hospitalization as the only avenue for treatment during a suicidal crisis.

1. Dimensions of suicidal behavior & Clinician's response:

- Suicidal behavior is seen as a problem-solving behavior.
- Of the 10 million people with SI each year fewer than 30,000 (0.3%) commit suicide. In ER studies only 1% of attempters go on to suicide in the following year.
- In the general population individuals experience: SI 20-40%, Attempt 10-12%, Completed .012%: Suicide from ideation 4000:1, Suicide from attempt 1200:1, typical prospective prediction study yields a 99% false positive. Conclusion-suicide even in the highest risk groups is impossible to predict.
- Therapy for Suicidal behavior should be based on a learning model with less dependence on assumptions that suicidal behavior can be predicted and controlled.
- If as a clinician you are not aware of your emotional reactions, moral or religious response, and personal values about suicidality, you will not treat your clients in a logical and consistent manner.
- You must have practice strategies in place that help protect you from the risk of malpractice litigation.
- Ethical practice involves keeping your personal reactions and legal fears in check while you pursue an evidence based approach to working with suicidal clients.

2. Basic Model of Suicidal Behavior:

- The essence of suicidal crisis involves the three Is: Emotional pain that is: **Intolerable** (Can't stand the pain), **Interminable** (cannot see the pain ending), **Inescapable** (Can't see a way to solve the pain)
- Suicidal behavior is a learned, reinforced problem-solving behavior that is used when all other options seem to have failed.
- Suicidal clients as a group have a very low willingness to experience emotional pain.
- The problem-solving function of suicidal behavior is that it allows the person to control or eliminate both internal and external problems. The client views suicide as a legitimate problem-solving device, despite social stigma. Goal of therapy is not to persuade the client that the act of suicide is bad but rather to get the client to discover that viable problem-solving options have been overlooked. Work on the ambivalence.

3. Assessment of Suicidal Behavior and Predisposing Factors:

- It is almost impossible in the short term to predict who will and who will not commit suicide. No predictive study has shown to be accurate. Beck hopeless scale was able to predict successful suicide by 80% but that was over a multiyear follow-up. That same scale misclassified 100% of high lethality suicide attempters in short term studies.
- Suicide risk prediction scales may provide useful clinical information but are not able to predict who will actually suicide.

- Client's evaluation of suicide as a problem-solving method is strongly related to ongoing suicidal behavior.
- Reframe suicidal behavior as problem solving behavior. Asking a limited number of questions about the client's belief in the effectiveness of suicidal behavior as a problem solving tactic and the client's willingness to stand negative feelings will help you assess the client's basic stance on suicide.
- Do not differentiate between assessment and treatment. Use the two strategies interchangeably.
- Always include in your initial assessment inventory of factors predisposing individuals to suicidal behaviors. Cognitive rigidity and poor problem solving skills; inability to regulate physical and cognitive components of stress; unwillingness to accept negative emotional states, cognitions, memories or physical symptoms; poor social skills; heightened chronic & acute life stresses.

4. Outpatient Interventions with Suicidal Clients:

- The major goals of treatment is to change one or more of the three Is (pain that is intolerable, inescapable, and interminable).
- The problem solving approach reframes suicidal behavior as a form of problem solving.
- Remember to always validate the client's emotional pain; focus on teaching the client methods to tolerate emotional pain; focus on using real life problems to teach the client better problem solving skills; teach the client that negative thoughts and feelings can be accepted and adaptive responses can still be made; focus on developing interpersonal, problem solving, self control and stress management skills in individual and group settings. (Like DBT); focus on reconciling conflicting beliefs that support ambivalence about life and living.

5. The Repetitiously Suicidal Client:

- The repetitiously suicidal client differs in degree, not kind from more functional clients.
- Suicidal behavior is a method of managing distress. Many clients die because they are playing with fire. In the UK they have developed overdose treatment centers that treat overdoses clients medically, refers them out and discharges back to the community. This approach has helped make suicidal behavior a non-reinforcing event and returns the individual to the natural environment where real life problem solving can occur.
- Multiproblem Clients (Borderline) exhibit behaviors that are: pervasive maladaptive responses across a broad array of situations; persistent-responses are consistent over time; resistant- responses do not change despite negative consequences; self defeating behaviors.
- Basic treatment approach: See the world of the repetitious client: 1-create a humanizing clinical foothold; 2- Attack the rational for and the

workability of suicidal behavior; 3- Substitute acceptance and willingness for emotion control; and 4-Develop a committed action plan.

- Goal of treatment same as for more functioning acutely suicidal clients: teach acceptance and tolerance of emotional pain and problem solving skills.
- Effective treatment avoids confrontation. Must learn how to be patient, one step at a time. Ride the Storm.
- The repetitiously suicidal client typically needs ongoing intermittent crisis and supportive care because beliefs and behaviors are very slow to change.
- Intersystem case management is a basic therapeutic function and requires collaboration with ER's, crisis units and inpatient psychiatric units.
- In general inpatient care is not helpful; consider using acute care alternatives (respite).

6. Managing Suicidal Emergencies:

- The two key skills in effective crisis intervention are validating emotional pain and forming an effective problem solving plan.
- Effective crisis intervention is not to prevent suicide per se but to help the client learn how to move through problems and tolerate negative affect. Stay consistent with problem solving model, focus on short term goals.
- Try to defocus on a suicidal behavior per se while increasing emphasis on solving specific problems that precipitated the crisis.
- Remember that almost all true suicidal crises are short-lived, no longer than 24-72 hours.
- Avoid using psychiatric hospitals for suicidal behavior in that in doing so you may inadvertently reinforce the behavior.

7. Hospitals and Suicidal Behavior:

- Hospitals are overused and have not been shown to reduce death by suicide in any population. No outcome studies have shown that the inpatient location per se is a critical factor in reducing suicide.
- Hospitalization has unintended side effects. As a rule the most invasive treatment have the most invasive side effect and hospitalization is no exception, and in many ways conflicts with the recovery model. There are 4 major adverse consequences of being hospitalized. (1). The client feels abandoned. (2). Labeling and stigma can determine behavior. (3). Loss of autonomy. The essence of a suicidal crisis is a struggle with one's self-control over suicidal impulses. Being hospitalized communicates that the person is out of control. (4). Hospitalization can act as a reinforcement of suicidal behavior.
- Avoid hospitalization for suicidal behavior per se. The hospital is to be used for treatment of (1) psychiatric illness (the client is manic or psychotic), can be used for (2) short term sanctuary (no more than 72 hours) but this is the case only if respite care is not available and the client is not engaged. If respite care is available use it instead of the hospital.

Lastly (3) for out of control repeat suicidal hospitalized clients use as a reshaping strategy.

- Do not let your fear of malpractice litigation override your clinical judgment. There is a chapter on how to avoid litigation and create a community standard of care. (chapter 2)
- An integrated crisis response system involves inpatient, step down and outpatient components in a model of service delivery.

This model has been adopted by many communities to deal with clients suffering with suicidal behavior. For me this is not just an intellectual exercise or theory to be considered. I managed a crisis program for a community mental health agency for almost a decade and formally adopted these ACT principles as our standard of care starting back in 1995. We had remarkable success treating suicidal individuals. In any given year my team evaluated 700 to 900 clients that were in crisis at our clinic, in local ER's, ICU's, jails or medical wards in three community hospitals. Our focus was always on engagement, problem solving and wrap around services. Looking at last years data of the more than 800 evaluations that were done by my team, we only hospitalized four clients that presented with suicidal behavior and three of the four had psychotic symptoms and thus hospitalization was indicated. Suicidal clients were not just turned away, but were engaged. The process of using ACT problem solving principles was started from the onset of care. Incidentally, of the more than 800 that were served we had no completed suicides. These ACT principles more than anything else gave us an attitude shift and a completely new and refreshing way to deal effectively with the challenges of suicidal behavior. If you have any questions or would like further information feel free to contact me at todd@abhabho.org

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