
# Exploring Intervention & Treatment Strategies for Suicide

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# Learning Objectives

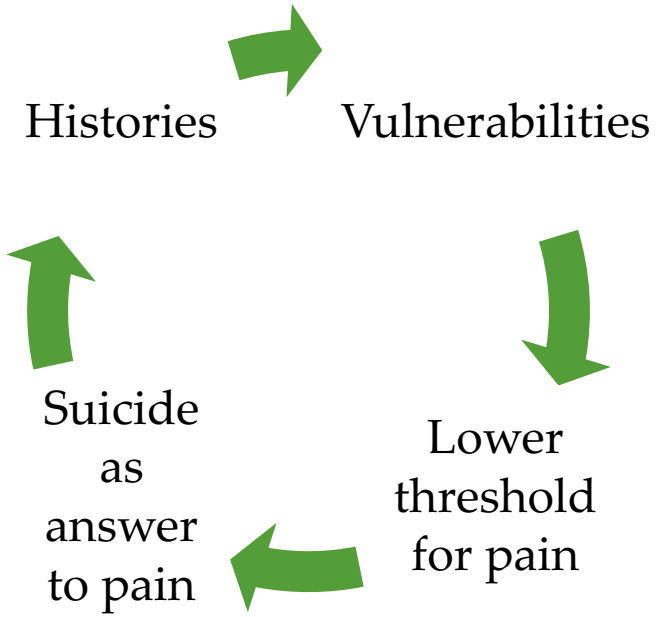
- Classify and describe various treatment modalities, including CBT, DBT, mindfulness, and ACT as they pertain to managing suicidality.
- Explore the CBT suicide mode and interventions of cognitive evaluation of unhelpful beliefs.
- Describe at least five DBT skills using mindfulness, distress tolerance, and emotional regulation.
- Distinguish ACT principles from other approaches and practices of responding to suicidality, including defusion and self as context.

HANDOUT:

Rights of Suicidal Individuals

# Phenomenology

- Developmental History – stress of life events and mental disorders. Client histories are pivotal:
  - Abuse histories
  - Psychiatric histories
  - Parenting histories (i.e. invalidating environment)
  - Traumatic experiences
  - Suicidal histories (reactions, perceptions, handling)



# Suicide

- Suicidal behavior is a learned response
- Suicidal behavior is shaped and reinforced by internal and external rewards
- Suicidal behavior is a problem-solving response to problems that are viewed as:
  - Intolerable (Can't stand the pain)
  - Interminable (Don't see the pain ending)
  - Inescapable (Can't see a way to solve the pain)

# Shneidman's Ten Commonalities of Suicide

1) Purpose → solution
2) Goal → cessation of consciousness
3) Stimulus → intolerable psychic pain
4) Stressor → frustrated psychological needs
5) Emotion → Helplessness/Hopelessness
6) Cognitive state → ambivalence
7) Perceptual state → constriction
8) Interpersonal act → communication of intention
9) Action → escape
10) Pattern → consistency in lifelong coping patters

HANDOUT:

Schneidman's Ten Commonalities

# "Suicide Mode" (Beck, 1996)

- Aaron Beck proposed the concept of "modes" to describe the "synchronous interactions" among the **cognitive, affective, physiological, motivational, and behavioral** systems of personality.
- Clients are taught that suicide can remain an option but not the *only* solution to one's life problem(s).
- The suicide mode can in fact be de-activated collaboratively by clients and their treatment providers who learn together:

  (1) to recognize personal warning signs for suicide, and

  (2) to effectively manage the interplay among the cognitive, affective, physiological, motivational, and behavioral systems.

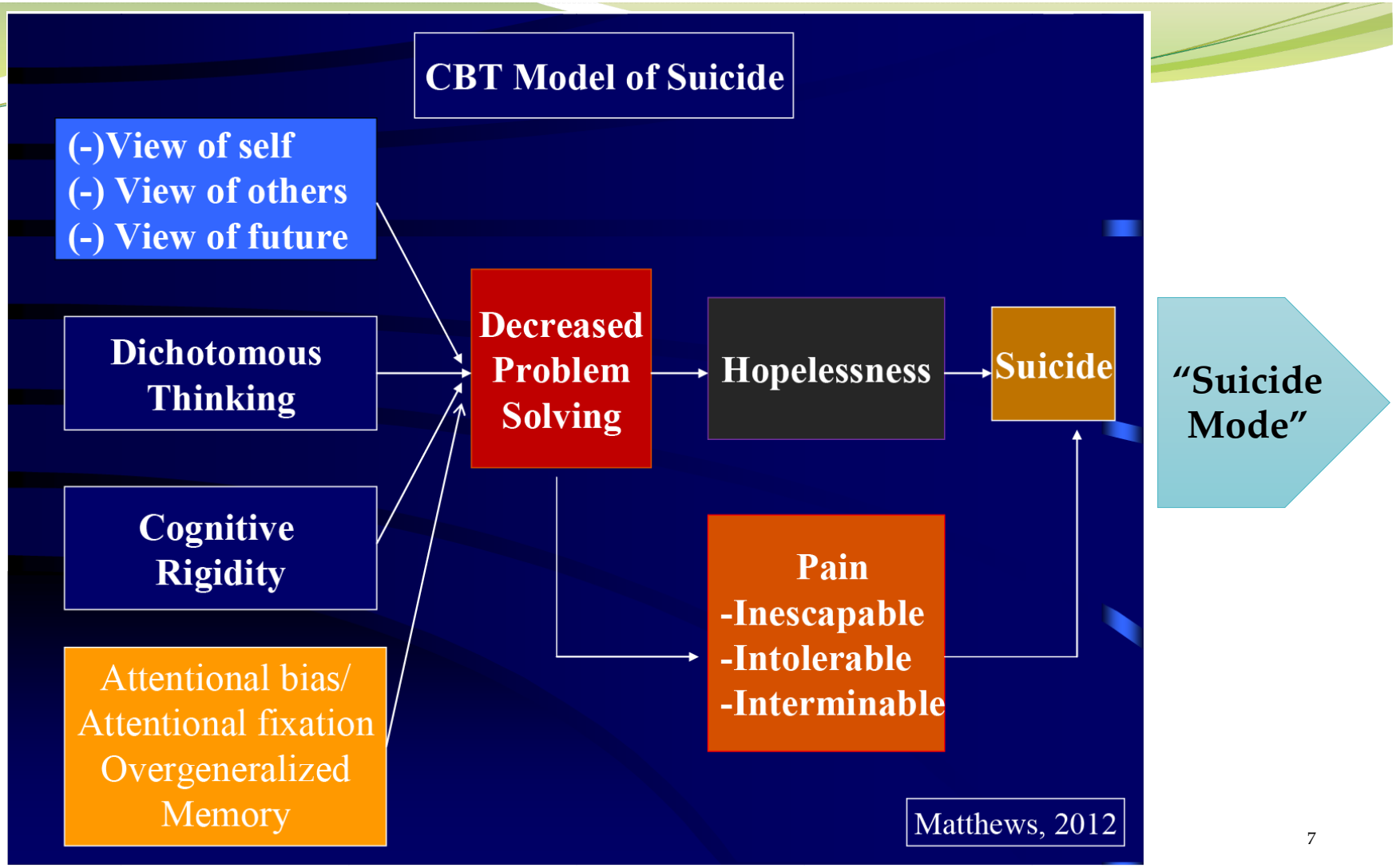



Image source: https://www.intechopen.com/chapters/41711

# Managing Suicide Risk

Appropriate management of suicidality requires more than simple delineation of factors that contributed to increased risk – it requires **ongoing management and active problem-solving** of contributing factors, including treatment of any underlying mental illness (e.g., combination of pharmacotherapy and counselling for treatment of mental illness) and problem-solving focused on increasing coping ability.

# Skills Needed To Work w/Chronically Suicidal Clients

- Have a solid theoretical framework
- Strong working alliance
- Patience
- Ability to tolerate risk
- Cognitive flexibility to manage uncertainty
- Phenomenological understanding
- A solid belief that healing can be achieved
- Not being uncomfortable/fearful of pain and
- intensity
- Be okay staying/processing in the ambivalence
- Treat the trauma

# Common Therapist Barriers

- Responding to suicide risk can be a tremendous source of stress and put therapists at odds with client
  - Therapist often has an agenda (keep client alive)
  - Power struggle can emerge in clinician interactions
- Fear of harm, ethical violation, and/or liability can arise. Systems requirements can reduce therapist autonomy.
- Therapist desire to control own discomfort.
  - Reluctance to do evocative interventions (Creative Hopelessness, Funeral Exercise), even if they would be clinically useful.
  - Might cling rigidly to interventions to fix/solve client's suicide.
  - Therapist might tend to overreact or underreact to suicide talk.
- Therapist barriers may lead to reduced clinical effectiveness

Video:
https://youtu.be/vqo3TQynIKM

# Video Reflection Questions

1. How do you clients present suicidal thoughts?
2. Why might clients avoid talking about suicide?
3. How do you feel when your clients talk about suicide?
4. What are your concerns when a client talks about suicide?
5. What do you do to support yourself and why is that important?
6. What advice would you offer new counselors?

Video: https://youtu.be/wPREXk_zCu4?si=ZNfX3ENJfbjVidWH

# Best Practices: Start With…

Rapport: compassion, empathy, acceptance, equality, normalization

(i.e. commonality of depression and suicidal thoughts & behavior)

Evolution of mind: normality and acceptance of psychological suffering

Instill hope, resources and coping strategies

# No Suicide Contracts

- The use of a no-suicide contract may create an illusion of safety
- The refusal of a client to agree to a no-suicide contract does not necessarily mean that he or she is at imminent risk of suicide.
- The willingness of a client to agree to a no-suicide contract does not necessarily mean that the risk of suicide has been lessened.
- The presence of psychiatric symptoms, such as severe depression or psychosis, may impede a client's mental capacity to enter into such an agreement.
- The client may be willing to sign such an agreement simply to placate the therapist.
- The therapist is asking a client to enter into an agreement with life and death consequences, even thought he or she may have had little time to develop genuine rapport with the client.
- The client who feels amendable to entering such into the agreement at one moment in time may feel quite differently after leaving the therapist's office.

# Crisis and Safety Plans Are Essential

## Collaborative Process

- Avoid controlling

## Patience

- Therapist self-regulation

## Start early and update constantly

- Things change!

## Find What Works

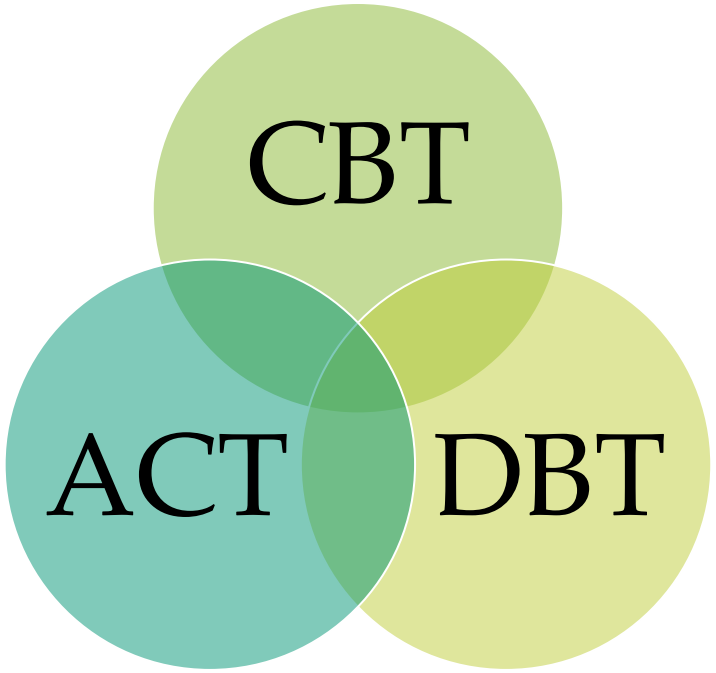
- Mindfulness
- Harm Reduction
- Relationships
- Distress Tolerance
- Emotional Regulation
- Distraction
- Humor
- Spirituality, Faith & Religion
- Cognitive Restructuring/Core Beliefs

HANDOUT:

Safety Plan, Crisis Self-Management Plan

# Evidenced-Based Strategies for Suicide Prevention

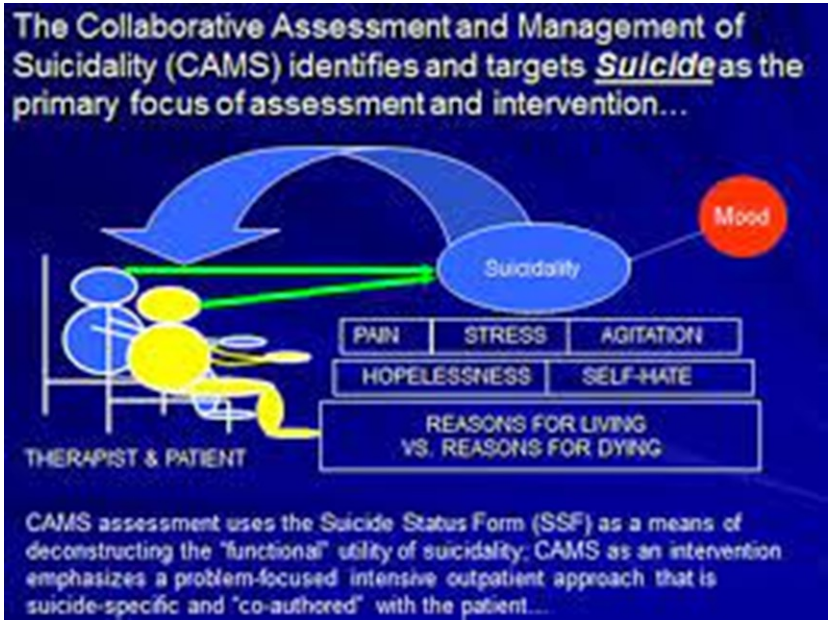
- Cognitive restructuring strategies, such as identifying and evaluating automatic thoughts from cognitive therapy
- Emotion regulation strategies, such as action urges and choices, emotions thermometer, index cue cards, mindfulness, opposite action, and distress tolerance skills from DBT
- Acceptance, values and choice - goal setting and problem-solving strategies.

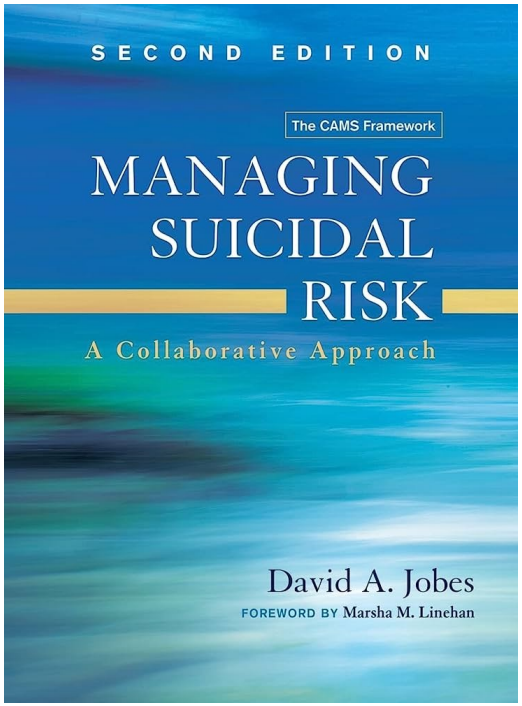



Video: It's a Mystery…
#1 https://youtu.be/vJG698U2Mvo
#2 https://youtu.be/UtKt8YF7dgQ

# The CAMS Model: A Must for Clinicians

Video: https://cams-care.com/about-cams/




# CAMS: Drivers

https://www.nystromcounseling.com/wp-content/uploads/CAMS-Forms.pdf

HANDOUT:

SSF Form (Page 1), Personal Story

- **Indirect Drivers:** Factors that make this person feel like s/he is in a state of "dis-ease" or "dis-order"
  - Examples include: negative life events, psychosocial stressors, psychiatric illnesses
  - These may be profoundly painful, but they do not necessarily trigger acute crises.
- **Direct Drivers:** The way this person thinks/feels about indirect drivers that sets suicide up as an option.
  - Suicidal ideation and behaviors are functional. They are possible solutions for pain.
  - By definition, direct drivers must be idiosyncratic.

Table 2

## Sample cognitive-behavioral conceptualization

| Concept | Example |
|---|---|
| Relevant childhood data | Invalidating family environment<br>Domestic violence |
| Core beliefs | "I am unlovable."<br>"I am worthless." |
| Intermediate beliefs | "If I disappoint people, they will leave me."<br>"If I try a new strategy in my life, I will fail." |
| Compensatory strategies | Adheres superficially to treatment because of fear of disappointing the provider<br>Avoids giving feedback to provider due to anxiety about being abandoned |
| Activating event | Appointment with provider and disclosure about recent challenges in maintaining safety |
| Automatic thoughts | "I have messed up again. There is no hope for me. I cause problems for everyone, including my therapist." |
| Meaning of automatic thoughts | "I am unlovable—I am worthless. I am a burden to others." |
| Emotions | Embarrassed, guilty, worried, agitated |
| Behaviors | Leaves apologetic suicide note on provider's voice mail and attempts suicide |

**Source:** Adapted from Beck JS. *Cognitive behavior therapy: Basics and beyond*, 2nd ed. New York, NY: Guilford Press; 2011

Table 3

## Skill-deficit domains, with examples of underdeveloped and overdeveloped skills[a]

| Skill-deficit domain | Underdeveloped skill | Overdeveloped skill |
|---|---|---|
| Coping strategies, self-efficacy, problem-solving | Self-soothing | Self-blame |
| Regulation of emotions | Modulating emotional intensity | Dissociation |
| Hopelessness<br>Reasons for dying > reasons for living | Optimism | Catastrophizing |
| Social support | Assertive communication | Social avoidance |
| Acquired capability for suicidal self-directed violence and motivation to repeat | Inhibition of impulsive urges to kill oneself | Pain endurance |
| Adherence to medical and psychiatric treatment | Ability to provide feedback on medication side effects | Missing medical and psychiatric appointments |

[a]Phase II

Image Sources: https://cdn.mdedge.com/files/s3fs-public/Document/September-2017/018_0814CP_Holloway_Cov_FINAL.pdf

Video: Jake's Experience in CBT
https://youtu.be/aQK_v0kBYsM

# Client Doe Journal Entry (April 2017)

"I'm tired of all the same bullshit every other day I'm in full on asses and there's nothing I can do about it. I DON'T WANT THIS LIFE. I DON'T WANT ANY LIFE. I JUST WANNA BE FUCKING DONE. WHY AM I SUCH A COWARD?

I just wanna slip into a fucking coma and have my family pull the plug. I want to be free to go at any time. I want to die now. What's the point of having a life I don't want. How is it you're there for me when I can't talk to you about this and you don't understand anyways.
No one does, no one will. I really am alone in this. That's reason one, that I will eventually end my life. I don't really matter."

Courtesy: Anna Lieber, LCMHC

HANDOUT:

PACT Interventions. Thought Patterns, Managing Suicide

Table 1

**Objectives of cognitive-behavioral therapy for preventing suicide**

| Objectives | Description |
|---|---|
| Provide psychoeducation | To educate the patient about the association between one's suicidal thoughts, urges, and feelings, and subsequent behaviors |
| Reduce suicide risk factors | To reduce the severity of established suicide risk factors (depression, hopelessness, suicidal ideation, etc.) |
| Enhance effective coping | To enhance effective coping, emotion regulation, and problem-solving skills, such that suicide is no longer viewed as the only solution to one's life problems |
| Minimize social isolation | To help the patient gradually establish a new social support network or more adaptively use an existing social support network |
| Increase medical adherence | To increase use of, and adherence to, adjunctive medical care, including mental health and treatment for substance-related disorders |
| Plan for safety | To prepare patients, family members, and friends to implement emergency safety plan procedures if suicidal urges recur |

R., a single female in her late 20s, cut her wrists in a moderately serious attempt to end her life. The attempt was impulsive and was made with a high degree of intent and a moderate degree of lethality. The attempt occurred at home after a seemingly minor argument with a relative with whom she had a history of conflict. After the argument, she experienced intense angry and depressive affect and had the following automatic thoughts: "I can't stand getting upset so easily" and "I can't take being depressed anymore." R. told the therapist that she wanted to die in order to escape from her strong negative emotions. R. had a history of chronic suicidal ideation and reported that on that day, prior to the argument, it was no greater than usual. She cut her wrists for an hour with a knife but was unable to find a vein. When she realized she was not going to die, she informed a family member of the attempt and asked to be taken to the hospital. She was admitted to an inpatient unit.

# CBT Intervention Tools

Video: https://youtu.be/aQKv0kBYsM

COPING CARD

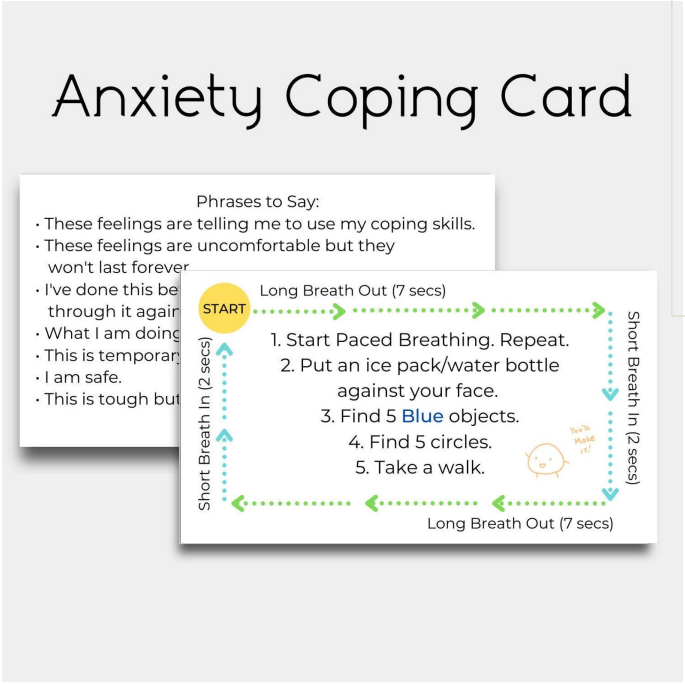



Image source: etsy


Image source: https://getselfhelp.co.uk/media/f51fi1zh/ace.jpg?width=296&height=309

Rob is a 19-year-old depressed young man with chronic suicidal ideation/images with repeated suicide attempts. All GP referrals are of a crisis nature since the age of 16. He was referred to a CBT clinician with specific training and experience in CBT-SP.

Let's look at the application of CBT-SP with Rob.

# CBT Interventions with Rob

- Socialization to treatment rationale was pivotal at the outset to help facilitate strong therapeutic alliance
- 'Buy-in' to the intended de-glamourization of suicide planning/daydreaming/rumination
- Effects of intrusive thoughts and feelings images on emotional well-being.
- Behavioral activation and increasing pleasurable activities;
- Mood monitoring
- Emotion regulation and distress tolerance techniques
- Cognitive restructuring
- Problem solving
- Goal setting
- Mobilizing social support
- Assertiveness skills.

# Four Primary DBT Skills

HANDOUT:

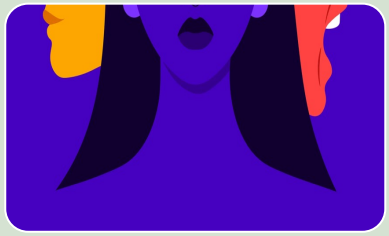
Chain Analysis, Reasons for Living, Diary Card

**Mindfulness**

Dissociation, lack of connection or awareness

**Distress Tolerance**

Impulsivity, low frustration threshold



**Emotional Regulation**

Emotional instability, fast and intense mood changes

**Interpersonal Effectiveness**

Pattern of difficulty keeping health relationships, keeping self-respect

# DBT CHEAT SHEET

**How to use these skills:**
**A**wareness
**A**cceptance
**A**ction

**Mindfulness**
*How skills:*
• One-mindfully
• Non-judgmentally
• Effective

*What skills:*
• Observe
• Describe
• Participate

**Distress Tolerance**
**A**ctivities
**C**ontributing
**C**omparisons
**E**motion opposites
**P**ushing away
**T**houghts
**S**ensations

**I**magery
**M**eaning
**R**elaxation
**O**ne thing at at time
**V**acation
**E**ncouragement

**T**emperature
**I**ntense Physical Exertion
**P**aced breathing

**Emotion Regulation Skills**
• Understand emotional experience
• Reduce emotional vulnerability
• Decrease emotional suffering

**Emotion Regulation**
**P & L** Physical Illness (treat)
**E**ating (balance)
**A**ltering drugs (avoid mood-altering drugs)
**S**leep (balance)
**E**xercise (get)

build **M A S T E R y**

**M**indful to emotion
**A**ct opposite to emotion
**S**elf-validation
**T**urn the mind
**E**xperience building positives
**R**adical acceptance

**Interpersonal Effectiveness**
**D**escribe
**E**xpress
**A**ssert
**R**einforce

**M**indful
**A**ppear confident
**N**egotiate

**G**entle
**I**nterested
**V**alidate
**E**asy Manner

**F**air
**A**pology-free
**S**tick to values
**T**ruthfulness

**Problem Solving**
1. Identify problem
2. Gather data
3. Analyze data
4. Find solution

**Validate**
**I**magine
**T**ake small steps
**A**pplaud yourself
**L**ighten your load
**S**weeten the pot

**Setting Goals**
**S**pecific
**M**eaningful
**A**chievable
**R**ecordable
**T**imeline plan

**Relapse Prevention**
• Practice skills daily
• Enhance positive states
• Disregard social pressure

**Thought Modification**
• Turn the mind
• Radical acceptance
• Willingness

**Behaviour Chain Analysis**
1. Prompting event
2. Problem thought
3. Problem emotion
4. Target behavior
5. Short-term relief
6. Long-term consequences

**Self-soothe with the senses**
Taste
Hearing
Smell
Sight
Touch

**Pros & Cons**

**1. THINKING DIALECTICALLY:** Maintain openness to contradictory and/or polarized thoughts and points of view. Blend these thoughts into a "truth" which best explains reality at the moment.

**2. WISE MIND:** Emotional mind is the feelings mind. Reason mind is the factual/knowledge mind. Wise mind is when they work together with intuition.

**3. OBSERVE, JUST NOTICE**: Look at the situation without emotion or judgment. Just notice what is happening without trying to change it.

**4. DESCRIBE:** Put words on it. Describe the event without judgment or emotion. "Just the facts."

**5. NON-JUDGMENTAL STANCE:** Avoid labelling something as "good" or "bad." Just observe, describe, participate.

**6. EFFECTIVENESS:** Focus on what works. Keep an eye on your objectives.

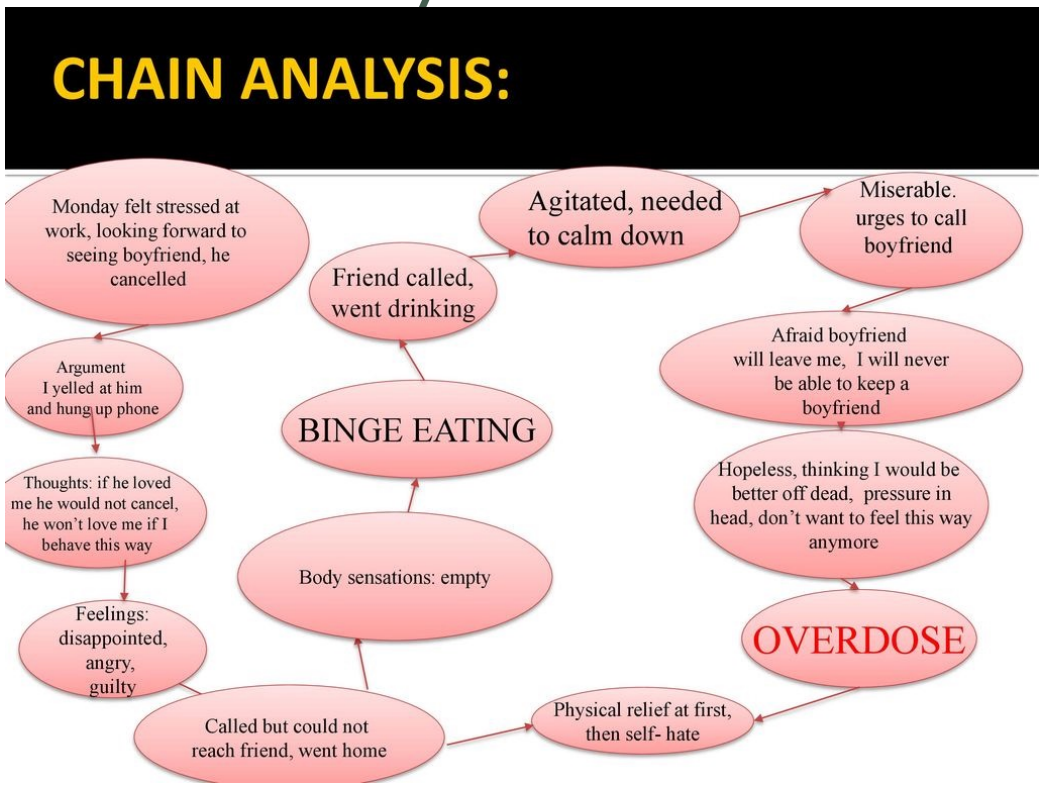
**7. MINDFULLY:** In the moment. Focus all of your senses on the one thing you are doing/thinking at a particular moment. If you notice other thoughts entering your mind, follow them, but let them go.

**Alice** is a 29-year-old woman with a college degree who works as an administrative assistant. She is in a serious relationship with her boyfriend, whom she has been dating for 1 year.

On Thursday of last week, she attended her therapy session and revealed that she had taken an overdose (with intent to die) of about 12 pills of Klonopin two days earlier. She slept it off and did not receive any medical attention at the time.

She and her therapist agreed to do a functional analysis in order to better understand why she made the overdose, and to problem solve to avoid doing so in the future.

# DBT Chain Analysis



# Motivational Interviewing

| Session | Educational content |
|---|---|
| First | Orientation: Reviewing suicidal behaviors, risk factors, protective factors (MI; practice the effect of suicidal attempt on different dimensions of life, and decisional balance practice) |
| Second | Identifying ambivalence and discussing the reasons and desires to die and live, coping strategies for stress and suicidal ideation, (MI; practicing identifying values and develop discrepancy to evocating of intrinsic motivation) |
| Third | Coping with suicidal ideation, safety planning, and limiting access to hazardous devices (MI; support self-efficacy as well as reinforcing beliefs about one's adequacy and ability to change, recognize tempting situations, and control behavior in those conditions) |

MI=Motivational interviewing

**Step 1:** Provide the client with the following instructions.

*On a scale of 0 to 10, where 0 is not important at all and 10 is extremely important, how important is living to you right now?*

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Not at all Important | | | | | | | | | Extremely Important | |

**Step 2:** After the client responds, ask the client:

*What made you choose a (client's number) and not a zero?*

**Note:** It is critical that the clinician ask the client why a higher and not a lower number was chosen. When clients are asked to compare a higher number to a lower number, they begin to talk about reasons for living, which is the goal of this exercise. When clients are asked to compare a lower number to a higher number, they will talk about reasons for thinking about suicide, which would be counter to the goal of the exercise.

**OPTIONAL:**

# Mindfulness of Clinicians in Treating Suicidal Clients

- Because emotional reactions to suicidal clients can often be more intense, mindfulness **IS** helpful for the therapist working with suicidal clients.
  - Helplessness/Hopelessness
  - Questions about professional competence
  - Anxiety over potential lawsuits
  - Resentment towards suicidal clients
  - Dissociation during sessions
- A number of studies have shown that mindfulness practice helps health professionals to experience less burnout and greater empathy for client situations (Krasner, et al,. 2009)

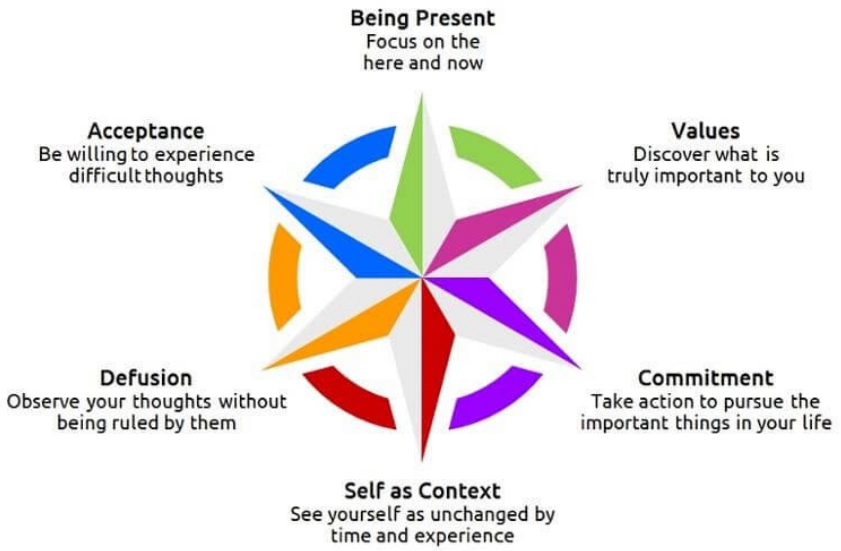
**EXAMPLES**

- Begin sessions by engaging in a brief mindfulness meditation along with the client.
- When a therapist notices difficult personal experiences arise during a session, such as tension in the body or uncomfortable emotional reactions, he or she might briefly practice mindful awareness of his or her thoughts and feelings, or focus more intentionally on the behavior and emotions of the client.
- A therapist might engage in brief mindfulness exercises just prior to sessions with suicidal clients.

# ACT and Suicide

HANDOUT:

Six Core Processes of ACT

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- Suicidal behavior is a problem solving response to problems that are viewed as:
  - Intolerable (Can't stand the pain)
  - Interminable (Don't see the pain ending)
  - Inescapable (Can't see a way to solve the pain)

"Attending Your Own Funeral" exercise

# ACT

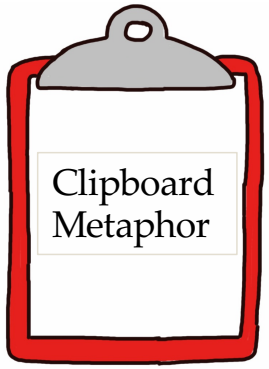
- ACT has two major goals:
  - To foster acceptance of unwanted private experiences which are out of personal control
  - To facilitate commitment and action towards living a valued life.

The aim of ACT is to create a rich, meaningful life while accepting the pain that inevitably goes with it.

## Typical ACT Moves!

- ✓ What would you be doing in life if you weren't stewing in your suicidal thoughts all the time?
- ✓ Your thoughts and feelings don't always have your best interests in mind.
- ✓ The greatest tragedy about your past would be turning it into your future!
- ✓ The clock of your life is ticking. Can you hear it?
- ✓ I don't know what will happen if you change. I do know what will happen if you don't.
- ✓ Your thoughts and feelings don't "cause" suicidal behavior! You do.
- ✓ What would happen if you just showed up for your life and let the chips fall where they may?
- ✓ Are you suffering more than you need to?
- ✓ What is the suicidality taking you away from that is important to you?

# The Four Steps




| | |
|---|---|
| Hold yourself kindly | • Learning to support and comfort ourselves.<br>• Self-compassion (Kristin Neff!) |
| Drop anchor | • To ground ourselves and take action during the storm. |
| Take a stand | • "What do I want to stand for in the face of this?"<br>• Using will, courage, grit, resilience, values, attitude |
| Find the treasure | • "What good is buried beneath my pain?"<br>• "What qualities are helping me withstand the storm?" |

# Fusion vs Defusion

**Fusion:**

**A thought can seem like…**

- the absolute truth
- a command you have to obey or a rule you have to follow
- a threat you need to get rid of as soon as possible
- something that's happening right here and now even though it's about the past or the future
- something very important that requires all your attention
- something you won't let go of even if it worsens your life

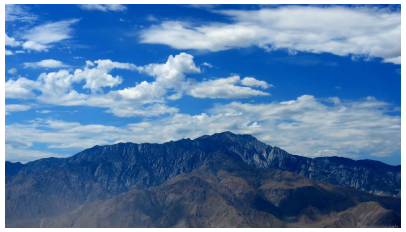
**Defusion:**

**Recognition that a thought…**

- may or may not be true
- is definitely not a command you have to obey or a rule you have to follow
- is definitely not a threat to you
- is not something happening in the physical world—it's merely words or pictures inside your head
- may or may not be important—you have a choice as to how much attention you pay it
- can be allowed to come and go of its own accord without any need for you to hold on to it or push it away

# Defusion Examples

- If you have the thought, ***"I should kill myself,"*** you can then observe, ***"I just had the thought that I should kill myself."***
- If you believe the thought, you might tell yourself, ***"I am believing the thought that I should kill myself."***
- These subtle changes in wording shift the focus from ***"I should kill myself"*** – a supposed truth – to ***"I think…" or "I am believing…"*** – which in turn highlights that your thought or belief may not be true.



**"I am the sky. Everything else is just weather."**
- Pema Chodron

**<u>Remaining Curious</u>**

- Mindful curiosity treats suicidal thoughts for what they are: a symptom, not a truth. They are a symptom that something in you needs healing. What might that be?
- In this way, you might respond to suicidal thoughts with the following:

***"Isn't it interesting that I am having the thought that I want to die?"***

***"I wonder why I am having the thought that I want to die."***

***"These thoughts are a symptom. What are they telling me?"***

# Dealing with Downer Statements: How Would You Respond?

HANDOUT:

40 Tips for Getting Unstuck

1. *I'm just tired of always having to struggle. I'd be better off dead.*
2. *You don't really know how I feel (said angrily)*
3. *You don't really care about me. You are just saying you do.*
4. *If you are asking me to accept the way I feel, I'd rather kill myself instead*
5. *If you felt the way I do, you'd be trying to kill yourself too.*
6. *What you are asking me to do is just too hard.*
7. *I don't feel any better than when I started working with you (said challengingly)*
8. *Why do you keep asking me what I want my life to be about? I can't set goals in my life when I'm always suicidal.*
9. (In response to a values type question) *I don't have any values! I just try to make it through one day at a time.*

HANDOUT:

Self-Compassion Break

# When Clients Kill Themselves

- Talk to someone who can help
- Avoid extreme reactions (i.e. avoidance or overcompensation)
- Take time to grieve
- Know the research
- Learn from experience
- Accept the limitations of your role
- Find value in your work with the client

- Good articles on the subject:
  - "When a Client Kills Themselves" https://www.psychotherapy.net/article/client-suicide-article
  - "Facing the Specter of Client Suicide" https://ct.counseling.org/2015/10/facing-the-specter-of-client-suicide/
  - "Dancing on the Razor's Edge: Reflections on a Client Suicide" https://www.socialworktoday.com/archive/exc_091213.shtml
  - "Coping and Learning After a Client's Suicide" https://www.psychotherapynetworker.org/blog/details/1291/coping-and-learning-after-a-clients-suicide
  - "Legal Considerations When a Client Dies by Suicide" https://naswcanews.org/legal-considerations-when-a-client-dies-by-suicide/

# Client Doe Journal Entry (April 2017)

"I'm tired of all the same bullshit every other day I'm in full on asses and there's nothing I can do about it. I DON'T WANT THIS LIFE. I DON'T WANT ANY LIFE. I JUST WANNA BE FUCKING DONE. WHY AM I SUCH A COWARD?

I just wanna slip into a fucking coma and have my family pull the plug. I want to be free to go at any time. I want to die now. What's the point of having a life I don't want. How is it you're there for me when I can't talk to you about this and you don't understand anyways.
No one does, no one will. I really am alone in this. That's reason one, that I will eventually end my life. I don't really matter."

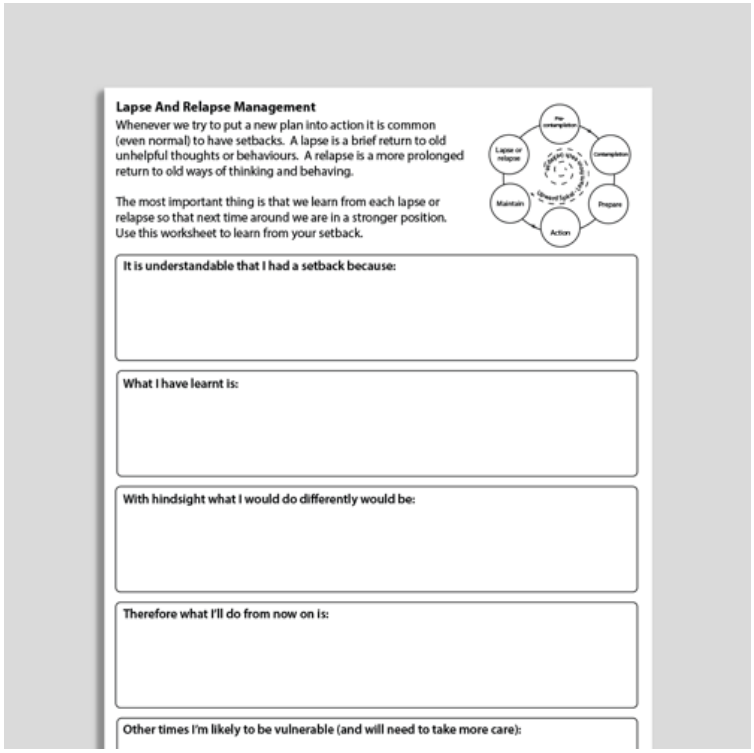
# Client Doe Journal Entry May 2020

It's weird to pick up a journal 3 years later but, not for me. I'll catch up later but first a quick thought on Hurt by Johnny Cash. I randomly decided to listen to this song because it has always explained how I feel. It will always be a favorite, but it isn't my truth anymore.
*"I wear this crown of thorns above my liars chair. Full of broken thoughts that I cannot repair."*
But I'm not full of broken thoughts anymore. The ones that are broken can be healed if I do the work.

*"I hurt myself today to see if I still feel. I focus on the pain, the only thing that's real."*
Hurting myself to cope is not my current reality. Pain is very real, but it is NOT the only thing that is real. Connection is real. Purpose is real.

*"The needle tears a hole, the old familiar sting. Try to kill it all away, but I remember everything."*
I don't have to self medicate to hide from pain. I medicate, meditate, feel the pain & endure to face tomorrow. My only job is to show up for tomorrow. Anna would be so proud of this journal entry. Olaf was right, this journal is proof: "EVERYTHING WILL MAKE SENSE WHEN I'M OLDERRRR!:

# Relapse Prevention



**Lapse And Relapse Management**

Whenever we try to put a new plan into action it is common (even normal) to have setbacks. A lapse is a brief return to old unhelpful thoughts or behaviours. A relapse is a more prolonged return to old ways of thinking and behaving.

The most important thing is that we learn from each lapse or relapse so that next time around we are in a stronger position. Use this worksheet to learn from your setback.

It is understandable that I had a setback because:

What I have learnt is:

With hindsight what I would do differently would be:

Therefore what I'll do from now on is:

Other times I'm likely to be vulnerable (and will need to take more care):

Image source: Psychology Tools

**Video Clips:**

**What is relapse prevention for suicide?**

https://youtu.be/jAz5QVJLl8k

**Relapse Prevention Exercise**

https://deploymentpsych.org/content/relapse-prevention-exercise-0

This video depicts the late phase of treatment where the therapist is conducting a relapse prevention exercise with a patient. The therapist explains the relapse prevention exercise by reminding him of their previous session and asks the patient to revisit the suicidal crisis by telling his story developed in the narrative timeline. After an initial telling the therapist then asks the patient to retell the story, but this time imagining using skills developed during treatment at critical moments during the crisis to explore how the patient could respond differently in a similar crisis.

# Resources!

HANDOUTS:

Supporting Survivors,
Coping w/Suicidal Thoughts,
Case Studies

- ACT for Suicidality: https://www.actmindfully.com.au/upimages/ACT_with_Depression_and_Chronic_Suicidality.pdf
- Understanding, Managing, and Treating Chronic Suicidality PPT: https://dsamh.utah.gov/wp-content/uploads/2020/08/Understanding-Managing-Treating-Chronic-Suicidality.pdf
- Therapy in a Nutshell YouTube channel: (Clean vs. Dirty pain video): https://youtu.be/X7ip0DNofcI
- A Cognitive Behavioral Strategy for Preventing Suicide article: https://cdn.mdedge.com/files/s3fs-public/Document/September-2017/018_0814CP_Holloway_Cov_FINAL.pdf
- Cognitive Therapy Interventions for Suicide Attempters: Case Studies article: https://www.gregghenriques.com/uploads/2/4/3/6/24368778/clincal_case.pdf
- Suicide Assessment video (Adrian, 45 mins): https://www.nova.edu/promo-k.html?id=samhsa&video=1_l4v8at1n&title=NSU%20Suicide%20and%20Violence%20Prevention%20Training&subtitle=Suicide%20Assessment
- DBT Worksheets: https://mydoctor.kaiserpermanente.org/ncal/Images/Distress%20Tolerance%20DBT%20Skills_ADA_04232020_tcm75-1598996.pdf
- Suicide Status Form (SSF) completed example: https://cams-care.com/wp-content/uploads/2018/03/Completed-SSF-4.pdf

www.dianebiglertraining.com


# More Resources!

- CAMS training website: https://cams-care.com/about-cams/
- "Before You Kill Yourself": How ACT Can Prevent Suicide: https://podcasts.apple.com/us/podcast/dr-steven-c-hayes-how-acceptance-commitment therapy/id1446501856?i=1000488105479&fbclid=IwAR3IrJSXORU3iO4RhdBKe9sqFndXe9tjxg xd2vP9XT4UkWpaBz4K3fkwKQM
- Working w/the Client Who is Suicidal toolkit: https://www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClie nt.pdf
- DBT Techniques for Self-Harm and Suicide: https://www.ucl.ac.uk/clinical-psychology/competency-maps/self-harm/adult-framework/Specific%20interventions/Specific%20interventions.pdf
- Self-Compassion (Kristin Neff): https://self-compassion.org/
- 35 Years of Working w/Suicidal Patients: Lessons Learned (Meichenbaum): https://www.melissainstitute.org/documents/35_Years_Suicidal_Patients.pdf