Psychotherapy with Suicidal Patients

An Integrative Psychodynamic Approach

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An “integrative” psychodynamic approach

- Psychodynamic – emphasizes importance of therapeutic alliance, unconscious and implicit processes, exploration of fantasy, and the use of the therapeutic relationship as an vehicle for change
- Integrates techniques use of exposure (CBT), “chain analysis,” problem-solving, teaching skills to manage distress (DBT)
- Draws on developmental, social psychology and suicide research

Major references

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Understanding the suicidal process

Suicide as escape

- “anguish”, “desperation”, “mental pain”, “psychache”, “emotional dysregulation,” “entrapment” (1)
- Can include anxiety, shame, humiliation, defeat, anger
- *Escape* most often cited reason for attempt (2)
- Cognition narrowed, capacities transiently lost – can feel intolerable and interminable
- Risk of suicide as “solution” if no perceived alternative

1. Maltsberger,1992; Hendin et al 2004; Orbach et al 2003; Shneidman 1993, 1996; Linehan 1991; Galynker, 2017; 2. Michel, 1994

Aloneness

- Different than loneliness –loss of "evocative memory,"(1) inability to experience connection/support, timeless quality
- "…an experience beyond hope….This anxiety is the anxiety of annihilation – panic and terror. People will do anything to escape from this experience" (1)

1. Adler and Buie, 1979; 2. Maltsberger, 1988; 3. Joiner, 2005, Van Orden et al, 2010

Emergence of suicidal intent

- Intent tends to emerge late in the process
- 50% of suicide attempters reported that intent emerged within 10 minutes of the act (1)
- Most suicidal planning occurred within a week, and the majority within 12 hours of attempt (2)
- SI fluctuates dramatically even within a day, and correlates with negative affective states (3)

1. Deisenehammer, 2009; Milner et al, 2016; Kleiman et al, 2017

Transient relief

- May be *transiently* moderated when away from stressors, in holding environment (e.g., hospital)
- May increase post-d/c - relates to increased risk (1)
  - Surprise, disillusionment, feelings of failure, etc.
- Psychotherapy: psychoeducation, skill building, “chain analysis,” crisis planning, rehearsal

1. Schechter et al. (2016)

Role of dissociation

- "Suicide mode" (1)
  - dissociated cognitive-affective state that feels unbearable and has internal logic, narrowed cognition → **suicide as only way out**
- "Suicide Crisis Syndrome" (2)
  - feelings of entrapment → "depressive turmoil," "frantic anxiety," "acute anhedonia," "emotional pain, ruminative flooding and hyperarousal" → **suicide as only way out**

1. Rudd, 2000; 2. Galynker, 2017; Schuck et al, 2018

Dissociation and continuity

- Continuum of dissociation, "self-states" (1)
- The patient likely cannot “connect the dots”
  - Between past experience and harsh self-judgment
  - Between feeling well one day, feeling suicidal the next
  - Between feeling engaged vs. *no connection*
- Loss of capacities: evocative memory, mentalization (2, 3)
- Therapist providing memory/continuity → gradual increase in patient’s capacity (4)
- Provision for contact between sessions

1. Bromberg PM, 1993; 2. Adler and Buie, 1979; 3. Bateman and Fonagy, 2010; 4. Schechter et al, 2019

Experience of the body

- Bodily love as both natural and *learned* (1)
- Suicidal adolescents - more negative bodily experiences, less pain sensitivity, fewer memories of positive touch, more physical dissociation, less attention to bodily cues (1, 2)
- Body can be experienced as “other,” “alien,” source of pain, etc. (3)
- “The body keeps the score” – somatic memory (4)

1. Orbach et al 2001; Orbach 2003; Orbach et al 2006; 2. Levinger, 2015; 3. Maltsberger, 2004; Goldblatt and Maltsberger, 2009; van der Kolk, 1994

How can psychotherapy help?

Instilling hope

- Hope [1]
  - **Agency**: motivation to try to effect positive change
  - **Pathways**: having a sense of possible routes
- Therapist holds the hope, needs "road map"
  - Remember: 90% of near lethal suicide attempters do *not* go on to die by suicide [2]
- Role of grief/mourning, accommodation

1. Snyder, C. R. (2002); Seiden 1978; Owens et al 2002; Suominin et al 2004; Finkelstein et al 2015

Validation

- Central element in *all* psychotherapy (1)
- Experience of non-judgmental acceptance *as I am*, even in context of needing to work toward change
- Patient's suicidality as *understandable*
- Accepting patient's perceptions of therapist
- Countering harsh self-criticism, shame – "functional neutrality" (2)

1. Schechter 2007; 2. Kris 1990

Enhancing “mitigating” factors

- Dialogue about consequences
  - Children “better off w/o me” vs. “worst thing that could possibly happen to them”
- Helping *patient* to see suicide as bad solution (1)
- Engagement vs. withdrawal

1. Chiles et al, 1985; Linehan, 1993; Joe et al 2007

Beliefs and fantasies

- May not be apparent without exploration
  - Deserved self-punishment
  - Wish for reunion with lost others
  - Retaliation
  - Destroying hated aspect(s) of self
  - Fantasies about death, consequences
- “De-idealizing” positively valanced fantasies
- Enhancing sense that it *matters*

1. Maltsberger et al (2010)

Affect Tolerance

- Increasing capacity to
  - Think in the presence of strong emotions
  - Bear feelings without having to suppress, dissociate or act impulsively
- Impulsive behavior as avoidance strategy
- *Exposure* to feelings, response prevention
- Relationship itself as exposure (e.g., shame)

Affect Tolerance

- Patients come into treatment unaware of unconscious avoidance of thoughts/feelings that make them anxious
- Noticing, disrupting avoidant defenses → gradual, repeated *exposure* to warded off thoughts/feelings
- Over time → increased affect tolerance → increased flexibility and freedom

Modification of narrative identity

- The stories we create about ourselves integrate experiences into a “self,” linking past, present and future, providing coherence (1)
- Narratives are changed (“co-created”) in the act of the telling/listening (1)
- Therapist is the active “listener,” demonstrates understanding, acceptance, empathy, has own perspective → gradual co-creation of narrative with greater self-empathy, less harsh self-judgment (2)

McAdams 1985; Pals 2006; Pasupathi 2014; 2. Schechter et al, 2018

Implicit narrative identity

- Early caregiver experiences → "implicit relational knowing,"[1] "inner working models,"[2] "core beliefs"[3]
- People selectively attend to confirmatory data, act in accordance with expectations → *evokes* confirmatory responses → *reinforcement* of negative self concept [4, 5]
- Goal is disruption of cycle (related to "interpersonal effectiveness") [5,6]

1. Stern et al, 1998; Lyons-Ruth 1999; 2006; 2.Bowlby, 1973: 3. Beck et al, 1990; 4. Swann and Read, 1981; 5. Wachtel, 2009; 6. Linehan, 1993

Therapeutic alliance – rupture and repair

- Ruptures as therapeutic *opportunities* (1)
- Learning that old relational pattern does not have to be repeated, possibility of trying something new
- "Moments of meeting,"(2) "radical genuineness" (3)
- Requires *affective experience* of therapist's engagement, caring (4)

1. Long et al, 2008; Lewis, 2000; 2. Stern et al, 1998; 3. Linehan, 1993; 4. Schechter et al, 2013;

Emergence of genuine capacities

- Requires the capacity to take in recognition from others without having to resort to automatic defenses
- Trauma, neglect, lack of early attunement can disrupt development
- Anxiety associated with positive experiences of self → unconscious automatic avoidant defenses → exacerbates harsh self-attack
- Therapist notices/disrupts avoidant defenses, helps patient to bear anxiety of taking in positive qualities/capacities

Buie, 2013; Schechter et al, 2019

Chronic Suicidality

- Clinical goal - to help patient cope safely with chronic despair, take control only when necessary
- Patient as competent decision-maker to the extent possible
- Defensive practice not in patient's best interest, so clinician and patient must assume degree of on-going risk

Attention to countertransference

Inherent challenges

- Anxiety and fear – suicide *may happen*
- Relentless suffering hard to bear - high motivation but low ability to alleviate distress
- Relentless hopelessness can become convincing
- Set up for “countertransference hate,” hopelessness, impulsive action or emotional withdrawal (1,2)

1. Maltsberger and Buie,1974; Schechter et al, 2019

Instrumental aspects of suicidality

- Early expression of wishes/needs may have not have been responded to or punished
- Erratic reinforcement of emotional escalation and threats erratically as a way of getting needs met
- Suicidal ideation/threats/behavior can be explicitly or implicitly contingent
- Unconscious instrumental behavior can be *experienced* as consciously “manipulative”

Consultation

- Consider when:
  - Significant anxiety re: degree of risk
  - Unsure about appropriate treatment plan
  - Concerned re: countertransference interference with "objective" risk assessment
  - Outside pressures are interfering with assessment
- "Never worry alone" (Gutheil)

Elements of Psychotherapy - Summary

- Affective attunement/engagement…*as experienced by the patient*
- Countering of self-criticism, self-blame, shame
- Instilling hope: pathway + enhancing agency
- Sustaining belief that patient *can* be helped
- Focus on affect tolerance, continuity of experience
- Clear crisis plan, availability between sessions

Elements of Psychotherapy - Summary

- Analysis of crises/self-harm, with skill building, coaching
- Attention to maladaptive relational patterns, including with therapist
- Willingness to step out of “usual” frame when needed
- Modeling of non-judgmental inquiry, goal of shared understanding of suicidality
- Explicit recognition of genuine capacities
- Support for therapist, consultation when needed

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