Psychosocial Intervention for the Treatment of Suicidal Behaviour

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Life Promotion Clinic

Life Promotion Clinic

- Outpatient clinic for the treatment of individuals at risk of suicide
- Referred from ED, MH teams
- No geographical boundaries
- Free of charge

Population

- Around 350 clients seen so far
- 70-80 clients seen each week
- Clinic open two days/week
- MDD, PTSD, GAD, OCD, Personality disorders

Staff

- 1 Part-Time Psychiatrists
- 2 Full-Time Trainee Psychiatrists
- 4 Part-Time Psychologists
- 1 Full-Time Mental Health Nurse
- 1 Part-time Receptionist

Clients

- 73% Female, 27% Male
- 15-76 years old Mean age=31.9
- Employed=35.9%
- Only 17.8% living with spouse/partner
- 66.6% year 12 or less

Clients

- 63.3% had two or more attempts
- 72.5% had high wish to die before attempt
- Beck Suicide Ideation(0-42)= mean score 15.5
- Active desire to die=72.5%
- Beck Hopelessness= 76.2% score>8
- DASS= over 50% in the severe range for anxiety and depression

Current limitations in treating suicidal clients

- Management of suicidal individuals is “hard work”
- Medication available only partially effective
- Psychotherapies require lengthy training and supervision
- One size does not fit all

The ideal psychotherapy

- Easy to learn
- Easy to deliver
- Easy to tailor to suit the clients' needs
- Easy for the client to understand and apply

Inspired by:

- Latest developments in neurophysiology
- Occupational psychology
- Sport psychology
- “How do we function?”

Effort

- Energy mobilised to perform
- Conscious and subconscious
- Mental and physical
- Level of arousal

Effort and performance (Hockey, 1986)

- We need energy to perform (Effort)
- Energy available to perform is limited
- The rate of energy consumption is capped
- The rate of energy restoration is capped
- Exhaustion and/or hyper-arousal if we override the system
- If we go too far we lose the ability to stop
- “snap rule” vs. bell curve

Physical Effort

- Easier to formulate realistic expectations
- Tissue damage hard to ignore
- Benchmarks are visible
- Body can be easily stopped if we get it wrong

Mental Effort

- Much harder to formulate realistic expectations
- No tissue damage
- Benchmarks are invisible
- The mind is very hard to stop if we go too far

Sleep deprivation as model (Pilcher, 1996)

- Only effort required is to stay awake and to complete lab tests
- Mood changes occur first, cognitive performance follows, motor performance always fails last
- Mood changes can progress to the point of significant mental illness (72 hours)
- Return to functional levels only after sufficient sleep

To maintain a functional state (ideal world)

- Invest only the effort required to produce action in an efficient way
- Avoid irrelevant/redundant physical or mental activity
- Maintain appropriate level of arousal
- Withdraw/reduce effort before we lose control of it
- Only start putting effort again when a fully functional state is restored

What our clients say….

- ?????????
- Effort creates energy (agitation)
- The amount of effort I put depends on the importance of the problem
- If there is no discomfort it means I haven't put enough effort
- Half of the clients need at least suicide ideation to feel comfortable with "stopping"

Observations

- No concept of excessive effort
- Any withdrawal/reduction of effort invested is perceived as inappropriate
- Skewed perception of effort invested
- Disregard of mental health symptoms

Quotes

- “How do you know you care if you do not get palpitations?”
- “I’m not a sitting still person. I don’t want people to think I’m lazy”
- “How can you still be sick if you are not thinking about suicide?”
- “…but if I am angry is because I am passionate about the issue”

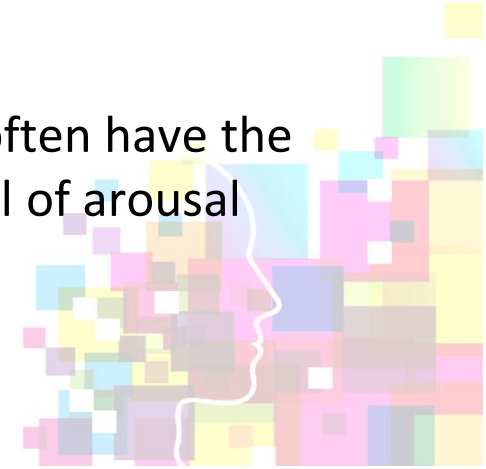
Effort and emotional disturbance

- Emotional disturbance develops whenever there is a gap between the level of energy (mental, emotional, physical) individuals expects to be able to invest and the energy available

- The kind and severity of the emotional disturbance are expression of the kind of effort individuals invest and the extent of the gap

- “overthinking” and “being too wound up”

- The impulsive and dysfunctional behaviours we observe often have the role of helping individuals reduce mental activity and level of arousal



Clinical examples

- PTSD
- OCD
- Depression
- GAD

Emotion Modulation Therapy

- Individual and group sessions
- Wide range of disorders treated so far
- Strong emphasis on phenomenology
- Focus on adjustment to change

EMT components

- Behavioural analysis
- Motivational interviewing
- Psycho-education
- Supportive psychotherapy (if change has occured)

Questions we try to answer in treatment

- Is it possible to put “too much” effort?
- Is it possible to be “too alert”?
- Is it possible to think “too much”?
- If yes, which mental or physical symptoms should we rely on?
- How many symptoms?
- How do you know if you are well enough to start again?

Treatment goals

- To encourage clients to assess the level of effort they invest
- To encourage clients to control level of effort they invest
- To encourage clients to use the level of performance as a gauge of effort instead of symptoms of discomfort

EMT vs. conventional treatments

Example: **relaxation techniques**

- Do you think you need them?
- How bad do you need to feel to start?
- How much better do you need to feel to stop?
- What is that you put a lot of effort in that only increases the need for them (worrying, analysing, critical self-talk)?
- Why do you think is so important to do that?

Barriers to treatment

- Clients try to apply learned strategies or new insight without changing the way they invest effort
- Often clients have only partial insight into their illness
- The treatment stops when the clients think they are well enough
- Identification with illness

Research so far

- Promising results with clients considered treatment resistant
- A significant number of clinicians trained with consistent results
- Randomised Controlled Trial
- Drop out rate only 20%

Thank you

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