

MEETING THE SUICIDAL PERSON

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PROBLEMS IN CLINICAL PRACTICE

The usual clinical practice

When clinicians are called to see a patient who has attempted suicide, they usually try to assess the risk of further suicidal behaviour by interviewing the patient in their search for clinical risk factors, particularly for signs of a psychiatric disorder, such as depression, substance abuse, severe personality disorder or schizophrenia. Clinical research has established that approximately 90% of suicides as well as suicide attempters are associated with psychiatric disorder (Isometsä et al, 1995, Haw et al. 2001).

Consistent with the medical model is that psychiatric diagnosis serves as a frame for the medical treatment, which, in the case of the suicidal patient, includes inpatient or outpatient treatment of the underlying psychiatric disorder, pharmacotherapy and psychotherapy. The medical model is undoubtedly helpful for physicians because it allows the administration of evidence based treatment strategies.

Yet we have to consider that even in the case of a severe depression, it is not the disorder itself, which initiates the suicidal act, but the "owner" of the depression, the individual itself.

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Clinicians' attitudes

Not surprisingly, health professionals have been found to have difficulties in accepting and understanding suicide attempters, especially in the absence of psychiatric illness (Patel 1975; Reimer and Arantewicz 1986). Physicians had a more favourable attitude towards patients whose motives were interpreted as "wanting to die" than those whose behaviour was seen as manipulative (Ramon et al, 1975; Hawton et al, 1981). Suicidal patients may not consider contacting their general practitioner or psychiatrist when in a suicidal crisis because they often perceive doctors as unhelpful (Hawton and Blackstock 1976; Wolk-Wasserman 1987). Suicidal adolescents are particularly reluctant to seek help (Choquet and Menke 1989). When suicidal persons expect that the physician will label an act of deliberate self-harm as pathological or irrational, they are likely to keep suicidal thoughts and their inner turmoil to themselves.

There is a tendency for physicians and psychiatrists to interpret suicidal behaviour as manipulative, as opposed to the patients themselves, who less often mention interpersonal reasons

for attempting suicide. For instance, Bancroft and colleagues (1979) found a striking discrepancy between patients' explanations of suicide attempts and those of examining psychiatrists. Clinicians most frequently chose reasons for attempting suicide such as "communicating hostility", "to frighten/to make someone feel sorry," "to show desperation," or "aiming to influence other people." The patients, however, were much more likely to explain themselves as wanting "to get relief from a terrible state of mind," or "to escape for a while from an impossible situation." Assuming manipulative reasons is not only a typical interpretation by an outside observer, but also an expression of the medical 'the professional-is-the-expert' attitude.

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Patients' dissatisfaction

"I got very angry when they kept asking me if I would do it again. They were not interested in my feelings. Life is not such a matter-of-fact thing and, if I was honest, I could not say if I would do it again or not. What was clear to me was that I could not trust any of these doctors enough to really talk openly about myself".

Quote from a 36-year old man seriously handicapped by rheumatism, who had taken an overdose of antidepressants after his discharge from the medical ward.

Suicide attempters on emergency wards are special cases. They are not admitted because of an illness or an accident, but because of an act, or an action. Health professionals by their training are ill equipped to understand emotional states that lead to an act of self-harm. The traditional biomedical illness model is a linear and causal model, i.e. it assumes some form of pathology, for which the cause must be identified and treated. Consistent with a causal illness model, health professionals search for the fault in the system, and they have been trained to be the experts in this search. Not surprisingly, patients sometimes report that nurses and social workers have been more helpful than physicians and that they would rather opt for a follow-up appointment with a nurse than with a doctor (Treolar et al. 1993). Treolar et al. found a significant relationship between the staff's listening behaviour and sympathy shown on one hand, and the patients' perception of the amount of help received on the other hand.

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Non-attendance in aftercare

A common problem in the aftercare of suicidal patients - and possibly a result of the shortcomings of the medical model - is that non-attendance at follow-up interviews is alarmingly high (Möller 1990, Morgan et al. 1976, O'Brien et al. 1987). Möller found that compliance was somewhat better if the clinic appointment offered to the patient was with the same person who conducted the initial assessment interview. Nevertheless, even in such cases, non-compliance for the first outpatient interview was as high as 50% or even 60% (Kurz et al. 1988, O'Brien et al. 1987). Similarly, De Vanna et al. (1990) found that 57% of patients after hospital admission due to attempting suicide had no contacts with medical staff after their hospitalization.

Torhorst et al. (1987) in a project aimed at increasing outpatient compliance found that compliance seemed to be a positive function of the therapist's experience with suicidal patients.

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Treatment failures

Coombs et al (1992) investigated the communication between professional caregivers and suicidal patients prior to attempting suicide. Clinicians often had failed to inquire about a potential suicide risk. When suicidality was addressed, clinicians tended to avoid further exploration of the suicidal thoughts, and rarely documented suicidal risk as a significant problem.

So far it has been virtually impossible to show that any aftercare strategy for suicide attempters effectively reduces the risk of further self-harm (see Hawton et al. 1998).

O'Sullivan et al (1999) found a 48% increase of uptake of hospital services in the year after the suicide attempt. This included visits to the emergency room as well as both general and psychiatric admissions and outpatient services. The authors write: "The significant increase in

health service costs following acts of parasuicide ... further highlights the need to address the problem of parasuicide.... The dilemma faced by most clinicians and administrators is how to provide a quality service in the face of increasing demand and reduced resources". Rightly, the Surgeon General (1999) in his call to action recommends training for all health, mental health, and human service professionals concerning suicide risk assessment and recognition, treatment, management and aftercare interventions.

However, in spite of a large literature on risk factors it remains difficult to introduce special treatment strategies (such as strict supervision and intensive medical care) for individuals at risk for any length of time. Factors predictive of infrequent behaviour lead to large numbers of false-positive and false-negative cases and may give the wrong impression of scientific predictability (Murphy 1984, Pokorny 1983). Identifying the rare acute high risk patient seems rather like searching for the needle in the haystack, particularly considering that the average general practitioner is faced with a suicide of a patient once every three to five years.

Clearly, we need new ideas to try to become more effective in the treatment of suicide attempters and suicidal persons in general.

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WHAT'S NEW: A PATIENT-ORIENTED APPROACH

New perspectives

In our view, what suicide research has largely neglected is the factor of the therapeutic relationship between suicidal patient and medical professional. We believe that a necessary prerequisite for the prevention of suicide is a good and trusting patient-doctor relationship. Only then can the communication of suicide intent be expected or the physician's enquiring about suicidal thoughts become possible. This does in no way diminish the importance of medical competence in the assessment of the mental state and in establishing a psychiatric diagnosis.

Therefore, mental health professionals faced with a patient at risk have a dual and difficult task. On the one hand they must have the empathy to understand the patient as a human being - a human being with his or her reasons for an act of deliberate self-harm, on the other hand they must act as an observer gathering clinical information, searching for suicide risk factors and finally come to a case formulation.

Most of us are not taught how to understand other persons' actions, and how people - i.e. patients that come to see us - think about and explain their actions. We have been taught that the art of helping depends on our knowledge and skills and that patients can contribute little to the understanding of their present condition. However, when we try to imagine what would help patients to share their thoughts about suicide and their motives, it becomes obvious that one prerequisite must be a shared frame of understanding how suicidal intentions develop.

Various approaches can be helpful for this purpose. Some authors have proposed a developmental view, i.e. that suicide should be understood in the context of a person's life. Maris (1981) used the concept of a suicide career. This model stresses that repeated painful experiences lead to an increasing feeling of unhappiness, or clinical depression, both resulting in a more internalized interpretation of life difficulties. He points out that suicide is neither perverse nor odd. "In fact it is normal and common". In describing intrapsychic experience, Baumeister (1990) suggests that in the biography of suicidal patients negative experiences and setbacks tend to result in unfavourable attributions about the self, leading to self-blame and low self-esteem. The essence of self-awareness is the comparison of the self with a person's standards.

In a psychodynamic view the ego-ideal constitutes a model toward which a person reaches and attempts to conform. Negative experiences lead to a loss of integrity and positive self-regard (Maltzberger 1997). Suicide is seen as an escape from aversive mental states and negative self-awareness.

Leenaars (1988) from the study of suicide notes concluded that suicide often appears as a solution to the present interpersonal situation as well as the individual's history.

Leenaars (1994) takes up Shneideman's (1993) notion that a suicide act is an intentional and conscious act but adds that it involves substantial unconscious processes, thus proposing an action model of suicide in which both conscious and unconscious processes are present.

Orbach (in press) suggests that the life narrative of a suicidal person can be formulated in terms of a sequence of losses, their nature, and their essence. From such an orientation it is possible for the therapist and the patient to review the past together to learn how the patient's life and the perspectives for the future have become unendurable. Empathic understanding allows therapists, and patients with them, to grasp how it is that suicide seemed the only available alternative.

A central element is unbearable mental pain prior to the suicide act. The related negative cognitions include the belief that a person is unneeded and useless. Emotionally, the negative perception of the self results in actual self-hate, rage and shame, or, as Orbach puts it: a total mental offense on the self. Orbach & Mikulincer (2000) in a phenomenological investigation into mental pain concluded that the

mental pain syndrome constitutes experiential aspects such as a sense of loss of control, emotional freezing and estrangement, emotional flooding, a sense of irreversibility of pain, etc. The fragmentation of the self, and, in particular, the dissociation of mind and body is a common intrapsychic mechanism found in suicidal states (Maltzberger 1993). Dissociation characterized by disengagement from one's self from body sensation (such as physical pain) and numbness may facilitate the actual physical attack on the body (Orbach 1994, 1996).

Jobes (2000) and colleagues have developed an assessment and treatment protocol called the Collaborative Assessment and Management of Suicidality (CAMS). This approach is designed to create a working partnership between the patient and the clinician. The patient's experience is conceptualized as the "gold standard"; the clinician's job is to understand that experience. In this sense, the assessment tool becomes the vehicle through which a joint construction of the meaning of the patient's suicidality is achieved. The assessment thus becomes interventive and the seeds of a viable alliance are sown.

Michel and Valach (1997) developed and clinically applied a model based on the theory of goal-directed action. Suicide in this view appears as a solution to a subjectively unbearable situation and may emerge as a possible goal ("to end a bad story") when a person's major identity goals are seriously threatened. Thus, the model contends that suicidal behaviour is strongly related to life career aspects. Suicidal behaviour is seen as part of a person's life story, emerging as a possible solution in times of crisis due to unsolvable difficulties, failures, or conflicts. An action theoretical model implies that people who have attempted suicide, or who are about to, can explain their actions. In a series of video-recorded interviews Michel and Valach (2001) have found that therapeutically effective narratives can be elicited in interviews when the clinician concentrates on helping the patient tell his or her story. An empathic therapist can help a suicide attempter explain himself in substantial, personally meaningful accounts in the first psychiatric interview after the attempt.

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Patient's narratives

We all make sense of the actions of others' through a person's narrative related to the action. Narratives have been described as representing a series of events and their associated meaning for the teller, and meaning is accomplished interactionally, between teller and listener. Therefore, in the clinical interview, the interviewer must become the participant (although observant) of the patient's narrative, and in this respect he is not the expert whose role is to find the cause or the pathology of the patient's self-harm. The patient's narrative is the basis of a shared understanding. A narrative approach requires openness towards the patient as the agent of his own actions who is well able to explain the subjective logic behind an act of deliberate self-harm

In a self-narrative, patients typically do not explain their suicide attempts with a single cause, but with a story which explains the short term development preceding the attempt, linking it with the relevant parts of the life history. Thus, the narrative contains (1) immediate action related aspects as well as (2) relevant life-projects and (3) central aspects of a person's biography, or life-career.

When asked to explain a suicide action, patients often ask: "How far back do you want me to go?", or "where do you want me to start?". They usually start with a life project relevant for the action in question. After the clinician's opening question, patients usually continue with their self-narrative which in its first part may often last between 5 and 15 minutes without significant interruption by the interviewer. However, clinical experience has shown that it is absolutely essential that right from the start of the of the clinical interview the interviewer asks the patient to tell his or her own story.

Adler (1997) in a paper about narrative clinical reasoning, wrote: "When we are able to formulate the right story, and it is heard in the right way by the right listener, we are able to deal more effectively with the experience". A candid and comprehensive history is generally best obtained by an interviewer who is able to take an insider's view. If clinicians are prepared to be open and listen, they can empathically put themselves in the patient's predicament, and it will be relatively easy to ask the most productive questions and to provide the most helpful responses. The patient and the physician then become fellow travellers on a journey undertaken through the patient's narrative.

A narrative based approach is no contradiction to evidence based medical practice (Greenhalgh 1999). The patient's narrative helps to establish a good doctor-patient relationship, and the interview will have to be completed by the examination of the mental state and the evaluation of risk factors (Hawton 2000, Michel 2000). There can be no doubt that psychiatric disorders must be properly identified and adequately treated. However, based on a joint understanding of the patient's suicidality, therapeutic measures will become a matter of shared decision making.

The endpoint in the suicidal person's narrative is either suicide or life. When the story is retold to a sensitive listener the endpoint may change from death orientation to life orientation. Thus, the narrative of the suicidal patient will not only have a beginning, a middle and an end, but also a future. Only if we are prepared to listen, and if we can join patients in their individual, and often extreme experience of pain, can we become influential in changing the course of actions and in re-establishing life-oriented goals.

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Patients' inner experiences

Interviewing suicidal patients with a narrative approach allows the clinician to join the patients in their inner experience of suffering. The typical mental state immediately before the initiation of deliberate self-harm patients describe in their narratives is characterized by an acute state of anxious emotional perturbation which the individual experiences as unbearable. This is consistent with Shneidman's (Shneidman 1993) concept of unbearable mental pain ("psychache") and of the thought that the cessation of consciousness is the solution for this unbearable condition. According to Baumeister's model (Baumeister 1990) of suicide as an escape from self, negative experiences and setbacks in the biography of suicidal patients tend to result in unfavourable attributions about the self, self-blame and low self-esteem, and, finally, in an acute "cognitive deconstruction".

Patients describe a state of mind, in which the suicide action took place as "automatic, robot-like, trance-like", and in which patients reported not to have felt pain or anxiety. Such experiences are typical for dissociative states. Dissociation has been defined as a lack of the normal integration of thoughts, feelings, and experiences into the stream of consciousness and memory (Bernstein and Putnam 1986). Dissociative reactions are characterized by a disruption of an individual's sense of identity (Nemiah 1980). In the frame of a homeostatic model of self-conservation dissociation is seen as a defence against pain, distress, or humiliation, or against the collapse of the self (Erdelyi 1994). Patients report having felt humiliated by important others prior to attempting suicide, which resulted in a feeling of worthlessness and a loss of self-respect, others report having felt emotionally abused, treated like an object, devaluated as a human being. Suicidal acts may be related to high tolerance for pain and indifference to the body (Orbach 1994, Maltzberger 1993). Our patients often reported that at the moment of the suicidal action (e.g. when cutting) they did not feel pain. Several reports have described automatisms, and feelings of numbness immediately prior to self-injury (Demitrack et al 1990, Orbach et al 1993).

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CAMS

Brief Overview of CAMS

The Collaborative Assessment and Management of Suicidality, otherwise known as CAMS (Jobes, 2000; Jobes, Luoma, Jacoby, & Mann, 1998), is one of only a handful of suicide-specific manualized assessment and treatment approaches for clinical care of suicidal patients. There are many novel aspects to this empirically developed protocol. For example, CAMS uses an evolved version of the Suicide Status Form - SSF (Jobes, Jacoby, Cimboric, & Hustead, 1997) to guide a collaborative phenomenological assessment of the patient's suicidality. The SSF used in CAMS has been expanded to include both quantitative measures as well qualitative measures that are used to reliably assess the patient's suicidality relying on their own words. This approach asserts that the patient's multidimensional experience of suicidality is the assessment gold standard that both the clinician and patient must thoroughly understand before effective treatment can occur. In this regard, our model defies traditional and reductionistic "medical-model" approaches that emphasize the expert-doctor searching for diagnostic symptoms and developing a treatment plan based only on the patient's DSM-IV diagnosis. Indeed, the collaborative use of the SSF leads to the emergence of underlying suicidal constructs that can be used to directly inform and shape the treatment plan. The patient thus becomes a co-author of his or her own clinical treatment plan, which increases compliance and strengthens the clinical alliance therein.

http://www.aeschiconference.unibe.ch/T_Model.pdf

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The Narrative Action Theoretical (NAT) approach

As explained above, the clinician's primary goal must be to establish a trusting relationship that allows patients to share their inner experiences of extreme pain and shame. It can be hypothesized that the ideal interviewer would demonstrate openness towards the patient's explanations of his or her suicide action, and would be able to make sense of the patient's narrative in such a way that his or her model of understanding matches closely with the patient's own understanding.

Michel and Valach (1997) suggested that for clinicians a theoretical model which views suicide as goal-directed action might be particularly useful in reaching a shared understanding of an action of self-harm together with the patient. This model is based on the assumption that actions are the expression of continual processes of moving toward, and away from, various kinds of mental goal representations (Carver and Scheier 1998, von Cranach and Valach 1986). Actions are best understood on the background of a person's short term and long term (life-)projects, such as building a relationship (Valach et al. 1996) or establishing a family (Valach 1990). Thus, action is strongly related to life career aspects. Suicide in this context appears as a possible solution to a subjectively unbearable situation and may repeatedly throughout a person's life emerge as a possible goal when in the patient's perception major identity goals are seriously threatened ("to end a bad story").

A study (Michel et al. 2001, Valach et al. submitted) on clinical interviews with suicide attempters was devised (1) to determine if an approach based on an action theoretical model of suicide would be useful in establishing a working alliance with suicidal patients, and, more specifically (2) to relate patients' perception of helping alliance to the sensitivity of the interviewer towards life-career issues related to the suicide attempt. Typically, a patient's narrative contains the person's central biographical themes (e.g. "I have great problems in coping with separation and loss") - issues that are instrumental for the breakdown of self-respect and the emergence of suicidal thoughts.

Michel et al. concluded that action theory is a useful model to understand a suicide action on the background of life projects and life career. In particular, the acknowledgement of central biographical issues fosters the development of a shared understanding of the patient's suicidality and of a therapeutic alliance between patient and interviewer. If we want to become more successful in suicide prevention we have to refine our models of understanding the patients' experience of suicidal desperation, and thus work towards a more patient-oriented understanding of suicidal behaviour. If clinicians are prepared to be open and listen to the patient's story, and if they understand suicide in a biographical context, they will be able to take an insider's view of the suicidal mind. They will be able to ask the right questions, and they will be in a better position to help the patient in re-establishing life-maintaining goals and restoring the sense of mastery. We should not forget that therapeutic alliance has emerged as the most consistent predictor of outcome across many studies in different models of psychotherapy (for an overview see Horvath and Luborsky 1993, Henry et al. 1994)

An action theoretical understanding of suicidal behaviour implies that people are agents of their actions and that they are able to explain their actions in the form of narratives. Indeed, throughout

the forty interviews Michel and coworkers found that suicide attempters usually have an excellent narrative competence in explaining their act of self-harm in the context of the central life career issues aspects, when the interviewer invites them to explain their action in their own words (Michel et al. submitted). Action theory claims that it represents the way people in an everyday context understand and explain actions (Vallacher and Wegner 1987), and therefore, it may be particularly useful in reaching a shared understanding of an action of self-harm together with the patient .

A narrative based approach is no contradiction to evidence based medical practice (Greenhalgh 1999). The basis of a good therapeutic intervention is a good doctor-patient relationship, and the interview will have to include the examination of the mental state and the evaluation of risk factors (Hawton 2000, Isacsson and Rich 2001). There can be no doubt that psychiatric disorders, if present, must be properly identified and adequately treated.

The endpoint in the suicidal person's narrative is either suicide or life. When the story is retold to a sensitive listener the endpoint may change from death orientation to life orientation. Thus, the narrative of the suicidal patient will not only have a beginning, a middle and an end, but also a future. Only if we are prepared to listen, and if we can join patients in their individual, and often extreme experience of pain, can we become influential in changing the course of actions and in re-establishing life-oriented goals.

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