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Social Work Lecture Series: Do No Harm: Working with Survivors of Sexual Violence

Friday, October 23, 2020, 9:00 am – 12:15 pm, Online Broadcast, Presented by: Mothyna James-Brightful, M.S. & Elisabet Martinez, MSW, LCSW-C, LICSW

Social Work Lecture Series: Clinical Supervision: The Tool for Enhancing the Ethical Practice of Those You Supervise

Friday, November 13, 2020, 9:00 am – 12:15 pm, Online Broadcast, Presented by: Gisele Ferretto, MSW, LCSW-C

Psychology Workshop: Clinical Work with African Americans: Moving Beyond Cultural Competence

Friday, November 6, 2020, 10:00 am – 11:00 am, Online Broadcast, Presented by: Danice Brown, PhD

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Learning Objectives

After attending this program, participants will be able to:

1. Articulate at least 3 basic principles of working psychotherapeutically with suicidal patients.
2. Describe 2 aspects of instilling hope.
3. Discuss the importance of ruptures and repairs in the alliance, and their therapeutic potential.

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Psychotherapy with Suicidal Patients

An Integrative Psychodynamic Approach

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Introduction

- What is an "integrative psychodynamic approach"?
- Discussion of the suicidal process
- Elements of psychotherapy
- Clinical examples

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 implicitly interpretive 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

Efficacy of psychodynamic treatments

- Emerging evidence base for psychodynamic treatments for a wide range of mental health conditions (1)
- Patients often continue to improve after treatment ends (2)
- Recent meta-analysis - psychodynamic psychotherapies can reduce suicidal behavior and self-harm (3)
- In addition to acute relief, goal is for continued development, improved relationships and increased life satisfaction over the long term

1. Abbass et al, 2014, 2015; Driessen et al, 2015, Fonagy 2015, Ougrin et al, 2015, Shedler 2010; Leichsenring and Rabung, 2008; Leichsenring and Klein, 2014; see Shedler, 2010; 3. Briggs et al 2019

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

- "…an experience beyond hope….This anxiety is the anxiety of annihilation – panic and terror. People will do anything to escape from this experience" (1)
- Different than loneliness –loss of "evocative memory,"(2) inability to experience connection/support, timeless quality
- Relationship to "thwarted belongingness"(3)

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

Emergence of suicidal intent

- 50% who survived attempts reported SI/intent emerged within 10 minutes of the act (1)
- Most 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; 2. Milner et al, 2016; 3. 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
  - Surprise/disillusionment/feelings of failure
- Denial of SI can be both genuine *and* unreliable
- Psychotherapy: psychoeducation, skill building, crisis planning, rehearsal while calm

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)

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 memories of mistreatment, more physical dissociation, less attention to bodily cues (1, 2)
- Body can be experienced as "other," "alien," source of pain (3)
- "The body keeps the score" – somatic memory (4)
- Psychotherapy: recognizing somatic experiences → emotions → connection with behavior

1. Orbach et al 2001; Orbach 2003; Orbach et al 2006; 2. Levinger, 2015; 3. Maltsberger, 2004; Goldblatt and Maltsberger, 2009; 4. van der Kolk, 1994

How can psychotherapy help?

Common elements of treatment

- Review of empirically supported treatments for suicidality – DBT, CBT, TFP, SFP, MBT
  - Clear framework
  - Clear plan for crisis management
  - Emphasis on exploratory and change interventions
  - **Close attention to affect**
  - **Active therapist**

Weinberg et al, 2010

Common elements of treatment

- Review of empirically supported treatments for BPD – DBT, TFP, SFP, MBT, GPM
  - Specific frame for treatment
  - **Recognition of patient's responsibilities**
  - Therapist has conceptual framework for treatment
  - **Attention to the therapeutic relationship**
  - Prioritization of suicidality when it emerges
  - **Support for the therapist**

Sledge et al., 2014

Instilling hope

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

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

Validation

- Essential to instilling hope
- Experience of non-judgmental acceptance *as I am*, even while needing to work toward change [2]
- Patient's suicidality as *understandable,* and that it *matters*
- Counters harsh self-criticism, shame –"functional neutrality" [2]

1. Linehan, 1993; 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)
- Bolstering sense that patient *matters*
- 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
- Facilitating vs. "life-sustaining" fantasies (1)
- Collaborative exploration, "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
- Incorporation of CBT/DBT techniques, while listening for effect of interventions

Affect Tolerance

- Patients come into treatment unaware of unconscious avoidance of thoughts/feelings that make them anxious, keep them stuck, etc
- 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

- People tell themselves and others stories that integrate experiences into a "self", link past, present and future, provide coherence (1)
- Narratives are changed ("co-created") in the act of the telling/listening (1)
- Therapist is the active "listener," demonstrates understanding, acceptance, empathy, adds 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

- "Implicit relational knowing", "inner working models" - derived from early caregiving experiences (1,2)
- People selectively attend to data, act in accordance with expectations, and *elicit* confirmatory responses from others → repeated social reinforcement of negative self concept (3)
- Relation to "transference," "projective identification"
- Goal is disruption of "vicious neurotic cycle" (4)

1. Stern et al, 1998; Lyons-Ruth 1999; 2006; 2. Bowlby, 1973: 3. Swann, 2011; 4. Wachtel,, 2009

Therapeutic alliance – rupture and repair

- Ruptures as therapeutic *opportunities* (1)
- Moments of meeting,"(2) "throwing away the book, (3) "radical genuineness" (4)
- Potential for learning that an old relational pattern does not have to be repeated, relationship holds promise of trying something new
- Patient needs *affective experience* of therapist's engagement, individual responsiveness (5)

1. Long et al, 2008; Lewis, 2000; 2. Stern et al, 1998; 3. Hoffman, 1994; 4. Linehan, 1993; 5. Schechter et al, 2013

Emergence of genuine capacities

- Learning about and growing into one's genuine capacities requires the capacity to take in recognition from others without having to resort to automatic defenses
- This is a critical developmental achievement and can be disrupted by trauma, neglect, lack of early attunement
- 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

Attention to countertransference

- Anxiety and fear – suicide *may happen*
- Relentless suffering hard to bear in context of high motivation/low ability to alleviate distress
- Relentless hopelessness can become convincing
- Set up for "countertransference hate," hopelessness, 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 (1)
- Erratic reinforcement of emotional escalation and threats as a way of getting needs met (1)
- Suicidal ideation/threats/behavior can be explicitly or implicitly contingent
- Unconscious instrumental behavior can be *experienced* as consciously "manipulative"

1. Linehan, 1993

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…*as experienced by the patient*
- Countering self-criticism, self-blame, shame
- Modeling of non-judgmental inquiry, goal of shared understanding of suicidality
- Instilling hope: pathway + enhancing agency
- Sustaining belief that patient *can* be helped
- Clear crisis plan
- Analysis of crises/self-harm, with skill building, coaching

Elements of Psychotherapy - Summary

- Continuity of experience as *goal*, not assumption
  - Provision for contact between sessions
- Building affect tolerance
- Attention to cyclic relational patterns – including with therapist
- Ruptures as therapeutic opportunities - willingness to step out of "usual" frame when needed
- Facilitating internalization of genuine capacities, including explicit recognition
- Support for therapist, consultation when needed

Conclusion

- An integrative approach to psychodynamic psychotherapy can be effective in alleviating suicidal crises while taking a long-term, developmental and relational approach
- This model offers a pathway to decreasing harsh self-judgment, greater connection with the body, lessening of harsh self-criticism, positive changes in narrative identity, emergence of the patient's genuine capacities, and more satisfying interpersonal relationships, all of which helps the patient to build a life worth living

Appendix – Clinical Examples

Clinical example – "suicide mode"

A 48 year old father of 3 had chronic intermittent SI with fleeting thoughts about hanging himself, but never actual intent. He said that loved but felt neglected by his wife, loved his children, and that he would never kill himself because of his concern for them. One day after feeling his wife had been dismissive, he suddenly felt detached and alone. He felt enraged at his wife and disconnected from any positive experience of her. He started to think that he was a terrible father and that his children would be better off without him, and he decided that he would hang himself in the basement. He had the noose set up and around his neck when the thought of his son finding him came to mind, and he suddenly realized that he did not want that to happen and aborted the attempt. Upon later reflection in the hospital he was amazed how disconnected and alone he had felt. He said that when he thought about his children it had felt detached from warmth and connection. He also wondered where the intensity of rage toward his wife had come from, since he no longer felt it.

Clinical example – the body

Elaine was a 43 year old suicidal woman who had been subjected to severe incestuous sexual abuse as a child. "When I think about how he used to abuse me," she said, "I could tear my hair out, I could rip up the blanket on the bed." The therapist asked: "I notice it is your hair, your body, that you think to attack when you remember, why not him?" "What's the difference?" she replied, "What does a 3 year old know about anything? My body? It was my body that was doing the hurting. My body that was giving the pain. It was his. I learned to hate it early. That's where the hurting and the fear and the humiliation was. I was trapped by him, and my body was his cage."

From Goldblatt and Maltsberger, 2009

Clinical example – genuine capacities

T: It sounds like you did a great job. **P**: (*Averts eyes, laughs*) Well, I don't know…I'm just glad things worked out. **T**: Hmm…What just happened there? Did you notice what you did? **P**: What? **T**: The way you averted your eyes, and laughed…That "your just glad it worked out." It seems like my saying how skillful you were made you uncomfortable. **P**: Yeah…I don't know why. **T**: Do you think you could tell me about how you think you did with this? **P**: (*Averting eyes*) Well…I think I did well enough. **T**: "Well enough"? **P**: (*Laughs*) I see what you mean…but it's so hard. **T**: Yeah. When I notice that you are good at something it makes you anxious and you deflect it. I think it keeps you from taking in that this is really *you.* **P**: I see what you mean…**T**: Can you try saying it to me again? Tell me about what you accomplished…and see if you can look at me. **P**: Well…(*looks at therapist*) There was a complicated situation, and I handled it really well…It took a lot of thought…and I pulled it off. **T**: How did that feel? **P**: It felt hard to do…I wanted to look away, and it was hard to say those words…But it also felt almost good in a way.

Clinical example - countertransference

A young therapist started working with a 23-year old man with BPD referred by a senior colleague who felt that he needed "a really talented therapist." He frequently talked about suicide in a worrisome way, but never with clear intent. The patient would often tell the therapist that he wasn't helping him the way his past therapist did. He worked as a counselor in a residential setting for children, and would sometimes describe behavior that sounded on the borderline of abuse. During one session he described behavior that worried the therapist more than usual. He thought about calling a supervisor, but decided that he was mandated to report. The patient then terminated treatment and refused any further contact. The therapist felt horrible, feeling he had acted prematurely, without taking the time to fully think it through and get consultation. In his own therapy, he realized that he had felt pressured to be a "special" therapist for this patient, and that if the patient ever were to die by suicide it would reflect on him. He felt helpless, like he was failing at the thing he cared most about. He also became aware of the devaluation that he had unconsciously accepted from the patient, and the unconscious rage and hopelessness that was ultimately expressed in decision to report. The therapist came to experience his work with this patient as an extremely painful but important clinical experience in his own development.

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