CAROLYN SPRING
reversing adversity

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PowerPoint handouts

(with space for notes)

Dealing with Distress:

Working with Suicide and Self-Harm

online training

SESSION 1

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- I made a number of suicide attempts starting when I was 20
- Too much pain + too few coping strategies = suicide
- My story brings hope, but I am not an 'outlier'
- Recovery is not just for a few 'special' people – it's for everyone

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- The cry of our pain is 'Why?!'
- We can feel conflicted towards a person who takes their own life
  - Compassion for their pain
  - Anger at the pain they have caused
- What is going on in the brain and body of a suicidal person?

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- The 'suicidal mode' is a brain profile identical to traumatic states
- We can become distressed and overwhelmed supporting someone who is distressed and overwhelmed
- Our anxiety may be the single greatest hindrance to helping
- We need solid hope to give hope

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- On this course we will look at:
  - How our current approach may actually increase the risk of suicide
  - The neurobiology of suicide and self-harm and its crossover with trauma
  - A collaborative, not coercive, approach to helping people

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- Our knowledge of suicide is largely limited to people who survived
- Self-harm and suicide are not inevitably linked although they share a common neurobiological basis
- Self-harm at times may be protective against suicide (in the short term)

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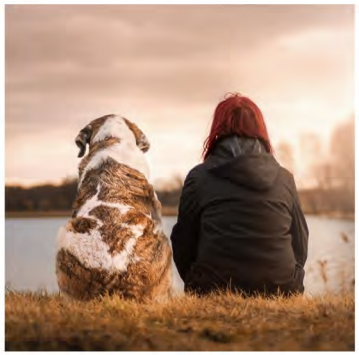
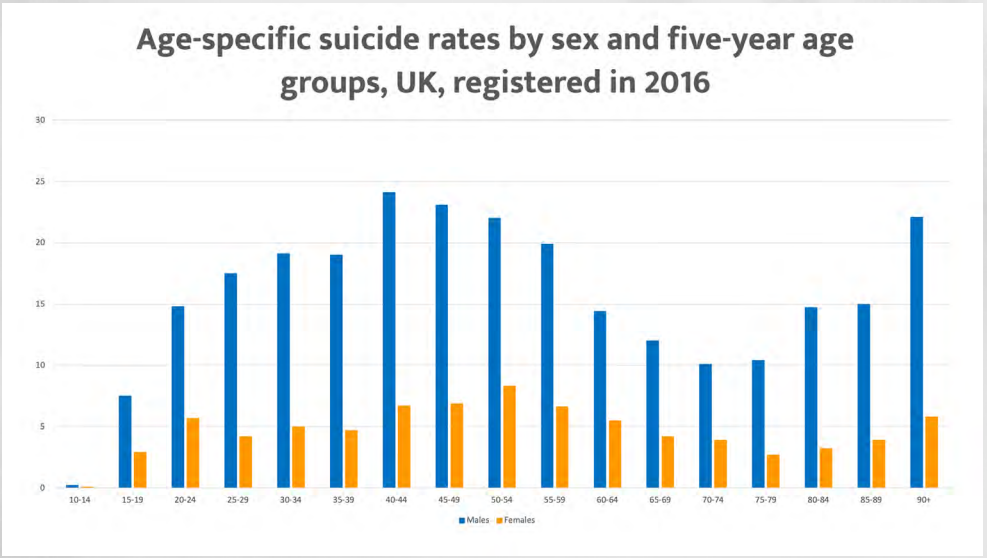
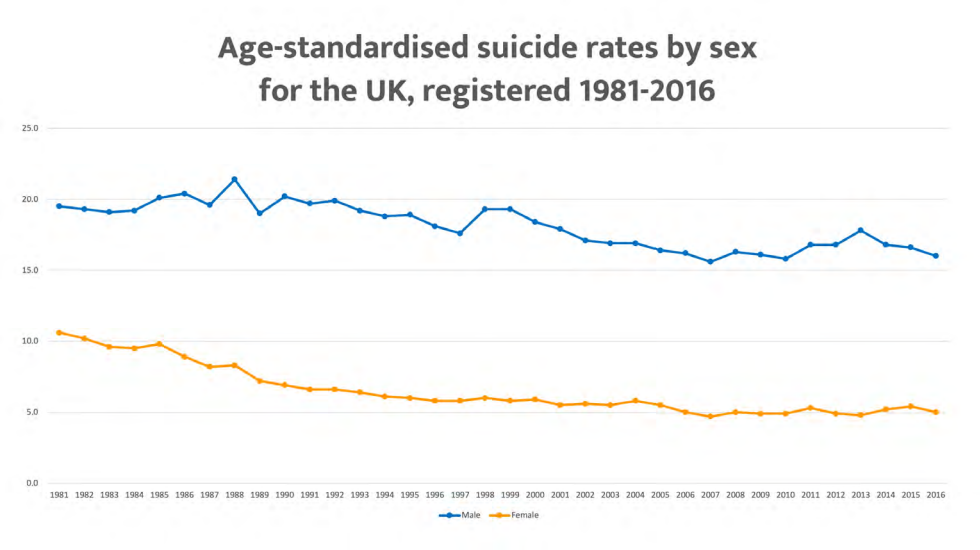
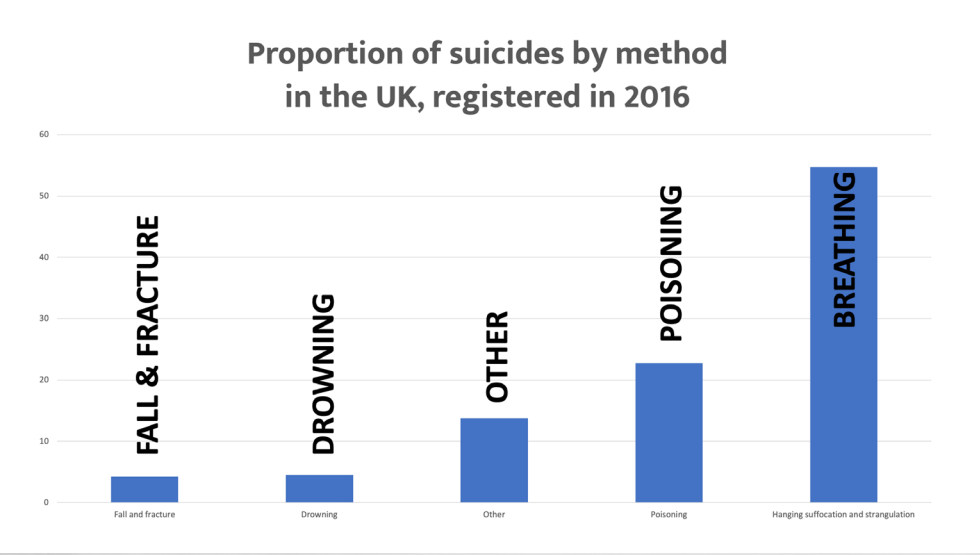
- Various theories of suicide:
  - The result or by-product of mental illness
  - The result of social pressures
  - The result of 'negative distortions of interpersonal experiences'
  - Escape from self
  - A 'way out' from suffering

- Reducing suicide to a theory can miss the unique suffering of the individual
- 'Why is this person, right here, right now, suicidal?'
- Your being may be your greatest doing
- Theories can be helpful if they aid us in reducing distress and suffering

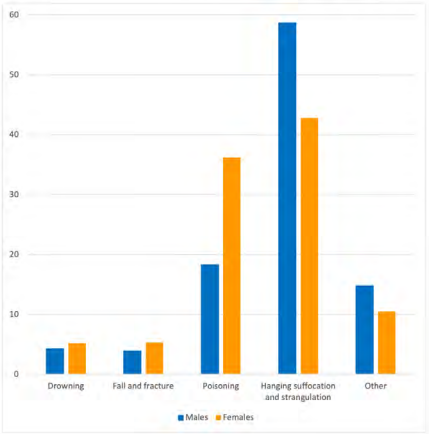


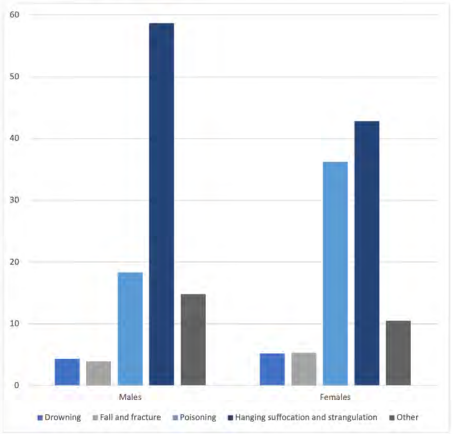




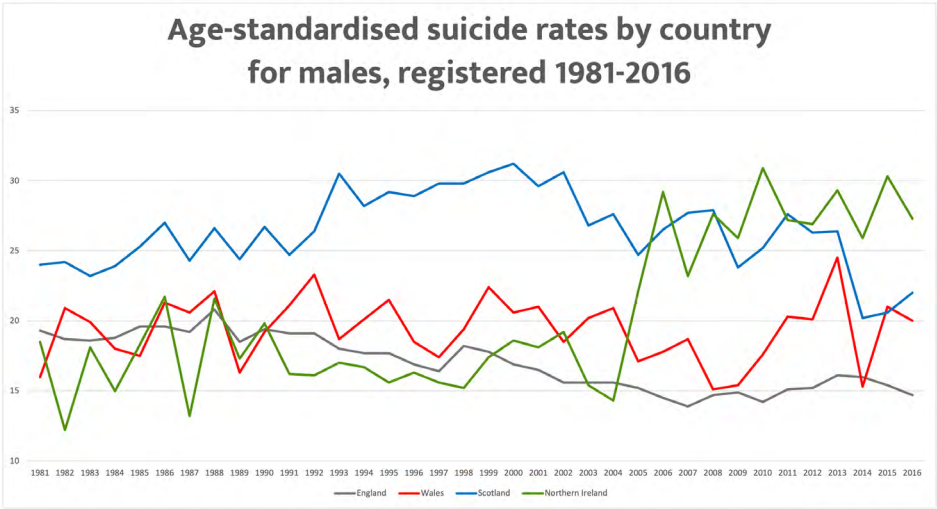


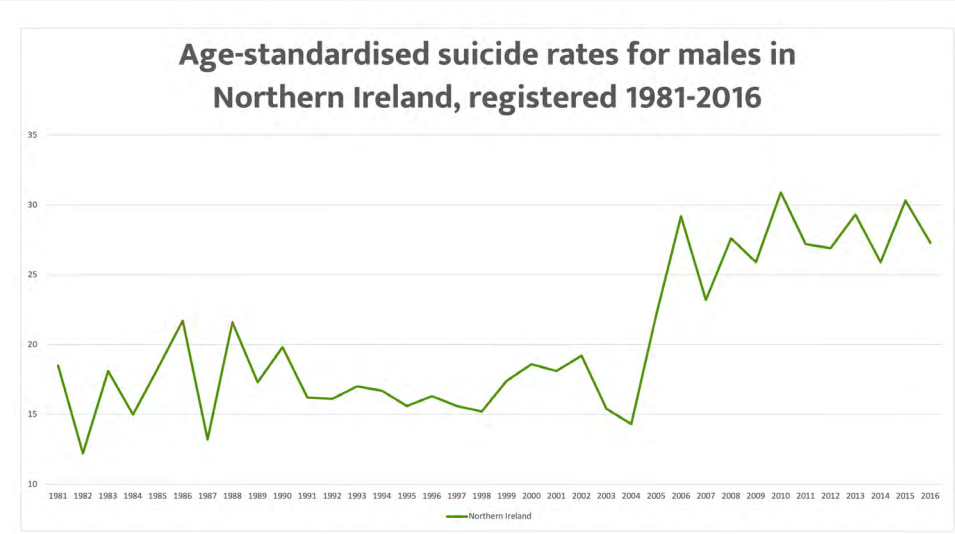
Proportion of suicides by method and sex in the UK, registered in 2016

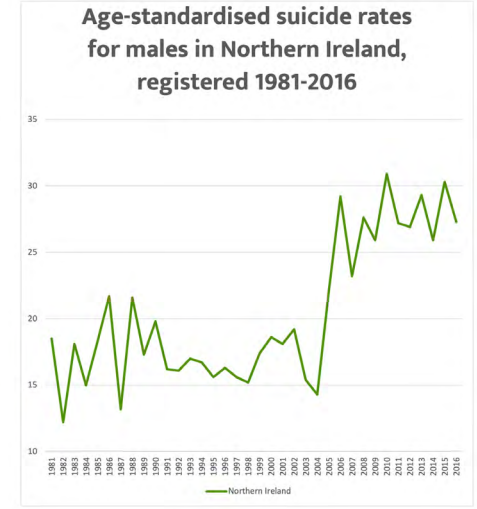




Age-standardised suicide rates by country for males, registered 1981-2016







'Those born into the conflict or who were children during the worst years of violence are the cohort which now has the highest suicide rates and the most rapidly increasing rates of all age groups.'

Prof Michael Tomlinson
Queen's University, Belfast

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Why do you think three times more men kill themselves compared to women?

Do you believe that recovery is possible for everyone, or just for a few?

What is your theory of suicide?

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- Factors for increased risk of suicide:
  - Genes (e.g. 5-HTTLPR – serotonin)
  - Prenatal exposure to glucocorticosteroids (stress hormones) resulting in HPA-axis sensitivity
  - Birth trauma
  - Suicide in the family

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- Childhood trauma (ACES study)
- Social factors (e.g. socioeconomic, employment, ethnicity, marriage)
- Alcohol-dependence
- Mental health conditions, e.g. depression
- A 'triggering event'
- Agitation

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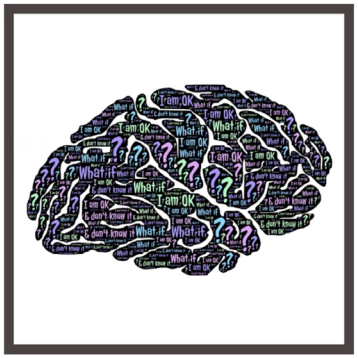
- History of suicidal coping behaviours
- 'Suicidal mode' brain activation
- Availability of means
- On your own
- Three A's are particularly significant:
  - Alone
  - Alcohol
  - Agitation



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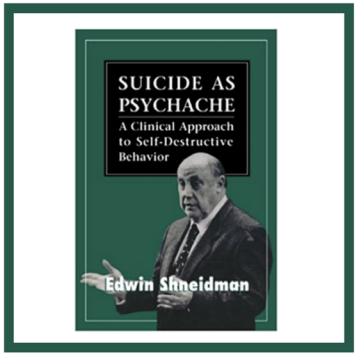
- Edwin Shneidman: 'perturbation'
- 'A unique and pivotal suicidal construct.'
- 'The state of being emotionally upset, disturbed, and disquieted.'
- 'Completed suicides rarely occur without the psychological 'oomph' to overcome our natural thresholds to avoid pain and death.'



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- Risk factors do not identify acute risk
- 'Is this overweight man in his fifties going to have a heart attack today?'
- Edwin Shneidman: cubic model of risk
  - Pain
  - Press
  - Perturbation

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- David Jobes: Suicide Status Form
  - Cubic model plus 3 more measures
  - Hopelessness (Aaron Beck): 'an expectation that your negative situation will not get better no matter what you do to change the situation'
  - Self-regard (Roy Baumeister): suicide as an escape from self

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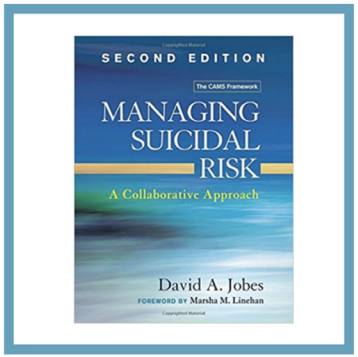
- David Jobes: Suicide Status Form
  - Final measure: 'overall risk'
  - 'How likely is this person to kill themselves now?'
  - Clear and imminent danger
- SSF-4 from the CAMS Framework
  - 'Collaborative Assessment and Management of Suicidality'



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- 'Vulnerability to suicide is dynamic and fluid, such that suicidal individuals are in greatest jeopardy for time-limited periods, that is, when they lapse into the **suicidal mode.**'
- Organisational risk assessment often uses non-specific forms
- Government strategy based on general risk factors

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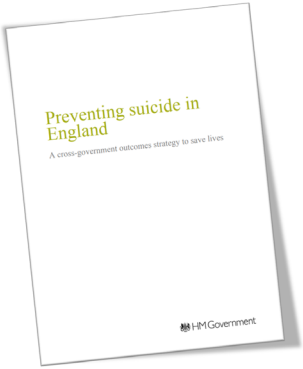
- Suicide Strategy for England (2012) – high-risk groups:
  - Young and middle-aged men
  - People in the care of mental health services, including inpatients
  - People with a history of self-harm
  - People in the criminal justice system
  - Specific occupational groups



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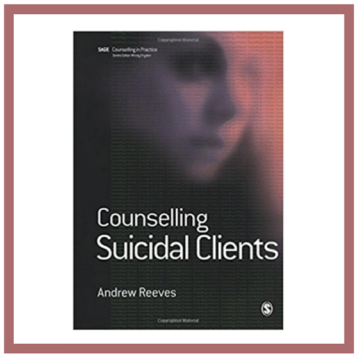
- 'While our current understanding helps us predict trends of risk within certain populations and demographic groups, we still do not understand enough to predict specific risk within individuals.' (Andrew Reeves)
- The 'prediction-prevention' model
- Cannot apply the general to the specific



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How would you go about assessing risk?

What makes you most anxious in working with suicidal people?

Do you think that suicide can (or even should) be predicted and prevented?

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- The 'prediction-prevention' model: engenders the belief that suicide is always avoidable
- A completed suicide is therefore a failure (blame-culture)
- 'If the patient dies by suicide, it is widely seen as the fault of the therapist, rather than the fault of a disease (or, more pointedly, the fault of the patient).' (David Jobes)

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- The clinician has the responsibility for the client, but the client has the power
- 'Most people who commit suicide talk about it; most people who talk about suicide do not commit it. Which to believe?' (Edwin Shneidman)

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- Two consequences of blame:
  - Destructive anxiety
  - Shift from reducing distress to reducing 'risk'
- Reduce risk to ourselves, not the client
- Pressure to refer on
- Default response becomes detention under the Mental Health Act

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- Inpatient care can make things worse by decreasing a sense of safety
- Unfamiliar environment
- Powerlessness and lack of choice
- Truncated 'flight' response increases likelihood of 'fight' response
- Loss of dignity
- Teaches that 'safety' is coercive and distressing

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- Removes responsibility for safety from the client/patient
- Frequent 'shame and blame' response
- Staff are responding to the prediction-prevention culture
- NICE Guidelines don't focus on soothing distress but on assessment-diagnosis-treatment

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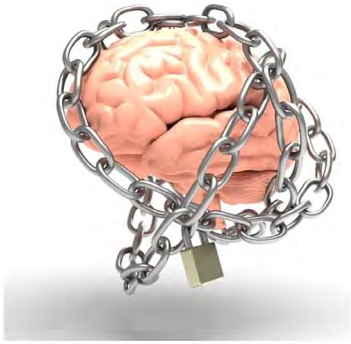
- Assessment is focused on pathology and risk (predict to prevent)
- Power is with the clinician and increases distress by decreasing safety
- Assumption of underlying 'mental illness' as driver for suicidality (rather than distress)
- Is non-compliance a sane response?



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- NICE pathway on self-harm
- 'Primary healthcare practitioners, ambulance staff, triage nurses and emergency department medical staff should assess and document mental capacity as part of the routine assessment of people who have self-harmed.'

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- Link between self-harm and mental incapacity
- But self-harm is a sane and rational method of relieving pain
- The standard response can increase a suicidal person's distress
- Like treating a head injury by banging the skull against a wall

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To what degree do you believe that suicide can be prevented?

Do you believe that suicide **should** always be prevented?

In what ways can you relieve distress and increase someone's sense of safety when they are feeling suicidal?

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- The suicidal mode is 'remembered'
- Increasing activation = increased risk
- Three characteristics:
  - Distress and pain
  - Constriction of cognitive function
  - Relational disturbance
- Normally anterior cingulate cortex (ACC) lights up when in pain (physical or psychological)

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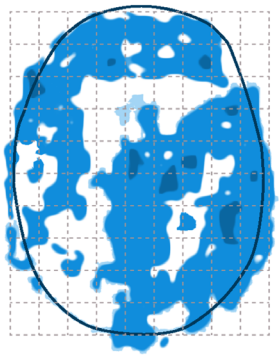
- This doesn't happen in suicidal states
- Instead, the 'suicidal mode' replicates the brain pattern activation of trauma
- Shutdown of 'front brain'
- 'Suicidal mode' = 'a traumatic state of mind'
- Two gear system:
  - 'danger mode'
  - 'daily life mode'



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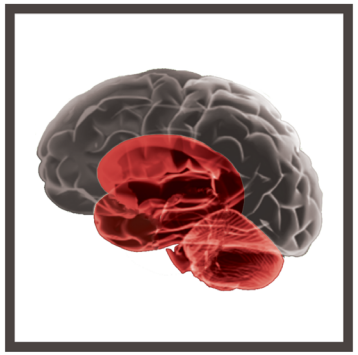
- 'Danger mode' = back brain
- 'Daily life' mode = front brain
- Being traumatised means to be stuck in 'danger mode'
- Trauma is not just 'big, scary events'
- Trauma is anything which switches modes in your brain and it remains stuck there
- Suicidal threats evoke 'danger mode'



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- These brain modes are innately linked with physiological states
- The vagus nerve is the primary conduit

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- Green zone – safety, front brain online, 'social engagement system'
- Amber zone – under threat, back brain online, 'fight or flight'
- Red zone – overwhelmed, front brain fully offline, 'freeze'

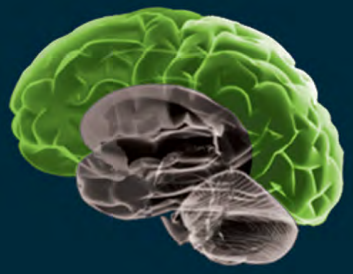
FRONT/BACK BRAIN AND THE TRAUMA TRAFFIC LIGHT

Red Zone

- Freeze
- Front brain off
- Parasympathetic (dorsal vagal circuit)

Amber Zone

- Fight/flight
- Front brain off
- Sympathetic



Green Zone

- Social engagement
- Front brain on
- Parasympathetic (ventral vagal circuit)

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- Suicide does not take place in the green zone
- Accurate 'prediction-prevention' should be based on the traffic light
- There is also a suicide-specific 'blue zone'
- Self-harm is an attempt to cope with the amber zone by evoking the red zone

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- Amber zone = agitation to do something
- Impairment of front brain functioning, including Broca's area (speech)
- When agitated, we want relief through numbing (e.g. drugs, alcohol)
- We can create our own opioid rush by pushing ourselves into the red zone

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- Self-harm makes sense at a neurobiological level – it is effective
- Self-harm is an attempt to relieve pain, not cause it
- Self-harm reduces distress in the short-term but with a long-term cost
- It becomes a vicious cycle (a self-reinforcing loop)

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What is your experience of working with people who self-harm?

When someone has self-harmed, what is their usual response towards themselves?

How might this be part of the vicious cycle too?

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- Self-harm is often cited as a risk factor for suicide
- But most people who self-harm do not go on to kill themselves
- Removing self-harm as a coping mechanism can increase risk and is experienced punitively
- Ally with the goal of reducing distress in the short-term AND long-term

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- Traffic-light approach:
  - Help soothe distress and agitation of amber
  - Bring the front brain online
  - Soothe the body
  - Come back into the green zone
  - NOT the temporary solution of 'numbness' in the red zone

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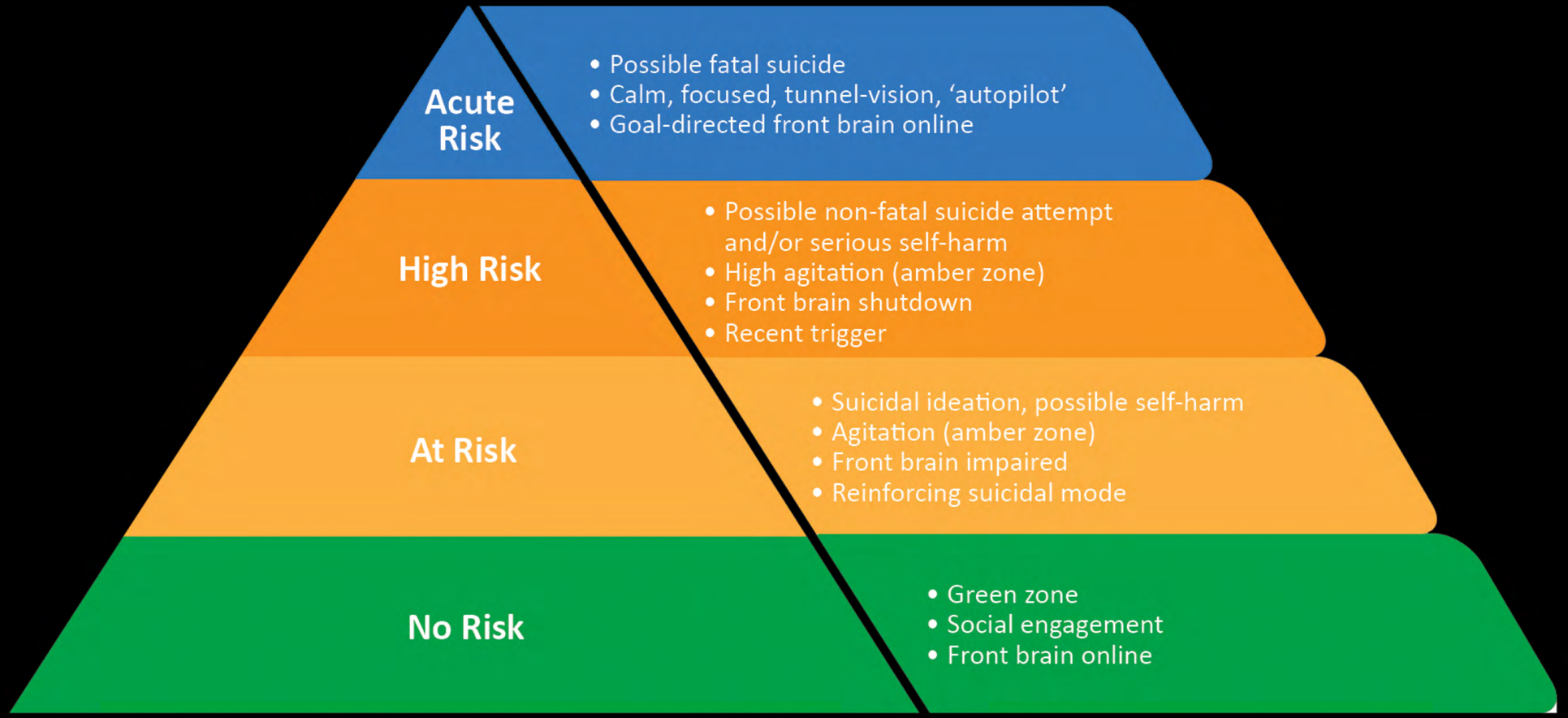

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- Blue zone is when someone makes the decision to kill themselves
- Not agitated or apparently 'suicidal'
- Very unique brain state
- There is the numbing calm of the red zone with front brain shut-off
- BUT ... 'goal-directed' front brain comes online in isolation

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- 'Autopilot'
- Often results in a fatality – is planned
- We need to take immediate action
- We tend to conflate amber and blue

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- Sectioning can increase distress dramatically in the amber zone
- Our goal should be the green zone
- Blue zone requires interventions that may temporarily increase distress

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- Your anxiety may be the greatest hindrance
- Our brains signal danger to other brains
- Not what is said, but how it is said

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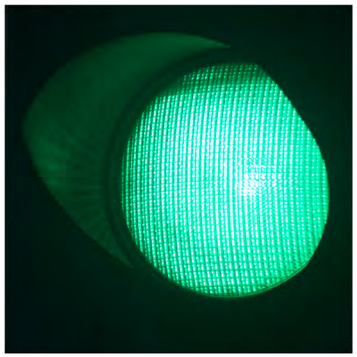
- Green zone provides double benefit:
  - reduced distress
  - AND reduced risk
- Are you working from your own green zone, and building capacity for it?



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Are you aware of signs that you're going out of the green zone, e.g. into amber? What are these signs?

What strategies work for you personally to bring you back into the green zone?

Are your current self-care and supervision practices sufficient to keep you in the green zone? What could be improved?

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- The front brain during the 'suicidal mode' goes offline
  - Strategies for getting it online
  - Reminders in an 'emergency box'
- Three parts of the front brain:
  - Front left (dorsolateral prefrontal cortex)
  - Front middle (medial prefrontal cortex)
  - Front right (right orbitofrontal cortex)

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- Front left (despair)
  - Impaired timekeeping
  - Impaired problem-solving
  - Impaired sequencing and planning
  - Impaired memory
  - Impaired impulse control
  - Loss of reference points
  - Impaired speech and language

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- Front middle (dissociation)
  - Lack of grounding and centeredness
  - Sense of body as 'other'
  - Failure of mindsight – to 'just notice' thoughts and feelings
  - Failure to mentalise – reflective function
  - Loss of empathy
  - Impaired ability to execute a plan

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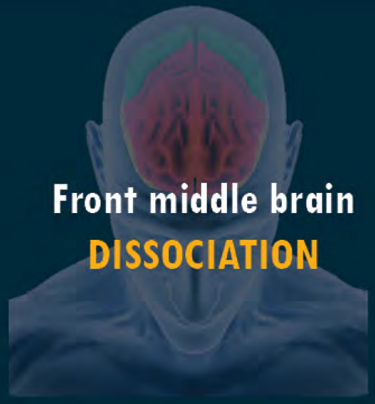
- Front right (disengagement)
  - High levels of emotional distress
  - Hyperarousal (amber zone)
  - Emotional states experienced somatically rather than verbally
  - Mental state is overwhelming
  - Breakdown of effective care-seeking

THREE PARTS OF THE BRAIN: IMPAIRMENTS DURING THE 'SUICIDAL MODE'

Front left brain
DESPAIR

- Impaired timekeeping
- Impaired problem-solving
- Impaired sequencing and planning
- Impaired memory (e.g. for what helped in the past)
- Impaired impulse control
- Loss of reference points for what's normal (e.g. reality testing, evaluation of others' intentions, expectations of outcomes)
- Impaired speech and language



Front middle brain
DISSOCIATION

- Lack of grounding and centeredness – experiences of dissociation
- Sense of body as 'other' (e.g. out of body experiences)
- Failure of mindsight – to 'just notice' thoughts and feelings
- Failure to mentalise – reflective function (see yourself from the outside-in and others from the inside-out)
- Loss of empathic capacity
- Impaired ability to execute a plan

Front right brain
DISENGAGEMENT

- High levels of emotional distress
- Hyperarousal (amber zone)
- Emotional states experienced somatically rather than verbally ('wordless terror')
- Mental state is overwhelming to both self and others
- Breakdown of effective care-seeking strategies (e.g. stuck in 'flight' or 'fight')

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What practical things can you do, or suggest be added to an emergency box, to bring the front left brain online?

How about the front middle brain?

And finally the front right brain?

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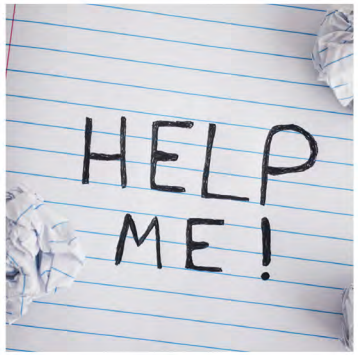
- This work is far from easy!
- Outside the green zone, we don't do relationships well
- Pain relief trumps all other priorities
- My co-dependent relationship evoked insecure-ambivalent attachment patterns from me
- Suicide became my 'language'



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- I didn't understand any of the reasons for my distress
- I was stuck in a cycle of separation anxiety
- I had no self-soothing strategies
- Being a saviour became a drag
- Self-preoccupation: response to the 'danger mode'

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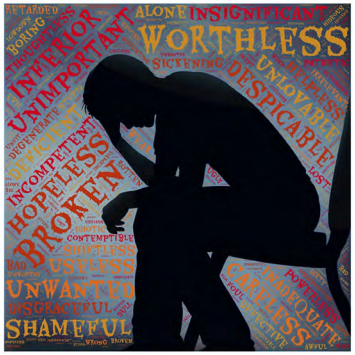
- Self-hatred
- Paradox: 'I won't love me, but you must!'
- Sense of entitlement
- All-or-nothing
- Demanding and self-pitying behaviours
- Surreptitious rage drove my suicidal gesturing



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- Developmental aspects: front brain doesn't fully come online until around 25 years of age
- I had no emotional regulation skills
- I had low resilience for what I wasn't 'gifted' at
- I believed I was 'defective'
- Self-hatred: suicide as escape from self

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- The anxiety of constant suicide threat pushes supporters into amber
- It is often easier to submit than to risk an explosion (and suicide)
- It is hard to remain compassionate
- Love can turn to hate

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- Two ends of a spectrum:
  - abandonment
  - rescuing
- Responding out of our neurobiology rather than our front brains
- Contact needs can quickly escalate

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- Therapeutic relationship becomes a battleground:
  - Clinician advocating for life
  - Client advocating for death
- 'Get rid of the client before they get rid of themselves' (unconscious act)

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Have you ever got into a cycle of giving more and more to a client, and it having less and less effect?

What kind of boundaries do you think need to be in place to sustain this kind of work long-term?

How do you get out of the battle between 'I want to die' versus 'I want you to live'?

SESSION 8

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- Very common to become a 'revolving-door' patient
- Suicide and self-harm are NOT the problem
- They are attempts to solve the problem
- The problem is distress – caused by a multitude of underlying drivers
- These need to be resolved

SESSION 8

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- Distress is often seen through the lens of pathology – 'mental illness'
- A drugs response is inadequate and can increase risk of suicide
- Drugs suppress symptoms but don't teach skills
- We need 'pain-handling skills'
- Distress is inevitable in life

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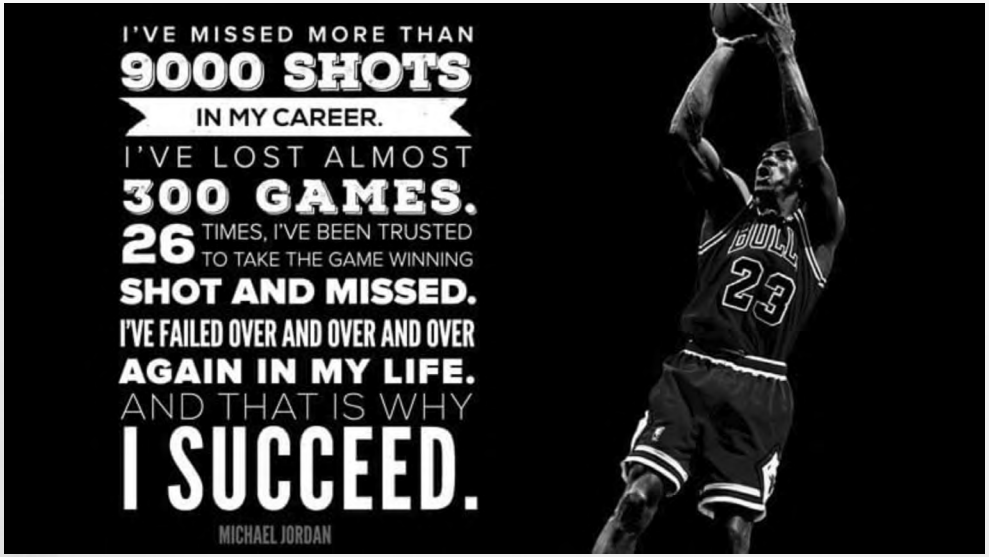
- The 'myth of specialness'
- Instagram-culture = ready-made success
- We need resilience for failure
- We tend to think that people are born as successes or failures
- We believe that mentally healthy people can handle life because they're mentally healthy



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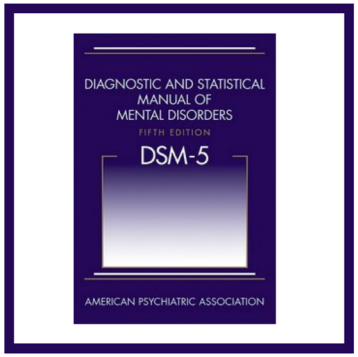
- Psychiatric diagnostic manual:
  - Axis I: most mental health disorders
  - Axis II: 'mental retardation and personality disorder'



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- With borderline personality disorder (BPD/EUPD), psychiatry says you cannot change or recover
- 'Pervasive instability of interpersonal relationships, self-image and mood and impulsive behaviour'

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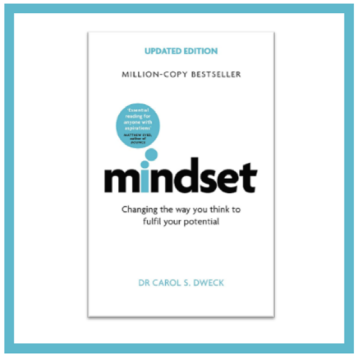
- This could have been me!
- The change in me is not because of me
- The change in me is because change is possible
- Fixed mindset -v- growth mindset
- What we believe about our capacity for change and growth can determine the degree of our change and growth



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- 'Fixed mindset'
  - A belief that your qualities (e.g. intelligence, personality) are fixed
  - You have what you are born with
- 'Growth mindset'
  - What you are born with is just the starting point for development
  - Abilities can be cultivated through effort

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- The key is 'purposeful engagement'
- We tend to think that people are brilliant because of inherent abilities, not because of their effort

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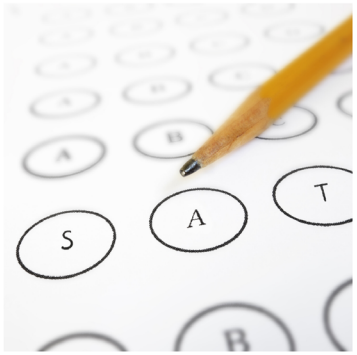
- If you believe ability is fixed, why waste time practising? – you won't get any better because you're no good
- 'It's not always the people who start out the smartest who end up the smartest' (Carol Dweck)



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- 'Mental wellness' is not about the hand you've been dealt
- It's about purposeful engagement to learn the necessary skills

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- I used to equate 'not having the skills to manage distress' with 'being mentally ill' (i.e. 'defective')
- Not being able to play the piano does not mean I have 'piano deficiency disorder'

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Do you tend to have a 'fixed' or a 'growth' mindset?

Thinking of the suicidal people you know or have worked with, what have been the underlying drivers for their distress?

How do you conceptualise your role in helping people develop 'skills to manage distress'?

SESSION 9

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- Everyone who is suicidal is ambivalent
- The suicidal client must battle their ambivalence themselves
- Advocate for strategies that reduce distress effectively and in the long-term
- Suicidality maintains distress
- Set goals for the work to set out expectations, boundaries and responsibilities

SESSION 9

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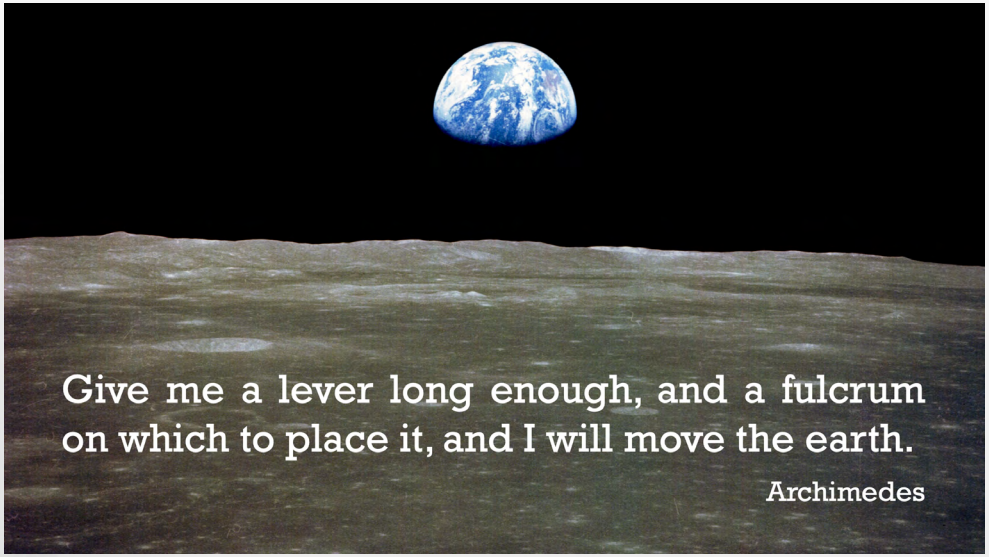
reversing adversity

- 'I am allying with your goal of reducing your distress'
- Equal responsibility and a collaboration
- Why do some people not make progress in recovery?
- Is someone somewhere colluding with their fixed mindset?
- We **can** be trained to deal with distress



SESSION 9

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- 'I care about your suffering so much that I have to see it relieved.'
- The antidote to wanting to die is wanting to live
- Not just learning to cope, but becoming an 'emotional athlete'
- However 'emotionally disabled' we are right now, we can achieve more

SESSION 9

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How can you contract with your suicidal clients so that you're letting them battle with their own ambivalence rather than taking sides for them?

Do you tend to focus on the size of the earth, or the length of the lever?

Are you limiting your clients in any way because of a lack of belief in them? How can you support them without doing things for them?

SESSION 10

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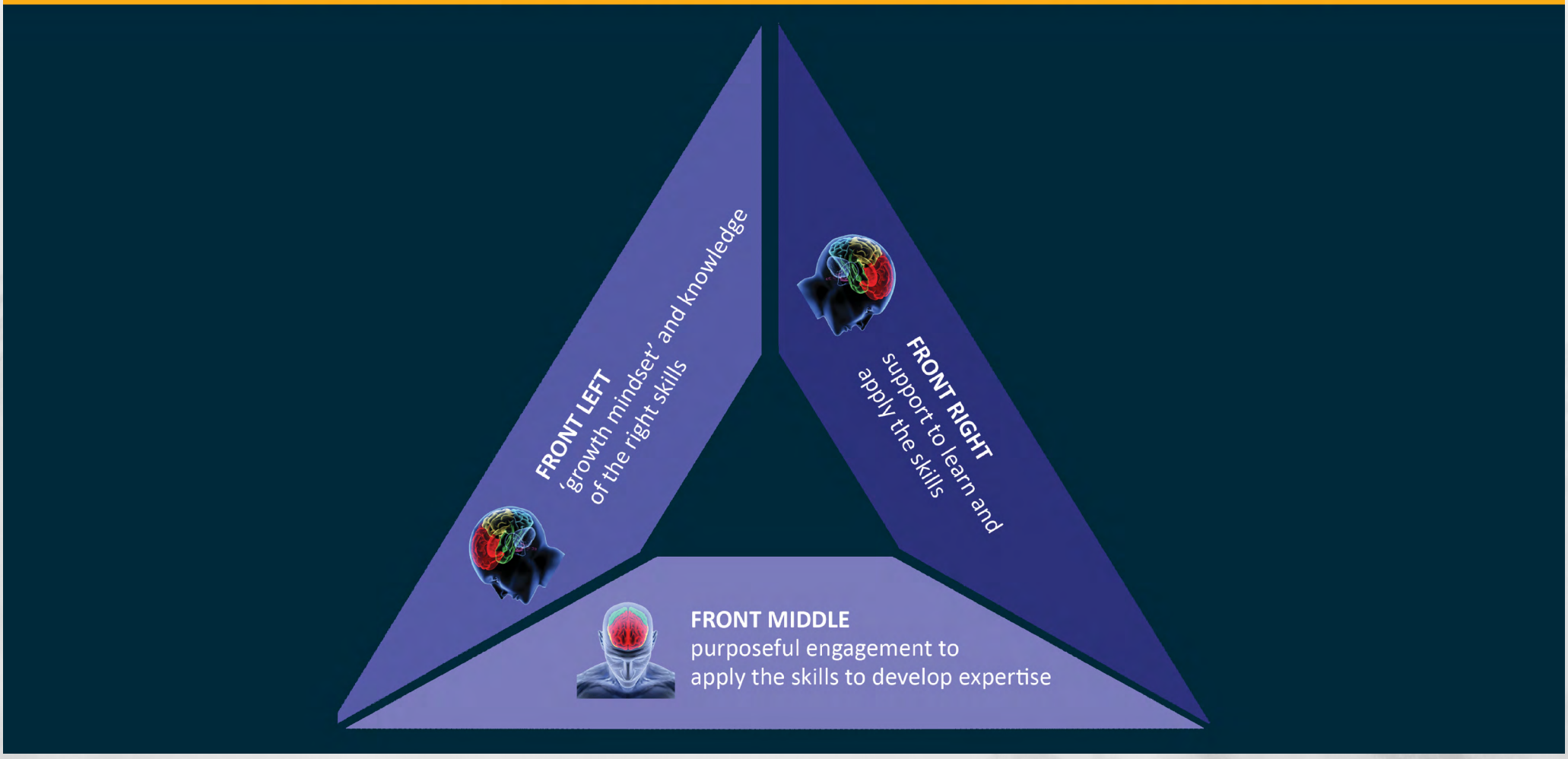
- Three things we need to become 'emotional athletes':
  - a 'growth mindset' and knowledge of the skills
  - a 'coach'
  - purposeful engagement: practicing the skills we need until we develop mastery

RECOVERY TRIANGLE:
HOW TO BECOME AN EMOTIONAL ATHLETE



- Attitude of the 'coach':
  - 'I will not do more for you than you will do for yourself.'
  - An expectation of greatness – not just sympathy or pity
  - Not making excuses: holding to account
  - The training will be hard

- Respect feels better than pity
- Have we settled for just keeping people alive?
- Often people are seeking to work with people who have had similar experiences
- A 'growth mindset' means we're more interested in getting out of the pit than being understood in it

RISK OF SUICIDE/SELF-HARM