



Stepping into Fog

ANZ ACBS Melbourne Conference November 2016

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Spectrum: Personality Disorder Service for Victoria



We're all in this together

- For the late comers...

please find yourself a seat,
settle in,

take a few grounding breaths

and join in the experiential activity as best you can.

Zoe

Values

Relationship: respectful, intimate, trusting, fun

Goal

Relationship with Maree

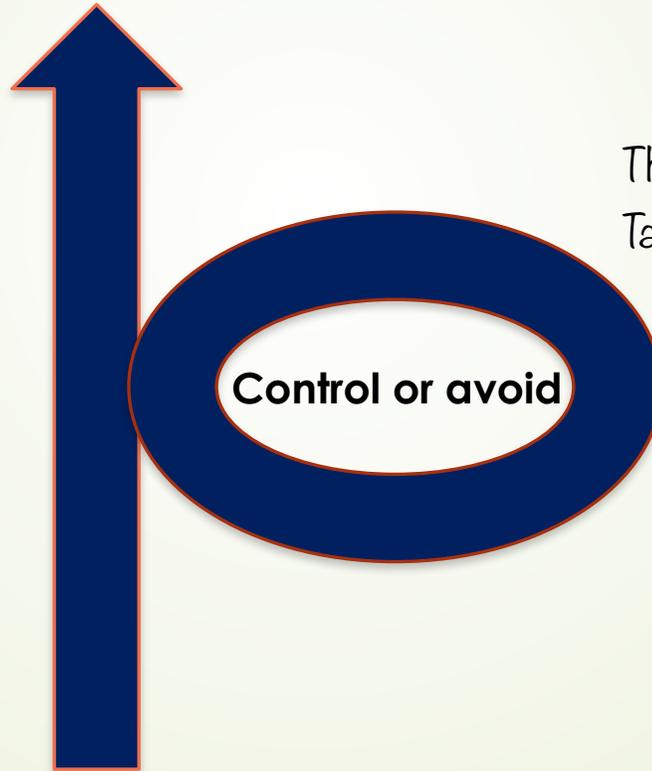
What shows up:

Panic

Feel disgusting and shit

"I can't exist without Maree"

"I can OD"



Think about taking an OD

Take an OD

Responding with a prevention focused assessment

Values

Relationship: respectful, intimate, trusting, fun

Goal

Relationship with Maree

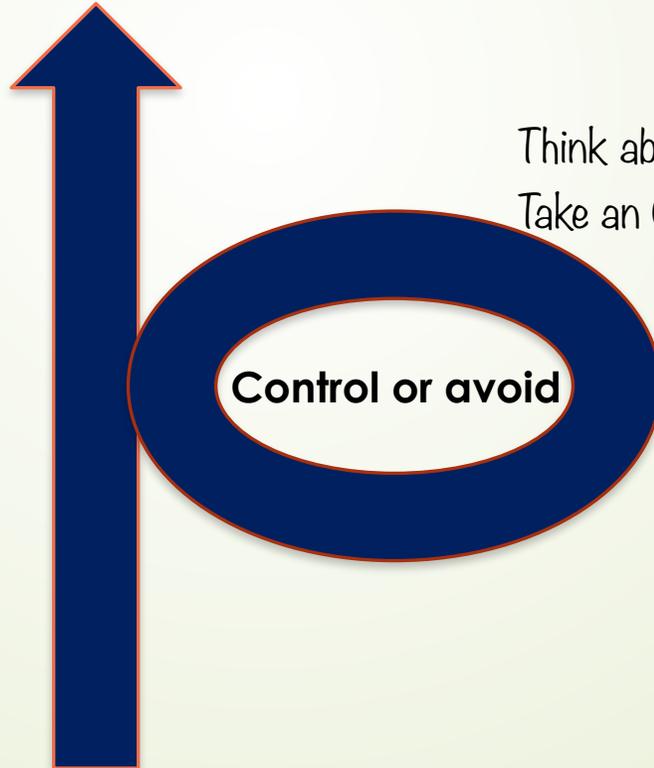
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Think about taking an OD

Take an OD

Thoughts to OD – constant since conflict.

Plan – use stockpile, acquire more, GP appointment booked.

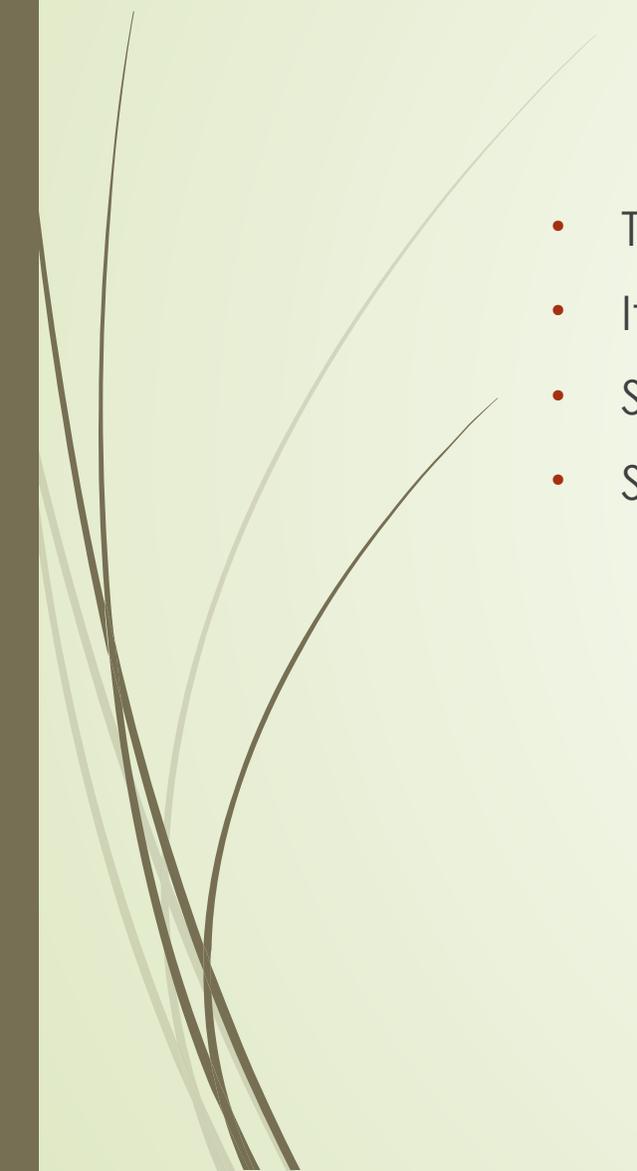
Has access to lethal means

History of impulsive near lethal OD, found by girlfriend.

Frequent (weekly) Episodic (few days) suicidal ideation.



Prevention focused assessment response

- This is about collecting data and determining risk
 - It is prevention focused – the aim is to prevent suicide
 - Suicide is centre stage
 - Suicide is the problem to be solved
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Responding to Zoe: The treatment focused assessment

Values

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Goal

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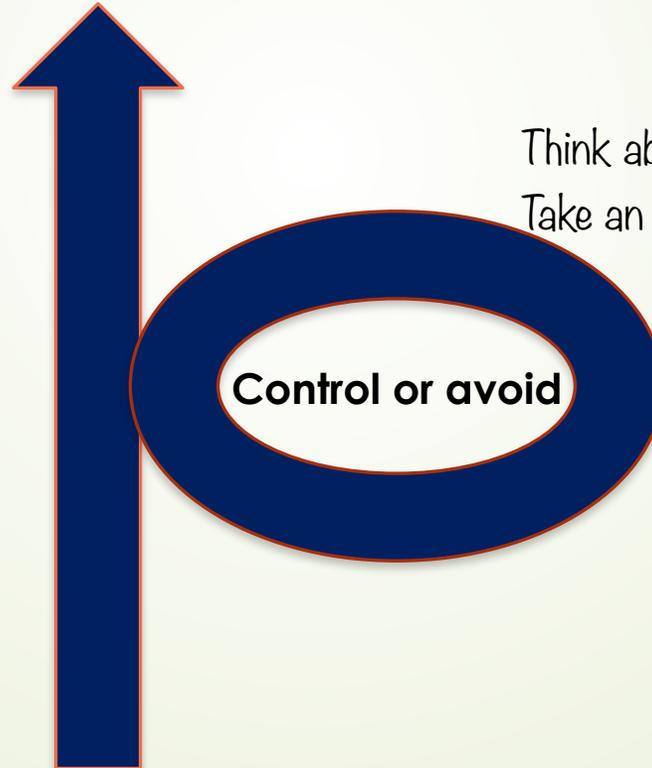
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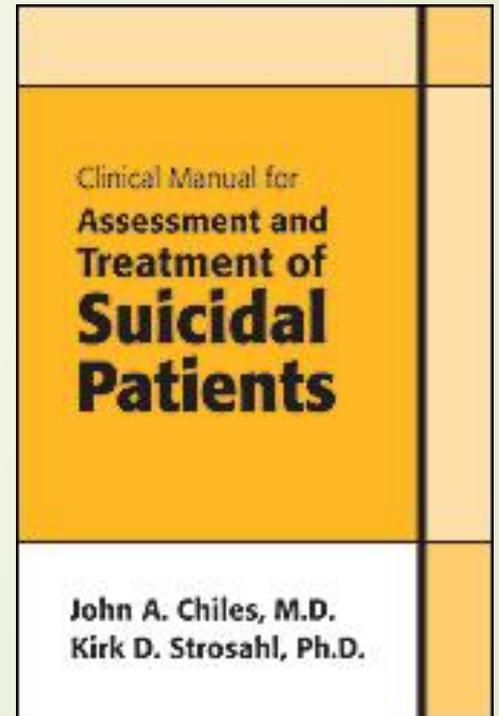
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Zoe, if you took the OD, what problems would it solve for you?

Treatment focused assessment response

- It does not preclude making a risk assessment
- It focuses on the function of the suicidal behaviour
- Suicidal behaviour is viewed as a problem solving behaviour
- It explores behaviour rather than judges behaviour
- It opens up opportunities for therapeutic intervention - looks for alternative ways to solve the problem which are in line with the clients values





Research

- Suicide cannot be predicted (low base rate, no reliable and sensitive methods to detect suicidal states) (Hawgood & De Leo, 2016)
- Self-harm cannot be accurately predicted (Hawgood & De Leo 2016)
- Hawgood and De Leo (2016) argue for “making determinations about the person’s current level of distress and psychache (referring to intolerable psychological pain) and to respond to the identified needs accordingly; not to predict subsequent suicidal behaviour.
- Not much research on ACT and suicidality. One study (Walser et al., 2015) showed decreased suicidal intent in a sample of veterans with depression receiving ACT treatment. Increased experiential acceptance was associated with reductions in suicidal intent.



Aims for today

- Today's workshop is about
 - How to make the shift from a prevention focussed response to a treatment focussed response
 - Having an experience of using these approaches
 - Consider an ACT therapists stance - that demonstrates, initiates and strengthens the clients psychological flexibility
- Definitions
 - Suicidality: refers to behaviour which is about wanting to die
 - Self-harm: refers to behaviour to injure self with no intent to die
 - Behaviour: it is not just what is observable, it is everything the person does (including thinking, feeling)
- Boundaries / consent
 - Choose material that will be challenging but not unmanageable for you
 - We invite you to take a few risks and we respect your boundaries and judgment about what you do and don't want to participate in.



Introduction to role plays

- Aim of role plays is to experience two different approaches to responding to suicidal behaviour
- It is less about getting it right and more about having an experience
- This means we invite you to be open to your experience

- Warm up

- Structure
 - Roleplay one: prevention focussed approach
 - Roleplay two: treatment focussed approach



Role play 1: prevention focused

- Purpose: having an experience of the prevention focused assessment approach and really tuning into what it is like for you, both as clinician and client.
- Steps for the role play
 - Find a partner
 - Assign a client and therapist
 - As client, pick a scenario to play as a chronically suicidal patient
 - As therapist, respond by doing a risk assessment (8 minutes for each role play)
 - You can use prompts on the next slide as a jumping off point, but you don't have to
 - Debrief (5 minutes for each)
 - Swap roles and repeat
 - Put your hand up at any time if you want one of us to come and help



Role play 1: prevention focused prompts

- Thoughts
- Current plan
- Method – immediacy, lethality and access to means
- History of self-harm or suicidal behaviour – frequency, last episode, outcome
- Current stressors
- Current distress and mental state
- External and internal resources.

- Debrief questions
 - What was that like, how did you feel in your role as therapist or client?
 - If you kept going what do you think would have happened?



BREAK

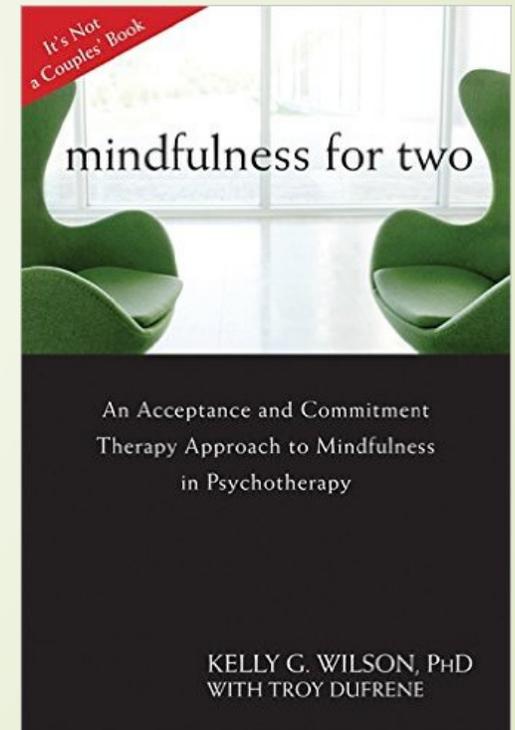
THEN.....

Warming up to another role play by looking at:

- Relevant theory
- Therapeutic stance
- Therapeutic tasks

Repertoires of behaviour in the therapeutic relationship

- "The time when your behaviour will most likely come under aversive control is when your clients behaviour is under aversive control" (p43, Wilson, 2009)
- Aversive control narrows our repertoire of behaviour





Repertoires of behaviour in the therapeutic relationship

- “some ACT interventions, such as values work, are about the consequences. Specifically, they are about reinforcers. However if the pattern of behaviour we see is under strong antecedent aversive control, talking about values (that is reinforcers) will have little effect. In fact, if the person notices how his own behaviour precipitates costs in some values domain, that too will be experienced as aversive, and narrow behaviour even more so. If you can **encourage this individual to sit quietly in the present moment and to experience the difficult emotion with acceptance and openness, then the strong antecedent stimulus control will lessen.** As it does, you’ll see the gradual emergence of flexibility in affect, speech pattern, physical posture, and other aspects. Now, if you begin to gently ask questions about valued living, those questions are much more likely to be received in a more flexible and open way.” (p.42, Wilson, 2009)



Therapeutic stance: Inspiration

- When we as human beings are able to hold our fear without shrinking back from our own or another's pain, when we turn toward another in the face of he or she feeling that life holds no point, when we suffer with while fully holding the other as whole and larger than their pain, we create space. Its in this space that the seeds of meaning, in that very connection with another, that purpose is born. (Robyn Walser, 2014)



Treatment focused response: guiding principles

- **What problem would be solved by the suicidal behaviour ?**
 - What painful internal experiences would be eliminated or reduced?
 - “Tell me about it.” Listen and attune to the internal experience. Reflective listening.
 - What external problem might be addressed?
 - Don’t move into problem solving, stay with the function.
- **Reframe the suicidal behaviour as an effective way to solve the problem**
 - This legitimises suicidal thoughts/behaviours as a response to the problem of emotional pain
 - It cuts through stigma and judgement
 - E.g. “If you did X, then Y would be less. It is a way to solve Y”
- **Open up other possibilities for solving the problem**
 - Painful thoughts, feelings, memories, sensations, urges – acceptance, mindfulness, defusion. SAC
 - External problem – problem solving, address skills deficits, values & committed action
- **Workability**
 - What happens in the longer term? Does it solve the problems? Does it take you closer towards the life you want for yourself?



Role play 2

- Purpose: having an experience of the prevention focused assessment approach, really tuning into what it is like for you as either a clinician or a client to be involve in this interaction
- Steps for the roleplay
 - Find a partner
 - Assign a client and therapist
 - As client pick a scenario to play as a chronically suicidal patient
 - As therapist respond by doing a risk assessment (10 minutes for roleplay)
 - You can refer to principles on next slide
 - Debrief (5 minutes each)
 - Swap roles and repeat
 - Put your hand up at any time if you want one of us to come and help



Treatment focused approach principles

- **What problem would be solved by the suicidal behaviour ?**
 - What painful internal experiences would be eliminated or reduced?
 - “Tell me about it.” Listen and attune to the internal experience. Reflective listening. Be present.
 - What external problem might be addressed?
- **Reframe the suicidal behaviour as an effective way to solve the problem**
 - E.g. “If you did X, then Y would be less. It is a way to solve Y.”
- Debrief questions
 - What was that like, how did you feel as client or therapist in this roleplay?
 - If you kept going what do you think would have happened?

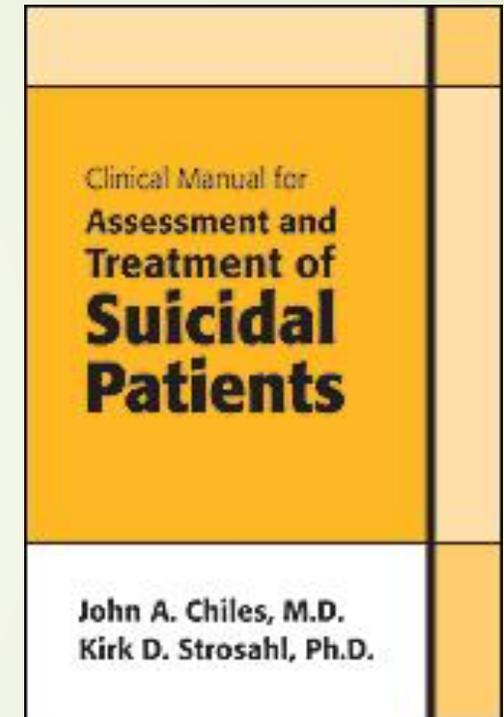
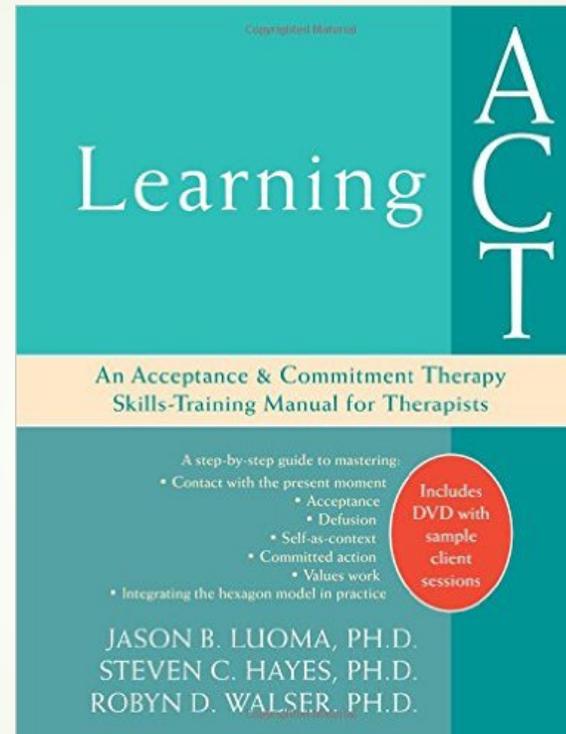
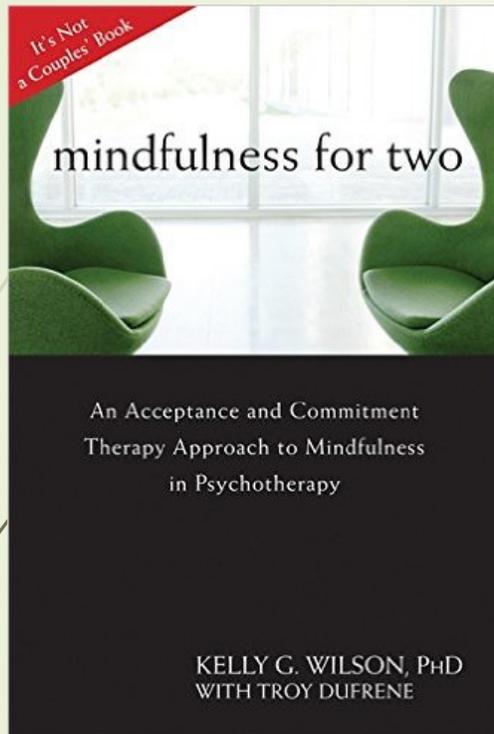


Reflections



- Comments about the experience of this role play?
- What did you notice?
- Questions?

References



- Nhmrc guidelines https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/mh25_borderline_personality_guideline.pdf
- Hawgood, J and De Leo, D. (2016). *Reconceptualising suicide risk assessment: A person-centred approach to needs-based exploration of current suicidality*. In *Psych* 38 (1).
- Walser, R., Garvert, D., Karlin, B., Trockel, M., Ryu, D. & Taylor, C. (2015). *Effectiveness of Acceptance and Commitment Therapy in treating depression and suicidal ideation in Veterans*. *Behaviour Research and Therapy* 74.

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- Please email us with your comments, question or if you would like a copy of the slides.



Part of

