Challenging Phone Calls in the Workplace: Listening, understanding and responding to people at risk of suicide

Prof Ella Arensman
Jacklyn McCarthy
National Suicide Research Foundation
Department of Epidemiology and Public Health, University College Cork

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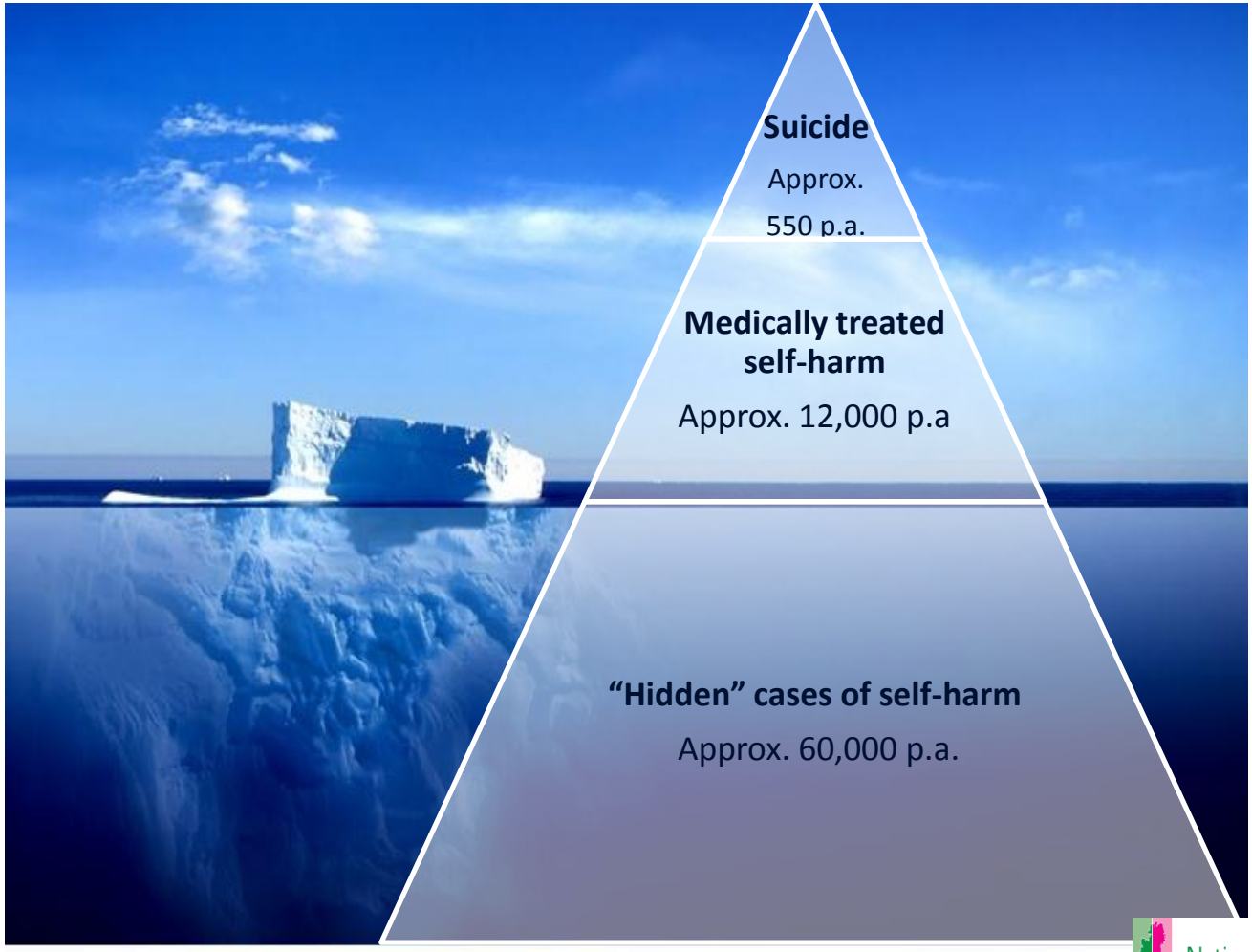
Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

Suicide and medically treated self-harm in Ireland: The tip of the iceberg



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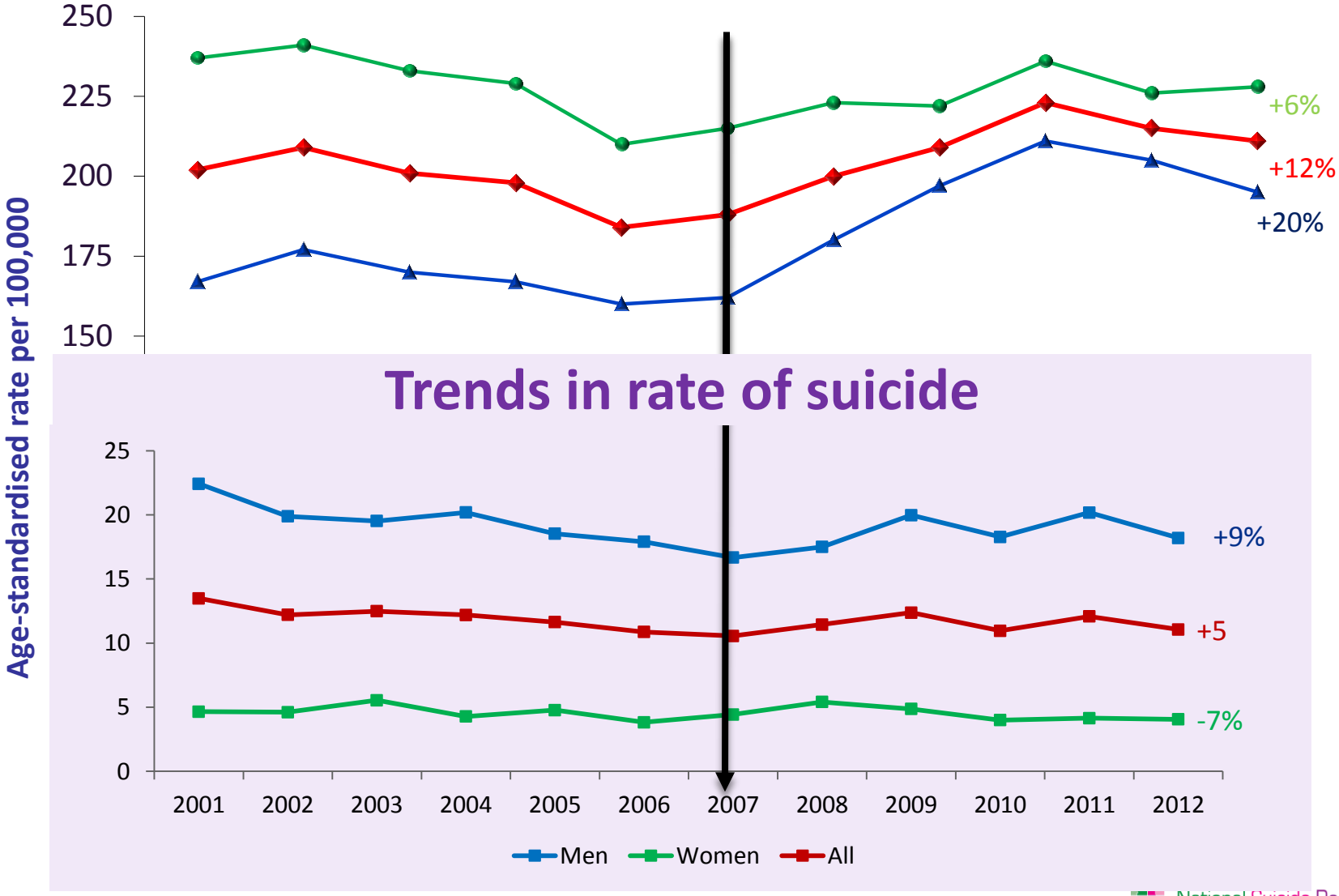
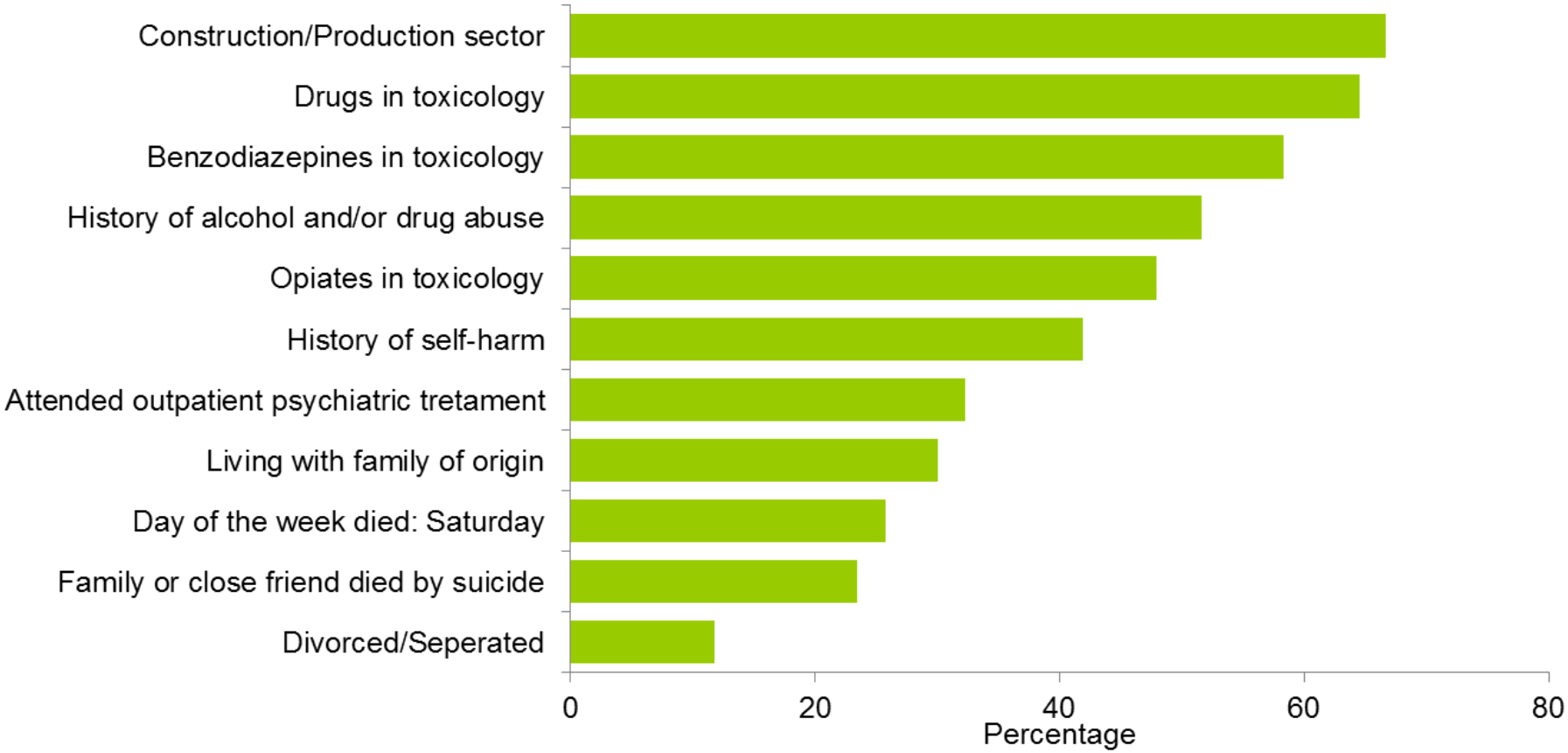
Trends in rates of self-harm and suicide in Ireland



Suicide is often associated with multiple risk factors –

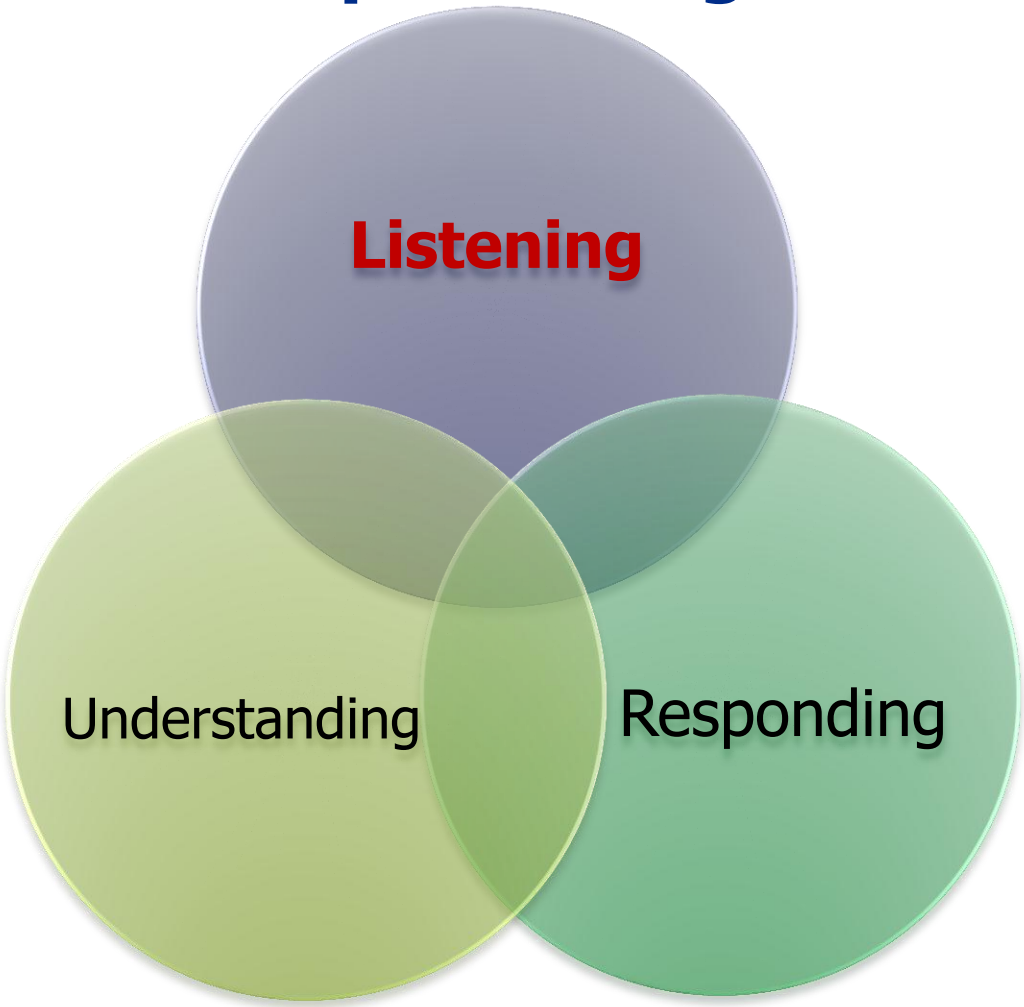
Combination of risk factors associated with suicide among people who were unemployed at time of death



Challenges when communicating with a distressed person by telephone

- No face to face contact
- No personal relationship with the individual, no information on the person's history
- Difficult to understand and interpret stressful situation 'from a distance'
- People becoming emotional during the telephone call
- Time pressure
- Access to services

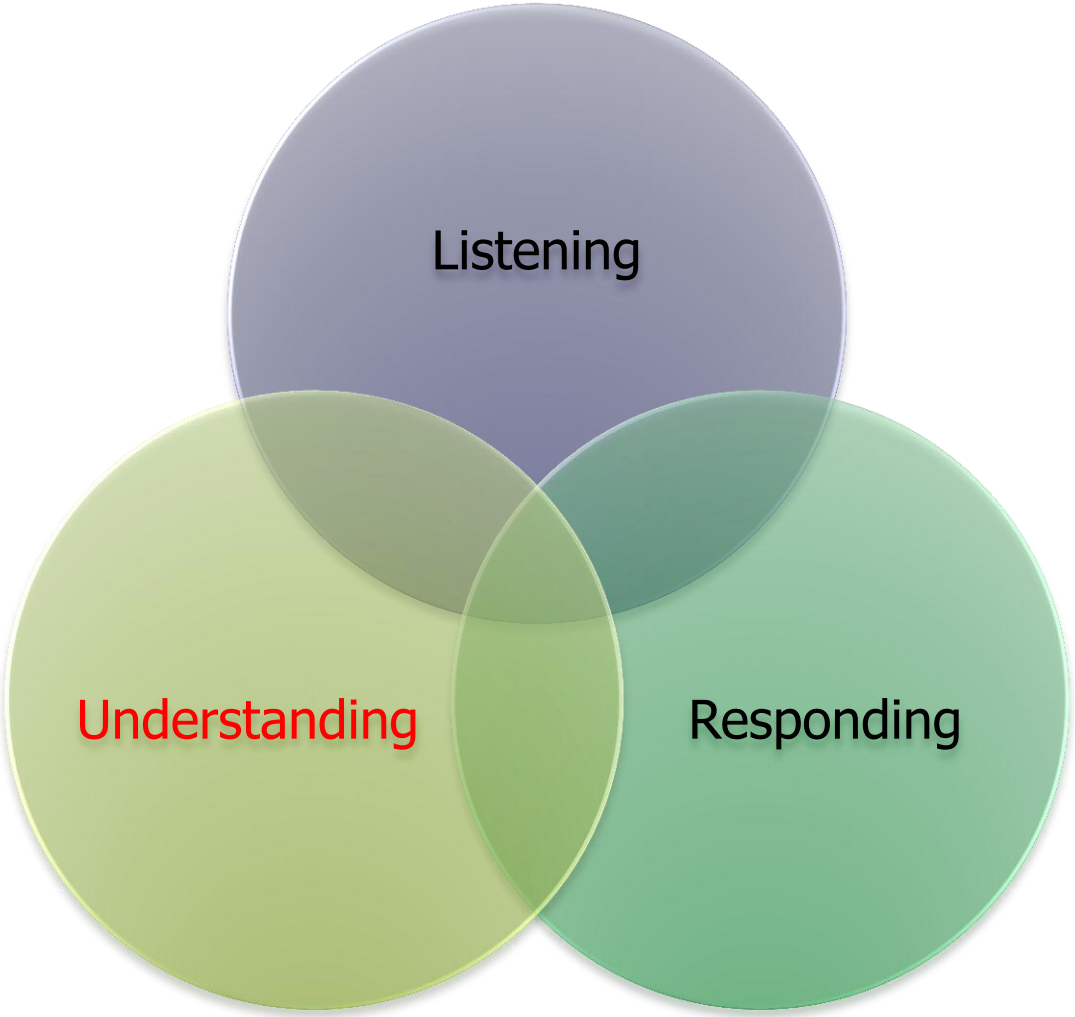
Listening is the first fundamental step towards preventing suicide



Active Listening

- Be warm and supportive
- Show interest
- Ask for clarification
- Be empathic
- Allow time
- Be silent

Understanding possible risk of suicide is fundamental to act effectively



Common myths about suicidal behaviour

"There is a risk of evoking suicidal thoughts in a persons mind if you ask about it"

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Common myths about suicidal behaviour

"Once a person has had suicidal thoughts, he/she will never let them go"

BJPsych The British Journal of Psychiatry (2008) 192, 202–211. doi: 10.1192/bjp.bp.107.037564

Cognitive–behavioural intervention for self-harm: randomised controlled trial

Nadja Slee, Nadia Garnefski, Rien van der Leeden, Ella Arensman and Philip Spinhoven

Background
Self-harm by young people is occurring with increasing frequency. Conventional in-patient and out-patient treatment has yet to be proved efficacious.

Aims
To investigate the efficacy of a short cognitive–behavioural therapy intervention with 90 adolescents and adults who had recently engaged in self-harm.

Method
Participants (aged 15–35 years) were randomly assigned to treatment as usual plus the intervention, or treatment as usual only. Assessments were completed at baseline and at 3 months, 6 months and 9 months follow-up.

Results
Patients who received cognitive–behavioural therapy in addition to treatment as usual were found to have significantly greater reductions in self-harm, suicidal cognitions and symptoms of depression and anxiety, and significantly greater improvements in self-esteem and problem-solving ability, compared with the control group.

Conclusions
These findings extend the evidence that a time-limited cognitive–behavioural intervention is effective for patients with recurrent and chronic self-harm.

Declaration of interest
None. Funding detailed in Acknowledgements.

In recent years there has been a marked rise in the frequency of young people engaging in self-harm.[1] Identifying those who are at risk is important because every episode of self-harm increases the risk of future episodes[2] and, eventually, of suicide.[3] In this paper the term 'self-harm' includes self-poisoning, with or without suicidal intent.[4] The risk of self-harm increases when multiple risk factors are present.[5] The presence of a severe psychiatric disorder such as major depression is among the strongest predictors of self-harm.[5] Anxiety, especially if acute and intense, also has an important role.[6] In addition to anxiety, patients who self-harm describe feelings of chronic emptiness, alienation and isolation.[7] In the context of these unpleasant experiences, they report thoughts of hopelessness,[8] helplessness,[9] of being a burden to loved ones,[10] of unlovability and poor distress tolerance,[11] and of low self-esteem.[12] Poor problem-solving ability is assumed to interact with suicidal cognitions, increasing the risk of self-harm.[13]

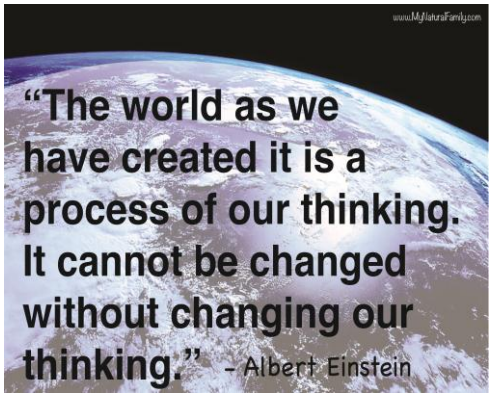
Although in-patient treatment is the standard of care for people who self-harm, it has never been found efficacious in a controlled clinical trial.[14] Furthermore, controlled cognitive–behavioural therapy (CBT) intervention studies for self-harm are limited and their results are inconsistent. Tyrer *et al* reported that brief CBT is no more effective than usual care when it comes to preventing repetition of self-harm,[15] whereas Brown *et al* reported positive effects of cognitive therapy on suicide attempts, depression and hopelessness.[16] In addition, several controlled studies have established the efficacy of dialectical behavioural therapy in reducing self-injury in (female) patients with borderline personality disorder.[17] Schema-focused therapy has also been found to reduce self-harm effectively in patients with borderline personality disorder.[18] Furthermore, cognitive–behavioural interventions with a problem-solving component seem to have positive effects on self-harm.[19] These findings are important, given the strong association between acts of self-harm and the risk of suicide described above. In addition, given the association between negative emotions, suicidal cognitions, problem-solving deficits and self-harm, it is important to assess in more detail the impact of treatment on these correlates of self-harm.

In the study reported here the efficacy of a short, manualised cognitive–behavioural intervention for self-harm was investigated. This intervention was based on a cognitive-behavioural model of maintenance factors of self-harm.[20] The model assumed that vulnerability to self-harm can be changed by changing suicidal and negative thinking and problem-solving deficits. The intervention aimed to develop cognitive and behavioural skills for coping with situations that trigger self-harm. Considering the wide range of psychiatric, psychological and social problems that patients present with, the intervention was intended to give therapists a clear framework to orient themselves within the therapy. At the same time, the intervention needed to be flexible enough to be of help to a broad range of patients, including those with high risk of repetition of self-harm and high levels of psychiatric comorbidity. The study was designed to determine the short-term and long-term efficacy of the intervention with respect to the rate of repetition of self-harm as well as emotional problems, suicidal cognitions and problem-solving deficits. It was predicted that the rate of self-harm of participants who received CBT in addition to treatment as usual (TAU) would be lower than in patients who received TAU only, and also that participants from the CBT condition would have significantly lower scores for emotional problems (depression and anxiety) and suicidal cognitions, and significantly higher scores for functional cognitions (self-esteem) and behavioural skills (problem-solving ability) following treatment, than participants from the TAU condition.

Method

Participants

Patients aged 15–35 years were included in the study if they had recently engaged in self-harm, defined as both deliberate self-poisoning (overdose) and self-injury.[4] Patients were excluded if they reported a severe psychiatric disorder (e.g. schizophrenia) requiring intensive in-patient treatment (as assessed during the baseline interview with a structured diagnostic interview: the Mini International Neuropsychiatric Interview (MINI)),[21] were unable to converse in Dutch, had cognitive impairments or lived outside the region of Leiden.



Cognitive Behavioural Intervention for self-harm

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Signs of depression and increased risk of self-harm and suicide

- Feelings of sadness or hopelessness
- Withdrawal from social activities/relationships
- Changes in sleeping or eating habits
- Lack of energy and fatigue
- Major changes in mood
- Problems with attention and concentration
- Poor performance at work or at school
- Accumulation of stress/traumatic events
- Direct/indirect communication referring to suicide

Often a combination of these aspects

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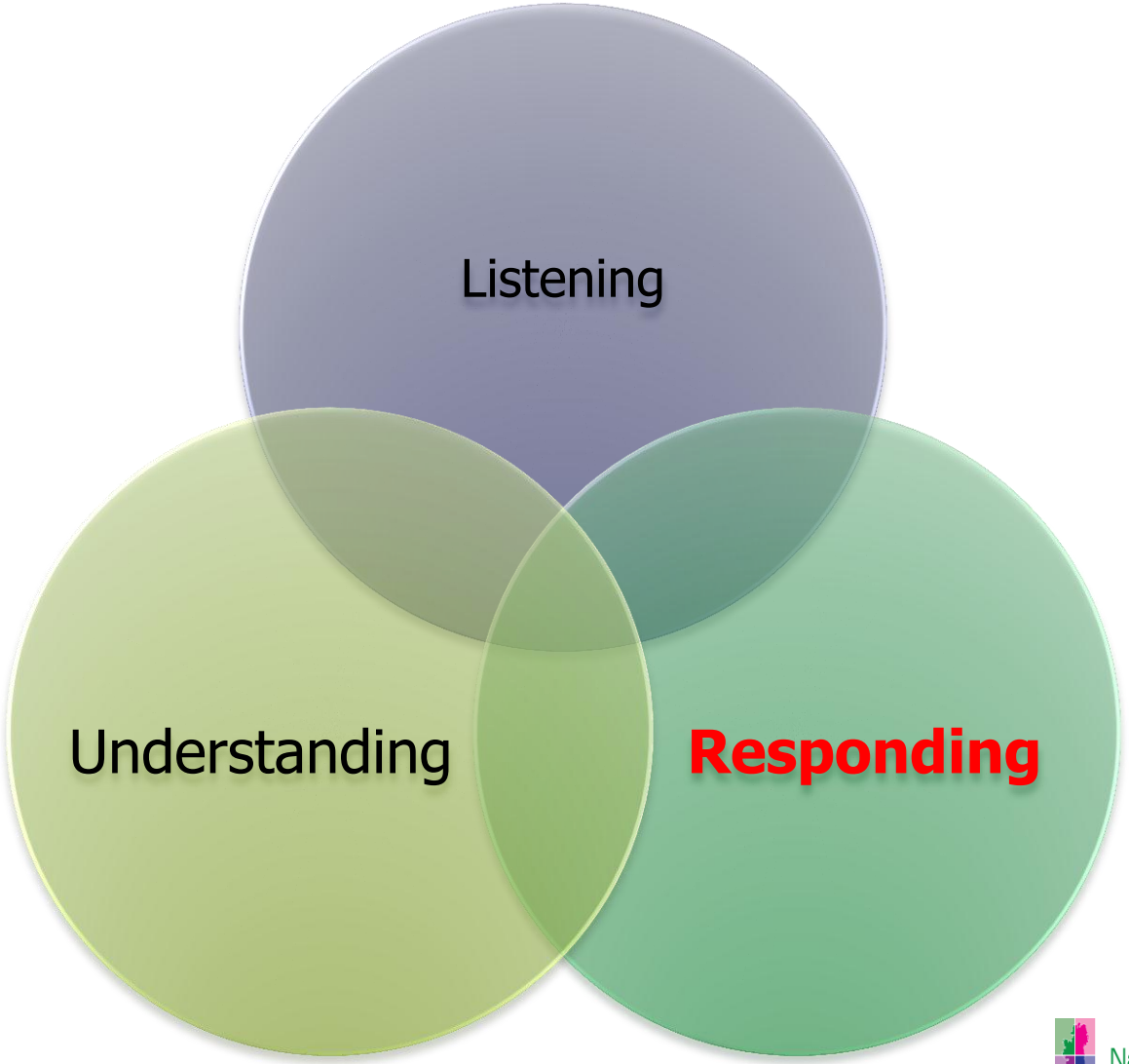
Risk factors associated with self-harm and suicide

- Mental health problems, including:
  - Depression
  - Alcohol and Drug abuse
  - Psychotic symptoms, such as schizophrenia
- People in a life crisis (social isolation, unemployment, debts, divorce, trauma)
- People who have experienced sexual abuse/physical maltreatment/emotional abuse in childhood
- People who have experienced either completed or attempted suicide in their family or among friends
- People who have engaged in self-harm
- People who have recently been discharged from a psychiatric hospital

Indicators for high risk of suicide

- Pressing suicidal thoughts
- Hopelessness and strong feelings of guilt
- Both open and undisclosed announcements of suicide
- Actual plans or preparations for suicidal acts
- No distance can be created from suicidal ideas or intention to attempt suicide

Responding appropriately to questions and immediate needs



Interaction and communication about suicidal thoughts - Advantages:

- Gives the person a chance to unburden
- Encourages help seeking behaviour
- Can impede or delay acting on suicidal impulses
- Keeps the lines of communication open and stay connected

Protective factors associated with prevention of mental health problems and suicide risk

- Social support
- Living with a partner /spouse
- Positive attitude towards the future
- Responsibilities towards others

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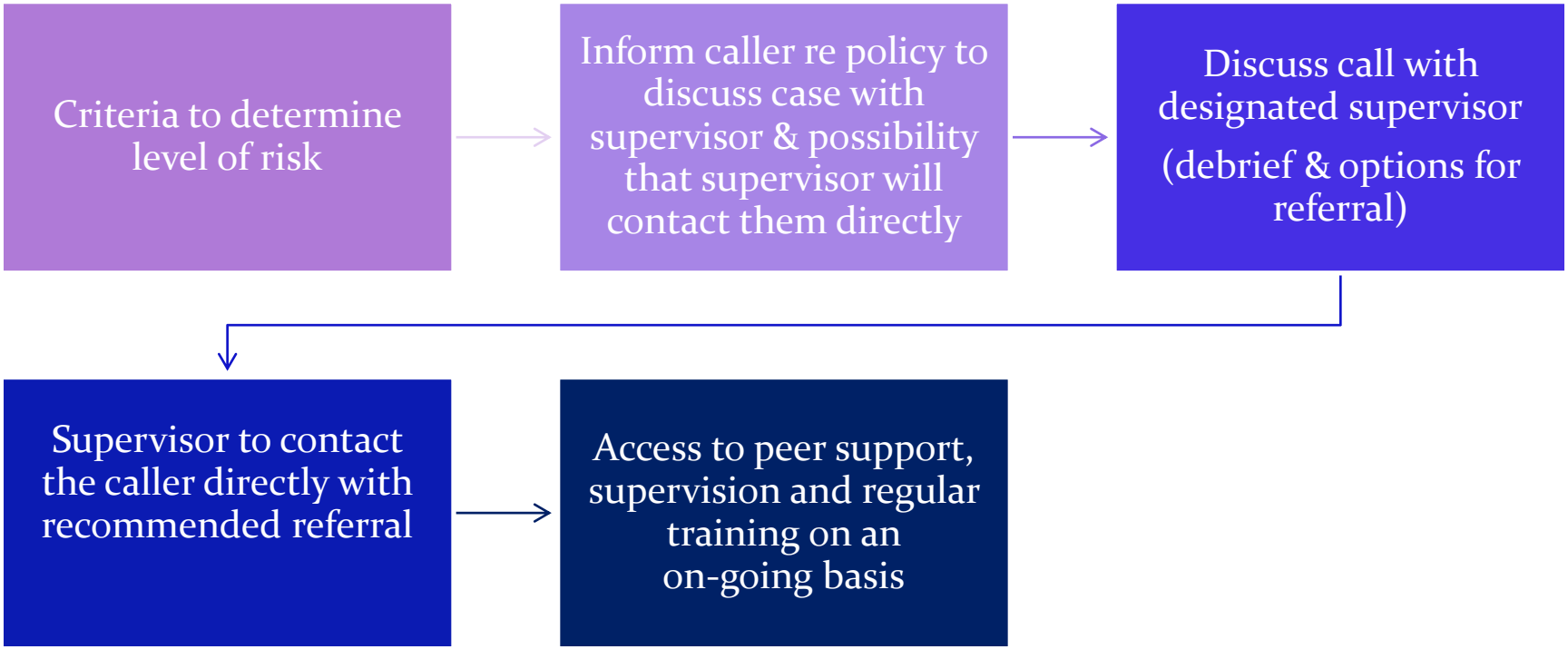
Short-term responses in dealing with risk of self-harm and suicide

- Involve the suicidal person where possible
- Elicit the extent of distress and intention using ordinary, everyday, sensitive conversation
- Do not be judgmental or display shock
- Listen empathically
- Motivate and support help seeking behaviour (provide information on relevant services)

Personal Safety

- Be aware of limitations to your role and responsibility
- In situations of possible suicide risk, it is important to operate according to clear policy around the responsibility and sharing of information
- Comprehensive assessment can only be provided by mental health professionals
- It would be important to have the possibility to debrief on a structural basis

Procedure for 'at risk' telephone call



Where to find help?

- Local GP or family doctor
- South-Doc:1890 335 999
- Samaritans: 1850 60 90 90
- Aware: 1890 303 302
- HSE Information Line: 1850 24 1850
- Pieta House: 021-4341400

www.yourmentalhealth.ie
www.samaritans.org
www.mabs.ie
www.aware.com

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"Suicide does not end the chances of life getting worse. Suicide eliminates the possibility of it ever getting better"

Thank you!

National Suicide Research Foundation
University College Cork
Ireland
T: 00353 214205551
E-mail: jacklynmccarthy@ucc.ie
www.nsrf.ie

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