Model of psychotherapeutic crisis intervention following suicide attempt

Model psihoterapijske intervencije u krizi nakon pokušaja samoubistva

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Curente Topic

Introduction

There is a strong evidence that suicide attempters need a psychiatric crisis intervention immediately after suicide attempt. Mental illness, in general, has become less stigmatized in recent years, but suicide remains nearly as stigmatized as ever diminishing motivation of some subjects to ask for psychiatric help after suicide attempt.

In some recent meta-analysis study cohorts it was noted that a year after suicide attempt and subsequent problem-oriented psychotherapy, the repeated suicide attempt rate was reduced for about 30%. After psychotherapeutic crisis intervention the number of hospitalizations was also reduced, but the number of those treated after the attempt in outpatient clinics was increased. All this suggests positive results in suicide recidivism reduction after psychotherapy.

On the other hand, some reviews and meta-analyses of the therapeutic effect of psychotherapeutic crisis intervention suggest that about one half of patients are resistant when referred to the psychiatrist. The background of this is fear of being stigmatized as a psychiatric patient, but also subjective self-assessment of unnecessary psychiatric consultation. The doctors who do not regularly refer their patients after suicide attempt to psychiatric control examinations also have an important role in this. The problem is even more evident when after hospitalization a patient is left to self-decision concerning psychiatric consultations.

Many reports on treatments of suicidal patients claim effectiveness in reducing suicidal behavior but fail to demonstrate which treatment interventions diminish suicidality.

The literature on a treatment model formation for suicidal patients is scanty. There are two types of these models: the first one is intervention in crisis which comprises actual dealing with the patient's suicidal ideations and the other one comprises continuous therapy emphasizing a long-term care of suicidal patients' feelings. This means that intervention in crisis is active, immediate intervention, while the continuous one is a long-lasting process. Yet, continuous treatment of patients after suicide attempt is advantageous because it offers a long-term improvement treating a patient as a responsible person and perceives suicidal behavior within the scope of a complete personality.

In psychotherapeutic approach to a patient various methods and techniques such as behavioral, cognitive, dynamic etc. have been applied. In cases of acute crisis, a supportive cognitively focused approach should be applied and in the chronic ones – an expressive, insight-oriented psychotherapy with elements of supportive approach. Dialectical behavior therapy devised by Linehan at al. has been proved as the most effective one in the treatment of adult borderline patients after suicide attempt. However, only a limited number of studies report outcome of psychodynamic approach.

The aim of the paper was to explain our model of psychotherapeutic crisis intervention following suicide attempt, an empirically supported psychological treatment-specific manual for suicidal patients. In this paper our findings, from an outcome study on the basis of experience and a few extensive clinical trials of the treatment of suicidal behavior are described. We studied the efficacy of our model of psychotherapeutic crisis intervention following suicide attempt by self-poisoning using psychodynamic approach with supporting elements.

Our model of psychotherapeutic crisis intervention following suicide attempt includes: conceptual frame for assessment and treatment of persons after the suicide attempt; psychodynamic approach in psychotherapeutic crisis intervention following the suicide attempt; assessment of the degree of support given by the family and broader social environment in the treatment of a patient after a suicide attempt.
In Serbia, all persons after a serious suicide attempt have been sent to the Clinic for Emergency and Clinical Toxicology, the Military Medical Academy (MMA) in Belgrade, which is a part of the National Poison Control Center. After being admitted to the Emergency Center, all admitters are hospitalized and treated in the Intensive Care Unit or at the appropriate department in dependence on the self-poisoning severity. Psychiatric consultation is possible only when the patient is restored to life.

Every patient after suicide attempt is first examined by a psychiatrist within the consultative psychiatric service of the Military Medical Academy. At the end of an examination of suicidal patients, a psychiatrist must define a conceptual frame for assessment and treatment of a person following suicide attempt.

**Conceptual frame for assessment and treatment of persons following suicide attempt**

Conceptual frame for assessment and treatment of persons after a suicide attempt includes: choice of the treatment method, selection of patients for psychotherapeutic crisis intervention and psychological assessment of persons following suicide attempt.

**Choice of the treatment method**

Within the consultative psychiatric service, a psychiatrist chooses the best treatment method (hospitalization, outpatient clinic treatment, psychotherapy and/or pharmacotherapy) for a suicidal patient. Pharmacotherapy in treatment of a suicide attempt is administered when necessary. It should be taken into consideration that pharmacotherapy is the only one among other therapeutic methods and that a registered drug for suicide prevention does not exist today. When choosing a drug, it is very important to have very detailed data on the type of a disorder, dominant symptoms excluding suicidal ideas, data on living conditions, environment support, side effects, as well as effect of the administered therapy.

**Selection of patients for psychotherapeutic crisis intervention**

In the therapeutic procedure with a suicidal patient one of the most important expertness is reflected in the assessment of indications for psychotherapy and intervention should be done according to this selection of patients for psychotherapeutic crisis.

Individual psychotherapeutic intervention is used in subjects who meet criteria for selection of patients for psychotherapeutic crisis intervention application. We excluded the patients with diagnosis from F 00 to F 09, F 10 to F 19 (except F1x.0), F 20 to F 29 and F 30 to F 31 and F 32.3 satisfying ICD 10 (World Health Organization – WHO-criteria). We excluded the patients who meet criteria for selection of patients for psychotherapeutic crisis intervention application. We excluded the patients who meet criteria for selection of patients for psychotherapeutic crisis intervention application.

**Psychological assessment of persons following suicide attempt**

In psychological assessment of persons following suicide attempt the following psychological tests are used: Hamilton Depression Rating Scale (HAMD), Center for Epidemiological Studies–Depression Scale (CES-D), Defensive Questionnaire Scale (DSQ-40), Scaling of Life Events (Paykel) and Pierce Suicide Intent Scale (SIS). Suicide attempters are depressed (HAMD = 22.60 ± 5.93), (CES – D = 29.67 ± 7.99), with medium suicide risk factor (SIS = 4.5 ± 4.17), use immature (projection, disassociation, devaluation, acting-out) and neurotic (altruism) defenses mechanisms. The most important motives for suicide attempt are separation problems, problems with parents and problem of loneliness. Commonest feelings and thoughts of a subject preceeding suicide attempt are wish to escape from unbearable situation, loss of control, desire to show love for partner and wish to be helped. After suicide attempt 90% of persons feel relief because it failed, while almost half of them intend to repeat it. Risk of the repeated suicide attempt is 1.8 (90% CI, 0.09–37.70; p < 0.001) times higher if values on the SIS Total Score are increased and 1.62 (90% CI, 0.03–81.39; p < 0.001) times higher if values on the Circumstances Score (SIS 1) subscale are increased, too.

**Psychodynamic approach in psychotherapeutic crisis intervention following the suicide attempt**

In the psychotherapeutic crisis intervention applied in our patients after the suicide attempt we use psychodynamic approach, which helps a patient to understand his/her pathologic behavior. Although there are two different modalities, crisis intervention and psychoanalytical psychotherapy are not antagonistic, but extremely compatible.

In our study we applied individual therapy of one session in which the psychotherapist had to have appropriate method for a short psychotherapy for each individual case structured as a complete therapy for that very moment, because it was not certain whether the next one would be possible, at all.

We can say that psychotherapeutic crisis intervention following suicide attempt is analogous to the early phase of psychotherapy. The most important processes in both analyst's and patient's internal world develop in the mutual relationship between the conscious and unconscious. The nature of the analyst's intervention depends on what is happening in a patient's mind.

Psychotherapeutic crisis intervention following suicide attempt should be carried out in a soundproof room simply equipped with a table and two armchairs. Calm atmosphere is convenient for conversation lasting up to 50 minutes with each patient.

Psychotherapeutic crisis intervention following suicide attempt is oriented toward the need for a patient's relations with his/her surrounding to remain preserved and that connections between the crisis and the life history will be specified toward reconstruction and redefinition of relations with important persons and also toward development of a new network of relations. In this way crisis can lose its characteristic of existential break and instead of this it can get a dynamic value contradictory to that existence as much as it refers to the crisis itself.
This intervention should be carried out in an un frightening tone and atmosphere in which a patient feels safe and the therapist's empathy for him. It also requires formulation of a clear model of intervention, which would enable work with a patient in a short period of time.

A model of psychodynamic approach in psychotherapeutic crisis intervention following suicide attempt is given in Figure 1.

Fig. 1 – Psychodynamic approach in psychotherapeutic crisis intervention following suicide attempt

Formation of a therapeutic alliance with a patient

In psychoanalytical psychotherapy the working alliance is emphasized. The first contact between the psychiatrist and a patient after suicide attempt is of great importance. Alliance realized in the first several minutes develops on the level of intuition and it is very important for further relationship between psychotherapist and a patient.

Successful psychotherapy with a suicidal patient requires a complete therapist's emotional and active engagement. A real relationship, not transfer, should be emphasized. The therapist should be available as a firm, safe object that the patient can be identified with. The therapist's attitude is an expression of favor, not of neutrality. Alliance should be created on the therapist's attention paid to the patient's capabilities and qualities necessary for a successful, mature functioning.

The goal of psychotherapeutic crisis intervention is to relieve the patient's suffering and to find out the way to improve his/her adaptation ability to a new situation. In a setting in which both patient and therapist should feel comfortable, the therapist offers emotional containing and support, helps in modulation of the painful affects, confirmation, reality testing and education.

Therapist's assessment of the patient's "part" of personality willing to live

The therapist communicates with the patient's “part” of personality willing to live and assesses elements of his/her survival and mental status. Crisis causes decrease in one's intellectual capacities, first in a sense of using something concrete and absence of the abstract thinking. Confusion in a person after suicide attempt arises a feeling that alternatives and choices do not exist at all.

The basic principle in psychotherapeutic work with a patient following suicide attempt is that death does not solve the problem and that it is behind the patient. Life solves the problem because changes are possible only in that way. The therapist's patience, knowledge and appropriate approach are necessary for that.

Identification of the most important risk factors

The psychotherapist should assess dynamic causative factors of the suicide attempt. Taking into consideration that deconstruction of the basic models of understanding the world has been developed, of essential importance is regression to lower, more primitive levels of functioning as well as partial regression of the transference readiness and capability which includes intensification of desire for dependence. In transfer, it is important to recognize negative and positive responses and limitations during the subsequent regression, which can lead to a longer adaptation period. Therefore, the therapist plays the role, particularly in serious cases, of a primary object having a task to help in establishment of the patient's cognitive and emotional organization and to clear the way to the life-giving powers.

Suppressed neurotic conflicts and deficit in ego organization influence upon a person's vulnerability to specific stressors. For this reason, selection of focus in crisis intervention is derived from the recognition of rigid defensive ways and problems in adaptation, which are partly reduced or dispelled by the newly occurred stress. With the help of the old problem in a new situation the crisis is allowed to develop out of symptoms and to enable solution of the conflict and the possibility of activity.

Psychotherapy can solve a feeling of aggression, envy, and jealousy of the introjected image, disturbed omnipotent control and of interpersonal relations and skills deficit. The therapist's task is to transform suicidal behavior into the reactivation of aggression toward the therapist.

A person after suicide attempt should be assisted to verbalize experience and to give it meaning. To change the experienced helplessness it is a focus of every psychotherapeutic effort. The offered therapist’s support does not lessen a patient's loneliness, but provides contact with reality and conviction that the world, the same as it was before, still exists and that the therapist is ready to help him/her to return to it.

Joint assessment of the psychotherapist and a patient about “what did really happen”

By using professional focusing on the problem the therapist explains critical situation to every individual patient giving him/her opportunity to perceive in another way the problem resulting in suicide attempt.

Immediate crisis intervention is focused exclusively on the presence; it is focused on situation, not on the person. Its goals are close, direct and help is provided to persons who were healthy a day or two ago. They are even at that moment considered healthy, but they only reacted to serious traumatic experience in their own lives “like typical humans”.

Emergency comprises urgent intervention in order to make the person return to normal life easier. Expectancy that recovery will be soon and effective and that the person will soon return to routine activities are present from the very beginning. In this way the possibility that a person after suicide attempt gets accustomed to the role of the patient is reduced, taking into consideration that it really is not a reaction of a sick person who can think of himself/herself in that way.

Giving hope to a patient ("what does the subject want to survive")

Finally, most persons in crisis are focused only on how to regain condition they previously used to function. Since only that is impossible, the therapist offers alternatives, which open the way out at least temporarily – offered, are activities enabling relaxation and control of some aspects of situation with the aim to eliminate the feeling of helplessness and hopelessness.

Crisis intervention should help a person to overcome the crisis and also to something else in the following period – a guide, advice, and education. By crisis intervention actual relations within the family and with friends can be evaluated as well as, if possible, relations with persons important in a patient's past. This also suggests the need to evaluate methods of solving previous crisis by patient's education, profession, marriage and through social achievements; which were its advantages, values and what does the subject expects of the help. A person tries to examine own strength, which provides understanding of planning of possible activity levels necessary for a successful coping with crisis.

Psychotherapeutic crisis intervention following suicide attempt is carried out through:

a) Showing empathy, confidence and unlimitedness of time – the therapist shows empathy for despair of a suicidal person which most often uses mechanism of the emotional suffering avoidance through suicide rather than to share problems with other individuals. The psychotherapist has to send a message that suicide is some sort of solution, but not the only one and, by all means, not the best one. Of special importance is to inform a suicidal person that the therapist has empathy and understanding for him/her, that he does not want a repeated suicide attempt and finally, that he/she is always at the attempter's disposal.

b) Testing the degree of despair – using data obtained in the interview and from analysis of the Scale of Life Events (Paykel), the therapist initiates conversation directing it toward change. In this test the therapist should not be scared of questions reviving feelings of despair and fatalism

c) Influence upon change in the way of thinking particularly in the segment where suicide is considered to be the single solution – to change the way of thinking that suicide is a single possible solution by simple comparisons familiar with and understandable to a suicidal person. To explain that suicide should not be treated as a single solution not giving any chance to see the possibility of any other one. Of special importance is to face a person with the fact that a long-lasting situation can be temporary and after several weeks the problem may seem quite different. In this way the time is saved, the response is delayed and a space of time is provided.

d) Help in problem solving – it is important to help a suicidal person to find alternatives. Following-up his/her process of thinking the psychotherapist helps such person also to perceive other situations. Also, it is of a particular importance to find out together some other ways in facing the problem.

e) Help in finding out possible solutions – it is very important to help a person after suicide attempt to start to believe in himself/herself and to develop self-confidence which will result in finding out a proper solution.

Assessment of the degree of support by the family and a broader social environment in treatment of a patient after suicide attempt

The psychotherapist should also assess sources of the external support that a person after suicide attempt could rely upon. The role of family support is a defender who relieves effect of the stressful events. It represents a very important source of the strength in overcoming the actual crisis, as well. Recognition that the subject is accepted, respected, loved, supported end that there are persons he/she can rely upon and get their help, enables regaining of self-respect and own image. All this helps to overcome even the most difficult life circumstances in an easier and faster way with less unfavorable consequences. On the contrary, hostile attitude of the family members can cause momentary withdrawal from the primary or secondary family of a person after suicide attempt. Family members often use denial and suppression as a mechanism of defense to protect themselves from terrifying thoughts and the feeling of guilt because a member of their family did that. Closeness of suicide as a frightening and terrifying possibility urges them to deny their connection with that act or to express empathy, or even to defend them against it. They also give it the status of extraterritoriality, foreign body, proclaiming it mental disease not affecting common people. In such case the therapist should intervene and include the family as cooperators in the treatment of their member.

Concerning a prevention plan the most can be done at the level of social community through activities oriented toward the reduction of the risk group, persons, and, isolationism, organization of various activities, groups, communities in which every person will feel safe and respected. Only positive activities are promoted, but negative ones influencing directly or indirectly upon possible suicide should be eliminated. Together with this, very important is, care for the feeling of belonging and change in the experience “I do not belong to anywhere”. Through education of a complete population about useful ways of facing stress and positive communication, positive way of thinking could be influenced upon and mass-media have great importance in all this. Legal support should also be provided for persons in crisis.

Comments

The model of psychotherapeutic crisis intervention following suicide attempt assesses actual mental status of an attempter comprising the therapist's rapid assessment of depression seriousness, degree of the suicidal risk, suicidal plan characteristics, reasons and motives of suicide, assessment of
actual fear of stigmatization and also of patients attitude toward acceptance of the psychiatric help after the suicide attempt. Assessment of conscientious and unconscientious conflicts leading to a suicide attempt represents initial basis for therapist's work with patient after the suicide attempt and for application of psychotherapeutic crisis intervention. Suicide attempters are depressed with medium suicide risk factor, use immature and neurotic defenses mechanisms. After the suicide attempt most of them feel relief because the attempt failed, while almost half of them intend to repeat it 19.

In therapeutic procedure we have contained patient's feeling of worthlessness, helplessness and feeling of guilt that we have transferred from the patient after suicidal attempt to us, psychotherapists. We have also tried to give him/her hope for life even though it was present only with us during the whole period of therapy. Patients were given alternatives suggesting values of life, which could be comprehended as realistic, and patients have learnt that there are ways to continue to live with pain instead to commit suicide. It is important to emphasize that both psychodynamic factors per se and psychopathology are not sufficient in assessment of a suicidal risk. Only by combination of all mentioned factors suicidal risk assessment in every phase of the treatment 24.

The most important motives for suicide attempt are separation problems, problems with parents and problem of loneliness. Commonest feelings and thoughts of a subject preceding the suicide attempt are wish to escape from unbearable situation, loss of control, desire to show love for partner and wish to be helped 19.

During our work with patients who attempted suicide and wanted to die we have tried through empathy to understand his/her suicidal fantasies, recognize released stimulating feelings of power but not underestimating their destructiveness. Together with all this we had in our mind that we should help him/her to overcome the actual situation 22.

Patients who have attempted suicide establish ambivalent relationship with their psychotherapist making him/her great countertransferential problems. In the course of psychotherapy patient often uses the therapist as a self-object, an experience which changes patient's narcissistic balance. Suicidal patients create a self-object transfer by attacking therapist, similarly to relations they had with important figures in their childhood. Concealed attacks are very unpleasant for the therapist's feelings of self-estimation. Unwillingness of the suicidal patient to confide a secret to therapist causes his/her ambivalence toward both therapist and life, in general. Behavior of the suicidal patient is additionally complicated by his/her emotional reactions and demands posed to the therapist, by the therapist's own reaction and by influence of some other important ones. Apart from this, therapist must not take over the whole patient's life on himself/herself only to support the patient. Therapist may be in the situation in which patient demands his/her availability in any moment aiming to include him into the wide range of own problems. Suicidal patient intends to get into a symbiotic relationship with the therapist, from which both partners can hardly get out without generating anxiety in each other. Degree to which the therapist yields patient in his/her dependent need or, on the contrary, to which he encourages patient to learn to be responsible, is a matter of clinical assessment 26.

Psychotherapist has to be permanently cool and ready for conversation with a suicidal person in all circumstances. However, to be able to fulfill that task the therapist himself must solve the own attitude toward death. If the therapist is scared of death he/she will neither be able to recognize signs which undoubtedly, lead the patient to suicide, nor to be on the side of value of even life defense together with the patient. Opinion not very rare even among psychiatrists that the failed suicide attempt means that, in fact, there was no serious suicidal intention has to be rejected. Therapist has to initiate conversation about suicidal intentions with his patient including detail of his/her suicidal plan.

On the other hand, therapist can play the role of the patient and experience his/her painful feelings. Because of the risk for therapist to be succumbed by the patient's way of thinking and to make or strengthen false mental structures which will create him/her problems, countertransferential supervision of the therapist's reactions is necessary 27.

A special problem in countertransference can be therapist's reaction of the patient and his/her withdrawal from analysis.

After the psychotherapeutic crisis intervention none of our patients was referred to the hospital treatment, but psychotherapy without any financial compensation was recommended to all of them. Only 16.7 % of our patients, however, came to psychiatric consultation to the outpatient clinic, at the Department for Mental Health and Military Psychology of the Military Medical Academy.

Fear of stigmatization in connection with psychiatric treatment transfers to fear of stigmatization related to psychiatric aid to patients after suicide attempt. Previously mentioned investigations speak in favor of the fact that a large number of patients after suicide attempt self-initiatively do not ask for psychiatric help either during the actual hospitalization or after hospital treatment because they do not recognize the need to accept psychiatric aid in their situation. The same happened with our patients. Therefore, it can be seen that psychotherapeutic crisis intervention applied in patients after suicide attempt during their hospitalization is their only contact with a psychiatrist, which is, in fact, its greatest importance.

The absence of motivation and refusal to continue psychotherapy confirm that we cannot have the omnipotent role in making decisions instead of our patients, either in present or in future, either in their lives or death. We also cannot bear responsibility for possible repeated suicide attempt of our patients. The only possible thing that we can do in psychotherapeutic crisis intervention is to convince our patients in vanness of escape into suicide, in, for them, already known refuge.

After the psychiatric crisis intervention 6.7 % of our patients repeated suicide attempt during the following year. One of them repeated suicide attempt by serious self-harming in the beginning of psychotically decompensation, and was hospitalized in the Clinic of Psychiatry; second repeated suicide attempt for the same reasons (financial prob-
lems) he had had at the moment of previously suicide attempt. Both of them did not ask psychiatric help before their suicide attempt.

In spite of a pessimistic prognosis that patients accept psychiatric aid with difficulty, effects of the psychiatric crisis intervention applied in the work with our patients represent great stimulus for our further professional efforts.

Conclusion

Assessment of conscientious and unconscious conflicts leading to suicide attempt represents initial basis for therapist's work with a patient after suicide attempt and for application of psychotherapeutic crisis intervention. In psychotherapeutic crisis intervention the psychotherapist renders help to the person who attempted suicide with the aim to relieve his/her suffering and to integrate painful feelings which can be helpful in coping with them in a more constructive way and find out how to enhance own capacities of adaptation to newly created situation, so that the person could regain normal mental functioning level.

Suicide attempters are depressed with a medium suicide risk factor, so it is very important to use an integrative therapeutic approach, combining pharmacotherapy and psychotherapy in psychotherapeutic crisis intervention following suicide attempt.

REFERENCES


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