Maximizing Therapeutic Alliance in Suicide Risk Assessment, Management, and Treatment

Katherine Anne Comtois, PhD, MPH
Professor
Department of Psychiatry and Behavioral Sciences
University of Washington
Disclosures

- No conflict of interest.
- No discussion of non-FDA-approved medications or devices.
Learning Objectives

At the conclusion of this presentation, participants will be able to:

▪ Describe two key aspects of the Aeschi model of psychotherapeutic care for suicidal patients
▪ Define management vs. treatment of suicidality
▪ Describe the therapeutic value of the clinical narrative
Core Elements of Suicide Care

Suicide Care in Systems Framework

Risk Detection → Assessment → Risk Formulation

Management → Treatment

Follow-up
The Core Question

Life stress

Why?

Shared Case Conceptualization

Non-suicidal

Guess I need to deal with it.

Suicidal

Time to check out.
Aeschi Model – Collaboration and the Suicidal Narrative

1. The clinician’s task is to reach, together with the patient, a shared understanding of the patient’s suicidality.

2. The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.

3. The interviewer’s attitude should be non-judgmental and supportive.

4. The interview should start with the patient’s narrative.

5. The ultimate goal must be to engage the patient in a therapeutic relationship.
Therapeutic Alliance

• The Aeschi goal is immediate and meaningful therapeutic alliance

• Therapeutic alliance has three essential elements:
  – Agreement on the goals of the treatment
  – Agreement on the tasks
  – The development of a personal bond made up of reciprocal positive feelings.
Aeschi Model – Core to Evidence-Based Practices for Suicide Care

1. Dialectical Behavior Therapy (DBT)
2. Cognitive Therapy for Suicide Prevention (CT-SP)
3. Safety Planning Intervention (SPI)
4. Attempted Suicide Short Intervention Program (ASSIP)
5. Collaborative Assessment and Management of Suicidality (CAMS)
Attempted Suicide Short Intervention Program (ASSIP)

• ASSIP is only three sessions
  – Clinical Narrative
  – Reflection on Clinical Narrative
  – Psychoeducation and Self-Management
  – Letters to maintain connection

• Demonstrated several meaningful outcomes:
  1. 80% reduced risk of suicide attempt over one year
  2. Cost-effectiveness
  3. Increased therapeutic alliance $\rightarrow$ ↓ suicidal ideation

Narrative interviewing: An effort find a story so that actions make sense. “Tell” and “story” correlated with alliance.

Narrative Interviewing

Please *tell* me the *story* of what led to the suicidal crisis. Just let me listen to you.

Aeschi Model

Themes

Self-esteem
Separation and Loss
Rejection
Restrained or Dependent

Michel et al., 2004 *Archives of Suicide Research, 8*(3), 203–213
Looking within the Narrative for Tangible and Useful ‘Drivers’ of Suicide

Standard risk factors often

- Can’t be changed (history of attempt, demographics, loss)
- Difficult to change (addiction, bipolar disorder, availability of a support system)

Risk factors are often uninteresting or can feel threatening to a suicidal patient

Compared to Interrogative Risk Assessment
Risk Assessment Following the Narrative

• Many risk factors will become apparent in the narrative
• Risk factors that do not become apparent can be asked after the narrative

• Will this take more time? Probably
• Will the overall course of treatment take more time? It could be shorter if suicidality resolves sooner
## Gendered Narratives of Veterans’ Suicide Attempts

<table>
<thead>
<tr>
<th>Topic</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gendered Narrative</td>
<td>‘I suck. I don’t feel worthy of life’</td>
<td>‘The world sucks; it’s not worth it’</td>
</tr>
<tr>
<td>Self-Concept</td>
<td>Feeling worthless, shameful, empty; internalizing abuse and trauma</td>
<td>Feeling not able to live up to ideal self</td>
</tr>
<tr>
<td>Social Power</td>
<td>Always on guard, often victims of sexual abuse/assault, and feel like they have to work extra hard for opportunities</td>
<td>Accustomed to spaces being male spaces, especially the military; may feel like ‘less of a man’ when not able to fulfill stereotypical gender role</td>
</tr>
</tbody>
</table>

Gendered Narratives of Veterans Suicide Attempt

<table>
<thead>
<tr>
<th>Topic</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>Source of abuse, trauma, and betrayal</td>
<td>Often a source of support, but sometimes stressful</td>
</tr>
<tr>
<td>Coping</td>
<td>Often reach out to others for support and are met with rejection</td>
<td>Tend to isolate (especially using substances); Not going to reach out for help</td>
</tr>
<tr>
<td>Stress</td>
<td>Struggle with navigating systems, figuring things out, wanting to make the right decision</td>
<td>Feel overwhelmed by setbacks and feel unable to maintain control over life</td>
</tr>
</tbody>
</table>

## Gender Differences in Veteran Recovery Needs after a Suicide Attempt

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Connection with Others</strong></td>
<td><strong>Try to Live and Do ‘Right’ Toward Becoming their Ideal Self</strong></td>
</tr>
<tr>
<td>• Desire to feel connected with others</td>
<td>• They have an idea of what ‘right’ is and are striving to get there</td>
</tr>
<tr>
<td>• Finding strength in helping others</td>
<td>• Having the ‘right’ mentality or mindset</td>
</tr>
<tr>
<td>• Wanting mutually supportive relationships</td>
<td></td>
</tr>
<tr>
<td><strong>Repair Self-Worth through Knowledge and Development</strong></td>
<td><strong>Want to Feel Needed and Accountable to Others</strong></td>
</tr>
<tr>
<td>• Why do they do, think or feel what they do</td>
<td>• Sense of obligation to family</td>
</tr>
<tr>
<td>• Wanting to feel ‘normal’</td>
<td>• Contributing to something bigger than themselves</td>
</tr>
<tr>
<td>• Wanting to to feel ‘whole’</td>
<td>• Desire to help others</td>
</tr>
<tr>
<td><strong>Stronger Sense of Purpose in Life</strong></td>
<td></td>
</tr>
</tbody>
</table>

Denneson, L. M. et al. (2021) *Medical Care* [https://doi.org/10.1097/MLR.0000000000001381](https://doi.org/10.1097/MLR.0000000000001381)
Video Examples

https://www.maketheconnection.net/stories/719/

https://www.maketheconnection.net/stories/622/

Public domain videos courtesy of the United States Department of Veteran Affairs.
Core Elements of Suicide Care

Suicide Care in Systems Framework

Risk Detection -> Assessment -> Risk Formulation

Management -> Treatment

Follow-up
Management vs. Treatment

1. Client: Nothing is working. I should just kill myself.
   Therapist: What do you think about a short hospitalization?

2. Client: Nothing is working. I should just kill myself.
   Therapist: Can we take a closer at that way of thinking?

Management of Suicide Risk

Therapist engages in interventions that seek to reduce risk by modifying risk factors related to suicide. Management is optimally, but not necessarily, collaborative.

Continuity of care (managing transitions, discharge & referral)
Psychiatric treatment
Safety planning, including means safety

Management

Therapist engages in interventions that seek to reduce risk by modifying risk factors related to suicide. Management is optimally, but not necessarily, collaborative.
Therapist and client engage in a collaborative relationship to resolve risk by targeting internal factors that are unique/intrinsic to suicide risk. Treatment is necessarily collaborative.
Over time, the patient grows in confidence and responsibility in self-management of suicide risk.

### Summary

<table>
<thead>
<tr>
<th>Management</th>
<th>Collaboration</th>
<th>Goal</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Optimal when collaborative</td>
<td>Reduce risk</td>
<td>External factors related to suicide risk</td>
</tr>
<tr>
<td>Treatment</td>
<td>Necessarily collaborative</td>
<td>Resolve risk</td>
<td>Internal factors intrinsic to suicide risk</td>
</tr>
</tbody>
</table>
Integrating Narrative with Suicide Management: Example of SPI

Safety Planning Intervention

Attempt or high-risk moment

Moment passes
It gets better

Suicide Risk Curve

Safety Plan – managing risk based on the narrative:

- Warning Signs
- Internal Coping
- People and Places for distraction

- People who can provide help
- Professional Resources
- Lethal means counseling
Core Elements of Suicide Care

Suicide Care in Systems Framework

Risk Detection → Assessment → Risk Formulation → Management → Treatment → Follow-up
Treatment based on the Clinical Narrative

• The narrative is a reflective process that asks the patient to
  – Examine and not avoid the suicide attempt or suicidal thoughts
  – Exposure to suicidal thoughts in effective environment
  – Overcomes limitations in episodic autobiographical memory

**Autobiographical memory:** the system involved in collecting, storing and retrieving episodes from an individual's life, and comprising a combination of *episodic* (e.g., personal experiences and specific objects, people and events experienced at particular time and place) and semantic (general knowledge and facts about the world) memory.
The Core Question

- Life stress
  - Shared Case Conceptualization
  - Why?
    - Non-suicidal
      - Guess I need to deal with it.
    - Suicidal
      - Time to check out.
Evidence-Based Treatments, the Clinical Narrative and Shared Case Conceptualization

EBPs respond to the shared conceptualization in different ways

• DBT → specific links on the chain of events that can be changed with increasing skills, exposure, cognitive, or contingency strategies; focus on affect regulation/tolerance

• CT-SP → problematic cognitions and cognitive patterns are identified that can be responded to with coping strategies

• ASSIP → reflection on the narrative by viewing videotape plus psychoeducation

• CAMS → problem-focused therapy approach using therapist’s theoretical orientation
Key Takeaways

- The clinical narrative is critically important
  - For alliance
  - Treatment itself?

- Consider how your limited session time is spent
  - Assessment vs. Intervention – Consider Opportunity Costs
  - Management vs. Treatment
  - Optimizing the flow to maximize retention and suicide resolution
References


Thank you. Happy to take Questions

Katherine Anne (Kate) Comtois, PhD, MPH
UW Center for Suicide Prevention and Recovery
uwcspar@uw.edu