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Update log	

PODS: Working with suicide and self harm.

Conference held on 23rd November 2018

At this conference Carolyn suggested suicidality is not the problem, it is the solution when there are no strategies in place to deal with psychological pain and suicide seems the only option. With this in mind, she sees recovery as learning skills for dealing with distress. What we know about suicide is limited as often what we learn about suicidality and suicidal behavioural is from those who have not completed suicide and therefore this is a different state.

There are so many different theories as to 'why' people commit suicide and rather than thinking which one is correct, it may be more useful to ask, 'are any of them entirely wrong?' There may be over a million reasons as to why someone commits suicide, but the minute that we reduce it to a theory, we reduce the individual's suffering. Rather than a theory, instead hope, compassion and relief is required. Carolyn states not to reduce pain to one's preconceptions and that 'Your being may be your greatest doing'.

Three quarters of people that complete suicide will deny suicidal thoughts, so how do we go about this? There is a blame culture, when a suicide happens everyone looks to who was involved in their care and why they didn't prevent it. The Prediction-Prevention model engenders the belief its always preventable and is seen as the fault of the therapist. The therapist has all of the responsibility, while the client has all of the power. With this the focus moves from decreasing risk, rather than distress and with professional anxiety entering this, it becomes about reducing risk to oneself as a practitioner. This can often lead to a cycle of onward referrals, so as not to be seen as failing to prevent and at fault.

The sad result of this is sectioning, which takes away a client's choice, independence and absolves them of responsibility to recover. By taking this approach prevention is imperative, not empathy and as a result clients are often asked about pathology and not 'what has happened to you, how are you feeling?'.

What increases the risk?

- The short version of 5-HTTLPR serotonin increases risk
- If one's mum was stressed at birth: glucocorticosteroil increased sensitivity on the HPA axis
- Birth trauma makes someone four times more at risk
- Family of suicide increases risk
- Childhood trauma
- Lack of emotional regulation and attachment issues, resulting in negative beliefs
- If then an ethnic minority or lower financial status

- If an alcoholic they are 7% more likely
- Physical illness

These are just a few, but it highlights how it is not surprising why someone might activate their 'suicidal mode'.

Carolyn spoke of the 'suicidal mode', in which impairments to the brain occur when feeling highly suicidal. In this mode empathy circuits and other parts of the brain are shut down and the neurobiological aspect is identical to that in trauma.

This consists of:

Front left brain – DESPAIR

- Impaired timekeeping
- Impaired problem solving
- Impaired sequencing and planning
- Impaired memory, particularly for what helped in the past
- Impaired impulse control
- Loss of reference points for what is normal ie. Reality testing
- Impaired speech and language

Front middle brain – DISSOCIATION

- Lack of grounding and centredness – experiences of dissociation
- Sense of body as 'other'
- Failure of mindsight – to just notice thoughts and feelings
- Failure to mentalise
- Loss of empathic capacity
- Impaired ability to execute a plan

Front right brain – DISENGAGEMENT

- High levels of emotional distress
- Hyperarousal
- Emotional state experienced somatically rather than verbally
- Mental state is overwhelming to self and others
- Breakdown of effective care-seeking strategies

Carolyn proposes a Front/Back Brain and Trauma Traffic Light System to self harm and suicide:

- Red Zone: Freeze, Front brain off, Parasympathetic circuit
- Amber Zone: Fight/flight, Front brain off, Sympathetic
- Green Zone: Social engagement, Front brain off, Parasympathetic

She also believes that the current way of assessing risk is inadequate and thinks that this model can be used to assess risk of suicide and self harm:

- ACUTE RISK: Possible fatal suicide, Calm, focused, tunnel vision, 'autopilot'
- HIGH RISK: Possible non fatal suicide attempt and/or serious self harm, High agitation, Front brain shut down, Recent trigger
- AT RISK: Suicidal ideation, possible self harm, Agitation, Front brain impaired, Reinforcing suicidal mode
- NO RISK: Green zone, Social engagement, Front brain online

Carolyn described how self harm is often a protective mechanism of suicide as it provides a temporary solution, either moving the individual into the red zone and dissociative state. However, many people do not realise that in the long term it makes everything worse as the leap into dissociation becomes more well-rehearsed and accessed at lower levels of agitation.

Carolyn speaks of becoming an 'emotional athlete' and uses the 'Recovery Triangle':

- FRONT LEFT – 'Growth mindset' and knowledge of the right skills
- FRONT RIGHT – support to learn and apply the skills
- FRONT MIDDLE – purposeful engagement to apply the skills to develop expertise

She spoke at length of prescribing hope, delivering compassion and relief, not a theory. Additionally she spoke of promoting equal responsibility and collaboration and a growth mindset, rather than a fixed mindset. We should always challenge and expect more from clients. We need an expectation of greatness and hold them to account. At the same time, Carolyn also described the importance of an 'emergency tool kit' and 'safety strategies' that an individual can use to manage psychological distress and bring themselves back to the green zone.