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Crisis psychology: opportunities and challenges for psychologists working with acute distress and suicidality

Complex Mental Health Network, ACP-UK

Building a pyramid of psychological care in a crisis and home treatment team

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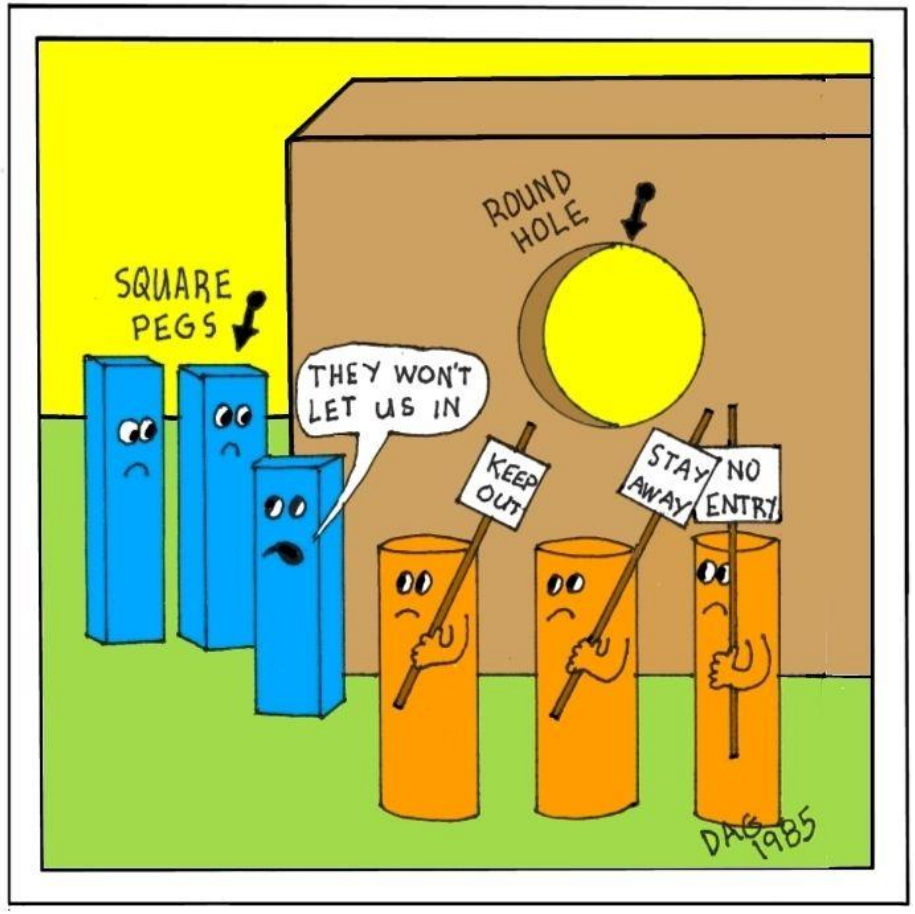
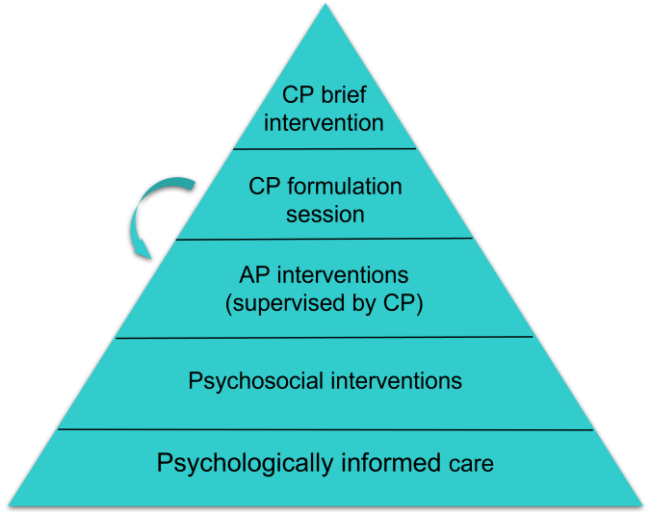
Background


ROUND HOLE
SQUARE PEGS
THEY WON'T LET US IN
KEEP OUT
STAY AWAY
NO ENTRY
DAS 1985

Overview

- Brief overview of the historical and current context
- Dilemmas of working psychologically at points of crisis
- My approach:
  - A pyramid of care
  - Risk formulation
  - Examples of interventions
- Linda's story



Historical context

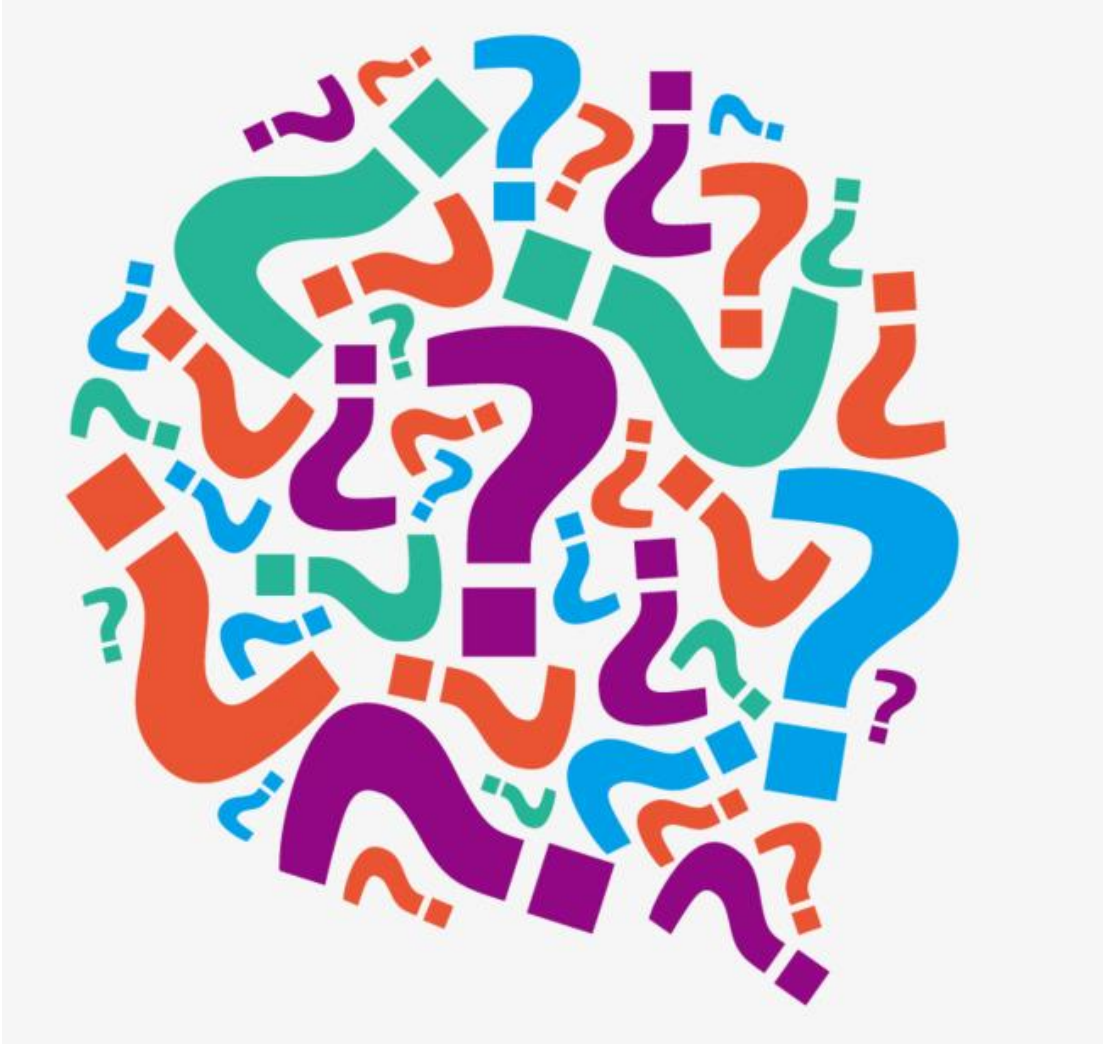
Dismissal: ψ in crisis is harmful, stay out

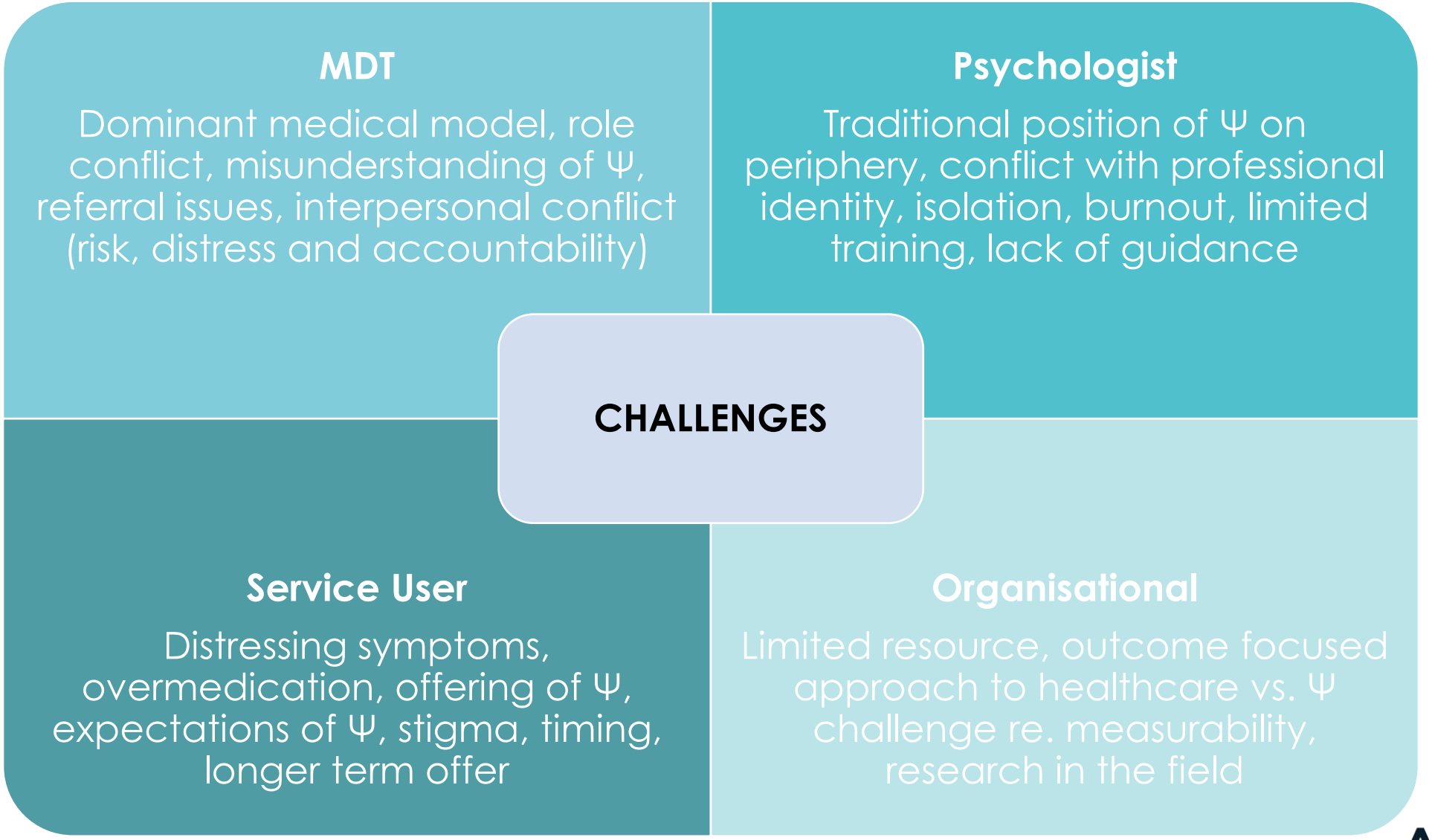
Suspicion: Unsure what ψ can offer

Acceptance: ψ nice, but not necessary

Current context

- Policy promotes the importance of ψ provision within acute settings (ACP-UK, 2021; NHS Long Term Plan, 2019).
- ψ interventions in acute services = decrease in distress and increase in confidence of self-management of symptoms (Araci & Clarke, 2016). Patient feedback is positive about psychological interventions in the acute care pathway (ACP-UK, 2021)
- Increasing hopefulness, resilience and reasons for living reduces suicide risk (McLean 2008). 'Suicide is perhaps the cause of death most directly affected by psychological factors because a person makes a conscious decision to end his or her own life' (O'Connor & Nock, 2014). Thus, psychology is central to understanding & preventing suicide (BPS, 2017)
- EMDR with CRHTT client group does not increase clinical risk but in fact reduces the desire for suicide, anxiety, depression and PTSD symptoms to a clinically significantly level (Proudlock, ****).
- Despite the above, there remains a lack of understanding of the role of psychology and the benefits it can bring to patients and teams dealing with crisis and suicidality (Wood et al., 2018)





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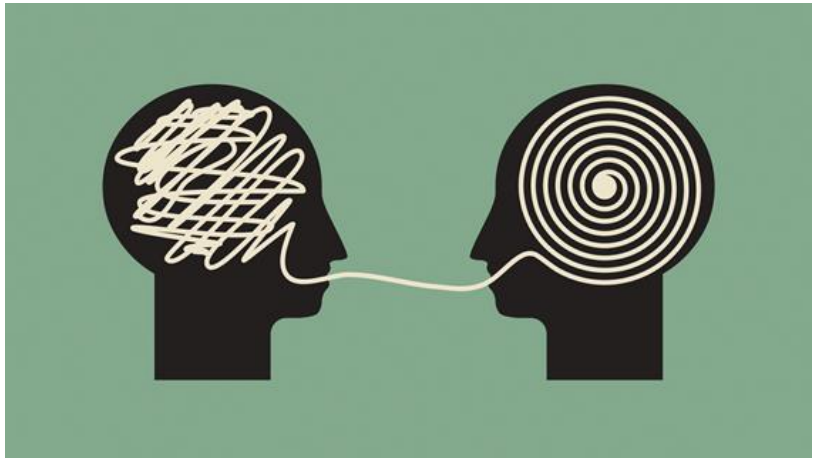
Dilemmas in the crisis context

- Brief window of time (acute) or switch of focus (therapy)
- Home / ward visits
- Limited collaboration
- How deep do we dive?
- System pressures and power dynamic
- Confidence in competence
- Own threat system activated
  - Unfamiliar, or distressingly familiar
  - Psychotherapy with suicidal patients is inherently challenging, requiring the therapist to bear intense emotional pain while attending to potentially derailing countertransference pressures (Schetter et al.)



"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet“

Rachel Remen

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My approach

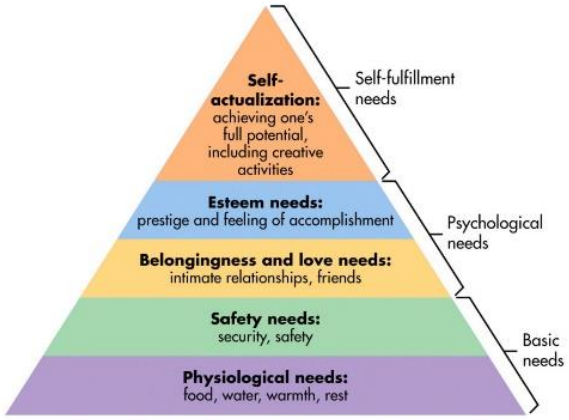
- 1 x 8b CP (0.8 wte)
- 1 x Band 7-8a CP (1.0 wte): starting Autumn 2023
- 2 x AP (2.0 wte)

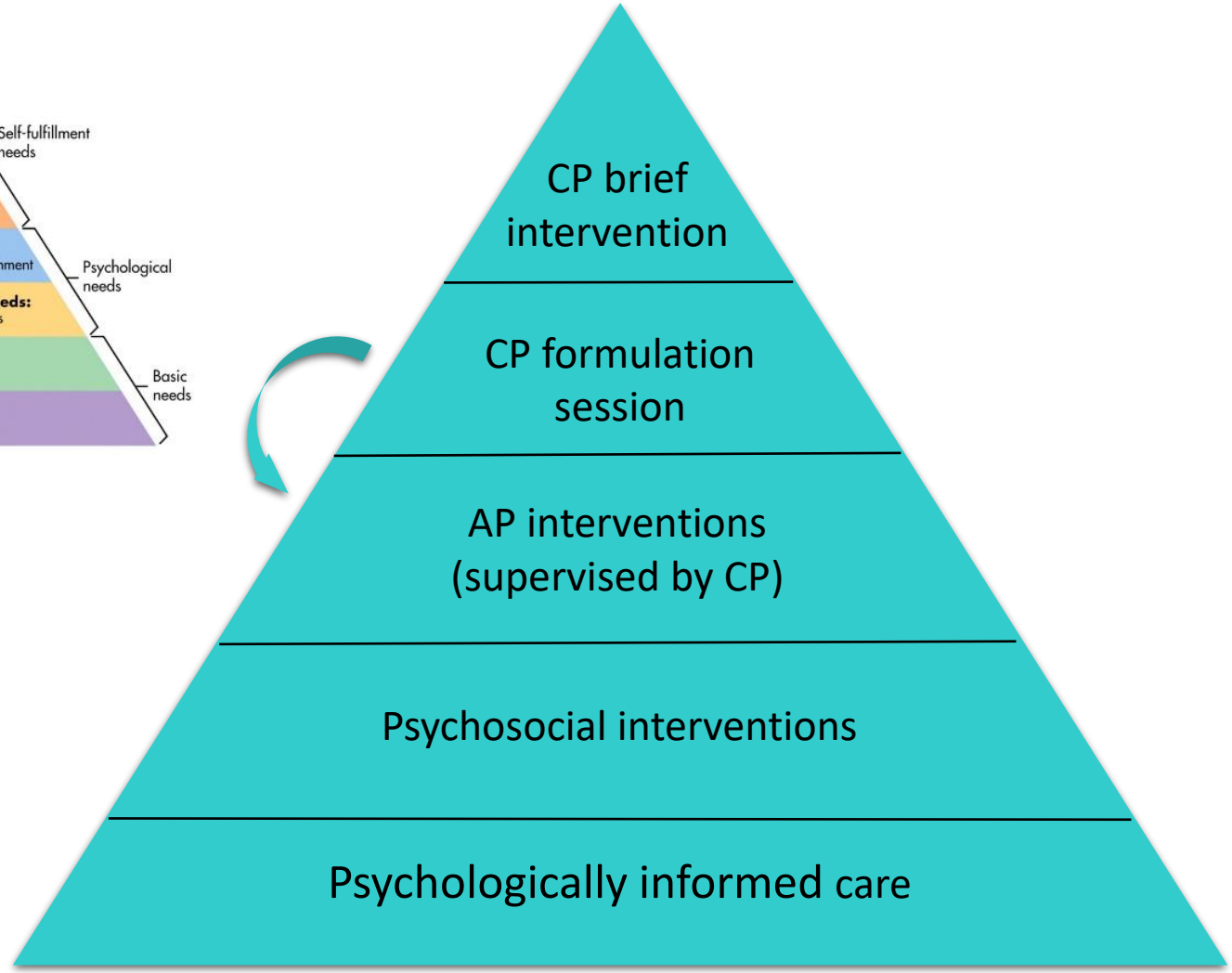
MDT of 2x medic, 2x OT, 12x RMN, 12x SSW, 1x PSW (+ researchers)

Caseload approximately 20-25 people. Geographical area 85 mi^2

In phase 3 development of a county wide full fidelity service

Pyramid of care





- Team Formulation
- Consultation
- Reflective practice
- CPD
- Staff wellbeing

CRHTT PSYCHOLOGY INPUT PYRAMID

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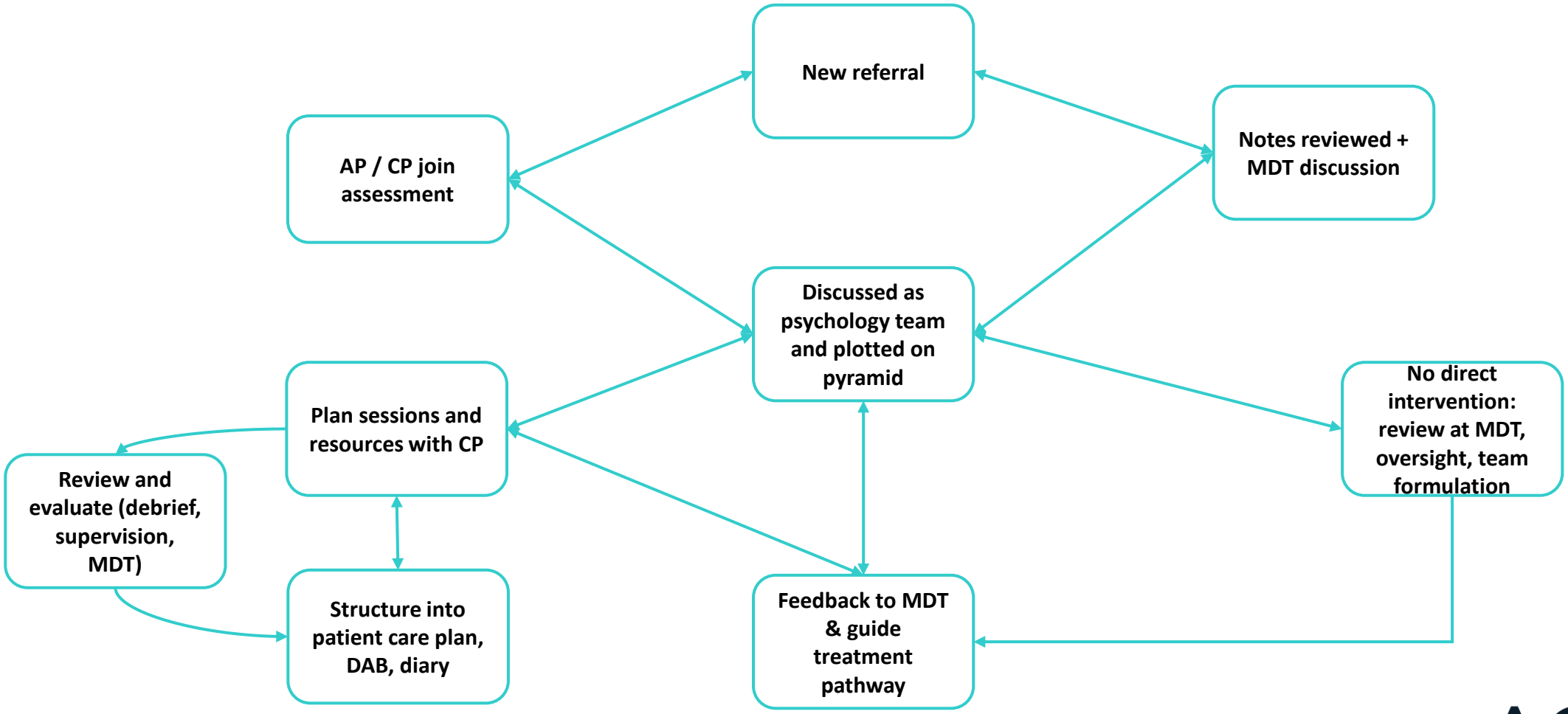
Clinical process

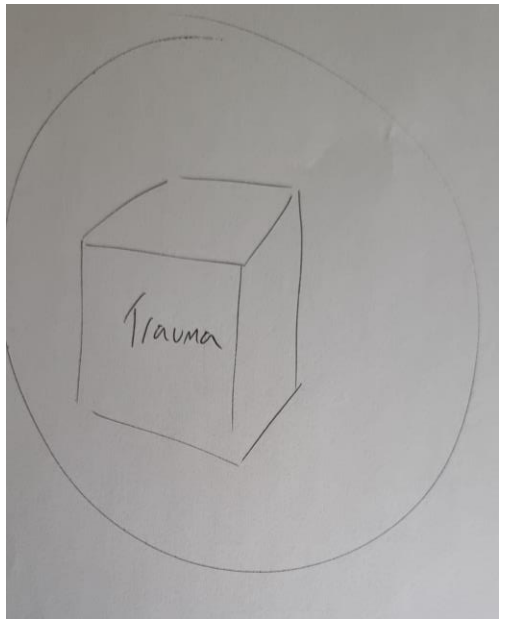


Psychology Team Roles

DIRECT WORK	INDIRECT WORK	RESEARCH	LEADERSHIP
• Joint assessments where indicated • 1:1 formulation sessions • 1:1 brief interventions - CBT / DBT / ACT/ CFT / MI / BA / SFT influences • Specialist assessment or screening if indicated e.g. cognitive or ASD • Carers support (AP's leading) • General support for team e.g. visits, telephone calls, administration as needed (AP's)	• Ad hoc clinical consultation • MDT meeting presence (daily) • Team formulation (weekly) • Reflective practice (fortnightly) • Staff training (monthly) • Supervision – group and 1:1 • Professional and interface meetings • Curating and maintaining psychosocial resources • Note reviews (usually AP's)	• Literature reviews • Audit • Service development / QI projects EXAMPLES: - Carer support pathway - CFT group crisis intervention - Post incident team support - Risk formulation training & templates • Keeping abreast of current research in the CRHTT field and disseminating • Coproduction	• PRESENCE • Supporting day to day business of CRHTT (crisis management!) • Recruitment and retention • Budget management • Staff support including post incident support • Team wellbeing advocate • Promoting a psychologically safe workplace • Promoting trauma informed care • Organisational influence

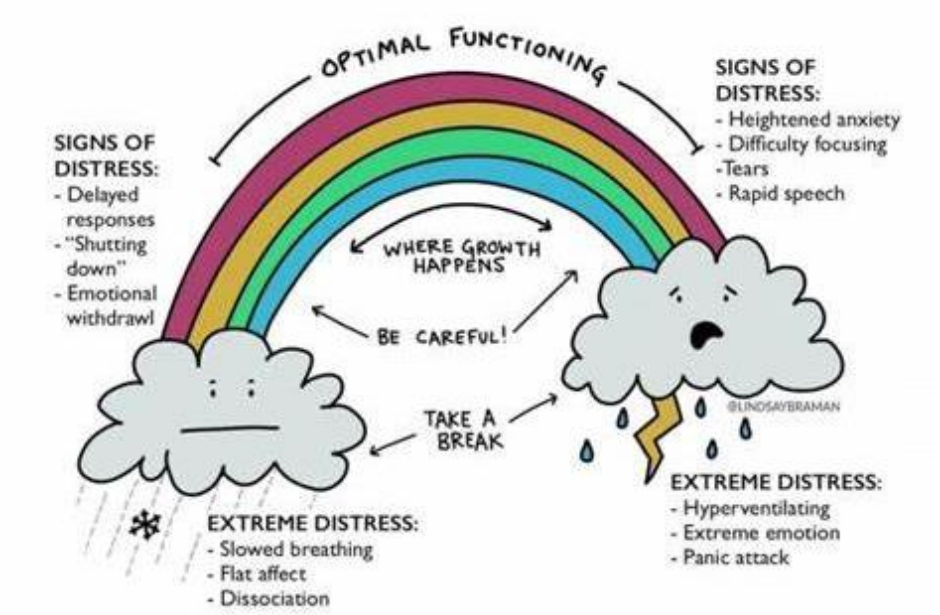
Formulation

- Predominant present focus
- Adapted
- Responsive
- Simple
- Targeting crisis/risk: own the remit
- Holding hope



Formulation models

- Depending on the purpose, audience and approach
- Can use the 5 P's to help guide a narrative structure (I often use this with teams)
- With service users I find simple bespoke visuals helpful



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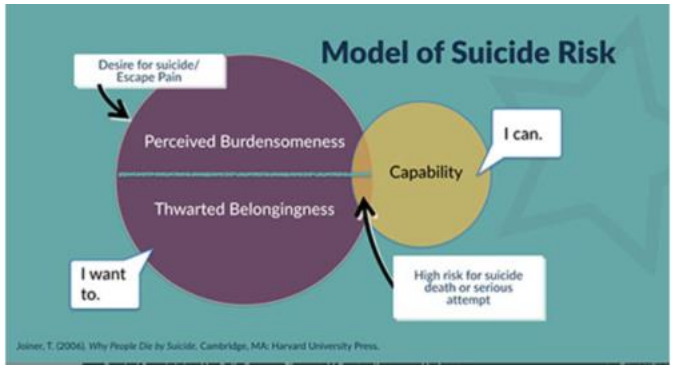
Diagnosis	List of factors	Formulation
Emotionally unstable personality disorder	**Presenting:** Repeated self-harm, substance misuse, emotional lability, chaotic lifestyle **Predisposing:** Early trauma including sexual abuse, lack of secure attachment figures, domestic abuse in adulthood **Precipitating:** End of a relationship, increase substance misuse, imminent loss of home **Perpetuating:** Lack of psychosocial stability. Negative self-concept. Addiction. Lack of alternative coping skills **Protective:** Supportive friendship. Willingness to engage in ongoing support.	Stacey was referred to the CRHTT in high distress with self-inflicted cuts to her arms. Stacey had a difficult childhood, during which she experienced sexual abuse at the hands of a close male family member and emotional neglect from her parents who had moved on in new relationships with other children. Stacey lacked a secure safe figure to turn to for help or understanding of her emotions. Instead she truanted and sought seeking comfort via older male figures some of whom abused her further. Through these aversive experiences, Stacey has developed negative core beliefs of herself as worthless and unlovable. She has struggled to hold down a job due to conflict with colleagues. Stacey feels that she cannot provide for, rely on or trust herself to keep safe, therefore seeks out others to care for her and when she finds this her mental health appears much improved. Unfortunately her boyfriend ended their relationship last week, leading Stacey to feel rejected and abandoned. She lacks healthy mechanisms to cope with or communicate this distress, therefore harms herself both to seek release of emotion and to convey the level of distress to her ex-partner and services. This is exacerbated by use of substances, which increase her impulsivity and the risk of serious harm. When not intoxicated and at points of lower distress, Stacey is keen for support and wants to feel differently. She has a supportive friend who has offered her somewhere to stay, and Stacey is willing to engage in longer term work to develop coping mechanisms and address her sense of self worth. A referral has therefore been made to the AMHT, with the recommendation that Stacey builds a therapeutic relationship with a care coordinator and works on distress tolerance skills. Stacey will be seen by CRHTT daily in the interim to support her in developing some basic skills in this area e.g. self soothe box, grounding. Stacey has also been signposted to substance misuse services, the employment support agency, housing support and given a crisis management plan; encouraging and empowering her to reach out for support at times of particular difficulty.

Risk

- Formulating risk - Using all our skills to make sense of it vs. assessing it (what is the story of this suicidal urge?)

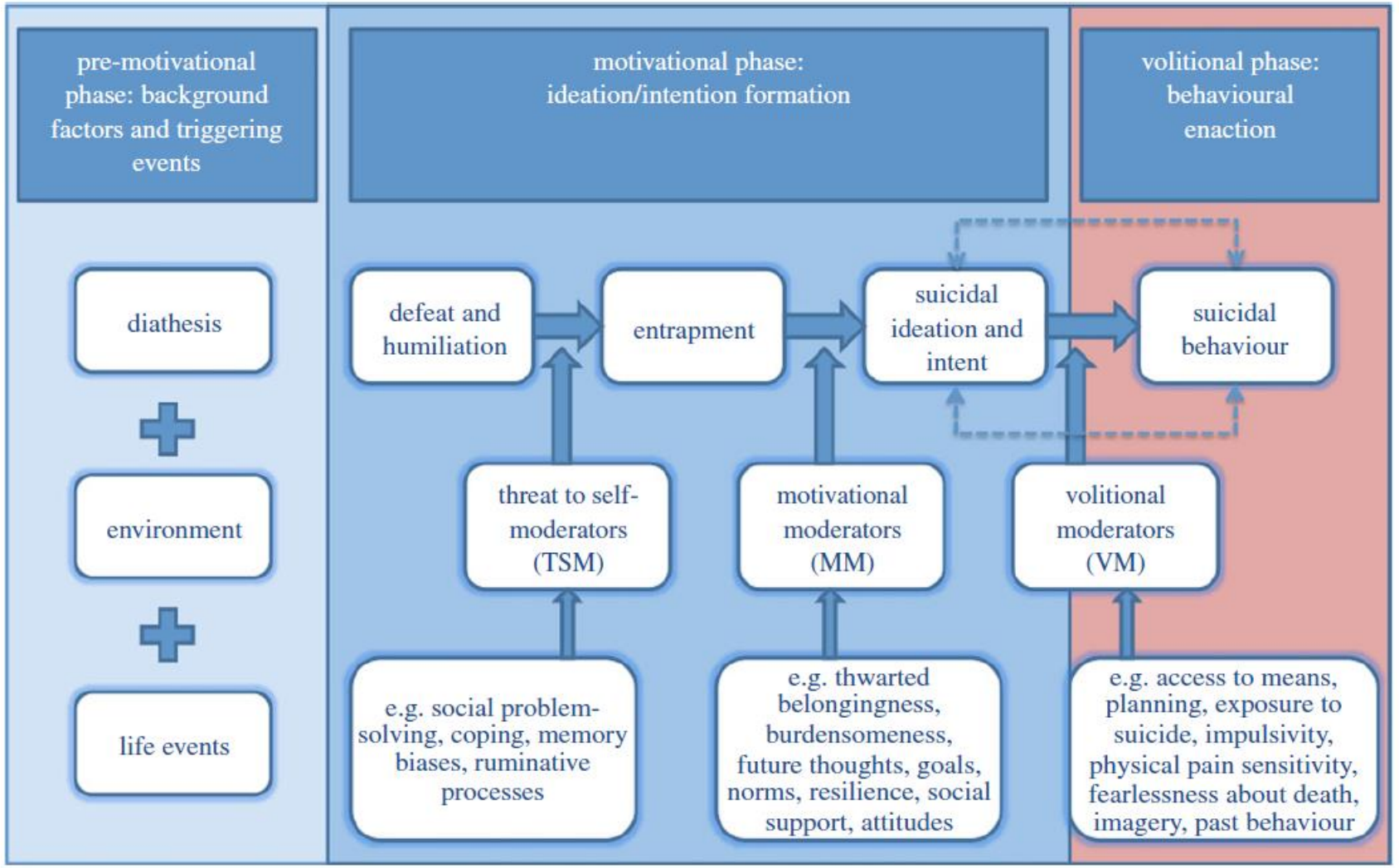
- Structured clinical judgement: incorporating what we know from data, with what we see and perceive
  - IMV model (O'Connor
  - Joiner's theory
  - **Alys Cole-King 'Compassionate approach to suicide mitigation'**

- Not being afraid to ask direct questions about suicide.
  - What does it mean to that person (Escape? Punishment? Relief for others?)
  - Passive vs. active suicidal ideation
  - Intent, plan, means
  - Using 1-10 type scales to help someone quantify their urges when appropriate



- Validate the dilemma and the urge, not the action ("this urge to end your life makes sense doesn't it, given what we have talked about". But help the person develop an alternative ending to the story.

- Use the risk formulation to shape interventions – e.g. If belonging is an issue, how can I create interventions that increase connectedness? If feeling burdensome, how can we foster a different perspective?



The IMV model of suicidal behaviour.

BOX 1 Guidance for clinicians on comprehensive assessment of suicidal thoughts

Suicide intent lies on a continuum from fairly common, vague, passive suicidal thoughts to rarer, high-intent/high-lethality suicidal acts. Some people find it hard to talk about their suicidal thoughts and may initially be reluctant to share them with you. Be aware of your own and the potentially suicidal person's voice and body language. If the patient delays in responding or if their response to a question is simply 'Alright' or 'OK', it might indicate that perhaps the patient is not quite as 'alright' as they claim. If you establish that a patient is experiencing suicidal thoughts, you need to ask further questions to gain as much information as possible.

After each answer, respond with appropriate compassion and then move on to the next step. Be mindful that the way you ask about suicidal thoughts, including responding with compassion, is just as important as the words and phrases you use.

All aspects of suicidal thoughts need to be identified:

- Perception of the future and any hopelessness
- Nature of the suicidal thoughts, i.e. frequency, intensity, persistence, getting worse, etc.
- Degree of suicide intent:

  Have they planned and prepared for a suicide attempt?

  Have they put their affairs in order?

  How detailed is the plan: have they thought about when, where and how; have they considered measures to prevent anyone from finding out about their possible attempt?
- Ability to resist acting on their thoughts of suicide or self-harm
- Whether they have told anyone else about their suicidal thoughts
- Whether they have access to the method they intend to use. If they do, try to disable their plan and remove their access to means.

BOX 2 Therapeutic strategies from the Cole-King Bank of Hope

Maximise the power of the individual not to act on their suicidal thoughts

- Increase resilience – enhance protective factors.
- Increase internal locus of control – 'Do not be a passive victim of suicidal thoughts'.
- Increase self-efficacy – uncover or teach the skills and techniques not to act on suicidal thoughts.
- Increase emotional resourcefulness and share simple problem-solving techniques to better equip them to deal with their triggers for suicidal thoughts or adverse life events should these occur/continue.

Reduce the power of suicidal thoughts

- Help the individual see that such intense suicidal thoughts do not last forever.
- Intense suicidal feelings are often short lived (although acknowledge that individuals may have intermittent but long-lasting low-grade suicidal thoughts, which can still be very distressing).
- Share examples of others who made serious and potentially lethal suicide attempts but who changed their mind immediately before or halfway through. Explain that they realised that they did not want to actually die – they had just felt so desperate and hopeless that they did not know what else to do to make those feelings go away. **Their real wish was to feel better, not to die.**
- Minimise and devalue the power of the individual's suicidal thoughts, while acknowledging and validating the distress they can cause to them.
- Help the individual to view their suicidal thoughts as nothing more than a symptom of their distress (like having a temperature due to a viral illness), rather than some powerful magical impulse that they cannot resist.

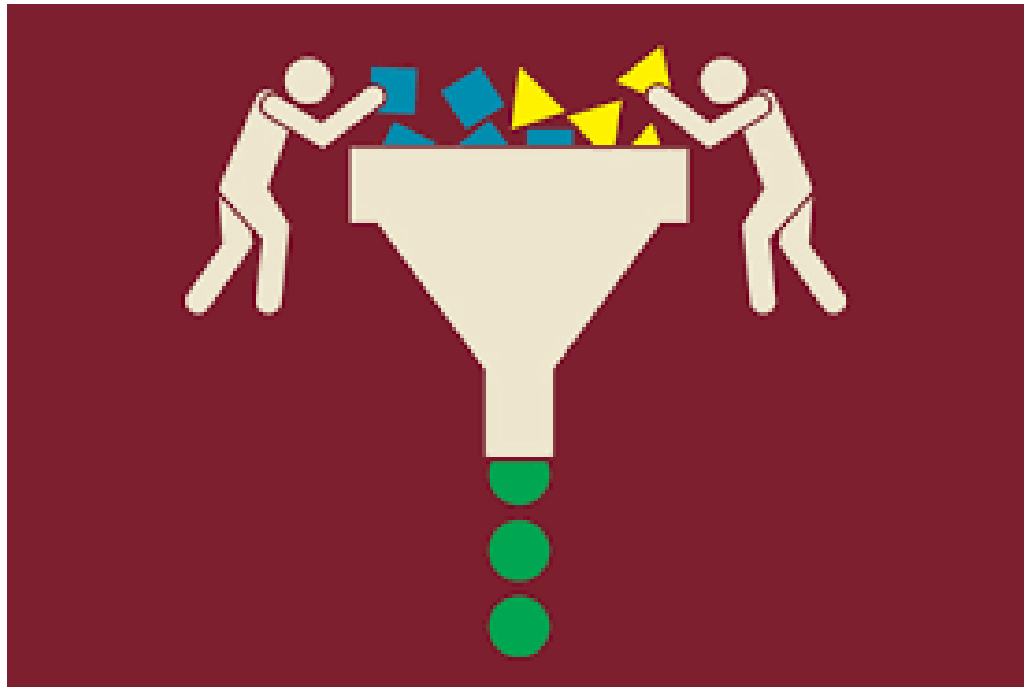
Collaborate to develop a safety plan

- This will be directed by the patient and facilitated by the clinician; generally, it will consist of tangible reminders of the patient's reasons for living, i.e. names, photos, etc.

Intervention

Interventions should ‘fall out’ of the psychological formulation:

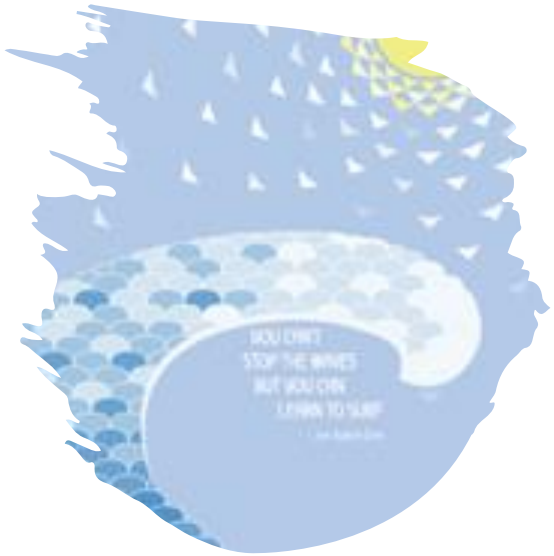
- 1) Short term. What does an individual need in the short term e.g. safety planning, distress tolerance strategies, social support, scaffolding. Often here you are addressing the **presenting** or **precipitating** factors, and utilising the **protective** factors.
- 2) Longer term. What have you identified in the formulation that may need longer term work. Often these are targeting the **predisposing** or **perpetuating** factors. May be things that are required after this crisis has passed

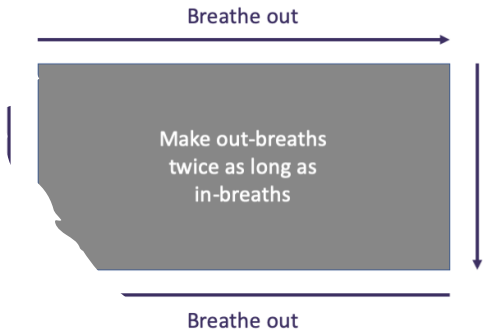


Step away from reliance on verbal / written word

- Threat mode = limited capacity for higher level cognitive function

- Be creative
  - Drawing
  - Metaphors
  - Music
  - Objects
  - Getting into the body
  - Location of session (use nature, physical space)

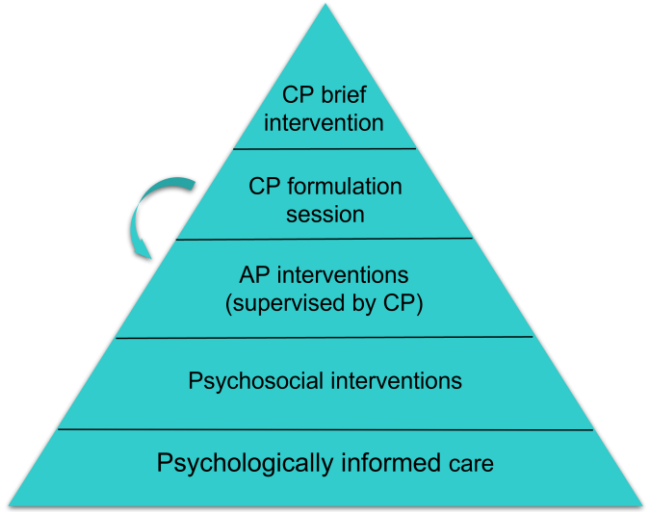




Examples of crisis interventions

- CFT therapeutic psychoeducation
- DBT distress tolerance skills
- ACT cognitive defusion & values work (carefully)
- CBT behavioural activation
- Relational mapping

… and many more(this is just a selection of examples chosen to show different models and level of depth)



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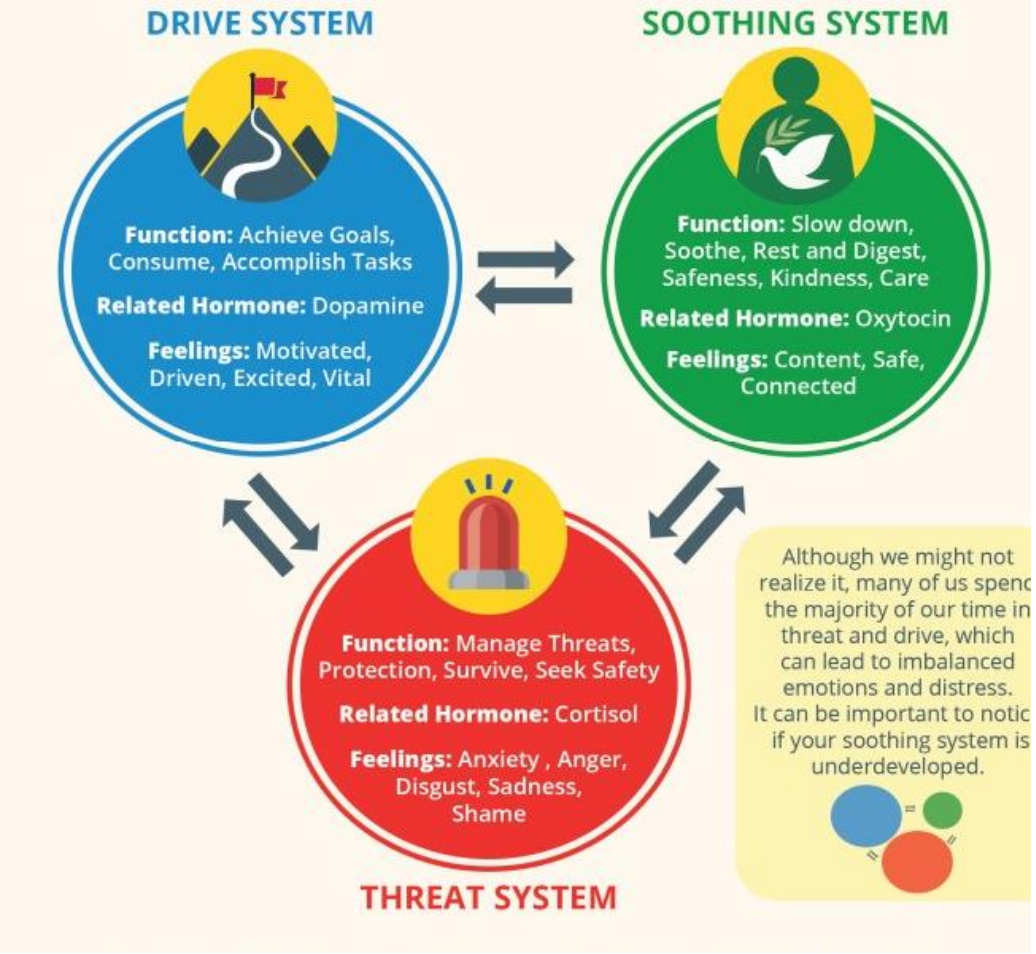
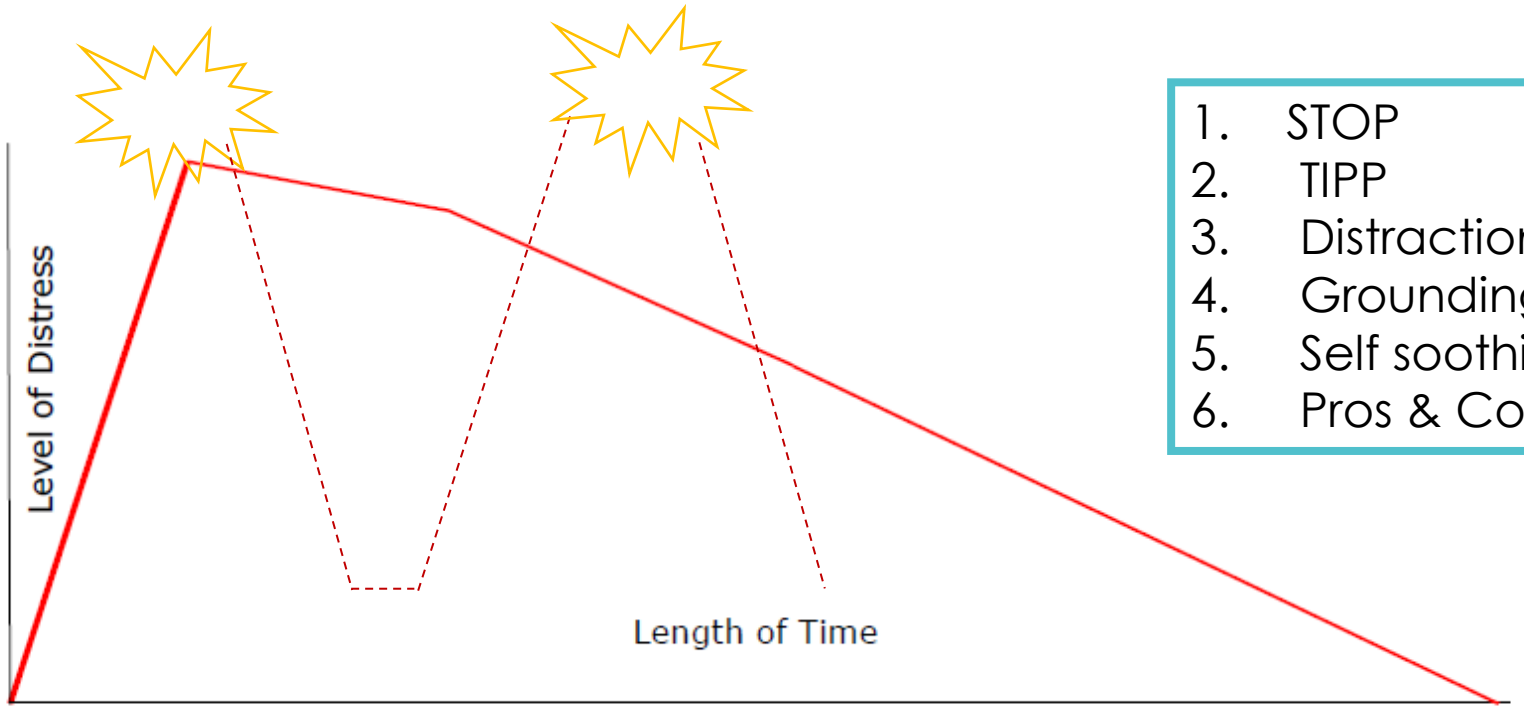
CFT therapeutic psychoeducation

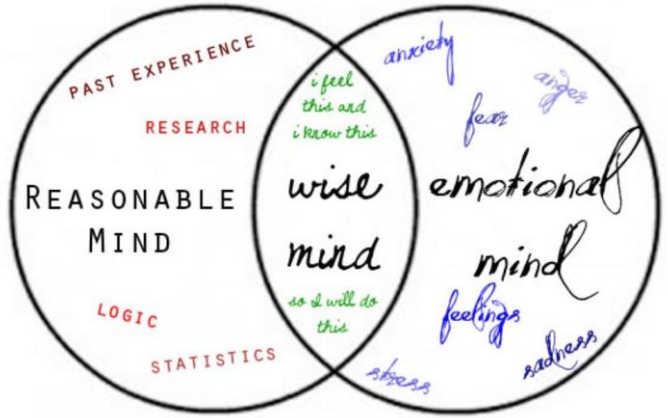


- Collaborative drawing of own current experience – giving the person the pen
- Psychoeducation about threat system: normalise, validate (particularly desire to escape)
- Consider interventions to Reduce Red, Build Blue, Grow Green
  - Grounding, self soothe kits, relational needs…

DBT Distress Tolerance

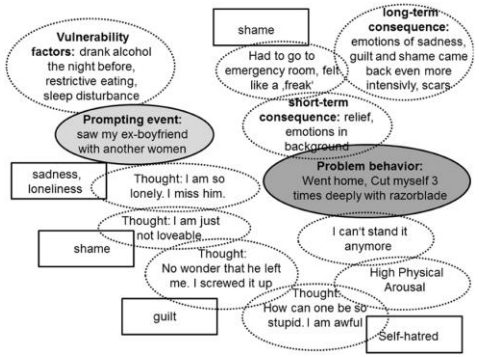


1. STOP
2. TIPP
3. Distraction
4. Grounding
5. Self soothing
6. Pros & Cons



SHORT TERM
Attempts to get rid of distress e.g. DSH, substances = usually successful (feel relief, release, congruence)

LONG TERM CONSEQUENCES
- *Don't learn that emotion passes*
- *Don't experience coping*
- *Negative implications of harmful strategies*



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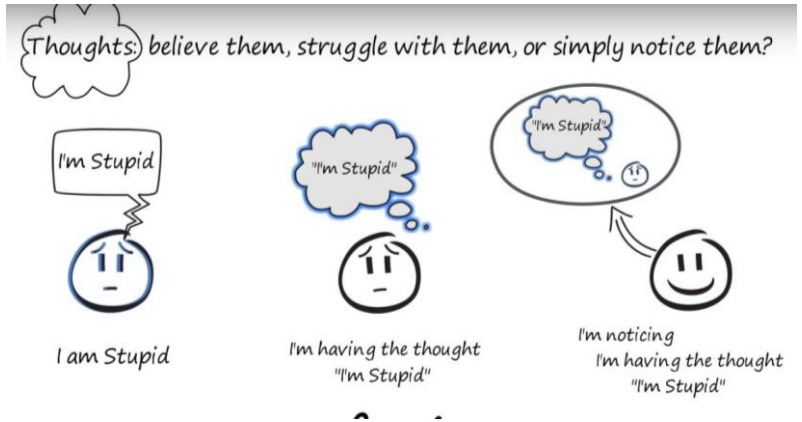
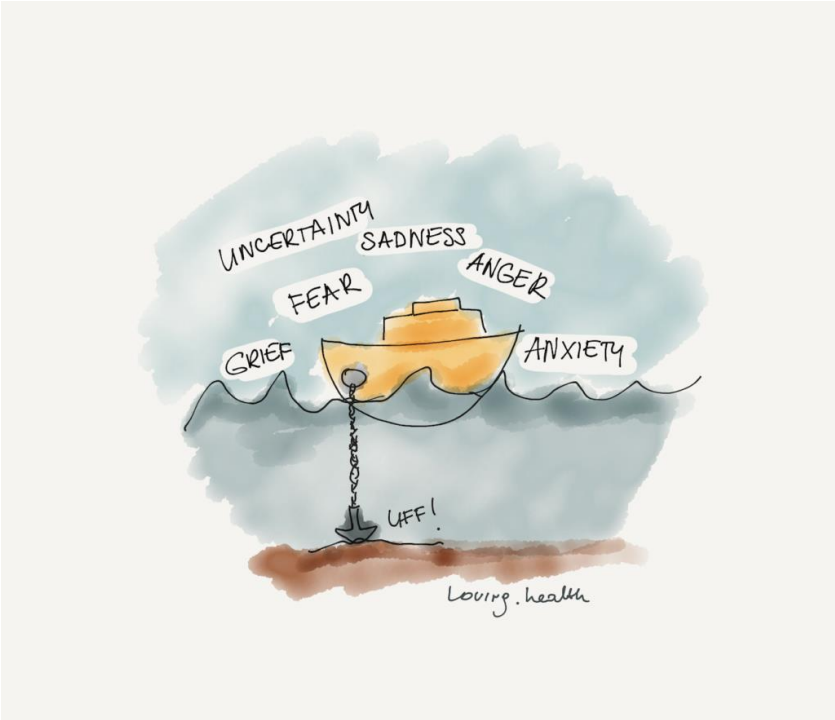
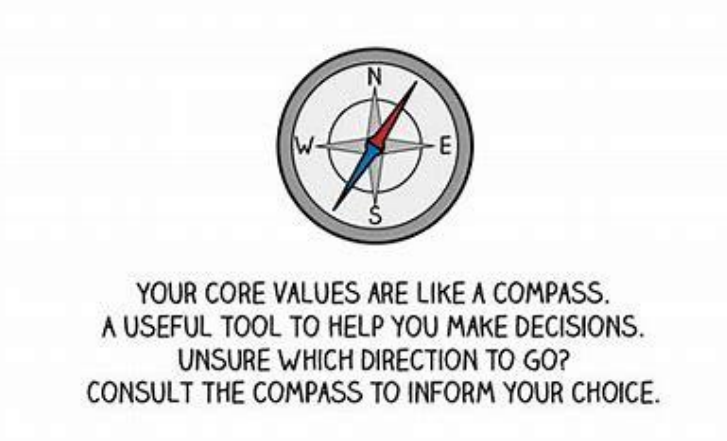
ACT based cognitive defusion & values

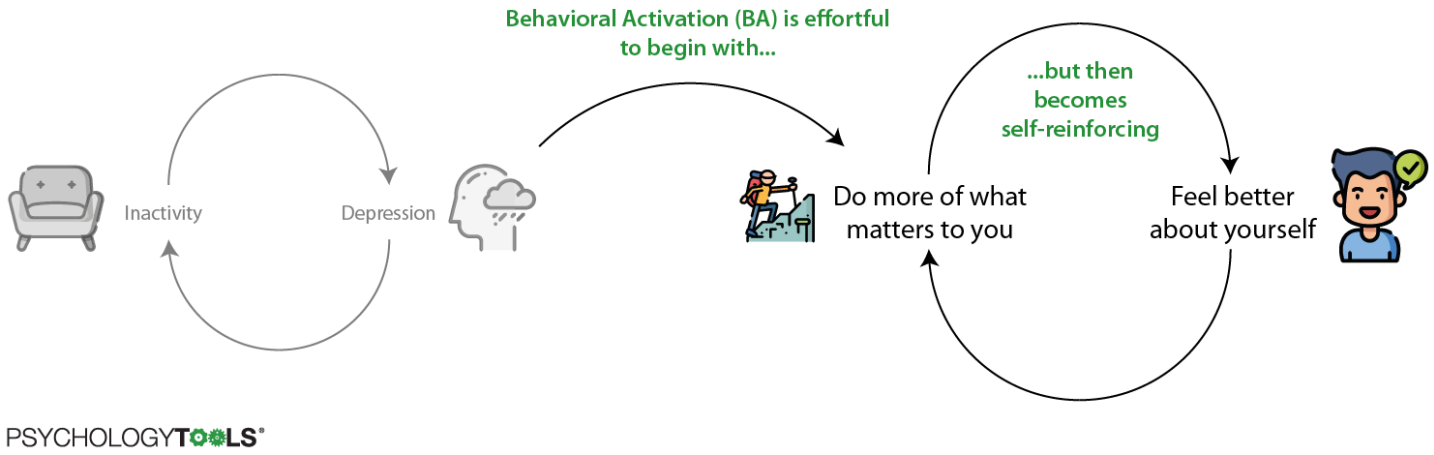


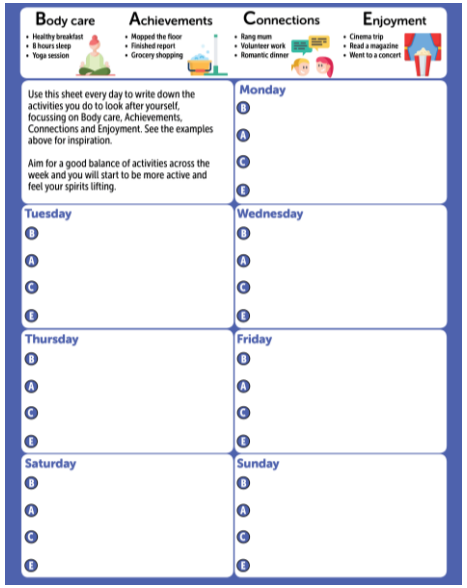




CBT Behavioural activation

- Low mood cycle psychoeducation
- Baseline activity & daily planning alongside OT





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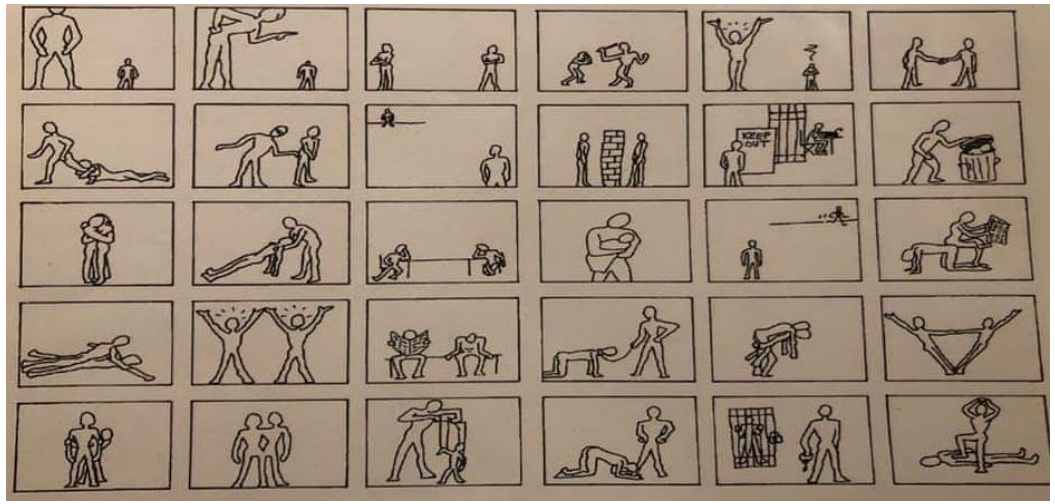
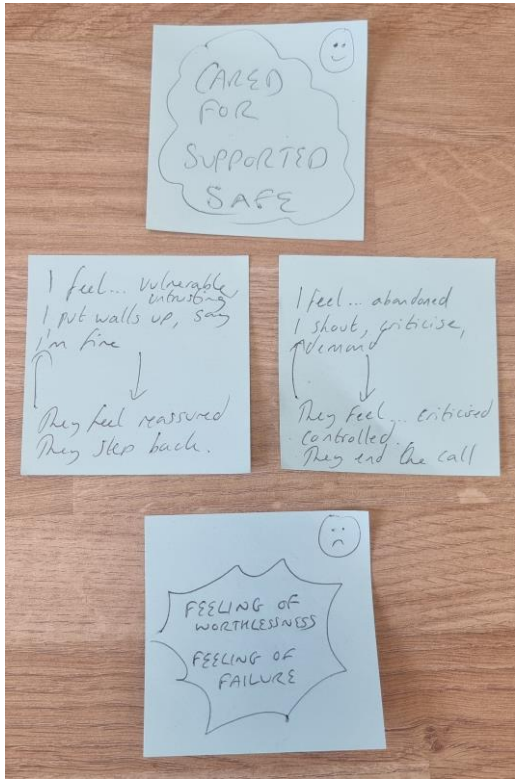
Relational mapping

- I do / feel… they do / feel… (reciprocal roles)
- Naming the dynamics associated with the crisis





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Take away messages

- Multiple ways psychologists can be valuable in crisis settings or situations
- Utilise skills we have in formulation to make sense of risk not just 'assess' it
- Adapt our existing therapeutic techniques (it's not new knowledge, but a different way of using it)
  - Simpler
  - Briefer
  - More dynamic
  - Focused on managing risk and calming crisis
- Embody compassion towards ourselves and open up to support. This is hard stuff to hold alone

"It sort of makes you stop and think, doesn't it."

References / useful resources

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Stay Alive App:

Distract

Calm Harm

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Developing a Reflective Acute/Crisis Team

Dr Isobel Scaife

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8th June 2023

Why do we need to be reflective in the face of crisis and complexity?

- Identifying actions to help learning, development, or improvement of practice
- Developing greater personal insight and self-awareness
- Improve team morale & cohesion
- Increase compassion for service users
- Greater professional & personal effectiveness
- Help manage the complexity and risk, it is intense work!

How can a psychologist facilitate this in practice?

- Fostering psychological safety
- Reflective practice
- Formulation sessions
- Trauma informed care
- Supervision
- Consultation
- Training

Fostering Psychological Safety

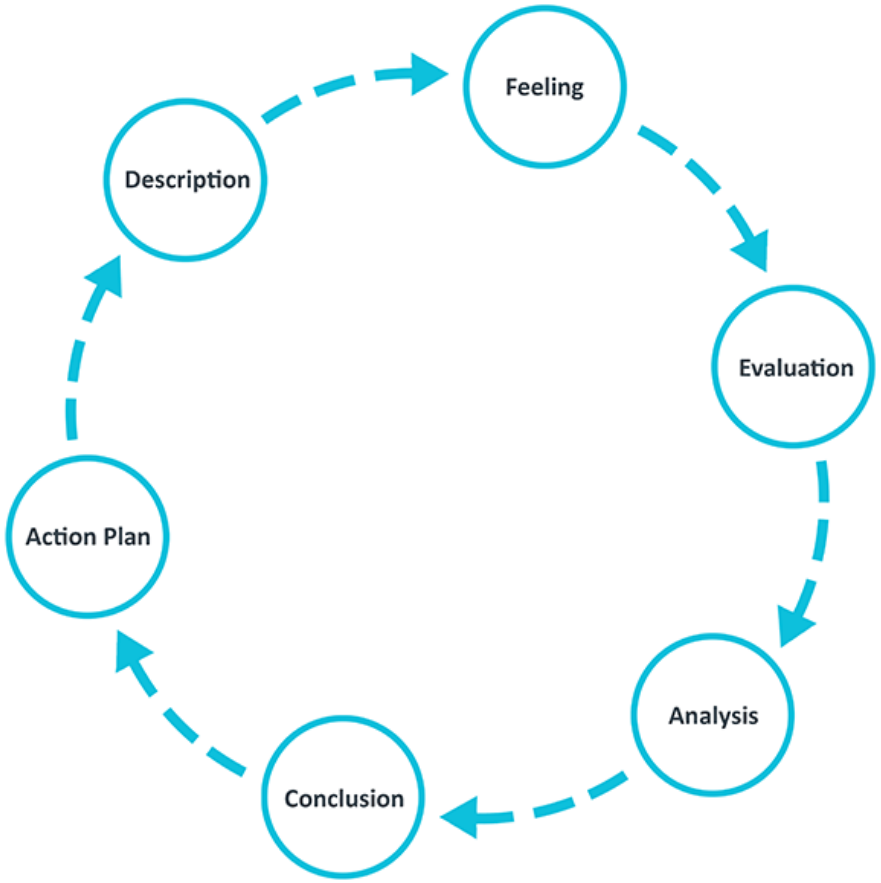
Psychological safety is a multi-dimensional, dynamic phenomenon concerning team members' perception of whether it is safe to take interpersonal risks at work.

Psychological safety is essential in teams to maintain and encourage key outcomes: patient safety, learning, and team performance (O'Donovan et al., 2020).

Ways to foster psychological safety:

- Allocating time
- One-to-one interactions
- Building relationships
- Establishing psychologically safe practice

Reflective practice



- Gibbs' (1988) reflective practice cycle
- Gives structure to learning from experience
- Either a stand-alone experience or a piece of work you do repeatedly (e.g. liaising with other teams)

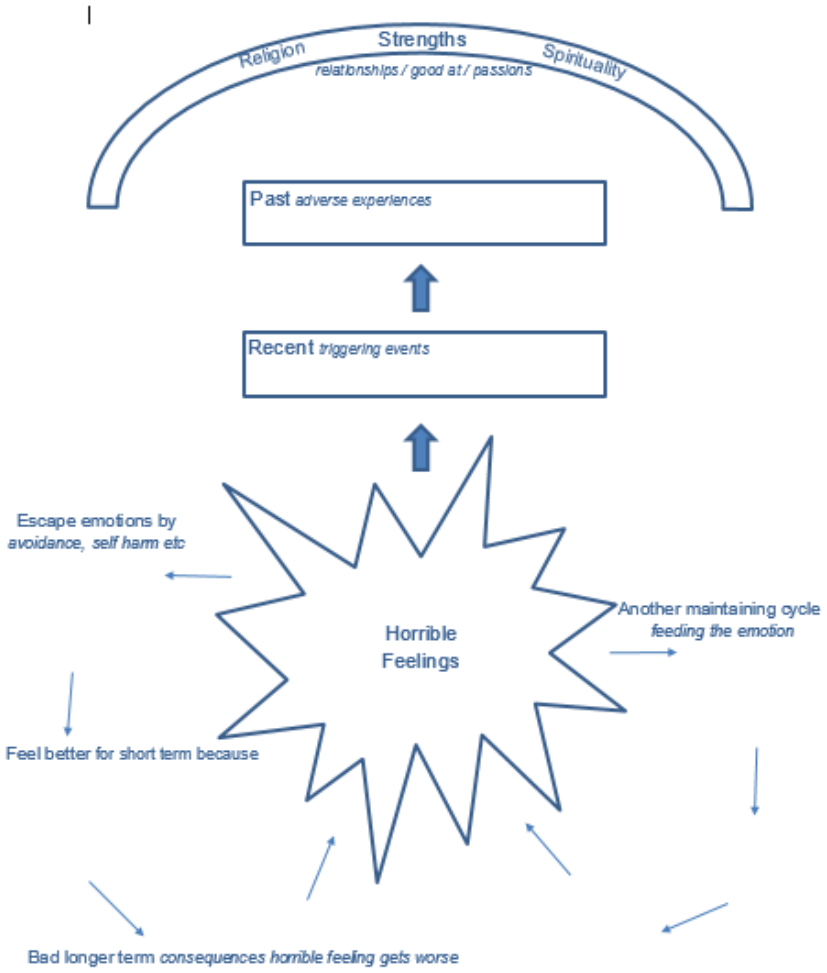
Reflective Practice in Action

- 1 hour per week, protected time
- Contracting
- Structure
- Confidentiality

Reflective vs. Reactive

- Schön's (1991) **Reflection in action/Reflection on action**
- 'In action' = Thinking in the midst of action
- Pros and cons of reactivity
- Centred reflexivity
- Reflective practice = Improved staff satisfaction & team working (Summers, 2006; Wainwright & Bergin, 2010)

Formulation in MDT – CCC Model



- Clarke's (2009) comprehend, connect, cope model
- Using this daily in MDT to formulate new/complex clients
- Embedding in routine practice

Challenges?

- High emotion/burnout
- Translating reflective practice (and practitioners) into changes
- Defensiveness
- Prioritising direct work over indirect work
  - Indirect work is time efficient & valued by MDT (Liberman et al., 2001)
- Embedding change generally is difficult

Going forwards…

- Further research/service evaluation around ‘crisis psychology’
- Develop understanding of how (in acute/crisis teams) we translate reflective practice into action and development of team
- Building networks of psychologists working in crisis/acute – EMAIL US! i.scaife@nhs.net or laura.goody@oxfordhealth.nhs.uk

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ASSOCIATION OF CLINICAL PSYCHOLOGISTS

Implementing a single session Comprehend Cope & Connect (CCC) intervention in crisis and acute mental health services

Dr Christopher Whiteley – CNWL

Bullock J, Whiteley C, Moakes K, Clarke I, Riches S. (2021)

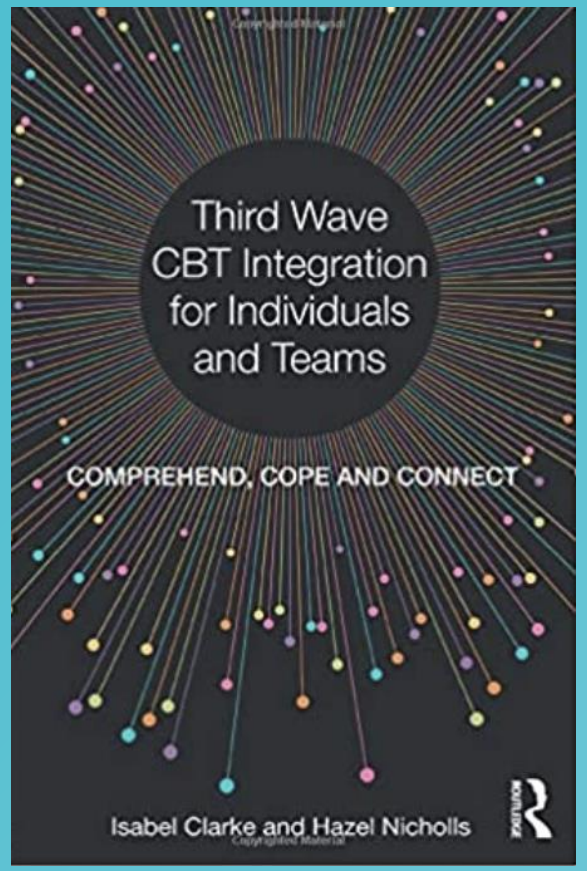
Outline

CCC Intervention – very briefly

Small feasibility & acceptability study

Discussion

Comprehend, Cope and Connect

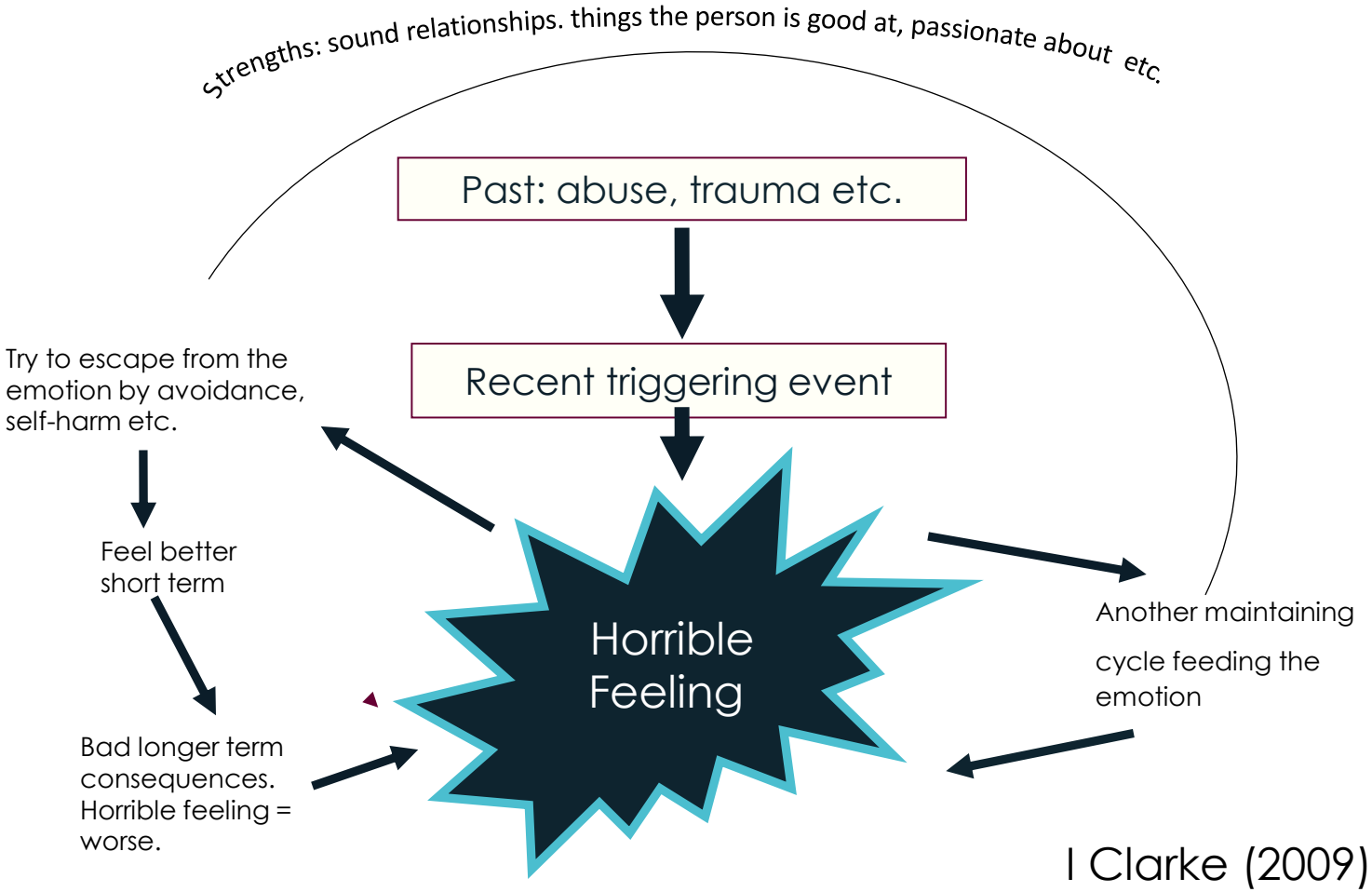


Clarke & Nicholls (2018)

One of the few crisis specific psychological models

Bullock et al (2020)

Comprehend, cope and connect – the formulation



I Clarke (2009)

Intervention components

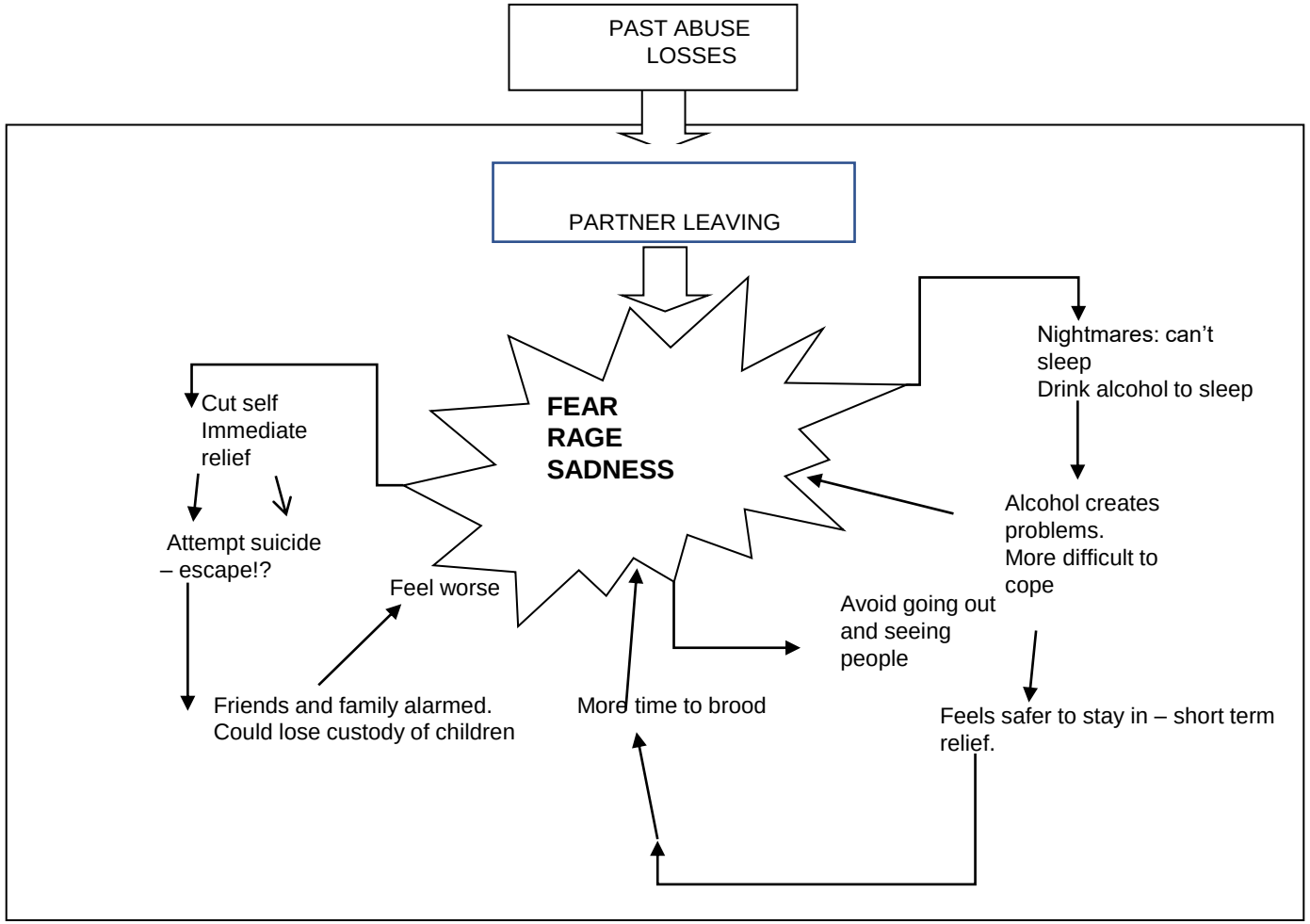
- Horrible feeling (Spikey diagram)
- Triggers
- Vulnerability factors
- Containing factors (strengths bow)
- Maintenance cycles
- Possible cycles breaks
- Specific short-term goals (SMART-ish)
- Specific actions that could support goals

Typical Formulation – ways forward

Don't let the feelings be in control:

- YOU ARE IN CHARGE
- Do things despite the feeling
- Breathing and mindfulness to get back to the present
- Use the energy of the anger positively

Typical Formulation – ways forward



I Clarke (2009)

Small Feasibility & Acceptability Study

Bullock et al (2021)

- Evaluate feasibility & acceptability of a single session crisis specific intervention
- N= 23 service users CRHTT and Acute Adult Inpatient Ward
- c.50% minorized ethnicity
- Aim of CCC: a) Foster a shared understanding b) Relieve crisis 'symptoms'
- Cross diagnostic, emotion focused model - + 12 sessions (Clarke 2009)
- 3rd Wave CBT; DBT, CFT, ACT
- Clinicians all trained by IC

Feasibility & Acceptability

- 22/23 service users took part when offered
- 80% completed in 1 session
- Average session length 65 mins (sd) 15 mins
- 20 completed collaborative formulation
- Pre-post mood rating (0 – 10) median = 7 median increase 5
- Post formulation helpfulness (0 – 10) mean = 7.8 (range 4 – 10)
- Follow up = 14/23. 9 completed at least one agreed action in 7 days post session
- High clinician fidelity (87% of components completed)