CADA
COUNCIL ON ALCOHOLISM & DRUG ABUSE
of Northwest Louisiana

School of Addiction and Behavioral Health

Educational Activity:

Deadly Despair: Getting Perspective on Suicide

INTRO

Suicide. The word conjures up all sorts of emotional responses in everyone, and mental health professionals are no exception. How do you feel when you know someone is contemplating ending their life? Fear? Panic? Maybe even anger at them? Most people know of at least one person who has killed themselves, and no one is immune from the feelings around the possibility of suicide or from the obligation to do everything humanly possible to keep it from happening.

Hello, everyone, and welcome to our podcast! We're coming to you from our studio at the Council on Alcoholism and Drug Abuse of Northwest Louisiana! I'm your host, Kent Dean, CADA's Director of Clinical Development. Today, we're discussing suicide prevention and how the reality of suicide affects us as mental health professionals. You'll be able to earn one contact hour of continuing education by completing the post-test after you listen to the podcast. We'll give you instructions on how to do that at the end of the show.

By far, the most-common cause of suicide is untreated or under-treated depression or other psychiatric disorder. Prevention begins with understanding what a suicidal episode is like, how it is experienced by the patient. To aid in understanding, here's a scenario:

As a demonstration, imagine you've been asked to fully extend your right arm out to your side parallel to the floor. With no additional support and no help from anyone, your task is to hold an extraordinarily expensive and somewhat heavy vase in your right hand for as long as you can without setting it down, resting it on the floor, or dropping it.

Going into this demonstration, basic common sense tells you that there's only a limited amount of time you'll be able to extend your arm and hold up the vase. You know that, at some point, you're going to lose the ability to support the vase in this way. Never forget, the vase is priceless, a one-of-a-kind treasure, so you don't want to let it fall and shatter on the floor. If you drop it, you fail the test. If you set it down, you also fail the test, because the test is one of endurance.

For a few moments, perhaps, you'll find this demonstration only mildly difficult and not very strenuous. More time passes, and you're continuing to stand there supporting the weighty vase. You're quickly finding that the exertion of holding out your arm and supporting the vase is becoming slightly more strenuous. You're noting the first inkling of weakness. For the moment, you're still holding up the vase. Although you were fully rested when you began this demonstration, the strain is becoming more intense as the seconds go by. It's becoming pretty clear to you that your ability to hold this vase up without help will soon be coming to an end.

A time of decision is drawing near for you, and quickly: you're going to have to do something to avoid setting the vase down or dropping it to the floor and letting it shatter. The options are few. The primary need to not let the vase fall is being replaced by another, more-pressing urge: to get relief from the pain and fatigue of exertion that is now spreading up and down your arm. As your arm muscles continue to contract, a buildup of lactic acid causes a burning sensation. This burning feeling is only getting worse; it's beginning to really hurt, and you're getting more fatigued as the seconds pass by. What started out as a minor ache has quickly become an excruciating fire-like sensation, and you're not sure how much longer you can stand it.

Unless help is extended to you by another human being, the outcome is certain. Pain and fatigue will overtake your arm's ability to remain horizontal. You'll ultimately have to let go of the vase one way or the other. You'll fail the test. You're now at the point that you desperately want help, but if you let someone help you, you fail the test.

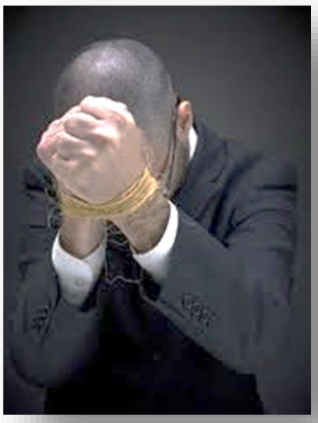
You drop the vase. Pain and fatigue have overtaken you. You held out as long as you could. You just couldn't hold on forever.

You might think this scenario is a metaphor for a suicidal episode. It isn't. This scenario is a metaphor for a normal, healthy human being who's challenged to exhaustion by some major task. Everyone has vases to hold, or, to use the famous metaphor, "crosses to bear." Here's the suicidal metaphor: At just the point that you drop the vase and feel completely exhausted, having given it your all for as long as you

could, you're instructed to pick up the vase and do it all again, with no time to rest. You may be able to summon some degree of resolve and pick up and hold the vase again, but you're not going to be able to do it for very long at all. When you started, you were fully rested, but now, you're taking up the challenge from the position of exhaustion. *Maybe it's time to change the rules of the test and let someone help you hold the vase.* (Just remember, even Christ had help, and someone who's suicidal has very likely already done more than enough "dying for someone else's sins.")

The most basic human urge is to survive. Everything we do, think, and feel guides us to one imperative: survival. Depression and many other situations can sap people of their will to survive. It isn't that they don't care about staying alive; it's that they're so physically, emotionally and spiritually exhausted that they can't care.

One crucial symptom of suicidality is thinking—and even planning—to harm one's self to escape excruciating emotional or physical pain. If it is determined that someone is having thoughts of hurting themselves, they must be seen as soon as possible by a physician so they can be assessed and, if necessary, treated in a protected environment until they are free of the desire to harm themselves. The most-common triggers to suicide are untreated (or undertreated) depression, bipolar disorder and substance-related disorders.



Also receiving more study is *undertreated* depression. **The term, "undertreated depression," or "residual depression," describes a stall in initial, marked improvement after beginning antidepressant therapy.** The depressed person begins a good, responsive recovery but does not attain the full measure of symptom relief and normal functioning that can be possible today.

The American Foundation for Suicide Prevention notes several risk factors of concern for possible suicide attempt, some of which are the following:[1]

Talk

- Being a burden to others
- Feeling trapped
- Having no reason to live
- Killing themselves

Behavior

- Looking for ways to kill themselves, such as searching online

Acting recklessly
Withdrawing from activities
Isolating from family and friends
Sleeping too much or too little
Visiting or calling people to say goodbye
Giving away prized possessions
Aggression

Mood

Depression
Loss of interest
Rage
Irritability
Humiliation
Anxiety

Psychiatric Disorders

Depression (including dysphoria from a serious or chronic health condition)
Bipolar disorder
Schizophrenia
Borderline or antisocial personality disorder
Anxiety disorders
Substance-related disorders

Environmental Factors

Stressful life events which may include a death, divorce, or job loss
Prolonged stress factors which may include harassment, bullying, relationship problems, and unemployment
Access to lethal means including firearms and drugs
Exposure to another person's suicide, or to graphic accounts of suicide

Historical Factors

Previous suicide attempts
Family history of suicide attempts

Any therapy that helps the person with socialization and a sense of belonging has direct neurochemical benefits in the same areas of the brain affected by addiction. Talking therapies have been found useful in helping recovering addicts reorient their self-image and stay abstinent from chemicals. Family networking therapy helps addicts "rejoin the human race" and take their place in their families and other relationships. Peer-support groups can be an important adjunct to treatment in providing a network of encouragement and shared progress.

Cognitive behavioral therapy (CBT) focuses on the development of personal coping strategies to solve current problems and change unhelpful patterns in thinking, behavior, and emotion. It was originally designed to treat depression and is now used for a number of mental health conditions, including addiction. **CBT is based on the belief that symptoms and associated distress can be reduced by teaching new information-processing skills and coping mechanisms.**

Dialectical behavior therapy focuses on building a meaningful life rather than merely remaining abstinent. It has been found helpful both for people who are suicidal and for those with addictive disorders. **The goal is to balance the patients' desire to avoid pain while at the same time helping them to learn how to tolerate the normal pain that goes with living "life on life's terms."** The addiction counselor helps patients bring about change as they discover new meanings from examining differing perspectives around a subject.

Interpersonal therapy (IP) incorporates several other theories: object relation, attachment and family systems: **Three assumptions central to IP are:**

1) Human beings are relational creatures, so many problems are interpersonal in nature;

2) Family experience is the central source of learning about ourselves and others;

3) The therapist-patient relationship can help solve problems.[2]

Contingency management helps addicts by providing positive consequences when they meet treatment goals and negative consequences when they don't. An example of a positive consequence for abstinence could be progressing in a phased treatment program or receiving vouchers (not cash!) exchangeable for retail goods. A negative consequence could be a negative report to a parole officer or withholding vouchers. Therapists can create written behavioral contracts that detail the desired behavior change and other treatment details.

While they don't cure it, there are medications, such as acamprosate, naltrexone, and some antidepressants, such as bupropion, that can stabilize the ongoing operating balance among the brain structures affected by addiction (specifically the ventral tegmental area, nucleus accumbens and frontal cortex). These medicines help do for the brain what it can't do for itself; in that sense, they're assistive technology for the brain. In moderating depressive symptoms, antidepressants also help the reward centers rebalance and stabilize as well. **Additionally, use of repetitive transcranial magnetic stimulation (rTMS) and other stimulatory devices (all of which are FDA-cleared) have been helpful to some patients in ameliorating intractable depressive episodes; however, the *long-term* efficacy of neurostimulatory interventions is under study.[3]**

OUTRO

That's our podcast for today. If you'd like one hour of CE credit for just $5.00, you can go to the School's website, cadaschool.com, click on "online courses," and just follow the instructions. Once you pass the post-test, which includes evaluation questions, you'll be able to download and print your certificate of completion. Be sure and stay in touch on Facebook! See you next time!

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[1] American Foundation for Suicide Prevention, https://afsp.org/

[2] Teyber E: Interpersonal Process in Psychotherapy. Pacific Grove: Brooks/Cole, 1997.

[3] Baeken C: Accelerated rTMS: a potential treatment to alleviate refractory depression. Bethesda, MD.NLM, 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6220029/