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Commentary on Empirically-Based Outpatient Treatment for a Patient at Risk for Suicide: The Case of "John"

Integrating Treatments for Suicidal Patients into an Effective Package

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ABSTRACT

Craig Bryan (2007) skillfully describes how he was able to successfully weave together several new developments in the treatment of suicidal behavior and deliver a coherent, effective treatment for "John," a military medical professional who experienced serious suicidal ideation and mixed bouts of anxiety and depression following a return from deployment in Iraq. I offer some comments about what I see as the particularly strong aspects of the intervention, and then I proceed to introduce some concepts that might have been used to facilitate greater socio-emotional awareness and a more adaptive social repertoire for the client.

Key words: suicidal behavior; treatment; integrative psychotherapy; Justification Hypothesis; Influence Matrix

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INTRODUCTION

Treating individuals who present with serious suicidal ideation is one of the most stressful aspects of being a mental health clinician. Anxiety is enhanced because, historically, there have been few empirically supported frames to guide the treatment decision-making process. However, in the past decade several important lines of research have emerged that suggest psychosocial interventions can be effective in reducing the occurrence of suicidal behavior in high risk individuals. In his rich and textured analysis, Bryan (this issue) skillfully describes how he was able to successfully weave together several of these developments and deliver an effective treatment for "John," a military medical professional who experienced serious suicidal ideation and mixed bouts of anxiety and depression following a return from deployment in Iraq. Specific presenting concerns included exposure to the trauma of war and difficulties adjusting to several major life changes.

As the former project director of a randomized controlled psychotherapy trial for suicide attempters (see Brown, Ten Have, Henriques, Xie., Hollander, & Beck, 2005), I can attest to the

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fact that cases involving serious suicidal ideation are normally extremely complicated and finding effective pathways for intervention is not easy. In my opinion, there are many things that Bryan does extremely well, and I will first report on what I see as the strengths in his treatment approach for John's suicidal behavior. I will then offer some thoughts regarding the latter half of the treatment, specifically on what Bryan labels "personality refinement." At the outset, let me say that it appears Bryan does a fine job during this period, and I will offer my perspective as simply an alternative way of conceptualizing his treatment. My perspective is integrative and informed by a new unified approach to psychological science (e.g., Henriques, 2003). I think that often the focus on coping skills and symptom reduction afforded by cognitive and behavioral approaches can be effectively complemented by approaches that offer a more detailed lens through which to examine social and emotional processes. The Justification Hypothesis and Influence Matrix (Henriques 2004, 2005) are two concepts that I find useful in understanding these processes, and I will offer some reflections on how these ideas might have informed my conceptualization of and intervention with John. But before offering those notions, let me describe what I see as the major strengths in this clinical case presentation.

STRENGTHS IN BRYAN'S APPROACH

I appreciated Bryan's up-to-date conceptual frame. Rudd's (2006) Fluid Vulnerability Theory (FVT) is an extremely useful model for understanding the dynamics and complexities of suicidal behavior. FVT is built on Beck's theory of modes (1996), which I believe substantively expands the original cognitive therapy model and offers a more compelling theoretical framework for how different parts of the overall psychological system interact in feedback loops. Mode theory also crucially allows for viewing behavior as functionally organized around goals, something that I believed was underdeveloped in earlier cognitive therapy formulations. Bryan skillfully uses FVT to identify the affective, physiological, motivational, cognitive and behavioral components of John's suicidal mode. Related to Bryan's theoretical frame, I was also impressed that the focus of his treatment was first and foremost on the suicidal behavior, as opposed to a disorder that was presumably causing the suicidal behavior. This is a subtle but I believe crucial shift that has taken place in treatment approaches in the last decade (Berk, Henriques, Warman, Brown, & Beck, 2004).

When dealing with suicidal patients, assessment and treatment must be intertwined. The reason for this is because it is crucial that the therapist assess the level of risk immediately in order to determine what action is necessary to ensure the safety of the patient. And yet, as was the case with John, many patients are quite resistant to disclose information about their suicidal thoughts and behaviors for at least two reasons. First, suicidal thoughts and actions are often the source of much shame and many patients are embarrassed that their lives have reached such a desperate point. It is often the case that they either have never discussed these thoughts and feelings with anyone, or have had bad experiences trying to talk about them. The second reason patients are often hesitant is because they fear forced hospitalization or other consequences that might follow from such disclosures. All this sets the stage for a power struggle. The clinician feels intense pressure to get as much information as possible to assess risk, whereas the patient fears the outcome of such disclosures. I have supervised several crisis situations where a gridlock

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emerged between patient and clinician because of these very issues. Bryan skillfully navigated the potential gridlock by sensing John's hesitancy to disclose and walking him through a hypothetical situation that gave John a more accurate sense of the consequences of disclosing his experiences.

The general point here is that the clinician needs to effectively develop the therapeutic alliance in conjunction with assessing levels of risk. And this is why Jobes' (2006) Collaborative Assessment and Management of Suicidality (CAMS) is such a helpful frame for guiding the clinician in their assessment of risk while simultaneously emphasizing the importance of maintaining a collaborative therapeutic frame. I particularly like the overt behavior of sitting next to the client. Although there have been some exceptions, my experience has been that patients feel very alone and isolated in regards to their suicidal thoughts. Thus the "moving towards" frame provided by Jobes' CAMS is generally deeply appreciated at an emotional level by many patients. Another positive aspect of the CAMS approach that Bryan successfully implemented is the continued use of quantitative assessments of suicidal thoughts and feelings until it was clear they are below a pre-specified cutoff. The additional use of the OQ-45 throughout the treatment allowed for the effective tracking of important symptoms.

The early development of a crisis plan for suicidal individuals is a must, and Bryan appropriately constructed such a plan in the intake, recognizing that immediate action needed to be taken. The crisis plan effectively listed graded behavioral steps with clear actions to be taken. Bryan's early involvement of a significant other in the treatment and the removal of access to lethal means was another strength. The payoff of involving John's wife was particularly clear later on as she was able to serve as a valuable informant regarding his worsening symptoms and proved to be an important therapeutic ally as Bryan renegotiated his treatment with John.

In the suicide attempter project I directed, we experienced a number of problems initially running our treatment protocol and ended up having to essentially start from scratch after the first year of work. Indeed, our unit labeled the data collection of that first year "Study 1," which was separated from the successfully run "Study 2." One of the biggest problems that we experienced in Study 1 was drop-outs and problems with treatment compliance. One of the ways in which we addressed this problem in Study 2 was to have the therapist take more responsibility for and a more active role in getting patients to the next therapy session. This meant contacts with significant others, phone calls to the patients between sessions, active searching for patients once contact was diminished, and a respectful but nonetheless reasonably insistent stance on the need for the patient to continue and comply with treatment. I was impressed that Bryan adopted a very similar frame and, much in accordance with the general pattern of results we found, was successful in re-establishing momentum in the therapy. The collaborative development of a treatment contract seemed to be particularly effective in specifying expectations and creating hope.

Bryan also incorporated many useful elements of Marsha Linehan's Dialectical Behavioral Therapy. Specifically, the reasons for living exercise and mindfulness training were two interventions that John clearly seemed to benefit from. One intervention that Bryan did not

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report using that I thought might have been effective is the development of coping cards (see Berk, et al., 2004 for examples). Coping cards are small, laminated cards that fit into a patient's wallet or back pocket and thus can be carried anywhere. On one side is a suicidal automatic thought that the patient has reported to frequently become salient during the activation of a suicidal mode. Through Socratic questioning and other cognitive therapy techniques the clinician works with the patient to develop more adaptive cognitive responses. For example, one possible automatic thought that John might have had was: "I can't cope with all this stress -- I need to escape and death is the only way." This could be put on the card and on the back might be three or four adaptive responses such as: "Yes, I feel stressed right now, but I don't always feel this way," or "There are other ways of solving my problems besides killing myself," or "I am working on new coping skills and am getting better. If I keep at it, I will be able to learn how to deal with the stress in my life." Our experience in working with suicide attempters was that the capacity to initiate adaptive thinking was significantly reduced when an individual was in a suicidal mode. As such, it was helpful to have the more adaptive responses accessible and written out in advance, so instead of having to engage in free recall, the patient could simply take out the card and read it. It was my clinical impression that this was one of the more effective interventions we developed.

John's treatment progressed in a strong manner after the lapse that occurred between sessions seven and eight. Additional skills were added and the focus appropriately shifted from more immediate symptom management to enhancing John's cognitive flexibility and thinking more about the long term direction of his life. While this certainly appeared to be both a useful and effective period in the treatment, I will offer some additional thoughts of how I would have likely tried to work with John in an attempt to foster in him greater insight and a stronger sense of self. In order to do that, I need to introduce two new theoretical ideas called the Justification Hypothesis (Henriques, 2003) and the Influence Matrix (Henriques, 2005).

TWO NEW CONCEPTS: THE JUSTIFICATION HYPOTHESIS AND THE INFLUENCE MATRIX

The Justification Hypothesis (JH) is a new theory of the human self-consciousness system and the evolution of human culture. The central idea that organizes the JH is the notion that humans have an elaborate self-consciousness system because the evolution of language created the problem of justification. It is commonly claimed that once the capacity for symbolic language emerged, it afforded many obvious advantages in terms of communicating information cheaply and effectively and coordinating the behaviors of large groups (e.g., Pinker, 1994). The JH agrees with these assertions but adds a very important point. Specifically, with the advent of language our hominid ancestors encountered a new but crucially important adaptive problem. For the first time, others had direct access to one's thought processes, and this resulted in humans becoming the first animal that had to explain why it did what it did. If one's interests always matched others, this would not be a problem. But, of course, interests frequently diverge. Consider, for example, if a male was interested forging a relationship with a particular female but she was pair-bonded with another male. If he starts spending time with her, but is then

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confronted by the other male with a question such as: "Why are you spending so much time around her?" the last thing he wants to do is simply translate his thought processes as follows: "I am hoping to separate the two of you and take her as my mate." Instead, he needs to justify his actions in a manner that affords social influence in accordance with his interests. So he might simply reply, "I enjoy hanging out with both of you."

This analysis suggests self-conscious linguistic thoughts are not just analytic descriptions of the world, but instead represent justifications that are designed to take into account the social context and function to legitimize actions in accordance with social influence. Indeed, when one looks for them, justifications are ubiquitous. Arguments, debates, moral dictates, rationalizations, and excuses all involve the process of explaining why one's claims, thoughts or actions are warranted. These phenomena are both uniquely human and ubiquitous in human affairs. In virtually every form of social exchange, from warfare to politics to family struggles to science, humans are constantly justifying their behavioral investments to themselves and others.

Through the lens of the JH, cognitive therapy can be seen as the detailed analysis of the individual's justification system (see Haaga, 2004). I believe the JH provides a method to deepen cognitive analysis because it provides an explicit framework to think about the function particular automatic thoughts serve. Specifically, clinicians who think in terms of justifications learn to ask: "What course of action does this belief legitimize in the current social context?" and "Developmentally, what did such beliefs legitimize in the past?" For example, instead of just hearing the belief "I am a loser" as a simple description of self, someone informed by the JH wonders what courses of action being "a loser" legitimizes now or did so in the past, which might be things such as: a) acknowledging defeat; b) discontinuing a task that has the risk of failure; c) disengaging competition with a more powerful other, or d) perhaps to display a need or elicit pity. Glossing over some details, the JH ultimately gives rise to the question of what is the nature of the social motives that play a role in the reason-giving behaviors in which people engage. And this question leads directly to the Influence Matrix.

The Influence Matrix (IM; Figure 1) is an integrated model of social motivation and affect that merges insights from evolutionary theory, psychodynamic theory, dynamical systems theory, cognitive science, behaviorism, and social psychology as well as research on trait theory and the connection between goals and emotions. The basics of the model will be reviewed here. It will then be combined with the JH to offer some ideas how John's character structure could be conceptualized and the types of interventions that might then follow.

The first basic assumption of the IM is that social influence is a resource all humans are motivated to acquire. That is, like nutritious food, social influence reflects a basic, primary need and desire. A somewhat simplistic but nonetheless useful way of thinking about amount of social influence a person has would be to conceptualize it as the joint product of their social role status (one's position in a group) and their reputation. High social status and an excellent social reputation is a position of high social influence, whereas the converse is a position of low social influence. The second basic assumption, depicted by the diagram, is that there are three conceptually distinct dimensions underlying the acquisition or loss of social influence.

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Specifically, they are: 1) power (competitive influence); 2) love (cooperative influence); and 3) freedom (freedom from influence). Power is marked by the poles of dominance and submission, and the second dimension, love, is marked by the poles of affiliation and hostility. Whereas power is characterized by attempting to take control of resources, love is characterized by altruism and sharing. Although the term "love" is often used to refer to the strongest affiliative bonds, usually among family and romantic partners, the term here refers to the general sense of identifying with and empathizing with others' interests in a manner that promotes cooperation and altruistic behavior. The third dimension on the IM is called "freedom" and is represented by the poles of autonomy and dependency. Unlike the other two dimensions, which involve directly influencing others, the goal here is to avoid being influenced by others. This counterbalancing drive is needed because all social exchange processes inevitably involve the process of negotiation, which takes time and energy that could be spent doing other things. This cost occurs in the best of cases. In the worst cases, social exchanges can result in individuals either being dominated and controlled or sacrificing without receiving any beneficial return. To avoid this result, individuals are motivated toward self-reliance and the avoidance of excessive dependency on others. In short, according to the Influence Matrix, humans are naturally inclined toward maximizing their social influence through achieving power, love, and freedom.

The IM further asserts that the three dimensions are dynamically interrelated. That is, changes in one dimension often, if not always, lead to changes in another. Consider, for example, how increases in exerting power over an individual may decrease affiliative feelings in that individual. Indeed, the old political adage, "It is better to be feared than loved," reflects an appreciation for this dynamic. Likewise, adopting a loving attitude towards others complicates the task of dominating and controlling others. Furthermore, increasing either power or love inevitably increases the rate of social exchange, which inescapably impacts on the amount of autonomy one can have.

The outer ring on the IM represents the notion that a person's emotions provide feedback as they either succeed or fail in relationship to achieving the goals and orient the individual toward corrective action. Thus, acquiring social influence in general is associated with positive emotions, and losing it is associated with negative affect. Furthermore, different emotions are designed to address different problems of social influence. For example, guilt orients one to the needs and feelings of others, whereas anger serves to protect one's own interests.

One final point to be made here is that the combination of the JH and IM result in a frame that is consistent with a two-domain model of the human mind. Specifically, human mental architecture can readily be understood as consisting of two broad domains: (1) a nonverbal, perceptual-motivational-affective, parallel information-processing, behavioral guidance system (the IM represents a part of this system); and (2) a verbal, logical-analytic, sequential information processing, justification system. Importantly, this two-domain system of human mental processes is consistent with work in consciousness (e.g., Ornstein, 1972), psychodynamic theory (e.g., Epstein, 1994), neuropsychology (e.g., Kolb & Wishaw, 1990), and cognitive psychology (e.g., Kaufman, 1990).

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The IM posits that all social exchanges are calculated on "self-other" ratios, and one of the first questions that emerges when analyzing someone through the lens of the IM is: "How does he navigate self-other tensions?" Power and autonomy motivations along with the emotions of anger and pride function to compute one's own self-interests. Affiliative motives along with the emotions of guilt and love orient an individual toward others' interests. Although the IM posits that the potential for both components are part of the basic human mental architecture, developmental processes often channel individuals to emphasize one side or the other of the self-other quadrants. For example, children with behavioral problems who exhibit more anger and hostility are conceptualized as having externalizing problems, whereas those who exhibit more guilt and shame are seen as internalizers. In the language of the IM, those who tend to be self-centered are labeled "upper left," whereas those who are other-oriented are labeled "lower right." It is useful to note that Beck offered a very similar formulation with his concepts of sociotropy and autonomy, with the former representing an other orientation and the latter representing a self orientation. In fact, the IM was used to demonstrate previously unseen linkages between sociotropy and autonomy, Leary's Interpersonal Circumplex and diagnosable personality disorders (Henriques & Beck, 2003).

APPLYING THE INFLUENCE MATRIX AND JUSTIFICATION HYPOTHESIS TO JOHN

With this brief conceptual background on the JH and IM, we can now turn to examine John's behaviors and hypothesize about his character structure with these lenses. I want to reiterate that I fully support the manner in the way Bryan treated John. I am just taking this opportunity to introduce an additional lens that may have been useful in deepening John's understanding of himself and his underlying social motivational tendencies, and in helping move him toward a more balanced, adaptive socio-emotional repertoire.

By analyzing Bryan's report of John's feelings, justifications, and behaviors, it seemed fairly clear that John had a strong "other orientation" and thus would be considered as tending to operate from the lower right quadrant on the IM. Or to use Beck's terminology, he was considerably more sociotropic than autonomous. A number of pieces suggested this. First, on several occasions John expressed concern about how others would view him and wanted very much to please and impress others. Second, it sounded like he had a reasonably strong and secure family background, which frequently produces individuals with strong affiliative tendencies. The fact that his wife was supportive of him suggested he was able to meet many of her needs and at least have a history of showing her satisfactory levels of love and attention. Third, John was described as being well liked by others, which enhances the notion that he had strong affiliative tendencies and often put others' needs before his own. Fourth, John had a strong streak of self-criticism that could be shame-inducing. Such shame-inducing criticisms reduce capacities for feeling pride and often function to justify submission and deference to others. Fifth, John expressed strong feelings of obligation toward his co-workers and comrades in the military and felt guilt at any thought that he might let them down. Indeed, much of the latter sessions can be interpreted as Bryan helping John realize that his autonomy motives warranted consideration and

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elaboration, and that such motives had likely been maladaptively suppressed due to his default affiliative tendencies (i.e., his strong obligatory feelings to the military). Sixth, although it was difficult to decipher based on the written description, both anger and pride seemed under-developed for John. Similarly, it did not appear as though John was comfortable or able to express hostility or criticism toward anyone other than himself. Finally, his career choice of a medical professional is obviously congruent with someone who has strong affiliative, self-sacrificing tendencies.

Given this conceptual frame, my therapy goal with John likely would have been to increase his meta-cognitive awareness of his other-oriented tendencies. For example, I might have pointed out to him that the ease with which he criticizes himself exists in stark contrast to the hesitancy with which he judges others (to the extent this is a valid inference). I would explore his role in his family, hunting to see if he had adopted (or been placed in) a strong care-giving role developmentally. Depending on our relationship and the course of therapy, I could imagine being fairly direct with him in terms of his power, love and freedom needs, and explicitly stating that his affiliative needs, while afforded him much, appeared to have also sometimes been followed to the exclusion of his needs for power and freedom. I would also explore in depth the manner in which he deals with anger toward others. Often, "lower right" individuals experience enormous anxiety when they begin to feel angry. The reason is that the anger, which orients them toward what they are entitled to, simultaneously threatens their affiliative motives. And because such individuals have had their best success achieving social influence via altruism and self-sacrifice, angry impulses that might cause a loss in affiliative connections are quickly inhibited. The angry feelings do not, however, disappear and often either emerge in indirect ways or continue to drain attentional resources as the affiliative individual needs to maintain focus on the reasons why the anger is unjustifiable or problematic.

In applying these concepts to the current therapy, one can use the IM and JH to wonder if possibly John subconsciously felt some anger at Bryan during the midpoint lull in therapy. John was reluctant to take anti-depressant meds and had a bad reaction. Then, shortly afterwards, Bryan took a vacation. It is important to note that two no-shows and a missed session followed this sequence, and John became very evasive about the difficulties he was having. Although clearly speculative, it seems plausible that at a subconscious level John felt controlled into taking the anti-depressants which failed and for which he had to suffer with the side effects. Then a part of him perhaps felt abandoned by his therapist who was heading out on vacation. Of course, if we were to ask John how he felt at that time, it is almost certainly the case that he would deny any such feelings. After all, he knows consciously that to be angry at Bryan for going on vacation is "unjustifiable" and anyone who felt that way would not be a good or fair patient. Indeed, one could easily imagine John having the following private conversation: "I can't believe Dr. Bryan left just now when I needed him the most…Wait a minute, I know it was planned long ago and has nothing to do with me. Besides what does that feeling say about me? Am I such a loser that I need him to cancel his vacation because I can't wait a week?" Notice how these private justifications can be tracked in terms of initial entitlement impulses which are deemed unjustifiable and result in criticism that suppresses the original selfish thought. One can further imagine how such an internal dialogue would ultimately result in John: a) withdrawing from

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therapy because he has unjustifiable feelings that create inner turmoil but can't be processed; b) experiencing a worsening of symptoms because as he psychically withdraws from therapy his hope for improvement drops; and c) minimizing his symptoms to Bryan. Of course, this is just speculation and likely an oversimplification. It is offered as an example of how the Influence Matrix and JH can be used to generate hypotheses about complex behavior patterns. Ultimately, my goals for John's latter part of his treatment would be to increase his conscious awareness of his self-sacrificing, affiliative tendencies. I would also want to connect those tendencies with the ease with which he criticizes himself and get him to understand the functional history of his self-criticizing tendencies and why such tendencies may be currently maladaptive. I would also explore the probable conflicts he experiences dealing with angry feelings. While I would certainly want to emphasize the adaptive nature of his affiliative motives in general, I would also want him to recognize that if he sacrifices his needs for power and autonomy too much, he will continue to experience distress. I would also want him to develop more meta-cognitive reflection on how his underlying motivations and feelings influence his justifications, which in turn feed back on his feelings and actions.

I believe strongly that the focus on John's socio-emotional patterns, subconscious feelings, and private justifications could be readily integrated with the frame that Bryan has laid out. The fact that one can seamlessly extend an integrative cognitive behavioral approach to focus on more traditionally psychodynamic concerns speaks volumes about the possibilities to one day in the future move from a "horse race" mentality around different therapeutic approaches to one where we are able to see how the various perspectives can be integrated into a coherent whole.

CONCLUSION

Bryan offers a rich and compelling treatment narrative for a medical professional dealing with suicidal ideation and clinically significant levels of anxiety and depression related to traumatic battlefield experiences and difficulties adjusting to a number of significant life changes. He integrated a number of different emerging lines of cognitive and behavioral theories and interventions into a coherent treatment that resulted in substantial symptom reduction, authentic reflection and probably wise alterations in John's life course. I then offered some thoughts about how Bryan's already integrative frame could have been expanded to potentially offer a more nuanced approach to John's social and emotional functioning. In so doing, I attempted to demonstrate the positive possibilities associated with finding a more unified approach to psychotherapy.

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Figure 1. The Influence Matrix