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# Recovery to Practice HIGHLIGHTS

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## Part 1. Toward a More Trauma- and Recovery-Informed Practice of Lethality Assessment and Suicide Prevention

by Jim Probert, Ph.D.

## A More Trauma- and Recovery-Informed Practice of Lethality Assessment and Suicide Prevention

It is not possible to estimate suicide danger, or respond to it appropriately, without understanding the depth of terror, rage, hopelessness, and powerlessness—and the potential for escalation of suicide danger—that can be evoked within many distressed individuals by the threat of involuntary hospitalization and all that can go with it. Yet instead of being heard with empathy—and with an awareness of the potential for either trauma reenactment or trauma renegotiation—the resistance of suicidal individuals to hospitalization, if it is voiced at all, may be dismissed as merely an indication of a symptomatic lack of insight into the necessity of medical stabilization for their disorders. A crisis point—at once a moment of danger that may lead to (re-) traumatization and increased suicide lethality and a moment of opportunity for healing and decrease of long-term suicide lethality—may be passed by without even a realization.

As a whole, healthcare professionals might both reduce unnecessary suffering and save more lives if we were to communicate clearly to our clients, their loved ones, and the general public our genuine intention to follow a guideline of the National Coalition of Mental Health Recovery (2011):

The use of involuntary interventions, which should never be considered treatment, is indicative of a failure to effectively engage the individual(s) involved. Involuntary interventions should only be used as a last resort, when all other approaches have been exhausted.

This is consistent with SAMHSA's National Center for Trauma-Informed Care (2013), which has identified a "consensus in the field that most consumers of mental health services are trauma survivors." The NCTIC has outlined what health care organizations might do to address this concern: When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and

potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid retraumatization.

## **Suicide Prevention and the Lived Experience of Mental Health Recovery—in Light of Current Research and Practice**

Increasingly—since 2006, when I discovered Dan Fisher and the international C/S/X movement—one of the most powerful ways I have had to talk about these issues is to include discussion of my own recovery from experiences diagnosed in the early 1980s as severe mental illness. Then, I was diagnosed with bipolar disorder. Yet my recovery involved not only coming to terms with the tremendous force of my emotions. It also involved coming to terms with those extreme experiences that, by themselves, would have met criteria for diagnosis of a psychotic disorder.

### **My Own Experience of Hospitalization and Suicidality**

I never thought about suicide at all until after my two hospitalizations, when I finally accepted what I was told to be true—that I had a severe and incurable mental illness. Then I stood alone many times in my parents' kitchen with a knife in my hand, wanting intensely to be dead and searching for the strength to kill myself. In my case, the psychiatric medication I was taking did hold off my more extreme states—in which I heard commanding voices, became Superman and Jesus, experienced a terrifying demon seizing control of my face and mind, and had many other experiences a good southern Presbyterian choir boy and National Merit Scholar was not generally expected to have. The medications held off those experiences but did not alleviate the misery of severe depression, anxiety, panic, and so much inner torment that remained. And I understood, then, after the hospitalizations, that my continuing misery was caused by an incurable chemical imbalance in my brain—which was not corrected by medication

and over which I had no possible influence.

I know, now, that Bessel van der Kolk and Alexander McFarlane (1996) have called the study of trauma the "soul of psychiatry." They explain that our modern understanding of posttraumatic stress disorder reintroduces the idea that what psychiatry once called "neurotic" symptoms are not actually caused by "some mysterious, well-nigh inexplicable, genetically based irrationality" but rather emerge from "people's inability to come to terms with real experiences that have overwhelmed their capacity to cope."

I also know that John Read and his colleagues (2005) have reported evidence from large-scale general population studies that symptoms of psychosis are just as strongly related to childhood abuse and neglect as the symptoms of other mental health difficulties. Read and colleagues recommend offering psychotherapy for trauma resolution to everyone who is psychotic, with or without known trauma, adding: "For some, simply making a connection between their life history and their previously incomprehensible symptoms may have a significant therapeutic effect."

During my hospitalizations, no one even appeared to consider the potential impact of life experiences and childhood trauma. If no one in the hospital had time to talk to me for long enough to begin learning about my life, no one even suggested my previous life experiences might have anything to do with my extreme distress. No one addressed the teasing, repeated assaults, and death threats that I suffered at the hands of childhood schoolmates or the sexual abuse by a mentor. No one addressed the traumatic impact of being overwhelmed as I was by my own inner states. No one addressed the traumatic impact of the hospitalization itself—of being handcuffed, put in isolation and restraint, and medicated with Haldol so I could barely walk and until my legs began to move uncontrollably, of being told what I must do to be released from the locked ward, and of becoming a mental patient, as we are conventionally treated in our world.

Certainly, no one suggested then that trauma recovery or grief work or mental health recovery might be vitally important as part of a concerted effort to enter the chaos of my inner world and heal my whole life.

The psychiatrist Richard Mollica is director of the Harvard Medical School Refugee Trauma Program. He has said (in Mollica et al., 2011), "I can't understand as a... psychiatrist how in an inpatient unit you can understand the diagnosis of the patient without understanding the impact of the traumatic life experience." But what may be even more important is Mollica's idea of the "self-healing response." Mollica's work with torture survivors has led him to see that the source of recovery from trauma is to be found within traumatized individuals themselves. Mollica sees the work of clinicians being to follow this source of healing, and to see the client as the "teacher."

And that is one of the traumatic experiences of many individuals who go through a psychiatric hospitalization—even when their distress is seen as less severe. There is something about involuntary hospitalization that can often transform individuals in a more profound manner than choosing to seek outpatient medical resources to address psychological distress. Our "inner" experiences may be even more deeply transformed from having something to do with our lives and our choices for making sense of them—to being about a medical diagnosis somehow understood to come out of our brains and over which we have no say and no power and absolutely no ability to heal. The general public and our significant others are also educated—through trauma—to see so many aspects of our lives as expressing a brain disorder over which they also have no direct influence or capacity for empathic healing.

This may be one of the reasons why Open Dialog is so effective. The Open Dialog approach (e.g., Seikkula et al., 2006; Mackler, 2011; Fisher, 2012a; Whitaker, 2010) is the mainstream mental health response to psychological crisis in Finnish Western Lapland—where it has been used with severe

depression as well as with any psychoses, regardless of diagnosis (e.g., Seikkula et al., 2006; Seikkula, 2011). The Open Dialog approach itself incorporates a type of hospital diversion program. The first choice of immediate response to crisis is to hold daily meetings in the homes of distressed individuals, with their support networks; the first choice of response to escalated danger is to leave a professional there in the home, overnight (Mackler, 2011). Still, the published results of Open Dialog are the source of its growing fame. Five-year recovery rates from first-break psychosis (and specifically nonaffective psychosis) are over 80 percent—with fewer than 30 percent ever taking neuroleptic medications and fewer than 20 percent still taking them at the end of the study (Seikkula et al., 2006).

While many other resources are employed or available, the primary mode of intervention in open dialog is family therapy. Psychologists, psychiatrists, and nurses all participate as therapists in this process (Mackler, 2011). Rather than encouraging blame, everyone in a distressed individual's social network is given opportunity to be part of a solution. Everyone in the network, including the most distressed individual, is seen as having his or her own voice, which is given space, attended to, and respected. And those communications of the most distressed individual that are coming out incomprehensible are also given space, attended to, and respected. Through this process of cultivating Open Dialog, comprehensible words are eventually voiced for even the "most difficult and traumatic memories," which are understood to have been previously stored in "nonverbal body memory" and in the disturbed communications between individuals in the social network. As Seikkula and Trimble (2005) wrote: "In the meeting, network members find it possible to live through the severity and hopelessness of the crisis even as they [rebuild] their solidarity as a family and intimate personal community" (p. 486).

I cannot overemphasize how helpful this would have been for me and my entire family—who were also in shambles when I went psychotic. Lacking

this kind of philosophy, I do not believe any one of those professionals in the hospital ever suspected I would eventually be able to turn inside myself and sort through the chaos of my own thoughts, emotions, sensations, and poetic imagination—what I might call my soul, now, although I support my clients to understand their own inner worlds in whatever manner works for them.

I eventually found a gifted experiential therapist who helped me begin this work. But even after that, I often had a feeling I was trespassing by paying attention to my own experience and even daring to believe I could ever sort it out. It felt like the authorities not only ignored the actual experience of my suffering. It also felt like they put up that yellow tape, all around me, which read: "Off Limits—Authorized Medical Personnel Only."

I have heard researchers and even clinicians disparage those who try to understand and negotiate "mental illness" in terms of religion, spirituality, or other traditional and nonscientific terms. Yet I did eventually reclaim my human right to make sense of my own "inner experience"—which is not in any event subject to verifiable empirical measurement. This included reclaiming my right to understand my experience from many very different perspectives.

For instance, I can now view and experience my emotions as emotions again—drawing on my experiences of heart-to-heart connection with so many individuals experiencing a full range of painful and joyous life events. I can look at the impact of traumatic experience—continuing to heal the deepest roots of old traumas as well as the impact of working as a therapist with so many traumatized people. I have also reclaimed my right to look at my spiritual experience—and my whole life—from a spiritual perspective.

The study of world spirituality helped me find many transformative ways of coping with my own extreme experiences and with my life in general. Spiritual practice was a profoundly important part of my recovery—and remains an essential part of my life—as Patte Randal has explained it was,

and still is, in hers (Randal et al., 2008).

This is also consistent with Peter Levine's description of trauma recovery: [It] is universally true that the renegotiation of trauma is an inherently mythic–poetic–heroic journey... [p. 119] [I]t is to our detriment that we live in a culture that does not honor the internal world. In many cultures, the internal world of dreams, feelings, images and sensations is sacred. Yet, most of us are only peripherally aware of its existence. We have little or no experience of finding our way around in this internal landscape. [Levine & Frederick, 1997, p. 188]

I do not know whether anyone without lived experience of this can truly understand—although many of us have been trying to help make this possible. I experienced falling into the grip of that exclusively medical approach to my life, and all the power behind it, as a profound violation of my innermost self. This experience stripped me of my remaining capacity to author my own life in even the most basic ways. By talking about my own experience, I have tried at least to begin to illustrate that the respect of human rights is not a luxury for emotionally distressed individuals and that any violation can not only be extremely traumatic but also evoke a significant increase in suicide risk. I would also hope for more dialog about these issues.

I worked incredibly hard to recover and to build the life I have today—where I can make a real difference in other people's lives. I am proud of that. Yet I remain aware of how truly fortunate I am. Given the resources available in most communities, many fewer people achieve meaningful levels of recovery than can and do with more trauma- and recovery-informed support (e.g., Davidson & Roe, 2007; DeSisto et al., 1995a; DeSisto et al., 1995b; Fisher & Ahern, 2012; Mosher, 1999; National Empowerment Center, 2012a; National Empowerment Center, 2012b; Seikkula et al., 2006). Too many people languish in unresolved trauma, overwhelming emotion, a lack of social support, and a lack of empowerment to find a valued role in the world.



Even after I recovered, even after my third psychiatrist actually helped me successfully stop taking psychiatric medications, even after I began working as a therapist, I have experienced pressures from fellow professionals—whom I have respected as caring human beings—to tell other people suffering extreme states that they too have incurable brain disorders that are the cause of their suffering.

Fortunately, fairly early in my career as a graduate student I found an approach for working empathically with human distress. It is an approach that takes suicide danger and other danger extremely seriously—while at the same time avoiding any exclusively diagnostic approach to human suffering and working exceptionally hard to avoid taking away people's human rights. If not always as fully responsive to the needs of mental health recovery as the peer movement, it allowed me to develop a humane and largely effective way of working with people that I could later translate into my subsequent work at a student healthcare center and then at a counseling center—both on the campus of a large university. Being philosophically consistent with both trauma and mental health recovery principles, it has also allowed me to integrate many of those principles into my work, over time.

## **Another Approach to Suicide Prevention**

I began learning suicide prevention in 1991, in a setting with decades of shared clinical experience working with clients who have presented as overwhelmed and desperate and with a face-value initial presentation of escalated lethality. At the Alachua County (Fla.) Crisis Center (ACCC), I learned how people frequently respond if you let them know—through a process of joining them in their deepest pain—that you genuinely do not want to take their civil rights away, and that you want to empower them to find the resources to survive the pain.

Standard practice at the ACCC never involves turning a blind eye to suicide risk. On the contrary, it involves an understanding that evidence of more risk

will actually often emerge if a counselor is willing to meet an individual's most intense and threatening emotions with genuine empathy and human connection—and without judgment or any effort to try to push the individual to stop feeling that way. A goal of this process is to understand why a suicidal individual "has to die"—to understand an individual's unbearable pain as deeply and thoroughly as possible.

At the ACCC, crisis workers are trained to understand that listening deeply to whatever a suicidal caller or therapy client is experiencing almost always allows that individual to experience a genuine reduction of lethality—and often to regain enough control to make an adequate safety plan or to continue to engage the crisis center through additional contacts until they are willing and able to do so. So it was not a surprise to us when Gould and colleagues (2007) reported that "seriously suicidal individuals" do call crisis centers and that "significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks." As these researchers reported, "the best predictor of subsequent suicide behavior was the stated intention of the caller at the end of the call" (p. 338).

The ACCC process also involves the constant availability of seasoned consultants—and the expectation of involving them as needed. It involves more frequent review of higher-risk contact notes by a clinical coordinator—who will post additional follow-up contacts, if not planned accordingly, and who will call counselors at home, if necessary, to inquire about any essential elements missing from their documentation.

This process also frequently involves developing more complex action plans for individuals whose presentation of suicide lethality requires more complex consideration—including many who are persistently or recurrently suicidal. This entire process is detailed more thoroughly in [part 2 of this article](#). As mentioned earlier, this is a suicide lethality assessment article also currently published as an American Association of Suicidology Crisis

Center Best Practice (Probert, 2012a).

*Jim is a psychologist at the University of Florida's Counseling and Wellness Center. Feel free to contact him at [jprobert@ufl.edu](mailto:jprobert@ufl.edu).*

**[Review references and additional resources on this topic here.](#)**

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