SUMMER_2024

EMDR Therapy and Suicide

By Simon Proudlock, CPsychol, AFBPsS

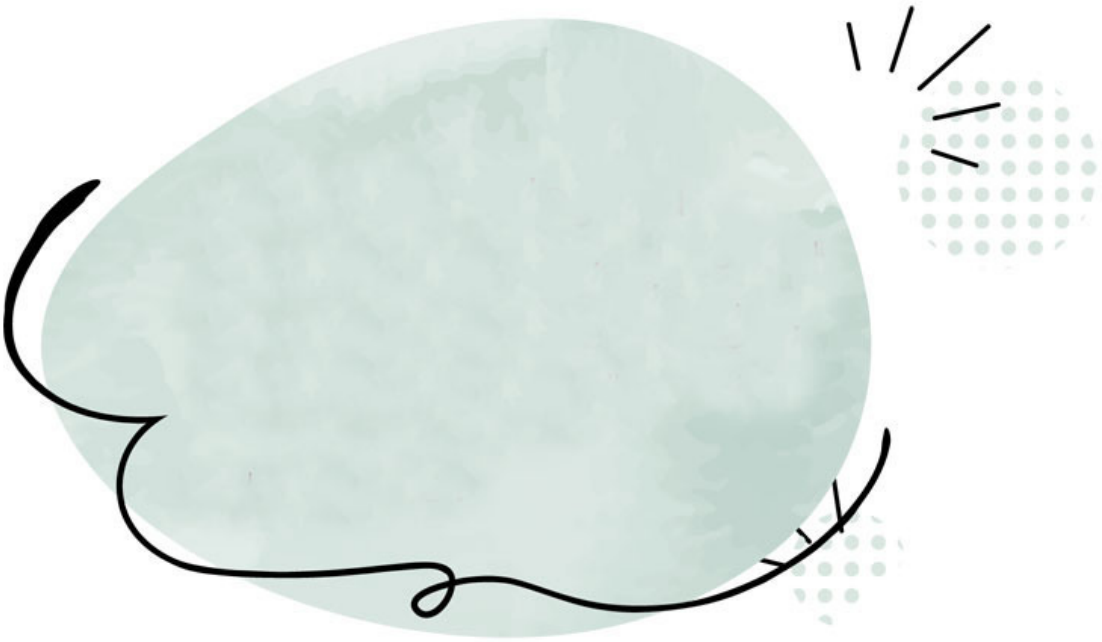
When I was initially trained in EMDR therapy back in 2007, using EMDR with clients who were suicidal or who were self-harming was contra-indicated; instead, it was thought it was best to spend longer resourcing them to help increase their stability. However, in my research on suicide and trauma, I discovered that those who have experienced trauma are 15 times more likely to die by suicide than those who haven't—a clear role for EMDR. Although resourcing is invaluable to these clients, moving on to the desensitization phase is just as important.

Research in this area has continued to grow. The first RCT was published in 2019 (Fereidouni et al., 2019), adding to the work I was undertaking within the National Health Service in the U.K. More recently, work by Burbank et al. (2024) has shown

that not only is EMDR therapy effective in processing the trauma of those who are suicidal, but it is also safe, often leading to a decrease in the desire for suicide.

TERMINOLOGY—WHAT ARE WE TALKING ABOUT?

Suicide is often the end point of a complex history of risk factors and distressing events. Most people who say they wish to die are essentially saying they want their misery to end or their lives to be renewed and transformed. Although, at times, a death by suicide can seem impulsive, it is extremely rare for it to actually be impulsive (Joiner, 2010); instead it is the endpoint of a difficult journey for the individual.



> **“Suicidal thinking is a normal response by normal people to an abnormal set of circumstances.”**
>
> **—John Henden**

> **“Suicide is a permanent solution to often temporary problems.”**
>
> **—Edwin Shneidman**

Self-harm is often seen as an intentional act of self-poisoning or self-injury, irrespective of the type of motivation or degree of suicidal intent.

Some clinicians can confuse the terms suicide and self-harm. Although self-harm can, for some, lead to suicide, often the two are entirely separate processes for the client, and as such, it is important to determine the intentions of each behavior. Many people who self-harm do not intend to die but instead self-harm as a way of tolerating very difficult emotions, reducing the desire to die. For some clients, stopping self-harming can lead to an increase in the risk of suicidal behavior (suicideinfo.ca).

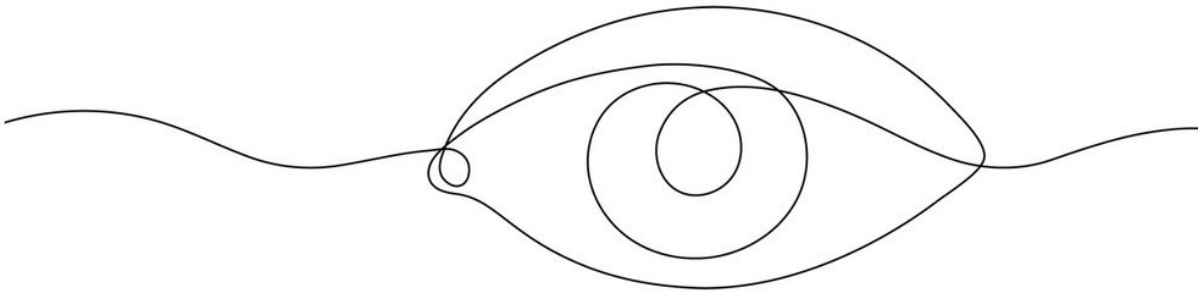
In clinicians, as well as in the general population, suicide can invoke a range of strong emotions–despair, fear, sadness, loss, isolation, responsibility, escape, trauma, and pain, to name just a few. Sometimes, our fear of working with such

clients can lead to us discharging them, increasing that cycle of isolation. However, in my experience and the experience of colleagues, we can take positive clinical risks and use EMDR therapy successfully with some of our most traumatized clients.

When working with someone who is suicidal, it can be useful to be aware of the language we are using both with our clients and with colleagues and families. Generally, there has been a move away from the term “committed suicide” to using “died by suicide” instead. It often strengthens the connection with my clients by reflecting on their need to “escape” from their situation and how “trapped” they feel. Acknowledging how “alone” they feel is also powerful in building that rapport. As the work progresses, talking to our clients about how a “part of you…” wants to die can help give the client some distance from that part, and as therapists, we can help them focus on the part that is ambivalent or does not want to die.

THEORIES OF SUICIDE

Before we can look at how we can use EMDR therapy with our clients, I would like to touch upon a couple of theories on suicide that can help guide us on how to resource our clients and what may be most useful to target with EMDR therapy.



JOINER’S MODEL OF SUICIDE

One of the most helpful models of suicide I have used over the last decade is from Thomas Joiner and his interpersonal needs theory of suicide. Joiner (2007) looks at the interaction between perceived burdensomeness, thwarted belongingness, and acquired capacity for suicide. Lack of social connectedness (isolation) is common across many models of suicide and is thought to be a key predictor of suicidal behavior. Perceived burdensomeness can be seen as the

common thread among risk factors such as family conflict, unemployment, and physical illness, and incorporates the interpretations from significant others that they are not needed or that things would be better off without them.

As EMDR clinicians, if we are picking up high levels of thwarted connectedness and burdensomeness, we can try to find a glimmer of positivity that we could resource. Those with high burdensomeness have care and concern for those around them—can this caring for others be a resource we could enhance? And what about exceptions—times when they did feel connected with others or less of a burden—can we enhance those times as a resource? Exploring clients' history to discover times when they felt better about themselves may be the antidote that we can install to mitigate the current risk factors.

The final part of Joiner's model looks at the acquired capability of dying. Dying by suicide is not an easy thing to do—individuals need to lose some of the fear associated with suicidal behaviors. Humans are biologically prepared to fear suicide and death, and as such, this increased capability is composed of increased physical pain tolerance and reduced fear of death through habituation and activation of opponent processes in response to repeated exposure— often, the greater the planning, the higher the risk = more desensitization to dying. However, for many, the self-preservation instinct will step in at the last minute with people not even being aware of their body's natural instinct kicking to save them.

THE ESCAPE THEORY OF SUICIDE

First proposed by Baumeister (1990), the escape theory of suicide incorporates the need of individuals to escape from themselves and their situation. Stressful life events fall short of standards or expectations, and these failures are attributed internally, leading to painful selfawareness. Trying to escape these negative feelings leads to cognitive deconstruction (constricted temporal focus, concrete thinking, immediate or proximal goals, cognitive rigidity, and rejection of meaning), removing inhibitions, passivity, and an absence of emotions with an increase in irrational thoughts.

Suicide is analyzed in terms of motivations to escape from the aversiveness of self-awareness. The cognitive effort of suppressing suicidal intrusions appears to

be counterproductive and inflates their frequency, more so when individuals realize their failure to attain an important standard—in essence, they are looking to escape from themselves and the constant barrage of suicidal thoughts. Those with high internal locus of control are seen as more at risk as they feel that their failure is internally attributed—this links with Joiner's model of feeling like a burden to others and adds to thwarted belongingness as they feel no one wants them due to their failings.

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDE (CAMS)

Although not a model of suicide itself, but more of a way of working with the individual expressing a high desire for suicide, the CAMS model proposed by Jobes (2016) offers a way of assessing and planning our work with the individual. Jobes proposes sitting side by side with clients to get to know their suicidality and hence to discover what it is that is driving them to want to end their lives. Working together with clients, we find an alternative pathway other than ending their lives. For example, "Let us see if together we can find a viable alternative to suicide to better deal with your pain and suffering."

Part of the CAMS framework looks at ascertaining from the client reasons for living and reasons for dying. Some common themes within reasons for living include family, friends, responsibility to others, burdening others, plans and goals, hopefulness for the future, enjoyable things, beliefs, and self. Some of the themes for reasons for dying include relationships, unburdening others, loneliness, hopelessness, general descriptors of self, escape in general, escape the past, escape the pain, and escape responsibilities.

These reasons for living and dying can help guide our EMDR work. The reasons for living can easily be enhanced as resources, and by gently exploring the reasons for dying, we can uncover clear traumas, past and present, that could become targets for our therapy.

Rory O'Connor (2021) talks about how feelings of entrapment are a key issue in suicidality. Suicidal behavior is seen as an attempt to escape from being trapped by mental pain—often trapped by *unbearable* pain. The individual can be thought

of as having 'tunnel vision'—unable to see a time when things may be different, and as such, any intervention should be aimed at interrupting these suicidal thoughts. Here, suicide should be seen as a cry of pain, not a cry for help.

One of the best predictors of suicidal behavior is levels of entrapment and history of suicidal behavior. O'Connor's entrapment scale can be a crucial intervention in determining suicidal intent, and from an EMDR perspective, what resources we might want to install and what we could target. The scale contains four questions:

1. I often have the feeling that I would like to run away.
2. I feel powerless to change things.
3. I feel trapped inside myself.
4. I feel that I am in a deep hole and cannot escape.

The first two questions assess external entrapment, with the last two assessing internal entrapment—internal entrapment appears to be much more dangerous—the need to escape from one's thoughts and feelings seems more unbearable and links into the Escape Theory of Suicide. A combination of high levels of entrapment and loneliness often leads to a high risk of suicide.

But can the answers to the entrapment questions become material for EMDR therapy resources and targets? For example, for someone expressing a high desire to run away, we could ask, *"When was the first/worst /most recent time you felt like you wanted to run away? What was going on at that time?"* And in terms of resourcing, *"Where would you like to run to?"* As we continue with those questions:

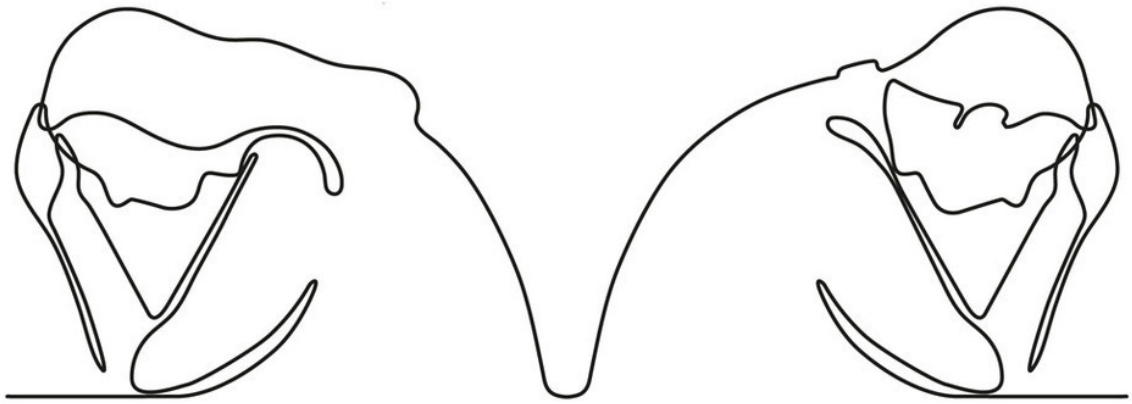
- *When was the first/worst time you felt powerless?*
- *What's the smallest thing we could work on together that might make you feel more in control (future template of being more in control or target the smallest thing)?*
- *Tell me about a time when you had the capacity to cope with all, or even some, of this (resource).*

Generally, if we ask when was the first/worst time they felt like this and what was going on then, we may be able to identify those BIG 'T' or little 't' traumas that are fuelling these desperate feelings of entrapment.

fuelling those desperate feelings of entrapment.

WHAT WORKS WITH SOMEONE WHO IS SUICIDAL: THE BASICS

When faced with people who are expressing a desire to end their lives, we, as therapists, can become overwhelmed. We all have an amazing array of tools and techniques in our therapy toolbox to work with people, but at that moment when you are with someone expressing suicidal thoughts, stop theorizing, explaining and analyzing, and just be. Connect with your clients to counter their sense of isolation and desperation they are feeling. Use your nervous system to help regulate theirs.



Bonnie Badenoch stresses that one of the most effective ways to respond to distressing affect in clients is to be present more and more without agenda so that mutual coregulation can take place, rather than responding to the urge to shift or 'do' something for the client. (Bonnie Badenoch, taken from Mark Grant, 2023). As Grant (2023) says, "One of the biggest obstacles to the therapeutic relationship is an overactive left hemisphere in the therapist (but also often the patient), the part of our brain that wants to fix things." I will happily acknowledge this.

And nothing activates this part more than sitting across someone who is acutely suicidal—we need to fix them before the session ends in 25 minutes. Our suicidal clients, like the clients Mark Grant talks about with chronic pain, may adopt a helpless and hopeless position in therapy— "failure to manage the demand characteristics of patients who present like this can lead to premature application of interventions… the therapist is pursuing a therapeutic agenda that the patient

is not ready for" (Grant, 2023).

Sometimes, we are so busy trying to be the *best* therapists for our clients that we forget how to be with them. Often, all we need to do is just listen—validate, normalize, and acknowledge—and then elicit hope, optimism, and confidence. Through our clients' stories, targets and core beliefs will emerge for future processing. Often, we do not have to wait for too long.

We can help our clients who present with high levels of clinical risk in a few simple ways. Firstly, do not ignore their suicidal thoughts and feelings— having an open conversation and validating their distress will enable trust, so they can tell you if things get bad. Work with them to develop a safety or crisis plan; if they are struggling, a brief phone call, text, or email after a difficult session can help them feel connected. Wherever possible, offer hope–reassure them that this will pass, and things will improve as often they are stuck with tunnel vision of their dark situation. And don't guilt trip them by reminding them about the people around them who will be devastated if they die by suicide—they are fully aware of them and can feel such a burden that this could only make things worse.

HOW CAN EMDR BE USED WITH CLIENTS WHO ARE SUICIDAL?

Historically, the guidance on using EMDR therapy with people who were suicidal or self-harming was to use extreme caution. In my research, I found that this caution was not unique to EMDR therapy but to all exploratory therapy in general. That same research discovered that the reasons behind this were not based on actual evidence but instead on more of a myth.

In my experience, EMDR therapy can be extremely beneficial for clients who present with elevated levels of clinical risk. However, if you have little or no knowledge of how to work with someone who is suicidal, jumping in with EMDR

knowledge of how to work with someone who is suicidal, jumping in with EMDR therapy is not recommended. Learning how to hold relatively high levels of clinical risk is essential before undertaking this type of work. Likewise, if you have only recently trained in EMDR, I urge you to gain that experience and knowledge before working with this client group.

As we look at our 8-phase protocol, some additional considerations that can be helpful in the history-taking phase include obtaining a history of previous suicide attempts and previous times the client has self-harmed. Equally, knowing the first time the client felt suicidal or self-harmed can help our treatment planning as there may be traumas around this time that are stuck in the nervous system. A recent change in nature/type of self-harm may also indicate current stressors that we could target with EMDR therapy. Likewise, times when the self-harm or suicidal ideations are worse could lead to other potential targets (sometimes the anniversaries of traumas or losses). And asking if they have an image of their death can also help us think about treatment planning as we can target this suicidal flashforward. In general, we need to know in more detail their history of self-harm and suicide.

As with a more standard historytaking phase, listening out for recent 'failures' (perceived or actual) in relationships, employment, status, or health as these can guide our treatment plan. And, of course, the traumas—from the most intrusive to those that seem to be directly related to the onset of the self-harm or desire to end their lives

ADDITIONAL CONSIDERATIONS IN THE PREPARATION PHASE

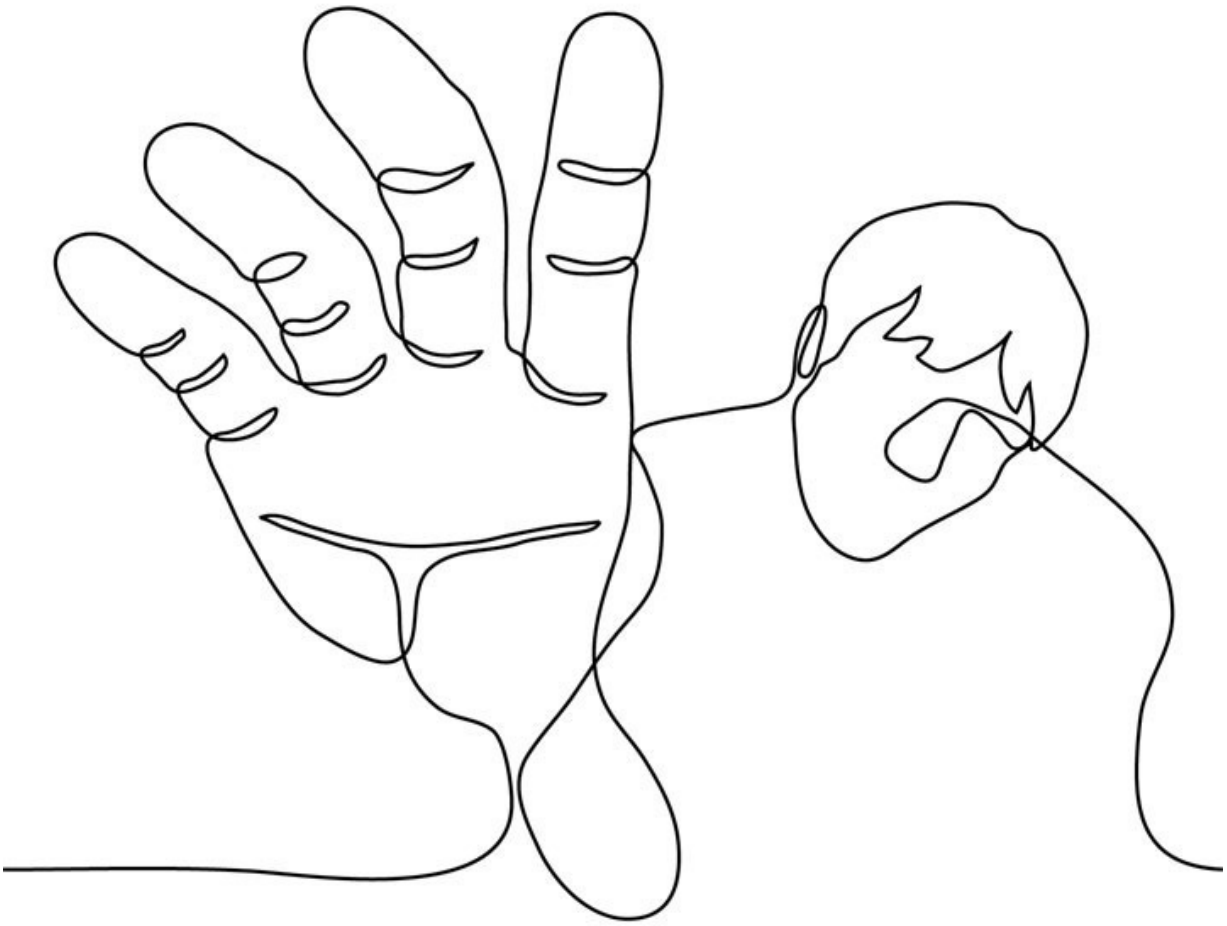
As with most of our more complex clients, ensuring our clients are resourced as much as possible is just as important with clients expressing high levels of suicidality. However, an increase in stabilization may not lead to a decrease in suicidality if it is being fuelled by the trauma(s), and generally, processing just one trauma may make the person safer.

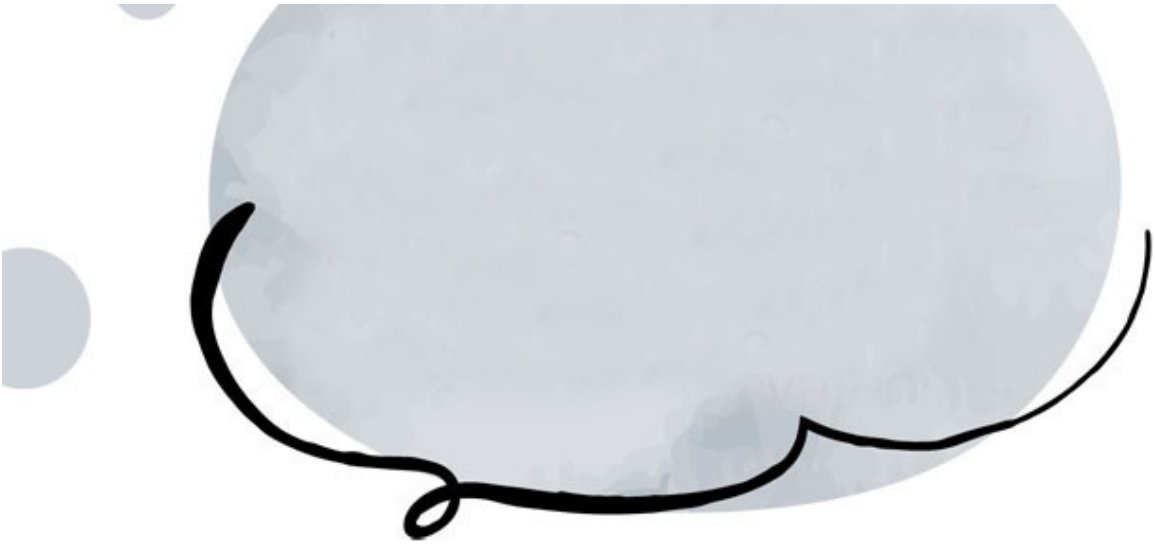
Before EMDR therapy, one of my main ways of working with clients was with solution-focused therapy, and this can help work with individuals who are suicidal. Working with our clients to find exceptions to their despair—times when things aren't quite as bad—can be great material to resource, no matter how

small. Past and current success, times when they have felt connected to people and less of a burden, and current ability to do even the smallest of tasks can help fuel the adaptive resources in even the most hunkered-down client. And sometimes, installing a future self can help instill some hope: “If you were no longer feeling this amount of despair, what would that look like?”

ADDITIONAL CONSIDERATIONS IN THE ASSESSMENT PHASE

Most people need the standard protocol, but often, with complex presentations, knowing what to target can lead to some difficulty. I find any mental health crisis is exacerbated by lack of sleep, and for some, is the cause of the crisis. If the trauma (s) are keeping the client awake, I would consider starting with these more intrusive memories—helping someone regain some sleep can have such a positive effect on their mental health.





> **In my experience, EMDR therapy can be extremely beneficial for clients who present with elevated levels of clinical risk.**

Other potential targets to consider would be to explore what's triggering the current mental health crisis, their previous suicidal behavior and/ or times of being hospitalized, and targeting a memory related to the desire to harm themselves. Based on the CAMS framework, can we identify suicidal drivers? What is driving the suicidality right now? And for the more advanced practitioner, targeting a suicidal flashforward (van Bentum et al., 2023) can significantly help reduce suicidal risk.

Often, suicidal clients will struggle to find a positive or preferred cognition (PC)—they can be in such a dark place that they can see nothing that is positive. However, generating a PC is at the heart of the Adaptive Information Processing (AIP) model as it allows the client to access the adaptive material held somewhere else in the brain. Exploring a preferred belief about how they want to see themselves if they are no longer in distress or crisis can activate the AIP and give clients something to hold onto. Can they generate a picture or image associated with that preferred belief—similar to the miracle question in solution-focused therapy–and generate a preferred future, instilling a sense of hope? With some

clients, this may need to be developed in phase 2 of EMDR to enable the client to generate a PC in phase 3 readily. Hoffman et al. (2022), in their book "Treating Depression with EMDR Therapy," discuss suicidal states and how memories of being suicidal sometimes feel true in the present. Intense feelings in the body can accompany these memories but often have no images or thoughts. EMDR therapy can be used to process the distress associated with previously being suicidal or being afraid of being suicidal again.

Within the desensitization phase, clients can often get stuck or start looping on the desire to end their lives. However, clients often respond well to interweaves. A two-handed interweave for suicide can be useful– one hand, keep living, the other hand, kill self, often allows the innate part that wants to live to step forward, capitalizing on the AIP theory. Other possible interweaves could be:

- Are you dead now? Can you get that sense of relief without being dead?
- Is there another way?
- I'm confused. What's good about doing this?
- Sending in a nurturing/rescue figure/significant current person
- Solidifying reasonable doubt. Helping the client see that there are other possibilities.

As with all of our clients, closure is critical so we can help them keep themselves safe until the next time we see them. Basic behavioral activation can be invaluable to get the client to do even the smallest thing that might make them feel better—encouraging them to connect with people, even if just for 30 minutes a day, can reduce the power of the feeling of thwarted belongingness. Work with them to develop a safety plan—what they can do and who they can contact between sessions if they feel things are getting worse. If applicable, talk to their prescriber to see if there is anything short-term they could be prescribed to calm themselves should the distress get too much.

Throughout treatment, we need to help our clients manage their suicidal risk. Responsibility must be placed on the clients to keep themselves safe. If you can validate and acknowledge their distress, they will be willing to work with you to help keep them safe. If you are working with someone prone to suicidal ideation,

when they are not suicidal, discuss with them a plan about how you can support them if they are.

Therapy rarely goes as it does in the videos we see on training courses and read about in books. More so when working with complexity. Often, things do not go as planned. However, in most cases, it is essential to return to processing the trauma's fuelling distress rather than stopping EMDR therapy. For example, if a client has self-harmed after a session, we could return to resourcing to stabilize our client. Nevertheless, the triggers will potentially still be there the next time you process. Instead, do the self-harm in detail.

1. When exactly after the processing did the self-harm happen?
2. What was the trigger?

By viewing self-harm as a behavior to deal with overwhelming emotions, we can target either the most recent trigger or float back to an earlier time when clients felt that self-harming effectively helped them manage difficult emotions.

THE EFFECT ON US AS THERAPISTS

Working with clients expressing a high level of clinical risk is not easy. Clients who die by suicide can result in stress and anxiety for even the most experienced clinician. It is essential to recognize the effect the loss of clients can have on the mental health of professionals. Clinicians are often left ruminating on what they could have done differently to stop that individual from dying by suicide and what else they could have done to support that individual. Still, in that process, we missed all the things we did to help them. We can only base our interventions on what clients tell us about their feelings and how they present to us in the session.

Effective supervision and support from an experienced supervisor are invaluable when working with individuals who are suicidal. And simply checking in with colleagues and supervisees, asking how they are doing, can lighten the load of working with suicide and self-harm.

FINAL THOUGHTS

During the first lockdown of the COVID-19 pandemic, I was working for a mental health crisis team and had to continue my work with a client online. Following the

health crisis team and had to continue my work with a client online. Following the end of therapy, he sent me this email. At the time therapy started, he was out of work, had applied for hundreds of jobs, and finally was successful on his 401st application:

"I still have a noose in the bottom of my cupboard. I have left it there as macabre keepsake/reminder for me not to get that dark again. All I know is that without your help and Paul's support—if I had been on my own throughout—I genuinely wouldn't have been around to make the 401st."

As mentioned at the start of this article, individuals who have experienced trauma are 15 times more likely to attempt suicide, showing a clear role for EMDR therapy. Both suicidal ideation and non-lethal attempts are **vastly** more common than lethal attempts, and only a small subset of those who think about suicide will go on to attempt, and even fewer will die by suicide (WHO, 1998). While working with clients with high clinical risk can be challenging, it is also hugely rewarding.

Simon Proudlock is an EMDR Europe Accredited Trainer, Consultant Psychologist, and Associate Fellow of the British Psychological Society. In 2018 he won the award for Innovative Practice from the Division of Counselling Psychology for his research in EMDR with people who are suicidal. He is author of The Solution Focused Way: Incorporating Solution Focused Therapy Tools and Techniques into Your Everyday Work.

Resources for our clients: Stay Alive Smart Phone App

Resources for us: EMDRIA *Focal Point Blog,* "EMDR Therapy and Suicide," September 10, 2021, ***www.emdria.org/blog/emdr-therapy-and-suicide***

References

Baumeister, R.F. Suicide as escape from self. *Psychol.* Rev. 1990, 97, 90–113

Burback, L., Yap, S., Purdon, S.E., Abba-Aji, A., O'Shea, K., Brémault-Phillips, S., Greenshaw, A.J., Winkler, O. Randomized controlled trial investigating web-based, therapist delivered eye movement desensitization and reprocessing for adults with suicidal ideation. *Frontiers in Psychiatry.* 2024 Feb 16;15:1361086.

Fereidouni, Z., Behnammoghadam, M., Jahanfar, A., Dehghan, A.: The Effect of Eye

Movement Desensitization and Reprocessing (EMDR) on the severity of suicidal thoughts in patients with major depressive disorder: a randomized controlled trial. *Neuropsychiatric Disease and Treatment* 2019, 15:2459-2466.

Grant, M. (2023) Pain Control with EMDR: Treatment Manual (8th Edition), 2023. California. CreateSpace Independent Publishing Platform.

Hofmann, A., Ostacoli, L., Lehnung, M., Hase, M., Luber, M. (2022). Treating depression with EMDR therapy: Techniques and interventions. New York, NY. Springer Publishing Company.

Jobes, D. A. (2016) Managing Suicidal Risk: A Collaborative Approach. Guilford Press, London and New York.

Joiner, T. (2007). Why People Die by Suicide. Cambridge, Mass. Harvard University Press.

Joiner T. Myths about suicide. (2010) Cambridge, Mass. Harvard University Press.

O'Connor, R.C. (2021). When it is Darkest. Vermillion, London.

Proudlock, S. & Peris, J. (2020) Using EMDR Therapy with Patients in an Acute Mental Health Crisis. *BMC Psychiatry.* ***https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2426-7***

Self-Harm and Suicide Toolkit – Downloaded 29th May 2024 **www.suicideinfo.ca/local_resource/self-harm-and-suicide**

van Bentum, J.S., Kerkhof, A.J., Huibers, M.J., Holmes, E.A., de Geus, S., Sijbrandij, M. The Suicidal Intrusions Attributes Scale (SINAS): a new tool measuring suicidal intrusions. *Frontiers in psychiatry.* 2023 Jul 5; 14:1158340.