ACT for Suicide Prevention with Sean Barnes

Sean Barnes: [00:00:00] We view suicide prevention as a vital, but, just an initial step in helping someone recover. You know, I think if we stop at suicide prevention, we fall short of our goal of helping people, you know, really live.

Debbie Sorensen: That was Dr. Sean Barnes on Psychologists Off the Clock.

Diana Hill: We are four clinical psychologists here to bring you cutting edge and science-based ideas from psychology to help you flourish in your relationships, work and health.

Debbie Sorensen: I'm Dr. Debbie Sorensn, practicing in mile high Denver, Colorado, and coauthor of ACT Daily Journal

Diana Hill: I'm Dr. Diana Hill coauthor with Debbie on ACT Daily Journal, and practicing in seaside Santa Barbara, California.

Yael Schonbrun: From coast to coast, I'm Dr. Yael Schonbrun, a Boston- based clinical psychologist and assistant professor at Brown University.

Jill Stoddard: And from sunny San Diego, I'm Dr. Jill Stoddard author of Be Mighty and The [00:01:00] Big Book of ACT Metaphors.

Debbie Sorensen: We hope you take what you learn here to build a rich and meaningful life.

Diana Hill: Thank you for listening to Psychologists Off the Clock!

We're so happy to be partnered with Praxis, continuing education here at psychologists off the clock, they offer continuing education for promoting lasting change with evidence-based training.

And they're the premier provider in continuing education for clinical professionals. Some of their ongoing on demand. Anytime classes include act immersion with Steve Hayes act in practice, and also the DNA VI model, which is with Louis Hayes who works with adolescents and is fantastic.

Debbie Sorensen: yes, and we have big news. We Diana and Debbie here are offering a Praxis training. It's a two hour workshop on Wednesday, April 28th. And you can sign up best of all, it's free and anyone can join. It's not limited to therapists. And what we're going to do is talk about some of the concepts from our book that we have coming out in may and offer you some practices [00:02:00] that you can use from acceptance and commitment therapy to thrive in your own life.

So we're really excited to be offering that. You should check it out and we hope you can join us.

Diana Hill: So go to our website offtheclockpsych.com to get a promotion code on live events through Praxis.

Debbie Sorensen: Hi, this is Debbie I'm here today to bring you an episode on suicide with my colleague, Sean Barnes, and to me, as the therapist, I think suicide is something that is really important to be aware of and to be thinking about and talking to clients about.

And I know that it's a hard topic and that this is a topic that sometimes is hard to talk about, hard to listen to. Um, it's it's there is truly, what do I say? And part of m mission behind wanting to bring this episode to you all, is that I really think it's important that we have a [00:03:00] conversation that we become more open to talking about this subject, because I think it's necessary to, to reduce some of the stigma that's associated with talking about suicide.

I know it can be really scary and hard, but I think the more that there is stigma attached to it, um, the harder it is for people who. Need help and who needs support if it's harder for them to reach out and get it. And Yale's here with me today. I know all you had some thoughts as well.

Yael Schonbrun: Yeah. I mean, just to dovetail on what you were saying, Debbie, it feels a little bit like the kind of mentality that we used to have around sex life. We don't talk about sex with teenagers, they just won't have it. And of course, we know that that's not true, that those kinds of urges exist and that we need to talk about it in order to give people the tools that they need.

And when it comes to the stigma, I mean, I've actually had some personal experience with this where, when I was in graduate school, um, for, to get my PhD in clinical psychology, [00:04:00] somebody very close to me made a pretty significant suicide attempt. And what is so ironic is that surrounded by people in clinical psychology.

I didn't feel comfortable reaching out for the support that I needed, both in terms of my own wellbeing, because it really shook me up, but also to be able to offer this person tools from people who had them. Um, and so I think that just really speaks to the fact that even within the field of clinical psychology, among people who have PhDs or are working towards PhDs, the stigma is so intense.

And I think that really. Does just make it a lot harder for people to access the kind of tools that would be useful. And the other thing that I was going to say is that this person who made a significant attempt is doing wonderfully today. I mean, it's many years later, but I think it also just speaks to some of that.

Um, stereotypes that we have about what a suicide attempt or suicidal thinking means for somebody life [00:05:00] course that, and the truth is, and the research bears this out, that if we intervene, if we give people tools that even if you're having significant suicidal thoughts,

or even if you make an attempt that recovery is possible and that a full and fulfilling and rewarding, healthy life is, is within.

Reach, if you access the tools and the more that we talk about it and make those tools available to people the better off we'll all be.

Debbie Sorensen: I love that message. I think that's a nice note too. Start the conversation with, as we move into the interview, because I think that there truly support is so helpful and there truly are. There's hope there's things out there that can help people. But sometimes the hardest part is to acknowledge that you're struggling and to reach out for that support.

So I really hope that's okay. Part of the message that we convey today and also that we help a little bit to get the conversation going and to reduce that stigma [00:06:00] because it's not an uncommon experience. and also for clinicians, I think, you know, we are trained in some ways too. Talk about suicide, but I think sometimes there's more continued learning and we can look at our own hangups and look at, you know, how best can I help my clients?

And so that is, that's what we're hoping for in the conversation today. I hope you find it useful.

Hi everyone today, I'm talking to my colleague and friend Dr. Sean Barnes. We're going to be talking today about using an acceptance and commitment therapy for suicide prevention. I just want to just start with a couple of quick notes. This episode is really geared a bit more toward clinicians. Although of course, anyone is welcome to listen to it, but I think it might be especially of interest to clinicians.

Um, I also wanted to just. Say that there are a lot of resources available for anyone who would find them helpful, whether you're a clinician, a loved one or family member of someone [00:07:00] who's struggling with suicidal thoughts or behaviors, or whether you yourself are experiencing that.

And so we're going to provide some resources on the show notes for today's episode that you might find helpful. So check that out. And they also wanted to just provide everyone with the national crisis hotline, which you can call anytime if it would be helpful if you're struggling. And that number is 1-800-273-8255

I also just wanted to let our. Clinicians who are listening, know that Sean and I together along with a few of our colleagues, Lauren Borges, Geoff Smith, Nazanin Bahraini. We are presenting a virtual two-day workshop for therapists on using act for suicide prevention. It's part of this year's virtual ACBS world. Conference it's a pre-conference event and it's happening on Saturday, June 12th and Sunday, June 13th. It's about four hours a day and there is [00:08:00] continuing education credit for that. We're going to be helping clinicians with some of the challenges in working with suicide. We're going to practice using this approach.

We're talking about today to help conceptualize suicide. Take a look at how contextual behavioral practices can help us work more effectively with suicide. And we're going to demonstrate how to create an act consistent suicide safety plan to manage suicide risks.

So if you like what you're here today, we hope you will join us and take a deeper dive and you can register for that@contextualscience.org. We'll put a link to it in our show notes for today's episode. Sean Barnes is a clinical research psychologist at the Rocky mountain mental illness, research education and clinical center, or MIRECC for veterans suicide prevention and an assistant professor in the department of psychiatry at the university of Colorado Denver school of medicine.

Sean is an act clinician and researcher. He is a national consultant with the [00:09:00] VA's suicide risk management. Consultation program, which provides free consultations, support and resources for providers working with veterans at risk of suicide. Sean is also a VA act for depression provider and training consultant.

Sean's research has focused on suicide prevention and recovery. He's the principal investigator of the act for life study. We'll be talking about that today a little bit, which is testing on brief act protocol for maximizing recovery after suicidal crises. And other aspects of Sean's research focus on act for moral injury and suicide risk assessment, and all of his projects share a common goal of alleviating suffering and helping others build vital, meaningful lives.

Sean, so happy you're here. Welcome.

Sean Barnes: Uh, thank you, Debbie. I'm so happy to be here as well. I really appreciate the opportunity to, uh, be able to speak with you and your listeners. What about some of the work that we've been doing together?

Debbie Sorensen: Well, we were just talking about how this is a topic near and dear [00:10:00] to both of our hearts and how it just feels really important to be able to share some of this with the world. So, so grateful that you're here, Sean. Um, I think you wanted to take a moment to thank a few people and make a, make a quick.

Disclaimer.

Sean Barnes: that'd be wonderful. , and this is, you know, work that we've been doing for a number of years, uh, with some wonderful collaborators. Um, you of course. And then also, uh, Lauren Borges Geoff Smith, Nazanin Bahraini and Robin Walzer. Um, we've also had great support from, uh, Lisa Brenner, the director of. The MIRECC and the VA in general.

Um, I also wanted to just kind of officially state that I am here as a psychologist off the clock. I, uh, do work for the VA in the university of Colorado, but I'm not here to speak on behalf of any organizations. And, you know, my statements really are my opinions alone and don't necessarily reflect the opinions of the VA or the U S government.

[00:11:00] **Debbie Sorensen:** I've had to make that disclaimer myself many times. And sometimes I'm like, thankfully, no, I'm just kidding. Yes, we do not represent the U S government. We are independent agents.

Sean Barnes: Yes, exactly.

Debbie Sorensen: Suicide prevention is always a really important topic. I think right at the moment, people are really concerned about suicide during the pandemic because of the mental health concerns that people have about what we've been going through.

Sean. And I happened to be recording this interview too the day after, uh, Megan Markle, you know, from the Royal family, she talked about suicide in an interview with Oprah Winfrey just yesterday. I didn't watch it. I know Sean, did you watch that?

Sean Barnes: Yeah, I did. I caught most of it. I in between, uh, trying to get my kids to go to sleep,

Debbie Sorensen: Okay. I'll try to watch it soon. Um, but I just noticed I checked social media and it was, there's a lot of conversations about this right now, just the stigma and kind of just opening up about it. [00:12:00] And I think that's part of our mission today is that it's really important in our quest to help with human suffering, suffering that we talk about this really hard subject and what's going on.

With suffering in this way. And as clinicians who are listening, I think it's really important that we think about how we can do our best to work effectively with suicide.

Sean Barnes: absolutely. Yeah, I think I really appreciated when public figures opened up about, uh, suicidal ideations. I think it is a place that our mind goes is as humans and really that's been. Make knowledge really from the beginning of, you know, kind of the first writings about acceptance and commitment therapy that we have this powerful word machine that helps us plan, but also can, can trap us.

And in the process of trying to think our way out of things from the most extreme, um, place our mind goes is considering suicide. And it's, uh, an issue that. You know, has been stigmatized, but, um, and there have been unfortunate myths about, you know, [00:13:00] talking about suicide or fears that that would somehow make people more suicidal and there couldn't be anything that's further from the truth.

Uh, I think we need to get people to open up about this issue acknowledged that it's a, um, not a terribly uncommon experience for people to have, and that there are many solutions and resources to help people find other options.

Debbie Sorensen: exactly the more we can open up to talking about it. The less it becomes this shameful hidden thing. And so then people can get the help that they, that they need.

I think for as a therapist, you know, we do get used to talking about it, I think more and yet it can still feel really stressful when we feel that there's risk of suicide. We're worried about our clients. Sean, can you tell us what are some of the challenges for therapists in terms of, you know, both managing suicide risk and working effectively with suicide?

Why is this such a [00:14:00] challenge for us?

Sean Barnes: I think one of the reasons it's such a challenge is because, you know, the people in this business really care. Uh, we go into this line of work because we want to help people. Right. And, um, don't want people to, to die by suicide. So a lot of times where. Sort of automatically put in a position of, um, being at odds with our clients when they start to talk about suicide.

Because, um, for most of us, probably if we're honest with ourselves, that's something that we don't want people an option. We don't want people to choose. Um, and we might also have expectations that are unrealistic in terms of our. Ability to prevent people from choosing suicide. If that's something that they are committed to.

Um, as I say that I want to be careful to not portray suicide as something that's inevitable. I think that there are are many, many options, um, to, uh, void. You know that, that path and that [00:15:00] choice, but as humans who have free will, uh, suicide is, is on the table for people and being in institutions that are also very motivated to prevent suicide.

Um, there's a lot of pressure on clinicians, uh, from an institutional or also legal, um, perspective. And we can. Start to work from a place of fear that is not aligned with where the client is at, and that can create a lot of challenges. So I think, you know, one of the main ones is that, you know, we typically have this agenda to keep patients alive and, and, um, clinicians can have fear of, you know, maybe saying the wrong thing at a critical moment and doing harm, um, somehow violating ethics or, or.

Being liable, you know, for malpractice, uh, suicide is one of, I think, consistently rated as one of the most sort of stressful issues to, to navigate as a clinician. I [00:16:00] think also, you know, working with suicide can be very emotionally challenging. Uh, clients, deaths from suicide are our reality that sometimes need to be faced. And, um, the people who are considering suicide are often. Um, you know, their mind is gone there because of the intense pain that they're in. So sitting with this real profound human suffering, , and not getting, , totally derailed by, you know, checklists or, , expectations in terms of, um, needing to do the right thing and make the right decision around hospitalization, particularly, you know, can, can kind of pull us out of our, Place where we would typically sit alongside a client.

Debbie Sorensen: I think it's so true. Sure. I say this a lot. That it's, it's a courageous act to kind of Wade into this level of suffering with people. And sometimes it's out of fear that we have so much pressure to, to handle this quote, right. I'm doing air quotes because I think there's this feeling that, Oh, we have to get this right to keep our client [00:17:00] alive, to make sure that we do everything we're supposed to be doing, but that when we get into that place of.

Being driven by fear. It can really interfere with our ability to do our best work.

Sean Barnes: absolutely. And I think it can also, you know, clients are certainly aware too, as we shift into a place, um, that can be perceived as. You know, therapists kind of covering themselves right. Or needing to check the boxes. So it can almost be stigmatizing and prevent discussion of suicidal ideation or urges.

And that once I, you know, as a client, once I say that, then we're going to need to go down this road of, of boxes to check. And as I say that I also, I. I think it's a somewhat controversial topic sometimes around the value of suicide risk assessment, but I firmly believe that suicide risk assessment is, is critical.

Um, I think that the steps that organizations have taken to implement universal [00:18:00] screening and, um, you know, mean the safety discussions are really important. Um, and I also acknowledged that at the same time, um, when we're really focused on needing to comply with a protocol correctly, it can take us out of the place where we're, you know, with the client.

I think that's one thing I'm, I'm actually looking forward to discussing more in the workshop is kind of how do you Meet the requirements of organizations in terms of suicide risk assessment, but also do an assessment. That's going to help you join with your client to better understand the function of the behavior that, suicidal ideation or, or, uh, you know, actions are playing for them.

Debbie Sorensen: I think that's right. This is my opinion. Is that. It is important to do a full, complete risk assessment, but it's partly the, how are you doing it? You know, are you doing it in this collaborative sort of open, exploration way? Or is it more like a box checking kind of thing, but then also [00:19:00] that's not all you're doing, right?

You want to do that, but then you also need to address it clinically because if all you're doing is the risk assessment and then that's it, you're missing an opportunity.

Sean Barnes: Absolutely. Yeah. Huge opportunity really. I mean, I think suicide, you know, consideration of suicide often comes at a time when people are feeling pretty hopeless about life and maybe have tried a lot of other solutions and are feeling lost. And, um, I think that can be a really poignant tone too. To do work to help them shift that hopelessness to, uh, more around the control agenda.

Right? So this, that kind of, you know, standard act, uh, idea that a lot of what we do is focused on avoiding our uncomfortable or unwanted internal experiences and, um, You know, it can be a really important time for change for people to sort of shift a trajectory when they're in a place where they're, they're considering suicide.

Um, but as you know, if we get too caught in our desire to kind of [00:20:00] control their behavior, check the right boxes and our anxiety shows through, I think that also can have unintended consequences as far as clients potentially, uh, shutting down and, and. Being less willing to go there with you, uh, to a place that's, I think scary for both parties.

A lot of the time, you know, such a high, high consequence, um, you know, in terms of lost opportunity. . I think for that reason, it's very important to know what kind of personal barriers tend to come up for you, you know, as a therapist, working with clients who are suicidal and practicing some mindfulness of your own behavior and your own thoughts and emotions that, uh, might be uncomfortable and difficult to sit with, that can go a long way to giving you the ability to be flexible in the way that you are as a clinician, um, and not have.

You know, unintended negative consequences, uh, come out of a place of concern and fear.

Debbie Sorensen: absolutely. I think it's important as a [00:21:00] therapist to really be open to that and have your own awareness. So they don't get in the way of doing the best work you can. Yeah. So Sean, how is the act approach to conceptualizing suicide unique compared to traditional approaches?

Sean Barnes: So often a suicide risk assessment focuses on more of a. Kind of structural assessment of, uh, suicidal ideation urges. So looking at things like, you know, frequency and duration and planning and behavior, which are all very important, but I think it can fall short in terms of understanding the function of suicidal behavior and, you know, act being based in, um, contextual behavioral science really does.

Call upon the clinician to help clients uncover why, why suicidal ideation and behavior is being maintained. So we can take a little bit more of an idiographic approach, I think, [00:22:00] and kind of dig into the specific experiences that people have, uh, to help them see. You know, why does suicide continue to come up for you?

We know. Why do you continue to think about this? And what different points might we be able to intervene to help you meet, meet your needs, but without using suicide or thinking about suicide as the solution to your problem.

So in considering the, the function of suicidal behavior, um, Act recognizes that, you know, are at clinicians should say, you know, recognize that there are many different pathways or, you know, events or, um, functions that can lead people to consider suicide.

But there's this big convergence on kind of rigid and unworkable attempts to control unwanted, mostly internal experiences. Right? So suicides, ultimately part of, um, this larger control agenda. That can be used to undermine. And one of the things that I think is amazing is when you can [00:23:00] demonstrate that for a client, it can be a real aha moment for them to see the connection between a lot of the social learning that, uh, we do, you know, as kids around, um, you know, needing to, uh, get rid of, or fix things that are bad or broken in the external world that we get pretty good at.

And then, um, Being delivered similar messages about our own emotions. You know, our society definitely teaches the message that we should be able to make ourselves happy all the time. And if we can't, then there's something wrong with us and that's just, you know, not. Not real life. Uh, you know, we are thankfully animals that experience, uh, a wide range of emotions, a wide range of thoughts, and that gives us the power to be successful, but can also keep us trapped.

And when people are working too hard to avoid, uh, these unwanted experiences, their behavior tends to get more and more constricted, more and more rigid. Um, you know, so you can think of, I think a [00:24:00] really good example is, um, someone who starts using

drugs as a way to avoid, right. So I can use heroin and pretty quickly escape, um, unwanted thoughts and emotions.

And it's pretty effective, you know, in the, in the short term, certainly reinforcing and then. You know, my life starts to revolve around that, right? The long-term consequences of, of heroin use, I would argue, I hear that, you know, very negative, um, and you know, life starts to become about a way of avoiding pain and suffering the way of not getting dope, sick, you know, a way of, um, continuing to be, be numb and, and avoid contact with this painful reality.

And a lot of ways suicide is, you know, another step in that direction. So when someone feels like they've. They've tried a lot of different ways to fix the way they're feeling that have been unsuccessful. The mind continues to play out this, this control agenda. Like we need to get rid of it. And if nothing else is working well, you know, maybe I'm the problem.

Maybe [00:25:00] life is the problem and it should. Should kill myself and it would stop. Um, so in a lot of the creative hopelessness work I do with clients, we will take a look at really all the things they've tried to, um, get rid of unwanted, um, internal experiences, you know, and wandered emotions and thoughts and, and kind of how, how that's worked for them.

You know how successful it's been and what the cost of that have been. Um, I think it's, it's a really nice, um, assessment method. I know it's one that, um, Kirk Strosahl and Patti Robinson talk about and in a focused acceptance and commitment therapy, and can be a nice way to highlight that, you know, suicide is just another part of this larger, larger series of things that you've tried that have.

You know, maybe had some short term efficacy, but don't last in the long run and typically come at a really high cost, you know, to the point where now your life is, feels so small and so constricted and so painful that. [00:26:00] There isn't as much worth saving as there might've once been, you know? Uh, so I think suicide or acceptance and commitment therapy rather is, uh, a wonderful way to, um, better understand the, the function of suicidal behavior within this context of this larger.

Control agenda. Um, sometimes that can oversimplify things a little bit. Cause I do think, you know, suicidal behavior has a lot of functions both internally and externally typically. And, um, that's why, you know, in, act we use functional analysis as clinicians to better understand behavior on a regular basis.

And, a lot of times we'll incorporate a chain analysis, um, which is a little bit more of a structured approach to a functional analysis that gets used a lot at a DBT it's kind of ground.

Out of that, Related, contextual behavioral therapy. Uh, so my colleague Lauren Borges has done a lot of great work. I [00:27:00] think considering how, um, to use chain analysis within the context of act and that's something, you know, we would definitely be talking more about at the workshop,

Debbie Sorensen: um, Oh, first of all, Lauren Borges has been on the podcast before she talked about moral injury.

So shout out to, she's also part of that pre-conference workshop we're doing. Um, I just wanted to say, I learned to do chain analysis when I was. Training in DBT years ago. And it's so helpful, I think, as a clinician and just often just really breaking it down, like what was the situation?

Okay. And then what happened? And then what happened and what were you thinking and what were you feeling? And, you know, these moments when people make decisions and they may be engaged in certain behaviors related to suicide, it's really important to understand what's going on there and also to help them kind of see places where.

Okay. Maybe I could have done this. Maybe I could've done that. You know, what are the consequences? And I mean, to your point about function, there's usually something reinforcing about it, especially if [00:28:00] it's a behavior that's maintained over time. You know, people wouldn't keep doing it. If it wasn't, if there wasn't something going on on the functional level to keep it going.

Sean Barnes: Yeah. Yeah, exactly. I mean, I think, um, suicide, uh, is considered because we're looking for some sort of, uh, a solution to a problem and often meets immediate needs, even, you know, just thinking about suicide. It's been interesting working more with chain analysis and teaching it to providers.

It's something that comes up a lot during that consultation service and, and, uh, Lauren and I have had the opportunity to do some, , seminars on it and, uh, also a podcast, uh, on it, which we can link to. I was able to interview her about chain analysis. And I think for a lot of clinicians who came from kind of behavioral programs or real behavioral training chain analysis, sort of a bread and butter thing that, that people know how to do.

Uh, and then for. Other clinicians, I [00:29:00] think like myself who were trained in more of a kind of cognitive behavioral, uh, program there's, uh, they've had less exposure to it. I think he described it really well. Debbie, in kind of the way that you help. Clients slow down and look at the sort of series of thoughts, emotions, physical sensations, urges, you know, behaviors that occurred leading up to a particular behavior.

You want to understand in this case often, you know, thinking about suicide, planning, suicide, or actual suicidal behavior, and then looking at the consequences of those behaviors. So, you know, how did I feel immediately after. I came up with a plan for suicide relative to how I felt immediately before.

Right. And often that can speak to the, the reinforcing, uh, nature of the suicidal ideation. Then also asking how, how did my environment respond right afterward? Right. So what happened? Um, when I, when my family found out that I was considering [00:30:00] suicide, you know, was there more support. That was given to me.

So it's a really nice way to help people look at suicidal behavior, um, and, uh, including internal behavior, you know, suicidal ideation and, and consider why they do it. I think when you just kind of blanket say, like, why were you considering suicide? You miss out on a lot of the richness that can come from the details of a chain analysis.

And it's also a really like non-stigmatizing way to help people recognize the. Role that their environment can sometimes play in reinforcing the behavior, you know? Often, um, we'll ask people, you know, is your suicide motivated by like escaping the pain you're in or trying to influence other people?

Um, and I think that was a, it's a standard question. One of the interviews that we used to do, and almost everybody said, you know, it wasn't all, it was just about. You know, the pain I was in. Um, but then if you take a closer look, um, even if they're not intending to influence their environment or other people, their environment, and other people still respond, [00:31:00] uh, so it can highlight, it can highlight useful ways to help families and loved ones provide support that isn't contingent or dependent on this, uh, suicidal, you know, behavior threats.

Debbie Sorensen: you know, I think that's so important. It's a little counterintuitive to think, to think of something like a suicide related thought or behavior having any kind of function that could be reinforcing because, I mean, I think our immediate instinct is like, Oh, that's not good. Why would you, why would you do that?

But if you take a look at it, I think as a clinician, Really understanding the functional level can also help inform it can help inform the clinical steps that you're going to take, because if you don't really understand the function, you won't really know what's needed to be able to work effectively with the client.

For instance, you know, if, if suicide is really like I'm suffering so much, I can't think of any other way to. Resolve this problem. That's one thing. [00:32:00] If it's more, you know, if it is getting sort of socially reinforced, that's another, I've also had clients before who they have these thoughts of about suicide.

And they're very disturbed by them because they've become this big powerful thing. But in fact, it's just more like a random thought, but then the thought itself becomes distressing. And I think that's a very different thing in that case. What you want to do is actually sort of disempower the thought and just be like, you know, it's just a thought, it's not really something you have to get too distressed about it.

Just let it come and go through your mind. And you could think how in all of those different situations, the way that you, as the clinician are going to approach. The work is going to be very different.

Sean Barnes: Yeah, absolutely. Yeah. Chain analysis does a great job of highlighting key cognitions and emotions to then target, you know, through, um, act processes, you know, by engaging now diffusion acceptance or more generally, you know, mindfulness [00:33:00] work. , So I think that it's a really useful tool, um, in the, we probably don't, don't have time to go into a lot of detail today about like what shading analysis is, but we can link to some other resources that, that have more information and, um, You know, just to say that I think, uh, although functional analysis is built into act, um, chain analysis, isn't something that is always used.

And I think it can help us move past. And understanding of suicide is only, um, experiential avoidance. I think it largely it's, uh, often, you know, related to experiential avoidance, but it's important to also capture, um, the way the person's environment is responding and, and, um, other ways that the.

Behaviors could be being reinforced. So it's kind of more of a fine grain. I find, fine grained way to assess the function of suicidal behavior.

Debbie Sorensen: I think we should move into talking a little bit more about the actual, you know, [00:34:00] intervention piece of using this act approach. And before we talk about that, I want to just say to me, you know, what you were saying earlier about just how There's something functional underneath us. Usually it's about trying to control something and people have tried so many things. And I want to just say, as a clinician, when I talk to my clients about this, I think they find it really validating because usually it's not the case that they're, they really want to die.

In fact, the opposite. It's more that they don't know what else to do. This, to me feels very, De-stigmatizing and validating. And then from there it sort of opens them up to other possibilities. Cause usually people are just really stuck. They're doing the best. We're all doing the best we can, but they're stuck.

And I think that there's so much hope in just acknowledging that and that, and then together saying, okay, let's try a new approach. Let's try something different here and see what happens. Because I think that, you know, people are reaching out for help because they just don't know what to else to do.

Sean Barnes: Yeah, [00:35:00] exactly. I think suicide comes when you really don't know what else to do. And there can be this. Kind of a tunnel vision that develops around, uh, suicide is the only option. It can be really difficult to see alternatives and in life very much can be about that escape from the unwanted, you know, experiences and act as a great job of both helping people.

kind of normalizing that, you know, like, of course your mind goes to this place, right? Your mind is this problem solving machine and look at stride, all these other things, and that hasn't worked. So we're going to go here, but like, what if there was another way, right? What if we didn't need to get rid of that thought?

What if you didn't need to get rid of that pain? Um, and, and really helping someone make a turn toward torn, willingness and calling out this, um, Geoff Smith often will say in his groups, which I, I love this, he'll often say that you've been, you know, sold this, uh, kind of false bill of goods. You know, you've, you've bought what society has taught you [00:36:00] and you're on an impossible mission, you know, to be able to just get rid of these things. Um, so there's this shift from I'm failing at this to wait.

This is like an unreasonable, unworkable. Thing to be trying to do to not feel sad, to not, to not experience, um, pain and instead, you know, helping people see, uh, opportunity in life, if they can, be willing to experience some of that discomfort and then move in a direction that actually has meaning to them.

Um, and what, we'll talk more about the specifics of that in a minute, but I think that's one of the most. It really rewarding, um, moments for me as a clinician that I've had is when clients have, you know, people who have had chronic suicidal ideation, you know, multiple suicide attempts off and we'll have this aha moment of like, wait, like I can have that thought and still. Like do the things I wanted to. and, and I think if you can [00:37:00] help people get to that point in a way that isn't, um, making light of it or presenting it as like easy, you know, it's not like, Oh, you just need to let go of this on workflow. Agenda of control. And your life is going to be great. Like, no, these people have like significant problems often.

That's why they're in the place. They are. But it's tremendously freeing to present an alternative for them, you know, a real shift in the way they've been working so hard on this problem of life.

Debbie Sorensen: Yeah, like it's not your fault, you know, it's the, it's the bill of goods. I love that. Well, let's talk a bit about your in, in intervention that you're working on. Cause you've been doing research on an intervention called act for life. Tell us a little bit about what you're doing.

Sean Barnes: All right. So we're doing act. I think one thing I want to say up front, right, is that we don't have, uh, there isn't like a say not trying to sell a secret sauce or anything. You know, I So, yeah, it was it, you know, initially this protocol was developed, [00:38:00] uh, as a way to help inpatient clinicians, Provide some guidance and engage people in act to help them maximize their recovery after a suicidal crisis has led to hospitalization.

Um, but the work that we've done has really expanded past that to kind of more generally considering how do you engage people and act to not only prevent suicide, but also, you know, build lives that people will find, um, you know, vital and meaningful and be motivated to. To live. So that's kind of why we've called the act for life.

Um, you know, we view suicide prevention as a, a vital, but, uh, just an initial step in helping someone recover. You know, I think if we stop at suicide prevention, we fall short of our goal of helping people, you know, really live. And, uh, this work, you know, initially, um, you know, was started by the, the group of collaborators that I've mentioned before.

So, Geoff Smith, Nasi [00:39:00] Bahraini, Robyn Walser and then, and then Lauren Borges has had a tremendous impact on it as well. And. We originally did a formative evaluation, which is just a fancy way of saying, we asked a bunch of leading experts in the field of act, um, kind of what they would do if they only had like three hours with the client who was considering suicide, or maybe it just attempted suicide.

And we proposed sort of an, an outline of some things that, you know, intentions that we would have things we would try to accomplish. Um, but then really looked to them for. For feedback. If I remember Debbie, I think that you were one of those, those experts, um, along with a bunch of other, um, you know, leaders in the field.

So I really, uh, in grateful to the people who participated in that

Debbie Sorensen: You're right. I did. Thank you, Sean.

Sean Barnes: you're welcome. Yeah. Thank you. So. There were a lot of people involved, I would say, [00:40:00] in the creation of this protocol. Um, and it is one that we haven't disseminated widely.

Cause it was meant to be more of a research protocol initially. And we've been moving in that direction of, you know, trying to figure out how to do, do you use, uh, a manual to, um, help people do this work? That's a little, I mean, Debbie, I guess, uh, you know, I think you've probably had people. Right. I know you've had people on the show.

Do you know, have, who have talked about, um, process-based therapies, right. And really the beauty of act is that we can respond to what the client's doing in front of us and not be stuck in a, uh, kind of paint-by-numbers therapy. So there's this tension between wanting to find a way to, um, teach people about how to use act for suicide and not make it be a paint by numbers, um, in a way that could have a negative.

Effect um, so. So after [00:41:00] we did that initial, uh, formative evaluation and kind of came up with a manual, we, um, were lucky enough to receive some support from VA rehabilitation, research and development, uh, to do an initial study of act for life, to see whether people found it. Uh, useful, whether they found it to kind of meet their, their needs and be, um, what we call it, you know, acceptable and whether it was feasible, whether we could actually engage people in the intervention during a brief hospital stay, um, kind of how well were people tolerated.

I think within the. Our community at the time, there were still questions about like, can you really do like creative hopelessness work with someone who is feeling really hopeless? Um, you know, and, and some concern that engaging in intensive therapy, you know, might be too much for someone who's recently had a suicidal crisis.

So this initial study helped us answer some of those questions. So, uh, after [00:42:00] we did the kind of evaluation, we had kind of a bare bones manual and that's been, you know, developed over a number of years through some research that we were able to do, uh, that was funded by, uh, VA rehabilitation, research and development. Over the course of a couple of years, we did an acceptability and feasibility study where we were able to kind of tweak and continue developing.

The the manual. And, um, it really is meant to be a, a process-based approach to using act and engaging act with people who are super suicidal or have been considering suicide. And. Isn't necessarily, um, a manual in the traditional sense of here's session, you know, I'm on session three. So today I'm going to say these things.

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But we do have kind of three broad overlapping modules with specific intentions and in the first. Yeah, the intention really is to join with the client to undermine the [00:43:00] control agenda. So it's, uh, a lot of, um, kind of what I, you know, we were just talking about helping people understand the function of their suicidal behavior, kind of pulling back the.

The curtain on the wizard of Oz, you know, of like, why, why do I keep doing this and normalizing it? Um, to some extent as, uh, you know, normalizing suicidal ideation, thoughts about suicidal ideation or even suicidal behaviors as, um, a place that it minds will turn to when they get stuck. Um,

so we do a lot of, you know, empathizing with the desire to end suffering by suicide and, uh, quite a lot of creative hopelessness work on the.

The front end to, to help people start to release, um, their, their grip on being determined that they're going to, you know, avoid these unwanted internal experiences and thoughts.

Debbie Sorensen: Well, I find that creative hopelessness is important and it's, well, first of all, I want you to maybe [00:44:00] say a little bit more about what it is. I also just as someone, you know, a clinician myself, but also I've trained other clinicians in this approach. I think sometimes. It feels a little, um, they might be reluctant to do this because it feels like trying to let go of something.

That's like, it feels a little scary. So tell, can you tell us a little bit more about that and like why it might be helpful?

Sean Barnes: Absolutely. Yeah. So I mean, creative hopelessness is about, um, helping people feel hopeless about the control agenda, right? So helping. People feel that the approach they've been taking to avoid in getting rid of unwanted internal experiences. So thoughts, emotions, physical sensations that that's going to.

Ever work, you know, so it's about helping them recognize that this pain is part of life. And, um, we want to help them get to a point where they're ready to pivot [00:45:00] toward a willingness, you know, and, and, um, being more accepting of, of, of that pain and still moving in a direction that they care about. But it's really, you know, and I think I can say as an early.

Like a clinician initially, as I was working with some of this stuff, it is kind of scary to sit with someone who feels so hopeless about life, right. That they've tried to take their own life or they've attempted suicide. And then to sit there and ask them, well, tell me about the things that you've tried and how miserably you failed.

Right? I mean, essentially is, is, um, that's an extreme way to say it, but you're asking about the workability of the different things that they've tried, knowing that it has brought them to this point. So. Clinicians, I think can be afraid to do creative hopelessness work with people who feel hopeless about life.

But I think the really important messages that creative hopelessness isn't about making them feel hopeless about life, right? It's about making them feel hopeless about this control agenda and instead turning toward an alternative [00:46:00] and. That turned toward the alternative is really important too. Right.

And I, I think maybe that's one place that I might differ a little bit in the work that I would do is, is I would want to turn, you know, make that turn like by the end of a session, as opposed

to letting someone sit as an outpatient for a long time with this, you know, um, on unknowing of, of what the alternative is.

So, you know, we present. We talk about, um, you know, like what, what if you didn't need to make your life about getting rid of that pain? What if your life didn't have to be about not thinking about suicide, about not feeling distress? Um, what if we could have that and do things that are, are meaningful and, and also addressing that, like, you know, we're not saying this is a, you know, you just need to have it and, and.

You know, agreed to do this and everything's going to be fine, but we're going to teach you ways to [00:47:00] change your relationship to that pain in a way that will free you up to still live your life. So we're creating hope for them about life, uh, but hopelessness about the control agenda.

Debbie Sorensen: Here to tell ya, as someone who's done this work for a while, that for clinicians, it does sound scary, but almost every client I've done this with or case I've, consulted or supervised on is that clients really resonate with this. And it's almost like this Phoenix rises from the ashes ready to start something new and different because they've been so stuck for so long that it feels kind of liberating.

Sean Barnes: Yeah. Yeah, absolutely. And. Yeah, it's we do it in a way that is very empathic and supportive and collaborative. Right. We're not, trying to belittle their experience or, offer like in a glib way, you know, kind of like, Oh, I have this solution, it's, you know, we're just going to do this. And then life is going to be, you know, better for [00:48:00] you.

Um, You know, it, it, and I think part of that early work in act for life that we're doing is helping to join with the client and, and, um, normalizing that their mind would go there because they've been taught this strategy right over time. So like, of course your mind would go there, but let's, let's look at what the cost of.

All of these things have been and what has made your life, but like, what if you didn't need to keep heading in that direction? Um, so I'll, I'll also S you know, help people highlight the, the cost of suicide, you know, in terms of lost opportunity. And I think even some of the people who have been you kind of the most committed to death by suicide, that I've worked with, you know, have been able to, um, They could still express a good amount of disbelief that they're going to like turn their life over down, but can see that, you know, death is guaranteed.

Like that's, so I'll use that like kind of dark humor sometimes too, you know, [00:49:00] like you're going to die at some point, like that's a given, right. But like, what if you have the opportunity to live? Cause you do. You're like you're sitting here with me. How can you use that opportunity? To maybe do something that will be of value to you.

That'll be important to you. And that that motivational component I think, is really important to suicide prevention work. I think I've done a lot of work with like safety planning. In general. So for folks who aren't familiar with safety planning, it's like making a hierarchical list of ways that you can cope if you're in a suicidal crisis.

So kind of based on this idea that we have trouble thinking clearly when we're in this, um, kind of suicidal frame of mind, you know, things can get narrowed in. It's tough to think about, um, Uh, ways to, to move past it. But suicidal crises typically lasts like 10 to 30 minutes, like the worst of them. So if we can get people through that [00:50:00] point, it can go a long way to preventing suicide.

Um, so we'll work on the inpatient unit to, to help people fill out these plans of how they're going to cope if they are in a suicidal crisis and would regularly be, you know, ask people like, have you filled out your safety plan? Yeah, I've done lots of safety plans. Right. But I haven't. I haven't used them.

I haven't like looked at them after I was discharged. So I think a lot of that is because we need to understand the larger context of their lives and help them have hope for a different and meaningful future, um, that will make it worthwhile to get that safety plan out and take the risk of, you know, calling others for help or, um, you know, Uh, kind of white knuckling it through some really difficult times.

Debbie Sorensen: It's like giving people a why, you know, behind why to do the Y by it's worth doing. And for folks who are listening, we will link to some safety planning tools and materials on our show [00:51:00] notes for today. And we'll be delving into co-creating with your client, an act consistent safety plan in our workshop in June.

So please join us if you want to learn more about. An act, act consistent approach to safety planning.

Sean Barnes: So. Well it's, we talked a little bit already about the first module, kind of, you know, more of joining with the client, helping them understand, uh, where suicide fits within this larger control agenda and trying to, to freedom from that control agenda to turn toward, um, willingness and acceptance of some, uh, pain while also moving toward their values, you know, putting their values into action.

So the second module really focuses on, um, helping to engage those sort of left sided techs of flex processes for that clinicians out there. Um, so things kind of more focused on, on mindfulness and acceptance, and it really, um, the intention is to, to teach skills, to [00:52:00] change the person's relationship with the pain, underlying their desire for death.

Right. So we're not just telling them like, Oh, you need to be okay. Having these thoughts and emotions. Right. Um, we're, we're teaching them mindfulness, um, cognitive diffusion strategies and, um, helping them be able to experience some of those things and, and still, um, move on with their lives. So, uh, I won't go into detail about that.

I think, you know, we use a lot of kind of standard act experiential exercises, um, but really focus in on the key, um, emotions and cognitions that and behaviors that have, uh, been highlighted through that initial work with the client and understanding the function of their suicidal behavior. Um,

Debbie Sorensen: For any listeners who want to learn more about act who are less familiar, check out our podcasts, cause we've done a ton of episodes on various [00:53:00] acts topics. So you have plenty of materials to work with.

Sean Barnes: Actually. Yeah, I think, uh, you know, there are some, some really awesome, uh, episodes on here, Debbie, that think for someone who's trying to get more familiar with act and, and get a sense of, you know, what it's all about. Um, In that second module will also, um, help them start to integrate some of the things we've been doing into their safety plan.

Um, we can talk more or we probably can't talk more today. I think in the interest of time, around what makes a safety plan ACT consistent. I think we'll be able to go into a lot more detail in the workshop we do, but often I just really briefly, I guess, um, we focus a little bit less on, on distraction and kind of, you know, how do you make sense of, uh, wanting to.

Uh, teach someone to use distraction when we're supposed to be about acceptance and, and showing up to your emotion. Uh, so we focus a lot on workability and kind of, you know, what is that distraction in the service of, we also help them, um, identify things that will really be like [00:54:00] a meaningful, positive behaviors that they can engage in while dealing with the crisis to kind of, um, hopefully increase the chances that they'll use that safety plan and do a lot with, um, values and reasons for living as well.

Debbie Sorensen: the way I look at it. When I do safety planning is about teaching them some flexible ways to respond, to build some new behaviors in, you know, expand their behavioral repertoire. Because I think often people get in these patterns in the safety plan can help people think of other ideas of things to do when they're going through a hard time.

So it's really about more flexibility.

Sean Barnes: definitely. Yeah. Um, because. You know, I think being able to consider other options when we're in a state of crisis can be so difficult. So we do a lot of work to help people start practicing things on their safety plan right away, you know, to kind of overlearn it. So it'll be more instinctual, uh, when the time comes.

And then the third module that I [00:55:00] mentioned, really the intention there is like building life. So it's a little bit more about the right side of the text effects processes and, um, engaging, um, values and committed action work to make behavior change. Right. And expand that, um, behavioral repertoire, you know, often we're at least on the inpatient unit.

When we, when we see folks their lives have been, um, pretty, uh, Constricted as a result of a lot of the behaviors they've been doing in the service of experiential avoidance, right. That they've lost a lot of the meaning in their lives. So the really critical part of the work, um, is helping people start to identify and frequently engage in value, consistent behaviors, to build more meaning into their life and help them identify more reasons for living.

Um, and. We do this right away with people, right. So it's not something like, Oh, when you get discharged, you're going to need to figure out how to do this. Or, um, you know, [00:56:00] as a, if I was working with someone as an outpatient, you know, that like, Oh, well,

we'll get to that. Um, You know, finding meaning part, but towards the end, once you've learned a bunch of skills, you know, instead it's like, what can you do?

You know, after the first session to, um, that would, that would bring, that'd be important to you, you know, that would, that would, um, bring one of your values into action. And then a lot of times, too, in the third module, we will help people with skill development, you know, so if they have, um, you know, deficits in, in problem solving or kind of setting realistic goals, we'll work with them, um, to, uh, build more workable ways of dealing with the problems that, um, are driving some of their suicidal behavior.

Debbie Sorensen: It's uh, was it Linehan from DBT who first said build a life worth living, right.

Sean Barnes: Yeah, exactly. I think, you know, [00:57:00] the work that we do is totally in service of that, that goal of building a life worth living. Um, and a lot of the times, you know, people who are. In a lot of distress and suicidal, um, have difficulty identifying what w what a life worth living would look like for them, because it seems so unattainable.

Um, so we'll help them kind of see the connection between their pain and their values. Um, you know, Steve Hayes, right. Um, and others have said that re we hurt where we care. Like we only care. We wouldn't, we wouldn't get upset about things unless we cared about them. So helping people see, you know, what about the pain they're in actually points toward a meaningful life for them?

Um, And in, in a way that's achievable. Yeah. So a lot of times, you know, it's about shifting, um, shifting their goals. Um, you know, people can get stuck on their minds, can get stuck on [00:58:00] those, you know, lost relationships, uh, decisions that are regretted, you know, missed opportunities, um, you know, morally injurious events and focus so hard on trying to.

Um, fix that things that happened in the past in a way that isn't achievable, you know, how can we recognize the values that are in the fact that you care about that? And then how can we put those values into action?

I really want people to have a vision of what a life could look like for them.

And also acknowledging that there are going to be bumps in the road. Uh, you know, it's not a, um, thankfully it's not a one and done kinda kind of thing. It's, uh, you know, life is something you get to continue working on and every day you have the opportunity to do something that's important.

Debbie Sorensen: well, this is great, Sean. I really appreciate the work that you're doing and, and that you're bringing. To the people who are suffering and also [00:59:00] to, to do this effective work. Is there anything else you wanted to add? Did you want to follow up with anything about

Sean Barnes: I think one of the, I think the only other thing I'd like to get in is just a quick, um, reference to like the article. If people want to know more about

Debbie Sorensen: yes. Oh yeah, yeah,

Sean Barnes: grant, um, for the efficacy trial, um,

Debbie Sorensen: Okay.

Sean Barnes: um,

Debbie Sorensen: Do you want

Sean Barnes: So, yeah, so, I mean, if people are interested in learning more about, uh, how are, you know, using act to, um, work with people who are at risk for suicide, um, there is a paper that's in press right now and available, uh, through.

The journal of contextual behavioral science that we published on the pilot trial for acceptability and feasibility trial that we did of act for life on the inpatient unit. So that, that has some good information in it. And, um, you know, thankfully the, the result of that study was that that veterans found.

The intervention, they perceived [01:00:00] it to be beneficial. It wasn't the study wasn't designed to see if act was going to prevent suicide or, or, um, improve functioning because the samples were still pretty small and we were still developing the protocol. Um, but it really supported moving forward to a larger trial.

So, um, recently we had, uh, an application for a multi-site, um, efficacy trial to look at whether act. You know, can be used to prevent suicide and increase functioning. Um, we recently had an application selected for funding, um, with the rehabilitation, research and development. So starting later this year, we should be doing, um, a four year study.

Uh, that's going to be looking at, uh, act for life is one intervention to help, um, improve functioning and prevent suicidal behavior. So I'm really grateful for it. Well, you know, I think it's going to be that opportunity and, uh, to get to continue this [01:01:00] work with you, Debbie.

Debbie Sorensen: well, likewise, Sean, I so appreciate the work that you're doing in this area. It's really important. And we will link to that article on our show notes as well as some other resources. For both clinical tools for working with suicide, but also some more general, you know, suicide research resources on our show notes for today.

And as a reminder, please join us along with our colleagues in June for our workshop, where we're going to delve more into this and learn more about using act for suicide. Shawn, thank you so much. It was really great to have you here today.

Sean Barnes: Ah, thank you, Debbie. I really appreciate the opportunity and, um, just love this work and, and you know, our, our collaborators in it. Uh, I really hope that anybody who's out there listening today who needs support, um, because of suicide. Ideation or behavior we'll we'll reach out. Cause there are, um, a lot of opportunities to, to find a way forward that doesn't [01:02:00] involve suicide.

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