Spring 2019

CCPA NEWS

The Contra Costa Psychological Association Newsletter

In this issue:

President's Message

Greetings Everyone,

Your lovely psych association currently has a few requests out to its members. Here is a rundown.

- Tell us who you want as a speaker. We want to provide informative, relevant, and intriguing CEs that you all want to hear. So please do let us know of any and all speakers and topics that peak your interest.
- Please post a photo of yourself on our official, public-facing membership list. The silhouette with a giant question mark is not what we would like to display on a website representing professionals.

This is you, isn't it?

- CCPA is *your* psychological association, so we are asking you to make a contribution as a board member. Please attend a board meeting to see what your board is doing for you, and consider joining. Meetings are on the second Tuesday of the month at 11:30 at Dr. Andy Pojman's office.

We would like to take the time to recognize several members who have dedicated their time and energy to making CCPA run.

- Thank you to Drs. Barbara Peterson and Ellin Sadur for their many years of service to the Board. Drs. Peterson and Sadur both served in several positions over the years including chair of our Disaster Response, LAN, and Secretary. Drs. Peterson and Sadur have both lent their years of experience and knowledge to our board, helping to keep the board on track and moving the whole of CCPA forward. We owe them many thanks for their dutiful service.
  - ◊ As Dr. Barbara Peterson has moved on from the board, we would like to welcome Dr. Paige Leopold as the new CCPA Secretary. Her first official duties were to record the minutes of our annual meeting in February which you can find on our website.
  - ◊ Dr. Jonathan H. Feinberg has taken the reigns of CPA representative from Dr. Ellin Sadur. He has just returned from his first training and lobby day in Sacramento and you can read about it in his article in this issue.
- Thank you also to Dr. Hengameh Maroufi who has left the position as our president. One of her great contributions as both Diversity Chair and President was to insist and guide us towards greater inclusiveness. Due to Dr. Maroufi's efforts, CCPA now formally, in writing, asks each presenter to include information from underrepresented groups.
  - ◊ Dr. Marc Komori Stager (me) has taken over as president from Dr. Maroufi. His greatest task is to transition from an empathic, client-centered active listener to an interrupting agenda-focused efficient leader.

Here are a few upcoming events the Board would like you all to know.

- If you would like to gather with psychologists to discuss the ins and outs of establishing and maintaining private practice, consider attending the Practice Building Group which meets once a month. Please contact Dr. Alexis Smith-Bauman for details.
- If you are looking for a casual way to connect with others within CCPA, don't forget about our ongoing First Friday's. Please contact Dr. Alissa Scanlin for details.

Sincerely,
Marc D. Komori Stager
Your CCPA president

CPA Leadership and Advocacy Conference 2019

Dr. Feinberg Goes to Sacramento

As the LAN Representative for Contra Costa, I attended the CPA Leadership and Advocacy Conference and Lobby Day on March 17th and 18th. The conference and lobby day are an opportunity to learn how to advocate and promote the profession of psychology. It was an incredible and invigorating experience that provided an opportunity to network with psychologists from across the state and lobby with colleagues on issues important to improving the mental health services provided in California.

On the first day of the conference, we learned from CPA president Dr. Daniel Rockers and CPA-PAC chair Dr. Sheila Morris about the work that California Psychological Association and the CPA-PAC have been doing to ensure psychologists have a voice when legislation is proposed in California. We also discussed CPA's official positions on a number of pieces of legislation (which can be found on the cpapsych.org website), which was led by the CPA lobbyist Amanda Levy and CPA LAN Chair Dr. David Hindman. We learned the "do's and don'ts" of lobbying and the ways in which we can increase psychologist's involvement in the community. It was also a wonderful opportunity to learn what events other chapters have organized, and I was able to meet with the president of the Orange County and Alameda County psychological associations.

On the second day, I joined psychologists and students from Alameda County to meet with staffers of Northern California state representatives. We met with the staff of the state representatives for Contra Costa County, including Assemblymembers Timothy Grayson (14th assembly district) and Rebecca Bauer-Kahan (16th assembly district), and Senator Steve Glazer (Senate District 7), as well as a number of representatives from Alameda County. We expressed CPA's support of three upcoming pieces of legislation and to inform them of a training program for dealing with distressed constituents that was developed by CPA. We provided information about the bills and explained why it is important to support them. The staff expressed support for these bills and were excited about the prospect of receiving the training at the district level.

The first, SB-66, proposed by Senator Atkinson, would require the Medi-Cal program to reimburse Federally Qualified Health Centers and Rural Health Clinics for two visits if a patient has both a medical and mental health visit on the same day. This would make it easier for patients, particularly individuals with fewer financial resources, to receive mental health care as they would not need to return on a second day to attend a mental health appointment.

The second, SB-11, proposed by Senator Beall, is related to mental health parity (no higher co-pays, more restrictive limits on visits, higher deductibles for mental health treatment compared to medical treatment) for insurance companies. It would require insurance companies

to submit an annual report to the Department of Manages Health Care of the Department of Insurance to certify compliance with state and federal mental health parity laws.

The final piece of legislation, AB-1601, proposed by Assemblymember Ramos, would establish a permanent Behavioral Health Deputy Director within the California Office of Emergency Services in order to better coordinate access to mental health and behavioral health services after a natural disaster or declaration of a state emergency.

Finally, we also discussed a training program that was developed by CPA in conjunction with the Senate Office of Training and the Capitol Institute, called the Guide to Dealing with Distressed Constituents. This training can be offered to staff members of state representatives either in Sacramento or at the district level.

It was a highly productive two days, and it was exciting to see the work that members of the CPA are advocating for psychologists on the state level. Continued support, financial and otherwise, is needed in order to represent the interests of psychologists and other mental health providers. If you are interested in learning more about the bills that CPA supports, the Guide to Dealing with Distressed Constituents training, or how you can help support CPA, I would be happy to speak with you!

Editor's Note: CCPA always appreciates contributions from members summarizing CEs and workshops. Below is a thoughtful article by member Bruce H. Feingold, Ph.D.. He provides information, commentary, and implications on CCPA's most recent CE by Dr. Joiner. If you would like to read a short synopsis of the CE, you can refer to CCPA's Ethics and Professional Relationships Board Member Dr. Susan O'Grady's summary in the link provided here.

THOMAS JOINER

WORKSHOP ON SUICIDE:

Clinical Implications and Comments

by Bruce H. Feingold, Ph.D.

On February 23, 2019, Contra Costa County Psychological Association hosted a continuing education course, *The Interpersonal Theory of Suicide: New Developments, Ethical Considerations*, led by Thomas Joiner, Ph.D., one of the premier contemporary thought leaders and researchers on suicide. This article summarizes the salient aspects of Dr. Joiner's Interpersonal Theory of Suicide drawing upon both the continuing education course and from his book, *The Interpersonal Theory of Suicide* (2009). Additionally, this article will include general information on suicide, comments on the clinical applications of Joiner's work, a discussion on complementary theories, and clinical implications.

General Information About Suicide

Dr. Joiner described how the suicide rate in the United States has increased significantly in the last 20 years, but the global suicide rate has actually decreased. There is no definitive answer to this discrepancy, but access to guns, increased exposure to violence in the media, increased substance abuse (especially opiates), and changes in economic status most likely play a large role. Poverty and lower economic status have been consistently correlated with higher suicide rates, and in the United States, the suicide rate along with the alcohol and substance use has increased from 2000 to 2016

for white Americans, especially in rural areas hit by the loss of economic opportunity (Weir, 2019).

Individuals who complete suicide range across every age, ethnic group, and diagnostic category. People suffering from anorexia, major depression, bipolar depression, schizophrenia, and borderline personality are most likely to attempt suicide, but only a small subset of any of these diagnostic groups will complete suicide in their lifetime. The higher risk populations include older white men, Native Americans, LGBT individuals, and Veterans. While women attempt suicide at a much higher rate than men, men complete suicide three to four times more often than women. Substance abuse, trauma, childhood abuse, previous suicide attempts, and a family history of suicide are risk factors for completed suicide (Weir, 2019). Finally, Joiner noted there is a new avenue of research which demonstrates the impact of genetics on suicide.

Dr. Joiner stated that 70% of persons who complete suicide discussed their ideation beforehand; however, 30% of individuals did not disclose thoughts and plans. It is troubling and humbling, and potentially damaging to clinician's feelings of effectiveness, to have patients with serious suicide attempts or who complete suicide yet deny suicidal thoughts or minimize suicidal thoughts and intentions. This dilemma points to the complexity of assessing risk factors and making accurate predictions that were highlighted in an extensive meta-study on predicting suicidal thoughts and behaviors (STB's). Franklin et al. (2017) summarized, "This meta-analysis found that, based on the existing literature, all STB risk (and protective) factors are weak and inaccurate. This general pattern has not changed over the past 50 years and was not meaningfully moderated by study characteristics (e.g., length, sample severity) or type of risk factor (e.g., internalizing psycho- pathology, prior STBs" (p. 217). Summarily, most psychologists will lose a patient during their career to suicide and unfortunately, psychologists are not omniscient. Accurate prediction is incredibly difficult, and tragic outcomes cannot always be prevented.

Dr. Joiner described suicide as a premeditated, carefully planned act that is not "done on a whim." Joiner did not link suicide with impulsivity given that older men are much more likely to complete suicide compared to adolescents who are developmentally more impulsive. Joiner described how a suicidal individual meticulously plans to kill him or herself; there is often a suicide note, a high level of intent, and a specific concrete plan with careful preparation. For example, Joiner described a typical scenario where a man plans to kill himself away from home so his wife or children would be spared from discovering his body, which shows forethought and planning as opposed to impulsivity.

Though suicide may not be linked to impulsivity, there is a category of individuals where under the duress of multiple stressors suicidal despair may rapidly appear. It is uncertain if Joiner would label these situations as "impulsive," but this profile does not seem to fit the category of individuals who carefully plot out their death ("Treat Suicidal Thoughts").

Finally, Dr. Joiner delineated the psychological state immediately before suicide as remote, detached, and resigned but may also include severe agitation, insomnia, and weight loss. To my knowledge there is not a specific name for this unique state of consciousness. On one hand, a person may be highly focused, organized, and intent on dying, but on the other hand, the person appears remote, as if he or she is not present, and life has been drained out of that person. The concepts of shock, dissociation, and derealization come to mind and is a different psychological state compared to an individual with schizophrenia who hears command voices to commit suicide.

Maltsberger (2004) described this same phenomenon from a psychoanalytical perspective that focused on affect and ego functioning. In the first phase an individual becomes overwhelmed and flooded by unbearable emotions of pain. In the second phase, the patient tries to master, regulate, or tolerate these feelings, but his or her defenses break down, resulting in unbearable anxiety. The key psychological state is "desperation." For example, I was with a patient during an episode like this and he screamed, he was "drowning," "feeling out of control," "losing my mind," and "I hate myself." As therapists (or family members) it is nearly impossible to calm someone down in this phase of a suicidal crisis. In the last phase, with a severe loss of ego functioning, the door is open for extreme attacks on the self, a loss of reality and an attempt to escape by killing the 'bad' or 'weak' self.

The Role of Suffering and Pain: The Groundbreaking Work of Edward Schneidman

In the course Dr. Joiner alluded to the intense pain and suffering of suicidal individuals. However, because Joiner focused on interpersonal cognitions, which in his view produces suicidality, there lacked an emphasis on the affective experience of suicidal persons.

Edward Shneidman, Ph.D. was the first prominent, contemporary suicidologist, who described the unbearable painful affect of suicidal individuals and the wish to escape the pain by killing themselves. Suicidal persons view suicide as a solution to a problem they perceive as impossible to resolve. Schneidman, who founded the American Association of Suicidology and one of the first Suicide Prevention Centers, coined the term "psychache" to describe the overwhelming, acute emotions of a suicidal person. I find Shneidman's concept of 'psychache' significant because it is imperative for patients to know we understand and can bear witness to their pain. While family and friends often reassure suicidal persons that everything will be okay, change the topic quickly, distance, or admonish them to buck-up and cope, psychotherapists are in a unique role to listen non-judgmentally and understand a patient's torment. Counter-transference issues of working with suicide may include, reassuring too quickly, minimizing pain and suffering, distancing, or teaching techniques too quickly, rather than sitting with and allowing individuals to express their pain and the ambivalence about living. From my perspective, acknowledging and listening to the profound ambivalence and the deepest level of a suicidal person's suffering is the foundation of suicide prevention (Meichenbaum, 2007).

Joiner's Interpersonal Theory of Suicide

Dr. Joiner founded the Interpersonal Theory of Suicide which describes three conditions which must be present for an individual to complete suicide: thwarted belongingness, perceived burdensomeness, and "acquired capacity." In other words, the dual experience of isolation and feeling like a burden, overwhelms an individual's ability to cope, increases pain and suffering and leads to a wish to die. Then, if the person has acquired the capacity to die, which will be defined later, a suicide attempt is likely.

In the course Dr. Joiner also portrayed the intense and tortured debate between an individual's wish to live and wish to die. He characterized ambivalence as a typical state of suicidal individuals and pointed out that killing oneself is hard to do; human beings are wired for self-preservation, and most human beings have an innate fear of pain and of dying. Joiner (2009) quoted Camus in the Myth of Sisyphus, "The body's judgment is as good as the mind's and the body shrinks from annihilation." Joiner recited how many individuals at the last moment cannot successfully terminate their life as the will to live kicks in.

Thwarted Belongingness

Thwarted Belongingness occurs when an individual feels isolated and alienated from his or her family, peer group, and/or culture. The predominant experience is "I am alone." (Joiner, 2009). In my experience the individual feels not only alone but unworthy and unlovable. Let me also connect that loneliness and isolation correlate with our knowledge about the role of loss, abandonment, insecure attachment, and poor parent-child attunement in the psychological features of depression. Also, loss is one of the primary triggers for a suicidal crisis.

It is important to note that Dr. Joiner illustrate that the feelings of isolation, loneliness, and lack of connection are based on the suicide person's perception and not objective reality. I will never forget, early in my career, a man, who later completed suicide, told group members that due to loss and work failure he was alone and no would care if he died. However, hundreds of mourners attended his funeral. There was clearly a tragic gap between this man's reality and his subjective experience. Brain research documents that cognition is severely impaired during major depression. Ego functioning declines causing marked loss of perspective, a pervasive sense of hopelessness, a dramatic sense that nothing can change, and a high level of self-

criticism and self-hate. Distortions are wired into a suicidal person's mind and emotions at the deepest level.

Perceived Burdensomeness

The second mindset, perceived burdensomeness, includes low self-esteem and feeling that one is defective and flawed. Joiner (2009) wrote that it goes beyond this: it is a perception that "I am a burden" to others, and that my death will be worth more than my life to my family, friends, and/or society.

From my work with men, I would like to elaborate on the concept of burdensomeness. For men, suicidal feelings and thoughts often are triggered by a work failure or financial stress which is experienced as a narcissistic injury and stimulates devastating feelings of shame, failure, inadequacy and self-criticalness which contributes and perhaps generates the experience of burdensomeness. So, not only do men in my practice feel like a burden, they feel, 'I am useless; I am inadequate; I am a failure." Perfectionism and a belief that one cannot live up to one's own or other's standards are also part of this dynamic.

Acquired Capacity

One of Dr. Joiner's major innovations is the emphasis on the acquired capability or capacity to kill oneself. Whereas the feeling one does not belong, and one is a burden are the core cognitions of suicidal desire, an individual must acquire an ability to kill him or herself to complete suicide. Joiner illustrated how human beings must acquire an ability to kill themselves by habituating to the pain of hurting their bodies, increasing pain tolerance, and lowering the fear of death. To successfully kill oneself, human beings need to become desensitized to pain and death.

Joiner depicted that when individuals are chronically exposed to death, pain, and violence, they may be more vulnerable to suicide. Chronic exposure to violence, being a victim of violence, past suicide attempts, chronic rumination about suicide, activities that numb oneself to pain like injecting drugs, the pain and/or violence of sports, or an individual with anorexia starving her or his body, are all ways that human beings may become desensitized to pain and the fear of death (Joiner, 2009). Habituation may explain why discrepant populations, like physicians, veterans, and individuals with anorexia have higher rates of suicide.

One last note: hopelessness, the major contribution by Dr. Aaron Beck to the study of suicide, consistently has been correlated with suicide. Also, since hopelessness is a major symptom of depression it is noteworthy that hopelessness predicts suicide, independent of depression. Hopelessness is pivotal in Joiner's theory, too. Joiner suggests that suicidal individuals are hopeless because they believe they do not belong ("I am alone") and because they believe they are a burden to others ("I am a burden"). In turn, hopelessness stimulates a wish to die.

Dr. Joiner reported a recent meta-analysis study that showed that The Interpersonal Theory of Suicide, has 'modest' ability to predict suicidal behavior (Chu et al, 2017). Given the complexity of suicide and the relative new efforts to study suicide empirically, this is a major achievement to help clinicians understand and treat suicidal individuals.

Assessment and Risk Factors

Evaluating belongingness, burdensomeness, intent, means and capacity of suicide are the foundation of assessing suicide potential. Direct discussion of access to means, especially guns, is critical. The distal risk factors of suicide are only barely useful since, for example, major depression is a risk factor, but most depressed patients do not complete suicide. The proximate risk factors described by Joiner, and many others, (Franklin, et. al., 2017) are more significant because they are red alerts that a patient might be in imminent danger and include: 1) Intent: talking and planning suicide, 2) Agitation: pacing, grimacing, and wringing of the hands, 3) Marked social withdrawal: being disconnected and not psychologically present, 4) Diminished speech, 5) Insomnia

(and nightmares), and 6) Not eating and sudden weight loss. Joiner noted that agitation, insomnia, and weight loss cut across culture, ethnic groups and gender. Also, Joiner (2009) suggested asking patients whether they are looking at suicide web sites to figure out ways to kill themselves or as a means of desensitization since rarely do patients volunteer this information. Joiner also noted a 'non-gun' person purchasing a gun is a critical red flag.

Joiner (2009) also recommends asking patients directly, "Do you feel like a burden?" but in the continuing education course I did not think he highlighted the effectiveness of asking this question. When I first incorporated this question as part of my assessment, I was astounded that asking directly about burden was like opening up Pandora's box. For example, I was working with an individual with schizophrenia who had multiple suicide attempts and I asked her if she felt like a burden. She immediately disclosed how she relied on her family and Social Security for financial support, felt guilty she had not been able to work for years, and that she was a burden to her family. She exclaimed, "Sometimes I think I'll throw myself in front of a bus." This question has also been useful when working with at-risk men who often are reluctant to talk for many reasons: the discomfort of being in therapy which emphasizes feelings and self-disclosure, traditional masculine beliefs that a 'real' man does not talk about vulnerable feelings or depend on anyone, and the neurobiology of depression which constricts affect and thoughts. With reserved or constricted men, their sense of failure, shame and burden rush out when asked about feeling like a burden and is thus an important question to integrate into risk assessment.

From studying Joiner, I became more focused on the distortion of thwarted belongingness and burdensomeness. In the early stages I carefully monitor these beliefs which are fundamental areas of exploration. In my experience, these distortions often lift or at least ameliorate with an in-depth and non-judgmental exploration, medication, increased family support, reduction of immediate stressors, educational approaches, and a caring therapeutic relationship. I often use a psycho-educational stance and talk with patients with severe depression and suicidal states where cognitions are distorted. For many patients this is relieving since they begin to understand and gain perspective that while their pain and suffering are very real, their conviction that no one cares, that they are a burden, and that it will never get better (hopelessness) may pass. As the crisis fades, the long-term issues of lack of connection and burden (often related to conflicts about success and failure) become the long-term issues of treatment.

Crisis Intervention: Mitigation

Joiner noted a legal and ethical issue that often psychotherapists document their assessment but not their actions of "mitigation." Joiner's recommendations for mitigation include direct behavioral interventions, including a safety plan, reducing access to means, especially guns (I also inquire whether an individual is hoarding pills), use of medication for agitation (mindfulness and exercise may be helpful if the patient is not overwhelmed by agitation), increasing social connection and addressing insomnia and nightmares.

Finally, Dr. Joiner described positive results using letters and postcards between sessions as a means to increase a patient's a sense of belonging ("Treat Suicidal Thoughts").

While Joiner emphasized the importance of caring in working with suicidal patients, I would emphasize that in the early stages of treatment or when a suicidal crisis occurs during treatment, a positive, safe and secure relationship with a patient is a protective factor because it provides an experience of connection. A sense of caring, being with a person in his or her pain and ambivalence, keeping steady and present, and expressing that you will protect the patient from harm are powerful interventions. Also, a positive therapeutic alliance is crucial because it helps a patient weather the hard work of therapy, and in long-term treatment the relationship itself may be reparative as the patient experiences a healing sense of connection and attachment.

I would like to comment on the ethics of treating suicidal patients: if your orientation is psychodynamic and perhaps less directive or problem solving oriented, it has become the standard of care to be knowledgeable and capable of being directive and behavioral to help patients cope with an immediate crisis. Relational psychotherapists may use their clinical expertise at joining with a patient, so the patient is more likely to take practical steps to reduce suicidal potential.

Long Term Therapy with Suicidal Patients

Dr. Joiner did not describe long term therapy with suicidal patients, and many of the interventions in the literature on suicide are short-term oriented. I consider suicidal thoughts, feelings. and attempts as both symptoms to be treated and reflective of the individual's life crisis. Hence, as an integrative therapist I have found it is crucial to be practical and directive during the crisis to reduce and ameliorate symptoms, and to work with the patient to understand the meaning of his or he suicidal crisis, including the role of biology, history, interpersonal relationships and psychodynamics (Meichenbaum, 2007). From my perspective short-term oriented therapists, who only focus on symptom reduction and management and do not treat the 'whole' person, shortchanges and potentially endangers the suicidal patient.

In my experience with teens and adults it is the rule, not the exception, that the suicidal crisis is an opportunity, albeit agonizing and dangerous, for major transformation and re-organization of the person's personality, coping mechanisms, relationships and life choices. Suicidal crises, paradoxically, are often the beginning of meaningful change. I worked with an elderly man who was lucky to survive a suicide attempt, stumbling into a family member's room, bleeding and crying, "I want to live." The immediate trigger was an exacerbation of a chronic physical problem, but he had been depressed about the loss of his career with feelings of failure, confusion and shame for many years. In his therapy, he realized he had over-focused on career, did not know how to enjoy himself outside of work and achievement, had neglected relationships, and had become rigid and stagnant. The suicidal crisis spurred tremendous change in a relatively small period of time as he hit a terrible bottom and in order to survive, he realized he had to make significant changes to his relationships, his self-concept, and what he valued as important.

Dr. Joiner is a master researcher whose seminal contribution, The Interpersonal Theory of Suicide, focuses on the role of belongingness, burdensomeness and acquired capacity in predicting suicide. Joiner's description of risk factors and mitigation represents the standard of care for suicide assessment and prevention. In this article I have attempted to delve into the clinical implications of Joiner's theory and examine the role of affect and ego functioning in the study of suicide while also providing considerations for the long-term therapy of suicidal patients.

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New Board Member Highlight

Introducing Paige Leopold, Ph.D.

CCPA Secretary

I am pleased to have joined the Board of the Contra Costa Psychological Association (CCPA). I became a member of CCPA ten years ago, right before opening my private practice. Prior to that, I worked for ten years as a staff psychologist in the public sector in San Francisco.

In my current practice in San Ramon, I provide psychotherapy and psychological evaluations. I specialize in treating young children, anxiety disorders, and neurodevelopmental disorders such as autism spectrum disorder. I also work with adults and enjoy providing parent consultation.

I joined the Board as a way to give back and to be more involved in this community of colleagues and friends that I so appreciate. I am continually humbled and honored to be a psychologist.

Random fun fact: I lived in France for four years in my 20's where I worked in advertising.

I look forward to getting to know and perhaps collaborating with more of you in CCPA.

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