Psychiatric Intensive Care for Acutely Suicidal Adolescent Patients

A Shift from Observation to Engagement

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- URMC is one of 126 U.S. academic health centers
- Our 750 bed university hospital is Strong Memorial Hospital
- 27 bed Child and Adolescent Inpatient Unit
Objectives

- Discuss how intensive engagement, validation and empathy strategies help to reduce symptoms with suicidal adolescents

- Describe elements of the psychiatric intensive care plan

- Review performance improvement outcomes to date related to improved satisfaction and symptom reduction
Nursing Care of Acutely Suicidal Patients


“…a disconcerting lack of empirically induced theory to guide practice
and even less empirical evidence to support specific interventions” (p. 942).

Emphasis of nursing care is based on defensive practices/close observation

- Physical integrity of the person
- Prevention of bodily harm
- Meeting the needs of the organization: policy
Nursing Care of Acutely Suicidal Patients

“Give me someone to talk to about my problems. It would keep me safe. It would help me get better. In fact, the absolute opposite happened… Most of the staff I got lumbered with did not, could not or would not make even small talk with me, let alone discuss my illness…

It always amazed me that the least experienced staff were given the most distressed patients to work with…

There have to be ways of helping a person feel safe and supported without reducing them to victims of voyeurism and seriously eroding away their basic human rights” (p. 256 – 257).

The Need for Change: From Observation to Engagement

Close observation alone

- Does not address the psychological and intense emotional needs of the patient
- Inhibits understanding of the patient’s experience
- May serve as a barrier to skill acquisition
- Minimizes opportunities for therapeutic engagement
- Diminishes the contribution of expert psychiatric nursing staff during intensive care episodes
The Need for Change: From Observation to Engagement

Intensive Engagement

- Provides validation of the patient’s emotional experience
- Staff are guided to coach the patient
- Nursing staff are uniquely positioned to observe and assess, to *know* the patient and to share observations. This has been critical in decreasing risk of repeat attempts on the unit.
- Evidenced based model, consistency for patients, families and staff. Everyone knows what to...
Our Intervention

- Implementation of DBT skills training and consultation group for nursing staff
- Integration of DBT across all unit programming
- Multi-disciplinary educational campaign
- Environmental changes
- Policy clarification and revision
- Leadership support and presence in milieu
- Introduction of the psychiatric intensive care plan during daily treatment planning
Guiding Principles

Patients who lack the skills to manage intense emotions are vulnerable to suicidal behavior

Patients are doing the best that they can

Suicidal patients will be safe, and will regain emotional control through least restrictive, individualized, empathic and validating care

Our patients will actively engage and partner with us in treatment

Our patients will learn to identify and understand their emotions, will learn to decrease emotional vulnerability, and will learn less destructive skills

Using the psychiatric intensive care plan, staff interactions with a patient are guided by DBT strategies including empathy, validation and skill acquisition with the following objectives:

- Decrease life threatening behaviors
- Decrease therapy interfering behaviors
- Increase behavioral skills

Nursing staff work with the patient to improve the patient’s motivation to change, enhance capabilities, and ensure skill generalization

- Diary cards
- Behavioral Chain Analysis
- Coaching the use of DBT Skills
Psychiatric Intensive Care Plan

Initiated when assessed to be a significant risk for suicidal behavior and thus requires 1:1 supervision.

**Suicide precautions with 1:1 assessment includes:**
- Level of impulsivity
- Degree for potential self-destructive behaviors
- Degree of social stimulation that would be safe and therapeutic

**Which determines:**
- Personal effects, furniture, linen, and clothes the patient may safely have in their room
- The amount of time to be spent in the milieu
- The amount of contact to have through visits and phone calls
- Type of engagement with 1:1 staff

**Safety plans are individualized:**
- Containment may be necessary for safety and to limit access to objects for self-harm
- Re-engagement and mobilization may be necessary to be therapeutic as well as safe
- Targets and interventions are determined based on patient’s current needs

**Psychiatric intensive care plan binder includes:**
- Guide to implementation
- Policy
**Biosocial Theory** – biology and social environment factors create skill deficits

**Biochemical compositions**
- Increase emotional reactivity
- Increase intensity of emotions
- Decrease ability to return to emotional baseline

**Invalidating environments**
- Dismiss or reject person’s behavior regardless of behavior’s validity
- Punish emotional displays
- Reinforce emotional escalation and oversimplify problem-solving

**Consequences of invalidating environment on individual**
- Does not learn how to trust their own reactions as valid
- Can not appropriately *label their own experiences*
- Can not effectively *regulate their own emotions*
- Conditioned to self invalidate and depend on the environment to know how to respond.
- Fails to learn to communicate pain effectively
- Fails to learn to accurately express emotion
- Alternates between inhibiting intense emotions and engaging in extreme emotional behavior
- Fails to learn distress tolerance and problem solving skills

(Linehan, 1993a, p. 49–52, Linehan, 1993b, p. 3–4, Miller et al., 2007, p. 42–44)
Validation - communicates that someone’s private responses are understandable and reasonable (is not the same as agreement)

Ways to provide validation
- Showing interest in the patient
- Accurately reflecting back
- Communicate understanding of patient’s experience & response when the patient can’t verbalize it
- Validate reaction in terms of past learning or biological dysfunction
- Communicate that the behavior is meaningful, reasonable, justified in the present, or serves a purpose
- Recognize the individual for themselves, their strengths & abilities, while keeping a firm empathic understanding of actual difficulties and incapacities (balance acceptance and change)

Validation requires
- Mindfulness and self-awareness
- Active listening
- Active acceptance and reflection without judgment
- Taking the patient and his or her responses seriously
- Realizing the inherent validity of their response
- Observing what the patient is feeling in the moment
- Looking for how the reaction makes sense for this person
DBT Problems, Skills, and Goal Work

Suicidal, self-injurious, destructive behaviors are learned ways of managing intense emotional pain.

We want to provide a validating environment and motivate patients to participate in treatment.

DBT worksheets and exercises are individualized according to problem:

- Confusion about self ⇒ Mindfulness
- Emotional instability ⇒ Emotion regulation
- Impulsivity ⇒ Distress tolerance
- Interpersonal problems ⇒ Interpersonal effectiveness
- Teenager–family dilemmas ⇒ Walking the middle path

Emotion/diary cards:

- Provide an opportunity to help the patient to be mindful of what they are feeling and put the feeling into words
- Help identify the intensity of that feeling, concurring thoughts, thoughts of SI or self harm, and self-destructive urges
- Recognizing the usefulness of practicing a skill (to get through the moment) and then evaluating the usefulness of the skill by re-rating the intensity of the emotion
- Recognize the patient’s efforts and abilities in recognizing, identifying, and communicating their thoughts and feelings
- Balancing validation of the patient’s experience while encouraging them to move forward

Behavioral chain analysis

- "On the other hand, if you think about..."

Nursing Staff Guide to Implementing the Psychiatric Intensive Care Plan
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Cheerleading is a form of validation and is the principle strategy for engaging our patients
- Patients may not want to engage in the psychiatric intensive care plan or in treatment
- We focus on helping the patient understand that destructive behavior is the highest priority and that nothing else can be addressed until they can be safe on the unit
- We recognize that the person likely feels a lack of hope that they can ever change their lives
- The purpose of cheerleading is to instill hope

Repair/ Debriefing
- Patients may experience secondary emotions related to perceived or actual failure
- Feelings such as guilt or shame may impact ability to engage with others and in treatment
- A careful assessment is important to help the patient identify and work through these emotions

Trauma
- The goal/focus of this care plan and its interventions is imminent safety
- As many of our patients have experienced trauma, our care and interventions are trauma-sensitive
- Patients are admitted for short-term acute crisis stabilization and are unable to tolerate trauma-focused work
- We do not focus on specific traumatic experiences, but know that the patient contends with fallout from their experience
- Trauma experiences can impact an individual’s coping capabilities, ability to regulate emotions, and can impact interpersonal effectiveness
- Trauma work is stressful and can increase suicidality; therefore it is imperative that patients have the ability to
Performance Improvement Project

Goals

Method

- Quantitative Study
  - Different Likert-scale surveys developed for patients, family and staff to gauge safety, communication, and effectiveness of each DBT component

- Qualitative Study
  - Open-ended survey questions used to assess patient, family and staff satisfaction, concerns, and improvement ideas

- Unit procedure

Preliminary findings

- Quantitative
  - safety, control, communication, understanding, DBT

- Qualitative
  - Patient: “DBT was most helpful...to focus on skills instead of bad thoughts” “Being monitored helped make sure I was safe” “the mindfulness and diary cards helped the most”
  - Staff: “Diary cards helped staff implement conversations and DBT interactions” “Simple DBT videos for clients who can’t cope with paperwork would help” “Some staff want more DBT training”
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- Policy
- Individualized care plan
- Staff agreement
- Goal work
Nursing Staff Guide to Implementing the Psychiatric Intensive Care Plan

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Behavioral chain analysis

- Organize process of changing a destructive behavior to a less destructive behavior
- When a patient is acutely dysregulated they are less likely to be able to do this work on their own
- The chain analysis is only useful if we can connect triggers, thoughts, emotions, urges, and
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Q & A

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