Can I Use EMDR With Clients Who Report Suicidal Ideation?

Editorial Note: This column is a regular *Journal* feature in which master clinicians answer a question posed by a reader who is requesting assistance with clinical challenges. In this issue's column, responses are written by two clinicians: John Spector, a consultant clinical psychologist in London, UK, and Sandra Kremer, a licensed clinical social worker in North Carolina, USA. Readers can send questions for future issues to journal@emdria.org

Question: *Can I use EMDR with clients who report suicidal ideation?*

ANSWER BY JOHN SPECTOR:

Suicidality is, as indicated by Dr. Shapiro, usually a contraindication for the use of EMDR. However, exceptionally one may work with clients with suicidal ideation given the answer to certain questions:

1. Proper Assessment of Risk

Most clients who voice any suicidal ideation will not go on to complete suicide. But some of them actually do. This is why you need a thorough evaluation before treatment and periodically afterward.

- How active or compelling is the suicidal ideation?
- What resources does the client have, both internal and external, that may counterbalance suicidal ideation?
- How motivated is the client to work on repairing him- or herself and to enter into a contract of safety through treatment?
- Is there a history of previous suicide attempts or dangerous self-harming (the best predictor of future such incidents)?
- Is the client involved with medical supervision, or is he or she an inpatient?

2. Other Factors

- Do you have a strong and trusting therapeutic alliance with your client?
- Have you fully assessed for dissociative phenomena, especially dissociative identity disorder?

The answer to these questions will tell the clinicians whether, with appropriate liaison with medical colleagues and appropriate consideration of the treatment setting and supervision, EMDR can be risked with the client.

If it is felt that the answers to the above questions give the clinician confidence to proceed with EMDR, then the following (in no particular order) may be helpful:

1. The client should be given stepped contacts (from phone numbers to facilities) that they can access in extremis if desperate.
2. As usual with such difficult cases, special care should be taken in the installation of resources and self-soothing and stabilizing techniques before commencing EMDR. Failure of any of these techniques raises a red flag. In this case, stop proceeding to EMDR until the client is stabilized and can self-soothe.
3. Empathizing with and holding the client's despair will be as important as any other action you take.
4. Encourage the client to make use of supportive resources they may have, such as friends, family, and colleagues, and, where appropriate, include them in the work.
5. Think about using positive cognitions in the ballpark of "I can learn to/from . . ." in relation to experiences that have contributed to the client's despair.
6. Use future templates more actively to focus the client on ways of moving forward.
7. Target touchstone events that may lie behind some of the recent traumatic experiences.

8. If the client seems to be stuck during the desensitization process, being hopeless/helpless or around the issue of control, consider using cognitive interweaves more actively and earlier than usual (with fewer sets). Use shorter sets and carefully observe the client to see what he or she is getting at.

Finally, obtaining supervision when working with these clients is invaluable in terms of holding one's own anxieties. Make a good documentation of thorough risk-benefit evaluation, discussions with family members or consultants, treatment recommendations, and any backup plans discussed. Informed consent may be required from the client on using EMDR in this situation.

ANSWER BY SANDRA KREMER:

Isn't suicidality about wanting things to be different? If so, then the key to helping is to envision with them a future that is different, what their part in doing so is, and how we can team with them to make that future different.

Primary to any work with clients with suicidality is safety. While the standard EMDR protocol is contraindicated for work with clients with suicidality, there are situations when using EMDR with these clients may be possible and helpful.

There are several variables in this issue:

1. How long is the therapeutic relationship? Safety first! If this is a new client and the relationship is tenuous, hospitalization may be the only option for safety. What are the self-soothing tools in place? Identify with them *healthy* things they can do during the day to self-soothe when alone, at night when

alone, during the day with others, and at night with others, especially the "when alone" self-soothing skills.

2. If the relationship is solid, the issue is not to talk them out of suicide, which often feels like a discount of the intensity of the feelings. Explore the parts of the client who don't share these intense feelings. How can they help?
3. Give empathy with their depth of emotion. We may be the only persons who can hear their level of pain/guilt/disappointment.
4. Find the touchstone event and, if not enough safety to do EMDR, use a "verbal future template" to open the possibility that they can learn to handle this pain while working to release it and move forward. Use other examples of a client having accomplished it and install using EMDR.
5. Give assurance that things can be different and that they are not alone in finding a way through this/these feeling(s). Help them review the times they have tolerated intense feelings.
6. Clients sometimes say, "I just want this to be over," and when I question how they envision the "over" part, they talk about the pain and struggle being gone. Then we have fodder for EMDR again.
7. Caveat: take care of the therapist first! If you are not comfortable working with suicidality, screen carefully during intake for previous attempts and hospitalizations.

If you accept clients with suicidality, be in consultation with and use your supervisor. Always have a plan B. Here we can call 911, identify ourselves as mental health clinicians, and request a safety and security check on a client who reports suicidality with plan.