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EMDR for Acute Suicidality Related to Significant Life Changes: A Case Study

Zaffer Iqbal[1,2]*, Aine McCloskey[2], Teyanne Y Stedford[2] and Nicola D Airey[2]

[1]*Faculty of Health Sciences, University of Hull, United Kingdom*

[2]*Navigo Health and Social Care CiC, United Kingdom*

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***Corresponding author:** Zaffer Iqbal, Faculty of Health Sciences, University of Hull, Navigo Health and Social Care CiC, United Kingdom

Abstract

Individuals with suicidal ideation regularly present at hospital emergency departments, or via crisis and acute mental health services. Negative life events are a key risk factor in the onset of recurring suicidal thoughts exacerbated by current environmental stressors. Eye Movement Desensitisation and Reprocessing (EMDR) may offer an effective intervention for individuals who present with such life-event triggered suicidality. This case study describes targeted EMDR as a means of effectively minimising the distress of individualised drivers of suicidality, with demonstrable improvements in outcome measures. The participant was subsequently discharged from mental health services and had not re-presented by six-month follow up. This provides promising preliminary evidence for the use of EMDR when working with acute suicidality, however further research is required with larger methodologies and broader samples.

Keywords: EMDR; Suicidality; Case Study; Trauma

Abbreviations: AD: Adjustment Disorder; AIP: Adaptive Information Processing; BCBT-SP: Brief Cognitive-Behavioural Therapy for suicide prevention; CBT: Cognitive Behavioural Therapy; CORE-OM: Clinical Outcome in Routine Evaluation Outcome Measure; CAMS: Collaborative Assessment and Management of Suicidality; CMHT: Community Mental Health Team; DBT: Dialectical Behavioural Therapy; E-CAU: Enhanced Care As Usual; EMDR: Eye Movement Desensitisation and Reprocessing; HTT: Home Treatment Team; HADS: Hospital Anxiety and Depression Scale; IES-R: Impact of Events Scale- Revised; INQ-15: Interpersonal Needs Questionnaire; MHCS: Mental Health Confidence Scale; NSSI: Non-Suicidal Self-Injury; SUDS: Subjective Units of Distress; ONS: Office for National Statistics; PMR: Progressive Muscular Relaxation; RCT: Randomised Control Trial; RCI: Reliable Change Index; SSF: Suicide Status Form; WHO: World Health Organisation

Introduction

Death by suicide constitutes a major public health concern worldwide: more than 700,000 people die by suicide per year [1]. In the United Kingdom (UK), over 5000 people take their own life annually and in 2020, approximately 28% had accessed mental health services within the 12 months prior to their death [2]. While suicide reduction and prevention have been recognised as a national healthcare priority [3], there has been little variation in suicide rates over the last decade [4].

Risk Factors for Suicidality

Evidence suggests that, among the many risk factors identified for attempts to die by suicide, the strongest associations were with psychological trauma and negative life experiences, particularly those that occurred during childhood [5-7]. Trauma or negative life events can also induce recurrent suicidal thoughts and increase the risk of suicide through moderating factors such as emotional dysregulation, poor distress tolerance, stress sensitivity and increased impulsivity via reduced self-inhibition [8,9]. Research indicates that environmental factors, including debt or financial difficulties, life transitions, bereavements and relationship breakdowns, increase the likelihood of developing suicidal behaviours; defined as attempted and completed deaths by suicide [10,11]. Indeed, a systematic review of twenty studies identified that individuals of varying demographics diagnosed with adjustment disorder (AD), commonly present to hospital emergency departments and liaison psychiatry services with suicidal ideation and behaviours [12]. Within the International Statistical Classification of Diseases 11th Edition (ICD-11), AD is situated within disorders specifically associated with stress, which all are directly related to an identifiable stressor(s) [13]. Although these eight disorders fall under same category of diagnostic systems, the context of the stressors varies, with some falling within the normal range of life experiences and others deemed as extremely threatening or

horrific in nature [13]. AD, as illustrated in the ICD-11, is described as "a maladaptive reaction to an identifiable psychosocial stressor or multiple stressors (e.g. divorce, illness or disability, socioeconomic problems, conflicts at home or work) that usually emerges within one month of the stressor". The development of AD may be a result of the individual's inability to tolerate current life stressors due to the historical loading of previous adverse life experiences, which when experienced together result in an acute dysregulated response [14].

In line with this, it has been postulated that current environmental stressors may trigger or exacerbate the psychological distress associated with historical adverse life events, leading to an impulsive urge to relieve this intensely painful emotional state by considering or attempting suicide [15-17]. As these adverse life experiences reduce an individual's tolerance to future life stressors [18] managing risk and reducing the potential for future death by suicide may be achieved by targeting the intrusive and additional loading of historical negative life events in a therapeutic intervention. Indeed, processing the historical life events will improve an individual's functioning [19] and ensure a potential for psychological robustness when experiencing future adversity. Such processing if successful may also reduce the potential for AD onset and presentation at crisis and emergency settings. These improvements may ensure a positive economic impact on the NHS by reducing the need for recurring admissions, hospital support and treatments [20].

Treatment for Suicidality

Current treatment for suicidality includes both protocol-based therapeutic interventions and comprehensive frameworks to explore the driver(s) behind suicidality.

Safety Planning: Safety planning is a proactive means of identifying strengths, previously acquired coping skills and support networks that can be drawn upon in crisis. There has been recent evidence to suggest that follow-up telephone intervention post-completion of a safety plan is an acceptable and feasible intervention to maintain safety [21].

Collaborative Assessment and Management of Suicidality (CAMS): CAMS is a suicide-specific intervention that centres on helping service users and staff to understand the individual's drivers to suicidality [22]. Drivers are defined by variables that are distinctive to the individual and their desire to die by suicide, such as major self-esteem issues [22,23]. A key component of CAMS is the collaborative approach, which strives to develop a high-quality therapeutic relationship with the service user and promote their involvement in the treatment planning. Through using the Suicide Status Form (SSF), CAMS is able to provide a comprehensive assessment tool, treatment plan and tracking of progress, to manage suicidality. A randomised control trial (RCT) which compared CAMS to enhanced care as usual (E-CAU), demonstrated a significant reduction of suicidal ideation and overall symptom distress, whilst increasing feelings of hope in those presenting to outpatient crisis services [24]. More recent RCT's have also demonstrated the efficiency of CAMS for reducing suicidality [25-27].

Cognitive Behavioural Therapy (CBT): Interventions to target suicidal drivers have predominantly focused on distress reduction through skills-based or cognitive methods. Research has provided evidence for a specific form of CBT as an efficacious treatment for individuals who attempted to die by suicide, [28-30]. In particular, Brief Cognitive-Behavioural Therapy for suicide prevention (BCBT-SP) has been established as a theory-driven and empirically supported treatment that is easily delivered and flexible for reducing suicidal risk [31,32]. Cognitive behavioural interventions have been devised for treating suicidality in specific patient groups, for example Cognitive Behavioural Suicide Prevention for Psychosis [33].

Dialectical Behavioural Therapy (DBT): DBT is a derivative of CBT, which was originally designed to treat suicidality and non-suicidal self-injury (NSSI), in those who experiences traits of borderline personality disorder [34]. DBT is a changed-focussed behavioural treatment, which utilises the development of skills training and how to implement these in everyday life, along with addressing barriers to motivation [35,36]. In a meta-analysis of 18 controlled trials, DeCou et al. [37] found that DBT could reduce NSSI and frequency of presentation to crisis services. Although DBT provides skills to manage the intensity of their emotions, without targeting the historical loading from previous adverse life experiences, individuals can continue to experience sensitivities to life stressors and these could be driving the suicidality.

EMDR as a treatment option: A promising treatment-based strategy that may impact upon suicidality, where suicidality is propagated by negative life events, is Eye Movement Desensitisation and Reprocessing (EMDR) therapy [38]. EMDR is an empirically validated trauma intervention that was initially developed for post-traumatic stress disorder (PTSD) [19]. It is a specialised, low-cost and often short-term treatment that aims to reprocess and desensitise painful memories of negative life events using standardised procedures [39]. Typically, EMDR therapy utilises a comprehensive protocol involving eight phases of treatment: history-taking, preparation, assessment and treatment-planning, desensitization, installation of a positive cognition, body scan, closure, and re-evaluation [19]. Within the therapeutic sessions, the individual is asked to remember these distressing memories and their associated negative cognitions for several minutes at a time whilst the clinician concurrently applies bilateral stimulation across the two cerebral hemispheres, typically via eye movements or a tactile stimulus such as bilateral tapping. The implementation of bilateral stimulation is guided by the Adaptive Information Processing (AIP) model, which suggests that trauma-related symptoms result from maladaptive information processing due to the individual having unprocessed memories stored within their brain [40]. Therefore, bilateral

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stimulation provides time for reprocessing of these traumatic memories, after which the level of emotional distress and physiological arousal is reduced, the negative cognitions are reformulated, and more adaptive beliefs for future scenarios are considered [41].

As highlighted in the EMDR for depression protocol, EMDR therapy can also be used to process suicidal states [42]. Preliminary evidence from a randomised controlled trial comparing nine sessions of EMDR treatment with no therapeutic intervention found a reduction in suicidal ideation for the former in thirty-five adult inpatients diagnosed with major depressive disorder [43]. Although the authors targeted a specific diagnosis, it is recognised that individuals exhibiting suicidal ideation and behaviours present with a range of needs that do not exist entirely in the context of pre-existing mental health conditions [11,44]. Rather, many death by suicides can occur impulsively due to the perceived inability to find a solution besides suicide to the perceived implications of life stressors, including financial, relationship and societal factors [1,22,45]. Indeed, the literature though scant does suggest that negative life events could be a key factor in the onset of recurring suicidal thoughts (as per AD), exacerbated by the impact of current environmental stress [5]. Furthermore, Burback, et al. [46] demonstrated that suicidal ideation crosses diagnostic boundaries, as they used web-based EMDR treatment to reduce suicidal ideation in outpatients who were not recruited for a specific diagnosis. The present research outlines a case study utilising EMDR therapy to reduce suicide ideation and intent in an individual presenting to a mental health crisis resolution and home treatment team within the NHS, with suicidality and no previous diagnosed mental health disorder. It was hypothesised that following completion of this short-term EMDR treatment, the individual would experience a reduction in their suicidal thoughts and behaviours, as well as a decrease in their perceived level of psychological distress.

Introduction to the Case

Following an attempt to die by suicide due to a recent relationship breakdown, the Police escorted a 32-year-old Caucasian male with no previous known history to mental health services to the local NHS crisis team. A suicide risk triage determined the severity of concern for clinicians [47], resulting in a CAMS [22] intervention being completed and a referral to a secondary care psychological therapies service was pursed the next day for management of his suicidal ideation. The client attended his first psychology appointment within the two days. He continued to receive support from the Crisis Home Treatment Team (HTT) for one month following the community psychology referral. He was also referred to the Community Mental Health Team (CMHT) for additional support whilst undergoing psychology therapy.

Presenting Problems

At the time of the psychological assessment, the client reported an improvement in his financial situation as he had recently secured full-time, skilled, office-based employment. He detailed that his mood had lowered into a "downward spiral" over the previous two years. He recognised feeling particularly low whilst in contact with his recent ex-partner, who reportedly made frequent comments that he was unkind and worthless. The client acknowledged that remaining in communication with his ex-partner was perpetuating his mental health difficulties, though he felt unable to cease this contact. Following their separation, the client explained that he became aware of his ex-partner's infidelity and he recognised that the subsequent distress triggered his suicidal behaviour, leading to him driving to a large suspension bridge and the Police attending on the same day. Since this disclosure, the client reported experiencing daily suicidal thoughts, particularly in the mornings.

At the time of assessment, the client was experiencing negative thoughts about himself daily, similar to those that his ex-partner relayed to him. He described low self-esteem and expressed feeling worthless and guilty, fuelled by his inability to provide financially for his children. He recognised that these thoughts occurred mostly when he was alone due to increased time for rumination. He identified that this rumination precipitated suicidal ideation and high anxiety, characterised by catastrophisation, future-focussed worry, and physical sensations, such as shaking and breathlessness. The client reported becoming particularly anxious when entering new environments or socialising with friends, as he felt self-conscious and needing to prove himself as a kind and socially acceptable individual. The client had tended to refrain from leaving his home for this reason, mostly remaining in bed and using his mobile phone, which increased his ruminative thinking. This prolonged use of his mobile made contact with his ex-partner more inviting and consequently he would spend the majority of his time looking at her social media profiles. These behaviours had resulted in poor sleep hygiene and difficulty falling asleep.

Client History

The client was a single heterosexual man in his early thirties with two adolescent children from a previous relationship. He described regular contact with his children, despite residing in different properties. He lived with his parents due to his recent psychological deterioration and a significant amount of debt equating to approximately £40,000. A family history of recurrent depression in one parent and sibling, particularly suicidal ideation in the former, was disclosed. The client stated that he was surrounded by a supportive and close-knit family, involving his parents who divorced when he was aged ten, four biological siblings, and his respective stepparents, both of whom had been involved in his life since childhood. Difficulties making friends at

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school were reported, compounded by bullying in his first year due to the social stigma of being new to the area. He described a period throughout adolescence of challenging behaviour, which involved fighting and smoking cannabis. The client sustained a head injury whilst playing football as a young adult, which ended his ambitions as a semi-professional sportsman, and he described this as particularly difficult for him to comprehend and adjust to. He had not previously engaged with mental health services, though informed that he self-harmed four times within a four-week period by making lacerations to his wrist five months prior to the assessment, and this was precipitated by another relationship breakdown.

Assessment

An initial comprehensive assessment was completed over two one-hour sessions within a two-week period. This aimed to ascertain the client's current presentation as well as his experiences throughout his lifespan, using a trauma-informed approach. Within the assessment, he completed five psychometric scales:

Psychometric Scales: The Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM)[48] is a 34-item measure of psychological distress, which is pan-theoretical, pan-diagnostic and draws upon the views of what practitioners considered to be the most important general aspects of psychological well-being to assess, comprising four domains of well-being, symptoms, functioning and risk [49]. This tool's utility for use in secondary care psychological services has been confirmed [49]. Evans et al. [50] reported good internal consistency for the subscales (Subjective Well-being: Cronbach's alpha = .75–.79, Problems: Cronbach's alpha = .89–.91, Functioning: Cronbach's alpha = .85–.87, Risk: Cronbach's alpha = .77–.81, All items: Cronbach's alpha = .93–.95).

The Impact of Events Scale- Revisted (IES-R) is a 22-item questionnaire across three subscales, which measures the extent of psychological distress created by a negative life event as well as the client's subjective response to trauma. Within this measure, high levels of internal consistency has been identified within the three sub-scales (Intrusion: Cronbach's alpha = .87–.94, Avoidance: Cronbach's alpha = .84–.87, Hyperarousal: Cronbach's alpha = .79–.91; [51]).

The Mental Health Confidence Scale (MHCS) [52] assesses the client's level of self-efficacy in regards to managing their own mental health difficulties using a 16-item self-report measure. This measure utilises three scales (coping, optimism and advocacy) and the Cronbach's alpha for the total score is reported as .91 [53].

The Interpersonal Needs Questionnaire (INQ-15) [54] is a measure of thwarted belongingness (nine items) and perceived burdensomeness (six items); central concepts within the Interpersonal Theory of Suicide where it postulated that suicidal desire emerges when an individual experiences unmanageable feelings of both these phenomena [55]. The INQ-15 has demonstrated high acceptability, with Cronbach's alphas of .94 for perceived burdensomeness and .91 for thwarted belongingness [56]. The Hospital Anxiety and Depression Scale (HADS) [57], is a 14-item self- measure to assess symptoms of anxiety and depression in the previous seven days. It is comprised of seven items within the anxiety subscale (Cronbach's alpha between .68 and .93), and seven items within the depression subscale (Cronbach's alpha between .67 and .90) and has acceptable criterion validity [58].

The client's total score of 59 on the CORE-OM is indicative of a moderate level of distress [59]. His score of 69 on the IES-R (maximum score of 88) suggests a high level of distress associated with his identified life event, the most recent crisis presentation following suicidal behaviour, particularly as a score of >36 is deemed distressing enough to suppress immune system functioning [51]. Qualitative descriptors for the client's HADS item responses indicated "borderline" depression (7) and "abnormal" anxiety (17). On the MHCS, the client scored 47 out of 96 on the MHCS and 58 out of 105 on the INQ-15. The MHCS and INQ-15 do not have formalized interpretation descriptors.

Case Conceptualisation

In summary, the client was a 32-year-old man with severe anxiety and borderline depression. His difficulties were maintained by his social isolation, due to his negative core schema, ongoing arduous relationship with an ex-partner, rumination and chronic worry when faced with life stressors. It seemed that his impulsivity could lead to future suicidal ideation and intent overwhelming him, which would be propagated by poor use of emotional intelligence and a rapid escalation of dysregulation when faced by life stress. Thus, it was agreed the therapy work would look to increase his awareness of his core schema that led to his inability to deal with emotional exacerbations, by providing him with psychological strategies to work through these issues. Furthermore, historical memories that fuelled his negative cognitions about himself would be tackled, using EMDR therapy, with the view to reduce their impact when he ruminated about the past and subsequently decreasing his suicidality in such situations.

Course of Treatment

The rationale for EMDR therapy was explained to the client, who consented to the therapy. He attended eight sessions over a four-month period, including the two psychological assessment sessions detailed above, followed by six sessions of EMDR therapy. All sessions took place within a community-based building within the CMHT. Therapy commenced three weeks following the assessment and the six EMDR therapy sessions occurred over an eight-week period.

Sessions three and four: Following the aforementioned protocol for EMDR therapy, preliminary skills were taught to the

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client to provide stability between sessions [40]. This included a bespoke recording developed in service, incorporating Progressive Muscular Relaxation (PMR) and diaphragmatic breathing. The PMR was created by Jacobson and requires tensing and releasing the 16 muscle groups [60]. A male-voiced recording, combined with mindfulness imagery, was provided and the client agreed to practice the recording twice a day. It was hoped that this would help improve his ability to mindfully focus and help him to develop control over intrusive thoughts and images. Following the EMDR protocol [40], the safe space technique was completed to manage his anxiety from intrusions of recent and historical past events, as it is recognised that these can be exacerbated during the EMDR process. When he self-reported that he was able to successfully implement the PMR and safe place as a means to reduce the impact of his intrusions and consequent anxiety, a hierarchy of memories to be processed was developed. This focussed on the ruminations during his most recent suicidal behaviour, and the past memories that were related to intrude during this exacerbation towards this consequence.

Session five: This was the first EMDR reprocessing session and targeted a memory of a relationship, which ended seven years ago. When focusing on the negative memory, the client experienced a range of bodily disturbances including a tightness in the throat, discomfort in the stomach, increased heart rate and tension in the neck and back. The Subjective Units of Distress (SUDS) were rated as 10 out of 10, endorsed by the negative cognition "I am incapable", whilst completely rejecting the positive alternative "I am capable". SUDS reduced from 10 to 0 over a series of bilateral stimulations. No alteration to the positive cognition was required and after further bilateral stimulations, the positive cognition was deemed to be completely true (7 out of 7). Finally, a body scan was completed, and no areas of bodily disturbance were noted; the client expressed feeling relaxed before leaving the session. The session and process of EMDR was discussed and he was provided with out-of-hours support for between sessions.

During this session, the client disclosed a history of childhood sexual abuse commencing when he was six-years old, which he informed he had never disclosed to anyone previously. These abuse memories were subsequently incorporated into the hierarchy of targeted memories and agreed as an additional objective for therapy. Although it was previously assumed the historical loading was fuelled by his negative core schema from previous relationships, his experience of childhood sexual abuse contributed to this and impacted upon his ability to deal with life stress. The use of trauma-informed care [61] allowed the client to build a rapport with the clinician and feel comfortable disclosing previous traumatic events. This disclosure improved the chance of success of therapy, as it provided a better explanation for why the client could be vulnerable to severe psychological distress.

Session six: This session was used to offer psychological support and for the client to provide an update on how his week had been after the previous EMDR reprocessing session. No reprocessing was completed in this session to consolidate what was gained in the previous session, along with reformulating and incorporating the sexual abuse disclosure

Session seven: This session focused on the EMDR reprocessing protocol relating to the traumatic memory of childhood sexual abuse. The client rated his SUDS as 10 out of 10, endorsing the negative cognition "I am not worthwhile". Following bilateral stimulations, his SUDS reduced from 10 to 0 and he rejected the negative cognition. After further bilateral stimulations, he fully accepted the positive cognition "I am worthwhile", rating this as 7 out of 7 representing a "completely true" affirmation. Finally, a body scan was completed, and he did not identify any areas of disturbance. The client's mood lifted markedly by the end of the session, and he was able to acknowledge that though tired, he was feeling more positive than on arrival.

Session eight: This session was used to offer psychological support and for the client to provide an update on how his week had been between sessions after the previous EMDR session He explained that he no longer felt distress or disturbance when thinking about the negative memories, which had intruded into his life at moments where he was overwhelmed with distress. He explained that he was no longer experiencing suicidal ideation, which was further corroborated by the CORE-OM score of zero on the risk subscale. He also informed that he was beginning to implement positive changes into his life, including restarting overnight visits with his children. He described a healthier work life due to reduced ruminations, tiredness and finding his workload more manageable, and had begun to notice the positive impact of this on his overall functioning. Therefore, the client was discharged following this session.

Six-month follow-up: Six months after completing EMDR, the client attended a review session. He denied any suicidal thoughts since EMDR, despite being involved in a road-traffic incident. His medical records were reviewed to reassess his access to mental health services over this period; he was discharged from CMHT two months following EMDR, as he no longer required support, and he had not accessed any subsequent support for his mental health from primary, secondary or tertiary care within the six-month period.

Outcome

Table 1 displays the client's outcome measure scores, both at the initial assessment and at discharge from treatment (session eight). These show an improvement in all the scales which demonstrates an effective and maintained impact of the EMDR treatment. For pre–post measures, the Reliable Change Index (RCI) was calculated [62] using the single-case Leeds Reliable Change Index calculator [63]. Previously published internal

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consistency ratings were utilised as detailed previously. Clinically significant change was calculated where possible using clinical and non-clinical means and standards deviations [50,53].

Table 1: Pre- and post-treatment scores and Reliable Change Index (RCI) calculation, and six-month follow-up scores.

	Pre	Post	RCI Pre-Post	Follow-up
CORE-OM (/136)	59	24	3.96*±	11
IES-R	69	12	13.79*±	12
MHCS	47	83	122.98*	96
INQ-15	58	17	-	15
HADS-A	17	5	29.83*	0
HADS-D	7	1	14.49*	2

Note: *Reliable Change. ±Clinically Significant Change. Anxiety (A); Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM); Depression (D); Hospital Anxiety and Depression Scale (HADS); Impact of Event Scale-Revised (IES-R); Interpersonal Needs Questionnaire (INQ-15); Mental Health Confidence Scale (MHCS).

Discussion

From referral to discharge, the client received six sessions of EMDR. Each of his outcome measures improved following treatment and these gains were maintained or further improvements were seen at six-month follow-up. These findings were corroborated by the client, who reported experiencing no suicidal thoughts since the cessation of his treatment, as well as a decrease in his overall psychological distress. This indicates that EMDR achieved its objective of reducing suicidality in an individual who presented to NHS crisis services after an attempt to die by suicide. Indeed, anecdotal evidence at the six-month follow up suggested that the reduction of historical stressors through trauma processing enabled the client to tolerate difficult circumstances more readily.

Implications for EMDR

This study is a promising implementation for EMDR where it may be effective for individuals who do not regularly experience past trauma impacting their ability to regulate their emotions and distress tolerance skills but do so during periods of environmentally and socially induced distress [8,9]. On such occasions, their risk for suicide could increase rapidly and be further maintained, if not exacerbated, by intrusions of previous unprocessed negative biographical memories. Thus, negative life events can be a key risk factor in the onset of recurring suicidal thoughts exacerbated by the impact of current environmental stress [5]. For the client, it appeared that his suicidality, driven by his recent relationship breakdown, was exacerbated by the psychological distress associated with past negative life events. This led to his impulsive suicidal behaviour by driving to the large suspension bridge. By reducing the psychological impact of past traumatic events, and the negative cognitions they invoked through a targeted EMDR intervention, the client was able to process and desensitise from these intrusive events. His improved distress tolerance and reduced impulsivity was evident at the six-month follow-up.

Environmental factors, including debt or financial difficulties, life transitions, bereavements and relationship breakdowns, increase the likelihood of developing suicidal ideations and behaviours [10,11]. This case study could support the rationale that historical negative memories can act as a psychological loading that induces suicidal intent when the individual is overwhelmed by current life events, acting as a pathway to overwhelming distress and suicide [18]. This can demonstrate the potential for a short-term intervention that could aid individuals who present with suicidality in response to over-sensitisation to current life stressors, given historical adverse life experiences.

Limitations and Recommendations

Despite the NHS commitment to the development of evidence-based, cost-effective suicide prevention strategies [3], most crisis and acute inpatient mental health services have little or no psychological input due to the short-term support package provided to individuals within their care [64,45]. Subsequently, the lack of psychological provision targeted at suicidality within these services may limit the service users' access to EMDR therapy as a treatment option. It is worth noting that it is not always feasible to implement an expedited process for individuals who present at crisis services to receive psychological therapies, or have access to a trained EMDR therapist, which is essential for the successful implementation into services. It is recommended that further validation of the feasibility of the treatment model applied in this case study is explored, prior to a randomised controlled trial. The opportunity to gain a detailed causal understanding of the possible impact of the therapy and the psychological variables that may impact upon rapid escalations in suicidality is an area that is poorly understood.

This single case study was of a white employed male with a good social support system, expanding the research to other demographics would aid in determining the validity of the therapy specifically for suicidality. Indeed, it would be useful to understand the impact of EMDR for suicidality in individuals who experience regular exacerbation in distress to suicidality when life stressors occur, including those who may present frequently at crisis services. In the first instance, a pilot study testing this intervention with a series of cases and heterogeneous suicide onset variables will allow further examination and clarification of the mechanisms and therapy impact outlined here.

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