Suicide Risk Reduction: Suicide Specific Treatment

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MAGELLAN BEHAVIORAL HEALTH OF PA

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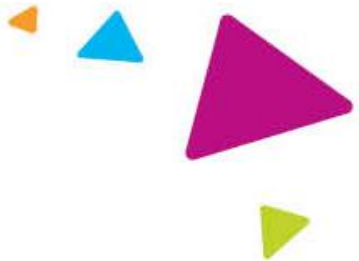
Course Outline

1. Review of Components of Suicide Risk Reduction
2. Conceptualizing Suicidality
3. The Concept of Suicide Specific Treatment
4. Evidence-based Suicide Specific Treatments
5. Safety Planning – An Ongoing Process
6. Resources for Further Training

Learning Objectives



01

Describe Components of Suicide Risk Reduction

02

Identify how to Conceptualize Suicidality

03

Apply the Rationale for Suicide Specific Treatment (SST)

04

Explain the Role of Empathy and Collaboration

05

Relate Elements Of Evidence-based SST

06

Recognize Available Evidence Based SST & Available Training

Addressing patient risk for suicide

No way to predict suicide based solely on psychiatric diagnosis

Few persons who suffer with a psychiatric disorder will attempt suicide

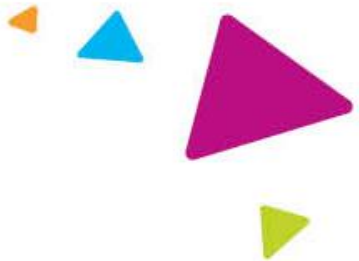
Most suicides are related to psychiatric disease (depression, SUD, & psychosis) are most relevant risk factors

The risk of suicide has been estimated to be 5–8% for several mental disorders

Major depression is a risk factor for suicide attempt

Many risk factors for suicide attempt, but none are predictive.

Components of Suicide Risk Reduction



Risk Assessment

Safety Planning*

Suicide Specific Treatment

*including Means Restriction Planning

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Assessment Tools and Training

- The Columba Suicide Severity Rating Scale (C-SSRS): https://cssrs.columbia.edu/documents/lifetimerecent/
- The Columba Suicide Severity Rating Scale - Pediatric Version (C-SSRS-PV): https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf
- Training on administering the Columba Suicide Severity Rating Scale: https://youtu.be/Xfddz_Yfnc4
- The Suicide Specific Form, 4th revision (SSF-4):
- https://cams-care.com/
- Training on use of the SSF-4 is available on the CAMS Care website
- Prevent Suicide PA Learning: Collecting Valid Data: https://youtu.be/WyxSuzWs7sw (challenges associated with assessing adolescents)

Safety Plan Tools and Training

- The Stanley Brown Safety Planning Intervention can be found here:

https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf

- You Tube - Safety Planning with the Stanley-Brown Safety Plan: Dr. Barbara Stanley

https://youtu.be/2g6PCKJ4m9o

“Why do people attempt suicide?”

Suicide is a highly complex and multifaceted phenomenon

Intrapersonal Perception (maladaptive cognitions, hopelessness, low self-esteem, meaninglessness, negative self attributions

External Environment (social status, lack of income, abuse, discrimination, poverty, unemployment)

Orsolini, L., Latini, R., Pompili, M., Serafini, G., Volpe, U., Vellante, F., Fornaro, M., Valchera, A., Tomasetti, C., Fraticelli, S., Alessandrini, M., La Rovere, R., Trotta, S., Martinotti, G., Di Giannantonio, M., & De Berardis, D. (2020). Understanding the Complex of Suicide in Depression: from Research to Clinics. *Psychiatry investigation*, *17*(3), 207–221. https://doi.org/10.30773/pi.2019.0171

Ten Commonalties of Suicide

1. The common stimulus in suicide is unendurable psychological pain.
2. The common stressor in suicide is frustrated psychological needs.
3. The common purpose of suicide is to seek a solution.
4. The common goal of suicide is the cessation of consciousness.
5. The common emotion in suicide is hopelessness-helplessness.
6. The common internal attitude toward suicide is ambivalence.
7. The common cognitive state in suicide is constriction.
8. The common interpersonal act in suicide is communication of intention.
9. The common action in suicide is egression.
10. The common consistency in suicide is with life-long coping patterns.

Stress–Diathesis Model of Suicidal Behavior

Risk for suicidal acts is determined by

↓

Psychiatric illness + individual circumstances (SDOH)

↓

Diathesis (tendency to experience more suicidal ideation/be more likely to act on suicidal feeling)

↓

Cognitive Stress–Diathesis Model (the “cry of pain” model) – 3 components:

Sensitivity to signals of defeat Hypersensitivity to stimuli signaling “loser” status	Perceived “no escape” Limited problem-solving abilities	Perceived “no rescue” limited fluency imagining positive future events

Why Suicide Specific Treatment

Treating the Psychiatric Disorder is not sufficient

Identify and target elements of the diathesis

Diathesis is unique to each person.

3 Theories of Suicidality

Cube Model

- External Psychological Stressors
- Agitation – impulsive desire to "do something"
- Psychological pain

Hopelessness

- Negative view of the self in relation to the future

Self-Regard

- Awareness of one's inadequacies
- Negative Attribution of Failures
- Self-awareness is painful.
- Escape from aversive self-awareness
- Self Loathing

Shneidman, E. S. (1999). The psychological pain assessment scale. Suicide and Life-Threatening Behavior, 29, (4), 287-294.

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., Steer, R. A. (2006). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. Focus, 4 (2), 291-296.

Beck, A. T., Brown, G., & Steer, R. A. (1989). Prediction of eventual suicide in psychiatric inpatients by clinical ratings of hopelessness. Journal of Consulting and Clinical Psychology, 57(2), 309–310.

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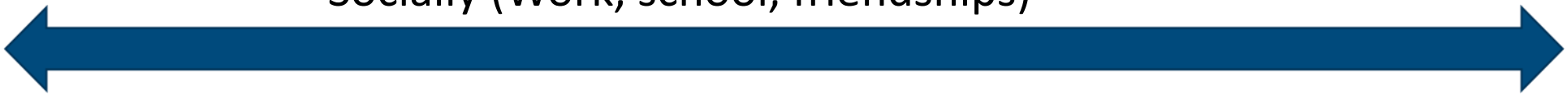
Engagement

Looking back over the last week, including today,
rate how you have been feeling about the following areas of your life

Individually (Personal well-being)

Interpersonally (Family, close relationships)

Socially (Work, school, friendships)



Overall (General sense of well-being)

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Assessing the Dimensions of Suicidality

_____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: _____
_____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: _____
_____	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: _____
_____	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: _____
_____	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: _____

Assessing the Dimensions of Suicidality

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**

2) How much is being suicidal related to thoughts and feeling about others? **Not at all: 1 2 3 4 5 : completely**

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

What is Suicide Specific Treatment

Assessment of suicide related self-report

Review of the Safety Plan

Treatment of patient defined problems

Brief Interventions for Suicide Risk

- Crisis Response Planning
- Safety Planning Intervention
- Teachable Moment Brief Intervention (TMBI)
- Motivational Interviewing For Suicidal Ideation (MI-SI)
- Attempted Suicide Short Intervention Program (ASSIP)

Crisis Response Planning

Component	Description
Narrative assessment	Chronological "story" of the suicidal crisis. Assessing for warning signs (e.g., thoughts feelings, physiology, behaviors), coping strategies, social support, and lethality. Typically done for first, worst/most lethal, and last suicidal crisis.
Warning signs	Indicators that a crisis may be starting and that the plan should be used. Warning signs can be behaviors, thoughts, emotions, or physical sensations and should be specific to a potential crisis.
Self-management	Helpful strategies that can be used to reduce stress. Should vary and be useful across situations.
Reasons for living	Reason for living; sense of purpose in life.
Social support	Someone who can be contacted to help reduce stress. May be family member, friend, coworker. Do not have to disclose to this person about the crisis.
Healthcare professionals	Contact information for psychologist/therapists, other medical providers, and other professional sources of help.
Crisis services	Crisis hotlines, emergency response, and/or presenting to an emergency department.

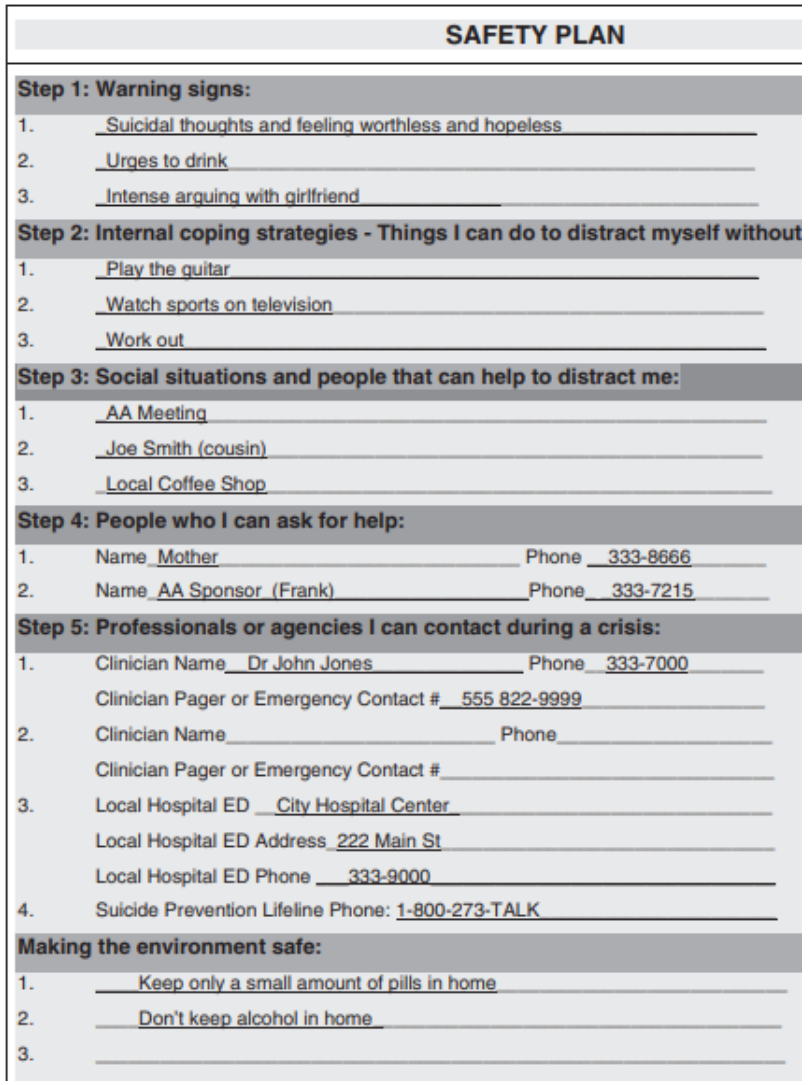
Stanley Brown Safety Planning Intervention

A brief standalone intervention that may reduce further suicidal behavior

A systematic and comprehensive approach to maintaining safety in suicidal patients.

Patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time, reducing the risk for suicide.

Includes means restriction and emergency contacts, and utilizes internal coping skills and distracting strategies



SAFETY PLAN

Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without

1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:

1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:

1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Dr John Jones Phone 333-7000
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name Phone
   Clinician Pager or Emergency Contact #
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3.

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Teachable Moment Brief Intervention (TMBI)

- Patients report elevated levels of motivation, hope, and reasons for living, shortly after a suicide attempt.
- TMBI is designed to sustain high levels of motivation, hope, and reasons for living.
- One 45-minute intervention during acute inpatient treatment
- May increase engagement in outpatient treatment upon discharge
- Establishing a collaborative relationship with the patient
- Focusing on identifying the unique factors associated with their suicidal ideation.

Motivational Interviewing For Suicidal Ideation (MI-SI)

2 sessions over 3 days

a patient's motivation to die in the direction of living with the goal of making life more worth living

MI-SI used as an adjunct to other treatment instead of as a standalone treatment

Attempted Suicide Short Intervention Program (ASSIP)

- Administered as add-on therapy to usual clinical management
- Video-recorded narrative interview of the suicidal crisis in a safe environment
- Review video to increase insight into the suicidal mode
- Develop list of future goals, individual warning signs, and safety plan
- Video prompted re-exposure to strengthen awareness of warning signs/safety plan
- Maintain contact with patient via 5 letters over 2 years.

Evidence Based Treatments for Suicidal Risk

Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)

Cognitive Therapy for Suicide Prevention (CT-SP)

Collaborative Assessment and Management of Suicidality (CAMS)

Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)

A manualized cognitive behavioral treatment for adolescents and adults who recently attempted suicide (≤90 days).

Proven effective treating episodes of acute suicide ideation in which precipitants can be identified.

Based on a stress-diathesis model of suicidal behavior

Primary goals of this intervention

- reduce suicidal risk factors
- enhance coping
- prevent suicidal behavior.

Cognitive Behavior Therapy-Suicide Prevention (CBT-SP)

CBT-SP was developed using a risk reduction, relapse prevention approach

Theoretically grounded in principles of cognitive behavior therapy & dialectical behavioral therapy

CBT-SP consists of acute and continuation phases, each lasting about 12 sessions includes:

- a chain analysis of the suicidal event
- safety plan development
- skill building
- psychoeducation
- family intervention (adolescents)
- relapse prevention

Cognitive Therapy for Suicide Prevention (CT-SP)

Evidence-based, manualized treatment developed for individuals who recently attempted suicide,

Protocol can also be applied to individuals with acute suicidal ideation.

Assumes individuals who are suicidal or who attempt suicide lack specific coping skills

Cognitive and behavioral strategies were applied to address identified thoughts and beliefs

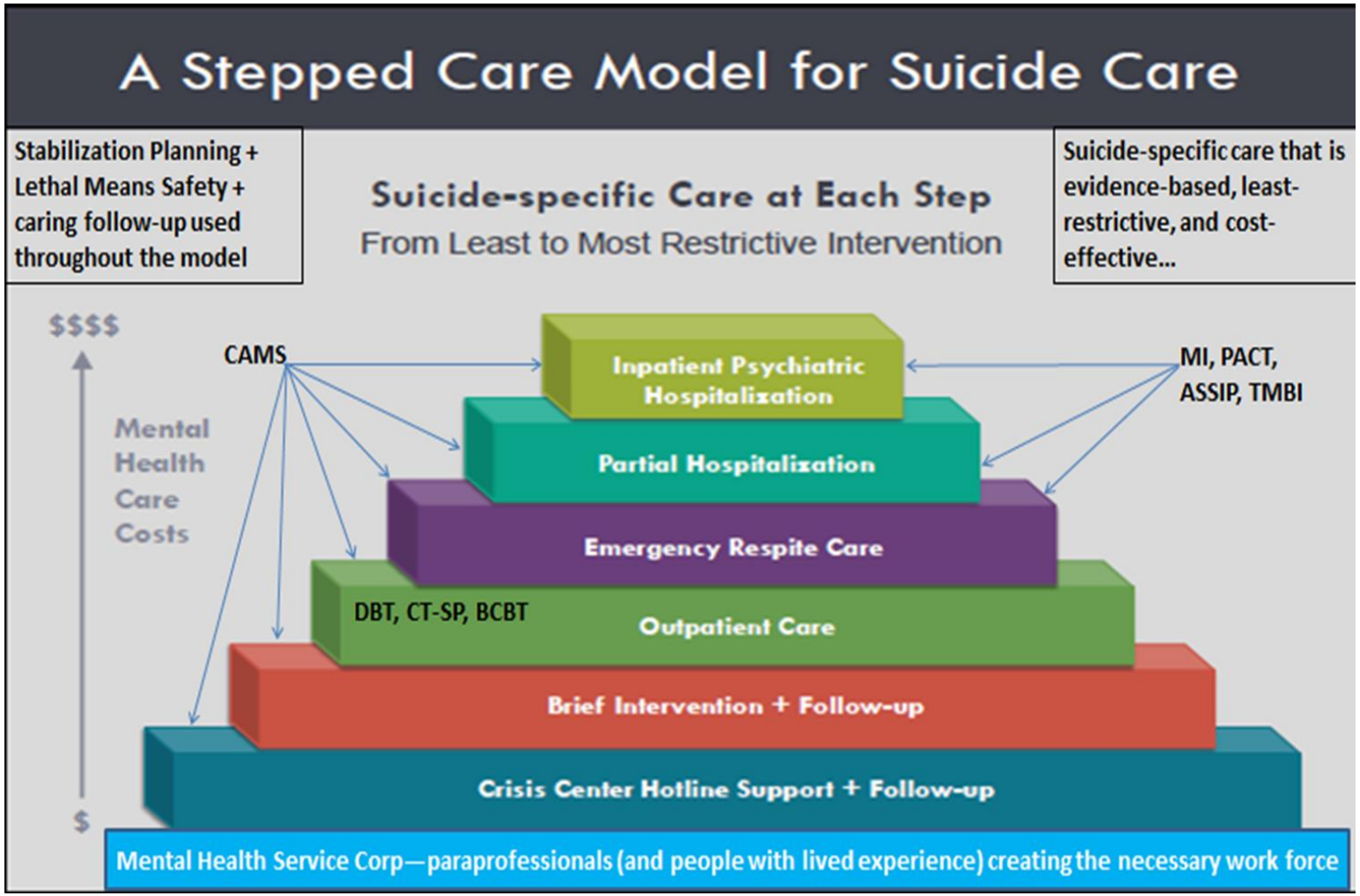
Patients develop adaptive ways of coping with stressors that provoked the suicidal crisis

CT-SP targets suicidal ideation and behavior directly

Collaborative Assessment and Management of Suicidality (CAMS)

- CAMS as a Well Supported intervention for suicidal ideation per Center of Disease Control and Prevention criteria.
- A phenomenological approach to understanding a patient's suicidality
- Suicide Status Form (SSF-4) used to document assessment, treatment planning, tracking, and outcome.
- # of sessions is determined by patient's progress in reducing SI
- Suicide-specific treatment planning

Suicide Specific Treatment



- Increase Member access to high quality suicide risk assessment and risk reduction interventions at ALL levels of care.
- Increase clinician access to high quality tools and training resources
- Increase utilization of high-quality suicide risk assessment and suicide risk reduction intervention at all levels of care

Jobes, D. A., Gregorian, M. J., & Colborn, V. A. (2018). A stepped care approach to clinical suicide prevention. *Psychological services*, *15*(3), 243.

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So, What about Trauma?

Trauma Informed Conceptualization

Seek to understand all the circumstances that contribute to the patient's perspective on the problems that drive suicidal ideation and behavior:

- The patient's experience of past adversity
- The patient's current exposure to adverse circumstances
- The patient's current capacity of emotional management
- The extent of the patient's suffering related to difficulty regulating emotions.

Factors to consider in identifying what kind of Suicide Specific Treatment might

- The chronicity of the patient's experience of suicidal ideation
- The patient's ability to identify discrete drivers for suicidal ideation or behavior may be related to

Trauma and Suicidality

Trauma has a potent impact on the risk of suicidality among individuals with PTSD

Childhood maltreatment appeared to have a remarkably strong relationship to suicidal behavior

Traumas relating to assaultive violence and peacekeeping also had similarly high rates of suicide attempt and suicidal ideation

Multiple traumas increased suicidality,

Trauma and Suicidality

Seriously neglected < 18 years by parent/caretaker
Saw serious fights at home < 18
Attacked/beaten/injured < 18 years by parent/caretaker
Attacked/beaten/injured by spouse/romantic partner
Attacked/beaten/injured by anyone else
Sexually assaulted/molested/raped
Stalked
Mugged/held up/threatened with weapon
Kidnapped/held hostage or prisoner of war
Serious/life-threatening accident
Serious/life-threatening illness
Serious fire/tornado/flood/hurricane
Active military combat
Peacekeeping/relief work in a war zone
Unarmed civilian in war/revolution/military coup
Refugee
Directly experienced terrorist attack
Injured in terrorist attack
Indirectly experienced terrorist attack
Saw someone badly injured/ killed or encountered corpse
Someone close died unexpectedly
Someone close died in terrorist attack
Someone close directly experienced terrorist attack
Someone close had other serious/life-threatening event
Someone close had other stressful/traumatic event
Other traumatic event

Rates of Suicidal Ideation and Suicide Attempt as a Function of the Number of Separate Traumas Reported

Separate traumas	Suicidal ideation			Suicide attempt		
	n	%	95% CI	*n*	%	95% CI
0	159	5.50	[4.5, 6.7]	24	0.9	[0.5, 1.5]
1–2	53	15.60	[11.4, 21]	13	3.3	[1.7, 6.3]
3	87	25.70	[20.5, 31.7]	18	5.8	[3.2, 10]
4	75	22.00	[17.2, 27.7]	24	7.1	[4.4, 11.2]
5	93	26.80	[21.8, 32.5]	33	8.3	[5.6, 12]
6	85	33.10	[26.8, 40.2]	27	8.7	[5.6, 13.3]
7	74	36.70	[29, 45.3]	29	14.9	[9.4, 22.7]
8	82	42.30	[34.5, 50.5]	44	21.6	[15.6, 29.2]
9	59	40.70	[31.3, 50.8]	30	19.3	[13.2, 27.3]
≥ 10	172	51.40	[44.7, 58.1]	122	36.9	[30.8, 43.6]

Note. Sample sizes are unweighted. Percentages and 95% confidence intervals (CIs) are weighted.

LeBouthillier, D. M., McMillan, K. A., Thibodeau, M. A., & Asmundson, G. J. (2015). Types and number of traumas associated with suicidal ideation and suicide attempts in PTSD: Findings from a US nationally representative sample. Journal of traumatic stress, 28(3), 183-190.

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Dialectical Behavioral Therapy (DBT)

DBT proven effective with suicidal "multiproblem adolescents"

DBT conceptualizes suicidal behavior as a learned method of coping

Suicidality with chronic, aversive emotional dysregulation

Safety Planning – A Continuous Quality Improvement Process

The Safety Plan is reviewed and revised during each session based on the patient's report of their response to know drivers and drivers not previously reported

The Safety Plan review in each session offers the patient an opportunity to reconsider their relationship to the suicidal crisis and the drivers for that crisis.

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