

Trauma, Life Events, & the Acquired Capability for Suicide: What's Risky About a Risk Factor?

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... a long day

- Understand the relationship between trauma, painful and provocative life events, and suicide risk in adults.
- Understand the how to conceptualize traditional risk factors according to the interpersonal theory of suicide.
- Conduct a theoretically informed suicide risk assessment interview.
- Develop a theoretically informed formulation of suicide risk and complete appropriate documentation.

... that keeps getting longer.

- 9:00-10:00
 - Working with individuals at risk for suicide: Attitudes and approach
 - Understanding Suicide
- 10:00-10:30
 - The Interpersonal Theory of Suicide
- 10:30-10:45
 - Break
- 10:45-12:00
 - Acquired Capability
 - Painful & Provocative Life Events
 - Trauma
- 12:30-1:30
 - Lunch
- 1:30-2:00
 - Using risk assessment frameworks
 - General issues in risk assessment
- 2:00-3:00
 - Using the interpersonal theory to guide risk assessment
- 3:00-3:15
 - Break
- 3:15-4:15pm
 - Documentation of risk
 - Clinical management
- 4:15-4:30
 - Complete evaluation
- 4:31pm
 - Leave!!

Before we go forward

Who do we have in the audience?

Core Competencies

- Domain 1: Working with Individuals at Risk for Suicide
- Domain 2: Understanding Suicide
- Domain 3: Collecting Accurate Assessment Information
- Domain 4: Formulating Risk
- Domain 5: Developing a Treatment & Services Plan
- Domain 6: Managing Care
- Domain 7: Understanding Legal & Regulatory Issues

Working with Suicidal Patients

Attitudes & Approach

Working with Suicidal Patients

- An un(der)-prepared graduate student's story...
- Why are we reactive to suicidal patients?
- Managing one's reactions to suicide
 - Self-awareness
 - Emotional reactions
 - Personal beliefs
 - Effect on patients?

Working with Suicidal Patients

- What is your goal when you realize you have a suicidal patient in front of you?
- What is the patient's goal?
- Differences (and potential conflict) in goals
- Skill acquisition
 - Provide an understandable model of suicidality
 - Identify common goals for treatment

Working with Suicidal Patients

- How do our emotions and beliefs about suicide influence our behavior w/ suicidal patients?
- Maintaining a collaborative, non-adversarial stance
 - Patience, empathy, understanding
 - Active listening
 - Acknowledging ambivalence about living
 - Contextualize/normalize feelings of despair
 - Provide an understandable model of suicidality
 - Identify common goals for treatment

Working with Suicidal Patients

- What can you do and what can you not do?
- *Realistically* assess your ability to assess and care for a suicidal patient
 - Identify the specific role for which you are best suited
- Skill acquisition
 - Recognize time and resource demands of suicidal patients
 - Articulate expectations regarding care of high-risk patients
 - Articulate and establish appropriate boundaries for a high-risk patient caseload

Understanding Suicide

Definitions, Epidemiology,
& Some Other Stuff

Understanding Suicide

- *Suicidality*...What does it mean!?
- Define basic terms related to suicidality
 - Differentiating
 - Morbid Ideation
 - Passive Suicide Ideation
 - Active Suicide Ideation
 - Self-harm
 - Suicide threat
 - Suicide attempt (with and without injury)
 - Suicide

What is it?

An adolescent male rushes to the kitchen after a heated argument with his parents. He frantically looks under the sink and impulsively drinks some bleach as his parents follow right after him. They take him to the local emergency room where he tells the ER physician that he was just mad and really didn't want to die.

What is it?

An intoxicated young female takes an overdose in her dorm room while her two college roommates are in the next room. Within a few minutes, she walks into the living area, obviously drunk, and tells her roommates that she took something because she wants her boyfriend to know how much she loves him. Her friends call 9-1-1 and she is taken to the local emergency room for evaluation.

What is it?

A middle-aged man retreats to an isolated, wooded area out by a lake near his house. He has not told anyone where he was going or that he has been thinking of suicide. He has been depressed since losing his job two months prior. He takes out a loaded gun, places it to his head and after a few minutes puts the gun away and returns home to his wife and child, never divulging anything to his family about what happened. He tells his primary care physician three weeks later during a routine check-up, at which time he hesitantly acknowledges that he's been very, very depressed.

Key Dimensions

- Ideation
 - Suicidal vs. Morbid
 - Active vs. Passive
- Intent
 - Subjective
 - Objective
- Evidence of Self-Infliction
- Outcome
 - Injury
 - No injury
 - Death

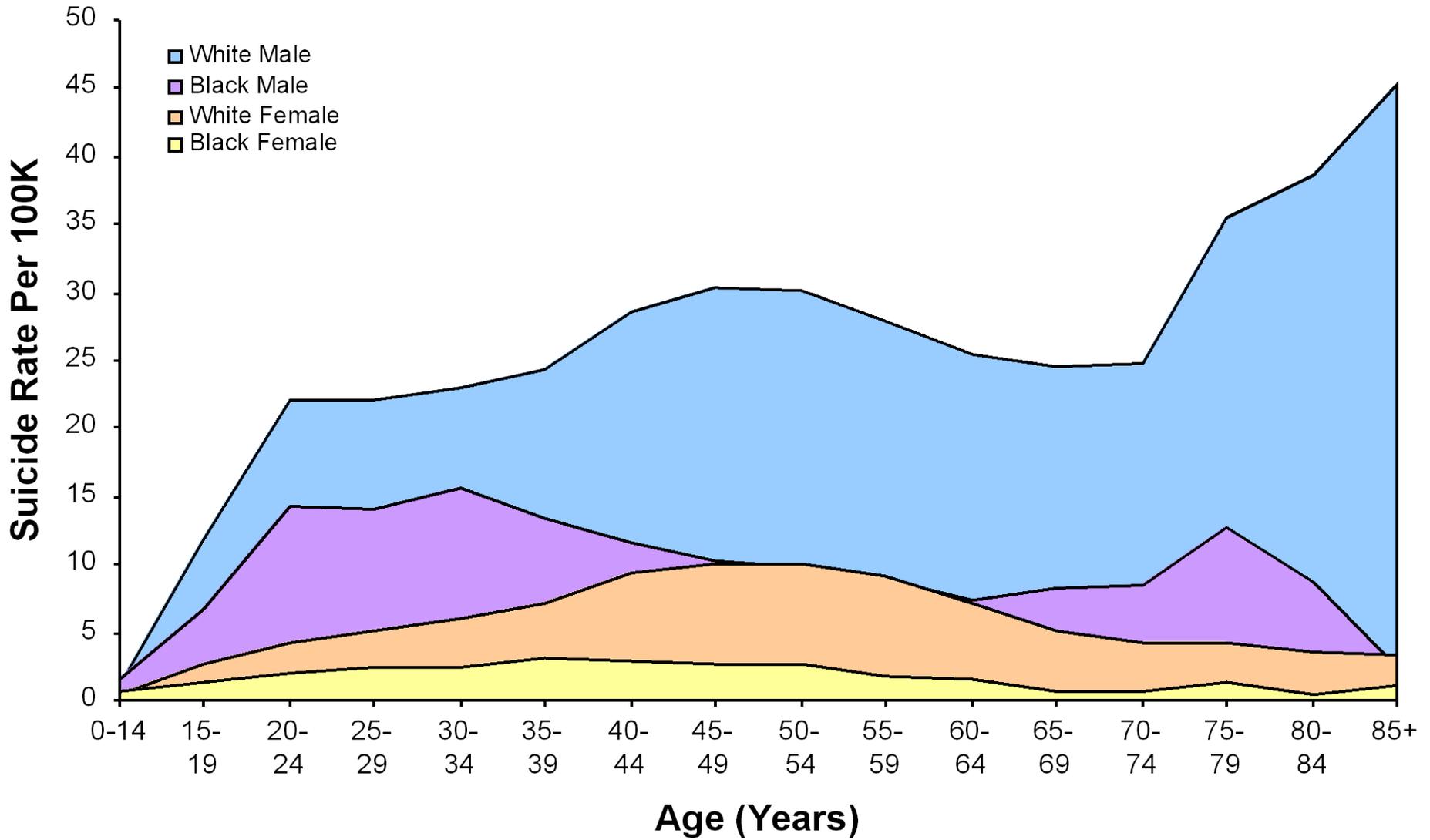
Understanding Suicide

- Epidemiology of Suicide
 - 2009: 36,909 deaths by suicide (12 per 100,000)
 - 1 death by suicide every 14 minutes
 - 101 deaths by suicide every day
 - 10th leading cause of death
 - Of these, about 79% (29,089) are male (19.2 per 100,000 for males)
 - About 21% (7,820) are females (5 per 100,000)
- 0.00012%

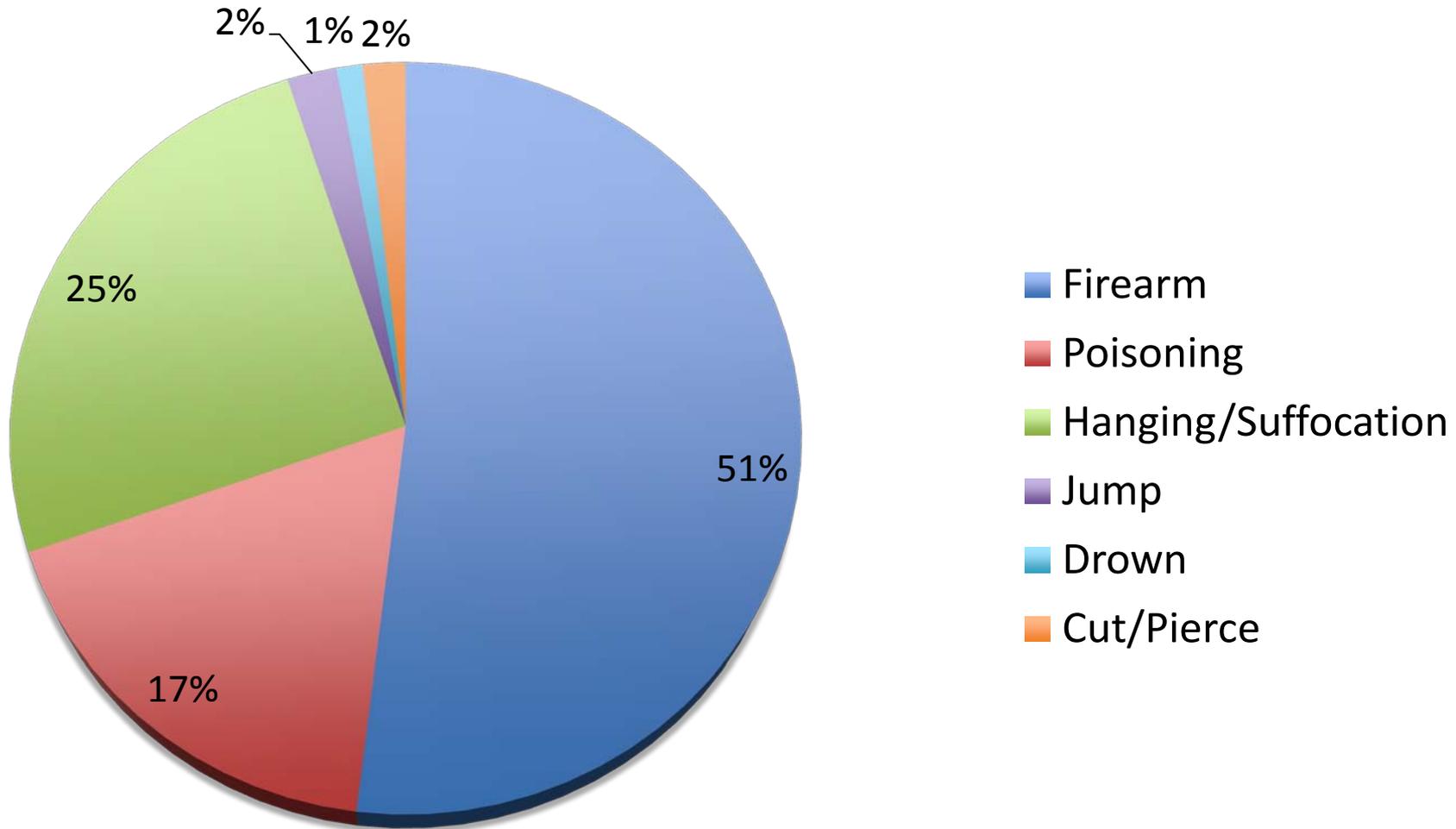
Understanding Suicide

- Epidemiology of Suicide attempts
 - 25 suicide attempts for each death by suicide
 - 750,000 suicide attempts per year
 - Age variability
 - 100-200 attempts per each death for adolescents and younger adults
 - 4 attempts per each death for older adults
 - 3 female attempts for each male attempt

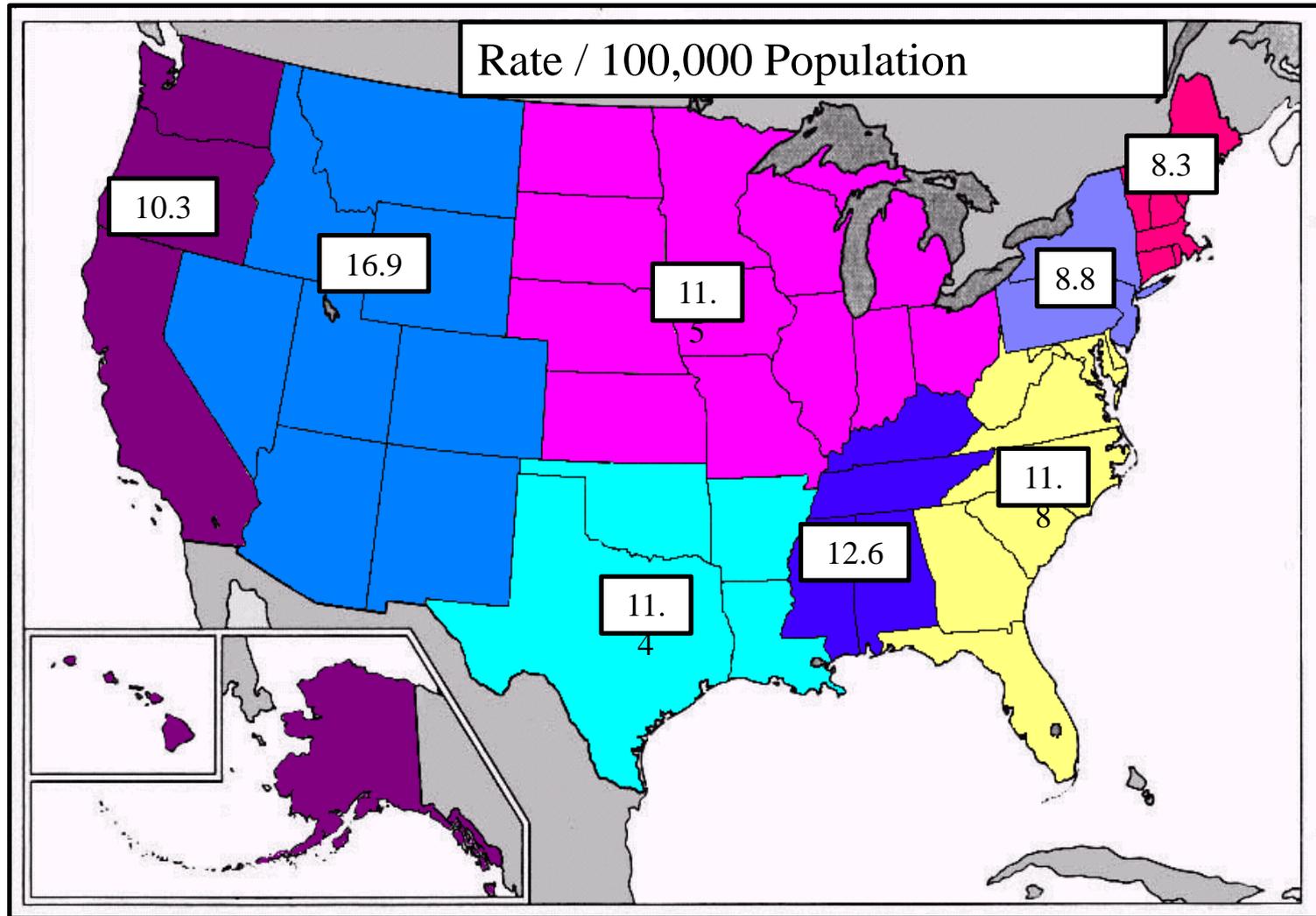
Suicide Rates by Age, Race, and Gender U.S. -- 2007



Understanding Suicide



Understanding Suicide



How do we understand all this?

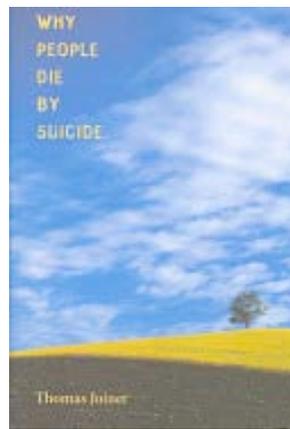
- What do risk assessments look like where you work?
- One typical suicide risk assessment is based on determining the number and severity of suicide risk and protective factors
 - If you have enough risk factors and not enough protective factors, you get worried

Risk Factors

- Mental disorder(s)
- Previous suicide attempts
- Social isolation
- Physical illness
- Unemployment
- Family conflict
- Family history
- Impulsivity
- Incarceration
- Hopelessness
- Agitation or sleep disturbance
- Childhood abuse
- Exposure to suicide
- Homelessness
- Combat exposure
- Self-esteem, shame

What's wrong w/ this approach?

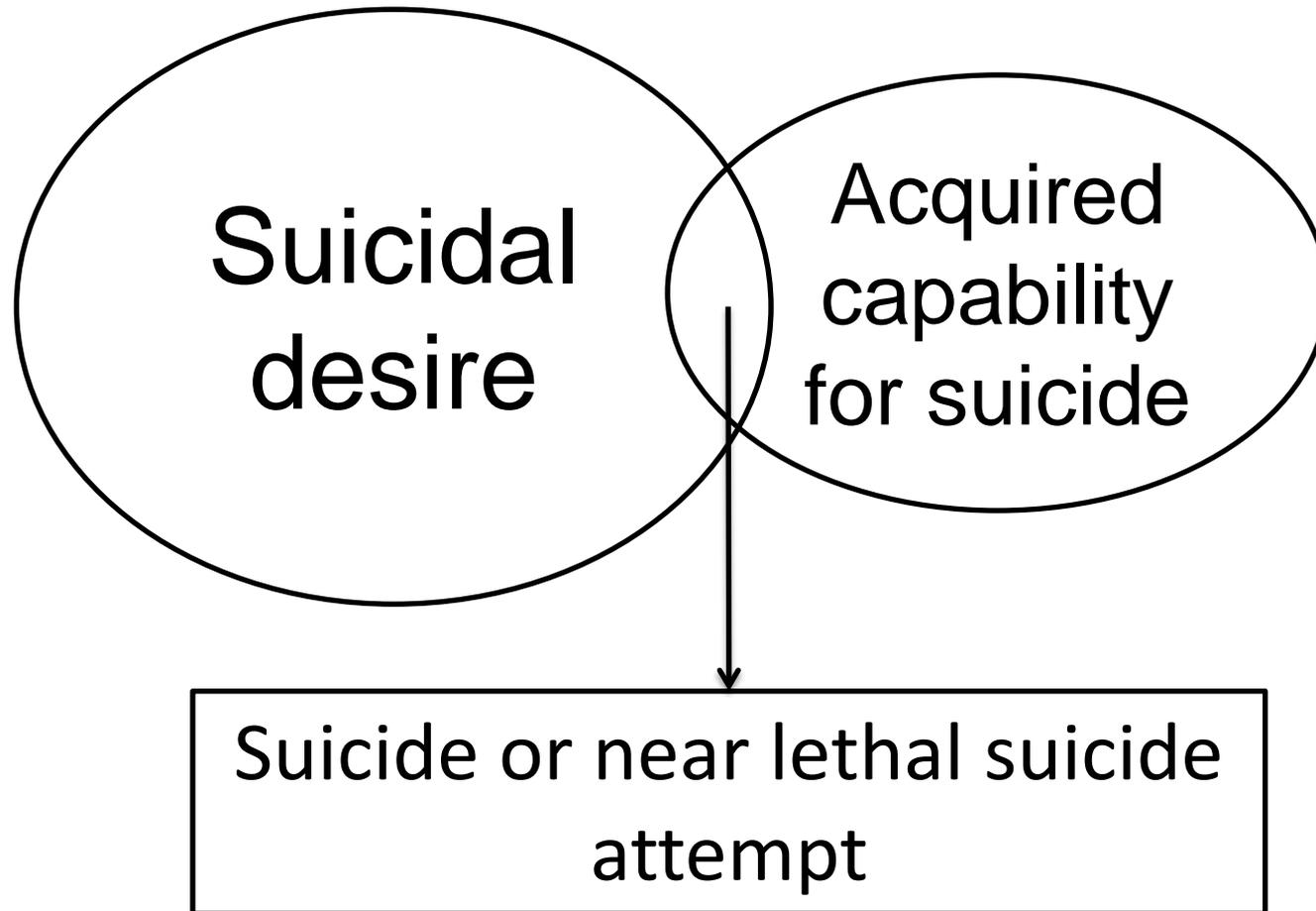
- Theory Driven Risk Conceptualization as an alternative
 - Provides full understanding, which, in turn:
 - Tells you how to understand and contextualize the interaction of risk and protective factors
 - Helps you focus on prioritize information when conceptualizing risk
 - Is a useful clinical tool in that can
 - Provide the patient w/ a framework for understanding his or her problems
 - Identifies critical points of intervention



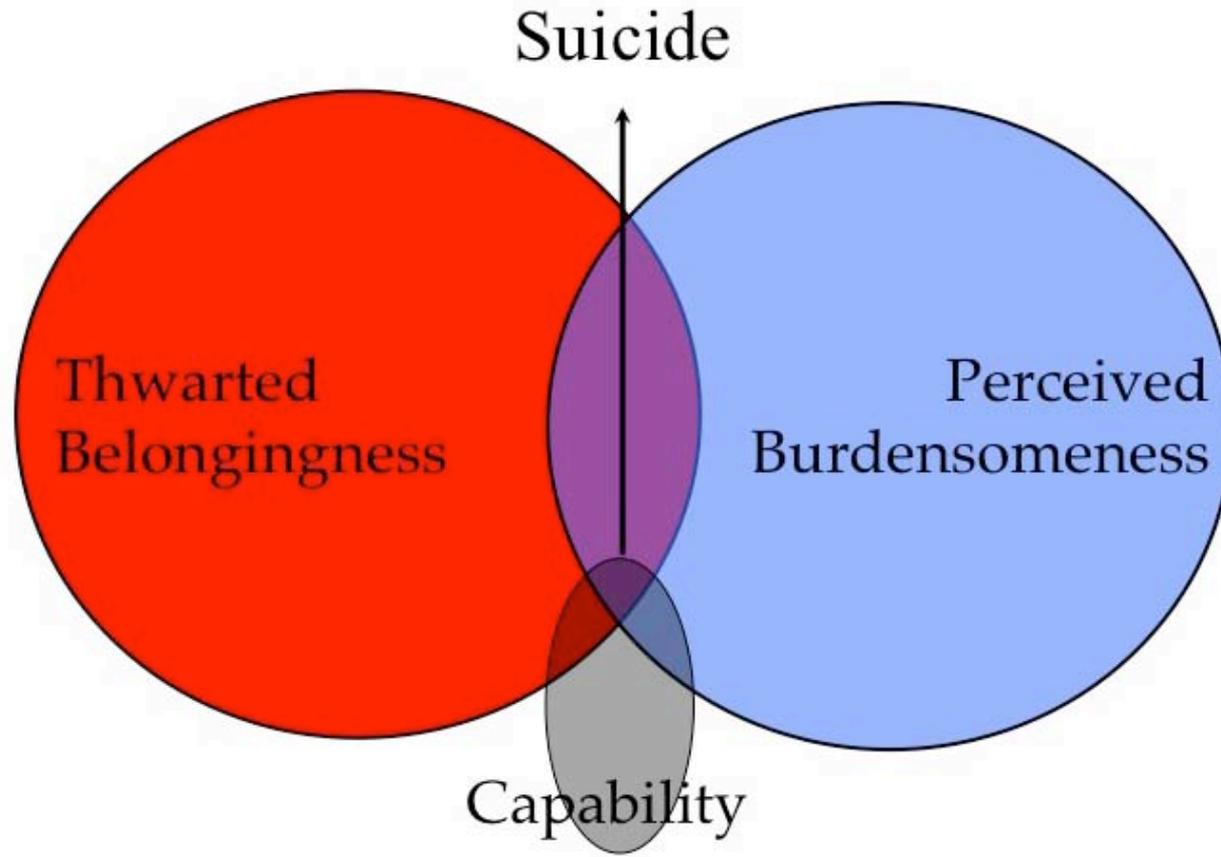
The Interpersonal Theory of Suicide

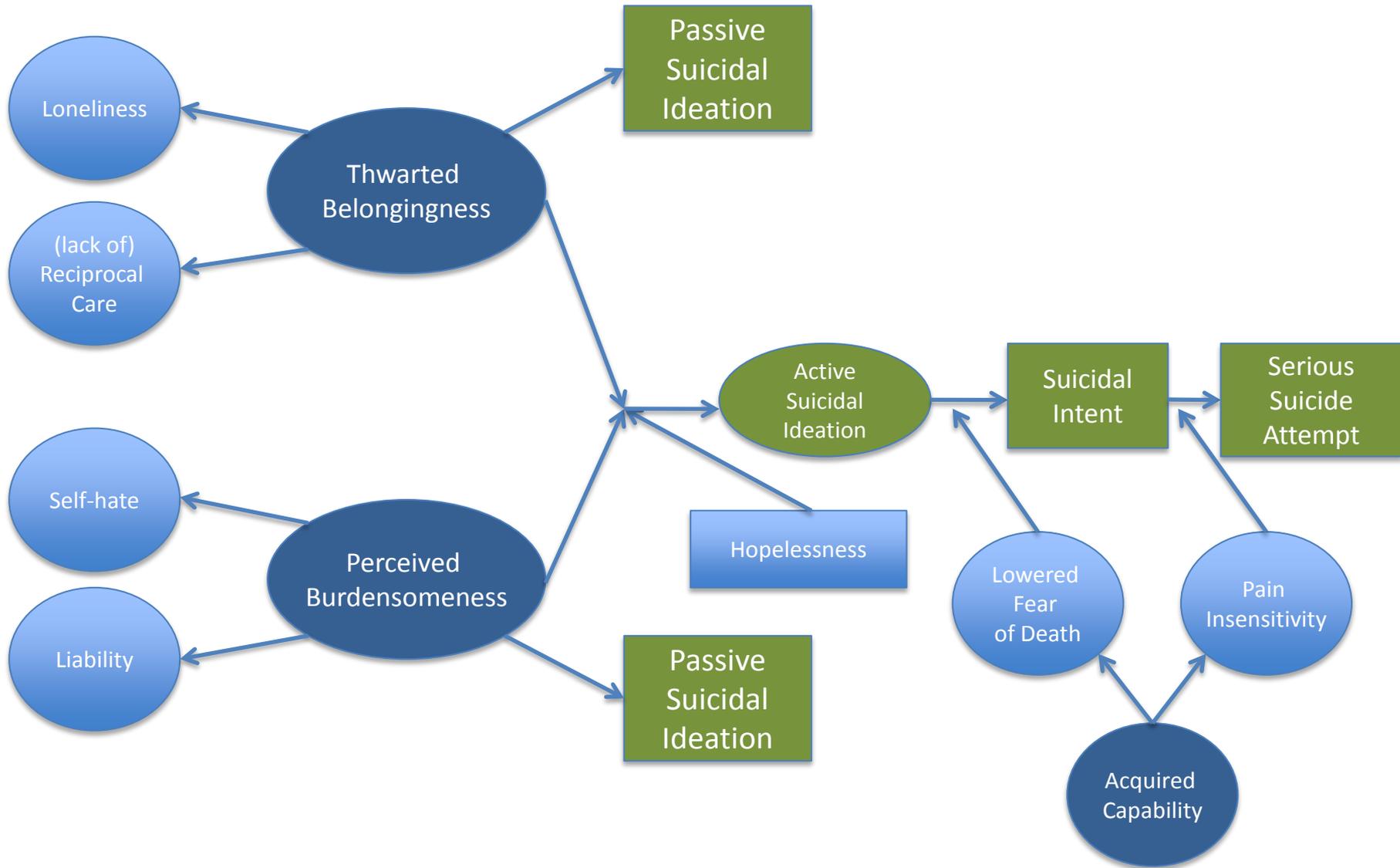
People die by suicide because they *want to* and because they are *able to* do so.

The Interpersonal Theory of Suicide

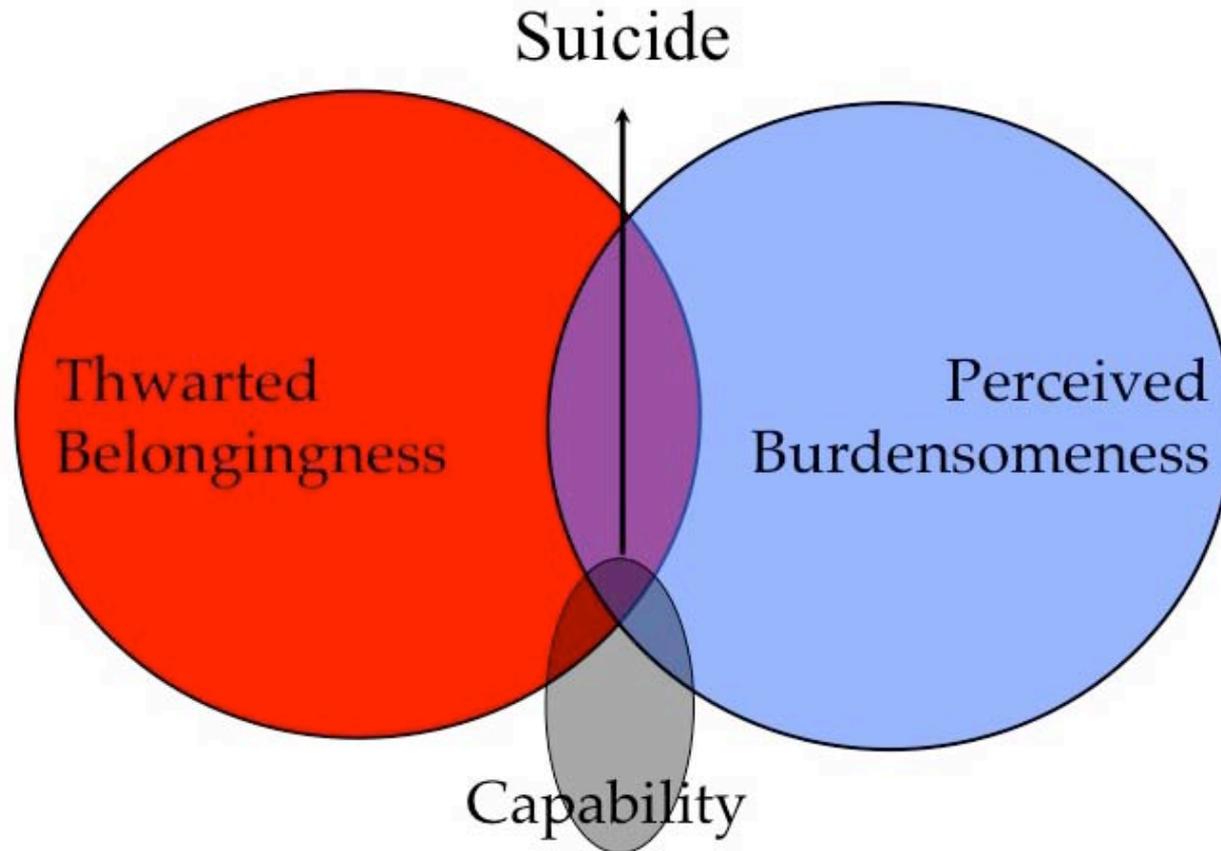


The Interpersonal Theory of Suicide





The Interpersonal Theory of Suicide



Thwarted belongingness

- Psychache
 - “stems from thwarted or distorted psychological needs” (Shneidman, 1996)
- The need to belong (Baumeister & Leary, 1995):
 - positive
 - frequent, proximal
 - perceptions of care

***Feeling connected and cared about
can be lifesaving***

Thwarted belongingness

- Living alone, unmarried
- Few social supports
- Lack of confidant
- Loneliness
- Social withdrawal
- Loss
- Family conflict



“I don’t
belong
anywhere
or with
anyone.”

Perceived burdensomeness

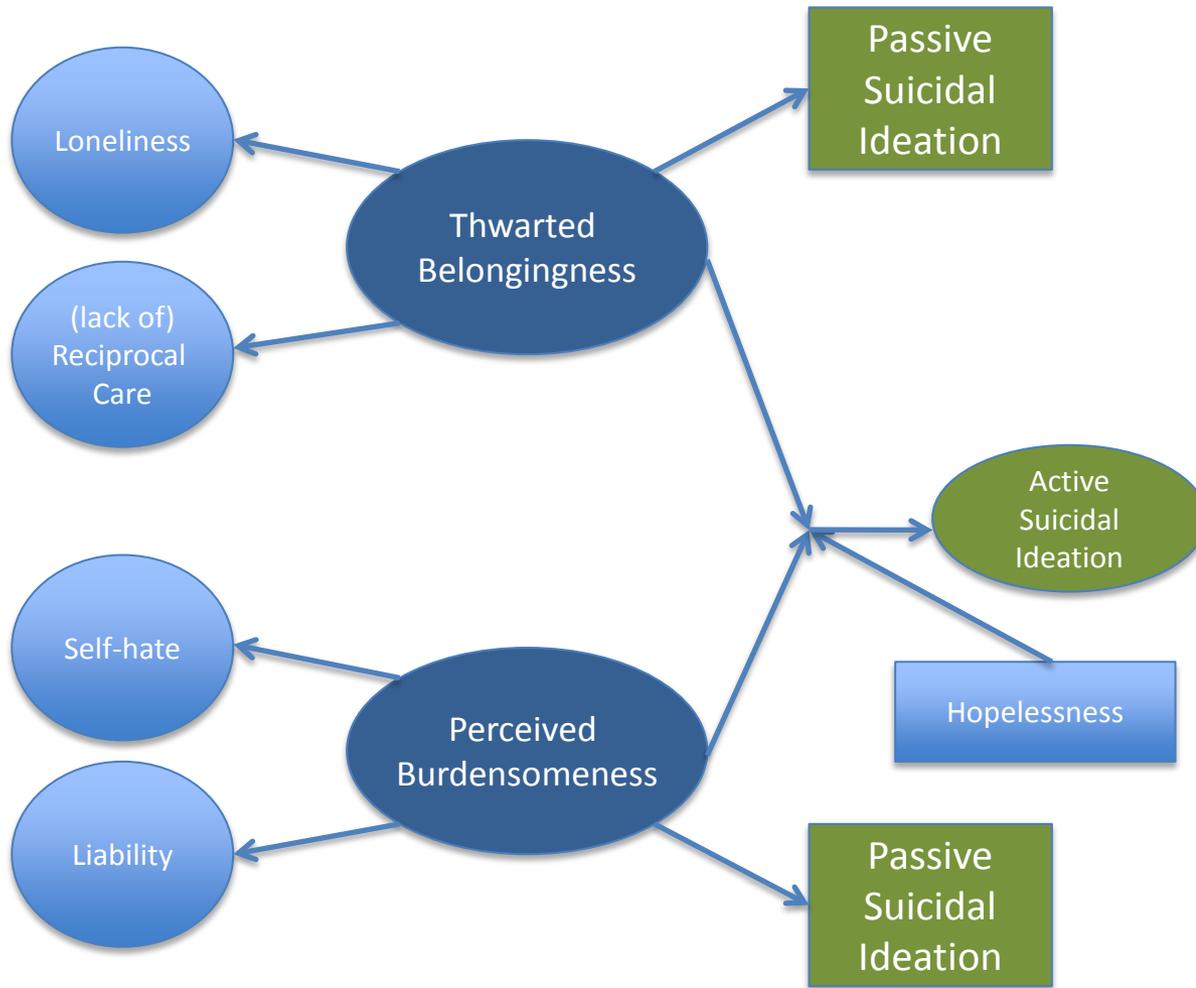
- Self-perceptions of incompetence
- Self-perceptions of self as a liability for others
 - My existence burdens family, friends, society
 - Mental calculation: “my death will be worth more than my life to family, friends, society, etc.”

Perceived burdensomeness

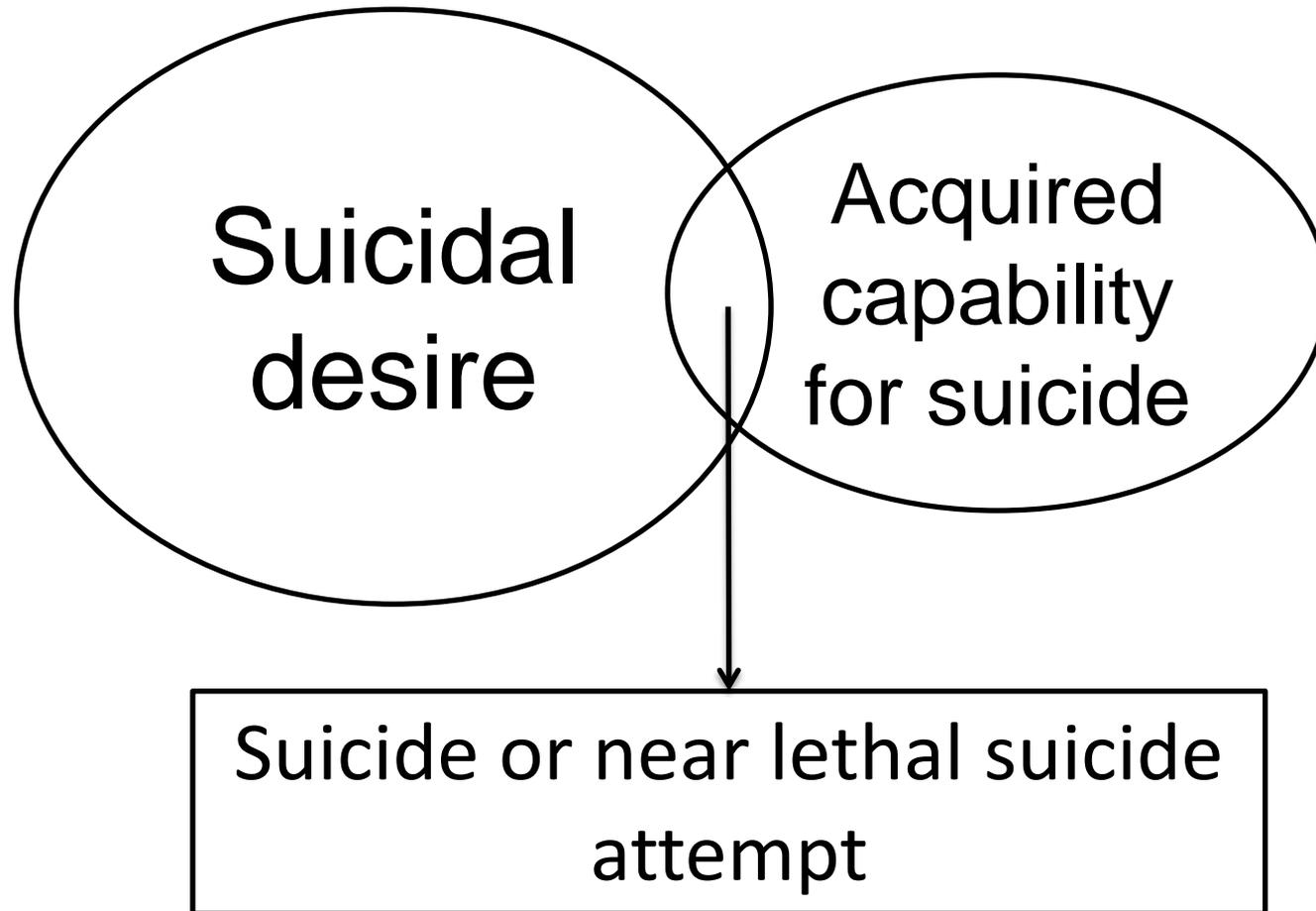
- Physical illness
- Functional impairment
- Unwanted, expendability in children
- Low self-esteem
- Unemployment
- Incarceration



“I am a
burden on
others”



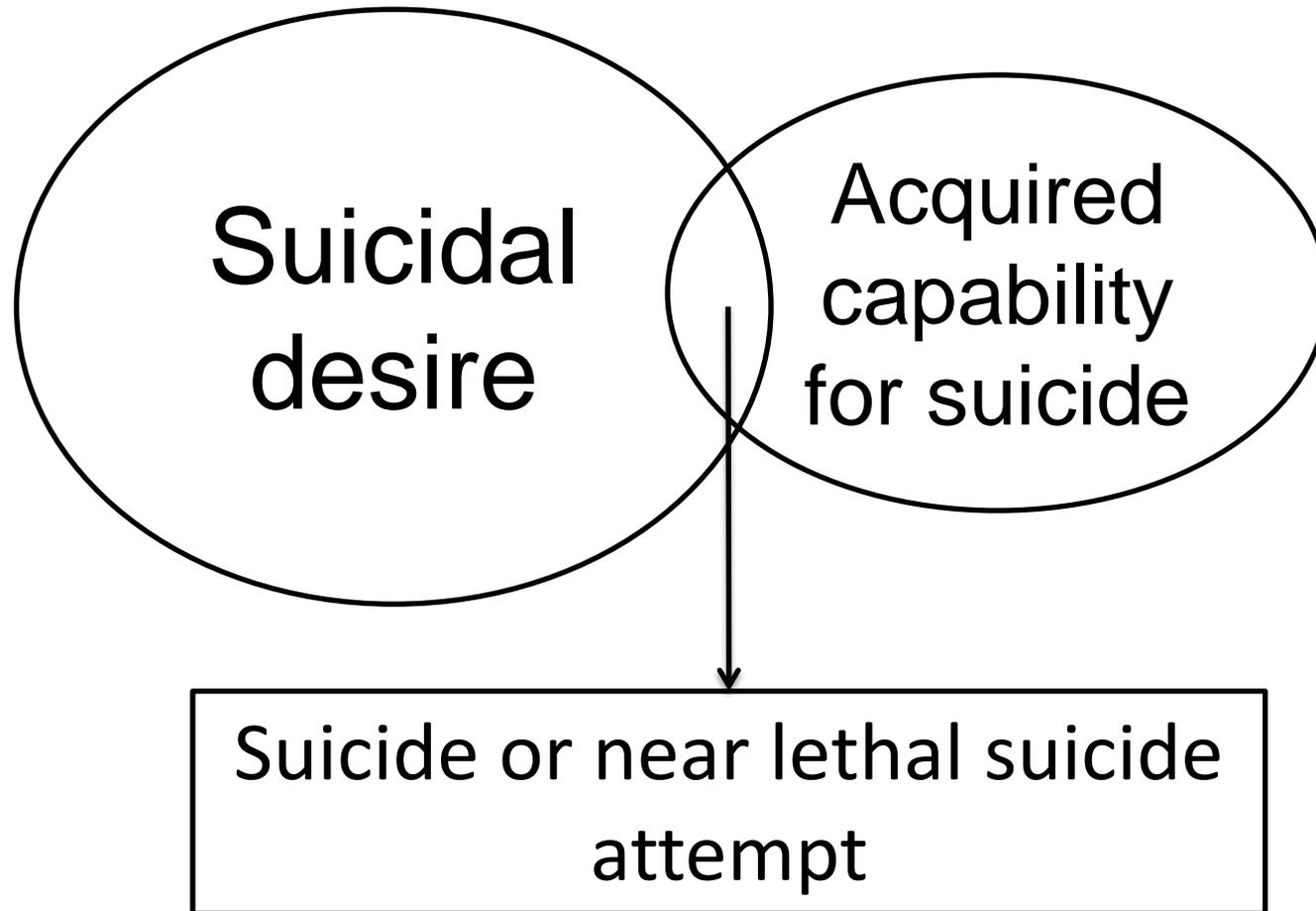
The Interpersonal Theory of Suicide



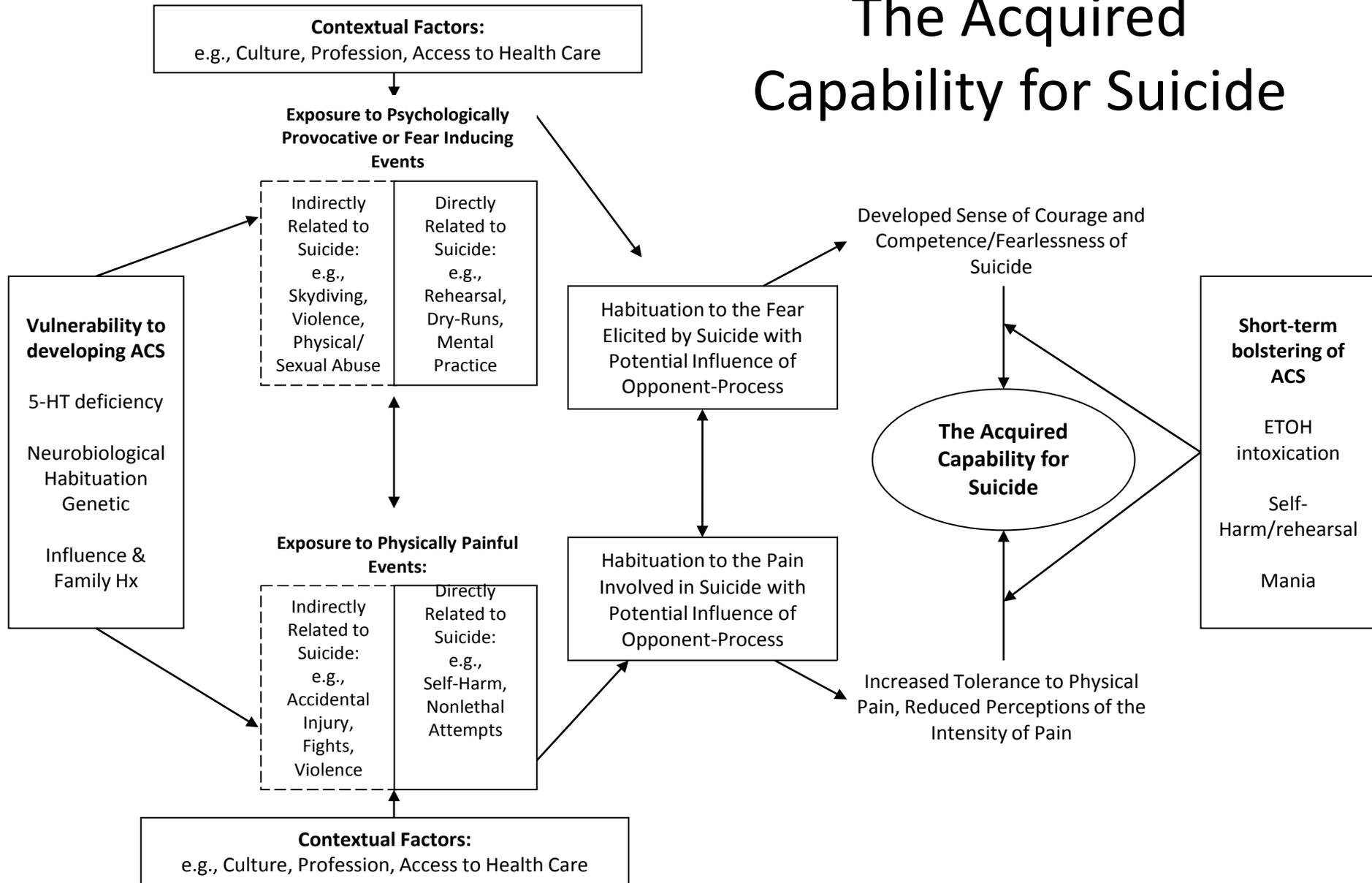
[Video](#)

BREAK TIME!

The Interpersonal Theory of Suicide

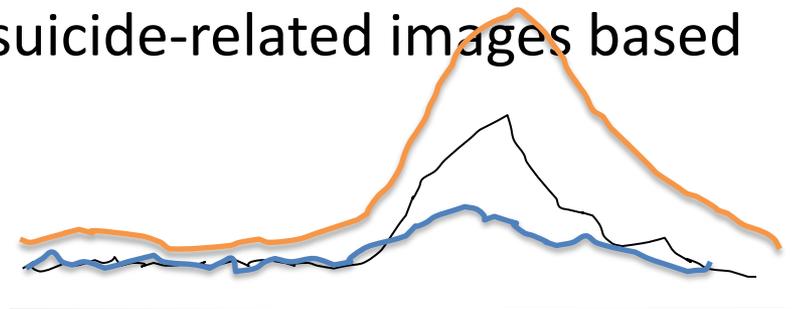


The Acquired Capability for Suicide



The Acquired Capability for Suicide

- Predictions
 - Suicide attempts, acquired capability, and painful & provocative life events
 - Painful & provocative life events and acquired capability
 - Individuals who have attempted suicide will show reduced self-preservation reflexes to suicidal threat cues
 - Differences in reactivity to suicide-related images based on suicide attempt status

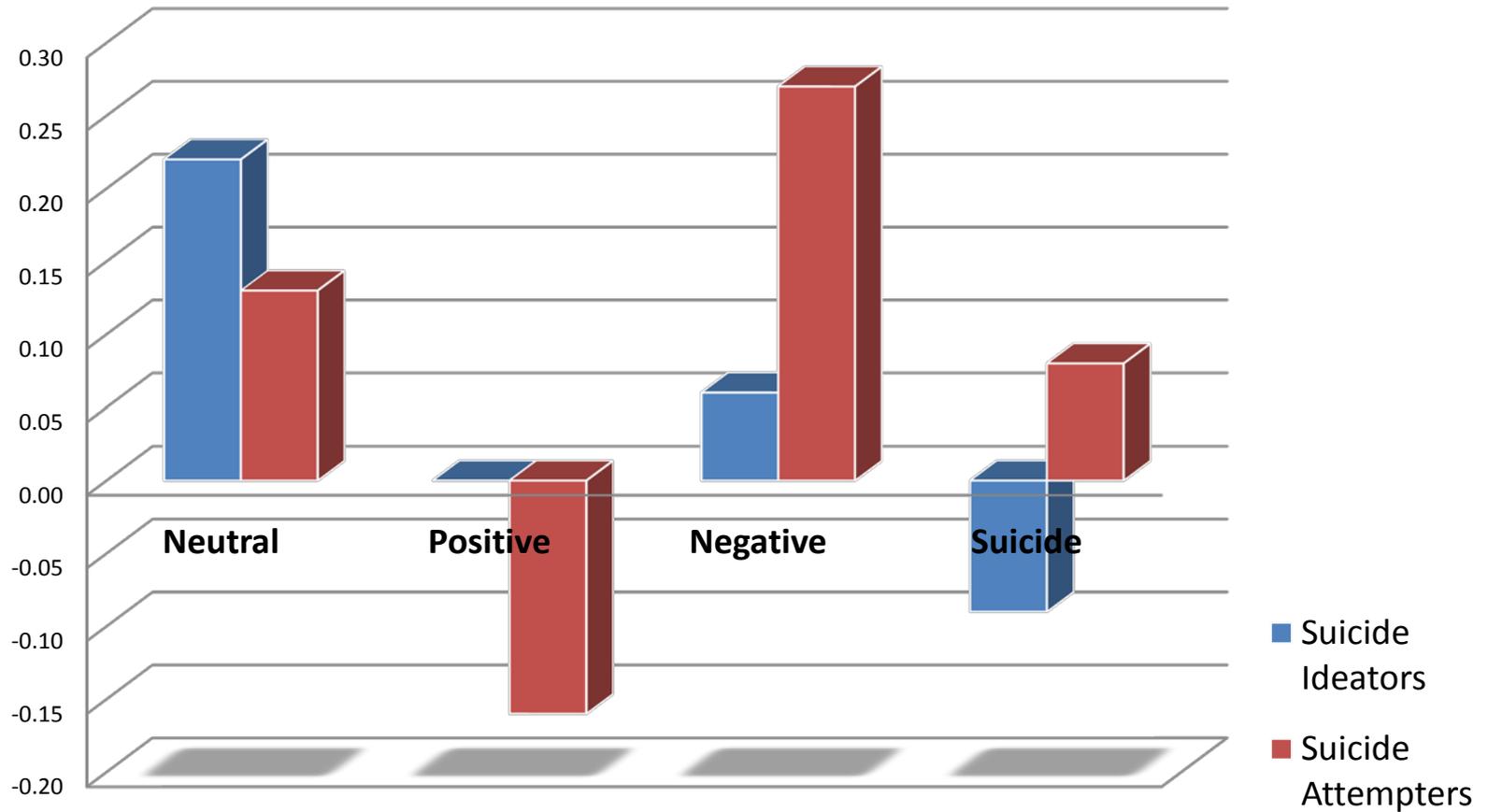


The Acquired Capability for Suicide

	ACSS*	PPES*	LES
Suicide Ideators	57.67 (15.16)	30.20 (16.66)	9.93 (4.01)
Suicide Attempters	71.13 (11.74)	61.80 (20.23)	11.07 (3.73)

- Step 1
 - Age: $\text{Exp}(b) = .98$
 - Gender: $\text{Exp}(b) = 1.41$
 - BHS: $\text{Exp}(b) = .86$
- Step 2 for each of the three regressions
 - ACSS: $\text{Exp}(b) = 1.11^*$
 - PPES: $\text{Exp}(b) = 1.12^*$
 - LES: $\text{Exp}(b) = .55$

The Acquired Capability for Suicide



The Acquired Capability for Suicide

- Suicide attempters report greater ACS compared to suicide ideators
 - Not evident on psychophysiological measures
- Who becomes capable of suicide?

The Acquired Capability for Suicide

- Male Vulnerability to Developing ACS?
 - Men die at higher rates, yet women attempt more
 - Men have higher ACS than women (Van Orden et al., 2008)
 - Men have higher pain tolerance than women
(Berkley, 1997)
- But why and how is this going to help us?



Traits that are valued in men

- “Denial, suppression, & control of emotion.”
(Wagstaff & Rowledge, 1995)
- Part of the stereotypical male gender role (Cheng, 1999)
- Associated with lower psychological well-being and unwillingness to seek mental health services (Murray et al., 2008)
- Could partially explain relationship between male gender and acquired capability

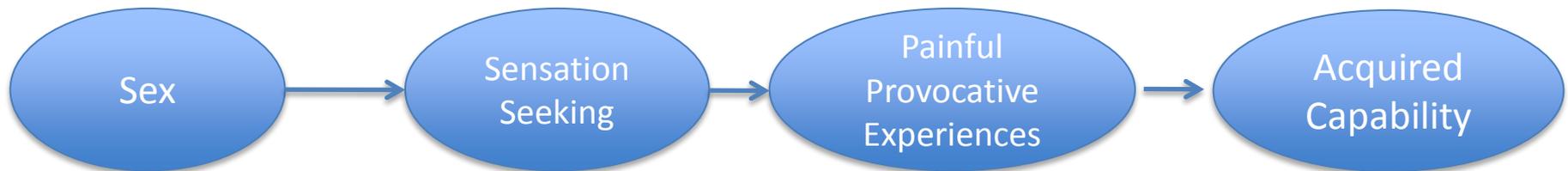


Stoicism





- “Tendency to seek excitement and adventure.” (e.g., Whiteside & Lynam, 2001)
- Associated with male gender (e.g., Zuckerman et al., 1978)
- Associated with exposure to painful and provocative experiences and acquired capability for suicide (Bender et al., in press)

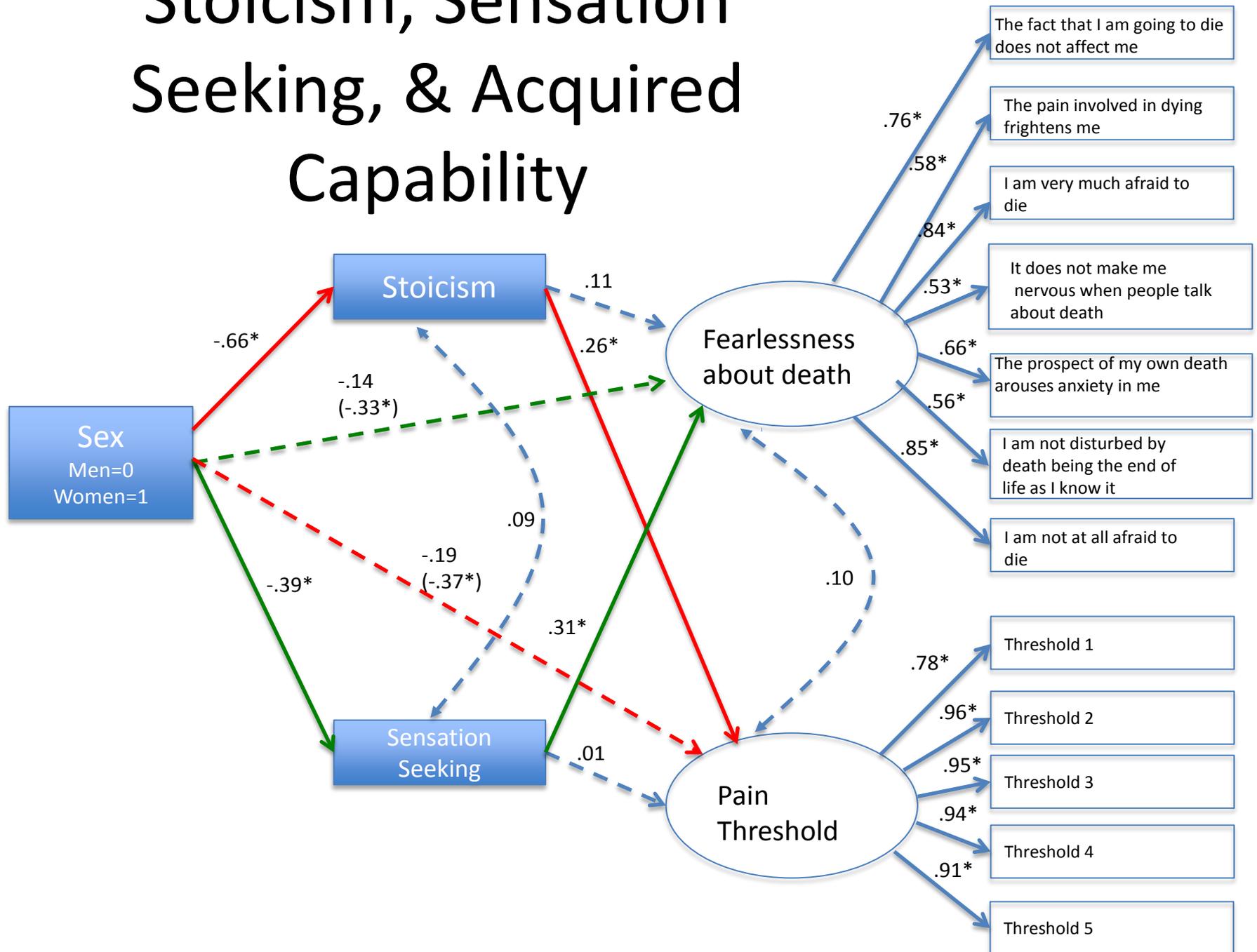


Sensation Seeking

Stoicism, Sensation Seeking, & Acquired Capability

- Test whether sensation seeking and stoicism account for the gender differences in acquired capability for suicide
- Determine if these variables differentially relate to the 2 domains of acquired capability for suicide
 - Self-reported fearlessness
 - Objectively assessed pain tolerance (pressure)

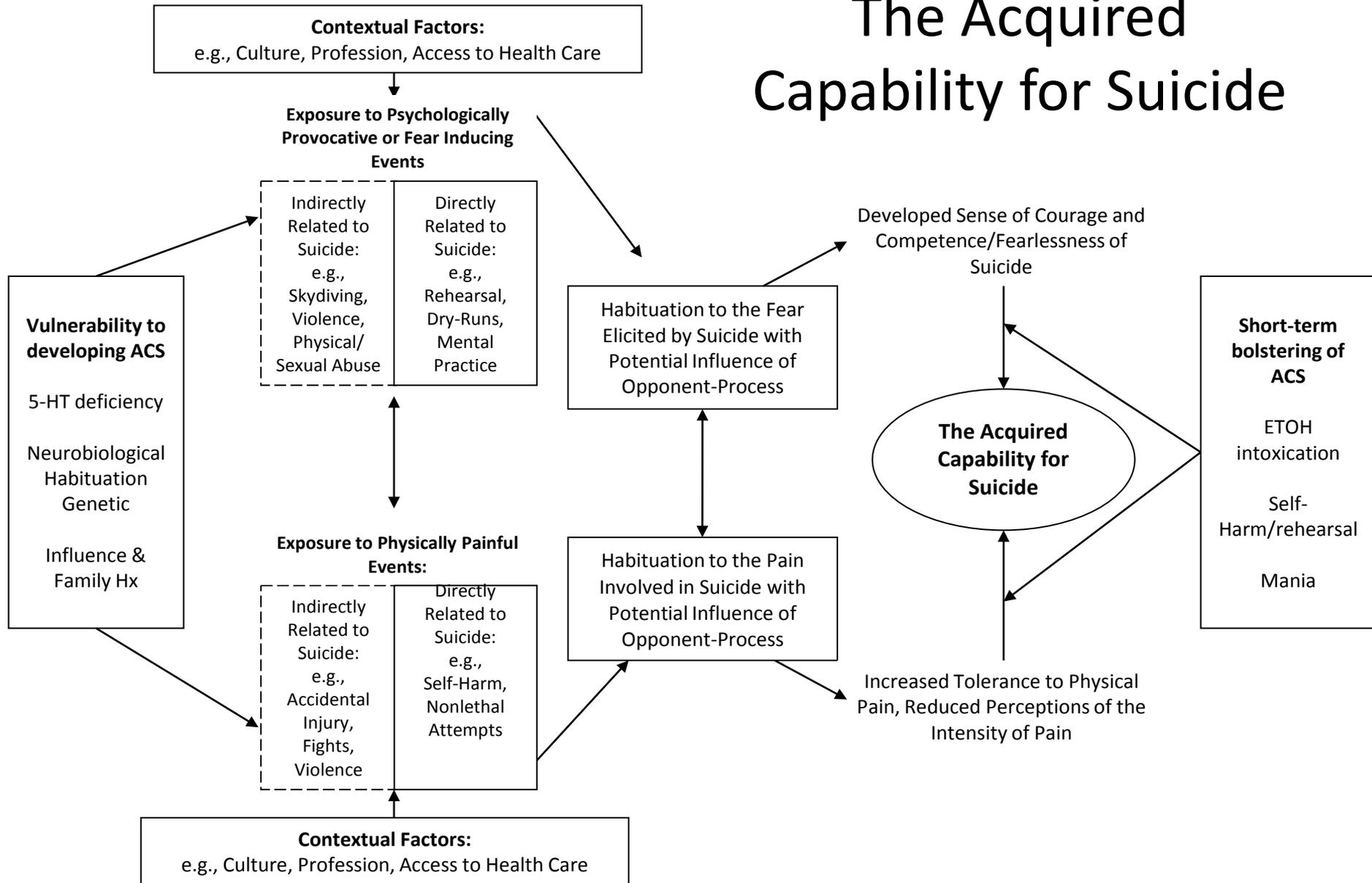
Stoicism, Sensation Seeking, & Acquired Capability



The Acquired Capability for Suicide

- Suicide attempters report greater ACS compared to suicide ideators
 - Not evident on psychophysiological measures
- Stoicism and Sensation seeking may explain why men are more vulnerable to developing ACS (pain tolerance & fearlessness, respectively)
- But outside of suicide attempts and personality traits, what life events promote ACS?

The Acquired Capability for Suicide



Life Events & Acquired Capability

- Can we identify dimensions of experiences and determine what types of experiences might promote acquired capability?
- Study of male prisoners
 - Exploratory Factor Analysis of self-reported life events by male prison inmates
 - Derived Scores and their relationship w/ acquired capability and attempt status

Event Domain	Sample Item(s)
Military Combat Experience	Have you been under enemy fire in a combat situation? Have you fired rounds at the enemy in a combat situation?
Accidental Injury & Natural Disaster Exposure	Has your apartment or home caught on fire? Have you ever had a serious animal bite that required medical attention?
Familiarity with Guns	Have you held a gun? Have you shot a gun at target practice?
Self-Harm and Suicide Attempts	Have you stopped yourself right before attempting suicide and did not carry out the attempt? Have you attempted suicide?
Cruelty to Animals	Have you ever hurt an animal on purpose? Have you experienced enjoyment by causing suffering in an animal?
IV Drug Use, Restricted Eating	Have you given yourself an injection for medical or drug use reasons? Have you gone 24 hours without eating?
Diuretics/Laxatives & Unprotected Sex	Have you taken diuretics? Have you had consensual, unprotected sex with someone you did not know very well?
Shot or Stabbed	Have you been stabbed? Have you been shot?
Excessive Exercise	Have you exercised even though you were physically ill? Have you kept on exercising even though you were in a lot of physical pain?
Extreme Sports	Have you gone risk climbing? Have you gone bungee jumping?
Reading/Thinking about Death/Suicide	Have you read detailed accounts about how various people have died (in ways other than suicide)? Have you spent time thinking about your own death in detail?
Physical Abuse	Have you been the victim of physical abuse? Have you been a witness to physical abuse?
Sexual Abuse	Have you been the victim of sexual abuse? Have you been a witness to sexual abuse?
Piercings & Tattoos	Did you get a tattoo? Did you get a piercing?

Event Domain	<i>β</i>	<i>t-value</i>	<i>p-value</i>
Military Combat Experience	.059	.952	.342
Accidental Injury & Natural Disaster Exposure	.029	.469	.640
Familiarity with Guns	.222	3.594	.000
Self-Harm and Suicide Attempts	.131	2.134	.034
Cruelty to Animals	.129	2.092	.038
IV Drug Use, Restricted Eating	.107	1.737	.084
Diuretics/Laxatives & Unprotected Sex	-.007	-.119	.905
Shot or Stabbed	.071	1.147	.253
Excessive Exercise	.117	1.902	.058
Extreme Sports	.022	.349	.728
Reading/Thinking about Death/Suicide	.107	1.739	.084
Physical Abuse	.172	2.759	.006
Sexual Abuse	.058	.929	.354
Piercings & Tattoos	.065	1.053	.294

Event Domain	<i>F-value</i>	<i>p-value</i>
Military Combat Experience	5.271	.006
Accidental Injury & Natural Disaster Exposure	.854	.427
Familiarity with Guns	1.383	.253
Self-Harm and Suicide Attempts	70.427	.000
Cruelty to Animals	3.278	.039
IV Drug Use, Restricted Eating	2.847	.060
Diuretics/Laxatives & Unprotected Sex	.404	.668
Shot or Stabbed	2.698	.069
Extreme Exercise	.075	.923
Extreme Sports	.403	.669
Reading/Thinking about Death/Suicide	10.841	.000
Physical Abuse	12.325	.000
Sexual Abuse	7.193	.001
Piercings & Tattoos	2.903	.057

The Acquired Capability for Suicide

- Suicide attempters report greater ACS compared to suicide ideators
 - Not evident on psychophysiological measures
- Stoicism and Sensation seeking may explain why men are more vulnerable to developing ACS (pain tolerance & fearlessness, respectively)
- Previous suicide attempts and self-harm, familiarity w/ guns, harming animals, and physical abuse appear to promote ACS
 - Combat exposure, reading/thinking about suicide, and sexual abuse also predict suicide attempt status
- So let's turn to interpersonal violence & intimate partner violence

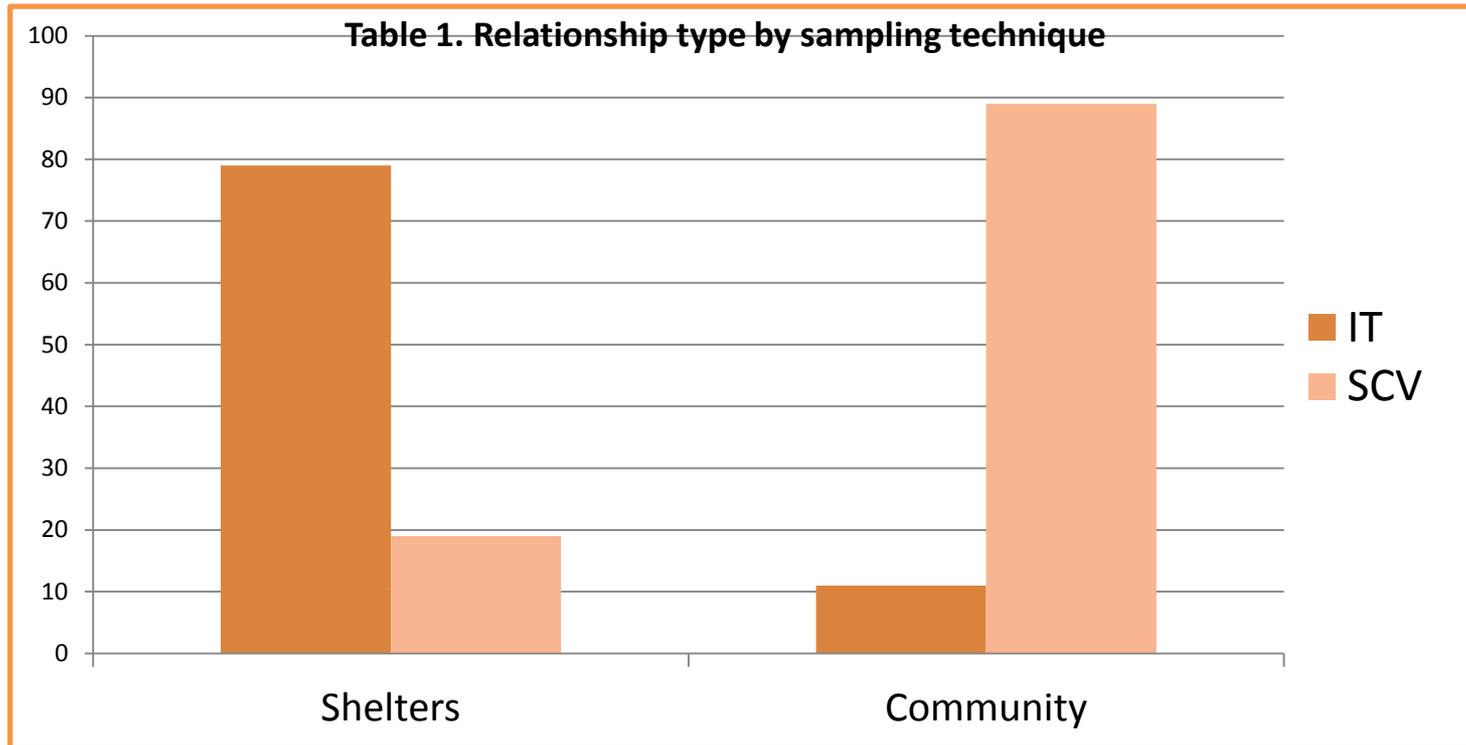
Interpersonal Trauma & Abuse

- ~10% of children are exposed to some form of sexual abuse in the US
 - Commonly co-occurs w/ physical abuse and neglect
 - Females are at higher risk (18% vs. 7.6%), though explanations for this are unclear
 - 12-17 years of age have highest incidence of sexual abuse
 - 4.5% of males and 11.8% of females grades 9-12 reported being victims of forced sexual intercourse

Interpersonal Trauma & Abuse

- ~25% of women have experienced physical and/or sexual abuse by an intimate partner
 - males comprise ~9% of reporting victims
- Some argue that rates are actually equivalent
 - Setting & function dependent
 - Coercive control/Intimate Terrorism v. situational violence

Interpersonal Trauma & Abuse



IT=intimate terrorism; SCV: situational couple violence;
Saltzman et al., (2002); Stark & Flitcraft (1995)

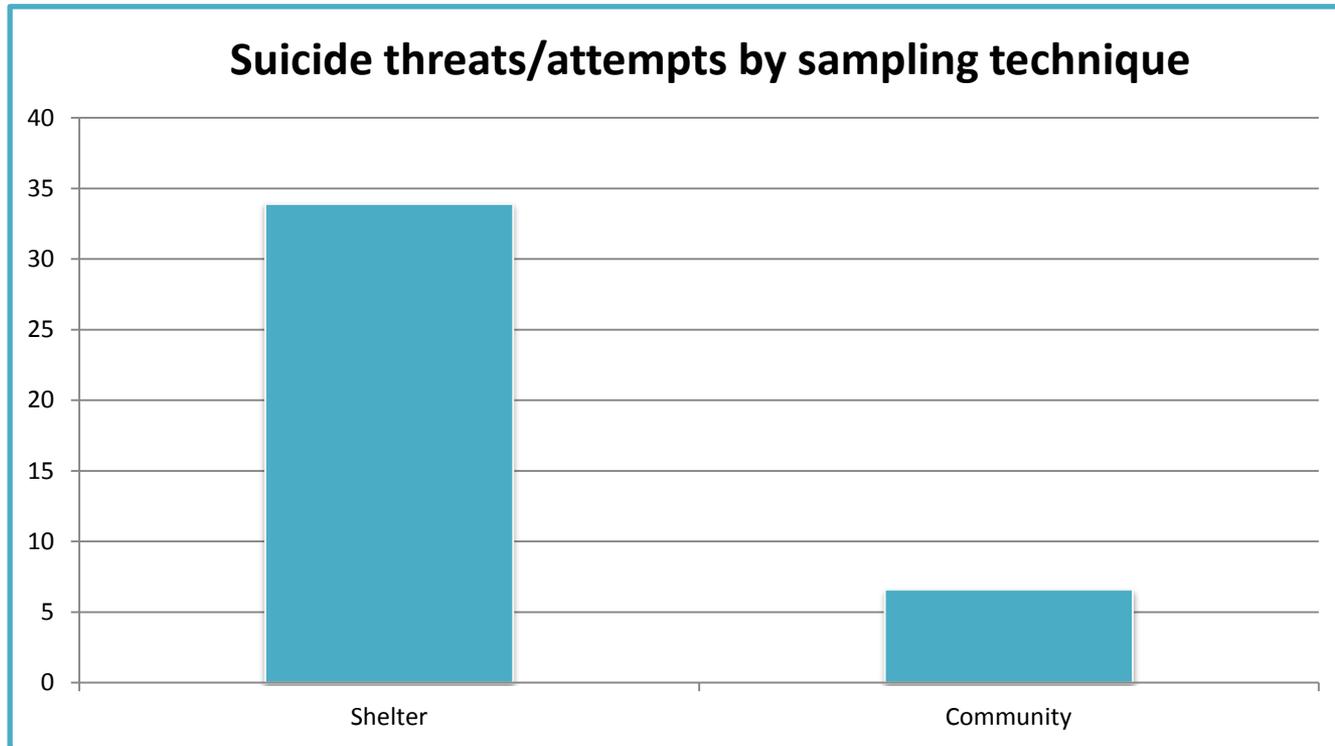
Interpersonal Trauma & Abuse

- Effects of:
 - Shame
 - Guilt
 - Isolation/social withdrawal
 - Feelings of inadequacy
 - Relational & attachment problems
 - Repeated victimization
 - Suicide ideation, attempts, and death

Interpersonal Trauma & Abuse

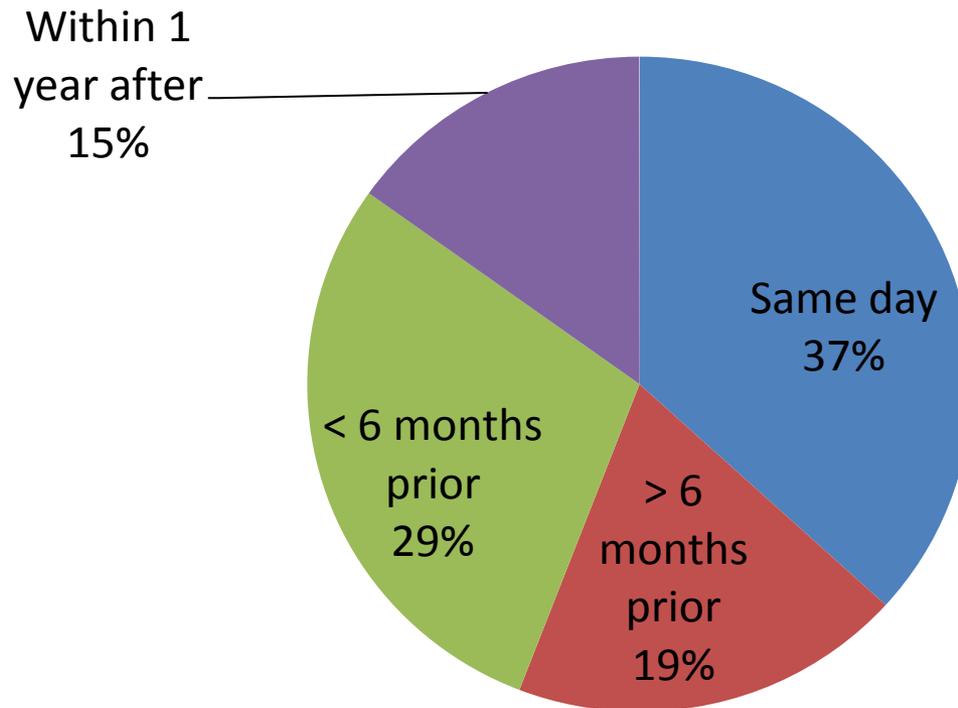
- Suicidal and self-harming individuals are more likely to have experienced interpersonal trauma and abuse compared to non-suicidal or self-harming individuals (Bebbington et al., 2009; Talbot, et al, 2004)

Interpersonal Trauma & Abuse



Interpersonal Trauma & Abuse

Most recent assault by partner among abused female suicide attempters



- Abused attempters more likely to be sent home and receive no mental health referrals than nonabused attempters.

Interpersonal Trauma & Abuse

- How does interpersonal trauma influence suicide ideation and attempts?
 - May function as a painful & provocative life event to promote acquired capability

Interpersonal Trauma & Abuse

- Is interpersonal violence associated with ACS and suicide attempt Hx?
 - Differences between fearlessness & pain tolerance?
- Women seeking shelter from domestic violence in the Upper Gulf Coast region
 - age $M=33.4$, $SD=8.64$
 - 51% white, 34% African American, 6% American Indian or Alaskan Native, 2% Asian

Interpersonal Trauma & Abuse

Predictor	$r_{\text{fearlessness}}$	$r_{\text{pain tolerance}}$
Frequency of Family Violence	-.05	.08
Frequency of Physical Violence Victimization	-.12	-.01
Frequency of Physical Violence Perpetration	.12	.33*
CSA before 13yo (perp 5+ years older)	-.12	.06
CSA before 13yo (perp w/in 5 years)	.06	.16
CSA 13-18yo	-.10	-.01
Adult Rape	.03	.23*
Sexual Harassment	.18	.18
Stalking	.29*	.09

* $p < .05$

Interpersonal violence and acquired capability in non-attempters and attempters

	Non-attempters	Attempters	Effect size (η_p^2)	Sig.
Acquired capability	12.85	16.09	.089	.046
Witnessing family violence	2.76	4.81	.114	.023
Physical partner violence victimization	4.68	5.64	.046	.156
Physical partner violence perpetration	.65	1.64	.062	.098
CSA before age 13; perpetrator > five yrs. older	1.18	4.18	.252	.001
CSA before age 13; perpetrator close in age	.35	2.81	.290	.001
CSA between ages 13 and 18	.85	1.90	.053	.128
Adult sexual assault	1.03	2.64	.092	.043
Stalking	2.94	3.54	.009	.538

Interpersonal Trauma & Abuse

- Stalking, adult rape, and violence perpetration may promote acquired capability
 - Distinct facets
 - CSA was also associated with suicide attempt HX
- Interpersonal violence may also influence relational & attachment systems
 - Do thwarted belongingness & perceived burdensomeness predict current suicide ideation?

Interpersonal Trauma & Abuse

Criterion: Suicide Ideation

Predictor	β	t	p
Depression sxs	.32	2.77	.01
INQ-Thwarted Belongingness	-.06	-.53	.60
INQ-Perceived Burdensomeness	.27	2.17	.03
TB x PB	-.08	-.23	.82

Interpersonal Trauma & Abuse

- Interpersonal trauma as a painful & provocative life event
 - Stalking, adult rape, violence perpetration
 - Distinct facets of acquired capability
- Perceived burdensomeness as particularly important in development of suicide ideation

Interpersonal Trauma & Abuse

- Not all who are traumatized are at risk for suicide
- Posttraumatic Stress Disorder
 - More specific predictor of suicide risk than trauma
 - Associated with additional/more severe negative psychological and social outcomes
 - Re-experiencing sx's, mood disturbance, affective instability, avoidance, dissociation, physiological hyperarousal, relational & attachment disturbance

Interpersonal Trauma & Abuse

- PTSD & DSM-5
 - Trauma- and Stressor-Related Disorders
 - Anxiety/fear
 - Anhedonic/dysphoric
 - Externalizing/angry
 - Dissociative

Interpersonal Trauma & Abuse

- PTSD & DSM-5
- Exposure to actual or threatened death, serious injury, or sexual violence
 - Direct experience
 - Witnessing
 - Learning that violent or accidental traumatic events occurred to close friend/family member
 - Repeated or extreme exposure to details of the event(s)(not via electronic media)
- Subjective reaction trauma eliminated
- Sxs Clusters
 - Re-experiencing
 - Arousal
 - Avoidance
 - Numbing

Interpersonal Trauma & Abuse

- Do PTSD sxs effect IPV targets' experience of thwarted belongingness, perceived burdensomeness, and acquired capability?

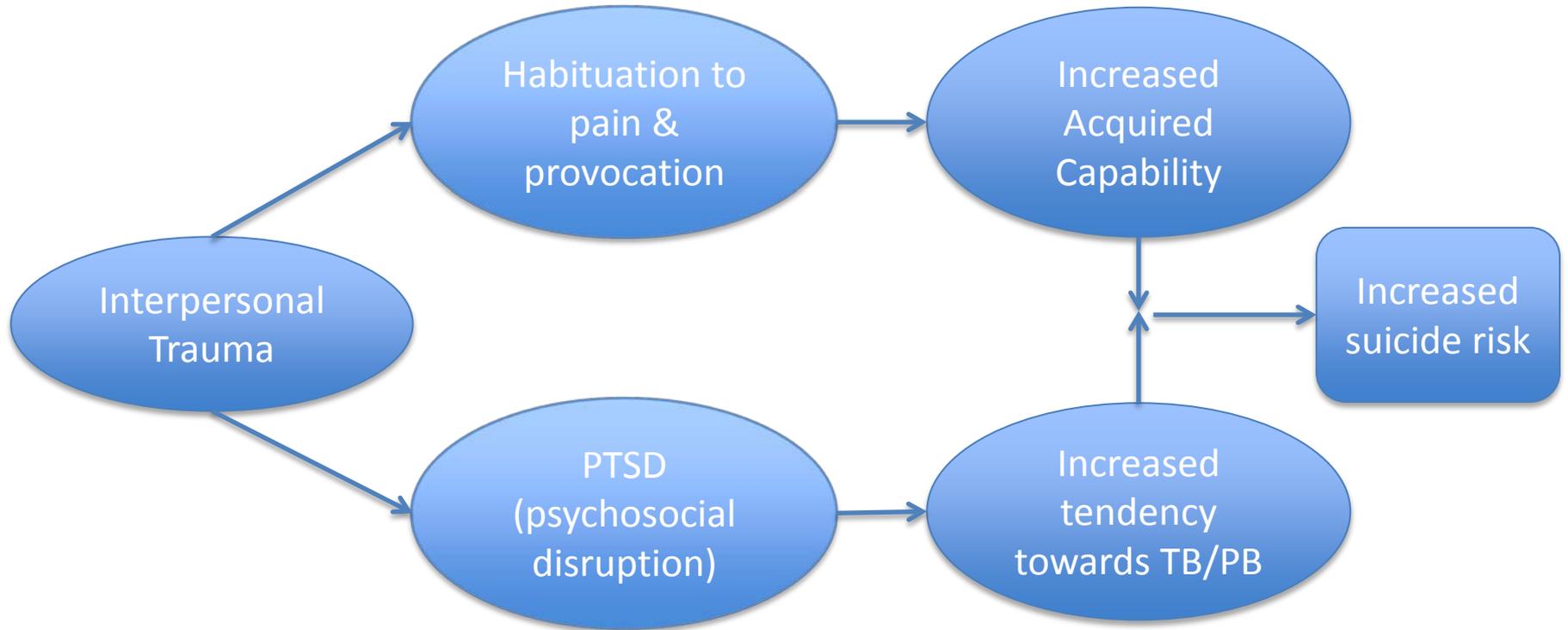
Interpersonal Trauma & Abuse

	<i>r</i> <i>Thwarted Belongingness</i>	<i>r</i> <i>perceived burdensomeness</i>	<i>r</i> <i>Acquired Capability</i>
PCL-Re-experiencing	.25*	.40*	-.17
PCL-Avoidance & Numbing	.40*	.50*	-.04
PCL-Hyperarousal	.32*	.15	.08
PCL-Total	.39*	.44*	-.06

Interpersonal Trauma & Abuse

- Interpersonal trauma as a painful & provocative life event
 - Stalking, adult rape, violence perpetration
 - Distinct facets of acquired capability
- Perceived burdensomeness as particularly important in development of suicide ideation
- PTSD
 - associated with thwarted belongingness & perceived burdensomeness
 - Not w/ acquired capability

Interpersonal Trauma & Abuse



Before we break

- The take to lunch message(s)
 - Working w/ suicidal individuals is a challenge
 - It is important to have a framework for understanding how risk factors and protective factors operate to result in acute suicide risk
 - The interpersonal theory of suicide is but one framework for conceptualizing why people die by suicide

LUNCH TIME

Half way home

- 9:00-10:00
 - Working with individuals at risk for suicide: Attitudes and approach
 - Understanding Suicide
- 10:00-10:30
 - The Interpersonal Theory of Suicide
- 10:30-10:45
 - Break
- 10:45-12:00
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 - Complete evaluation
- 4:31pm
 - Leave!!

Risk Assessment

Frameworks & Critical Issues

Graduate student: “Oh, I will leave while you both have your session.”

Psychiatrist: “Oh no don’t go. This won’t take long. Hello Mr. Jones. We have your paperwork all ready for your transfer to the substance abuse treatment facility. You will be leaving tomorrow.”

Patient: “Thank you. I am glad to finally be getting some help”

Psychiatrist: “How are you feeling lately since we have changed your medicines?”

Patient: “I wanted to talk to you about that, I have been having more thoughts of hurting myself lately.”

Psychiatrist: “Hmm, when”

Patient: “When I am alone at night. I start feeling lonely and hopeless and fearful that I won’t ever get help.”

Psychiatrist: “It sounds like it is off and on, and not as bad as when you came in.”

Patient: “Well I guess not, I guess the thoughts don’t last long.”

Psychiatrist: “If you’re still seriously considering suicide we cannot release you tomorrow and I know you are looking forward to treatment”

- **Patient:** “Well its not as intense as before, and I think I may just be lonely. Maybe we should up my meds?”
- **Psychiatrist:** “I think we should wait. Your body is still adjusting to the medicine I’m sure you will be feeling better once your body adjusts but that can take a few weeks.”

Patient: “Well I guess I’m ready to go then.”

Psychiatrist: “Good luck with everything, the staff will give you your paperwork and prescriptions before you go.”

Patient: “Thanks doc.”

The end.

Suicide Risk Assessment

- Well...?

Suicide Risk Assessment

- Some sadly common approaches
 - If you voice SI the sky starts to fall
 - Adding up risk factors, subtracting protective factors
 - Gut feeling
 - Get the individual to sign a no-harm contract and call a psychiatrist (or not)
 - Convince the patient that suicide is a bad thing that he or she shouldn't do
 - Don't ask, don't tell

Suicide Risk Assessment

- How do you identify a patient that requires risk assessment?
- US Preventive Services Task Force
 - Routine screening in primary care does not appear to result in reduced suicides...?
- What does routine screening do?

PHQ-9

Mood Scale (PHQ)

I am now going to ask you some questions regarding your emotional health.

In the <u>past two weeks</u> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

j. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

Total Score PHQ: _____

Question “i”

- If any positive response, FOLLOW-UP
 - determine passive vs. active ideation
 - “In the last 2 weeks, have you had any thoughts of hurting or killing yourself?”
 - If yes = active suicidal ideation, FOLLOW-UP
- Follow-up by...?

Suicide Risk Assessment

- Risk Assessment Frameworks
 - Formalized procedures that provide structured ways to assess signs and symptoms of current and more long-standing risk.
 - Indications of what signs and sx's to assess & what questions to ask
 - How to combine info on past & current sx's to determine current risk
 - What actions to take
 - GOAL: establish degree of current risk, including if clear & imminent risk so that appropriate clinical actions are taken.

Critical Issues in Risk Assessment

- Risk Factors vs. Warning Signs?
- Chronic vs. acute suicide risk
 - The Suicide Zone

Risk Factors

Often long-standing
and unchanging
Predispose individuals
to suicidal behavior

- Mental disorder(s)
- Previous suicide attempts
- Social isolation
- Physical illness
- Unemployment
- Family conflict
- Family history
- Impulsivity
- Incarceration
- Hopelessness
- Agitation or sleep disturbance
- Childhood abuse
- Exposure to suicide
- Homelessness
- Combat exposure
- Self-esteem, shame

Warning Signs

Dynamic & proximal
Indicate presence of
current suicidal crisis

IS

Ideation
Substance Abuse

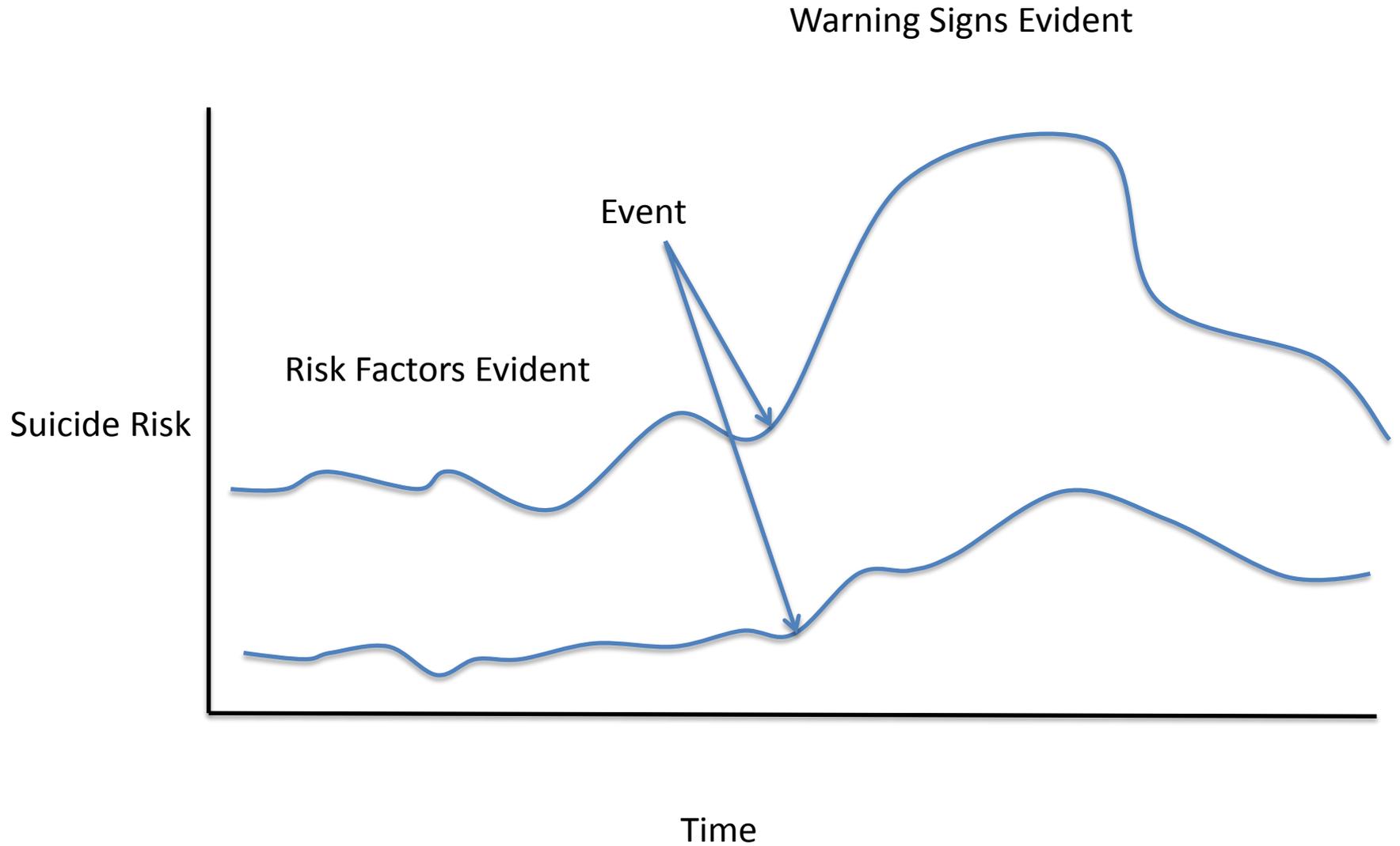
PATH

Purposeless
Agitation
Trapped
Hopelessness

WARM

Withdrawal
Anger
Restlessness
Mood changes

Critical Issues in Risk Assessment



Risk Assessment Frameworks

- The Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2006)
- Chronological Assessment of Suicidal Events (CASE; Shea, 2002)
- U. of Washington Risk Assessment Protocol (UWRAP; Linehan et al., 2000)
- The Suicide Risk Assessment Decision Tree (Joiner et al., 1999)

Suicide Status Form-SSF II-R (Initial Session)

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	1) RATE PSYCHOLOGICAL PAIN (<i>hurt, anguish, or misery in your mind, <u>not</u> stress, <u>not</u> physical pain</i>): <p align="center">Low pain: 1 2 3 4 5 :High pain</p> _____ What I find most painful is: _____
	2) RATE STRESS (<i>your general feeling of being pressured or overwhelmed</i>): <p align="center">Low stress: 1 2 3 4 5 :High stress</p> _____ What I find most stressful is: _____
	3) RATE AGITATION (<i>emotional urgency; feeling that you need to take action; <u>not</u> irritation; <u>not</u> annoyance</i>): <p align="center">Low agitation: 1 2 3 4 5 :High agitation</p> _____ I most need to take action when: _____
	4) RATE HOPELESSNESS (<i>your expectation that things will not get better no matter what you do</i>): <p align="center">Low hopelessness: 1 2 3 4 5 :High hopelessness</p> _____ I am most hopeless about: _____
	5) RATE SELF-HATE (<i>your general feeling of disliking yourself; having no self-esteem; having no self-respect</i>): <p align="center">Low self-hate: 1 2 3 4 5 :High self-hate</p> _____ What I hate most about myself is: _____
N/A	6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: 1 2 3 4 5 :Extremely high risk (will <u>not</u> kill self) (will kill self)

- 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 feelings about others? **Not at all: 1 2 3 4 5 : completely**

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

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: _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
© 2008 The Research Foundation for Mental Hygiene, Inc.

RISK ASSESSMENT VERSION

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.			
Suicidal and Self-Injurious Behavior (Past week)		Clinical Status (Recent)	
<input type="checkbox"/>	Actual suicide attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Interrupted attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Aborted or Self-Interrupted attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Other preparatory acts to kill self	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Self-injurious behavior without suicidal intent	<input type="checkbox"/>	Lifetime
Suicidal Ideation (Most Severe in Past Week)		<input type="checkbox"/>	Substance abuse or dependence
<input type="checkbox"/>	Wish to be dead	<input type="checkbox"/>	Agitation or severe anxiety
<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	Perceived burden on family or others
<input type="checkbox"/>	Suicidal thoughts with method (but without specific plan or intent to act)	<input type="checkbox"/>	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
<input type="checkbox"/>	Suicidal intent (without specific plan)	<input type="checkbox"/>	Homicidal ideation
<input type="checkbox"/>	Suicidal intent with specific plan	<input type="checkbox"/>	Aggressive behavior towards others
Activating Events (Recent)		<input type="checkbox"/>	Method for suicide available (gun, pills, etc.)
<input type="checkbox"/>	Recent loss or other significant negative event	<input type="checkbox"/>	Refuses or feels unable to agree to safety plan
	Describe:	<input type="checkbox"/>	Sexual abuse (lifetime)
		<input type="checkbox"/>	Family history of suicide (lifetime)
<input type="checkbox"/>	Pending incarceration or homelessness	Protective Factors (Recent)	
<input type="checkbox"/>	Current or pending isolation or feeling alone	<input type="checkbox"/>	Identifies reasons for living
Treatment History		<input type="checkbox"/>	Responsibility to family or others; living with family
<input type="checkbox"/>	Previous psychiatric diagnoses and treatments	<input type="checkbox"/>	Supportive social network or family
<input type="checkbox"/>	Hopeless or dissatisfied with treatment	<input type="checkbox"/>	Fear of death or dying due to pain and suffering
<input type="checkbox"/>	Noncompliant with treatment	<input type="checkbox"/>	Belief that suicide is immoral; high spirituality
<input type="checkbox"/>	Not receiving treatment	<input type="checkbox"/>	Engaged in work or school
Other Risk Factors:		Other Protective Factors:	
<input type="checkbox"/>		<input type="checkbox"/>	
Describe any suicidal, self-injurious or aggressive behavior (include dates):			

Risk Assessment Frameworks

- For me... there's still something missing
- Problems w/ such approaches
 - Descriptive
 - Atheoretical
 - Can turn into a laundry list
- Theory Driven Risk Conceptualization as an alternative
- Provides full understanding, which, in turn:
 - contextualizes the interaction of risk and protective factors
 - prioritizes information when conceptualizing risk
 - Is a useful clinical tool in that can
 - Provide the patient w/ a framework for understanding his or her problems
 - Identifies critical points of intervention

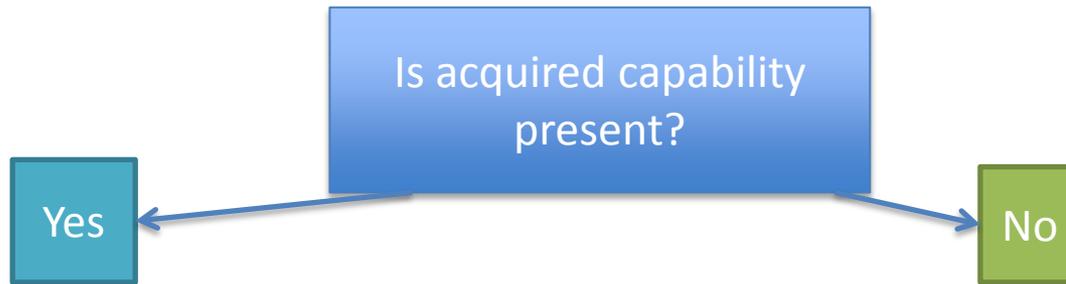
A Theoretically Driven Risk Assessment Framework

- Two Most Important Areas:
 - The capability for suicide
 - Nature of current suicidal symptoms
 - Resolved plans & preparations
 - Desire for death by suicide

Toward a Risk Assessment Framework

- The idea of the Risk Assessment Framework is:
 - Other Risk Factors (e.g., Substance Abuse, Marked Impulsivity, Personality Disorder, others discussed above) are Interpreted In Light of
 - The capability for suicide
 - Nature of current suicidal symptoms
- This relieves somewhat the “laundry list” problem

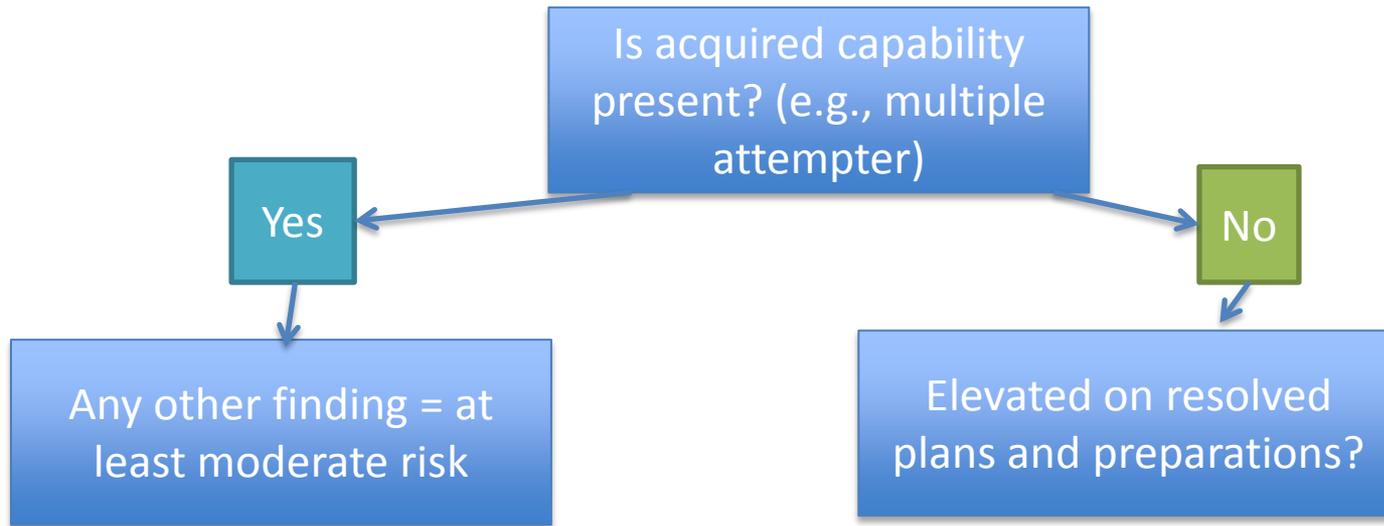
Suicide Risk Assessment Decision Tree



Is Acquired Capability Present?

- Experiences of pain and provocation:
 - Past suicide attempts (especially multiple attempter status)
 - Aborted suicide attempts
 - Self-injecting drug use
 - Self harm (i.e., non-suicidal self-injury)
 - Frequent exposure to, or participation in, physical violence
- Indicators
 - High intent for suicide
 - Fearlessness about suicide
 - Long duration of ideation with preoccupation about suicide
 - Highly detailed and vivid plan for suicide
 - Specified time and place for suicide

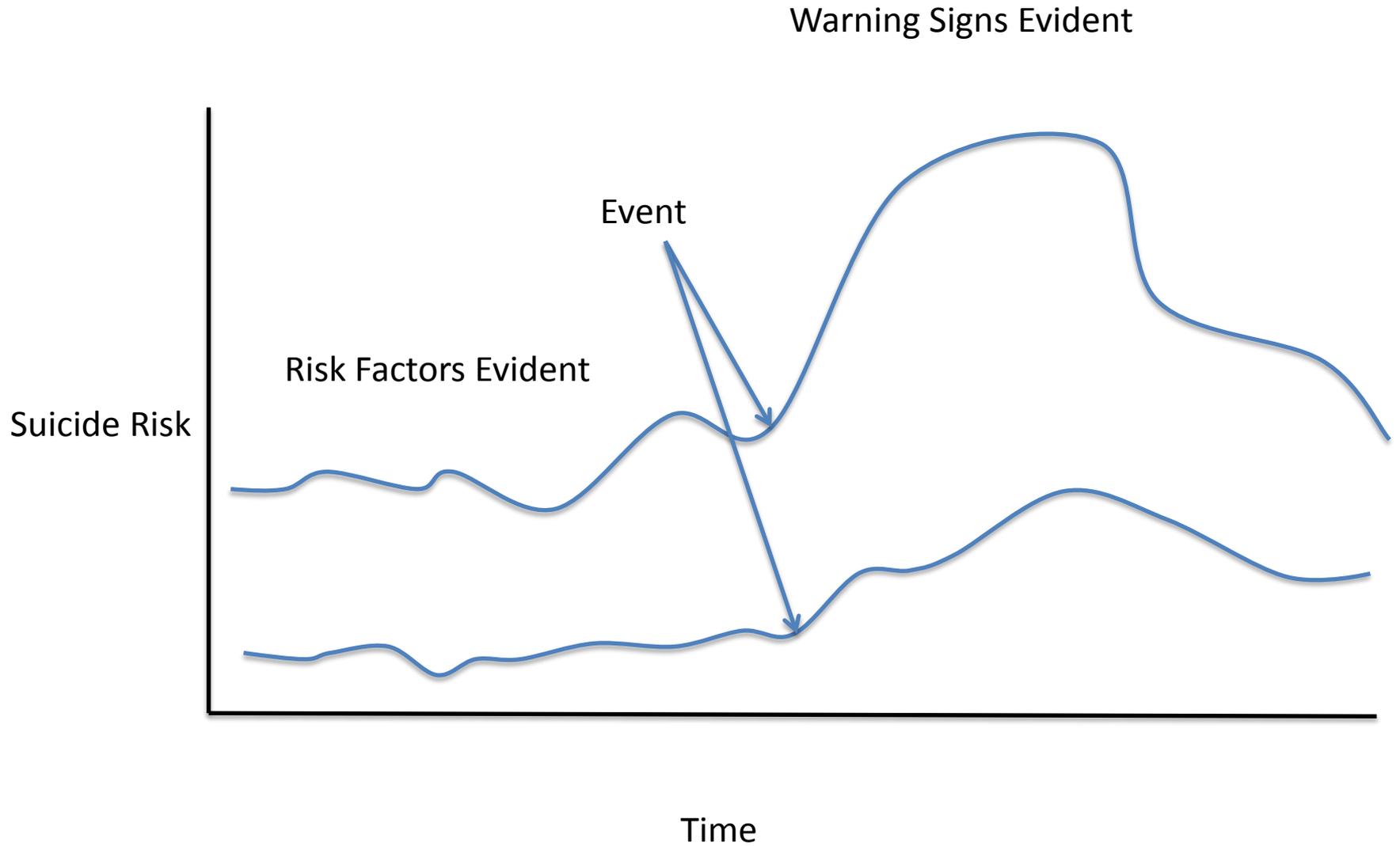
Suicide Risk Assessment Decision Tree



Suicide Risk Assessment Decision Tree

- “Other significant finding”
 - Suicide risk factors
 - Severe recent negative life events
 - Marked hopelessness
 - Deteriorating health
 - Loneliness
 - and so on

Critical Issues in Risk Assessment



What to assess?

- Resolved plans & preparations
 - sense of courage to make an attempt
 - competence to attempt
 - availability of means/opportunity
 - specificity of plan
 - preparations
 - duration of SI
 - Intensity of SI
- This symptom cluster includes
 - Vivid, detailed, long-lasting ideas about suicide
 - A sense of competence about suicide
 - A sense of fearlessness about suicide
 - Well-developed plans
 - Opportunity

Suicide Risk Assessment Decision Tree

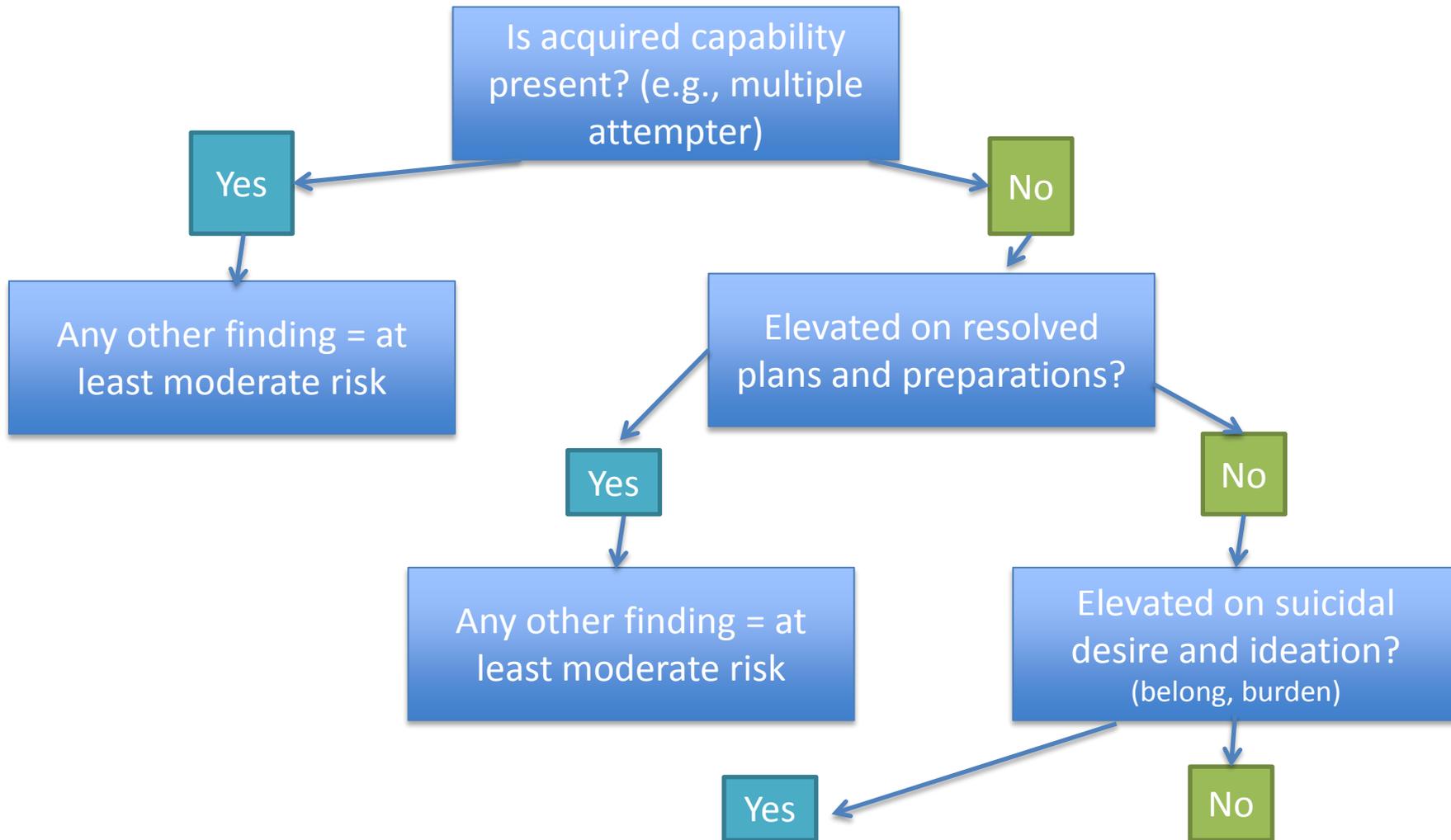


Figure 2.3. Abbreviated Suicide Risk Assessment Decision Tree. Reprinted from "Scientizing and Routinizing the Assessment of Suicidality in Outpatient Practice," by T. E. Joiner Jr., R. L. Walker, M. D. Rudd, & D. A. Jobes, 1999, *Professional Psychology: Research and Practice*, 30, p. 451. Copyright 1999 by the American Psychological Association.

What to assess?

- Suicidal desire and ideation
 - absence of reasons for living
 - wish to die
 - frequency of ideation
 - wish not to live
 - passive attempt
 - desire for attempt
 - talk of death/suicide
- Sx cluster includes
 - Vague and fleeting ideas about suicide
 - Statements like “would be better off dead.”
 - No well-developed plans

What to assess?

- Thwarted belongingness
 - The absence of caring, meaningful connections to others
 - Absence of friends/relatives patient can call when upset
 - Recent losses through death or divorce
- Perceived burdensomeness
 - Statements that others would be better off if the patient were gone
 - Statements that the patient is a burden on others
 - Recent stressors involving a loss of self-competency (e.g., job loss)

Suicide Risk Assessment Decision Tree

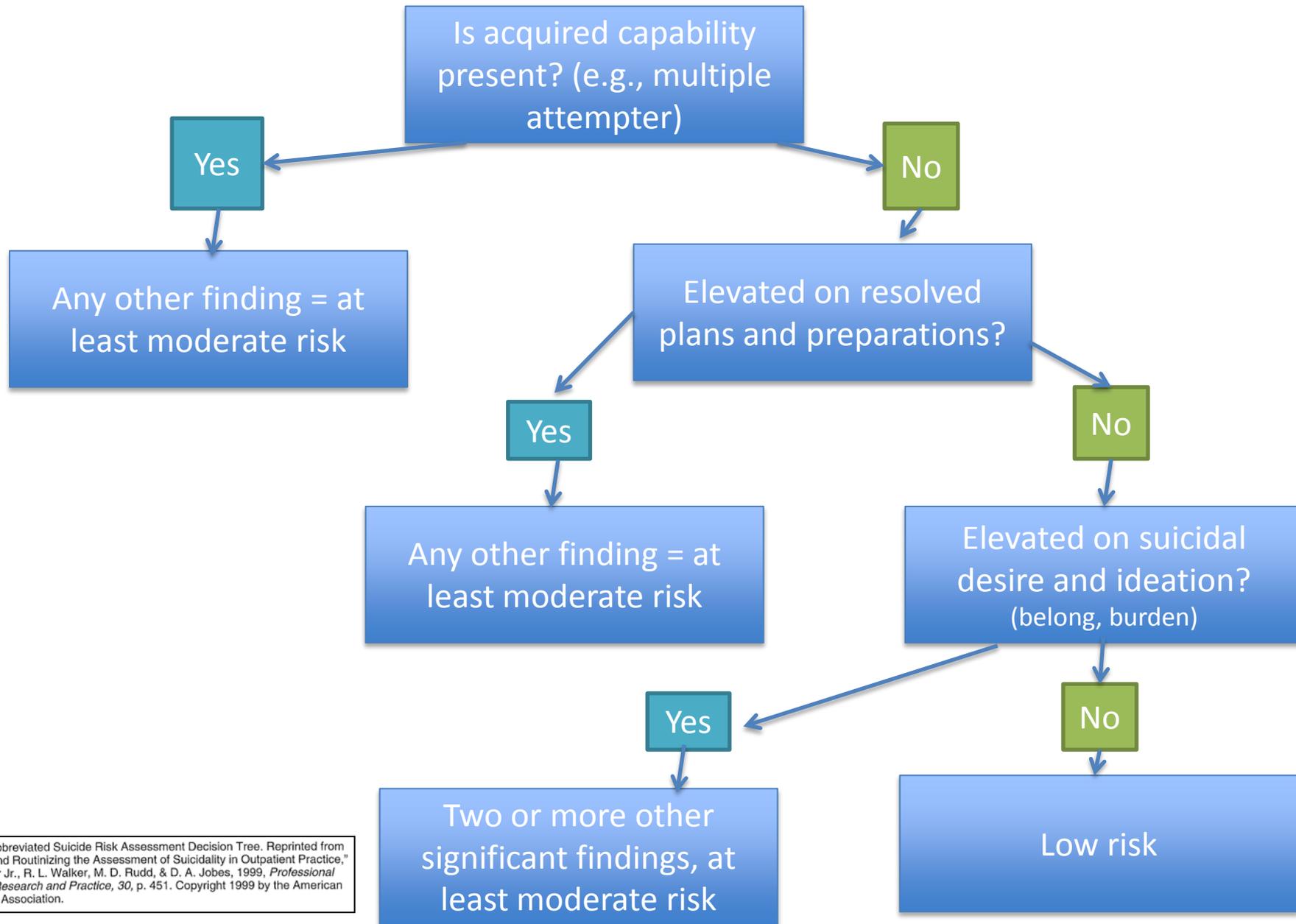


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Risk Designations

- Low
 - A person with no identifiable suicidal symptoms
 - An individual with Acquired Capability with NO other risk factors (including NO suicidal ideation)
 - An individual without Acquired Capability with suicide ideation of limited intensity and duration, no or mild symptoms of the Resolved Plans and Preparation factor AND no or few other risk factors

Risk Designations

- Moderate
 - An individual with Acquired Capability with any other notable finding (e.g., suicidal ideation, hopelessness, etc.)
 - An individual without Acquired Capability with moderate to severe symptoms of the Resolved Plans and Preparation factor
 - An individual without Acquired Capability with moderate to severe symptoms of the Suicidal Desire and Ideation factor (but mild or no Resolved Plans and Preparation) AND at least two other notable risk factors

Risk Designations

- High
 - An individual with Acquired Capability with any two or more other notable findings
 - An individual without Acquired Capability with moderate to severe symptoms of the Resolved Plans and Preparation factor and at least one other risk factor

Case example

Samantha is a 20-year-old White female who presented for therapy after the break-up of a long-term relationship. During intake, Samantha noted that she wanted help for her “serious abandonment issues” and stated that she often “jumped from one relationship to another.” Samantha noted that she “can’t be alone” and that she had suffered from these problems over the past 5 years. Samantha had no prior treatment history. Samantha did not meet criteria for an Axis I disorder, though she exhibited some symptoms of binge eating disorder. Samantha met criteria for Borderline Personality Disorder. Samantha had no history of engaging in self-injurious behaviors and denied current and past suicidal ideation.

Risk Level?

Suicide Risk Assessment Decision Tree

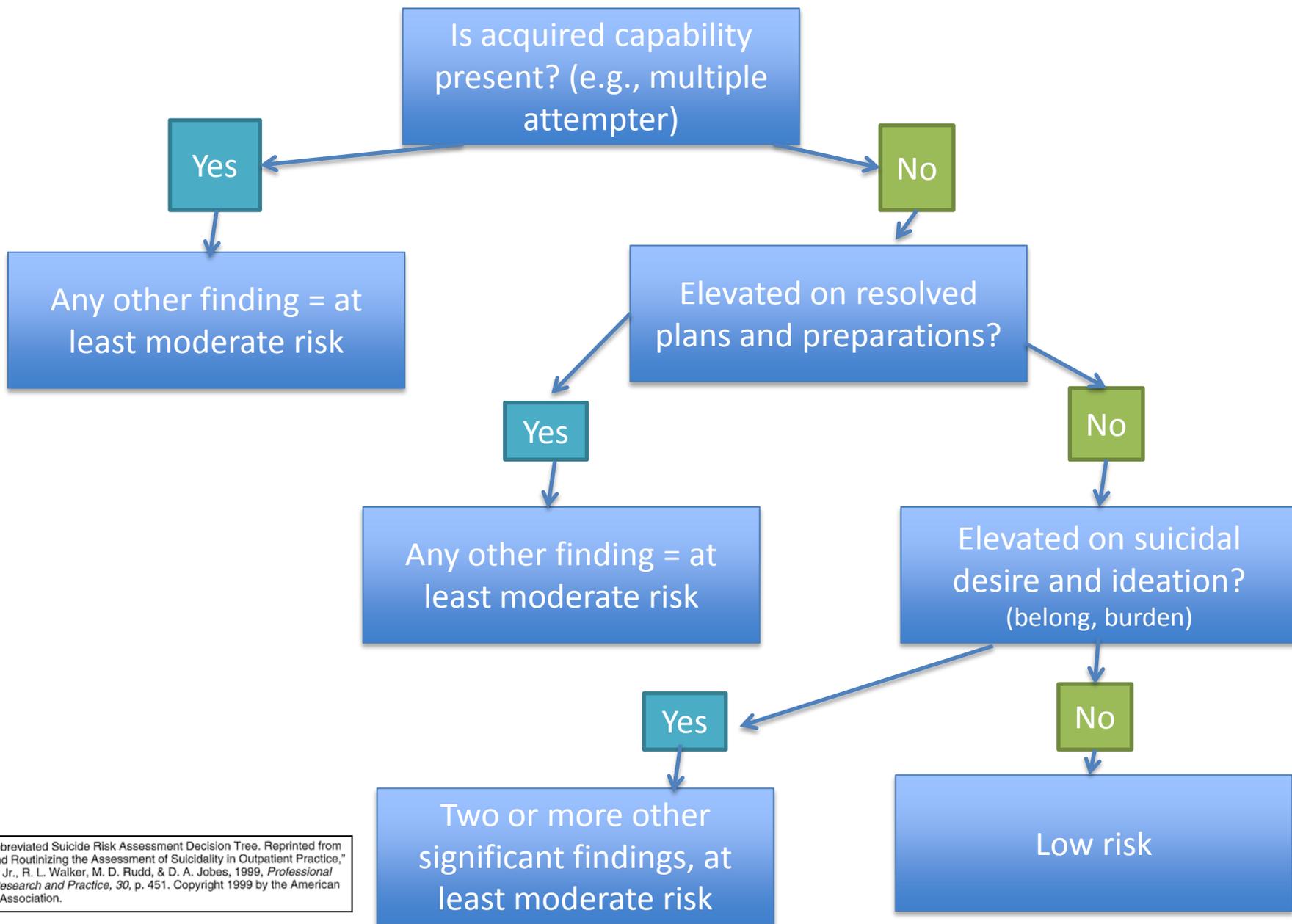


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Case example

Megan is a 37-year-old White female who presented for treatment of depression. She reported that she had been depressed her entire life. As a teenager, Megan abused alcohol and drugs including speed, marijuana, and LSD, and received inpatient substance use treatment at the age of 18. Shortly thereafter Megan joined Alcoholics Anonymous and has not used alcohol or drugs since that time. Megan attempted suicide twice, once by overdose and once by carbon monoxide poisoning, and cut herself in several locations once while in substance use treatment. Megan was diagnosed with major depressive disorder (MDD), dysthymia, and BPD. She scored in the severe range on the BDI (31) and reported frequent suicidal ideation but denied suicidal intent. Megan also reported difficulties in her romantic relationship and indicated that she had no close friends. In addition, she reported that she had been unable to maintain employment due to difficulty communicating with others.

Risk Level?

Suicide Risk Assessment Decision Tree

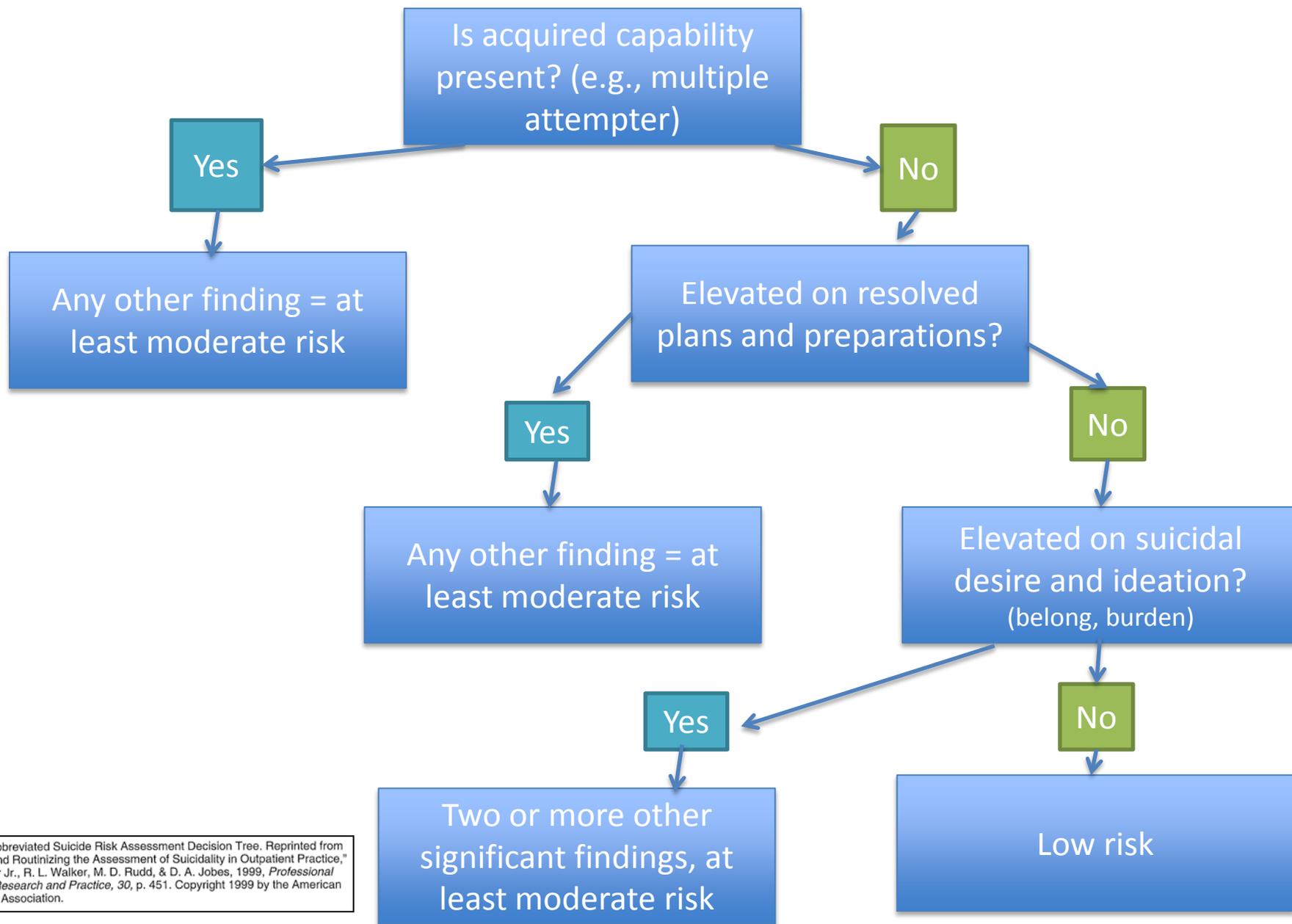


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AND BREAK

Documentation

If you don't record it, it didn't
happen

Section D (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER: _____

ABSTRACTION: WNL NOTABLY CONCRETE
OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____

MEMORY: GROSSLY INTACT
OTHER: _____

REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

PRELIMINARY DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- No Significant Risk** Explanation: _____
- Mild** _____
- Moderate** _____
- Severe** _____
- Extreme** _____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

Next Appointment Scheduled: _____ Treatment Modality: _____

Clinician Signature

Date

Supervisor Signature

Date

Documentation

- Chronic & acute risk designation
- Substantiation of risk designation
- Disposition
- Markers of risk
 - Open & Closed
 - Monitoring markers

What would we do w/ this?

A middle-aged man retreats to an isolated, wooded area out by a lake near his house. He has not told anyone where he was going or that he has been thinking of suicide. He has been depressed since losing his job two months prior. He takes out a loaded gun, places it to his head and after a few minutes puts the gun away and returns home to his wife and child, never divulging anything to his family about what happened. He tells his primary care physician three weeks later during a routine check-up, at which time he hesitantly acknowledges that he's been very, very depressed... Now he's in your office!

Suicide Risk Assessment Decision Tree

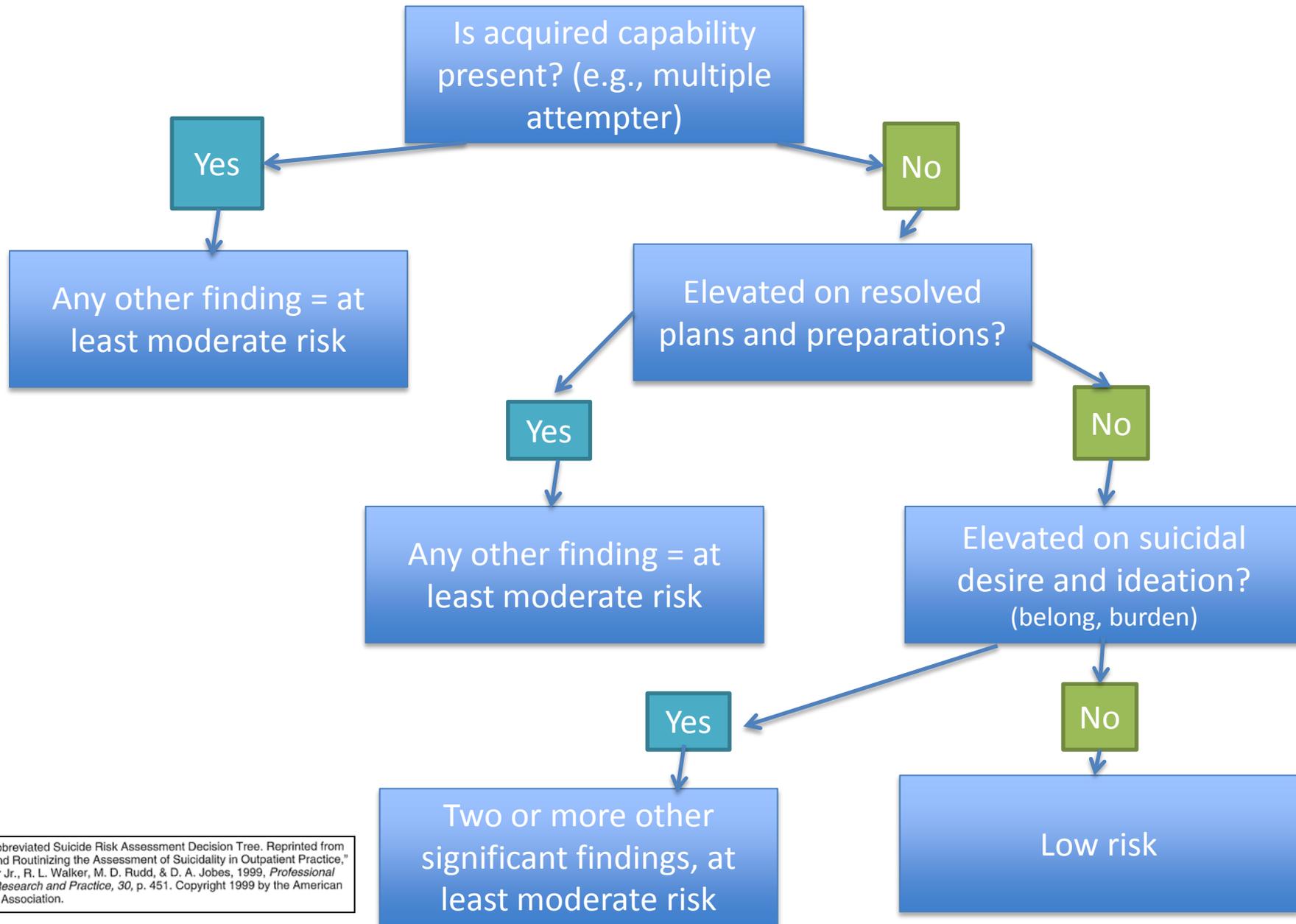


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Clinical Management

Clinical Management

- What can we do for suicidal patients?
- What are the goals of a therapeutic interaction?

Clinical Management

- Don't offer simple solutions to serious problems
- Don't try to minimize his/her feelings or situation or try to tell him/her how to feel
- Don't be sworn to secrecy
- Don't leave the person alone until you arrange for support, either immediate or long-term
- Be direct: ask the person if s/he is contemplating suicide.
- Let the person know that you care and want to help.
- Be non-judgmental.
- Focus on the problem that suicide is designed to solve. Offer hope that it can be solved by other means.
- Use her/his ambivalence to advantage.

Clinical Management

- No-harm contracts
 - Signed agreement in which patient asserts they will not attempt suicide
- Problems w/?
- Safety plans and related activities
 - Coping card
 - Commitment to treatment plan

Clinical Management

- Means restriction interventions

Clinical Management

- Psychological Treatments
 - Dialectical Behavior Therapy
 - Problem Solving Therapy
 - Cognitive Therapy
- Psychiatric Treatments
 - Antidepressants
 - Lithium

Theory Driven Treatment

- Interpersonal Psychotherapy (IPT) for Depression (Stuart & Robertson, 1993)
 - Validated psychotherapy for depression (and others)
 - Initial evidence for usefulness in reducing suicide ideation in older adults (Heisel, et al., 2009)
- IPT
 - Interpersonal orientation
 - Manage ongoing relational difficulties
 - Expand & improve social supports
 - Time limited
 - Present-focused

Biopsychosocial Diatheses

Biological Factors

Genetic Predisposition to Stress
Temperament

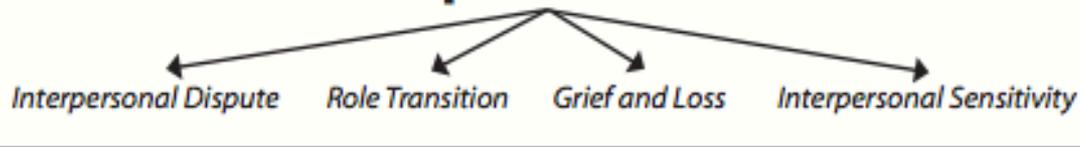
Psychological Factors

Early Life Experiences
Attachment Style

Social Factors

Current Significant Relationships
Current Social Support

Interpersonal Crisis



Subthreshold Intensity

Resolution

Sufficient Social Support

Resolution

Suprathreshold Intensity

Insufficient Social Support

Attachment Needs Unmet

**Maladaptive Communication
of Attachment Needs**

**Interpersonal Problems and
Psychiatric Symptoms**

Theory Driven Treatment

- How specific to match Interpersonal Theory?
- Principles
 - Suicidal desire results from unmet interpersonal needs
 - To belong (manifests as needs for attachment, reassurance, companionship)
 - To contribute (manifests as perceived burdensomeness)

Biopsychosocial Diatheses

Biological Factors

Genetic Predisposition to Stress
Temperament

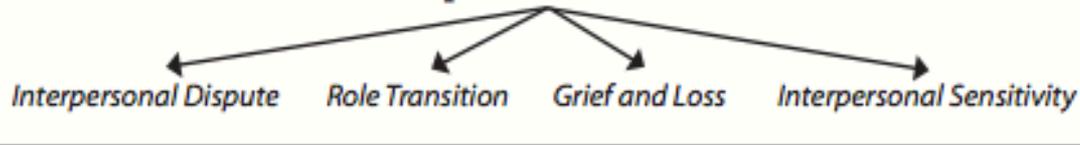
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Early Life Experiences
Attachment Style

Social Factors

Current Significant Relationships
Current Social Support

Interpersonal Crisis



Subthreshold Intensity

Resolution

Sufficient Social Support

Resolution

Suprathreshold Intensity

Insufficient Social Support

Attachment Needs Unmet

**Maladaptive Communication
of Attachment Needs**

**Interpersonal Problems and
Psychiatric Symptoms**

Theory Driven Treatment

- According to the Interpersonal Theory
 - Mitigation of either thwarted belongingness, perceived burdensomeness, or acquired capability will result in reduced risk
- So what to improve?
- Improve communication of needs
- Expand social supports
- Contribution to others

Theory Driven Treatment

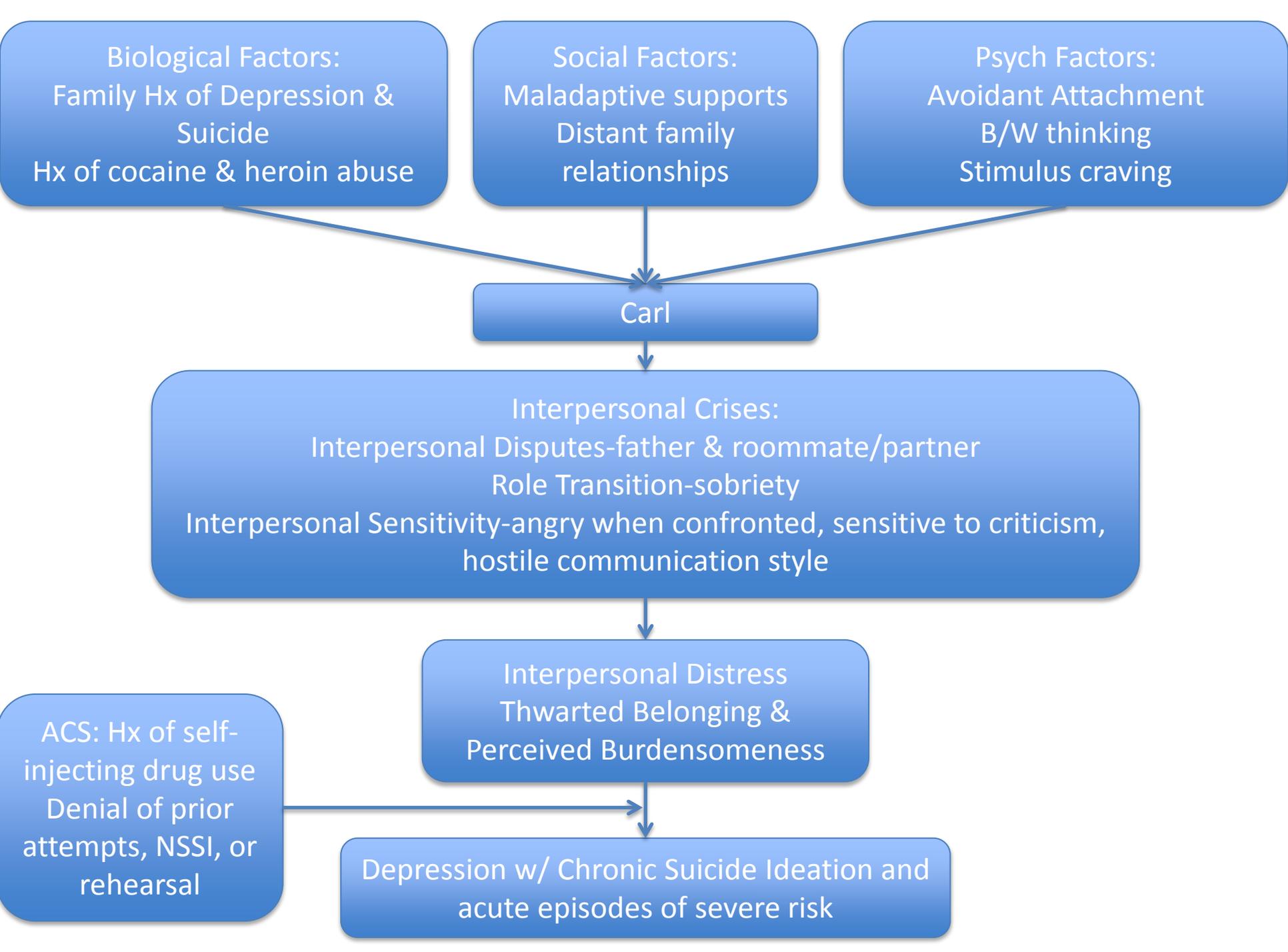
- IPT Tools
 - Interpersonal Inventory
 - Interpersonal formulation
 - Communication analysis & Interpersonal Incident analysis
 - Specific focus on suicidal crises highlighting the role of thwarted belongingness & perceived burdensomeness

Theory Driven Treatment

- The Interpersonal Inventory & Formulation
 - Thorough assessment and conceptualization of
 - Contemporary relationships
 - Significant past relationships
 - Social supports
 - Communication patterns

Theory Driven Treatment

- Some dimensions to consider
- Attachment Security & Style
 - Anxious
 - Avoidant
- Communication Style & Reciprocation
 - Affiliation
 - Dominance
 - Inclusion
- Relationship Quality
 - Dependability
 - Ease of interaction
 - Belonging
 - Intimacy
- Temperament
 - Harm avoidance
 - Stimulus craving
 - Reward-dependent
- Cognitive Style
- Coping Mechanisms



Theory Driven Treatment

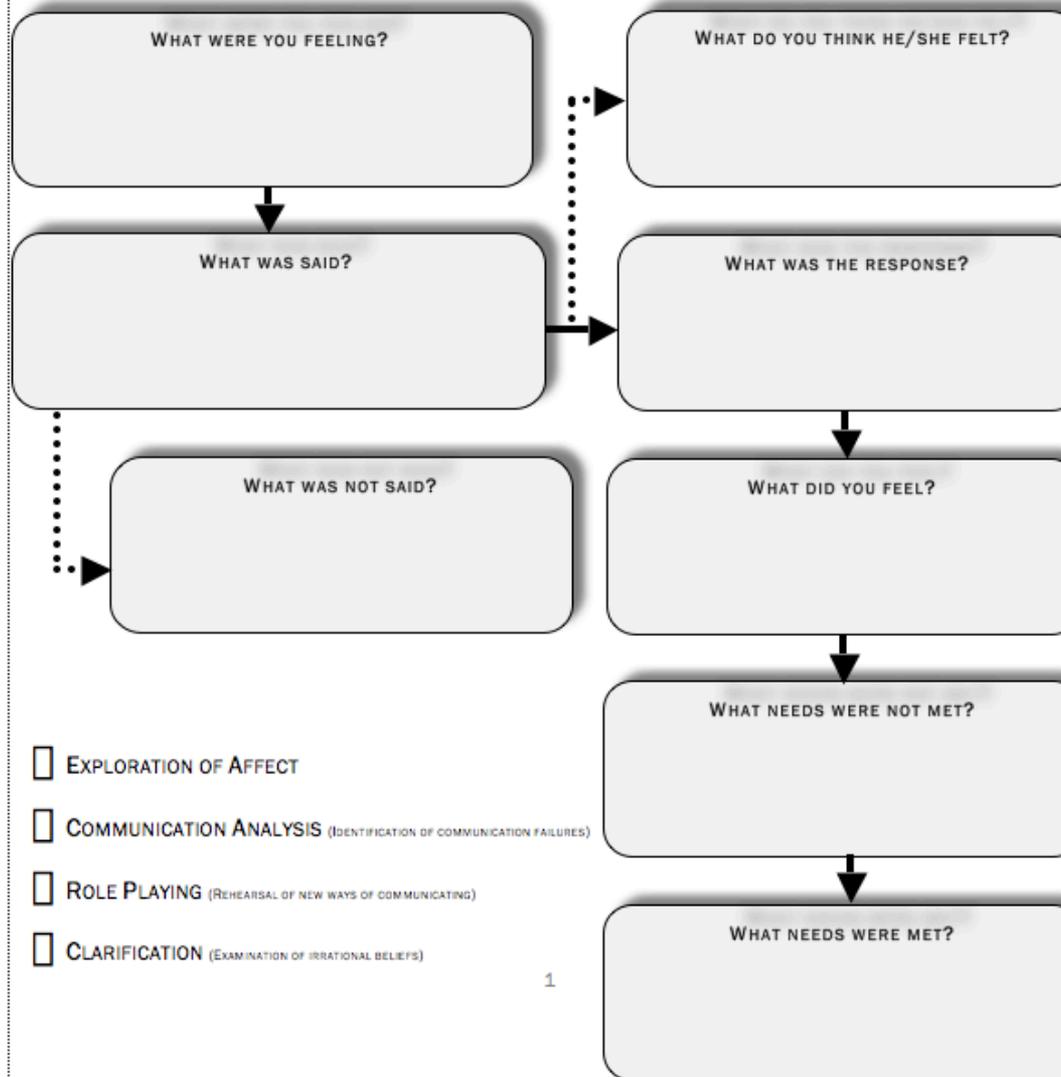
- The Interpersonal Incident Analysis
 - Thorough examination of specific event
 - Goals
 - Test hypothesized patterns
 - Develop awareness of patterns
 - Reduce generalized thinking
 - Develop awareness of emotional reactions
 - Identify and practice specific behavior changes
- Play-by-play of the event
 - Beginning
 - Middle
 - End
- Concrete & specific
 - Avoid *post hoc* interpretations

IPT

Date: _____

Patient Initials: _____

- PROBLEM AREA: _____
- INTERPERSONAL INCIDENT ANALYSIS
 - RECREATE INCIDENT (PERSON, PLACE, & TIME)
 - EXPLORE EMOTIONAL REACTIONS AND UNMET NEEDS
 - PROBLEM SOLVE



- EXPLORATION OF AFFECT
- COMMUNICATION ANALYSIS (IDENTIFICATION OF COMMUNICATION FAILURES)
- ROLE PLAYING (REHEARSAL OF NEW WAYS OF COMMUNICATING)
- CLARIFICATION (EXAMINATION OF IRRATIONAL BELIEFS)

Theory Driven Treatment

- What to do w/ the information
 - Exploration of Affect
 - Communication Analysis
 - Role Playing
 - Clarification

LET'S WRAP IT UP

The Learning Objectives... achieved?

- Understand the relationship between trauma, painful and provocative life events, and suicide risk in adults.
- Understand the how to conceptualize traditional risk factors according to the interpersonal theory of suicide.
- Conduct a theoretically informed suicide risk assessment interview.
- Develop a theoretically informed formulation of suicide risk and complete appropriate documentation.

Thanks.

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