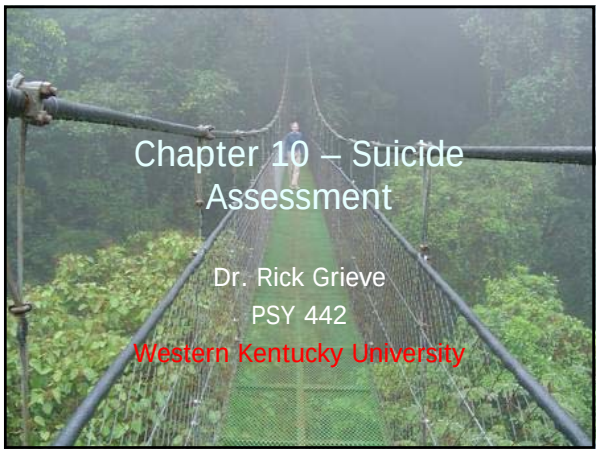

Chapter 10 – Suicide Assessment

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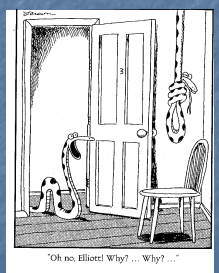
- Not this:

"Suicide is man's way of telling God, You can't fire me, I quit."

Bill Maher



"Oh no, Elliott! Why? ... Why? ..."

Suicide Assessment

- Personal Reactions to Suicide
  - As we discuss suicide and suicide assessment, be sure to monitor your own personal reactions and take time to talk with someone you trust if this topic raises strong emotions in you

Statistics

- Suicide Statistics
  - In 1991, the average suicide rate was 12.2 deaths per 100,000 people
  - It was under 10.0 deaths per 100,000 people in 1999
  - In 2004, it was 11.0 deaths per 100,000 people
  - In 2014, it was 13.0 deaths per 100,000 people, the highest it has been since 1986

Statistics

- Suicide Statistics
  - Worse in military veterans
    - 22-23 per day
  - The suicide rate for American men is about four times higher than for American women
    - Women are more likely to attempt suicide, but men are more likely to succeed
      - Lethality of methods
  - Suicide is very difficult to predict

Risk Factors

- A suicide risk factor is a measurable demographic, trait, behavior, or situation that has a positive correlation with suicide attempts and/or death by suicide
- Risk factor checklists aren't especially helpful
- But understanding risk factors helps understand suicide-related dynamics

Risk Factors II

- Mental Disorders and Psychiatric Treatment
  - Depression
  - PTSD
  - Bipolar disorder
  - Substance abuse/dependence
  - Schizophrenia
  - Anorexia nervosa
  - Borderline personality disorder
  - Conduct disorder
  - Insomnia
  - Post-hospital discharge
  - Recent SSRI treatment

Risk Factors III

- Social, Personal, Contextual, and Demographic Factors
  - Social isolation/loneliness
  - Previous attempts
  - Non-suicidal self-injury
  - Physical illness
  - Unemployment or personal loss
  - Military or veteran status
  - Sexual orientation/sexuality
  - Firearms availability
  - Suicide contagion
  - Abuse and bullying
  - Demographics: Sex, age, and race

Suicide Assessment

- Suicide Risk Factors and Suicide Risk Factor Assessment
  - Recent Loss
  - Past History
  - Psychological Disorders
  - Impulsivity
  - A&D Use
  - Social/Cultural Risk Factors
  - Suicide Exposure
  - Stressful Life Events
  - Hopelessness

Suicide Assessment

- Suicide is viewed as the only solution – there is no other way out
- Self-doubt, self-loathing
- Selective serotonin reuptake inhibitors (SSRIs)
- Sexual orientation
- Trauma and abuse history
- Warning signs
  - talk of death or committing suicide
  - loss of interest in hobbies, work, or school
  - withdrawal from family or friends

Suicide Assessment

- taking unnecessary risks or increases alcohol or drug use
- making final arrangements or gives away prized possessions

Protective Factors

- Protective factors are personal or contextual factors shown to decrease suicide risk or aid in resisting suicide impulses
- Protective factors may be:
  - Empirically linked to reduced suicide risk in the general U.S. population
  - Factors that protect against suicide for individuals within specific populations

Protective Factors II

- General protective factors include
  - Reasons for living (e.g., having children or loved ones)
  - Higher global functioning
  - Social support (e.g., reporting many friendships)
  - Life evaluations (e.g., life is meaningful)
  - Frequent religious service attendance
  - Suicide-related beliefs

Protective Factors III

- Specific protective factors include:
  - Parent connectedness (for adolescents)
  - Neighborhood safety (for adolescents)
  - Academic achievement (for adolescents)
  - Supportive school climate (for sexual minority youth)
  - Coming out/disclosing (for transgender adults)

Suicide Assessment

- Conducting a Thorough Suicide Assessment
  - A reformulation of suicide assessment
  - A constructive critique
    - Differential activation theory
    - Depressogenic social, cultural, and interview factors
    - Adopting a new client and suicide-friendly interview attitude

Warning Signs

- IS PATH WARM was created to facilitate recall of important warning signs:
  - I = Ideation
  - S = Substance Use
  - P = Purposelessness
  - A = Anxiety
  - T = Trapped
  - H = Hopelessness
  - W = Withdrawal
  - A = Anger
  - R = Recklessness
  - M = Mood Change

Building a Theoretical and Research-Based Foundation

- Shneidman posited three factors that directly contribute to suicidality.
  - Psychache: Intense personal pain and anguish
  - Mental Constriction: A problem-solving deficit
  - Perturbability: Agitation or heightened arousal

Theory and Research II

- Joiner theorized that two interpersonal factors can be proximal causes of suicidal intent
  - Thwarted belongingness (social isolation)
  - Perceived burdensomeness

Theory and Research III

- Based on constructive theory, whatever we consciously focus on, be it relaxation or anxiety or depression or happiness, shapes individual reality
- This implies that clinicians should move away from illness-based weaknesses, deficits, and limitations and instead, adopt a stronger emphasis on clients strengths, resources, and potentials

Suicide Ideation is a Sign of Distress, Not Deviance

- Suicide ideation occurs at a high rate among the general U.S. population
- Suicide ideation is primarily a means of communicating emotional pain and distress
- Holding the belief that suicide ideation is pathological creates distance between clinician and client

Emphasize Protective Factors over Risk Factors and Wellness over Diagnosis

- Don't over-emphasize risk factor assessment during clinical interviews
- An illness-oriented perspective can inadvertently facilitate an iatrogenic process
- Be sure to ask about wellness and positive experiences

Collaborate with Clients who are Suicidal

- If you try arguing clients out of suicidal thoughts and impulses, they may shut down and become less open
- Using the Collaborative Assessment and Management of Suicide model, therapist and client collaborate to monitor suicide ideation and develop an individualized treatment plan

Suicide Assessment Interviewing

- Use this acronym to remember suicide interview content
  - R – Risk and protective factors
  - I – Suicide Ideation
  - P – Suicide Plan
  - SC – Client self-control and agitation
  - I – Suicide Intent and Reasons for Living
  - P – Safety Planning

Suicide Assessment

- Assessing Client Depression
  - DSM forms of depression
  - Mood-related symptoms
  - Physical or neurovegetative symptoms
  - Cognitive symptoms
  - Social/interpersonal symptoms

Suicide Assessment

- Personal and Family History
  - It is good practice to assess for previous attempts within the individual and within his/her family
  - A family constellation interview or genogram can help with this

Exploring Suicide Ideation

- It's standard practice to ask directly
  - Asking will not create thoughts of suicide in a client
- But it's possible to ask: "Have you ever thought about suicide?" while nonverbally communicating to the client: "Please, please say no!"
- Before asking about suicide ideation, you need the right attitude about asking the question

Suicide Ideation II

- The right attitude involves these beliefs:
  - Suicide ideation is normal and natural
  - I can be of better help to clients if they tell me their emotional pain, distress, and suicidal thoughts
  - I want my clients to share their suicidal thoughts
  - If my clients share their suicidal thoughts and plans, I can handle it!

Suicide Ideation III

- Asking Directly about Suicide Ideation:
  - Use a normalizing frame: ". . . it is very normal when one feels so down in the dumps. The thought itself is not harmful" (Wollersheim, 1974, p. 223)
  - Use gentle assumption: "When was the last time when you had thoughts about suicide?"
  - Use mood ratings with a suicidal floor

Practice: Asking About Suicide Ideation

- Get with a partner or small group
- Practice each of the three approaches to asking about suicide ideation
  - Normalizing frame
  - Gentle assumption
  - Mood ratings with a suicidal floor
- Report your experiences back to the large group

Responding to Suicide Ideation

- Validate and normalize: “Given the stress you’re experiencing . . .”
- Collaboratively explore the frequency, triggers, duration, and intensity
- Strive to emanate calmness, and curiosity, rather than judgment

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Exploring Depressive Symptoms

- Use the ICD or DSM and check on the following with balanced questioning:
  - Explore mood-related symptoms
  - Check on anhedonia
  - Ask about physical or neurovegetative symptoms
  - Explore cognitive symptoms
  - Ask about social/interpersonal symptoms

Assessing Suicide Plans

- S-L-A-P the Plan, by asking about:
  - Specificity
  - Lethality
  - Availability
  - Proximity of social support

Assessing Client Self-Control

- This is challenging, but you can:
  - Ask Directly
  - Observe for Arousal/Agitation
  - How can you do this?

Assessing Suicide Intent

- Suicide intent is defined as how much an individual wants to die by suicide – and is difficult to assess
- You can infer it from a balanced and collaborative exploration of:
  - Suicide planning
  - Severity of previous attempts
  - Reasons for living and other protective factors

Using Outside Information to initiate Risk and Protective Factor Assessment

- Suicide assessment may be initiated based on information from the following:
  - Client Records
  - Assessment Instruments
  - Collateral Informants

Suicide Interventions

- Listening and being empathic
- Establishing a therapeutic relationship
- Safety planning
- Alternatives to suicide
- Separating the psychic pain from the self
- Becoming directive and responsible
- Making decisions about hospitalization

Suicide Interventions II

- Find a partner or small group
- Discuss the interventions listed on the preceding slide
- Identify the ones you are comfortable with
- Practice applying them with each other

Ethical and Professional Issues

- Consider how you can address these:
  - Can you work with suicidal clients?
  - Consultation
  - Documentation
  - Dealing with completed suicides

Suicide Assessment

- Suicide Prevention Hotline
  - 1-800-273-8255 (1-800-273-TALK)
  - Text: 741741
  - www.suicidepreventionapp.com