


**Working with Suicidal Clients**  
Hope and Recovery in Suicide Care



Jeffrey C. Sung, M.D.

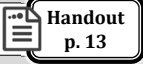
1

## Hope and Recovery in Suicide Care

Jeffrey C. Sung, M.D.  
2910 E. Madison St., Ste 213  
Seattle, Washington 98112  
Phone: 206-633-4844  
Fax: 206-860-2411  
drjcsung@yahoo.com

2

### Hope and Recovery in Suicide Care

8:30am	Registration
9:00-10:30am	Overview and Rationale Assessment of Suicide Risk 
10:30-10:45am	Morning Break: 15min
10:45am-12:00noon	Management of Suicide Risk
12 noon-1:00pm	Lunch
1:00-1:45pm	Management of Suicide Risk
1:45-2:30pm	Treatment of Suicide Risk
2:30-2:45pm	Afternoon Break: 15min
2:45-4:30pm	Treatment of Suicide Risk Chronic Suicidality: Respondent vs. Operant Suicidality Summary

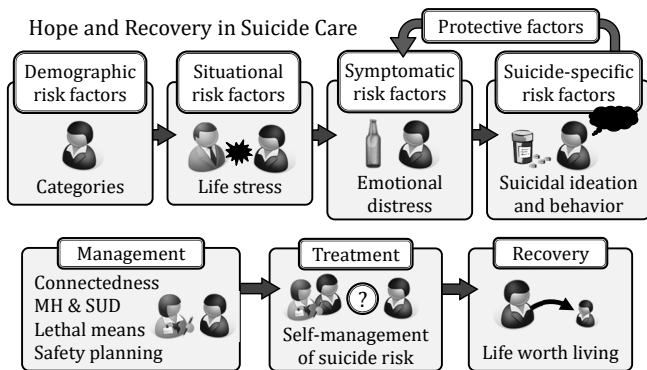
3

### Hope and Recovery in Suicide Care

- Suicide is **preventable**.
- Suicide is **not inevitable**.
- **Suicide care** includes screening, assessment and risk formulation followed by management and treatment of suicide risk.
- **Treatment of suicide risk** involves a collaborative relationship to facilitate self-awareness and self-management of suicide risk.

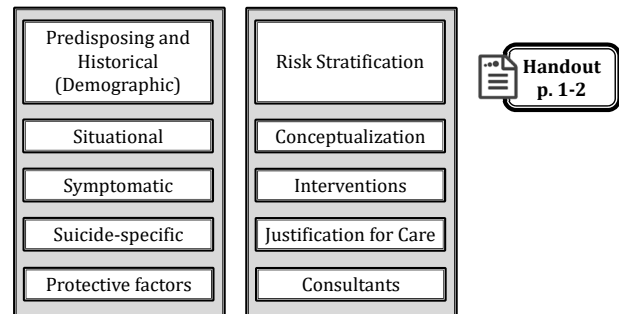


4



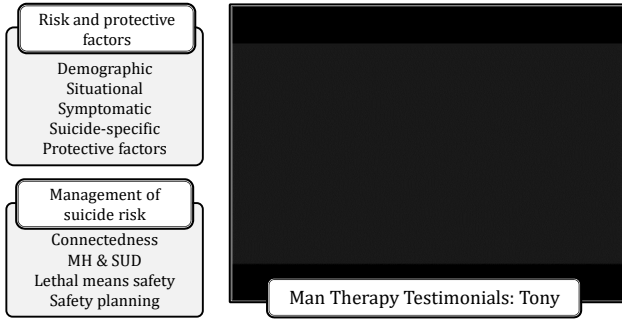
5

### Suicide Risk Assessment & Management



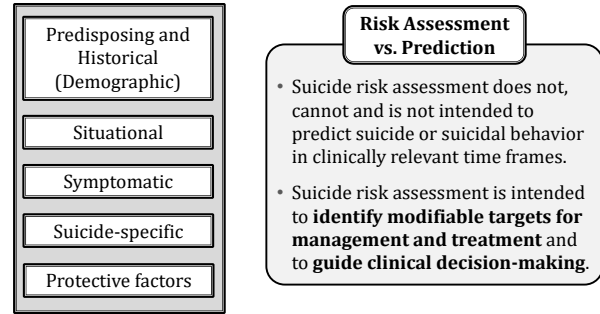
6

Example: Hope and Recovery in Suicide Care



7

Suicide Risk Assessment

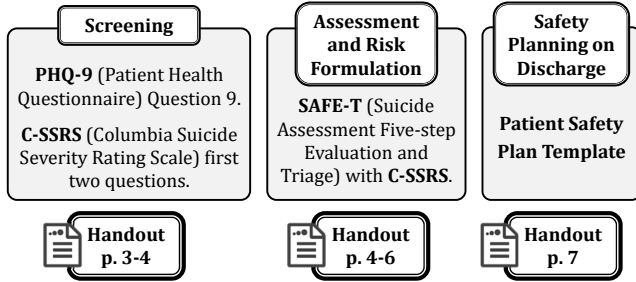


8

Suicide Care in Medical Systems

TJC NPSG 15.01.01: Suicide Prevention Portal

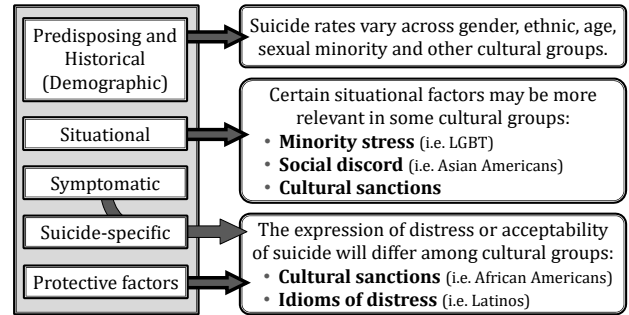
The Bree Collaborative: Suicide Care Recommendations



9

Cultural Factors and Suicide Risk

Chu, et al., 2013 & 2018



10

**Cultural sanctions:** Shameful events or prohibitions on suicide

- *Suicide would bring shame to my family.*
- *I consider suicide to be morally wrong.*

**Idioms of distress:** Ways of expressing distress, including suicidality

- *When I get angry at something or someone, it takes me a long time to get over it.*
- *There is something in my life I feel ashamed of.*

**Minority stress:** Negative experiences based on minority status

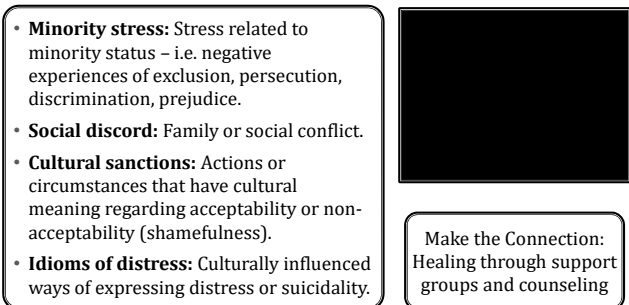
- *The decision to hide my sexual or gender orientation to others causes me significant distress.*
- *Adjusting to America has been difficult for me.*

**Social discord:** Relationship conflict, especially with family

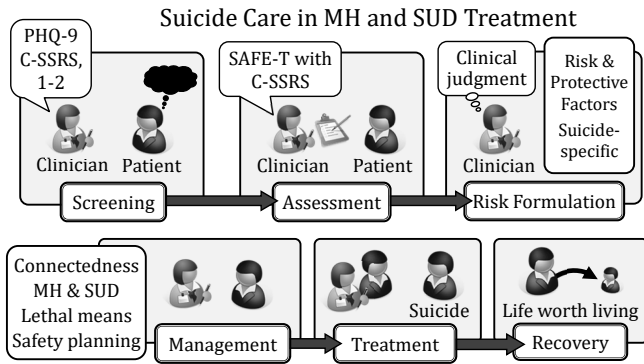
- *There is conflict between myself and members of my family.*

11

Cultural Factors and Suicide Risk

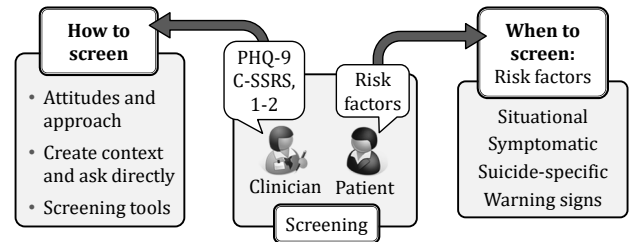


12



13

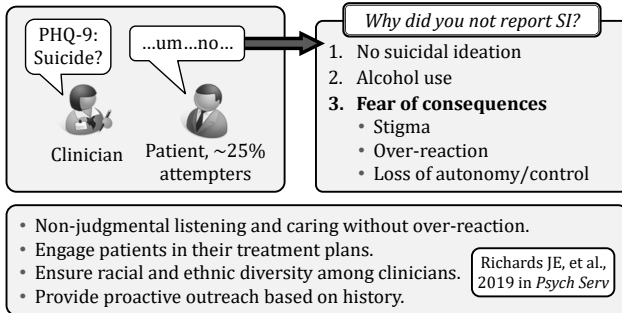
### Indicated Screening: When and How



Continue with suicide-specific assessment using C-SSRS for a positive screen.

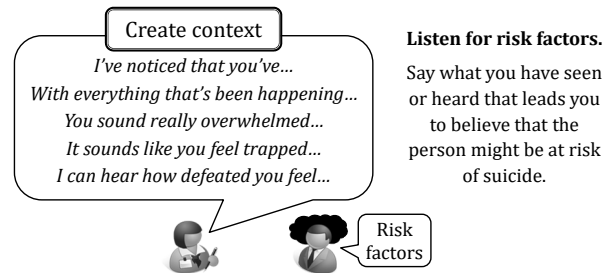
14

### Attitudes and Approach: Barriers to Assessment



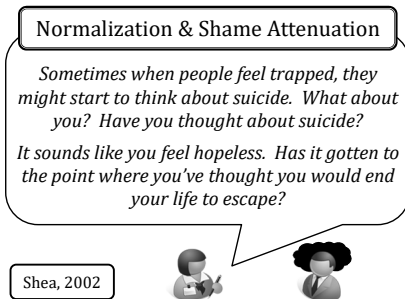
15

### Indicated Screening when Risk Factors Are Present How to Ask: Create Context and Ask Directly



16

### Create Context and Ask Directly



17

### Normalization:

Others in a similar situation have had suicidal thoughts.

### Shame attenuation:

Suicidal thoughts make sense, given the circumstances.

### Ask directly:

Use the words *suicide*, *killing yourself* or *end your life*.

### Asking Directly about Suicide Risk

**Normalization:** Others have had similar experiences.

*Sometimes when people feel overwhelmed like this, they might start to wish they could be dead or think about suicide. What about you? Have you had those thoughts?*

*Just to be safe, I try to check in with people I know are having a tough time to see whether it ever gets so bad they start thinking they'd be better off dead.*

**Shame attenuation:** Suicidal thoughts are understandable.

*When it's at its worst, have you ever thought about suicide as a way out? Have you thought that it would be easier if you were dead?*

18

Columbia Suicide Severity Rating Scale:  
Suicidal Ideation



- **Passive:** *Have you ever wished you were dead or that you wouldn't wake up from sleep?*
- **Active:** *Have you had actual thoughts of killing yourself?*
- **With method:** *Have you thought about how you would do it?*
- **With intent:** *Do you intend to act on your suicidal thoughts?*
- **With plan:** *Have you worked out the details of a plan for how you might kill yourself?*

19

Columbia Suicide Severity Rating Scale:  
Suicidal Behavior



- **Suicide attempt:** Potentially self-injurious act done with ANY intent to die. No actual injury is necessary.  
*Have you ever tried to kill yourself?*
- **Interrupted attempt:** Potentially self-injurious act that was stopped by another person or event before any injury could occur.  
*Have you ever started to do something to end your life – but someone or something stopped you before you actually did anything?*

20

Columbia Suicide Severity Rating Scale:  
Suicidal Behavior

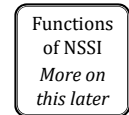


- **Aborted (self-interrupted) attempt:** Potentially self-injurious act that was stopped by the person before any injury could occur.  
*Have you ever started to do something to end your life and then stopped yourself before you did anything?*
- **Preparatory behavior:** Acts or preparation towards imminently making a suicide attempt.  
*Have you prepared or rehearsed in way for your death? Have you taken any steps towards killing yourself?*

21

Columbia Suicide Severity Rating Scale:  
Suicidal Behavior

- **Non-suicidal self-injury:** Self-injurious acts done with NO intent to die (i.e. to feel different, to influence someone else, to end emotional pain).  
*Have you ever injured yourself without wanting to die?*
- **Emotion regulation:** *"I couldn't take the [emotional] pain anymore. Anything was better than how I was feeling."*
  - **Problem-solving:** *"I was so overwhelmed, I didn't know what else to do. I don't know what I wanted."*
  - **Communication:** *"If you can't give me anything for the pain, I should just kill myself."*



22

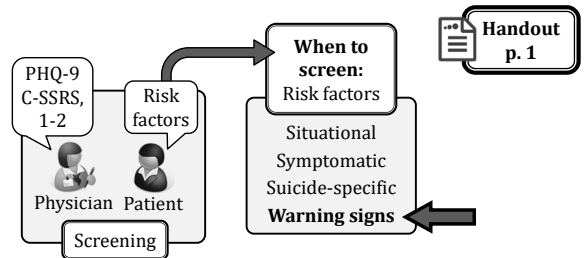
Columbia Suicide Severity Rating Scale:  
Suicidal Ideation



- **Intensity** (frequency, duration, control): *When you have suicidal thoughts, how frequent are they? Do they come and go? Or are they all the time? Can you stop yourself from thinking about it if you try? Or does it feel like you can't control them?*
- **Reasons:** *What makes you want to kill yourself?*
- **Deterrents:** *What keeps you going? What are your reasons for living? What keeps you from killing yourself?*

23

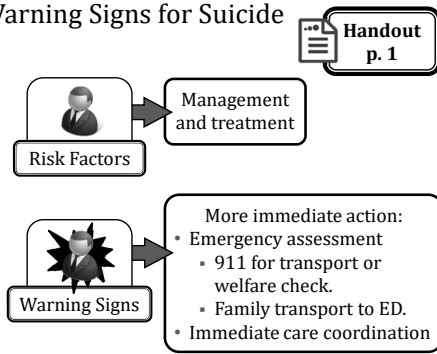
Indicated Screening: When and How



24

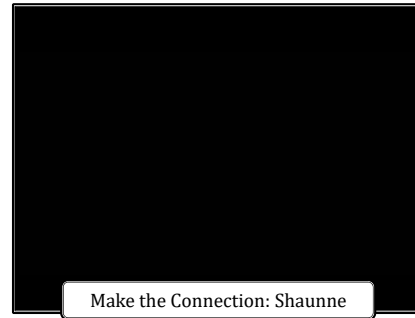
### Warning Signs for Suicide

- I: Suicidal Ideation
- S: Substance use
- P: Purposelessness
- A: Anxiety
- T: Feeling Trapped
- H: Hopelessness
- W: Withdrawal
- A: Anger
- R: Recklessness
- M: Mood changes
- ?: You must ask



25

### Example: Screening and suicide-specific assessment



26

### Breakout Group: Screening and suicide-specific assessment

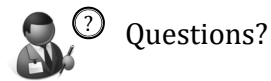
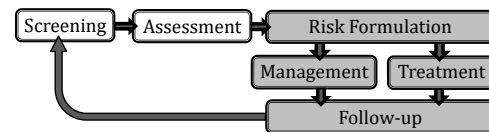
#### Role Play

- Enter the **breakout group** with other participants.
- Decide who will be the **Clinician** and who will be the **Patient**.
- The **Clinician** will conduct screening and assessment by **asking all questions in italics**:
  - Creating context and asking directly
  - Transitioning to suicide-specific assessment.
  - Assessing suicidal ideation and behavior using the C-SSRS questions.
- The **Patient** will answer yes to all questions and provide more information – **suggestions are in italics**.



27

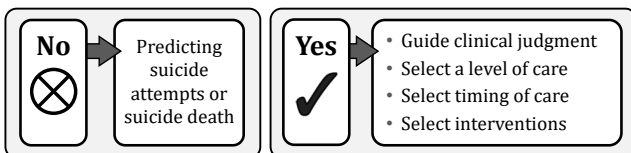
### Screening and Assessment for Suicide Risk



28

### Suicide Risk Formulation (Stratification)

"The estimation of suicide risk, at the culmination of the suicide assessment, is the **quintessential clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior." *AJP*, 2003



29

### Suicide Risk Formulation/Stratification

Risk level	Suicidal ideation	Suicidal behavior	Risk & Protective Factors
High	<b>SI with intent or intent with plan in the past month</b>	Suicidal behavior <b>within the past 3 mon</b>	
Moderate	SI with <b>method</b> WITHOUT intent, plan or behavior	Suicidal behavior <b>more than 3mon ago</b>	Multiple risk factors and few protective factors
Low	<b>Wish to die or SI</b> WITHOUT method, intent, plan or behavior <b>OR no h/o SI or behavior</b>	No reported history of SI or behavior	Modifiable risk factors and strong protective factors

30

### Breakout Group: Suicide Risk Stratification

- Enter the **breakout group** with other participants.
- Review the examples with (limited) clinical information about suicidal ideation and behavior.
- Assign a level of risk using the risk stratification scheme of the C-SSRS.
- What additional information would you want to make a clinical judgment about risk?



Handout p. 10

31

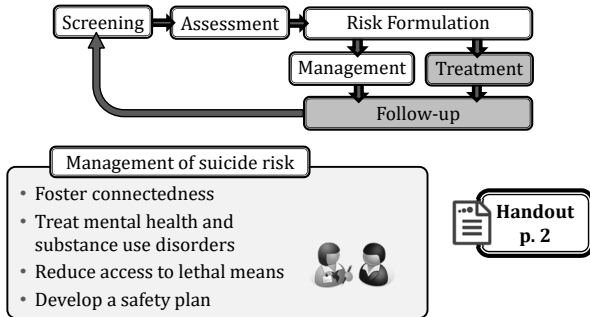
### Suicide Risk Formulation/Stratification

Handout p. 6

Risk level	Suggested interventions
High	<ul style="list-style-type: none"> <li>• <b>Immediate consultation</b> with behavioral health.</li> <li>• Consider referral for <b>inpatient hospitalization</b>.</li> <li>• Immediate referral for behavioral health.</li> </ul>
Moderate	<ul style="list-style-type: none"> <li>• <b>Immediate consultation</b> and referral for behavioral health.</li> <li>• Referral for <b>outpatient behavioral health</b>.</li> <li>• <b>Suicide-specific management strategies</b>.</li> </ul>
Low	<ul style="list-style-type: none"> <li>• Discretionary outpatient referral.</li> <li>• <b>Provide crisis resources:</b> NSPL, Crisis Text Line.</li> </ul>

32

### Management of Suicide Risk



33

### Suicide Risk Management: Emergency Care

**Emergency Care:** Call 911 or arrange emergency assessment

- **Level of risk:** Immediate high risk
- **Outpatient plan:** Not feasible or insufficient
- **Future circumstances:** No foreseeable changes

Hospital?

You can call the National Suicide Prevention Lifeline for consultation.  
**800-273-TALK**  
**800-273-8255**

34

### Breaking Confidentiality

PRMS, 2015

Family member

Consider contacting family members when:

- Risk is judged to be high.
- Family members are likely unaware of the risk.
- Family members are likely to be able to intervene to reduce risk.

35

### Breaking Confidentiality: HIPAA Privacy Rule: 45 CFR § 164.512(j)

A covered entity may disclose PHI consistent with laws and ethical standards and in good faith if the use of the disclosure:

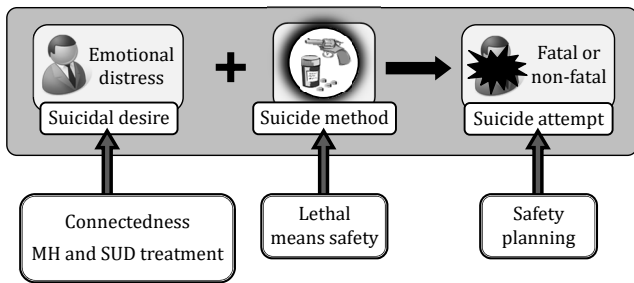
(A) Is **necessary to prevent or lessen a serious and imminent threat to the health or safety of a person** or the public; and

(B) Is **to a person or persons reasonably able to prevent or lessen the threat**, including the target of the threat.

- Document the basis for the risk being serious and imminent based on your risk assessment – i.e. findings from your suicide risk assessment and management plan.
- Document the basis for contacting the person who could lessen the risk – i.e. how this person might prevent or lessen the threat.

36

### Suicide Risk Management What is the theory behind this?



37

Outpatient Management of Suicide Risk

- **Connectedness**
  - Trusting relationship with platoon sergeant.
  - Immediate access to mental health services.
  - Army crisis line.
- **Depression treatment**
  - Medication treatment for depression.
  - Psychiatrist and psychologist for ongoing care.
- **Lethal means safety**
  - "They took away my weapon."
  - "They took my bolt away for a while - like a week."
- **Safety planning**
  - Plan for how to respond to suicidal thoughts: "If I felt like hurting myself, did I tell anybody?"

38

### Outpatient Management of Suicide Risk

- Connectedness
- Depression treatment (co-occurring mental disorders)
- Lethal means safety
- Safety planning
- Other modifiable risk factors



39

### Veterans and Suicide Risk

#### Knowledge about suicide

- 22% of suicide deaths are veterans.
- Firearm suicide is more common among veterans: 70% for men and 35% for women.

#### Suicide risk assessment

- Ask: *Have you ever served in the armed forces, guard or reserves?*
- Demographic and situational factors: TBI, PTSD, transitions (deployment, re-integration).

#### Suicide risk management

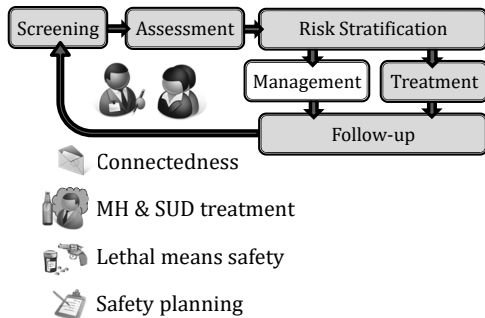
- Veterans Crisis Line: 800-273-8255, Press 1
- Veterans crisis chat: [veteranscrisischat.net](http://veteranscrisischat.net)
- VHA: [mentalhealth.va.gov](http://mentalhealth.va.gov)

Handout p. 11

For clinicians: U.S. DVA Suicide Risk Management Consultation Program (SRM) - free one-time consultation, resources and support for working with veterans.

40

### Suicide Risk Management



41

### Caring Letters: Connectedness

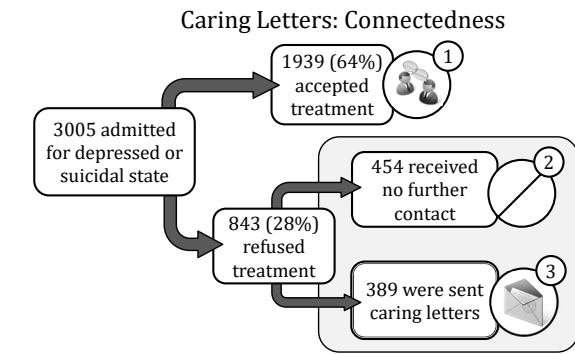
Motto and Bostrom (2001) identified 3005 persons in the San Francisco area hospitalized because of a depressive or suicidal state and contacted them 30 days after discharge about follow-up treatment.



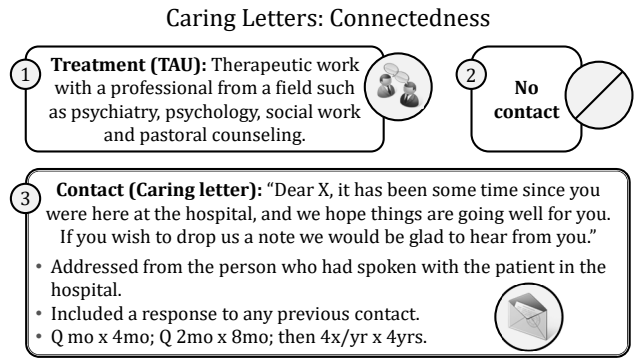
Motto & Bostrom. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psych Services*



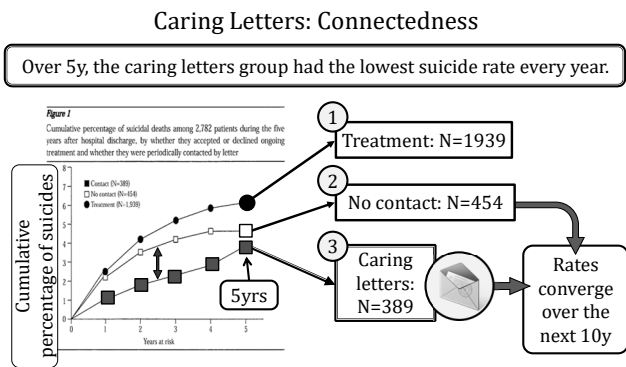
42



43



44



45

### Caring Letters: Connectedness

Conclusion: A systematic program of contact with persons who are at risk of suicide and who refuse to remain in the health care system appears to exert a significant preventive influence for at least 2y.

*"I always think someone cares about me, even if my family did kick me out."*

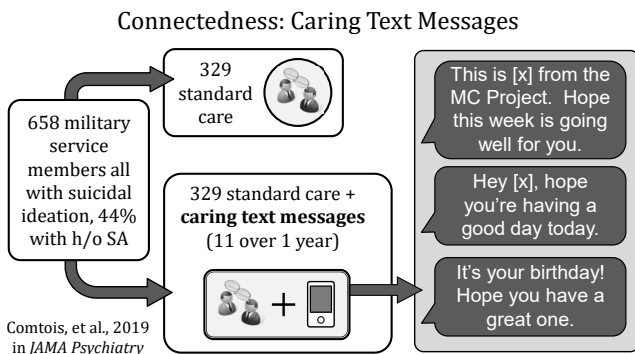
*"You are the most persistent son of a bitch I've ever encountered, so you must really be sincere in your interest in me."*

Social connectedness for suicide prevention.

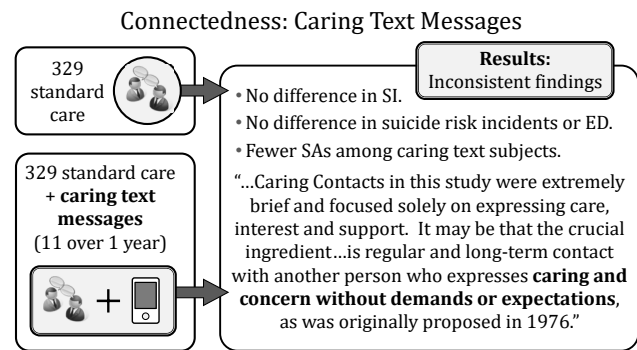
**Reach Out: Ways to help a loved one at risk of suicide** - Chatterjee for NPR, 2019

**The Best Way to Save People from Suicide** - Cherkis for The Huffington Post, 2018

46



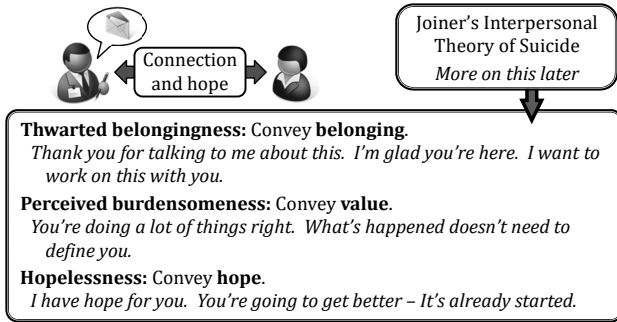
47



48



Connectedness: Building Therapeutic Alliance



49



Connectedness: Caring Letters in Health Care

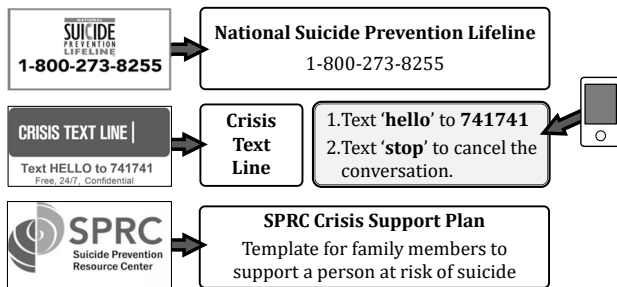
**Zero Suicide: Contact after Leaving Care**  
Examples of caring contacts for use in health care settings.  
[zerosuicide.sprc.org](http://zerosuicide.sprc.org)

*Jeff - Thank you for coming in today and for answering all the questions. I know you weren't comfortable. Based on our brief time together, I can see you know how to get through hard times. I wish you didn't have to be - but it seems to me you are very strong. - Ursula*

Visit [nowmattersnow.org](http://nowmattersnow.org) for strategies that have helped us survive and build more manageable and meaningful lives.

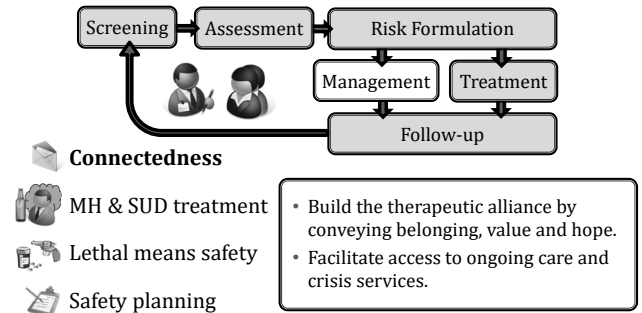
50

Connectedness: Access to Crisis Support



51

Suicide Risk Management: **Connectedness**



52

Depression Treatment: Antidepressants & Suicide Risk

FDA Black Box Warning (2007)

- Children, adolescents and young adults ≤ 24:** Increased risk of *suicidality* (ideation and behavior - *not suicide death*). 4% vs. 2%.
- Adults 25-64:** No difference in risk.
- Adults 65+:** Protective effect.

Cases of Suicidality in Drug Group per 1000 Patients			
<18yo	18-24yo	25-64yo	65+yo
14 more per 1000	5 more per 1000	1 less per 1000	6 less per 1000

Monitor for anxiety, agitation, insomnia, akathisia (uncomfortable, internal restlessness and inability to be still).

53

Intranasal Esketamine for Treatment Resistant Depression

- History of use:** Ketamine was developed in 1962 as an alternative to PCP for dissociative anesthesia and has been FDA approved since 1970 for this use in adults and children.
- Novel mechanism of action:** Antidepressant actions of ketamine are believed to relate to effects on glutamate transmission at NMDA and AMPA receptors. These differ from monoamine neurotransmitters (serotonin, norepinephrine, dopamine) implicated in the effects of conventional antidepressants.
- Rapid effects:** Single doses of intravenous ketamine have been shown to have rapid antidepressant effects, including reductions in suicidality, that may begin within an hour, peak at 24 hrs and dissipate by 1 wk.
- FDA approval:** In 2019, the FDA approved the use of intranasal esketamine (an enantiomer of ketamine) as an adjunct to antidepressant medication for treatment resistant depression (unresponsive to 2+ adequate AD trials).

54

**Intranasal Esketamine for Treatment Resistant Depression**

- **Administration:** Intranasal esketamine may only be administered through a Risk Evaluation and Mitigation Strategy (REMS) program by a certified medical clinic with patients enrolled in a registry. The patient self-administers the nasal spray at the clinic, is observed for at least 2 hours and may not drive until the next day after restful sleep.

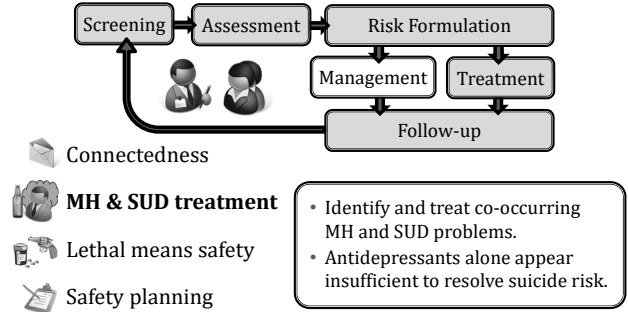


- **Side effects:** Increased BP, dissociation, dizziness, nausea, sedation, others.
- **Uncertainties:** Addictive and abuse potential, optimal dosing duration, optimal dosing frequency, suicide risk.

Park, et al. in *Focus*, Winter 2019; FDA SPRAVATO prescribing information

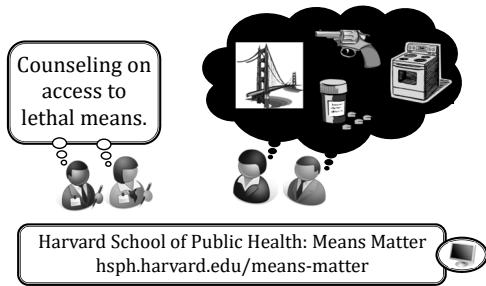
55

**Suicide Risk Management: MH & SUD Treatment**



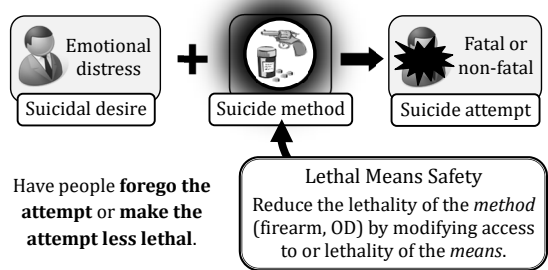
56

**Suicide Risk Management: Lethal Means Safety**



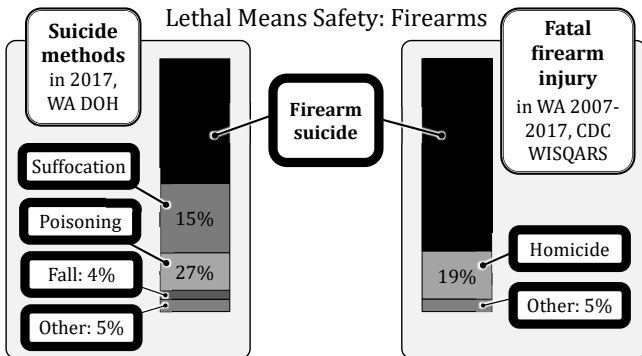
57

**Suicide Risk Management: Lethal Means Safety**



58

**Lethal Means Safety: Firearms**



59

**Firearm Suicide: 23,854 deaths in 2017 (CDC)**

Male firearm  
20,615  
(86%)

F: 3,239

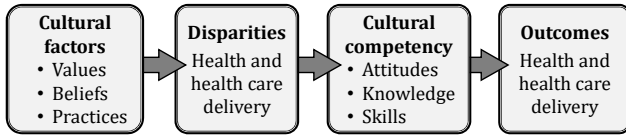
- ~265,000,000 firearms in the U.S. (Azrael, et al., 2017. Stock and Flow of U.S. Firearms in *RSF JSS*)
- Firearm type: Handgun (73%), Shotgun (15%), Rifle (12%)
- NVDRS data on firearm suicide from 13 states, 2005-2015 (Hanlon, et al., 2019 in *J Adolescent Health*)
- Suicide with recent firearm purchase or rental: 11/144 (8%) (Vriniotis, et al., 2015 in *SLTB*)
- Interval between handgun purchase and firearm suicide: Median of 11 years (Cummings, et al., 1997 in *AJPH*)
- Would have passed a background check on the date of death: 92% (Barber, et al, 2019 in *Health Affairs*)

Adult men with pre-existing, longstanding firearm ownership

60

### Cultural Competence: Firearms and Suicide

**Culture:** "...the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group." (Cross, et al., 1989)

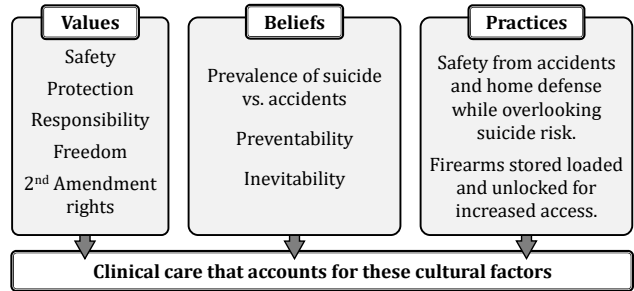


Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care (IOM, 2003)  
National Standards for CLAS in Health and Health Care (U.S. DHHS, 2013)

61

### Firearms culture and suicide care

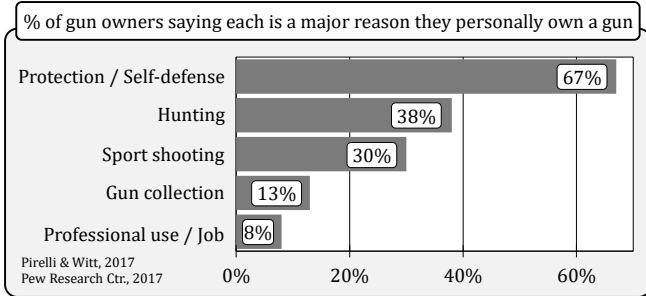
Cultural factors related to suicide risk



62

### Multiple Sub-Populations

Values: Safety and Protection



63

### Values: Responsibility, Protection & The Rifleman's Creed

**This is my rifle. There are many like it, but this one is mine. My rifle is my best friend. It is my life. I must master it as I must master my life.**

Without me, my rifle is useless. Without my rifle, I am useless. I must fire my rifle true. I must shoot straighter than my enemy who is trying to kill me. I must shoot him before he shoots me. I will ...

My rifle and I know that what counts in war is not the rounds we fire, the noise of our burst, nor the smoke we make. We know that it is the hits that count. We will hit ...

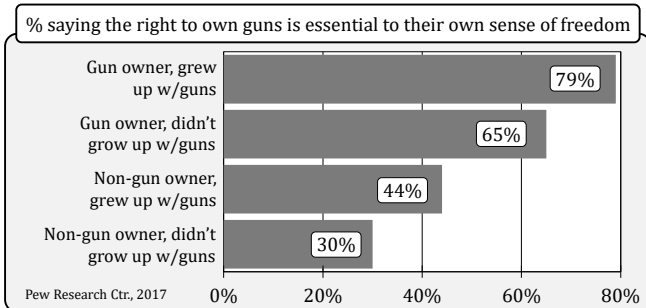
My rifle is human, even as I, because it is my life. Thus, I will learn it as a brother. I will learn its weaknesses, its strength, its parts, its accessories, its sights and its barrel. I will keep my rifle clean and ready, even as I am clean and ready. We will become part of each other. We will ...

Before God, I swear this creed. My rifle and I are the defenders of my country. We are the masters of our enemy. We are the saviors of my life.

So be it, until victory is America's and there is no enemy, but peace!

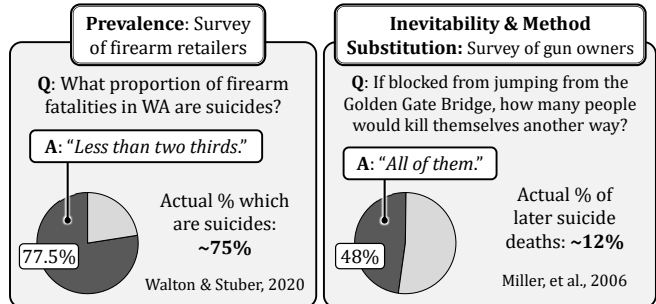
64

### Values: Freedom



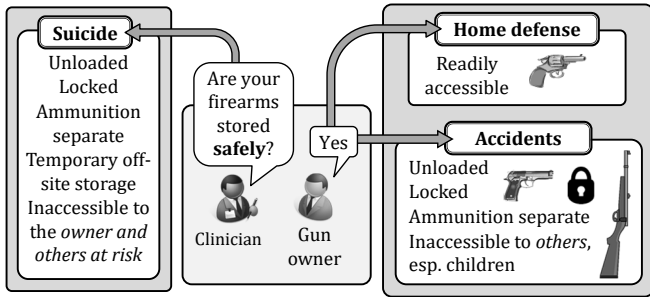
65

### Beliefs: Prevalence of Suicide, Inevitability & Method Substitution



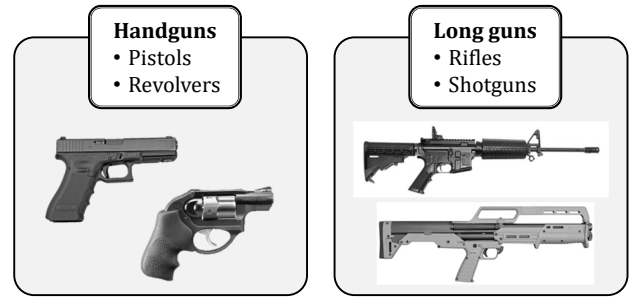
66

### Firearms Culture and Suicide Care Values, Beliefs and Practices: What is "safety"?



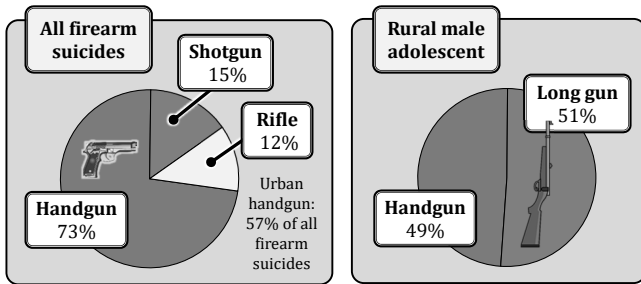
67

### Handguns & Long guns



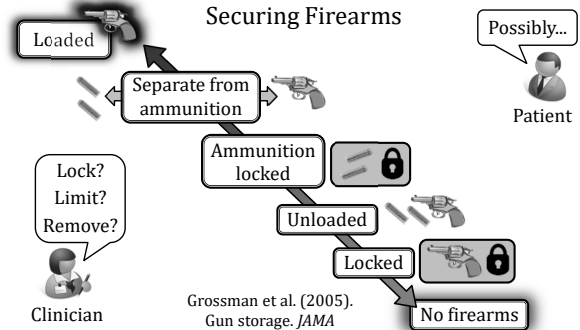
68

### Type of Firearm Used in Suicides NVDRS: 13 States, N=44,540 (Hanlon, et al., 2019)



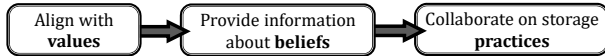
69

### Lethal Means Safety Securing Firearms



70

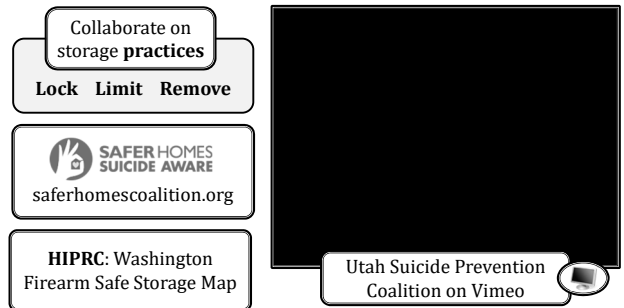
### Firearms Culture and Suicide Care



- **Values:** I'm thinking about how protecting yourself and your family might also mean protection against suicide.
- In the state of Washington, about 75% of all gun deaths are suicides. Sometimes people don't know that the most common safety issue with firearms is suicide risk.
- **Beliefs:** A common myth is that if someone doesn't have access to a gun for suicide, they'll just find another way. Instead what we find is when people don't have immediate access to a lethal method of suicide, almost everyone overcomes the crisis and makes it through to live.
- **Practices:** When someone is going through a hard time, temporarily reducing access to the firearms can give some time to work through the crisis. Do you have some ideas about what would make sense for you? Someone who could hold your guns until things get better?

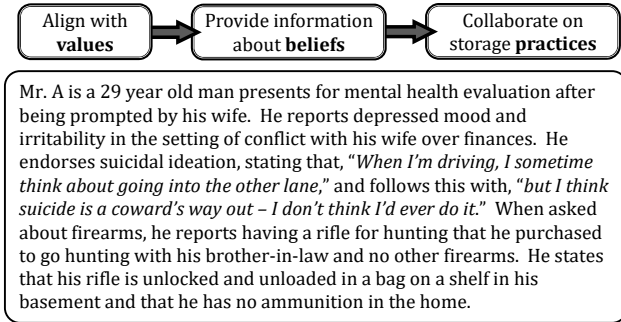
71

### Lethal Means Safety: Firearms



72

### Firearms Culture and Suicide Care

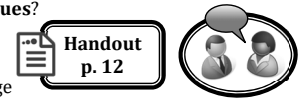


73

### Breakout Group: Firearms, Culture and Suicide Care

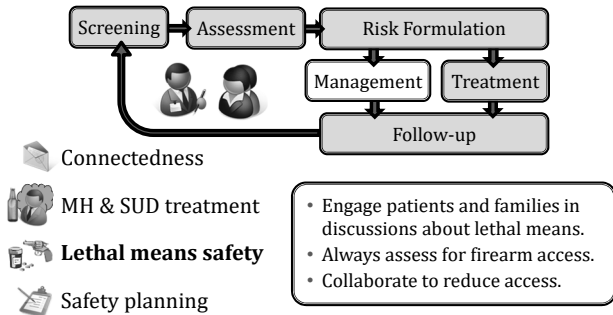
The therapist suggests, "You've had thoughts about suicide, and we know that firearms are the most lethal suicide method. While we're working things out and getting you feeling better, what do you think about having someone else hold onto your rifle or locking it up more securely in your home?" Mr. A replies, "I don't know what you mean. There's no ammunition in the house, so it's not like I could shoot myself anyway. Besides, there's a lot of other ways people kill themselves."

- What would you say to align with values?
- What would you say to provide information on beliefs?
- How would you collaborate on storage practices?



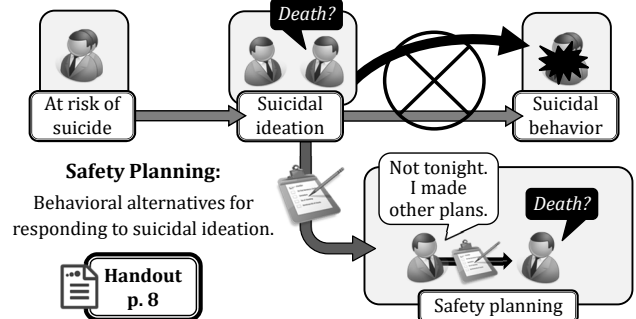
74

### Management of Suicide Risk



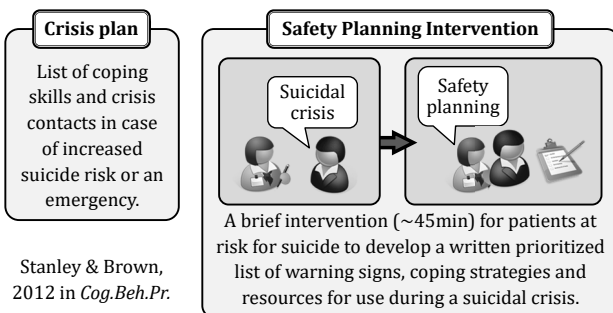
75

### Safety Planning



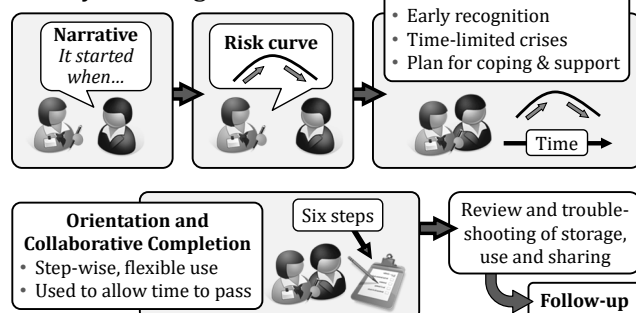
76

### Safety Planning



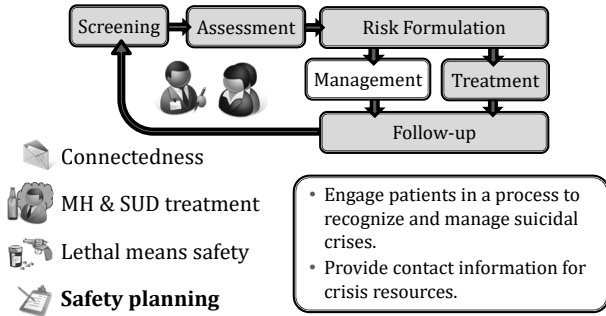
77

### Safety Planning Intervention



78

**Suicide Risk Management: Safety Planning**



79

**Please refrain from no-harm contracts**



Suicide prevention contracts can create the illusion of patient safety, reducing staff anxiety without achieving the intended purpose of effective safety management for the suicidal patient.  
 Simon. (2004). *Assessing and managing suicide risk*. American Psychiatric Publishing

Perform a risk assessment and establish a therapeutic alliance. Use a commitment to treatment statement (Rudd, 2006) whereby the clinician explains the treatment and the patient agrees to participate. Safety planning is more effective than extracting a promise for no self-harm.

80

**Documentation: Justification for Level of Care**

Risk Stratification	<p><b>Why did you not hospitalize or refer for emergency evaluation?</b></p> <input type="checkbox"/> Risk is judged to be low. <input type="checkbox"/> Detrimental to <i>clinical status</i> . <input type="checkbox"/> Detrimental to <i>treatment</i> . <input type="checkbox"/> Risk likely to decrease due to future events. <input type="checkbox"/> Addressing current problems more likely to be effective. <input type="checkbox"/> Suicidality appears <i>operant</i> .
Conceptualization	
Interventions	
Justification	
Consultants	

Handout p. 13

81

**Five Components of Documentation**

1. Database: Risk factors, protective factors, warning signs
  2. Overall level of risk
  3. Interventions for suicide risk
  4. Justification for care
  5. Consultants
- Once at baseline. Then modify and update with clinically significant changes - environmental event, symptom change, etc.
- Interventions for suicide risk:** Foster connectedness with ongoing mental health appointments; target depression with medication treatment; motivational interviewing for alcohol use; pt. has confirmed no firearm access; selection of medications of lower toxicity in overdose; pt. given contact information for NSPL and after-hours crisis services.

82

**Breakout Group: Management of Suicide Risk**

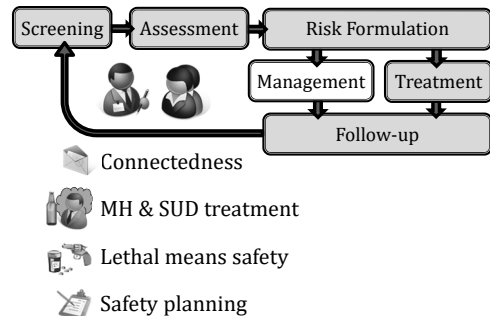
Handout p. 13-14

- Connectedness
- Mental health and substance use disorders
- Lethal means safety
- Safety planning
- Other modifiable risk factors

U.S. Department of Veterans Affairs  
 Make the Connection

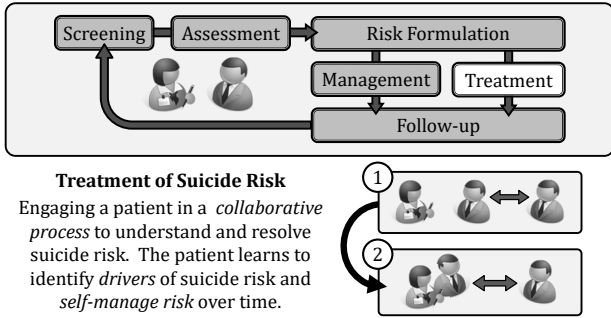
83

**Questions?**



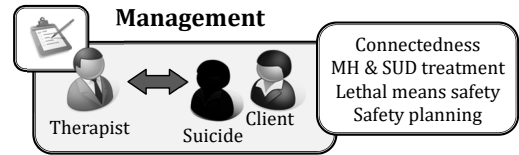
84

Suicide Care: Treatment of Suicide Risk



85

Management vs. Treatment

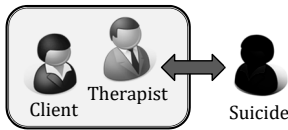


**Management:** Therapist engages in interventions that seek to reduce risk by modifying risk factors related to suicide. Management is optimally, but not necessarily, collaborative.  
**Doing what is needed to keep the client alive.**

86

Management vs. Treatment

**Treatment**

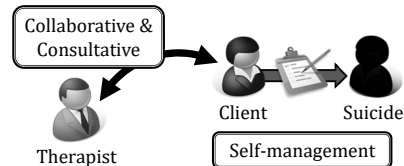


**Treatment:** Therapist and client engage in a collaborative relationship to resolve internal factors that are unique/intrinsic to suicide risk (i.e. "drivers" of suicide).  
**Working together so that the client learns over time how to self-manage suicide risk.**

87

Management vs. Treatment

**Treatment**

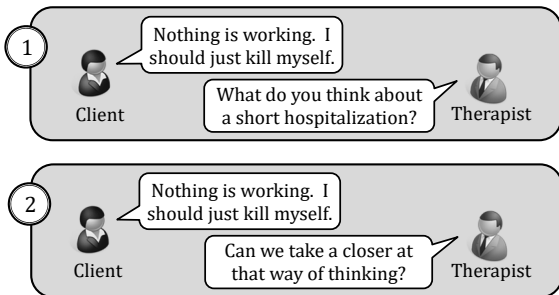


Over time, the client grows in confidence and responsibility in self-managing suicide risk.

Ellis. (2004). Collaboration and a self-help orientation in therapy with suicidal clients

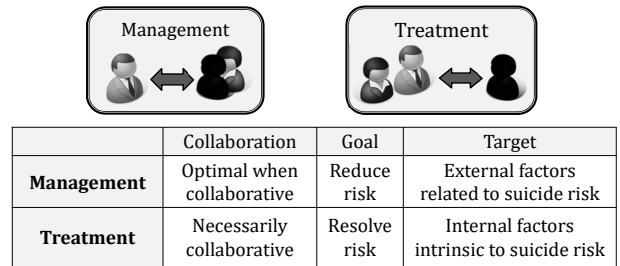
88

Management vs. Treatment



89

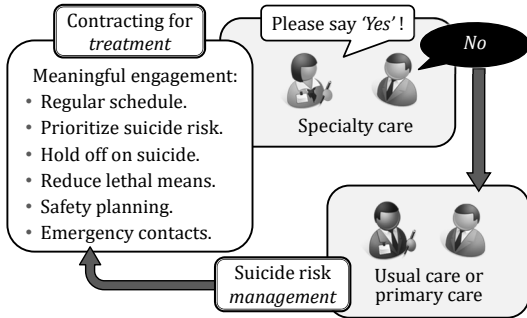
Management vs. Treatment



Sung & Jobes. (2017). Managing high-risk suicidal clients in private practice in *Handbook of Private Practice*. Oxford.

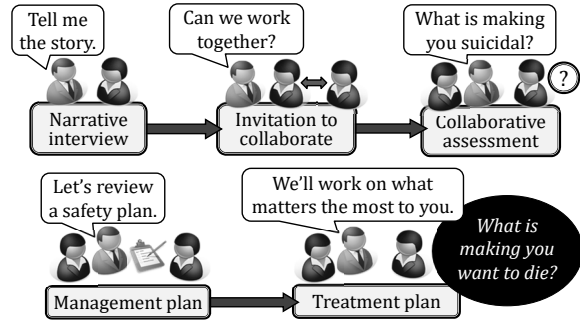
90

Contracting for **Treatment** vs. **Management** of Risk



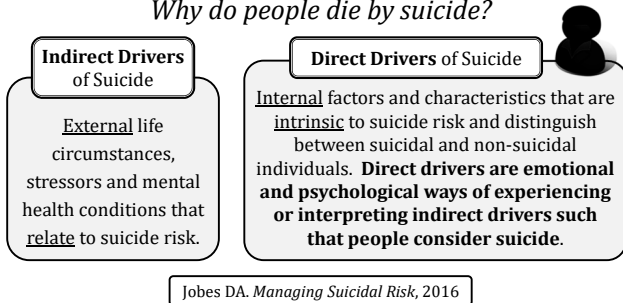
91

Treatment to Resolve Suicide Risk



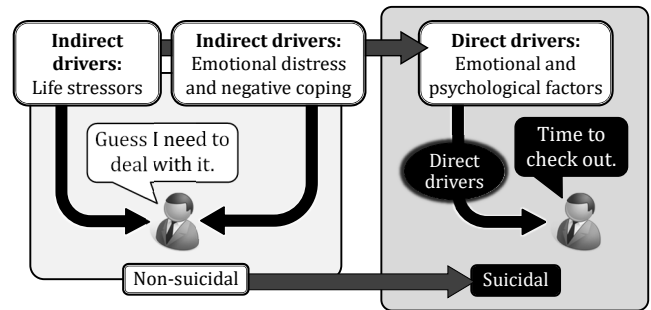
92

Treatment of Direct Drivers  
*Why do people die by suicide?*



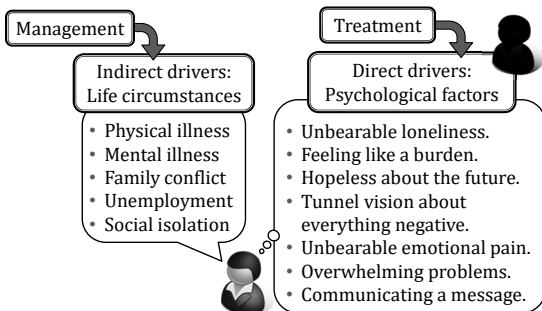
93

Indirect vs. Direct Drivers of Suicide



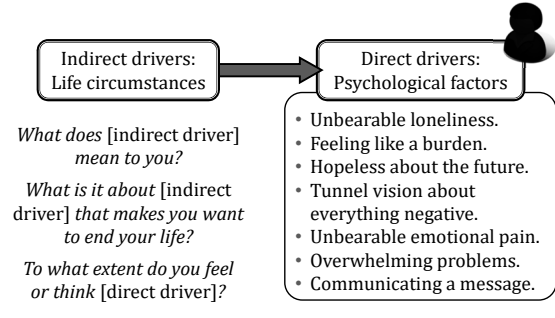
94

Indirect vs. Direct Drivers of Suicide



95

Indirect vs. Direct Drivers of Suicide



96



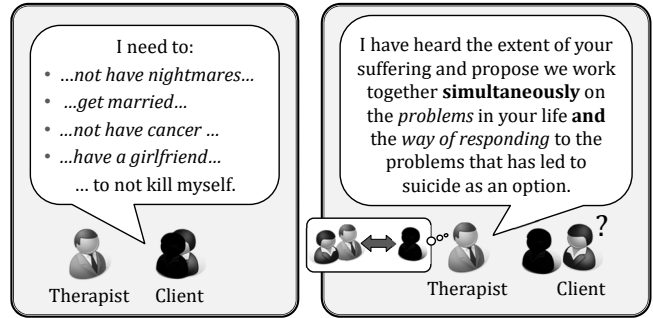
Indirect vs. Direct Drivers of Suicide



Ms. A is a 37yo single woman who works as a project manager for a sales company. For the past 2 years she has been having an affair with her supervisor who is married with two children. When she reveals to him that she is pregnant, he appears to look right through her as he states, "It's fine. I'll pay for the abortion." Ms. A, who has "always wanted a family," reports to her therapist that her supervisor has suggested that if she raises any concerns about his behavior, he will arrange for her to be laid off due to his knowledge of her unethical behavior on a previous work project. She states, "I'm the only one to blame. I'm going to end this hopeless pregnancy, and then I'm going to end this hopeless life."

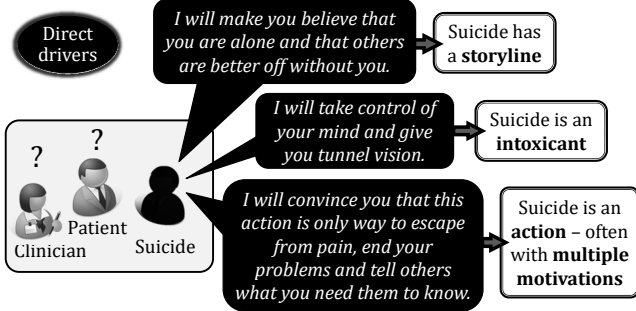
97

"Suicide-Specific Treatment"



98

Direct Drivers: The Suicidal Process



99

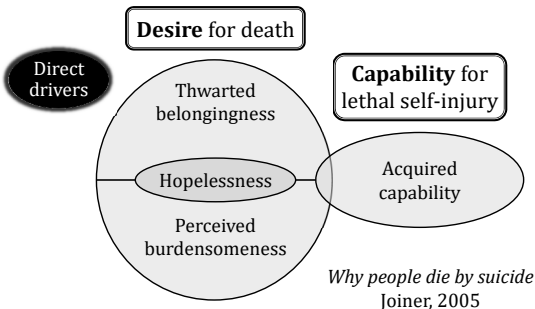
Direct Drivers: Psychological Theory of Suicide

Why do people die by suicide?

- Suicide has a **storyline**: Thought content
- **Interpersonal Theory of Suicide** (Joiner, 2005)
- Suicide is an **intoxicant**: Thought processes
- **Cognitive Theory of Suicide** (Wenzel & Beck, 2008).
- Suicide is an **action**, often with **multiple motivations**
- **Dialectical Behavior Therapy Theory of Emotions - Emotion dysregulation** (Linehan, 1993).

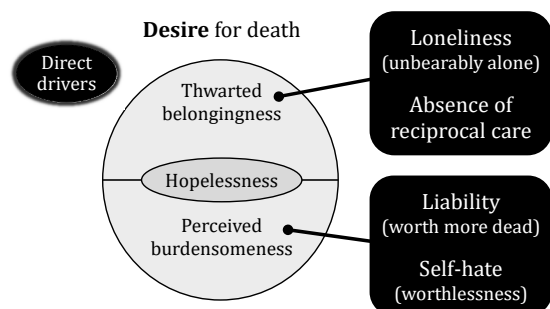
100

Suicide has a storyline: Interpersonal Theory



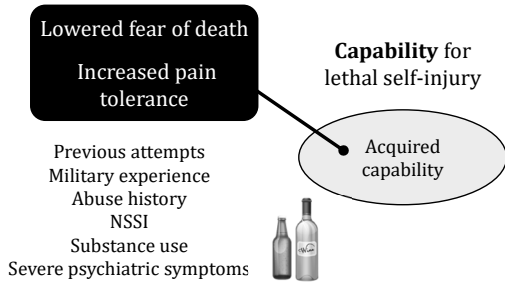
101

Suicide has a storyline: Interpersonal Theory



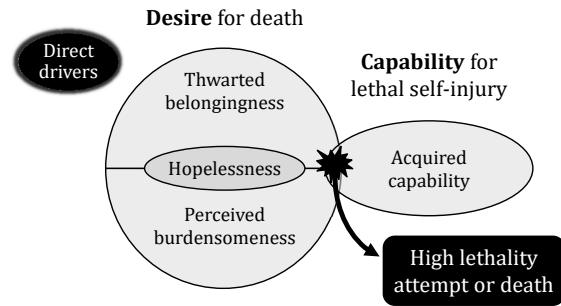
102

**Suicide has a storyline: Interpersonal Theory**



103

**Suicide has a storyline: Interpersonal Theory**



104

**Example: Thwarted Belongingness**

Mr. B is a 39yo man who lives alone in an apartment and works for a software company. He has experienced long-standing depression and SI dating to the suicide death of his mother when he was 6yo. Throughout his life he has experienced painful loneliness as he misses his mother and longs to join her in death. His therapist, focusing on thwarted belongingness as the most relevant direct driver of suicide, discusses with the patient a plan for Mr. B to light candles each evening while calling to mind a positive, loving memory of his mother. With some consistency, Mr. B follows through with this and reports no improvement for months, stating that this only makes him feel more sadness and loss. Appointments are spent discussing the pain of the loneliness in his life.

105

**Example: Thwarted Belongingness**

After six months, Mr. B arrives for an appointment stating that over the past week he fell asleep on his couch one night while watching television. In a dream, he is awakened from sleep on the couch by his mother smiling while seated next to him. He awakens from the dream to find that he has been crying while asleep. As he and his therapist discuss the dream, Mr. B states, "I don't know. I feel different. I feel like my mother wants me to live - like she wouldn't want me to be so sad all the time." The therapist conceptualizes the shift as the development of a living, internal presence of Mr. B's mother that resolved the unbearable loneliness of thwarted belongingness.

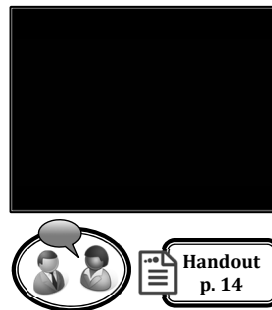
106

**Cognitive Content: Suicide Has a Story Line**

- Problem-solving:** Fostering development of connections.
- Cognitive restructuring**
  - Address the validity of thoughts
  - Address the utility of thoughts
- Mindfulness**
  - Noticing thoughts and letting these go
  - ACT: Defusion from thoughts
- Processing grief:** Grieving to restore an inner relationship.
- Addressing hopelessness:** Behavioral activation, cognitive restructuring - "Hope is a skill" that is practiced continuously rather than achieved entirely.

107

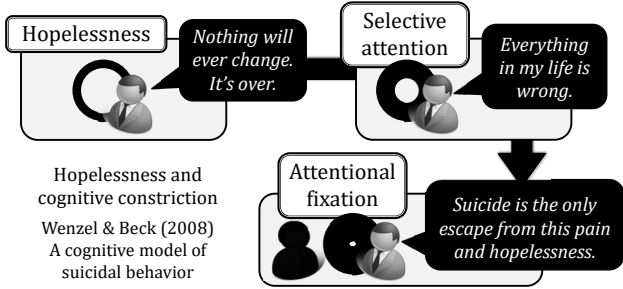
**Breakout Group: Indirect and Direct Drivers of Suicide**



1. What are the **indirect drivers** - i.e. mental health conditions and life stressors?
2. What are the **direct drivers** - i.e. the suicidal storyline? What did you hear to indicate thwarted belongingness, perceived burdensomeness and hopelessness?
3. How were the direct drivers targeted in a way that resolved suicide risk?
4. What other interventions would you consider?

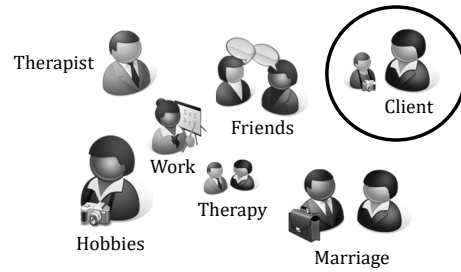
108

**Suicide is an intoxicant: Cognitive Theory**  
*Tunnel vision, suicide as the only escape from pain and hopelessness*



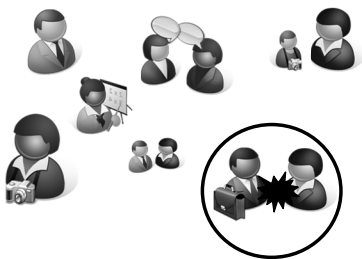
109

**Direct Drivers: Cognitive Model of Suicide**



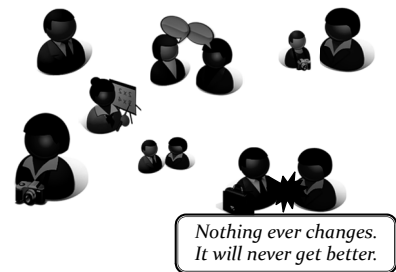
110

**Trigger (Loss)**



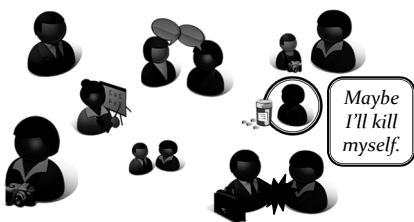
111

**Hopelessness**



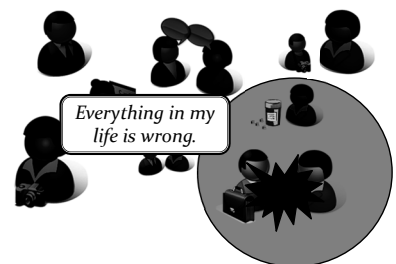
112

**Suicidal Ideation**



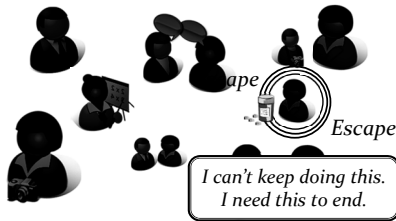
113

**Selective Attention**

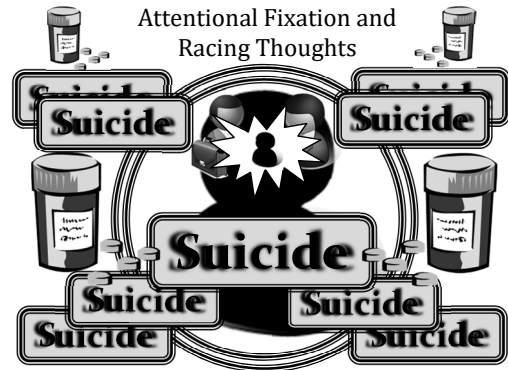


114

Attentional Fixation



115



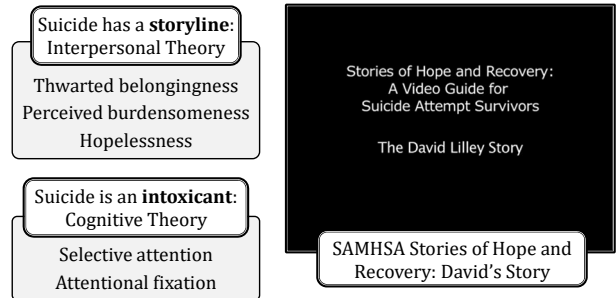
116

Hopelessness



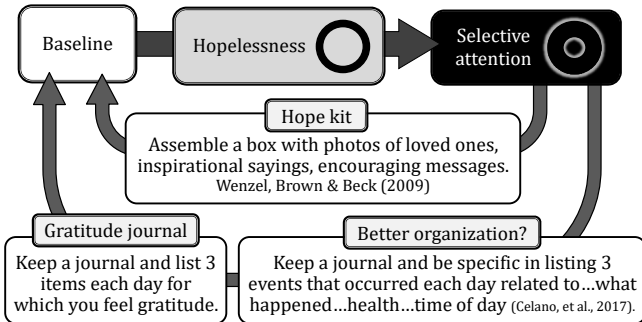
117

Suicide is an intoxicant: Cognitive Model of Suicide



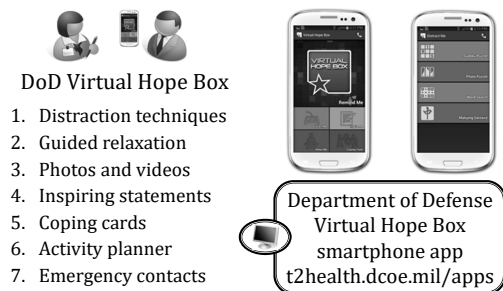
118

Direct Drivers of Suicide: Hopelessness & Selective Attention



119

Direct Drivers of Suicide: Hopelessness & Selective Attention



120

Example: Selective Attention and Attentional Fixation

Ms. C is a 24yo graduate student whose research has been complicated by departmental politics. Her boyfriend recently ended the relationship with Ms. C after their mutual advisor made sexual advances towards him – which he rejected. Simultaneously, Ms. C’s mother has been calling Ms. C on the phone repeatedly, telling Ms. C that she “should not have gone into that useless field” and that “your father is sick and needs you to help take care of him.” Ms. C tells her therapist that she has been living in fear of her advisor while enraged with her mother. Ms. C reports having fantasies of killing herself while on the phone with her mother. The therapist engages Ms. C in the safety planning intervention – during which Ms. C states repeatedly, “I know this already” and “this won’t work.”

121

Example: Selective Attention and Attentional Fixation

Three months later, Ms. C presents to her appointment, stating “something happened that I wanted to talk to you about.” Ms. C reports that she was on the phone with her mother while driving on the highway. Ms. C hung up on her mother in a rage, after which, “I was literally screaming in my car and felt completely out of control. I was either going to drive into another car or pull over. I pulled over, and I couldn’t think of a single thing to do to calm myself down. Then I remembered that we had written down ‘listen to music’ on that safety plan so I turned on the music full blast to block out all my thoughts. I was shocked that it only took 15 minutes to feel like I was in better control. Is that what you meant by ‘the feelings go up and down?’” The therapist uses the experience to reinforce successful coping and discuss the emerging ability to observe and describe suicide-related stressors, thoughts and feelings.

122

**Suicide is an action, often with multiple motivations:**  
Emotion Dysregulation

- Overwhelming emotions.
- Lack of skills.
- Suicidal ideation and behavior functioning as emotion regulation, problem-solving and communication.

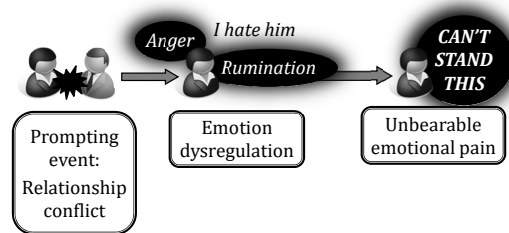
Dialectical Behavior Therapy Theory of Emotions

Can't stand this anymore

Linehan. (1993). Cognitive-behavioral therapy for borderline personality disorder

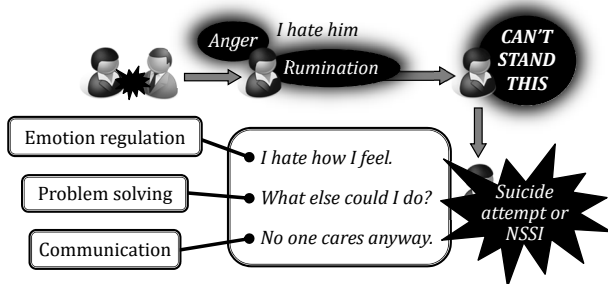
123

Direct Drivers: Emotion Dysregulation



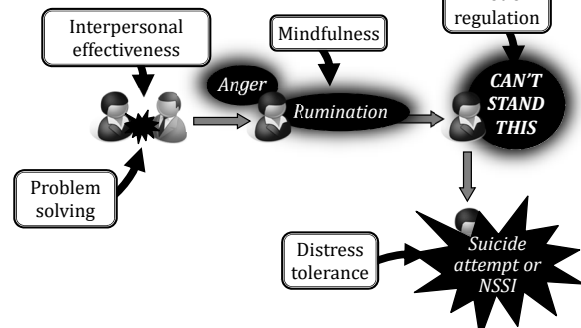
124

Direct Drivers: Emotion Dysregulation



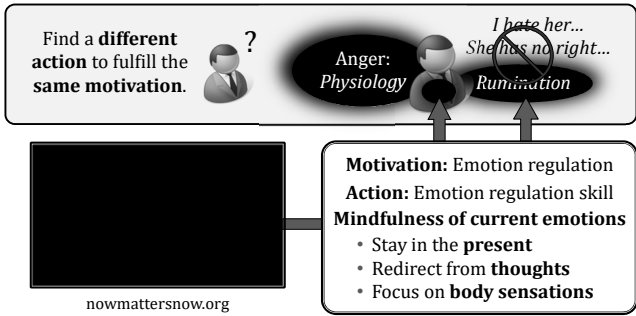
125

Dialectical Behavior Therapy



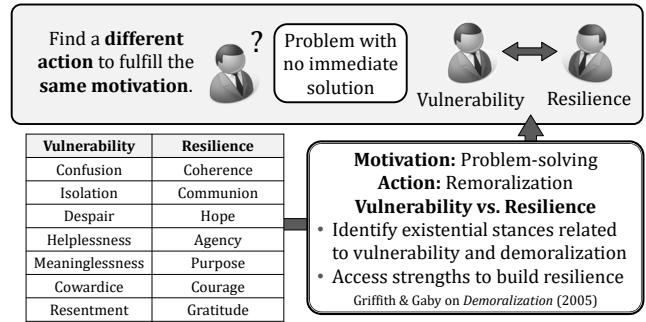
126

Suicide is an **action**, often with **multiple motivations**



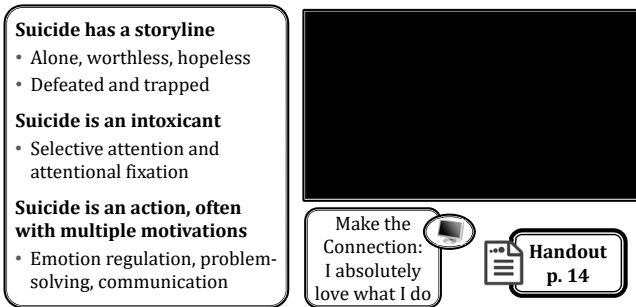
127

Suicide is an **action**, often with **multiple motivations**



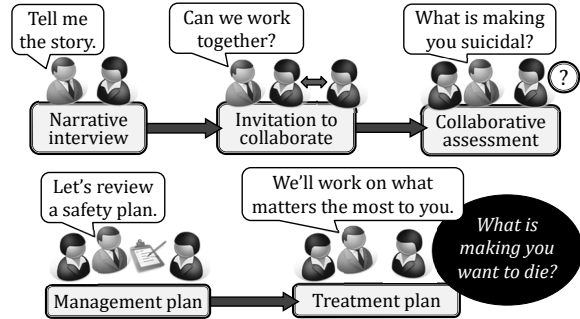
128

Example: Indirect and Direct Drivers of Suicide



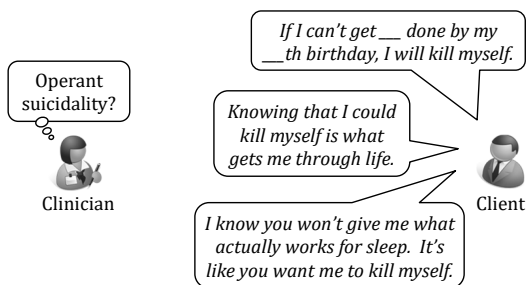
129

Treatment to Resolve Suicide Risk: Questions?



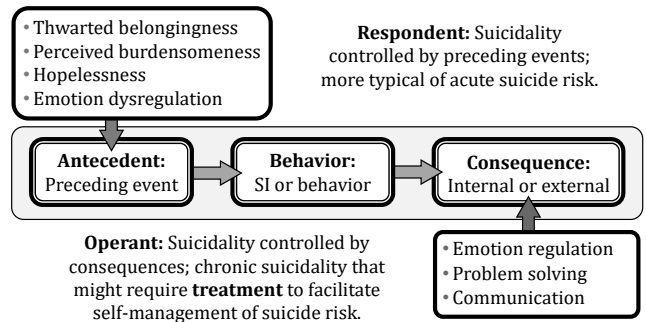
130

Chronic Suicidality: Respondent vs. Operant Suicidality



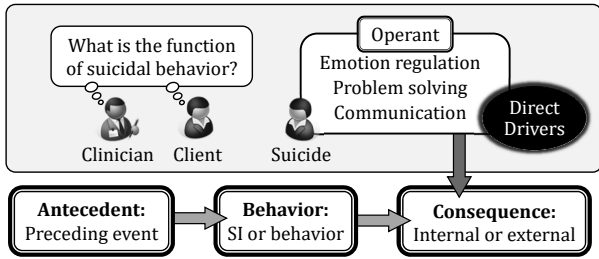
131

Respondent and Operant Suicidality



132

Respondent and Operant Suicidality



Linehan, MM. (1993). Cognitive-Behavioral Treatment of Borderline Personality Disorder. Guilford. P. 486-488.

Operant Suicidality

**Emotion regulation:**

**Negative reinforcement:** *I did it because I couldn't stand the pain anymore. Knowing I'll always have a way out gives me some relief.*

**Positive reinforcement:** *I wanted to feel something, anything, even if it meant feeling pain.*

**Problem solving:**

*I need more pain medication. If you don't give me something, I'll kill myself. There's no way I'm going back to the street. I'll kill myself if I have to be homeless again.*

**Communication:**

*No one was listening to me.*

*Do I have to kill myself to get you to hear me?*

133

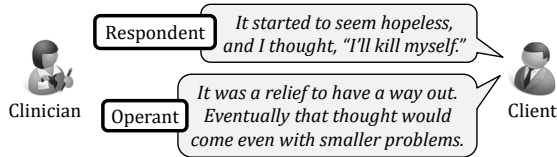
134

Suicide Care with Operant Suicidality

**Assessment and Formulation:**

Which aspects of the client's suicidality are respondent? Which are operant?

If some aspects are operant, what is the function of the suicidal ideation or behavior – i.e. how does the behavior function to regulate emotion, solve problems or communicate distress?



135

Management vs. Treatment: Operant Suicidality

**Management of Operant Suicidality:** Fulfilling the functions of the suicidal ideation or behavior with external interventions.

**Emotion regulation:** **Validation** strategies or **medication** to help regulate emotion.

**Problem-solving:**

- **Case management** strategies to address problems (housing instability, relationship conflict, substance use, financial distress, employment).
- Coordination with social service agencies to address problems related to suicide risk.

**Communication:**

- **Validation** to convey understanding of distress.
- Scheduled meeting times to provide predictable support.

Acceptance

136

Management vs. Treatment: Operant Suicidality

**Treatment of Operant Suicidality:** A consultative and collaborative approach whereby the client grows in self-awareness and self-management of suicide risk.

**Insight, orientation and commitment:** Use of communication strategies to provide an explainable model of suicidality to the client – i.e. describe how suicidal behavior can function to regulate emotion, solve problems and communicate distress.

Change

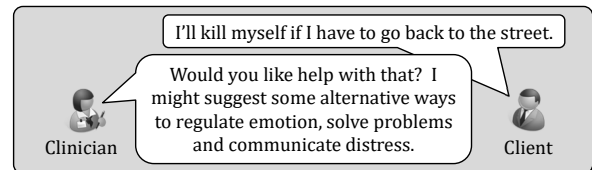
**Skills training:** Propose alternative strategies to regulate emotion, solve problems and communicate distress – i.e. review mindfulness, distress tolerance, emotion regulation, problem-solving and interpersonal effectiveness skills.

137

Suicide Care with Operant Suicidality

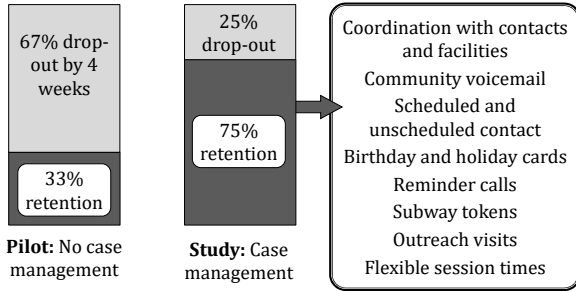
**Follow-up:**

Clients with chronic suicidality that is operant will likely need longer term outpatient **treatment** to resolve suicide risk over time. Options will depend on the client's **ability** and **willingness** to participate in treatment and the **availability** of treatment. If treatment is not possible, clients may be referred for outpatient care that provides **management** of suicide risk.



138

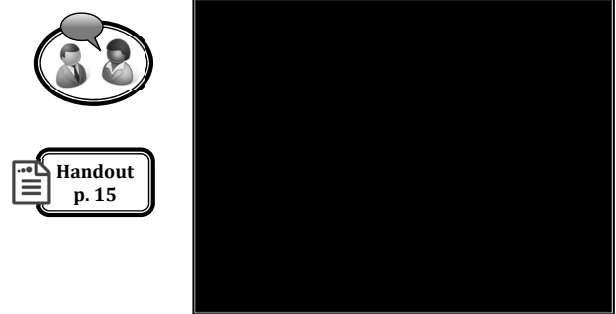
Case Management to Facilitate Treatment (CT-SP)



Berk, et al., 2004; Brown, et al., 2005; Gibbons, et al., 2010

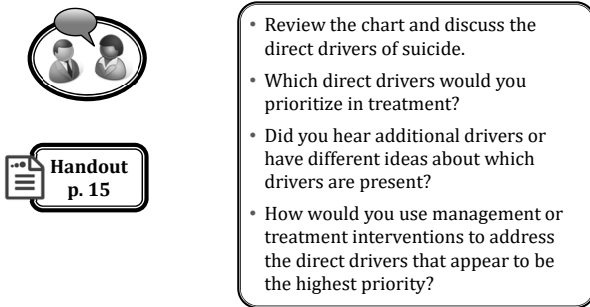
139

Respondent and Operant Suicidality



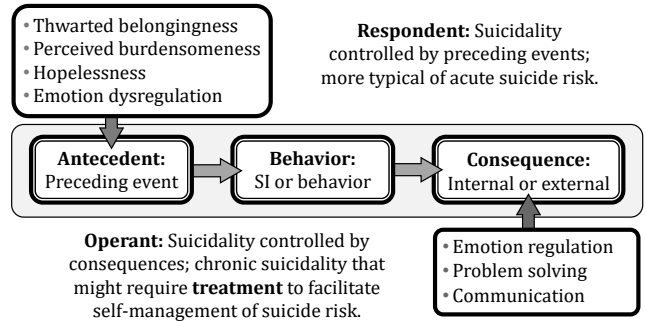
140

Breakout Group: Respondent and Operant Suicidality



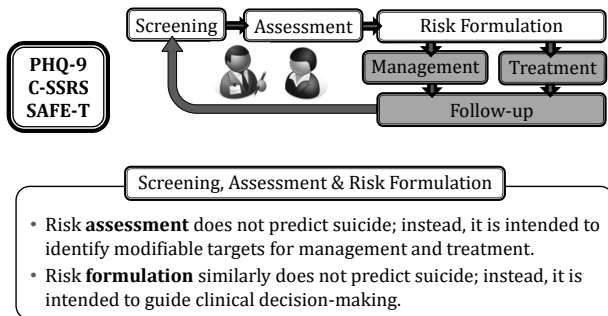
141

Respondent and Operant Suicidality: Questions?



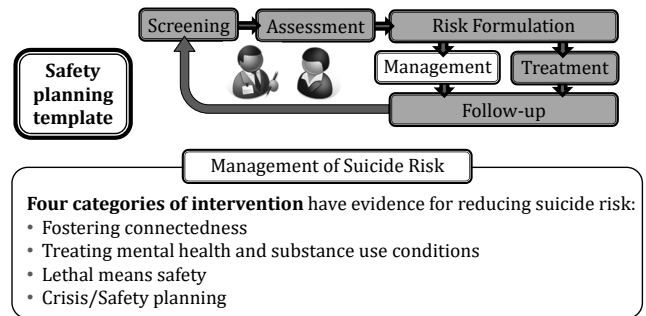
142

Suicide Care: Summary



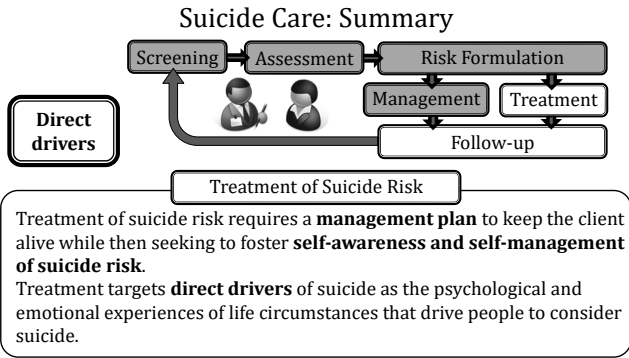
143

Suicide Care: Summary



144





145

### Hope and Recovery in Suicide Care

- Suicide is **preventable**.
- Suicide is **not inevitable**.
- **Suicide care** includes screening, assessment and risk formulation followed by management and treatment of suicide risk.
- **Treatment of suicide risk** involves a collaborative relationship to facilitate self-awareness and self-management of suicide risk.

Questions?  
Comments?  
Observations?



146