Virginia Mason™

Suicide – something Psychometrists should know more about

Tom Erickson, MA, CSP, NCC, LMHC

National Association of Psychometrists
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Objectives

- What is Suicide
- State of Washington mandate – what about other states?
- Why Suicide for Psychometrists
- Ethical guidelines
- Experience with SI/SA
- About Suicide
- Statistics on suicide
- The forgotten victims
- Causes and Risks for suicide
- Some insights into the mind of the suicidal person
- Features of Suicide
- Myths and Facts of Suicide
- Quick Crisis Intervention + Case Example
- Quiz – *yes! – there is a quiz as part of this presentation*
- Organizations & Resources
- Q & A

Disclosures

Credits:

- CE days
- funding still a work in progress …

Conflicts:

- Tom has no conflicts of interests to disclose
- Tom is not an expert in the topic of suicide
- Content provided for informational purposes only
- No animals were harmed in the preparation of this presentation

Slides will be made available on the NAP website

What is Suicide?

The intentional taking of one's life.

The decision is forever.

WA State Law – Matt Adler

Matthew D. Adler, age 40, died February 18, 2011, in Seattle by suicide. He had a family including two small children and many friends. Matt was a successful corporate attorney.

(http://www.intheforefront.org/about/mattadler)

In 2012, the Matt Adler Suicide Assessment, Treatment, and Management Act was passed in the State of Washington making it the first state that mandates suicide prevention training for mental health workers. The law was passed by over **97%** of the House and Senate

The bill is named for Matt Adler, a husband, father, and attorney who took his own life after experiencing anxiety. Adler sought mental health treatment for his symptoms, **but the treatment providers he saw "were not prepared to detect and prevent suicide"**, according to his wife.

WA State Law

New Requirements for Mental Health Professionals

The law, which went into effect January 1, 2014, requires the following professionals, including those with retired active licenses*, to complete at least **6 hours of suicide prevention training – once every 6 yrs**:

- MFTs
- CDs
- OTs and OT assistants
- Psychologists
- MH counselors
- MSWs

State, local government employees & community MH agency employees are exempt from the training requirements.

**Applies to all certified or licensed healthcare workers.*

http://app.leg.wa.gov/rcw/default.aspx?Cite=43.70.442

WA State Law

Others who only need to complete the **6-hrs of training 1x** include:

- Chiropractors;
- Naturopaths,
- LPNs/RNs/ARNPs
- OD & OD assistants
- PTs & PT assistants
- MDs, surgeons & MD assistants

http://app.leg.wa.gov/rcw/default.aspx?Cite=43.70.442

WA State Law

Training

"Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate disciplining authority that contains the following elements:

- suicide assessment,
- including screening and referral,
- suicide treatment, and
- suicide management.

http://app.leg.wa.gov/rcw/default.aspx?Cite=43.70.442

WA State Law

Some amendments …

- 7/1/15: School RNs, School MSWs, School PhDs and School Counselors must complete training in youth suicide screening and referral as a condition for certification.
- Certified registered anesthetists and medical school graduates with limited training licenses are exempt from training requirements.
- ? 3-hr trainings will be available for some professions – TBD (most likely the medical professions)
- By 6/30/16 the DOH must adopt rules establishing minimum standards for training programs that include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injuries behaviors.
- Beginning 7/1/17 (Engrossed Substitute House Bill 1424), the new law requires the DOH to develop minimum training standards.

This law is still new and there may be more changes…

http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bill%20Reports/House/1424-S.E%20HBR%20F_BR%2015.pdf

Coming to a state near you …

Supporting pioneering legislation in **Washington and Kentucky** that now mandates regular suicide prevention training for certain health and mental health professionals.

Supporting legislation in **Maine, Nebraska, North Dakota, Ohio, Pennsylvania, Texas, Washington and Wyoming** that now mandates regular suicide prevention training for school personnel.

Organizing or co-organizing lobby days in **Montgomery, Alabama; Phoenix, Arizona; Sacramento, California; Springfield, Illinois; Albany, New York; Columbia, South Carolina; and Nashville, Tennessee** to educate state officials on the importance of suicide prevention and mental health.

https://www.afsp.org/advocacy-public-policy/state-policy

Why important to us

Have you ever had a pt tell you they feel unsafe?

Are in danger of self-harm?

Feeling they are not safe now (or when they leave/get home)?

Tells you they may want to end their life?

Why important to us

- **We often spend more time with a pt than anyone else. Through this unique time together pt's sometimes feel like they can share with us something personal they haven't felt like sharing with anyone else.**
- **We have the responsibility and obligation to do what is right for every pt.**
- **The welfare and safety of each pt is our responsibility – just like it is for other healthcare workers.**
- **Healthcare workers have a higher risk of suicide**
- **DK of any Psychometrists who have committed suicide**

We are healthcare workers

Neuropsych Measures - Suicide

Do you administer any of the following measures?

- **BDI-II**
- **PHQ9**
- **GDS**
- **MMPI-2(RF)/-A**
- **PAI**

All of these measures touch on suicide

Neuropsych Measures - Suicide

E.g., - BDI-II #9

Suicidal Thoughts or Wishes

0 - I don't have any thoughts of killing myself.
1 - I have thoughts of killing myself, but would not carry them out.
2 - I would like to kill myself.
3 - I would kill myself if I had the chance.

At what point do you address this?

I'll cover what I've done in the Case Example

Measures for Suicide Assessment

Beck Hopelessness Scale

20-item self report inventory - Beck et al (1990) – normed on 1958 out-pt with Dep

In a small study, Beck et al found that a scale cutoff score of >9 correctly identified 94% (16 of 17) pts who eventually committed suicide.

The high-risk group based on this cutoff score is 11x more likely to commit suicide than other out-pts

Measures for Suicide Assessment

Beck Hopeless Scale (BHS)

No item specifically asks
if pt is suicidal


BHS

16

Experience with SI/SA

Tom's experience with SI/SA

- **7.5 yrs volunteering at the King Country Crisis Clinic**
- **2 clients in internship**

- **Jim**
- **Sander**

Both of them had redundancies in their methods to ensure "success" and to avoid the potential of surviving/ending in up rehab

17

Ethics

What do our Ethical Guidelines tell us about pt safety?

Are psychometrists held to an ethical standard to protect pts from potential suicide(s)?

18

Ethics

ETHICAL STANDARDS (for NAP and CSPs)

Section A. Personal and Professional Limitations

- **A-8.** Psychometrists are accountable at all times for their work-related behavior. They must be aware that all actions and behaviors of the Psychometrist reflect on professional integrity and, when inappropriate, can damage the public trust in the Psychometry profession. To protect public confidence in the Psychometry profession, Psychometrists avoid behavior that is clearly in violation of accepted moral and legal standards.

Section B: Psychometry Relationship

- **B-1.** The primary obligation of Psychometrists is to respect the integrity and promote the welfare of patient/client. The Psychometrist is also responsible for taking reasonable precautions to protect individuals from physical and/or psychological trauma.
- **B-2.** When a patient's/client's condition indicates that there is a clear and imminent danger to the patient/client or others, the Psychometrist must take reasonable action to inform the supervising Psychologist/Neuropsychologist or facility so that potential victim(s) and/or responsible authorities may be informed.

What do you do when there is no supervisor or PhD available? – you are alone.

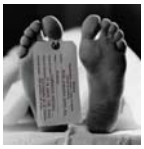
Source: http://psychometristcertification.org/ethics

19

About Suicide

How many will die by suicide (USA) during this presentation?

~4.7



Source: American Foundation for Suicide Prevention - https://www.afsp.org

20

About Suicide

Suicide: "A self-inflicted death with evidence (either explicit or implicit) that the person intended to die."

(Suicide Assessment, Treatment, and Management – 2014)

10th leading cause of death in USA = >41k deaths

Highest suicide rates are in the 45-64 age range, followed by age 85+ (CDC)

Women have ~4x number attempts;
Men die by suicide at a rate 4x that of women (CDC)

21

About Suicide

On average, there are 11 attempts for each successful suicide

>90% who commit suicide have a psychiatric Dx (mostly Dep) +/- Substance Abuse

Of those who have attempted suicide, 50% will attempt again

Increases in SA happen during life stressors

Being widowed has greater risk of SI/SA in the first 4 yrs

About Suicide

On average, suicide rates in the USA are mostly stable with a slight tendency toward rising.

Suicide rates are higher in the western USA, Mountain States have the highest rates bringing suicide to the 8th or 9th leading cause of death

Suicide rates increase during economic crisis while decrease during times of war

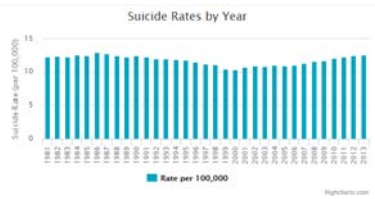
There are more suicides in spring; Monday has the highest rate of any other day

Generally, older adults (age 65+) have the highest rate of suicides – but are often much more "silent" – >50% for all ages

Suicides by Year – CDC

In **2013** (the most recent year for which full data are available), **41,149 suicides** were reported, making suicide the 10th leading cause of death for Americans;
1 suicide every 12.8 minute

From 1986 to 2000, suicide rates in the U.S. dropped from **12.5 to 10.4** suicide deaths per 100,000 people in the population.
2001-2012 the rate generally increased and by 2013 stood at **12.6** deaths per 100,000



About Suicide

Youths (ages 15-24) suicide rates have more than doubled from the 1950's to 1970's, then plateaued for a couple of decades and appear to be rising slowly.

Among "young" Americans, suicide ranks as 3rd leading cause of death – following *accidents (includes MVAs)* and *homicides*

Caucasians have ~2x the rate of suicides compared to non-Caucasians

Overall, Native Americans are the racial/ethnic group with the highest rates

Suicide is unpredictable

About Suicide

MH Factors

>90% of those committing suicide have a psychiatric Dx +/- Substance Abuse

BAD = 25x increase in risk of suicides

Youth with BPD = 400x; Young Women with BPD = 800x (compared to gen pop)

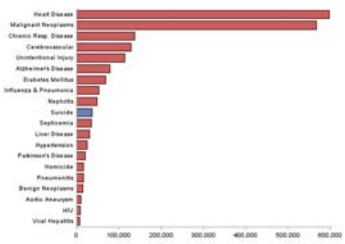
Schizophrenia pts have ~5% risk of suicide (contrary to Hollywood's depictions)

Depression is more common than AIDS, cancer, and diabetes combined.

Source: Ce4less.com – Suicide Assessment, Tx and Mgmt – 2014

Stats from the CDC

20 Leading Causes of Death Among Persons Ages 10 Years and Older, United States, 2009



In 2009, suicide was ranked as the 10th leading cause of death among persons ages 10 years and older, accounting for 36,891 deaths. Stats are much the same for 2013 though there were >41k suicidal deaths.

Source: American Foundation for Suicide Prevention - https://www.afsp.org

Stats from the CDC

Number of emergency department visits for **self-inflicted injury: 836,000**

All suicides
Number of deaths: 41,149

41k represents only 5% of 836,000 self-inflicted injuries … REALLY??

Firearm suicides
Number of deaths: 21,175 **(~½ of ALL suicides)**

http://www.suicide.org/suicide-statistics.html

Comparison of Methods

Global Methods of Suicides

USA	Non-USA
1 – Firearms	1 – Hanging*
2 – Hanging	2 – Pesticides/Poisoning
3 – Suffocation	3 – Firearms
4 – Poisoning	4 – Jumping
	5 – Drowning

* Hanging increased in countries where firearms access decreased (Australia & Canada)

http://www.who.int/bulletin/volumes/86/9/07-043489/en/

Suicide and Firearms

How does the USA suicide rate compare to countries with strict gun laws?

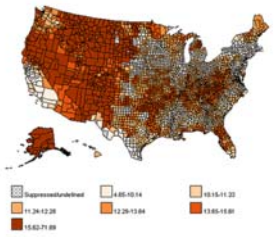
(per 100,000)

USA = 6.7 (2013)
UK = 0.17 (2010)= 39x less that of the USA
Japan = 0.09 (1999)= 74x less that of the USA
Australia = 0.05 (2011)= 134x less that of the USA

Source: https://en.wikipedia.org/wiki/List_of_countries_by_firearm-related_death_rate

Stats from the CDC

Smoothed, Age-adjusted Suicide Rates* per 100,000 population, by County, United States, 2000–2006



From 2000–2006, the **western US counties, including Alaska, had predominantly high suicide rates. Suicide rates were also high in certain Appalachian counties of Kentucky and West Virginia, southern Oklahoma and northern Florida.**
Footnote: *All rates are age-adjusted to the standard 2000 population. Rates based on less than 20 deaths are statistically unreliable and are suppressed (see legend above). **Montana, Alaska & Nevada have the top 3 highest rates in the USA.**

Stats for Canada

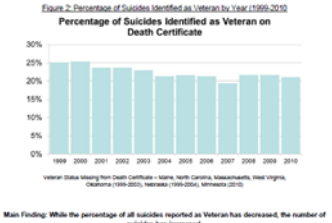
Leading causes of death (ICD-10) [1] [2] [3]	Characteristics	2007	2008	2009	2010	2011
Footnotes						
Malignant neoplasms [C00-C97]	Rank of leading causes of death [4]	1	1	1	1	1
	Number of deaths	69,595	70,558	71,125	71,882	72,476
Diabetes mellitus [E10-E14]	Rank of leading causes of death [4]	6	6	6	6	6
	Number of deaths	7,394	7,521	6,923	6,942	7,194
Alzheimer's disease [G30]	Rank of leading causes of death [4]	7	7	7	7	7
	Number of deaths	5,903	6,573	6,281	6,452	6,356
Diseases of heart [I00-I09, I11, I13, I20-I51]	Rank of leading causes of death [4]	2	2	2	2	2
	Number of deaths	50,499	50,722	49,271	48,757	47,627
Cerebrovascular diseases [I60-I69]	Rank of leading causes of death [4]	3	3	3	3	3
	Number of deaths	13,981	13,870	14,105	13,706	13,283
Influenza and pneumonia [J09-J18]	Rank of leading causes of death [4]	8	8	8	8	8
	Number of deaths	5,452	5,386	5,826	5,106	5,767
Chronic lower respiratory diseases [J40-J47]	Rank of leading causes of death [4]	4	4	4	5	4
	Number of deaths	10,659	10,923	10,859	10,757	11,184
Nephritis, nephrotic syndrome and nephrosis [N00-N07, N17-N19, N25-N27]	Rank of leading causes of death [4]	9	9	10	10	10
	Number of deaths	3,803	3,846	3,609	3,868	3,294
Accidents (unintentional injuries) [V01-X59, Y85-Y86]	Rank of leading causes of death [4]	5	5	5	4	5
	Number of deaths	9,951	10,234	10,250	10,866	10,716
Intentional self-harm (suicide) [X60-X84, Y87.0]	**Rank of leading causes of death [4]**	**10**	**10**	**9**	**9**	**9**
	Number of deaths	**3,611**	**3,705**	**3,890**	**3,951**	**3,728**
Assault (homicide) [X85-Y09, Y87.1]	Rank of leading causes of death [4]	21	21	21	21	22
	Number of deaths	515	575	574	524	527

USA Suicide estimate = 41k (~35M Canadian vs. ~320M Americans) = rate is about the same in both countries
Source: http://www5.statcan.gc.ca/cansim/a05?lang=eng&id=1020561

Stats for Veterans

22 veterans commit suicide every day (1 every 65')

Source: http://tbbf.org/22-veterans-commit-suicide-daily/08-2014#pk_campaign=GA2481?matchtype=b&keyword=veteran%20suicide%20rate%202014&adposition=1t1



Main Finding: While the percentage of all suicides reported as Veteran has decreased, the number of suicides has increased.

http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf

Stats for the Homeless

Lifetime prevalence of suicide among the homeless has been estimated to be as high as **66%** - especially among the mentally ill (Eynan et al, 2002; Desai et al, 2003)

The homeless seem to have everything wrong = very high risk of suicide

- Homeless (duh)
- Unstable family histories
- Often significant psychiatric illness (unmedicated)
- ETOH and Substance abuse
- Academic limitations
- Vocational skill limitations
- Increased law enforcement contacts
- Axis II issues – wanting to live "free"
- Marginalized by mainstream society
- Limited access to social services
- (live life day-to-day = not future oriented)

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Stats for the Elderly

- The elderly (ages 65 and older) made up 13.75% of the population; account for **16.37% of all suicides in the US.**
- The rate of suicides for the elderly for 2012 was 15.4 per 100,000.
- **The rate of suicide for women typically declines after age 60** (after peaking in the middle adulthood, ages 45-49).
- **White men over the age of 85 were at the greatest risk of all age-gender-race groups**. In 2012, the suicide rate for these men was 50.67 per 100,000. That was **almost 2.5 times the current rate for men of all ages** (20.57 per 100,000). The suicide rate for the elderly reached a peak in 1987 at 21.8 per 100,000 people.
- Although older adults attempt suicide less often than those in other age groups, they have a **higher completion rate**. Over the age of 65, there is estimated **1:4 attempted suicides vs. 1:11 for all ages.**
- **Firearms were the most common means (72.1%)** used for completing suicide among the elderly. Men use firearms more often than women.
- **Alcohol or substance abuse plays a diminishing role in later life suicides** compared to younger suicides.

Source: http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/Elderly2012.pdf

Summary of Stats

Summary of Suicide rates per 100,000
(sorted from highest to lowest)

- White men age ≥85 = 50.67
- Native Americans = 31.27 (ages 10-24)
- All men = 20.57
- The elderly = 15.4
- *All ages = 12.68*
- Veterans = 10.1
- African-Americans = 9.23
- Hispanics = 5.36
  - Age 15-19 = 5.75
  - Age 80-84 = 20.82

***In all cases, the very old have significantly higher rates of suicides – by factor of 2-4x!**
****The Homeless may have the highest rates of suicide of any single group.**

Some comments on the stats

There are no *complete* counts of actual suicides – the CDC gathers its data from "hospitals on non-fatal injuries resulting from self-harm behavior" = underestimation

836,000 people (2013) visited hospitals for self-harm injuries; ~41k were identified as suicide attempts.

"Guestimates" speculate it may be 3x the reported 41k

There are discrepancies in various stats, the prevalence of SI/SA is undoubtedly higher than estimated.

Forgotten Victims

~3.5 million Americans are Survivors of Suicide (SOS) where a family member &/or friend remains alive following the death of a loved one by suicide.

Are you a SOS?

http://www.suicidology.org/suicide-survivors/sos-directory

Sources: various including 2003 Crisis Clinic training manual

World Causes of Death

WHO World Health Report, top 12 causes of death make up ~58% of all deaths

	Disease / Condition	% of Total
1	Ischemic Heart Disease	12.6
2	CVA Disease	9.7
3	Lower Respiratory Infections (e.g., pneumonia)	6.8
4	HIV/AIDS	4.9
5	COPD	4.8
6	Diarrhea	3.2
7	TB / Malaria (tied)	2.7
8	Tracheal CA / Bronchitis (tied)	2.2
9	Traffic Accidents	2.1
10	CHD	2.0
11	Other unintentional injuries / Hypertensive heart disease (tied)	1.6
12	**Suicide** / Stomach CA (tied)	1.5

Top 10 Countries for Suicide

Which country has the highest suicide rate?(2011)

Suicides per 100,000 people per year[2]

Rank	Country	Male	Female	Average	Year
1	Greenland[3][4][5] (more info)	116.9	45.0	83.0 (0.0830%)	2011
2	Lithuania[6] (more info)	65.1	12.4	36.7 (0.0367%)	2013
3	South Korea[7] (more info)	39.8	17.3	28.5 (0.0285%)	2013
4	Guyana[8](more info)	39.0	13.4	26.4 (0.0264%)	2006
5	Kazakhstan[9](more info)	43.0	9.4	25.6 (0.0256%)	2008
6	Slovenia[9]	34.6	9.4	21.8 (0.0218%)	2011
7	Japan (more info)[10]	28.2	12.3	20.1 (0.0201%)	2014
8	Slovakia[11]	17.4	2.8	9.9 (0.0099%)	2011
9	Hungary[12]			21.1 (0.0211%)	2013
10	Belarus[13][14]			20.5 (0.0205%)	2012

USA was ranked 30th while Canada was ranked 40th

Sources: http://en.wikipedia.org/wiki/List_of_countries_by_suicide_rate & http://www.therichest.com/rich-list/the-biggest/10-countries-with-the-highest-suicide-rates-in-the-world/?view=all

40

Stats for World, USA & Canada

WorldLifeExpectancy
live longer live better

Suicide is the world's 16th leading cause of death

For Canada it is 13th while the USA it is 15th

Source: http://www.worldlifeexpectancy.com/world-rankings-total-deaths

41

Longevity vs. Suicide

WorldLifeExpectancy
live longer live better

Sierra Leone has the worst life expectancy – but ranks 34th for suicide.

Japan ranks highest for life expectancy – but ranks 8th for suicide.

Source: http://www.worldlifeexpectancy.com/world-rankings-total-deaths

42

World Stats

How many around the world will die from suicide during this presentation?

~90

~ 1 every 40 seconds (WHO)

~1.25M people take their own lives per year

1:5610 USA vs. 1:5600 globally

Source: http://www.therichest.com/rich-list/the-biggest/10-countries-with-the-highest-suicide-rates-in-the-world/?view=all

Suicides by Occupation

Rank	Professional	Times More Likely to Commit Suicide than Average Occupations
1	**Physicians** / Marine Engineers	1.87-1.89
2	**Dentists**	1.67
3	**Veterinarians**	1.54
4	Police Officers	1.38-1.54
5	Finance workers	1.51
6	**Chiropractors**	1.50
7	Heavy construction operators	1.46
8	Urban planners	1.43
9	Hand molders	1.39
10	Realtors / Sellers of real estate	1.38
11	Electricians / Electrical Assemblers	1.31-1.36
12	Lawyers	1.33
13	Lathe operators	1.33
14	Farmers / Farm managers	1.32
15	Operators of heat treating equipment	1.32
17	Precision woodworkers	1.30
18	**Pharmacists**	1.29
19	Chemists / Natural scientists	1.28

http://www.newhealthguide.org/Highest-Suicide-Rate-By-Profession.html & http://www.therichest.com/rich-list/the-biggest/the-10-professions-with-the-highest-suicide-rates/?view=all & http://mentalhealthdaily.com/2015/01/06/top-11-professions-with-highest-suicide-rates/ & http://www.insidermonkey.com/blog/the-10-highest-suicide-rates-by-profession-331520/

No data found specific for Psychometrists

Rates of Depression by Occupation

Rank	10 Careers With High Rates of Depression
1	**Nursing Home & Childcare Workers**
2	Food Service Staff
3	**Social Workers**
4	**Healthcare Workers**
5	Artists, Entertainers & Writers
6	Teachers
7	Administrative Support Staff
8	Maintenance & Grounds Workers
9	Financial Advisors and Accountants
10	Sales People

Did you know that presenting at a NAP conference lowers the level of Depression?!

http://www.health.com/health/gallery/thumbnails/0,,20428990,00.html

No data found specific for Psychometrists

Causes of Suicide

Rank	15 Possible Common Causes of Suicide
1	Mental Illness (GAD, Dep, BAD, Schiz)
2	Traumatic Event (PTSD, Abuse, War)
3	Bullying
4	Personality DOs
5	Drug and Substance Abuse
6	Eating DOs
7	Unemployment
8	Social Isolation / Loneliness
9	Relationship Problems
10	Genetics & Family Hx
11	Philosophical Desire / Existential Crisis
12	Terminal Illness
13	Chronic Pain
14	Financial Problems
15	Rx Drugs

When all of these possible causes are combined
No one is immune to the risk of suicide

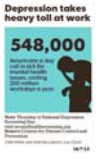
Source: http://mentalhealthdaily.com/2014/07/23/15-common-causes-of-suicide-why-do-people-kill-themselves/

Causes of Suicide

#1 cause of suicide is:

untreated depression

Projected to be #1 reason for MD visit by 2050.



Protective Factors against Suicide

Reasons to Live: (Malone et al 2000)

- Strong social support network
- Greater responsibility toward family
- Better overall coping skills
- Greater fear of disapproval and moral objection toward suicide

- **Effective clinical** care for mental, physical and substance use disorders
- **Easy access** to a variety of clinical interventions
- **Restricted access to highly lethal means of suicide**
- **Strong connections to family** and community support
- **Support through ongoing medical and mental health care relationships**
- **Skills in problem solving**, conflict resolution and handling problems in a non-violent way
- **Cultural and religious beliefs** that discourage suicide and support self-preservation

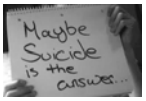
Source: National Suicide Prevention Lifeline

#1 Protective Factor = family
(unless you have already burned that bridge)

State of Mind of a Suicidal Person

The state of mind of a suicidal person

1. **Ambivalence:** Most people have mixed feelings about committing suicide; urge to relieve the pain and loss of desire (unhappy with life). If support is given and the wish to live is increased, the suicidal risk is decreased.
2. **Rigidity:** When people are suicidal, their thinking, feelings and actions are constricted - constantly thinking about suicide and are unable to perceive other ways out of the problem. All or none/drastically
3. **Impulsivity:** Suicide is also an impulsive act and is transient (minutes to hours) usually triggered by negative day-to-day events. By defusing such crises and by playing for time can help to reduce the suicide wish.



Sources: Preventing Suicide – A resource for primary healthcare workers – WHO, 2000

Features of Suicide

SI feels frightening in the beginning

As it is repeatedly rehearsed it becomes more comforting as the desire progresses.

As hopelessness increases so do the reasons to die.

As Dep ↓ & energy ↑ so does the risk of SA (↑)

Inside the suicidal mind

Feelings	Thoughts
Sad, depressed	"I wish I were dead"
Lonely	"I can't do anything"
Helpless	"I can't take it anymore"
Hopeless	"I am a loser and a burden"
Worthless	"Others will be happier without me"

Sources: Preventing Suicide – A resource for primary healthcare workers – WHO, 2000

Why Suicide?

The act of self-destruction is neither random nor without purpose.

Suicide is an act of problem solving – where the problem(s) consist of overwhelming psychological pain and suicide is perceived as the solution.

Suicide is perceived as the "best" and sometimes the only possible solution to a perceived problem, dilemma, impulsive, crisis or desperation (due to cognitive rigidity.) – "tunnel vision"

Hopelessness makes one feel that living is *always* going to be painful and miserable.

Hopelessness + lack of problem-solving skills + rigid cognitive perspective where suicide is perceived to be the *only* alternative to rid oneself of pain.

Suicide is often for the purpose of escaping pain – not to escape life/living.

Understanding Suicide

The ↑ the # of MH diagnoses = ↑ risk for suicide

Attitudes and Approaches

What goes on in our minds:

When with a pt we too could feel fear, anxiety, hopelessness, helplessness, anger, rage, guilt, shame, etc. – just like our pt feels. Working with suicidal pts requires therapeutic and collaborative alliance.

- Be empathetic to the pt's desire to die by suicide
- Demonstrate patience and warmth both verbally and nonverbally
- Acknowledging the pt's ambivalence
- Convey understanding of both sides of pt's position to help pt feel understood about his/her pain
- Maintain collaborative stance with pt
- Validate pt's desire to be free of pain
- Normalize pt's feelings in the context of stressors

Can Suicide Risk be Predicted?

SI is an independent predictor of suicide risk and beyond mental illness.

Suicide cannot be predicted and sometimes cannot be prevented.

An individual's suicide risk can be assessed and a Tx plan can be designed with the **goal of reducing the risk** (APA Guidelines, 2003)

Assessing suicide risk is not a science, more of an art, and is more subjective as well as complicated.

What can prevent SA?

Can something actually prevent SI/SA?

Fear

Activation of the amygdala

SA requires fearlessness to contemplate and attempt self-harm

Calling 911, or telling someone, is when fear is activated.

Feeling your life is threatened triggers fear (E.g., Kosovo)

Ethical conflict …

Suicide Myths and Facts

Myth or Fact: - Using the word "suicide" will increase likelihood of an attempt.

There is no evidence of this. In fact, it opens the opportunity for direct dialogue about suicide – it gives permission to talk about it (often to great relief)

If there is presence of SI then the word "suicide" is already in play.

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Suicide Myths and Facts

Myth or Fact: - When people who are suicidal feel better, they are no longer suicidal.

Sometimes suicidal people feel better because they have decided to die by suicide, and may feel a sense of relief that the pain will soon be over = ↑ Risk

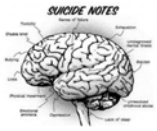
As Dep ↓ & energy ↑ so does the risk of SA (↑)

Source: http://www.suicide.org/suicide-myths.html

Suicide Myths and Facts

Myth or Fact: - People always leave notes.

Nope



Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Suicide Myths and Facts

Myth or Fact: - People who talk about wanting to kill themselves will not talk about suicide.

The evidence is mixed here.

It is important to always take people seriously when they do express SI.

Do not dismiss a "cry for attention."

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Suicide Myths and Facts

Myth or Fact: - "Birthday Blues" lead to increases in suicide attempts.

Nope.

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Suicide Myths and Facts

Myth or Fact: - Suicide contracts are the best way to ensure safety.

Research does not support the use of such contracts as effective methods to prevent suicide attempts (Lewis, 2007).

Nor does it protect clinicians from malpractice litigation in the event of a suicide.

While a safety agreement (aka safety plan) may be more effective as a way to support the pt/client.

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Suicide Myths and Facts

Myth or Fact: - Increased suicides in the fall and winter

Research shows an increase in spring and early summer with a decrease in late fall and early winter.

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Suicide Myths and Facts

Myth or Fact: - An unsuccessful attempt means they were not serious about ending their life.

Don't be naïve! The attempt in and of itself is the most important factor, not the method or outcome

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Suicide Myths and Facts

Myth or Fact: - Talk therapy and/or medications don't work.

Tx can work. One of the best ways to prevent suicide is by getting Tx for mental illnesses such as depression, bipolar illness and/or substance abuse and learning ways to solve problems. Finding the best Tx can take some time, and the right Tx can greatly reduce risk of suicide. In fact, it can bring you back your life.

Source: http://www.suicide.org/suicide-myths.html

Quick Crisis Intervention

1. ***"Are you thinking about killing yourself?" "Are you suicidal?" "Do you feel you are unable to be safe?" "Are you thinking about harming yourself?"***
2. Assess level of risk (**CPR**):
   - **a) Current Plan**: method, availability, when?
   - **b) Previous Behavior**: previous attempts
     - a) Family hx or Friend hx of SA
   - **c) Resources**:
     - a) **Internal** – coping skills, personal strengths & beliefs – How have you handled this difficult situation in the past? (Do not use your own perceptions/beliefs = remain calm and non-judgmental)
     - b) **External** – Do you have family/friends?– they care about you; do you have a MHP? How can I help you right now?
   - **d) Explore Ambivalence** through direct communication
   - **e) Action Plan (future plan):** at a minimum obtain verbal contract to remain safe; encourage to contact family/friend; if need to call local Crisis Line or 911; go to any ER; what can you do to be safe? (bath, eat, go for walk, etc.) – avoid ETOH

King Co Crisis Clinic

Case Example

46yo, white married male, 16 yrs educ, on SSD for Dep, was Regional Sales Mgr
BAI = 39; BDI-II = 48, #9 = 2 ("I would like to kill myself."); MMPI-2-RF = invalid (not scored)
Obs: markedly flat affect w/ no response to humor

1. **Are you in imminent danger of harming yourself? = "It's not a matter of if, but when."**
2. **Are you in imminent danger of harming yourself today? = "No"**
3. **Have you attempted suicide in the past? = "This past June."**
4. **What happened? = "I was looking for rope to hang myself but I could not find any."**
5. **I understand you have a MHP, what safety plan have you developed and agree to? = "I have my psychiatrist, therapist, my sister is a psychologist too. I'm to call them if I don't think I can stay safe."**
6. **Do you also have the Crisis Line phone number? – they are available 24/7 = "No" (phone number provided and had him add it to his smartphone)**
7. **Call them any time, they are there to help you when you need them. Will you be safe when you leave here today? = "Yes … can you give me directions to the ferry?" (contracted to be safe)**
8. **Called/consulted NP before pt left. PhD had not mentioned to me the SI/SA hx, only that the pt was very depressed.**

Document, document, document

Confidentiality/PHI/HIPAA are waived in life-threatening situations

Case Example

What if he had said he was in imminent danger of harming himself?

Follow the CPR steps:

1. **Are you in imminent danger of harming yourself? = "Yes"**
2. **Do you have a plan? / Access to the means? (Current Plan)**
3. **Have you attempted to harm yourself in the past? (Previous Hx)**
4. **Do you have a safety plan, MHP? (Resources)**
5. **What is the safety plan you and your MHP have agreed to? (Action Plan)**
6. **What resources do you have to keep safe?** (family, MHP, calling hotlines, going to ER, hang out with friends, take bath, listen to music, read, watch a movie, etc. – all to distract and reduce isolation)
7. **If necessary – escort them to the ER, or accompanying family, call CL on their behalf, call 911 if needed**
8. **Contact/consult with PhD, supervisor, or call the authorities.**

Document, document, document

Confidentiality/PHI/HIPAA are waived in life-threatening situations

What can help right now?

Crisis Interventions

Need to show person they have resources to lessen the pain: family, friends, faith, etc.

Distraction from the current feelings
(eat, take a walk, listen to music, watch a movie/TV, etc.)

Keep busy with other people

Avoid isolation

50-60% will talk with family/friends about how they are feeling suicidal.
Only 10% will talk with their therapist about it!

When you try to help

You can't do it wrong if you care
There are no absolutes
Be yourself
Your worst fears aren't realistic
There are no stupid questions
You are not responsible for someone else's actions

The focus is on what can be done to keep the person safe right now.

Some motivational thoughts shared by The King County Crisis Line workers.

Quiz

The CDC estimates ____ attempted suicides occur per every suicide death.

a) 4
b) 7
c) 11
d) 18

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

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Quiz

The CDC reported the highest suicide rate was among those ages _____.

a) 16 - 23
b) 24 - 44
c) 45 - 64
d) 65 - 85

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Quiz

The most consistent protective factor found in suicide research is

a) employment and physical health
b) social support and connectedness
c) physical health and social support
d) connectedness and employment

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

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Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Quiz

The following are all risk factors with strong association with later suicide EXCEPT:

a) Male
b) Young
c) Low level of education
d) Family hx of suicide
e) Hx of SA

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

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Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Quiz

Which is a misconception about suicide?

a) Using the word "suicide" will increase the likelihood of making an attempt

b) Suicides increase in fall and winter

c) Suicide contract is the best way to ensure safety

d) All of the above

Source: ce4less.com – Suicide Assessment, Tx and Mgmt

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Source: ce4less.com – Suicide Assessment, Tx and Mgmt

Organizations & Resources

Where to turn?

- **National Suicide Prevention Lifeline (for both adults and teens)** (http://www.suicidepreventionlifeline.org/) – **800/273-8255 (TALK)**
- **Local Crisis Hotlines/Clinics** (E.g., CrisisClinic.org)
- **Crisis Text Line** - **TEXT "GO" TO 741-741**
- **Veterans -** Veterans and their loved ones can call **800/273-8255** and **Press 1**, chat online, or send a text message to **838255** - http://www.veteranscrisisline.net/
- **Teens – TeenLine (teens for teens) -** https://teenlineonline.org/ask-teen-line/ **- email us via the Talk Now page, call us at (310) 855-HOPE (4673) or (800) TLC-TEEN (852-8336) (toll-free in California only), OR text TEEN LINE by texting "TEEN" to 83986; Covenant House NineLine – 800/999-9999**
- **en Español** - **888/628-9454**
- **211** (connects people with essential health and human services – including emergencies)
- Call **911**

Organizations & Resources

- **National Suicide Prevention Lifeline**: http://www.suicidepreventionlifeline.org/
- Suicide Prevention Resource Center: www.sprc.org
- Suicide.org: http://www.suicide.org/
- SAMHSA (Substance Abuse and Mental Health Services Administration): www.samhsa.gov
- Office of the Surgeon General of the United States: www.surgeongeneral.gov
- The Surgeon General's Call To Action To Prevent Suicide: www.surgeongeneral.gov/library/calltoaction/default.htm
- National Institute of Mental Health: www.nimh.nih.gov
- SPAN (Suicide Prevention Advocacy Network): www.spanusa.org/
- American Association of Suicidology (AAS): www.suicidology.org
- American Foundation for Suicide Prevention: www.afsp.org
- Survivors of Suicide (SOS) Support Groups: http://www.suicidology.org/suicide-survivors/sos-directory
- Youth Suicide Prevention Program (WA): http://www.yspp.org/
- Trevor Project (LGBT) for Youths: http://www.thetrevorproject.org/

Thank you

Q & A

We continue to avoid addressing the problem &
continue to pretend it will never happen again.