Understanding and Helping a Suicidal Person

Satellite Conference and Live Webcast
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1:00-3:00 p.m. Central Time

Produced by the Alabama Department of Public Health
Video Communications and Distance Learning Division

Faculty

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Dr. Bartlett is an approved trainer for the Suicide Prevention Resource Center and the American Association of Suicidology. The information presented should not be construed or used as legal advice.

Overview

- **Defining the problem**
- **Understanding the suicidal mind**
- **Risk and protective factors**
- **Warning signs**
- **Assessment process**
- **Intervention and treatment considerations**
- **Reflections and closing**

Defining the Problem

- **Few counselor education, psychology, or psychiatry programs train clinicians to deal with suicidal clients**
- **No other patient behavior generates more stress and fear among mental health professionals than suicidal behavior**

Defining the Problem

- **There have been exponential increases in suicide-related malpractice liability lawsuits against mental health clinicians**
- **Over 50% of family members who survive a loved one's suicide consider contacting an attorney**
  - **Foster & McAdams, 1999; Peterson, Luoma, & Dunne 2002; Wozny, 2005**

Defining the Problem

- Suicidal behavior is the most frequently encountered mental health emergency
- 50% of practitioners fail to detect suicidal ideation
- One in five mental health counselors will lose a client to suicide

Defining the Problem

- 71% of mental health counselors have at least one client attempt
- Most mental health professionals receive only two hours of formal suicide training
  - Berman, 2007; Beutler, Clarkin, & Bonger, 2000; Foster & McAdams, 1999; Peterson, Luoma, & Dunne, 2002; Rogers, et al., 2001

Defining the Problem

- Suicide across our world
  - In 2000, nearly 1 million people died from suicide
  - Suicide rates up worldwide by 60% since 1950
  - High rates among elderly men dominate everywhere

Defining the Problem

- The prevention of suicide has not been adequately addressed and remains a taboo topic
- Only a few countries have included prevention of suicide among their national public health priorities

Defining the Problem

- Most cultures agree that suicide prevention requires multi-social and increased government involvement
  - World Health Organization, 2009

Defining the Problem

- Suicide in the United States
  - More than 34,500 suicides in the U.S. in 2007
  - 95 suicides per day
    - One every 15 minutes
  - 864,950 annual attempts
    - One every 38 seconds

Defining the Problem

- 25 attempts for every death by suicide
- 11th leading cause of death
  - Homicide is 15th
- 3rd leading cause of death for youth aged 15-24
- 52% of suicides were completed with firearms

– Centers for Disease Control and Prevention, 2010; American Association of Suicidology, 2010

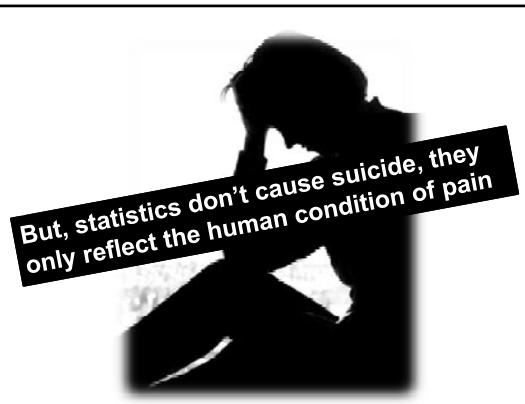
Defining the Problem

- Suicide in youth
  - Only 25% of teens say they would tell an adult if a peer was suicidal
  - More than 86% of parents are unaware of their child's suicidal behaviors
  - Most adolescent suicides are precipitated by interpersonal conflict

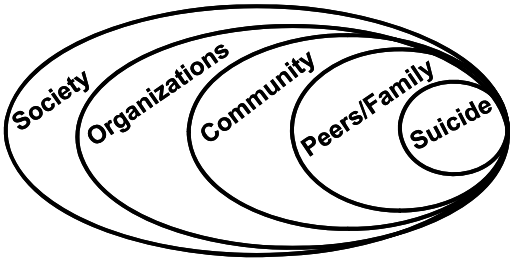
Defining the Problem

- For every completed youth suicide, about 200 attempts are made
- 1 in 12 high school students report having attempted suicide

– AAS 2010; CDC 2010; Capuzzi, 2002; Granello & Granello, 2007



Defining the Problem: Impact of Suicide

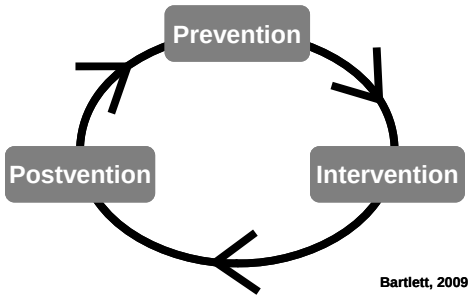


Adapted from Connect, 2009

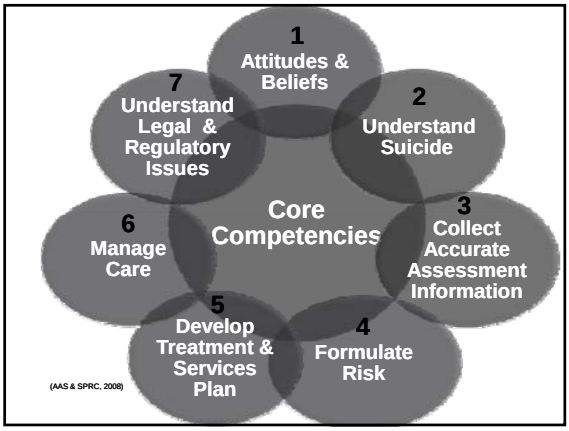
Defining the Problem

- Which aspects of suicide and its prevention do you feel most comfortable with?
- What aspects of suicide and its prevention do you feel least comfortable with?

Defining the Problem: The Prevention Cycle



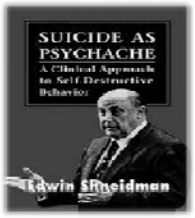
Bartlett, 2009



Understanding the Suicidal Mind

"Every suicide makes this statement: 'This far, and no further.'"

Dr. Edwin Shneidman
Founder of the AAS
1918-2009



Understanding the Suicidal Mind

- **Suicide typically does not have a simple cause**
  - **It has a complex developmental history**
- **Mental pain or "psychache" may lead one to seek death through suicide as an escape**

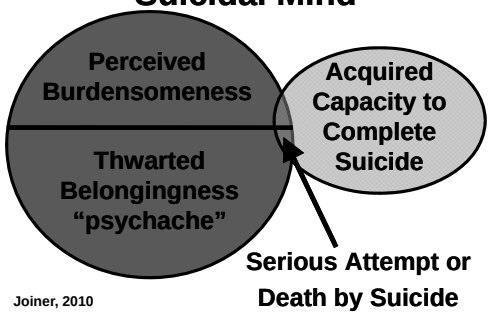
Understanding the Suicidal Mind

- **Suicide is not a specific disorder, but a painful process accompanied by biological, psychological, social, and existential factors**
- **Psychological studies indicate that more than 90% of completed suicides had a psychiatric disorder**

Understanding the Suicidal Mind

- **Suicide attempts are not attention-seeking**
  - **They are help-seeking**
    - **Foster & McAdams, 1999; Peterson, Luoma, & Dunne 2002; Shneidman, 1999**

Understanding the Suicidal Mind



Joiner, 2010

Understanding the Suicidal Mind

- What a suicidal person may experience:
  - Can't stop the pain
  - Can't feel anything
  - Can't think clearly
  - Can't see way out
  - Can't see a future

Understanding the Suicidal Mind

- Can't get control
- Can't see self as worthy
- Can't sleep, eat, or work
- Can't get help
- Can't live with burden
- Can't live "like this"
- Can't cope with feelings

– AAS & SPRC, 2008

Suicide Prevention

- General suicide risk factors:
  - Mental illness
  - Physical illness
  - Relationship instability
  - Perceptions of suicide
  - Poor support system

Suicide Prevention

- Access to weapons
- Financial debt
- Substance abuse
- Loss
- Childhood trauma
- Inadequate coping skills

Suicide Prevention

- Previous attempts
- Suicide rehearsal
- Disconnect from peers
- Barriers to care

– AAS & SPRC, 2008

Suicide Prevention

- Risk factors for youth:
  - New and unfamiliar environment
  - Academic and social pressures
  - Feelings of failure and alienation
  - Contagion
  - Difficulty adjusting
  - Juvenile delinquency

Suicide Prevention

- Confusion about sexual orientation
- Parasuicide and self-harm behaviors

– AAS & SPRC, 2008

Suicide Prevention

- General protective factors:
  - Family cohesion
  - Religion/spirituality
  - Optimistic outlook
  - Problem-solving skills
  - Conflict resolution skills
  - Restricting means

Suicide Prevention

- Extended supports
- Pets
- Access to care
- Good coping skills
- Community connection
- Increased resiliency

– AAS & SPRC, 2008

Suicide Prevention

- Protective factors for youth:
  - Support from teachers, family, and providers
  - Involving youth in decisions
  - Culture that encourages help seeking
  - Protection from bullying and harassment

Suicide Prevention

- Prevention and life skills education
- Restricted access to means
- Availability of peer support

– AAS & SPRC, 2008; National Mental Health Association [NMHA], 2002

"I still see my hands coming off the railing, and I instantly realized that everything in my life that I had thought was unfixable was totally fixable - except having just jumped."
- Friend, 2003

Suicide Prevention

- **General warning signs:**
  - **Quiet and withdrawn behavior**
  - **Changes in behavior and personality**
  - **Recent family changes**
  - **Recent loss or losses**
  - **Symptomatic statements and acts**

Suicide Prevention

- **Difficulty concentrating**
- **Preoccupation with death**
- **Burdensomeness, lack of belongingness, and capacity to complete suicide act**

– **AAS & SPRC, 2008; Joiner, 2010**

Therapeutic Principles

- **Acknowledge the client's perspective**
- **Convey that the client has choices**
- **Provide meaningful rationale for sudden crisis**
- **Support autonomy**
- **Support client's perceived competence**
- **Attend to quality of relationship**

– **Hendin et al., 2006**

"Given increasing malpractice litigation for wrongful death following a suicide, it is striking that clinicians often fail to even ask about, thoroughly assess, and document a patient's potential suicide risk."

Coombs, et al., 1992

Assessment Guidelines

- **Assess for and rule out emergency risk**
- **Plan to conduct multiple assessments**
- **Integrate risk assessment early and often**
- **Elicit risk and protective factors**

Assessment Guidelines

- Elicit suicide ideation, behavior, and plans
- Elicit warning signs
- Obtain records from collateral sources
- Formulate a clinical judgment of risk
- Be able to justify your decision

– AAS & SPRC, 2008

Formulating Risk

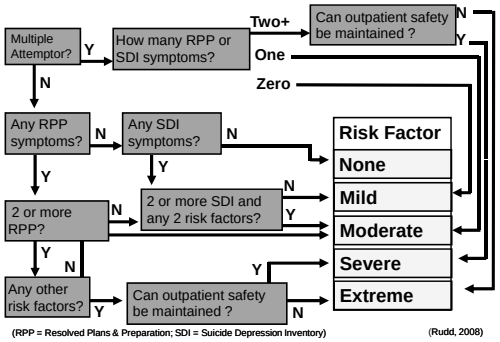
- Is a subjective clinical judgment
- Based on clinical and collaborative evidence
- Gauge coping skills and resources
- Gauge intent and lethality
- Consider psychopathology
- Assess compliance with the clinician

Formulating Risk

- Be able to justify your decision
- Document your rationale

– Jobes, 2007

Suicide Risk Level Decision Tree



(RPP = Resolved Plans & Preparation; SDI = Suicide Depression Inventory)

(Rudd, 2008)

Effective Treatments

- Treatment model clearly articulated with suicidality as target
- Treatment compliance closely monitored and addressed
- Skills deficiencies targeted
- Self-reliance, self-awareness, and individual control addressed

Effective Treatments

- Access to crisis management and emergency services provided
- Access to lethal means limited

– Rudd, 2008

Cognitive Restructuring

- Listen and explore client narrative
- Identify and explore thought distortions
- Explore the suicidal belief system
- Emphasize suicide ideation events or attempt events
- Use socratic questioning to lead client to find understanding

– Jobes, 2007

Treatment Targets: Suicidality

Crisis Symptom Management	Depression Hopelessness Suicidal thoughts Anxiety
Skills Deficits	Self-monitoring Emotional Regulation Interpersonal skills Problem solving Distress tolerance Anger management
Maladaptive Traits	Self-image Interpersonal relations

Inpatient vs. Outpatient Care

- Do not automatically assume that inpatient care is in the patient's best interest
- Change orientation to keep patient out of hospital
- Be familiar with civil commitment requirements

Inpatient vs. Outpatient Care

- Be aware of patient's insurance coverage
- Consider hospital's policy on involvement of clinician
- Be clear about goals for inpatient hospitalization
- Capitalize on opportunities created by inpatient stay

Inpatient vs. Outpatient Care

- Work on outpatient treatment discharge plan

– Jobes, 2007

Risk Related Hospitalization

- Two sharp peaks of increased risk
  - First week after hospital admission
  - First week after discharge from hospital
- Shorter admissions means increased risk
  - Admission less than 5 days

Risk Related Hospitalization

- Risk levels after discharge from hospital are high
  - Last week: 278% increased risk
  - Last month: 133% increased risk
  - Last year: 34 - 61% increased risk

– Qin & Nordentoft, 2005

Interventions

- Ask if the person is thinking about suicide
- Avoid advice giving
- Don't dare a person to do it
- Listen to what is said
- Avoid being judgmental or argumentative
- Be caring to the person

Interventions

- Tell person you can't keep a suicidal secret
- Be honest about who you will tell
- Remain calm
  - Don't panic
- Recognize your own feelings
- Listen more than you talk

Interventions

- Show you aren't afraid of the topic
- Build the relationship
- Use supportive words
- Let person know you will help
- Get help for person
  - Tell someone immediately

– Capuzzi, 2009; Jobes, 2008

Things Not to Say

- "You'll get over it"
- "You have so much to live for"
- "Oh come on, things aren't that bad"
- "You have it good compared to..."
- "You may be exaggerating a bit"
- "Hang in there, things will blow over"

Things Not to Say

- "Suicide is no way to solve problems"
- "Go ahead, do it"

– Capuzzi, 2009;Jared Story, 2010; Jobes, 2008

Things to Say

- "Seems like you're having a rough time"
- "I'm really worried about you"
- "It's ok to ask for help"
- "I want you to live"
- "We can get help together"
- "This is really serious"

Things to Say

- "Tell me who you like talking with"
  - Capuzzi, 2009;Jared Story, 2010; Jobes, 2008

Reflections

- Working with suicidal clients is inevitable
- Counselor feelings of fear and anger are normal
- Understand biological, psychological, social, and cultural factors that impact suicide choice

Reflections

- Approaches to working with suicidal clients require periodic evaluation
  - Training is critical
- Assess often and target suicide directly
- Deconstruct suicide belief system
- Acknowledge elevated risk to client and family

Reflections

- Be active and directive
- Enhance client life skills
- Alliance is critical
  - Collaborate with client
- Continuity of care is vital
- If you experience the loss of a client by suicide, seek support

National Suicide Prevention Hotline
1 - 800 - 273 - TALK

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