# The Assessment and Management of Suicide Risk
## *The Basics*

***M. David Rudd, Ph.D., ABPP***

**University of Utah**

- Suicide and Public Misunderstanding
  - Issue of unreasonable expectations
    - Lack of understanding of high risk nature of suicidal patients
    - No expectation of risk for death among psychiatrically ill

# MIT

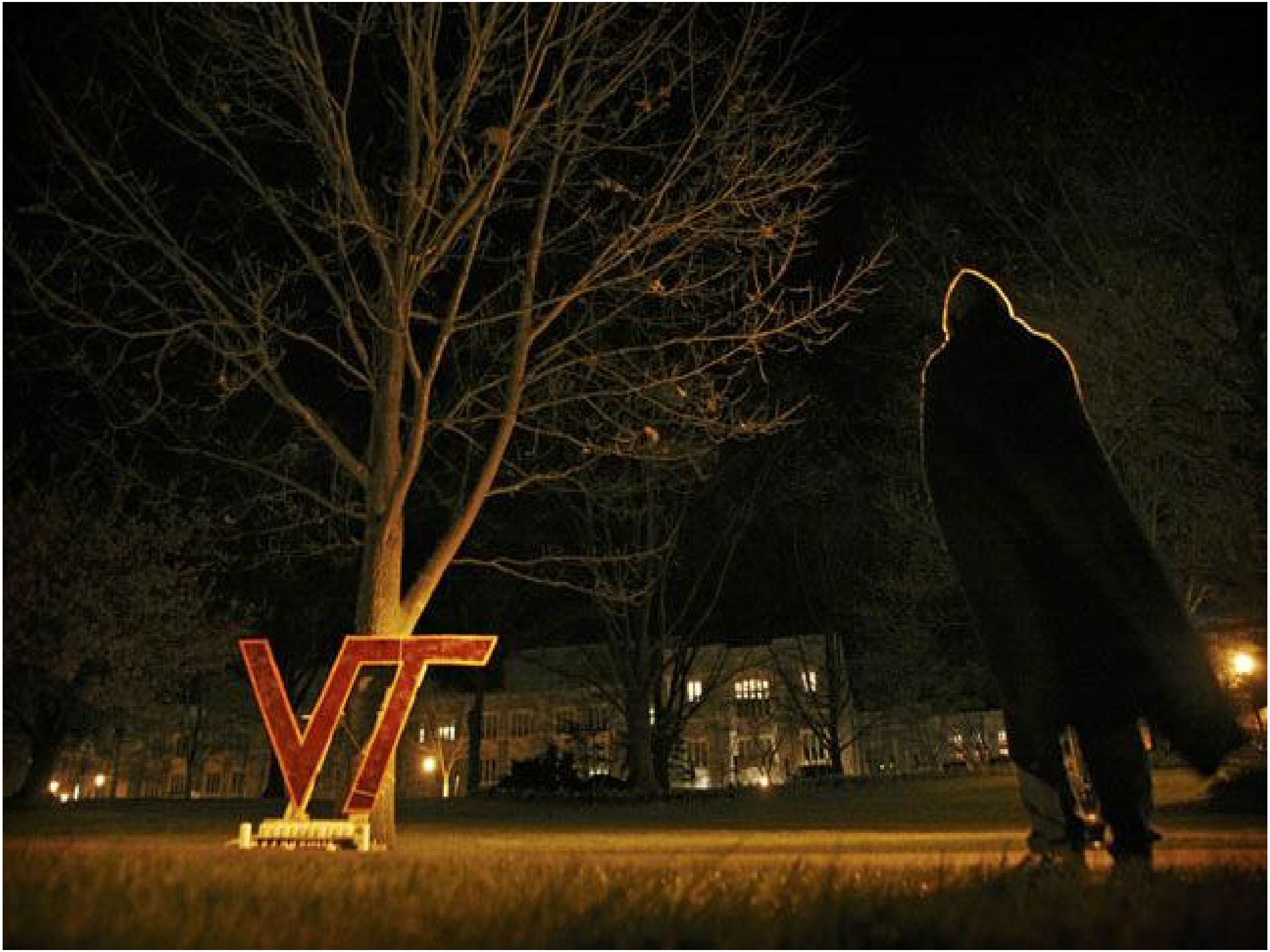
- **MIT responds, denies liability in Shin case**
- Kenneth D. Campbell, News Office
  March 13, 2002
- Lawyers filed answers Friday and Monday to the complaint in the $27 million lawsuit against MIT filed by the parents of Elizabeth Shin, the sophomore who died in April 2000 as a result of burns she suffered in a fire in her Random Hall room.
- The MIT answer filed Friday categorically denies "that any MIT Mental Health Service professionals [failed] to provide Ms. Shin with appropriate care" and denies "that her death was proximately caused by any failure on the part of MIT or anyone affiliated with MIT."

boston.com

The Boston Globe

- **11 years, 11 suicides**
  **Critics say spate of MIT jumping deaths show a 'contagion'**

  By PATRICK HEALY
- **Students at the Massachusetts Institute of Technology have been far more likely to kill themselves over the past decade compared to those at 11 other universities with elite science and engineering programs — 38 percent more often than the next school, Harvard, and four times more than campuses with the lowest rate — a Globe study has found.**


VT

updated 1 hour, 36 minutes ago

# Dad: Virginia Tech treated suicidal son like 'joke'

**STORY HIGHLIGHTS**

- Daniel Kim killed himself after falling into depression after Virginia T
- His father says school officials treated his son's warning signs like a
- School policy says suicidal students should be seen by on-campus
- Kim was never referred to psychologist, but school stands by its acti

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READ | VIDEO

From Abbie Boudreau and Scott Zamost
CNN Special Investigations Unit

**RESTON, Virginia (CNN)** -- William Kim still calls the cell phone of his son, a 21-year-old senior at Virginia Tech, just to hear his voice. He feels cheated out of a chance to save his only boy.


Daniel Kim, 21, was a senior at Virginia Tech who had fallen into a deep depression after last year's massacre.

1 of 2

His son, Daniel Kim, wasn't a victim of last year's massacre that left 32 students and professors dead. His son committed suicide eight months later after falling into a deep depression. A Korean-American, Kim feared classmates might mistake him for shooter Seung-Hui Cho.

"They treated it like some kind of joke," William Kim said of the way the university handled his son's warning signs.

In fact, one of Kim's friends from another state had e-mailed the Virginia Tech health center with the subject line: "Emergency About Suicidal Student."

"Daniel has been acting very suicidal recently, purchasing a $200 pistol and claiming he'll go through with it," said the e-mail from Shaun Pribush, who had become an online friend of



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# Public Response can make things worse.....

February 26, 2008 

STRING OF TEENAGE SUICIDES IN WALES 

# 'Do You Feel Like Shit?'

*By Barbara Hans in Bridgend, Wales*

**The county of Bridgend in Wales has been hit by a spate of suicides by young people over the last year, and is struggling to stop the trend. Parents of the victims say the intense media coverage has been encouraging copycat suicides.**

"I'm going to kill myself and it will be your fault," Nathaniel Pritchard wrote to his ex-girlfriend via an Internet instant messaging service. A few hours later he was dead, the latest in a series of suicides by young people in the southern Welsh county of Bridgend.

**PHOTO GALLERY: "SUICIDE TOWN" BRIDGEND**


Click on a picture to launch the image gallery (6 Photos)

In the last 13 months more than 17 young people have died in the former mining town and the surrounding county. Hannah and 15-year-old Nathaniel had split up after eight months. Nathaniel's profile on the Bebo social networking site was full of photos of



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- Photo Gallery: Five Years of War in Iraq
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# The Bridge: Sending the Wrong Message

The sadness and fatalism the film can instill are perhaps best expressed by a surviving loved one's description of a jumper: "Some people say the body is a temple. He thought his body was a prison. In his mind, he knew he was loved, that he had everything and could do anything. And yet he felt trapped, and that was the only way he could get free."

By STEPHEN HOLDEN

- http://www.thebridge-themovie.com/new/index.html

PFNC / Nick Fain

***Prediction is hard, especially when you're talking about the future.***

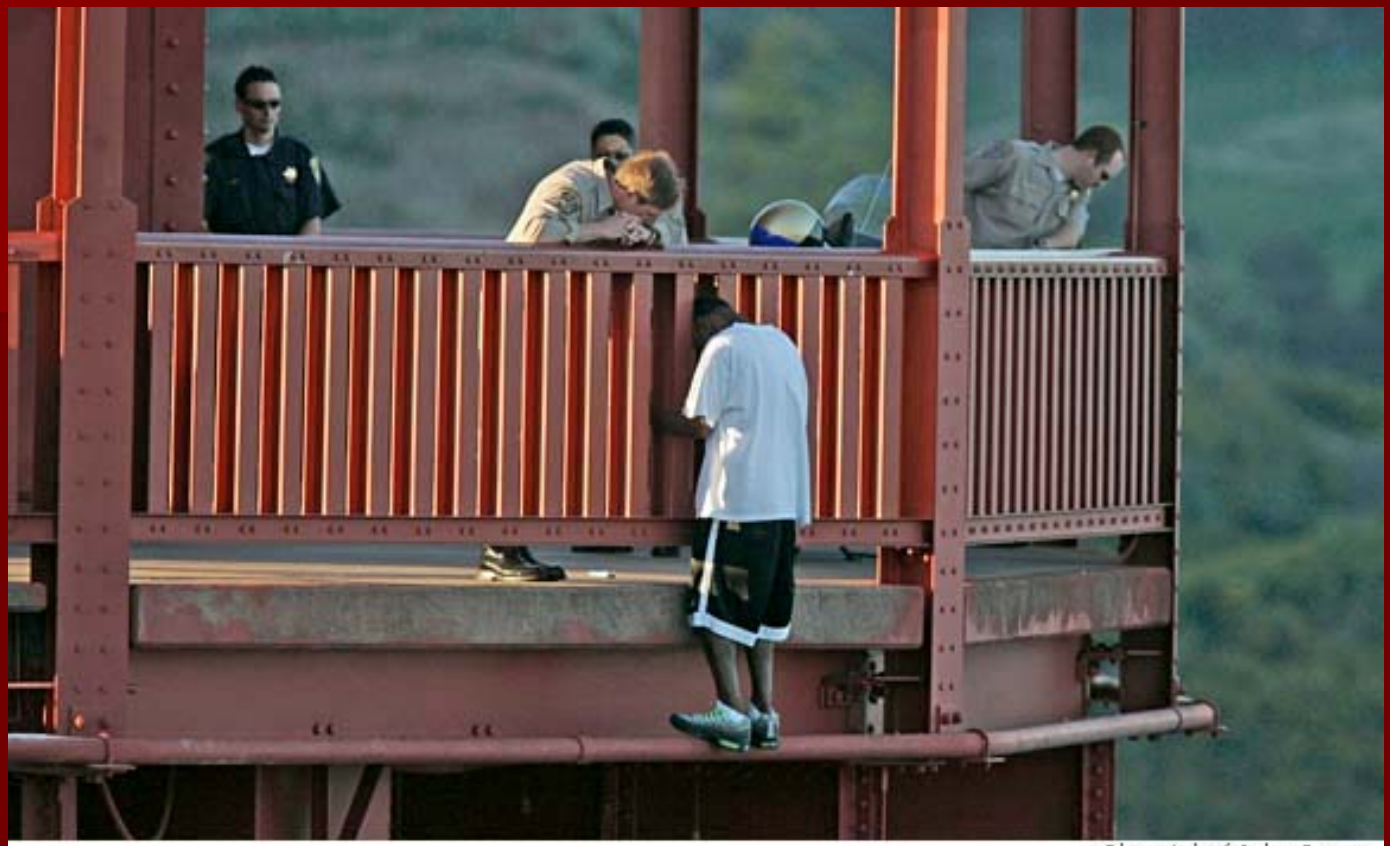
Yogi Berra

*Why is it so difficult to assess suicide risk?*

*The nature of intent*

# Kevin Hines: Survived a Jump from the Golden Gate Bridge

- I took another bus to the Golden Gate Bridge. I was crying. I was just so tired, so emotionally drained. I was just looking at people, wanting someone, anyone, to say, "Are you okay?" As much as I wanted that, I was hearing these voices saying, "You have to die."
- I got off the bus at the bridge, and stood there crying. I went onto the span very slowly. Almost reluctantly. The whole time begging myself not to jump, but the voices were too strong, I just couldn't fight them.
- **There were tons of people, it was 10 in the morning, bikers, joggers, tourists, workers, cops biking around. I found my spot. And I said to myself, if just one person, just one, comes up to me and asks me if I need help, I'll tell [them] everything. And this beautiful woman walked up to me, and she goes, "Will you take my picture?" And I thought, "What? Lady, I'm going to kill myself, are you crazy?" But she had sunglasses on, her hair blowing in the wind, she was a tourist, all she could see was this guy standing right where she wanted her picture taken. I must have taken five pictures of this lady. She had no clue.**
- **I thought at that moment, nobody cares. Nobody cares. So I handed her her camera. She walked away. I walked as far back to the railing closest to the traffic as I could, I ran, and I catapulted myself over the bridge. I didn't get on the ledge to have people talk me down. I just jumped.**



Chronicle / John Storey

On the bridge, Baldwin counted to ten and stayed frozen. He counted to ten again, then vaulted over. “I still see my hands coming off the railing,” he said. As he crossed the chord in flight, Baldwin recalls, “I instantly realized that everything in my life that I’d thought was unfixable was totally fixable—except for having just jumped.”

Tad Friend. Jumpers. The New Yorker (2003)

# Understanding the Challenge of the Suicidal Patient.....

- *Robert, a 21 year old African-American male.....died of a gunshot wound to the head.*

- *Well, I've come down to the fact that the people I care about, depend on, and have supported in their time of need, don't give a crap about me. Thoughts of murder and suicide constantly go through my head. What I'm I to do? I don't trust anyone. I'm not going to expose myself again to the backstabbing, two-faced reality that is friendship. I want to blow my brains out plain and simple. I'm not taking it anymore.*

# The Challenge of the Suicidal Patient.....

- Brad, a 20 year old Caucasian male.....died of a gunshot wound to the head.

- *I don't want to be a burden on my parents anymore. My life has always been full of depression. I've never lived up to my potential. I've decided to end all of this pain. I am at peace. Goodbye.*

# Elements of Intent Tell Us What We Should be Asking!

- Willingness to act (motivation to die)
  - *What are your reasons for dying?*
- Preparation to act (preparation and rehearsal behaviors
  - Clearly differentiates ideators and attempters
  - *Have you prepared for your death in any way?*
    - *Will, letters, finances, research?*
  - *Have you rehearsed your suicide?*
- Capability to act (previous suicidality, self-harm, trauma exposure)
  - Builds over time with exosure
  - *Have you made a previous suicide attempt(s)?*
  - *Have you ever done things to harm or hurt hurself?*
  - *Have you ever experienced something you consider traumatic?*
- Barriers to act (reasons for living)
  - *What are your reasons for living?*
  - *What keeps you alive, what keeps you going?*

# We Need to Differentiate Subjective and Objective Suicide Intent

- Remember
  - Always look for convergence and divergence
  - Always reconcile discrepancies
- Subjective Intent
  - *What the patient says*
  - *Ask for "subtle" or indirect markers of intent*
- Objective Intent
  - *What the patient does (behavioral markers)*

# Understanding Objective Markers of Intent
# **Noncompliance = Hopelessness**

Non-compliance with certain aspects of treatment, therapy and/or medicines

- Refusal to access care during crises
- Multiple suicide attempts
- Little engagement during sessions
- Preparation, rehearsal behavior (plan being enacted)
  - *Internet research, communication*
- Refusal to relinquish access to method (symbolic)
- Persistent recklessness and risk-taking
- Ongoing substance abuse (when suicidality occurs in that context)

– Detailed and specific suicidal thoughts

# Confronting Non-Compliance
## *A Warning Sign*

- Effective treatments confront non-compliance quickly
  - Recognize
    - It represents a persistence of hopelessness and intent
    - The issue of personal responsibility for care
    - The relationship to crisis management
    - The implicit messages if not addressed
      - *Treatment doesn't work*
      - *Treatment is hopeless*

# Hospital Discharge Data and Variable Intent
## *The Best Predictor of Suicide*

- Recent discharge from inpatient facility (within month):
- Study SMR
- (the **standardized mortality ratio** or **SMR** is the ratio of observed deaths to expected deaths)
- Ho et al. 113 (males)
- 178 (females)
- Goldacre et al. 213 (males)
- 134 (females)
- Lawrence et al. 253 (males) within a week*
- 350 (females) within a week*

# Variables Related to Suicide After Discharge

## (*Persistence or Reemergence of Intent)*

- Past suicide attempts (precipitating admission)
- Suicide attempt/self-harm during admission
- Non-compliance with treatment
  - *First three are behavioral markers of hopelessness, evidence of intent*
- Unplanned discharge (usually related to insurance coverage)
  - *Possible persistence of intent*
- Continuity of care (follow-up appointment)
- Short admission (inadequate symptom recovery)

# Persistence of Intent During Treatment: What's the Expected Re-Attempt Rate?

- Rudd & Bryan (2009)
  - Reviewed all available clinical trials targeting suicidality with a comparison group (not all randomized)
  - N=53, with 12-month follow-up
  - Classified samples as High, Moderate, and Low risk (IAW inclusion/exclusion criteria)
    - High: suicide attempts
    - Moderate: self-harm, undetermined suicide-related behavior
    - Low: ideation

- High: Suicide Attempt Precipitating Treatment
  - Range: E (24%-64%), C (30%-96%)
  - Mean: E (40%), C (56%)
  - If there's a reattempt, the average is slightly over 2 in the first year
- Moderate:
  - Mean: E (17%), C (26%)
- *What does this mean? With high risk patients you can expect repeat attempts in half or more of the sample during the first year of treatment----WHEN THINGS ARE GOING WELL*

# *Variable Themes to Hopelessness Deceptive?*

- Cognitive (Hopelessness) Themes
  - Identity-based suicide specific beliefs
    - Guilt (*I've done some bad things*) Remember the notion of "earned" and "learned" guilt (integration of history)
      - Related to behavior
        - Proactive: *I've hurt people*
        - Passive: *I should have done more……..*
      - Diffuse guilt
        - *I don't deserve to live…..*
    - Shame (*There's something wrong with me*)
      - *I'm a Failure*
      - *I'm Damaged*
      - *I'm Weak*
      - *I'm Lost*

- Burdensomeness *(My family would be better off if I were dead*)
  - Related to disruption created by behavior, financial concerns
- Helplessness (*I can't change it)*
- Distress Tolerance (*I can't stand the way I feel*)

# Implications for Risk Classification
# There are TWO Levels of Risk!

- Acute Risk (1 or fewer previous attempts)
  - Mild
  - Moderate
  - Severe (objective markers of intent, none stated)
  - Extreme (objective and subjective intent)
- Chronic Risk (2 or more previous attempts)
  - with/without acute exacerbation

# Always differentiate acute and chronic risk

Entries should always differentiate acute and chronic risk

For example:

*Although the patient does not evidence any acute suicide risk at present, there are markers indicating chronic or enduring risk. More specifically, the patient has made multiple suicide attempts, has a history of recurrent major depressive episodes, treatment non-compliance, episodic substance abuse (alcohol and cannabis), unresolved sexual abuse, and related chronic PTSD symptoms. The patient's diagnosis of BPD also indicates impaired interpersonal problem solving. These issues are being addressed with both medications and ongoing outpatient psychotherapy.*

# What can we learn from clinical trials?

# What Do Effective Treatments Have in Common? Why do They Work?

- We need to talk in simple and understandable terms about suicide
  - Clearly articulated treatment model and suicidality as targets
  - Patients can understand and invest
  - Better compliance, motivation?
  - Facilitates hope? Sense of control?
- People that are suicidal have poor skills
  - Skills deficiencies targeted, not just symptoms
- When People drop out of treatment or are non-compliant, action needs to be taken
  - Treatment compliance closely monitored and addressed
  - Motivation, ambivalence, and intent to die

- People need to take ownership of their treatment
  - Addressed self-reliance, self-awareness, individual control
  - Commitment to treatment statement

- People need to know what to do during a crisis
  - Crisis management/access to emergency services
  - Limited access to method

# Clinical Guidelines and Standards of Care

- American Psychiatric Association Guidelines
- SPRC Assessment and Management of Suicide Risk (AMSR)
- AAS Recognizing and Responding to Suicide Risk (RRSR)

# Skill Sets, Competence, and the Standard of Care: Attitudes and Approach

- Awareness of emotional reactions, attitudes, and beliefs related to suicide
- Tolerate and regulate one's emotional reactions to suicide
- Clarity of beliefs related to suicide and end of life
- Understand the impact of these factors in the clinical scenario
- Reconcile the difference between the clinical goal to prevent suicide and the client's goal to eliminate psychological pain

- A Clinical Example: Establishing a Therapeutic Alliance

- What behaviors did the clinician use to help form an alliance?
- What is the clinician's attitude toward the client?
- What are the indicators an alliance is forming?
- What does the clinician do to reassure the client?

# Theory, Treatment, and Individual Differences?

- Why do people kill themselves?
- Is it ever acceptable to suicide?
- Can suicide be prevented?
- Do people that access care want to die?
- What are your individual responsibilities?

# Therapist Variables

- Answers depend on:
  - Personal experience with suicidality
  - Attitudes, beliefs, religiosity re: suicide, life
  - Professional experience with suicidality

# What Are Common Emotional Reactions?

- Fear/Anxiety Spectrum:
  - Related to beliefs that
    - Suicidal behavior will occur
    - Will be held responsible
    - Detailed discussion will encourage suicidality
- Anger Spectrum:
  - Related to beliefs that
    - Helpless, hopeless
    - Must control

# Clinician's Emotional Reaction Can....

- Trigger suicidal behavior
- Encourage suicidal ideation and behavior to be kept secret
- Limit growth and development
- Damage alliance
- Result in client's withdrawal and isolation

# The Importance of Informed Consent

- Provides a foundation to relationship
  - Honest, caring, blunt
- Articulates responsibilities
  - Patient and clinician
- Reduces fearfulness of patient
  - Consequences and boundaries are clear
- Raises the issue of death as “risk”
  - Targeted disorders
  - Chronic suicidality

*Why is there NOT a perception of risk in the treatment of suicidal patients? That is, in the informed consent document.*

# Failure to Acknowledge Suicide and Suicide Attempt Rates：

- Treatment Outcome Studies
  - Reattempt rates range from 40%-47% in the first year of treatment
  - If there's a reattempt, the average is slightly over 2 in the first year
- Bipolar Disorder
  - 25-50% suicide attempt
  - 10-20% suicide
    - ***Goodwin FK, Jamison KR. Manic Depressive Illness. 1990.***
- Schizophrenia
  - 20-40% suicide attempt
    - Meltzer & Fatemi, 1995
  - 9-13% suicide
    - Caldwell & Gottesman, 1990
- Major Depression
  - 2% ever treated in outpatient setting will suicide
  - 4% ever treated inpatient setting will suicide
    - 7% of men with lifetime history will suicide
    - 1% of women with lifetime history will suicide
    - NIMH

# Agreements with Suicidal Patients: Expectations and Recognition of Risk

- How do they relate to informed consent?
  - Why don't we routinely quote death and attempt rates in informed consent statements?
- No-suicide contract
  - No-harm contracts
  - Safety agreements
  - Suicide prevention contract
  - *Means of gaining a patient's commitment to not act on suicidal or self-destructive urges and to inform clinicians of the status of those urges* (Miller, 1999)
  - *Agreement between the patient and clinician in which the patient agrees not to harm herself and/or seek help when in a suicidal state and she believes she is unable to honor the commitment*

# The Bad: No Empirical Foundation

- A total of 21 articles identified
  - Frequency of use
  - Opinions (favorable, non-favorable)
    - Patients
    - Clinicians
  - Perceived utility
  - Potential problems, liability concerns

# Some Troubling Trends and Questions?

- Evidence of lack of formal training and theoretical models for use with suicidal patients
- Evidence of increasing use with those at higher risk
  - Despite a lack of data on effectiveness
- Evidence of high-rates of attempts/suicides while in use
  - 41% made an attempt, completed suicide

# The Ugly

- **Lawsuit Prompts College to End Policy on Suicide Attempts**

- **A student evicted by Hunter College for seeking psychiatric treatment after a suicide attempt wins a settlement and succeeds in getting the school to overturn its controversial policy.**
- Hunter College of the City University of New York has overturned a policy under which a 19-year-old honors student was evicted from her dormitory after attempting suicide in 2004. The school also settled a lawsuit later filed by the student as a result of the eviction for $65,000 in August.

# The Importance of Language: Do We Mean What We Say and Say What We Mean?

- Informed Consent
- Capacity
- Compliance
- Competence
- Commitment
- Contract
- Responsibility

# The Central Role of Competence

- Fundamental Assumptions
  - There is an inverse relationship between impairment and competence
  - There is an inverse relationship between risk level and competence
  - Risk level and impairment are fluid constructs

- Chronic risk carries some limitations in competence
  - In crisis management
  - Daily living
  - Therapy

# Impaired.....by Definition?

- Brad, a 20 year old Caucasian male.....died of a gunshot wound to the head.

- *I don't want to be a burden on my parents anymore. My life has always been full of depression. I've never lived up to my potential. I've decided to end all of this pain. I am at peace. Goodbye.*

- *Robert, a 21 year old African-American male……..died of a gunshot wound to the head.*

- *Well, I've come down to the fact that the people I care about, depend on, and have supported in their time of need, don't give a crap about me. Thoughts of murder and suicide constantly go through my head. What I'm I to do? I don't trust anyone. I'm not going to expose myself again to the backstabbing, two-faced reality that is friendship. I want to blow my brains out plain and simple. I'm not taking it anymore.*

# What's a Commitment to Treatment Agreement

- *An explicit agreement that identifies patient and clinician responsibilities in ongoing care. Such an agreement always includes a crisis response plan and incorporates behaviors consistent with the patient's identified level of competence and unique to his or her presentation.*

# Elements of a Good Agreement?

- Defined as a commitment to
  - Living
  - Treatment and care
- Incorporates a crisis management or response plan
- Specifically identifies responsibilities
  - Patient
  - Clinician

- Includes behaviors for which the patient has demonstrated competence
- Is modified routinely
  - At request of patient or clinician
  - When indicated by clinical markers
- Is individualized

# Commitment to Treatment Statement

- *I agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment including:*
- *attending sessions (or letting you know when I can't make it)*
- *voicing my opinions, thoughts, and feeling honestly and openly, whether negative or positive*

# CTS (continued)

- *being actively involved **during** sessions*
- *completing homework assignments*
- *experimenting with new behaviors and new ways of doing things*
- *taking medication as prescribed*
- *implementing my crisis response plan.*

# CTS (continued)

- *I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. It it's not working, I'll discuss it with my therapist. In short, I agree to make a* ***commitment to living for……***
- ***I also understand that this means we're working toward the common goals of***
  - *Feeling better*
  - *Improving my abilities to handle different situations and problems*
  - *Finding direction and meaning in my life*

# Effective Management of Crises Means Facilitating Hope in Treatment

- Define *crisis*
- Make it accessible!
- Identify warning signs! (for parents as well)
- Provide a simple model of suicidality---Identify trigger(s) and associated thoughts, feelings, behaviors.
- Specific goal is to reduce escalation of suicidal crisis and reduce manifest intent (increase hope)
- Moves from self-management to external intervention—improve self-efficacy.
- If not successful, access emergency care and assistance in manner that facilitates skill development (always understand the cost and consequence)

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# Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities - seemingly without thinking
- Feeling trapped-like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

# Practice, Practice, Practice

- *When thinking about suicide, I agree to do the following:*
- *When I find myself making plans to suicide, I agree to do the following:*
- *1. Use my hope box.*
- *2. Review my treatment journal*
- *4. Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk*
- *5. Repeat all of the above*
- *6. If the thoughts continue,get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX*
- *7. If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room*

# Creating a Hope Box

- The notion of reciprocal inhibition
- Include items that generate productive, hopeful thoughts and feelings
- Always review items individually
- Practice use of Hope Box
  - Review each item
  - Ask patient to describe item, “tell a little about it”
  - What are they thinking?
  - What are they feeling?
  - More hopeful?

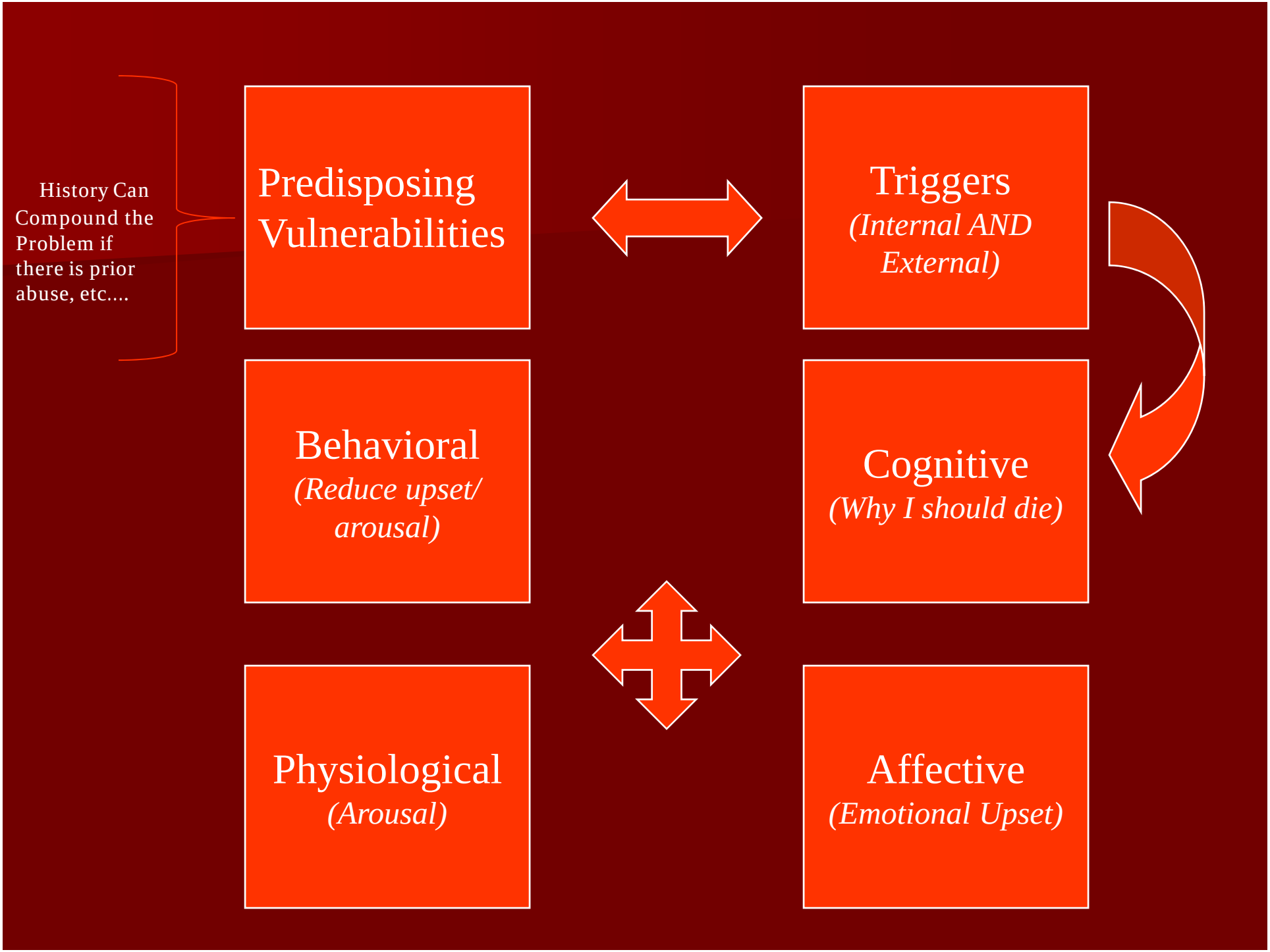
# Crisis Response Plan Pointers

- Be specific
  - when to use, steps to take, where to go, what numbers to call
- Be concrete
- Ensure safety, remove access, availability
- Make it accessible
  - put on a card, can be carried in a wallet or purse
- Practice, role play
- Periodically review and update
- Use of STR

# A Conceptual Model for Treatment and Management

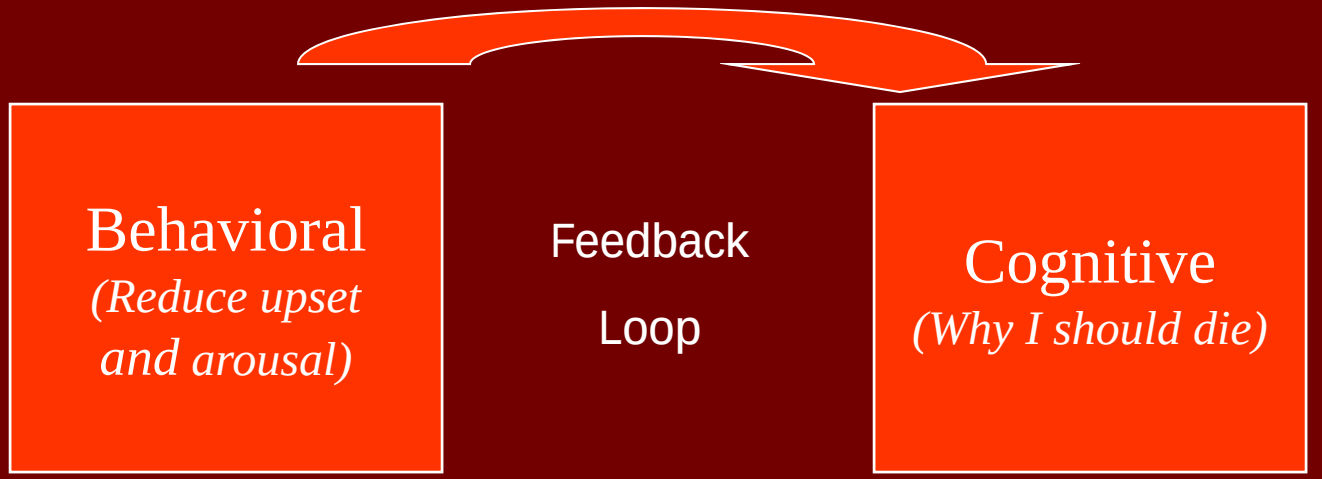
- Skill Set: Understand suicide
  - Basic definitions and terms
  - Phenomenology of suicide
  - A biopsychosocial perspective
    - Assessing each domain
    - Consider each in formulating risk
    - Integrate each into treatment
    - Consider each in management decisions
    - Document each in record

- A Clinical Example:  Understanding Suicidality


History Can Compound the Problem if there is prior abuse, etc....
Predisposing Vulnerabilities
Triggers (Internal AND External)
Behavioral (Reduce upset/ arousal)
Cognitive (Why I should die)
Physiological (Arousal)
Affective (Emotional Upset)

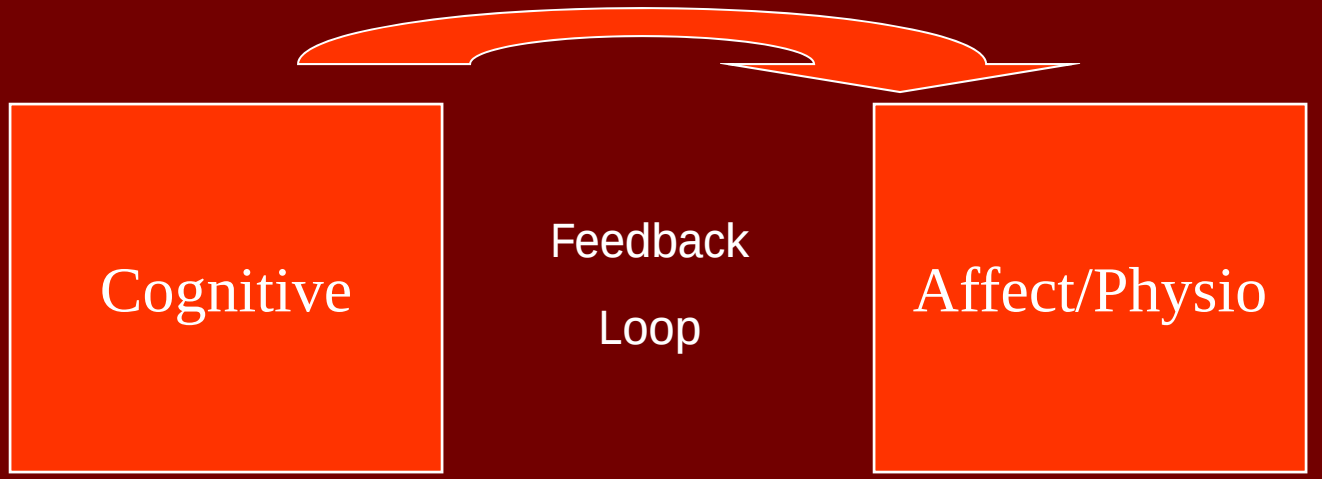
# Behavioral Feedback Loop

- Every time there is behavior (avoidance) there is a COGNITIVE CONSEQUENCE that facilitates the cycle of despair and suicidality. It's almost always self-image related.
  - Alcohol Abuse…*the only way to get relief is drinking*
  - Suicide attempt….*I can't handle living, I'm a failure*



# Facilitates Symptom Persistence/Increased Severity

- PTSD is a disorder based on hyperarousal, hypervigilance, fearfulness associated with perceived threat. Beliefs about individual vulnerability facilitate the suicidal process, with the belief itself confirming a threat to individual integrity
  - *I'm out of control, I can't handle this…….*



# The Nature of Hopelessness in Soldiers and Combat Veterans

- Cognitive (Hopelessness) Themes for Soldiers and Veterans
  - Identity-based
    - Guilt (*I've done some bad things*) Remember the notion of "earned" and "learned" guilt (integration of history)
      - Related to behavior
        - Proactive: *I took a life*
        - Passive: *I should have done more to save him*
      - Diffuse Survivor guilt
        - *I should have died….*
    - Shame (*There's something wrong with me*)
      - *I'm a Failure*
      - *I'm Damaged*
      - *I'm Weak*
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- Burdensomeness *(My family would be better off if I were dead*)
  - Related to disruption created by behavior, financial concerns
- Helplessness (*I can't change it)*
- Distress Tolerance (*I can't stand the way I feel*)

# The Role of PTSD in the Suicidal Mode

- Symptoms include
  - COGNITIVE (distorted thinking/motivation/intent)
    - Recurrent, intrusive and distressing recollections
  - AFFECTIVE/PHYSIOLOGICAL (impaired thinking/mental status)
    - Persistent symptoms of arousal (and related dysfunction)
      - Sleep difficulties
      - Irritability and angry outbursts
      - Concentration problems
      - Hypervigilance
      - Exaggerated startle response
  - BEHAVIORAL (seeking relief)
    - Persistent avoidance of stimuli associated with the trauma and a generalized numbing of response

# Primary Goals

- Predisposing Vulnerabilities
  - *Can't change history but can build resilience*
  - *Redefine vulnerability as "normal", providing context*
- Triggers
  - *Don't avoid, exposure is critical*
    - *Avoidance facilitates generalization*
  - *Recognize and understand the triggers*
    - *Build a sense of competency, control, mastery, hope*
- Cognitive
  - Restructure the suicidal beliefs (suicidal belief system)
    - Motivation to die, intent
- Affective/Physiological
  - Reduce suffering, arousal, depressive symptoms, etc....
- Behavioral
  - Recognize high-risk behavior
  - Reduce high-risk behavior
  - Generate problem-solving behavior, appropriate regulatory behavior

# Synchronous Activation: John (Reservist)

- *I was doing ok. There was not much going on at work. I really didn't have a bad day. But it had been a pretty bad month. I got home, went to the bedroom and saw my weapon laying on the dresser. I felt compelled to pick it up. The though flashed through my head, 'just kill yourself and get this over, you'll be better off and so will everyone else'. I remember my heart started racing, I had a hard time breathing, and I started sweating. I hate to admit it, but it scared me. I don't know why, but I put the gun down and called my wife. Now, I'm glad I did. It scares me to think about what I would have done if I stayed there alone. I don't think I'd be here right now.*

# An Empirically Informed Approach to Assessment


Front porch forecasters

# SUICIDE PREDICTION vs. SUICIDE ASSESSMENT

- **Suicide Prediction refers to the foretelling of whether suicide will or will not occur at some future time, based on the presence or absence of a specific number of defined factors, within definable limits of statistical probability**

- **Suicide (risk) Assessment refers to the establishment of a clinical judgment of risk in the very near future, based on the weighing of a very large mass of available clinical detail. Risk assessment carried out in a systematic, disciplined way is more than a guess or intuition – it is a reasoned, inductive process, and a necessary exercise in estimating probability over short periods.**

# SUICIDE: A MULTI-FACTORIAL EVENT

# Areas to Evaluate in Suicide Assessment

| | |
|---|---|
| Psychiatric Illnesses | **Comorbidity,** Affective Disorders, Alcohol / Substance Abuse, Schizophrenia, Cluster B Personality disorders. |
| History | Prior suicide attempts, aborted attempts or self harm; Medical diagnoses, Family history of suicide / attempts / mental illness |
| Individual strengths / vulnerabilities | Coping skills; personality traits; past responses to stress; capacity for reality testing; tolerance of psychological pain |
| Psychosocial situation | Acute and chronic stressors; changes in status; quality of support; religious beliefs |
| Suicidality and Symptoms | Past and present suicidal ideation, plans, behaviors, intent; methods; hopelessness, anhedonia, anxiety symptoms; reasons for living; associated substance use; homicidal ideation |

**Adapted from APA guidelines, part A, p. 4**

# Definitional Issues

Differentiated on three features:

- Intent (i.e., subjective versus objective)
- Evidence of self-infliction
- Outcome (i.e., injury, no injury, death)

# Advantages

- Remove pejorative language: gestures
- Improve consistency of documentation
- Improve communication between clinicians
- Improve accuracy of risk assessments
- Improve clinical decision making
- Improve treatment outcomes

# Intent: Subjective vs. Objective

- Subjective: *stated intent*
- Objective markers of intent: lethal method, preparation (letter writing, financial records, giving away possessions), prior attempts with serious injury, efforts to prevent discovery/rescue, help seeking behavior after an attempt

# Understanding Objective Markers of Intent (and Hopelessness)

- Recognizing objective markers of intent is critical to risk assessment (particularly for high-risk cases)
  - Making multiple suicide attempts
  - Non-compliance with treatment, therapy and/or medicines
  - Refusal to access care during crises
  - Little engagement during sessions
  - Detailed and specific suicidal thoughts
  - Preparation, rehearsal behavior (plan being enacted)
  - Refusal to relinquish access to method (symbolic)
  - Persistent recklessness and risk-taking
  - Ongoing substance abuse (when suicidality occurs in that context)

# Example of Objective Markers of Intent

- 28 y/o African-American male hung himself in the closet (highly lethal method), waited till his wife and child left, prepared a financial and insurance packet, made no effort to seek help, was only discovered because his wife *forgot something at the house* and returned

# Terminology

- Suicide attempt with injuries
  - non-fatal injury, intent, extent of injuries
- Suicide attempt without injuries
  - potentially self-injurious behavior, intent
- **Self-Harm Behavior**
  - potentially self-injurious behavior, motivation other than death, with/without injuries
- Suicide Threat
  - interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act

# Terminology and the Clinical Scenario: Working with Chronic Individuals

- Sara, 21 year old Hispanic female.....
- *Thoughts of wanting to be dead flew through my head. I felt like cutting myself, looking for places it wouldn't show and wouldn't drain on my clothes. I though about taking my pills to excess. It wouldn't have killed me but probably would have numbed me and I really want that right now.....*

# Skill Sets: Collecting Assessment Information

- Obtain accurate information
  - Integrate risk assessment for suicide within the context of a clinical interview in multiple settings, knowing that all clients are potentially at risk for suicide and that the risk for suicide must be ruled out in each case.
    - Obtain records and information from collateral sources
    - Continue to collect assessment data, including asking the client about his/her urge to quit treatment, at critical times
      - Precipitating events, transitions, increased stress, mental status changes, immediately following an attempt or hospitalization, when treatment setting changes, and the end of a crisis intervention incident.

# Content vs. Process

- Content: questions, risk variables
- Process: interpersonal factors determine emotional response, disclosure, can be conceptualized as intervention

# Risk Assessment: Process

- Interpersonal variables important:
  - to engage, listen
  - direct, unambiguous language
  - eye contact
  - specific questions
  - repetitive questions (method, plan)
  - collaborative decision making
  - role of hierarchical questioning
  - acknowledge resistance

# Monitoring Process

- Initial Phase: historical focus, what's already happened
- Assessment Phase: current status
- Action (Intervention) Phase: future plans
- Phase changes occur during and across sessions

# Risk Categories: Static

- Predisposition to Suicidality
  - prior suicidality, attempts, ideation
  - frequency, context, perceived lethality, outcome, stated intent, rescue opportunity, preparatory behaviors (psychological/practical), help seeking behaviors
    - Risk/Rescue issues
      - Method, timing, place, arranging sequence of events
  - psychiatric hx, diagnosis, treatment hx, response, compliance
  - abuse hx, sexual, physical, emotional

- Primary Distinctions:
  - Multiple attempters vs. single attempters or ideators
  - Psychotic vs. non-psychotic
  - Presence vs. absence of substance abuse

# Risk Categories: Aggravating

- Precipitant/Stressors
  - Interpersonal loss or conflict
  - Economic or legal problems
  - Consider in the context of individual vulnerability, strengths, and support system
- Symptoms (essentially Axis I picture)
  - Emphasis on depression and anxiety (79% of inpatient suicides reported severe anxiety/agitation), command hallucinations
  - type, breadth, severity, duration
  - associated cognitive disruption, mental status impairment
- Hopelessness
  - severity, duration, source(s)

- Sleep disturbance, nightmares
- Perceived burdensomeness

- **The importance of sequencing and specificity in questions**
- ***Always thinking about…….***
  - ***Severity***
  - ***Immediacy***
  - ***Volatility (impulsivity/self-control)***

# Skill Set: Eliciting Suicidal Ideation

- Comfort in asking about suicide
- Elicit past, present, and current suicidal thoughts, behaviors, plans, intent
- Sequence and word questions in effective manner
  - First attempt, past several years, past several months, current episode
    - Undermines resistance, reduces anxiety, develops trust, improves accuracy of report, differentiates suicidal and instrumental beahviors
- Address client fears about “what will happen” if suicidal thoughts are acknowledged

- Nature of Suicidal Thinking
  - Ideation: frequency, intensity/severity, duration, specificity (plans), availability/accessibility, active behaviors (preparation, rehearsal), intent (subj. vs. obj.), perceived lethality, degree of ambivalence, deterrents (family, religion, positive treatment relationship, support system)
  - Severity of psychological distress pain
    - Distress tolerance

- Impulsivity/Self-Control
  - objective vs. subjective
  - duration, severity, source

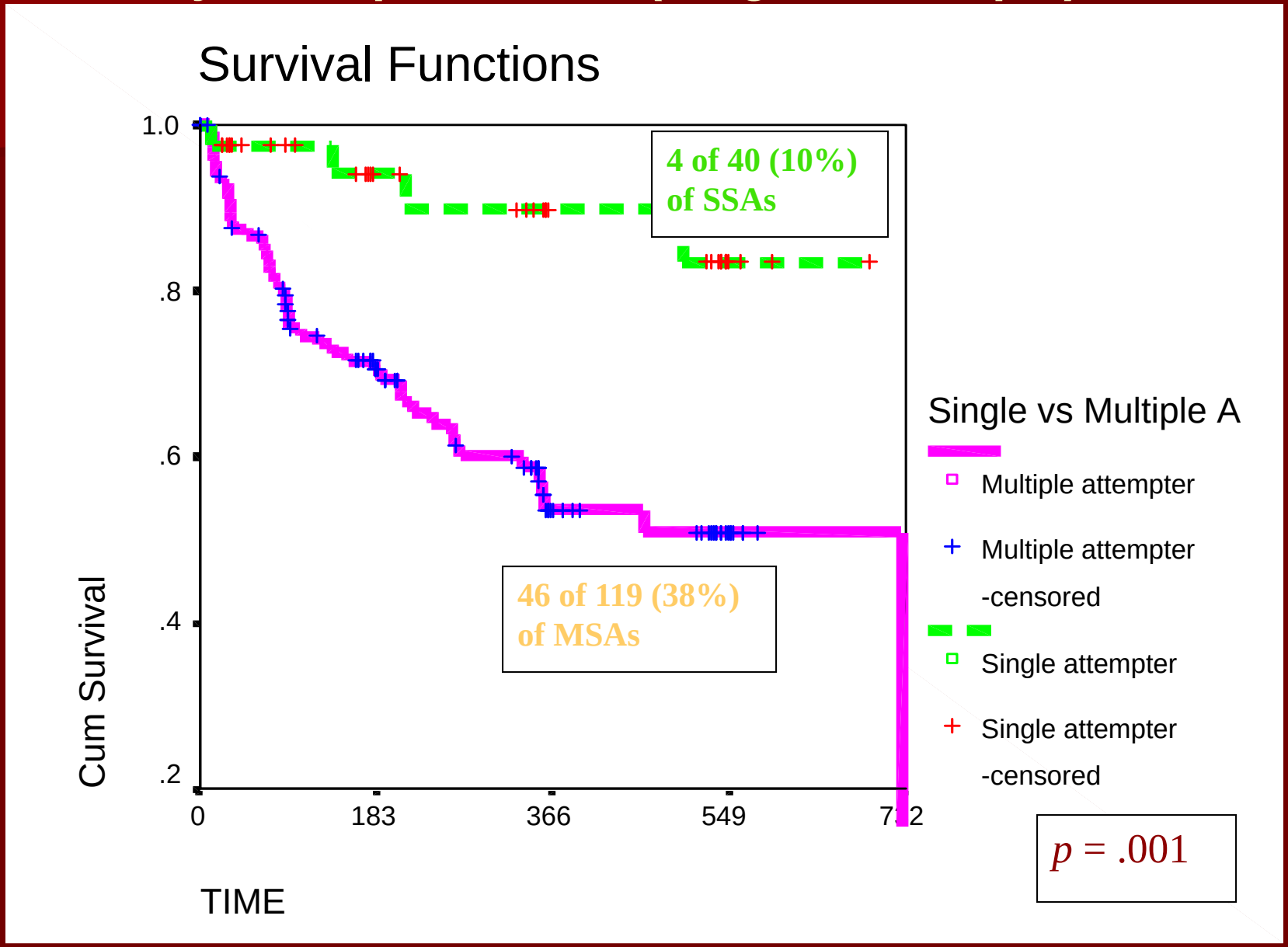
# Risk Categories: Protective

- Protective Factors
  - Social support, available and accessible
    - previous crises
  - Coping/problem-solving skills
    - previous crisis management
  - Religious beliefs
  - Life satisfaction
  - Good reality testing
  - Pregnancy
  - Good therapeutic relationship
  - Treatment compliance hx critical
    - investment/commitment to treatment

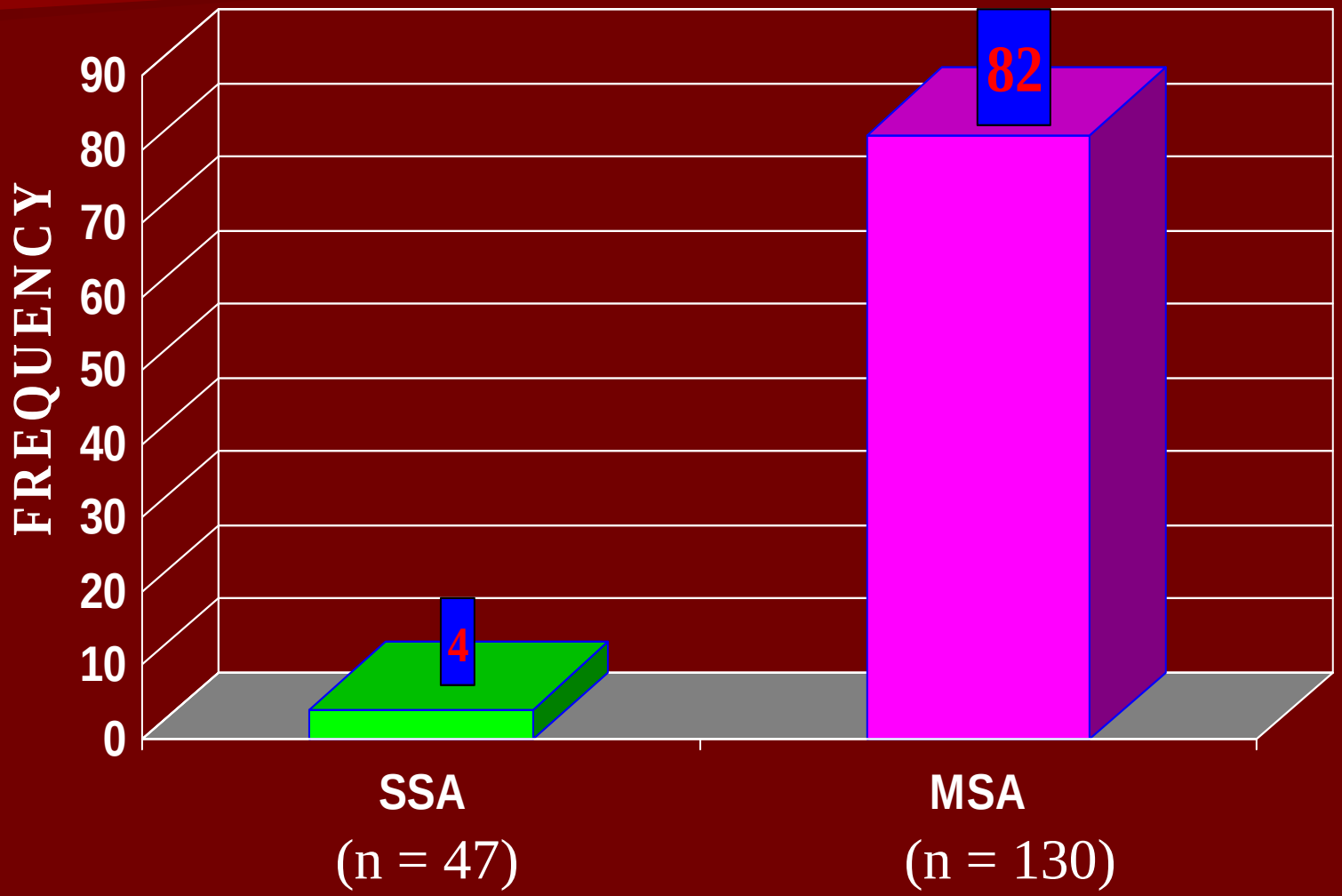
# Recognizing Multiple Attempters as a Special High-Risk Group

- Distinctive in every way
  - Greater likelihood to have diagnosis, co-morbidity, personality disorder
  - Younger at time of first attempt (greater chronicity)
    - Lower lethality first attempt (raises question about intent, function of behavior)
    - More impulsive
    - More likely to be associated with substance abuse
  - Greater symptom severity
    - Anxiety, depression, hopelessness, anger, suicidal ideation (frequency, intensity, specificity, duration, intent)
  - More frequent histories of trauma, abuse
  - Distinctive characteristics of crises

# Survival Curves for Days until First Suicide Attempt by Attempter Status (Single v. Multiple)



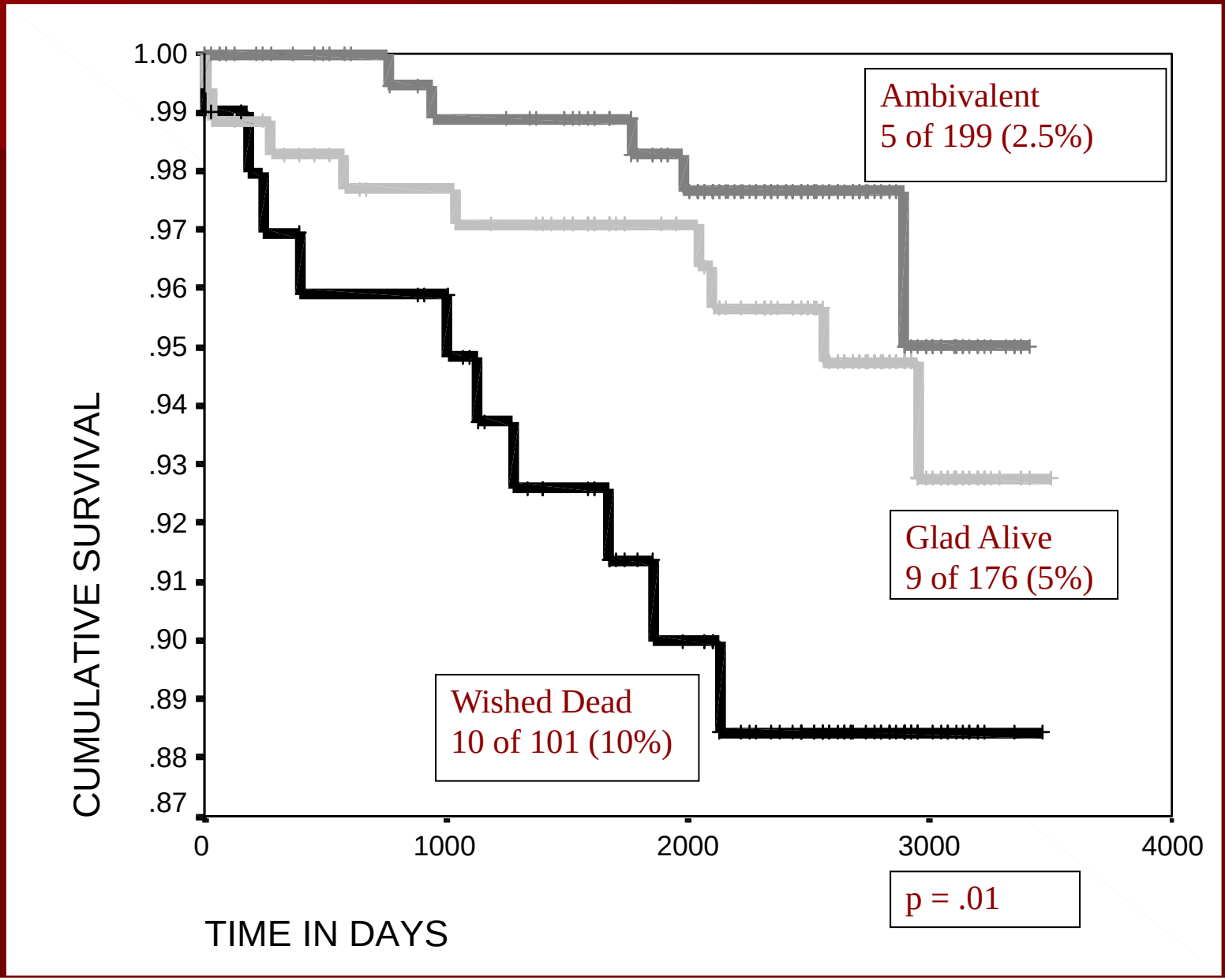
# Total Number of Subsequent Suicide Attempts by Single v. Multiple Attempters



# Suicide Attempters' Reaction to Their Attempt as a Predictor of Eventual Suicide

- Suicide attempters have varied reactions to their suicide attempt after it happens.
- We hypothesized and found that those who wished they had died following the attempt would be more likely to eventually kill themselves
- Easily assessed variable that should be documented and considered when evaluating for risk of suicide.
- Revision of article reporting these findings is under review at *JCCP.*

# Survival Curves for Days until Suicide by Reaction to Attempt (Glad Alive, Ambivalent, Wish Dead).



# Risk Quotient

- Risk = $\frac{\text{Static Factors + Aggravating Factors}}{\text{Protective Factors}}$

# Practical Implications

- Risk: high risk can be enduring, resistant to short-term interventions
- Treatment: short-term, long-term targets
- Liability: limited predictability, control
- Patient responsibility: significant for crisis management, treatment

# Risk Classification

- Acute Risk (1 or fewer previous attempts)
  - Mild
  - Moderate
  - Severe (objective markers of intent, none stated)
  - Extreme (objective and subjective intent)
- Chronic Risk (2 or more previous attempts)
  - with/without acute exacerbation

# Always Consider Hospitalization

- If the suicidal patient is psychotic or intoxicated (i.e. impaired mental status).
- If symptoms are so severe as to limit the patient's ability to actively engage in treatment and follow a crisis response or safety plan.
- If the patient voices "intent" or motivation to act on their suicidal thoughts.
- If a patient refuses to develop and follow a crisis response plan (or safety plan).
- If the patient expresses variable intent (i.e. it comes and goes), has access to a lethal method and refuses to give up access.
- If a patient with variable intent continues to engage in episodic substance abuse (and refused to stop substance abuse) and has previous suicide attempts while intoxicated.
- If objective markers of intent (e.g. preparation and rehearsal) indicate clear intent and the patient refuses to give up access and/or use a crisis response plan.

# Risk and Response

- Severe, Extreme
  - immediate psychiatric evaluation
  - accompanied and monitored
- Moderate
  - increase frequency, duration of sessions
  - periodic consideration of need for hospitalization
  - involvement of family

- Reevaluation of treatment goals
- 24-hour availability of ER services
- frequent reevaluation of suicide risk
- consideration of medication for symptom relief/stabilization
- Use of telephone monitoring
- consultation
- frequent input from family members

# Concrete Management of Suicide Risk

- Informed Consent
  - Lays the ground rules, expectations (risks/benefits)
- LIMIT ACCESS TO METHOD
- SYMPTOM MANAGEMENT
  - ALWAYS CONSIDER MEDICATIONS!
- Commitment to Treatment Agreements
- Crisis Response Plans
  - Using a Hope Box
- ER Discharge Cards
- Coping Cards: Reasons for Living (Hope Box)
- Non-compliance Protocols/plans

# Facilitating Hope (*and feeling in control*) During the First Contact

- Provide an understandable model
  - Explain why the suicide attempt(s) happened
- Contextualize/Normalize the problem
  - Sensitized to the sights, sounds, smells of war (problem is that many generalize to day to day living, particularly given the urban nature of much of this conflict)
- Label and reinforce the presence of ambivalence
  - *Reasons for living, reasons for dying*
- Don't struggle for control by arguing about suicide as an option
  - *Data mentioned previously, it's a risk with psychiatric illness*
- Identify a common goal (reduces adversarial tension)
  - *Reduce suffering and emotional pain*
- Provide a crisis management or safety plan (and practice it)

# Journaling Plays a Critical Role (development of insight)

- Keeping a treatment journal
  - Start at the first session
  - Provides structure, safe outlet, historical memory, ability to track change
  - *Journals have been demonstrated to be a useful intervention in treatment, particularly to improve self-awareness, understanding of change over time and as tool for relapse prevention. Your journal will provide an easy and ready reference for what you've done in treatment, identifying what's worked and what has not, with an emphasis on becoming more efficient and effective in problem solving, regardless of the situation. Here are the ground rules for keeping your journal:*

- Journal for 15-30 minutes per day. Try to do it at the same time each day, it's important to make this part of your daily routine. I want you to write only as much as I can reasonably read and cover with you in treatment. This is particularly important early in the treatment process. I'll make copies of your journal to keep and review.
- For the first month I'd like for you to journal about things that are *important* to you. That is, what's on your mind? What's upsetting you? How are you feeling about yourself? How are you feeling about other people? When you write about these things, please try to identify specifically what the problem is so that we can target it in treatment. We'll talk about a specific approach to problem solving.

- If you write about suicidal thoughts, feelings and plans, we'll target these directly in treatment. If you right about reasons for dying, I'm going to ask you to always include your reasons for living. If you have trouble identifying them, I'll help you. Use your coping card.
- Within the first couple of weeks, I'm going to ask you to identify the problem specifically when you write, generate and write about alternative responses, practice implementing the alternatives (we'll role play these to help you), evaluate whether or not it's working, and if it's not, identify a new one and try again.
- Finally, I'm going to ask you to always close your writing each day by adding a single sentence about what your hopeful about in treatment and life.

# Philosophy of Living Statement

- *After careful review, much time and effort, I've decided to make the following changes in my rules for living:*
  - *Accept the fact that I'm not perfect and never will be*
  - *Do the best job I can and feel good about it.*
  - *Work on accepting the things I can't change*

# ER Discharge Card

- *You (or your child) have been referred to the Emergency Room in order to be evaluated for hospital admission. This means that your level of risk for suicide is currently considered to be elevated and we are concerned about your safety. If you are discharged from the Emergency Room and NOT admitted to the hospital please follow these steps:*

- Prior to leaving the ER, call the emergency call number (XXX-XXXX) and tell the individual on call what has happened. They will have some questions for you and may well ask you to stay in the ER until they have had a chance to talk with the ER physician about your situation. Please wait until the staff member on call gives you permission to leave the ER. The staff member on call will confirm that you do NOT have access to any method for suicide if you are leaving the ER. They will also confirm you do NOT have access to substances such as alcohol or other drugs.
- The staff member on call will provide you with a specific day and time for your emergent follow-up appointment in the clinic. This will likely be the next morning. Please do NOT leave the ER without a specific day and time to follow-up in the clinic.

- Use your crisis response plan until you follow-up in the clinic. This is what you normally do between appointments and you should have practiced this with your therapist.
- If you do not feel safe leaving the ER, please tell the on call staff member.
- For parents, it is requested that you closely monitor and supervise your child until the follow-up appointment. This means that your child should not be left alone until the follow-up appointment and should not be allowed to leave you or another identified adult's presence. They should be monitored at all times until the follow-up appointment. The on-call staff member will review with you the importance of removing access to all methods for suicide (and related safety procedures regarding constant observation and access to substances). If you do not believe you can accomplish careful monitoring you need to let the on call staff member know.

# Reasons for Living Coping Card

- Provides a ready reminder of reasons for living
  - Facilitates cognitive fluency, problem solving
- Can be integrated into Hope Box
- Make it accessible and specific
  - If reasons are not available, strategize offer reasons
    - Building relationships important

# Non-Compliance Protocols/Plans

- Follow-up no-shows, treatment withdrawals
  - Phone calls, letters
- Identify reasons for drop-out, non-compliance
  - Can be addressed during initial intake, informed consent
- Rewrite commitment to treatment agreement to address compliance problems
- Make sure to address non-compliance with crisis response plan

# Symptom Hierarchies

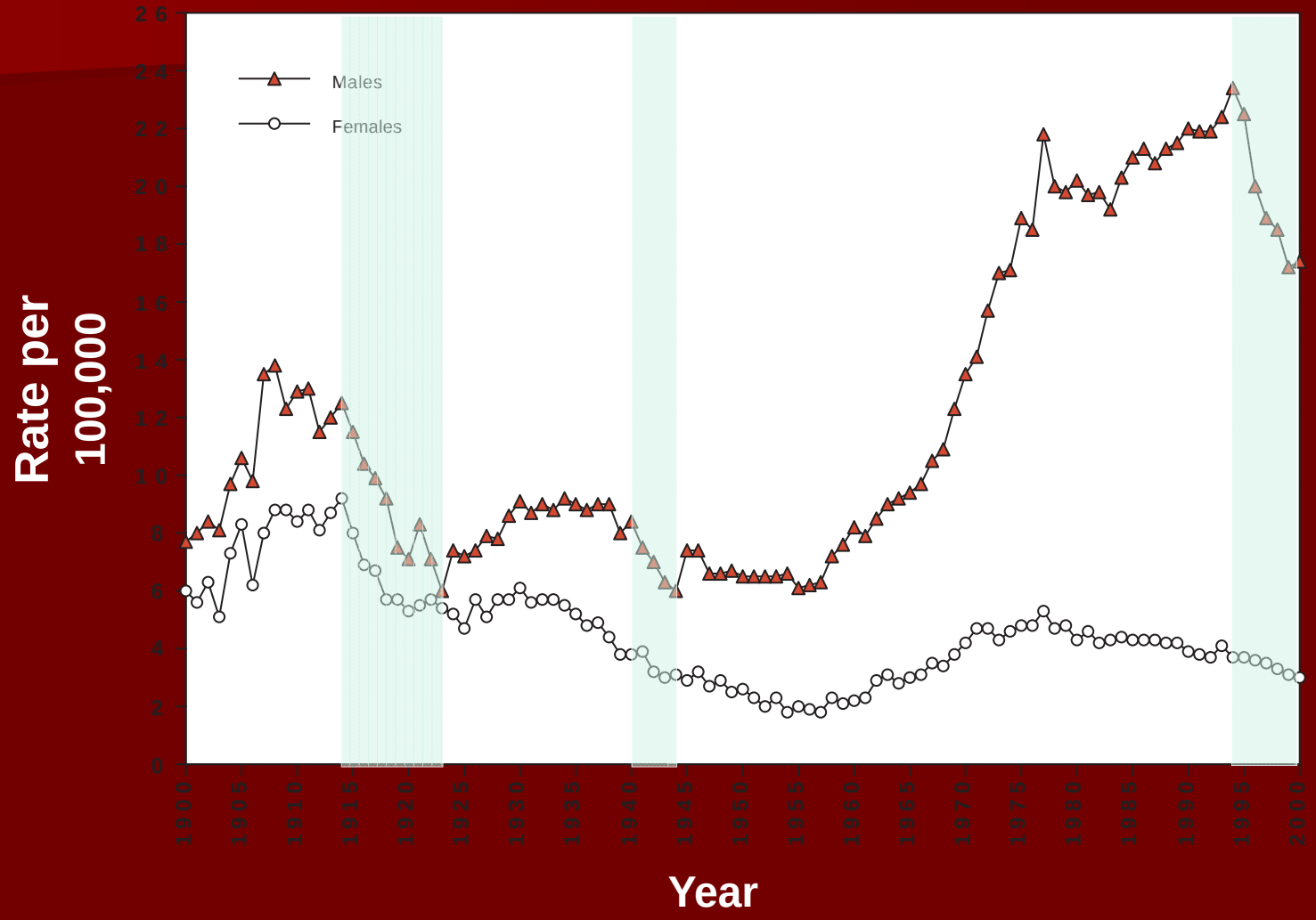
- Early in process mixed symptomatology
- Severity and related disruption fuels hopelessness and feelings of being out of control
  - *What symptoms cause you the most trouble?*
- Rank symptoms from low to high (1-10)
  - *Severity, distress, upset, dysfunction*
- Target one symptom at a time
  - Although they're interconnected

# Example: JoAnn

- 10: Sleep Disturbance
- 9: Binge/purge episodes
- 8: Anxiety/panic attacks
- 7: Cutting
- 6: Depression

# FLUCTUATIONS IN 20TH-CENTURY YOUTH SUICIDE RATES

## — UNITED STATES, AGES 15–24 —




Anderson 2002, CDC Wonder 2002, USDHEW 1956, Vital Statistics U.S. 1954–1978

# The FDA Warning for Children and Adolescents.....

**Suicidality in Children and Adolescents**

**Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Insert established name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Insert established name] is not approved for use in pediatric patients. (See Warnings and Precautions: Pediatric Use) [This sentence would be revised to reflect if a drug were approved for a pediatric indication(s). Such as, [Insert established name] is not approved for use in pediatric patients except for patients with [Insert approved pediatric indication(s)]. (See Warnings and Precautions: Pediatric Use)]**

**Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.**

The suicide rate climbed 18 percent from 2003 to 2004 for Americans under age 20, from 1,737 deaths to 1,985. Most suicides occurred in older teens, according to the data — the most current to date from the federal Centers for Disease Control and Prevention.

- Lineberry et al. (2007). Impact of the FDA Black Box Warning on Physician Prescribing and Practice Patterns: Opening Pandora's Box, Mayo Clinic Proceedings, 82 (4), 516-522.
  - 70% of Generalists change in practice
    - Less likely to prescribe (9%)
    - Referral to mental health (17%)
  - 68% of Other Specialists change in practice
    - Less likely to prescribe (20%)
    - Referral to mental health (23%)

- Rudd, Cordero & Bryan (2008) found that 91% of general practitioners did not accurately present drug label data to patients and their families.

# THE VANCOUVER SUN



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## Suicides, untreated depression follow anti-depressant warnings

**Sharon Kirkey, Canwest News Service**
Published: Monday, April 07, 2008

Two years after Health Canada warned about prescribing anti-depressants to children, the number of children and teens who died by suicide increased 25 per cent after years of steady decline, major new Canadian research shows.

And the increased suicide rate coincided with a 10-per-cent decrease in the rate of visits to doctors for the treatment of depression in children.

For the study, researchers tracked what happened in Manitoba before and after Health Canada warned in 2004 that newer antidepressants may be associated with an increased risk of "suicide-related" events in patients under 18.

They found the warning was followed by an overall 14-per-cent drop in antidepressant use among children and adolescents, fewer visits to doctors for depression, and - among eight- to 17-year-olds - increased rates of completed suicide.

More than 90 per cent of the children and teens who killed themselves were not taking antidepressants when they died.

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**Today's Sun**


Wine protects women from dementia:

- Katz, Kozyrskyj, Prior, Enns, Cox, & Sareen (2008), Canadian Medical Association Journal.
  - Rate of antidepressant prescriptions in Canada decreased after the warning label

# Treatment Resistance

- What's the function of the resistance?
- Does it fit the developmental pattern?
- What is the client afraid of if he/she complies?
- Does the client agree with or misunderstand the interventions?
- Are the client's skills inadequate?
- What situational factors prevent change?

# Treatment Resistance

- Is change inconsistent with the client's self-image?

# Termination

- Clarify expectations, obligations, goals from the beginning, document agreement
- Address financial issue from outset, plan for non-payment
- Provide referrals, assist in transition
- Follow-up on withdrawals if continued care indicated, document

# Follow-up Procedures

- Monitoring of implementation of follow-up plan, compliance-----specific appointments, use of reminder letters/calls, coordination with family

# Suicide Assessment Measures: Problems

- Little predictive validity
- Limited settings for development, application: psychiatric patients, college students, few used in ER's, primary care settings
- Most target children, adolescents, young adults, few for elderly, none address potential differences with minority populations

# Suicide Assessment Measures: Problems

- Potential differences between self-report and clinician-rated scales---recommend use of both
- Clinician's rate risk as more extreme in comparison to self-report
- Issue of liability in primary care settings---availability of immediate intervention

# WHEN TO DOCUMENT SUICIDE RISK ASSESSMENTS

- At first psychiatric assessment or admission.
- With occurrence of any suicidal behavior or ideation.
- Whenever there is any noteworthy clinical change.
- For inpatients:
  - Before increasing privileges/giving passes
  - Before discharge
- The issue of firearms:
  - If present - document instructions
  - If absent - document as pertinent negative

# WHAT TO DOCUMENT IN A SUICIDE ASSESSMENT

- **Document:**
  - **The risk level**
  - **The basis for the risk level**
  - **The treatment plan for reducing the risk**

**Example:**

**This 62 y.o., recently separated man is experiencing his first episode of major depressive disorder. In spite of his denial of current suicidal ideation, he is at moderate to high risk for suicide, because of his serious suicide attempt and his continued anxiety and hopelessness. The plan is to hospitalize with suicide precautions and medications, consider ECT w/u. Reassess tomorrow.**

# Documentation continued

- The patient's actual statements (quotes if possible) regarding the increase or alleviation of suicidal thoughts
- The content of discussions about risk and safety
- Any contemporaneous information provided by concerned family members
- Any attempts to obtain prior treatment records
- All increases in treatment intensity or frequency
- Any special precautions taken, or arrangements made
- Any attempts to have the patient voluntarily admit himself or herself to a hospital
- All reasons why hospitalization was rejected as an alternative
- Evening, weekend, and emergency arrangements that were made

(Baerger, 2001)

# WHEN A SUICIDE OCCURS

**Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice**

**Approximately, 12,000-14,000 suicides per year occur while in treatment.**

**To facilitate the aftercare process:**

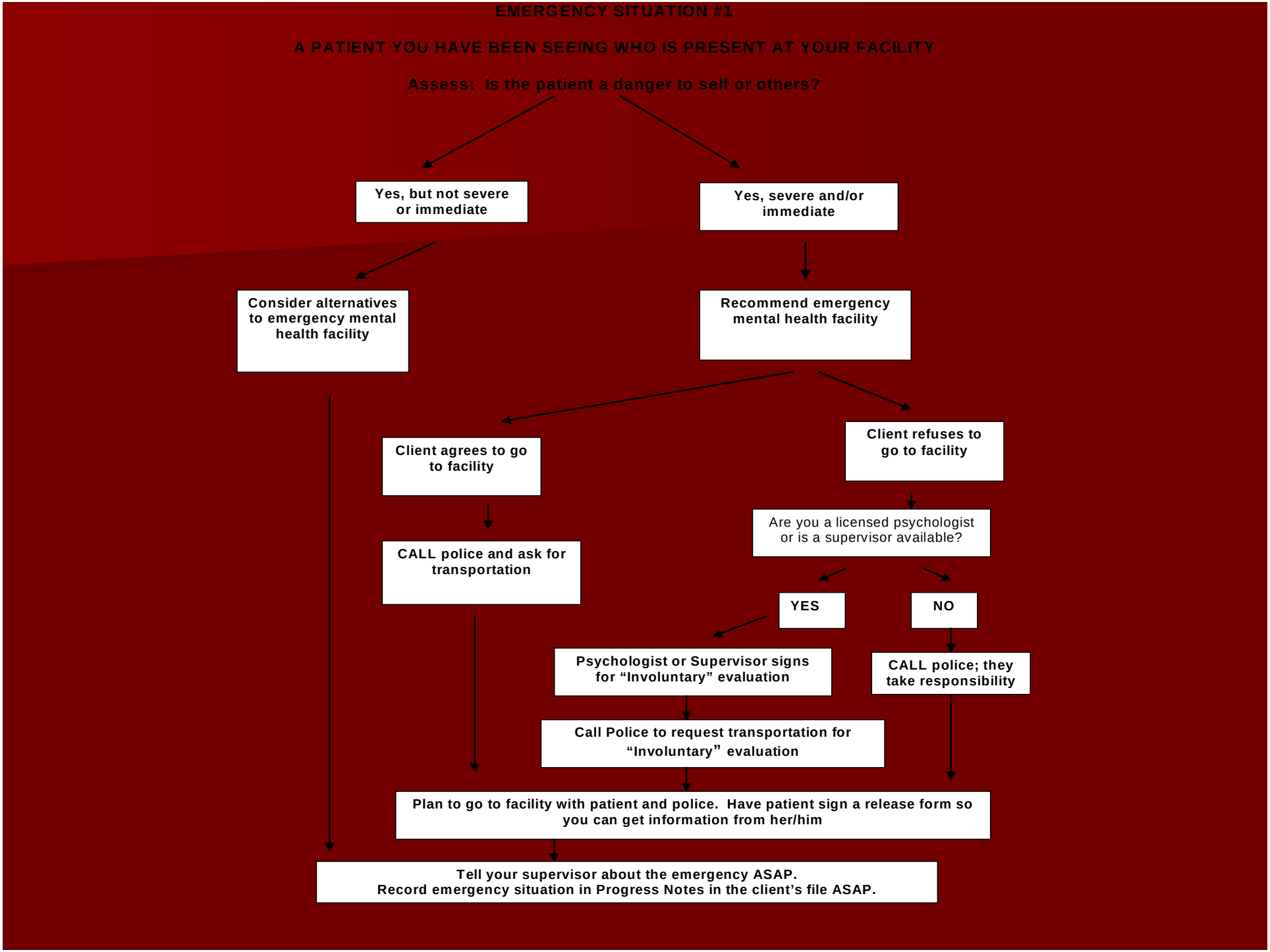
- **Ensure that the patient's records are complete**
- **Be available to assist grieving family members**
- **Remember the medical record is still official and confidentiality still exists**
- **Seek support from colleagues / supervisors**
- **Consult risk managers**

# Consider the Utility of Flow Charts.....

**EMERGENCY SITUATION #1**

**A PATIENT YOU HAVE BEEN SEEING WHO IS PRESENT AT YOUR FACILITY**

**Assess: Is the patient a danger to self or others?**



**EMERGENCY SITUATION #2**

A PATIENT YOU ARE SEEING WHO IS NOT PRESENT AT YOUR FACILITY

Assess: Is the patient a danger to self or others?

**Try to get the patient to come to your facility!! Before the patient hangs up, find out where the patient is located and her/his phone number**

**NO**
**Patient refuses to come to the facility OR patient agrees but you doubt s/he will show**

**CALL POLICE**

**YES**
**Patient agrees to come to the clinic**

**GIVE Patient A TIME LIMIT!!!!**
**"I am expecting you to be at the clinic within an hour. If you are not here, I will send someone to your house."**

**GO BACK TO EMERGENCY SITUATION #1 AND FOLLOW PROCEDURES**

**Tell your supervisor about the emergency ASAP**
**Record emergency situation in the Progress Notes in the patient's file ASAP**

# Risk Management and Malpractice Liability

- Plaintiff attorneys file malpractice wrongful death suits against clinicians listing various complaints (i.e., failures of practice)
- Plaintiff will argue that acts of omission or commission were direct proximate causes of injury or death
- The defending clinician's practice will then be evaluated as per the "standard of care"
- The standard of care is established on a case-by-case basis by experts on both sides who testify as to whether there was or was not a failure to meet the standard of care

# Malpractice and Negligence

- *Dereliction* of
- *Duty*
- *Directly* causing
- *Damages*

# Malpractice: Outpatient

- Failure to address possible need for pharmacotherapy
- Failure to specify criteria and implement hospitalization
- Failure to maintain appropriate clinician-client relationship
- Failure to evaluate for suicide risk: intake, transition points, termination

# Malpractice: Outpatient

- Failure to secure previous records, inadequate history taking
- Failure to monitor mental status, changes
- Failure to diagnosis
- Failure to establish formal treatment plan
- Failure to safeguard environment
- Failure to document judgment, rationale, observations

# What is “The Standard of Care”???

- That degree of care which a reasonably prudent person or professional should exercise in same or similar circumstances (Black, 1979, p. 1260
- The duty of therapists to exercise adequate care and skill in diagnosing suicidality is well established (see Meier v. Ross General Hospital, 1968).
- When the risk of self-injurious behavior is identified an additional duty to take adequate precautions arises (Abille v. United States, 1980; Pisel v. Stamford Hospital, 1980).
- 
- When psychotherapists fail to meet these responsibilities, they may be held responsible for injuries that result (Meyer, Landis, & Hays, 1988, p. 38).

*Bongar, B., Berman, A. L., Maris, R. W., Silverman, M. M., Harris, E. A., & Packman, W. L. (eds.). Risk Management with Suicidal Patients. New York: Guilford Press.*

# Three Pillars of Malpractice Liability

## (Jobes & Berman, 1993)

- Foreseeability
  - Assessment and documentation of risk
- Treatment Planning
  - Documentation of plan based on determined risk
- Follow-up/Follow Through
- Documentation of executing and following the plan

## Forseeability

**Risk assessment was conducted**

**Risk assessment was thorough**

**Possible use of assessment instruments**

**Possible use of psychological testing**

**Make overall clinical judgment of suicide risk**

**Seek consultation and adequately document assessment information**

## Treatment Planning

**Use overall risk to inform and shape treatment plan**

**Identify both short and long term treatment goals**

**Consider full range of treatments—what will be used and why**

**Consider various safety contingencies**

**Routinely revise and up-date treatment plan**

**Overhaul treatment plan when necessary**

**Seek consultation and adequately document treatment information**

## Follow-up and Follow-Through

**Make sure treatments are being implemented**

**Coordinate care with others as needed**

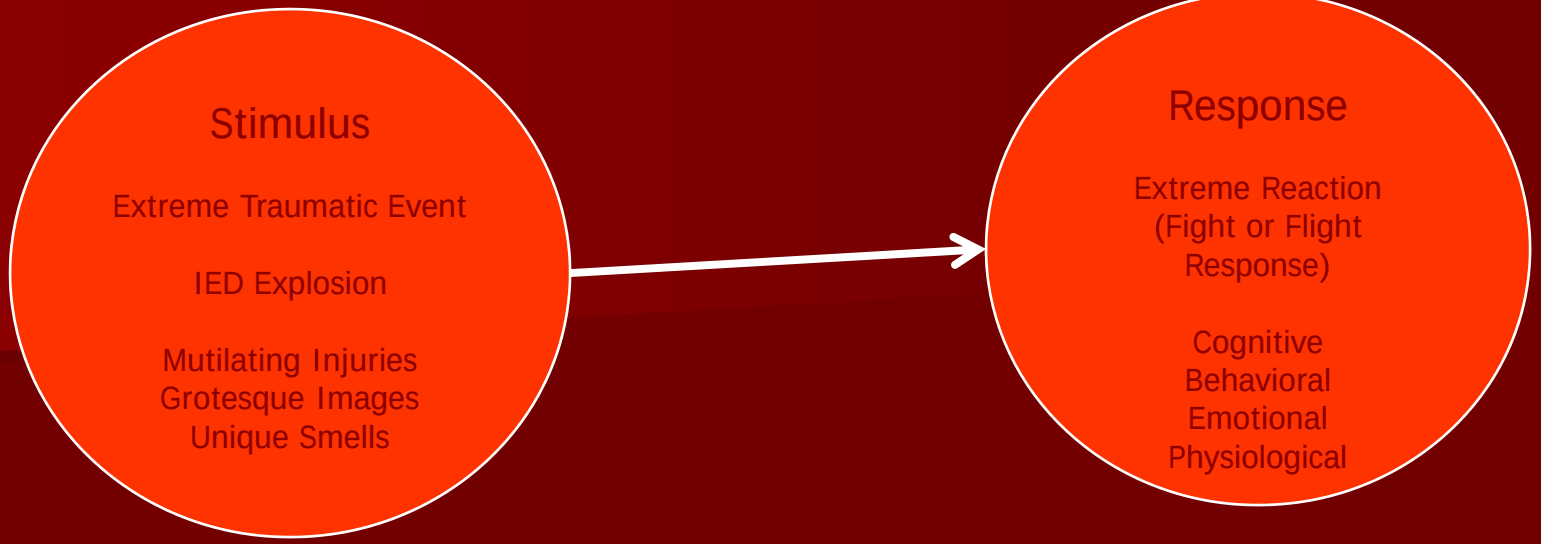
**Always insure clinical coverage when unavailable**

**Carefully make referrals and follow-up (issues of clinical abandonment)**

**Seek consultation and adequately document follow-up/follow-through**

# Etiology of PTSD: Understanding where suicidality fits?


Stimulus
Extreme Traumatic Event
IED Explosion
Mutilating Injuries
Grotesque Images
Unique Smells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IED Explosion
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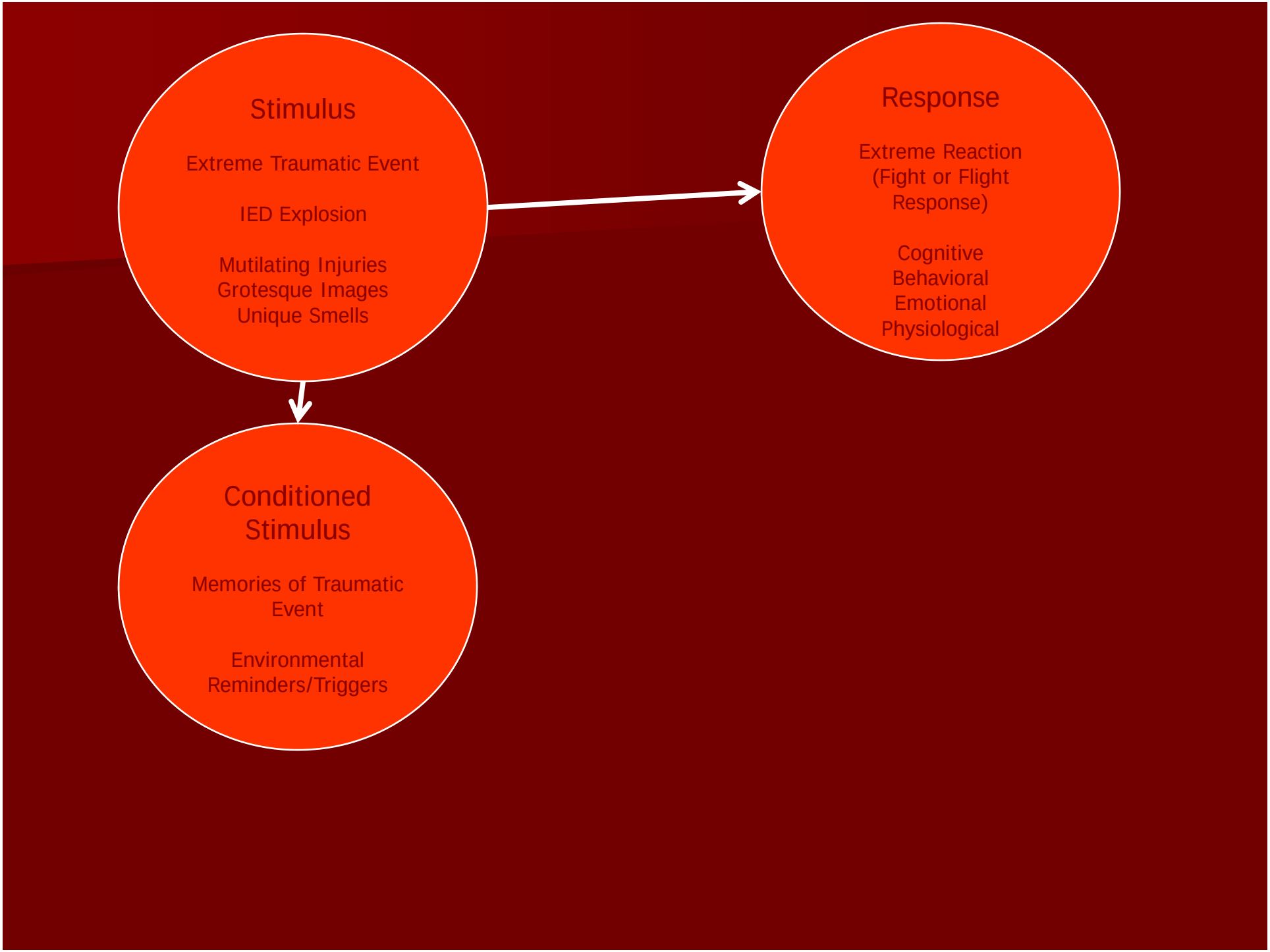
Grotesque Images
Unique Smells
Response
Extreme Reaction
(Fight or Flight
Response)
Cognitive
Behavioral
Emotional
Physiological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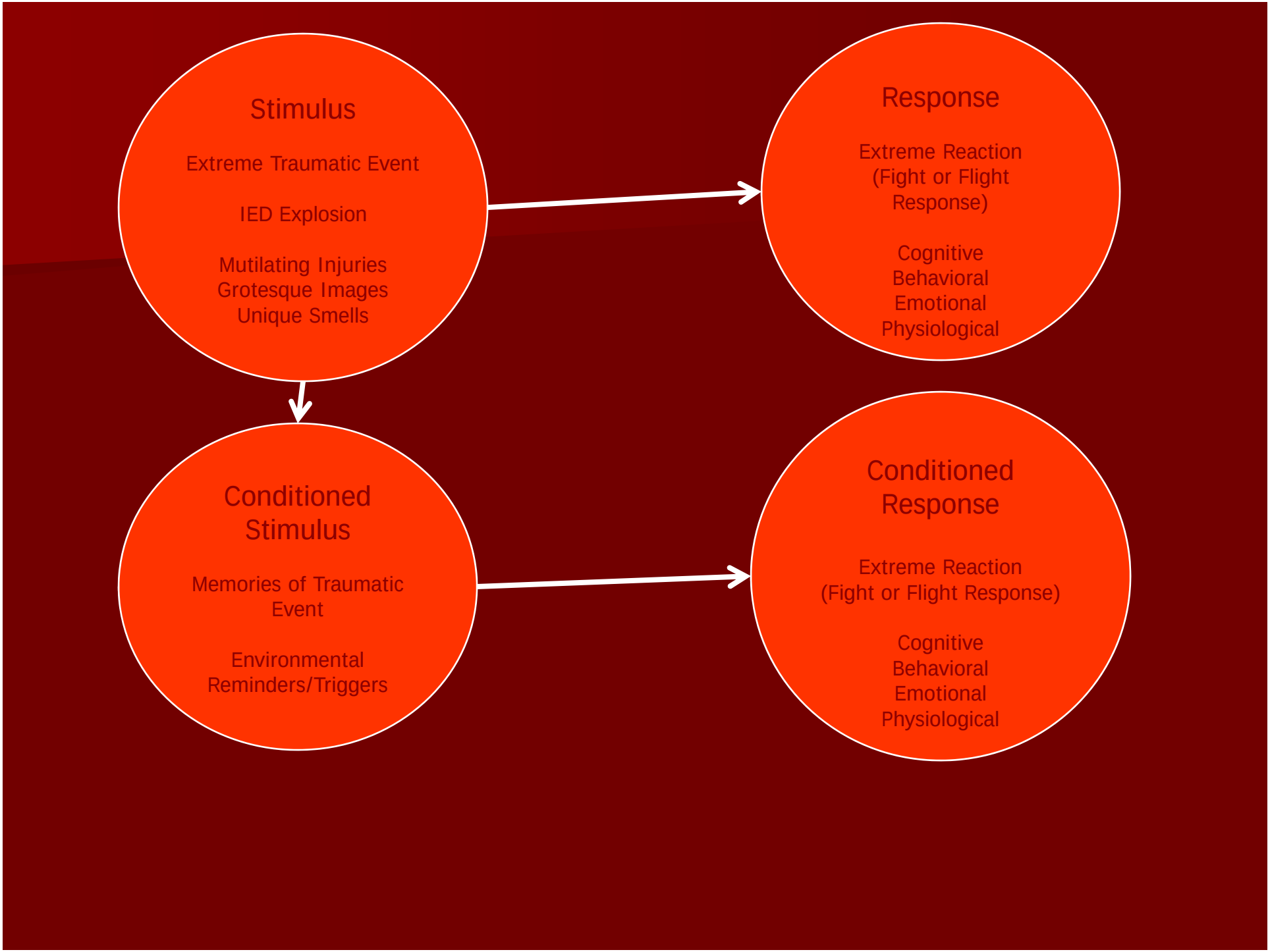
Physiological
Conditioned
Stimulus
Memories of Traumatic
Event
Environmental
Reminders/Triggers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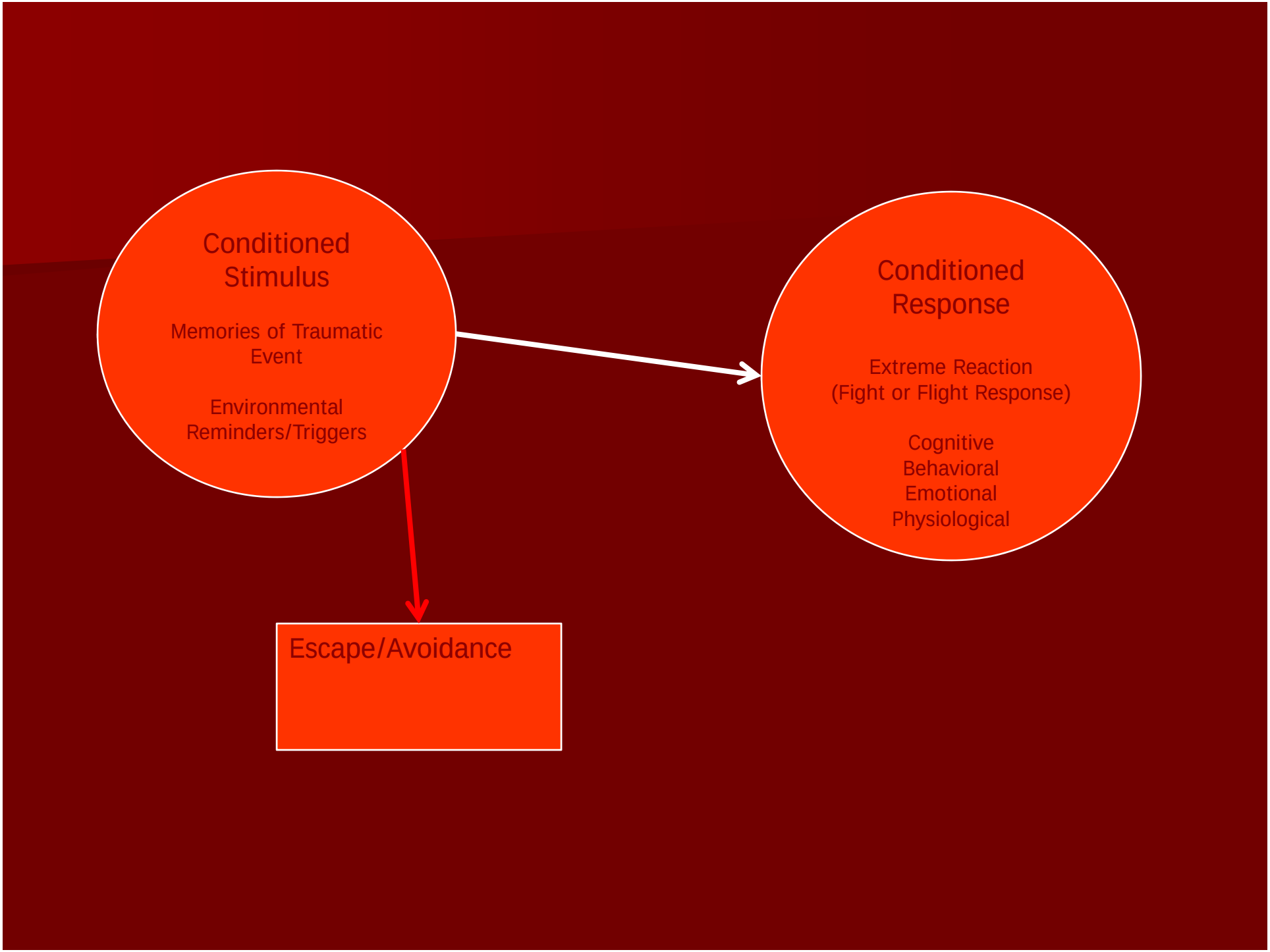
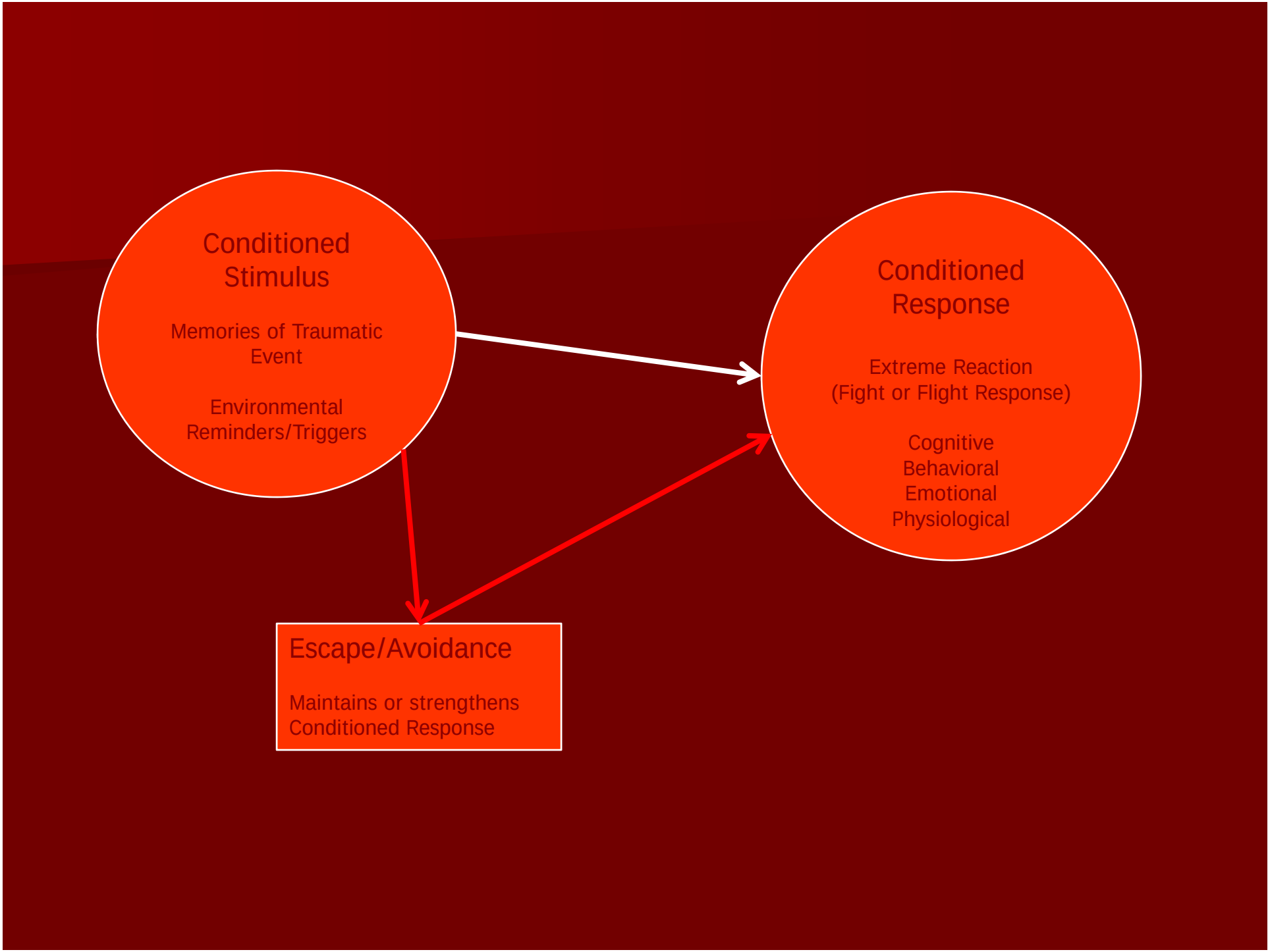

Conditioned Stimulus
Memories of Traumatic Event
Environmental Reminders/Triggers
Conditioned Response
Extreme Reaction (Fight or Flight Response)
Cognitive
Behavioral
Emotional
Physiological
Escape/Avoidance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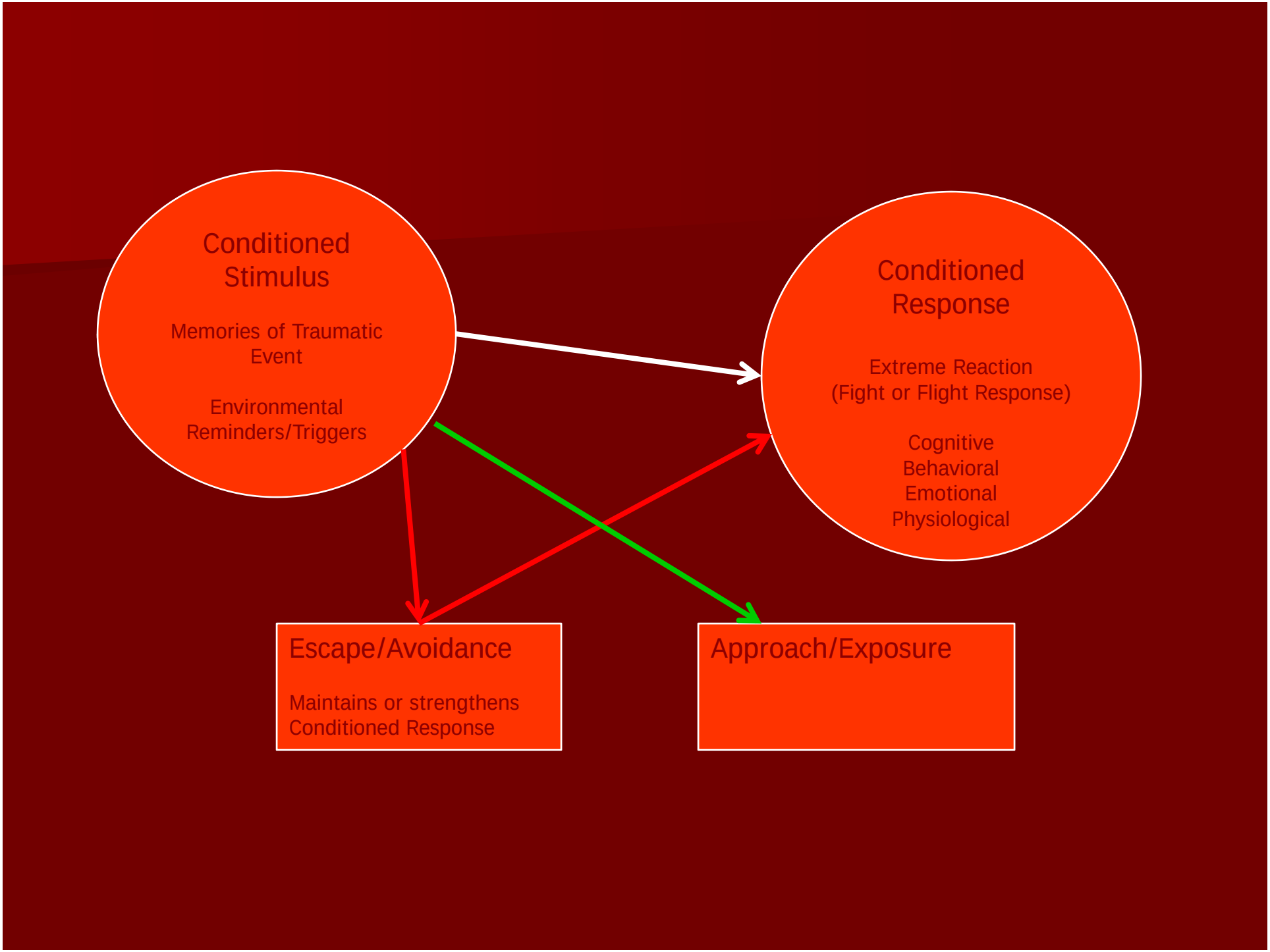
Escape/Avoidance
Maintains or strengthens Conditioned Response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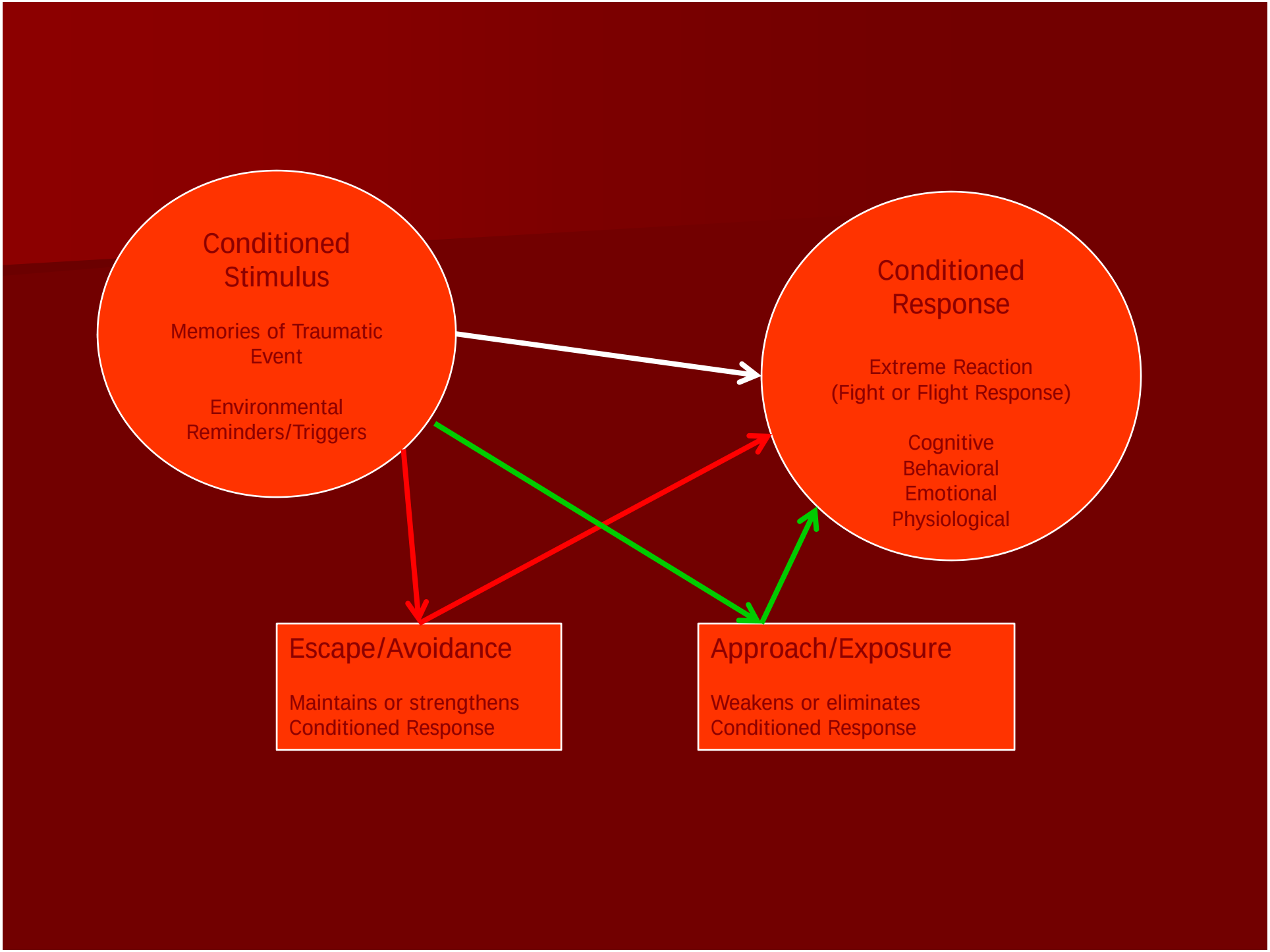
Escape/Avoidance
Maintains or strengthens Conditioned Response
Approach/Exposure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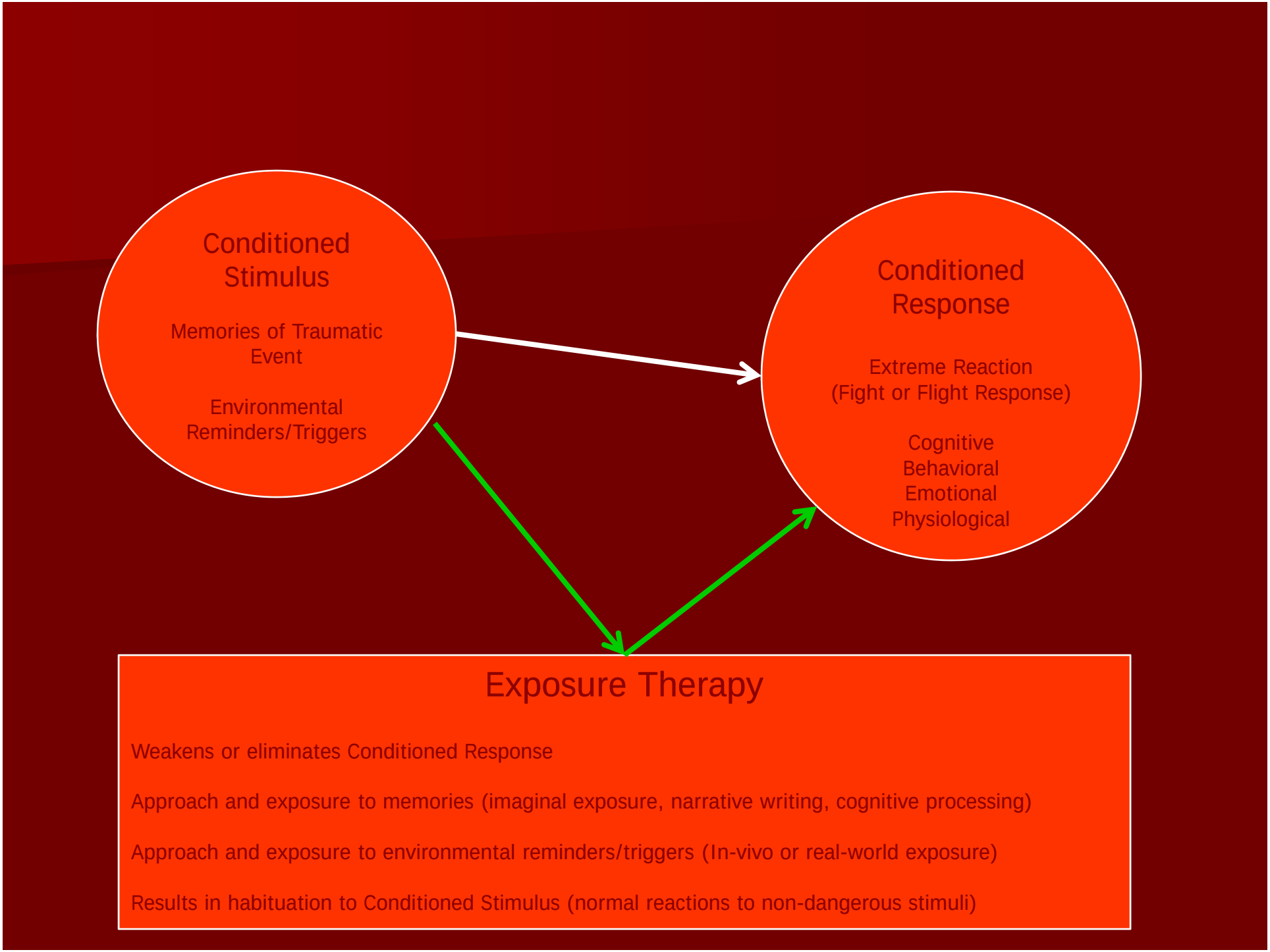
Escape/Avoidance
Maintains or strengthens Conditioned Response
Approach/Exposure
Weakens or eliminates Conditioned Response


Conditioned Stimulus
Memories of Traumatic Event
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Exposure Therapy
Weakens or eliminates Conditioned Response
Approach and exposure to memories (imaginal exposure, narrative writing, cognitive processing)
Approach and exposure to environmental reminders/triggers (In-vivo or real-world exposure)
Results in habituation to Conditioned Stimulus (normal reactions to non-dangerous stimuli)

# What suicide adds to the picture

- Identity-based hopelessness
  - Avoidance involves cognitive elements
  - Guilt and shame
  - Perceived burdensomeness

# Treatment of PTSD

# Treatment of PTSD

- PTSD Clinical Practice Guidelines (PTSD CPG)
- Available on-line at: http://www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm

# Evidence-Based Treatments for PTSD (IOM, 2007)

- The committee concludes that the current scientific evidence is:
  - Sufficient to conclude the efficacy of exposure therapies
  - Inadequate to determine the efficacy of EMDR, cognitive restructuring, coping skills training, and group format psychotherapy
  - Inadequate to determine the efficacy in the treatment of PTSD with pharmacotherapy

# Top Civilian Treatments for PTSD

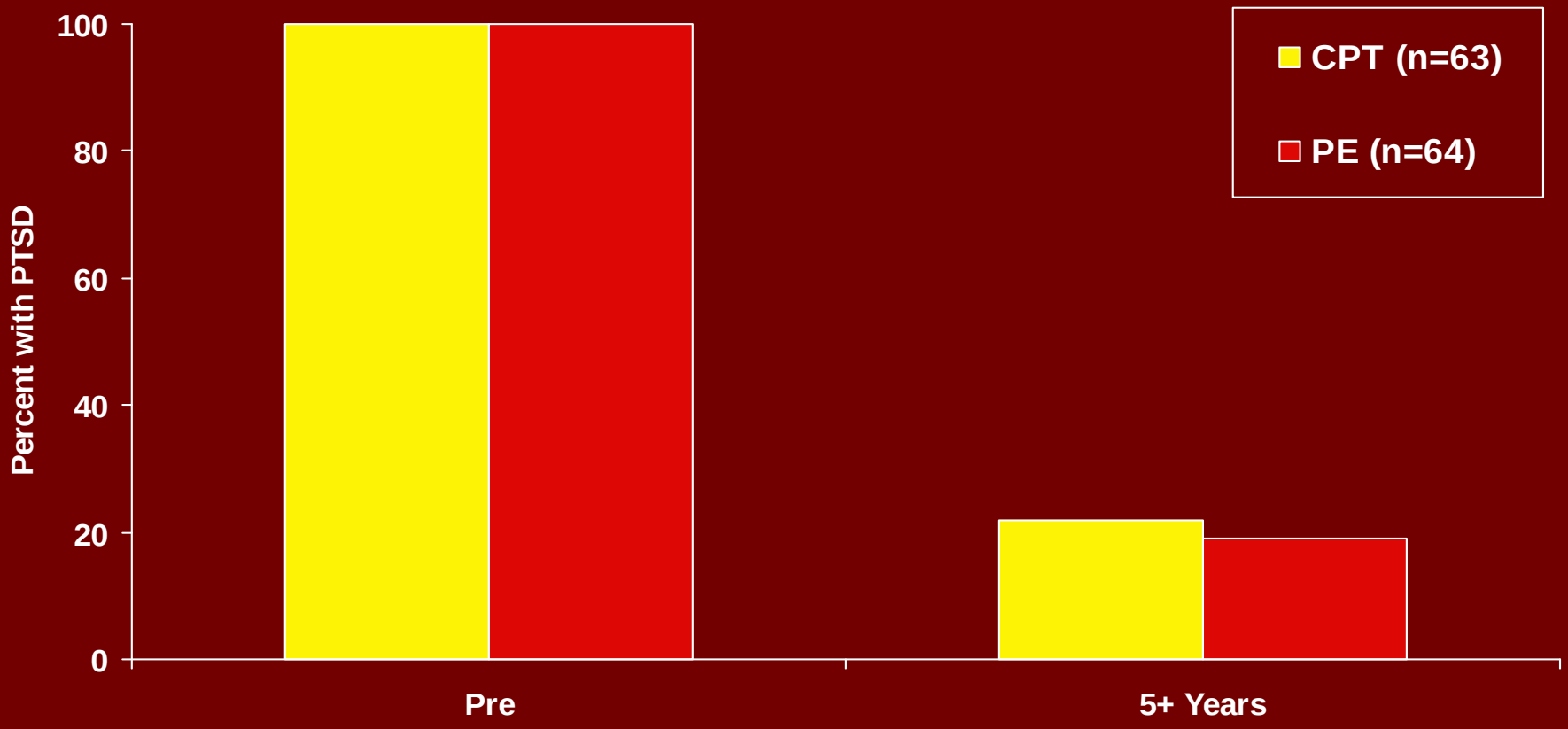
- Prolonged Exposure (PE)
  - Edna Foa, PhD
  - Involves repeated exposure to
    - memories of the trauma
    - trauma-related situations
- Cognitive Processing Therapy (CPT)
  - Patricia Resick, PhD
  - Involves exposure to trauma through
    - Writing and reading accounts of the trauma
    - Challenge and modify maladaptive thoughts and beliefs related to trauma

# Resick et al., 2001

**Treatment of Civilians with PTSD**

- **Prolonged Exposure (PE)**
- **Cognitive Processing Therapy (CPT)**
- **Wait-List**
- **PE treatment 9 weekly sessions (90-minute)**
- **CPT treatment 12 weekly sessions (60-minute)**
- **Treatments equated for contact time**

# Percent with PTSD Diagnosis in Civilians after Tx with PE and CPT




Resick et al., 2005

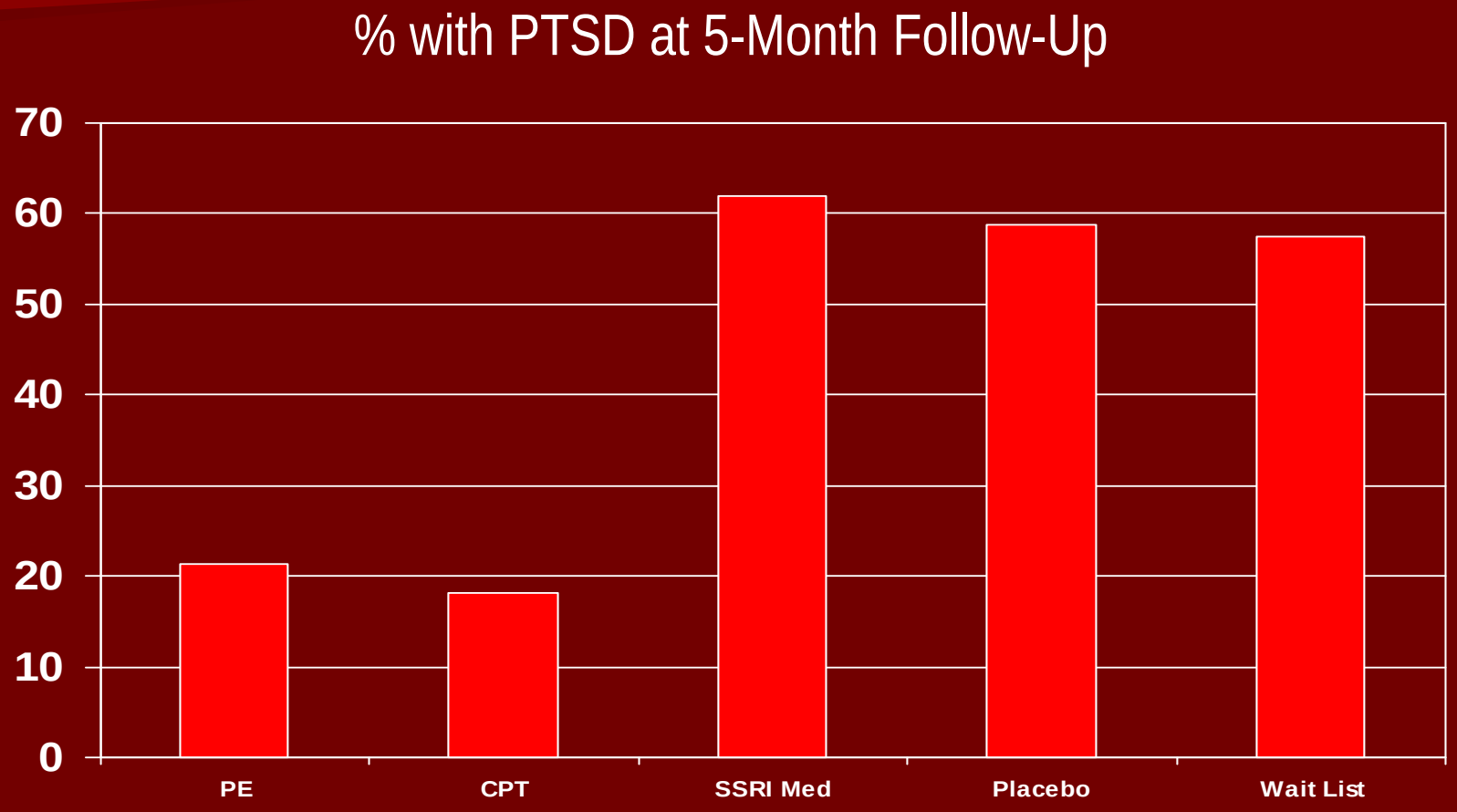
# Prevention of PTSD by Early Treatment of Acute Stress Disorder

# Prevention of PTSD in Civilians by Early Treatment

- Participants
  - Adult survivors of trauma
  - Hadassah University Hospital, Israel between 2003-2007
  - N = 289 with full or partial ASD

Shalev et al., 2008

# Prevention of PTSD in Civilians with Early Treatment




Shalev et al., 2008

# Opportunities and Challenges

# Research Gap Analysis

- Previous clinical trials have targeted:
  - PTSD in civilian populations
  - PTSD in discharged Vietnam veterans
- No clinical trial has ever been published to evaluate treatment of combat-related PTSD in active-duty military personnel

# Lessons from the Vietnam War

- 500,000 Vietnam vets have chronic PTSD
- Rates not decreasing; may be increasing
- Annual cost for disability payments $4.3B
  - 20.5% of all VA compensation payments
- Medical discharge of 1 active duty member for PTSD costs an estimated $250,000 in medical disability alone

# Potential Health Crisis

- U.S. facing potential national health crisis
- Current need to treat active-duty military may exceed current capabilities
- Lack of published clinical trials on treating PTSD in active-duty military
- No evidence-based treatment protocols currently exist for PTSD in active-duty

# Unanswered Questions

- How effective are treatments for combat-related PTSD in active duty military?
- What percentage of patients can be treated to the point of remission, recovery, or the loss of diagnosis?
- What is the impact of redeployment and re-exposure to combat trauma after treatment for PTSD?
- What is the best way to measure impact on occupational or social functioning?

# Unanswered Questions

- Can PTSD be treated in groups?
- Can PTSD be treated in an intensive outpatient program such as daily treatment for 2 weeks?
- Can exposure therapy treatments be delivered in primary care settings?
- Can PTSD be treated more effectively with spouse involved in therapy?
- Can PTSD be treated during deployment?

# Unanswered Questions

- What is the impact of comorbid conditions on the treatment of PTSD and:
  - TBI?
  - Substance abuse?
  - Burn?
  - Amputee?
  - Chronic pain?
  - Insomnia and other sleep disorders?

# Unanswered Questions

- How does the brain change after effective treatment for PTSD?
- Are there genetic factors that determine who develops combat-related PTSD?
- Can PTSD be prevented by using prophylactic medications?
- What factors are related to risk and resiliency?