Centering + Connecting
Introductions + Reflections

What have you noticed makes suicide difficult to talk about w/ clients? w/ colleagues? w/ CITs?

How do you incorporate assessment into your work? What assessments do you conduct?

What strategies do you use to treat suicide? Supervise?

How is suicide prevention included within your clinical work? In your curriculum?
Assessing, Treating, and Preventing Suicide as Professional Counselors and Counselor Educators

Gideon Litherland MA, LCPC, CCMHC, BC-TMH
Clinical Counselor, Supervisor, and Consultant
Veduta Consulting, LLC.
Language Matters
Choosing Compassionate & Accurate Language

Died of/by Suicide \textit{vs} Committed Suicide
Suicide \textit{vs} Successful Attempt
Suicide Attempt \textit{vs} Unsuccessful Attempt
Describe Behavior \textit{vs} Manipulative/Attention-Seeking
Describe Behavior \textit{vs} Suicidal Gesture/Cry for Help
Diagnosed with \textit{vs} they're Borderline/Schizophrenic
Working with \textit{vs} Dealing with Suicidal Patients
Suicides by County

- 15 or fewer (28)
- 15 to 28 (21)
- 29 to 60 (25)
- 61 or above (29)
Learning Objectives

1. Define ITS and its related constructs

2. Demonstrate increased confidence in assessing, treating, and preventing suicide

3. Apply ITS to clinical and training environments
Learning Objectives

1. Define ITS and its related constructs
   a. Develop research-driven treatment plans, assessments, and relationships (2009: III.G.2)
   b. Link andragogy practices to reflect current research knowledge and projected public mental health needs (2016: 2.B, E)

2. Demonstrate increased confidence in assessing, treating, and preventing suicide
   a. Apply self-reflective, critical counseling theory and related competencies to assessment, treatment, and prevention of suicide (2009: III.D.2, 9; III.F.3)
   b. Utilize procedures for assessing risk of suicide (2016: 2.F.1.c, d; 2.F.7.c, e)

3. Apply ITS to current caseload
   a. Conceptualize and utilize the treatment relationship to create insight, facilitate change, and identify treatment foci (2009: II.G.5.b, c, d; 2016: 2.F.3.g, h; 2.F.5.f-l)
Agenda

● Situating suicide within our context
● Fundamentals of Interpersonal Theory of Suicide
  ○ Theory
  ○ Practice Implications
● Integration into training and clinical work
● Debrief/Q+A
National Context
“At a global level, suicide is down by 29% since 2000.”

November 24, 2018
“The suicide rate in America is up by 18% since 2000.”

November 24, 2018
Suicide rate up 33% in less than 20 years, yet funding lags behind other top killers

Suicide rates are up 33% in the U.S., yet funding lags behind that of all other top causes of death — leaving suicide research in its “infancy.”

Anne Godlasky and Alia E. Dastagir, USA TODAY
9:32 p.m. CST Dec. 2, 2018
The suicide rate has increased more than 33%
Only accidents have increased faster

- Accidents: 39.9%
- Suicide: 33.3%
- Chronic respiratory disease: -9.9%
- Cancer: -24.1%
- Heart disease: -38.1%
- Stroke: -39%

Source: NIH, Centers for Disease Control and Prevention
NIH spending on suicide research is dwarfed by spending for the other leading causes of death

- Cancer: $6 billion
- Heart disease: $1.37 billion
- Alzheimer’s: $1.36 billion
- Diabetes: $1.11 billion
- Cerebrovascular: $610 million
- Kidney disease: $592 million
- Accidents: $496 million
- Pneumonia and Influenza: $408 million
- Suicide: $68 million

Source: NIH, Centers for Disease Control and Prevention
NIH spending on suicide research is dwarfed by spending for the other leading causes of death

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Source: NIH, Centers for Disease Control and Prevention
From 2007 to 2017, the annual rate of deaths by suicide for adolescents (15-19 yo) has increased:

7 suicides per 100,000 in 2007

12 suicides per 100,000 in 2017

(Lindsey, Sheftall, Xiao, & Joe, 2019)
From 2007 to 2017, the annual rate of deaths by suicide for adolescents (15-19 yo) has increased:

The most dramatic increase was found for black girls:

- **7 suicides per 100,000 in 2007**
- **12 suicides per 100,000 in 2017**
- **1.2 suicides per 100,000 in 2007**
- **4 suicides per 100,000 in 2017**

(Lindsey, Sheftall, Xiao, & Joe, 2019)
Our

Context
Issues in Counselor Education

A bleak picture....
Issues in Counselor Education

Jahn, Quinnett, & Ries (2016, n=289 mental health workers)

• 48.4% reported feeling fearful of patient death by suicide
• 29.8% reported their suicide training was not sufficient
Issues in Counselor Education

Schmitz et al. (2012)

- 76% of directors of graduate programs in psychology report encountering barriers to including more suicide-specific training
- <25% of social workers reported receiving any training in suicide prevention, majority of which reported it as inadequate
Issues in Counselor Education

Wachter Morris & Barrio Minton (2012, n=193 post-master’s PC)

- 67.4% reported NOT taking a crisis course during MA/MS/MEd
- Reported “NO” or “MINIMAL” training:
  - 71.5% in community disaster intervention
  - 70.99% in crisis theory
  - 60.63% in crisis related to physical assault
  - 59.58% in crisis related to sexual assault
  - 57.51% in collaboration skills for crisis intervention
  - 26.95% in suicide assessment
Greater Risk of Suicide

Major Depressive Disorder
Bipolar Disorder
Anorexia Nervosa
Schizophrenia
Borderline Personality Disorder

Do you see these presentations?
Use this pocket card as a job aid or training tool when implementing universal suicide screening in acute care settings.

The Patient Safety Screener can be used during the Triage or Primary Nursing Assessment in acute care settings. Ask all three screening questions. Do not skip items.

**Introduction**

"Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy, and it helps us to make sure we are not missing anything important."

<table>
<thead>
<tr>
<th>Depression</th>
<th>1. Over the past 2 weeks, have you felt down, depressed, or hopeless?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal ideation</th>
<th>2. Over the past 2 weeks, have you had thoughts of killing yourself?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicide attempt</th>
<th>3. Have you ever attempted to kill yourself?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

...3a. If Yes to item 3, ask: when did this last happen?

- Within the past 24 hours (including today)
- Between 1 and 6 months ago
- More than 6 months ago
- Refused
- Patient unable to complete

**TIPS**

- Ask all questions exactly as worded
- Do not bundle or re-word questions
- Treat the patient with empathy

**Patient Safety Screener (PSS-3) Pocket Card**

The Patient Safety Screener 3 (PSS-3) has been validated in prospective studies and is detailed in Boudreaux et al. (2015)
Learning Objectives

1. Define ITS and its related constructs

2. Demonstrate increased confidence in assessing, treating, and preventing suicide

3. Apply ITS to clinical and training environments
A good theory....

Helps focus clinicians & Predicts outcomes
What theoretical model of suicide do you use clinically?

What theoretical model of Suicide do you teach CITs?
<table>
<thead>
<tr>
<th>Model of Suicidal Behaviour</th>
<th>Author</th>
<th>Basic Premise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cubic model of suicide</td>
<td>Shneidman (1985)</td>
<td>The combination of press (stress), pain (psychache), and perturbation result in suicide risk</td>
</tr>
<tr>
<td>Diathesis-stress-hopelessness model of suicidal behaviour</td>
<td>Schotte and Clum (1987)</td>
<td>Cognitive vulnerability (eg, social problem solving) accounts for the association between stress and suicide risk</td>
</tr>
<tr>
<td>Suicide as escape from self</td>
<td>Baumeister (1990)</td>
<td>Main motivation of suicide is to escape from painful self-awareness</td>
</tr>
<tr>
<td>Clinical model of suicidal behaviour</td>
<td>Mann and colleagues (1999)</td>
<td>Stress-diathesis model, wherein suicide risk is caused not only by psychiatric disorder (stressor) but also by a diathesis (ie, tendency to experience more suicidal ideation or impulsivity)</td>
</tr>
<tr>
<td>Suicidal mode as cognitive behavioural model of suicidality</td>
<td>Rudd and colleagues (2001)</td>
<td>Based on the ten principles of cognitive theory, the model describes the cognitive, affective, behavioural, and physiological system characteristics associated with the development of suicide risk</td>
</tr>
<tr>
<td>Arrested flight model</td>
<td>Williams (2001)</td>
<td>Suicide risk is increased when feelings of defeat and entrapment are high and the potential for rescue (eg, social support) is low</td>
</tr>
<tr>
<td>Interpersonal-psychological model</td>
<td>Joiner (2005)</td>
<td>Suicidal desire is caused by high levels of burdensomeness, and thwarted belongingness; desire is probably translated into suicidal behaviour when capability is high</td>
</tr>
<tr>
<td>Schematic appraisal model of suicide</td>
<td>Johnson and colleagues (2008)</td>
<td>An appraisal model which proposes that risk is caused by the interplay between biases in information processing, schema, and appraisal systems</td>
</tr>
<tr>
<td>Differential activation theory of suicidality</td>
<td>Williams and colleagues (2008)</td>
<td>Associative network model, in which the experience of suicidal ideation or behaviour during a depressive episode increases the likelihood that it will re-emerge during subsequent episodes</td>
</tr>
<tr>
<td>Integrated motivational-volitional model of suicidal behaviour</td>
<td>O’Connor (2011)</td>
<td>The model is a diathesis–stress model, which specifies the components of the premotivational, motivational (ideation and intent formation), and volitional (behavioural enactment) phases of suicidality</td>
</tr>
</tbody>
</table>
Interpersonal Theory of Suicide (ITS)
Thwarted Belongingness

- Loneliness
- (lack of) Reciprocal Care

Perceived Burdensomeness

- Self-hate
- Liability

Passive Suicidal Ideation

Active Suicidal Ideation

Suicidal Intent

- Serious Suicide Attempt
- Lowered Fear of Death
- Pain Insensitivity
- Acquired Capability

Hopelessness

(Van Orden, Witte, et al., 2010, Psychological Review)
Interpersonal Theory of Suicide

Why do people die by suicide?
Who attempts suicide?
Interpersonal Theory of Suicide

People die by suicide because they want to and because they’re able to.
Interpersonal Theory of Suicide

People die by suicide because they want to and because they’re able to.
Interpersonal Theory of Suicide

Suicidal desire + Capability = Suicide attempt
Fundamental Constructs

Perceived Burdensomeness (PB)
Fundamental Constructs

Perceived Burdensomeness (SD)

Self-perceptions of incompetence; Misperception of being suicide being worth more to others than their lives

Sense of “defectiveness or flawed-ness” that one’s existence burdens family, friends, and society

“I am a burden.”
Perceived Burdensomeness

Liability
My death is worth more than my life to others.

Perceived burdensomeness
I am a burden.

Self-Hate
I hate myself.

Distress from homelessness

Distress from Incarceration

Distress from unemployment

Distress from physical illness

Low self-esteem

Self-blame, shame

Agitation

Expendability, unwanted

Belief that one is a burden on family
Fundamental Constructs

Thwarted Belongingness (SD)
Thwarted Belongingness (SD)

Innate need to connect with others through relationships

Absence of positive, frequent, perceptions of care

“I don’t belong anywhere or with anyone.”

“I am alone.”
Thwarted Belongingness

Self report loneliness
Pulling Together
Caring letters prevention
Seasonal variation
Marriage, # children, friends
Living alone, few social supports; non-intact family

Loneliness
I feel disconnected from others

Social withdrawal
Single jail cell
Domestic Violence
Loss through death/divorce
Childhood abuse
Family Conflict

(Absence of) Reciprocal Care
I have no one to turn to & I don’t support others.
Fundamental Constructs

Acquired Capability (AC)
Pain
Fundamental Constructs

Acquired Capability (C)

- Diminished pain and fear response due to repeated exposure to painful and provocative experiences (Fearlessness)

- Direct pathway: previous suicide attempts, intensity of ideation

- Indirect pathway: painful/provocative events, ACEs, NSSI

History of painful and provocative experiences
Acquired Capability

Opponent Process Theory (Solomon & Corbit, 1974)

Skydiving Study: Beginners experience extreme fear, then relief upon landing. With repeated jumps the fear decreases and post-jump pleasure increases. Emotional reactions to a stimulus are followed by opposite reaction with conditioning. *Thanks, social psychology friends!

Scary things become less scary and painful things become less painful over time.
Acquired Capability

- Lowered fear of death
- Elevated physical pain tolerance

Factors influencing Acquired capability:
- Family history of suicide
- Serotonergic dysfunction
- Impulsivity
- Clustering/exposure to suicidality
- Combat exposure
- Suicide attempts
- Childhood maltreatment
People die by suicide because they want to and because they’re able to.
Interpersonal Theory of Suicide

Suicidal desire + Capability = Suicide attempt
(Van Orden, Witte, et al., 2010, *Psychological Review*)
Symptom Clusters

Suicidal Desire and Ideation

- Absence of reasons for living, wish to die, frequency of ideation, wish to not live, passive attempt, desire for attempt, expectancy of attempt, lack of deterrents to attempt, talk of death or suicide

Resolved Plans and Preparation

- Sense of courage or competence to make attempt, availability of means and opportunity for attempt, specificity of plan for attempt, preparations for attempt, duration of suicidal ideation, intensity of ideation
So, what about non-suicidal self-injury (NSSI)?
Nonsuicidal Self-Injury (NSSI)

“...refers to the intentional destruction of one’s body tissue without suicidal intent and for purposes not socially sanctioned.”

(Klonsky, Muehlenkamp, Lewis and Walsch, 2011, p. 6)
Nonsuicidal Self-Injury (NSSI)

“...refers to the intentional destruction of one’s body tissue without suicidal intent and for purposes not socially sanctioned.”

Question: Theoretically, NSSI reinforces Suicidal Desire or Acquired Capability?

(Klonsky, Muehlenkamp, Lewis and Walsch, 2011, p. 6)
Quick Tip!

The best predictor of NSSI is previous NSSI.

How does this inform our clinical stance?
Examples include:

- Skin cutting, scraping, or carving
- Banging, bruising, and self-hitting
- Biting
- Skin picking
- Wound excoriation
- Bone breaking

What else have you seen in your clinical practice?
Taxonomy of NSSI

- **Major NSSI**
  - This includes a one time, significant event of self-injury. Generally occurs during psychosis. E.g. self-castration, self-amputation, actions requiring an implement/device

- **Stereotypic NSSI**
  - Tends to occur quite frequently and is often associated with a developmental disability of some sort. E.g. biting, head banging, hitting.

- **Superficial to Moderate NSSI**
  - This is our focus and concern related to suicide. These behaviors are often ritualistic and can be compulsive, episodic, or repetitive in nature. E.g. hair pulling, cutting, and burning.
Quick Tip!

In general, things like binging, purging, food restriction, and excessive alcohol or substance use are not considered NSSI.

Why?
NSSI Assessment

Foci

- Previous NSSI
  - History
    - (methods, recency, frequency, severity, location of injury, number of wounds)
  - Urge
    - frequency and resistance capacity
  - Context
    - Environmental, cognitive, affective, biological variables
    - Timeline: before, during, after (targets for intervention!)
  - Functions
    - Intrapersonal/automatic: regulating emotions *(most common)*
    - Interpersonal/social: desire to receive care; bond; assert autonomy
  - Suicidality
    - Habituation to painful, violent, and provocative experiences
NSSI Assessment Foci

- Comorbidity
  - Borderline Personality Disorder
  - Psychiatric illness (MDD, BPD, PTSD, Sub Use Disorders, ED)

- Personality Factors
  - **Emotionality**: reactivity and sensitivity result in intense and persistent experience of negative emotions.
  - **Self-Derogation**: Anger, self-loathing lead to self-punishment.
  - **Impulsivity**: Urgency is profound, lack of ability to resist acting on urge during negative emotion.

ISAS Assessment ([Klonsky & Glenn, 2009](#))
Discussion Question: Where does NSSI fit into a discussion of suicide?
Suicide + Nonsuicidal Self-Injury (NSSI)

Assessment

Crisis Intervention

Treatment

Prevention
ITS: Practice Implications
ITS: Practice Implications
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Crisis Intervention</th>
<th>Treatment</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus: Determine <strong>level of risk</strong> to die by suicide</td>
<td>Focus: Recognize triggers, deactivate suicidal thought processes, access emergency care</td>
<td>Focus: Increase mind/planfulness, emotional and behavioral regulation; <strong>SCRIPT</strong>; Therapeutic relationship</td>
<td>Focus: Reduce morbidity of suicide among individuals who have not exhibited signs or symptoms; Decrease suicidal desire in clts</td>
</tr>
</tbody>
</table>

### Perceived Burdensomeness
**Target:** Desire to die

**Tools:** Interpersonal Needs Questionnaire (INQ), Expendable Child Measure

- No current suicidal ideation
- NSPL (1.800.273.TALK)
- Monitor exposure to **prosuicide** materials
- Elicit social support

### Thwarted Belongingness
**Target:** Absence of meaningful connection

**Tools:** INQ

- Moderate Risk
  - Midweek phone check-ins
  - Inform about adjunctive treatments
  - **Commitment-to-Treatment Statement** (CTS)

### Acquired Capability
**Target:** Fearlessness

**Tools:** Impulsive Behavior Scale; Painful and Provocative Events

- Imminent/High Risk
  - Clt to be accompanied and monitored at all times
  - Remove access to lethal means
  - Hospitalization per completed Safety Plan (choice of hospitals, activities to be attended to)

### Secondary (at risk populations)
- Recent suicide attempters
- Older adults
- Children and adolescents

**Primary (general population)**
- Limit access to lethal methods
- Public education about warning signs
  - 1st Tier
  - 2nd Tier
- Mass media campaigns
  - Awareness of resources
  - Change attitudes about suicide
Assessment

Stance: nonalarmist and nondismissive

- Risk factors v. warning signs
  (static)          (dynamic/proximal)

AAS’  IS  PATH  WARM

(ideation, substance use; purposelessness, agitation, trapped, hopelessness; withdrawal, anger, restlessness, mood changes)
Assessment
Assessment

Focus: determine level of risk to die by suicide

- Interpersonal Needs Questionnaire
- Expendable Child Measure
- Impulsive Behavior Scale, Painful and Provocative Events Scale
- Acquired Capability for Suicide Scale
- Decision Tree Interview
Assessment

Acquired Capability for Suicide Scale

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

0 1 2 3 4
Not at all like me

Very much like me

1. Things that scare most people do not scare me.
2. The sight of my own blood does not bother me.
3. I avoid certain situations (e.g., certain sports) because of the possibility of injury.*
4. I can tolerate a lot more pain than most people.
5. People describe me as fearless.
6. The sight of blood bothers me a great deal.*
7. The fact that I am going to die does not affect me.
8. The pain involved in dying frightens me.*
9. Killing animals in a science course would not bother me.

10. I am very much afraid to die.*
11. It does not make me nervous when people talk about death.
12. The sight of a dead body is horrifying to me.*
13. The prospect of my own death arouses anxiety in me.*
14. I am not disturbed by death being the end of life as I know it.
15. I like watching aggressive contact in sports games.
16. The best parts of hockey games are the fights.
17. When I see a fight, I stop to watch.
18. I prefer to shut my eyes during the violent parts of movies.*
19. I am not at all afraid to die.
20. I could kill myself if I wanted to. (Even if you have never wanted to kill yourself, please answer this question.)

* denote reverse scored
### Assessment

**Decision Tree Interview**


<table>
<thead>
<tr>
<th><strong>Assess History of Suicidal Behavior:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Past suicidal behavior: Have you attempted suicide in the past? How many times? Methods used?</td>
</tr>
<tr>
<td>What happened (e.g., went to hospital)?</td>
</tr>
<tr>
<td>2. Do you have a history of non-suicidal self-injury? (e.g., burning, cutting, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assess Suicidal Desire and Ideation:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Have you been having thoughts or images of suicide?</td>
</tr>
<tr>
<td>4. Do you ever think about wanting to be dead?</td>
</tr>
<tr>
<td>5. Frequency of ideation: How often do you think about suicide?</td>
</tr>
<tr>
<td>6. What reasons do you have for dying? What reasons do you have to continue living?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assess Resolved Plans and Preparations:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Duration [look for pre-occupation]: When have these thoughts, how long do they last?</td>
</tr>
<tr>
<td>8. Intensity: How strong is your intent to kill yourself? (0 = not intense at all, 10 = very intense)</td>
</tr>
<tr>
<td>9. Specified plan [look for vividness, detail]: Do you have a plan for how you would kill yourself?</td>
</tr>
<tr>
<td>10. Means and opportunity: Do you have [the pills, a gun, etc.]? Do you think you’ll have an opportunity to do this?</td>
</tr>
<tr>
<td>11. Have you made preparations for a suicide attempt? [e.g., buying pills]</td>
</tr>
<tr>
<td>12. Do you know when you expect to use your plan?</td>
</tr>
<tr>
<td>13. Courage &amp; competence: How scared do you feel about making an attempt? How courageous do you feel about making an attempt? How able do you feel to make an attempt?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assess Other Significant Findings:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Precipitant stressors: Has anything especially stressful happened to you recently?</td>
</tr>
<tr>
<td>15. Hopelessness: Do you feel hopeless?</td>
</tr>
<tr>
<td>16. Impulsivity: When you’re feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? [e.g., drinking alcohol, running away, binge eating]</td>
</tr>
<tr>
<td>17. Has anyone in your family made a suicide attempt or died by suicide? Relationship to you? Thoughts and feelings about this?</td>
</tr>
<tr>
<td>18. Presence of psychopathology (rated by interviewer)</td>
</tr>
<tr>
<td>19. Thwarted belongingness: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you’re feeling badly? [are supportive relationships completely absent?]</td>
</tr>
<tr>
<td>20. Perceived burdensomeness: Sometimes people think: “The people in my life would be better off if I were gone.” Do you think that? In what ways do you feel like you contribute meaningfully to those around you? (e.g., at work, at home, in the community)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Protective Factors:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Adequate social support (use responses to item 19 to assess this)</td>
</tr>
<tr>
<td>22. Responsibility to others (use responses to item 20 to assess this)</td>
</tr>
<tr>
<td>23. Good problem-solving ability: When you are experiencing distress, what do you do to resolve it? When you encounter something difficult, do you sometimes feel like you have no idea what to do to get through it?</td>
</tr>
<tr>
<td>24. Cultural and religious beliefs against suicide</td>
</tr>
</tbody>
</table>
ITS: Practice Implications
Crisis Intervention
Crisis Intervention

Focus: recognize triggers, deactivate suicidal thought process, access emergency care

- Level of risk determined by Decision Tree Interview
Crisis Intervention

- No current suicidal ideation
  - NSPL (1.800.273.TALK) + CTL “START” to 741741
  - Monitor exposure to prosuicide materials
  - Elicit social support; rally allies!
Crisis Intervention

● Low Risk
  ○ Crisis Card
  ○ Mood Graphing
  ○ Symptom-Matching Hierarchy
  ○ Physical or Digital Hope Kit
Crisis Intervention

- **Moderate Risk**
  - Midweek phone check-ins
  - Inform about adjunctive services
  - **Commitment-to-Treatment Statements**

- **Imminent/High Risk**
  - Remove access to lethal means
  - Hospitalization per completed Safety Plan
ITS: Practice Implications

- Assessment
- Intervention
- Treatment
- Prevention
Treatment
Thwarted belongingness
I am alone

Desire for suicide

Perceived burdensomeness
I am a burden

Capability for suicide

Lethal (or near-lethal) suicide attempts
Treatment

Suicidal Desire
● Perceived burdensomeness + Thwarted belongingness are more dynamic and malleable

Capability
● Acquired Capability is considered trait-like, static
Treatment

Self-control Regulation Interpersonal Psychotherapy

(SCRIPT)
Treatment

Foci:

● Increase mindfulness and planfulness
● Increase ability to emotionally and behaviorally regulate in times of stress
● Therapeutic relationship
Treatment

Targeting planfulness and emotion regulation

- Thorough assessment
  - Motivational Interviewing (MI)
- Stress tolerance + Emotion regulation
- Fostering mindful awareness
- Relapse prevention
- Social Activation
Therapeutic Relationship

- Foster autonomy
- Sense of togetherness/teanwork
- Openness about all aspects of treatment
- Between-session accessibility (check w/ Sup)
- Interpersonal process (Teyber & McClure, 2011)
Therapeutic Relationship

Foster autonomy

- Autonomy support strategies!

  Perspective taking + Choice provision + Rationale provision
Therapeutic Relationship

Sense of togetherness/teamwork

- Sit next to client during session
- Interpersonal Discrimination Exercise
- Attend to psychopathology dynamics in SPMI (e.g. reassurance seeking + depression)
Therapeutic Relationship

Openness about all aspects of treatment

- Behavioral incident - focus on details of ideation and behavior at the time of event
- Gentle assumption - “What ways have you thought of killing yourself?”, not “Have you thought of killing yourself?”
- Denial of specificity - “Have you thought of methods of killing yourself?”, not “Have you thought of jumping off a bridge?”

Validity techniques!
Therapeutic Relationship

Between-session accessibility

- Reinforces support seeking behaviors and planfulness in clt
- Opportunities to practice interpersonal skills learned

*Consider this similar to PRN medications.*
Interpersonal Process *(Teyber & McClure, 2011)*

- Identify recurrent themes
  - Repetitive relational themes or interpersonal patterns
  - Pathogenic beliefs, automatic thoughts, or faulty expectations
  - Recurrent affective themes or central feelings
- Identify relational images and discrepant images
Treatment

VIP Care

voluntary hospitalization, intensify treatment, phone check-ins


To cite this, please use:

A couple of downbeats...

What feels present for you in this moment?

What is unclear? What is helpful? What should we double back to?
Safety Planning

- Interpersonal Theory of Suicide call this commitment to treatment.
- Safety planning is NOT the same as contracting for safety.
- Focuses on the here and now—what can the client do right now to remain safe.
- Is often in stages or sections.
- Apps can be useful here!
  - Hope Kit App
  - Calm App
- Gives the client concrete skills to use in the moment of crisis which they can turn to.
- Gives the clinician guidance during times of clinical ambivalence.
Safety Plan Format

- **Recognize warning signs**: What sorts of thoughts, images, moods, situations, and behaviors indicate to you that a crisis may be developing? Write these down in your own words.

- **Use coping strategies – without contacting another person**: What are some things that you can do on your own to help you not act on thoughts/urges to harm yourself?

- **Socialize with others who may offer support as well as distraction from the crisis**: Make a list of people (with phone numbers) and social settings that may help take your mind off things.
Safety Plan Format

- **Contact family members or friends who may help to resolve a crisis:** Make a list of family members (with phone numbers) who are supportive and who you feel you can talk to when under stress.

- **Contact mental health professionals or agencies:** List names, numbers and/or locations of clinicians, local emergency rooms, crisis hotlines.

- **Ensure the environment is safe:** Have you thought of ways in which you might harm yourself? Work with your counselor to develop a plan to limit your access to these means.
Some Examples

- Patient Safety Plan Template
- Patient Safety Plan Template #2
- Safety Plan

See handouts for more examples! There are many choices which are readily available online.
Crisis Cards
A small card the client can carry with them

● Needs to be more than just emergency numbers.
● Best practice says cards are made in collaboration with client.
● Engaging activities are better than passive.
  ○ Should include mood regulation techniques, pleasant activities, and emergency numbers to use in the event these activities do not provide relief.
● Consider ITS constructs as well- can the client engage in some sort of role which alleviates some of these concerns?
● Best to allow for client to work through what the card looks like with some guidance vs a boilerplate template.
Symptom Matching Hierarchy

Counselor asks client to list their most distressing symptoms, and possible resolutions

- These symptoms are then ranked from least distressing to most distressing.
- The counselor then makes concrete and specific suggestions for alleviating each of these symptoms.
- ITS states that particular attention should be paid to symptoms related to thwarted belongingness and perceived burdensomeness.
- Suggestions must be:
  - concrete and simple enough that someone in crisis can manage them.
  - straightforward and not require any clinical skills.
- Timing of this is important and should happen early on in the counseling relationship.
Mood Graphing

- Client is asked to record their moods at specific intervals during the day.
- The counselor then transposes this data onto a graph.
- Counselor and client then discuss any emerging or noted patterns.
- The message the counselor wants to get across is that moods pass—so when client is feeling like this mood is a be all, end all (narrowing of focus) they now can see that is not the case. Client can be taught to think “this too shall pass” as a coping technique.
- Counselor should pay particular attention to the negative moods pertinent to the IPS constructs.
Hope Kit

- Provides an “emergency kit” for when client is in crisis.
- Often a small box which contains concrete reasons for living.
- Can be done in session as a collaborative project.
- Encourage items which help address perceived burdensomeness and thwarted belongingness.
- Client should keep kit somewhere prominent in their household.
- Crisis cards can be incorporated into this activity.
Prevention
NIH spending on suicide research is dwarfed by spending for the other leading causes of death

<table>
<thead>
<tr>
<th>Disease</th>
<th>Spending</th>
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<tr>
<td>Cancer</td>
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<tr>
<td>Heart disease</td>
<td>$1.37 billion</td>
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<tr>
<td>Alzheimer’s</td>
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<td>Diabetes</td>
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<td>Cerebrovascular</td>
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<td>Kidney disease</td>
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<td>Accidents</td>
<td>$496 million</td>
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<tr>
<td>Pneumonia and Influenza</td>
<td>$408 million</td>
</tr>
<tr>
<td>Suicide</td>
<td>$68 million</td>
</tr>
</tbody>
</table>

Source: NIH, Centers for Disease Control and Prevention
Suicide Prevention Strategies Suggested by the WHO

- reducing access to the means of suicide (e.g. pesticides, firearms, certain medications);
- reporting by media in a responsible way;
- introducing alcohol policies to reduce the harmful use of alcohol;
- early identification, treatment and care of people with mental and substance use disorders, chronic pain and acute emotional distress;
- training of non-specialized health workers in the assessment and management of suicidal behaviour;
- follow-up care for people who attempted suicide and provision of community support.
Prevention

Reduce morbidity of suicide among individuals without signs/symptoms

+ Decrease suicidal desire in individuals with signs/symptoms
Prevention

Reduce morbidity of suicide among individuals without signs/symptoms (**PRIMARY**)

+ Decrease suicidal desire in individuals with signs/symptoms (**SECONDARY**)

Prevention

Primary (target: general population)

- Limit access to lethal means
- Public education about warning signs (IS.PATH.WARM)
  - 1st Tier - immediate need/action required
  - 2nd Tier - monitoring and follow up required
- Mass media campaigns (awareness of resources + change attitudes about suicide)
Prevention

Secondary *(target: at-risk populations)*

- Recent suicide attempters
- Older adults
- Children and adolescents
Integrating ITS
Let’s Try It!

- Decide if you want to work on paper or use the apps on your phone.
- Apps:
  - Virtual Hope Box
  - Calm: Be Safe
Designing Counselor Education

The concern:

“...graduate programs, licensure boards, and credentialing bodies do not require evidence of student competency and preparation in suicide assessment, intervention, and management.”

(Montague, Cassidy, & Liles, 2016, p. 5)
Designing Counselor Education

Kene, Yee, and Gimmestad (2019) offer these targets:

- **Increase trainee confidence and self-efficacy** in assessment and treatment of suicide (e.g. teach theory and offer early exposure)
- **Incorporate multiple opportunities and methods** to develop competency in suicide assessment, treatment, and prevention
- **Identify clinical decision making frameworks** and increase self-reflectiveness/awareness of beliefs/values related to suicide
- **Institute a “suicide risk supervisor”** to track research and provides periodic trainings
What sole intervention is effective in preventing death by suicide?
Dear «FirstName»

It has been a short time since you were here at the Newcastle Mater Hospital, and we hope things are going well for you.

If you wish to drop us a note we would be happy to hear from you.

Best wishes,

Dr Andrew Dawson

Dr Ian Whyte

Newcastle Mater Misericordiae Hospital
......... Bag 7, Hunter Regional Mail Centre NSW 2310
Phone: 49 211 283 Fax 49 211 870
What sole intervention is effective in preventing death by suicide?

Letters
Motto & Bostrom, 2001

+ 

Postcards
Carter et al., 2005
What sole intervention is effective in preventing death by suicide?

- **Letters**
  - Motto & Bostrom, 2001 +
  - Postcards
    - Carter et al., 2005

Sent to clients refusing treatment and unresponsive to outreach **significantly** reduced suicide attempts at follow up
What are you taking away from today?