Enhancing Suicide Assessments

Samuel Knapp, Ed.D., ABPP
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Learning Objective
At the end of this program the participants will be able to better:

1. Detect suicidal patients who are likely to deny or minimize suicidal thoughts
2. Develop interventions based on a clearer understanding of suicidal plans
3. Parse out the emotions associated with suicide.

Thank You

Staff at the Indiana Community Guidance Center (Indiana, PA) and Dauphin County, PA MH/MR.

Drs. Leon VandeCreek, Jeff Leitzel, Jeff Sternlieb, and Brett Schur

Many many suicide researchers, educators, and suicide prevention advocates
Act 74 of 2016

Act 74 of 2016 requires all psychologists, social workers, marriage and family therapists, and licensed professional counselors to have one (1) hour of continuing education each renewal period in the assessment, management, and treatment of suicidal persons.

What I Assume

Participants represent average Americans in that 49% have had a family member or friend who has died from suicide (Fiegelman et al., 2018)

What I Assume -2

Within the last year,

6% of PPA members had a patient die from suicide,
89% had a patient with suicidal ideation,
49% had a patient with a suicidal plan, and
29% had a patient who attempted suicide while in treatment (Leitzel & Knapp, 2021).
What I Assume-3

You do a good job... 

Know the basics of suicide assessment, management, treatment, and so on.

Three Part Agenda

1. Identifying patients with suicidal thoughts
2. Suicidal plans
3. Suicide-related emotions

My review of the literature on some of the ideas and findings that are new in the last five years that have practical implications.

Learning Objective I: False Deniers, Non-ideators, or Minimizers

Non-disclosure is common in all health care.

About 38% of patients who were suicidal did not report this to their PCP when asked (Levy et al., 2019).

Comparable non-disclosure rates for sexual assault.
False Deniers and Minimizers

About 75% of suicide decedents denied suicidal thoughts at their last appointment with a health care professional (Berman, 2018), although rates of disclosure were higher for mental health professionals than general health professionals (Hom et al., 2017).

Rose’s Public Health Theorem

As many cases occur in the larger low risk population than in the smaller high-risk population.

For example, 9% of sample with high risk factors accounted for 55% of suicides, while the other 91% accounted for 45% of all suicides (Kessler et al., 1999).

Implications

“We have encountered too many cases of individuals who have died from suicide who were married with children, were religious leaders . . . , were in treatment with a mental health professional, or had future plans” (Berman & Silverman, 2014, p. 438).
What Are False Deniers, Non-Ideators, and Minimizers?

**False deniers:** have suicidal thoughts but do not reveal them.

**Non-Ideators:** at risk for suicide who have not had explicit ideation about suicide (Bernecker et al., 2018).

**Minimizers:** have suicidal thoughts but minimize their frequency, intensity, or duration OR who have had past attempts or plans that they do not fully reveal.

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Three Steps to Identify False Deniers, Non-Ideators, or Minimizers

1. Use both written and verbal question.
2. Ask about burdensomeness and entrapment.
3. Anticipate and address specific reasons for non-disclosure.

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Step One: Use Two Questions

People who report suicidal thoughts in a response to a written question might deny them in response to a verbal question.

Vice versa.
Sample Written Question

“What have you ever had thoughts of killing yourself?”

Open time frame-
Be explicit about suicide (NOT harming yourself)
Avoid negative questions

Avoid Negative Questions

e.g., “No thoughts of suicide, right?”

McCabe (2017) found that 75% of clinicians asked negative questions about suicide, thus conveying the expectation of a negative response and that the clinician did not want to hear the real response.

Negative Questions (continued)

Positively phrased questions elicited an affirmative response in 38% of cases and a narrative in 19% of responses.

Negatively phrased questions elicited an affirmative response in 7% of cases and a narrative in 25% of cases (McCabe et al., 2017).
Why Two Questions?

Based on self-reports of suicidal persons and ecologically momentary assessments (EMAs), suicidal ideation fluctuates sometimes very rapidly.

Asking twice allows patients to report on their ideation at two points in time and a "yes" response may reflect either the presence or the intensity of the thought.

Also, the format of asking the question may influence response.

Step Two: To Help Identify Non-Ideators or Fluctuators

Ask about burdensomeness or entrapment—

Some patients may appear to become suicidal "out of the blue."

BUT burdensomeness or entrapment may predispose them to develop suicidal ideation

Sample Burdensomeness/Entrapment Questions

Sometimes, I feel that life is unbearable when I get upset.

I do not deserve to live another moment.

I cannot imagine anyone being able to withstand this kind of pain (Bryan & Harris, 2019)
Cultural Issues

Patients from some cultural groups tend to somaticize distress and that some religions strongly condemn suicide.

“I do not have energy to get things done”

“I wish the Lord would just take me away”

Passive Suicide

If patient denies suicidal intent but has high risk factors, ask about passive death thoughts

“Do you ever feel that you would be better off dead?”

“Do you ever feel that you would like to go to bed and never wake up?”

“Would you rather be dead than alive?”

Ideation v. Attempts

Those who think of suicide may differ systematically from those who attempt suicide.

One factor that discriminates ideators from attempters is the perception of burdensomeness or unbearability (entrapment) even if they do NOT express suicidal ideation.
Step 3: Addressing False Denial or Minimization

We do NOT know who is falsely denying or minimizing.

AND most patients who deny suicidal thoughts do not have suicidal thoughts.

Repeatedly asking suicide questions to a patient who denies suicidal thoughts could seriously harm the treatment relationship.

High Risk Factors for False Deniers or Non-ideators

Self-disgust, perceived burdensomeness, entrapment
Life stressor, e.g., interpersonal loss or stress, incarceration, poor health
Adverse childhood events including bullying
Desensitized to violence and access to means
And hundreds of factors with less predictive power

Demographics and Risk Factors

Demographics only predict risk to the extent that an individual has had certain experiences and life events.

Nothing about being an older white male makes a person suicidal.

Nothing about having a LGBTQ? orientation makes a person inherently suicidal, etc.
Common Reasons for Withholding or Minimizing

**Self-stigma**– e.g., suicidal people are weak

**Self-negation**– I do not deserve to be helped OR

**Shame, self-disgust**– there is something terribly wrong with me because . . .

**Fear of “punishment”**– they will put me in a hospital, they will tell my family, etc.

**Demoralized**– treatment does not work

**Poor Introspective Awareness**– poor self-awareness

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**Stigma**

Stigma refers to the negative beliefs, attitudes, or behaviors about someone who has a problem. May involve labeling, loss of status, or sense of separation.

Stereotypic masculine norms of stoicism and independence may exacerbate stigma.

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**Self-Stigma**

Those who chose “prefer not to respond” to question on suicide had higher psychological distress, lower social support, and higher ratings of self-stigma than either those who acknowledged suicidal thoughts (Kron et al., 2020)

Those who did not respond to question on suicide scored the highest on suicide risk factors (Podlogar et al., 2016).
Harm of Self-Stigma

Perhaps the secrecy associated with stigma contributes to perceived burdensomeness.

Perhaps it reflects self-disgust.

Perhaps it is a form of perfectionism—unrealistic expectations for oneself.

Addressing Shame, Self-Stigma, Self-Disgust and Self-Negation

Data on who dies by suicide: police, military, physicians, etc.

Normalize: “A lot of people who have been through as much as you would have thoughts of suicide? Do you ever have such thoughts?”

Reinforce talking about thoughts and feelings by noting that doing so takes courage—even small steps

Display Concerned Alertness

The assessment is also the first part of building a relationship with the patient

A form of mindful and attentive practice that is neither alarmist nor uninterested, but calm, nonjudgmental, sympathetic, and curious.
Elicit Their Story

Invite people to tell their story
Learn what is important to them
Ask what led up to their suicidal crisis
(O’Connor, 2021)

At end of assessment, patients should have a sense that
you cared about them AND
they had a chance to tell their stories

Address Fear of Punishment

As part of informed consent process, state that you work collaboratively— involuntary treatment or breaking confidentiality last resort

Not only SAY those things, but SHOW them by treating patients respectfully

Fear of Punishment

Respondents who were hospitalized in the past were more likely to deny suicidal thoughts than respondents who had outpatient psychotherapy only— consistent with an interpretation that fear of hospitalizations reduced willingness to be honest (Podlogar et al., 2021).
More Informed Consent

Other parts of informed consent

Patient should tell psychotherapists when they missed the boat or misunderstand something

Emphasize collaborative arrangements

Addressing Demoralization

Stories of patient survivors- AAS survivor stories

Summary of outcome data

Address the overwhelming burden that people feel. “For most, suicide is not about wanting to end one’s life, but about wanting unbearable pain to end” (O’Connor, 2021, p. 13).

I Think That I Can Help You with That

Psychologist: “If the pain you feel would go away, would you still have thoughts of suicide?”

Patient: “No”

Psychologist: “I think I can help you with that.”
Learning Objective 1: Summary

To improve Identification of suicidal persons

1. Ask twice, in different formats
2. Ask about burdensomeness and entrapment which may capture false deniers and non-ideators
3. Create facilitative conditions that address common reasons for non-disclosure.

Learning Objective 2

Improve Evaluation of Suicidal Plans

Back-Up Plans

Patient Predictions

Collaborative Safety Plans

Suicidal Plans

Psychotherapists ask their patients about plans for killing themselves.

This question guides suicide management including means safety (e.g., barriers to quick access to guns)
Ask About Back-Up Plans
But what if they have more than one plan?

Ask patients with suicidal plans if they have secondary or tertiary plans?

“If that did not work, what other plans do you have?”

Dormant or Partial Plans
Do they have a plan that is dormant? A partial plan, such as time and place but not method, etc.

“Did you ever have another plan that you decided would not work?”
“Have you ever started to work on a plan?”
“How far have you gotten on the plan?”

More Questions About Plans
Ask about time and place as well as method.

Ask about preparations and rehearsals (e.g., putting gun to head, but not firing)

Do you visualize (daydream about, having mental images of) your death?
“What Is the Likelihood You Will Die from Suicide?
On a scale of 1 to 5, what is the likelihood that you will die from suicide?
Why did you give yourself that score?
Patients have opportunity to identify risk and protective factors.

Effective Safety Plans
Collaboratively developed, evolving document designed to reduce risk until treatment has a chance to work
“A safety plan is some one else's plan. It is not your plan” (O’Connor, 2021, p. 198)
See VA sample template (references)

What is in a Safety Plan?
Anticipate crisis.
A safety plan might include:
- Reasons for living
- Warning signs
- Steps to diffuse their distress
- Crisis numbers
Ask Patients if They Will Follow the Safety Plan?

Ask patients on a scale of 1 to 5 “What is the likelihood that you will follow the safety plan?”

Do they understand the safety plan?
Are the steps too hard?
Do they believe it will work?
Do they believe that their life is worth saving?

Learning Objective 2: Summary

Ask about back-up, partial, or dormant plans

Ask about the likelihood that they would eventually die from suicide

Ask about the likelihood of that they would follow the collaboratively developed safety plan.

Learning Objective 3: Clarify Emotions

One goal of assessment is to help develop an effective treatment plan.

Clarify experiences and emotions to develop more targeted treatment interventions.

So, focus on understanding and defining emotions
Parse Out Experiences and Emotions

Research on the experiences and emotions commonly surrounding a suicide attempt.

Joiner’s team: Acute Suicidal Affective Disturbance (ASAD)

Galynker’s team: the Suicide Crisis State (SCS)

Jobes et al: “drivers of suicide.”

Commonalities

Can occur suddenly—sometimes within hours

Intense emotions, such as anxiety, irritability, impulsivity and so on.

Insomnia is also commonly present

Common Warning Signs

Overarousal (Agitation or Insomnia)
Self-disgust, self-hatred
Feelings of entrapment (hopelessness)
Perceive oneself as a burden to others
Social isolation
Suicidal thoughts
**Differences**

Galynker includes distorted and rigid thinking processes and emphasizes entrapment.

Joiner focuses on self-alienation (including self-disgust) and social alienation (social withdrawal and perceived burdensomeness).

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**Insomnia**

Insomnia: independently predicts suicide risk even when accounting for other factors such as depression. Ask about insomnia, nightmares or other sleep disturbances and address it through

- Sleep hygiene,
- CBT for insomnia (CBT-I), or
- Imaginal rehearsal therapy for nightmares.

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**Agitation**

“time limited state of both psychological and behavioral overarousal often characterized by restless and/or repetitive behaviors coupled with expressions of emotional turmoil and/or mental anguish or unrest”

(Ribiero et al., 2014).
Agitation and Anxiety

Anxiety focuses on future worries.

Agitation focuses on one’s current emotional state.

Agitation

Brief Agitation Scale (Ribeiro et al., 2014)

6 point scale- rating

Recently I want to crawl out of my skin
Recently I feel so stirred up I could scream
Recently I feel a lot of emotional turmoil in my gut

Agitation- Treatment

Behavioral- no evidence-based studies but consensus is calm, pragmatic approach that focuses on distraction and safety

Medications for profound agitation: anti-psychotics, benzodiazepines; Martinez-Raga, 2018; ketamine.
Types of Impulsivity

Behavioral— difficult preventing the initiation of a behavior or stopping a behavior that has already started; lack of preservation- easily distracted with monotonous tasks

Distinguished from negative urgency— the tendency to act rashly to reduce the intensity of the negative feelings

Shame and Guilt

Both occur when patients violate a social norm.

BUT, in guilt the person is motivated to rectify the problem by taking reparative action.

In shame, the person is so overwhelmed by internal disapproval that they socially withdraw

Perfectionism

Perfectionism— can be self-oriented (what we expect of ourselves), other-oriented (what we expect from others), or socially prescribed (what we think others expect from us).

Socially prescribed: “beliefs about the excessive expectations that we perceive significant others to have of us” (O’Connor et al., 2007, p. 1544).
Socially Prescribed Perfectionism

Studies, including longitudinal studies, have found the strongest link between socially prescribed perfectionism and suicide compared to other forms of perfectionism.

Are shame and socially prescribed perfectionism related? Self-compassion focused treatments may be appropriate for either (e.g., Neff et al., 2020)

Other Emotion Parsing

Anxiety and anxiety sensitivity

Anger and its gradients

Reflection, rumination, and brooding

Anxiety and Anxiety Sensitivity

Anxiety sensitivity is the fear of negative consequences from anxiety sensations

1. Cognitive—fear of going crazy
2. Physical—reactions to sweating or heart rate (e.g., “Am I have a heart attack?”)
3. Social—others will see my reaction and judge me
Anger and Its Gradients

When a triggering event activates feelings of a perceived wrong. Represents a continuum from Annoyance

Irritability: a low threshold for becoming angry

Anger

Reflection, Rumination, and Brooding

All involve some form of introspection

Reflection—productive may lead to solutions

Rumination—reflective characterized by absolute thinking, overgeneralization, catastrophizing, or dichotomous thinking

Brooding—dwelling on the negative consequences of a poor mood

Caution on Experiences and Emotions

Studies on the ASAD and SCS have been primarily American and 80-90% Caucasian, depending on the study. Specific responses among different ethnic groups have not been studied in this research.

BUT Chu et al. (2020) have found most of the same symptoms in their Asian samples AND a high influence of family conflict and noted cultural idioms of distress such as somatization, e.g., “I feel so tired that I do not want to get up in the morning.”
Learning Objective 3: Summary

Look for overarousal (insomnia and agitation)

Types of impulsivity, esp. negative urgency

And self-disgust which may reveal itself through shame or socially prescribed perfectionism

Learning Objective 3: Summary (continued)

Also, in thinking about interventions consider

Anxiety sensitivity as well as anxiety

Continuums of anger

Rumination/brooding v. reflection

BONUS: Assessment Is Ongoing

Continue to monitor suicidal thoughts and plans as long as necessary.

Routine questions either orally or written- or both. More than one way to phrase it

Continually monitor acceptance of safety plan and response to treatment.
Learning Objective 1

How to better identify false deniers, non-ideators, and minimizers

1. Ask two questions
2. Avoid negative questions
3. Ask about burdensomeness and entrapment
4. Know reasons for denial or minimizing and address them.

Learning Objective 2

Better understand suicidal plans.

1. Ask about dormant, partial or incomplete plans
2. Ask likelihood that they will die from suicide
3. Ask likelihood that they will follow safety plan

Learning Objective 3

Parse about emotions related to suicide

Identify
  socially prescribed perfectionism
  negative urgency as a type of impulsiveness
Learning Objective 3 (continued)

Distinguish
agitation from anxiety
anxiety from anxiety sensitivity
rumination and brooding from reflection
shame from guilt
gradients of anger

Thank You!!

Questions or Comments

References


Anestis, M.D. (2016). Prior suicide attempts are less common in suicide decedents who died by firearms relative to those who died by other means. Journal of Affective Disorders, 200, 199-209.


References


References 3

References 4


References- 5


