Ten Steps for Improving Outcomes with Suicidal Patients

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November 2018

Workshop Description

Suicide is the 10th leading cause of death in the United States and the most frequent crisis encountered by mental health professionals.

This program reviews ten steps that psychotherapists can take to improve their outcomes with suicidal patients.

This program fulfills Act 74 requirements for Pennsylvania licensed psychologists, social workers, marriage and family therapists, and professional counselors

Learning Objective

At the end of this program the participants will be able to:

Identify ten (10) steps to improve their outcomes with suicidal patients

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.

Act 74 (continued)

The State Board of Psychology has opined that the CE would be handled the same way the ethics CE mandate is handled:

Complete the CE, like other CEs;

No monitoring EXCEPT the routine audits of all CE

Psychologists and Suicide

1 in 5 psychologists will have a patient die from suicide in their career (Chemtob et al., 1989)–

Has the increase in suicide rates since 1989 led to an increase in the number of psychologists who have had a patient die from suicide?

Within one year, 4% of psychologists had at least one patient die from suicide (Knapp & Letizel, 2017).

Psychologists and Suicide in PA

87% patient with suicidal ideation in 2016
54% patient with a suicide plan
23% patient who had attempted suicide while in treatment

Distress Treating Suicidal Patients

- On a scale of 1 to 5, 28% of PPA members described treating suicidal patients as very distressing or somewhat distressing?
- The goal should be one of **alert concern**: neither alarmist nor dismissing?
- What about the other 72%? How many have alert concern?

Data on Suicide

45,000 Americans died from suicide in 2015

10th or 11th leading cause of death in USA

Rate of suicide increased 20% since 1999

Historical Trends in Suicide

In periods of time of social turmoil, American suicide rates have been higher

e.g., post Civil-War, 1930s,
Rapid industrialization from 1900-1910 etc.

What We Assume

Participants have basic information about suicide prevention. They know :

- The static and dynamic factors that predict suicide
- The role of ideation, past attempts, and future plans in predicting suicide

What We Assume about Management

Good psychotherapists will develop safety plans and crisis intervention plans

- Involve family members when appropriate
- Seek medications when appropriate
- Motivate and encourage patients to participate and engage in treatment, etc.

The Role of the 10 Steps

These are 10 steps identified from our clinical experience and reading that some competent psychotherapists did not always remember and which can help a good intervention become an excellent one.

Ten Steps (1 though 5)

1. How do you feel about suicide?
2. Are you alert for false deniers?
3. Do you ask about back-up suicide plans?
4. Ask patients the likelihood that they will die from suicide?
5. Do you focus on the relationship?

Ten Steps (steps 6 to10)

6. Do you review the safety plan with patients?
7. Do you ask patients how likely will they follow the safety plan?
8. Make expectations for treatment explicit
9. Monitor progress
10. Be alert for binary thinking

1. How Do You Feel about Suicide?

Have you known someone who died from suicide? (50% of Americans have)

What was your reaction to the death?

What Do You Think?

- What do *you* think about suicidal persons?
- Are they cowardly? Selfish?
- Do you believe you have the right to intervene and safe the life of someone who "really wants to die?" (Thomas Szasz)

What Do You Feel?

What does it feel like to sit in a room with a patient who has strong feelings of killing him/herself?

Fear?
Helplessness?
Anger?

Compassion?
Confidence?
Acceptance?

Psychotherapist Feelings

Often psychotherapists feel fear:

having a patient die from suicide OR of litigation in case something goes wrong

Those with a good background in assessment, management, and treatment of suicide will have confidence which will keep their fear in check.

Reflect on Your Attitudes toward Suicidal Patients

Are you alarmist? – endorse overly restrictive or punitive responses?

Are you dismissive? "if they were really suicidal, they would have done it already!"

Alert Concern

The best attitude is one of alert concern:

Recognizing that suicidal thoughts need to be taken serious, but having a calm and focused attitude that neither over reacts nor under reacts.

2. Be Alert for False Deniers

How do you reduce the number of suicidal patients who deny having such thoughts?

About 70% of persons who died from suicide denied suicidal thoughts at their last appointment with a health care professional (Berman, 2018). Some may have not been suicidal at the time, but others probably were.

Accuracy of Screening?

- *True Deniers:* deny suicidal thoughts and do not have them: 70% -80%
- *False Deniers:* have suicidal thoughts but deny them– 10% - 15%
- *True Reporters*: have suicidal thoughts and acknowledge them, 10%-15%

Identify False Deniers?

No clear way to identify them, but take an especially hard look at those who have high risk factors for suicide in general.

Reasons for Withholding

- Self-negation- I do not deserve to be helped
- Self-stigma– suicidal people are weak and cowardly
- Shame, self-disgust– there is something terribly wrong with me because I have these thoughts
- Fear of punitive responses- they will put me in a hospital, they will tell my family, etc.
- Demoralized– treatment does not work

Anticipate Withholding

- Calm, nonjudgmental--
- Normalize– "many people that have gone through so much think of suicide. Have you ever thought of suicide?"
- Transparency– about nature of treatment and treatment philosophy

Patients' Fear of Thoughts

- A few patients feel calm when they have thoughts of suicide.
- Most patients feel upset by them.
- Can the thoughts be reframed as an indication that something is wrong in my life (thinking, reactions, etc.)?

Living Well?

If suicidal thoughts are a barometer of distressed living, then an option is to ask patients to consider the question, "What does it mean to live well?"

3. Ask about Secondary or Tertiary Suicidal Plans

Psychotherapists will ask their patients about future plans for killing themselves.

This helps guide suicide management including means restriction (such as removing access to guns or other lethal means)

Future Plan(s)

But what if they have more than one plan?

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

Reasons for the Rating

Look at the reasons for the rating. Does it reflect absolutist or binary thinking? Such as, "If my wife leaves, then I will have no reason to live."

The psychologist can listen to the patient and ensure that they feel heard, without necessarily endorsing their thinking patterns.

5. Do You Focus on the Relationship?

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

Calm, nonjudgmental, sympathetic, interested

Neither alarmist nor uninterested

At the End of the Assessment

Patients should have a sense that:

- you care about them AND
- they had a chance to tell their stories

6. Ensure Patients Understand the Safety Plans

Management is an important part of suicide prevention.

Management steps are designed to keep patient alive until psychotherapy has a chance to work.

What is in a Safety Plan?

Anticipate crisis

A safety plan might include:

- Warning signs
- Steps patients can take to diffuse their distress
- Crisis numbers
- Emergency room

Sample Summary on 3 X 5 Card

Line 1: feeling nervous, agitated, having suicidal thoughts

Line 2: Walk my dog, call Brett (555-1212), go to swimming pool

Line 3: Call Dr. Schur (555-1313), Call national suicide prevention line (800-528-8273)

7. 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?
- Do they believe it will work?
- Do they believe that they are worth saving?

Incorporate Patient Insights

The best safety plans emerge out of discussions with patients – incorporating their insights and perspectives as much as clinically indicated.

Follow the Safety Plan

After developing the plan, ask patients how likely would it be, in a scale of 1 to 5, that they would implement the plan and why?

- Are steps too hard?
- Are steps not helpful?
- Do they feel that they are worth saving?

Look at Patient Reasoning

A large part of treatment is going to be focusing on the thinking processes of patients. Do they adopt absolutist and binary ways of looking at problems? Do they fail to think of other options?

These thinking problems may emerge in the discussions of the value of the safety plan.

8. Make Expectations for Patient Explicit

The number one goal of treatment failure is the failure to follow through with treatment

Part of the informed consent process is to make expectations explicit

- Attend treatment

Expectations (2)

- Be honest
- Commit to giving treatment a try
- Tell psychotherapists when missed the boat of misunderstands something
- Psychotherapists will try to reduce discomfort as much as possible, but some topics will be painful

Step 9: Monitor Level of Risk

Ask patients about their level of risk to die from suicide?

Not: "Are you still having thoughts of suicide?"

But: "In the last week did you have any period of time in which you had thoughts of suicide?"

Monitor Suicidality (2)

Do you look for second sources of data?

- Friends, family members (with permission)
- Brief rating scales of suicidality
- Other treatment providers (e.g., psychiatrist, primary care provider)

10. Be Alert for Binary Thinking

Watch for patients presenting only two choices.

* I either have to live with this chronic pain or die

* If my daughter can't live with me, I will kill myself.

Be Alert for Binary Thinking (2)

Often when patients present only two choices, one of them is really unacceptable, contributing to the tunnel thinking which leads down the path to suicide.

Be Alert for Binary Thinking

Help patients find multiple choices:

- Instead of "You have to live with the pain because..." "What would help make your pain more tolerable?" or "Can we come up with some ideas together to help you manage your pain better?"
- "How often would you like to see your daughter?" or "What would make your time with your daughter more rewarding?"

What Steps Would You Add?

Would you add a step not considered here?

Would you delete a step or modify a step presented here?

What Do These Steps Have in Common?

- Respect patient autonomy- empowered collaboration
- Focus on transparency- make the implicit explicit
- Be vigilant about progress
- Observe patient thinking processes

Respect Patient Autonomy

Do you want to change safety plan?

Do you want to tell me your thoughts?

Do you think the safety plan is helpful?

Respect Patient Autonomy (2)

Seek patient in-put

- on self-prediction of suicide
- on how helpful safety plans are
- on helpfulness of treatment

Make the Hidden Explicit

- feelings and fears about suicidal patient
- patient hidden thoughts
- patient hidden secondary thoughts
- expectations for patient
- your concern for patient well-being

Vigilance about Progress

- Monitor treatment carefully including
- Patient perceptions of the value of management plans and patient response to treatment

Patient Thinking Processes

- Suicidal thoughts and behaviors are usually accompanied by dysfunctional thinking patterns such as either/or thinking or rigid interpretations of events.
- Look for these thinking patterns throughout such as when asking about the likelihood that they will die from suicide, or likelihood that they will follow through with safety plan, etc.

Thank You!!

Questions?