Ten Steps for Improving Outcomes with Suicidal Patients

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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 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.

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

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

Learning Objective

Appreciation

Dr. Brett Schur who collaborated with me on the article in the Pennsylvania Psychologist that informed this presentation.

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
Caution

If you do everything exactly as described in this presentation, you will probably be doing something wrong.

You need to use your judgment based on the unique presentations of the patients and the context of treatment.

Psychologists and Suicide

1 in 5 psychologists will have a patient die from suicide in their career (Chemtob et al., 1989)—probably much higher today

Within one year, 5% of psychologists had at least one patient die from suicide (Leitzel & Knapp, 2018).

Psychologists and Suicide in PA

90% patient with suicidal ideation in 2017
63% patient with a suicide plan
29% patient who had attempted suicide

19% of psychologists in PA reported that treating suicidal patients was distressing or very distressing

Data on Suicide

46,000 suicides in US in 2017
Estimated 8% of attempts result in deaths
Deaths highest among older white males
Firearms account for 50%+ of suicides

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 can help a good intervention become an excellent one.

Ten Steps (1 though 5)

1. How do you think and feel about persons with thoughts of 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 to 10)

6. Do you review the safety plan with patients?
7. Do you ask patients how likely are they to follow the safety plan?
8. Do you make expectations for treatment explicit?
9. Do you monitor progress?
10. Are you alert for cognitive rigidity, such as 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?

Step One (continued)

What do you think about suicidal persons?

Have you been influenced by societal myths about suicide? Are they cowardly? Selfish?

Do you believe you have the right to intervene and safe the life of someone who “really wants to die?”

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?  Compassion?
Helplessness?  Confidence?
Anger?  Acceptance?
Psychotherapist Feelings

Often psychotherapists feel fear:

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

BUT those with a good background in handling suicidal patients will have confidence which will keep their fear in check.

Reflect on Your Attitudes

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

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

**Concerned Alertness**- appropriate balance

What is Your Role?

Ultimately you cannot prevent a suicide. You cannot promise a patient that you can keep them safe.

How do you feel about that statement?

What is Your Role (2)

But you can promise to provide good quality treatment.

Delivered humanely
Informed by scientific research

2. Be Alert for False Deniers

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

About 75% 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: 75% - 80%

**False Deniers**: have suicidal thoughts but deny them—10% - 15%

**True Reporters**: have suicidal thoughts and acknowledge them, 5% - 15%
Two Steps to Identify False Deniers

1. Use both written and verbal question.
2. Look hard at those who have high risk factors for suicide

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.

Reasons for Withholding

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

Address Reasons

I do not deserve to be helped?
Would you help others?
How would others react to your death?
Weak/cowardly?
Belied by the evidence, war heroes, police officers,
Punishment?
Transparent – I work collaboratively with patients
Treatment does not work?
Evidence says otherwise

How Would You Feel If . . .

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.”

Normalize

“A lot of people who have been through as much as you would have thoughts of suicide? Do you ever have such thoughts?”
3. Ask about Secondary, Tertiary or Partial Suicidal Plans

Psychotherapists will ask their patients about plans for killing themselves.

This guides suicide management including means restriction (e.g., removing access to guns).

Detail on Suicide Plans

The more detail in the plan the greater the risk.

Have steps been taken to implement the plan (e.g., accumulating pills)

Has the plan been rehearsed (e.g., pointing an empty gun to one’s head)?

Plans and Past Attempts

Were there previous suicide attempts?

What methods were used?

Would you try that method again? Why or why not?

Were there past overdoses of drugs?

Plan(s)

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?”

Back-Up Plans

Do they have a plan that is dormant?

Do they have a partial plan? Time and place but not method, etc.

“How have you ever started to work on a plan?”

“How far have you gotten on the plan?”

Alcohol and Attempts?

The role of alcohol and plans is unclear.

Most attempts occur without alcohol or very little.

BUT—sometimes drink to get courage to attempt AND sometimes induces a suicidal mode.
Substance Misuse and Attempts
The classification of overdoses into accidental and intentional may be misleading
Taking too many drugs may reflect indifference to one's life which may not be technically suicide, but nonetheless reflects a disregard for one's well-being

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.

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

Caring about Patients
When asked why they did not kill themselves, one sample reported that the number one reason was: “my psychotherapist cared about me.”
One important step toward reducing social isolation.

Do Not Argue with Patients
You will always lose. For every reason for living you give, patients can give two reasons for killing themselves
BUT, if you develop a human connection with them, you are providing the type of experience that make life worth while.
### A Good Initial Meeting

1. Information was obtained about suicidal risk  
2. Patients had a chance to “tell their stories”  
3. Patients sensed that you cared about them.  
4. You conveyed confidence that you would provide them with good quality treatment

### 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.

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### 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

### Warning Signs

Every patient is unique, some warning signs can be learned from behaviors associated with past attempts or associated with current plans or ideation.  

BUT, some behaviors have been empirically found to be highly associated with suicide attempts.

### Common Warning Signs

- Agitation (not the same as anxiety)  
- **Insomnia**  
- Self-disgust, self-hatred  
- Feelings of entrapment (hopelessness)  
- Perceive oneself as a burden to others  
- Social isolation  
- Suicidal thoughts

### Common Activities to Interrupt Suicidal Thoughts

- Walking  
- Talking to a friend  
- Going to the theater etc.  

Best activities involve interaction with others, motor movements, or engagement of the senses
Reasons for Living

Some include reasons for living.

If patients cannot identify reasons for living ask,

“What did you used to feel was important?”
“What would be important to you if you were not so depressed?” etc.

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. Knapp (555-1313), Call national suicide prevention line (800-528-8273)

If-Then

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

Do patients understand the plan? Do you rehearse it with them?

If-then. If I feel suicidal then I activate the plan

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?
Are the steps too hard?
Do they believe it will work?
Do they believe that they are worth saving?

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

Give treatment a try: Attend sessions

Expectations (2)

Be honest
Tell psychotherapists when they missed the boat of misunderstands something
Psychotherapists will try to reduce discomfort as much as possible, but some topics may be painful
Remove lethal means of suicide
Non-adherence could result in termination
Step 9: Monitor Patients

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?”
“Tell me the frequency, duration, and intensity of those thoughts.”

Second Sources to Monitor Suicide

Do you look for second sources of data?
Friends, family members (with permission)
Brief rating scales of suicidality

Monitor Treatment Progress

In each session:
Did you get a chance to talk about what was important to you?
Are there things that you wanted to talk about that we did not get to?
What was helpful/not helpful about the session today?
What should we do differently? The same?

10. Cognitive Rigidity

During periods of stress, all persons will tend to narrow options and decline in their problem solving abilities.

e.g., “If my wife leaves me, I will have nothing to live for.”

Is this true?

What Are Your Insights?

From your experiences, what have you found to be especially effective when working with suicidal patients?

What really seems to help?

What have you learned NOT to do?

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 10 Steps Have in Common?

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

Make the Implicit Explicit

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

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?

References


