



UNDERSTANDING AND RESPONDING TO SUICIDE IN OUR COMMUNITIES

Ronda Oswalt Reitz, Ph.D.
Department of Mental Health

Clinician Responses to Suicide

Free writing exercise:

Without evaluation, be a witness to your deepest thoughts and feelings about death by suicide. Consider: do consumers have a right to take their own lives when they deem them intolerable to live?

Desensitizing to Suicide

- *Effective assessment requires a low emotional response to the words and images of self-harm and suicide.*

Differences in World View That Block Effective Treatment

- For the consumer, suicide is the only solution to an intolerable problem.
- For the provider, suicide IS the problem.

Suicide as a Cause of Death

- 9th worldwide
- 11th in U.S
 - 3rd ages 15-24
 - 4th ages 25-44
 - 8th ages 45-64
- 8th for men, 17th for women

CDC, 2006 (2004 data)

- 4th world wide for people ages 15-44
- 300/100,000 patients seen in the ER for suicide attempt
- 1 in every 25 attempts results in death

WHO, 1993

Suicide in the U.S.A.

- 32, 637 die by suicide each year
- Average of 85 suicides per day

SPRC.Org 2004

- 500,000 ER visits for attempts in 1997
- 13.5 of people think about suicide

Kessler, Borges, & Walter, 1999

- 1.7 more die by suicide than by homicide

CDC Website

Mental Disorders and Suicide

Review of 83 mortality studies

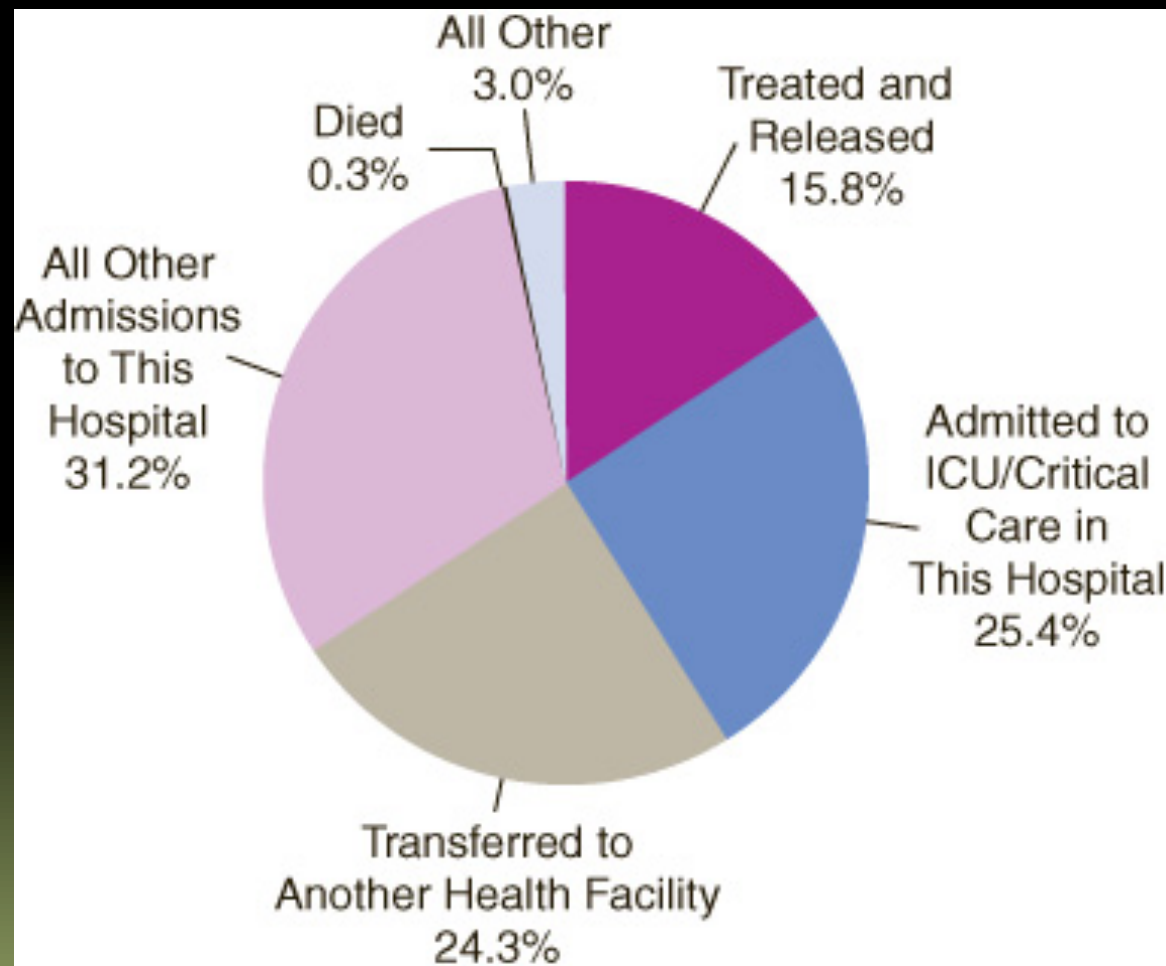
- Schizophrenia.....4-5%
- Depression/Bipolar Disorders.....6%
- Addiction Disorders.....7%


Br J Psych, 1996; Palmer et al., 2005

- Borderline Personality Disorder.....8-10%


Black, Blum, Pfohl, Hale, 2004

Disposition from ER Visits for Drug-Related Suicide Attempts among Adults Aged 18 and Older: National Estimates, 2004 DAWN





In 2004, a psychiatric condition was diagnosed in 41 percent (43,176) of the drug-related suicide attempts treated in the ED; the most frequent psychiatric diagnosis was depression.

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- Among adults aged 18 or older who experienced a past year major depressive episode (MDE):
 - 56.3 percent thought, during their worst or most recent episode, that it would be better if they were dead,
 - 40.3 percent thought about committing suicide,
 - 14.5 percent made a suicide plan, and
 - 10.4 percent made a suicide attempt

Personality Disorders (PD) and Suicidal Behaviors

- Among SUICIDES


---40-65% have Personality Disorder

Linehan, Rizvi, Welch, & Page, 2000

- Among Personality Disorder

---Borderline Personality Disorder highest suicide

Yen et al., 2004



Increased Risk of Suicide
with 3 or more co-occurring
disorders

Axis I Diagnoses within Suicidal BPD

Diagnosis	Life Time	Current
Major Depression	96.7%	75%
Dysthymic Disorder	N/A	14.3%
Substance Abuse	15.2%	5.4%
Substance Dependence	56.5%	26.1%
PTSD	56.5%	51.1%
Social Phobia	21.7%	16.3%
Panic Disorder	52.2%	40.2%
OCD	23.9%	19.8%
Eating Disorder	41.3%	23.9%

Axis II Diagnoses within Suicidal BPD

■ Diagnosis	%
■ Anti-Social	10.9%
■ Histrionic	2.0%
■ Narcissistic	0
■ Avoidant	20.8%
■ Dependent	5.9%
■ Obsessive Compulsive	7.9%
■ Paranoid	3.0%
■ Schizoid	0
■ Schizotypal	0

Suicide Risk Factors: Schizophrenia

- Good Premorbid Level of Functioning
- Immediately after Diagnosis
- Early in Course of Disorder
- During Hospitalization
- Shortly After Discharge from Inpatient
- Depression and Hopelessness
- Lower Negative Symptoms
 - particularly when suspiciousness and delusions are present
- Only 8% of suicides are in response to command hallucinations

Hert & Peuskens, 2000 in Hawton and van Heeringen

Suicide Risk Factors: Alcohol/ Substance Use Disorders

- Acute Alcohol Intoxication
- Co-morbid BPD
- Co-morbid Major Depression
- Depression, Hopelessness, Impulsive Aggression

Wilson et al., 2006

Suicide Risk Factors: Affective Disorders

- History of Suicide Attempt
- History of Inpatient Hospitalization
- Comorbid BPD
- Subjective Rating of Severity of Depression
- Pessimism
- Aggression/Impulsivity

Oquendo et al., 2004; Bostwick & Pankratz, 2000

Suicide Risk Factors: Borderline Personality Disorder

- Criteria predictive of suicidal behavior

- Affective Instability

- Identity Disturbance

- Impulsivity

- Criteria predictive of suicide attempts

- Affective Instability

Yen, et al., 2004

- Suicidality highest in early 20's

- Completed suicide highest after age 30

Brodsky et al., 1997

Dialectical Behavior Therapy

- Multiple mental disorders and Borderline Personality Disorder are associated with high risk for suicidal behavior.
- DBT was developed for the high risk for suicide individual with multiple mental disorders.
- Suicide management protocols in DBT are effective at reducing suicidal behaviors.

Step-by-Step Management of Suicidal Behavior

- 1. Assess Risk
- 2. Follow General Guidelines
- 3. Develop a Treatment Plan
- 4. Follow Appropriate Protocols:
 - Crisis Protocol
 - On-going Suicidal Behavior Protocols
 - Hospitalization Protocol
- 5. Actively Respond to Patient Suicide

Assessment of Suicide Risk

- Long-Term Risk
- Imminent Risk

Long-Term Suicide Risk

- Person Variables:
 - Bio-chemical/Genetics
 - Learning History
 - Demographics (Gender, Race, Age, Nationality)
- Behavior Variables:
 - Cognitive: Content and Process
 - Physiological/Emotional/Mental Disorders
 - Action/Overt Motor
- Environmental Variables

Long-term Suicide Risk

- Method Availability
- Suicidal Models
- Low Social Support/Minority Status
- Negative Life Events

Assessing Imminent Risk

Direct Indices:

1. Suicidal Ideation
2. Suicide threats
3. Suicidal Planning and/or preparation
4. Intentional self-injury in the last year, especially if suicide intent was expressed at the time

Linehan, 1993; Hjelmeland, 1996

Assessing Imminent Risk

- **Indirect Indices:**
 - **1. Patient in suicide/self-injury risk group**
 - **2. Recent disruption or loss of relationship; negative changes in past month**
 - **3. Malignant alienation from therapy; medication non-compliance**
 - **4. Acute hopelessness, anger or both; extreme psychological perturbation**
 - **5. Recent medical care**
 - **6. Recent clinical improvement**

Indices of Suicidal Behavior in the Next Several Hours/Days

- 1. Methods available or easily obtained
- 2. Alcohol consumption; Current overuse
- 3. Isolation
- 4. 1st week of inpatient treatment
- 5. 1st week after inpatient discharge
- 6. Precautions against discovery; deception/concealment of timing, etc.

General Guidelines for Treating Suicidal Behaviors

- 1. Be flexible in considering response options.
- 2. Be more active when suicide risk is high.
- 3. Base non-conservative response on failure of conservative responses.
- 4. Be honest about reasons for responses.
- 5. Talk about suicide openly and matter-of-factly.
- 6. Avoid pejorative explanations.

General Guidelines for Treating Suicidal Behaviors

- 7. Present suicidal behavior as a response to a problem.
- 8. Maintain the stance that suicide is a maladaptive/ineffective solution.
- 9. Involve significant others, including other therapists.
- 10. Schedule sessions frequently enough with additional sessions as needed.

General Guidelines for Treating Suicidal Behaviors

11. Stay aware of the multitude of variables
 - impinging upon clients.
12. Avoid omnipotent taking or accepting of
 - responsibility for patient's suicidal behaviors.
13. Maintain professional consultation with a colleague. Get expert consultation if needed.
14. Maintain occasional, non-demanding contact with persons who reject/drop out of therapy.

Treatment Planning with Suicidal Clients

Standard Model of Care

Suicidal behavior is a
symptom of a mental disorder:

Treat the disorder and
suicide risk will go down.

(Maybe NOT)



New Model of Care

- Suicidal behavior is
Disordered behavior:
- Treat the BEHAVIOR

Crisis Protocol: Suicidal Behavior

- 1. Assess long-term and imminent risk of SIB
- 2. Focus on the present
- 3. Problem solve current problem
- 4. Reduce high risk environmental factors
- 5. Reduce high risk behavioral factors
- 6. Commit to plan of action
- 7. Trouble shoot the plan
- 8. Anticipate a recurrence of crisis response
- 9. Re-assess a suicide potential

Respond to On-Going Suicidal Behavior

- 1. Assess medical danger
- (consult, ER, medical services).
- 2. End phone contact immediately...
 - ...if phone calls are a reinforcer.
 - ...insist on STAYING ON THE PHONE if phone calls
 - are aversive.

Intervening *AFTER* Suicidal Behavior

- 1. Assess frequency, intensity, and severity of suicidal behavior.
- 2. Conduct a comprehensive chain analysis
- 3. Relate current behavior to overall patterns.
- 4. Validate the client's pain.

Intervening *AFTER* Suicidal Behavior

- 5. Focus on negative effects of suicidal behavior.
- 6. Reinforce non-suicidal responses.
- 7. Discuss solving problem vs. distress tolerance.
- 8. Obtain commitment to non-suicidal behavior plan

Acute Hospitalization Protocol

- Recommend Hospitalization When:
 - 1. Psychotic state plus suicide threats.
 - 2. Suicide risk outweighs risk of inappropriate hospitalization.
 - 3. Operant suicide threats escalating plus hospitalization is aversive.
 - 4. Serious strain in therapeutic relationship creates a suicide risk or crisis.

Acute Hospitalization Protocol

- 5. To monitor psychotropic medications
 - when overdose risk is high.
- 6. The therapist needs a vacation.

CONSIDER

Acute Hospitalization When:

- 1. Conducting exposure treatment of PTSD
- 2. Non-response to therapy plus a severe depression or disabling anxiety.
- 3. Overwhelming crisis plus no other safe environment.
- 4. Overwhelming, emergent psychosis plus no social support.

For Further Information:

- www.behavioraltech.org
 - Information about Dialectical Behavior Therapy
- Ronda.Reitz@dmh.mo.gov