THE GLENDON ASSOCIATION & PSYCHALIVE

Welcome to the Webinar, Suicide: What Every Mental Health Professional Needs to Know

Lisa Firestone, Ph.D.

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THE GLENDON ASSOCIATION & PSYCHALIVE

Suicide: What Every Mental Health Professional Needs to Know

with Lisa Firestone, Ph.D.

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THE GLENDON ASSOCIATION

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Facts About Suicide

- According to the World Health Organization, every 40 seconds a life is lost to suicide, which means that each year we lose nearly 1 million people to suicide.

- For every one person who dies by suicide, 20 or more attempt to end their lives.

- Worldwide, more people die by suicide than from all homicides and wars combined.

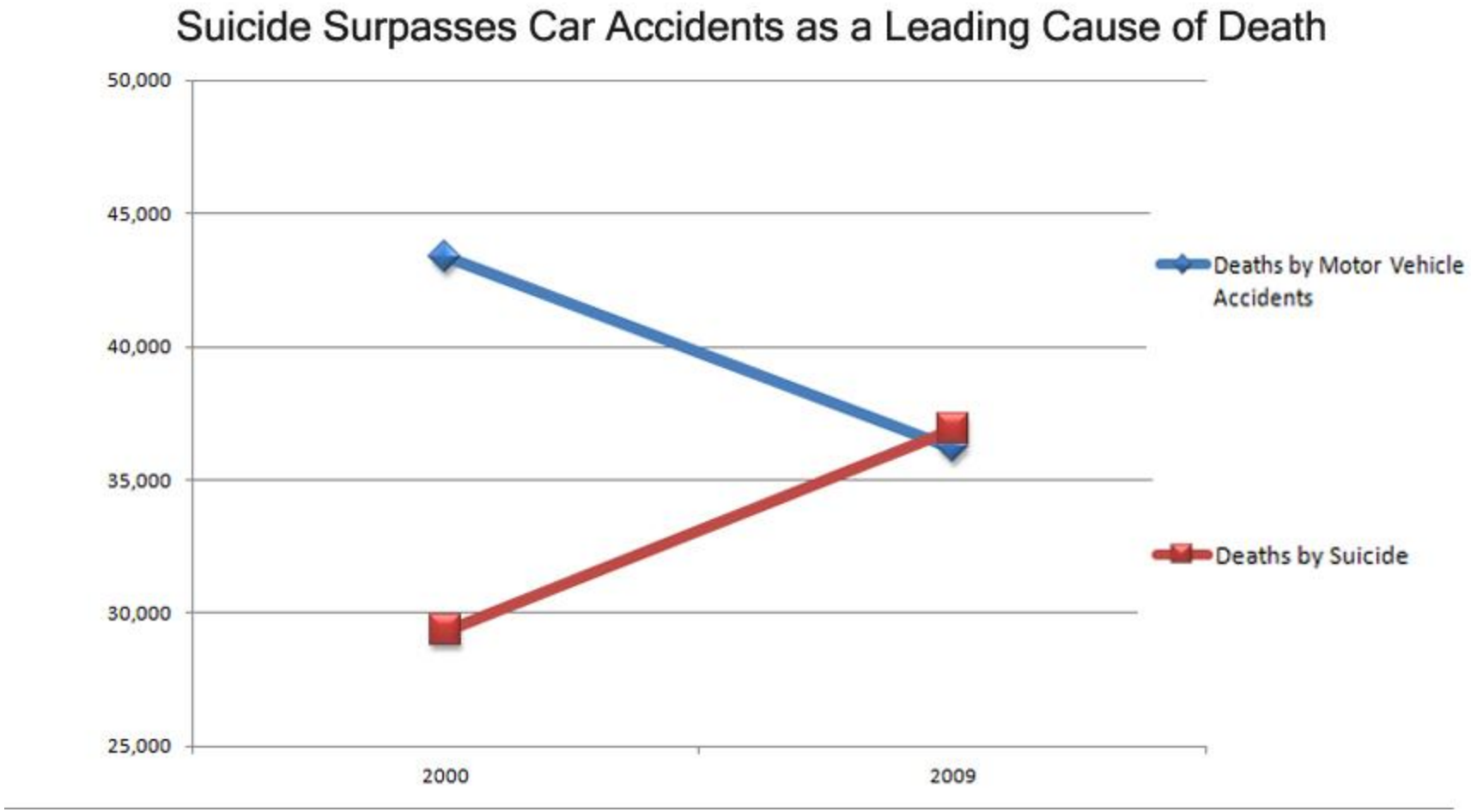
- Each person who dies by suicide leaves behind an average of five closely impacted survivors.

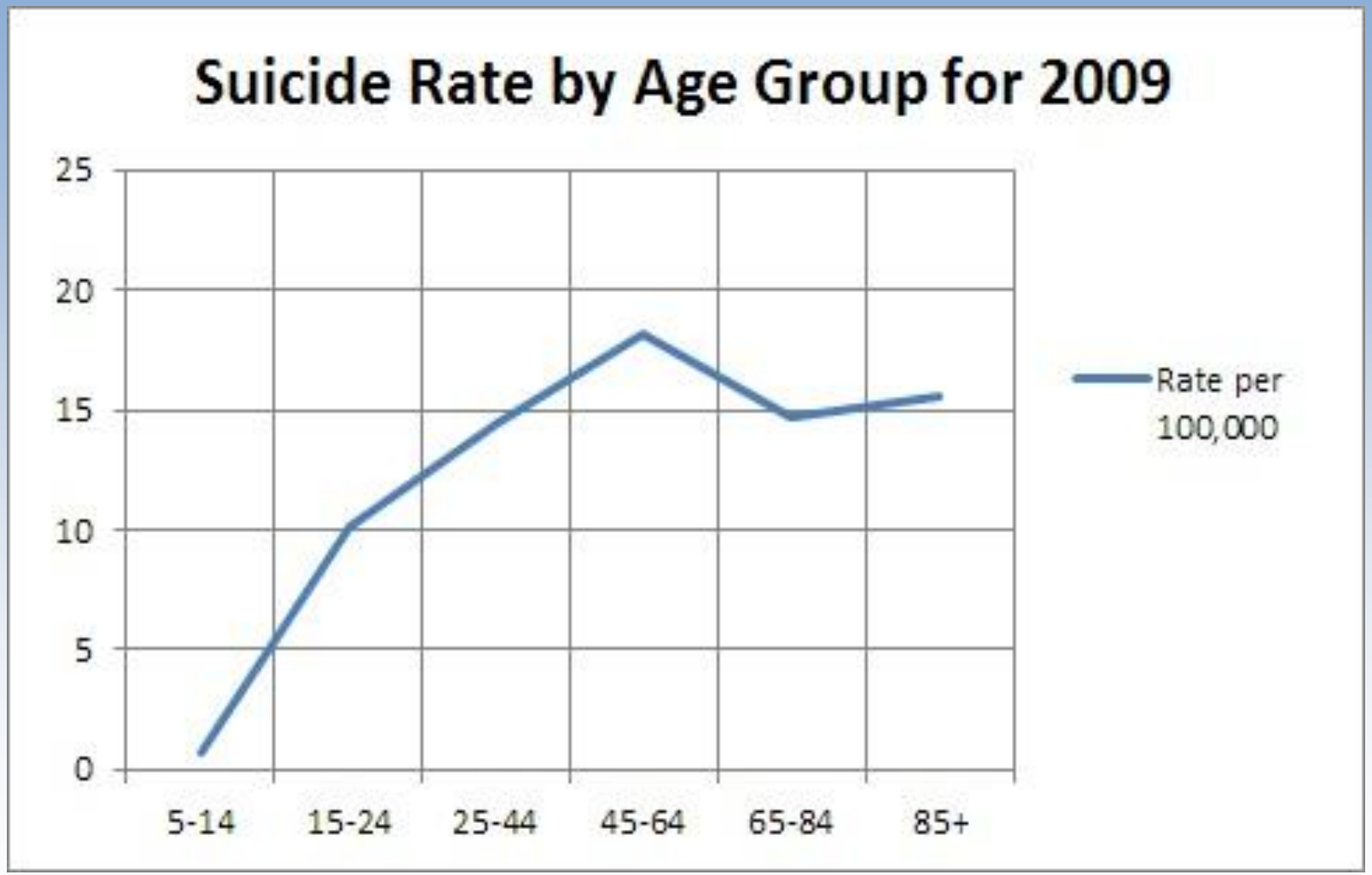
- According to a 2009 statistic from SAMHSA, 8.4 million adults in the U.S. had serious thoughts of committing suicide in the past year.

- In 2008, 13.4 percent of people who committed suicide had experienced job and financial problems

- In 2012, more members of the U.S. military committed suicide than were killed in combat in Afghanistan, with an average of one soldier dying by suicide each day.

- 18 veterans die by suicide each day.


Suicide Surpasses Car Accidents as a Leading Cause of Death
50,000
45,000
40,000
35,000
30,000
25,000
2000
2009
Deaths by Motor Vehicle Accidents
Deaths by Suicide



Suicide Figures from the Centers for Disease Control for the year 2009.

All rates are per 100,000 population.

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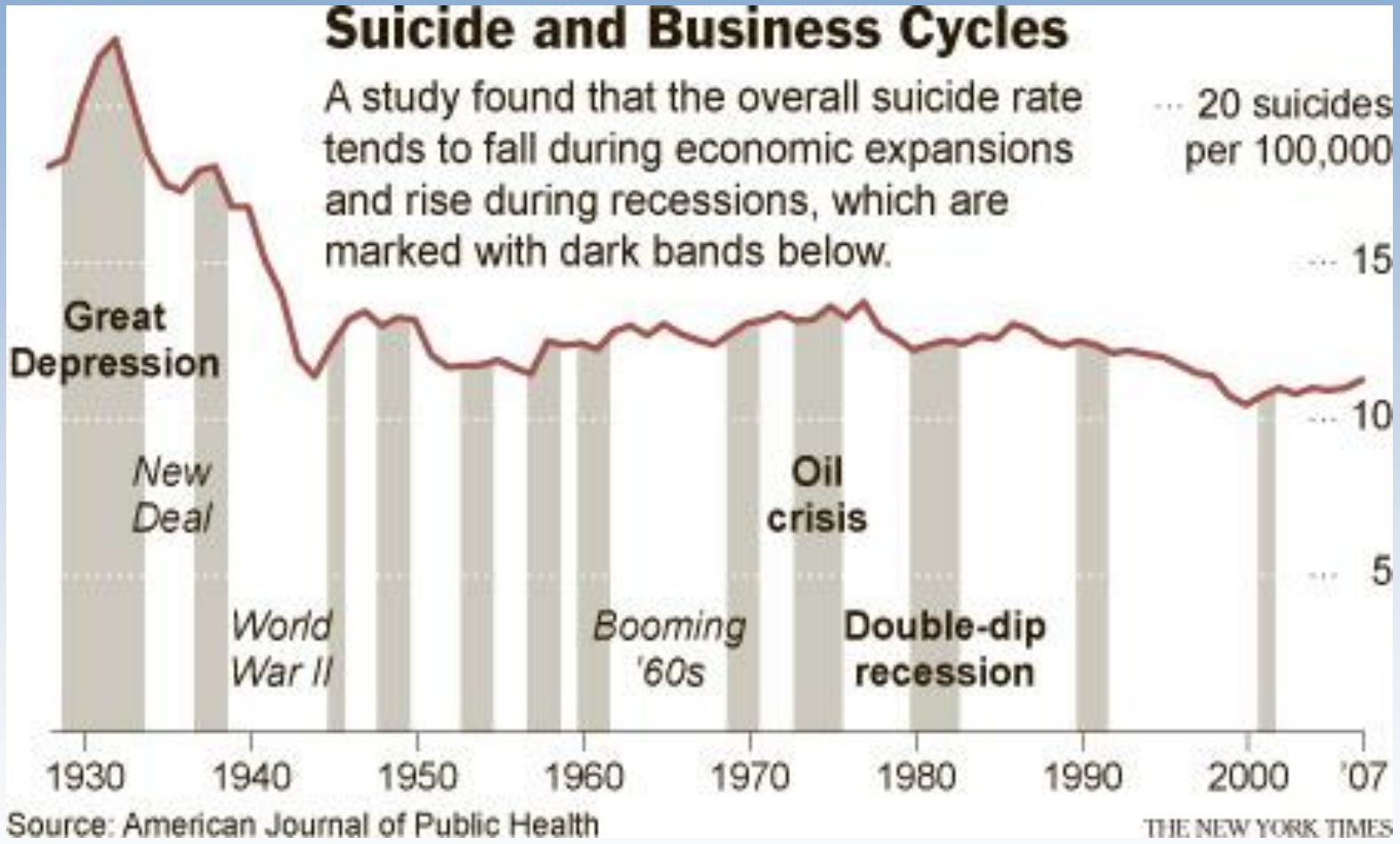
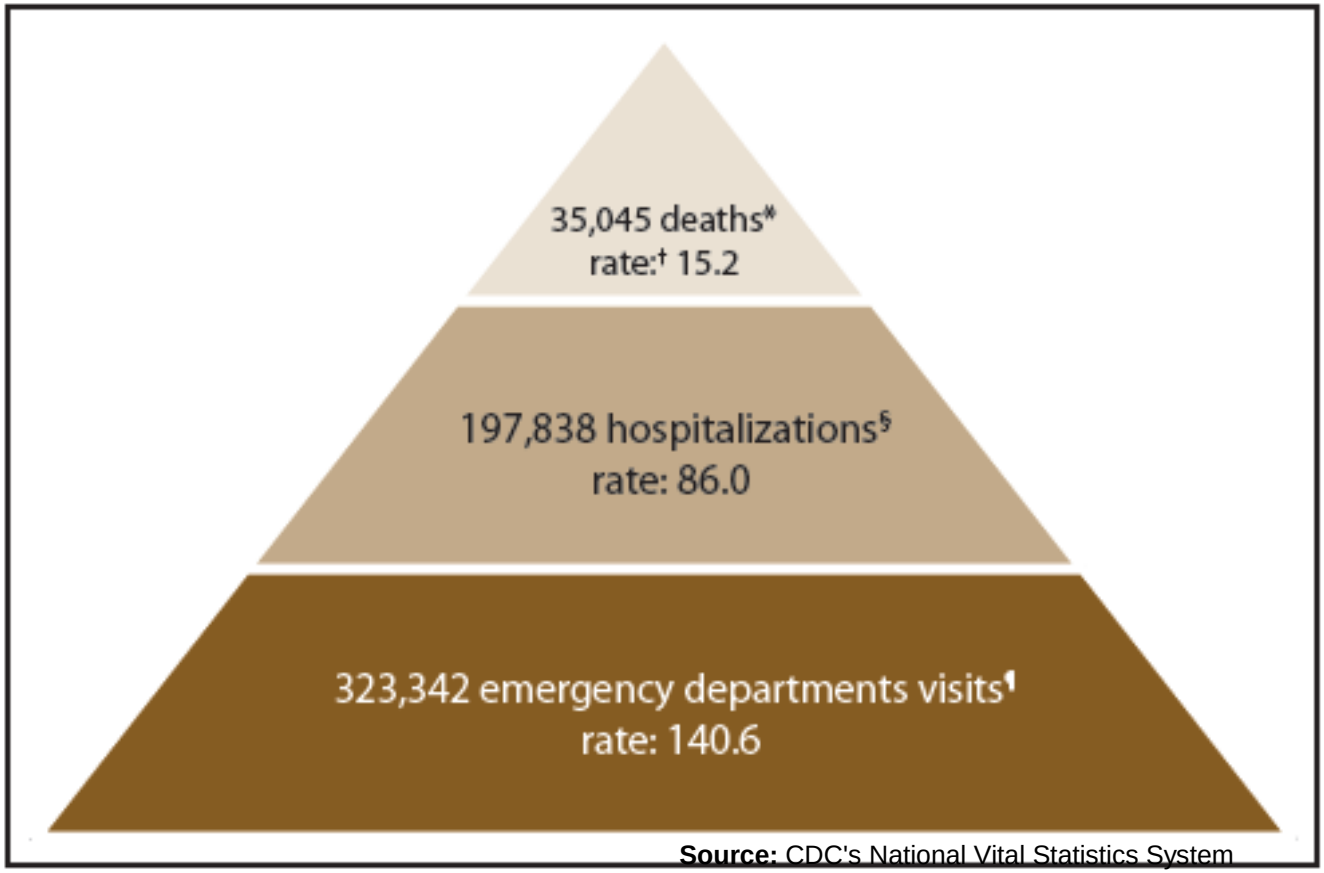


ED Treatment of Mental Disorders

One in 10 suicides are by people seen in the ED within two months of dying.

Public health burden of suicidal behavior among adults>18 years-United States, 2008



Link: http://www.cdc.gov/mmwr/pdf/ss/ss6013.pdf

Poll #1

Have you been impacted by
a suicide attempt or the loss of someone to suicide
either personally or professionally?

Professionally

Personally

Both

Neither

Mental Health Services

- 19 % of suicides had contact with MH within the past month; 32% within the past year (Luoma, 2002)
- 41% of suicide decedents who had received inpatient psychiatric care died within one year of their discharge; 9% within one day (Pirkis, 1998)
- 71% of psychotherapists report having at least one client who has attempted suicide, while 28% report having had at least one client die by suicide
- Approximately 50% of those who die by suicide in America will have seen a mental health provider at some time in their life
- 25 % of family members of suicidal patients take legal actions against the patient's mental health treatment team

Suicide in Adults

- Rector et al. (2008) indicate that the risk of suicide is highest at transition points. They observe that suicide rates are most prevalent in the first month after arrival at a prison; suicide rates in psychiatric hospitals are highest during the first week of being institutionalized, and bereavement-related suicides occur soon after the death of a loved one.

Implications of Epidemiological Data

There is a need to intervene early in the development trajectory of the depression and suicidal behavior.

Misconceptions About Suicide

- Most suicides are caused by one particular trigger event.
- Most suicides occur with little or no warning.
- It is best to avoid the topic of suicide.
- People who talk about suicide don't do it.
- Nonfatal self-destructive acts (suicide attempts) are only attention-getting behaviors.

Misconceptions About Suicide

- A suicidal person clearly wants to die.
- Once a person attempts suicide, he or she won't try it again.
- Suicide is a complex problem.
- If a person who has been depressed is suddenly feeling better, the danger of suicide is gone.
- Poor people are the source of most suicides.
- Being religious protects against suicide.

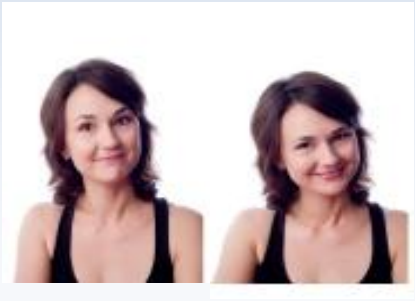
Our Approach to Suicide

Each person is divided:

- One part wants to live and is goal directed and life affirming.

- And one part is self-critical, self-hating and at its ultimate end, self-destructive. The nature and degree of this division varies for each individual.

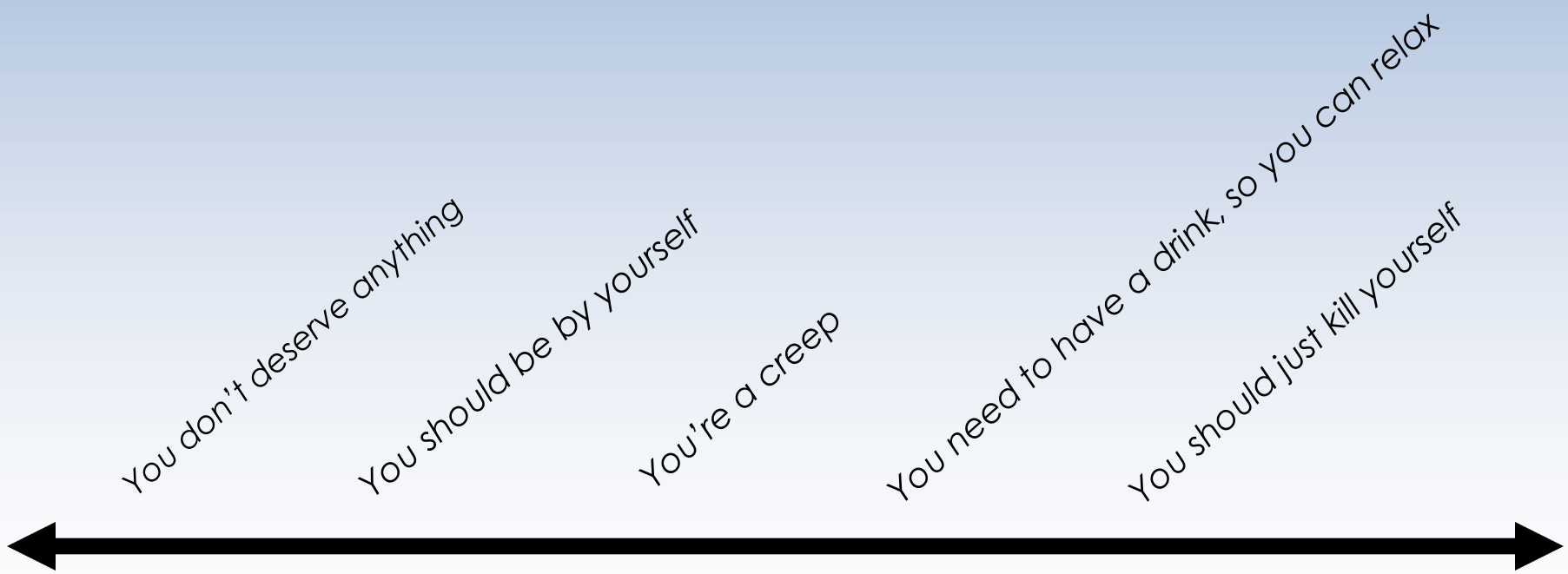
Real Self - Positive



Anti-Self - Critical

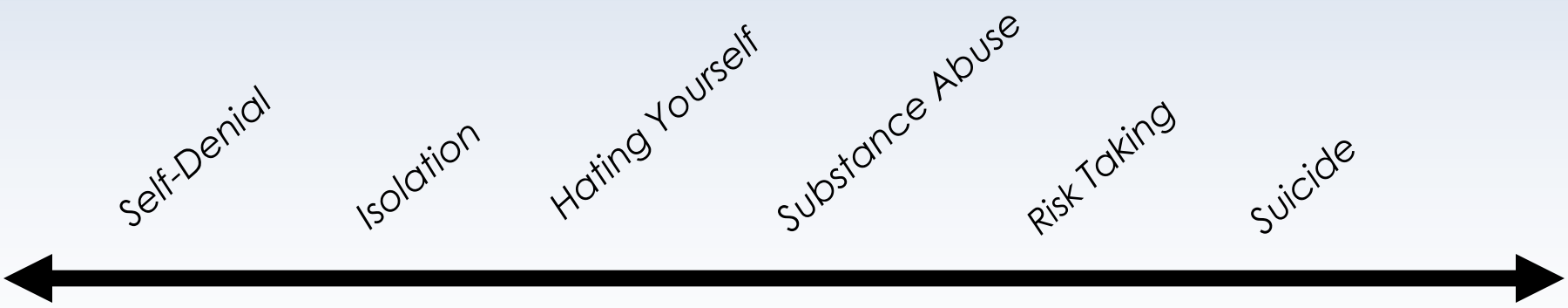
Our Approach to Suicide

Negative thoughts exist on a continuum, from mild self-critical thoughts to extreme self-hatred to thoughts about suicide



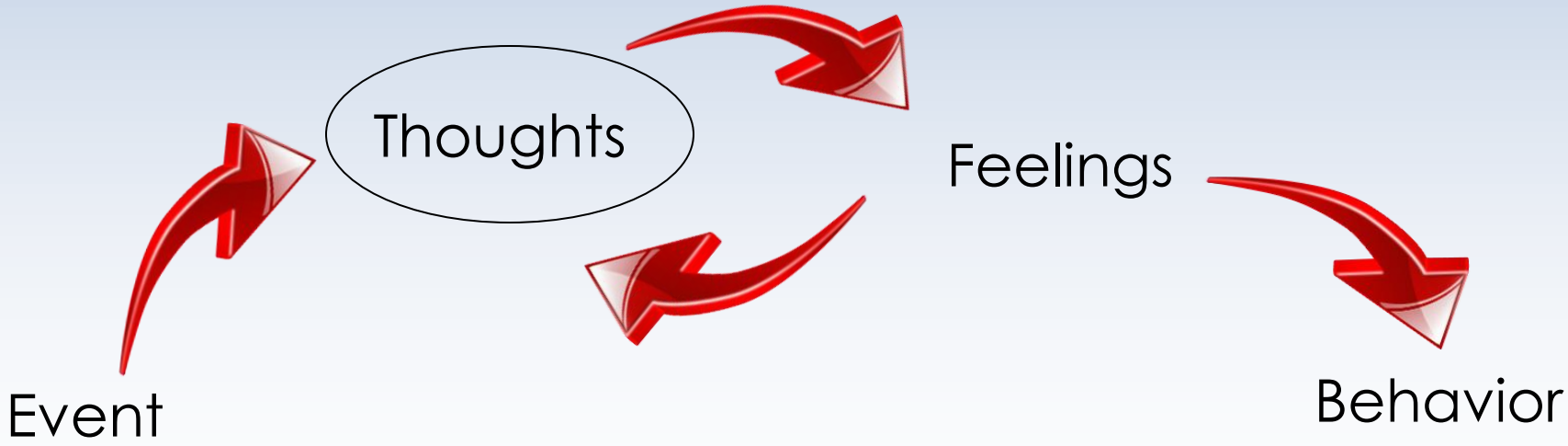
Our Approach to Suicide

Self-destructive behaviors exist on a continuum from self-denial to substance abuse to actual suicide.



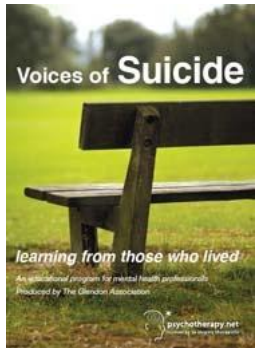
Our Approach to Suicide

There is a relationship between these two continuums. How a person is thinking is predictive of how he or she is likely to behave.



Voices of Suicide

From "Voices of Suicide: Learning From Those Who Lived"



http://www.youtube.com/watch?v=Es7s_z-YVLE

Poll #2

Have you had clients who've expressed thoughts similar to these?

Definition of the Voice

The critical inner voice refers to a well-integrated pattern of destructive thoughts toward our selves and others. The "voices" that make up this internalized dialogue are at the root of much of our maladaptive behavior. This internal enemy fosters inwardness, distrust, self-criticism, self-denial, addictions and a retreat from goal-directed activities. The critical inner voice effects every aspect of our lives: our self-esteem and confidence, our personal and intimate relationships, and our performance and accomplishments at school and work.

Where Do Critical Inner Voices Come From?

How Voices Pass From Generation to Generation

What causes insecure attachment?

- Unresolved trauma/loss in the life of the parents statistically predict attachment style far more than:
  - Maternal Sensitivity
  - Child Temperament
  - Social Status
  - Culture

"Type D" Attachment Disorganized/Disoriented

Predicts later chronic disturbances of:

- affect regulation
- stress management
- hostile-aggressive behavior

Division of the Mind

Self System

Positive Parenting Behaviors
Attunement, Affection, Control
Parental Nurturance/Genetic Predisposition/Temperament

Other nurturing experiences:
Caring adults, education

Anti–Self System

Destructive Parental Behaviors/ Misattunement, lack of affection, reject, neglect, hostility, permissiveness, Genetic Predisposition, Temperament

Other factors: accidents, illnesses, traumatic separation

Self System

Unique make-up of the individual –harmonious identification and incorporation of parent's positive attitudes and traits and the effect of experience on the maturing self-system resulting in a stronger sense of self and a greater degree of differentiation from parents or early caretakers.

Prenatal Influences

Disease Trauma

Substance Abuse/ Domestic Violence

Birth

Trauma

Baby

Genetic

Structure

Temperament

Physicality

Sex

Personal Attitudes/Goals/Conscience

Realistic, Positive Attitudes Towards Self

Realistic evaluation of talents, abilities, etc…with generally positive/ compassionate attitude towards self and others.

Goals
Needs, wants, search for meaning in life

Moral Principles

Behavior

Ethical behavior
towards self and others

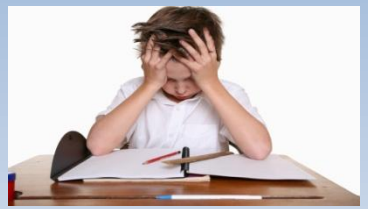
Goal Directed Behavior

Acting with Integrity

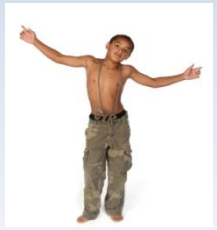
The Anti-Self System

The Fantasy Bond (core defense) furthers a self-parenting process made up of both the helpless, needy child, and the self-punishing, self-nurturing parent. Either aspect may be acted out in romantic relationships. The degree of reliance on this defense is proportional to the amount of damage sustained while growing up.

The Self-Parenting Process
Self-Punishing Voices

Voice Process	Behaviors
Critical thoughts toward self 	Verbal attacks-a generally negative attitude toward self and others predisposing alienation
2. Micro-suicidal injunctions (punitive/cruel thoughts) 	Addictive Patterns/thoughts heightening emotional distress
3. Suicidal injunctions – suicidal ideation 	Actions that jeopardize one's health and safety; physical attacks on the self, and actual suicide

The Self-Parenting Process
Self-Soothing Voices



Voice Process

1. Self Soothing Attitudes
2. Micro-suicidal injunctions (seductive/self-indulgent thoughts)
3. Aggrandizing thoughts towards self
4. Suspicious paranoid thoughts toward others

Behaviors

Self-limiting or self-protective lifestyles, Inwardness

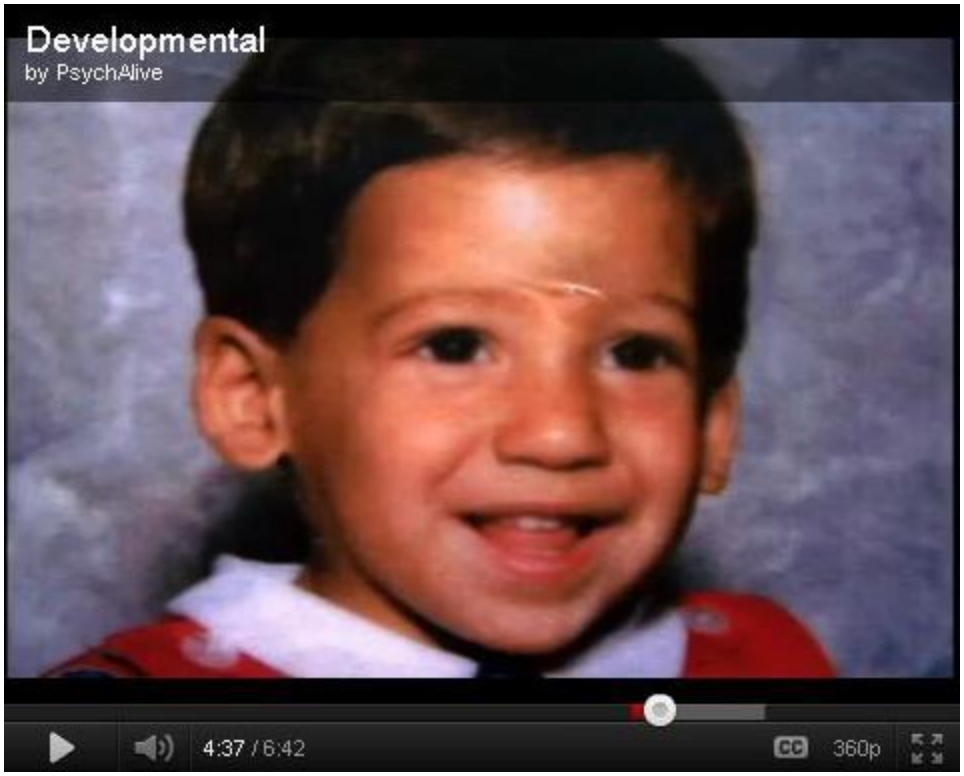
Addictive patterns/ numbing emotional distress

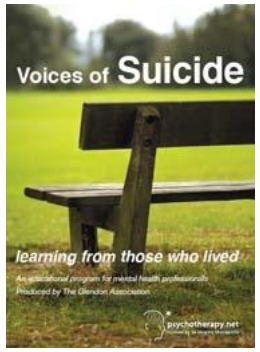
Narcissism/ Vanity and aggressive behavior towards others

Alienation, hostile attitudes towards others and aggressive behavior

Developmental

From "Voices of Suicide: Learning From Those Who Lived"





http://www.youtube.com/watch?v=xPcgkm9AlhU

How does a Suicide Occur?

Underlying Vulnerability

e.g.: Mood Disorder / Substance Abuse / Aggression / Anxiety / Impulsivity/ Sexual Orientation/ Abnormal Serotonin Metabolism/ Family Characteristics, including history of suicidality/ Sexual Abuse/Physical Abuse/Social adversity

↓

Stress Event

(often caused by underlying condition)
e.g.: In Trouble With Law or School / Loss/ ***Bullied***

↓

Acute Mood Change

Anxiety/Dread/Hopelessness/Anger

Inhibition

e.g.: Family cohesion/Religiosity / Available Support/ ***Internet/ Help-seeking attitudes***

↓

Survival

Facilitation

e.g.: Method/Weapon available / Recent example / Media displays/ ***Internet***

↓

Suicide

Gould, 2012

Continuum of Negative Thought Patterns

Thoughts that lead to low-self-esteem or inwardness (self-defeating thoughts):

Levels of Increasing Suicidal Intention	Content of Voice Statements
1. Self-depreciating thoughts of everyday life	*You're incompetent, stupid. You're not very attractive. You're going to make a fool of yourself.*
2. Thoughts rationalizing self-denial; thoughts discouraging the person from engaging in pleasurable activities	*You're too young (old) and inexperienced to apply for this job. You're too shy to make any new friends. Why go on this trip? It'll be such hassle. You'll save money by staying home.*
3 Cynical attitudes towards others, leading to alienation and distancing	*Why go out with her/him? She's cold, unreliable; she'll reject you. She wouldn't go out with you anyway. You can't trust men/women.*

Continuum of Negative Thought Patterns

Thoughts that lead to low-self-esteem or inwardness (self-defeating thoughts):

Levels of Increasing Suicidal Intention		Content of Voice Statements
4. Thoughts influencing isolation; rationalizations for time alone, but using time to become more negative toward oneself	⟷	***Just be by yourself. You're miserable company anyway; who'd want to be with you? Just stay in the background, out of view.***
5. Self-contempt; vicious self-abusive thoughts and accusations (accompanied by intense angry affect)	⟷	***You idiot! You bitch! You creep! You stupid shit! You don't deserve anything; you're worthless.***

Continuum of Negative Thought Patterns

Thoughts that support the cycle of addiction (addictions):

Levels of Increasing Suicidal Intention	⟷	Content of Voice Statements
6. Thoughts urging use of substances or food followed by self-criticisms (weakens inhibitions against self-destructive actions, while increasing guilt and self-recrimination following acting out).		*It's okay to do drugs, you'll be more relaxed. Go ahead and have a drink, you deserve it. (Later) You weak-willed jerk! You're nothing but a drugged-out drunken freak.*

Continuum of Negative Thought Patterns

Thoughts that lead to suicide (self-annihilating thoughts):

Levels of Increasing Suicidal Intention		Content of Voice Statements
7. Thoughts contributing to a sense of hopelessness urging withdrawal or removal of oneself completely from the lives of people closest.	⟷	*See how bad you make your family (friends) feel. They'd be better off without you. It's the only decent thing to do; just stay away and stop bothering them.*
8. Thoughts influencing a person to give up priorities and favored activities (points of identity).	⟷	*What's the use? Your work doesn't matter any more. Why bother even trying? Nothing matters anyway.*
9. Injunctions to inflict self-harm at an action level; intense rage against self.	⟷	*Why don't you just drive across the center divider? Just shove your hand under that power saw!*

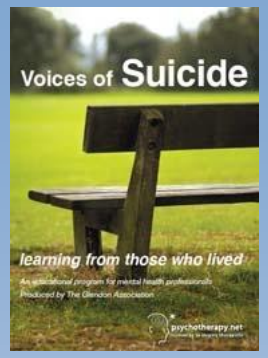
Continuum of Negative Thought Patterns

Thoughts that lead to suicide (self-annihilating thoughts):

Levels of Increasing Suicidal Intention		Content of Voice Statements
10. Thoughts planning details of suicide (calm, rational, often obsessive, indicating complete loss of feeling for the self).	⟷	*You have to get hold of some pills, then go to a hotel, etc.*
11. Injunctions to carry out suicide plans; thoughts baiting the person to commit suicide (extreme thought constriction).	⟷	*You've thought about this long enough. Just get it over with. It's the only way out.*

Thoughts to Actions

From "Voices of Suicide: Learning From Those Who Lived"



http://www.youtube.com/watch?v=lMR1I2Gu5Vo

Examples of the Narrative of Suicidal Individuals

" I can't stand being so depressed anymore." "I can stop this pain by killing myself." "I am damaged goods." (Scneidman, 2001 has characterized this intractable emotional pain as psychache)

"Suicide is the only choice I have." (The word "only" is considered one of the most dangerous words in suicidology)

"My family would be better off without me." "I was just a lifeless think-breathing, but worthless. I knew everyone would be better off if I were dead. It would end my misery and relieve their burden." "My death will be worth more than my life to my family." (Joiner, 2005, and Joiner and Van Orden, 2008, have highlighted the perception of being a burden on others as related to suicidal tendencies).

"I am useless and unwanted." (Joiner, 2005, highlights a sense of "thwarted belongingness," as contributing to suicidal ideation and actions.) Perceive others as uncaring and unsupportive; feel socially disconnected and lack emotional intimacy.

Examples of the Narrative of Suicidal Individuals cont'd

"No one cares whether I live or die." (Feel rejected, marginalized, worthless, unlovable, isolated, alone and a failure)

"I am worthless and don't deserve to live." (The presence of guilt and shame exacerbates suicidal ideation)

" I have an enemy within that I have to escape." (Baumeister, 2004, has viewed suicide as a form of escape from self. It also reflects the "drama of the mind" that suicidal individuals are prone to engage in).

I am a tailspin, like a freight train or tsunami hit me. There is no hope. I cant get caught up. What is the point?" (Riskind et al. 2000 and Rector et al. 2008 have noted that anxious and suicidal individuals are prone to produce elaborate mental scenarios anticipating rapidly rising risk with multiply increasing threats. They tend to exaggerate the time course of perceived catastrophic outcomes and have an increased sense of urgency for escape and avoidance).

" I hate myself." (Suicidal individuals have an over-generalized memory and tend to selectively recall negative events that contribute to invalidating themselves).

Examples of the Narrative of Suicidal Individuals cont'd

" I can't fix this problem and I should just die." (Tunnel vision, inflexibility in generating alternatives, feel trapped and perceived inescapability)

" I would rather die than feel this way." (Evidence poor distress tolerance)

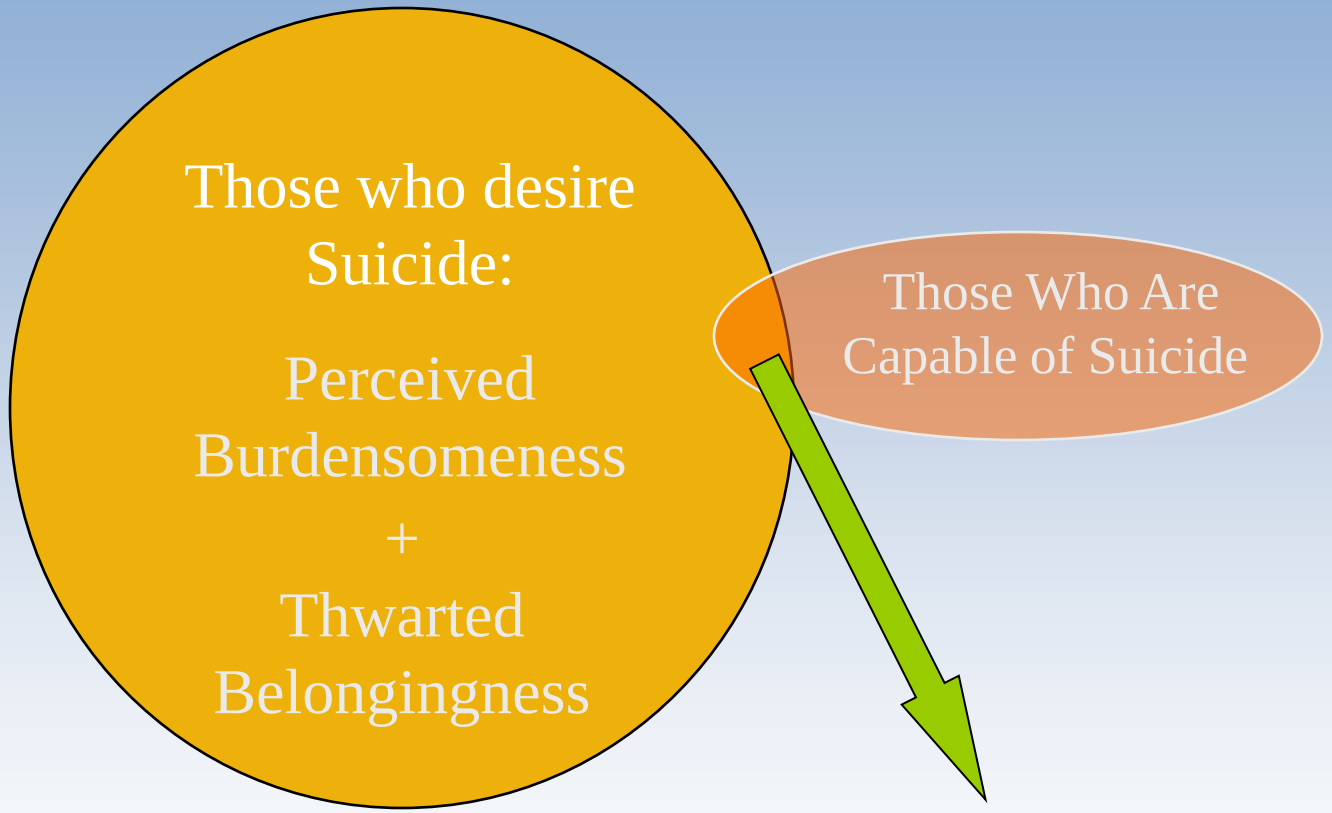
" I have lost everything important to me." "My future looks empty." "Life is no longer worth living." "Nothing will change." " There is no hope for me." (Ghahramanlou- Holloway et al., 2008, highlight the impact of such loss-related cognitions and the role of feelings of helplessness and hopelessness that exacerbate suicidal tendencies).

"I have screwed up, so I might as well screw up all the way." (Perception that he or she does not deserve to live which contributes to suicidal ideation)

"Those who hurt me will be sorry." (Perceived benefits of suicide, revenge)

"Suicide is a way of life for me and I can't stop it." (Kernberg, 2001)

Those Who Desire Suicide



Serious Attempt or Death by Suicide

Joiner, Thomas. *Why People Die By Suicide.* "The Three Components of Completed Suicide." Harvard University Press, 2005.

Poll #3

Do you use objective measures to assess suicide risk?

Why Use Objective Measures? What Interferes with Clinical Judgment

- Anxiety
- Counter Transference
- Psych Ache
- Research Minimizing
- Diverse Menu of Risk Factors

Our Measures

Based on Separation Theory developed by Robert W. Firestone, PhD. and represents a broadly based coherent system of concepts and hypothesis that integrates psychoanalytic and existential systems of thought. The theoretical approach focuses on internal negative thought processes. These thoughts (i.e. "voices") actually direct behavior and, thus, are likely to predict how an individual will behave.

Firestone Assessment of Self-Destructive Thoughts

		Never	Rarely	Once In A While	Frequently	Most Of The Time
1.	**Just stay in the background.**	0	1	2	3	4
2.	**Get them to leave you alone. You don't need them.**	0	1	2	3	4
3.	**You'll save money by staying home. Why do you need to go out anyway?**	0	1	2	3	4
4.	**You better take something so you can relax with those people tonight.**	0	1	2	3	4
5.	**Don't buy that new outfit. Look at all the money you are saving.**	0	1	2	3	4

Figure 4.3. Mean *T* Scores for the Depression Sample: Inpatients and Outpatients—Ideators Versus Nonideators (*N* = 296)

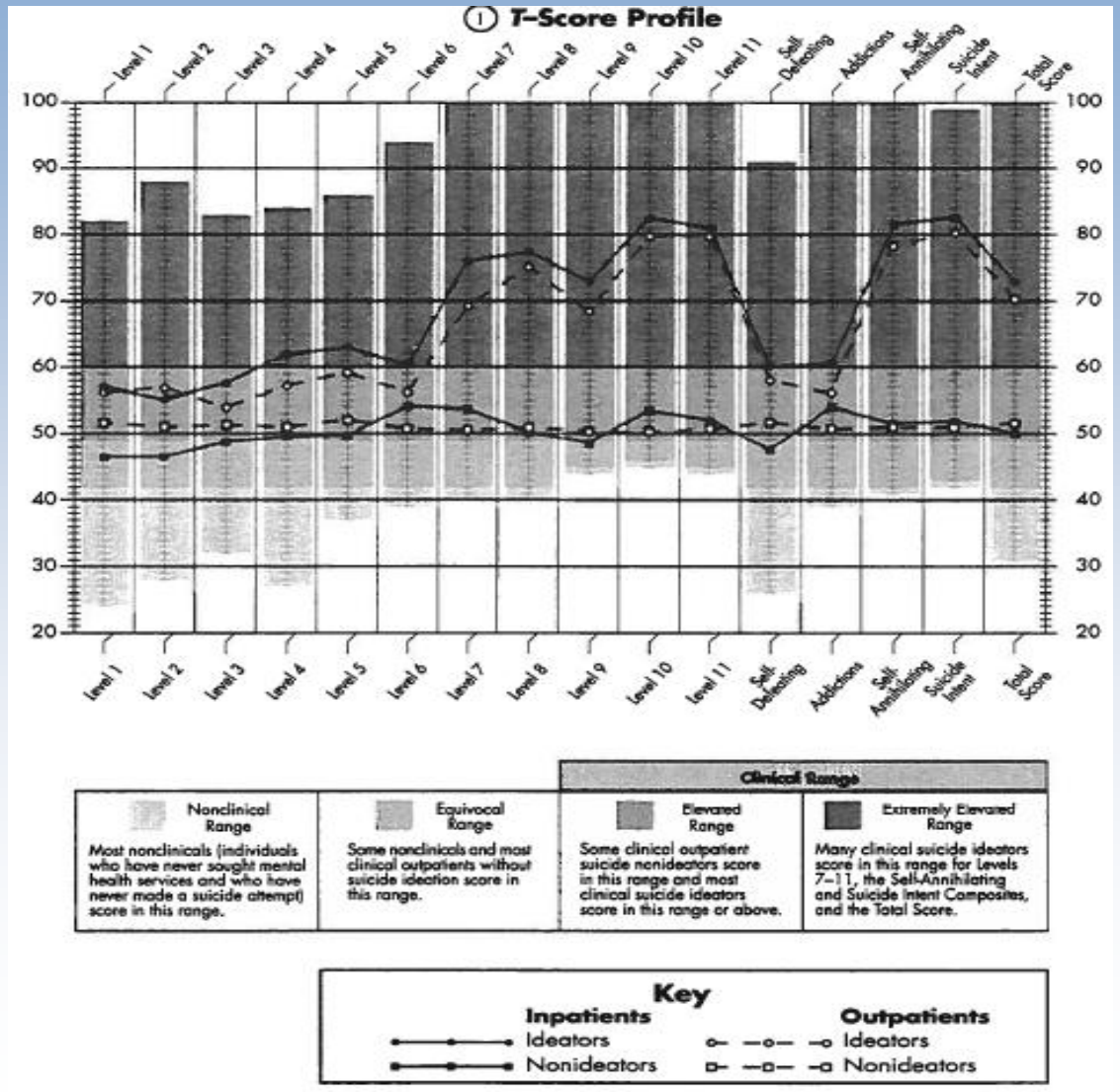


Figure 4.5. Mean *T* Scores for the Bipolar Disorder Sample—Ideators Versus Nonideators (*N* = 68)

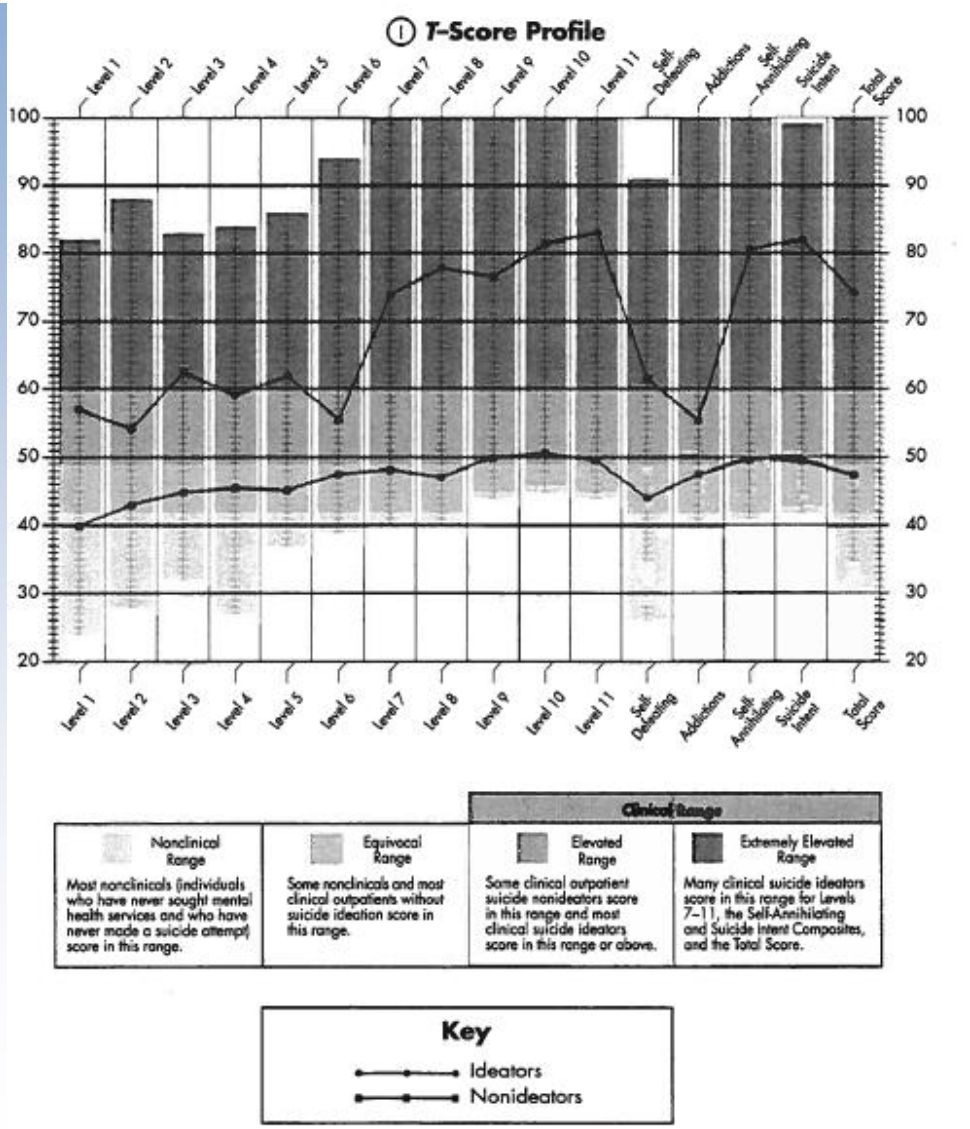


Figure 4.7. Mean *T* Scores for the Substance Abuse Sample: Inpatients and Outpatients—Ideators Versus Nonideators (*N* = 202)

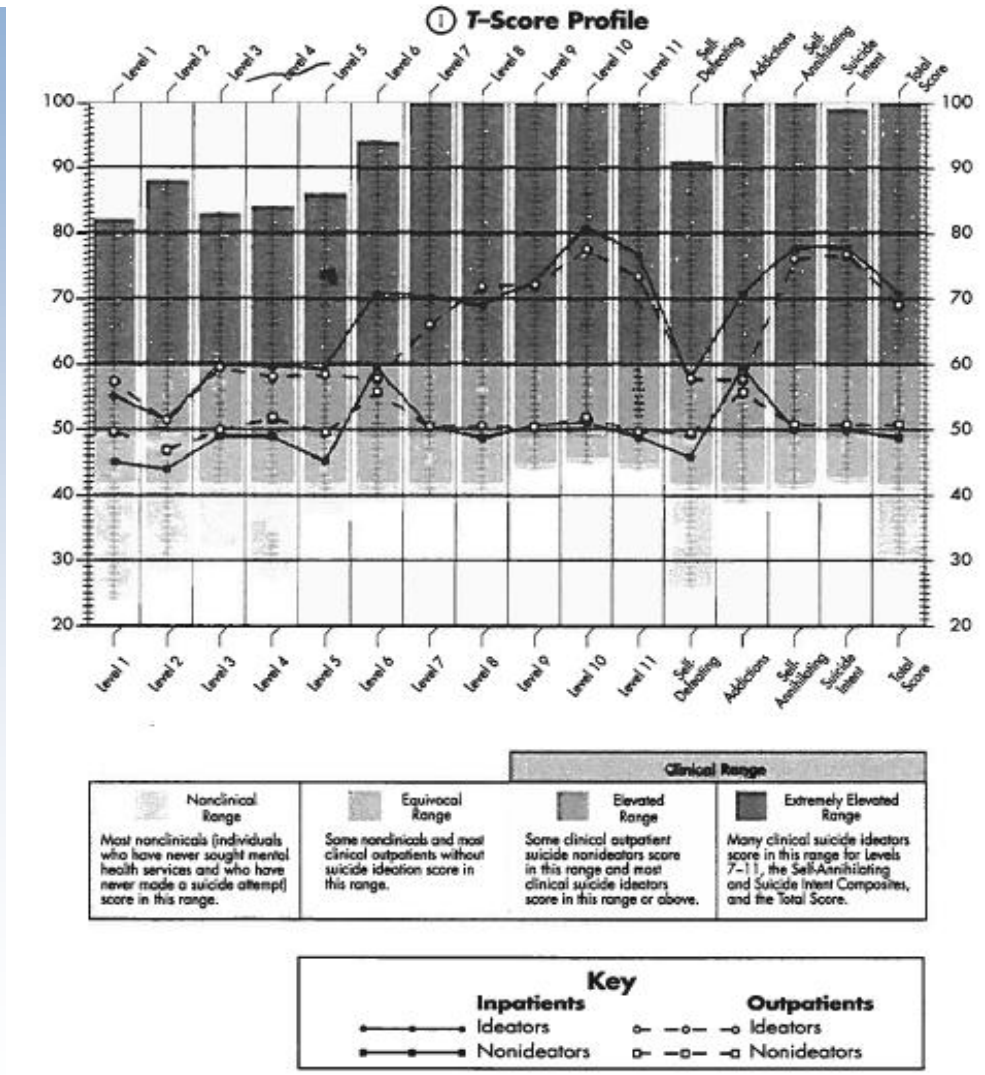


Figure 4.6. Mean *T* Scores for the Inpatient Schizophrenia Sample—Ideators Versus Nonideators (*N* = 115)

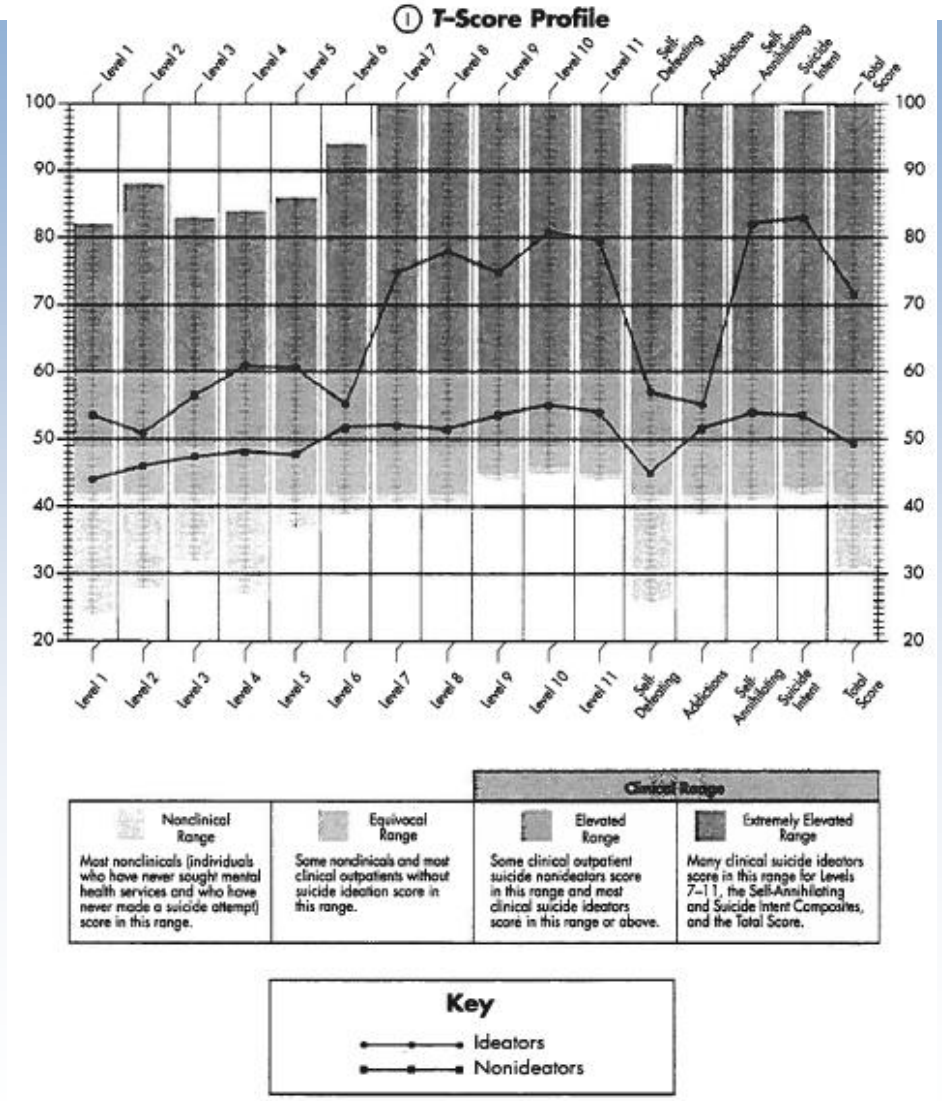
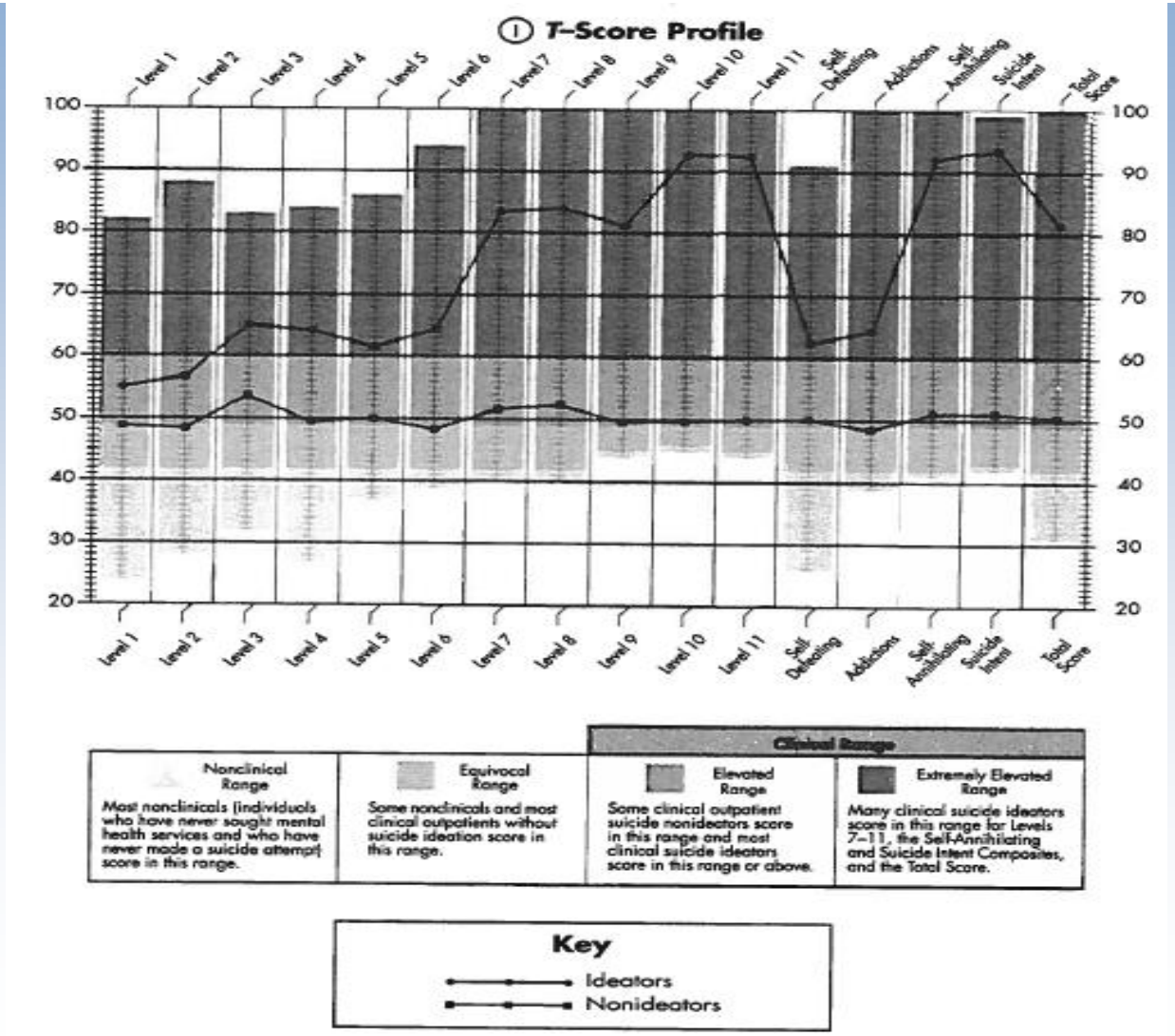


Figure 4.4. Mean *T* Scores for the Outpatient Personality Disorder Sample—Ideators Versus Nonideators (*N* = 35)

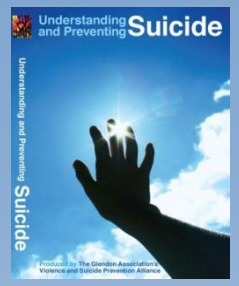


Uses for Our Measures

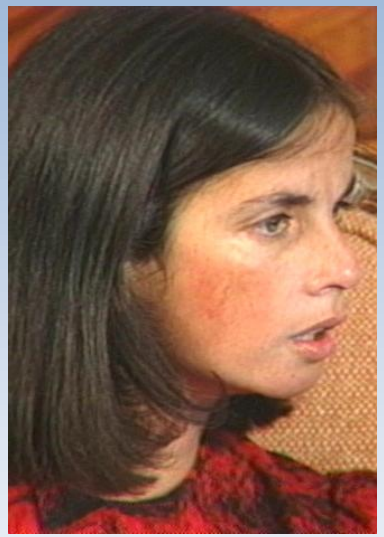
- Risk Assessment
- Treatment Planning
- Targeting Intervention
- Outcome Evaluation

Warning Signs for Suicide

From *Understanding and Preventing Suicide*

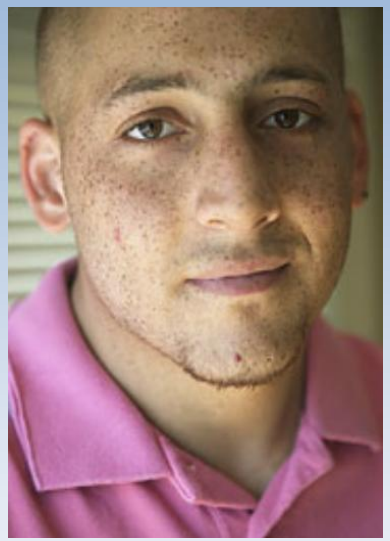


Susan



Trish

Kevin



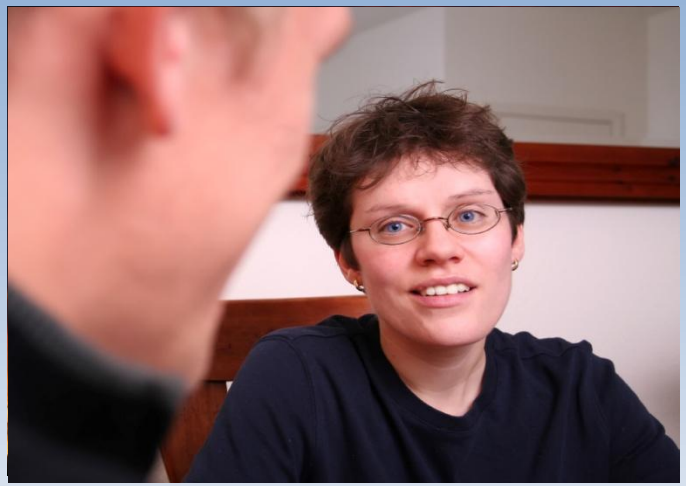
http://www.youtube.com/watch?v=0hY6dJkV8I8

Suicide Warning Signs

- Disturbed sleep patterns
- Anxiety, agitation
- Pulling away from friends and family
- Past attempts
- Extremely self-hating thoughts
- Feeling like they don't belong
- Hopelessness
- Rage

Suicide Warning Signs

- Feeling trapped
- Increased use of alcohol or drugs
- Feeling that they are a burden to others
- Loss of interest in favorite activities -"nothing matters"
- Giving up on themselves
- Risk-taking behavior
- Suicidal thoughts, plans, actions
- Sudden mood changes for the better



Suicide Risk Factors Checklist

- Psychiatric
  - Major Depression-particularly endogenous
  - Alcohol dependence-rate 50x the general population, 25% of all suicides
  - Drug addiction- 10% die by suicide
  - Personality Disorders- especially borderline or compulsive
  - Schizophrenia-frequently with command hallucinations
  - Organic psychoses

Suicide Risk Factors Checklist

- Psychiatric
  - Past history- especially if attempts were serious
  - Family History-increased risk in twin and adoption studies
  - Possible biologic markers: Decreased CSF 5-HIAA, increased CSF MHPG, nonsuppressing DST, low platelet MAO, low platelet serotonin, high platelet serotonin-2 receptor responsibility
  - Poor physical health- renal dialysis patients have a suicide rate 400X higher than the general population

Suicide Risk Factors Checklist

- Psychological
  - History of Recent Loss
  - History of parental Loss During Childhood
  - Important Days-anniversaries, holidays, etc.
  - Family instability
  - Social Isolation-loss of social supports

Suicide Risk Factors Checklist

- Social
  - Sex-

    Male 3X female
  - Race-

    Whites 2x nonwhites, except urban areas where rate is the same: Native Americans have higher rates
  - Age-

    in men rates rise with age above age 45; in women the peak risk is about age 55, then the rate declines
  - Geography-

    urban rates higher
  - Marital Status-

    divorced> single>widowed>married

Protective Factors

- Family and community connections/ support
- Clinical Care (availability and accessibility)
- Resilience
- Coping Skills
- Frustration tolerance and emotion regulation
- Cultural and religious beliefs; spirituality

Poll #4

Do you find it stressful to assess and manage suicide risk?

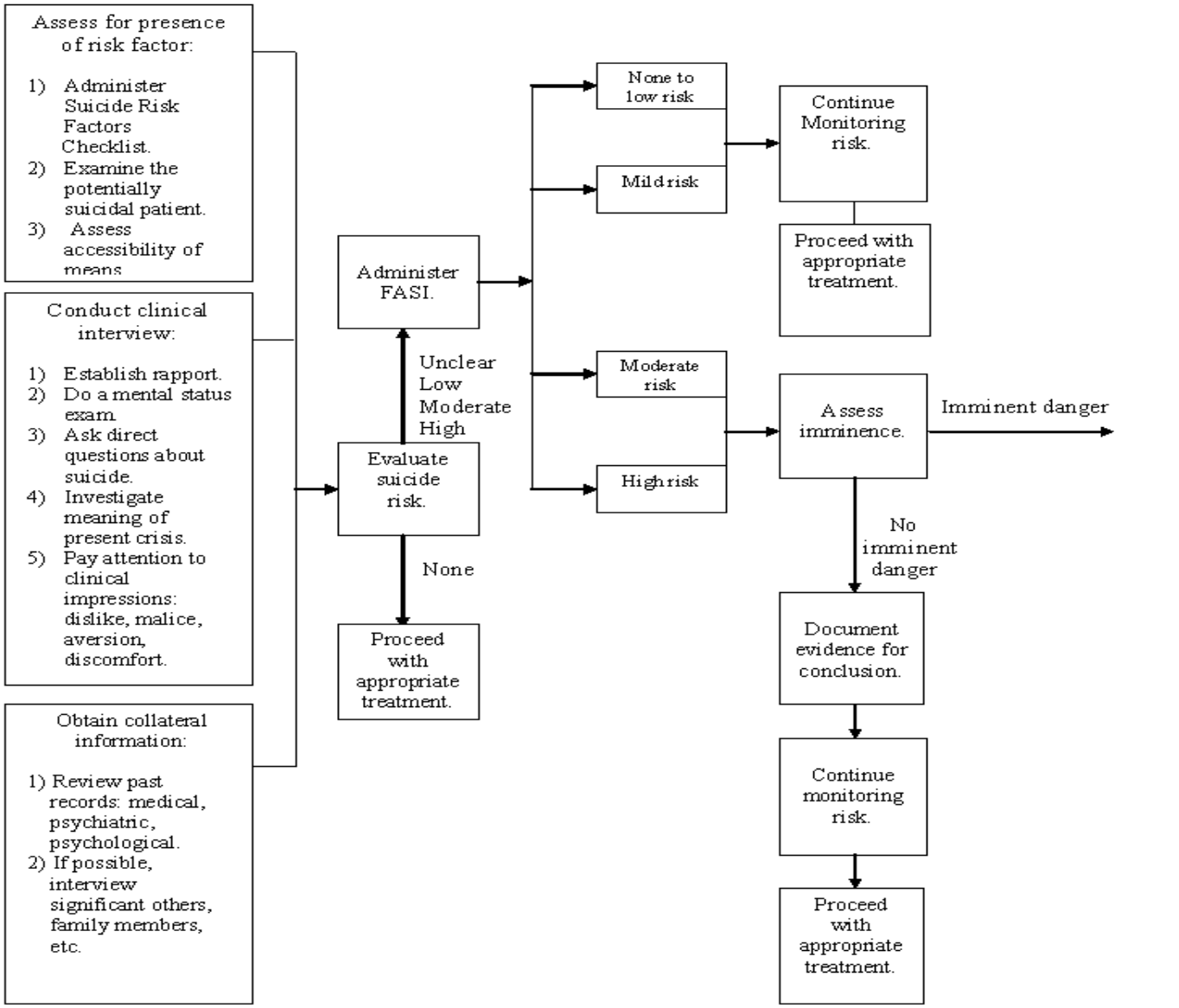


Figure 5.1. Assessment and Management of the Suicidal Patient

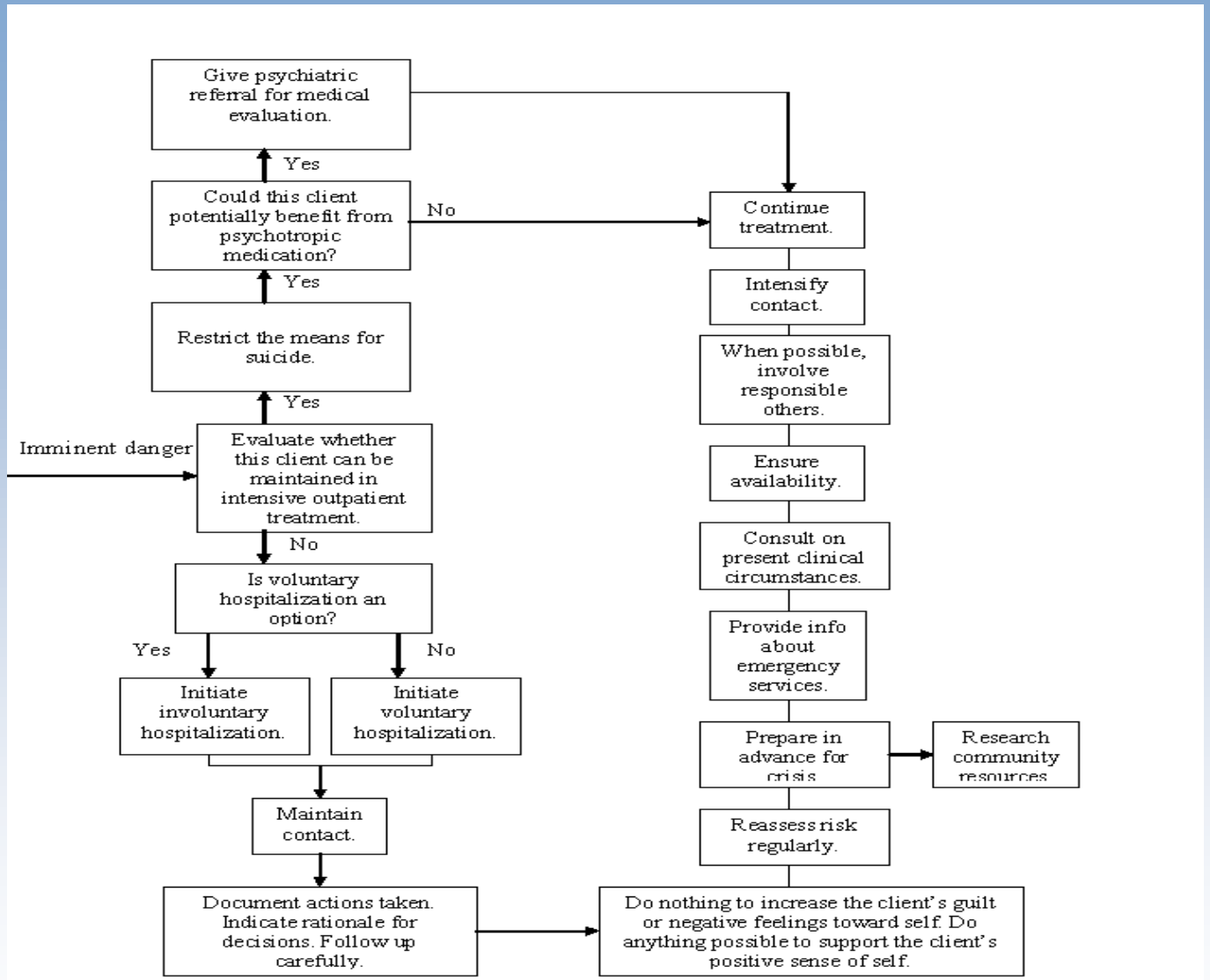


Figure 5.1. Assessment and Management of the Suicidal Patient

Poll #5

Do you see clients who have had prior suicide attempts?

- 0
- 1 past attempt
- 2 or more past attempts

Multiple Attempters as a Special High-Risk Group (in comparison to single attempters/ideators)

- Distinctive in every way
  - Greater likelihood to have diagnosis, co-morbidity, personality disorder
  - Younger at time of first attempt (greater chronicity)
    - Lower lethality first attempt (raises question about intent, function of behavior)
    - More impulsive
    - More likely to be associated with substance abuse
  - Greater symptom severity
    - Anxiety, depression, hopelessness, anger, suicidal ideation (frequency, intensity, specificity, duration, intent)
  - More frequent histories of trauma, abuse
  - Distinctive characteristics of crises

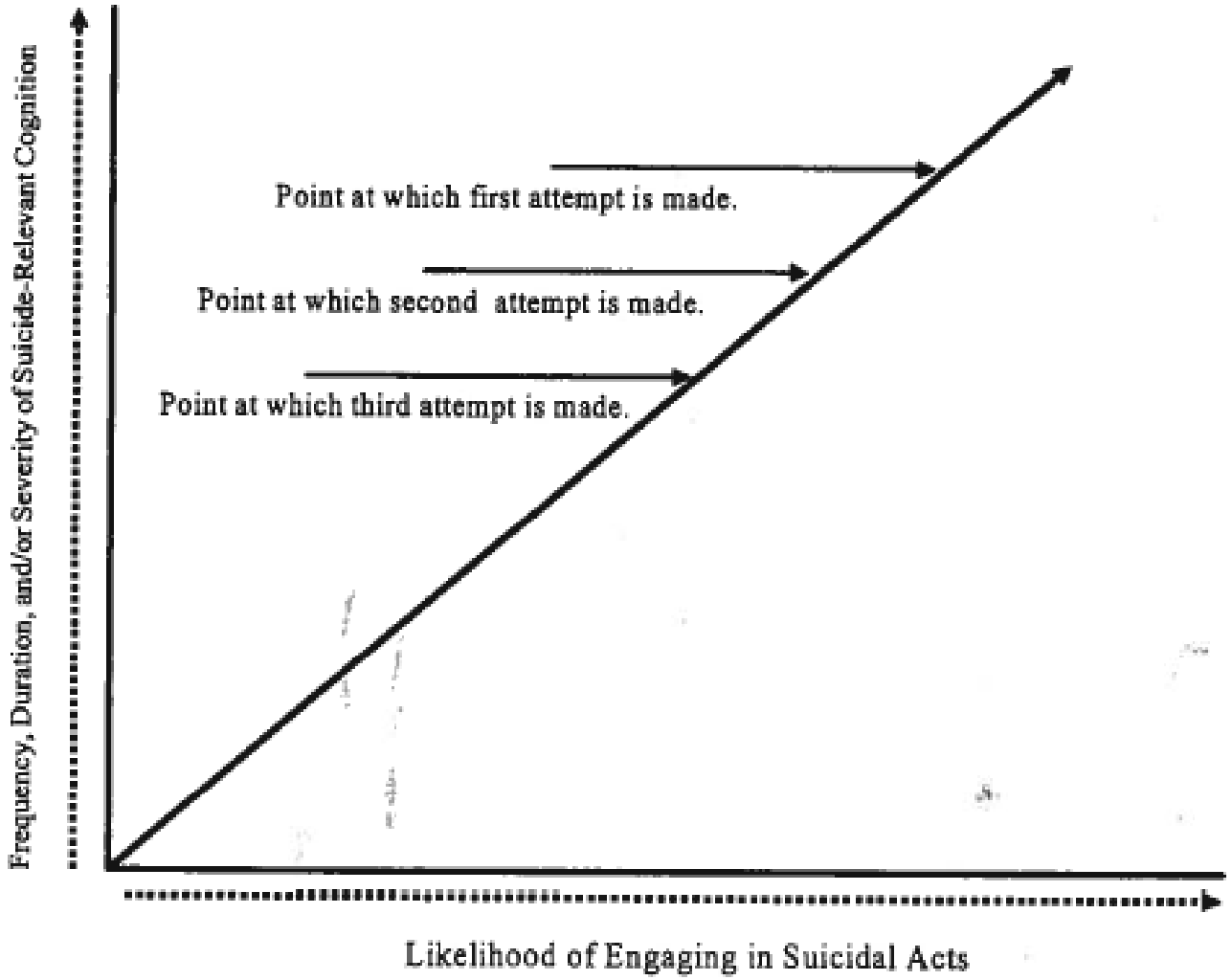


Figure 3.3. Suicide-relevant cognitions and the likelihood of engaging in suicidal acts.

Safety Plan, Stanley and Brown, 2008

Figure 6.3. Example of a safety plan developed during the early phase of treatment. ED=emergency department

1. Warning signs (when I am to use the safety plan):

- ❑ wanting to go to sleep and not wake up
- ❑ wanting to hurt myself
- ❑ thinking "I can't take it anymore"

2. Coping strategies (things I can try to do on my own):

- ❑ listening to rock music
- ❑ rocking in a chair
- ❑ going for a walk
- ❑ controlled breathing
- ❑ taking a hot or cold shower
- ❑ exercising

3. Contacting other people:

- ❑ Calling a friend to distract myself: _____ Phone:_____

If distraction does not work, I will tell any of the following people that I am in crisis and ask for help:

- ❑ Calling a family member:_____Phone:_____
- ❑ Calling or talking to someone else:_____Phone:_____

4. Contacting a health care professional during business hours:

Calling my therapist:_____Phone:_____
Calling my psychiatrist:_____Phone:_____
Calling my case manager:_____Phone:_____
The following agencies or services may be called 24 hours a day/7 days a week:
Calling the psychiatrist ED:_____Phone:_____
Calling National Suicide Prevention Lifeline Phone: 1-800-273-TALK

Patients signature:_____Date:_____
Clinician signature:_____Date:_____

ASK

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TX Suicide Prevention App for Smartphones

The ASK & Prevent Suicide mobile app, developed by the Texas Youth Suicide Prevention Project, helps users recognize warning signs, ask about suicidal thoughts, and find help for people at risk, including LGBTQ people and veterans.

Read more

TX Suicide Prevention App for Smartphones

ASK About Suicide to Save a Life is an app that helps users recognize the warning signs for suicide, ask about suicidal thoughts, and find help for people at risk. It includes sections dedicated to LGBTQ people and veterans, as well as a list of crisis hotlines in Texas and links to national and state suicide prevention resources. The app was developed by the Texas Department of State Health Services and Mental Health America of Texas as part of the Texas Youth Suicide Prevention Project.

Versions are available, at no-cost, for both iPhones/iPads and Android phones and mobile web browsers.

Ten Most Common Errors in Suicide Prevention

1. Superficial Reassurance
2. Avoidance of Strong Feelings
3. Professionalism
4. Inadequate Assessment of suicidal intent
5. Failure to identify the precipitating event
6. Passivity
7. Insufficient Directiveness
8. Advice Giving
9. Stereotypic Responses
10. Defensiveness

Practice Recommendations

1. When imminent risk does not dictate hospitalization, the intensity of outpatient treatment (i.e., more frequent appointments, telephone contacts, concurrent individual and group treatment) should vary in accordance with risk indicators for those identified as high risk.

Practice Recommendations

2. If the target goal is a reduction in suicide attempts and related behaviors, treatment should be conceptualized as long-term and target identified skills deficits (e.g., emotion regulation, distress tolerance, impulsivity, problem-solving, interpersonal assertiveness, anger management), in addition to other salent treatment issues.

Practice Recommendations

3. If therapy is brief and the target variable are suicidal ideation, or related sumptomatology such as depression, hopelessness, or loneliness, a problem-solving component should be used in some form or fashion as a core intervation.

Practice Recommendations

4. Regardless of therapeutic orientation, an explanatory model should be detailed identifying treatment targets, both direct (i.e., suicidal ideation, attempts, related self-destructive and self-multistory behaviors) and indirect (depression, hopelessness, anxiety, and anger; interpersonal relationship dysfunction; low self-esteem and poor self-image; day-to-day functioning at work and home).

Practice Recommendations

5. Use of standardized follow-up and referral procedure (e.g., letters or phone calls) is recommended for those dropping out of treatment prematurely in an effort to enhance compliance and reduce risk for subsequent attempts.

Practice Recommendations

6. The lack of definitive data regarding the efficacy of one approach over another should be reviewed with the patient as a component of informed consent.

Poll #6

Have you received formal training in treating suicidal individuals?

The Aeschi Working Group:

- Konrad Michel, Antoon Leenaars, David Jobes, Terry Maltsberger, Israel Orbach, Ladislav Valach, Richard Young, Michael Bostwick.

Aeschi Principles:

- Empathic, non-judgmental attitude
- Narrative approach
- Understanding suicide as escape from unbearable affective state
- Active interventions
- Resolve therapist's ambivalence and fear

AESCHI West

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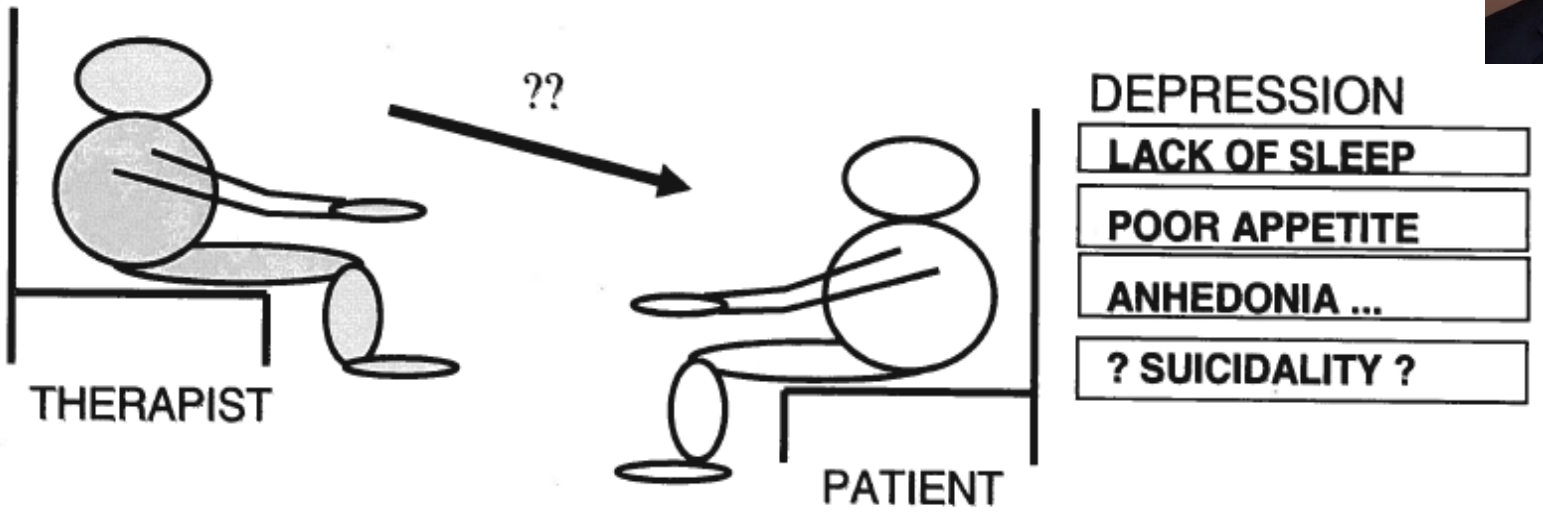
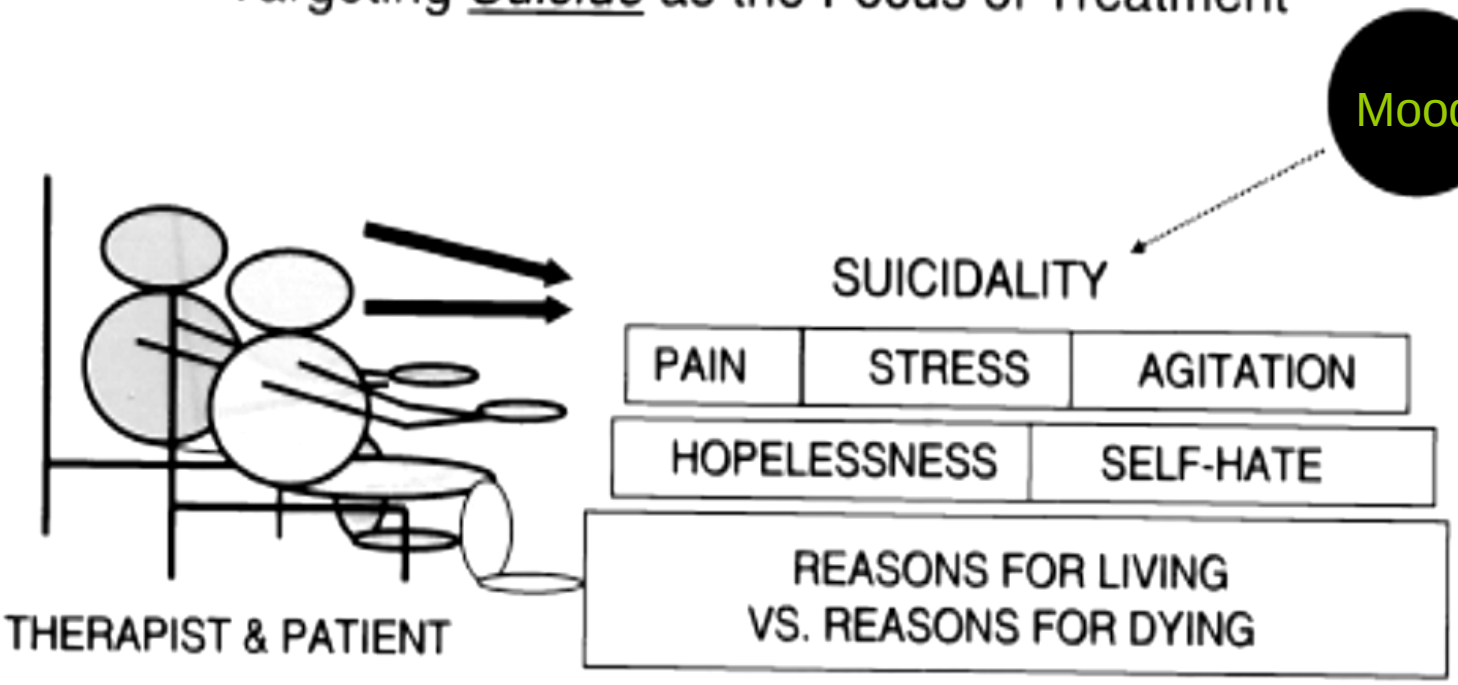
CONVENTIONAL MODEL:
Suicide = Symptom



Traditional treatment = main focus on the psychiatric disorder (suicidality as symptom). Use of devices such as the no-suicide contract.

Jobes, DA (2006). *Managing Suicide Risk* (CAMS). New York: Guilford.

COLLABORATIVELY ASSESSING RISK:
Targeting *Suicide* as the Focus of Treatment



CAMS Treatment = Intensive intervention that is suicide-specific, emphasizing the development of new means of coping and problem-solving, thereby eliminating the need for suicidal coping.

Jobes, DA (2006). *Managing Suicide Risk* (CAMS). New York: Guilford.

Suicide Status Form-III (SSF III) Initial Session

Rank

Patient_____ Clinician_____ Date_____ Time_____

Section A-Patient

Rate and fill out each item according to how you feel right now. Then rank items in order of importance 1 to 5 (1=most important, 5=least important)

_____ 1. Rate psychological pain (hurt, anguish, or misery in your mind; not stress; not physical pain):

Low Pain: 1 2 3 4 5 :High Pain

What I find most painful is:_____

_____ 2. Rate stress(your general feeling of being pressured or overwhelmed):

Low Stress: 1 2 3 4 5 :High Stress

What I find most stressful is:_____

_____ 3. Rate agitation(emotional urgency; feeling that you need to take action; not irritation; not annoyance):

Low Agitation: 1 2 3 4 5 :High Agitation

I most need to take action when:_____

_____ 4. Rate Hopelessness (your expectation that things will not get better no matter what you do)

Low Hopelessness: 1 2 3 4 5 :High Hopelessness

I am most hopeless about:_____

_____ 5. Rate Self-Hate (your general feeling or disliking of yourself; having no self-esteem; having no self-respect)

Low Self-Hate: 1 2 3 4 5 :High Self-Hate

N/A What I hate most about myself is:_____

_____ 6. Rate overall Risk of Suicide:

Extremely Low Risk (will not kill self: 1 2 3 4 5 :Extremely High Risk (will kill self)

1.How much is being suicidal related to thoughts and feelings about yourself? Not at all:1 2 3 4 5 :Completely
2. How much is being suicidal related to thoughts and feelings about others? Not at all:1 2 3 4 5 :Completely

Rank	Reason for living
____	•
____	•
____	•
____	•
____	•
____	•
____	•
____	•
____	•

Rank	Reason for dying
____	•
____	•
____	•
____	•
____	•
____	•
____	•
____	•
____	•

CAMS patients reached resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients. (Jobes et al., 2003, Wong, 2003)

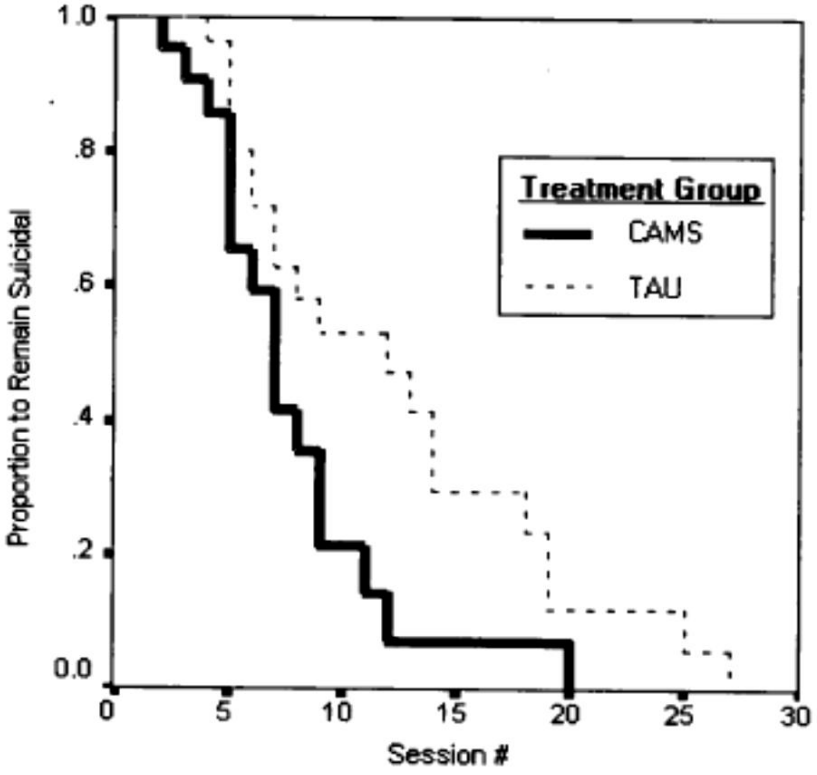


Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.

Effective Therapy Approaches for Treating the Suicidal Person

- Cognitive Therapy for suicidal people was developed by Aaron *Beck* and Gregory *Brown*. Unlike other CBT treatments, this approach is not time limited. The third and last stage is "Relapse Prevention with a Twist." Clients do not graduate from treatment until they demonstrate that they are ready to do this on their own.

- Dialectical Behavior Therapy, developed by *Marsha* M. *Linehan*, is designed to treat emotion regulation difficulties and suicidal behavior. One element, the skill-building component of DBT, addresses the issues of distress tolerance and the development of healthy affect regulation strategies, both of which are essential for suicidal clients.

- Mentalizing Treatment, developed by Jon *Allen* and Peter *Fonagy,* emphasizes emotional regulation and expressiveness. The techniques implemented assist clients in forming good affect regulation and tolerance through the process of developing the mentalizing capability to observe and understand their mind and the minds of others, accurately seeing the mind behind the behavior.

- Transference Focused Therapy, developed by Kernberg, Clarkin, and Yeomans, concentrates on the intermediate interaction between the client and therapist in session by focusing on the therapeutic relationship.

- Voice Therapy, which was developed by Robert Firestone, is a cognitive-affective-behavioral therapeutic methodology that brings introjected hostile thoughts, with the accompanying negative affect, to consciousness, rendering them accessible for treatment. This technique facilitates the identification of the negative cognitions driving the suicidal actions, which in turn helps clients to gain a measure of control over all aspects of their self-destructive or suicidal behavior. This process helps clients expand their personal boundaries, develop a sense of meaning in life, and reduce the risk of self-destructive behavior, including suicide.

Construction of a Hope Kit*

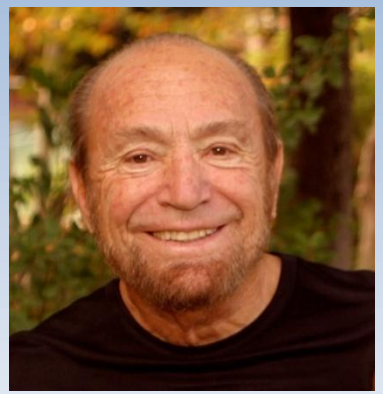
Another activity that is undertaken in the middle phase of therapy is the construction of a hope kit. A hope kit consists of a container that holds mementos (photographs, letters, souvenirs) that serve as reminders of reasons to live. Patients are instructed to be as creative as possible when creating their hope kit, so that the end result is a powerful and personal reminder of their connection to live that can be used when feeling suicidal. We have found that patients report making their hope kits to be a highly rewarding experience that often leads them to discover reasons to live they had previously overlooked.

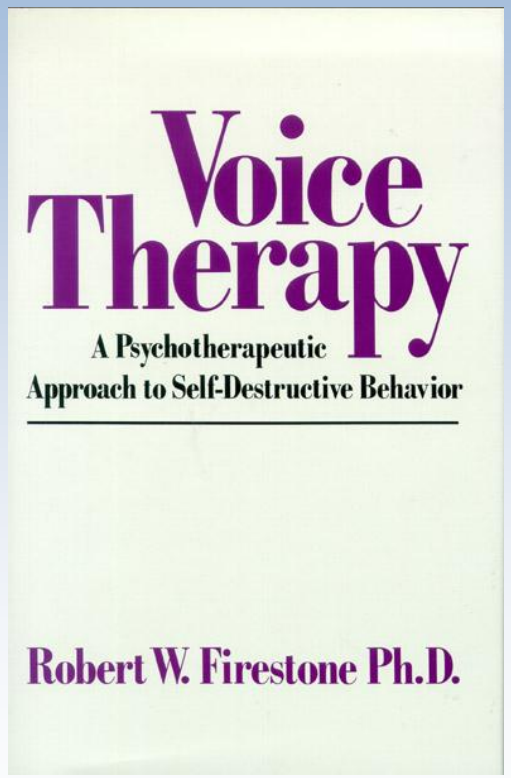
Suzanne was rather artistic and reported that she enjoyed this task. She found an old shoe box and decorated it using some of her favorite pictures. Inside she included pictures of her mother, her friends, and her cart. She also included the lyrics of her favorite song, a potpourri bag filled with her favorite scent, and a piece of her childhood blanket. Suzanne kept the hope box on her dresser, and it frequently reminded her of all the good things in her life.

**Excerpted from "Cognitive Therapy, Cognition, and Suicidal Behavior" by GK Brown, E Jeglic, GR Henriques, and AT Beck In *T.E. Ellis (Ed.), Cognition and Suicide (APA Books, 2006).*

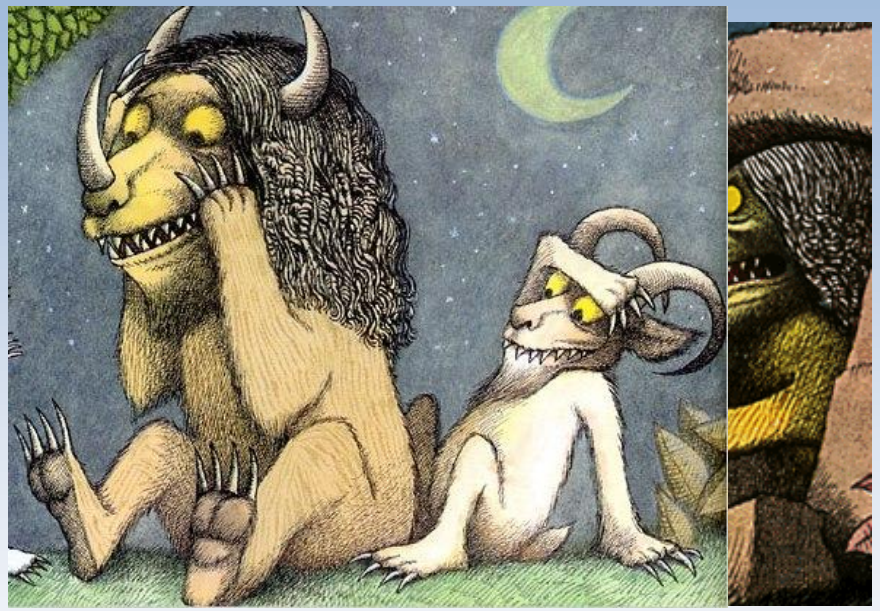
Voice Therapy

Cognitive Affective Behavioral Approach



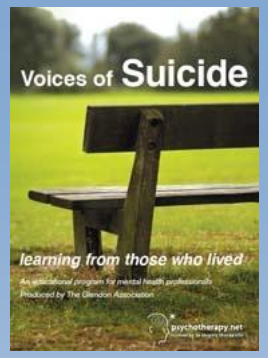


- Self
- Anti-Self



Treatment

From "Voices of Suicide: Learning From Those Who Lived"



http://www.youtube.com/watch?v=H4i9G9g-1kk

Most Helpful Aspects from Client Perspective

Validating Relationships

- Participants describe the existence of an affirming and validating relationship as a catalyst for reconnection with others and with oneself. A difficult part of the recovery process was breaking through, cognitive, emotional, and behavioral barriers that participants had generated for survival.

Most Helpful Aspects from Client Perspective

Working with Emotions

- Dealing with the intense emotions underlying suicidal behavior was perceived as crucial to participant's healing. The resolution of despair and helplessness was a pivotal and highly potent experience for all participants in the study. Almost paradoxically, if a client did not receive acknowledgement of these powerful and overwhelming feelings, they reported being unable to move beyond them.

Most Helpful Aspects from Client Perspective

Developing Autonomy and Identity

- Participants identified understanding suicidal behaviors , developing self-awareness, and constructing personal identity as key components of the therapeutic process. Participants conceptualized the therapeutic experience as confronting and discarding negative patterns while establishing new, more positive ones.

Common Emotions Experienced in Grief:

- Shock
- Guilt
- Despair
- Stress
- Rejection
- Confusion
- Helplessness
- Denial
- Anger
- Disbelief
- Sadness
- Loneliness
- Self-Blame
- Depression
- Pain
- Shame
- Hopelessness
- Numbness
- Abandonment
- Anxiety

These feelings are normal reactions, and the expression of them is a natural part of grieving. Grief is different for everyone. There is no fixed schedule or one way to cope.

Self-Care & Help Seeking Behaviors

- Ask for help
- Talk to others
- Get plenty of rest
- Drink plenty of water, avoid caffeine
- Do not use alcohol and other drugs
- Exercise
- Use relaxation skills

PSYCHALIVE.ORG – Suicide Prevention Advice Page

http://www.psychalive.org/2011/09/suicide-prevention-advice-2/

National Action Alliance for Suicide Prevention

http://actionallianceforsuicideprevention.org/

American Association of Suicidology's Survivors' Support Group Directory
http://www.suicidology.org/web/guest/support-group-directory

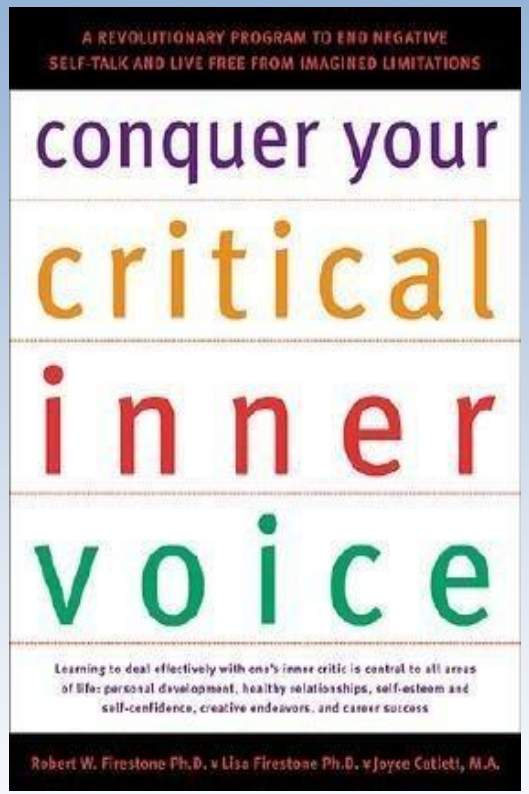
IASP Suicide Survivor Organizations (listed by country) -

http://www.iasp.info/resources/Postvention/National_Suicide_Survivor_Organizations/

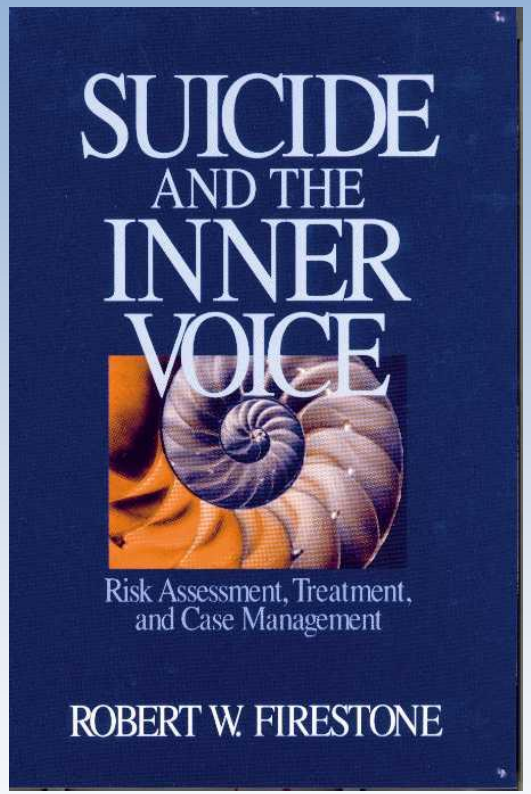
The Healthy Mind Platter

The Healthy Mind Platter, for Optimal Brain Matter

Resources: Books



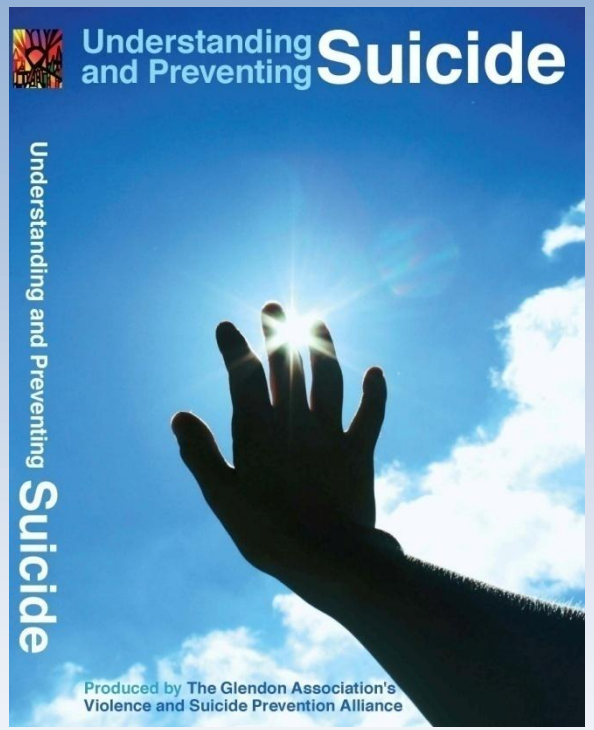
For Public and Professionals



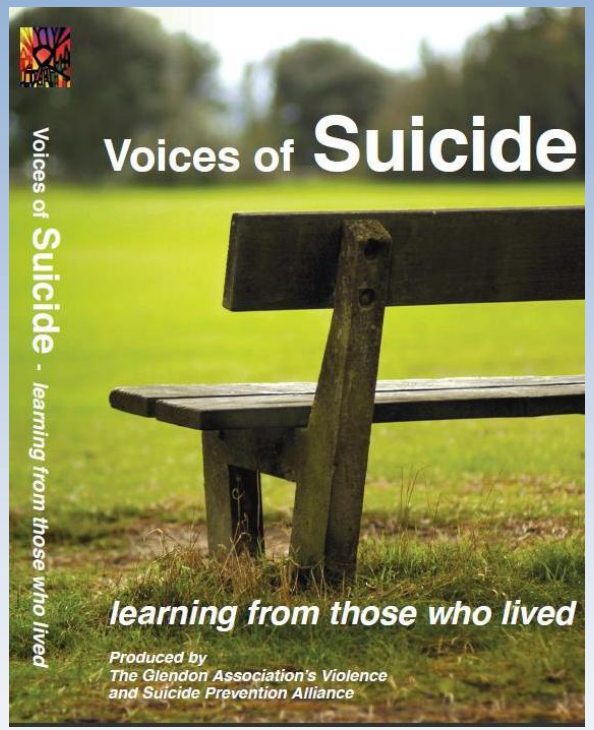
For Professionals

Visit www.psychalive.org for resource links

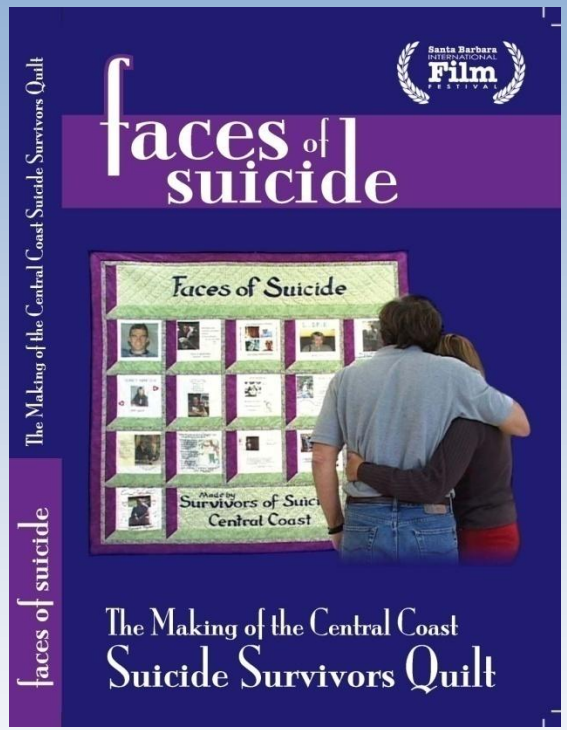
Resources: Films



For the Public



For Professionals



For Survivors

Visit www.psychalive.org for resource links

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Presenter: James Gilligan
Oct. 16 - 4pm – 5:30pm PDT

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Why Does Violence Occur & How Can We Prevent It?
Presenter: James Gilligan
Nov. 13 - 11am- 12pm PST

How to Raise an Emotionally Healthy Child
Presenter: Lisa Firestone
Dec. 4 - 12pm – 1pm PST

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