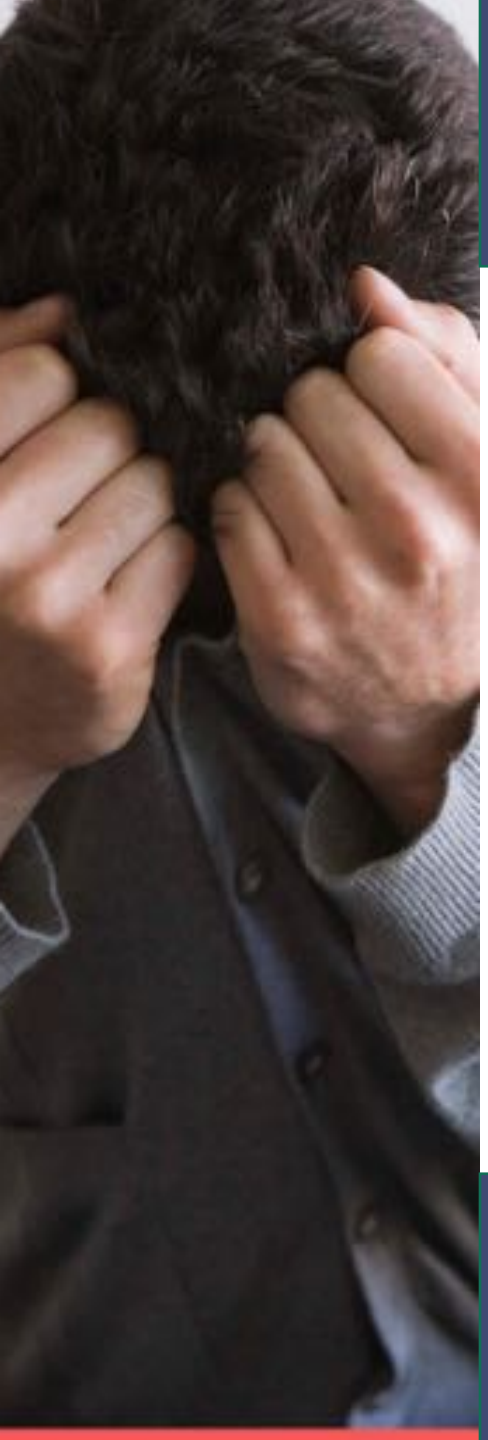


Relationship Training Institute

Suicide Therapies that Work

Presented
by Dr. Lisa Firestone

Learning Objectives

- ✓ Identify the most important techniques/tools for assessing suicidal risk
- ✓ Recognize innovative and effective suicide therapies which will assist clinicians in practicing to the standard of care
- ✓ Activate strategies to minimize the risk of successful lawsuits or sanctions
- ✓ Find effective coping strategies for the emotional impact of working with clients who attempt suicide or actually commit suicide
- ✓ Implement effective state-of-the-art crisis interventions for suicidal patients

Introduction

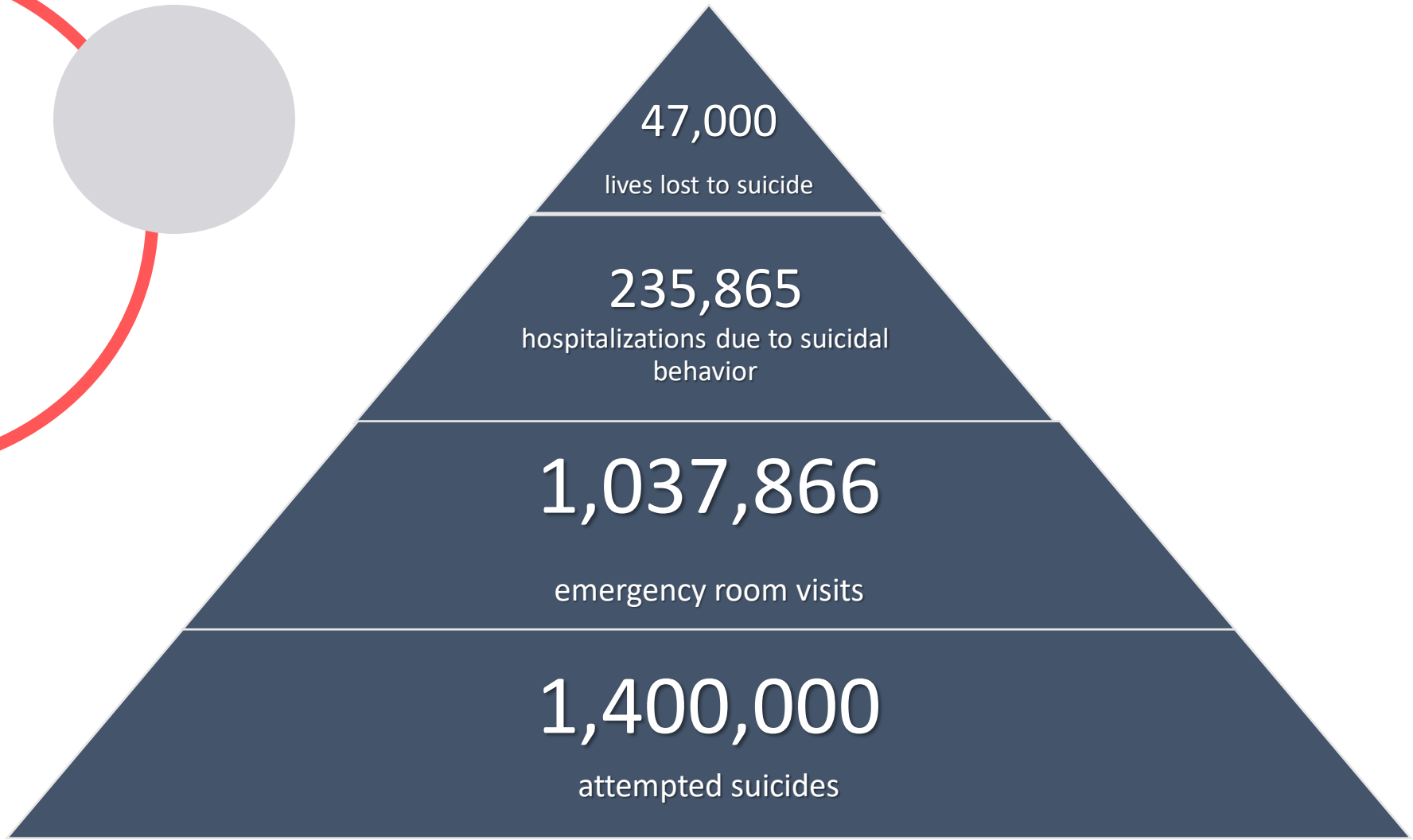
Facts about Suicide

- According to the World Health Organization, every 40 seconds a life is lost to suicide, which means that each year we lose nearly 800,000 people to suicide worldwide.
- Worldwide, more people die by suicide than from all homicides and wars combined.*
- For every 1 person who dies by suicide, 25 attempts were made (in 2017).**
- Each person who dies by suicide leaves behind an average of 25 closely impacted survivors**

** = SOURCE: https://www.voanews.com/a/a-13-2009-09-10-voa31-68662367/408350.html*

*** = SOURCE: McIntosh, J., American Association of Suicidology, 2017*

Attempted Suicides



SOURCE: American Association of Suicidology, 2017

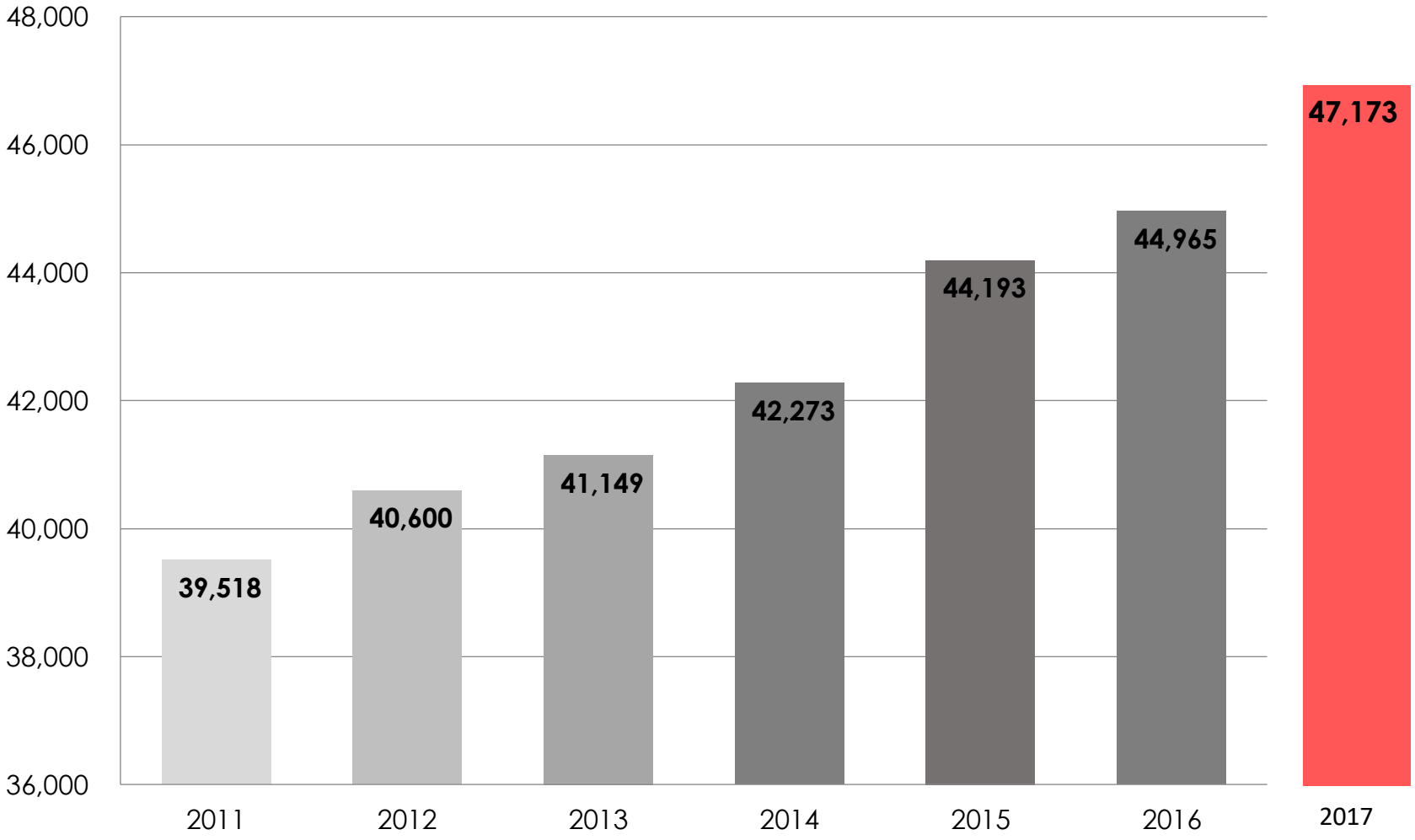
More Americans Die By Suicide Each Year Than by Homicide

- **142% more** people killed themselves than were murdered by others
- Suicide 47,173
- Homicide 19,510

MORE THAN TWICE THE NUMBER

SOURCE: American Association of Suicidology

Annual Number of USA Suicides



SOURCE: American Association of Suicidology

Causes of Death by Age in USA

- Suicide ranks among the top four causes of death for all age groups 10 to 54 years of age.
- 10th ranking cause for nation

Age Groups

Rank	10-14	15-24	25-34	35-44	45-54
1	Unintentional Injury 860	Unintentional Injury 13,441	Unintentional Injury 25,669	Unintentional Injury 22,828	Malignant Neoplasms 39,266
2	Suicide 517	Suicide 6,252	Suicide 7,948	Malignant Neoplasms 10,900	Heart Disease 32,658
3	Malignant Neoplasms 437	Homicide 4,905	Homicide 5,488	Heart Disease 10,401	Unintentional Injury 24,461
4	Congenital Anomalies 191	Malignant Neoplasms 1,374	Heart Disease 3,681	Suicide 7,335	Suicide 8,561

55-64: 8th [7,982]
65+: 16th [8,568]

SOURCE: American Association of Suicidology, 2017

In 2015, the Typical High School Classroom…

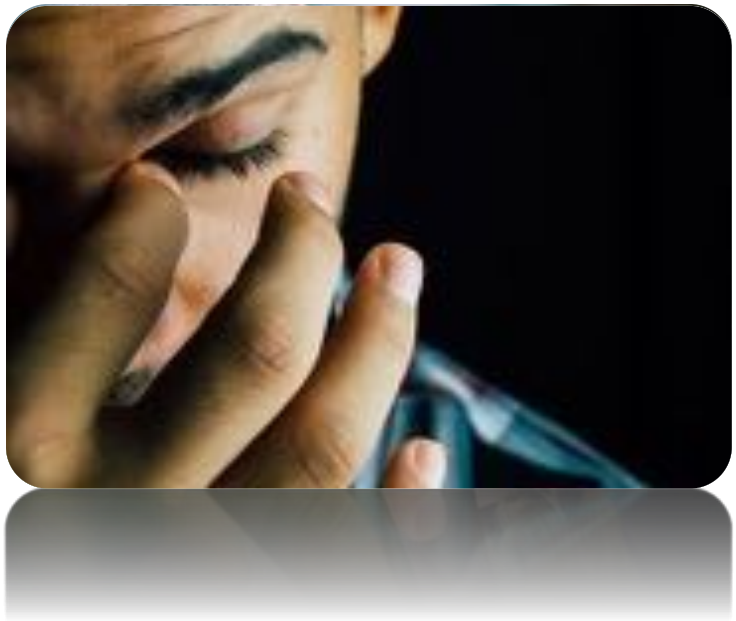
- **1 male and 2 females** have probably attempted suicide in the past year.

- **7.4%** of high school students attempted.

SOURCE: McIntosh, J., American Association of Suicidology, 2017

Suicide Attempts vs Suicide Completion & Gender (2015)

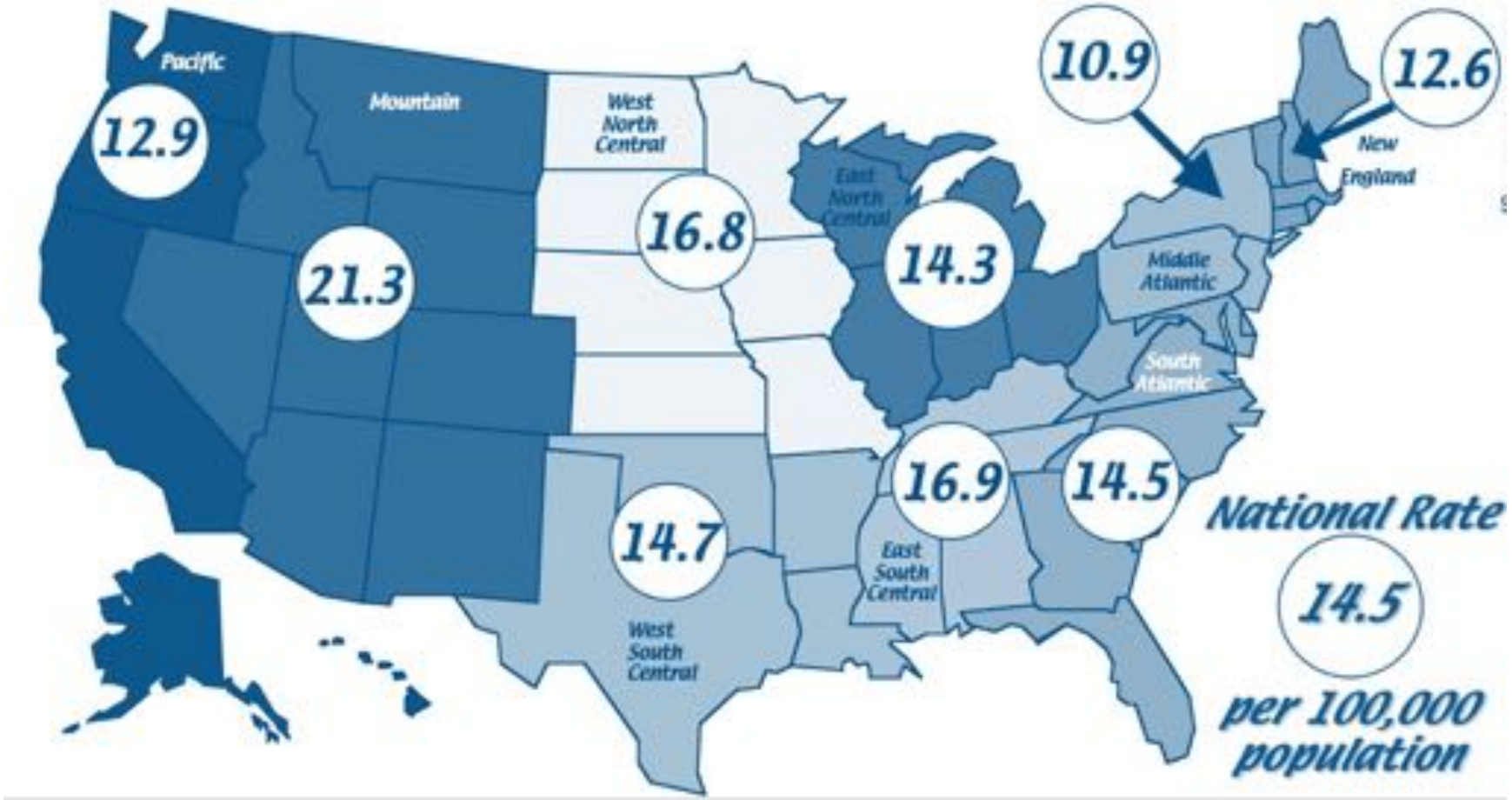
- For every 100 suicide attempts by **younger adults**, there is 1 completion.
- For every 4 attempts by elderly adults, there is 1 completion.
- For every 1 attempt by a man, there are 3 attempts by a woman.



SOURCE: McIntosh, J., American Association of Suicidology, 2017

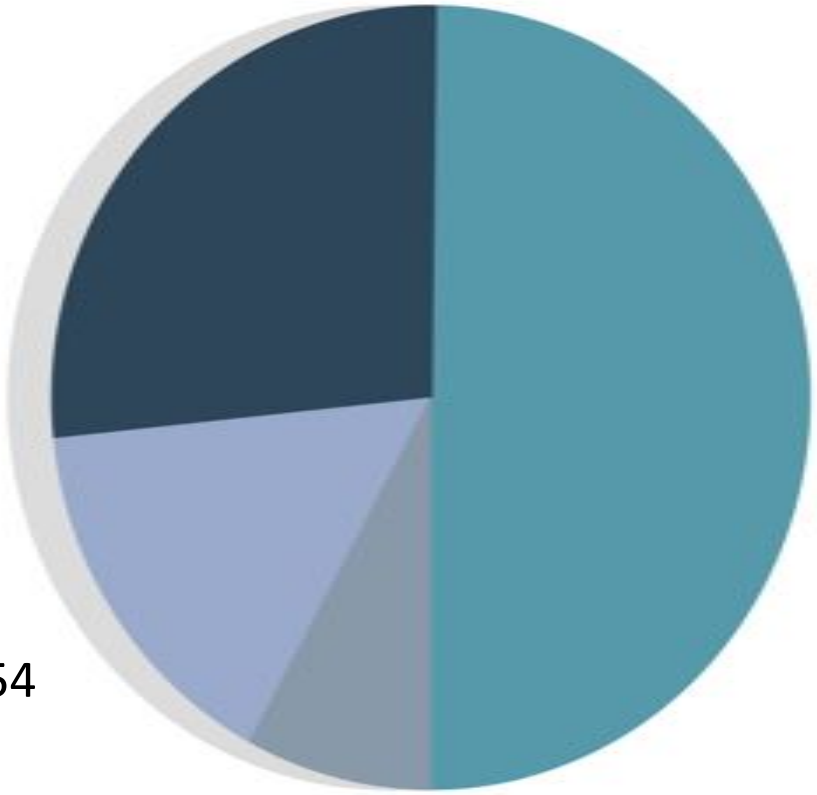
Divisional Differences in USA Suicide

Suicide highest in the Mountain States



SOURCE: McIntosh, J., American Association of Suicidology, 2017

Methods in USA Suicides (2015)



Suffocation
13,075

Firearms
23,854

Poisoning
6,554

All Other Methods
3,690

Firearms are the leading method!

SOURCE: McIntosh, J., American Association of Suicidology, 2017

Clinical Practice & Suicide

- A practicing psychologist will average 5 suicidal patients a month.
- 25% of psychologists lose a patient to suicide.
- 25% to 50% of psychiatrists will experience a patient's suicide.
- **1 in 6** psychiatric patients who die by suicide die in active treatment with a healthcare provider.

SOURCE: The Melissa Institute

Clinical Practice & Suicide

- Approximately 57% of those who die by suicide in America will have seen a mental health provider at some time in their life.
- **21%** had seen a mental health professional in the prior month
- **10%** of people who died by suicide saw a mental health professional within the prior week.
- 25% of family members of suicidal patients take legal actions against the patient's mental health treatment team.

SOURCE: The Melissa Institute & Scandinavian Journal of Public Health Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 - 2017

Clinical Practice & Suicide

Of patients admitted for attempt (Owens et al., 2002):

- 16% repeat attempts within one year.
- 7% die by suicide within 10 years.
- Risk of suicide “hundreds of times higher” than general population.

SOURCE: The Melissa Institute

Implications of Epidemiological Data

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

SOURCE: The Melissa Institute

Theory:

Our Approach to Understanding Suicide

Orbach, Clip 111, Mental Pain Short, 1.15

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

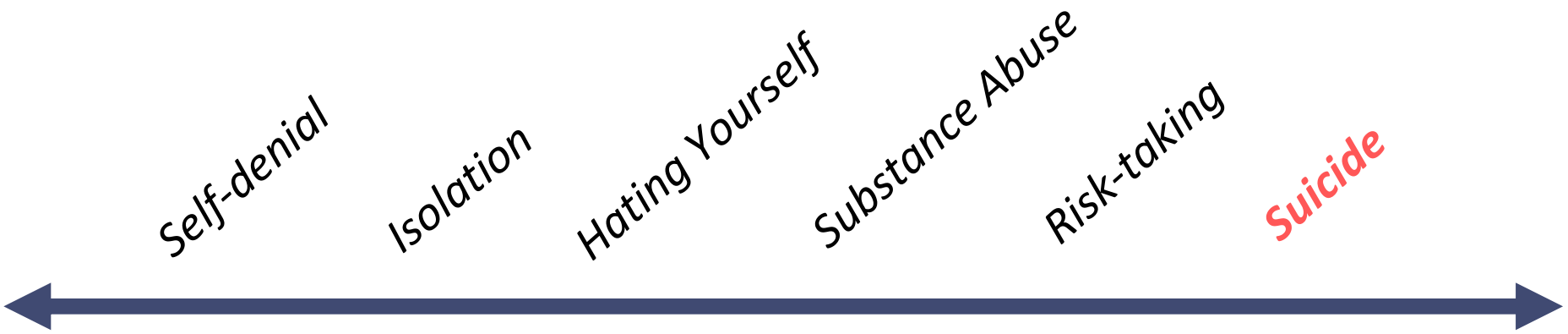
Anti-Self - Critical

Our Approach to SUICIDE

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

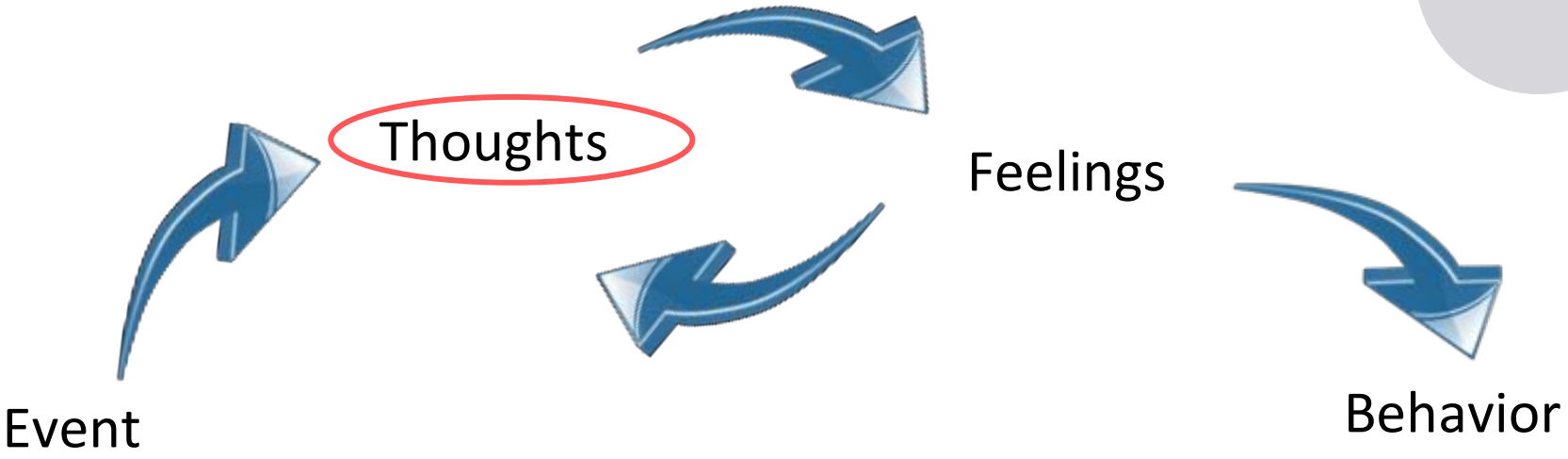
Our Approach to SUICIDE

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.



Definition of the VOICE

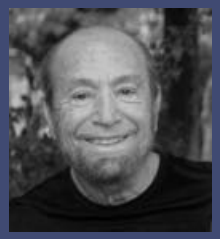
The Critical Inner Voice

- Well-integrated pattern of destructive thoughts toward ourselves and others
- The “voices” that make up this internalized dialogue are at the root of much of our maladaptive behavior
- Fosters inwardness, distrust, self-criticism, self-denial, addictions and a retreat from goal-directed activities

Definition of the VOICE

The Critical Inner Voice

- Affects every aspect of our lives:
  - Self-esteem and confidence
  - Personal and intimate relationships
  - Performance and accomplishments at school or work
  - ESPECIALLY self-destructive behavior



Separation Theory

Robert W. Firestone, Ph.D.

Integrates psychoanalytic and existential systems of thought

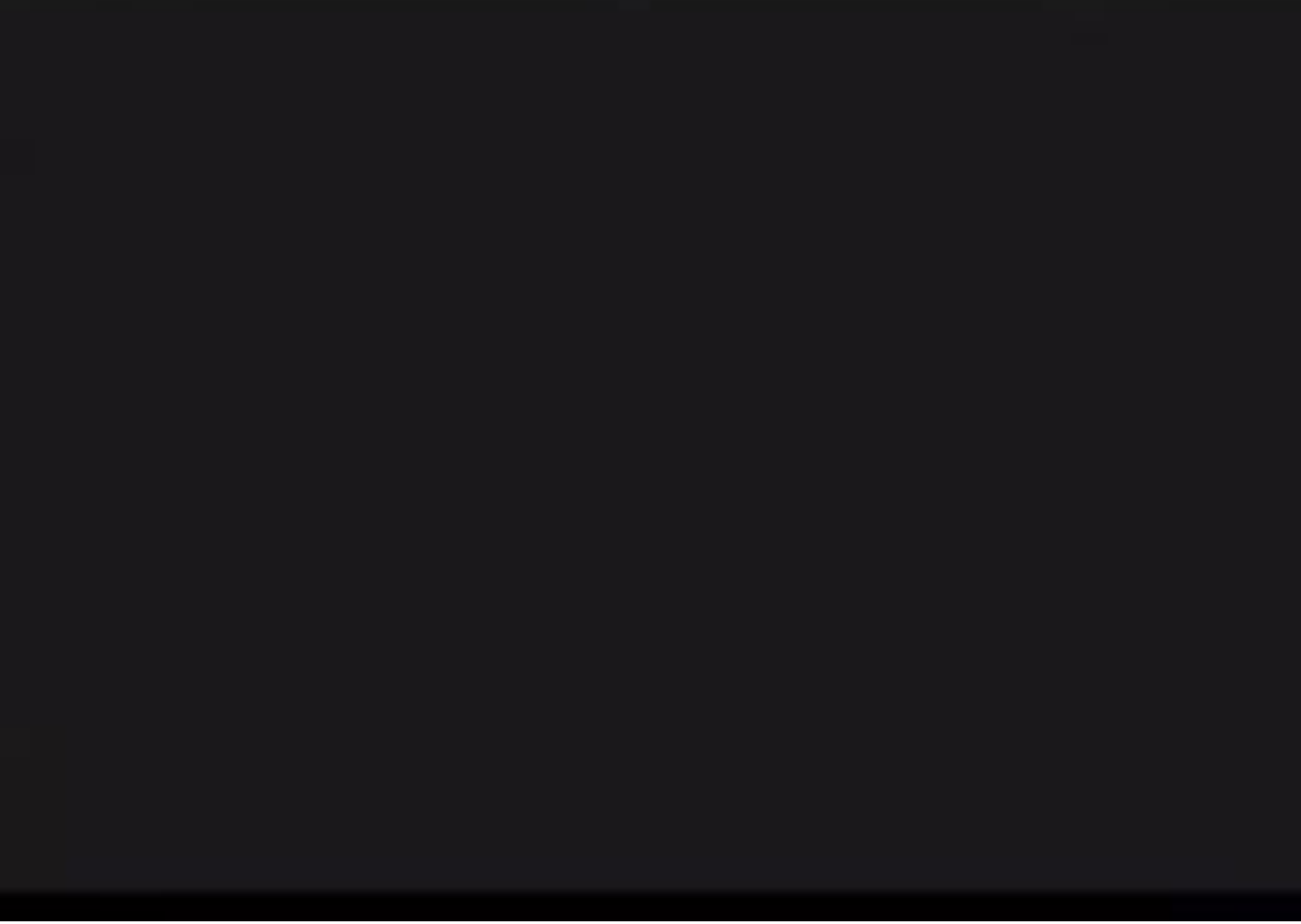
Core Conflict:

Two kinds of emotional pain:

UNDEFENDED

DEFENDED

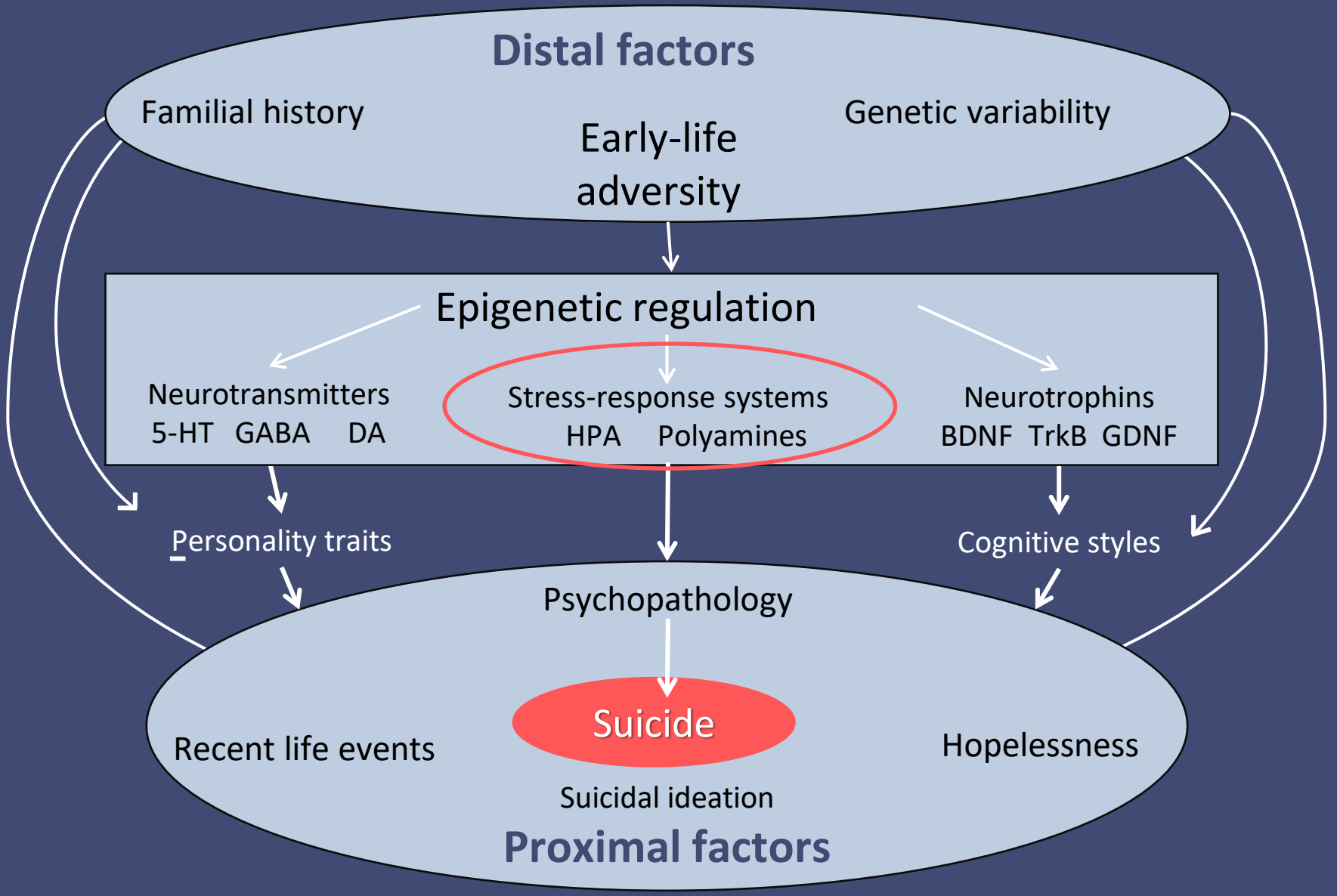
INTERPERSONAL | **EXISTENTIAL** | **FANTASY BOND** | **CRITICAL INNER VOICE**



Clip 15, VOS – Cath and Jenny, 4.59

Development of Risk

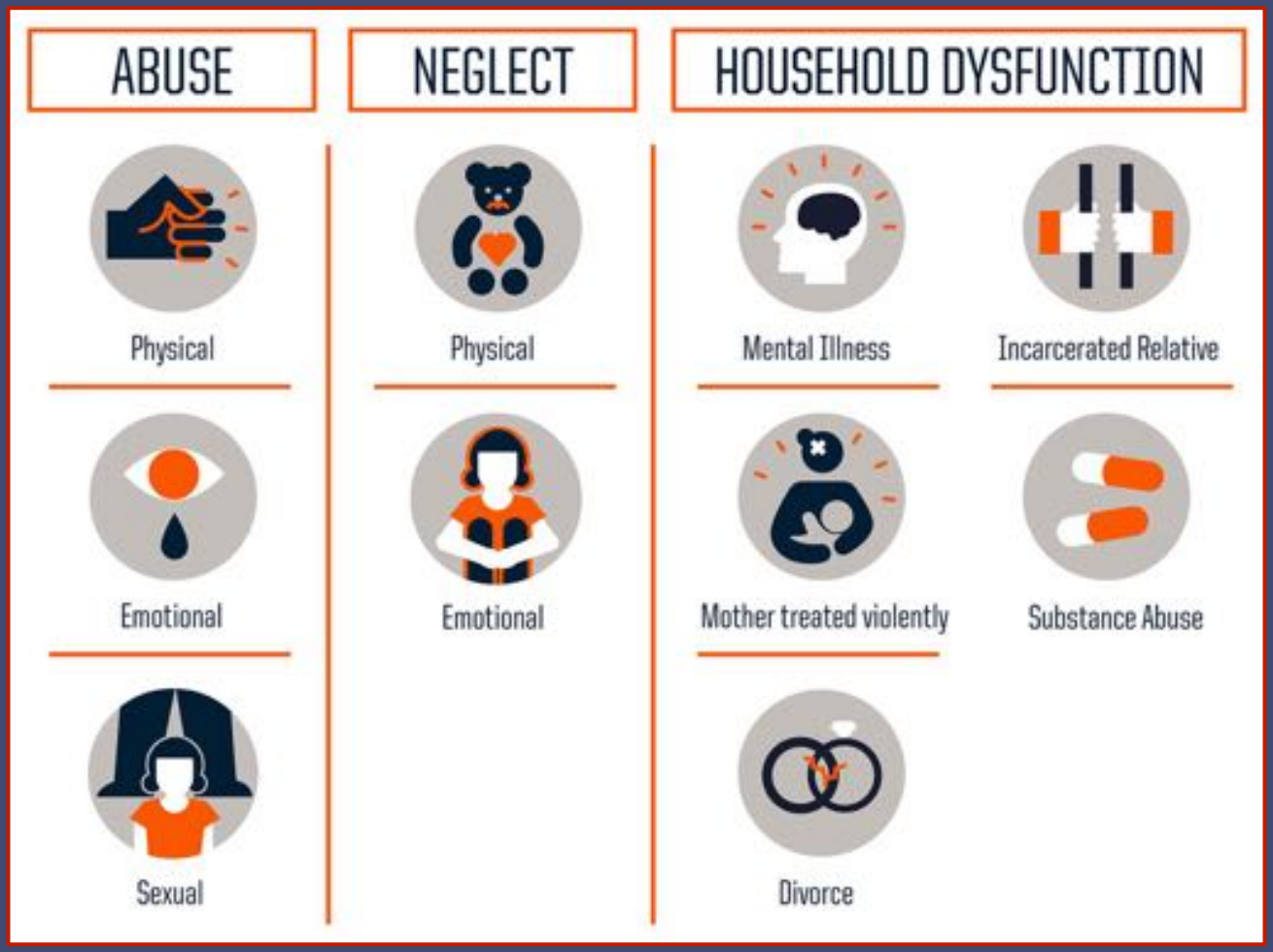
Epigenetic Studies



SOURCE: Turecki, G., 2014, American Journal of Preventive Medicine

Adverse Childhood Experiences

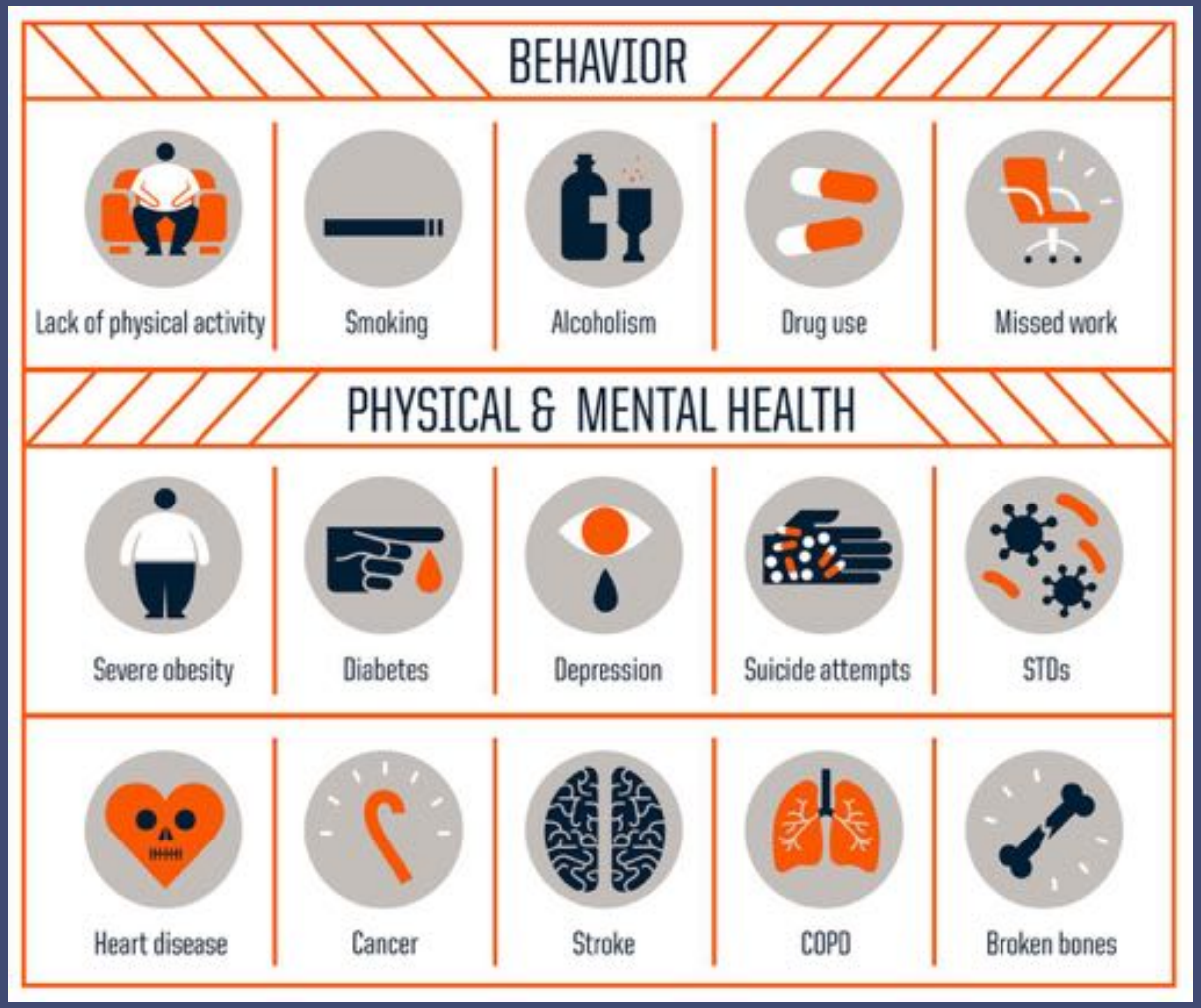
Three Types of ACEs



SOURCE: https://www.npr.org/sections/ed/2018/01/23/578280721/what-do-asthma-heart-disease-and-cancer-have-in-common-maybe-childhood-trauma

Adverse Childhood Experiences

Results of ACEs



SOURCE: https://www.npr.org/sections/ed/2018/01/23/578280721/what-do-asthma-heart-disease-and-cancer-have-in-common-maybe-childhood-trauma

Associations between suicidal behavior and childhood abuse and neglect: Meta-analysis

- Maltreatment increases the risk of suicidal behavior, but not suicidal ideation.

- **Emotional abuse was the strongest risk of suicidal behavior.**

SOURCE: Liu, J., Fang, Y., Gong, J., Cui, X., Meng, T., Xiao, B., He, Y., Shen, Y., & Luo, X., 2017, Journal of Affective Disorders

Numerous studies link insecure attachment to suicide.

Patterns of ATTACHMENT in Children

Attachment Style

- Secure

Parental Interactive Pattern

- Emotionally available, percep
  responsive

Source: Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & Child Health*, *9*(8), 541–545.

Patterns of ATTACHMENT in Children

Attachment Style

- Insecure - avoidant

Parental Interactive Pattern

- Emotionally unavailable, imperceptive, unresp[illegible], and rejecting

Source: Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & Child Health*, *9*(8), 541–545.

Patterns of ATTACHMENT in Children

Attachment Style

▷ Insecure – anxious/ ambivalent

Parental Interactive Pattern

▷ Inconsistently available, perceptive and responsive, and intrusive

Source: Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & Child Health*, *9*(8), 541–545.

Patterns of ATTACHMENT in Children

Attachment Style

- Insecure – disorganized

Parental Interactive Pattern

- Frightening, frightened, disorienting, alarming

Source: Benoit, D. (2004). Infant-parent attachment: Definition, types, antecedents, measurement and outcome. *Paediatrics & Child Health*, *9*(8), 541–545.

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

Implicit vs Explicit MEMORY

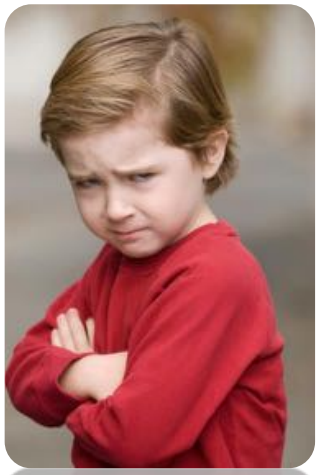
Implicit

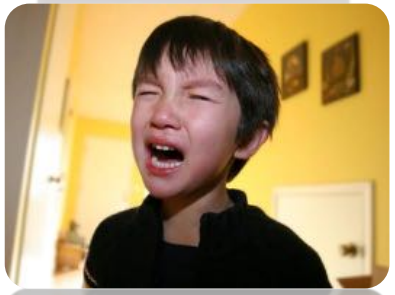
Explicit

How does disorganized attachment pass from generation to generation?

Implicit memory of terrifying experiences may create:

- Impulsive behaviors
- Distorted perceptions
- Rigid thoughts and impaired decision making patterns
- Difficulty tolerating a range of emotions

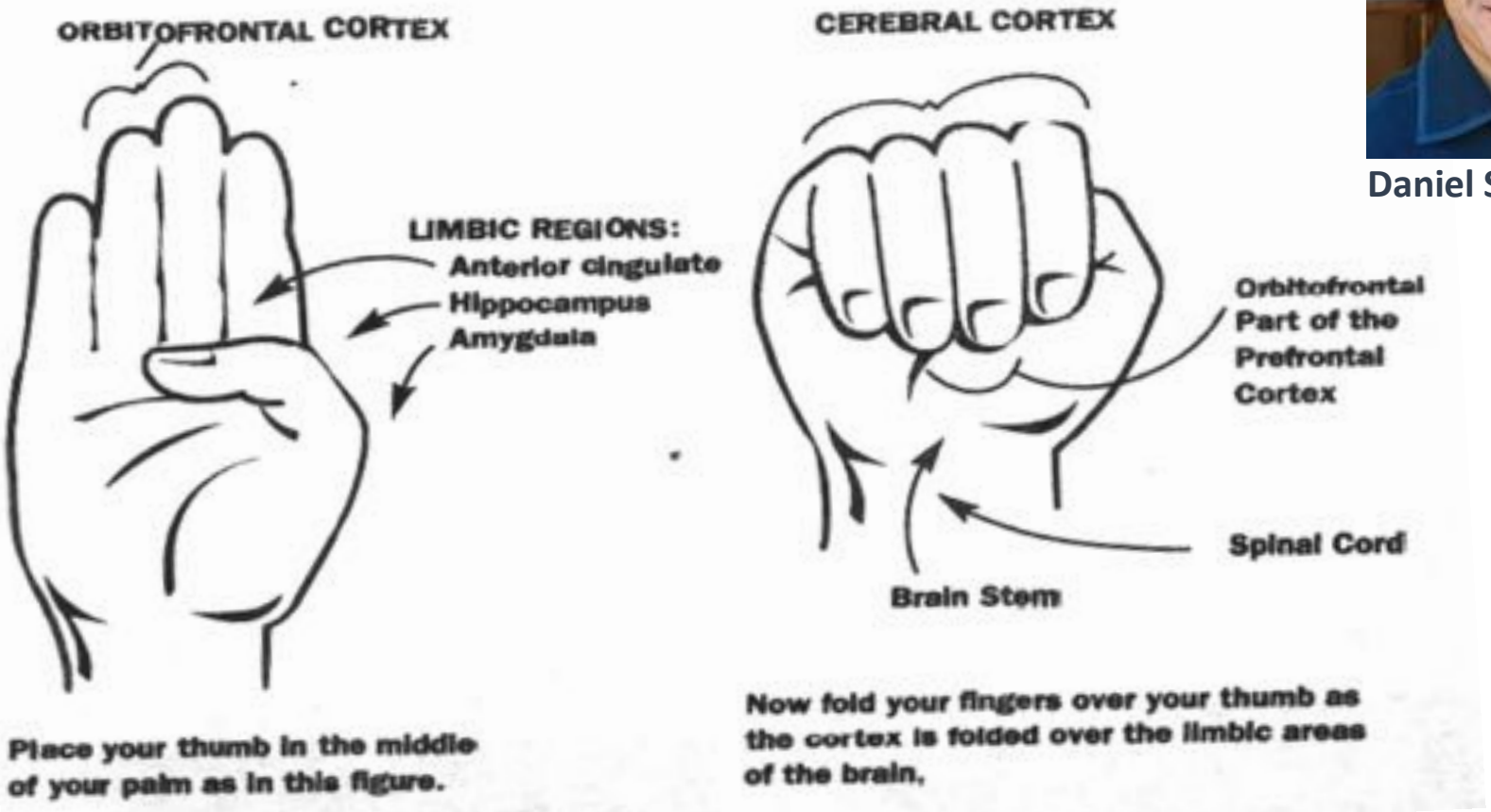




The Brain in the Palm of Your Hand

Interpersonal Neurobiology

Daniel Siegel, M.D.



9 Important Functions of the Pre-Frontal Cortex

1. Body Regulation
2. Attunement
3. Emotional Balance
4. Response Flexibility
5. Empathy
6. Self-Knowing Awareness (Insight
7. Fear Modulation
8. Intuition
9. Morality









“Type D” Attachment: Disorganized/Disoriented

Predicts later chronic disturbances of:

- Affect regulation
- Stress management
- Hostile-aggressive behavior



Division of the Mind

Parental Ambivalence

Parents both love and hate themselves and extend both reactions to their productions, i.e., their children.

Parental Nurturance

Parental Rejection, Hostility

Neglect

Prenatal Influences

Disease Trauma

Substance Abuse/ Domest
Violence

Birth Trauma

Baby

Genetic

Structure

Temperament

Physicality

Sex

Self-System
Parental Nurturance

- Unique make-up of the individual (genetic predisposition and temperament)

- Harmonious identification and incorporation of parent's positive attitudes and traits and parents positive behaviors:
  - Attunement
  - Affection
  - Control
  - Nurturance
  - Effect of other nurturing experience and education on the maturing self-system resulting in a sense of self and a greater degree of differentiation from parents and early caretakers

Personal Attitudes/Goals/Conscience

Realistic, Positive Attitudes Toward Self	Behavior
Realistic evaluation of talents, abilities, etc. with generally positive/compassionate attitude towards self and others	Ethical behavior toward self and others
Goals: Needs, wants, search for meaning in life	Goal-directed behavior
Moral principles	Acting with integrity

Anti-Self System

- Unique vulnerability: genetic predisposition and temperament

- Destructive parental behavior: misattunement, lack of affection, rejection, neglect, hostility, over-permissiveness

- Other Factors: accidents, illnesses, traumatic separation, death anxiety

Anti-Self System

THE FANTASY BOND
(core defense) is a self-parenting process made up of two elements: the helpless, needy child, and the self-punishing, self-nurturing parent. Either aspect may be extended to relationships. The degree of defense is proportional to the amount of damage sustained while growing up.

Anti-Self System

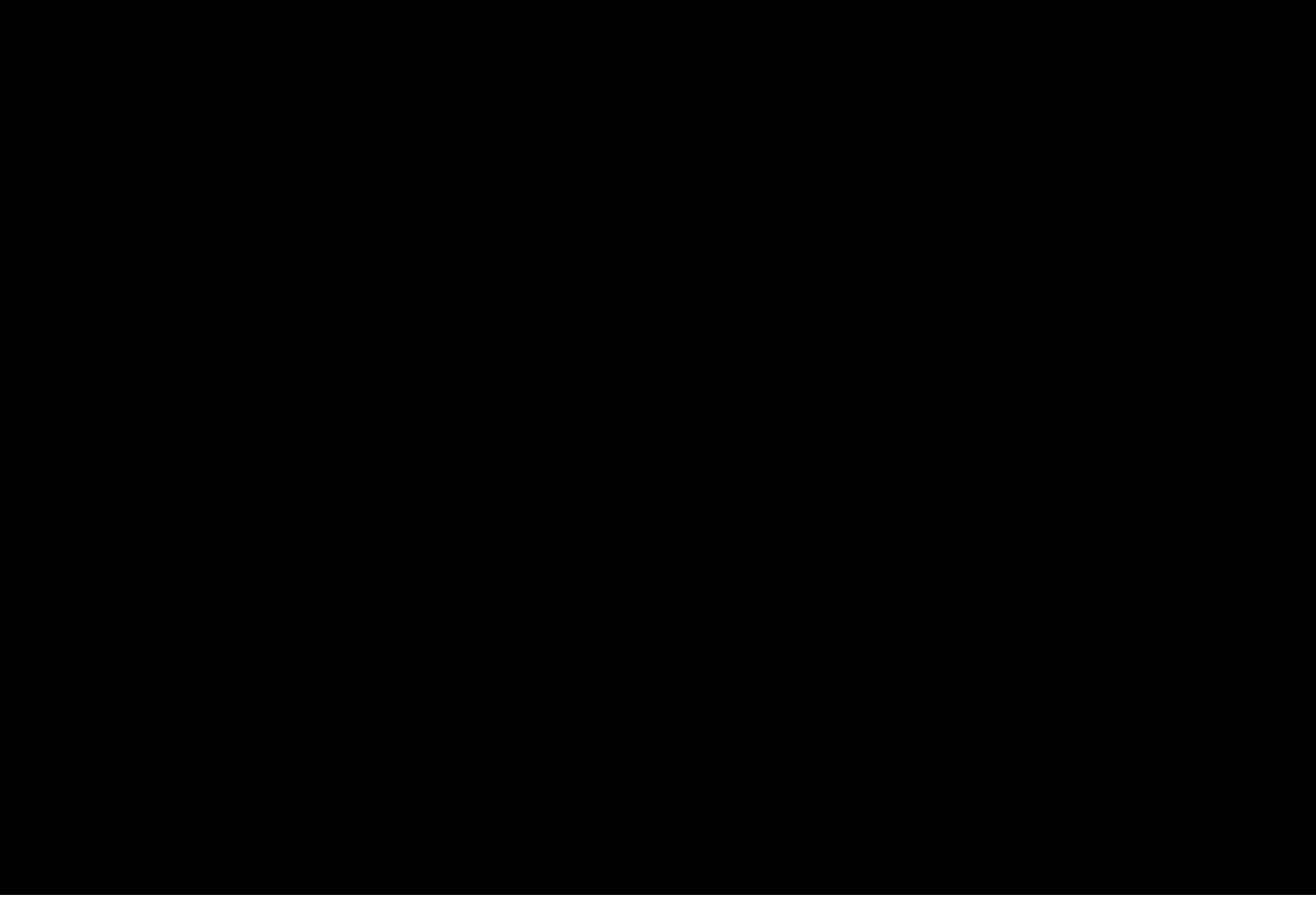
Self-Punishing Voice Process

	Voice Process	Behaviors
	Critical thoughts toward self	Verbal self-attacks – a generally negative attitude toward self and others predisposing alienation.
	Micro-suicidal injunctions	Addictive patterns. Self-punitive thoughts after indulging.
	Suicidal injunctions - suicidal ideation	Actions that jeopardize, such as carelessness with one's body, physical attacks on the self, and actual suicide

Anti-Self System

Self-Soothing Voice Process

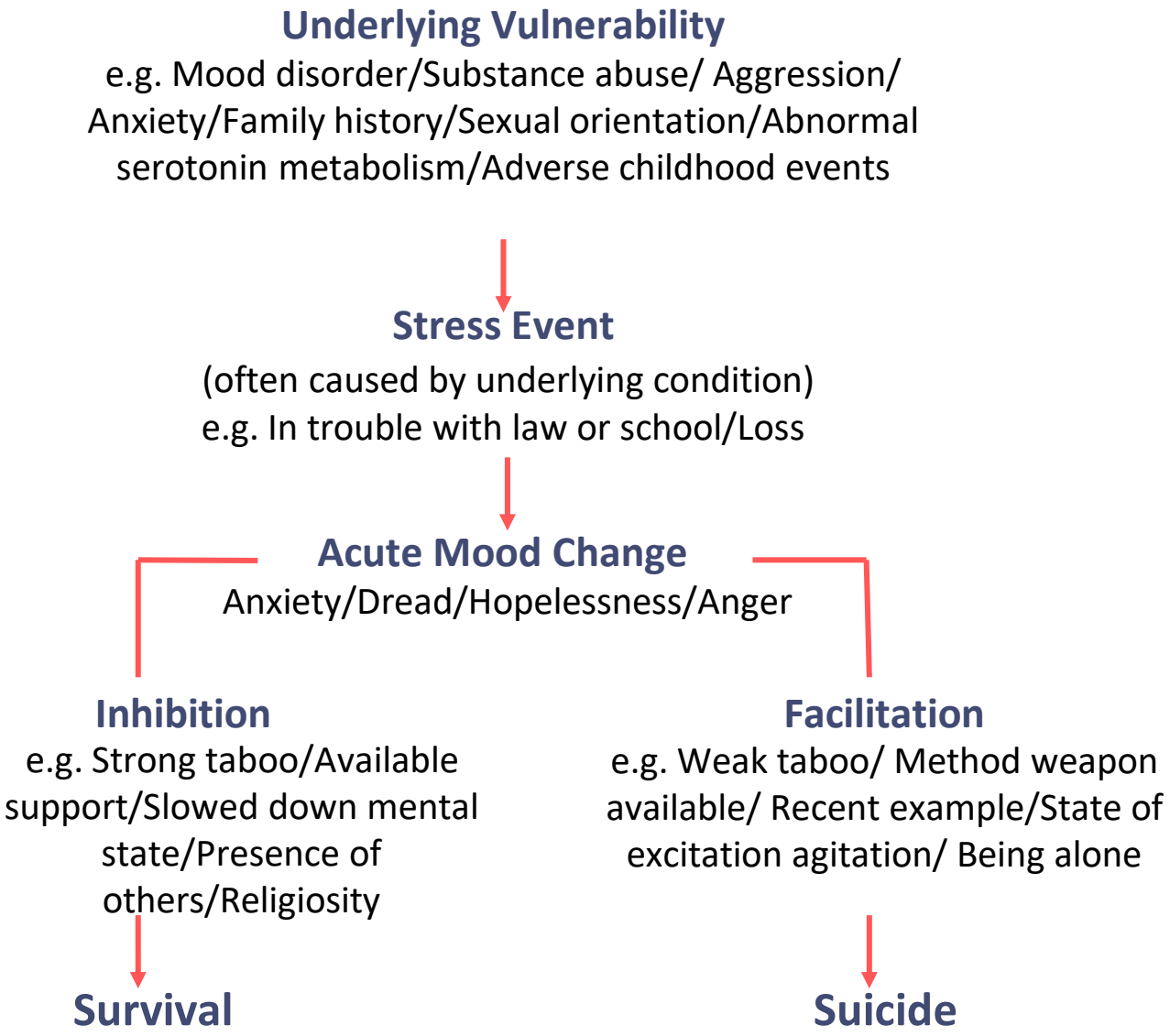
	Voice Process	Behaviors
	Self-soothing attitudes	Self-limiting or self-protective lifestyles, Inwardness
	Aggrandizing thoughts toward self	Verbal build up toward self
	Suspicious paranoid thoughts toward others	Alienation from others, destructive behavior towards others
	Micro-suicidal injunctions	Addictive patterns - Thoughts luring the person into indulging
	Overtly violent thoughts	Aggressive actions, actual violence



Clip 105, Orbach – Identifying with the aggressor, .32

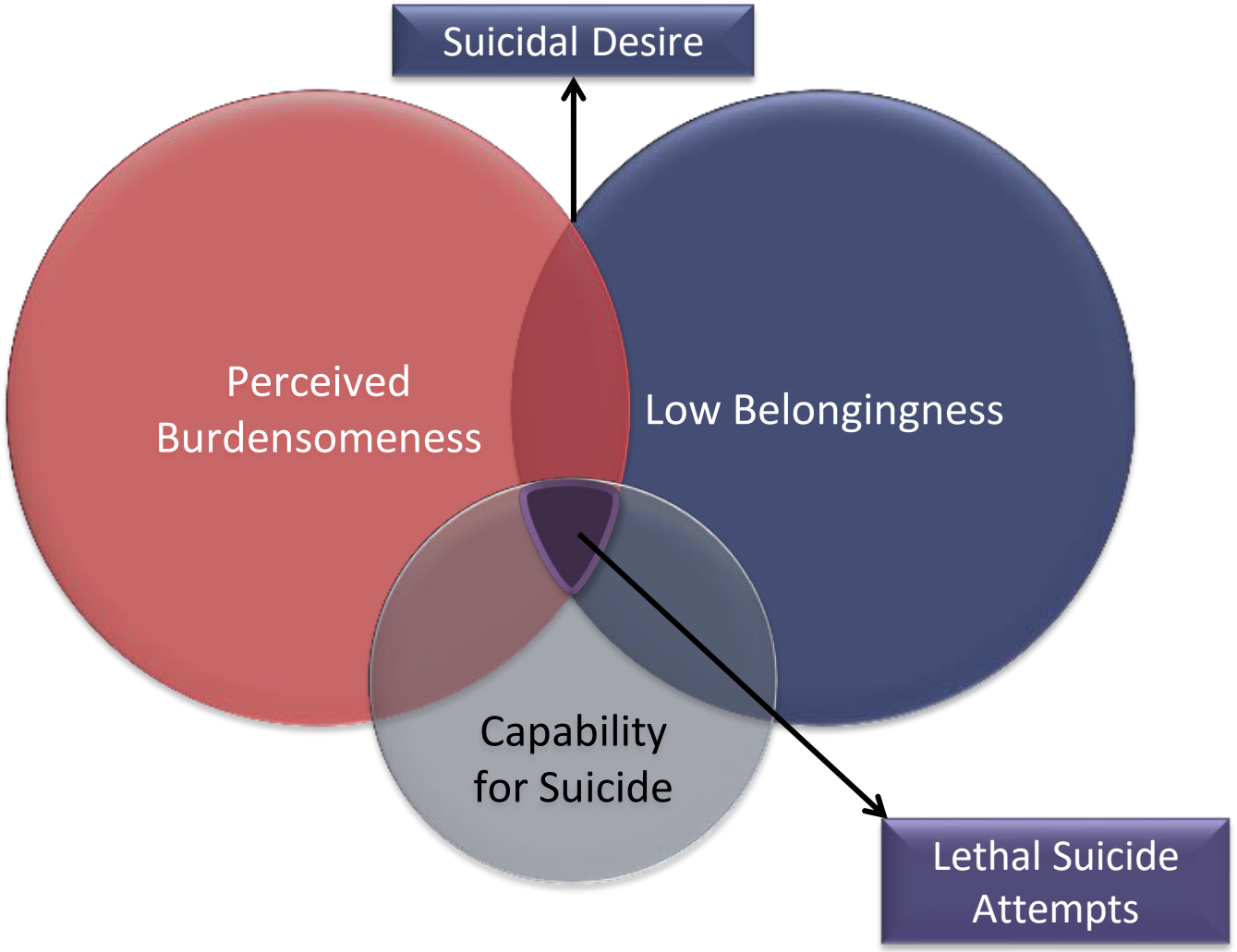
How Suicide Occurs

How does a suicide occur?



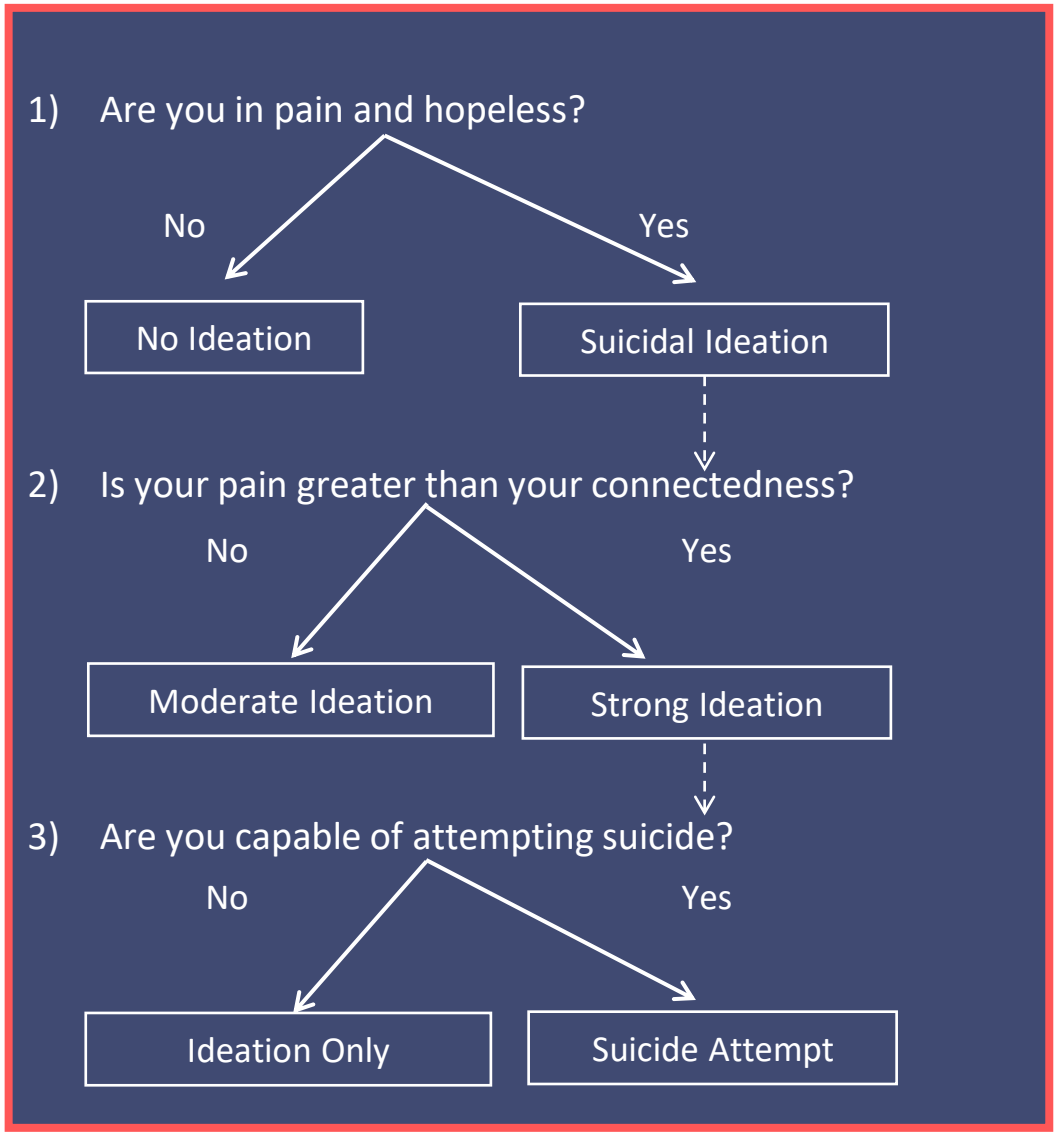
SOURCE: Gould, Madelyn, 2012

Those Who Desire Suicide



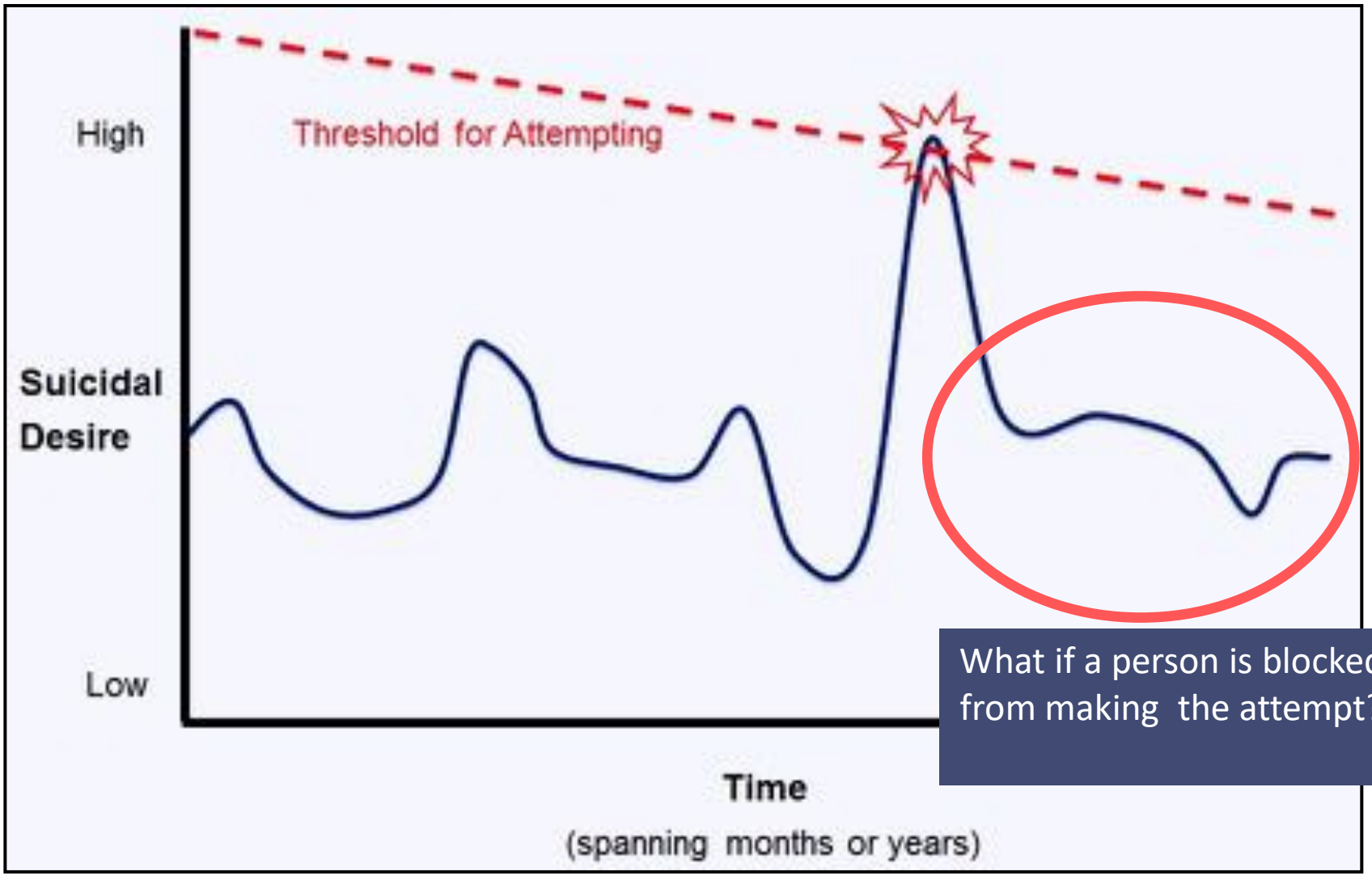
SOURCE: Joiner, Thomas. The Interpersonal Theory of Suicide. 2009.

Three-Step Theory of Suicide



SOURCE: Klonsky, D. & May, A., International Journal of Cognitive Therapy, 2015

Plot Desire & Capability Together Over



SOURCE: Klonsky, E., University of British Columbia, 2017

The Biological Model

- For humans, trigger situations:
  - Rarely involve external life-threatening dangers
  - Usually involve stressful psychological and psychosocial experiences, resulting in an increase of the cortisol-releasing hormone
- Cortisol
- HPA axis function can be tested with the dexamethasone suppression test. (Coryell & Schlesser, 2001).
- Early adverse life events, resulting in a long-term hyperactive HPA axis have been associated with suicidality (Heim et al., 2009; Laponte & Turecki, 2010).

What Patients Tell Us

Dissociative Symptoms

"At that moment I felt that I was outside myself. I watched the blood dripping and felt no pain. I was not afraid, and somehow, the red blood in the water looked quite nice.

I was somewhere between trance and reality. I walked through the woods for about an hour and wasn't thinking about reasons not to do it. I only thought about that later when I had found the spot. Then I started thinking: "Why am I throwing my life away?" But these were only short episodes. My feelings were confused – I was on an emotional roller-coaster. I was not myself."

SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

Clip 498, Orbach Developmental, 1.30

What Patients Tell Us

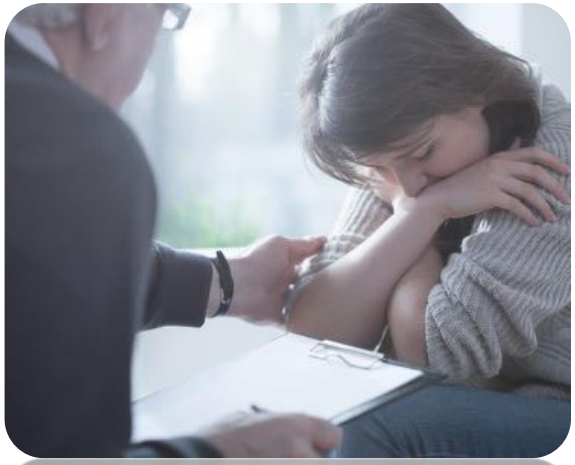
After an act of self-harm, patients describe how they switched back to “normal:”

> *“With the last cut I got suddenly frightened. There was the sudden fear of death and the realization: what you are doing is wrong. And then I was no more outside myself. I put some cloth onto the bleeding wound and called my mother.”*

SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

What Patients Tell Us

- Conditions enable an individual to commit the act.
- Indifference to one's own body
- Absence of pain and fear
- Altered experience of time



SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

The Suicidal Mode

- Acute mental states whose function is to prepare the organism to deal with exceptional and threatening situations

- Modes encompass:
  - Cognitions
  - Emotions
  - Physiological symptoms
  - Behavior patterns

SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

The Suicidal Mode

Experienced as:

- Mental pain
- Strong feelings of anger, anxiety, embarrassment, humiliation and shame
- Dissociative symptoms such as emotional numbing, detachment from body, and indifference to physical pain (Orbach, 1994)

SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

The Suicidal Mode

In suicidal mode, the cognitive system is characterized by the suicidal belief system, with core beliefs such as:

- Feeling helpless ("I can't do anything about my problems")
- Being unlovable ("I don't deserve to live, I am worthless")

SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

Clip 50, VOS-Thoughts to Actions, 6.35

The Suicidal Mode

A suicidal mode typically:

- Has an on/off mechanism and can occur suddenly

- Is time-limited

SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

What Patients Tell Us

“I then said to myself that I didn’t want my children to end up with a disturbed mother and that they would have to come to see me in a psychiatric hospital, but that they should rather have no mother at all, then. I didn’t want that for my children or my relatives would have to suffer because I was nuts.”

SOURCE: Gysin-Maillart, A., & Michel, K. (2015). ASSIP--Attempted Suicide Short Intervention Program: a manual for clinicians.

What Patients Tell Us

Quotations from video-recorded clinical interviews:

"I was devastated, I hated myself, and I couldn't stand my thoughts any more – I kind of wanted to kill them."

"I heard a negative voice telling me, "You're worthless. Because of your inadequacies you'll never make it – I've always told you so – and you won't make it again this time. You have no right to live. "The feeling of bitterness, hopelessness, and desperation at that moment was so strong that I could not bear it any more, and couldn't see the point in carrying on."

SOURCE: Firestone, L. (2006). Suicide and the inner voice. In Cognition and suicide: theory, research, and therapy. Washington, DC: American Psychological Association.

Risk Factors and Warning Signs

SUICIDE RISK FACTORS

Risk factors are characteristics that make it more likely that someone will consider, attempt, or die by suicide. They can't cause or predict a suicide attempt, but they're important to be aware of.

Suicide Risk Factors

- Mental disorders, particularly **mood disorders, schizophrenia, anxiety disorders** and certain personality disorders
- Alcohol and other substance use disorders
- Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illnesses

Suicide Risk Factors

- Previous suicide attempt
- Family history of suicide
- Job or financial loss
- Loss of relationship
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of health care, especially mental health and substance abuse treatment

Suicide Risk Factors

- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)
- Key symptoms: **anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication.** For children and adolescents: oppositionality and conduct problems.
- Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).

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
- Feeling trapped

Suicide Warning Signs

- 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

Increasing Suicide Rates among those without known mental health conditions

(54% of decedants did not have known mental health condition)

- **relationship problems/loss**

45.1%

life stressors

50.5%

- **recent/impending crises**

32.9%

SOURCE: Center for Disease Control Morbidity and Mortality Weekly Report June 8, 2018 Vital Signs: Trends in State Suicide Rates United States, 1999 – 2016 and circumstances contributing to Suicide – 27 States, 2015

Drugs most associated with Suicide

Substance	Total	%
Alcohol	4,442	40.6
Antidepressants	2,214	40.8
Benzodiazepines	2,464	30.3
Opiods	2,279	26.6

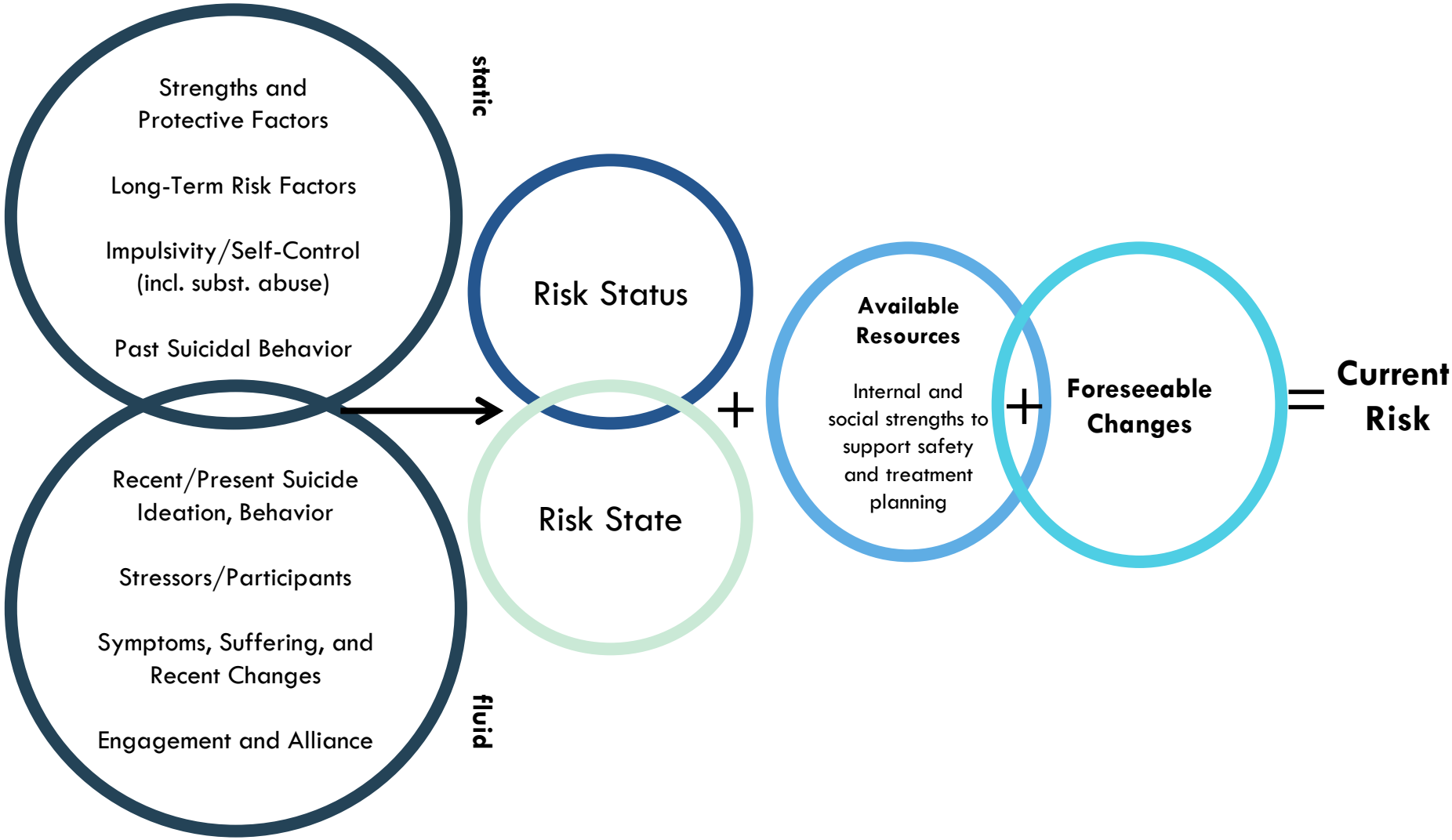
Protective Factors

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

Protective Factors

- External: responsibility to children or pets, positive therapeutic relationships, social supports
- Resilience
- Coping skills

Risk Formulation



SOURCE: Pisani, A. R., Murrie, D. C., & Silverman, M. M. (2016). Reformulating Suicide Risk Formulation: From Prediction to Prevention. Academic Psychiatry, 40, 623–629. http://doi.org/10.1007/s40596-015-0434-6

Clinical Example

“…if I know that this person feels like a horrible human being because of multiple interpersonal relationship failures, the only thing keeping them going at the moment is their relationship with their significant other, and said significant other is threatening to kick them out of the house then I sure as heck am going to do everything I can to address that relationship issue. Furthermore, I’m going to ask about the stability of the relationship every time I speak with them and I’m going to want them to tell me right away if the relationship status changes.”

SOURCE: Gutierrez, P., 2017. American Association of Suicidology

Assessment

Clip 628, Teen Suicide Prevention, 3.47

Assessment Interview

Ask:

- “Do you think about killing yourself?”
- Normalize, contextualize, exaggerate
- About each specific method
- About prior attempts

Assessment Interview

Assess:

- Pain tolerance & lack of fear of death
- Family history of adverse events & suicidal behavior
- Self-control & agitation
- Ability to safety plan
- Reasons for living

Why use objective measures?

What interferes with clinical judgment?

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

The Suicidal Child

Spectrum of Suicidal Behavior

1. Nonsuicidal - No evidence of any self-destructive or suicidal thoughts or actions.

2. Suicidal Ideation - Thoughts or verbalization of suicidal intention.

Examples:

a) "I want to kill myself."
b) Auditory hallucination to commit suicide

The Suicidal Child

Spectrum of Suicidal Behavior

3. Suicidal Threat - Verbalization of impending suicidal action and/ or a precursor action which. If fully carried out, could have led to harm.

Examples:

a) "I am going to run in front of a car."
b) Child puts a knife under his or her pillow.
c) Child stands near an open window and threatens to jump.

Columbia - Suicide Severity Scale C-SSS

- Suicidal Behavior
- Suicidal Ideation

Columbia - Suicide Severity Rating Scale C-SSRS

- Intensity of Ideation
- Frequency
- Duration
- Controllability
- Deterrents
- Reason for Ideation

Columbia - Suicide Severity Rating Scale C-SSRS

- Interrupted Attempt:
- Aborted Attempt:
- Preparatory Acts or Behaviors:

Interpersonal Model of Suicide

a. Acquired Ability to Enact Lethal Self-Injury

Things that scare most people do <u>not</u> scare me.
I can tolerate a lot more pain than most people.
I avoid certain situations (e.g., certain sports) because of the possibility of injury (Reversed scored)

b. Burdensomeness

The people I care about would be better off if I were gone.
I have failed the people in my life.

SOURCE: Joiner, 2005, p. 227

Columbia - Suicide Severity Rating Scale C-SSRS

c. Belongingness

These days I am connected to other people.

These days I feel like an outsider in social situations. (Reversed scored)

These days I often interact with people who care about me.

SOURCE: Joiner, 2005, p. 227

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 4.1 Guttman Scalogram Analysis for the FAST

Self-Deprecation **Levels 1-3**	Isolation **Level 4**	Self-Contempt **Level 5**	Addictions **Level 6**	Hopelessness **Level 7**	Giving Up **Level 8**	Self-Harm Suicidal Plans **Levels 9-10**	Suicide Intent **Level 11**
Self-deprecating thoughts in everyday life; thoughts rationalizing self-denial; cynical attitudes toward others	Thoughts influencing isolation	Self-contempt: vicious self-abusive thoughts	Thoughts that support the cycle of addictions	Thoughts contributing to a sense of hopelessness	Giving up on oneself	Injunctions to inflict self-harm; thoughts planning details of suicide	Injunctions to carry out suicide plans

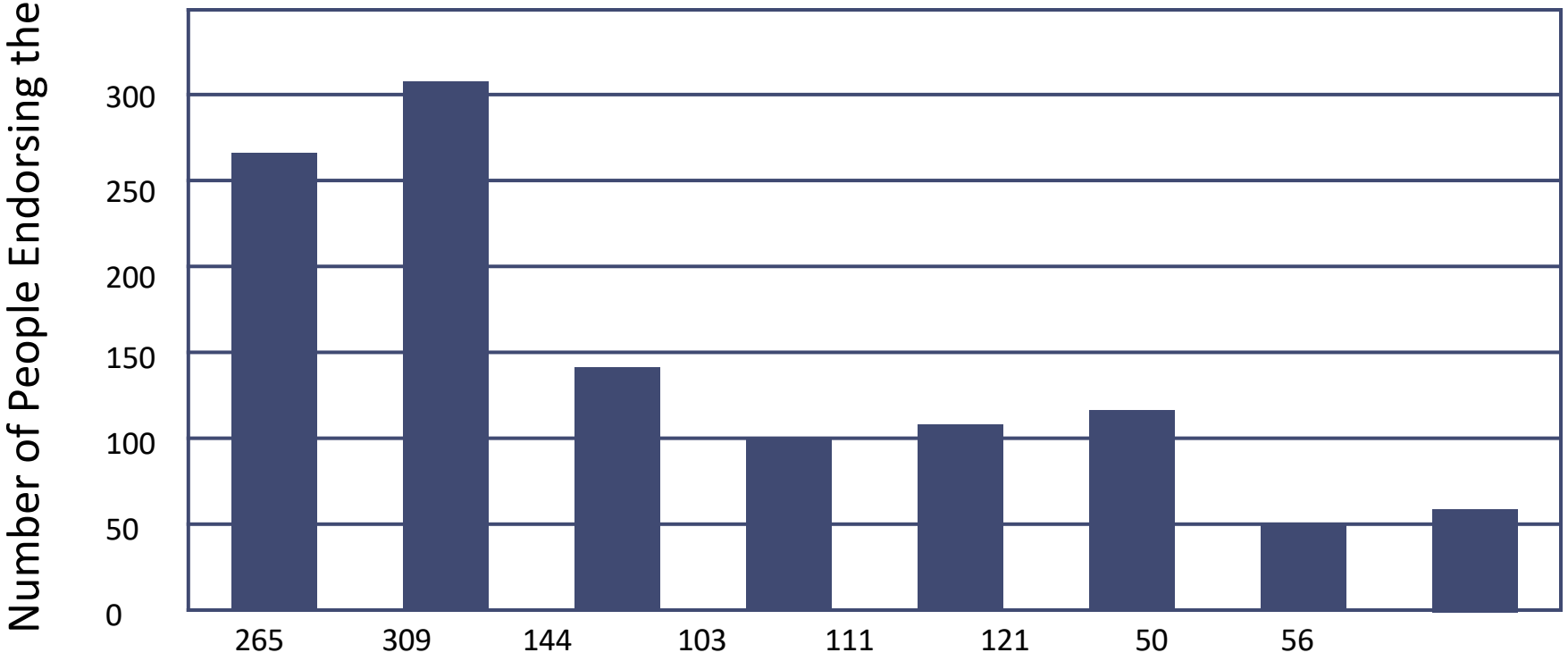


Figure 3: Approx. ROC Curves for the FVSSDB, SPS, & BHS

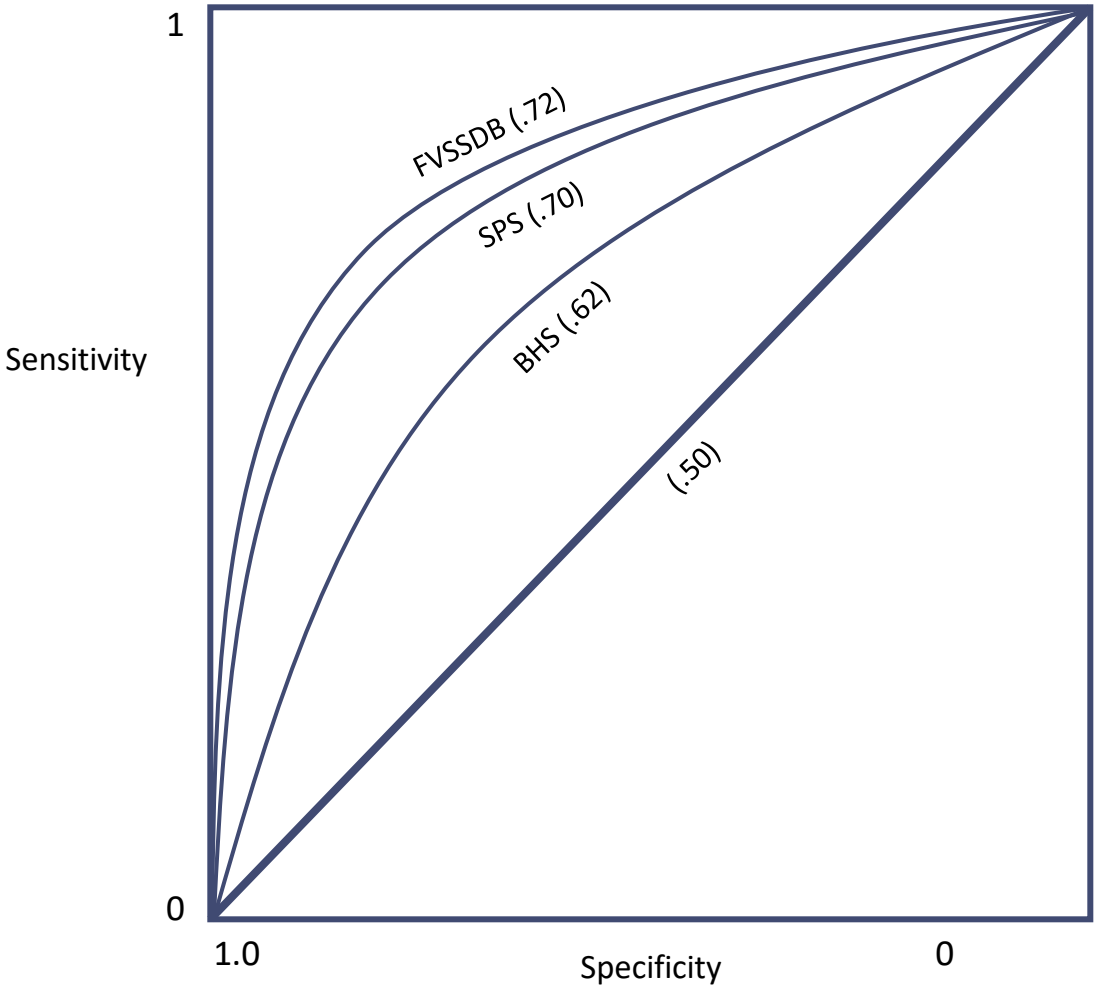
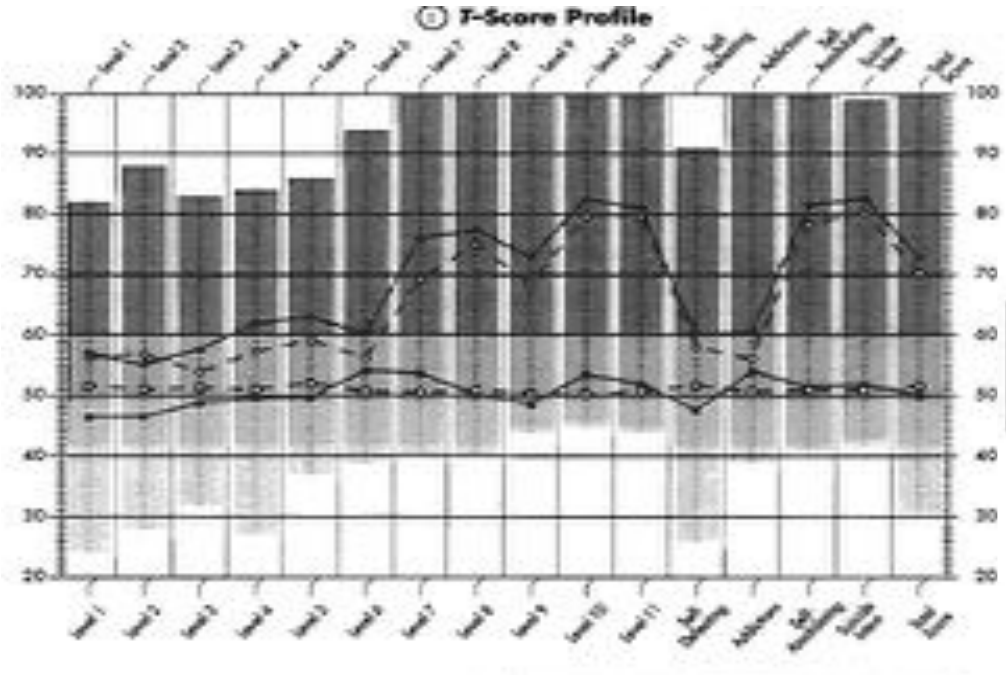
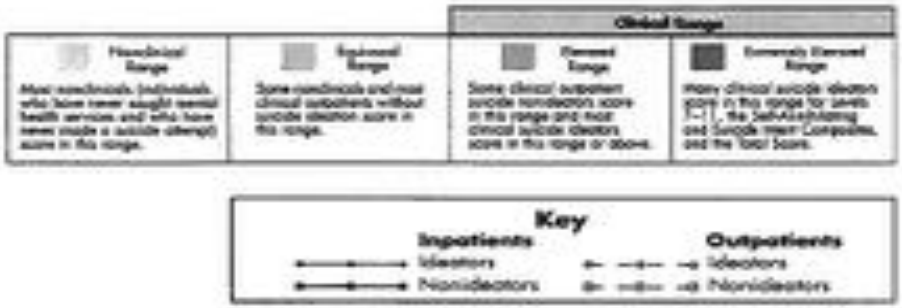


Figure 4.3

Mean *T* Scores for the Depression

Sample: Inpatients and Outpatients – Ideators VS Nonideators (N=296)



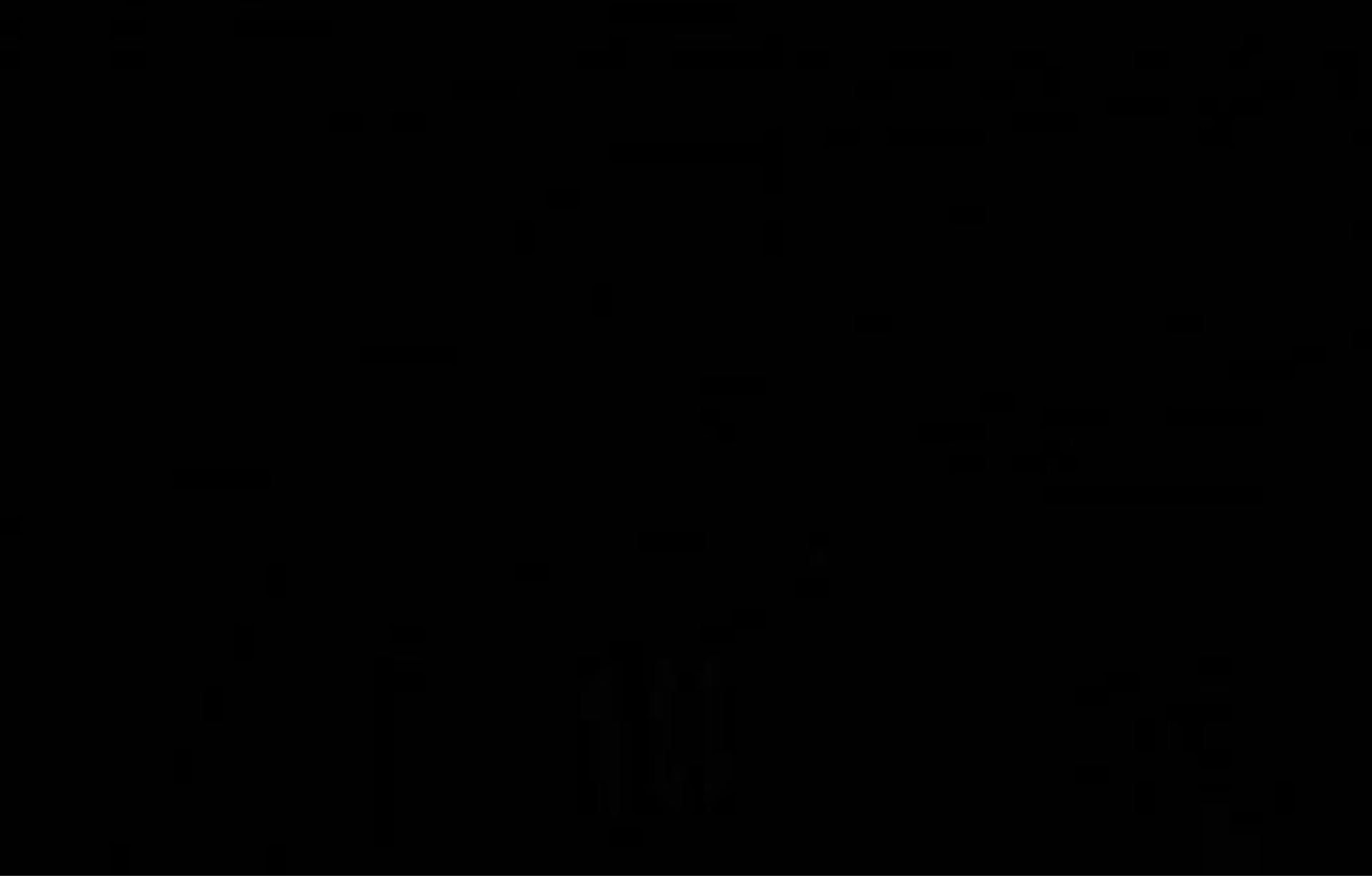


Uses for Our Measures

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

Assessment of Suicidal Ideation and Suicidal Behavior

1. Comprehensive evaluations
2. Cannot rely on a single indicator
3. Risk assessment on an ongoing basis
4. Capture the ambivalence and internal debate



Clip 74, David Jobes, 9.58

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

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

- Greater symptom severity
  - Anxiety, depression, hopelessness, anger, suicidal ideation (frequency, intensity, specificity, duration, intent)
- More frequent histories of trauma, abuse
- Distinctive characteristics of crises

Safety Planning

What a Crisis Response Plan Is:

- a memory aid to facilitate early identification of emotional crises
- a checklist of personalized strategies to follow during emotional crises
- a problem solving tool
- a collaboratively-developed strategy for managing acute periods of risk

Source: Craig J. Bryan, PsyD, ABPP, 2018

What a Crisis Response Plan Is NOT:

- a no-suicide contract
- a no-harm contract
- a contract for safety

Source: Craig J. Bryan, PsyD, ABPP, 2018

Crisis Response Plan

1. Explain rationale for CRP
2. Provide card for patient to record CRP
3. Identify personal warning signs
4. Identify self-management strategies
5. Identify reasons for living
6. Identify social supports
7. Provide crisis/emergency steps
8. Verbally review and rate likelihood of use

Source: Craig J. Bryan, PsyD, ABPP, 2018

Tips for Effective Crisis Response Planning

- Ask patients to generate ideas by asking what has worked in the past
- Use index cards or business cards, not sheets of paper
- Handwrite the plan, do not “fill in the blanks” with pre-printed paper
- Laminate the card
- Take a picture of the card to keep in their smart phone
- Complement with the “Virtual Hope Box” app

Source: Craig J. Bryan, PsyD, ABPP, 2018

Virtual Hope Box App

6 Steps of Safety Planning

Step 1: Recognizing warning signs

Step 2: Using internal coping strategies

Step 3: Utilizing social contacts that can serve as a distraction from suicidal thoughts and who may offer support

Step 4: Contacting family members or friends who may offer help to resolve the crisis

Step 5: Contacting professionals and agencies

Step 6: Reducing the potential for use of lethal means

Safety Planning with Anthony 9.55

Practice Safety Planning

Safety Plan App

My 3 App

Create your support system.

Add the contact information of the 3 people you feel you would like to talk to when you are having thoughts of suicide.

Build your safety plan.

Customize your safety plan by identifying your personal warning signs, coping strategies, distractions and personal networks. This safety plan will be with you at all times and can help you stay safe when you start thinking about suicide. Learn more about safety planning.

Access Important Resources.

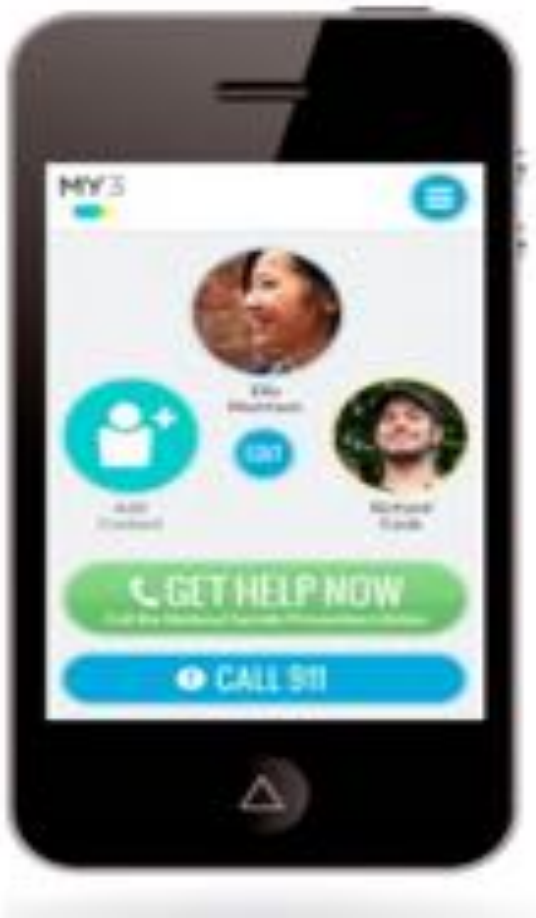
Hold all your resources in the palm of your hand. Whether you're a veteran, want support from your local community, or want to learn more about suicide prevention, pick the resources that best support you.

Get support at times of greatest risk.

When you're having thoughts of suicide and it feels like there's no hope in sight, find support at your fingertips at any time of the day.

Access the National Suicide Prevention Lifeline 24/7.

A trained counselor from a crisis center near you can be reached 24 hours a day, 7 days a week. Anyone can call, whether you're concerned for yourself or someone else. If you need someone to talk to, the National Suicide Prevention Lifeline is always ready for the call.



Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers:
A randomized clinical trial

- Contracting for safety (CFS) is widely used for managing acute suicide risk.
- Crisis response planning (CRP) is recommended instead of CFS.
- Suicide attempts and ideation were significantly reduced in CRP relative to CFS.

SOURCE: Bryan, C., Mintz, J., Clemans, T., Leeson, B., Burch, T., Williams, S., Maney, E., & Rudd, D., 2017, Journal of Affective Disorders

CRP as Stand-Alone Intervention

Study	Design	Tx	Comparison Condition	Setting	Sample	Follow-Up	Attempt Rates
Bryan et al. (2017) N=97	RCT	Standard CRP & Enhanced CRP	TAU	ED, Outpt MH	Military, 78% male, 26 y	6 months	5% CRP vs. 19% TAU (76% rel. reduction)
Miller et al. (2017) N=1376	Quasi	Self-guided Safety Plan + f/u phone calls	TAU	ED	ED patients, 55% male, 56 y	12 months	18% SP vs. 23% TAU (20% rel. reduction)

Source: Craig J. Bryan, PsyD, ABPP, 2018

Treatments With Embedded CRP

Study	Design	Tx	**# of** Sessions	Comparison Condition	Setting	Sample	**Follow-Up**	Findings
Brown et al. (2005) N=120	RCT	CT-SP	10	TAU	Outpt MH	Attempters, 40% male, 35 y	18 months	24% CT-SP vs. 42% TAU (50% rel. reduction)
Rudd et al. (2015) N=152	RCT	Brief CBT	12	TAU	Outpt MH	Military, 87% male, 27 y	24 months	14% BCBT vs. 40% TAU (60% rel. reduction)
Gysin-Maillart et al. (2016) N=120	RCT	ASSIP	3	TAU	Outpt MH	Attempters, 45% male, 38 y	24 months	5% ASSIP vs. 27% TAU (80% rel. reduction)

Source: Craig J. Bryan, PsyD, ABPP, 2018

Firearms & Suicide

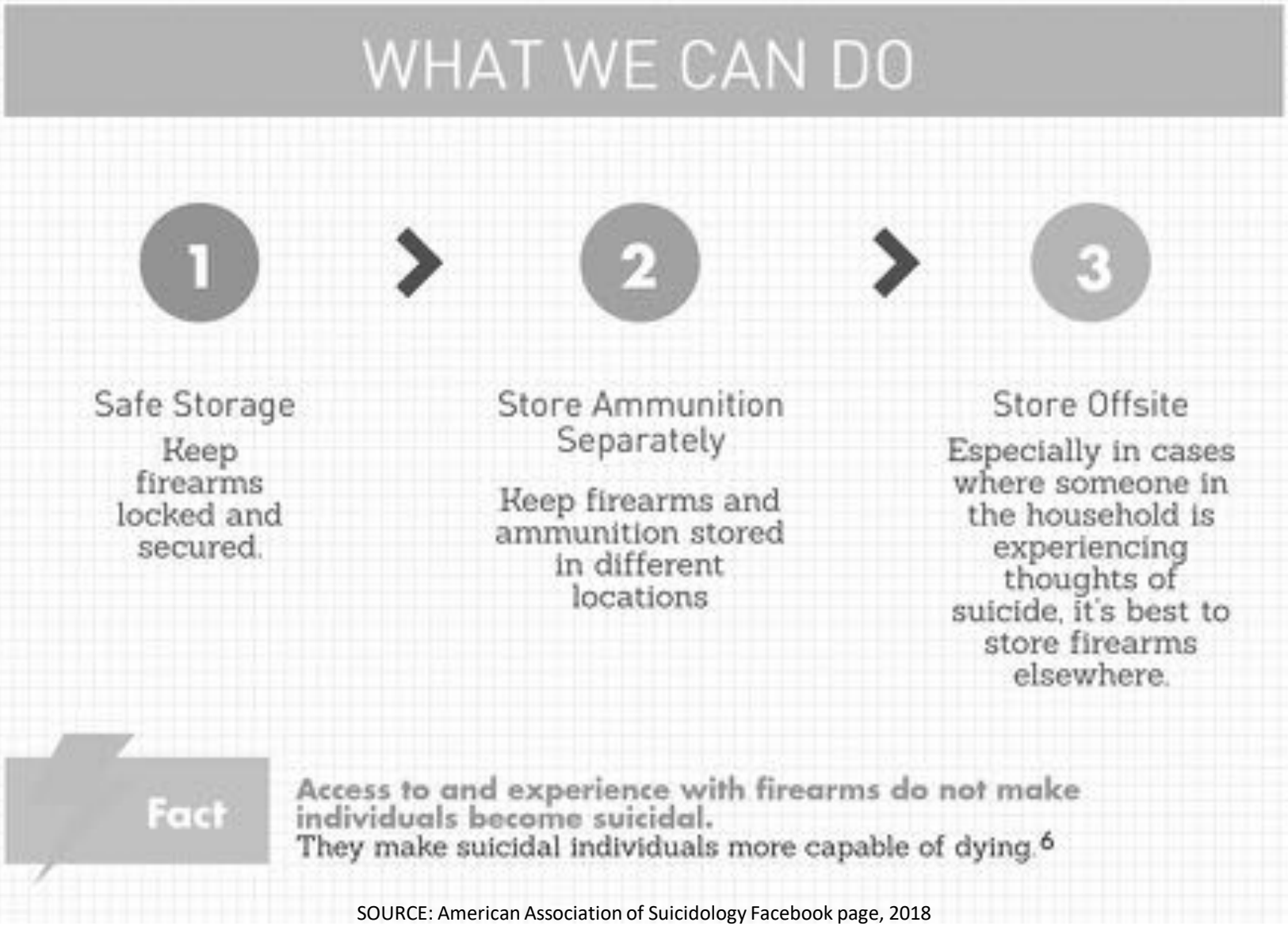
- Time and space between a person with thoughts of suicide and a firearm, using safe storage, can potentially save their life.

- When individuals are kept from using a specific suicide method, they do not simply "find another way."

- Firearms are more deadly than other methods. Firearms result in death in 85-95% of suicide attempts.

SOURCE: American Association of Suicidology Facebook page, 2018

Firearms & Suicide



SOURCE: American Association of Suicidology Facebook page, 2018

Safety Planning Clip, 2.05

SOURCE: Barbara Stanley and the U.S. Department of Veterans Affairs

Clip 74 Safety Planning Craig Bryan 7.34

Firearms & Suicide

There is a course on “Counseling on Access to Lethal Means” through the *Suicide Prevention Resource Center*

Assessment & Management of Suicide

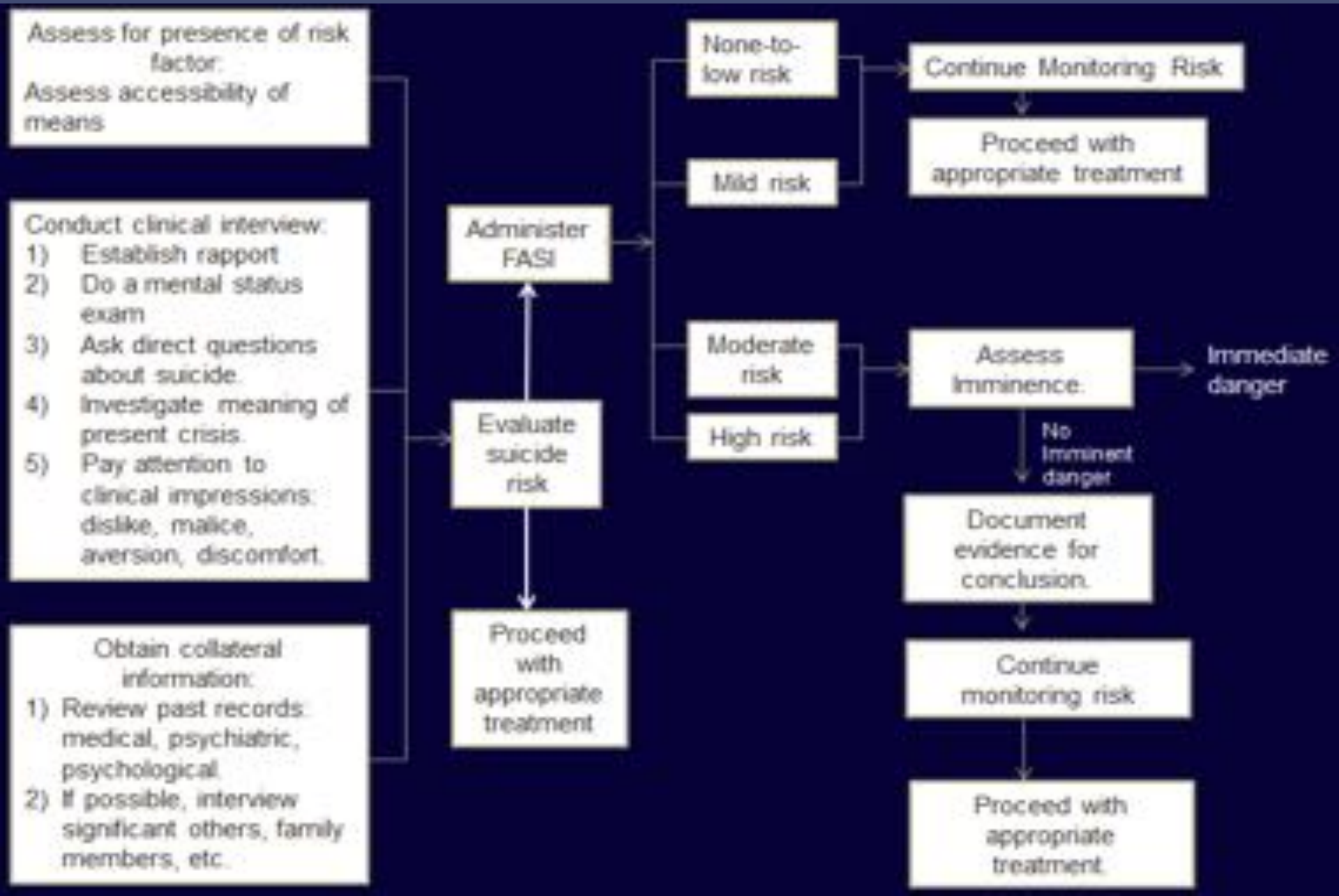


Figure 3.3, Flowchart: Assessment and management of potentially violent individuals in restrictive settings

Practice Recommendations

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 at high risk.

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

SOURCE: Bongar, B. (2002), The Suicidal Patient: Second Edition (pp. 148-150) Washington, D.C.: American Psychological Association

Practice Recommendations

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

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-injurious 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).

SOURCE: Bongar, B. (2002), The Suicidal Patient: Second Edition (pp. 148-150) Washington, D.C.: American Psychological Association

Practice Recommendations

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

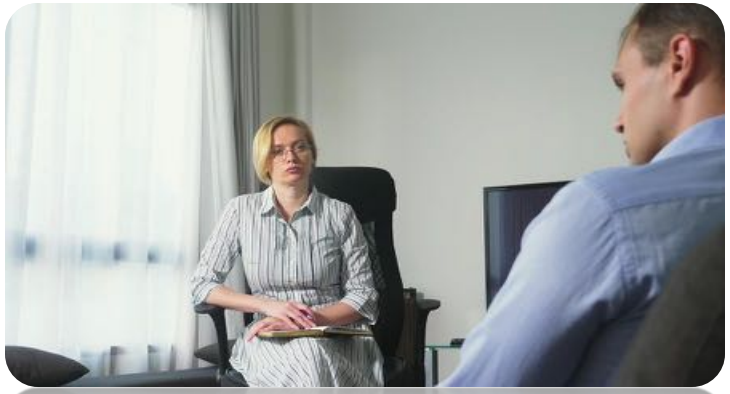
6) Informed consent pertaining to limits of confidentiality in relation to clear and imminent suicide risk and a detailed review of available treatment options, fees for service (both short and long term), risks and benefits, and the likely duration of treatment (especially for multiple attempters and those with chronic psychiatric problems) should be provided.

SOURCE: Bongar, B. (2002), The Suicidal Patient: Second Edition (pp. 148-150) Washington, D.C.: American Psychological Association

Practice Recommendations

7) An extended evaluation should be provided before specific treatment recommendations when patients present with more complex diagnostic issues of chronic suicidality.

8) **Countertransference reactions to the suicidal patient** (particularly to those who are chronically suicidal) should be monitored and responded to, and professional consultation, supervision, and support for difficult cases should be sought routinely.



SOURCE: Bongar, B. (2002), The Suicidal Patient: Second Edition (pp. 148-150) Washington, D.C.: American Psychological Association

Summary of Recommended
Standard Care Elements by Major Care Setting

1. In a malpractice case, the plaintiff's attorney and expert(s) look for evidence that the clinician acted negligently.

2. Whether or not the clinician's actions were similar to what reasonable clinicians would do under the same or similar circumstances (that's part of the definition of "standard of care" in most jurisdictions).

SOURCE: SKIP SIMPSON, JD and MICHAEL STACY, JD. "Avoiding the Malpractice Snare: Documenting Suicide Risk Assessment". Journal of Psychiatric Practice. 2004.

Summary of Recommended
Standard Care Elements by Major Care Setting

3. If one documents a reasonable and fairly complete thought process and clinical considerations—in addition to the final decision—it is difficult for a plaintiff's expert to criticize that final decision.

4. It is generally more important to document the details of decisions that increase risk than those that decrease it.

SOURCE: SKIP SIMPSON, JD and MICHAEL STACY, JD. "Avoiding the Malpractice Snare: Documenting Suicide Risk Assessment". Journal of Psychiatric Practice. 2004.

Clinician's Conflicting Emotional Response

"Clinicians' conflicting emotional responses to high-risk patients predicted subsequent suicidal behavior, independent of traditional risk factors.
Our findings demonstrate the potential clinical value of assessing such responses."

SOURCE: Zimri S. Yaseen, Igor I. Galynker, Lisa J. Cohen, Jessica Briggs. "Clinicians' conflicting emotional responses to high suicide-risk patients—Association with short-term suicide behaviors: A prospective pilot study". Comprehensive Psychiatry. 2017.

Essential Ingredients of Effective Interventions

1. Based on a simple, empirically-supported model
2. High fidelity by the clinician, adherence by the patient
3. Emphasis on skills training
4. Prioritization of self-management
5. Easy access to crisis services

Source: Craig J. Bryan, PsyD, ABPP, 2018; Rudd et al. (2009)

Patient-Oriented Approaches to Working with Suicidal People

Clip 499, Orbach Suicidal wish, 1.24

The Aeschi Working Group

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

The Patient-Oriented Approach: The Aeschi Philosophy

The key issues are:

- Shared Understanding
- Narrative approach
- Empathic approach
- Life-oriented goals
- Suicidal crisis has history
- Understanding context
- Ultimate goal to engage the patient in a therapeutic relationship
- Empathize with the patient's inner experience
- Understand the logic of the suicidal urge
- Window of opportunity
- First encounter, compliance to future therapy

SUICIDE IS AN ACTION, NOT AN ILLNESS

- Each suicide and attempted suicide has its individual background and individual story.
- Typically, patients who have attempted suicide report an unbearable state of despair, hopelessness, and the inability to see a future, a condition, which is known as “mental pain,” or psychological pain.
- Suicide appears as a solution for **putting an end to a, temporarily, unbearable state of mind**.

SOURCE: Michel & Valach, 1997

SUICIDE IS AN ACTION, NOT AN ILLNESS

In critical times, when a person's self evaluation is negative ("I have failed, I am a failure"), suicide may appear as a possible solution to a subjectively unbearable state of mind, and may reemerge throughout life as a possible goal in similar critical life situations.

SOURCE: Michel & Valach, 1997

Clip 113, Rudd Client Relationship, 3.52

Effective Brief Interventions

Elements of ASSIP
(Attempted Suicide Short Intervention Program)

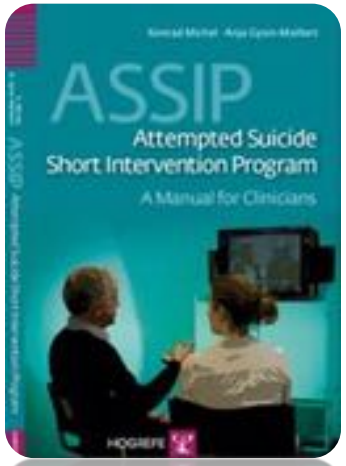
a. Exploring the background of a suicidal crisis with a narrative interview and establishing a therapeutic alliance;

b. Video playback for emotional and cognitive activation of the triggering mental pain condition. Important life issues relevant for a person's vulnerability are identified. Emotional and cognitive activation and restructuring;

c. Improving self-awareness through identification of individual warning signs. Establishing behavioral strategies for future suicidal crises, and reexposure to initial narrative interview.

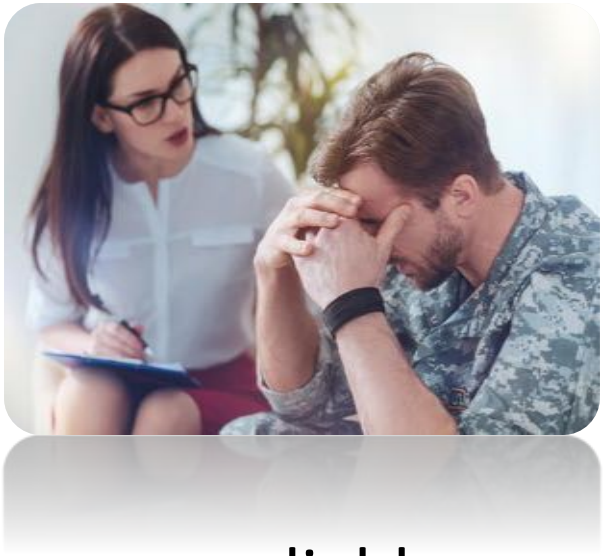
d. Long-term contact with patients through regular letters, reinforcing the therapeutic alliance, and reminding patients of preventive strategies.

Konrad Michel &
Anja Gysin-Maillart



The Therapist as “Secure Base”

- The concept of the secure base is a key element in attachment theory (Bowlby, 1988).
- Attachment security – Sensitive and responsive caregiving
- Good therapist characterized as reliable, sensitive, responsive, consistent, and psychologically minded (Holmes, 2001, p. 16).



The Therapist as “Secure Base”

- Essential parts in the ASSIP brief therapy:
  - Narrative interview, therapeutic alliance, collaborative exploration.
  - Patients experience the painful emotions in the context of an attachment relationship
  - They are no longer alone
  - Experience their mind being held in mind by the therapist (Allen, 2011).
  - Enhance their capacity to mentalize in the midst of emotional states
  - “Secure anchorage”

First Session: Conducting a Narrative Interview

Structure of the First Session

I would like to hear in your own words how you came to the point of harming yourself…

In my experience, there is always a story behind a suicide attempt, and I would like to hear your story…

- ✓ “Start where you like.”
- ✓ Allow patients to make pauses in their speech and do not interrupt
- ✓ Clarifying questions
- ✓ Open questions
- ✓ Avoid asking why

Therapy Process Factors in ASSIP

- Emphatic, patient-oriented understanding of the patient's story leading up to the suicidal crisis.
- Video playback is then used to activate the suicidal mode in a safe environment and to reconstruct the patient's sto
- This process enables the identific and restructuring of cognitive-emotional schemata.

A Novel Brief Therapy for Patients Who Attempt Suicide

A 24-months Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP)

- The study represents a real-world clinical setting at an outpatient clinic of a university hospital of psychiatry.
- During the 24-month follow-up period, five repeat suicide attempts were recorded in the ASSIP group and 41 attempts in the control group.
- The rates of participants reattempting suicide at least once were 8.3% (n = 5) and 26.7% (n = 16).

SOURCE: Gysin-Maillart, A., Schwab, S., Soravia, L., Megert, M., & Michel, K., 2016, PLOS Medicine

A Novel Brief Therapy for Patients Who Attempt Suicide

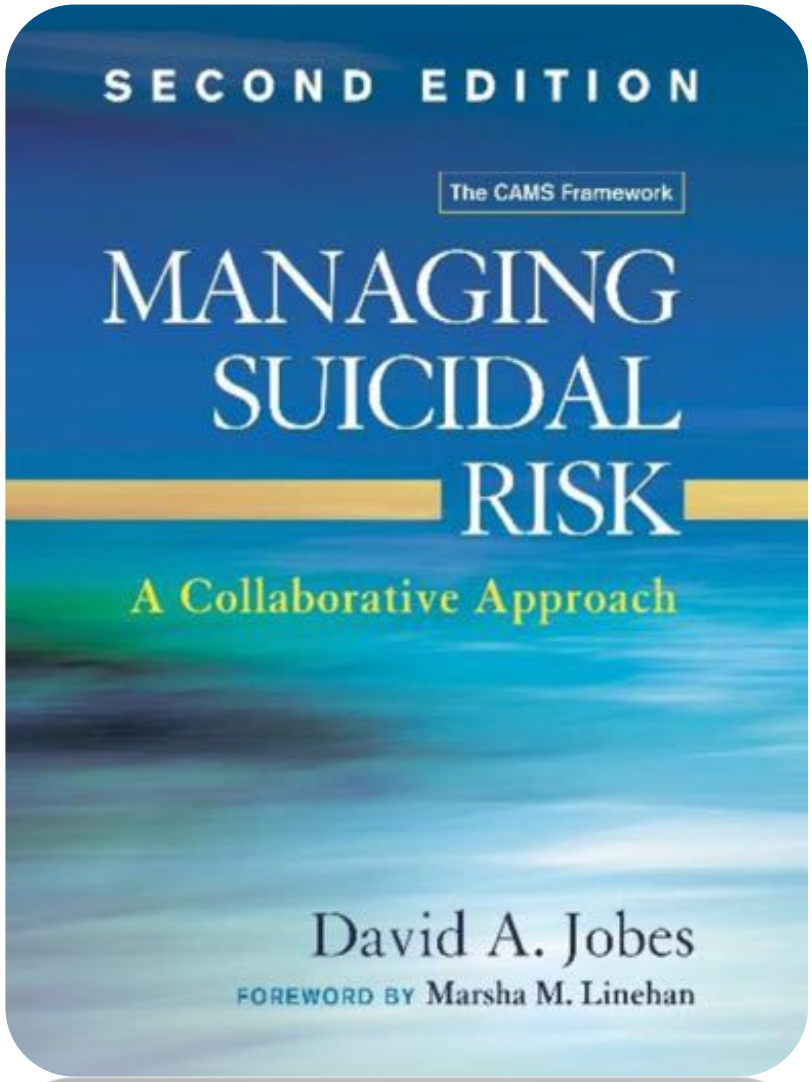
A 24-months Follow-Up Randomized Controlled Study of the Attempted Suicide Short Intervention Program (ASSIP)

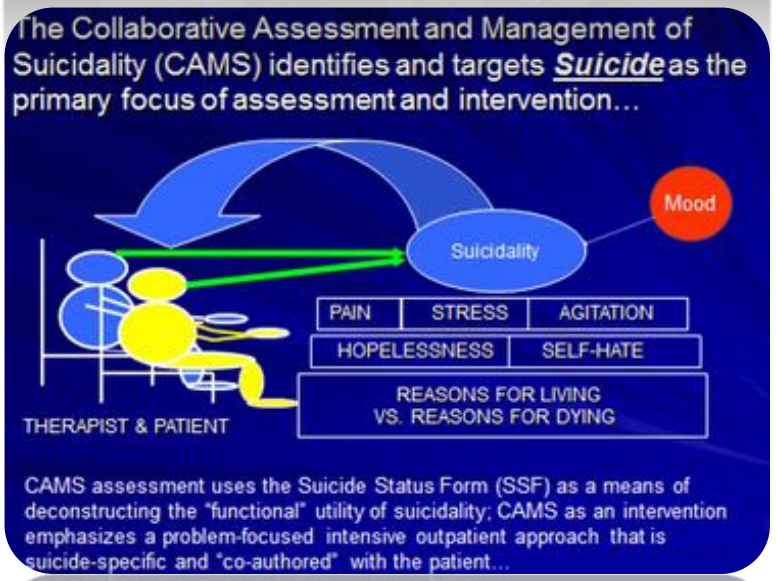
- ASSIP was associated with an approximately 80% reduced risk of participants making at least one repeat suicide attempt ($Wald_X^2{}_1$ = 13.1, 95% CI 12.4-13.7, $p<0.001$).

- ASSIP participants spent 72% fewer days in the hospital during follow-up (ASSIP: 29 d; control group: 105 d; W = 94.5, p = 0.038).

- Higher scores of patient-rated therapeutic alliance in the ASSIP group were associated with a lower rate of repeat suicide attempts.

The Collaborative Assessment and Management of Suicidality (CAMS)





SOURCE: Jobes, D., http://cams-care.com/

CAMS

First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation

CAMS Suicide **Status Forms**


CAMS Suicide Status Form (SSF-IV-R) Initial Session

Stabilization Planning


CAMS Suicide Status Form (SSF-IV-R) Initial Session


CAMS Suicide Status Form (SSF-IV-R) STABILIZATION PLAN

Mental Status Exam/ Diagnosis/Risk Level


MENTAL STATUS EXAM

SOURCE: Jobes, D., http://cams-care.com/

CAMS

CAMS Interim Tracking Sessions

CAMS Suicide Status Form (SSF-IV-R) Tracking/Update Interim Session

Patient _____ Clinician _____ Date _____ Time _____

Section A (Patient)

Rate each item according to how you feel right now

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind and nerves and physical pain):
Low pain 1 2 3 4 5 High pain

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
Low stress 1 2 3 4 5 High stress

3) RATE AGITATION (emotional urgency: feeling that you need to take action, not frustration and annoyance):
Low agitation 1 2 3 4 5 High agitation

4) RATE HOPELESSNESS (your expectation that things will not get better or support what you do):
Low hopelessness 1 2 3 4 5 High hopelessness

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-respect; hating no self-respect):
Low self-hate 1 2 3 4 5 High self-hate

6) RATE OVERALL RISK OF SUICIDE:
Extremely low risk (will not kill self) 1 2 3 4 5 Extremely high risk (will kill self)

In the past week: Suicidal Thoughts/Inner Voices Y__ N__ Managed Thoughts/Inner Voices Y__ N__ Suicidal Behavior Y__ N__

Section B (Clinician)

Recalculate (if calculated, if current overall risk of suicide (-7, in past week: no suicidal behavior and/or effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session

1st/2nd/3rd Outcome Form at 3rd consecutive resolution session**

TREATMENT PLAN UPDATE

Patient Status:
☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Hate Primarily*	*Safety and Stability*	*Safety plan* *Plan Updated* ☐	
2				
3				

_____ Patient Signature Date _____ Clinician Signature Date

Section C (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERT/WNL DROWSY LETHARGIC STUPOROUS OTHER

ORIENTED TO PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE HOPELESSNESS WORTHLESSNESS OTHER

ATTENTION: WNL SUICIDAL CONCRETE OTHER

SPEECH: WNL RAPID SLOW SCARCE IMPOVERISHED INTERRUPT OTHER

MEMORY: GROSSLY INTACT OTHER

REALITY TESTING: WNL OTHER

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ MILD (WTL/RFL) Explanation:

☐ MODERATE (AMB)

☐ HIGH (WTD/RFD)

CASE NOTES:

Next Appointment Scheduled _____ Treatment Modality: _____

_____ Clinician Signature Date

CAMS Outcome/ Disposition Session

CAMS Suicide Status Form (SSF-IV-R: Outcome/Disposition Final Session

Patient _____ Clinician _____ Date _____ Time _____

Section A (Patient)

Rate each item according to how you feel right now

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind and nerves and physical pain):
Low pain 1 2 3 4 5 High pain

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
Low stress 1 2 3 4 5 High stress

3) RATE AGITATION (emotional urgency: feeling that you need to take action, not frustration and annoyance):
Low agitation 1 2 3 4 5 High agitation

4) RATE HOPELESSNESS (your expectation that things will not get better or support what you do):
Low hopelessness 1 2 3 4 5 High hopelessness

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-respect; hating no self-respect):
Low self-hate 1 2 3 4 5 High self-hate

6) RATE OVERALL RISK OF SUICIDE:
Extremely low risk (will not kill self) 1 2 3 4 5 Extremely high risk (will kill self)

In the past week: Suicidal Thoughts/Inner Voices Y__ N__ Managed Thoughts/Inner Voices Y__ N__ Suicidal Behavior Y__ N__

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe them. Be as specific as possible.

What have you learned from your clinical care that could help you if you become suicidal in the future?

Section B (Clinician)

Third consecutive session of resolved suicidality: ___ Yes ___ No (If no, continue CAMS tracking)

**Recalculate if calculated, if for third consecutive week: current overall risk of suicide (-7, in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

OUTCOME/DISPOSITION (Check all that apply):

___ Continuing outpatient psychotherapy ___ Inpatient hospitalization

___ Marital termination ___ Patient chooses to discontinued treatment (unilaterally)

___ Referral to _____

___ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

_____ Patient Signature Date _____ Clinician Signature Date

Section C (Clinician Outcome Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERT/WNL DROWSY LETHARGIC STUPOROUS OTHER

ORIENTED TO PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE HOPELESSNESS WORTHLESSNESS OTHER

ATTENTION: WNL SUICIDAL CONCRETE OTHER

SPEECH: WNL RAPID SLOW SCARCE IMPOVERISHED INTERRUPT OTHER

MEMORY: GROSSLY INTACT OTHER

REALITY TESTING: WNL OTHER

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ LOW (WTL/RFL) Explanation:

☐ MODERATE (AMB)

☐ HIGH (WTD/RFD)

CASE NOTES:

_____ Clinician Signature Date

SOURCE: Jobes, D., http://cams-care.com/

SSF IV

Suicide Status Form-4 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

What I hate most about myself is:_____

N/A

_____ 6. Rate overall Risk of Suicide:

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

SSF IV

Suicide Status Form-4 Initial Session

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

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

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

The one thing that would help me no longer feel suicidal_____

_____

Section B (*Clinician*):

Y N Suicide ideation — Describe: _____
- Frequency — _____ per day _____ per week _____ per month
- Duration — _____ seconds _____ minutes _____ hours

Y N Suicide plan
When: _____
Where: _____
How: _____ Access to means Y N
How: _____ Access to means Y N

Y N Suicide preparation — Describe: _____

Y N Suicide rehearsal — Describe: _____

Y N History of suicidal behaviors
- Single attempt — Describe: _____
- Multiple attempts — Describe: _____

Y N Impulsivity — Describe: _____

Y N Substance abuse — Describe: _____

Y N Significant loss — Describe: _____

Y N Relationship problems — Describe: _____

Y N Burden to others — Describe: _____

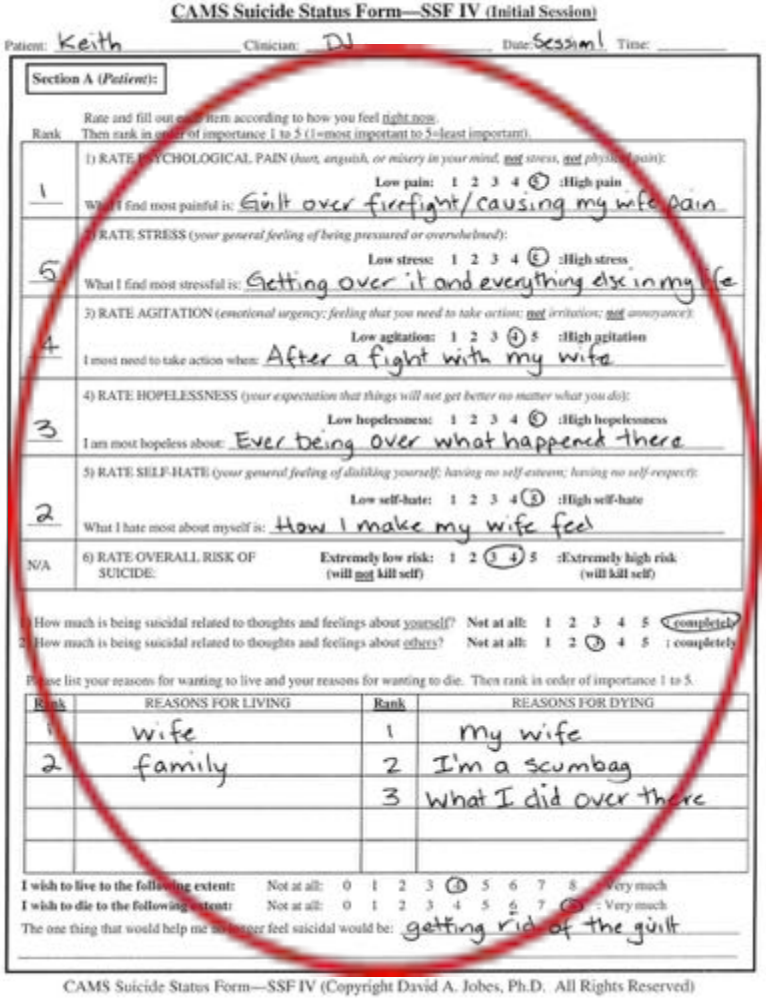
Y N Health/pain problems — Describe: _____

Y N Sleep problems — Describe: _____

Y N Legal/financial issues — Describe: _____

Y N Shame — Describe: _____

CAMS
Assessment & Treatment



CAMS Suicide Status Form—SSF IV (Initial Session)

Patient: Keith Clinician: DJ Date: Session1 Time:

Section A (*Patient*):

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

Rank 1 — 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: Guilt over firefight/causing my wife pain

Rank 5 — 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: Getting over it and everything else in my life

Rank 4 — 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: After a fight with my wife

Rank 3 — 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: Ever being over what happened there

Rank 2 — 5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 2 3 4 (5) :High self-hate
What I hate most about myself is: How I make my wife feel

N/A — 6) RATE OVERALL RISK OF SUICIDE: Extremely low risk (will not kill self): 1 2 (3) 4 5 :Extremely high risk (will kill self)

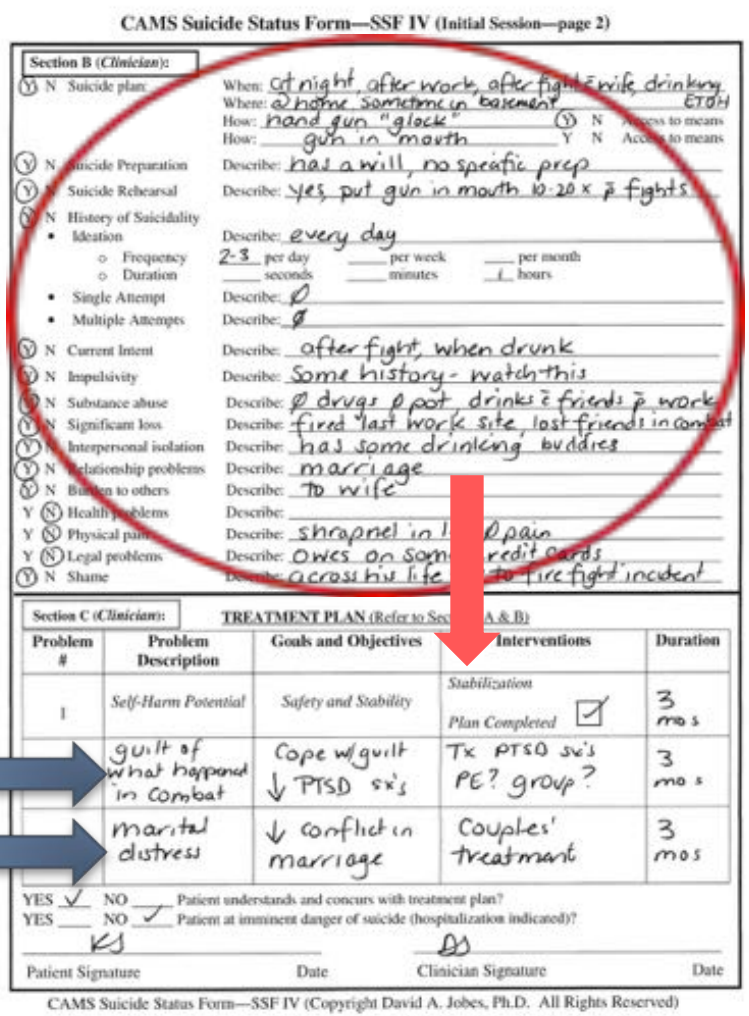
1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 (completely)
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 (3) 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
1	Wife	1	My wife
2	family	2	I'm a scumbag
		3	What I did over there

I wish to live to the following extent: Not at all: 0 1 2 3 (4) 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 (8) : Very much
The one thing that would help me no longer feel suicidal would be: getting rid of the guilt

CAMS Suicide Status Form—SSF IV (Copyright David A. Jobes, Ph.D. All Rights Reserved)



CAMS Suicide Status Form—SSF IV (Initial Session—page 2)

Section B (*Clinician*):

(Y) N Suicide plan: When: at night, after work, after fight w/ wife drinking
Where: at home sometimes in basement ETOH
How: hand gun "glock" (Y) N Access to means
How: gun in mouth Y N Access to means

(Y) N Suicide Preparation Describe: has a will, no specific prep
(Y) N Suicide Rehearsal Describe: yes, put gun in mouth 10-20 x past fights
(Y) N History of Suicidality
- Ideation Describe: every day
  - Frequency 2-3 per day ____ per week ____ per month
  - Duration ____ seconds ____ minutes 1 hours
- Single Attempt Describe: ∅
- Multiple Attempts Describe: ∅

(Y) N Current Intent Describe: after fight, when drunk
(Y) N Impulsivity Describe: some history - watch this
(Y) N Substance abuse Describe: ∅ drugs ∅ pot drinks c friends p work
(Y) N Significant loss Describe: fired last work site, lost friends in combat
(Y) N Interpersonal isolation Describe: has some drinking buddies
(Y) N Relationship problems Describe: marriage
(Y) N Burden to others Describe: To wife
Y (N) Health problems Describe:
Y (N) Physical pain Describe: shrapnel in l ∅ pain
Y (N) Legal problems Describe: owes on some credit cards
(Y) N Shame Describe: across his life re firefight incident

Section C (*Clinician*): TREATMENT PLAN (Refer to Sec A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization* Plan Completed ☑	3 mos
	guilt of what happened in combat	Cope w/guilt ↓ PTSD sx's	Tx PTSD sx's PE? group?	3 mos
	marital distress	↓ conflict in marriage	Couples' treatment	3 mos

YES ✓ NO ____ Patient understands and concurs with treatment plan?
YES ____ NO ✓ Patient at imminent danger of suicide (hospitalization indicated)?

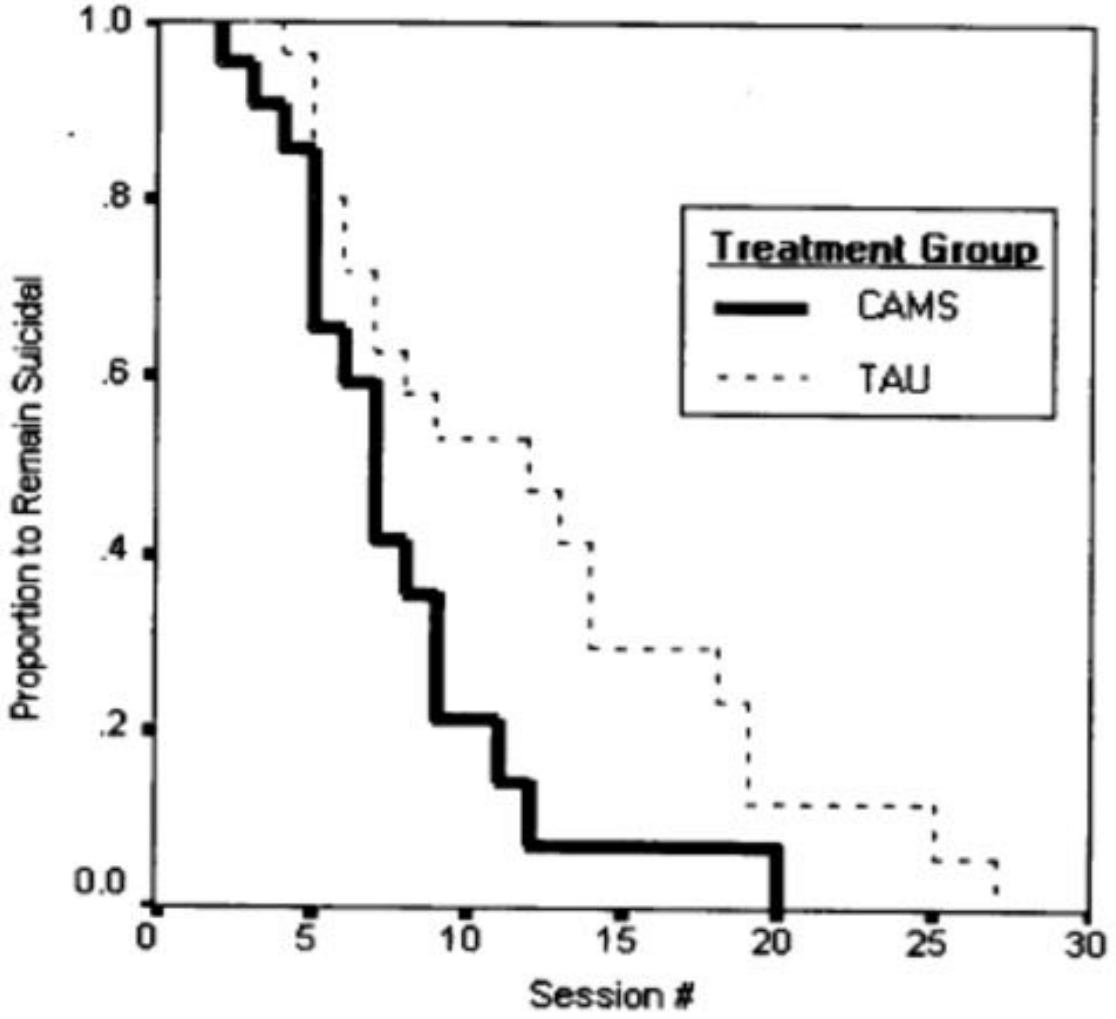
KJ — Patient Signature — Date
DJ — Clinician Signature — Date

CAMS Suicide Status Form—SSF IV (Copyright David A. Jobes, Ph.D. All Rights Reserved)

SOURCE: Jobes, D., http://cams-care.com/

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

CAMS patients reached resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients.



SOURCE: Jobes et al., 2003, Wong, 2003

Randomized Controlled Trials of CAMS

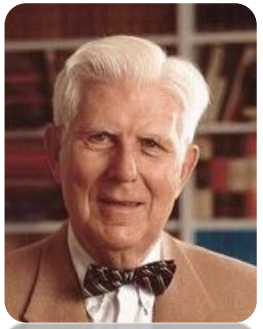
Principal Investigator	Setting & Population	Design & Method	Sample Size	Status Update
Comtois (Jobes)	Harborview/Seattle CMH Patients	CAMS vs.VTAU Next Day Appts.	32	★ 2011 published article
Andreasson (Nordentoft)	Danish Centers CMH patients	DBT vs. CAMS superiority trial	108	★ 2016 published article
Jobes (Comtois et al)	Ft. Stewart, GA US Army Soldiers	CAMS vs. E-CAU	148	★ 2017 published article
Ryberg (Fosse)	Norwegian Centers Outpatient/Inpatient	CAMS vs. TAU	78	★ 2019 published article
Pistorello (Jobes)	Univ. Nevada (Reno) College Students	SMART Design CAMS/TAU/DBT	62	Manuscript under review
Comtois (Jobes)	Harborview/Seattle Suicide attempters	CAMS vs. TAU Post-Hospital D/C	150	ITT Complete; on-going assess
Santel et al	German Crisis Unit Inpatients	CAMS vs. TAU	110	ITT Complete; on-going assess
Depp et al	San Diego VAMC Walk In Veterans	CAMS vs. Outreach Same Day Services	176	RTC preparation on-going

SOURCE: Jobes, D., http://cams-care.com/

Clip 520, David Jobes on the CAMS Approach, 6.56

Cognitive Behavioral Therapy for Suicide

Gregory Brown



Aaron Beck

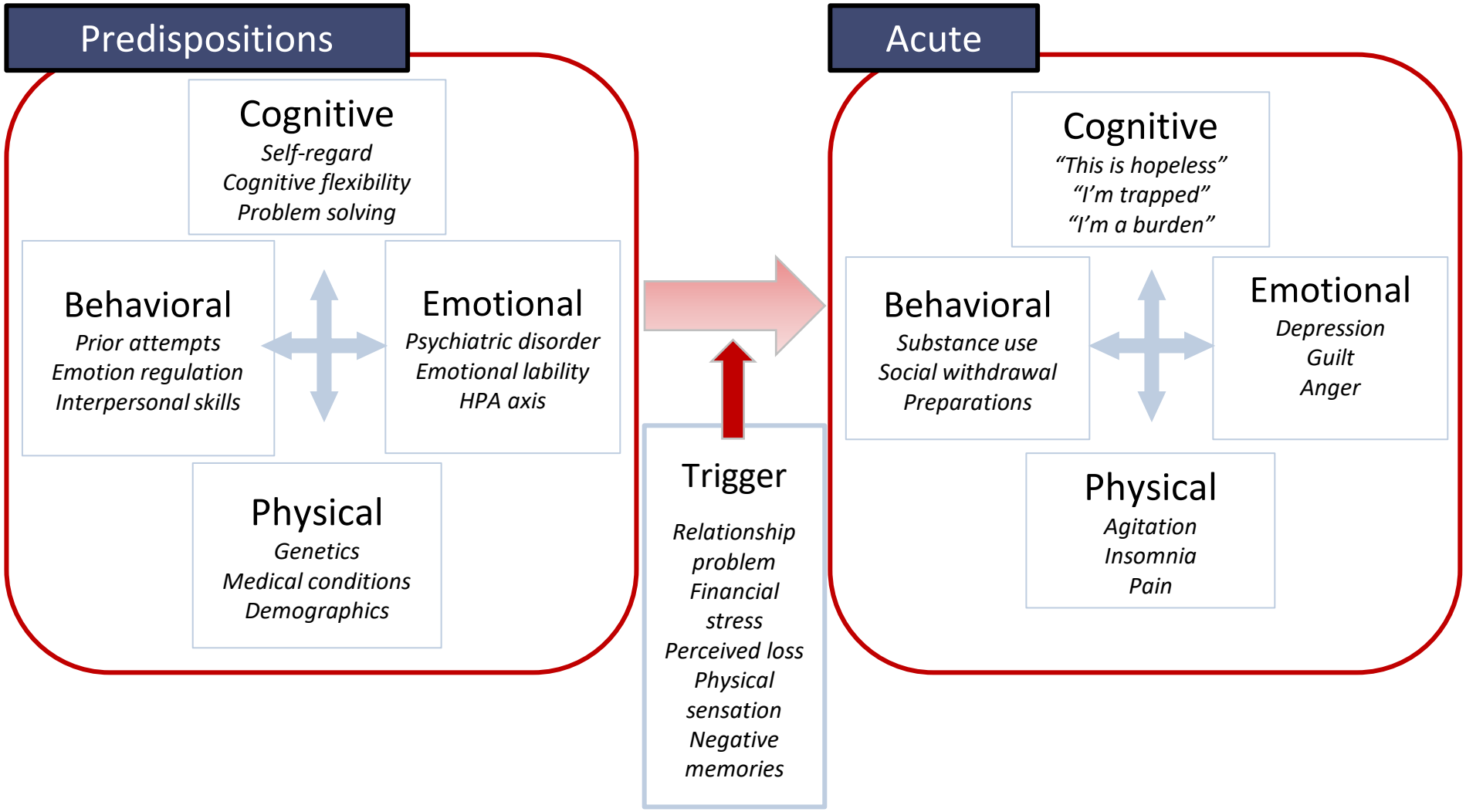
Stage 1

- Creating a crisis plan
- Teaching the cognitive model
- Creating treatment goals

Stage 2

- In depth focus on Suicidal behavior
- Cognitive restructuring, behavioral techniques
- Coping cards, Hope kit, behavioral coping skills
- Skills for tolerating distress - similar to DBT

The CBT Model of the Suicidal Mode



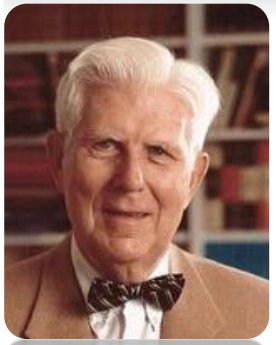
Virtual Hope Box App

Cognitive Behavioral Therapy for Suicide

Stage 3

- **Relapse Prevention with a twist**
- Guided imagery used to recreate the situation before the latest attempt
- Client imagines using the coping skills acquired in treatment rather than attempting suicide
- Client also imagines other future situations that would lead to suicidal urges and again imagines using the learned coping skills
- Inability to imagine adaptive coping is an indicator that additional skills coaching is needed- more sessions

Gregory Brown



Aaron Beck

Evidence-Based Psychotherapies for Suicide Prevention

…suicide attempters who received CT-SP were 50% less likely to reattempt than participants who received enhanced usual care (EUC) with tracking and referrals.

SOURCE: Brown, G. & Jager-Hyman, S, 2014, American Journal of Preventive Medicine

Clip 586b, Dr. Rudd discusses effective therapies for self-destructive individuals - shorter, 1.10

TAU vs BCBT

David Rudd

Craig Bryan

TAU (n = 76)

(Treatment as Usual)

- Suicide as symptom of psychiatric diagnosis
- Remission is treatment focus
- Emphasizes external self-management (e.g. hospitalization)
- Clinician responsibility for preventing suicide

BCBT (n = 76)

(Brief Cognitive Behavioral Therapy)

- Suicide as problem distinct from diagnosis
- Identifiable skill deficits as treatment focus
- Focus on suicide risk
- Emphasizes internal self-management
- Shared patient-clinician responsibility for preventing suicide

Findings

- Consistent with predications
  - Levels of self-reported depression, anxiety, and suicidal thinking comparable at intake, 3, 6, 12 and 24 months
  - Reduced suicide attempt rate 60% at 24 months
    - 8/76 in BCBT (13.8%)
    - 18/76 in TAU (40.2%)

Study Design/Methodology

Treatment As Usual (TAU)	Crisis Response Plan (CRP)	Crisis Response Plan + Reasons for Living (CRP+RFL)
Suicide risk assessment	Suicide risk assessment	Suicide risk assessment
Supportive listening	Supportive listening	Supportive listening
	Identify warning signs	Identify warning signs
	Identify self-mgt skills	Identify self-mgt skills
		Identify reasons for living
	Identify social support	Identify social support
Crisis mgt education	Crisis mgt education	Crisis mgt education
Referrals to treatment & community resources	Referrals to treatment & community resources	Referrals to treatment & community resources

SOURCE: Bryan, C., National Center for Veterans Studies, http://veterans.utah.edu/

Conclusions

- Brief treatment can be as/more effective than traditional approaches
  - Safety not an issue
- Consistent with previous findings
  - Brown et al.
  - Linehan et al.
- Targeting suicidal behavior as skill deficit critical to success

Additional Treatment Approaches

Dialectical Behavior Therapy (DBT)

Dialectics:

- Helping clients find balance in emotions, thoughts, behavior and choices. Teaching them and showing them how to live in balance.

Marsha Linehan

Validation:

- Acknowledging another person's reality, noting that their thoughts feelings responses are real and valid in their own right.

Dialectical Behavior Therapy (DBT)

Components of DBT

- Individual Treatment
- Group Skills Training
- Skills Coaching
- Consultation Team

Dialectical Behavior Therapy (DBT)

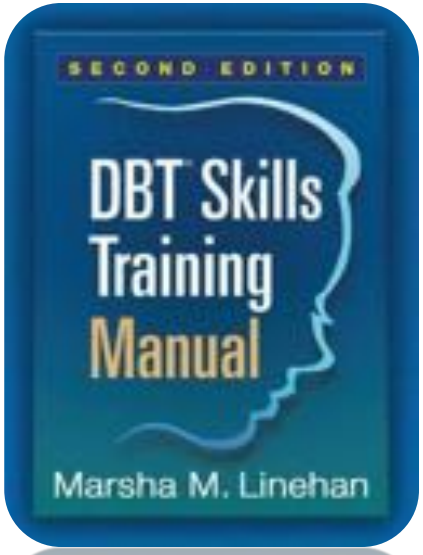
Functions of DBT

- Structuring the Environment
- Enhancing Client Capabilities
- Generalizing Skills to the Natural Environment
- Improving Client Motivation

DBT: Weekly Group Meetings

Concentrate on Behavioral Skills in 4 areas:

1) Interpersonal effectiveness skills
2) Distress tolerance skills
3) Emotion-regulation skills
4) Mindfulness skills



DBT appears to be uniquely effective in reducing suicide attempts.

Conclusions and Relevance:

A variety of DBT interventions with therapists trained in the DBT suicide risk assessment and management protocol are effective for reducing suicide attempts and NSSI episodes. Interventions that include DBT skills training are more effective than DBT without skills training, and standard DBT may be superior in some areas.*

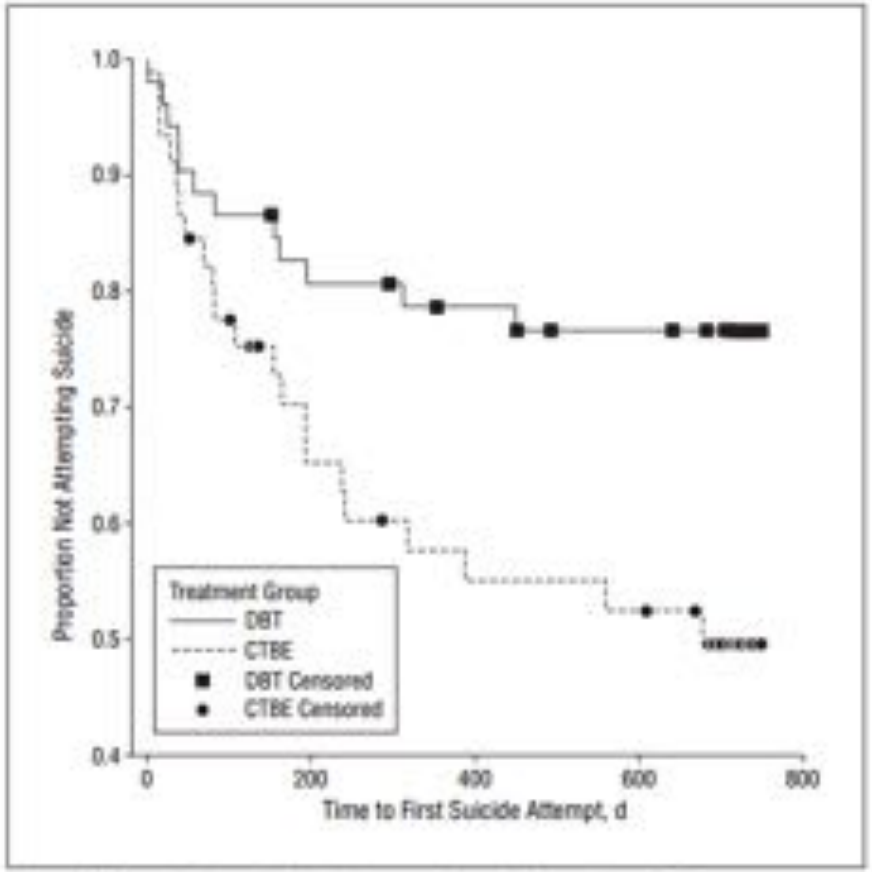
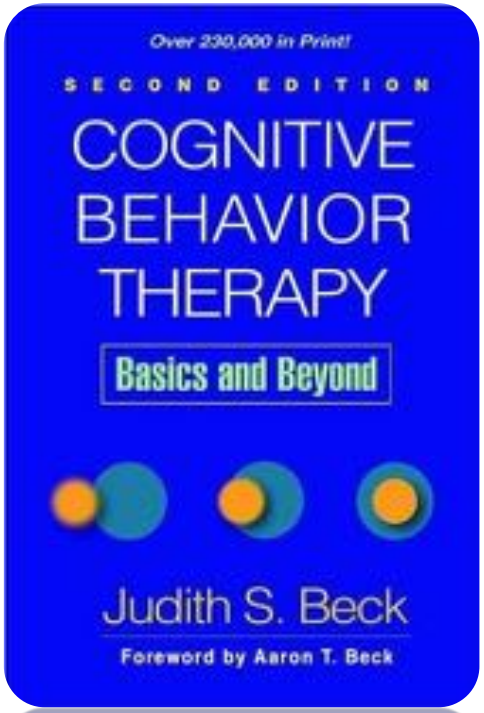


Figure 3. Survival analysis for time to first suicide attempt. The treatment period ended at 365 days, and the follow-up period ended at 730 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

*SOURCE: Linehan, M., et al., 2007, Archives General Psychiatry, *=SOURCE: Linehan, M., Korslund, K., Harned, M., Gallop, R., Lungu, A., Neacsiu, A., McDavid, J., Comtois, A., Murray-Gregory, A., American Medical Association, 2015*

Cognitive Therapy: Basics and Beyond

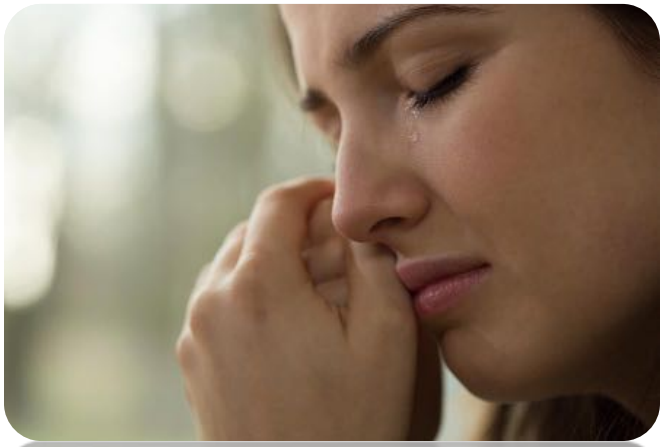
*"It is vital to be alert to both verbal and nonverbal cues from the patient, so as to be able to elicit "**hot cognitions**" - that is, important automatic thoughts and images that arise in the therapy session itself and are associated with a change or increase in emotion. Eliciting the hot cognitions are important because they often have critical importance in conceptualization."*



SOURCE: Beck, J., Guilford Press, 2011

Emotion Focused Therapy (EFT)

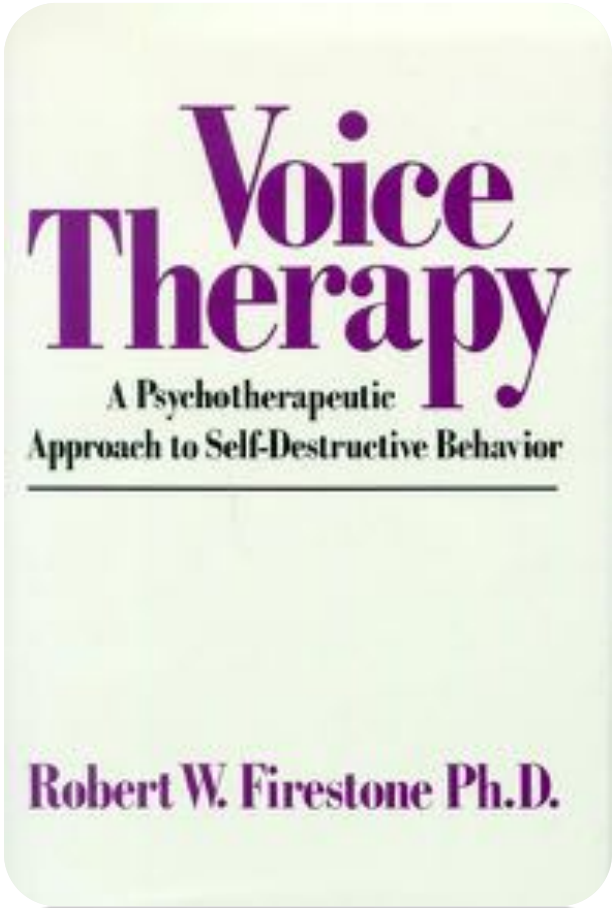
- Emotion-focused therapy (EFT), focuses primarily on **eliciting emotion by directing the client to amplify his or her self-critical statements**.
- For example, if the client says “you’re worthless” or sneers while criticizing, direct the client to “do this again…,” “do this some more…”; “put some words to this…” This operation will **intensify the client’s affective arousal and help access core criticisms**.



SOURCE: “Facilitating Emotional Change: The Moment-by-Moment Process” by L. Greenberg, Rice, and Elliot. 1993

VOICE Therapy

Cognitive/Affective/ Behavioral Approach



The Therapeutic Process in Voice Therapy

Step I

Identify the content of the person's negative thought process. The person is taught to articulate his or her self-attacks in the second person. The person is encouraged to say the attack as he or she hears it or experiences it. If the person is holding back feelings, he or she is encouraged to express them.

The Therapeutic Process in Voice Therapy

Step 2

The person discusses insights and reactions to verbalizing the voice. The person attempts to understand the relationship between voice attacks and early life experience.

The Therapeutic Process in Voice Therapy

Step 3

The person answers back to the voice attacks, which is often a cathartic experience. Afterwards, it is important for the person to make a rational statement about how he or she really is, how other people really are, what is true about his or her social world.

The Therapeutic Process in Voice Therapy

Step 4

The person develops insight about how the voice attacks are influencing his or her present-day behaviors.

The Therapeutic Process in Voice Therapy

Step 5

The person then collaborates with the therapist to plan changes in these behaviors. The person is encouraged to not engage in self-destructive behavior dictated by his or her negative thoughts and to also increase the positive behaviors these negative thoughts discourage.

The Self vs the Anti-Self

Self

Anti-Self

Self-Compassion
A Healthier Way of Relating to Yourself

Kristen Neff

From Kristin Neff:

Self-compassion is not based on self-evaluation. It is not a way of judging ourselves positively; it is a way of relating to ourselves kindly.

> "Being touched by and not avoiding your suffering"

SOURCE: http://www.self-compassion.org/

Self-Compassion

Three Elements:

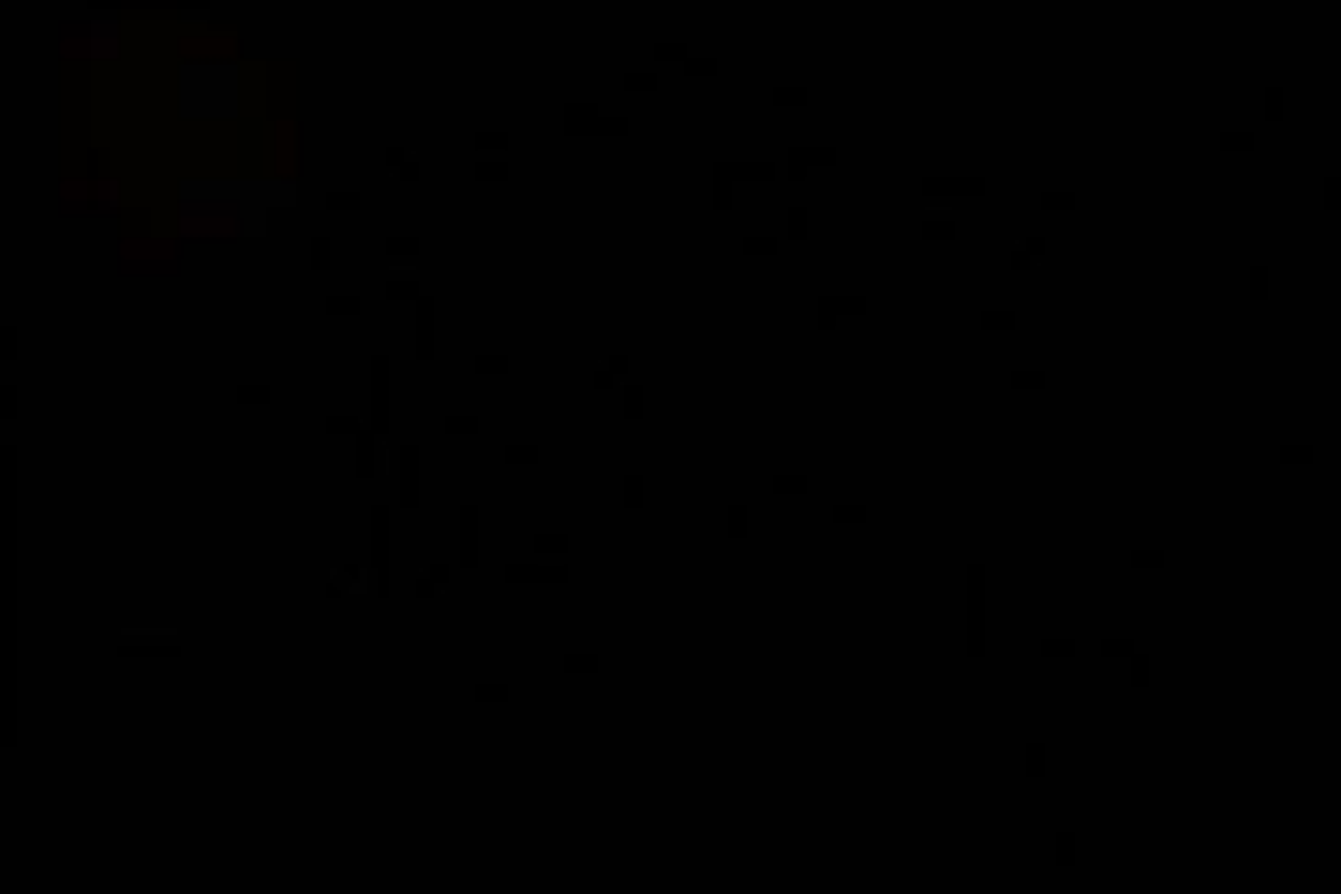
1. Self-kindness vs. Self-judgment
2. Mindfulness vs. Over-identification with thoughts
3. Common humanity vs. Isolation



SOURCE: http://www.self-compassion.org/

Interpersonal Neurobiology

Curious
Open
Accepting
Loving



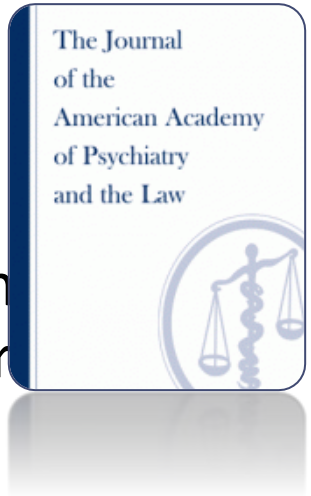
Clip 51, VOS-Treatment, 6.59

Conclusion

6 Probable Standards of Care for Suicide Risk Assessment

1. **Gathering Information from the Patient**
   To the extent that the patient is cooperative and the treatment context permits, the clinician inquires about current suicidal thinking, surveys current and historical suicide risk factors, and assesses mental status.

1. **Gathering Data from Other Sources**
   Whenever relevant and possible, the clinician pertinent documentation, makes reasonable attem obtain past records, and collects collateral reports fr professionals, family, or significant others.

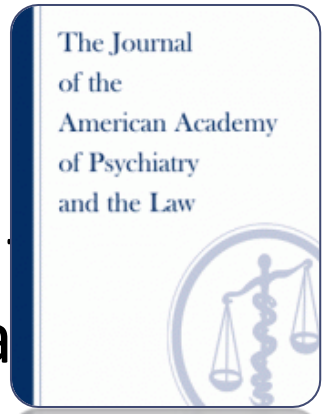


SOURCE: Probable Standards of Care for Suicide Risk Assessment. Journal of the American Academy of Psychiatry and the Law. Joseph H. Obegi. 2017.

6 Probable Standards of Care for Suicide Risk Assessment

3. **Estimating Suicide Risk**
   The clinician estimates the degree of suicide risk based on collected information.

4. **Treatment Planning**
   When there is substantial risk of suicide, the clinician formulates and follows through on a treatment plan, the components of which reasonably correspond to the severity of the suicide risk estimate.

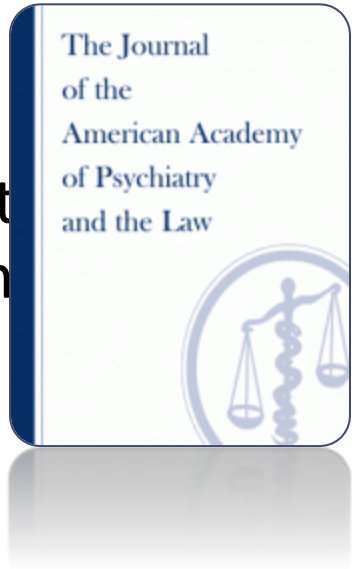


SOURCE: Probable Standards of Care for Suicide Risk Assessment. Journal of the American Academy of Psychiatry and the Law. Joseph H. Obegi. 2017.

6 Probable Standards of Care for Suicide Risk Assessment

5. **Documentation**
   The clinician documents the findings of the suicide risk assessment and, when substantial suicide risk exists, the rationale for the selected course of treatment.

6. **Monitoring**
   The clinician updates the suicide risk estimat there are clinically significant changes in th circumstances or condition and reassesses significant treatment junctures.



SOURCE: Probable Standards of Care for Suicide Risk Assessment. Journal of the American Academy of Psychiatry and the Law. Joseph H. Obegi. 2017.

National Action Alliance for Suicide Prevention:
Recommended Standard of Care

- Provide treatment and support for individuals who may have elevated suicide risk.
- On intake and periodically, assess all patients for suicide risk using a standardized instrument or scale. Reassess risk at every visit until the risk is reduced.
- Complete the brief Safety Planning Intervention during the visit where risk is identified. Update the safety plan at each visit as long as risk remains high.

National Action Alliance for Suicide Prevention:
Recommended Standard of Care

- As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.
- Initiate caring contacts during care transitions or if appointments are missed.

SOURCE: National Action Alliance for Suicide Prevention: Recommended Standard Care for People with Suicide Risk: MAKING HEALTH CARE SUICIDE SAFE

Key Points to Keep in Mind

1. Know and manage your attitude and reactions toward suicide when with a client
2. Develop and maintain a collaborative, empathic stance toward the client
3. Know and elicit evidence-based risk and protective factors
4. Focus on current plan and intent of suicidal ideation
5. Determine level of risk

SOURCE: Suicide Risk Assessment Training for Psychology Doctoral Programs. Robert J. Cramer, Shara M. Johnson, and Jennifer McLaughlin. Sam Houston State University. 2013.

Key Points to Keep in Mind

6. Develop and enact a collaborative evidence-based treatment plan
7. Notify and involve other persons
8. Document risk, plan, and reasoning for clinical decisions
9. Know the law concerning suicide
10. Engage in debriefing and self-care

Seek Consultation

SOURCE: Suicide Risk Assessment Training for Psychology Doctoral Programs. Robert J. Cramer, Shara M. Johnson, and Jennifer McLaughlin. Sam Houston State University. 2013.

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.

SOURCE: Counseling for Suicide: Client Perspective. Paulson & Worth, 2002

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.

SOURCE: Counseling for Suicide: Client Perspective. Paulson & Worth, 2002

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.

SOURCE: Counseling for Suicide: Client Perspective. Paulson & Worth, 2002

Common Emotions Experienced in Suicide 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

Resources

Useful Resources

National Action Alliance for Suicide Prevention
www.actionallianceforsuicideprevention.org/

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

AFSP American Foundation for Suicide Prevention
www.afsp.org/

IASP Suicide Survivor Organizations (listed by country)
www.iasp.info/resources/Postvention/National_Suicide_Survivor_Organizations/

Suicide Prevention Resource Center
www.sprc.org

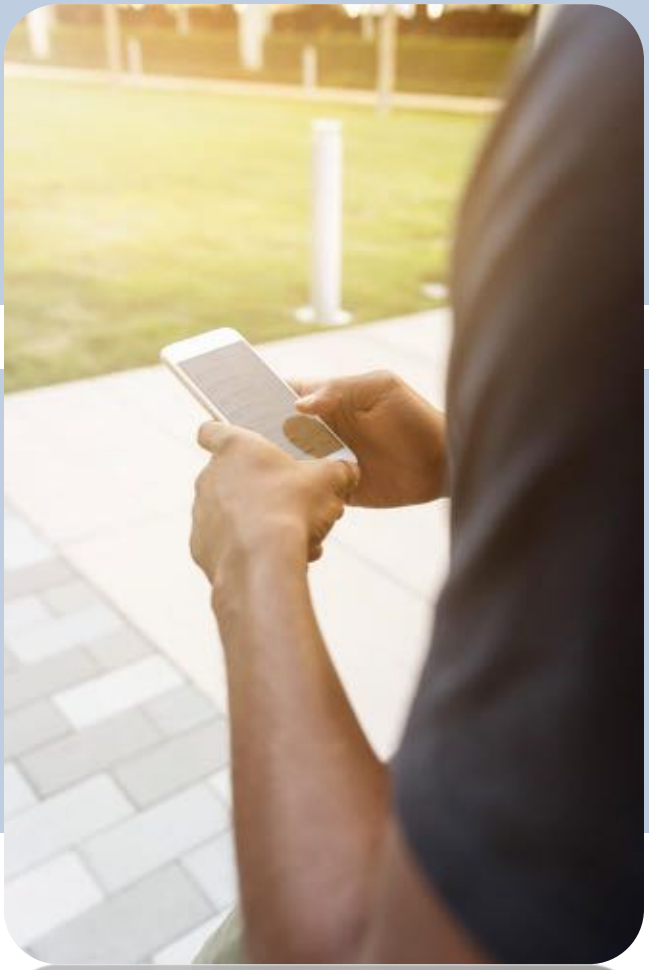
ZERO Suicide in Health and Behavioral Health Care
www.zerosuicide.sprc.org

Useful Resources

National Suicide Prevention Lifeline (Call or Chat online)

www.suicidepreventionlifeline.org

1-800-273-TALK (8255)



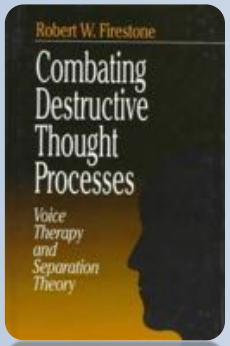
Crisis Text Line

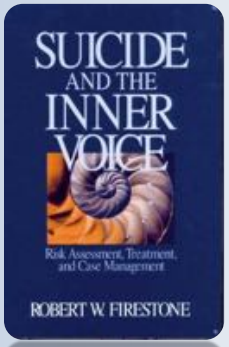
www.crisistextline.org

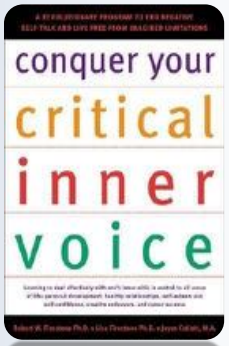
Text CONNECT to 741741

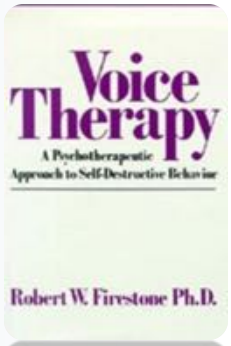
Resources

Books









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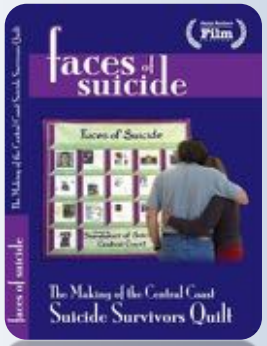

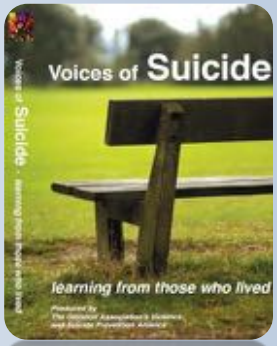

Webinars

Live, archived, free, and CE Webinars can be watched at PsychAlive.org

Visit www.**PsychAlive.org**
for these resources and more

Resources

Free Webinar

Dr. Lisa Firestone will outline steps we can all take to reach out and help someone who may be suicidal. She will talk about the warning signs of suicide as well as the helper tasks that can save a life.

E-Course

Visit www.**PsychAlive.org**
for these resources and more

Mental Health Expert Interview Series

Dr. Carol Gilligan
Dr. Donald Meichenbaum
Dr. James Garbarino
Dr. James Gilligan
Dr. Peter Fonagy
Dr. Sheldon Solomon
Dr. John Kabat-Zinn
Dr. David Rudd
Dr. Stephen Porges
Dr. Pat Love
Dr. David Jobes
Dr. Christine Courtois
Dr. Israel Orbach
Dr. Jeff Greenberg
Dr. Pat Ogden
Father Greg Boyle
Dr. Kirk Schneider
Dr. Donna Rockwell
Dr. John Norcross
Dr. Robert Stolorow
Dr. Peter Levine
Dr. Felicity de Zulueta
Dr. Jaak Panksepp

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Contact Information

Glendon@Glendon.org
(800) 663-5281

Lisa Firestone, Ph.D.

Director of Research and Education
The Glendon Association

lfirestone@glendon.org

Senior Editor
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