

# The Four E's of Suicide Risk Assessment and Management

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# The Emergence of Core Competencies

- Attitudes and Approach
- Understanding Suicide: Conceptual Model
- Collecting Accurate Assessment Information
- Formulation of Risk
- Treatment Planning
- Management of Care

# Understanding the Challenge of the Suicidal Patient.....

- *Robert, a 21 year old African-American male.....died of a gunshot wound to the head.*
- *Well, I've come down to the fact that the people I care about, depend on, and have supported in their time of need, don't give a crap about me. Thoughts of murder and suicide constantly go through my head. What I'm I to do? I don't trust anyone. I'm not going to expose myself again to the backstabbing, two-faced reality that is friendship. I want to blow my brains out plain and simple. I'm not taking it anymore.*

# The Challenge of the Suicidal Patient.....

- Brad, a 20 year old Caucasian male.....died of a gunshot wound to the head.
- *I don't want to be a burden on my parents anymore. My life has always been full of depression. I've never lived up to my potential. I've decided to end all of this pain. I am at peace. Goodbye.*

# The Checklist

*Making the Complex Simple*

- Engage
  - *Build a relationship*
- Evaluate
  - *Assess risk*
- Educate
  - *Provide a foundation for treatment*
- Equip
  - *Crisis management and safety planning*

What can we learn from  
clinical trials?

# What Do Effective Treatments Have in Common? Why do They Work?

- We need to talk in simple and understandable terms about suicide
  - Clearly articulated treatment model and suicidality as targets
  - Patients can understand and invest
  - Better compliance, motivation?
  - Facilitates hope? Sense of control?
- People that are suicidal have poor skills
  - Skills deficiencies targeted, not just symptoms
- When People drop out of treatment or are non-compliant, action needs to be taken
  - Treatment compliance closely monitored and addressed
  - Motivation, ambivalence, and intent to die

- People need to take ownership of their treatment
  - Addressed self-reliance, self-awareness, individual control
  - Commitment to treatment statement

- People need to know what to do during a crisis
  - Crisis management/access to emergency services
  - Limited access to method

# Engage

## Facilitating Hope (*and feeling in control*) During the First Contact

- Provide an understandable model
  - Explain why the suicide attempt(s) happened
- Contextualize/Normalize the problem
  - Sensitized to the sights, sounds, smells of war (problem is that many generalize to day to day living, particularly given the urban nature of much of this conflict)
- Label and reinforce the presence of ambivalence
  - *Reasons for living, reasons for dying*
  - *Recognize hope is embedded in ambivalence*
- Identify a common goal (reduces adversarial tension)
  - *Reduce suffering and emotional pain*

# What Are Common Emotional Reactions that Limit Ability to Engage?

## ■ Fear/Anxiety Spectrum:

- Related to beliefs that
  - Suicidal behavior will occur
  - Will be held responsible
  - Detailed discussion will encourage suicidality

## ■ Anger Spectrum:

- Related to beliefs that
  - Helpless, hopeless
  - Must control

# The Importance of Informed Consent

- Provides a foundation to relationship
  - Honest, caring, blunt
- Articulates responsibilities
  - Patient and clinician
- Reduces fearfulness of patient
  - Consequences and boundaries are clear
- Raises the issue of death as “risk”
  - Targeted disorders
  - Chronic suicidality

*Why is there NOT a  
perception of risk in the  
treatment of suicidal patients?  
That is, in the informed  
consent document.*

# Failure to Acknowledge Suicide and Suicide Attempt Rates :

- Treatment Outcome Studies
  - Reattempt rates range from 40%-47% in the first year of treatment
  - If there's a reattempt, the average is slightly over 2 in the first year
- Bipolar Disorder
  - 25-50% suicide attempt
  - 10-20% suicide
    - Goodwin FK, Jamison KR. *Manic Depressive Illness*. 1990.
- Schizophrenia
  - 20-40% suicide attempt
    - Meltzer & Fatemi, 1995
  - 9-13% suicide
    - Caldwell & Gottesman, 1990
- Major Depression
  - 2% ever treated in outpatient setting will suicide
  - 4% ever treated inpatient setting will suicide
    - 7% of men with lifetime history will suicide
    - 1% of women with lifetime history will suicide
    - NIMH

# Agreements with Suicidal Patients: Expectations and Recognition of Risk

- How do they relate to informed consent?
  - Why don't we routinely quote death and attempt rates in informed consent statements?
- No-suicide contract
  - No-harm contracts
  - Safety agreements
  - Suicide prevention contract
  - *Means of gaining a patient's commitment to not act on suicidal or self-destructive urges and to inform clinicians of the status of those urges (Miller, 1999)*
  - *Agreement between the patient and clinician in which the patient agrees not to harm herself and/or seek help when in a suicidal state and she believes she is unable to honor the commitment*

# What's a Commitment to Treatment Agreement

- *An explicit agreement that identifies patient and clinician responsibilities in ongoing care. Such an agreement always includes a crisis response plan and incorporates behaviors consistent with the patient's identified level of competence and unique to his or her presentation.*

# Elements of a Good Agreement?

- Defined as a commitment to
  - Living
  - Treatment and care
- Incorporates a crisis management or response plan
- Specifically identifies responsibilities
  - Patient
  - Clinician

- Includes behaviors for which the patient has demonstrated competence
- Is modified routinely
  - At request of patient or clinician
  - When indicated by clinical markers
- Is individualized

# Commitment to Treatment Statement

- *I agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment including:*
- *attending sessions (or letting you know when I can't make it)*
- *voicing my opinions, thoughts, and feeling honestly and openly, whether negative or positive*

# CTS (continued)

- *being actively involved **during** sessions*
- *completing homework assignments*
- *experimenting with new behaviors and new ways of doing things*
- *taking medication as prescribed*
- *implementing my crisis response plan.*

# CTS (continued)

- *I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. If it's not working, I'll discuss it with my therapist. In short, I agree to make a **commitment to living for.....***
- ***I also understand that this means we're working toward the common goals of***
  - *Feeling better*
  - *Improving my abilities to handle different situations and problems*
  - *Finding direction and meaning in my life*

# Evaluate

## *Assess Risk*

- Understand the role and nature of intent
- Recognize the importance of
  - Specificity of questions
  - Acute versus chronic nature of risk
  - Sequencing questions
    - First and worst for multiple attempts
  - Variable themes of hopelessness
    - State versus trait elements

# Implications for Risk Classification

## There are TWO Levels of Risk!

- Acute Risk (1 or fewer previous attempts)
  - Mild
  - Moderate
  - Severe (objective markers of intent, none stated)
  - Extreme (objective and subjective intent)
- Chronic Risk (2 or more previous attempts)
  - with/without acute exacerbation

# Always differentiate acute and chronic risk

Entries should always differentiate acute and chronic risk

For example:

*Although the patient does not evidence any acute suicide risk at present, there are markers indicating chronic or enduring risk. More specifically, the patient has made multiple suicide attempts, has a history of recurrent major depressive episodes, treatment non-compliance, episodic substance abuse (alcohol and cannabis), unresolved sexual abuse, and related chronic PTSD symptoms. The patient's diagnosis of BPD also indicates impaired interpersonal problem solving. These issues are being addressed with both medications and ongoing outpatient psychotherapy.*

# Understanding Objective Markers of Intent

## **Noncompliance=Hopelessness**

Non-compliance with certain aspects of treatment, therapy and/or medicines

- Refusal to access care during crises
- Multiple suicide attempts
- Little engagement during sessions
- Preparation, rehearsal behavior (plan being enacted)
  - *Internet research, communication*
- Refusal to relinquish access to method (symbolic)
- Persistent recklessness and risk-taking
- Ongoing substance abuse (when suicidality occurs in that context)
  - Detailed and specific suicidal thoughts

# Confronting Non-Compliance

## *A Warning Sign*

- Effective treatments confront non-compliance quickly
  - Recognize
    - It represents a persistence of hopelessness and intent
    - The issue of personal responsibility for care
    - The relationship to crisis management
    - The implicit messages if not addressed
      - *Treatment doesn't work*
      - *Treatment is hopeless*

# Monitoring Process

- Initial Phase: historical focus, what's already happened
- Assessment Phase: current status
- Action (Intervention) Phase: future plans
- Phase changes occur during and across sessions

# Elements of Intent Tell Us What We Should be Asking!

- Willingness to act (motivation to die)
  - *What are your reasons for dying?*
- Preparation to act (preparation and rehearsal behaviors)
  - Clearly differentiates ideators and attempters
  - *Have you prepared for your death in any way?*
    - *Will, letters, finances, research?*
  - *Have you rehearsed your suicide?*
- Capability to act (previous suicidality, self-harm, trauma exposure)
  - Builds over time with exposure
  - *Have you made a previous suicide attempt(s)?*
  - *Have you ever done things to harm or hurt yourself?*
  - *Have you ever experienced something you consider traumatic?*
- Barriers to act (reasons for living)
  - *What are your reasons for living?*
  - *What keeps you alive, what keeps you going?*

# We Need to Differentiate Subjective and Objective Suicide Intent

## ■ Remember

- Always look for convergence and divergence
- Always reconcile discrepancies

## ■ Subjective Intent

- *What the patient says*
- *Ask for “subtle” or indirect markers of intent*

## ■ Objective Intent

- *What the patient does (behavioral markers)*

# Critical Symptoms

- Anxiety
- Agitation
  - *Differentiate from Anxiety*
- Depression
- Hopelessness
- Sleep disturbance, nightmares
- Perceived burdensomeness

# The use of Simple Ratings

- Ratings on a 1-10 scale
- Provides quick review, update, tracking
- Improves and simplifies communication
- Facilitates self-control, self-management
- Symptoms to target
  - Anxiety
  - Agitation
  - Depression
  - Hopelessness
  - Urge to use substances
  - Urge to quit treatment

# *Variable and Deceptive Themes to Hopelessness*

- Cognitive (Hopelessness) Themes
  - Identity-based suicide specific beliefs
    - Guilt (*I've done some bad things*) Remember the notion of “earned” and “learned” guilt (integration of history)
      - Related to behavior
        - Proactive: *I've hurt people*
        - Passive: *I should have done more.....*
      - Diffuse guilt
        - *I don't deserve to live.....*
    - Shame (*There's something wrong with me*)
      - *I'm a Failure*
      - *I'm Damaged*
      - *I'm Weak*
      - *I'm Lost*

- Burdensomeness (*My family would be better off if I were dead*)
  - Related to disruption created by behavior, financial concerns
- Helplessness (*I can't change it*)
- Distress Tolerance (*I can't stand the way I feel*)

# Sequencing Assessment of Suicidal Thinking

- Comfort in asking about suicide
- Elicit past, present, and current suicidal thoughts, behaviors, plans, intent
- Sequence and word questions in effective manner
  - First attempt, past several years, past several months, current episode
    - Undermines resistance, reduces anxiety, develops trust, improves accuracy of report, differentiates suicidal and instrumental behaviors
- Address client fears about “what will happen” if suicidal thoughts are acknowledged

## ■ Nature of Suicidal Thinking

- Ideation: frequency, intensity/severity, duration, specificity (plans), availability/accessibility, active behaviors (preparation, rehearsal), intent (subj. vs. obj.), perceived lethality, degree of ambivalence, deterrents (family, religion, positive treatment relationship, support system)
- Severity of psychological distress pain
  - Distress tolerance

# Educate

- Provide a simple model for understanding
  - Improve motivation for care, compliance
    - The importance of understanding what it means to be “in treatment”.
  - Reduce shame, guilt, self-hate
- A model with an empirical foundation

History Can  
Compound the  
Problem if  
there is prior  
abuse, etc....

Predisposing  
Vulnerabilities

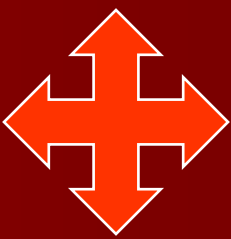


Triggers  
*(Internal AND  
External)*



Behavioral  
*(Reduce upset/  
arousal)*

Cognitive  
*(Why I should die)*

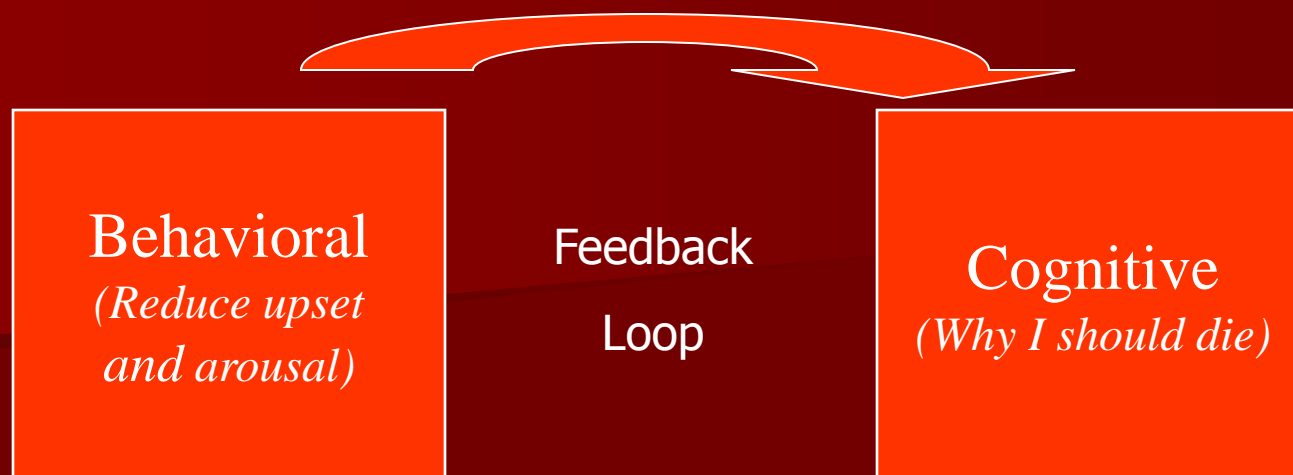


Physiological  
*(Arousal)*

Affective  
*(Emotional Upset)*

# Behavioral Feedback Loop

- Every time there is behavior (avoidance) there is a **COGNITIVE CONSEQUENCE** that facilitates the cycle of despair and suicidality. It's almost always self-image related.
  - Alcohol Abuse...*the only way to get relief is drinking*
  - Suicide attempt....*I can't handle living, I'm a failure*



# Equip

## *Managing Crises*

- Define *crisis*
- Make it accessible!
- Identify warning signs! (for parents as well)
- Provide a simple model of suicidality---Identify trigger(s) and associated thoughts, feelings, behaviors.
- Specific goal is to reduce escalation of suicidal crisis and reduce manifest intent (increase hope)
- Moves from self-management to external intervention—improve self-efficacy.
- If not successful, access emergency care and assistance in manner that facilitates skill development (always understand the cost and consequence)



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## Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities - seemingly without thinking
- Feeling trapped-like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Are you or  
someone you love  
at risk of suicide?

NATIONAL

SUICIDE  
PREVENTION

LIFELINE™

1-800-273-TALK

www.suicidepreventionlifeline.org

Get the facts and take  
appropriate action.

# Practice, Practice, Practice

- *When thinking about suicide, I agree to do the following:*
- *When I find myself making plans to suicide, I agree to do the following:*
  - *1. Use my hope box.*
  - *2. Review my treatment journal*
  - *4. Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk*
  - *5. Repeat all of the above*
  - *6. If the thoughts continue, get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX*
  - *7. If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room*

# Creating a Hope Box

- The notion of reciprocal inhibition
- Include items that generate productive, hopeful thoughts and feelings
- Always review items individually
- Practice use of Hope Box
  - Review each item
  - Ask patient to describe item, “tell a little about it”
  - What are they thinking?
  - What are they feeling?
  - More hopeful?

# Crisis Response Plan Pointers

- Be specific
  - when to use, steps to take, where to go, what numbers to call
- Be concrete
- Ensure safety, remove access, availability
- Make it accessible
  - put on a card, can be carried in a wallet or purse
- Practice, role play
- Periodically review and update
- Use of STR

# Journaling Plays a Critical Role (development of insight)

- Keeping a treatment journal
  - Start at the first session
  - Provides structure, safe outlet, historical memory, ability to track change
  - *Journals have been demonstrated to be a useful intervention in treatment, particularly to improve self-awareness, understanding of change over time and as tool for relapse prevention. Your journal will provide an easy and ready reference for what you've done in treatment, identifying what's worked and what has not, with an emphasis on becoming more efficient and effective in problem solving, regardless of the situation. Here are the ground rules for keeping your journal:*

- Journal for 15-30 minutes per day. Try to do it at the same time each day, it's important to make this part of your daily routine. I want you to write only as much as I can reasonably read and cover with you in treatment. This is particularly important early in the treatment process. I'll make copies of your journal to keep and review.
- For the first month I'd like for you to journal about things that are *important* to you. That is, what's on your mind? What's upsetting you? How are you feeling about yourself? How are you feeling about other people? When you write about these things, please try to identify specifically what the problem is so that we can target it in treatment. We'll talk about a specific approach to problem solving.

- If you write about suicidal thoughts, feelings and plans, we'll target these directly in treatment. If you right about reasons for dying, I'm going to ask you to always include your reasons for living. If you have trouble identifying them, I'll help you. Use your coping card.
- Within the first couple of weeks, I'm going to ask you to identify the problem specifically when you write, generate and write about alternative responses, practice implementing the alternatives (we'll role play these to help you), evaluate whether or not it's working, and if it's not, identify a new one and try again.
- Finally, I'm going to ask you to always close your writing each day by adding a single sentence about what your hopeful about in treatment and life.

# Philosophy of Living Statement

- *After careful review, much time and effort, I've decided to make the following changes in my rules for living:*
  - *Accept the fact that I'm not perfect and never will be*
  - *Do the best job I can and feel good about it.*
  - *Work on accepting the things I can't change*

# ER Discharge Card

- *You (or your child) have been referred to the Emergency Room in order to be evaluated for hospital admission. This means that your level of risk for suicide is currently considered to be elevated and we are concerned about your safety. If you are discharged from the Emergency Room and NOT admitted to the hospital please follow these steps:*

- Prior to leaving the ER, call the emergency call number (XXX-XXXX) and tell the individual on call what has happened. They will have some questions for you and may well ask you to stay in the ER until they have had a chance to talk with the ER physician about your situation. Please wait until the staff member on call gives you permission to leave the ER. The staff member on call will confirm that you do NOT have access to any method for suicide if you are leaving the ER. They will also confirm you do NOT have access to substances such as alcohol or other drugs.
- The staff member on call will provide you with a specific day and time for your emergent follow-up appointment in the clinic. This will likely be the next morning. Please do NOT leave the ER without a specific day and time to follow-up in the clinic.

# Reasons for Living Coping Card

- Provides a ready reminder of reasons for living
  - Facilitates cognitive fluency, problem solving
- Can be integrated into Hope Box
- Make it accessible and specific
  - If reasons are not available, strategize offer reasons
    - Building relationships important

# Non-Compliance Protocols/Plans

- Follow-up no-shows, treatment withdrawals
  - Phone calls, letters
- Identify reasons for drop-out, non-compliance
  - Can be addressed during initial intake, informed consent
- Rewrite commitment to treatment agreement to address compliance problems
- Make sure to address non-compliance with crisis response plan

# Symptom Hierarchies

- Early in process mixed symptomatology
- Severity and related disruption fuels hopelessness and feelings of being out of control
  - *What symptoms cause you the most trouble?*
- Rank symptoms from low to high (1-10)
  - *Severity, distress, upset, dysfunction*
- Target one symptom at a time
  - Although they're interconnected

# Example: JoAnn

- 10: Sleep Disturbance
- 9: Binge/purge episodes
- 8: Anxiety/panic attacks
- 7: Cutting
- 6: Depression