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Discovering hope, one life at a time

Working With Suicidal Patients: What's New and Why It's Important

Thomas E. Ellis, PsyD, ABPP
The Menninger Clinic
Baylor College of Medicine

2011 Texas Suicide Prevention Symposium
June 16, 2011

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Take-home Messages

- This is important work.
- It’s a very tough job.
- Special preparation is needed.
- New, useful tools are becoming available.

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Federal Research Funding

Cause of Death	Deaths/yr (2007)	2010 NIH Research Funding (millions/yr)
Asthma	3,447	$292
HIV/AIDS	11,295	$3,086
Parkinson's Disease	20,058	$166
Suicide	**34,598**	**$37**
Breast cancer	40,970	$741
Diabetes	71,382	$1,052

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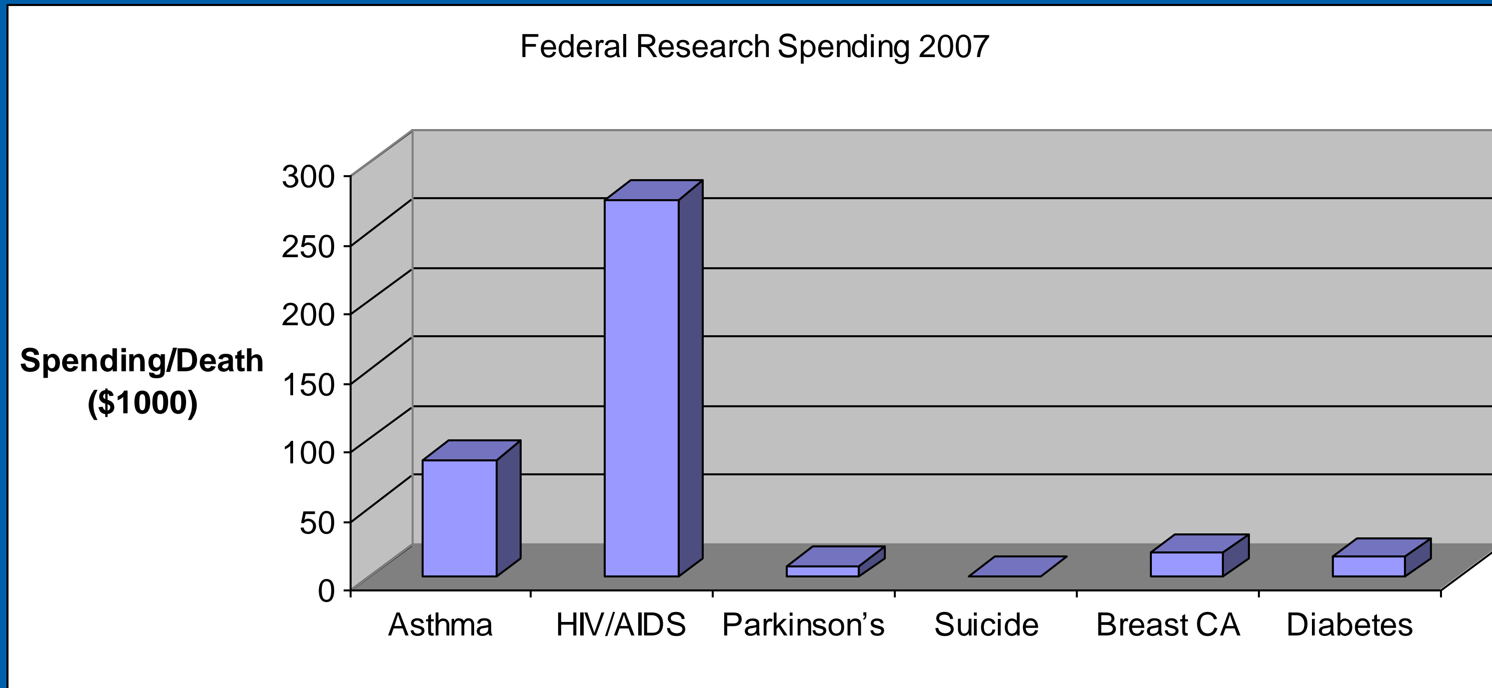

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Editorial Comment

There is a general perception in the field that generic training is adequate preparation for working with suicidal people, that no special preparation is needed.

This view is reflected in graduate training curricula and in the relative lack of standards for provider competencies in mental health service organizations.

Yet these are the patients in greatest need, and the implications are life-and-death, and suicide science tells us we can do better. How can we account for this disconnect?

One (though not the only) contributor is a general lack of awareness of options. Hence, today's program…

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It seems pertinent to raise a countertransference issue that many interviewers do not like to admit, but one which I think is present in most of us. Namely, if we uncover serious suicidal ideation, we are potentially *creating a mess for ourselves.*

Shawn Shea, M.D.

Psychiatric Interviewing: The Art of Understanding

.

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Countertransference and Suicide

Anxiety/avoidance *I don't accept suicidal patients into my practice.*

Hopelessness *If a person's really intent on killing himself, there's nothing you can to do stop him.*

Contempt *If I were him, I'd kill myself, too*.

Disdain *It wasn't serious – just a manipulative gesture.*

Hostility *Maybe he'll get it right the next time.*

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Clients seem to be able to sense when a clinician is comfortable with the topic of suicide. At that point, and with such a clinician, clients may feel safe enough to share the immediacy of their pull toward death.

Shawn Shea, M.D.
The Practical Art of Suicide Assessment

Another consideration:

To be in a position to help the suicidal patient, the clinician must manage negative emotions, and this requires cultivating understanding of and *empathy for the suicidal wish*…

…there's nothing to be done. I can't think, I can't calm this murderous cauldron, my grand ideas of an hour ago seem absurd and pathetic, my life is in ruins and – worse still – ruinous; my body is uninhabitable. It is raging and weeping and full of destruction and wild energy gone amok. In the mirror I see a creature I don't know but must live and share my mind with.

I understand why Jekyll killed himself before Hyde had taken over completely.

I took a massive overdose of lithium with no regrets.

Jamison, K.R. (1995). *An Unquiet Mind: A Memoir of Moods and Madness.*

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Suicide as a Public Health Problem

- Close to 1 million suicide deaths worldwide per year (more than homicide and war combined)
- More than 30,000 deaths per year in U.S. (3 per hour)
- 11th leading cause of death in U.S.
- 50% more suicide deaths than homicides
- 50% more suicide deaths than AIDS
- Approx. 1.1 million suicide attempts/yr in U.S. (2 per minute; SAMHSA, 2009)

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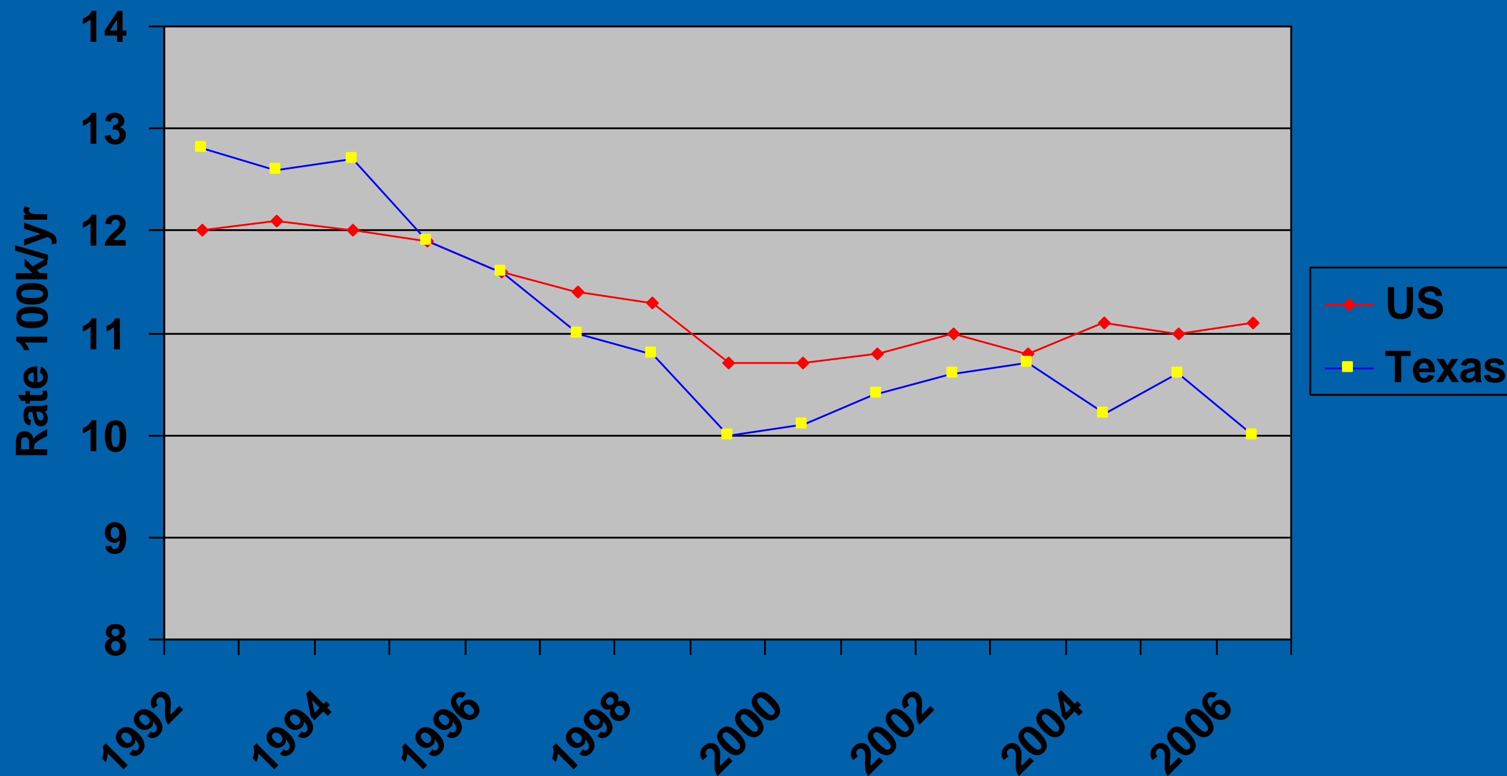
Suicide Rates: U.S. vs. Texas



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Closer to home…

City	2006 # deaths	2006 Rate	2005 # deaths	2005 Rate	2004 # deaths	2004 Rate	2004-2006 Avg #	2004-2006 Avg Rate
Austin	**104**	**14.7**	**94**	**13.6**	**87**	**12.8**	**95**	**13.7**
Dallas	96	7.8	94	7.7	116	9.6	102	8.4
El Paso	54	8.9	46	7.7	43	7.3	48	7.9
Ft. Worth	66	10.1	44	7.1	54	9.0	55	8.7
Houston	195	9.1	230	10.9	256	12.3	227	10.7
San Antonio	147	11.3	141	11.2	114	9.2	134	10.6

Rates are crude (unadjusted) deaths/100,000/yr.

Source: Texas Dept of State Health Services (2009).

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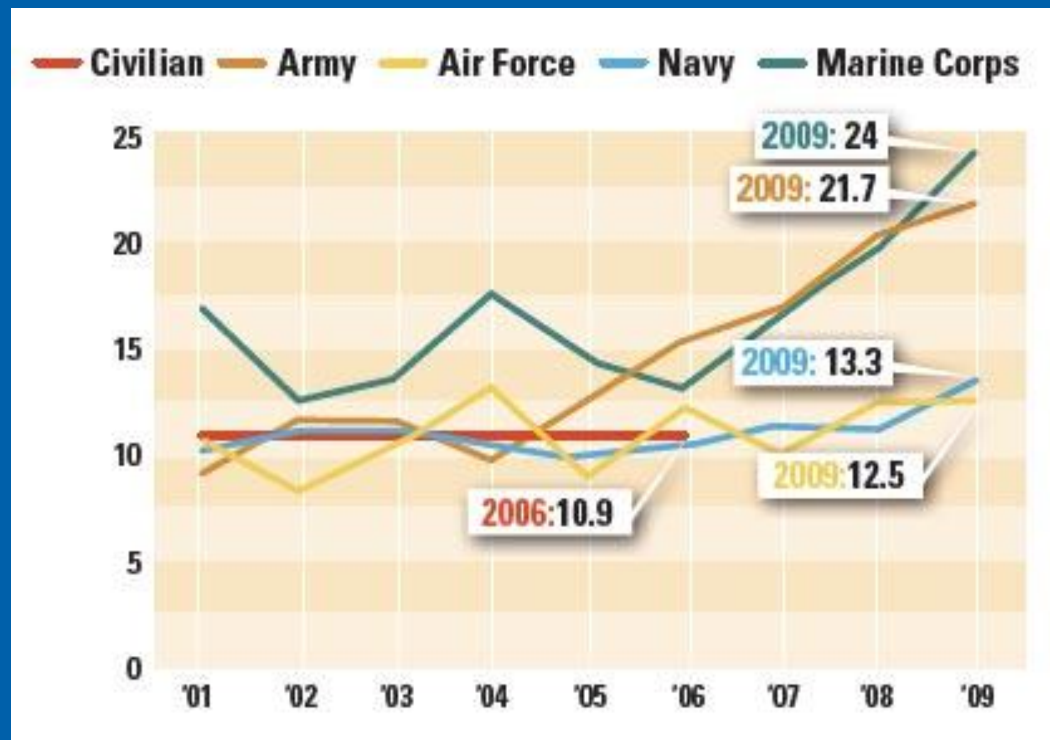
Suicide Trends in the Military



Source: U.S. military branches (2001–09) and Centers for Disease Control and Prevention via APA Monitor on Psychology, September, 2010

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Patient Suicide as Occupational Hazard for Clinicians

More than half of psychiatrists and 20% of psychologists report having lost at least one patient to suicide.

Between 20% and 50% of trainees report losing a patient to suicide during internship or residency.

Research shows that suicide is the #1 source of stress for therapists (the emotional impact of a patient's suicide is comparable to the death of a family member).

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Prediction of Suicide

Studies have consistently failed in efforts to statistically predict suicide on an individual basis.

Prediction via clinical assessment is equally problematic.

Busch (2003) study of 76 inpatient suicides: At last communication, 77% denied suicidality; 28% had no-suicide contracts.

More bad news…

- Studies have consistently shown that most mental health professionals are seriously underprepared to assess and treat suicidal patients.
- Ellis & Dickey (1998): While >90% of residency programs addressed suicide risk in some fashion, only 28% provided skills training (cp. learning to play piano from a book on music theory).
- Melton & Coverdale (2009): Half or more of chief residents reported a need for greater exposure to a variety of topics regarding suicidal patients.

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Treatment of Suicidal Patients

- Considering the size of the problem, there are remarkably few randomized controlled trials of psychosocial treatments for suicidal patients.
- Compared to the hundreds of outcome studies on anxiety and mood disorders, only 40 RCTs have been conducted focusing on suicidal behavior as an outcome.
- Upshot: We have remarkably little empirical evidence that our interventions actually reduce suicides.

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Take-home Messages

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What's new?

Competencies

Risk factors vs. warning signs

Growing consensus on no-suicide contracts

Identification of cognitive vulnerabilities

Development of empirically-supported, suicide-specific therapies

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What's New #1

Competencies for Care Providers

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Competencies

- Derived by expert consensus (2004)
- Sponsored by the American Association of Suicidology
- Designed to facilitate training, consistent with the National Strategy for Suicide Prevention from the U.S. Surgeon General's office

Identified Competencies

- Basic knowledge about suicide (4)
- Basic attitudes and approach (4)
- Collecting accurate assessment information (5)
- Formulating risk (2)
- Developing an intervention plan (3)
- Managing care (3)
- Understanding legal and liability issues (3)

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For more information about competencies in suicide risk assessment and intervention:

American Association of Suicidology

www.suicidology.org

Suicide Prevention Resource Center

www.sprc.org

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What's New #2

Risk Factors vs. Warning Signs

Psychopathology as Risk Factor for Suicide

- About 1.4% of deaths overall are self-inflicted.
- Suicide rates for various psychiatric disorders range as high as 10-15%.
- Suicide is associated with psychiatric disorder in at least 90% of cases.
- About half of people who die by suicide are in treatment.

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Psychopathology as Risk Factor for Suicide

SMR (Standardized Mortality Ratio) for Psychiatric Disorders

Major depression	20
Anorexia nervosa	23
Schizophrenia	9
Anxiety disorder	8
Prior suicide attempt	*38.4*

Harris & Barraclough (1997)

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Predictive of suicide occurring w/i 12 mos. vs. later suicides in 10-yr study:

- Severe psychic anxiety (intense and pervasive)
- Panic attacks
- Global insomnia
- Alcohol abuse (moderate-recent onset)
- Agitation (depressive turmoil, incl. mixed dysphoric mania)
- Severe anhedonia

Fawcett, J. et al. (1990). *American Journal of Psychiatry*. Vol 147(9), 1189-1194.

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Predictors of Severe Suicide Attempts (N=100)

(Hall, Platt, & Hall (1999), *Psychosomatics*, 40,18-27)

90% severely anxious before

92% insomnia (46% global insomnia)

84% saw MHP in past month

80% panic attacks before

78% relational conflict

68% alcohol/SA

83% no harm contract

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Correlates of 76 Inpatient Suicides

(Busch, Fawcett, & Jacobs, *J Clin Psychiatry,* 2003)

- 5-6% of U.S. suicides occur in the hospital
- Only 49% had history of a prior attempt
- 78% denied suicidal ideation at last assessment
- 28% had a no-suicide contract in place
- 79% exhibited severe or extreme anxiety and/or agitation

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Suicide Risk Factors vs. Warning Signs

Risk Factors	Warning Signs
Sex	Current substance abuse
Age	Agitation
Race	Anxiety/panic attacks
Marital status	Social withdrawal
Diagnosis	Insomnia
Prior suicide attempts	Purposelessness
Family history	Plans/preparations
Unemployment	"Desperation"
Firearms	
Etc.	

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In other words, warning signs (implying imminent risk) have more to do with the patient’s psychological state than diagnosis or demographics.

A memory device…

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A New Mnemonic:
IS PATH WARM?

I Ideation/threatened or communicated
S Substance Abuse/excessive or increased

P Purposeless/no reasons for living
A Anxiety, Agitation/Insomnia
T Trapped/feeling no way out
H Hopelessness

W Withdrawal, disconnection from friends, family, society
A Anger (uncontrolled)/rage/seeking revenge
R Recklessness/risky acts - unthinking
M Mood changes (dramatic)

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For more information about suicide warning signs:

American Association of Suicidology

www.suicidology.org

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What's New #3

Emerging Consensus on No-Suicide Contracts

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No-Suicide Contracts

- Psychiatrists who make use of no-suicide contracts: 57%
- Psychiatrists reporting patients who have attempted or died by suicide after agreeing to a no-suicide contract: 41%

Kroll, J. (2000). *American Journal of Psychiatry, 157,* 452-460.

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No-Suicide Contracts

- Percentage of outpatient therapists using no-suicide agreements: 83%
- Percentage of therapists with no training in use of NSAs: 43%
- Percentage of therapists reporting suicide attempts or deaths by patients while NSA was in place: 31%

Page, SA, & King, MC (2008). *Canadian Journal of Psychiatry, 53*, 169-176 .

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Growing Consensus on No-Suicide Contracts

The Case Against No-Suicide Contracts:

The Commitment to Treatment Statement as a Practice Alternative

M. David Rudd
Baylor University

Michael Mandrusiak
Baylor University

Thomas E. Joiner Jr.
Florida State University

…. Our primary conclusion is that no-suicide contracts **suffer from a broad range of conceptual, practical, and empirical problems**. Most significantly, they have **no empirical support for their effectiveness** in the clinical environment. The authors [recommend] the commitment to treatment statement as a practice alternative to the no-suicide contract.

Journal of Clinical Psychology 62: 243–251, 2006.

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Problems with the No Suicide Contract

- No scientific proof of effectiveness in preventing suicidal behavior
- Potentially destructive to therapeutic relationship (CYA)
- May lead to patient’s concealment of suicidal ideation and behavior
- May lead to false sense of security in the clinician
- Useless as defense in liability litigation

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Alternatives to No-Suicide Contracts

Evolving model:

- A collaboratively developed safety plan
- Specification of what to do, whom to call in a crisis (alternatives to self-harm)
- Family, support system included, where appropriate
- Goal is to promote patient autonomy, facilitate positive coping responses, and prevent hospitalization

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Safety Plan Form

A. Warning signs that problems may be developing:

1.____

2.____

3.____

B. Things I can do on my own to cope:

1.____

2.____

3.____

C. Ways I can reach out for help:

People who can help distract me: 1._____________________ 2.__________________

People I can ask for help: 1.________________ 2.___________________

Professionals I can ask for help:

Therapist Name____

Phone #_______________ Pager # or Emergency Contact #__________________

Other Professional Name____

Phone #______________ Pager # or Emergency Contact #__________________

National Suicide Hotline (free 24/7): (800) 273-TALK

Hospital ER _______________________ Address___________________________________

Phone #____________________________

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For More on Safety Planning:

Cognitive Therapy for Suicidal Patients

A. Wenzel, G. Brown, & A. Beck

APA Books (2008)

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What's New #4

Cognitive Vulnerabilities (The Suicidal Mind)

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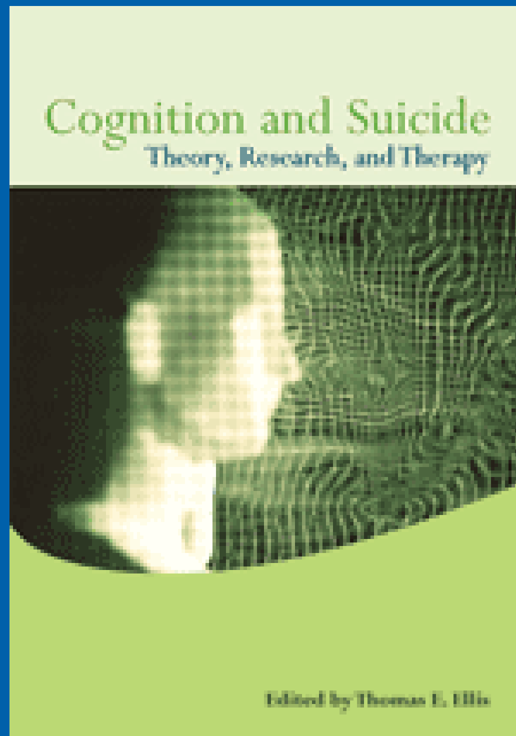
Cognition and Suicide: Theory, Research, and Therapy

Editor: Thomas E. Ellis, PsyD, ABPP (2006)



APA BOOKS
LIST PRICE: **$69.95**
MEMBER/AFFILIATE PRICE: **$49.95**
400 pages
ISBN: 1-59147-357-8
PUBLICATION DATE: January 2006
EDITION: Hardcover

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Cognition and Suicide: Research Findings

Cognitive rigidity
Problem-solving deficits
Hopelessness
Dysfunctional attitudes/irrational beliefs
Reasons for living/dying
Low self-esteem
Perfectionism
Rumination
Overgeneral autobiographical memory

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Joiner's Interpersonal Theory

Question: What makes it possible for a person to harm or kill himself?

Desire for death

- Failed belongingness (disconnection)
- Perceived burdensomeness
- [Unbearability]

Acquired capability to self-harm

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Cognitive Therapy and Suicide

The introduction of the cognitive model marks a paradigm shift in the study of suicide. For perhaps the first time, *thought processes contributing to suicide risk are seen, not only as part of the problem of suicide, but as causal components that may also be targeted as part of a potential solution*.

Ellis, T.E., & Rutherford, B. (2008). Cognition and suicide: Two decades of progress. *International Journal of Cognitive Therapy, 1*, 47-68.

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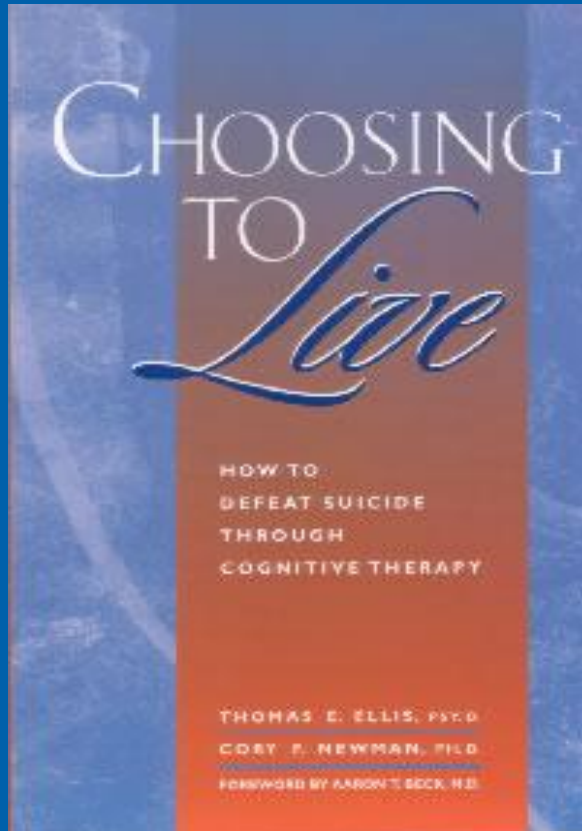

Choosing to Live:
How to Defeat Suicide
through Cognitive Therapy

Thomas E. Ellis
and
Cory F. Newman

New Harbinger (1996)

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What's New #5

Development of evidence-based therapies designed for suicidal patients

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Conventional Therapy

"When the person is no longer highly suicidal-then the usual methods of psychotherapy…can be usefully employed p. 345)."

Shneidman, E.S. (1981). Psychotherapy with suicidal patients. *Suicide and Life-Threatening Behavior, 11*, 341-346.

Really?

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Conventional Therapy
(current standard of care)

- Suicidality viewed as a symptom
- Measures to ensure safety
- Crisis stabilization
- Treat primary disorder

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Empirically-supported foci for conventional psychotherapy with suicidal patients

- Effective management of psychiatric illness
- Inspiring hope
- Improving self-esteem
- Enhancing interpersonal relationships
- Cultivating reasons for living (existential issues)

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Editorial comment #2:

The problem with conventional therapy with suicidal patients is that, although the patient may feel better, if underlying vulnerabilities are not addressed, the next stressful life event is likely to again precipitate a suicidal crisis.

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Suicide-focused therapy

- Suicidality center-stage in treatment
- Emphasis on collaboration, acceptance, and empathy for the suicidal wish (validation)
- Suicidal behavior labeled as a *coping response*
- Intensive training in coping skills
  - Crisis management
  - Emotion regulation
  - Relationship management
- Addressing vulnerability to future suicidal episodes

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Empirically Supported Interventions for Suicidal Patients

Problem-solving Training

Dialectical Behavior Therapy (DBT)

Rudd and Joiner's CBT

Beck's Cognitive Therapy for Suicidality

Mentalization-based Therapy

Collaborative Assessment and Management of Suicidality (CAMS)

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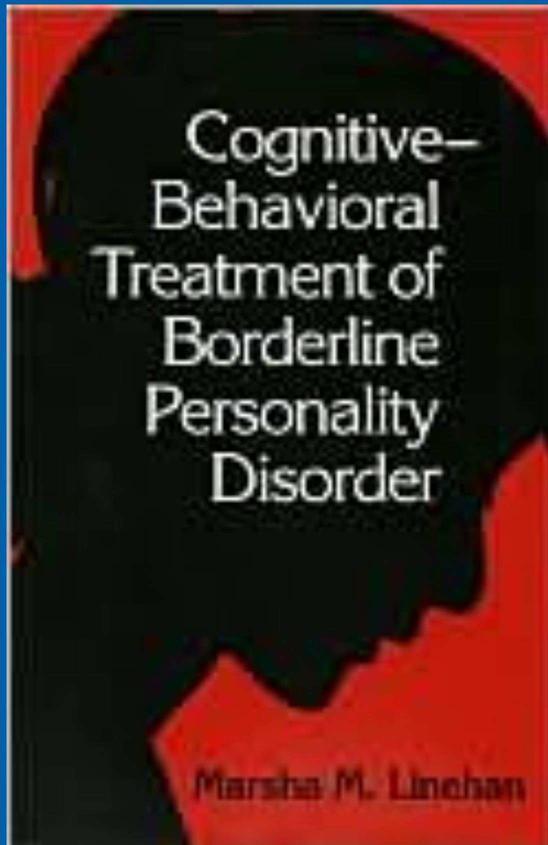

Cognitive-Behavioral Treatment of Borderline Personality Disorder

Marsha M. Linehan

Guilford (1993)

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Dialectical Behavior Therapy

Initially designed for patients with borderline personality disorder, but now applied to various disorders

Employs a combination of cognitive-behavioral and mindfulness/acceptance-based interventions.

Combines group therapy for skills training together with individual therapy (12 mos.)

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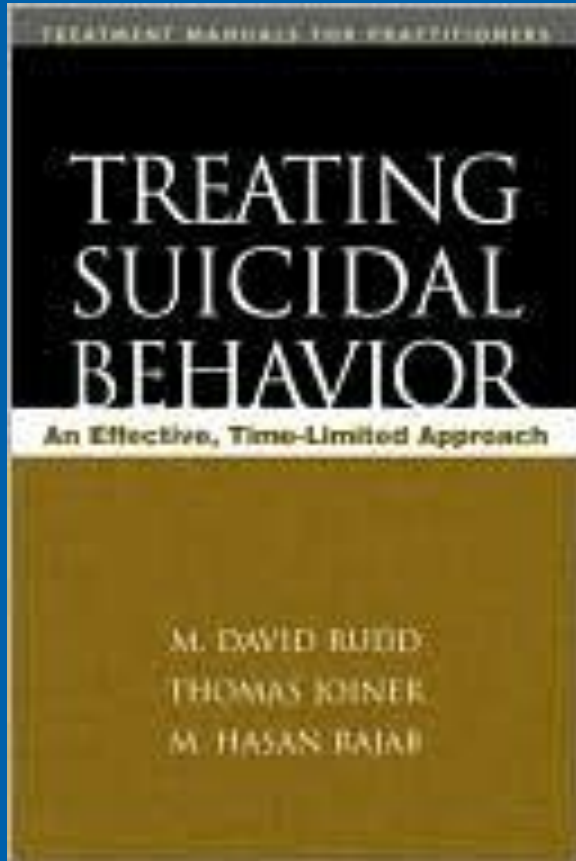

Treating Suicidal Behavior : An Effective, Time-Limited Approach

Rudd, Joiner & Rajab

Guilford (2004)

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Rudd and Joiner’s CBT

- Cognitive-behavioral model of suicidality
- Description of the Suicidal Belief System and “suicidal mode”
- Structured, time-limited protocol (20 sessions)
- Emphasis on skill building and problem-solving
- Promising results in a randomized controlled trial

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Cognitive Therapy for Suicidal Patients
Scientific and Clinical Applications

Amy Wenzel
Gregory K. Brown
Aaron T. Beck

Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications

Wenzel, Brown, & Beck

APA Books (2009)

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Cognitive Therapy RCT (JAMA)

(Brown, Ten Have, Henriques, Xie, Hollander, & Beck, 2005)

Randomized controlled trial

Enhanced Usual Care (with vs. w/o CT)

N=120 pts with recent suicide attempt

10 sessions of CT, 18-month follow-up

Repeat attempts by 13 pts (24%) in CT group, 23 pts (42%) in control group

Risk of repeat suicide attempts was 50% lower in the CT group (hazard ratio=.51)

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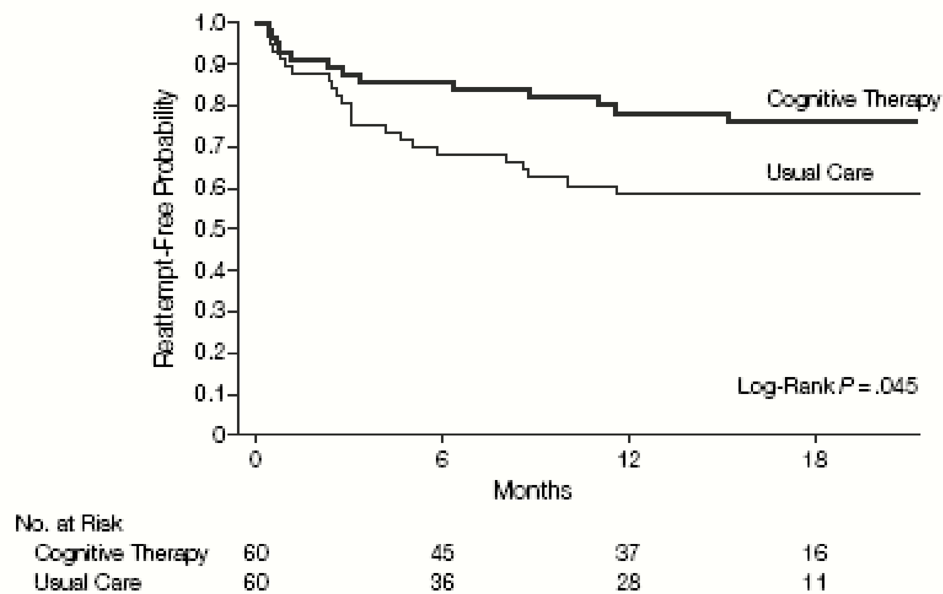
Cognitive Therapy for Suicidality
(Brown et al., 2005)



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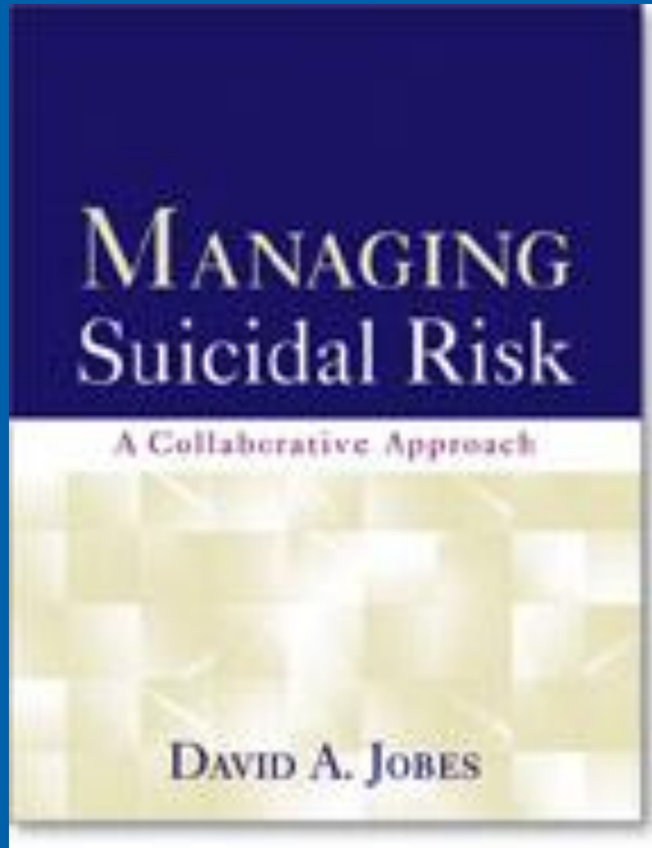

Managing Suicidal Risk
A Collaborative Approach

David A. Jobes

Guilford (2006)

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Collaborative Assessment and Management of Suicidality (CAMS)

- A structured approach to risk assessment, including assessment of the nature of psychic distress, reasons for living and dying, treatment goals, and safety planning
- Places particular emphasis on development of collaborative process
- Maintains focus on suicidality and its “drivers” (esp. self-hatred)

SUICIDE STATUS FORM–III (SSF III) INITIAL SESSION

Patient: ______________ Clinician: ______________ Date: ________ Time: ________

Section A (*Patient*):

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

Rank	
____	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 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: ______________
N/A	6) **RATE OVERALL RISK OF SUICIDE:** **Extremely Low Risk: 1 2 3 4 5 :Extremely High Risk** **(will not kill self)** **(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

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: ______________

From *Managing Suicidal Risk* by David A. Jobes. Copyright 2006 by The Guilford Press. Permission to photocopy this page is granted to purchasers of this book for personal use only (see copyright page for details).

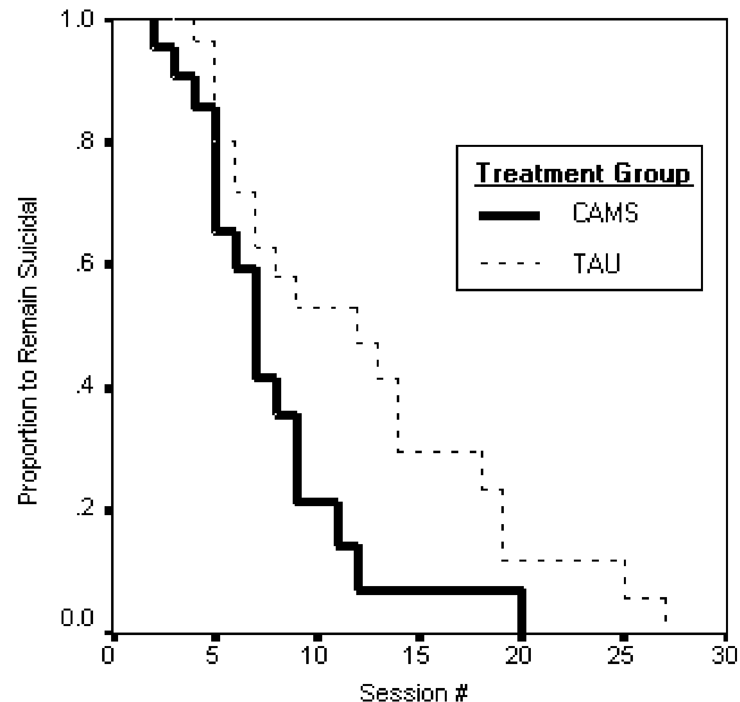

Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.

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

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CAMS-M Outcome Study

- Team of Menninger therapists trained and certified in CAMS
- Small (N=21) feasibility study
- Case series design (nonrandomized)
- Repeated measures to track suicide-specific variables such as hopelessness and suicidal ideation

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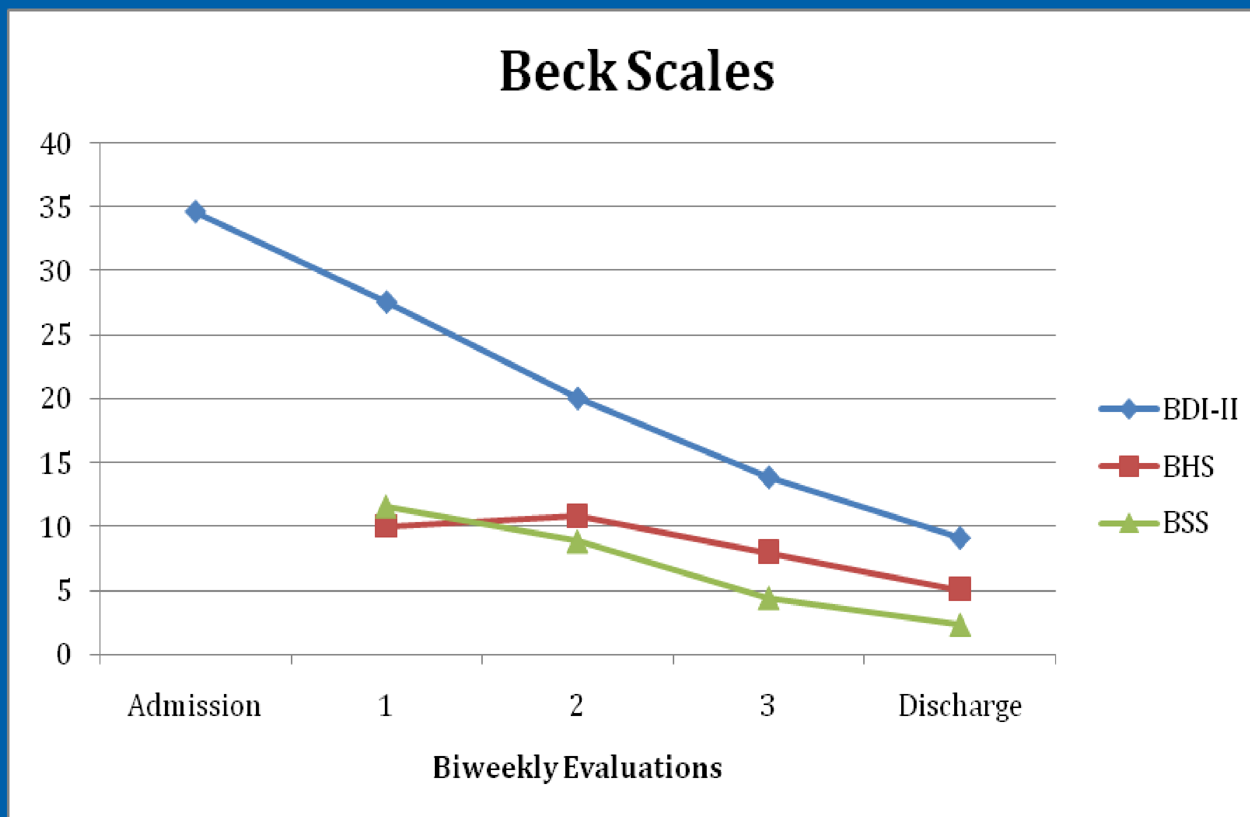
Outcomes from Menninger Pilot Study of CAMS with Suicidal Psychiatric Inpatients (N=21)



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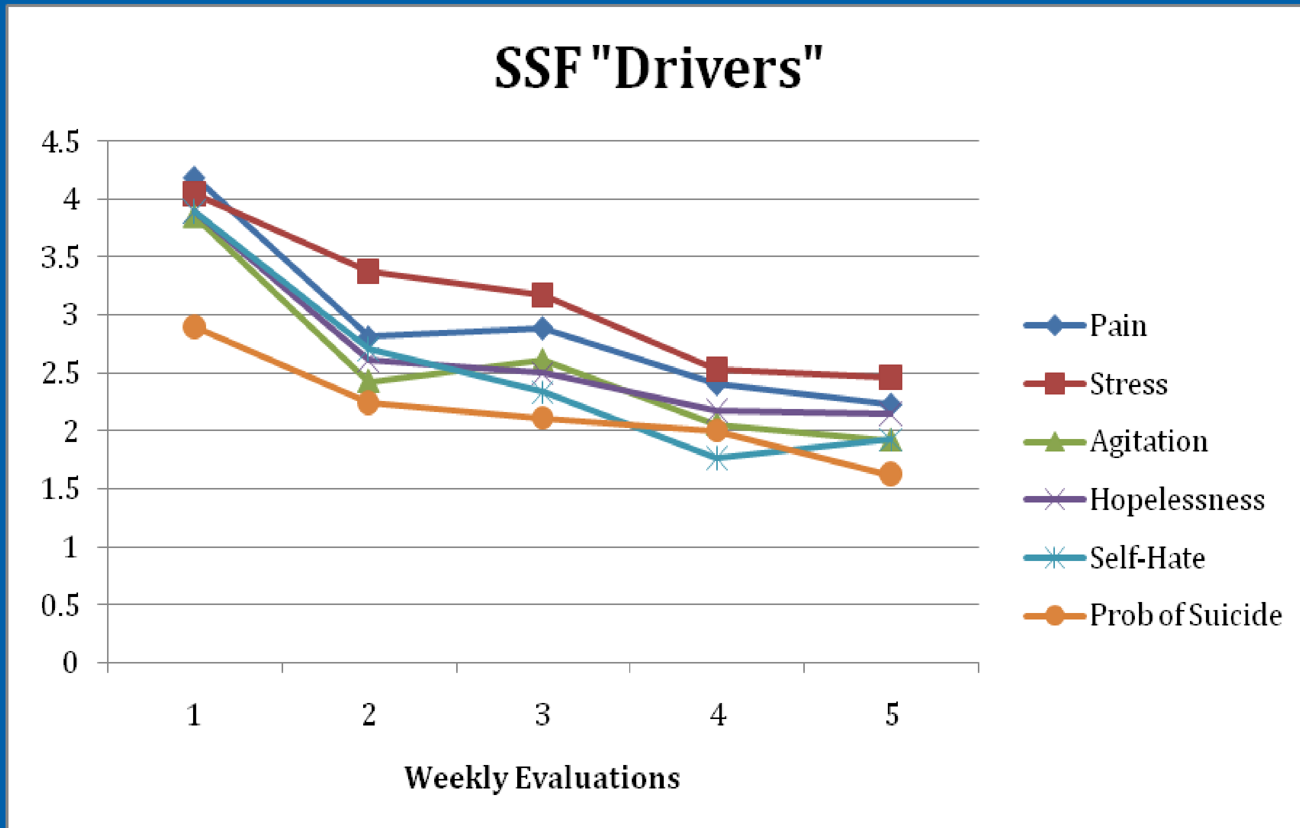

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Discussion

Why are these interventions effective?

Probably a combination of:

- Emphasis on collaborative relationship
- Suicide as focus of therapy rather than symptom
- Training in alternate coping responses (e.g., Coping Cards, Safety Plan, etc.)
- Enhancement of social support
- Problem-solving training
- Addressing cognitive vulnerabilities

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So, what’s the bottom line?

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Conventional Treatment

- Risk often assessed via risk factors (long-term risk) rather than warning signs (imminent risk)
- Routine use of no-suicide contracts
- Suicidal patients treated essentially the same therapeutically as nonsuicidal patients.
- Suicidality treated as a symptom of Axis I or Axis II disorder, expected to lift as the disorder is treated
- Crisis stabilization, followed by treatment-as-usual

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New Paradigm?

- Risk assessment focused on warning signs rather than risk factors
- No-suicide contracts replaced with collaborative safety planning
- Suicidal patients assessed for trait-like vulnerabilities to suicide (e.g., self-hate, low distress tolerance)
- After the crisis is resolved, treatment is focused on those specific vulnerabilities (e.g., trait hopelessness)
- Suicidality viewed as central focus of therapy rather than symptom

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Thoughts in closing…

- Don’t be afraid to “go there.” Keep suicidality front and center (and measure regularly).
- Endeavor to work with (not on) the patient around his or her pain, eschewing a struggle over the suicide option.
- Teach patients practical coping skills (insight is not enough).
- Cultivate empathy (rather than judgment) for the suicidal wish (read William Styron or Kay Jamison).
- Practice relapse prevention by anticipating future trigger events.

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Thoughts re: professional development

Training opportunities: American Association of Suicidology www.suicidology.org

Jobes, DA (2006) *Managing Suicide Risk* (CAMS)

Wenzel, Brown, & Beck (2008). *Cognitive Therapy for Suicidal Patients.*

Joiner, TE (2008). *The Interpersonal Theory of Suicide*.

Ellis, T, & Newman, C. (1996). *Choosing to Live: How to Defeat Suicide through Cognitive Therapy.*

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Please do not be afraid to ask your patients about their death thoughts…Empathize first, and ask how the suicidal thoughts affected them. Ask for the details…

Keep asking, so that your patient knows you care, you're willing to hear about this symptom without overreacting to it, and you're not afraid of it. You might remind them that the decision to die is such an important one, such a final choice, that we want to be sure it is being made wisely and well. Shneidman (1998) offers this maxim: 'Never kill yourself while you are suicidal'. It is not a decision to be made impulsively, or in an altered state or when one's brain is ill.

Walen, S. (2008). It's a funny thing about suicide. In Palmer, S. (Ed). (2008). *Suicide: Strategies and interventions for reduction and prevention*. New York, NY: Routledge.

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I would add only one important piece: you and your patient are teammates or colleagues in the fight against depression and despair. Your contribution at this empathic juncture requires your *active* support, your *unflagging* optimism that pain will pass, your *conviction* that problems can be managed, and your *dogged devotion* to the patient. I learned that from experience.

Walen, S. (2008). It's a funny thing about suicide. Palmer, Stephen (Ed). (2008). *Suicide: Strategies and interventions for reduction and prevention*. (pp. 103-119). New York, NY: Routledge/Taylor & Francis .

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Thank you!