Suicide……

A Presentation by Bill Bakalars
Viterbo University
For
Inclusa Inc.

Suicide Experiences are NOT Uncommon

Each year, approximately 10 million Americans adults think seriously about killing themselves, 3 million make suicide plans, and 1 million make a suicide attempt.

Substance Abuse and Mental Health Services Administration.
HHS Publication No. (SMA) 13-4795 2013

Demographics

- The suicide rate among Wisconsin residents increased by 40%, 2000–2017.
- The majority of suicide deaths were male, 2013–2017.
- The majority of those hospitalized or presenting at the emergency department with self-harm injuries were female, 2016–2017.
- The suicide rate was highest among individuals ages 45–54, 2013–2017.
- The suicide rate (per 100,000) for Wisconsin residents ages 45–54 has more than doubled from 2000 to 2017.
- Suicide rates were highest among American Indians/Alaska Natives and Whites, 2013–2017.
- Suicide rates were higher in rural counties than urban/suburban counties, 2013–2017.

Circumstances of Suicide Deaths

- 887 Total…..
- Firearm was the most commonly used method of suicide, 2013–2017.
- 71% of all deaths by firearm in Wisconsin from 2013 through 2017 were suicide deaths.
- Nearly 1 in 4 individuals who died by suicide had a previous suicide attempt, 2013–2017.
- Prescription medications were the most common type of substances determined to contribute to death among poisoning suicides, 2014–2017.
- Among suicide deaths in which toxicology testing was performed, alcohol was the most commonly detected substance, 2014–2017. Approximately 1 in 4 individuals who died by suicide had a reported alcohol issue that contributed to suicide, 2013–2017.
- Approximately 1 in 4 individuals who died by suicide had a reported physical health problem, 2013–2017.
- Approximately 1 in 5 individuals who died by suicide had a reported job problem, financial problem, or both.
- 1 in 3 individuals who died by suicide had a reported intimate partner issue, 2013–2017.

- **Suicide among Veterans**
- Veterans accounted for almost 1 in every 5 suicide deaths, 2013–2017.
- Veterans who died by suicide were more likely to have a reported physical health problem and less likely to have reported a mental health issue when compared with non-veterans, 2013–2017.
- Veterans were more likely to use a firearm (70% of all veteran suicides) as the method of suicide and be male (97% of all veteran suicides) when compared to non-veterans, 2013–2017.

- **Suicide among Youth**
- 271 adolescents (ages 10–19) died by suicide from 2013–2017.
- Suicide was the second leading cause of death among 10 to 19 year olds, 2013–2017.
- Suicidal ideation was reported by approximately 1 in 6 Wisconsin public high school students, 2017 Youth Risk Behavior Survey.
- Adolescents who died by suicide were more likely to disclose suicide intent to a friend or peer when compared with adults, 2013–2017.
- Adolescents who died by suicide were more likely to have a reported family problem, school problem, or both when compared with adults, 2013–2017.
- Females ages 15–17 had the highest rates of emergency department visits and hospitalization stays with self-harm injuries, 2016–2017.

Why Focus on Health Care Settings?

- 84% of those who die by suicide have a health care visit in the year before their death.
- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt.
- Almost 40% of individuals who died by suicide had an ED visit, but not a mental health diagnosis.

Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909-916..

Risk Factors - Individual

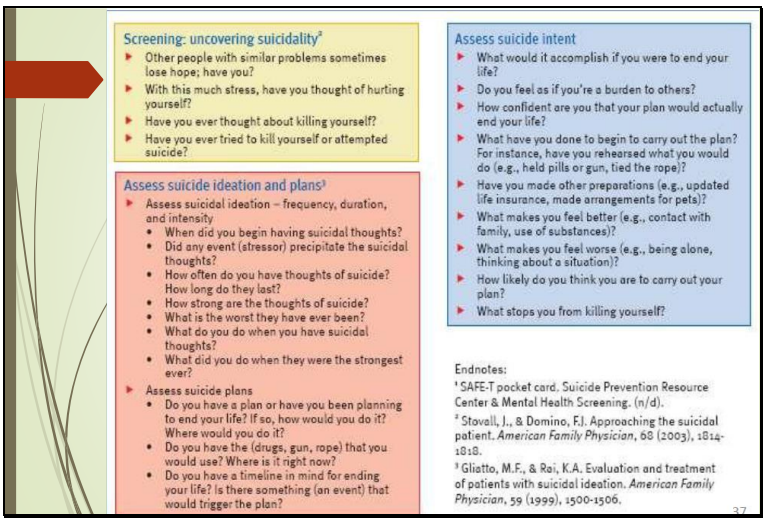
- Previous suicide attempt
- Mental disorders (depression; bipolar; schizophrenia, panic disorder)
- Cognitive distortions
- Substance abuse
- Family history of suicide
- Hopelessness; isolation; perfectionism
- Impulsive and/or aggressive tendencies
- Easy access to lethal methods (esp. guns)
- Local "epidemics" of suicide

4. Select Acute Suicide Risk Factors

ACUTE RISK FACTORS	Not Reported/ Not Observed	No	Somewhat	Yes
Current suicide intent, including client belief that he/she is going to commit suicide or hurt self	☐	☐	☐	☐
Current suicide plan, rehearsals and/or preparation	☐	☐	☐	☐
Preferred method currently or easily available	☐	☐	☐	☐
Access to lethal means	☐	☐	☐	☐
Perceived burdensomeness to others	☐	☐	☐	☐
Current severe hopelessness or pessimism	☐	☐	☐	☐
Diminished concentration and impaired decision-making	☐	☐	☐	☐
Alcohol intoxication (currently or likely to be)	☐	☐	☐	☐
Severe loss of interest or pleasure (anhedonia)	☐	☐	☐	☐
Recent discharge from psychiatric hospital	☐	☐	☐	☐
Currently or will be isolated or alone	☐	☐	☐	☐
Recent stressful life events (e.g. recent interpersonal losses, disciplinary and legal crises)	☐	☐	☐	☐
Recent diagnosis of a mental disorder	☐	☐	☐	☐
Recent diagnosis of chronic and/or life threatening physical illness (e.g., cancer, multiple sclerosis)	☐	☐	☐	☐
Client motivated to under-report/lie about risk	☐	☐	☐	☐

Population/Setting Specific ACUTE SUICIDE RISK FACTORS	Not Reported/ Not Observed	No	Somewhat	Yes
Psychiatric Inpatient: Suicide attempt at time of admission	☐	☐	☐	☐
Psychiatric Inpatient: Escalating agitation, anxiety, and motor restlessness, particularly in conjunction with sleep difficulties	☐	☐	☐	☐
Jail/Prison: First week of incarceration	☐	☐	☐	☐
Youth: Exposure to recent suicide in media, community, etc.	☐	☐	☐	☐

PROTECTIVE FACTORS	Not Reported/ Not Observed	No	Somewhat	Yes
Hope for the future	☐	☐	☐	☐
Confidence in ability to solve or cope with problems	☐	☐	☐	☐
Attachment to life	☐	☐	☐	☐
Responsibility to children, family, or others, including pets, who client would not abandon	☐	☐	☐	☐
Social support or connectedness	☐	☐	☐	☐
Attached to therapist, counselor, or other service provider	☐	☐	☐	☐
Fear of suicide, death and dying	☐	☐	☐	☐
Fear of social disapproval of suicide	☐	☐	☐	☐
Belief that suicide is immoral	☐	☐	☐	☐
Frequently attends religious services	☐	☐	☐	☐
Client motivated to over-report risk	☐	☐	☐	☐
Other	☐	☐	☐	☐



Screening: uncovering suicidality[2]

- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought of hurting yourself?
- Have you ever thought about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans[3]

- Assess suicidal ideation – frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (stressor) precipitate the suicidal thoughts?
  - How often do you have thoughts of suicide? How long do they last?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
  - What did you do when they were the strongest ever?
- Assess suicide plans
  - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
  - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
  - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Assess suicide intent

- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- How confident are you that your plan would actually end your life?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

Endnotes:

[1] SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n/d).

[2] Stovall, J., & Domino, F.J. Approaching the suicidal patient. *American Family Physician*, 68 (2003), 1814-1818.

[3] Gliatto, M.F., & Rai, K.A. Evaluation and treatment of patients with suicidal ideation. *American Family Physician*, 59 (1999), 1500-1506.

37

Warning Signs of Suicide

- 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 or agitated or is unable to sleep or sleeps all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

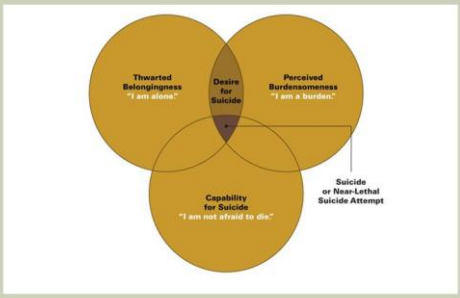
[11] American Association of Suicidology.

Warning Signs of Suicide[10]

- 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, available 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

[10] American Association of Suicidology.

THOMAS JOINER'S MODEL OF INTERPERSONAL THEORY OF SUICIDE



- Kimberly A. Van Orden et al., "The Interpersonal Theory of Suicide," Psychol Rev. 117(2) (2010): 575

Screening…

- Just ask…..do not mince words.
- Ask first time…..every time. Standard practice protocol.

SAD PERSONS (Handout)

SEX	**R**ATIONAL THINKING LOSS
AGE	**S**UPPORT SYSTEM LOSS
DEPRESSION	**O**RGANIZED PLAN
PRIOR HISTORY	**N**O SIGNIFICANT OTHER
ETHANOL ABUSE	**S**ICKNESS

Assessment

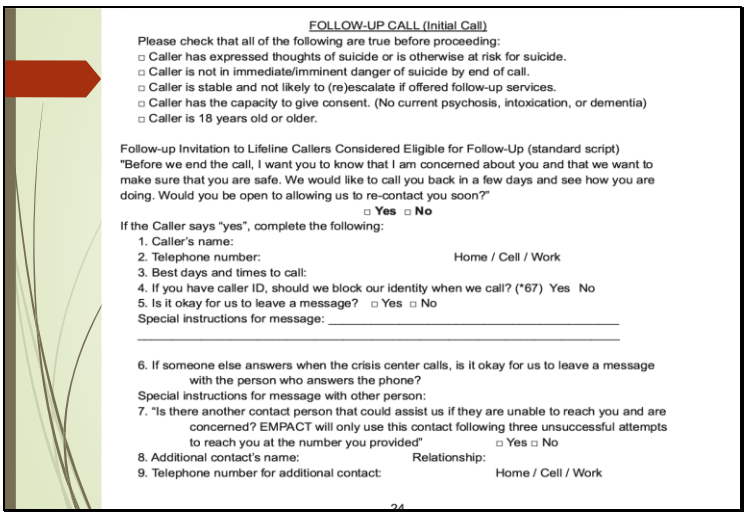
- SAD PERSONS
- Adapted SAD PERSONS (for adolescents)
- Suicide Checklist
- Suicide Assessment Checklist
- Suicide Lethality Checklist
- Suicide Checklist for Parents
- Suicide Checklist for Parents of Teenagers
- Becks Hopelessness Scale

Formal Assessments

- Beck Scale for Suicide Ideation
- Inventory of Suicide Orientation
- Suicide Probability Scale
- Suicide Ideation Questionnaire
- Adult Suicidal Ideation Questionnaire
- Columbia Suicide Severity Scale C-SSRS(Gold Standard)

SUICIDE CONTRACTS

- **Problems: Commonly used, but no studies demonstrating ability to reduce suicide.**
  - **Not a legal document, whether signed or not.**
  - **Used pro-forma, without evaluation by psychiatrist.**
- **Possibilities: Useful when there is positive therapeutic relationship (do not use when covering for colleague).**
  - **If employed, outline terms in patient's record.**
  - **Useful when they emphasize availability of clinician.**
  - **Rejection of contracts have significance.**
- **Bottom line – still considered within standard of care but usage should not be seen as an intervention**



FOLLOW-UP CALL (Initial Call)

Please check that all of the following are true before proceeding:
- □ Caller has expressed thoughts of suicide or is otherwise at risk for suicide.
- □ Caller is not in immediate/imminent danger of suicide by end of call.
- □ Caller is stable and not likely to (re)escalate if offered follow-up services.
- □ Caller has the capacity to give consent. (No current psychosis, intoxication, or dementia)
- □ Caller is 18 years old or older.

Follow-up Invitation to Lifeline Callers Considered Eligible for Follow-Up (standard script)
"Before we end the call, I want you to know that I am concerned about you and that we want to make sure that you are safe. We would like to call you back in a few days and see how you are doing. Would you be open to allowing us to re-contact you soon?"

□ **Yes** □ **No**

If the Caller says "yes", complete the following:
1. Caller's name:
2. Telephone number: Home / Cell / Work
3. Best days and times to call:
4. If you have caller ID, should we block our identity when we call? (*67) Yes No
5. Is it okay for us to leave a message? □ Yes □ No

Special instructions for message: _____

_____

6. If someone else answers when the crisis center calls, is it okay for us to leave a message with the person who answers the phone?

Special instructions for message with other person:

7. "Is there another contact person that could assist us if they are unable to reach you and are concerned? EMPACT will only use this contact following three unsuccessful attempts to reach you at the number you provided" □ Yes □ No
8. Additional contact's name: Relationship:
9. Telephone number for additional contact: Home / Cell / Work

24

Follow-Up

- Follow-Up Call 1. For continuity of care and to build on established rapport, an attempt will be made for the initial clinician to also place the follow-up phone call(s).
- 2. Unsuccessful attempts to reach the caller should be logged in the space provided on the follow-up form.
- 3. If the caller is reached, the clinician will inquire as to how they are doing, how safe they are feeling, and what actions they have taken to keep themselves safe.
- 4. Ask the caller to rate their risk of suicide on a scale of 1 to 10, 1 being lowest risk and 10 being highest risk.
- 5. Address a change in score, or lack thereof, compared to their previous rating. If the caller'sreported rating/score has lowered, help them to identify the successful coping skills/mechanisms they utilized. If their reported rating/score has gone up or remained the same, re-assess for immediate safety and engage in an appropriate clinical intervention.

Follow-Up

- 6. Identify any barriers to improvement and assist the caller in problem solving as you would on an initial call.
- 7. Schedule future follow-up as needed.
- 8. Summarize your call in narrative form in the space provided below the risk assessment scale on the follow-up form. If additional space is needed, communication logs should be attached and clearly marked with time/date of the call to which they are referring.

COVID and Suicide….

- Suicide rates have been increasing over the past 2 decades….
- Secondary consequences of social distancing may increase the risk of suicide. It is important to consider changes in a variety of economic, psychosocial, and health-associated risk factors:
  - Economic Stressors
  - Social Isolation
  - Decrease Access to community and religious support
  - Barriers to mental health treatments
  - Illness itself
  - Mixed messages in social media
- Give natural human resilience during a crisis…we may find increases in suicide as the crisis begins to wane….

Terms for self-injury

- Self-inflicted violence
- Self-mutilation
- Self-abuse
- Self-injury
- Self-harm
- Para-suicide
- Delicate cutting

Instruments

- Knives
- Razors
- Glass
- Pins
- Any sharp object

Methods

- Burning (35%)
- Cutting, scratching (72%)
- Hitting your body with an object or your fists (35%)
- Hitting a heavy object (like a wall)
- Picking at skin or scab until it bleeds (22%)
- Biting yourself
- Pulling your hair out (10%)
- Inserting objects in body openings
- Bruising or breaking bones (8%)

What do self-Injurers say about .....Why they do it?

'to run away from my feelings'
'to feel pain on the outside instead of the inside'
'to cope with my feelings'
'to express my anger toward myself'
'to feel like I'm real'
'to turn off emotions and hide from reality'
'to tell people that I need help'
'to get people's attention to my pain'
'to tell people I need to be in hospital'
'to get people to care about me'
'to make other people feel guilty'
'to drive people away'
'to get away from stress and responsibility'

Overall picture of Self-injurer

- Person who strongly dislikes/invalidates oneself, low self-esteem
- Are hypersensitive to rejection
- Chronically angry, usually at themselves, tend to suppress their anger, high levels of aggressive feelings which they disapprove of strongly and which are suppressed or directed inward
- More impulsive, lacking in impulse control, act in accordance with their mood of the moment
- Tend not to plan for future

Picture cont...

- Depressed and suicidal/self-destructive
- Suffer chronic anxiety
- Tend toward irritability
- Do not see themselves as skilled in coping
- Do not have a flexible repertoire of coping skills
- Do not think they have much control over how/whether they cope with life
- Tend to be avoidant
- Do not see themselves as empowered

Warning Signs

- Unexplained frequent injuries, including cuts and burns
- Wearing long pants and sleeves in warm weather
- Low self-esteem
- Difficulty handling feelings
- Poor functioning at work, school or home
- Relationship problems

Predictors

- Past trauma/invalidation
  - Van der Kolk, Perry, and Herman (1991)
    - Exposure to physical or sexual abuse
    - Physical or emotional neglect
    - Chaotic family conditions during childhood, latency, and adolescence
- Invalidation independent of abuse
  - Linehan (1993a)
    - "invalidating environments" –one in which communication of private experiences is met by erratic, inappropriate, or extreme responses

Forms of invalidation

- "You're angry but you just won't admit it"
- "You say no but you mean yes, I know"
- You really did do (something you in truth hadn't). Stop lying"
- "You're being hypersensitive"
- "You're just lazy"
- "I won't let you manipulate me like that"
- "Cheer up. Snap out of it. You can get over this"
- "If you'd just look on the bright side and stop being a pessimist…"
- "You're just not trying hard enough"
- "I'll give you something to cry about"

What Helps/Hinders healing from self-injury

Helpful

- Unconditional acceptance and compassion
- A non-judgmental attitude
- Trust and reliability
- Kindness, caring, honesty
- Empathy, warmth, genuineness
- Active listening
- Being treated with firmness/gentleness
- Confidential and safe setting
- Being trusted to take care of one's own wounds
- support and space to explore difficult issues
- Gaining self-awareness and insight into the thought processes
- Revealing scars for the first time
- Being listened to, believed, taken seriously, feeling understood
- Feeling safe to cry and express feelings
- Developing healthier coping strategies

Unhelpful

- A dictatorial, arrogant and judgmental approach
- Denying the problem exists
- Lack of continuity
- Deeply engrained issues not being addressed
- Sympathy
- Personal prejudice
- Not being heard
- Preconceived ideas/stereotyping
- Being left alone to cope with the aftermath
- "No self-harming" contracts
- Being "labeled"
- Too much too soon-probing into where a client is not ready to go

Bill Bakalars

Viterbo University Department of Psychology and Master's In Mental Health Counseling……..

wrbakalars@viterbo.edu