

Contemporary Innovations in Clinical Suicidology

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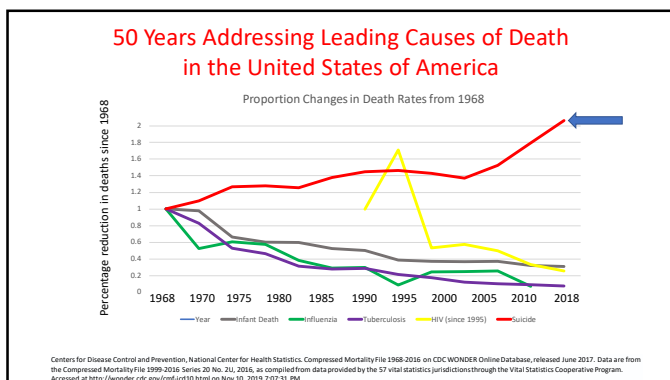
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- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy of the Department of Defense, the Department of the Army, the US Army Medical Department, Veteran's Affairs, or the United States Government.

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The Public Health—and Mental Health—Challenge of Suicide in the USA

Suicidal Populations (2019) Proven Interventions Universal Responses

47,511 Suicide deaths
12M Suicidal Ideators (SI)
1.4M Suicide Attempters (SA)
5M (approx.) BPD with chronic SI

Suicidal and not seeking treatment—33,257 (approx.)


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Suicide-Specific Assessment Measures (from Brown, 2001)

- Scale for Suicide Ideation
- Beck Scale for Suicide Ideation
- Modified Scale for Suicide Ideation
- Self-Monitoring Suicide Ideation Scale
- Suicide Intent Scale
- Parasuicide History Inventory
- Suicide Behavior Questionnaire—Revised
- Suicide Behavior Interview
- Suicide Probability Scale
- Positive and Negative Suicide Ideation
- Adult Suicide Ideation Questionnaire
- Suicide Ideation Scale
- Suicide Status Form...

And hundreds more!


Professor Paul Meehl



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Suicide-IAT

- Does the suicide IAT distinguish between adults presenting to the ED for a suicide attempt ($n=43$) versus other psychiatric emergency ($n=114$)?

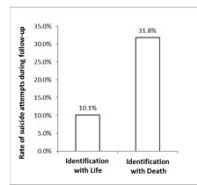


*SAs had a stronger implicit death ID ($t=2.46$, $p<.05$)

Nock et al (2010). Psychological Science

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2. Need objective markers of suicide risk



*Those with death ID were an attempt after discharge

*Replication in ED in Alberta, Canada

*IAT added incrementally to predict beyond diagnosis, clinician, patient (OR=5.9, $p<.05$)

*IAT added incrementally to the prediction of self-harm at 3-month follow-up (OR=5.1, $p<.05$)

*Sensitivity= .50; Specificity= .81

*Sensitivity= .43; Specificity= .79

Nock et al (2010). *Psychological Science*

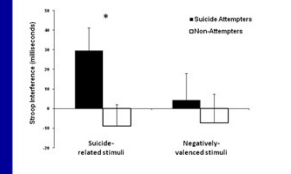
Randall et al (2013). *Psychological Assessment*

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Suicide Stroop

- Does the suicide Stroop distinguish between suicide attempters ($n=68$) and non-attempters presenting to the ED ($n=56$)?

Fig 1. Suicide Attempters Demonstrate Greater Interference for Suicide-Related Words



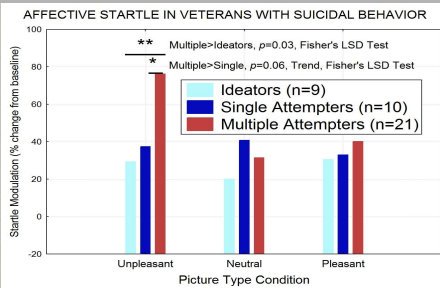
*SAs had a stronger attentional bias toward suicide ($t=2.37, p<.05$)

*Stroop interference predicts 6-month SA beyond all other clinical predictors

Cha et al (2010). *Journal of Abnormal Psychology*

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Affective Startle and Suicide Risk (PI: Goodman/Hazlett)



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Managing Acute Risk: Stabilization Planning

SAFETY PLAN: VA OR VERSION	
Step 1: Working status:	
1.	
2.	
Step 2: Internal support and strategies: I think I can't take any more of my current situation and need to take additional coping strategies:	
1.	
2.	
3.	
4.	
Step 3: Support and social settings that provide distraction:	
1. Name	Phone
2. Name	Phone
3. Place	4. Place
Step 4: Professional resources for coping for VA or Version:	
1. Name	Phone
2. Name	Phone
3. Name	Phone
Step 5: Professional resources for agencies I can contact during a crisis:	
Crisis Page or Emergency Contact #	
Crisis Page or Emergency Contact #	Phone
Crisis Page or Emergency Contact #	
Local Urgent Care Services	
Urgent Care Services Address	
Urgent Care Services Phone	
VA Suicide Prevention Resource Coordinator Name	
VA Suicide Prevention Resource Coordinator Phone	
VA Suicide Prevention Resource Coordinator Phone	1-800-273-8255, press 7 to reach a VA suicide prevention hotline
VA mental health provider	
Step 6: Safety the environment: a or A	
1. Safety the Treatment Setting to Reduce Suicide Risk: Violence Victims (Violence & Injury Prevention)	

Warning Signs: pacing
feeling irritable
thinking "it'll never
get better"

- go for a walk 10 mins
- watch Friends episodes
- play with my dog
- think about my kids
 - vacation to beach in Florida
 - Christmas Day 2012
- call/text my Mom or Jennifer
- call Dr. Brown: 555-555-5555
 - leave msg+ name, time, phone #
- 1-800-273-TALK
- go to hospital
- call 911

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New Meta-Analysis on Safety Planning-Type Interventions!



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Managing Acute Suicidal Risk:
Crisis Lifeline and Textline and lethal means safety

NATIONAL
SUICIDE
PREVENTION
LIFELINE
1-800-273-TALK
www.suicidepreventionlifeline.org
Logo of the National Suicide Prevention Lifeline

Formation	December 6, 2002 ⁽¹⁰⁾
Purpose	Suicide prevention
Headquarters	50 Broadway, New York City, New York, U.S. 10004
Region	Nationwide
Official language	English
Key people	Dr. John Draper
Volunteers	150
Website	suicidepreventionlifeline.org (https://suicidepreventionlifeline.org/)

- 1) Always provide Lifeline/Textline number
- 2) Discuss access to lethal means
- 3) Verify that means have been secured
- 4) Consider providing access to your own number

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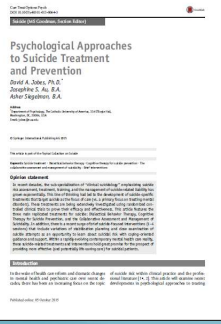
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Discussing and trying
to remove or decrease
access to any lethal
means is a clinical
must to help save lives!

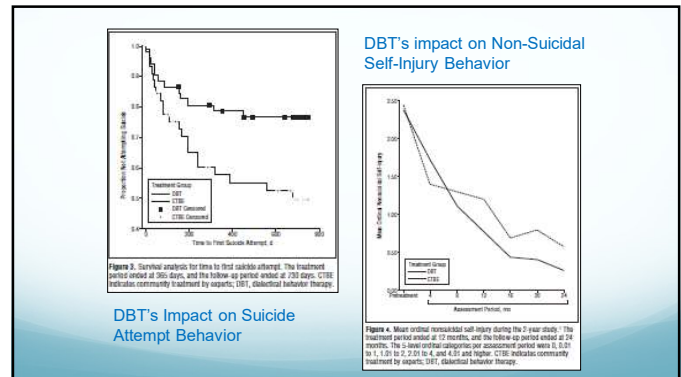
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Evidence-Based Treatments for Suicidal Risk



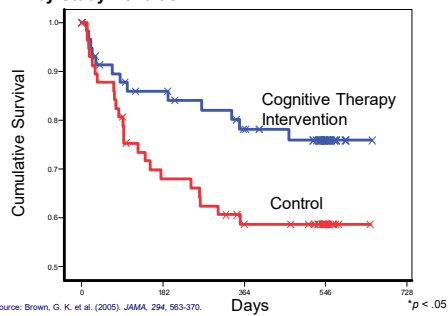
- There are 90+ RCT's with suicidal ideation and behavioral outcomes
- There is no support for inpatient hospitalization; there is increased risk of suicide post-discharge
- There are a few treatments with single a single RCT or a need of independent replication (e.g., ASSIP and Mentalization-Based Therapy)
- There are now well-studied suicide-specific interventions with *replicated* RCT support; these include:
 - Dialectical Behavior Therapy (DBT)
 - Two types of suicide-specific CBT (CT-SP & BCBT)
 - Collaborative Assessment and Management of Suicidality (CAMS)
- Non-demand follow-up "caring contact"

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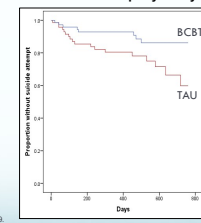
Survival Functions for Repeat Suicide Attempt by Study Condition



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Brief Cognitive Behavioral Therapy (BCBT)

Time to First Suicide Attempt by Study Condition

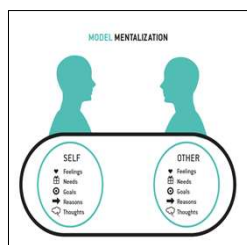


Source: Rudd MD et al. (2015). Am J Psychiatry, 172, 441-449.

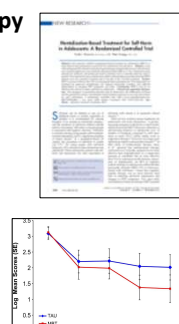
Slide courtesy of Craig Bryon

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Mentalization-Based Therapy



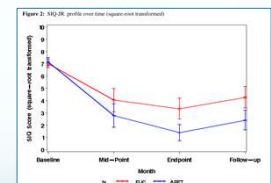
MBT needs independent RCT replication



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Attachment-Based Family Therapy (ABFT)

- Improving family relationships
 - Parent-child attachment
- Weekly individual, parent, and family sessions (3 months)
- 2 RCTs found reduction in suicide ideation
 - Rapid reduction at post-treatment (vs. Waitlist control condition)
 - Maintained at 6-month follow-up (vs. E-Usual Care)
- Limitations
 - Comparison groups had low treatment completion
 - Suicide behaviors not assessed



Diamond et al., 2010; Diamond, Reis, Diamond, Sigekland, & Isaacs, 2002

ABFT also needs independent RCT replication

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The Collaborative Assessment and Management of Suicidality (CAMS)

The four pillars of the CAMS framework:

- 1) Empathy
- 2) Collaboration
- 3) Honesty
- 4) Suicide-focused

Goal: Build a strong therapeutic alliance that increases patient-motivation; CAMS targets and treats patient-defined suicidal "drivers"

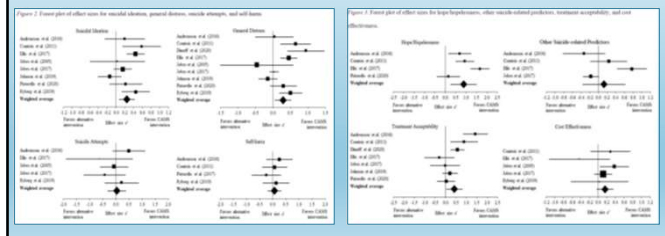
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Randomized Controlled Trials of CAMS

Principal Investigator	Setting & Population	Design & Method	Sample Size	Status Update
Comtois (Jobes)	Harborview/Seattle CMH patients	CAMS vs. TAU 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)	Fl. 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 articles
Pistorello (Jobes)	Univ. Nevada (Reno) College Students	SMART Design CAMS/TAU/DBT	62	★ 2017 and 2020 - articles
Comtois (Jobes)	Harborview/Seattle Suicide attempters	CAMS vs. TAU Post-Hosp. D/C	150	ITT complete; on-going assess
Santel et al	German Crisis Unit Inpatients	CAMS vs. TAU	60	ITT complete; on-going assess
Depp et al	San Diego VAMC Walk-In Veterans	CAMS vs. Outreach Same day services	176	ITT underway (telehealth)

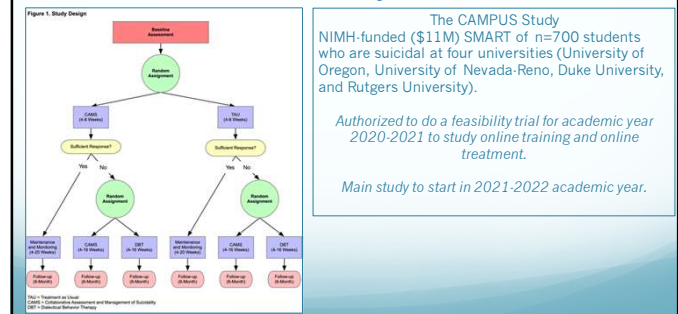
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Swift et al (2021) new meta-analysis: CAMS is a "well supported" intervention for suicidal ideation as per CDC criteria



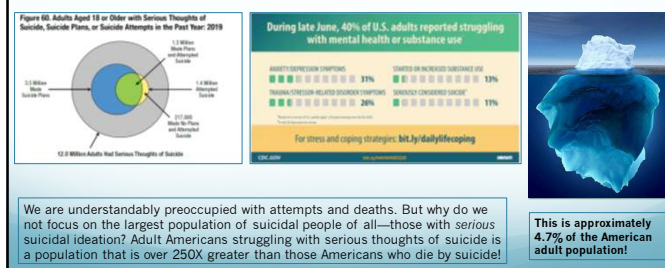
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Comprehensive Adaptive Multisite Prevention of University student Suicide



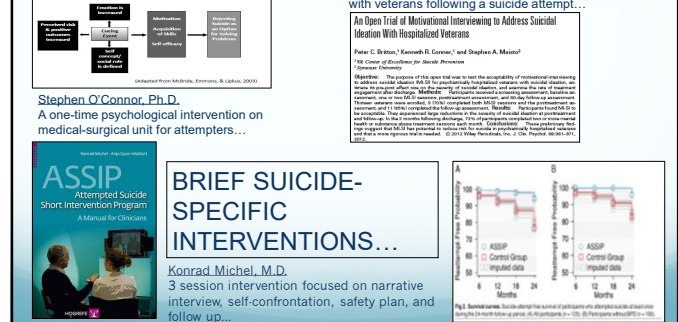
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Arguing for the Relative Importance of Suicidal Ideation



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Model for Teachable Moments as Related to a Suicide Attempt



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