Assessment & Clinical Response to Suicide Intent or Motivation to Die

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Current Measures Fall Short In Real-World Settings

Table 1. Performance of the Columbia-suicide severity rating scale screener for predicting suicide after emergency department visit

	Bjureberg 2021 et al.		Simpson 2020 et al.	
Setting and participants	18 684 psychiatric ED patients in Stockholm, Sweden		92 643 general and psychiatric ED patients in Denver, Colorado, USA	
Timeframe for suicide outcome after ED visit	30 days	365 days	30 days	365 days
Sensitivity (95% CI)	53.9% (52.1–55.7%)	41.4% (40.5–42.4%)	18.2% (0–41.0%)	27.0% (16.0–38.0%)
Specificity (95% CI)	75.6% (75.5–76.7%)	75.6% (75.6–75.7%)	99% (99–99%)	96.4% (96.3–96.5%)
AUC (95% CI)	69% (59–79%)	62% (52–72%)	57% (40–75%)	62% (54–70%)

AUC, area under the receiver operating characteristic curve; CI, confidence interval; ED, emergency department.

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What the Latest Clinical Science Says

1. A disproportionately large percentage of patients in healthcare and clinical settings are either unwilling or unable to reveal active suicidal thinking and motivation to die when responding to direct questions about suicide.
2. Routine variations in suicidal thinking and motivation to die include significant shifts from moment to moment, day to day, and week to week, i.e., from detailed and specific thoughts with significant wish to die and related preparation behaviors, to fleeting, non-specific thoughts with no significant wish to die.

Rudd, M.D. (2021). Recognizing Flawed Assumptions in Suicide Risk Assessment Research and Clinical Practice, *Psychological Medicine,* In press.

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Underlying Assumptions

3. There are some characteristics of chronic suicidal thinking that do not elevate near-term suicide risk and are not clinically meaningful when not coupled with motivation to die and related preparation behavior.
4. Many suicidal patients acknowledge the emergence and sharp increases in motivation to die in distinctively brief windows of time.
5. Access to method, independent of current suicidal thinking, elevates risk for death by suicide.
6. A critical part of the assessment process is appraisal of individual capacity to self-manage risk when it surfaces. By definition, multiple attempters have poor or limited self-management capacity.

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Critical Questions

1. What features make a suicidal thought clinically meaningful and elevates risk for death by suicide?
2. What other questions should we be asking?
3. How can we assess motivation to die in an accurate and meaningful way?
4. What interventions are routinely needed given the unique characteristics of suicidal thinking and motivation to die?

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Rethinking Suicide Risk and the Ability to Self-Manage

- A core multi-component skill deficit compounds risk
  - Emotion dysregulation, hyperarousal (compounded by early trauma)
  - Poor emotional awareness and self-understanding
    - Poor understanding of emotional experience, self-blame, shame, guilt
    - Punitive self-attributions, related identity disturbance
  - Difficulty tolerating intimacy
    - Dysregulation secondary to vulnerability in interpersonal context
    - Suicidal mode activated, i.e. upsetting rather than comforting
  - Inability to ask for help
    - Related to ability to tolerate intimacy? Vulnerability as risk
    - Difficulty describing needs secondary to poor emotional awareness
  - Poor problem solving (focus on problem NOT solutions)
    - Reappraisal to down regulate hyperarousal?
    - Lack of cognitive content
  - Interpersonal functioning (poor social problem solving)
    - Focus on interpersonal isolation, rejection

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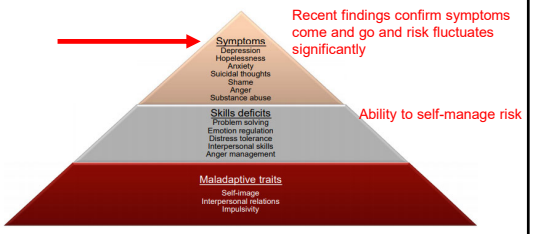
Multiple Levels of Suicide Risk



Recent findings confirm symptoms come and go and risk fluctuates significantly

Ability to self-manage risk

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Hope as a Skill: Resilience in the Face of Adversity

- Components (and Targets of Assessment and Treatment)
  - Cognitive
    - Capacity to engage in effective problem solving: Reservoir of Hope
    - Recall/memory: issue of long-term trauma/abuse
    - Disproportionate percentage of cognitive content negative/trauma-based
  - Emotional/Physiological
    - Emotional awareness and understanding---limited ability to understand own risk
    - Emotion-regulation ability
    - Distress tolerance
    - Self-soothing
  - Interpersonal
    - Capacity for intimacy (ability to establish/maintain close relationships)
      - Boundaries
    - Assertiveness
    - Social problem-solving
    - Ability to ask for help

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Impact of Complex Models: Risk Factors

Table 4. Factors Associated With an Increased Risk for Suicide

Suicidal thoughts/behaviors
Suicidal ideas (current or previous)
Suicidal plans (current or previous)
Suicide attempts (including aborted or interrupted attempts)
Lethality of suicidal plans or attempts
Suicidal intent
Psychiatric diagnoses
Major depressive disorder
Bipolar disorder (primarily in depressive or mixed episodes)
Schizophrenia
Anorexia nervosa
Alcohol use disorder
Other substance use disorders
Cluster B personality disorders (particularly borderline personality disorder)
Comorbidity of axis I and/or axis II disorders
Physical illnesses
Diseases of the nervous system
Multiple sclerosis
Huntington's disease
Brain and spinal cord injury
Seizure disorders
Malignant neoplasms
HIV/AIDS
Peptic ulcer disease
Chronic obstructive pulmonary disease, especially in men
Chronic hemodialysis-treated renal failure
Systemic lupus erythematosus
Pain syndromes
Functional impairment
Psychosocial features
Recent lack of social support (including living alone)
Unemployment
Drop in socioeconomic status
Poor relationship with family[a]
Domestic partner violence[a]
Recent stressful life event
Childhood trauma
Sexual abuse
Physical abuse
Genetic and familial effects
Family history of suicide (particularly in first-degree relatives)
Family history of mental illness, including substance use disorders
Psychological features
Hopelessness
Psychic pain[a]
Severe or unremitting anxiety
Panic attacks
Shame or humiliation[a]
Psychological turmoil[a]
Decreased self-esteem[a]
Extreme narcissistic vulnerability[a]
Behavioral features
Impulsiveness
Aggression, including violence against others
Agitation
Cognitive features
Loss of executive function[a]
Thought constriction (tunnel vision)
Polarized thinking
Closed-mindedness

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Demographic features
Male gender[a]
Widowed, divorced, or single marital status, particularly for men
Elderly age group (age group with greatest proportionate risk for suicide)
Adolescent and young adult age groups (age groups with highest numbers of suicides)
White race
Gay, lesbian, or bisexual orientation[b]
Additional features
Access to firearms
Substance intoxication (in the absence of a formal substance use disorder diagnosis)
Unstable or poor therapeutic relationship[a]

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Understanding the Impact of the Push for Complexity

- Focus on variables with clinical relevance
- Issue of clinical timeframes, i.e., decisions re: hours, a few days, weeks
- Need for targeted interventions during assessment facilitating self-management/emotion regulation
  - Reasons for living (shifting ambivalence)
  - Simple explanatory model that is skill-based to diffuse shame/guilt
  - Simple self-ratings
  - Recognizing, responding to, and reconciling discrepancies
  - Crisis response plan/safety plan
  - Means safety discussion
  - Survival kit

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Goals of Suicide Risk Assessment

- Two essential questions to answer
  - How to differentiate moderate from high risk?
  - How do differentiate high risk from need for hospitalization?
- Understand *Motivation to Die* (Suicide Intent)
- Recognize presence of *Residual Intent*
  - *Most likely to be present with multiple attempters*
- Differentiate *Objective and Subjective Intent*
  - *Recognize, respond to, and reconcile discrepancies*
- Recognize Warning Signs, Suicide Intent and Related Activation
  - Activation of suicidal mode
- Track patient behavior during risk assessment
  - Responsiveness, compliance, self-ratings, skill level/capacity
- Recognize the presence of *Trait Suicidality*
  - Importance of identity-based hopelessness
    - Unlovability, Unbearability, and Unsolvability
- **Convergence of elements of intent/motivation to die**

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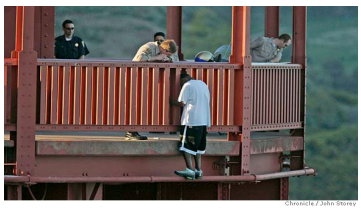
Relationship Between Motivation to Die & Skills



Chronicle / John Storey

On the bridge, Baldwin counted to ten and stayed frozen. He counted to ten again, then vaulted over. "I still see my hands coming off the railing," he said. As he crossed the chord in flight, Baldwin recalls, "I instantly realized that everything in my life that I'd thought was unfixable was totally fixable—except for having just jumped."

Tad Friend. Jumpers. The New Yorker (2003)

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Of those who attempt suicide...

25-40% made the final decision to act within 5 mins of the attempt

70% made the final decision to act within 1 hour of the attempt

Simon et al. (2001), Williams, Davidson & Montgomery (1980)

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ACCESS TO GUNS RAISES THE RISK OF SUICIDE

VARIABLE	States with the Highest Rates of Gun Ownership	States with the Lowest Rates of Gun Ownership
Average population 2001–2005	49 million	50 million
Percent of households with guns	47	15
Total firearm suicides	16,577	4,257
Total nonfirearm suicides	9,172	9,259

Source: Miller M and Hemenway D. Guns and suicide in the United States. *New England Journal of Medicine* 2008; 359:672-3.

Cut it however you want: In places where exposure to guns is higher, more people die of suicide.

Deborah Azrael, associate director of the Harvard Youth Violence Prevention Center

4X

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Availability of means is strongly correlated with suicide attempt lethality

Unsafe storage, accessibility, and proximity of pesticides associated with increased likelihood of death by pesticide ingestion

Eddleston, Buckley, Gunnell, Dawson, & Konradsen (2006)

Among patients treated for self-inflicted gunshot wound, none wrote a suicide note, less than half had mental health diagnosis

Peterson, Peterson, O'Shanick, & Swann (1980)

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Kevin Hines: The Nature of Ambivalence About Living/Dying

- There were tons of people, it was 10 in the morning, bikers, joggers, tourists, workers, cops biking around. I found my spot. And I said to myself, if just one person, just one, comes up to me and asks me if I need help, I'll tell [them] everything. And this beautiful woman walked up to me, and she goes, "Will you take my picture?" And I thought, "What? Lady, I'm going to kill myself, are you crazy?" But she had sunglasses on, her hair blowing in the wind, she was a tourist, all she could see was this guy standing right where she wanted her picture taken. I must have taken five pictures of this lady. She had no clue.
- I thought at that moment, nobody cares. Nobody cares. So I handed her the camera. She walked away. I walked as far back to the railing closest to the traffic as I could, I ran, and I catapulted myself over the bridge. I didn't get on the ledge to have people talk me down. I just jumped.

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Consequences of Hopelessness and Trait Suicidality

- Inability
  - To recognize ambivalence about death, wish to live
  - Access available support, *ask for help*
    - *Emergency phones on Golden Gate Bridge*
  - Access problem solving alternatives (build hope and wish to live)
    - Cognitive skill, lack of cognitive reservoir of hope
    - Wealth of traumatic memories and associations
  - Effectively regulate emotional upset, distress
    - Limited ability to self-soothe, poor distress tolerance
- Emergence and persistence of fearlessness about death---capability to die
  - Limited ability to inhibit impulse to die, access to method

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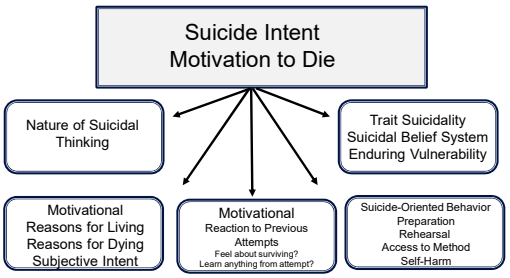
CBT Framework for Understanding and Assessing Suicide Intent–Motivation to Die



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Elements of Intent and *Motivation to Die*

- Nature of suicidal thinking
- Willingness to act, wish to die
  - Reasons for dying
- Barriers to act, wish to live
  - Reasons for living
  - Ambivalence manifest in difference between RFD-RFL
  - Always reinforce the presence of ambivalence
- Preparation and rehearsal behaviors
  - People prepare and plan for their death
    - Will, letters, finances, research, communication with others
    - Guarding against discovery
    - Access to method
- Reaction to previous attempts
  - How do you feel about surviving?
  - Did you learn anything from your attempt?

  } **Residual Intent**
- Trait suicidality
  - Unlovability, unbearability, unsolvability
- Capability to act and fearlessness about death
  - Simply observed
  - Builds over time with exposure

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A Simple Intervention Targeting Wish to Live During Assessment

Reasons for living card

- Provide patient with an index card (or do on their phone)
- Ask them to think about what is worth living for
- Ask follow-up questions to increase the emotional vividness and specificity of the memory
- Record the RFL onto the card
- Practice thinking about the RFL
  - Paired associations
- Ask patient to think about a stressful situation and then think about their RFL (integrate into Crisis Response Plan)
- Rate your wish to live today on a scale of 1-10
- Rate likelihood you'll use the card on a scale of 1-10

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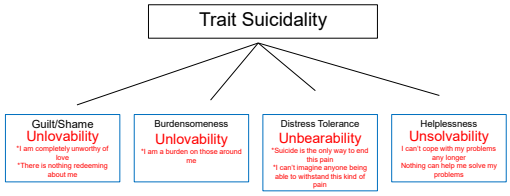
Components of Trait Suicidality



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Trait Suicidality in 7 Statements

- Unlovability
  - I am completely unworthy of love
  - There is nothing redeeming about me
  - I am a burden on those around me
- Unbearability
  - Suicide is the only way to end this pain
  - I can't imagine anyone being able to withstand this kind of pain
- Unsolvability
  - I can't cope with my problems any longer
  - Nothing can help me solve my problems

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The Nature of Suicidal Thinking Clarity as a Clinical Intervention

Suicide attempt

Intentional, self-enacted, potentially injurious behavior with any (nonzero) amount of intent to die, with or without injury

Nonsuicidal self-injury or Self Harm

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

Suicidal ideation

Thoughts of ending one's life or enacting one's death

Morbid ideation

Thoughts about one's death without suicidal or self-enacted injurious content

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Sara, 29 year old Hispanic female…….

- *Thoughts of wanting to be dead flew through my head. I felt like cutting myself, looking for places it wouldn't show and wouldn't drain on my clothes. I though about taking my pills to excess. It wouldn't have killed me but probably would have numbed me and I really want that right now……..*

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The More Specific, The Better

- Recognize great variability in ideation
  - Ask about this!
  - "For some people, suicidal thoughts come and go. Is this the case for you?"
  - "Let's talk about the last time you thought about suicide"
- Greater variability may suggest greater vulnerability and less self-management capacity
  - Recognize this!
- Greater specificity usually associated with greater motivation to die, preparation/rehearsal behavior
  - Frequency, intensity/severity, duration (FID) specificity (plans), How, why, where and when
  - Method:
    - availability/accessibility, multiple methods
  - Active behaviors
    - Preparation and rehearsal

From Thinking to Doing

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Asking About Previous Attempts

- Elicit past episodes before exploring current
  - First and Worst Attempts
  - What, why, outcome?
    - How'd you feel about surviving?
    - Did you learn anything from the attempt?

Persistence of Intent
Residual 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

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Recognize Residual Intent

- Persistent motivation to die after a suicide attempt
  - Associated with
    - Greater chronicity
    - Multiple suicide attempts
    - Planning and preparation
    - Access to method
    - Trait hopelessness
    - Poor treatment compliance
    - Limited skills

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Differentiating Suicidal Thinking The Problem of Chronic Risk

- Suicidal memories versus clinical relevance
  - Fleeting, non-specific
  - Likely to be lifelong in nature given traumatic history/memories
  - Those with chronic suicidality
  - Activated with resurgence of traumatic memories
  - No associated motivation to die/intent
  - No associated behavior
  - Mild/moderate emotional activation

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- Meaningful suicidal thinking:
  - Enduring, detailed and specific
  - Access to method (high risk)
  - Associated motivation to die/intent/reasons for dying
    - Ambivalence weighted in direction of dying
  - Associated behavior (preparation/rehearsal)
  - Emotional activation/upset/arousal
    - And related capacity to self-manage

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3R's: Recognize, Respond and Reconcile Discrepancies

- Subjective: *stated intent*
  - I will or will not act on my thoughts…..
- Objective markers of intent:
  - Specificity and duration of suicidal thoughts
    - How, when, where, why?
  - Reasons for living, reasons for dying (ambivalence)
  - Preparation and Rehearsal
  - Reaction to previous attempts (residual intent)
  - Characteristics of prior attempts
    - Efforts to prevent discovery/rescue
    - Help seeking after attempt

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Recognize Presence of Capability to Act/Die Fearlessness

- Hurting yourself isn't about attention, or proving your emo, or being tough it's an addiction, a sickness. It starts off as almost a form or punishment torward yourself, but it quickly becomes an addiction, like a drug. You simply "have" to do it. Shortly after, you can't feel it, you can't feel pain. It actually feels good. You can cut yourself a half-inch deep and not even feel as much pain as a paper cut would. You do it again and again, wanting to feel pain, but you just don't feel it. Many people have killed themselves by doing this. You don't even want attention, you try to hide it. People that do this wear hoodies in 100 degree weather, just so people won't see the scars.

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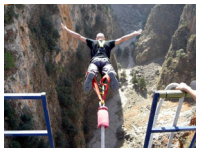
Understanding Capability to Act

- Opponent Process Theory



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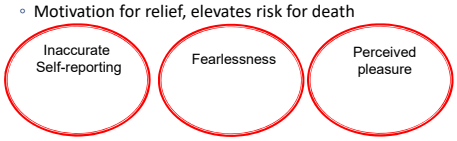
Implications of Capability to Act

- Loss of ability to accurately gauge own lethality
- Development of fearlessness about death
  - Loss of natural barriers of fear and anxiety
- Development of opposing process (from fear to excitement, relief, pleasure)
  - Motivation for relief, elevates risk for death



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Differentiating Levels of Risk

- Critical Variables (H, M, and L)
  - Symptom severity (and related disruption in functioning)
  - Escalation of intent, motivation to die
    - Emergence of behavior-thought to action
  - Access to method, willingness to engage in safety planning
  - Therapeutic alliance
  - Social connectedness
  - Observable skills

Protective

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Symptoms as Clinical Warning Signs

- Anxiety
  - Unrecognized/untreated physical symptoms elevate risk.
- Agitation
  - *Differentiate from Anxiety*
  - *Extreme emotional disturbance; perturbation*
- Hopelessness
  - Related to intent
  - Little specificity
  - Not helpful unless identity-based hopelessness
- Sleep disturbance, nightmares
- Perceived burdensomeness
  - *Everyone would be better off if I were dead*

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Warning Signs Embedded in PTSD: Dysregulation

- Persistent symptoms of arousal (and related dysregulation)
  - Sleep difficulties
  - Irritability and angry outbursts
  - Concentration problems
  - Hypervigilance
  - Exaggerated startle response

Reduced Cognitive Fluency
Problem Solving
Impaired Mental Status
Elevates Suicide Risk

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Recognize and Differentiate Levels of Risk

- Acute Risk (1 or fewer previous attempts)
- Has a starting point and an end point
  - Low
  - Moderate (objective markers of intent, none stated)
  - High (objective and subjective intent)
- Chronic Risk (2 or more previous attempts)
  - Present or absent
  - Elevates risk for future episodes
  - Is a lifelong issue

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Richard……A Case Example

- 21 y/o male referred for voicing suicidal thoughts to a fellow student, following a recent breakup with a girlfriend (first serious relationship).
- Reports fleeting thoughts about killing himself (lasts a few seconds). Has had previous fleeing thoughts about suicide during high school. No previous attempts.
- When asked if he would act on his thoughts, he responds “no”, but further exploration reveals several letters to family members detailing “what to do with his body” and ”the stuff he owns”.

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- Spontaneously reveals he's thought about "how and when" to suicide, noting access to a handgun at his parents home. Reassures the clinician he's not yet taken the firearm, but "has checked to make sure it's there".
- When asked for reasons for dying, he offers "because I'll never find another relationship like this", noting they were "soulmates".
- He offers a range of reasons for living, including his family members, some excitement about "going to medical school someday", and a few close friends.

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- He reports being depressed for "a few weeks", sleeping poorly, and feeling "anxious" (with difficulty breathing, pressure on his chest, headaches, and GI problems).
- Also notes that he's "always felt like a burden on his parents", reporting that his younger brother is "way more successful".
- No substance abuse/use. No psychiatric history.
- Poll Question: Low, Moderate or High Risk?

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Convergence Characterizing High Risk States

- Nature of Suicidal Thinking
  - Discrepancy in reports, a fluctuating process, hence the importance of behavior
  - Specificity revealed spontaneously
- Preparation, potentially rehearsal
- Reasons for Living, wish to live
- Reasons for Dying, wish to die

Need to clarify ambivalence

- Trait Suicidality
  - Unlovability ("always felt like a burden on his parents")
  - Unsolvability ("because I'll never find another relationship like this")
- Presence of Warning Signs
  - Activation, arousal

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Documenting Intent/Motivation to Die

- Patient reported fleeting, non-specific suicidal thoughts with no subjective intent and limited reasons for dying. However, patient later spontaneously reveled specific ideations regarding method. Patient also reported markers of objective intent including preparation (letters to family about being cremated and what to do with his belongings, checked on availability of gun). Reported trait suicidality with beliefs regarding unlovability (burdensomeness) and unsolvability (loss of soulmate), along with multiple warning signs (sleep disturbance, physical symptoms of anxiety, burdensomeness).

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- Reconciled discrepancy between subjective and objective intent, patient acknowledged specific suicidal thoughts but was agreeable to a crisis response plan and restricting access to method. Accordingly, current acute risk does not warrant hospitalization. No evidence of chronic risk.

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Richard with Chronic Risk

- He reports being depressed for “a few weeks”, sleeping poorly, and feeling ”anxious” (with difficulty breathing, pressure on his chest, headaches, and GI problems).
- Also notes that he’s “always felt like a burden on his parents”, reporting that his younger brother is ”way more successful”.
- No substance abuse/use. History of trauma (sexual abuse) and two previous suicide attempts.

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Documenting Chronic Risk

- Patient reported fleeting, non-specific suicidal thoughts with no subjective intent and limited reasons for dying. However, patient later spontaneously reveled specific ideations regarding method. Patient also reported markers of objective intent including preparation (letters to family about being cremated and what to do with his belongings, checked on availability of gun). He Reported identity-based hopelessness (burdensomeness) and multiple warning signs (sleep disturbance, anxiety, burdensomeness).

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- Reconciled discrepancy between subjective and objective intent, with patient agreeing to a crisis response plan and restricting access to method. Accordingly, acute risk does not warrant hospitalization. Patient reports several markers of chronic risk including previous history of trauma and multiple attempts most appropriately addressed in outpatient therapy given lack of evidence of acute risk requiring hospitalization.

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The Outcome of Richard's Case

- Clinician designated as high risk
- Completed commitment to treatment, safety plan, and means safety counseling
- Parents agreed to check gun safe and signed means receipt
- Anxiolytics prescribed for acute anxiety and sleep
- Patient agreed to immediate follow-up next week
- Patient's death secondary firearm
  - Left extended note
  - Had taken gun several weeks prior

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The hate that rages within me, rages not for those I love so dearly or those who have crossed my path.

This hate rages full force towards me and only me.

I have long forgiven those who've hurt me, but I have not and cannot come to terms to forgive myself for the things I have done to myself, and the things I've done to hurt those in my life.

You have all touched my life in one way or another, especially those whom I call family.

I cannot tell you how sorry I am for ending my life the way I did. I hope that you can all find it in your heart to see it as way for me not suffering anymore and that I am finally at rest with myself, for being at rest with the guilt that constantly ate at me for so long.

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The Role of Hope in Treatment and Recovery

- Not about symptom reduction
- Wish to live, wish to die interrelated but separate constructs
- Each has different impact on predicting suicide attempt following treatment
- Wish to die comparable across groups at start
  - Question of Trait Suicidality
  - Persistence of risk over time

  } Active Suicidal Mode
- Wish to live was greater following treatment
  - Strengthening wish to live as potential mechanism of action
  - Way to assess overall improvement across domains?
- For treatment group—drove down motivation to die

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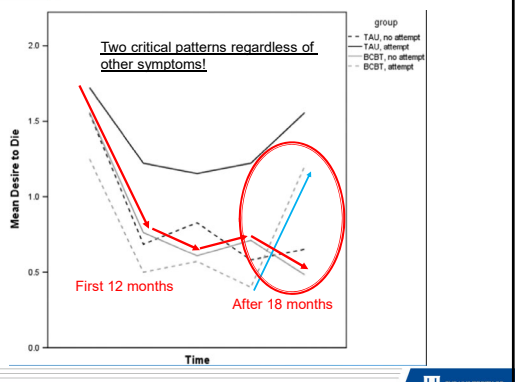

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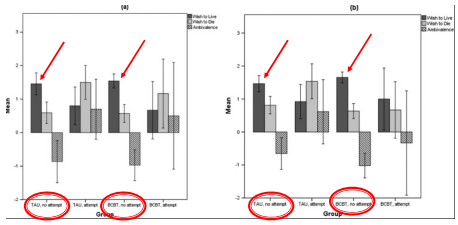
Ambivalence in Treatment
Wish to Die – Wish to live

12 Months 24 Months



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Targeting Wish to Live and Hope in Treatment

- Model for understanding suicidal behavior
  - Identification of problem as a skill deficit
  - Psychological injury versus mental illness
  - Suicidal belief system, Trait Suicidality
- Commitment to treatment and living
- Treatment compliance protocol
- Reasons for living
- Survival kit—Hope Kit
  - Guide to self-management for living
- Crisis response plan
- Means safety counseling
  - Commitment to keeping yourself safe
- Skill development tied to identity change

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Compliance Facilitation Protocol

- For each and every targeted intervention employed
  - Explain how it fits in the model, why it's important
  - Ask for "rating the likelihood you'll use on a 1-10 scale"
- Normalize the problem and treatment
- Utilize caring and encouraging contact outside of office visits
  - Caring texts
  - Encouraging phone calls
- Writing things down
  - Crisis response plan
  - Survival kit
- Asking for homework
- Role playing, demonstrating skills
- Overcoming practical barriers such as travel

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Taking Personal Responsibility

- Improved self-awareness and understanding
  - Personal responsibility
  - Self as capable and efficacious
  - Problems as solvable
  - Feelings as manageable
- Emphasis on patient self-reliance and self-management
  - *Commitment to Treatment Statement*
  - *Crisis management/response/safety plan*
  - *Means safety*
- Patients assume high level of responsibility for their care, including crisis management and means safety
- Implications for suicidal belief system
  - Trait Suicidality

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Elements of a Good Agreement?

- Defines expectations! Making the implicit explicit
- Defined as a commitment to
  - Living (not limiting one's right to die)
  - Treatment and care
  - Crisis management
  - Means safety
- Incorporates a crisis management or response plan
- It's not about suicide it's about self-management
- Specifically identifies responsibilities
  - Patient
  - Clinician

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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*

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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.*

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CTS (continued)

- *I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. It 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*

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Ease of Access to Treatment and Crisis Services

- Proactive problem solving (unsolvability)
- Self-management tool (unlovability)
  - Self as capable and efficacious
- Upset manageable with practice (unbearability)
- Clear plan of action for emergencies
  - Crisis management/safety plan
  - Means safety
- Dedication of time to practicing skills necessary to identify true crisis, using crisis plan, and using external support services judiciously

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Effective Management of Crises Means Facilitating Hope in Treatment

- Define *crisis. Making the implicit explicit*
- Make it accessible! Card or phone
- Identify warning signs! (for family as well)
- Specific goal is to reduce escalation of suicidal crisis and reduce manifest intent (increase hope and wish to live)
- 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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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

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What a Crisis Response Plan Is Not

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

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Essential Elements of a CRP
Safety Plan

- Self-management prior to external intervention
- Possible integration of external support
  - Identification of healthy support resources
  - Role play how to access support
  - Practice
- Includes means saftey counseling
  - Use of receipt (see article)

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Means safety counseling

- Ask every patient about access to lethal means
- Specifically ask every patient about firearms access
- Develop a written plan for means restriction
- Be cautious about engaging in power struggles with patients about access to means
  - Emphasize shared goal of pain reduction and suffering alleviation, not suicide prevention or means restriction

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Means safety counseling associated with increased likelihood of enacting safety procedures

86%
of parents who received means safety counseling in ED following child's suicide attempt locked up/disposed medications

32%
of parents who did not receive means safety counseling in ED following child's suicide attempt locked up/disposed medications

McManus et al. (1997)
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Practice, Practice, Practice

- *When I find myself making plans to suicide, I agree to do the following:*
- *1. Use my survival kit or Reasons for Living Card*
- *2. Review my treatment journal lessons learned*
- *3. Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk (integrate when possible)*
- *4. If the thoughts continue, get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX*
- *5. If I 'm still feeling suicidal and don 't feel like I can control my behavior, I go to the emergency room*

Establish Threshold

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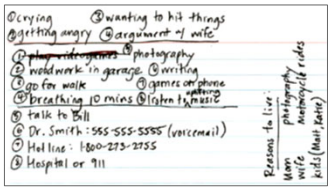
Sample Crisis Response Plans



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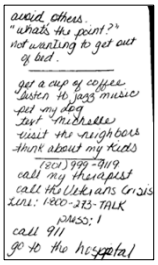

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Creating a Survival Kit---Hope Kit

- The notion of reciprocal inhibition
- Include items that generate productive, hopeful thoughts and feelings
- Cuts across all three domains
  - Unlovability, unbearability, unsolvability
- Always review items individually
- Practice use of Survival Kit
  - Review each item
  - Ask patient to describe item, "tell a little about it"
  - *What are they thinking?*
  - *What are they feeling?*
  - *More hopeful?*

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