

Conceptualizing Suicide Risk in TBI



Supplemental Handbook

**Department of Veterans Affairs
Employee Education System and Mental Health Services
Suicide Prevention Conference
November 22, 2013**

**VISN 19 Mental Illness Research, Education, and Clinical Center
<http://www.mirecc.va.gov/visn19/>**

Basics of TBI

A TBI is caused by a **BUMP**, **BLOW** or **JOLT** to the **HEAD** or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI.¹

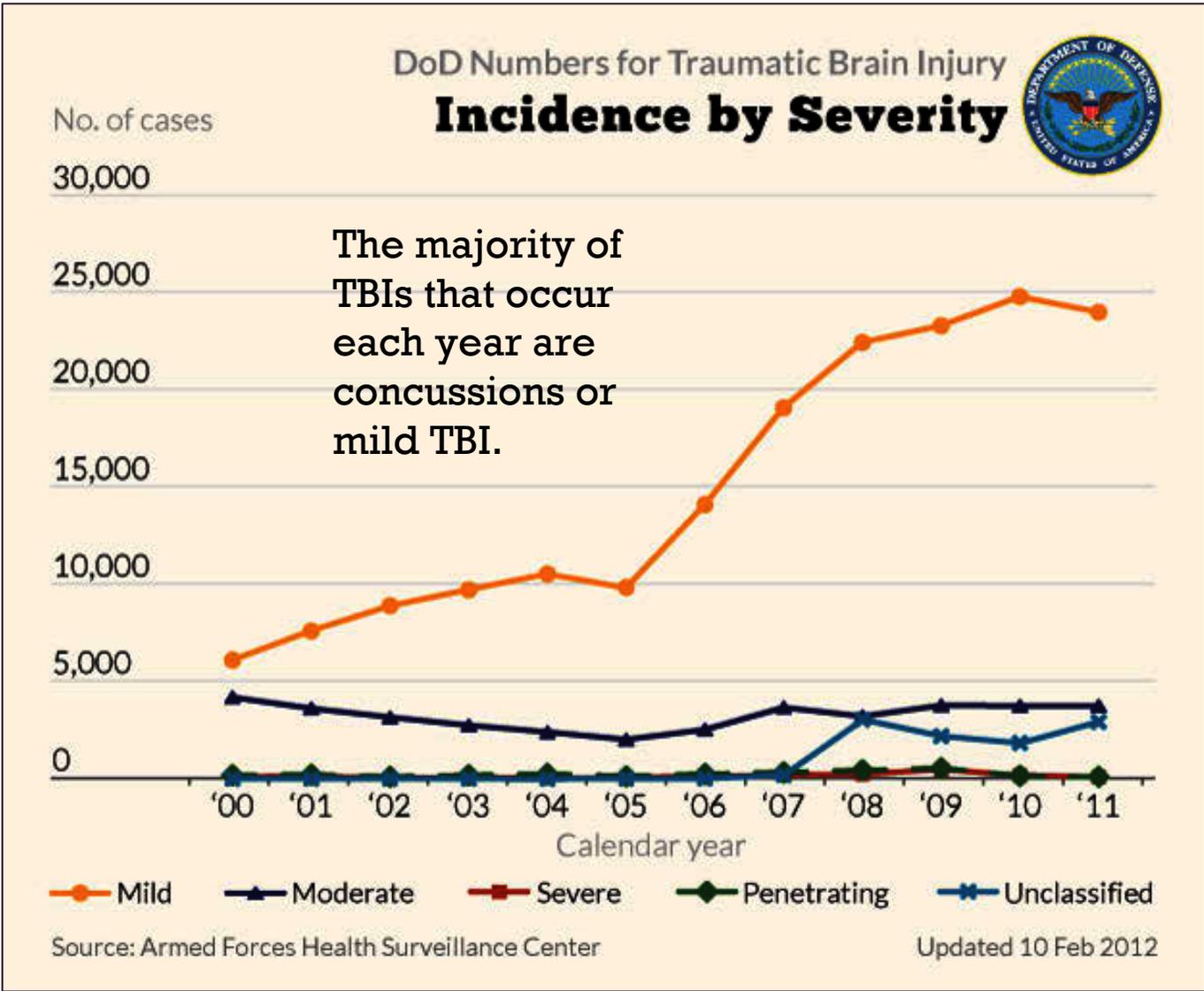


The severity of a TBI may range from “mild,” i.e., a brief change in mental status or consciousness to “severe,” i.e., an extended period of unconsciousness or amnesia after the injury.

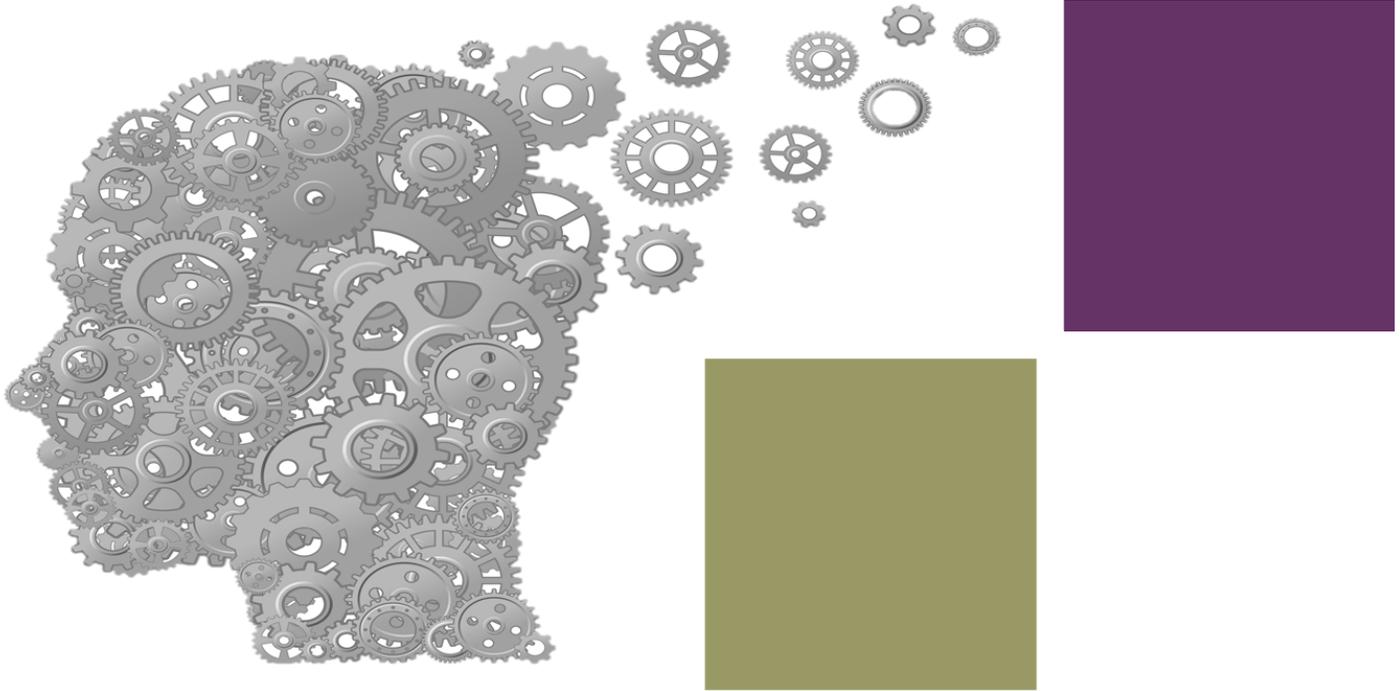
Criteria	Mild	Moderate	Severe
Structural Imaging	Normal	Normal or Abnormal	Normal or Abnormal
Loss of Consciousness	0-30 min	>30 min and < 24 hours	> 24 hours
Alterations of mental state	A moment up to 24 hours	>24 hours	Severity based on other criteria
Post-Traumatic Amnesia	0-1 day	>1 and < 7 days	>7 days
Glasgow Coma Scale (best available score in first 24 hrs)	13-15	9-12	<9

Department of Veterans Affairs and Department of Defense. (2009). VA/DOD clinical practice guideline for the management of concussion/mild traumatic brain injury. Retrieved from http://www.healthquality.va.gov/mtbi/concussion_mtbi_full_1_0.pdf.

Incidence of TBI in Service Members by Severity



Retrieved from: <http://www.dvbic.org/dod-worldwide-numbers-tbi>



mTBI and post-concussive symptoms

The majority of TBIs that occur each year are concussions or other forms of mild TBI.

Post-concussive symptoms

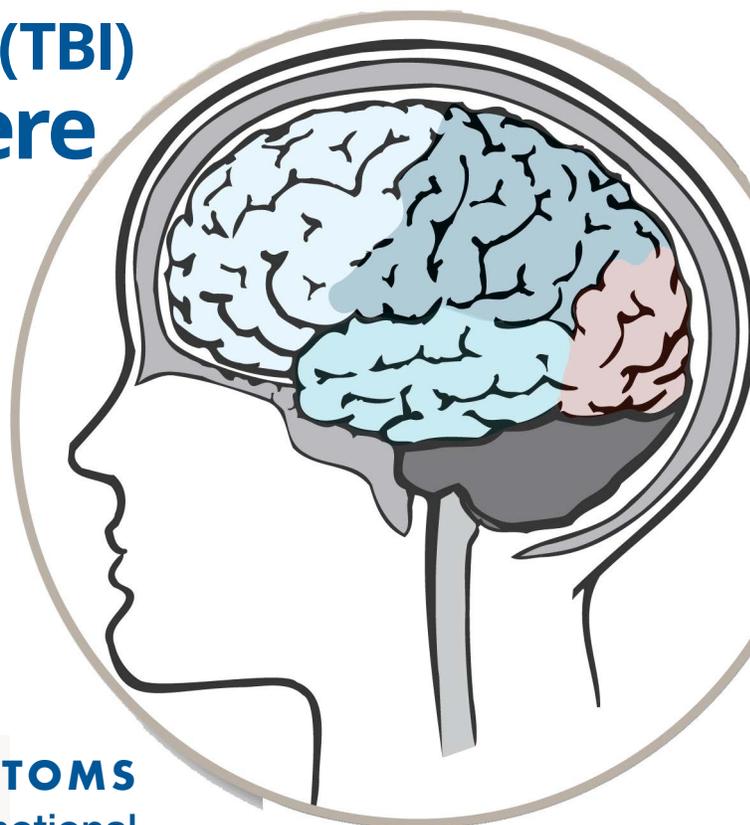
- Fatigue
- Headaches
- Memory Loss
- Visual Disturbance
- Poor attention/
concentration
- Sleep disturbances
- Dizziness/loss of balance
- Irritability/emotional
disturbance

Most people who sustain a mTBI recover fully within three to six months; 10-15% go on to experience persistent symptoms

Psychoeducation and promoting expectations of recovery is the most effective intervention for preventing persistent symptoms

Retrieved from: <http://www.dvbic.org/dod-worldwide-numbers-tbi>

Traumatic Brain Injury (TBI) Moderate or Severe



DEFINITION

A TBI is classified as moderate or severe when a patient experiences any of the following:

- Is knocked out or blacks out for more than 30 minutes
- Has memory loss or is confused for hours, days or weeks
- Has an abnormal brain scan (CT or MRI)

COMMON SIGNS AND SYMPTOMS

Physical

Headaches
Changes in sleep
Dizziness
Balance problems
Fatigue
Sexual dysfunction
Seizures
Sensory changes
Loss of strength

Cognitive

Confusion/Agitation
Attention problems
Memory problems
Difficulty with decision making
Difficulty with speech
Slowed thinking

Emotional

Depression
Anxiety
Irritability
Impulsivity
Mood swings
Inappropriate behavior
Acting out of character

DID YOU KNOW?

There are two types of TBIs:

Closed Head Injury

Caused by a blow or jolt to the head that does not penetrate the skull

Penetrating Head Injury

Occurs when an object goes through the skull and enters the brain

RELATED INJURIES

- **Skull fracture:** a break in the bones that surround the brain
- **Cerebral edema:** swelling of the brain
- **Hematoma or hemorrhage:** bleeding in or around the brain
- **Contusion:** bruising of the brain
- **Hypoxia or anoxia:** lack of oxygen to the brain
- **Diffuse Axonal Injury:** twisting and/or tearing of the connections between brain cells

Defense and Veterans Brain Injury Center

PATIENTS
FAMILIES

Traumatic Brain Injury (TBI) Moderate or Severe



Photo Credit:
www.gettyimages.com

STAGES OF TREATMENT

Inpatient care requires an overnight stay at a medical center.

Acute/critical care is inpatient treatment that often begins in an intensive care unit.

This can last from a few days to several weeks depending on how serious the injury is.

Outpatient care occurs after a patient is released from a medical center.

Outpatient care may include appointments or therapy at a hospital, doctor's office or other rehabilitation center. No overnight stay is required.

RECOVERY TIPS:

- Stay organized by following routines.
- Get seven to eight hours of sleep.
- Avoid overdoing mental and physical activities.
- Avoid smoking.
- Avoid drinking alcoholic or energy drinks.
- Do not isolate yourself — stay in touch with friends and family.
- Keep appointments and take an active role in your therapy sessions.

AND REMEMBER...

- There is no "normal" time frame for recovery.
- Recovery depends on how serious the injury is and what areas of the brain are affected. Other injuries to the body also can affect recovery.
- The most rapid recovery will happen in the first six months following the injury, although recovery may continue for years.
- Most patients will learn useful ways to work around the new challenges from their injury.

For more information on the Family Caregiver Guide, for families of patients with moderate or severe TBI, contact info@DVBIC.org or visit www.DVBIC.org.

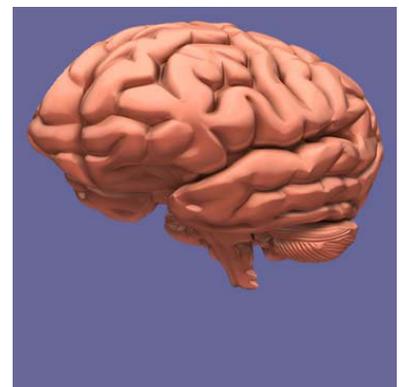


Screening

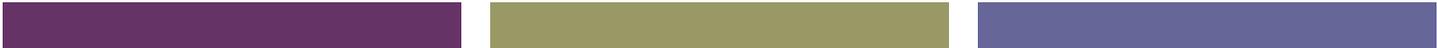
Questions that can help you screen for TBI

- “Have you ever been hospitalized or treated in an emergency room following a head or neck injury?”
- “Have you ever been knocked out or unconscious following an accident or injury?”
- “Have you ever injured your head or neck in a car accident or from some other moving vehicle accident?”
- “Have you ever injured your head or neck in a fight or fall?”

An answer of "YES" to any of these questions may indicate a need for formal TBI assessment



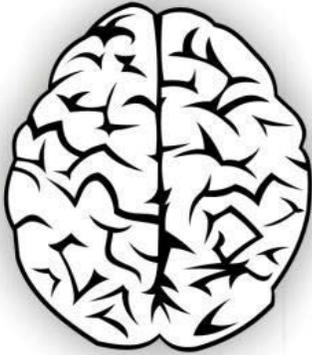
Brenner, L.A., Homaifar, B.Y., Olson-Madden, J.H., Nagamoto, H., Huggins, J., Schneider, A.L., Forster, J.E., Matarazzo, B., Bogner, J.A., & Corrigan, J.D. Prevalence and Screening of Traumatic Brain Injury among Veterans Seeking Mental Health Services. *Journal of Head Trauma Rehabilitation*. 2012;28(1):21–30.



Difficulties with initiating, organizing and carrying out activities	<ul style="list-style-type: none"> • Loss of 'get up and go'. This can often be mistaken for 'laziness' or a lack of motivation and energy. • Problems with thinking ahead and carrying out the sequence of steps needed to complete a task.
Rigidity in thoughts and actions	<ul style="list-style-type: none"> • Difficulty in evaluating the result of actions and reduced ability to change behavior or switch between tasks if needed. • Difficulty being flexible
Poor problem solving	<ul style="list-style-type: none"> • Finding it hard to anticipate consequences. • Decreased ability to make accurate judgments or find solutions if things are going wrong.
Impulsivity	<ul style="list-style-type: none"> • Acting too quickly and impulsively without fully thinking through the consequences. For example, spending more money than can be afforded.
Mood disturbances	<ul style="list-style-type: none"> • Difficulty in controlling emotions which may lead to outbursts of emotion such as anger or crying. • Rapid mood changes may occur. For example, switching from happiness to sadness for no apparent reason.
Difficulties in social situations	<ul style="list-style-type: none"> • Reduced ability to engage in social interactions. • Finding it hard to initiate, participate in, or pay attention to conversations. • Poor judgment in social situations, which may lead to saying or doing inappropriate things.
Difficulties with memory and attention	<ul style="list-style-type: none"> • Finding it harder to concentrate. • Difficulty with learning new information. • Decreased memory for past or current events, which may lead to disorientation.

Modified from: <https://www.headway.org.uk/executive-dysfunction-after-brain-injury.aspx>

Psychiatric Disorders After TBI



Depression and Mood Disorders



PTSD and other Anxiety Disorders



Substance Use Disorders



Self-Directed Violence After TBI

Individuals with TBI are more likely to

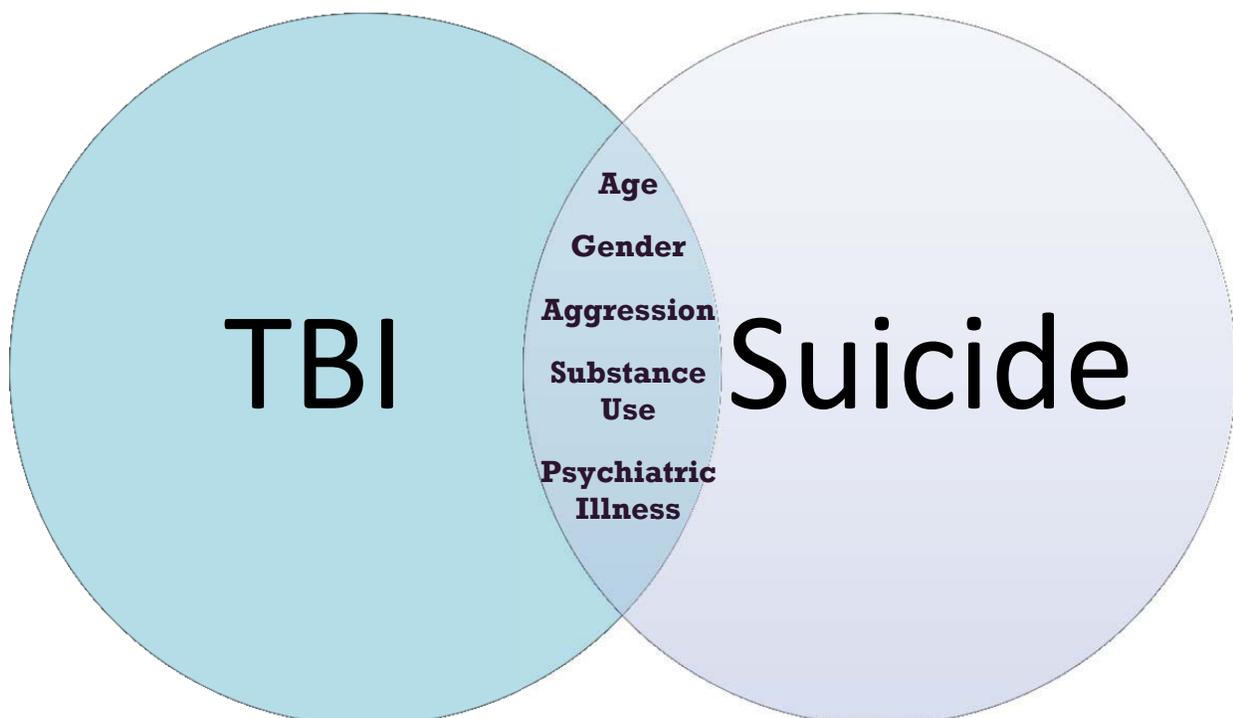
Think about suicide

Attempt Suicide

Die by suicide

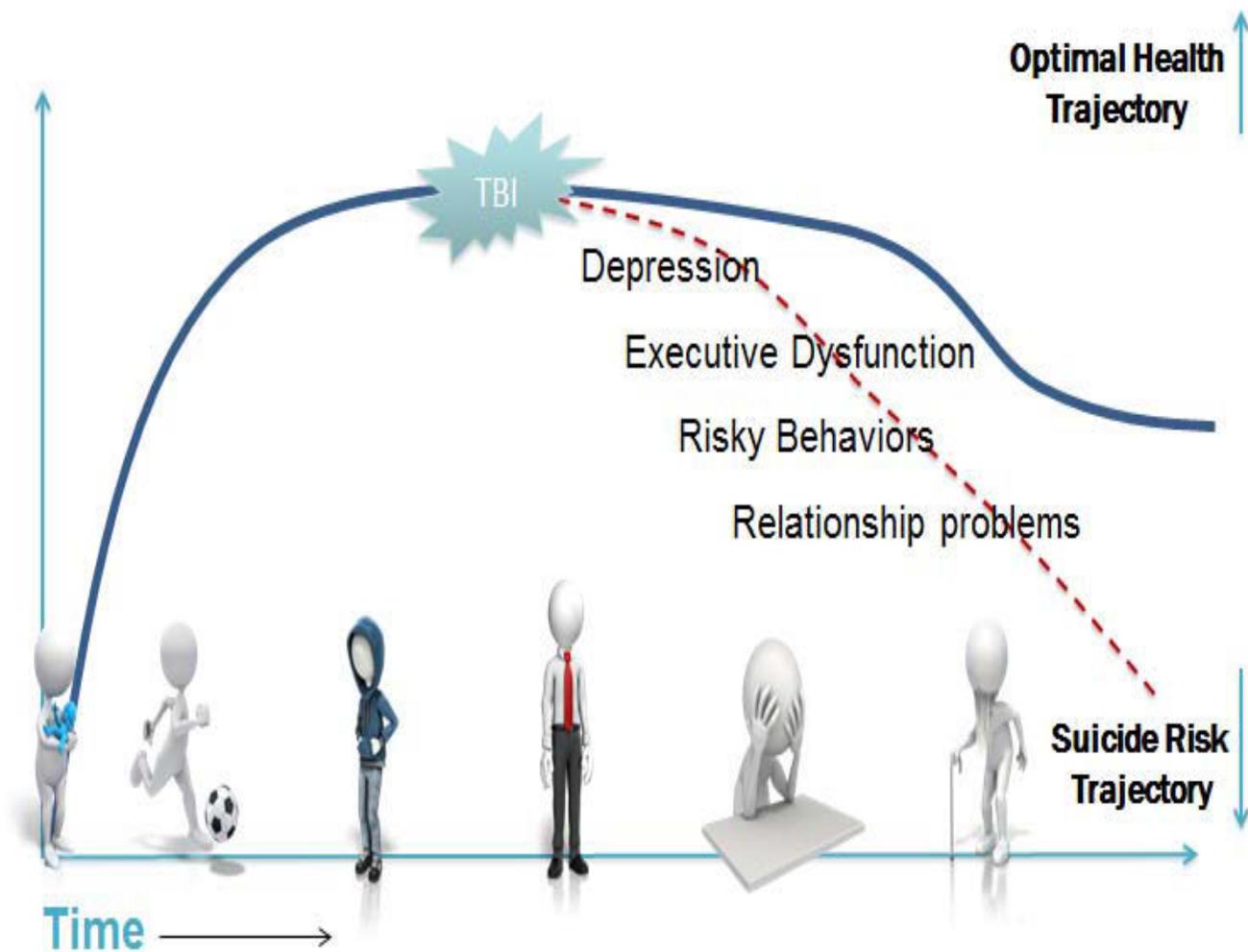
**This risk is for TBIs of all severity
(mild, moderate, and severe)**

TBI and Suicide have Shared Risk Factors



Risk of suicide continues long after TBI and may persist for decades

TBI Shifts the Health Trajectory



Conceptualization

An interpreted evaluation incorporating our ideas about

- WHY things happened as they did
- HOW this particular person is affected
- WHAT needs to happen next in the clinical situation



Step 1

What does the client think is driving his/her suicidal behavior?

Step 2

How it is that he/she came to have these particular problems?

How have they coped thus far?

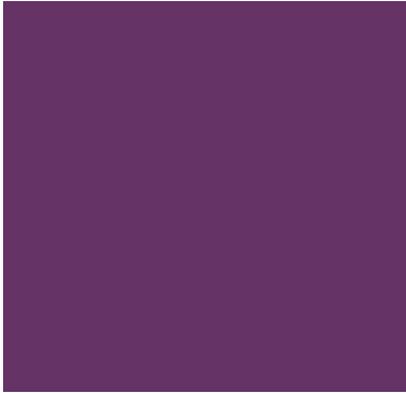
- Coping will require an ability to flexibly employ various strategies, potentially adapting them to the circumstance, until one works.

What theory or set of theories can help explain this information?

Step 3

What interventions could be implemented to help address the suicidal thinking/behaviors?

Executive Dysfunction and Understanding Suicide Risk



Impulsivity: (Inhibition) An individual's inability to inhibit or modulate a particular behavior

- When impaired inhibition is present, individuals may be less likely to make use of Safety Plans, consequently perhaps making them more likely to act on suicidal ideation

Insight: An appreciation of one's own behavior as well as the impact one makes on others

- Individuals with impaired insight may believe they are not valuable to others, despite evidence to the contrary, and may not appreciate the impact on others if they were to act on their suicidal ideation, thus further fueling their resolve to die by suicide

Problem Solving: The ability to be flexible in how one thinks, shifting behavior when necessary

- Individuals with concrete, inflexible thinking may have a bevy of maladaptive coping strategies that they continue using to no avail during a crisis



Evaluating Executive Functioning for Conceptualization

Impulsivity: Infer from past behaviors (e.g., reckless driving, etc.)

The following questions were taken from Rudd (2006):

1. Do you consider yourself an impulsive person?
2. Why or why not?
3. When have you felt out of control in the past?
4. What did you do that you thought was out of control?
5. What did you do to help yourself feel more in control?
6. When you're feeling out of control, how long does it usually take for you to recover?

Insight: Is the individual aware of the interaction between their problems and their behavior and do they believe they need treatment?

Joiner et al (2009) encourage clinicians to assess:

“The degree to which clients feel connected to – and cared about – by others, as well as the degree to which clients believe that others would be better off if they were gone”

Problem Solving: Paying attention to the individual's manner of answering questions throughout the clinical interview (e.g., note when client thinks of only the most obvious solutions to various problems)

Zuckerman (2000) suggests noting a tendency to:

1. Not grasp the nature of abstract questions such that it is difficult to find metaphors simple enough to help them understand
2. Note only surface features of life experiences
3. Offer only very specific examples to general questions
4. Have an overly broad or narrow degree of generalization



Interventions leading from Conceptualization

Impulsivity: If possible, the first line of intervention should include removing access to lethal means. In cases where this is not possible, devising barriers to lethal means is encouraged. With regard to managing safety, clinicians could make items on Safety Plans simpler and ensure that the coping strategies have a component of immediate gratification that has positive emotional valence.

If your patient is impulsive and you believe s/he may have less than 2-3 minutes from ideation to behavior, what things might you not put on a Safety Plan?

Insight: Involving family and loved ones in treatment, as appropriate, may help bolster an individual's sense of feeling connected to others, as well as giving them an opportunity to see firsthand how their suicide would affect those around them. Additionally, providing patients with psychoeducation about psychiatric illness may be an effective way to help them gain insight into their mental disorder, improve their perceptions of the illness, and promote expectations of recovery.

Example: If insight is an issue, clinicians cannot assume that the patient will be aware of when they may need to use their Safety Plan, so role-playing use of the plan and practicing outside of session will be paramount

Problem Solving: Providing patients with a variety of coping strategies, including barriers to their use, (i.e. Safety Plan) may be a particularly effective way of helping them to

come up with alternative ways to manage extreme emotional distress.

*****Example: Once items are listed (e.g., taking a walk), clinicians can trouble-shoot with patients regarding scenarios in which the patient may not be able to engage in the coping strategies listed (e.g., what if it is raining outside?)* ****

Executive Functioning Component	Sample Questions to Augment a Suicide Risk Assessment	What to Listen For	Intervention
Impulsivity	When you're feeling out of control, how long is it before you feel like you have to act on your thoughts?	A coping strategy that would take too long to reduce feelings of being out of control (e.g. if it takes 5 minutes before they feel they must act on their thoughts, then coping via watching a 2-hour movie may not be the best choice)	Coping strategies should be tailored to produce immediate gratification (e.g. calling a loved one or playing with a pet)
Insight	How much do you think that others would be better off if you were gone? Does this happen regardless of whether you feel like they value you?	Lack of awareness of the impact their suicide would make on others and/or their value to others	Helping patients identify triggers that contribute to their problems with insight (e.g., an argument with a spouse that makes them feel devalued)
Thinking Process	How would you cope during a suicidal crisis? What if that doesn't work?	Degrees of concreteness, inflexible thinking	Once coping strategies are identified, trouble-shooting with patients (e.g., if visiting a friend makes things better, what happens if the friend is busy?)

Homaifar, B., Bahraimi N., Silverman, M., & Brenner, L. Executive Functioning as a Component of Suicide Risk Assessment: Clarifying its Role in Standard Clinical Applications. *Journal of Mental Health Counseling*. 2012;34(2):110–120.

The VA Suicide Risk Management Consultation Service is now available to VA providers.

Information regarding this service can be found on our website:

<http://vaww.mirecc.va.gov/srm/>

To schedule a consultation or for general questions email: srmconsult@va.gov

What is the Consultation Service?

The Suicide Risk Management Consultation Service is a national resource that extends local suicide prevention resources, with a specific focus on providing additional input from experts in evidence based psychotherapy, treatment planning, pharmacology, conceptualization of the drivers of self-directed violence, as well as risk assessment/management. This confidential service is clinician-focused (i.e., we do not follow specific Veterans), and is not meant to replace the hard work being done by local SPCs. Consultations regularly encourage clinicians to contact their local SPCs to keep them abreast of difficult cases.

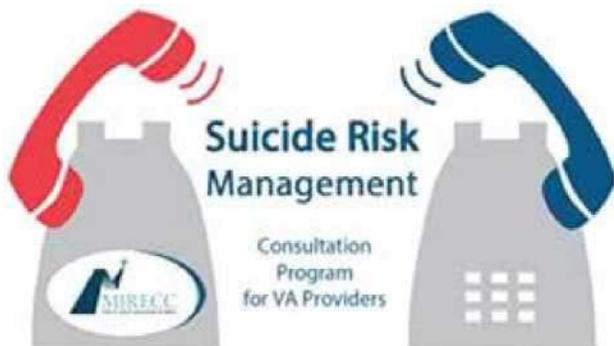
Consultation Process

Consultations can encompass brainstorming and specific suggestions; however clinicians are not bound by these suggestions and are encouraged to run suggestions through their local chain of command as appropriate. Many consultations have resulted in providing resources that clinicians often do not have access to, and/or distilling large amounts of information that clinicians may not have the time to read in entirety.

Types of Referral Questions

In the 90+ consultations we have completed thus far, we have answered questions spanning from 'Can you provide a second opinion about a complex case?' to 'Can you help us augment current suicide risk assessment in a particular clinic at our facility?' to 'What are best practices for suicide prevention for a Veteran who has recently been diagnosed with a medical illness?'

VA SUICIDE RISK MANAGEMENT CONSULTATION PROGRAM



Email: srmconsult@va.gov or
Call: (866) 948-7880
to Schedule a Consult

srmconsult@va.gov
(866) 948-7880
One-on-one
consultation at no charge
for VA providers with
questions about Suicide
Risk Management
Intranet: vawww.mirecc.va.gov/srm

Speak directly with staff psychologists and physicians about:

- ✓ TREATMENT
- ✓ CLINICAL MANAGEMENT
- ✓ RESOURCES FOR SUICIDE RISK MANAGEMENT
- ✓ ASSESSMENT
- ✓ PROGRAMMATIC ISSUES
- ✓ IMPROVING CARE FOR THOSE WITH SUICIDAL THOUGHTS & BEHAVIORS

Who can call?

ANYONE working with Veterans with suicidal thoughts & behaviors, from mental health professionals to primary care clinicians, to care coordinators, may request a consult. The Consultation Program manager will ask for some brief contact information and the reason for the request.

How does it work?

STEP 1. EMAIL srmconsult@va.gov

OR CALL 1-866-948-7880

You'll answer a few brief questions and provide your location.

STEP 2. DISCUSS YOUR QUESTIONS

Consults are up to 30 minutes in length, but can vary according to need.

STEP 3. REVIEW RECOMMENDATIONS & GIVE FEEDBACK

You and the consultant will review the recommendations. Later, you can provide your feedback on the process.

Consultation Program Team
Beeta Homaifar, PhD, Hal Wortzel, MD

The Consultation Program does not provide emergency services. For emergencies, contact 911 or the Veteran Crisis line at (800)273-8255, then press "1"



<http://www.mirecc.va.gov/visn19/>