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PTSD/Suicide: Conceptualization and Assessment

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Disclosure Statement

This presentation is based on work supported, in part, by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.



Disclaimer

Information during this presentation is for educational purposes only – it is not a substitute for informed medical advice or training. You should not use this information to diagnose or treat a mental health problem without consulting a qualified professional/provider



Training Overview

Objective: to understand the overlap in PTSD and suicide as it applies to relevant clinical application

1. The scope of Veteran suicide
2. PTSD/Suicide
3. Conceptual model of suicide
4. Suicide risk assessment
5. Questions and Comments



1. The Scope of Veteran Suicide



Suicide in the Veteran Population

The following are the most recent Veteran suicide data (2014), released by the Office of Suicide Prevention in August of 2017

- An average of 20 Veterans died by suicide daily with 6/20 being users of VHA services in 2013/2014
- Veterans accounted for 18% of all deaths by suicide among U.S. adults despite only representing 8.5% of the U.S. adult population
- After accounting for age and sex, risk for suicide was 22% higher among Veterans compared to U.S. civilian adults



Sources of Increased Suicide Risk

Increased risk for suicide in veterans has been noted in the following

- Those receiving outpatient mental health services (Desai et al., 2008)
- Those who have received psychiatric discharge (Desai et al., 2008)
- Patients receiving treatment for depression (Ziven et al., 2007)
- Men with bipolar disorder and women with substance use disorders (Ilgen et al., 2010)
- Patients with a history of previous suicide attempts or non-suicidal self-directed violence (Bryan et al., 2014; Bryan et al., 2015; Haney et al., 2012)

Suicidal Ideation and Attempts in Veteran Samples

Among 2,602 veterans 3.8% and 0.4% reported suicidal ideation and a suicide attempt respectively in the past 12 months (Bossarte et al., 2012)

However, in a sample of treatment seeking OEF-OIF Veterans, 21.6% reported suicidal ideation in the past 2 weeks (Pietrzak et al., 2011)

- Risk for suicidal ideation and attempt likely differs based on clinical population and presentation



2. PTSD/Suicide



What do we know about PTSD/Suicide?

Significant increase in research focusing on the association between these two constructs

The association, though often significant, is complicated with numerous identified potential mediators and moderators



Relationship Between PTSD and Suicide

A systematic review in 2013 found that among veterans, a history of PTSD is associated with increased risk for suicide (Pompili et al., 2013)

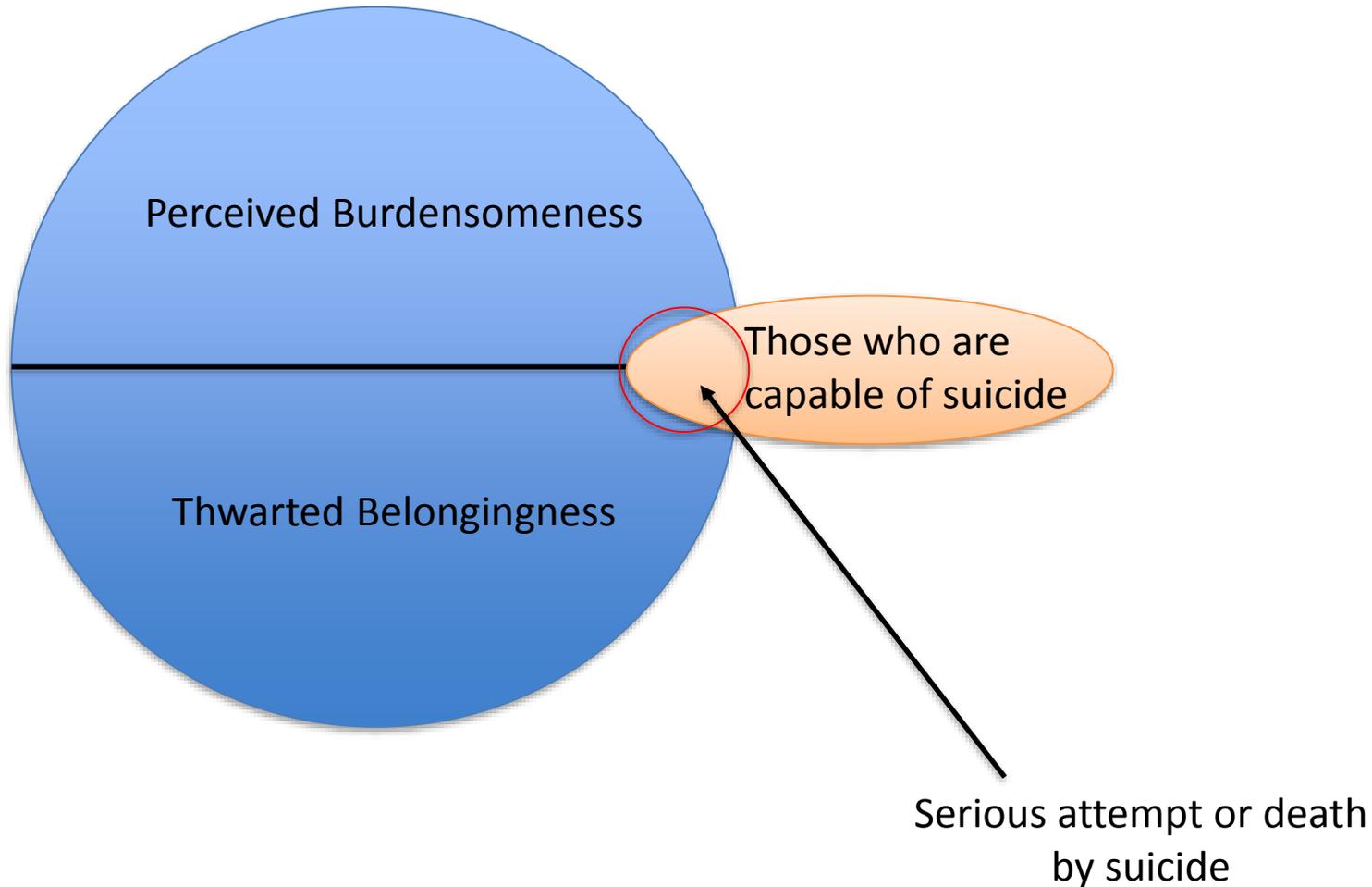
However, numerous concurrent factors also increase risk in this population including:

- Trauma-related belief systems (e.g., guilt, shame, posttraumatic cognitions; Bryan et al., 2013; Cunningham et al., 2017; McLean et al., 2017; Tripp & McDevitt-Murphy, 2016)
- Lack of post-deployment social support (DeBeer et al., 2014)
- Comorbid psychiatric diagnoses (e.g., depression, substance use; Jakupcak et al., 2009; Oquendo et al., 2005)



3. Conceptual Model of Suicide in the Context of PTSD

Interpersonal Theory of Suicide (Joiner, 2005)





Perceived Burdensomeness

The perception that one is a burden to others

“My death is worth more than my life to my loved ones/family/society”



Thwarted Belongingness

An unmet psychological need to socially belong

“No one cares. I’m all alone.”



Those Capable of Suicide

Desire to die by suicide (e.g., perceived burdensomeness and thwarted belongingness) are not sufficient for engaging in suicidal self-directed violence

Acquired capability to engage in suicidal self-directed violence is achieved by losing fear associated with suicidal self-directed violence and increasing physical pain tolerance (Van Orden et al., 2010)

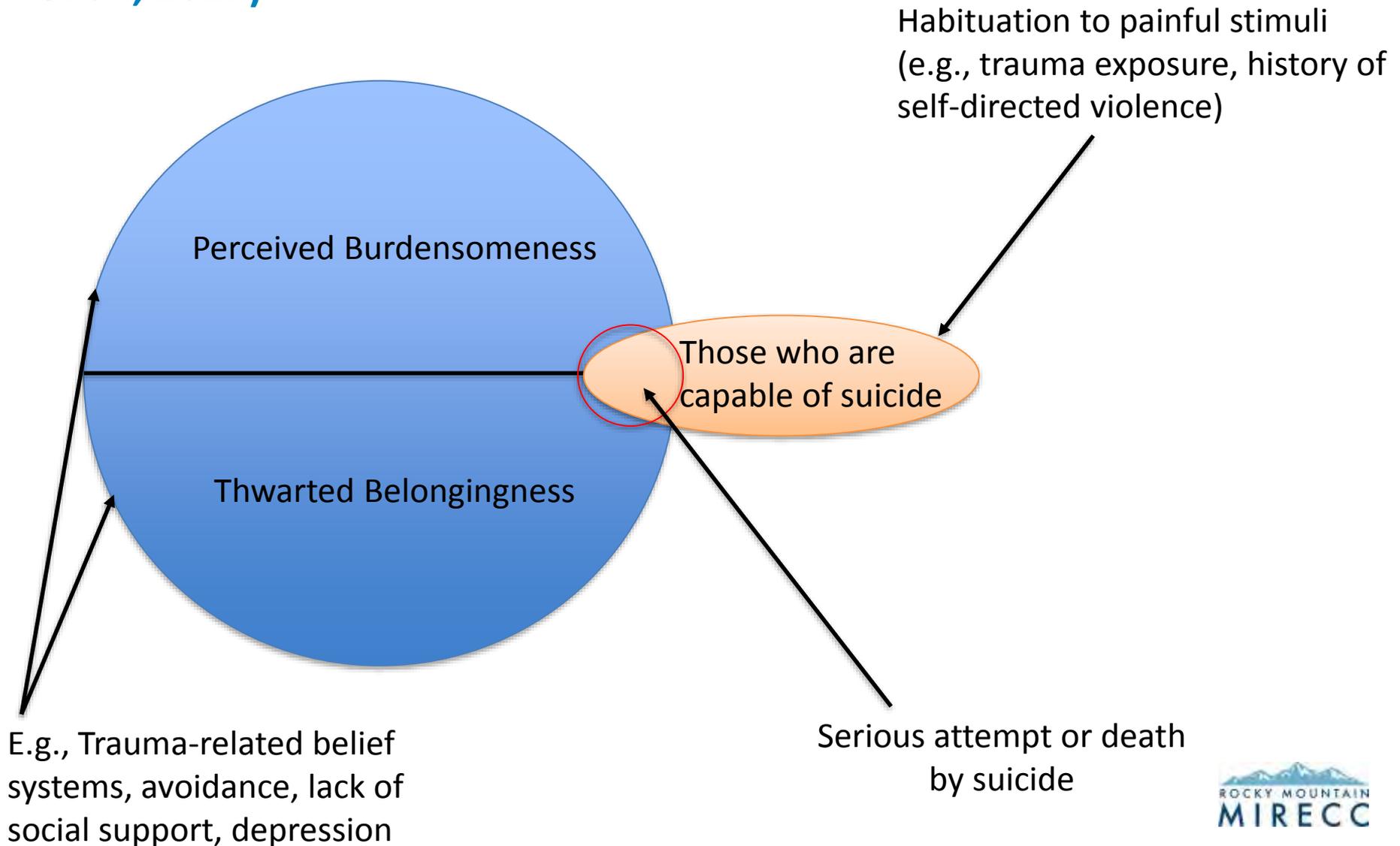


Those Capable of Suicide

Habituation to painful stimuli (e.g., previous self-directed violence, military [e.g., military sexual trauma, combat exposure] and non-military [e.g., childhood abuse, intimate partner violence]) functions to lower the fear of death **AND** elevate tolerance to pain (Bryan et al., 2017)

Capability develops as a function of repeated exposure to these painful stimuli through which the individual habituates to the previously aversive stimuli (Van Orden et al., 2010)

Interpersonal Theory of Suicide: PTSD/Suicide (Joiner, 2005; Bryan et al., 2017)



The Role of Trauma Exposure

Exposure to painful and provocative experiences, especially those characterized by violence and aggression, contribute to fearlessness about death and increased pain tolerance, enhancing an individual's capability to attempt suicide (Bryan et al., 2017; Selby et al., 2010)



Not all Trauma Experiences are Equal

For example:

- Combat traumas can vary in terms of (Bryan et al., 2011)
 - Level of violence (firefights vs. non-hostile, routine patrols)
 - Proximity (hand-to-hand combat vs. artillery fire in the distance)
 - Personal responsibility (killing an enemy combatant vs. witnessing others engaged in combat)
 - Occupation (medic vs. infantrymen)
 - Location of deployment (well-controlled area vs. hostile area with high combat operations)
- Military sexual traumas can vary in terms of (Monteith et al., 2015)
 - Harassment vs. sexual assault

What does this all mean?

Take in aggregate, from the Interpersonal Theory of Suicide (Joiner, 2005), variance in risk for suicide among patients with PTSD may be partially explained based on differing levels of acquired capability based on perceptual and contextual components of the patient's trauma history, especially traumas characterized by violence and aggression



Treatment Implications

The Interpersonal Theory of Suicide posits that prevention of acquired ability **OR** perceived burdenesomeness **OR** thwarted belongingness will decrease risk for suicide

It is crucial to assess for these three constructs as well as use evidence-based principles to amend cognitive distortions, negative interpersonal response styles, and ineffective coping behaviors (Stellrecht et al., 2006)



3. Suicide Risk Assessment

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Therapeutic Risk Management of the Suicidal Patient

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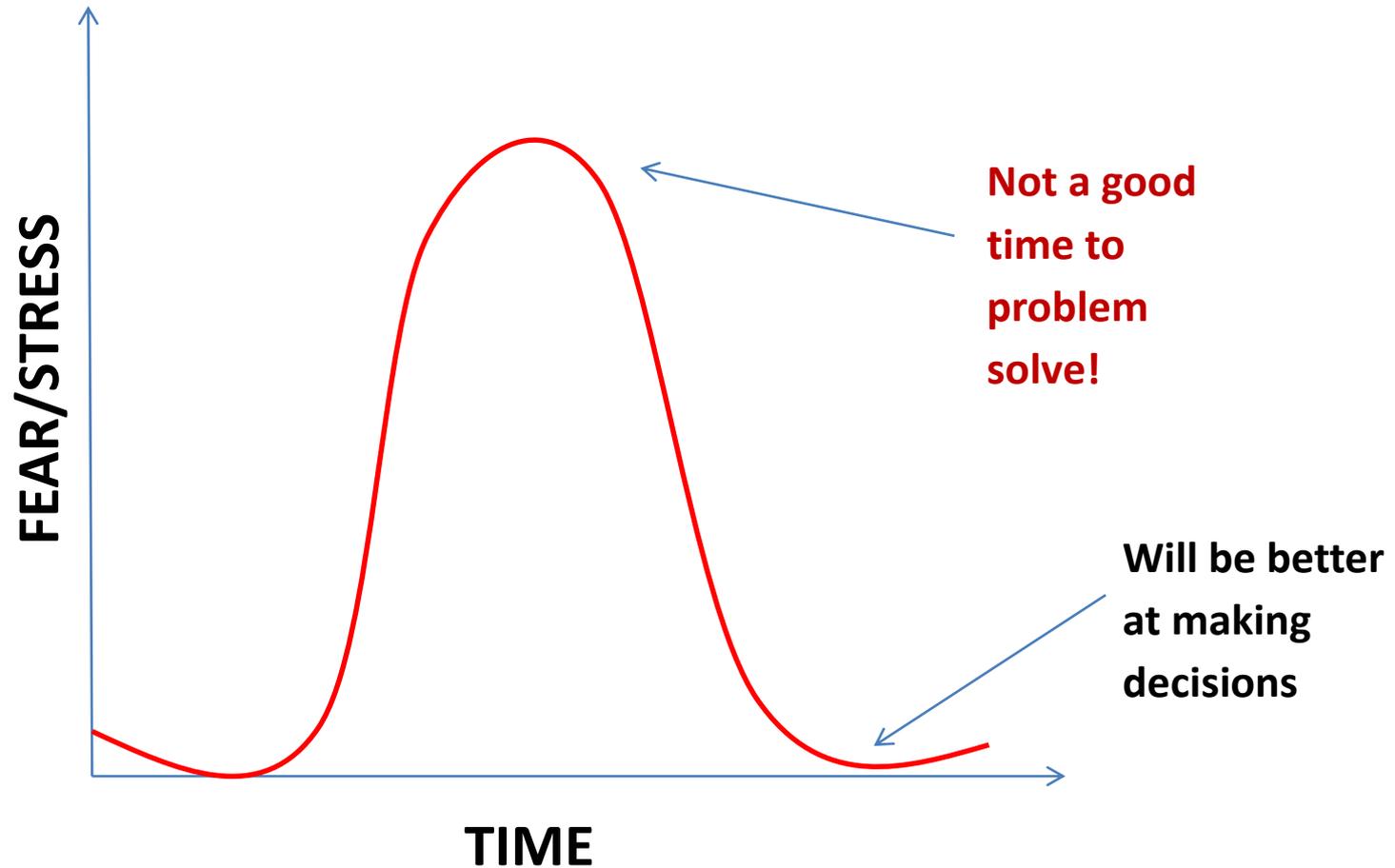


Why Assess Risk?

- **Take good care of our patients and to guide our interventions**
- **Take good care of ourselves**
 - Risk management is a reality of psychiatric practice
 - 15-68% of psychiatrists have experienced a patient suicide
 - Suicide/attempted suicide is one of the most common malpractice claim



Fear/Stress and Clinical Decision Making





Mitigating Fear...

- **Via medicolegally informed practice that exceeds the standard of care**
- **Fortunately, the best way to care for our potentially suicidal patients and ourselves are one in the same**
- **Clinically based risk management is patient centered**
 - Supports treatment process and therapeutic alliance
- **Good clinical care = best risk management**



Therapeutic Risk Management (TRM) with the Suicidal Patient

1. Conduct and document clinical risk assessment
2. Augment clinical risk assessment with structured instruments
3. Stratify risk in terms of both severity and temporality
4. Develop and document a Safety Plan

The series can be found in *The Journal of Psychiatric Practice*

Acknowledgements:

Hal Wortzel, PhD

Beeta Homaifar, PhD

Bridget Matarazzo, PsyD

Lisa Brenner, PhD, ABPP (Rp)



Therapeutic Risk Management

- Supports the patient's treatment and the therapeutic alliance
- Seeks to balance the sometimes competing ethical principles of autonomy, non-maleficence, and beneficence
- Avoids defensive practices of dubious benefit that, paradoxically, can invite a malpractice suit
- Unduly defensive mindset can distract the clinician from providing good patient care



1. Conduct and document clinical risk assessment



Concepts to be on the same page about

- Suicide is a rare event
- No standard of care for the prediction of suicide
- Efforts at prediction yield lots of false-positives as well as some false-negatives
- Structured scales may augment, but do not replace systematic risk assessment
- Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients



Overarching Goal

- Gather information related to the patient's intent to engage in suicide-related behavior
- Evaluate factors that elevate or reduce the risk of acting on that intent
- Integrate all available information to determine the level of risk and appropriate care

Suicide Risk



Not just suicidal ideation



Risk Factors
Warning Signs
Protective Factors



Indicators of Risk

Ideation → Intent → Plan → Access to Means

Information from measures can help with this.



Ideation → Intent → Plan → Access to Means

Specific & Direct

- “Tell me about what you think/what goes through your head”

Assess

- Onset, Frequency, duration, severity



Ideation → Intent → Plan → Access to Means

Intent

- Willingness to act/reasons for dying
- How do these size up to barriers to act/reasons for living?



Suicide Intent

Subjective
Suicide Intent



Objective Suicide
Intent



Ideation → Intent → Plan → Access to Means

Plan

- Preparatory Behaviors?
 - Access to means, letters, rehearsal, research



Recognize Warning Signs

Precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk

Direct Warning Signs

1. Suicidal communication
2. Preparation for suicide
3. Seeking access or recent use of lethal means



Other Potential Warning Signs

Substance abuse – increasing or excessive substance use

Hopelessness – feels that nothing can be done to improve the situation

Purposelessness –no sense of purpose, no reason for living

Anger – rage, seeking revenge

Recklessness –engaging impulsively in risky behavior

Feeling Trapped –feelings of being trapped with no way out

Social Withdrawal – withdrawing from family, friends, society

Anxiety – agitation, irritability, feeling like wants to “jump out of my skin”

Mood changes – dramatic changes in mood, lack of interest in usual activities

Sleep Disturbances – insomnia, unable to sleep or sleeping all the time

Guilt or Shame – Expressing overwhelming self-blame or remorse



Risk Factors

- Increase the likelihood of suicidal behavior and include modifiable and non-modifiable indicators

Protective Factors

- Capacities, qualities, environmental and personal resources that increase resilience drive individuals towards growth, stability, and health and increase coping with different life events and decrease the likelihood of suicidal behavior



2. Augment clinical risk assessment with structured instruments



Formal Assessment Approaches

- Providers across disciplines generally avoid using formal assessment approaches (e.g., validated tools) in favor of using their own clinical interviews (Jobes, 1993)
- Unstructured clinical interviews have the potential to miss important aspects of risk assessment
- Using both will facilitate a more nuanced, multifaceted approach to suicide risk assessment





The addition of reliable/valid self-report measures can...

- Augment clinical care
- Serve an important medicolegal function
- Help to realize therapeutic risk management of the suicidal patient

A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults

Gregory K. Brown, Ph.D.

University of Pennsylvania

<http://www.sprc.org/sites/sprc.org/files/library/BrownReviewAssessmentMeasuresAdultsOlderAdults.pdf>



Things to Consider

- Time
- Accessibility
- Credentials/Training of administrator
- How it will inform risk assessment
- Measuring baseline and movement over time



Some Measures Used by Rocky Mountain MIRECC Suicide Consult

- Beck Hopelessness Scale (BHS)
 - Assesses hopelessness within the past week
 - ~5 minutes
 - One of the few measures that has demonstrated an association with death by suicide
- Reasons for Living Inventory (RFL)
 - Assesses reasons for living that may serve a protective function for someone considering suicide
 - ~10 minutes
- Beck Scale for Suicidal Ideation (BSS)
 - ~5 minutes
 - One of the few measures that has shown an association with death by suicide



Caveat

While suicide-specific assessment instruments can assist providers in the clinical assessment of suicidal ideation and behavior, such instruments are not a substitute for clinical judgment

No single assessment or series of assessments is able to accurately predict the emergence of a suicidal crisis



3. Stratification of Risk



What's the Risk?

- **29 y/o female**
- **18 suicide attempts and chronic SI**
 - Currently reports below baseline SI & stable mood
- **Numerous psychiatric admissions**
- **Family history of suicide**
- **Owns a gun**
- **Intermittent homelessness**
 - Currently reports having stable housing
- **Alcohol dependence**
 - Has sustained sobriety for 6 months
- **Borderline Personality Disorder**



Severity

Low

Intermediate

High



Stratify Risk – Severity & Temporality

Low

Intermediate

High

Acute

Chronic



High Acute Risk

- **Essential features:**
 - SI with intent to die by suicide **AND**
 - Inability to maintain safety independent of external support/help
- **Likely to be present:**
 - Plan
 - Access to means
 - Recent/ongoing preparatory behaviors and/or SA
 - Acute Axis I illness (e.g., MDD episode, acute mania, acute psychosis, drug relapse)
 - Exacerbation of Axis II condition
 - Acute psychosocial stressor (e.g., job loss, relationship change)
- **Action:**
 - Psychiatric hospitalization



Intermediate Acute Risk

- **Essential features:**
 - Ability to maintain safety independent of external support/help
- **Likely to be present:**
 - May present similarly to those at high acute risk except for:
 - Lack of intent or preparatory behaviors
 - Reasons for living
 - Ability/desire to abide by Safety Plan
- **Action:**
 - Consider psychiatric hospitalization
 - Intensive outpatient management



Low Acute Risk

- **Essential features:**

- No current intent **AND**
- No suicidal plan **AND**
- No preparatory behaviors **AND**
- Collective high confidence (e.g., patient, care providers, family members) in the ability of the patient to independently maintain safety

- **Likely to be present:**

- May have SI but **without** intent/plan
- If plan is present, it is likely **vague** with **no preparatory behaviors**
- Capable of using appropriate coping strategies
 - Willing/able to use Safety Plan

- **Action:**

- Can be managed in primary care
- Mental health treatment may be indicated



Chronic Risk

- **High**

- Prior SA, chronic conditions (diagnoses, pain, substance use), limited coping skills, unstable/erratic psychosocial status (housing, rltp), limited reasons for living
- **Can become acutely suicidal**, often in the context of unpredictable situational contingencies
- Routine mental health f/up, safety plan, routine screening, means restriction, intervention work on coping skills/augmenting protective factors

- **Intermediate**

- **BALANCE** of protective factors, coping skills, reasons for living, and stability suggests **ENHANCED** ability to endure crises without resorting to SDV
- Routine mental health care to monitor conditions and maintain/enhance coping skills/protective factors, safety plan

- **Low**

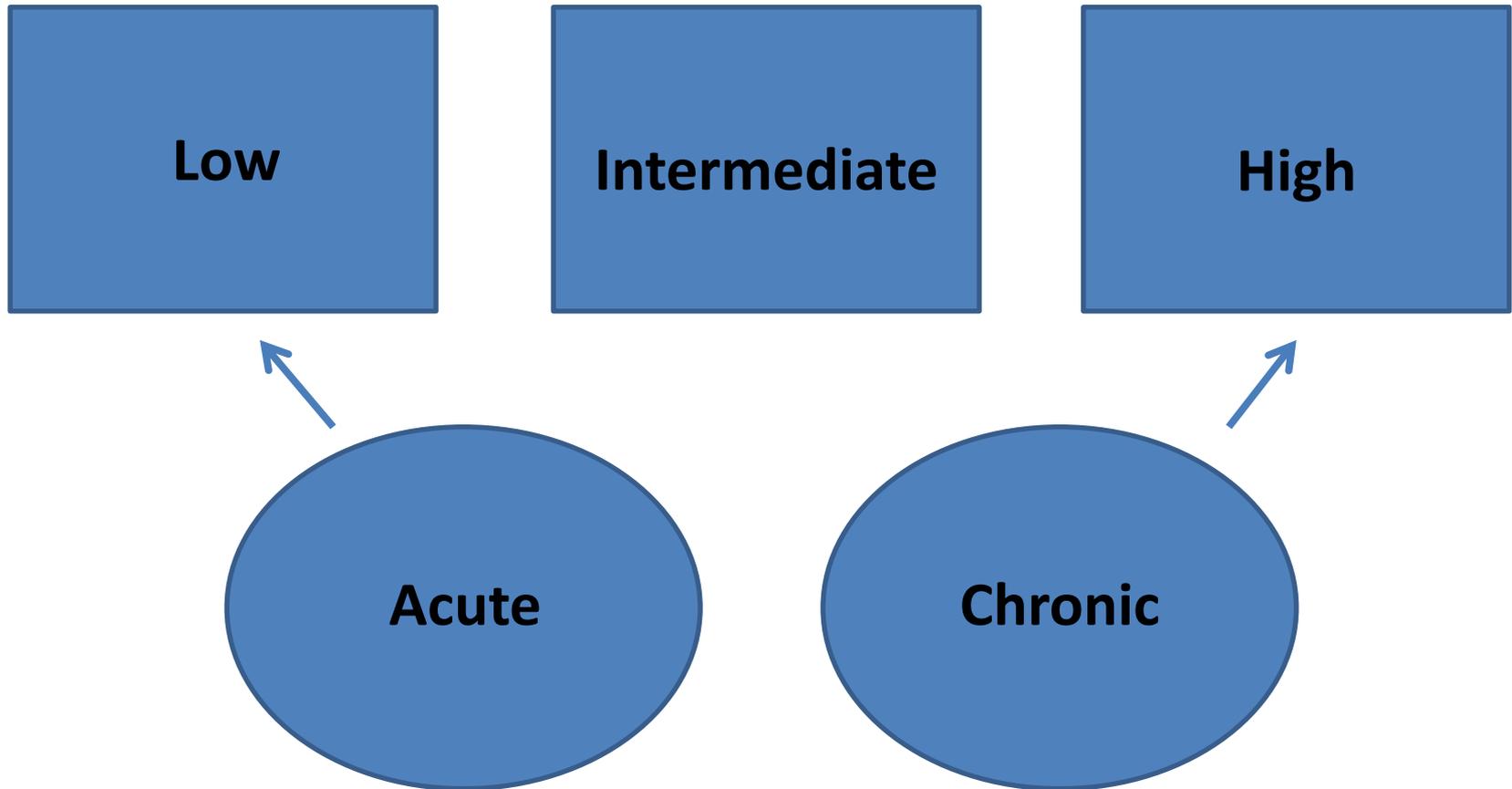
- History of **managing stressors without resorting to SI**
- Typically absent: history of SDV, chronic SI, tendency toward impulsive/risky behaviors, severe/persistent mental illness, marginal psychosocial functioning



What's the Risk?

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Stratify Risk – Severity & Temporality



Risk Assessment and Formulation: Documentation

Ideation → Intent → Plan → Access to Means

X is presently considered to be at **LOW ACUTE RISK** for SDV given that her mood is stable and SI is at baseline. Furthermore, she denies current intent and plan for suicide and has additional markers indicative of current psychosocial stability (e.g., stable housing, sustained sobriety). She is regularly using her safety plan and is actively engaged in weekly outpatient therapy.

X is presently considered to be at **HIGH CHRONIC RISK** for SDV given her chronic SI, past SDV, mental health diagnoses (borderline personality disorder, history of substance dependence), limited coping skills, and demographic factors (e.g., family history of suicide).



4. Develop and Document a Safety Plan



“No-Suicide Contracts”

- Typically entails a patient agreeing to not harm themselves
- Despite a lack of empirical support, commonly used (up to 79%) by mental health professionals
- Not recommended for multiple reasons
 - No medicolegal protection
 - Negatively influences provider behavior
 - Not patient-centered

Drew, 1999; Range et al., 2002; Rudd et al., 2006; Simon, 1999

Safety Planning

- Brief clinical intervention
- Follows risk assessment
- Hierarchical and prioritized list of strategies
- Used preceding or during a suicidal crisis
- Involves collaboration between the client and clinician

SAFETY PLAN	
Step 1: Warning signs:	
1.	<u>Suicidal thoughts and feeling worthless and hopeless</u>
2.	<u>Urges to drink</u>
3.	<u>Intense arguing with girlfriend</u>
Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:	
1.	<u>Play the guitar</u>
2.	<u>Watch sports on television</u>
3.	<u>Work out</u>
Step 3: Social situations and people that can help to distract me:	
1.	<u>AA Meeting</u>
2.	<u>Joe Smith (cousin)</u>
3.	<u>Local Coffee Shop</u>
Step 4: People who I can ask for help:	
1.	Name <u>Mother</u> Phone <u>333-8666</u>
2.	Name <u>AA Sponsor (Frank)</u> Phone <u>333-7215</u>
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician Name <u>Dr. John Jones</u> Phone <u>333-7000</u> Clinician/Pager or Emergency Contact # <u>555-822-9999</u>
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Local Hospital ED <u>City Hospital Center</u> Local Hospital ED Address <u>222 Main St</u> Local Hospital ED Phone <u>333-9000</u>
4.	Suicide Prevention Lifeline Phone: <u>1-800-273-TALK</u>
Making the environment safe:	
1.	<u>Keep only a small amount of pills in home</u>
2.	<u>Don't keep alcohol in home</u>
3.	_____

Stanley, B., & Brown, G.K. (with Karlin, B., Kemp, J.E., & VonBergen, H.A.). (2008). *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*.



Safety Plan Steps

1. Warning Signs
2. Internal Coping Strategies
3. Social Contacts and Settings for Distraction
4. People Who I Can Ask for Help
5. Professionals and Agencies to Contact for Help
6. Making the Environment Safe



Enhancing Patient Use of the Safety Plan

- Increase access
- Personalize
- Encourage regular practice
- Share with others
- Update regularly
- Use technology

Smartphone Applications



Safety Plan

- Coming soon!
- Includes built in coping strategies and quick links for reaching out for help
- <http://www.myvaapps.com/>

Smartphone Applications



Virtual Hope Box

- VHB contains simple tools to help patients with coping, relaxation, distraction and positive thinking
- <http://www.myvaapps.com/>

Safety Planning Resources for Providers

Safety Plan Treatment Manual to Reduce Suicide Risk

http://www.mentalhealth.va.gov/docs/va_safety_planning_manual.pdf

Safety Plan Quick Guide for Clinicians

<http://www.mentalhealth.va.gov/docs/VASafetyPlanColor.pdf>



Thank you!

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Rocky Mountain MIRECC Website

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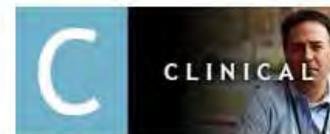
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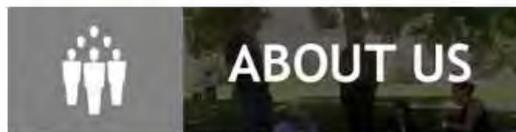
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Suicide is complex but it is also preventable. Beyond treating Veterans in crisis there are so many ways to tackle this. When you look at the topics we investigate, from gut bacteria to community gatherings, you see the possibilities.





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5. Questions and Comments