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A SERVICE OF RIVERSIDE COMMUNITY CARE

1

Understanding Suicide 101 Course for DDS Service Coordinators

presented by:

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2

Housekeeping / Logistics

- Plan for our time together
- Cell phones/texts (or mute microphone)
- Not tx focused
- Self-care for today

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Course Objectives

- Describe the scope of the problem.
- Provide a clinically accurate definition of suicide.
- Manage personal reactions to suicidal clients.
- Review suicide warning signs and risk and protective factors.
- Identify ways to elicit suicidal ideation and history of behaviors.
- Identify strategies and tools to better understand risk, especially in the context of a person served by DDS
- Practice use of safety plan tool
- Understand ambivalence around suicide and the idea of suicide as a coping strategy.

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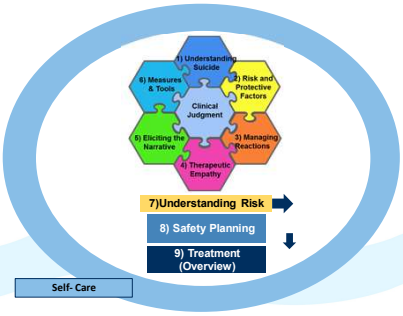
Suicide Assessment and Intervention Training



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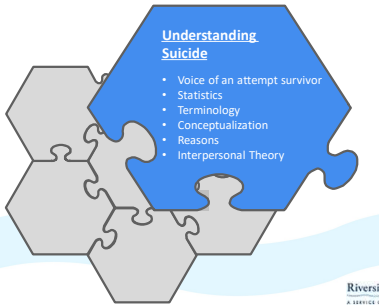
Module 1: Understanding Suicide



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Craig Miller

Survived a suicide attempt at 20 years old and has written a book about his experience entitled "This is How it Feels: Attempting Suicide and Finding Life"

www. thisishowitfeels.com

- Began thinking of suicide at age 8
- Early experiences with mental health
- Suicidal thoughts became a coping mechanism

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A Major Public Health Issue Nationally

- In 2020: **45,855 suicide deaths** in the US (SAMHSA 2021)
- **10th leading** cause of death (www.cdc.gov)
- Over 90% of people who die by suicide suffer from a **diagnosable mental illness** – most often **depression**. (Mann, Michel, & Auerbach, 2021)

…**AND**…

- It is important to emphasize that there is no single cause for suicide – it is always a **complex, multi-factorial event**

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A Major Public Health Issue in Massachusetts

615 suicide deaths in 2020, down from 642 in 2019 (preliminary data, www.mass.gov)

From 2009-2019, the MA suicide rate **increased** by 13%

MA is 49th of the states in terms of suicide rate in 2019 (cdc.gov)

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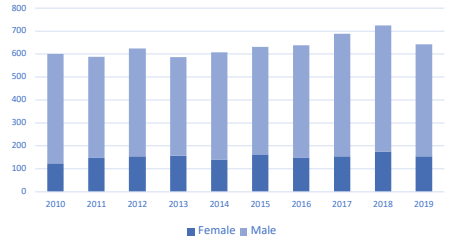
Suicide Rates by Sex in MA, 2009-2019



Massachusetts Violent Death Reporting System (MAVDRS), Massachusetts Department of Public Health; National Center for Health Statistics Vintage 2019 postcensal estimates

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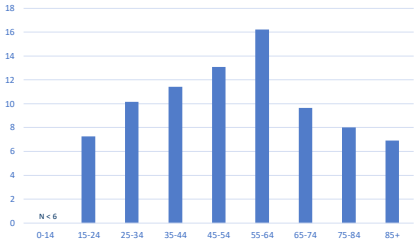
Suicide Rates by Age in MA, 2019



Massachusetts Violent Death Reporting System (MAVDRS), Massachusetts Department of Public Health

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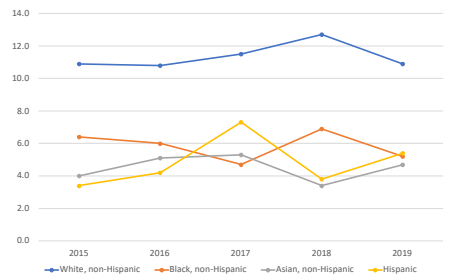
Suicide Rates by Ethnicity in MA, 2015-2019



Massachusetts Violent Death Reporting System (MAVDRS), Massachusetts Department of Public Health; National Center for Health Statistics Vintage 2019 postcensal estimates

12

Even Young Children Know About Suicide

Mishara

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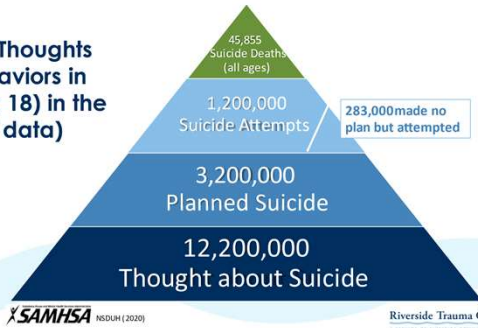
Suicidal Thoughts and Behaviors in Adults (≥ 18) in the US (2020 data)



SAMHSA NSDUH (2020)

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The Language of Suicide

- Is it a crime? a sin?
- Can you be "successful" at suicide?
- What is a suicidal gesture?

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The Language of Suicide

Lack of clarity regarding definitions and concepts about suicidal behavior results in misunderstandings about the seriousness of attempts:

- Some commonly used terms may convey unwanted "value judgments" and contribute to the stigma of suicide.
- Events that should be called suicide or suicidal may be missed.
- Events may be inappropriately called "suicidal."
- Difficulty in communicating about the meaning of suicidal occurrences may lead to misdiagnosis and mistreatment.
- Efforts to research causes and treatments for suicide are hampered.

CDC Crosby, Ortega, & Melanson (2011)

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The Language of Suicide: Definitions

- **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- **Suicide attempt:** A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
- **Suicidal ideation:** Thoughts of engaging in suicide-related behavior.

CDC Crosby, Ortega, & Melanson (2011)

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How Do We Clinically Understand Suicide?

Suicide is an attempt to solve the problem of intense psychological pain and hopelessness.

Adapted from Schneidman (1985)

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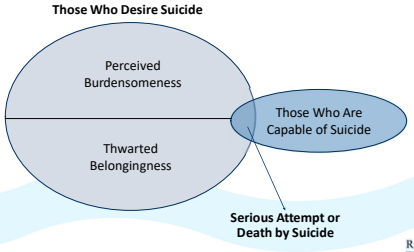
Interpersonal-Psychological Theory of Suicidal Behavior



Joiner et al. (2009)

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Three-Step Theory

Klonsky & May (2015)

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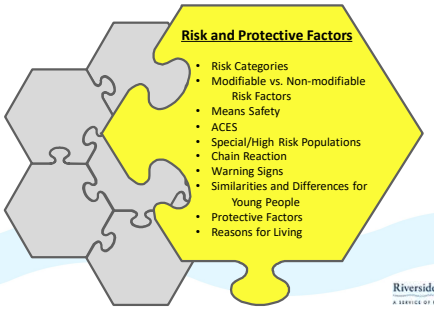
20

Module 2: Risk Factors, Warning Signs & Protective Factors



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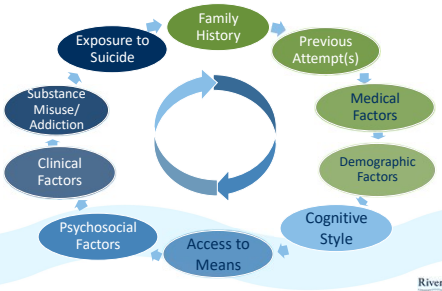
21

Risk Categories



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Means Safely

15 U.S. States with the Highest vs. 6 U.S. States with the Lowest Average Household Gun Ownership (2000-2002)

	High Gun States	Low Gun States
Population	39 million	40 million
Gun Ownership	47%	15%
Firearm Suicide	9,749	2,606
Non-Firearm Suicide	5,060	5,446
Total Suicide	14,809	8,052

- Many suicide attempts occur with little planning during a short-term crisis.
- Intent isn't all that determines whether someone who made an attempt lives or dies; means also matter.
- 90% of people who make an attempt who survive do NOT go on to die by suicide.

Miller, et al. (2007); www.hsph.harvard.edu/means-matter/

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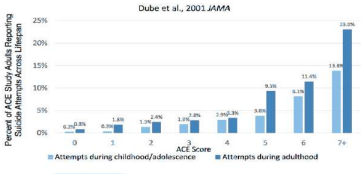
Adverse Childhood Experiences



- 80% of suicide attempts during childhood/adolescence were attributable to ACEs.
- Childhood and adolescent suicide attempts increased 51-fold, or 5,100% with an ACE score of 7 or more.

CDC

Dube et al. (2001)

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How Does a Suicide Occur?

Underlying Vulnerability

eg: mood disorder, substance abuse, aggression, anxiety, family history, sexual orientation, trauma, low serotonin

↓

Stress Event

(Often caused by underlying vulnerability) eg: trouble with law or school, loss, etc

↓

Acute Mood Change

eg: anxiety, dread, hopelessness, anger

Inhibition:	Facilitation:
Strong taboo, available support, slowed down mental state, presence of others	Weak taboo, method/weapon available, recent example, agitation, being alone
↓	↓
SURVIVAL	SUICIDE

Shaffer (1996); Gould (2001-2006)

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WARNING SIGNS OF SUICIDE:

The behaviors listed below may be some of the signs that someone is thinking about suicide.

TALKING ABOUT:
- Wanting to die
- Great guilt or shame
- Being a burden to others

FEELING:
- Empty, hopeless, trapped, or having no reason to live
- Extremely sad, more anxious, agitated, or full of rage
- Unbearable emotional or physical pain

CHANGING BEHAVIOR, SUCH AS:
- Making a plan or researching ways to die
- Withdrawing from friends, saying good bye, giving away important items, or making a will
- Taking dangerous risks such as driving extremely fast
- Displaying extreme mood swings
- Eating or sleeping more or less
- Using drugs or alcohol more often

If these warning signs apply to you or someone you know, get help as soon as possible, particularly if the behavior is new or has increased recently.

National Suicide Prevention Lifeline 1-800-273-TALK

Crisis Text Line Text "HELLO" to 741741

NIH National Institute of Mental Health

www.nimh.nih.gov/suicideprevention

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Communication of Intent

Studies have indicated that, on average, 45% of people communicate intent prior to making a suicide attempt or dying by suicide

In most cases these communications are behavioral or coded rather than direct threats.

Pompili, et.al. 2016

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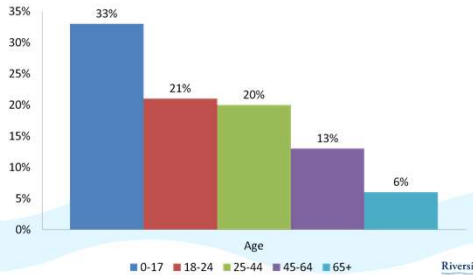
26

Impulsivity



Barber & Miller (2010)

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Protective Factors

- Availability of Physical and mental health care
- Restrictions on lethal means of suicide
- Safe and supportive school and community environments
- Sources of continued care after psychiatric hospitalization
- Connectedness to individuals, family , community, and social institutions
- Supportive relationships with health care providers
- Coping and problem solving skills
- Reasons for living (e.g. children in the home)
- Moral objections to suicide

2012 National Strategy for Suicide Prevention

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"People always asked me why I wanted to die… Nobody ever asked me why I wanted to live."

(Miller, 2013)

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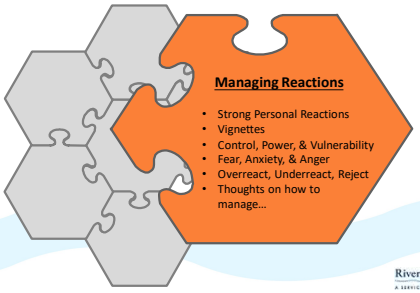
30

Module 3: Managing Reactions



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"When my therapist found out I had slit my wrists she fired me over the telephone… nothing gets rid of people like a suicide attempt."

- Ella Wilson, "Came Down a Person,"
in Same Time Next Week: True Stories of Working Through Mental Illness,
ed. Lee Gutkind, 2015

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Suicide Engenders Strong Personal and Emotional Reactions

- "I am so frustrated with (this client)"
- "I'm afraid if I ask him about suicide I may give him the idea"
- "I get a knot in my stomach every time I go to their home"
- "I'm relieved when they postpone a meeting"
- "I don't have enough experience or training to know if there's a real risk"
- "He needs a more intensive setting"
- "He's just being manipulative"
- "Suicide is cowardly… Selfish…"
- "This situation is just hopeless"
- "If he dies his family will sue me and I will lose my job"

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Vignette

Jorge is a 25-year-old man you have known and worked with for the past two years. He works in a supported employment setting in the community. You recently spoke with his parents, with whom he lives. They mentioned that he was talking about wishing he was dead, but they told you he's talked like that for years. "He just does that to get attention," his father said.

You set at time to visit Jorge during his lunch break, and he tells you the following:

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Case Study: Jorge

Well once again I tried to kill myself, and once again I failed. More proof I can screw anything up. When I told my family I wanted to kill myself, they all laughed. I just went to my bedroom and hit myself on my head twelve times before I started to feel better. Right now, that is the only thing that makes me feel better at all. Work is no better. It reminds me of school where I was bullied since I was in the second grade. Every day is a living hell. I try to be friendly to people at work but no one is friendly back. I love helping people so much that I would give up my life if someone needed it. But for now I feel dead inside. It won't be much longer before I'm dead on the outside as well.

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Vignette

Janice is a 40-year-old person who has struggled with thoughts of suicide for many years. Recently, you helped her to find a new therapist at the local mental health center, after her previous therapist moved to a private practice and stopped accepting insurance payments. You agreed to accompany Janice to the first couple of meetings with the new therapist. After about 20 minutes, the topic of suicide comes up.

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Managing Your Reactions

- Power and control issues
- If the client dies it is the worker's fault
- An attempt may feel like betrayal to the professionals involved – especially if long-term relationship.
- Others

Michel & Jobes (2011)

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Emotional Reactions Lead to Mistakes

- **Overreact** and perhaps impose unnecessary external controls or reactions.
- **Underreact** and perhaps deny the need for protective measures.
- **Reject** or abandon the person.

Bryan (2014)

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Thoughts on How to Manage Reactions

- Affect Management tools/skills
- Maintain a "low-key dispassionate demeanor" (Walsh, 2012)
- "Notice" don't judge your reactions
- Pay attention to your body language
- Monitor your breathing
- Don't worry alone – regular supervision

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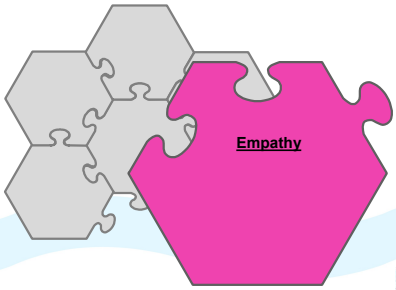
39

Module 4: Developing Empathy for the Suicidal Wish



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Imagine Being in So Much Pain that You Were Thinking About Ending Your Life…

- Would you tell anyone?
- Whom would you tell?
- How would you tell them?
- How many times would you tell them?
- What if they didn't respond, changed the subject, or told you to stop being so dramatic?

Adapted from QPR Institute

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Why People Attempt Suicide

What mental health professionals have said:

- "it's manipulative"
- "to communicate hostility"
- "to frighten someone"
- "to make someone feel sorry"
- "to show desperation"

What clients say:

- " To get relief from a terrible state of mind"
- " To escape from an impossible situation"

www.aeschiconference.unibe.ch

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Different Goals

Mental Health/ Social Service professionals: Keep person safe, focus on parent capacity, prevent death, don't get blamed

Suicidal person: Alleviate suffering/emotional distress

Adapted from Bryan (2014)

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43

This Discrepancy Results In…

People not contacting providers when they are in crisis because they perceive them as "unhelpful."

Adolescents have a stronger reaction:

- "I will be labeled as pathological or irrational"
- "I will keep my inner thoughts to myself"

www.aeschiconference.unibe.ch

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Resolving the Discrepancy

1) Understand that the person thinking of suicide engages in harmful behaviors because they "make sense" and they work.
2) Recognize the functional purpose of the behaviors.
3) View the person as an individual with a unique set of issues and circumstances.
4) Listen to the person's "story."

Adapted from Bryan (2014)

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The Aeschi Approach

The clinician may be the expert on mental disorders but "when it comes to the client's suicidal story the client is the expert" – Michel and Jobes

Our task is to develop a "therapeutic empathy for the suicidal wish" – Israel Orbach

Michel and Jobes (2011)

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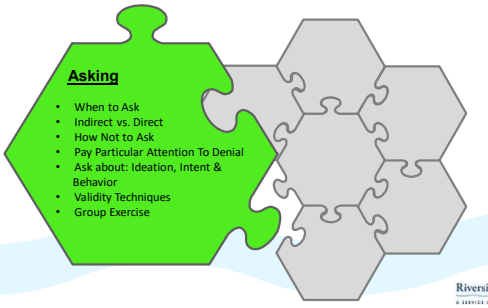
46

Module 5: Asking About Suicide



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When to Assess for Suicidal Thoughts/Behaviors

- At initial intake
- With any subsequent suicidal behavior
- Increased ideation
- With pertinent clinical change
- Transitions
  - Changes in living situations
  - Vacations
  - Rx Changes
- Discharge (inpatients)

Adapted from Jacobs (1999)

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Indirect vs. Direct

Indirect:

- "Do you wish you would go to sleep and not wake up?"
- "Do you wish you were dead?"

Direct:

- "Have you thought about killing yourself?"
- "Have you had thoughts about suicide?"

Shea (2002)

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How NOT to Ask the Question

"You're not thinking about suicide, are you?"

Quinnett (2000)

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Why Not?

"Have you thought about hurting yourself?"

Quinnett (2000)

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Looking Beyond Ideation

Why might someone deny suicidal ideation?

- Fear of loss of autonomy
- Fear of negative judgment or stigma
- Belief that they cannot be helped
- Belief that it is a sign of weakness
- Fear of disappointing others
- Unclear wording of the question
- Poor comprehension of the question
- Not thinking of suicide at that moment

Adapted from Berman (2014)

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What to Ask: Ideation, Intent, & Behavior

Intent:

- Assess for evidence of wish to die
- Means to kill him/herself
- Understanding of the probable consequences of his/her actions

VA/DoD (2013)

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What to Ask: Ideation, Intent, & Behavior

Behavior:

Assess if the person has engaged in any actual behavior of preparation for engaging in self-directed violence.

VA/DoD (2013)

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Validity Techniques

- Normalization
- Gentle Assumption
- Symptom Amplification

Shea (2002)

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Validity Techniques: Normalization

"Sometimes when people feel as bad as you feel it crosses their mind to kill themselves. Have you had any thoughts like that?"

"Sometimes when people feel as depressed as you do, they might feel they would rather be dead. Have you ever felt that way…?"

Shea (2002)

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Validity Techniques: Gentle Assumption

Rather than:

"Have you thought about other ways to kill yourself?"

Instead:

"What other ways have you thought about killing yourself?"

Shea (2002)

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Validity Techniques: Symptom Amplification

"You mentioned you think about suicide often… How many times a day do you think about it?... 50 times a day? 100 times a day?"

Shea (2002)

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Practice Asking the Question…

You are out for a walk with Jorge during a visit. He seems down but when you ask, he says, "no, I'm just tired. I'm tired all the time." He mentions that he has been engaging in a few incidents of hitting himself on the head after not doing so for several months. He further says he is really getting tired of arguing with his parents and is worried he may be doing poorly at his supported work placement.

Shea (2002)

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59

Group Exercise

- Vignette
- Pair up – one person is Jorge, one is Service Coordinator
- Ask directly about suicide
- Employ at least two Validity Techniques:
  - Normalization
  - Gentle Assumption
  - Symptom Amplification
- Switch roles

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60

Collateral Sources

Try not to do your assessment in a vacuum! What are your usual sources for collateral information?

- Previous Emergency Service summary
- Contact with therapists
- Contact with PCP
- Family/friends
- Schools/Clubs/Etc…

Possible challenges/obstacles in accessing collateral information?

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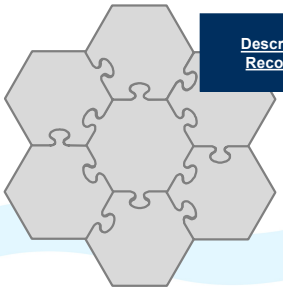
61

Module 7: Describing Risk and Recommendations



Describing Risk and Recommendations

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62

When a therapist describes risk, they should be considering:

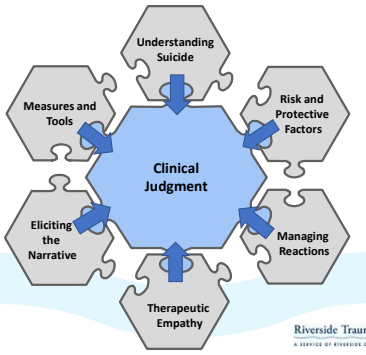
Low?

Moderate?

High?

Chronic?

Acute?



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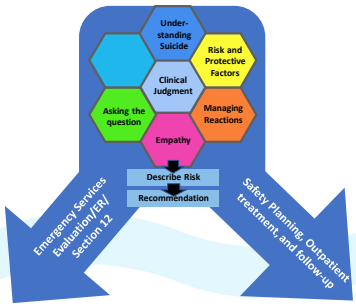
Now What? For DDS Professionals:



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Understanding Risk and Recommendations

Risk Level	Risk/Protective Factors	Suicidal Thoughts/Behaviors	Possible Interventions
High	Psychiatric disorders w/ severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan but no intent or behavior	Admission may be necessary depending on risk factors. Safety Plan.
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction, Safety Plan

This chart is intended to represent a range of risk levels and interventions, not actual determinations.

Adapted from Jacobs (2007)

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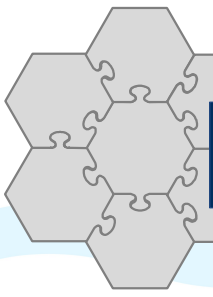
65

Module 8: Suicide Safety Planning



Crisis Intervention & Safety Planning

- Crisis Intervention Techniques
- Safety Planning
- Safety Planning Activity/Discussion

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Principles of Suicidal Crisis Intervention

- Restricting access
- Decreasing isolation
- Decreasing agitation
- Providing/increasing structure
- Providing hope and reality testing
- Developing a suicide safety plan

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…So promise me you won't kill yourself…

- Safety planning vs. contracting for safety
- No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive.
- No-suicide contracts may provide a false sense of assurance to the clinician.
- No evidence "no suicide" contracts work

Stanley & Brown (2011)

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Suicide Safety Plan: What is It? How Can You Help Support It?

- Hierarchically-arranged list of coping strategies for use during a suicidal crisis or when suicidal urges emerge
- Written document
- Brief, easy-to-read format
- In client's own words
- Collaboratively developed with the client in any clinical or therapeutic setting. Families and DDS staff may provide input.

Stanley & Brown (2011); Brown & Wenzel (2011)

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69

Safety Planning: When is It Appropriate?

- A safety plan may be done at any point during the assessment or treatment process
- Usually follows a suicide risk assessment
- A safety plan may not be appropriate when patients are at imminent suicide risk or have profound cognitive impairment.
- Adapt the approach to the client's needs – such as involving family members in using the safety plan.

Stanley & Brown (2011)

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Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with family members or others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help to resolve a crisis
5. Contacting mental health professionals or agencies.
6. Reducing the potential use of lethal means

Additional question:
"The one thing that is most important to me and worth living for is:_____"

Stanley & Brown (2011)

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71

Step 1: Recognizing Warning Signs

- A safety plan is only useful if the client can recognize the warning signs and describe the "arc" of their crises.
- *"How will you know when you need to use your safety plan?" How can caregivers help identify when to use?*
- *"What do you experience when you start to think about suicide or feel extremely distressed?"*
- Examples
  - Automatic Thoughts: "I am a nobody,""I hate my life"
  - Images: "Flashbacks"
  - Mood: "Feeling depressed"
  - Behavior: "Crying""Isolating myself""Using drugs"

Stanley & Brown (2011)

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72

Step 2: Using Internal Coping Strategies

- List activities that person can do by themselves.
- Activities function as a way to help people take their minds off their problems and promote meaning in their life.
- *"How likely do you think it is that you would be able to do this during a time of crisis?"*
- *"What might stand in the way of you thinking of these activities or doing them if you think of them?"*
- Use a collaborative, problem solving approach to address potential roadblocks.

Go for a walk	Listen to music
Take a hot shower	Walk the dog

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73

Step 3: Using External Strategies: Socializing with Family Members or Others

- Coach clients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Family, friends, or acquaintances who may offer support and distraction from the crisis
- *"Who helps you take your mind off your problems at least for a little while?"*
- *"Who do you enjoy socializing with?"*
- Ask clients to list several people, in case they cannot reach the first person on the list.

Stanley & Brown (2011)

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Step 4: Seeking Support: Contacting Family Members or Friends for Help

- Coach clients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- *"How likely would you be to contact these individuals?"*
- Identify potential obstacles and problem solve ways to overcome them.

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75

Step 5: Contacting Professionals and Agencies

- Coach clients or caregivers to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- *"Which clinicians should be on your safety plan?"*
- Identify potential obstacles and develop ways to overcome them.
- List names, numbers and/or locations of:
  - Clinicians
  - Local urgent care services
  - Text lines/ helplines

Stanley & Brown (2011)

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76

Step 6: Reducing the Potential for Use of Lethal Means

- Ask clients/ (caregivers) what means/method they would consider using during a suicidal crisis.
  - Regardless, the social worker should always ask client and caregivers whether the client has access to a firearm.
- For methods with low lethality, clinicians may ask adult clients to remove or restrict their access to these methods themselves.
  - For example, if patients are considering overdosing, discuss throwing out any unnecessary medication, using lockbox, etc.
- For methods with high lethality, collaboratively identify ways for a responsible person (eg: caregivers) to secure or limit access.
  - For example, if clients are considering shooting themselves, suggest that they ask a trusted family member to store any gun that is in the home in a secure place- preferably outside the home.

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Safety Plan — Alicia

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. When I start thinking my family hates me
2. When I'm thinking about kids being mean to me
3. When I start getting urges to cut

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. Listen to music
2. Watch videos on You Tube
3. Get out of the house- go for a walk and listen to my music

Step 3: People and social settings that provide distraction:

1. Name Text with my friend, Daniela Phone
2. Name Call Alex Phone
3. Place See who's posting on Instagram 4. Place

Step 4: People whom I can ask for help:

1. Name Isabella- my cousin Phone
2. Name School counselor Phone
3. Name Phone

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Phone
   Clinician Pager or Emergency Contact #
2. Clinician Name Phone
   Clinician Pager or Emergency Contact #
3. Local Urgent Care Services
   Urgent Care Services Address
   Urgent Care Services Phone
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. Keep sharp things out of my room
2.

The one thing that is most important to me and worth living for is:
I really want to get a job and move out of here some day

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78

Implementation: What is the Likelihood of Use?

- *"Where will you keep your safety plan?"*
- *"How likely is it that you will use the Safety Plan when you notice the warning signs that we have discussed?"*
- *"What might get in the way or serve as a barrier to your using the safety plan?"*
  - Help the client find ways to overcome these barriers.
- May be adapted for brief crisis cards, cell phones or other portable electronic devices must be readily accessible and easy-to-use.
- Can caregiver support and keep person safe?

Stanley & Brown (2011)

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Safety Plan Implementation

- Periodically review, discuss, and possibly revise the safety plan after each time it is used.
- The plan is not a static document.
- It should be revised as the clients' circumstances and needs change over time.
- Decide with whom and how to share the safety plan. Involve DDS/ therapist/ school/ family
- Discuss the location of the safety plan.
- Discuss how it should be used during a crisis.

Stanley & Brown (2011)

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80

Safety Planning Practice

Jorge: is a 25 year old who has recently been talking with you about thoughts of suicide. He was hospitalized as an adolescent for a suicide attempt.

- One person is Jorge and the other is the Service Coordinator
- Practice collaboratively developing a safety plan.
- Switch roles. (when halfway, switch but continue from where you left off)

Stanley & Brown (2011)

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Case Study: Jorge

Well once again I tried to kill myself, and once again I failed. More proof I can screw anything up. When I told my family I wanted to kill myself, they all laughed. I just went to my bedroom and hit myself on my head twelve times before I started to feel better. Right now, that is the only thing that makes me feel better at all. Work is no better. It reminds me of school where I was bullied since I was in the second grade. Every day is a living hell. I try to be friendly to people at work but no one is friendly back. I love helping people so much that I would give up my life if someone needed it. But for now I feel dead inside. It won't be much longer before I'm dead on the outside as well.

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82

Module 9: Overarching Principles of Treatment

Overarching Principles of Treatment

- Spectrum of Intervention
- Targeting Suicide as Focus of Tx
- Symptom Matching
- Modalities: CBT, DBT, MI
- Enhancing Resilience

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83

Targeting Suicide as the Focus of Treatment

Traditional Treatment:

- Inpatient hospitalization
- Treating the psychiatric disorder
- Using no suicide contracts…

Collaborative Approaches to Suicide Treatment:

- Intensive outpatient care that is suicide-specific
- Emphasizes the development of other means of coping and problem-solving thereby systematically eliminating the need for suicidal coping…

Jobes (2006)

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84

Symptom Matching / Distillation of Risk Factors

Symptom	Intervention
Insomnia	*Sleep hygiene, Stimulus control*
Anhedonia or Sadness	*Behavioral activation*
Agitation	*Relaxation, Exercise, Benzodiazepines*
Loneliness	*Behavioral activation w/ an interpersonal focus*
Hopelessness	*Engage in pleasant activities*
Anxiety	*Exercise, Distraction*

Adapted from Joiner, et al. (2009)

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85

Interventions / Approaches

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Motivational Interviewing
- Collaborative Assessment and Management of Suicidality (CAMS)
- Attachment-Based Family Therapy
- Pharmacotherapy

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86

Virtual Hope Box

Focuses the user on cherished memories, reminders in digital media: Photos, videos, recorded messages, music.

Distraction pieces for the user: Activity Planner, and puzzles/word search games taken from user content.

Relaxation pieces, such as a deep breathing tool, progressive muscle relaxation, etc.

User customized support contacts, hotline info.

Preloaded inspirational quotes can be supplemented or replaced by personal quotes, family aphorisms, biblical phrases, etc.

Coping Cards highlight adaptive thoughts and behaviors when in crisis or managing problematic core beliefs.

msrc.fsu.edu/funded-research/improved-virtual-hope-box

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87

Pharmacotherapy

- Evidence for medicine is limited: most clinical trials exclude suicidal patients
- Psychopharm interventions are helpful in managing underlying disorders
- Must be targeted to a specific diagnosis
- All medicines used by at-risk clients should be reviewed for lethality, side effects (ie – black box warning)
- Clients of all ages – esp 18-24 – started on any medicine should be monitored closely for emergence or worsening of suicidal thoughts or behaviors during the initial trial period
- Consider limiting quantities in cases where there is a risk of overdose- how do you support safety?

VA/DoD (2013)

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88

Pharmacotherapy

- Antidepressants may provide benefit to address suicidal behavior in clients with mood disorders
- Lithium is particularly effective in reducing suicide risk for those with bi-polar disorder
- Clozapine should be considered for those clients with schizophrenia at high risk of suicide
- Anti-anxiety agents may have the potential to decrease suicide risk for those clients with anxiety but require extreme caution (due to risk of overdose as well as possibility for disinhibition)

VA/DoD (2013)

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89

Key Goals for Prevention and Protection

+ PROSOCIALITY

Supportive social networks
Empathy and concern about the welfare and rights of others

- TOXIC INFLUENCES

Biological, Psychological, Social, Environmental, Cultural

+ CORE CAPABILITIES

Executive Functioning - Problem solving, response inhibition, working memory, task switching, etc.
Self-Regulation – Psychological flexibility, managing emotions, etc.

Adapted from Center on the Developing Child (2017); Biglan, et al. (2012)

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Key Goals for Prevention and Protection

- Reduce Pain
- Increase Hope
- Increase Connections
- Decrease Capability

Klonsky & May (2015)

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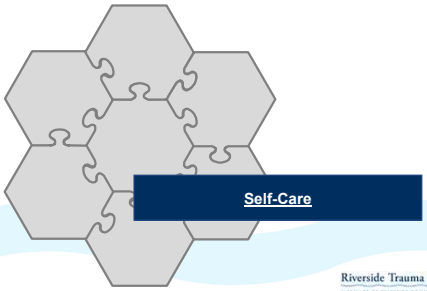
91

Module 12: Compassion Fatigue and Self-Care



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92

Self-Care as an Ethical Obligation

"We can't teach what we don't know.
We can't lead where we won't go."
- Malcolm X

"If you don't live it, it won't come out of your horn."
- Charlie Parker

VA/DoD (2013)

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93

Self-Care the 3Rs

1) Reflection
- Take time to reflect on the clients you are working with, your relationships with them, and what assistance that you might need
- What are they doing, and why? What is their behavior telling you?

2) Regulation
- Acknowledge and regulate the reactions that working with suicidal clients might evoke in you
- Be aware that strong emotions are contagious
- Know what your own trigger points are and what upsets you
- Take time to calm yourself when you do get angry or hurt and ask for help and debrief when necessary

3) Relaxation
- Make time for yourself to relax and "play"
- Maintain/develop your social support system
- Maintain a sense of humor
- Be patient and realistic with yourself

Reminder: Take Care of Myself

Adapted from State of Victoria, Child Safety Commissioner (2007)

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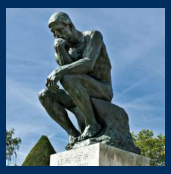
94

The Takeaway



Your takeaways?

New learnings?

What have you been doing that was reinforced?

Something you want to change in your work?

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96

Understanding Suicide -101

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97

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98