“I not only use all the brains that I have, but all that I can borrow”

WOODROW WILSON

Understanding Suicide

THE FUNDAMENTALS OF THEORY, INTERVENTION, AND TREATMENT OF A SUICIDAL CLIENT

OBJECTIVES

- Gaining knowledge of suicide statistics
- Importance of the LANGUAGE OF Suicidology
- Review what is known about suicide risk and warning signs
- UNDERSTANDING research-based mental health Assessments and Treatments
- Identify relevant resources available to practitioners

PART I

FACTS AND STATISTICS

Why People Die by Suicide
by Dr. Thomas Joiner

Pg. 25 of Dr. Joiner's book

Something to think about :

Outdoor soccer game…Five full fields of play going on….spectators present for each game….approx. 150 people.

In the distance, lighting struck……field officials decided to cancel the games going on…grumbling about the decision but of course everyone understood the rationale…..lightning can be lethal. How lethal is it? Eighty deaths per year from lightning strikes!

During the same time period there were MORE than eighty deaths per DAY from SUICIDE

STATISTICS

- More than 43,00 people died by suicide in the U.S. yearly
- An average of 108.3 individuals per day will die by suicide
- There are twice as many deaths due to suicide than HIV/AIDS

(CDC, 2014; AAS, 2015)

STATISTICS

- AVERAGE OF ONE AMERICAN DIES BY SUICIDE EVERY 12.3 MIN.
- SUICIDE RANKS 10TH IN CAUSE OF DEATH
  HOMICIDE RANKS 16TH

(CDC, 2014; AAS, 2015)

STATISTICS

- 1 in 65,000 children ages **10 to 14** will complete suicide each year.
- One Youth (ages 15-24) completes suicide every 1 hour and 43 min. which is about 13 each day
- SUICIDE IS THE 2ND LEADING CAUSE OF DEATH FOR YOUTH (AGES 15-24)

(CDC, 2014; AAS 2015)

ATTEMPTS STATISTICS

- There are an estimated 100 ATTEMPTS to suicide to EVERY ONE completion

- AMERICANS ATTEMPT SUICIDE AT THE RATE OF 1.1 MILLION PER YEAR

- 3 FEMALE ATTEMPTS FOR EVERY 1 MALE

(CDC, 2014; AAS 2015)

ATTEMPT STATISTICS

2012 SAMHSA study shows that 1.3 MILLION ADULTS (18-up) attempted suicide.

Worldwide.

This translates to one suicide attempt every 32 seconds

(CDC, 2014; AAS, 2015)

STATISTICS

80% of people that seek treatment for depression are treated successfully.

Even greater reason to encourage treatment.

FACTS AND STATISTICS ABOUT SUICIDE AFTERMATH

EACH SUICIDE INTIMATELY AFFECTS AT LEAST 25 OTHER PEOPLE

If there is a suicide every 13.3 min. then there are 25 new survivors every 13.4 min. as well

- DR. JULIE CEREL'S video can be found on University of Kentucky College of Social Work website "why 6?" (Cerel, 2015)

PART II

LANGUAGE OF SUICIDALITY

The Assessment of Management of Suicidality by M. David Rudd

"I want to emphasize the importance of language in clinical practice. We need to be precise in the definitions of language in clinical practice. We need to be precise in the definitions we use; this include how we talk to patients, how we talk to one another, and how we document our assessment and management decisions" (Rudd, 2006,p2)

LANGUAGE COMPLETED VS. COMMITTED

- DECREASES STIGMA
- DECREASES HURT TO SURVIVORS
- ACTUAL DESCRIPTION OF WHAT HAS TRANSPIRED
- EXPLAINS MENTAL HEALTH ISSUES DEALING WITH SUICIDAL THOUGHTS
- SOUNDS AS IF A LAW HAS BEEN BROKEN
- THAT LOVED ONE WAS A CRIMINAL
- HISTORICALLY USED
- LANGUAGE WAS USED WHEN MENTAL ILLNESS WAS DEMONIZED

Language of Suicide

- ACUTE FACTORS
- CHRONIC FACTORS
- LEVEL OF RISK
- TRIGGERS

(Joiner, 2005, Rudd, 2006)

Language of suicide

- SELF-ABUSE
- SUICIDE THREAT
- SELF-INJURY
- MORBID RUMINATIONS
- SELF-DESTRUCTIVE BEHAVIORS
- PSYCHACHE

(Joiner, 2005, Rudd, 2006)

Language of Suicide

- SUICIDE ATTEMPT WITH INJURIES
- SUICIDE ATTEMPT WITHOUT INJURIES
- SUICIDAL IDEATION
- CHRONIC SUICIDALITY

(Joiner, 2005, Rudd, 2006)

“AS A RULE, HE OR SHE WHO HAS THE MOST INFORMATION WILL HAVE THE GREATEST SUCCESS IN LIFE.”

DISRAELI

PART IV

RISK FACTORS

Standard Framework for Suicide Risk Assessment

1. Grounded in empirical research and the science of clinical psychology
2. Modifications can be over time as more information becomes available
3. Can be applied seamlessly and consistently across all patient in your practice
4. Be predictable, blunt, and straightforward with a suicidal patient
5. Provide a firm foundation and predictable process throughout the clinical relationship
6. Consistent, clear, and thorough documentation
7. Accessible, reliable, and well-informed consultation is critical

(Rudd, 2006, p2)

Risk Factors

The most frequently cited risk factors for suicide:

- PTSD
- Mental disorders, in particular: Depression or bipolar (manic-depressive) disorder
- Alcohol or substance abuse or dependence
- Borderline or antisocial personality disorder

- (DSM-5, 2015)

Risk Factors

- Conduct disorder (in youth)
- Psychotic disorders; psychotic symptoms in the context of any disorder
- Impulsivity and aggression, especially in the context of the above mental disorders

Risk Factors

- Anxiety disorders
- Schizophrenia
- Previous suicide attempt
- Family history of attempted or completed suicide
- Serious medical condition and/or pain

Environmental Factors That Increase Suicide Risk

Some people who have one or more of the major risk factors above can become suicidal in the face of factors in their environment:

- A highly stressful life event such as losing someone close, financial loss, or trouble within the legal system
- Exposure to violence, substance abuse, sexual abuse and poverty
- Exposure to war, destruction and death

Environmental Factors that Increase Suicide Risk

Prolonged stress due to adversities such as:

- Unemployment,
- Intimate Partner Violence
- Harassment, Bullying
- Exposure to another person’s suicide
- Graphic or sensualized suicides

PART V

PROTECTIVE FACTORS

Protective factors for suicidal persons

- Receiving effective mental health care
- Positive connections to family, peers, community, and social institutions such as marriage and religion that foster resilience
- The skills and ability to solve problems

PART VI

THEORIES OF SUICIDE

THEORIES OF SUICIDE

THREE PREDOMINANT THEORIES OF “WHY PEOPLE DIE BY SUICIDE”

INTERPERSONAL THEORY OF SUICIDE

Thomas Joiner, Researcher, Professor of Psychology

at Florida State University

FAILED BELONGINGNESS

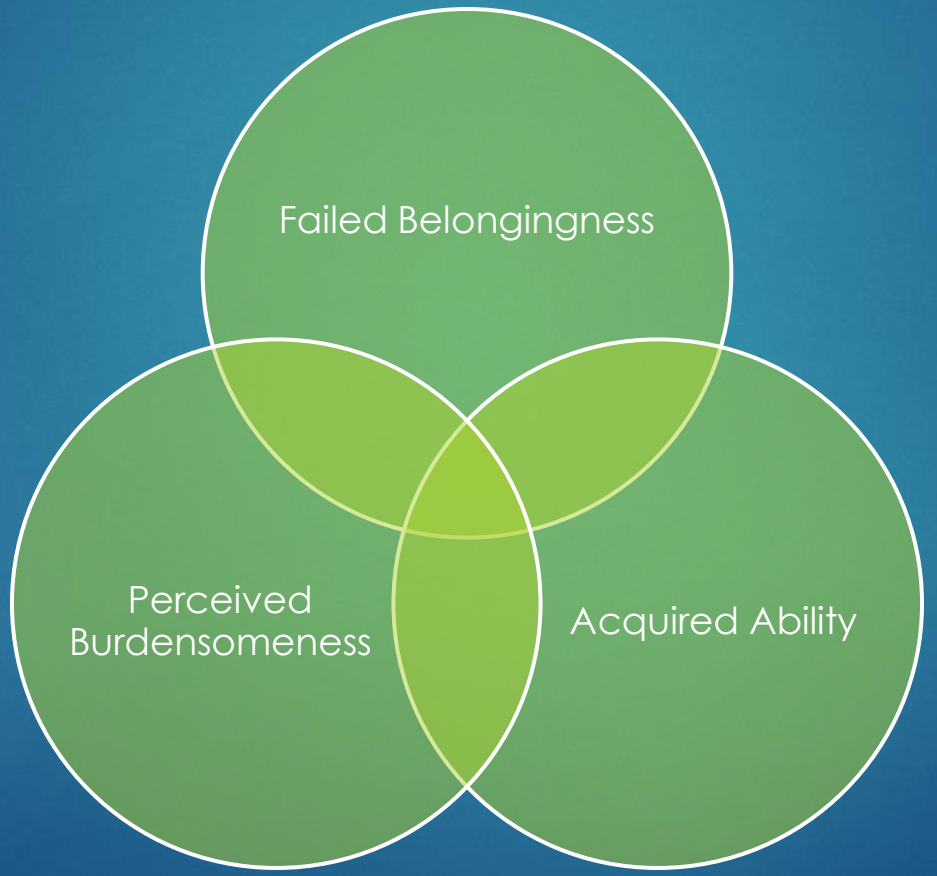
PERCEIVED BURDENSOMENESS

AQUIRED ABILITY

IPT by Dr. Thomas Joiner

- Failed Belongingness and Perceived Burdensomeness are both reflected in Shneidman's "Psych-ache" (Joiner, 2005, p38).
- Both are reflected in the key factor found in research by Beck and colleagues cognitive perspective on suicidality with emphasizes the role of "Hopelessness" (Joiner, 2005, p38).
- Developing framework that is conceptually more precise and epistemically broader, explaining more suicide-related facts (Joiner, 2005, p38).

Joiner's Interpersonal Theory



FLUID VUNDERABILITY

Way to understand the distinctions among ideators, attempters, and multiple attempters (Rudd, 2006) Model that helps us understand the process of risk, short and long term periods (Rudd, 2006).

1. All individuals have a baseline level of risk that varies which relates to personal history and related static factors (Rudd, 2006).
2. Static factors are personal variable that will not change (Rudd, 2006).
3. Multiple attempts create a higher risk baseline (two or more) than those who think about suicide or have made single attempt (Rudd, 2006).
4. It takes less to trigger suicidality in multiple attempters (Rudd, 2006)
5. More severe symptoms, more specific suicidal thoughts, express more intent to die, and symptoms tend to last longer (Rudd, 2006)

FVT emphasizes two primary points

1. MULTIPLE ATTEMPTERS ARE VULNERABLE, FOR ANY NUMBER OF REASONS AND IT TAKES LESS TO TRIGGER AN ACUTE EPISODE OF SUICIDALTIY (RUDD, 2006).

2. SUICIDAL STATES ARE TIME-LIMITED; SUICIDAL INTENT AND ASSOCIATED HEIGHTENED SYMPTOMATOLOGY DO NOT LAST AN INDETERMINATE PERIOD OF TIME (RUDD, 2006).

Core Competencies of Suicidality

Foreseeability

Treatment planning

Follow-up

Core competencies of suicidality

- Documentation: effective, accurate, clinical
- Standard framework: tools/outline
- Suicide risk assessment: best practices tools
- Continuity of care: connecting clients with additional care

Level of training & tool-kit basics

- Natural helpers
- Student in training
- Novice practitioner
- Seasoned clinician

- Standard framework
- Documentation
- Suicide risk assessment
- Documentation
- Continuity of care
- Documentation

EMOTIONALLY. I'M DONE
MENTALLY. I'M DRAINED
SPIRITUALLY. I FEEL DEAD
PHYSICALLY. I SMILE

CAMS TRAINING

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY

CAMS

Overall process of clinical assessment, treatment planning, and management of suicidal risk with suicidal outpatients (Jobes, 2006)

Three distinct phases

1) Initial Assessment/Treatment planning
2) Clinical Tracking
3) Clinical Outcomes

Clinical Approach oriented toward keeping patients

out of inpatient care settings

These slides are based on the individualized works and research of Dr. David A. Jobes, Dr. M. David Rudd, Dr. Thomas Joiner, Dr. Julie Cerel, and Dr. Melinda Moore.

Their contributions toward the awareness and understanding of the suicidal client has saved untold number of lives and will continue to do so in the future. This as a clinician, I am very thankful for their contributions to the study of suicide.

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