Suicide Prevention Awareness

Connie Kramer, MA, LPC, NBCC
Gestalt Institute of Pittsburgh
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Dramatic Increase in Suicide Rate in Allegheny County

A CDC report Thursday showed that the national suicide rate increased 25 percent between 1999 and 2016 and by 30 percent in Pennsylvania during that time. But data from the Allegheny County Medical Examiner's Office found that in Allegheny County the suicide rate ***increased 66 percent just between 2010 and 2017****, when the number of suicides here increased from 130 to 215 cases.*

Suicide Prevention Awareness Training – Agenda

- Introductions
- Language of Suicide
- Ethical and Legal Issues
- Beliefs
- Statistics
- Risk Factors
- Assessments
- Suicidologist
- Golden Gate Bridge
- A Gestalt Approach to Suicide intervention
- Suicide Prevention Planning with Clients
- Myths of Suicide
- Summary

Avoid Stigmatizing Terminology

- Committed suicide
- Successful suicide
- Completed suicide
- Failed attempt at suicide
- Unsuccessful suicide

Use Appropriate Terminology

- Died by suicide
- Suicided
- Ended his/her life
- Took his/her life
- Attempt to end his/her life

Language of Suicide

Ethical and Legal Issues of Suicide

Confidentiality - the ethical duty to fulfill the promise that client information received during therapy will not be disclosed without authorization. Breaching confidentiality can result in harm to the counseling relationship and subsequently the client.

Section B of American Counseling Association outlines exceptions to confidentiality "when disclosure is required to prevent clear and imminent danger to the client…."

Limitations of Confidentiality

Safety and protection of the client trumps confidentiality in certain crisis situations

Informed Consent

- Share ideas on informed consent related to suicide, suicidal ideation, and suicide assessment? Successes versus growth edges
- How is suicide discussed in your first session?
- Can you add more information in your informed consent that would support you as a therapist related to this topic of suicide?

- **“Determining that a client is at risk of committing suicide leads to actions that can be exceptionally disruptive to a client’s life. Just as counselors can be accused of malpractice for neglecting to take action to prevent harm when a client is determined to be suicidal, counselors also can be accused of wrongdoing if they overreact and precipitously take actions that violate a client’s privacy or freedom when there is not basis for doing so” (Remley and Herlihy, 2001)**

What are your own personal views regarding suicide?

Reasonable Duty in Terms of Suicide Prevention:

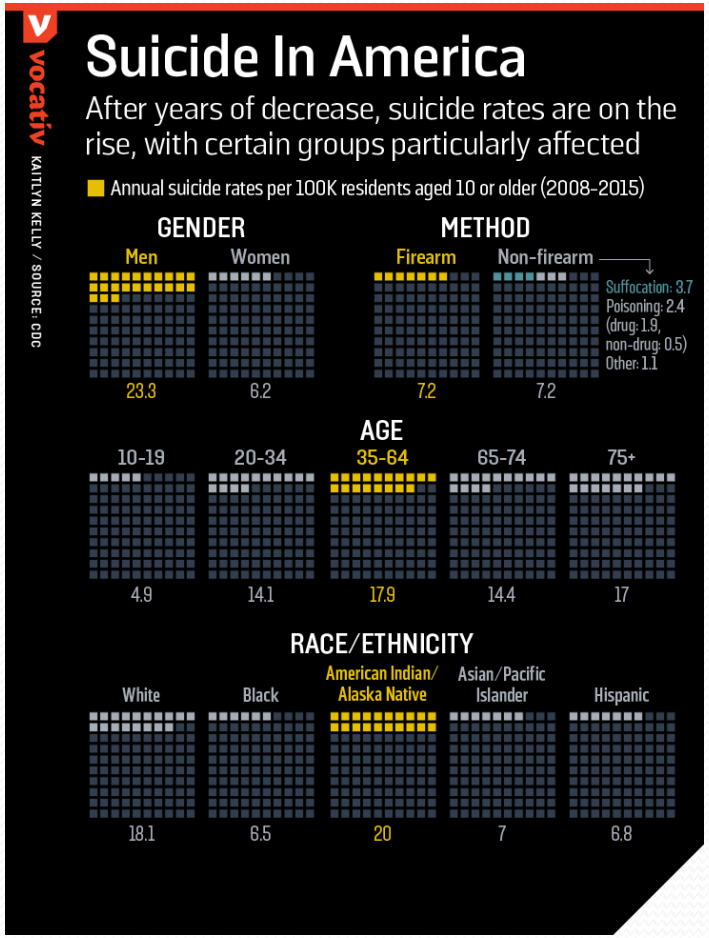
COUNSELORS MUST KNOW HOW TO MAKE ASSESSMENTS OF A CLIENT'S RISK FOR SUICIDE AND MUST BE ABLE TO DEFEND THEIR DECISIONS.

WHEN A DECISION IS MADE THAT THE CLIENT IS A DANGER TO SELF COUNSELORS MUST TAKE WHATEVER STEPS ARE NECESSARY TO PREVENT THE HARM.

ACTIONS TO PREVENT HARM MUST BE THE LEAST INTRUSIVE TO ACCOMPLISH THAT RESULT.

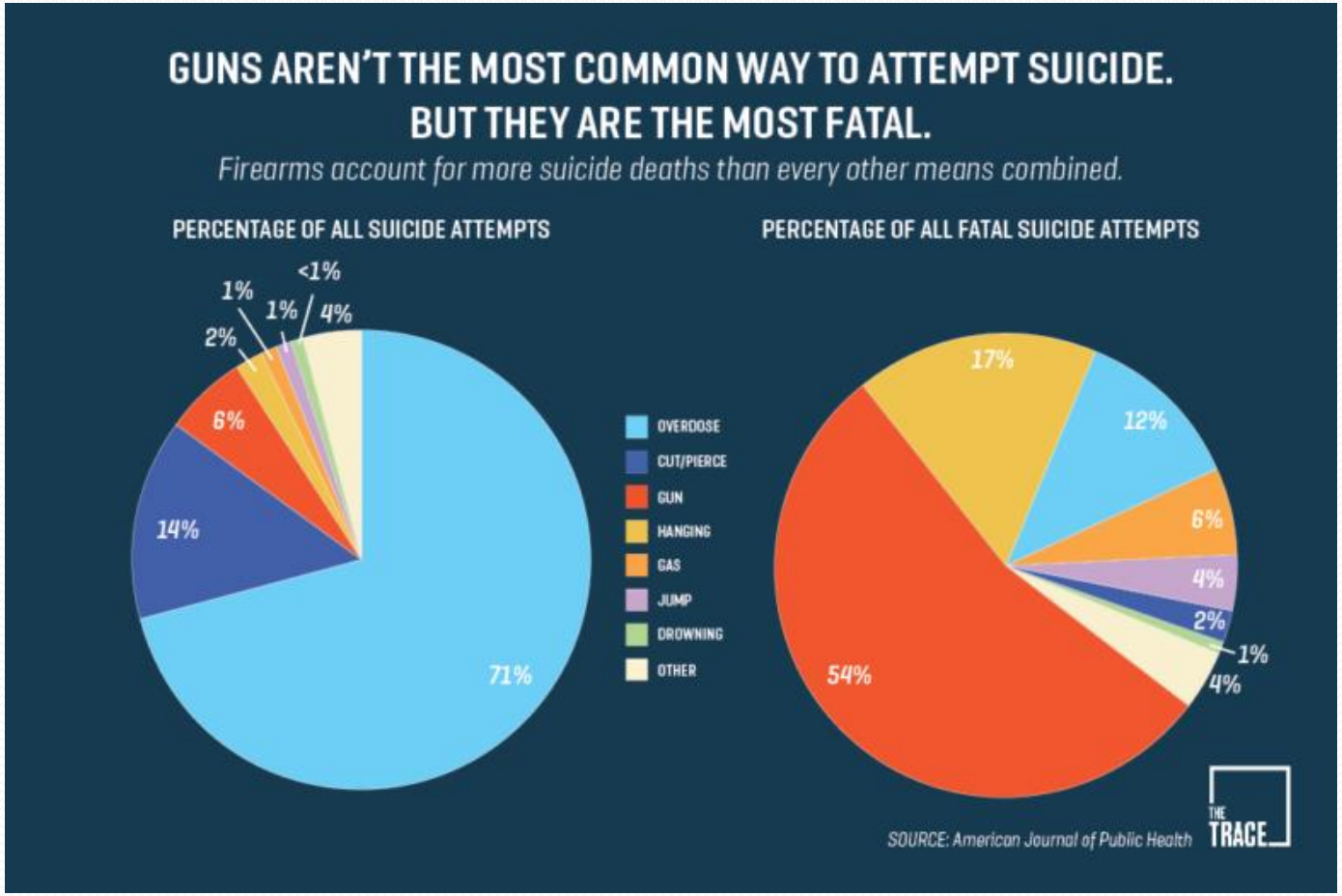
"***Any therapist, regardless of how competent, successful, and skilled may lose a client through suicide. What will distinguish this therapist from another who was clearly negligent, careless and indifferent to her or his client's suicidal state is the presence of well-documented, thorough client record.***" (Freemouw, Perczel, & Ellis, 1990)

Statistics

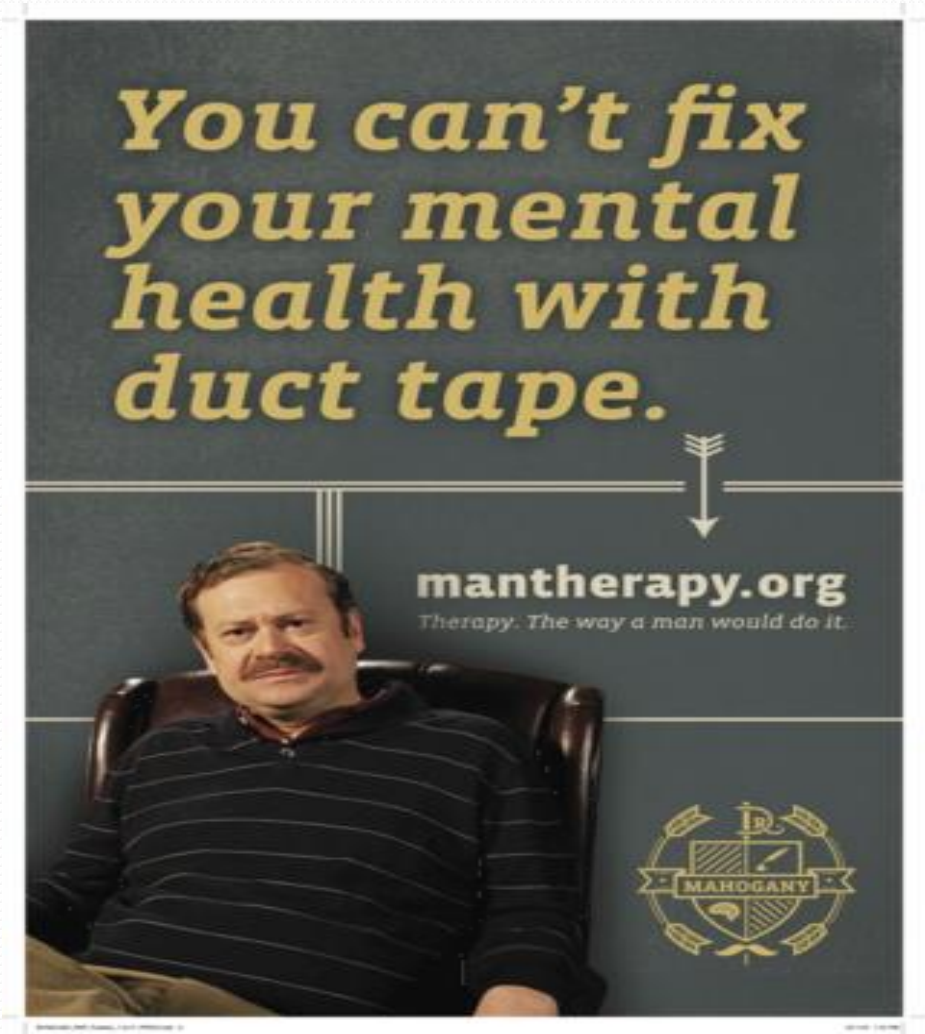


- 1,000,000 Die by Suicide Worldwide
- Top Ten Causes of Death in the US
- 2nd Leading Cause of Death for people from 15-29
- One Death for Every Twenty Attempts
- Four times more men than women die by suicide
- More women than men attempt suicide

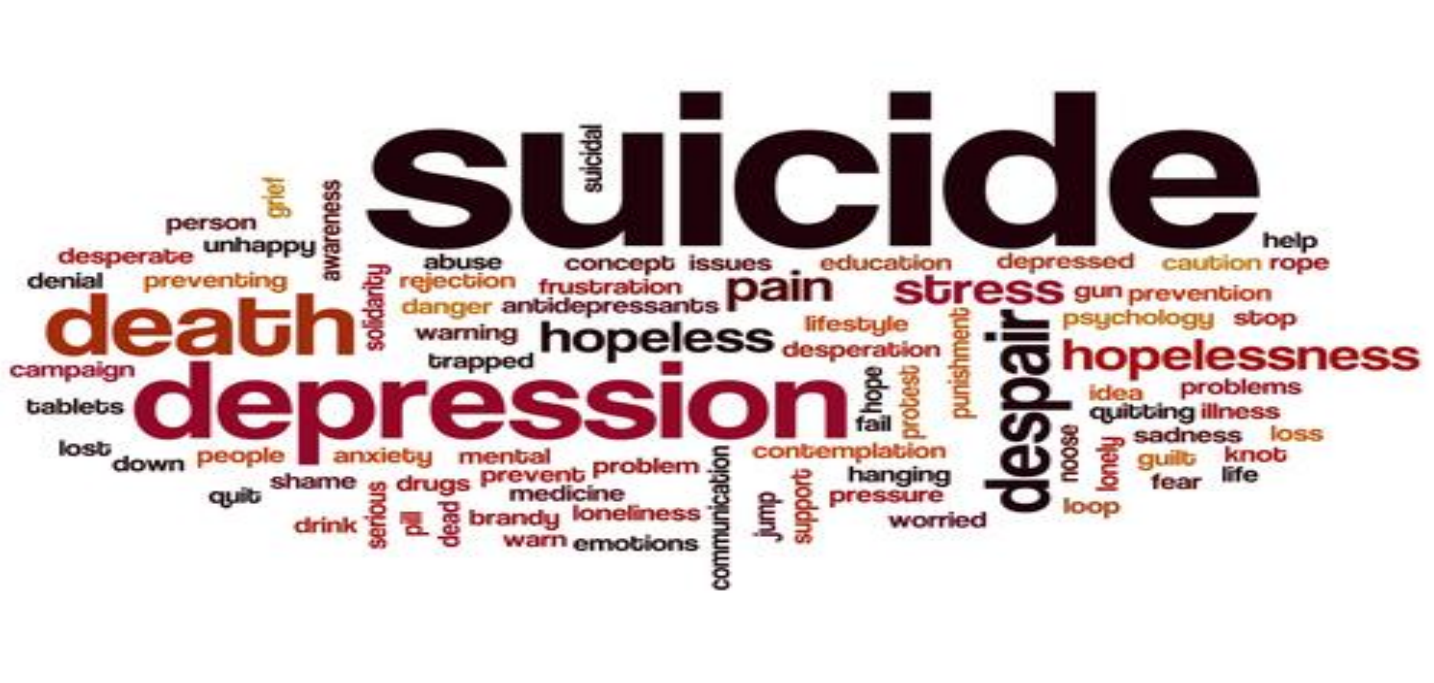
Means

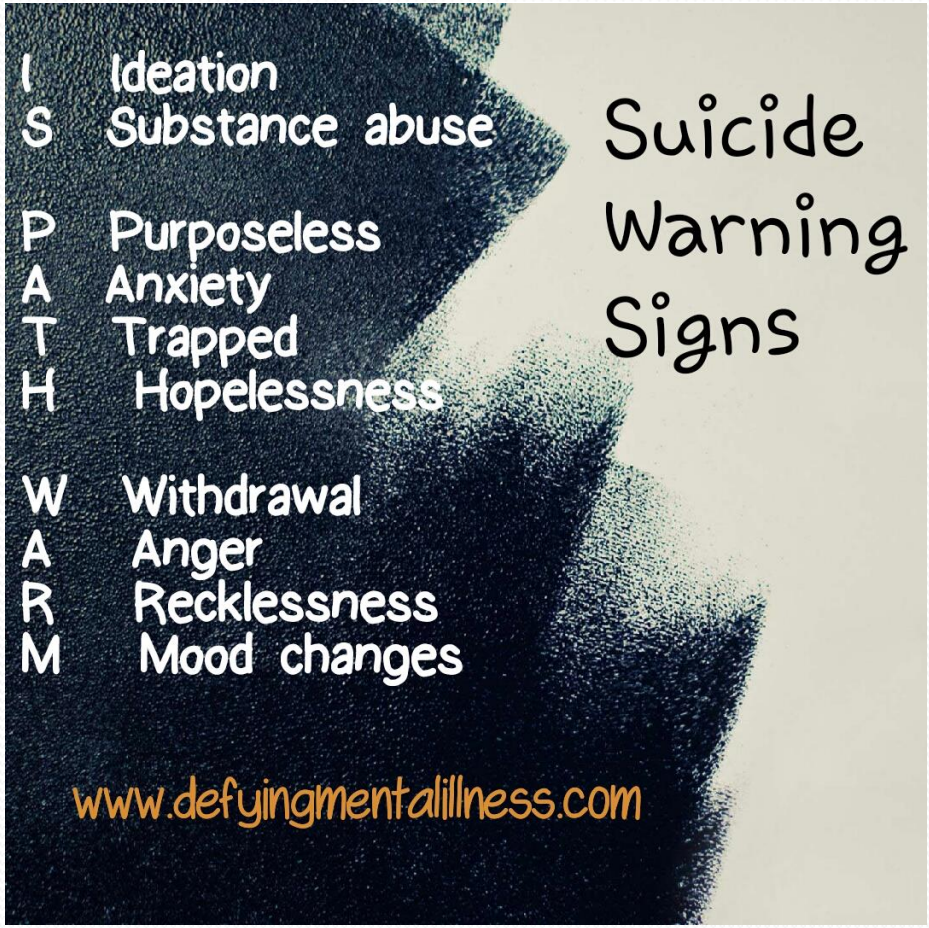

GUNS AREN'T THE MOST COMMON WAY TO ATTEMPT SUICIDE.
BUT THEY ARE THE MOST FATAL.
Firearms account for more suicide deaths than every other means combined.
PERCENTAGE OF ALL SUICIDE ATTEMPTS
71%
14%
6%
2%
1%
1%
<1%
4%
OVERDOSE
CUT/PIERCE
GUN
HANGING
GAS
JUMP
DROWNING
OTHER
PERCENTAGE OF ALL FATAL SUICIDE ATTEMPTS
54%
17%
12%
6%
4%
2%
1%
4%
SOURCE: American Journal of Public Health
THE TRACE

http://mantherapy.org/



Risk Factors




I Ideation
S Substance abuse
P Purposeless
A Anxiety
T Trapped
H Hopelessness
W Withdrawal
A Anger
R Recklessness
M Mood changes
Suicide Warning Signs
www.defyingmentalillness.com

Is Path Warm?

Centers For Disease Control

Suicide is never the result of one single factor or event, but rather results from a complex interaction of many factors and usually involves a history of psychosocial problems.

- Mental Illness (approximately 95%) Big Five include: Borderline Personality Disorder (400 times higher) anorexia (increases suicide risk 23 times) major depressive disorder (20 times greater risk) bipolar disorder (15 times greater risk) and schizophrenia (8.5 times greater risk)
- Agitation (behavioral, pacing)
- Extreme Alienation from Family and Community
- Heredity Dispositions (Hemingway- four generations included five suicides)
- Alcoholism- almost six times as many people who have a diagnosis of alcohol abuse or dependence die by suicide, compared to general population
- Being Unemployed
- Living Alone
- Significant physical illness
- History of Prior Attempts- with each attempt a person develops a greater ability to harm using increasingly more lethal methods. Previous attempt increases risk to eventually die by suicide by almost 40%
- Loneliness (increases odds of an early death by 45%)
- The Higher the education the more likely to commit suicide (however, more correlation between an individual's religion and suicide rate than an individual's education level. Jewish people were generally highly educated but had a low suicide rate.

- Assessments

- Ideation: Do you have thoughts of suicide? How many times a day or week do you have these thoughts? How much time do you spend thinking about suicide? How strong are the thoughts? Do you hear voices that tell you to kill yourself? What is the worst suicidal thinking you have ever had? When did you start having these thoughts?
- Intent to Die: Do you think you will follow through on these thoughts? On a scale from 1-10, how likely do you think you think you will act on these thoughts?
- Plan: Have you thought about how you would kill yourself? How have your prepared for your death? Are you fearless enough to follow through on your plan?
- Means: Do you have the means to follow through on your plan? (You will need to determine if these means are lethal)
- Imminence: When do you think you might follow through on your plan?

Aaron Beck has the most thorough research in the area of assessing for suicidal risk:

- Beck's Depression Inventory
- Beck's Suicide Inventory
- Beck's Hopelessness Scale

Columbia-Suicide Severity Rating Scale (C-SSRS)

Posner et al, 2007

- Developed by leading experts/evidence-based
- Feasible, low- burden (typical admin time 5 minutes)
- Assesses *both* behavior and ideation,
- Appropriately assesses and tracks suicidal all events
- Uniquely address the need for a summary measure of suicidality
- Lethality of Attempts
- Other Features of Ideation
  - Frequency
  - Duration
  - Controllability
  - Reasons for Ideation
  - Deterrents

Columbia Suicide Severity Rating Scale (C-SSRS) Training for the C-SSRS

- Firestone Assessment of Self Destructive Thoughts (FAST)
  - Firestone and Firestone 1996
  - This scale discriminates attempters versus non-attempters more accurately than any other scales

SUICIDOLOGISTS

Edwin Schneidman

- Considered the Father of Contemporary Suicidology - A pioneer.
- He defined suicide as Psychological Pain or Psychache. Psychache is the hurt, anguish, soreness, aching psychological pain in the psyche, the mind.
- He Believed that Individuals who are acutely suicidal are so for a relatively short period of this time, and even during this acute phase, they are extremely ambivalent about living and dying.

Schneidman, cont.

Therapeutic Strategies

- Monitoring - a continuous, preferably daily, monitoring of the patients lethality
- Consultation - there is no instance in a therapist professional life when consultation with peers is as important as it is when one is dealing with a highly suicidal patient
- Attention to transference - the successful treatment of a highly suicidal person depends heavily on transference. The therapist can be active, show concern, increase session frequency, invoke the magic of the unique therapist-patient relationship and give transfusions of hope and nurturance.
- The involvement of the significant other. Therapist can break away from usual practice of dealing exclusively with the patient.

Thomas Joiner

- When people hold two specific psychological states in their minds, simultaneously and long enough, the develop the desire for death.

- Two States =
  - Perceived burdensomeness
  - Sense of low belonging

Joiner, cont.

- Psychological state of cognitive constriction or cognitive destruction
  - The actual physiological functioning of certain parts of the brain changes in this acute suicidal moment.
- Virtually everyone who desires death also desires life
- Suicide Note- about 25% leave a note (Notes are mundane and contain positivity- reflective of a person in suicide crisis, unrepresentative of their lived life)

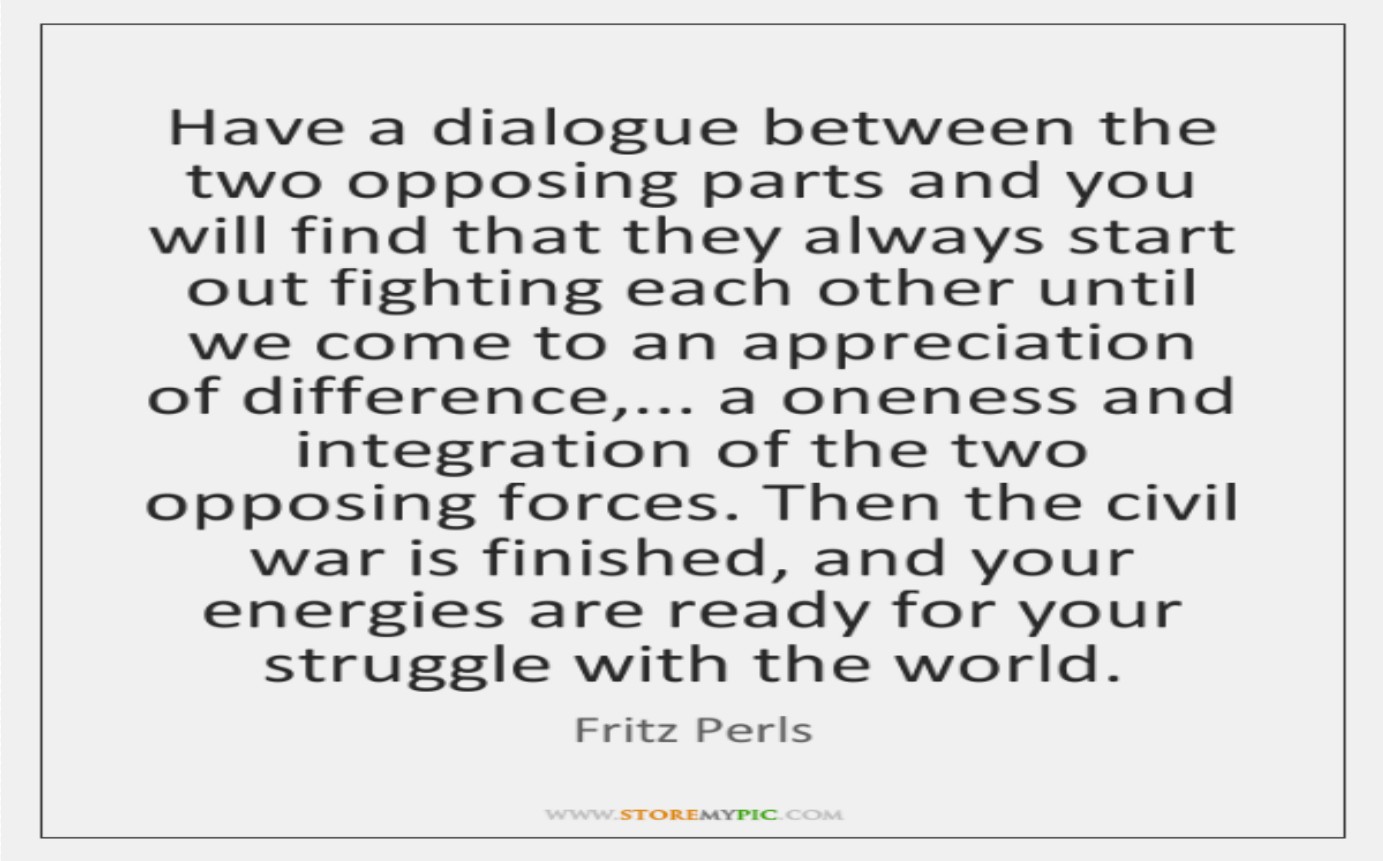
Golden Gate Bridge The Bridge

What have we learned from the Golden Gate Bridge?

- Ted Talk Golden Gate Bridge

- Kevin Hines

A Gestalt Approach to Suicide Intervention



- When Suicide Risk is in the Air, Do NOT Shy Away from the Issue
- Exploration of the Suicidal Plan will allow clients to discover a largely dissociate part of the self and begin to integrate rather than simply suffer
- Exploration of death and funeral fantasies can assist them to integrate death concepts, reduce the romantic aspects (as it is discussed in a down to earth manner) and facilitate awareness of revenge aspects involved in their suicidal desires.
- Ultimate Retroflection- suicidal clients may be unaware of this retroflected expression of anger. Help clients locate the sensations of anger and stay in touch physically with the sensations until the energy dissipates.
- Ambivalence - Help clients recognize that it is possible and normal to hold conflicting thoughts. They do not have to make a decision right now. "Do you want to die, or do you wish to escape your turmoil and confusion?". This can help bring the unbearable pain to the foreground.
- Work with polarities and hold awareness for both polarities
- Help client become aware of where they are and how they stand to gain from being there. Consistent talking about feelings is different from experiencing them
- Loneliness- parallel process. Are they lonely now

Gestalt

- Integration of polarities (connection and disconnection to the world)
- Ventilation and Awareness of Emotion
- Attention to Loneliness
- Ambivalence
- Lack of Constructive Intimacy
- Unbearable Psychological Suffering
- Attune to the client while non-judgmentally accepting the clients suicidal wish.
- How has the client successfully creatively adjusted to environment in the past? (as Gestalt therapist, we must assess the degree of risk present in our client's creative adjustments)

- If we are to remain true to our phenomenological approach as Gestalt therapists, we need to remain open to what unfolds before us while at the same time maintaining a tentative grip on indicators on risk in the field

- Formulate a personal set of warning signs (sleep, increasing agitation, critical inner voices
- Is their home safe? Remove items that could be dangerous such as guns or medications.
- Have client develop a complete safety plan, including specific behaviors to calm down. It should include suggestions for interrupting isolation or passivity.
- Identify, list and complete contact information for clients family or friendship circle who they can call if they start to feel bad. Help the client plan to notify these people
- Make yourself available for the client to call, provide RESOLV numbers or local crisis centers
- Make sure the client has the number to the National Suicide Prevention Lifeline (800)273-8255.
- Keep a copy of this plan in your chart and provide one for the client to keep

Safety Planning

Suicide prevention planning with clients

- Most effective counselors ask with concern, not alarm
- Explain the reasons for your concern
- Elicit input with what may help them be safe
- Safety Contracts?

Innovative Ideas for Suicide Prevention

- Emergency Room Interventions – Safety Planning Intervention can reduce the risk of future attempts. Creating a Safety Plan and follow up with phone calls-(within 72 hours from discharge and follow up on therapy appointment) Reduce the odds of suicidal Behavior by Half. This study shows that brief interventions work (Jama Psychiatry)

- Zero Suicide Initiative
- Apps
- Man Therapy

National Suicide Prevention Hotline
1-800-273-8255

Trevor Project Lifeline
1-866-488-7386

Trans Lifeline
1-877-565-8860

Crisis Text Line
Text "Start" to 741-741

SOMEONE WORTHY OF LOVE MAY NEED THESE NUMBERS RIGHT NOW. PLEASE SHARE.

Crisis Text Line

Text a trained crisis counselor, 24/7.

Always CONFIDENTIAL.

Always FREE.

Need Help Now?

TEXT "START" TO 741-741

Crisis Text Line has processed over 10 million texts to date!

www.AllianceforSafeKids.org

ASK

Questions Related to Negligence

- Was the counselor aware of or should have been aware of the risk?
- Was the counselor thorough in assessment of the clients suicide risk?
- Did the counselor make “reasonable and prudent efforts” to collect sufficient and necessary data to assess risk?
- Were the assessment data misused, thus leading to a misdiagnosis where the same data would have resulted in appropriate diagnosis by another mental health professional?
- Did the counselor mismanage the case, being either “unavailable or unresponsive” to the client’s emergency situation?
- Did the counselor make adequate attempts to keep the client safe (i.e. set up a plan of contingencies with appropriate resources, phone numbers, etc.)
- Did the counselor remove the means to be used by the client in the suicide attempt?
- In cases of minors, were the parents or caretakers informed of the client’s potential risk?

- Aggressively questioning the client about thoughts and feelings
- Demanding assurance of safety when a client cannot provide such assurance
- Becoming autocratic and failing to collaborate with the client
- Avoiding sensitive topics so as not to provoke sadness

Are you employing counter-therapeutic practices when encountering suicidal thoughts or behaviors?

- ***Stay grounded***
- ***Make use of your therapeutic skills***
- ***Collect objective data while holding onto empathy and concern***
- ***Practice, Practice, Practice (other counselors or supervisors)***
- ***Get feedback***
- ***Start asking every one of your clients about suicidality***
- ***Explore and discuss your attitudes toward clients who are suicidal***
- ***Employ a treatment team approach***

Summary

Most suicidal people have made up their minds that they really want to die.

Truth or Myth?

Truth or Myth

There is no correlation between drug and alcohol abuse and suicide.

Truth or Myth

Most Suicides Occur over the Holidays.

Truth or Myth

There are more homicides than suicides in the United States.

Truth or Myth

Most suicidal people develop a plan for suicide. The more specific the plan, the greater the danger.