

# Assessment, Evaluation, and Treatment of Suicidality

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# Sources

- Dulcan's Textbook of Child and Adolescent Psychiatry. 2012 Edition. Chapter 35: Youth Suicide. Pages 531-542.
- Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook. Fourth Edition. 2007. Chapter 5.4.3: Suicidal Behavior in Children and Adolescents: Causes and Management. Pages 529 – 537
- Dialectical Behavior Therapy with Suicidal Adolescents. Alec Miller, Jill Rathus, and Marsha Linehan. 2007. Guilford Press.

# TERMINOLOGY

- Non-Suicidal Self-Injurious Behavior (“NSIB”): Attempts to injure one’s self for the purpose of relieving emotional pain (cutting, burning, etc.)
- Parasuicidal Behavior: Suicidal gestures or self-harming behaviors in the context of suicidal ideation and for the purpose of alerting others. These are not typically behaviors which could have led to successful committing suicide.

# TERMINOLOGY

- Suicidal Ideation (“SI”): thoughts about suicide. Can be active or passive and can be with or without intent or a plan.
  - Passive: General feelings of not wanting to be alive
  - Active: Wanting to commit suicide in the present, often times with a specific plan and intent (having the intention of completed suicide)
- Suicide Attempts versus Committing Suicide: An attempt is an action taken to end one’s life, while committing suicide refers to succumbing to suicide. Attempts can be stratified according to degree of lethality (spectrum of NSIB all the way to completed suicide)

# Take home message

- Any or all suicidal statements or behaviors, regardless of how extreme, must be taken very seriously!

# EPIDEMIOLOGY

- Approximately 20% of students in high school have had serious suicidal ideation
- In 2003, there were 3921 suicides among 15-24 year olds. That means almost 11 suicides per day, or that approximately every two hours there is a completed suicide in this age group

# EPIDEMIOLOGY

- Females are more likely to attempt suicide, while males are more likely to successfully commit suicide (males are identified as more commonly using lethal means such as hanging or firearms)
- Ethnic differences: suicide is prevalent in all ethnic groups, notwithstanding Native Americans
- Sexual identity: youth may be more likely to experience bullying or rejection from peers and/or family members

# EPIDEMIOLOGY

- Most Common Co-Morbid Psychiatric Disorders
  - Mood (61-76%)
  - Substance Abuse (27-62%)
  - Conduct/Disruptive Behavior
  - Borderline or Antisocial Personality
  - Post Traumatic Stress (PTSD)
  - Chronic Medical Illnesses



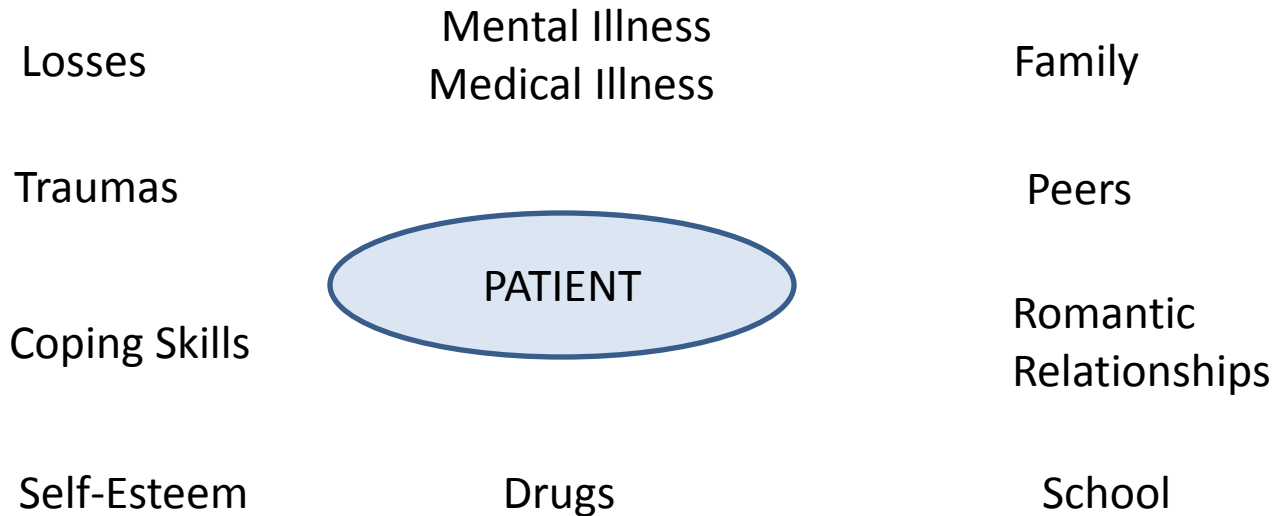
# ASSESSMENT/EVALUATION

- 90% of teens who commit suicide have a psychiatric disorder at the time of death
- Take Home: we need to screen **ALL** of our patients for suicidality, even if we do not expect it in the least

# ASSESSMENT/Evaluation

- Once suicide is on the radar, a safety determination is required to place the patient in the appropriate treatment setting
  - Inpatient
  - Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP)
  - Multi-Systemic Therapy (MST) or Wraparound Services
  - Traditional Outpatient Therapy and Medication management
- The best way to assess a patient's level of acuity is to take a look at the risk factors and protective factors at play (will refer to scales later)

# RISK/PROTECTIVE FACTOR ANALYSIS



# RISK/PROTECTIVE FACTOR ANALYSIS

| <b>PROTECTIVE</b>                                   | <b>FACTOR</b>   | <b>RISK</b>  |
|---|-----------------|--|
| In Treatment, Good Services in Place<br>No Prior SI | Mental Illness  | No Treatment or Improper Treatment<br>Prior SI               |
| Well Treated  | Medical Illness | Ongoing Issues   |
| Sober<br>In-Remission<br>or<br>In Treatment         | Substance Use   | No Treatment, Ongoing Use<br>Impulsivity/Risky<br>Dependence |

# RISK/PROTECTIVE FACTOR ANALYSIS

| PROTECTIVE              | FACTOR                      | RISK                                 |
|-------------------------|-----------------------------|--------------------------------------|
| Resilient               | Family                      | Trigger                              |
| Supportive              | Peers<br>*Social Networking | Social Isolation<br>Bullying/Abuse   |
| Mature                  | Romantic Relationships      | Trigger<br>Abusive<br>*Pregnancy     |
| Sense of Accomplishment | School                      | Sense of Failure<br>*Learning Issues |

# RISK/PROTECTIVE FACTOR ANALYSIS

| PROTECTIVE                         | FACTOR                              | RISK  |
|------------------------------------|-------------------------------------|---|
| Treatment Resiliency               | Losses                              | Grief<br>Abandonment                            |
| Treatment Resiliency               | Traumas                             | “Psychic Ache”<br>Self-Destructiveness<br>*PTSD |
| Self Worth<br>*Any positive = good | Self-Esteem                         | Self-Doubt<br>*Lack of any positive             |
| Multiple<br>Mature                 | Coping Skills<br>*Ability to Access | Limited<br>Immature                             |

# RED FLAGS

- History of Impulsive Aggression
- Prior Suicide Attempts
- Hopelessness/Helplessness
- No Future Orientation
- Access to Means
- Exposure to Recent Suicide

# SAFETY PLAN

- This is an essential step in treating any patient in the community for whom suicide is or has been a concern
  - Lock up potentially hazardous materials
  - Increase family and peer supervision and support
  - Engage in treatment with easy access to providers
  - Emergency Plan: know when to call 911 or come to the emergency for an urgent evaluation



# SAFETY PLAN

- Common questions that should be answered when creating a safety plan:
  - What are common triggers for you?
  - What is the first sign that you may be entering a crisis (thoughts, feelings, body sensations)?
  - Which coping skills have been most useful in crisis?
  - Who can you call when feeling upset (create a support network)?
  - How do you know when things are getting out of control and you need help?

# SPECIAL ISSUES

- Copycat Suicides
  - Typically occur after a suicide (Palo Alto)
  - Peer to peer groups have been incredibly helpful
- Social Networking
  - New forum for bullying
  - Can be a trigger, but also can alert others to cries of help and even suicidal thoughts and attempts
- Ethnic, Socioeconomic, and Sexual Minorities
  - At risk for targeting by peers

# SUICIDE RATING SCALES

- These can be used if there is a sense that the patient is not fully disclosing information. Some sources recommend the use of one of these scales routinely. Tests include:
  - Suicide Probability Scale (SPS): Used at the Children's Psychiatric Hospital of UNM (inpatient unit)
  - Suicidal Ideation Questionnaire (SIQ)
  - Lifetime Parasuicide Count (LPC)
  - Reasons for Living Inventory for Adolescents (RFL-A)

# TREATMENT

- Treatment of Co-Morbid Psychiatric Conditions
  - Psychotherapies aimed at specific conditions
  - Medications aimed at symptom reduction (SSRI's for depression)
  - Lithium has shown some benefit in adults for reducing persistent suicidality
- Dialectical Behavior Therapy
  - The only therapy to date which has been shown to reduce suicidal and self harming behaviors in adolescents
  - Will be covering some DBT background and skills in upcoming talks

# QUESTIONS?

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