

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

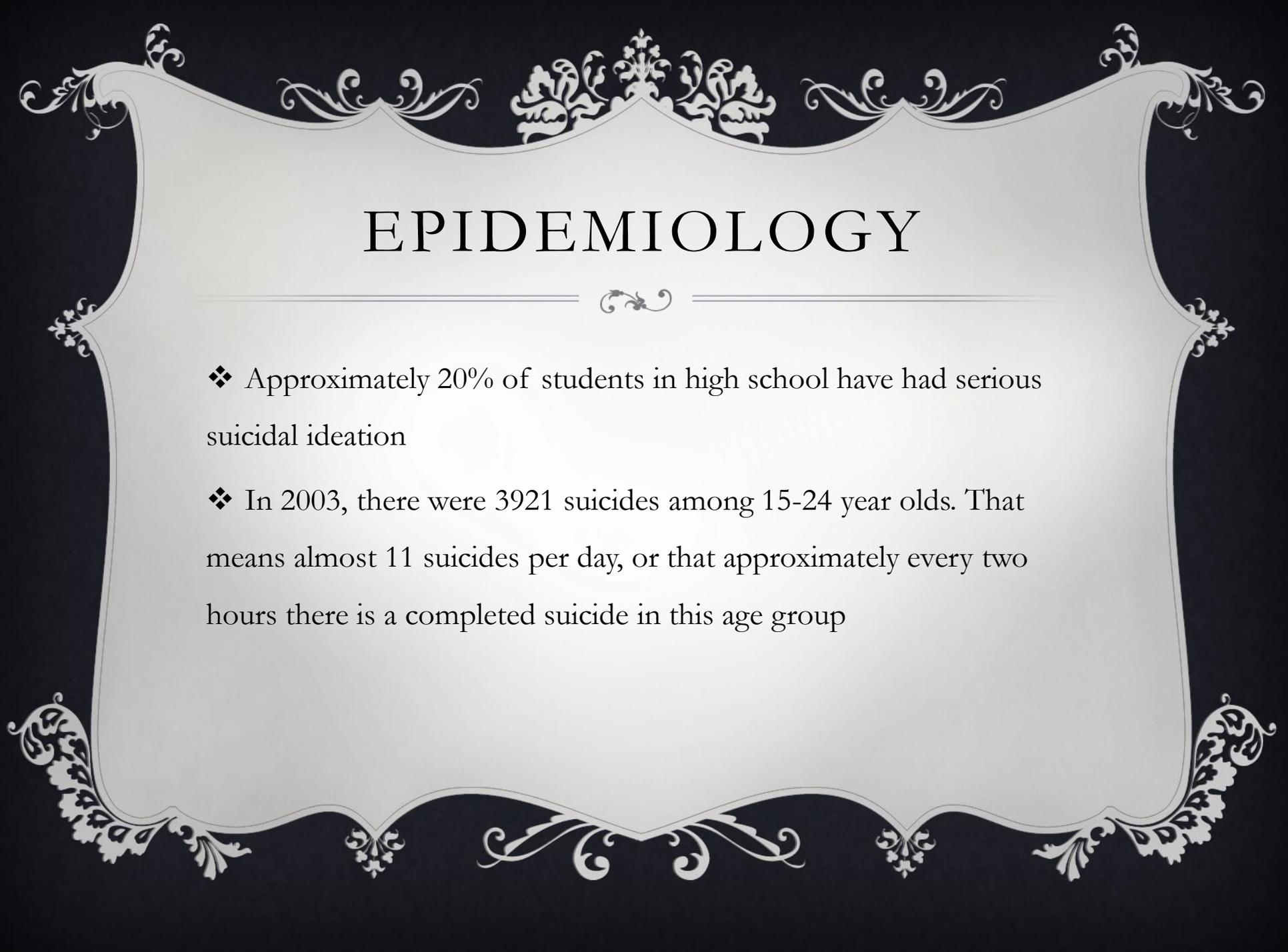
Active: Wanting to commit suicide in the present, often times with a specific plan and intent (having the intention of completed suicide)

❖ 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)



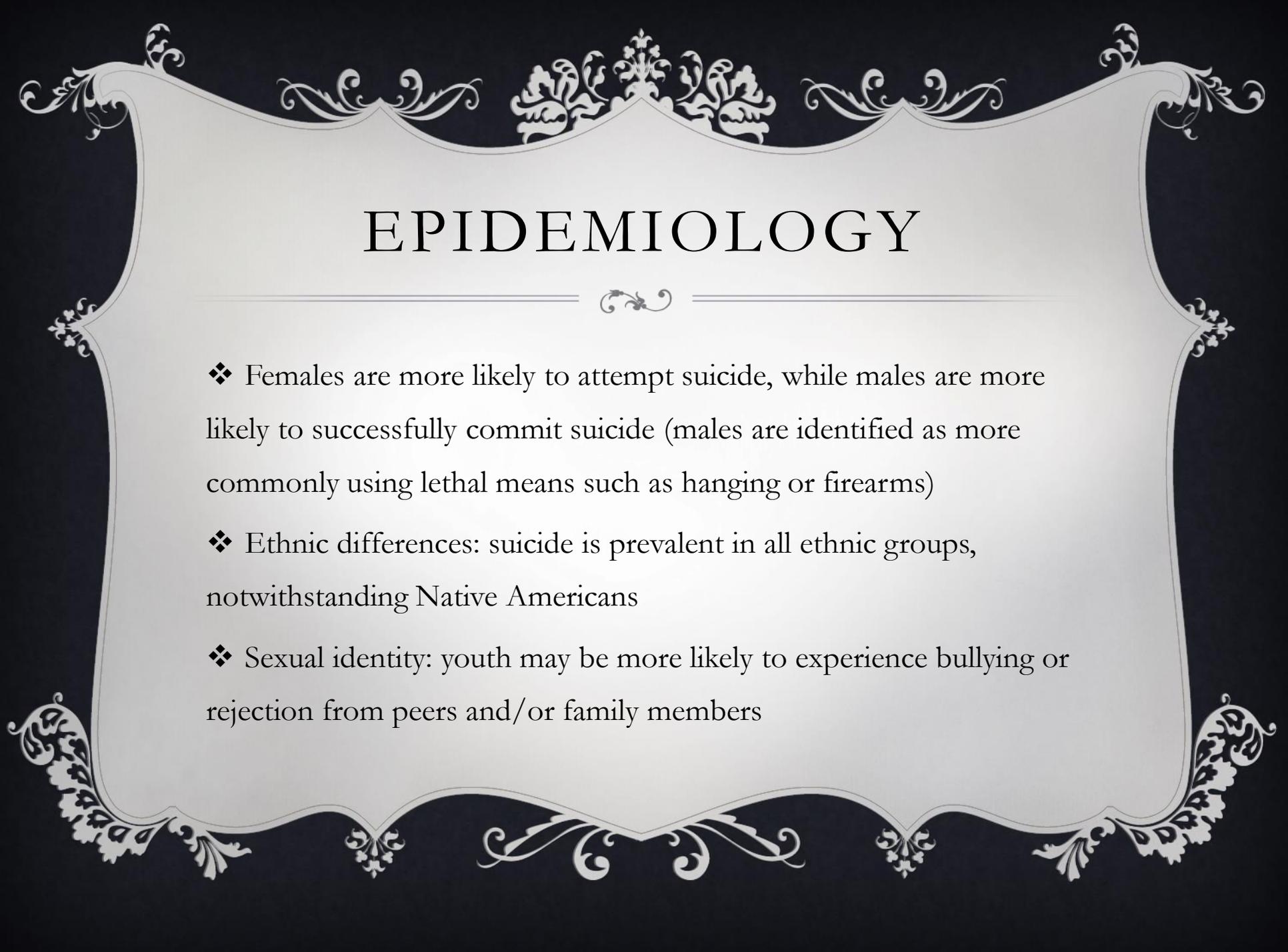
TAKE HOME MESSAGE

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



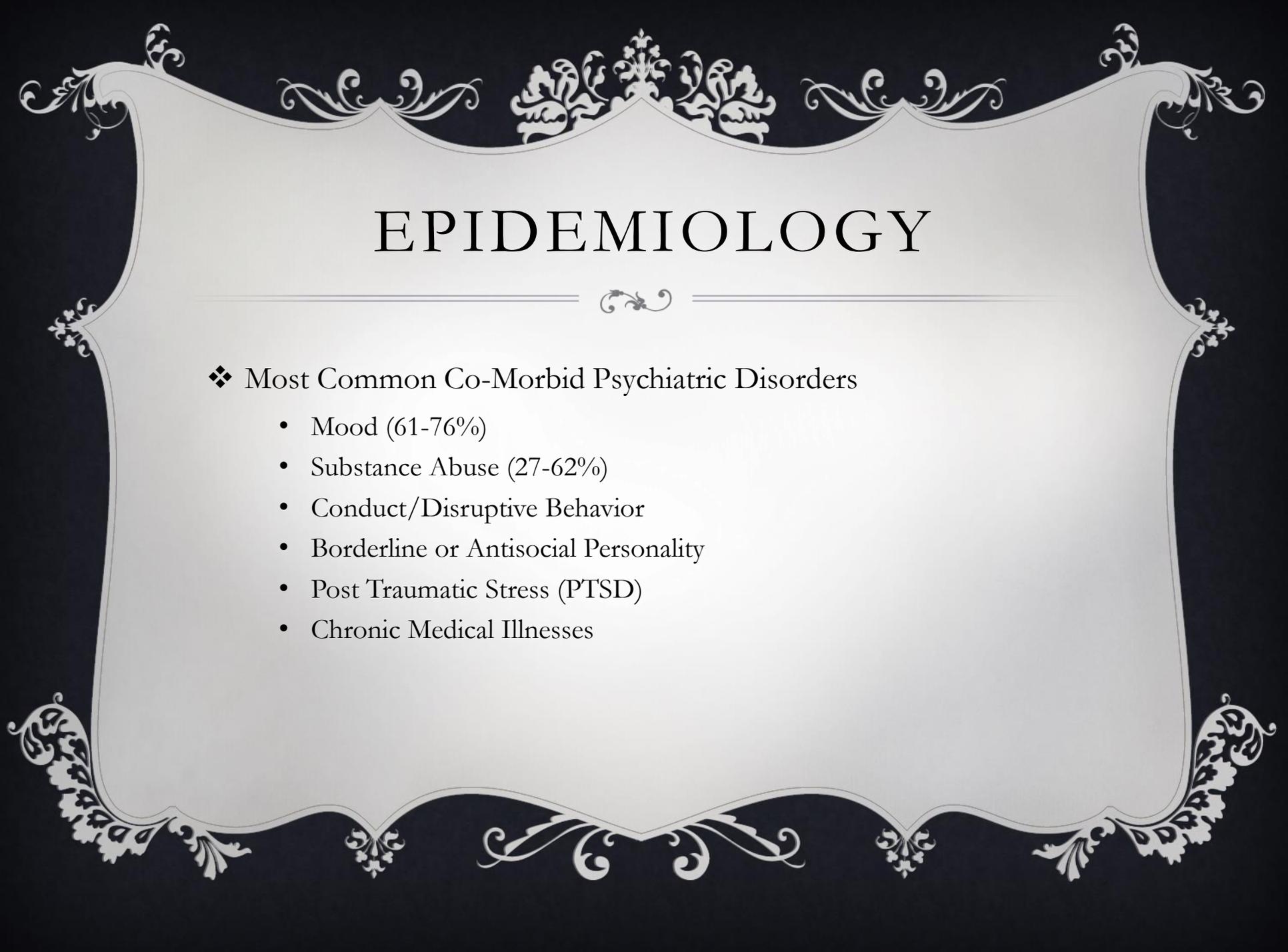
EPIDEMIOLOGY

- ❖ 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

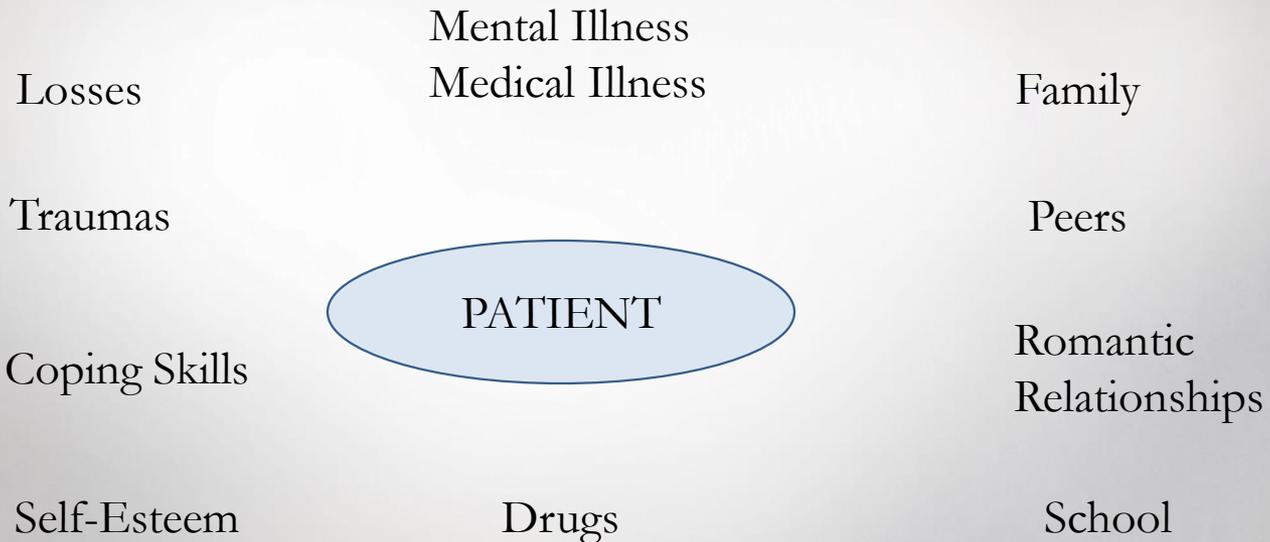
ASSESSMENT/EVALUATION

❖ 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

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

RISK/PROTECTIVE FACTOR ANALYSIS

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

RISK/PROTECTIVE FACTOR ANALYSIS

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

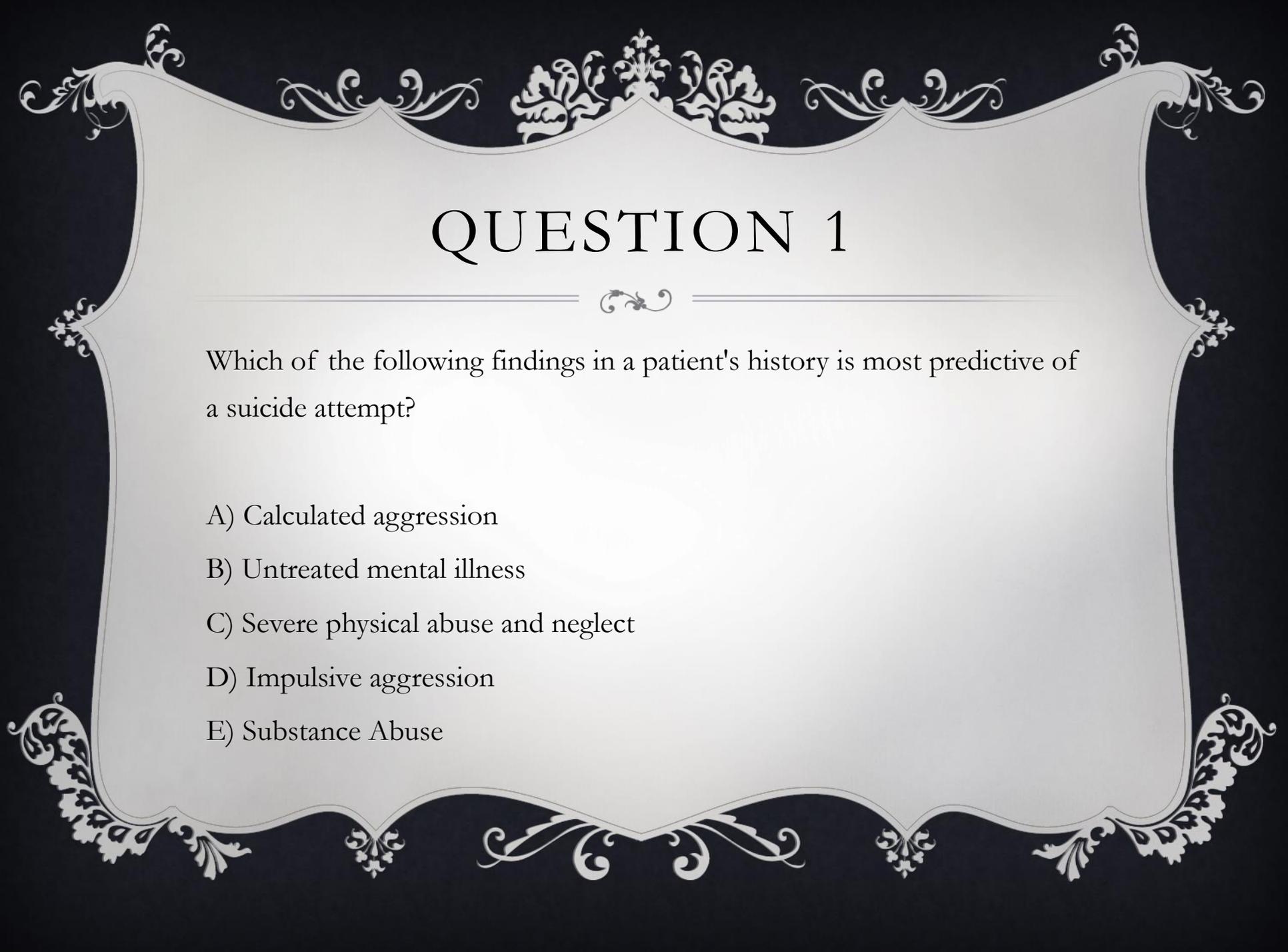
TREATMENT

❖ 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

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QUESTION 1

Which of the following findings in a patient's history is most predictive of a suicide attempt?

- A) Calculated aggression
- B) Untreated mental illness
- C) Severe physical abuse and neglect
- D) Impulsive aggression
- E) Substance Abuse

QUESTION 2

A 17 year old female presents to the emergency department following an argument with her boyfriend in which she overdosed on a handful of Ibuprofen. When asked why she did this, the patient states through tears, "I don't want to die and I'm glad I am alive now...I can't really remember whether I wanted to kill myself when I took the pills...I just couldn't imagine life without my boyfriend and I hoped that this would show him that I can't live without him?" While several of the following answer choices could be true, which best characterizes this patient's presentation?

- A) Suicidal Ideation
- B) Non-Suicidal Self-Injurious Behavior
- C) Suicide Attempt
- D) Death by Suicide
- E) Parasuicidal Behavior



QUESTION 3

Which form of psychotherapy directly targets impulsivity?

- A) Dialectical Behavior Therapy
- B) Cognitive Behavioral Therapy
- C) Interpersonal psychotherapy
- D) Psychodynamic Psychotherapy
- E) Exposure-Response Prevention Therapy



QUESTIONS?

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