Conceptualizing Suicide Risk for Effective Safety Planning

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Why We Need New Models

- 32 yr old, Male Veteran, married, two young children. Deployed on 4 occasions; rescue missions, combat exposure, flight experience. Moved up ranks, leadership/training role. Family moves approx. every 4 yrs. Supportive, stay-at-home wife. Successful career, well liked, adequate but not a close social support network of friends and colleagues. No drug/alcohol problems. Family of origin is in tact but characterized as aloof, occasionally hostile, not engaged, high criticism of others, pressures for success, lacks warmth. No known history of maltreatment. Admits to struggling with depression, low self-esteem, self-doubt for majority of life – never sought treatment – fears consequences with military if know about MH concerns. Past few years increasing tension with wife; he feels disconnected, relationship is “exhausting,” can’t fully trust her (no reason), lack of emotional intimacy; perceives no truly close friends (features of paranoid/schizoid personality disorder). Wife increasingly distraught, pushing for therapy, begins talking about divorce. Client feeling pressured, believes divorce might be best, admits to wife he had frequent suicidal thoughts during deployments. Admits to some suicidal thoughts now. Agrees to seek marital counseling and at wife’s encouragement has begun a self-help workbook for people with personality disorders / depression.
Current Standard of Care: Risk Assessment

- Gather data about observable & reported risk and protective factors
- No guidance on how to organize, prioritize, synthesize data
- Clinical Intuition; Clinician Judgment

Categorical Probabilistic Judgment:
- Low
- Moderate
- High

INFORMS
Assumes Prediction of Likelihood Suicide Attempt will occur

DECISION:
- Hospitalization
- Release
- Triage

Treatment Risk Management

Pisani et al., 2015; Silverman, 2014
New Standard of Care: Suicide Risk Formulation

Purpose = Planning

- Anchor each person’s RISK within a context (research; individual hx)
- Engage client and strengthen therapeutic alliance

Incorporate Recent Advances in Field, SRF:

- Anchored in the clinical context and patient population served
  - need to describe risk in relative terms given population/setting work within
- Capture fluid nature of suicide risk within life of person
  - How current risk compares to risk at previous times
  - How risk might change in response to future events
- Directly informs intervention strategies
  - Data collected should produce risk management strategies

Pisani et al., 2015; Silverman, 2014
Key Elements of the Risk Formulation

Risk Status
Client vs. Others

- Client compared to reference group
  - often your work setting
  - population of interest
  - elements that do not change
  - include enduring risk factors

Risk State
Client vs. Self

- Client compared to themselves
  - stressors that elevate risk
  - fluctuates across time & events

In your work setting, what “makes up” high suicide risk?

What actions, events, factors increase this individual’s risk?
Example: Jasmine

- 16yr old, Hispanic-American female, bisexual (not disclosed)
- inner city/Low-Mid SES, Mother & Step-Dad traditional ethnic & cultural beliefs
- Hx depression, anxiety, NSSI, referred after serious suicide attempt
  - NSSI reduced, triggered by conflict w/Mother & Peers
  - Failing course, Emergence of Hallucinations, Behavior Prob in school (mom conflict)
  - Increasing alcohol consumption, “Love-triangle,” Learns will need summer school
- Mom discovered drinking @ party, NSSI increases
- Suicidal ideation “intense but manageable”
- Engaged in treatment, Mom involved, Aunt is support, Future goals, Pos Peers
Intervention Response
Safety Plan
Crisis Stabilization
Specific Treatment
- CBT, DBT, CAMS
- Interpersonal Skills
- Emotion Regulation
- Symptom Reduction
- Family Communication

Available Resources
Internal and social strengths to support safety and treatment planning

Foreseeable Changes
Changes that could quickly increase risk state

Risk Status
Relative to others in a stated population

Risk State
Relative to self at baseline or selected time period

Clinical data
Traditional SRA

Strengths and Protective Factors
Long-term risk factors
Impulsivity/Self-Control (incl. subst. abuse)
Past suicidal behavior
Recent/present suicide ideation, behavior
Stressors/Precipitants
Symptoms, suffering, and recent changes
Engagement and Alliance

Identified in collaboration with client

Pisani et al., 2015; Silverman, 2014
Client is 16yo Hispanic female with long history of depression w/psychotic features and anxiety. She shows impulsivity through NSSI, occasional binge drinking, and has one previous suicide attempt that led to hospitalization. Current suicidal ideation is fleeting but of high intensity with no clear plan or intent to act. After 4 months of no NSSI, client has engaged in occasional acts over past 3 weeks reporting the NSSI is “less effective.” In light of these factors, client’s risk status is comparable to other adolescents treated at our outpatient mood disorders clinic. Given a recent increase in stressors including hallucinations, NSSI, and interpersonal conflict her current risk state is elevated compared to one month ago but remains lower than when admitted. Client is actively engaged in therapy, has a positive connection with her maternal aunt, and identifies peers as supportive. She continues to practice use of distress tolerance and interpersonal skills. Her suicide risk could increase pending significant arguments with her mother or a romantic relationship break-up and contingency plans for safety related to these events were discussed. Client’s safety plan was reviewed and treatment will continue to address conflict resolution and distress tolerance skills along with ongoing CBT for depressive symptoms.
Greg, 48 yo male, w/ long hx of bipolar disorder and substance abuse. He was referred by his PCP, arriving reluctantly after endorsing “nearly every day” on the suicide-risk item of a depression screener. When asked about it, he stated “You never know what can happen when a guy is cleaning his gun, Doc.” Greg has hx of inpatient hospitalizations due to erratic manic behavior & past suicide attempts (1) shortly after learning of his diagnosis & particularly bad episodes of depression (2). Most recent hospitalization (mania) = 6 months ago. He’s med compliant & symptoms were managed. Greg has been binge drinking more frequently in the past 3 months since discovering his wife and best friend in bed together. After confronting them, Greg drank heavily at a local bar, sped off in his car and struck a concrete wall, fracturing a hip and femur – injuries that continue to give him pain. Greg’s wife strongly assures Greg that she has ended the relationship. Greg remains distrustful, moody, and angry. He binge drinks with coworkers at least 3 days/wk, which intensifies his suicidal thoughts. Greg is increasingly agitated, irritable, and withdrawn from his wife and good friends despite stating that he is agreeable to repairing the marriage. He admits his work is suffering: his boss made a comment that has Greg concerned about losing his job as a restructuring process has begun. During an argument with his wife in the past week, Greg stated: “Maybe I should just shoot myself so you can screw Tom again without guilt.” An avid hunter, Greg owns three guns. When asked about the comment, Greg emphatically states: “I say that when I am mad and overwhelmed, but I wouldn’t do it.” He agreed to let a close friend keep his guns temporarily for safety. Greg is reluctant about therapy, not highly engaged; is cooperative & states open to receiving “some assistance” to get “back on track.”
Clinical data

- Strengths and Protective Factors
- Long-term risk factors
- Impulsivity/Self-Control (incl. subst. abuse)
- Past suicidal behavior

- Recent/prepresent suicide ideation, behavior
- Stressors/Precipitants
- Symptoms, suffering, and recent changes
- Engagement and Alliance

Risk Formulation

- Risk Status: Relative to others in a stated population
- Available Resources: Internal and social strengths to support safety and treatment planning
- Risk State: Relative to self at baseline or selected time period
- Foreseeable Changes: Changes that could quickly increase risk state

Planning
Safety Planning

Sharing Risk Formulation
Collaborative Process
Evidence of Effectiveness

Bryan et al., 2017

CRP 76% Less Likely to attempt

CRP sig. FEWER inpatient days
Fig. 3. Mean Beck Scale for Suicide Ideation (BSSI) scores over time among suicidal active duty Soldiers receiving a crisis response plan (CRP) versus the contract for safety (CFS). **p < 0.01, ***p < 0.001.

CRP sig faster decline in suicidal ideation
Enhanced Crisis Response Plan: Safety Planning Intervention

Stanley & Brown, 2008; 2012

– Research supports Engaging & Empowering Clients
  – Assist with self-awareness of potential triggers
    – “foreseeable changes”
    – Self-monitoring
  – Draws upon Internal and External Resources of Client
    – Self-management = Empowerment
    – Sense of Self-Efficacy
Step 1: Recognize Warning Signs
Client-specific “signs” that a crisis is developing
Early Warning Signs
How will you know when the plan should be used?
What do you experience before/when you start to think about suicide?

Step 2: Using Internal Coping Strategies
Activities or Things Client can do on OWN to distract
Address roadblocks to implementation
What can you do, on your own, to help yourself not act on your thoughts or urges? To distract from distress?
“How likely do you think you can do this step during a crisis?”
Step 3: Social Contacts for DISTRACTION
People or Social Settings can **Take Mind Off** distress
Safe Places to go to be around others
*Who helps you feel better when you socialize with them?*
*What social settings help you take your mind off your problems at least for a little while?*

Step 4: Persons to Contact for Help to Resolve Crisis
Individuals willing, comfortable to access for help
Disclose in crisis and need help
*Who is supportive of you and who do you feel that you can talk with when you’re under stress?*
Step 5: Professionals & Agencies to Contact
Names, Numbers, Locations of Urgent Care
Suicide Prevention Specific Resources (NSPL; HOPELINE)

Who are the mental health professionals we should identify to be on your safety plan?

Step 6: Reducing Access to Lethal Means
Discuss ways to limit or remove access to primary means
Often need to include collateral support

How can we work together to keep your environment safe?
**Safety Plan**

The one thing that is most important to me and worth living for is:

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<th>Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:</th>
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<th>Step 2: Internal coping strategies – Things I can do on my own to take my mind off my problems (relaxation technique, physical activity):</th>
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<th>Step 3: People and social settings that provide distraction:</th>
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<th>Step 4: People whom I can ask for help:</th>
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<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
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<td>University Counseling Services: Phone (715) 836-5521</td>
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<td>Clinician Name</td>
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<td>Phone:</td>
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<th>Step 6: Ways I can make the environments safe:</th>
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**SAFETY PLAN**

**Step 1: Warning signs:**
1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguments with girlfriend

**Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:**
1. Play the guitar
2. Watch sports on television
3. Work out

**Step 3: Social situations and people that can help to distract me:**
1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

**Step 4: People who I can ask for help:**
1. Name: Mother                           Phone: 333-8666
2. Name: AA Sponsor (Frank)               Phone: 333-7215

**Step 5: Professionals or agencies I can contact during a crisis:**
1. Clinician Name_ Dr John Jones_ Phone 333-7000
2. Clinician Name_ Phone

**Making the environment safe:**
1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3.
Remind Me focused the user on cherished memories and digital media reminders of the user’s worth (photos, videos, recorded messages, music) selected from existing files on the phone or added using the phone audiovisual capabilities.

Distract Me offered distraction tools for the user, an activity planner, and puzzles/word search games built from existing user content.

Relax Me featured relaxation and stress-coping tools, such as diaphragmatic breathing coaching and progressive muscle relaxation.

Support Contacts allowed the users to insert links to chosen support contacts and hotline resources.

Inspire Me: Preloaded inspirational quotes could be supplemented or replaced by favorite personal quotations, family aphorisms, biblical phrases, etc. that the user found to be personally comforting, supportive, or inspiring.

Coping Cards highlighted adaptive thoughts and behaviors when in crisis or managing problematic core beliefs.
Veteran Response to Hope Box App

- Found setting up easy: 78% (VHB), 44% (CHB)
- Reported using at least 1-4/week: 94% (VHB), 67% (CHB)
- Found helpful & beneficial: 89% (VHB), 67% (CHB)
- Would consider using in the future: 94% (VHB), 78% (CHB)
- Would recommend to a fellow veteran or service member: 100% (VHB), 78% (CHB)

N=18
Professional Reflection & Questions

What changes might you incorporate into your practice tomorrow and/or share with colleagues?

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