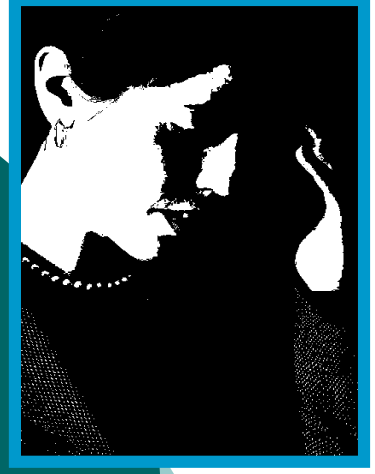
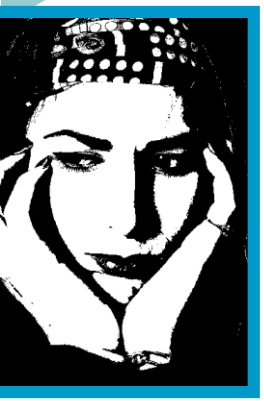


What Drives Suicidal Behavior



George M. Wohlreich, MD

HESPC Conference

Pittsburgh, PA

March 13, 2017

Content

1. Introduction and Caveat
2. Definitions
3. Epidemiology, Esp. Young Adults
4. Malpractice
5. Suicide Vulnerability
6. The Crisis
7. Assessment
8. Treatment
9. Impact on Clinicians

CAVEATS

Caveat #1

"Ah, what a dusty answer gets the soul when hot for certainty in this our life."*

*George Meredith, "Modern Love," 1891

CAVEAT #2

Every slide today could be, and has been, the topic of a separate lecture and/or a separate journal article.

DEFINITIONS

Definitions

- The killing of oneself
  - Self-inflicted
  - Self-intentioned
  - Non-coerced
- Character structure's reaction to stress.

The “Way” of Suicide

- A way of “getting out” of life
  - Episodic
  - Unremitting
- A way of “getting on” in life
  - Characterological
  - A paradoxical ”lifeline”

The Suicide Continuum

- Ideation
- Parasuicide ("suicidal gesture")
  - 25 times more frequent than completed suicide
- Failed suicides (serious attempts that do not succeed)
- Completed suicide

EPIDEMIOLOGY

Epidemiology--1

- Methodologic challenges in the study of suicide
  - No control group validity
    - 90% of attempters do not complete
    - False negatives—concealment of intent and/or impulsivity
    - False positives—ideation w/o intent

Epidemiology--2

- Gross under-reporting
  - Shame
  - Cultural, religious, and social taboos
  - Occupational taboos

Epidemiology--3

- Regardless of the aforementioned problems with reporting:
- Suicide is the 10th leading, over-all cause of death in the USA
- Suicide is the 2nd leading cause of death for the age 15-34 cohort

Suicide Completers

- >90% have or could have a psychiatric Dx
- >8% had expressed suicidal ideation.
- >40% had made a previous suicide attempt.
- 30% were in current psychiatric treatment.
- 4% are in the hospital (Perhaps)
- 50% never had any psychiatric contact.
- 75% saw a physician in the 6 months prior to suicide. (*Only 1 in 6 physicians had prior knowledge of the suicide preoccupation*.)

(Multiple sources)

MALPRACTICE

Malpractice: Two Views $

#1: 26% of psychiatric related claims, and more than 50% of the dollar losses from psychiatry are related to suicide.

#2: Suicides probably make up to 90% of malpractice suits.

1. Risk Management Foundation of the Harvard Medical Institution
2. (Reid, "Carlat Report," Jan. 2015

SUICIDE PREDICTION

Suicide Prediction

- EHR data-mining capable of predicting subsequent suicidal behavior w/ 90% specificity and 45% sensitivity.
- Main foci: Psychiatric and SUD's and specific injuries/illnesses.

  - Barak-Corren, Am J Psychiatry, Sept, 2016

Three Major Factors

- Predisposition--Vulnerability
- Precipitation—”Crisis” (Int./Ext.)
- Perpetuation--Maintenance

Predicting Suicide: Vulnerability

Picking a group is much, much easier than picking an individual within that group.

"An 'n' of one is highly significant when you're the one."

Therefore, if we cannot know "who", maybe knowing "why" could be very helpful.

Darcy Wentworth Thomas

Suicidal Vulnerability--1

Final common pathway is **despair** (not depression)

Two Parts:

- Intolerable affective state
- Recognition of that state and subsequent giving up oneself.

Suicidal Vulnerability--2

Affective State

- Aloneness (not loneliness)—Represents existential dread.

- Worthlessness—Implies irrevocable abandonment. The person is beyond love and care. There is murderous self-contempt due to an implacable superego.

- Rage—When threatened with abandonment, there is murderous rage and hate and the wish to escape.

Suicidal Vulnerability--3

Having a Dx, by itself, is Not Helpful>>Vulnerability to suicide appears at all levels of descriptive psychopathology and normalcy. The most useful way to assess someone for suicidality is the old-fashioned way—

- history
- mental status examination
- psychodynamic formulation
- **?scales**

College Student “Uniqueness”--1

- We often forget: These are adolescents/late adolescents.
- They are particularly interested in, sensitive to, and subject to their relationships with their different peer groups.
- A generation ago: The obloquy of the school bus/cafeteria table vs that of the entire school/campus due to social media

College Student “Uniqueness”--2

- A “zit” is not pancreatic cancer--?Really
- Getting a “B-” is not the end of the universe--?Really
- Getting snubbed by “Suzy Q/Joe Cool” is not the end of the world--?Really
- Getting straight “A’s,” being captain of field hockey is great--?Really

THE CRISIS

The Suicide Crisis--1

- Illness—Loss of valued abilities
- Object Loss
  - Real, threat, or fantasy of abandonment
- Loss of sources of relief
  - Clearing of a paranoid psychosis
  - Cessation of drugs and/or alcohol
- Change—Undesirable or very desirable
- Occupational/school difficulties and humiliation

The Suicide Crisis--2

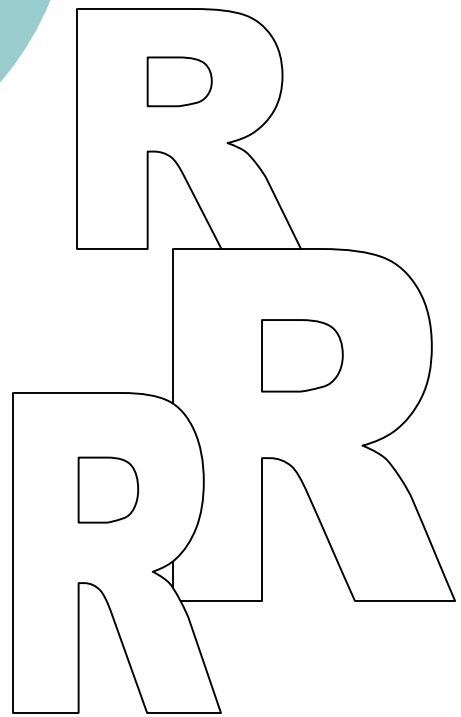
- Family strife and psychopathology of parents—Even from afar.
- Parental emotional abuse—Even from afar.
- Physical and sexual assault—Even from afar
- Changes in physical and/or sexual activity
- The extent to which the student precipitated the event

METAPHOR

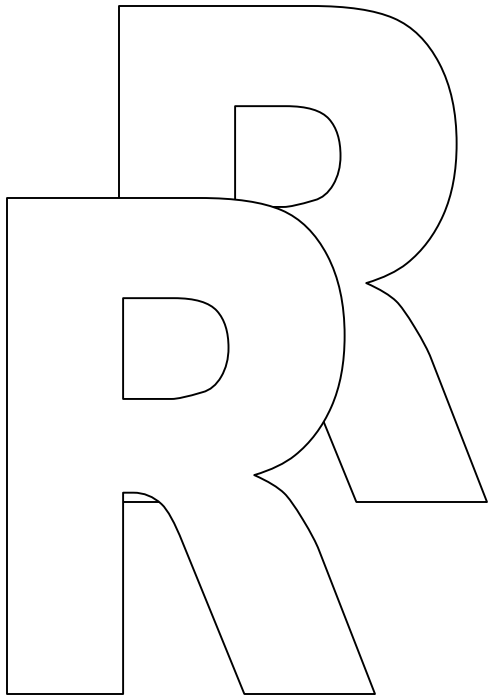
- Perhaps some of the most powerful things in life can only be, or can best be, expressed as metaphor.

“Fantasy” of Suicide

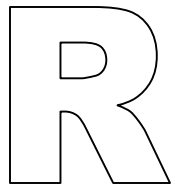
The Five “**R**”s



- **R**eunion
- **R**ebirth
- **R**iddance
- **R**evenge
- **R**est
- (Maltsberger, Suicide Risk, 1986)



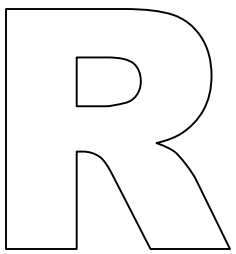
“Fantasy” of Suicide



- **R**eunion with a beloved or going on a journey
- **R**ebirth—a transformation to a new, higher/different level of being
- **R**iddance—escape from intolerable affect or feeling

“Fantasy” of Suicide

- **R**evenge—Against the hostile others
  - Guilt and sorrow around the coffin
  - Attacking something (oneself) dearly cherished by another



  - **R**est—Nothingness—What does it mean?
  - State of feeling of sleeping, satiated infant, insentient, unconscious, incorporeal, timeless

ASSESSMENT

Suicide Assessment Scales

- Hamilton Rating Scale for Depression (Suicide item)
- Beck Depression Inventory BDI-II (Suicide, Hopelessness items)
- Scale for Suicide Ideation (and SSI-Worst)
- Beck Hopelessness Scale/Suicide Intent Scale
- Acute Suicidal Ideation Questionnaire
- Columbia Univ. Protocol
- SAMHSA SAFE-T
- APA "Practice Guidelines etc."

CAVEAT: Low base rate means high false positives.

Therefore, comprehensive evaluation is needed.

Assessment of Suicide-1

"The diagnosis of despair can be as difficult and elusive as the most difficult diagnostic problems that general medicine presents."(Leston Havens)

The courts do not expect evaluators to predict the future, but the courts do expect them to consider likely signs/sxs/circumstances. "Good faith" judgment almost never gets penalized.

Assessment for Suicide-2

- Exploration of mood, affect, behavior
- Exploration of why and how he cannot bear his life
- **Manifest content is not sufficient to rule in or out suicidality. Manifest denial is not sufficient to rule it out.**
- Age, sex, sexual orientation, marital status, living arrangements, physical health, previous suicide attempts, and drug and alcohol uses-past and present.

Assessment for Suicide-3

- Evaluation of loss
  - Real or imagined
  - Neurotic or psychotic
  - Temporary or permanent
  - Already happened or anticipated
  - Available substitutes

Assessment for Suicide-4

- Exploration of history of actual self-harm and lethality of the attempt(s)
  - Serious attempt vs. gamble vs. "histrionic/dramatic"
- Evaluate the intent and nature of what was done, social content, etc.
- Exploration of communication of intent
  - Telegraphing
  - Anticipated response from others

Assessment for Suicide-5

Suggestions from others to suicide—

- Manifest
  - "Why don't you kill yourself?"
  - "Dear, you're not thinking of killing yourself, again, are you?"
- Latent
  - The most deadly—the silent withdrawal or indifference and frigidity

?CAN PSYCHODYNAMICS HELP

Psychodynamic Formulation

- Who is suffering from what?
- How is it experienced?
- How was it experienced in the past?
- What in his personality structure led to this problem in the past?
- What is his characteristic response likely to be?
- What defenses are likely to be used?

Psychodynamic Formulation

- Major defenses:
  - Denial
  - Projection
  - Acting Out
  - Splitting
- Defenses prevent:
  - Experiencing
  - Identifying
  - Remembering
  - Articulating

PROTECTIVE FACTORS

Protective Factors--1

- Easy access to effective care
- Restricted access to highly lethal means of committing suicide
- Strong family, community ties
- Cultural and religious beliefs that discourage suicide

Protective Factors-2

- Skills in problem solving, conflict resolution, and non-violent handling of disputes
- BUT, ***impulsiveness can trump all of the above***

TREATMENT

Treatment of Suicide-1

- Pharmacotherapy—May be Necessary But Almost Never Sufficient
  - Direct pharmacotherapy toward the underlying disorder
    - Antidepressants
    - Mood stabilizers
    - Antipsychotics
    - Benzodiazapines
    - Sedative-Hypnotics

- Electro-Convulsive Therapy

Treatment of Suicide-2

- Psychotherapy—The role of the therapist is to help the patient
  - Recognize what's going on
  - Accept responsibility for it
  - Change patterns of feeling, thinking, and acting

  Also to…
  - Decrease morbid fantasies, fantasies of loss, rejection, and punishment

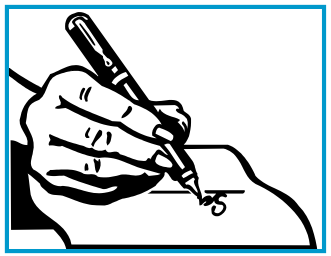
  - ***NOTE:*** CBT—Good evidence for effectiveness, but one can *still* envisage all of this talk at a meta-level of understanding

Treatment of Suicide-3

What the therapist must ***also*** do:

- Convey interest and respect
- Show the patient that his sensitivity and vulnerability results from internalized beliefs in his own worthlessness (rather than “mere reality”).
- Help patient see suicidality as a pattern, a logical misperception, a series of steps, which can be changed. (”Negative” and “automatic thinking” in CBT language)
- Understand his countertransference
- “Sincerity is the sine qua non which guarantees nothing.”

Treatment of Suicide-4



- Contracts
  - Do they prevent suicide?
  - Are they a consequence for misbehavior or a set of expectations?
  - Vs.
- Alliance
  - Focus on ability to participate in treatment and develop an alliance, rather than on a promise.

Treatment of Suicide--5

- Limit Setting
  - An attempt to stop maladaptive behavior
  - Must be balanced against abdication of responsibility
- Confrontation
  - Focus inner experience onto outer reality
- Empathy
  - “Vicarious introspection”

SPECIAL SITUATIONS

Chronic Suicidality

- Secondary gain from chronic suicidality
- Family education—”psychological cancer”
- Chronic discussion of suicidal behavior
- Countertransference and heroism

ERRORS & WARNINGS

Common Errors

- Countertransference difficulties
- Excessive reliance on clinical intuition
- False beliefs—Contracts, meds, family, etc.
- Failure to take into account the sources and reliability of emotional support
- The belief that suicide may be prevented by impersonal means
- Legal Issues
  - Patient's safety ALWAYS takes precedence (Forget HIPPA)

Difficulties & Warnings for Clinicians--1

- Avoid reassuring self by reassuring the student
- Avoid undue self-revelation
- Counterpoint to "malice and aversion" is the wish to save
- Avoid feeling overwhelmed
- Develop a set of protective professional stances

Difficulties & Warnings for Clinicians--2

- Manifest Mood—is not sufficient without a context
  - Despair vs. Depression
- Intuition
  - Dangerous without context
- Sustaining Resources
  - Are they immediately adequate?

Difficulties & Warnings for Clinicians--3

- Diurnal Change in Mood & Mental Status
  - Alters the way one deals with suicidality

Difficulties & Warnings for Clinicians--4

- Empathize with, but don't get trapped by:
  - Suicidal temptation
  - Longing for peace
  - Excitement of self-directed aggression
  - Pleasure in taking revenge against others
  - Exhilarating sense of power

TAKING CARE of ONESELF

Taking Care of Survivors

- For every suicide, there are eleven (11) victims—the deceased and ten (10) caregivers.
- Formal "Postvention" Efforts
  - 1. Active, early
  - 2. Therapy-centered techniques
  - 3. Containment strategies
    - Insel, NIMH Director's Blog, 2014
    - Erlich, GAP, Psychopath.Comm., 2016

How Therapists Treat themselves

- Develop outside interests
- Take vacations
- Communicate and collaborate with peers
- Modify duties and responsibilities
- Restrict the number of difficult patients
- Give a talk like this one