Innovations in Clinical Assessment and Treatment of Suicide Risk

David A. Jobes, Ph.D., ABPP
Professor of Psychology
Associate Director of Clinical Training
The Catholic University of America
Washington, DC USA

All Ohio Institute on Community Psychiatry
Cleveland Ohio
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Growing up in suicidology since the 1980’s

State of the art early on...
- Psychological autopsy studies of completed suicides
- Establishing the key role of psychopathology and suicide
- The epidemiology of suicide and suicidal behaviors
- Youth suicide focus (Secretary’s Task Force)
- The birth of the suicide survivor movement
- Routine use of lengthy inpatient hospitalization
- Routine use of “no-suicide” contracts—“commitment to safety”

Today the field is exploding...
- Suicide research is increasing exponentially
- VA and DOD are spending multi-millions on suicide prevention
- State legislation requiring suicide-specific training for mental health professionals continuing education (e.g., Washington)
- The potential impact of the lived-experience and attempt survivor movement
- National Action Alliance (Clinical Care Task Force → “Zero Suicide” movement to raise the standard of clinical care)
- An increasing emphasis on evidence-based treatments, but...

There is still a professional crisis...

Clinical Work with Suicidal Patients: Ethical Issues and Professional Challenges (PRPP: Jobes, Rudd, Overholser, & Joiner, 2008)

1. Issues of sufficient informed consent about suicide risk.
2. Issues of competent and thorough assessment of suicide risk.
3. Little use of evidence-based clinical interventions and treatments for suicide risk.
4. Issues with risk management and paralyzing concerns about malpractice liability.

Reflections on “clinical suicidology”
Innovation in Suicide Assessments

- "Traditional" clinical approaches
  - Clinical interviewing
  - Risk assessment tools
- Stratification of suicidal risk—typologies of suicidal states
  - Quantitative approaches
  - Qualitative approaches
- Indirect assessments ("occult" suicidal risk)
  - Risk assessment tools
  - Objective assessment
- Indirect assessments of risk through measures of CNS arousal
  - Eye-blink startle response
  - Autonomic nervous system activation

Internal Struggle Hypothesis (Kovacs & Beck, 1977)

WTL ratings – WTD ratings = Suicide Index Score

1) WTL
2) AMB
3) WTD

SSI results generated significant odds ratios for suicidal behaviors...

Suicide Index Score = WTL – WTD

Scale for Suicide Ideation (SSI)  Suicide Status Form (SSF)

SSF “Macro-Coding” RFL/RFD Motivation

- AMBIENT MOTIVATION
  - RFL = RFD

- DEATH MOTIVATION
  - RFL < RFD

- LIFE MOTIVATION
  - RFL > RFD

“Stratifying” risk and creating typologies of suicidal states...

Indirect Assessments
Suicide IAT

Does the suicide IAT distinguish between adults presenting to the ED for a suicide attempt (n=43) versus other psychiatric emergency (n=114)?

*SAs had a stronger implicit death ID (t=2.46, p<.05)


Suicide IAT

Does S-IAT add incrementally to prediction of future suicide attempts?

*Those with death ID were more likely to make an attempt after discharge
*IAT added incrementally to prediction of SA beyond diagnosis, clinician, patient, and SSI (OR=5.9, p<.05)

PI: Marianne Goodman, M.D.
Startle Eye-blink Measurement

PI: Jide Familoni, PhD
Human Signatures Exploitation Branch, NVESD
Co-PI: Ann Rasmusson, MD
VA Boston

Affective Startle and Suicide Risk
(PI: Goodman/Hazlett)

Randomized Controlled Study: Tailored Evaluation and Treatment for PTSD Progression and Suicide Prevention by Application of Thermal Imaging.

As pores open, they are automatically counted in real time.

SAFE: Real time tracking of pore activity on the face or finger as an indication of autonomic nervous system arousal.

SAFEGM: Non-contact, passive, high resolution imaging of sweat pores.
Pore count is a quantified surrogate for autonomic nervous system activity
Government invented, developed, and owned.

悅: As pores open, they are automatically counted in real time.

Thermal imagery of Face and Thumb

• Non-contact, passive, high resolution imaging of sweat pores.
• Pore count is a quantified surrogate for autonomic nervous system activity.
• Government invented, developed, and owned.
Evidence-Based Treatments for Suicidality

- With 50+ studies there are few evidence-based treatments
- There is little to no support for medication-only or hospitalization
- RCT’s and replications support:
  - Dialectical Behavior Therapy (DBT)
  - Cognitive Therapy for Suicide Prevention (CBT-SP)
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Non-demand follow-up contact

Innovation in Suicide Treatments

- Suicide-specific treatments
- Brief Interventions
- Alternative interventions and modalities
- Non-demand caring contact
- Matching different interventions and doses of care to different suicidal presentations...
  - Least restrictive
  - Evidence-based
  - Cost-effective

Resources for Dialectical Behavior Therapy

Source Texts:
http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/linehan.htm&dir=pp/pd

Training Website: http://behavioraltech.org/index.cfm

DBT’s Impact on Non-Suicidal Self-Injury Behavior

DBT’s Impact on Suicide Attempt Behavior
Survival Functions for Repeat Suicide Attempt by Study Condition

Cognitive Therapy Intervention

Control


Brief Cognitive Behavior Therapy (B-CBT)

M. David Rudd, Ph.D. & Craig Bryan, Psy.D.
Ft. Carson Randomized Clinical Trial

60% between-group reduction in suicide attempts (American Journal of Psychiatry, in press)

Resources for Cognitive Behavioral Therapy

Source Text:

Cognitive Therapy Training:
http://www.beckinstitute.org/cbt-workshop-registration/

Other Key Websites:
http://veterans.utah.edu/home
http://www.usuhs.mil/faculty/holloway/index.html

The Collaborative Assessment and Management of Suicidality (CAMS)

Strong Correlational and Open Trial Support for SSF/CAMS

<table>
<thead>
<tr>
<th>Authors</th>
<th>Sample/Setting</th>
<th>n</th>
<th>Significant Results</th>
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<tbody>
<tr>
<td>Jobes et al., 1997</td>
<td>College Students</td>
<td>106</td>
<td>Pre/Post Distress</td>
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<tr>
<td></td>
<td>Univ. Counseling</td>
<td></td>
<td>Pre/Post Core SSF</td>
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<td>Clinic</td>
<td></td>
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<td>Jobes et al., 2005</td>
<td>Air Force Personnel</td>
<td>56</td>
<td>Between Group Suicide Ideation, ED/PC Appts.</td>
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<td></td>
<td>Outpatient Clinic</td>
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<td>Arkov et al., 2008</td>
<td>Danish Outpatients</td>
<td>27</td>
<td>Pre/Post Core SSF</td>
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<td>CMH Clinic</td>
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<td>Qualitative findings</td>
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<td>College Students</td>
<td>55</td>
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<td>Univ. Counseling</td>
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<td>Distress/Ideation</td>
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<tr>
<td></td>
<td>Clinic</td>
<td></td>
<td></td>
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<tr>
<td>Nielsen et al., 2011</td>
<td>Danish Outpatients</td>
<td>42</td>
<td>Pre/Post Core SSF</td>
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<td></td>
<td>CMH Clinic</td>
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<tr>
<td>Ells et al., 2012</td>
<td>Psychiatric Inpatients</td>
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<td>Pre/Post Core SSF</td>
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<td></td>
<td></td>
<td></td>
<td>Suicidal Ideation, depression, hopelessness</td>
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<tr>
<td>Ells et al., 2015</td>
<td>Psychiatric Inpatients</td>
<td>52</td>
<td>Suicide ideation/cognitions</td>
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</table>
CAMS RCT (Comtois et al., 2011)

Significantly higher patient satisfaction ratings and better clinical retention...

Operation Worth Living: DOD-Funded CAMS RCT at Ft. Stewart, GA

Consenting Suicidal Soldiers (n=150)

Control Group
E-CAU
3 months of outpatient care (n=75)

Experimental Group
CAMS
3 months of outpatient care (n=75)

Dependent Variables: Suicidal ideation/attempts, Symptom Distress, Resilience, Primary Care visits, Emergency Department Visits, and Hospitalizations.

Measures: SSI, OQ-45, SHBG, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)

NIMH-Funded R-34
Figure 1. College Student Client Flow through the SMART

Resources for CAMS
CUA Suicide Prevention Lab: https://sites.google.com/site/cuajsplab/home
CAMS e-learning: www.empathosresources.com

CAMS Dissemination and Adherence: e-Learning + role-plays + consultation

Craig Bryan, Psy.D.
Brief intervention using Crisis Response Plan + Reasons for Living with suicidal Soldiers...

Stephen O’Connor, Ph.D.
Use of a one-time psychological intervention on medical-surgical units with inpatient suicide attempters...

Peter Britton, Ph.D.
1-2 sessions of Motivational Interviewing With veterans following a suicide attempt...
ASSIP – Attempted Suicide Short Intervention Program
Anja Gysin-Maillart, Konrad Michel

4 Sessions, followed by regular letters over 2 years

<table>
<thead>
<tr>
<th>Session No.</th>
<th>Therapeutic elements</th>
<th>ASSIP Modules</th>
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<tbody>
<tr>
<td>1</td>
<td>Establish a therapeutic relationship</td>
<td>- Narrative interview, video recorded; SSF-II</td>
</tr>
<tr>
<td>2</td>
<td>Emotional activation, restructuring</td>
<td>- Video playback; confrontation</td>
</tr>
<tr>
<td>3</td>
<td>Develop a shared understanding</td>
<td>- Handout (homework; psychoeducation)</td>
</tr>
<tr>
<td>4</td>
<td>Protocol rehearsal</td>
<td>- Written summary of vulnerability and triggers</td>
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<tr>
<td></td>
<td>Safety planning</td>
<td>- Individual safety card (&quot;Leporello&quot;)</td>
</tr>
<tr>
<td>(5)</td>
<td>Continuous therapeutic relationship</td>
<td>- Re-exposure to trigger event (video)</td>
</tr>
</tbody>
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ASSIP – 12 Months Follow-up Suicide Attempts

<table>
<thead>
<tr>
<th>Follow-up period</th>
<th>Group</th>
<th>N</th>
<th>Attempts</th>
<th>Percente</th>
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<tbody>
<tr>
<td>4 months</td>
<td>ASSIP Control 69</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4-12 months</td>
<td>ASSIP Control 56</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>12 months</td>
<td>ASSIP Control 48</td>
<td>25</td>
<td>31</td>
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<tr>
<th>Independent T test</th>
<th>df</th>
<th>p</th>
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<tr>
<td>6 months</td>
<td>2.38</td>
<td>0.021</td>
</tr>
<tr>
<td>6-12 months</td>
<td>2.01</td>
<td>0.056</td>
</tr>
<tr>
<td>1-12 months</td>
<td>2.04</td>
<td>0.047</td>
</tr>
</tbody>
</table>

Between Groups Effect Size (d) at 12 months: 0.87

Caring-Contact Research: Motto’s Classic Caring Letter Study

3,005 Depressive or Suicidal Persons Identified at 9 psychiatric inpatient hospitals

1,939 Received Treatment 843 Refused or No Treatment 223 Treatment Undetermined

Randomization

389 Contact 454 No Contact

Source: Motto & Bostrom, 2001

Contact Letter sent every 1-4 months over 5 year period

Dear Patient’s Name:

“It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note, we would be glad to hear from you.”

Source: Motto & Bostrom, 2001
Non-Demand/Caring Contact Outreach

- Caring letters
- Caring postcards
- Caring phone calls
- Caring emails
- Caring texts
- ED follow-up calls
- Inpatient follow-up calls
- Post D/C home visits

Matching Interventions to Suicidal States

Levels of Clinical Care Based on Stratified Risk (Ordered by Least-Restrictive Treatment)

Key post health care reform constructs: Evidence-Based, Least-Restrictive, and Cost-Effective...

Suicide Prevention

Postscript:

Considering the implications, the rewards of effective suicide prevention are considerable...

Thank You!

Email: Jobes@cua.edu