Building Capacity to Meet the Demand for Services: Beyond the Therapist’s Office

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January 18, 2007
National Comorbidity Study
(1990-92; 15-54 yrs; 5877 respondents)

Cumulative Probabilities for Transition:

Ideation → Plan  34%

Plan → Attempt  72%

Ideation → Unplanned Attempt  26%

Kessler et al; AGP 56: 617-626, 1999
National Comorbidity Study
(1990-92; 15-54 yrs; 5877 respondents)

ATTEMPTERS

39.3% made a “serious” life-threatening attempt

13.3% made a “serious,” but “not fool-proof” method

47.3% made a “cry for help,” and did not want to die

Kessler et al; AGP 56: 617-626, 1999

The Aftermath of Suicide Attempts

- No further attempts 66%
- Further attempts in lifetime 33%
- Attempt within 1 year 10-20%
- Suicide within 1 year 1-2%
- Suicide in lifetime 10-15%

Fremouw. De Percel, & Ellis (1990)
Systematic Review of Repetition of Suicide Attempt

Risk of Suicide

1.8 % (0.8 - 2.6%) within 1 yr. of an attempt
3.0 % (2.0 - 4.4%) within 1-4 years
3.4 % (2.5 - 6.0%) within 5-10 years
6.7 % (5.0 - 11.0%) within 9 or more years

Owens, et al., 2002

Overlap of Suicidal Behaviors

ATTEMPTS to COMPLETIONS:

10-20% who have attempted will subsequently complete (Ettlinger, 1975)

7-10% who have made a non-fatal suicide attempt eventually die by suicide (Ettlinger, 1964; Weiss & Scott, 1964; Motto, 1965; Cullberg, et al., 1988)
Overlap of Suicidal Behaviors

COMPLETIONS after prior ATTEMPTS:

30-40% of completions have had prior attempts (Ottosson, 1979)

18-38% of completers have made prior attempts (Dorpat & Ripley, 1960; Barracough, et al., 1974; Robins, 1981; Rich, et al., 1986)
Overlap of Suicidal Behaviors

CONCLUSION:

80-93% of attempters will never die by suicide

60-82% of completers have no known history of prior attempts

Question: What % of completers have a history of DSH and what % of DSH patients eventually die by suicide?

See Maris, Linehan, Hawton, Beautrais, Kessler

Clinical Challenges

• How to identify the most at risk individuals within the ideator population
• How to identify the most at risk individuals within the attempter population
• What other behaviors or markers can help identify the population of “silent” completers
• What distinct strategies do we use to prevent:
  1. first attempts
  2. repeat attempts
  3. completions
What Exactly Are We Trying to Prevent?

1. Precursors to “suicidality”?  
2. Suicidal Ideation?  
3. Suicidal Motives?  
4. Suicidal Intent?  
5. Suicidal Plans?  
6. Suicidal Actions/Attempts?  
7. Repeat attempts?  
8. Suicide?  
9. Associated/Contributory/Correlated Disorders and Dysfunctions?

National Comorbidity Study  
(1990-92; 15-54 yrs; 5877 respondents)

• **LIFETIME IDEATION**: 13.5%  
• **LIFETIME PLAN**: 3.9%  
• **LIFETIME ATTEMPT**: 4.6%

Kessler et al; AGP 56: 617-626, 1999
What Do We Know How to Prevent?

- Ideation – Thoughts (Cognition)
- Motivation – Reasons (Cognition)
- Intent – Desire; Wish (Emotion)
- Plan – Construct (Cognition)
- Attempt – (Behavior)
- Completion – (Behavior)

But Remember………..

Suicide is NOT the problem………..

Suicide is only the solution to a perceived insoluble problem that is no longer tolerable
LET’S THINK ABOUT THIS FROM OUTSIDE OF THE THERAPIST’S OFFICE (and DSM-IV TR)

Psychological Needs

• Shneidman: “For practical purposes, most suicides tend to fall into one of five clusters of psychological needs. They reflect different kinds of psychological pain.” (1996, p. 25)

• They are:
  thwarted love
  ruptured relationships
  assaulted self-image
  fractured control
  excessive anger related to frustrated needs for dominance
Sketch of Joiner’s Theory

Those Who Desire Suicide

Perceived Burdensomeness

Thwarted Belongingness

Those Who Are Capable of Suicide

Serious Attempt or Death by Suicide

The Acquired Capability to Enact Lethal Self-Injury

• Accrues with repeated and escalating experiences involving pain and provocation, such as
  – Past suicidal behavior, but not only that…
  – Repeated injuries (e.g., childhood physical abuse).
  – Repeated witnessing of pain, violence, or injury
  – Any repeated exposure to pain and provocation.
The Acquired Capability to Enact Lethal Self-Injury

• With repeated exposure, one habituates – the “taboo” and prohibited quality of suicidal behavior diminishes, and so may the fear and pain associated with self-harm.

Perceived Burdensomeness

• Feeling ineffective to the degree that others are burdened
Thwarted Belongingness

- Feeling rejected, unattached, detached, without social support, without peer identity, without group identity, without connectedness

Thwarted Belongingness

- This fundamental need is so powerful that, when satisfied, it can prevent suicide even when perceived burdensomeness and the acquired ability to enact lethal self-injury are in place.
- By the same token, when the need is thwarted, risk for suicide is increased.
- The thwarting of this fundamental need is powerful enough to contribute to the desire for death.
Prevention Implications

- Prevention of “acquired ability,” OR “burdensomeness,” OR “thwarted belongingness” will prevent future suicidal behaviors.
- Belongingness may be the most malleable and most powerful.
- Example PSA: “Keep your old friends and make new ones – it’s powerful medicine.”

Sketch of Joiner’s Theory

Those Who Desire Suicide

Perceived Burdensomeness

Thwarted Belongingness

Serious Attempt or Death by Suicide

Those Who Are Capable of Suicide
Incidence

Albee (1982)

\[
\text{Incidence} = \frac{\text{Organic Factor} + \text{Stress}}{\text{Coping Skills} + \text{Self Esteem} + \text{Support Groups}}
\]
Stress
Social Network * Social Competence * Resources

Stress Moderators

= Risk for Substance Abuse

Figure 1. Social Stress Model of Alcohol and Other Drug Abuse

Rhodes and Jason (1990)

Jed Foundation/EDC
Comprehensive Approach

Identify Students at Risk
Increase Help-seeking Behavior
Provide Mental Health Services
Follow Crisis Management Procedures
Restrict Access to Potentially Lethal Means
Develop Life Skills
Promote Social Networks

Comprehensive Approach to Suicide Prevention and Mental Health Promotion
## Prevention vs. Treatment

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<td>Reduce Disability $3^0$</td>
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<td>Disease Prevention</td>
<td>Restore to Prior Status</td>
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<td></td>
<td>Reduce Incidence - $1^0$</td>
<td>Correct Deficits</td>
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<td>Reduce Prevalence - $2^0$</td>
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### Prevention vs. Treatment

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<td>Media/ Conferences</td>
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<td>Crisis Intervention</td>
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### Types of Preventive Interventions

- **Biological** (drugs, nutrition, diet)
- **Physiological** (relaxation therapy, exercise)
- **Cognitive/Learning** (problem-solving techniques; CBT, DBT)
- **Behavioral** (stress reduction; management; avoidance)
- **Social Skills/Life Skills/Competency Training**
- **Environmental/Ecological** (family, friends, community)
- **Psycho-educational** (coping, adaptation)
- **Media** (print, radio, TV)
- **Social Support**
- **Job Training/Career Development**
- **Employment**
THE BUCK SHOULD NOT ALWAYS STOP AT THE FRONT DOOR OF THE COUNSELING CENTER.....

HOWEVER........................

Jerome Motto

• “There is surely at least one common theme through the centuries (regarding suicide prevention) – it is the provision of human contact, the comfort of another concerned person, often authoritative but maybe not, conveying a message of hope consonant with the assumptions and values relevant to that particular time.”

Motto & Bostrom, 2001, p. 829