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

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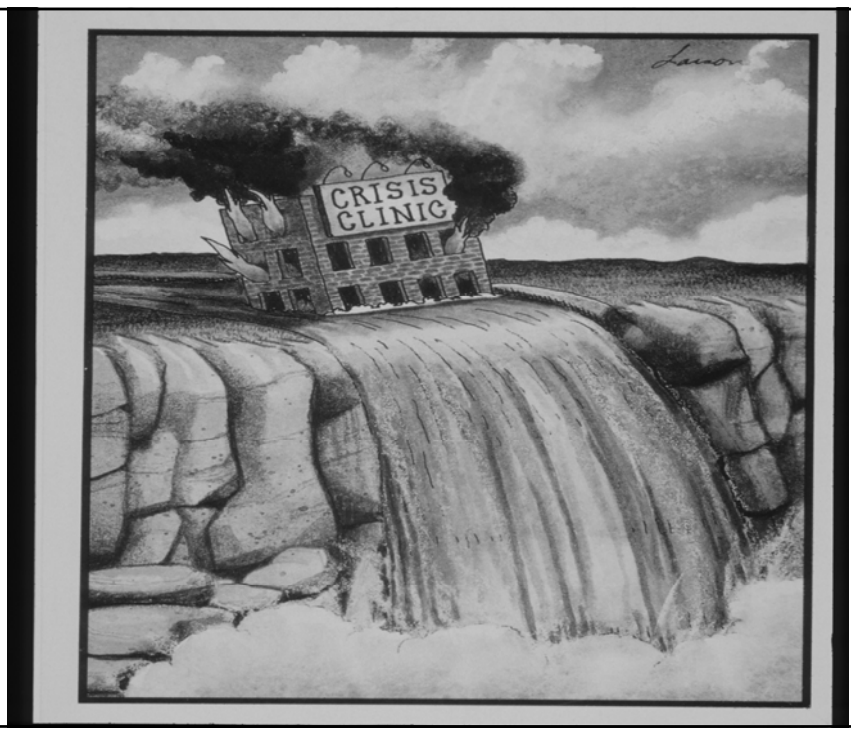


National Comorbidity Study

(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)

Within 1 Year of Onset of IDEATION:

60% of all planned 1st attempts occur

90% of all unplanned 1st attempts occur

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)

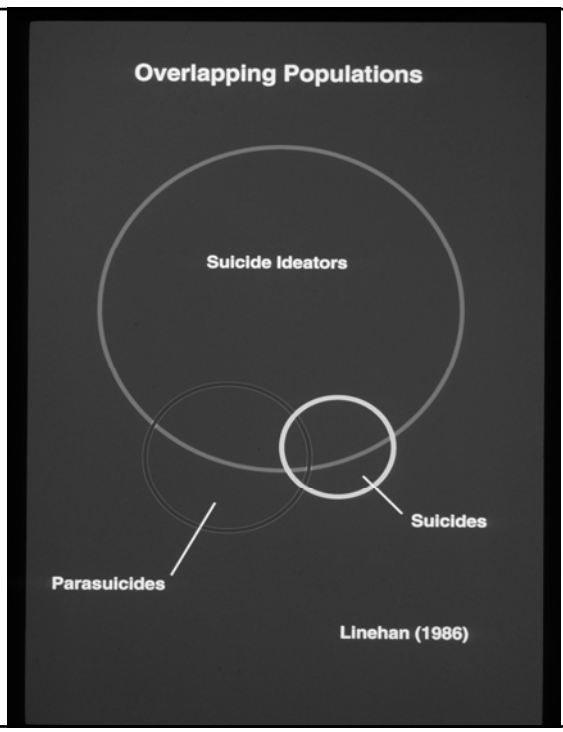
7-10% who have made a non-fatal suicide attempt eventually die by suicide (Ettlinger, 1964; Weiss & Scott, 1964; Motto, 1965; Cullberg, et al., 1988)

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; Barraclough, 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

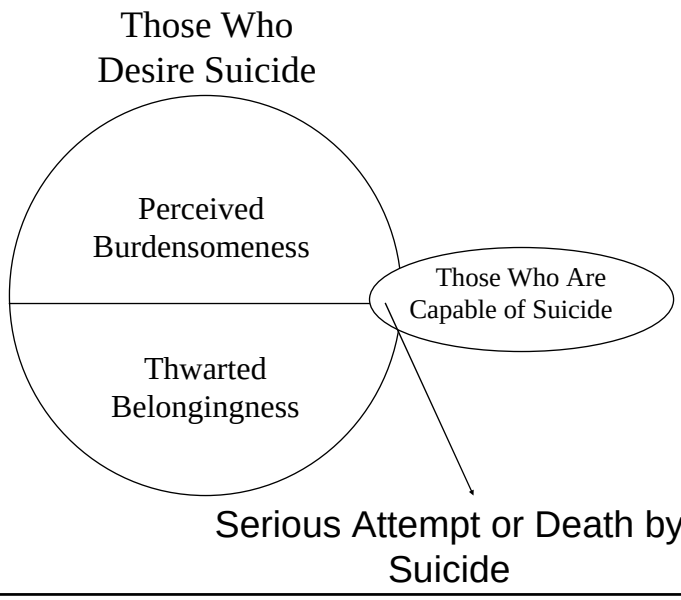
SO……

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



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

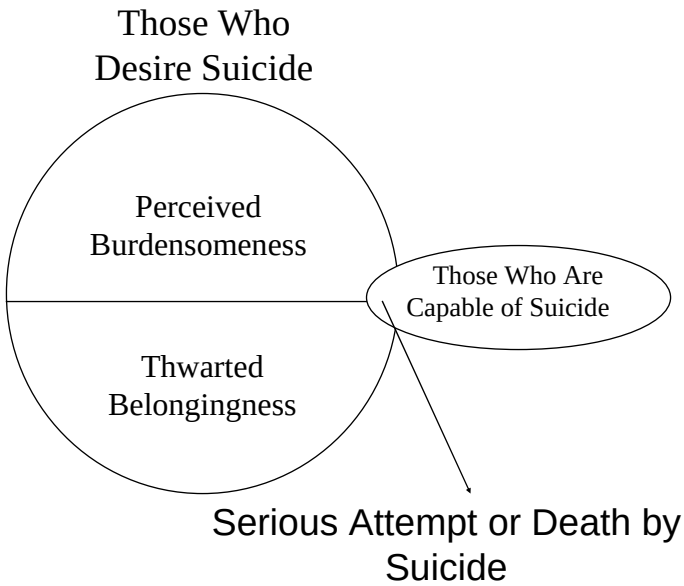
Thwarted Belongingness

- 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

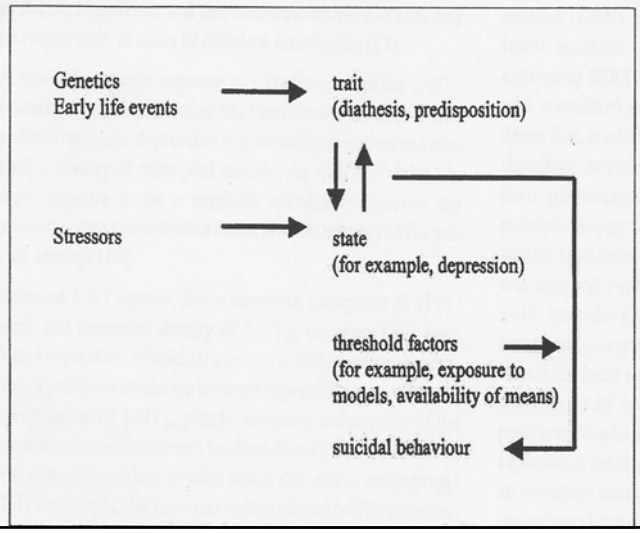
- Prevention of "acquired ability," **OR** "burdensomeness," **OR** "thwarted belongingness" will prevent future suicidal behaviors.
- Belongingness may be the most malleable and most powerful.
- Example PSA: "Keep your old friends and make new ones – it's powerful medicine."

Sketch of Joiner's Theory



Stress-Diathesis Hypothesis

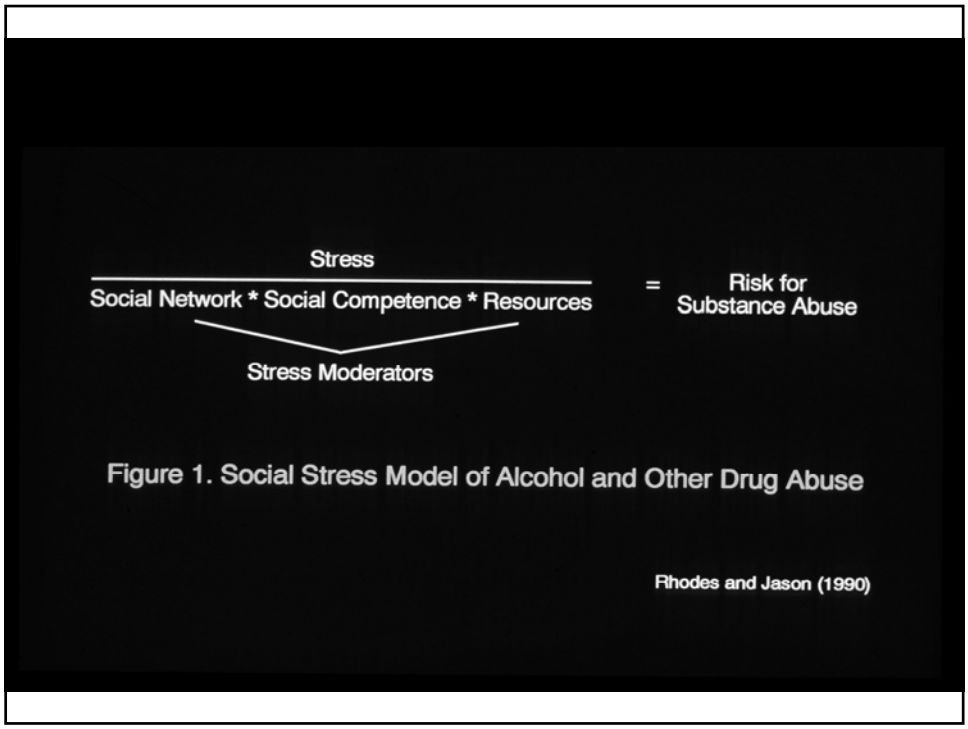
Figure 1 The state–trait interaction component of the process model



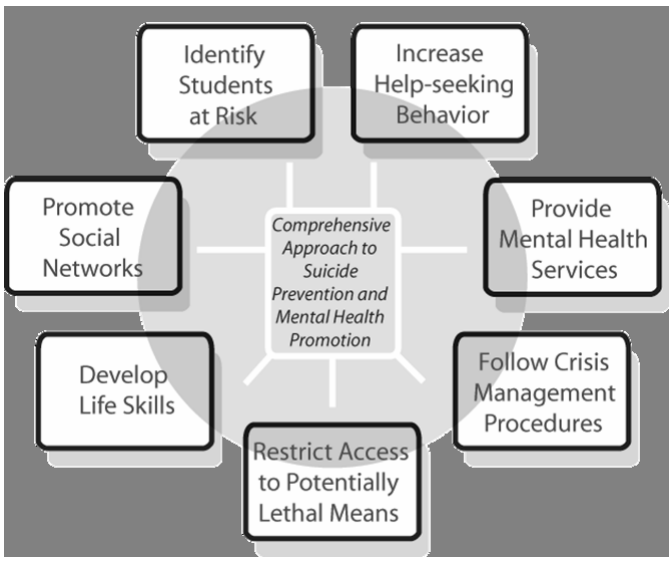
Incidence

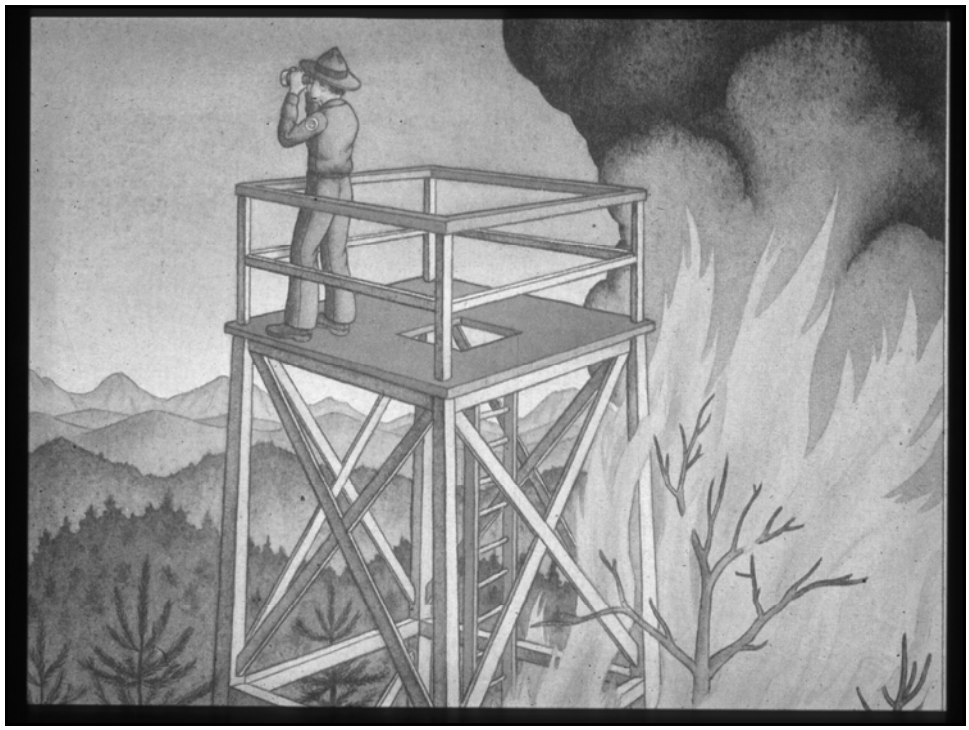
Albee (1982)

$$\text{Incidence} = \frac{\text{Organic Factor} + \text{Stress}}{\text{Coping Skills} + \text{Self Esteem} + \text{Support Groups}}$$



Jed Foundation/EDC Comprehensive Approach





Prevention vs. Treatment		
	Prevention	Treatment
Goals	Health Promotion Disease Prevention Reduce Incidence - 1^0 Reduce Prevalence - 2^0	Reduce Disability 3^0 Restore to Prior Status Correct Deficits
Target Audience	Communities Groups at Risk	Individual Patients
Settings	Community/School Regional/ National	Office/Clinic (1:1)
Duration	Lifespan	Time-limited Time-specific

Prevention vs. Treatment

	Prevention	Treatment
Focus	Knowledge Change Attitude Change Behavior Change	Symptom-specific Specific Disorders or Diseases
Tools	Surveillance Development Implementation Evaluation	Cognitive/Behavioral Emotional Retrospective
Techniques	Education/Training Social Support Outreach Media/ Conferences	Introspection/Insight Medications Physical Therapies Crisis Intervention

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

SO……

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