Walking the Tightrope: Best Practices and Ethics for Treating Suicidal Patients

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About me

Early losses

Unclear Path

Summer in Nepal

Joined Research Labs

Military Veteran Research

Thesis on Veteran Suicide

Practicum at UCEBT

DBT Training

DBT Therapist

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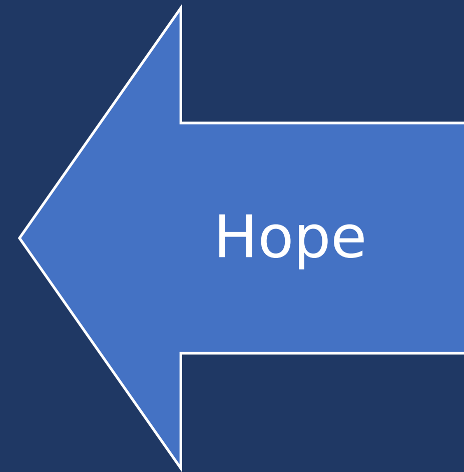
Presentation Goals

- 1) Review suicide statistics: clarify scope
- 2) Review Principles of APA ethics code and standards
- 3) Introduce lenses to confront ethical dilemmas in suicide treatment
- 4) Discuss treatment options for suicide
  - Differentiate between acute and chronic suicidality



- Suicide is a heart wrenching, heavy topic to explore
- The statistics are sobering
- The systems that contribute to suicide feel immense
- We're on our 3rd generational crisis in a decade
- Its scary to deal with each day

- Community of talented, brilliant, empathetic clinicians and researchers
- Suicide is less in the shadows than ever before
- The treatments, when implemented, work
- We are making progress

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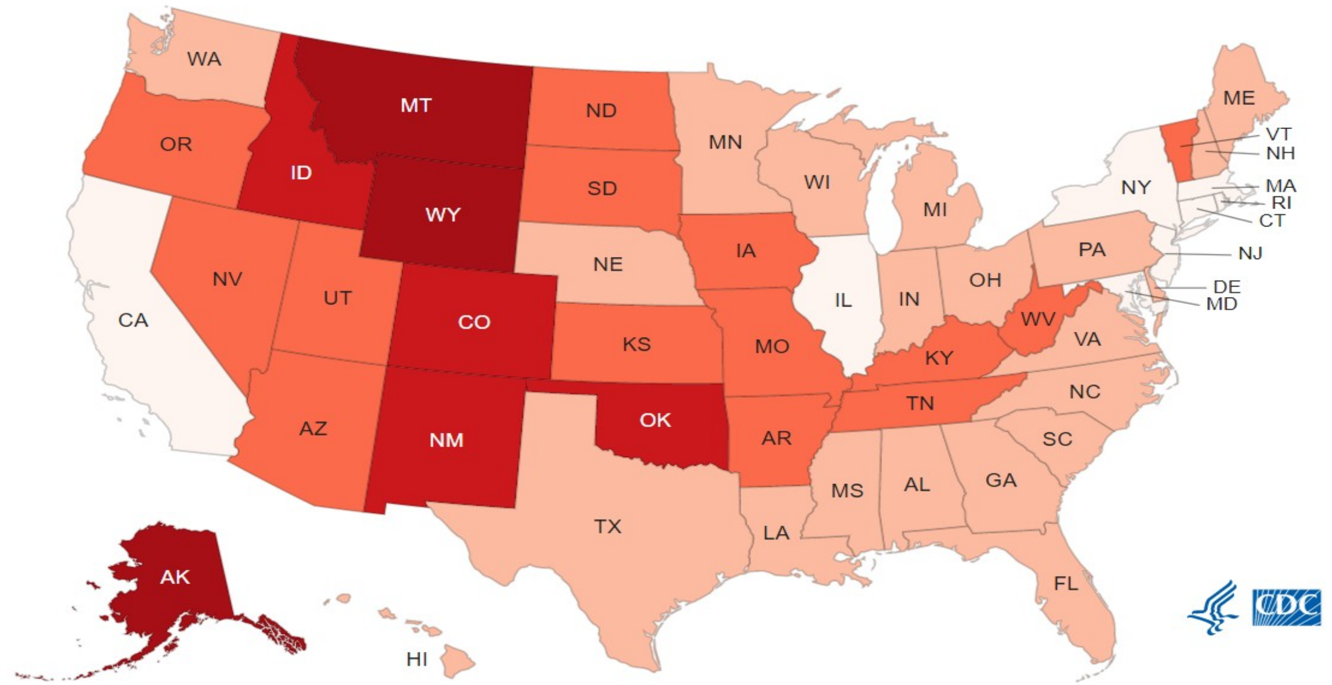
Suicide Rates are Rising

- Suicide rates increased 30% between 2000-2018 and declined slightly in 2019-2020
- Nearly 46,000 people died by suicide in 2020
  - 1 death every 11 minutes
- 12.2 million seriously considered suicide
- 3.2 million made a plan
- 1.2 million attempted

Suicide Rates are Rising

2020



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Suicide Spans Life

- Suicide is a top 9 cause of death from ages 10-64
- 3rd leading cause of death for young people (10-24)
- Middle aged adults (35-64) account for 47.2% of all suicides
- Older Adults (75 and older) have the highest rate of suicide (19.1 per 100k)
    - Men over 75 (40.5 per 100k), non Hispanic white men (47.8 per 100k)

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High Risk Populations

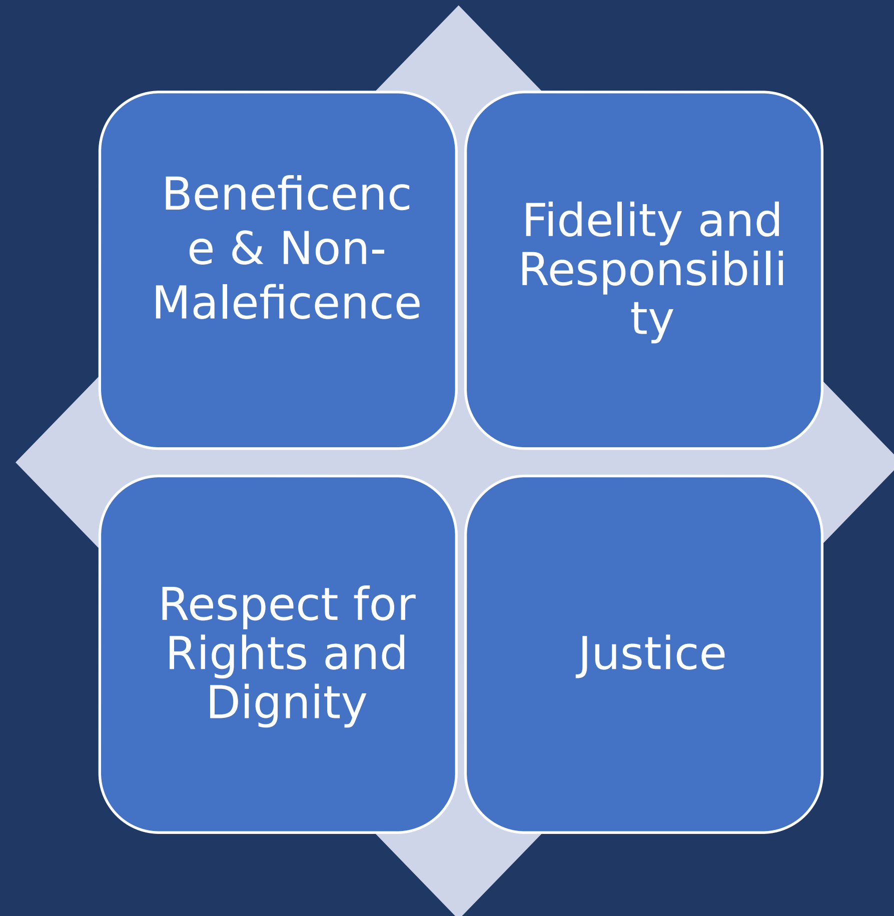
At risk groups relative to the general US population

- Veterans
- People in rural areas
- Sexual and gender minorities
- Middle aged adults
- Tribal populations

Systemic factors impacting these groups

- Financial insecurity
- Substance misuse
- Easy access to lethal means
- Higher rates of bullying, sexual violence
- Relationship problems

Brief Review: Ethical Principles and Standards



Standards	Quick Summary
2.01: Boundaries of Competence	Practice within areas that you have training and experience in and seek appropriate consultation. Know when to refer!
2.02: Providing Services in Emergencies	When services aren't available, you may stretch your competence to ensure service. Discontinue as soon as the emergency has been resolved

American Psychological Association, 2002

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Principles of Ethical Intelligence

- 1) Ethical intelligence is an active process of continuous awareness that involves constant questioning and personal responsibility
- 2) Awareness of ethics codes is crucial, but cannot take the place of an active, thoughtful, creative approach to our ethical responsibilities
- 3) Awareness of laws is crucial, but legal standards should not be confused with ethical responsibilities

Pope & Vasquez, 2016

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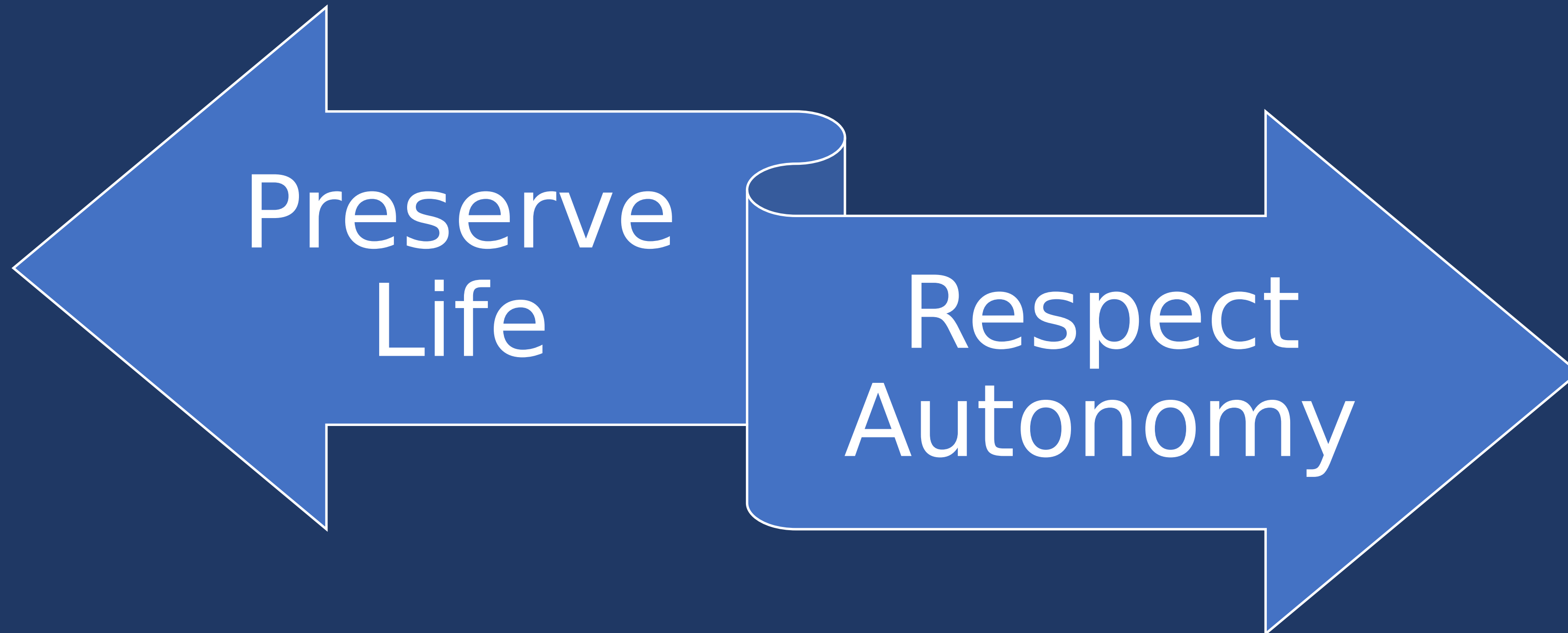
Principles of Ethical Intelligence

- 4) The overwhelming majority of therapists are conscientious, dedicated, caring individuals who are committed to ethical behavior. But none of us are infallible
- 5) It is easier to question the ethics of others than to question what we believe and do
- 6) We explore the intriguing topics we don’t understand, questions the obvious ones too.

Pope & Vasquez, 2016

Ethical Issues in Suicide Treatment

Dialectical Tension



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Ethical Perspectives on Suicide

MORALIST POSITION

- Suicide is unacceptable and we have an obligation to preserve life.
- Roots in religion and responsibility to society
- Generally, preserving life is the foremost principle in decision making

Mishara & Weisstub, 2005

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Moralist Influence on Law

- Some countries outwardly state suicidal behavior as illegal
- Most have decriminalized suicidal behavior
  - Assisting an individual in suicide outlawed
- Mandated reporter laws for imminent harm to self
- Involuntary hospitalization
- Good Samaritan laws put in place

Ethical Perspectives on Suicide

Libertarian Positions

- Freedom of choice to live or die
  - Adequate information and stable state of mind assumed
- Wide range of philosophical roots
- Generally, a person has a right to choose to avoid pain and OR outsiders are neutral on life and death decisions

Legal reflections

- Decriminalization of suicidal behaviors
- Legalization of Medical assistance in dying (MAID) procedures
- Crisis services with Samaritans principles

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Ethical Perspectives on Suicide

Relativist Approaches: Contextualists

- Appropriateness of suicide is determined by:
  - Situational factors
  - Cultural variables
- Obligation to protect life depends upon careful analysis of the situation

Relativist Approaches: Utilitarian

- Best interests of society based on cost-benefit of utility
- Maximize social utility as the vehicle to alleviate social misery

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Ethical Perspectives on Suicide

Relativist Approaches: Consequentialist

- Appropriateness of suicide is determined by:
  - Anticipated consequences of action and inaction
- Individual level: “I will be better off dead”
  - After forced intervention many individuals thank crisis teams for saving their life

Legal reflections

- Good Samaritan laws
- US tends to favor individual rights over collective duty
- Less emphasis globally on holding individuals responsible for preventing suicide of another

Ethical Issues that Impact Research on Suicide Treatments

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- Random assignment experimental methodology cannot be applied as usual
  - Most governing bodies consider suicidal patients vulnerable
  - Vulnerability raises questions of competence and capacity to provide informed consent
    - No-treatment-control groups typically not offered to test suicide interventions
  - Medication studies often exclude suicidal patients for this reason

Ethical Issues that Impact Research on Suicide Treatments

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- What ethical perspective informs this dilemma? What perspective is violated?
- How might a moralist/libertarian/relativist view this dilemma?

Ethical Perspective on Rescue Procedures

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- Most intervention studies include rescue criteria for suicidal individuals
- Determining at risk individuals is difficult
- Sensitivity to false positives is the key issue for who receives the rescue intervention

- Moralist Perspective
  - High sensitivity and implementation of the most effective procedure to preserve life. Autonomy not as important when risk is high
- Libertarian perspective
  - Rescue is never implemented against the will of the individual. Information given about potential rescue would be acceptable.
- Relativist perspective
  - Pros and cons of each procedure are weighed. Severely limited by lack of data and unreliable assessment.

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Ethical Perspectives on Obtaining Informed Consent for Suicide treatment

- Basic principle of research and treatment is Informed Consent of participants with guaranteed confidentiality.
  - APA Ethics code Standard 3.10, 10.01
- For high risk individuals, confidentiality is not guaranteed under certain circumstances, or rescue procedures are outlines.
- Can a person in the midst of a crisis give informed consent?
  - Complicators of crises: substance use, physical pain, SMI

- Moralist Perspective
  - Anything that compromises the ability of suicidal people to obtain help should not occur. Likely to favor compromising informed consent in favor of providing quality service.
- Libertarian Perspective
  - Free choice to participate in treatment and research. May be concerned if research practices interfere with intervention quality (i.e., explanations etc)
- Relativist Perspective
  - Balancing potential benefits with potential harm, likely to have insufficient data.

Ethical Perspectives on New and Unproven Interventions

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- Balancing unknowns of new interventions with dynamic suicide risk
- General tendency to avoid something new because of the potential risks. Limits diverse interventions.
- E.G., past informed practice was *not* to ask depressed or vulnerable individuals about suicide. Risk was "putting ideas in their minds."

- Moralist perspective
  - Without firm data on the effect of a practice likely to be very hesitant to utilize it.
- Libertarian perspective
  - Choice to participate in a new intervention resides with the individual, recognize they may not have enough information to make an informed decision.
- Relativists
  - Limited participation due to inability to analyze cost and benefit.

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Ethical Perspectives on Confidentiality in Treatment

- Confidentiality is promised at the outset of treatment and most crisis calls
- Duty to do no harm conflicts with support of autonomous behavior.
- Imminent risk to harm is usually the qualifier to break confidentiality

- Ethical Dilemma: You have been informed by your client that their family member is having intense thoughts of suicide, to what extent do you intervene, if at all?

- Moralist perspective
  - Protecting human life>principle of confidentiality
  - May be conflicted if suicide risk involves a 3rd party.
- Libertarian perspective
  - Respect the person’s autonomy. Key question would be if they are aware of or want help. Duty would be placed on the client rather than the clinician to intervene.
  - Does this change with perceived impairment or SMI?
- Relativist
  - Likely would explore evidence for intervention and weigh against inaction. Cultural variables may impact decision as well (i.e., expectations of privacy)

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Factors Impacting Ethical Perspective

- Past/recent death by suicide
- Length of treatment relationship
  - Stage of change
  - Chronic/ongoing stressors
- Burnout and compassion
  - Unrelenting crises
  - Active passivity
  - Apparent competence

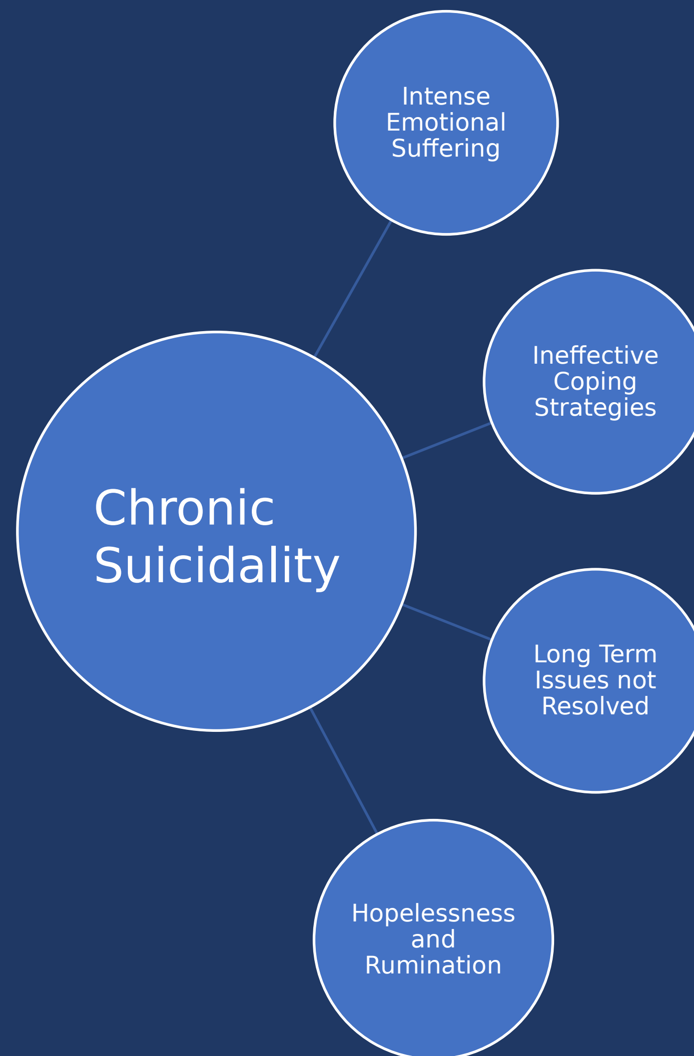
Treatments for Suicidality

Acute Suicide Crises

Risk Factors

- Traumatic event
- Fall/change in interpersonal status
  - Interpersonal
  - Legal/criminal
  - Rejection or Bullying
- Financial or occupational event
- Health problems
- Impulsivity
- Access to lethal means

Chronic Suicidality



Risk Factors

- Chronically Invalidating environment
- Biological vulnerability for intense emotions
- Expressions of intense emotion/helplessness have been reinforced
- Ruminative or obsessive cognitive style

Brief Interventions for Acute Suicide Crises

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Safety Planning Intervention

- Stabilization-oriented brief intervention (l-2 sessions)
- Primary goal: increase treatment engagement and develop suicide-specific coping strategies
- Safety plan
  - 20-45 minutes to be used as risk elevates
  - Identify warning signs of suicide risk-elevation
  - 6 steps (hierarchy) according to level of risk and disorder
    - Internal and external coping skills
  - Clinician evaluates and builds motivation for implementation

Stanley & Brown, 2012

Crisis Response Planning

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- Similar to safety plan
- CRP written on an index card and functions as a problem solving toolkit for suicide crises
- Patient encouraged to tell the “narrative” experience of most recent suicide crisis
  - Client gains exposure and clinician recognizes presentation of crisis
- Research supports integration into other evidence based treatments
  - Brief Cognitive Behavioral Therapy (60% reduction in attempts)
  - Cognitive Processing Therapy for PTSD (reduction in SI and PTSD symptoms)
- Emphasis on connectivity, coping ahead and means reduction

Rozek & Bryan, 2020

Components of the Crisis Response Plan and their descriptions

Component	Description
Narrative assessment	Chronological "story" of the suicidal crisis. Assessing for warning signs (e.g., thoughts feelings, physiology, behaviors), coping strategies, social support, and lethality. Typically done for first, worst/most lethal, and last suicidal crisis.
Warning signs	Indicators that a crisis may be starting and that the plan should be used. Warning signs can be behaviors, thoughts, emotions, or physical sensations and should be specific to a potential crisis.
Self-management	Helpful strategies that can be used to reduce stress. Should vary and be useful across situations.
Reasons for living	Reason for living; sense of purpose in life.
Social support	Someone who can be contacted to help reduce stress. May be family member, friend, coworker. Do not have to disclose to this person about the crisis.
Healthcare professionals	Contact information for psychologist/therapists, other medical providers, and other professional sources of help.
Crisis services	Crisis hotlines, emergency response, and/or presenting to an emergency department.

Rozek & Bryan, 2020

Warning Signs: I'm worthless
I'm out of control
Angry at myself
Pit in my stomach

What to do:

1. TV: watch episode of Seinfeld
2. Yoga: 15 minutes
3. Walk dogs 10 minutes
4. Run 1 mile
5. Listen to music (Beatles)
6. CBW
7. Look through CPT binder

Happy things:

1. Mom - ski trip to Colorado
2. Dogs: Lucky - chasing squirrels
   Chance - learning to go up stairs
3. Dad - growing up & water fight

To Call:

Bella (call or text): 555-555-5555
Bart (call): 777-777-7777
Mom (call): 999-999-9999
Dr. Smith: 333-333-3333 Leave no
Number,
1-800-273-8255

Go to Hospital
Call 911

Rozek & Bryan, 2020

Brief Interventions Under Further Study

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- Attempted Suicide Short Intervention Program (Gysin-Maillart et al., 2015)
  - Three sessions: 1) Patient narrates suicide crisis, 2) narration played back to clinician and create handout of key events 3) discuss warning signs and individual coping skills plan
- Teachable Moment Brief Intervention (O'Connor et al., 2015)
  - Following a suicide attempt, examination of the suicide crisis with different interpretations
  - Draws from CAMS and functional analysis
  - Build Rapport, identify factors that preceded suicide attempt, collaborative crisis planning and connect to outpatient services

Evidence-Based Treatments for Chronic Suicidality

Cognitive Therapy for Suicide Prevention

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- Cognitive-behavioral, suicide specific therapy
- Reduce risk factors for suicide and increase coping skills
  - Primary target is eliminating suicidal behavior
- Increase awareness and understanding of *suicidal mode*
  - Thought patterns, triggers, behaviors and interaction styles that precede suicidal behavior
- Assumes that triggers will continue but with improved coping suicidal behavior will decrease

Brown, et al., 2005

Collaborative Assessment and management of Suicidality

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- Collaborative, phenomenological approach that emphasizes the creation of a suicide treatment plan together.
  - Includes an outpatient stabilization plan
  - Extensive assessment in understanding the patient’s suicidal drivers
- Key element is motivating the patient to be a member of the treatment team
- Suicide Status Form: Central tool that combines initial assessment, treatment planning, daily tracking and outcome monitoring

CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: ______________ Clinician: ______________ Date: ________ Time: ________

Section A (*Patient*):

Rank	Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)
______	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: ______________
______	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: ______________
______	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: ______________
______	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: ______________
______	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: ______________
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will *not* kill self) 1 2 3 4 5 :Extremely high risk (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**

2) How much is being suicidal related to thoughts and feeling about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: ______________

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CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. ______________________________
2. ______________________________
3. ______________________________

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. **Life or death emergency contact number:** ______________________________

People I can call for help or to decrease my isolation:

1. ______________________________
2. ______________________________
3. ______________________________

Attending treatment as scheduled:

Potential barrier: Solutions I will try:

1. ______________________________
2. ______________________________

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About Dialectical Behavior Therapy

- Dialectics – a flexible world view, a philosophy, a way of *being*
  - “The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time and still retain the ability to function. One should, for example, be able to see that things are hopeless and yet be determined to make them otherwise.” -F.Scott Fitzgerald (1936)
- Behaviorism – the principle underlying change
  - All thoughts, emotions, actions, and urges are under behavioral control and can be shaped
- Acceptance – Mindfully experiencing reality as it is
  - Life = pain; pain + non-acceptance = suffering
  - The path to reducing suffering involves accepting painful realities.

DBT

About DBT - Assumptions

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- People are doing the best they can
- People want to improve
- People need to do better, try harder, and be more motivated to change
- People may not have caused all their problems, but they need to solve them anyway
- People must learn new behaviors in all contexts
- All behaviors, thoughts, emotions, etc. have causes
- Figuring out and changing the causes of behavior is more effective than judging and blaming
- DBT Therapists also are participating in treatment

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Suicide Prevention

- Coping and problem solving
- Connection to friends, family and community support
- Supportive care providers
- Availability of mental health care
- Limited access to lethal means among at risk groups

Preventing Burnout and Protecting Yourself

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- Document the crisis, but do not transcribe
  - As soon as is feasible.
  - 2-3 sentences is too short, 3-5 paragraphs likely too long
  - Note observed risks, protective factors, commitments and safety plans
  - Rationalize decision to elevate care
- CONSULT and do not worry alone!
  - DBT has it built into the model for this reason
- Recognize your burnout and how it affects your ability to hold suicidal patients compassionately
- Know your limits and constantly reflect on your ethical perspective on suicide
  - Expect it to change with life events, following an unexpected suicide you may lean more towards moralistic principles, after a long suffering patient chooses to end their life you may be more libertarian. Be aware of these changes in your daily actions

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www.ucebt.com/about-us/work-at-ucebt

UPCOMING EVENTS

April 8	Working with Narcissism: Caring for Our Clients and Ourselves -- Robin Lange, Ph.D.
May 20	Calm and confident approaches for assessing self-harm and suicidality: Best practices for risk and liability management -- Sheila Crowell, Ph.D.

REGISTER: WWW.UCEBT.COM/EVENTS

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Thank you

- To those who shaped my life in the Midwest and the Mountains
- To my clients who let me share in their journey
- To you, for your openness to this training
- To my consultation team and supervisors for challenging and supporting me
- Slides will be posted at www.ucebt.com
- Contact me: Jordan.Kugler@ucebt.com