"Working with the Bereaved: Suicide Risk Assessment"

Expert Speaker:

David A. Jobes, PhD, ABPP

January 8, 2009

12pm-1pm EST

Presented by the
Tragedy Assistance Program for Survivors
Washington, D.C.
www.taps.org

Course I Vol.1

Welcome

Moderator:
Jill Harrington LaMorie, LSW, ACSW
Tragedy Assistance Program for Survivors

Expert Speaker:
David A. Jobes, PhD, ABPP

Professor of Psychology, Co-Director, Clinical Training, The Catholic University of America, Washington, DC

Dr. Jobes is a member of the American Psychological Association, the American Association of Suicidology, the International Association for Suicide Prevention, and the International Academy of Suicide Research. He has published extensively in suicide prevention; he consults widely and routinely provides professional training in clinical suicidology. Dr. Jobes is currently a consultant to the Department of Defense, Veterans Affairs, and the U.S. Air Force Suicide Prevention Program. He is also on the Advisory Board of Give-an-Hour.

Activity Goal

The goal of this activity is to teach professionals how to identify risk factors, protective factors and warning signs for suicide among the bereaved, as well as learn elements of formal risk assessment and intervention strategies.

Learning Objectives

- Increase knowledge of risk factors, protective factors and warning signs of suicide in the bereaved.
- Increase knowledge of suicide as a multi-factoral event.
- Learn elements of a formal risk assessment and intervention strategies.
- Improve awareness of military culture and unique needs of grieving families.

Continuing Education Credits/ Certificates of Attendance

- Certificates of Attendance will be provided for all who attend the entire program.
- The Association of Professional Chaplains will accept certificates of attendance for use in reporting continuing education hours.
- This program is approved by the National Association of Social Workers, provider # 886505639, for 1.0 continuing education contact hours.
- Provider approved by the California Board of Registered Nursing for 1.0 contact hours.
- Please check with your state licensing board for your professional discipline requirements for continuing education.

Evaluation

- ALL PARTICIPANTS SEEKING EITHER A CERTIFICATE OF ATTENDANCE OR CONTINUING EDUCATION CREDITS **MUST** FILL OUT THE ONLINE EVALUATION FORM NO LATER THAN 30 DAYS AFTER THE PROGRAM.

- YOU **MUST** PROVIDE YOUR DISCIPLINE AND STATE LICENSE NUMBER ON YOUR EVALUATION IN ORDER TO RECEIVE CREDIT.

- The evaluation form can be found at www.taps.org/professionaleducation

QUESTIONS TODAY?

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TAPS Toll Free #: 1-800-959-8277

The Tragedy Assistance Program for Survivors (T☆A☆P☆S)

www.taps.org

Our Mission

TAPS provides ongoing emotional help, hope, and healing to all who are grieving the death of a loved one in military service to America, regardless of relationship to the deceased, geography, or circumstance of the death. TAPS meets its mission by providing peer-based support, crisis care, casualty casework assistance, and grief and trauma resources.

Since it's inception, **T★A★P★S**

has assisted more than 25,000

surviving family members, casualty officers and professional caregivers

FOR MORE INFORMATION
or TO REFER SOMEONE
YOU KNOW:

www.taps.org

or

800-959-TAPS (8277)

Military Death, Grief & Loss

Grief is a normal reaction to death

- Sadness, loneliness, crying, feelings of emptiness, feelings like “am I going crazy” are all normal reactions to grief. These feelings of despair, sorrow and mourning can persist for weeks and many months after a loved one’s death.

Complicated and Traumatic Grief

- Recent studies have identified complicated grief as an important distinct reaction to bereavement that is separate from normal grief and other psychiatric disorders, such as bereavement-related depression and anxiety disorders (Prigerson, Frank, et al., 1995; Prigerson, et al., 1997; Jacobs, Mazure, & Priger,2000).

- Complicated grief has been found to be associated with a heightened risk of suicidal thoughts and actions among young adult friends of adolescents who died by suicide (Prigerson, Bridge, et al., 1999).

Military Deaths

Military Deaths

Often:

- Unexpected and sudden (combat-related incidents, accidents, suicides, homicides, acts of terrorism, stroke, heart attack, overdose)
- Traumatic and sometimes violent in Nature
- Bodily remains may not be intact or bodily remains may not be recovered
- In a foreign country or on the high seas (away from their families)
- During war or are war-related
- After a long period of separation from the family – maybe during a deployment
- Involve the death of a young adult (18-40), who may leave behind a young spouse/significant other, young children, young adult siblings and younger parents who are unprepared to cope with their loved ones untimely and unexpected death (Brookings Institute Iraq Index, as of August 2008 states that 51% of troop casualties in Iraq have been less than 25 years old).
- As seen with OIF/OEF, bases have suffered multiple deaths with intense, repetitive frequency, affecting and re-traumatizing families and the entire close knit, base community who bears witness to many funerals, memorials and bereaved families.

Survivors

- Death Notification
- Limited Family Support
- Deal with bodily remains:
  - May Require a long period of preparation or
  - If far away, may require a long period before the remains are delivered home for burial
  - Remains may also not be intact, therefore survivors may not be able to view their loved one, which may further complicate the acceptance of the death and mourning
- Need to work closely with military casualty in the first few weeks:
  - Planning funerals arrangements
  - Tremendous Amounts of Paperwork and Benefits
  - Death Investigation Process (under certain circumstances).
- Intense support in the first few weeks after the death both from the military and often times the community. Then as weeks and months pass, the support becomes less intense during this period of transition.

Survivor Losses

Experience multiple, sudden losses:

- actual death,
- the loss of a way of life – no longer being a military family
- loss of housing if living on base (may need to make decision quickly about where to move)
- loss of being part of a greater military community and the intense camaraderie and peer network in the military
- Involuntary loss of being a military family to being a civilian family.

- Due to these losses, complexities involved with a military death and circumstances of their loved one's death, survivors may experience intense feelings of loneliness and isolation.

Sometimes the bereaved may even have thoughts of suicide.

When do intensified psychological and grief reactions warrant further assessment into the potential risk of suicide in the bereaved?

Working with the Bereaved: Suicide Risk Assessment

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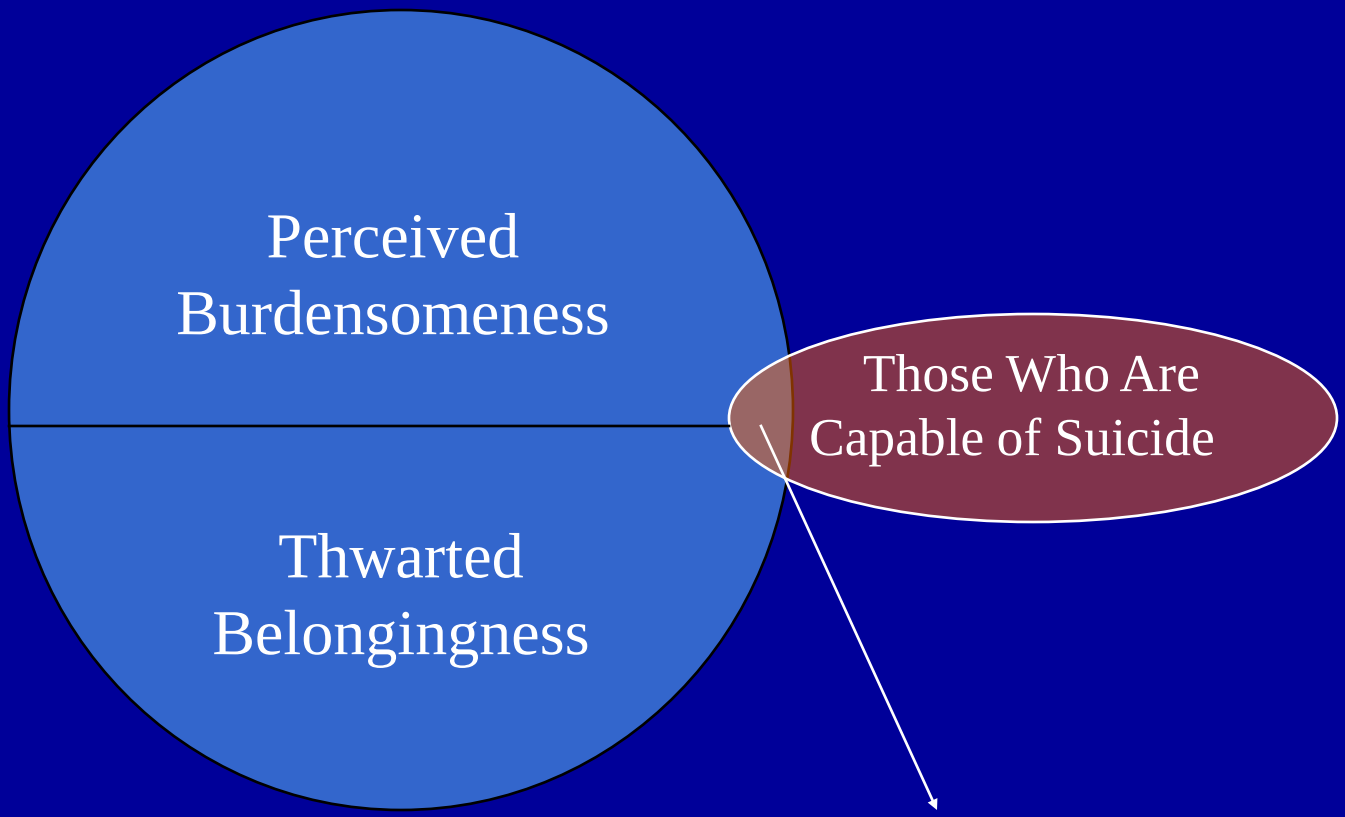
T.A.P.S. Continuing
Education and Training Webinar
December 4, 2008

Major Theoretical and Research Domains in Suicidology

- Sociological Theory and Research (e.g., the Werther Effect)
- Psychological/Psychiatric Theory and Research (e.g., Freud, Shneidman, Beck, Joiner, etc.)
- Biological/Genetic Research (e.g., frontal lobe functioning, genetic vulnerabilities)

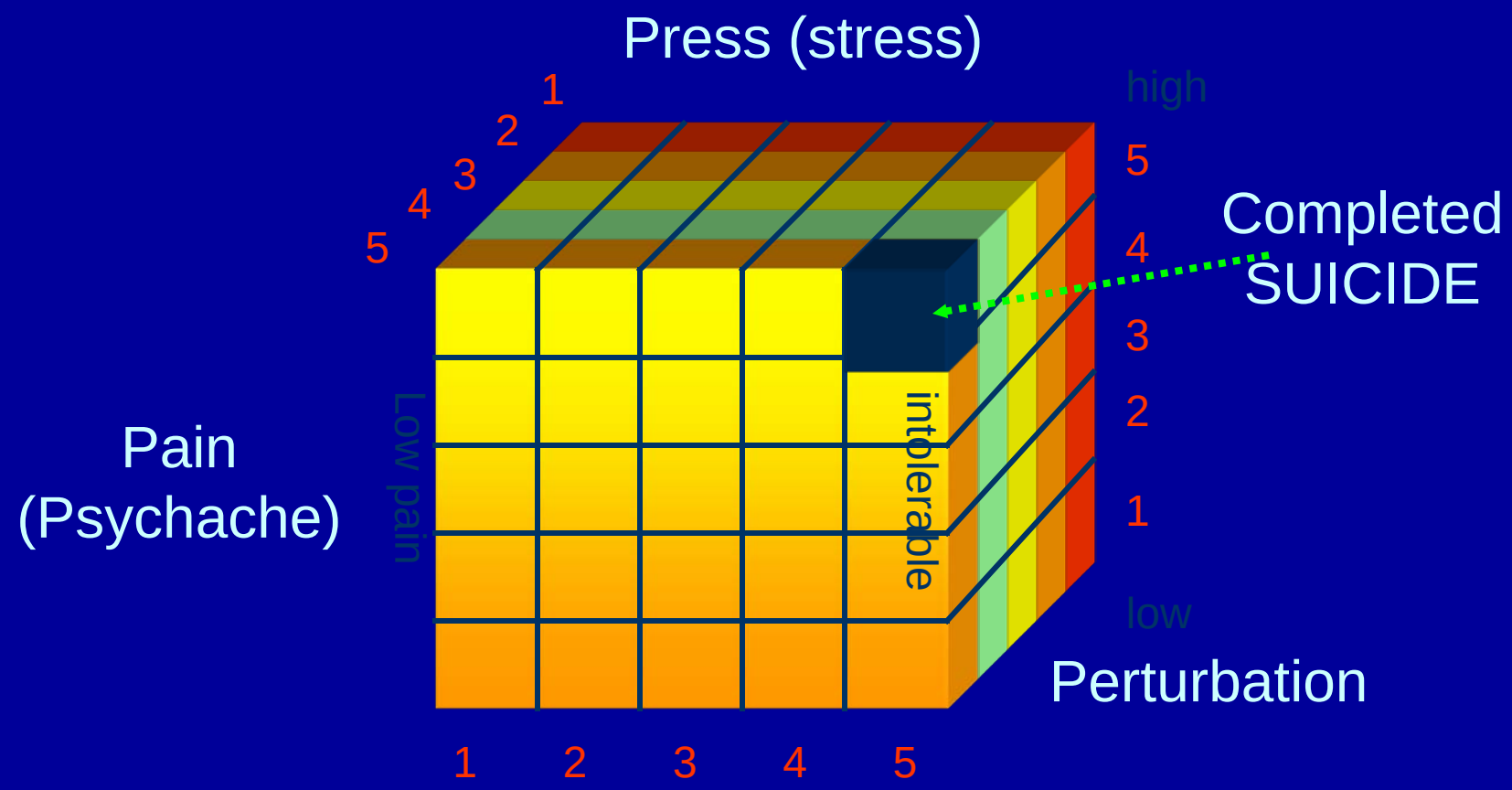
New theory…

Those Who Desire Suicide (Joiner, 2005)



Serious Attempt or Death by Suicide

Shneidman's Cubic Model of Suicide



(Shneidman, 1987)

Psychological Autopsy Studies: Summary of Empirically-Based Static Risk Factors

- Age: In the general population, risk escalates with age, particularly after age 60.
- Sex: Risk greater for males.
- Previous Axis I or II psychiatric diagnosis
- Previous history of suicidal behavior

  Rudd et al's work on the increased risk associated with multiple attempters.
- History of family suicide
- History of physical, emotional, or sexual abuse

Key Assessment Constructs

- **Psychological intent**
- **Meaning of suicidal thoughts and behavior, and motivation for suicide**
- **Specifics of the plan and rehearsal**
- **Overt suicidal/self-destructive behavior**
- **Physiological, cognitive, and affective states**
- **Coping potential and protective factors**
- **Impulsivity and self-restraint**
- **Substance abuse or dependence**
- **Significant psychosocial stressors**
- **Static risk factors**

Overall Qualitative Findings of SSF Core Assessment (Jobes et al., 2004)

- From two diverse samples there were 636 written responses to SSF prompts (n = 152).
- Collapsing data across constructs, 22% of responses pertain to ***Relational*** issues.
- 20% of written responses pertained to issues of ***Role Responsibility***.
- 15% of responses related to issues of ***Self***.
- 10% of responses related to ***Unpleasant Internal States.***
- Collapsing across constructs, 67% of responses were related to relational issues, vocational challenges, self-related concerns, and internal emotional distress.

Frequencies and Percentages of Reasons for Living and Reasons for Dying

U.S. Air Force Personnel Data (n=30)

Reasons for Living

Category	Frequency	Percent
Family	21	25.6%
Plans and Goals	20	24.4%
Enjoyable Things	15	18.3%
Friends	8	9.8%
Burdening Others	6	7.3%
Hopelessness For Future	4	4.9%
Responsibility to Others	3	3.7%
Beliefs	3	3.7%
Self	2	2.4%

Reasons For Dying

Category	Frequency	Percent
Escape General	15	27.8%
General Descriptors of Self	10	18.5%
Escape Pain	7	13.0%
Others	7	13.0%
Escape- Responsibilities	6	11.1%
Hopelessness	3	5.6%
Unburdening Others	3	5.6%
Loneliness	2	3.7%
Escape Past	1	1.9%

Note: Total number of RFL responses = 82. Total number of RFD responses= 54.

Source: Peterson, E. M., Mann, R. E., Jobes, D. A., & Kiernan, A. (2002, April). Reasons for Living vs. Reasons for Dying. Paper presented at the Annual Conference of the American Association of Suicidology, Washington, DC.

Note: Opinions expressed in this presentation are the authors' and do not reflect the official policy of the United States Air Force or Department of Defense

Frequencies and Percentages of Reasons for Living and Reasons for Dying

College Counseling Center Data (n=201)

Reasons for Living

Category	Frequency	Percent
Plans and Goals	108	18.1%
Family	99	16.6%
Enjoyable Things	88	14.7%
Hopefulness for Future	76	12.7%
Friends	61	10.2%
Self	58	9.7%
Burdening Others	49	8.2%
Beliefs	34	5.7%
Responsibility to Others	25	4.2%

Reasons For Dying

Category	Frequency	Percent
General Descriptors of Self	160	31.1%
Escape in General	125	24.3%
Others/Relationships	57	11.1%
Escape Pain	54	10.5%
Hopelessness	52	10.1%
Unburdening Others	22	4.3%
Escape Responsibilities	21	4.1%
Loneliness	20	3.9%
Escape Past	3	.6%

Note: Total number of RFL responses = 598; χ^2 (8) = 98.10, $p < .001$. Total number of RFD responses = 514; χ^2 (8) = 386.49, $p < .001$

Source: Peterson, E. M., Mann, R. E., Jobes, D. A., & Kiernan, A. (2002, April). Reasons for Living vs. Reasons for Dying. Paper presented at the Annual Conference of the American Association of Suicidology, Washington, DC.

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Reasons for Living: Non-Suicidal vs. Suicidal Samples (Nademin, Jobes, Downing, & Mann, 2005)

Reasons for Living Frequency: Contrasts Between Non-Clinical and Clinical Samples

	Non-Clinical Sample (n=201)		Clinical Sample (n=201)		
	Frequency	Percentage	Frequency	Percentage	Chi-Square
Family	89	8.86	**99**	**16.6**	**22.16***
Friends	86	8.57	61	10.2	1.36
Responsibility to Others	45	4.48	25	4.2	0.06
Burdening Others	12	1.2	**49**	**8.2**	**50.84***
Plans and Goals	**312**	**31.08**	108	18.1	**31.41***
Hopefulness for the Future	**241**	**24.00**	76	12.7	**29.02***
Enjoyable Things	28	2.79	***88***	**14.7**	**80.61***
Beliefs	**90**	**8.96**	34	5.7	**5.37***
Self	101	10.06	58	9.7	0.03

p < .05 Frequency = 1004 Frequency = 598

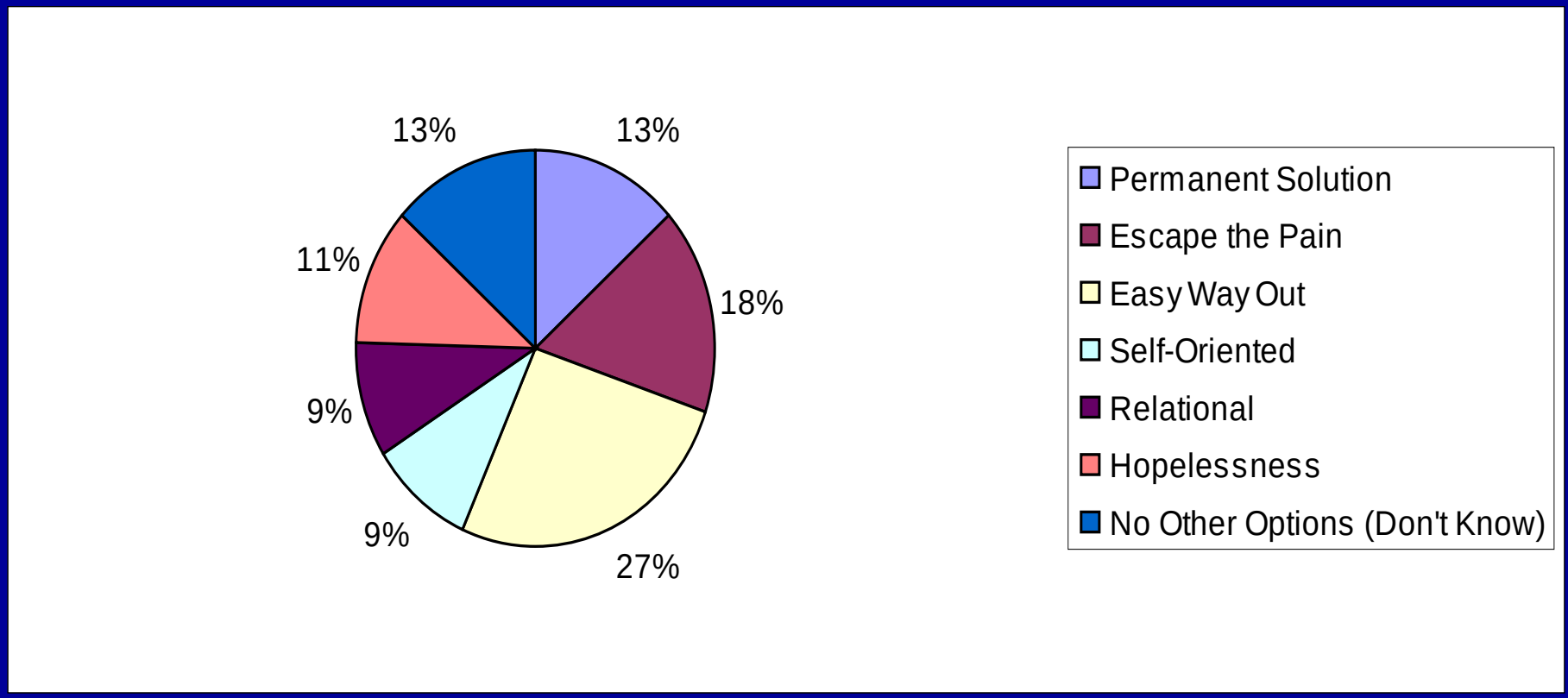
Why Suicide?

- For every survivor who loses a loved one to suicide, there is one question that dominates the grief process…why?

- Suicidal inpatients (n=53) at the Mayo Clinic were administered a modified version of the SSF within forty-eight hours of admission.

- Patients were posed with following query:
  - *There are many ways of dealing with psychological pain and emotional suffering. As you reflect on your own struggle, why suicide?*

To capture these responses, we derived seven coding categories with high inter-rater reliability (Average Kappa Coefficient's = .75)



A Multifocal Approach to Assessment of Suicidal Risk

- **Imminent Risk**
- **Intent and Lethality**
- **Predisposing Conditions and Precipitating Factors**
- **Psychopathology**
- **Coping Skills and Resources**
- **Compliance with the Clinician**

Clinical Interviewing

- Approach the risk assessment interview of suicidality in a value-neutral manner—try to not moralize, intimidate, or patronize the client.
- A critical goal of the interview is to gather useful data about how suicidality psychologically "works" for the client.
- Be oriented toward outpatient care; shape the interview assessment towards gathering information that will justify outpatient care over inpatient care.
- Work to be empathic of the suicidal wish.
- Be sure to ask "why suicide?" but also be sure to ask "why not suicide?"
- Work to remain on the same team vs. getting into a power struggle.

Summary Assessment of Clinical Risk Level

- No significant risk
- Mild
- Moderate
- Severe
- Extreme

General Guidelines for Practice and Treatment

- **Provide sufficient informed consent about confidentiality and safety as earlier as possible in the clinical relationship.**
- **Always be sure to ask about suicide directly, forthrightly, with no judgment or threat.**
- **Thoroughly assess the suicide risk and try to gather and evaluate multiple sources of risk data (e.g., behavioral observations, verbal interviewing, use of assessment instruments).**
- **Formulate an overall assessment of suicide risk and document the risk in the client's record (e.g., a judgment of Low, Medium, or High Risk based on what evidence).**
- **Establish a clear treatment plan with the client as to how suicidal thoughts, feelings, and behaviors will be managed on an outpatient basis.**

Guidelines Continued

- **Closely monitor and document on-going suicidality until it resolves.**
- **Consider and use all appropriate modalities (e.g., various forms of psychotherapy, vocational counseling, medication, etc.).**
- **Collaboratively assess and modify with the client the treatment plan as needed.**
- **Routinely seek professional consultation and document any consultation.**
- **Document the resolution of suicidality; monitor for any future reoccurrence**

Suggested Safety Interventions

- **Establish understanding about between session access (phone and email contact)**
- **Establish the appropriate amount of therapeutic contact**
- **Remove access to the means**
- **Develop a comprehensive crisis contingency plan**
- **Use a “Crisis Card” approach**
- **Develop a suicide prevention tool kit**
- **Increase any and all social supports**
- **Consider full range of other modalities**
- **Initiate behavioral activities**
- **Create future linkage**

Crisis Card

1. _____
2. _____
3. _____
4. _____
5. _____
6. My phone # _____

Short-Term Care

Stage II: Short Term Cognitive-Behavioral Treatment

- **Transition from crisis to post crisis stage of treatment**
- **Modify treatment plan with increased stability**
- **Emphasis should be on cognitive behavioral problem-solving and skill-building**
- **Further develop interpersonal supports and resources**
- **Focus work on deconstructing reasons for dying while constructing reasons for living**
- **Explore preliminary underlying psychodynamic issues**
- **Pay close attention to issues of termination referral, and possible relapse**

Longer Term Care

Stage III: Longer Term Psychodynamic Treatment

- **Emphasize and use the therapeutic alliance to create a "corrective emotional experience" over time**
- **Attend to potential transference issues—imagined object vs. "real" object**
- **Closely monitor countertransference and use it to inform on-going care**
- **Working-through; re-growth and maturing**
- **Attend to issues of termination and meaningfully terminate with focus on what has been internalized through psychotherapy experience**

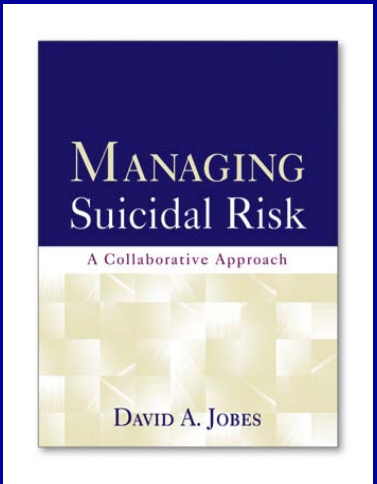
The Collaborative Assessment and Management of Suicidality (CAMS)

The Overarching Goal of CAMS

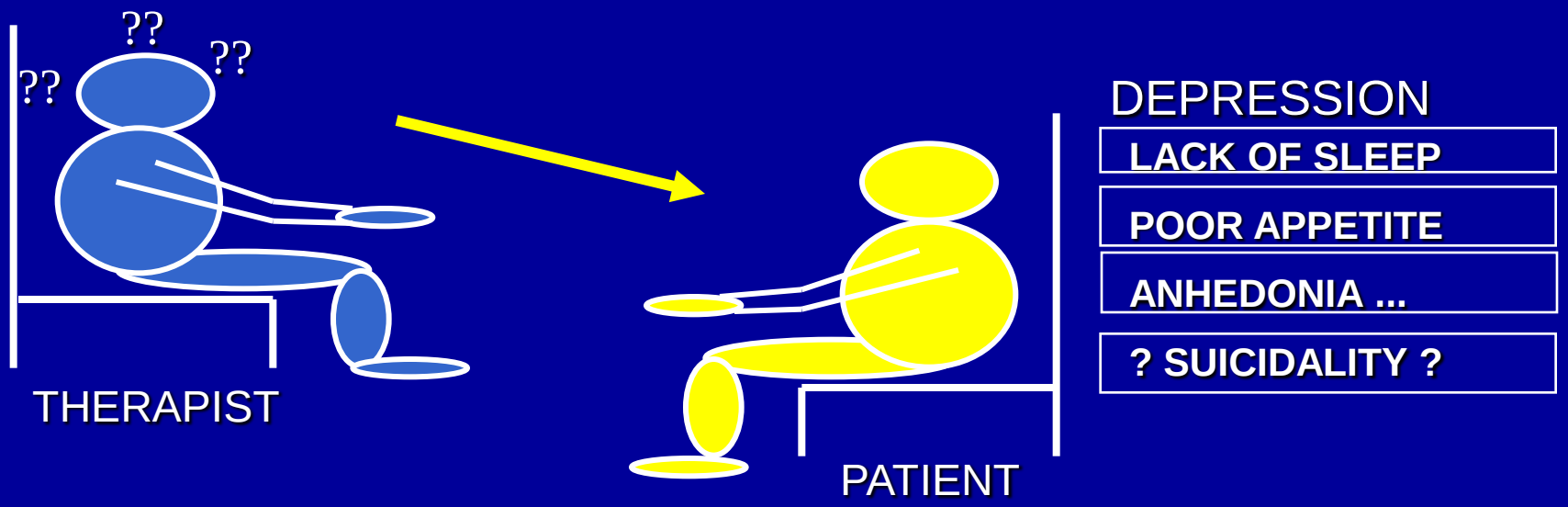
1. To provide a novel, comprehensive, multidisciplinary clinical assessment, treatment planning, and clinical management approach for reducing suicidal thoughts, feelings, and behaviors in outpatient settings.

2. CAMS is specifically designed to provide an alternative to traditional risk factor and purely diagnostically-driven approaches to suicide (Jobes, 2000; 2006; Jobes & Drozd, 2004).

3. On-going clinical research since 1998 is providing further empirical support for the CAMS approach.

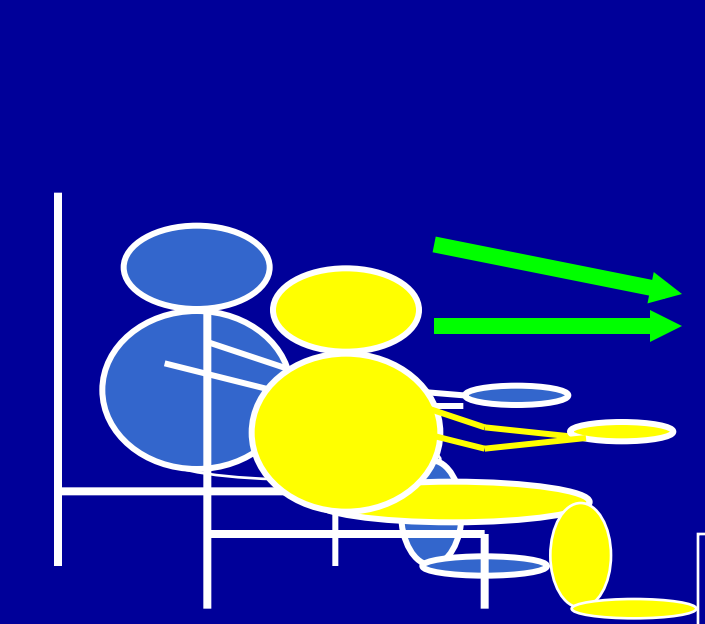


REDUCTIONISTIC MODEL:
Suicide = Symptom



Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts…

COLLABORATIVELY ASSESSING RISK: Targeting *Suicide* as the Focus of Treatment



THERAPIST & PATIENT

Mood

SUICIDALITY

PAIN	STRESS	AGITATION
HOPELESSNESS	SELF-HATE	
REASONS FOR LIVING VS. REASONS FOR DYING		

CAMS Treatment = Intensive outpatient care that is suicide-specific, emphasizing the developing of other means of coping and problem-solving thereby systematically eliminating the need for suicidal coping…

Empirical research from USAF 10th Medical Group (n=55) has shown that CAMS patients reach complete resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients (Jobes et al., 2005; Wong, 2003)

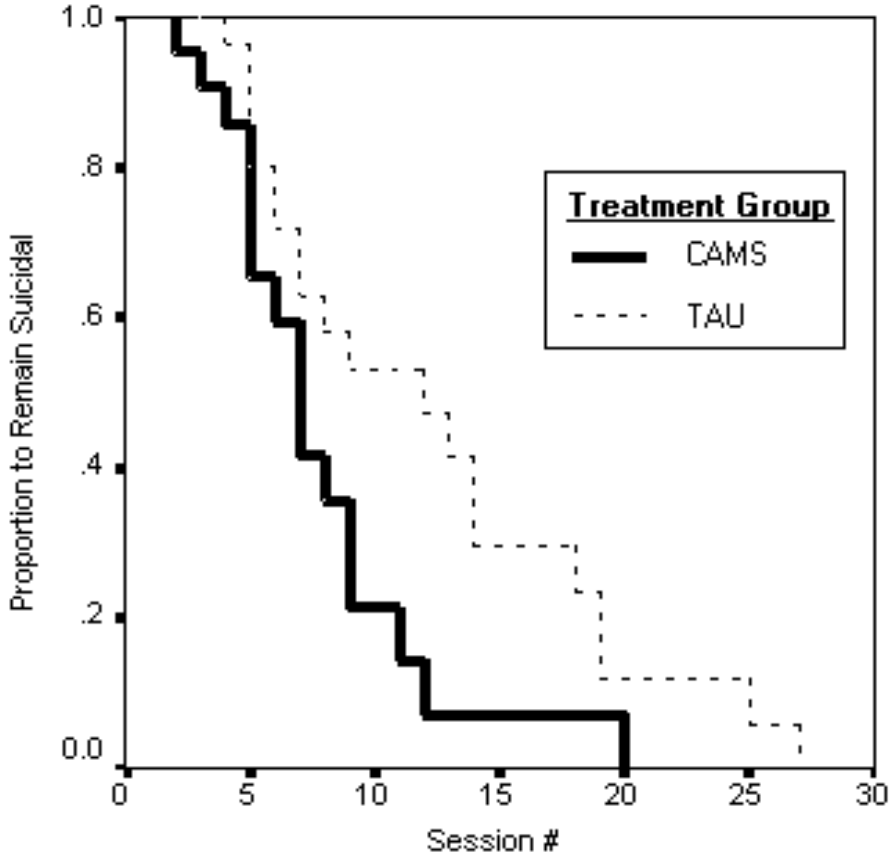


Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.

10th Medical Group Research: Six Month Period After the Start of Mental Health Care—Mean Health Care Costs