Clinical Management of Suicide Risk in Individuals with OCD: An Evidence-Based Approach

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MEF Disclosures

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- SAB, American Foundation for Suicide Prevention
- SAB, Cohen Veterans Network

OCD Criteria: Obsessions

- Unwanted thoughts or images that cause marked anxiety/distress
- Attempts to ignore, suppress or neutralize
- Not simply excessive worries about real-life problems
- Recognized as the product of one's mind
- Ego dystonic & avoided rather than elaborated upon

OCD Criteria: Compulsions

- Repetitive behaviors or mental acts performed in response to obsessions
- Aimed at reducing anxiety/distress or preventing dreaded event (e.g., contracting diseases)
- Cardinal feature: Compulsions neutralize unwanted thoughts and decrease associated negative affect

Clinical Conundrum: Tricky Content…

- Some content areas – e.g., sexual, homicidal, other loss of impulse control thoughts, and suicide-related thoughts – may be more difficult to conceptualize properly
- Need a functional analysis of the antecedents and consequences of particular thoughts & behaviors to see if OCD model applies
- If OCD doesn't apply, need to determine which conceptual model that does apply and use that to guide treatment
- May have more than one type of thought in a given client

Questions to Consider

- What is the primary affect at the time the thought is experienced? Anxiety? Discomfort? Relief? Sadness? Anger?
- Are the behaviors that immediately follow these thoughts efforts to neutralize the thoughts or to elaborate upon them?
- Effect of these behaviors on the emotions being experienced: Does it dissipate these emotions or increase them?

Application of Functional Analysis to Differentiating Obsessions Pertaining to Suicide, NSSI, and Suicidality

Obsessions About Suicide if:

» Thoughts are experienced as intrusive

» Primary affect is anxiety

» Behaviors are intentional efforts to neutralize or reduce thoughts and the associated anxiety

» Individual does not report an intent to die

» "What if?" language is used

Suicidal Ideation if:

» Intention to die is prominent

» Direct efforts to intentionally end one's own life

» Function is to escape negative affect; negative urgency

» Perceived burdensomeness

» Thwarted belonging

» Precautions taken against being discovered

Wenzel et al., (2011) *Jnl Affective Dis*; Anestis & Joiner (2011); Jnl Affective Dis

Why is This Important?

Different empirically supported techniques for different symptom presentations

Suicide and OCD

» Storch et al. (2015):

- 36 – 63% of adults w/ OCD reported clinically significant suicidal ideation (SI) at some point
- 13% of a pediatric OCD sample reported current SI; associated w/ self-rated anxiety & depression as well as sexual/religious obsessions

» Angelakis et al. (2015):

- Moderate to large effect links OCD and suicidality
- Associated w/ comorbidity, hopelessness, prior attempts

Relationship with Thought Control Strategies

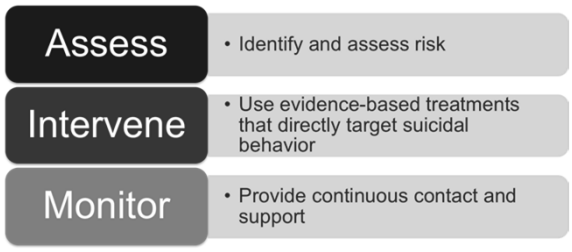
Allen et al. (2016):

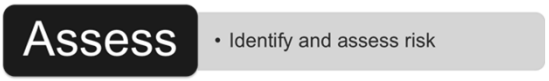
- **OCD patients are particularly vulnerable to use of maladaptive strategies to control intrusive thoughts**
- **ERP is associated w/ decreased use of such strategies**
- **Increased use of distraction and social control strategies over course of ERP**
- **OCD patients may particularly benefit from interventions that facilitate focused distraction from intrusive thoughts**

So you've concluded that your patient is suffering from suicidal ideation and is considering ending their life…

Now What?

The AIM Model





Why Screen for Suicide Risk?

- **Screening for suicide risk is the first step in any suicide prevention program. Helps to raise awareness.**
- **Screening provides for a common language about suicide within a specific setting, agency, health system, or institution.**
- **Screening helps to ensure that clinicians are following a standardized, evidence-based protocol to identify individuals at risk.**
- **Screening offers guidance for developing an action plan to manage risk.**
- **Screening may serve as a "proxy" measure of program effectiveness.**

Joint Commission: Detecting and Treating Suicidal Ideation in All Clinical Settings

Sentinel Event Alert

1. **Review each patient's personal and family medical history for suicide risk factors.**
2. **Screen all patients using a brief, standardized, evidenced-based, screening tool.**
3. **Review screening questionnaires before the patient leaves the appointment or is discharged.**
4. **Take action, using the assessment results to inform the level of safety measures needed.**

***The Joint Commission, 56*, February 24, 2016**

Joint Commission: Detecting and Treating Suicidal Ideation in All Clinical Settings

Sentinel Event Alert

Use Evidence-Based Screening Measures:

- Patient Health Questionnaire (PHQ-9 and PHQ-2)
- ED-SAFE Patient Safety Screener
- Suicide Behaviors Questionnaire-Revised (SBQ-R)
- Columbia Suicide Severity Rating Scale (CSSRS)

The Joint Commission, 56, February 24, 2016

General Approach for Screening for Suicide Risk

- Prior to screening for suicide risk, it is helpful to ask a brief, open-ended question(s) to establish rapport.
  - For example, "How has been mood been during the past week?"
- Ask questions using a non-judgmental, matter-of-fact, and collaborative style.
  - For example, "I would like to ask you some additional routine questions. Is that okay?"
- For patients who become uncomfortable or upset during the interview, listen and provide a summary (empathy), and then ask them if they would like to continue with the discussion.

Working with Suicidal Individuals

Be Aware of Your Reactions When Working with Suicidal Patients and Seek Consultation When Indicated

- Feeling overwhelmed, fearful or uncomfortable
- Fear of being "responsible" for someone else's life; always being "on call" (whether or not one is actually on call)
- Fear of connecting with someone's profound psychological pain and suffering
- Fear of legal liability
- Feeling hopeless or "stuck" in helping others with their problems

Determination of Suicide Risk

- Suicide risk assessment is primarily a reasoned clinical judgment. This process must be documented and should include:
  - The analysis and synthesis of the presence (or absence) of risk and protective factors leading to a final assessment of risk and corresponding action plan
  - Assessment of both long-term and short-term (imminent) risk
- Checklists of risk and protective factors without a narrative analysis and synthesis are inadequate.

Suicide Risk Factors

- Suicidal and Injury Behavior
  - Suicide attempt
  - Interrupted/aborted attempt
  - Preparatory behavior
  - Nonsuicidal self-Injury behavior
- Suicidal Ideation
  - Wish to be dead
  - Active suicidal ideation
  - Suicidal ideation with general method
  - Suicidal intent w/o a plan
  - Suicidal intent with a specific plan
- Activating Event
  - Recent loss or significant life event
  - Pending incarceration or homelessness
- Psychiatric Treatment History
  - Discharged from psychiatric inpatient care within the past few weeks, months, or year
  - Hopeless, dissatisfied, non-compliant with treatment

Suicide Risk Factors

- Clinical Status (Recent)
  - Hopelessness
  - Major depressive episode
  - Mixed affective episode (e.g. Bipolar)
  - Command hallucinations to hurt self
  - Highly impulsive behavior
  - Substance abuse or dependence
  - Agitation or severe anxiety
  - Perceived burden on family or others
- Clinical Status (Recent)
  - Chronic physical pain or other serious medical problem or impairment
  - Social isolation
  - Homicidal ideation
  - Aggressive behavior towards others
  - Access to lethal means when suicidal (firearms, pills, etc.)
  - Sexual abuse (lifetime)
  - Traumatic event (lifetime)
  - Family history of suicide (lifetime)

Suicide Protective Factors

- Protective Factors (Recent)
  - Identifies reasons for living
  - Responsibility to family or others; living with family
  - Supportive social network or family
  - Fear of death or dying due to pain and suffering
  - Belief that suicide is immoral, high spirituality
  - Engaged in work or school

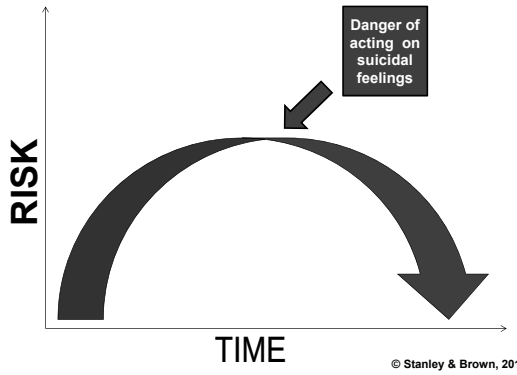
Narrative Description of the Crisis

- Obtain a detailed description of the suicidal crisis:
  - "I would like to hear from your perspective about what happened that led you to think about suicide (or suicide behavior). Tell me about the sequence of the events that occurred and your reactions to these events."
- Construct a timeline that indicates the warning signs or activating events (triggers) and the patient's reactions to these events that were proximal to the suicidal crisis

Narrative Description of the Crisis

- Be a good listener (and do capsule summaries).
- Understand the motivations for suicide from the client's perspective. Assume the patient is the expert and that suicidal thinking and behavior "makes sense" in the context of his or her history, vulnerabilities, and circumstances.
- Empathize/validate the client's feelings and desire to reduce emotional pain but maintain that suicide is not a good option.

Suicide Risk Fluctuates Over Time



Final Determination of Risk

1. Evaluate the severity of each risk factor
2. Evaluate the overall weight of the risk factors versus the protective factors (or absence of risk factors
3. Then, determine overall suicide risk as one of the following:
   - ❑ Low
   - ❑ Moderate
   - ❑ High / Imminent

Intervene

- Use evidence-based treatments that directly target suicidal behavior

Safety Planning Intervention

- **Clinical intervention that results in a prioritized written list of warning signs, coping strategies and resources to use during a suicidal crisis**
- **Safety Plan is a brief intervention (20+ minutes)**
- **Safety Plan is NOT a "no-suicide contract**

Stanley & Brown, Cognitive Behav Pract,19, 2012


SAFETY PLAN

Step 1: Warning signs:
1.
2.
3.

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:
1.
2.
3.

Step 3: People and social settings that provide distraction:
1. Name Phone
2. Name Phone
3. Place
4. Place

Step 4: People whom I can ask for help:
1. Name Phone
2. Name Phone
3. Name Phone

Step 5: Professional or agencies I can contact during a crisis:
1. Clinician Name Phone
Clinician Pager or Emergency Contact #
2. Clinician Name Phone
Clinician Pager or Emergency Contact #
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service
Emergency Services Address
Emergency Services Phone

Making the environment safe:
1.
2.

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Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19, 256-264.

Research

JAMA Psychiatry | Original Investigation

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

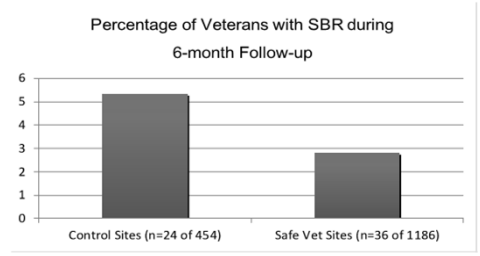
Barbara Stanley, PhD; Gregory K. Brown, PhD; Lisa A. Brenner, PhD; Hanga C. Galfalvy, PhD; Glenn W. Currier, MD; Kerry L. Knox, PhD; Sadia R. Chaudhury, PhD; Ashley L. Bush, MMA; Kelly L. Green, PhD

Author Audio Interview

IMPORTANCE Suicidal behavior is a major public health problem in the United States. The suicide rate has steadily increased over the past 2 decades; middle-aged men and military veterans are at particularly high risk. There is a dearth of empirically supported brief intervention strategies to address this problem in health care settings generally and particularly in emergency departments (EDs), where many suicidal patients present for care.

OBJECTIVE To determine whether the Safety Planning Intervention (SPI), administered in EDs with follow-up contact for suicidal patients, was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge, an established high-risk period.

Does SPI help to decrease suicidal behavior?
Suicide Behavior Reports (SBR) During Follow-up



$\chi 2(1, N = 1640) = 4.72$, $p = .029$; OR = 0.56, 95% CI: 0.33, 0.95

SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behaviors over 6 months

Stanley, B., Brown, G.K., Brenner, L.A. et al. (2018). JAMA Psychiatry

Target Population for Safety Planning Intervention

- **Patients who have…**
  - **Lifetime history of suicidal behavior including:**
    - » **Suicide attempts**
    - » **Aborted/Interrupted attempts**
    - » **Preparing for suicide**
  - **Recent history of suicidal ideation**
  - **Otherwise determined to be at risk for suicide**

Safety Plan Intervention Approach

- **Individuals may have trouble recognizing when a crisis is beginning to occur**
- **Problem solving and coping skills diminish during emotional and suicidal crises**
- **The clinician and patient work together to develop better ways of coping during crises that uses the patient's own words**
- **Over-practicing skills using a predetermined set of skills may improve coping capacity**

Fire Safety: Stop, Drop and Roll

Safety Plan Intervention Tasks

The Safety Plan Intervention involves more tasks than simply completing the Safety Plan form

Introduce Safety Planning

- **Introduce the safety plan as a method for helping to recognize warning signs and to take action to reduce risk or keep it from escalating.**
- **Describe how suicidal thoughts come and go; that suicidal crises pass and that the safety plan helps not act on feelings, giving suicidal thoughts time to diminish and become more manageable.**
- **Describe the suicide risk curve**
- **Explain how using the strategies enhances self-efficacy and a sense of self control**

Overview of Safety Planning: 6 Steps

1. **Recognizing warning signs**
2. **Employing internal coping strategies without needing to contact another person**
3. **Socializing with others who may offer support as well as distraction from the crisis**
4. **Contacting family members or friends who may help resolve a crisis**
5. **Contacting mental health professionals or agencies**
6. **Reducing the potential for use of lethal means**

Explain How to Follow the Steps

- **Make sure each response listed on the plan is feasible and potentially helpful.**
- **Explain how to progress through each step listed on the plan. If following one step is not helpful in reducing risk, then go to the next step.**
- **Explain that if the suicide risk has subsided after a step, then the next step is not necessary.**
- **Explain that the patients can skip steps if they are in danger of acting on their suicidal feelings.**

Making the Environment Safer (STEP 6 on the Safety Plan)

- **If individuals identify a potentially lethal method to kill themselves, such as taking pills, ask, "Do you have access to this method?"**
- **Be aware of the potential view that having access to a lethal mean to kill oneself may be a strategy used to cope with crises.**
- **Express concern about the patient's safety.**
- **Explain that making the environment safer will help to lower risk of acting on suicidal feelings (delays urge to act on suicidal thoughts)**

Making the Environment Safer

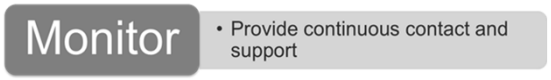
- For some patients who attempt suicide, the interval between thinking about and acting on suicidal urges is usually a matter of minutes.
- Always ask about access to firearms regardless of the method or plan to kill oneself. Ask, "Do you have access to a firearm that you would use for protection or for sport?"
  - If yes, ask about multiple firearms, use of gun safes and locks, storage of ammunition.

Making the Environment Safer

- For each lethal method, ask "How can we go about developing a plan to make your environment safer so that you'll be less likely to use this method to harm yourself?"
  - "How likely are you to do this? What might get in the way? How can we address the obstacles?"
- If doubt is expressed about limiting access, ask,
  - "What are the pros of having access to this method and what are the cons?"
  - "Is there an alternative way of limiting access so that it is safer?"
  - "What does it mean to you to limit access?"

Implementation of the Safety Plan

- Review the steps of the safety plan with the individual and ask about the likelihood of using it:
  - "What are the barriers that might get in the way of using it?"
  - "Where should keep the safety plan so that you will be more likely to use it?"
- Explain that they will receive a copy of the plan and a copy will be retained in their records.



Length and Frequency of Follow-up Monitoring

- The number and frequency of calls need to be determined and may vary depending on the suicidal individual's needs
- Determine procedure if suicidal individual is consistently unreachable
- Follow-up period ends
  - » When individual is engaged in treatment
  - » When individual no longer wishes to be called
  - » When Individual's risk diminishes and individual rejects further treatment

Typical Agenda for Follow-up Calls

- Mood check and risk assessment; determine if immediate rescue is required
- Review and revision of safety plan; discuss access to means
- Treatment engagement discussion and problem solve obstacles
- Obtain consent/willingness for additional follow-up

Review and Revision of Safety Plan

- Determine if the safety plan has been used.
  - If not, why not? (forgetting to use it, how to use it or where to find it)
- Determine what has been helpful and what isn't helpful.
- Always review access to means and whether there is a need to remove means.
- Revise plan as indicated---remove unhelpful items, discuss with individual what may be more helpful. Both the clinician and the suicidal individual notes the changes on the plan.

Now you know what AIM is…but what might that actually look like in practice?

A Demonstration

Demo Participants

Questions? Comments?

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www.suicidesafetyplan.com