DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's webinar is:

Managing Suicidal Behaviors

Sept. 27, 2012

1-2:30 p.m. (EDT)

DVBIC Defense and Veterans Brain Injury Center

DHCC Deployment Health Clinical Center

National Center for Telehealth & Technology

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Managing Suicidal Behaviors

DCoE Monthly Webinar, Sept. 27, 2012

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Marjan G. Holloway, Ph.D.
Associate Professor, Department of Medical & Clinical Psychology, Department of Psychiatry
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Director, Laboratory for the Treatment of Suicide-Related Ideation and Behavior

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Webinar Details

- The following continuing education (CE) and continuing medical education (CME) credit is approved for this activity:
  - 1.5 AMA PRA Category 1 Credits™
  - 1.75 CE Contact Hours Physical Therapy and Occupational Therapy
  - 1.5 Nursing Contact Hours
  - 1.5 Social Work CE Hours
  - 1.5 APA Credits for Psychologists
- For complete accreditation statements, visit the DCoE website to review CE and CME credit
- Webinar pre-registration **required** to receive CE or CME credit
  - Registration is open for the next 15 minutes; register at dcoe.adobeconnect.com/dcoeseptemberwebinar/event/registration.html
  - Some network securities limit access to Adobe Connect

Additional Webinar Details (continued)

- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
  - Dial: **888-455-4265**
  - Use participant pass code: **9415208#**
- Webinar information
  - Visit dcoe.health.mil/webinars
- Question-and-answer session
  - Submit questions via the Adobe Connect or Defense Connect Online question box

Agenda

- Welcome and Introduction
- Suicide Overview, Screening and Risk Assessment
  - Peter M. Gutierrez, Ph.D.
    - Clinical/Research Psychologist, Mental Illness Research, Education and Clinical Center (MIRECC), Eastern Colorado Health Care System (ECHCS) Veterans Affairs Medical Center
- Interventions for Managing Suicidal Behaviors
  - Marjan G. Holloway, Ph.D.
    - Associate Professor, Department of Medical & Clinical Psychology, Department of Psychiatry, Uniformed Services University of the Health Sciences (USUHS)
    - Director, Laboratory for the Treatment of Suicide-Related Ideation and Behavior, USUHS
- Military and Veterans Crisis Line
  - Janet Kemp, R.N., Ph.D.
    - National Mental Health Program Director for Suicide Prevention, Department of Veterans Affairs, Office of Mental Health Services
- Question-and-answer session/discussion

Webinar Overview

Managing Suicidal Behaviors

- Since 2004, the number of suicides among active-duty service members has increased dramatically.
- The rise in military suicide rates may be associated with psychological health problems and/or interpersonal and family stressors.
- Research has suggested that of those who died by suicide, many had visited a health care provider within the month prior to their death.

The goal of this webinar is to educate health care providers about their role in identifying and managing suicidal behaviors. Specifically, this webinar will:

- Review the public health significance of suicide
- Describe screening and assessment methods for identifying suicidal patients
- Identify interventions for managing suicidal behaviors

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Suicide Overview, Screening and Risk Assessment

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Required Disclosure

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Suicide Overview, Screening and Risk Assessment

Peter M. Gutierrez, Ph.D.

VISN 19 Mental Illness, Research, Education and Clinical Center (MIRECC)

DCoE Webinar

Sept. 27, 2012

Suicide Statistics

- 36,909 deaths in 2009
  - 100.8 per day
  - 12.0 per 100,000 population
  - 1.5 % of all deaths
- Male rate 19.2
- Female rate 5.0
- 922,725 (estimated) annual attempts in U.S.
  - Translates to one attempt every 34 seconds
  - 25 attempts for every death by suicide
  - Three female attempts for each male attempt

Reference: Deaths: Final Data for 2009. *National Vital Statistics Reports, 60(3)*

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Fatal Outcomes

- Average of one person every 14.2 minutes
- Average of one old person every one hour and 30 minutes
- Average of one young person every two hours
- 10th ranking cause of death in U.S.; homicide 15th
- 3.7 male deaths by suicide for each female death by suicide

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Impact on Family and Friends

- Each suicide intimately affects at least six other people (estimate)
- Estimated that the number of survivors of suicides in the U.S. is 4.73 million
- Six new survivors every 14.2 minutes

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Public Health Burden

- 533,000 presentations to U.S. emergency departments in 2005-2006 for self-directed violence (SDV)
  - Estimated that more than half of people who engage in SDV never seek care
- Costs associated with SDV in 2000 were approximately $33 billion
  - $1 billion for medical care
  - $32 billion in lost productivity

Reference: Crosby, Ortega, & Melanson C. (2011). Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements: CDC.

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Screening vs. Assessment

Photo source: bugeurope.com

Photo source: saveourrailways.com

What's the Goal?

Screening

- Snapshot
- Quick
- Focused
- Next steps

Assessment

- Comprehensive
- Specialty care
- Case conceptualization
- Treatment planning

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Who Should Be Screened?

- At a minimum, anyone being seen for depression or with a history of depression
- Those with alcohol-abuse problems
- Receiving catastrophic medical news
- Exhibiting significant changes in mood

Reference: McDowell et al., 2011

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Other Conditions to Monitor

- Comorbid anxiety or agitation
  - Particularly PTSD, panic disorder, social anxiety disorder and generalized anxiety disorder
- Significant sleep problems (Ribeiro et al., 2012)

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Mention of Suicide/Desire for Death

Does not always mean there is a crisis

Photo source: triwest.com

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Know the Red Flags

- Significant anxiety
- Psychomotor agitation (e.g., “feeling like want to crawl out of my skin”)
- Poor sleep
- Concentration problems
- Hopelessness
- Social isolation
- Significant increase in substance use

Reference: McDowell et al., 2011

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What Information Do You Need?

- Step-wise approach
  - Move from general to specific
- Feeling hopeless or thinking about death
- Specific thoughts about suicide
- Family history and own history of self-directed violence

Reference: McDowell et al., 2011

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What Tools Should I Use?

- No standardized measure can predict who will/will not engage in self-directed violence
- Identification of similarity between an individual patient and known groups
- Single-item indicators have **very limited utility**
- Valid and reliable, in particular, with good criterion validity

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Potential Measures

- Heisel and colleagues (2010) reported 15-item Geriatric Depression Scale cut-off of **5** for men and **3** for women accurately identifying ideation
  - Designed for primary care patients 65 and older
- Patient Health Questionnaire-9 78.9% agreement with SCID-I
  - 10.2% false positives, 10.8% false negatives (Uebalacker et al., 2011)

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Suicidal Behaviors Questionnaire-Revised (SBQ-R)

- Cut-off score of **8** discriminates between adult psychiatric inpatients with/without history of suicide attempt/serious consideration
- **7** cut-off for non-clinical
- Valid, reliable, easy to administer and score
- Self-report can be completed in a variety of settings
- Specifically designed as a suicide screening tool

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How Accurate is the SBQ-R?

- Adult psychiatric inpatients 95% of those with a history of serious ideation/attempts (positive predictive value)
- 87% of those without a history of suicidality (negative predictive value)
- 5% false-positives
- 13% false-negatives
- Non-clinical undergrads PPV and NPV = 1.00

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Suicide Risk Assessment

We assess risk to…

- Take good care of our patients and to guide our interventions
- Identify modifiable and treatable risk factors that inform the patient's overall treatment and management requirements (Simon, 2001)

Fortunately, the best way to care for our potentially suicidal patients and ourselves are one in the same (Simon, 2006)

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Suicide Risk Assessment

- Refers to the establishment of a clinical judgment of risk in the near future
  - based on the weighing of a very large amount of available clinical detail

Reference: Jacobs, 2003

Suicide Risk Assessment

- No standard of care for the prediction of suicide
- Suicide is a rare event
- Efforts at prediction yield lots of false-positives as well as some false-negatives
- Structured scales may augment, but do not replace systematic risk assessment
- Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients

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Suicide Risk Assessment

- Standard of care does require suicide risk assessment whenever indicated
- Best assessments will attend to both risk and protective factors
- Risk assessment is not an event, it is a process
- Inductive process to generate specific patient data to guide clinical judgment, treatment and management
- Research identifying risk and protective factors enables evidence-based treatment and safety management decision making

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Specific Inquiry of Thoughts, Plans and Behaviors

- Elicit any suicidal ideation
  - Focus on nature, frequency, extent, timing
  - Assess feelings about living
- Presence or absence of plan
  - What are plans, what steps have been taken
  - Investigate patient's belief regarding lethality
  - Ask what circumstances might lead them to enact plan
  - Ask about GUNS and address the issue

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Specific Inquiry of Thoughts, Plans, and Behaviors

- Assess patient's degree of suicidality, including intent and lethality of the plan
  - Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, lethality of method, feasibility
  - Realize that suicide assessment scales have low predictive values
- ***Strive to know your patient and their specific or idiosyncratic warning signs***

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Identify Suicide Risk Factors

- Specific factors that may generally increase risk for suicide or other self-directed violent behaviors
- A major focus of research for past 30 years
- Categories of risk factors
  - Demographic
  - Psychiatric
  - Psychosocial stressors
  - Past history

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Warning Signs

- Warning signs – person-specific emotions, thoughts or behaviors precipitating suicidal behavior
- Proximal to the suicidal behavior and imply imminent risk
- The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct further suicide risk assessment

Reference: Rudd et al., 2006

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Risk Factors vs. Warning Signs

Risk Factors	Warning Signs
• Suicidal ideas/behaviors • Psychiatric diagnoses • Physical illness • Childhood trauma • Genetic/family effects • Psychological features (i.e., hopelessness) • Cognitive features • Demographic features • Access to means • Substance intoxication • Poor therapeutic relationship	• Threatening to hurt or kill self or talking of wanting to hurt or kill self • Seeking access to lethal means • Talking or writing about death, dying or suicide • Increased substance (alcohol or drug) use • No reason for living; no sense of purpose in life • Feeling trapped – like there is no way out • Anxiety, agitation, unable to sleep • Hopelessness • Withdrawal, isolation

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Determine If Factors Are Modifiable

Non-Modifiable Risk Factors

- Family history
- History
- Demographics

Modifiable Risk Factors

- Treat psychiatric symptoms
- Increase social support
- Remove access to lethal means

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Develop a Treatment Plan

- For the suicidal patient, particular attention should be paid to modifiable risk and protective factors
- Static risk factors help stratify level of risk, but are typically of little use in treatment; cannot change age, gender or history
- Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc.

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Do Not Neglect Modifiable Protective Factors

- These are often key to addressing long-term or chronic risk
- Sense of responsibility to family
- Reality-testing ability
- Positive coping skills
- Positive problem-solving skills
- Enhanced social support
- Positive therapeutic relationships

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Assessment Measures

Elements of Useful Assessment Tools

- Clear operational definitions of construct assessed
- Focused on specific domains
- Developed through systematic, multistage process
  - Empirical support for item content, clear administration and scoring instructions, reliability and validity
- Range of normative data available

Reference: Gutierrez and Osman, 2008

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Self-Report Measures

- Advantages
  - Fast and easy to administer
  - Patients often more comfortable disclosing sensitive information
  - Quantitative measures of risk/protective factors

- Disadvantages
  - Report bias
  - Face validity

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Suicide Specific Self-Report Measures

- Self-Harm Behavior Questionnaire
  - SHBQ; Gutierrez et al., 2001
- Reasons for Living Inventory
  - RFL; Linehan et al., 1983
- Suicide Cognitions Scale-Revised
  - SCS-R; Rudd, 2004
- Beck Scale for Suicidal Ideation
  - BSS; Beck, 1991

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Sample SHBQ Question

Times you hurt yourself badly on purpose or tried to kill yourself.

2. Have you ever attempted suicide? **YES** **NO**

   If no, go on to question # 4.

   If yes, how? _____

   (**Note:** if you took pills, what kind? _____; how many? _____ ;
   over how long a period of time did you take them? _____)

   a. How many times have you attempted suicide? _____
   b. When was the most recent attempt? *(write your age)* _____
   c. Did you tell anyone about the attempt? **YES** **NO**
      Who? _____
   d. Did you require medical attention after the attempt? **YES** **NO**
      If yes, were you hospitalized overnight or longer? **YES** **NO**
      How long were you hospitalized? _____
   e. Did you talk to a counselor or some other person like that after your attempt?
      YES **NO** Who? _____

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Sample RFL Items

____ 1. I have a responsibility and commitment to my family.

____ 2. I believe I can learn to adjust or cope with my problems.

____ 3. I believe I have control over my life and destiny.

____ 4. I have a desire to live.

____ 5. I believe only God has the right to end a life.

____ 6. I am afraid of death.

____ 7. My family might believe I did not love them.

____ 8. I do not believe that things get miserable or hopeless enough that I would rather be dead.

____ 9. My family depends upon me and needs me.

____ 10. I do not want to die.

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Sample SCS-R Items

1) The world would be better off without me.
2) Suicide is the only way to solve my problems.
3) I can't stand this pain anymore.
4) I am an unnecessary burden to my family.
5) I've never been successful at anything.
6) I can't tolerate being this upset any longer.
7) I can never be forgiven for the mistakes I have made.
8) No one can help solve my problems.
9) It is unbearable when I get this upset.
10) I am completely unworthy of love.

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Questions?

Thank You

- Throughout the webinar, you are welcome to submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.

- The question box is monitored during the webinar, and questions will be forwarded to our presenters for response during the question-and-answer session of the webinar.

- Our presenters will respond to as many questions as time permits.

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Interventions for Managing Suicidal Behaviors

Marjan G. Holloway, Ph.D.

Associate Professor
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Interventions for Managing Suicidal Behaviors

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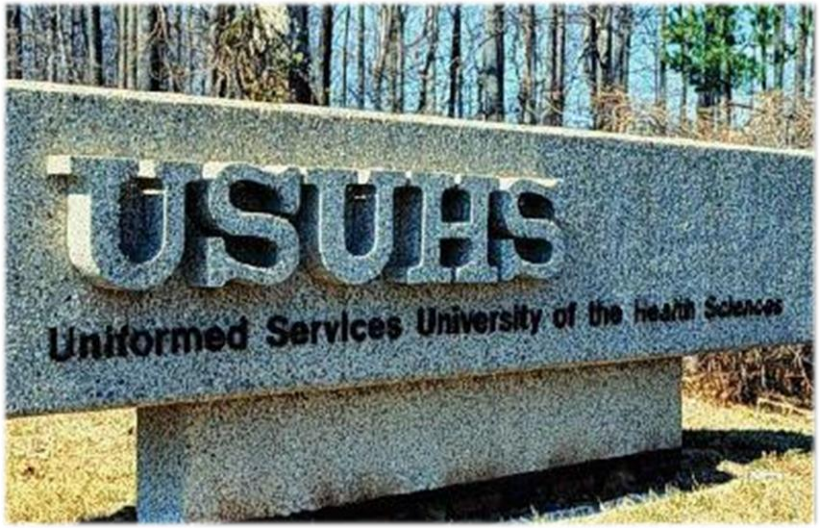

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Presentation Outline

- Evidence-based clinical practices for the prevention of suicide
- Cognitive behavior therapy for the prevention of suicide
- Professional burnout and maladaptive provider cognitions

Evidence-based Clinical Practices for the Prevention of Suicide

Do suicide prevention programs actually prevent suicide?

We do not really know because of the following:

- Low base rate problem for deaths by suicide
- Burdensome (albeit necessary) regulatory requirements
- Liability and risk management concerns
- Infrequent usage of reliable and valid measures of suicide-related ideation and behaviors in suicide prevention literature
- Ethical issues that constrain research design
- Heterogeneous samples (different sets of co-occurring psychiatric disorders)
- Low compliance with treatment for suicidal individuals (Mann et al., 2005)
- Participation bias in randomized controlled trials (Wiltsey-Stirman et al., 2011)
- **Most intervention studies for individuals with psychiatric disorders have excluded those who are at high risk for suicide**

Meta-Analysis of Cognitive-Behavioral Interventions to Reduce Suicide Behavior

- Terrier, Taylor & Gooding, 2008
  - 28 studies
  - CBT (includes DBT) versus control
  - Used suicide behavior as outcome

Note: CBT = Cognitive Behavior Therapy; DBT = Dialectical Behavior Therapy

Table 2
Effect Size (Hedge's *g*), Confidence Intervals, and *z* Scores Overall and for Six Subgroup Analyses

		Effect Size and 95% Confidence Interval						Test of Null (Two-Tailed)	
		Data Points	Point Estimate	*SE*	Variance	Lower limit	Upper limit	*z*	*p*
All studies		25	−0.591	0.112	0.013	−0.811	−0.371	−5.265	.000
Age group	Adolescents	7	−0.260	0.192	0.037	−0.635	0.116	−1.355	.175
	Adult	18	−0.775	0.141	0.020	−1.051	−0.498	−5.497	.000
Comparison group	Placebo, WLC, or nothing	5	−0.808	0.239	0.057	−1.276	−0.341	−3.389	.001
	TAU	14	−0.594	0.166	0.028	−0.920	−0.269	−3.574	.000
	Therapy	6	−0.412	0.254	0.065	−0.910	0.087	−1.619	.105
Study focus	Direct	21	−0.712	0.130	0.017	−0.967	−0.457	−5.469	.000
	Indirect	4	−0.228	0.228	0.052	−0.674	0.219	−1.000	.318
Outcome measure	Hopelessness	2	−0.530	0.330	0.109	−1.177	0.116	−1.608	.108
	Satisfaction with life scale	1	−2.585	0.561	0.315	−3.685	−1.484	−4.604	.000
	Suicide ideation	9	−0.390	0.155	0.024	−0.693	−0.087	−2.522	.012
	Suicide, attempt, plan, potential, problem	13	−0.574	0.145	0.021	−0.858	−0.290	−3.957	.000
Therapy type	CBT	18	−0.562	0.132	0.018	−0.822	−0.302	−4.244	.000
	DBT	7	−0.697	0.228	0.052	−1.143	−0.250	−3.057	.002
Therapy mode	Group	5	−0.263	0.186	0.035	−0.628	0.102	−1.410	.159
	Individual	11	−0.576	0.155	0.024	−0.881	−0.271	−3.704	.000
	Individual plus family	2	−0.212	0.325	0.106	−0.849	0.425	−0.652	.514
	Individual plus group	6	−0.790	0.228	0.052	−1.237	−0.343	−3.466	.001
	Telephone plus group	1	−2.585	0.561	0.314	−3.684	−1.486	−4.610	.000

Note: The fully random effects model was used for all analyses. CBT = cognitive-behavioral therapy; DBT = dialectic behavior therapy; TAU = treatment as usual; WLC = waiting-list control.

Significant effects when compared to control

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Adults showed significant treatment effects

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Adolescents did not

Table 2
Effect Size (Hedge's *g*), Confidence Intervals, and *z* Scores Overall and for Six Subgroup Analyses

		Effect Size and 95% Confidence Interval						Test of Null (Two-Tailed)	
		Data Points	Point Estimate	*SE*	Variance	Lower limit	Upper limit	*z*	*p*
All studies		25	−0.591	0.112	0.013	−0.811	−0.371	−5.265	.000
Age group	Adolescents	7	−0.260	0.192	0.037	−0.635	0.116	−1.355	.175
	Adult	18	−0.775	0.141	0.020	−1.051	−0.498	−5.497	.000
Comparison group	Placebo, WLC, or nothing	5	−0.808	0.239	0.057	−1.276	−0.341	−3.389	.001
	TAU	14	−0.594	0.166	0.028	−0.920	−0.269	−3.574	.000
	Therapy	6	−0.412	0.254	0.065	−0.910	0.087	−1.619	.105
Study focus	Direct	21	−0.712	0.130	0.017	−0.967	−0.457	−5.469	.000
	Indirect	4	−0.228	0.228	0.052	−0.674	0.219	−1.000	.318
Outcome measure	Hopelessness	2	−0.530	0.330	0.109	−1.177	0.116	−1.608	.108
	Satisfaction with life scale	1	−2.585	0.561	0.315	−3.685	−1.484	−4.604	.000
	Suicide ideation	9	−0.390	0.155	0.024	−0.693	−0.087	−2.522	.012
	Suicide, attempt, plan, potential, problem	13	−0.574	0.145	0.021	−0.858	−0.290	−3.957	.000
Therapy type	CBT	18	−0.562	0.132	0.018	−0.822	−0.302	−4.244	.000
	DBT	7	−0.697	0.228	0.052	−1.143	−0.250	−3.057	.002
Therapy mode	Group	5	−0.263	0.186	0.035	−0.628	0.102	−1.410	.159
	Individual	11	−0.576	0.155	0.024	−0.881	−0.271	−3.704	.000
	Individual plus family	2	−0.212	0.325	0.106	−0.849	0.425	−0.652	.514
	Individual plus group	6	−0.790	0.228	0.052	−1.237	−0.343	−3.466	.001
	Telephone plus group	1	−2.585	0.561	0.314	−3.684	−1.486	−4.610	.000

Note: The fully random effects model was used for all analyses. CBT = cognitive-behavioral therapy; DBT = dialectic behavior therapy; TAU = treatment as usual; WLC = waiting-list control.

No significant effects when compared to another active treatment

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CBT & DBT showed significant effects

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Commonalities of Treatments
Weinberg et al., (2010)

1970 to 2007 Randomized Controlled Trials on Psychotherapy to Address Suicide-Related Behaviors

- Dialectical Behavior Therapy (DBT)
- Mentalization-Based Treatment (MBT)
- Transference-Focused Psychotherapy (TFP)
- Schema-Focused Therapy (SFT)
- Cognitive Behavior Therapy (CBT)

Photo source: optimindhealth.com

Dr. Igor Weinberg

Commonalities of Treatments
Weinberg et al., (2010)

Agreed Upon Treatment Framework	Attention to Affect	Active Therapist
Suicide Must Be Understood Exploration OR Behavioral Analysis	Change in Thinking and Behavior	Agreed Upon Strategy for Managing Suicidal Crises

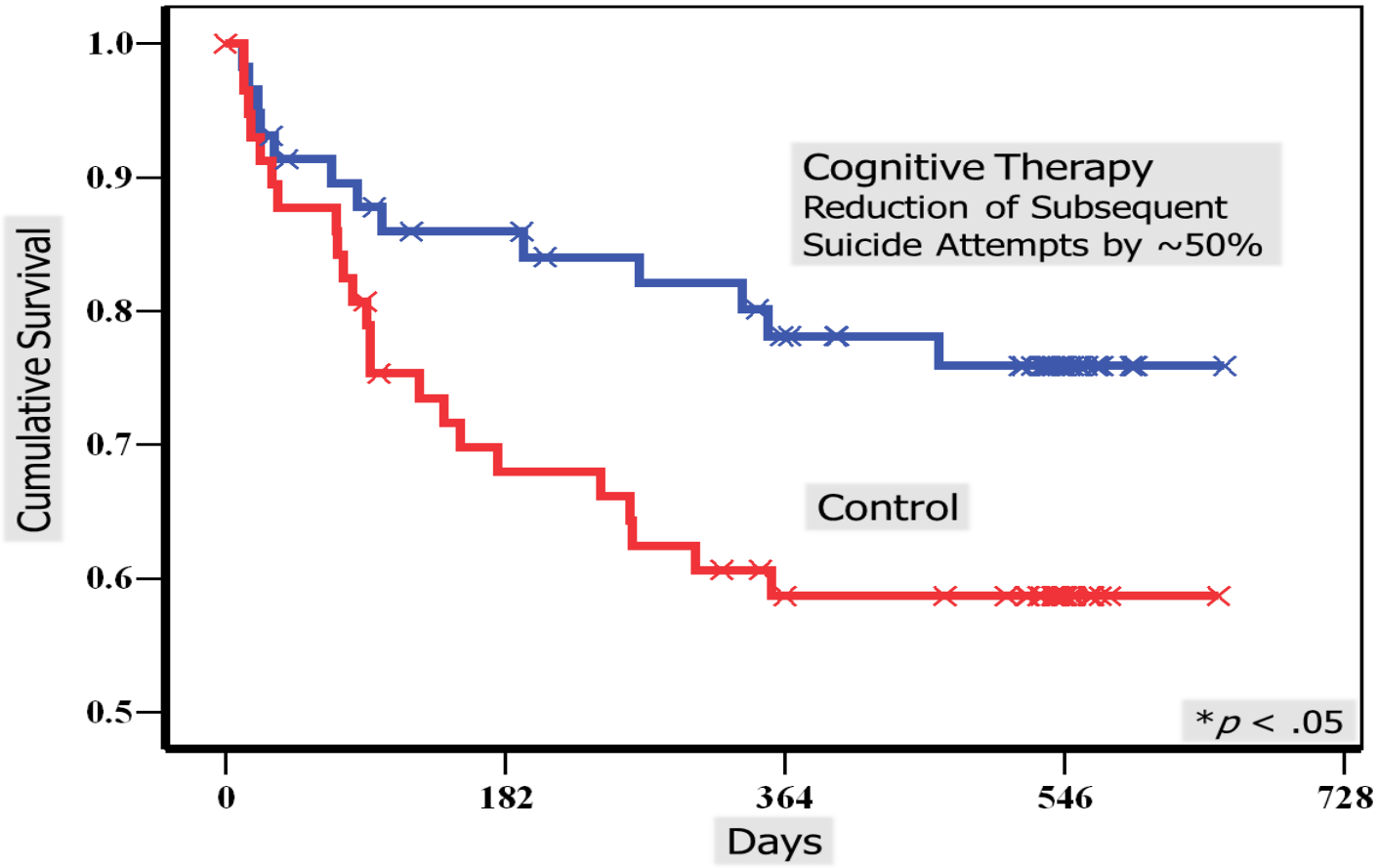
Cognitive Behavior Therapy (CBT) for the Prevention of Suicide

Results of a Randomized Controlled Trial

Reference: Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *Journal of the American Medical Association*, 294, 563-570.

10-Session Outpatient Cognitive Therapy for the Prevention of Suicide

Survival Functions for Repeat Suicide Attempt by Study Condition



Reference: Brown et al., (2005)

Cognitive Behavior Therapy for Prevention of Suicide

SUICIDE-RELATED BEHAVIORS

Problematic coping

Primary problem rather than symptom of a disorder

10-Session
Cognitive Therapy Protocol

- **Early Phase of Treatment (Sessions 1-3)**
  - Engage patient in treatment – Plan for safety
  - Process suicide story
  - Develop case conceptualization – Treatment plan

- **Middle Phase of Treatment (Sessions 4-7)**
  - Address problematic coping – Teach problem-solving
  - Address emotion regulation – Teach distress tolerance
  - Address social support problems – Teach social skills
  - Address helping services utilization – Teach self-care
  - Address hopelessness – Teach ways to build reasons for living

- **Final Phase of Treatment (Sessions 8-10)**
  - Relapse prevention

Early Sessions

Sample Activity: Process Suicide Story

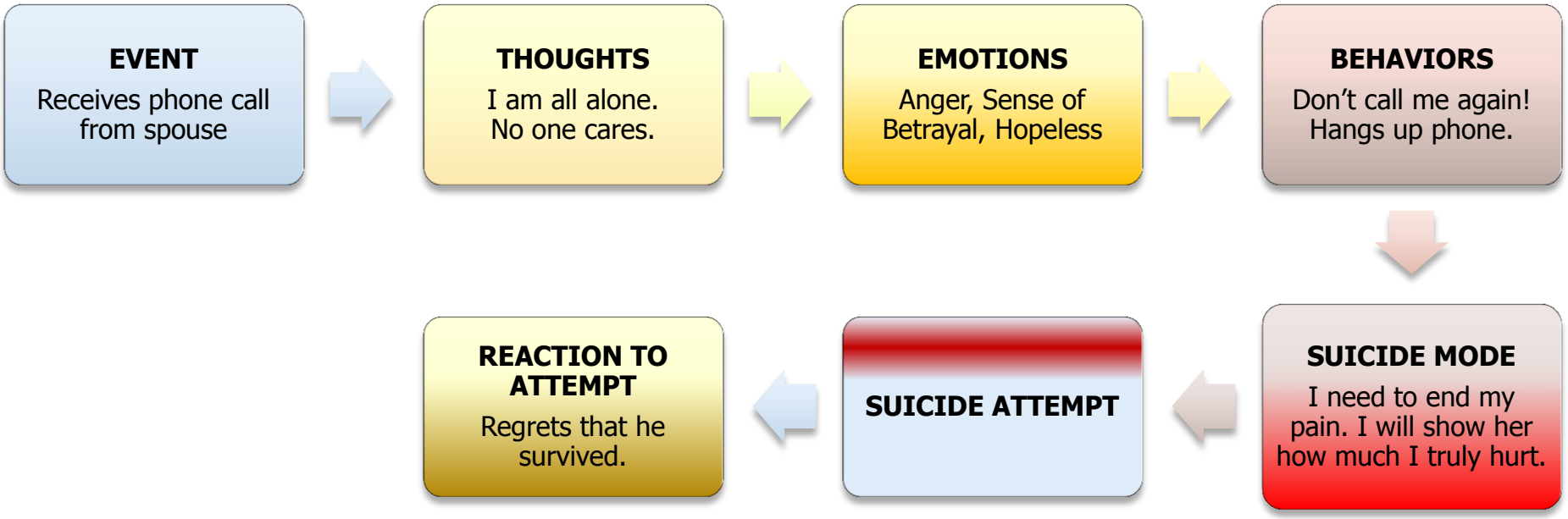
Describe Activity

- Let's first focus on your suicide narrative. Please tell me about the circumstances, thoughts, feelings and actions that resulted in your decision to attempt suicide. I would be interested to hear about your reasons for wanting to die (and your reactions to the hospitalization), and your reactions to having survived the attempt.

- If you were to construct a story with a beginning, a middle and an end, please tell me a story about what happened on the day of your suicide attempt. Your job in today's session is to tell me your suicide story.

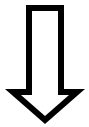
- My job in today's session is to best understand what happened. I will remain quiet for the most part, will take notes for both of us, and let you do most of the talking. If you move away from the story, I will help refocus you. Given our limited time together, it is my responsibility to make sure that we get you the highest dose of this treatment by keeping us focused. Do you have any questions?

Timeline of Suicide Attempt

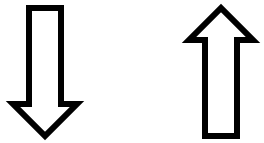


Understand Suicide Mode

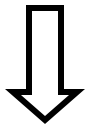
VULNERABILITY FACTORS



ACTIVATING EVENTS



SUICIDE MODE



SUICIDE-RELATED BEHAVIOR

Suicide Mode

Food Cravings?

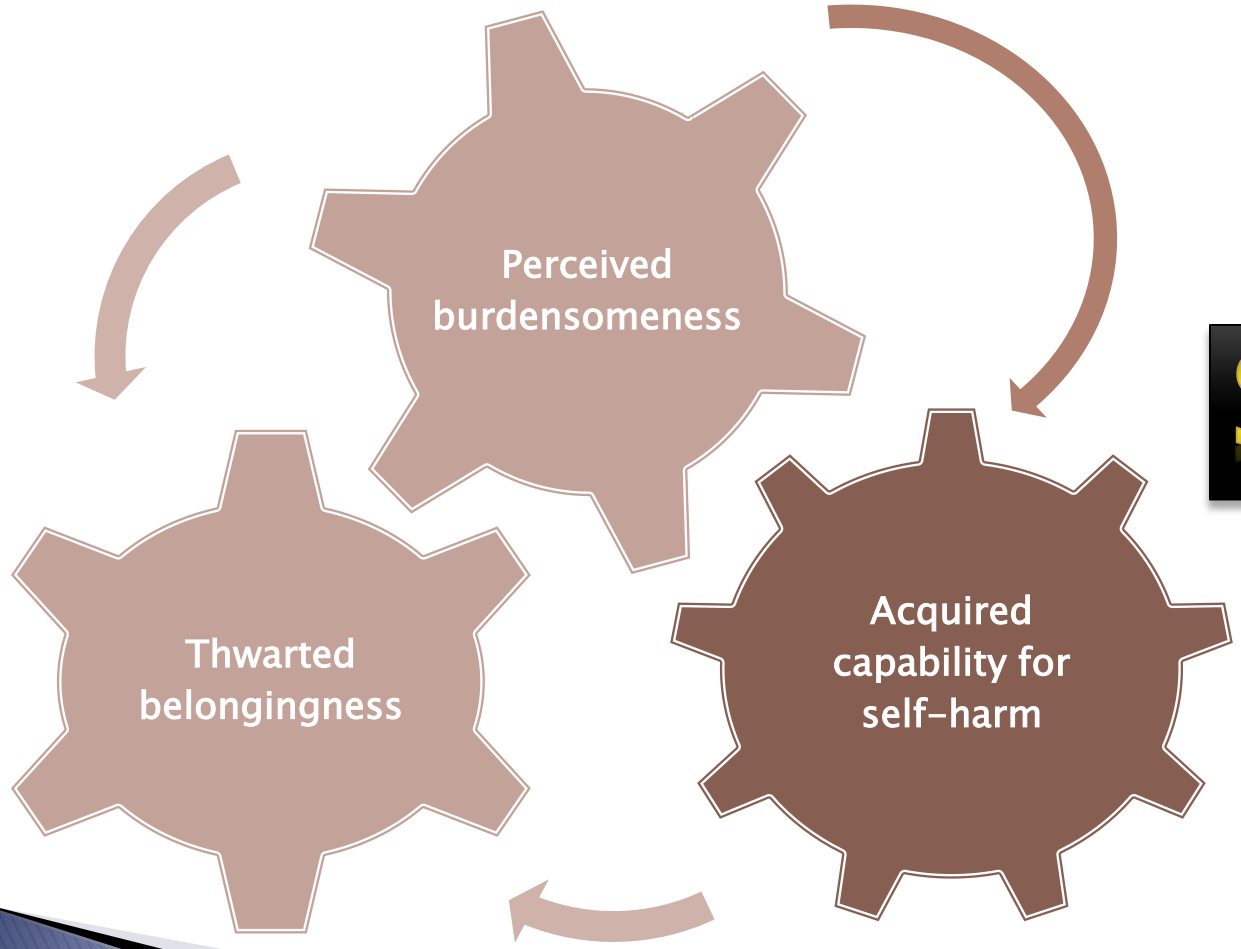
Photo source: webmd.com

Cake Craving Mode

- Event = Bad day at work
- Thoughts about cake
  - Sometimes ruminative
  - Sometimes intrusive
- Physiological reactivity
  - Salivating over the cake
- Feeling that I must have it
- Motivated to get a piece of cake
- Intent and plan on how to get the best slice
- Disappointed with anything else but the cake!

Photo source: opensourcefood.com

Interpersonal-Psychological Theory
(Joiner, 2005)



SUICIDE

Middle Sessions

Sample Activity: Address Problematic Coping

Problem Solving Skills

- Address impulsivity, avoidance and suicide as an option BUT not the ONLY solution

Problem Solving Pattern

- Which problem-solving strategies did the person develop over time to cope with life stressors?

Common Strategy 1: Avoidant Strategies

Examples: Avoids confrontation; avoids negative emotions

Common Strategy 2: Impulsive Strategies

Examples: Drinking; making quick decisions

Steps to Problem Solving

Define the Problem

Be Specific | Be Constructive

Brainstorm

List Ideas | Be Creative & Non-Evaluative

Evaluate and Choose a Course of Action

Evaluate Pros & Cons | Choose BEST Solution

Take Action and Evaluate Results

Ideas = Experiments | Change Action If Needed

Sample Coping Card

Automatic thought:

"There's no way out of this."

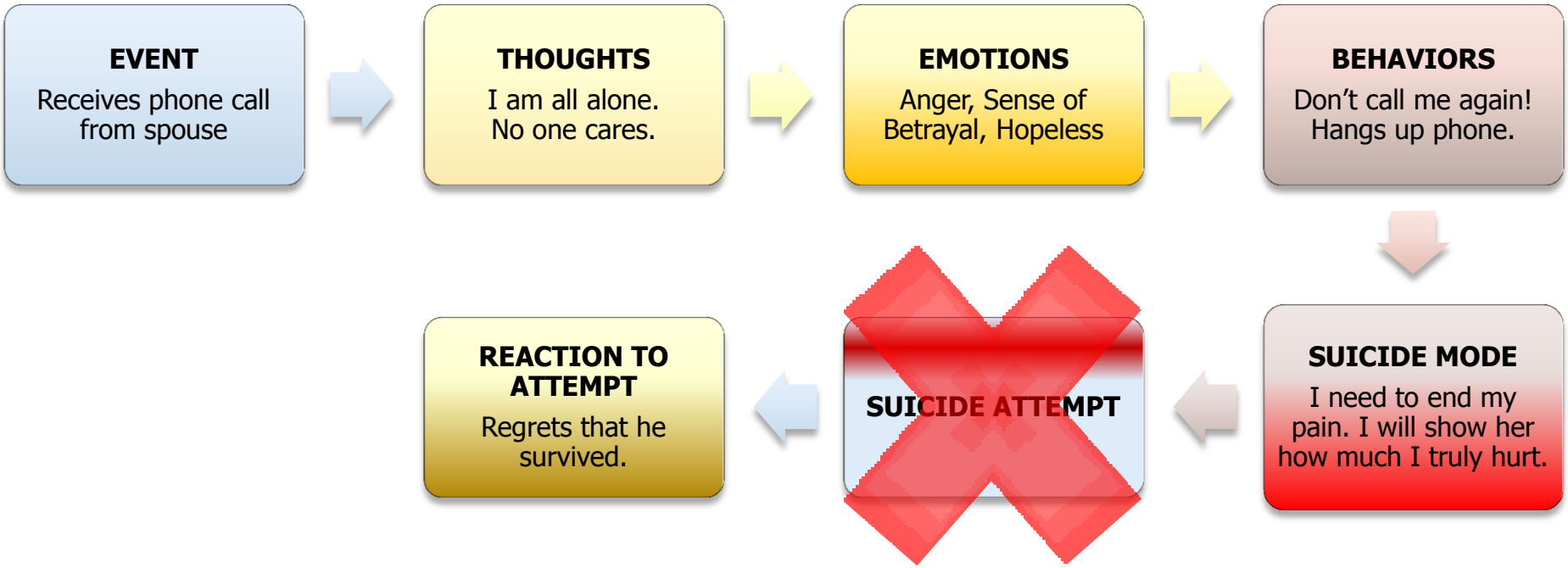
Response:

Things are really tough right now, but that doesn't mean there's no way out. I've been through a lot of hard times before, and I've always made it through. I know I can talk to my friends about how much I miss my family. We will help each other to get through this.

Later Sessions

Sample Activity: Relapse Prevention

Change the Outcome



PACT

6 Individual Therapy Sessions – 90 Min. Each

Sessions Transcribed

Treatment Phase	Therapeutic Goals
Phase I Sessions 1 and 2	❑ Build therapeutic alliance ❑ Provide psychoeducation ❑ Collaboratively plan for safety ❑ Develop suicide mode conceptualization ❑ Assess readiness for change
Phase II Sessions 3 and 4	❑ Instill hope – increase reasons for living ❑ Teach adaptive coping strategies ❑ Target deficits in problem-solving ❑ Address social support concerns
Phase III Sessions 5 and 6	❑ Promote self-care ❑ Promote linkage to outpatient aftercare ❑ Teach relapse prevention strategies ❑ Refine safety plan before discharge

Professional Burnout

Maladaptive Provider Cognitions

Professional Burnout
Maslach (1982)

- **Three key dimensions**
  - An overwhelming exhaustion
  - Feelings of cynicism
    - Cognitive distancing or depersonalization
  - A sense of ineffectiveness
    - Detachment from the job

Photo source: berkeley.edu

Dr. Christina Maslach

Maladaptive Provider Cognitions

- **Personalizing**
  - "As an incompetent therapist, it's my fault that my patient remains suicidal."
- **Catastrophizing**
  - "He is right - there is *really* no hope."
- **Shoulds**
  - "You should show up to every session and follow your safety plan."
- **Overgeneralizing**
  - "They are all malingering – if they really wanted to kill themselves, they would just take care of it."

Your Negative Affect

- Therapy interfering?
- Respond to own dysfunctional thoughts or beliefs
- Get additional training in suicide prevention
- Consult with colleague(s)
  - Form a peer consultation group
  - Seek a senior mentor

Further Reading

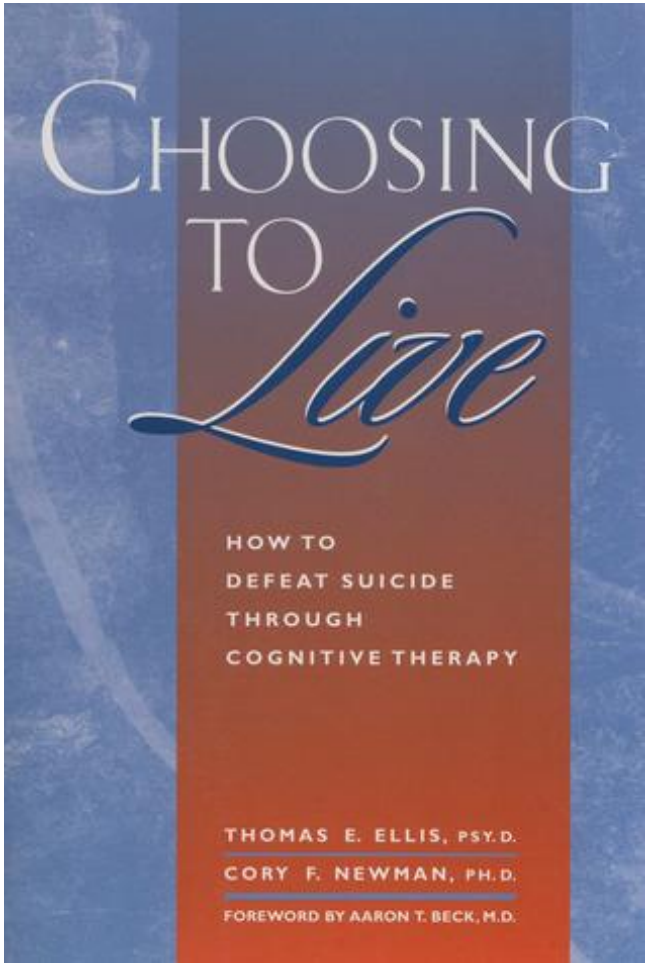
- Ghahramanlou-Holloway, M., Brown, G. K., & Beck, A. T. (2008). Suicide. In M. Whisman (Ed.), *Adapting cognitive therapy for depression: Managing complexity and comorbidity.* New York: Guilford Publications, Inc.

- Dennis, J., Ghahramanlou-Holloway, M., Cox, D., & Brown, G. (2011). A guide for the assessment and treatment of suicidal patients with traumatic brain injuries. *Journal of Head Trauma Rehabilitation,* 26, 244-256.

- Ghahramanlou-Holloway, M., Cox, D., & Greene, F. (2012). Post-admission cognitive therapy: A brief intervention for psychiatric inpatients admitted after a suicide attempt. *Cognitive and Behavioral Practice,* 19, 233-244.

Further Reading

- Book recommendation
  - Self-help book for adults



Questions?

Thank You

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- Our presenters will respond to as many questions as time permits.

DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Veterans and Military Crisis Line

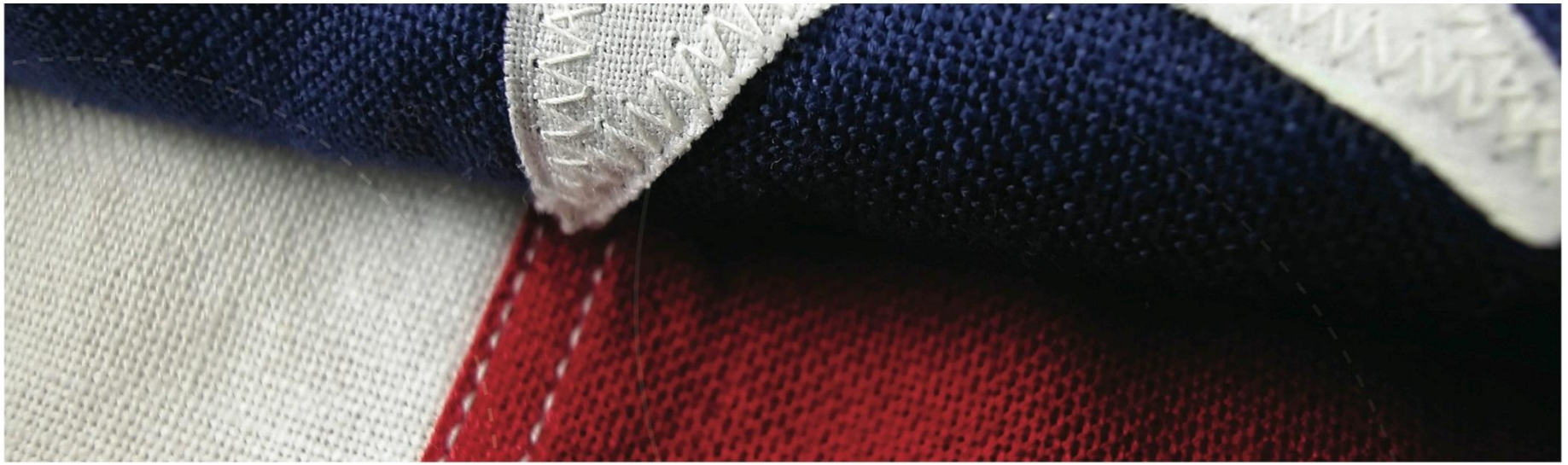
Janet Kemp, R.N., Ph.D.

National Mental Health Program Director for
Suicide Prevention/Community Engagement,
Department of Veterans Affairs, Office of Mental Health Services

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

Required Disclaimer

I have no relevant financial relationships and do not intend to discuss the off-label/investigative (unapproved) use of commercial products/devices.



Veterans and Military Crisis Line

Janet Kemp R.N., Ph.D.
VA National Mental Health Program Director
Suicide Prevention / Community Engagement

Sept. 27, 2012

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

Veterans Affairs and Defense Department

Veterans and Military Crisis Line

- Veterans and Military Crisis Line is the same phone number/crisis line
  - Paid for and operated by the Department of Veterans Affairs (VA)
  - Strong Department of Defense collaboration
- A toll-free, confidential resource that connects Veterans and Service Members in crisis and their families and friends with qualified, caring VA responders.
- Responders are specially trained and experienced in helping Veterans and Service Members of all ages and circumstances
- 800-273-8255, press 1

Veterans Affairs and Defense Department

Veterans and Military Chat Service

- Anonymous, online chats occur with a trained VA counselor
- Potential to transfer the visitor to the VA Suicide Prevention Hotline, where further counseling and referral services are provided and crisis-intervention steps can be taken.
- Intended to reach out to all Veterans and Service Members
- Launched in July 2009

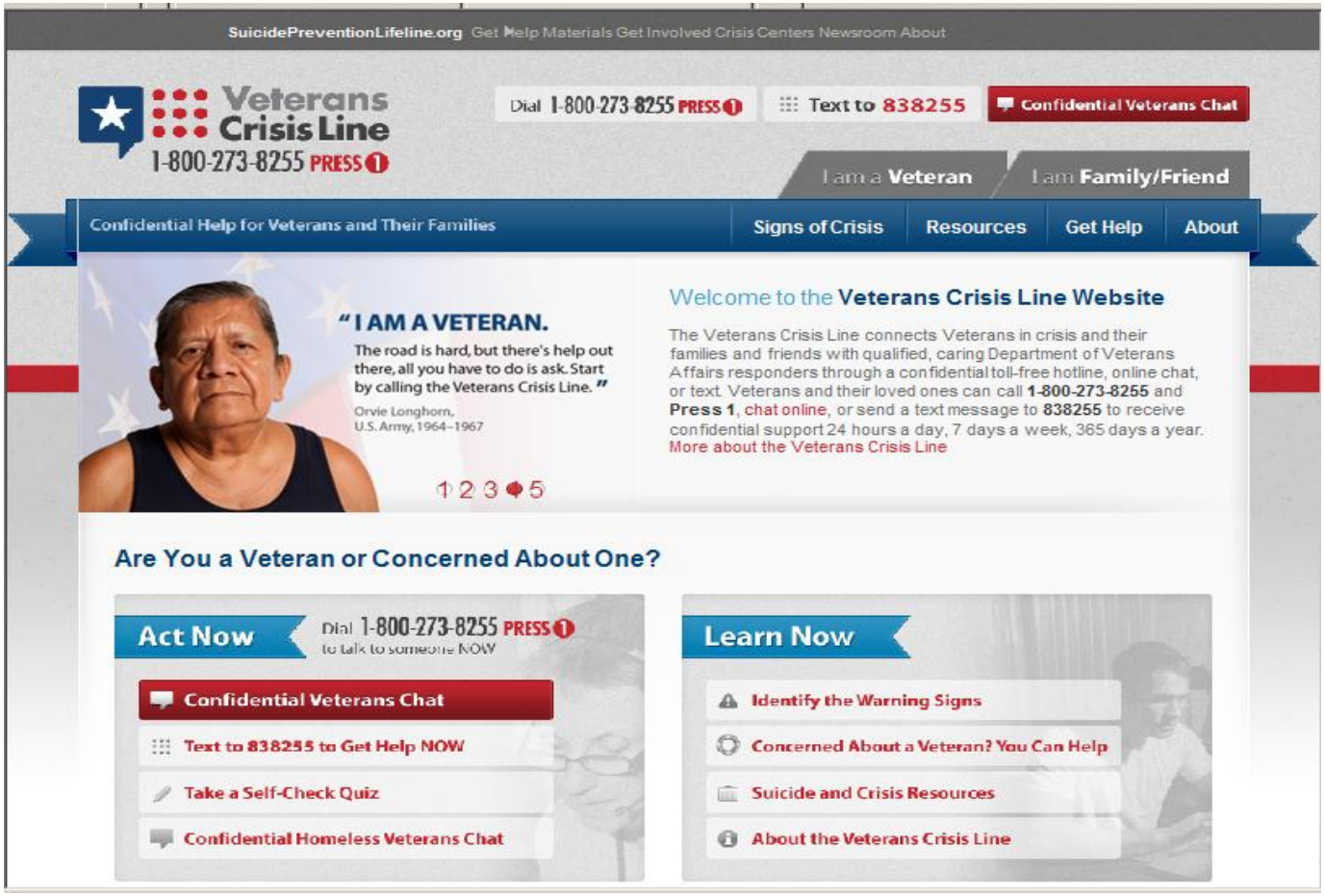
Veterans Affairs and Defense Department

Veterans and Military Text

- 838255 (VETALK)
- Free!
- Same clinical skills as Chat
- Primary differences between Chat and Text
  - Text is limited to 160 characters
  - Performance of texting software is dependent on visitor's cell phone and cell phone service provider

Veterans Affairs and Defense Department

WWW.VETERANSCRISISLINE.NET
WWW.MILITARYCRISISLINE.NET



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- Did you pre-register on or before Monday, **Sept. 24**, 2012?
  - If yes, please visit conf.swankhealth.com/dcoe to complete the online CE/CME evaluation and download your continuing education certificate.
- Did you pre-register between Tuesday, **Sept. 25**, 2012, and now?
  - If yes, your online CE/CME evaluation and continuing education certificate will not be available until Monday, **Oct. 1**, 2012.
- The Swank HealthCare website will be open through Tuesday **Oct. 9**, 2012.
  - If you did not pre-register, you will not be able to receive CE/CME credit for this event.

Save the Date

DCoE Monthly Webinar:

Understanding Psychopharmacology Polypharmacy in Service Members and Veterans

Oct. 25, 2012
1-2:30 p.m. (EDT)

OCTOBER						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

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