Richard McKeon

Advances in Psychotherapy –
Evidence-Based Practice

Suicidal Behavior

2nd edition

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Suicidal Behavior

About the Author

Richard T. McKeon, PhD, MPH, received his doctorate in clinical psychology from the University of Arizona, and a master of public health degree in Health Administration from Columbia University. He has spent most of his career working in community mental health, including 11 years as director of a psychiatric emergency service and 4 years as associate administrator/clinical director of a hospital-based community mental health center in Newton, New Jersey. He established the first evidence-based treatment program for chronically suicidal borderline patients in the state of New Jersey utilizing Marsha Linehan's Dialectical Behavior Therapy. In 2001, he was awarded an American Psychological Association Congressional Fellowship and worked for US Senator Paul Wellstone, covering health and mental health policy issues. He spent 5 years on the Board of the American Association of Suicidology as Clinical Division Director and has also served on the Board of the Division of Clinical Psychology of the American Psychological Association. He is currently Chief of the Suicide Prevention Branch for the Substance Abuse and Mental Health Services Administration in the US Department of Health and Human Services. In 2009, he was appointed by the Secretary of Defense to the Department of Defense Task Force on Suicide Prevention in the Military. He also serves as Co-Chair of the Federal Working Group on Suicide Prevention and participated in the development of the World Suicide Report for the World Health Organization

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Richard T. McKeon
Former Clinical Division Director, American Association of Suicidology

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Phone 978 255 3700; E-mail customerservice@hogrefe.com

EUROPE: Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950 0, Fax +49 551 99950 111; E-mail publishing@hogrefe.com

SALES & DISTRIBUTION

USA: Hogrefe Publishing, Customer Services Department,
30 Amberwood Parkway, Ashland, OH 44805
Phone 800 228 3749, Fax 419 281 6883; E-mail customerservice@hogrefe.com

UK: Hogrefe Publishing, c/o Marston Book Services Ltd., 160 Eastern Ave.,
Milton Park, Abingdon, OX14 4SB
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EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950 0, Fax +49 551 99950 111; E-mail publishing@hogrefe.com

OTHER OFFICES

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Disclaimer

All opinions expressed in this book are those of the author alone and do not represent the views of the Substance Abuse and Mental Health Services Administration.

Dedication

This book is dedicated to the memory of my sister Kathy, who taught me how important it is to fight for every hour of life.

Contents

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Description

Suicide is a tragic end to an individual's life, a devastating loss to families and friends, a diminishment of our communities, and a public health crisis around the world. For clinicians, losing a patient to suicide is probably our worst fear. In 2018, over 48,000 Americans died by suicide (CDC, 2021) and suicide rates have increased in 49 of the 50 states (Stone et al., 2018). Worldwide, it is estimated 800,000 people die by suicide each year, more than are lost to homicide or to war (WHO, 2019b), leading the World Health Organization to issue the first world suicide report, *Preventing Suicide: A Global Imperative* (WHO, 2014), urging nations around the globe to adopt national suicide prevention strategies and programs. In addition, self-inflicted injury is estimated to account for 1.4% of the total burden of disease worldwide (World Federation for Mental Health, 2006). Yet, despite the magnitude of these losses, or perhaps because of the depth of our distress and uncertainty when confronted with acts of deliberate self-destruction, we have tended as a society to look away and not grapple with the issue of suicidal behavior, despite the tragic toll it exacts.

Worldwide, about 800,000 people die by suicide each year, more than are lost to homicide or to war

Kay Redfield Jamison has eloquently stated that in dealing with suicide, "The gap between what we know and what we do is lethal" (Jamison, 1999). In the two decades since Dr. Jamison wrote these words, we have learned much more, yet the lethal gap continues. In *Night Falls Fast,* her first-person account of her struggles with intense suicidal urges, she emphasizes the powerful link between mental illness and suicide, and the disturbing reality that the majority of those who die by suicide have never received mental health treatment (Jamison, 1999). Despite the fact that we know how to treat successfully many of the conditions that are risk factors for suicide, such as depression, substance abuse, and bipolar illness, so many of those who die by suicide never receive such treatment for these disorders (Luoma et al., 2002). When they do receive treatment, often this treatment does not focus on their suicidality, despite clear evidence that such a focus reduces suicidal behavior.

"The gap between what we know and what we do is lethal" (Kay Redfield Jamison)

While the gap between what we know and what we do is undoubtedly lethal, there is still much more that we need to know. For, example, we do not have controlled trial research that confirms that inpatient treatment is effective in preventing suicide, let alone under what circumstances hospitalization might be effective. We lack this knowledge even though reliance on inpatient hospitalization is a cornerstone of how almost all mental health systems respond to suicidal individuals. The face of inpatient psychiatric care in the US has drastically changed overtime and in a Cochrane systematic review published in 2014 high income countries around the world the lengths of stay for people with serious mental illness were found to have been reduced drastically

Table 2
Differential Diagnosis of Suicide Attempt Versus Self-Harm

Self-Harm (with no suicidal intent) Similar terms: self-mutilation, deliberate self-harm, nonsuicidal self-injury		
	Similarities	**Differences**
Self-harm with no suicidal intent	Intentional act (may result in fatal or nonfatal injuries)	No intent to die (may be a variety of different intents, such as reduce pain, punish self)
Suicide attempt	Intentional act (may result in fatal or nonfatal injuries)	Intent to die

may deny it because of concern they will be hospitalized or because of shame or embarrassment. Others may claim suicidal intent when in reality there was none, feeling that otherwise what they have done may be minimized or invalidated by others. And this distinction presumes that a person was clear at the time of their self-destructive act regarding their intentions. It also presumes they were remembering it clearly, since such acts frequently take place during moments of intense emotional dysregulation (Linehan, 1993).

The following are examples of self-harm with no suicidal intent in Clinical Vignette 2 (nonsuicidal self-injury), a suicide attempt with clear suicidal intent, and a suicide-related behavior with undetermined intent.

Clinical Vignette 2
Role of Suicidal Intent

Self-Harm With No Suicidal Intent (Nonsuicidal Self-Injury)

A physical education teacher noticed during gym class that Julie was trying to conceal multiple cuts on her arms. When interviewed later by the school psychologist, she admitted to cutting herself repeatedly to "relieve my pain." She denied any thoughts about wanting to die or kill herself.

Suicide Attempt With Clear Suicidal Intent

Richard had a long history of depression and alcohol abuse. Following his third arrest for driving while intoxicated, which would trigger the loss of his driver's license, which in turn would force him to quit his job, he took an overdose of approximately 40 of his antidepressants and went to bed, fully expecting he would die in his sleep. In the middle of the night his wife found him stumbling around the bedroom delirious and called 911. When interviewed in the emergency department he reported being upset he was still alive.

Suicide-Related Behavior With Undetermined Intent

Harold was a 31-year-old Caucasian male. Since the onset of legal problems that had been pending over a period of many months, he had been experiencing recurrent suicidal ideation. Intensive outpatient therapy had averted a hospitalization, but he was still being monitored carefully for suicidal risk. While on vacation, he

2

Theories and Models of Suicidal Behavior

2.1 Neuropsychiatric Theories

In the United States over 90% of deaths by suicide are associated with diagnosable mental disorder

Neuropsychiatric theories of suicide emphasize the genetic and biomedical vulnerabilities associated with these tragic deaths. An important method for estimating the contribution of genetics to suicide are twin studies, which compare the concordance of death by suicide among identical twins who share the same genetic material, to fraternal twins who do not. In a review of twin studies of deaths by suicide, Roy and colleagues (1997) found that out of 129 identical twin pairs, there were 17 occasions when both twins died by suicide. In contrast, out of 270 nonidentical twin pairs, there were only two times when both twins died by suicide. This difference provides strong evidence for the important contribution of genetics to suicide.

Additional evidence comes from adoption studies in which the rate of suicide among biological relatives of adoptees was found to be higher than among the adopted families (Shulsinger et al., 1979). However, as Jamison (1999) points out, the concordance rate of 15%, while supporting a genetic contribution, also demonstrates that psychological and environmental factors have a clear role. In fact, the concordance rate for suicide is actually less than for severe mental illnesses such as manic depression and schizophrenia (Jamison, 1999).

The genetic contribution to suicide presumably acts by creating a biological vulnerability, which then interacts with environmental factors to intensify risk. A frequently replicated finding is the association between suicide risk and low levels of CSF 5-HIAAA, a metabolite of serotonin (Jamison, 1999). Persons with mood disorders who attempted suicide and who had low levels of this serotonin metabolite were more likely to die by suicide within a year than those with higher levels (Asberg, 1997). Postmortem studies have also found serotonin abnormalities in the prefrontal cortex of the brain (Stanley & Stanley, 1989), which could be associated with disinhibition or impulsivity. The potential role of the serotonin system in suicidal behavior is important for two other reasons: Early adverse events have been shown to impact the serotonergic system and with the widespread use of selective serotonin reuptake inhibitors (SSRIs), there was hope that these medications could reduce suicide (Institute of Medicine et al., 2002). While these medications are demonstrably effective as treatments for depression, their effectiveness in preventing suicide is still uncertain. In addition, there has been concern that prescribing SSRIs to youth could increase suicidal ideation or attempts for some (Friedman, 2014).

3

Risk Assessment and Treatment Planning

Treatment for individuals at risk for suicide must begin with a treatment plan based on a comprehensive suicide risk assessment. This presumes that suicidality was either the reason for treatment or was uncovered during the initial assessment. When suicidality emerges during the course of treatment (i.e., a person with no past history of suicidal behavior makes a suicide attempt or discloses suicidal ideation while in treatment), the treatment plan should be immediately modified to address the suicide risk. This does not mean that other issues previously being addressed in therapy need to be dropped, but neither should there be a return to treatment as usual.

Treatment planning for individuals at risk for suicide should always directly target the individual's suicide risk, and include attention to how suicide risk will be assessed, managed, and treated on an ongoing basis.

Treatment planning for people at risk for suicide should always directly target the individual's suicide risk

Berman and colleagues (2006) have emphasized that too often clinicians utilize the treatment they are comfortable with rather than directly addressing suicidal behavior.

Not directly addressing suicidal behavior in the treatment plan is often associated with the view that treating the underlying diagnostic conditions is synonymous with addressing suicidal risk. The clear link between mental illness and suicide has led mental health professionals to assume that by treating the underlying disorder (e.g., depression or substance abuse), suicide risk can be reduced and suicide prevented. However, there is little evidence this is the case (Linehan, 2008). The systematic exclusion of suicidal patients from both medication and psychotherapy trials mean that the efficacy for reducing suicide risk of many treatments for the diagnostic conditions associated with suicide are simply unknown. The implications of this lack of evidence is certainly not that such disorders should go untreated, nor that treating the underlying disorder should not be part of the treatment plan. There is compelling logic for using treatment to modify any risk factors whenever possible. For example, reducing substance abuse clearly is an important goal in the treatment of suicidal persons. The problem is assuming that treating the underlying disorder is sufficient to prevent suicide. It is not, and it is important for therapists to treat the suicidal behavior, thoughts, or desires directly. Treating suicidality directly is the common thread among the growing list of therapies that have now been shown to reduce suicidal behavior.

This direct attention on suicide risk must be reflected in the treatment plan as well. Not including suicide risk in the treatment plan makes the clinician seem oblivious to the possibility of suicide or suicide attempts. For patients with a past history of suicidal thoughts or behavior, the possibility must be anticipated.

Not including suicide risk in the treatment plan makes the clinician seem oblivious to the possibility of suicide or a suicide attempt

Clinical Pearl:
Treatment Planning With Suicidal Persons

- Identify the pain driving the suicidal thoughts or behavior
- Assess risk and protective factors
- Estimate risk level from risk and protective factor information
- Distinguish between acute and chronic risk levels
- Resolve contradictory risk factors
- Determine whether risk and protective factors can be modified
- Target interventions to lower risk factors or increase protective factors

Every comprehensive clinical assessment needs to answer several key questions. These include determining the current level of suicide risk (including whether an acute emergency exists that requires emergency intervention) and obtaining information about risk and protective factors that may need to be addressed in long- term treatment planning. This must be accomplished while maintaining a flexible and collaborative relationship with the patient that allows them to tell their story and explain the pain that is leading them to consider ending their life.

3.1 Assessing Suicide Risk and Protective Factors

The treatment plan should identify both risk and protective factors, estimate risk based on these factors (including how risk may be expected to change over time), determine whether risk and protective factors can be modified, and explain how the treatment plan will attempt to reduce this risk level.

Assessing suicide risk factors should include, but not be limited to, examining the roles of depression and substance abuse. As Joiner suggests, those who die by suicide will be those who have the desire to, and who have also acquired the capacity to do so. Suicidal ideation is very prevalent among those with major depressive episodes with almost 30% of them having seriously considered suicide, indicating an intense desire to die (Piscopo et al., 2016). Those who abuse substances may be more likely to experience the kind of provocative experiences that will increase the capacity to inflict lethal self-harm.

But in addition to depression and substance abuse, other risk factors must be assessed as well (see Box 5).

Social withdrawal, social isolation, and the experience of oneself as a burden to loved ones must be explored. The patient's sense of belonging and the existence of meaningful social connections should be actively assessed and addressed in the treatment plan. Social withdrawal is common in depression, and substance abuse can cause alienating conflict. It is noteworthy that the research of Murphy and colleagues (1979) on suicide in alcoholics identified interpersonal conflict as a major precipitant. However, neither depression nor substance abuse needs to be present for these risk factors to contribute to increased risk.

Additional risk factors to be assessed include the presence of past suicidal behavior, access to potentially lethal means, including firearms, as well as hopelessness and impulsivity.

4

Treatment

While there is substantial evidence that pharmacological treatment of disorders that are risk factors for suicide (such as depression) can be effective, pharmacological studies that have targeted suicide directly have had much more equivocal results. In part, this is because clinical trials of medication have historically excluded those at risk for suicide (as have psychotherapy studies). Evidence for the effectiveness of lithium in preventing suicide is probably stronger than for any other medication (Cipriani et al., 2005). Meltzer (1999) has examined clozapine vs. olanzapine for patients with schizophrenia or schizoaffective disorder who were at high risk for suicide and found that those receiving clozapine were less likely to attempt suicide or be hospitalized for suicide risk. More recently, two national register-based cohort studies of patients diagnosed with schizophrenia in Sweden and Finland found that clozapine was the only antipsychotic consistently associated with decreased risk of suicidal outcomes. The risk for attempted or completed suicide was 36% lower in the Finnish cohort and 34% lower in the Swedish cohort (Taipale et al., 2020).

An area of significant controversy has been the relationship between the use of selective serotonin reuptake inhibitors (SSRIs) and suicide risk. While initially the major debate within the field has focused on whether the significantly increased rates of prescription of SSRIs was responsible for a decrease in national suicide rates in various countries around the world (Safer & Zito, 2007), fears about the potential role of SSRIs in causing suicide later erupted in England and the United States. This concern about suicidality as a possible side effect from the use of SSRIs led the US Food and Drug Administration to issue a black box warning. The focus of concern was initially on youths because the evidence of efficacy for treatment of depression using SSRIs among this group was much more equivocal than the evidence among adults, making the risk–benefit ratio more problematic among youths than adults. Following this warning, prescriptions of SSRIs fell significantly. When the youth suicide rate increased in 2004, after almost a decade of decline, some argued that the decrease in use of SSRIs was to blame. While there may be a subgroup of those who take SSRIs who experience an increase in suicidality (Maris, 2007), this does not mean that they are not safe for most patients, particularly those with serious depression. Gibbons and colleagues (2007b) report that among male veterans treated with SSRIs, suicide attempts decreased. However, their effectiveness in preventing death by suicide is still uncertain.

More recently, significant attention has been given to the potential of ketamine because of early studies showing a rapid antidepressant effect including rapid remission of suicidal ideation. In a randomized trial comparing intrave-

nous infusion of ketamine to midazolam 55% showed clinically significant remission of suicidal ideation compared to 30% (Gruenbaum et al., 2018). In 2018, the US Food and Drug Administration approved the use of an esketamine nasal spray for treatment resistant depression when used along with an oral antidepressant (US Food and Drug Administration, 2018).

A review of the literature by Rudd and colleagues (2001), which focused only on nonpharmacologic interventions, revealed only 25 randomized or controlled studies that targeted suicidality. These authors divided their review into intervention studies and treatment studies. Intervention studies were those that did not provide any kind of psychotherapy or medication treatment. These studies made changes in either procedures associated with treatment (letters, phone calls) or facilitated access to mental health services and assessed any subsequent reductions in suicide attempts. Of particular note was a study by Motto (1976) that found a reduction in death by suicide over a 2-year period of patients who refused treatment, who received nondemanding letters compared to those who did not receive such letters. However, the impact was not maintained over the full 5 years of the study.

The review by Rudd and colleagues (2001) of the intervention studies yielded the following conclusions: Intensive follow-up, case management, telephone contacts, letters or home visits may improve treatment compliance over the short-term for lower risk cases. Improved ease of access (i.e., a clearly stated crisis plan) to emergency services can potentially reduce subsequent attempts and service demand by first-time suicide attempters. Their conclusions are summarized in Box 7.

Dialectal behavior therapy (DBT) is the best validated approach for reducing suicidal behavior

In review studies published following the 2001 summary by Rudd and colleagues, the best validated approach for reducing suicidal behavior remains dialectical behavior therapy (DBT; Linehan, 1993), which has been shown in randomized control studies to reduce suicidal behavior, as well as reduce time spent in the hospital for patients with histories of chronic suicidal behavior.

Box 7
Summary of the Review by Rudd, Joiner, and Rajab (2001)

Implications for clinical practice from the treatment studies were:

- Intensive, longer term treatment following a suicide attempt is most appropriate and effective for those identified at high risk as indicated by multiple attempts, psychiatric history, and diagnostic comorbidity.
- Short-term CBT, integrating problem-solving training as a core intervention, is effective at reducing suicidal ideation, depression, and hopelessness over periods of up to 1 year. Such brief approaches do not appear effective at reducing attempts over longer time frames.
- Reducing suicide attempts requires longer term treatment modalities targeting specific skill deficits such as emotional regulation, poor distress tolerance (e.g., impulsivity), anger management, and interpersonal assertiveness, as well as other enduring problems such as interpersonal relationships and self-image disturbance (e.g., personality disturbance).
- High-risk suicidal patients can be safely and effectively treated on an outpatient basis if acute hospitalization is also available and accessible.

sis intervention and management of acute risk and then at treatment to reduce long-term risk.

4.2 Crisis Intervention and the Management of Acute Risk

For the clinician working with patients at risk for suicide, the potential need to manage an acute crisis must be anticipated, and it is essential that the clinician obtain information about both the capabilities and the limitations of the psychiatric emergency system in the communities in which the clinician practices. This should include a clear understanding of what the clinician can provide, as well as the role and limitations of EDs, crisis lines, the police, ambulance and emergency medical technicians, and psychiatric emergency services. The availability of rapid, around the clock crisis services has been shown to be associated with decreases in suicide (While et al., 2012).

The availability of rapid, around the clock crisis services is associated with decreases in suicide

Clinical Pearl:
Checklist for Being Prepared for Psychiatric Emergencies

- Determine your phone availability and emergency appointment capacity
- Understand your local psychiatric emergency response system
- Know your ED characteristics (i.e., Is there mental health capacity within the emergency room? Will they consult with you prior to disposition?)
- Determine your community's mobile outreach capacity and how to access a mobile crisis team
- Know the role, capacities, and limitations of involving the police. Are they trained in CIT (crisis intervention training) or have a similar training? Weigh the risks and advantages of involving the police
- Understand the capacities of local suicide prevention hotlines and crisis centers
- Know how to arrange for a patient at acute and high risk to be voluntarily hospitalized
- Understand involuntary commitment laws including the procedures in your jurisdiction to initiate involuntary hospitalization
- Understand your own personal limits

4.2.1 Assuring Telephone Accessibility After Hours

Treating suicidal patients requires availability outside of the psychotherapy session. A patient may experience a suicidal crisis or an intensification of suicidal thoughts or intent at any time, and the clinician must anticipate this possibility. This need for greater availability is one reason many clinicians may be reluctant to take on suicidal patients. Linehan (1993), working with chronically suicidal borderline patients, has made an important contribution by emphasizing the clinician's need to be able to provide telephone consultation outside of normally scheduled psychotherapy sessions but within the context of personal limits. No clinician can tolerate being on-call 24 hours a day, 7 days a week, on an ongoing basis. Further, different clinicians will establish different limits. But a clinician must provide suicidal patients with some

Clinicians working with suicidal patients need to provide telephone availability outside of scheduled sessions

6

Case Example

Intake Evaluation and Treatment Plan

Identifying Data:
Dana is a 17-year-old, Caucasian female who was referred by her mother who accompanied her to the intake evaluation. This is her first application for outpatient treatment.

Chief Complaint:
Her boyfriend's suicide.

History of Present Problem:
Two weeks ago, the patient's boyfriend died by suicide. She had been unaware of any prior suicidal thinking on his part. At the time that he killed himself, she had just been on the telephone with him.

They had had a disagreement earlier, but had just resolved it. She had asked to speak to a mutual friend who was at the boyfriend's house at the time. While the patient and the friend were on the telephone, there was a noise and the friend told the patient that the boyfriend had shot himself, and told her to get help. She did not believe him at first. When the friend put the phone next to her boyfriend, she heard a low moaning sound. She then hung up in a panic and called the police who went to the house. She did not hear anything for a few hours and then was informed that her boyfriend was dead. The patient has internalized blame for this tragedy and feels that he killed himself because of her. This is because she had been told by the friend that her boyfriend had made a statement shortly before the phone call, referring to her and saying "I love her too much. I can't take it." She also felt guilty that she did not believe that he had shot himself, and did not immediately call for help.

However, she remains extremely confused as she is unable to recall anything from the telephone conversation itself that would seem to even hint at suicide. For this reason, she wonders whether it could have been an accident, or even whether the friend may have shot him. (There are apparently rumors to this effect circulating at the local high school.)

In the days following the death, Dana was mostly at home alone with her sister. Her parents were at a retreat. They were in telephone contact with Dana and asked her if she needed them to come home but she told them no. However, she later acknowledged to them, and to this clinician, that she was having suicidal ideation. Dana felt that her boyfriend wanted her to join him.

She had thought about carbon monoxide poisoning and about cutting her wrists, and finally developed a plan where she would take an overdose of Prozac, which had been prescribed for her by her family physician to help her through the bereavement. The day she picked for the suicide attempt was 1 week prior to this appointment and one day before her parents returned from their retreat. She states that she had the bottle of pills in front of her and wrote a suicide note. But then she began to think about what her parents would go through if she killed herself. She also thought that at least now she had memories of her boyfriend and if she killed herself, she didn't know whether she would still have those memories. Finally, she was also afraid that if she took the overdose she might end up as a vegetable. She ultimately aborted the attempt by deciding that if her boyfriend really wanted her to join him, then he would find a way to tell her. She didn't really feel that he would be likely to somehow materialize and so in an important sense this was a way of deciding not to die by suicide. However, she does experience him as being close by and she talks to him frequently. After her parents arrived home, she told them that she had thought of suicide, and they made arrangements for this appointment. Since that time, she has continued to have suicidal thoughts, though she reports these thoughts are weaker and less frequent than previously and are easier to distract herself from. She reports that she has not had any thoughts about suicide today. When asked if talking about her boyfriend's death in the therapy session made her think about suicide, she said no.

Past Psychiatric History:
Dana has no past episodes of psychiatric illness. There also does not appear to be any past history of drug or alcohol abuse. There is no family history of depression or suicide, although there was an uncle who had some kind of emotional disturbance, the nature of which is unknown at present.

Mental Status:
Dana was oriented to person, place, and time. She exhibited no unusual motor behaviors. Her long- and short- term memory seemed intact. Intelligence was judged to be at least average. Judgment and insight seemed good. Mood appeared to be depressed as would be expected in someone recently bereaved. She admitted to occasional suicidal ideation, but no homicidal ideation. Thought processes were logical and coherent. There was no evidence of any thought disorder or delusional thinking. She denied auditory or visual hallucinations.

Assessment:
F43.21 Adjustment Disorder with depressed mood: complicated grieving
Dana presents with depressed mood and suicidal ideation which clearly had its onset at the time of her boyfriend's suicide. What would probably best capture the essence of Dana's clinical condition at this time is to consider this a bereavement that is complicated because of the presence of suicidal ideation. The death of a loved one through suicide often results in a complicated bereavement with a wide range of intense emotional responses and in this instance her reaction is intensified by the fact that she had been on the telephone with him at the time he died by suicide.