

Psychologists can use advances in assessments and new technology to prevent a suicidal patient from acting on suicidal ideations.



CE

CONTINUING EDUCATION HOW TO ASSESS AND INTERVENE WITH PATIENTS AT RISK OF SUICIDE

BY REBECCA A. CLAY

After rising steadily for 15 years, the suicide rate in the United States dipped in 2019 and again in 2020. Provisional data released by the U.S. Centers for Disease Control and Prevention show a 5% decrease from the 2018 peak in suicides (Curtin, S. C., et al., *Vital Statistics Rapid Release*, No. 16, 2021).

CE credits: 1

Learning Objectives: After reading this article, CE candidates will be able to:

1. Discuss new approaches to screening for suicidality.
2. Describe evidence-based interventions for suicidal children, adolescents, and adults.
3. Explain the importance of collaboration with suicidal patients.

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That said, suicidal ideation is up, with about twice as many adults in 2020 reporting that they had seriously considered suicide in the previous month than in 2018 (Czeisler, M. É., et al., *Morbidity and Mortality Weekly Report*, Vol. 69, No. 32, 2020). “Suicide deaths and attempts are the tip of the iceberg,” said psychology professor David A. Jobes, PhD, ABPP, who directs the Suicide Prevention Lab at The Catholic University of America in Washington, D.C. “Suicide ideation is the bigger challenge lurking under the water.”

And what is frustrating, he said, is that practicing psychologists too often are failing to take advantage of recent advances in clinical research on what works best when it comes to detecting suicide risk and treating patients with proven suicide-focused care.

“Psychologists don’t know how much evidence we’ve produced and that clinical practice is lagging behind what works,” said Jobes. “It’s exasperating to know that there is rigorous clinical trial research providing effective suicide-focused interventions . . . , yet most practicing psychologists don’t know about them.”

Part of the problem is that seeing patients who are suicidal can be both challenging and disconcerting, acknowledged Samuel Knapp, EdD, ABPP, author of *Suicide Prevention: An Ethically and Scientifically Informed Approach* (APA, 2020). All too often, Knapp said,

psychologists feel the best way to respond to a patient who is suicidal is to send them to the emergency room and get them on antidepressants as soon as possible. But that is usually not the best approach, he said.

The field has come a long way since assessment consisted only of asking people if they were depressed and thinking of harming themselves and going no further, said Knapp. And treatment has progressed far beyond what was once the standard of care but has now been proven ineffective—asking people to sign a contract promising not to harm themselves. Today, said Knapp, there are three treatments that are well supported by outcome research—brief cognitive behavioral therapy (BCBT), dialectical behavior therapy (DBT), and Collaborative Assessment and Management of Suicidality (CAMS)—as well as other promising but less replicated strategies. Psychologists are also harnessing technology to help patients who are suicidal and shifting from top-down approaches to more collaborative ones.

ASSESSING SUICIDE RISK

Psychologists often use one of two screening instruments to assess suicidality: the Ask Suicide-Screening Questions tool or the Columbia-Suicide Severity Rating Scale. But these and other traditional assessments ask the wrong questions, said Craig Bryan, PsyD, ABPP, who directs the Suicide Prevention

Program at The Ohio State University College of Medicine.

“The traditional approach is to think about suicidal ideation as the gateway to suicidal behaviors,” said Bryan, author of *Rethinking Suicide: Why Prevention Fails, and How We Can Do Better* (Oxford University Press, 2021). “But there’s increasing recognition that there are different trajectories toward suicide.” Some people may progress through the sequence in a matter of hours; others may not follow the sequence at all.

A scale Bryan and colleagues developed called the Suicide Cognitions Scale asks questions that get at emotions that can render people vulnerable, such as feeling that people would be better off without you or that no one can help you solve your problems. Administering that scale alongside the Patient Health Questionnaire-9 depression screener improved the identification of patients most likely to progress to suicidal behavior in the next month, Bryan and colleagues found (*Annals of Family Medicine*, Vol. 19, No. 6, 2021).

Plus, suicidality can look different in different populations. Take Black adolescents, whose rate of suicide has escalated in recent years. Instead of harming themselves outright, they may put themselves in harm’s way because they are willing to die, said W. LaVone Robinson, PhD, a psychology professor at DePaul University in Chicago (Robinson, W. L., et al., *Journal of Community Psychology*, Vol. 49, No. 5, 2021). “They may engage in more aggressive kinds of behaviors that draw harm or fire,” said

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Robinson. Engaging in criminal or violent acts, for example, could result in someone else shooting an adolescent.

In addition to asking about risky behaviors, she said, psychologists should also identify sources of resilience within the Black community. “Racial socialization” efforts by families, schools, community, and the media can help adolescents develop a strong sense of racial and ethnic identity, which can help mitigate stressors like racism and discrimination and thereby lessen hopelessness and suicidality (Robinson, W. L., et al., *Annual Review of Clinical Psychology*, Vol. 18, 2022).

Adolescents may also be reluctant to disclose suicidal feelings for fear that health care providers will share that information with their parents. If psychologists feel that parents need to be informed of risks, they should actively collaborate with young people to develop a plan for disclosing that information to parents, said Taylor Burke, PhD, a clinical psychologist and associate director of suicide research within the Division of Child and Adolescent Psychiatry at Massachusetts General Hospital/Harvard Medical School. Providers should explain the rationale for breaching confidentiality and attempt to obtain permission to do so, said Burke. They should also offer teens options for how this can be done in a way that would make them feel most comfortable, whether that means having the provider tell parents or helping teens tell their parents directly.

“Unfortunately, our research indicates that almost half of

treatment-seeking youth report a history of non-collaborative breaches of confidentiality, such as telling a teen’s parent without permission or forcing a teen to tell their parent,” said Burke (Fox, K. R., et al., *Research on Child and Adolescent Psychopathology*, online first publication, 2021). “These experiences were associated with negative outcomes, including poorer mental health outcomes, lowered trust in therapy, and lower likelihood of honest disclosures in the future.”

The way clinicians ask patients about suicidality can also make a difference. Researchers have found that asking about suicidality in a way that suggests that no is the right response—questions like, “You’re not thinking of harming yourself, are you?”—can cause patients to hide their true thoughts (Ford, J., et al., *Patient Education and Counseling*, Vol. 104, No. 4, 2021).

INTERVENING WITH PATIENTS AT RISK

In the intervention realm, researchers have found that another big shift is needed—the dismantling of the common idea that suicide is caused by mental illness. “We don’t conceptualize suicide as a symptom of mental illness—diagnosing depression and treating depression,” said Bryan. “We target suicide directly.”

One way to do that is through BCBT focused on two key vulnerabilities: emotional dysregulation and cognitive rigidity. In a randomized controlled trial of soldiers with suicidal ideation or recent suicide attempts, Bryan and colleagues found that those who received BCBT were 60%

less likely to report a suicide attempt during the follow-up (Rudd, M. D., et al., *The American Journal of Psychiatry*, Vol. 172, No. 5, 2015).

CAMS is another intervention based on the idea of targeting suicide rather than depression or other mental illness. “The idea of relegating suicidal ideation and behaviors to a symptom of depression isn’t supported by the evidence,” said Jobes. “The evidence shows that when we target and treat suicidal ideation and behaviors with different psychological treatment, we can significantly reduce suicidal risk.”

CAMS also represents a shift from an adversarial model in which the doctor knows best and must control the patient to a deeply collaborative approach in which the patient becomes a “coauthor” of their own treatment plan. The interactive process over six to eight sessions addresses the “drivers”—the problems that patients say make them suicidal, such as losing a job or intense self-hatred. “This approach is compelling to patients,” said Jobes. And it works. A recent meta-analysis of nine CAMS trials found that when compared with other commonly used interventions, CAMS significantly reduces suicidal ideation, overall distress, and hopelessness (Swift, J. K., et al., *Suicide and Life-Threatening Behavior*, Vol. 51, No. 5, 2021).

When it comes to children and adolescents, there is still a paucity of evidence-based interventions despite the fact that suicide rates among youth ages 12 to 17 doubled between 2003 and 2018, said Joan Rosenbaum Asarnow, PhD, a professor of psychiatry

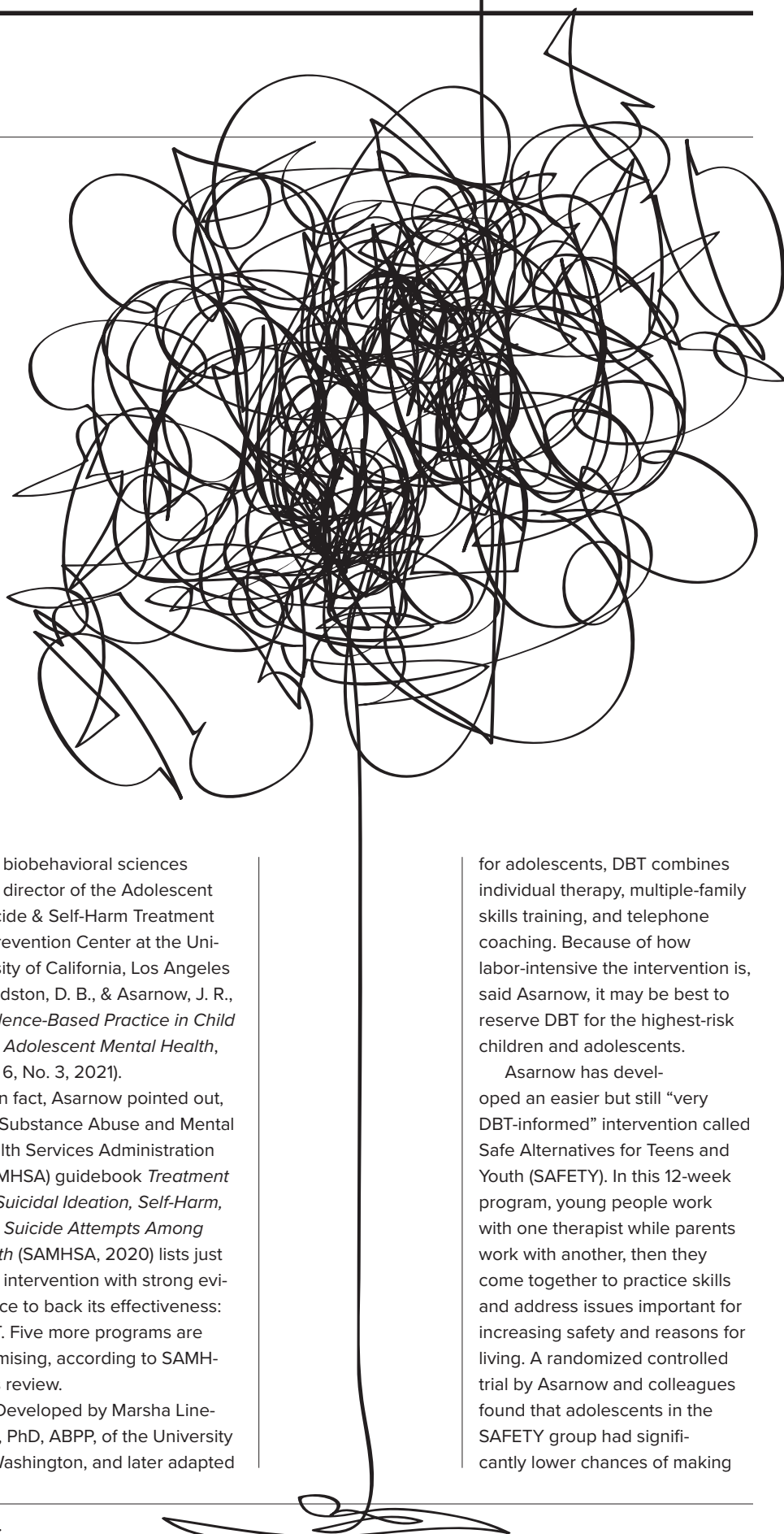
and biobehavioral sciences and director of the Adolescent Suicide & Self-Harm Treatment & Prevention Center at the University of California, Los Angeles (Goldston, D. B., & Asarnow, J. R., *Evidence-Based Practice in Child and Adolescent Mental Health*, Vol. 6, No. 3, 2021).

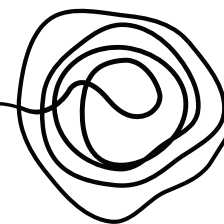
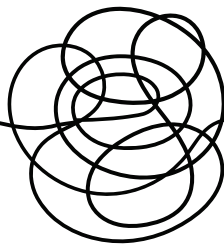
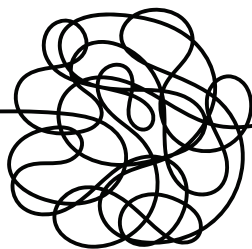
In fact, Asarnow pointed out, the Substance Abuse and Mental Health Services Administration (SAMHSA) guidebook *Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth* (SAMHSA, 2020) lists just one intervention with strong evidence to back its effectiveness: DBT. Five more programs are promising, according to SAMHSA’s review.

Developed by Marsha Linehan, PhD, ABPP, of the University of Washington, and later adapted

for adolescents, DBT combines individual therapy, multiple-family skills training, and telephone coaching. Because of how labor-intensive the intervention is, said Asarnow, it may be best to reserve DBT for the highest-risk children and adolescents.

Asarnow has developed an easier but still “very DBT-informed” intervention called Safe Alternatives for Teens and Youth (SAFETY). In this 12-week program, young people work with one therapist while parents work with another, then they come together to practice skills and address issues important for increasing safety and reasons for living. A randomized controlled trial by Asarnow and colleagues found that adolescents in the SAFETY group had significantly lower chances of making





suicide attempts than those in a treatment-as-usual group (Asarnow, J. R., et al., *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 56, No. 6, 2017).

Suicide attempt survivors themselves are also offering ideas for improving treatment, said Melanie Hom, PhD, who along with colleagues asked survivors for their recommendations (Hom, M. A., et al., *Psychological Services*, Vol. 18, No.3, 2021).

Many of those recommendations represent a return to psychotherapy basics: Be empathetic. Use active listening. Collaborate with patients. “These are things psychologists are well trained to do, but they can go out the window when clinicians are focused on risk and safety concerns,” said Hom, a clinical assistant professor of psychiatry and behavioral sciences at Stanford University School of Medicine.

Psychologists should also avoid stigmatizing patients who are suicidal. It may be harmful, for example, to tell patients that they have so much to live for or that it is selfish to consider suicide because they have children. “The provider might think that that will bolster someone’s reasons for living, but it unintentionally can make someone feel ashamed about their suicidal thoughts or

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past behavior,” Hom said, noting that such comments can also shut down honest discussion and make people less likely to seek help in the future. Instead, she said, be curious and ask what led the person to attempt suicide.

USING TECHNOLOGY

Other psychologists are working on technological approaches to expanding access to suicidality assessments and interventions beyond the clinician’s office.

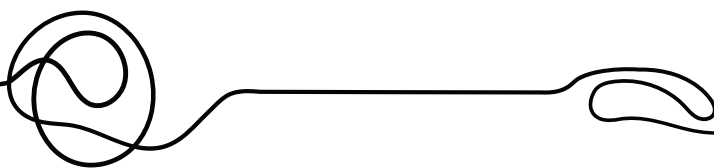
In one recent randomized controlled trial, researchers tested brief videos designed to teach DBT skills to college students, for whom suicide is the second most common cause of death (Rizvi, S. L., et al., *Behaviour Research and Therapy*, Vol. 149, 2022). Participants also underwent ecological momentary assessment—via smartphone surveys—to assess their moods as they fluctuated over the course of a day. The intervention seemed to help prevent a worsening of symptoms as time progressed. And those who watched the videos more than once saw decreases in negative mood and increases in positive mood.

Tech approaches like this may be especially appealing to young people, said senior author Evan Kleiman, PhD, an assistant professor of psychology at Rutgers University. “Kids are comfortable

using their phones,” he said. “We have to meet them where they’re at.” Kleiman predicts that technological tools that are designed to assess people’s suicidality, supplement therapy, serve as a bridge for those on waiting lists, and help those not yet ready for therapy will become widely available to psychologists in the next 2 to 3 years.

Emergency departments are already using technology in new ways. Patients who are suicidal often end up in the emergency department expecting to receive care, but what typically happens is long wait times while staff members search for an inpatient facility opening, said psychologist Linda Dimeff, PhD, chief scientific officer at Jaspr Health, a company that develops technology to help health care systems help people in suicidal crises.

“If a patient comes in on Friday, they may not leave until Monday or Tuesday when an inpatient facility is identified and they have arranged transport,” she said. “What does a patient do during that time? They get more depressed, ruminating about what’s not right.” To better fill that waiting time, Jaspr created a tablet-based digital platform that gives patients access to evidence-based strategies they can start working on even as they



wait for in-person help.

Survivors of suicide attempts helped design the program alongside Jaspr psychologists, other experts in suicide science, and representatives from health care systems. The survivors also tell their stories via videos on the platform, sharing the strategies that helped them, but also offering hope. “Suddenly, you’re not only getting suicide care but you’re also having people who really understand where you’re at helping you feel not so alone,” said Dimeff.

While ecological momentary assessment and smartphone apps are attracting a lot of attention, clinicians should remember that telepsychology is also effective, even for high-risk patients. “For folks without as much experience with high-risk individuals, there’s definitely still a lot of anxiety about using telepsychology,” said Candice Johnson, PsyD, a staff psychologist for the National Suicide Prevention Telehealth Program at the VA Maryland Health Care System. For one, technological disruptions could be especially devastating for someone in crisis, said Johnson. And when a high-risk patient is not in your office, the psychologist must have a detailed plan for rallying help remotely if the patient needs it.

To assuage those fears,

psychologists should review APA’s *Guidelines for the Practice of Telepsychology*, Johnson recommended (Johnson, C. C., & Aldea, M. A., *Ethics & Behavior*, online first publication, 2021). Safety protocols are especially important when working with patients who are suicidal. Know where your patient is, look up the closest emergency services ahead of time, and get the patient’s permission to contact others in their household in emergencies. Also make sure you are proficient enough that you can troubleshoot any tech problems patients face, Johnson added, and have contingency plans so you can reconnect in case you are cut off.

FOLLOWING UP

Other interventions focus on crises. Safety planning—written steps to follow in moments of intense distress—has been demonstrated to reduce suicidal ideation, attempts, and suicides, said Megan L. Rogers, PhD, a postdoctoral research fellow at Mount Sinai Beth Israel (Rogers, M. L., et al., *Professional Psychology: Research and Practice*, Vol. 53, No. 1, 2022). Many suicidal individuals are not in treatment, and even those who are do not see clinicians very often. “Sometimes it is only a 50-minute-a-week session,” said Rogers. “What tools do they

KEY POINTS

1. **Researchers recommend supplementing traditional screening tools that focus on depression or suicidality with questions about the circumstances that render patients vulnerable.**
2. **Clinicians should target suicide directly, using evidence-based interventions.**
3. **A collaborative approach that makes patients “coauthors” of their treatment is key.**
4. **Technology is taking suicide assessment and intervention beyond the clinician’s office.**

have for the other 167 hours of the week?”

There are two evidence-based safety-planning interventions, said Rogers: the Crisis Response Plan (Rudd, M. D., et al, *Treating Suicidal Behavior*, Guilford Press, 2004) and the Safety Planning Intervention (Stanley, B., & Brown, G. K., *Cognitive and Behavioral Practice*, Vol. 19, No. 2, 2012). Emphasizing collaboration, both interventions consist of recognizing warning signs; listing self-management strategies, like ways to distract oneself; and identifying possible sources of external help, including family and friends, health care providers, and crisis services. The Safety Planning Intervention also calls for removing guns and other items that could be used for suicide. (See www.suicidesafetyplan.com for a step-by-step guide and the April/May *Monitor* CE Corner on talking with patients about firearm safety.)

For Jobes, all these developments point to the crucial role that psychologists can play in suicide prevention. “Psychologists should be proud that we have developed suicide-focused interventions that are proven to be effective for reducing suicidal thoughts and behaviors,” he said. “This reality is not sufficiently recognized by psychologists, let alone the larger mental health field, the news media, or the general public.” ■