



Psychosocial Risk Factor Survey

Policy and
Procedures

Psychosocial Risk Factor Survey

POLICY

Psychosocial risk factors bear a significant effect on cardiac disease comparable to more publicized factors such as serum cholesterol, hypertension, cigarette smoking, and diabetes. In particular, depression, anxiety, anger/hostility, and social isolation each affect the incidence, progression and mortality rates of coronary artery disease (CAD).

As well, these psychosocial factors influence complications in pulmonary disease.

The American Heart Association/American Association of Cardiovascular and Pulmonary Rehabilitation Core Components of Cardiac Rehabilitation Programs recommends that programs “identify psychological distress as indicated by clinically significant levels of depression, anxiety, anger or hostility, social isolation, marital/family distress, sexual dysfunction/adjustment, and substance abuse (alcohol or other psychotropic agents), using interview and/or standardized measurement tools”.

Toward this end, the Cardiopulmonary Rehabilitation Program of Memorial Hospital of Union County will administer the Psychosocial Risk Factor Survey, which will address the primary psychosocial risk factors of depression, anxiety, anger/hostility, and social isolation, to all patients upon entry and exit of their rehab programming.

PROCEDURE

Staff response to PRFS results:

First, determine if the patient marked a 3 or 4 on item 12 that would suggest suicidal ideation. If the patient did mark a 3 or 4, this can suggest a range of suicidal thinking from generalized "wondering what it would be like" to harm oneself to more specific thinking that could pose an immediate risk to the person's life. If the patient indicates this concern, please refer to [steps noted on page 5](#) following the interpretation of the individual scales.

Following are percentile classifications for the PRFS scales:

Mild Range: 65th to 83rd percentiles

Moderate Range: 84th to 94th percentiles

Severe Range: 95th percentile and above

Elevations on Depression scale:

Mild Range

- Share symptoms of Depression that this scale measures using [video demonstration](#) for guidance.
- Share handout *Depression and our Health*.
- Ensure the patient is aware that Depression is an important psychosocial risk factor that influences our health.

Moderate and Severe Ranges

- Share symptoms of Depression that this scale measures using [video demonstration](#) for guidance.
- Share handout *Depression and our Health*.
- Ensure that the patient is aware that Depression is an important psychosocial risk factor that influences our health and that it is necessary to refer the patient back to his or her PCP or a mental health specialist to explore options for treating this risk factor. As well, offer referral information for mental health providers encouraging the patient to follow up to address this risk factor.

Elevations on Anxiety scale:

Mild Range

- Share symptoms of Anxiety that this scale measures using [video demonstration](#) for guidance.
- Share handout *Anxiety and our Health*.
- Ensure patient is aware that Anxiety is an important psychosocial risk factor that influences our health.

Moderate and Severe Ranges

- Share symptoms of Anxiety that this scale measures using [video demonstration](#) for guidance.
- Share handout *Anxiety and our Health*.
- Ensure that the patient is aware that Anxiety is an important psychosocial risk factor that influences our health and that it is necessary to refer the patient back to his or her PCP or specialist to explore options for treating this risk factor. As well, offer referral information for mental health providers encouraging the patient to follow up to address this risk factor.

Elevations on Anger/Hostility scale:

Mild Range

- Share symptoms of Anger and Hostility that this scale measures using [video demonstration](#) for guidance.

- Share handout *Hostility and our Health*
- Ensure the patient is aware that Anger and Hostility is an important psychosocial risk factor that influences our health

Moderate and Severe Ranges

- Share symptoms of Anger and Hostility that this scale measures using [video demonstration](#) for guidance.
- Share handout *Hostility and our Health*.
- Ensure that the patient is aware that Anger and Hostility are important psychosocial risk factors that influence our health and that it is necessary to refer the patient back to his or her PCP or to a specialist to explore options for treating this risk factor. As well, offer referral information for mental health providers encouraging the patient to follow up to address this risk factor.

Elevations on Social Isolation scale:

Mild Range

- Share symptoms of Social Isolation that this scale measures using [video demonstration](#) for guidance.
- Share handout *Relationships and our Health*.
- Ensure the patient is aware that Social Isolation is an important psychosocial risk factor that influences our health.

Moderate and Severe Ranges

- Share symptoms of Social Isolation that this scale measures using [video demonstration](#) for guidance.
- Share handout *Relationships and our Health*.
- Ensure that the patient is aware that Social Isolation is an important psychosocial risk factor that influences our health and that it is necessary to refer the patient back to his or her PCP or to a specialist to explore options for treating this risk factor. As well, offer referral information for mental health providers encouraging the patient to follow up to address this risk factor.

Elevations on Emotional Guardedness scale:

Mild Range

- Share symptoms of Emotional Guardedness that this scale measures using [video demonstration](#) for guidance.
- Share handout *Emotional Guardedness and our Health*
- Ensure the patient is aware that Emotional Guardedness is a psychosocial risk factor that influences our health

Moderate and Severe Ranges

- Share symptoms of Emotional Guardedness that this scale measures using [video demonstration](#) for guidance.
- Share handout *Emotional Guardedness and our Health*
- Ensure that the patient is aware that Emotional Guardedness is an important psychosocial risk factor that influences our health. As well, offer referral information for mental health providers encouraging the patient to follow up to address this risk factor.

Suicidal Ideation:

If the patient responds to item #12 by indicating a 3 or 4, follow these steps:

- See [Suicide Risk Assessment Pocket Card](#) Developed by the US Department of Veterans Affairs and see attached document immediately below, developed by the VA, for further descriptive information related to this pocket card.
- Staff should be trained to perform an initial assessment of suicidal risk to ensure the patient is not an imminent risk of harming himself or herself.
- If the patient is determined to be at imminent risk, then, with sensitivity and compassion, immediate transfer to an emergency department should be arranged to ensure the patient's safety.
- If the patient is not determined to be an imminent risk of self-harm, then a referral for specialized treatment should be facilitated. This includes:
 - At a minimum, a call to the patient's primary care physician for consultation with the provider in arranging the earliest possible appointment befitting the patients level of distress.
 - Similarly, arranging for the patient's follow up with a mental health specialist for therapeutic assistance in managing his or her distress.
 - If the rehab program already has a working relationship with a mental health specialist, consultation with this specialist during the management of the patient's crisis is advisable.
 - A "safety net" level of assistance can be accessed via calling the National Suicide Prevention Hotline at 800-273-8255.

SUICIDE RISK ASSESSMENT GUIDE

US Department of Veterans Affairs

www.mentalhealth.va.gov/docs/Suicide_Risk_Assessment_Guide.doc

REFERENCE MANUAL

INTRODUCTION

The Suicide Risk Assessment Pocket Card was developed to assist clinicians in all areas but especially in primary care and the emergency room/triage area to make an assessment and care decisions regarding patients who present with suicidal ideation or provide reason to believe that there is cause for concern. This reference guide provides more specific information and the rationale for the sections on the pocket card. The sections of the guide correspond with the sections of the card. The Reference Guide may also be used as a teaching aid for new providers, residents and students at all levels and disciplines as well as other caregivers. This

introduction provides general information regarding the nature and prevalence of suicidal behaviors and factors associated with increased risk for suicide and suicide attempts. Suicidal thoughts and behaviors (including suicide attempts and death by suicide) are commonly found at increased rates among individuals with psychiatric disorders, especially major depressive disorder, bipolar disorders, schizophrenia, PTSD, anxiety, chemical dependency, and personality disorders (e.g., antisocial and borderline). A history of a suicide attempt is the strongest predictor of future suicide attempts, as well as death by suicide. Intentional self-harm (i.e., intentional self-injury without the expressed intent to die) is also associated with long-term risk for repeated attempts as well as death by suicide.

Psychiatric co-morbidity (greater than one psychiatric disorder present at the same time) increases risk for suicide, especially when substance abuse or depressive symptoms coexist with another psychiatric disorder..

A number of psychosocial factors are also associated with risk for suicide and suicide attempts. These include recent life events such as losses (esp. employment, careers, finances, housing, marital relationships, physical health, and a sense of a future), and chronic or long-term problems such as relationship difficulties, unemployment, and problems with the legal authorities (legal charges). Psychological states of acute or extreme distress (especially humiliation, despair, guilt and shame) are often present in association with suicidal ideation, planning and attempts. While not uniformly predictive of suicidal ideation and behavior, they are warning signs of psychological vulnerability and indicate a need for mental health evaluation to minimize immediate discomfort and to evaluate suicide risk.

Certain physical disorders are associated with an increased risk for suicide including diseases of the central nervous system (epilepsy, tumors, Huntington's Chorea, Alzheimer's Disease, Multiple Sclerosis, spinal cord injuries, and traumatic brain injury), cancers (esp. head and neck), autoimmune diseases, renal disease, and HIV/AIDS. Chronic pain syndromes can contribute substantially to increased suicide risk in affected individuals.

Patients with traumatic brain injuries may be at increased risk for suicide. In comparison to the general population TBI survivors are at increased risk for suicide ideation (Simpson and Tate, 2002), suicide attempts (Silver et al. 2001) and suicide completions (Teasdale and Engberg, 2001). TBI-related sequelae can be enduring and may include motor disturbances, sensory deficits, and psychiatric symptoms (such as depression, anxiety, psychosis, and personality changes) as well as cognitive dysfunction. These cognitive impairments include impaired attention, concentration, processing speed, memory, language and communication, problem solving, concept formation, judgment, and initiation. Another important TBI sequelae that contributes to suicidal risk is the frequent increase in impulsivity. These impairments may lead to a life-long increased suicide risk which requires constant attention.

Although relatively rare, suicidal thoughts and behaviors are not uncommonly reported in the general population. A recent national survey (Kessler, et al., 1999) found that 13.5 % of

Americans report a history of suicide ideation at some point over the lifetime, 3.9% report having made a suicide plan, and 4.6% report having attempted suicide. Among attempters, about 50% report having made a “serious” attempt. The percentages are higher for high school students asked about suicidal ideation and behavior over the preceding year: 16% report having seriously considered attempting suicide, 13% report having made a suicide plan, and 8.4% report having made an attempt during the prior 12 months (CDC, YRBS 2005). These numbers are even higher when a psychiatric disorder is present.

Often there is a transition that takes place along the continuum from ideation to plan to attempts. 34 % of individuals who think about suicide report transitioning from seriously thinking about suicide to making a plan, and 72% of planners move from a plan to an attempt. Among those who make attempts, 60% of planned attempts occur within the first year of ideation onset and 90% of unplanned attempts (which probably represent impulsive self-injurious behaviors) occur within this time period (Kessler, et al., 1999). These findings illustrate the importance of eliciting and exploring suicidal ideation and give credence to its role in initiating and fueling the suicidal process.

LOOK FOR THE WARNING SIGNS

What are warning signs and why are they important?

There are a number of known suicide risk factors. Nevertheless, these risk factors are not necessarily closely related in time to the onset of suicidal behaviors – nor does any risk factor alone increase or decrease risk. Population-based research suggests that the risk for suicide increases with an increase in the number of risk factors present, such that when more risk factors are present at any one time the more likely that they indicate an increased risk for suicidal behaviors at that time.

A recent review of the world’s literature has identified a number of warning signs that empirically have been shown to be temporally related to the acute onset of suicidal behaviors (e.g., within hours to a few days). These signs should warn the clinician of ACUTE risk for the expression of suicidal behaviors, especially in those individuals with other risk factors (Rudd, et al., 2006). Three of these warning signs (bolded on the VA SUICIDE RISK ASSESSMENT Pocket Card) carry the highest likelihood of short-term onset of suicidal behaviors and require immediate attention, evaluation, referral, or consideration of hospitalization.

THE FIRST THREE WARNING SIGNS ARE:

- Threatening to hurt or kill self
- Looking for ways to kill self; seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide

The remaining list of warning signs should alert the clinician that a mental health evaluation needs to be conducted in the VERY near future and that precautions need to be put into place IMMEDIATELY to ensure the safety, stability and security of the individual.

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug abuse
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life

Other behaviors that may be associated with increased short-term risk for suicide are when the patient makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

SPECIFIC FACTORS THAT MAY INCREASE OR DECREASE RISK FOR SUICIDE

Risk and protective factors:

Factors that may increase risk or factors that may decrease risk are those that have been found to be statistically related to the presence or absence of suicidal behaviors. They do not necessarily impart a causal relationship. Rather they serve as guidelines for the clinician to weigh the relative risk of an individual engaging in suicidal behaviors within the context of the current clinical presentation and psychosocial setting. Individuals differ in the degree to which risk and protective factors affect their propensity for engaging in suicidal behaviors. Within an individual, the contribution of each risk and protective factor to their suicidality will vary over the course of their lives.

No one risk factor, or set of risk factors, necessarily conveys increased suicidal risk. Nor does one protective factor, or set of protective factors, insure protection against engagement in

suicidal behaviors. Furthermore, because of their different statistical correlations with suicidal behaviors, these factors are not equal and one cannot “balance” one set of factors against another in order to derive a sum total score of relative suicidal risk. Some risk factors are immutable (e.g., age, gender, race/ethnicity), while others are more situation-specific (e.g., loss of housing, exacerbation of pain in a chronic condition, and onset or exacerbation of psychiatric symptoms).

Ideally, with the elucidation and knowledge of an individual’s risk and protective factors as a backdrop, the sensitive clinician will inquire about the individual’s reasons for living and reasons for dying to better evaluate current risk for suicide.

Factors that may increase a person’s risk for suicide include:

- Current ideation, intent, plan, access to means
- Previous suicide attempt or attempts
- Alcohol / Substance abuse
- Current or previous history of psychiatric diagnosis
- Impulsivity and poor self control
- Hopelessness – presence, duration, severity
- Recent losses – physical, financial, personal
- Recent discharge from an inpatient psychiatric unit
- Family history of suicide
- History of abuse (physical, sexual or emotional)
- Co-morbid health problems, especially a newly diagnosed problem or worsening symptoms
- Age, gender, race (elderly or young adult, unmarried, white, male, living alone)
- Same- sex sexual orientation

Factors that may decrease the risk for suicide are also called protective factors. These include:

- Positive social support
- Spirituality
- Sense of responsibility to family
- Children in the home, pregnancy
- Life satisfaction
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Positive therapeutic relationship

ASK THE QUESTIONS

Introduction:

Asking questions about suicidal ideation, intent, plan, and attempts is not easy. Sometimes the patient will provide the opening to ask about suicide, but usually the topic does not readily flow from the presenting complaint and gathering of history related to the present illness. This can be particularly true in medical as opposed to behavioral health type settings. Nevertheless it is important to ask a screening set of questions whenever the clinical situation or presentation warrants it. The key is to set the stage for the questions and to signal to the patient that they are naturally part of the overall assessment of the current problem. A great deal depends upon the clinician's familiarity with the key screening questions and the ease and comfortableness he/she has with the topic and the asking of the questions. A good place in the clinical interaction for beginning this discussion is immediately following the report and/or the elicitation of the patient/veteran's pain (physical or psychic) and distress. Introductory statements that lead into the questions pave the way to ensuring an informative and smooth dialogue and reassure the patient that you are prepared for and interested in the answers.

For example:

I appreciate how difficult this problem must be for you at this time. Some of my patients with similar problems/symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts?

The questions on the pocket card are examples of the items that should be asked. They form a cascading questioning strategy where the answer would naturally lead to another question which will elicit additional important information.

Are you feeling hopeless about the present or future?

If yes ask.....

Have you had thoughts about taking your life?

If yes ask....

When did you have these thoughts and do you have a plan to take your life?

Have you ever had a suicide attempt?

It is worth keeping in mind that suicidality can be understood as an attempt by the individual to solve a problem, one that they find overwhelming. It can be much easier for the provider to be nonjudgmental when s/he keeps this perspective in mind. The provider then works with the suicidal individual to develop alternative solutions to the problems leading to suicidal feelings, intent and/or behaviors. The execution of this strategy can of course be more difficult than its conceptualization.

Why is it important to ask about a history of attempts?

Most people who attempt suicide do not attempt again. However, about 16% repeat within one year and 21% repeat within 1-4 years. (Owens et al., 2002; Beautrais, 2003). The majority of repeat attempters will use more lethal means on subsequent attempts – increasing the likelihood of increased morbidity or mortality. Approximately 2% of attempters die by suicide within 1 year of their attempt. The history of a prior suicide attempt is the best known predictor for future suicidal behaviors, including death by suicide. Approximately 8-10% of attempters will eventually die by suicide.

Why is it important to ask about feeling hopeless?

Hopelessness – about the present and the future – has been found to be a very strong predictor of suicidal ideation and self-destructive behaviors. Associated with hopelessness are feelings of helplessness, worthlessness, and despair. Although often found in depressed patients, these affective states can be present in many disorders – both psychiatric and physical. If present it is important to explore these feelings with the individual to better assess for the development or expression of suicidal behaviors.

Why is it important to ask about ideation?

In most cases, suicidal ideation is believed to precede the onset of suicidal planning and action. Suicidal ideation can be associated with a desire or wish to die (intent) and a reason or rationale for wanting to die (motivation). Hence, it is essential to explore the presence or absence of ideation – currently, in the recent past, and concurrent with any change in physical health or other major psychosocial life stress.

Many individuals will initially deny the presence of suicidal ideation for a variety of reasons including: 1. the stigma that is associated with acknowledging symptoms of a mental disorder; 2. fear of being ridiculed, maligned and/or being judged negatively by the clinician; 3. loss of autonomy and control over the situation; and 4. fear that the clinician might overreact and hospitalize the individual involuntarily.

Even if denied, certain observable cues (affective and behavioral) should prompt the clinician to remain alert to the possible presence of suicidal ideation. Some signs and symptoms include: profound social withdrawal, irrational thinking, paranoia, global insomnia, depressed affect, agitation, anxiety, irritability, despair, shame, humiliation, disgrace, anger and rage. The clinician may point out the apparent disparity between the current observable clinical condition (what is seen and felt in the examining room) and a denial of suicidal thinking on the part of the

patient. Identifying and labeling the clinical concern may pave the way for an open and frank discussion of what the patient is thinking and feeling – and help shape a treatment response.

Asking about suicidal ideation and intent does not increase the likelihood of someone thinking about suicide for the first time or engaging in such behaviors. In fact, most patients report a sense of relief and support when a caring, concerned clinician non-judgmentally expresses interest in exploring and understanding the patient's current psychological pain and distress that leads them to consider suicide or other self-injurious behaviors.

All suicidal ideations and suicidal threats need to be taken seriously.

Why is it important to ask about timing of ideation and presence of a plan?

Although a minority of individuals are chronically suicidal, most people become suicidal in response to negative life events or psychosocial stressors that overwhelm their capacity to cope and maintain control, especially in the presence of a psychiatric disorder. Hence it is important to understand what elicits suicidal thoughts and the context of these thoughts. Knowing how much time has been spent thinking about suicide alerts the clinician to its role and influence in the daily life of the patient. Knowing what makes things better and what makes things worse regarding the onset, intensity, duration and frequency of suicidal thoughts and feelings assists the clinician in developing a treatment plan. Also knowing what situations in the future might engender the return of suicidal thoughts helps the clinician and patient agree upon a safety plan and techniques to avoid or manage such situations.

The presence of a suicide plan indicates that the individual has some intent to die and has begun preparing to die. It is important to know the possibilities and potential for implementation of the plan, the likelihood of being rescued if the plan is undertaken, and the relative lethality of the plan.

Although some research suggests a relationship between the degree of suicidal intent and the lethality of the means, the clinician should not dismiss the presence of suicidal planning even if the method chosen does not appear to be necessarily lethal (Brown, et al., 2004). It is also important to know whether the individual has begun to enact the plan, by engaging in such behaviors as rehearsals, hoarding of medications, gaining access to firearms or other lethal means, writing a suicide note, etc.

RESPONDING TO SUICIDE RISK

What is a crisis?

A crisis is when the patient's usual and customary coping skills are no longer adequate to address a perceived stressful situation. Often such situations are novel and unexpected. A crisis occurs when unusual stress, brought on by unexpected and disruptive events, render an individual physically and emotionally disabled – because their usual coping mechanisms and past behavioral repertoire prove ineffective. A crisis overrides an individual's normal psychological and biological coping mechanisms – moving the individual towards maladaptive behaviors. A crisis limits one's ability to utilize more cognitively sophisticated problem-solving skills and conflict resolution skills. Crises are, by definition, time-limited. However, every crisis is a high risk situation.

Crisis intervention and management:

The goals of crisis intervention are to lessen the intensity, duration, and presence of a crisis that is perceived as overwhelming and that can lead to self-injurious behaviors. This is accomplished by shifting the focus from an emergency that is life-threatening to a plan of action that is understandable and perceived as doable. The goal is to protect the individual from self-harm. In the process, it is critical to identify and discuss the underlying disorder, dysfunction, and/or event that precipitated the crisis. Involving family, partners, friends, and social support networks is advisable.

The objectives are to assist the patient in regaining mastery, control, and predictability. This is accomplished by reinforcing healthy coping skills and substituting more effective skills and responses for less effective skills and dysfunctional responses. The goal of crisis management is to re-establish equilibrium and restore the individual to a state of feeling in control in a safe, secure, and stable environment. Under certain circumstances this might require hospitalization.

The techniques include removing or securing any lethal methods of self-harm, decreasing isolation, decreasing anxiety and agitation, and engaging the individual in a safety plan (crisis management or contingency planning). It also involves a simple set of reminders for the patient to utilize the crisis safety plan and skills agreed upon by both the provider and the patient.

Referrals for mental health assessment and follow-up:

Any reference to suicidal ideation, intent, or plans mandates a mental health assessment. If the patient is deemed not to be at immediate risk for engaging in self-destructive behaviors, then the clinician needs to collaboratively develop a follow-up and follow-through plan of action.

This activity best involves the patient along with significant others such as family members, friends, spouse, partner, close friends, etc.).

Here are some ways to be helpful to someone who is threatening suicide or engaging in suicidal behaviors:

- Be aware – learn the risk factors and warning signs for suicide and where to get help
- Be direct – talk openly and matter-of-factly about suicide, what you have observed, and what your concerns are regarding his/her well-being
- Be willing to listen – allow expression of feelings, accept the feelings, and be patient
- Be non-judgmental – don't debate whether suicide is right or wrong or whether the person's feelings are good or bad; don't give a lecture on the value of life
- Be available – show interest, understanding, and support
- Don't dare him/her to engage in suicidal behaviors.
- Don't act shocked
- Don't ask "why"
- Don't be sworn to secrecy
- Offer hope that alternatives are available – but don't offer reassurances that any one alternative will turn things around in the near future.
- Take action – remove lethal means of self-harm such as pills, ropes, firearms, and alcohol or other drugs
- Get help from others with more experience and expertise
- Be actively involved in encouraging the person to see a mental health professional as soon as possible and ensure that an appointment is made.

Individuals contemplating suicide often don't believe that they can be helped, so you may have to be active and persistent in helping them to get the help they need. And, after helping a friend, family member, or patient during a mental health crisis, be aware of how you may have been affected emotionally and seek the necessary support for yourself.

IMMEDIATE PSYCHOPHARMACOLOGICAL INTERVENTIONS

The most common psychiatric symptoms associated with acute risk for suicidal behaviors include: agitation, anxiety, insomnia, acute substance abuse, affective dysregulation, profound depression, and psychosis. The only two evidence-based medications that have been shown to lower suicidal behaviors are lithium (usually prescribed for bipolar disorder and recurrent unipolar depression) and clozapine (usually prescribed for schizophrenic disorders). However these medications do not reach therapeutic levels immediately. In addition,

sedatives/hypnotics are recommended for symptoms of insomnia, and anxiolytics for the treatment of anxiety and agitation.

Staying within VHA clinical practice guidelines, it is indicated to prescribe anxiolytics, sedative/hypnotics, and short-acting antipsychotic medications up to or at the maximum indicated dosages to directly address agitation, irritability, psychic anxiety, insomnia, and acute psychosis, until such time as a behavioral health assessment can be made. The amount and type of medications to address these clinical presentations needs to be carefully chosen and titrated when the individual is deemed to be under the influence of alcohol, illicit substances, or other medication in prescribed or overdose amounts.

Although depressive symptoms are often associated with risk for suicide, no antidepressant medication has yet to be shown to lower suicide risk in depressed patients. However, because of the relationship between low CSF serotonin levels and the emergence of aggression and impulsivity, the selective serotonin reuptake inhibitors (SSRIs) have been recommended for the treatment of depressive disorders when suicidal risk is present. However, treatment with SSRIs must be carefully monitored and managed during the initial treatment phase because of the potential for the possible emergence of suicidal ideation and behaviors during this time. The FDA has recently created a black box warning when prescribing SSRIs for persons under the age of 25.

MYTHS ABOUT SUICIDE

There are many myths about suicide and suicidal behavior that have been passed down through generations of healthcare providers that some providers still believe today and may have actually been taught. Examples of these myths are:

- Myth: Asking about suicide would plant the idea in my patient's head.
- Reality: Asking how your patient feels doesn't create suicidal thoughts any more than asking how your patient's chest feels would cause angina.

- Myth: There are talkers and there are doers.
- Reality: Most people who die by suicide have communicated some intent. Someone who talks about suicide gives the physician an opportunity to intervene before suicidal behaviors occur.

- Myth: If somebody really wants to die by suicide, there is nothing you can do about it.
- Reality: Most suicidal ideas are associated with the presence of underlying treatable disorders. Providing a safe environment for treatment of the underlying cause can save lives. The acute risk for suicide is often time-limited. If you can help the person survive the

immediate crisis and the strong intent to die by suicide, then you will have gone a long way towards promoting a positive outcome.

- Myth: He/she really wouldn't kill themselves since _____.
 - he just made plans for a vacation
 - she has young children at home
 - he signed a No Harm Contract
 - he knows how dearly his family loves him
 - Reality: The intent to die can override any rational thinking. In the presence of suicidal ideation or intent, the physician should not be dissuaded from thinking that the patient is capable of acting on these thoughts and feelings. No Harm or No Suicide contracts have been shown to be essentially worthless from a clinical and management perspective. The anecdotal reports of their usefulness can all be explained by the strength of the alliance with the care provider that results from such a collaborative exchange, not from the specifics of the contract itself.
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- Myth: Multiple and apparently manipulative self-injurious behaviors mean that the patient is just trying to get attention and are not really suicidal.
 - Reality: Suicide “gestures” require thoughtful assessment and treatment. Multiple prior suicide attempts increase the likelihood of eventually dying by suicide. The task is to empathically and non-judgmentally engage the patient in understanding the behavior and finding safer and healthier ways of asking for help.

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Other references that may be useful:

Suicide Information Web Sites:

American Association of Suicidology: <http://www.suicidology.org>

American Foundation of Suicide Prevention: <http://www.afsp.org>

Suicide Prevention Action Network (SPAN): <http://www.spanusa.org>

Suicide Prevention Resource Center: <http://www.sprc.org>

US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

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