INTEGRATING SUICIDE PREVENTION INTO OVERALL HEALTHCARE ©2017

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Suicidality is more common than we think

All age groups studied reported suicidal thought – highest percentage in young adults aged 18 – 25 y.o. (SAMHSA, 2009)

8.3 mil U.S. adults reported serious thoughts in previous year (1.1 mil made attempts) (SAMHSA, 2009)

50% of military veterans currently attending college reveal active suicidal ideation (Rudd, 2011)
THEORIES OF SUICIDE

- **Societal and Cultural** – Emile Durkheim (1867) Masaryk (1881) & Wolman (1976) – social integration and associated cultural connections determine risk – social regulation provides protection not individual factors

- **Biological and Genetic** – lower serotonin levels in brain predisposes depression/ Dysfunction of Hypothalamic-pituitary-adrenal axis (stress response) predicts suicide in depressed patients

- **Biological and Stress** - (Diathesis Model) – life events cause increased stress combined with an innate biologic vulnerability to suicide
THEORIES OF SUICIDE

- **Psychological** –
  - **Edwin Schneidman** (father of suicidology, 1993) - ambivalence toward life and death, and feelings of hopelessness and helplessness – “psychache” conflict of internal aspects of self to which the only response is the ending of the personality
  - **Interpersonal** (Joiner, 2011) – thwarted belongingness & perceived burdensomeness and acquired capability
  - **Psychobiological** (Jensen, 2012) – childhood trauma with inability to alter situation creates a neural pathway of “not wanting to be here” which leads to subconscious default suicidal thought pattern
CONSIDER POSSIBLE ETIOLOGIES OF SUICIDALITY

- **Situational Suicidality** (depression with SI e.g.: post-partum, terminal Dx, adjustment D/O) (Wu, 2016, medical newstoday.com)

- **Psychotic state** – persistent or cyclical (e.g.: schizophrenia, bipolar with psychosis) (psychiatrictimes, 2014)

- **Early trauma with chronic course** - suicidality with roots in childhood or adolescent trauma (ACES, 1998)
“Of several types of childhood maltreatment investigated, childhood **sexual abuse** directly predicted suicidal ideation.

*(Brown et al, 1999; Thompson et al, 2005; Eisenberg, Ackard, & Resnick, 2007)*

Childhood **physical and emotional abuse** indicated suicidal ideation through their association with anxiety.

*(Bahk et al, 2016)*
Suicidality can begin as thoughts of “not wanting to be here” as a way to save your life.

When first faced with a situation that is untenable, you can’t stop it and you can’t change it – the only way to live through it is to find a way to endure it. The mind looks for ways to “not be here” so you can live through trauma and pain.

This starts a neural pathway that becomes a permanent and a default mechanism.

It is unconsciously driven by endorphins and other “feel good” neurochemicals (enkephalins, dopamine, etc.).
Endogenous opioids (endorphins) relieve pain by binding to brain cell receptors called mu-opioid receptors, which stops the transmission of pain signals from one nerve to the next. 

(Zubieta et al, 2005; Benedetti et al, 2005)

“Hope” of relief alone releases pain-relieving endorphins.

Just thinking about a way to relieve pain, relieves pain. (Petrovic et al, 2002).
Psychobiologically:

- Physical and emotional sensations (pain & pleasure) share many of the same neural pathways...
  
  *(Dewall et al, 2009; Eisenberger, 2011)*

  therefore those sensations evoke the same initial endorphinergic response.

- Thought patterns can be driven and reinforced by endorphins, “feel good” neurochemicals. *(Dunbar et al, 2011)*

alpha-Endorphin

beta-Endorphin

gamma-Endorphin
The average brain is born with 100 billion neurons each over time make tens of thousands of connections which translates to **10 quadrillion calculations per second.**  
(Disabled World, 2008; Eagleman, 2011)

The “thought” or stimulus message in the brain is an electrical impulse which jumps the microscopic spaces (synapses) from neuron to neuron. Over time, similar stimuli create highways of synaptic trails known as “neural pathways”.  
(Rodi, C., 2009; Bernard, S, 2010; Mengia-Seraina Rioult-Pedotti, 2000)
Atrophying unproductive neural pathways and creating new neural connections in the brain by learning, thinking, and choosing new experiences.

“My goal is that you understand and can see how there might be a scientific basis for accepting that your thoughts can create your reality. For the doubter, I would like you to entertain the possibility that the way you think directly affects your life.”

Dr. Joe Dispenza
And, finally... Cells are activated leaving “neural” connection trails known as “Neural Pathways”.

It’s about biology – one of the brain’s job is to find a way to relieve pain – (part of the biological imperative to live)

The pain-relieving thoughts start out like this trail...

They become deeper and deeper over time...
OVER TIME...

AUTOMATIC NEURAL PATHWAYS unconsciously increased and deepened over time become default thought patterns.

(Jensen, R. 2012)
Suicidal thinking is not volitional –

It is an unconscious process.

“The unconscious handles a variety of important tasks that are best accomplished automatically, with great speed and no opportunity for deviation, or, in other words, no room for choice.”

(Viamontes & Beitman, 2007)

Once suicide is on the table there is no problem-solving. The default thought pathway is fully developed and stronger than any other because it initially feels good to think about being free from pain.

To recover, it takes a conscious effort to retrain the brain.
Stigma – **WHAT DOES IT FEEL LIKE?**

S/he...

- does not want the attempt to be thwarted.
- feels that suicide is a sign of weakness and is ashamed.
- feels that suicide is immoral or a sin.
- is worried that the clinician will perceive him as crazy.
- fears that s/he will be locked up or hospitalized.
- does not fully trust the clinician or believe that anyone can help.

*NOT ALL PATIENTS RELAY THEIR SUICIDAL IDEATION TO CLINICIANS (HALL, PLATT, & HALL, 1999)*
Based on building a true therapeutic alliance

Developed by Miller and Rollnick for counseling in substance abuse

Goal-directed and strategic based on how and what the patient will do and how they will effect the change they say they desire.

It works because:
- Shame and intimidation resulted in repeated recidivism.
- Individuals will follow through with change if they are the arbiter of their own change process.
- Designed expressly to resolve ambivalence

THE QUESTION OF WHETHER TO LIVE OR DIE IS THE HEIGHT OF AMBIVALENCE
WHAT EXACTLY IS AMBIVALENCE?

A natural state of uncertainty that is experienced throughout most change processes (e.g., dieting; exercising; maintaining health; Restructuring an organization).

It occurs because of conflicting feelings about the process & the outcomes.
A man convinced against his will is of the same opinion still.

---Benjamin Franklin

“Pushing or arguing against resistance seems particularly counterproductive, in that it evokes further defense of the status quo.” (Miller & Rose, 2009)

Telling patients what they “should” do does nothing to resolve their ambivalence about the outcome of doing anything.

“A guiding principle of MI is to have the client, rather than the counselor, voice the arguments for change.” (Miller & Rose, 2009)
Listening/Interview Techniques
“OARS”

► **Open-ended questions** – asking for more info *(When too many questions sound like an interrogation, use the “repeat technique” by repeating the client’s last word(s) with a questioning intonation. – “So, can you tell me how this all started?”)*

► **Affirm and validate client strengths** *(Infer patient’s values in coming along side with empathy, support and encouragement. – “It’s clear being there for your kids is important to you. And how can you be there for them when it’s so hard to be there for yourself?”)*

► **Reflect an understanding of meaning and feeling** *(Show you fully understand the difficulty involved. – “This sounds like you’ve had a really tough time dealing with your pain.”)*

► **Summarize** *(In your own words, what you have heard to encourage more elaboration - “So, let me see if we are on the same page here, what I’ve heard you say is…”)*

*(Do you know when to summarize?)*
#1 TASK – Establish the will to live –

“If you could have these problems resolved, would you want to live?”

- **Accurate Empathy** - build therapeutic alliance, listen reflectively without judgment – and **VALIDATE**

  “Tell me about your situation. It sounds like you have suffered for a long time.”

- **Build Discrepancy** - establish desire to live by showing understanding and drawing the difference between where they are and where they want to be – **MOVE CLOSER IN AGREEMENT**

  “You sound like you feel hopeless – I’m guessing there are also days when you feel differently, could that be?”
• **Roll with Resistance** - to reduce defensiveness, refrain from argument - *FIND ANYTHING POSITIVE YOU CAN AGREE WITH*

  “Yes, it is your life and you have the right to do whatever you want. How would you feel if you could live without this pain? What would that feel like?”

**Build self-efficacy** – to reduce helplessness, draw out capability – **BUILD CONFIDENCE**

“I bet you’ve done lots of things in your life that you did not think you could do when you started out.”
Sometimes we give information that the client knows and it can feel condescending. So ask them what they already know about the subject.

“Sounds like you’re pretty fearful about losing control and picking up a gun...What do you know about having lethal means for suicide readily available in your house?”

Reflect understanding of that information adding more fully to it

“I imagine it would be very dangerous to have the means right there.” – “You’re exactly right...putting distance between the means and the individual struggling with suicide has saved countless lives.”

3. Ask what they want to know more about

“Do you think you’d be interested in knowing more about how you can intervene on your own self or others to prevent suicide? There are lots of things you can do – there is hope.”
MANY FORMAL ASSESSMENT TOOLS

- Columbia-Suicide Severity Rating Scale C-SSRS (currently most used and recommended) Screening tool, full & Military version
- Is Path² Warm² - Ideation and attempt History
- PHQ9- – multiple use – and excellent ongoing monitoring tool – most used in a medical setting
- SAFE-T – method of conversational assessment developed by SAMHSA
<table>
<thead>
<tr>
<th>Problem</th>
<th>PHQ-9</th>
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<tbody>
<tr>
<td>Little interest or pleasure in doing things?</td>
<td>0  Not at all</td>
</tr>
<tr>
<td></td>
<td>+1  Several days</td>
</tr>
<tr>
<td></td>
<td>+2  More than half the days</td>
</tr>
<tr>
<td></td>
<td>+3  Nearly every day</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless?</td>
<td>0  Not at all</td>
</tr>
<tr>
<td></td>
<td>+1  Several days</td>
</tr>
<tr>
<td></td>
<td>+2  More than half the days</td>
</tr>
<tr>
<td></td>
<td>+3  Nearly every day</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much?</td>
<td>0  Not at all</td>
</tr>
<tr>
<td></td>
<td>+1  Several days</td>
</tr>
<tr>
<td></td>
<td>+2  More than half the days</td>
</tr>
<tr>
<td></td>
<td>+3  Nearly every day</td>
</tr>
<tr>
<td>Feeling tired or having little energy?</td>
<td>0  Not at all</td>
</tr>
<tr>
<td></td>
<td>+1  Several days</td>
</tr>
<tr>
<td></td>
<td>+2  More than half the days</td>
</tr>
<tr>
<td></td>
<td>+3  Nearly every day</td>
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<tr>
<td>Poor appetite or overeating?</td>
<td>0  Not at all</td>
</tr>
<tr>
<td></td>
<td>+1  Several days</td>
</tr>
<tr>
<td></td>
<td>+2  More than half the days</td>
</tr>
<tr>
<td></td>
<td>+3  Nearly every day</td>
</tr>
<tr>
<td>Question</td>
<td>Score Options</td>
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<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Feeling bad about yourself — or that you are a failure or have let yourself or your family down? | 0  Not at all  
+1  Several days  
+2  More than half the days  
+3  Nearly every day |
| Trouble concentrating on things, such as reading the newspaper or watching television? | 0  Not at all  
+1  Several days  
+2  More than half the days  
+3  Nearly every day |
| Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual? | 0  Not at all  
+1  Several days  
+2  More than half the days  
+3  Nearly every day |
| Thoughts that you would be better off dead, or thoughts of hurting yourself in some way? | 0  Not at all  
+1  Several days  
+2  More than half the days  
+3  Nearly every day |
| If any of the above were scored more than “Not at all”: How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | 0  Not at all  
+1  Somewhat difficult  
+2  Very difficult  
+3  Extremely difficult |
Scores ≤4 suggest minimal depression which may not require treatment. Functionally, the patient does not report limitations due to their symptoms.

<table>
<thead>
<tr>
<th>Score</th>
<th>Depression severity</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>0-4</td>
<td>Minimal or none</td>
<td>Monitor; may not require treatment</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild</td>
<td>Use clinical judgment (symptom duration, functional impairment) to determine necessity of treatment</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
<td>Warrants active treatment with psychotherapy, medications, or combination</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe</td>
<td>Warrants active treatment with psychotherapy, medications, or combination</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe</td>
<td></td>
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Final diagnosis should be made with clinical interview and mental status examination including assessment of patient’s level of distress and functional impairment.

**CRITICAL ACTIONS**
- Perform suicide risk assessment in patients who respond positively to item 9 “Thoughts that you would be better off dead or of hurting yourself in some way.”
- Rule out bipolar disorder, normal bereavement, and medical disorders causing depression.
THINGS YOU NEED TO REMEMBER AND ASCERTAIN IMMEDIATELY

- Just because someone says they are thinking of suicide does not mean that they need hospitalization
- Develop a therapeutic alliance
- First task in assessment is to *listen and ask* about:
  - What’s been going on in your life?
  - How long has it been going on?
  - How long has suicide been a consideration in your life?
  - Does anyone but you and I know about how you’re feeling right now?
  - Do you have a plan right now?
How you ask is as important as what you ask

Ask questions in the positive not negative

- “Do you feel safe?” instead of “You don’t feel unsafe, do you?”
- “Have you ever considered ending your life?” instead of “You’re not considering suicide, are you?”

With Children: “Have things ever gotten so bad that you’ve thought about hurting yourself?” or “Have you ever wished you were dead?” or “Have you ever wanted to go to sleep and never wake up?” or even “Sometimes when kids feel very upset, they think about killing themselves. Has that ever happened to you?”
“Assessment of acute risk alone is how the overwhelming majority of clinicians approach the task. Over the past decade, converging scientific evidence suggests it is important to address enduring or "chronic" suicidality in patients. More specifically, those who have made two or more suicide attempts likely have a "chronic" aspect to their presentation. Although acute risk may well resolve, it is important for the clinician to make a note about the individual's enduring vulnerabilities and continuing suicide risk.”

(Suicidologist David Rudd)
HOW WOULD A PATIENT KNOW YOUR OFFICE IS A SAFE PLACE TO TALK ABOUT SUICIDE?

Consider:

- **Displaying a placard** in the lobby, hallway, or information board which lends to open talk about suicidality.

- Displaying an easily **accessible information bulletin board for brochures** about suicidality.

- **Organizing an easily accessible file** which includes all needed paperwork for assessment and referral, if needed.

- Remind your patients that **Means Matter** (copies of Harvard “means matter” handout)
  - Let patients know where to dispose of expired, unused or unwanted medications in WA state.  
    *(https://www.fda.gov)*
Working together to keep people alive until they can keep themselves alive.

Jensen Suicide Prevention Peer Protocol - The JSP3©

Jensen Suicide Prevention Prevention Peer Protocol - The JSP3© for Battle Buddies, their Families & Concerned Others

“Soldiers take care of Soldiers… It doesn’t matter if it’s carrying a wounded comrade off a battlefield, or making sure a traumatized warrior gets the help he or she needs. And that means suicide prevention fits into what Battle Buddies do every day...”

– Col. R. Porter
RESOURCES

- TWLOHA – To Write Love on Her Arms http://twloha.com
- American Association of Suicidology http://www.suicidology.org
- Suicide Prevention Resource Center http://www.sprc.org
- American Foundation for Suicide Prevention http://www.afsp.org
- Suicide.org (Suicide Survivors) http://www.suicide.org
- The Jed Foundation http://www.jedfoundation.org
- Stop Soldier Suicide: Military & Veteran Suicide Prevention http://stopsoldierssuicide.org
- Veterans Crisis Line | Suicide Prevention Hotline, Chat, & Text https://www.veteranscrisisline.net/

- Monitored CHAT LINES (online only)
  http://www.suicidepreventionlifeline.org/
    /r/SuicideWatch
    /r/offmychest
    /r/trueoffmychest
    /r/depression
  (These reddit chat lines are rigorously monitored for trolls)
<table>
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<tr>
<th>Call 911</th>
<th>1-800-SUICIDE (1-800-784-2433)</th>
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</table>
| SuicidePreventionLifeline.org  
1-800-273-TALK (1-800-273-8255) | Text Telephone:  
1-800-799-4TTY (1-800-799-4889) |
| Military Veterans Crisis Line:  
1-800-273-8255 (Press 1) | Suicide Hotline in Spanish:  
1-800-273-TALK (Press 2) |
| Teen line:  
Call (310) 855-HOPE from 6pm to 10pm PST. | Teen Talk Line:  
Call 866.825.5856, or Text 215.703.8411 |
| LGBT Youth Suicide Hotline:  
1-866-4-U-TREVOR | For a list of hotlines world wide:  
“With eloquence, compassion and a big dose of brain chemistry, Randi Jensen’s book provides a rich tapestry of information and support for those struggling to understand suicide. This is possibly the most useful self-help book ever – where else can one learn how to stay alive and help someone else stay alive? A must read for clinicians, family and friends.” – Terry Courtney, MPH, LAc, former Dean, School of Acupuncture and Oriental Medicine, Bastyr Univ.

“The formula of the Jensen Suicide Prevention Peer Protocol© (JSP3©) will save the lives of our Veterans! Finally you will understand what is happening in your brain and will move forward on a plan that works.” – Rod Wittmier, founder - National Alliance to End Veteran Suicide

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