Reducing Suicidal Behavior: Improving Outcomes in the Face of Substance Abuse

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*Suggestions of possible texts/protocols, are based solely on my knowledge of the current state of the empirical literature.*
A focus on the primary prevention of alcohol and drug use disorders and other psychopathological disorders associated with suicide, as well as intervention for those showing early indication of such disorders, are needed in order to have a meaningful impact on the population rate of suicide.

Overview of Today’s Talk on Substance Abuse and Suicide

- Empirical findings: *What does the science say?*
- Special populations
- Assessment
  - TIP 50: “Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment”
  - CAMS
- Treatment: Best Practices
Why should substance use providers worry about suicide?

- Research consistently shows a high prevalence of suicidal thoughts and suicide attempts among persons with substance abuse problems who are in treatment.

- HOWEVER, Substance abuse treatment may serve a protective function against suicide attempts, especially if the individual is more fully engaged in treatment.
Suicidal Behavior while Under the Influence is Common

- While 95 percent of individuals with a mental illness and/or substance use disorder will never complete suicide....
  - 90%+ of suicide completers experience a mental and/or substance use disorder

- Data from the National Comorbidity Survey indicate that alcohol and drug abuse disorders are associated with a risk 6.2 times greater than average risk of suicide attempts
Empirical Literature

“What does the science say?”
Continuum of suicidal behavior includes:

- Suicidal thoughts
  - Ideation
  - Plans
- Suicide attempts
- Completed suicide
- Non-suicidal self-injury
- Self-destructive behaviors
Rates of Suicidal Behavior

- NIHM, 2007
  - Suicide: 10th leading cause of death
  - 7th leading cause of death for males
  - 15th leading cause of death for females

- CDC, 2009
  - 36,909 suicide deaths
  - The rate of suicide has been increasing since 2000.
Associations of substance use, abuse, and dependence with subsequent suicidal behavior.

National Comorbidity Study data (1990-92)

- Alcohol and drug use predict subsequent suicide attempts
  - Controlling for sociodemographics and comorbid mental disorders
- Substance use disorders were also significantly associated with higher rates of suicide attempts
  - Odds of attempt significantly higher for:
    1. alcohol use disorders
    2. heroin use disorders
    3. inhalant use disorders.
Associations of substance use, abuse, and dependence with subsequent suicidal behavior, cont

- The number of substances used increased the odds of a suicide attempt far more than did the type of substance used.
- For most substances, current substance use (at the time of the suicide attempt) was what mattered.
- Substance use combined with suicidal ideation was associated with a greater risk of suicide attempt even when there was no suicide plan.
What is the role of sub use on suicidal behavior?

- **Causal relationship model?**
  - Substance use increases the likelihood of suicidal behavior regardless of other known risk factors

- **Coexisting relationship model?**
  - Substance use as a marker of some personality proneness to suicide or as a consequence of other known risk factors, such as depressed mood

**NCS-R data**

- Disorders characterized by anxiety/agitation (for example, post-traumatic stress disorder) and poor impulse-control (for example, bipolar disorder, conduct disorder, substance disorders) emerged as the strongest predictors of which ideators make suicide plans and attempts
10 years later...

Review of studies from developed and developing nations:

- Alcohol use disorders:
  - 2.0-2.5 OR for suicidal ideation
  - 2.6–3.7 OR for suicide attempt

- Drug use disorders:
  - 2.3-3.0 OR for suicidal ideation
  - 2.0–4.0 OR for suicide attempt

- Drinking alcohol prior to the suicide attempt: 6.2-9.6 OR
Characteristics of precontemplative vs. impulsive suicide attempts

Participants had current alcohol dependence and history of suicide attempt

- **Pre-contemplators:**
  - Greater intent to die
  - More likely to require medical treatment as a result of the attempt.
  - More likely to be dependent on illicit drugs & alcohol
  - More likely to have a history of depression

- **Impulsive**
  - Women
  - Higher levels of alcohol-related aggression
Characteristics of suicide attempters vs. suicide completers

Suicide attempters and family member informants of suicide completers were interviewed; all patients had depression.

**Attempters:**
- Female
- Younger
- Previous suicide attempts
- Previous inpatient psychiatric treatment

**Completers**
- More likely to use drugs/alcohol before attempt
- More lethal method
- Leave suicide note
- Sig job stress
- Financial stress
Suicide Attempts within 12 Months of Treatment for Substance Use Disorders

2.6% of approx 3,000 treated patients attempted suicide within one year of SUD treatment

**Baseline predictors:**
- Lifetime history of suicide attempt
- Suicidal ideation
- Depression
- Cocaine-drug of choice
- Outpatient methadone txt
- Short-term inpt txt

**Follow-up predictors**
- Daily + use of cocaine
- Suicidal ideation during follow-up
Special Populations
Women: Sub Use, Suicide, & Trauma

- Posttraumatic stress disorder (PTSD) and substance dependence (SD) are each associated with increased rates of:
  - Self-harm
  - Suicidal ideation
  - Suicide attempts.

- Findings hold after controlling for the diagnosis of borderline personality disorder.
Rates of self-harm among women with SUD and PTSD

In the past 3 months, women with SUD and PTSD:
- Engaged in self-harm behavior (21.5%)
  - overdosing (26.1%)
  - cutting/scratching (20.0%)
- Attempted suicide (18.5%)
- Had suicidal ideation (72.3%)
- Had self-harm ideation (49.2%)
- 61.9% of the women who had made a suicide attempt and/or harmed themselves in the prior three months reported drinking alcohol or using drugs immediately before or during the episode.
“Is suicide common among children and young people?”

- In 2007, suicide was the third leading cause of death for young people ages 15 to 24. (CDC)

- Among those ages 25-34, suicide is the second leading cause of death, behind unintentional injuries. (CDC)

- Males are 4-6x more likely to die by suicide than females at ages 15 to 19 and 20 to 24, respectively

- For every suicide completed in the 15 to 24 age group in the U.S., there are 100-200 attempted suicides (Arias et al. 2003).
Risk Factors for Suicidal Behavior Among a National Sample of Adolescents

- Weighted population prevalence estimates of 23.3% experiencing suicidal ideation and 3.1% attempting suicide.

- Suicidal ideation was positively associated with:
  - female gender, age, family alcohol and drug problems, violence exposure, lifetime depression, and posttraumatic stress disorder (PTSD).

- Suicide attempts were associated with:
  - female gender, age, sexual and physical assault, lifetime substance abuse or dependence, PTSD, & depression.

(Waldrop et al, 2007)
Veterans

- Highest rates of suicide among male vets with Bipolar Disorder and female vets with Substance Use disorders
- Most veteran suicides involve violent means
- Among vets engaged in sub use treatment, baseline predictors of a suicide attempt before follow-up included:
  - Elevated suicidal/psychiatric symptoms
  - More recent problematic alcohol use,
  - Longer duration of cocaine use
- Contact with the criminal justice system and greater engagement in SUD treatment were protective factors.
Assessment
Assessment of Suicidality

- Be Direct
- Increase Your Knowledge About Suicidality
- Do What You Already Do Well
- Practice, Practice, Practice

- Get Good Clinical Supervision /Consultation
- Work Collaboratively with Suicidal Clients
- Acknowledge and Express Limits of Confidentiality
- Maintain Positive Attitudes

Reference: TIP 50
“Points to Keep You on Track”

1. Almost all of your clients who are suicidal are ambivalent about living or not living
2. Suicidal crises can be overcome
3. Although suicide cannot be predicted with certainty, suicide risk assessment is a valuable clinical tool
4. Suicide prevention actions should extend beyond the immediate crisis.
5. Suicide contracts are not recommended and are never sufficient.

Reference: TIP 50
“Points to Keep You on Track”

6. Some clients will be at risk of suicide, even after getting clean and sober.
7. Suicide attempts always must be taken seriously.
8. Suicidal individuals generally show warning signs.
9. It is best to ask clients about suicide, and ask directly.
10. The outcome does not tell the whole story.

Reference: TIP 50
Warning Signs of Suicide

- **Direct**
  - Suicidal communication
  - Seeking access to a method
  - Making preparations

- **Indirect**
  - I = Ideation
  - S = Substance Abuse
  - P = Purposelessness
  - A = Anxiety
  - T = Trapped
  - H = Hopelessness
  - W = Withdrawal
  - A = Anger
  - R = Recklessness
  - M = Mood Changes

Reference: TIP 50
Risk vs. Protective Factors

**RISK**
- Prior history of suicide attempt
- Family history of suicide
- **Severe substance use**
- Co-occurring mental health disorder
- History of child abuse
- Life stressors
- Personality traits
- Firearm ownership

**PROTECTIVE**
- “Reasons for living”
- Being clean and sober
- Attendance at AA/NA
- Religion/spirituality
- Children in home
- Intact marriage
- Trusting relationship with mental health professionals
- Employment
- Trait optimism

Reference: TIP 50
Reasons for Suicidal Behavior

- Desire to die
- Hopelessness
- Extreme/prolonged sadness
- Perceived failure or self-hate following relapse
- Loneliness
- Feeling like a burden
- Disinhibition while intoxicated

- Escape from a painful emotional state
- Escape from entrapping situation
- Get attention
- Impulsive reaction to stressful situation
- Hurt another individual
- Paranoia/psychosis
- Escape a progressively deteriorating health situation

Reference: TIP 50
Do triggers to suicide and substance use vary?

- Need to explore triggers for suicidal behaviors and/or substance use in the presence of stress
- Examined markers for relapse
- Parasuicide was significantly more likely to be linked to interpersonal problems
- Drug use was more likely to be preceded by addiction cues (i.e., being near drugs or people who use drugs).

(Welsh & Linehan, 2002)
Suicide attempts vs. Nonsuicidal self-injury

- Nonsuicidal acts were more often reported as intended to express anger, punish oneself, generate normal feelings, and distract oneself.
- Suicide attempts were more often reported as intended to make others better off.
- Almost all participants reported that both types of parasuicide were intended to relieve negative emotions.
- Need to consider role of substance use....

(Brown, Comtois, & Linehan, 2002)
Treatment Improvement Protocol (TIP 50)

- “Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment”
- Provided by SAMHSA
- FREE!! Download or order manuals on www.kap.samhsa.gov
TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

GATE

- Gather information
- Access supervision
- Take responsible action
- Extend the action
CAMS—Collaborative Assessment and Management of Suicidality

- Suicide Status Form (SSF), a multipurpose clinical instrument designed to assess suicide risk and promote treatment planning (Jobes, Jacoby, Cimbolic, & Hustead, 1997)
- Assesses subjective ratings of psychological pain, stress, agitation, hopelessness, and self-hate
- Core Assessment
- Safety plan/ “Hope Kit”
Managing Suicidal Risk: A Collaborative Approach

By David A. Jobes PhD & Edwin S. Shneidman PhD
Treatment of Suicidal Thoughts and Behavior
VA Safety Plan: Brief Instructions

Step 1: Recognizing Warning Signs

• ___ Ask “How will you know when the safety plan should be used?”

• ___ Ask, “What do you experience when you start to think about suicide or feel extremely distressed?”

• ___ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients’ own words.
Step 2: Using Internal Coping Strategies

- Ask “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
- Ask “How likely do you think you would be able to do this step during a time of crisis?”
- If doubt about using coping strategies is expressed, ask “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.
Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask “Who or what social settings help you take your mind off your problems at least for a little while? “Who helps you feel better when you socialize with them?”
- Ask patients to list several people and social settings, in case the first option is unavailable.
- Ask for safe places they can go to do be around people, e.g. coffee shop.
- Remember, in this step, suicidal thoughts and feelings are not revealed.
Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

- Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- Ask “Among your family or friends, who do you think you could contact for help during a crisis?” or “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”
- Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.
Step 5: Contacting Professionals and Agencies

- Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.

- Ask “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”

- List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator, VA Suicide Prevention Hotline (1-800-273-TALK (8255))

- If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.
Step 6: Reducing the Potential for Use of Lethal Means

- The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.

- For methods with low lethality, clinicians may ask veterans to remove or restrict their access to these methods themselves.

- Restricting the veterans’ access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.
Medication

- Clozapine is approved by the FDA for suicide prevention in people with schizophrenia. (Meltzer et al., 2003)

- May consider pharmacotherapy aimed at reduction of anxiety/depression/aggression and/or substance use behavior
Cognitive behavioral therapy can reduce suicidal behavior

- **Linehan and colleagues, 1991:**
  - After a 1 year of treatment, DBT patients made fewer self-inflicted injuries than usual care

- **Linehan and colleagues, 2004:**
  - 50% fewer suicide attempts among chronically suicidal women meeting criteria for BPD: using DBT versus nonbehavioral community expert psychotherapy.

- **Brown and colleagues (2005):**
  - 10 sessions of cognitive therapy plus case management and usual care versus case management and usual care alone
  - Participants found in the ER after a suicide attempt.
  - Participants in the cognitive therapy condition made significantly fewer suicide attempts over the 18-month follow-up period
Dialectical Behavior Skills (DBT)

- Evidence-Based Practice for Borderline Personality Disorder (Linehan and colleagues)

- Skills taught include:
  - Distress Tolerance
  - Mindfulness
  - Emotion Regulation
  - Interpersonal Effectiveness
Dialectical Behavior Therapy (DBT)

- Developed by Dr. Marsha Linehan
- Over 25 years of research
- DBT was originally developed to treat suicidal patients
- Evolved into a treatment for suicidal patients with Borderline Personality Disorder
- Adapted for the treatment of BPD patients with presenting problems other than suicidal behaviors
Dialectical Behavior Therapy (DBT)

- Hierarchy of treatment targets
  - 1) life-threatening behaviors (primarily suicidal and self-injurious behavior)
  - 2) therapy-interfering behaviors (e.g., poor attendance),
  - 3) severe quality of life-interfering behaviors (e.g., frequent use of crisis services, substance abuse)
Dialectical Behavior Therapy (DBT)

Components to full treatment protocol:

- Individual therapy focuses on increasing client motivation
- Group skills training teaches basic capabilities
- Phone coaching
- Therapist consultation team
Dialetic

- “dialectic”: the synthesis of two opposites
- Fundamental principle of DBT:
  - Create a dynamic that promotes two opposed goals for patients: change and acceptance.

Dilemma...

- Finding effective treatment for suicidal patients
- Want to be dead but don’t have the skills to create a life worth living?
DBT with and without substance use problems

- Does DBT work in a mixed population of borderline patients with or without comorbid substance abuse (SA)? **YES**
- Does standard DBT work to reduce severity of substance use problems? **NO**
- Need to adapt DBT to pathology across the impulse control spectrum, including suicidal and self-damaging behaviors, binge eating, and substance use behaviors
  
  (van den Bosch et al, 2002)
DBT Adapted to Address Substance Abuse

- Key modifications include:
  - Address application of dialectics to abstinence
  - Substance abuse behavioral targets
  - Attachment strategies for difficult-to-engage and easily lost clients

- Research with patients with comorbid BPD and substance use have found:
  - Completion of treatment
  - 6 month abstinence markers

  (Dimeff, Rizvi, Brown, & Linehan, 2000)
Dialectical Behavior Therapy for Substance Abusers

DBT’s substance-abuse–specific behavioral targets include:

- Decreasing abuse of substances
- Alleviating physical discomfort associated with abstinence and/or withdrawal
- Diminishing urges, cravings, and temptations to abuse
- Avoiding opportunities and cues to abuse
- Reducing behaviors conducive to drug abuse
- Increasing community reinforcement of healthy behaviors
Dialectical Behavior Therapy for Substance Abusers

- **Establishing Abstinence Through Promoting Change**
  - Commit to a length of abstinence that the patient feels certain is attainable
  - “Cope Ahead”—behavioral skill of anticipating potential cues in the coming moments, hours, and days, and then proactively preparing responses to high-risk situations that otherwise might imperil abstinence

- **Supporting Abstinence by Encouraging Acceptance**
  - Making a behavioral analysis of the events that led to and followed drug use, and gleaning all that can be learned and applied to future situations

- “Addict Mind” vs. “Clean Mind” → “Clear Mind”
DBT for Substance Use & Suicidal Behaviors

Dialectical Behavior Therapy for Substance Abusers
by Linda A. Dimeff & Marsha M. Linehan

Dialectical Behavior Therapy with Suicidal Adolescents
by Alec L. Miller PsyD, Jill H. Rathus Phd, Marsha M. Linehan PhD ABPP and MD Charles R. Swenson
RESOURCES

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Out of the DARKNESS
COMMUNITY WALKS
American Foundation for Suicide Prevention

PRESS “1” FOR VETERANS
Web-based resources for kids/teens

Report Suicidal Content

IMPORTANT: If you have encountered a direct threat of suicide on Facebook, please immediately contact law enforcement or a suicide hotline.

Full name of the person who posted the content: [input field]

Please include the exact first and last name as it appears on Facebook:

Web address (URL) leading to his/her profile or search listing: [input field]

Additional relevant information: [input field]

[Submit] [Cancel]


References


