Beyond the hospital protocol: Responding to suicidal ideation

Presented by

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Special thanks to

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Disclosures

Dr. Whited and Dr. Hughes have no relationships with entities that are relevant to this presentation to disclose.

Learning Objectives

1. Participants will learn strategies to initiate conversations with patients in cardiopulmonary rehabilitation who screen positive for suicidal ideation.
2. Participants will learn less well-known risk factors for a suicide attempt.
3. Participants will be able to describe action steps for supporting suicidal patients that go beyond an emergency psych referral.
4. Participants will develop at least one action item to implement upon returning to their cardiopulmonary rehabilitation site.

Suicidal ideation and CVPR

- People with COPD are 2X likely to die by suicide than people without COPD.
  - Sampaio, M.S., Vieira, W.A., Bernardino, I.M., Herval, A.M., Flores-Mir, C., Paranhos, L. R., 2019. Chronic obstructive pulmonary disease as a risk factor for suicide: a systematic review and meta-analysis. *Respir. Med.* 151, 11–18.
- People with cardiac disease are also at elevated risk.
  - Alias A, Bertrand L, Bisson-Gervais V, Henry M. Suicide in obstructive lung, cardiovascular and oncological disease. *Preventive Medicine: An International Journal Devoted to Practice and Theory*. 2021;152(Part 1). doi:10.1016/j.ypmed.2021.106543
  - Moazzami K, Dolmatova EV, Feurdean M. Suicidal ideation among adults with cardiovascular disease: The National Health and Nutrition Examination Survey. General hospital psychiatry. 2018;51:5-9. doi:10.1016/j.*genhosppsych*.2017.12.001

Suicidal ideation and CVPR

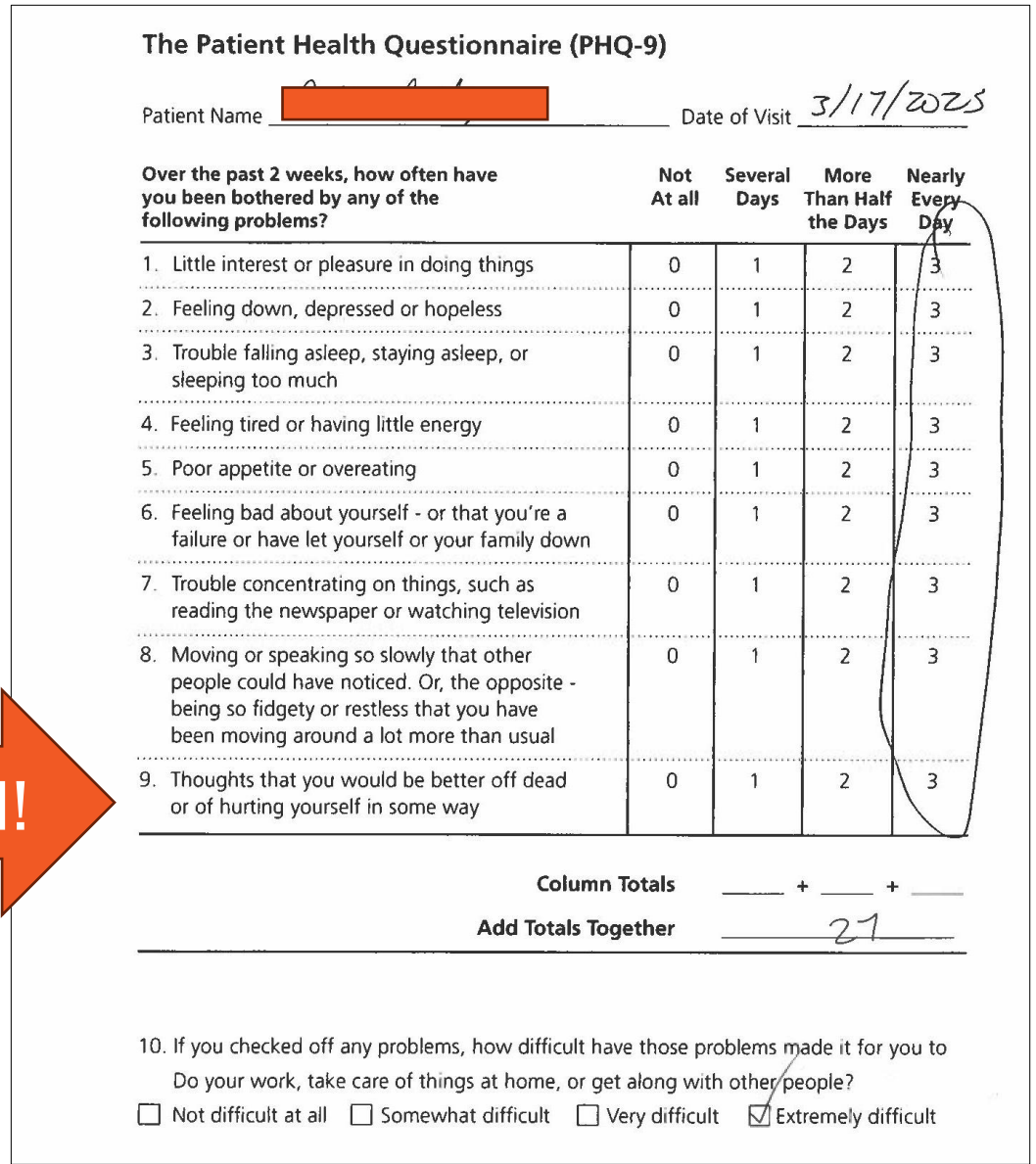
- For cardiac disease:
  - Suicidal ideation (SI) is 10-17% (vs. 2% in the general population).
  - SI is typically *passive* (80% vs. 5% in the general population) as opposed to *active.*
  - Risk is highest shortly after the cardiac event *(i.e.,* when they would enroll in CR).
  - Risk is *much higher* in patients with pre-existing psychiatric conditions.
  - No studies reported whether SI is lower in patients who enroll in CR than those who do not.

E, Annunziato RA, Rubinstein D, et al. Screening for depression and suicidality in patients with cardiovascular illnesses. *The American journal of cardiology*. 2009;104(9):1194-1197. doi:10.1016/j.amjcard.2009.06.033

Imagine this scenario during a routine intake

- Peter's PHQ-9…
  - Item 9 "Thoughts that you would be better off dead or of hurting yourself in some way."

Nearly *every day*! That can't be good!



The Patient Health Questionnaire (PHQ-9)

Patient Name [redacted] Date of Visit 3/17/2025

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals ____ + ____ + ____

Add Totals Together 21

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☑ Extremely difficult

Suicidal ideation and CVPR

- Yes, there is risk – but it is nuanced.
  - Much SI is *passive*
  - Possibly high false positives
  - Fear of being wrong or doing the wrong thing
- Follow the hospital protocol
  - Go *beyond* the hospital protocol to provide better care
    - It's not hard!

Let’s Review

Myths and misconceptions about suicide assessment and prevention

Contributed by Dr. Ashley Griffith.
Psychology Postdoctoral Fellow
Rocky Mountain MIRECC for Suicide Prevention
U.S. Department of Veterans Affairs

Myths and Misconceptions

- Talking about suicide increases the chance a person will act on it.
  - Talking about suicide decreases stigma and opens up communication. Thinking seriously about dying by suicide is a temporary state and talking can help a person consider other courses of action.
- People who talk about suicide are just seeking attention.
  - It is risky to be dismissive of people who talk about wanting to die.
- Suicide cannot be prevented.
  - People have autonomy to make their own decisions and we cannot control them in this. At the same time, SI is a temporary state and we can note signs of people experiencing suicidal ideation and intervene to help them through this state.

Myths and Misconceptions

- People who take their own lives are selfish, cowards, or weak.
  - People who attempt suicide typically have reached the end of a long series of attempts to end their suffering. They perceive other solutions as ineffective and/or feel that continuing to live only brings intolerable suffering.
- Teenagers and college students are most at risk for suicide.
  - Suicide is a problem among all ages and group, but this group actually has a lower risk than the national average. Risk tends to increase with age. Some groups have a particularly high risk (e.g. LGBTQ+ especially transgender individuals).
- Barriers to bridges, safe firearm storage and other actions to reduce access to lethal methods of suicide don’t work.
  - This is actually a key prevention strategy.

Myths and Misconceptions

- Suicide always occurs without warning.
  - There are almost always verbal or behavioral warning signs in retrospect. This is another reason talking about suicide is important.
- Talk therapy and medications don't work.
  - Treatment for mental health issues is part of long term suicide prevention
- Suicide only affects individuals with a mental health condition.
  - Many other stressors are associated with suicide. Only about half of those who die by suicide have a mental illness.
- Once an individual is suicidal, he or she will always be suicidal.
  - Suicidal ideation is temporary and situation-specific. Reducing the distress leading to SI reduces SI.

The Typical Hospital Protocol

The typical protocol

- Identify patients at risk with a screening measure or observation
  - e.g., PHQ-9 ← most cardiopulmonary rehab programs use the PHQ-9.
- Proceed with a formal assessment based on apparent risk level
  - e.g., Colombia Suicide Severity Rating Scale
  - Less structured assessment aimed at assessing

    Ideation → Intent → Plan → Access to means

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

"Item 9"

Imagine this scenario during a routine intake

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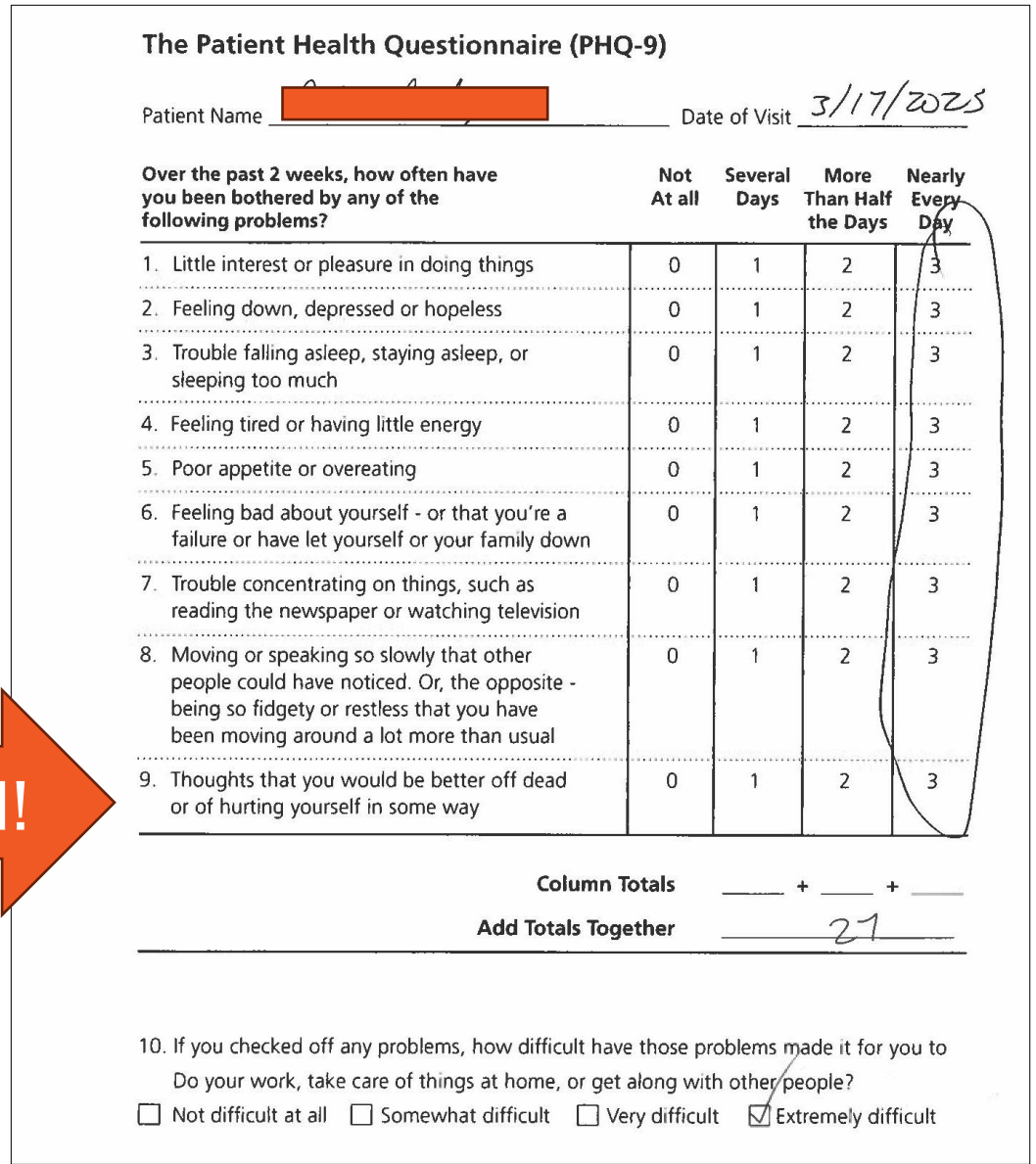

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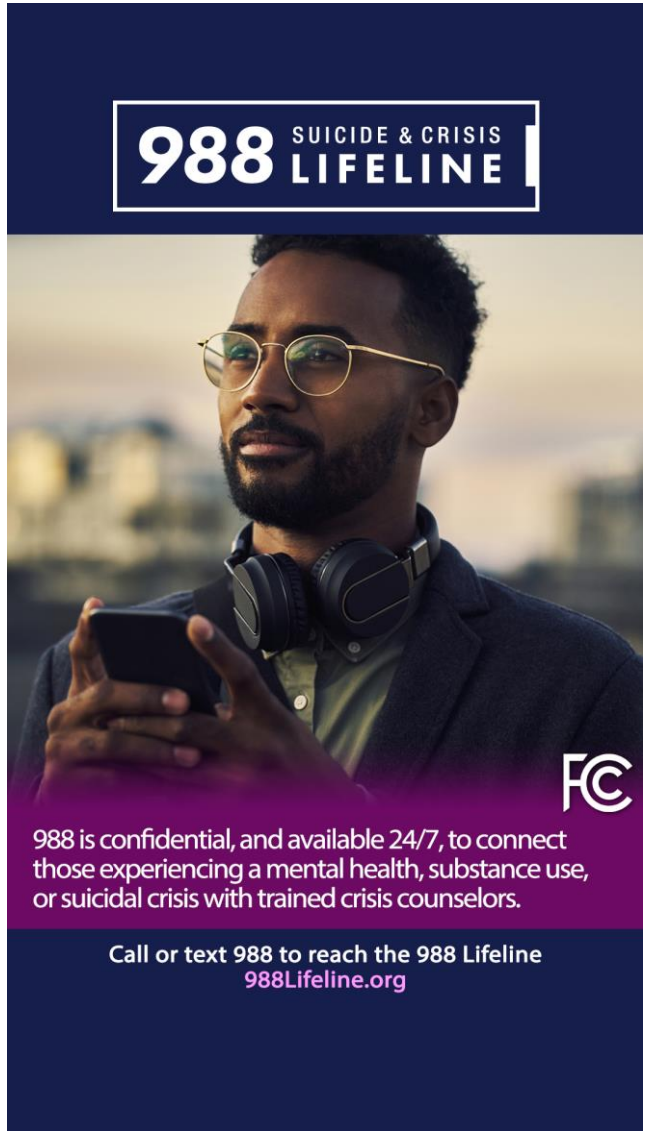
Colombia Scales

- There are more and less thorough versions that assess associated risk factors to a varying degrees. There are also different versions for different settings (e.g., community, health care, etc.)
  - Fuller version with risk factors, protective factors, and specific assessment of thoughts, plans, intent:
    - https://cssrs.columbia.edu/wp-content/uploads/SAFE-T-Protocol-w-C-SSRS-and-Columbia-RP-Factors-Lifetime-Recent-2023b.docx

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Life-time**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**		**High Risk**

What has the government provided?

- Today, “988” is the three-digit, nationwide phone number to connect directly to the 988 Suicide and Crisis Lifeline.



Beyond the Hospital Protocol

Assessment

SI specific screeners do exist

- e.g., Beck Scale for Suicidal Ideation

- ….but an interview-based assessment is needed at some point anyway and typically gets at the same questions.

- Review of SI screeners and future challenges
  - https://www.researchgate.net/publication/229054594_A_review_of_suicide_assessment_measures_for_intervention_research_with_adults_and_older_adults

Non-traditional risk factors

- These are factors to both be aware of as risk factors, and also to incorporate into SI assessment.
- Ideally assessing these factors moves you beyond impersonal (but necessary!) screening measures to a connected conversation.
- 3 newer models of SI
  - No model is perfect or comprehensive because SI is complex and highly dependent on the individual and their situation.
  - Don’t worry about “which is the best theory”.
  - Focus on **“What can I learn from this model?”**

The Interpersonal Theory of Suicide

- Suicidal desire emerges when individuals experience intractable feelings of **perceived burdensomeness** and **thwarted belongingness** and that near-lethal or lethal suicidal behavior occurs in the presence of suicidal desire and **capability for suicide**.
  - Perceived burdensomeness: Perception (miscalculation) that death is more beneficial to others than continued life.
  - Thwarted belongingness: Loneliness and lack of reciprocity in care/support
  - Hopelessness: Belief that the above two won't get any better.
  - Capability for suicide: History of experiences that lower fear of death and increase physical pain tolerance.

Chu, C., Buchman-Schmitt, J. M., Stanley, I. H., Hom, M. A., Tucker, R. P., Hagan, C. R., ... & Joiner Jr, T. E. (2017). The interpersonal theory of suicide: A systematic review and meta-analysis of a decade of cross-national research. *Psychological bulletin*, *143*(12), 1313.

The Interpersonal Theory of Suicide

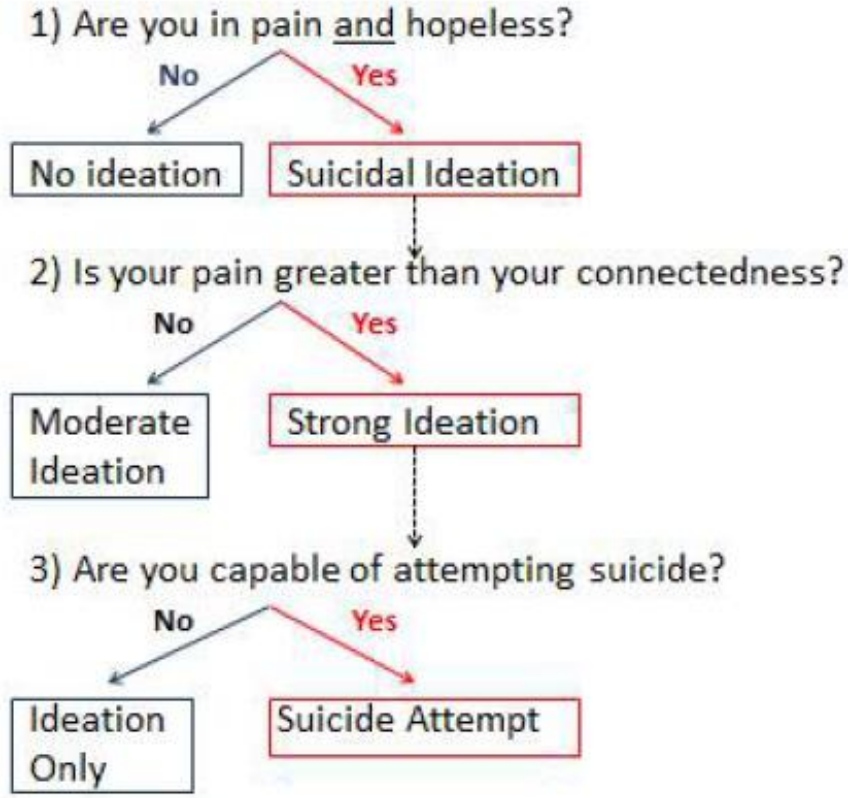
- Research Findings
  - Moderated by traditional risk factors
    - Depression symptoms
    - Demographics
  - Stronger associations between belongingness and burdensomeness with SI/attempts/etc. than capability.
  - Traditional Risk factors are about as strong of predictors as these
  - Risk factors may not interact exactly as predicted

Assessing Factors within the Interpersonal Theory of Suicide

- Perceived burdensomeness: “Do you feel valued by the people in your support network?” “Are you feeling like too much of a burden to the people around you?”
- Thwarted belongingness: “How are things at home and in your social life?” “Do you feel like you’re getting support from your support network?”
- Hopelessness: “Where do you see things going from here?” “Do you feel your health/life is improving?”
- Capability for suicide: “Have you had experiences where you had to endure a lot of pain or where you felt you were going to die?” “Do you have chronic pain?”
  - Note that this will likely elicit information about trauma history.

The Three-Step Theory of Suicide

- Suicidal ideation results from a combination of emotional pain and hopelessness.
- Connectedness (Meaningfulness) is a protective factor.
- Capacity is determined by a combination of dispositional, acquired, and practical factors
  - Dispositional: fear of pain or death
  - Acquired: above has decreased over time
  - Practical: access and knowledge



Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy*, *8*(2), 114-129.

The Three-Step Theory of Suicide

- Research Findings
  - Not as extensively researched
  - Some strong evidence in one study for interaction between Pain and Hopelessness predicting SI and attempts, with Connectedness as protective.
  - Not strong substantiation of the decision-making process of weighing
    - (pain x hopelessness) > or < connectedness?
  - Noticeable overlap with interpersonal theory
    - This isn't the perfect theory, but also we're on to something if these factors are showing up repeatedly

Assessing Factors within the Three-Step Theory of Suicide

- Pain: “We know that often emotional pain can be as powerful as physical pain. Have you been experiencing emotional pain recently?”
- Connectedness: “How connected do you feel to your (support network, family, work, friends, etc.)?” “What does this connection look like?” “How does this connection make you feel?”
- Capacity: “Can you me about your tolerance for pain (emotional and physical)?” “Has that changed over time?”
  - You can also assess for access to means and ability to attempt suicide. You’ll see this in safety planning later on.

The Cultural Theory and Model of Suicide (4 Components)

1. Cultural Sanctions: messages of approval or acceptability supported by one's culture
   - Acceptability of suicide as an option
   - Unacceptability and shame associated with life events
2. Idioms of distress: One's likelihood to express suicidality, means of expression, chosen methods
   - Interesting that some "common knowledge" pertains to whites more than blacks (e.g. lower relation to depression among blacks, lower drug use among blacks, hopelessness connected to whites, etc.)
   - Non-firearm means primary among some groups, drugs more prominent among some minority groups.

Chu, J. P., Goldblum, P., Floyd, R., & Bongar, B. (2010). The cultural theory and model of suicide. *Applied and Preventive Psychology*, *14*(1-4), 25-40.

Example Idioms of Distress from Chu. Et al.

- African Americans
  - Hopelessness linked to lower reasons for living in Whites but not Blacks, other than Blacks with a less “African-centered” world view (Walker et al., 2010)
  - Suicide deaths related with heavy drinking and depression in Whites but not Blacks (Kung et al., 2005)
- Asian Americans
  - Impulsive, antisocial, and undercontrolled behaviors unrelated to risk among Asian youth (Lau et al., 2002)
- Latino/as
  - Suicide methods different between Cuban-born (42% hanging and 48% gunshot) versus American-born (74% gunshot) Cuban elderly male decedents (Llorente, Eisdorder, Zoewenstein, & Zarate, 1996)

Example Idioms of Distress from Chu. Et al.

- Sexual minorities (LGBTQ)
  - LGB youth attempters worried more about excessive alcohol use. Attempt methods included: 70% drug overdose, 7% knives, 6% razor blades, 7% cars, 4% alcohol abuse, and 2% guns (D'Augelli & Hershberger, 1993).
- Literature with more than one cultural minority group
  - White suicide decedents more likely to have depression or bipolar disorder;
  - Blacks decedents more likely to have schizophrenia.
  - Latino decedents more likely than Black and White decedents to have substance abuse without comorbid mental health problems.
  - Black decedents lower on alcohol use, and Whites had less cocaine but more antidepressants and opiates (Karch et al., 2006)

The Cultural Theory and Model of Suicide (4 Components)

3. Minority Stress: Stresses cultural minorities experience because of social identity or position (acculturation, discrimination-related strain, social disadvantages)
   - Interesting that being out was not necessarily a protective factor
4. Social Discord: Conflict, lack of integration, or alienation from family/community/friends

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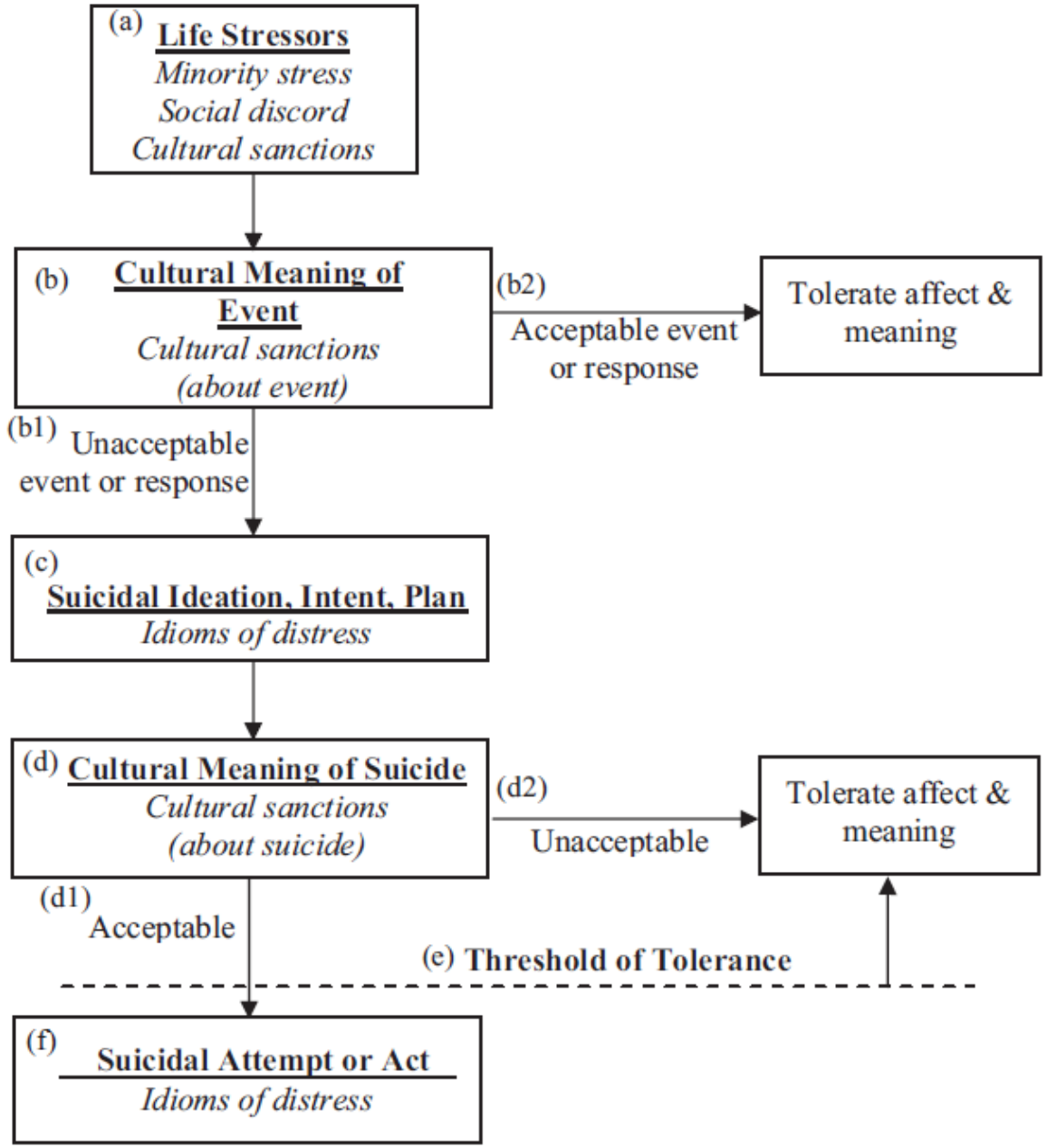
(a) Life Stressors
Minority stress
Social discord
Cultural sanctions
(b) Cultural Meaning of Event
Cultural sanctions
(about event)
(b2) Acceptable event or response
Tolerate affect & meaning
(b1) Unacceptable event or response
(c) Suicidal Ideation, Intent, Plan
Idioms of distress
(d) Cultural Meaning of Suicide
Cultural sanctions
(about suicide)
(d2) Unacceptable
Tolerate affect & meaning
(d1) Acceptable
(e) Threshold of Tolerance
(f) Suicidal Attempt or Act
Idioms of distress

The Cultural Theory and Model of Suicide

- Research Findings
  - The model itself emerges from literature reviews that include studies where culturally minorities are adequately represented.
  - As noted, there are situations where traditional (and even non-traditional) risk factors apply differently to specific cultural minorities.
  - Much of the predominant research and theory has been developed with data from predominantly White samples.
  - Further research is needed to identify prominent risk factors and replicate prior findings.

Assessing Factors within the Cultural Theory and Model of Suicide

- Read the article and review the tables to get a better appreciation for what people from other cultures may be experiencing that you are unlikely to assume. (Search for the title in Google Scholar for a free .pdf).
- Cultural Sanctions: “How do you think other people in your life would feel about these thoughts (SI) that you are having?” “Are you experiencing a lot of guilt or shame over something that’s happened?”
- Idioms of Distress: Ask questions based on what you know of the person’s culture and the specific things that may be missed.

Assessing Factors within the Cultural Theory and Model of Suicide

- Minority Stress: “People from different cultures can experience stress from many different directions. I’m wondering if there are things causing you stress that are particularly due to your cultural background?” “To what extent do you experience XYZ on a regular basis”.
  - “When I say Culture, I’m thinking about things like race, religion, age, the way we were raised, where we live, things like that.”
- Social Discord: “How is your social life, community, and family relationships?” “Are you experiencing any major conflicts or feeling alienated?”

Beyond the Hospital Protocol

Suicide Prevention

Safety Planning

The typical protocol

- Identify patients at risk with a screening measure or observation
- Proceed with formal assessment based on apparent risk level
- Options are not typically vast
  - Referral to mental health care provider
    - If there is one in-house you are at a supreme advantage here!
  - Referral to psychiatric ED
  - Determination that no actions are needed
- What's missing here are actionable solutions in-between doing nothing and hospitalization.

Safety planning

- A safety plan is a written list of sequential coping strategies that a patient can employ when they are experiencing suicidal ideation or intent.
- It is meant to reduce risk and put a patient in contact with resources to help them tolerate these feelings and ensure their safety
- It is created collaboratively with the patient using a form.

Walk through of a safety plan worksheet

- https://store.samhsa.gov/product/988-suicide-crisis-lifeline-safety-plan-pads

SAMHSA
Substance Abuse and Mental Health Services Administration

- https://www.healthquality.va.gov/guidelines/MH/srb/

U.S. Department of Veterans Affairs

Consider a 7th step…

- List your reasons for living!

Beyond the Hospital Protocol

Self Care

Self Care

- A common reaction to anxiety/worry is *avoidance*. Don't let concerns regarding patient SI and intent persuade you to *avoid* assessing and intervening!
- Even brief training can boost self-confidence and comfort level.
  - Wakai S, Schilling EA, Aseltine RH Jr, et al. Suicide prevention skills, confidence and training: Results from the Zero Suicide Workforce Survey of behavioral health care professionals. SAGE open medicine. 2020;8:205031212093315 2. doi:10.1177/205031212093315 2

Self Care – when you encounter *distressing* SI/intent

- Focus on what you *can do* (or have done), not what you can't (or didn't).
- Give yourself permission to feel. It's natural to care.
- Talk about it – when you're ready.
- Get support – you are part of a healthcare team.

Self Care – when a patient self-harms or dies by suicide

- A patient suicide can adversely affect healthcare providers.
  - Grief, anger, disbelief, betrayal, guilt, loss of self-confidence, powerlessness, etc.
    - Draper B, Kõlves K, De Leo D, Snowdon J. The impact of patient suicide and sudden death on health care professionals. General hospital psychiatry. 2014;36(6):721-725.

Self Care – when a patient self-harms or dies by suicide

- It's not your fault.
  - Suicide is *very* hard to predict.
    - Franklin JC, Ribeiro JD, Fox KR, et al. Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. Psychological bulletin. 2017;143(2):187-232. doi:10.1037/bul0000084
  - By itself, item 9 is not an accurate suicide screen.
    - Razykov I, Ziegelstein RC, Whooley MA, Thombs BD. The PHQ-9 versus the PHQ-8--is item 9 useful for assessing suicide risk in coronary artery disease patients? Data from the Heart and Soul Study. Journal of psychosomatic research. 2012;73(3):163-168. doi:10.1016/j.jpsychores.2012.06.001
    - Suarez L, Beach SR, Moore SV, et al. Use of the Patient Health Questionnaire-9 and a detailed suicide evaluation in determining imminent suicidality in distressed patients with cardiac disease. Psychosomatics. 2015;56(2):181-189. doi:10.1016/j.psym.2014.12.005
  - Some people with committed suicidal intent will never tell you (25-50%).

Presentation Take Away's

1. Be sure to assess for social stressors and people's sense of community and belongingness. Review other non-traditional factors you want to look out for.
2. People from different cultural minority groups may respond with SI to different stressors and be at higher risk for different means based on individual differences in stressors and cultural sanctions. Read the tables in the Chu article!
3. Print out some safety planning sheets so they are ready when you need them.
4. Take care of yourself, be kind to yourself, and know what your go-to ways to decompress are. You'll need them for more things than just working with patients with SI.

What questions do you have?