Richard McKeon

Advances in Psychotherapy –
Evidence-Based Practice

Suicidal Behavior

2nd edition

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Suicidal Behavior

About the Author

Richard T. McKeon, PhD, MPH, received his doctorate in clinical psychology from the University of Arizona, and a master of public health degree in Health Administration from Columbia University. He has spent most of his career working in community mental health, including 11 years as director of a psychiatric emergency service and 4 years as associate administrator/clinical director of a hospital-based community mental health center in Newton, New Jersey. He established the first evidence-based treatment program for chronically suicidal borderline patients in the state of New Jersey utilizing Marsha Linehan's Dialectical Behavior Therapy. In 2001, he was awarded an American Psychological Association Congressional Fellowship and worked for US Senator Paul Wellstone, covering health and mental health policy issues. He spent 5 years on the Board of the American Association of Suicidology as Clinical Division Director and has also served on the Board of the Division of Clinical Psychology of the American Psychological Association. He is currently Chief of the Suicide Prevention Branch for the Substance Abuse and Mental Health Services Administration in the US Department of Health and Human Services. In 2009, he was appointed by the Secretary of Defense to the Department of Defense Task Force on Suicide Prevention in the Military. He also serves as Co-Chair of the Federal Working Group on Suicide Prevention and participated in the development of the World Suicide Report for the World Health Organization

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Disclaimer

All opinions expressed in this book are those of the author alone and do not represent the views of the Substance Abuse and Mental Health Services Administration.

Dedication

This book is dedicated to the memory of my sister Kathy, who taught me how important it is to fight for every hour of life.

Contents

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Description

Suicide is a tragic end to an individual's life, a devastating loss to families and friends, a diminishment of our communities, and a public health crisis around the world. For clinicians, losing a patient to suicide is probably our worst fear. In 2018, over 48,000 Americans died by suicide (CDC, 2021) and suicide rates have increased in 49 of the 50 states (Stone et al., 2018). Worldwide, it is estimated 800,000 people die by suicide each year, more than are lost to homicide or to war (WHO, 2019b), leading the World Health Organization to issue the first world suicide report, *Preventing Suicide: A Global Imperative* (WHO, 2014), urging nations around the globe to adopt national suicide prevention strategies and programs. In addition, self-inflicted injury is estimated to account for 1.4% of the total burden of disease worldwide (World Federation for Mental Health, 2006). Yet, despite the magnitude of these losses, or perhaps because of the depth of our distress and uncertainty when confronted with acts of deliberate self-destruction, we have tended as a society to look away and not grapple with the issue of suicidal behavior, despite the tragic toll it exacts.

Worldwide, about 800,000 people die by suicide each year, more than are lost to homicide or to war

Kay Redfield Jamison has eloquently stated that in dealing with suicide, "The gap between what we know and what we do is lethal" (Jamison, 1999). In the two decades since Dr. Jamison wrote these words, we have learned much more, yet the lethal gap continues. In *Night Falls Fast,* her first-person account of her struggles with intense suicidal urges, she emphasizes the powerful link between mental illness and suicide, and the disturbing reality that the majority of those who die by suicide have never received mental health treatment (Jamison, 1999). Despite the fact that we know how to treat successfully many of the conditions that are risk factors for suicide, such as depression, substance abuse, and bipolar illness, so many of those who die by suicide never receive such treatment for these disorders (Luoma et al., 2002). When they do receive treatment, often this treatment does not focus on their suicidality, despite clear evidence that such a focus reduces suicidal behavior.

"The gap between what we know and what we do is lethal" (Kay Redfield Jamison)

While the gap between what we know and what we do is undoubtedly lethal, there is still much more that we need to know. For, example, we do not have controlled trial research that confirms that inpatient treatment is effective in preventing suicide, let alone under what circumstances hospitalization might be effective. We lack this knowledge even though reliance on inpatient hospitalization is a cornerstone of how almost all mental health systems respond to suicidal individuals. The face of inpatient psychiatric care in the US has drastically changed overtime and in a Cochrane systematic review published in 2014 high income countries around the world the lengths of stay for people with serious mental illness were found to have been reduced drastically

(Babalola et al., 2014) This has amounted to a major, uncontrolled experiment in how we treat suicidal people, yet we know little about the impact such massive changes have had. In addition, despite the fact that involuntary hospitalization laws across the United States utilize the concept of imminent risk, the research on acute risk factors for suicide measures risk in months, not in hours or days (Simon, 2006). While the emerging literature on predictive analytics for suicide is encouraging, it also speaks to suicide risk in months (Kessler et al., 2015). Predictive analytics may be most helpful by identifying those who are at significantly lower risk of suicide, and those who may become suicidal months in the future, rather than identifying those who will die by suicide in the coming hours or days. Simon (2006) has characterized imminent risk prediction as an illusion. Because of this, Hogan (personal communication, February 2020) has argued that we should stop chasing the illusion of individual prediction and focus instead on improving care for groups identified as at elevated risk. Just as cardiology focuses less on predicting when an individual will die from a heart attack, and more on focusing on reducing risk in high-risk groups, so too should mental health focus on improving care and intervention using the accumulating evidence we now have for groups who have been identified as being at elevated risk.

We need to focus on improving care for groups at elevated risk

We also need to know much more about how to successfully engage at risk people in treatment. The Utah Youth Suicide study showed that even though 44% of youth who died by suicide and had received psychiatric diagnoses had been prescribed psychotropic medication, upon autopsy none

of the youth were found to have either therapeutic or sub-therapeutic medication levels (Moskos et al., 2005), In the United States, the National Violent Death Reporting System has shown that while approximately half of women who die by suicide are receiving some type of mental health treatment, more than 70% of men are not (Niederkrotenthaler et al., 2014). Given the preponderance of suicides among males in the United States as well as in many other countries (Kapur & Goldney, 2019), this leads to the need to better understand what drives help seeking among men, particularly for mental healthcare and particularly when the depth of pain leads to suicidal thoughts or behaviors. This likely involves both men's interpretation of their own experience of suicidality as well as their views about the kind of help is available and its potential for alleviating their pain. How people at risk for suicide respond not only to the interventions we have but the way they can be accessed, and how we can promote collaborations to stay safe are also critical issues.

The field of suicide prevention has begun to advance the state of knowledge by examining the full range of suicidal behavior as an outcome variable, rather than focusing exclusively on deaths by suicide. Demonstrating reductions in deaths by suicide in controlled trials is very challenging because the number of participants in the study needs to be extremely large. For example, a WHO study that demonstrated reduction in death by suicide by an emergency room intervention and follow-up with those who had attempted suicide had 1,867 participants from five different countries (Fleischmann et al., 2008). Because suicidal ideation and attempts are much more common than death by suicide, research demonstrating the effectiveness of interventions are much more feasible. Both treatment and prevention studies have demonstrated reductions in suicide attempts (Allmon et al., 1991; Aseltine &

DeMartino, 2004; Brown et al., 2005; May et al., 2005). While some would argue that those who die by suicide are a very different population from those who attempt suicide, and that therefore findings based on research on suicide attempters cannot be generalized to those who die by suicide, research that highlights both the subsequent mortality and morbidity associated with suicide attempts (Beautrais, 2004) supports the importance of research focused on this population. Further, even though suicidal ideation by itself is not considered to be a strong predictor of death by suicide given that the overwhelming majority of people who think about killing themselves do not go on to die by suicide, suicidal ideation is invariably associated with intense pain and despair and such suffering deserves effective treatment in its own right. Suicidal ideation, suicide attempts, and death by suicide are closely linked clinical phenomenon even if they are found in overlapping and not identical populations. Only by considering suicidal ideation, suicide attempts and death by suicide together do we see the true scope and impact of suicidality nationally and worldwide.

Both treatment and prevention studies have demonstrated reductions in suicidal behavior

Advances in violence research focusing on imminent and near-term risk have taken place in part because of a willingness to look at violent behavior as a continuum, rather than focusing solely on homicide. As a result, findings with significant clinical implications, such as the ability to assess the risk of violent behavior on inpatient units at the time of hospital admission (McNiel et al., 2003), have occurred in violence research. Such findings in the violence risk literature suggest that while evidence identifying imminent risk for suicidal behavior may now be lacking, it may be possible to obtain this evidence, particularly if we include all suicidal behavior and not only fatal suicidal behavior.

Additional research has demonstrated reductions in suicidal thinking or in suicidal intent (Bruce et al., 2004; Gould et al., 2007). While reducing suicidal ideation or intent certainly does not assure a concomitant reduction in suicide attempts or in death by suicide, such cognitive phenomena are clearly very meaningful intermediate variables as they are very likely preconditions for suicide attempts or death by suicide.

The failure in the past, both nationally and internationally, to focus on suicide prevention has thankfully been changing. In a study of nations implementing national suicide prevention strategies, Lewitzka and colleagues (2019) showed a statistically significant decline in suicide in Norway, Sweden, Finland, and Australia compared to control countries. The decline was strongest in males, particularly ages 25–44 years and 45–64 years.

In 2001, the US Department of Health and Human Services, on behalf of a coalition of federal agencies and private nonprofit organizations, issued the *National Strategy for Suicide Prevention (NSSP).* In 2012, to capitalize on advances in suicide prevention over the past decade, a revised *National Strategy for Suicide Prevention* was released by the Office of the Surgeon General and the National Action Alliance for Suicide Prevention (US Department of Health and Human Services, 2012). WHO released its first suicide report, *Preventing Suicide: A Global Imperative*, in 2014, which called on nations to develop national programs or strategies for suicide prevention and highlighted efforts in nations as diverse as Japan, Scotland and Chile (WHO, 2014b). The Substance Abuse and Mental Health Services Administration