Effective Strategies for Treating Suicidality in Complex Female Cases

Jennifer Tucker, PhD, Jennifer Greenberg, MPH & Ruth Quah, MPH
Psychological Health Center of Excellence, Defense Health Agency, Silver Spring, MD

INTRODUCTION

- Nearly every suicidal individual constitutes a complex case, in many instances due to multiple diagnoses and numerous significant life problems
- Clinicians can become quickly overwhelmed by the breadth and depth of a suicidal individual's problems, which makes planning and guiding treatment difficult
- To help guide clinicians in their treatment plans, this poster will present strategies from two types of psychotherapy used to treat suicidal individuals: Cognitive Therapy for Suicide Prevention and Problem Solving Therapy
- Both types of therapy focus on identifying and changing maladaptive patterns of thoughts, emotions, and behaviors involved in suicidal crises and have shown some effectiveness in treating suicidality[1]
- While therapeutic objectives do not vary with the sex of the patient, the relative prevalence of risk factors may. Female military Service members may have increased suicide risk associated with sexual assault, domestic violence, and postpartum depression.

2010-2015 MILITARY HEALTH SYSTEM DATA

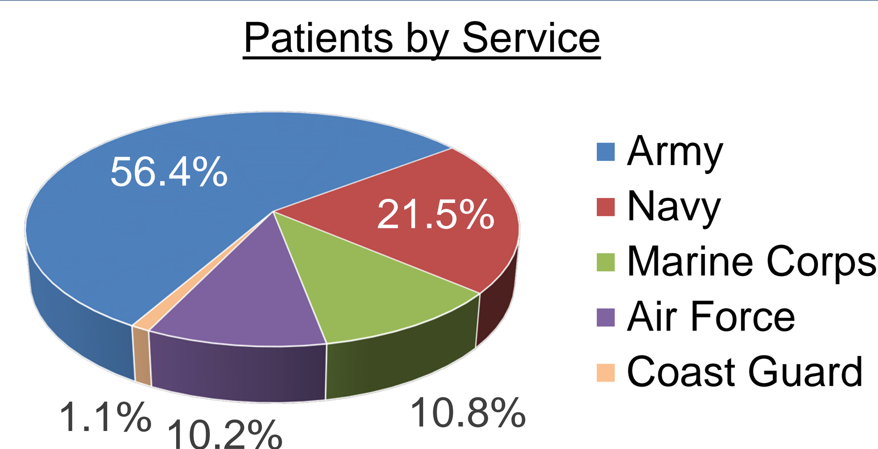
Female Active Duty Service Members Coded with Suicide Attempt or Self-Inflicted Injury (ICD-9 Code E95*)

Demographics (N=3,251)†

44.2% White, Non-Hispanic
24.7% Black, Non-Hispanic
15.1% Hispanic

65.1% aged 18-24 years
27.9% aged 25-34 years

95.9% Enlisted rank

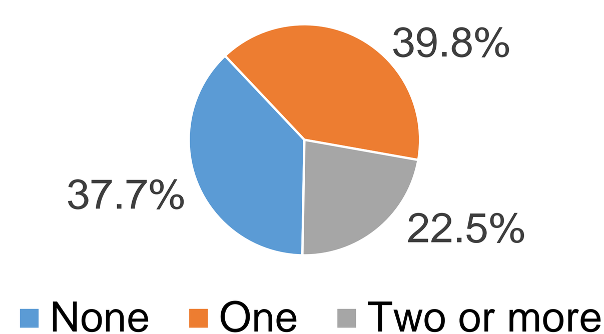


Method of Injury (Top 4)

64.1% - poisoning by a solid or liquid
24.6% - cutting and/or piercing
7.4% - unspecified methods
2.2% - hanging, strangulation, or suffocation

Psychiatric Diagnoses

Number of Psychiatric Diagnoses Per Patient at Index Visit



Top 5 Psychiatric Diagnostic Categories

At index visit		At 3 months	
30.9%	Depression	Adjustment Disorder	65.5%
21.4%	Adjustment Disorder	Depression	60.8%
9.1%	Alcohol Abuse	Anxiety	30.2%
7.0%	PTSD	Personality Disorder	22.6%
6.6%	Anxiety	PTSD	21.0%

Treatment Characteristics

56.5% of patients attended at least one outpatient behavioral health appointment in our health system within 3 months of E95* diagnosis

Median number of outpatient behavioral health appointments per patient = 24.0

Most frequently used behavioral health services: psychotherapy, group therapy, and therapy+medication sessions

None of the 58,991 outpatient appointments was coded with the Current Procedural Terminology (CPT) code for suicide risk assessment

COGNITIVE THERAPY FOR SUICIDE PREVENTION (CT-SP) AND PROBLEM SOLVING THERAPY (PST)

	CT-SP Techniques[2,3]	PST Techniques[4,5,6]
Overall Treatment Goal: Prevention of repeated self-directed violence in individuals with one or more previous suicide attempts		
Treatment Objectives	**Corresponding Strategies**	
1. Engagement, orientation to treatment, introduce collaboration, increase hope	**Psychoeducation about treatment** – includes ground rules, collaborative nature of treatment planning as well as the treatment itself, rationale for strategies and techniques to be used, instill hope for coping successfully with suicidal crises	
2. Recognize and identify suicidal triggers and warning signs	**Suicide narrative** – patient's suicidal crisis story with a beginning, middle, and end **Safety plan** – list of warning signs and corresponding coping skills **Case conceptualization** – understanding a suicidal crisis and its historical origins by exploring cognitive, emotional, and behavioral reactions to experiences	**Rational problem solving: Step 1 – define problems** using very specific language. Focus discussion on problems that seem unsolvable, cause the patient pain, keep her from reaching her life goals, and contribute to her suicidality
3. Choose targets for treatment	**Treatment planning** – clinician and patient determine which cognitive targets could have the greatest impact on changing the trajectory of a future suicidal crisis	**Rational problem solving: Step 2 – set goal** of a problem to solve in treatment. Help patient aim at a problem that serves as an obstacle to reaching an important, life-affirming goal
4. Teach strategies that ameliorate suicidal triggers (i.e., treatment targets)	Common strategies include **cognitive restructuring**, **distress tolerance**, **problem-solving**, **behavioral activation**	**Rational problem solving: Step 3 – generate solutions** that utilize a variety of strategies
5. Evaluate and adjust strategies	**Role play** and **homework** – used to practice and evaluate the effectiveness of learned strategies **Relapse prevention protocol** – the suicide narrative is re-told in order to place the patient in the crisis and the patient is instructed to practice the strategies learned in treatment in order to both gain mastery in using the strategies and confidence in maintaining safety	**Rational problem solving: Step 4 – choose the best solution** by predicting consequences of each solution and conducting a cost-benefit analysis of predicted outcomes **Rational problem solving: Step 5 – Implement the chosen solution** according to plan **Rational problem solving: Step 6 - Evaluate the solution** by monitoring the consequences of its implementation and determining whether problem-solving efforts were successful

RECOMMENDED BEST PRACTICES[1]

- To determine suicide risk level, conduct a complete risk assessment that includes risk and protective factors as well as warning signs
- When imminent risk is detected, maintain direct observation of the patient, remove access to lethal means, and escort to an appropriate care setting
- Work with the patient to create a safety plan during intake or the first therapy session as well as before hospital discharge
- Use recommended and effective treatments (e.g., CT-SP, PST)
- Make regular, caring contact between sessions with patients at risk for suicide
- Document the CPT code for suicide risk assessment (3085F) when appropriate

REFERENCES

[1]Department of Veterans Affairs & Department of Defense. (2013). VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide. Washington (DC): Department of Veterans Affairs, Department of Defense.

[2]Brown, G. K., Jeglic, E., Henriques, G. R., & Beck, A. T. (2006). Cognitive Therapy, Cognition, and Suicidal Behavior. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 53-74). Washington, DC, US: American Psychological Association.

[3]Ghahramanlou-Holloway, M., Neely, L. L., & Tucker, J. (2014). A cognitive behavioral strategy for preventing suicide. *Current Psychiatry*, *13*(8), 18-25.

[4]Reinecke, M. A. (2006). Problem Solving: A Conceptual Approach to Suicidality and Psychotherapy. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 237-260). Washington, DC, US: American Psychological Association.

[5]Barnes, S. M., Monteith, L. L., Gerard, G. R., Hoffberg, A. S., Homaifar, B. Y., & Brenner, L. A. (2017). Problem-solving therapy for suicide prevention in veterans with moderate-to-severe traumatic brain injury. *Rehabilitation psychology*, *62*(4), 600.

[6]Eskin, M., Ertekin, K., & Demir, H. (2008). Efficacy of a problem-solving therapy for depression and suicide potential in adolescents and young adults. *Cognitive Therapy and Research*, *32*(2), 227-245.

† Approximate number of female Active Duty Service members serving each year during this timeframe is 200,000. Source: 2010 Demographics Profile of the Military Community, http://download.militaryonesource.mil/12038/MOS/Reports/2010-Demographics-Report.pdf

Poster presented at the VA/DoD Women's Mental Health Mini-Residency conference in August, 2018. For more information, please contact Jennifer.Tucker@SalientCRGT.com. The views expressed in this presentation are those of the authors and do not necessarily represent the official policy or position of the Psychological Health Center of Excellence, Department of Defense, Department of Veterans Affairs, or any other US government agency. PUID 4923. UNCLASSIFIED