Dying Well: Overcoming the Risk of Suicide in Hospice Care

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Learning Objectives

- Identify primary risk factors for increased suicidality, particularly among the terminally ill population
- Identify and explore contributing emotional, psychosocial, and motivational factors leading to increased suicidality
- Distinguish the psychological differences between suicidality, ideation, and self-mutilation
- Describe predominant socio-cultural myths surrounding the psychology of suicide
- Explore effective clinical protocol for maintaining adequate assessment, prevention and intervention for suicidal hospice patients
Guiding Principles

- “The first task of therapy is to identify the locus of the client’s unbearable pain and to decrease the perturbation associated with that condition”
  - Edwin Schneidman, 1974

- “In the context of a caring relationship we assist the client (patient) in discovering their hurt and help them manage life’s challenges.”
  - Edwin Schneidman, 1970
Guiding Principles

- Effective counseling and therapy emphasizes an approach that focuses on treating the PERSON and NOT the BEHAVIOR.

- All Behaviors are Purposeful

- Nobody changes Behaviors without Motivation
The Statistics of Suicide

- 2012 Statistics: 40,600 deaths due to self-inflicted injury / suicide (CDCP)
- Tenth leading cause of death in the U.S. (12.5 per 100,000)
- 1) Heart Disease (596,577)
- 2) Cancer (576,691)
- 3) Chronic lower respiratory diseases (142,943)
- 4) Stroke (cerebrovascular disease) (128,932)
- 5) Accidents (unintentional injuries) (126,438)
- 6) Alzheimer’s Disease / Dementia (89,974)
- 7) Diabetes (73,831)
- 8) Influenza & Pneumonia (53,826)
- 9) Nephritis / nephrosis (45,591)
Total Deaths (2012) (In Thousands)

- Diabetes
- Influenza/Pneumonia
- Nephritis/nephrosis
- Suicide
- Heart Disease
- Cancer
- Chronic Respiratory Disease
- Stroke / Cerebrovascular
- Alzheimer’s / Dementia
- Accidents (unintentional)
- Diabetes
- Influenza/Pneumonia
- Nephritis/nephrosis
- Suicide
- Heart Disease
- Cancer
- Chronic Respiratory Disease
- Stroke / Cerebrovascular
- Alzheimer’s / Dementia
- Accidents (unintentional)
Suicide Rate by Age (2012) – per 100,000

Rate per 100,000

- 15-24
- 25-44
- 45-59
- 60-74
- 75+

Vertical axis: Rate per 100,000

Horizontal axis: Age groups
Suicide % by Identified Gender (2012)
Suicide Rates by Ethnicity (2012) – per 100,000

- White/Caucasian
- American Indian
- Pacific Islander / Asian American
- African American
- Latino/Hispanic

[VALUE] [VALUE] [VALUE] [VALUE] [VALUE]
Suicide Rate by State (1990-2010)
Primary Methods of Suicide (2012)

- Firearm: [VALUE]%
- Suffocation: [VALUE]%
- Poisoning: [VALUE]%
- Other: [VALUE]%

Legend: ▢ Firearm ▢ Suffocation ▢ Poisoning ▢ Other
The Statistics of Suicide

- Difficulty identifying cause of death / under-reported
- Approximately 1800 of the 39K deaths in 2011 were studied based on Psychological Autopsies (4.6%)
- Misrepresentation and distortion of data when learning about suicide through subjective bias
Risk Factors
Suicide and Hospice Patients

- Due to the significant degree of situational stressors, all hospice patients are at a higher risk of suicide than the general population.
- Many hospice patients are within the second highest risk of demographics for suicide (older White males, 75+ years).
- It is important to distinguish between a normal range of expressing wishes to die and active suicidality of initiating self-harm with the intent to die (e.g., passive ideation; active ideation).
Typical Risk Factors for Suicidality

- Family history of suicide (particularly if completed by same-sex parents); models an option for coping
- Previous attempts
- Poor coping ability; low stress tolerance
- Substance use or abuse
- Depression (history of symptoms or current symptoms)
- Significant life stressor (e.g., financial hardship; loss of relationship; chronic or terminal illness; traumatic experience)
- White males (16-30) & older White males (75+)
- Females make more attempts; males are more successful
- Suicidal behavior becomes a rationalized possibility when stressors produce a sense of loss
The Issue of Loss & Suicide

Demographic populations that are significantly vulnerable to an increased suicide risk have experienced multiple losses:

- Primary relationships / Survivor of suicide death
- Health
- Financial Security
- Social Definition
- Occupational Definition
- Self-Esteem
- Autonomy / Independence
Primary Correlations of Suicide Completion

- **Previous mental disorder**
  - Suicide rarely occurs outside the context of a mental disorder; 93-97% of suicide deaths linked with previously identified mental disorder

- **Social Stressors**
  - Suicide never occurs outside the context of a social stressor (based on reports of ψ autopsies since 1954)

- **Psychological vulnerability** (personality factors)

- **Previous attempt** that was disrupted
  - Suicide attempters rarely survive one attempt

- **Alcohol / Substance use** is a consistent correlation with increased suicide risk
The Psychology of Suicide
Suicide is Complex

“Suicide is the result of an untimely convergence of multiple psychiatric, psychological, social, environmental, occupational, cultural, medical, academic stressors that severely challenges an individual’s capacity to cope.”

– Edwin Schneidman, 1954

The expression of suicidality is idiosyncratic for each individual. It is the ultimate expression of an individual response to unbearable distress. There is no clear causality to suicide.
Contributing Emotions

- **HOPELESSNESS**
  - Situation-focused
  - Fatalistic Despair
  - The problem cannot be solved

- **HELPLESSNESS**
  - Self-referential
  - Severe self-devaluation/self-hate
  - I cannot solve the problem
Motivational Factors for Suicide

- **Attachment** – Those people and things with which we form a close emotional bond are our attachments (relationships, beliefs, activities, roles, identities).

  - Self-inflicted behaviors can result from problems with attachments (e.g., interpersonal loss). Suicidal gestures can be a “cry for help” in order to secure desired attachments.

  - A suicidal person might also be giving up on maintaining their attachments (as a motivation for living) and shift their attention from living to dying.
Motivational Factors for Suicide

- **Escape** – A suicidal impulse can result from feeling helpless against circumstances that are difficult to bear or tolerate emotionally.

- A suicide attempt might be a carefully calculated or an impulsively desperate act that signals a need to try to escape a constraining or helpless situation.

- When an individual’s emotional and psychological tolerance is so overwhelmed that the value of life is diminished, suicide can appear to be a practical alternative.
Motivational Factors for Suicide

- **Control** – the motivation to kill oneself can also result from a desperate attempt to exercise control over a situation in which she or he feels helpless.
- The intention is to remain in charge of some aspect of one’s life, no matter how narrow the limits.
- This need to be in control can include a desire to control other people through one’s own suicidal gestures.
- It is critical to be creative in our approach with hospice patients to see how we can instill in them a sense of control in relation to their dying process.
Motivational Factors for Suicide

- **Release** – Self-inflicted harm might also be a result of attempting to lessen an intolerable feeling of tension.
- Physical pain, or the sense of “bleeding,” by self-inflicted injuries can release the sensation of physical pain and psychological pressure.
- Identify the difference between self-harming mutilation and actual suicidality.
- In relation to hospice care, this emphasizes the critical importance of managing our patients’ experiences of pain (physical, emotional, spiritual).
Motivational Factors for Suicide

- Suicidal gestures might be expressed with an intention to live or an intention to die.
- Some gestures or attempts are enacted as a type of “life attempt” – to restore fractured relational attachments; to gain control; to release tension; to escape pain.
- Individuals that attempt to harm themselves as an intention to die have given up on finding a way to live – the attachments can’t be made; the tension can’t be released; the only conceivable form of having control or feeling escape is to physically die.
The “Danger Zone”

Suicide Risk

- Burdensomeness
- Loneliness
- Fearlessness
The Psychic Need to Experience Death

- James Hillman’s *Suicide and the Soul*
- Individual vs. Collective view of our “self”
- Suicide as an act of claiming independence and done with a privatized view of the self
- Viewing “self” as a individual expression of the collective
- Freud’s *thanatos* drive (or “death drive”)
- What is the “death experience” that the suicidal person’s psyche needs to experience?
- What is the psychological “death” that needs to be experienced without requiring a physical death?
Myths of Suicide
Myths of Suicide

- Myth: “Most suicides occur with little or no warning.”
- Rationalization: “If you can’t see suicide coming, there’s nothing anybody can do.”
- Truth: Most people communicate warning signs of how they are feeling about a situation that is moving them towards suicide.
- These warning signs might be in the form of verbal statements, physical signs, emotional reactions, or behavioral cues.
Myths of Suicide

- Myth: “You shouldn’t talk about suicide with someone whom you think might be at risk because you may give them the idea.”
- Rationalization: “It is best just to avoid it altogether.”
- Truth: Suicide cannot be passed from one person to another like a contagious disease. The best way to identify one’s intention of suicide is to ask directly. Open talk and genuine concern about one’s thoughts and feelings of suicide can often be experienced as a relief for that individual.
Myths of Suicide

- Myth: “People who talk about suicide don’t do it.”
- Rationalization: “There is no need to get involved with talkers.”
- Truth: People who attempt suicide usually talk about their intentions (although there are exceptions to this, of course). Four out of five people who commit suicide talk about it in some way with someone before they die.
Myths of Suicide

- Myth: “A suicidal person clearly wants to die.”
- Rationalization: “There’s no point in helping; they will just keep trying until they succeed.”
- Truth: Most suicidal people are ambivalent about living and dying, as well as their suicidal intentions right up until the point of death. Very few are absolutely determined or incorrigible about ending their life.
Myths of Suicide

- Myth: “Once a person attempts suicide, they won’t do it again.”
- Rationalization: “I don’t need to be concerned now; the attempt will be enough of a cure.”
- Truth: Most people who attempt suicide will attempt again. The suicide rate for those who have attempted before is 40-50 times higher than the general population rate.
Myths of Suicide

- Myth: “If a person has been depressed and suddenly seems to feel better, the danger of suicide is gone.”

- Rationalization: “It’s over. I won’t have to talk to them about suicide anymore.”

- Truth: The outcome of feeling good can actually be a sign that an individual’s conflict or ambivalence about choosing to kill themselves has lifted. For those with chronic or severe depression, increased energy actually gives them the ability to follow through with an attempt they might have previously not had enough energy to even try.
Myths of Suicide

- Myth: “If you are religious, you won’t kill yourself.”
- Rationalization: “All we need to do is get everyone attending church or help them see their spiritual potential.”
- Truth: While spiritual fulfillment might be the answer for some, it is not the answer for everyone. Each individual's set of psychological elements that protect them against suicide will vary.
The Different Faces of Suicide
Suicidality, Ideation, and Self-Mutilation

- ALL BEHAVIORS ARE PURPOSEFUL

- The psychological motivation is very distinct between suicidality, suicidal ideation, and self-mutilation

- SUICIDE: Attachment, Escape, Control, Release
Suicidality, Ideation, and Self-Mutilation

- The Suicide Ideator:
  - A person who has experienced:
    1). A traumatic event or chronic condition that creates ...
    2). Personally defined levels of unbearable emotional, psychological pain, which ...
    3). Defies the person's capacity to cope, and motivates them to ...
    4). Think about suicide/death to eliminate the pain.
Suicidality, Ideation, and Self-Mutilation

- The Suicide Ideator:
  - SI is a common experience for him/her
  - Never pathologize
  - All are vulnerable
  - Ambivalence regarding the wish to die
  - Openly communicates suicidal fears
  - Actively seeks counseling support
  - Excellent prognosis
  - Remain alert to any “disruptions” within the counseling/therapeutic relationship
Suicidality, Ideation, and Self-Mutilation

Ambivalent Suicide Ideators will often want to communicate about their suicidal fears. If they do communicate this, it is often without the intent of actually dying.

- They tend to communicate the following:
  1). Tell you what happened
  2). Tell you about the pain
  3). Tell you that they can’t cope
  4). Tell you they wish they were dead
Suicidality, Ideation, and Self-Mutilation

- DSM-5 definition of non-suicidal self-injurious behavior includes:
  - Cutting
  - Scarring
  - Slashing
  - Burning

These are all behaviors that bring varied levels of pain or harm to the body for the purpose of relief from psychological/psychiatric discomfort.

- Self-mutilation can be considered a suicide “protector”
Suicidality, Ideation, and Self-Mutilation

- People who self-mutilate are typically motivated by the following correlations:
  - Relief from Dissociative Conditions
  - Responding to Body Dysmorphic cognitions
  - Attempting to regulate intense feeling states
  - Responding to psychotic symptoms (internal stimuli)
  - Attempting to manage anxiety/depression
  - Avoidance of isolation and abandonment (attention-seeking behavior)
Assessing Risk
We assess suicide by degrees of lethality.

Lethality increases through the following criteria:

- Passive Ideation
- Active Ideation
- Vague Plan
- Specified Plan
- Identified Means
- Identified Time
- Identified Reason
Assessing Risk: Primary Profile of a Completer

- Male
- Caucasian
- Age: 75+
- Living alone and unemployed
- Suffering from depressive or anxiety-based disorder & substance use disorder with the purpose of self-medicating
- Does not seek treatment or support
- Extreme issues of fatalism, despair and self-devaluation
- No intent communication
- Visited PCP within six months of suicide
Assessing Risk: Suicide Attempts

- There is some gender variation among suicide attempters:
  - Female Dominant Behavior:
    - A potentially lethal act with the intent to die, but the activity is reversible and allows time for rescue (e.g., slashing, gassing, overdosing)
  - Male Dominant Behavior:
    - Often attempt through “irreversible” means that mitigate the possibility of interruption or rescue (e.g., firearm, hanging, jumping from a bridge)
Assessing Risk: Suicide | Homicide Profile #1

- An elderly male caring for an acutely ill intimate partner or spouse
  - The primary intent is suicide—not homicide
  - Feeling of hopelessness and helplessness
  - Homicide is rationalized as altruistic
  - Substance use (ETOH) is used as a previous coping strategy
  - Lifetime pattern of poor problem-solving and tendency for relational/emotional dependency
Assessing Risk: Suicide | Homicide Profile #2

- Homicide is the primary intent—not suicide
- Suicide is used to avoid anticipated consequences
- Demonstrates the need for control in relational experiences
- Demonstrates patterns of the following:
  - Social Isolation
  - Paranoia
  - Insecurity
  - Sense of Inadequacy
  - Pattern of violence to obtain needs
  - Emotional constriction
Interventions
Basic Treatment Interventions

- **Engage** the person in a conversation that focuses on his or her feelings (identify the “locus” of pain)
- **Identify** if the person is thinking about suicide or demonstrating a passive process of “letting go”
- **Inquire** about the reasons for and against suicide (developing discrepancy – must be identified by the patient)
- **Assess** the degree of risk for suicide at this point in time (consider lethality)
- **Prevent** the immediate risk by agreeing to a plan with the person (do not use the term “contract” in clinical documentation)
Basic Treatment Interventions

- Screening for History of Suicide Attempts:
  - “Has anyone in your family or close friends experienced a situation of suicide?”
  - “Can you share with me any experiences you have felt the urge to harm yourself on purpose?”
  - Explore the secondary gain (e.g., death, ideation, gesturing)
  - For previous attempts: “Help me understand why you are still alive” (explore the rescue narrative)
Basic Treatment Interventions

- DO NO HARM
- Safety Planning
- Crisis Planning
- Problem Identification – “The Locus of Pain”
- Problem Solving:
  - Mindfulness Skills
  - Stress Tolerance Skills
  - Emotional Regulation Skills
  - Personal Relationship Skills
Prevention & Protocol
Remain Familiar with Warning Signs

- Verbalized comments of despair or fatalism
- Anhedonia
- Morbid, shame-based preoccupation with the past
- Expressed apathy toward life and an anticipation toward death (very remote suicidal communication)
- Expressions of self-devaluation and self-hate
- Refusal to seek help
- Persistent Dysphoria
- Lacking capacity for future-forward thinking
Operational Suggestions for Managing Suicide Risk

- Include initial intake documentation of previous history of SI/SA & current presence of SI (psychosocial and/or nursing assessment)
- Develop additional High-Risk Assessment plan for high-risk patients
- Consider implementing an Emotional Pain Scale
- Establish multidisciplinary expectations regarding the monitoring of possible suicidality (all team members are responsible)
- Maintain regular discussion within IDT meetings regarding patients displaying potential suicidal risk
- Create a “decision-tree” process for determining appropriate interventions
Operational Suggestions for Managing Suicide Risk

- Administrator
- DPCS
  - Social Worker
  - RN Case Manager
  - Volunteer
- CHHA / CNA
  - Spiritual Counselor
  - Bereavement Counselor
- RN Case Manager
- Bereavement Counselor
- Volunteer
- Social Worker
- RN Case Manager
- Bereavement Counselor
- Administrator
- DPCS
  - Social Worker
  - RN Case Manager
  - Volunteer
- CHHA / CNA
  - Spiritual Counselor
  - Bereavement Counselor
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  - Bereavement Counselor
  - Administrator
  - DPCS
    - Social Worker
    - RN Case Manager
    - Volunteer
- CHHA / CNA
  - Spiritual Counselor
  - Bereavement Counselor
  - Administrator
  - DPCS
    - Social Worker
    - RN Case Manager
    - Volunteer
Operational Suggestions for Managing Suicide Risk

- Implementation of protocol for managing identified high-risk patients:
  - inquiry about access and presence of firearms in the home
  - family education
  - increased attention to subtle emotional and psychiatric symptomatic changes
  - consider consultation with psychiatrist, psychiatric nurse and/or psychologist
- Identify interventions that provide patient with increased sense of control
Operational Suggestions for Managing Suicide Risk

- Identify a trustworthy local cleaning agency that is available to respond promptly in case of an in-home firearm suicide.
- Assure prompt and ongoing debriefing for hospice team employees and staff (e.g., CISD process; regular staff support group).
- Establish QA tracking of patient demographics for identified High-Risk patients as well as confirmed SI among patients (e.g., high-risk patient profile data).
Hospice team protocol for managing suicide

- All hospice team members are responsible for monitoring suicide risk among our patients and their family members.
- Consider which team leader is most appropriate for immediate notification if any staff member has concerns about a patient or family members’ potential risk for suicide (DPCS, DFFS, etc.).
- Consider utilizing the hospice social worker as a primary team member for conducting a more thorough suicide assessment to determine the degree of risk and appropriate interventions.
- Maintain regular discussion about potential suicide risk during IDT meetings.
QUESTIONS
References


- Klott, Jack (2014). Suicide and self-mutilation: Stopping the pain. (Presentation provided in September 2014 on behalf of PESI, Inc.).

References


References