Questions from 'CDP Presents: Suicide Risk Assessment' Webinar 9/13/2017, answered by presenter: Sean Convoy, DNP, PMHNP-BC

1. ***Could the presenter say more about how information about the history of the base/units where you work translates into helping patients?***

   I commonly conceptualize military culture (and military subculture) as operating like a wolf pack. Therein, they are inclined to take care of their own ahead of self and see outsiders as threats until proven otherwise. I would argue that mental health providers (AKA *Wizards*) represent the ultimate outsider (until proven otherwise). Going back to the analogy that I offered during the lecture, military service members and veterans always carry their "remote control" and liberally use it when interacting with non-wolf pack members. Developing general military culture (e.g. larger military structure) as well as refined military subculture (e.g. specific command knowledge and military occupational specialties) competence brings with it the opportunity to be seen as less of an outsider which may reduce the risk of them muting you.

2. ***Can you list all of those titles of books again? Or have those in the resources?***

   Frankl, V. E. (1992). Man's search for meaning: an introduction to logotherapy. Boston, Beacon Press.

   Jamison, K. R. (1999). Night falls fast: understanding suicide. New York, Knopf.

   Shay, J. (1994). Achilles in Vietnam: combat trauma and the undoing of character. New York Toronto, Atheneum ;Maxwell Macmillan Canada ;Maxwell Macmillan International.

   Shay, J. (2002). Odysseus in America: combat trauma and the trials of homecoming. New York, Scribner.

   Styron, W. (1992). Darkness visible: a memoir of madness. New York, Vintage Books.

3. ***What will be the response when the client or patient says that nothing is helping or no one can help?***

   This is the response I usually encounter. As I eluded to in the presentation, the strategies that were introduced will not always be successful. One of the challenges associated with such a hopeless and helpless state comes from the notion that the patient has apparently accepted that the way they currently feel is the way they will always feel and we both understand this is not necessarily accurate. When a patient gets stuck in such state you can (1) challenge the premise which could sound like, "I can appreciate you feeling as if nothing is helping. That being said, would it be accurate to suggest that we have exhausted all possible avenues to get help?" You could also try to (2) temporalize the experience. It could sound something like this, "Do I understand you to mean that because you feel this way in the current moment that there is no hope for the future? If that is the case I need you to help me understand how that works." Lastly, you could try to (3) make the concept less absolute. That could sound like, "Help me understand what you mean when you say *nothing is helping* or *no one can help*." These 3 strategies aspire to soften the patient's rigidity of thought. Now, if they are locked in their intent this and other strategies will likely not work and you have to elevate care.

4. ***What are your thoughts on reframing the Warrior Ethos for a service member contemplating suicide? Projecting it in a manner that makes their mental health the mission?***

I think this is an inspired notion! The only potential challenge with this would be the patient accepting your premise. My instincts suggest to me that such an approach would be more easily accepted by a veteran that is now out of service than a service member who is still on active or reserve duty.

5. ***Can you please address strategies to get around the Silo Effect, specifically the confidentiality piece? When a patient has various providers i.e./ Case Manager, Clinician, Psychiatrist, Commanding Officer, Advocate etc., trying to get all together with HIPPA and other confidential information I feel like the Silo Effect is the reality. Curious of how to combat this?***

Super grateful for this question! Strategies are as follows: (1) create an opportunity for a specific discussion between parties (at risk for siloing) about the concept of siloing. Once individuals have been sensitized to the phenomenon they are more inclined to be mindful of its future impact, (2) have a standing - recurrent meeting between mutually treating providers in a practice or community about at-risk patients, (3) work with specific military units (and associated legal representatives) to develop a memorandum of understanding between the practice and command that outlines communication strategies for crisis situations & (4) with patient's consent, invite family members or loved ones into the clinical space to have open discussions about how patient is doing which creates opportunities for disclosure.

6. ***As the LGBTQ community tends to have a higher rate of suicide, can you speak to that in the military? I was in under don't ask don't tell, so it was a bit different than it was now***

I thought long and hard about this question because I had not really considered before now. My conclusion is that other than being sensitive to the unique risk factors associated with this population and aware of the mercurial political dynamic that seems to make a non-issue an issue (insert my liberal bias here), the strategies I have offered can be applied unchanged.

7. ***How do you intervene when substance abuse intersects with depressive suicide?***

Dual diagnosis presentations can have a profound impact on both the risk for harm as well as the potential utility of the risk prevention strategies offered in the webinar. While there is no universal approach in situations like this I would recommend that in the presence of substance (e.g. intoxication, withdrawal and general use disorder state): (1) concern for impulsivity should commensurately increase, (2) patient autonomy falls below patient/provider/public safety, (3) don't assume only one substance issue is in play, & (4) don't assume suicidality or homicidality will soften in the presence of sobriety. As clinicians, we can walk and chew gum at the same time. Consequently, we have to address both issues simultaneously and do so with safety serving as our guiding light.

8. ***If someone states they have nothing to live for and have done everything they want in life, what is the best response?***

I think context is important here. My approach would be different for an elderly patient who is struggling with a chronic illness versus a younger patient with an acute illness. If a patient stated that they have "nothing to live for" I would not be inclined to challenge the notion with a countervailing argument (e.g. "What about your children!"). Alternatively, I would ask them something like, "I'm not sure I understand what you mean by nothing to live for. Can you explain what you mean by that?" In this instance, I would try to engage them in a dialogue where they are giving me information as opposed to me trying to fill them with my (presumed) evidence to the contrary. If a patient said to me, "I have done everything I wanted to in life" I would be inclined to ask them to tell me what they have done. I try to ask more questions about living and loving than dying or avoiding pain.

9. ***What if they don't have time and have a terminal illness?***

Well, let me invoke the potential influence of my own counter transference before I answer. Also, be advised that my opinion here doesn't necessarily reflect the Centers for Deployment Psychology or the Cohen Network. When a patient has a terminal illness, I see the issue of suicide very differently. I bring you back to the discussion on the webinar about locus of control. I operate from the premise that it is all together possible to have a good death. I determine a good death as a process where the patient feels in control and has the opportunity to maintain dignity and obtain closure before passing.

10. ***Can pushing the suicide into the future be misconstrued to patients as it is ok to commit suicide?***

Grateful for this question! It is important to remember that this approach is premised upon the notion that the provider really has zero control over the patient. I think the question implies, to some degree, that we possess more control than we actually do. Let me invoke the story of Goldilocks and the 3 bears. If you remember, Goldilocks tried 3 bowls of porridge. One was *too hot*. One was *too cold*. And one was *just right*. When it comes to the provider trying to influence the patient we have to pick the *just right* porridge. If we are aggressive the porridge is *too hot*. If we are apathetic the porridge is *too cold*. If we are with them in the moment, demonstrate unconditional positive regard and acknowledge and invoke their locus of control the porridge is *just right*. It is critical to reinforce that using this approach requires regular follow up and active care.

Questions not addressed during the webinar:

1. ***Can you address how your use of the concept of control relates to how AA uses it? (in certain instances it requires the giving up of control)***

   Interesting question. My interpretation of control in the context of navigating suicide with patients, as informed by Jamison, was for the provider to acknowledge that he/she has very limited control over the outcome. Given this reality, it is likely more beneficial to establish/invoke/reinforce the patients sense of control and push the object of control (suicide) into the future (with obvious aggressive follow up). If I understand the question, you are speaking to AA Recovery Model, Step 3 (e.g. made a decision to turn our will and our lives over to the care of God as we understood him."). Therein, I can see how the concepts could be congruent. My interpretation, again informed by Jamison, is that the patient has control. My understanding of AA recovery is that God (however defined) has control. In either case, the provider is not in control (insert serenity prayer here).

2. ***In terms of reframing power, would you suggest against having the PT reflect on a time when things were better?***

   This is a tried and tested strategy. The only confounders here would be associated with the patient's ability to cognate in the present. Invoking past evidence of control as potential for current or future evidence of control implies that the patient can sufficiently do that kind of cognitive calisthenics during the period of inferred crisis. In certain circumstances (e.g. acute substance intoxication, substance withdrawal, acute or chronic cognitive impairment, psychosis, mania or extreme stress) this may not always be possible.

The SAFE-T link is bad. "Product SUICIDE not found." Sorry!

- https://www.integration.samhsa.gov/images/res/SAFE_T.pdf
- https://www.oqmeasures.com/measures/adult-measures/oq-45/
- https://www.nimh.nih.gov/news/science-news/2013/file_143902.pdf
- http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/