Clinical management of obsessions related to suicide and overlap with acute suicidality

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September 22, 2023

ROGERS Behavioral Health

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Disclosures

The presenter has declared that he does not, nor does his family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Recognize OCD patients for whom obsessions related to suicide are a primary part of the clinical picture, and how to apply at least two of the principles and procedures of ERP in such cases.
2. Differentiate symptoms of OCD related to suicide from symptoms of depression and acute suicidality, and to list at least two situations when ERP's tenets and procedures do and do not apply depending on clinical phenomenology.
3. Identify at least one situation when treatment should proceed in accordance with ERP protocols, and one when it needs to be modified to directly address acute suicidality and suicidal behaviors.

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What will be covered in this webinar

- Recognition of obsessions related to suicide and clinical application of ERP in such cases
- Differentiation of suicidal obsessions from acute suicidality, and clinical management of both
- Application of ERP and behavioral treatments for suicidality including safety planning when phenomenology of both OCD and suicidality are present

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Presenter subjectivities

Dr. Martin E. Franklin

Professional identities

- Clinical Director, Rogers Behavioral Health Philadelphia
- Associate Professor Emeritus, Penn Medicine
- Ph.D. in Clinical Psychology, 1993, University of Rhode Island
- Clinician, Clinical Supervisor, Researcher, Educator

Personal identities

- He/him/his
- Husband to Marlene, father of three young adults (Gwen, Delia, Ted)
- Possesses a disturbing amount of knowledge about baseball & its history

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Recognition of obsessions related to suicide and clinical application of ERP in such cases

Q&A Please use the Q&A feature to send your questions to the moderator.

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Guiding theory and principles of ERP for OCD

OCD criteria: Obsessions

- Unwanted thoughts or images that cause marked anxiety/distress
- Attempts to ignore, suppress or neutralize
- Not simply excessive worries about real-life problems
- Recognized as the product of one's mind
- ***Ego dystonic and avoided rather than elaborated upon***

OCD criteria: Compulsions

- Repetitive behaviors or mental acts performed in response to obsessions
- Aimed at reducing anxiety/distress or preventing dreaded event (e.g., contracting diseases)
- ***Cardinal feature:*** Compulsions neutralize unwanted thoughts and decrease associated negative affect

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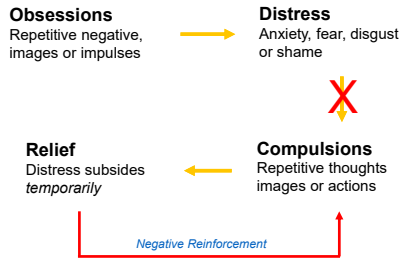
Mowrer's Two Factor Theory (1960): The OCD cycle



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Psychological Bulletin
1986, Vol. 99, No. 1, 20-35

0033-2909/86/$00.75

Emotional Processing of Fear: Exposure to Corrective Information

Edna B. Foa and Michael J. Kozak
Temple University

In this article we propose mechanisms that govern the processing of emotional information, particularly those involved in fear reduction. Emotions are viewed as represented by information structures in memory, and anxiety is thought to occur when an information structure that serves as program to escape or avoid danger is activated. Emotional processing is defined as the modification of memory structures that underlie emotions. It is argued that some form of exposure to feared situations is common to many psychotherapies for anxiety, and that confrontation with feared objects or situations is an effective treatment. Physiological activation and habituation within and across exposure sessions are cited as indicators of emotional processing, and variables that influence activation and habituation of fear responses are examined. These variables and the indicators are analyzed to yield an account of what information must be integrated for emotional processing of a fear structure. The elements of such a structure are viewed as cognitive representations of the stimulus characteristic of the fear situation, the individual's responses in it, and aspects of its meaning for the individual. Treatment failures are interpreted with respect to the interference of cognitive defenses, autonomic arousal, mood state, and erroneous ideation with reformation of targeted fear structures. Applications of the concepts advanced here to therapeutic practice and to the broader study of psychopathology are discussed.

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Anxiety treatment: Modifying the fear structure

Foa & Kozak (1986) posited that:

Two conditions are necessary:

1. Activation of the fear structure
2. Incorporation of ***incompatible*** information

This process is indicated by:

- Between-session decreases in fear
- Change in evaluations (cognitions)

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CBT: A succinct explanation

Blah, blah, blah, do the thing you're afraid of,

Blah, blah, blah, the more you do it the easier it gets…

~ Gwen Franklin, age 6, to her father

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Its application with specific obsessional content requires a "forest level" approach…

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CBT protocol for OCD

- Psychoeducation
- Cognitive training
- Mapping OCD: Development of treatment hierarchies
- Exposure and Response Prevention (EX/RP)
- Relapse prevention

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Cognitive behavioral treatment for OCD: Essential components

Exposure in vivo: Prolonged confrontation with anxiety-evoking stimuli (e.g., contact with contamination)

Imaginal exposure: Prolonged imaginal confrontation with feared images (e.g., buried alive, hitting a pedestrian while driving)

Response prevention: Blocking of compulsions (e.g., leaving school without checking locker repeatedly)

Cognitive methods: Correcting erroneous cognitions (e.g., "anxiety won't decrease unless I ritualize;" "If I don't check someone will break in and kill my family")

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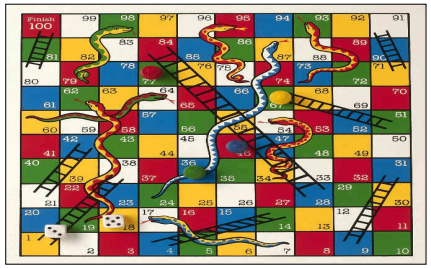
Climbing the exposure hierarchy



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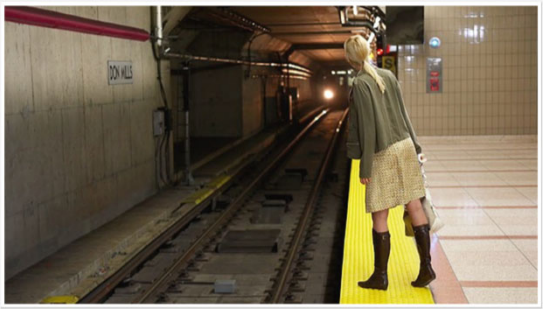

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ERP: You gotta go where the action is –

Well, to an extent…

- Intrusive images of classmate in high school yearbook
- Fear of being trapped in someone else's dream
- Intrusive images of being buried alive
- Intrusive thoughts of stabbing others in eye
- Fears of disrobing in public
- Images of eating human flesh

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Overcorrection:

Well, to an extent…

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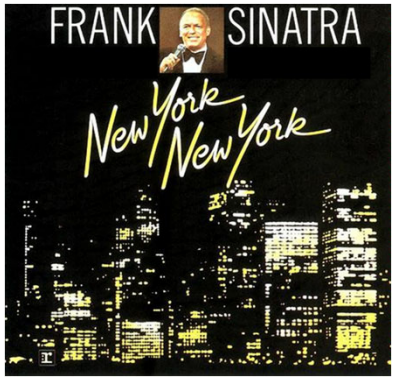
Here's another way to put it…



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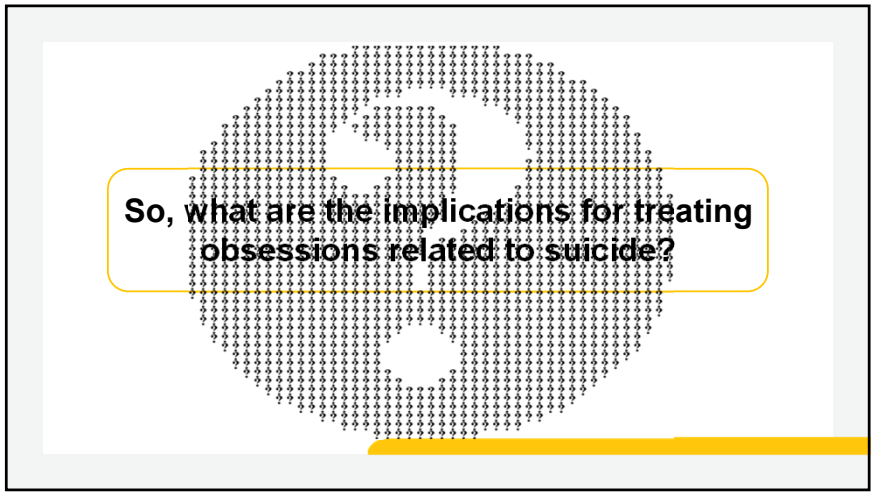

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Differentiation of suicidal obsessions from acute suicidality, and clinical management of both

Please use the Q&A feature to send your questions to the moderator.

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Clinical conundrum: Tricky content…

- Some content areas – *e.g., sexual, homicidal, other loss of impulse control thoughts, and suicide-related thoughts* – may be more difficult to conceptualize properly
- Need a functional analysis of the antecedents and consequences of particular thoughts and behaviors to see if OCD model applies
- If OCD doesn't apply, need to determine which conceptual model does apply and use that to guide treatment
- May have more than one type of thought in a given client

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Obsessions about suicide if:

- Thoughts are experienced as intrusive
- Primary affect is anxiety
- Behaviors are intentional efforts to neutralize or reduce thoughts and the associated anxiety
- Individual does not report an intent to die
- "What if?" language is used

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Suicidal ideation if:

- Intention to die is prominent
- Direct efforts to intentionally end one's own life
- Function is to escape negative affect; negative urgency
- Perceived burdensomeness
- Thwarted belonging
- Precautions taken against being discovered

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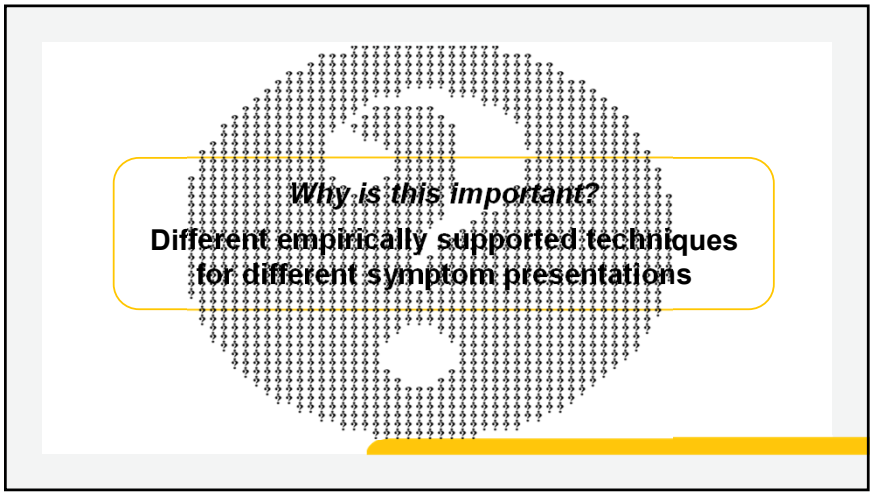

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Suicide and OCD

Storch et al. (2015):

- 36 to 63% of adults w/ OCD reported clinically significant suicidal ideation (SI) at some point
- 13% of a pediatric OCD sample reported current SI; associated with self-rated anxiety and depression as well as sexual/religious obsessions

Angelakis et al. (2015):

- Moderate to large effect links OCD and suicidality
- Associated w/ comorbidity, hopelessness, prior attempts

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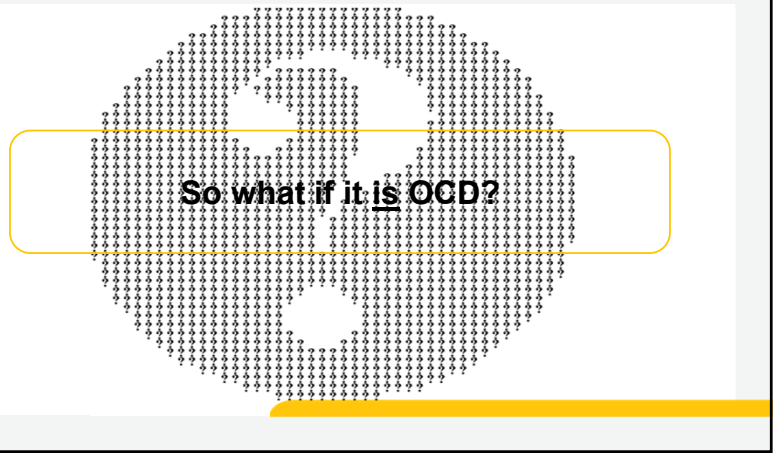

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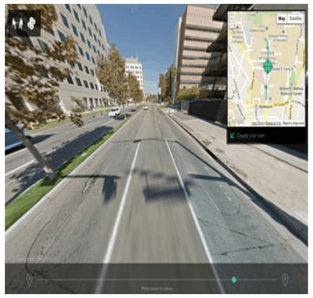
You've already got a map: Use it!



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Application of ERP and behavioral treatments for suicidality including safety planning when phenomenology of both OCD and suicidality are present

Please use the Q&A feature to send your questions to the moderator.

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ERP principles applied to obsessions about suicide: Encourage approach, reduce avoidance

- What increases likelihood of intrusive thoughts?
- What does the patient avoid to prevent thoughts?
- Create a map/hierarchy
- Climb the hierarchy and reduce compulsions/avoidance
- Teach theory, modify, and expand as needed
- Define progress, reduce abstinence violation effects
- Changing relationship to ALL obsessions, including these

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But what if it's *not* obsessional?

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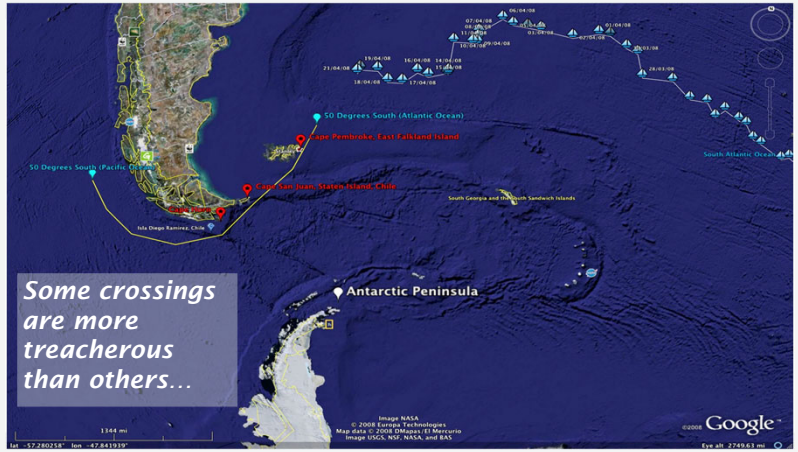

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So, you've concluded that your patient is suffering from suicidal ideation and is considering ending their life…

Now what?!?

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Phenomenology that just might give one pause…

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Drs. Greg Brown & Martin Franklin

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The AIM model

Assess • Identify and assess risk

Intervene • Use evidence-based treatments that directly target suicidal behavior

Monitor • Provide continuous contact and support

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Joint Commission: Detecting and treating suicidal ideation in all clinical settings

Assess

1. Review each patient's personal and family medical history for suicide risk factors.
2. Screen all patients using a brief, standardized, evidenced-based, screening tool.
3. Review screening questionnaires before the patient leaves the appointment or is discharged.
4. Take action, using the assessment results to inform the level of safety measures needed.

Sentinel Event Alert

The Joint Commission, 56, February 24, 2016

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Screening for suicide risk: General approach

Assess

- Prior to screening for suicide risk, it is helpful to ask a brief, open-ended question(s) to establish rapport.
  - For example, *"How has been mood been during the past week?"*
- Ask questions using a non-judgmental, matter-of-fact, and collaborative style.
  - For example, *"I would like to ask you some additional routine questions. Is that okay?"*
- For patients who become uncomfortable or upset during the interview, listen and provide a summary (empathy), and then ask them if they would like to continue with the discussion.

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Determination of suicide risk

Assess

- Suicide risk assessment is ***primarily a reasoned clinical judgment***. This process must be documented and should include:
  - The analysis and synthesis of the presence (***or absence***) of risk and protective factors leading to a final assessment of risk ***and*** corresponding action plan
  - Assessment of both long-term and short-term (imminent) risk
- Checklists of risk and protective factors without a narrative analysis and synthesis are inadequate.

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Suicide risk factors

Assess

Suicidal and injury behavior
- Suicide attempt
- Interrupted/aborted attempt
- Preparatory behavior
- Nonsuicidal self-Injury behavior

Suicidal ideation
- Wish to be dead
- Active suicidal ideation
- Suicidal ideation with general method
- Suicidal intent
- Suicidal intent with a specific plan

Activating event
- Recent loss or significant life event
- Pending incarceration or homelessness

Psychiatric treatment history
- Discharged from psychiatric inpatient care within the past few weeks, months, or year
- Hopeless, dissatisfied, non-compliant with treatment

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Suicide risk factors:

Assess

- Hopelessness
- Major depressive episode
- Mixed affective episode (e.g., Bipolar)
- Command hallucinations to hurt self
- Highly impulsive behavior
- Substance abuse or dependence
- Agitation or severe anxiety
- Perceived burden on family or others
- Chronic physical pain or other serious medical problem or impairment
- Social isolation
- Homicidal ideation
- Aggressive behavior towards others
- Access to lethal means when suicidal (firearms, pills, etc.)
- Sexual abuse (lifetime)
- Traumatic event (lifetime)
- Family history of suicide (lifetime)

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OCD/suicidality and race/ethnicity

National Survey of American Life (Himle et al., 2008) suggest comparable base rates across various racial and ethnic groups, yet:

- Representativeness/generalizability at issue for all races/ethnicities other than white: most published clinical trials include > 90% White patients
  - Higher risk of missed OCD diagnosis in Black Americans (Chasson et al., 2017) and in multi-ethnic urban clinics (Friedman et al., 2003)
  - Experiences of racial discrimination exacerbate obsessions and compulsions in Black Americans (Williams et al., 2017)
  - Ethnic group membership moderated relationship between obsessive beliefs and certain OC symptom dimensions (Wheaton et al., 2013)
  - Experience of racial discrimination is linked to suicidality in Black male youth, esp. when mothers also experienced such discrimination (Arshanapally et al., 2018)

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Suicide protective factors (recent)

Assess

- Identifies reasons for living
- Responsibility to family or others; living with family
- Supportive social network or family
- Fear of death or dying due to pain and suffering
- Belief that suicide is immoral, high spirituality
- Engaged in work or school

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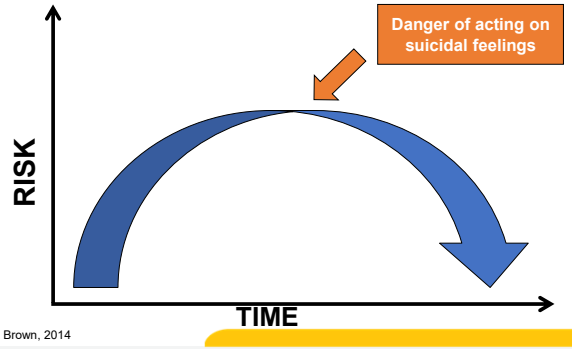
Suicide risk fluctuates over time



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Safety planning intervention (SPI)

Intervene

- Clinical intervention that results in a prioritized written list of warning signs, coping strategies and resources to use during a suicidal crisis
- Safety Plan is a brief intervention (20+ minutes)
- Safety Plan is *NOT* a "no suicide contract"

(Stanley & Brown,, 2012)

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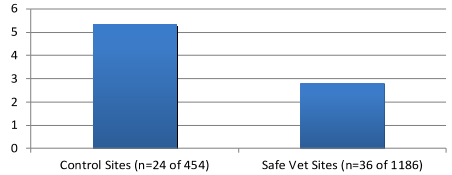
Does SPI help to decrease suicidal behavior?

Suicide Behavior Reports (SBR) During Follow-up

Percentage of Veterans with SBR during 6-month Follow-up



$\chi 2(1, N = 1640) = 4.72, p = .029$; OR = 0.56, 95% CI: 0.33, 0.95

SPI+ was associated with 45% fewer suicidal behaviors, approximately halving the odds of suicidal behaviors over 6 months

(Stanley, Brown, Brenner, et al, 2018).

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Safety plan intervention approach

Intervene

- Individuals may have trouble recognizing when a crisis is beginning to occur
- Problem solving and coping skills diminish during emotional and suicidal crises
- The clinician and patient work together to develop better ways of coping during crises that uses the patient's own words
- Over-practicing skills using a predetermined set of skills may improve coping capacity

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Overview of safety planning: 6 steps

Intervene

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

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Explain how to follow the steps

Intervene

Explain how to progress through each step listed on safety plan.

- If following one step is not helpful in reducing risk, then go to the next step.
- If the suicide risk has subsided after a step, then the next step is not necessary.
- If they are in danger of acting on their suicidal feelings, they can skip steps.

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Making the environment safer

Intervene

6. Reducing the potential for use of lethal means

- If individuals identify a potentially lethal method to kill themselves, such as taking pills, ask, “Do you have access to this method?”
- Be aware of the potential view that having access to a lethal mean to kill oneself may be a strategy used to cope with crises.
- Express concern about the patient’s safety.
- Explain that making the environment safer will help to lower risk of acting on suicidal feelings (delays urge to act on suicidal thoughts)

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Making the environment safer

Intervene

- For some patients who attempt suicide, the interval between thinking about and acting on suicidal urges is usually a matter of minutes.
- ***Always ask*** about access to firearms regardless of the method or plan to kill oneself.
  - Ask, *“Do you have access to a firearm that you would use for protection or for sport?”*
  - If yes, ask about multiple firearms, use of gun safes and locks, storage of ammunition.

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Making the environment safer

Intervene

For each lethal method, ask:

- *"How can we go about developing a plan to make your environment safer so that you'll be less likely to use this method to harm yourself?"*
- *"How likely are you to do this?"*
- *"What might get in the way?"*
- *"How can we address the obstacles?"*

If doubt is expressed about limiting access, ask:

- *"What are the pros of having access to this method and what are the cons?"*
- *"Is there an alternative way of limiting access so that it is safer?"*
- *"What does it mean to you to limit access?"*

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Implementation of the safety plan

Intervene

- Review the steps of the safety plan with the individual and ask about the likelihood of using it.
  - "What are the barriers that might get in the way of using it?"
  - "Where should keep the safety plan so that you will be more likely to use it?"
- Explain that they will receive a copy of the plan and a copy will be retained in their records.

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Typical agenda for follow-up calls

Monitor

- Mood check and risk assessment; determine if immediate rescue is required
- Review and revision of safety plan; discuss access to means
- Treatment engagement discussion and problem solve obstacles
- Obtain consent/willingness for additional follow-up

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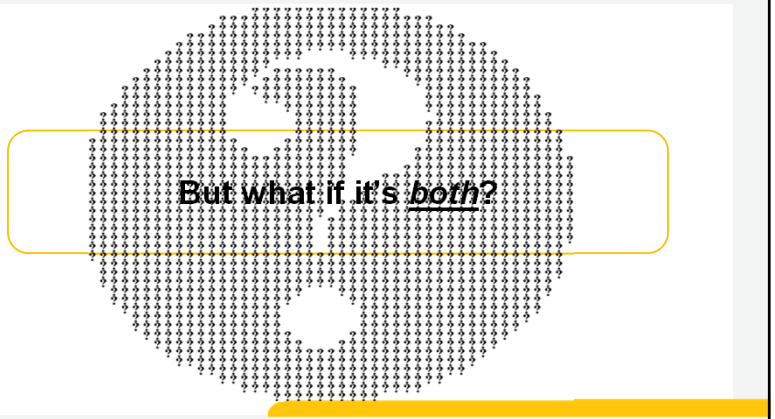

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Focus of and in treatment is determined by:

Monitor

- Which conditions is primary?
- Regardless of that, is SI under good control? Is patient willing and able to work the Safety Plan?
- Clinical judgment of what's in patient's best interests?
- Consider concomitant treatments (e.g., meds)
- Be open about the potential need to pivot, and why

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Case example

Clarence is a 35 yo Black cisgender male who presents to the clinic with symptoms of OCD and a prior diagnosis of depression, driven largely by the presence of what the referring clinician suggested was a history of "unusual suicidal ideation." Clarence is employed full time as a teacher in a local high school, but is finding it increasingly difficult to concentrate at work and to sleep at night, which has begun to affect his punctuality in the morning. Clarence is already taking a daily dose of 75 mg of sertraline for OCD and depression, but has not had CBT for either condition nor ERP for OCD. He reports several recent negative life events, including having been pulled over while driving home in his own neighborhood and subjected to interrogation about recent burglaries before being released.

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Three key take-home messages:

1. Obsessions related to suicide are treatable using the usual ERP theory and clinical procedures
2. Differentiation from suicidal ideation is critical, and treatment cannot proceed safely unless that has been addressed carefully
3. If suicidal ideation instead or in addition, consider a pivot to empirically supported interventions to mitigate risk such as Safety Planning

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About the presenter….

Martin E. Franklin, PhD

Dr. Franklin is an internationally renowned expert on OCD, OC-spectrum disorders, and body-focused repetitive behaviors, as well as the study and treatment of anxiety and related conditions. In addition to serving as the clinical director of Rogers' Philadelphia location, Dr. Franklin is an associate professor emeritus of clinical psychology in psychiatry at the University of Pennsylvania Perelman School of Medicine.

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