SEARCHING FOR HOPE FROM MINDS STEEPED IN HOPELESSNESS:
WHAT PREDICTS, WHAT PREVENTS AND WHAT HEALS A SUICIDAL MIND

Tayyab Rashid, Ph.D., C.Psych | University of Toronto Scarborough
Amanda Uliaszek | University of Toronto Scarborough
Mark Sinyor, MSc., MD, FRCP|C | Sunnybrook Health Sciences Centre
We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca and, most recently, the Mississaugas of the Credit River. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.
This project, in part, was supported through the Mental Health Innovation Fund (MHIF) from the Ministry of Training of Colleges & Universities (TCU)

UTSC: Danielle Uy, Arey Maharaj, Irfan Hakim, Dr. Andrew Cooper & Dr. Suzanne Erb
Health & Wellness Staff & IITS
OVERVIEW

Context
• What is suicidal behaviour?
• What are insights from existing literature and surveys in post-secondary settings?
  • Correlates & predictors of suicidal behaviour (symptoms & strengths)
• Who improves and what facilitates improvement?

Treatment
• How many seek treatment
• Engagement
• Resources
• Policy Implications
SELF-HARMING BEHAVIOURS

• Suicidal Behaviour (SB)

• Non-suicidal Self Injury (NSSI)

• This presentation is about Suicidal Behaviour
NONSUICIDAL SELF-INJURY (NSSI)

**Definition:** Deliberate self-harm, parasuicide behaviour, self-injurious & self-wounding

*Suicidal Intent is absent*

**Prevalence:** Clinical Samples: 21% adults; 40% adolescents

**Onset:** 12-16

**Signs:** repeated cutting, stabbing, burning, hitting, excessive rubbing to inflict self damage to body tissue for socially sanctioned reasons
SUICIDAL BEHAVIOUR

Actions taken to deal with intolerable mental anguish & pain
  • Despair about value of living & hope in life

**Suicidal Complexity:** Unique mix of interconnected factors

**Prevalence**
  • Stat Can (2009): 11.5 per 100,000
    • Highest rate: age 40-59
    • Gender difference
    • Protective Factors
COURSE & PROGRESSION

- Suicide has no clear course & prognosis
- Suicidal ideation is relatively common
- Topography of suicidal thoughts -- on a continuum: from passive longing for death to suicidal intent and plans

The mind scans its options: the topic of suicide comes up, the mind rejects it, scans it again, there is suicide, it is rejected again, and then finally the mind accepts suicide as a solution, then plans it, then fixes on it as the only answer (p. 15; Shnedman, 1996; The Suicide mind)

- 60% who transition from ideation to first attempt tend to be within first year year after the onset of suicidal ideation
Mix of Risk Factors
Kiran et al, 2013

- Gender, Age
- Continued Intent
- Desire to "feel"
- Trauma/Abuse
- Hopelessness
- Acculturation
RISK FACTORS

A relative risk of 1 = there is no difference in risk between individuals with the risk factor and the general population.

A relative risk of > 1 (more than one) means the event is more likely to occur in individuals with the risk factor than in the general population.

A relative risk of < (less than) 1 means the event is less likely to occur in individuals with the risk factor than in the general population.
RELATIVE RISK OF SUICIDE IN SPECIFIC DISORDERS

- Bipolar Disorder 15
- Mixed Drug Abuse 19.2
- Major Depression 20.4
- Eating Disorders 23.1
- Previous Attempt 38.4

Adapted from American Psychiatric Association, 2003, pp. 30, 41
AGE-SPECIFIC RISK OF SELF-HARM IN SPECIFIC PSYCHIATRIC CONDITIONS
(SINGHAL ET AL., 2014)

Age range: 10—24

High Risk Ratio

• Depression
• Bipolar
• Alcohol Abuse
• Anxiety
• Eating Disorders
• Schizophrenia
• Substance Abuse
## CANADIAN CONTEXT: SUICIDAL THOUGHTS, PLANS AND ATTEMPTS

<table>
<thead>
<tr>
<th></th>
<th>STAT CAN (N=4,032) (15-24 years)</th>
<th>NCHA 2016 (N=43,780) 74% (18-24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal Thoughts</td>
<td>14.1%</td>
<td>13%</td>
</tr>
<tr>
<td>Suicide Plan</td>
<td>4.95</td>
<td>2.2%</td>
</tr>
<tr>
<td>Suicide Attempt</td>
<td>3.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>NSSI</td>
<td>N/A</td>
<td>8.7%</td>
</tr>
</tbody>
</table>
# STANDARDIZED ASSESSMENT: A FEW ILLUSTRATIONS

<table>
<thead>
<tr>
<th>Tool/Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Suicide Status Form-SSF III</td>
<td>Psychological Pain, Stress, Agitation, Hopelessness, Self-hate, Reasons for Living, Reasons for Dying</td>
</tr>
<tr>
<td>2 The Columbia-Suicide Severity Rating Scale (C-SSRS)</td>
<td>Available in 114 country-specific languages</td>
</tr>
<tr>
<td>3 SAF-T: Suicide Assessment Five-Step Evaluation and Triage</td>
<td>Follows American Psychiatric Association Practice Guidelines</td>
</tr>
<tr>
<td>4 Cultural Assessment of Risk for Suicide (CARS)</td>
<td>First measure which identifies cultural suicide risk factors not previously attended to in suicide assessment.</td>
</tr>
<tr>
<td>5 Beck Scale for Suicide Ideation</td>
<td>BSI is a 21-item self-report questionnaire that may be used to identify the presence and severity of suicidal ideation.</td>
</tr>
</tbody>
</table>
SUICIDAL BEHAVIOUR: INSIGHTS
DEMOGRAPHICS: AGE & GENDER

- REB APPROVED
- N=2757 (2012-1017)
- Age: 20.9 years (SD 3.32)
  - 89% (18-23)

- Gender
  - 60% females

- Full Time: 93%
ETHNICITY %
N=2757

- East Asian: 33%
- South Asian: 19%
- Caucasian: 22%
- Middle Eastern/Peruvian: 6%
- Caribbean: 6%
- African: 5%
- Hispanic: 2%
- Aboriginal: 0%
- Mixed: 7%
LIVING SITUATION

- Family: 65%
- Alone: 7%
- Roommate: 14%
- Student Residence: 9%
- Partner: 2%
- Other: 3%
METHODOLOGY

• **Intake:** Online & In-person

• **Presenting Concerns**
  • Client Reported
  • Clinician Interpreted
  • Coding: Grounded Theory (Strauss & Corbin, 1998)

  • Coded Presenting Concerns by 4 coders
  • Weekly meetings to discuss codes, construct clarified
  • Redundant codes incorporated into broader categories
OUTCOME MEASURE

• Intake Process included Outcome Questionnaire (OQ-45)

• Students completed on a tablet, before in-person part of the intake.

• The measure assesses suicidal ideation through an item,
  • “I have thoughts of ending my life”.
  • Students respond to the question on a 5-point Likert Scale.
IN-PERSON INTAKE : RISK ASSESSMENT

• Have you ever seriously thought about killing yourself?
  • No
  • Yes: (if yes, follow-up)

• Are you currently thinking of killing yourself?

• Have you ever engaged in self-harming behaviour?

• Are you currently engaged in self-harming behaviour?
PREVALENCE SUICIDALITY – 2 METHODS

• Intake suicidal ideation question, clinical interview at intake:
  “Are you currently thinking of killing yourself?”
  • Yes/No per clinician judgment during initial session 9.8%

• OQ-45 suicide item, per self-report prior to intake:
  “Have you had thoughts of ending your life?”
  • 1 (never) – 5 (almost always)*
    • 4+ treated as endorsement 8.5%
CAPTURING SUICIDAL IDEATION
CLINICAL INTERVIEW VS. OBJECTIVE MEASURE: OVERLAP %

- Almost Always, 66.7%
- Frequently, 51.9%
- Sometimes, 21.4%
SUICIDALITY & DEMOGRAPHICS

Female

Visible minority

Good Academic Standing

PC-Suicidality

No Suicidality

36.80

45.20

86.40

29.3

47.6

85.5

%
SUICIDALITY AS PRESENTING CONCERNS & CGPA

PC_Suicidality: 2.18
No Suicidality: 2.43
SUICIDALITY & NUMBER OF PRESENTING CONCERNS

Number of Presenting Concerns
- PC-Suicidality: 2.32
- No Suicidality: 1.79
SUICIDALITY & SPECIFIC PRESENTING CONCERNS

Depression
- PC-Suicidality: 52.3%
- No Suicidality: 23.8%

General Anxiety
- PC-Suicidality: 4.5%
- No Suicidality: 18.3%
SUICIDALITY & SYMPTOM SEVERITY AT THE TIME OF INTAKE

<table>
<thead>
<tr>
<th></th>
<th>PC-Suicidality</th>
<th>No Suicidality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellbeing</td>
<td>13.73</td>
<td>19.92</td>
</tr>
<tr>
<td>Symptomatic Distress</td>
<td>65.09</td>
<td>50.25</td>
</tr>
<tr>
<td>Interpersonal Relations</td>
<td>23.48</td>
<td>18.35</td>
</tr>
</tbody>
</table>
SUICIDALITY & STRENGTHS

- Appreciation of Beauty
- Authenticity
- Curiosity
- Fairness
- Mercy
- Gratitude
- Generosity
- Love of learning
- Humility
- Critical thinking
- Spirituality

- Lower
- Bravery
- Capacity to love
- Creativity
- Emotional Intelligence
- Hope
- Humor & Playfulness
- Leadership
- Perseverance
- Perspective
- Prudence

- Self control
- Teamwork & Citizenship
- Zest
SI: PREDICTORS

1. Those who presented with suicidal ideation (OQ-45) showed significantly more
   • Worthlessness
   • Feeling loved (inverse)
   • Lower overall wellbeing
   • Higher overall symptomatic distress

2. OQ SI is associated with a greater chance of a presenting concerns related to
   relationship (general), motivation/interest, emotion dysregulation, depressive
   symptoms, anxiety/panic & general anxiety
SI: PREDICTORS

Does the knowledge of Strengths tell anything about overall distress?

42% of variance in total OQ

• **unique predictors of SI included**: forgiveness, gratitude, hope, kindness, capacity to love, persistence, prudence, spirituality, self regulation, citizenship, zest

How Much?

Strengths explained **16% of variance in OQ suicidal ideation**

Strengths predict incrementally over all presenting concerns when predicting OQ Risk of suicidal ideation
FINAL MODEL OF SUICIDAL IDEATION
IDEATORS AT THE INTAKE

• History of Suicide Attempts: Odds Ratio (OR)  2.35***
• OQ Symptom Distress, OR 1.08***
• Hope, OR .92**
• Persistence, OR 1.08**

**p < .001; ***p < .001
WHO IMPROVES & WHO DETERIORATES

- Zest
- Hope
- Love
- Curiosity
- Gratitude

Mean # Sessions

Median # Sessions

# of Signature "Strengths of the Heart"
TREATMENT AND POLICY IMPLICATIONS FOR POST SECONDARY INSTITUTES
ENGAGEMENT
HOW MANY YOUTH SEEK TREATMENT?

Szumails & Kutcher, 2009
Reviewed quality of online information about suicide

Stat Can (N= 4,013), age 15-24

• Discuss with Family doctor/GP: 6%
• Seek clinical services: 5%
• Seek psychiatric consultation: 3%
• Use online diagnostic information: 8%
• Share it on social media: 2%

Immigrants are less likely to seek services
EVIDENCE-BASED PROGRAMS FOR SELF-HARMING BEHAVIOUR

Suicide Gatekeeper Training: ASSIST, MH First AID, QPR, KOGNITO, ASK, LISTEN, REFER

1. Cognitive Behaviour Therapy
   • Manual-Assisted CBT: Working Through advantages & disadvantages

2. Problem Solving Therapy
   • Problem Definition, Brainstorming, Alternative Solution

3. Multi systemic Therapy
   • Behavioural Parenting Training

4. Dialectical Behaviour Therapy

5. Emergency "Green Cards."

6. Mentalization-Based Treatment (MBT)
   • Understanding actions in terms of thoughts & feelings

7. Physical Activity
Survival analysis for time to first suicide attempt

Cumulative percentages of suicides over the 15-year follow-up period.

Numbers at risk:

- Males: 4622, 3709, 2352, 1317
- Females: 6961, 5778, 3904, 2255
RISK FACTORS VS. WARNING SIGNS

**SOME EXAMPLES:**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Warning Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (older)</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>Seeking access to lethal means</td>
</tr>
<tr>
<td>Genetic factors/family history</td>
<td>Threatening to hurt/kill self</td>
</tr>
<tr>
<td>Childhood trauma</td>
<td>Escalating substance use</td>
</tr>
<tr>
<td>Psychiatric diagnoses</td>
<td>Social withdrawal/isolation</td>
</tr>
<tr>
<td>Past suicidal behaviour</td>
<td>Agitation/sleep disruption</td>
</tr>
</tbody>
</table>
What can give my life meaning?
(e.g. people, places, activities, values, dreams)

Who can I call for distraction?

Who do I trust to share my distress and ask for help?

Who can I contact in my expert support system?
(e.g. family doctor, therapist, psychiatrist)

Other Crisis Resources:

What are my warning signs?
(e.g. sad thoughts or feelings, behavior – social withdrawal, physical symptoms – sleep problems)

How can I distract myself?
(e.g. listen to music, watch TV/movie, play with a pet, exercise, journaling)

What skills can I learn to lower my distress?
(e.g. breathing exercises, progressive muscle relaxation, meditation, create hope kit, visit: sunnybrook.ca/mentalhealthresources)

Remember to check your environment and make sure it is safe. Stay away from objects or people that could put you at risk. For example if you have an alcohol problem, avoid having it in your home.
3 killed in hospital shooting

BREAKING A police officer, a doctor and a pharmaceutical assistant are dead after a shooting at Chicago's Mercy Hospital. The gunman was also killed.

Ivanka Trump used personal account for emails about government business

White House backs down from legal fight, restores Jim Acosta's press pass

There won't be a comedian at the White House press dinner

16 Democrats sign letter opposing Pelosi as House speaker

Brianna Keilar: Trump has a pattern of insulting military leaders

Fact-checking Trump's latest claims about Whitaker and Mueller

Trump on bin Laden: Told you so

Democrats have picked up 37 House seats

Multiple people shot in downtown Denver

Federal Air Marshals accused of more than 200 gun mishaps

Doctors start movement in response to NRA, calling for more gun research

Chris Watts gets life in prison for 'inhumane' killings of 2 daughters and pregnant wife

Dow closes down 306 points

NK defector shares startling insights

Nissan boss Carlos Ghosn arrested

Trump has doubts about journalist's death

Exclusive: Trump expected to give troops authority to protect border personnel
Monthly number of suicides in the United States from January 2010 to December 2015

Aug-Dec 2014
expected: 16,849 deaths
observed: 18,690 deaths
excess: 1,841 deaths (9.85%↑)

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0191405
Exposure to School Suicide

Suicide Attempts

• Empathic description of how to cope with suicidal ideation / attempt.

• Personal experience.

• Similarities to narratives in self-help literature.

Association with small-sized decrease in suicide rates


**Assessment and care of adults at risk for suicidal ideation and behaviour**
Registered Nurses' Association of Ontario, 2009

**Treating depressed and suicidal adolescents: a clinician's guide**

**Preventing patient suicide: clinical assessment and management**
RESOURCES: WEBSITES & HELPLINES

1-866 627 3342; MON - FRI (6-9 PM)

Canadian Association of Suicide Prevention
https://suicideprevention.ca/
613)702-4446

Suicide Prevention Resource Centre
www.sprc.org

Ontario Mental Health Helpline
www.mentalhealthhelpline.ca/
1-866-531-2600
See resources on Self-harm & Self-cutting page

Self-Injury Outreach and Support
http://www.sioutreach.org
POLICY IMPLICATIONS

• Comprehensive risk assessment
  • Better false positives than false negatives; Flags clients, guides treatment planning

• Understanding Campus: Every campus presents a complex and variable constellation of risk and protective factors. Have a system in place to track specific risk and protective factors.

• Consistent Evaluation: Consistent tracking of risk indices AND client needs is critical to evaluating outcomes and projecting clinical needs
  • Including links to other treatment providers
POLICY IMPLICATIONS

• **Digital systems** (e.g., OQ-45 analyst, BHM-20) offer immediate clinically relevant feedback to providers, including projected outcome and flags for high risk items.

• **Personalized Treatment**: Intra-individual variability helps to personalize the treatment.

• **Offer evidence-based specific programs** which are directly related to mitigating risks and enhancing resilience.
ADDITIONAL SLIDES IF NEEDED
Every encounter/interaction with the self-harming young person is an opportunity to intervene and has the potential to save life

**Explain Confidentiality:**
- Ensure person understand the limits
- Understand Family/Cultural barriers
- Collaborate how it can work to keep the individual safe but also helps them to “unload”
- “how can we make this a safe and comfortable place to discuss most uncomfortable things.”
EXPLORE

Questions

• Are You thinking about Suicide?
• Are you thinking about Killing yourself?
• Are you thinking about ending your life?
• Do you feel hopeless? So hopeless that you will kill yourself?
• Do you ever wish you were dead? When?

(McKeon, 2008)

Evidence

Static: Risk Factors: Strongest one is....?

Dynamic: Warning Signs: Preparations (e.g., note, future mindedness, acquiesces, recent trauma, online groups affiliation)

Contagion Management: impact on others

Ambivalence vs. Assuredness
REASONS FOR SUICIDAL BEHAVIOR

1. Cognitive Constriction
   • Addictive quality
     • Prior to engaging: a period of pre-occupation that is difficult to resist

2. Emotional Anguish
   to stop feeling bad, “to feel anything at all, even pain.”

3. Interpersonal Entanglement
   • To get reaction or attention from others, even if it is negative

4. Control
   locus of control
• 6146 individuals aged 18–33 years, 59% Females, 82% Caucasian, 8% Asian, 6% African Americans,

• Recruited 2002-03 & followed up 2007-10.
• 91 cases (no history) of self-reported suicide attempts during the follow-up (5-year incidence of 1.5%)
• 4% reported previous attempts
• 2.2% will likely try again someday
• 7.5% thought of suicide in the last year
  • Of these 41.4% never told anyone
• 24% classified with suicide risk based on empirically established idea