Clinical High Risk for Psychosis and Harm Risk in Clinical Practice

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Agenda

- Brief overview of suicide risk theories
- Overview of clinical high risk for psychosis & self-harm risk
- Introduce case example
- Review intervention (assessment, treatment) options & case discussion
- Discussion

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Terms

- Clinical high risk for psychosis (CHR or CHR-p)
- First episode psychosis (FEP)

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Harm Risk Overview

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General Suicide Risk Conceptualization

- Many theories explaining suicidality
  - Interpersonal Theory of Suicide (Joiner, 2005)
  - Dialectical Behavioral Therapy (DBT; Linehan, 1993)
  - Cognitive Model of Suicidality (Wenzel & Beck, 2008)
- Many acronyms describing suicide risk factors (see next slide)
- Can be a bit overwhelming in the moment with a particular client!

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Example of Suicide Risk Factors

- **SAD PERSONS** (Paterson et al., 1983)
  - **S: S**ex (male)
  - **A: A**ge less than 19 or greater than 45 years
  - **D: D**epression
  - **P: P**revious suicide attempt or psychiatric care
  - **E: E**xcessive alcohol or drug use
  - **R: R**ational thinking loss
  - **S: S**eparated, divorced, or widowed
  - **O: O**rganized plan or serious attempt
  - **N: N**o social support
  - **S: S**tated future intent

- **Additional Suicide Risk Factors**
  - Family history of suicide
  - Access to firearms/lethal means
  - Serious or chronic medical condition
  - Prolonged stress
  - Agitation
  - Sleep deprivation
  - Recent loss or tragedy

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How to Organize Factors/Theories? Model Integrating Theories of Suicidality

Ideation to Action: Three-Step Theory (3ST; Klonsky & May, 2015)

- Step 1: SI results from combo of pain (usually psychological pain) + hopelessness
  - DBT: Desire to immediately stop overwhelming unpleasant emotional state (Linehan, 1993)
  - CBT: Cognitive triad – hopeless thoughts about self, others, & future (Wenzel & Beck, 2008)
- Step 2: Further escalation in ideation if the person feels disconnected/like a burden
  - Interpersonal Theory of Suicide: Thwarted connectedness (feeling you don't belong) & thwarted effectiveness (feeling like a burden) (Joiner, 2005)
- Step 3: Progress to attempts through dispositional, acquired, & practical contributors to capacity to attempt suicide (e.g., exposure to suicide methods, agitation)
  - Imminent Risk: rapid escalation in suicidality, profound alienation, & profound hopelessness

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Acute vs. Longer-Term Suicide Risk

- Acute Suicidal Affective Disturbance (ASAD; Joiner): Considered for DSM diagnosis
  - "Geometric" (rapid) increase in suicidal intent (hours to days)
  - One (or both) of the following:
    - Marked social-alienation (severe social withdrawal, extreme disgust with others, perceived liability to others)
    - Marked self-alienation (views that one's selfhood is an onerous burden, self-disgust)
  - Perception that the above are hopelessly intractable
  - Two or more manifestations of over-arousal (insomnia, nightmares, agitation, irritability)

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Non-Acute Suicide Risk: Treatment Planning

- Assess factors that contribute to risk for harm
  - Regularly assess for change in risk
  - Prioritize treatment targets collaboratively with client - which factors are key?
- Target drivers of suicidality; enhance strengths & coping skills
  - Engagement in appropriate treatment is key factor in reducing risk!!
  - Identify & reduce access to means for harm, especially highly lethal means
  - Identify & enhance strong social connections (family, friends, community)
  - Practice & reinforce skills: distress tolerance, cognitive restructuring, problem solving
  - Reinforce cultural/religious beliefs that discourage suicide
  - Highlight hope for improvement (while validating & avoiding minimization of distress)

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CHR-P and Harm Risk Overview

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Early Psychosis & Increased Suicide Risk

- Large prospective study of adolescents (age 13-16) in Ireland (Kellerer et al., 2013)
  - 7% endorsed psychotic symptoms
  - 34% who had psychosis symptoms plus other psychopathology attempted suicide within a year
  - Those endorsing psychotic symptoms had ~10x increased odds of any suicidal behavior
  - Those with comorbid depression had ~14x increased odds of suicide plans/acts compared to youth with depression but no psychosis
- About 18% of participants with FEP attempted suicide prior to treatment (Challis et al., 2013)
- 82.5% of females and 54.6% of males at CHR-p endorsed SI (Lindgren et al., 2017)
- In a community sample, 34.6% of CHR-p and 73.3% of FEP participants endorsed SI (Haining et al., 2021)

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Early Psychosis & Self-Harm Risk

- Self-harm is associated with suicide risk
- Self-harm behavior common in early psychosis samples (Haining et al., 2021): in CHR-p 28.5%, in FEP 60%

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When Psychosis Directly Relates to Harm Risk

- Suicidality as a reaction to psychosis
  - Meaning of psychotic symptoms for the person (e.g., expect worsening symptoms, interference with future goals)
  - Social impact (stigma, psychosis makes me a burden, social withdrawal)
- Harm-related content in psychosis symptoms
  - Ex: command hallucinations to harm self
  - Violent content fairly common; 71% of an early psychosis sample had had self-directed violent experiences (Marshall et al., 2016)

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When Psychosis is Unrelated to Harm Risk

- Like anyone, people with psychosis may exhibit self-harm risk for reasons separate from psychosis
  - Arguments with family
  - Depression/despair
  - Etc.

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Considering Comorbid Depression

- Comorbid depression is very common for early psychosis, and appears to interact to increase harm risk for people with psychosis
- 48% of FEP clients experienced at least 1 major depressive episode (Romm et al., 2010)
  - 17% before onset of psychosis
  - 30% during or after onset of psychosis
- Longitudinal study of FEP, depression, & suicidality (Upthegrove et al., 2010)
  - Clinically significant depression occurred in 80% of clients at one or more points during the study period
  - Combination of depression + suicidal thinking present in 63%
  - Depression in the CHR-p phase (present for 56%) was the most significant predictor of future depression & self-harm

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Early Psychosis Suicidality Drivers

- Most research so far has been with FEP, highlighting features associated with suicidality:
  - Hopelessness (Klonsky et al., 2012)
  - Longer duration of psychotic symptoms (Verdoux et al., 2012)
  - Self-injury (Fedyszyn et al., 2012)
  - Prior history of self-harm, SI, better insight, depressed mood, substance misuse, younger age of onset, & DUP (Challs et al., 2013)
- Insight has a complex relationship with suicidality among people with psychosis
  - May increase suicidality among people with schizophrenia (Schwartz & Peterson, 2000)
  - Intensified positive symptoms may be a suicide risk factor for CHR-p (Ventriglio et al., 2016)
- Social disconnection, feeling like a burden may also be a driver (Heeli s et al., 2016; Joiner, 2005)

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CHR-P and Harm Risk Intervention

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Clinician Level Considerations

- Discussing suicidality can be difficult for clinicians → urge to avoid
- Clinicians cannot predict who will die by suicide, and no one can prevent suicide attempts except for the client
  - Clients commonly do not communicate suicide intentions to providers (Busch et al., 2003; Robins et al., 1959)
- Both under-reacting and over-reacting may be problematic
  - Under-reacting: may communicate to the client that you don't care, miss opportunities for reducing risk for attempts
  - Over-reacting: may lead client to not report suicide risk to you, drop out of outpatient treatment, interfere in life roles
- Useful to have a guide: evidence-based assessments & interventions

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Case Example: "David" Summary

- 16-year-old Latino male high school student
- Depressive symptoms: numbness, loss of interest/pleasure, self-hatred
- Psychosis risk symptoms: hearing a voice in his mind (resolved), seeing shadows (weekly, attenuated)
  - Other symptoms (e.g., mistrustfulness) that may be attributed to other concerns (e.g., gang activity in his school, prior trauma)
- Risk of harm to self:
  - 1 suicide attempt: cutting; over a year ago; self-aborted
  - Suicidal ideation: cutting deeply enough to die, hanging, jumping from a high place, general desire to not exist; ongoing, varies in frequency
  - Self-harm: cutting, burning, punching walls; ongoing, varies, generally weekly

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How to Ask: Style, General considerations

- Style
  - Be direct (don't avoid), calm demeanor
- Start general (i.e., common experiences), get more specific
  - Check recent & lifetime
  - Content of ideation (passive/vague, specific strategies, planning, intent)
  - Urges to act (intensity, response to them)
  - Actions (preparation behaviors, harm behaviors)
  - Details, context related to any endorsed experiences
- Consider whether risk is acute (crisis intervention) versus non-acute (ongoing treatment target)

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How to Ask: History of Ideation & Behavior

- Ideation
  - Have you ever wished to be dead?
  - Have you ever had thoughts about hurting yourself?
- Behavior
  - How close have you gotten to acting on these thoughts?
  - Have you ever taken steps preparing to act?
  - Have you ever attempted kill yourself?
  - When was the last time? What did you do? What was the outcome?
  - How many times in your life?

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How to Ask: Core Areas for Current Risk

- Intent
  - How likely are you to act on these thoughts to end your life?
  - What keeps you from acting on your thoughts? What do you do instead?
- Plan
  - What have you thought about doing? Have you done anything to prepare?
- Means
  - Many suicide attempts occur with little planning → reduce/slow down access to quick means
  - Do you have access to a gun? Do you keep things at home that you think about using to harm yourself?

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Suicide Risk Assessment Tools

- What are your / your program's go to self-harm assessment tools?
- Recommend evidence-based measures of suicidality (e.g., as part of FEP program's assessment batteries / tool for ongoing treatment)
  - Note: there is increased urgency to attend to suicidality in healthcare, with the Joint Commission & standard of care requiring use of evidence-based measures of suicidality in practice
- Examples:
  - Columbia Suicide Severity Rating Scale (C-SSRS) – also a brief self-report version
  - Collaborative Assessment and Management of Risk (CAMS)
    - https://www.mycasat.org/wp-content/uploads/2017/05/CAMS-care_SSF-4.pdf
  - Linehan Risk Assessment & Management Protocol (L-RAMP)

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Suicide Interventions

- Any favorite treatment approaches from the group?
- Safety Planning Intervention (SPI; Stanley & Brown, 2012; Stanley et al., 2018)
  - 1-session
  - Strategies: brief problem-solving/coping skills, enhance social support, emergency contacts, means restriction, motivate further treatment
- Collaborative Assessment and Management of Suicide (CAMS)
  - Outpatient, suicide-specific, focus on developing other means of coping/problem-solving, aim to eliminate need for suicidal coping, targets suicide 'drivers'
  - Initial & follow-up session forms
- DBT:
  - Comprehensive DBT (e.g., skills group, individual therapy, phone coaching)
  - DBT skills (distress tolerance); functional analysis (verbally, in writing)

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Case Example: "David" Treatment Course

- Thorough initial assessment + ask about SI/SH each session
- Assess/remove access to deadly means
- Identify reasons for not acting / for living
  - Impact on loved ones like mother, wanting to be independent
- Identify what he has tried / what has worked before
  - Client noted he hates written forms in therapy
- Functional analysis of relevant events:
  - Social tension, intense emotion, dissociation, impulsivity
- Suicidality drivers
  - Emotional pain + impulsivity → Distress tolerance skills
  - Self-hatred & burdensomeness → Cognitive therapy skills

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Case Example: "David" Challenges/Q's

- Impulsivity: hard to remove means to self-harm
- Dislike of forms: hard to formally do a measure like the CAMS
- Dissociation: sometimes not aware of injuring himself
- Reluctance to seek social support when distressed (combined with strong drive to be supported)

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Discussion

- Other case examples, consultation questions?
- Other questions?

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Take Home Points

- Essential to screen for suicide risk in this population
- When present, regularly asses suicide / risk factors
- Engaging clients in treatment at this stage is key
- Consider acute versus longer-term suicide risk
- Collaboratively identify & target identified drivers of suicidality

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Suicide Hotline Support

- National
  - Suicide prevention lifeline: 1-800-273-8255, https://suicidepreventionlifeline.org/
- Local (research in your region):
  - 24/7 Colorado Crisis Services: 1-844-493-8255, text "TALK" to 38255, or https://coloradocrisisservices.org

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