How Clinicians Understand Passive Suicidal Ideation in Risk Assessment

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Background

- Suicide is an increasing problem in forensic settings
  - Rose over 30% in one year
- Suicide risk assessment is a common referral question
  - Difficult to decide the best approach
  - Multiple structured violence risk assessments used in forensic settings but not for suicide risk
- Clinicians ask about current thoughts of wanting to kill self, and about intent and/or plan to kill oneself (active SI)
- Endorsed suicidal ideation as a gatekeeper for suicide risk assessment

Relying on Active SI

- Few people disclose SI
  - 70% of people denied SI to providers before attempting suicide
- Relies on current feelings/thoughts
  - Worst SI ever is better predictor than current SI
  - History of SI without prior attempt, less likely to make future attempt
- Plan doesn't necessarily predict later attempts
  - 6-13% of people who attempted suicide had no plan
  - Plan isn't always made at time of evaluation
  - Lack of plan does not DECREASE risk
- Intent to kill oneself: May disclose or not disclose for various reasons

Problem

Are we overlooking key components by relying on reported active suicidal ideation?

Do we too quickly dismiss patients who deny active SI but have other symptoms?

Passive Suicidal Ideation

- Passive SI includes: Desire to die, hopelessness, burdensomeness, and anhedonia
- Minimal research on passive SI
  - Desire to die: higher rates of suicide compared to no thoughts of suicide, but less than active SI
  - Hopelessness: differentiated those who went on to commit suicide, beyond depression, thoughts of suicide, or previous attempts
  - Burdensomeness and anhedonia differentiated those who attempted suicide from those did not
  - Anhedonia more severe in people who attempted suicide

Research Question

How do clinicians perceive passive SI when assessing suicide risk, if at all?

Procedure

Psychiatric crisis teams across 25 cities were asked to participate in an online survey

Participants could enter to win one of ten $50 Amazon gift cards

Qualification criteria:

- Conducted at least one suicide risk screening in prior six months
- Degree in social sciences (Bachelors to Doctorate)

Survey included consent, demographics, and three vignettes

Design

	Vignette		
Factor	A	B	C
Major depressive disorder	X		
Passive suicidal ideation	X		
History of suicide attempt	X		
Intent to kill self		X	
Plan for suicide		X	
Desire to die		X	
Hopelessness			X
Burdensomeness			X
Anhedonia			X
Number of versions	**8**	**8**	**8**

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Vignette

Mary is a 42-year-old married woman who presented to her Primary Care Physician with complaints of anxiety and depression. The physician would like you to assess her suicide risk and refer her to an appropriate level of care. Mary reported a history of treatment for ***Major Depressive disorder***, and ***one prior suicide attempt*** in which she took too many sleeping pills and was hospitalized for one night. During your interview, she appeared nervous and tired. She reported being depressed for the last month following a job loss and having trouble with concentration, decreased appetite, and increased sleep. She reported feeling ***hopeless about ever feeling better, losing interest in hobbies she used to enjoy, and feeling like she was a burden to her family***. She wished ***she wouldn't wake up in the morning***.

Outcome Variables

What do you believe is Mary's risk of suicide in the next 30 days?

1 (Extremely Low) --------------- 7 (Extremely High)

What do you believe is Mary's risk of suicide in the next 2 years?

1 (Extremely Low) --------------- 7 (Extremely High)

What level of care do you believe would be most helpful for Mary if access to resources were not an issue?

- ❑ No services needed
- ❑ Outpatient referral
- ❑ Partial hospitalization
- ❑ Stabilization/Respite
- ❑ Voluntary hospitalization
- ❑ Involuntary hospitalization

Hypotheses

Aim 1: To understand how risk factors for suicide influence clinician perception of suicide risk.

Hypothesis 1a: Passive SI will be less influential than MDD or a prior suicide attempt.

Hypothesis 1b: Intent to kill self will be more influential than desire to die or plan for suicide.

Hypothesis 1c: Hopelessness will be more influential than burdensomeness or anhedonia.

Aim 2: To explore how risk perception changes when comparing short term risk to long term risk perception.

Hypothesis 2: Risk ratings would be higher for long term risk than compared to short term risk

Participants

	N	%
Total Sample	91	100
Gender: Female	75	82.4
Race: White	70	77
Ethnicity: Non Hispanic/Latino	72	79.1
Highest Level of Education		
Bachelor level clinician	13	14.3
Social Worker	37	40.7
Mental Health Counselor	35	38.5
Licensed clinician	69	75.8
	Mean	Range
Age (Years)	35.59	22-66
Years since finishing degree	7.36	1-33
Years working	4.44	0-28
Suicide screenings in last 6 months	123	1-1200

Note. Participants could select more than one response for race

Aim 1
Hypothesis 1a: Passive SI will be less influential than MDD or a prior suicide attempt

	30-day	2-year
Factor	η^2	η^2
Major Depressive Dx	.07*	.02
Passive SI	.43***	.28***
Prior suicide attempt	.10**	.06*

*$p<.05$ **$p<.01$ ***$p<.001$

Aim 1
Hypothesis 1b: Intent to kill self will be more influential than desire to die or plan for suicide

	30-day	2-year
Factor	η^2	η^2
Intent to kill self	.17***	.09**
Plan for suicide	.20***	.15***
Desire to die	.17***	.14***

**p*<.05 ***p*<.01 ****p*<.001

Aim 1
Hypothesis 1c: Hopelessness will be more influential than burdensomeness or anhedonia

	30-day	2-year
Factor	η^2	η^2
Hopelessness	.08*	.07*
Burdensomeness	.02	.01
Anhedonia	.01	.02

**p*<.05 ***p*<.01 ****p*<.001

Aim 2
Hypothesis 2a: Risk ratings would be higher for long term risk than short term risk

	30-day	2-year	Correlation	Effect
	M (SD)	M (SD)	r^2	d
Vignette A	3.41 (1.49)	3.22 (1.48)	.77***	.13
Vignette B	4.17 (1.49)	3.64 (1.31)	.76***	.38***
Vignette C	3.99 (1.58)	3.66 (1.41)	.81***	.22**

*p<.05 **p<.01 ***p<.001

Conclusions and Implications

Clinicians do take into account passive SI

Clinician's don't give more weight to intent to die or plan compared to desire to die

Hopelessness was seen as a significant predictor for suicide
- Burdensomeness and anhedonia were not, incongruent to literature

Risk was uniformly perceived to decrease over time
- May have focused on acute risk rather than long term risk

May need more specific training in this area

Limitations & Future Direction

Limitations
- Did not compare all components of passive SI in single vignette
- Couldn't assess accuracy of these judgements
- Doesn't illustrate how these evaluations are actually completed
- Modest sample size
- Too many experts?

Future Directions
- Assess how these evaluations are actually completed, especially by non-specialized clinicians
- Study how these determinations affect level of care decisions

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