

# To Include or Not to Include Suicidal Participants in Research?

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# Research Team

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# Presentation Outline

Introduction

Study design & methods

Findings

Conclusions

Implications for research

# Why Not Ask or Talk About Suicide

- Fear of suggesting or planting the idea of suicide

(Meerwijk et al., 2010:72; Feldman et al., 2007:416; Stoppe et al., 1999: 196; Jobes, 1995:5)

- Normalization of suicidal behaviours or desensitizing

(Chambers et al, 2005:136; Dyck, 1991:42);

- Uncertainty of how to response/inadequate training/knowledge

(Feldman et al., 2007:416; Stoppe et al., 1999: 197; Lawrence & Ureda, 1990:167; Frankenfeld et al., 2000:163; Tatarelli et al, 2005;209)

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# Why Ask and Talk About Suicide?

- Asking provides relief

Meerwijk et al., 2010:72; Tatarelli et al, 2005:209;Doyle, 1990:396;  
Giliatto & Rai , 1999:1502)

- Increasing public and personal awareness (Higgitt, 2000:18;Biblarz, 1992:3)

- People already know about or have considered suicide (Mishara, 2003:128; Dyck 1991:42; Tatarelli et al, 2005:210)

- Not asking increases suicide risk (Ross, 1980: 242; Capuzzi, 1994:112)

# Rationale for not including suicidal participants in Research

- Sensitive questions can cause distress (Jacomb 1999; Henderson 1990; Parslow 2000)
  - Research assessments are potentially harmful for participant; they might heighten risk
  - Possible emotional and legal fallout for researcher (Jobes 2009; Lakeman 2009)
  - Increased resources and competencies needed to manage suicide risk (Lakeman 2009)

# Rationale for including suicidal participants in research studies

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- Suicide is statistical rarity
  - 10.8 per 100,000 Canadians (StatsCan 2006)
  - Requires large number of subjects and long study duration for statistical power
- Attempted suicide and suicidal ideation
  - Predictors of suicide
  - More prevalent than suicide (CIHI 2004)
  - Can serve as proxy measures (Links et al., 2007)

# Including suicidal participants in Research

- Distress and suicidality vary independently (Reynolds et al., 2006)
- Suicidal questions do not increase suicidality in most cases (Gould et al., 2005; Reynolds et al., 2006)
- Increased risk was manageable through low-level means in nearly all cases (Reynolds et al., 2006)

# Purpose and Design

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The purpose of this study was to examine the post-assessment changes in suicidality of study participants with a lifetime history of suicide attempts.

# Procedure

- Baseline assessment for risk factors.
- Re-assessment for suicidal ideation at 1, 3, and 6 months following admission.
- Participants were assessed for suicide risk at the start and at the end of each follow-up interview.

# Measures

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- Outcome: Scale for Suicidal Ideation; Suicide Behaviour over 6 months
- Risk assessment-Mood and Risk screening:

# Mood and Risk Screening Form

1. Please rate your urges to self-harm on a scale of 0-7 (none-severe).
2. Please rate your urges to suicide on a scale of 0-7 (none-severe).
3. Please rate your sense of control over any self-harm or suicide urges using a scale of 0-7 (out of control-in control).

# Changes in Mood and Risk Mean Score

	<u>1 Month Follow-up</u>		<u>3 Months Follow-up</u>		<u>6 Months Follow-up</u>	
	Pre	Post	Pre	Post	Pre	Post
<b>Urges to self-harm</b>	1.31 (1.7)	1.13 (1.7)*	1.07 (1.6)	1.01 (1.5)	.73 (1.3)	.70 (1.2)*
<b>Urges to suicide</b>	1.36 (1.8)	1.10 (1.6)*	1.06 (1.5)	1.06 (1.6)	.90 (1.5)	.85 (1.5)*
<b>Sense of control over self harm or suicide urge</b>	6.06 (1.2)	6.19 (1.2)	6.04 (1.3)	6.17 (1.3)*	6.37 (1.1)	6.42 (1.1)

\* Based on paired sample t test  $p < .05$

# Changes in Mood and Risk Mean Score

	1 month follow-up	3 months follow-up	6 months follow-up
No change in pre-post self-rated suicidality	73.5%	80.9%	90.5%
Decrease in pre-post self-rated suicidality	21.4%	10.6%	9.5%
Increase in pre-post self-rated suicidality	5.1%	8.5%	0%
Intervention was required	4.8%	3.1%	5.2%

# Increase in Suicidality Mean Risk Scores

	Pre	Post
<b>1 Month</b>		
Urges to self-harm (n=3)	1.0(1.0)	3.0(2.7)*
Urges to suicide (n=2)	1.5(0.7)	3.5(0.7)*
<b>3 Months</b>		
Urges to self-harm (n=6)	2.0(2.0)	3.7 (2.0)*
Urges to suicide (n=7)	1.0(2.3)	4.0 (2.3)*
<b>6 Months</b> (n=0)		

# Decrease in Suicidality Mean Risk Scores

Time/Measure	Pre	Post
<b>Month 1</b>		
Urges to self harm (n=16)	2.4 (1.9)	.94(1.9)*
Urges to suicide (n=14)	2.9(2.0)	1.0(1.2)*
<b>Month 3</b>		
Urges to self harm (n=6)	3.2(2.1)	.67(0.8)*
Urges to suicide (n=7)	3.3(2.2)	1.0( 1.5)*
<b>Month 6</b>		
Urges to self harm (n=9)	2.5(1.3)	1.5 (1.3)**
Urges to suicide (n= 4)	1.8(0.5)	0.8(0.5)**

p value < .5 \*based on paired t test; \*\* based on Wilcoxon Signed Ranks test

# Increase in Self Rated Control Over Suicidality Urges

	Pre	Post	$\Delta$	P value
Time 1 n=12	4.9 (1.4)	6.4 (0.7)	+1.5	.01
Time 2 n=9	4.9 (1.2)	6.4 (0.8)	+1.45	.01
Time 3 n=7	5.0 (1.2)	6.0 (1.2)	+1.0	.08

# Intervention

- 9 (7.5%) participants required “soft” intervention
- 9 (7.5%) were referred to ER

# Reason for Hospitalization

	Sample n=98	Intervention n=9	“Soft” Intervention n=9
First suicide attempt	24.5%	11.1%	0%
Recurrent suicidal behaviour # of attempts	56.1% 1.5(1.8)	77.8% 3.4(4.6)	88.9% 4.4(4.3)*
Current ideation/no attempt	19.4%	11.1%	11.1%

\* No intervention vs. soft intervention p value = .003

# Baseline Comparisons

	Sample	Intervention	“Soft” Intervention
Previous hospitalization	71.1%	100%	77.8%
Length of current admission	10.9(11.0) 1-60 days	7.3 (8.4) 2-25 days	7.1(5.12) 3-15 days
SSI at baseline	23.3(3.8)	24.1(4.0)	24.8(3.2)

# Comparison of Psychiatric Diagnoses

	Sample	Intervention
Affective disorders		
MDE	70%	64%
BAD	19%	29%
Anxiety Disorders		
Panic	28%	36%
OCD	13%	21%
<b>PTSD</b>	<b>30%</b>	<b>50%*</b>
GAD	49%	57%

\* Chi-square P value=.025

# Comparisons of Suicidal Ideation Scale Mean Score

	Sample	Intervention	P value
1 Month Follow-up	7.2 (8.5)	21.2 (9.8)	.001
3 Months Follow-up	5.9 (7.1)	25.7 (1.5)	<.001
6 Months Follow-up	4.5 (6.3)	25.0 (3.2)	<.001

Time 1 n=94, n=5; T2 n=93, n=3, T3 n=91, n=5

# Psychiatric Diagnoses: “Soft” Intervention sub-sample

MDD, PTSD, Substance, Alcohol, BPD

MDD, GAD, Panic, PTSD, Substance, Alcohol,  
BPD

MDD, GAD, Panic, PTSD, Eating d/o

BAD, GAD, Panic, Substance, Alcohol, BPD

Schizoaffective

MDD, BPD

MDD, GAD, Panic, OCD, PTSD

BAD, BPD

MDD, GAD, PTSD, BPD

# Psychiatric Diagnoses: Intervention sub-sample

MDD, GAD, Panic, OCD, Substance, Alcohol, BPD

MDD, GAD, PTSD,

MDD, GAD, PTSD, BPD

BAD, GAD, Panic, Substance, Alcohol, BPD

BAD, Substance, Alcohol

GAD, Panic, PTSD,

MDD, GAD, Panic, Substance, Alcohol, BPD

Schizophrenia, Substance, Alcohol

BAD, GAD, Panic, OCD, PTSD

# Recently Discharged Study: Conclusions

Participants who required intervention:

- 9 were taken to ED
- 9 required “soft” clinical intervention

All 18 presented in distress

- 4 participants died by suicide prior to intervention

# Recently Discharged Study: Conclusions

- Changes in suicidality were small, infrequent and were most likely to reflect a decrease in suicidality.
- At the 6 month follow-up period, increases in suicidality post-assessment were not seen.
- Participants rarely reported worsening self-control over suicidal urges, and when they did, the effect was minimal.
- These findings are consistent with Reynolds et al. (2006) findings that a small proportion of suicidal participants will require intervention following an assessment.

# Implication for Research

- Research assessment can be safely conducted with suicidal participants:
  - Protocols to manage the distressed participant
  - The burden on research is manageable
  - Supports to assist research staff who deal with high risk participants

# Thank You

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