Suicide: Risk Factors, Assessment and Treatment

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Conflicts

- I have no conflicts to declare

Learning Objectives

- Identify psychosocial risk factors for suicidal ideation and behavior
- Explain how to screen patients for suicidal risk
- Understand the difference between suicidal ideation, plans and intent
- Recognize common suicide drivers
- Describe the evidence-based treatments for suicidal ideation and behavior

Questions?

- What training have you received in suicide assessment and counseling the patient?
- How confident are you in asking patients about suicidal thoughts or behavior?
- What experiences have you had in discussing this with patients?
- What policies do you have in your work setting for screening for suicidal risk?
- What knowledge and skills would you like to take away from today's training session?

VA/DoD CLINICAL PRACTICE GUIDELINE FOR ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

Department of Veterans Affairs
Department of Defense

Prepared by:

The Assessment and Management of Risk for Suicide Working Group

With support from:

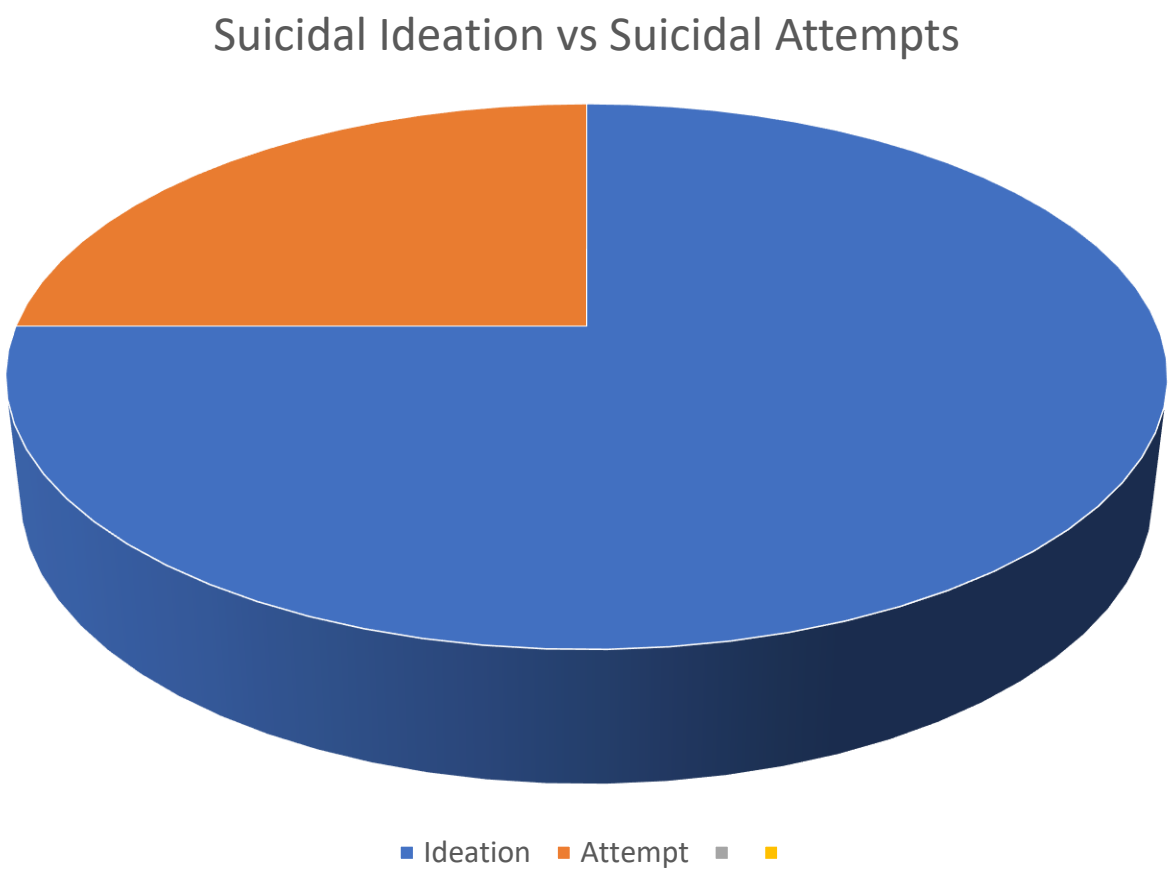
The Office of Quality Safety and Value, VA, Washington, DC

&

Quality Management Division, United States Army MEDCOM

Version 1.0 – June 2013

Suicidal Ideation vs. Suicide Attempts



O'Connor & Nock, (2014), The Lancet, 1, 73-85

Alarming Increase in Suicides!!

- The rate of suicide is increasing in America.
- Now the 10th leading cause of death, suicide claims more lives that traffic accidents and more than twice as many as homicides.
- Providers often do not detect the suicidal thoughts or individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death usually for reasons unrelated to suicide or mental health.
- For completed suicides: 33% tested positive for alcohol, 23% for antidepressants and 20.8% for opiates, including heroin and prescription pain killers
- 50% had a diagnosis of a mental health condition in their medical record
- There is a lack of strong evidence for any intervention in preventing suicide and suicide attempts (the clinical trial dilemma, low rate of studies, exclusions in research)

The Joint Commission, 2016, Sentinel Event Alert, Detecting and Treating Suicide Ideation in all Settings

VA/DOD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide

Statistics

- Suicide is the 15th leading cause of death worldwide, the 10th leading cause of death among Americans overall, and the 2nd leading cause of death among individual in the age range from 10-34. (An estimated 1.3 million people made a suicide attempt in the past year.
- Homicide ranks 16th
- Almost 10 million adults reported having serious thoughts about suicide in the past year.
- Suicide and self-harm injuries cost society about $70 billion a year in combined medical and work loss costs.
- International lifetime prevalence: suicidal ideation (9.2%), plans (3.1%) and non-lethal attempts (2.7%).
- US suicide rate is now similar to where it was at 30 years ago after suicide rates fell markedly in the 1980s and 1990s.

Klonsky et al., 2016, Annual Review of Clinical Psychology, 12, 307-330

O'Connor & Nock, 2014, Lancet Psychiatry, 1, 73-85

www.cdc.gov, retrieved October 20, 2018.

10 Leading Causes of Death by Age Group, United States – 2016

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,816	Unintentional Injury 1,261	Unintentional Injury 787	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118	Heart Disease 635,260
2	Short Gestation 3,927	Congenital Anomalies 433	Malignant Neoplasms 449	Suicide 436	Suicide 5,723	Suicide 7,366	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927	Malignant Neoplasms 598,038
3	SIDS 1,500	Malignant Neoplasms 377	Congenital Anomalies 203	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	Chronic Low. Respiratory Disease 131,002	Unintentional Injury 161,374
4	Maternal Pregnancy Comp. 1,402	Homicide 339	Homicide 139	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	Suicide 7,030	Suicide 8,437	Chronic Low. Respiratory Disease 17,810	Cerebro-vascular 121,630	Chronic Low. Respiratory Disease 154,596
5	Unintentional Injury 1,219	Heart Disease 118	Heart Disease 77	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883	Cerebro-vascular 142,142
6	Placenta Cord. Membranes 841	Influenza & Pneumonia 103	Chronic Low. Respiratory Disease 68	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452	Alzheimer's Disease 116,103
7	Bacterial Sepsis 583	Septicemia 70	Influenza & Pneumonia 48	Chronic Low Respiratory Disease 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebro-vascular 5,353	Cerebro-vascular 12,310	Unintentional Injury 53,141	Diabetes Mellitus 80,058
8	Respiratory Distress 488	Perinatal Period 60	Septicemia 40	Cerebro-vascular 50	Chronic Low Respiratory Disease 206	Cerebro-vascular 575	Cerebro-vascular 1,851	Chronic Low. Respiratory Disease 4,307	Suicide 7,759	Influenza & Pneumonia 42,479	Influenza & Pneumonia 51,537
9	Circulatory System Disease 460	Cerebro-vascular 55	Cerebro-vascular 38	Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546	HIV 971	Septicemia 2,472	Septicemia 5,941	Nephritis 41,095	Nephritis 50,046
10	Neonatal Hemorrhage 398	Chronic Low Respiratory Disease 51	Benign Neoplasms 31	Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472	Septicemia 897	Homicide 2,152	Nephritis 5,650	Septicemia 30,405	Suicide 44,965

Rise in US Suicide Rate

- Socioeconomic changes
- Deaths from suicide, drugs and alcohol have risen steeply among white, middle-aged Americans since 2000.
- Deaths of despair are linked to a deterioration of economic and social well-being among the white working class.
- Suicide rates have increased sharply in rural communities, where loss of farming and manufacturing jobs has led to economic declines over the past quarter century.
- US has fallen behind other developed countries in promoting risk assessment and using data to address the public health changes of suicide.

Weir, K, 2019, APA Monitor, 50(3), pg 24

Sociodemographic Correlates

- High-income countries have higher suicide rates than low- or middle-income countries, however, low-income countries account for over 75% of all suicides worldwide.
- Men account for roughly three times the number of suicides than women, and this gender disparity is even greater in high-income countries.
- Suicide rates are highest in adults aged 70 and older across both men and women.
- Suicide is the second leading cause of death among those 15-29 year old, and the leading cause of death among young women aged 15-19.
- Whereas Canada experienced an 11% decrease in suicide rates from 2000 to 2012, the United States experienced a 24% increase.

Klonsky et al., 2016, Annual Review of Clinical Psychology, 12, 307-330

What Else Do We Know?

- There has been a 31-37% increase in the suicide rates in Michigan from 1999 to 2016.
- No known mental health condition: 16% female, 84% male; death by firearm (41%), suffocation (27%) and poisoning (10%) were the most prevalent methods.
- Known mental health condition: 31% female, 69% male; death by firearm (41%), suffocation (31%) and poisoning (20%) were the most prevalent methods.
- Trigger factors include: relationship problems (42%), crisis in the past or upcoming two weeks (29%), problematic substance abuse (28%), **physical health problem (22%),** job/financial problem (16%), criminal legal problem (9%), and loss of housing (4%).
- Not all patients in a suicidal crisis are depressed; they may suffer from other forms of distress.

Wenzel & Jaher-Hyman, 2012, Behavior Therapy, 35(7), 121-130

www.cdc.gov, retrieved October 20, 2018

Mental Disorders and Other Clinical Correlates

- It is often stated that over 90% of individuals who die by suicide have mental disorders. However, it is also true that the overwhelming majority of individuals with mental disorders—more than 98%--do not die by suicide.
- In developed countries, the disorders that most strongly predict a subsequent suicide attempt are bipolar disorder, post traumatic stress disorder, and major depression.
- In developing countries, the most predictive disorders are post traumatic stress disorder, conduct disorder, and drug abuse/dependence.
- Potential risk factors predict suicidal thoughts better than attempts.
- Most individuals with suicidal ideation do not go on to make attempts.

Klonsky et al., 2016, Annual Review of Clinical Psychology, 12, 307-330

Suicide and Firearms

- Of the 39,000 gun deaths per year in the United States, 60% are the result of suicide.
- The proportion of suicides involving a firearm, as well as the overall, is higher in states with less-stringent gun control legislation.
- Thomas E. Joiner, Jr., PhD (2005), "*Why People Die by Suicide.*" First to identify: thwarted belongingness/feeling disconnected from others + perceived burdensomeness = increased desire for suicide, and acquired capability = possibility of suicide.
- Capability for suicide = ↑ tolerance of physical pain, ↓ fear of death and bodily harm, and a history of painful or provocative behavior.

Palmer (2018), *Monitor in Psychology*, *November 2018*, 88-90

CDC Definitions

Suicidal Ideation	Thoughts of engaging in suicide-related behavior. (Various degrees of frequency, Intensity and duration.)
Preparatory Behavior	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away.
Suicidal Intent	There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and Inferred in the absence of suicidal behavior.
Suicide Attempt	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.

Interrupted by Self or Others	A person takes steps to injure self but is stopped by self or another person prior to fatal injury. The interruption may occur at any point.
Suicide	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

Ask!

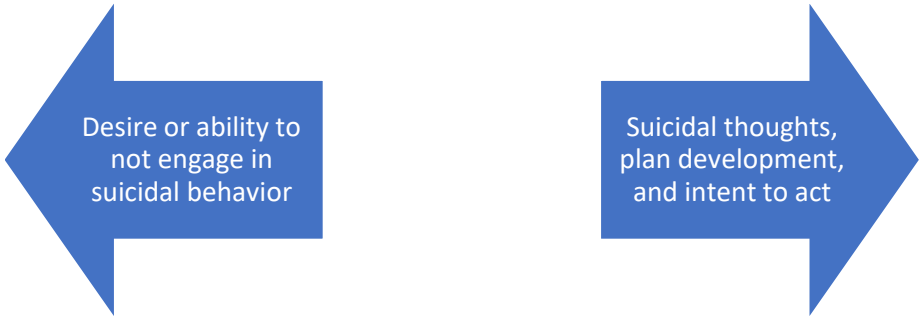
Evidence shows that direct assessment of suicidal ideation and intent does not increase the risk for suicide. There is a greater risk in ignoring it.

Most people struggling with suicidal thoughts and behaviors (roughly 60%) do not receive treatment. Low perceived need and the desire to handle the problems personally are the main reasons behind this.

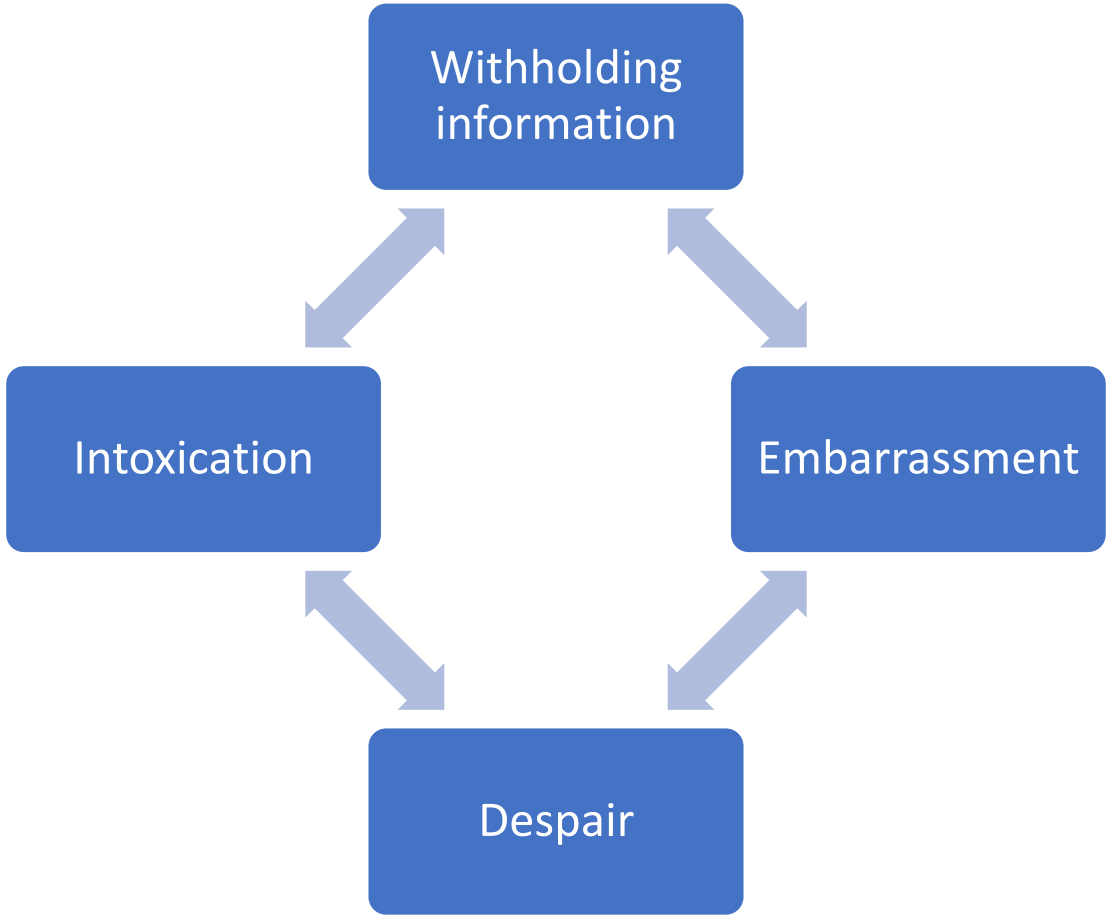
O'Connor & Nock, (2014), The Lancet, 1, 73-85

Suicide Risk Assessment

- A person's risk for suicide is dynamic—changing over time based on affective states, life events, and the complex interplay of risk and protective factors
- A suicide risk assessment must include the evaluation of the patient's:
  - internal experience, thoughts, beliefs and attitudes
  - external world of relationships and stressors
  - myriad of factors that increase the likelihood of suicide and those that prevent them from action



Barriers to a Full Assessment



PHQ-9

Over the ***last two weeks*** , how often have you been bothered by any of the following problems? (please circle your answer & **check the boxes that apply to you**)	Not at all	Several days	More than half the days	Nearly Every day	
1. Little interest or pleasure in doing things	0	1	**2**	**3**	
2. Feeling down, depressed, or hopeless	0	1	**2**	**3**	
3. ☐ Trouble falling or staying asleep, or ☐ sleeping too much	0	1	**2**	**3**	
4. Feeling tired or having little energy	0	1	**2**	**3**	
5. ☐ Poor appetite or ☐ overeating	0	1	**2**	**3**	
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	**2**	**3**	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	**2**	**3**	
8. ☐ Moving or speaking so slowly that other people could have noticed, or ☐ the opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	**2**	**3**	
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	**1**	**2**	**3**	**Total**
(10)	add columns:				

Prevention

Most individuals who commit suicide have had a contact with a primary care physician within a month of death.

VA/DOD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide

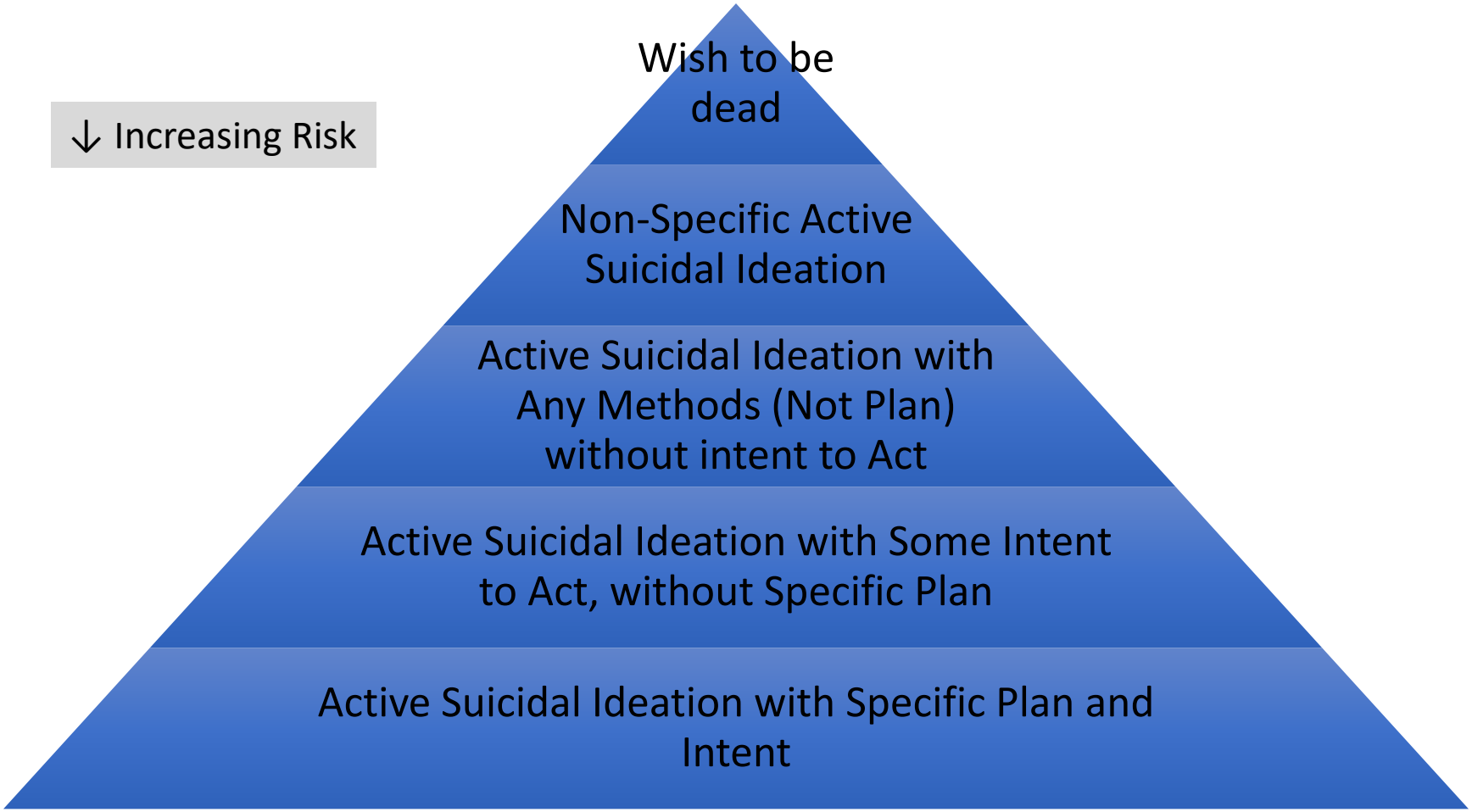
Tension: patient autonomy and safety

Early identification of suicidal ideation presents the greatest opportunity to reduce the risk of suicide attempt and death.

Recognition of warning signs is the key to creating an opportunity for early assessment and intervention.

Three direct warning signs are particularly indicative of suicide risk: *communicating suicidal thought verbally or in writing; seeking access to lethal means such as firearms or medications; and demonstrating preparatory behaviors such as putting affairs in order.*

Suicidal Ideation - Content



Suicidal Ideation - Intensity

Psychological Pain

Belongingness

Perceived burdensomeness

Capability

Cognitive inflexibility

Previous attempt

Substance abuse
Hopelessness
Purposelessness
Feeling of defeat
Anger
Recklessness
Feeling trapped
Social withdrawal
Anxiety
Mood changes
Sleep disturbance
Guilt or shame
Chronic illness and disability
History of trauma/ACE
Chronic stress

Suicidal Intent

Plan?

Feasible?

Time devoted?

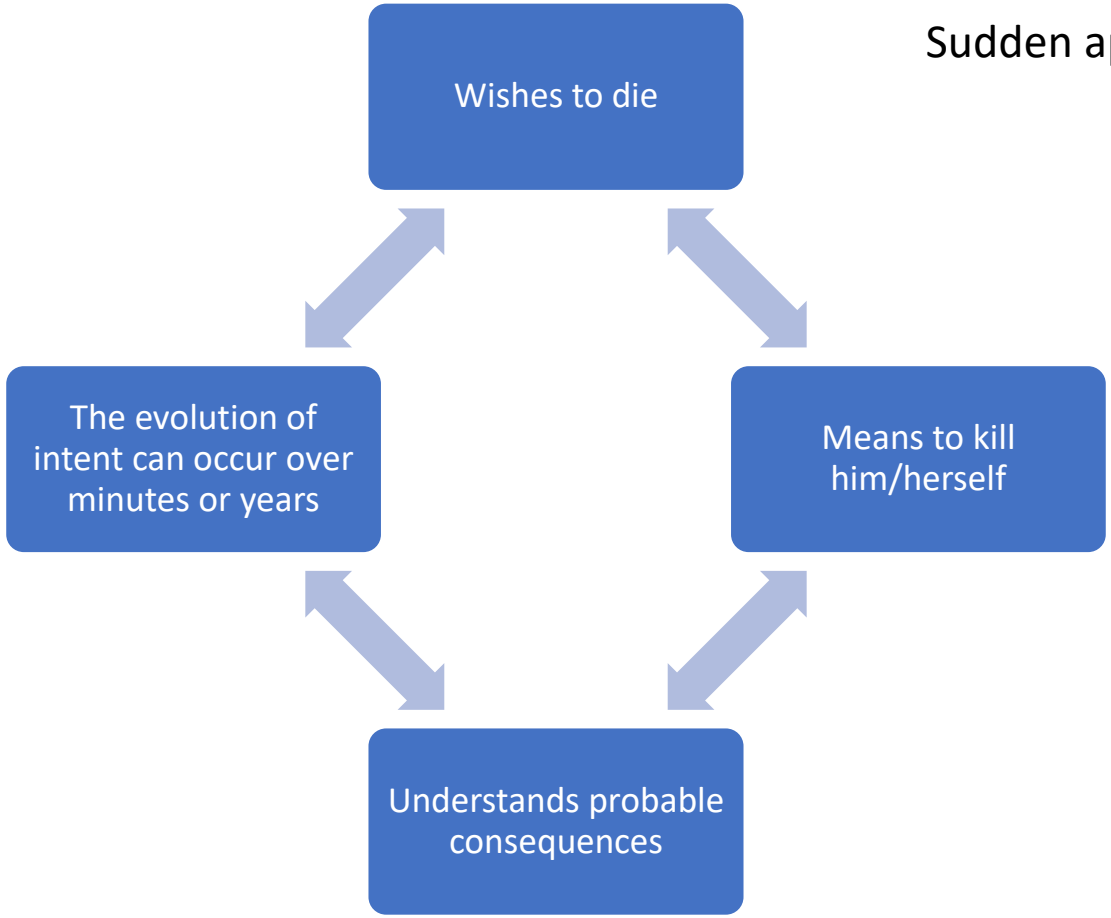
Contingency?

Preparatory behavior?

Timeline?

Confidence in plan?

Previous suicide attempt?



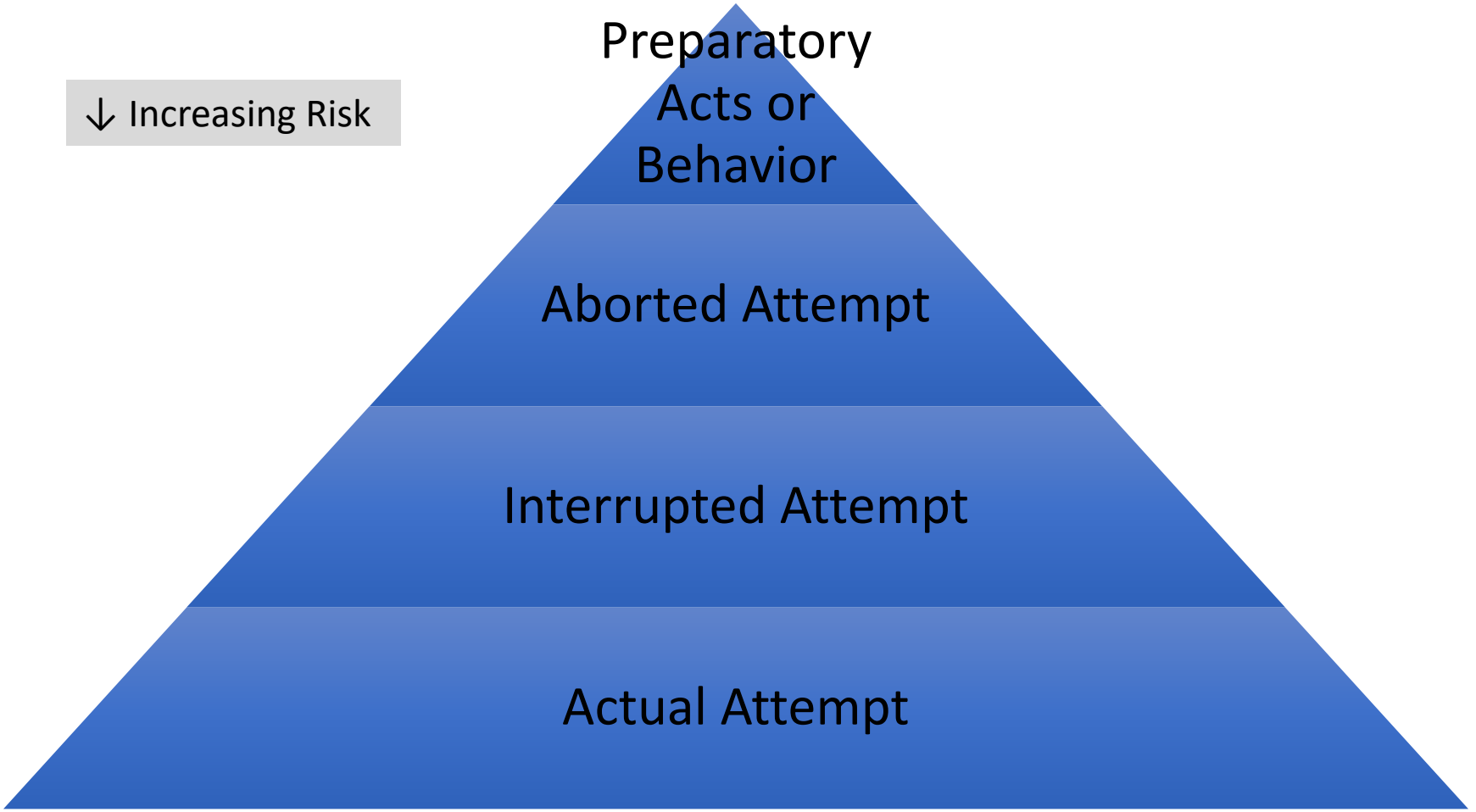
Sudden apparent decrease in distress!!!!

Previous Suicide Attempts

- The risk for completed suicide is considerably increased in individuals with a previous suicide attempt.
- Regretting survival
- Multiple attempts
- High medical lethality

Suicidal Behavior

↓ Increasing Risk



Protective Factors

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

www.cssrs.columbia.edu, retrieved October 20, 2018

Table 1. Determine Level of Risk For Suicide and Appropriate Action in Primary Care

Risk of Suicide Attempt	Indicators of Suicide Risk	Contributing Factors †	Initial Action Based on Level of Risk
High Acute Risk	• Persistent suicidal **ideation** or thoughts • Strong **intention** to act or plan • Not able to control **impulse** OR • **Recent suicide attempt** or **preparatory behavior** ††	• Acute state of mental disorder or acute psychiatric symptoms • Acute **precipitating** event(s) • Inadequate **protective factors**	• Maintain direct observational control of the patient. • Limit access to lethal means • Immediate transfer with escort to Urgent/ Emergency Care setting for Hospitalization
Intermediate Acute Risk	• Current suicidal **ideation** or thoughts • **No intention** to act • Able to control the **impulse** • **No recent attempt** or **preparatory behavior** or rehearsal of act	• Existence of **warning signs** or **risk factors** †† AND • Limited **protective factor**	• Refer to Behavioral Health provider for complete evaluation and interventions • Contact Behavioral Health provider to determine acuity of referral • Limit access to lethal means
Low Acute Risk	• Recent suicidal **ideation** or thoughts • No **intention** to act or plan • Able to control the **impulse** • No planning or rehearsing a suicide act • No previous attempt	• Existence of **protective factors** AND • Limited **risk factors**	• Consider consultation with Behavioral Health to determine: - Need for referral - Treatment • Treat presenting problems • Address safety issues • Document care and rational for action

† Modifiers that increase the level of risk for suicide of any defined level :

- **Acute state of Substance Use**: Alcohol or substance abuse history is associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act
- **Access to means** :(firearms, medications) may increase the risk for suicide act
- **Existence of multiple risk factors or warning signs** or lack of protective factors

†† Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation)

A Systematic Approach!

The Columbia Protocol

- Columbia University, the University of Pennsylvania, and the University of Pittsburgh—supported by the National Institute of Mental Health (NIMH)—developed the **Columbia-Suicide Severity Rating Scale (C-SSRS)** for a 2007 NIMH study of treatments to decrease suicide risk among adolescents with depression.
- The Columbia Protocol is supported by 20 years of research.
- It is the first tool to assess the full range of a person's suicidal ideation and behavior, including intensity, frequency and changes over time.
- 2011: CDC recommends the Columbia Protocol for data collection.
- 2012: Food and Drug Administration (FDA) declares the Columbia Protocol the standard for measuring suicidal ideation and behavior in clinical trials.

CSSR Scale – Emergency Screen

COLUMBIA-SUICIDE SEVERITY RATING SCALE
*Screen with Triage Points for **Emergency Department***

Ask questions that are bolded and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
	Past 3 Months	
If YES, ask: *Was this within the past three months?*		

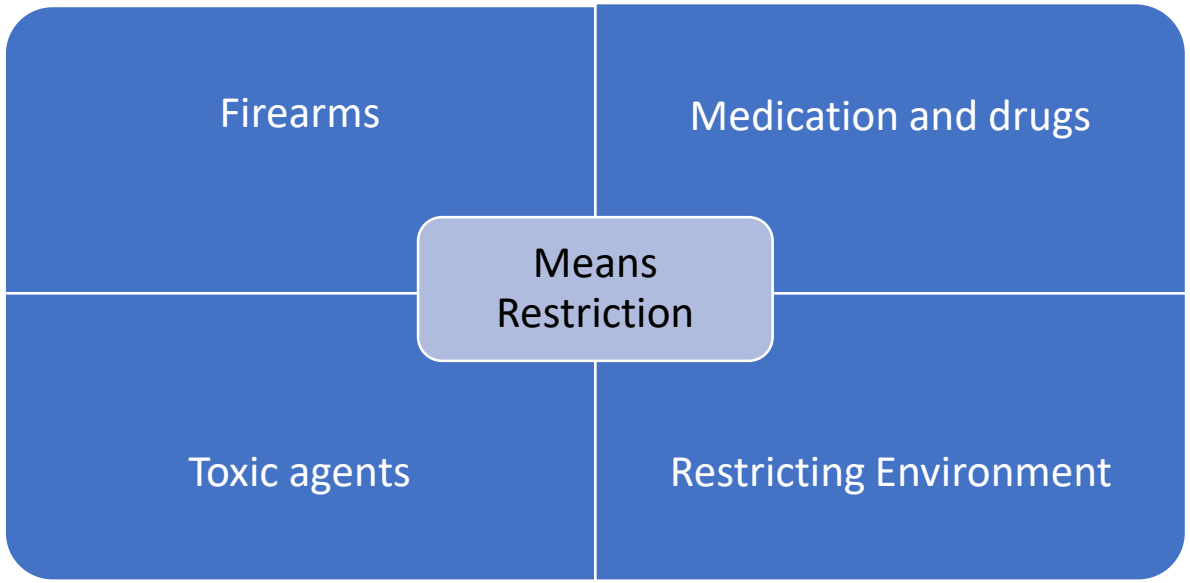
Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Treating Suicidal Crises

- Determine appropriate level and components of care (e.g., availability of support systems, capacity of patient follow through on safety plan, and assurance that access to lethal means can be restricted)
- In most cases, suicidal behavior should be viewed as the primary problem and the psychiatric condition as the secondary problem.
- Cognitive Behavioral Therapy (CBT), and Dialectical Behavior Therapy (DBT) and Collaborative Assessment and Management of Suicide (CAMS) are effective treatments for suicidal behavior.
- CBT targets unhelpful cognitions and maladaptive behavioral problems that fuel suicidal behavior.
- CAMS integrates empathy, CBT strategies and regular re-assessment.
- DBT focuses on radical acceptance, mindfulness, distress-tolerance and emotional regulation.

Means Restriction

- Modification of the environment to decrease access to suicide means is an important strategy to reduce risk.
- Since attempts are often method-specific, the probability of attempting suicide decreases when the patient is precluded from implementing a preferred method.



The Collaborative Assessment and Management of Suicide (CAMS)

- Person-centered approach
- Focus on understanding an individual's experience of suicidality
- "Nondenominational" regarding techniques
- Identification and targeted treatment of suicide "drivers"
- Collaborative assessment and treatment planning
- Patient is "coauthor" of their own treatment plan
- Importance of therapeutic alliance and consistent reassessment
- The Suicide Status Form (SSF) services as a multipurpose assessment, treatment planning, tracking, and outcome tool that functions as a "clinical roadmap."

Jobes et al., 2018, Psychological Services, 15(3), 243-250

Suicide Status Form (SSF)

Rate Psychological Pain (hurt, anguish, or misery in your mind, not stress, not physical pain)

Low pain 1 2 3 4 5 High Pain

What I find most pain painful is: _____

Rate Stress (your general feeling of being pressure or overwhelmed)

Low stress 1 2 3 4 5 High stress

What I find most stressful is: _____

Rate Agitation (emotional urgency; feeling that you need to take action; not irritation; not annoyance)

Low agitation 1 2 3 4 5 High agitation

I most need to take action when: _____

Rate Hopelessness (your expectation that things will not get better no matter what you do);

Low hopelessness 1 2 3 4 5 High hopelessness

I am most hopeless about: _____

Rate Self-Hate (your general feeling of disliking yourself; having no self-esteem; having no self-respect)

Low self-hate 1 2 3 4 5 High self-hate

What I hate most about myself is: _____

Rate Overall Suicide Risk: Extremely low risk (will not kill self) 1 2 3 4 5 Extremely high risk (will kill self)

How much is being suicidal related to thoughts and feelings about yourself?

Not at all: 1 2 3 4 5 :completely

How much is being suicidal related to thoughts and feelings about others?

Not at all: 1 2 3 4 5 :completely

Please list your reasons for wanting to live (rank in order of importance)

Please list your reasons for wanting to die (rank in order of importance)

I wish to live to the following extent: Not at all: 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

CAMS Stabilization Plan

Ways to reduce access to lethal means

Things I can do to cope differently when I am in a suicidal crisis

People I can call for help or to decrease my isolation

Attending treatment as scheduled: a) potential barrier and b) solution I will try

CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. _____

2. _____

3. _____

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. _____

2. _____

3. _____

4. _____

5. _____

6. **Life or death emergency contact number:** _____

People I can call for help or to decrease my isolation:

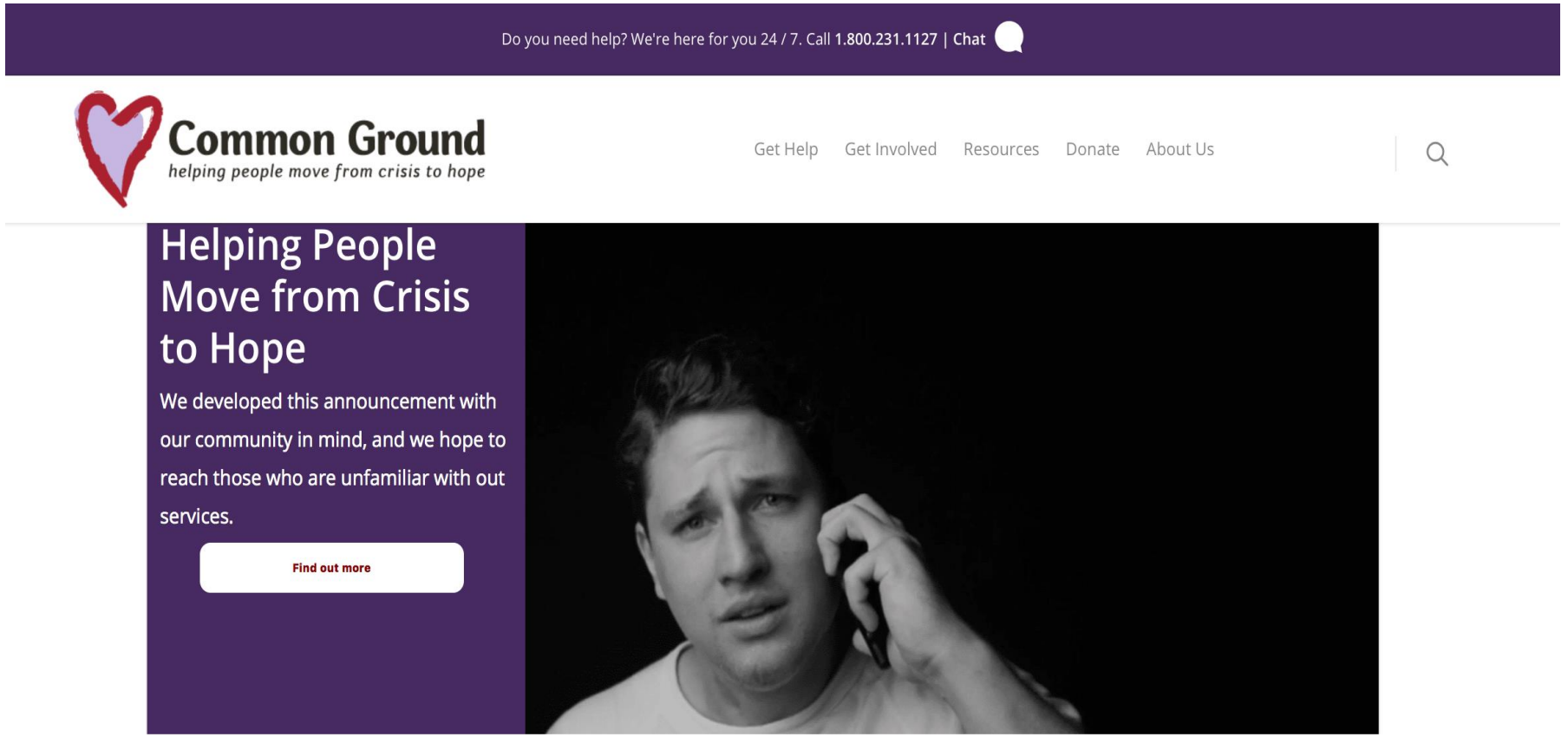
1. _____

2. _____

3. _____

Attending treatment as scheduled:

Potential barrier:	Solutions I will try:
1. _____	
2. _____	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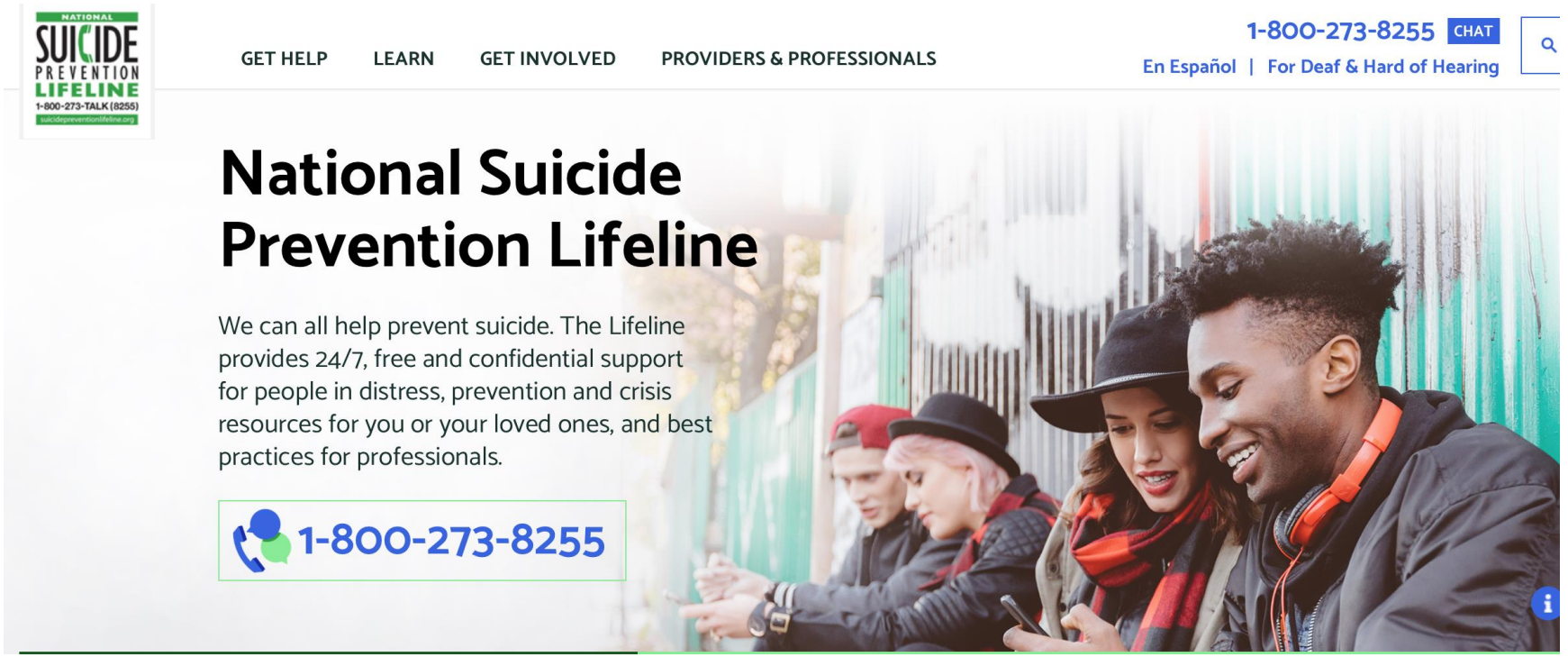
*Deadline for submissions is October, 31 2018**

Email info@suicidology.org if you are experiencing issues submitting your abstract until 11:59pm EST on October 31, 2018.

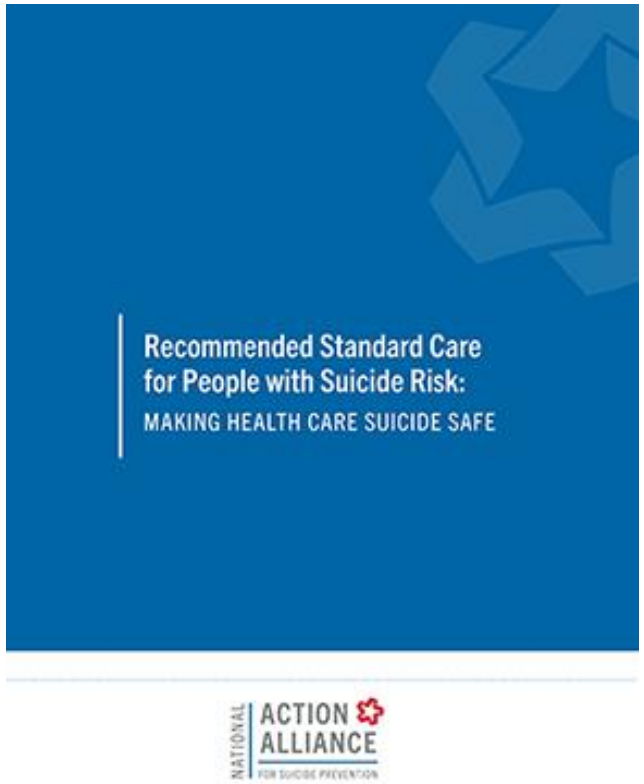
Sponsorship Opportunities

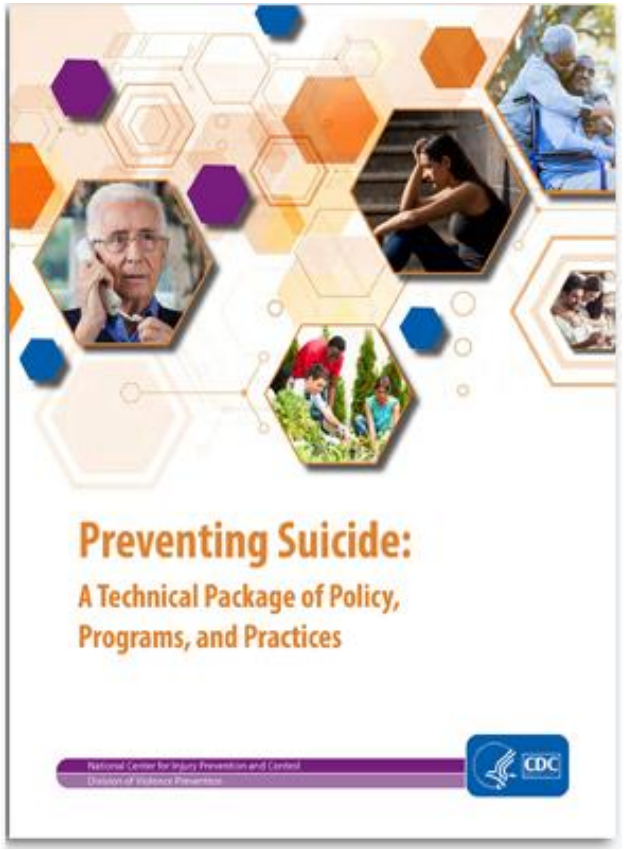
- Click here to download the Sponsor Prospectus

National Suicide Prevention Lifeline



Helpful Resources: https://cams-care.com/





Stress and Burnout: Resilience + Organizational Advocacy

J. Bruce Hillenberg, PhD, ABPP

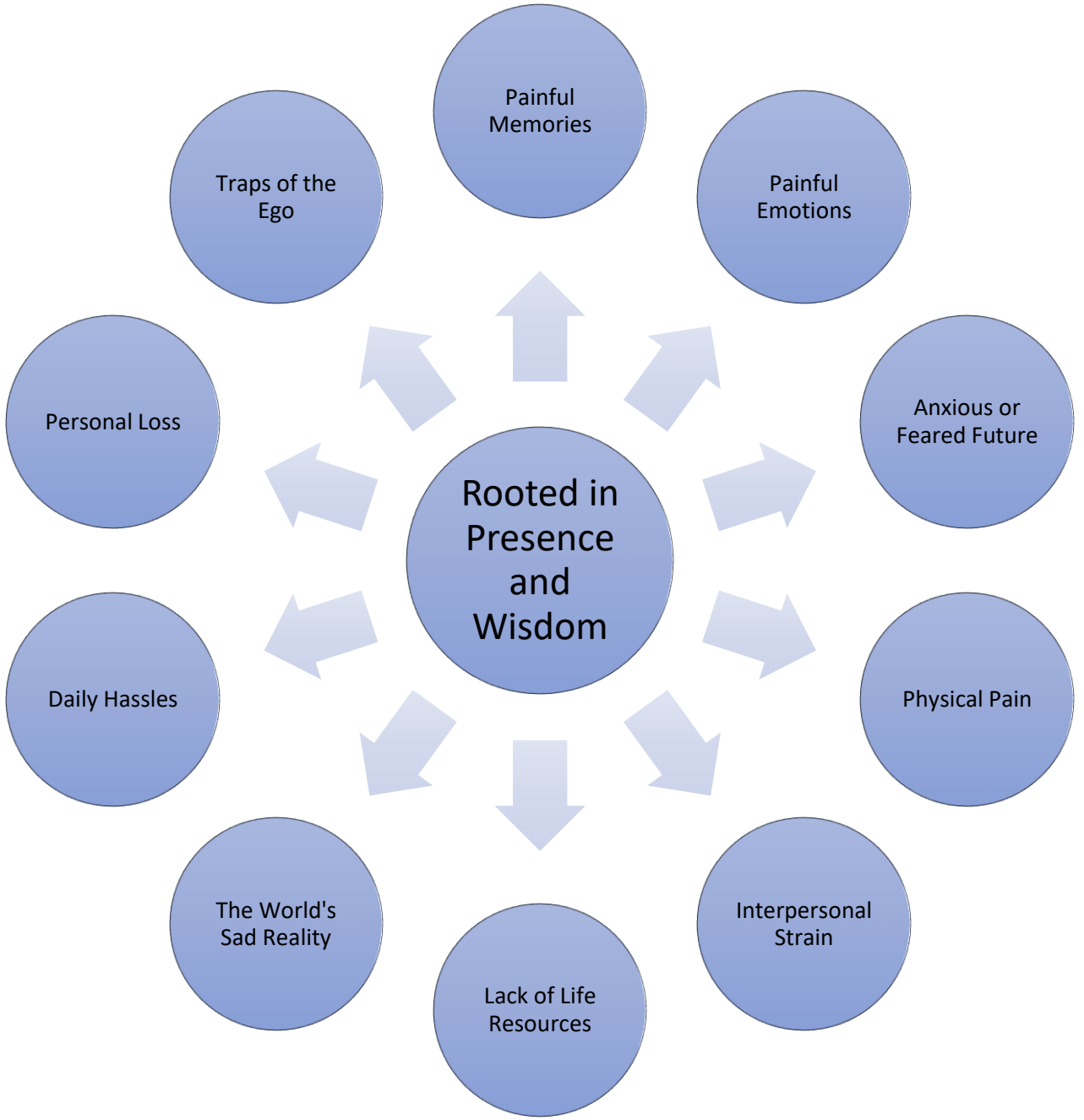
Board-Certified in Clinical Health Psychology

Conflicts

- I have no conflicts to declare

Learning Objectives

- Understand the relationship between stressors, individuals, and stress response
- Recognize patterns of stress in society
- Identify the health consequences of persistent stress
- Describe how psychological flexibility enables individuals to remain resilient in the face of stressors
- Explain why healthcare providers are at risk for burnout and the steps they can take to protect themselves against this problem


Rooted in Presence and Wisdom
Painful Memories
Painful Emotions
Anxious or Feared Future
Physical Pain
Interpersonal Strain
Lack of Life Resources
The World's Sad Reality
Daily Hassles
Personal Loss
Traps of the Ego

Stress

- How an individual appraises a stressor determines how she or he copes with or responds to the stressor.
- Whether or not a stressor is experienced as discomforting is influenced by a variety of personal and contextual factors including capacities, skills and abilities, constraints, resources, and norms.
- Primary appraisal involves determining whether the stressor poses a threat.
- Secondary appraisal involves the individual's evaluation of the resources or coping strategies at her or his disposal for addressing any perceived threats.
- The process of reappraisal is ongoing and involves continually reappraising both the nature of the stressor and the resources available for responding to the stressor.
- Emotion- and problem-focused coping

Lazarus and Folkman, 1984, Stress appraisal and coping

Mechanic, 1978, Students under stress

Stress: What Matters?

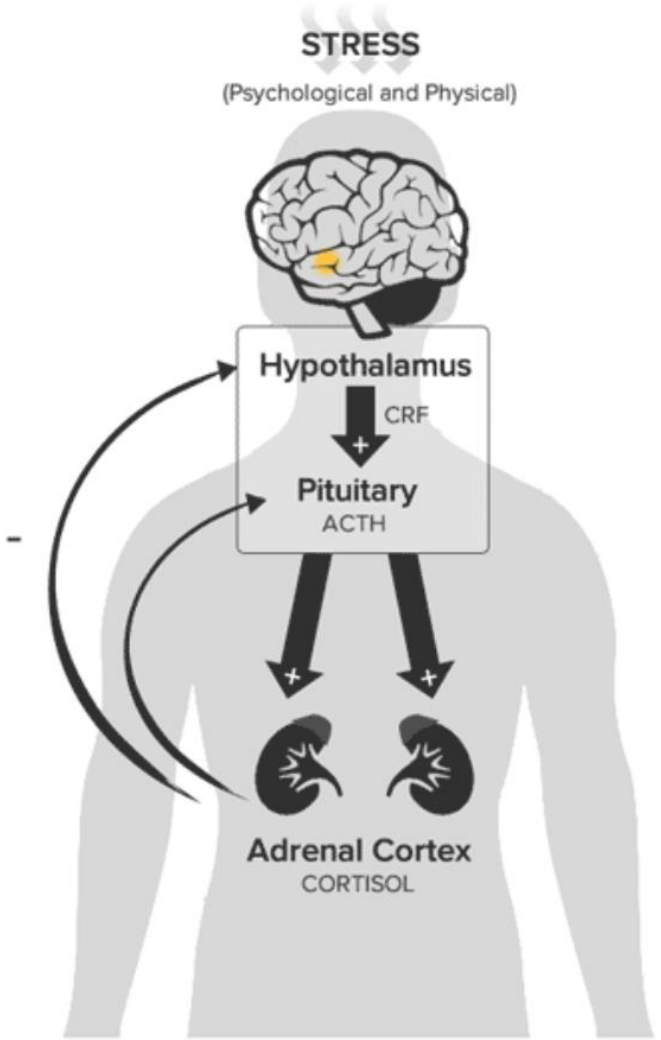
Life Events versus Daily Hassles

Holmes & Rahe, 1967, Journal of Psychosomatic Research, 11, 213

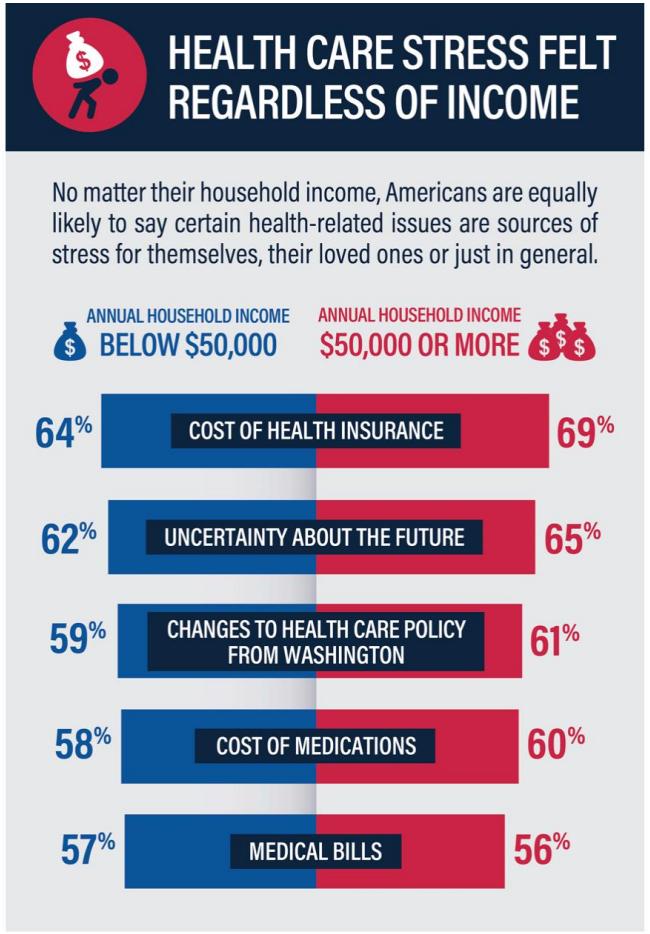
Kanner et al, 1981, Journal of Behavioral Medicine, 4(1), 1-39

Rahe et al, 1970, Journal of Psychosomatic Research, 13(4), 401-406

Stress Responses



Stress in America: Healthcare



Note: Percentages refer to the respondents who indicated stress for themselves, their loved ones or just in general with regard to certain health-related issues.

The Mental Health of the USA!

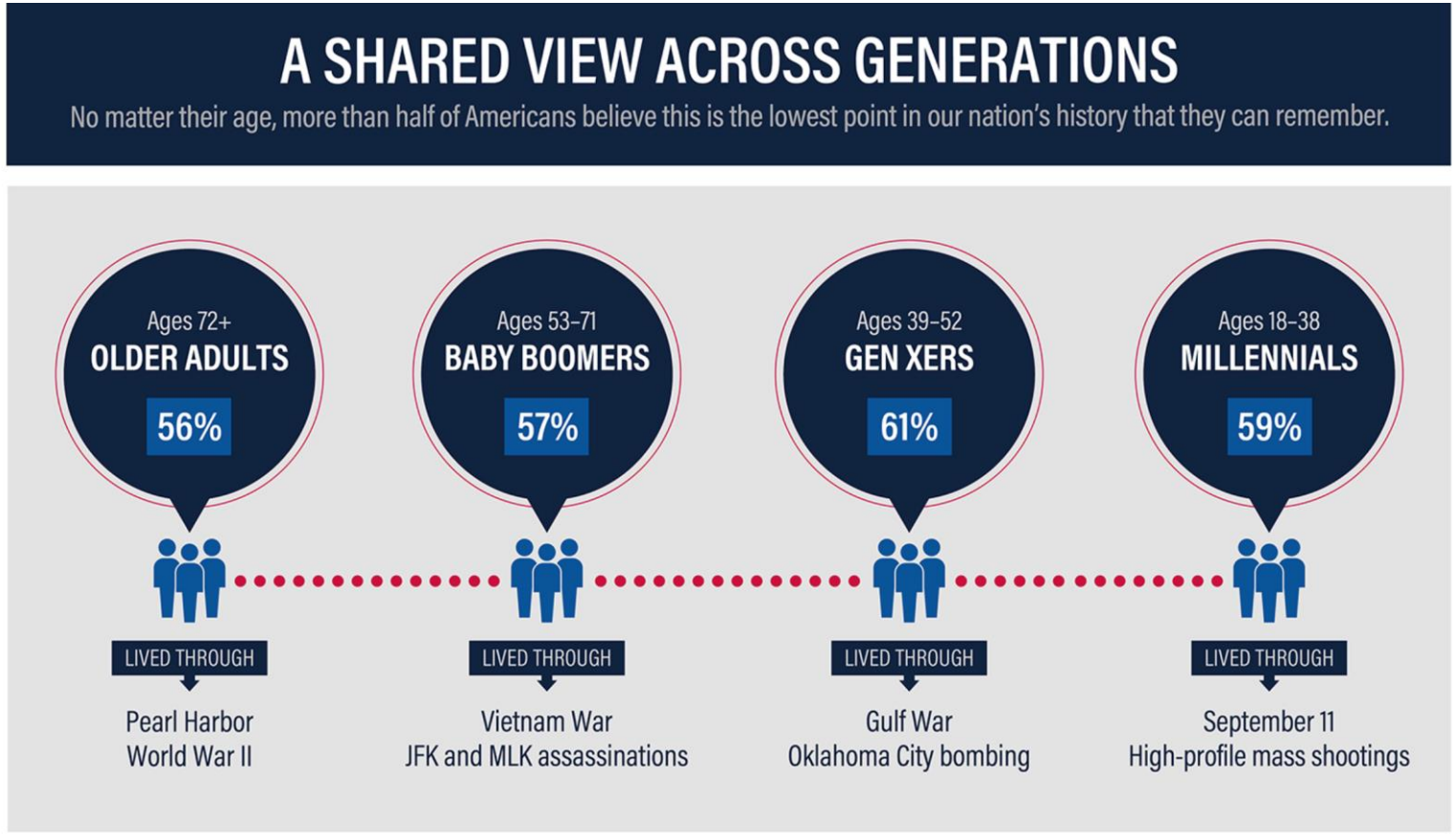
Americans Are Among the Most Stressed People in the World, Poll Finds

In 2018, Americans reported experiencing stress, anger and worry at the highest levels in a decade, according to a new Gallup poll. Sarah Silbiger/The New York Times

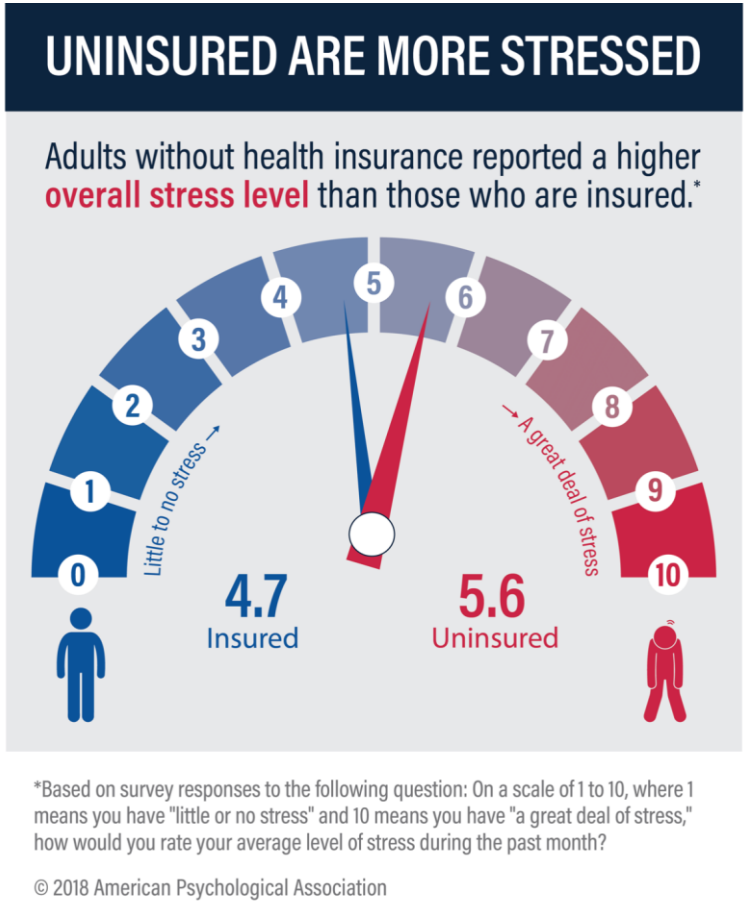
Stress in America

Note: Sources of stress reflect two separate questions; the sources of stress listed above were not shown within one list.

Stress in America: Nation at a Low Point



Stress in America: Insurance Coverage

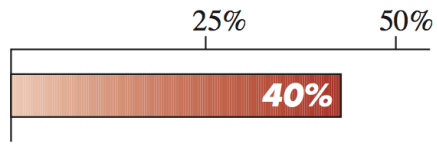


STRESS
...AT WORK

What Workers Say About Stress on the Job

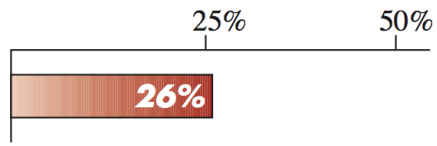
Survey by Northwestern National Life

Percentage of workers who report their job is "very or extremely stressful."



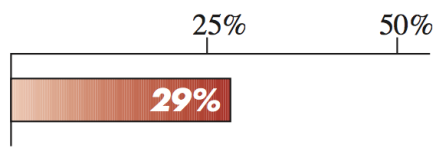
Survey by the Families and Work Institute

Percentage of workers who report they are "often or very often burned out or stressed by their work."



Survey by Yale University

Percentage of workers who report they feel "quite a bit or extremely stressed at work."

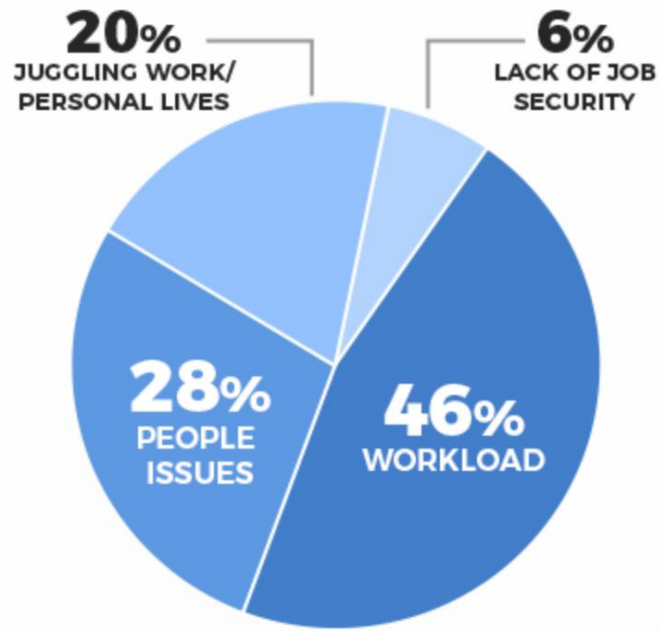


Job stress is costly. Job Stress carries a price tag for U.S. industry estimated at over $300 billion annually as a result of:

- Accidents
- Absenteeism
- Employee turnover
- Diminished productivity
- Direct medical, legal, and insurance costs
- Workers' compensation awards as well as tort and FELA judgments

American Stress Institute, 2019

Main Causes of Stress



Source: EAP provider ComPsych's first half of 2006 StressPulse Survey.

American Heart Association.

CEO ROUNDTABLE

Commissioned by the
American Heart Association CEO Roundtable
and conducted by the **American Heart Association's**
Center for Workplace Health

Highlighted Findings

A national poll of U.S. employees conducted by Harris Poll for the CEO Roundtable found:

A Prevalence of Mental Health Disorders

76%

- Roughly three in four employees (76 percent) indicate they have struggled with at least one issue that affected their mental health.

42%

- About two in five employees (42 percent) answered yes when asked if they have ever been diagnosed with a mental health disorder.

63%

- Although many were willing to divulge their disorder in this confidential survey, 63 percent of those diagnosed with a disorder say they have not disclosed it to their employer.

Your Experience of Stress

- What are your work stressors?
- How do you experience stress? Mind? Body? Behaviors?
- Which stressors do you find more challenging to deal with?
- Which stress management strategies work for you?

Unique Challenges of the Healthcare Workforce

Advisory Board

Abo

RESEARCH UPCOMING EVENTS NEWS + BLOGS

Home / Daily Briefing / The Daily Briefing / Health care workers may be the nation's most stressed employees

Today's Daily Briefing | View the Archives | Print Today's Stories

Health care workers may be the nation's most stressed employees

Medical personnel report more stress than retail workers

11:19 AM - February 13, 2014

Share this story with your colleagues.

Health care providers have higher stress levels and complaints than employees of any industry, including the professional, business service, and retail sectors, according to a recent **CareerBuilder** survey.

Stress and Healthcare Professionals

American health-care workers are committing suicide in unprecedented numbers

BY DR. VINITA PARKASH, OPINION CONTRIBUTOR — 05/31/18 06:30 AM EDT

THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

711 COMMENTS

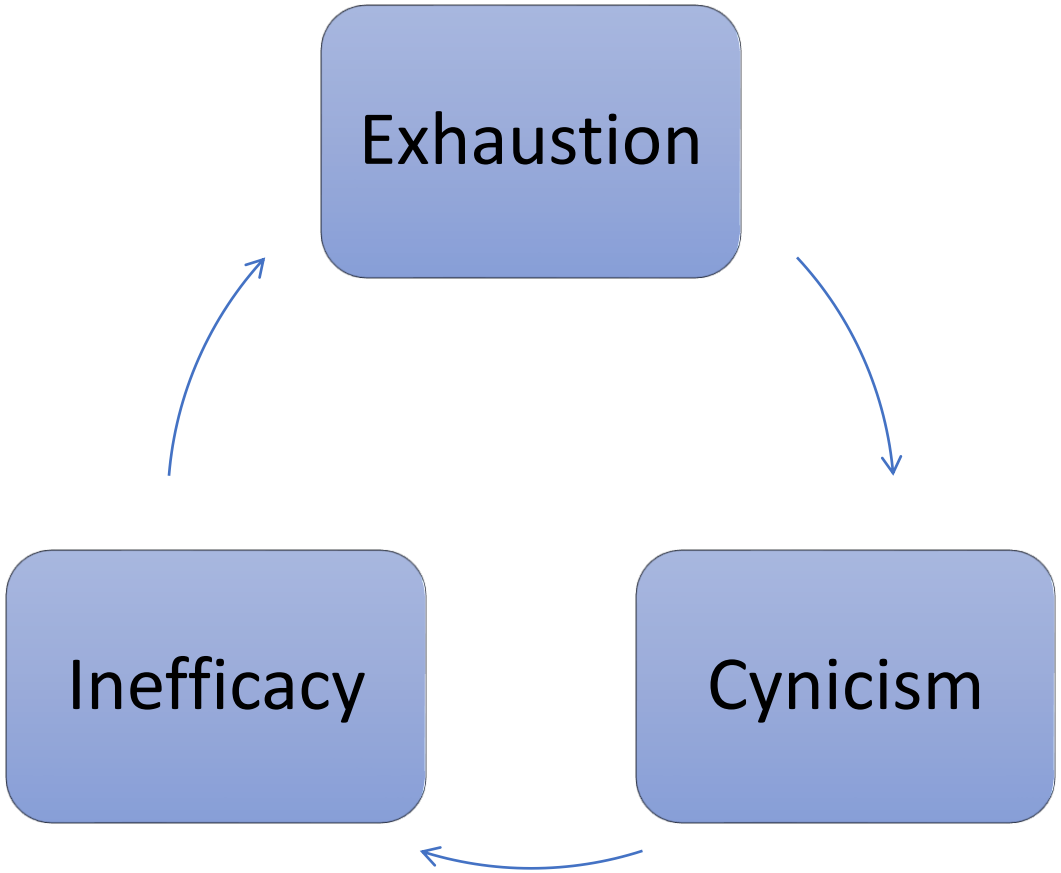
Burnout and Moral Injury

- Increased clerical burden
- Lack of feedback and communication
- Doing more with less
- Increased production expectations
- Workforce shortages
- Metrics overload
- Individual factors
- Training deficits

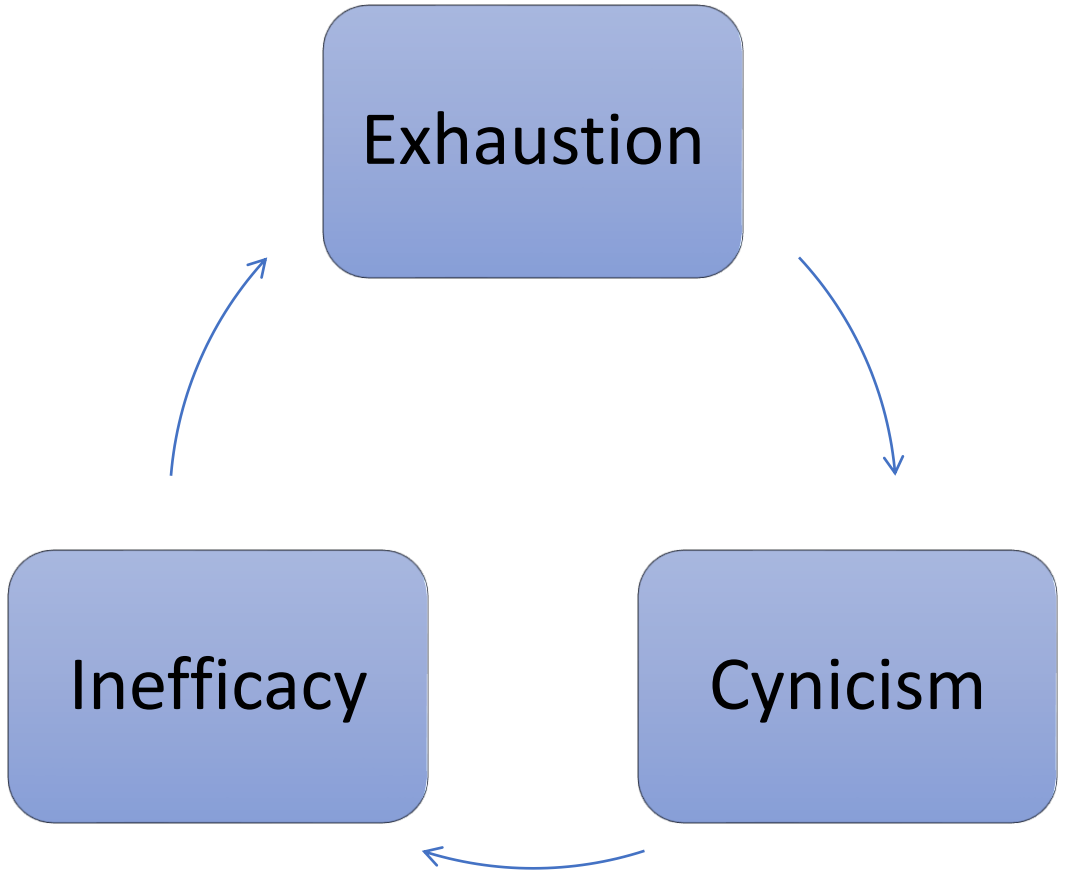
Cedoline, 1982, Job Burnout in Public Education: Symptoms, Causes and Survival Skills

Shanafelt & Noseworthy, 2017, Mayo Clin Proc, 92(1), 129-144

Burnout



Burnout



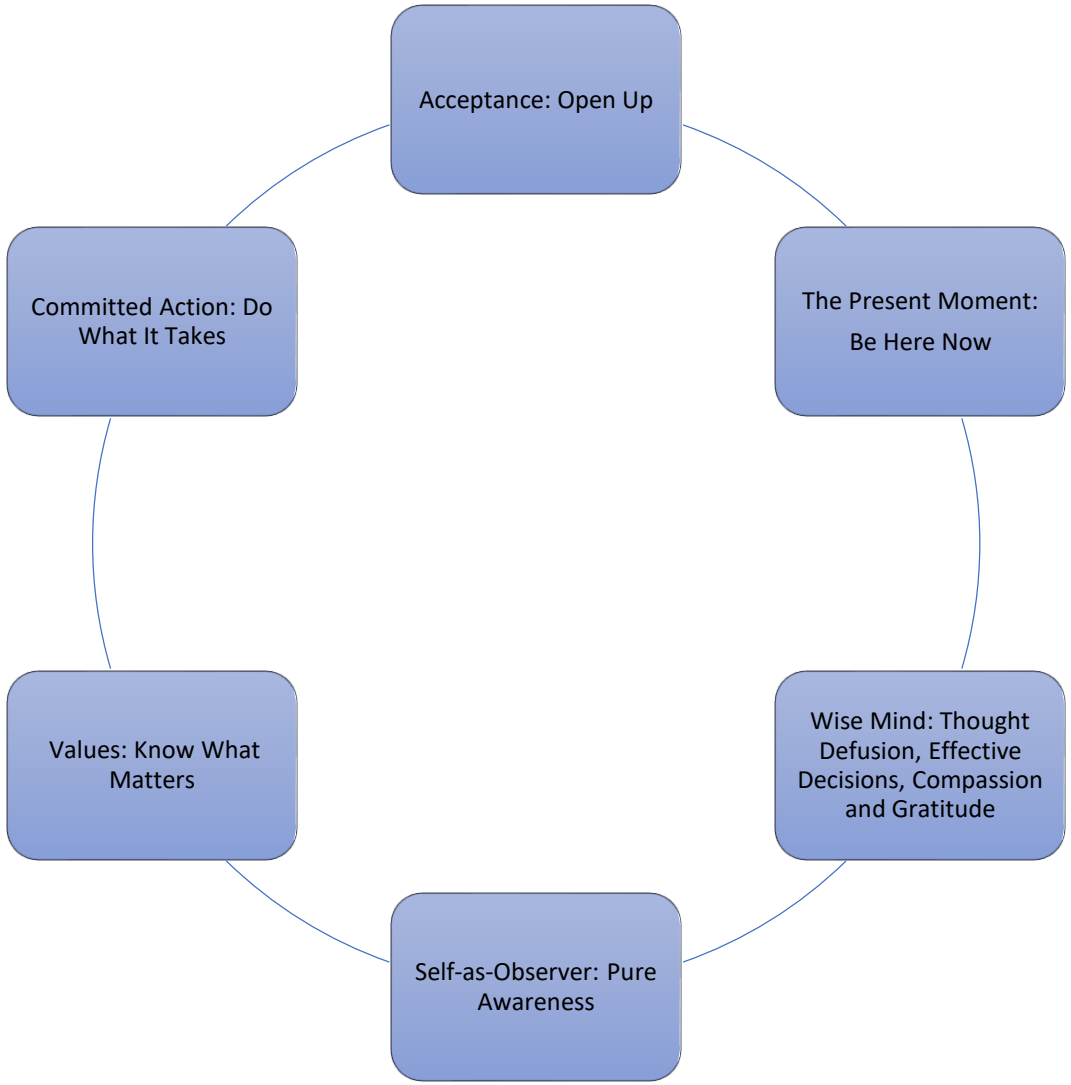
Realistic expectations
Psychological breaks
Maintain relationships
Meaning beyond work
Self-care
Get involved

Organizational Strategies to Promote Engagement and Reduce Burnout

- Acknowledge and assess the problem
- Pick the right leaders
- Focus on high-opportunity work units
- Enhance peer support
- Challenge mono-focus on productivity—reward other dimensions
- Check in with value alignment
- Promote flexibility and work-life integration
- Provide resources to promote resilience and self-care
- Facilitate and fund organization science

Shanafelt & Noseworthy, 2017, Mayo Clin Proc, 92(1), 129-144

Psychological Flexibility



Health Benefits

Published in final edited form as:
Clin Psychol Rev. 2010 November 1; 30(7): 865–878. doi:10.1016/j.cpr.2010.03.001.

Psychological Flexibility as a Fundamental Aspect of Health

Todd B. Kashdan
George Mason University Jonathan Rottenberg University of South Florida

Acceptance

- Acknowledging reality
- Without judgement
- Suffering occurs when we are unwilling to accept the pain in our life
- Expansion versus contraction
- Starting where you are
- Doing what is uncomfortable because it is important to the person we want to be

Acceptance

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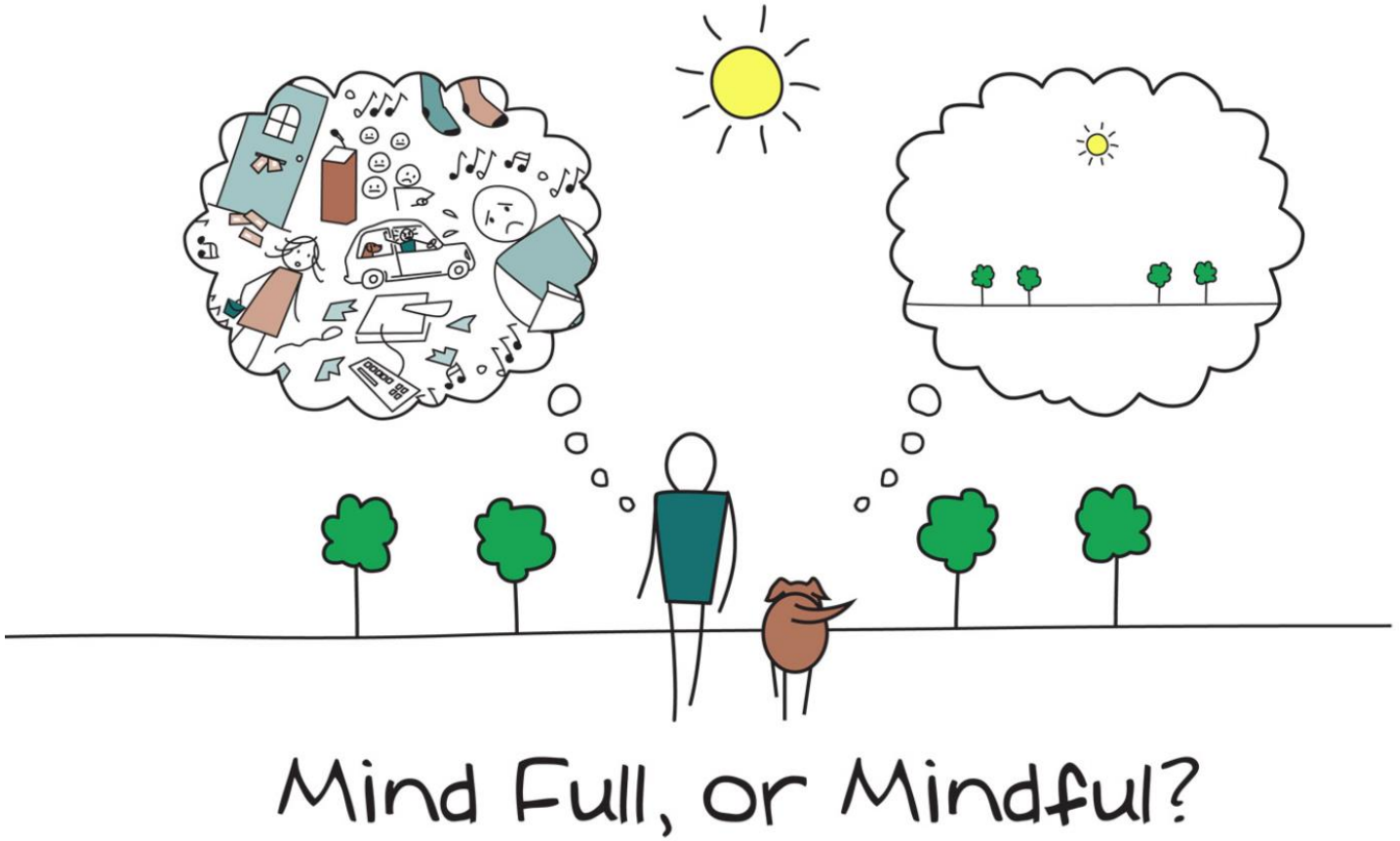
Challenge of acceptance?

Impact on patient resilience?

Presence



Presence

- Formal and informal practice > on purpose
- Bring the wandering mind back to the breath and what is present
- Self-compassion for the wandering mind
- Efficient use of psyche energy
- Maximize the moment

Presence

- Formal and informal practice > on purpose
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- Maximize the moment

Mindfulness

Daily mindfulness practice?

Wise Mind

- Images, thoughts, memories and beliefs
- Helpful ---------- Unhelpful
- Modify
- Defuse (10-second rule)
- Seeing the truth in the situation
- Use breath as an anchor
- Taking effective action
- Doing what is in your best interest

Wise Mind

- Images, thoughts, memories and beliefs
- Helpful ---------- Unhelpful
- Modify
- Defuse (10-second rule)
- Seeing the truth in the situation
- Use breath as an anchor
- Taking effective action
- Doing what is in your best interest

Take a pause, breath deeply, and then observe the flow of your thoughts. Let thoughts come and go. Try to watch them as an observer without reaction.

What was this like?

What did you notice?

Helpful versus unhelpful?

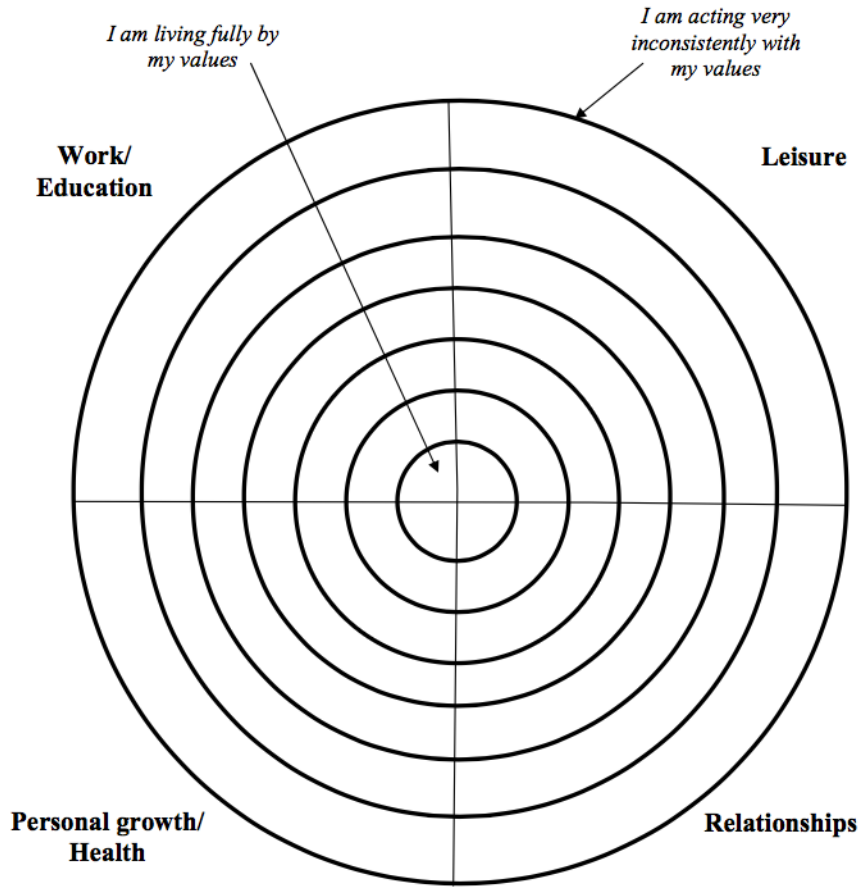
Self-As-Observer

- Beginner’s Mind
- Transcend the Past
- Non-judgment
- Simple Awareness

Values and Committed Action

Experiential Avoidance

Distracted by the Emotion Mind



Values and Committed Action

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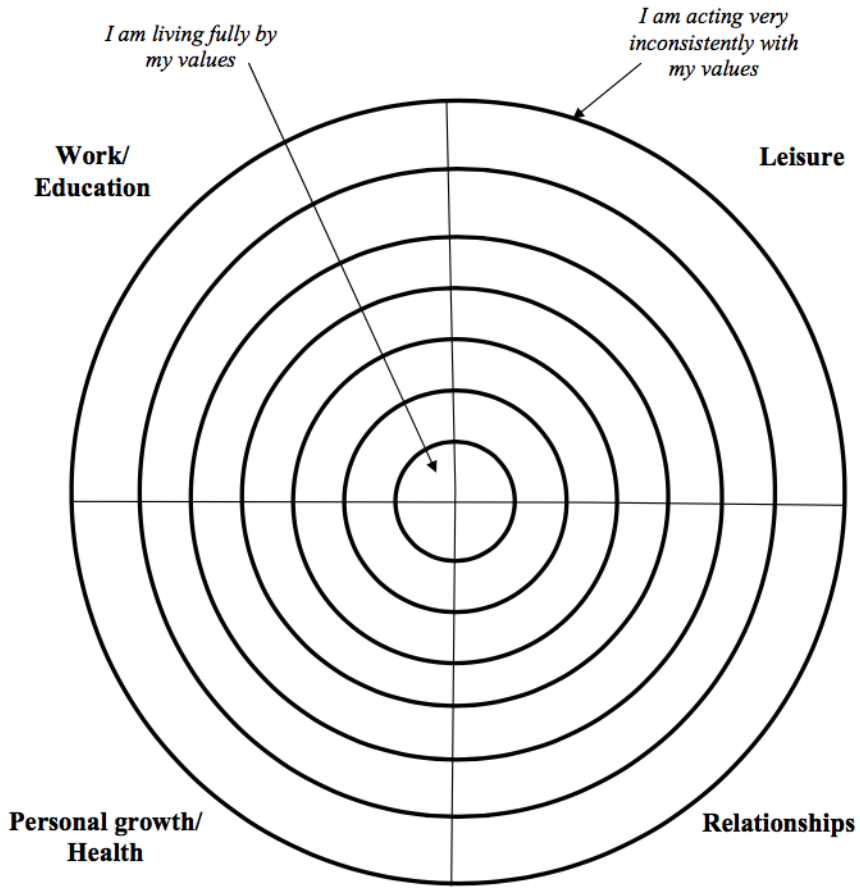


What gets in the way?

Impact on daily life?

How to change?

Meaning and Purpose

OPEN ACCESS Freely available online

PLOS ONE

Purpose in Life Predicts Better Emotional Recovery from Negative Stimuli

Stacey M. Schaefer[1,2,3]*, Jennifer Morozink Boylan[4], Carien M. van Reekum[6], Regina C. Lapate[1,2,3], Catherine J. Norris[7], Carol D. Ryff[1,5], Richard J. Davidson[1,2,3]

1 Department of Psychology, University of Wisconsin – Madison, Madison, Wisconsin, United States of America, **2** Waisman Laboratory for Brain Imaging and Behavior, University of Wisconsin – Madison, Madison, Wisconsin, United States of America, **3** Center for Investigating Healthy Minds, University of Wisconsin – Madison, Madison, Wisconsin, United States of America, **4** Center for Women's Health and Health Disparities Research, University of Wisconsin – Madison, Madison, Wisconsin, United States of America, **5** Institute on Aging, University of Wisconsin – Madison, Madison, Wisconsin, United States of America, **6** Centre for Integrative Neuroscience and Neurodynamics, School of Psychology and Clinical Language Sciences, University of Reading, Reading, United Kingdom, **7** Department of Psychology, Swarthmore College, Swarthmore, Pennsylvania, United States of America

Self-Compassion

1. Self-kindness vs. Self-judgment.

Warmth

Gentle in the face of Imperfection

Accept that we can't always get what we want

2. Common humanity vs. Isolation.

All people suffer

Appreciate that everyone struggles with imperfection

3. Mindfulness vs. Over-identification.

Observe without judgement

Not become over-identified with thoughts and emotions

Become less involved with the narrative of the "self"

Neff, 2015, Mindfulness, doi 10.1007/s12671-015-0479-3

Conscientiousness and Self-efficacy

Conscientiousness and Longevity: An Examination of Possible Mediators

Patrick L. Hill
University of Illinois at Urbana-Champaign

Nicholas A. Turiano
Purdue University

Michael D. Hurd
RAND Center for the Study of Aging

Daniel K. Mroczek
Purdue University

Brent W. Roberts
University of Illinois at Urbana-Champaign

Objective: Conscientious individuals tend to experience a number of health benefits, not the least of which being greater longevity. However, it remains an open question as to why this link with longevity occurs. The current study tested two possible mediators (physical health and cognitive functioning) of the link between conscientiousness and longevity. ***Method:*** We tested these mediators using a 10-year longitudinal sample ($N = 512$), a subset of the long-running Health and Retirement Study of aging adults. Measures included an adjective-rating measure of conscientiousness, self-reported health conditions, and three measures of cognitive functioning (word recall, delayed recall, and vocabulary) included in the 1996 wave of the HRS study. ***Results:*** Our results found that conscientiousness significantly predicted greater longevity, even in a model including the two proposed mediator variables, gender, age, and years of education. Moreover, cognitive functioning appears to partially mediate this relationship. ***Conclusions:*** This study replicates previous research showing that conscientious individuals tend to lead longer lives, and provides further insight into why this effect occurs. In addition, it underscores the importance of measurement considerations.

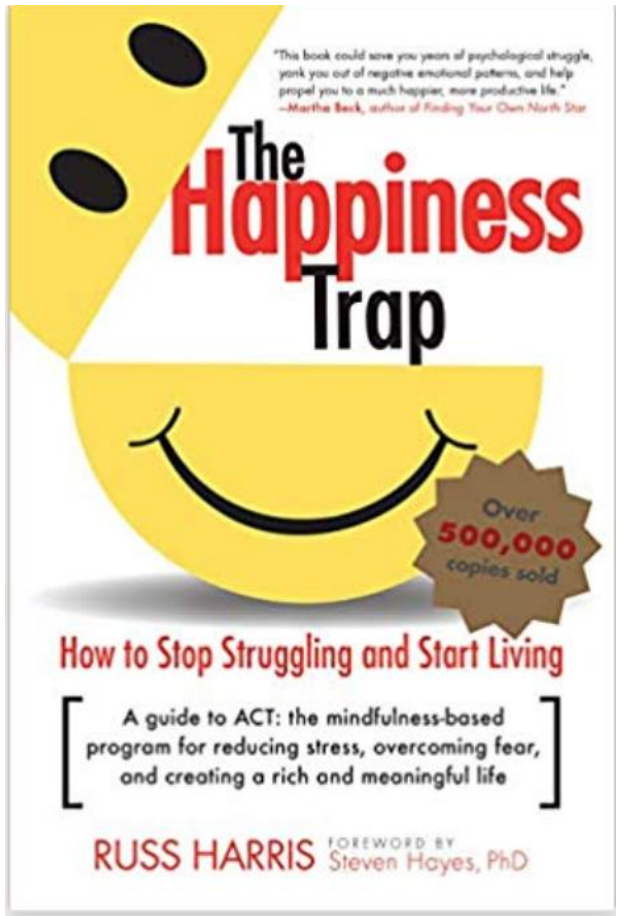
Keywords: conscientiousness, longevity, cognitive functioning, personality and health

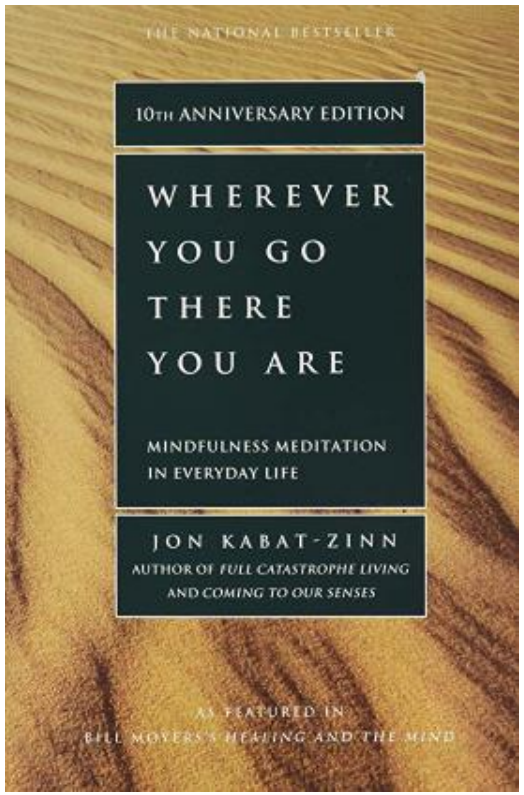
Self-Efficacy

- An individual's capacity to produce desired effects
- Beliefs about what means lead to what goals and about possessing the personal capacity to use these means
- Self-efficacy is the opposite of learned helplessness
- Linked to health behaviors
- Practice makes permanent, but perfect

Psychological Flexibility

- What ideas are your taking away from our discussion of the role of psychological flexibility in coping and resilience?
- What goals are you interested in setting as a result of this discussion?
- How might you approach patients differently due to this discussion?


"This book could save you years of psychological struggle, yank you out of negative emotional patterns, and help propel you to a much happier, more productive life."
—Martha Beck, author of Finding Your Own North Star
The Happiness Trap
Over 500,000 copies sold
How to Stop Struggling and Start Living
A guide to ACT: the mindfulness-based program for reducing stress, overcoming fear, and creating a rich and meaningful life
RUSS HARRIS
FOREWORD BY Steven Hayes, PhD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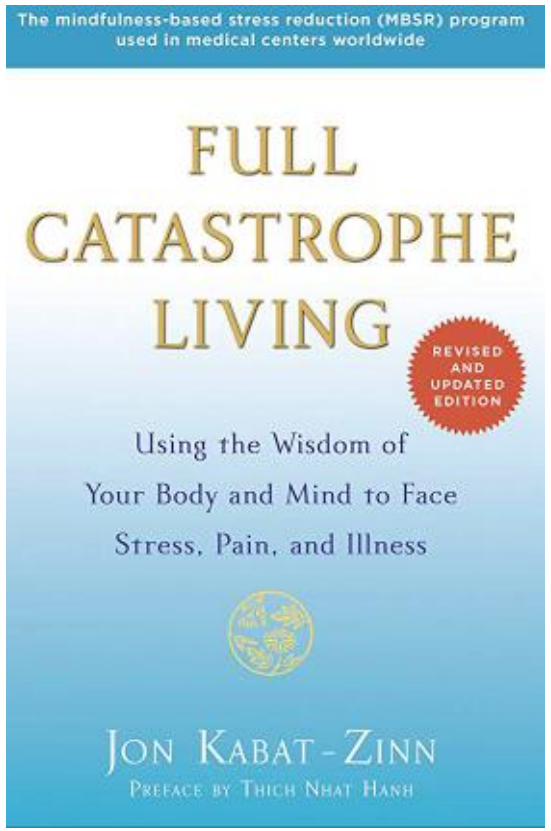
WHEREVER YOU GO THERE YOU ARE
MINDFULNESS MEDITATION IN EVERYDAY LIFE
JON KABAT-ZINN
AUTHOR OF FULL CATASTROPHE LIVING AND COMING TO OUR SENSES
AS FEATURED IN BILL MOYERS'S HEALING AND THE MIND


The mindfulness-based stress reduction (MBSR) program used in medical centers worldwide
FULL CATASTROPHE LIVING
REVISED AND UPDATED EDITION
Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness
JON KABAT-ZINN
PREFACE BY THICH NHAT HANH

Village Advocacy

- Get involved
- Take a stand
- Big goals
- Create a wave
- Network
- Challenge the status quo

Questions?

drhillenberg@gmail.com

248.892-4364