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How to Hear What Your Patients AREN'T Saying: Recognizing the Risk Signs for Suicide or Self-Harm

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Today’s Learner Outcomes:
As a result of this course, participants will be able to...

1) Explain why tinnitus, hyperacusis, and misophonia can be bothersome to patients

2) Recognize risk factors and warning signs for suicidal behavior and use that information to formulate a plan for how to react when patients disclose suicidal intent

3) Explain how to access resources that can help both you (the provider) and the patient
Disclosure:

Lori Zitelli is employed by UPMC and the University of Pittsburgh.

She has no additional relevant disclosures to divulge.

I’m sure many of you have worked with patients who...

- Suffer from bothersome tinnitus...
- Suffer from decreased sound tolerance...
- Suffer from anxiety or depression...

Have you ever had a conversation with one of these patients (or any other) that left you feeling uneasy or worried for their safety?
Tinnitus is any noise in your ears or head that is not related to external sound.

The neurophysiological model of tinnitus created by the Jastreboffs is based on connections between the auditory, limbic, and autonomic-nervous systems.

Decreased Sound Tolerance (DST) is considered to be any negative reactions exhibited when exposed to a sound that would not evoke the same response in the average listener.

**Hyperacusis**
- Decreased tolerance to sound (meaning and context of sound occurrence are IRRELEVANT)
- Reaction based only on physical characteristics (intensity, frequency spectrum, etc)

**Misophonia**
- “Hatred of sound”
- Decreased tolerance to SPECIFIC sound in SPECIFIC context
- Reaction based on previous learned experience with sound

Hyperacusis is defined as abnormally high activation of the autonomic nervous system due to high amplification of the auditory system passed to autonomic nervous system resulting in behavioral reaction to sound.

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Misophonia is defined as abnormally high activation of the autonomic nervous system due to overamplification occurring at connections between the auditory pathways and autonomic nervous system resulting in behavioral reaction to sound.

![Diagram](image)


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Treatment of patients who suffer from tinnitus and DST involves extensive counseling.

- Informational counseling topics include the patient’s audiometric test results, hearing anatomy, suppression and enhancement of auditory signals, conditioned reflexes, and sound therapy.

- As for other counseling...anything goes.

- Limbic & autonomic-nervous system involvement complicates things.

- Not every TRT patient is diagnosed with a psychiatric disorder, although...
The prevalence of psychiatric disorders (especially anxiety and depression) is high in tinnitus patients.  
(Pinto et al, 2014)

- Most patients studied were affected by mood disorders (depression and anxiety)
- Can’t establish cause
  - Which came first, the tinnitus or the psychiatric disorder?
  - Where is the starting point in the vicious cycle?

The over-representation of anxiety disorders and anxiety-related personality traits in patients with hyperacusis suggests common or cooperating mechanisms.  
(Juris, Larsen, & Ekselius, 2013)

- Patients with LDLs under 90 dB HL in one or both ears
  - 500, 1000, 2000, and 3000 Hz
- Mini International neuropsychiatric interview (MINI)
  - Psychiatric disorders
- Swedish Universities scales of Personality (SSP)
  - Personality traits
- 56% fulfilled criteria for at least one current psychiatric disorder
It has been suggested that misophonia should be classified as a discrete psychiatric disorder.  
(Schröder, Vulink, & Denys, 2013)

- Structured Clinical Interview for DSM-IV Axis II Personality Disorders
- Hamilton Depression Rating Scale
- Hamilton Anxiety Rating Scale
- Symptom Checklist (SCL-90)
- Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
- Common traits found in all patients
- Symptom patterns of misophonia don’t quite fit any other diagnosis

You may primarily identify as an audiologist, but you’re also a counselor in this capacity.  
Clark (2006)

Here are some tips:

- Greet your patient in a way that inspires confidence & trust
- Ensure private, unhurried time together
- Be conscious of verbal & nonverbal communications
- Use silence
- Encourage feelings to be expressed
- Respond with empathy and warmth
- Listen attentively and nonjudgmentally
Interviewing patients who are suffering from tinnitus & DST is tough...
You will need to ask difficult questions and make the patient feel comfortable
enough to answer honestly.

- What is the major reason your tinnitus or DST is a problem?
- Does your tinnitus or DST cause you to feel depressed or anxious?
- Does your tinnitus or DST prevent you from...

<table>
<thead>
<tr>
<th>Concentrating?</th>
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<tbody>
<tr>
<td>Sleeping?</td>
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<tr>
<td>Participating in social activities?</td>
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<td>Working effectively?</td>
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<td>Attending church?</td>
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<td>Doing household activities?</td>
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<td>Completing childcare duties?</td>
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<td>Attending concerts?</td>
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<tr>
<td>Driving?</td>
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<tr>
<td>Shopping?</td>
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<tr>
<td>Going to the movies?</td>
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</tbody>
</table>

You need to be able to be an informational counselor AND an emotional counselor.
(English, Mendel, Rojeski, & Hornak, 1999)

- Differentiate between a content message and an affective message
- Respond in a way that lets your patient know that their primary message is being heard.
  - If the patient requests information, your response should provide information.
  - If the patient expresses an emotion, your response should acknowledge that emotion.
- “Why is my tinnitus is so annoying????”
  - Informational response: We believe your tinnitus is annoying because of the heightened connections between your auditory, limbic, and autonomic nervous systems.
  - Emotional response: I can tell that it is really bothersome – it clearly has a big impact on your life and is very disruptive. What’s the major reason that it’s such a problem for you?
ASHA and AAA both include non-medical management of tinnitus using education and counseling (among other things) in their scope of practice guidelines.

- ASHA: “...Assessment and non-medical management of tinnitus using biofeedback, behavioral management, masking, hearing aids, education, and counseling...”

- AAA: “Audiologists assess and provide audiological treatment for persons with tinnitus using techniques that include, but are not limited to, biofeedback, masking, hearing aids, education, and counseling.”

- You can be qualified to provide this service to patients and when you do it well, you can be very effective.

- Please take every opportunity to learn about and practice these skills very seriously. The stakes can be very high.

One in six (16%) patients with tinnitus reported suicidal thoughts. (Fox-Thomas, 2016)

- Jacobson & McCaslin (2001) reported that the majority of patients that they studied with tinnitus who committed suicide had preexisting psychiatric conditions

- Primary psychiatric disease was depression

- Take away message: The practicing audiologist and otologist need to be aware of the possible risk of suicide among clinically depressed tinnitus sufferers
Because these patients can be very distressed (and often suffer from comorbid mental health issues), you need to be prepared if someone threatens self-harm.

Many patients do not spontaneously report their suicidal thoughts & intentions to their care providers, so you need to **be alert to any signals** that they may be at risk (Matthews, Milne, & Ashcroft, 1994).

Sometimes providers are afraid to ask about suicidal intentions because they think it may lead to suicidal thinking – there is **no evidence to support this** (Zimmerman et al, 1995).

The risk of suicide should be **considered imminent** if the patient expresses the intention to die, has a plan, & has lethal means available (Hirschfeld & Russell, 1997).

- Expressions of despair, hopelessness, and extreme pessimism also suggest imminent risk (Hirschfeld & Russell, 1997).

Audiologists need to be able to recognize suicidal tendencies and have a plan for appropriate preventive intervention. (Flasher & Fogle, 2012)

- **It is not your responsibility** to conduct a suicide evaluation, but you should **collect critical information** to provide to qualified professionals that can help.

- **We are mandatory reporters.** You must disclose suicidal ideation to a mental health professional regardless of whether you think the person is actually at risk.

- “Mr. So-and-so, in order to ensure your safety I feel it is necessary to share this information with your doctor. They will be able to take the appropriate steps to make sure you don’t harm yourself.”

- If the patient protests your disclosure of this confidential information, you can apologize while maintaining that **your primary concern and responsibility is the patient’s safety.**

- Take good notes (mental or actual written) about what the patient says and does. **Record what steps you took** to alert other professionals to the patient’s suicidal thoughts.
Where the HIPAA Privacy Rule applies, does it permit a health care provider to disclose protected health information (PHI) about a patient to law enforcement, family members, or others if the provider believes the patient presents a serious danger to self or others?

- 45 CFR § 164.512(j)(1)(i) & 45 CFR § 164.512(j)(4)

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required:

- A covered entity may use or disclose protected health information without the written authorization of the individual, as described in § 164.508, or the opportunity for the individual to agree or object as described in § 164.502, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(j) Standard: Uses and disclosures to assert a serious threat to health or safety

- (1) Permitted disclosures. A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:
  - (i) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
  - (ii) Is made in good faith to a person who may be able to lessen the threat.

- (2) Presumption of good faith belief. A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1)(ii) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) of this section, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good faith belief can mitigate the threat.


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Please be aware of these warning signs (sign that indicates heightened risk for suicide in the near-term [i.e., within minutes, hours, or days]).

Rudd et al (2006)
suicidepreventionlifeline.org

<table>
<thead>
<tr>
<th>Talking about wanting to die or to kill themselves</th>
<th>Looking for a way to kill themselves, such as searching online or buying a gun</th>
<th>Talking about feeling trapped or in unbearable pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking about being a burden to others</td>
<td>Increasing the use of alcohol or drugs</td>
<td>Sleeping too little or too much</td>
</tr>
<tr>
<td>Withdrawing or isolating themselves</td>
<td>Acting anxious or agitated; behaving recklessly</td>
<td>Getting affairs in order / saying goodbye</td>
</tr>
<tr>
<td>Showing rage or talking about seeking revenge</td>
<td>Displaying extreme mood swings</td>
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Results indicate that participants who read the suicide warning signs reported greater abilities to recognize if someone is suicidal.

Hearing what patients are *saying* vs hearing what patients *mean*

“Sometimes I wish I could just walk and walk and walk... and leave my tinnitus behind.”

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Ok – so I’ve identified that my patient is at risk. Now what?!  
Flasher & Fogle (2012)

- **ASK** about their intentions  
  - “What are you thinking about doing?”  
  - “Are you thinking of harming yourself in some way?”

- **ASK** follow-up questions to get more specific information  
  - “Could you tell me more about your thoughts?”  
  - “Do you have a plan about how you would kill yourself?”

- If your patient discloses this information to you, it means that they trust you and you are in a position to help them.
There are areas that you should pay specific attention to when asking questions and listening to responses.
Flasher & Fogle (2012)

Specificity > Lethality > Availability > Proximity > Intent

Remember — it’s not your responsibility to conduct a suicide evaluation.

These are not necessarily questions that you need to ask, but if the patient addresses them in any way you will want to write their words down.

If you get specific information about any of these things, your goal is to pass it along to a qualified professional.

Try to remember these tips when dealing with someone who is threatening suicide or displaying warning signs.
suicidepreventionlifeline.org

Be direct. Talk openly and matter-of-factly about suicide.

Be willing to listen. Allow expressions of feelings. Accept the feelings.

Be non-judgmental. Don’t debate whether suicide is right or wrong, or whether feelings are good or bad. Don’t lecture on the value of life.

Get involved. Become available. Show interest and support.

Don’t dare him or her to do it.

Don’t act shocked. This will put distance between you.

Don’t be sworn to secrecy. Seek support.

Offer hope that alternatives are available but do not offer glib reassurance.

Take action. Remove means, such as guns or stockpiled pills.

Get help from persons or agencies specializing in crisis intervention and suicide prevention.
Use the National Suicide Prevention Lifeline when you’re not sure how to help someone or if you should take action. 
suicidepreventionlifeline.org

- The National Suicide Prevention Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week.
- Even if you are not the one having a crisis, you can call for help.
- **1-800-273-TALK (1-800-273-8255)**

Visit http://suicidepreventionlifeline.org/help-someone-else/ for resources to help you help someone else online. Social media safety teams will reach out to connect the user with the help they need via Facebook, Twitter, Instagram, MySpace, & YouTube. 
suicidepreventionlifeline.org

- Facebook: **Click here** to anonymously report someone as suicidal on Facebook. A member of Facebook’s Safety Team will send the user an e-mail with the Lifeline number and possibly a link to chat with Lifeline counselor.
- Twitter: **Click here** and select “Self-Harm” to send an e-mail to Twitter reporting a suicidal user. Twitter will send the user a direct message with the Lifeline number.
- Instagram: To report threats of suicide or self-harm on Instagram: Tap "..." below the post, Tap Report Inappropriate, Select This Photo Puts People At Risk > Self-Harm.
- MySpace: Click on the “Report Abuse” link that appears at the bottom of every MySpace page and complete the form. MySpace will then send an e-mail to the MySpace user with the Lifeline number.
- YouTube: To report threats of suicide or self-harm, click “More,” Highlight and click “Report” in the drop-down menu. Click “ Harmful dangerous acts,” then “Suicide or self-injury.” YouTube will review the video and may send a message to the uploader with the Lifeline number.
- Tumblr: Tumblr no longer directly responds to reports of suicide or self-harm. Message the user with the Lifeline number and a message of support.
- Pinterest: Go to the person’s profile. Click the gear menu, then Report. Pick the reason for your report. Confirm that you want to report.
If your patient has hearing loss or difficulty speaking, you can still help them by providing information for an online chat with a LifeLine counselor or the TTY number. suicidepreventionlifeline.org

- The Lifeline Crisis Chat service is available within the United States and territories 24/7.
- If all chat specialists are busy assisting other visitors, you will be asked to try the chat again in a half hour.
- If the chat service is not open, you are encouraged to call the National Suicide Prevention Lifeline at 1-800-273-8255.

- If you are hard of hearing and a veteran, service member, or any person concerned about one, there are several ways to contact the Veterans Crisis Line:
  - To text with a Veterans Crisis Line responder, send a text message to 828255.
  - To chat with a Veterans Crisis Line responder online, click the chat button below: https://www.veteranscrisisline.net/Chat/termsofservice.aspx?account=Veterans%20Chat

- Contact the Lifeline via TTY by dialing 800-799-4889


- **Contact re:solve Crisis Network 24 hours a day, 365 days a year**

- **Telephone:** call any time and speak with a trained counselor at 1-888-7-YOU CAN (1-888-796-8626).

- **Mobile:** our trained crisis counselors will travel to where you are — anywhere in Allegheny County.

- **Walk in:** you don’t need an appointment when you visit our North Braddock Avenue location, near Pittsburgh, Pa. Just walk in and talk about your concerns or those of a family member or friend.

- **Residential services:** Residential and/or overnight services are available for individuals, ages 14 and older, whose crisis extends over a period of time. We provide up to 72 hours of residential services at our North Braddock Avenue location. An individual may not admit him or herself for residential services, but rather would be assessed during walk-in and then referred to residential services by a staff member. Individuals must have a diagnosis to be admitted to residential, (but that could happen during a walk-in evaluation).

  This service is specific to Allegheny County but your city may provide a similar service. You can also call the re:solve Crisis Network from outside of Allegheny County and they can help you figure out what to do from there.
If you are a provider whose patient has committed suicide, it is common to experience distress. A range of emotions can be expected.

1/3 of the therapists studied experienced severe distress after the suicide of a patient.

Shock
Disbelief
Grief
Guilt
Fear of Blame
Fear of Lawsuit
Self-doubt
Inadequacy

Anxiety
Anger
Betrayal
Shame
Emarrassment
Frustration
Relief

There are several emotional issues (for YOU, the provider) to be addressed in the case of client-suicide.
Ellis & Patel (2012)

Address the need for social support
Take advantage of resources that are available to you
Seek psychotherapy, if indicated
Support from clinical supervisors/administrators

continued™
If you are a provider or student who thinks you don’t need to worry about this topic because they want to work with children, you’re wrong (Jadhav, Prakash, Chandra, & Saranga, 2011).

Suicide represents 12% of deaths each year in the American 15-to-19-year-old age cohort.

It is the third leading cause of mortality in 15-to-19-year-old youth, and the fifth leading cause of mortality in the 10-to-14-year-old group.

Each year, more than 5,000 United States teenagers commit suicide.

What responsibilities does a training program have to its students?

(Ellis & Dickey, 1998)

- In the area of patient suicide, training programs have 2 responsibilities:
  - Take all reasonable steps to prevent patient suicides from occurring.
  - This objective, in addition to the obvious role in quality patient care, also has liability implications for both the training program and supervising faculty members.
- Attend to the needs of the trainee
  - Ensure that, if suicides do occur, the trainee’s emotional needs are met and retrospective analysis occurs to minimize the probability of future suicides, either in the trainee’s future patient caseload or in the training program in general
A 2014 systematic review found no data on the prevalence of the experience of death of a patient by suicide among med students or residents in specialties other than psychiatry...

_We have no idea how often this happens._
(Puttagunta, Lomax, McGuinness, & Coverdale, 2014)

- They also did not find any programs with outcome data for helping medical students or residents, other than psychiatry residents, cope with the death of a patient by suicide.
- There is little information about...
  - The prevalence of the experience of death of a patient by suicide during medical school.
  - The prevalence of the experience of death of a patient by suicide in residencies other than in psychiatry.

_There is a need to develop research on this topic for learners who are in specialties outside of psychiatry!_

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**Please remember these take-home messages when working with patients.**

- You can be qualified to provide counseling to your patients.
- It takes awareness and practice to develop these skills.
  - If you invest the appropriate time and attention to this, you can become quite effective at it!
- It is not only within your scope of practice to recognize the risk factors and warning signs of suicide – it is your responsibility!
- Please use the Suicide Prevention Hotline & other crisis prevention resources.
- Don’t be afraid of working with patients who suffer from mental health problems – embrace it as a chance to help them and potentially save their lives.
- It’s important to be open, honest, non-judgmental, and empathetic...but it’s most important to be PREPARED for this situation if it ever arises.
- There are resources available to you if you need them to cope with the death of a patient.
Thank you for your attention.

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