Adult Suicide Risk and Psychopathology Elevations in a CMHQ

Taylor Gamble and Dr. David M. McCord

INTRODUCTION

In 2019, an estimated 703.000 people died by suicide resulting in suicide being the fourth leading cause of death for individuals who are 15-19 years old with males dying by suicide more often (World Health Organization, [WHO], 2021). Classification of suicide risk is crucial in evaluating suicidality, as the consequences of over-estimating risk can lead to unnecessary allocation of time and professional resources, but under-estimating risk can be catastrophic. In addition, community mental health centers (CMHQ)'s typically have a higher percentage of individuals who have been diagnosed with a disorder which makes them have a higher suicide risk level (chu et al., 2015). In addition, there has been an influx of patients with Medicaid who are seeking treatment and to receive disability which may impact scores which is why the MMPI-3 is utilized since it has 10 validity scales to ensure content-responsiveness (were they engaging in the test), over-reporting (their scores compared to individuals identified with the difficulty), and under-reporting (purposeful hiding of symptoms or presenting themselves in a good light). Furthermore, there are 42 substantive scales that measure different aspects of internalizing, externalizing, somatic, interpersonal, and thought dysfunction.

METHODS

We are collecting data at Blue Ridge Health Services in Sylva, North Carolina. Participants are identified by being at least 12 years old who are referred for a psychological assessment. During the assessment the Minnesota Multiphasic Personality Inventory – Third Edition (MMPI-3) is administered to assess adults' psychopathology. In addition, a suicide risk interview based upon the interpersonal psychological theory of suicide (IPTS) revamped by Chu et al., 2015 Is administered. Data collection is ongoing with IRB approval.

GOALS for Overall Study

Goals of this poster:

1. Examine mean comparisons between CMHQ and the general population
2. Compare the mean number of elevations that each adult elevates on the MMPI-3 compared to the normative samples mean of 8%.

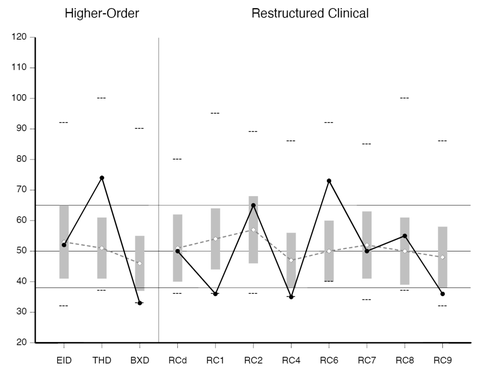
There are several overarching goals that we plan to answer:

1. Create cohesive suicide-risk scale for the adolescents MMPI instrument
2. Examine the ability of the MMPI-3 and MMPI-A-RF to detect and predict adult and adolescent suicide risk

Current Objective

For the purpose of this poster and due to data collection being ongoing, we will focus on the mean number of elevations per scale and per client

Sample Report of Minnesota Multiphasic Personality Inventory – Third Edition



The MMPI-3 has a mean of 50
8% of the general population elevates any one scale

Demographics of Participants

N = 23

Three participants were excluded due to over-reporting

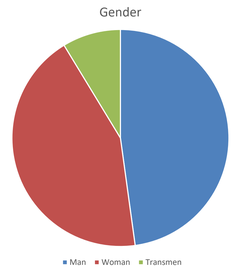
Ethnicity:

- White: 21
- Black: 1
- Asian: 1

Age: M = 30

Gender:

- 11 men
- 10 women
- 2 transgender men



Common Referral Questions

Autism
Attention and concentration
Hallucinations/delusions
Disability
Substance Use
Suicide-Risk
Mania

RESULTS

Validity		
Scales	Mean	% Elevated
Combined Response Inconsistency	51.00	
Variable Response Inconsistency	52.00	
True Response Inconsistency	57.00	
Infrequent Response	61.00	
Infrequent Psychopathology Responses	57.90	
Infrequent Somatic Responses	60.55	
Symptom Validity Scale	63.60	
Response Bias Scale	69.05	
Uncommon Virtues	50.40	
Adjustment Validity	43.25	
Internalizing Dysfunction		
Emotion/internalizing	66.20	52%
Demoralization	64.10	47%
Suicide/Death Ideation	47.15	17%
Helpless/hopelessness	54.65	26%
Self-Doubt	63.15	57%
Inefficacy	63.85	44%
Low Positive Emotions	66.60	56%
Introversion	37.15	65%
Negative Emotionality	61.20	39%
Stress	62.90	44%
Worry	58.15	39%
Compulsivity	60.50	48%
Anxiety Related	60.40	26%
Anger Proneness	53.50	9%
Brief Restricted Fears	61.45	22%
Behavioral/Externalizing		
Behavioral/externalizing	47.85	4%
Antisocial	48.25	4%
Family Problems	53.40	17%
Juvenile Conduct Problems	49.25	0%
Substance Use	47.70	9%
Hypomanic Activation	49.75	4%
Impulsivity	55.00	26%
Activation	51.35	13%
Aggression	51.75	6%
Cynicism	51.25	13%
Disconstraint	48.00	9%
Thought Dysfunction		
Ideas of Persecution	50.80	4%
Aberrant Experiences	53.35	13%
Psychotic	51.50	9%
Somatic		
Somatic Complaints	61.40	34%
Malaise	56.45	26%
Neruological complaints	59.95	35%
Eat	49.55	13%
Cognitive Complaints	68.50	65%
Interpersonal Functioning		
Self Importance	41.15	0%
Dominance	41.30	0%
Disaffiliativeness	62.90	43%
Social Avoidance	67.85	65%
Shyness	63.60	39%

CONCLUSIONS AND RECOMMENDATIONS

As a preliminary study, there were significant differences in the elevation rates on the internalizing, externalizing, somatic, and interpersonal functioning scales. Individuals were reporting more helplessness/hopelessness, suicidal/death ideation, self-doubt, stress, worry, demoralization, impulsivity, cynicism, and cognitive complaints. In addition, they reported more symptoms relating to physical symptoms, as well as social avoidance and disaffiliativeness.

- On average 12.42 scales were elevated per client
- Suicide/Death Ideation was ~2x higher than the general population
- There were significantly different mean scores on 19 of the 42 substantive scales

References

1. Chu, C., Klein, K. M., Buchman-Schmitt, J. M., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Routinized assessment of suicide risk in clinical practice: An empirically informed update. *Journal of clinical psychology*, *71*(12), 1186-1200.
2. Grunbaum, J.A., Kann, L., Kinchen, S., Ross, J., Hawkins, J., Lowry, R., *et al.* (2004). Youth risk behavior surveillance – United States, 2003. *MMWR Surveillance Summaries: Morbidity and Mortality Weekly Report Surveillance Summaries/CDC*, 53(2), 1– 96.
3. Joiner Jr, T. E., Walker, R. L., Rudd, M. D., & Jobes, D. A. (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. *Professional psychology: Research and practice*, *30*(5), 447.
4. Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.
5. Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, *117*(2), 575.

World Health Organization. (2021). Suicide worldwide in 2019: global health estimates.

Acknowledgements

Thank you to Western Carolina University's Graduate School for funding this project and giving me the opportunity to collect this data. In addition, I would like to thank Dr. Joesph Ruebel, Dr. Tiffany Simpson, and Dr. Richard Hudspeth for allowing me this opportunity to collect data at Blue Ridge Health Services. Lastly, thank you to Kent State University and the Minnesota Press for their continued support.

Affiliate logos