Suicide Assessment, Treatment, and Management

Introduction

Case Vignette

Gerald Abbot is a psychology intern in a college counseling center. He has been working with Kyra, a college freshman, over the past month. She initially sought treatment due to depression, and Gerald feels she has made progress. She appears more engaged in treatment, and is less isolated. He is surprised when he receives a phone call from the center’s crisis clinician, indicating that Kyra had called in to their hotline the prior night, expressing suicidal ideation. She was sent to a local psychiatric hospital for evaluation. Gerald is upset, and asks himself what he missed.

One of the most challenging — and prevalent — issues clinicians can face is a client’s suicidal crisis. Suicide is defined as self-inflicted death with evidence (either explicit or implicit) that the person intended to die. Although many clients experience major depressive episodes, training on how to manage suicidality is often not a component of training curriculums. Many recommendations are impractical in managing an emerging crisis. Working with a client in suicidal crisis can be difficult, and evoke strong feelings in the therapist.

In a recent APA Monitor (April, 2014) message, APA president Nadine Kaslow sends a call to arms, urging psychologists to continue to focus on developing a public health perspective to reducing suicide. She states that such an agenda must address diverse populations and span the continuum of suicidal behavior. Some of Kaslow’s suggestions include: a) standardizing and providing training to psychologists and trainees on suicide assessment and treatment, b) training community members as gatekeepers for identifying and referring those at risk, and c) creating, assessing and disseminating programs that have a broad impact.

There certainly seems to be a need for such services. Just how prevalent is suicide? The National Institute of Mental Health terms suicide “a major, preventable public health problem.” According to CDC statistics, suicide was the tenth leading cause of mortality in the U.S., accounting for 34,364 deaths in 2010. Many people attempt suicide, but do not actually complete the attempt. These statistics estimate 11 attempted suicides occur per every suicide death (CDC, 2010). More than 90 percent of people who die by suicide have these risk factors depression and other mental health issues, a substance-abuse disorder, or a combination (Moscicki, 2001).

In addition to the numbers quoted above, suicide is a growing concern for providers treating adolescents. Suicide is the third leading cause of death among teenagers (CDC, 2009). One out of every 53 high school students (1.9
percent) reported having made a suicide attempt that was serious enough to be treated by a doctor or a nurse (CDC, 2010). For each suicide death among young people, there may be as many as 100–200 suicide attempts (McIntosh, 2010).

As these statistics would suggest, therapists may often see suicidal ideation and suicidal behaviors among their patients. The identification of suicide risk remains among the most important, complex and difficult tasks performed by clinicians (Bongar, 2002). Foley and Kelly (2007) estimate that 50–70% of mental health professionals have experienced at least one patient suicide. Patient suicide can have profound personal and professional effects, including increased levels of anxiety and stress, isolation and withdrawal, and damage to the therapists’ personal relationships. There may also be evidence of depression, a protracted grieving process or symptoms of posttraumatic stress or vicarious traumatization.

Therapists working with suicidal clients have a number of areas of responsibility. These include developing a skill set and protocols for 1) treating clients who may be at risk for suicide, 2) accurately assessing suicidal risk, 3) responding to a client’s suicide attempt, and 4) implementing self-care activities. It is important for clinicians to be knowledgeable when asking clients about suicidal ideation and behavior. It may be challenging to balance your comfort level with the need to obtain accurate and clear information.

This course will provide guidelines on suicide assessment, treatment and management. After completing this course the participant will:

- Discuss prevalence of suicide
- Discuss theories of suicidal behavior
- Discuss key research approaches/findings
- Describe protective factors
- Discuss suicide and mental health issues
- Discuss issues related to at-risk/vulnerable populations
- Discuss risk and protective factors among various ethnic and racial groups
- List issues in assessing suicidal risk, including suicide myths, common warning signs, assessment questions and ensuring therapeutic alliance
- Discuss various treatment approaches (CBT, DBT, Interpersonal Therapy)
- Discuss issues in therapist self-care in the aftermath of suicide
- Outline ethical and legal considerations
- Discuss working with survivors of suicide
Terminology

Prior to looking at assessment and treatment of suicidal behavior, it is helpful to review some important terms:

- **Suicide** — self-inflicted death with evidence that the person intended to die
- **Suicide attempt** — self-injurious behavior with a nonfatal outcome and accompanied by evidence that the person intended to die
- **Parasuicide** — any nonlethal intentional self-injurious behavior; often used in discussion of personality disorders
- **Suicidal ideation** — thoughts of suicide. Suicidal ideation may vary in seriousness depending how specific a suicide plan is and the degree of intent
- **Suicidal intent** — the seriousness or intensity of the person’s wish to terminate his or her life
- **Lethality of suicidal behavior** — objective danger to life associated with a suicidal method. Lethality may not always coincide with an individual’s expectation of what is medically dangerous
- **Contagion** — a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person’s suicidal acts. The CDC specifies that a contagion occurs when the deaths and/or attempts are “connected by person, place, or time”
- **Cluster** — the CDC specifies that a cluster has occurred when attempts and/or deaths occur at a higher number than would normally be expected for a specific population in a specific area.
- **Resilience** — Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Prevalence

Prior to looking at the factors that play a role in suicide attempts/completed suicide, it is helpful to look at prevalence. The Centers for Disease Control and Prevention (CDC) collects data about deaths by suicide. The following reflects prevalence of suicide according to CDC data:

- In 2010, suicide was the 10th leading cause of death for Americans. Over the 20-year period from 1990 to 2010, suicide rates dropped, and then rose again. Between 1990 and 2000, the suicide rate decreased from 12.5 suicide deaths to 10.4 per 100,000 people in the population. Over the next 10 years, however, the rate generally increased and by 2010 stood at 12.1 deaths per 100,000.
Suicide death rates vary considerably among demographic variables including age, sex, race/ethnicity, and geographic region/state. Other variables that may also affect suicide rates are socioeconomic status, employment, occupation, sexual orientation, and gender identity. Although individual states collect data on some of these characteristics, they are not included in national reports issued by the CDC.

The highest suicide rate (18.6) was among people 45 to 64 years old. The second highest rate (17.6) occurred in those 85 years and older. Younger groups have had consistently lower suicide. Suicide rates among men are about 4 times higher than among women. In 2010, men had a suicide rate of 19.9, and women had a rate of 5.2. Of those who died by suicide in 2010, 78.9% were male and 21.1% were female.

Suicide was highest was among Whites (14.1) and American Indians and Alaskans (11.0). Lower and rates were found among Asians and Pacific Islanders (6.2), Blacks (5.1) and Hispanics (5.9).

In 2010, suicide rates were highest in the West (13.6), followed by the South (12.6), the Midwest (12.0) and the Northeast (9.3). Firearms were the most common method of death by suicide, accounting for a little more than half (50.6%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 24.8% and poisoning at 17.3%.

No complete count is kept of suicide attempts in the U.S.; however, the CDC gathers data each year from hospitals on non-fatal injuries resulting from self-harm behavior.

In 2010, 464,995 people visited a hospital for injuries due to self-harm behavior, suggesting that approximately 12 people harm themselves for every reported death by suicide. Together, those harming themselves made an estimated total of more than 650,000 hospital visits related to injuries sustained in one or more separate incidents of self-harm behavior.

It is important to note that these prevalence statistics are rough estimates only. It difficult to know exactly how common suicidal behaviors are in the general population and in particular subgroups. Suicides are often underreported, in part because it may be difficult to determine intent. Existing data collection instruments may also fail to include questions that would help determine the prevalence of suicidal behaviors among particular groups. For example, because death certificates do not indicate sexual orientation and gender identity, rates of deaths by suicide in lesbian, gay, bisexual, and transgender (LGBT) populations are unknown and many of the research studies provide estimates only.
Theories of Suicidal Behavior

There is no universal theory to explain suicidal behavior. As is the trend in mental health, many of the current theories of suicide use a stress-diathesis approach. According to stress-diathesis models, suicidal behavior involves a combination of trait-dependent/more constant risk factors (diathesis) and a state-dependent trigger or stressor present only during certain periods of time. When only one of these domains are present, it is not enough to elicit suicidal behavior. When risk factors from both domains are present, the combined effect increases the likelihood of suicidal behavior. This model also accounts for variability of suicidality across cultures (Worchel & Gearing, 2013). This approach presupposes additivity, that is, the idea that diathesis and stress add together to produce suicidality. A number of researchers have used this type of model (e.g., Malone et al., 1995; Mann et al., 1999; McGirr & Turecki, 2007 Williams and Pollock, 2001).

Cognitive Stress Diathesis Model

Williams and Pollock (2001) propose a model that they term the Cognitive Stress Diathesis Model of suicide. This model looks at suicidality as resulting from a combination of neuropsychological deficits in areas of memory, attention or problem solving along with stressors that result in perceptions of hopelessness, immovability, or esteem issues. The three primary components of this model are:

1. Oversensitivity to signals of defeat: The researchers used the “emotional Stroop task,” (measuring response time of the participants to name colors of negative emotional words), and isolated attentional biases/perceptual pop-outs) in association with suicidal behavior—hypersensitivity to stimuli signaling “loser” status increases the risk that the defeat response will be triggered.

2. Perceived “no escape”: The researchers theorize that problems with autobiographical memory limit the person’s inability to problem-solve. When faced with stress, they may feel as if there is no escape from problems or life events. They may also think in an overly general way that does not allow sufficient detail to solve problems effectively.

3. Perceived “no rescue”: Suicidal behavior may be associated with limited fluency, and an inability to come up with positive events that might happen in the future. Thus, people may feel as if there is “no rescue” from the current life situation. Additionally they may be unable to generate positive future events, and may experience significant
levels of hopelessness, a core clinical predictor of suicidal behavior.

**Clinical Stress Diathesis Models**

A number of researchers have proposed clinical stress diathesis models (Mann et al., 1999; McGirr & Turecki, 2007). The McGirr & Turecki (2007) model is based on the idea that psychopathology is a necessary, but not sufficient, factor for suicide. They look at the combination of genetics, which interact with the onset of psychiatric disorders (the stressor) to result in suicide. The primary proposed genetic factors are impulsivity and aggression. McGirr & Turecki (2007) state that individuals with suicidality engage in behaviors without consideration of consequences, are risky or inappropriate to the situation, and are accompanied by undesirable outcomes. These behaviors are not necessarily aggressive, but high levels of impulsivity correlate with high levels of aggression. Bohanna & Wang (2012) and Brent et al., (2003) propose the involvement of impulsivity and aggression in the diathesis of suicidal behavior.

**Neurobiological Stress Diathesis Model**

Another example of a stress diathesis approach arises from the research of Jollant et al. (2008). They propose a neurobiological stress diathesis model of suicide. Jollant et al. (2008) conducted PET studies to compare young men with a history of attempted suicide to young men no suicide history. They showed the groups pictures of angry, happy, and neutral faces. The young men with a suicide history demonstrated significant differences in brain activity. Suicide attempters were distinguished from non-suicidal patients by responses to angry and happy faces, suggesting increased sensitivity to others’ disapproval, higher propensity to act on negative emotions, and reduced attention to mildly positive stimuli. Jollant et al. (2008) concluded that these patterns of neural activity and cognitive processes may represent vulnerability markers of suicidal behavior in men with a history of depression.

**Interpersonal Model of Suicidal Behavior**

Another approach to understanding the etiology of suicidal behavior is the Interpersonal Theory of Suicide (Joiner, 2009; Van Orden et al., 2010). According to Van Orden et al. (2010) suicidality is caused by the simultaneous presence of two interpersonal constructs—thwarted belongingness and perceived burdensomeness. A low sense of belongingness is the experience that one is alienated from others, not an integral part of a family, circle of friends, or other valued group. Perceived burdensomeness is the view that one’s existence burdens family, friends, and/or society. This view produces the idea that “my death will be worth more than my life to family, friends, society, etc.”
Joiner (2009) states that while feelings of burdensomeness and low belongingness may instill a desire for suicide, they are not sufficient to ensure that desire will lead to a suicide attempt. There must also be the ability for lethal self-injury. The capability for suicidal behavior emerges in response to repeated exposure to physically painful and/or fear-inducing experiences. Such repeated exposure results in habituation and ultimately a higher tolerance for pain and a sense of fearlessness about death. Joiner (2009) suggests that clinicians should be cognizant of their patients' levels of belongingness, burdensomeness, and acquired capability (especially previous suicide attempts), in assessing suicide risk and in targeting therapeutic interventions.

**Research in Suicidology**

Suicidology is the scientific study of suicide. Suicide research is aimed at understanding and preventing suicide. The primary fields involved in suicide research are psychology and sociology. The following approaches help to shed light on the research (Bongar, 2002).

1. Psychological research focuses on the psychological states experienced by the person attempting or completing suicide. This can include the cognitive, behavioral or emotional components and states.

2. Psychodynamic researchers focus on the role of anxiety and inner conflicts, often arriving at the idea that suicide is a way that individuals express anger and hostility, generally as a way of turning these emotions inward. Rage, hopelessness, despair, and guilt are seen as important affective states leading to suicide. The meanings of suicide can be usefully organized around the conscious and unconscious meanings given to death by the suicidal patient (i.e., death as retaliatory abandonment, death as revenge, death as self-punishment or atonement).

3. Biological, biochemical and constitutional research looks at the relationship between genetics, neurotransmitters, hormone and biochemistry in suicide. Biological suicide research has developed as an offshoot of biological depression research. Many of the studies are conducted after a person has committed suicide or are twin studies.

4. Sociocultural research assesses the degree to which someone's surroundings exert a positive or negative influence depends on individual factors (e.g., demographic characteristics, life stressors, coping skills, and the biological dimensions linked to suicide described earlier) as well as whether an individual's family, community and country are supportive or stressful.
5. Psychiatric and mental illness researchers look at the connections between mental illness and suicide. The DSM-5 contains specific information on suicide prevalence and course in the various disorders. Often psychiatric research looks at the interactions of comorbid conditions, such as suicidality in people with depression and substance abuse.

6. Epidemiological and demographic research identified populations most at risk for suicide. Some of the demographic factors studied are gender, race, sexual orientation, health issues, seasonal factors and trends.

7. Prevention, intervention and postvention research looks at how to prevent suicide from occurring (usually in specific at-risk groups), how to intervene in cases of active suicidality, and how to respond following completed suicide (alleviating the effects in family members and community).
Key Research Findings/Risk Factors

Case Vignettes
Emma is a 24-year-old survivor of multiple traumas and recently diagnosed with a dissociative disorder. She is overwhelmed by the diagnosis, and the need to start to work on her past trauma. She expresses that “this is too hard,” and “I don’t want to live like this any more.” Her therapist expresses understanding of the difficulty of the diagnosis and task, assuming that the expression of suicidal ideation is a communication of this difficulty. Her therapist is upset when she receives a call indicating that Emma has been admitted to a hospital following a serious suicide attempt. Fortunately, Emma will be ok.

Kevin is a 35-year-old man who has struggled with depression and alcoholism for many years. While he is attending therapy groups, his level of commitment appears minimal. He does not appear actively suicidal, but his group therapist is alarmed by disclosures in the group that indicate that Kevin does not feel that he has a reason to live. The therapist does an assessment, which indicates that Kevin’s level of suicidal ideation is high, that he has a plan and fully intends to kill himself. She is able to persuade Kevin to consider hospitalization, and is hopeful that the situation will resolve.

The situations discussed above are not uncommon in clinical practice. In understanding why some clients consider and follow through with suicide attempts, it is helpful to look at the research literature. Our effectiveness in preventing suicide depends on more fully understanding how and why suicide occurs. There has been an increase in suicide research, which looks at the complex factors involved in this concern, over the past 25 years.

Previous Suicide Attempts

In looking at the data on completed suicide, both in the United States and abroad, researchers find a correlation between prior suicide attempts and completed suicide (Suokas et al., 2004; Jenkins, 2002). Risk appears to be especially high immediately following hospitalization for a suicide attempt, especially in people with diagnoses of major depression, bipolar disorder, and schizophrenia (Tidemalm, et al., 2008).

The majority of people that attempt suicide, do not ultimately die by suicide. Researchers have found that about 7-10% of people who have attempted suicide ultimately complete it. These numbers may be underestimated due to them being based on individuals identified in hospital emergency room samples (Jenkins, et al., 2002). Data collected by the Centers for Disease Control and Prevention show differences in the gender and age patterns of suicide attempters and those who die by suicide. These differences are important in increasing our understanding of parasuicide. Young women are
estimated to make 100 or more suicide attempts for every completed suicide.

In contrast, the elderly have a suicide rate that is twice the rate among youth, but make relatively few non-fatal suicide attempts. This may be because the elderly are generally more frail, and may be more likely to successfully kill themselves.

**Family History**

Just how big a role does genetics/family history play in suicide? Research has shown that this link does exist (Voracek & Loibl, 2007; Lester, 2002). Voracek & Loibl (2007) and Lester (2002) conducted a twin study to look at the genetic basis of suicide. Voracek & Loibl conducted a meta-analysis of case reports, which showed that concordance for completed suicide is significantly more frequent among monozygotic (identical) than dizygotic (fraternal) twin pairs. The results of co-twin studies rule out exclusively psychosocially based explanations of this pattern. Population-based epidemiological studies demonstrate a significant contribution of additive genetic factors (heritability estimates: 30-55%) to the broader phenotype of suicidal behavior (suicide thoughts, plans and attempts) that largely overlaps for different types of suicidal behavior and is largely independent of the inheritance of psychiatric disorders. Non-shared environmental effects (i.e. personal experiences) also contribute substantially to the risk of suicidal behavior, whereas effects of shared (family) environment do not.

Lester (2002) found that identical twins have stronger concordance for suicide than fraternal twins, even when raised separately. Although studies show that depression runs in families, the heritability of suicide appears to exist even independent from inherited depression.

Another interesting approach is the “social model” thesis (de Leo & Heller, 2008). Simply put, this model says that exposure to completed and attempted suicide in the family has also been found to increase suicide risk among family members by providing a “social model” of self-harm behavior. The researchers suggest “containment” of information regarding suicidal behaviors in prevention of suicidality.

**Medical Conditions**

Patients with serious medical conditions may be at increased risk for suicide. These conditions include chronic pain (Lowry, 2013; Braden & Sullivan, 2008; Kanzler et al., 2012), trigeminal neuralgia (Sarmah, 2008), cancers (especially head and neck), HIV/AIDS (Yamuchi, 2014) lupus (Mock, 2014), headache (Rozen & Fishman, 2012) and traumatic brain injury (Carroll et al., 2014) diseases of the central nervous system (epilepsy, tumors, Huntington’s
Chorea, Alzheimer’s Disease, Multiple Sclerosis, spinal cord injuries, and traumatic brain injury), autoimmune diseases and renal disease.

Chronic Pain and Suicide

Given the connection between suicide and chronic medical conditions, it is helpful to consider the reasons/attributions that result in suicidal thoughts. When considering these connections researchers have attempted to isolate the variable of “pain” as a separate entity from comorbid conditions. Evidence supports the contribution of pain severity outside of other predictive factors such as medical and psychiatric comorbidities. In a large-scale study, Kikuchi and colleagues (2009) assessed the risk for suicide in 21,083 Japanese men. The researchers and found that greater pain severity remained significantly associated with suicide mortality even after controlling for many key covariates such as demographic factors, health status, physical functioning, medical comorbidities, sleep duration, alcohol consumption, body mass index, smoking, and psychological stress.

Other studies have examined the impact of specific pain conditions on suicide risk. For example, two separate studies evaluated patients with fibromyalgia. Dreyer et al. ((2010) conducted a 15-year prospective cohort study of 1,269 Danish patients with fibromyalgia. They found that although these women were not at increased risk for all-cause mortality compared to the general population, they were at increased risk of death from suicide. Wolfe et al. (2011) evaluated 8,186 patients with fibromyalgia who were seen at three different sites in the United States. They found that individuals with fibromyalgia were at least three times as likely of successfully completing suicide as compared to the general population.

Chronic pain has many psychological ramifications including increased depression, feelings of hopelessness or helplessness, or a lack of control over symptoms (death being one thing within the person’s control). Other contributing factors are chronic pain, insomnia and adverse effects of medications.

Hausett et al. (2014) states that the presence of chronic pain appears to confer an increased risk for suicidal behavior, and suggests that a reason for this is that people with chronic medical conditions often express the idea that they are a “burden” to their families. Joiner (2009) describes perceived burdensomeness as the idea that “my death will be worth more than my life to family, friends, society, etc.” This author cites a number of studies that support the link between perceived burdensomeness and suicide. He also states that direct tests of the theory have been supportive.

Environmental Stressors
Another known risk factor for suicide is the presence of a highly stressful life event, such as the death of a close relative or friend, unemployment (Pompili et al., 2014) other financial setback, or legal issues (Liu & Miller, 2014) and loss or separation (Duggan et al., 1991) or domestic violence (Simon et al., 2002).

Suicide is also connected to more prolonged stress, such as relationship conflict, harassment or bullying. Bullying is particularly problematic in adolescents (Shireen et al., 2014; van Geel et al., 2014) and others who are different from the norm, due to issues such as Aspergers/autism (Richa et al., 2014) and sexual orientation (Carney, 2014; Stone et al., 2014; Mustanski et al., 2014). It is difficult to separate the presence of the stressor — bullying — from depression. According to the American Foundation for Suicide Prevention, bullying likely precipitates suicidal thinking and suicide attempts in youth who are already depressed, or who have prolonged involvement as both victims and bullies, points to the role of individual vulnerability in determining the impact of environmental stressors.

Contagion

Another finding involves the role of contagion, or “copycat”/imitative suicide. This problem seems to be a particular concern among adolescents. While authors acknowledge that there are a number of factors that play a role in suicide, several studies of suicide “clusters” have found that adolescent suicide is sometimes linked to publicizing the suicide in some way, whether through media coverage or through the use of electronic media (Facebook, text messaging, etc.).

A study by Bohanna and Wang (2012) found that media coverage of suicide that sensationalized suicide, was very prominent, or that romanticized suicide in some ways was associated with an increase of suicide, particularly among adolescents. These authors suggest that while media guidelines can change reporting style and prevent imitative suicide, that approaches centered on consultation, collaboration, media ownership, and training are likely to achieve the greatest success (please see appendix for list of media guidelines). Cox et al. (2012) also looked at suicide clusters among adolescents in order to identify postvention strategies. They state that a number of strategies show promise, including developing a community response plan; educational/psychological debriefings; providing both individual and group counseling to affected peers; screening high risk individuals; responsible media reporting of suicide clusters; and promotion of health recovery within the community to prevent further suicides. Zenere (n.d.) suggests that postvention programs should seek to identify specific people in an affected community that may have identified with the person who died by suicide including peers/family members currently demonstrating suicide–related warning signs. Zenere also recommends screening survivors to determine whether they blame themselves for the suicide or have experienced previous trauma that was never
addressed. For recommendations on postvention strategies, see the appendix of this document.

Exposure to suicide or suicide attempts by family members or friends is a risk factor for suicidal behavior. Research also indicates that lesbian, gay and bisexual teens who reported suicidal ideation/attempts were more likely to report that a member of their family or close friend has attempted or died by suicide (D'Augelli, Hershberger, & Pilkington, 2001). More than half of these youth knew of a suicide attempt by a close friend, while for adolescents generally another study estimates 20 percent knew of a friend’s suicide attempt (D'Augelli, Hershberger, & Pilkington, 2001).

Access to Lethal Methods/Impulsivity

Another area of research involves access to suicidal means. The primary issue with this is that many suicide attempts are impulsive/unplanned and occur during an acute period of ambivalence (Bohanna & Wang, 2012). In fact, impulsivity and aggression have been shown to be risk factors for suicide (Brent et al., 2003). Given this, it is helpful to limit a person’s means to suicidal means such as firearms or toxic medications.

In the U.S., the most common method of suicide is firearms, used in 51% of all suicides. Currently, firearms are involved in 56% of male suicides and 30% of female suicides. Among U.S. women, the most common suicide method involves poisonous substances, especially overdoses of medications. Poisoning accounts for 37% of female suicides, compared to only 12% of male suicides. Hanging or other means of suffocation are used in about 25% of both male and female suicides. The greater availability of firearms in rural parts of the country also contributes to higher suicide rates in the more rural Western states.

Biological Bases of Suicide

Researchers have studied the brains of people who have died by suicide, looking for visible differences from brains of those who died by other causes. Most frequently studied have been the serotonergic system, adrenergic system and the Hypothalamic-Pituitary Axis (HPA), which relate to mood, thinking and stress response. A key challenge of neurobiological studies is determining the abnormalities in genes, brain structures or brain function that differentiate depressed people who died by suicide from depressed people who died by other causes.

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<th>Summary of risk factors</th>
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<td>• Previous suicide attempts</td>
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<td>• Family history of suicidal behavior</td>
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- Medical conditions and chronic pain
- Contagion (Local epidemics of suicide)
- Access to lethal methods
- Isolation, a feeling of being cut off from other people
- Previous suicide attempt(s)
- Loss (relational, social, work or financial)
- Unwillingness to seek help due to stigma

**Protective Factors**

Protective factors for suicide are characteristics or conditions that may help to decrease a person’s suicide risk. It is important to note that these factors have not been nearly as well studied, and that while these factors do not eliminate the possibility of suicide, especially in someone with risk factors, they may help to reduce that risk. This section will look at factors that are overall protective factors; factors more pertinent to specific at-risk groups are discussed in the subsequent section of this material. Understanding of protective factors is important in selecting prevention interventions.

According to the American Foundation for Suicide Prevention, some protective factors for suicide include:

- Receiving effective mental health care
- The skills and ability to solve problems
- Positive connections to family, peers, community, and social institutions such as marriage and religion that foster resilience
- Support from ongoing medical and mental health care relationships
- Easy access to a variety of clinical interventions and support for help seeking
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation
- Restricted access to highly lethal means of suicide

The most consistent protective factor found in suicide research is social support and connectedness (Kleiman, Riskind, Schafer, 2014; Goldfarb et al., 2014; Donaldson et. al, 2006). Marital status is linked with suicide risk. Married individuals are less likely to commit suicide than divorced or separated people (Kposowa, 2003). Among females, another protective factor appears to be parenting (Agerbo, 2005), which provides a sense of purpose and reason for women to not give up despite depression or suicidal thoughts. Similarly the idea of agency, the sense that one is competent, effective, and in control of one's life, has shown to reduce the effects of hopelessness and emotional distress on suicidal thoughts and attempts (Bryan et al., 2014).

Malone et al. (2000) looked at protective factors against suicidal acts in major depression. The researchers assessed inpatients with major depression were
assessed for depression, general psychopathology, suicide history, reasons for living, and hopelessness. Of the 84 patients, 45 had attempted suicide and 39 had not. The depressed patients who had not attempted suicide expressed more feelings of responsibility toward family, more fear of social disapproval, more moral objections to suicide, greater survival and coping skills, and a greater fear of suicide than the depressed patients who had attempted suicide.

Reasons for living, as measured by the Linehan Reasons for Living Inventory (LRFL; Linehan, Goodstein, Nielsen, & Chiles, 1983) is said to reflect adaptive beliefs and expectations that help people resist suicidal urges. The LRFL inventory is a 48-item self-report measure that assesses the beliefs and expectations for not committing suicide. The instrument may be used to explore differences in the reasons for living for individuals who engage in suicidal behavior and those who do not. Each item is rated on a 6-point Likert scale ranging from 1 (“not at all important”) to 6 (“extremely important”).

The LRFL consists of six subscales and a total scale. The subscales include: Survival and Coping Beliefs (24 items), Responsibility to Family (7 items), Child-Related Concerns (3 items), Fear of Suicide (7 items), Fear of Social Disapproval (3 items), and Moral Objections (4 items).

Another protective factor concerns the role of religion and spirituality. Religion appears to play a protective role in suicide due to the strict sanctions against suicide in most major religions. Religiosity has been shown to be associated with reduced risk of suicidality (Dervic et al., 2004; Lizardi et al., 2007). Christianity, Hinduism, Islam and Judaism, all condemn suicide, although the strictness of this condemnation can vary across sects. Many religions also foster social support networks, which are also a protective factor (Colucci & Martin, 2008; Gearing & Lizardi, 2009; Worchel & Gearing, 2010). Research also confirms that more traditional or orthodox religions tend to have lower suicide rates (Kelleher et al., 1998). Fostering a suicidal person’s spiritual or religious faith may contribute to the effectiveness of interventions.

In looking at protective factors, it is interesting to consider why suicide rates may be particularly low among some groups, such as African American women. In 2009, the suicide rate among black women aged 20–59 years was 2.77 per 100,000, the lowest rate among adults in this age range (CDC, 2009). It is possible that many of the factors discussed in this section, such as greater social support, larger extended families, and deeper religious views against suicide may help protect some groups from suicide. A better understanding of these and other protective factors would help inform future suicide prevention efforts.

An area of emerging research concerns the protective factor of high distress tolerance. Simply put, distress tolerance concerns the accepting, finding meaning for, and tolerating distress. Distress intolerance, on the other hand, is
a perceived inability to fully experience unpleasant, aversive or uncomfortable emotions, and is accompanied by a desperate need to escape the uncomfortable emotions. Distress tolerance skills support the ability to accept, in a non-evaluative and nonjudgmental fashion, both oneself and the current situation.

Research indicates that nonsuicidal self-injury (NSSI) and suicidal behavior are strongly related to one another, with a sizable portion of individuals with a history of NSSI also reporting a history of nonlethal suicide attempts. In a study, 93 adult inpatients (54.8% male) receiving treatment for substance use disorders completed a structured interview assessing suicide potential. Results indicated in at-risk populations the capacity to tolerate aversive physiological and affective arousal may reduce the risk of serious or lethal suicidal behavior (Anestis et al., 2013).
Suicide and Mental Health Issues

Mental Health Issues

Suicidal ideation/attempts are a clear indication that something is very wrong in a person’s life. Most people who die by suicide have a mental or emotional disorder. Suicide research often uses a method of termed “psychological autopsy,” in which researchers conduct interviews with family members and friends, who provide information on their understanding of the likely factors that contributed to the person’s death. The results of several of these studies suggest that over 90% of those who committed suicide had a psychiatric diagnosis at the time of death (Bertolote & Fleischmann, 2002.)

While all psychological disorders have the potential to increase the risk for suicide, the most common disorders among people researchers have looked at, are those diagnoses most closely associated with suicide deaths. Bertolote & Fleischmann, 2002 found that the mental illnesses most prevalent for people who die by suicide are major depression and other mood disorders, substance use disorders, schizophrenia and personality disorders. Similarly, Kutcher and Chehil (2007) have identified five psychiatric disorders with the greatest increase in suicide risk. These diagnoses include mood disorders accounting for 50% of all completed suicides, psychotic disorders, anxiety disorders, alcohol and other substance use disorders, and personality disorders. Suicidal thoughts and/or behaviors are also common among patients with bipolar disorders, and suicide rates are estimated to be more than 25 times higher for these patients than among the general population. Another mental disorder that may increase the risk for suicide is schizophrenia. Suicide has been estimated to occur in approximately 5 percent of patients with schizophrenia (Palmer et al., 2005). There is current research that indicates that women with anorexia are also at increased risk for suicide (Franko & Keel, 2006).

Prior to looking at the connections between suicide and specific mental illnesses, it is helpful to briefly explore the connections between mental illness and stigma as a causal factor of suicide. Throughout history, mental illness has been associated with stigma and seen as a sign of weakness or deficiency. There is also the sense that those affected by mental illnesses may be dangerous or unpredictable. This sense of stigma increases the risk of suicide by increasing secrecy precipitating shame and self-blame all of which discourage affected individuals from seeking treatment. This is especially true among certain ethnic and racial groups. Reducing stigma is certainly one target area for suicide prevention.

Mood Disorders and Suicide

Depression and other mood disorders are among the most prevalent psychiatric disorders and are the most common disorders associated with
suicide attempts. The hallmarks of mood disorders include depressed mood, anhedonia, irritability, feelings of hopelessness and low self-esteem, guilt, loss of appetite/weight, low energy, and sleep problems. Bipolar disorder is also associated with inappropriately elevated or manic mood.

Bostwick and Pankratz (2000), researchers at the Mayo Clinic, conducted an examination of affective disorders and suicide. Their results reinforced the strong connection between mood disorders and suicidality. Bostwick and Pankratz (2000) found that lifetime mortality of suicide in people with mood disorders has been estimated to be 2% to 15% for individuals with mood disorders and 15% to 20% for those individuals who have a history of psychiatric hospitalization for this disorder. Estimates of completed suicide among individuals with bipolar depression is approximately 15% and it is estimated that between 25% to 50% attempt suicide at least once.

There are a number of evidence-based practices, including cognitive-behavioral therapy and medication that can help with treatment of depression. A barrier to treatment is the continued stigma against mental illness, which may keep people with depression, bipolar disorder and other mental illnesses from seeking treatment. Additionally there is often a misperception of some of the symptoms of depression, with others interpreting symptoms as evidence of “laziness,” poor work ethic, oppositional behavior (especially among adolescents), etc. (Worchel and Gearing, 2010).

A key aspect of risk among people with mood disorders is the presence of hopelessness (Malone et al., 2000), as indicated by negative attitudes, or pessimism, about the future. According to Hopelessness Theory, people with depression tend to make internal, stable, and global attributions to explain the causes of negative events, and external, unstable, and specific attributions about positive events. This attributional style results in the individual taking personal blame for negative events in his or her life.

One measure of hopelessness is the Beck Hopelessness Scale. The Beck Hopelessness Scale is a 20-item self-report inventory. Beck et al. (1990) conducted a study of 1,958 outpatients with depression. The researchers used the Beck Hopelessness Scale significantly related to eventual suicide. A scale cutoff score of 9 or above identified 16 (94.2%) of the 17 patients who eventually committed suicide. The high-risk group identified by this cutoff score was 11 times more likely to commit suicide than other outpatients.

In addition to the Beck Hopelessness Scale, Beck has also developed the Beck Scale for Suicidal Ideation (1991). This scale can be used with persons ages 17 and older and takes less than 5 minutes to administer. Like the Beck Hopelessness Scale, this measure has shown an association with death by suicide.
Other risk factors for suicide among people with mood disorders include previous suicide attempts (Malone et al., 2000); family history of depression/suicidal behavior (Melhem et al., 2007); impulsive or aggressive behavior (Melhem et al., 2007), loss or separation (Malone et al., 2000); severity of depression (Rihmer, 2007); and comorbidity with anxiety or substance abuse (Rihmer, 2007).

Researchers have also studied protective factors. Conwell, Duberstein and Caine (2002) found having a strong social support network to be protective against suicide. Malone et al. (2000) found that feelings of greater responsibility towards family, better overall coping skills, more fear of disapproval and moral objections towards suicide were reasons people gave for wanting to live.

**Substance Abuse and Suicide**

Substance use disorders have also been associated with suicide attempts and completion (Bertolote & Fleischmann, 2002; Dhossche, Meloukheia & Chakravorty, 2000; Lejoyeux et al., 2008; Kutcher and Chehil, 2007). Substance abuse as a broad category includes both drug and alcohol-related disorders. Research has also just begun to look at addictive disorders, such as pathological gambling or Internet addiction. While it appears that substance use disorders have the potential to increase suicidality, the pathways are not always clear due to the frequency with which substance abuse is a comorbid condition associated with depression, anxiety, personality disorders and impulsive behaviors in adolescent and adult populations. Substance abuse, occurs along a broad continuum from low use to extremely heavy use. The likelihood of an individual experiencing problems stemming from substance use typically increases as the rate of use increases. A significant number of suicide attempts are made following consumption of alcohol (Lejoyeux, et al., 2008).

While the connections between suicide risk for individuals with alcohol and drug use disorders are underinvestigated, it is clear that alcohol and substance use are strongly related to suicide risk. Suicide risk is highly increased in substance use disorders, particularly in alcohol use disorders, and in co-morbid alcoholism and depression (Schneider, 2009; Niederkrotenthaler et al., 2014; Beghi et al., 2013). Alcohol and drug abuse are second only to mood disorders as the most frequent risk factors for suicidal behaviors. In 2008, alcohol was a factor in approximately one-third of suicides reported in 16 states (Karch, Logan & Patel, 2011). Substance use is also an increased risk factor in sexual minority youth (Savin-Williams & Ream, 2003).

The hallmarks of substance use disorders in their more extreme form are failure to fulfill major role obligations at work, school, or home (e.g., absenteeism, school problems, etc.); continued use in spite of physical
hazards (e.g., driving under the influence); interpersonal or social problems; and in some cases trouble with the law (e.g., DUI charges).

The most researched conditions are combined depression and substance abuse in suicide attempters. Dhosscha, Meloukheia, and Chakravorty (2000) conducted a chart review study of 1136 inpatients. Among 371 cases with self-harm, 311 (84%) attempted suicide. Suicide attempters were younger and diagnosed more often with comorbid substance abuse than patients without self-harm. Depressive disorders were found in 59% and substance abuse disorders in 46%. Comorbid depression and substance abuse was the most frequent category in suicide attempters (37%). Kaley, Mancino, and Messias (2014) studied the associations between various substances, depression and suicidality in youth in Arkansas. They found that three types of substance misuse were reported by more than 10% of Arkansas high school students: cannabis (33.3% ever use), inhalants (18.7% ever use), and prescription drugs without a prescription (13.2% ever use). They found in all suicide outcomes a stronger association with prescription drug abuse, followed by inhalant abuse, then cannabis abuse.

An emerging area of study involves the connection between addictive disorders, such as pathological gambling, and suicidality. In pathological gambling, multiple financial, occupational and relationship problems and losses, humiliation of the person and the environment are possible side effects and may lead to hopelessness, suicidal ideation and suicidal behavior. Suicide attempt rates among pathological gamblers of between 4% and 40% and suicidal ideation of between 12% and 92% have been reported (Thon et al., 2014).

There are a number of risk factors for suicide among substance users. In addition to depression, as a risk factor, another connection between alcohol/substance abuse and suicide may be in part due to the fact that alcohol increases aggression and impulsivity, another risk factor for suicide (Dvorak, Lamas & Malone, 2013). Other psychosocial risk factors include the presence of life stressors, living alone, hopelessness, interpersonal losses, and younger onset of alcohol use (Conner et al., 2012). Other risk factors include being male, older than 50 years of age, being unemployed, poor social support, continued drinking, consumption of a greater amount of alcohol when drinking, a recent alcohol binge, previous alcohol treatment, a family history of alcoholism, use of multiple substances (e.g., alcohol and cocaine use together), serious medical illness, suicidal communication, and prior suicidal behavior (Sher, 2006).

In substance abusing populations, the most important protective factor against suicide has been found to be strong connections to family and community support (Sher, 2006). Other protective factors include effective clinical care for psychiatric (including alcoholism and drug abuse) and physical disorders, easy
access to a variety of clinical interventions and support for seeking help, restricted access to highly lethal means of suicide, skills in problem solving and conflict resolution, cultural and religious beliefs that discourage suicide.

The main modalities used to address suicidality among this population are Alcoholics/Narcotics Anonymous, cognitive-behavioral therapy, motivational enhancement therapy and medication (Worchel & Gearing, 2010).

**Schizophrenia and Suicide**

Schizophrenia and psychotic disorders (schizophreniform disorder, brief psychotic disorder, delusional disorder) also heighten risk of suicide. Lifetime rates of completed suicide for individuals with schizophrenia is 5% (Palmer, Pankratz & Bostwick, 2005). About 20% of individuals with schizophrenia attempt suicide on more than one occasion (DSM-5, 2013). In examining mortality rates of patients with schizophrenia, many suicide attempts and deaths occur shortly after initial diagnosis. Crumlish (2005) found that 18% of first episode patients with psychosis attempt suicide 4 years after onset of the illness.

Schizophrenia spectrum and other psychotic disorders include schizophrenia, and other psychotic disorders and schizotypal personality disorder. They are defined by abnormalities in one or more of the following domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia) and negative symptoms (DSM-5, 2013). People with schizophrenia can sometimes act impulsively. Some of the features associated with schizophrenia, including dysphoric mood, hostility and aggression, may contribute to suicidality.

There are a number of key predictors of suicide for individuals with psychotic disorders. Hor and Taylor (2010) conducted a review of risk factors. The authors found that risk factors with a strong association with later suicide included being young, male, and with a high level of education. Illness-related risk factors were important predictors, with number of prior suicide attempts, depressive symptoms, active hallucinations and delusions, and the presence of insight all having a strong evidential basis. A family history of suicide, and comorbid substance misuse were also positively associated with later suicide.

Suicide risk remains high over the lifespan for both males and females with psychotic disorders, although it may be especially high for males with comorbid substance abuse. Other risk factors include having depressive symptoms or feelings of hopelessness, and being unemployed. The risk is also higher after a psychotic episode and after hospital discharge (DSM-5, 2013).

Protective factors include supportive family environments (Chan, 2003) and adherence to effective treatment (Hor and Taylor, 2010). Kasckow, Felmet, and Zisook (2011) recommend an integrated psychosocial and
pharmacological approach to managing this population. Specific psychopharmacological treatments, such as Clozapine, have demonstrated effectiveness in treatment (Meltzer, 2005). In addition, treating depressive symptoms in patients with schizophrenia is an important component of suicide risk reduction. Selective serotonin receptor inhibitors (SSRIs) ameliorate depressive symptoms in patients with schizophrenia, and can reduce suicidal thoughts (Kasckow, Felmet & Zisook, 2011). Evidence-based practices include psychoeducation about the illness, social skills and life skills training, and coping and problem-solving, and other cognitive-behavioral strategies.

**Anxiety Disorders and Suicide**

Anxiety disorders, including panic disorder, agoraphobia, social phobia, specific phobia, generalized anxiety disorder, and posttraumatic stress disorder have also been connected with suicide (Sareen et. al, 2005; Weissman, 1989). There are, however, high levels of comorbidity found within anxiety disorders. One question is whether it is this comorbidity, and not simply the presence of an anxiety disorder, that is associated with increased suicidal behavior.

Sareen et al., (2005) conducted a prospective population-based survey of adults in the Netherlands who were diagnosed with social phobia, simple phobia, generalized anxiety disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder. This is the first study to demonstrate that a preexisting anxiety disorder is an independent risk factor for subsequent onset of suicidal ideation and attempts. After adjusting for sociodemographic factors and all other mental disorders assessed in the survey, baseline presence of any anxiety disorder was significantly associated with suicidal ideation and suicide attempts. Among the specific anxiety disorders, the study found that OCD, social phobia, and GAD were strongly linked with SI at baseline and follow-up. The presence of an anxiety disorder in combination with a mood disorder increased the likelihood of suicidal behavior. These findings underscore the importance of early recognition and treatment of anxiety disorders, especially those with comorbid mood disorders.

Nepon et al. (2011) attempted to tease out the presence of personality issues from anxiety disorders in looking at suicide attempters. These researchers reviewed data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). The data showed that among individuals reporting a lifetime history of suicide attempt, over 70% had an anxiety disorder. Even after adjusting for sociodemographic factors, Axis I and Axis II disorders, the presence of an anxiety disorder was significantly associated with having made a suicide attempt.

Because the connection between anxiety and suicide is an emerging field, specific risk and protective factors are not known. It is likely that they are
similar to those of other mood disorders. It is clear, however, that suicide prevention programs should focus on anxiety symptoms, and not only on depression.

**Sleep Disorders and Suicide**

Sleep disruption is associated with many of the mental illnesses discussed so far, particularly depression (Ohayon, 2002). Insomnia is the most common sleep problem with about one third of the general population suffering from this condition (Ohayon, 2002). Several researchers have looked at whether sleep disturbance itself is a risk factor for suicide. Findings indicate that suicidal ideation and behaviors are closely associated with sleep complaints, and in some cases, this association exists above and beyond depression (Bernert & Nadorff, 2015; Bernert & Joiner, 2007).

Hall et al. (1999) examined emergency patients after serious suicide attempts. 46% of the patients reported global insomnia, 92% of the patients reported partial insomnia, i.e., difficulty falling asleep, sleep continuity disorder and early morning awaking. Only 14% of suicide attempters had suicidal thoughts with any previous plan prior to the suicide attempt. Sjöström et al. (2009) found similar rates with 89% of patients admitted after suicide attempts reporting sleep disturbances with main complaints of difficulties initiating sleep (73%), difficulties maintaining sleep (69%), nightmares (66%) and early morning awakening (58%).

There is body of literature on nightmares and suicidality strongly pointing to its link (Bernert et al., 2005; Sjöström et al., 2009). Sjöström et al. (2009) found nightmares in 66% of medical and psychiatric patients and nightmares were associated with a 5-fold increase in risk for high suicidality. Bernert et al. (2005) found that insomnia and nightmares were significantly associated with depressive and suicidal symptoms, particularly among women.

Bernert and Nadorff (2015) looked at sleep disturbance as a risk factor for suicide. They found that insomnia symptoms and nightmares appear to present elevated risk for suicidal ideation, attempts, and death by suicide. They found that preliminary research suggests that subjective sleep complaints may confer independent risk for suicidal behaviors.

Several cross-sectional investigations indicate a unique association between nightmares and suicidal ideation, whereas the relationship between insomnia and suicidality requires further study. Underlying neurobiological factors may, in part, account for the relationship between sleep and suicide. Serotonergic neurotransmission appears to play a critical role in both sleep and suicide (Bernert & Nadorff, 2015).

While there is need for further study of the link between sleep disorders and
suicide (some sleep disorders have not yet been studied including narcolepsy and restless leg syndrome), it does appear that sleep-oriented interventions may reduce risk for suicidal behaviors. Unlike other suicide risk factors, sleep complaints may be particularly amenable to treatment (Bernert & Nadorff, 2015; Norra et al, 2011). As a warning sign, disturbances in sleep may thus be especially useful to research and may serve as an important clinical target for future suicide intervention efforts.

**Trauma, Personality Disorders and Suicide**

A history of trauma, particularly repeated trauma, also appears to influence suicide attempts and gestures. Nock and Kessler (2006) studied a sample of 268 people who had made suicide attempts. They found that respondents who had been raped or experienced sexual molestation did not differ significantly between suicidal gestures and attempts, however, the risk of suicide attempt was significantly increased in the presence of multiple rapes and multiple sexual molestations as well as with higher rates of physical assault. Research has also helped clarify the link between early childhood adverse events and suicide later in life, and of the role of connectedness in protecting individuals from a wide range of health problems, including suicide. Efforts that promote overall health and that help build positive relationships can play an important role in suicide prevention.

People with personality disorders, particularly those with a trauma history, have much higher incidences of suicide. Bennett et al., (2006) addressed the high-risk group of patients diagnosed with Cluster B personality disorders such as borderline personality disorder (BPD). They describe these patients as often having chronic thoughts of suicide and heightened levels of self-mutilation, gestures and attempts.

Jylha et al. (2015) also looked at Comorbid personality disorders as a predisposing factor in suicide attempts, as well as factors mediating this effect. They interviewed 597 patients at baseline, at 18 months, and at 5 years, including in this assessment evidence of personality disorders (PDs), number of previous suicide attempts, life-charted time spent in major depressive episodes, and timing of suicide attempts. Overall, 36.7% of patients had a total of 718 lifetime suicide attempts; 14.7% of patients had 242 suicide attempts during the prospective follow-up. Having any personality disorder diagnosis increased the suicide attempt rate, both lifetime and prospectively evaluated, by 90% and 102%, respectively. All PD clusters increased the rate of new suicide attempts, although cluster C personality disorders more than the others. After adjusting for time spent in major depressive episodes, only cluster C further increased the suicide attempt rate (by 52%).

The hallmarks of personality disorders are impairment in personality (defined as self/other functioning), one or more pathological personality traits, and the
relative stability of these impairments across environments. Personality disorders include antisocial personality disorder, avoidant personality disorder, borderline personality disorder, narcissistic personality disorder, obsessive-compulsive personality disorder and schizotypal personality disorder. Of these disorders, borderline personality disorder is the most researched in terms of suicidality.

Personality disorders can be grouped into three clusters based on descriptive similarities within each cluster. These clusters are:

- Cluster A (the "odd, eccentric" cluster)
- Cluster B (the "dramatic, emotional, erratic" cluster)
- Cluster C (the "anxious, fearful" cluster)

**Borderline Personality Disorder**

According to the Borderline Personality Disorder Resource Center, 10% of people with borderline personality disorder commit suicide. 33% of youth who commit suicide have features, or traits, of borderline personality disorder. This number is 400 times higher than the general population, and young women with BPD have a suicide rate 800 times higher than the general population. Additionally research also suggests that engaging in acts of self-injury may lead to suicide later in life (Lofthouse & Yager, 2009) both in cases when the self-injury involves the intent to die, as well as in cases when there is no suicidal intent (Hawton, Harriss & Zahl, 2006).

Typical features of borderline personality disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy (DSM-5, 2013, p. 766). All of these characteristics may be related to suicidality. Additionally, the personality traits of emotional lability, impulsivity, depression, risk-taking and hostility have also been cited as factors in suicide attempts and completion.

Risk factors for suicidal behavior in patients with borderline personality disorder include older age, prior suicide attempts, antisocial personality, impulsive actions, and depressive moods (Soloff et al., 1994).

McGirr et al. (2007) also studied risk factors for people with personality disorders, focusing on Borderline personality disorder. These researchers attempted to look at whether impulsivity and aggression interact to increase suicide risk. They concluded that the lethality of borderline personality disorder suicide attempts results from an interaction between impulsivity and the violent-aggressive features. The anxious trait of harm avoidance appears to be protective against suicidal behavior resulting in death.

Prevention of suicide in individuals with personality disorders presents some
challenges. Gregory (2012) makes a number of suggestions regarding inpatient and outpatient management of suicidality in patients with personality disorders. He suggests that clinicians working with people with borderline personality disorder look for triggers of suicidal ideation or behavior, especially abuse, separation, or loss; that they treat the patient with care and respect, avoiding sarcasm; and that they carefully consider actions that may be perceived as abandonment (i.e., handling referrals to inpatient with care). In hospitalizing patients, Gregory (2012) suggests short stays for stabilization only. With regard to continuous treatment, Gregory (2012) recommends manual-based treatments, such as dialectical behavior therapy (Linehan et al., 2006); clear and consistent patient/clinician boundaries; using the technique of helping the patient to verbalize recent upsetting interpersonal experiences, and creating sequential narratives of these experiences, and label associated emotions; and encouraging patients to take responsibility for maintaining safety and working toward recovery (as part of treatment goals and expectations).

One significant contribution has been Linehan’s Dialectical Behavior therapy. The effectiveness of DBT in reducing suicide has been shown in a number of studies (Gagliesi, 2010; Hamed et al., 2008; Linehan et al., 2006; McMain, et al., 2009). DBT is support-oriented, collaborative, and based on other cognitive approaches. One of the key components of DBT is in that clients learn specific distress-tolerance skills that they can use in times of crisis. These skills include self-soothing, which allow them cope with overwhelming negative emotions. There are also specific skills connected to emotional regulation, including interpreting and describing emotions, as well as letting go of negative emotions, skills that are helpful in times of suicidal crisis. While DBT was initially developed for use with people with borderline personality disorder, the utility of these techniques allows for use with a variety of treatment issues.

Eating Disorders and Suicide

Eating disorders as a whole seem to be a risk factor for suicide. Because people with eating disorders have an increased risk of mortality in general (Franko & Keel, 2006; Harris & Barraclough, 1997). It is difficult to determine the exact risk as the rates of suicide in eating disorders may be subject to underreporting bias due to internalized shame about the disorders.

Anorexia nervosa is an eating disorder characterized by food restriction, irrational fear of gaining weight and consequent weight loss. High mortality rates have been reported, mostly due to suicide and malnutrition. Good outcomes largely vary between 18 and 42 % (Errichiello et al., 2015). Bulik et al. (2008) looked at prevalence and patterns of suicide attempts in persons with anorexia. Participants were the first 432 persons (22 male, 410 female) enrolled in the NIH funded Genetics of Anorexia Nervosa Collaborative Study. All participants had current or lifetime anorexia and ranged in age from 16 to
76. About 16.9% of those with AN attempted suicide. Significantly fewer persons with the restricting subtype (7.4%) reported at least one attempt than those with purging AN (26.1%), AN with binge eating (29.3%), and a mixed picture of AN and bulimia nervosa (21.2%). While there may be many reasons for the findings cited in these studies, one often cited theory concerns the cognitive inflexibility and impaired decision-making often seen with this group.

Suicide is also seen in men and women with bulimia and binge eating disorder. Portzky, van Heeringen & Vervaet (2014) looked at 1,436 patients with eating disorders. They found that a history of attempted suicide was found in 11.8% of the ED patients and lifetime suicidal ideation was reported by 43.3%. The presence of particular personality traits, of cognitive schemes, and of purging and depressive symptoms should increase vigilance for suicidal behavior. Childhood emotional, physical, and sexual abuse were also significantly associated with the presence of a lifetime suicide attempt in women with bulimia. Childhood emotional and physical neglect were not associated with suicide attempts (Smith et al., 2015).

Binge eating disorder is the most prevalent eating disorder, and the impact of untreated BED is underappreciated. Sheehan and Herman (2015) state that there is a significant relationship between binge eating disorder, physical and mental health, quality of life, and functionality. The researchers looked at 326 identified publications, 43 were relevant to the topic and reported on the association of binge eating disorder with psychiatric and medical comorbidities, quality of life, and functional outcomes. They found that individuals diagnosed with binge eating disorder have increased rates of mental health comorbidities (eg, depression, anxiety, suicidal ideation and suicidality) and more pronounced medical impairments (eg, cardiovascular disorders) compared with individuals without binge eating disorder.

Suicidality in individuals with eating disorders may also be connected to genetics. An Australian study (Wade et al., 2015) looked at over 1000 female twins with anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder, and purging disorder (PD), suicidality (ranging transitory thoughts to suicide attempts), and major depression. Any suicidal thoughts were reported by 24% of the sample, but prevalence of lifetime suicidality among female twins with EDs was much higher (43%), presence of an ED diagnosis more than doubling likelihood of suicidality. Monozygotic twins had uniformly higher estimates than dizygotic counterparts, inferring a common genetic pathway for suicidality and eating disorders.

While future research is needed to understand the mechanism to address in treatment and prevention efforts, it is important to routinely monitor those with disordered eating for suicidal ideation.
Traumatic Brain Injury (TBI) and Suicide

Traumatic brain injury is defined as “a sudden trauma causing damage to the brain.” (National Institute of Neurological Disorders and Stroke, 2002). The severity of such an injury may range from mild (i.e., a brief change in mental status or consciousness) to severe (i.e., an extended period of unconsciousness or amnesia after the injury). Depending on severity levels, a traumatic brain injury can result in chronic problems with independent function.

Traumatic brain injury has been associated with higher risk of suicide. For the first 6 years after the traumatic brain injury, suicide attempt probability is 18.4% (Berman & Pompili, 2011). One significant aspect of these attempts is that patients with traumatic brain injury have a strong intent to die.

Suicidal ideation and attempts may be directly associated with some of the effects of the traumatic brain injury. These include the physical effects, such as change in eyesight (limiting driving ability and independence), difficulty with balance and coordination, and inability to use certain motor functions; the cognitive effects, such as difficulty concentrating, making decisions/judgment, or expressing oneself, and aphasia; and the behavioral effects such as becoming angry and frustrated easily, and acting without thinking. There may also be mood-related changes, including apathy, anxiety, egocentricity emotional lability and depression. The risk of suicide attempts increases if the individual also has post-injury psychiatric/emotional disturbance and substance abuse problems (Simpson & Tate, 2005).

Risk factors for suicide in individuals with traumatic brain injury include loss of support systems (loneliness and isolation), loss of job and income levels, and change of roles within the family unit. Screening, even many years after the injury, for post-TBI related psychiatric sequelae is indicated (Kemp et al., n.d.).

Some of the protective factors to help prevent suicide in individuals with traumatic brain injury include: supports/support groups, medication, having accessible providers, having a belief system (spirituality), having responsibility (a job or pet), and caring family members. It is also important that caregivers receive support (Kemp et al., n.d.).

Emotional Regulation and Suicide

Difficulties with affect modulation/emotional regulation are also seen in suicide attempts in people who do not meet criteria for personality disorders, particularly among youth. A recent study looked at high school students who had attempted (but not completed) suicide. Participants completed an in-depth computer-assisted self-interview about their most recent attempts as well as additional psychosocial measures. Results indicated that nearly 75% of the adolescents engaged in suicide attempts for reasons other than killing.
themselves, such as interpersonal communication and emotion regulation. Depressive symptoms were significantly associated with increased risk for engaging in the attempts (Jacobson et al., 2013).

People demonstrating difficulties with emotional modulation may be helped by the DBT skills and therapy described in the preceding section. One helpful resource for teens is the workbook entitled *Don’t let Your Emotions Run Your Life* (Van Dijk, 2011), which contains specific crisis management skills.

Service Utilization and Treatment-Seeking

One of the challenging aspects of suicide prevention is that people who consider suicide do not always seek counseling. Bertolote and Fleischmann (2002) found that about one-third of people who took their lives did not directly communicate their suicide intent to anyone, including medical professionals, family members or friends. This implies the need for increased public awareness of more subtle signs of suicidal ideation. These direct and subtle signs will be addressed later in this training material.

Another interesting consideration is that people considering suicide are often more likely to initiate a consultation with a primary care providers than with mental health providers. An analysis of 40 postmortem studies conducted by Luoma, et al., (2002) found that 45% of those who died by suicide had seen a primary care provider within the month before their death, and 77% had such contact within the past year. Older adults who died by suicide were even more likely to have had recent contact with a primary care provider. By contrast, only about 30% of all those who died by suicide had received mental health services during the last year of life, and only 19% in the last month. These findings suggest that suicide rates may be reduced if primary care providers were better able to recognize patients who demonstrate warning signs of suicide and refer them to appropriate mental health resources, calling to mind one of the issues Kaslow (2014) raises.
At-Risk or Vulnerable Groups

Case Vignette

Rutgers University made headlines in 2010 due to the suicide of freshman student Tyler Clementi, who killed himself by jumping from the George Washington Bridge. Tyler reportedly was distraught when his roommate broadcast intimate footage of Tyler and another young man. Tyler's death brought national and international attention to the issue of cyberbullying and the struggles facing LGBT youth.

While the case vignette above highlights the vulnerability of lesbian, gay, bisexual and transgendered (LGBT) individuals — particularly youth — several diverse groups in society are at increased risk for suicide. These include LGBT, armed forces personnel, Native Americans, the homeless and incarcerated individuals. This section will highlight these at-risk populations.

Lesbian, Gay, Bisexual and Transgendered Clients

Lesbian, gay, bisexual and transgendered and questioning (LGBTQ) individuals appear to be particularly at risk for suicide/suicide attempts. Population studies suggest that about 4 to 8 percent of all young people have attempted suicide by age 20 (Beautrais, 2003). In contrast, studies have found that 37 percent of LGBT ages 14 to 21 had attempted suicide at some point (D'Augelli, 2002). Additionally in comparing the seriousness of suicide attempts by lesbian, gay, and/or bisexual youth and heterosexual youth Safren & Heimberg (1999) found that 58 percent of LGB people who had attempted suicide reported that they had really hoped to die. In contrast, only 33 percent of heterosexuals who had attempted suicide reported that they had really hoped to die. Transgendered individuals are also at risk. One study that was not restricted to young people found that 83 percent of transgender people had thought about suicide and 54 percent had attempted it (Dean et al., 2000).

What causes LGBTQ individuals to be so vulnerable? Berman et al. (2006) grouped risk factors into themes such as mental illness, negative personal history (including previous self-harm and parental mental illness), isolation and alienation, and availability of a method. The American Society for Suicide Prevention reports significantly higher rates of depression, generalized anxiety disorder, conduct disorder and substance use disorder among GLBTQ individuals than among heterosexual counterparts. They also found that GLBTQ people commonly report experiencing stresses such as social stigma, prejudice and institutional and individual discrimination.

Beautrais (2003) reviewed the literature on risk factors for suicidal behavior in LGBTQ youth. She identified a complex interplay of factors including adverse events (such as family discord, abuse, and neglect), stresses (relationship
losses or conflicts and legal or disciplinary crises), personality traits (such as low self-esteem, impulsivity, and hopelessness), and mental health problems. She found that youth who demonstrated suicidal behavior may have had not only more stresses but also more severe stresses and that a majority of youth attempting suicide has some form of mental disorder at the time of the attempt (Beautrais, 2003).

It is also important to recognize the influence of the larger society on the LGBTQ population, especially youth; stigma remains a prevalent issue. Morrow (2004) states “GLBT adolescents must cope with developing a sexual minority identity in the midst of negative comments, jokes, and often the threat of violence because of their sexual orientation and/or transgender identity.” This social environment puts stresses on LGBT people that elevate the risk of substance abuse, depression, anxiety, and other emotional problems.

Other studies find that internalized homophobia and conflict about sexual orientation appear to contribute to suicide risk among LGB youth. A study of gay men found that internalized homophobia was associated with depression and anxiety, which increased suicide risk (Igartua, Gill, & Montoro, 2003).

Conversely, in a qualitative study entitled “Life in the Seesaw: A qualitative study of suicide resiliency factors for young gay men Fenaughty & Harre (2003) found that positive role models and high self-esteem are protective factors against suicide in young gay men. Additional protective factors include family acceptance and connectedness, caring supports, and school/institutional safety serve as protective factors from suicide for LGB individuals (Eisenberg & Resnick, 2006). These factors are helpful in developing prevention programs.

Another idea in developing GBLTQ suicide prevention services involves utilizing a cultural competence approach. This means that it is important to train mental health professionals on GBLTQ-specific, basic skills and competencies will ensure that those individuals feel welcome and secure, ensuring that services and providers are inclusive, responsive to, and affirming of the needs of GBLTQ people. Peer support and programs that respond to coping with stress and discrimination are also helpful. Prevention efforts should also incorporate activities to support individuals and their family members throughout the development of sexual orientation and gender identity, and span all ages, including address children and adolescents. Additional helpful resources include organizations that support LGBT youth, such as Gay-Straight Alliances and Parents, Families, and Friends of Lesbians & Gays (PFLAG) and the Trevor Project (http://www.thetrevorproject.org/) which operates a suicide hotline with people specifically trained in working with LGBTQ youth. The Suicide Prevention Resource Center Training institute also has a workshop leaders guide with excellent information (http://www.sprc.org/training-institute/lgbt-youth-workshop).
Suicide and Childhood Sexual Abuse

Trauma, especially sexual trauma, is a known risk factor for both suicide attempts and completed suicide. According to Shapiro (1992), one of the first researchers to look at Suicidality and the sequelae of childhood victimization, “Sexual victimization... creates an overwhelming sense of powerlessness, worthlessness, and a felt inability to change or control one’s environment. It creates self-loathing... it facilitates internalized feelings of shame, not the guilt of feeling one has done something bad, but a more pervasive sense of being bad. It creates self-blame.”

A 2014 meta analysis of 9 studies from 6 different countries, with a total of almost 9000 participants, showed that those who experienced childhood sexual abuse before the age of 16 to 18 years were more than twice as likely to attempt or complete suicides (Devries et al., 2014). These statistics are even higher than once thought.

While it is difficult to specifically say why adults with a history of childhood sexual abuse have such a high rate of suicidality, it appears to be related to both psychological and physiological reasons. As Shapiro (1992) notes, survivors of childhood trauma may internalize the abuse and develop feelings of self-blame and self-hatred. Childhood sexual abuse may also lead to changes in the stress response system within the brain: Sexual abuse is associated with changes within the metabolism of serotonin.

These factors point to the need for specific screening and support for adult survivors of childhood sexual traumas.

Suicide and the Armed-Forces

Suicide is also a problem in the military (Bryan, 2014). In the past decade, increases in the rate of suicide among members of the U.S. Armed Forces has led to the implementation of extensive prevention programs in all branches of the military. Concern about suicide among veterans has also led to extensive suicide prevention efforts, although it is unclear what the reasons are for this increased risk. While it has commonly been proposed that unique stressors, such as combat deployment underlie the increasing incidence, a study by LeardMann et al. (2013) did not find that to be the case. In fact, the authors of this study concluded that suicide risk was independently associated with male sex and mental disorders but not with military-specific variables.

Other studies, however, have confirmed the risk between military service and suicide. Gradus et al., looked at suicide attempts and completed suicides among current and former Marines in the 10 years following recruit training.
Stressful and traumatic life events (e.g., childhood physical, sexual, and emotional abuse, sexual harassment during recruit training) and pre-recruit training suicide attempts emerged as having strong associations with post-recruit training attempts. About half of those individuals who died by suicide in the 10 years following recruit training endorsed at least one significant life stressor prior to joining the Marines. This study highlights the importance of screening for stressful and potentially traumatic experiences occurring both before and during military service as part of a comprehensive suicide risk assessment in military samples.

While suicide prevention is discussed later in this material, of interest in looking at suicide and the military is the U.S. Air Force Suicide Prevention Program (AFSPP). The program, which has been in effect since 1996 has been shown to reduce the risk of suicide among Air Force personnel by one-third (Knox et al., 2003). Participation in the program was also linked to decreases in homicide, family violence (including severe family violence), and accidental death.

Strategies included in the AFSPP program include:

- Increasing awareness of mental health services and encouraging help-seeking behaviors
- Involving leadership
- Including suicide prevention in professional training
- Developing a central surveillance system for tracking fatal and nonfatal self-injuries
- Allowing mental health professionals to deliver community preventive services in nonclinical settings
- Establishing trauma stress response teams;
- Conducting a behavioral health survey to help identify suicide risk factors.

**Elderly Clients**

“The capacity of an individual with mental or behavioral problems to respond to mental health interventions knows no end-point in the life cycle. Even serious mental disorders in later life can respond to clinical interventions and rehabilitation strategies aimed at preventing excess disability in affected individuals.”

_C Everett Koop, Surgeon General’s Workshop Health Promotion and Aging, 1988_

The elderly – particularly males – are at higher risk for suicide compared to other age groups. The elderly make fewer suicide attempts compared to youth; however, older people are more likely than any other age group to die by suicide. According to the American Association of Marriage and Family
Therapists (AAMFT), older adults make up 12% of the US population, but account for 18% of all suicide deaths. The elderly are one of the fastest growing segments of the population, making the issue of later-life suicide a major public health priority.

In 2002, the annual suicide rate for persons over the age of 65 was over 15 per 100,000 individuals; this number increases for those aged 75 to 84, with over 17 suicide deaths per every 100,000. The number rises even higher for those over age 85. The AAMFT estimates that elder suicide may be under-reported by 40% or more, due to what they term "silent suicides." Examples of these include deaths from overdoses, self-starvation or dehydration, and "accidents." The elderly have a high rate of completing suicide because they use firearms, hanging, and drowning. Additionally double suicides involving spouses or partners occur most frequently among the aged.

Risk and protective factors for suicide among the elderly have been extensively studied (Van Orden et al., 2014; Conwell, Van Orden & Caine, 2011). Risk factors include:

- Increasing age
- Male gender
- Being single or divorced, or living alone
- Social isolation/closed family systems
- Generational biases against mental health services
- Poor physical health or illness, particularly inadequate pain control;
- Losses (health, status, social roles, independence, significant relationships)
- Grief
- Depression
- Fear of institutionalization
- Frailty

While the idea of social isolation and loneliness has been mentioned, its importance as a contributing factor in suicide among the elderly cannot be underscored strongly enough (Choi & Morrow-Howell, 2007). Precipitating life events that create increased isolation, such retirement, becoming a widow or widower or relationship problems have been noted in a number of studies.

Among the elderly there is also a high degree of psychiatric illness; one in four older adults has a significant mental disorder. The most common problems are depression, anxiety disorders and dementia (Bartels et al., 2005).

According to an American Psychological Association resource guide, depressed older adults tend to use health services at high rates, engage in poorer health behaviors, and evidence what is known as "excess disability." Older adults have the highest rates of suicide of any age group, and this is
particularly pronounced among men. Depression may be situational and related to any of the life stressors discussed previously. Additionally one hypothesis about depression in the elderly is the so-called "vascular depression hypothesis" which suggests that cerebrovascular disease can predispose, precipitate, or perpetuate a depressive syndrome in many elderly patients with underlying neurologic brain disorders (Alexopoulos et. al, 1997). Those who subscribe to this hypothesis state that it is supported by the high frequency of depression in patients with hypertension, diabetes, coronary artery disease, and stroke; the frequency occurrence of silent stroke and white matter hyperintensities in geriatric depression; and the association of depression with lesions impairing the integrity or regulation of the circuits linking basal ganglia and prefrontal cortex (Alexopoulos et. al, 1997).

One other area to consider when discussing suicide and the elderly is the possible role of substance abuse. A substantial and growing percentage of older adults misuse alcohol, prescription drugs, or other substances. The number of older adults in need of substance abuse treatment is estimated to more than double from 1.7 million in 2000 and 2001 to 4.4 million in 2020 (Bartels et al., 2005). Substance abuse and mental health problems among the elderly are associated with higher risk of suicide. Many older adults with these problems do not receive the treatment they need.

Prevention efforts can be increased by detecting and reducing the factors that increase suicide risk by treating physical and psychiatric disorders, reducing social isolation, improving resources, enhancing self-esteem, and helping elderly clients find meaning or satisfaction in life. Talking about suicide with the elderly reduces barriers to accessing help. Interventions that improve self-esteem, manage depression, decrease negative thinking patterns, and improve social support can decrease suicide risk (Valente, 1997).

Teen Suicide

Suicide is the second leading cause of death for ages 10-24 (CDC WISQUARS, 2013). It is also the second leading cause of death for college-age youth and ages 12-18. (2013 CDC WISQARS). Each day in our nation there are an average of over 5,400 attempts by young people grades 7-12. Male youth die by suicide (4.34) more frequently than female. Native American/Alaska Native youth have the highest rate with 20.89 suicides per 100,000. White youth are the next highest with 11.30 deaths per 100,000. Black youth had 6.59 deaths by suicide per 100,000. While these statistics are staggering, perhaps the most sobering is that four out of five teens that attempt suicide have given clear warning signs.

Suicidal distress in teens can be caused by psychological, environmental and social factors. Risk factors for teen suicide include:
The risk for suicide frequently occurs in combination with external circumstances that seem to overwhelm at-risk teens that have predisposing vulnerabilities such as mental health issues. Examples of stressors are disciplinary problems, interpersonal losses, family violence, sexual orientation confusion, physical and sexual abuse and being the victim of bullying.

In 2015 SAMHSA released a consensus statement on Warning Signs for Youth Suicide. These signs are based on the collaboration of several expert organizations including American Association of Suicidology, Columbia University, the Indian Health Service, the National Center for the Prevention of Youth Suicide and The Trevor Project.

These factors include:

- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Displaying severe/overwhelming emotional pain or distress
- Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above. Specifically, this includes significant:
  - Withdrawal from or changing in social connections/situations
  - Changes in sleep (increased or decreased)
  - Anger or hostility that seems out of character or out of context
  - Recent increased agitation or irritability

Protective factors moderate the impact of stress on depression and suicidal behavior. Some of the protective factors that mediate adolescent suicidality include:

- Family connectedness and school connectedness (Kaminski et al., 2010)
- Reduced access to firearms (Grossman et al., 2005)
- Safe schools (Eisenberg et al., 2007)
The Homeless

The lifetime prevalence of suicide among the homeless has been estimated to be as high as 66% (Eynan et al., 2002; Desai et al., 2003), especially among those with mental illness. According to the U.S. Department of Housing and Urban Development, there are over 600,000 homeless people in the U.S.; approximately 138,000 are children under the age of 18. Over 57,000 veterans are homeless. More than 90% of homeless women are victims of severe physical or sexual abuse and escaping that abuse is a leading cause of their homelessness.

While some of these people are living in homeless shelters or transitional living arrangements, many others are unsheltered. This is due in part to the scarcity of low-income housing.

Middle-age homeless individuals are at highest risk. Suicide is also the leading cause of non-natural death among homeless older veterans. Risk factors for suicide among the homeless are similar to the population at large and include alcohol and/or drug abuse, psychiatric history (particularly the presence of schizophrenia), and inpatient hospitalizations.

Serious mental illness disrupts peoples' abilities to carry out essential aspects of daily life including self-care and household management. It may also affect a person’s ability to maintain stable and supportive relationships or place stress on family and caregivers. Thus people with severe mental illnesses are more likely to become homeless (National Coalition for the Homeless, 2009). While about 6% of the general population suffers from severe mental illness, 20 to 25% of the homeless suffer from severe mental illness according to government studies. Patients with bipolar disorder and schizophrenia are particularly vulnerable.

Homelessness carries a number of hardships including economic, social and physical. It limits a person’s privacy and compromises their sense of personal safety. Homelessness results in an increased risk of interpersonal violence and victimization. There is also a general sense of stigma rejection or discrimination from other people and a loss of usual relationships with the mainstream.

The concept of resiliency is often applied to homeless individuals, particularly youth, and is seen as a significant protective factor. Cleverly and Kidd (2011) conducted a qualitative study of quantitative examination of personal and street-related demographics, psychological distress, self-esteem, resilience, and suicidality among 47 homeless and street-involved youth. They found that
those youths’ perceived resilience was associated with less suicidal ideation whereas higher psychological distress was associated with higher suicidal ideation, even when accounting for resiliency. Douglass (1996) also looked at this issue and presents an account of the unique resiliencies and coping abilities of some homeless youth. These studies also point out that due to reliance on others to fill basic survival needs, the ability to delineate who is trustworthy is an important resiliency factor.

Incarcerated Individuals

Suicide is a major public health issue among incarcerated individuals, both in the U.S. and worldwide. According to the World Health Organization (WHO) and the International Association for Suicide Prevention IASP), Suicide is often the single most common cause of death in correctional settings (WHO/IASP, 2007). Hayes (2005) found suicide to be the most common cause of death in secure justice settings, with more than 400 suicides each year in local jails at a rate three times greater than among the general population. A subsequent national study of jail suicides found that between 2005-2006 there were 612 deaths that occurred in detention centers and 84 in holding facilities. 464 of these were suicides (Hayes, 2010).

A combination of individual and environmental factors likely accounts for the higher rates of suicide in correctional settings. Jails and prisons contain vulnerable groups that are traditionally among the highest risk for suicide, including young males, persons with mental disorders, people who are socially disenfranchised or socially isolated, people with substance use problems, and those who have had previous suicidal behaviors ((WHO/IASP, 2007). Another common factor was that many of the inmates who had committed suicide had been held on or convicted of violent charges (Hayes, 2010).

The experience of incarceration may be particularly difficult for juvenile offenders who are separated from their families and friends. There is also the psychological impact of the arrest, and the stresses of prison life (WHO/IASP, 2007).

While incarceration facilities differ, there are a number of contextual issues that could influence suicidality among incarcerated individuals. Some of these include overcrowding, lack of possibility of purposeful activity, sanitation, broad sociocultural conditions, the prevalence of HIV/AIDS, levels of stress, and access to basic health or services for mental health or substance issues. Prisons are also characterized by social isolation and violence (Fruehwald et. al, 2004).

While some systems have initiated prevention programs, opportunities continue to exist. Some recommendations include identifying those inmates who are at greatest risk for suicide attempts (expressing a great deal of
shame, prior attempts/current plan, mental health issues), staff training on
suicide prevention, mental health counseling and support, routine checks,
cultivating relationships between staff and inmates, monitoring, and
communication. Additionally more innovative programs, such as those that
decrease social isolation (e.g., trained inmate “buddies) may also help reduce
risk (Junker et al., 2005).

**Foster Care**

There is also concern that youth in the foster care system may be at an
increased risk for suicidal behaviors and other related problems (Leslie et al.,
2010). In 2006, over 3.5 million US children were reported as abused and
neglected, with 905 000 confirmed victims (US Department of Health and
Human Services, Administration for Children and Families, Children’s Bureau
2008). When a child’s safety cannot be assured in the home, he or she is often
removed by child protective services and placed into the foster care system.

Adolescents who had been in foster care were about two and a half times
more likely to have seriously considered suicide and almost four times more
likely to have attempted suicide than other youth (Pilowsky & Wu, 2006). Most
youth who die as a result of suicide have a psychological disorder such as
depression, severe anxiety or a substance use disorder. Youth in foster care
are more likely to have a mental disorder or substance use disorder than those
who were never in foster care (Pilowsky & Wu, 2006; Pecora et al., 2009).

Many youth in foster care are there because of experiences of instability in the
home environment include abuse or neglect; Another subset of children enter
foster care because of behavioral problems. (Berrick et al. 1998; US
Departmentof Health and Human Services, Administration for Children and
Families, Children’s Bureau 2008a). According to a study by Pecora et al.,
(2005), 54 percent of foster children had been sexually abused before
they were placed with foster families, while another 28 percent had been
physically abused or neglected. Those numbers demonstrate the high
proportion of traumatized youth in foster care.

Experiencing childhood abuse or trauma increased the risk of attempted
suicide 2- to 5-fold (Dube et al., 2001). Adverse childhood experiences play a
major role in suicide attempts. One study found that approximately two thirds
of suicide attempts may be attributable to abusive or traumatic childhood
experiences (Dube et al., 2001).

While the home environment is not a positive one for youth in foster care,
many youth in the system still struggle with separation from their other
caregivers and supports (friends, school supports such as teachers,
neighbors). They may also experience further maltreatment in foster care, and
may frequently be moved from home to home. These experiences may result
in a sense of loss. They may also carry the shame of being placed in foster care. These experiences of loss, isolation, and lack of social support are all risk factors for suicide.

Other common risk factors among youth in foster care include:

- Mental illness including substance abuse
- Access to medications
- Prior suicide attempt
- Self injury
- Parental mental illness and substance abuse
- Family conflict and dysfunction
- Family history of suicidal behavior
- Poor coping skills
- Social alienation
- Exposure to suicides and attempts
- Suicide means availability (access to lethal means)
- Other risk-taking behaviors (promiscuous sex, driving recklessly, petty theft, vandalism)
- Minority sexual orientation or gender identity
- Violence and victimization
- Bullying

Protective factors that reduce the likelihood of suicide are positive self-esteem, a supportive family/foster family, other caring adults, safe schools, and helpful friends and mentors.

A number of factors should be considered in reducing risk. These educating treatment providers and foster parents on warning signs of depression/suicide, supporting the development of positive coping skills, facilitating connectedness, support, communication with parents, counseling to develop higher self-esteem and support overall emotional well-being. While these suggestions are helpful, there is a need for additional research.

Physician Suicide

Another at-risk group are physicians (including medical doctors, psychiatrists, psychologists and other mental health clinicians). Andrew et al. (2015) estimate that in the United States about 400 physicians die each year from suicide. They make the statement that this is equivalent to losing at least a medical school full of physicians yearly.

Interestingly, physicians are at much lower risk of dying from certain physical illnesses including cancer and heart disease, likely due to self-care measures. A number of authors theorize that for mental health issues, including depression, physicians may be less willing to seek treatment. Bright & Krahn
(2011) suggest that physicians may not seek treatment due to stigma, may attempt to diagnose and treat themselves, or may receive “VIP” treatment (which may be inadequate or may underestimate severity and needs) from other healthcare professionals. Physicians may also be less likely to seek treatment due to licensure and insurance concerns.

Depression is very prevalent among medical students and residents, with 15-30% of them screening positive for depressive symptoms (Andrew et al., 2015; Bright & Krahn, 2011). While many enter medical school with no symptoms of depression, depression scores rise over time. This may be due to some of the stressful aspects of physician training, including long hours, distance from family and supports, and harassment from professors. Suicide is the most common cause of death among medical students.

After completing residency, the risk of depression persists. The lifetime prevalence of depression among physicians is 13% in men and 20% in women; these rates are comparable to those of the general population. Physicians often have a difficult time recognizing depression among themselves and among colleagues. Some of the predictors of depression in physicians include:

- Difficult relationships with senior doctors, staff, and/or patients
- Lack of sleep
- Dealing with death
- Making mistakes
- Loneliness
- Divorce or marital conflict
- 24-hour responsibility
- Self-criticism
- Litigation-related stress
- Employment discrimination related to judgments or settlements
- Substance abuse
- History of risk taking

A survey of American Surgeons found that although 1 in 16 had experienced suicidal ideation in the past 12 months, only 26% had sought help. There was a strong correlation between depressive symptoms, as well as indicators of burn out, with the incidence of suicidal ideation (Shanafelt et al., 2011). Suicide attempts more often are lethal, perhaps because they have greater knowledge of toxicology and access to lethal drugs.

Andrew et al. (2015) suggest that more education is needed regarding depression/suicidal ideation and its toll on the medical profession, beginning in the earliest stages of physician training. There is also a need to change the attitudes of those in health care (including those in the regulatory system), as well as the attitudes of the general public, toward mental illness. These
changes might encourage physicians to be more receptive to a diagnosis of depression and enable them seek treatment.

**Culture and Ethnicity As Risk Factors**

While prevalence data outlines the increased vulnerability of certain ethnic and cultural groups, it does not necessarily provide insight into culturally relevant risk and protective factors. It is important that clinicians be able to treat suicidality from a culturally competent perspective. Additionally there are a number of myths associated with various ethnic groups and suicide risk (i.e., because Hispanics are predominately Catholic, suicide is not a problem) that may incorrectly influence therapists.

**Suicide Trends By Culture/Ethnicity**

**Caucasians**

According to CDC data, suicide rates are highest among Caucasian individuals, particularly those who are older, male, and have anxiety disorders (CDC, 2010; Vanderwerker et al., 2007). The lifetime prevalence of suicidal ideation and suicide attempts of Whites has been placed at 16.10% and 4.69%, respectively. In the United States, in all age groups, for all races, men have higher suicide rates than women. (NPIC, 2007). Men over age 70 have the highest rate of suicide in the United States.

Risk factors among Caucasians include mood and anxiety disorders (Malone et al., 2000; Vanderwerker, Charpentier & Michalski, 2007), a disrupted family environment (Handy et al., 1991), heavy alcohol use (Groves et al., 2007; Kung, Liu & Juon, 1998), social isolation/living alone (Kung, Liu & Juon, 1998), loss of a family member or friend (Borrowsky et al., 2001), at least a high school education (Kung, Liu & Juon, 1998), those in blue collar occupations (Kung, Liu & Juon, 1998) and access to firearms (Brent at. Al., 1993). Physical illness has also been shown to increase suicide risk in Caucasians (Juurlink et al., 2004; Quan et al., 2002), especially among elderly Caucasians (Vanderwerker et. al, 2007). Among non-U.S. born Caucasians, conflicts between the values of their family and the dominant culture are associated with suicide attempts (Gomez, Miranda, & Polanco, 2011).

Dallo, Kindratt, and Snell (2013) propose another construct that they use as a risk factor, serious psychological distress (SPD). The researchers define SPD as non-specific psychological distress as opposed to specific mental illnesses. Its symptoms can overlap with those of disorders that are known risk factors for suicide, such as depression and anxiety.
In their study, the prevalence of SPD was 3% among both U.S. born and foreign-born Whites. There were differences, however, among those who were foreign born. The prevalence was 6% for those from the Middle East, 3% for those from Europe, and 2% for those from Russia. Possible reasons for higher rates among Middle Easterners are the political and social conflicts and stigma associated with mental illness in that region. (Dallo, Kindratt, & Snell, 2013).

Although Caucasians who reported suicidal thoughts or attempts were much more likely than other ethnic groups to seek or receive psychiatric services, there were still a significant number who did not. 42.8% of Caucasians who reported suicidal thoughts did not seek mental health treatment, and 24.1% of Caucasians who made suicide attempts did not seek mental health treatment (Ahmedani et al., 2012).

Because the majority of the U.S. population is Caucasian (72.4%), most research on risk and protective factors for suicide has been done with samples comprised mainly of Whites. So, the risk and protective factors that have been identified as most important across all U.S. populations are especially relevant for Caucasians. These include effective mental health care; connectedness to individuals, family, community, and social institutions; problem-solving skills; contacts with caregivers (Suicide Prevention Resource Center & Rodgers, P., 2011). As will be discussed later, these factors also apply to African Americans.

Additional protective factors among Caucasians include marriage, female gender, low levels of aggression and impulsivity, and spirituality (Oquendo et al., 2001). Among Caucasian youth, the most significant protective factor was the presence of social support, especially family cohesion. (Borrowsky, Ireland & Resnick, 2001).

**African Americans**

In 2007, 1,958 African Americans completed suicide in the U.S. Of these, 1,606 (82%) were males (rate of 8.4 per 100,000). The suicide rate for females was 1.7 per 100,000. Suicide was the third leading cause of death among African American youth (ages 10-19), after homicides and accidents. The suicide rate for young African American youth was 2.68 per 100,000. Firearms were the predominant method of suicide among African Americans regardless of gender and age, accounting for roughly 50.4% of all suicides. (American Association of Suicidology Fact Sheet, 2007).

Many of the risk factors found across all populations apply to African Americans (e.g., prior suicide attempt(s), substance abuse, mood and anxiety disorders family violence (intimate partner abuse, childhood trauma), relationship discord and access to lethal means). Triggering events causing shame or despair may heighten risk.
Additional risk factors include: being divorced or widowed (Joe et al., 2006); negative interaction with family members (Lincoln et al., 2013; Price, Dake, & Kucharewski, 2001); increased acculturation into White society (Castle et al., 2011); and the impact of hopelessness, racism, and discrimination (Hirsch et al., 2012). According to Williams & Williams-Morris (2000), racial stereotypes and negative images can be internalized, denigrating individuals’ self-worth and adversely affecting their social and psychological functioning; racism and discrimination have resulted in minorities’ lower socioeconomic status and poorer living conditions in which poverty, crime, and violence are persistent stressors that can affect mental health; and racism and discrimination are stressful events that can directly lead to psychological distress and physiological changes affecting mental health.

African Americans are also significantly overrepresented in the most vulnerable segments of the population, and those previously discussed for being at high risk for suicide. More African Americans than Caucasians or members of other racial and ethnic minority groups are homeless, incarcerated, or are children in foster care or otherwise supervised by the child welfare system. African Americans are especially likely to be exposed to violence-related trauma, as were the large number of African American soldiers assigned to war zones in Vietnam. Such exposure to trauma leads to increased vulnerability to mental disorders (US Department of Health and Human Services, 2001).

Access to mental health services and service utilization also appears to play a role: African Americans who reported suicidal thoughts or attempts were less likely than Whites to seek or receive psychiatric services (Ahmedani, 2012; Freedenthal, 2007.) Lack of health insurance is a barrier to seeking mental health care. Nearly one-fourth of African Americans are uninsured (Brown et al., 2000). The overrepresentation of African Americans in high-need populations implies great reliance on the programs and providers such as public hospitals, community health centers, and local health departments (Lewin & Altman, 2000). State and local mental health authorities figure most prominently in the treatment of mental illness among African Americans. African Americans are also more likely to utilize complementary therapies for mental health or other health problems (Koss-Chioino, 2000).

The significant protective factors found for all populations apply for African Americans: effective mental health care; connectedness to individuals, family, community, and social institutions; problem-solving skills; contacts with caregivers (Suicide Prevention Resource Center & Rodgers, P., 2011). Adaptive traditions have sustained African Americans through long periods of hardship imposed by the larger society. Their resilience is an important protective resource. Additionally, research has shown significant protective factors in African American populations, particularly the role of spirituality and religious beliefs.
Neeleman, Wessely & Lewis (1998) found that the comparatively low level of suicide acceptability among African-Americans high levels of orthodox religious beliefs and personal devotion was protective against suicide. Taylor, Chatter and Joe (2011) also found as a protective factor participation in organized religious practices, such as church attendance. In fact, Among African American with psychiatric disorders, religiosity has been found to delay age of onset and to decrease the number of psychiatric disorders (Assari, Lankarani, & Moazen, 2012).

In addition to spirituality as a protective factor, the role of support and connection is a significant protective factor. Family support, peer support, and community connectedness have been shown to help protect African American adolescents from suicidal behavior.

Matlin, Molock and Tebes (2011) studied the relationship between various types of social support and suicide, and the extent to which support moderates the relationship between depressive symptoms and suicidality. The researchers asked 212 African American adolescents to rate three types of social support: family support, peer support, and community connectedness. The survey also addressed depressive symptoms and suicidality, as measured by reasons for living, a cognitive measure of suicide risk. The results indicated that increased family support and peer support are associated with decreased suicidality, and peer support and community connectedness moderated the relationship between depressive symptoms and suicidality.

Similarly, positive interactions and social and family support have been shown to significantly reduce risk for suicide attempts among African American adults (Lincoln et al., 2012). Emotional support from family also decreased the risk of suicide attempts for Caribbean Blacks (Lincoln et al., 2012).

Two small studies of African American women found that having a strong sense of African American identity, heritage, and history was protective against suicide due to moderating the effects of racism and sexism (Borum, 2012; Perry, Stevens-Watkins & Oser, 2013).

Native Americans

One of the most at-risk groups for suicide is Native Americans. According to CDC statistics, during 2005–2009, the highest suicide rates were among American Indian/Alaskan Native males with 27.61 suicides per 100,000. Within Native American communities, the group at the highest risk for suicide attempts is females between the ages of 15 and 24. Those at highest risk of completed suicides are males in the same age group; suicide represents the second-leading cause of death among American Indian/Alaska Native (AI/AN)
There are a number of risk factors associated with suicidality among Native Americans. Worchel and Gearing (2010) found that these risk factors include depression, alcohol and substance use, being a victim of violence, previous suicide attempts, friends or family members attempting/completing suicide (contagion), physical or sexual abuse, family disruption, and loss of native/ethnic identity. Additionally many Native Americans have had negative boarding school experiences, family histories of mental illness, historical trauma and cultural distress as well as poverty, unemployment, geographic isolation, and other environmental factors (Walker, Walker & Bigelow, 2006).

The role of historical trauma is one that is unique to Native Americans within the predominant culture and thus merits additional consideration. Broadly defined, historical trauma is defined as an event or events that affect multiple generations of a particular culture. For Native Americans there has been the historical trauma of forced relocation known as the Trail of Tears. The Indian Removal Act of 1830 mandated relocation of members of the Cherokee, Muscogee, Seminole, Chickasaw, and Choctaw nations from their ancestral homelands in the southeastern U.S. to an area west of the Mississippi River that had been designated as Indian Territory. This is one widespread example of such actions. A related trauma was the removal of children who were sent to boarding schools during the late 19th and early 20th centuries. Originally established by Christian missionaries, these Boarding Schools immersed children in European-American culture through appearance changes with haircuts; children were forbidden to speak their native languages, and traditional names were replaced by new European-American names. In numerous ways, children were encouraged or forced to abandon their Native American identities and cultures. While today tribal nations have increasingly insisted on community-based schools and have also founded numerous tribal colleges and universities, these memories are still fresh for many Native American families.

These experiences may be part of the challenges of help-seeking behaviors among these groups, who may believe these services represent the “white man’s” system and culture or that the professionals will not understand Native ways (U.S. Department of Health and Human Services, 2010). Another aspect in recognizing suicidal ideation in Native American people concerns “politeness theory.” In Native culture, people considering suicide may not be more direct in making their personal pain known in order to avoid placing a burden on others. Additionally vague or indirect calls for help helps protect them from their own embarrassment if others fail to respond. Additionally there is a cultural stigma against suicide and following a suicide attempt.

Individual risk factors that apply to both youth and adults in Native American families include: feeling disconnected from family, feeling that one is
a burden, unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts, and concerns associated with suicide contagion or cluster suicide.

While these challenges do exist, it is also important to look at protective factors that can help guide mental health interventions. Protective factors that have been found to prevent suicide include effective and appropriate clinical care for mental, physical, and substance abuse disorders; easy access to a variety of clinical interventions and support for seeking help; restricted access to highly lethal methods of suicide; family and community support; support from ongoing medical and mental health care relationships; learned skills in problem-solving, conflict resolution, and nonviolent handling of disputes; and cultural and religious beliefs that discourage suicide and support self-preservation instincts.

Spirituality has also been shown to be a buffer against suicidality in Native Americans. Due to experiences of assimilation, many Native Americans try to achieve a spiritual balance between what may be Christian religious practices and while others may be grounded in traditional spiritualism. According to Trimble (2010) it is important to integrate traditional spirituality into the therapy, including the use of traditional healing practices, sacred rituals, and ancestral knowledge. Examples include the use of the medicine wheel, the Sacred pipe, Sweat lodges, the Sundance, the Seeking of a Vision, the Womanhood ceremony, the Throwing of the Ball, the Keeping of a Spirit, and the Making a Relative.

While there have been many organized efforts to include these ideas, one that provides a good example is called Native H.O.P.E. (Helping Our People Endure). Aimed at youth, Native H.O.P.E. is a curriculum based on the theory that suicide prevention can be successful in Indian Country when Native youth become committed to breaking the “code of silence” that is prevalent among all youth. The program also is premised on the foundation of increasing “strengths” among Native youth as well as increasing their awareness of suicide warning signs. The program supports the full inclusion of Native culture, traditions, spirituality, ceremonies, and humor. The 3-day Native H.O.P.E. youth leadership curriculum takes a proactive approach to suicide prevention.

For more information on supporting Native American clients, including the American Indian Community Suicide Prevention Assessment Tool developed by the One Sky Center, a national resource center for American Indians and Alaska Natives, please see the One Sky Center Web site at http://www.oneskycenter.org/osc/presentationspublications/publications/

Immigration and the Risk of Suicide
The groups we have discussed to this point have primarily been assimilated into the United States for many years. This is not necessarily the case for those cultural/ethnic groups that will be discussed in the next segments of this training material, which may contain individuals completely assimilated into the United States, as well as people who have recently immigrated to the United States. Immigration has been found to have a number of stressors that may heighten the risk for suicide.

Every year since 1990 approximately one million new immigrants have entered the United States. According to the U.S. Census Bureau (2011), over 40 million U.S. residents are foreign-born (13% of the total population). Since 1965, more than three quarters of immigrants arriving in the United States are “of color.” It is hard to generalize about the U.S. immigrant population, which is quite diverse in terms of education levels, language, religion, and wealth.

Immigrants typically demonstrate a number of strengths and resiliencies, and research suggests that among these strengths is the motivation to learn English and engage in the labor market. Despite these strengths, few would argue that the act of moving to another country is a stressful life event. Recently arrived immigrants face many risks, including potential poverty, discrimination, employment problems and social isolation. These problems are heightened for undocumented immigrants.

Additional challenges may be connected to the immigration process (separation from country of origin and families; navigation of unfamiliar cultural contexts); acculturation (language, cultural and ethnic identity, customs, gender roles, etc.) Intergenerational and familial conflicts may result from the acculturation process. Many immigrants have also faced traumatic experiences within their countries of origin. These factors result in immigrants being at higher risk for mental health problems including depression and anxiety disorders and posttraumatic stress disorder, all potentially related to suicidality.

Kposowa et al. (2008) looked at the impact of immigration on suicide using an unmatched case-control design. Data on cases were obtained on suicides in one county in California from 1998 to 2001. Information on controls was obtained from the 2000 Census. The researchers found that immigration increased suicide risk. Immigrant divorced persons were over 2 times more likely to commit suicide than natives. Single immigrants were nearly 2.6 times more likely to kill themselves than the native born. Shorter duration of residence was associated with higher suicide risk. Kposowa suggests that integration of immigrants in receiving societies is important for decreasing suicide and that policies aimed at reducing suicide should target more recent immigrants.
While more formal research is needed, clinicians should be advised to consider the affects of immigration as a risk factor for suicidality.

Hispanic/Latinos

According to census data, there are currently 53 million Hispanics in the United States making people of Hispanic origin the nation's largest ethnic or racial minority. Hispanics constituted 17 percent of the nation's total population. 65% of Hispanic-origin people were of Mexican background in 2011. Another 9.4 percent were of Puerto Rican background, 3.8 percent Salvadoran, 3.6 percent Cuban, 3.0 percent Dominican and 2.3 percent Guatemalan. The remainder was of some other Central American, South American or other Hispanic/Latino origin (US Census Bureau, 2012). These statistics show that Hispanic individuals are a diverse group.

There is often a perception that Hispanic Americans do not commit suicide due to the strong Catholic strictures against it, this is an invalid assumption. While the role of religiosity is an important protective factor, Hispanic Americans are a diverse group who are impacted by suicide. Latinos are identified as a high-risk group for depression, anxiety, and substance abuse, risk factors for suicide (National Alliance for Hispanic Health, 2001). According to the CDC (2007), while the suicide rate among Hispanics is lower than that for Non-Hispanics among all age groups, suicide was still the third leading cause of death for Hispanic Americans aged 15 to 24, the third leading cause of death for those aged 25-34, and the 13th leading cause of death for Hispanics of all ages. Research on suicidal ideation found that foreign-born Mexican Americans are at significantly lower risk of suicide and depression than those born in the United States (Swanson et al., 1992).

According to sociological researchers, risk factors for suicide among Hispanics include affluence, cultural assimilation, mobility, and divorce (Wadsworth & Kubrin, 2007.) These researchers also found that immigrants have a slightly higher rate of suicide (5.4) than non-immigrants (5.0). The use of alcohol (CDC, 2009) is another risk factor. Fatalism, the cultural belief that life is predetermined by fate, and which results in an external locus of control, may also be a risk factor.

Although rates of completed suicide among Hispanic youth are lower than those for Non-Hispanics, school-aged Hispanic youth self-report higher rates of feeling sad or hopeless (36%), of thinking about suicide (18%), and of attempting suicide (14%) (CDC, 2005). Hispanic young women are at particular risk for feelings of depression, sadness and hopelessness. Stress caused by the immigration experience, minority status, and increased levels of acculturation have been associated with the increased abuse of alcohol and other substances by Hispanic youth, and are known factors in suicide ideation and attempts (Cannon & Levy, 2008).
In an effort to capture data that can help in suicide prevention for Hispanic youth, Garcia et al. (2012) conducted a small pilot study of 84 Latino and Caucasian participants to assess similarities and differences in suicide risk and coping behaviors (help-seeking, maladaptive coping and suicide normalization). While the groups reported generally congruent perceptions of suicide risk and coping, there were some differences between Latinos and Caucasian youths. Latinos were less likely to seek out advice from a friend for another suicidal friend and to characterize those who die by suicide as mentally ill. There were no differences in seeking out professional help resources.

There are a number of relevant cultural considerations when assessing reasons for suicide prevalence in Hispanic Americans. Goldston et al. (2008) propose that suicidal behavior among Hispanics may be connected to cultural expectation that family needs are placed above individual needs; suicidality in young Hispanic females may be related to the stress caused by the expectation of obligation to the family. Additionally recently immigrated Hispanic families may not fully understand the health care system and may be reluctant to seek help in the fear of being reported as undocumented. Among Latinos with mental disorders, fewer than 1 in 11 contact mental health care specialists, while fewer than 1 in 5 contact general health care providers (Surgeon General, 2001). Older Hispanic adults and Hispanic youth are especially vulnerable to the stresses of immigration and acculturation (National Council of La Raza, 2005). Hispanic families may also avoid seeking mental health treatment because they feel that suicide should be addressed by the family or faith community first.

There are also treatment barriers related to provision of mental health services, primary among these language differences are a barrier to seeking mental health help. Latino youth with mental illness are often misdiagnosed as having anger problems or just conduct disorders (National Alliance for Hispanic Health, 2001). Other barriers to treatment include economic barriers, stigma associated with mental illness, lack of education and pervasive poverty, lack of culturally appropriate services, lack of appropriate intervention strategies, and mental health professional shortages (APA, 2010).

While these barriers are daunting, there are also a number of protective factors. The cultural role of familism, which emphasizes close family relationships and extended family permeates the lives of many Hispanics. While there are some negatives that may be associated with familism, it can also be seen as a protective factor. The role of connection and family involvement are primary, particularly in adolescent prevention efforts (Goldston et al., 2008; Garcia et. al, 2008). Family support may also serve as a protective factor from acculturative stress (Canino & Roberts, 2001), particularly for those who have emigrated from their native country at a young age.
age (Borges, Mondragón, & Breslau, 2010). Fostering connection and decreasing isolation can also serve as a protective factor. The provision of home-based mental health services as an intervention strategy may be valuable (Garcia et al., 2012). Additionally the strong sanctions against suicide may permeate Latinos with deep religious convictions and may serve as a deterrent. The impact of Catholicism may be particularly unique considering the Church’s influence in Latino culture and it’s history of condemning suicide and recognizing it as a mortal sin (Bostwick & Rummans, 2007; Colucci, & Martin, 2008).

**Asian Americans/Pacific Islanders**

In 2012, there were 18.1 million Asian or Pacific Islander residents living in the United States (CDC). Asian Americans and Pacific Islanders are a diverse group and vary greatly in terms of their cultural and historical experiences. While many Asian Americans and Pacific Islanders have lived in the U.S. for several generations, there are also a high number of recent immigrants. Due to this variability, it is difficult to make generalizations about Asian Americans/Pacific Islanders in terms of mental health utilization and treatment. This broad group includes individuals of Chinese, Filipino, Asian Indian, Vietnamese, Japanese, and Pacific Islander descent (Native Hawaiian, Samoan, and Guamanian/Chamorro ethnicity.)

Among all ethnicities, Asian Americans and Pacific Islanders are the least likely to seek help for psychological disorders. This may be due to Asian cultural values of self-reliance and reservation and fears of shaming the family by seeking psychological treatment or to the strong stigma related to mental illness (Sue & Sue, 2012). Asian American and Pacific Islanders may also be concerned about negatively affecting their social network, which keeps them from seeking help (Kim et al., 2006). Mental illness is often believed to reflect poorly on one’s family lineage and can influence others’ beliefs about how suitable someone is for marriage if he or she comes from a family with a history of mental illness.

According to the CDC between 1999 and 2004, in the Asian American and Pacific Islander population the suicide rate was 5.40 per 100,000. The highest rate, 27.43 per 100,000, was found among adult males 85 and older. Suicide ranked as the eighth leading cause of death for all ages. Elderly Asian American/Pacific Islander women have higher rates of suicide than whites or blacks. For women aged 75 and older, the suicide rate for Asian Americans/Pacific Islanders was 7.95 per 100,000, compared to the white rate of 4.18 and the black rate of 1.18. Youth are also at risk, with suicide ranking as the third leading cause of death for those 15 to 24 years old.

Chu et al. (2014) studied suicidal Ideation and behaviors among Asian Americans. The researchers looked at 191 Asian Americans with a history of
serious suicidal ideation or attempts. They discovered two main subtypes which they termed "psychiatric" (48%) and "nonpsychiatric" (52%). The nonpsychiatric subtype was predominantly characterized by sociocultural factors (discrimination, family conflict, and low acculturation), medical problems, and limited functioning. The nonpsychiatric was less likely than the psychiatric subtype to seek help for mental health but was no different in access to a medical doctor, highlighting possible points of outreach.

Due to the diversity of Asian Americans and Pacific Islanders, it is often difficult to isolate risk factors for suicide. Researchers propose that there are a number of groups at high risk for many types of psychological disorders, including immigrants who lack of English proficiency and experience more difficulty acculturating, and those experiencing other forms of acculturative stress, prejudice, discrimination, and racial hate crimes, which place them at risk for emotional and behavioral problems. Southeast Asian refugees, in particular, are considered to be at high risk, as are Cambodians, many of whom experienced horrible traumas prior to immigrating to the United States, including starvation, torture, and losing family members to the war (US Department of Health and Human Services, 2001).

Zhang et al. (2013) compared depression, anxiety, and suicidal ideation among Chinese Americans, looking at immigration-related factors. The researchers found that U.S.-born Chinese and those who immigrated to the U.S. at 18 years or younger were at higher risk for lifetime depressive or anxiety disorders or suicidal ideation than were their China-born counterparts who arrived in the country at or after 18 years of age. For Chinese Americans, immigration-related factors were associated with depression and anxiety disorders and suicidal ideation. The researchers conclude that the higher prevalence of these disorders might be attributed to the psychological strains experienced by those who are at higher risk of cultural conflicts.

In Asian Americans, suicide risk increases with age. Some explanations for the increase are related to difficulties adapting to the U.S. culture. Elders who are not treated with the level of respect of their native cultures and may feel burdensome. Many Asian American men who are in the U.S. without their families are isolated not just from family but also culture (Range et. al, 1999).

Other risk factors for Asian Americans/Pacific Islanders include depression, anxiety or hopelessness; a coping style in which problems are kept inside/unexpressed; feelings of loneliness, guilt, shame, or inadequacy, academic concerns; social isolation, particularly from family or spiritual community; conflict with parents and other family members about choice of academic major, career, or dating/marriage partner; and unwillingness to seek help because of shame in seeking mental health services.

There are a number of barriers to treatment of depression/suicidal ideation in
Asian Americans/Pacific Islanders. For nearly half of Asian Americans and Pacific Islanders, access to the mental health care system is limited due to their lack of English proficiency and to a shortage of providers with appropriate language skills. Additionally, about 21 percent of Asian Americans and Pacific Islanders lack health insurance (US Department of Health and Human Services, 2001). Asian Americans may be more likely to utilize complementary or alternative approaches (e.g., acupuncture and traditional Chinese medicine) rather than traditional mental health treatment. These approaches do not carry the same shame/stigma associated with counseling.

Many Asian American and Pacific Islander cultures view the psychological and physical as highly interconnected, unlike the common view in Western cultures. Asian Americans and Pacific Islanders may be more likely to express emotional distress through physical problems (somatization) and to believe that physical problems cause emotional disturbances.

Protective factors include strong self-esteem; a sense of personal control; attitudes, values, and norms prohibiting suicide; cultural, religious, or spiritual beliefs that discourage suicide; and willingness to seek help and access mental health services. Additional protective factors include strong connections to friends, family, and supportive significant others and a sense of spiritual well-being. Confucianist, Buddhist, and Taoist beliefs may contribute to lower suicide rates among Asian Americans, since they emphasize interdependence and interconnectedness and the group over the individual.
Assessing Suicidal Risk

Warning Signs of Suicide

While there are a number of risk factors for suicide, any risk factor alone does not increase or decrease risk. Population-based research suggests that the risk for suicide increases with an increase in the number of risk factors present, such that when more risk factors are present at any one time the more likely that they indicate an increased risk for suicidal behaviors at that time.

Rudd (2006) outlines a number of warning signs that are related to the acute onset of suicidal behaviors. These signs warn the clinician of acute risk for the expression of suicidal behaviors, especially in those individuals with other risk factors. Three of these warning signs carry the highest likelihood of short-term onset of suicidal behaviors and require immediate attention, evaluation, referral, or consideration of hospitalization.

These warning signs are:

- Threatening to hurt or kill self
- Looking for ways to kill self; seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide

Additionally, the remaining list of warning signs should alert the clinician that a mental health evaluation needs to be conducted in the very near future and that precautions need to be put into place immediately to ensure the safety, stability and security of the individual.

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Talking about feeling “trapped” or like “there’s no way out”
- Increasing alcohol or drug abuse
- Withdrawing from friends, family or society
- Talking about being a “burden” to others
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- Person expresses that there is no reason for living, no sense of purpose in life
- Displaying extreme mood swings

Other behaviors that may be associated with increased short-term risk for suicide are when the patient makes arrangements to divest responsibility for
dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

The Warning Signs for Suicide Prevention was developed by an expert working group convened by the American Association of Suicidology. Citing the importance of distinguishing warning signs from risk factors, the group defined warning signs as the earliest detectable signs that indicate heightened risk for suicide in the near-term (i.e., within minutes, hours, or days), as opposed to risk factors that suggest longer-term risk (i.e., a year to lifetime.) They also noted that, aside from direct statements or behaviors threatening suicide, it is often a constellation of signs that raises concern, rather than one or two symptoms alone. The working group presented the warning signs in a hierarchical manner, organized by degree of risk

**High Risk (activity in the following areas):**

- Threatening to hurt or kill oneself
- Talking of wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, drugs (prescription or illicit) or other means
- Talking, writing or posting on social media about death, dying and suicide

**Chronic/Ongoing Risk:** feelings and behavior that is experienced over an extended period of time. The five key feelings and behaviors are:

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Behaviors</th>
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<tbody>
<tr>
<td>No reason for living, or no sense of purpose in life</td>
<td>Increased substance use</td>
</tr>
<tr>
<td>Feeling trapped, like there’s no way out</td>
<td>Withdrawal from friends, family and/or society</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Rage, anger, revenge-seeking behavior</td>
</tr>
<tr>
<td>Dramatic mood changes</td>
<td>Reckless or risky decision making and actions</td>
</tr>
<tr>
<td>Anxiety/agitation</td>
<td>Unable to sleep or sleeping all the time</td>
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**Myths and Misconceptions about Suicide**

Among clinicians and laypersons, a number of beliefs exist relating to suicide. While many of these beliefs are harmless, some may negatively influence clinical assessments. Worochel and Gearing (2010) describe the following myths:
1. Using the word “suicide” with a client will increase the likelihood that they will make an attempt. There is no evidence that the use of the word “suicide” increases the risk (Thobaben, 2000). There may, in fact, be evidence that the use of this word opens a more direct dialogue.

2. People who want to kill themselves will not talk about suicide. Research on this idea has yielded mixed results. While some people actively considering suicide do not seek help, others do. It is always important to take people seriously when they express suicidal ideation. It is important not to dismiss talk of suicide as a “cry for attention.” Another, related myth, is that people who commit suicide always leave notes, which is not actually the case.

3. “Birthday Blues” lead to an increase in suicide. While some people believe that people are more likely to commit suicide on or near ones birthday, there is not evidence to support this conception. Reulbach et al. (2007) conducted a population-based study of 11378 deaths from suicide, comparing the date of death and birth. The authors found no significant association between birthdays and dates of suicide.

4. Suicides increase in fall and winter. Research has actually shown an increase in suicide during the spring and early summer and a decrease in suicide during the late fall and early winter (Voracek, Tran & Sonneck, 2007).

5. An unsuccessful attempt means that the person wasn’t serious about ending their life. Some people are naive about how to kill themselves. The attempt in and of itself is the most important factor, not the method or outcome.

Assessment Process

In looking at the scope of the suicide as a social problem, it is clear that clinicians need to be skilled at assessing and treating suicidal ideation and intent. Suicide assessment may be viewed as an individualized, ongoing process, and should occur with every client. Thus, it is helpful to consider that there is always some degree of risk.

While the process of suicide assessment is unique to client and therapist, there are some overall components that are integral parts of the process. During the assessment the clinician obtains information about the patient’s psychiatric and other medical history and current mental state. The clinician may do so through direct questioning about suicidal thinking, through, observation of behavior and through collateral history, if indicated. The
information collected during this process allows the clinician to 1) identify specific factors and features that may generally increase or decrease risk for suicide or other suicidal behaviors and that may serve as modifiable targets for both acute and ongoing interventions, 2) address the patient’s immediate safety and determine the most appropriate setting for treatment, and 3) develop diagnosis to further guide treatment planning (APA Practice Guidelines, 2003). Practice guidelines suggest that while standardized suicide assessment tools may be appropriate for research purposes, they are not substitutes for clinical evaluation.

Times to assess and document suicide risk are:

- At intake
- At the first occurrence of suicidal behavior or suicidal ideation
- Whenever there is any noteworthy clinical or life change
- When family/significant others provide input or concern regarding suicidality
- Whenever the level of care received by the client/patient is significantly changed (e.g., entry into inpatient hospital)
- Before treatment termination

While there are a number of important pieces of information to gather, Worchel & Gearing (2010) present what they term the core suicide assessment question. Simply put, the question is “Are you suicidal?” or “Have you ever thought about killing yourself?” These authors recommend that the clinician present the question with a neutral tone, and view it as an opening for further dialogue. Some of the possible things that may emerge following the question are: 1) a clear denial of suicidal feelings, thoughts, and plans; 2) a clear endorsement of suicidal feelings, thoughts, and plans or 3) a vague response that neither endorses or denies suicidality.

**Suicide Assessment Components**

Best practices and established guidelines for suicide assessment come from many professional bodies, including the American Psychiatric Association (2003) and the Academy of Child and Adolescent Psychiatry (2001). These detail the:

1. Sociodemographic data
2. Current Presentation of suicidality
3. Psychiatric illnesses
4. History
5. Psychosocial situation
6. Individual strengths and vulnerabilities (risk and protective factors)

Each of these will be detailed below.
Sociodemographic Data
As discussed in the previous sections of this material, there are risk factors that may be associated with various demographic data. Assessment of sociodemographic data allows the clinician to determine risk and protective factors. While not an exhaustive list, the clinician should assess many of the following factors:

Age
Gender
Race
Culture/ethnicity
Immigration status and experiences (including traumas)
Languages, including primary language spoken/spoken at home
Religion
Marital status
Occupation/employment (past/present)
SES
Education level and academic history
Recent changes (moves, deaths, separation, etc.)
Acute stressors
Overall health
Current and past medical history

Current Presentation of Suicidality
In assessing current presentation of suicidality/self-harming behaviors, there are a number of critical considerations. These include: suicidal ideation, planning/feasibility and intent, lethality of proposed plan, timing, impulsivity and risk factors, hopelessness, reasons for living.

Ideation:
Have you ever felt that life is not worth living?
When did these thoughts occur?
What led up to these thoughts?
Have you discussed these thoughts with anyone?

Planning/Feasibility:
Do you have a specific plan? What is it? When are you considering carrying it out?
Do you have the means to carry it out (e.g., purchasing pills or access to a gun)
Have you ever tried to carry out the plan? Rehearsed it in any way?
Are you engaging in behaviors such as getting your affairs in order, saying goodbyes, writing notes, giving things away?
Is there anything that stops you from carrying out this plan?
Intent:
On a scale of 1-10, how likely are you of carrying out this plan?
If there was another solution to your problem(s) would you take it?
How often are these thoughts occurring? Do they occur in specific instances?
Do you have a will?

Lethality of Proposed Plan:
Elicit plan details, and determine degree of lethality associated with method.
Assess: Is death likely to result? How completely have they researched the method (e.g., Internet, books)? If intervention occurs, will the person still die?

Impulsivity/Risk Factors
Assess history of impulsivity, aggression, presence of personality disorder; gather examples of impulsivity and risk, feelings of control
Assess engagement in other high risk/dangerous behaviors (self-injurious behaviors, promiscuity)
Note that substance use can increase impulsivity
In youth, assessment of factors such as lack of family support, poor family communication, low grades, familial violence

Hopelessness:
Do you feel hopeless? How long have you felt this way?
What things allow you to feel more or less hopeless about the future?
Assess degree of future-orientation

Reasons for living:
What would be a deterrent to killing yourself? Why?
Assess for specific factors: Morality, fears of death, family/children, friends, job, and importance to others
Cultural or religious beliefs about death or suicide

History
Assess previous suicide attempts, aborted suicide attempts, self-harming behaviors
In assessing previous attempts, look at number of attempts, severity/lethality, circumstances/precipitants, what happened
Assess postvention efforts (were they found, how did others intervene, consequences), feelings after the attempt
Elicit information about support, including family/friends, previous therapy

Previous or current medical diagnoses and treatments, including surgeries or hospitalizations
Assess family history of suicide or suicide attempts or a family history of mental illness, including substance abuse
Assess peer suicide history, including postvention
Risk Factors
There are a number of risk factors that increase risk of suicidality. Assess whether these risk factors exist, whether they are acute or chronic. These include: Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect; Employment status, living situation (including whether or not there are infants or children in the home), poverty, access to mental health care and presence or absence of external supports; Immigration history; Family constellation and quality of family relationships; Psychiatric risk factors as outlined below

Psychiatric History/Current Status
Assess for DSM diagnosis(es), especially current signs and symptoms of psychiatric disorders with particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders, and personality disorders (primarily borderline and antisocial personality disorders)

Current mental status, including cognitive and emotional functioning

Psychiatric treatment history: inpatient and outpatient treatment, hospital admissions, emergency room visits, medications, treatment compliance

Individual Strengths and Vulnerabilities
Assess for: coping skills, personality traits, past responses to stress, external locus of control, low self-esteem/self-efficacy, shame, acculturation issues, perfectionism, low frustration tolerance, reality testing, ability to tolerate psychological pain and satisfy psychological needs

Protective Factors
Assess for the presence of protective factors including family strengths and resources, spiritual and religious beliefs, ethnic/cultural treatments, stable employment/financial situation, self-efficacy, effective interpersonal skills, good affect modulation, consistent use of coping and self-soothing

Recommendations for Conducting A Suicide Assessment
As mentioned previously, suicide assessment is something that is highly individual to each clinician and to each clinical case. There are some guidelines that can be used to support and facilitate the information gathering process. These are (Worchel & Gearing, 2010):
1. The clinician should adopt a neutral, non-judgmental stance as a way to encourage honesty and openness on the part of the client.
2. Developing and maintaining a good therapeutic alliance enhances risk assessment.
3. The clinician should avoid an interrogational style when asking questions. Encourage a comfortable conversation.
4. The therapist should strive to still hope, especially in the future.
5. It is important to convey that the assessment is only the first step in the overall process.
6. The clinician should commend the client for honesty in thoughts and feelings.

Similarly there are a number of things that should be guarded against during a crisis situation:

1. Marginalizing the client through adopting a stance of “power” and authority. There is a line between being an expert and marginalizing.
2. Contributing to stigma of suicide through shaming a client.
3. Superficial reassurance and minimization of intense affect. While it is important to be hopeful, it is equally important not to minimize difficult and intense emotions.
4. Passivity. This process requires active and direct responses. Passivity on the part of the clinician can have a negative effect.

**Documentation**

It is important to thoroughly document the assessment. Suicide assessment is an ongoing process and its documentation will occur after an initial evaluation or, for patients in ongoing treatment, when suicidal ideation or behaviors begin or when there is significant worsening or unanticipated improvement in the patient’s condition. Documentation will be discussed in more detail later in this document.

**Estimation of Suicide Risk**

Following the assessment, the clinician must make an estimate of suicide risk. While a portion of this assessment certainly rests on sound clinical judgment, the following factors are helpful to consider. The following factors have been found to increase suicide risk (APA Guidelines, Shneidman at cited by Bonger, 2002):

- **Suicidal thoughts/behaviors**
  - Suicidal ideas (current or previous)
  - Suicidal plans (current or previous)
  - Suicide attempts (including aborted or interrupted attempts)
  - Lethality of suicidal plans or attempts
Suicidal intent
Chronic suicidality or manipulative suicidality

**Psychiatric diagnoses**
Major depressive disorder
Bipolar disorder (primarily in depressive or mixed episodes)
Schizophrenia
Anorexia nervosa
Alcohol use disorder
Panic disorder
Eating disorder (particularly connected to weight gain)
Other substance use disorders
Cluster B personality disorders (particularly borderline personality disorder)
Comorbidity of axis I and/or axis II disorders

**Physical illnesses**
Diseases of the nervous system
HIV/AIDS
Lupus
Pain syndromes
Functional impairment
High utilization of medical care

**Psychosocial features**
Recent lack of social support (including living alone)
Unemployment
Drop in socioeconomic status
Poor relationship with family
Recent stressful life event

**Childhood traumas**
Sexual abuse
Physical abuse

**Genetic and familial effects**
Family history of suicide (particularly in first-degree relatives) or suicide attempts
Family history of mental illness, including affective disorders and substance use disorders

**Psychological features**
Depression/Hopelessness/Helplessness
Psychic pain
Loss of pleasure or interest in life
Severe anxiety
Acute upset/agitation
Decreased self-esteem
Increased self-hatred/self-loathing
Extreme narcissistic vulnerability
Impulsiveness
Aggression

**Cognitive features**
Loss of executive function
Thought constriction/inability to see alternatives to present situation
Polarized thinking

**Thought patterns**
Idea that death may be a “way out” of terrible psychological pain
Fantasies of death as an escape
Feeling that he/she is a source of shame to his/her family
Having suffered a recent humiliation

**Demographic features**
Male
Widowed, divorced, or single marital status, particularly for men
Elderly age group (age group with greatest proportionate risk for suicide)
Adolescent and young adult age groups (age groups with highest numbers of suicides)
White race
GBLT orientation

**Additional features**
Access to or availability of lethal means (purchasing or having available a gun, rope, poison)
Substance intoxication
Recent discharge from a psychiatric hospital (many suicides occur within 3 months of discharge)
Unstable or poor therapeutic relationship
Absence or limited meaningful supportive relationships
Be sure to screen for positives. “What is keeping you alive right now?”

**Therapeutic Rapport and Alliance**

The relationship between the clinician and the client is probably the most important factor in the assessment and treatment of suicidal behavior. In *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors*, the American Psychiatric Association (APA, 2003) acknowledges that, “… a positive and cooperative psychotherapeutic relationship can be an invaluable and even life-sustaining force for suicidal
patients” (p. 30). Jobes (2000) describes the stance of what he terms the therapist-participant—“one who finds the capacity to truly join in the depths of suicidal despair while never losing the judgment and clinical wisdom of being a therapist”. It is helpful to communicate this empathic but clinically sound path during the assessment process.

The clinician begins to develop therapeutic rapport from the first moment he or she meets the client. Some rapport building strategies include:

- Explain the purpose of the assessment
- Ask the client for their preference on how they would like to be addressed (especially a culturally diverse client)
- Use a calm, neutral and reassuring tone of voice
- Listen deeply
- Avoid quickly jumping to a decision

Suicidal clients often present as hopeless and this is an easy stance to transmit to the clinician. Be aware and monitor your own feelings.

**Managing Suicidal Clients**

The next section of this document addresses therapeutic approaches to suicide. The following general guidelines are helpful in day-to-day management of high-risk clients:

Clinicians should:

- Evaluate risk on an ongoing/recurrent basis, especially the need for a secure environment or hospitalization
- Increase in frequency or duration of outpatient visits
- Reevaluate treatment goals that address symptom remission, improved hopefulness, improved problem-solving/adaptive coping, improved self-control and self-esteem
- Establish a support system and appropriately communicate safety plan
- Develop a safety plan collaboratively with the client
- Provide emergency contacts, including a crisis line
- Consider medication/hospitalization if symptoms persist or worsens
- Be sure to ask about current protective factors, as this can provide clues for developing interventions for short-term management of suicidality

**Guidelines for Hospitalization**

If outpatient treatment strategies are unsuccessful, or suicide risk is imminent the clinician should consider hospitalizing the patient in a secure in-patient setting. Hospitalization is also indicated when for treatment of a serious
underlying psychiatric disorder such as psychosis or severe depression.

Additional considerations for determining the need for hospitalization include (Linehan et al., 1993):

- The client is in a psychotic state and is threatening suicide
- Suicide threats are escalating and the client is determined to be at risk to self or others
- The client is on psychotropic medications and has a history of serious medication overdose and needs close monitoring of medications or dosage
- The suicidal client is not responding to outpatient treatment and there is severe depression or disabling anxiety
- The client is in an overwhelming crisis and cannot cope with it alone without the risk of serious harm to him or herself, and no other safe environment can be found. The risk of suicide outweighs the risk of hospitalization
- There is existing psychosis and the client cannot cope with such a state, the client has little or no social support, and the client is suicidal

While inpatient hospitalization is needed in these situations, it is also important to note that some research has found that the risk of suicide increases following inpatient care (Gladstone et al., 2001).

Gladstone and colleagues studied eight hundred thirteen patients with a major depressive episode (DSM-III, DSM-III-R, or DSM-IV criteria) were assessed in a Mood Disorders Unit over a 10-year period. Follow-up at the end of that period confirmed that 31 patients (3.8%) had completed suicide. The most consistent finding, across all 3 comparisons, was that the suicide completers were more likely to have been inpatients at the time of the index Mood Disorders Unit assessment. Other characteristics of completers were a greater number of prior admissions for depression, being older and in a relationship, and being male and married or female and single. Somewhat paradoxically, suicide completers also evidenced fewer previous suicide attempts and less suicidal ideation compared with living subjects who had attempted suicide at the time of index assessment. Thus it is important not to assume that a person does not require further monitoring and assessment following discharge.
Therapy for Suicidality

There are a number of treatment approaches that have been shown to be helpful for treating clients with suicidal ideation. In working with acutely suicidal clients, a dual approach, including a combination of therapy and medication (antidepressant, anti-anxiety, antipsychotic, and/or mood stabilizing medications), is most helpful. While there is no medication that can directly prevent suicide, these medications treat symptoms related to suicidality including depression, hallucinations and anxiety.

In cases of acute suicidality, hospitalization may be required to ensure safety (see more below). Additionally ECT may be used if therapy and medication proves unsuccessful or in cases of chronic suicidal ideation and attempts (APA, 2003). Bryant et al., (2009) published a set of practice guidelines for behavioral health consultants. These authors suggest that inpatient evaluations are most appropriate when a non-multiple attempter reports two or more symptoms of resolved plans and preparation, significant emotional distress, and the absence of a social support network that can assist with outpatient safety. For multiple attempters, refer for further evaluation in the presence of two or more symptoms of suicidal ideation including plans and preparation.

Efficacy of Outpatient Treatment

It is commonly assumed that inpatient hospitalization is the “gold standard” for treatment of suicide risk. This may, in fact, not be the case. Inpatient hospitalization has not been found to be efficacious in a clinical trial (Comtois & Linehan, 2006), and its effectiveness has been described as “questionable” by the Institute of Medicine (2002, p.251).

Hospitalization also carries the added burdens of increased financial costs and social stressors resulting from missed work, inability to take care of personal responsibilities, and possible stigma. Outpatient psychosocial treatments that specifically target problem-solving strategies and suicidal symptoms and behaviors demonstrate the greatest level of efficacy (Comtois & Linehan, 2006) and are more effective at retaining the patients at highest risk than is inpatient treatment (Rudd et al 1996).

Outpatient Management of Suicidality

Slaby (as cited in Bonger, 2002) details the following elements in managing outpatient care of suicidal patients:

- Conduct an initial and current evaluation for suicidal ideation/plans
- Address factors that directly contribute to risk
- Evaluate as needed the patient's need for hospitalization
- Implement referral for medication to treat underlying disorder(s)
- Encourage increased social support from patient’s friends and family
- Provide individual and family (where indicated) therapy
- Address any concurrent substance use issues
- Use psychoeducation with patient and significant others
- Keep accurate and current records
- Arrange for emergency coverage for evenings and weekends

Clinicians in outpatient practice must be able to provide emergency coverage and respond appropriately if a patient is actively suicidal. This may mean consultation and connection family members (with appropriate acknowledgment of confidentiality issues), more frequent sessions or telephone “check-ins.”

In addition to the guidelines proposed by Slaby, Rudd and colleagues (1999) developed practice guidelines that apply to clinical practice, informed consent, diagnosis, monitoring suicidality, treatment duration and therapeutic outcome. These best practices remain a standard of care and include:

- When imminent risk does not dictate hospitalization, intensity of outpatient treatment should increase. This should include more frequent appointments or telephone contacts.

- If target is reduction of suicide attempts and behaviors treatment should focus on identified skill deficits such as difficulties with problem-solving, effectiveness, anger management, or emotional regulation.

- Identify both direct and indirect targets. Examples of direct targets include suicidal ideation, related self-destructive and injurious behaviors. Interact includes depression, anxiety, anger, and poor self image.

- Follow up should be employed to avoid the patient dropping out of treatment prematurely. This may include use of letters or telephone calls.

- Conduct informed consent pertaining to limits of confidentiality. Also include information about treatment options, risks and benefits, and likely duration of treatment.

- Extended evaluation may be necessary.

- Suicide risk should be monitored on and on going basis. This should be documented as monitored. Interventions for maintaining safety should also be documented.
• For chronic case presentations this should also be noted. Any symptoms that indicate escalating risk should be clearly delineated.

• A strong therapeutic alliance should be developed with the suicidal patient. Use the clinical relationship to support safety during times of crisis.

• Involvement of family members, including parents or guardians in treatment is important. They are contribution should be acknowledged and they should be empowered to have a positive influence on patient.

Models of Therapy

Shneidman

Edward Shneidman is considered one of the “fathers” of suicidology, and is still considered an expert in the field. According to Shneidman (as cited by Bonger, 2002), the primary difference between therapy with a suicidal/non-suicidal client involves the level of therapeutic involvement needed to appropriately and effectively manage care. Additionally the goal of treatment at that point is to keep the person alive.

Shneidman further states that while the interventions, such as talking, listening and interpretation remain the same, the clinician needs to focus on increasing the person’s sense of possible choices and the experience of feeling emotionally supported and collaborated with. Support may also be a function of involving the person’s significant others, family, friends, etc. in the overall treatment process. Ancillary therapists, clergy and community resources may also be added for additional support.

Shneidman describes as the four components of the highly suicidal state: heightened hostility, elevated anxiety/uneasiness, constriction of intellectual focus and the idea of cessation as a solution. He concluded that treatment must focus on decreasing lethality and reducing these emotional states during this crisis period.

Collaborative Assessment and Management of Suicidality (CAMS)

The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based clinical intervention. CAMS is a therapeutic framework that emphasizes a collaborative assessment and treatment planning process between the suicidal patient and clinician. The CAMS process is designed to enhance the therapeutic alliance and increase treatment motivation in the suicidal patient (Jobes, 2012).
The CAMS approach to suicidal patients is fundamentally focused on developing a strong therapeutic relationship with a suicidal person; the clinical alliance is considered to be the essential vehicle a potentially lifesaving series of clinical interventions (Jobes, 2012). The CAMS approach engages the suicidal patient in the assessment of their own suicidal risk and by collaborating as “co-author” of their suicide-specific treatment plan. CAMS is a philosophy of treatment and a clinical procedure, guided by a tool known as the Suicide Assessment Form (SAS).

Philosophically CAMS recognizes that suicidal thinking is generally a “sensible” response to troubling worries, and intense psychological pain and suffering. While it is not a desirable response or one that a clinician would like to see occur, Jobes (2012) suggests that treatment proceed through this empathic lens. He states that there are times in other approaches where clients are shamed for having suicidal thoughts but that when clinicians understand the When we truly understand the “functional” aspects of suicidality, they are better positioned to propose alternative and less life-threatening ways of coping.

Procedurally the CAMS approach takes the following steps:

1) Early identification of risk. This may be through verbal self-report of suicidal ideation, through discussion of symptoms or on a suicide or depression-screening tool. This is done in the first ten minutes of treatment.

2) Collaborative assessment using the Suicide Assessment Form (SAS). This provides a more in-depth assessment of suicidal thoughts, plans, etc., using various rating scales, qualitative assessments and rankings. This is done with clinician and client working together. Some examples of areas that the SAS looks at are: psychological pain, stress, agitation, hopelessness and self-hate; reasons for living and dying; suicide plan; history of prior attempts; and other risk factors (e.g., substance abuse, health problems, legal problems, etc.)

3) Collaborative treatment planning. The dyad co-authors the outpatient treatment plan fully addressing outpatient safety needs, a crisis response plan, supports, etc.

4) Clinical tracking of suicidal ideation. At each subsequent clinical contact, the patient’s self-report SSF assessment is quickly completed at the start of each session; at the end of the session the Outpatient Treatment Plan is up-dated depending on clinical progress or any new emerging suicidal issues that need to become a focus of treatment.
5) Clinical resolution of suicide status. Three consecutive sessions of no suicidal thoughts, feelings, and behaviors marks the resolution on suicide risk; the SSF Suicide Tracking Outcome Forms are completed and the patient is taken off Suicide Status as CAMS comes to a close.

Cognitive and Behavioral Approaches to Therapy

There are a number of approaches to working with suicidal clients, and cognitive and behavioral approaches have a significant evidence base supporting its efficacy.

Behavioral Therapies

In a broad sense the term “behavioral therapy” refers to methods that aim to reduce unwanted or negative behaviors. Behavioral therapy focuses on current problems and behavior, and attempts to remove behavior the patient finds troublesome.

Comtois (2010) states that a primary goal in treating suicidal ideation is prevention. Thus behavioral interventions are focused on treating suicidal behavior. According to Comtois, effective therapy for suicidality must have two components: 1) Treating suicide directly (not just treating the diagnosis) and 2) Using an overtly collaborative stance rather than a psychiatric interview.

In the behavioral view, primary drivers of suicidality are inability to solve problems, intense emotional dysregulation, reasons for dying (e.g., thinking they are a burden), and lack of reasons for living. These are the areas that are most amenable to skills and learning.

Additionally Comtois’ behavioral approach suggests that the targets for change are the stressors that are contributing to the suicidal thoughts. These may include interpersonal conflict or loss, medical issues (including pain), financial stress, and homelessness to name a few. The most effective treatments focus on the unique problems of suicidal people that prevent them from solving secondary drivers.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) integrates a problem-solving approach as a core intervention for reducing suicidal ideation, and related symptomatology such as depression, hopelessness, and loneliness. Cognitive-behavioral treatment focuses on the cognitive distortions and deficits that disrupt a client’s ability to solve interpersonal problems, as well as on the capacity to regulate emotions (Rudd, 2006).
CBT describes suicidal behavior as due to vulnerabilities from certain cognitive characteristics, such as rigidity and poor problem solving and coping skills. When faced with problems, people with suicidality often have difficulty generating solutions, and may have a negative attributional style, including negative views of themselves and the future. Suicidal people will often experience distortions, irrational beliefs and ways of viewing the world that lead to hopelessness (Worchel & Gearing, 2010).

In CBT, clients are actively challenged on their negative beliefs, and their tendency to view themselves, their circumstances and their future in unrealistically negative terms. Clients focus on skills such as problem solving, coping, assertiveness, and interpersonal communication. In this approach, therapists actively educate clients about suicide, and teach them to recognize and understand their own self-limiting and negative beliefs (Rudd, Joiner & Rajab, 2001; Rudd, 2006).

Wenzel, Brown and Beck (2009) have developed a version of CBT specific to suicidality. It is not a time-limited or brief approach. The third and last stage is "Relapse Prevention with a Twist," which involves evoking a suicidal crisis in session. The theory is that people who are suicidal have trouble using newly acquired skills when in crisis. By evoking the crisis in session, the client is able to apply and test coping skills with the therapist's support. Clients do not graduate from treatment until they demonstrate that they are ready to do this on their own.

A number of research studies have confirmed that CBT is an effective intervention for suicidality. Gudmundsdottir & Thome (2014) looked at the reduction of hopelessness in matched groups of suicidal individuals. The groups that had individual CBT received lower scores for depression and hopelessness. Alavi et al. (2013) conducted a similar study with a sample of depressed 12 to 18 year-old adolescents who had at least one previous suicidal attempt. These researchers also found evidence that CBT supported suicide prevention by decreasing suicidal ideation and hopelessness. Handler et al. (2013) looked at the effectiveness of CBT as the reduction of suicide vulnerability in individuals experiencing comorbid depression and alcohol use. They found that CBT appears to be associated with reductions in hopelessness in people with co-occurring depression and alcohol misuse, even when it is not the focus of treatment.

Clinical guidelines for CBT in suicidality are similar to that of depression or anxiety, and include targeting automatic thoughts, summarizing, and providing homework assignments to practice strategies and techniques outside of session. Additionally guidelines state that CBT treatments target suicidality directly, rather than as a symptom of another presenting disorder. Thus treatment needs to be implemented around the client's suicidality.
Many of these guidelines have been applied to adult populations. Several researchers/clinicians have looked at adolescents with suicidal behaviors to assess the efficacy and develop treatment protocols for this population.

Stanley et al. (2009) also look at the use of cognitive behavior therapy for suicide prevention. These researchers developed a manualized cognitive behavioral treatment for adolescents who recently attempted suicide (less than 90 days). The primary goals of this intervention were to reduce suicidal risk factors, enhance coping and to prevent suicidal behavior. Thus the intervention was designed to help adolescents use more effective means of coping when faced with their stressors and problems that trigger suicidal crises. Parents also met with the therapist for family sessions focused specifically on suicide risk reduction strategies.

A central focus of Stanley’s (2009) approach is the identification of risk factors and stressors, including emotional, cognitive, behavioral and family processes active just prior to and following the adolescent’s suicide attempt or recent suicidal crisis. These include deficits in the adolescent’s abilities or motivations to cope with suicidal crises. Family issues are addressed to the extent that they are relevant to the case conceptualization and the prevention of a future suicide attempts. The initial phase of acute treatment occurs during the first three sessions and consist of five main components: Chain Analysis, Safety Planning, Psychoeducation, Developing Reasons for Living and Hope, Case Conceptualization. During the middle phase of acute treatment and after the immediate suicidal crisis has resolved, the primary area of intervention is behavioral and/or cognitive skills training using individual or family sessions. The final component of the acute intervention phase includes a relapse prevention task.

**Dialectical Behavior Therapy**

Dialectical Behavioral Therapy (DBT) is a behavioral treatment for suicidal and parasuicidal behavior (Linehan, 1993). DBT includes simultaneous individual and group treatment modalities, and is based on the principles of cognitive, behavioral, and interpersonal therapy.

DBT is a problem-solving approach that had particular applicability to chronically suicidal and personality disordered individuals. Among chronically suicidal clients, distress tolerance tends to be low and coping resources and responses are limited (Jobes, 2000). DBT targets identified skills deficits (e.g., inability or reduced ability for emotion regulation, distress tolerance, managing impulsivity, problem-solving, interpersonal assertiveness, anger management; Rudd, 2006).
Treatment strategies that guide the treatment process are: dialectical strategies, problem-solving, irreverent communication, consultant approach directed toward the client rather than other professional, validation, capability enhancement, relationship strategies, and contingency strategies (Linehan, 1993).

DBT was initially developed for use with individuals with borderline personality disorder, but the applicability and research base has expanded to other vulnerable populations. Fisher and Peterson (2014) conducted a study of dialectical behavior therapy for adolescent binge eating, purging, suicidal behavior, and non-suicidal self-injury. Treatment included access to a crisis management system, individual therapy, skills training, and a therapist consultation team. At post-treatment, participants had significantly reduced self-harm, frequency of binge and purging episodes and all but one participant were abstinent of non-suicidal self-injury. Ward-Ciesielski (2014) conducted a pilot study of brief dialectical behavior therapy skills-based intervention for suicidal individuals. Ward-Ciesielski found that Suicide ideation was significantly lower at the 1-month follow-up, while use of the specific skills taught in the intervention increased significantly across time points.

To target the suicidal adolescent population, Dialectical Behavioral Therapy was adapted into a protocol called DBT-A (Rathus & Miller, 2002). DBT-A employs individual therapy and group skills training and targets suicidal behavior. An investigation of DBT-A versus usual care in suicidal adolescents with borderline personality disorder features found that in the DBT-A group, although not statistically significant, fewer subjects made suicide attempts, fewer subjects were hospitalized, and the completion rates for treatment were higher. However this study focused only on adolescents with borderline symptoms.

**Psychodynamic Therapies**

There are a number of psychodynamically-oriented approaches to suicidal behavior. According to Plakun (2009) psychodynamic therapy looks at the encoded or unconscious meaning of suicidal and self-destructive behavior. In making the unconscious conscious, the patient can communicate pain, despair, and rage in words rather than action.

Psychodynamic approaches also look whether the patient has experienced a breakdown in ego defenses and an increase of destructive, instinctual energy, including (Bonger, 2002):

- A loss of love objects
- Aggression directed toward a love object
- Narcissistic injury
- Overwhelming, uncontrollable affect
- Seeing self as abandoned/unworthy of concern
- Lack of internal psychodynamic resources for self-soothing
- Inability to feel a sense of self-value
- Rage directed inwardly

**Alliance-Based Therapy (ABT)**

ABT focuses on the therapeutic alliance with patients as a way to treat suicidal behavior (Plakun, 2009). Alliance-based therapy is guided by a set of principles that allows therapists to notice, engage and verbalize the interpersonal meaning of suicide. Through this process, and if there is a strong therapeutic alliance, suicidality shifts from symptom to interpersonal communication between the therapist and client and becomes something under the patient’s conscious control. Some of the principles of ABT include:

- Differentiate lethal from non-lethal self-destructive behaviors
- Offer a non-punitive interpretation of the patient’s aggression
- Metabolize the countertransference
- Assign responsibility of the preservation of treatment to the patient
- Provide an opportunity for repair

**Interpersonal Psychotherapy (IPT)**

IPT is informed by the Interpersonal Theory of Suicide (Joiner, 2009; Van Orden et al., 2010). This theoretical model proposes that thwarted belongingness and perceived burdensomeness are causes of suicide ideation. IPT principles guide clinicians to look for interpersonal stressors that may be present in a client’s life. Examples of these stressors include grief, role transitions, interpersonal disputes, and interpersonal sensitivity (i.e., skills deficits). The theory suggests that clinicians be cognizant of their patients’ levels of belongingness, burdensomeness, and acquired capability (especially previous suicide attempts), which may aid clinicians in the task of suicide risk assessment and of target interventions.

Mufson et al. (2004) studied the effectiveness of interpersonal psychotherapy for depressed adolescents, noting that adolescent depression is highly prevalent and has substantial morbidity, including suicide attempts. The researchers found that adolescents treated with interpersonal psychotherapy showed symptom reduction and improvement in overall functioning. McLeavey et. al (1994) looked at the use of Interpersonal problem-solving skills training in the treatment of self-poisoning patients. The researchers found interpersonal therapy reduced that number of presenting problems and hopelessness levels. Interpersonal problem-solving skills training was also significantly more effective than control conditions on measures of interpersonal cognitive problem solving, self-rated personal problem-solving ability, perceived ability to cope with ongoing problems, and self-perception.
Other Approaches/Adolescent Protocols

Family, group-oriented and brief, adjunctive psychosocial intervention models have been tested in suicidal adolescents. Wood, Trainor, Rothwell, Moore, and Harrington (2001) evaluated the effectiveness of developmental group therapy for adolescents with self-injury behavior. Patients attended six sessions organized around specific themes (i.e., relationships, school problems and peer relationships, family problems, anger management, depression and self-harm, hopelessness and feelings about the future), followed by weekly group therapy. The treatment showed a reduction in episodes of self-harm, time to first repetition of self-harm was also delayed and school attendance was improved.

Other strategies employed with high risk adolescents included cognitive behavioral family intervention (see Rotheram-Borus et al., 2000); home-based family intervention (see Harrington et al., 1998); and use of suicide support teams (see King et al., 2006.)

Care for the Clinician

As seen throughout this training material, working with suicidal clients is demanding and encompasses unique challenges for the clinician. Research consistently finds that suicidal statements and behaviors are among the most stressful client behaviors for clinicians. Additionally, a client’s completed suicide is very difficult. Hendin, Lipschitz, Maltsberger, Haas, and Wynecoop (2000) found that therapists described losing a client as “the most profoundly disturbing event of their professional careers,” noting that one-third of these therapists experienced severe distress that lasted at least one year beyond the initial loss. Shock, grief, guilt, fear of blame, self-doubt, shame, anger, and betrayal were the major emotional reactions. Many consider leaving the profession after losing a client to suicide. Clinicians must be aware of their reactions to suicidal clients during the treatment process, taking appropriate steps to increase self-care. They also need to monitor responses should a client suicide occur.

Pearlman and Saakvitne (1995, p. 31) define vicarious traumatization as the "negative effects of caring about and caring for others". Vicarious Traumatization is the “cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's traumatic material.” Burnout is a somewhat similar condition that occurs as a result of prolonged response to chronic emotional and interpersonal stressors and consists of three components: Exhaustion, depersonalization and diminished feelings of self-efficacy.
Treatment of a chronically suicidal client presents many challenges to caregivers. Among the most common are anger at being manipulated, fear that the client will die, and fear of being held responsible for the client’s actions via a malpractice suit (Frances & Miller, 1989).

**Supervision/Consultation**

Kohlenberg, Tsai, & Kohlenberg, R.J. (2006) suggest that peer supervision/consultation as one of the most effective strategies for therapists working with suicidal or high-risk patients. Supervision provides an opportunity for the clinician to explore and discuss feelings and fears.

Treatement of a chronically suicidal client presents many challenges for clinicians. These include (Frances & Miller, 1989):

- Anger at being “manipulated” by the client (who may be seeking extra support)
- Fear that the client will die
- Fear of being held responsible for the client’s actions via a malpractice suit

Supervision provides an opportunity for the clinician to explore and discuss these common feelings and fears. Supervision/consultation can also assist the clinician in separating the meaning of the suicide to him/her from its meaning to their client.

Supervisors, or clinical consultants, can often assist in allowing clinicians to separate the meaning of the suicide to him/her from its meaning to their client. Supervisors can also help recognizing the anxiety that comes from “holding the client’s pain,” and can offer needed empathy, perspective, and support.

One way to support clinicians is to use regular team consultation. For example, one of the components of Dialectical Behavior Therapy (DBT) with clients who are suicidal is that DBT therapists to attend team consultation meetings. (Linehan, 1993; Miller et al. 2007). While less formal in nature it is also helpful to engage in activities such as peer debriefing, or in “buddy systems,” in which novice therapists are paired with more experienced clinicians.

Appropriate supervision/consultation, reduces emotional risk to the clinician, and increases awareness of internal feeling states. These can be useful as a barometer of the state of the client, can aid diagnostic formulation, can help clarify how others may respond to the individual, and may facilitate therapeutic intervention (Kernberg, as cited by Samra & Monk, 2004). Regularly scheduled, formal supervision is considered to be the most effective buffer to
burnout (MacFadden, as cited by Samra & Monk, 2004) and enhanced clinical practice.

**Signs of Burnout**

Burnout first begun to be identified as problematic among caregivers in the early 1980s. Freudenberger (1980) suggests that burnout is a state of fatigue or frustration brought about by a devotion to a cause, a way of life, or a relationship that failed to produce the expected reward.

Burnout is manifested by a lack of energy and a feeling that one's emotional resources are lacking. It can negatively affect the clinician on both a personal and professional level. Burnout can be hastened by working with suicidal clients.

Signs of burnout can be physiological (e.g., fatigue, irritability, headaches, weight shifts, GI disturbances), behavioral (e.g., loss of enthusiasm, calling off from work, accomplishing little despite long hours, indecisiveness, irritation at co-workers), psychological (e.g., depression, negativeness, pessimism, low self-esteem, self-blame, anxiety, guilt) or spiritual (e.g., loss of faith, loss of meaning, loss of purpose, despair, changes in religious beliefs) or clinical (cynicism, boredom, hostility, blaming clients, daydreaming in sessions). Clinicians suffering from burnout may use an unhealthy means to find relief, such as quitting a job or occupational field, suffering from problematic substance use or attempting suicide themselves (Rothschild, 2006; Skovholt, 2001).

**Vicarious/Secondary Traumatic Stress**

Secondary traumatic stress (also referred to as vicarious traumatization) differs from burnout. Burnout is the result of accumulated stress, whereas secondary traumatic stress can occur following one traumatic incident. Burnout is also a more gradual condition while secondary traumatic stress can emerge suddenly (Figley, 1995). One thing that could result in secondary traumatic stress is the strain that clinicians feel as they engage and maintain empathetic connections with suicidal clients. Secondary traumatic stress can also occur following a client suicide.

Yaseen et al. (2013) looked at clinician responses to suicidal patients. The researchers assessed clinician response through the use of the Therapist Response/Countertransference Questionnaire. Clinicians reported on patients who had completed suicide, made high-lethality attempts, low-lethality attempts, or died unexpectedly from non-suicidal deaths. The researchers found that clinicians treating imminently suicidal patients had less positive feelings towards these patients than for non-suicidal patients, but had higher
hopes for their treatment, while finding themselves notably more overwhelmed, distressed by, and to some degree avoidant of them.

Some of the signs of secondary traumatic stress include (Ambrose, 2000):

- Intrusive thoughts or images of personal or work-related trauma events
- Lowered frustration tolerance, irritability or outbursts of anger
- Dread of working with certain people/situations
- Feelings of depression, loss of hope and optimism, sadness, upset
- Decreased feelings of competence, sense of purpose/ enjoyment with career
- Feeling hardened, detached, cynical
- Isolation from others
- Substance abuse to mask feelings

**Compassion Fatigue**

Closely related to the idea of vicarious traumatization is that of compassion fatigue. This is another phenomenon that can occur as a result of working with suicidal individuals. Compassion fatigue refers to the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995). According to Figley, professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain and suffering because they care.

**Antidotes to Burnout/Secondary Traumatic Stress/Compassion Fatigue**

While working with suicidal clients can have negative effects, there are things that can be done to mediate these stressors. Edward (2005) looked at the phenomenon of “resilience” in crisis care mental health clinicians. Edward defined resilience as “the ability of an individual to bounce back from adversity and persevere through difficult times.” The study, while small, did provide some significant insights into protective factors. A number of themes were explicated from the participants’ interview transcripts. Participants identified the experience of resilience through five factors, which included: 1) Working in a team as a protective veneer to work stress; 2) Sense of self; 3) Faith and hope; 4) Having insight; and 5) Self-care.

Taking these themes, and integrating insights from other studies of traumatic stress, it is clear that there are many facets to self-care needs, but that clinicians working with suicidal clients need to be vigilant about self-care. While not an exhaustive list, some helpful antidotes to burnout/secondary traumatic stress include:

- Emotional self-care (Taylor, 2006)
- Asking for support from colleagues when needed
- Participate in educational and training group forums
Suicide Assessment, Treatment, and Management

- Engage in positive coping skills
- Exercise
- Work-life balance (time for hobbies, leisure, family and friends)
- Pace the work
- Meditation and mindfulness skills
- Avoiding workoholism
- Therapeutic self-awareness/regular self-examination
- Limiting caseload/severity of cases

**Personal and Professional Boundaries**

Another important thing to bear in mind when working with suicidal clients is the importance of keeping a balance between empathy and a proper professional distance. This is often challenging. It is helpful to determine, in advance of specific situations, the boundaries that are comfortable based on each clinician’s orientation and training.

Firestone (n.d.), writing for the American Psychological Association’s Education Directorate, discussed recommendations for boundary setting, and balancing client and clinician needs during a suicidal crisis. Firestone states that the clinician should provide structure for the client, which will help with feelings of fragmentation. She also recommends that the clinician and client actively plan for safety and that they include support people in the client’s life to add needed physical and emotional resources during treatment.

Firestone makes the following additional recommendations for working with suicidal clients:

- Obtain a commitment to treatment from the client. Outline a clear treatment plan, including specific tasks of therapy (i.e., engaging in homework, attending therapy multiple times a week.
- See clients more frequently when in crisis.
- Allow clients to express the strong negative feelings that are creating intense psychological pain. They will less likely to act on self-destructive thoughts and feelings if they have the opportunity to share them.
- Follow up if the client drops out of therapy or does not show up for a session.
- Monitor relationships with suicidal clients: does my client feel connected?
- Recognize the importance of the relationship. Suicidal clients describe the existence of an affirming and validating relationship as a catalyst for reconnecting with others and themselves.
- Repair relationship ruptures
- Help clients learn coping strategies

**Client Suicide**
There may be times that despite our best effort, a client makes the choice to take his or her life. The loss of a client by suicide is a traumatic event. Many clinicians who have lost a client to suicide describe as the most profoundly disturbing event of their professional careers.

Hendrin et al. (2000) looked at the experience of losing a client to suicide. The researchers asked these clinicians to complete a semi-structured questionnaire about their reactions, as well as to write a case narrative, and participate in a workshop to discuss their cases. The therapists discussed what they would do differently, the impact of the death on their treatment of suicidal patients, their interaction with patients’ relatives after the suicides, and the reactions of their colleagues and supervisors. The major reactions were shock, grief, guilt, fear of blame, self-doubt, shame, anger, and betrayal. Most of the therapists would have changed the course of treatment by recommending a different level of care or consultation with prior therapists. None of the therapists who saw family members felt criticized or blamed. Some of the therapists were reluctant to accept subsequent suicidal patients into their practices. Although colleagues were supportive, institutional responses and case reviews were rarely helpful, offering either blame or false reassurance that the suicide was inevitable.

The American Association of Suicidology has put together a Clinical Survivor Task Force for Therapists as Survivors of Suicide. For more information, see the appendix. The Association offers several suggestions (Ellis):

1. Procedural (Immediate)
   a. Notify supervisor
   b. Notify supervisors or contact peer consultant
   c. Strongly consider contacting family
   d. Consider attending funeral

2. Emotional (soon)
   a. Attend to your need to mourn
   b. Seek support from your supervisor, colleagues, significant others
   c. Use cognitive strategies to dispute dysfunctional self-statements and beliefs

3. Educational (later with supervisor or review group)
   a. Write a case summary, including course of treatment
   b. Review case formulation, identifying risk and protective factors
   c. Review intervention strategies
Ethical and Legal Issues

The training material thus far has presented the foundation for working with suicidal clients. As a clinician it is important to be aware of the ethical and legal issues connected to client suicide. The detection, prediction, and management of patient suicide present an array of ethical and legal challenges.

**Ethical Issues**

In addition to the clinical challenges associated with managing a client’s suicidality, there are also some specific ethical challenges. The general ethical standards that are involved are:

- Autonomy/Nonmaleficence
- Informed Consent
- Confidentiality
- Duty to Protect/Confidentiality

*Autonomy/Nonmaleficence.* Autonomy or self-determination concerns the idea that clients have a right to decision-making on their own behalf. This poses an ethical dilemma when faced with a client who wants to kill him or her self. Many authors discuss the idea of “rational suicide” (see for example Schramme, 2013). Granting a suicidal person the right to choice, however, comes into conflict with other ethical principles. The NASW Ethical Code allows social workers to limit self-determination when self-determination poses a serious risk to the person. Additionally nonmaleficence is the ethical principle addressing the therapist’s responsibility to “do no harm” including the removal of present harm and the prevention of future harm (Gladding, 2004). Thus clinicians are expected to take active steps to prevent client suicide.

*Informed Consent.* The process of “informed consent” is an opportunity for the therapist and client to make sure they understand their shared venture. Knapp and VandeCreek (2012) term informed consent “empowered collaboration.” Clients have the right to actively participate in their care. With regard to informed consent, clinicians should explain the process of a suicide assessment, their recommendations with regard to treatment, and the limits of confidentiality.

Whenever possible, the client should be involved in developing a plan of treatment (e.g., determining where they are hospitalized) and how family members will be involved. While the clinician should clarify the limits of information sharing, he or she should reinforce that during periods of acute and imminent suicide risk, family involvement is integral. Family involvement will likely involve some education about suicide risk. It is important to attend to family feedback.
Four exceptions to the need for informed consent are (Simon & Shuman, 2007):

- Emergencies: immediate treatment is needed to prevent imminent harm;
- Waiver: the patient waives the right to informed consent;
- Therapeutic privilege: the psychologist determines that a complete disclosure might have deleterious effects on the patient's well-being; and
- Incompetence: the patient is unable to give consent.

*Duty to Protect/Confidentiality.* When clients are at immediate risk of suicide, the clinician’s primary obligation is to protect the client from harming himself or herself (Welfel, 2002). One of the most valuable tools is the strength of the therapeutic relationship and the power of the therapist to diffuse the situation. Ideally clients will be able to consent to a course of treatment that is clinically sound, such as involving a trusted family member in the safety plan.

Research indicates that it may be advisable to warn the support system and significant others of a patient's suicidal potential and generally to increase their involvement in management and treatment (Bongar, 2002.)

In situations where a therapist believes that a client is in immediate danger, and they refuse treatment, the clinician may be required to breach confidentiality. Any decision to breach confidentiality should be made with careful consideration. The difficulty in making a decision, even in cases of suicide risk, lays in assessing “clear and imminent danger.” According to Remley and Herlihy (2001) “Determining that a client is at risk of committing suicide leads to actions that can be exceptionally disruptive to the client’s life. Just as counselors can be accused of malpractice for neglecting to take action to prevent harm when a client is determined to be suicidal, counselors also can be accused of wrongdoing if they overreact and precipitously take actions that violate a client’s privacy or freedom when there is no basis for doing so.”

*Risk Management/Therapeutic Risk Management*

The term risk management refers to a therapist’s efforts to identify the risk factors for suicide that may be present in a given case, and the therapist’s efforts to prevent the client from harming him or herself thus preventing the possibility of legal action. Matarazzo (2015), whose work is more clinically oriented, coins the term “therapeutic risk management” to encompass the range of interventions needed to assure that clinical interventions are both ethically driven and therapeutically sound.

Matarazzo (2015) makes the point that clinicians vary in their direct familiarity with suicide risk management. Some clinicians have little to no experience,
some encounter client suicidality on a weekly or monthly basis, and others, such as crisis clinicians have jobs with daily risk management needs. Often (but not always) comfort levels with risk management are tied to the frequency with which clinicians address these concerns in their work. Whatever the comfort level, Matarazzo stresses the need for clinicians to increase this familiarity at a time when immediate crisis is not occurring, which will enable them to make sounder decisions.

What is good risk management? Experts including Matarazzo agree that the best risk management is medicolegally informed practice that exceeds the standards of care, and that it is also is patient centered (supports treatment process and therapeutic alliance). Thus, good clinical care is the best risk management.

Aspects of Risk Management

In order for client interventions to be considered both ethical and thorough, therapists must maintain an acceptable standard of care. Standard of care is defined as the degree of skill and care that would be used by a typical practitioner in a similar situation (Gutheil, 1992). Practices of dubious benefit can invite a malpractice suit and are clinically unsound.

Another legal factor involves the idea of negligence. The act of suicide is impossible to predict, and negligence is not synonymous with inaccurate prediction. In order for negligence to occur, there must be 1) a professional relationship; 2) violation of a standard of care; 3) violation results in damage or harm; 4) there is a direct causal relationship between the clinician’s actions and the suicidal act (Bonger, 2002).

The following are considered reasonable duty for therapists in terms of suicide prevention (Remley & Herlihy, 2001):

- Clinicians must know how to make assessments of a client’s risk for suicide and must be able to defend their decisions
- When a decision is made that the client is a danger to self, counselors must take whatever steps are necessary to prevent the harm
- Actions to prevent harm must be the least intrusive to accomplish that result

Examples of such steps to prevent harm include facilitating the client’s psychiatric hospitalization; involving a family member or friend in the treatment plan; consulting with the client’s psychiatrist; increasing the frequency or intensity of the client’s treatment; or attempting to increase the degree of social support available to the client (Griffin, 2011). The preventive measures which a therapist employs when working with a particular client, depends on the needs
of the client, the surrounding circumstances, and any information which may be available to him or her regarding the client.

Some overall guidelines for working with suicidal patients include (Bonger, 2002; Guthiel, 1992; Matarazzo, 2015; Packman & Harris, 1998; Worchel & Gearing, 2010):

1. Maintain competence. Possess the training, knowledge and skills to treat and assess suicidality. Understand the literature related to suicide including risk factors, epidemiology, and management of the suicidal patient.

2. Conduct an initial suicide assessment with every client. Take a complete patient history that includes indicators of suicide risk based known risk factors for suicide. Throughout treatment when risk is elevated the clinician should ask specific questions about suicidal feelings and thoughts and depression and hopelessness.

3. Repeat suicide assessments as needed. Any person who is identified as being at possible suicide risk should be formally assessed for suicide risk. This includes any person reports suicidal thoughts on depression screening tool, one who scores very high on depression, who is seeking help (self-referral) and reporting suicidal thoughts or for whom the provider has concerns about suicide based on the provider’s clinical judgment.

4. Keep accurate and up-to-date records. In cases of suicidality, this should include a risk-benefit note.

5. Refer the client to a psychiatrist for evaluation for diagnosis and treatment of any co-morbid medical and psychiatric condition.

6. Obtain releases to consult with past therapists and secure the patient’s medical and mental health records. Relying on a patient’s personal report of suicide is insufficient when there is a prior treatment history. When patient refuses to give a clinician permission to get past treatment records, it may be an indicator of a high-risk situation and the clinician may need. With patient permission, it is also helpful to contact family members, who can help to determine the gravity of past suicide attempts if applicable (Bongar, 2002).

7. Develop an adequate treatment plan that encompasses the suicidality (see Klott & Jongsma, 2004)

8. Take preventive measures (as discussed above), such as hospitalization, consultation with family or friends.
9. Seek consultations from professional colleagues who have expertise in treating suicidal patients.

Suicide Risk Assessment

To review, suicide risk assessment is a process in which the healthcare provider gathers clinical information in order to determine the patient’s risk for suicide. The assessment and determination of risk includes gathering information related to the person’s intent to engage in suicide-related behavior, evaluating factors that elevate or reduce the risk of acting on the intent, and integrating all available information to determine the level of risk and appropriate care. Indicators of risk include ideation, intent, plan and access to means.

The Risk-Benefit Note

A risk-benefit note is a specific type of documentation recommended in the cases of a client’s suicidal ideation. The risk-benefit note documents factors went into the clinical decision, and how the factors were balanced by the use of a risk/benefit assessment. Such risk/benefit notes are the decisional road marks in a psychotherapist's clinical formulation of the management/treatment plan (Simon & Shuman, 2007).

The risk-benefit progress note should include the following (Packman & Harris, 1998; Simon & Shuman, 2007):

(a) an assessment of suicide risk
(b) the information alerting the clinician to that risk
(c) which high-risk factors were present in that situation and in the patient's background
(d) what low-risk factors were present (such as reasons to live, care of minor child, etc.)
(e) what information, namely the patient's history and the clinician's professional judgment, led to actions taken and rejected

The risk-benefit note should also indicate that the therapist understood the role of informed consent and the patient’s ability to collaborate in the decision-making process. This would include details pertaining to discussions with the client, including risks and benefits of the various courses of action. The record should be presented chronologically. If there is family involvement, the therapist should also detail this involvement, whether the involvement occurred with or without client consent, and what the outcome of the involvement was. The note should also indicate whether the therapist has contacted any other parties, such as a hospital or insurance companies.
**Other Helpful Interventions**

Other things that are helpful include family involvement for support and increased safety (see confidentiality); the provision of hope, particularly to new-onset patients; assessment of and restriction of the availability of lethal agents; and assessment of the indications for psychiatric hospitalization (Brent et al., 1988).

**Suicide/Safety Contracts and Risk Management**

There has been much debate in the literature regarding the use of “No Suicide/Safety Contracts as either a clinical intervention or as a risk management strategy. In general, safety contracts are a plan that the client is supposed to follow when feeling suicidal, which contains specific things that a patient can do when he/she is feeling unsafe, a list of reasons that suicide or self/harm is not a good option, and a list of emergency contacts. The premise is that by signing this contract, patients make a binding agreement to keep themselves safe.

Safety plans (also called Crisis Response Plans) can be viewed within clinical context (as part of an overall strategy for helping to increase client safety) or as an agreement between therapist and client. A safety plan is a list of strategies that a client can use to decrease suicidal ideation and involves collaboration between clinician and client. The use of a safety plan as a clinical strategy is supported by many of the major therapeutic and evidence-based approaches to treatment, including cognitive-behavioral approaches. It is also an integral part of treatment planning (Klott & Jongsma, 2004).

Garvey et al. (2009) conducted a literature review to assess empirical support for safety planning and reviewed legal cases in which safety contracting was employed. The researchers looked at safety contracting as a risk-management strategy. They found that empirically based evidence to support the use of the safety plan in any population is limited, particularly in adolescent populations. A legal review revealed that contracting for safety does not protect against legal liability. Safety contracts should be considered for use only in patients who are deemed capable of giving informed consent and, even in these circumstances, should be used with caution. The authors conclude that a contract should never replace a thorough assessment of a patient's suicide risk factors.

Potter and Dawson (2001) looked at safety through a nursing lens and a rational perspective. They discuss incorporating what they call as Safety Agreement. Potter and Dawson state that the key ingredients in a safety agreement are identifying patients’ immediate safety needs and decreasing immediate distress related to safety through the clinical relationship. The value of a safety agreement lies not in the tool itself but in its promotion of a clinical relationship that involves communication and collaboration.
Process of Safety Planning

Collaboration is essential when working with individuals who are suicidal. Some ways to increase collaboration are (Rudd, 2006):

- Sit side-by-side
- Use a paper form
- Have the individual write
- Provide brief instructions using client’s words
- Conversational approach
- Jointly address barriers and use problem-solving

Steps to safety planning:

1) Identify warning signs/triggers to suicidal ideation. These may include situations, thoughts, emotions, behaviors and physical sensations (personal red flags)

2) Identify coping strategies that will distract/prevent escalation of suicidal ideation. List specific activities. Some of these should be things that the individual is likely to do and do not involve the need to contact another person (e.g. listening to music, journaling, exercise)

3) Encourage contact rather than isolation, people or places that offer distraction (family, friends, going to church, etc.)

4) Include in the safety plan people who are aware of the crisis situation, including phone numbers

5) List professionals and agencies to contact for help (primary mental health provider, emergency psychiatric services)

6) Ensure safety in the environment, such as ensuring that the person does not have direct access to lethal means

7) Update this plan as needed

Sample Safety Plan

The following are strategies I can employ when feeling unsafe:

1) Situations, thoughts or warning signs that I am unsafe:
   Fighting with boyfriend, feeling angry and overwhelmed
2) Some things that are soothing/comforting I can do:
   Writing in my journal, petting my cat, taking a walk in the park

3) People/places that help me to feel connected:
   Talking to my priest or going to church

4) Family member or friends I can talk with (list names and phones #s):
   Pam 777-251-6278
   Uncle Jim 888-976-8743

5) Phone number of professionals and other services:
   Dr. Benjamin 777-251-6321
   National Suicide Prevention Line: 800-273-TALK (8255)

6) Other safety actions that I can do are:
   If I need to distract myself I can call Jennifer 267-652-8724

7) I can make my environment safe by (think about items you might be likely to use to hurt yourself, and detail how you can remove or secure them):
   Give razor blades to Dr. Benjamin

Keep this written plan in a place where you can access it
Supporting Family and Friends Following Suicide

Case Study

Bridgette is a 40-year-old woman presenting for treatment six months after the death of her son by suicide. She reports continued and intense grief, feelings of isolation, marital distance and lack of support from family. She also experiences intense nightmares of being with son in hospital as he was removed from life support. Bridgette feels she may never get over the loss, and that if it were not for her daughter she may “join my son.”

According to the American Association of Suicide Prevention (2011), about 85% of people in the United States will know someone personally who has completed suicide. For the purposes of this discussion, a survivor of suicide is “anyone who is significantly negatively impacted by the suicide of someone in their social network” (Jordan, 2008).

The term “grief” describes the emotional, cognitive, functional and behavioral responses to the death. While there are some general things that we know about the grieving process, grief is different for every person and every loss. The intensity and duration of grief is also highly variable, not only in the same individual over time or after different losses, but also in different people dealing with ostensibly similar losses. According to Zisook & Shear (2009) Some of the things that affect the grieving process include the individual’s preexisting personality, attachment style, genetic makeup and unique vulnerabilities; age and health; spirituality and cultural identity; supports and resources; the number of losses; the nature of the relationship (e.g., interdependent vs. distant, loving vs. ambivalent); the relation (parent vs. child vs. spouse vs. sibling vs. friend, etc.); type of loss (sudden and unanticipated vs. gradual and anticipated, or natural causes vs. suicide, accident or homicide.)

Reactions to the loss of a loved one from suicide vary from person to person and those closest to the death appear to be the most adversely affected (Mitchell et al., 2009). Individuals who lose a loved one to suicide often go through a grieving process that can sometimes be more difficult than those people who experience other types of loss. Grief is a universal and adaptive reaction to the loss of a loved one. Grief can be subcategorized as acute grief, which is the initial painful response, integrated grief, which is the ongoing, attenuated adaptation to the death of a loved one, and finally complicated grief (CG), which is sometimes labeled as prolonged, unresolved, or traumatic grief. Complicated grief remains persistent and intense and does not transition into integrated grief.

Acute Grief
Grief is not a state, but a process (Zisook & Shear, 2009). In the acute grieving process, emotions are often intense. Common emotions include defensiveness (uncertainty about how others will react), depression and anxiety, and despair. Shock is a common immediate reaction, especially to a death by suicide, as are feelings of numbness, disorientation. This denial phase may be adaptive as it allows survivors to manage the realities of loss, such as planning a funeral or settling an estate. It may be some time following the death when the reality of loss settles in.

At this point in the grieving process, survivors of suicide loss may experience more acute symptoms of depression, including disturbed sleep, loss of appetite, and difficulty concentrating, intense sadness, and lack of energy. There may be fears about not being able to live with the loss. Physical symptoms, such as headaches, stomach upset, and compromised immune systems are common. In a death from suicide, there may also be PTSD-type responses, such as intrusive images, depersonalization, and a state of feeling overwhelmed. Anger towards the deceased, another family member, a therapist, or oneself is also common. Guilt around actions taken or not taken may also occur. At first, these acute feelings of sadness may seem like they will never end.

Following the initial stages of the acute grieving process, feelings are sometimes experienced in waves or bursts of emotion. These types of reactions are sometimes seen by those experiencing them as frightening or shameful. Over time the waves of feeling become less frequent and intense, or are provoked by thoughts of the deceased. There may be other reactions, such as relief that a loved one’s physical or emotional suffering has ended, or there may be positive associations towards the deceased. It is helpful to normalize these feelings for family members.

During the acute stage of grief, when the loss is due to a suicide, there is some is the elevated risk of suicidality. Several studies have confirmed this connection. One study (Crosby & Sacks, 2002) for example found that people who had known someone who died by suicide within the past year were 1.6 times more likely to have suicidal ideation, 2.9 times more likely to have suicidal plans, and 3.7 times more likely to have made a suicide attempt than those who did not. This is especially true with complicated grief (to be discussed later in this document).

**Integrated Grief**

For most people who have lost a loved one under circumstances other than suicide, acute grief transitions to what we call integrated grief within several months. For those that have lost a loved one to suicide, this period may be extended. In this stage of grieving, the survivor begins to assimilate the reality and meaning of the death. The survivor begins to once again engage in
pleasurable and satisfying relationships and activities. While the survivor still misses their loved one, the loss becomes integrated into autobiographical memory and the thoughts and memories of the deceased are no longer preoccupying or disabling. Unlike acute grief phase, integrated grief does not persistently preoccupy the mind or disrupt other activities. There may be periods when the acute grief reoccurs, such as around significant life events such as holidays, birthdays, anniversaries, etc.

Something that is often helpful following the acute grieving process is for the survivor to find meaning and connection in the loss. This may include wearing clothing that belonged to the deceased, establishing a memorial for their loved one, or lighting candles to keep the memory alive. Some of the rituals in various religions, such as saying mass for Catholics, may support this process. Bereaved individuals may take some comfort in learning that the relationship does not need to be totally severed, but that it is perfectly acceptable and even normal for the relationship to endure (Zisook & Shear, 2009).

While death from suicide may result in a more complicated picture, there is no empirical evidence to suggest that all survivors require specific therapeutic interventions. Most people who have lost loved ones to suicide achieve an acceptable level of adjustment. Some do require additional support from clergy or a support group.

A small percentage of individuals are not able to come to such a resolution and go on to develop a “complicated grief” reaction.

*Complicated Grief*

Some studies have suggested that bereavement after suicide is qualitatively and/or quantitatively different from mourning after other types of deaths. With suicide loss, grief may be prolonged or indefinite.

Symptoms of complicated grief include (Jordan, 2008; Zisook & Shear, 2009):

- Continued waves of emotions/swings in mood
- Intense longing for the deceased and preoccupation with thoughts of deceased
- Disbelief regarding the death, anger and bitterness, distressing, intrusive thoughts related to the death, and avoidance of reminders of the death
- Intense guilt or feelings of responsibility for the death, a ruminative need to explain or make sense of the death
• Strong feelings of rejection, abandonment, anger at the deceased

• Shame about the manner of death

• A change in personal identity (e.g., no longer viewing oneself as a “good” parent)

• Overestimation of own role in contributing to, or failing to prevent, the suicide

The shame and stigma associated with death by suicide may also lead to relational disruption. Fear of social ostracism and self-isolation are common among survivors. Some survivors may choose to keep the suicide a secret, which further increases this isolation. There is evidence that suicide survivors experience more stigmatization from their social networks than survivors of most other types of death. Thus it is helpful for clinicians to distinguish between experiences of stigmatization from others, and self-stigmatization, avoidance of friends and family out of a sense of shame and guilt.

Additionally survivors of suicide may have re-experiencing symptoms traumatic stress reactions. There may be a sense of horror about the manner of death, and the intrusive reliving and avoidance behaviors that are typical of posttraumatic stress disorder. Survivors may also ruminate about the physical or emotional suffering of the deceased. In some cases it has been the survivor that has discovered the body or suicide note or has needed to address the realities of clearing out the space in which their loved one has died. Depending on the circumstances of the death, and the symptom picture, interventions commonly associated with posttraumatic stress disorder would be appropriate.

McMenamy, Jordan & Mitchell (2008) looked at natural coping efforts used by suicide survivors, and specific problems and needs survivors experience following the death of a significant other by suicide. Results indicated that survivors experienced high levels of psychological distress since the suicide, including elevated symptoms of depression, guilt, anxiety, and trauma. Participants experienced substantial difficulties in the social arena (e.g., talking with others about the suicide). The majority of the sample viewed professional help as beneficial; although many informal sources of support were also valued (e.g., one-to-one contact with other survivors). Depression and a lack of information about where to find help served as barriers to help-seeking behaviors for our participants. Participants who reported higher levels of functional impairment were more likely to report higher levels of psychological distress, social isolation, and barriers to seeking help.

Mitchell et al. (2004) conducted a pilot study of 60 primarily female subjects. All were Caucasian, Christian, employed, and had lost loved ones to suicide. The rate of complicated grief among the group was 43%. This is at about
double the rates of up to 10% to 20% reported in the general population. Feigelman et al. (2008-2009) conducted a study of grieving time for survivors of a loved one’s suicide. The study suggests that 3 to 5 years is the time point at which grief after a suicide loss begins to integrate. Thus it may be important to not use amount of time as a framework for norms, but to use symptom picture and severity.

**Family Impact**

As mentioned previously, suicide loss has an impact on the entire family system. Some of the prominent themes for survivors include (Jordan, 2008):

- **Information Management** – there is often the question of who and what to tell others. The family may choose to keep the suicide a secret or to make up a story about death by another manner.

- **Disruption of family routines, rituals, and role functions:**
  - Changes in role functioning (e.g., surviving children may take on a parental role)
  - Changes in emotional availability of survivors and lack of a comforting presence for one another
  - Changes in distance and power in relationships
  - Communication shut-down (between husband and wife, parents and children)
  - Perceived fragility of members (keeping secrets from other family members for fear that they “cannot handle” the suicide)
  - Anger/conflict management

- **Coping Asynchrony** – family members may exhibit differences in grieving styles, which may lead to conflict with one another. This is an important area of education.

- **Blame/Scapegoating.** This may contribute to the development of cut-offs and estrangement from family members and friends, who survivors fear may not be accepting of the suicide. Family members may also struggle to construct a shared narrative.

- **Developmental anxiety about repetition.** There may be hypervigilence about surviving children, which may contribute to overprotectiveness, and lack of age-appropriate autonomy. Families may also experience problems with developmental separations, including college, young adulthood, etc.

- The result of these problems may be a loss of family cohesion.
Interventions/Postvention

In situations where there is a normal grieving process (acute grief followed by integrated grief, specific psychological interventions are not needed. If there are symptoms of posttraumatic stress, major depression/suicidal ideation (as opposed to intense sadness) then therapy can be beneficial.

Generally interventions for suicide loss are supportive or psychoeducational. It may be helpful to provide information about things including causes of suicide and its impact on the family system and to normalize emotions such as sadness or anger. Therapy can also allow survivors of suicide loss to express thoughts or feelings, share memories of the deceased (it is often helpful to create a box of mementos and photos or a journal of memories), or to develop rituals to mark the person's life, such as creating a lasting memorial or by an act such as lighting a candle at the same time each week.

Jordan (n.d.) suggests that part of the role of therapy is to allow the survivor to develop a narrative of the suicide, which he calls a “psychological autopsy.” This enables survivors to understand the mental state of the deceased, sort out realistic responsibility for the death and develop a realistic perspective about the multiple causes of suicide.

The goal of the therapeutic intervention is to provide a safe and sheltered context for doing griefwork and learning coping skills (Jordan, n.d.). It can also help the survivor learn how to pick up the pieces and go on living in as meaningful a way as possible.

Guidelines for clinicians include:

- Provide a sense of connectedness and help reduce self-imposed isolation

- Therapists should recognize and be aware of their attitudes, including prejudices, about suicide (some questions to ask: beliefs about why people take their lives; can suicide be prevented?)

- Be present with survivors’ pain rather than trying to “fix” it; listen

- Remember that there are no “pat” or easy answers to the question of “why?”

- Pace treatment to allow survivors to break down experiences into smaller doses

- Allow the ability for survivors to integrate the loss into their narratives and to honor the deceased’s life not focus on their death
- Provide for containment of the trauma and restoration of control

- Be aware of the causes, impact, family affects of suicide and be able to communicate these to survivors; address family and social network issues

- Set realistic expectations about the grieving process, including the uniqueness of each situation

- Be empathic, compassionate and non-judgmental

- Help the survivor to address guilt and self-blame; communicate that suicide losses are beyond anyone’s control

- Promote focus on survivor self-care and use of positive ways to cope (sleep, exercise, stress-reduction); if self-medicating point this out in a non-judgmental way

- Encourage the survivor to continue to participate in things they enjoy, such as sports, social events or music

- Make concrete suggestions, such as journaling, spending time outside, or developing an “emotional first aid kit” including things that can help when survivors are feeling low, such as a music playlist, or a pillow to punch

- Offer idea of additional help through friends, family, support groups and faith leaders

- Reinforce idea that connecting with others promotes healing and helps reduce the natural response to isolate

- Allow the survivor to finding new connections and pathways for the self

- Promote the power of s survivor mission, such as suicide prevention advocacy, participation in community events such as suicide awareness walks

Contact with other survivors, such through participation in peer or professionally led support groups, also appears to be helpful. Support groups may provide a safe and non-judgmental environment to compare and normalize experiences, reduce the sense of social isolation and stigma, and to receive support. It may be beneficial for survivors to seek out a suicide-specific survivors (such as Survivors of Suicide or Samaritans) group rather than a more general support group.
Growth

While the discussion thus far has been on the negative aspects for family members of those who have successfully completed suicide, there are some hopeful theories about growth. Jordan (n.d.), an expert in working with family members, suggests that there can be what he terms “post-traumatic growth” after suicide. He describes that there is often a changed identity of being a “survivor,” and thus worthier of self-care. These survivors may also have changed relationships with others and place more priority on relationships, they may express more love and affection for family and friends and may demonstrate more compassion for others. There may also be an ending of dysfunctional relationships.

Jordan suggests that suicide survivors may also have a changed outlook on life. They may have a greater sense of purpose or a new purpose, a greater appreciation and sense of gratitude, and may experience a positive shift in faith, such as a deeper feeling of spirituality and hope.

Children and Suicide Loss

Children experience loss by suicide differently from adults. While there may be individual differences in how adults choose to explain suicide to children, and one must take into account development and maturity, there are some general guidelines that may be helpful.

According to the American Foundation for Suicide Prevention, it is important to provide truthful information, encourage questions, and offer loving reassurance when explaining the suicide to a child or adolescent. They stress that talking honestly about suicide does not give others the idea to take their own lives, rather understanding mental illness and suicide helps surviving family members to be watchful about their own health, and to take preventative steps when something is wrong. While there is sometimes a pull towards “protecting” a child from the reality of suicide by telling the child that a family member died from an accident or illness, honesty is a better policy.

While there are differences in the reasons that people chose to take their own lives, many who die from suicide do so as a result of mental illness. Harpel and Rapport (n.d.) suggest that looking at suicide as “tragic outcome of a serious illness, rather than as a moral weakness, a character flaw, irresponsibility, or a hostile act” is a schema for explaining suicide to children in a caring and compassionate way.

Some overall guidelines include:
Suicide Assessment, Treatment, and Management

- Be honest and use direct, non-judgment language. “Mommy died by suicide. Suicide means she killed herself.”

- Talk to the child in a quiet place where you will not be interrupted. If possible, include a family member of other person whose presence they find comforting.

- Very young children do not understand the permanence of death but primarily need comfort, physical affection and the reassurance that there is someone there to care for them.

- Adults should not try to hide their sadness, but to reassure children that sadness in themselves and others is a normal reaction to grief.

- Reassure children that they are not responsible, and that nothing they said or did caused anyone else to take their life. Young children tend to be especially focused on what the death means to them (is it my fault? who will take care of me and read me stories? Reassure them by addressing their (often unexpressed) concerns that they will continue to be loved and cared for.

- Adults should be prepared to talk about the suicide multiple times during the first days and weeks, and later throughout the child’s life. Young children may ask the same questions repeatedly in an effort to understand the death.

- Let the child lead the conversation. Answer questions honestly and avoid euphemisms (such as “passed away” or “went to a better place”), which can confuse children. If adults cannot answer a question it is better to say “I don’t know” than to make up an answer.

- Emphasize that suicide is complicated and there may be some answers that adults do not know.

- A child-focused support group may also be helpful

Children grieve differently than adults. They may not display emotions in the same way that adults do. Children may ask repetitive questions “When is Mommy coming back?” or make repetitive statements (sometimes to strangers) such as “My mommy died.” Short-term regressive behavior such as bedwetting, thumb sucking, troubles getting dressed, or separation anxiety is also common.

Children may also behave in a seemingly perplexing manner. They may seem unfazed by the news of suicide, or they may want to go on as if nothing dramatic has happened. Experts emphasize that this may simply mean that
they need time to process the loss. Be assured that they don’t have to talk about it in order to heal.
Appendix

*Media Guidelines for Safe Reporting on Suicide*

**Things to Avoid**

- Avoid detailed descriptions of the suicide, including specifics
- Avoid romanticizing someone who has died by suicide
- Avoid featuring tributes by friends or relatives
- Avoid first-person accounts from adolescents about their suicide attempts
- Avoid glamorizing the suicide of a celebrity
- Avoid oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable
- Avoid overstating the frequency of suicide
- Avoid using the words "committed suicide," or a "failed" or "successful" suicide attempt

**What To Do**

- Always include a referral phone number and information about local crisis intervention services
- Emphasize recent treatment advances for depression and other mental illnesses
- Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide
- Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.
- Emphasize decreasing trends in national suicide rates over the past decade
- Emphasize actions that communities can take to prevent suicides.
- Report on activities coordinated by a local or State suicide prevention coalition.

Appendix

Suicide Postvention Guidelines, American Association of Suicidology, 1994

- Explain, encourage, and normalize the expression of shock, fear, sadness, guilt, and anger at others or at the victim, and provide assurance that painful feelings may be reduced through discussion, counseling and support.

- The aim is not resolution of sorrow. Survivors will need to experience their pain to progress through grief. They may also have feelings of guilt, which are common feelings related to grief caused by suicide deaths.

- Clarify the facts of the suicide, to the extent possible. Encourage and support family/friends to be open about the death being a suicide so that they may grieve appropriately.

- Challenge the common misconception that someone is to blame for the death.

- Do not focus on the suicide as a romantic or heroic act; rather, emphasize ways of getting attention without threatening or attempting suicide.

- Focus on the suicide victim as a person in unbearable pain who unfortunately did not believe he or she had other ways to resolve emotional or psychological problems.

- Encourage the survivors to talk about their happy, sad, or angry memories of the victim, what they did together, and what the person was like. Ask about the last time they saw the person and what they said to him or her or what they wished they would have said if they had known it was the last time they were to see him or her.

- Encourage discussion of recent losses.

- Acknowledge that suicidal thoughts are common but do not have to be acted on. Other options and alternatives are possible.

- Encourage discussion with family and friends (people in their natural support network) about their feelings and thoughts of suicide. Ask them who they turn to for support or help.

- Provide information about available community resources for follow-up support including telephone numbers.

- Assess for suicidal ideation or plans and implement safety plan as
required.
# Appendix

## Resources

<p>| <strong>Air Force Suicide Prevention Program</strong>&lt;br&gt;<a href="http://afspp.afms.mil">http://afspp.afms.mil</a> | This website offers an Air Force description of their suicide prevention program and offers communities a model with elements that can be adapted for communities. |
| <strong>American Association of Suicidology</strong>&lt;br&gt;<a href="http://www.suicidology.org/home">http://www.suicidology.org/home</a> | This organization advance Suicidology as a science; encouraging, developing and disseminating scholarly work in suicidology. Many clinical resources are available. |
| <strong>American Association of Suicidology Clinician Survivor Task Force</strong>&lt;br&gt;<a href="http://mypage.iu.edu/~jmcintosh/basicinfo.htm">http://mypage.iu.edu/~jmcintosh/basicinfo.htm</a> | Develops and provides postvention for clinicians who had lost a patient to death by suicide. |
| <strong>Charting the future of suicide prevention: A 2010 progress review of the national strategy and recommendations for the decade ahead</strong>&lt;br&gt;<a href="http://www.sprc.org/sites/sprc.org/files/library/ChartingTheFuture_Full">http://www.sprc.org/sites/sprc.org/files/library/ChartingTheFuture_Full</a> book.pdf | This document reviews developments in the field of suicide prevention since the National Strategy for Suicide Prevention was published. |
| <strong>Depression Screening</strong>&lt;br&gt;<a href="http://www.mentalhealthamerica.net/llw/depression_screen.cfm">http://www.mentalhealthamerica.net/llw/depression_screen.cfm</a> | Mental Health America has a Depression Screening site as part of their Campaign for America’s Mental Health. The webpage educates people about clinical depression, offers a confidential way for people to get screened for symptoms of the illness, and guides people toward appropriate professional help if necessary. |
| <strong>International Association for Suicide Prevention (IASP)</strong>&lt;br&gt;<a href="http://www.iasp.info/">http://www.iasp.info/</a> | IASP is dedicated to preventing suicidal behavior, to alleviate its effects, and to provide a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors. |
| <strong>National Suicide Prevention Lifeline</strong> | The National Suicide Prevention Lifeline |</p>
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<tr>
<th><strong>Suicide Assessment, Treatment, and Management</strong></th>
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<td><strong><a href="http://www.suicidepreventionlifeline.org/">http://www.suicidepreventionlifeline.org/</a></strong></td>
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<td><strong>National Alliance on Mental Illness</strong>&lt;br&gt;<a href="http://nami.org">http://nami.org</a></td>
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<td><strong>S.O.S (Signs of Suicide)</strong>&lt;br&gt;<a href="http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/">http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/</a></td>
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<tr>
<td><strong>Suicide Prevention Resource Center</strong>&lt;br&gt;<a href="http://www.sprc.org/">http://www.sprc.org/</a></td>
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Suicide Assessment, Treatment, and Management

| Substance Abuse and Mental Health Services Administration (SAMHSA )  
http://www.samhsa.gov/ | different ethnic groups and vulnerable populations.  
A division of the U.S. Department of Health and Human Services, SAMHSA provides leadership in promoting quality behavioral health services to local communities throughout the country, through grants and funding for research and programs. |
References


Castle, K., Conner, K., Kaukeinen, K., & Tu, X. (2011). Perceived racism, discrimination, and acculturation in suicidal ideation and suicide attempts


http://health-equity.pitt.edu/866/1/sma-01-3613.pdf


American Psychological Association.


