**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
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, 2007Williams 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 a 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 underrepresented 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 and Pain**

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.

Given the connection between suicide and chronic medical conditions, it is helpful to consider the reasons/attribution that result in suicidal thoughts. There may be a number of potential reasons 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.

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. In studies of suicide notes, Joiner et al. (2002) found that raters detected more expressions of burdensomeness in the notes of people who had died by suicide compared to the notes of those who intended to die but survived.

Kanzler et al. (2012) applied the test of perceived burdensomeness to patients with chronic pain. Kanzler and his colleagues conducted a retrospective study that examined the relationship between depression, perceived burdensomeness, and suicidal ideation in a patient sample seeking behavioral treatment for chronic pain management. Results of the study indicated that perceived burdensomeness was the sole predictor of suicidal ideation, even in the presence of other well-established risk factors such as age, gender, depressive symptoms, and pain severity.

The connection between chronic medical conditions and suicide suggest the need for screening for suicidal ideation and behavior in medical settings.

*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.

Summary of risk factors

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

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.

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
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; Niederkotenthaler 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 (DMS-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.

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 molestation 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.

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.

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.

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).

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, particularly anorexia nervosa, are a risk factor for suicide. 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. Suicide attempts are also seen in individuals with bulimia and in those with co-morbid mood disorders, aggression, or impulsivity. People who attempt suicide may have increased rates of abnormal eating behaviors. Clinicians should be attentive to the presence of eating disorders and especially the co-occurrence of eating disorders with behaviors or symptoms such as deliberate self-harm or depression.
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 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
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. The suicide rate among Native American youth is also high; Suicide represents the second-leading cause of death among American Indian/Alaska Native (AI/AN) youth aged 15-24 years.

Shaughnessy, Doshi, & Jones (2004) looked at suicide and risk behaviors among Native American Youth. Data from the 2001 Bureau of Indian Affairs (BIA) Youth Risk Behavior Survey were used to examine the association between attempted suicide among high school students and unintentional injury and violence behaviors, sexual risk behaviors, tobacco use, and alcohol and other drug use. The study included students in BIA-funded high schools. Overall, 16% of BIA high school students attempted suicide one or more times in the 12 months preceding the survey. In addition to suicide attempts, youth who attempted suicide were more likely than youth who did not attempt suicide to engage in every risk behavior analyzed: unintentional injury and violence behaviors, sexual risk behaviors, tobacco use, and alcohol and other drug use.

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).

One challenging 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.

While these challenges do exist, it is also important to look at protective factors. Spirituality has been shown to be a buffer against suicidality in Native Americans. A recent study by Garoutte and colleagues (2003) indicates that a commitment to spirituality in the form of high endorsement of cultural spiritual orientations is associated with a decrease in the number of reported suicide
Suicide Assessment, Treatment, and Management

attempts. Perceived strong family connectedness, social support, and affective relationships with tribal leaders, have also been demonstrated to have a protective effect in the reduction of suicidal behaviors (Borowsky et al., 1999). Positive attitudes toward education, perceived interpersonal communication skills, as well as habitual discussion of problems with friends or family members, were also correlated with fewer reporting of suicidal behaviors in these studies. Cultural continuity — set of shared attitudes, values, goals, and practices — is also emerging as a useful construct in understanding Native American youth suicide. The presence of cultural continuity was associated with low/reduced rates of suicide in certain Native American communities (Chandler et al., 2003).

The American Indian Community Suicide Prevention Assessment Tool was developed by the One Sky Center, a national resource center for American Indians and Alaska Natives. It is dedicated to improving the prevention and treatment of substance abuse and mental health disorders across Indian Country. The tool is designed as a template for assessing risk and protective factors within a Native community. It also is helpful in identifying available and needed prevention resources. Aspects of community health, such as the economic status of the Tribe, community readiness, and community self-help are integrated into a holistic evaluation of prevention opportunities. Some of the suggested uses of this tool include internal program assessment and planning. It can download the tool free from the One Sky Center Web site at http://www.oneskycenter.org/osc/presentationspublications/publications/

Elderly Clients

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 underreported 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

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).

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. Middle-age homeless individuals are at highest risk. 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.

Much of the research has centered on homelessness and youth. Many homeless youth come from backgrounds in which there are abusive, neglectful, and unstable family histories, factors that appear to increase risk. Additionally substance abuse, depression, legal and academic difficulties and LGBTQ orientation are risk factors for this population (Noell & Ochs, 2001).

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 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. 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). Adolescents who had been in foster care were nearly four times more likely to have attempted suicide than other youth (Pilowsky & Wu, 2006). Many youth in foster care are there because of experiences of instability in the home environment. 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).

Risk factors among youth in foster care include:

- Mental illness including substance abuse
- Prior suicide attempt
- Self injury
- Abuse and neglect
- Trauma
- Parental mental illness and substance abuse
- Family conflict and dysfunction
- Family history of suicidal behavior
- Poor coping skills
- Social/interpersonal isolation/alienation
- Exposure to suicides and attempts
- Suicide means availability/firearm in household
- Violence and victimization
- Being bullied, bullying

A number of factors should be considered in reducing risk. These include supporting 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.

**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 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).

**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 (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 which 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. Worchel 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. Suicide contracts are the best way to ensure safety. Lewis (2007) conducted a review of the literature on the use of no suicide contracts (NSC). The author found that the existing research does not support the use of such contracts as a method for preventing suicide, nor for protecting clinicians from malpractice litigation in the event of a client suicide. A safety agreement or safety plan may be more effective as a way to support clients.

4. “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.

5. 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).

6. 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
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. According to APA guidelines, the following factors have been found to increase suicide risk:

**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

**Psychiatric diagnoses**
- Major depressive disorder
- Bipolar disorder (primarily in depressive or mixed episodes)
- Schizophrenia
- Anorexia nervosa
- Alcohol use disorder
- 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

**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)
Family history of mental illness, including substance use disorders

**Psychological features**
Hopelessness
Psychic pain
Severe anxiety
Shame
Decreased self-esteem
Extreme narcissistic vulnerability
Impulsiveness
Aggression

**Cognitive features**
Loss of executive function
Thought constriction
Polarized thinking

**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 firearms
Substance intoxication
Unstable or poor therapeutic relationship

*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
Develop a safety plan collaboratively with the client
Provide emergency contacts, including a crisis line
Consider medication/hospitalization if symptoms persist or worsens

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
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. Additionally ECT may be used if therapy and medication proves unsuccessful or in cases of chronic suicidal ideation and attempts (APA, 2003).

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.

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.

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.

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 posttreatment, 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.

**Care for the Clinician**

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. 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.

Signs of Burnout

Burnout, as described previously, 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, headaches, weight shifts), behavioral (e.g., calling off from work, indecisiveness), psychological (e.g., depression, anxiety, guilt) or spiritual (e.g., loss of faith, despair) or clinical (cynicism, boredom, blaming clients). 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 clinicians feel as they engage and maintain empathetic connections with suicidal clients. Secondary traumatic stress can also occur following a client suicide.

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

Antidotes to Burnout/Secondary Traumatic Stress

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
• Engage in positive coping skills
• Exercise
• Work-life balance (time for hobbies, leisure, family and friends)
• Pace the work
• Meditation and mindfulness skills
• Avoid 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**

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.

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

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

5. 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).

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

7. Take preventive measures (as discussed above), such as hospitalization, consultation with family or friends.

8. Seek consultations from professional colleagues who have expertise in treating suicidal patients.

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" (see Appendix) 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 a binding agreement between therapist and client (i.e., as a Safety Contact, which is both clinical and risk-based). 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 contracting 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 contract for safety in any population is limited, particularly in adolescent populations. A legal review revealed that contracting for safety does not protect against legal liability. 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 patients' immediate distress related to safety through the clinical relationship. These authors state that value of a safety agreement lies not in the tool itself but in its promotion of a clinical relationship that involves communication and
collaboration.
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

Safety Plan

The following are strategies I can employ when feeling unsafe:

1) Situations, thoughts or warning signs that I am unsafe:

2) Family member or friends I can talk with (list names and phones #s):

3) Some things that are soothing/comforting I can do:

4) Other safety actions that I can do are:

5) 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):

6) Professionals/safety hotline phone number:

Keep this written plan in a place where you can access it
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

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
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<tr>
<td><strong>Air Force Suicide Prevention Program</strong></td>
<td>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.</td>
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<td><strong>Charting the future of suicide prevention: A 2010 progress review of the national strategy and recommendations for the decade ahead</strong></td>
<td>This document reviews developments in the field of suicide prevention since the National Strategy for Suicide Prevention was published.</td>
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<td><strong>Depression Screening</strong></td>
<td>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.</td>
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<td><strong>International Association for Suicide Prevention (IASP)</strong></td>
<td>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.</td>
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<td><a href="http://www.suicidepreventionlifeline.org/">http://www.suicidepreventionlifeline.org/</a></td>
<td>Prevention Lifeline provides confidential support to people in suicidal crisis 24 hours a day, 7 days a week (1-800-suicide). It also operates a Veterans Crisis line (1-800-273-TALK).</td>
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<td>National Alliance on Mental Illness <a href="http://nami.org">http://nami.org</a></td>
<td>A nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders.</td>
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<td>S.O.S (Signs of Suicide) <a href="http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/">http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/</a></td>
<td>SOS is a school-based prevention program that incorporates two prominent suicide prevention strategies into a single program, combining a curriculum that aims to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors. The educational component is expected to reduce suicidality by increasing middle or high school students’ understanding of and promoting more adaptive attitudes toward depression and suicidal behavior. The self-screening component enables students to recognize depression and suicidal thoughts and behaviors in themselves and prompts them to seek assistance.</td>
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<td>Suicide Prevention Resource Center <a href="http://www.sprc.org/">http://www.sprc.org/</a></td>
<td>Promotes a public health approach to suicide prevention and includes suicide prevention basics, news and events, a training institute, best practices registry, and a library of resources. There are additional training documents specific to</td>
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different ethnic groups and vulnerable populations.

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<th>Substance Abuse and Mental Health Services Administration (SAMHSA)</th>
<th>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.</th>
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</table>
References


Assari, S., Lankarani, M. M., & Moazen, B. (2012). Religious beliefs may reduce the negative effect of psychiatric disorders on age of onset of suicidal


National Center for Injury Prevention and Control (2007). WISQAR fatal


