Suicide Assessment and Treatment

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, or 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.

This document will provide guidelines on managing suicidality. After completing this course the participant will:

- Discuss prevalence of suicide
- 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 ethic and racial groups
- List issues in assessing suicidal risk, including suicide myths, common warning signs, assessment questions and ensuring therapeutic alliance
- Outline ethical and legal considerations
- Discuss issues pertinent to suicide survivors
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.

- 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).

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.

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).

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 identical than 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.

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

Other studies have examined the impact of specific pain conditions on suicide risk. For example, two separate studies evaluated patients with fibromyalgia. Dreyer et al. ((2010) conducted a 15-year prospective cohort study of 1,269 Danish patients with fibromyalgia. They found that although these women were not at increased risk for all-cause mortality compared to the general population, they were at increased risk of death from suicide. Wolfe et al. (2011) evaluated 8,186 patients with fibromyalgia who were seen at three different sites in the United States. They found that individuals with fibromyalgia were at least three times as likely of successfully completing suicide as compared to the general population.
Chronic pain has many psychological ramifications including increased depression, feelings of hopelessness or helplessness, or a lack of control over symptoms (death being one thing within the person’s control). Other contributing factors are chronic pain, insomnia and adverse effects of medications.

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

**Environmental Stressors**

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

Suicide is also connected to more prolonged stress, such as relationship conflict, harassment or bullying. Bullying is particularly problematic in adolescents (Shireen et al., 2014; van Geel et al., 2014) and others who are different from the norm, due to issues such as Aspergers/autism (Richa et al., 2014) and sexual orientation (Carney, 2014; Stone et al., 2014; Mustanski et al., 2014).

**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
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.

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.

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
- Support from ongoing medical and mental health care relationships
- Easy access to a variety of clinical interventions and support
- Cultural and religious beliefs that discourage suicide
- 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).

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.

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.
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.)

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 completion (Bertolote & Fleischmann, 2002; Dhossche, Meloukheia & Chakravorty, 2000; Lejoyeux et al., 2008; Kutcher and Chehil, 2007). Substance abuse as a board 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-
comorbid alcoholism and depression (Schneider, 2009; Niederkrotenthaler et al.,
2014; Beghi et al., 2013). Alcohol and drug abuse are second only to mood
disorders as the most frequent risk factors for suicidal behaviors. In 2008,
alcohol was a factor in approximately one-third of suicides reported in 16
states (Karch, Logan & Patel, 2011). Substance use is also an increased risk
factor in sexual minority youth (Savin-Williams & Ream, 2003).

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

The most researched conditions are combined depression and substance
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, depress 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.

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, 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 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, the risk of suicide attempt was significantly increased in the presence of multiple rapes and multiple sexual molestations as well as with higher rates of physical assault. Research has also helped clarify the link between early childhood adverse events and suicide later in life, and of the role of connectedness in protecting individuals from a wide range of health problems, including suicide (CDC (c)). 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 high 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 of 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 that 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 will be discussed later in this training material.

**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.

**Traumatic Brain Injury (TBI) and Suicide**

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

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

Suicidal ideation and attempts may be directly associated with some of the effects of the traumatic brain injury. These include the physical effects, such as change in eyesight (limiting driving ability and independence), difficulty with balance and coordination, and inability to use certain motor functions; the cognitive effects, such as difficulty concentrating, making decisions/judgment, or expressing oneself, and aphasia; and the behavioral effects such as becoming angry and frustrated easily, and acting without thinking. There may also be mood-related changes, including apathy, anxiety, egocentricity, emotional lability and depression. The risk of suicide attempts increases if the individual also has post-injury psychiatric/emotional disturbance and substance abuse problems (Simpson & Tate, 2005).
Risk factors for suicide in individuals with traumatic brain injury include loss of support systems (loneliness and isolation), loss of job and income levels, and change of roles within the family unit. Screening, even many years after the injury, for post-TBI related psychiatric sequelae is indicated (Kemp et al., n.d.).

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

**Emotional Regulation and Suicide**

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

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

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.

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.

**Suicide and Childhood Sexual Abuse**

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

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

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

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

**Suicide and the Armed-Forces**

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

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

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

Elderly Clients

The 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.

Risk and protective factors for suicide among the elderly have been extensively studied (Van Orden et al., 2014; Conwell, Van Orden & Caine, 2011). Risk factors include:
• Increasing age
• Male gender
• Being single or divorced, or living alone
• Social isolation/closed family systems
• Generational biases against mental health services
• Poor physical health or illness, particularly inadequate pain control;
• Losses (health, status, social roles, independence, significant relationships)
• Grief
• Depression
• Fear of institutionalization
• Frailty

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

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

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

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

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

**Teen Suicide**

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

Suicidal distress in teens can be caused by psychological, environmental and social factors. Risk factors for teen suicide include:

- Mental illness (depression, anxiety, psychotic disorders) and substance abuse (Brenton et al., 2015; Fleischmann et. al, 2005)
- Previous suicide attempts (Beautrais, SLTB, 2004)
- Exposure to friends’ or family members’ suicidal behavior (Borowsky et al., 2001)
- Low self-esteem
- Neurological and developmental factors (Manceaux & Zdanowicz, 2015)
- Cyberbullying (Sampasa-Kanyinga & Hamilton, 2015) and other experiences of victimization
- Firearms in the household (American Association of Suicidiology, 2012)
- Nonsuicidal self injury (American Association of Suicidiology, 2012)

The risk for suicide frequently occurs in combination with external circumstances that seem to overwhelm at-risk teens that have predisposing vulnerabilities such as mental health issues. Examples of stressors are disciplinary problems, interpersonal losses, family violence, sexual orientation confusion, physical and sexual abuse and being the victim of bullying.
In 2015 SAMHSA released a consensus statement on Warning Signs for Youth Suicide. These signs are based on the collaboration of several expert organizations including American Association of Suicidology, Columbia University, the Indian Health Service, the National Center for the Prevention of Youth Suicide and The Trevor Project.

These factors include:

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

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

- Family connectedness and school connectedness (Kaminski et al., 2010)
- Reduced access to firearms (Grossman et al., 2005)
- Safe schools (Eisenberg et al., 2007)
- Academic Achievement (Borowsky et al., 2001)
- Self-esteem (Sharaf et al., 2009)

**The Homeless**

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

While some of these people are living in homeless shelters or transitional living arrangements, many others are unsheltered. This is due in part to the scarcity of low-income housing.
Middle-age homeless individuals are at highest risk. Suicide is also the leading cause of non-natural death among homeless older veterans. Risk factors for suicide among the homeless are similar to the population at large and include alcohol and/or drug abuse, psychiatric history (particularly the presence of schizophrenia), and inpatient hospitalizations.

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

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

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

*Incarcerated Individuals*

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

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

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

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

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

Foster Care

There is also concern that youth in the foster care system may be at an increased risk for suicidal behaviors and other related problems (Leslie et al., 2010). In 2006, over 3.5 million US children were reported as abused and neglected, with 905 000 confirmed victims (US Department of Health and Human Services, Administration for Children and Families, Children’s Bureau 2008). When a child’s safety cannot be assured in the home, he or she is often removed by child protective services and placed into the foster care system.
Adolescents who had been in foster care were about two and a half times more likely to have seriously considered suicide and almost four times more likely to have attempted suicide than other youth (Pilowsky & Wu, 2006). Most youth who die as a result of suicide have a psychological disorder such as depression, severe anxiety or a substance use disorder. Youth in foster care are more likely to have a mental disorder or substance use disorder than those who were never in foster care (Pilowsky & Wu, 2006; Pecora et al., 2009).

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

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

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

Other common risk factors among youth in foster care include:

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

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

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

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 (Borowsky 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 et 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).

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, 2011). As will be discussed later, these factors also apply to African Americans.

**African Americans**

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

Many of the risk factors found across all populations apply to African Americans (e.g., prior suicide attempt(s), substance abuse, mood and anxiety disorders family violence (intimate partner abuse, childhood trauma), relationship discord and access to lethal means). Triggering events causing shame or despair may heighten risk.

Additional risk factors include: being divorced or widowed (Joe et al., 2006); negative interaction with family members (Lincoln et al., 2013; Price, Dake, & Kucharewski, 2001); increased acculturation into White society (Castle et al., 2011); and the impact of hopelessness, racism, and discrimination (Hirsch et al., 2012). According to Williams & Williams-Morris (2000), racial stereotypes and negative images can be internalized, denigrating individuals’ self-worth.
and adversely affecting their social and psychological functioning; racism and discrimination have resulted in minorities' lower socioeconomic status and poorer living conditions in which poverty, crime, and violence are persistent stressors that can affect mental health; and racism and discrimination are stressful events that can directly lead to psychological distress and physiological changes affecting mental health.

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

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

The significant protective factors found for all populations apply for African Americans: effective mental health care; connectedness to individuals, family, community, and social institutions; problem-solving skills; contacts with caregivers (Suicide Prevention Resource Center & Rodgers, P., 2011). Adaptive traditions have sustained African Americans through long periods of hardship imposed by the larger society. Their resilience is an important protective resource. Additionally, research has shown significant protective factors in African American populations, particularly the role of spirituality and religious beliefs.

Neeleman, Wessely & Lewis (1998) found that the comparatively low level of suicide acceptability among African-Americans high levels of orthodox religious beliefs and personal devotion was protective against suicide. Taylor, Chatter and Joe (2011) also found as a protective factor participation in organized religious practices, such as church attendance. In fact, Among
African American with psychiatric disorders, religiosity has been found to delay age of onset and to decrease the number of psychiatric disorders (Assari, Lankarani, & Moazen, 2012).

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

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

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

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

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
Suicide Assessment and Treatment, 32

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.

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).

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.

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.

Native Americans

One of the most at-risk groups for suicide is Native Americans. According to CDC statistics, during 2005–2009, the highest suicide rates were among American Indian/Alaskan Native males with 27.61 suicides per 100,000. Within Native American communities, the group at the highest risk for suicide attempts is females between the ages of 15 and 24. Those at highest risk of completed suicides are males in the same age group; suicide represents the second-leading cause of death among American Indian/Alaska Native (AI/AN) youth aged 15-24 years (U.S. Department of Health and Human Services, 2010).

There are a number of risk factors associated with suicidality among Native Americans. Worchel and Gearing (2010) found that these risk factors include depression, alcohol and substance use, being a victim of violence, previous suicide attempts, friends or family members attempting/completing suicide (contagion), physical or sexual abuse, family disruption, and loss of native/ethnic identity. Additionally many Native Americans have had negative boarding school experiences, family histories of mental illness, historical trauma and cultural distress as well as poverty, unemployment, geographic isolation, and other environmental factors (Walker, Walker & Bigelow, 2006).
The role of historical trauma is one that is unique to Native Americans within the predominant culture and thus merits additional consideration. Broadly defined, historical trauma is defined as an event or events that affect multiple generations of a particular culture. For Native Americans there has been the historical trauma of forced relocation known as the Trail of Tears. The Indian Removal Act of 1830 mandated relocation of members of the Cherokee, Muscogee, Seminole, Chickasaw, and Choctaw nations from their ancestral homelands in the southeastern U.S. to an area west of the Mississippi River that had been designated as Indian Territory. This is one widespread example of such actions. A related trauma was the removal of children who were sent to boarding schools during the late 19th and early 20th centuries. Originally established by Christian missionaries, these Boarding Schools immersed children in European-American culture through appearance changes with haircuts; children were forbidden to speak their native languages, and traditional names were replaced by new European-American names. In numerous ways, children were encouraged or forced to abandon their Native American identities and cultures. While today tribal nations have increasingly insisted on community-based schools and have also founded numerous tribal colleges and universities, these memories are still fresh for many Native American families.

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

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

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

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

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

For more information on supporting Native American clients, including the American Indian Community Suicide Prevention Assessment Tool developed by the One Sky Center, a national resource center for American Indians and Alaska Natives, please see the One Sky Center Web site at http://www.oneskycenter.org/osc/presentationspublications/publications/
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 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. 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>
</tr>
</thead>
<tbody>
<tr>
<td>No reason for living, or no sense of</td>
<td>Increased substance use</td>
</tr>
<tr>
<td>purpose in life</td>
<td>Withdrawal from friends, family and/or society</td>
</tr>
<tr>
<td>Feeling trapped, like there’s no way</td>
<td>Rage, anger, revenge-seeking behavior</td>
</tr>
<tr>
<td>out</td>
<td>Reckless or risky decision making and actions</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Unable to sleep or sleeping all the time</td>
</tr>
<tr>
<td>Dramatic mood changes</td>
<td></td>
</tr>
<tr>
<td>Anxiety/agitation</td>
<td></td>
</tr>
</tbody>
</table>

**Assessment Process**

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.

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. This information 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.
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).

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 a 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
Treatment of Client Suicidality

The training material thus far has presented the foundation for working with suicidal clients. Treating clinicians should also be aware of appropriate strategies for working with clients who express suicidal thoughts and demonstrate self-harm behaviors.

Ethical and Legal Issues

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:

- Informed Consent
- Confidentiality
- Duty to Protect/Confidentiality

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.

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. While this is separate from provision of treatment, effective risk management strategies also aid appropriate treatment interventions.

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; 3) there is a direct causal relationship between the clinician’s actions and the suicidal act (Bongar, 2002).

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 relevant literature.

2. Conduct a complete suicide assessment with every client, using the questions in this material as a guide.

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. (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 background
(d) what low-risk factors were present (such as reasons to live, care of minor child, etc.)
(e) what information led to actions taken and rejected

_Suicide/Safety Contracts and Risk Management_

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

Safety plans (also called Crisis Response Plans) can be viewed within clinical context (as part of an overall strategy for helping to increase client safety) or as 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).
Supporting Family and Friends Following Suicide

Case Study

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

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

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

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

Acute Grief
Grief is not a state, but a process (Zisook & Shear, 2009). In the acute grieving process, emotions are often intense. Shock is a common immediate reaction, especially to a death by suicide, as are feelings of numbness, disorientation. This denial phase may be adaptive as it allows survivors to manage the realities of loss, such as planning a funeral or settling an estate. It may be some time following the death when the reality of loss settles in. At this point, survivors of suicide may experience symptoms of depression, including disturbed sleep, loss of appetite, and difficulty concentrating, intense sadness, and lack of energy. In a death from suicide, there may also be PTSD-type responses, such as intrusive images, depersonalization, and a state of feeling overwhelmed. Anger towards the deceased, another family member, a therapist, or oneself is also common. Guilt around actions taken or not taken may also occur. At first, these acute feelings of sadness may seem like they will never end.

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

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

Integrated Grief

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

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

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

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

Complicated Grief

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

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

- Continued waves of emotions/swings in mood
- Intense longing for the deceased and preoccupation with thoughts of deceased
- Disbelief regarding the death, anger and bitterness, distressing, intrusive thoughts related to the death, and avoidance of reminders of the death
- Intense guilt or feelings of responsibility for the death, a ruminative need to explain or make sense of the death
- Strong feelings of rejection, abandonment, anger at the deceased
- Shame about the manner of death
• A change in personal identity (e.g., no longer viewing oneself as a “good” parent)

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

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

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

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

Interventions

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

Generally interventions for suicide loss are supportive or psychoeducational. It may be helpful to provide information about things including causes of suicide and its impact on the family system and to normalize emotions such as sadness or anger. An additional focus is the need for survivor self-care.
Guidelines for clinicians include:

- Therapists should recognize and be aware of their attitudes, including prejudices, about suicide
- Be present with survivors’ pain rather than trying to “fix” it; listen
- Allow the ability for survivors to integrate the loss into their narratives
- Be aware of the causes, impact, family affects of suicide and be able to communicate these to survivors
- Set realistic expectations about the grieving process, including the uniqueness of each situation
- Be empathic and compassionate

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


Colucci, E & Martin, G. (2008). Religion and spirituality along the suicidal path. Suicide and Life Threatening Behavior, 38(2), 229-44.


Kanzler, K.E. et al., (2012). Suicidal ideation and perceived burdensomeness
Suicide Assessment and Treatment, 60

in patients with chronic pain.


Suicide Assessment and Treatment, 61


Journal of Affective Disorders, 34, 173-185.


Mustanski et al. (2014). A syndemic of psychosocial health disparities and associations with risk for attempting suicide among young sexual minority
men.


Nepon, J. et al. (2011). The Relationship Between Anxiety Disorders and Suicide Attempts: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. Depression and Anxiety, 27(9), 791–798.


Suicide Assessment and Treatment, 65


Shireen et al. (2014). Trauma experience of youngsters and Teens: A key issue in suicidal behavior among victims of bullying? Pakistan Journal of


U.S. Department of Health and Human Services (2010). To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults. DHHS Publication SMA (10)-4480, CMHS-NSPL-0196, Printed 2010. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.


