Introduction

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

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

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

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

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

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

This document will provide guidelines on suicide assessment, treatment and management. 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 ethnic 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
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 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. There may be a number of potential reasons including increased depression, feelings of hopelessness or helplessness, or a lack of control over symptoms (death being one thing within the person’s control). Other contributing factors are chronic pain, insomnia and adverse effects of medications.

People with chronic medical conditions often express the idea that they are a “burden” to their families. Joiner (2009) describes perceived burdensomeness as the idea that “my death will be worth more than my life to family, friends, society, etc.” This author cites a number of studies that support the link between perceived burdensomeness and suicide. He also states that direct tests of the theory have been supportive.

**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 states.

**Biological Bases of Suicide**

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

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

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

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

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

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

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

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

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

**Schizophrenia and Suicide**

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

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

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

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

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

**Anxiety Disorders and Suicide**

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

Sareen et al., (2005) conducted a prospective population-based survey of adults in the Netherlands who were diagnosed with social phobia, simple phobia, generalized anxiety disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder. This is the first study to demonstrate that a preexisting anxiety disorder is an independent risk factor for subsequent onset of suicidal ideation and attempts. After adjusting for sociodemographic factors and all other mental disorders assessed in the survey, baseline presence of any anxiety disorder was significantly associated with suicidal ideation and suicide attempts. Among the specific anxiety disorders, the study found that OCD, social phobia, and GAD were strongly linked with SI at baseline and follow-up. The presence of an anxiety disorder in combination with a mood disorder increased the likelihood of suicidal behavior. These findings underscore the importance of early recognition and treatment of anxiety disorders, especially those with comorbid mood disorders.
Nepon et al. (2011) attempted to tease out the presence of personality issues from anxiety disorders in looking at suicide attempters. These researchers reviewed data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). The data showed that among individuals reporting a lifetime history of suicide attempt, over 70% had an anxiety disorder. Even after adjusting for sociodemographic factors, Axis I and Axis II disorders, the presence of an anxiety disorder was significantly associated with having made a suicide attempt.

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

**Trauma, Personality Disorders and Suicide**

A history of trauma, particularly repeated trauma, also appears to influence suicide attempts and gestures. Nock and Kessler (2006) studied a sample of 268 people who had made suicide attempts. They found that respondents who had been raped or experienced sexual molestation did not differ significantly between suicidal gestures and attempts, however, the risk of suicide attempt was significantly increased in the presence of multiple rapes and multiple sexual molestatons 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 higher incidences of suicide. Bennett et al., (2006) addressed the high-risk group of patients diagnosed with Cluster B personality disorders such as borderline personality disorder (BPD). They describe these patients as often having chronic thoughts of suicide and heightened levels of self-mutilation, gestures and attempts.

The hallmarks of personality disorders are impairment in personality (defined as self/other functioning), one or more pathological personality traits, and the relative stability of these impairments across environments. Personality disorders include antisocial personality disorder, avoidant personality disorder, borderline personality disorder, narcissistic personality disorder, obsessive-compulsive personality disorder and schizotypal personality disorder. Of these disorders, borderline personality disorder is the most researched in terms of suicidality.
Typical features of borderline personality disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy (DSM-5, 2013, p. 766). All of these characteristics may be related to suicidality. Additionally, the personality traits of emotional lability, impulsivity, depression, risk-taking and hostility have also been cited as factors in suicide attempts and completion.

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

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

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

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

One significant contribution has been Linehan’s Dialectical Behavior therapy. The effectiveness of DBT in reducing suicide has been shown in a number of studies (Gagliesi, 2010; Hamed et al., 2008; Linehan et al., 2006; McMain, et al., 2009). DBT 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.

**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 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
Native Americans

One of the most at-risk groups for suicide is Native Americans. According to CDC statistics, during 2005–2009, the highest suicide rates were among American Indian/Alaskan Native males with 27.61 suicides per 100,000. The suicide rate among Native American youth is also high; Suicide represents the second-leading cause of death among American Indian/Alaska Native (AI/AN) youth aged 15-24 years.

There are a number of risk factors associated with suicidality among Native Americans. Worchel and Gearing (2010) found that these risk factors include depression, alcohol and substance use, being a victim of violence, previous suicide attempts, friends or family members attempting/completing suicide (contagion), physical or sexual abuse, family disruption, and loss of native/ethnic identity. Additionally many Native Americans have had negative boarding school experiences, family histories of mental illness, historical trauma and cultural distress as well as poverty, unemployment, geographic isolation, and other environmental factors (Walker, Walker & Bigelow, 2006).

One challenging aspect in recognizing suicidal ideation in Native American people concerns “politeness theory.” In Native culture, people considering suicide may not be more direct in making their personal pain known in order to avoid placing a burden on others. Additionally vague or indirect calls for help helps protect them from their own embarrassment if others fail to respond. Additionally there is a cultural stigma against suicide and following a suicide attempt.

While these challenges do exist, it is also important to look at protective factors. Spirituality has been shown to be a buffer against suicidality in Native Americans. Perceived strong family connectedness, social support, and affective relationships with tribal leaders, have also been demonstrated to have a protective effect in the reduction of suicidal behaviors (Borowsky et al., 1999).

The American Indian Community Suicide Prevention Assessment Tool was developed by the One Sky Center, a national resource center for American Indians and Alaska Natives. It can downloaded from the One Sky Center Web site at http://www.oneskycenter.org/osc/presentationspublications/publications/

Elderly Clients

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

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

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

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

**The Homeless**

The lifetime prevalence of suicide among the homeless has been estimated to be as high as 66% (Eynan et al., 2002; Desai et. al, 2003), especially among those with mental illness. Middle-age homeless individuals are at highest risk. Risk factors for suicide among the homeless are similar to the population at large and include alcohol and/or drug abuse, psychiatric history (particularly the presence of schizophrenia), and inpatient hospitalizations.

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

**Incarcerated Individuals**

Suicide is a major public health issue among incarcerated individuals, both in the U.S. and worldwide. According to the World Health Organization (WHO) and the International Association for Suicide Prevention (IASP), Suicide is often the single most common cause of death in correctional settings (WHO/IASP, 2007). Hayes (2005) found suicide to be the most common cause of death in secure justice settings, with more than 400 suicides each year in local jails at a rate three times greater than among the general population.

A combination of individual and environmental factors likely accounts for the higher rates of suicide in correctional settings. Jails and prisons contain vulnerable groups that are traditionally among the highest risk for suicide, including young males, persons with mental disorders, people who are socially disenfranchised or socially isolated, people with substance use problems, and those who have had previous suicidal behaviors. The experience of incarceration may be particularly difficult for juvenile offenders who are separated from their families and friends. There is also the psychological impact of the arrest, and the stresses of prison life (WHO/IASP, 2007).

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

**Foster Care**

There is also concern that youth in the foster care system may be at an increased risk for suicidal behaviors and other related problems (Leslie et al., 2010). Adolescents who had been in foster care were nearly four times more likely to have attempted suicide than other youth (Pilowsky & Wu, 2006). Many youth in foster care are there because of experiences of instability in the home environment. Experiencing childhood abuse or trauma increased the risk of attempted suicide 2- to 5-fold (Dube et al., 2001). Adverse childhood
experiences play a major role in suicide attempts. One study found that approximately two thirds of suicide attempts may be attributable to abusive or traumatic childhood experiences (Dube et al., 2001).

Risk factors among youth in foster care include:

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

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

Culture and Ethnicity As Risk Factors

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

Suicide Trends By Culture/Ethnicity

Caucasians

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

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

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

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

African Americans

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

Many of the risk factors found across all populations apply to African Americans (e.g., Prior suicide attempt(s), substance abuse, mood and anxiety disorders and access to lethal means). Triggering events causing shame or
despair may heighten risk.

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.

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).

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 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.

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

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.
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 purpose in life</td>
<td>Increased substance use</td>
</tr>
<tr>
<td>Feeling trapped, like there’s no way out</td>
<td>Withdrawal from friends, family and/or society</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Rage, anger, revenge-seeking behavior</td>
</tr>
<tr>
<td>Dramatic mood changes</td>
<td>Reckless or risky decision making and actions</td>
</tr>
<tr>
<td>Anxiety/agitation</td>
<td>Unable to sleep or sleeping all the time</td>
</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 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
Managing Suicidal Clients

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

Clinicians should:

Evaluate risk on an ongoing/recurrent basis, especially the need for a secure environment or hospitalization
Increase in frequency or duration of outpatient visits
Reevaluate treatment goals that address symptom remission, improved hopefulness, improved problem-solving/adaptive coping, improved self-control and self-esteem
Establish a support system
Develop a safety plan collaboratively with the client
Provide emergency contacts, including a crisis line
Consider medication/hospitalization if symptoms persist or worsen

Guidelines for Hospitalization

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

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

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

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

In cases of acute suicidality, hospitalization may be required to ensure safety. Additionally ECT may be used if therapy and medication proves unsuccessful or in cases of chronic suicidal ideation and attempts (APA, 2003).

Psychodynamic Therapies

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

Alliance-Based Therapy (ABT)

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

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

Interpersonal Psychotherapy (IPT)

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

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

*Cognitive Behavioral Therapy*

Cognitive-behavioral therapy (CBT) integrates a problem-solving approach as a core intervention for reducing suicidal ideation, and related symptomatology such as depression, hopelessness, and loneliness. Cognitive-behavioral treatment focuses on the cognitive distortions and deficits that disrupt a client’s ability to solve interpersonal problems, as well as on the capacity to regulate emotions (Rudd, 2006).

CBT describes suicidal behavior as due to vulnerabilities from certain cognitive characteristics, such as rigidity and poor problem solving and coping skills. When faced with problems, people with suicidality often have difficulty generating solutions, and may have a negative attributional style, including negative views of themselves and the future. Suicidal people will often experience distortions, irrational beliefs and ways of viewing the world that lead to hopelessness (Worchel & Gearing, 2010).

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

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

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

Clinical guidelines for CBT in suicidality are similar to that of depression or anxiety, and include targeting automatic thoughts, summarizing, and providing homework assignments to practice strategies and techniques outside of session. Additionally guidelines state that CBT treatments target suicidality directly, rather than as a symptom of another presenting disorder. Thus treatment needs to be implemented around the client's suicidality.

**Dialectical Behavior Therapy**

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

DBT is a problem-solving approach that had particular applicability to chronically suicidal and personality disordered individuals. Among chronically suicidal clients, distress tolerance tends to be low and coping resources and responses are limited (Jobes, 2000). DBT targets identified skills deficits (e.g., inability or reduced ability for emotion regulation, distress tolerance, managing impulsivity, problem-solving, interpersonal assertiveness, anger management; Rudd, 2006).

Treatment strategies that guide the treatment process are: dialectical strategies, problem-solving, irreverent communication, consultant approach directed toward the client rather than other professional, validation, capability
enhancement, relationship strategies, and contingency strategies (Linehan, 1993).

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

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

Ethical Issues

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

- 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 (Weifel, 2002). One of the most valuable tools is the strength of the therapeutic relationship and the power of the therapist to diffuse the situation. Ideally clients will be able to consent to a course of treatment that is clinically sound, such as involving a trusted family member in the safety plan.

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

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

**Risk Management**

The term risk management refers to a therapist’s efforts to identify the risk factors for suicide that may be present in a given case, and the therapist’s efforts to prevent the client from harming him or herself thus preventing the possibility of legal action.

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

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

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).
References


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


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


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.


Wadsworth, T., & Kubrin, C.E. (2007). Hispanic suicide in US metropolitan areas: examining the effects of immigration, assimilation, affluence, and


