SUICIDE: RISK, ASSESSMENT, and INTERVENTION

Presented by

CONTINUING PSYCHOLOGY EDUCATION INC.

6 CONTINUING EDUCATION HOURS

"Suicide is complicated and tragic, but it is often preventable."
National Institute of Mental Health (2022)

Course Objective

This course examines suicide with respect to risk, assessment, and intervention. The process of suicide risk assessment, including methodologies, risk and protective factors is indicated. The difference between suicide myths and realities is revealed. Three recommended suicide interventions are explored, including a suicide safety plan, cognitive behavioral therapy, and dialectical behavior therapy.

Accreditation

Continuing Psychology Education Inc. is recognized by the New York State Education Department's State Board for: Social Work as an approved provider of continuing education for licensed social workers #SW-0387, Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors #MHC-0080, and licensed marriage and family therapists #MFT-0043; Psychology as an approved provider of continuing education for licensed psychologists #PSY-0006.

Mission Statement

Continuing Psychology Education Inc. provides the highest quality continuing education designed to fulfill the professional needs and interests of mental health professionals. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives

Upon completion, the participant will be able to:

1. Discuss the prevalence of suicide.
2. Indicate common suicide risk factors.
3. Articulate relevant suicide protective factors.
4. Comprehend the process of suicide risk assessment.
5. Understand the difference between suicide myth and reality.
6. Describe the seven steps of a suicide safety plan.
7. Convey the cognitive behavioral therapy approach for suicidal thinking.
8. Acknowledge the dialectical behavior therapy principles for high-risk suicide clients.

Contributors

Richard Shuman, MFT
Kathryn Wright, LCSW, consultant
DeAnne Brining, RN, consultant

SUICIDE RISK

The Centers for Disease Control and Prevention (CDC) classifies suicide as part of a broader class of behavior entitled self-directed violence. Self-directed violence is behavior directed at oneself that intentionally culminates in injury or the potential for injury (Crosby & Melanson, 2011) and it can be suicidal or non-suicidal in nature. Suicide may be operationally defined as a death caused by self-directed behavior with any intent to die as a result of the behavior. A suicide attempt is defined as a non-fatal self-directed and potentially injurious behavior with any intent to die as a consequence of the behavior, and the suicide attempt may or may not cause injury.

Suicide is prevalent and manifests as a significant challenge to public health in America and worldwide as it causes premature death, morbidity, lost productivity and rising health care costs. There were 44,193 suicide deaths in the United States in 2015, which equates to approximately one suicide every 12 minutes (Centers for Disease Control and Prevention. Web-Based Injury Statistics, 2018). In 2015, suicide was the 10th leading cause of death and has been ranked in the top 12 leading causes of death since 1975 in the U.S. (Centers for Disease Control and Prevention, National Center for Health Statistics, 2015). Alarmingly, suicide rates increased by 28% from 2000 to 2015 (Centers for Disease Control and Prevention. Web-Based Injury Statistics, 2018). Suicide presents as an issue throughout the life span as it is the third leading cause of death for those 10-14 years of age, the second leading cause of death among individuals 15-24 and 25-34 years of age, the fourth leading cause of death in the 35-44 age bracket, the fifth leading cause of death among people aged 45-54, and the eighth leading cause of death in the 55-64 age bracket (Centers for Disease Control and Prevention. Web-Based Injury Statistics, 2018).

In 2018, the CDC reported 48,344 Americans died by suicide which is over two and a half times the number of homicides (18,830) committed that year. In 2019, 12 million American adults aged 18 or older reported having serious thoughts of suicide, while 1.4 million adults attempted suicide, and there were 47,511 suicide deaths.

The rates of suicide vary by race, ethnicity, age, and other population characteristics, while the highest rates across the life span occur among non-Hispanic American Indian/Alaska Native and non-Hispanic White population groups. The rates for these two groups in 2015 were 19.9 and 16.9 per 100,000 population, respectively (Centers for Disease Control and Prevention. Web-Based Injury Statistics, 2018). Additional groups disproportionately affected by suicide include middle-aged adults, aged 35-64 years, whose rates increased 35% from 2000 to 2015, with sharp increases among males (29%) and females (53%) (Centers for Disease Control and Prevention. Web-Based Injury Statistics, 2018); Veterans and other military personnel whose suicide rate almost doubled from 2003 to 2008, which outpaced the suicide rate among civilians for the first time in decades (Bachynski et al., 2012; Lineberry & O'Connor, 2012); workers in certain occupational groups (Han et al. 2016; McIntosh et al., 2016); and sexual minority youth, who exhibit suicidal ideation and behavior relative to their non-sexual minority youth (Kann, McManus, Harris et al., 2016; Russell & Joyner, 2001; Stone et al., 2014).

Suicides represent only a fraction of the concern because many more people are hospitalized due to nonfatal suicidal behavior (e.g., suicide attempts) than are the fatally injured, and a larger number of people are treated in ambulatory settings (i.e., emergency departments) or receive no treatment at all (Crosby et al., 2011). In 2014, for example, within the age bracket of 18 years and older, for every one suicide there were 9 people treated in emergency departments for self-harm injuries, 27 that reported a suicide attempt, and 227 who disclosed seriously considering suicide (CDC. Web-Based Injury Statistics; Lipari et al., 2014).

Several risk and protective factors are linked to suicide rather than a single determining cause. Various biological, psychological, interpersonal, environmental, and societal influences that interact with one another, usually over a period of time, incites suicide (U.S. Office of the Surgeon General, 2012; World Health Organization, 2014). The social ecological model offers a broad-based perspective for recognizing suicide risk and protective factors as it includes multiple perspectives from the individual, relationship, community, and societal levels (Dahlberg & Krug, 2002). Risk and protective factors within the social ecological model, at each of the four levels include:

Individual level - a history of depression and other mental illnesses, feelings of hopelessness, history of substance abuse, certain health conditions, past suicide attempt, being a victim or perpetrator of violence, and genetic/biological determinants.

Relationship level - having high conflict or violent relationships, feeling isolated with absence of social support, history of a family member or loved one who committed suicide, financial and work stress.

Community level - insufficient community connectedness, limited access to health care such as providers and medications.

Societal level - access to lethal means of suicide, dangerous media depictions of suicide, stigma connected to seeking help and mental illness (U.S. Office of the Surgeon General, 2012; World Health Organization, 2014).

Suicide behavioral warning signs include: threats or comments about killing oneself; social withdrawal from friends, family, and community; aggressive behavior; talking, thinking, or writing about death; and impulsive or reckless behavior. Intentional self-harm (i.e., intentionally

injuring oneself without the desire to die) is linked to a long-term risk for repeated attempts and death by suicide.

Some overt warning signs suggesting an individual may be considering suicide include: disclosing feeling hopeless, trapped, or alone; expressing no reason to continue living; making a will or giving away personal possessions; searching for a means of doing self-harm (i.e., buying a gun); over- or under-sleeping; over- or under-eating, yielding weight gain or loss; avoiding social interaction; expressing rage or intent to seek revenge; exhibiting signs of intense anxiousness or agitation; experiencing dramatic mood swings; and verbally stating that suicide is an option for a way out.

Having a mental health disorder can increase suicide risk; depression is the most common mental health risk factor, while bipolar disorder, schizophrenia, anxiety disorders, and personality disorders are also included. Yet, over 50% of people who die by suicide do not have a mental illness at the time of death, thus, additional variables that heighten suicide risk include: incarceration; low level of job security and satisfaction; history of being abused or witnessing continuous abuse; receiving a diagnosis of a serious medical condition such as cancer or HIV; being socially isolated or a bullying/harassment victim; substance use disorder; childhood abuse or trauma; family history of suicide; a history of suicide attempts; living with a chronic disease; experiencing a significant relationship loss; losing a job; access to lethal means, including firearms and drugs; exposure to suicide; difficulty in garnering help or support; limited access to mental health or substance use treatment; adhering to belief systems that accept suicide as a solution to life's difficulties (www.healthline.com/health 2017).

The groups who are at higher risk for suicide are: men; people over age 45; and Caucasians, American Indians, or Alaskan Natives. In 2017, 78% of suicide deaths were among white males while the highest rate was in people age 45 to 54 and the second highest rate aged 85 and older; on average, there were 129 suicides per day.

Fortunately, most individuals who actually attempt suicide, who are depressed, or exhibit other risk factors do not die by suicide (Olfson et al., 2015; Owens, 2002). Further, the importance of each risk factor may vary by age, race, gender, sexual orientation, residential geography, and socio-cultural/economic status (U.S. Office of the Surgeon General, 2012; World Health Organization, 2014).

The most accurate predictor of suicide is having a history of suicide attempts. Roughly 20% of suicides have had a previous attempt, and for those with a previous attempt, 1% complete suicide within one year and over 5% die by suicide within 10 years (Chang, Gitlin, & Patel, 2011). Self-harm behavior usually does not culminate in a suicide attempt and most people who self-harm are not at high risk of suicide. In contrast, some people who self-harm do die by suicide, hence, the risk for self-harm and suicide may overlap.

Key additional psychological factors that increase suicide risk include: loss of pleasure in life, rigid thinking, rumination, thought suppression, poor coping skills, poor problem-solving abilities, loss of abilities and function that one previously had, and poor impulse control. Older adults who perceive themselves to be a burden to others, people who never married, and those experiencing life stresses such as loss of a family member, friend, or job are at greater risk.

High levels of neuroticism and introversion have been associated with suicide as these traits may lead those who are isolated or sensitive to distress to be at greater suicide risk. Optimism has been demonstrated to produce a protective effect against suicide.

Poverty increases suicide risk, by example, over 200,000 farmers in India have died by suicide since 1997, in part due to debt issues, and in China, suicide is three times more likely to occur in rural areas compared to urban regions, partly due to financial difficulties (Lerner, 2010; Law & Liu, 2008).

Being religious may lower likelihood of suicide whereas maintaining beliefs that suicide is noble can increase its chance. Such probabilities are attributed to the negative perspective that religions promote against suicide and to the social connectedness religion may offer (Koenig, 2009).

Substance abuse is the second most common suicide risk factor after major depression and bipolar disorder (Levin et al., 2001). Chronic substance abuse as well as acute intoxication are associated with suicide, and when combined with personal grief (e.g., bereavement) the risk increases.

Most people who die by suicide are under the influence of sedative-hypnotic drugs such as alcohol or benzodiazepines (i.e., Xanax, Librium, Valium); alcoholism is present from 15% to 61% of the time. Supportively, higher suicide rates occur in countries with higher alcohol use rates and the existence of more bars. Approximately, 2.2 - 3.4% of individuals who have received treatment for alcoholism die by suicide. Alcoholics that attempt suicide are often male, older, and have attempted suicide in the past. Among adolescents who misuse alcohol, psychological and neurological dysfunction may add to increased suicide risk. Prescribed benzodiazepines associate with an increased rate of attempted and completed suicide, possibly due to the adverse side effects of disinhibition or withdrawal symptoms. From 3 to 35% of heroin users die by suicide which is fourteen times greater than those who do not use. Likewise, cocaine and methamphetamine users exhibit a high rate of suicide; the risk is highest for cocaine users during the withdrawal phase.

Surprisingly, smoking cigarettes is associated with a risk of suicide. Little evidence exists, but it is hypothesized that: a) smoking causes health problems that make some people want to end their life; b) smoking affects brain chemistry producing an inclination for suicide; and c) individuals predisposed to smoking are also predisposed to suicide.

Suicidality associates with physical health issues such as chronic pain, central nervous system diseases (e.g., epilepsy, tumors, Huntington's Chorea, Alzheimer's Disease, Multiple Sclerosis, spinal cord injuries, and traumatic brain injury), cancer (particularly head and neck), chronic fatigue syndrome, kidney failure that requires hemodialysis, HIV, and systemic lupus erythematosus. Receiving a cancer diagnosis roughly doubles the rate of suicide, and having more than one medical condition yields a higher rate. Health problems are indicated to be the main justification for suicide in Japan.

The media and internet can increase suicide occurrence by repetitively glorifying or romanticizing suicide. When these sources describe in detail how to kill oneself via a specific method then vulnerable individuals can attempt to duplicate the process. To lower the negative influence of media suicide depictions, journalists are advised to report suicide news in a style that might lessen the likelihood of imitation and to recommend people at risk to seek help (Ayd, 2000).

Experiencing trauma is a suicide risk factor in adults and children. One may take their life as an escape from being bullied or undergoing prejudice. Having endured childhood sexual abuse as well as time spent in foster care are risk factors. Significant early life adversity may affect problem-solving and memory, and both functions are implicated in suicide (O'Connor & Nock 2014).

Problem gambling associates with increased suicidal ideation and suicidal attempts relative to the general population - from 12 to 24% of pathological gamblers attempt suicide. The spouses of pathological gamblers die by suicide at a rate of three times greater than the general population. The risk of suicide among problem gamblers increases given concomitant mental illness, alcohol, and drug abuse (Pallanti, Rossi, & Hollander, 2006).

Genetics may affect suicide rates as adoption research has shown that such is the case for biological but not adopted relatives - this renders family risk factors not likely to be due to imitation. The estimated heritability rate, with mental disorders accounted for, is 36% for suicidal ideation and 17% for suicide attempts. A family history of suicide, particularly in the mother, affects children more than adolescents or adults (Turecki & Brent, 2016).

Frequently, an attitudinal and behavioral transition occurs along the path from suicidal ideation to making a plan to suicide attempts. 34% of people who seriously think about suicide indicate transitioning to making a plan, and 72% of planners elevate to making an attempt. 60% of planned attempts happen within one year after ideation, and 90% of unplanned attempts (mainly impulsive self-injurious behaviors) also occur within one year after ideation (Kessler et al., 1999). Such high percentages reveal the importance of uncovering suicidal ideation and highlights its influence in starting and perpetuating the suicidal process.

Suicide risk factors are not automatically connected in time to the onset of suicidal behavior, and any single risk factor alone does not increase or decrease risk. Suicide risk is greater when the number of risk factors increase, hence, the more risk factors present at any one time increases suicidal behavior at that time. Nonetheless, three heavily weighted warning signs that have been shown to be temporally related to the acute onset of suicidal behavior (e.g., within hours to several days) requiring immediate attention, evaluation, referral, or consideration of hospitalization are: threatening to hurt or kill oneself; seeking ways to kill oneself such as acquiring pills, weapons or other means; talking or writing about death, dying or suicide.

The following client warning signs suggest the need for the therapist to conduct a mental health evaluation soon and to take precautions to immediately ensure client safety, stability, and security: hopelessness; rage, anger, or seeking revenge; reckless behavior or thoughtlessly engaging in risky activity; feeling trapped and not seeing a way out; increased alcohol or drug abuse; withdrawing from friends, family or society; anxiety, agitation, inability to sleep or sleeping all the time; dramatic mood changes; and a lack of reason for living or sense of purpose.

Additional warning signs that may be associated with short-term suicide risk include the client making arrangements to divest responsibility for dependent others (children, elders, pets); updating wills; making financial arrangements for paying bills; saying goodbye to loved ones, etc.

Exposure to violence, such as child abuse and neglect, bullying, peer violence, dating violence, sexual violence, and intimate partner violence is associated with greater risk for depression, post-traumatic stress disorder, anxiety, suicide, and suicide attempts (Leeb, Lewis, & Zolotor, 2011). Women who have been exposed to partner violence are almost 5 times more likely to attempt suicide compared to women not exposed to partner violence (World Health Organization, 2013). Exposure to childhood adverse experiences (i.e., physical, sexual, emotional abuse and neglect, and living in a household with violence, mental health or substance abuse issues, and other forms of instability) associates with increased risk for suicide and suicide attempts (Dube et al., 2001). The effects of childhood and adolescent exposure to violence may manifest decades later via severe issues with finances, family, jobs, and stress, which are factors that can increase suicide risk. Suicide and other types of violence routinely share the same individual, relationship, community, and societal risk factors, hence, preventing interpersonal violence has the potential to prevent suicide (Wilkins et al., 2014). Additionally, protective factors common to suicide and interpersonal violence overlap, for example, connectedness to one's community, school, family, caring adults, and pro-social peers can promote resilience and lower the risk for suicide and other forms of violence (Capaldi et al., 2012).

The prevalence of suicide is extensive, for example, Cerel et al. (2016) found that 48% of Kentucky residents knew at least one person who died by suicide. The effect of knowing someone who died by suicide and/or having lived the experience (e.g., personally attempted suicide, had suicidal thoughts, was impacted by suicidal loss) may have long-term consequences. Loss of a loved one to suicide may produce ongoing pain and suffering such as complicated grief, stigma, depression, anxiety, post-traumatic stress disorder, and increased risk of suicidal ideation and suicide (Cerel et al., 2014). Those who lived the experience may sustain long-term physical and mental health consequences, ranging from anger and guilt to physical impairment, dependent upon the means and severity of the attempt (Chapman & Dixon-Gordon, 2007).

The economic effect of suicide upon society is substantial as well. Florence et al. (2015) determined that, in 2013, suicide cost $50.8 billion in estimated lifetime medical and work-loss costs alone. Another study factored in potential under-reporting of suicide, health expenditures per capita, and gross domestic product per capita, then estimated the total lifetime costs linked to nonfatal injuries and death caused by self-directed violence at about $93.5 billion in 2013 (Shepard et al., 2016). The main cause of these costs was due to lost productivity over the life span, with each suicide costing over $1.3 million.

Protective factors, defined as factors that may lessen suicide risk, or influences that safeguard against suicide risk within the four levels of the social ecological model involve: adequate coping and problem-solving abilities, moral objection to suicide, supportive social relationships; involvement in school, community, and other social institutions; accessible effective and ongoing physical and mental health care, and lowered access to lethal means of suicide (U.S. Office of the Surgeon General, 2012; World Health Organization, 2014). Such protective factors may buffer against a single or multiple risk factors.

Additional protective factors include spirituality, a sense of responsibility to family, children in the home, pregnancy, life satisfaction, reality testing ability, and having a positive therapeutic relationship.

DIFFERENCE BETWEEN SUICIDE and SELF-HARM

The term, non-suicidal self-injury (NSSI) refers to behaviors designed to intentionally hurt oneself without trying to kill oneself. NSSI ranges from relatively mild forms such as scratching, plucking hair, or impeding wound healing, to relatively severe forms as cutting, burning, or hitting (Gratz et al. 2002).

Suicide attempts and NSSI are thought to be distinct behaviors. NSSI individuals generally have thoughts of temporary relief whereas people who engage in suicidal behaviors have thoughts of permanent relief through death. NSSI is more prevalent than completed suicide and suicide attempts.

NSSI typically occurs for purposes of tension reduction, emotion regulation, anger expression, self-punishment, and reduced dissociation, while suicide attempts are frequently reported being intended to make others better off (Nock & Prinstein, 2005). Having experienced sexual abuse is a specific risk factor for exhibiting NSSI (Hamdullahpur et al., 2018). Sexual abuse and parental/other family member mental illness are linked to a greater chance of a past suicide attempt among males and females, and emotional neglect is also a factor for men.

Various psychosocial correlates of NSSI include depression, anxiety, eating disorders, alexithymia (inability to describe or recognize one's emotions), hostility, negative self-esteem, antisocial behavior, anger, smoking, and emotional reactivity. Suicide ideation predicts later suicide attempts but does not predict NSSI.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), criteria for NSSI includes: intentional self-inflicted injury performed with the expectation of physical harm, but without suicidal intent, on 5 or more days in the past year; and the behavior is performed for at least one of the following reasons: to relieve negative thoughts or feelings; to resolve an interpersonal problem; and to cause a positive feeling or emotion.

NSSI is associated with at least one of these cognitions: negative thoughts or feelings or interpersonal problems that occur immediately prior to engaging in NSSI, preoccupation with NSSI that is difficult to resist, and frequent urge to engage in NSSI (APA, 2013).

Suicide attempts and NSSI correlate with one another, specifically, individuals who exhibit NSSI are at greater risk for suicide compared to those who do not self-injure; 3-7% of people who self-injure ultimately die by their self-injury. The chance of death is much higher for those with previous suicide attempts such that about 50% of people who died by suicide had exhibited at least one previous suicide attempt.

Adults diagnosed with borderline personality disorder commonly perform NSSI, in fact, one of the criteria for borderline personality disorder is engaging in self-injurious behaviors or threats, inclusive of both suicide attempts and self-mutilation (APA, 2013).

SUICIDE ASSESSMENT

Suicide risk assessment is a clinical competency involving the evaluation of client suicide probability that occurs throughout clinical care. For potentially suicidal clients, every point of client contact requires some amount of risk evaluation, but each session does not necessitate the same degree of risk evaluation. The extent of evaluation is a function of clinical judgment, knowledge of client, and awareness of client's circumstances. Knowledge of client

can be obtained directly from client or from collateral sources such as family members, friends, coworkers, etc.

Suicide risk may vary over the course of treatment, therefore, suicide risk assessment is an ongoing process. Factors that may alter client risk include the development of hopelessness within a depressive episode, command hallucinations telling client to take her/his life, increased deterioration of a clinical condition such as increased substance use or greater severity of depression, a weighted life event as loss of a loved one or suicide of a friend or respected person, or change in clinical care involving discharge from a hospital or emergency room visit care.

Suicide risk assessment may assist therapist in evaluating the probability of death by suicide in the short-term (generally covering hours to several days), however, long-term predictions are not reliable, as such, suicide risk assessment is continuous. Some clients experience acute suicide risk while for others it can be chronic, and chronic clients can be affected by acute exacerbations.

An effective clinician is aware that suicide risk is not a static event and risk can change with time. An appropriate degree of suicide risk assessment need occur at each client contact and will include any new information obtained between client visits. Suicide risk assessment is the responsibility of the healthcare provider and the entire healthcare team working with client (Sadek, 2019).

Asking the client questions about suicidal ideation, intent, plan, and past attempts may not always be easy but at times deemed necessary. Periodically, the client will initiate the opening to ask about suicide but generally the topic does not automatically flow from the presenting issue and acquiring of history related to the present concern. Nonetheless, asking a set of screening questions when the clinical situation supports the need is important. It is facilitative to prepare the client for the questions by indicating that they are a natural part of the complete assessment of the current issue. One good point within the clinical interaction to introduce the suicide questions is immediately after client discloses their distress. Making introductory statements that flow into the suicide questions relaxes client allowing for full disclosure and assures client that therapist is prepared and interested in the answers (www.mentalhealth.va.gov 2009).

An example introductory statement is: "I appreciate how difficult this problem must be for you at this time. Some of my clients with similar problems/symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts?

Suicidality can also be operationally defined as an attempt to solve a problem, which is perceived as overwhelming. Such a framing of the issue may help the therapist be nonjudgmental and objective in helping client to create alternative solutions to the issues that are prompting suicidal feelings, intent and/or behaviors (Veterans Administration, 2009).

During assessment, it is important to ask about a history of suicide attempts because the history of a previous suicide attempt is the best known predictor for future suicidal behaviors, including death by suicide. Though most individuals who attempt suicide do not attempt again, approximately 16% do repeat within one year and 21% repeat within 1-4 years (Beautrais, 2003). The majority of repeat attempters use even more lethal means on future attempts, thus increasing the chance of increased morbidity and mortality. Roughly 2% of attempters die within one year of their attempt, and about 8-10% of attempters ultimately die by suicide.

It is recommended to ask client about feeling hopeless because hopelessness, about the present and future, is a very strong predictor of suicidal ideation and self-destructive behaviors. Related to hopelessness are feelings of helplessness, worthlessness, and despair. These affective states abound in depression and many disorders, hence, it is advised to explore these feelings with client to assess development or expression of suicidal behaviors.

Suicide assessment includes asking about suicidal ideation. Generally, suicidal ideation precedes suicidal planning and action. Suicidal ideation can include a desire or wish to die (intent) and a reason or rationale for wanting to die (motivation). Exploring the past, or concurrent with significant life stress or change in physical health is considered essential.

Many individuals will deny having suicidal ideation for various reasons, including: 1) the stigma of admitting to having symptoms of a mental disorder; 2) fear of being judged negatively or ridiculed by the practitioner; 3) loss of independence and control over the situation; and 4) concern that the practitioner may overreact and hospitalize the individual involuntarily.

Upon client denying suicidal ideation, therapist can remain vigilant of behavioral and affective cues which suggest client suicidal ideation. Signs and symptoms of ideation include: depressed affect, anxiety, profound social withdrawal, irrational thinking, paranoia, insomnia, agitation, irritability, despair, shame, humiliation, disgrace, anger and rage. If therapist suspects ideation despite client denial of such, the practitioner may gently disclose the apparent disparity between observable clinical factors (what therapist sees, hears and feels during the session) and client denial of suicidal thinking. Identifying and labeling the ideation concern may facilitate client disclosure of relevant thoughts and feelings and potentially guide a treatment response.

Inquiring about suicidal ideation and intent does not increase the likelihood of an individual contemplating suicide for the first time or enacting such. Actually, most clients indicate a feeling of relief and support when a therapist reveals desire to explore and understand the client's psychological distress that prompts them to consider suicide or self-injurious behaviors.

It is relevant for the clinician to know what evokes client's suicidal thoughts and the context of the thoughts, hence, inquiring about the timing of ideation and presence of a plan is significant. Though a minority of people are chronically suicidal, most individuals become suicidal as a response to unfortunate life events or psychosocial stressors that overpower their coping and self-control skills, especially in combination with a pre-existing disorder. Comprehending the length of time client has thought about suicide informs the practitioner of the role and influence of this action in the individual's daily life. Awareness of that which improves and worsens the onset, intensity, duration, and frequency of suicidal thoughts and feelings facilitates developing a treatment plan. Likewise, knowing what future situations and events might lead to suicidal thoughts assists therapist and client to agree on a safety plan along with techniques to avoid or control such scenarios.

An individual who has a suicide plan is revealing some intent to die and has started preparation to die. It is relevant to know the possibilities and potential for executing the plan, the chance of being rescued if the plan is carried out, and the relative lethality of the plan.

The therapist should not take the existence of suicidal planning lightly, even if the chosen method does not seem to be necessarily lethal (Brown et al., 2004). All suicidal ideations and threats are to be taken seriously. It is advised for therapist to know if client has started to enact the plan, via, for example, behavioral rehearsals, hoarding medications, accessing firearms or other lethal means, writing a suicide note or letter, etc.

An individual in crisis represents a higher suicide risk situation. A crisis occurs when a person's usual and customary problem-solving and coping skills do not effectively address a perceived stressful situation; the situation is usually new and unexpected. The unusual stress elicited by the disruptive event renders a sense of being physically and emotionally disabled because past behavioral responses are not effective. A crisis supersedes one's customary psychological and biological coping mechanisms resulting in a greater likelihood of maladaptive behavior. The crisis hinders the utilization of more sophisticated conflict resolution and problem-solving skills. Though crises are time-limited, by definition, every crisis is viewed as a high risk situation.

Crisis intervention involves the goals of lessening the intensity, duration, and existence of a crisis that is perceived as overpowering and that can culminate in self-injurious behaviors. The process centers on changing client's focus from a life-threatening emergency to a plan of action that is understandable and considered doable. Therapist's goal is to protect client from self-harm. It is important to identify and talk about the underlying disorder, dysfunction, and/or event that triggered the crisis; including family, friends, and social support individuals may be helpful.

Therapy will focus on assisting client to regain mastery, control, and predictability. The goal is to substitute more functional skills and responses for less effective and dysfunctional responses, and to reinforce healthy coping skills. Thus, crisis management re-establishes equilibrium and renders the individual feeling in control within a secure and stable environment. This may require hospitalization in some cases. Behaviorally, client will remove or stop securing any lethal means of self-harm, decrease isolation, diminish anxiety and agitation, and will become committed to a safety plan involving crisis management or contingency planning. Additionally, therapist and client will agree upon a list of simple reminders for client to enact the crisis safety plan and required skills.

The World Health Organization recommends that everyone over the age of 10 who has a mental disorder or other risk factor should be asked whether they have had thoughts or plans of self-harm within the past month. The assessment itself correlates with a lower probability of future suicidal behavior (Olfson et al., 2013) which highlights the beneficial effect of the therapist-client contact embedded in the risk assessment process (Bolton et al., 2015).

Psychological autopsy, defined as an in-depth reconstruction of an unclear suicide death which utilizes interviews with family members, friends, and other relevant informants along with examination of official records to gather information about the victim's behavior and events that preceded the death, reveals that psychiatric disorders abound in approximately 90% of suicides and contribute to 47-74% of the population risk for suicide (Cavanagh et al., 2003).

Risk assessment involves assembling client history, and administering a mental status exam - which will provide baseline information. Relevant risk factors such as history of prior attempts and substance use are included in the generalized history. Gathering information from collateral sources may offer perspective on risk factors, recent activities, escalation patterns, planned or impulsive violence toward self or others (Pinals & Anacker, 2016).

Suicide risk assessment can be difficult because many who are labeled as high suicide risk do not die by suicide while some who are considered low suicide risk do end their life. Conducting a suicide risk assessment can be a challenge for these reasons: a) therapists may experience difficulty in identifying a client at impending high suicide risk; b) Practitioners routinely rely on client's subjectively disclosed information, which may not reveal the underlying risk; collateral information can produce a clearer picture of risk; c) Suicide risk assessment scales do not always predict death by suicide, though they may provide a useful clinical tool or serve as documentation of the type of suicide risk assessment that was completed; d) The education and training of health care providers in the abilities needed to conduct a suicide risk assessment is inconsistent;

e) Clinicians may experience anxiety or strong emotional responses when confronted with suicidal behavior. Such unacknowledged emotions can yield negative therapist reactions that restrict competence in working with acutely suicidal individuals; f) Some mental health workers may harbor a negative attitude toward suicidal people; g) Working within some health care organizations can be inherently challenging due to limited resources, crowded working conditions, multiple priorities, and limited time (Betz et al., 2016; Kene et al., 2018).

THE PROCESS OF SUICIDE RISK ASSESSMENT

The first step involves therapist establishing a therapeutic relationship with client which will facilitate exploration into client's issues, suicidal ideation, and suicidal plan. Building an effective therapeutic alliance requires empathy, active listening, respect, trust, support, a non-adversarial and cooperative position, nonjudgmental acceptance, transparency, and a desire to understand the individual and nature and cause of their pain (Bryan et al., 2012).

Practitioners are advised to be cognizant of their personal reactions to suicide and to the client with whom a suicide risk assessment is being conducted and to professionally manage those reactions.

The therapeutic bond is important for various reasons including: 1) The alliance lowers client anxiety during the suicide risk assessment which enhances client honest and accurate self-disclosure; 2) The therapeutic process is improved because open self-disclosure facilitates clients' ability to evoke dormant awareness and answers to their distress then better alternatives to suicide can be explored with therapist (Jobes, 2012); 3) It is suggested that a strong therapy bond helps clinician to administer the interventions and teach needed skills that foster resolution of the suicide risk (Bryan et al., 2012); 4) Therapeutic bonding may become an additional client protective factor by promoting a feeling of hopefulness and connection.

Naturally, therapeutic alliance begins with the first contact. Transition from therapeutic bonding to suicide risk determination initiates with therapist validating and confirming client's challenges and stressors by responding with acknowledgement statements such as, "I understand that you are experiencing some very challenging times as of late," or "It sounds like you are having a difficult time lately," or "It must be frustrating and difficult to go through this." These statements set the stage for more detailed questions regarding suicide ideation and suicide plans. Such validating statements connect client's experiences with counselor's consideration of those experiences and establishes a supportive and caring concern. At this point, therapist can move to the next step by identifying client risk factors.

A risk factor increases the probability of a specified outcome. Risk factors are usually not causal in nature, modifiable, or of equal importance in determining the probability of an outcome. Collectively, however, they can assist therapist in considering the chance of an outcome, in this case, death by suicide. Risk factors assist clinician in making a risk determination.

Practitioners can utilize information received from client and collateral sources (i.e., family, friends, police, health providers, medical records, etc.) when orchestrating a suicide risk assessment.

Recommended suicide risk factors to consider when completing a suicide risk assessment include the following four categories:

I. Interview risk profile - a) suicidal thinking or ideation, b) access to lethal means, c) suicide intent or a lethal plan, or a plan for after death (e.g., a letter with instructions), d) hopelessness, e) intense emotions such as rage, anger, agitation, revenge, humiliation, panic, severe anxiety, f) Ongoing alcohol or substance intoxication or problematic use, g) withdrawal from family and friends, h) poor reasoning or judgment, i) recent significant change in mood, j) recent crisis, conflict, or loss, k) the clinical intuition of the therapist in assessing the situation.

II. Degree of illness management - a) amount of clinical support, b) level of compliance, c) response to treatment.

III. Individual risk profile - a) ethnic, cultural risk group, or a refugee, b) a family history of suicide, c) trauma, for example, domestic violence, sexual abuse/neglect, d) display of poor self-control such as impulsive, violent, or aggressive behavior, e) a recent suicide attempt, f) history of past suicide attempts, particularly with low rescue potential, g) mental illness or addiction issues, h) depression or anhedonia, i) psychotic, j) presence of command hallucinations, k) recent admission or discharge from a psychiatric facility, or history of emergency department visits, l) has chronic medical illness or pain, m) reveals a disability or impairment, n) collateral information expresses suicide intent.

IV. Support system - a) limited support from family or friend, b) does not have a caregiver, c) frequent change of residence.

In addition to the above suicide risk factors to be considered during a suicide risk assessment, therapists are recommended to create a series of questions yielding thorough coverage of the risk factor being explored. Practitioner can assess the frequency, intensity, duration, plans, and behaviors of client's suicidal thinking (ideation), including suicidal ideation in the past 24 hours, 48 hours, past month, and worst ever.

Jacobs et al. (2010) highlight the following excerpt from the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors: "Whether or not a plan is present, if a patient has acknowledged suicidal ideation, there should be a specific inquiry about the presence or absence of a firearm in the home. It is also helpful to ask whether there have been

recent changes in access to firearms or other weapons, including recent purchases or altered arrangements for storage. If the patient has access to a firearm, the clinician is advised to discuss with and recommend to the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons. Such discussions should be documented in the medical record, including any instructions that have been given to patient and significant others about firearms or other weapons."

Some researchers advocate two levels of inquiry regarding firearms and thus arriving at a more sound clinical decision. Level 1 inquiry includes: firearm access; firearm storage; firearm ammunition availability; social support network which can assist with firearms.
Level 2 inquiry involves: time spent with guns; violent fantasies about guns; any psychodynamic attachment to guns; how family and friends perceive guns; how guns are used by the client (i.e., hobby, sharpshooting); past experience with guns (e.g., new behavior or interest) (Pinals & Anacker, 2016).

A logical flow of client questions would next assess the possibility of suicidal ideation, for example, therapist can ask: Due to your life experience now, I'm curious if you have had any thoughts that it would be better if you were dead or that you would think about taking your own life? At times, in a situation that you are going through, people may think or feel that they would be better off dead or that they may seriously ponder ending their own life - how do you feel about this?

Therapist must further explore the situation if client discloses suicidal ideation in response to the above questions. The goal of this assessment is to determine the intensity and persistence of the suicidal ideation, whether a past attempt occurred, client's coping strategies, and efficacy of their coping skills. For example, Sadek (2019) suggests the following sample questions about suicidal intent and plan: You say that you have thought about dying, can you tell me more about that? Can you tell me more about the thoughts of taking your life that you are having? How often do you have those thoughts? How strong are they? How do you deal with them when they come? Can you overcome those thoughts or are you concerned that they may overcome you? When you are having those thoughts, what do you do? Do you feel safe? What have you done to act on those thoughts: Have you done anything that might have caused you harm or lead to death? Can you tell me about what happened?

If questioning affirms that client has continuous and substantial suicidal ideation, then therapist next determines if client has a plan. Client immediately enters a higher risk category given existence of a plan. Sample suicidal plan questions include: You disclosed to me your thoughts about dying or taking your own life, what are you planning on doing? or Please share with me thoughts you have had about taking your life.

Upon confirming client has a suicide plan, therapist is advised to understand all the specific plan details, including: a) When is this planned to happen? b) How lethal is the plan? c) How committed is client to implementing the plan? d) What are the facilitating factors? (such as client owns a gun or has collected many bottles of pills).

Once a plan is recognized, evaluate client's procedure to carry out the plan (e.g., learning about inhaling automobile carbon monoxide emission or effect of certain pill overdose), preparations made for dying, and client expectations of lethality.

Assessing level of risk includes the essential factors of timing, location of plan, lethality of method, and availability of means. Further, therapist may inquire about a plan for after-death including writing a suicide note or giving personal belongings to specified people.

During the process of suicide risk assessment, therapist preserves the therapeutic bond while simultaneously utilizing a risk evaluation strategy that includes client's answers to questions and responses to a checklist of risk factors.

The following six important suicide assessment inquiries are recommended:

1. Past attempts - Given a history of past suicide attempts, therapist asks client when, the method, client's understanding of the lethality of the method, and result of the attempt. A history of suicide attempts or self-harm is highly linked with increased risk (Bolton et al., 2015).
2. Stressors - If recent life stressors exist, therapist inquires about impact upon client and her/his significant others, and effect on financial matters.
3. Alcohol or substance use - Determine frequency, severity, dependence, precipitating factors, outcome.
4. Homicidal ideation - Assess for homicidal thoughts, especially in postpartum women, clients with cluster B personality disorders (involves dramatic, overly emotional or unpredictable thinking or behavior; includes antisocial personality disorder, borderline personality disorder, histrionic personality disorder, and narcissistic personality disorder), and those who are psychotic or paranoid.
5. Social support - Determine client's degree of social support, and acquire collateral information from family regarding withdrawal and isolation from them and from friends.
6. Therapist will acknowledge client's diagnosis and comorbidity - For example, affective disorder is the most common psychiatric disorder, substance misuse (especially alcohol) is second, and schizophrenia is third. Comorbidity of these disorders significantly increases suicide risk. Cluster B personality disorders or traits, eating disorders, as well as anxiety disorders increase suicide risk (Cavanagh et al., 2003). The key symptoms include anhedonia, impulsivity, hopelessness or despair, anxiety/panic, anger, agitation, insomnia,

and command hallucinations.

SUICIDE RISK ASSESSMENT FACTORS

Affective disorders - These disorders, especially unipolar or bipolar depression, pose a strong risk factor for suicide. More severe depressive psychopathology is linked with suicide risk and manifesting a severe degree of impairment is also associated with an increased suicide risk (Mattisson et al., 2007). Risk is substantially increased for individuals who disclose feelings of hopelessness. Hawton and Casanas (2013) identified these suicide risk factors for people with depression: male gender, family history of psychiatric disorder, past attempted suicide, more severe depression, hopelessness, and comorbid disorders, including anxiety and alcohol/drug misuse. The ratio of completed suicides relative to attempts in affective disorders is higher compared to the general population, which shows the higher lethality of suicidal behavior in this population (Undurraga et al., 2012). Psychological autopsy research indicates that more than 50% of people who die by suicide have a current depressive disorder (Cavanagh et al., 2003). 10-15% of bipolar disorder individuals die by suicide, often early in the disorder course (Goodwin and Jamison, 2007).

Schizophrenia - This disorder can create a heightened suicide risk, particularly during the initial years of the illness. Having command hallucinations increases suicide risk. A National Institute of Mental Health (NIMH) longitudinal study on chronic schizophrenia observed that, over an average of six years, 38% of the individuals had at least one suicide attempt and 57% expressed having substantial suicidal ideation. Roy and Pompili (2009) suggested that 10 to 13% of schizophrenics die by suicide. Suicide risk is high in those with first-episode psychosis (FEP), additionally, high rates of premature mortality, especially from suicide, may occur during early phases of schizophrenia (Pompili et al., (2011).

Various studies on suicide risk in schizophrenia show less correlation with core symptoms of schizophrenia (e.g., delusions) but more with depression and specific affective symptoms such as agitation, sense of worthlessness, and hopelessness. Additional relevant factors include previous suicide attempts, drug misuse, fear of mental disintegration, recent loss, and poor adherence to treatment (Hawton et al., 2005).

Alcohol or substance use - Therapist inquires about alcohol or substance use and a possibility of such warrants asking about problematic use or a recent usage increase. Practitioner should assess for current intoxication or withdrawal.

Suicide is significantly increased given current substance misuse (i.e., alcohol and/or drug) and this applies to the separate misuse of alcohol or drug. Several studies reveal high rates of suicidal behavior in alcohol use disorder (AUD), with 16-29% of individuals who sought treatment for AUD having reported at least one lifetime suicide attempt, rates of suicide completion ranged between 2.4% and 7%, and alcoholism contributed to approximately 25% of the suicides (Murphy & alcohol Wetzel, 1990; Oquendo et al., 2010).

The severity of the use disorder, aggression, impulsivity, and hopelessness appears to predispose suicidal behavior. The primary precipitating factors are depression and stressful life events, especially disruption of personal relationships (Conner and Duberstein, 2004).

A meta-analysis observed a strong significant association between alcohol use disorder and suicidal ideation, suicide attempt, and suicide death.

Poorolajal et al. (2016) notes that more research is needed to assess and compare the association between suicide outcomes and different types of illicit drugs, dose-response connection, and the way the drugs are used.

Usage of multiple substances can elicit suicidal behavior. Withdrawal from amphetamines, cocaine, and other addictive drugs can lead to increased suicidal ideation and attempts. Lengthy use of sedatives, hypnotics, and anti-anxiety drugs can increase suicidal ideation and attempts.

An analysis of global burden disease revealed that illicit drug use is a relevant contributor to the global burden of disease, and opioid and amphetamine dependence are the two most common types of illicit drug dependence worldwide. Most people dependent on drugs were male (64% each regarding cannabis and amphetamines and 70% each pertaining to opioids and cocaine). Suicide was found to be a significant contributor to illicit drug burden because suicide is a common cause of death in those who regularly use opioids, cocaine, or amphetamines.

Suicide as a risk of amphetamine dependence represented 854,000 disability-adjusted life years (DALYs; One DALY is the loss of the equivalent of one year of full health. DALY's for a disease or health condition are calculated by adding the years of life lost due to premature mortality and the years lived with a disability due to prevalent cases of the disease or health condition in a given population). Suicide as a risk of opioid dependence accounted for 671,000 DALYs, and as a risk of cocaine dependence for 324,000 DALYs. Nations with the highest rate of burden (defined as at least 650 DALYs per 100,000 population) included America, United Kingdom, Russia, and Australia (Whiteford et al., 2013).

The presence of anxiety symptoms are associated with an increased risk of suicide.

Suicide risk is strongly associated with having an Axis II disorder (e.g., borderline or antisocial personality disorder); 30-40% of those who die by suicide manifest personality disorders.

Chronic physical illness is associated with suicide risk, including HIV/AIDS, peptic ulcer disease, hemodialysis, malignant neoplasms (tumors), systemic lupus, erythematosus (SLE; abnormal redness of the skin or

mucous membranes), Huntington's disease, multiple sclerosis, epilepsy, renal disease, pain syndromes, nervous system diseases, and functional impairment (Hawton & van Heeringen, 2009).

Other medical disorders, including undiagnosed diabetes, and iron/thyroid deficiency are linked to people over age 60 who died by suicide (Bradvik et al., 2008).

Suicide is a common cause of death in those with eating disorders. Suicide risk is increased in the diagnoses of adjustment disorder, attention deficit hyperactivity disorder (ADHD), anxiety disorders, and panic disorder.

Suicide risk for people admitted to an inpatient facility is high; it occurs early during the admission (40% within the first 3 days). Suicide rate has been reported as five per 1000 occupied beds each year and as much as 860 suicides per 100,000 (Bolton et al., 2015).

A meta-analysis of 27 studies on inpatient suicide reflected a steep increase in the suicide rates per 100,000 inpatient years after 1980, with America revealing the highest number followed by the UK and Ireland, Continental Europe, Australia/New Zealand, and the Nordic countries. The pooled estimate of suicides was 147 per 100,000 inpatient years.

Multiple factors may be attributed to the increased suicide rate among admitted and discharged individuals, including changing legal and other criteria for admission, shorter duration of inpatient treatment, increased substance use prevalence, and increased acuity of illness among people admitted during the era of deinstitutionalization (Walsh et al., 2015).

Suicide risk is high during the first week after discharge from a psychiatric hospital admission, stays high for the first few months after discharge, then slowly decreases. Risk of suicide is particularly high in psychiatric patients admitted to the hospital with a suicide attempt (Bolton et al., 2015).

The rate of future suicide in those presenting to the emergency department with self-harm is high: 2% will kill themselves within one year, and the 5-year estimate is 4%. This risk is over 50 times more than the general population and yields a 40-year reduction in average life expectancy. The rate of repeat self-harm after emergency department contact is 10% at one month and up to 27% at six months (Bolton et al., 2015).

A study by Qin and Nordentoft (2005) on psychiatric hospitalizations concluded: a) A higher suicide risk exists in people with a history of previous psychiatric hospital admissions; b) There are two significant peaks for suicide risk within psychiatric hospitalization, specifically, in the first week after admission, and in the first week after discharge; c) Suicide risk is significantly higher in individuals who receive a shorter than median length of hospital treatment; d) Suicide risk associated with affective and schizophrenia spectrum disorders decreased rapidly after treatment and recovery whereas the risk associated with substance abuse disorders decreased comparatively slower; and e) A history of admissions increases suicide risk more in women than men.

A meta-analysis of studies examining mental health service contact before suicide found that within the prior year, 18.3% of people who died by suicide had contact with inpatient mental health services, 26.1% had contact with outpatient mental health services, and 25.7% had contact with inpatient or outpatient mental health services (Walby et al., 2018).

Luoma et al. (2002) published a review in the American Journal of Psychiatry which indicated approximately 32% of persons who died by suicide had contact with mental health services in the year prior to death, across all age groups. Contact with primary care providers in the month prior to suicide averaged roughly 45% (with a range of 20-76%), and primary provider contact within one year of suicide averaged approximately 77% (range = 57-90%).

Earlier research revealed that up to 41% of those who died by suicide had contact with inpatient services in the year prior to death (Pirkis & Burgess, 1998).

Suicide risk is increased given a family history of mental disorder, and such increase exists with a family history of suicide (Bolton et al., 2015). A family history of suicide at least doubles the risk, particularly in girls and women, independently of family psychiatric history (Qin et al., 2003; Hawton & van Heeringen, 2009).

Physical, and particularly, sexual abuse during childhood is highly associated with suicide. Childhood maltreatment effects related to suicide are compounded by intergenerational transmission of abuse. Family transmission of suicidal behavior is most likely if the suicide attempter was sexually abused as a child. Abuse is, therefore, a suicide risk factor for people abused as children and for their offspring (Bridge et al., 2006).

PROTECTIVE FACTORS

A thorough suicide risk assessment includes risk factors as well as protective factors that may lower suicide risk. Individuals displaying protecting factors do attempt and complete suicide, however, possessing multiple protective factors generally heightens client resiliency when confronting stress and adversity.

Therapist may examine protective factors in client's life domains of family, work, and community. Internal protective factors include, for example, ability to cope with stress, religious beliefs, and frustration tolerance. External protective factors may involve, for instance, responsibility to children, having supportive relationships, and maintaining effective therapeutic relationships (Hawton & van Heeringen, 2009).

The above-mentioned protective factors may offer a degree of protection but clinicians must acknowledge the poor predictive ability and limitations of relying upon the

presence or absence of these factors (Large et al., 2011; National Collaborating Centre for Mental Health, 2011).

ASSESSING RISK

Based upon the accumulated client disclosure therapist makes a clinical judgment of client's risk to attempt or complete suicide in the short or long term. Factors to be considered include the following: 1) Integrate and prioritize client risk and protective factors; 2) Assess whether client is minimizing or escalating their reported risk; 3) Assess acute and likely suicidality; 4) Assess chronic and recurring suicidality; and 5) Assess acute exacerbation of a client with chronic risk.

Clinician categorizes the risk level as either low acute risk, medium acute risk, high acute risk, low chronic risk, medium chronic risk, or high chronic risk.

Low acute risk - This level exists given the absence of specific risk factors that require intervention and few active concerns pertaining to suicide. There is no suicidal intent, plan, or preparatory actions. Client is willing and capable to utilize a safety plan if suicidal thought increases or a change in intent arises. Client's family and therapist are convinced that client will maintain her or his safety.

When client previously exhibited suicidal gestures or behaviors, low risk in the current case means no new, treatable risk factors to target exist - client is displaying "their baseline risk."

Client may need follow-up monitoring of clinical status and suicide risk if either of the following two conditions are present (but not limited to these two conditions):

- Life situation and/or mental status changes occur that might change suicide risk.
- Changes in care delivery or continuity arise (i.e., moving from a day-hospital to a community clinic).

Medium acute risk - This level involves the presence of some identified risk factors that may impact risk and there is need of a suicide plan to address risk factors. Risk of suicide is present but not imminent, client does not have suicide intent, and clinician's perspective is that suicide risk is manageable with current supports and continuing clinical care. Suicide preparatory acts are not occurring, and practitioner senses that client can maintain safety independently and adhere to the safety plan.

Medium acute risk requires ongoing monitoring for suicide risk, and the following is recommended:

- Thoroughly assess suicide risk and document the assessment outcome.
- Establish a suicide risk monitoring and management plan, document, communicate, and implement the plan, and review the plan as clinically needed.
- Document a suicide risk status change and communicate such.
- Document the current risk level and appropriately communicate such.

High acute risk - This status is reached when therapist believes suicide risk is imminent (high). Multiple risk factors suggest a strong degree of risk, client has intent to die by suicide and cannot maintain safety independently of external help or support. Significant intervention or monitoring is needed such as hospitalization. Therapist senses a state of urgency to address the risk factors as soon as possible. Client requires increased suicide risk monitoring along with the following:

- Document the high suicide risk level and communicate to all relevant providers and clinically determined significant individuals within client's circle of care.
- Implement and document within client's individual care plan a suicide risk assessment, intervention, and monitoring protocol. Enact constant, close, or other monitoring strategies as clinically determined.
- Communicate the risk assessment and monitoring plan to all relevant providers and clinically determined significant individuals within client's circle of care.
- Therapist shall determine the appropriate level of care and location of such care using her/his best clinical judgment.

Clinician shall implement an ongoing formal review of client's suicide risk status as deemed appropriate.

Low chronic risk - An example of this level is clients with personality disorders who can manage their stressors without reverting to suicidal ideation or behavior.

Medium chronic risk - This risk level includes individuals with major mental illnesses and/or personality disorders, substance abuse/dependence, and/or chronic medical conditions or chronic pain. Those in this group, however, possess the counterbalance of protective factors, coping skills, reasons for living, and psychosocial stability facilitating tolerance of future crises without committing self-directed violence and/or suicidal behaviors.

High chronic risk - Individuals in this group include those with chronic major mental illness and/or personality disorders, a history of prior suicide attempt(s), history of substance abuse/dependence, chronic pain, chronic suicidal ideation, chronic medical illness, and limited coping skills who generally self-harm. When confronted with a new stressful situation such as loss of a job or partner, however, this person is at chronic risk of becoming acutely suicidal.

A suicide risk assessment is based on the combination of information obtained from client along with the determination and assessment of additional risk factors. By example, client may report persistent ideation but with no plan, has ability to push suicide thoughts away from their mind, and can control their behavior. Contrarily, therapist

knows this client made two suicide attempts the past year, is undergoing depression, feeling hopeless, and recently became unemployed. Consequently, practitioner benefits from a more global assessment by combining client interview information and additional risk factors in determining risk for suicide.

The premise that the clinical formulation of risk relies on a cognitive understanding of gathered data regarding risk, ideation, and protective factors coupled with an intuitive process that includes therapist familiarity with client and client's character structure is supported by some researchers (Berman & Silverman, 2014; Wortzel et al., 2014).

SUICIDE MYTHS

Numerous myths about suicide abound that some practitioners believe and may have been actually taught. Disproving common suicide myths can help society understand the value of helping suicidal persons to seek treatment, and can reveal to suicidal persons the importance of confronting and overcoming their mental health concerns. Common suicide myths include the following:

Myth - I should not ask my client about suicide because this could plant the idea into his or her head.

Reality - Inquiring how your patient feels does not create suicidal thoughts, similarly, asking how your client's chest feels would not cause angina. Asking clients directly about suicide will not create thoughts they did not already consider. Those with suicidal thoughts usually want to be heard and validated but may not know how to share these deep feelings. Introducing this theme may foster self-disclosure and allow therapist to share relevant resources. Independent of their response, opening such a discussion informs client that therapist is there to help and cares about their safety. Therapist courage is required to ask the question: “Are you considering suicide?" The stigma associated with suicide makes it a difficult subject to talk about. The stigma is reduced by talking about the subject and such disclosure fosters individuals to seek help, re-evaluate their perspective and options, release pent-up emotion and tension that is causing their suicidal feelings, and acquire additional time to re-think their decision.

Myth - The world is composed of talkers and doers.

Reality - Most individuals who die by suicide have disclosed some intent. A client who talks about suicide gives the clinician an opportunity to intervene before suicidal behaviors begin.

Myth - There is nothing that can be done if a person truly wants to die by suicide.

Reality - "Mental health is treatable. Suicide is preventable" (Active Minds, 2021). Most suicidal ideation is associated with the existence of underlying treatable disorders. Effectively treating the underlying cause can prevent suicide. The acute risk for suicide is generally time-limited, and situation-specific, hence, assisting client to manage the immediate crisis along with the powerful intent to die may allow client to perceive the situation more calmly and optimistically and yield a favorable result. By acknowledging and acting upon suicide warning signs, therapist may decrease or eliminate the risk of suicide. Suicidal individuals are often ambivalent about the act and experience uncertainty whether to live or die; most do not want to die, rather, they simply want to end their pain. Often, suicide attempters feel regret for the attempt or feel constructively changed yielding a desire to live, thus, this myth is not true. (Active Minds, 2021)

Myth - People do not kill themselves if they have a valid reason to live, such as having young children, a loving family, have signed a No Harm Contract.

Reality - The intent to die can nullify rational thinking. Suicidal thoughts and actions affect people of all life experiences, levels of success, and outward appearance. One's life may appear need-fulfilled from the outside but may be replete with struggle, anxiety, and depression on the inside. No person is invulnerable to mental health challenges. Given client disclosure of suicidal ideation or intent, therapist should accept that client is capable of enacting these thoughts and feelings.

Myth - Multiple and possibly manipulative self-injurious behaviors show that client is simply seeking attention and is not actually suicidal.

Reality - Multiple previous suicide attempts increase the chance of ultimately dying by suicide. Therapist is advised to provide effective assessment and treatment in the presence of suicide "gestures." Clinician's goal is to non-judgmentally and empathically help client to understand the gesturing behavior and to learn appropriate ways of asking for help. (Veterans Administration, 2009)

Myth - Generally, there is a single cause that precipitates suicide.

Reality - Suicide is rarely caused by only one determining factor, even if that factor is mental illness. Suicide is a complex concept and cannot be oversimplified.

Myth - All individuals who have suicidal thoughts have been admitted to a psychiatric hospital.

Reality - Some people can control their suicidal thoughts with less intensive care such as mental health practitioners or family/friend support, hence, in-patient treatment is not always required.

Myth - Everyone who has suicidal thoughts will ultimately

act on them.

Reality - Some individuals who struggle with suicidal ideation are not automatically in immediate danger. Passive suicidal ideation is a mindset that spans from fleeting thoughts of indifference toward life to considering a suicide attempt. Those who experience passive suicidal ideation may need to manage such thoughts daily with the aid of mental health professionals and their support systems. Passive suicidal ideation can transform into active ideation, therefore, crisis safety plans and honest disclosure with treatment providers, family, and supportive friends are critical protective determinants.

Myth - People will find a different way to end their life if their access to lethal means is blocked.

Reality - Given that most suicidal crises are short-lived, limiting access to fatal means, especially firearms, can significantly lower suicide risk.

Myth - Most people die by suicide unexpectedly without warning or clue.

Reality - To the contrary, individuals who die by suicide frequently have struggled for a long time through various hardships. Behavioral or verbal warning signs often foreshadow most suicides. Many suicidal individuals only reveal suicide warning signs to those closest to them. These loved ones may not acknowledge the warning signs which yields the perception that the suicide was sudden and unpredictable.

Myth - Suicide and suicidal ideation is limited to those who have depression or another diagnosed mental illness.

Reality - Suicide can affect anyone, without regard to having a diagnosed mental health condition. Many circumstances may induce suicide in people with or without known mental health conditions, for example, relationship loss/issues, crisis or trauma, substance use, financial or criminal/legal issues, persecution, a devastating or debilitating illness, sexual abuse, rejection.

Myth - People who made a suicide attempt and "recovered" will no longer exhibit suicidal behavior.

Reality - Some people who attempted suicide and were effectively treated may never engage in suicidal thoughts again, but some people will repeat, thus, it is wise for client to have support options and ongoing treatment. Often, the highest risk of suicide occurs when the person first leaves the hospital - the time when a favorable prognosis is is expected. One explanation is that it takes a lot of energy to attempt suicide and an individual in the early stages of depression recovery may gain the energy required to carry out the suicide plan. Additionally, some suicidal people feel better because they decided to die by suicide, and now experience relief that their enduring pain will end soon.

Myth - All people who struggle with suicidal thoughts have depression.

Reality - Many individuals affected by suicidal thoughts are not diagnosed with depression, likewise, many people who have depression do not encounter suicidal ideation.

Myth - Those who self-harm desire to end their life.

Reality - The two forms of self-harm include either an intent to end one's life, or the absence of any intention to end one's life. Some people self-harm as a coping mechanism for various reasons, including: to process negative feelings; to feel something physical when they feel numb; or to punish themselves for a perceived wrong they committed. Self-harm behavior is dangerous and should not be taken lightly despite it does not unequivocally mean the person is suicidal.

Myth - Once a person is suicidal, she or he will always be suicidal.

Reality - Active suicidal ideation, as previously mentioned, is generally short-term and situation-specific, as such, the individual will not always remain suicidal. The act of suicide is usually an attempt to control painful thoughts and emotions and the suicidal ideation will cease upon these thoughts dissipating. Though suicidal thoughts can re-appear, they are not permanent, in fact, a person who experiences suicidal thoughts and attempts can live a long and successful life.

Myth - Those who die by suicide take the easy way out and are selfish.

Reality - Most do not die by suicide because they do not wish to live, rather, they want to end their suffering. They feel deep pain which renders feelings of hopelessness and helplessness. Their suicidal ideations are not by choice and they are not only thinking about themselves, instead, such individuals are experiencing a weighted mental health symptom due to a mental illness or a difficult life situation.
(National Alliance on Mental Illness, 2020)

Myth - It is particularly dangerous to ask a depressed client if she or he is considering suicide.

Reality - Therapists may be concerned about broaching the topic to such a vulnerable person, however, clients may feel relieved to share their distressing thoughts with an empathic professional. Talking about depressive or suicidal feelings validates clients' perspectives and may encourage them to to think and feel differently.

Myth - People who appear to have their act together are not at risk for suicide.
Reality - An individual may appear to have it all together on the outside but one does not know how another is thinking and feeling on the inside.
Myth - Suicide most frequently occurs during the winter holiday season.
Reality - Surprisingly, suicides do not peak during the winter holidays, instead, the height is in the springtime. The empirical reason for this fact is unclear but it highlights that sunny days will not brighten the mood of a struggling person.
Myth - Giving someone a suicide hotline number to call is automatically preventive.
Reality - Suicide hotlines can be helpful, unfortunately, the suicidal person may not follow through with the call.
Myth - There are more homicides than suicides.
Reality - There are twice as many suicides as homicides.
Myth - More men attempt suicide than women.
Reality - Women attempt suicide more often than men, however, men are two to three times more likely to actually die by suicide. Men attempt suicide by more lethal means than women such as with firearms, and this is based on the fact that men are more likely to have access to and own guns.
Myth - Individuals who talk about suicide do not truly have the intent to carry out the plan.
Reality - Those who disclose their suicidal feelings may be seeking help or support and are at risk if relief does not occur (WHO.INT, 2021).
Myth - Individuals who talk about suicide are just trying to get attention.
Reality - Those who die by suicide generally talk about the subject first. They are living in pain and usually reach out for help because they are unaware of a resolution and feel hopeless. Therapists are encouraged to seriously address the subject of suicide.
Myth - People who talk about a desire to die by suicide do not actually try to kill themselves.
Reality - People who disclose wanting to die by suicide oftentimes do kill themselves.
Myth - Suicide only affects individuals of specific gender, race, socio-economic status, age, etc.
Reality - Suicide can affect anyone.
Myth - Those who attempt suicide are weak.
Reality - This is not the case, instead, they are in pain and may have a chemical imbalance in their brain. Many individuals who are very "strong" die by suicide.
Myth - People who talk about suicide are simply trying to manipulate others.
Reality - Persons who talk about suicide are experiencing significant pain and need help. Telling clients that they are being manipulative or self-centered is not advised. People generally talk about suicide before dying by suicide, thus, therapists are wise to take such talk seriously.
Myth - Young people do not contemplate suicide, they have a long life ahead.
Reality - Suicide is the third leading cause of death for people aged 15-24, and children under age 10 sometimes die by suicide.
Myth - Alcohol and drug abuse are not correlated with suicide.
Reality - Often, those who die by suicide are under the influence of alcohol or drugs.
Myth - Suicidal individuals do not seek help.
Reality - Many people who are suicidal seek help
(Baylor University counseling center, 2021).

Challenging these suicide myths can assist therapists to view the subject from a healthier and more helpful angle, enhancing greater compassion and understanding for a person who is struggling greatly. The client may be challenged by a mental illness or an extreme stressor and may lack effective coping skills or an encouraging support system (National Alliance on Mental Illness, 2020).

SUICIDE INTERVENTION

Research-supported suicide intervention strategies include the following methods: a safety plan, cognitive behavioral therapy, and dialectical behavior therapy.

SAFETY PLAN

A safety plan is a document that supports and guides client when experiencing suicidal thoughts with intent to have client avoid an intense suicidal crisis. A suicide crisis is defined as "a suicide attempt or an incident in which an emotionally distraught person seriously considers or plans to imminently attempt to take his or her own life." (Suicide Prevention Resource Center, n.d.).

Therapist assists client to identify:
- her/his personal warning signs
- coping strategies that worked for client in the past and strategies that may work in the future
- support people in client's life such as family, friends, professionals, crisis supports
- how means of suicide will be removed from their surroundings
- her/his personal reasons for living or what has helped them to remain living (Centre for Suicide Prevention, 2021).

The safety plan is written when client is not having intense suicidal thoughts thus allowing clear thinking regarding the possibility of life, hope for life, identification of reasons for living, and preventive actions to manage overwhelming

negative ideation. The plan may need to be updated as client's circumstances change.

The concept of a safety plan is based on an assets-based model focusing on client's personal strengths and resources, and self-assertiveness to seek help if needed (Xie, 2013). Safety plans become self-assuring as clients gain the additional strength of acknowledging they have successfully moved through intense suicidal ideation before.

The Centre for Suicide Prevention (2021) recommends the following seven steps for a suicide safety plan:

Step 1: List the warning signs that reveal a suicidal crisis may be developing.

A sample open-ended question is: What thoughts, situations, body sensations, or behaviors occur that lead you to think about suicide, or that tell you that you are not mentally well? Think about some of these subtle cues.

An example scenario is:
Situation: A heated argument with spouse
Thoughts: "I can't handle this situation anymore."
Body sensations: An impulse to drink alcohol
Behaviors: Isolate myself in my bedroom and eat when not hungry.
When to implement safety plan: Any time before a suicidal crisis
How to implement safety plan: Clients' self-awareness of their warning signs can alert them of a risk for suicidal thoughts given certain thoughts, situations, or body sensations. At this point they can initiate the safety plan and proceed to the next step that addresses coping strategies.

A client who is aware of personal warning signs can facilitate caregivers and friends to identify when the person requires additional support, potentially before the individual is so aware or has asked for help.

Step 2: List coping strategies that can divert negative thoughts, including suicidal thoughts.

A possible guiding question is: What allows you to free yourself from uncomfortable, negative, or scary thought patterns, or from thoughts of suicide, for example, physical activity, a relaxation or soothing technique, a distracting activity?

A possible scenario is:
Distracting activity: Watch an enjoyable television program
Relaxation technique: deep breathing
Physical activity: Take a brisk walk
When to implement safety plan: Any time before a suicidal crisis, or when suicidal thoughts begin but are not intense.
How to implement safety plan: Utilize the discussed coping strategies to take attention away from the negative thoughts and lead themselves to a more positive frame of mind.

Friends and caregivers can encourage the person to enact their coping strategies and offer support if needed.

Step 3: List the people and places that can offer needed distraction from suicidal thoughts.

Potential questions include: Where can you go to feel centered and grounded, a place which calms you and stops suicidal thoughts? Is there a person who calms your mind and helps to cease thoughts of suicide?

Example responses include:
Places: Walking in a park; Attending a movie theater
People: Call a friend (indicate name and phone number); Go to lunch with a co-worker (indicate name and phone number).
When to implement safety plan: Any time before a suicidal crisis, or when suicidal thoughts begin but are not intense.
How to implement safety plan: The suicidal person can visit the chosen places or contact the chosen people to distract the suicidal ideation and foster a more positive mental state of mind.

Step 4: List all people, and their contact information, who can be contacted in a crisis.

A guiding question, for example, is: Who can you call among your family, friends, acquaintances, and service providers when your thoughts become overwhelming or you are thinking about suicide?

Example responses:
My brother: indicate phone number
A neighbor: indicate phone number
When to implement safety plan: Any time before a suicidal crisis or when suicidal thoughts begin but are not intense.
How to implement safety plan: The suicidal individual can contact the chosen people at any time to distract their suicidal thoughts or upon needing help with intense negative thoughts.

Individuals on client's list can be supportive during the challenging time by actively listening, visiting in person, checking on client, and asking how s/he can be of assistance.

Step 5: List mental health providers, their available hours of assistance, and 24/7 emergency contact phone numbers that can offer help in a time of crisis.

Relevant questions include: Which professionals have you already worked with who could offer help in a crisis? Which additional professionals or organizations can help you in a crisis?

Example responses:
My therapist: work phone, cell phone, available hours
Hospital of choice: City Hospital, 100 Main St.
Crisis Line: 1-800-273-8255
When to implement safety plan: Upon suicidal thoughts becoming very intense and the individual thinks coping on her or his own is not possible.
How to implement safety plan: The suicidal individual should immediately call or visit their crisis contacts.

Step 6: List the steps needed to remove access to means of

suicide.

Guiding questions include: What items could be used to die by suicide in your environment?
In the past, by what means have you thought about dying by suicide, and what can you do to make that method more difficult to access?

Sample responses:

Pills: I could give the pills to a pharmacist or friend for disposal.

Gun or rope: I could remove the item from my home or give it to a friend.

When to implement safety plan: Before a suicidal crisis develops, ideally immediately after the safety plan is constructed.
How to implement safety plan: The suicidal individual can remove the potentially lethal items from their environment themselves or give the item to a friend or caregiver. The professional working with the suicidal client should confirm that all means of suicide have been removed from home and work.
Friends and caregivers can offer help to dispose of the potentially lethal items; firearms should be removed from the home even if they were not listed as a means of suicide.

Step 7: List relevant reasons to live, or why/how the individual is still alive.

Relevant questions include: At what point during the day do you feel most calm and relaxed?
Who do you care about?
What do you like to do?
What did you like to do in the past?
What is important to you?
What was important to you in the past?
What has kept you alive until the present time?

Answers to the above open-ended questions can surface during conversation with the individual and throughout the process of suicide intervention. Therapist may need to identify and highlight this relevant information for client.

Possible responses:

My pet is important to me and I want to live so I may continue to take care of him.

When to implement safety plan: At any time before or during a suicidal crisis.
How to implement safety plan: The suicidal person can refer to their reasons for living any time, and as frequently as desired to reinforce the positive features of their life.
Friends and caregivers can remind client of these reasons for living during normal conversation to casually remind the person of their motivations for living (Stanley & Brown, 2012).

Once the safety plan is completed, client is advised to keep the safety plan in an accessible place such as in their purse/wallet or on their phone. A readily available safety plan can potentially counter intense suicidal ideation.

As circumstances change, the safety plan can be reviewed and revised as often as needed. For example, if a contact person has been unreliable several times, or a coping strategy is ineffective or inaccessible.

A no-suicide contract differs from a safety plan in that the former "is an agreement, usually written, between a mental health service user and clinician, whereby the service user pledges not to harm himself or herself" (McMyler & Prymachuk, 2008, p. 512). Clients are expected to seek help when feeling they cannot uphold their commitment to the contract (Rudd, Mandrusiak & Joiner, 2006).

Since the introduction of the no-suicide contract by Robert Drye, Robert Goulding, and Mary Goulding, in 1973, this contract has been widely used by practitioners when working with clients at risk of suicide (Rudd, Mandrusiak & Joiner, 2006). Unfortunately, supportive evidence is lacking for no-suicide contracts being clinically effective tools. Therapists and clients have expressed strong opposition to these contracts. Further, ethical and conceptual issues have arisen in the usage of no-suicide contracts, including the possibility of therapist-coercion for their own protection, and ethical implications of limiting client's choices at a time when they may be struggling for control. A strength-based method such as a safety plan, contrarily, promotes client's involvement and agency, creates a partnership with clinician, and fosters hope (Rudd, Mandrusiak & Joiner, 2006).

COGNITIVE BEHAVIORAL THERAPY APPROACH FOR SUICIDAL THINKING

Over time, we acquire beliefs about ourselves, others, our environment, our present and future, and these durable and rigid beliefs are termed 'core beliefs.' Beck (2005) categorizes core beliefs based on one's sense of lovability, worth, and control. Core beliefs can be adaptive or maladaptive due to experience with significant others and situations. Maladaptive core beliefs correspond with beliefs of unlovability, worthlessness, and helplessness. Given stress, crisis, or acute onset or recurrence of psychiatric disorder, maladaptive core beliefs rise to conscious awareness and negatively impact how we perceive our environment and process new information.

Cognitive theory professes that emotions, physiological responses, and behaviors are a result of our thinking in the present moment. The interpretations associated with events in the present moment are called 'automatic thoughts.' Dysfunctional automatic thoughts occur when the automatic thoughts are misinterpretations of current events and this process may produce sadness, anxiety, increased autonomic system activity, and a desire to avoid people. Likewise, emotions, physiological responses, and behaviors influence thinking and beliefs, for example, depressed people have difficulty accessing past positive memories and successes.

Cognitive therapy reduces negative emotional reactions, distressing physiological responses, and self-defeating behaviors by modifying dysfunctional automatic thoughts and then modifying maladaptive core beliefs. Therapist challenges dysfunctional automatic thoughts by having client consider evidence against the negative thoughts and/or identifying alternative explanations to a specific situation. Maladaptive core beliefs are confronted by doing "belief work" involving observing patterns of dysfunctional automatic thoughts occurring in multiple situations in the present. Cognitive and behavioral interventions are needed to implement stable change to underlying maladaptive core beliefs.

Additionally, two other negative cognitive tendencies are explored: maladaptive intermediate beliefs and errors in logic. Emotional distress arises from awareness of having maladaptive core beliefs, in turn, the individual uses maladaptive intermediate beliefs to prevent maladaptive core beliefs from actuating. Maladaptive intermediate beliefs are rules or assumptions that guide interactions with others and the environment, and manifest in "if... then..." statements with a positive or negative valence. For example, a core belief of "I am incompetent" can form a maladaptive intermediate belief of "If I do not make mistakes then my weakness will not be viewed by others" (the positive valence), or "If I do not respond perfectly, then I will fail" (the negative valence). Such maladaptive intermediate beliefs contribute to self-defeating behaviors and are addressed in treatment.

Often, corresponding maladaptive behaviors are linked to maladaptive intermediate beliefs and Beck (2011) terms these behaviors as 'compensatory strategies.' Similar to adaptive intermediate beliefs, compensatory strategies prevent maladaptive core beliefs from activation. By the above mentioned example, "If I do not make mistakes then my weakness will not be viewed by others," a common behavioral compensatory strategy is perfectionism. Client may try to complete work perfectly to prevent activation of the core belief "I am incompetent." Perfectionism may ultimately limit fulfilling value-based goals.

Errors in logic foster faulty information processing and misinterpretation of events and experiences in the present and are most commonly exemplified by: a) mind reading - assuming others are responding negatively without supportive evidence, b) overgeneralization - isolated or specific events describe life in general, c) all-or-nothing thinking - events are perceived in one of two mutually exclusive extreme ways, d) personalization - taking responsibility for negative outcomes without assessing other contributing causes, and e) catastrophic thinking - experiences or events are viewed as the worst possible outcomes.

The two primary motives for suicide involve escaping from life given pain, and/or producing an interpersonal change or environmental change. Suicide triggers are categorized as being internal (i.e., thoughts, images, feelings, physical sensations), external (e.g., people, places, circumstances, situations), and themes (i.e., activation of abandonment issues, fear of rejection). Two methods used to identify triggers are dysfunctional thought record and Chain Analysis. A dysfunctional thought record is composed of five columns including: situation, emotions, dysfunctional automatic thoughts, rational response, and re-rating the belief within the original dysfunctional automatic thoughts. This record helps to identify the trigger for the decision to choose suicide and it identifies the misinterpretations related to the trigger. The Chain Analysis strategy is a set of sequential links including: vulnerabilities (e.g., depression, stress, substance use, medical issues), prompting event (the external event that was the "last straw"), linked thoughts and feelings, reviewing consequences of the suicide attempt, and reviewing alternatives to the suicide attempt.

Treatment goals for the depressed suicidal client include: addressing cognitive biases and distortions, developing behavioral skills such as problem solving, ability to accept and tolerate emotional pain, enhance communication skills (conflict resolution skills, social skills, assertiveness training), lower stress, and develop supports.

Cognitive and behavioral treatment targets include hopelessness, cognitive rigidity, dichotomous thinking, acceptance of pain, and the perspective that suicide is a desirable solution.

In review, Matthews (2013) recommends the following methodology to work with depressed clients with suicidal thoughts and behaviors. Initially, therapist must identify the problem that's precipitating suicidal thoughts, followed by determining the person's motive for suicide; for instance, is the purpose of suicide to escape pain or to implement a change in her or his relationships or environment or a combination of both. To gain understanding of client's perspective while furthering trust, therapist will ask what led client to the position that suicide was apparently the only solution. Upon therapist understanding client's logic, therapist can acknowledge with client that therapist may have drawn the same conclusion under similar conditions - this response helps to normalize client's experience. Next, therapist offers hope by stating that solutions or partial solutions abound that client may have overlooked and that by working together alternatives to suicide will surface. Client is more likely to engage in treatment upon feeling that therapist understands his or her perspective and rationale without judgment.

Therapist then seeks to understand the triggering internal, external, or themes that lead to suicidal ideation and behaviors along with the factors that maintain the desire for suicide, by using thoughts records and chain analyses. In the next step, clinician helps client to challenge the distortions, misconceptions, and core beliefs that decreased her or his motivation to begin the problem solving process;

if needed, development of problem solving skills ensues. Additionally, practitioner discusses client's mindset that he or she lacks the internal or external resources to solve the problem(s).

Therapist completes an advantages and disadvantages analysis of suicide versus not-suicide early in treatment for the purpose of identifying the positive and negative reinforcers for suicide. The negative reinforcers may motivate client to consider reasons to live and not choose suicide while the positive reinforcers are used to uncover alternatives to suicide. Identifying alternatives to suicide also assists in initiating the problem-solving process. Upon identification of the alternatives to suicide, client continues with a pros and cons analysis of each alternative. Next, therapist and client develop an action plan based on the best alternative which helps motivate client to implement the plan; this is followed by an assessment of the outcome.

Productive problem solving will help to promote self-efficacy and counter a sense of helplessness, hopelessness, and worthlessness. The problem solving process also helps client to lower distress levels through working on acceptance of physical and/or emotional pain. A mindfulness strategy designed to broaden awareness of the present moment may help client feel there is more to her or his reality than pain. Helpful mindfulness techniques include learning to refocus one's attention on purpose without making a judgment, and observing the pain in order to identify factors that hurt or help the situation.

The final phase of treatment, as is the case in cognitive behavioral therapy, centers on relapse prevention. The relapse prevention phase enables client to disclose ability to utilize techniques and skills learned during the treatment process, and it informs therapist whether client is appropriately implementing the new skills and has reached termination. Lastly, relapse prevention has client imagine possible future suicide crises and discuss in detail utilization of cognitive and behavioral strategies to lower the chance of engaging in suicidal ideation and behaviors.

DIALECTICAL BEHAVIOR THERAPY

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach involving two primary characteristics: a problem-solving, behavioral emphasis combined with acceptance-based strategies, coupled with utilization of dialectical processes. The term "dialectical" relates to the factors involved in treating individuals with multiple disorders along with the type of thought processes and behavioral styles that are emphasized in the treatment strategies.

The Suicide Prevention Resource Center designated DBT as a "program with evidence of effectiveness" due to its inclusion in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). For example, among those with borderline personality disorder with recurrent suicidal behavior, DBT has lowered the suicide rate by 50% compared to non-behavioral therapy performed by community experts (Linehan et al., 2006).

The DBT model adheres to the following treatment principles for high-risk suicide clients:

1. Target suicide directly - Therapist focuses on suicidal thoughts and behaviors as the essential issue to be solved. This step involves assessment of factors that are causing or maintaining specific episodes of suicidal ideation and behaviors and creating solutions which address these factors.
2. Assess suicide risk thoroughly and continually as needed. Clinician routinely conducts suicide risk assessments to determine if suicide risk is present, for example, at intake and when clinically indicated during treatment (i.e., when client discloses increased suicidal ideation). The assessment will address: a) direct suicide risk indicators such as suicidal ideation, plans, and preparation, b) indirect suicide risk indicators as severe hopelessness, access to lethal means, and c) protective factors, including family responsibility and the belief that suicide is immoral.
3. Routinely monitor suicidal thoughts and urges. Suicidal thoughts and urges may come and go hourly, daily, weekly, or over several months for high-risk individuals, hence, therapist routinely monitors suicidal thoughts and urges, especially among clients with a history of suicidal behavior. Such monitoring in DBT is performed by client completing a diary card that includes daily ratings of urges to kill oneself. Further, clinician asks clients to rate their current urges to kill themselves at the beginning of each session. This routine monitoring allows therapist to intervene upon urges becoming high and assess the factors that precipitated suicidal increases and decreases over time.
4. Lower usage of psychiatric hospitalization. DBT tries to treat high-risk clients in the least restrictive possible setting, therefore, DBT therapists generally do not recommend or rely on psychiatric hospitalization given high suicide risk. This perspective is founded upon lack of empirical evidence that psychiatric hospitalization lowers suicide risk along with the possibility that it may increase long-term risk. The DBT approach contends that quality of life is lowered by repeatedly going in and out of psychiatric hospitals, and clients need to learn ways to reduce suicide risk while living in their natural environment. Many studies show that DBT significantly lowers utilization of expensive crisis services, such as emergency room visits and psychiatric hospitalizations, while also reducing suicidal behaviors.
5. Provide skill-based solutions to manage acute suicide risk. DBT perceives suicide as the client's effort to problem-solve, usually regarding intense emotional pain that client views as intolerable and unchangeable.

Clinician helps client to identify and activate alternative solutions to the issue to lower the immediate suicide risk. DBT teaches clients the behavioral skills to: a) increase ability to regulate emotions, b) tolerate distress, c) improve relationships, and d) live mindfully. The goal is to have clients actualize these skills to prevent escalation of suicide urges and to not act on suicide urges when present. Research reveals that usage of DBT skills leads to lower suicidal and self-injurious behaviors (i.e., Neacsiu, Rizvi, & Linehan, 2010), showing that learning and implementing skillful coping strategies is conducive to lowering suicide risk.

6. Identify and activate long-term solutions to suicide. Once acute suicidal risk is addressed, therapist helps client identify solutions to reduce long-term suicide risk. DBT strives to help individuals build a worthwhile life in which suicide is not considered viable or necessary. Practitioner seeks to understand precisely what needs to be different for client to be alive and then to facilitate such changes. Commonly, this equates to working on value-driven goals that are slower to change, for example, creating positive and lasting relationships, making meaningful contributions to others, and establishing financial stability. Many self-reports by DBT clients disclose the possibility for highly suicidal people to build worthwhile lives.
7. Therapists must be available to their clients between sessions High risk suicidal individuals often need coaching to move through difficult situations without reverting to suicide, thus, DBT requires phone coaching between sessions. Coaching calls are usually brief and center upon assisting client to identify skills necessary to manage current and ongoing troublesome situations. Given that the between-session contacts might unintentionally reinforce suicidal behavior, DBT applies several strategies, for example, the "24-hour rule" disallows therapist contact for 24 hours after a suicide attempt or non-suicidal self-injurious behavior.
8. Therapists need support and consultation. Therapist fear and exhaustion may arise knowing one's clients may die by suicide coupled with being available to high-risk clients between sessions. Further, it is recommended for therapists to seek consultation to address effective interventions. DBT thus requires therapists to participate with a therapist consultation team composed of a team of providers working together to provide DBT to a community of clients. The purpose of the therapist consultation team is to provide therapists with support, increase therapist motivation, lower burnout, enhance therapist competence, and essentially, assist therapists to competently remain engaged in this challenging but rewarding function.

More than 45,000 people in the United States (Centers for Disease Control and Prevention, 2018) and 800,000 worldwide die by suicide each year (Global Burden of Disease, 2016). Therapists are in position to potentially prevent suicide due to their in-depth disclosure interactions with suicidal clients (Stene-Larsen & Reneflot, 2019). Research suggests that among clients who died by suicide, 80 percent had contact with primary care clinicians within one year of their death (Stene-Larsen & Reneflot, 2019). Unfortunately, there is no data revealing that routine screening for suicide in primary care settings reduces mortality. Further, predicting which clients with suicidal thoughts will die by suicide is not achievable with a high degree of sensitivity or certainty (Hyman & Tesar, 1994; Sher, 2004).

Nonetheless, primary care clinicians work with a large percentage of the clients who ultimately die by suicide, therefore, it is advised for therapists to be sensitive to client risk factors, high risk situations, assessment of suicidal ideation and behavior, depression issues, and so forth. Such practitioner awareness and conscientiousness may uncover clients who subtly or clearly disclose their intent to die and can benefit from treatment.

REFERENCES

Active Minds (2021). https://www.activeminds.org/blog/myths-about-suicide/

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Washington DC.

Ayd, F.J. (2000). Lexicon of psychiatry, neurology, and the neurosciences (2nd ed.). Philadelphia [u.a.]: Lippincott, Williams & Wilkins. p. 256.

Bachynskim K.E., Canham-Chervak, M., Black, S.A., Dada, E.O., Millikan, A.M., Jones, B.H. (2012). Mental health risk factors for suicides in the US Army, 2007–8. *Injury Prevention*. 18(6):405-412.

Baylor University Counseling Center (2021). Common myths about suicide. https://www.baylor.edu/counseling_center/index.php?id=937125

Beautrais, A.L. (2003). Subsequent mortality in medically serious suicide attempts: A 5 year follow-up. Australian and *New Zealand Journal of Psychiatry*; 37: 595-599.

Berman, A.L., Silverman, M.M. (2014). Suicide risk assessment and risk formulation part II: suicide risk formulation and the determination of levels of risk. *Suicide Life Threat Behavior*. 44(4); 432-443.

Betz, M.E., Wintersteen, M., Boudreaux, E.D., et al. (2016). Suicide risk: challenges and opportunities in the emergency department. *Annals of Emerging Medicine*. 68(6): 758-765.

Bolton, J.M., Gunnell, D., Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. BMJ Publishing Group. 351:h4978.

Bradvik, L., Mattisson, C., Bogren, M., Nettlebladt, P. (2008). Long-term suicide risk of depression in the Lundby cohort 1947-1997- severity and gender. *Acta Psychiatrica Scandanavica*. 117; 185-191.

Bridge, J.A., et al. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology Psychiatry*. 47: 372-394.

Brown, G.K., Henriques, G.R., Sosdjan, D., & Beck, A.T. (2004). Suicide intent and accurate expectations of lethality: Predictors of medical lethality of suicide attempts. *Journal of Consulting and Clinical Psychology*; 72, 1170-1174.

Bryan, C.J., Corso, K.A., et al. (2012). Therapeutic alliance and change in suicidal ideation during treatment in integrated primary care settings. *Archives of Suicide Research*. 16(4): 316-323.

Capaldi, D.M., Knoble, N.B., Shortt, J.W., Kim, H.K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse*. 3(2): 231-280.

Cavanagh, J.T.O., Carson, A.J., Sharpe, M., Lawrie, S.M. (2003). Psychological autopsy studies of suicide: a systematic review. *Psychological Medicine*. (33), 395-405.

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System. (2015). https://www.cdc.gov/nchs/nvss/deaths.htm.

Centers for Disease Control and Prevention (2014). Web-Based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: National Center for Injury Prevention and Control. Available online: http://www.cdc.gov/injury/wisqars/index.html.

Centers for Disease Control and Prevention (Accessed on April 17, 2018). Web-based Injury Statistics Query and Reporting System (WISQARS). Leading Causes of Death Reports 1981 - 2016. Atlanta, GA. U.S department of Health and Human Services. https://www.cdc.gov/injury/wisqars/fatal.html

Centre for Suicide Prevention (2021). Safety plans to prevent suicide. https://www.suicideinfo.ca/resource/safety-plans/

Cerel, J., Maple, M., De Venne, A., Moore, M., Flaherty, C., Brown, M. (2016). Exposure to suicide in the community: prevalence and correlates in one US state. Public Health Rep (Washington, D.C.: 1974). 131(1): 100-107. Preventing Suicide: A Technical Package of Policy, Programs, and Practices.

Cerel, J., McIntosh, J.L., Neimeyer, R.A., Maple, M., Marshall, D. (2014). The continuum of "survivorship": definitional issues in the aftermath of suicide. *Suicide Life Threat Behavior*. 44(6): 591-600.

Chang, B., Gitlin, D., Patel, R. (2011). The depressed patient and suicidal patient in the emergency department: evidence-based management and treatment strategies. *Emergency Medicine Practice*. 13 (9): 1-23.

Chapman, A.L., Dixon-Gordon, K.L. (2007). Emotional antecedents and consequences of deliberate self-harm and suicide attempts. *Suicide Life Threat Behavior*. 37(5): 543-552.

Connor, K.R., Duberstein, P.R. (2004). Predisposing and precipitating factors for suicide among alcoholics: empirical review and conceptual integration. *Alcohol Clinical and Experimental Research*. 28: 6S-17S.

Crosby AE, Ortega L, Melanson C. (2011). Self-directed violence surveillance: uniform definitions and recommended data elements, version 1.0. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Crosby AE, Han B, Ortega LA, Parks SE, Gfroerer J. (2011). Suicidal thoughts and behaviors among adults aged ≥18 years-- United States, 2008-2009. MMWR CDC Surveillance Summaries. 60(13):1-22.

Dahlberg, L.L., Krug, E.G. (2002). Violence-a global public health problem. In: Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., Lozano, R., eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization: 1-21.

Dube, S.R., Anda, R.F., Felitti, V.J., Chapman, D.P., Williamson, D.F., Giles, W.H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *JAMA*. 286(24): 3089-3096.

Florence, C., Simon, T., Haegerich, T., Luo, F., Zhou, C. (2015). Estimated lifetime medical and work-loss costs of fatal injuries-United States, 2013. MMWR *Morbidity and Mortality Weekly Report*. 64(38): 1074-1077

Goodwin, F.K., Jamison, K.R. (2007). *Manic-depressive illness: bipolar disorders and recurrent depression.* 2nd ed. New York: Oxford University Press.

Gratz, K.L., Conrad, S.D., Roemer, L. (2002). Risk factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry*. (72), 128-140.

Global Burden of Disease, 2015. Mortality and causes of death collaborators (2016). Global, regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980-2015: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet.* 388:1459.

Hamdullahpur, K., Jacobs, K.W.J., Gill, K.J. (2018). Mental health among help-seeking urban women: the relationships between adverse childhood experiences, sexual abuse, and suicidality. *Violence Against Women*. 1077.

Han, B., Crosby, A.E., Ortega, .LA., Parks, S.E., Compton, W.M., Gfroerer, J. (2016). Suicidal ideation, suicide attempt, and occupations among employed adults aged 18–64 years in the United States. *Comprehensive Psychiatry*. 66:176-186.

Hawton, K., Casanas, I., et al. (2013). Risk factors for suicide in individuals with depression: a systematic review. *Journal of Affect Disorders.* 147(1-3): 17-28.

Hawton, K., van Heeringen, K. (2009). Suicide. *Lancet.* 373 (9672); 1372-1381.

Hawton, K., Sutton, L., Haw, C., et al. (2005). Schizophrenia and suicide: a systematic review of risk factors. *British Journal of Psychiatry*. 187: 9-20.

Hyman, S.E., Tesar, G.E. (1994). The suicidal patient. In: *Manual of Psychiatric Emergencies*, 3rd Ed.

Jacobs, D., Baldessarini, R., et al. (2010). Practice guideline for the assessment and treatment of patients with suicidal behaviors.

Jobes, D.A. (2012). The collaborative Assessment and management of suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. *Suicide Life Threat Behavior*. 42(6): 640-653.

Kann, L., McManus, T., Harris, W.A., et al. (2016). Youth Risk Behavior Surveillance - United States, 2015. MMWR CDC Surveillance Summaries. 65(6):1-174.

Kene, P., Yee, E.T., Gimmestad, K.D. (2018). Suicide assessment and treatment: gaps between theory, research, and practice. *Death Studies*. 1-9.

Kessler, R.C., Borges, B., & Walters, E.E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry*; 56, 617-626.

Koenig HG. (2009). Research on religion, spirituality, and mental health: a review. *Canadian Journal of Psychiatry*. 54(5): 283-291.

Large, M., Smith, G., Sharma, S., Nielssen, O, Singh, S.P. (2011). Systematic review and meta-analysis of the clinical factors associated with the suicide of psychiatric in-patients. *Acta Psychiatry Scandanavia*. 124:18-29.

Law S, Liu P (2008). Suicide in China: unique demographic patterns and relationship to depressive disorder. *Current Psychiatry Reports*. 10(1): 80-86.

Leeb RT, Lewis T, Zolotor AJ. (2011). A review of physical and mental health consequences of child abuse and neglect and implications for practice. *American Journal of Lifestyle Medicine*. 5(5): 454-468.

Lerner G. (2010). Activist: Farmer suicides linked to debt in India, globalization. *CNN World*. Archived 2013.

Levin, JD, Culkin J, Perrotto RS (2001). *Introduction to chemical dependency counseling*. Northvale, NJ: Jason Aronson. pp. 150-152.

Lineberry, T.W., O'Connor, S.S. (2012). Suicide in the US Army. *Mayo Clinic Proceedings*. 87(9):871-878.

Lipari, R., Piscopo, K., Kroutil, L.A., Kilmer, Miller G. (2015). Suicidal thoughts and behavior among adults: results from the 2014 National Survey on Drug Use and Health. NSDUH Data Review. https://www.samhsa.gov/data/sites/default/files/ NSDUH-FRR2-2014/NSDUH-FRR2-2014.pdf.

Luoma, J.B., Martin, C.E., Pearson, J. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*. 159: 909-916.

Mathews, J. (2013). Cognitive Behavioral Therapy approach for suicidal thinking and behaviors in depression. *IntechOpen*. https://www.intechopen.com/chapters/41711.

Mattisson, C., Bogren, M., Horstmann, V., Munk-Jorgensen, P., Nettelbladt, P. (2007). The long-term course of depressive disorders in the Lundby Study. *Psychological Medicine*. (37): 883-891.

McIntosh, W.L., Spies, E., Stone, D.M., Lokey, C.N., Trudeau, A.R., Bartholow, B. (2016). Suicide rates by occupational group - 17 states, 2012. MMWR Morb. *Mortal Weekly Report*. 65(25): 641-645.

McMyler, C., Prymachuk, S. (2008). Do "no-suicide" contracts work? *Journal of Psychiatric and Mental Health Nursing*, 15(6), 512-522.

Murphy, G.E., Wetzel, R.D. (1990). The lifetime risk of suicide in alcoholism. *Archives of General Psychiatry*. 47(4): 383-392.

National Alliance on Mental Illness (2020). https://www.name.org/Blogs/ NAMI-Blog/September-2020/5-Common-Myths-About-Suicide-Debunked

National Collaborating Centre for Mental Health (2011). *The NICE guideline on longer-term management*. London: National Collaborating Centre for Mental Health

National Institute of Mental Health (2022). Suicide Prevention. NIMH.NIH.gov/health/topics/suicide-prevention

Neacsiu A.D., Rizvi, S.L., Linehan, M.M. (2010). Dialectical behavior therapy skills use as a mediator and outcome of treatment for borderline personality disorder. *Behavior Research and Therapy*. Sep; 48(9): 832-839.

Nock, M.K., Prinsten, M.J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology*. Vol. 114(1): 140-146.

O'Connor, R.C., Nock, M.D. (June 2014). The psychology of suicidal behaviour. *The Lancet*. Psychiatry. 1 (1): 73-85.

Olfson, M., Marcus, S.C., Bridge, J.A. (2013). Emergency department recognition of mental disorders and short-term outcome of deliberate self-harm. *American Journal of Psychiatry*. (170): 1142-1150.

Olfson, M., Gerhard, T., Huang, C., Crystal, S., Stroup, T.S. (2015). Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry*. 72(12): 1172-1181.

Oquendo, M.A., Currier, D., Liu, S.M., Hasin, D.S., Grant, B.F., Blanco C. (2010). Increased risk for suicidal behavior in comorbid bipolar disorder and alcohol use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Journal of Clinical Psychiatry*. 71(7): 902-909.

Owens D. (2002). Fatal and non-fatal repetition of self-harm: systematic review. *British Journal of Psychiatry*. 181(3): 193-199.

Pallanti, S., Rossi, N.B., Hollander, E. (2006). Pathological Gambling. In Hollander E, Stein DJ (eds). Clinical manual of impulse-control disorders. *American Psychiatric Publishing*. p. 253.

Pinals, D.A., Anacker, L. (2016). Mental illness and firearms: legal context and clinical approaches. *Psychiatry Clinics of North America*. 39(4): 611-621.

Pirkis, J., Burgess, P. (1998). Suicide and recency of health care contacts: a systematic review. *British Journal of Psychiatry*. 173: 462-474.

Pompili, M., Serafini, G., Innamorati, M., Lester, D., et al. (2011). Suicide risk in first episode psychosis: a selective review of the current literature. *Schizophrenia Research*. 129(1): 1-11.

Poorolajal, J., Hahgtalab, T., Farhadi, M., Darvishi, N. (2016). Substance use disorder and risk of suicidal ideation, suicide attempt and suicide death: a meta-analysis. *Journal of Public Health (Oxf)*. 38(3): e282-291.

Qin, P., Agerbo, E., et al. (2003). Suicide risk in relation to socioeconomic, demographic, psychiatric and familiar factors: a national register based study of all suicides in Denmark, 1981-1997. *American Journal of Psychiatry*. 160: 765-772.

Qin, P., Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization: evidence based on longitudinal registers. *Archives of General Psychiatry*. 62(4): 427-432.

Roy, A., Pomili, M. (2009). Management of schizophrenia with suicide risk. *Psychiatric Clinics of North America*. 32(4): 863-883.

Rudd, M., Mandriusiak, M., Joiner, T. (2006). The case against no-suicide contracts: the commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology*. DOI:10.1002/jclp.20227.

Russell, S.T., Joyner, K. (2001). Adolescent sexual orientation and suicide risk: evidence from a national study. *American Journal of Public Health*. 91(8):1276-1281.

Sadek J. (2019). A clinician's guide to suicide risk assessment and management. Springer International Publishing.

Schreiber, J., Culpepper, L. (2022). Suicidal ideation and behavior in adults. https://uptodate.com/contents/suicidal-ideation-and-behavior-in-adults

Shepard DS, Gurewich D, Lwin AK, Reed GA, Jr., Silverman MM. (2016). Suicide and suicidal attempts in the United States: costs and policy implications. *Suicide Life Threat Behavior*. 46(3): 352-362.

Sher, L. (2004). Preventing suicide. *QJM: An International Journal of Medicine*. 97:677.

Stanley, B., Brown, G. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256-264.

Stene-Larsen, K., Reneflot, A. (2019). Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017. *Scandanavian Journal of Public Health*. 47:9.

Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Stone DM, Luo F, Ouyang L, Lippy C, Hertz MF, Crosby AE. (2014). Sexual orientation and suicide ideation, plans, attempts, and medically 2001-2009. *American Journal of Public Health*. 2014; 104(2):262-271.

Suicide Prevention Resource Center (n.d.). Retrieved from https://www.sprc.org/about-suicide/topics-terms

Turecki G, Brent DA (2016). Suicide and suicidal behaviour. *Lancet*. 387 (10024): 1227-39.

U.S. Office of the Surgeon General, National Action Alliance for Suicide Prevention. 2012 National strategy for suicide prevention: goals and objectives for action. Washington, D.C.: HHS; 2012. www.healthline.com/health/suicide-and-suicidal-behavior#risk-factors 2017.

Undurraga, J., Baldessarini, R.J., Valenti, M., Pacchiarotti, I., Vieta, E. (2012). Suicidal risk factors in bipolar I and II disorder patients. *Journal of Clinical Psychiatry*. (73): 778-782.

Veterans Administration (2009). Suicide risk assessment guide. www.mentalhealth.va.gov/docs/suicide_risk_ assessment_guide.doc

Walby, F.A., Myhre, M., Kildahl, A.T. (2018). Contact with mental health services prior to suicide: systematic review and meta-analysis. *Psychiatric Services*. appips201700475.

Walsh, G., Sara, G., Ryan, CJ., Large, M. (2015). Meta-analysis of suicide

rates among psychiatric in-patients. *Acta Psychiatrica Scandinavica*. 131(3): 174-184.
Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., et al. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet*. 382(9904): 1575-1586.
WHO.INT/mental health/suicide-prevention/myths.pdf (2021). Preventing suicide: a global imperative.
Wortzel, H., et al. (2014). Therapeutic risk management of the suicidal patient: stratifying risk in terms of severity and temporality. *Journal of Psychiatric Practice*. 20(1): 63-67.
Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the dots: an overview of the links among multiple forms of violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
World Health Organization (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization.
World Health Organization. (2014). Suicide prevention: a global imperative. Geneva, Switzerland: WHO Press.
Xie, H. (2013). Strengths-based approach for mental health recovery. *Iranian Journal of Psychiatry and Behavioral Science*, 7(2), 5-10. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3939995

TEST - SUICIDE: RISK, ASSESSMENT, and INTERVENTION

6 Continuing Education Hours
Record your answers on the online Answer Sheet (click the "New York LMSW/LCSW/LMHC/LMFT/Psychologist" Answer Sheet" link on Home Page and click your answers).
Passing is 70% or better.
For True/False questions: A = True and B = False.

Continuing Psychology Education Inc. is recognized by the New York State Education Department's State Board for: Social Work as an approved provider of continuing education for licensed social workers #SW-0387; Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors #MHC-0080, and licensed marriage and family therapists #MFT-0043; Psychology as an approved provider of continuing education for licensed psychologists #PSY-0006.

TRUE/FALSE

1. **Suicide may be operationally defined as a death caused by self-directed behavior with any intent to die as a result of the behavior.**
   A) True B) False

2. **A suicide attempt is defined as a non-fatal self-directed and potentially injurious behavior with any intent to die as a consequence of the behavior, and the suicide attempt may or may not cause injury.**
   A) True B) False

3. **The highest suicide rates across the life span occur among non-Hispanic American Indian/Alaska Native and non-Hispanic White population groups.**
   A) True B) False

4. **The most accurate predictor of suicide is having a history of suicide attempts.**
   A) True B) False

5. **Optimism has not been demonstrated to produce a protective effect against suicide.**
   A) True B) False

6. **Inquiring about suicidal ideation and intent does not increase the likelihood of an individual contemplating suicide for the first time or enacting such.**
   A) True B) False

7. **The World Health Organization recommends that everyone over the age of 10 who has a mental disorder or other risk factor should be asked whether they have had thoughts or plans of self-harm within the past month.**
   A) True B) False

8. **Suicide risk may vary over the course of treatment, therefore, suicide risk assessment is an ongoing process.**
   A) True B) False

9. **A thorough suicide risk assessment only includes risk factors and does not include protective factors that may lower suicide risk.**
   A) True B) False

10. **In cognitive behavioral therapy, therapist challenges dysfunctional automatic thoughts by having client consider evidence against the negative thoughts and/or identifying alternative explanations to a specific situation.**
    A) True B) False

11. **In 2019, approximately _____ Americans died by suicide.**
    A) 10,000
    B) 5,000
    C) 47,000
    D) 15,000

12. **_____ is the second most common suicide risk factor after major depression and bipolar disorder.**
    A) Substance abuse
    B) Fatigue
    C) Marital discord
    D) Boredom

13. **Protective factors, defined as factors that may lessen suicide risk, or influences that safeguard against suicide risk within the four levels of the social ecological model involve:**
    A) adequate coping and problem-solving abilities
    B) moral objection to suicide
    C) lowered access to lethal means of suicide
    D) All of the above

14. **Many individuals will deny having suicidal ideation for various reasons, including:**
    A) the stigma of admitting to having symptoms of a mental disorder
    B) fear of being judged negatively or ridiculed by the practitioner
    C) concern that the practitioner may overreact and hospitalize the individual involuntarily
    D) All of the above

15. **The ability to cope with stress is _____.**
    A) an example of a suicide external protective factor.
    B) an example of a suicide internal protective factor.
    C) unrelated to suicide.
    D) none of the above

16. **A clinician would categorize the suicide risk level for a client who has intent to die by suicide and cannot maintain safety independently of external help or support as _____.**
    A) low acute risk
    B) medium acute risk
    C) high acute risk
    D) low chronic risk

17. **A _____ is a document that supports and guides client when experiencing suicidal thoughts with intent to have client avoid an intense suicidal crisis.**
    A) safety plan
    B) NSSI (non-suicidal self-injury report)
    C) maladaptive core belief form
    D) maladaptive intermediate beliefs form

18. **The safety plan is written _____.**
    A) when client is in a high anxiety state.
    B) when client is having intense suicidal thoughts.
    C) when client is deep in depression.
    D) when client is not having intense suicidal thoughts thus allowing clear thinking regarding the possibility of life.

19. **_____ reduces negative emotional reactions, distressing physiological responses, and self-defeating behaviors by modifying dysfunctional automatic thoughts and then modifying maladaptive core beliefs.**
    A) Rational-Emotive therapy
    B) Gestalt therapy
    C) Client-centered therapy
    D) Cognitive therapy

20. **_____ is a cognitive-behavioral treatment approach involving two primary characteristics: a problem-solving, behavioral emphasis combined with acceptance-based strategies, coupled with utilization of dialectical processes.**
    A) No-suicide contract
    B) Dialectical Behavior Therapy
    C) Safety plan
    D) Suicide protective factor therapy

Click the link "New York LMSW/LCSW/LMHC/LMFT/Psychologist Answer Sheet" on Home Page, then follow the prompts, which include making your payment, transferring your test answers to the online answer sheet, and printing your certificate immediately.

Press "Back" to return to "New York LMSW/LCSW/LMHC/LMFT/Psychologist Courses" page.