Chapter 10
Suicide

"Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis." ~ Judith Herman

OBJECTIVES FOR THIS CHAPTER

- Become more comfortable with the topic of suicide
- Recognize signs of risk for suicide
- Be knowledgeable about risk assessment and the intervention techniques used for different levels of risk

Suicide is a topic that can make helpers feel helpless. A suicidal victim is not much different from any other victim, with the possible exception of the level of despair. In addition to basic listening, rapport building and helping skills, you will also use some different tools with this type of victim.

Many victims make statements that indicate they may be contemplating ending their lives. RVAP advocates are in an excellent position to successfully help victims through this stage in their healing. This chapter will teach you the tools needed to help a victim re-connect with other options.

DEFINITIONS[1,2,3,4]

- **Intervention:** Suicide intervention is preventing an act of self-destruction. It is a supportive confrontation with troubled people through a compassionate response to their crisis
- **Lethality level:** The degree of risk inherent in a self-destructive situation
- **Postvention:** To understand and assist the family and friends after the death of a loved one who has committed suicide
- **Precipitating event:** The negative event that creates a situation so intolerable that the person affected by it becomes suicidal
- **Suicidal crisis:** What occurs after the person begins to actively do self-harm. Most suicidal crises are of extremely short duration
- **Suicidal gesture**: An act that is indicative of self-destructiveness, but the level of lethality is so low that the act could not cause death. The lethality level is so low that it is apparent that there is no intention of dying. Adolescents are especially prone to suicidal gesturing
- **Suicidal ideation:** Having thoughts about killing yourself. It is normal for people to have such thoughts at one time or another in their lives. However, a healthy, well-integrated personality will quickly dismiss such thoughts as representing an unacceptable alternative
- **Suicide attempt:** A non-fatal, self-inflicted, destructive act with the explicit or inferred intent to die

SUICIDE MYTHS AND FACTS

Many of the commonly believed myths about suicide can be detrimental for people who need help with their suicidal feelings. As advocates, we need to be familiar with the myths and facts about suicide to provide suicidal victims with a high level of service.

MYTH: Suicide is commonly believed to happen "out of the blue," without warning. It is believed that people who talk about suicide do not actually commit the act.

[1] Crisis Center. *Crisis Center Training Manual.* Iowa City, IA: 2003. Print.

[2] "Suicide Prevention, Scientific Information: Risk and Protective Factors." *Centers for Disease Control and Prevention*. Department of Health and Human Services, 19 November 2008. Web. 27 December 2010. <www.cdc.gov/ncipc/dvp/suicide/suicide_risk_pfactors.htm>

[3] American Foundation for Suicide Prevention. <www.afsp.org>

[4] National Institute of Mental Health. <www.nimh.nih.gov>

FACT: At least two thirds of people who commit suicide tell someone about their plan, give clues or exhibit suicidal behavior.

MYTH: Because suicidal people are fully intent on dying, reaching out to them cannot prevent suicide.
FACT: While ultimately the choice to end one's life lies with the individual, other people including concerned friends, family, mental health providers, and peer counselors, can intervene successfully. Most suicidal people are ambivalent about dying, and will recover from the suicidal crisis with the proper support and assistance from their support system.

MYTH: If you ask them about suicide, you will put the idea in their heads.
FACT: Asking someone calmly and directly about their suicidal intentions will open the door for developing a rapport with them and provide a safe environment for them to share. Talking openly about suicidal ideation can often lower anxiety and encourages venting feelings and exploring other options.

SUICIDE STATISTICS[5]

- Rape victims are 8.7 times more likely to attempt suicide when compared to non-victims.
- Males take their own life four times more frequently than females, but women attempt suicide two to three times more than men do.
- Suicide rates are highest during April, June and July. Suicide rates are the lowest from September to December.
- Firearms are the most commonly used method for suicide for men and women, accounting for 60% of all suicides.
- Suicide is the second leading cause of death in 25 to 34 year olds, and the third leading cause of death in 15 to 24 year olds.
- In 2007, 14.5% of U.S. high school students reported that they had seriously considered attempting suicide during the previous 12 months.
- Suicide rates are highest among the elderly, particularly older white males. Among white males 65 and older, risk increases with age. In the U.S., white men 75 and older have the highest suicide rate.

[5] Centers for Disease Control and Prevention. "Suicide: Facts at a Glance." Summer 2010. PDF file. <http://www.cdc.gov/violenceprevention/pdf/suicide_datasheet-a.pdf>

SIGNS OF SOMEONE AT RISK[6]

Some examples of suicidal behavior include:

- "Tying up loose ends," such as writing a will, giving away possessions
- Calling family and friends to say good-bye
- Seeming preoccupied with death, joking about death or suicide
- Statements of futility, such as "I can't go on anymore," "This will all be over soon," or "The world would be better off without me"
- Rehearsing suicide
- Expressing unbearable feelings of hopelessness/helplessness

Not all victims will make statements that clue the advocate in to their suicidal intentions. Many times, you will pick up that a victim may be suicidal from the story the victim is telling you. For example, the victim may share feeling isolated, that someone in the immediate family committed suicide, or that the victim has been using alcohol or other drugs to "numb out." The victim has what is called "suicidal potential," meaning there are signs of risk for suicide.

Make sure to listen for signs of suicidal potential. If you hear more than one of these indicators, you will know to ask if the victim is thinking about committing suicide. The following items are all part of doing an assessment of suicidal potential:

- **Situational:** People who are in difficult situations, such as bad relationships, stressful jobs or experiencing rape, may feel a loss, helplessness and out of control. They may believe there is no hope for improving their condition.
- **Physical or mental illness:** People with chronic and/or painful conditions may consider suicide, rather than endure suffering. They may decide they want to die in a way and at a time of their own choosing. People with depression, anxiety, or other mental health issues are also at greater risk.
- **Previous attempts:** People are particularly at risk 80 to 100 days after a previous attempt.
- **Chemical use and abuse:** Loss of inhibitions and debilitated decision-making are typical of those under the influence and can increase the likelihood of an attempted suicide.
- **Lacking social support:** Someone who does not have understanding, supportive people to talk to, has recently moved to a new city or state, has lost a

[6] "Depression Guide: Recognizing the Warning Signs of Suicide." *WebMD.com*. WebMD, LLC., 2005-2010. Web. 27 December 2010. <http://www.webmd.com/depression/guide/depression-recognizing-signs-of-suicide>

loved one, or has ended an important relationship may feel isolated and alone, increasing the risk for suicide.

- **Depression:** A majority of suicides are linked to untreated, and in many cases, undiagnosed mood disorders, including depression. It is important to understand the disease and recognize the signs. These include: feelings of hopelessness, powerlessness, worthlessness, shame, guilt, self-hatred, perfectionism; expressions of irritability, aggressiveness, nervousness and anger outbursts; anxiety; apathy and loss of interest in hobbies, work, school, and personal appearance; changes in sleeping patterns, like insomnia or sleeping all the time; loss of appetite or overeating; social isolation and declining interest in sex, friends and activities previously enjoyed.

ASK ABOUT SUICIDE

If you sense the victim is dancing around the subject saying things like "sometimes I just want it all to go away" or "I don't want to be here anymore", you can ask:

- "Are you thinking about killing yourself?"
- "Have you been thinking about suicide?"
- "Do you want to cease to exist or do you want the pain to stop and can't see any other way right now for that to happen short of dying?"

If the victim is not talking about suicide, the answer may be "No, that's not what I was talking about," and then go on to clarify what was meant. However, if the victim was thinking of suicide, bringing it up can be a great relief for the caller. It signals that RVAP is a safe place to talk about suicide and pain, and lets the victim know that you will be able to listen without expressing fear or judgment about the victim's deepest and scariest thoughts.

If the victim is talking about suicide, assess immediate danger and establish an open, trusting relationship. Be direct and caring. Discuss death in real terms rather than ineffective terms such as "going away."

Suicide is a way to take back control, so explore other ways the victim can take control in her or his life. Offer the victim information, resources and choices. Listen for the victim's strengths. Killing yourself takes planning, courage, energy, and determination. How can the victim use those skills to change the situation in other ways besides dying?

If you do not ask about suicide and the victim has been thinking about it, the victim may assume you are afraid to discuss it and that it is not okay to be thinking about it. As a result, the victiim may feel even more isolated.

IMMEDIATE RISK ASSESSMENT[7]

After the victim expresses thoughts of committing suicide, ask specific questions to determine the level of risk. The level of risk will determine how direct and immediate you should be in your response. Keep in mind, the vicim does not need your participation to commit suicide. The call can be seen as an attempt to identify ulterior options to feel better.

The acronym SLAP can be used for an immediate risk assessment.

- **Specific:** How specific is the plan? Is it detailed and well thought-out? What means will be used? Has the victim planned how to obtain the means? If using pills, does the victim know exactly how many to swallow to make the attempt lethal? When and where will the attempt take place? How sure is the victim that this is the best choice?
- **Lethality:** How lethal is the method to be used? Guns and hanging are more lethal than drugs, but the determining factor is whether the victim believes the method is fatal. The risk is higher for methods that have a higher lethality. There are five key questions for assessing lethality:
    - Are you thinking of killing yourself?
    - Have you thought about how you would do it?
    - Do you have ___________ (the means to do it)?
    - Do you know when you will do it?
    - Have you done anything yet to hurt yourself?
- **Availability:** Does the victim possess the means or is it readily accessible? The risk is considerably more serious if the means are readily available than it would be if the victim does not have easy access.
- **Proximity:** Is the attempt planned at a time when someone will be around or is it planned to occur in isolation? An attempt that takes place when there are people around has a greater likelihood of rescue. If, however, it is to be done in an isolated area, rescue is less likely. The risk is greater if there is a smaller chance of rescue.

LEVELS OF RISK AND HOW TO RESPOND

[7] Miller, P.H. "Training Workshop Manual." San Diego: Information Center. 1985.

Low Risk

- No specific plan
- Suicide has been thought about in vague terms
- Support is being given by significant others and is accepted
- Some evidence exists of planning for the future

How to Respond:
If the victim is safe, it is appropriate to continue active listening. One helpful clarifying question is "Do you want to end your life, or do you want the pain to end?" Likely, the victim will say they just want the pain to end and does not know how else to make that happen.

At this point, listening to the victim is most critical. Explore the pain: (1) what kind of pain is it? (2) Where does it hurt? When? Has anything helped? What thoughts does the caller have during this pain?

As you listen, you may want to help the victim identify areas where they have some control. Identify choices: "So it sounds like you could ______ or you could _____?" Sometimes, part of feeling suicidal is feeling like you do not have control over any part of your life. As always, give a lot of encouragement about the active choice by calling for help.

Medium Risk

- One or more plans have been considered, but the victim has not clearly chosen a method
- Means are not immediately available or not highly lethal (e.g. taking six Tylenol)
- Diminished contact with others
- Expressed hopelessness

How to Respond:
If there is a plan, you might want to know more. You could ask, "Have you done anything to hurt yourself today?" or "Are you safe now?"

While suicidal thoughts and the situations leading up to them is complex, the impulse to carry out a plan can be brief. You can intervene until that impulse passes. You can ask if the victim would be willing to talk with a therapist or check into the hospital. As soon as you can, notify your SBU that you are dealing with a victim who is discussing suicide.

If you know the victim's full name and location, the SBU can, if necessary and with the victim's permission, call the police to intervene.

High Risk

- Specific plan
- Availability of means
- Method has potential to be lethal
- Expressed desire to die
- Low chance of being found and rescued
- Isolation from others
- Previous attempts
- No future plans
- Suicide attempt made or in progress

How to Respond:
If the victim has pills, a knife, razor blade, gun, or other object, ask the victim to put the object in the next room or across the room while you talk. You could say, "Would it be okay if you put the razor blade across the room on the dresser while we talk? I am worried about you hurting yourself while we are talking. I can listen better if I know you are safe." You are not taking choice or control away, just taking a break from it. Having the object at some distance reduces the risk of acting impulsively when the conversation is difficult. You want to ensure that the victim has clear thinking on all the options. It is a delicate balance, of course, but it is easier for you to listen to feelings and talk out options if you feel that the victim is "safe."

Discuss the possibility of their suicide attempt failing. People have unrealistic expectations of what death is like. If the victim shoots themselves, they may end up surviving but permanently disfigured, disabled, and/or in a coma. Drugs do severe damage to internal organs and most people vomit, lose control of their bowels, have convulsions, and other reactions. Death is far different from what is shown in the movies, where people die peacefully. Thus, they would have even less control over their lives than they feel now.

Suicidal Crisis

In a worst-case scenario, you have the advantage that people in the process of dying become more suggestible the more blood they lose or the more time drugs have had to affect them. They may at the last minute become scared and change their mind. They are more likely to get immediate help if they actually make an attempt than people who just say they are suicidal.

Make a Referral

If the victim wants help immediately, keep the caller on the line and use another phone to call your SBU (you will need to get her or his name and address if the caller wants someone to come help). Remember, do this only with the caller's permission, as it requires a breach of confidentiality.

If you still have some concerns, or the caller expresses some more suicidal ideology at the end of your call, you may want to make a referral to the Crisis Center in Iowa City (351-0140) or to the National Suicide Prevention Lifeline (1-800-273-8255 or 1-800-273-TALK).

SPECIFIC ACTION TECHNIQUES FOR ALL SUICIDE CALLS

This section goes further into some of the specific actions you can take while talking with a suicidal caller. While not an exhaustive list, the tools below set a solid foundation for peer counseling with a suicidal caller.

- **Assess the risk level using SLAP** and determine which interventions are appropriate.
- **Obtain as much information as you can** through active listening but avoid grilling the caller for information. A caller who refuses to answer direct questions about identity, location, plan, etc. will often inadvertently reveal information during the call. In addition, the caller will be more likely to give information to a counselor who has taken time to establish rapport and build trust. Do not rush the caller. It is vital that you provide an opportunity for the caller to talk about her or his strong emotions. Communicate to her or him that you are not going to give up just because she or he will not give identifying information.
- **Ask questions, but be aware of the caller's reactions.** Open-ended questions facilitate rapport, but gentle closed-ended questions are useful for obtaining information quickly. Intersperse questions with "understanding" comments (empathy statements).

- **Ask the caller about feeling this way before, and if so, what happened.** This gives the caller the chance to reflect and remember that things did improve and eventually feel better.
- **Ask, "If suicide were not an option, what else might you do?"** This allows the caller to drop the option of suicide long enough to consider other potential solutions.
- **Use the direct terms** (die, kill yourself, suicide, death, corpse) to help the person with suicidal ideation face the reality and finality of death. This discourages "romanticizing" of suicide.
- **Address the ambivalence the caller is likely experiencing.** Acknowledge that part of her or him wants to live, but that another part finds life too painful. Without giving false assurances that "everything will be okay," search for the side of the caller that wants to live.
- **Help the suicidal person identify issues or problems.** Break them down into smaller, more manageable pieces so that not to feel so overwhelmed.
- **Encourage the person to refrain from making any serious, irreversible decisions while in a crisis.** Talk about positive alternatives, which may establish hope for the future. It may even be asking the caller to wait – at least until talking to a counselor the next day. (Refer caller to staff and alert your SBU.)
- **Help the person think of one small task to do** (get a glass of water or Kleenex). This will help the caller feel a sense of control.
- **If the caller has already acted on the suicidal plan**, for example, taking pills in an attempt to overdose, it is termed a suicide in progress.
  - If pills or drugs are involved, ask when they were taken, how many, what kind, the person's current physical condition, height, weight and whether anything else has been taken (alcohol for example). You may also want to ask when the person last ate. Tell the person that you will contact Poison Control (for the state of Iowa, the number is 1-800-222-1222) with her or his permission, then share whatever information you obtain. Ask for a call back number.

THE SAFETY CONTRACT

Wrapping up an advocacy with a written agreement from the client that they will not kill themselves can be helpful for those at medium risk for suicide, or for high-risk callers that have worked through the crisis and are de-escalated.

Ask the client to agree to a safety contract to stay safe at this time (see next page for a sample). If the client becomes agitated and states that they cannot agree to a contract, do not push. Go back to reflecting feelings and building rapport.

- Summarize your concern that the client may become desperate or hopeless again.
- Tell the client that you would like to work out a plan to keep the client safe during this crisis. Ask permission to do so.
- Some suicidal clients will already be familiar with safety contracts; many will not. For those who are not familiar with this, a brief summary of the elements below may be helpful.
- As with all interventions, it is important that your concern is sincere. A client's perception that this is a generic "counselor thing to do" may destroy rapport and decrease the likelihood that the client will agree to a contract.
- If the client agrees to contract with you, the first thing to emphasize is that the contract goes into effect at the *clear risk* of engaging in self-injurious behavior, *not after* such behavior has been attempted. The contract should include:
  - **Definitions of self-injurious behavior:** Address the specific means identified by the client (e.g., agreeing to not take an overdose of medication or any other behavior that puts the caller at risk).
  - **Action plan:** (1) Call RVAP office the next day to set up an appointment with an RVAP counselor for follow-up to the immediate call. (2) Determine what the client will do if they feel suicidal again (e.g., call the Rape Crisis Line, talk to a friend, or call the Crisis Center).
  - **Time frame:** Set a time frame that is reasonable for the client. Make the contract effective until the client's next contact with another supportive person (their therapist, spouse, etc.).

After all of the above specifics have been agreed to, it is useful to review them with the client. The contract may be used to empower the client by pointing out that you trust them to honor it. Ask the client to say the contract with you, which communicates to them that you are committed to helping them live.

Note: The Safety Contract is not effective with clients who have begun an attempt, or with those at low risk. If you contract with a client, document the contract completely.

Sample Safety Contract

The client and advocate will both get pen and paper and write out the same contract, each signing and dating their own copy.

I, ___________, agree not to hurt myself by ______________________________ or any other means.

If I should have urges to injure or kill myself between this day and _________ (date) I will talk to ________________ (name) or ___________ (name).

If these people are unavailable, I agree to go directly to ________________ hospital or an emergency room.

I will follow this agreement until ____________ (date) and renew this agreement as necessary with _____________________ (counselor, supportive person, or other professional).

Signature: _____________________________ Date: _____________

Advocate: _____________________________ Date: _____________

POST-INTERVENTION (IN THE EVENT OF A COMPLETED SUICIDE)

When someone commits suicide, everyone wonders if they did enough or what could have been done differently to help. A complete suicide does not mean the advocate (or other helper) failed; it means that the person had already decided to die. Support must be made available to everyone close to the suicide, including you, the advocate. We have the advantage of being our own support group. Talking about how we intervened can be helpful and supportive. It is important to acknowledge that suicide is still a taboo subject. Ordinary bereavement actions on the part of friends and neighbors such as attending the funeral, visiting the family, making and bringing them food, cleaning their house and so on are often denied to family who experience a suicide. Their friends, not knowing what to say, say nothing.

Families that have experienced a suicide might also be deprived of friendships and other relationships. Suicide is not perceived to be an ordinary death. Survivors experience increased pain on the anniversary of the death or on special occasions they shared with the deceased. If they discovered the deceased, they may have flashbacks for many years. It is beneficial to talk about the deceased because that friend, child, spouse or loved one is very much on the mind of the survivor and it is counterproductive to pretend that the person never existed.

Our experience has shown that people do not get over it within a predetermined period of time. Some seem to be done with grief rather quickly but if the person was especially close, it will most likely take a long time. The person who has lost someone to suicide may also find himself or herself wondering about his or her own death. Suicide survivors sometimes begin to consider suicide to be an option to them as well.

WHAT YOU NEED TO KNOW

We are well trained and strive to do the very best with each interaction we have, but we are not omnipotent. When we intervene, we must realize that we are not responsible for another person's life. Do your best to build rapport, assess risk, and refer appropriately. Make sure to call your SBU after any call involving talk of suicide. Most victims use the language of suicide to express pain and inability to think of alternatives. That is where we come in.

FOR FURTHER READING

Jamison, Kay R. *Night Falls Fast.* New York: Knopf, 1999. Print.

American Foundation for Suicide Prevention: <www.afsp.org>

National Institute of Mental Health: <www.nimh.nih.gov>

Centers for Disease Control and Prevention:
<www.cdc.gov/ViolencePrevention/suicide/>

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