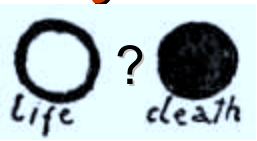
Suicide Prevention

- Professional responsibility to disrupt and interfere with suicidal plans of clients
- Most clients, even when extremely suicidal, are ambivalent about dying



- Even with careful assessment and protective interventions, a small number of clients will find a way to commit suicide.

Suicide Prevention/Interventions: Basic Strategies

- Explore suicidal thoughts and ideation
- Make risk assessment
- Act to disrupt suicide plans
- Take protective action
- Suicide contracts
- “Dirty tricks”

Explore Suicidal Ideation:

- Ask directly about suicidal ideation:
  - "Have you thought about harming yourself ?"
  - "Have you had thoughts about killing yourself?"
  - "Have you been thinking about committing suicide?"
- Ask directly about immediacy and frequency of suicidal ideation:
  - "When did you last think about harming yourself?"
  - "How often you you think about killing yourself?"

Explore Suicidal Ideation:



- Ask directly about SLAP dimensions:
  - "How would you try to kill yourself?"
  - "Where would you do it?"
  - "Do you have a deadline when you would do it?"
  - "Do you own a gun or have access to a gun?"
  - "Is the gun loaded and where is it kept?"
  - "Is there anyone around who would stop you from trying to kill yourself?"

Explore Suicidal Ideation:

- Asking about suicidal thoughts will not put these thoughts in a client's mind
- Rookie practitioners are sometimes reluctant to ask about suicidal ideation - not to ask is an ineffective tactic
- Often clients are disturbed by these thoughts and feel relief in talking directly about suicide with the practitioner.

Make Risk Assessment

- Consider demographic risk factors:
  - What is the age, gender, ethnicity, and sexual orientation of the client
- Consider the possibility of psychopathology in the client:
  - Depression
  - Psychosis
  - Substance Abuse - alcohol, prescription/street drugs

Make Risk Assessment

- Explore recent, negative life events:
  - "Have there been any sudden, uncontrolled changes in your life recently?"
  - "Have there been an deaths or losses of loved ones?"
  - "Have there been any disappointments lately in your life?"
  - "Have you lost a job, been laid off or fired lately?"
  - "Have there been any serious accidents or severe illnesses lately?"

Make Risk Assessment

- Explore other risk factors with client:
  - "Have you ever tried to commit suicide in the past?"
  - "Tell me about these past attempts and what happened?"
  - "Has anyone in your family ever tried (or succeeded) in killing themselves?"
  - "How did they kill themselves and how old were you when they died?"

Make Risk Assessment

- Explore other risk factors with client: (cont.)
  - "Has there been any change in your alcohol consumption?"
  - "Are you drinking more than usual?"
  - "Do you live alone?"
  - "Are there any loved ones, friends, or relatives nearby?"

Make Risk Assessment

- Explore risk factors that are specific to client's situation:
  - Adolescent suicide may be triggered by:
    - a poor grade on a test,
    - a spat with a boy or girl friend,
    - the object of an adolescent prank,
    - bullying at school
    - rejection on college admission
    - failure to make the cut on an athletic team
    - unwanted pregnancy

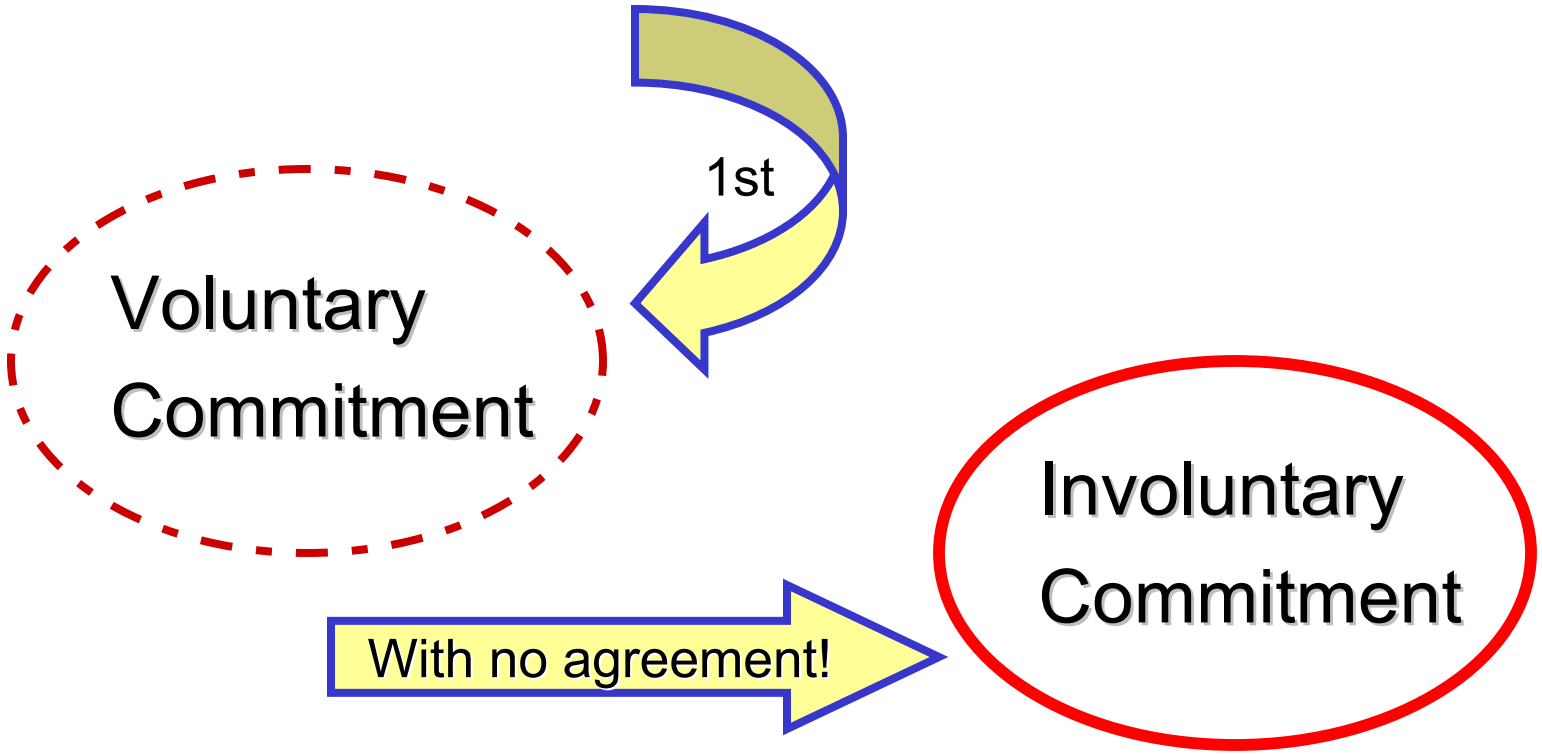
Disrupt Suicidal Plan:

- Break confidence and alert significant others - warn others about client's plan
- Recruit significant others to remove lethal means of plan - hide bullets, remove knife or gun, confiscate pills, etc.
- Recruit significant others to accompany client to ER or to monitor client for a given time period.



Take Protective Action:

With Dangerously Suicidal Clients



Involuntary Commitment:

In most states,

involuntary commitment requires two conditions:

Psychiatric Diagnosis: such as Depression, Schizophrenia, Substance Abuse

+

Assessment of Dangerousness: to Self and/or Others

Dimensions of Dangerousness:

- **Six Criteria of Dangerousness:**
  - **1. Imminence of behavior**
  - **2. Target of danger**
  - **3. Clarity of danger**
  - **4. Intent of behavior**
  - **5. Lethality of behavior**
  - **6. Probability of behavior occurring**

Dimensions of Dangerousness:

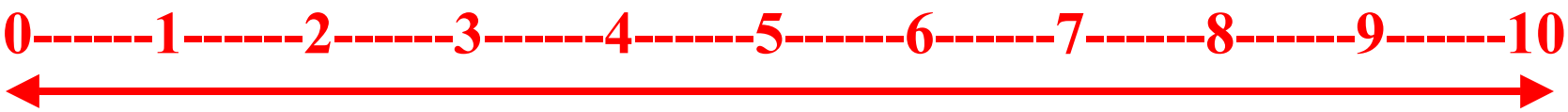
- 1. **Imminence of behavior** - immediacy of suicidal act: Does the client plan to act soon or in the distant future on his/her suicidal impulses? Danger is highest when act is planned within hours or days.
- 2. **Target of danger** - self, specific others, non-specific or global target: Are there homicidal as well as suicidal thoughts? May be necessary to warn others whether client is hospitalized or not.

Dimensions of Dangerousness:

- 3. **Clarity of danger** - time, place, method, opportunity (same factors as SLAP Scale): Specific plans are most dangerous.
- 4. **Intent of behavior** - is suicidal act intended to cause death, or is it manipulative, a cry for help, or serving some other purpose? Some clients threatening suicide have no intention of actually killing themselves (parasuicide) and some clearly do intend to die.

Dimensions of Dangerousness:

- **5. Lethality of Behavior** - probability of death resulting from the act:



Death is highly unlikely - no need for medical attention

Death is almost certain even with medical attention

- Ingesting a bottle of antibiotics or vitamins is unlikely to be lethal whereas 7 Sudafed tablets may result in death. Slashing the wrist is not as lethal as slashing the throat.

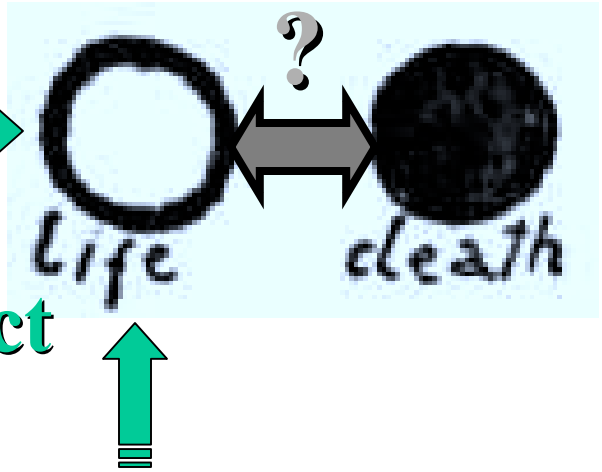
Dimensions of Dangerousness:

- **6. Probability of behavior occurring:** Though it is impossible to predict with any certainty the behavior of clients - the clinician must make a judgement (guesstimate) about whether the client will act on his/her suicidal impulses. Malpractice does not rest on being "right" but on whether the clinician weighed the evidence and reached some kind of decision.

Outpatient Interventions:

- **Interventions designed to reinforce the "life" side of the ambivalence about living or dying that exists with suicidal clients:**

1. **Offer Hope**
2. **Event Focused**
3. **Suicide Contract**
4. **"Dirty Tricks"**





1.Global Strategy - Offer Hope:

- Hopelessness is such a common experience for suicidal clients, that the worker should actively work to counteract this attitude.
- "Offering hope" is an important therapeutic variable in all forms of therapy, and it is especially critical in work with suicidal clients.
- Workers should approach clients with a positive, optimistic attitude. "No matter how bad things seem now, they can get better!"

CAVEAT:

"Offer hope" but NEVER "make promises"

A worker should not promise the client that the distressful circumstances will definitely improve, even though that may be what the client wants to hear. The worker can not offer any guarantees but instead should offer support and encouragement that change is possible if the client tries.

CAVEAT:

"When the worker feels the situation is hopeless"

"Offering hope" and conveying optimistic expectations is a powerful, healing strategy that has been documented in practice research. Positive expectancy is so important that a worker who feels that there is no hope for a client should probably help the client find another helping professional.

2. Stay Event Focused:

- Help the client locate the triggering event - the last event before the suicidal crisis
  - "Have there been any sudden changes in your life these past few days?"
  - "What was going on in your life when you started to get these suicidal thoughts?"
  - "Have there been any disappointments recently in your life over which you have no control?"

2. Stay Event Focused:

- **Help the client to begin coping with the triggers and recent life stressors:**
  - "Where do you think we ought to start working?"
  - "Would it help if we made a list of things you could do today?"
  - In the past, how did you cope when your friends treated you that way?"

3. Suicide Contracts:

- Clinical Intervention - very difficult to demonstrate whether it is effective scientifically though it is employed by many practitioners.
- Usually handwritten in client's presence and signed by both client and practitioner.
- Two copies - one for client and the other for case record.
- If client refuses to sign or agree to terms, then more protective measures may be necessary.

3. Suicide Contracts:

Sample (Date)

I __(client's name)_ agree that as long as I am a client of (practitioner's name),
I will not hurt or try to kill myself. If I feel that I cannot keep this promise, then I agree to call:

1. Crisis phone #
2. Possible friend, parent, sibling etc.
3. Practitioner's phone #

and if necessary to go to the Emergency Room.

Signed __(client's signature)
Witness __(practitioner's signature)__

4. "Dirty Tricks":

- "Dirty Tricks" ARE deceitful and manipulative but NOT unethical.
- They involve lying to the client about the consequences of suicide.
- They are employed because of the potential finality of suicide gestures.
- These are clinical interventions, and like the suicide contract, have not been scientifically validated.

4. "Dirty Tricks":

- Legacy argument for parents with children:
  - "If you kill yourself, you know there is a good chance your children will commit suicide too!"
- Disfigurement argument with vane clients:
  - "Suicide is such a messy way to die. Your body will be bloated and disgusting to those who discover you!"
- Pain argument with clients:
  - "Suicide is such an agonizingly painful way to die!"

4. "Dirty Tricks":

- Botched attempt argument:
  - "The rehabilitation wards are full of folks who did not succeed but instead end up living with debilitating disabilities as paraplegics, semi comatose patients, or with uncontrollable pain."
  - "Even the most carefully planned suicide can go astray and rescuers may intervene to bring you back to life in a vegetative state!"
- Dirty tricks are never used alone and should accompany tactics that offer the client hope.

SUMMARY

It is the responsibility of practitioners to:

A. Explore for suicidal thoughts and impulses

B. Determine the risk of suicide

C. Act to disrupt/prevent the client from acting on suicidal impulses

It may be possible to work with suicidal clients on an out-patient basis until the suicidal crisis is resolved.

It may be necessary to hospitalize clients either through a voluntary commitment or involuntary commitment:

A. When a client exhibits a psychiatric condition

B. And when conditions for "dangerousness" can be established

Return to Table of Contents

