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Letter from the Editor

Upon becoming Editor, one of my goals was to publish a "*Special Edition*" of *The Alabama Counseling Association Journal*. There certainly are many topics, which deserve this distinction. However when reflecting on topics and who to choose as '*Special Edition Guest Editor*" for each topic, my list suddenly grew shorter and shorter. Finally, after consulting with several colleagues, I decided on the topic of Suicide and asked Dr. Judith Harrington to work with me as *Special Edition Guest Editor*. I could not be more pleased with this effort. It is not easy to ask both academicians and practitioners to contribute to a journal such as this. I do appreciate their effort and time and most importantly, patience. As Dr. Harrington and I worked through multiple time lines, time zones, and areas of expertise, this effort became more and more "adventurous." My sincere thank you to the contributors who put up with us. However, I must reserve my most heart-felt thank you to Dr. Judith Harrington, whose spirit and knowledge is felt throughout this journal. It is through her passion for this topic and her work for the individuals and families that have been touched by suicide that is most evident. I hope the contents within this journal serve you well.

Lawrence E. Tyson, Ph.D.

Editor, *The Alabama Counseling Association Journal*

Letter from the Special Edition Editor

Thank you for giving your attention to this first ever Special Edition of the ALCA Journal on *Suicide Prevention, Intervention, and Postvention with Youth, Adults and the Elderly*. Suicide prevention advocacy no longer became optional for me after several years of working with the families experiencing suicide bereavement. Having been attached to my local crisis center in a variety of volunteer and professional roles since 1983, the last thirteen years have been primarily spent assisting survivors of suicide loss, over 300 individuals and families who have taught me about the descent into suicidal risk and the ravages of its bereavement.

In the last decade, I have watched many Alabama mental health professionals do much to embrace suicide prevention advocacy. The Alabama Suicide Prevention Task Force was formed in 2001 and after ten years, became a 501c3 non-profit, now called the Alabama Suicide Prevention and Resources Coalition (ASPARC). At least two universities have added a suicide-specific three credit hour graduate course and others have regularly infused more content and best practices literature into their curricula. There have been many conferences and continuing opportunity events for ongoing training for mental health professionals. The Alabama chapter of the American

Suicide Foundation for Suicide Prevention formed and has been one of the top 5 most successful fund-raising chapters in the nation each year since its inception. Experts in the state continue to have a statewide, regional, and national presence in policy formation and state and national strategies and standards, public health initiatives, research and publication, and training, to name a few advancements.

In spite of Alabama's strong indicators of suicide prevention advocacy, a high number of our Alabamian community members continue to die from suicide. Inversely related to the hard work so many are doing to prevent suicide, Alabama has continued to see its rate of suicide rise, a trend that has also been seen in national statistics as well. In the mid-2000's, Alabama lost approximately 500 sons and daughters, mothers and fathers, mates and partners, friends and coworkers to suicide. In 2009, 667 persons lost their battle with hopelessness and co-occurring depression and other psychological factors such as feelings of burdensomeness, feeling trapped and socially isolated, perhaps from symptoms of bipolar disorder and other conditions (Hodges & Coombs, 2010).

Nationally, we lost 36,909 individuals to suicide in 2009. Both nationally and statewide, this is much higher than lives lost to homicide. The rate of suicide has increased while concurrently we have suffered through many natural and human-made disasters such as multiple hurricanes, flooding along the Gulf Coast and inbound, the Gulf Oil Spill, the economic recession, and the devastating losses due to the April 27th tornadoes. The rate of suicide compared to the national average has been on the rise and has exceeded the national rate of suicide for several years. Alabamians die from suicide at a rate of 14.2 per 100,000 compared to the 2009 national average, now 12 per 100,000. Suicide has gone from being the 11th cause of death to the 10th cause of death (Hodges & Coombs, 2011; American Association of Suicidology, 2012).

Additionally, the effects of suicide loss, bereavement, and trauma on the directly impacted family members and loved ones is staggering. Every 14.2 minutes, someone in the nation dies from suicide, thus newly identifying no less than 6 individuals who become survivors of suicide loss, a conservative estimate (Knieper, 1999). In 2009, this number would have been 4,002 Alabamians, and nationally, 221,454 persons who, as a result of suicide loss, experience more protracted depression, longer bereavement, post traumatic stress, suffer health and wellness setbacks, and increased risk for suicide themselves. If this number was steady, then every ten years, this number would mean 40,020 in Alabama and 2,214,540 are accommodating the aftermath of suicide and its complications. Grief experts and survivors alike say survivors of loss never really recover from loss; they merely accommodate the tragedy into a new self-concept and family narrative. It is somewhat indiscernible what this means in terms of healing and restored wellness for survivors'

return to "normalcy." Additionally, there is much concern about first responders and their exposure to suicide and the cumulative vicarious trauma that may place them at risk.

In the last thirteen years, I have learned three essential lessons about suicide risk. In addition to the myths and fables that exist about suicide in the general public, I want to highlight these three important observations.

1. Suicide is multi-factorial in its causes.

When someone dies from suicide, a universal question is often "Why?" It is never easy for the families or for the profession, but often it seems seductive to pin the cause of suicide on a specific reason....*Her boyfriend broke up with her. His boss fired him. She was humiliated by the affair. He fell into bankruptcy. She felt like such a burden on everyone.* The media, which operates in a sound-byte age, and considers a two minute story lengthy, often lead viewers to be persuaded by the one-cause theory of suicide.

It is important to remember the multiple variables, which cause suicide so we as caregivers have a more fair-fighting chance to reduce risk factors and increase protective factors. If we subscribe to the one-cause reasoning for suicide, we will surely omit important preventative and interventive considerations. If we believe suicide was caused, for example, because his or her partner ended the relationship, we fail to consider that many relationships are ending right now, and most of them do not result in suicide. What is it about some persons that makes a break-up so life-threateningly hopeless? Our case conceptualization should lead us to multi-factorial thinking, such as the need for appropriate diagnosis, psychopharmacological interventions, social support, training for better life skills and coping skills (such as help-seeking, stress-management, self-esteem, problem-solving, conflict resolution, etc.), safety planning (including means restriction, self-soothing, family support, crisis response, etc.)

2. Suicide is *not* a rational choice.

Andrew Slaby (2004) wrote this of the "choice" to become suicidal:

People who die by suicide do not want to die; they simply want to end the pain often caused by depression. If there were another way to end the pain, they would seek it. Failing to find a source of reprieve, they become hopeless. More than depression, hopelessness predicts who will die by suicide…

And Kay Redfield Jamison, notable psychologist and professor of psychiatry at Johns Hopkins University who herself has suffered from bipolar disorder since adolescence wrote:

In short, when people are suicidal, their thinking is paralyzed, their options appear spare or nonexistent, their mood is despairing, and hopelessness permeates their entire mental domain. The future cannot be separated from the present, and the present is painful beyond solace. (1995, p. 93).

To my personal question of Madelyn Gould, renowned epidemiologist and researcher on suicidality at Columbia University, she replied, "Do I think suicide is a rational choice? No." (personal communication, November, 2010). Rather, it is considered to be a fatal outcome of a combination of multiple factors that renders an at-risk individual to become unable to think clearly about problem-solving, help-seeking, or tolerating high levels of psychological pain. The preferred nomenclature by professionals in the mental health and public health fields and in the media is "died by suicide," "died from suicide," or "completed suicide," as contrasted with the formerly used phrases such as committed suicide or *chose* to end his or her life.

Often, the media or a representative of a community will say that someone committed suicide after _____(fill in the blank with one reason, such as getting a divorce, filing for bankruptcy, losing a job, etc.) as if the one event resulted in a choice to die. There are hundreds of people right now who are experiencing these challenges, yet they do not have thoughts or actions of suicidal risk. Suicide is a psychiatric emergency, with events, contextual, psychological, emotional, physical, neurological, bio-chemical, cognitive, and cultural causes. We should not expect someone in suicidal crisis or emergency to function as if clear-minded and fully capable of reasoning through problems and solutions. Thus, it is incumbent for mental health professionals to understand clearly their clinical burden to know how to assess and manage care, and to not displace that burden onto the client, assuming that he or she is capable of clearly being able to be knowledgeable about suicide more competently than the counselor. This is in part, why "no-harm" contracts are currently viewed as ill-advised because the client, when in a suicidal state of mind, may not be functionally capable of understanding, deciding, or committing to the passé no harm contract.

3. Suicide is a public health problem.

The field of counseling and psychology has historically focused on the individual person, and family therapy has given its attention to the family system. Social work by tradition has given more attention to assisting individuals and families within a larger context of groups, agencies, community organizations and systems for mental health. In the field of suicidology, the emphasis does not exclude these focus areas, but rather addresses the causes and incidence of suicide within the context of the public health profession. On charts produced by the Center for Disease Control (CDC), the top ten causes of death include illnesses such as heart disease, cancer, respiratory

disease, cerebro-vascular disease, diabetes, Alzheimer's disease, and, yes, suicide. Suicide as a cause of death is not reflected as people who "chose to end life," "decided to kill him or herself," or "performed a selfish or hostile act against his or her family." Suicide is a public health problem.

This paradigm may be new and different for mental health counselors who spend the better part of their working lives in offices with individuals, families, and small groups. It is important for the mental health community to understand the context of the public health prevention initiative, because this view maintains that suicide is a national health concern, and it underscores that suicide is both illness-related and preventable, that there is something larger than just counseling that will have to reduce suicide rates. There are plentiful and successful public health campaigns that have saved lives...CPR (cardio-pulmonary resuscitation), MADD (Mothers Against Drunk Drivers), STR (stroke symptom checklist-smile, talk, reach), EDITH (exit drills in the home for fire safety), and many others such as seatbelt safety, car seat safety, no texting while driving safety, and many more. All of these initiatives depend on widespread public education about safety measures and early symptom warning signs. And so does suicide prevention. In suicide prevention, there is the emphasis on public education, and some gatekeeper initiatives include but are not limited to QPR (Question, Persuade, Refer), ACE (military for Ask, Care, and Escort), and more. The mental health community alongside the public health approach is making strides in educating the public about the myths of suicide, the ways to detect early warning signs, and how to take action with someone who may be at risk. Mental health professionals alone cannot prevent suicide; they are partners with family members, school systems, neighborhoods, faith-based organizations, legislators and local government, community groups and many others to work together as linked arms around persons who may fall into the death spiral of suicide.

Knieper (1999) wrote about mental health professionals' roles in conjunction with suicide bereavement, presenting many good ideas about how counselors can interface with the families and the systems around them after a loss. I provide you a modified version of it here, adapted for how mental health professionals can function with a public health and inter-systemic approach during the preventive, interventive, and postventive stages.

1. Mental health professionals can act as a mediator between at-risk persons, their families, and essential care-delivery systems in the preventative, interventive and postventive stages (with team members such as physicians, allied medical caregivers, first responders, community agencies and groups, schools and school systems, specialized service systems such as DHR, juvenile health, elderly care, advocacy groups for special interests, first responders, legislators, coroners, and funeral specialists, etc.).

2. Counselors can build bridges and provide extensive training to any unenlightened or indifferent persons in the profession or in the public about risk, warning signs, risk factors, protective factors, and can model modern approaches while de-mythologizing inaccurate attitudes about suicide or suicide loss.

3. They can shape and model responsible reactions to suicide risk and loss, and lend influence to appropriate prevention, intervention, and postvention reactions, with evidence-based and best practices as a guide, striving to eliminate bias and inadequate responding in the face of psychiatric emergencies.

In closing, I want to thank, first and foremost, our team of capable and expert authors who worked diligently to deliver these important manuscripts to the readers of ALCA's first ever special edition journal. It is not a small job to write a scholarly piece as a sole author or with a team, when maintaining busy schedules. Most of our contributors are clinicians and not tasked with the job of publishing as a professional expectation. Thank you each and all for volunteering your time and expertise. And additionally, I want to thank each of you... our readers, our state counselors, our messengers of hope to anyone in suicidal despair. You make a difference. Together, let's suicide-proof Alabama.

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Suicide and its Prevention on College Campuses

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In recent years suicide and suicide prevention initiatives have gained much attention across the nation. Spurred on by tragedies in Virginia, Illinois, Arizona and other states, many higher education institutions have implemented proactive programs which seek to identify students in distress as early as possible in the development of their emotional health issues, assist them with timely referrals for treatment, and monitor their progress over a period of time. As parents are highly involved in their child's college education and better educated about mental health in general, and as college administrators bear witness to managing the burden of psychological illnesses on their campuses, the fact is none of us can afford to dismiss suicide as an issue unworthy of our attention, planning and effort.

Approximately 1,100 college students die by suicide each year (Wilcox, Arria, Caldeira, Vincent, Pinchevsky & O'Grady, 2010). The most recent Centers for Disease Control and Prevention (2007) estimate of suicide prevalence is 11.0/100,000 for the general population (Xu, Kochanek, Murphy & Tejada-Vera, 2010). Prevalance rates for college students fall somewhere between 6.5 and 7.5/100,000 (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997; Drum, Brownson, Denmark & Smith 2009). This suggests a buffering effect merely by being in college, which is intuitive because those in college are typically late adolescents and early adults and older groups have higher rates of suicide. Furthermore, by virtue of career planning, they are projecting into future enrollment. In the State of Alabama, prevalence rates for *all citizens* aged 15-19 and 20-24 are 7.3 and 13.9, based on census estimates, respectively (Alabama Department of Public Health, 2009). The actual prevalence rate for college students in Alabama is not known. Looking deeper, however, one finds that 46% of college students have stated they have been depressed to the point of not being able to function within the past school year (American College Health Association, 2005). It is estimated about 10% of all college students have seriously considered suicide (Brener, Hassan & Barrios 1999). At the University of Alabama alone these data would translate to about 14,000 students affected by depression and 3,000 by suicidal thoughts.

The pain due to loss of life is immense. Other costs of this burden in human and financial terms are of course difficult to calculate, but when one considers events such as course and enrollment withdrawals, academic and nonacademic misconduct secondary to mental health problems, disruption in residence halls and classrooms, absence from class and other functions, and hours devoted to working with such students, it must be quite high indeed. Examples like these are compelling reasons to address these mental health concerns. In their landmark study Drum et al., (2009) called for a paradigm shift in suicide prevention which is problem-focused, and intervenes at multiple points in the continuum of suicidal ideation. Community-wide interventions and education are among the most important initiatives campuses can undertake at the earliest points in that continuum.

Examples of Campus Prevention Efforts

What follows is not an exhaustive list of all prevention efforts, but rather a sampling, which hopefully will provide examples of the types of activities involved. There are a wide range of prevention programs in existence on college campuses. Some focus on peer training to recognize and respond to mental health distress (e.g., Student Support Network, Worcester Polytechnic Institute, (www.wpi.edu/Admin/SDCC/network.html). The Question, Persuade, Refer (*PQR)*) Institute (www.qprinstitute.com) provides another and widely-used model of training community members in effective responding. Aggie C.A.R.E.S. at North Carolina Agricultural and Technological Institute is an example of an approach based upon the QPR model. The basic theory undergirding these approaches is an educated community can help prevent suicide by knowing what to look for and how to communicate with a person in distress.

In a similar vein, a very large number of college mental health centers provide outreach programming and web-based material on the topic of suicide. A recent search on this resulted in 130,000 unique web pages hosted by such centers across the country. These pages typically provide facts concerning suicide, tips on responding to distressed students, and invite readers to contact the center to request a speaker, program or event related to the topic. These models, however, rely on community members reaching out for information and help from the centers and not the other way around. Some centers take this approach a step further and provide targeted programming through an awareness week, which includes an anchor event and smaller-scale programming around that. Such programming is available, for example, at the University of Connecticut and the University of Alabama. The anchor event at the University of Alabama (and also the University of Montvallo and the University of Alabama at Birmingham) is a community awareness walk in partnership with the Alabama chapter of the American Foundation for Suicide Prevention (AFSP) (www.afsp.org.) Awareness events like these engage participants in meaningful activity while also providing information concerning suicide and responding to individuals in need.

Some institutions have created more interactive web-based resources. An excellent example is the University Life Café at Kansas State University (www.universitylifecafe.org). This resource provides information and interactions on many topics, including suicide. The interaction opportunity includes a chat utility and methods in which students can contribute to and improve the site itself. As college students are among the most media-savvy consumers, these resources hold great promise for engaging college students on the topic of suicide and other mental health issues. The AFSP's Interactive Screening Program, currently in use at 25 institutions, is an application, which facilitates communication between students in distress and a mental health professional using internet resources. The anonymity involved in early encounters is thought to increase the likelihood of self-identification, which in turn is thought to increase the likelihood of actually meeting with a mental health professional (Garlow, Rosenberg, Moore & Haas 2008; Haas, Koestner, Rosenberg, Moore & Garlow 2008).

Funded by the Garrett Lee Smith Youth Suicide Prevention Act, the Substance Abuse and Mental Health Services Administration (SAMHSA, www.samhsa.gov) provides grant opportunities for college campuses to provide outreach concerning suicide. SAMHSA also provides information concerning a *National Strategy for Suicide Prevention*. Programs at East Tennessee State University, the University of Guam and Boston University are examples of recent awardees. This opportunity is highly important because many college mental health services require additional funding to mount large-scale suicide prevention programming. Like all grant-based initiatives, this does have

limitations as it requires a significant amount of labor to manage the grant and report on the program's progress. As many college counseling services are under-staffed, this can be a prohibitive challenge.

A number of colleges and universities have focused their suicide prevention efforts on the identification, referral and monitoring of students who have communicated suicidal distress and/or engaged in suicide-related behavior. One example of this approach is known as the Illinois Model (Joffe, 2008). The essential elements of this empirically-supported model, currently in use at the University of Alabama, include the establishment of a critical incident response team, campus-wide referrals of such students to the dean of students or other office with administrative authority, mandated mental health referral for a more than one visit evaluation (the number is four at Alabama), and ongoing monitoring by the referring office for compliance and progress. Students can face escalating consequences should disruptive or alarming behavior continue, which addresses what is thought to be dynamics involving an abuse of power by the student. A primary purpose of such approaches, however, is to facilitate the identification of students in distress and effectively get them help at times when they may not seek it themselves. The University of Illinois, where this process was first developed, reports a 58% reduction in suicide since it began in 1984. It is not know how many schools employ this method, but a recent listserv query on this topic resulted in 30 affirmative responses.

Related to this is the development of behavior intervention teams (BIT) on college campuses. These teams are comprised of several campus offices, which are typically involved in helping students in distress, such as the counseling service, dean of students, housing and campus police or public safety. The National Behavioral Intervention Team Association (www.nabita.org) is an entity, which provides resources and training on BIT development. The National Center for Higher Education Risk Management (www.ncherm.org) is an entity, which provides similar resources and recommendations, some of which relate to BITs. It functions as a central repository for referrals of students in distress, and also as the entity, which provides on-going monitoring of such students. A chief advantage of BITs is their ability to collaborate across offices and communicate widely across campus. An intent of this model is to eliminate the "silo effect", whereby offices do not or cannot communicate with each other, which so often can limit a school's effectiveness with distressed students and has been widely reported as being implicated in some campus tragedies.

Among the most effective and empirically-supported efforts in suicide prevention is means restriction (Anderson, 2008). These methods include eliminating or reducing access to the means of suicide. Gun control statutes and policy, restricting access to windows, bridges, poisons and the like are all known to effectively reduce the incidence of suicide. Due to recent suicides by jumping from campus bridges, Cornell University instituted some means restriction measures as a part of its overall prevention efforts (Marchell, 2011).

Other Important Resources on Suicide Prevention for College Campuses

There are several important entities, which provide educational material, training for community members and mental health professionals, screening and interactive resources regarding suicide. In addition to the AFSP there are the Suicide Prevention Resource Center (SPRC, www.sprc.org,) which contains a section on best practices), the Jed Foundation and its Ulifeline tool (www.thejedfoundation.org, www.ulifeline.org), the American Association of Suicidology (AAS, www.suicidology.org), and the National Suicide Prevention Lifeline (1-800-273-TALK). Colleges

and their students can benefit greatly from incorporating these resources in their prevention plans. One highly important product of the AAS is its Assessment and Management of Suicide Risk (AMSR), a training program developed for the SPRC for mental health professionals which includes a set of competencies for clinical work.

Research of Suicide Prevention Program Efficacy

Many of the resources noted above have sections for current research. The reader is encouraged to consult those resources as that research will not be repeated here. As is usually the case when needs are urgent, and therefore programs are developed quickly, efficacy studies for specific suicide prevention activities are limited (Gould, Greenberg, Velting, & Shaffer, 2003). Randomized, controlled studies are scant. One meta-analysis which evaluated a total of 20 articles covering the efficacy of a wide variety of programs concluded there was not enough evidence to support or refute the effectiveness of curriculum-based initiatives (Guo & Harstall, 2004). Means restriction, QPR, and AFSP's ISP are examples of programs with some or strong supporting literature, as noted above. Smaller-scale and less formal programs and events most often do not have accompanying empirical support beyond what is generally known about educational outreach.

There have been a few studies in this area, however. Tompkins and Witt (2009) evaluated QPR and found continued gains in learning by participants post-training, but its effect on suicide prevention or reduction was not evaluated. Similar "gatekeeper" training was evaluated by Cross, Matthieu, Lezine, & Knox (2010), and with similar results, in that participants did in fact exhibit increased skill post-training. Effects such as those reported in the above studies are noted in the short-term; long-term retention of knowledge and skills is not known. Gould et al., (2003) found that educational programs do in fact increase the likelihood of participants inquiring about suicide, but little to no effect beyond this was noted.

Though it did not address college populations, one example of strong supporting evidence reported on the outcome for the Sources of Strength (www.sourcesofstrength.org) prevention program for high school students (Wyman, Brown, LoMurray, Schmeelk-Cone, Petrova, Yu, Walsh, Tu & Wang 2010). In this study 18 high schools were randomly assigned to a wait-list control group or the intervention group. Assessments were administered at baseline and four-month follow up to 453 peer leaders and 2,675 students. Peer leaders were found to be four times more likely to refer a student. Perceptions of adult support and acceptability of seeking help increased among the students, with the largest increases in perception of adult support occurring in a group with previous suicidal ideation. The authors note this program is the first with evidence of peer leaders enhancing protective factors at the population level.

Conclusion

Suicide is a significant issue facing higher education institutions. Many campuses are involved in a variety of procedures, programs and initiatives, which seek to reduce or prevent suicide and the impact of suicide-related behavior. There are a wide range of options available, and many educational and training resources exist for a good number of them. College mental health professionals are strongly encouraged to become familiar with these resources and select options that best meet the needs and culture of their campuses. There is literature, which supports some programs, and some elements of others. In general there is much needed research in this area as the actual effect of many programs on suicide attempts and completions is not known. The issue of

suicide and the need for competent responding will not wait for research, however. It is most accurate to say no single method or approach is best or all-encompassing, therefore those interested in developing initiatives on their campuses would benefit from selecting a range of materials, resources and programs. Any menu of prevention efforts chosen should probably include community education, interaction with students, web-based resources, highly publicized campus activities, screening tools, and proactive identification, referral and monitoring processes. Because a non-suicidal student may not attend to delivered information but later become suicidal, it is crucial to saturate the campus community with messages and to do so repeatedly over the course of the academic year. This is true in particular during various campus milestones such as the beginning of the term, mid-term and final exams, and other known stressful periods which students face.

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Suicide Prevention for Counselors Working with Youth in Secondary and Post-Secondary School

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Abstract

According to the latest statistics, suicide is the 3rd leading cause of death in those aged 15-24 (CDC, 2010), when many are enrolled in secondary and post-secondary institutions. Because of such alarming statistics, the need for prevention education is great. However, many counselors and educators feel ill-equipped in prevention and intervention techniques that directly address the frightening subject of suicide (Heath, Toast, & Beattam, 2006.). Because of increased legislative action requiring the implementation of school wide prevention programs, many counselors have been tasked with creating programs that address this growing mental health concern. Understanding the signs and risk factors associated with adolescent suicide along with possible implementation guidelines and helpful resources assist in creating a comprehensive program designed at incident prevention.

Background

The topic of suicide is a difficult one to broach with administrators, faculty, parents and students. Many are uncomfortable with the topic because of the mental health stigma long associated with suicide. Others believe that talking openly about suicide and prevention can actually lead to increased suicide ideation. There are still others who steer from the topic due to an uncertainty of what to say or do to provide substantive prevention and support. However, because suicide continues to be a leading cause of death for high school aged students (CDC, 2010), school wide programs are essential in helping create a community of awareness, education, prevention and support when dealing with youth suicide (Doan, Roggenbaum & Lazear, 2003).

The national statistics show an unsettling trend in suicide rates among youth in the 15-24 age range. Since the 1950's, the rate of youth suicide has doubled. It is estimated that there are 12 youth suicides every day and that approximately every 2 hours a youth completes suicide. ("Suicide in the U.S.A," n.d.). On a local level, since the 1990's, the youth suicide rate in Alabama has remained higher than that of the national average, peaking at a rate of 12.2 with the national average at 10.1 (Alabama Vital Statistics, 2009). Of those that die by suicide, 90% have a diagnosable mental disorder ("Facts and Figures," n.d.). Teen depression rates continue to rise, which is considered a contributing factor to suicide ("Facts and Figures," n.d.).. Yet, depression and suicide remain tenuous subjects in the school arena. School officials are concerned with parent pushback and liability. School staff remains undertrained in helping identify at risk students. We have seen the push toward academic success out shadow the need for much needed awareness and prevention training in the school systems.

In 1999, the U.S. Surgeon General's *Call to Action to Prevent Suicide* identified suicide as a "public health issue" noting that more youth die by suicide than by "cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease **combined**." (U.S. Public Health

Service, 1999). The emphasis was on creating a national strategy to promote suicide prevention through AIM – awareness, intervention, and methodology. These components are those that create substantive school and community programs that best address the growing concern of suicidal tendencies in youth.

In July of 2009, House Bill 216 (Alabama Student Harassment Prevention Act, 2009) was passed in the state of Alabama, requiring that all school districts have in place a written policy directed at harassment and suicide prevention. This bill required compliance of each district by July, 2010. The requirements included awareness, comprehensive training, prevention and intervention practices, as well as strategies to assist those in immediate crisis. However, most suicide training happens through postvention services, after a suicide has occurred. We must make every effort to be proactive in our efforts to reduce the rates of youth suicide by implementing programs that attempt to successfully identify at risk students, providing immediate and long-term assistance resources before a tragedy occurs.

As educators and professionals working with youth on a daily basis, we often misread true calls for help as adolescent drama, often overlooking those students in crisis. A school wide suicide prevention program can assist all faculty and staff in a greater awareness of this topic and offer more in depth training on identification which can lead to expediting therapeutic intervention. The fear of implementation has often stemmed from the idea that talking openly about suicide causes students to see it as a means to relief, possibly introducing an idea that was until then foreign. This is widely renounced as a myth. Professionals agree that education and prevention training actually assist in a better understanding of mental health issues and available resources. Most people do not want to die, but are unable to envision outcomes to alleviate the pervasive pain and suffering. Awareness training helps guide those suffering to immediate resources.

Suicide Awareness and Prevention Planning

Suicide prevention requires a unified team and should involve faculty, staff, parents, students, and community members. The emphasis should be on awareness and reducing the stigma associated with suicide and mental health issues. A comprehensive education program has better success when infused in an already established curriculum through health classes, advisory programs, or guidance lessons instead of a large group suicide assembly or one time prevention lesson (Doan, Roggenbaum & Lazear, 2003, p. 4). Most schools include information regarding the dangers of drugs, alcohol, teen driving, and risky behaviors in some area of the required curriculum. Depression awareness and suicide prevention should be included in this type of program of study on an age appropriate level.

Comprehensive suicide prevention starts with an overview of the population of the community. Several groups are at a higher risk for suicide. The rate of suicide for American Native/ Alaskan youth and young adults is 1.8 times higher than the national average of all youth in that age group, for example (CDC, 2009). Research also shows that GLBT teens have a much higher rate of suicide. GLBT youths are twice as likely to attempt suicide than their heterosexual peers (CDC, 2011). This may be attributed to increased harassment, exclusion, and level of parental rejection. Understanding the needs of the community population will assure that the comprehensive program is directed towards helping all in crisis. A look into the population and culture of the community can assist in designing a program suitable to the current demographic make-up of the school.

Suicide awareness, training, and prevention must be systemic in nature to create a proactive, supportive community in combating this public health issue. The components of a substantive program include a community partnership of faculty, staff, parents, and students in an effort to educate all stakeholders. It should also include a written plan with procedures to be followed for prevention education, assessment, identification, referral, intervention, and postvention. There should be some plan for gatekeeper training for all stakeholders, the implementation of an assessment tool, and a comprehensive curriculum for prevention education, along with immediate available resources for distribution to all.

Many students who suffer from depression and are experiencing suicide ideation are hesitant to discuss issues with adults or peers because of labels and the possibility of exclusion often associated with such mental health issues. While it is important to have all faculty and staff trained on suicide prevention with an emphasis on identification, it is also important to provide training for the student population in an effort to promote awareness, understanding, as well as peer referral. Students are much more likely to discuss their intentions with a peer than with an adult. In fact, the majority of youth considering suicide have told a peer of their intent.

Early Identification

Many screening programs and techniques discuss the warning signs and offer questionnaires to assist in identification. However, a student in crisis may not answer honestly when asked to complete a questionnaire. Alerting faculty, staff, parents, and students to the warning signs of possible suicidal behavior may be a more direct way of assessing imminent risk. Some of the possible warning signs include:

- Hopelessness, depression, desperation
- Sudden loss of interest in hobbies, sports, activities
- Drop in academic performance
- Increased anger or irritability
- Difficulty sleeping or sleeping too much
- Drug or alcohol abuse
- Previous suicide attempt
- Talking openly about dying
- Having a plan
- Sudden improvement of symptoms

Most students are in immediate crisis for 24–72 hours (Clayton, n.d.) so early identification and immediate action can save lives. Once the student has been identified and referred to a school professional, the professional can then make further determinations as to the suicidality of the student. One technique used by school professionals is a pneumonic device called IS *THE PATH WARM.* This tool assists in identifying ideation, substance abuse, purposefulness, anxiety, trapped,

hopelessness, withdrawal, anger, recklessness, and mood changes. ("Know the Warning Signs",n.d.). The counselor should ascertain through interviewing, the student's intent, plan, and availability of means. Parents should be alerted to the professional's assessment of risk and a list of resources, including those offering immediate assistance, should be made available. Another such device used for identification purposes is the Specific, Lethality, Availability, Proximity (*SLAP)* method (Opalewski, 2008, p.33). Through questioning, the counselor is able to determine the specificity of a plan, the lethality of method, the availability of the means and the proximity to crisis responders. The identification process can prove to be a frustrating one in that many students may or may not give pertinent information regarding possible intentions. While these methods may assist in identifying at-risk youth, they should not be considered the sole means of identification since many students will be reticent in providing information through questioning techniques.

Gatekeeper Training and Prevention Curriculum

Gatekeeper training has been at the forefront of most suicide prevention programs. One such training program that is widely used is that creation of Dr. Paul Quinnett, the QPR Training Method. This Question, Persuade, and Refer method trains those "first responders" to identify those who are potentially suicidal and move them to mental health services that can quickly intervene. The idea behind this program is to train many gatekeepers who "enhance the probability that a potentially suicidal person is identified and referred for assessment and care before an adverse event occurs." (Quinnett, 2007, p.2) More information can be found about this type of method and training at http://www.qprinstitute.com/. A complete list of possible gatekeeper training programs can be found at http://www.sprc.org/.

A more comprehensive approach to suicide prevention is through on-going school based prevention programs. Several organizations offer suicide prevention resources for the implementation of evidence-based practices to be implemented in schools. *The Youth Suicide Prevention School Based Guide* is a tool that assists schools in assessing their current prevention plan and offers methods to assist in identifying at risk students, provide information to students, faculty, and staff, as well as offering prevention, intervention, and postvention resources. This document is available by accessing the Florida Mental Health Institute website at http://theguide.fmhi.usf.edu/.

The American Foundation for Suicide Prevention (AFSP) offers a relatively inexpensive video program to be used in schools. The *More Than Sad* videos provide training for faculty and staff on the mental health warning signs of suicide in school aged children. While there is discussion about several mental health diagnoses, there is an in-depth discussion about depression and what it looks like in children and adolescents. Several real life scenarios are used as examples of what the suicidal student might exhibit in a school setting. The second video focuses on training for the students so that they might better identify depression in themselves or peers. The video is a set of vignettes with explanations of how the warning signs of suicide could easily be misinterpreted. The video discusses with students how and where to get help and reinforces the fact that depression is a treatable disease and that there is hope. More information concerning these video and other educational resources can be found at www.afsp.org.

Many evidenced-based programs can be accessed through the *SAMHSA National Registry of Evidence Based Programs & Practices.* These practices include assessment and evaluation, awareness education, and prevention techniques that have been implemented and reviewed for

efficacy. Statistics, warning signs, and prevention tools may also be found through the American Association of Suicidology (www.suicidology.org). Programs directed at prevention and intervention with American Indian and Alaskan Native students can be found at http://www.ihs.gov/nonmedicalprograms/nspn/.

Conclusion

The current statistics reveal that youth suicide is a prevalent issue in our communities; one that requires early identification and referral, as well a systemic change in education and awareness programs needed to help students better understand mental health issues and the potential tragic consequences of untreated depression. School counselors continue to be the key to program planning and implementation as well as the liaison between potential suicidal students and the mental health resources needed for intervention. Creating a school wide plan to include a prevention program, along with understanding the warning signs, and possible mental health influences can assist school communities in creating a proactive, yet supportive, environment aimed at reducing the stigma and incidence of youth suicide.

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Suicide in the Middle Years

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Abstract

This article presents an overview of adult suicide in the United States and Alabama. This includes the latest available information on the prevalence of suicide in the US and Alabama, demographic characteristics of suicide victims, trends in suicide, and known reasons behind adult suicide. With respect to adult suicide in Alabama, it focuses on economic issues and the recent occurrences of natural disasters. Also provided are risk factors and early, acute warning signs for potentially suicidal adults as well as selected strategies for preventing individual suicides.

Suicide in the Middle Years

The U.S. and Alabama

Alabama's rate of suicide for 2010 is 14.1 per 100,000. Although the U.S. rate will not be available for 2-4 years, provisional rates have been released by the Centers for Disease Control and Prevention (CDC) for 2008 and 2009. These rates are 11.7 and 11.9 per 100,000 respectively, and lower than the Alabama rates for the same period. Figure 1 shows a comparison of U.S. and Alabama suicide rates from 1960 until present. During the first two decades of this chart, the Alabama rates were lower than the U.S. rates, then Alabama exceeded the U.S. rates forming an elongated X pattern that still exists. No logical explanation for this crossover of rates has been found, although researchers suggest that the upsurge that began in 2006 may have been caused by a series of natural disasters combined with the economic downturn (e.g., Goldstein, Osofsky, & Lichtveld, 2011; Luo, Florence, Quispe-Agnoli, Ouyang, & Crosby, 2011; Phillips, Robin, Nugent, & Idler, 2010).

Alabama's Demographic Profile

Like many rural states, Alabama's population is not widely diverse. Although the large urban centers may have racial and ethnic diversity, in most of the 67 counties in Alabama 95% of the state's population is either Black/African American or White. The official publications of Alabama's Center for Health Statistics display all demographic data as either "White" or "Black and Other" due to the extremely small populations of other racial groups. Although this may appear archaic, it is actually to preserve anonymity according to the World Health Organization guidelines regarding suppressing small population numbers in specific locations. Figure 2 illustrates the actual proportions of other populations in the state as a whole. All of the other demographic groups

account for 5.3% of the total population and people of Hispanic or Latino ethnicity, which may include Blacks and Whites, account for 3.9% of the population (U.S. Census Bureau, 2011).

Alabama Suicides by Age Group

In Alabama, the total number of suicides for 2010 was 477, only slightly higher than 2009 (471), although the rate shows a small decrease (14.1 – 14.2). Figure 3 is a chart showing the actual number of suicides by age group in 2010, overlaid with a line showing 2009 suicides for comparison. There was little change between 2009 and 2010, with the number increasing slightly (2009-667; 2010-676) and the rate decreasing by 0.10%.

Some researchers posit that suicide rates in middle age, when rates historically decline before rising again in the elderly, are rising as baby boomers grow older (e.g. Phillips et al., 2010; Luo et al., 2011). Publications that are not research-based, cite statistics relating to rising rates in middle age, particularly the large cohort of those who are considered Baby Boomers—those born between 1946 and 1964 (Fields, 2010; Pew Research Center, 2010; Dubin, 2011). "The middle years may be times of disillusionment and regret about stalled careers and stale marriages. This time of life can also be filled with anxieties about mounting debt, while putting kids through school and caring for aging parents. Plus, men at midlife discover that their own bodies aren't what they used to be." Dan Fields states in a 2010 article entitled Middle-Age Suicide. The aging of such a large birth cohort creates "a so-called period effect" (Phillips et al., 2010) when competition for limited resources continues throughout the lifespan. This trend, too, is slightly higher in Alabama than the most recent U.S. rates as shown in Figure 4.

Racial and Gender Disparities

Indisputably, white males at all ages have the highest rates of suicides. As shown in Table 1, in Alabama, white females aged 25-64, have the second highest rates. Black and Other males in Alabama have lower rates, with females in that category having extremely low rates. White women's rates have risen during late middle age (e.g. Reinberg, 2008; Dubin, 2011) in recent years. During adolescence and young adulthood, White women's suicide rates are generally slightly lower than Black and Other males. Table 1 shows that, in Alabama for ages 25-44, their suicide rate is only slightly higher than Black and Other males, but in ages 45-64 their rate is almost double that of Black and Other males. Black and Other females have extremely low rates during ages 25-64 in Alabama, indeed have the lowest suicide rates of any group, whether delineated by age or race.

Among suicide researchers, it is common knowledge that the number of suicide deaths "by demographic characteristics is unavoidably an undercount due to misclassification of some suicides as accidental or as undetermined in official mortality data" (Phillips et al., 2010). In Alabama, deaths of undetermined intent from 2007 through 2009 averaged 85.67 per year.

Suicide by cop (SBC) is another phenomenon that may add to the actual number of suicides. There is a body of literature that supports the hypothesis that many deaths by legal intervention are actually subject precipitated homicides (e.g. Kennedy, Homant, and Hupp, 1998; Mohandie, Meloy, and Collins, 2009; Lord and Sloop, 2010) in which the subject does not lose perceived self-esteem by appearing to be a suicide. Kennedy et al. (1998) in an examination of 240 police shootings between 1980 and 1995 found that 16% had probable suicidal intentions and 46% contained some evidence of suicidal intent. Although the demographic profile of SBC is very difficult to determine,

generally the proportion of African-Americans and Hispanic/Latinos is higher than that proportion of the population (Mohandie et al., 2009). Risk factors are a high degree of impulsivity, aggression, often alcohol or substance abuse is involved. Deindustrialization, racism, and discrimination leading to unemployment or underemployment may be a factor, as well as cultural stigmas attached to vulnerability. Clinical indicators may include internalization of feelings, bravado, limited social support, low self-concept, hopelessness, frustration, and anger.

Methods Used in Alabama

According to the American Association of Suicidology (AAS), the most recent available data (2007), show that in the U.S. firearms account for 50% of all suicides, 25% are by suffocation, which includes hanging, and the third leading method is poisoning, which includes both legal and illegal drugs, as well as substances such as pesticides, drain cleaners, and other caustic or poisonous substances. In Alabama, 71% of all known suicides are by firearms, 15% by suffocation, and 9% by poisoning, with the remaining 5% accounting for all other possible methods (see Figure 5).

Obviously, firearms are the most used method, almost 22% higher than the national percentage. Males use firearms in 75% of known suicides and females a surprising 56% as shown in Table 2. The percentage of women using firearms has increased greatly; the national rate for women using firearms is 32%. During the latter half of the 20th century, women generally used poison or cut their wrists. It was commonly believed that they did not want to damage their faces. Poisoning does account for 24% of known female suicides in Alabama, but cutting or piercing only accounts for 1% of Alabama suicides.

Suffocation has greatly increased as a method for suicide in the U.S. during this century, but it remains at 15% for males and 14% for females in Alabama, which is about 10% less than the national statistics. One note regarding suffocation—there is often confusion regarding the Choking Game. This is not to be confused with autoerotic asphyxiation, but a method often used by adolescents and young adults to get high without using alcohol or illegal drugs. The National Center for Health Statistics considers a death by the choking game an accidental death because the intent was not to die, but many coroners disregard those instructions since it was a voluntary act and deem it suicide.

Trends in the US and Alabama

Why have suicide rates among adults increased in the United States and Alabama since the 1990s? Many reasons are at work. First of all, they involve macro-level changes at the societal and community levels that affect individuals by producing feelings of helplessness, hopelessness, and despair that may ultimately lead to suicide unless timely and effective help is forthcoming. A major economic downturn causes increasing numbers of individuals to lose their jobs, income, and homes, and perhaps their marriages and families. All these events are often accompanied by a perceived loss of face among family and friends and a gradual decline in self esteem leading to anxiety and depression and, for some, despair, hopelessness, and a tunnel vision that can see no remedy but death.

The Economy

Although many researchers have believed that the economy and job markets have a distinct effect upon suicide rates, there was little to support those beliefs. With the present economic conditions and unemployment at high levels, there is new evidence to support these beliefs (e.g., Phillips et al., 2010; Luo et al., 2011; AAS, 2011; SAMHSA, 2010). The National Survey on Drug Use and Health (SAMHSA, 2010) reported that combined averages of adults during 2008 and 2009 indicated that 8.4 million adults had seriously thought about committing suicide. The report further stated that employment status was a major risk factor with 6.5 of the unemployed having suicidal thoughts and behaviors, as well as 4.5 of those employed part time, and 3.9 in the "other" category, which includes retired, disabled, homemakers, students, or other persons not in the labor force.

The AAS (2011) issued a position statement on the economy and suicide stating "there is a clear and direct relationship between rates of unemployment and suicide….economic strain and personal financial crises have been well documented as precipitating events in individual deaths by suicide". In 2009, Alabama was one of only five states where foreclosure rates doubled in one year (Gray, 2010) and the state's homeless population grew by 13%. Other studies have reported that business cycles and economic hardships have a direct association among groups with other risk factors for suicide (e.g. Luo et al., 2011); higher rates of bankruptcy, personal financial losses, and high unemployment and underemployment have caused an increase in suicide in all age groups, but "is impacting those aged 50-64 years most severely, with respondents in this age range more likely to have incurred substantial investment losses and to report that they will have difficulty affording retirement" (e.g. Phillips et al., 2010). Luo et.al, (2011) state that "these people were breadwinners in their homes, and their jobs supported mortgage payments, health insurance, children's education and other expenses". They urge preventive efforts in settings where vulnerable individuals are found, such as workplace and employee assistance programs. Yet many will have already lost employment. Thus, settings where the unemployed gather should be the highest priority. These include employment agencies and programs, churches, colleges, and support groups.

Philips, Robin, Nugent, Idler, (2010) speculated that the rise in suicide rates after 1999 was possibly due to baby-boomers (who have had higher suicide rates since adolescence) passing into middle-age. They found that the increase in suicide rates after 1999 is especially pronounced for white men aged 50 to 59, the unmarried, and the less educated. Although the baby-boomer "effect" was present it was far outweighed by what they called "period effects" or circumstances occurring after 1999 such as higher unemployment and increasingly unstable economic conditions of all kinds including a rise in bankruptcy, a decline in permanent, full-time employment in favor of temporary, lower paid jobs without benefits, and losses of investment assets—homes, stocks, etc. More evidence for period effects was derived from the fact that the largest increases in economic problems occurred among boomers without a college education. A college degree and graduate studies have been a major protective factor for the cohort. Finally, a Pew poll quoted in the New York Times (May 15, 2009) indicated these events, along with the loss or downsizing of pensions, have combined to seriously threaten affordable retirement for increasing numbers of those in middle age.

Now, as in the past, less skilled or technical jobs are the most vulnerable to downsizing and movement off-shore. The less-skilled experience not only a loss of income but also the loss of health care and education opportunities. Sadly, these are the people with the fewest resources of any kind to deal with job loss or salary decreases. They have the least access to psychological

support, professional or otherwise, to deal with significantly declining self-esteem, family issues and depression. In the state of Alabama all of these macro-level factors are at work. Job gains in the auto sector have been more than offset by losses in textile industries and in the service sector (Richard Burleson, Personal Communication, 2010). And in this state, resources to cope with these problems are in short supply whether mental health counseling, unemployment benefits, and public assistance of all kinds.

Finally a longer-term secular trend is at play in the United States. Sally Spencer-Thomas also suspected that fraying social ties may play a role (2006). She noted that Americans' circle of confidants shrank by one-third in the previous two decades. And the number of people who said they have no one with whom to discuss important matters more than doubled in that time, to nearly twenty-five percent.

Natural Disasters

Compounding the difficulties with the current economic situation, are the proliferation of natural disasters affecting Alabama in recent years. In Figure 6, a three year examination of the National Suicide Prevention Lifeline calls from Alabama show a 41% increase since 2008. In a personal conversation, Chandra Brown, the director of a major crisis center with 5 locations in Gulf Coast counties stated that their call volume had more than doubled by mid-year 2011 over 2010 rates (June, 2011). These include some of the National Suicide Lifeline calls, but the majority was local calls made directly to the crisis center.

Alabama's Gulf Coast has been hard hit—Hurricanes Ivan, Katrina, and Rita, followed by the mortgage bust, then in 2010 the BP Gulf Oil Spill. Figure 7 shows a timeline of these natural and financial disasters, and the impact on the number of suicides in the region. It appears clear that after one hurricane, Ivan, residents began to work together to overcome adversity, then when Hurricane Katrina hit the region, followed quickly by Rita, suicides rose as the devastation to families and businesses became clear. The rate dropped in 2008, until the financial crisis began.

The Gulf Oil Spill struck a region already under financial stress, with widespread loss of employment, homes, and still living with psychological distress. "Although many problems in the immediate aftermath of the hurricane had been resolved, others—remained….many residents met the criteria for partial and complete PTSD" (Goldstein et al., 2011). We are likely to see more repercussions as time progresses. A Gallup survey in September 2010 of 2,600 coastal residents showed that depression cases were up more than 25% since the oil spill (Reeves, 2010). The survey further described sleeplessness, anxiety, depression, anger, substance abuse, and domestic violence being reported at higher rates by mental health agencies—all symptoms of PTSD (2010). The Alabama Department of Public Health with the Department of Mental Health and the CDC conducted a survey of households in Mobile and Baldwin Counties during August 2011. CDC Epidemic Intelligence Service Officer Dr. Danielle Buttke said, "….the economic impacts of the oil spill have had lasting mental health effects on the community members whose household incomes were directly affected" (ADPH, 2011). The report further states that it may be several years before mental health returns to normal for these individuals.

This is representative of expectations for the state as a whole, after tornadoes struck dozens of cities in Alabama on April 25, 2011. There were 239 deaths due directly to the storms with several fatalities during the search and rescue, and clean-up initiatives. Some power outages lasted as long

as eight days, causing difficulties with water treatment, as well as shortages of food and gasoline. Typically, during natural disasters, the first issues are immediate safety, finding shelter and food, then grieving losses, whether human losses or financial losses. Once those immanent needs are met, there is an increase in depression, and in disasters, often PTSD, which may be followed by an increase in the suicide rate.

Suicide Prevention

First know who's at risk of suicide. Understanding who's at a higher risk can help prevent a tragedy. While you don't necessarily need to constantly monitor someone at higher risk, you may be more alert for serious problems. Factors that increase the risk of suicide are below.

Environmental Reasons for Adult Suicidal Behaviors

1. Unemployment, underemployment and economic problems such as foreclosures or threats of home foreclosures. In 2009, Alabama was one of only 5 states where foreclosure rates doubled in one year (Gray, 2011). High levels of joblessness or unemployment motivate depression and suicidal behaviors at all levels.

2. A decline in life circumstances is closely related to the above. These include the loss or downsizing of pensions, retirement programs, and health care coverage.

3. A lack of mental health treatment resources results in a decline in mental health treatment. One of the unresolved community problems in suicide prevention is lack of access to and availability of health care and mental health care. There is also the problem of locating available resources—many people don't know where to go to get help.

4. A decline in religiosity or spirituality removes a strong protective factor against suicide as Emile Durkheim showed in perhaps the greatest analysis of suicide yet done (1899; 1950).

5. Cohort characteristics. It has been hypothesized, but not verified, that the passage of the baby boomers into middle age has raised adult suicide rates since that cohort manifested high rates throughout adolescence and young adulthood.

6. Changes in social norms include the increasing acceptability of suicide as shown in polls and access to internet support for suicide in the form of chat groups, on-line suicide pacts, recipes for suicide, and dose information such as that found on the website Final Exit.

7. Increasing PTSD in vets who are victims of the wars in Iraq and Afghanistan.

8. Access to more lethal means—e.g. oxycontin instead of aspirin—other prescription medications, internet information on painless methods, and, above all, easy access to guns. Guns are readily available almost anywhere in the United States. Use of a gun almost always guarantees a fatal outcome. Impulsivity and easy access to a gun is particularly bad for a depressed person with substance abuse issues. In Alabama accidental deaths by firearms in Alabama are 4 times the US average. Gun owners say they keep a gun at home for self-defense or protection. States with stricter gun control laws have lower rates of suicide. The reverse is true for states with loose gun laws like Alabama. Scientists said that women generally used poison or cut their wrists, so as not to damage their faces. The percentage of

women using firearms has increased greatly, the national rate for women using firearms is 32%---it is 56% in Alabama. It is also noteworthy that 80% of gun-related deaths in American homes were suicides and 85% of all youth suicides under 18 used a parent's gun. Meaningful gun control in Alabama is unlikely. Focus now is on gun safety programs like:

a. Means Matter from the Harvard School of Public Health,

b. Lok-It-Up (trigger locks and guns kept under lock and key), and

c. Child Access Protection (CAP) laws holding adults responsible for keeping guns away from kids. These laws have been passed in 18 states. (http://Washington.Post.com/wp-srv/health/interactives/guns/gunsafety.html)

The good news is a decline in overall rates of gun suicides since 1991 in all regions. Polling data show decline in self-reported gun ownership during same period.

Individual Reasons for Suicidal Behaviors.

1. Chronic unemployment and loss of earnings, particularly for men, who invest their identity in their jobs.

2. Major Depression and other mental illness. The most frequent mental illness diagnosis for suicidal behaviors is depression—85.2%; next is bipolar disorder—7.4%; then schizophrenia—3.3%. Mental Illness in adolescence leads to compromised functioning in adulthood, psychopathology, suicidal behaviors, and poor overall functioning. Major depression left untreated leads to increasingly negative self perceptions of one's coping ability, low self-esteem, impoverished social skills, and bad interpersonal relations along with increasing social isolation. (Reinherz, Tanner, Berger, Beardslee, Fitzmaurice, 2006). A family history of depression is also a red flag.

3. A Previous suicide attempt is the best single predictor of suicide.

4. Substance abuse is often co-morbid with mental illness. When substance abuse and depression are co-morbid—the risk of suicide is much higher.

5. Family history of suicide increases risk of suicide pointing to possible genetic reasons.

6. Chronic Interpersonal Conflict. Frequent violence including physical and sexual abuse between significant others and within families increases risk. This broad category includes Intimate Partner Violence (IPM). A study of 662 racially and ethnically diverse sample of physically abused adult women found that 20% had threatened or attempted suicide during their lifetimes. The greater the severity or potential lethality of the violence the more likely PTSD, depression, anxiety and suicidal behaviors especially among white women, younger women and women who were chronically ill or disabled. Being chronically ill or disabled was associated with IPM irrespective of its severity implying an independent effect on suicidality. (Cavanaugh, Theresa-Messing, Del-Colle, O'Sullivan, Campbell, 2011).

Another facet is childhood and adolescent trauma or abuse, as well as, neglect and rejection. These exacerbate depression and anxiety through behavioral, emotional, and cognitive pathways, and increase the risk of substance abuse, and subsequent violent behavior of all kinds including suicidal

(Ilgen, Burnette, Connor, Czyz,, Murray, Chermack, 2010) along with psychiatric diseases in adulthood and impulsivity (Braquehais, Oquendo, Baca-Garcia, 2010; Clements-Noelle, Wolden, Bargmann-Losche 2009). The risk for suicidal behaviors in adults after childhood sexual abuse significantly elevates the risk for depression, PTSD, and persistent suicidal behaviors in both men and women with women at higher risk overall and earlier onset—by age 13 in many cases (Bedi, Nelson, Lynskey, McCutcheon, Heath, Madden, Martin, 2011).

7. Functional impairment in daily living (Freidman, Conwell, Delavan, Wamsley, Eggert, 2005). Persons who are permanently impaired, physically or mentally, are at high risk for suicide especially if social support is absent.

8. Marital status. Despite interpersonal conflict in family life, marriage is a protective factor for men but not women; divorced or widowed men have the highest rates of suicide. The presence of children is also a protective factor for both men and women.

9. Age**.** Immaturity and lack of impulse control especially in younger adults is a cause of suicidal behaviors for men and women who are depressed, substance abusers and involved in interpersonal conflict. This is especially so for men.

10. Gender. Males have more risk-taking behaviors, and the lack of impulse control often plays a part. Men are less likely to seek medical help, and gender role issues may emerge. Females tend to ruminate. Rumination is a psychological term for when you focus your thoughts on one thing to an unhealthy degree, that is, you turn it over and over in your head. Women also indulge in more dramatic behaviors. But women rarely invest their total identity in careers as do most American men—for men failure at work = failure in life and as a human being.

    Women also have more social roles as wives, mothers, and daughters to express their identity. They usually still feel needed and loved by others whatever happens in their careers.

    Women are less likely to be socially isolated and have stronger social support at all ages. They are more likely to seek help, professional or otherwise. Women use less lethal means such as overdoses and thus are more likely to be rescued. Women report greater religiosity. Child-rearing responsibilities are a deterrent. Women often have a less intense wish to die.

11. Incarceration. Suicide rates in city or county jails are higher than in state or Federal prisons. This may be due to intense feelings of despair and guilt by newly incarcerated persons. About 32% of all jail deaths are suicides (2% are homicides). Six percent of all prison deaths are suicides (1.5% are homicides). The risk is highest within first 24 hours of incarceration. Hanging is the usual method.

12. Social Isolation/Lack of Social Support. This refers directly to connectedness, social engagement, and feeling useful or wanted. Joiner (2001) calls this "thwarted belongingness" or wanting human contact and connection but being unable to develop or sustain these for a variety of reasons. This broad but crucial issue is indicated by numbers of friends, frequency of social contacts, low levels of isolation and loneliness. Connectedness works well for all age groups (CDC, 2011).

13. Feelings of burdensomeness or feeling that one is a useless and heavy burden on others. Joiner (2001) believes that this factor plus thwarted belongingness and availability of lethal means put one at serious risk for suicide.

14. Procurement of means to commit suicide including buying or borrowing a gun, obtaining a supply of lethal medications.

Demographically speaking, the person at highest risk is white or American Indian male over 60 years, unemployed, living alone without significant social support or social life. When you add psychosocial risk factors–substance abuse, depression and chronic illness—the probability of suicide is much higher. Yet they are least likely to ask for help. Below is information on how they might be helped.

How Do You Personally Help Someone Who Is Suicidal?

Learn The Warning Signs And Symptoms of Acute Suicidal Ideation.

Warning signs, unlike risk/protective factors, imply immediate or acute risk. They are more episodic and variable—e.g. threatening to kill oneself or checking the internet for methods. They can vary from day to day. They are linked to so-called precipitating factors like losing a job, recent discharge from mental health treatment, a traumatic break-up or chronic rejection.

Here are typical warning signs:

1. Talking about suicide, including such statements as "I'm going to kill myself," "I wish I were dead" or "I wish I hadn't been born". Statements that seem to be self-deprecating or jokes often are deadly serious.

2. Obtaining the means to commit suicide, such as getting a gun or stockpiling pills, checking the internet for methods.

3. Withdrawing from social contact and wanting to be left alone resulting in disruption of social networks, social life, family discord, termination of close relationships (Duberstein PR, Conwell Y, Conner KR, Eberly S, Evinger JS, Caine ED 2004; Beautrais, AL, 2002).

4. Expressions of burdensomeness and social isolation, (Joiner, T.E., 2005)—felt these two in combination with acquiring the means to kill oneself are three primary risk factors, each of which is necessary but not sufficient to contribute to the overall risk of suicidal behavior. A review of empirical research found that social disengagement or social disconnection or rejection were one of the 5 most consistent predictors of suicide, independent of depression. (Conner KR, Duberstein PR, Conwell Y, Seidlitz L, Caine ED, 2001). Perceived burdensomeness is the perception, right or wrong that one's existence is a burden on others, that one is incompetent or ineffective. This is especially dangerous when the person can foresee no change and thus believes his/her burdensomeness is permanent (Joiner, 2001).

6. Dramatic mood swings, such as being emotionally high one day and deeply discouraged the next.

7. Being preoccupied with death, dying, or violence.

8. Feeling trapped or hopeless about a situation.

9. Increasing use of alcohol or drugs.

10. Changing normal routine, including eating or sleeping patterns.

11. Engaging in risky or self-destructive behavior, such as using drugs or driving recklessly.

12. Giving away belongings or getting affairs in order.

13. Saying goodbye to people as if they won't be seen again.

14. Radical personality changes, such as becoming very outgoing after being shy.

Don't always expect to see warning signs of suicide. Some people keep thoughts of suicide secret or deny having suicidal intentions even when directly asked. And many who consider or attempt suicide do so when you thought they should be feeling better — during what may seem like a recovery from depression, for instance. That's because they may finally muster the emotional energy to take action on suicidal thoughts.

Warning signs do not necessarily indicate one is imminently or truly suicidal. Many are depressed, experience losses or changes in behavior without suicidal tendencies. However, if a number of these signs occur simultaneously or in quick succession, help is needed. Intervene immediately by talking to the person at-risk, inquiring about suicidal feelings and behaviors, and obtaining any resources needed to prevent a suicide attempt.

Ask Questions When Someone Seems Suicidal

Mayo Clinic Strategies For Asking About Suicidal Thinking

The best way to find out if someone is considering suicide is to directly but gently ask. Asking them won't give them the idea or push them into doing something self-destructive. To the contrary, your willingness to ask can decrease the risk of suicide by giving them an opportunity to talk about their feelings. If someone denies having suicidal intentions but you're still worried, continue to gently raise the issue. You can ask open-ended questions about their feelings or specific questions about suicide. Here are examples of questions you can ask someone you're concerned about:

- Are you thinking about dying?
- Are you thinking about hurting yourself?
- Are you thinking about suicide?
- Have you thought about how you would do it?
- Do you know when you would do it?

- Do you have the means to do it?
- How are you coping with what's been happening in your life?
- Do you ever feel like just giving up?

If a friend or loved one is considering suicide, he or she needs professional help. Don't tell him or her that you promise not to tell anyone. The safety of your friend or loved one is of the utmost importance. Don't worry about losing a friendship when someone's life is at stake. Signs to monitor after treatment begins include worsening depression and anxiety, new or worsening symptoms of anger, agitation or irritability, and unusual behavior of any kind.

Challenges in Helping Suicidal Adults

Many suicidal persons, especially adults, will not respond to public health messages to seek help, take a free depression screening, or call a crisis center. These will likely be: working males and high profile females; those who fear being stigmatized; those suffering from serious mental illness or dementia; already too hopeless to believe they can be helped; using substances which a counselor will ask them to give up.

Men

Men of all ages have gender role conflicts—they try to suppress emotionality and depression, they are less likely to seek help for mental problems because they have negative or ambivalent attitudes toward help-seeking. When help is sought they may present physical problems.

"Women seek help—men die." This quote from a 1990 medical journal article is an overgeneralization, of course. There are plenty of women who do not seek help for their emotional distress. After all, women in the United States are three times more likely to *attempt* suicide than men. But "men tend to hold their own counsel," says psychiatrist Yeates Conwell, co-director of the Center for the Study and Prevention of Suicide at the University of Rochester. "They often don't build supportive networks that allow them to share their concerns with others."

Men are also more likely to drink heavily when feeling distraught, and to reach for guns in order to kill themselves. Nearly sixty percent of suicides among males occur by firearms. Guns are almost invariably lethal and this helps explain why there are four male suicides for every female suicide. There's evidence that men are more likely than women to feel there is a stigma attached to a "failed" suicide attempt. Men may use more lethal methods to avoid being seen as unmanly—even as they're planning their own death.

How do we find and help suicidal persons, especially men, who will not self-refer?

Paul Quinnett (2010) recommends the following: a. worksite depression screenings; b. open and advertise new anonymous places to get help—texting to trained crisis volunteers/mental health professionals; c. train community-base gatekeepers to recognize suicide warning signs and intervene to bring about a referral. (QPR); d. follow-up is vital, especially after treatment.

Community-Based Suicide Prevention

CASE FINDING

One basic approach to community-based suicide prevention links public health and mental health—CASE FINDING. Case finding is synonymous with "early detection and referral".
It is accomplished by:

-school-based suicide awareness programs,

-gatekeeper training programs,

-screening programs by primary care or mental health providers and

-crisis centers or hotlines.

Early detection and referral is the cornerstone of prevention for most diseases. Public health messages about warning signs for heart disease, diabetes, cancer—you name it—are well known. They are designed for case finding—identifying those at risk and motivating the at-risk to get help from qualified care-givers.

Equally important to case finding is referral to accessible and competent care-givers. If not, terrible frustration occurs.

Most suicidal people send detectable warning signs. These are usually sent to intimate others already known to the suicidal person—family, friends, co-workers, fellow students, bartenders, hairdressers, bank loan officers, bus drivers, almost anyone in their immediate surroundings.

1. Make gatekeeper training—on line or otherwise—for the identification and assessment of potentially suicidal persons available to health, mental health, substance abuse and human service professionals as well as to natural community helpers such as: coaches; hairdressers; bartenders; faith leaders; primary care physicians; police and fire protection first responders; clergy; teachers; correctional workers; school counselors; adult and child protective service social workers; and other social workers.
Establish state-wide access to an evidence-based, low-cost source for on-line gatekeeper training for a nominal fee.
Develop a state-wide cadre of licensed trainers to conduct training.
Maintain and update gatekeeper training/education for first responders on a continuing basis.

2. Make gatekeeper training—on-line or face-to-face–for the identification and assessment of suicidal behaviors also available to family members of persons at risk.

3. Collaborate with primary care providers to help at-risk patients acknowledge and seek treatment for depression, substance abuse, and other major mental illnesses. Emphasize suicidal assessment training for primary care physicians.

4. Gun Control at Home. With respect to our most used method—guns—there are programs that provide "means restriction" methods to gun owners in order to make a household gun difficult to

access or use. These include trigger locks and gun boxes or safes that can be locked. They are especially important when there is a depressed or suicidal person in the household and, for whatever reason, guns cannot be removed. They can be obtained at almost any gun store.

5. Community-wide publicizing of Crisis or Suicide Prevention Centers. These prevent suicide among the acutely suicidal. The depressed and suicidal DO CALL these agencies.

6. Social Media. These include all manner of internet websites that provide information on suicide and suicide prevention. Notable ones are listed on the ALABAMA SUICIDE PREVENTION AND RESOURCE CENTER website.

An emerging social media approach is "Entertainment Education" (EE) or the use of entertainment media to educate people on health and social issues. In developing countries this approach is widely used to promote women's development, reproductive health and more recently HIV/AIDS and chronic disease prevention (Galavotti C, Pappas-DeLuca KA, Lansky A, 2001). EE is based on social cognitive theory (Bandura A, 2004) and uses modeling to demonstrate the consequences of pro-social and pro-health behaviors along with the consequences of anti-health and antisocial behaviors. It has also been effective in changing social norms (Singhal A, Cody MJ, Rogers E, Sabido M, 2004). The Hollywood, Health and Society program is a partnership between the CDC and the Norman Lear Institute, through which mainstream media program writers are advised on health issues that need to be addressed and how to appropriately and accurately address them (http://www.learcenter.org/html/projects/?cm=hhs). More localized approaches have been implemented in which original radio and TV dramas are written and broadcast in response to specific, local health issues. In Alabama, the BodyLove radio drama was broadcast in 16 communities across the state to promote chronic disease prevention among African American adults (Chen N, Kohler **C**, Schoenberger Y, Suzuki-Crumly J, Davis K, Powell J, 2009). Through the radio series listeners learned about behavioral risk factors for diabetes and hypertension and for secondary complications of the diseases as they affected the characters in the drama (Kawamura Y, Ivankova N, Permunean-Chaney S. Kohler CL, 2009).

EE is a potentially effective way to increase knowledge about suicide-related issues and to change negative attitudes by de-stigmatizing mental health issues. In one BodyLove program a storyline featured a young woman who became depressed, attempted suicide and subsequently participated in mental health counseling with her family. The consequences of not recognizing the young woman's depression and responding appropriately were modeled in a series of episodes in which a "well meaning" friend introduced her to the local bar scene to "get her out and feel better". Following this story line presentation, there was a 30% increase in the percentage of listeners surveyed who reported talking to friends and family about depression either often or very often (27.5% to 36.5%).

The national suicide hotline is 1-800-273-TALK. It functions as a national hotline that links callers to certified crisis centers or hotlines within each state.

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Risk Factors and Prevention Strategies for Suicide Among the Elderly

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Abstract

Suicide is a preventable public health concern affecting the nation as the 10th leading cause of death. The prevalence of suicide among the elderly is higher than any other group. Risk factors attributed to this phenomenon are depression, social isolation, substance abuse, poor physical health or function, financial stress, and access to lethal means, among others. Protective factors have been identified, as well. Prevention of suicide among the elderly is of utmost importance, and national and state-level task forces and prevention strategies are leading prevention efforts. Suicidality is considered to be "a state of total pain, which, coupled with neurological impairment, limits the perceived options to either enduring (suffering through) or ending utter agony." This represents an important paradigm shift in the way researchers believe suicide occurs. This article provides an overview of factors that contribute to suicide among the elderly, prevention strategies, and examples of national, state and community-based prevention programs.

Risk Factors and Prevention Strategies for Suicide Among the Elderly

An example of a suicide note written by an elderly man follows: "Death is as much a reality as birth, growth, maturity, and old age—it is one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence, and hopeless pain…Dear family, I cannot stand it anymore" (Holmes & Holmes, 2005, p. 51-52). Suicide among the elderly has been described sequentially. As older adults continue to age, they may experience multiple losses, then stress, followed by depression, pain, and, finally, suicide (Alabama Department of Public Health [ADPH], n.d.; Osgood, 1985). The group at highest risk for suicide is that of elderly men; however, elderly women are also affected (Szanto, Prigerson, & Reynolds, 2001). Major losses occur while aging, such as in physical health, social interaction, mental status, loss of job through retirement, financial loss, loss of close relationship ties through changes in family structure, and cognitive loss (Osgood, 1985). The elderly are less resilient and more vulnerable to the stress of loss. Many coping mechanisms fail with age, and depression may result. Helplessness, hopelessness, anxiety, decreased self-concept, lowered self-esteem, loneliness, and loss of control may accompany a

sense of despair (Mann, 2005; Osgood, 1985), leading to a serious life crisis, the perception of crisis, and unbearable pain. The new paradigm emphasizes the suicidal individual sees death as the only option to relieve this pain. This is a shift from the old paradigm that considers suicide as a way to kill the self rather than the pain. It is now believed that suicidal individuals are "no longer capable of choice. Suicidality is a state of total pain which, coupled with neurological impairment, limits the perceived options to either enduring (suffering through) or ending utter agony" (ADPH, The suicide paradigm, n.d., para 3). This article provides an overview of factors that contribute to suicide among the elderly, prevention strategies, and examples of national, state and community-based prevention programs.

The *National Strategy for Suicide Prevention: Goals and Objectives for Action* articulates a set of 11 goals and 68 objectives, providing a framework for prevention efforts and the development of programs (Department of Health and Human Services [DHHS], 2001). These goals and objectives make it clear that primary and secondary prevention are fundamental to the reduction of suicides among all age groups. Awareness (Goal 1), support (Goal 2), research (Goal 10), and monitoring (Goal 11) of suicide prevention efforts and the reduction of the stigma associated with using mental health services (Goal 3) are important first steps in recognizing the complexity of developing suicide prevention programs (Goal 4). Restricting access to lethal means of self harm (Goal 5) is supported by data reporting that elderly males are more likely to use firearms as a method of suicide (Conwell & Thompson, 2008). The importance of clinical training and good professional practices in recognizing and referring patients at risk for suicide and delivering effective treatment (Goal 6 and7) are also prevention goals. Increasing access to and improving community linkages with substance abuse and mental health services and improving the media's reporting and portrayal of suicidal behaviors are the final goals (Goals 8 and 9).

On the state level, the multidisciplinary Alabama Suicide Task Force was convened in 2002 to begin developing a plan for suicide prevention. Alabama's Suicide Prevention Plan addresses goals stated in *The Surgeon General's Call to Action to Prevent Suicide* (U.S. Public Health Service, 1999). The recognition of suicide as a preventable public health problem affecting Alabamians forms the basis for outlining a state-wide prevention strategy. Identifying federal, state and local resources to support the plan is critical to implementing the plan. The Website for the Alabama Department of Public Health (ADPH, Alabama Suicide Prevention Plan, n.d.) provides information about the state plan.

Suicide death rates for Alabama were compared to national suicide death rates. Figure 1 displays the comparison data for the overall population of the state with a breakdown by ethnicity (ADPH, Table 56, n.d.). Data for Alabama reports higher rates for Whites than the national average, while rates for Blacks and other ethnic groups (combined) are lower. It is important to note that suicide death rates may be higher than reported, especially for Blacks, due to the stigma attached to recording suicide as the cause of death (Rockett et al., 2010).

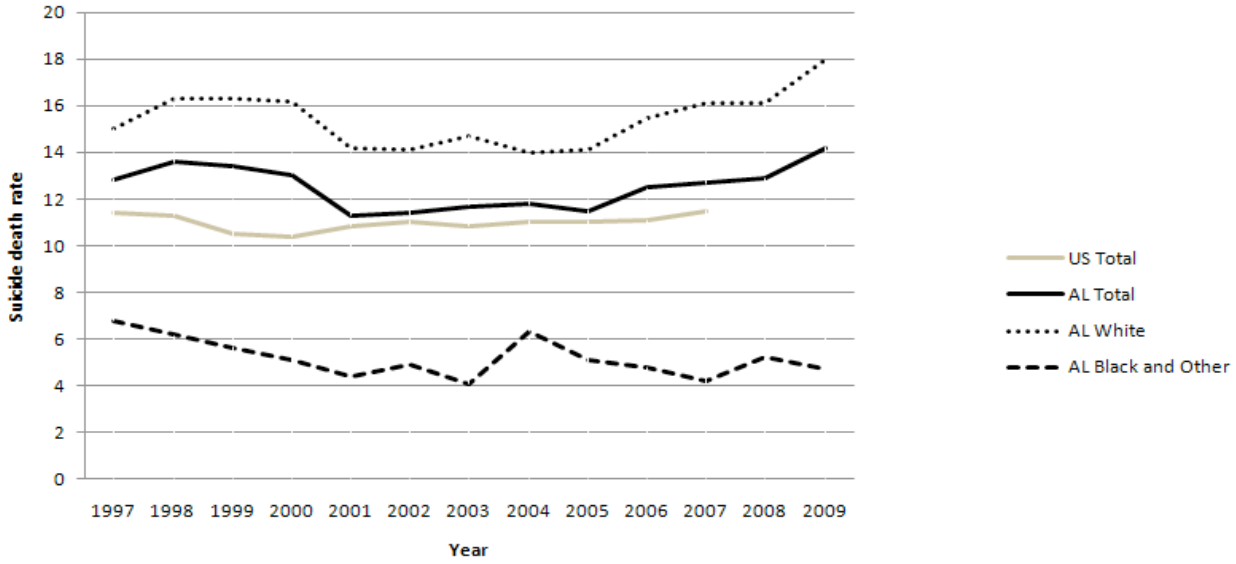

Figure 1. Alabama suicide death rate, 2009, by ethnicity.

The suicide death rate for Alabama in 2009 was 14.2 per 100,000 population (Male = 23.6; Female = 5.3; White = 18.0; Black and Other = 4.7). Figure 2 displays the breakdown of the 2009 suicide death rate data by age group, ethnicity and gender. (ADPH, Table 57, n.d.).

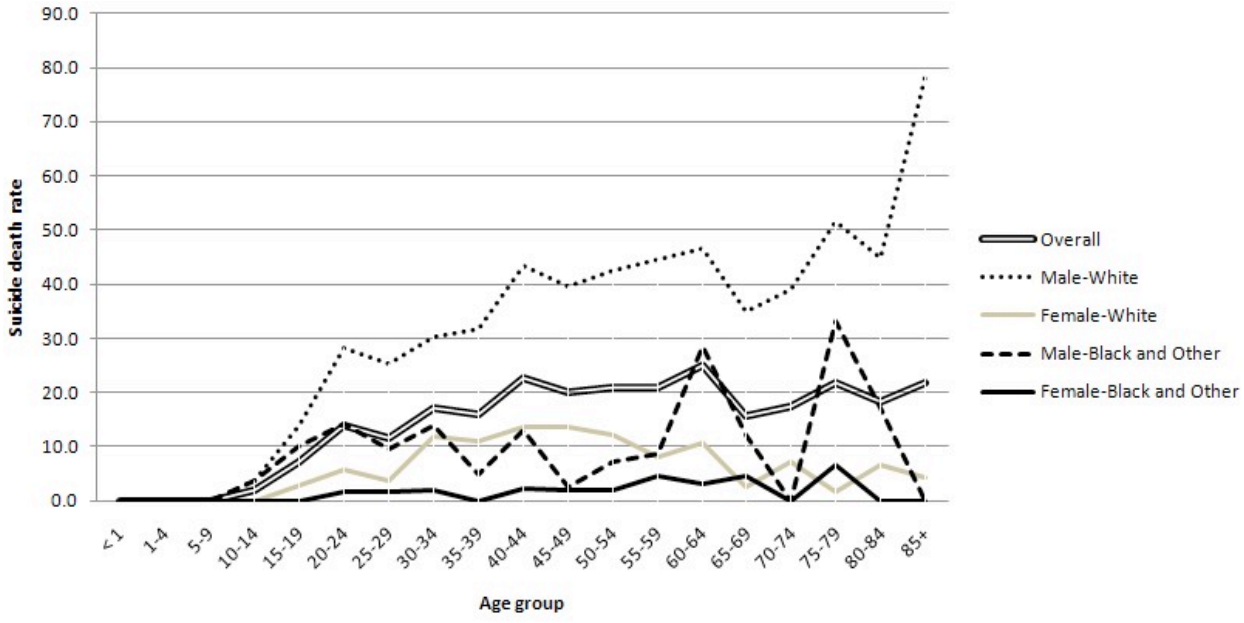

Figure 2. Alabama suicide death rate, 2009, by age group, ethnicity and gender.

Approximately 75% of elderly suicide completers visited a medical provider in the 30 days prior to their death, with approximately 50% of these visits occurring in the week leading up to the suicide (Conwell & Thompson, 2008). Of elderly suicide completers, 75% had no history of a

previous suicide attempt nor displayed warning signs. According to Conwell and Thompson (2008), 72% of attempters over the age of 65 used firearms to complete the suicide attempt. Researchers reported that suicidal firearm usage is on the increase among both Blacks and Whites, increasing the likelihood of successful suicide completion (Joe & Niedermeier, 2008).

Risk and Protective Factors

Risk factors for elderly suicide exist in mental, physical and social domains. These risk factors may be grouped into four categories: individual, relational, community, and societal. Individual factors include psychiatric illness/depression, substance abuse, financial stress, and physical health and function (Mann et al., 2005; Oquendo et al., 2010). An estimated 90% of completers aged 60 or older had at least one DSM Axis 1 diagnosis (Moscicki, 2001; Pearson, & Conwell, 1996). Podgorski, Langford, Pearson, and Conwell (2010) reported findings of a one-year retrospective study in Finland indicating depressive disorders in 75% of completed suicides, with recognizable symptoms of depression in only 33% of the cases. Other individual risk factors include prior suicide attempt, access to lethal means, impulsivity (Neufeld, & O'Rourke, 2009), and complicated grief (Latham, & Prigerson, 2004). When assessing individual suicidal risk factors, it is important to determine if the symptoms are acute or chronic, and if the risk is low, moderate or high; this assessment is critical in the determination of next steps to prevent potential suicide. For example, chronic problems may represent low, but not unimportant, risk whereas sudden loss or traumatic precipitating events may indicate a higher risk. Suicidal individuals with a concrete plan and access to lethal means would be at higher risk than those without a plan or access to means (J. Harrington, personal communication, May 28, 2008).

Relational factors for suicide include living alone, low social interaction, relationship problems, marital status, family history of suicide, family history of substance abuse or mental disorder, domestic violence, and being exposed to suicidal behavior of media figures, peers, or family members (Mann et al., 2005; NIMH, 2010). Community factors include limited availability and access to senior programs and health care services, transportation, proximity and access to faith communities, and demographics of the community. Societal factors include gun control policies, attitudes towards the care of the elderly, and the stigma of utilizing mental health services (Conwell, Van Orden, & Caine, 2011; Sirey et al., 2008).

Protective factors for suicide include access to and effective clinical care for mental, substance abuse and physical problems; connectedness; supportive therapeutic relationships with physicians and mental health professionals; problem solving and non-violent conflict resolution skills; and attitudes and beliefs discouraging suicide (NIMH, 2010). According to Conwell and Thompson (2008), "the weight of the evidence indicates that, like psychological and medical factors, social stressors place older adults at risk, whereas robust social supports seem to be a buffer against suicide" (p. 342).

Leach (2006) offers three explanations for lower suicide death rates for African Americans based on social supports. First, there is the African American church, where members—especially men—have increased roles. According to Gibbs (1997), lower rates of suicide occur in conjunction with church attendance or affiliation. Further, the African American church serves as a source of social support and stress reduction for the African American community. Other researchers found that religiousness and social support are strongly inversely related to suicidal behavior, including ideation, attempts and completed suicides (June, Segal, Coolidge, & Klebe, 2009; Sirey et al., 2008).

Suicide trend data for African American men, however, is on the increase. The strength of the African American church, while serving as a potentially protective factor for suicidal behavior, may also contribute to an internal angst that could lead to suicide. This is due to the stigma associated with seeking mental health services, the condemnation of suicide by the church, and the false assumption that African Americans are strong enough to avoid suicide (Day-Vines, 2009).

The second protective factor offered by Leach (2006) is that the majority of African Americans live in the South, which gives them a collective experience as a group. Leach claims that being in a homogeneous group may reduce the risk for suicide.

Finally, African American adults are often primary caretakers of grandchildren or co-reside with other family members (Leach, 2006). African Americans are disproportionately more likely to be primary caregivers for dependent grandchildren than Whites (Peek, Koropeckyj-Cox, Zsembik, & Coward, 2004). Researchers found that the percentages of grandparents that lived with at least one grandchild ranked at 11.7% for African Americans, and 3.6% for Whites (Compton, Thompson, & Kaslow, 2005; Leach). Additionally, African Americans are more likely to reside with family members in multi-generational households and less likely to live alone or in institutions (Peek et al.).

Prevention Strategies

A consensus among researchers is that regular screening for depression and suicidality at every entry point into medical and mental health systems, as well as effective treatment for depression, is a significant primary prevention strategy for suicide (Cheung, Liu, & Yip, 2007; Heisel, Dubelstin, Lyness, & Feldman, 2010; Mann et al., 2005; Plaweski, & Amrhein, 2010). According to Conwell and Thompson (2008), "if all late-life major depressive episodes could be prevented, suicide rates among older adults would drop by almost 75%" (p. 342). The National Institute of Mental Health (NIMH; 2007) reported that approximately 80% of depressed elderly adults in otherwise good health recovered with a combined treatment of psychotherapy and antidepressant medication, which was more effective in preventing the recurrence of depression than with the use of either psychotherapy or medication alone. A systematic review of suicide prevention strategies published in the *Journal of the American Medical Association* listed recommendations for screening those at high risk; raising awareness; and, educating primary care physicians, the general public and organizational and community gatekeepers about suicide (Mann et al., 2005). They also recommend the restriction of access to lethal means, follow-up care for suicide attempters, and the development of guidelines for media reporting of suicide.

A second strategy is decreasing social isolation of the elderly through family and community support; however, experts do not agree on what the social lives of the elderly should look like. Disengagement theory suggests that adults voluntarily retire, creating a mutual withdrawal expected by society. According to Podgorski et al. (2010), this is normal and benefits society as well as older individuals. Activity theory suggests that the elderly are more satisfied with life the more active they remain. Selectivity theory states that the elderly may benefit from maintaining some activity while disengaging from other activities. The elderly are proactive in managing their self-selected social activity. Continuity theory declares that the elderly will usually follow the same path as their past experience, maintaining the same type of activities, relationships, and behaviors from earlier years. Prevention strategies aimed at improving the social lives of the

elderly should be designed according to individual needs, weighing the need to maintain independence against the increased risk of death by suicide due to living in isolation. Community gatekeepers, who have access to at-risk seniors, may notice changes in those they serve and may be trained to identify and refer distressed elders for evaluation and care. This may include bank tellers, pharmacists, mail carriers, clergy, and employees and volunteers at senior centers, nutrition programs, outreach programs, and transportation services (Conwell, & Thompson, 2002).

A ten-year study conducted by De Leo, Dello Buono and Dwyer (2002) examined the long-term effects of telephone support on suicide in an elderly population in Italy. Physicians and social workers from local health services initiated referrals to the TeleHelp-TeleCheck service. Referrals were contacted and given an opportunity to participate in the study. Participants (n = 18,641; Female, n = 15,658; Male, n = 2,983) were called twice weekly to provide telephone support, needs assessment, and 24-hour emergency services. The study hypothesis was that there would be a significant difference in suicide rates between the TeleHelp-TeleCheck Line users and the general population. The results showed that, of those elderly individuals who used the TeleHelp-TeleCheck Line, the observed suicide rate was 5.99 times lower than expected. Chi square statistic was used to compare standardized and observed mortality rates after calculating the standardized mortality ratio (SMR), indicating a statistically significant difference ($\chi^2 = 8.36$, $p < 0.01$) between the rates (De Leo, Buono, & Dwyer, 2002). In the United States, talk lines exist; however, for these talk lines, individuals are required to call into the talk line rather than being called by volunteers. For example, the National Suicide Prevention Lifeline, 800-273-TALK, is a confidential hotline available to anyone in distress or crisis. Contact information for other national and state crisis center help lines are available online (ADPH, Crisis numbers, n.d.).

In Alabama, the Senior Talk Line located in Birmingham operates under the Crisis Center network in a similar fashion as the TeleHelp-TeleCheck Line. Although the Senior Talk Line is not a suicide hotline per se, it meets social needs of seniors and offers protective factors by providing someone to talk who is compassionate and can offer reassurance. The Senior Talk Line was developed by Anna Sullivan of the Crisis Center in Birmingham, modeled after the successful TeleHelp-TeleCheck Line in Italy (A. Sullivan, personal communication, September 28, 2010). Prior to the introduction of the Senior Talk Line, the Crisis Center received all calls, some of which were not crises; thus, the implementation of the Senior Talk Line in 2001, with the goal to reduce social isolation among the elderly. The Senior Talk Line is the only one of its kind in the state, serving Jefferson, Blount, Shelby, Walker, and St. Clair counties (Crisis Center, n.d.). Seniors call 205-328-TALK to request to receive the service or they may be referred by those working with this population. More research is needed to determine the effectiveness of programs like the Senior Talk Line with suicide.

On the community level, mental health services are available through community mental health centers that often serve as safety nets in rural communities (Hartley, Bird, Lambert, & Coffin, 2002). Senior outreach programs may exist in communities to serve those in need of social support, such as day programs for the elderly. Religious communities serving seniors help to meet social needs, if elders are able to attend services or program activities. When elders are homebound or living in residential facilities, it is more difficult to reach them; however, many residential facilities have programs for residents that address social needs.

An innovative program in the Birmingham area is Ruth and Naomi Senior Outreach, a 501©3 non-profit founded by Chaplains Rev. Lynn Bledsoe and Rev. Dr. Mary Porter. The pair began their work serving elder orphans and isolated elder adults in 2004. Through their work with hospice, they encountered a likely but unidentified form of suicide—a condition called "failure to thrive," in which persons having lost the will to live quit eating and gradually waste away. This passive approach to ending the pain and difficulty of life (often taken by persons with dementia) is typically overlooked by those addressing elderly suicide and raises important questions about this behavior yet to be answered. Ruth and Naomi Senior Outreach is a community of volunteers (trained by the two chaplains) visiting in long term care facilities, hospitals, hospices and private homes. Protective factors identified in the primary prevention of elderly suicide may be noted in the Ruth and Naomi mission: "To become spiritual companions to isolated older adults and to call, equip, and support others to do so as well" (Ruth & Naomi, Mission, 2009, para 1).

Bledsoe and Porter teach volunteers using the values of PRISM©, which they developed: *presence, relationship, interdependence, silence, and mystery.* In their role as ordained clergy, the chaplains also practice the therapeutic ministry of presence as they more directly address spiritual issues, administer the sacraments, pray, and sing familiar hymns/songs with seniors (L. Bledsoe, personal correspondence, July 20, 2011). They approach their work in a way that is contemplative and open-ended, addressing many protective factors through non-pharmacological interventions: animal companionship, art, music, and body memory activities. Body memory activities include bread making, dancing, and singing, among others. The focus on quality of life embodied in Ruth and Naomi chaplains and volunteers is summed up in the organization's vision statement: "in living and in dying, every elder upheld in a community of care" (M. Porter, personal correspondence, July 21, 2011).

A third important strategy is increasing the awareness of suicide as a preventable public health issue. Health communication campaigns designed to educate the general public about suicide risk factors and resources for suicide prevention are essential. This should be a coordinated effort by a multi-disciplinary group of stakeholders, including primary care physicians (Chambers et al., 2005; Mann et al., 2005). In the same way that social marketing efforts communicate life-saving information for stroke and other emergencies, messages designed to educate the public about the warning signs and risk factors for suicide are warranted. For example, the acronym IS PATH WARM, was adopted by the American Association of Suicidology to help remember the evidence-based signs and symptoms of suicide: Ideation, Substance abuse, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, and Mood changes (American Association of Suicidology, n.d.). Due to high suicide death rates among men,strategies designed specifically for men are needed. Formative data gathered in focus groups, interviews, and surveys, are urgently needed to reach the most vulnerable and resistant target groups and secondary audiences. Considering the gap between the suicide death rates of Caucasian and African American men, it is likely that differing public health messages would be needed for these groups. All public health messages about suicide should aim to decrease the stigma of suicide and create a more open platform for public dialogue. Working with various media outlets would assist in this important strategy. The Alabama Suicide Prevention Plan promotes a "collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of suicide and its associated risk factors, including mental illness and substance abuse disorders and approaches to prevention and treatment" (ADPH, Alabama Suicide Prevention Plan, Point 11).

A forth strategy important to early and effective treatment of suicidal clients includes improvements in the training of counseling and mental health professionals to identify and treat underlying issues, such as substance abuse, depression, and other mental health issues related to suicide risk. This would include promoting continuing education opportunities related to suicidality, such as the American Association of Suicidology Conference, as well as other events. The Alabama Strategy for Suicide Prevention recommends initiating "training for all health, mental health, substance abuse and human service professionals concerning suicide risk assessment and recognition, treatment, management, and aftercare intervention" (ADPH, Alabama Suicide Prevention Plan, Point 7). This includes educating primary care physicians, who provide pharmacological support for their patients. As future research findings provide additional clues to solving this public health problem, education of service providers must remain current. For example, researchers have identified a modest level of support for using suicidal ideation as a surrogate endpoint for suicide among the elderly and call for additional research for this important marker (Links, Heisel, & Quastel, 2005). Other research efforts are needed to increase understanding of this 10th highest cause of death in the United States (NIMH, 2007).

Making a positive impact on the suicide crisis among the elderly will take a proactive and multi-faceted approach. Strategies that influence this at-risk group must be implemented at the individual, relational, community and societal levels. Those in contact with the elderly can learn to ask the question, "Are you feeling suicidal today?," and be prepared to administer emotional CPR if the answer is "yes." It is hoped that the outcome of these prevention strategies would be that risk factors are identified and reduced, that individuals and families are educated, and that lives are saved.

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Suicide Interventions Targeted Toward At-Risk Youth

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Abstract

Suicide is currently the third leading cause of death among youth; it has been named a public health concern. A number of programs have been developed to prevent suicide; many of these involve intervening with youth who are known to be at-risk because of their depression, expressed suicide ideation, or previous suicide attempts. This paper serves as a qualitative review of existing interventions for adolescent suicide. Long-term outcome data on existing programs are relatively scarce. However, promising current interventions include strategies to help youth tolerate intense negative affect and maintain emotional regulation. Individual psychotherapy for suicide prone youth is often conducted in conjunction with pharmacological treatments. Other noteworthy suicide interventions address the family dynamics surrounding suicidal youth, often by including the family in treatment. Interventions that increase the adolescent's motivation for treatment and likelihood of treatment compliance are also under current investigation. Modes of delivery for suicide interventions may also be changing with the inclusion of technology in service access and provision. Essential elements of effective suicide prevention programs and concerns with existing suicide-related interventions are also summarized.

Suicide Interventions Targeted Toward At-Risk Youth

Suicide is the third leading cause of death among both 10- to 14-year-olds and 15- to 19-year olds in the United States (Centers for Disease Control and Prevention [CDC], 2008). According to their self-report, approximately 15% of high school students have seriously contemplated suicide in the past 12 months while 7% indicated they had made an actual suicide attempt (Eaton et al., 2006). Suicidal ideation is a precursor of later suicide-related behavior (Crosby, Cheltenham, & Sacks, 1999), as 34.7% of life-time suicide ideators eventually make a suicide attempt (Kessler, Borges, & Walters, 1999). Although most adolescents who contemplate completing suicide will never act on those thoughts, the presence of suicide ideation is one of the most significant risk factors for subsequent suicide attempts in youth (Pinto, Whisman, & McCoy, 1997; Suominen et al., 2004) and thus it is often a focal point of adolescent suicide intervention and prevention efforts.

Suicidal behavior has been frequently considered to be defined along a continuum of severity (Mazza, 2006). One end of the continuum begins with thoughts of death and dying. Next is suicidal ideation, followed by plans to attempt suicide, and then suicide attempts. The final node of the continuum consists of suicide completion (Barrios, Everett, Simon, & Brener, 2000; Hovey & King, 2002; Scocco & De Leo, 2002). Recently, researchers have added risk-taking and self-injurious behaviors as initial points on the continuum (Ellis & Trumpower, 2008; Langhinrichsen-Rohling & Lamis, 2008), as these less overtly suicidal behaviors have been shown to constitute a component

of suicide proneness and may serve as another focus of early intervention and/or suicide prevention efforts (Langhinrichsen-Rohling & Lamis).

Overall, one important suicide prevention strategy has been to identify and intervene with individuals who are at early points along the continuum (e.g., target programs toward individuals who are engaging in high levels of risk taking behavior, or who are expressing suicide ideation, or who have made a suicide attempt). In fact, numerous suicide prevention efforts have focused on individuals who are deemed at-risk because of their experience of related risk factors for suicide including increased depression and/or hopelessness (Garrison, Lewinsohn, Marsteller, Langhinrichsen, & Lann, 1991; Konick & Gutierrez, 2005; Lamis, Malone, Langhinrichsen-Rohling, & Ellis, 2010). These programs have variously been considered either secondary prevention programs or early intervention programs. Compiling and reviewing the existing programs (whether they are considered secondary prevention or suicide intervention) that are specifically targeted toward at-risk youth and/or their families is the primary purpose of the current paper.

At the outset, it should be noted these interventions stand in contrast to primary suicide prevention efforts, which are distributed to the population as a whole (universal) and have often been delivered to youth in school settings. These primary prevention programs have been supported by U.S. Government Initiatives. Specifically, in 2000, the United States Department of Health and Human Services (USDHHS, 2000) launched the Healthy People 2010 initiative, which is a health promotion and disease prevention agenda designed to improve the health of people in the U.S. during the first decade of the new millennium. One of the objectives was to increase the proportion of middle and high schools that provide health education to prevent suicide (USDHHS). As of 2007, Kann, Brener, and Wechsler reported although the number of suicide prevention programs implemented in schools went up from 59.1% in 2005 to 63.1% in 2007, this figure falls far short of the 2010 target of 80% of schools regularly delivering effective suicide prevention programs. Additionally, the 2010 Healthy People suicide health objective does not identify a specific universal program that should be employed throughout the U.S. (Kann, Brener, & Allensworth, 2001).

In fact, a review of the literature indicates many different youth suicide prevention programs have been proposed (Miller, Eckert, & Mazza, 2009). However, the majority of these programs share at least one of two general goals: 1) enhancement of protective factors and reduction of risk factors and/or 2) identification and referral of individuals who emerge as high-risk (Gould & Kramer, 2001). Accordingly, these goals have been addressed among high school students in a variety of ways including suicide awareness curriculums (Ciffone, 2007; Kalafat & Elias, 1994), skills training (Thompson, Eggert, Randell, & Pike, 2001; Zenere & Lazarus, 2009), screening (Aseltine & DeMartino, 2004), and peer helper and gatekeeper training (Stuart, Waalen, & Haelstromm, 2003). Although numerous suicide prevention strategies have been developed and implemented, the majority of them have not been subjected to rigorous testing and evaluation (Macgowan, 2004). This means there is considerable diversity in programming even among schools that are currently offering a suicide prevention curriculum.

Consequently, an alternative route has been to target suicide intervention programs toward adolescents who are already exhibiting risk factors for suicide. This strategy makes particular sense given suicide is a very low base rate behavior. However, when designing and/or implementing a suicide intervention for adolescents, there are essential developmental elements to consider. These elements may vary among at-risk adolescents of different ages and young adults (e.g., there are risk factors that are specific to college students vs. those in high school, Langhinrichsen-Rohling, Klibert,

& Williams, 2011). There are also aspects of adolescent suicidal behavior that may manifest differently in particular subgroups of adolescents (e.g., suicidal behavior may manifest differently in adolescents who have been adjudicated as delinquent (Langhinrichsen-Rohling, Arata, Bowers, O'Brien, & Morgan, 2004), versus those who have co-morbid depression, (Kisch, Leino, & Silverman, 2005). Some of the important program-related considerations will be described below.

First, adolescents tend not to be formal help-seekers, even in times of acute crisis (Gould et al., 2004; Gulliver, Griffiths, & Christensen, 2010). Therefore, offering informal opportunities for guidance and non-stigmatizing ways to access effective help are important considerations for adolescent-directed interventions. Furthermore, intervention efforts for adolescents must be appropriate to their developmental level (which can vary widely among youth of the same age and across youth in middle versus high school versus college). Successful programs should also work well in concert with the multiple contexts to which the adolescent belongs (e.g., school, church, friends, and family; Daniel & Goldston, 2009). One important context facing today's youth is the widespread use of technology and the greater likelihood of exposure of personal information via social networking cites such as Facebook. Navigating this new technology in a socially acceptable and appropriate fashion requires the development of an additional set of adolescent social skills; unfortunately, many of these skills may be unfamiliar to adult help providers.

Of particular concern is some adolescents have used the internet and social networking sites as a forum to harm others. Specifically, cyber-bullying has been defined as "willful and repeated harm inflicted through the use of computers, cell phones, and other electronic devices" (Hinduja & Patchin, 2010, p. 208). Cyberbullying involves sending harassing or threatening messages (via text or email), posting insulting comments about someone on an online site or social networking site such as Facebook or Myspace, or threatening or intimidating someone through an online medium (Patchin & Hinduja, 2006). To date, very little research has been conducted on cyberbullying and suicidal behavior. However, one study, which utilized a large sample of middle-school students (Hinduja & Patchin, 2010), determined that youth who experienced cyberbullying, as either an offender or a victim, had significantly more suicidal thoughts and were more likely to attempt suicide than those who had not experienced bullying through an online setting.

Conversely, online resources may serve as a protective factor against suicide for some at-risk adolescents (Barak, 2007) as they offer many ways for socially isolated youth to find a peer group and to develop a sense of belonging to a like-minded community. These sites also are impacting and potentially enhancing our ability to reach adolescents who may be reluctant to seek more formal help. For example, Greidanus and Everall (2010) found that internet-based helping communities provided a peer-based support system for adolescents experiencing suicidal thoughts. These communities are able to offer feedback and support to others on an immediate basis; they are often active around the clock, and the help occurs in a relatively informal and anonymous context, a context that is particularly well-suited to the developmental needs of at-risk adolescents. In support of these contentions, Barak reported a confidential online environment has facilitated the rescue of a significant number of individuals who were threatening to commit suicide or were actually in the process of attempting suicide. Moreover, well-timed supportive conversations or referrals to appropriate help resources through online websites have often been shown to prevent impulsive death-promoting decisions by distressed people contemplating suicide (Barak).

Directing suicide interventions towards high-risk youth has worrisome aspects. One concern is there is a documented contagion factor related to adolescent suicide (Poijula, Wahlberg, &

Dyregrov, 2001). Talking about, glorifying, or highly publicizing an existing adolescent suicide may particularly increase the risk of copycat behaviors among high-risk youth (Range et al., 1997).

It is also possible exposure to some types of suicide prevention materials can inadvertently promote suicidality in at-risk adolescents and young adults. For example, some programs tend to downplay the link between suicide and mental illness (paradoxically suggesting the suicide is a mentally healthy response). Some programs exaggerate suicide rates to dramatize the degree of the problem (paradoxically implying that adolescent suicidal behavior is more common and normative than it is). Many programs show case examples, which are meant to depict familiar situations (paradoxically suggesting that suicidal behaviors can be normative coping responses). Clearly, rigorous research is needed to determine what elements are effective and which should be avoided in suicide interventions targeted toward male and female at-risk youth (Langhinrichsen-Rohling, Kilbert & Williams, 2011).

Furthermore, if the intervention is targeted toward adolescents who have already made a suicide attempt, an understanding of the community's standard of care for an adolescent suicide attempt is essential. For example, if formal attention is received, the majority of suicide cases are handled through hospital emergency departments. Care in these environments typically consists of being hospitalized, briefly treated by the psychiatrist on call, and then referred to providers in the community upon discharge (Daniel & Goldston, 2009). Consequently, suicide interventions with at-risk youth should be designed not only to reduce the prevalence of recurrent suicidal behavior, ideation, and attempts, but also to increase compliance with efficacious follow-up medical recommendations upon discharge from residential care (Daniel & Goldston).

It is also well-established that a substantial number of risk factors tend to co-occur among high-risk adolescents (Jessor, 1992). Similarly, adolescents at risk for suicide have been shown to have a variety of life stressors (Grover et al., 2009; Wilburn & Smith, 2005) and interpersonal problems (Beautrais, Joyce, & Mulder, 1997; Kerr & Capaldi, 2011). They tend to be more impulsive (Langhinrichsen-Rohling & Lamis, 2008), and have more diagnosable psychiatric disorders than low-risk adolescents. Most notably there is a high rate of affective disorders (Major Depressive Disorder, Bipolor Disorder) among suicidal adolescents (Jacobson, Marrocco, Kleinman, & Gould, 2011; Javdani, Sadeh, & Verona, 2011; Lewinsohn, Rohde, & Seeley, 1996). Taken together, these findings support the need for programs aimed at reducing a wide array of co-occurring risk factors while enhancing the use of generally effective social and emotional coping mechanisms for youth at risk for suicide. Effective programs may also need to provide adolescents with skills to cope with intense negative affect and/or experiences of emotional dysregulation.

In a series of publications generated from a longitudinal study of the suicidal behavior of depressed adolescents, Lewinsohn and colleagues employed a multiple risk factor model of suicidal behavior (Lewinsohn, Rohde, & Seeley, 1993; Lewinsohn, Rohde, & Seeley, 1994; Lewinsohn, Rohde, & Seeley, 1996; Lewinsohn, Rohde, Seeley, & Baldwin, 2001). This model is in keeping with the concept that an array of factors associated with suicide risk should be considered when developing suicide interventions for youth. It is also relevant to Bronfenbrenner's (1977; 1994) ecological model in that risk and protective factors are thought to occur at multiple levels of the microsystem (individual, school, and family) to the macrosystem (institutional patterns of culture including customs, economics, and bodies of knowledge). According to this model, in order to understand the development of the desire to end one's life, it is necessary to consider both characteristics of the individual as well as features of the entire ecological system in which the individual is operating.

Two important considerations can be derived from this model. First, reducing related risk factors (e.g., depressive symptoms, alcohol use and misuses) can be expected to have the ancillary benefit of reducing suicidal behavior in youth. Second, adolescents each have a unique constellation of factors operating in their unique ecological system. Some aspects of particular systems may require the development of a culture-specific intervention. In other cases, a culturally relevant adaptation of an already accepted program may be warranted. While we know the prevalence of suicidal behavior differs between genders, across age groups, and among cultures (Langhinrichsen-Rohling, Friend, & Powell, 2009), relatively little research has been conducted to determine what, if any, adaptations are needed for existing suicide interventions.

Kraemer and colleagues (1997) suggested the effectiveness of most suicide interventions will depend largely on how well each of these programs serves to mitigate the key risk factors for suicidal behavior. It is also essential that a wide variety of strategies be utilized to identify the whole range of at-risk individuals, as evidence suggests existing suicide prevention centers and traditional mental health resources will miss the majority of young people at high risk for suicide (Kisch, Leino, & Silverman, 2005). Unfortunately, the majority of current clinical suicide risk assessment methods focus on assessing suicide risk directly. Few clinicians are routinely using indirect suicide risk assessment methods or systematically measuring an array of risk factors that may be associated with a higher probability of suicidal behavior.

Nock and Banaji (2007a) noted that relying on overtly assessing suicidal intent is problematic because individuals who are experiencing suicidal thoughts often conceal or deny such thoughts in order to avoid unwanted formal interventions and/or potentially stigmatizing treatment. Thus, although research using direct methods has shown suicide ideation to be prevalent among adolescents, relying on youth to self-report their suicidal thoughts so they may be included in a formal suicide intervention may not best serve our need in identifying as many at-risk adolescents as possible.

In keeping with this goal, researchers have delineated a construct of suicide proneness (Lewinsohn et al., 1995; Lewinsohn, Langhinrichsen-Rohling, Rohde, & Langford, 2004) that is defined to include both overtly suicidal behaviors and less overtly death-promoting behaviors that have known associations with suicidality. According to Lewinsohn and colleagues' theory, suicide proneness consists of a single domain to which all varieties of potentially life-threatening and life-extending behaviors belong. Life-threatening and life-extending behaviors were broadly defined to include thoughts, feelings, and actions by these colleagues. Therefore, the high-risk suicide prone individual is one who is both engaging in life-threatening thoughts, feelings, and actions as well as failing to engage in various types of life-extending behaviors. Measuring both aspects broadly should facilitate our ability to detect high-risk adolescents.

At the theoretical level, Lewinsohn et al. (1995) also asserted that suicide proneness is comprised of four disparate suicide-related domains: death and overtly suicide behaviors; illness and health behaviors; risk and injury behaviors; and self-denigrating or self-enhancing behaviors. Recognizing the interrelationships among these four suicide-related domains was expected to facilitate the process of identifying individuals engaging in life-threatening behavior that may be less overtly suicidal and thus, missed by other suicide-focused assessment strategies. Lewinsohn and colleagues then constructed an instrument to measure the overall construct of suicide proneness. This measure, the Life Attitudes Schedule (LAS), subsequently evolved to include the Life Attitudes Schedule-Short Form (LAS-SF). Use of either of these measures has shown to be effective in

identifying youths at-risk for suicide (Langhinrichsen-Rohling & Lamis, 2008; Langhinrichsen-Rohling, Sanders, Crane, & Monson, 1998). Consequently, it should be considered as an additional screening measure for youth suicide prevention programs.

Another group of researchers have also considered using less overt or direct methods to identify youth at-risk for suicide. Specifically, a variation of the computer administered Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998) has been developed to assess suicidal behavior through the measurement of implicit cognitions (Nock & Banaji, 2007b). To date, the studies which have used this task to assess suicidal intentions indirectly have been shown to add incremental validity to the suicide risk assessment process (Nock & Banaji, 2007a; 2007b; Nock et al., 2010). Although this type of assessment requires more resources for administration, it also should be considered as an addition to a traditional screening protocol for suicide among youth.

A recent model of how suicide develops has generated considerable recent research and clinical interest; this model also has important implications for suicide risk assessment and suicide intervention efforts with youth. The model is called The Interpersonal-Psychological model of suicide (Joiner, 2005). It was developed to increase the precision with which suicidal behavior could be predicted. This model consists of three proximal, causal, and interactive factors (Van Orden et al., 2010). According to Joiner's theory, two of these factors work in concert to increase a person's desire to commit suicide. The first factor is thwarted belongingness, which is experienced through intense feelings of loneliness and social isolation. Joiner theorized that the need to belong is fundamental. When this need is satisfied, it operates as a protective factor but, when unmet, it becomes a significant risk factor for suicidal behavior. Joiner's belongingness construct is similar to what Heisel, Flett, & Hewitt, (2003) has labeled as social hopelessness. Social hopelessness has been characterized as the anticipation that one will never "fit in" and that the need to belong will be left unsatisfied indefinitely. Thwarted belongingness or social hopelessness is thought to occur when one feels alienated from others or when a person is displaced outside of one's desired social support network.

Joiner's second factor is perceived burdensomeness. Individuals who perceive themselves to be a burden on others, particularly family members and loved ones, have been shown to be more likely to think about killing themselves (Van Orden, Witte, Gordon, Bender, & Joiner, 2008). These individuals are also more likely to possess misinterpretations about their ability to be effective in group activities. Specifically, they believe their feelings of ineffectiveness are stable and permanent and are impinging upon other people's ability to accomplish goals and tasks (i.e., they believe that their loved ones would be better off without them). Theoretically, according to Joiner's Interpersonal-Psychological model, when both thwarted belongingness and perceived burdensomeness are activated, it is expected the individual will have a strong desire to kill himself or herself. This desire might manifest in youth engagement in suicidal gestures and behaviors.

Joiner's Interpersonal-Psychological model of suicide contains a third factor that is hypothesized to explain how an individual might progress from a desire to die (suicide ideation) to actually engaging in a suicide attempt or completing the act of suicide. According to Joiner's model, suicidal behaviors and actions will only occur in individuals who have acquired the capability to suppress their physiological self-preservation mechanisms. Self-preservation instincts help individuals avoid painful experiences and self-harm whenever possible. According to the model, in order to attempt or complete suicide, an individual has to have an acquired capability for the self-destructive behavior (i.e., an increased tolerance of pain in conjunction with a reduced fear of death). While

habitual self-mutilation or intentional self-injury are proposed ways to learn to suppress self-preservation instincts, Joiner also noted that accidental injuries, illness, violent victimization, child abuse and/or repeated engagement in risky or dare-devil behaviors would also be effective ways to reduce fear of death and increase one's tolerance of self-inflicted pain. As predicted by the model, painful and provocative experiences have been shown to predict adolescents' levels of acquired capability for self-harm (Witte et al., 2008). Thus, this model has already received a considerable amount of research support; however, it has yet to be directly translated into an efficacious intervention for youth. None-the-less, measuring these constructs in youth (thwarted belongingness, perceived burdensomeness, and acquired capability) are also likely to aid the suicide risk assessment process. These constructs may also serve as markers of success in an efficacious intervention.

Existing Interventions

There have been two very recent and comprehensive review papers that focused on evaluating suicidal interventions for young people (Daniel & Goldston, 2009; Robinson, Hetrick, & Martin, 2010). Both reviewers concluded there is limited evidence about the effectiveness of existing interventions and there is not enough data from controlled trials to recommend one intervention over another. However, each systematically searched the literature for effectiveness trials that contained outcome data (Daniel & Goldstein, 2009; Robinson et al., 2010) and both compiled tables of existing suicide interventions. Thus, each made an important contribution to the literature.

Another recent review (2009) by Miller, Eckert, and Mazza focused only on suicide prevention programs (n = 13) that were implemented in schools. Consistent with the other reviews, these authors lamented the absence of measures of program implementation integrity, component analysis, and longitudinal data about program replicability. However, Miller et al. did identify two programs that may be particularly efficacious. One was a universal program that focused on psychological education about suicide, while including distress and coping skills (Klingman & Hochdorf, 1993). The other was a 30-week program (3 session per week) that combined suicide awareness with a focus on addressing and diminishing related risk-taking behaviors (LaFromboise & Howard-Pitney, 1995).

Another systematic review, utilizing the *Guide to Community Preventive Services* was recently conducted by York and colleagues (in press). This later review focused exclusively on universal suicide prevention programs (strategies directed toward the population as a whole) of which 16 were identified. The approaches included in this review included behavioral change interventions, health and education system level interventions, and environmental interventions. No studies evaluating legislation or public policy interventions were identified for inclusion; however, many have suggested that restricting youth access to firearms shows promise as a prevention approach (e.g., Eddy, Wolpert, & Rosenberg, 1987).

Several conclusions were derived from the York and colleagues (in press) review. First, student curriculum, competence based programs, and student curriculum in conjunction with gatekeeper training, have been demonstrated to increase students' knowledge of suicide and to positively impact their suicide-related attitudes and risk factors (e.g., hopelessness). Unfortunately, however, there is little evidence that these universal programs serve to decrease youth engagement in suicidal behavior (York et al., in press).

In addition, in 2003, Gould, Greenberg, Velting, and Shaffer published a critical review of the previous ten years of youth suicide risk and prevention interventions. They focused on the three domains in which youth suicide programs are implemented: school, community, and health-care systems. School programs vary in nature and include: adding awareness curriculum; offering skills training, introducing a screening protocol, giving school based personnel gatekeeper training, developing peer mentors, and providing more accessible crisis/postvention services within the school environment. Community services range from crisis centers and hotlines, to media education and guideline development about the nature and extent of the publicity that should be accorded to a youth suicide. Within the health-services domain, efforts have focused on increasing provider education, facilitating service utilization and access to psychotherapy and medication, training staff in suicide crisis management, and encouraging compliance with inpatient care and outpatient follow-up treatment. Across these domains, Gould et al. (2003) concluded that school based skills-training, physician and media education, and restriction of access to firearms, in conjunction with enhanced access to and utilization of psychopharmacological and psychological interventions for individuals screened to be at-risk, all show promise and warrant continued investigation.

Therefore, to take a different approach from the existing reviews, in the current review, we will limit our focus to existing interventions that can be categorized into one of three categories: interventions dedicated to primarily improving the well-being of the already suicidal youth, interventions dedicated to helping the suicidal youth and their family, and interventions primarily dedicated to improving the family functioning as a whole in the wake of suicidal activity by the youth. These programs can all be considered interventions rather than general suicide prevention programs. When there has been research to determine the effectiveness of each of these programs, most of these existing youth suicide interventions have been compared to standard emergency department care (routine care or treatment as usual); as a wait-list or no treatment condition for suicidal youth would be unethical.

Youth Focused Suicide Interventions

When discussing interventions wherein the primary intended effect is improving the well-being of the suicidal youth, a number of interventions have been utilized including: the rapid response intervention (Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002), the supportive and educational intervention (Deykin, Hsieh, Joshi, & McNamara, 1986), the social support intervention (King et al., 2006), the skills based (cognitive-behavioral) intervention (Donaldson, Spirito, & Esposito-Smythers, 2005), the developmental group therapy intervention (Wood, Trainor, Rothwell, Moore, & Harrington, 2001), the service utilization "green card" intervention (Cotgrove, Zirinsky, Black, & Weston, 1995), the psychopharmacological intervention (Brent et al., 2009), the interpersonal problem solving intervention (McLeavey, Daly, Ludgate, & Murray, 1994), the LifeSPAN therapy intervention (Power et al., 2003), and variants of cognitive-behavioral therapy (CBT) (Slee, Garnefski, van der Leeden, Arensman, & Spinhoven, 2008). Even though each one of these interventions embraces the same goal of suicide prevention in high-risk youth and most primarily focus on intervening directly with the suicidal youth; each has at least one important difference in how the intervention approach is manifested. These differences will be highlighted in the descriptions below.

Specifically, the rapid response intervention (Greenfield et al., 2002) helps facilitate post-emergency department care by contacting families and arranging after-care services to begin

immediately following the emergency department visit. This strategy differs from standard emergency department care or treatment as usual in which there can be long waits for after-care service provisions to begin and often access to these services must be initiated by the suicidal youth and his or her family.

The supportive and educational intervention (Deykin et al., 1986) uses community outreach social workers to provide support and advocacy to the suicidal adolescent. This pragmatic type of intervention is administered rather than providing more feeling focused therapy. This intervention also offers education to potentially suicidal youth who are located within the school or health service systems.

In the social support intervention (King et al., 2006), suicidal youths are assigned to a Youth-Nominated Support Team (YST) on which they can independently choose who they desire as their support persons. During this intervention, weekly contact between the YST and the suicidal youth is encouraged. Special training is provided to the members of the YST in order to enhance their effectiveness. The purpose of this intervention is to decrease suicidal youth's feelings of loneliness or thwarted belongingness.

The skills based intervention (Donaldson et al., 2005) emphasizes enhancing the youth's ability to problem solve and manage their affect appropriately. This intervention is predicated on the notion that the youth feels powerless to influence others in socially acceptable ways (Berman & Jobes, 1991). In this intervention, parents can provide collateral information to the help providers when it is deemed necessary. Other interventions that focus on improving interpersonal problem solving skills exist (McLeavey et al., 1994; Rudd, et al., 1996); some of these interventions are conducted in a group format (Hazell, et al., 2009). Others focus on problem-solving around barriers to post-discharge treatment compliance (Spirito, Boergers, Donaldson, Bishop, & Lewander, 2002).

Moreover, several therapists have adapted cognitive-behavioral therapy to meet the needs of suicidal adolescents. One of the most well-known adaptations was constructed by Rudd, Joiner, and Rajab (2001). These authors have created a treatment manual for their time-limited approach that is described in their book, "Treating suicidal behavior: An effective, time-limited approach." Slee and colleagues (2008) utilized a similar approach by providing 12-sessions of cognitive behavioral therapy for individuals who had engaged in deliberate self-harm.

The developmental group therapy intervention for suicidal youth (Wood et al., 2001) consists of an initial assessment and six acute group sessions. Each of these sessions focuses on one of the six main themes that are deemed relevant to the suicidal adolescent. After this, the adolescent remains in a more general long-term therapy group until the youth feels ready to terminate the help.

As a component of the service utilization intervention (Cotgrove et al., 1995), adolescents are presented with a green card or token. This token allows each adolescent to gain re-admission to the hospital as needed. Youths in this intervention also receive routine care. It is thought that possession of the token will provide the youth with a general mental safety net, as well as access to a physical oasis should they need additional safety as they work through their suicidal crisis.

Some individually focused suicide interventions (Brent et al., 2009) are psychopharmacological in approach. They tend to consist of treating youth with medications such as selective serotonin reuptake inhibitors (SSRIs) in order to alleviate the underlying depression or the presumed

neurochemical imbalance. These interventions are often used in conjunction with individual psycho-therapy.

In contrast, the LifeSPAN suicide intervention (Power et al., 2003) was developed for adolescents with severe mental illness. This intervention consists of individual sessions that directly focus on cognitive-oriented therapy and suicide prevention as manifested in an individual who is suffering with a severe mental disorder. Lastly, many existing youth-focused suicide interventions use variants of cognitive behavior therapy combined with treatment as usual in order to prevent subsequent suicidal behavior (Slee et al., 2008).

Family Inclusive Suicide Interventions

Interventions dedicated to simultaneously helping the suicidal youth and their families have also been developed and implemented. These programs are thought to be beneficial as an adolescent suicide attempt typically has a widespread impact on the youth's family (Daniel & Goldston, 2009). Family factors that are related to youth suicide include frequent and unresolved parental conflict, the presence of childhood abuse or neglect, and the occurrence of unmet or unrealistic expectations (Langhinrichsen-Rohling, Monson, Meyer, Caster, & Sanders, 1998).

There are several existing family based interventions for youth suicide which deserve comment. For example, there is the motivational educational emergency room intervention (Rotheram-Borus et al., 1996, 2000), which begins with requiring the family to view a videotaped presentation which describes the dangers of youth suicidal behavior and benefits of treatment for the adolescent and the family. This treatment also includes one crisis family therapy session. The youth simultaneously receives brief individual cognitive-behavioral therapy. As part of this intervention, all emergency department staff are also provided with education about youth suicidal behavior. In contrast, Harrington and colleagues (1998) offer a brief 5-session home-based family intervention that occurs once the adolescent is discharged from inpatient treatment. Donaldson and colleagues (2005) tested a 6-month intervention that combined individual and family sessions and included both an active phase of treatment (over the first three months) and a maintenance phase of treatment (over the last three months).

Recently, several groups have begun utilizing family-inclusive adaptations of dialectical behavior therapy (DBT) to treat suicidal youth (Katz, Cox, Gunasekara, & Miller, 2004; Rathus & Miller, 2002, Turner, 2000). These adaptations have worked to increase their relevance to adolescents by reducing the length of therapy and by simplifying the skills training components of traditional DBT. In the modified DBT, the parents are involved in the skills training group. They are then encouraged to serve as coaches for their adolescent. The family members are also involved in the individual therapy sessions. A recent treatment outcome study of suicide-related DBT compared with treatment as usual (n = 62 adolescents) revealed that while both treatments reduced youth parasuicidal behavior, depressive symptoms and one year incidence of suicide ideation, DBT also resulted in a significant reduction of behavior incidents during admission (Katz et al., 2004).

Even more recently, Diamond and colleagues (2010) reported on an attachment-based family therapy intervention for suicidal youth (Diamond et al., 2010). This intervention combines behavioral, cognitive, and psycho-educational therapy. The treatment consists of five tasks for the family to complete. These tasks are: a relational reframe task, the adolescent alliance task, the parent alliance task, the reattachment task, and the competency task. It is thought that the family

will increase their sense of connectedness and improve their ability to communicate effectively through completion of these tasks.

Family Focused Suicide Interventions for Youth

The third set of youth suicidal interventions are predicated on the assumption that any youth who is engaging in suicidal behavior has experienced a family environment which is in some way dysfunctional. Consequently, these interventions target the family's functioning as the way to reduce the suicide risk to the adolescent. One of these interventions is the in-home family program and another is called multi-systemic family therapy (MST) (Harrington et al., 1998; Huey et al., 2004). The in-home family intervention sessions focus on improving family problem solving and communication while simultaneously exploring how the adolescent's developmental issues may be affecting the family. In contrast, the MST intervention was designed for families that contain a youth who has identified behavioral and emotional problems. This intervention works to improve parenting abilities while enhancing the families' ability to communicate with their problematic youth. The program also encourages social activity among youth involved in the program. Other general family-focused interventions may also be effective with suicidal adolescents and their families (The Strengthening Families Program, Kumpfer, 2004).

Taken as a whole, the existing interventions for youth seem to recognize the need to enhance the suicidal adolescent's sense of belonging by increasing social skills and through involvement in group therapy. In many of the programs, there is also a recognition that facilitating the relationships between the youth and his or her family is likely to reduce suicidality. Strategies to help families include enhancing communication skills, facilitating family problem solving, and encouraging the completion of shared family-oriented tasks that promote alliance building and perceived support among family members.

Evidence for the Effectiveness of Suicide Interventions

The empirical literature validating the effectiveness of particular suicide interventions is relatively sparse; clearly, this is an area that needs continued attention in spite of the difficulties inherent in studying programs directed toward youth who are potentially suicidal (Daniel & Goldston, 2009). In fact, in 2009, Daniel and Goldston's review concluded that "despite public health concern, there are insufficient data available from controlled trials to recommend one intervention over another for the treatment of suicidal youths" and "to date, however, it appears that interventions for suicidal youth have been, in general, more successful at affecting aspects of service utilization and delivery than in reducing rates of suicide attempts per se" (Daniel & Goldston, 2009, p. 259).

Gender, At-risk Populations, and Youth Suicidal Behavior

Even less is known about the degree to which existing suicide interventions may be differentially effective for male versus female adolescents or for youth who are embedded in an at-risk population or culture (Langhinrichsen-Rohling et al., 2009). However, we do know that the prevalence and expression of various types of suicidal behaviors are impacted by gender, age, race, sexual orientation, and culture. It stands to follow existing interventions may need to be modified to be well-suited for delivery in particular contexts and with particular subgroups of individuals (Langhinrichsen-Rohling, O'Brien, Klibert, Arata, & Bowers, 2006).

For example, a gender paradox has been demonstrated such that women are more likely than men to express suicide ideation and make non-fatal suicide attempts, whereas men complete suicide at higher rates than women (Canetto & Sakinofsky, 1998). In keeping with this paradox, a recent review of 128 studies of 513,188 adolescents indicated that girls engage in suicide ideation, plans and attempts at higher rates than do boys (Evans, Hawton, Rodham, & Deeks, 2005). At the same time, however, within the United States, male adolescents have been shown to complete suicide at higher rates than female adolescents (American Association of Suicidology [AAS], 2010) and the rate at which male youth commit suicide increases from ages 11 to 21 (Conner & Goldston, 2007).

In addition, two important risk factors for suicide are known to have gender-specific components to their prevalence and expression. The first is depressive symptomology, which tends to be more frequently reported by girls (Blair-West & Mellsop, 2001; Lamis et al., 2010). The second is alcohol and substance use (see Bagge & Sher, 2008 for a review) which tends to be more frequently reported by boys. Across these two risk factors, cross-gender behavior may signal greater risk. For example, depression is more commonly diagnosed in women than in men. However, the risk of suicide may be as much as ten times higher for men with depression than women with depression (Blair-West & Mellsop, 2001). Similarly, although mood variability is more common for college women than men, emotional dysregulation or variability was a better predictor of the suicide attempts of college men than of college women (Witte, Fitzpatrick, Joiner, & Schmidt, 2005).

Conversely, boys have been shown to have higher rates of conduct disorder and to engage in more frequent acts of delinquency than girls. However, higher levels of delinquency were more associated with suicide proneness for female than male college students (Langhinrichsen-Rohling et al., 2004). Likewise, recent alcohol consumption was a unique predictor of suicide ideation for college women but not for men (Stephenson, Pena-Shaff, & Quirk, 2006), even though alcohol abuse disorders are more common among men than women (Canetto, 1991).

Identifying with a sexual orientation other than heterosexual may also be associated with additional suicide risk. Researchers have consistently demonstrated that adolescents experiencing same-sex sexual attractions or endorsing a lesbian, gay, or bisexual (LGB) sexual orientation report more suicidal ideation and higher rates of suicide attempts than exclusively heterosexual adolescents (e.g., Haas et al., 2011; Kitts, 2005; Langhinrichsen-Rohling, Lamis, & Malone, 2011; Russell, 2003). Specifically, a review of the relevant research studies concludes LGB youth are one and a half to three times more likely to report suicidal ideation and one and a half to seven times more likely to have attempted suicide than non-LGB youth (Suicide Prevention Resource Center, 2008). Likewise, a 2003 meta-analysis concluded that sexual minority youth and young adults are two to four times more likely to make a suicide attempt than are their non-sexual minority peers (Burckell & Goldfried, 2003). A second even more recent meta-analysis focusing on population based studies reported a two fold increase in suicide attempts in gay, lesbian, and bisexual individuals (King et al., 2008). Suicide interventions directed toward these at-risk factors may need to be tailored to address the particular concerns and challenges faced by LGB youth, including increased incidents of discrimination and harassment, and greater likelihood of experiencing thwarted belongingness.

Ethnicity has also been related to suicide risk. For example, Native American adolescents form another specific high-risk group while both Asian Americans and African Americans tend to exhibit lower rates of suicide compared Caucasian adolescents (Langhinrichsen-Rohling et al., 2009). Subgroup differences within ethnic groups may also influence the risk of suicidal behavior. For

example, although African Americans have a low overall risk of suicide, the gender disparity in their rates is high (African American males are disproportionately at risk). Conversely, although Native Americans have a high overall risk of suicide, the gender disparity between rates is very low (e.g., Native American females are disproportionally at risk, Langhinrichsen-Rohling et al., 2009). These subgroup differences in suicide rates and risk factors have highlighted the need for researchers to develop, adapt, and evaluate existing suicide intervention programs so they can be appropriately targeted toward particular high-risk groups (Arria et al., 2009).

In conclusion, additional work is needed in order to develop and test evidence-based interventions to intervene with suicidal adolescents of both genders who are embedded in a variety of types of romantic relationships, who come from different family structures and who have experienced different cultural contexts. It is likely that inventions that impact multiple risk factors, and that are gender-specific, multi-contextual, and developmentally appropriate, will be the most successful. In the review by Robinson and colleagues (2010), it is clear that research on the effectiveness of interventions is ongoing as a number of current studies have been registered with the clinical trials registry. These include testing SAFETY (Arsanow, 2011), mindfulness based cognitive therapy (Klerk, 2011) and an integrated suicide and substance use intervention (Esposito-Smythers, 2011) among others.

As of now, promising suicide interventions are including strategies to help youth tolerate intense negative affect and maintain emotional regulation. Individual psychotherapy for suicide prone youth is typically being conducted in conjunction with pharmacological treatments; advances in anti-depressant medication that can be used with adolescents is ongoing. Other noteworthy suicide interventions have highlighted the need to address the family dynamics surrounding suicidal youth, often by including the family in treatment. Interventions that increase the adolescent's motivation for treatment and likelihood of treatment compliance are also under current investigation. Modes of delivery for suicide interventions may also be changing with the inclusion of technology in service access and provision. Advances in the nature of suicide interventions, their adaptability to particular subgroups of youth, and their mode of delivery are likely to be emerging. It is expected that these innovations will improve our ability to prevent suicide in youth.

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Best Practice Clinical Interventions for Working with Suicidal Adults

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Abstract

Drawing from existing empirical literature, this article examines best practices for working with adults who are in suicidal crisis. An explanation of suicidal thinking and how to assess for suicidality is provided, and specific clinical interventions and techniques that have been empirically evidenced as useful with this population are highlighted. Based on the premise that understanding the suicidal mind leads to more effective intervention, a consideration of psychache as the basis for behavior in suicidal clients is discussed. Finally, dialectical behavioral therapy, problem solving therapy, and cognitive therapy are examined as mechanisms for addressing the needs of suicidal clients, with a consideration of specific counseling techniques available and effective within those contexts.

Working with suicidal clients is challenging. Given that more suicidal clients at moderate and high levels of risk are being treated in outpatient facilities, often by overworked or undertrained counselors, it becomes critical for persons treating such clients to be familiar with the latest empirical developments in this area. Counselors often report struggling to understand suicide, to assess suicidality in their clients, and to properly classify suicide risk level. Further, utilizing empirically-evidenced interventions represents the present standard of care in this area but are commonly misunderstood and underused.

Understanding the Suicidal Mind

Suicide as Psychache

According to Shneidman (1993), people die by suicide because they have an overwhelming psychological pain that drives their need to end what he coined "psychache" (p.51). This psychological pain, pressured by fear, shame, anxiety, rejection, threat, guilt, unhappiness, and other negative emotions facilitates a pain in the mind. It is described as so debilitating that the person experiencing it wants only to have the psychache end, which makes suicide a viable option. While it is acknowledged not all people die by suicide because they experience psychache, this phenomenon is an explanation for many suicides (Shneidman, 1996). Leading suicidologists agree this storm of the mind includes many elements (e.g., biological, interpersonal). Yet, at its root is the essential element of psychological chaos that drives the suicidal drama leading to a decision of

death by suicide (Joiner, 2005; Joiner, Van Orden, Witte & Rudd, 2009; Peterson, Luoma, & Dunne, 2002; Shneidman, 1996, 2004).

Commonalities of psychache and suicide exist and include seeking escape as a solution and an end to an unbearable psychological pain. The desire to escape stems from frustrated needs and a sense of hopelessness and helplessness, which lead to constricted thinking, in spite of any previous ambivalence toward death (Shneidman, 1993). The profound psychache drives a suicidal person to experience an inability to effectively problem-solve, seek alternate solutions, or imagine a future. It also includes difficulty with eating, sleeping, working, and soliciting help from others, as well as feeling unable to live with the burden they perceive themselves as carrying (American Association of Suicidology, 2011). Early on, psychache was described as a drama of the mind that stems from a variety of thwarted or distorted psychological needs (Shneidman, 1996). More recently, Joiner (2005) proposed *The Interpersonal Theory of Suicide,* which provides greater specificity regarding causes of psychache that are most likely to result in suicidality. According to Joiner's theory, the pain that results from feeling as though one's death is worth more than one's life (i.e., perceived burdensomeness) and feeling disconnected from others (i.e., thwarted belongingness) are key causal factors for suicidal desire. Further, Joiner explains if a person acquires a sense of fearlessness toward death and tolerance of physical pain, he or she may become more capable of suicide. It is where burdensomeness, thwarted belongingness, and acquired capacity intersect in which the suicidal mind erupts and can lead to a fatal outcome.

Traditionally, people feel uncomfortable discussing suicide because killing oneself goes against societal expectations and Western norms (Suicide Prevention Resource Center, 2008). However, for a counselor, understanding the suicidal mind and suicidal thinking is critical to the process of helping a suicidal person. In any treatment of suicidality, addressing psychache is fundamental to treatment. Addressing psychache necessarily includes identification, understanding, and mitigation. This approach represents the core of effective work with suicidal clients, and begins with the assessment process (Granello &Granello, 2007; Shneidman, 2005).

Assessment of Suicide Risk: Best Practice

Barriers to Conducting Appropriate Suicide Risk Assessment

In a survey of 376 professional counselors, nearly one-quarter reported one of their clients had died by suicide (McAdams & Foster, 2000). The likelihood of encountering a client experiencing suicidal ideation is even higher. Essentially all clinical psychologists report they encountered at least one client who was suicidal during graduate school (Dexter-Mazza, & Freeman, 2003), and this likelihood is probably comparable to a counselor encountering a suicidal client at some point in his or her career.

Despite the high likelihood of counselors working with suicidal individuals, it is not clear that all counselors routinely assess for suicide with all clients. Although no studies were identified regarding the frequency of suicide risk assessment among counselors specifically, Simon (2002) reported it is extraordinarily difficult to ensure that psychiatrists routinely perform suicide risk assessments, and it seems reasonable to assume there is a similar level of noncompliance among others who are charged with mental health care (e.g., counselors, clinical psychologists).

Given the importance of preventing suicide among clients, why is it that relatively few counselors and other mental health professionals routinely assess suicide risk? Lang, Uttaro, Caine, Carpinello, and Felton (2009) conducted a feasibility study for a suicide screening process in an outpatient mental health facility that may shed light on this matter. The authors found the most common reasons for this failure to assess suicide risk included concerns that the discussion of suicide with vulnerable clients could make the idea of suicide seem more appealing and therefore increase danger and/or that routine screening could increase risk for legal liability on the part of counselors.

Regarding the former of these concerns, there is fairly compelling evidence across multiple research studies that the act of suicide risk assessment does not appear to elevate risk even among vulnerable populations (Reynolds, Lindenboim, Comtois, & Linehan, 2006). Regarding the latter, failing to assess for suicide risk, take action given that risk, and/or document the counselor's actions can actually increase liability. It is important to keep in mind counselors are not expected to predict who will attempt or die by suicide with 100% accuracy. This would be impossible, given the extremely low base-rate of suicide even within clinical populations. Rather, the expectation is that counselors take steps to meet the standard of care in their profession, which would typically involve performing systematic risk assessment and implementing a treatment plan based upon this assessment (Simon, 2002).

What Not to Do: Widespread but Insufficient Practices

A competent suicide risk assessment must be comprehensive in nature. Although self-report suicide risk assessment checklists are commonly found in clinical settings (Simon, 2009), these checklists have not usually been subjected to rigorous psychometric validation that provides evidence they have any utility in predicting suicide risk. As such, they do not necessarily protect mental health providers in suicide malpractice cases when they are not combined with a comprehensive clinical suicide risk assessment (Simon). Even more importantly, with a lack of psychometric data providing evidence for their utility, these forms do not necessarily ensure the physical safety of clients. This does not necessarily indicate that such checklists have no place in counseling settings; rather, they can only be considered one tool in the counselor's toolbox. It is necessary to also conduct a more comprehensive and integrative clinical assessment with each client that is encountered; simply documenting that a client completed a suicide risk assessment checklist is not sufficient to meet the standard of care.

Along similar lines, it is also fairly common for clinical settings to routinely utilize no-suicide contracts (Miller, Jacobs, & Gutheil, 1998), which require a client to agree he or she will not engage in suicidal behavior. Simon (1992) noted counselors might mistakenly believe that they have met the standard of care with a no-suicide contract and therefore engage in insufficient suicide risk management procedures otherwise. To date, there is no evidence that no-suicide contracts actually prevent suicidal behavior (Joiner, Van Orden, Witte, & Rudd, 2009), and there are documented instances where individuals who had signed a no-suicide contract have died by suicide (Kroll, 2000). Additionally, there has been no legal precedent in which a no-suicide contract has protected clinicians in liability (Simon). In sum, documenting that a client has signed a no-suicide contract without further detail regarding a comprehensive suicide risk assessment and other actions taken is not adequate to protect clients from self-harm or to protect oneself from liability (Miller et al., 1998).

What to Do: Evidence-based Suicide Risk Assessment

There are several available evidence-based risk assessment frameworks that have been published in the last decade, and a comprehensive review of all of these is beyond the scope of the current article. For a fairly detailed exposition of several different frameworks, we encourage interested readers to consult Chapter 2 of Joiner et al. (2009). Provided is an abbreviated discussion of just one assessment framework, the Suicide Risk Assessment Decision Tree (Joiner, Walker, Rudd, & Jobes, 1999) that is both evidence-based and has been demonstrated to be feasible, even with novice graduate student clinicians (Cukrowicz, Wingate, Driscoll, & Joiner, 2004). Interested readers are encouraged to consult Cukrowicz et al. (2004), Joiner et al. (2009) or Joiner et al. (1999) for more detail on this particular risk assessment tool.

The Suicide Risk Decision tree involves assessing three "core" indicators of suicide risk (i.e., past suicidal behavior, current suicidal desire/ideation, and current resolved plans and preparations, all of which will be discussed in more detail below) as well as some additional risk and protective factors. The interview outlined in Figure 1 should be conducted in full during the first session with a client. In subsequent sessions, this can be abbreviated as appropriate, as it is not necessary to assess for long-standing risk factors at every session (e.g., family history of suicide). This interview is semi-structured in nature and was not created for use by individuals without appropriate clinical training to assess for suicide risk. In this way, it differs from the more formulaic suicide risk checklists discussed above that are not integrative in nature. It is designed to assess for the most notable risk factors for suicide that have been borne out by the literature, although it is not intended to be exhaustive. Counselors are encouraged to use their clinical judgment when conducting suicide risk assessments and to include other risk and protective factors as warranted.

The risk assessment framework begins with assessing for past suicidal behavior, which has been identified as the most potent predictor of subsequent suicidal ideation (Rudd, Joiner, & Rajab, 1996), suicide attempts (Putnins, 2005), and death by suicide (Brown, Beck, Steer, & Grisham, 2000). In particular, these studies demonstrate that a history of more than one suicide attempt is substantially more predictive of future suicidal behavior than a history of one suicide attempt. Thus, a multiple suicide attempter would be assigned to a higher risk category than a non- or single-attempter, all other risk factors being equal. This is followed by assessing the nature of any current thoughts of suicide. Thoughts that fall into the category *Suicidal Desire and Ideation* (i.e., relatively vague thoughts about wanting to be dead) have been demonstrated to have a weaker association with suicidal behavior than thoughts that fall into the category *Resolved Plans and Preparations* (i.e., more specific thoughts about and planning for a suicide attempt; Holden, & DeLisle, 2005; Joiner, Rudd, & Rajab, 1997; Pettit, Garza, Grover, Schatte, Morgan, Harper, & Sanders, 2009). Therefore, a counselor should be more concerned about a client expressing Resolved Plans and Preparations for suicide than a client expressing only Suicidal Desire and Ideation, with all other risk factors being equal. Next, the counselor should assess for other significant findings (e.g., precipitant stressors, such as a recent divorce) and protective factors (e.g., strong social support). Positive endorsement of additional significant findings would result in possibly increasing the risk designation of the client (e.g., from *low* to *moderate*). In contrast, clients who endorse many important protective factors might be placed in a lower risk category than they would be otherwise, although it is prudent to err on the side of caution when making the decision to adjust a risk category downward based upon protective factors (Joiner et al., 1999).

Subsequently, the information gleaned from the clinical interview found in Figure 1 is utilized to categorize the suicide risk of an individual into *low*, *moderate,* and *high* risk, using the flow chart from Figure 2. This flow chart provides a method for weighting risk factors that are believed to be more pernicious than others (e.g., a history of multiple suicide attempts is weighted more heavily than a family history of suicide). These risk categories help the clinician identify the most appropriate actions to take (Figure 3).

The Suicide Risk Assessment Decision tree provides a fairly straightforward method to assess suicide risk and clinical interventions taken to mitigate that risk, yet it also allows for some degree of flexibility on the part of the counselor. Further, the use of a systematic, research-based assessment tool greatly simplifies the documentation process for a risk assessment. A counselor using the Suicide Risk Assessment Decision tree can include a variant of the following in his or her progress notes: "The client was assessed for suicide risk according to the Joiner et al., (1999) Suicide Risk Assessment Decision tree. Risk category = low (*provide details regarding the basis for this; for example, no current suicidal desire and ideation and no history of attempts*). Actions taken: created a coping card with the client that included the following recommendations if the client experiences increased suicidality/distress [*list everything from the coping card*]. The counselor will continue to monitor risk in subsequent sessions and adjust interventions accordingly." In this way, the counselor is meeting the standard of care by conducting a comprehensive risk assessment that includes distal and proximal risk factors, selecting interventions based upon that level of risk, and documenting all of this in the client's file.

Interventions for Suicidality in Clients

Several outpatient psychotherapies have been shown to be effective in the treatment of suicidality, including dialectical behavior therapy (DBT; Linehan, Comtois, Murray, et al., 2006), problem solving therapy (PST; Rudd, Rajab, et al., 1996), and cognitive therapy (CT; Brown et al., 2005). It is noteworthy that most studies have only addressed non-fatal suicidal behavior as outcome variables, and to date only one has demonstrated an effective intervention for reducing death by suicide (Motto & Bostrom, 2001). In terms of death by suicide, the most effective intervention appears to be a restriction in access to lethal means (Hawton et al., 2001).

Dialectical Behavior Therapy (DBT)

DBT is a type of cognitive behavior therapy that facilitates change through assisting the client in achieving a life worth living, even in the face of intense emotions (Linehan, 1991). DBT includes four components: mindfulness, distress tolerance, interpersonal effectiveness, and emotional regulation. DBT is delivered in four necessary integrated modalities: individual psychotherapy, group skills training, team consultation, and between-sessions phone calls. It has been found to reduce suicide attempts among clients with recent suicide attempts, individuals with self-harm behaviors, and clients with borderline personality disorder (Linehan, Comtois, Murray, et al., 2006).

Of the types of outpatient psychotherapy discussed in this article, only DBT has been replicated in randomized controlled trials by independent research groups, and is thus the only outpatient therapy recognized as an "efficacious" treatment for suicidality based on the criteria outlined by Chambless and Hollon (1998, p.9). Initial research indicates that DBT may also hold promise for suicidal adolescents with borderline personality features and for older adults (Lynch, Morse, Mendelson, & Robbins, 2003).

The possible mechanisms by which DBT is effective in reducing suicidality have been reviewed (Lynch, Chapman, & Rosenthal, 2006) and can be separated into interventions common to all behavioral therapies and interventions unique to DBT (see Table 1). As it pertains to suicidality, several specific DBT interventions may be particularly effectual: 1) *Behavior Chain Analysis*. As part of the DBT treatment package, clients are taught to dissect their behaviors, identifying urges, thoughts, situations that contributed to the behavior. A solution analysis is then conducted to develop an alternative solution to the problem behavior; 2) *Between Sessions Phone Calls*. Central to DBT treatment is use of between-session telephone calls. These calls may be effective in reducing suicidality by strengthening the client-therapist relationship, allowing for *in vivo* coaching through urges, and by fostering distress tolerance skills (e.g., "I can call my therapist if this doesn't work, but if I cut I can't call her."); 3) *Mindfulness.* In DBT mindfulness skills are the foundation of all other DBT skills. These skills may be particularly helpful in suicidality by allowing clients to approach situations with perspective rather than emotionality and with a stance of acceptance rather than judgment; and 4) *Distress Tolerance.* Distress tolerance skills allow clients with suicidality to experience and accept intense emotions rather than acting on them in self-destructive ways. These skills may also allow clients to feel more equipped for difficult situations, thereby increasing feelings of self-mastery.

Although specific DBT techniques may be responsible for reduction of suicidality, the underlying philosophy of DBT may be one of the strongest influences in its success. DBT's dual focus on acceptance and change may connect to the ambivalence in clients with suicidality. Additionally, the authenticity of the therapist inherent to DBT may be responsible for an interpersonal connection that may reduce suicidality (Joiner et al., 2009).

Problem Solving Therapy (PST)

There have been mixed results in terms of the effectiveness of PST in reducing suicidality. Some research has shown that PST is no more effective than other interventions in treatment of suicidality (McLeavey, Daly, Ludgate, & Murray, 1994; Donaldson, Spirito, & Esposito-Smythers, 2005). Other research has indicated that PST and variants of PST decrease suicide attempts and suicidal ideation (Salkovskis, Atha, & Storer, 1990; Rudd, Rajab, et al., 1996). The effectiveness of PST in patients with suicidality centers on the idea that individuals who are suicidal have a deficit in problem solving skills and in interpersonal problem solving skills (Sourander, Helstelä, Haavisto, & Bergroth, 2001; D'Zurilla, Chang, Nottingham, Faccini, 1998). PST appears to be effective by teaching skills that compensate for problem solving deficits (Wingate, VanOrden, Joiner, Williams, & Rudd, 2005). This treatment includes six steps (i.e., Define the problem; Identify the goal; Generate alternatives; Evaluate alternatives; Implement an alternative; Evaluate efforts and modify approach as needed) that center on identifying and evaluating problems and pursuing solutions as alternatives to suicide. These six steps can be written on a portable note card for easy accessibility to reduce impulsive coping (Berk, Henriques, Warman, Brown, & Beck, 2004).

Cognitive Therapy (CT)

CT has also been supported in the literature as an effective intervention in reducing and delaying subsequent suicide attempts and in individuals who have attempted suicide (Brown et al., 2005). Additionally, clinical trials have supported the use of various forms of CT in the treatment of many psychiatric disorders associated with suicidality (e.g., major depressive disorder; Butler, Chapman, Forman, & Beck, 2006). The central premise of cognitive theory is that behaviors and emotions are

a result of the meanings assigned to events (Wenzel, Brown, & Beck, 2009). It has been hypothesized that the route by which cognitive therapy reduces suicidal behavior is through its impact on depressive thinking and symptoms of hopelessness, as opposed to a reduction in suicidal ideation (Brown et al.,). CT therapy for suicide involves three stages of treatment: (1) Establishing a framework for treatment; (2) In depth focus on suicidal behavior utilizing cognitive restructuring and behavioral interventions; (3) Relapse Prevention (Henriques, et al., 2003; Berk et al., 2004). Several specific CT interventions may be particularly helpful for clients with suicidality:

Hope Kit. Henriques et al. (2003) described an intervention in which clients construct a kit of mementos, pictures, souvenirs, and reminders of their reasons for living. The actual assembly of the kit may provide hope through correction of cognitive errors related to reasons to die versus reasons to live. The completed kit can then serve as a tangible reminder of reasons for living during times of crisis (Wentzel, et al., 2009).

Crisis Coping Card. Several versions of crisis cards (Rudd, Joiner & Rajab, 2001) and coping cards (Berk et al., 2004) have been described in the literature. These cards can be used as a safety plan of what to do when feeling overwhelmed when it is difficult to think clearly (e.g, call a friend at XXX-XXXX); ways to counteract core beliefs (e.g., reasons I am not a failure); and reminders of skills to employ during stressful situations (e.g., listen to music on my iPod). Clients tend to respond well to coping cards/crisis cards because they provide a tangible and concrete method of coping during difficult situations, when intense emotions can often interfere with healthy coping (Wenzel et al., 2009).

Guided Imagery. Wenzel et al. (2009) presented a relapse-prevention intervention that utilizes guided imagery adapted for suicidal clients. The client is instructed to imagine a future situation in which she may feel suicidal and guided through cognitive restructuring, healthy coping, and problem solving. This intervention serves as a role-play for future events and creates an imaginal self-mastery experience to strengthen resilience in preparation for those events.

Discussion

Working with suicidal clients represents a unique challenge for counselors who are conventionally trained and certified to assume that the client will act in synergy with the counselor and contribute to a helping partnership toward a resolution of the presenting issues. For most clients seeking the help of a counselor represents the first of many steps toward recovery—a step that in many cases may be the most difficult one to take. Suicidal clients turn the traditional client-counselor partnership on its head in that suicidal clients are typically cognizant of the fact their presence in counseling is as a result of an overt and intentional self-initiated act that was conceived by them and intended to meet a predetermined need. This need includes a degree of psychache as described above, which may be only one of many factors that have played into the client's decision to die by suicide. The challenge for the counselor is to understand the psychological basis for arriving at the decision to attempt a suicide as part of a reasoned and reasonable chain of logic—most suicidal clients will be able to conceive and describe their justification for engaging in this behavior.

Most of the techniques that have been shown to be effective with this population involve a recalibration of the thinking processes that have led to this decision. Additionally, addressing the often deficient problem-solving, conflict-resolution, and personal-interaction skills of suicidal clients can be a useful adjunct in addressing the problems that forced them into the path of

reasoned conclusions that ended with a decision to suicide. However untenable this chain of logic is to the client's family members and significant others or even the counselor, it must be examined and understood if effective means of addressing the deficits in thinking that, in combination with the client's actual challenges, have led to the problem behavior.

Figure 1. Decision Tree Interview. Adapted From *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients,* by T. E. Joiner, Jr., K. A. Van Orden, T. K. Witte, and M. D. Rudd, 2009, p. 72. Copyright 2009 by the American Psychological Association (APA). Reprinted under APA's fair use policy.

Assess History of Suicidal Behavior:

1. Past suicidal behavior: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., went to hospital?).
2. Do you have a history of non-suicidal self-injury? (e.g., burning, cutting, etc.)

Assess Suicidal Desire and Ideation:

3. Have you been having thoughts or images of suicide?
4. Do you ever think about wanting to be dead?
5. Frequency of ideation: How often do you think about suicide?
6. What reasons do you have for dying? What reasons do you have to continue living?

Assess Resolved Plans and Preparations:

7. Duration [look for pre-occupation]: When you have these thoughts, how long do they last?
8. Intensity: How strong is your intent to kill yourself? (0 = *not intense at all*, 10 = *very intense*)
9. Specified plan [look for vividness, detail]: Do you have a plan for how you would kill yourself?
10. Means and opportunity: Do you have [the pills, a gun, etc.]? Do you think you'll have an opportunity to do this?
11. Have you made preparations for a suicide attempt? [e.g., buying pills]
12. Do you know when you expect to use your plan?
13. Courage & competence: How scared do you feel about making an attempt? How courageous do you feel about making an attempt? How able do you feel to make an attempt?

Assess "other significant findings":

14. Precipitant stressors: Has anything especially stressful happened to you recently?
15. Hopelessness: Do you feel hopeless?

16. Impulsivity: When you're feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? [e.g., drinking alcohol, running away, binge eating]

17. Has anyone in your family made a suicide attempt or died by suicide? Relationship to you? Thoughts and feelings about this?

18. Presence of psychopathology (rated by interviewer)

19. Thwarted belongingness: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you're feeling badly? [are supportive relationships completely absent?]

20. Perceived burdensomeness: Sometimes people think: "The people in my life would be better off if I were gone." Do you think that? In what ways to you feel like you contribute meaningfully to those around you? (e.g., at work, at home, in the community)

Protective Factors:

21. Adequate social support (use responses to item 19 to assess this)

22. Responsibility to others (use responses to item 20 to assess this)

23. Good problem-solving ability: When you are experiencing distress, what do you do to resolve it? When you encounter something difficult, do you sometimes feel like you have no idea what to do to get through it?

24. Cultural and religious beliefs against suicide

Figure 2. Suicide Risk Assessment Decision Tree. Adapted from "Scientizing and Routinizing the Assessment of Suicidality in Outpatient Practice," by T. E. Joiner Jr., R. L. Walker, M. D. Rudd, & D. A. Jobes, 1999. *Professional Psychology: Research and Practice, 30,* p. 451. Copyright 1999 by the American Psychological Association. Reprinted under APA's fair use policy.

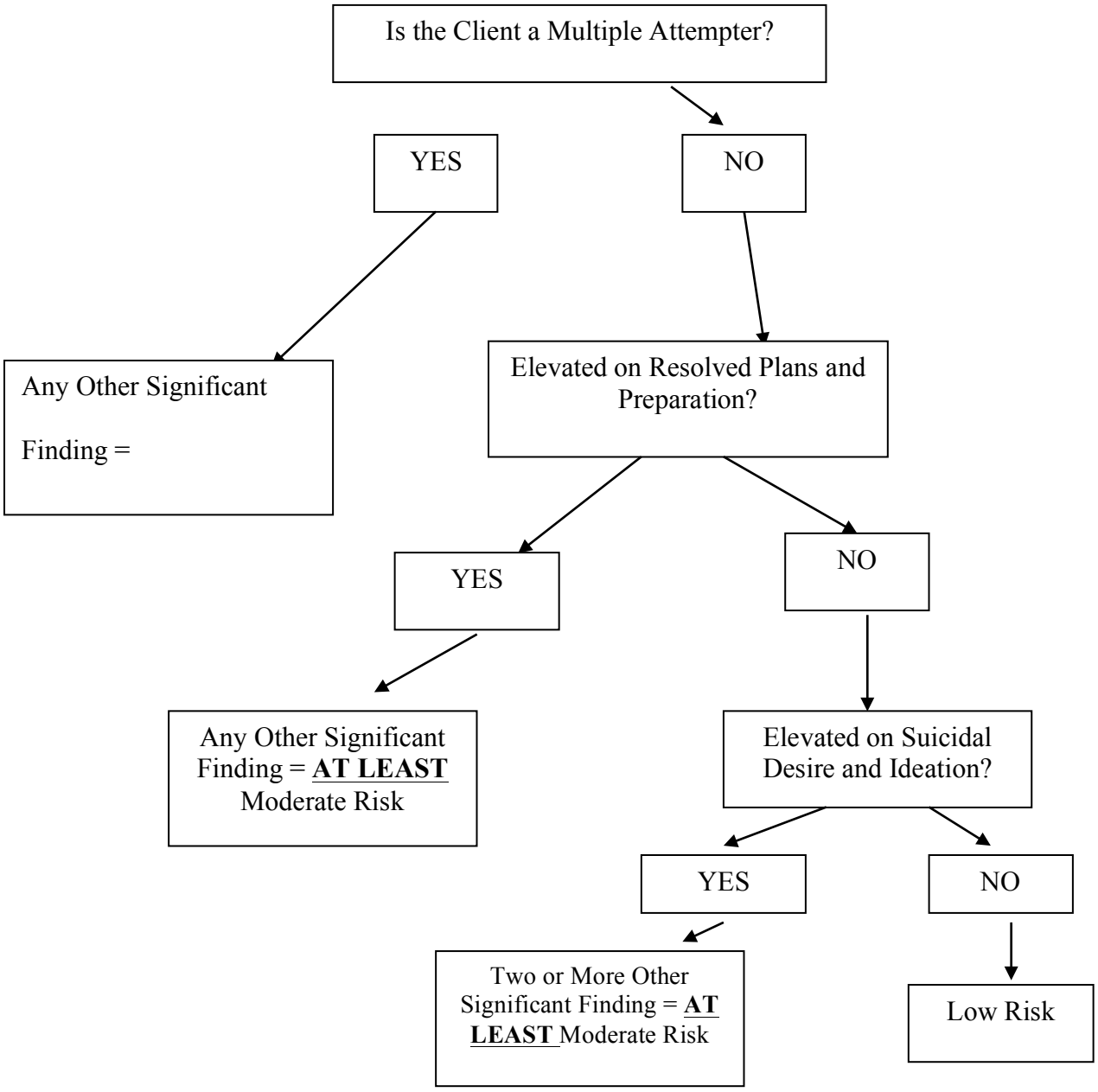

Figure 3. Interventions for each level of suicide risk. Adapted From *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients,* by T. E. Joiner, Jr., K. A. Van Orden, T. K. Witte, and M. D. Rudd, 2009, p. 106. Copyright 2009 by the American Psychological Association (APA). Reprinted under APA's fair use policy.

Risk Category (circle one and check off each action taken):

Low Risk (actions taken)

- ☐☐ Create a coping card with the client that includes a variant of the following, "In the event that you begin to develop suicidal feelings (or if your existing feelings become more intense), here's what I want you to do:"
    - List at least three pleasant activities that a client could realistically do when feeling distressed (e.g., work on crossword puzzles, listen to soothing music)
    - List two or three people from the client's support network that could be called (e.g., mother, friend)
    - List emergency numbers (including that for the National Suicide Prevention Lifeline; 1-800-273-TALK and 911)
- ☐☐ Continue to regularly monitor suicide risk
- ☐☐ Document all activities in progress notes

Moderate Risk (actions taken)

- ☐☐ Consult with a supervisor if you are a trainee
- ☐☐ Create a coping card (see above)
- ☐☐ Consider midweek phone check-ins to assess suicide risk more frequently
- ☐☐ Inform about existence of adjunctive treatments (e.g., medication)
- ☐☐ Increase social support:
    - Encourage client to seek support from friends and family
    - Plan with client to have someone check in on him or her regularly
    - Ask client's permission for you to contact the person who will be checking in
- ☐☐ Attempt to remove access to lethal means (e.g., firearms, pills, etc.)
- ☐☐ Ask for permission to speak with an informant (e.g., family member, romantic partner), with the appropriate release
- ☐☐ Continue to regularly monitor suicide risk

- Document all activities in progress notes

High Risk (actions taken)

- Consult with a supervisor if you are a trainee or with a colleague if you are not a trainee
- Consider emergency mental health options (e.g., hospitalization)
- Client should be accompanied and monitored at all times
- If hospitalization is not warranted, use suggestions from the Moderate Risk category
- Document all activities in progress notes (including documentation that hospitalization was at least considered)

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Counseling Older Adults at Risk of Suicide: Recognizing Barriers, Reviewing Strategies, and Exploring Opportunities for Intervention

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Abstract

Age-related challenges to health and well-being among older adults give rise to a distinctive array of risk factors for suicide, calling for a unique approach to suicide interventions. Americans over the age of 65 are disproportionally overrepresented in the number of completed suicides. This paper examines the epidemiology of geriatric suicide, reviews age-specific risk factors for suicide, discusses interventional modalities for use with suicidal older adults, and describes the role of the counselor in geriatric suicide interventions. In particular, we focus on a gerocounseling perspective to guide strategies for intervening with older adults contemplating suicide. This model utilizes a multidisciplinary approach derived from the integration of physical, psychological, and sociological aspects of aging. Additionally we consider the potential for emerging therapeutic models promoting resilience, sense of coherence, and dignity to be incorporated into counseling services for older adults. Specific therapies discussed include Cognitive Reappraisal, Reminiscence Therapy, and Dignity Therapy. We conclude with a discussion of the potential application of the principles of palliative care in designing and implementing holistic approaches to counseling older adults presenting with suicidal ideation.

Background

Suicide is a phenomenon of public significance with implications on the personal, interpersonal, and institutional levels of society. Of considerable concern is the fact that the highest rates of suicide occur among older adults and the recognition that with the aging of the baby boom population this may be a problem of increasing magnitude (Van Orden & Conwell, 2011). While theorists and practitioners have contributed to our knowledge of the origins, manifestations, and management of suicidal behavior, there are unique challenges in intervention strategies when working with older adults. As scientists have explored the predisposing and precipitating factors associated with suicide, health care professionals have developed medical and psychosocial modalities for use in suicide prevention, intervention, and postvention.

Individual suicidal behavior can be viewed on a trajectory that includes suicidal ideation, attempts, and death (Van Orden & Conwell, 2011). Van Orden and Conwell highlighted the importance of intervening early in this trajectory. Thus, there is a blurring of classification between prevention and intervention when discussing actions to interrupt the progress from suicide ideation to attempts to take one's life. For example, activities generally labeled as "prevention," such as Suicide Prevention Hotlines can be seen as an intervention, requiring that individual thinking about suicide make an overt effort to seek someone with whom he/she can discuss thoughts and feelings.

Epidemiology of Geriatric Suicide

Describing the landscape of older adult suicide is the first step in identifying risk factors and understanding the unique characteristics of older adults who should be targeted for counseling interventions. Americans over the age of 65 comprise approximately 13% of the population, yet account for almost 19% of the suicides (Mental Health Association of Colorado, 2011). This is equivalent to "one elderly suicide every one hour thirty minutes" across the United States (Mental Health Association of Colorado). While this statistic is startling, it is even more striking that 83% of elderly suicides are among men, the majority of whom are white (Edelstein, Heisel, et al. 2009). Indeed, the rate of suicide for older black women is particularly low, 1.1 per 100,000 for women 55 years and older (Cohen, Colemon, Yafee, Casimer, 2008).

Older adults are less likely to attempt suicide, yet they are more likely to complete suicide (Edelstein, 2009). Over 75% of older men and 35% of older women used firearms to complete their suicide (Meehan, Saltzman, & Sattin, 1991). The scope of geriatric suicide is hard to ascertain due to societal pressure to attribute death by suicide to other causes. Because suicide data is abstracted from death certificates, this may not be a true reflection of the magnitude of the problem. Thus, the data presented here may underestimate suicide rates among older adults (Breiding & Wiersema, 2006). Moreover, research suggests that suicides are more likely to be attributed to injury of undetermined intent among people of color, perhaps contributing to higher reported rates of suicide among whites (Rockett et al., 2010).

Additionally, while it is often assumed that older adults attempting suicide are suffering from chronic disease at the end of life, only a small number (2-4%) have been diagnosed as being terminal (Mental Health Association of Colorado, 2011). Moreover, 70% of older adults who died by suicide had seen a health care provider within a month of their death (Edelstein), and 20% had seen a physician with 24 hours of completed suicide (Luoma, Martin, & Pearson, 2002; Conwell, Lyness, Duberstein et al., 2000).

Characterizing Older Adulthood

While this discussion uses chronological years as the basis for discussing older adulthood, it is only one perspective from which to view the aging process. Functional ability interacts with societal expectations and attitudes to influence personal perceptions of age (Chudacoff, 1989). The experience of "feeling old" has been associated with poor physical ability and health, and may be more prevalent among persons of lower socioeconomic status (Quadagno, 2011, p. 7). Gender differences in the perception of chronological and functional aging are important, as well, giving rise to sex-based variations in patterns of suicidal ideation across the life course. For example, although women may feel subjectively "older" than men in society, suicide among women declines after middle age (Mental Health Association of Colorado, 2011). In contrast, while cultural

perceptions of aging men are more favorable than those of older women, suicide rates are higher for older men than older women. In discussing the rates of suicide among older adults, it must be remembered that older women outnumber men and that this gap widens with increasing age.

Coming to Terms with Mortality in Older Adulthood

Older adulthood is characterized by a sense of the boundedness of the human life span. For the older adult, awareness of mortality interacts with the mental and physical challenges of aging to impact the existential relationship to the world. While younger adults may view time as a limitless resource, the older adult faces a limited future. When Erik Erikson was in the final stage of life, his wife noted that they had been premature in limiting development to eight stages, ending with "integrity and despair" (Erikson, 1997). She suggested adding a ninth stage, *gerotranscendence,* during which the older adult defines his/her position in the universe – an existential (or spiritual) time of life during which the older adult comes to terms with increasing vulnerability and disability while realizing that death is eminent (Tornstam, 2005). Kahana and Kahana (1996) also identified the period of declining health as a unique stage of the life-cycle and note three requirements to cope with this period of life: (a) a social support system; (b) the ability to find new roles to substitute for lost roles; and (c) having the resources to modify one's environment, all of which reflect strengths developed earlier in the life-course. The therapeutic approach can be particularly relevant when helping the older adult to assess and to access the resources suitable to their individual situations. These can be important considerations for clinicians when designing interventions with a suicidal individual.

Although individual situations will vary, older adulthood can be characterized as an interaction of physical, mental, and social losses with potentially deleterious effects on wellbeing and quality of life. While counselors' efforts to intervene in suicide prevention are perhaps targeted at helping older adults find meaning in life, it is also critical for counselors to understand the physical and mental challenges faced by older adult clients.

Aging-Related Challenges to Health and Well-Being

A useful framework for organizing the challenges faced by older adults was developed by George (1994) who conceptualized a model of the social antecedents of geriatric depression. Factors include: (a) demographic characteristics; 2) early-life events and achievements; 3) later life events and achievements including financial status; 4) social integration and support; as well as 5) vulnerability factors resulting from physical and mental illness. This model which addresses how the balance of provoking agents (chronic stresses as well as acute life events) and the presence or lack of coping strategies interact to result in depression has been adapted by researchers (Cohen, Colemon, Yafee, & Casimer, 2008).

Our utilization of this model highlights the importance of taking a life-course approach to suicide risk. The individual's thought to consider and/or attempt suicide can be viewed in the context of earlier life experiences and exposures as well as current conditions, taking into account both personal life events and societal historical influences. On the individual level, personality, defined as "a social construct that defines who we are and how we react to our environment" (Quadagno, pg. 162), is a key factor carried into the later part of the life course and can be directly linked to the adaptive skills necessary to maintain resilience in the face of age-related decrements.

On the social and historical level, early life socio-economic and cultural constraints to the individual's pursuit of education may have resulted in a life time of lower paying jobs and a lack of financial resources for retirement. Likewise, in a period of economic recession, older adults might face the stress of being forced into retirement involuntarily because of workplace forces beyond their control. Similarly, the resources and investments an older adult had counted on to provide a secure retirement may be diminished by the societal economic situation. While the aging process is tempered by social and historical forces, the experience of becoming an older adult is shaped by challenges to health, function and wellbeing.

Physical and Mental Challenges of Older Adulthood

The geriatrician has the primary goal of helping "the patient regain lost function and maintain as much independence as possible. It is important to note that physical and mental illnesses affecting the elderly often interact and result in a loss of functional ability much more than any one problem in itself. The elderly are particularly vulnerable as they have less 'reserve capacity'" (Gambert, 2009, p. 1). Although many adults do not suffer disease-related functional disability, with age there is increased risk of functional decline measured by Instrumental Activities of Daily Living (such as doing housework, preparing meals, using the telephone, and handling finances) and Activities of Daily Living (such as getting out of bed, eating, toileting, dressing, and bathing) (Hooyman & Kiyak, 2011). Additionally older adults face the specter of Alzheimer's dementia, even if they have not been diagnosed (French, Floyd, Wilkins, & Osato, 2011)

Chronic Conditions and Geriatric Syndromes

Chronic conditions are prevalent among older adults, rarely occurring alone (multi-morbidity) and often requiring older persons to deal with ongoing and multiple challenges, including declining health and function (Yates, 2001). Available data suggests that 80% of those over the age of 65 years have a minimum of one chronic condition, while 20% have four or more conditions (Chodosh et al., 2005).

The term "geriatric syndromes," captures the distinctive features and complex nature of health processes commonly affecting aging individuals that are not uniquely due to any single underlying disease or cause. Thus, geriatric syndromes are "multi-factorial health conditions that occur when the accumulated effects of impairments in multiple systems render [an older] person vulnerable to situational challenges" (Inouye, Studenski, Tinetti, & Kuchel, 2007, p. 781.) Although these challenges are typically physical in nature, such as frailty, impaired mobility, incontinence, and cognitive decline, their course and ultimate outcomes are influenced by psychosocial factors including the individual's ability to adjust, adapt, and harness resilience in the face of changing circumstances (Hildon et al., 2010).

Social and Emotional Challenges of Older Adulthood

Anecdotally, we know that older adults often will tolerate socially-limiting conditions, excusing them as "What do you expect? I'm old." For example, older women may limit activities such as attending church because they need to stay close to a bathroom due to incontinence. An older adult with hearing problems may withdraw from interacting with others because of the communication difficulty. Medication regimens and side effects of medication may interact with physical disability to impose limitations on the life-style of the older adult.

Caregiving for a sick spouse presents physical and mental health challenges for the caregiver; when the spouse dies, widowhood may expose the older adult to loneliness and/or social isolation. Self preservation in the face of aging-related losses is an important task of advancing old age (Tobin, 1988), particularly in the presence of physical ailments. Physical disability may prompt role loss. For older persons, the coexistence of mental and physical illness, social and economic stressors, and age-related physiological changes and functional losses can have a destabilizing impact on the sense of self. Suicidal ideation among older adults may be a response to a diminishing sense the threat of continuity of self, reflecting a loss of personal meaning and purpose.

Feelings of hopelessness, inadequacy and perceived burden on others, particularly those for whom one feels a sense of responsibility, can engender or exacerbate thoughts of suicide as a means of bringing relief to loved ones (Britton et al, 2008; Cukrowicz, Cheavens, Van Orden, Ragain, & Cook, 2011; Jahn, Cukrowicz, Linton, & Prabhu, 2011). As an example of such thinking, we note that 55% of adults aged 55 and older in Alabama, reported that "being a burden to others" was an end-of-life concern (Baker & Allman, 2004).

One of the most challenging issues for aging adults is the pressure and desire to live independently in the face of age-related changes in health, function, and social roles. While medical care can target the maintenance of health for older adults, social services may be needed to assist older adults to maintain independent living. The counselor needs to help the older client explore services that may be available or consult with a social worker to provide this information. This would include options for transportation and nutrition (Senior Center programs and Meals on Wheels). It should be noted that the notion of intergenerational living is not equally devalued; some families will view such situations as reciprocal while others see the need as burdensome. As in retirement, the impact of the decision to live with others may reflect the voluntary versus. forced nature of the move and may result in the older adults feeling that they cannot contribute equitably to the social relationship (Wilmoth, 2000) The counselor can assist the older adult to understand this sense of imbalance in social reciprocity and find ways to restore a sense of control and dignity.

Risk Factors for Suicide

Societal and Structural Risk Factors

Why do older adults consider suicide? The classic discussion of suicide by the Sociologist, Émile Durkheim (1897, translated 1951) acknowledges that the act of suicide represents both a socio-historical fact, situated in the structure of society and a personal biographic feature, rooted in the subjective reality of the individual (Durkheim, 1897). Durkheim articulated four types of suicide: (a) egoistic, (b) altruistic, (c) anomic, and (d) fatalistic. In Durkheim's typology, *egoistic suicide* was the act of an excessively individuated person with tenuous ties to the norms and values of the larger, cohesive social group. This may be the case of the isolated older adults whose social ties to family and others are weak or have been severed over time. *Altruistic suicide* was the polar opposite of egoistic suicide, occurring among individuals willing to sacrifice their life for the greater good of a larger social group to whose ideals and goals they were tightly bound. This may be the case for the older adult who worries about depleting family resources such as money, time, and physical care capabilities and becoming a burden.

In Durkheim's conceptual scheme, *anomic suicide* occurred among individuals lacking personal and social direction who were living in societies characterized by social disruption and economic

instability. This may be the case of the older adult who lacks a sense of meaning and purpose in life. In contrast, *fatalistic suicide* arouse in highly regulated, oppressive societies where the absence of personal autonomy engendered a sense of hopelessness, severely limiting the individual's options for acting on their own behalf. This may be the case of the older adult who feels powerless to effect positive change on their own behalf and cannot envision a future worth living. The interaction of aging-related social, emotional, and physical changes can engender a vulnerability to suicidality stemming from one or more aspects articulated in Durkheim typology.

Physician Assisted Suicide (PAS) and euthanasia are contemporary issues that have relevance for our consideration of suicide among older adults. Because of the contested nature of this topic, we sometimes overlook that fact that it involves a decision to end one's life that can be understood in the context of Durkheim's conceptualization of the causes of suicide: egoism, altruism, fatalism, and/or anomie. However, attempts to legalize PAS or euthanasia may lead to the de-stigmatization and decriminalization of the act, effectively making it qualitatively different from other suicide methods.

Physician assisted suicide is legal in only three U. S. states (American Medical News, 2010). Although it is reported that the American public is divided about whether or not physician assisted suicide should be legal (Quill and Greenlaw, 2008), 27% of older Alabamians reported that there might be might be a situation when they would consider requesting physician assisted suicide or euthanasia (Baker & Allman, 2004). There are three levels to consider: physician assisted suicide refers to the situation where the patient receives information or the means (medication) to perform the act themselves. Perhaps in response to the stigma associated with suicide, the trend is to call this physician assisted death (Quill and Greenlaw, 2008). Active euthanasia refers to assisting another to terminate his/her life while passive euthanasia refers to withholding treatment and/or life-sustaining activities (Quadagno,2011). Another issue is self-neglect, the inability or refusal to adequately take care of one's health, hygiene, nutrition, or social needs (Abrams, Lachs, McAvay, Keohane, Bruce, 2002). Intentionality would place this in the literature on suicide.

In general, health care professionals equate the desire for suicide to be associated with mental illness and unclear thinking, often manifest as depression and cognitive impairment (Quill, et al., 2008; Abrams, et al., 2002). There is common agreement that death may be seen as the only way to escape suffering (Quill, et al.,) and that it is rare for persons with life-threatening disease not to consider suicide, at least in passing (EndLink Resource for End of Life Care Education, 2004). However, current medical practice has the means to relieve physical suffering and this should be available to all. The tenets of palliative care are based on the belief that all patients with life-threatening illness should have access to optimal symptom control and supportive care (Quill, et al.) which would greatly reduce the desire to hasten death. This model complements causes of suicide for individuals of all ages (Lester, 2001).

Psychosocial and Biographical Risk Factors

While suicidal ideation is "the clinical precursor" of suicide among older adults (Bruce et al., 2004, p. 1081), other psychosocial, biographic level, risk factors for geriatric suicide have been articulated (see Table 1). Such factors are useful not only for identifying high risk patients, but also for designing interventions appropriate for the older adult. Sadly, older adults completing suicide are more than twice as likely to have visited a primary care provider than a mental health specialist in the month preceding death (Vannoy, Tai-Seale, Duberstein, Eaton, & Cook, 2011). Therefore, it is

imperative to establish a systematic referral process from primary care to mental health services so that at-risk older adults are seen by counselors with training and experience in assessing risk and targeting interventions for geriatric suicidality.

Widowhood and bereavement. Research suggests that changes in marital status due to marriage, divorce, or spousal loss elevate the risk for suicidal behavior among older adults, especially during the 12 months immediately following the shift in status (Roškar, et al., 2011). Among older adults, spousal loss is a commonly occurring event, and is associated with increased risk of all-cause mortality, in general, and death by suicide, in particular. Compared to married persons, recently bereaved men have an excess mortality rate of 131%. In age-adjusted analysis, newly bereaved individuals are four times more likely to die from suicide than their married counterparts (Martikainen & Valkonen, 1996)

Although this bereavement effect has been widely studied, the mechanisms linking widowhood to excess mortality remain unclear. It has been suggested that exposure to the psychosocial stress of spousal loss has a deleterious effect on physiological processes, increasing the individual's risk for physical and psychiatric problems. Bereaved older adults are likely to avoid professional help because they fear a diagnosis of mental illness and the perception that they are unable to live independently. For these reasons, professional counseling services framed as supportive or self help programs tend to have greater acceptance among bereaved older adults (Bambauer & Prigerson, 2006).

Depression. Among aging individuals, an episode of depression is present in the majority of suicide cases. Geriatric depression is a major risk factor for suicide among older adults and is present in up to 75% of older adults who complete suicide. Clinical depression, in particular, is associated with an array of physical symptoms as well as problems with rational thought and concentration, feelings of guilt and worthlessness, desire for death, and recurring suicidal ideation (American Geriatric Society Foundation for Health in Aging, 2005). Because mental and physical health are inseparable in older adults (Katz, 1996), treatment for depression is an essential element of the medical care plan for suicidal persons. At the same time, seeking help for depression and other mental health concerns may be socially and personally unacceptable to some older persons, often engendering feelings of shame, and producing a stigmatized identity (Conner et al., 2010; Raue, Weinberger, Sirey, Meyers, & Bruce, 2011)

Substance Abuse. Substance abuse is on the rise among older adults and is associated with physical and mental health problems, particularly among older men. Abuse of alcohol and drugs is associated with elevated risk for impaired physical and psychological functioning and is a major risk factor for suicide among older adults (Kennedy, 2000). Misuse of alcohol, in particular, is harmful to the physical, psychological, and social wellbeing of older persons, negatively impacting self-esteem, coping skills, and relationships with others. Older adults are more likely to abuse prescription medicines than illicit drugs (Simoni-Wastila & Yang, 2006); and even medications taken as prescribed have side-effects of depression and/or dementia.

Although geriatric alcohol abuse can have its roots earlier in life, later life onset of problem drinking is associated with aging-related stresses, losses, and transitions such as retirement, bereavement, and the emergence of chronic health problems. Alcohol abuse can develop out of attempts to use alcohol to numb emotional, physical, or psychosocial pain of such losses. A subset of older adults who abuse alcohol are close to 3 times more likely than other older adults to suffer from other

psychiatric conditions including dementia, depressed mood, and suicide. Additionally, alcohol abuse is associated with deleterious interaction effects when mixed with over-the-counter or prescription medications and complicates the management of geriatric depression (American Geriatric Society Foundation for Health in Aging, 2005).

Table 1. Risk Profile for Late-Life Suicide

Clinical:

Expressed intent

Depression or other nondementing mental disorder

Alcohol use, moderate to heavy

Cancer, heart disease, lung disease

Chronic pain

Poor self-assessed health

Smoking

Sociodemographic:

White male

Age 85 or older

Firearms purchase/possession

Divorced, widowed

Recent life change event

Historical:

Previous attempt

Lethality of attempt (firearms, jumping from height)

Family history of attempted or completed suicide

Low probability of rescue

Recent visit to primary care physician or mental health specialist

Anniversary of loss

Source: Kennedy, 2000. Table reprinted with permission of publisher

Table 2. Practitioner-Based Interventions to Reduce the Risk of Late Life Suicide

When few risk factors are present
Annual screening for depression
Advanced directives (Patient Self-Determination Act)
Encourage abstinence or moderation in alcohol intake
Encourage active social network
When several risk factors are present but suicidal ideas are denied
All the above and . . .
Optimize treatment of depression, anxiety, insomnia, pain, alcohol abuse
When risk factors and thoughts of suicide are present but without intent or a plan
All of the above and . . .
Make family aware of elevated risk and ensure physician availability
Family or third party to remove lethal means and alcohol
Identify countervailing forces (concern for family, religion, life event goals)
Fix an appointment (not as needed), ask that family attend
When lethal means are at hand, a plan is expressed, or intent is evident
Refer for emergency psychiatric evaluation (involuntary if needed)
Consider hospitalization, electroconvulsive therapy

When suicide has been attempted with lethal means, or countervailing forces are not available to prevent recurrent attempts

Emergency psychiatric evaluation (involuntary if need be)

Hospitalize if intent not convincingly recanted or attempt is a recurrence

Source: Kennedy, 2000. Table reprinted with permission of publisher

Table 3. Countervailing Forces That Might Lessen the Older Adult's Likelihood of Acting on a Suicidal Impulse

Supportive, involved family

Presence of spouse

Social network

Financial security

Physically independent

Alcohol abstinence

Dementia (inability to sequence steps toward death)

Positively anticipated life events in family members (e.g. graduation, bar or bat Mitzvah, confirmation, marriage, childbirth)

Religious beliefs and values (optimistic rather than fatalistic)

Advanced directives, health care proxy

Practitioner's optimism and concern, regular appointments for ongoing care

Treatment of depression, anxiety, insomnia, pain

Source: Kennedy, 2000. Table reprinted with permission of publisher

Counseling the Older Adult

Counselors can make the greatest inroads against suicidal thoughts and behavior in the area of the older adult's life choices and decision-making processes (Dickerson & Watkins, 2009). The aging process is shaped not only by age-associated physical changes, but also by what is termed "secondary aging" — how the individual perceives and responds to growing older, in general, and the choices he or she makes to maintain well-being and quality of life, in particular. Social and cultural stereotypes about aging (ageism) persist, presenting unique challenges for the counselor working with older adults. Dickerson and Watkins (2009) delineated several issues that require additional attention by counselors serving the geriatric population. These include longer counseling sessions, more flexible scheduling, sensitivity to intergenerational barriers, and the potential for ageism on the part of both the counselor and the patient. In particular, older adults' attitudes about aging and mental health can impede client progress. At the same time, counselors' stereotypical perceptions of older adulthood can be a therapeutic barrier.

Among today's older adults there may be a cohort effect such that the stigma associated with seeking mental health services will be a barrier to providing interventions. Thus, seniors not likely to seek "counseling" may be open to interventions under another name. For example, group therapy may be more attractive reframed as a peer support group. Likewise, older adults may be more open to telephone intervention programs if they are reframed from crisis interventions to talking opportunities. For example, a telephone help/check line was shown to be successful in reducing suicides (Van Orden & Conwell 2011). The Senior Talk Line sponsored by the Jefferson County Crisis Center is another example.

Gerocounseling

Gerocounseling is a subspecialty targeting the needs of older adults. It is premised on the belief that aging is associated with a distinctive array of developmental tasks and life processes that distinguishes older adulthood from other phases and stages of the life course. The Gerocounseling Model (Burlingame, 1995) utilizes a biopsychosocial approach, drawing upon theories of aging from the biological, psychological, and sociological sciences and differentiating among processes of optimal aging, normal aging, and pathological aging (Dickerson & Watkins, 2009). In Gerocounseling educational programs, trainees are urged to (a) "explore their feelings about aging and themselves;" (b) "challenge personal myths and stereotypes regarding the older adult;" and (c) develop "awareness of their personal responses to older adults who are their clients" (Cavallaro & Ramsey, 1984, pp 75-76). The Gerocounseling Model is generating renewed interest, and has promise for the care of suicidal older adults (Foster & Kreider, 2009).

There is an increasing need for professional counselors to provide services to community-dwelling older adults. Gerontological counseling services range from one-time consultations and referrals to community resources, social services, and medical providers to ongoing therapeutic interventions related to issues of physical and emotional function, family stress, and existential crises involving role loss, meaninglessness and hopelessness. Additionally, counseling services for older adults may require putting into place coordinated client support systems on the family, community, and the organizational levels to support long-term situational management needs (Cavallaro & Ramsey, 1984).

Developing Geriatric Suicide Interventions

A 2011 systematic review on suicide prevention and intervention programs for older adults recommended the development and implementation of multi-component clinical strategies to promote positive aging and resilience among at-risk geriatric patients (Lapierre et al., 2011). In response, an international consensus panel on suicide among older adults articulated key considerations for evidence-based suicide interventions targeting the geriatric population. These guidelines for interventions are organized into universal, selective, indicated, and general classifications, which in combination, provide the most effective and comprehensive approach to reduce the prevalence and impact of suicidal behavior (Erlangsen et al, 2011).

Universal interventions. Universal interventions target older adults in general. They include programs for self-administered depression screenings, limited access to means of suicide, attention to concerns about aging and age-related dependency on others, and educational interventions to (a) promote healthy aging, resiliency, and empowerment; (b) increase awareness of suicide risk factors and suicide protective mechanisms; and (c) systematize and publicize procedures for reporting suicidal behavior (Erlangsen et al., 2011).

Selective interventions. Selective interventions target multiple stakeholders, including medical, social, and psychological service providers, high risk elders, and the community at large. For medical practitioners and trainees, the panel recommends: (a) providing systematic screening tools in medical care (primary, specialty, and long term) and social and psychological service settings and (b)) sensitizing medical, social, and psychological service trainees to the relevance of geriatric losses associated with declines mobility and sensory acuity. For caring for high risk elders, the panel's recommendations include the following; (a) offering systematic outreach services to assess and support recently retired or bereaved, socially-isolated older men suffering from functional decline, chronic pain, and subject to marital and family stressors; (b) improving quality of life and reducing suicidal ideation by optimizing treatments for pain and non-pain symptoms; and (c) enhancing psychiatric treatment modalities (i.e. drug compliance) by designating case managers and introducing psychotherapeutic, psychosocial, and other non pharmacologic adjuvant therapy such as problem solving training. For sensitizing the community at large, the panel recommends drawing attention to the problem of geriatric alcohol abuse (Erlangsen et al., 2011).

Indicated interventions. Indicated interventions target risk reduction among older adult survivors of suicide attempts, as well as those presenting with acute suicidal ideation. For the highest-risk patient and their family, the panel's recommends that social and psychological service providers: (a) communicate with elderly suicidal patients, their family and caregivers before initiating treatment, stressing the importance of monitoring suicide risk status; (b) help at-risk older adults to envision a future self that is congruent with reality; and (c) engage the older adult in follow-up activities (home visits, phone calls, post cards) to reassure them of ongoing interest in their wellbeing and to communicate appreciation for the meaning and value of their life. Additionally, the panel urges implementing lay "gate-keeping" training programs for identifying at risk individuals and referring them for treatment for depression.

For professional providers and trainees in a wide variety of helping specialties, the panel advocates (a) offering training and continuing education to detect, intervene, and manage depression and suicide risk in older adults; (b) designing and implementing interdisciplinary depression care management modalities; (c) promulgating practice guidelines for detecting and management later-

life suicide; and (d) facilitating referrals to social and community services with resources and expertise to assess and manage a wide variety of physical and psychosocial problems and to activate programs for improving living conditions, reducing stress, and providing psychological support. Finally, ongoing assessment of the impact of the intervention, surveillance of patient status, and provision of educational and social support is critical during the post-intervention period to the prevention of future suicide attempts (Erlangsen et al, 2011).

Considerations on the Older Adult's Interventional Readiness

Applying the Transtheoretical (TTM) model of change, typically used to describe adopting healthy behaviors, can target points of intervention to prevent suicide among older adults. The stages of precontemplation, contemplation, preparation, and action are particularly applicable as target points for interventions although the specific time periods may not be applicable (Redding, 2000). *Precontemplation* (defined as no intention of action within the next 6 months) nonetheless may represent a time when the act of suicide becomes a conscious option. Both passive thoughts about death and active ideation of wanting to die (Cohen, et al., 2008) could be placed in this phase of the model. Understanding the risk factors for older adults who commit suicide would allow targeting vulnerable individuals before they themselves have thoughts of employing lethal actions.

As older adults move from being aware of suicide as an "option" to individualizing and *contemplating* what that would mean for themselves, significant others may remain unaware of the suicidal ideation. In the TTM model this is time defined as contemplated action within a six month period. Careful attention to verbal cues for persons identified at risk could trigger intervention strategies and prevent the progression to the stage of *Preparation*, defined by TTM as action within 30 days, and action. Older adults typically do not verbalize movement as they progress between contemplation to preparation to action, and because most suicide attempts in older adults are likely to be completed, interventions must necessarily occur early in the process.

Specific Recommendations for Counselors

In many cases the counselor of a suicidal older adult may need to recommend a geriatric assessment to identify undiagnosed or undertreated conditions for which medical care is available. Once medical and social support aspects of clients' lives have been explored, and the counselor has the opportunity to address reasons their clients are in despair, the counselor may want to consider recent therapeutic approaches that have emerged as a way to increase meaning and the desire to live. These modalities, promoting resilience and dignity, were developed to for older adults (and others) suffering from life-threatening disease and have relevance for adults with suicidal ideation.

A Focus on Resilience

Resilience can be defined as "the experience of being disrupted by change, opportunities, adversity, stressors or challenges, and after some disorder, accessing gifts and character to grow stronger through the disruption (Bradshaw et al., 2007, p. 643)." Resilience theory is comprised of a growing body of knowledge that describes the *qualities* of resilient individuals, delineates the *processes* through which resilient qualities are acquired, and models the *pathways* by which resilience responses emerge (Richardson, 2002). Resilience is both a biopsychosocial phenomenon comprised of: (a) *recovery or the capacity to* regain equilibrium physiologically and psychosocially following acute stressors; and (b) *sustainability* or the capacity to endure and carry on in the face of chronic

stressors (Zautra, 2009, p. 1935). Resilience is thought to be a common response to stress, representing a distinct trajectory in the process of recovery and sustainability with multiple pathways based on individual characteristics and circumstances (Bonanno, 2004). The role of the counselor fits nicely into helping the suicidal older adults discover (or rediscover) strengths and coping strategies.

There is growing interest in utilizing resilience interventions as clinical tools in primary care settings for a variety of chronic conditions, including depression (Bradshaw, Richardson, & Kulkarni, 2007; Dowrick et al., 2008). Adaptive responses to aging are pervasive in the daily lives of older adults and not restricted to acute life events (Ong, Bergeman, & Boker, 2009). Historically, research on resilience among older adults has been tied closely to the concept of optimal aging (Baltes & Baltes, 1990; Rowe & Kahn, 1987; Schulz & Heckhausen, 1996). Using data from the MacArthur Foundation Network on Successful Aging, Seeman and colleagues studied functional levels of community dwelling older adults and found that psychosocial resources provided a protective benefit against the deleterious impact of advancing years (Seeman, et al., 1995). In a similar vein, Ryff and colleagues recognized the need for research focused on resilience among older adults, to examine the unique strengths and capacities that enable them to respond positively to chronic stress or adversity (Ryff, Singer, Love, & Essex, 1998). Fry and Debats (2010) believe that identification of the source of personal life-strengths is linked to the capacity for resilient aging. Thus, although individuals may vary in whether or not their major life-strength resides within themselves or comes from an outside force, the acknowledgement itself promotes resilience.

Sense of Coherence

The theoretical framework of resilience utilizes an autogenic rather than pathogenic approach to health and illness, focusing on individual strengths and assets, rather than deficits (Antonovsky, 1979). It is theorized that resilience stems from the interplay of biological, psychological, social and environmental resources. One of the most important psychosocial resources at work in resilience is the sense of coherence. Antonovsky defined sense of coherence as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (b) the resources are available to one to meet the demands posed by these stimuli; and 3) these demands are challenges, worthy of investment and engagement (Antonovsky, 1987, p. 11).

Cognitive Reappraisal

Research suggests that good or excellent self-rated health is a surrogate for resilience (Hardy, Concato, & Gill, 2004; Pierini & Stuifbergen, 2010). Other markers of resilience have been described in the research literature as well. Primary among them is the process of cognitive transformation, characterized by a reappraisal of the impact of the adverse experience from a negative and life diminishing perspective to one that is positive and life enhancing (Tebes, Irish, Puglisi Vasquez, & Perkins, 2004). Cognitive re-interpretation is closely associated with the process of adversarial growth or stress related growth, the experience of positive change emerging from trauma and loss. Cognitive appraisal variables such as acceptance, optimism, and positive affect have been shown to be correlated with adversarial growth and are described in the literature as markers of resilience (Linely & Joseph, 2004; Ai & Park, 2005). Additional markers of resilience examined in the literature include positive affect, in general, which has been associated with

physiological resilience (Fredrickson & Joiner, 2002; Tugade & Fredrickson, 2004; Tugade, Fredrickson, & Barrett, 2004) and optimism, in particular, which has been linked to perseverance and coping (Peterson, 2000; Segerstrom, Taylor, Kemeny, & Fahey, 1998).

Reminiscence Therapy

There is increasing interest in the use of reminiscence as therapy for older adults struggling with issues of hopelessness, meaninglessness, or loss of social roles. Structured reminiscence has been shown to be a useful psychosocial intervention, targeting patient mood, well-being, and behavior. As a psychosocial tool, structured reminiscence can promote mastery, reduce depression, and increase meaning in life (Bohlmeijer et al, 2009; Bohlmeijer, Westerhof & Emmerik-de Jong, 2008; Peng, Huang, Chen & Lu, 2009; Stinson, 2009; Stinson, Young, Kirk & Waller, 2010).

Dignity Therapy

Dignity Therapy is an empirically-derived psychotherapeutic reminiscence intervention, originally designed to moderate psychological distress among terminally-ill cancer patients. The goal of Dignity Therapy is to generate positive emotions, improve the sense of mastery and esteem, and promote psychosocial wellbeing. Dignity Therapy uses the process of guided life review to promote a sense of personal continuity, enhance feelings of mastery, and restore meaning to life (Chochinov, 2002; Chochinov, 2004; Chochinov, 2006; Chochinov, Hack, Hassard, Kristjanson, McClement & Harlos, 2004; Chochinov, Hack, McClement, Kristjanson & Harlos, 2002; Hack , Chochinov, Hassard, Kristjanson, McClement & Harlos, 2004; Thompson & Chochinov, 2008).

Dignity Therapy is derived from Erikson's theory of psychosocial development and focuses on the Integrity versus Despair stage of the life course where life review and acceptance are important psychological tasks (Erikson, 1950 & 1959). Dignity therapy is thought to be both generative and restorative for patients facing the end of life. In particular, the life review process utilized in dignity therapy fosters the creation of a legacy document, helping to dispel feelings of meaninglessness and despair over a lost past, a stressful present, and an uncertain future. As part of dignity therapy, patients tell the story of their life, recalling important events, reminiscing about significant relationships, expressing values and beliefs, and articulating how they would want to be remembered by posterity. Dignity therapy sessions are conducted by trained interviewers, audio-recorded, transcribed, and edited into a generativity document, celebrating the patient's life and preserving his or her memories.

Dignity therapy has been shown to ease psychological suffering among terminally ill patients, with benefits including an enhanced sense of self-esteem and self worth, as well as a heightened sense of purpose and connectedness (Chochinov, et al., 2002: McClement et. al, 2007). In a randomized control trial comparing dignity therapy with client-centered care or standard palliative care, terminally ill patients in the dignity therapy arm saw greater reduction in sadness and depression than those receiving palliative care as well as greater improvement in spiritual wellbeing than those in client-centered care (Chochinov et al., 2011). Additionally, researchers have also explored the efficacy of family-based life review activities with older adults approaching end of life. A study conducted by Allen et al (2008), found that patients in the intervention group reported a reduction in depressive symptomology.

Research in the area of dignity therapy shows promise for a variety of clinical applications (McClement et al., 2004). In the clinical setting, dignity therapy offers a way for the therapist to focus on the patient's life stories, valued memories, and unique composite of character and personality traits (Chibnall, Tumosa & Desai, 2009). A recent study by Montross, Winters & Irwin (2011) examined the use of Dignity Therapy in a clinical setting where patients were referred by members of an acute care interdisciplinary team such as social workers, nurses, and physicians. The completion of an individualized dignity therapy document required an average of 6.3 hours over 4 sessions. Training manuals and workshops on the use of dignity therapy are available (Chochinov, 2010).

Dignity therapy is a "new horizon" and "emerging paradigm" for the care of persons approaching the end of life (Kissane, Treece, Breitbart, McKeen & Chochinov, 2009, p. 342; Chochinov, 2006, p. 84), offering a window into the subjective experience of facing death (Hack et al., 2010). As such, Dignity Therapy offers a therapeutic modality for targeting psychosocial distress among older adults facing death for any reason, including suicidal ideation. Although the efficacy of dignity therapy as a clinical intervention for suicidality has yet to be tested, evidence to date points to a potential role in the care of suicidal older adults (Chochinov et al., 2011)

Palliative Care

Palliative care may provide a model for suicidal interventions among older adults. According to the World Health Organization (2004):

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

Palliative care modalities encompass holistic, multidisciplinary approaches and can inform suicide intervention therapies and policy. Recent literature advocates the role of counselors in the palliative care setting, highlighting the specific skills of counselors to address "complex emotional, cultural, and spiritual" issues and enhance communication between patient's, families, and health care providers (Babcock & Robinson, 2011).

At present, the literature does not describe a well-defined role for palliative care interventions for suicide among older adults, except in specific cases. These include responses to individuals with terminal or progressive and life-limiting conditions who express the desire to end life or request physician-assisted suicide or euthanasia. In such cases, palliative medicine implements interventions to relieve physical pain, emotional/psychological suffering, and psychosocial, spiritual, and existential distress. Growing evidence shows that relief of suffering decreases the desire for death, and that meaning-making interventions such as Dignity Therapy reduce depression among the terminally ill.

Conclusion

Increasingly, counselors will encounter older adults who are contemplating suicide. Because the work of the counselor is client based they are in the position to understand that today's older adult is part of a cohort of individuals with unique attitudes and expectations based on the social and historical period in which they came of age. Intervention targeting suicidal behavior in older adults requires a multi-faceted interdisciplinary approach that adopts emerging therapeutic modalities such as those used in palliative care. Counselors have a unique role in suicide interventions based on their training, expertise, and experience. Partnerships with institutional and community health care professionals can strengthen and support the work of the counselor in this endeavor.

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Youth Suicide Postvention: Support for Survivors and Recommendations for School Personnel

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Abstract

Suicide postvention is a concept related to the prevention of subsequent suicides, provision of mental health services, and the community response following a completed suicide. Many people including parents, school mates, friends, siblings, teammates and extended family are impacted in different ways by the loss of a family member or person of close connection, to suicide. In Alabama, suicide contributed to 667 lives lost in 2009 of which 76 (11.4%) were youth age 5-24 (D. Hodges, Alabama Injury Prevention Branch, personal communication, August 12, 2011). All suicides have one thing in common—the production of survivors, who grieve, attempt to understand and rationalize death by suicide, and to move forward in their lives. Despite robust data sources, it is estimated that for every suicide there are six survivors, a conservative estimate. This paper will provide an overview of postvention, characteristics of a survivor of suicide loss, general postvention program goals, school system preparation, support for families and peers in the wake of a youth suicide. For the purposes of this paper, youth is defined as a person between the ages of five and 24.

Background

Understanding Postvention

While death by suicide is final for the decedent, prevention risk is just beginning for the survivor of loss. Postvention, a term first coined by Shneidman at the first conference of the American Association of Suicidology (AAS), is used to describe "appropriate and helpful acts that come after a dire event" (1972). Andriessen (2009) offers yet another definition of postvention: "those activities developed by, with, or for suicide loss survivors in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior." Shneidman also contended "The largest public health problem was neither the prevention of the suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors of loss whose lives are forever altered" (1972, p. xi). The definition of "survivor" is complex and refers to the "behavior of someone else (not one's own suicide attempt), to the subsequent death and absence of that person, and to the subsequent impact on close others" (Andriessen, 2009). The survivor as discussed in this paper

describes a person who has lost a loved one to death by suicide, and should not be confused with an individual that has survived a suicide attempt. Nomenclature in the field of suicidology is important, therefore key terms warrant definition.

Historically, postvention services have been delivered using a passive model. This approach requires the bereaved to acquire resources in obscure ways (Campbell, 1997). For example, survivors may collect a pamphlet at a funeral home, see an advertisement for a survivor support group at a community event, or happen to locate a website when researching support for themselves or their family (Cerel & Campbell, 2008). In contrast, active models of postvention provide immediate and direct referrals for additional support to individuals impacted by the suicide loss. Friends, neighbors, co-workers, and distant family members are often overlooked, yet they are just as significantly impacted by the death as members of the immediate family (Campbell, Cataldie, McIntosh, & Miller, 2004). Postvention is thought to be an act provided to close relatives; however, the quality of the personal relationship would be an important factor to assess when addressing the sense of loss experienced by others (Chapman, 2007; McIntosh, 2003). Examples of active postvention include immediately providing survivors with a list of support groups they can attend and introducing the bereaved to others who have experienced suicide loss in hopes of strengthening the survivor's local support network. Specific group meetings and their meeting details can be easily found by searching the websites of the American Foundation for Suicide Prevention and/or the American Association of Suicidology. Given that school personnel are responsible not just for the intellectual development of youth, but their physical and emotional development, when a youth suicide occurs in a school, the emotional ripple effect it has must be actively addressed (Cerel & Campbell, 2008).

Characteristics of Survivors

Suicide postvention is a crisis intervention strategy describing actions taken after death by suicide "to help survivors such as family, friends, and co-workers cope with the loss of a loved one" (Suicide Prevention Resource Center [SPRC], 2008), dissuade social stigma associated with suicide, and disseminate fact-based information (Brock, 2002). Assistive efforts available after a death vary by type, location, and geographical distance of resources in given community. The sudden or unpredicted loss of a loved one to suicide triggers different emotions among survivors than does other means of death that are anticipatory, such as terminal cancer. Counseling professionals should know that survivors of suicide are at risk for complicated reactions and other mental health challenges, including direct suicide risk. The nature of such abrupt loss often generates a state of complicated grief for the survivor. Absence of preparation, the potential for self-blame, and guilt for not reading into behavioral cues conveyed by the decedent disrupt and can prolong the grief recovery cycle. The coping process is altered and the resources a survivor needs to move past the situation are varied and the specific needs of survivors are difficult to anticipate (Jordan & McIntosh, 2011).

Family and Close Others

People who experience youth suicide, in particular those who discovered the decedent, are likely to experience a wide range of intense feelings. Kubler-Ross and Kessler (2007) indicated that people experience a cycle of grief related to any death process including denial, anger, bargaining, depression, and acceptance. According to Jackson and McIntosh (2011), it is not uncommon for survivors of suicide to experience complicated grief which can include shame, embarrassment,

isolation, unusual grieving patterns, and intrusive thoughts. Co-occurring problems such as acute and post-traumatic stress, depression, anxiety, social marginalization, family stress, and physiological and medical problems intensify the loss and grief process. In particular, survivors struggle with guilt because they may believe they were given warning from the decedent or were the last person to have contact with the decedent or both.

When suicide occurs, it is a traumatic event for survivors (Leenaars & Wenckstern, 1990) who often report receiving less social support than expected. The stigma attached to mental health and the taboo approach that cultures take with regard to issues of self-harm pressure some to view suicide as a sinful, selfish, or angry act. Just as those who die by suicide are not focused on the outcome their death will have on those left behind, survivors are not prepared for the negative association and stigmatization. Suicide survivors often need more care, comfort, and compassion than people who anticipated the death of a loved one, but the needs of survivors are often left unmet. When death occurs, it is culturally traditional to send flowers or a note of condolences to the immediate family or friends. Many times, observers or acquaintances do not understand or know the appropriate means by which to communicate their empathy towards a survivor of suicide; therefore, supportive acts such as sending cards, making phone calls, and being present at other supportive gatherings often do not take place. The absence of communal response leaves the survivor feeling further isolated and removed from potential support systems (Jordan &McIntosh, 2011; Granello & Granello, 2007).

Youth

While it is beyond the scope of this paper to present information related to specific race, gender, ethnic groups, and special youth populations, youth response to suicide should be considered. Useful articles for further investigation include Kaslow, Ivy, Berry-Mitchell, Franklin, Bethea (2009) and Silenzio, Pena, Duberstein, Cerel, and Knox (2007). It is important to recognize that youth respond to suicide in ways different than adults. Given that youth have a less developed cognitive capacity and coping skills to draw from, they often believe that they were responsible for the suicide in some way. Secrecy about a suicide can lead to additional psychosocial complications. Explaining the circumstances surrounding the death, and responding to questions with age-appropriate answers will thwart the potential for guilt and improve understanding (Cerel, Roberts, & Nilsen, 2005; Jordan & McIntosh, 2011).

Youth age four to eight years old may not talk directly about their feelings. Rather they act out their emotions through temper tantrums and anxiety when separated from certain adults. Youth age nine to 13 years old also commonly do not want to discuss their feelings directly but can respond to suicide with sleep disturbance or other difficult-to-manage behaviors. Youth age 14 to 18 may isolate and hide the information from their peers out of fear of being misunderstood or rejected (U.S. Department of Veterans Affairs, 2011a, 2011b, 2011c).

Cerel et al., (2005) found that high school students exposed to peer suicidal behavior were more likely to smoke cigarettes and marijuana, participate in high risk drinking, and engage in aggressive behaviors resulting in injury. Other studies have found youth to be at greater risk for depression, post-traumatic stress, suicidal ideation, relationship conflict, and traumatic grief and should be monitored to prevent these behaviors from emerging (Granello & Granello, 2007; Melhem, Day, Shear, Day, Reynolds, & Brent, 2004).

The imitation of suicide behavior, coined *contagion*, may occur following a death by suicide**.** Contagion, also referred to as cluster suicide, is a phenomenon whereby people who are already susceptible to suicide are influenced towards suicidal behavior through their knowledge of another person's suicidal act (AAS, 2012a; AAS, 2012b; Hawton &Williams, 2001; SPRC, 2008). The phenomena of suicide clusters are indeed unique to teenagers and young adults, and there is evidence of its existence primarily among youth for whom the underlying mechanism is peer modeling (Insel & Gould, 2008). Ways to reduce contagion include avoiding unnecessary inappropriate attention to the initial suicide, avoiding glorifying the act, and avoiding the portrayal of the decedent in a negative light. Minimizing the amount of details shared among peers is also useful in avoiding contagion after a suicide. Often there is a label, stigma, or negative frame placed around the individual who died from suicide. Stigma further perpetuates the myth that a formal discussion about suicide will encourage suicidal behaviors; this myth creates a gap between the survivors of loss and linkages with support resources.

School System Preparation

Suicide postvention in schools refers to "school activities occurring after a student has threatened, attempted, or completed suicide" (King, 2001, p.136). Schools are a place where youth spend the majority of their day and are a place where student safety and well-being are of utmost importance (Granello & Granello, 2007). Further, a high percentage of teens are acquainted with a suicidal peer, yet many are not equipped with appropriate response skills (Kalafat & Elias, 1992) and the help-seeking response differs by racial and ethnic factors (Goldston, Davis, Whitbeck, Murakami, Zayas, & Nagayama, 2008). When a death by suicide does take place, schools are encouraged to provide factual and truthful information to faculty, students, and staff.

Crisis planning and implementation

Schools systems often have a crisis plan in place, but the plan may or may not directly address suicide or specify a course of action, given the seriousness of the event. In a study with 1,200 educators conducted by Speaker and Petersen (2000), 20 percent of respondents reported active suicide prevention plans in place at their school, leaving 80 percent without a plan in place. Mr. Terry Talbott, a principal with 34-years of experience in a K-12 educational system explained “We had safety plans for natural disasters, and plans for notifying authorities if an intruder entered the building, but not a plan for addressing that crisis resulting from a student suicide.” Many school systems do not draft suicide prevention or postvention plans or policies in advance of youth crises. As a result, when a youth suicide occurs and school resources are unorganized, personnel are unsure of their role in this crisis intervention and everyone is placed in a reactive position when a timely response is critical (Jordan & McIntosh, 2011; Juhnke, Granello, & Granello, 2011). In the absence of a plan that is practiced and documented, personnel are ill-equipped to respond to the suicide event in a compassionate manner to effectively serve student survivors of the loss.

The issue of coping with problems as they arise is not a new phenomenon for school officials; even under the best of circumstances, potential student problems are not easily anticipated. However, the growing rate of media attention, prevalence of youth suicide, and schools as a natural partner in prevention should inform administrators that planning at the “early stages before crisis conditions develop is the best remedy for the administrator” (Gorton & Alston, 2012, p. 206). Some schools are reluctant to seek help when a death by suicide of a currently enrolled student takes place or when the tragedy is linked to recent alumni; as a result, the incident is not properly disclosed to other

students or the general community until the facts are revealed (Pirkis, Blood, Beautrais, Burgess, & Skehan, 2007).

Unfortunately, some schools are reactive rather than proactive, while postvention is the best prevention for subsequent suicides, postvention generally requires a loss of life to draw attention. Schools also fail to plan based on the common assumption that youth will disclose thoughts or actions about intended suicide self-harm to parents or caregivers; however, research indicates that youth keep these emotions suppressed and it may be a more distant self-other relationship (such as a teacher, coach, counselor, nurse, or classmate) that identifies potentially risky behaviors (Miller & McConaughy, 2005). Since youth spend a large amount of time in the school environment, many feel connected to their schools, believe teachers care about them, and develop positive student relationships which can reduce suicidal behaviors. Conversely, given the amount of time spent at school, youth may communicate their desire to die by suicide to several people in the school environment. When personnel and peers are not trained to detect risk factors, warning signs and appropriate intervention skills suicidal youth go undetected and without intervention (Capuzzi, 2009; Granello & Granello, 2007).

There are many tools available for school professionals to evaluate programs when determining the type of policy, extent of training, and level of community capacity building that should be given to suicide crisis planning. The examples provided in Table 1 are not exhaustive, but will provide a basis for school procedural implementation, assessment, and discussion. A sample school-based postvention checklist is also provided (Table 2). School systems that ignore suicide prevention and postvention as a component of student success open themselves for potential litigation. School officials should be informed of legal obligations resulting from failure to plan and respond to youth suicide crises (Bartlett & Talbott, 2011; Berman, Jobes, and Silverman, 2006; Capuzzi, 2009). Table 3 provides a sample notification letter to proactively inform parents and to serve as evidence if litigation is pursued. It is just one of various forms available for school system consideration.

Schools with active crisis plans should take pride in their proactive efforts and publish them, select and train a crisis team that includes diverse faculty, staff, and school board members (King, 2001; New Hampshire National Alliance for Mental Illness, 2011) and make sure the plan is realistic should there be the need to execute it. The time between the death, release of information (within 24 hours of the suicide), and subsequent deterioration of peer emotional responses is a short and crucial window (King, 2001). As part of planning in advance, specific crisis response duties should be pre-assigned to personnel (such as media correspondence, communications dissemination with students, faculty and parents, and response from community mental health professionals) and the school must take time to identify natural partners, such as law enforcement, mental health professionals, media outlets, medical examiner, police, and clergy (Maples, Packman, Abney, Daugherty, Casey, & Pirtle, 2005; New Hampshire National Alliance for Mental Illness, 2011; Stack, 2003).

Enough emphasis cannot be placed on the importance of training school personnel to respond appropriately to suicide symptomology, to the school's crisis plan, and to intervene as needed (Roberts, Lepkowski, & Davidson, 1998; King, 2001). Should a death by suicide occur, teachers should announce the occurrence of the death during the first class meeting of the day and share with students that counseling services are available (Goldney & Berman, 1996). It is suggested that school personnel monitor the victim's classes and the school's emotional climate for several days to a week or weeks after the suicide for purposes of evaluating changes in peer behavior related to the

death (King, 2001). During the days immediately following a death by suicide, students, faculty (Poland, 1995), and staff should be made aware of designated discussion rooms in the building where counseling is available, if that is the case. Both individual and group counseling options should be provided to increase survivor comfort level and to best accommodate emotional needs and wishes regarding privacy. Specifically, school personnel should be cognizant that survivor-siblings attending the same school system may be in need of tailored assistance when coping with a loss of this magnitude. When approaching a sibling or other close youth, it is important to reduce psychological pain when intervening to prevent further suicidal behaviors (Miller & Eckert, 2009).

Inappropriate school responses

Even with the best of intentions and a crisis plan in place, well-intended school officials that are not trained mental health professionals need support during this time of stress and tragedy. Schools are dissuaded from discussing or releasing facts related to the topic of suicide or the death by suicide at a mass school assembly or over the intercom for fear of perpetuating suicide contagion, as previously discussed. For much the same reason, school officials should not allow for cancellation of regularly scheduled activities so that students may attend the planned funeral service. Schools should also dissuade perhaps well-intended others from authoring a memorial in the school yearbook or from dedicating a bench or tree as a reminder of the decedent, and refrain from allowing graduation speeches that reintroduce the incident. These activities are not advised as they may evoke emotional responses that are unpredictable and frame suicide as a positive option. Rather, the school should work toward communicating the message that other options to resolve emotional problems exist. This encourages other youth who may already be contemplating suicide to reconsider that choice (Capuzzi, 2009; Juhnke, Granello & Granello, 2011).

Survivor communication

The school plan should include verifying the facts of the death from several sources, such as law enforcement or, in some cases, the parents, family, or legal guardian of the deceased. Schools administrators are encouraged to contact the family in a concerned and conservative manner with the intent to apprise them of the school's intervention efforts, identify close friends of the decedent that are potentially at risk for suicide, and offer to assist with funeral arrangements. Initial contact between school officials and the family begins the process of community resource infusion and is perhaps the first time a family in crisis will learn about community mental health and other resources available to them. Therefore, well-prepared school personnel can engage the bereaved in active postvention methods and perhaps link them to early survivor support for positive self-care (Bartlett & Daughhetee, 2009; Chapman, 2007; McIntosh, 2003).

School community collaboration

There are many community entities that can serve as helpful resources to the school, family members, and other survivors. Partnerships and contacts with community resources such as law enforcement should take place as part of the school's comprehensive crisis intervention planning process. For example, school officials may want to communicate with the local medical examiner about the facts of the death by suicide; while this information may be necessary to decrease speculation about a recent death, the facts may point to gaps in the school crisis plan and serve as a learning tool (Juhnke, Granello & Granello, 2011). A proactive school system should have a pre-determined list of community mental health providers; those providers should be notified that

survivors will be referred to them by the school for support services. The lack of connection between the local school system and community mental health resources may delay response time of perhaps the most critical starting point to the healing process. Further, in the postvention planning process, school leadership is advised to include community mental health providers and organizations to collaborate as partners. An ideal outcome is for those counselors who are not part of the suicide loss to respond and support students and school personnel who are affected by the loss (SPRC, 2011).

School relations with media

In crisis situations, it is critical that schools be proactive in their communication, including having a plan in place. After the occurrence of death by suicide, rumors of the event may become exaggerated and spiral out of control; as a result, it is imperative that accurate postvention information be accessible. A systematic and cautious approach that provides for dissemination of information related to suicide is ideal. Information distributed should not glorify the behavior, but be provided in a kind and caring way.

A significant point to emphasize with media and parents is that no one thing or person is to blame for the suicide event and that help is available; rather, the cause of suicide is considered to be multifactorial by experts. There is no one event (such as a break up, a defeat, etc.) that causes suicide; suicidality is caused by neurological, biological, cognitive, contextual, emotional, and other factors. In light of the fact that school personnel are often intimidated when interfacing with media, it is recommended that school leadership prepare information such as email messages, blogs, news releases, and parent letters in advance for inclusion in the postvention plan. Media releases should include these four key elements: (1) general facts regarding the suicide incident, (2) that the crisis incident is over, and if true, that safety has been restored, (3) messaging that does not glamorize the event, and (4) where students should go for class or counseling (Juhnke, Granello & Granello, 2011). As mentioned previously, one person should serve as the primary point of contact for all media inquiries; school personnel need to know who the school media representative is and direct all media requests for information to the designee specified in the postvention plan (Heath & Sheen, 2005). This process will reduce reported misinformation, preserve school integrity, and protect the privacy of the decedent's family. There are many resources for schools related to interaction with the media including guidelines that the American Foundation for Suicide Prevention and the American Association of Suicidology have developed and post on their websites for school leaders.

Conclusion

Suicide is an act that school systems must be prepared for and respond to. In the wake of a youth suicide, postvention resources and programs should support the needs of students to grieve and display emotion, as well as address issues related to suicide contagion early in the process. Good postvention can be the best prevention in that collective effort; postvention may detect and deter the onset of subsequent survivor or cluster suicides. Having a postvention plan of action ready to implement may facilitate the healthy adaptation of youth, families, and communities to suicide loss and serve to prevent suicides. It is important to note that a comprehensive school-based effort will include ongoing preventive, interventive, and tertiary training and evaluation for faculty, staff, administrators, and the community—all of whom are impacted by the loss of a youth to suicide. Intuitively, postvention makes sense; however, no known systematic evaluation of postvention processes or procedures to respond to deaths by suicide in schools, organizations, or community

settings exist. Given the paucity of research school-based postvention effectiveness further investigation is necessary.

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U.S. Department of Veterans Affairs. *How to talk to 4 to 8 year old teen about suicide attempt in your family.* Retrieved November 25, 2011a from:http://www.mirecc.va.gov/visn19/VISN_19_education.asp

U.S. Department of Veterans Affairs. *How to talk to a 9 to 13 year old teen about suicide attempt in your family.* Retrieved November 25, 2011b from:http://www.mirecc.va.gov/visn19/VISN_19_education.asp

U.S. Department of Veterans Affairs. *How to talk to a 14-18 year old teen about suicide attempt in your family.* Retrieved November 25, 2011c from:http://www.mirecc.va.gov/visn19/VISN_19_education.asp

Table 1: Postvention Resources

School Resources

After a Suicide: A Toolkit for Schools (SPRC/AFSP): www.sprc.org/afterasuicideforschools.asp

Archived: Research to Practice webinar: Responding After a Suicide: Best Practices for Schools (SPRC): www.sprc.org/traininginstitute/disc_series/index.asp

Mental Health America of Wisconsin: Components of School-Based Prevention, Intervention, and Postvention Model: www.mhawisconsin.org/schoolbasedmodel.aspx

'Postvention' category in SPRC online Library: www.library.sprc.org/browse.php?catid=40

School Suicide Postvention Accreditation Program (AAS): www.suicidology.org/web/guest/certification-programs/school-professionals

School Safety and Crisis Resources (NASP): www.nasponline.org/resources/crisis_safety/index.aspx

List-servers and Chat Addresses

1000 Deaths	www.1000deaths.com/lists.html
Survivor Support	www/afsp.org/support/support.html

Meeting of Hearts	www.meetingofhearts.com
Bereaved by Suicide	www.bereavedbysuicide.com
Suicide Survivors Organization	www.suicidesurvivors.org
Alliance of Hope for Suicide Survivors	www.forsuicidesurvivors.com
Survivors of Suicide	www.survivorsofsuicide.com
Surivors Road2 Healing	www.road2healing.com
Sibling Survivors	www.siblingsurvivors.com
Parents of Survivors	http://www.pos-ffos.com/

Table 2: Checklist for Components of a School Suicide Postvention Program

Consider checking off the following components that are currently in place in your school system, and take notice of the components that might need to be implemented.

Currently, does your school (or district):

1. _____**Contact the police, coroner's office, or local hospital to verify the death and get the facts?**

It is essential that the suicide be officially confirmed before the postvention protocol is implemented. A determination of suicide mU.S.t be made by a medical examiner or coroner.

2. _____**Inform the school superintendent & administrators of schools where siblings are enrolled?**

Does the school have a process or routine to coordinate and track this process? Does the school have a documentation process for this?

3. _____**Contact the family of the deceased student to express condolences?**

Does the school outline applicable guidelines for confidentiality in this situation? Does the school have a process for who to confer with prior to making this call (e.g. FERPA/HIPPA coordinator, etc.)?

4. _____**Notify and activate the school's crisis response team?**

Does the school use a telephone tree or other approach that allows for direct communication with the crisis response team?

5. _____**Schedule a time and place to notify faculty members and staff?**

Does the school set up a meeting before the start of the school day, if possible? Does the school prepare school staff for possible student reactions? Does the school include support staff (kitchen

staff, bus drivers, custodians, substitute teachers)? Does the school allow time for staff to ask questions and express feelings? Does the school remind staff of the possibility of contagion? Does the school ask staff to identify concern about individual students?

6. _____**Activate procedures for responding to the media?**

Does the school announce how media representatives will be interacted with? Does the school remind staff members not to the press, spread rumors, or repeat stories? Are all inquires directed to the designated spokesperson?

7. _____**Contact community support services, local mental health agencies, other school counselors, and clergy to arrange for crisis intervention assistance?**

Is the school prepared to identify and refer students who are most likely to be at high risk because of their close physical and emotional contact with the deceased student?

8. _____**Announce the death to students through a prearranged system?**

Does the school make the announcement in person and in small groups or in classroom settings?

9. _____**Use caution in allowing students to leave school unattended?**

Does the school make every effort to maintain a routine schedule? Does the school use a reliable system to track student presence and location?

10. _____**Provide written information for parents/guardians as soon as possible so they can be prepared and available to provide support for their children?**

Does the notification include information about how the school is responding to the crisis and resources available to them for specific concerns?

11. _____**Have crisis teams available in the deceased student's classes?**

Do teams follow the deceased student's schedule to observe reactions of students and to follow up as necessary?

12. _____**Establish support stations and counseling rooms and publicize their availability for students?**

Does the school document who attends and the time of attendance so that follow up may be provided?

13. _____**Make sure administrators and staff are visible in hallways and during lunch to monitor students and provide a calming presence for the school?**

Does the school identify which staff and administrators will coordinate and complete this task? Does the school give guidance on how those who complete this task will collaborate, exchange and document their efforts?

14. _____**Provide secretaries or others who answer phones with a prepared script to field telephone calls or answer inquiries from people who show up at school?**

Does the school train the staff in this process? How is this process tracked? How are concerns that secretaries have about inquiries communicated to school administrators or other appropriate staff and personnel?

15. _____**Use a prearranged strategy to monitor and assist students who may be at increased risk for suicide?**

Does the school provide additional support serves and education about suicide bereavement? Does the school follow up with students identified at increased risk? Does the school make sure all students have access to suicide hotline numbers? Does the school give special attention to student sin peer groups, friends, teams, romantic partners, and others who may be at higher risk?

16. _____**Conduct daily debriefing with faculty and staff during the initial crisis and postvention periods?**

In the event of a student suicide, is there a plan in place for how the system or district will respond to the other students, school personnel, media, and community at large?

17. _____**Reschedule any immediate stressful academic exercises or tests, but try to stay with the general school schedule as much as possible?**

Does the school keep the facility open and follow regular school routines to the greatest extent possible? Does the school convey the message that while we all grieve, life must go on?

18. _____**_ Provide information about the funeral to students and parents?**

Does the school work with family and ask, if possible, if the funeral can be held after school hours? If this is not possible, does the school allow the students to attend the funeral with parental permission and announce the policy regarding school absences for funeral attendance?

19. _____**Offer ongoing grief counseling for students and staff?**

Does the school train staff on this kind of counseling activity? Does the school bring in professionals from the community to assist? Does the school have a list of community resources to give students and staff to obtain support outside of school hours?

20. _____**Follow up with students identified as at risk, and maintain follow up for as long as possible?**

Does the school have a process on how to share and collaborate in this circumstance? Who will decide when this process is complete (e.g. the students are no longer at risk)? Does the school have a documentation process?

21. _____**Carefully monitor memorial activities or events?**

Does the school select commemorative activities so as to avoid glamorizing the event?

22. _____**Follow prearranged protocol for emptying the student's locker and returning personal items to the family?**

In the event of a student suicide, is there a plan in place for how the system or district will respond to the other students, school personnel, media, and community at large?

23. _____**Determine how diplomas, athletic letters, and other awards will be given posthumously?**

Has the school confirmed the process through the school system?

24. _____**Provide support for the crisis response team members?**

Does the school evaluate the needs of the crisis response team? How are decisions made regarding what supports may be needed, how to implement them, pay for them, etc.? Who facilitates and coordinates this process?

25. _____**Document activities as dictated by school protocols?**

Does the school have written protocols regarding what needs to be documented? By whom? Who the information is shared with? How the information is stored or integrated into the continual development of the postvention protocol?

Adapted from: Juhnke, G. A., Granello, D. H., & Granello, P. F. (2011). *Suicide, self-injury, and violence in the schools: Assessment, Prevention, and intervention strategies.* Hoboken, NJ: John Wiley & Sons.

Table 3: Sample Suicide Risk Notification and Agreement Form

_____

Name of the student (or person) who may be at risk for suicide

I acknowledge that the school employee who has signed this form has told me that he or she believes that the individual listed above may be at risk for suicide. I understand that this belief is based on specific information regarding this individual. I further understand that this employee is not in a position to make a determination as to whether the individual listed above is at risk for suicide.

I agree to care for the individual listed above until he or she can be evaluated by a qualified professional to determine whether the individual is at risk. I will share the evaluation results with the school administration or designee. I further agree to ensure that the individual listed above is provided the mental health care he or she needs after the evaluation is completed, and based on the recommendations of the evaluator.

I understand that if an emergency arises, I should take the individual listed above to a hospital emergency room for emergency mental health treatment.

_____

Printed Name of Parent or Guardian of Student (or Person)

_____ _____

Signature of Parent or Guardian of Student (or Person) Date

_____

Printed Name of School Employee

_____ _____

Signature of School Employee Date

_____

Printed Name of School Employee Witness

_____ _____

Signature of School Employee Witness Date

Source: Modified by Mary L. Bartlett, LPC, PhD. with permission, from original form developed by Theodore P. Remley, Jr., JD, PhD., Old Dominion University, Norfolk, Virginia.

Patrick's Story – The Aftermath of a Suicide in a Young Adult

Sue G. Matthews, Vice President, ASPARC

On Sunday, December 17, 2006, I lost my son, Patrick, to suicide. He was only thirty-two years old. His death completely shattered my world. After the numbness of my grief began to wear off and the guilt and reality started setting in, I even found myself contemplating my own suicide. It took almost two years after his death before I was able to wake up in the morning without dreading another day without him.

In the United States over 35,000 people take their own lives. There are at least six people affected by this tragic loss, and many of those survivors .also become at risk for suicide. Of course I was not the only one affected by his death. Our family is very small, but even in our small family he left his sister, his aunts and uncles, his father, his girlfriend, and uncountable friends.

I shouldn't have been shocked by Patrick's death because, like so many others who have taken their own lives, Patrick had been struggling to overcome a debilitating depression for years. He had even made several attempts before completing the final act. But shocked I was. Somehow each time he had always pulled himself out of the depths of despair, and I really thought he would finally overcome his depression and ultimately his addiction to drugs. He wanted so badly to be what he referred to as "normal." I even dared to hope that one day someone might find a miraculous drug or therapy that would give my son back to me.

That was not to be, however. On that Sunday afternoon in December, I was startled by a knock on my front door. Immediately I knew it had to be bad news when I opened the door and saw the policeman standing on my front porch. What a job to have. It was already dark outside, and he was standing in the shadows as he said, "Ms. Matthews, did you know that your son was incarcerated in the Birmingham City Jail?" I nodded, and he said, "I am so sorry to inform you, the coroner pronounced him dead at 11:47 this morning."

I remember getting very hot and then very cold. I remember crying out loud and then freezing up inside. It was as if my whole life was ending at that moment in time. I couldn't seem to comprehend, and then suddenly, without any warning, I felt my whole body start to shiver.

It was of course December 17, 2006, and with that simple knock on my front door, my first life ended, and I crossed over that fragile threshold into my second life. I didn't know it at that moment, but my son's death was to change my life forever. In the moment that the policeman told me that my son was dead, I forgot how to breathe. I was in a nightmare, but I knew I was still awake. At first I thought I knew how he had died, but then I wondered if he could have been murdered. Could he have had a heart attack? I must have imagined a dozen scenarios before I heard the policeman tell me it was an apparent suicide.

Later I found out that Patrick had been despondent all morning and actually voiced to the nurse that he was in pain and "that he was just going to die in here." The nurse told him that she couldn't help him, and a short time later he hung himself from a window frame with his own bed sheet. I had asked that he be put on suicide watch when he was arrested a week earlier, but I found out much later that the psychiatrist who had evaluated him determined that "he was not a threat to himself or others." In her report to the court she stated that she did not recommend he be put on suicide watch.

After the policeman left, I sat down in my chair and tried calling my family. None of my family lives in the state of Alabama, and to make everything worse I couldn't get in touch with anyone. Never have I felt so alone. Finally my brother in law answered the telephone. I must not have been coherent, because I remember him calling out to my sister, "It's your sister, and something bad must have happened." When I hung up the telephone after talking with my sister, I tried calling Patrick's girl friend again, and this time she answered too. She just kept screaming over and over again, "No, it's not true. Please tell me it's not true."

I had been able to stay in control long enough to make those telephone calls, but after I talked to my sister and Patrick's girl friend everything around me became a blur. I continued to function, but I wasn't inside my physical body any longer. I was a stranger watching myself from the sidelines. I don't remember how long it took for someone to get to my house. I honestly don't even remember waiting for someone to get there, because my own body defenses kicked in, and a welcoming numbness finally started to settle over me. Gradually time just stood still.

I was later told that people talked to me, and that I answered, but all those words of comfort and concern just blended together and became a part of the haze that step by step had already started to envelope me. I know people came to my house both before and after the funeral, and I know I talked to them, but I remember little, if any, of our conversations. Some of my friends reminded me of some of those conversations we had; others reminded me that we walked in my garden. I don't remember any of it. I don't remember eating or sleeping or bathing or even getting dressed. All I could understand was that my worst nightmare had finally come true. My precious son was dead, and there was nothing I could do to change that fact.

That feeling is not a feeling that can be described to anyone. It is a feeling only those who have lost a loved one to suicide can even begin to imagine. I know that any death will change your perspective on life, but now I know that a death by suicide is an unbelievably traumatic event that keeps surfacing and re-surfacing in your mind all day and all night. It is completely inescapable and unanswerable.

An article I read later on suicide postvention by Dr. Tyler Woods, accurately describes this feeling. He says, "People who lose someone to suicide tend to have greater psycho-social vulnerabilities that can cause complications in the grieving process. Complicated grief differs than a non complicated grief. The symptoms can include, extreme focus on the loss and reminders of the loved one, problems accepting the death, detachment, and an unusual preoccupation with sorrow and bitterness about the loss."

Along with all that pain were all of my memories and guilt about his death. The one that I could not get out of my head was the last time I saw my son alive. He and his girl friend were living day to day in an old run down hotel. After five years of being clean, he had started abusing drugs again. He was

skeletally thin, his clothes reeked of stale cigarette smoke, and his face was scruffy because he hadn't shaved in several days. I remember his weary eyes the most. They were troubled, but clear. I believe I said, "You look awful, please get some help." I don't even remember if I told him I loved him. I didn't get out of the car, so I know I didn't hug him.

Each night after his death, when I would finally fall asleep, I would wake up, only minutes later, in tears, because I was always dreaming about the last time I saw him. He was standing in front of the hotel parking lot and watching me drive off. I was seeing him in my rear view mirror, his right hand raised in the air. He was waving at me, and he kept waving until I could no longer see him in my mirror. He is always waving at me as if he knew he was telling me good bye forever.

After Patrick's funeral, the numbness began to subside a little, but the pain and disbelief that moved in with me were unbearable. After a couple of weeks the initial shock of his death began to wear off, but as it did some strong emotions started to rise to the surface. Along with the obvious feelings of despair came the guilt and the anger. Two months later, I was still barely able to get out of bed on some days. The normal process of waking up and getting dressed for work every morning had become a complicated task.

My employees must have thought I resembled a walking zombie as I tried to go about my everyday tasks. I am still baffled that I was able to process my thoughts while I was at work every day, because some of those days I was just a sleepwalker wandering around in a thick fog. My once confident mind was unraveling and becoming entangled in the loose threads of my soul. I was afraid I would trip and never be able to get up again.

There were times when I unexpectedly lost my train of thought in the middle of a sentence, and several times I posted bills that didn't include any checks. Any form of creativity literally came to a halt, and sometimes I would burst into uncontrollable tears when one of my clients or co workers told me they were sorry. Many of them knew Patrick because he had worked at my retail store only a few years before. Now that several years have passed, I believe it was a miracle that I was able to continue to run my small design business as well as I did during those seemingly endless weeks of grief. I guess some mechanical instinct automatically kicked in, because somehow I kept moving forward.

About four months after Patrick's death, when I thought I was over the hardest part, I was suddenly slammed with extreme negative feelings and complete despair. Those feelings of utter hopelessness would plow into me without warning at any time, day or night. I secretly began wishing for my own death, and nothing, absolutely nothing, made me happy anymore. Unfortunately by this time, most of my family and friends probably thought I was getting better. What a mistake, because when you are numb and your body is in shut down mode, you are naturally protected. When the reality starts setting in, every little problem becomes an overwhelming obstacle.

By this time I was beginning to realize that my son was really gone, the numbness had finally worn off, and reality was starting to seep into my brain. I was now fully aware of that ultimate finality, and it was forcing me to live with my own intolerable pain. Patrick was really never coming back. I was never going to see him again or hear his voice again or share that funny story with him. My son was really gone forever.

Almost immediately after Patrick's death I started reading anything I could find about suicide. At the end of one those books I found a listing for the Crisis Center and their survivor of suicide support group. Shortly after I started attending the support group, I realized that almost everyone in the group was also reading books about suicide too. I am not sure why, but somehow it validates and normalizes the death as well as helps us to better understand the "whys." I know now that attending that group was one of the best things I did for myself after Patrick's death.

I also started seeing a grief counselor twice a week. I was now living alone, Patrick was gone, my family lived in other states, and my friendship base had been declining for years, mainly because I was afraid to let anyone see how disturbing my everyday life had become. The year before Patrick died he had relapsed so badly that he was living on the streets periodically and self medicating himself with a combination of Methadone, Xanax, and cold and allergy medication. Because he had wrecked his car and lost his license, he started camping out in the woods just down the street from the Methadone Clinic in order to get his dose every morning. I don't like to think where he got the money to pay for his doses. And I still don't understand a medical facility that continues to give daily highly addictive medications to an adult who is obviously on the verge of a psychological breakdown.

Sometimes when he came to my house he would literally fall into a coma-like state, so deep that I couldn't wake him up. When I could physically put him in my car I took him to emergency rooms to try to get help for him, but he no longer had health insurance, so the visits usually resulted in his being released with nothing accomplished. It had become a no end situation for both of us.

In one of my first sessions with the counselor, she encouraged me to keep a journal. Every morning and every afternoon I started putting my thoughts on paper. It was one of the ways I was able to let go of the aching grief and painful memories that were always building inside of me. That journal, along with caring grief counseling, the survivor of suicide loss support group, the love and support from my family and close friends, and my own determination helped get me through the most difficult time I have experienced in my entire life.

Looking back at my journal now I can see that on some days I sounded somewhat positive and optimistic that I would be able to work through my grief. Then the next day I had lost all that optimism and was ready to give up. Through the survivors of suicide loss group, I discovered that so many survivors seem to express these same feelings. Unfortunately we often discount our own feelings, because our grief seems so foreign to us. Some of us have experienced loss before, but loss from suicide seems so unnecessary and completely unexplainable. We can't comprehend what has happened, and we certainly can't make sense of it. We also begin to question our own grief process and wonder if we are the only ones experiencing these thoughts.

It doesn't help us to hear unthinkable comments or watch the alarmed reactions from those who either have not experienced a death by suicide, or just don't understand it. Sometimes these remarks actually add to our pain and make us feel even more confused. Too often well meaning individuals offer words of torture such as, "It was God's will," or, "I know how you feel," or even, "Maybe it was for the best." There are also many remarks from some of those people with religious back grounds that can't seem to help talking about suicide as a sin and wondering whether your loved one is now living in Hell.

One of the comments that no one who is suffering such a raw and painful grief wants to hear either is that "time heals." No, time doesn't heal, but I have found that time does soften the edges that are so painfully sharp at the beginning. I also know that time can't be rushed. Don't think that the process of grieving is something you can do for a little while and then just be finished. If you do, you are only kidding yourself. It is a long slow process. Everyone is unique, and everyone works through it on their own time table. I think it helps, however, to know that you aren't the only one who has had to go through this painful grieving, and there are other people out there who can help you through it. You just have to open up to the process and be willing to let them help you.

Along with the pain of losing your loved one by suicide, there is the guilt and anger that a survivor of suicide loss faces every day. If you are not careful this guilt and anger will overtake you and become all consuming. I did have a great support system, but I think because I was journaling, I realized about midway through my first year of grieving that my journal entries were full of despair and guilt, especially when I wrote at the end of the day.

I think it is so important to remember to be open to what eases your own pain, if only for a moment, and remember to give yourself a break. Let that guilt and anger go for a minute and breathe. That moment in time that changed your life forever has passed, but you are still here. Even though you may think no one else could have possibly experienced such pain, you aren't the only one who has suffered in this way, and unfortunately you won't be the last. At first you can't imagine it, but one day there will be a day when your experience will help someone else ease through their own pain.

About a year after Patrick's death my grief was compounded when I opened a box in his bedroom and discovered several journals that he had written only a few years before he died. As I began to read, I noticed some alarming similarities in his entries and in my own journal entries. We both seemed to be coping pretty well one day, and then the next day falling apart. Both of us were suffering from the pressure of anxiety and from an irreplaceable and catastrophic loss. Patrick had lost his best friend to suicide only a few years before some of these entries. The future seemed intolerable when we were in that deep despair. By now I was aware that this state of mind is sometimes called depression and can be linked to the first symptoms of suicide.

I noticed that here and there Patrick actually touched on a little humor, but for the most part, his were the writings of a very depressed, unhappy, and angry young man. My own entries persisted in wishing that I were with him and the worry that I couldn't live the rest of my life without him or with my grief. Those entries were very real for me for a long time after his death.

Early in my grief (February 11, 2007) I wrote in my journal:

"Shock, denial, guilt, disbelief, confusion, emptiness, loneliness, sadness, restlessness, panic, anger and fear are only some of the emotions I am experiencing. I am no longer in shock. I am able to get through each day, although I cry every single day. I know he is dead. I just stare at all of his pictures as if I could will him back to me, as if I could make sense of something, a note or a sign. Then I realize again that I will never know. I feel constant guilt for letting him be by himself too long. I feel restless. I am afraid to be by myself, especially on Sundays, the day he died. Sometimes I panic, and I think I can never work through all of this grief. I can't seem to stop worrying about someone or something else dying. My biggest fear is that I can't learn to live with this grief for the rest of my life."

Since Patrick's entries were so compelling to me, I decided to try to write a book and share some of his journal entries with my own entries. By now I had come to believe that there was no one single incident that could have changed his fate; it was a combination of events that led up to that final act. I reasoned that by sharing his journal entries, they might alert another parent to some of the warning signs of depression and substance abuse and possibly save a life as well as save another parent from experience such an agonizing grief.

During my journey through that wilderness of grief, I continued to spend every day for almost two years after Patrick's death asking myself the "what if question." What if I had done something differently, would my son have been here today? Then one afternoon I came home from work to find an ambulance, three police cars, and the "glaring yellow crime tape" around the home of my next door neighbor. His son, Patrick's friend, had also killed himself, and suddenly the shock forced me to ask myself another question. "What if I had tried to help someone else, could I have made a difference?"

David, Patrick's friend, was also dead, and I had been right here all the time. He had talked to me about Patrick's death and how much he missed his mother who had died only a few years earlier. He had helped me carry pea gravel and bales of pine straw to my back yard only a few months ago. He had always waved at me from his car when we were both leaving for work at the same time each morning, and I didn't even realize he was possibly contemplating taking his own life all that time.

I believe it was the shock of losing my next door neighbor and the role I was thrown into as a friend to his family after his death that propelled me in the direction that I have taken since the death of Patrick. One of the many passages I have read about the process of grieving urges us to tell the story, share and keep sharing the life that has passed. That story can also be a gift to others. By sharing the life that has passed, and our own story of how we got through it and how it affected us, it will contribute to our own healing, it says, and maybe help someone else in the process.

Back in the early stages of my grief, one of my clients sent me a book called "Healing After Loss," by Martha Whitmore Hickman. I received it only a few weeks after Patrick's death, but for almost two years I read a passage from that book every morning before I started my day. As soon as I learned about David's death, I bought that same book to give David's father. I also wrote the number of the Crisis Center's Survivors of Suicide Group in the front of the book as well as the counselor's name that had helped me work through my own loss. I don't know if it helped him because he moved away from our neighborhood soon after his son's death, but in a way it helped me. I cannot even count how many of those books I have given to others who have lost a loved one.

Two years after Patrick's death I facilitated my own survivors of suicide loss support group, and during some of my research I discovered the following list. It was compiled as a means of grief support for survivors of suicide.

- Suicide is an unpredictable event. Mental health professionals do the best they can to recognize and deal with suicide indicators given the complexity of a suicide event. There is no predictable "profile" of a person who will take their own life. Suicide risk factors and thinking are present in many individuals with depression who do not take suicidal actions.

- Studies show that patients frequently deny any suicidal ideation, intent or plan before taking action to end their lives. In some cases, those who die by suicide, appear especially functional and engaged with life before they kill themselves.

- Although there are some warning signs for suicide and intervention usually works people with a high intent to die, usually do not tell others they are thinking about suicide. They hide the information from treatment providers and family, friends and colleagues. Occasionally, family and friends are surprised to learn that someone who had been deeply depressed but getting better dies by suicide. Experts theorize that only on the way up did they have the psychic energy to take their life.

- Every suicide is a unique story. Suicide is an act which is determined by a complex interaction of many factors including, but not limited to: family history of suicide, psychiatric illness such as depression, resilience, substance use, physical illness and chronic pain, hopelessness, high anxiety and agitation, life crises, access to means, and willingness to secure professional treatment.

I do know that at some point in my journey I started moving forward, and I believe it was a combination of so many things I experienced during that journey that helped me arrive at that point. It was toward the end of my second year of grief that I realized I had reached that turning point. One day, almost by accident, I discovered that I was actually beginning to accept his death, and I was ready to help others.

At first I didn't even realize I was beginning to change. My first real step was to talk to a classroom about my son's death and to answer their questions. I also began to volunteer to help at the Out of the Darkness Walk that is held each year in our city. This walk is a fund raiser hosted by the American Foundation for Suicide Prevention. Thousands of people nationwide walk to raise money that is used for vital research and education programs to prevent suicide and save lives, increase national awareness about depression and suicide and assist survivors of suicide loss.

Once I started speaking out about suicide, I found that so many people I met along the way had lost a loved one to suicide in their own families. Many of them said that they hadn't discussed it openly partly because of the stigma associated with a suicide and partly because their families just didn't want to talk about it. Some of them, like me, wanted to talk about it and make a difference.

I now believe that one of the first ways suicide postvention can help adults cope with this complicated grief is education. Stress debriefing helps people understand and deal with their trauma in the first days after the suicide. Although I am sure the policeman who came to my door on that December day was concerned, I believe that if he had been educated about complicated grief he could have reduced the anxiety and stress that his news was to bring me in the days ahead. Even a simple pamphlet listing the emotions that a survivor will experience as well as contact information about support groups in the community would have given me a better way to process my grief when the numbness finally wore off and the reality set in.

Funeral homes might also be another place for pamphlets about grief. I know that I had to do all of the research myself to find help in the days after my son's death, and from talking to others who have lost a loved one to suicide, they had to do the same thing.

It has now been five and a half years since Patrick's death, and I still miss him every day. We planted a dog wood tree in my back yard in December of 2001, a few months after he had gotten out of the drug rehabilitation clinic. I had tagged that twig in the woods the spring before, and we both laughed as he dug the hole for it in the freezing cold. He said it would never live, but I told him that someday that tree would be taller than both of us and that it was a new beginning.

Every year thereafter we watched it grow, and gradually it was covered in white blossoms. It is now much taller than either of us, and even though I have to enjoy those white blossoms by myself now, it is a memory that makes me smile.

Every time I pass that tree in my yard I can see his face and hear his laughter, and although I wish he were still here with me to watch it grow, blossom and then turn brilliant red in the fall, I am so thankful I have thirty two years of beautiful memories of my son.

Early in my grief on Sunday, February 11, 2007, I wrote this poem. It still resonates in my mind and gives me comfort four and a half years after his death. I titled it "Memories."

I hear his voice sometimes.

I see his face everywhere.

He is in the birds in the trees.

He is in the clouds and the rainbows.

He is in the grocery store.

He is in my car.

He is in my dreams.

He will always be there.

I will never be without him.

He will always be in my memories.

The End

APPENDICES

Appendix A

RIGHTS OF SUICIDAL INDIVIDUALS

Adapted from source: Survivors of Loved Ones' Suicides, Inc. (SOLOS)

1. ***Suicidal individuals have the right to have any expression of intent taken very seriously by those to whom they have communicated.*** Those at risk often make a "cry for help." This should be regarded as a sincere request for aid.

2. ***Suicidal individuals have the right to have their suicidal risk viewed as their most serious problem. There is not a problem more serious.*** Those at risk may have other problems, which may be related to their suicidality. However, once the potential for suicide is determined, it must take precedence until it is abated.

3. ***Suicidal individuals have the right to be seen as wanting to be helped. They want their pain to end. They do not want to die.*** Those at risk are often ambivalent about living or dying because they may equate living with pain and dying with freedom from pain. Intervene on the side of life.

4. ***Suicidal individuals have the right to have their condition brought to the attention of someone in their life who cares for them.*** Family members and friends are available and easily mobilized. Moreover they stand to be irrevocably harmed if a suicide occurs. Let them help.

5. ***Suicidal individuals have the right to know that they are experiencing a chemical deficiency in their bodies brought on by stress and/or mental illness.*** Those at risk have a deteriorating sense of self-esteem and control. They must know that they are not causing what is happening in their bodies.

6. ***Suicidal individuals have the right to know that medications are available which present viable means for stabilizing their situation.*** Those at risk must have early access to antidepressants and other drugs, which may take time to reach clinical effectiveness.

7. ***Suicidal individuals have the right to acknowledgment of their pain, which may be physical, psychological, or emotional in origin.*** Those at risk have severe stress and psychological pain. Ask about their pain, and help to ameliorate it.

8. ***Suicidal individuals have the right to meaningful intervention by those responsible for their care when they are manifesting critical symptoms.*** Those at risk cannot help themselves because of the process of debilitation that they are experiencing. At some point they can only be helped by others.

9. Finally, ***suicidal individuals have the right to pursue treatment for their illness without stigma and fear of financial hardship due to lack of parity between mental and physical health coverage.***

Appendix B

THE SUICIDE PARADIGM

Adapted from Survivors of Loved Ones' Suicides, Inc. (SOLOS)

Suicide is the outcome of neurobiological breakdown. The process begins in severe stress and pain generated by a serious life crisis. These increase as the crisis, or the individual's perception of it, worsens. Feelings of control and self-esteem deteriorate.

Suicidality occurs when the stress induces pain so unbearable that death is seen as the only relief. Suicidality entails changes in brain chemistry and physiology. Suicidal individual manifest various chemical imbalances.

As one becomes suicidal, he or she is no longer capable of choice. Suicidality is a state of total pain which, coupled with neurological impairment, limits the perceived options to either enduring (suffering through) or ending utter agony.

The study of suicide and the treatment of suicidal individuals involve a shared paradigm. New insights are laying the groundwork for a new paradigm which entails a change in how we see suicide.

OLD PARADIGM

a. Suicide: Killing of oneself

b. Goal: End life

c. It is seen as an event or a behavior.

d. Viewed as a decision and a personal choice.

e. Viewed as a means of control or manipulation.

f. Seen as a voluntary action and individual responsibility.

g. The individual is seen as a decision-maker.

h. Thought to be a phenomenon involving the mind.

i. Etiology: Emotional disorder, personality disorder, poor coping skills

NEW PARADIGM

a. Penacide: Killing the pain.

b. Goal: End pain and suffering.

c. It is seen as a process of debilitation.

d. Viewed as a disease outcome; no choice involved beyond crisis point in the process of debilitation.

e. Viewed as the result of severe stress and psychological pain.

f. Seen as an involuntary response.

g. The individual is seen as a victim.

h. Thought to be a physiological or neurobiological phenomenon involving the brain.

i. Etiology: A biochemical deficiency created or aggravated by pain

Appendix C

MYTHS AND FACTS ABOUT SUICIDE

MYTH 1
A person who talks about committing suicide won't actually do it.

FACT 1
About 80% of persons who commit suicide express their intentions to one and often more than one person.

MYTH 2
Suicide usually occurs without warning.

FACT 2
A person planning suicide usually gives clues about his or her intentions.

MYTH 3
A suicidal person fully intends to dies.

FACT 3
Most suicidal people feel ambivalent toward death and arrange an attempted suicide in the hope that someone will intervene.

MYTH 4
If a person attempts suicide once, he or she remains at constant risk for suicide throughout life.

FACT 4
Suicidal intentions are often limited to a specific period of time, especially if help is sought and received. Help can be effective.

MYTH 5
If a person shows improvement after a suicidal crisis, the risk has passed.

FACT 5
Most suicides occur within three months or so after the onset of improvement, when the person has the energy to act on intentions.

MYTH 6
Suicide occurs most often among the very rich and the very poor.

FACT 6
Suicide occurs in equal proportions among persons of all socioeconomic levels.

MYTH 7
Families can pass on a predisposition to suicidal behavior.

FACT 7
Suicide is not an inherited trait, but an individual characteristic resulting from a combination of variables. One variable may be that another family member has died by suicide.

MYTH 8
All suicidal persons are mentally ill, and only a psychotic person will commit suicide.

FACT 8
Studies of hundreds of suicide notes indicate that suicidal persons are not necessarily mentally ill.

Source: The Crisis Center, Birmingham, AL

Appendix D

MYTHS ABOUT SUICIDE AS INTERPRETED BY JOINER

Adapted from *Myths about Suicide* by Thomas Joiner

Suicide's an easy escape, one that cowards use
Truth: It's not so easy; most attempts at suicide fail. The self-preservation instinct is very strong. The body can resist many forms of self-injury. Some murderers have reported a desire to kill self, but killed others as an easier alternative.

Suicide is an act of aggression, anger, or revenge
Truth: Can be true, but isn't always—or even often. Rage and desire for revenge can be a risk factor. Majority of angry people don't suicide, and…majority of suicides are not angry.

Suicide is selfish, a way to show excess self-love
Truth: Suicidal thinking is often based on the belief that one's social connections are ruptured. Those who die by suicide often feel that the act is an expression of selflessness. There is not increased incidence of suicide in those felt to be selfish by family or friends.

Suicide is a form of self-mastery
Truth: Idea stems from the phenomenon of suicidal people wanting to retain the means as a "last resort." But a "last resort" implies the anti-suicidal retention of other, non-suicidal options.

People who die by suicide don't make future plans
Truth: When the irrevocable act leading to suicide is taken, nearly all survivors report immediate regret. For many, the suicide is part of future plans for those whom the person imagines he or she burdens**.** Evidence suggests that desire to live and desire to die is present in those who die by suicide.

People often die by suicide on a whim.
Truth: Common in literature; almost never in real life. Secretive planning and preparation can make a suicide seem impulsive when in fact it is not. Most survivors of suicide attempts report thoughts of suicide long prior to the attempt.

You can tell who will die by suicide by their appearance
Truth: Warning signs do exist, but generally involves a dramatic change in appearance, hygiene, etc. Paradoxically, some take better care of their appearance after the decision to suicide is made. Some lifestyle choices that may lead to suicide may also lead to an unkempt appearance.

You'd have to be out of your mind to die by suicide
Truth: Translation: "Suicide is foreign to my thinking." But it may not be foreign to others' thinking. Attempting suicide is not itself indicative of psychosis, dementia, or mental illness. But certainly can be an indicator of disturbance.

Mary Bartlett summarized this from Joiner, T. (2010). *Myths about suicide*. Boston, MA: Harvard University Press.

Appendix E

SUICIDE RISK ASSESSMENT

Source: The American Association of Suicidology website (www.suicidology.org)

The identified caller/client is:

____ The suicidal person him or herself

____ Someone concerned about a suicidal person (check boxes below that apply to the suicidal person in question)

Primary Risk Factors (High Risk if ANY ONE factor is present = consider seeking consultation)

____ Recent suicide attempt (last 6 months) with lethal methods (firearms, hanging, strangulation, jumping from high places, or any other lethal method).

____ Recent suicide attempt (last 6 months) resulting in moderate to severe wound or harm.

____ Recent suicide attempt (last 6 months) with low rescue-ability (no known communicationregarding the attempt, discovery of chosen location and timing, no one nearby or in contact, active precaution to prevent discovery)

____ Recent suicide attempt (last 6 months) with subsequent expressed regret that it was not completed AND continued expressed desire to complete suicide

____ Stated intent to complete suicide imminently.

____ Stated intent to complete suicide with a lethal method selected and readily available.

____ Stated intent to complete suicide AND preparations made for death (writing a will or a suicide note, giving away possessions, making certain business or insurance arrangements).

____ Stated intent to complete suicide with time and place planned AND foreseeable opportunity to complete suicide.

____ Stated intent to complete suicide without ambivalence OR with inability to see alternatives to suicide.

____ State intent to complete suicide with current active psychosis.

____ Stated intent to complete suicide with major affective disorder, schizophrenia, or recent alcohol abuse.

____ Stated intent to complete suicide during the week after hospital admission or the month immediately after discharge.

____ Presence of active command hallucinations to kill self whether or not there is expressed intent.

Secondary Risk Factors (Consider seeking consultation if SIX OR MORE factors are present)

The following factors all significantly contribute to suicide risk but are of a less critical nature.

____ Recent separation or divorce

____ Recent death of significant other

____ Recent loss or severe financial setback

____ Other significant loss/stress/life changes

____ Social isolation/poor social supports

____ Current or past chemical dependency/abuse

____ Persistent long-standing insomnia

____ History of suicide attempt(s) or aborted attempts without actual harm

____ Current or past difficulties with impulse control or antisocial behavior

____ Significant depression, especially accompanied by guilt, worthlessness, or helplessness

____ Rigidity (difficulty adapting to life changes)

____ History of sexual abuse

____ Pattern of failures in previous therapy

____ Conflict / confusion over sexual orientation

____ More than one psychiatric hospitalization

___ Expressed hopelessness

___ History of family suicide (or recent suicide by close friend)

Major Contributing Demographics Factors

___ Male

___ Single, divorced, separated or widowed

___ Living alone

___ Elderly

Assessment of Risk - Use your clinical judgment to rate the level of risk (check only one)

___ High Risk (risk factors are severe, suicidal person needs to be contained to ensure safety)

___ Moderate Risk (suicidal person has enough risk factors with enough severity to merit special precautions including supervisory review)

___ Low Risk (suicidal person can be treated in a community setting; risk factors do not suggest imminent risk).

Appendix F

I. RISK FACTORS FOR SUICIDE AND SUICIDAL BEHAVIORS

CHRONIC RISK FACTORS (If present, these increase risk over one's lifetime.)

PERPETUATING RISK FACTORS - permanent and non-modifiable
• Demographics: White, American Indian, Male, Older Age (review current rates 1), Separation or Divorce, Early Widowhood
• History of suicide attempts - especially if repeated • Prior suicide ideation
• History of self-harm behavior
• History of suicide or suicidal behavior in family
• Parental history of: o violence o substance abuse (drugs or alcohol) o hospitalization for major psychiatric disorder o divorce
• History of Trauma or Abuse (physical or sexual) • History of psychiatric hospitalization • History of Frequent Mobility • History of violent behaviors • History of impulsive / reckless behaviors
PREDISPOSING AND POTENTIALLY MODIFIABLE RISK FACTORS
• Major Axis I psychiatric disorder, especially: o mood disorder, o anxiety disorder o schizophrenia o substance use disorder (alcohol abuse or drug abuse / dependence) o Eating disorders o body dysmorphic disorder o Conduct disorder
• Axis II Personality Disorder especially if cluster B
• Axis III Medical disorder especially if involves function impairment and/or chronic pain) • Traumatic brain injury
• Co-morbidity of Axis I disorders (especially depression and alcohol misuse), of Axis I and Axis II (especially if Axis II disorder is Antisocial PD or Borderline PD), of Axis I and Axis III Disorders
• Low Self-esteem/High self-hate
• Tolerant/Accepting Attitude toward suicide
• Exposure to another's death by suicide
• Lack of self or familial acceptance of sexual orientation
• Smoking
• Perfectionism (especially in context of depression)
[1] Available from http://webapp.cdc.gov/sasweb/ncipc/mortrate.html

Source: Source: The American Association of Suicidology website (www.suicidology.org)

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Appendix G

II. RISK FACTORS FOR SUICIDE AND SUICIDAL BEHAVIORS

Contributory Risk Factors
• Firearm ownership or easy accessibility • Acute or enduring unemployment • Stress (job, marriage, school, relationship...)

<u>ACUTE RISK FACTORS</u> (If present, these increase risk in the near-term)

• Demographics: Recently divorced or separated with feelings of victimization or rage
• Suicide ideation (threatened, communicated, planned or prepared for)
• Current self-harm behavior
• Recent suicide attempt
• Excessive or increased use of substances (alcohol or drugs)
• Psychological pain (acute distress in response to loss, defeat, rejection, etc.)
• Recent discharge from psychiatric hospitalization
• Anger, rage, seeking revenge • Aggressive behavior
• Withdrawal from usual activities, supports, interests, school or work, isolation (e.g., lives alone)
• Anhedonia • Anxiety, panic • Agitation • Insomnia • Persistent nightmares • Suspiciousness, paranoia (ideas of persecution or reference) • Severe feelings of confusion or disorganization • Command hallucinations urging suicide • Intense affect states (e.g. desperation, intolerable aloneness, self-hate...) • Dramatic mood changes
• Hopelessness, poor problem-solving, cognitive constriction (thinking in black and white terms, not able to see gray areas, alternatives...), rumination, few reasons for living, inability to imagine possibly positive future events
• Perceived burdensomeness • Recent diagnosis of terminal condition
• Feeling trapped, like there is no way out (other than death); poor problem-solving
• Sense of purposelessness or Loss of meaning; No reasons for living
• negative or mixed attitude toward help-receiving • Negative or mixed attitude by potential caregiver to individual
• Recklessness or excessive risk-taking behavior, especially if out of character or seemingly without thinking of consequences, tendency toward impulsivity
PRECIPITATING OR TRIGGERING STIMULI (HEIGHTEN PERIOD OF RISK IF VULNERABLE TO SUICIDE)
• Any real or anticipated event causing or threatening: ○ Shame, guilt, despair, humiliation, unacceptable loss of face or status

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- Legal problems (loss of freedom), financial problems, feelings of rejection/abandonment
- Recent exposure to another's suicide (of family, friend, acquaintance, or of celebrity through the media....)

Source: The American Association of Suicidology website (www.suicidology.org)

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Appendix H

QUICK AT-A-GLANCE SUICIDE RISK ASSESSMENT

Warning: *This risk assessment alone is not enough to formulate a clinical impression. Practitioners are advised to study all warning signs and predictors in context with patients and clients. This is designed to assist in the process of a complete and thorough assessment. You must assess for lethality, prior history of suicidality, recency of suicidality, current functioning, changes in behavior and mood, etc. Additionally, there are more formal validated suicide assessment protocols available from publishers, and one might seriously consider psychiatric evaluation from a qualified psychiatrist skilled in suicide risk assessment. Interventionists should always assess risk with more than one and only one measure.*

VARIABLE		**"LOW" RISK**	**"MODERATE" RISK**	**"HIGH" RISK**
Plan				
	Method	Pills, slash wrists	Drugs, alcohol, car wreck	Gun, hanging, jumping
	Specificity	Vague, no plan	Some specifics	Very specific-knows how, when, where
	Availability of means	Not available-will have to get	Available-has means close by	Has in hand or in progress
	When attempt is planned	48 hours or more	24 - 18 hours	Presently or in the next 24 hours
Chance of intervention		Others are present	Others are available or expected	No one nearby, alone, isolated
Intoxication		Has not been drinking	Limited use of alcohol (1-2 drinks)	Heavy drinking, combining with drugs, and/or evidence of intoxication
Degree of ambivalence		Readily acknowledges desire to live	Aware of some desire to live	Does not consciously acknowledge any ambivalence. Decision is made.
Acute vs. Chronic		Problems are chronic/chronic suicidal ideation		Sudden loss or traumatic precipitating event (Loss or trauma is defined by the client.)

Remember, **lethality** is not the same but is related to **reversibility**. One may ingest chemicals or suffocate with a sock, and yet take a long time to die, but irreversible damage may be done, thus rendering "life" and survival highly compromised or could result in death.
Source: The Crisis Center, Birmingham, AL
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Appendix I.1

SUICIDE SAFETY PLAN

Note to Mental Health Professionals regarding Safety Planning

A suicide safety plan is considered a standard of practice and should be developed in conjunction with a client when the individual is at risk for harm or intent to self-injure or intent to die. The following is a sample safety plan for a person who may be at risk for suicidal behaviors, along with a blank form for clinicians' use to customize with clients.

A safety plan is widely used and is an essential technique in many types of mental health service delivery settings, particularly in protecting victims from domestic violence. A suicide safety plan is predicated on advance planning in the event of emergent risk to self, and assists an at-risk person when a psychiatric, emotional or situational crisis may not allow for enough time to think clearly.

A safety plan is in direct contrast to a "no-harm 'contract'" or a "no-suicide 'contract'". The emphasis in a no-harm contract is on what the client should NOT DO; it provides little clarity on what a client can do to be safe. By contrast, a safety plan spells out clearly actions that a person at risk for self-harm CAN DO, developed jointly with a counselor, therapist, or interventionist. The key difference is intentionality and clarity about options to remain safe, to obtain safety, and to seek support when one's own self-functioning cannot prevail protectively enough. Because suicide safety planning is considered a standard of care, by contrast a no-harm contract is not and is therefore not likely to be viewed as a protection to legal liability. A clinician shoulders the burden for knowing suicide risk assessment and appropriate intervention techniques, including safety planning, and it unadvisable to place the burden of responsibility for risk protection on an at-risk person who may be psychiatrically unable to understand or intervene with oneself clearly.

There may be several components of a safety plan, uniquely customized to match the client's needs. These components are not limited to but may include several specific behavioral ideas developed with the client related to:

Means Restriction

One of the most important interventions in preventing suicide is the removal of means by which the individual may attempt suicide. It is advisable that means restriction be addressed routinely and comprehensively with all safety plans. Firearms are the most prevalently used method to die by suicide, and in certain cultures are widely available. Know what your client's intended means and method are and recommend appropriate means removal as a part of every safety plan.

Soothing distressful feelings

Examples: listen to upbeat music, take a bubble bath, play with my dog, go for a walk, knitting, work out at the gym, etc.

Self-care

Examples: Eat nutritionally, go to bed and wake up at regular hours, have healthy boundaries, practice assertiveness by....., take stress breaks, etc.

:

Obtaining family support

Examples: confide in a trusted family member about your depression, ask for specific help from a family member such as staying with him or her, talking each day, etc.

Responding to a crisis

Examples: Have your insurance paperwork together in a pre-determined place, list which hospital you prefer to be taken too, names and contact information of family members, names and contact information of physician(s) and therapists, names and contact information for crisis centers and community agencies, etc.

Resources and call centers as needed:

Examples: List of appropriate therapeutic call centers and chat rooms, crisis centers, community support groups and agencies, customized for the client's locale, etc.

Clinicians are advised to review and incorporate professional literature from the field for more information and to customize their formatting and development with their agencies. Barbara Stanley and Greg Brown provide another model of safety planning which may be found in their copyrighted materials and/or on the internet.

The U.S. military branches, wherein there is currently an alarming high rate of suicide related to but not limited to the Iraq and Afghanistan wars, have provisions for at least three sessions devoted solely to safety planning. These materials presented here developed by Harrington have been developed as a response to her understanding of the culture of mental health services as they exist in her state.

A sample safety plan is provided below, followed by a form that can be copied and used with clients if so desired.

Notes:

Gillian Murphy, Ph.D., Director of Standards, Training, and Practices: *...we would always use the term "safety plan" ...other terms ...* [crisis response plan or self-care plan] *are too vague and do not explicitly reference the fact that keeping the individual safe is the primary goal in developing a plan – vagueness is not good. In addition, we would never reference a "safety plan" without explicitly stating the avoidance of anything that resembles a "no harm contract" – so would attempt to eliminate any confusion at the outset.* (September 22, 2010).

This sample was developed in consultation with Dr. Gillian Murphy, Director of Standards, Training, and Practices of the National Suicide Prevention Lifeline, Dr. Madelyn Gould, Epidemiologist and suicide researcher/author with Columbia University, and Dr. David Jobes, researcher and author on suicide, Catholic University, in November, 2010.

Form developed by and copyrighted by Judith Harrington, Ph.D. harringtonjudith@bellsouth.net

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Appendix I.2

SAMPLE SAFETY PLAN FOR SUICIDAL RISK FOR NAME:_____

□ **Copy to client** □ **Copy with clinician**

If you are feeling vulnerable, it is advisable that you not be alone. Together with your counselor and your trusted friends or family, we want for you to have some plans for safe and soothing things you could do.

If you are feeling unable to get through a difficult time, then please call the Crisis Center (205-323-7777) or the suicide help line (800-273-TALK), call your doctor or go to the Emergency Room.

Safety Behaviors: List specific behavioral options that are most related to your needs in the event that you are feeling increasingly despondent and suicidal.

I will...(list specific behavior) *Examples* listed below: **Customize one with your client !**	Related to **Means Restriction**	Related to **Soothing Feelings**	Related to **Self-care**	Related to **Family Support**	Related to **Using Resources**	Related to **Crisis or Emergency support**
Gun and ammunition removed from house, car, truck, cabin, barn.	√					
Doctor doses prescriptions weekly	√					
Take my dog to play in the park		√				
Call a friend		√				
Eat three meals a day			√			
Avoid drinking caffeine or alcohol			√			
Avoid lonely times, go to my sister's				√		
Spend the night at my cousin's house				√		
Go to bipolar support group					√	
Call my sponsor, or go to a meeting					√	
Call local crisis center or NSPL 800-273-TALK (8255) or 800-SUICIDE						√
Go to my PCD, psychiatrist, ER						√

I agree that if things become difficult for me and I feel that I might hurt myself, I will first attempt to do the soothing things above, call my friends or family, and then, in necessary, call my counselor immediately at his/her phone number _____.

:

I, my counselor, or the Crisis Center can contact the following person for support or assistance:

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

If my counselor is not available,I will call my local crisis center or 800-273-TALK (8255)

:

Appendix I.3

SAFETY PLAN FOR SUICIDAL RISK FOR NAME:_____

□ **Copy to client** □ **Copy with clinician**

If you are feeling vulnerable, it is advisable that you not be alone. Together with your counselor and your trusted friends or family, we want for you to have some plans for safe and soothing things you could do.

If you are feeling unable to get through a difficult time, then please call the Crisis Center (205-323-7777) or the suicide help line (800-273-TALK), call your doctor or go to the Emergency Room.

Safety Behaviors: List specific behavioral options that are most related to your needs in the event that you are feeling increasingly despondent and suicidal.

I will...(list specific behavior) Customize behaviorally specific strategies with your client.	Related to **Means Restriction**	Related to **Soothing Feelings**	Related to **Self-care**	Related to **Family Support**	Related to **Using Resources**	Related to **Crisis or Emergency support**

I agree that if things become difficult for me and I feel that I might hurt myself, I will first attempt to do the soothing things above, call my friends or family, and then, in necessary, call my counselor immediately at his/her phone number _____.

I, my counselor, or the Crisis Center can contact the following person for support or assistance:

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____

:

Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

Name:_____
Relationship to you:_____
Phone numbers:_____

If my counselor is not available,I will call my local crisis center or 800-273-TALK (8255)

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Appendix J

SURVIVOR OF SUICIDE LOSS BILL OF RIGHTS

1. I have the right to be free of guilt.

2. I have the right not to feel responsible for the death by suicide.

3. I have the right to express my feelings and emotions, even if they do not seem acceptable, as long as they do not interfere with the rights of others.

4. I have the right to have my questions answered honestly by authorities and family members, if possible.

5. I have the right not to be deceived because others believe that they can spare me further grief.

6. I have the right to maintain a sense of hopefulness.

7. I have the right to peace and dignity.

8. I have the right to positive feelings about one I lost through suicide, regardless of events prior to or at the time of the untimely death.

9. I have the right to retain my individuality and not be judged because of this loss through suicide.

10. I have the right to seek counseling and support groups to enable me to explore my feelings honestly to further the acceptance process.

11. I have the right to reach acceptance about this loss and the complex factors leading up to it.

12. I have the right to a new beginning. I have the right to be.

Source: Jackson, J. (2003). SOS: A Handbook for Survivors of Suicide. Washington, D.C.: American Association of Suicidology.

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Appendix K

SUICIDE BEREAVEMENT GROUPS IN ALABAMA

CITY	MEETING TIMES	ADDRESS, PHONE, EMAIL	OTHER INFO
Alexander City Counties served: Tallapoosa, Clay, Chambers, Coosa, Elmore, Randolph, Macon, Lee	2nd Monday of each month, 6-8 pm	Lake Martin Family Therapy, LLC Karen Lewis, LCSW, LMFT 393 Green Street Alexander City, 35010 256-625-9514 Karen@lewisinc.net	**Charge**: No, Free **Newsletter**: No **Intake mtg required**: No
Birmingham / Jefferson County Counties served: Jefferson, Shelby, St. Clair, Blount, Walker, Central Alabama	1st & 3rd Thursdays of every month, 7:00-8:30 pm Some holidays affect the schedule, no meetings on 5th Thursdays	The Crisis Center 3600 8th Avenue South Birmingham 35222 205-323-7777 or Judith Harrington, Ph.D., LPC, LMFT at 205-226-2400 harringtonjudith@bellsouth.net	**Charge**: No, Free **Newsletter**: No **Intake mtg required:** yes, before 1st meeting, call to schedule
Decatur Counties served: Morgan, Lawrence and surrounding counties	3rd Thursday of each month	Hospice of the Valley Kristin Cox 256-350-5585 kgilchrist@hospiceofthevalley.net	**Charge**: No, Free **Newsletter**: No **Intake mtg required:**
Dothan	Monday evenings, 6:00 pm (except on "Monday Holidays)	Wiregrass Suicide Prevention Survivor Group, 148 East Main St., Dothan, AL 36301, wiregrasssuicideprevention@yahoo.com Contact: Rose Blakey 334-792-9814	**Charge**: **Newsletter**: **Intake mtg required:**
Headland	1st Sunday of each month, 2:00 pm	Living Waters Counseling 125 Henry County Road Sylvia Shepard 334-693-3380 lwcsos@yahoo.com	**Charge**: No, Free **Newsletter**: No **Intake mtg required:**
Huntsville Counties served: Northern Alabama	1st & 3d Mondays at 6:00 pm	Crisis Services of North Alabama Martha Bosworth, LCSW 256-716-4052, Ext. 106 Martha@csna.org	**Charge**: No, Free **Newsletter**: **Intake mtg required:**
Marion (Winfield, Guin, Gu-Win, Hamilton, Sulligent, Hackleburg, etc.)	1st & 3rd from 6 - 8 pm	Hilda Smith, certified grief worker, supportsurvivor@aol.com 205-495-1846	**Charge**: No, Free **Newsletter**: **Intake mtg required:**

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Mobile / Bay area	1st & 3rd Wednesdays	Call 251-431-5111 705 Oak Circle Drive E., Mobile, 36609 Contact: Jan Pressley	**Charge**: No, Free **Newsletter**: **Intake mtg required:**
Tuscaloosa Counties served: Tuscaloosa, Hale, Greene, Bibb, Pickens, Walker,west Alabama region	2nd & 4th Thursday of every month, 7-8:30 pm	Canterbury Chapel, Student Life Center 812 5th Avenue Mary Turner 205-247-5011 Sostuscaloosa@aol.com	**Charge**: No, Free **Newsletter**: No **Intake mtg required:**
Tuscumbia	2nd Tuesday of the month, 6:00-7:15 pm	The Healing Place Kay Parker 5604 Ricks Lane Tuscumbia 35674 256-383-7133 thehealingplace@bellsouth.net	**Charge**: No, Free **Newsletter**: No **Intake mtg required:** yes, before 1st meeting, call to schedule

Please contact Judith Harrington at harringtonjudith@bellsouth.net to make changes or updates to this list.

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Appendix L

SUICIDE PREVENTION, INTERVENTION, AND POSTVENTION WEBSITES, RESOURCES, AND CALL CENTERS

Current as of 7/25/2012. This document has been prepared and maintaind by Judith Harrington. Please send any additions or updates to harringtonjudith@bellsouth.net

L.1 GENERAL SUICIDE SITES AND ASSOCIATIONS

Alabama Department of Public Health Suicide Prevention Task Force (ASPTF) — www.adph.org\suicideprevention
The American Association of Suicidology — www.suicidology.org
The American Foundation for Suicide Prevention — www.afsp.org
The Suicide Prevention Advocacy Network — www.spanusa.org
The Suicide Awareness Voices of Education — www.save.org
Suicide & Mental Health Association International — www.suicideandmentalhealthassociationinternational.org
International Association for Suicide Prevention — www.iasp.info/
National Organization for People of Color Against Suicide — www.nopcas.com
Association for Death Education and Counseling — www.adec.org
National Suicide Prevention Lifeline — www.suicidpreventionlifeline.org
National Hotline: 1-800-273-TALK (8255)
The Suicide Prevention Resource Center — www.sprc.org
The Suicide Information & Education Collection (SIEC) — www.suicideinfo.ca
National Center for Suicide Prevention Training — www.ncspt.org
Suicide Prevention Center — www.suicidepreventioncenter.org
Preventing Suicide Network — www.preventingsuicide.com
Befrienders Worldwide / The Samaritans — www.befrienders.org
The Link Counseling Center (Atlanta) — www.thelink.org/
Suicide Prevention and Aftercare The National Resource Center at The Link Counseling Center
www.thelink.org/national_resource_center.htm
National Council for Suicide Prevention. — www.thelink.org/nrc_ncsp.htm
Yellow Ribbon International Suicide Prevention Program — www.yellowribbon.org/
Light for Life Foundation — www.lightforlifefoundation.org
Healing from Depression — www.healingfromdepression.com
Dr. Grohol's Suicide Helpline — www.psychcentral.com/helpme.htm
GrowthHouse — www.growthhouse.org/suicide.html
Metanoia (Change of Mind) — www.metanoia.org
Lifegard — www.Lifegard.tripod.com/ssfaqs.html
Suicide Prevention News and Comment
www.suicidepreventioncommunity.wordpress.com
S.A.F.E. Alternatives Self Abuse Finally Ends — www.selfinjury.com

L.2 YOUTH (SUICIDE SPECIFIC OR GENERAL MENTAL HEALTH)

The Jed Foundation — www.jedfoundation.org or www.ulifeline.org
The Jason Foundation — www.jasonfoundation.com
Screening for Mental Health Youth Programs — www.mentalhealthscreening.org/schools
For Kids Sake — www.forkidsake.net/

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Not My Kid www.notmykid.org
Youth Suicide School-Based Prevention Guide www.theguide.fmhi.usf.edu/
Youth Suicide Prevention Program www.yspp.org
Teen Screen TeenScreeninfo@childpsych.columbia.edu
Childhelp 1-800-4-A-CHILD www.childhelp.org
Teen Advice/Support www.teenhelp.org
Suicide.org: Teen and Youth Suicide www.suicide.org/teen-suicide-and-youth-suicide.html
Suicide Prevention Resource Center: Youth Suicide Basics www.sprc.org/suicide_prev_basics/youth.asp
National Youth Violence Prevention Resource Ctr www.safeyouth.org/scripts/facts/suicide.asp
Center for Disease Control & Prevention Youth Suicide www.cdc.gov/ncipc/dvp/suicide/youthsuicide.htm
The Prevention Researcher: Teen Suicide www.tpronline.org
National Association of Social Workers Adolescent Girls Shift Project www.socialworkers.org/practice/adolescent_health/shift/
Real Talk Youth Summit www.realtalkyouthsummit.com
American Academy of Child and Adolescent Psychiatry Teen Suicides & Symptoms www.aacap.org
For youth crisis response and grief information www.smhp.psych.ucla.edu/qf/p3003_01.htm
Find Youth Info www.findyouthinfo.gov

Awareness & Education Programs

Hazelden Lifelines Youth Suicide Prevention Curriculum www.hazelden.org/web/go/lifelines www.hazelden.org/web/public/onlinecommission_1.page
Signs of Suicide program www.signsofsuicide.org
Human Relations Media (curriculum, resources on school age wellness, including youth suicide prevention) www.hrmvideo.com
Well Aware Suicide Prevention www.wellawaresp.org/webinars.php
RESPONSE High School Based Suicide Prevention Awareness Program. www.columbiacare.org/Page.asp?NavID=99
Jennifer Claire Moore Foundation, Baldwin Cty, AL www.jennifermoorefoundation.com/

Gatekeeper Training

Living Works Applied Suicide Intervention Skills Training (ASIST) www.livingworks.net/AS.php
The QPR Institute www.qprinstitute.com/
The Connect Project for both adults and peers www.theconnectproject.org
Kognito Gatekeeper Training Simulations www.kognito.com

Screening Programs

Signs of Suicide program www.signsofsuicide.org
Teen Screen Center (Mental Health Screening for Youth), Columbia University www.teenscreen.org

Life Skills Training

American Indian Life Skills Development Curriculum www.ihs.gov/nonmedicalprograms/nspn/
Coping Skills www.coping.us
Reconnecting Youth www.reconnectingyouth.com/
Students Mastering Important Lifeskills Education (SMILE) www.smilelifework.org/

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DBT Self Help www.dbtselfhelp.com

Sites to Get Support from Others

To Write Love on her Arm www.twloha.com
Life Line Gallery Stories of Hope & Recover www.lifeline-gallery.org
Reach Out us.reachout.com
Shoutin out from the South blogspot www.shoutinoutfromthesouth.blogspot.com/

Bullying

Suicide Prevention Resource Center Brief on Bullying:

www.sprc.org/library/Suicide_Bullying_Issue_Brief.pdf
Best Practices in Bullying Prevention and Intervention Stopbullying.gov

www.stopbullying.gov/community/tip_sheets/best_practices.pdf Bullying and Youth Suicide: Breaking the Connection (NASP)

www.nasponline.org/resources/principals/Bullying_Suicide_Oct2011.pdf Understanding Bullying (CDC) www.cdc.gov/ViolencePrevention/pub/understanding_bullying.html
Blueprints for Violence Prevention www.colorado.edu/cspv/blueprints/
Beat Bullying www.beatbullying.org
Olweus Bulling Prevention Program www.olweus.org
Bullying.org www.bullying.org
Bullycide.com www.bullycide.org
Bully Police USA www.brendahigh.com
Bullypolice.com www.bullypolice.com
Jared Story www.JaredStory.com
Community United Against Violence Hotline (CUAV) www.cuav.org
Stop Bullying www.stopbullying.gov
Stop Bullying Now www.stopbullyingnow.com
Stop Bullying Now (US Dept. HHS) www.stopbullyingnow.hrsa.gov
Stop Bullying: Speak Up (Cartoon Network) www.stopbullyingspeakup.com
Stop Cyber-Bullying www.stopcyberbullying.org
Cyber Bullying www.cyberbullying.org
Cyberbullying Research Center www.cyberbullying.us
Bullying Information Center www.education.com/topic/school-**bullying**-teasing/
Netsmartz www.netsmartz.org
National Domestic Violence Hotline www.thehotline.org
GLSEN (Gay, Lesbian and Straight Education Network, 212-727-0135)
www.glsenlorg/bullying
Life Links Resources for Youth www.linksforteens.org
(LGBTQ, bullying, suicide)
Gay-Straight Alliance Network www.gsanetwork.org
The Matthew Shepard Foundation www.matthewshepard.org
Safe Schools Coalition www.safeschoolscoalition.org
Anti-Defamation League www.adl.org/combatbullying
Wired Safety www.wiredsafety.org
It Gets Better Project www.youtube.com/user/itgetsbetterproject
Make it Better www.makeitbetterproject.org/
Cyberbullying www.guardingkids.com
Youth Conflict Resolution Center www.youngmediators.org/

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L.3 GLBTQ RESOURCES

Youth Suicide Problems: Gay Bisexual Male Focus www.youth-suicide.com/gay-bisexual
GLSEN (Gay, Lesbian and Straight Education Network, 212-727-0135) www.glsenlorg/bullying
Life Links Resources for Youth (LGBTQ, bullying, suicide) www.linksforteens.org
Gay-Straight Alliance Network www.gsanetwork.org
Camp Ten Trees (206-288-9568) www.camptentrees.org
Campus Pride www.campuspride.org
Centerlink www.lgbtcenters.org
The Trevor Project www.thetrevorproject.org, OR www.trevorspace.org/
Free to Be Me www.freetobeme.com
Gay & Lesbian Medical Association (415-255-4547) www.glma.org
GYC: The Gay Youth Corner www.thegyc.com
LGBT Career Link www.lgbtcareerlink.com
QA: The Gay Teen & LGBT Youth Community www.queerattitude.com
LYRIC Spirituality Page www.lyric.org/resources/spirituality_resources.html
Transyouth www.transyouth.com
Youth OUTreach of LAMBDA www.lambda.org/youth
Youth Resource www.amplifyyourvoice.org/youthresource
The Matthew Shepard Foundation www.matthewshepard.org
National Youth Advocacy Coalition www.nyacyouth.org
American Civil Liberties Union www.aclu.org/lgbt-rights
Human Rights Campaign www.hrc.org
National Gay & Lesbian Task Force www.thetaskforce.org
Association of Gay & Lesbian Psychiatrists www.aglp.org
Brattleboro Retreat LGBT Program (recovery) www.brattlebororetreat.org
The Gay & Lesbian National Hotline www.glbtnationalhelpcenter.orgPride
Institute for LGBTQ addiction treatment www.pride-institute.com

L.4 MILITARY AND VETERANS

Army Suicide Prevention Program www.armyg1.army.mil/hr/suicide/default.asp
Department of Veterans Affairs www.mentalhealth.va.gov/
Suicide Prevention in the Military www.suicide.org/suicide-prevention-in-the-military.html
Real Warriors - Real Battles www.realwarriors.net/family/support/preventsuicide.php
Marine Corps Community Services www.usmc-mccs.org/suicideprevent/officertrng/index.cfm
Psych Central-Suicide & the Military www.psychcentral.com/lib/2011/suicide-and-the-military/all/1/
Military Homefront www.militaryhomefront.dod.mil/pls/psgprod/f?p=MHF:HOME1:0::::SID:20.40.500.585.0.0.0.0.0
Comprehensive Soldier Fitness Program www.csf.army.mil/
Make the Connection www.maketheconnection.net/
Defense Centers of Excellence www.dcoe.health.mil/
DoD/VA Suicide Outreach www.suicideoutreach.org/
After Deployment www.afterdeployment.org/
Veterans Crisis Line www.veteranscrisisline.net/, 1-800-273-8255 then Press 1; Text to 838255, online chat go to website

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Military One Source www.militaryonesource.mil/MOS/f?p=MOS:HOME:0::::
ACE: Army Suicide Prevention
dmna.ny.gov/**suicideprevention**/**ACE**InterventionProgram.ppt

L.5 GENERAL MENTAL HEALTH

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov key word search suicide
Man Therapy www.mantherapy.org
The American Psychological Association www.apa.org
The National Institute of Mental Health www.nimh.nih.gov
The National Mental Health Association www.nmha.org
The National Alliance for the Mentally Ill www.nami.org
Web MD www.webmd.com
University and College Mental Health www.ulifeline.org
Center for Disease Control and Prevention www.cdc.gov or www.cdc.gov/ncipc/dvp/suicide/youthsuicide.htm
The World Health Organization www.who.int
The Mayo Clinic
www.mayoclinic.com/health/suicide/MH00048
Internat'l Fndtn for Research & Edn on Depression www.ifred.org
General info on abuse, addiction, depression, etc. www.helpguide.orge
Link to locate Suicide Assessment Scales provides links to PDF files that can be downloaded at no cost and used with author permission. Links to contact authors provided.
www.neurotransmitter.net/suicidescales.html

L.6 GENERAL MEDICAL AND SAFETY

Emergency Nurses Association www.ena.org
International School Safety Association www.issa.nu
National Emergency Call Institute 911 Solutions www.neci911.com
The Public Safety Group 911 Dispatch Training www.publicsafetygroup.com
Law Enforcement Wellness Associates www.cophealth.com/
Health Begin directory www.healthbegin.com/mental-health.html
Health Resources www.healthecho.com/
National Domestic Violence Helpline www.ndvh.org 1-800-799-SAFE
Rape, Abuse & Incest National Network (RAINN) www.rainn.org 1-800-656-HOPE
National Eating Disorders Association www.nationaleatingdisorders.org 1-800-931-2237
National Association of Crisis Center Directors www.nascod.org

L.7 MEANS RESTRICTION

Harvard Injury Control Research Center www.meansmatter.org
www.hsph.harvard.edu/means-matter/index.html
Washington State Lok it Up http://depts.washington.edu/lokitup/
SPRC library.sprc.org/browse.php?catid=43

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Science Direct www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V5S-4FV9MM3-1&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&view=c&_searchStrId=1092714399&_rerunOrigin=google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=1b66dd3eb6e022a3a6a303a935d76564

Office of Mental Health New York www.omh.state.ny.us/omhweb/savinglives/volume2/means_rest.html

Virtual Boot Camp for Civilian Mental Health Professionals

www.coping.us/focusonthemilitary/virtualbootcampforcivilians.html

L.8 SUICIDE LOSS / BEREAVEMENT

- www.suicidesurvivors.org
- www.forsuicidesurvivors.com/
- www.heartbeatsurvivorsaftersuicide.org
- www.survivorsofsuicide.com
- www.road2healing.com
- www.siblingsurvivors.com
- www.parentsofsuicide.com
- www.pos-ffos.com Friends and Families of Suicides-
- www.suicideaftercare.org/links.html
- www.heartbeatsurvivorsaftersuicide.org
- www.thegiftofkeith.org
- www.Lifegard.tripod.com/ssfaqs.html
- www.tearsofacop.com
- Clinicians as Survivors Task Force mypage.iusb.edu/~jmcintos/therapists_mainpg.htm

L.9 NATIONAL POSITION PAPERS, MONOGRAPHS, BEST OR EVIDENCE BASED PRACTICES, ETC.

- The National Strategy for Suicide Prevention, www.mentalhealth.org/suicideprevention
- SAMHSA's *Guide to Evidence-Based Practices on the Web,* www.samhsa.gov/ebpwebguide;
- SAMHSA's *National Registry of Evidence-based Programs & Practices,* www.nrepp.samhsa.gov
- Center for Mental Health Services' (CMHS) *Evidence-based Practice Tool Kits,* www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/about.asp
- Model programs in the *President's New Freedom Commission on Mental Health Report,* www.mentalhealthcommission.gov/reports/reports.htm
- Practices in the Institute of Medicine's Report, *Reducing Suicide: A National Imperative,* www.nap.edu/books/0309083214/html
- U.S. Surgeon David Satcher's Call to Action, www.surgeongeneral.gov/library/calltoaction/ OR www.surgeongeneral.gov/library/mentalhealth/summary.html
- Adolescent Mental Health Checkups in Medicaid, www.teenscreen.org/policy-center

L.10 CALL CENTERS IN ALABAMA

- The Crisis Center, Central Alabama: www.crisiscenterbham.com
  205-323-7777,
  - Teen Link 205-328-LINK (5465) and online at www.crisiscenterbham.com
  - Kids' Help Line 205-328-KIDS (5437)
  - Senior Talk Line 205-328-TALK (8255)
- Huntsville, northern region: www.csna.org Crisis Line 256-716-1000 OR 1-800-691-8426

:

- Mobile, Gulf Coast, Family Counseling Center of Mobile, Inc. www.helplinemobile.org 251-431-5111 or 1-800-239-1117

L.11 CALL CENTERS - NATIONAL

- National Suicide Prevention Lifeline (SAMHSA-funded): 1-800-273-TALK (8255) 1-800-SUICIDE, www.suicide-helplines.org
- Crisis Hotline 1-800-442-HOPE (4673)

ELDERLY

- Elderly: 1-800-971-0016
- Friendship Line: 1-800-971-0016
  www.ioaging.org/services/cesp_suicide_prevention_help.html

YOUTH

- Youth: 1-800-252-TEEN
- ChildHelp: 1-800-4-A-CHILD
- National Runaway Switchboard, 1-800-231-6946, 1-800-RUNAWAY, 24 / 7 / 365
- Covenant House Nineline www.covenanthouse.org 1-800-999-9999
- Girls & Boys Town National Hotline: www.boystown.org 1-800-448-3000, 1-800-448-1833 tty
- National Graduate Student Crisis Line 1-877-GRAD-HLP (1-877-4723-457)
- Samariteens 1-800-252-TEENS (8336)
- Youth America Hotline (YAH!) 1-877-YOUTHLINE (1-877-968-8454)
- Youth Crisis Hotline 1-800-HIT-HOME (1-800-448-4663)

GLBTQ

- GLBT Teens: 1-800-4UTREVOR, 1-866-850-8078, www.thetrevorproject.org, www.trevorspace.org/
- The Gay & Lesbian National Hotline, 888-THE GLNH (888-843-4564),www.glbtnationalhelpcenter.org
- LYRIC Youth Talk Line, 800-246-PRIDE (77433), www.lyric.org
- Pride Institute for LGBTQ addiction treatment, 800-547-7433, www.pride-institute.com
- Community United Against Violence Hotline (CUAV), 415-333-HELP (4357), www.cuav.org
- Parents, Family and Friends of Lesbians & Gays (PFLAG) 202-467-8180, www.pflag.org
- National AIDS Information Line 800-CDC-INFO 24/7/365
- Youth Suicide Problems: Gay Bisexual Male Focus www.youth-suicide.com/gay-bisexual

VETERANS, MILITARY PERSONNEL

- Veterans Crisis Line www.veteranscrisisline.net/ 1-800-273-8255 Press 1 Text to 838255
  online chat go to website

GENERAL

- Poison Control Center: www.alapoisoncenter.org 1-800-222-1222 for emergencies**;** For Non-Emergencies, Administrative and Educational Information 1-800-462-0800
- National Domestic Violence Helpline: www.ndvh.org 1-800-799-SAFE
- Love is Respect, 866-331-9474, www.loveisrespect.org
- Rape, Abuse & Incest National Network (RAINN): www.rainn.org 1-800-656-HOPE
- National Eating Disorders Association: www.nationaleatingdisorders.org 1-800-931-2237

L.12 FOR SUICIDE RISK RELATED TO NATURAL OR HUMAN-MADE DISASTERS:

FOR RESIDENTS AFFECTED BY THE OIL SPILL:

http://oilspilldistress.samhsa.gov/oil-spill-distress-helpline a crisis line that is helping people cope with the oil spill as well as the recent hurricanes and flooding. 1-800-985-5990 This number soon

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(3/1/2012 and currently is in a soft launch period until then) will be a general disaster response number for any area in the country affected by a disaster (not only the oil spill).

Assessing and responding to mental health needs after a disaster

URL: http://www.sprc.org/grantees/pdf/2006/Crosby_Disaster.pdf
State/Tribal/Adolescents at Risk Suicide Prevention Grantee Technical Assistance Meeting. December 12–14, 2006, North Bethesda, MD. Discusses: definition of and types of disasters; psychological impact; and results from field investigations.
Show details

Research on the mental health consequences of disaster (Presentation)

URL: http://www.sprc.org/grantees/pdf/2006/Tuma.pdf
State/Tribal/Adolescents at Risk Suicide Prevention Grantee Technical Assistance Meeting. December 12–14, 2006, North Bethesda, MD. Considers the following aspects of the research on the mental health consequences of disaster: the reasons to study the effects of disasters and mass trauma; what has been studied; what has been learned; and implications for intervention.
Show details

Podcasts at CDC: Suicide [click on the link below, then search for "suicide" under Topic.]

URL: http://www2a.cdc.gov/podcasts/browse.asp
This collection includes the following podcasts: "Toxicology testing and results for suicide victims" (in English and Spanish); "Preventing suicide in young people" (in English and Spanish); "Coping with depression and thoughts of suicide after a disaster"; "Keeping schools safe from violence"; and "Traumatic events and suicide". To see the collection, choose "Suicide" in "By topic" browsing box.
Show details

A guide to managing stress in crisis response professions

URL: http://store.samhsa.gov/shin/content//SMA05-4113/SMA05-4113.pdf
This pocket guide focuses on general principles of stress management and offers strategies that can be incorporated into the daily routine of crisis response managers and workers. Includes sections on: understanding the stress cycle; managing stress before, during, and after an event; promoting a positive workplace environment; self-care for crisis response professionals; and references and recommended reading.
Show details

Mental Health Intervention in the Event of a Disaster

http://www.in.gov/fssa/dmha/files/Disastet_Mental_Health_Guide_9-2010.pdf

Disaster Preparedness & Recovery

http://store.samhsa.gov/facet/Professional-Research-Topics/term/Disaster-Preparedness-Recovery?headerForList

Pan American Health Organization Publications Catalog/Disasters and Humanitarian Assistance/Mental Health Includes:

- Practical guidelines for mental health in disaster situations (Spanish only)
- Stress Management in Disasters
- Mental Health Services in Disasters - Instructor´s Guide
- Mental Health Care in Disaster Situations (Slides)
- Mental Health Services in Disasters - Manual for Humanitarian Workers

http://www.disasterpublications.info/english/viewtopic.php?topic=saludmental

If you have a website or call center to add to this list,
please contact harringtonjudith@bellsouth.net. **Thank you.**

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Appendix M

SCHOOL-BASED PREVENTION RESOURCES FOR EDUCATORS, PARENTS, & YOUTH

Many adults maintain that suicide prevention in schools or other youth-focused settings will "give kids the idea to try suicide" and that the subject should be avoided so as to not "plant the seed" that suicide is an option. When viewed through the lens of suicide prevention as a public health initiative, however, there are many health education emphases designed especially for the young, such as no-smoking campaigns, prevention of sexually transmitted diseases, drug and alcohol abuse prevention, safe-driving initiatives, and bully response programs (Gould, 2010). Among the many authenticated professional organizations and federal departments, youth suicide prevention programs have the endorsement and recommendations from the American Medical Association, the American Academy of Pediatrics, National Institutes of Health, the National Association of Secondary School Principals, the U.S. Department of Education, the American School Counselors Association, to name a few (Gould, 2010). Gould identifies the goals of school-based suicide prevention to be 1) case-finding with referral and treatment, and 2) risk factor reduction and cites 30 evidence-based and best practice based programs in her training associated with Well Aware (www.wellawaresp.org/webinars.php).

There are five types of suicide prevention programs from which to select a school-based initiative. They include awareness/education curricula, screening programs, gatekeeper training for both adults and peer gatekeepers, and life skills training programs which can augment a youth's protective factors. The following chart itemizes some of the existing programs available for implementation.

There is a plethora of information, data, warning signs, intervention assistance, gatekeeper training, and curricula and programming resources accessible both on the internet and from advocacy and publishing houses. For a brief review of some of them including sites to learn more

about school-based programs, the list below is provided, both for educators and youths themselves.

See chart below.

SCHOOL BASED SUICIDE PREVENTION PROGRAMS				
Awareness & Education Curricula	**Screening Programs**	**Gatekeeper Training (Adults)**	**Gatekeeper Training (Peers)**	**Skills Training**
* Lifelines (Hazelden)	* Signs of Suicide, Signs of Self-Injury	* Lifelines (Hazelden)	**Sources of Strength Connecting Peers and Caring Adults	* American Indian Life Skills Development Curriculum
* Signs of Suicide, Signs of Self-Injury	500 Communities Turning Science into Service	QPR Gatekeeper Training for Suicide Prevention (Question, Persuade, Refer)		* Reconnecting Youth Prevention Program
RESPONSE High School Based Suicide Prevention Awareness Program***		Connect: It Takes a Community to Prevent Suicide (NAMI)		
		Living Works ASIST		
* Evidence-based ***Pending Evidence-based approval			**Best Practice	
For a list of strengths and weaknesses of each training approach with commentary about some of these programs, go to www.wellawaresp.org/webinars.php.				

And from the University of South Florida, www.www.theguide.fmhl.usf.edu, school personnel are encouraged to check their website for Suicide Prevention Programs, which lists a comprehensive set of resources obtained from Best Practices and Evidence-based Registries.

In Coombs, D., Harrington, J. **A.** & Talbott, L.L. (2010). Youth suicides in Alabama: A focus on gun safety. *Alabama State Association for Health, Physical Education, Recreation, and Dance Journal 31(1),*31-35.

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The Alabama Counseling Association Journal

An official publication of the Alabama Counseling Association, *The Alabama Counseling Association Journal* is an electronic journal published twice a year. A primary purpose is to communicate ideas and information which can help counselors in a variety of work settings implement their roles and develop the profession of counseling. *The Journal* may include thought-provoking articles, theoretical summaries, reports of research, and discussions of professional issues, summaries of presentations, reader reactions, and reviews of books or media. The ALCA Journal is located on the ALCA website (www.alabamacounseling.org).

Inquiries about *The Journal* should be directed to:

Dr. Ervin L. Wood

ALCA Executive Director

217 Daryle Street

Livingston, Alabama 35470

Telephone: (205) 652-1712 chip@alabamacounseling.org

MANUSCRIPTS: Practitioners, educators, and researchers in the fields of guidance, counseling, and development are encouraged to submit manuscripts. While priority will be given to ALCA members, counselors from other states and countries are valued contributors. Manuscripts, which conform to the Guidelines for Authors, must be submitted to the Editor:

Dr. Lawrence E. Tyson

The University of Alabama at Birmingham

(205) 975-2491 ltyson@uab.edu

EDITORIAL BOARD: *The ALCA Journal* Editorial Board consists of one representative from each division of The Alabama Counseling Association. Members serve three-year terms for which a rotation schedule has been established. The primary function of the Editorial Board is to assist in determining the content of publications. At least two members of the Editorial Board read each manuscript submitted to the publication through a blind review system. No honoraria or travel funds are provided for Editorial Board members. Editorial Board members and their respective divisions and terms are:

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Guidelines for Authors

The purpose of *The Alabama Counseling Association Journal* is to communicate ideas and information that can help counselors in a variety of work settings implement their counseling roles and develop the profession of counseling. A function of *The Journal* is to strengthen the common bond among counselors and to help maintain a mutual awareness of the roles, the problems, and the progress of the profession at its various levels. In this context, thought provoking articles, theoretical summaries, reports of research, descriptive techniques, summaries of presentations, discussions of professional issues, reader reactions, and reviews of books and media are highly recommended. Manuscripts that are theoretical, philosophical, or researched-oriented should contain discussion of the implications and /or practical applications. All manuscripts that contain data derived from human subjects and are submitted by individuals associated with a university or college, are required to obtain Institutional Review Board approval from their respective institution. Description of such approval will be stated in the Methodology section of the manuscript. Authors should ground their work with an appropriate review of the literature.

Review Process

Authors are asked to submit an electronic original copy in Microsoft Word. All manuscripts should be prepared according to the Publication Manual of the American Psychological Association (6th Edition) Manu- scripts that are not written in compliance with publication guidelines will be returned to the author with a general explanation of the deficiencies. Manuscripts that meet The ALCA Journal publication guidelines will be distributed to a minimum of two (2) members of the Editorial Board. The Editor will synthesize the reviewers‟ comments and inform the authors of both publication decisions and recommendations. Anonymity of authors and reviewers will be protected.

PROCEDURES TO BE FOLLOWED BY AUTHORS:

1. Manuscripts must be word processed on eight-and-one-half by eleven inch white paper with double spacing and one-inch margins

2. Authors should make every effort to submit a manuscript that contains no clues to the author's identity. Citations that may reveal the author's identity should be masked within the text and reference listing.

3. Author notes including current position, work address, telephone number, and email address should be included on a separate page. Other pages should exclude such affiliations.

4. Camera-ready tables or figures should be prepared and submitted on separate pages.

5. Recommended length of manuscripts is between 13 and 20 pages.

6. Authors should submit only original work that has not been published elsewhere and is not under review by another journal. Lengthy quotations (300-500 words) require written permission from the copyright holder for reproduction. Adaptation of figures and tables also requires reproduction approval. It is the author's responsibility to secure such permission and provide documentation to the ALCA Journal Editor upon acceptance for publication.

7. Protection of client and subject anonymity is the responsibility of authors. Identifying information should be avoided in description and discussion.

8. Authors should consult the APA Publications Manual (6th edition) for guidelines related to discriminatory language in regard to gender, sexual orientation, racial and ethnic identity, disability, and age.

9. Authors should consult the APA Publications Manual (6th edition) for guidelines regarding the format of the manuscript and matters of editorial style.

10. The terms counselor, counseling, and client are preferred, rather than their many synonyms.

11. Authors bear full responsibility for the accuracy of references, quotations, tables, figures, and other matters of editorial style.

12. The ALCA Journal expects authors to follow the Code of Ethics and Standards of Practice of the American Counseling Association (also adopted by the Alabama Counseling Association) related to

publication including authorship, concurrent submissions, and Institutional Review Board approval for studies involving human subjects.

PUBLICATION PROCEDURES:

Authors of accepted manuscripts will be asked to submit a final, electronic manuscript in Word format. All manuscripts accepted for publication will be edited and altered for clarity. No alterations that change the integrity of the article will be made without the primary author's permission. Authors whose manuscripts are accepted may be asked to review manuscripts subsequent to the publication of the article in The ALCA Journal.