SUICIDE,
CRY FOR HELP AND CRISIS INTERVENTION

Medical psychology seminar
Tamás Dömötör SZALAI
Semmelweis University, Institute of Behavioural Sciences
szalai.domotor@gmail.com
www.behsci.sote.hu
Crisis

- **Definition (Caplan, 1964):** occurring when individuals are confronted with problems that cannot be solved. These irresolvable issues result in an increase in tension, signs of anxiety, a subsequent state of emotional unrest, and an inability to function for extended periods.

- **James and Gilliland (2005):** events or situations perceived as intolerably difficult that exceed an individual’s available resources and coping mechanisms

**Several meanings:**

- A situation that has reached a critical phase
- Emotionally significant event or radical change of a person's life
- An unstable or crucial time or state of affairs in which a decisive change is impending, especially: one with the distinct possibility of a highly undesirable outcome
- Turning point for better or worse
- The decisive moment
Examples

- The following are examples of crises:
  - An accident (automobile or in home)
  - Death/loss of a loved one
  - Natural disaster
  - Physical illness (self or significant other)
  - Divorce/separation
  - Unemployment
  - Unexpected pregnancy
  - Financial difficulties
Characteristics of a crisis

Basic features:

- Emergency case – transitive diagnosis can be applied
- Occurrence is sudden and unexpected
- Threatening, frightening quality
- Uncertain, unpredictable outcome
- Has a compelling force
- The event precipitating the crisis is perceived as threatening.
- Apparent inability to modify or reduce the impact of stressful events.
- Increased fear, tension, and/or confusion.
- High level of subjective discomfort.
- A state of disequilibrium is followed by rapid transition to an active state of crisis
A crisis is distinguished from a trauma by timing and by how quickly it is resolved. Most crises develop into traumas; conversely, most traumas begin as crises.

Crises are temporary, usually with short span, no longer than a month, although the effects may become long-lasting. Trauma is longer.

Socioeconomic status, availability of emotional support, and the nature of the crisis will dictate how soon the individual can resolve it and resume regular functioning.
Types of crises

- **Accidental** *(Caplan, 1964)*
  - Negative life event, critical stressful experiences, traumas, losses

- **Epigenetic** = developmental / maturtional = psycho-social *(Erikson, 1965)*
  - A life-stage with increased vulnerability
  - At the change of life cycles (eg. 8 stages of Erikson)

- **Crisis matrix theory** *(Jacobson, 1969)*
  - The developmental and the accidental criseses occur together
  - Extremely dangerous situation -> risk for suicide
Practice

1. Recall an already solved crisis
2. Draw a picture about the crisis situation
   - Write down the causes and components
3. Draw down the solution stage on the other side of the page
   - What have helped, who have supported you, what were the consequences, what was renewed in your life and yourself?
4. Discuss it with a partner for 5-5 minutes
1. An initial rise in tension occurs in response to an event.

2. Increased tension disrupts daily living.

3. Unresolved tension results in depression.

4. Failure to resolve the crisis may result in a psychological breakdown.
1. Acute Phase

- Initial crisis reactions in response to a traumatic event usually encompass the physiological and psychological realm.

- Reactions include overwhelming anxiety, despair, hopelessness, guilt, intense fears, grief, confusion, panic, disorientation, numbness, shock, and a sense of disbelief.

- The victim may appear incoherent, disorganized, agitated, and volatile.

- Conversely, the victim may present as calm, subdued, withdrawn, and apathetic.
2. Outward Adjustment Phase

- For some people, the outward adjustment phase can begin within 24 hours of the trauma.
- They may then attempt to gain mastery by resuming external control through engaging in routine activities.
- However, this should not preclude the possibility that victims who outwardly appear to be “back to normal” may inwardly remain “deeply affected.”
- Other victims isolate themselves from sources of support; they may appear to have withdrawn from society completely.
- The tension and fluctuating reactions involved in this phase should be noted as an attempt to return to normal while still processing the trauma.
3. Integration Phase

- The victim attempts to make sense of what has happened.
- An important task of this phase is to resolve one’s sense of blame and guilt.
- Individuals who can recognize and identify the assumptions about their world and others that have changed because of the trauma develop a sense of integration sooner.
- Most importantly, clients should begin to make the changes necessary to minimize the recurrence of a crisis.
- Some clients will cycle and recycle through these phases as they attempt to come to terms with their trauma.
- There are also those clients who cycle through phases too quickly or even skip a phase altogether.
- It may come as no surprise to find these clients later overwhelmed.
Factors effecting the long-time recovery

- Frequent triggers may remind people of the traumatic event and/or their losses (e.g., living in a chronically violent area)
- A second assault occurs when the media reports the traumatic event, when court appearances are made, or when the anniversary of the event approaches
- Developmental factors, such as the victim’s age, will play a role in the recovery process. Younger children and the elderly may need a large amount of additional support
- Trauma history and the number of prior losses experienced will compound or intensify a person’s current reactions
- The availability of environmental support or lack of support will determine how the survivor experiences the traumatic event
Vin and Li Nguyen are recent immigrants to the United States. They reside in a small town along the Gulf Coast of Mississippi, where a number of other Vietnamese immigrants have settled. Like many members of the community, the Nguyens are learning to speak, read, and write English and are hoping to become naturalized citizens of the United States some day. After arriving in the United States, the Nguyens invested all of their money in an old shrimp boat in order to support themselves by selling their daily catch to local seafood processing facilities.

In 2005, the shrimp boat was heavily damaged, and the seafood processing facilities were destroyed by Hurricane Katrina. Subsequently, the Nguyens had no income for quite awhile. With limited income and no health insurance, they relied on the county department of public health for prenatal care when Li became pregnant. Li’s pregnancy progressed normally; however, her daughter was born with Spina Bifida.

As you read this chapter, try to conceptualize the Nguyens’ situation according to the crisis models presented.

Discussion Questions

- What incidents have occurred in the Nguyens’ lives that could be considered provoking stressor events?
- Beyond the provoking stressor events, are there additional stressors that the Nguyens must address?
- What resources are the Nguyens utilizing? What further information do you need to determine if the Nguyens are in crisis?
- What factors will predict the outcome for this family?
Crisis intervention

= Emergency psychological care aimed at assisting individuals in a crisis situation to restore equilibrium to their biopsychosocial functioning and to minimize the potential for psychological trauma.

☐ The goals of crisis intervention are different from the goals of other therapies.

☐ The priority is to increase stabilization.

☐ Crisis interventions can occur at the spur of the moment and in a variety of settings.

☐ In order to interrupt the downward spiral of maladaptive behavior and return the individual to their usual level of pre-crisis functioning
Elements of crisis intervention

Elements of Crisis Intervention

- Event or Situation (A)
- Perception (C)
- Resources (B)
- Degree of Stress (Low, High)
Gilliland’s Six-Step Model (2005)

1. Listening
   - defining the problem
   - ensuring client safety
   - providing support

2. Action
   - examining alternatives
   - making plans
   - obtaining commitment
Seven-Stage Model of Crisis Intervention (Roberts, 1990)

1. Plan and conduct a thorough biopsychosocial and crisis assessment. This also includes assessing suicidal and homicidal risk, need for medical attention, drug and alcohol use, and negative coping strategies. Assessing resilience and protective factors as well as family and other support networks is helpful.

2. Make psychological contact and establish rapport. By conveying respect and acceptance, the responder develops a solid therapeutic relationship with the client. Displaying a nonjudgmental attitude and neutrality are important in crisis work.

3. Examine and define the dimensions of the problem or crisis. Identifying any issues and challenges the client may have faced, especially the precipitant to the crisis, will provide valuable insight into the presenting problem.
Seven-Stage Model of Crisis Intervention (Roberts, 1990)

4. Encourage an exploration of feelings and emotions. This can be achieved by actively listening to the client and responding with encouraging statements. Reflection and paraphrasing can also help this process.

5. Explore past positive coping strategies and alternatives. Viewing the individual as a resourceful and resilient person with an array of potential resources and alternatives can help this process. Crisis workers should be creative and flexible in resolving crisis situations.

6. Implement the action plan. At this stage, identify supportive individuals and contact referral sources. The client should be able to implement some coping strategies.

7. Establish a follow-up plan. It is important to follow up with clients after the initial intervention to determine the client’s status and ensure that the crisis has been resolved.
Other interventions techniques

- Assist the patient to reexamine any feelings that might block adaptive coping & realize the potential for growth.
- Teach the patient that it is alright to ask for help, people who place high value on independence may have difficulty.
- Encourage adaptive coping methods such as expression of feelings, progressive relaxation, and physical exercise, as well as drinking warm milk or herbal tea to aid in relaxation & sleep.
- Assist the patient to focus on the problem & specific goals leading to its resolution.
- Another approach to care includes a crisis team – possibly consisting of a psychiatrist, nurse, psychologist, social worker, aide, minister & students.
- The disadvantage of this approach is a possible loss in continuity of care – which should be monitored closely.
Risk factors of suicide

Historical Factors

- Previous Suicide Attempts -> the highest predictive value
- Family History of Suicide Attempts.
- Self harm (12 self harm:1 suicide)
Risk factors of suicide

Health Factors

- **Mental health conditions.**
  - Depression (agitated depression)
  - Bipolar (manic-depressive) disorder.
  - Schizophrenia.
  - Borderline or antisocial personality disorder.
  - Conduct disorder.
  - Psychotic disorders, or psychotic symptoms in the context of any disorder
  - Anxiety disorder
  - > impulsivity, low mood, low control, suffering

- **Substance abuse disorders** -&gt; hidden problems, impulsive acts

- **Serious or chronic health condition or pain**
Risk factors of suicide

Environmental Factors

- „No weapon, no suicide”: access to Lethal Means including firearms and drugs.
- England: smaller package of paracetamol
- Exposure to another person’s suicide, or to graphic or sensationalized accounts of suicide (Goethhe: The sorrows of young Werther)
- Prolonged Stress Factors which may include harassment, bullying, relationship problems, and unemployment.
- Stressful Life Events which may include a death, divorce, or job loss.
- Isolatedness
- Culturally given pattern
Risk factors of suicide

Gender

- Women have more attempts
- Accomplished suicide rate is 4 times higher among men: in 2013, 77.9% were male and 22.1% were female.

SES

Age
The first step in preventing suicide is to identify and understand risk factors. The Department of Health and Human Services (1999) identifies the following as risk factors:

- Previous suicide attempt(s)
- History of mental disorders, particularly depression
- History of alcohol and substance abuse
- Family history of suicide
- Family history of child maltreatment
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)

- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health, substance abuse disorders, or suicidal thoughts
- Cultural and religious beliefs, for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide
- Isolation or a feeling of being disconnected from other people
### Single variable analysis conditional logistic regression of risk factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Controls $n = 195$ (%)</th>
<th>Cases $n = 127$ (%)</th>
<th>Odds ratio</th>
<th>95% CI</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical and personal history</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of violence</td>
<td>23 (12)</td>
<td>19 (15)</td>
<td>1.47</td>
<td>0.71, 3.02</td>
<td>0.30</td>
</tr>
<tr>
<td>History of problem drinking</td>
<td>50 (26)</td>
<td>34 (27)</td>
<td>1.02</td>
<td>0.60, 1.74</td>
<td>0.93</td>
</tr>
<tr>
<td>History of substance misuse</td>
<td>23 (12)</td>
<td>13 (10)</td>
<td>0.80</td>
<td>0.37, 1.72</td>
<td>0.56</td>
</tr>
<tr>
<td>Deliberate self harm</td>
<td>90 (47)</td>
<td>99 (78)</td>
<td>4.98</td>
<td>2.70, 9.19</td>
<td>$&gt;0.001$</td>
</tr>
<tr>
<td>Family history of mental illness</td>
<td>65 (34)</td>
<td>49 (40)</td>
<td>1.34</td>
<td>0.83, 2.17</td>
<td>0.24</td>
</tr>
<tr>
<td>Family history of suicide</td>
<td>12 (6)</td>
<td>17 (14)</td>
<td>2.49</td>
<td>1.13, 5.51</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Course of illness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years ill (&gt;5 years)</td>
<td>80 (41)</td>
<td>57 (45)</td>
<td>1.13</td>
<td>0.71, 1.81</td>
<td>0.61</td>
</tr>
<tr>
<td>1+ hospital admissions</td>
<td>88 (45)</td>
<td>54 (42)</td>
<td>0.87</td>
<td>0.54, 1.39</td>
<td>0.55</td>
</tr>
<tr>
<td><strong>Demographic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social class IV or V</td>
<td>19 (25)</td>
<td>19 (26)</td>
<td>0.57</td>
<td>0.21, 1.54</td>
<td>0.27</td>
</tr>
<tr>
<td>Ethnicity (white)</td>
<td>183 (96)</td>
<td>119 (98)</td>
<td>1.87</td>
<td>0.46, 7.51</td>
<td>0.38</td>
</tr>
<tr>
<td>Living alone</td>
<td>62 (32)</td>
<td>48 (38)</td>
<td>1.61</td>
<td>0.97, 2.70</td>
<td>0.07</td>
</tr>
<tr>
<td>Paid employment</td>
<td>50 (26)</td>
<td>51 (40)</td>
<td>2.03</td>
<td>1.20, 3.44</td>
<td>0.008</td>
</tr>
<tr>
<td>Marital status (single)</td>
<td>45 (23)</td>
<td>24 (19)</td>
<td>0.66</td>
<td>0.35, 1.24</td>
<td>0.20</td>
</tr>
<tr>
<td><strong>Reason for admission</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social factors</td>
<td>121 (62)</td>
<td>53 (42)</td>
<td>0.45</td>
<td>0.28, 0.73</td>
<td>$0.001^a$</td>
</tr>
<tr>
<td>Deliberate self harm</td>
<td>41 (21)</td>
<td>48 (38)</td>
<td>2.40</td>
<td>1.42, 4.06</td>
<td>0.002</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>106 (54)</td>
<td>88 (69)</td>
<td>2.03</td>
<td>1.21, 3.40</td>
<td>0.007</td>
</tr>
<tr>
<td><strong>Clinical features at final admission</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delusions/hallucinations</td>
<td>17 (9)</td>
<td>7 (6)</td>
<td>0.55</td>
<td>0.21, 1.42</td>
<td>0.22</td>
</tr>
<tr>
<td>Suicidal ideas</td>
<td>103 (53)</td>
<td>74 (59)</td>
<td>1.24</td>
<td>0.76, 2.01</td>
<td>0.39</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>47 (24)</td>
<td>52 (41)</td>
<td>2.58</td>
<td>1.47, 4.54</td>
<td>0.001</td>
</tr>
<tr>
<td>Physical illness</td>
<td>71 (36)</td>
<td>51 (40)</td>
<td>1.23</td>
<td>0.73, 2.08</td>
<td>0.42</td>
</tr>
</tbody>
</table>
How do we get to such an intention?

**Main theories:**

1. **Isolatedness** — „cosmic solitude” and „burn-out from the society”

2. **Hopelessness** — loss of motivations and happiness about life

   -> Longer way the suicide

3. **Sudden attempt:**

   -> Sudden crisis

   -> Impulsive attempts, because of alcohol, personality disorder, health condition etc.
How to recognize communication signs of suicide?

- **Depressive signs:** despondency, hopelessness, anhedonia, apathia, anergia, insomnia, problems of appetite, wish for death, slow motor functions

- Sorrowful pale eyes, faded, week gestures or agitatedness and tension.

- **Cognitive triple+1:** word, self, future + even others are negative

- **Agitated depression** (restless)

- „larved” depression (minor somatic complaints)
Presuicidal syndrome (Rigle, 1976)

1. Dynamic constriction
2. Inhibited aggression turned towards the self
3. Suicidal fantasies

- isolation from the environment
- drawing off into themselves
- loss of previous interests
- self-accusation
- damped self-aggression
- suicidal thoughts, dreams and fantasies
Suicidal progress according to W. Pöldinger

Suicidal progress means particular steps in a potential suicide's thinking:

1. **Consideration**
2. **Ambivalence** – the suicidal intention was adopted but hasn’t yet tilted the scale
3. **Decision** – observable relief and getting ready for suicide

There is also a slightly enhanced model of Pöldinger's suicidal progress containing five steps:

1. **Thoughts** – e.g. life is not worth while, I can't go on anymore...
2. **Tendencies** – I'll kill myself...
3. **Consideration** – How to do it? To jump? To shoot myself? To drown myself?
4. **Decision** – e.g. I'll buy and drink a bottle of whisky and then jump.
5. **Realization**
„Cry for help”

= An expression of suicidal intent in the hope of receiving help and being rescued.

- May take many different forms such as a telephone call, a message left on an answering phone, a note left in a conspicuous place, or an e-mail message.

- It may also be a symbolic gesture such as a superficial cut on the wrist.

- Ambivalent state of mind, grammar of negation, indirect statement indicates the intention to commit suicide eg:

  „I can’t stand it any longer, another girl has thrown me out. When she left, I’ve burned the pages of my diary.”
- It is critical to assess the deterents in the client’s environment, such as family or religion, that may help prevent implementation of the suicidal plan. Identifying deterents will help assess clients’ ability to maintain safety once they leave the therapy session.

- It is helpful to ascertain prevailing co-morbid symptoms. When making an assessment, the crisis responder must know whether a client is actively abusing substances or suffering from depressive symptoms. This includes knowing whether the client takes any psychiatric medications, whether these medications have been recently changed, or whether a client has recently stopped taking the medication altogether.

- The specific characteristics of the suicidal ideation also provide helpful information. How often (frequency) does the client think about suicide and for how long (duration)? Does the client have control over suicidal thoughts?

- When a client has made actual preparation for suicide, or when a suicide note is written, the responder should proceed with great caution. Final acts in anticipation of death, such as cashing life insurance, securing a will, and distributing one’s possessions as gifts, are a significant forewarning of serious intent. Additionally, a deception or concealment of a contemplated attempt (failure to communicate ideation) also serves to warn the crisis responder that a client is a high suicide risk.
Video

Signs of depression and suicidal intention

- What signs of depression could you observe?
- Was it a „cry for help”? Does she thinking about suicide?
- What signals of suicidal intentions can be observed?
Isn’t it normal to feel depressed sometimes? Do we all need mental health treatment?

Someone who is seriously depressed may feel like a failure, or that they’ve let themselves or someone else down, and may feel that they would be better off dead.

Even though we all sometimes feel stressed and depressed, this type of persistent depression is not normal and it can be treated.
What doctors should have or do

- Supporting, empathic behaviour
- Avoid confronting the cover story, thus ask directly about the intention!
- Clarify the message
- „I see you are very dejected. Has it ever passed through your mind that it would be better not being alive?”
- Acute psychiatric care is the most suitable
PHQ 9 symptom check-up list

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(For office coding: Total Score = __ + __ + __)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult

[ ] □ □ □ □
<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Depression Severity</th>
<th>Proposed Treatment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 4</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>5 to 9</td>
<td>Mild</td>
<td>Watchful waiting; repeat PHQ-9 at follow-up</td>
</tr>
<tr>
<td>10 to 14</td>
<td>Moderate</td>
<td>Treatment plan, considering counseling, follow-up and/or pharmacotherapy</td>
</tr>
<tr>
<td>15 to 19</td>
<td>Moderately Severe</td>
<td>Immediate initiation of pharmacotherapy and/or psychotherapy</td>
</tr>
<tr>
<td>20 to 27</td>
<td>Severe</td>
<td>Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management</td>
</tr>
</tbody>
</table>
Teen Suicide Risk Assessment
Interview
Suicide Warning Signs

The more warning signs, the greater the risk.

Talk
- If a person talks about:
  - Killing themselves.
  - Having no reason to live.
  - Being a burden to others.
  - Feeling trapped.
  - Unbearable pain.

Mood
- People who are considering suicide often display one or more of the following moods.
  - Depression.
  - Loss of interest.
  - Rage.
  - Irritability.
  - Humiliation.
  - Anxiety.
Suicide warning signs

**Behavior**

- A person’s suicide risk is greater if a behavior is new or has increased, especially if it’s related to a painful event, loss, or change.
- Increased use of alcohol or drugs.
- Looking for a way to kill themselves, such as searching online for materials or means.
- Acting recklessly.
- Withdrawing from activities.
- Isolating from family and friends.
- Sleeping too much or too little.
- Visiting or calling people to say goodbye.
- Giving away prized possessions.
- Aggression.
Signs in everyday life

- Always talking or thinking about death
- Clinical depression -- deep sadness, loss of interest, trouble sleeping and eating -- that gets worse
- Having a "death wish," tempting fate by taking risks that could lead to death, such as driving fast or running red lights
- Losing interest in things one used to care about
- Making comments about being hopeless, helpless, or worthless
- Putting affairs in order, tying up loose ends, changing a will
- Saying things like "it would be better if I wasn't here" or "I want out"
- Sudden, unexpected switch from being very sad to being very calm or appearing to be happy
- Talking about suicide or killing one's self
- Visiting or calling people to say goodbye
Make a protocol or action plan for registering intention of suicide

- Work in 2-3 groups
- How would you approach to the person?
- How would you talk? Wht would you ask?
- What would you do?
- Where would you send or how would you treat the case?
Interview after attempt of suicide

1. Calm surroundings, active role, structured situation
2. Establish rapport (vs. distrust, discomfort, negative picture of the world and others)
3. Assess the current mental state + diminish the likelihood of another attempt
4. The depth and nature of the crisis
5. Use open questions, empathic orientation, supportive presence, sometimes more directive questioning
6. Active facilitating attention, summarizing, reframing
7. Managing emotional problems + assessment
8. Closing the conversation
VIDEO

Interview with a suicide attempt survival

- Is he already over it?
- Wht would you do now?
Several protective factors can buffer individuals from attempting suicide (Department of Health and Human Services, 1999):

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support
- Family and community support
- Support from ongoing medical and mental health services
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation
What should I do if someone tells me they are thinking about suicide?

- Even though you may wish you could talk them out of it, that is not the best way to help.
- Avoid saying things like, “You have so much to live for,” or “Think about how this will hurt your family.”
- Get them to talk. Show concern and compassion by saying, “Things must really be awful for you to be feeling that way.”
- Let them know you are there to listen. Encourage them to share what they are feeling (disappointedness, helplessness, repressed anger).
- Tell them you will support them to find help.
- Ask if they have a specific suicide plan.
- If they do, do not leave them alone, take away any firearms, drugs, or objects they could use to hurt themselves.
- Take them to a mental health professional, or hospital emergency room, you can ask for ambulance if you are outside of the hospital.
Is it true that a person who talks about suicide isn’t really planning to do it?

- No, that is not true.
- In fact, most people who die by suicide tell someone they plan to hurt themselves before they take their lives.
- When someone tells you they are thinking of suicide, they are giving you a precious opportunity to help before it’s too late.
- All mentions of suicide should be taken seriously.
If a friend tells me that they are thinking of suicide and makes me promise not to tell, shouldn’t I respect their right to privacy?

- Privacy is very important, but your friend’s life is even more important.
- Depression and other mental disorders may be distorting their judgment and leading them to want to hurt themselves.
- Even if you lose your friendship, saving a life is the most important priority. Tell someone you trust about your friend and ask for their assistance getting them to a professional.
My friend purposely cuts herself when she is upset. Is this the same as making a suicide attempt?

- Some people cut or otherwise hurt themselves when they feel overwhelmed by difficult or stressful feelings, or to relieve their inner tension.
- Many people who cut themselves never attempt to kill themselves.
- However, in some cases, self-harm is the first indication that someone may be at risk for suicidal behavior. Whether or not they feel an impulse to take their own lives, someone who is cutting or otherwise hurting themselves needs help.
- Health and mental health professionals are trained to determine whether a person is at risk for suicide, and to suggest a treatment plan to help them with their self-harm behavior and underlying feelings.
Is someone who has had suicidal ideation or a recent attempt and is now feeling better still at risk for suicide?

- Even, when a treatment was efficient, it can be difficult to know where a suicidal person is in their recovery.
- Someone who has felt suicidal may work hard to hide his or her feelings, and may appear to be functioning.
- In some cases, a person who has made the decision to die may seem calmer and at peace.
- Staying in treatment after the suicidal thoughts and symptoms seem to be the best way to ensure a successful recovery.
- The decision to stop treatment should be made together by the mental health professional and patient.
Ninety percent of people who die by suicide have a mental disorder at the time of their deaths.

One of the best ways to prevent suicide is by understanding and treating these disorders.

There are biological and psychological treatments.
Research shows that teaching health care professionals to recognize and treat depression is an effective way to reduce suicide rates.

If the depression is mild, the doctor may begin with psychotherapy alone and add medication later if the symptoms don’t improve.

There is clear evidence from research studies that combining antidepressants with any one of these psychotherapies is the best treatment for chronic depression, meaning that they have had a depressive illness for two years or more.
Treatment for Suicide Attempts

**Medication:**
- There are meta-analyses of small lithium studies that show that suicide is reduced in those patients with either bipolar disorder or major depression taking lithium, but there are other studies that do not support that claim and are still controversial.

**Two proven psychotherapies:**
- **Cognitive behavior therapy** (CBT) for suicide attempters
- **Dialectical behavioral therapy** (DBT) for patients with borderline personality disorder and recurrent suicidal ideation and behaviors.

+ Promising short term therapies that include the family that show that repeat suicide attempts are reduced.
Medication

When the optimal dose with the best medication is achieved, the antidepressant may take from 4–12 weeks to achieve maximum benefit, but it is possible for one or two symptoms to improve in the first few weeks.

- The person may look or sound better than he/she feels early in the treatment.
- When antidepressants are started or when doses are increased, a few patients, especially children and adolescents may experience increased anxiety, agitation, restlessness, irritability or anger which may lead to suicidal thoughts or attempts. If the patient or the family sees this developing, they should immediately call the doctor.
- If the person is not feeling better or much improved after 12 weeks on the medication, the doctor may add a second antidepressant, another drug, switch to a different antidepressant or add psychotherapy, if that has not already been instigated.
- The doctor may ask the patient to take a depression rating scale so that both the patient and the doctor can see whether things are improving.
- The treatment should be continued until the patient is no longer experiencing symptoms.
- Even after that is achieved, the doctor will typically recommend continuing the treatment for another 9–12 months.
Specific psychotherapies have been proven effective for treating depression:

- 12–16 weeks, formalized and interactive, one to two times a week with a professional who has been specifically trained and certified in the treatment they are using
- Cognitive behavior therapy (CBT)
- Interpersonal therapy (IPT)
- Dialectical Behaviour Therap (DBT)
- CBT ans DBT greatly reduced rates of suicide attempts during the 18 months following the attempt
- Supportive psychotherapy for depression is less well defined.
- Even after depression was successfully treated, it often recurs.
- Antidepressants and some of the therapies noted above can prevent or reduce the frequency of these recurrences.
Thank you for your kind attention!