

Human Services, 2003), which translates into about 85 people a day. That number is probably very conservative because many suicides are ruled accidental either due to political, religious, and emotional considerations or because medical examiners just can't say for sure (Granello & Granello, 2007, pp. 3–5). Most official reports indicate that the real numbers of suicide attempts as well as injury caused by suicide attempts are grossly underreported. Experts claim that upward of 60,000 Americans die annually by suicide (Ross, 1999). Bottom line the data are a lot more guesstimate than estimate. The National Violent Death Reporting System (NVDRS) is now in place in 18 states. Presently, the large mass of data on violent deaths (homicide or suicide) remains in local, state, and federal jurisdictions. If the NVDRS ever gets fully funded by Congress, it will be able to provide meaningful data that will help in making decisions on how to combat both (Barber et al., 2013).

Depending on where you live, worldwide suicide completions range between 10 and 40 per 100,000. Between 300,000 and 600,000 U.S. citizens a year survive a suicide attempt, and about 19,000 of those survivors are permanently disabled as a result of the attempted suicide (Stone, 1999, p. 1; U.S. Department of Health and Human Services, 2003). Suicide ranges from the 10th to 11th leading cause of death in the United States (National Institute of Mental Health, 2011).

Young people between the ages of 15 and 24 account for the largest increase in suicides during the past 30 years. Men kill themselves at approximately four times the rate for women (Stone, 1999, p. 10). The highest-risk group for many years has been Caucasian men over 35, but the suicide rate among teenagers and young black males has been increasing dramatically since the middle of the 20th century (Fujimura, Weis, & Cochran, 1985; National Institute of Mental Health, 2003). Native Americans kill themselves at a rate about 1.5 times the national average (U.S. Department of Health and Human Services, 2003). Even though the elderly make up roughly 10% of the total population, 25% percent of all suicides occur in the over-65 population, and rates move up exponentially after age 70 (National Institute of Mental Health, 2011; U.S. Department of Health and Human Services, 2003).

The suicide rate among children and adolescents tripled between 1950 and 1985, and suicide is now the second to third (behind accidents but forging ahead, and in hot competition with murder) leading cause of death among children and teens in the United States and has tended to stay that way (Malley, Kush, & Bogo,

1994; National Institute of Mental Health, 2011; U.S. Department of Health and Human Services, 2003). The bottom line is that a person in the United States is less likely to be murdered than to commit suicide! Granello and Granello's (2007, p. 1) analogy is an excellent one. If an airliner crashed every day and 85 people were killed, there would be national outrage, and the government would be forced to do something about it. Yet the same suicide rate evokes little outcry. Why is that so?

In Goldney's (2005) review of suicide prevention, he noted that as far back as 1993 the World Health Organization laid out six steps for worldwide suicide prevention: comprehensive and follow-up treatment of psychiatric patients, gun-possession control, detoxification of domestic gas and car emissions, and tempering the sensationalism of press reports of suicide. It's pretty safe to say that no other chapter in this book has more written about it, more research done about it, more models and theories of why it occurs and what it actually is than suicide. As one example in a veritable tsunami of books that deal with suicide, you can cruise through 744 pages of the American Psychiatric Association's textbook on suicide assessment and management and find out about everything you ever wanted to know and were afraid to ask about it (Simon & Hales, 2012). Yet, as to good odds specific treatments that could prevent suicide, Goldney's survey found no clear research evidence to indicate what treatments might significantly reduce suicide. Ten years hence that hasn't changed much. Why is that so?

The National Action Alliance for Suicide Prevention (NAASP) (2014), whose mission is to advance a national strategy for suicide prevention, has four questions they believe would reduce suicide deaths by 20% in 5 years. Their four basic questions are (Classen et al., 2014):

1. Why do people become suicidal?
2. How can we better detect and predict risk?
3. What interventions, treatments, and services are effective to predict suicidal risk and behavior?
4. What research infrastructure is needed to reduce suicidal behavior?

This chapter describes what is being done to answer those questions.

Suicide and the Moral Dilemma

Shneidman's (1980) quote from *Moby Dick's* **LO2** opening paragraph, a “damp, drizzly November in my soul,” captures the essence of what most suicide is: a dreary, wintry storm of endless life-or-death

debate. It is at times low, moaning, and incessant and other times howling and strident in its demands that consciousness must STOP! It is a titanic and reasoned argument that constantly questions and pleads against the continued struggle in the storm of life. It is into this wind-lashed, flat, frozen, forbidding wasteland of the suicide's mind that the crisis interventionist enters. It is neither a simple nor a painless place to be. If you are planning to become a mental health professional, the odds are about 1 in 4 that you will come face to face with a suicide (Granello & Granello, 2007, p. 1).

Of all the crises in this book, it is perhaps the most written about and the most difficult with which to deal. The simple fact is that the worldwide suicide rate hasn't decreased very much in a very long time despite all of the prevention and treatment approaches (Bell, Richardson, & Blount, 2006, p. 227). The background "attempt" statistic perhaps is as important as suicide itself. About 1.0%–2.5% of the world population attempt it and about 6% think about it every year, but very few of these people ever avail themselves of a mental health service provider (Artieda-Urrutia et al., 2014). Why is that so? First of all, for all its sensationalism, the base rate of completion for any given suicide-prone population is low. So it is difficult to ascertain who are the "few needles in a very large haystack" and study and design treatments that will prevent and stop them from committing suicide. The bottom line is that there are many false positives that are predicted by the conventional risk factors associated with suicide (Goldney, 2005). In other words, lots of people think about suicide, some attempt it, and few complete it. Yet those "few" number in the hundreds of thousands when taken worldwide, and the traumatic wake they leave for survivors numbers in the millions (Granello & Granello, 2007, p. 276).

Perhaps even more problematic for good prevention and intervention outcomes, suicidal ideation and behavior raise complex moral, legal, ethical, and philosophical questions for the crisis interventionist (Stone, 1999, pp. 69–75; Wirth, 1999). Colucci (2013) has examined the reasons why culture is of critical importance in understanding why suicide varies across borders, regions, and ethnicities. Their work pretty much substantiates why Chapter 2's Culturally Effective Helping in Crisis is important to know when dealing with suicide.

Now compare your own philosophical view of death to what Everstine (1998, p. 15) has to say about various kinds of deaths: "Death by murder carries no

stigma and is seen as a tragedy" (i.e., It is a criminal act and somebody must pay). "Accidental death is fully condoned providing the person didn't do something stupid or careless" (i.e., It is a tragedy—unless they were bungee jumping or sky diving, then it was idiotic). "Death by natural causes and resistance to the end allows grieving without animosity" (i.e., It was a tragedy but he lived a long, good life; or she was too young and heroic to the end). "Less forgivable is natural death by neglect or overindulgence" (i.e., The speeder had it coming; or what did he think drinking would do to his liver?). "The least forgivable death is suicide, for which there is little sympathy and no absolution" (i.e., A sin! A moral flaw! A character deficit! Not up to the task of living).

While in Eastern culture suicide may be seen as a way of removing dishonor, shame, and humiliation from oneself and one's family (Granello & Granello, 2007, p. 17), that has not been so in the Western world. Historically, suicide has been seen as a sin by almost every major religion. It has been seen by civil authority as an abrogation of the citizen's contract to serve the state and for a long time was called "self-murder." Self-murder was often blamed on the instigation of the devil. In the Middle Ages in England, self-murder was an offense against the king and nature, and all of the deceased's lands and goods were forfeit to the crown. Indeed, it was not until 1961 that the common law of felony self-murder was repealed in England. Further, a Christian burial was denied, and suicides were often buried in the middle of a crossroads with a stake driven through the heart (Williams, 1997, p. 12). (The reason for the middle of the crossroads rumored to be that horses and ox carts would stop at a crossroad and animals would relieve themselves there.)

Freud's (1916) view that suicide resulted from mental illness has been a double-edged sword. On one side he gave credence to the idea that the suicide was not a person of weak moral fiber "seized by the devil." Yet for the general public a stigma of mental illness that attached to the suicide and the suicide's family has equally negative social attributions.

Euthanasia. Counterpointed against suicide as an act of the devil has been the notion from the Stoic and Epicurean philosophers that suicide could be the right thing to do given terminal illness, unrelenting pain, and/or astronomical financial burdens (Williams, 1997, p. 12). Beginning in the latter half of the 20th century, much attention has been paid to **assisted**

suicide and **euthanasia** in both the literature and the popular media. The two terms are not synonymous. Stone (1999, pp. 76–89) differentiates between the two by pointing out that in assisted suicide someone else provides the means (lethal agent), but the person who is dying administers it. In euthanasia someone else administers it.

We live in a time characterized by what Stone (1999, p. 77) calls “prolonged dying.” Prior to the 20th century, people typically died fairly young and fairly quickly at home. They generally died as a result of infectious diseases or injury. Today 70% to 80% of adults will die in an institution, such as a hospital or nursing home, and probably as a result of degenerative diseases such as heart disease, diabetes, stroke, or cancer. Our deaths may be prolonged, painful, and financially draining for ourselves, our families, and society. Do we have a right to refuse medical treatment, to refuse heroic or artificial interventions to keep us alive when there is no hope of getting better or even of survival?

Further, should a therapist intervene when it is clear that a person wishes to die to end suffering? Every facet of these questions must be examined by our society as we confront the changing human conditions and health care problems in this new millennium (Stone, 1999, pp. 76–82). However, in this chapter, the position is that it is the appropriate role of the crisis worker to intervene and attempt to prevent all suicides and homicides that he or she possibly can.

The Dynamics of Suicide

Psychological Theories

Freudian Inward Aggression. In the Freudian **LO3** (1916) psychodynamic view, suicide is triggered by an intrapsychic conflict that emerges when a person experiences great psychological stress. Sometimes such stress emerges either as regression to a more primitive ego state or as inhibition of one’s hostility toward other people or toward society so that one’s aggressive feelings are turned inward toward the self. Freud called this a melancholic state, and it is what we now call depression. In extreme cases, the melancholy becomes so severe that self-destruction or self-punishment is chosen over urges to lash out at others.

Developmental. Developmental psychology views suicide in terms of life stages. Individuals who do not

successfully navigate life stages become mistrustful, guilt ridden, isolated, and stagnant (Erikson, 1963) until they are unable to cope any longer and may choose suicide as a way out.

Deficiencies. This model is embedded in the mental illness tradition and proposes that there is some mental deficiency in the suicidal individual as opposed to the nonsuicidal person. These mental deficiencies then become risk factors that can lead to suicide (Rogers, 2001a).

Escape. Escapist suicide is one of flight from a situation sensed by the person as intolerable (Baumeister, 1990). This theory has a six-step causal chain. The first step involves the individual’s belief that they fall short of their own or others’ imposed standards. Second, self-blame occurs for falling short, and heightened state of awareness as to those shortcomings occurs in the third step. Negative affect follows as a fourth step. The result is cognitive disintegration that becomes more narrowly focused on deficits to the exclusion of broader more integrative aspects of self until the only option is suicide. Closely allied to escape theory is the concept of perfectionism where less than perfect behavior becomes less and less tolerable, amplifies hopelessness, psychache, and the risk of suicide (Flett et al., 2014).

Hopelessness. The hopelessness theory (Abramson et al., 2000) posits that some individuals believe that highly desired outcomes will not occur or that highly aversive outcomes will occur and that there is nothing they can do to change the situation. Hopelessness represents a key cognitive vulnerability for suicide risk. The only escape is death. Beck’s (Beck et al., 1979) cognitive triad of negative thoughts about self, the world, and the future are at the heart of hopelessness.

Psychache. Psychache is a term coined by the founder of suicidology, Edwin Shneidman (1993). Shneidman’s (1987) **cubic model** combines psychache, **perturbation** (how disturbed one is and degree of pain), and **press** (stress increased due to more negative factors piling up); when all three are combined, they create the critical mass necessary to activate a suicide. While it’s hard to define behaviorally, it’s about the most impactful word Shneidman could have thought up to describe what most people with suicidal ideation are going through. Psychache refers to the hurt, anguish, soreness, and aching pain of the psyche or mind. It

may have to do with guilt, shame, fear of growing old, love lost, or any debilitating cognition or affect. Intolerable psychological pain is the one variable that relates to all suicides. Psychache is tied to frustrated, blocked, and thwarted psychological needs. Suicide thus serves to eliminate the tension related to those blocked needs (Shneidman, 2001). As psychache increases perturbation increases as well and the need press to end it all becomes severe.

Sociological Theory

Durkheim's Social Integration. The most important sociological theory about suicide was originally proposed in 1897 by Emile Durkheim and still holds as the top sociological theory more than a century later. In Durkheim's (1897/1951) approach, societal integration (the degree to which people are bound together in social networks) and social regulation (the degree to which the individual's desires and emotions are regulated by societal norms and customs) are major determinants of suicidal behavior. Durkheim identified four types of suicide: egoistic, anomic, altruistic, and fatalistic (pp. 152–176).

Egoistic suicide is related to one's lack of integration or identification with a group. **Anomic suicide** arises from a perceived or real breakdown in the norms of society, such as the financial and economic ruin of the Great Depression. **Altruistic suicide** is related to perceived or real social solidarity, such as the traditional Japanese *hara-kiri* or, to put it in a current context, the suicide attacks by members of Middle Eastern extremist groups. **Fatalistic suicide** occurs when a person sees no way out of an intolerable or oppressive situation, such as being confined in a concentration camp.

Suicide Trajectory Model. This model considers the total constellation of risk factors: biological (substance abuse, being male, genetic predisposition to depression); psychological (low self-concept, hopelessness, borderline personality disorder); cognitive (rigid, dogmatic, irrational, black-and-white, all-or-none thinking); and environmental (access to firearms, high-stress occupations, loss, family, and job stressors). The more these factors are present and pile up, the greater the potential for suicide (Stillion & McDowell, 1996).

Three Element Model. The three elements composing this model are predisposing factors such as drug abuse and mental illness and potentiating factors ranging

from family history to romantic and occupational losses to whether one has easy access to weapons. When enough predisposing and potentiating components are mixed together, over time, at some point a critical mass is created and a threshold into suicidal ideation and behavior is crossed (Westefeld et al., 2000).

Interpersonal Theory

According to Van Orden and associates (2010), two interpersonal states, lack of belongingness and the feeling of burdensomeness, are primary motivators in the need to commit suicide. Thwarted belongingness is manifested by loneliness and the absence of positive, reciprocal relationships and burdensomeness is the perception that one is a burden on significant others and they will be better off if the individual is dead (Ribeiro et al., 2013). Joiner and associates (2009) propose that people commit suicide because they can and because they want to kill themselves. This seemingly simplistic, straightforward statement addresses three central components of interpersonal theory. First and foremost, people **acquire suicidal capability** by decreasing their innate fear of death by habituating themselves to the fear and pain of self-injury. Second, they **perceive burdensomeness** to others to the extent that they are so flawed or defective they are beyond repair. They see themselves as such a millstone for themselves, their family, or society that everyone will be better-off as a result of their death. Third, **failed belongingness** means that the person has no attachments or value to any other member of society. The theory proposes that while many people consider committing suicide, and large numbers develop the capability, few actually do so because all three ingredients must be present at once to create the critical mass necessary for the act to occur (pp. 5–7).

This theory proposes that those with past suicide attempts will be habituated to pain more than other people because their past attempts help inure them to the potential for pain that accompanies most suicide attempts. Second, those whose job entails exposure to the pain of others will themselves have higher suicide rates than other people because of vicariously experiencing others' pain and thus habituating themselves to it. Indeed, there is a fair amount of research that supports these two notions (Hill & Pettit, 2014).

Existential-Constructivist Framework

The existentialist side of the framework comes from Yalom's (1980) work on human pathology and involves what he believes are the four corner posts of

existence: **death**, which is unavoidable; **existential isolation**, which means that each of us enters existence alone and leaves it alone; **meaninglessness**, our attempt to make sense out of a universe that is beyond knowing; and **freedom**, the absence of external structure, which means that each person is responsible for making choices, taking actions, and enjoying or suffering the consequences of those decisions.

On the other side of the frame, constructivism views death, existential isolation, and meaninglessness as the principal ingredients that provide the motivation for meaning-making activities central to human life (Neimeyer & Mahoney, 1995). As individuals construct their view of self, others, and their relationships, they also construct a worldview where they encounter environmental challenges to which they have to respond. They essentially have three options in response to these challenges. They can retain their original constructions, alter them to build new constructions, or decide that neither response is viable and consider suicide as a final construct. This final construct occurs because trigger events that come from suicide trajectory risk factors (Stillion & McDowell, 1996) combine to form the critical mass that allows the individual to construct a worldview that it is a better choice to no longer view the world at all (Rogers, 2001b). A study of suicide notes' motivational components (Rogers et al., 2007) supports the existential-constructivist model of suicide. The researchers found that suicide notes contained relational, spiritual, somatic, and psychological motivators that are the primary motivational components of the existential-constructivist model.

Other Explanations

Accident. Individuals who have no real intention of killing themselves may do so by pushing their luck too far. These may range from the teenager who decides in a fit of pique to take “a bunch of pills,” passes out, and chokes on her own vomit, to the depressed alcoholic with a blood alcohol content of 0.25 who drives his car into a bridge abutment (Everstine, 1998, pp. 20–21).

Biochemical or Neurochemical Malfunction. This theory proposes that dysfunction in the central nervous system is the primary underlying cause of suicidal/homicidal behavior. Suicide, aggression, and depression are closely related (van Praag, 2001). Bongar and Sullivan (2013, p. 31) report that over the last 30 years that research demonstrates neurochemical changes seem to be highly correlated with

attempted and completed suicides. There is evidence that hyperactivity in the neuroendocrine hypothalamic-pituitary-adrenal axis may have a special relationship to suicidal behavior (Stoff & Mann, 1997, pp. 1–2). It is also now becoming apparent that a serotonin metabolite named 5-HIAA is low (Asberg et al., 1986; Leonard, 2005) in those persons who attempt suicide and that the serotonin transporter 5-HTT gene plays a role in family clustering of depression and suicide (Leonard, 2005; Lopes de Lara et al., 2006). While these biological differences may be correlates and not causes of suicide, evidence continues to mount that they do play a definite role (Asberg & Forslund, 2000; Chiles & Strosahl, 1995, p. 13; Lester, 1988, 1995, 2000; Stoff & Mann, 1997; van Praag, 2001).

Chaos. Chaos theory proposes that, paradoxically, unpredictable behavior can occur within predictable systems. Relatively minor environmental events may lead to suicidal behavior or not within the same individual at different points in time (Rogers, 2001a) while major ecosystem events such as financial depressions can do the same.

Dying With Dignity/Rational Suicide. This type of suicide is typified by a person's rationally choosing death in the face of a painful, decimating, and incurable illness, or some other major calamity that has no foreseeable positive outcome for a reasonable person. The person has further considered the impact on others and found the action to be more beneficial than harmful. As a result, the person makes a reasoned decision to end his or her life (Fujimura, Weis, & Cochran, 1985; Stone, 1999, pp. 76–93; Wirth, 1999).

Ecological/Integrative. In seeking to understand suicide, an ecological/integrative theory takes into account that the painful intrapsychic factors within the individual interact with negative interpersonal and societal issues on multiple systemic levels (Leenaars, 1996, 2004; Potter, 2001). Leenaars (2004) proposes that while a person may be highly perturbed and suffer a great deal of psychic pain, lethality must be present for the person to commit suicide. An ecological/integrative theory proposes that both perturbation and lethality, and the resultant contemplation of suicide, can only result from a complex interaction of all these environmental variables with the individual (Potter, 2001).

Interactional. Everstine's (1998) interactional view of suicide is in direct contrast to Freud's and Durkheim's. Everstine proposes that suicide is not fomented by anger turned inward or social isolation, but by an external rage toward another. It is not at all passive toward the significant other, but is highly aggressive and has a "get even" attitude and revenge as its goal. The suicide's hatred and desire to punish is so consuming that the aggrieved's life or a significant other's life is used as a weapon against the hated other person. The hope is that the survivors have the albatross of guilt over the suicide or homicide hung round their own necks forever.

Ludic. Ludic suicides (Baechler, 1979) relate to the desire to experience an ordeal or a way to prove oneself in gamesmanship. Perhaps the ultimate such game of proving oneself is Russian roulette. Any tribal rite of passage in which death may be an outcome could be considered a ludic suicide.

Oblative. Oblative suicides (Baechler, 1979) are those that are sacrificial in nature and seen to transfigure one to a higher, transcendental plane. Buddhist monks who set themselves on fire and the LSD user who "wants to meet God personally" and overdoses on a smorgasbord of drugs fall into this category.

Overlap Model. The overlap model includes lack of social support, a biological propensity to suicide, the presence of psychiatric disorders, personality issues such as impulsivity, hostility, and depression, and a family history of suicide. The more these areas overlap, the greater the potential for suicide (Blumenthal & Kupfer, 1986).

Parasuicide. **Parasuicide** (closely resembling suicide) involves commissioned acts which, although not directly lethal, can habituate persons to the pain necessary to kill themselves by inflicting **hesitation wounds** (the idea that it is extremely difficult to kill yourself and people hesitate in their initial attempts to complete the act are hesitant (Joiner et al., 2009, p. 8). Clients may also engage in self-injurious behavior, such as cutting or burning their bodies to reconnect to reality from a dissociative state. Or they may indirectly set themselves up to harm themselves by abusing alcohol, driving too fast, combining the two, or engaging in other risky, daredevil behaviors (Jobes, 2006, p. 90). Any one of these acts may end up with the person dead, injured, disabled, disfigured, or maimed.

Suicide by Cop. More a method than a theory or model, **suicide by cop** (as described in Chapter 5) occurs when a person gets the police to kill him or her by engaging in a threatening act toward the police or someone else, such as in a hostage situation. It is an **indirect suicide** wherein suicidal persons may not have the courage to kill themselves, or they seek to publicize their deaths through the media by "going out in a blaze of glory." Suicide by cop is now so common that many cases get a coroner's verdict of **suicide by legal intervention** (Lindsay & Lester, 2004; Miller, 2006).

Characteristics of People Who Commit Suicide

What is it about a person's inner dynam- **LO4**
ics that may make suicide or expressive homicide seem sensible? Shneidman formulated 10 common characteristics present in an individual when the act is accomplished. His characteristics are grouped under six aspects (1985, pp. 121-149; italics added throughout):

1. *Situational characteristics:* (1) "The common *stimulus* in suicide is unendurable psychological pain" (p. 124); (2) "The common *stressor* in suicide is frustrated psychological needs" (p. 126).
2. *Motivational characteristics:* (1) "The common *purpose* of suicide is to seek solution" (p. 129); (2) "The common *goal* of suicide is cessation of consciousness" (p. 129).
3. *Affective characteristics:* "The common *emotions* in suicide are hopelessness and helplessness" (p. 131).
4. *Cognitive characteristics:* (1) "The common *cognitive state* in suicide is ambivalence between doing it and wanting to be rescued" (p. 135); (2) "The common *perception* is of constriction such that one's options become very narrowed and the world is seen through tunnel vision so that no alternative thoughts can emerge" (p. 138).
5. *Relational characteristics:* (1) "The common *interpersonal act* in suicide is communication of intention" (letting another person know that one's decision makes sense) (p. 143); (2) "The common *action* in suicide is egression" (the right to exit or go out as one wishes, or the right to autonomously find a way out of one's pain) (p. 144).
6. *Serial characteristic:* "The common *consistency* in suicide is with lifelong coping patterns when deep perturbation, distress, threat, and psychological pain are present" (p. 147).

This list of characteristics points us toward what makes sense to the individual about to embark on suicide. It is not meant to suggest that all suicides are alike. In using the word “common,” Shneidman reminds us that suicides, taken together, do reflect similarities. However, he is also careful to note that each suicide is idiosyncratic and that there are no absolutes or universals (1985, pp. 121–122).

Overarching these characteristics and common to all suicides is the individual’s sense of perturbation and degree of lethality (Shneidman, 1999a). *Perturbation* is the degree to which the individual is upset. Perturbation in itself does not lead to suicide. Many of us are upset by events, people, and things a great deal of the time, but we get over being upset. However, when perturbation is combined with how oriented the person is toward death, lethality level rises, and the person becomes more prone to suicide or homicide.

Similarities Between Suicide and Homicide

Often the person who is suicidal is also homicidal. Approximately 30% of violent individuals have a history of self-destructive behavior, and 10%–20% of suicidal persons have a history of violent behavior (Plutchik & van Praag, 1990). West’s (1966) study of murderers found that about 30% went on to kill themselves after they killed somebody else, and many had long histories of violent behavior and high levels of aggression. That fact is particularly relevant with murder/suicide in elderly couples, domestic violence, infanticide by overwrought parents, and mental illness (Granello & Granello, 2007; Malmquist, 2006; Nock & Marzuk, 2000). The frequency of murder/suicide in American society emphasizes the similarities of motive, sense of hopelessness, opportunity, means, and lethality of method. The 1999 mass murder and suicide witnessed at Columbine High School in Littleton, Colorado, represents a prime example of the parallels of suicide and homicide. However, it should be emphasized that not all suicides or suicidal persons are homicidal. There is a thin line between murder and suicide as an expressive act. According to Everstine (1998, p. 103), suicide is often intended to take the place of homicide and brand the intended victim as the person who is really responsible for the suicide. Given the right circumstances, the choice of homicide or suicide or both may tilt in either or both directions. The major problem is predicting when either will happen because lethal behavior is internally

generated and highly idiosyncratic. Thus, it is not easy for an external observer to ascertain or predict when the individual’s thoughts cross a threshold to action (Pridmore & Walter, 2013).

Analyzing Suicide/Homicide Notes/Videos

Suicide/homicide notes can provide valuable information, but they do not necessarily provide an open pathway to understanding suicidal/homicidal intention. Contrary to popular opinion, suicide notes are not commonly left. Notes are left in only about 15%–40% of completed suicides (Holmes & Holmes, 2006; Shneidman & Farberow, 1961). Suicide notes typically fall into four categories (Holmes & Holmes, 2006, pp. 82–97; Jacobs, 1967, pp. 67–68). In the first, the writers beg forgiveness, see their problems as not of their own making but nevertheless overwhelming, and indicate they know what they are doing. Many times financial problems predominate in this type of note. The second category involves an incurable physical or mental illness, and the suicide is tired of putting up with the pain. The third type typically deals with love scorned, and the note is directed toward the significant other who has rejected the suicide. Finally, the fourth type is generally a “last will and testament” with instructions and gives little if any reason for the suicide.

Suicide/homicide notes may generally be characterized by their dichotomous (black-and-white) logic, hostility, and self-blame. As Shneidman (1999c) says, “Suicide notes are testimonials to tortuous life journeys that come to wrecked ends” (p. 277). Many suicide notes are rather mundane, using very specific names, details, and instructions if there are survivors. Interestingly, there tends to be less evidence of how one is thinking and much more about how one is feeling. Hate, disgust, fear, loathing, rejection, shame, disgrace, and failure are constant themes. Rock star Kurt Cobain’s suicide note is a classic vitriolic, self-loathing statement about why he ended his life (Shea, 2002, pp. 36–37). As one might suspect, considerable space is given to the various meanings of “love” (Shneidman, 1973).

Unfortunately, a universal, psychodynamic breakthrough in regard to understanding suicide has not occurred after a great deal of research into suicide notes. About the only consistent results found have been that note writers lived alone, were more involved in personal conflicts such as divorce, were less often psychiatrically disturbed, and were less likely to be under medical supervision (Callanan & Davis, 2009;

Haines, Williams, & Lester, 2011). Studies examining the degree to which training could improve participants' ability to determine the authenticity of suicide notes have also been conducted. The results indicated that trainees could not accurately discriminate between real and fake notes beyond chance (Bennell, Jones, & Taylor, 2011).

What suicide notes indicate over and over is the idiosyncratic reasons for the suicides and the tunneled, constricted view that there is absolutely no other way out. Paradoxically, while suicide notes are rather barren in themselves, when they are put into context with a detailed life history of the individual they can tell us a great deal about why the individual committed the act (Shneidman, 1999c). An examination of the following suicide/homicide notes graphically illustrates what Shneidman's (1973) research into suicide notes has uncovered.

An Analysis of Seung-hui Cho. In 2007, Seung-hui Cho, a student at Virginia Polytechnic Institute and State University, killed 32 people, wounded 14 more, and then took his own life on the Virginia Tech campus. His "note," in the form of a videotape that he sent to NBC News, certainly gives a description of him that fits well into Shneidman's (1985) typology of the classic suicidal person who crosses through a psychological door into becoming homicidal as well. Here again are Shneidman's characteristics, supported by Cho's videotaped statements, as excerpted from the *Memphis Commercial Appeal*, April 19, 2007 (Apuzzo, 2007):

1. *Situational characteristics* of unendurable pain: "You have vandalized my heart and raped my soul." His needs are frustrated: "You forced me in a corner."
2. *Motivational characteristics* directed toward ending his emotional problems and becoming a martyr for all the weak and disenfranchised: "You thought it was one weak boy you were extinguishing. Thanks to you, I die like Jesus Christ to inspire generations of the weak and defenseless."
3. *Affective characteristics* of hopelessness, helplessness, and abandonment: "You loved to crucify me. You loved inducing cancer in my head, terror in my heart, and ripping my soul all this time."
4. *Cognitive characteristics* indicated in his previous history of psychotic behavior and by his tunnel vision of an unjust world, with logic-tight compartments of being persecuted by the rich: "Your Mercedes

wasn't enough, you brats. Golden necklaces weren't enough, you snobs." Such statements mark him as a person with paranoid schizophrenia and extremely dangerous to both himself and others.

5. *Relational characteristics* marked by his communication of intention, stating why his rampage across the campus makes absolute sense: "You had a hundred billion chances, but forced me into a corner and gave me no option."
6. *Serial characteristic* discerned in a long history of difficulty in coping, of being different, and of being bullied (see Chapter 13, Crises in Schools). The intended victims are those "who had everything and spit on my face and shoved trash down my throat."

The continuing and unendurable *psychache* (Shneidman, 1993) Cho felt and verbalized in the foregoing statements propels him toward an *egoistic* (Durkheim, 1897/1951) suicidal/homicidal rampage. His alienation, along with a lack of integration into and identification with the group, is both chronic and acute. His isolation and aloneness, manifest in the videotape, are profound, and he broods over real and imagined injustices he has suffered that caused him "to be humiliated and be impaled upon a cross to bleed to death for your amusement." At some point his egoistic suicidal impulses transgress a psychological line to move into Everstine's (1998) *interactional* model of suicide. As with other mass murderers, Cho's depression and pent-up anger turn inside out in a classic Freudian dynamic example of the suicidal and homicidal person (Freud, 1916). At that point the paranoid rage he feels explodes outward and focuses externally on others who have persecuted him. When that occurs and blame is externalized, Seung-hui Cho becomes a candidate to commit mass murder on that large amorphous mass of his tormentors. Why is this so? To the survivors it makes no sense and is the very essence of *chaos* theory (Rogers, 2001a) at work. To Seung-hui Cho, with malice and coldness aforethought, it makes perfect sense to end his pain and air his narcissistic grievances to the world. Why? His martyrlike rationalization to justify his act is: "If not for me, for my children and my brothers and sisters . . . I did it for them." But finally, the real reason very simply is, "I had to."

Myths About Suicide

There are a good many commonly held myths about suicide that the crisis worker should know and take into account when assessing potentially

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suicidal clients (Bonner, 2001; Duberstein & Witte, 2009; Fujimura, Weis, & Cochran, 1985; Granello & Granello, 2007, pp. 8–11; Kirk, 1993, pp. 1–4; Lester, 1997; McGlothlin, 2008; Shneidman, 1999b; Shneidman, Farberow, & Litman, 1976, p. 130; Stack, 2001; Stone, 1999, pp. 51–63; Webb & Griffiths, 1998–1999, p. B42). Some of the myths are as follows:

1. *Discussing suicide will cause the client to move toward doing it.* The opposite is generally true. Discussing it with an empathic person will more likely provide the client with a sense of relief and a desire to buy time to regain control.
2. *Clients who threaten suicide don't do it.* A large percentage of people who kill themselves have previously threatened it or disclosed their intent to others.
3. *Suicide is an irrational act.* Nearly all suicides and suicide attempts make *perfect sense* when viewed from the perspective of the people doing them.
4. *People who commit suicide are insane.* There is evidence of a high degree of association between mental illness and suicide, particularly with chronic depression; schizophrenia; obsessive-compulsive, borderline, schizoid, panic antisocial personality disorder, and panic disorders; and co-occurring substance abuse. However, most suicidal people appear to be normal people who are acutely depressed, lonely, hopeless, helpless, newly aggrieved, shocked, deeply disappointed, jilted, or otherwise overcome by some emotionally charged situation.
5. *Suicide runs in families—it is an inherited tendency.* This may or may not be a myth. Sometimes more than one member of a family does commit suicide. Blood type has been found to be associated with suicide (Lester, 2005). Blood metabolites also appear to play a part in suicide. There is now a great deal of evidence that 5-HIAA, a main serotonin metabolite, is low in people who attempt suicide (Leonard, 2005; Stoff & Mann, 1997) and that the S-Tin2 serotonin transporter gene is variant in families that have a history of suicidal behavior (Lopes de Lara et al., 2006). In counterpoint to a purely gene pool theory, self-destructive tendencies may be learned, situational, or linked to depression or other hopeless environmental conditions. The very act of completion in one family member may propel other family members to model that behavior.
6. *Once suicidal, always suicidal.* Many people contemplate suicide at some time during their lives. Most of them recover from the immediate threat, learn appropriate responses and controls, live long, productive lives free of the threat of self-inflicted harm, and never again consider it.
7. *When a person has attempted suicide and pulls out of it, the danger is over.* Most suicides occur within 3 months following the beginning of “improvement.” One danger signal is a period of euphoria following a depressed or suicidal episode, which often means the person has everything settled and planned and is at peace with the idea of committing suicide. About 10% of those who have previously attempted suicide will go on to kill themselves.
8. *A suicidal person who begins to show generosity and share personal possessions is showing signs of renewal and recovery.* Many suicidal people begin to dispose of their most prized possessions once they experience enough upswing in energy to make a definite plan. Such disposal of personal effects is sometimes tantamount to acting out the last will and testament.
9. *Suicide is always an impulsive act.* There are several types of suicide. Some involve impulsive actions; others are very deliberately planned and carried out.
10. *Suicide strikes only the rich.* Suicide is democratic and strikes at all levels of society. A review of the literature over the past 30 years indicates poor people are generally at greater risk.
11. *Suicide happens without warning.* People invariably give many signs and symptoms of their suicidal intentions.
12. *Suicide is a painless way to die.* It often is not, and many suicide attempts that go awry bring terrible suffering in the form of chronic pain and permanent disfigurement.
13. *Few professional people kill themselves.* Physicians, pharmacists, lawyers, and dentists have high rates of suicide, but who keeps track of truck drivers and laborers?
14. *Christmas season is lethal.* December has the lowest suicide rate of any month.
15. *Women don't use guns to kill themselves because of disfigurement.* Women use guns more often than drugs to kill themselves.
16. *More suicides occur during a full moon.* There is no increased number of suicides during a full moon.
17. *Suicidal people rarely seek medical attention.* Research shows that about 75% of people who kill themselves visit a doctor within the month that they kill themselves.

18. *Most elderly people who commit suicide are terminally ill.* While many elderly who attempt suicide may be depressed, they are not terminally ill.
19. *Suicide is limited to the young.* Suicide rates rise with age and reach their highest level among white males in their 70s and 80s.
20. *Suicidal thoughts are relatively rare.* Each year in the United States approximately 8.3 million people (4%) seriously consider suicide. About 1% make a plan, and about half of those carry it out.

Assessment

Suicide Clues

The overarching, cardinal rule for *all* crisis workers is this: Workers who deal with *any* type of crisis client should always assess for the presence of clues and risk factors for lethal behavior. Fortunately for the crisis worker, nearly all suicidal/homicidal people reveal some kind of clues or cries for help. According to Shneidman, Farberow, and Litman (1976), no one is 100% suicidal. People with the strongest death wishes are invariably ambivalent, confused, and grasping for life (p. 128). Most suicidal clients, feeling high levels of ambivalence or inner conflict, either emit some clues or hints about their serious trouble or call for help in some way (pp. 429–440). The clues may be verbal, behavioral, situational, or syndromatic.

Verbal clues are spoken or written statements, which may be either direct (“I’m going to do it this time—kill myself”) or indirect (“I’m of no use to anyone anymore”).

Behavioral clues may range from prowling the Internet suicide sites to slashing one’s wrist as a “practice run” or suicidal gesture.

Situational clues might include concerns over a wide array of conditions such as the death of a spouse, divorce, a painful physical injury or terminal illness, sudden bankruptcy, preoccupation with the anniversary of a loved one’s death, or other drastic changes in one’s life situation.

Syndromatic clues include such constellations of suicidal symptoms as severe depression, loneliness, hopelessness, dependence, and dissatisfaction with life. (Shneidman, Farberow, & Litman, 1976, pp. 431–434)

All of these clues may be considered as cries for help, no matter how subtle or camouflaged they are.

Risk Factors. Let’s suppose you fall into some of the foregoing categories and have decided life isn’t worth living and you are going to kill yourself. How good a candidate are you to take yourself off this planet? Here are some of the high probability suicide risk categories, so check them off to see how far gone you really are (Bongar & Sullivan, 2013, pp. 41; Cantor, 2000; Cheng & Lee, 2000; Granello & Granello, 2007; Holmes & Holmes, 2006; Joiner et al., 2009; Kerkhof, 2000; Lester, 2001; Lester & Gunn, 2011; Moberg et al., 2014; Roy et al., 2000; World Health Organization, 2011): You are older than 70 or younger than 20 and a male Caucasian. You came out of a troubled home and got in trouble at school for fighting. You still get in trouble for fighting except now it’s in bars. You have a history of alcoholism, and you abuse other drugs. You have been diagnosed (choose one or more): (a) schizophrenic, (b) bipolar, (c) borderline, (d) anorexic, or you are just plain (e) depressed. You are single, and you don’t have a very good job because you lost a really good job just lately. To make up for that you got drunk, had a hit-and-run accident, were caught, and are now spending your first night in jail. Your spouse has announced he or she is divorcing you, and most of your former friends won’t speak to you anymore. This isn’t the first time you’ve tried to kill yourself, and you have thought about it quite a bit since that time. You collect guns and know how to use every one of them and know a nice, quiet wooded area where no one ventures at night. You are now a resident of Lithuania, and have been planning on moving to Russia if you get out of jail or don’t kill yourself first. It is 5 days after Christmas, and the only cards you got were from a lawyer foreclosing your house and the Internal Revenue Service who sent you an audit notice. Meanwhile, your rheumatoid arthritis is really bothering you, the only thing that helped was Vioxx, and it is now off the market. You’ve been to an internist twice in the last 2 months for stomach pains but you didn’t mention anything about being depressed and he didn’t ask. Sadly and ominously, your mother and your mother’s father both committed suicide. To top it all off, you originally come from a European country that has a lot of low notes in its national anthem and you think it’s pretty gloomy. If this now sounds like a bad country music song and you fit most of these criteria, do not despair or go step in front of a train (all really good country songs must include a train, so that is the way you are going to kill yourself, but you better not do it in Japan or the train company will make your estate pay for the damages since so many people do just that in Japan).

The ability to predict suicide and who will attempt or commit it is problematic, to say the least. Here's a really good example of the problem. There's a lot of research evidence that indicates people who commit suicide will have seen a medical doctor for a health problem in the 3 months prior to killing themselves (Ahmedani et al., 2014; Cho et al., 2013; De Leo et al., 2013). This variable is so significant that there are efforts underway to make suicide screens as standard as cholesterol screens when you visit your internist or ER (Ahmedani et al., 2014; Horowitz et al., 2012, 2013; Wintersteen & Diamond, 2013) and direct intervention (Ginnis et al., 2015; Wintersteen & Diamond, 2013). So okay, how many of you have been to the doctor in the last 3 months and never thought about killing yourself or someone else? Get the point! While all of the foregoing demographics, personality traits, behaviors, and socioeconomic risk factors can predict incident rates by group and are certainly risk factors, none of them taken singly or collectively predicts very well whether an individual will complete a suicide (Bonner, 2001; Goldney, 2000; Granello & Granello, 2007). So what a crisis interventionist needs is a fast check off when face-to-face on a bridge with a jumper and here it is.

Warning Signs. There are a number of acronym suicide check off lists that will work in catching warning signs. Here is one of the more common ones. The American Association of Suicidology (n.d.) has created a list of suicide warning signs with the mnemonic IS PATH WARM:

- I is for ideation
- S is for substance abuse
- P is for purposelessness
- A is for anxiety and agitation
- T is for feeling trapped
- H is for hopelessness
- W is for withdrawal
- A is for anger
- R is for recklessness
- M is for mood fluctuations

Warning signs are different from symptoms. While symptoms can only be described, warning signs are observable. So how many letters do you have to fill before the path to suicide changes from warm to hot? That's a really good question. Maybe only one or maybe all of them depending on your clinical judgment but in regard to due diligence and any future legal problems it's best to have done them as thorough a risk assessment as

you are able to do under the circumstances (Bongar & Sullivan, 2013; Kleespies, 2014). Thus you can say you did a thorough on-the-ground clinical assessment and, therefore, at that time the individual needed to be taken into protective custody because not only did he or she spell out IPAHWAM, but he or she totaled up $A = 8, B = 9, C = 10$ for a total TAF of 27, which means a night's rest in a secure facility and a talk with someone before release.

Assessment Instruments

A variety of instruments have been used in an attempt to identify suicidal ideation and behavior (Joiner et al., 2009; Laux, 2003; McGlothlin, 2008; Westefeld et al., 2000). They cover personality characteristics, risk factors, and warning signs. The Minnesota Multiphasic Personality Inventory-2 (Hathaway & McKinley, 1989), the Hopelessness Scale (Beck et al., 1974), the Beck Depression Inventory (Beck & Steer, 1987), and the Psychological Pain Assessment Scale (Shneidman, 1999e) are examples of tests that address personality characteristics associated with suicide.

The Interpersonal Needs Questionnaire (Van Orden et al., 2008) assesses the critical interpersonal issues of burdensomeness to others and lack of belongingness. Along with the Painful and Provocative Events Scale (Bender et al., 2011), which is a self-report of how much the client engages in impulsive, dangerous, pathological, and risk-taking activities, these scales significantly predict high scores on the Acquired Capability for Suicide Scale, which indicates how lethal the client is (Van Orden et al., 2008).

A number of other instruments such as SAD PERSONS (Sex, Age, Depressive symptoms, Previous attempts, Ethanol use, Rational thinking loss, Social support lacking, Organized plan, No spouse, Sick-ness) (Patterson et al., 1983) are designed to assess manifestations of clinical suicide ideation and empirical factors that have been previously identified as being related to risk for suicide attempts. These scales accumulate data on relevant demographics, symptoms of suicidal behavior, stress, resources outside of self, personal and social history, and historical and situational variables currently identified in the suicide literature as significant predictors of suicide attempts. However, these devices alone have had a notoriously poor track record for prediction. Risk assessment is greatly improved when these instruments are backed up by a clinical interview and third-party collateral information (Rogers, 2001a).

Clinical Interview

The American Association of Suicidology (1997); Battle, Battle, and Tolley (1993); Gunn and Lester (2013); Hazell and Lewin (1993); Jobes (2006); Joiner and associates (2009); Kirk (1993, p. 7); Kleespies (2014, pp. 99–100); McGlothlin (2008); Patterson and associates (1983); Stone (1999, pp. 57–60); Webb and Griffiths (1998–1999, pp. A44–45); and Won and associates (2013) have identified numerous risk factors and warning signs that may help the crisis worker in assessing suicide potential. While there are all kinds of scoring systems for the wide variety of checklists available today, they are rife with the possibility of yielding false positives or, worse yet, false negatives (Sullivan & Bongar, 2006). Here is where science and art commingle and the interview and diagnostic skill of the interventionist comes into play. Whenever a person manifests four or five of these risk factors, it should be an immediate signal for the crisis worker to treat the person as high risk in terms of suicide potential. The client:

1. Exhibits the presence of suicidal or homicidal impulses and serious intent.
2. Has a family history of suicide, threats of harm, drug abuse, and abuse of others.
3. Has a history of previous attempts.
4. Has formulated a specific plan.
5. Has experienced recent loss of a loved one through death, divorce, or separation.
6. Is part of a family that is destabilized as a result of loss, personal abuse, violence, and/or because the client has been sexually abused.
7. Is preoccupied with the anniversary of a particularly traumatic loss.
8. Is psychotic (and may have discontinued taking prescribed medications).
9. Has a history of drug and/or alcohol abuse.
10. Has had recent physical and/or psychological trauma or history of it as a child.
11. Has a history of unsuccessful medical treatment, chronic pain, or terminal illness.
12. Is living alone and is cut off from contact with others.
13. Is depressed, is recovering from depression, or has recently been hospitalized for depression.
14. Is giving away prized possessions or putting personal affairs in order.
15. Displays radical shifts in characteristic behaviors or moods, such as apathy, withdrawal, isolation, irritability, panic, or anxiety, or changed social, sleeping, eating, study, dress, grooming, or work habits.
16. Is experiencing a pervasive feeling of hopelessness/helplessness.

17. Is preoccupied and troubled by earlier episodes of experienced physical, emotional, or sexual abuse.
18. Exhibits a profound degree of one or more emotions—such as anger, aggression, loneliness, guilt, hostility, grief, or disappointment—that are uncharacteristic of the individual's normal emotional behavior.
19. Faces threatened financial loss.
20. Exhibits ideas of persecution.
21. Has difficulty in dealing with sexual orientation.
22. Has an unplanned pregnancy.
23. Has a history of running away or of incarceration.
24. Manifests ideas and themes of depression, death, and suicide in conversation, written essays, reading selections, artwork, or drawings.
25. Cognitively has black-and-white, all-or-none cognitions, tunnel vision, limited problem-solving ability, difficult self-soothing, and resolving guilt, and is perfectionistic.
26. Is a burden and doesn't feel belongingness, and makes statements or suggestions that he or she would not be missed if gone.
27. Has easy access to firearms, medications, and other fast lethal means.
28. Experiences chronic or acute stressors, and perseverates on them.
29. Has used the Internet or social media to explore suicide methods.
30. Has recently been to a medical doctor in the last 3–6 months for other than an annual physical checkup.

In and of themselves, each of these factors may mean little in regard to suicide. Further, this extensive suicide shopping list of risk factors would make a lot of people suicidal (false positive in statistical terms) who do not have the remotest notion of killing themselves. The crisis worker must realize that assessing suicidal or homicidal risk is no simple matter. Indeed, some risk factors such as previous attempts or having a concrete plan are more lethal than others and must be given more weight or attention. There are no direct “if-then” connections. Suicidal risk factors are much more relevant when identifying groups than individuals (Chiles & Strosahl, 1995, p. 8). Yet as these risk factors pile up, the potential for the individual to engage in a lethal act most certainly increases. Therefore, the clinical interview and how it is structured and handled are critical in making on-target assessments of lethality.

CAMS. The Collaborative Assessment and Management of Suicidality (CAMS) is a risk assessment clinical interview framework developed by Jobes

(2006). Creation of the therapeutic alliance is critical to this framework, so the emphasis is on collaboration. The Suicide Status Form III is used in this interview to measure psychological pain, self-hatred, hopelessness, stress, and the degree of emotional agitation necessary to take action and end the pain. Clients also give themselves an overall risk of suicide and list reasons for living and dying. Clients self-report their status on these dimensions on a scale of 1 to 5. A rating of 5s across the components signals a clear and imminent danger of suicide.

CASE. Chronological Assessment of Suicide Events (CASE) is a risk assessment clinical interview framework developed by Shea (2002) that has two primary assumptions: first, that people rarely kill themselves without engaging in concrete planning and making plans to do so; and second, that clients may not voluntarily come forward with information about their suicidal thoughts without a lot of rapport building on the part of the interviewer.

RFL. The Reasons for Living scale (RFL; Linehan et al., 1983) is a different kind of suicide assessment tool in that it queries a person's reasons for staying alive by posing 48 questions as to why people would *not* kill themselves. It has a six-point Likert scoring system for each question, and the items can be categorized into six factors: survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral issues.

SRADT. The Suicide Risk Assessment Decision Tree is a risk assessment clinical interview framework (Cukrowicz et al., 2004; Joiner et al., 1999) that moves through a series of yes-or-no questions to come to a decision about how present and pronounced is the person's acquired capability of killing himself or herself. Interviewers query three domains: previous suicidal behavior, current suicidal symptoms, and empirically related variables that would exacerbate (hopelessness, impulsivity) or diminish (engaging with social supports, stopping drug abuse) suicidal behavior. Completing the decision tree involves obtaining information about the aforementioned areas, inputting the data into the decision tree to determine how high the acquired capability of suicide attempt risk level is, and then using the risk level to determine appropriate intervention. Compelling evidence for a high acquired capability would include multiple suicide attempts or three of the following five symptoms: single suicide attempt, aborted attempt, self-injecting

drug use, self-harm practices such as cutting, and frequent exposure to or participation in physical violence (Joiner et al., 2009, pp. 69–70).

Using the Triage Assessment Form in Addressing Lethality

Crisis workers intervening with clients in acute crises should *never* omit an assessment for suicide lethality (McGlothlin, 2008; Jobes, 2006; Shea, 2002; Sullivan & Bongar, 2009). The worker must not hesitate to ask questions such as “Are you thinking about killing yourself?” “. . . about killing someone else?” “How?” “When?” “Where?” We absolutely agree with McGlothlin (2008, p. 39) that you don't sugarcoat this question for fear of activating suicidal urges in the client or of sounding callous or offensive in broaching such a personal and culturally sensitive topic. Mealy mouthed questions such as “Have you . . . considered hurting yourself,” “thought about giving up,” “felt overwhelmed/really down/strung out/at the end of your rope,” along with qualifiers such as “sorta” or “kinda,” are not the same as straight questions about “killing yourself” and imply wholly different interpretations that can cause the worker to completely miss lethal ideation.

Asking *the* question about killing oneself or others does not mean doing so in an abrasive, callous manner. As in CAM and CASE interview formats previously mentioned, collaboration and empathy are key components. Asking *the* question about killing oneself or others is a closed-ended question that seeks a yes-or-no response. However, there are varying degrees of “yesness” that range from “Well, not in a long time!” to “I have the 9mm cleaned and loaded and am going out to the state park this afternoon” (McGlothlin, 2008, pp. 38–39). Therefore, if you get a positive answer, you need to fully explore the dimensions and degree of that lethality by assessing across affective, behavioral, and cognitive dimensions. McGlothlin's (2008, pp. 36–37) acronym SIMPLE STEPS provides a step-by-step method to assess lethality and get a good read on the client's affective, behavioral, and cognitive representation of the dilemma.

Suicidal/homicidal? Are you thinking of killing yourself/someone else?

Ideation: How likely are you to kill yourself/somebody else in the next 72 hours?

Method: How will you kill yourself/somebody else?

Pain: On a scale of 1 to 10, how much psychological pain are you in at the moment? Is there anything you can think of that would make it go higher?

Loss: Have you suffered a loss recently or a significant loss in the past you are not over?

Earlier attempts: Have you ever tried to kill yourself/somebody else before? What happened? What made it not work?

Substance use: Are you currently drinking alcohol or using drugs? What medications are you taking, and are you taking them as prescribed?

Troubleshooting: How tied up in this are your job, family, and so on? And what might change to stop this? Are you willing not to consider killing yourself/somebody? If a miracle happened and you awakened tomorrow and everything were fine, what would that look like?

Emotions/diagnosis: Have you ever been diagnosed with a physical or psychological illness? How are you feeling right now, and have you ever felt this way before? If so, how often? Have you or are you currently seeing a human service worker of any kind for this problem?

Parental/family history: Has anybody in your family thought about or committed suicide or homicide? Have your parents experienced any emotional problems?

Stressors and life events: What is going on in your life that leads you to think that suicide/homicide is a viable option or solution to your problems?

The triage assessment of the client in acute crisis provides for immediate revision of the worker's estimate of crisis severity based on the client's responses to these important and necessary questions or on rapidly elevated TAF ratings due to a sudden change in client feeling, behaving, or thinking about committing suicide or homicide when previously there was no indication of ideation. A client triage profile that may have looked safe before such answers may look quite different a few moments later. If the client is seriously thinking of killing or harming some specific other person, the worker will need to consider the duty-to-warn implications dictated by law developed in the *Tarasoff* case, described in Chapter 15, Crisis Intervention: Legal and Ethical Issues.

Consider the following example. *Before* the lethality questions, the client's presenting problem to a career counselor is job loss due to a plant closing. The counselor identifies the client's depression and frustration over failure to find a suitable replacement job, but the estimated TAF affect value of 3 or 4, cognition score of 6 or 7, and behavior score of 4 or 5 (total TAF of 13 to 16) yields a "low to moderate" severity summary. Such a

total score shows no urgent or immediate concern for the client's severity/lethality status.

Nevertheless, the career counselor senses that something is not quite right. The client's voice reveals a hint of verbal euphoria, while the body language seems to contradict the verbal behavior with a slight hint of hopelessness. The worker further knows that job loss, particularly after a lengthy tenure, and suicide are related (Stack, 2001). As a result of the emerging hints and cues (as an example, the client makes a nonchalant side remark implying that he or she will not be around much longer), the counselor probes directly into the client's inner world by asking, "What does that mean?" "How?" "When?" and "Where?" and then rethinks and reframes the TAF assessment.

After the lethality questions—the client's responses, which reflect obvious stress and depression, are "For me, there is no future, no life left. I am too old to retrain, and nobody wants me anyway! I might as well curl up and die," and the client answers "Yes" to the question "Are you thinking of killing yourself because things look so hopeless?"—a second TAF assessment of 9 or 10 on affect, 8 or 9 on cognition, and 8 or 9 on behavior (total of 25 to 28), amounts to a dramatic escalation and would trigger an intervention strategy of immediate hospitalization to ensure the client's safety.

This example of using the TAF as a rapid assessment tool shows how quickly the emotional tone may change in a crisis intervention case. It clearly demonstrates that whenever a crisis worker begins to suspect a higher level of severity or lethality than at first revealed, the worker should not hesitate to directly ask the question and probe deeply into the emotionally charged world of the client. A similar rapid increase in the worker's assessment of lethality is also applicable in cases of homicidal intent or any other situation involving threats of harm to self or others.

Level of Risk. The last piece of this complex puzzle is level of risk. Joiner and associates (1999) and Bryan and Rudd (2006) have put together risk tables that range from nonexistent to extreme. As individuals move up the scale to extreme these things happen. They get more courage and a sense of competence as they make preparations for and practice run the attempt. They indeed have made unsuccessful attempts before. They have continuous, intense, and enduring ideation, impaired self-control, severe feelings of hopelessness, multiple other symptoms, and no protective factors.

At this point in time the best bet on making determinations about the potential for lethal behavior is Kleepies' (2014, pp. 108–122) **structured professional judgment**. That is, combining what professional crisis workers' experience tells them as they use the foregoing verbal and visual assessments along with a reliable paper-and-pencil test—if time is available to make a decision on potential lethality.

Intervention Strategies

This section contains examples of general **108** counseling strategies to use with adults of different ages and different problems. Lethal children will be addressed in Chapter 13, Crises in Schools. Before you even start reading this section, your question might well be: Should one even try, with treatment outcomes so equivocal? While there are no absolutes in suicide treatment, there are some promising approaches (Goldney, 2005; Hawton & Van Heeringen, 2000; Hepp et al., 2004; Jobes, 2006; Joiner et al., 2009; Lester, 2000; Linehan & Schmidt, 1995; Wenzel et al., 2009), and it is these that will be considered. Suicide intervention strategies involve “interrupting a suicide attempt that is imminent or in the process of occurring” (Fujimura, Weis, & Cochran, 1985, p. 612). Crisis intervention with suicidal/homicidal clients generally falls into two broad categories, dealing with perturbations and reducing lethality levels.

The Three I's

The major causes of perturbation have to do with the three I's. The person confronts a situation he or she believes to be **inescapable** (I can't get away from this pain no matter what I do), **intolerable** (I've gone beyond what any human could endure), and **interminable** (If I don't do something about this now, it'll go on forever). The goal of intervention is to change one or more of these I's (Chiles & Strosahl, 1995, p. 74). At the beginning of the interview, the crisis worker must quickly establish a sense of rapport and trust in order to create a working relationship and provide clients with an anchor to life (Michel, 2011). It is also important to begin to reestablish in clients a sense of hope and to diminish their sense of helplessness—to take immediate steps to speak and act on clients' current pain.

The most effective way to do this is to address not the lethality directly but the perturbation the I's are causing. When the perturbation level of the three I's is lowered and some modicum of control and hope

is restored in the person's life, lethality will drop below the explosive level. What this means is not just dealing passively with only the intrapersonal issues but actively confronting the interpersonal and environmental issues that afflict and assail the individual (Shneidman, 1999a).

Clients need to be taught to either use existing problem-solving skills or generate new ones so that they can shed the inescapability of unsolvable problems. Clients need to develop self-awareness and self-observation strategies to observe natural fluctuations in pain levels and make associations between doing things a bit differently and feeling better. As a result, they can learn that emotional pain will not be constantly intense and interminable. Clients also need to learn that negative feelings can be tolerated by distancing and distraction skills so that they are seen as a part of life and not something that is overwhelming and interminable (Chiles & Strosahl, 1995, p. 74). Typically, some form of cognitive-behavioral therapy will be used that employs active support for the person; teaches cognitive restructuring, emotional regulation, and learning to balance change and acceptance of how things are and will be; and changes destructive and negative behaviors through psychoeducation and problem solving (Berk et al., 2004; Guthrie et al., 2001; Linehan et al., 2006; Townsend et al., 2001; Wenzel et al., 2009). The following cases demonstrate how a crisis interventionist goes about “dotting the I's.”

LeAnn, Age 21. LeAnn was a senior at a large university. During her freshman year at a small liberal arts college, she had experienced an emotional and suicidal breakdown as the anniversary date of her older sister's suicide approached. She had left the small college, returned home, and undergone psychiatric treatment. LeAnn had later enrolled in the university in her hometown, where she lived in a residence hall. She went home frequently but managed to succeed fairly well in her studies and social life. LeAnn was referred to the crisis worker by her mother following a weekend mother–daughter discussion during which LeAnn disclosed some recurring suicidal thoughts. The mother expressed concern that the fifth anniversary of her sister's suicide seemed to be looming in LeAnn's mind and asked the crisis worker to call LeAnn in for a conference. During the first interview with LeAnn, the worker established that LeAnn did not have a specific, highly lethal plan, but that she did have a lot of suicidal ruminations.

LeAnn: I think Mother thinks I'm crazy. Sometimes I wonder if she's right. (*Long pause.*) I don't seem to handle stress very well, and this is my last semester with my senior thesis due. . . . Sometimes I think I am about to lose it. Do you think I may be going crazy?

CW: No, I certainly don't. What I'm hearing is a lot of confusion and unsettled emotion and a lot of pressure. I'm glad you feel comfortable enough to ask me. I'm wondering what's happening in you to bring up the question. Are you thinking of killing yourself?

LeAnn: Well, I've just been sitting in my room by myself, staring at the wall. I can't get anywhere on that stupid thesis. Not sleeping, not eating, not going out. And I've had this strange sensation of both wanting to run and scream, and to just give up. And I've thought about my sister's death constantly. More than at any time since I was a freshman. It's like I'm destined to go the way she went. Sometimes I think I can't stand it any longer. Then I catch myself and wonder if I *am* nuts. My sister killed herself, and her birthday is coming up. I miss her so much.

CW: Okay, I'm going to ask you a bunch of questions and I've got a couple of forms I want you to fill out. Some of the questions may seem a little intrusive but it's a way of determining where we are going to need to go. When we're done, I'll tell you where I think we need to go.

LeAnn's thoughts and responses are enough to activate the worker to conduct a suicidal assessment process. He first gives her the Suicide Status Form III (Jobes, 2006). Her scores for psychological pain are 3. She reports missing her sister, particularly on the anniversary of her death. Her stress is a 4–5, but she mainly sees her stressors as completing her thesis. Her agitation is low, with no sense of need to take any action that would lead to a suicide. She feels a bit hopeless, but again this has more to do with her senior thesis completion and resulting graduation. She indicates no self-hatred and gives it no score at all. She rates her overall risk of suicide as extremely low. Her reasons for living are graduation, her parents, friends, and a chance to go on to graduate school. She has no reasons for dying, other than she might see her sister in heaven. Her wish to live is "very much" and her wish to die is "not at all." Her Interpersonal Needs Questionnaire (Van Orden et al., 2008) indicates she does not feel she is a burden and has a very strong sense of

belonging to her parents and college sorority sisters. Follow-up questions by the worker using McGlothlin's (2008) SIMPLE STEPS indicate few if any of the "hot" cognitions that activate suicidal thinking. The worker relays this information to her in a straightforward, collaborative, and empathic manner.

CW: As you can see, your scale scores are really low, all well within a normal range. I believe that more than anything the anniversary of your sister's death and how much you miss her are contributing to the loneliness and isolation you are feeling. I also think you are pretty normal and reacting pretty normally to school. I wonder if we might talk about those a little and help you make some plans to get out of this rut?

Many people who have suicidal ideation believe they are "going crazy." While some people who are psychotic or suffer from personality disorders are suicidal, suicide is not the first step on the road to "going crazy." The crisis worker positively affirms that LeAnn is not going "nuts" and seeks to normalize the crisis. The crisis worker focuses on the underlying emotional content of the loss of her sister and the upcoming anniversary as likely a key element in decreasing the client's perturbation.

The same is true of getting a handle on a huge source that would perturb most any student—the dreaded senior thesis. While her suicidal ideation is not dismissed out of hand, it is put in perspective as one component of her overall response to the loss of her sister and the other normal stressors she is experiencing at school. For many individuals a suicidal crisis may be a onetime occurrence brought on by acute situational events that, once handled, disappears forever.

Deborah, Age 27. Deborah had been in therapy, on and off, for 11 years—since she was 16. Deborah (1) had a history of suicide attempts, some of them serious, some of them gestures; (2) had used a wide variety of drugs in her college years—in fact, she had dropped out of college after 2 years because of drug use and resulting poor academic performance; (3) had a history of episodes of severe depression, loneliness, hopelessness, and helplessness followed by mood swings to euphoric and deep religious activity and commitment; (4) had been hospitalized numerous times for psychiatric care; (5) had experienced a great sense of loss and grief at the divorce of her parents when she was 16; (6) had recently gone into self-imposed isolation and remorse—cutting herself off from friends, family, and coworkers; and (7) was

feeling a new sense of meaninglessness related to her career—she had been seeking something that she really chose to do (as opposed to working for her father). Deborah, in tears, was trembling and in a state of acute anxiety and standing on the railing of a Mississippi river bridge preparing to jump.

The crisis worker is a Crisis Intervention Team police officer, described in Chapter 5, Crisis Case Handling. Police and highway patrol officers have stopped all traffic, and people are out of their cars, watching. The scene is tense, and it appears that at any moment Deborah will jump. The officer immediately implements Cochran's game plan model of giving his name (play 1) and getting her name (play 2) in order to establish personal contact. His use of "I" owning statements (play 3) and reflection and summarization (play 4) (Kirchberg et al., 2013) are designed to let her know he is listening and focused in on her alone and hopefully to develop a working bond.

CIT Officer: (*in a clearly audible but confident, soft, caring, and empathic voice*) My name is Mark. Tell me your name.

Deborah: (*hesitantly*) My name . . . is . . . Deborah. What . . . what do you want?

CIT Officer: I want to help you, if I can, Deborah. I can see that you are under some kind of terrible pressure to make you think about jumping off this bridge. I'd like to talk to you and see if there is any way I can be of help to you.

Deborah: I don't know that anybody can help me. (*a little indignantly*) Certainly not a cop! Shrinks haven't helped. How can you?

CIT Officer: Deborah, I'm concerned about your safety and about what's bothering you right now. I'm a cop all right, but I am also a Crisis Intervention Team officer. I deal with all kinds of people in crisis, and that's why they called me. For you to consider jumping, there must be a lot of pain that you can't seem to get relief from. If the shrinks haven't worked, how about giving a cop a chance? What's the harm? We have plenty of time.

The CIT officer immediately seeks to establish rapport with the jumper by establishing a first-name basis of communication. He validates her suicidal actions as a way to relieve emotional pain by matter-of-factly stating what she is doing and seeks to elicit what is causing her to do it. He uses a validation technique from dialectical behavior therapy (DBT;

Linehan, 1997) that sets up what at first might seem the exact opposite of what one would do. He promotes the central "dialectic" in DBT, which is that he accepts the client exactly as she is in the moment, with her suicide attempt as being her best problem-solving attempt available, but also simultaneously pushes the client toward changing the maladaptive behavior patterns that have gotten her onto the bridge (Rizvi, 2011). He further acknowledges who he is and what he is capable of doing, without any false promises. He works very hard to immediately build a trusting, empathic relationship that demonstrates congruence, honesty, and caring (Kirchberg et al., 2013). While it may seem like we are harping on this subject, building a therapeutic alliance (and this most certainly includes this police officer on the bridge with this client) is absolutely critical. Michel and Jobes's (2011) book spends more than 400 pages on this topic, providing clinicians with an arsenal of theoretical techniques on how to build the relationship. Michel (2011) quotes a woman whom he met in a support group of people with depression who had attempted suicide. She had the chainsaw scars around her neck to prove the gruesome way she had attempted to kill herself. He asked why these people had not sought help. She said, "We could only have talked to another person we knew would not be afraid of listening, without judging. In a suicidal crisis we could never have trusted a person who would want to talk us out of it" (pp. 5–6).

More than other types of crisis workers, though, the CIT officer's job is dealing with the imminent lethality of the situation. Safety of a suicidal/homicidal client (Rudd, Joiner, & Rajab, 2001, p. 152) is the overriding priority, along with the safety of the officer (Memphis Police Department, 2011).

CIT Officer: With the wind blowing and all the commotion around here, I'm having a difficult time hearing you. I need for you to come down off that railing and come over here to the curb and sit down so we can talk. You look like you could use a friendly ear to listen, and I'll take the time to do just that.

Deborah: I'm not sure talking will do any good. Just go away, and leave me alone. I don't need you here.

CIT Officer: Deborah, do you remember my name? My name is Mark. Let's take some time to talk. We've got time, plenty of time to just sit down together and talk. You do remember my name, don't you?

The crisis worker makes a point to try to establish a first-name mutual communication with

Deborah. Whenever a person such as Deborah is emotionally overwhelmed and immobile, one effective way to break through that immobility is to *personalize* the interaction. A good way to personalize a relationship with a client in crisis is to establish a first-name communication as early as possible (Memphis Police Department, 2011). He also attempts to slow the emotionally charged situation by repeating that there is time, plenty of time, to find out what is going on. That tells the client that in this moment, he is committed to the relationship, as transitory as it may be. “We have plenty of time” is almost a default phrase for us to slow down the rapid cognitive and affective cycling that is present in many kinds of crisis and to convey a sense of patience, understanding, interest, and thoroughness that usually is missing in crisis clients’ relationships (Kirchberg et al., 2013).

Deborah: Your name is Mark. So? How do I know I can trust you, Mark? I don’t see how you can make my life any better. I’ve about had it with this life, with this great big lump of hurt deep inside me that won’t go away. I’m really tired of this. Anyway, how do I know you won’t just put me in jail or that nuthouse they put me in last time?

CIT Officer: (*in a calm, low-key, confident, reassuring, caring voice tone*) Deborah, what I want to do is to understand what’s bothering you, so I can get you some help. What is it that we need to focus on to get you some relief? Right now, all I’m asking you to do for me is just to come over here to the curb, so you and I can take plenty of time to talk, so I can clearly understand just what is upsetting you. I’m certainly *not* here to put you in jail or the nuthouse. What I want to do is to try to find out what part of you is hurting inside so that I can get you to some place to get the help that you deserve. I can see you’re carrying such a heavy load to think that the only way of unburdening yourself is jumping off this bridge. I don’t want to see you get hurt. So could you at least step off the railing?

Deborah: (*Steps down off the railing and takes a few tentative steps toward the CIT officer.*) It’s just so overwhelming and hopeless. Nothing seems to work. Everything I touch turns to crap, school, love life, job, parents. I am tired of it. So tired.

CIT Officer: Okay, thanks for getting off the railing. (*Deborah sits down. Mark slowly moves by her side, sits down, and listens to her story unfold.*) Wow! That is a load. No wonder you felt like jumping. It takes

some courage to step away from ending all that pain and taking a chance on talking to me. I really appreciate that. I want to take you to a guy I know. He’s not a shrink. He’s a former police resource officer who works on the mobile crisis team. First I have to take you to the medical center and get you checked out. Is that okay?

Deborah: Will they give me electroshock treatments? I don’t want those.

CIT Officer: No, they’ll just evaluate you. Look! I want you to ride down there with me. I’ll have to put you in handcuffs for the ride there because that’s part of the police procedure. That may mean an all-night stay at the medical center, I don’t know. But I think I can get them to do the evaluation and then see about getting you out of there pretty quickly to a place and a guy I know about. While they are doing that, I’ll call Pete, the guy I told you about. As soon as you are checked out I’ll come back and get you and take you to see Pete—with no handcuffs. You ride up front with me. I think you’d like talking to him. I know sometimes I sure do when I’m in a bind. But let’s just sit down here and talk awhile, so I can kinda clue Pete in. Would that be okay?

Deborah: What the heck! I’ve never had my head shrunk by a cop. It can’t get any worse. Okay! (*Talks a bit more about what got her here while the CIT officer listens attentively.*)

In this case, the crisis worker was able, in a few minutes’ time, to validate himself to Deborah and gain her trust by focusing in on what is disturbing her and exploring her issues (Leenaars, 1994). Suicidal clients often cannot concentrate, so the crisis worker repeats himself using the broken record technique and continuously seeks to slow things down. He also attempts to get Deborah to a place of safety by asking her to move off the railing. He immediately reinforces her for getting off the bridge and again for being willing to talk with him. He does not make a promise he cannot keep. As an example, he promises her no electric shock treatments. He can do that because that procedure has not been done in years in his jurisdiction.

CIT officers like Mark have a great deal of discretion in what they can do with emotionally disturbed individuals they take into protective custody. While he might be able to get Deborah off the railing by lying to her about not taking her to jail or the “nuthouse,” the next time a police officer was asked to deal

with Deborah, she would remember the lie and be much more difficult to work with. Deborah complied with the crisis worker's request and was later taken to the emergency room of a public hospital, where she received medical and psychological evaluations.

The case of Deborah provides a brief example of how some simple verbal techniques, delivered with compassion, caring, and genuineness, can make a dramatic difference in the compliance and survival of many clients who are in acute disequilibrium and actively trying to kill themselves. After being checked out, Deborah meets Pete.

CW: I'm Pete, and you must be Deborah. Mark told me about you. I'm glad to meet you. It sounds like you had a heck of a night, and Mark tells me this isn't the first time you've felt so bad you wanted to kill yourself.

Deborah: He's right. I don't know why I didn't just go ahead. I was as close as I've ever been. I think next time that will be it.

CW: I'd like to do something a little different from what you are maybe used to. Instead of doing crisis intervention, I kinda do crisis management here with the Midtown mobile crisis unit. Are you interested in learning how to manage some of this stuff?

Deborah: Man, if I just could. That would be something else.

Crisis Management. Dealing with chronic or episodic suicidal behavior is different from one-time suicide attempts. **Crisis management** refers to the act of planning a response to recurring suicidal behavior in *collaboration* with the client (Bongar & Sullivan, 2013, pp. 157–240; Chiles & Strosahl, 1995, pp. 125–147; Jobes, 2006; Kleespies, 2014, pp. 20–24). While we are indeed involved in treatment of a lethal behavior, there is an important distinction between treatment and management. Treatment implies an end point “cure.” Management implies an ongoing problem that needs a continuous collaborative effort between the client and the worker until such time as the client decides that lethality really is no longer a viable option (Jobes, 2006, p. 69). While little can be done about static (unchanging) risk factors such as race, age, and chronic mental illness, dynamic factors (modifiable) and risk factors such as hopelessness, alcohol abuse, financial crisis, or acute depression can be managed (Kleespies, 2014, p. 21), and those individuals who are operating at a moderate risk level can

benefit through outpatient management (Bongar & Sullivan, 2013, pp. 157–200).

The goal is to establish a framework that rewards alternatives to suicidal behavior and minimizes the short-term reinforcements that occur when suicidal ideation and behavior start to develop (Rizvi, 2011; Wenzel, Brown, & Beck, 2009, pp. 173–198) and develop a safety plan (Stanley & Brown, 2012). Pete is a member of the mobile crisis team for Midtown Mental Health Unit and a licensed professional counselor. He is a retired police officer and still serves as a resource officer for police officers who are experiencing personal and professional difficulties. He will use a collaborative cognitive-behavioral therapy approach (Brown, Wenzel, & Rudd, 2011; Wenzel, Brown, & Beck, 2009) with Deborah. To do that he will need to determine the central cognitive pathway that leads her to consider suicide. He will need answers to the following questions:

1. What about the client's history generates the suicidal behavior?
2. What precipitated this crisis, and is it different from other trigger events?
3. How does the client think about suicide?
4. What does she feel during the crisis?
5. What is she feeling physically?
6. What active or planned suicidal behaviors have occurred or are occurring? (Rudd, 2004, p. 67)

He is straightforward, honest, empathic, supportive, a bit cynical and worldly wise, with little professional psychobabble, one-upmanship, or discounting in his approach. He represents the potential for a perfect match in bonding for a person who has had very few positive attachment figures or trustworthy support persons in her life (Holmes, 2011). Overall, his goals and strategies closely follow Bongar and Sullivan (2013), Chiles and Strosahl's (1995), Jobes's (2006), Sommers-Flanagan, Sommers-Flanagan, and Lynch's (2001), and Joiner and associates' (2009) management plans for continuing treatment of a suicidal client:

1. Destigmatize the suicidal behavior by using an objective, personal (self), scientific approach through teaching self-monitoring and hypothesis testing of behaviors.
2. Objectify the client's suicidal behavior by using reframing and problem solving, validate the emotional pain, move suicidal behavior off center stage, and calmly discuss past, present, and likely future suicidal behavior.

3. Address the likelihood of recurrent suicide behavior by developing agreements with clients about a behavioral crisis protocol and crisis management plan.
4. Activate problem-solving behavior in the client through teaching problem-solving skills, look for spontaneous problem solving, reinforce and enhance skills, and better understand short- and long-term consequences of behavior.
5. Develop emotional pain tolerance by teaching the distinction between just having and getting rid of a feeling, understand that suicide is an emotional cop-out, differentiate between emotional involvement and suffering, impart a contextual approach to negative thoughts and feelings as opposed to a global, pervasive view of negative emotion, and learn how to distance oneself by accepting that negative emotions are merely a part of living and not catastrophic.
6. Develop specific interpersonal problem-solving skills that promote interaction rather than avoidance and isolation. Get the concept of belonging back into her life and the idea that she has something to contribute to the world rather than being a burden on it.
7. Develop intermediate-term life direction through concrete, positive, initial steps that stress the process of goal striving as opposed to the all-or-none, success-or-failure approach to reaching goals.
8. Stay calm while listening with empathy.
9. Instill hope and confidence while establishing a therapeutic alliance.
10. Establish a crisis management plan for living and a backup plan that can be employed at the first sign that suicidal ideation is emerging.
11. Find out what part the specific minicultural microsystems (family and community) (Hirsch & Cukrowicz, 2014) play in contributing to suicidal ideation and conversely what they can contribute to lethality resistance.
12. Use the ADDRESSING model of Hays (2001, 2008) and the RESPECTFUL model of D'Andrea and Daniels (2005) to understand and incorporate general cultural components along with Nobbman's (Nobbman et al., 2014) specific crisis SAFETY social locations into the suicide management plan (see Chapter 2, Culturally Effective Helping in Crisis, for these acronyms).

CW: Here are some things that I'd like you to think about doing with me. We work together on this,

and sometimes other people get involved, but mainly it is you and I. First off, let's just take it as a given that you will probably consider suicide again. That is at present a fact of life. It is not forever, however. What we want to do is take away the reinforcing value of it as a short-term solution and look at the long-term benefits of doing something else. If it happens again, we don't see that as a failure but rather as something to troubleshoot and figure out what we have to do to fine-tune the plan so it is less and less likely to happen. I also want to take a look at when you are having thought disorders and mood symptoms. Those are important to know when they start in, so we can do something about them as opposed to just waiting for them to become a tidal wave of emotions and thought that wash over and drown you. The same is true of booze and drugs. If you are using those, we need to do something about that because they go hand in hand with thinking about killing yourself.

You don't get lectures from me. You choose what it is you want to do about it and I will support you. If you believe AA or other treatment programs are needed, we can work on that. We need to plan activities that substitute for those times when you might drink or get high. We want to think small, specific, and concrete on this plan and just keep it a few days ahead, so it doesn't get too big and cumbersome and hard to do. We want you to see positive, concrete changes in your life and get control back in it. When that happens, suicide behavior won't happen because you won't see the situation as unchangeable. So if I were to ask you if you were to do *something* in the next two days, and you could, would you see that as a sign of progress, and would you be able to tell me exactly what that was and why it was a sign of progress? Those are the things we are looking for in this plan. Things like decreasing social isolation, increasing pleasant and healthful activities, engaging in a work or leisure activity with someone you like. Something that is small to start with, but very concrete. Something you can hang your hat on and say, "See, Pete, that is progress!"

While this is going to be focused on changing behavior and problem solving, we need to remember that suicidal behavior is supported by emotional pain and the feeling that "I can't escape it, and it is intolerable." To that extent we are going to talk about emotions—journal emotions, tape-record emotions—and take them apart and put them back

together again. We are going to listen to those emotions and work through them so they don't build up and blow up and become all-encompassing and overwhelming.

Now, if suicidal behavior shows up again, we need to plan for it and be in control. First, I'd like to write down a crisis protocol card, so that you would know exactly what to do. You would be in control of it and not vice versa. On that card we would put the resources you could use and call on, like telephone numbers, e-mail addresses, hours of operation, and so on. We also want to put two or three cues on the card. Things like "Okay, I am starting to feel anxious. I need to take a deep breath and relax, just relax." Or "Whoa! Wait a second. What am I getting into here? If my hands are sweating, that means I need to step back and take a look at this and see what the behavior is getting me." By having these cue cards, lots of times we can spot trouble and stop it before it gets started.

I am going to text you at random to see how you are doing. I may also call you if things get more complex than a text will take care of. This is not going to be "snooping." It is going to be concern. The calls won't be long, just brief checkups of 2 to 3 minutes. You can also text to me or call if you want. Just to keep a check on the plan. If things really go to hell in a handcart and you can't get me for some reason, you'll call the local hotline or the national line. So there are no cop-outs or excuses on this plan. You always have backup just like cops call for backup. Backup keeps you safe and alive.

We are also going to talk honestly about when you need to be admitted to a hospital. If that happens, it would be better if you decided to check yourself in for a time-out rather than having me, or somebody like me, involuntarily hospitalize you. I understand that's not real palatable, but it would be you who would be deciding and not somebody else. We are going to do the same thing with medication. What you have been on has not worked very well. I want to look into getting that reevaluated. The whole idea is for you to take more and more control over your decisions. If suicidal behavior should occur, we will see it not as a failure but as an opportunity to troubleshoot what we are doing and change things. The bottom line is that we want to neutralize the reinforcement of suicidal behavior so that it no longer has positive valence, and have other more positive, addicting behaviors and healthful living activities take its place. I will help you manage this, but it is going to be you

who will have more and more say in what is to be done. That is a big, long speech. And it sounds like a lot, but we will take it one day and one step at a time. What do you think?

Deborah: It's kinda scary, but kinda thrilling too. I don't know. I kinda feel good for the first time. Maybe like in some control, but that's scary, I've been out of it so long.

The key component in crisis management is normalizing the situation and showing the client that everything comes down to problem solving in a matter-of-fact way. Suicide behavior will invariably recur in a client like Deborah. To keep her from getting discouraged, we treat suicide as an annoying, inconvenient, but important piece of business that is not catastrophic and does not mean she is an abysmal failure. By focusing on problem solving, developing tolerance to emotional distress, changing disturbing self-images, halting impulsive behaviors, creating anger-management skills, and generating better day-to-day functioning at home and work (Michenbaum, 2005), we start to build resiliency and emotional toughness in the chronic, suicidal client. This is not an easy task, but it is one that can be done and can be successful.

CW: We are going to work out a treatment plan for living, but first thing is I'm gonna give you my business card with phone and text number and e-mail on it. That is for you to call, no ifs, ands, or buts, if things are really starting to go in the toilet. But the important thing is, it is your crisis card and on the back we are going to brainstorm and come up with five activities that when things start to go to hell in a handcart are positive actions that will break that doom-despair thinking and turn off that emotional motor running wild with affective dysregulation, so you don't need to call me but can take control of things yourself. It sounds simplistic but it works. These are positive activities that will require you to get off your rear end and go do something so that you get busy and take your mind off of those inner voices.

Of all the things that don't work in the lethality intervention business, Pete uses a couple of very simple tactics that do work—particularly for those clients who have been hospitalized: follow-up phone calls

(Vaiva et al., 2006), text messaging (Berrouiquet et al., 2014), and crisis coping cards (Jobes, 2006, pp. 80–82). The phone calls and texts provide follow-up support that says you belong and you are not a burden. The protocol card helps clients kick-start their crisis management plan, because lots of times it is difficult for clients to initiate problem-solving skills on their own. A bullet point cue card that is concrete gives them specific real-time instructions on recognizing warning signs and instituting coping skills (Brown, Wenzel, & Rudd, 2011). While there have been online services (Best et al., 2013) and phone apps developed for suicide intervention (Aguirre et al., 2013), they are so new we are not willing to make any recommendations on them as of yet, although it's fairly clear they'll start to play a larger part in prevention.

Simone, Age 36. Simone was the director of a rape crisis center in a large metropolitan area. She had established a reputation as an effective leader, public relations person, fund-raiser, recruiter, and trainer of volunteer workers for the center. She was tireless, dedicated, popular, and widely known as the leader of one of the best organized and most effective crisis agencies in the community.

Now, after 6 years as director of the center, Simone was approaching burnout. She was also experiencing grief and rage over a broken relationship. Simone was astute enough to finally recognize that she was on the verge of some kind of breakdown and was considering suicide or homicide, so she sought counseling at her agency's employee assistance program (EAP) clinic.

CW: So, Simone, from what I can glean from your intake material and from what you just said, I sense that *you* are fully aware of your vulnerability right now, but are keeping up a good front for the troops.

Simone: (*in a clinical, detached fashion*) That's right. And there's no use in my problems interfering with the work at the center. That's the most important thing. Even so, my issues are affecting me, at least. And, right now, I'm really feeling trapped; no good to them or myself either.

CW: What's the most pressing issue in your entrapment?

Simone: (*Starts to tremble and shake with a tremor in her voice.*) Well, part of the problem is at home. I've had the rug pulled out from under me . . . literally. (*Laughs ironically.*) My partner, Rene, my soul mate for over 6 years, has taken off. It happened

right under my nose. (*Hits her chest in recrimination.*) So stupid! So blind! I didn't see it! She has managed to leave me high and dry with little money and with all the bills. She took most of our furniture, much of which I bought myself. And she took both our dogs too! That cold-hearted bitch! This all happened just when we were getting ready for our one big fund-raising event of the year at the center and just as we were preparing for the accreditation site team to visit the center in a few weeks.

I'm feeling so hurt, so humiliated, and so betrayed that I am overwhelmed with anger, disappointment, and depression. I have scarcely slept or eaten for over a week. I thought our relationship was for keeps. I feel like killing her if I could get my hands on the cheating rat, but I still care about her so much! I want the miserable creep back! I'd kill that little blonde bitch if I could find out where they took off to. Her too! I'm feeling so worthless and undesirable and tired of this nightmare that sometimes I just wish I'd sleep forever.

CW: What you've just said worries me. Now I'm concerned about your safety. Are you feeling so depressed and angry that you might consider suicide—or homicide for that matter?

Simone: I don't know how I feel anymore. I guess I wouldn't go that far. Suicide, that is. I want her back more than anything. But I've even thought to myself, "If I can't have her, then nobody can." But I know that's not realistic either.

CW: Simone. Does that mean that you might consider doing harm to Rene or even to her new girlfriend? Have you thought about how you might hurt them if you were going to?

Simone: When it came right down to it, I don't think so. But I'd certainly feel like it sometimes. No, I'm just distraught and mad as hell right now. I'm really harmless, I guess. I don't know what I need. Some space, maybe. Another job, maybe. I don't know. Just some relief and love and rest and to get over this crushing pain.

Simone continues her catharsis about her romantic betrayal and the deep hurt it has caused her for another 30 minutes. The crisis worker listens intently for signs that she may have the means, access, and availability of acting on her stress and perturbation. During that time she gradually subsides emotionally and regains a good deal of her cognitive ability, to the point the crisis worker rates her affect as 7, behavior as 5, and

cognition as 5, for a full scale score of 17. Her Suicide Status Form III (Jobes, 2006) is in the average to above range, with 3's and 4's and an overall rating of 3.5. Her Interpersonal Needs Questionnaire (Van Orden et al., 2008) indicates some feelings of burdensomeness and a lack of belonging in the middle range "as somewhat true." However, she does give "very true" endorsements of people who care about and support her, which is a major plus. More ominous is her Maslach Burnout Scale (Maslach & Jackson, 1981), which indicates an extremely high score on the Emotional Exhaustion and Depersonalization scale and a low score on the Personal Accomplishment scale, indicating she is well on the road to burnout (see Chapter 16, Human Services Workers in Crisis: Burnout, Vicarious Traumatization, and Compassion Fatigue).

Some safety measures will need to be put in place before she walks out the door.

CW: I believe you, but I need a no-harm contract from you, written down and signed before you leave here today. Can I trust you to do that? I also want to institute a treatment plan. Your scores on the two lethality assessments are not in the lethal range, but they are fairly high. The fact that you have considered lethal action is a warning we need to take seriously. You are a smart professional, but even smart professionals don't always know when they are in burnout and your scores on the burnout scale tell me you are, along with what you self-report.

The case of Simone provides one glimpse of a crisis worker inquiring about both the client's suicidal and homicidal potential. The worker has determined that Simone's possible threat to herself and others is in the low-to-moderate range on all dimensions of the TAF. However, she writes an anti-suicide/homicide contract with the client. There is a good deal of divisiveness in regard to "no harm" contracts (Dorrmann, 2005; Granello & Granello, 2007; Joiner et al., 2009, p. 92; Range, 2005). Chiles and Strosahl (1995, pp. 131–132) have criticized the no-harm contract because it specifies what a person *should not* do instead of *should* do, and they question its utility if a person starts to feel guilty about not abiding by it and terminates therapy as a result. Everstine (1998, p. 101) somewhat cynically believes that at least a no-harm contract is protection against a malpractice suit, which Joiner and his associates emphatically refute (2009, p. 92). To that end, the American Psychiatric Association has stated that no-suicide contracts should not be used with patients who are actively suicidal.

Reasoning for Living Contracts. Undoubtedly, what we are about to say is going to create some controversy with contemporary suicidologists. First of all "no harm" or "antisuicide" contracts signed between worker and client have absolutely no legal bearing or support if you get sued. They absolutely do not substitute for a thorough management and treatment plan (Bongar & Sullivan, 2013, p. 6), and there is little research to support their use as effective suicide deterrents (Range et al., 2002). However, Davis and associates (2002) interviewed psychiatric patients and found they viewed them as beneficial to treatment with the exception of multiple attempters who did not believe antiharm contracts were helpful. Further, the Granellos (2007, p. 239) and Jacobs (1999) believe that most clients view contracts as positive, and that they communicate a sense of caring and help build a strong therapeutic relationship.

While such contracts have no legal bearing and cannot guarantee the client's or anyone else's safety, your authors have found that clients will rarely if ever go back on their word when asked to commit to such a contract if a commitment to treatment statement is put in place with it. The contract is really a tactical move to buy time and create a bond. It gives time a chance to operate and ameliorate the hot cognitions that are driving the client's suicidal ideation. To be as emphatic as we can possibly be, this is only a technique and NOT A LEGAL FAIL-SAFE. It does not replace or substitute for a fulsome treatment and management plan either legally or ethically.

Following are two very different types of no-harm contracts. The first is the more standard type of contract. The stay-alive, no-harm contract is instituted and negotiated in a realistic manner. It is simple and to the point, with no vagueness or wiggle room (Hipple & Cimboric, 1979, pp. 67–73).

Simone's Stay-Alive, Do-No-Harm Contract

I will not harm myself or anyone else for the next month while I work on my problems.

I will not attempt to kill myself or kill anyone else without talking to you first. If I cannot reach you, that is not an excuse for abrogating the contract. I will call the suicide hotline and talk to them. I will voluntarily check myself into Mid-south Hospital if all else fails.

Date _____ Signature _____

Date _____ Witness _____

A different, somewhat controversial contract has been developed by Everstine (1998, p. 118). Everstine believes that most suicidal/homicidal behavior is caused by our anger toward others. Therefore, his contract focuses on the significant other that the anger is directed toward, but more important, it states that the person's life is important to someone else. Everstine proposes that the self-contract be shown to the beneficiary of it, which will make the contract explicit and change the commitment to a shared one (p. 119). Such a contract fits really well with Simone's anger, so we would attempt to turn her anger and hurt into an asset through the contract.

Simone's Self-Contract

1. The person whom I hate most is: That snake who stole Rene from me. I KNOW THAT THIS HATRED COULD COST ME MY LIFE!
2. If I die, other people who will suffer are: All of the rape victims I could serve and the great staff I have built.
3. I have decided to stay alive because of: The work I do and the possibility of finding another fulfilling relationship.
4. I am also going to commit to a treatment plan that will help with not just my personal issues but professional issues as well, because I need to get a handle on these issues so I can get back to the competent and happy Simone I liked a lot before this happened.

Date _____ Signature _____
Date _____ Witness (Center Staff) _____

Courtois (1991) cautions that antilethality contracts must not be imposed on clients. Rather, such stay-alive contracts must be mutually agreed on by both client and crisis worker. That caution applies also to no-harm homicidal contracts.

Latasha, Age 51. Latasha was an eminent and successful elementary school principal who had devoted her life to children and the teaching profession. She was exceptionally capable, hardworking, conscientious, and efficient. She was also compulsive and a perfectionist in her work and personal habits. At age 51, Latasha faced some life and career decisions that she regarded as catastrophic: (1) She had recently had bypass heart surgery only to discover she had breast cancer, and she could not bear to think about her physician's recommendation to accept early retirement and undergo a mastectomy.

(2) She felt trapped between the two perceived unacceptable choices of continuing to hold the principalship in her debilitating physical condition, or becoming the ex-principal who had been forced into early retirement. (3) She was totally unprepared to alter her whole identity, which had included serving the students, faculty, parents, community, school, and the teaching profession. Latasha had no family. She had never married because she had devoted all her energies and talents to education. She came to her longtime friend and colleague, the Jefferson Elementary School counselor, in desperation.

Latasha: (*in tears*) It is so hopeless. Why me? Why has God forsaken me? I have been a good Christian. A good person. A good teacher. A good principal. What have I done to cause me to come to this? I don't think I can bear it. (*Sobs. Pause.*) It's so unfair. I have no choice. (*Sobs.*)

CW: (*reaches out and touches Latasha's arm*) You're feeling hurt, hopeless, and vulnerable—and you're looking for better answers and choices than you've been able to find so far. Because so far there are none.

Latasha: (*still in tears*) For the first time in my life I have no ideas, no options.

CW: I want you to know that I'm glad you have the courage to discuss it. What scares me is the desperation and danger you're feeling. You're feeling that, right now, there are no acceptable choices. That's a really tunnel vision view that's not like you at all.

Latasha: (*Still in tears. Nonverbal clues show that she is experiencing acute fear, anxiety, and hopelessness, and has almost given up.*) None. None at all. There is no future.

CW: Latasha, it sounds to me like you've considered suicide. I want to know your thinking on this subject.

Latasha: (*still in tears*) Oh God! I've thought about that a lot. Toyed with it a lot. And I'll have to admit that it becomes more appealing all the time. I have these pain pills for the cancer treatment. I could take them all at once.

CW: Do you have a plan on how to do it?

Latasha: I would put on some Brahms, get a large glass of Chablis, rip the phone line out so I wouldn't chicken out. No one would be in the office. It'd be June 9th, the day school is out, about

11 in the evening. Everything would be finished up at school, and everybody would be gone. I work late a lot on Friday so security wouldn't bother me. That would give them time to get another principal. I even made some recommendations I have written down. It would be all settled. Actually, I am feeling a little peace with myself as I talk about it. Strange!

Latasha's plan is highly lethal. She has thought carefully about it. She has the means and the method, and the plan is close to irreversible. Her contemplation that she feels at peace is another highly lethal indication that she has settled her affairs. The fact that her colleague and friend is hearing this makes the decision the school counselor is about to make terribly difficult, but it is one that her training has instilled in her. In such instances, it is critical not to match the client's anxiety level. Moralizing, placating, coercion, lecturing, or other attempts to discount the client will only exacerbate the problem (Chiles & Strosahl, 1995, pp. 113–115). The potential for countertransference to arise in such situations is high. Disregarding cries for help because of their threatening nature, denying the facts because of the personal relationship with the client, feeling a lack of expertise because the person is not an "expert" suicidologist but merely a school counselor, and being lulled into a false sense of security by who the client has been as opposed to the state of being the client is now in are serious dangers, and staying in self-control and not becoming vague and tangential are critical to the process of stopping this suicide situation (Leenaars, 1994, pp. 56–57). The *Tarasoff* ruling has just come into play here, and if the school counselor did not assess for suicide and did not take action, she could be held legally accountable as negligent (Granello & Granello, 2007, pp. 266–268).

CW: (Very clearly, empathically, and emphatically makes the following declaratory and exclamatory statements.) What you have just said scares the daylights out of me, Latasha. I cannot and will not let you do that! If you won't go to the superintendent with me right now and tell him you need some help, I will call him myself! If I have to, I will call the school resource police officer to contain you until we can get you to a place of safety. I believe that you have become so constricted you see no options. There are options, and you need to stay alive to find them out! I don't think you would have talked to me if you didn't believe there was

something left and you needed another view. Well, I am giving you that view. So which do you wish to do? Go with me to the superintendent or have me make the call? You could run right out of here and go swallow all those pills, I suppose, but then we would call an ambulance and they would take you out in front of the kids, which I don't think you would see as real uplifting. So you see there are some choices left, and the first one is, "Do we go now, or do I call now?"

There are no ifs, ands, or buts about this scenario, and there is no need or time to do any kind of written assessment. The TAF puts her clearly in the high 20s. The school counselor is ethically and legally bound to take action (Chiles & Strosahl, 1995, pp. 17–35; Granello & Granello, 2007, pp. 266–268; Hipple & Cimbolic, 1979, pp. 94–100; Leenaars, 1994) no matter what the client's protestations about confidentiality, broken friendship, trust, or any other pleas. The school counselor, like any other helping services professional, has a duty to disclose life-threatening behavior. That the client is her boss makes no difference. The counselor also lays a guilt trip on the principal to stop any impulsive attempts by reminding her that it would not be good form or model very good behavior to be hauled off in front of the school in an ambulance or police car. This tactic is one used by Everstine (1998, pp. 113–114) to remind clients that there are many more potential victims than their constricted view of things allows them to see. Latasha's love for the children of her school would be a powerful deterrent to doing anything foolish and precipitous.

While hospitalizing a potential suicide is no guarantee that the person will not kill herself, given the clear intent to do harm to herself, at the very least the crisis worker is removing the principal's immediate access to killing herself (Joiner et al., 2009, pp. 88–89). Whether she goes ahead in the future is another matter, but putting her in the hospital will bring the psychological perturbation she feels into full view of her oncology team who can then step in to deal with that aspect of her cancer.

While professional ethics frown on close friends or professional associates counseling one another, we believe that crisis lethality issues override that ethical standard. In the real world, this example of a close relationship between two colleagues is included here because all too often this is exactly how the discovery of a potential suicide occurs. Close friends should be aware of what they need to do and do it proactively

and without guilt (see Chapter 16, the case of burnout in Dr. Jane Lee). If the worker is not sure about what to do, doesn't feel he or she has the necessary expertise, or is too close to the client personally, the watchwords are "refer if possible" and "consult"! There is no instance in a helping professional's life when consultation with a peer is more important than when dealing with lethality (Leenaars, 1994).

Older Adults

The number of older adults across the world is growing rapidly. As baby boomers age, this fact, combined with the high suicide rate in the elderly, means that a lot more service providers for geriatric populations are going to be needed, and those providers are going to need to get into the suicide prevention/intervention business (Erlangsen et al., 2011). Suicide in the elderly is treatable and preventable (LaPierre et al., 2011), yet it is one of the most neglected areas in the entire field of suicidology (Richman, 1994). It is the age of the highest incidence of suicide and, concomitantly, depression, cognitive impairment, isolation, and physical illness (Granello & Granello, 2007, pp. 75–79; Harwood & Jacoby, 2000; Heisel, 2006). Suicide among the elderly is also the most lethal, in that it uses lethal means and is well planned. It is rarely a cry for help or some spontaneous impulsive act (McGlothlin, 2008, p. 124). By far and away, it is the male Caucasian in this age group that is at highest risk (Granello & Granello, 2007, p. 79). Research indicates that the percentage of failed attempted suicides decreases with age, and the percentage of completed suicides increases with age (Stone, 1999, pp. 45–50). The same is true for homicide/suicide in the elderly, which occurs at nearly double the rate of young adults. Usually the perpetrator is a male who kills his wife or other intimate and then commits suicide himself (Cohen, 2003).

The worker's assessment brings to the forefront a special consideration for dealing with older people. That assessment should include ego-weakening factors such as chronic and acute physical and mental illness, elder abuse, alcoholism, prolonged stress, failure to respond to medical treatment, and complicated/prolonged grief (for a complete description of this phenomenon see Chapter 12, Personal Loss: Bereavement and Grief). A variety of social factors, such as having fewer friends, living alone, being excluded or living on the periphery of social and family events, and being separated from the family through children leaving, all contribute to the potential for

suicide (McGlothlin, 2008, p. 124–126). Psychodynamic factors most often include the stress and strain of various losses, such as the loss of a spouse, friends, work roles, and income. Chalking these risk factors up to "just growing old" is to put the elderly at risk for suicide (Richman, 1994).

Roy, Age 68. Roy had been a farmer all his life. At age 65 he went into semiretirement, turning his land, equipment, buildings, and livestock over to his two sons, who also were career farmers. One year after he began his semiretirement, his wife died. About a year later, he was despondent and could find no purpose in life, even though he was in excellent health and had the good fortune of financial independence. He has been somewhat alienated and estranged from his two sons because of disagreements and arguments over their "newfangled" farming practices that he doesn't always agree with. The foreman of the farm, Juan, came upon Roy standing on a tractor in the hall of the barn. Roy held a rope with a hangman's noose in it, and he was attaching the rope to an overhead crossbeam. Roy, thinking he was completely alone, was surprised at Juan's appearance.

Juan: What on earth are you doing there, man?

Roy: (*Almost falls off the tractor he is so startled.*) Where the hell did you come from? What are you doing here?

Juan: I'll tell you what I'm gonna do right now! I'm taking that rope away from you this minute! You're going to get in my pickup truck this minute. I'm driving you straight to the mental health center. That's where we're going. And I'll tell those boys of yours what you've tried to do too! Don't you know that it'd just kill those boys if you finished what you were planning to do? What the hell did you think you were doing, anyway?

Juan's alert and decisive actions clearly show that one does not have to be a trained human services worker to contain and control a situation in which human life is at risk. The crisis worker at the mental health center knew nothing about Roy's problems, but he recognized that a person of Roy's age, gender, life circumstance, style, and sense of private independence would rarely, if ever, present himself for counseling (Chiles & Strosahl, 1995, p. 240). In assessing Roy's responses, the worker quickly concluded that he definitely exhibited six of the lethality characteristics that Fujimura, Weis, and Cochran (1985) defined as high-risk factors: (1) the plan was definite and readily

accessible, (2) the method was irreversible, (3) there was indication of sleep disruption, (4) support people would not be around, (5) rescue would be improbable, and (6) the most valued possessions had been disposed of. Also, the crisis worker knew that among men Roy's age, there are very few suicide gestures or attempts. Older men are more likely to accomplish the act than to merely attempt it (Shneidman, Farberow, & Litman, 1976; Stone, 1999). The crisis worker immediately suspected loss as a factor in Roy's decision to kill himself. Shea (2002, pp. 27–28) proposes that the elderly are subject to a series of losses, and as they suffer these losses, the potential for lethality rises. They include loss of health, mobility, cognitive functioning, ability for self-care, role with family or society, skills, job or job opportunity, means of self-support, home or cherished possessions, and loved ones including pets.

CW: Roy, lots of times men who have had lots of responsibility find that as they age, their ability to take on those responsibilities becomes more difficult. They also may not feel like they mean much to anyone because they don't have much importance or lose their capabilities—that in fact they are becoming a burden. I'm wondering how you feel about what I just said?

Roy: Well, now there's really nothing else to live for. A man's got to have some purpose. I've got nothing to go to—nothing to get up for in the morning. I just don't know what's gonna happen, and I frankly don't give a tinker's damn. My wife's dead. I can't hardly do anything anymore. The boys don't need me to run the farm, and I damn sure don't need no therapy or no shrink.

CW: *(Thinking to himself: "Wow! He's not fooling! With all this intake information pointing toward suicide lethality, I don't need any more assessment data right now. I'm remembering his age, his male image, his having disposed of all his property, his wife's death—these are potent indicators—and this morning, an aborted self-hanging! It's a wonder he's even here!")* Roy, what happened this morning is scary indeed. I'm setting up a complete medical evaluation for you today. I have called your family doctor. I have also called your sons, who are on their way in here right now. To say that they are very concerned is putting it mildly. I know you probably hate it that I called them, but we need to get some support systems in place and straighten some things out between you and your family.

While older clients will see their family doctors for a variety of physical complaints, they will seldom,

if ever, speak about psychological duress or even consider it as a possibility! Conwell and Heisel (2006) found that up to 75% of older adults who committed suicide had been to their family doctor within the previous 30 days. All of Roy's symptoms indicate he has slid, ever so gradually, into being at least demoralized, if not depressed, by life's circumstances. Even though he would appear to have everything to live for, the loss of his wife, when they had grand plans for retirement together, the death of other close friends, and the disintegration of his social network as friends die, go to nursing homes, or move away, all have slowly led Roy to perceive life is no longer worth living.

The benign neglect and estrangement with his sons is another piece of the suicide puzzle that needs to be dealt with. While it might be readily apparent why elderly people would commit suicide if they were physically abused or neglected, more often their adult children are guilty of benign neglect or annoyance at dealing with the foibles and frailties of older people. Grown children have their own lives to lead. They may either believe that their parents have little or no need of them, or become annoyed by their increasing dependence. As a result, they tend to avoid and exclude their parents not only from activities but from decision making.

Social isolation is further compounded by the loss of friends. As a result, one of the key factors in dealing with the elderly is to set up in step-by-step fashion a new set of life supports. Reconnecting with people is paramount. If a person is unable to engage in former leisure or work activities because of a decrease in physical or mental functioning, then new activities that are socially connective and challenging to the client's physical and mental capacity need to be instituted (Richman, 1994).

While at first glance these therapeutic goals may seem a long way from suicide intervention, they are in fact directly related to it! Disengagement (a progressive withdrawal from the wider world), activity (decreased levels of physical, emotional, and cognitive activity), role exit (social usefulness diminishes as work activity ceases), and social exchange (limited ability to engage in new relationships) theories all play a significant part in whether older persons become suicidal (Granello & Granello, 2007, p. 78).

The other compounding problem is medication and neurotransmitter changes. Jacobs (1999) and Wenzel, Brown, and Beck (2009, p. 267) propose that older adults may engage in **chronic suicide** or **passive suicide** when they decide to quit taking their medication because of side effects, cost, or the notion

that stopping taking it will hasten death. In many instances, forgetting to take medication, misdosage, polymedication administered by different doctors, and bad drug interactions contribute to depression. For this reason, it is paramount that primary care providers be contacted and physical and mental health issues be coordinated (McGlothlin, 2008, p. 125). Combined with the effects of alcohol or illicit drugs, the potential for psychological problems becomes exponentially greater in older adults (Chiles & Strosahl, 1995, p. 243). Added to the foregoing is the mounting suspicion that serotonin levels are affected by aging. Thus, the mere fact of getting old may biologically predispose a person to suicide (Granello & Granello, 2007, p. 79; Harwood & Jacoby, 2000).

One of the primary techniques for bringing elderly clients out of suicidal ideation is to remotivate them to live. Chiles and Strosahl (1995) have developed a Reasons for Living Inventory that may be given to clients; it covers survival and coping skills, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections. While clients may naysay many items, there are invariably some they will agree with. The crisis worker may then use these items to combat the suicidal ideation and reinforce the elderly client's desire to live.

CW: *(Two days after Roy has been medically evaluated for an antidepressant and has had an emotional but positive family session with his two sons.)* So, after talking with your boys and taking the inventory, you have said at least these items would be important: not wanting to be seen as a coward or selfish; my sons might not believe I loved them; I do want to watch my grandchildren grow up; others might think I am weak or selfish; I wouldn't want people to think I didn't have control; I have had a love of life; and there are some experiences I haven't had yet. So those are some reasons for living. I further think that the antidepressant the doctor has prescribed will kick in and you will start to feel like your old self. I want to let you know that there is a group of folks that meet at St. Mark's church that I work with. I understand that might be pretty repulsive to you, but I asked Jim Joyner if he wouldn't mind talking to you about our group. I believe you know him. In the meantime, I'd just like to make sure that if you start to feel down, you know you can call me before we meet next week. I have also done a little investigating

and I believe the agriculture teacher at the high school would be very interested in your expertise in no-till planting, the top-flight soil conservation you are known for, and working with him on the school ag program.

Roy: Hell, I guess it wouldn't kill me to listen to Jim. It's gut wrenching, but I do appreciate what you're trying to do. I particularly appreciate the head-to-head with Leroy and Ronnie. I couldn't have done that myself. I do take a lot of pride in them and the grandkids. I don't know what got into me. Hmm! The ag teacher said that? Hmmm! Well, maybe.

CW: Roy, I want you to know that I feel good about your progress and, given I have dealt with a lot of people in a situation like yours, the prognosis for you is good. There are a couple of things I want to do, though. First off, we are going to put together a treatment plan. It isn't a forever plan, and I really believe that it's about 4 to 6 weeks' worth of work. That plan is going to involve coordinating your medication with your primary care doctor; some more meetings with your sons that I want our family therapist here at the clinic to do; getting you back socially involved again; and not just letting all that knowledge you have sit out there and ossify on 1300 County Road 1321 East. I also want you to make a contract for living with me. It is essentially a "I won't kill myself while we are working on this" contract. I believe your word is good, so I am willing to talk through it and get a handshake to seal the deal.

CW: Well you've done okay so far, so I don't see why not. You got my word. *(Leans over and shakes hands.)*

We have spoken to the controversial aspects of no-harm contracting. However, we believe as does Jacobs (1999) that when combined with a treatment plan, a no-harm contract is particularly effective with the elderly because they are excellent at keeping their word and adhering to contracts. Getting Roy involved in a support group with a former friend is a key ingredient in getting a social support group of peers in place. Social support is critical and needs to target the peer groups and pleasurable and stimulating activities with which the elderly are involved (Wenzel, Brown, & Beck, 2009, p. 278). The crisis worker is very directive and active in instigating these interventions because most people who are depressed are going to have a very difficult time initially acting on their own.

CW: (*one week later*) You have a couple of what we call “automatic thoughts” linked with some recently developed core beliefs that have helped kick this depression into high gear. Listening to you, they are very different from what you typically have thought and are really typical of the kind of thing that gets a person depressed. For instance, some of your core beliefs are “I am on a downhill slide and there’s no upside. I am a burden and I can’t stand that.” Some of the automatic thoughts are “It’s hopeless and I am helpless to do anything about it. I am a weak old man. I might as well give up. They’d be better off without me.” I am going to give you a cue card with what we call positive counter injunctions on it. For instance, when you are at home sitting alone at night watching TV and all of a sudden one of those thoughts pops up, I want you to pull this card out and read it. It will say something like “That’s not true! I am engaged and I am putting my knowledge back to work. I am not a hopeless piece of used junk. I have reestablished my relationships with my family and am enjoying the hell out of helping raise my grandkids. Yes! I miss Helen, but I know she’d want me involved in rearing our grandkids. I don’t have a terminal case of ‘I-can’t-stand-it-itis.’ I have withstood a lot of things in life as tough as this. It’s inconvenient, all these aches and pains, but I can move and think and I intend to do so and enjoy myself, which is what Helen would want.”

These are the positive automatic thoughts I want you to get habituated to. I also have another little program called a Hope Kit I want you to assemble. It consists of a container that holds mementos that will serve as reminders to live and enjoy life. It is not about getting all caught up and getting maudlin about what was, but what symbolizes you and the good life you have lived. I particularly would recommend some photographs or keepsakes of the good times and good memories. But this is definitely not about living in the past; in fact, you just might have some new mementos you want to put in there—like that Future Farmers of America hat you are wearing that I might guess you stole (*both laugh*) from the ag teacher. I want you to use that as a negative thought stopping device, so if you get down in the dumps you can pull it out and start going through it.

As simplistic as it sounds, the Hope Kit (Wenzel, Brown, & Beck, 2009) is extremely effective because it is a concrete reminder of all the positive aspects of the

person’s life (Jobes, 2006, p. 83). The positive counter injunctions are typical of cognitive-behavioral approaches to stop catastrophic thinking (Beck et al., 1979). Putting these on a crisis card (Rudd, Joiner, & Rajab, 2001) and placing the Hope Kit in a readily accessible place are easily implemented crisis intervention techniques designed to stop negative cognitions in their tracks.

Roy’s situation is not unique to older clients. Roy is fortunate in a sense. He is not faced with debilitating financial or health problems, as many of his peers are. These problems further exacerbate the notion that suicide is a viable option. Finally, a compounding problem is that sometimes the problems the elderly face ripple over to spouses or significant other caretakers, who may also come under lethal threat.

Guidelines for Family, Friends, and Associates

The crisis worker often has to deal with gritty issues that involve family. Getting clients like Roy to come to terms with long-smoldering family issues is not easy. Urging clients to engage in new, resocializing activities is also difficult. However, if they can be done, the quality of life goes up and lethality comes down. Mishara, Houle, and Lavoie (2005) found that direct intervention with families who called into a suicide prevention line resulted in potential suicides’ having less suicidal ideation, fewer suicide attempts, and fewer depressive symptoms. Family and friends reported less psychological distress and use of more positive coping mechanisms, and reported that their communication with the suicidal person was more helpful. The family, friends, and associates of the suicidal/homicidal person can do many things to contribute to prevention, especially in the area of correcting the alienated lifestyle that cuts off the at-risk person’s connectedness with others. Indeed, there are parent training programs in suicide prevention such as Parents-CARE (Hooven, 2013) that are effective interventions for suicidal adolescents.

Crisis workers can serve an important educational role by helping families, friends, and associates learn about and become attuned to the risk factors, cues, and cries for help that suicidal/homicidal people generally display in some way (Hipple & Cimboric, 1979, pp. 76–78). The crisis worker who talked with Roy’s sons focused on including Roy back in their lives

both as grandfather and as a wise consultant whose knowledge and skill of farming can complement their own. Families can and should be an integral part of treatment and should be fully informed about the positive role (along with the limits) they can play (Rudd, Joiner, & Rajab, 2001, p. 105). Perhaps the most important component of family involvement is helping the whole family system become aware of how the suicidal member's feelings and actions influence the family and how they are reciprocally influenced by the family members' feelings (Softas-Nall & Francis, 1998, p. 227). To that end, dealing with past issues and recriminations is out of bounds. At least until the suicidal events are resolved, bringing up old psychological baggage does little good. Emphasis is on the present and future and developing new behavioral contracts for positive change in the total family constellation (McLean & Taylor, 1994).

Family, friends, and associates who attend to the many cues that have been described in this chapter can help the suicidal/homicidal person by genuinely and assertively confronting the lethal issues. For instance, they can watch for the lethal person's preoccupation with an anniversary date of a significant loss, such as the death of a loved one, or the resulting depression that a job loss or academic failure generates and intervene in a directive manner if needed (McLean & Taylor, 1994). Significant others can help the survivors cope with suicide/homicide after it happens. On the other hand, if fractures in the family system are severe, discretion may be the better part of valor. Pushing family members together who have long-standing agendas of anger and recrimination is about the last thing that needs to happen.

When family or other bereaved groups cannot get past the shock of the death and/or exhibit excessive blame or guilt, crisis workers can meet with them and help them deal with their grief (Shneidman, 1975). On a final note, McGlothlin (2008, p. 137) believes that all of the family needs to be checked out for suicidal/homicidal ideation because in many families suicide/homicide and violence are operational ways to settle problems.

Some Don'ts and a Few Dos. A number of **LO10** authors (Bongar & Sullivan, 2013; Hipple, 1985; Jobes, 2006; Kirk, 1993; Kleespies, 2014; Michel, 2011; Neimeyer & Pfeiffer, 1994; Shea, 2002) have identified some don'ts and dos of suicide management that serve to supplement the intervention considerations already listed. Our comments are added to each point

in the following list. These don'ts and dos apply to almost anyone you work with who is suicidal. It's a long list and you don't need to memorize it, but you do need to remember where it is and check it out—particularly when you get those big furry moths flapping around in your stomach making you feel really queasy when you have a hot client in front of you.

1. Don't lecture, blame, give advice, judge, or preach to clients. If that had worked, they wouldn't be with you now.
2. Don't criticize clients or their choices or behaviors. Do remember that as "crazy" and "nuts" as it seems, the lethal behavior makes perfect sense to the client.
3. Don't debate the pros and cons of suicide. Philosophy has nothing to do with what is going on in a lethality case.
4. Don't be misled by the client's telling you the crisis is past. Never just take the client's word that things are "settled" and "okay now." Do keep checking!
5. Don't deny the client's suicidal ideas. Ideation leads to action. If a person says he or she has lethal intent, even in a joking or offhand way, check it out.
6. Don't try to challenge for shock effects. This is not "Scared Straight" therapy. Challenges may be acted on to show you the client means business.
7. Don't leave the client isolated, unobserved, and disconnected. Provision needs to be made for keeping the client safe and secure, and that means somebody needs to monitor him or her.
8. Don't diagnose and analyze behavior or confront the client with interpretations during the acute phase. Psychodynamic interpretations involving "why" are unimportant at this point.
9. Don't be passive. Suicides are high on the triage scale. You must become active and directive.
10. Don't overreact. Suicidal/homicidal behavior is scary, but it is behavior that can be handled. Do stay calm and keep your voice well modulated. That's what this book and chapter are about. You don't have to be a superhero to do this stuff. Just keep calm and practice what you have learned!
11. Don't keep the client's suicidal risk a secret (be trapped in the confidentiality issue) or worry about "snitching" on the client. Whether you are a bosom friend or a professional, this is life-threatening behavior. You do need to tell someone in authority who can keep the client safe.

12. Don't get sidetracked on extraneous or external issues or persons. Forget about all the other real and imagined ills and issues. Do deal with the lethality in a straightforward, businesslike manner. The other stuff can and should be acknowledged as important to the person, but that's it.
13. Don't glamorize, martyrize, glorify, heroize, or deify suicidal behavior in others, past or present. If you want somebody to kill himself or herself or copycat a friend or idol, this is an excellent way to have that happen.
14. Don't become defensive or avoid strong feelings. The possibility for transference is great in lethal behavior. While lethal feelings are scary, they are exactly what need to be discussed and uncovered.
15. Don't hide behind pseudop professionalism and clinical objectivity as a way of distancing yourself psychologically from painful and scary material. What you are actually trying to do is insulate yourself from the brutal reality of what is going on, and that is not helpful. You must get into the game and build the relationship.
16. Don't fail to identify the precipitating event. Find what specifically caused the client to decide to become lethal. Global reasons are not helpful. Do identify the reason the client got here today, so action plans can be generated to deal with it.
17. Don't terminate the intervention without obtaining some level of positive commitment (you may get sued if you don't). Even if the person later goes ahead and kills himself or herself or somebody else, try as hard as you can to get a commitment from the client to do no harm.
18. Don't forget to follow up (you may get sued if you don't). Do keep track of lethal people until the crisis has passed.
19. Don't forget to document and report (you may get sued if you don't). Do keep good records of your assessment of the client and when and what you did with your recommendations.
20. Don't be so embarrassed or vain that you don't consult (you may get sued if you don't). Substantiation by another professional in a difficult case makes good therapeutic and legal sense.
21. Don't fail to make yourself available and accessible (you may get sued if you don't). If you come in contact with a suicidal/homicidal client, you must stay the course, be available, and have backup support.
22. Do take your time. Don't be hurried. Things may be frantic and frenetic in the immediate

environment, but you are the rock in the middle of the maelstrom. You have time!

23. Do watch for countertransference. Shea (2002, p. 122) poses two questions to keep you grounded: "What am I feeling right now?" and "Is there any part of me that doesn't want to hear the truth right now?" Those are caution lights and reality checks on your potential loss of objectivity and treatment goals. Do get supervision.
24. Don't be blackmailed into caving in to client demands. Do set limits and keep them. Clients with borderline personality disorder are especially adept at treatment blackmail. For example, keeping one's guns isn't an option with a highly suicidal client. Refusal to comply with treatment is not an option, nor is maintaining the right to kill oneself during treatment. Refusal to treat this client is not abandonment, but good clinical judgment.
25. Don't fail to take adequate protective measures. If you are working with an outpatient client who owns guns, do get them in safe keeping. You may get sued if you don't. If you are working in an inpatient setting with a suicidal person, follow the institution's protocol to the t crossed and i dotted. The institution may still get sued but you likely won't.

The Psychological Autopsy

Shneidman (1987) developed the psycho- **LO11** logical autopsy technique for the purpose of compiling detailed postmortem mental histories following suicides or deaths that were equivocal (not sure of cause). Psychological autopsies involve examination of personal demographics such as work, criminal, school, and medical records along with in-depth interviews of friends, relatives, coworkers, and health care professionals to attempt to ascertain the suicide's intent. They also attempt to determine what the trigger events were that might have contributed to the suicide. For instance, normative data from psychological autopsies indicate that an average of 40% of suicides had a medical illness and that HIV/AIDS and cancer are two particular illnesses that increase suicidal risk (Kleepies, Hough, & Romeo, 2009). Psychological autopsies also attempt to determine what, if any, psychopathology was present in completed suicides. For example, it appears that between 30% and 40% of suicides may meet criteria for personality disorders. Psychological autopsies have determined that besides the big five psychiatric diagnoses of major depressive,

bipolar, anorexia nervosa, schizophrenia, and borderline personality disorder that are precursors to suicide (Joiner et al., 2009), schizoid and antisocial personality disorder also have strong associations with suicidal behavior (Duberstein & Witte, 2009). The autopsy was initially conceived by Schneidman to help clinicians become more cognizant of the warning signs of suicide in cases where intent, reason, and motivation are muddled and unclear.

The following questions seek to flesh out the psychological profile of the decedent's death—indeed, to determine first and foremost whether it was a suicide (Shneidman, 1999d). These questions are posed in an empathic manner to the survivors: Why did the person do it? How did he or she do it? When? That is, why at that particular time? What is the most probable mode of death? Besides details of the death itself, the autopsy seeks to determine the person's personality and lifestyle, typical patterns of reactions to stress, emotional upsets, and periods of disequilibrium, particularly in the recent past. What role did alcohol and/or drugs play in the person's life? What was the nature of his or her interpersonal relationships? What were the person's fantasies, dreams, thoughts, premonitions, or fears relating to death, accident, or suicide? What changes, if any, occurred in the person's habits, hobbies, eating, sexual relations, and other life routines? Information is garnered regarding the person's lifestyle, such as mood up- or downswings, successes, and plans for the future. Not only can these questions help determine whether the death was a suicide, they can also help determine how staff who may have been involved with the client can better prevent suicides (Shneidman, 1999d).

As with many important discoveries, Shneidman (1971) found a serendipitous function of the psychological autopsy. By being empathic and supportive to the survivors in order to elicit more information, the autopsy was therapeutic for the survivors. Thus, the psychological autopsy (Shneidman, 1987) may not only provide information that helps prevent future suicides, but may also represent a postvention method of helping survivors either gain a better understanding of why it happened or feel less guilt and responsibility for the deceased's demise. Indeed, what the psychological autopsy spawned was a variety of postvention strategies to help survivors of a suicide.

Postvention

Emotional Toll. The “real victim” of suicide is **LO12** said to be not the body in the coffin but the family

and other loved ones (Hansen & Frantz, 1984, p. 36). Osterweis, Solomon, and Green (1984) report that survivors of the death of a loved one by suicide are thought to be more vulnerable to physical and mental health problems than are grieverers from other causes of death (p. 87). The average suicide leaves 6 to 10 survivors who experience extreme grief (Mitchell et al., 2004). Shneidman (2001, p. 154) puts it eloquently when he says that the person who commits suicide puts his psychological skeleton in the survivors' emotional closet. If that is true, then in the United States alone, with about 4 million survivors, the closet is chock-full of skeletons.

Survivors are faced with guilt, shock, trauma from body discovery, police interrogation, legal issues, shame, sleep difficulties, concentration problems, denial, family relationship problems, and complicated long-term grief (Granello & Granello, 2007, pp. 281–282). Survivors may also feel double binds of guilt and anger—guilty that they didn't do enough to stop the suicide, and angry that now they are left behind having to raise children alone, struggle with debts, and so on, while the suicide skipped out on his or her responsibilities (Shea, 2002, p. 95).

Survivors of suicidal people generally receive less sympathy and encounter more social isolation, negative cultural messages, and stigmatization than do other bereaved individuals (Moore & Freeman, 1995). Most of us have lost loved ones and been to funerals; we know the routine. Suicide survivors have no such formal guidelines. Survivors frequently sense that they are the objects of gossip and criticism, and they may be right. Bereaved loved ones often blame themselves for the suicide, and more than in any other form of loss, they tend to perceive that they are being neglected by others. Therefore, the loss of a loved one by suicide is doubly stressful (Edelstein, 1984, p. 21; Rando, 1984, p. 150). Grieving loved ones left behind by a suicide may refer to themselves as “victims” because, in addition to the emotional stress of the death itself, the survivors must also deal with burdens such as social stigma, guilt, blame, a search for the cause or meaning, unfinished business, and perceived rejection wrought by the suicide (Rando, 1984, pp. 151–152).

Child Survivors. The potential for children whose parents have committed suicide to suffer severe pathological problems is extremely high (Cain & Fast, 1966; Sethi & Bhargava, 2003). Psychosomatic disorder, learning disabilities, obesity, running away, tics, delinquency, sleepwalking, fire setting, encopresis,

along with social adjustment problems, depression, and PTSD symptoms fly out of a Pandora's box of evil outcomes of a parental suicide. Intervention is particularly important in dealing with children coping with a parent's suicide, who may exhibit shame, denial, and concealment and experience ostracism by their peers. If intervention does not occur, these children may experience a host of feelings that lead them to believe they are bound to suffer the same fate as their parent. Feelings of guilt in the child and distortion in communication between adults and children are constant companions. To neglect such children and assume they'll get over it is an extreme therapeutic error. School counselors, school social workers, and school psychologists are particularly critical in understanding what the suicide of a parent may mean to a child and need to be able to intervene with them and their peers. This kind of traumatic event can cause complicated traumatic grief in children and is absolutely within the purview of crisis workers who operate in school buildings (Cohen & Mannarino, 2011; Webb, 2011).

Parent Survivors. Parents whose children commit suicide are also likely to suffer severe psychological repercussions as they attempt to come to terms with their loss. Herzog and Resnik (1967) and Lester (2004) have found that the immediate parental response to a child's suicide tends to be hostility toward others, denial of the suicide, and rationalization of the death as accidental. Guilt and depression soon follow, and the likelihood of severe and continuing dysfunction with the surviving family members grows. Getting both children and parents into support groups and keeping them from becoming more isolated with their negative feelings are critical.

Support Groups. Crisis workers need to be aware of local services that provide such group support. Many organizations, school systems, and communities fail to develop postvention plans for suicide/homicide loss, with the result that survivors have psychological issues that affect those systems (Berkowitz et al., 2011). Baton Rouge, Louisiana, has a model comprehensive program that provides immediate referral for all survivors of suicides from the local coroner. It utilizes an Active Postvention Model that provides trained crisis workers who specialize in the immediate aftermath of a suicide to provide support services to survivors. It provides group support and 24-hour access to services (Campbell, 2011). Communities could not do better than to adopt this model. The

following model is fairly representative of what these support groups look like.

Hatton and Valente (1984) conducted a supportive group therapy experience for parents who sought relief from painful grief after the suicide of a child. They held 10 meetings with parents who felt shame, guilt, self-doubt, confusion, and isolation. The first three meetings were spent sharing and ventilating feelings. Four reactions surfaced. First, there was a prohibition of mourning by the parents' social network. The outside world was seen as hostile and incapable of understanding their grief. Second, former coping mechanisms for dealing with grief were useless. Attempting to share the pain even with spouses was impeded by the fear of burdening or depressing the person even further. Third, extreme isolation was felt both from friends and from family. Fourth, parents developed an identity crisis and questioned their ability to parent and maintain self-control.

The next five meetings were spent doing grief work. Sessions focused on giving support and reassurance, looking at adaptive and maladaptive coping mechanisms, gaining a new perspective on the loss, considering the effect of the suicide on their other children, and dealing with the anger they felt at society and the bureaucratic bumbling of authorities. The last 2 weeks were spent reminiscing about the good times, becoming more future oriented, letting go of anger, and sadness at termination of the group.

Transcrisis Postvention. Resnik (1969) proposes that crisis intervention should occur in three phases. First is **resuscitation**. Within 24 hours, the crisis worker needs to make a supportive visit to assist the survivors in dealing with their initial shock, grief, anger, and most likely self-recrimination, guilt, and blame. This phase may last for several weeks. Survivors should be encouraged to talk about the suicide and experience the full range of feelings associated with it, without feeling ashamed or embarrassed to do so, and tell the story as many times as it needs to be told (Granello & Granello, 2007, p. 283). Phase two involves **resynthesis**. The crisis worker helps the survivors learn new ways of coping with their loss and prevents the development of pathological family responding. Finding a therapist who is experienced with grief work or a self-help group is critical during this time, and this most assuredly holds for children. This second phase may last for several months. The third phase is **renewal**. The crisis worker helps the family reformulate itself in a context of growth and movement beyond the

suicide. This process may occur up to a year after the suicide and is usually terminated on the first anniversary of the suicide. What Resnick proposes in these chronological phases is a vivid example of dealing with transcrisis states.

The Case of Leah. Leah Nichols, 54-year-old manager of a branch bank, returned home from work Friday evening and discovered her 24-year-old son, Ronnie, dead from a gunshot wound. Ronnie had left a suicide note where he had apparently killed himself in his bedroom. Leah's husband, a college professor, had been dead (of heart failure) about a year, and she and Ronnie lived in the family home. Ronnie's siblings, Brenda, age 31, Richard, age 27, and Larry, age 22, were married and living in cities scattered about the region. Ronnie was a warm, friendly, loving, and lovable person who had never married or dated much. He was very sensitive and was given to mood swings from deep depression to euphoria. He had expressed suicidal ideation since his primary school years and had been under psychiatric care since his adolescent years. But in recent months he had appeared to be gaining in maturity and had gotten off his medication.

Leah's grief had moved progressively toward becoming complicated (see Chapter 12, Personal Loss: Bereavement and Grief, for a complete description of this problem), but she felt she should set a controlled and circumspect image for the three siblings and other friends and relatives. After being admitted to the emergency room and spending 3 days in the hospital for nervous exhaustion, she was referred to the crisis worker.

The following intervention strategy was provided for Leah during the days and weeks immediately following Ronnie's suicide and represents one component of Resnik's (1969) resynthesis phase. The individual follow-up grief work dealt with many issues that are common in suicide work: denial, guilt, bargaining, and depression. The issue of Leah's martyrdom came out during an individual session approximately 3 weeks after Ronnie's funeral.

Leah: My kids think I'm holding back. They say I'm too stoic, too unaffected, or too aloof. They think my lack of showing emotions is not normal—not healthy.

CW: What do you think?

Leah: I don't know. I guess I believe somebody has to keep the lid on—keep a steady head during all this. I haven't wanted to trouble any of them with

my problems. Their daddy's death, then Ronnie's. They've had enough without me dumping my grief on them.

CW: What are you saying, at a deep level, below the surface, right now?

Leah: I guess I am saying I'm hurting like hell. I guess my actions have looked pretty cold and strange to them. I guess I've been trying to protect them—to keep them from hurting.

CW: What will it do for you to keep them from hurting?

Leah: Make me a martyr, I guess. I don't know what else it could be.

CW: I wonder if it could keep you from the hurt and anger you have pushed back?

Leah: (*Starts sobbing.*) I . . . I . . . guess . . . I feel so helpless and always have had that feeling for that poor little boy I could not help despite everything I did. (*Weeps while the crisis worker moves over and holds and comforts her.*)

The crisis worker does not attempt to steer Leah to any particular conclusion. Rather, the questioning strategy—a combination of techniques from reality therapy, rational-emotive behavior therapy, and Gestalt therapy—is used to help Leah gain conscious contact with her own inner world. This crisis intervention technique would be ineffective if the worker were trying to analyze or identify pathology in Leah's behavior. Diagnosing, prescribing a cure, and managing Leah's recovery for her would have also been inappropriate. Leah needs to move forward at her own speed and pace to Resnik's (1969) renewal phase.

The Case of Handley. Adults who have been traumatized by the suicide of a close associate, coworker, or friend can profit as well. A brief example of one type of group intervention/psychological autopsy illustrates this point.

Handley, age 27, killed himself by carbon monoxide poisoning. He had had a chaotic and turbulent life, punctuated by a destabilized family, drug and alcohol addiction, and numerous suicide attempts. Despite all his problems, he was a friendly, energetic, charismatic person who worked in a restaurant supply business. He left behind several friends and coworkers who admired him and were surprised at his suicide, even though some of them were aware of his dilemmas and his occasional suicidal ideations.

Several days after Handley's funeral, his coworkers were still in acute grief. Some were emotionally stuck, asking themselves and each other, "Why?" Some were feeling guilty because they did not pick up on the cues and do something to save Handley. The following description is a modified psychological autopsy/group processing that we have developed to aid coworkers affected by a colleague's suicide. It is a variation of a grief debriefing procedure (Mitchell & Wesner, 2011) that is designed to help people share feelings, thoughts, and behaviors both of the deceased's actions and their own responses.

Handley's modified psychological autopsy was convened by a crisis interventionist who met with the group of bereaved coworkers and led them through the following steps:

1. *Introduction.* The worker made a brief introduction, outlining the purposes and structure of the meeting.
2. *Constructing the "why."* The crisis worker helped the group piece together the cues, clues, and signs (pooled from the knowledge contained within the group) that made Handley's suicide more understandable (from Handley's point of view).
3. *Commemorating the positive traits and accomplishments.* The group made a list of Handley's attributes and achievements that they particularly wanted to highlight and remember.
4. *Saying good-bye.* During the second round, each coworker was given an opportunity to take care of unfinished business with Handley and to verbally say good-bye using the "empty chair" strategy. Some members expressed anger as well as love. This was a very emotional and cathartic experience for everyone.
5. *Turning loose.* The crisis worker summarized the material from the preceding three steps and led the group in brainstorming and making another list, gleaned from Handley's case, to help them learn how to detect and prevent future suicides. Further, it allowed the group to turn loose the idea that they might have been in any way responsible or negligent in Handley's death.
6. *Absolving guilt.* The crisis worker obtained a commitment from a member of the group to edit and distribute the psychological autopsy lists to every member of the group. Last, the crisis worker made a statement that essentially (a) expressed appreciation for the group's participation, (b) assured the members that they were not responsible for Handley's death, and (c) gave the

group permission to end the acute grieving phase and enter the long-term period of grief.

The crisis worker tapped into the power and cohesiveness of the group to provide stability and equilibrium for individual members. A variation of this group technique would be appropriate with a family, a fraternal group, the employees in a workplace, a school group, or a church group (any group dealing with a loss-related crisis).

Comans and associates (2013) report on a community intervention program in Australia, for people who are bereaved and suffering grief from a suicide. Called the Stand By service, they found that through direct bereavement and grief intervention that health outcomes, quality adjusted additional years of life, time off of work, and medical costs were all positively affected by this community service.

Finally where specialized support groups are not available, the Samaritans are available 24/7. The Samaritans originated in England but now operate in the United States and Australia. While specifically focused on suicide and grieving, they are an eclectic crisis line manned by highly trained volunteers (Hurtig, Bullit, & Kates, 2011). People feeling lonely and hopeless are their stock-in-trade (Jordan & McIntosh, 2011). You can reach them by telephone, chat, or text. Just search "Samaritans crisis line" to get one near you.

Losing a Client to Suicide

Crisis intervention does not always work. **LO13** Client incidence of suicide among psychologists, social workers, and counselors ranges from 22% to 33% (Kleespies & Ponce, 2009). Sometimes even the most skilled professionals and crisis workers cannot succeed. We must remember that if people really intend to kill themselves, despite our best efforts to intervene, they can manage to accomplish the task. The following suggestions have been provided to help workers cope with the loss of clients (Farberow, 2001; Sommers-Flanagan, Sommers-Flanagan, & Lynch, 2001).

Guided debriefings by experts are necessary for workers who have lost a client. Having a client commit suicide or homicide is one of the most stressful events that can occur in the experience of a crisis worker. The guilt, recrimination, rumination, and perseveration may lead to constant second-guessing. The "what ifs," "shoulds," "oughts," and "might have beens" all lead to feelings of owning responsibility. If a client commits suicide or homicide, a psychological autopsy, or debriefing (see the section on critical incident stress

debriefing in Chapter 17, Disaster Response), and supervision should be mandatory for the worker.

Indeed, the impact of having failed to save a person who was a client, or a victim of the client, can be overwhelming and can cause the crisis worker to experience what is called *vicarious traumatization* (see the section on vicarious traumatization in Chapter 16, Human Services Workers in Crisis: Burnout, Vicarious

Traumatization, and Compassion Fatigue). Such cases call for the utmost of professional expertise to provide intentional and intensive debriefing of the traumatized workers. It is absolutely essential that such workers realistically examine (under the guidance of outside consultants) what happened, learn from the event, and absolve themselves from guilt and responsibility for the regrettable loss.

SUMMARY

The phenomenon of suicide is democratic in that it affects every segment of society, and it is everybody's business. Suicide and homicide as expressive problem-solving acts have many similarities and parallels in terms of motive, risk, and assessment of lethality. Suicide is a serious problem that is on the rise among all groups, especially youth, but the highest-risk group is, and has remained for many years, Caucasian males over 65. Researchers find few common denominators in their quest to identify suicide/homicide risk types and to predict and prevent suicide/homicide. The two oldest and most prevalent theories of suicide are Freud's notion that suicidal behavior is rage at others turned inward and Durkheim's concept that suicide is tied closely to social pressures and influences. Other theories that have emerged more recently see the basis or cause of suicide as largely accidental, a method of escape, a pervasive sense of hopelessness, interactional and revenge driven, biochemically induced, chaotic, interpersonal, or completely rational in the face of unendurable pain or suffering.

The dynamics of suicide are important because crisis workers who deal with suicidal clients need to know that there are several different types and characteristics of suicide. There are many reasons why people kill or attempt to kill themselves, and there are differing moral and cultural points of view about suicide among various social, ethnic, and age groups. Among the many myths of suicide are two that are particularly salient in impeding crisis work: (1) discussing suicide will cause a person to think about doing it or to act upon it, and (2) people who threaten suicide don't do it. Crisis workers are advised to directly question clients who display any suicidal or homicidal ideation.

Many risk factors have been identified that serve as danger signals and help to determine levels of lethality.

Some of the highest risks are the presence of serious intent, a history of prior attempts, and evidence of a specific and lethal plan. These risk factors are important criteria for both assessing and acting in the realm of suicide intervention. Workers who are sensitized to the dynamics find that suicidal people often send out subtle but definite clues and/or cries for help.

Intervention strategies show how crisis workers can be appropriately assertive, directive, and forceful. In work with suicidal clients, workers should not be passive. In suicide intervention, workers must consider many environmental and social factors in addition to attending to client safety (for example, age, gender, social status, availability of supports from family and friends, and community attitudes surrounding the person at risk). Counseling around the issue of suicide/homicide also involves facilitating the grief and healing of clients who are survivors, as well as the care and debriefing of crisis workers who experience the loss of clients to suicide or homicide. Finally, the psychological autopsy is a primary way of both learning how to prevent suicides and alleviating the guilt and shame of survivors.

If you or someone you know is in a bind and you or they can't get through on your local hotline and can't get help with feelings of lethality, the national suicide hotline is open 24/7 at 1-800-SUICIDE. Across the world, the Samaritans in England answer e-mails at jo@samaritans.org. To find help in a language other than English, e-mail www.befrienders.org.

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