Suicide Prevention
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“Darkness silenced the wary depths of despair I dwelt in. I sat upon a cloud of loneliness, secluded from my family and friends. I was in my room, devoid of light. I huddled in a little corner with my head hung. How I wanted to reach out to others—this emptiness in my soul craved another human being.”

-Jenny Joseph, 17

excerpt from “Ophelia Speaks” by Sara Shandler
Agenda

- Myths
- Collecting Valid Data
- Suicide Risk Assessment
- Considerations for Children and Those with Cognitive Impairment
- Safety Planning
- Adaptation for Autism
- Resources

Youth Suicide

Myths
Myth #1: Suicides happen without warning

- Most people who attempt or die by suicide have communicated their distress or plans to at least one other person

Myth #2: Talking about suicide makes people more likely to kill themselves

- There are no iatrogenic effects of asking about suicide (Gould et al., 2005)
- Talking about suicide gives one an opportunity to express thoughts and feelings about something they may have been keeping secret
- Discussion brings it into the open and allows an opportunity for intervention
Myth #3: People who talk about suicide are not serious about killing themselves

• Many people who are considering suicide tell others about these thoughts
• However, mention of suicide often makes people uncomfortable, and as a result they may not take the person seriously.

• This myth further complicates matters as...

Myth #4: Suicidal thoughts and behaviors are ways to get attention

• Take any mention of suicide or suicidal behavior seriously regardless of your thoughts about their true motives
• We need to help people identify more effective ways to seek having their needs met without dismissing the severity of their expressed thoughts, concerns, and/or behaviors
Myth #5: Suicidal teens overreact to life events

• Problems that may not seem like a big deal to one person, particularly adults, may be causing a great deal of distress for the suicidal teen.
• We have to remember that perceived crises are just as concerning and predictive of suicidal behavior as actual crises.

Myth #6: Suicide cannot be prevented

• Most people are acutely suicidal between 24-72 hours.
• Providing help and intervention during this time makes it less likely that they will make another attempt.
• A caring, concerned individual can help someone in distress.
• Taking someone’s feelings seriously and listening can truly save a life.
Tips for Collecting Valid Data

Key Points (Shea, 2002)

1. Any hesitancy may = suicidal thoughts, even if followed by denial of these thoughts.
2. “No, not really” may = SI, but clinician may not be interested due to lack of serious consideration
3. Pay attention to body language indicative of deception or anxiety
4. Taking notes during assessment may = clinician disinterest
   • The clinician can document the assessment while also reviewing the accuracy of the information during a summary
5. Avoid any evidence of personal discomfort during the assessment interview.
6. Avoid appearing hurried
   • Individuals with borderline personality disorder, in particular, may be thrown into a state of emotional dysregulation when feeling rushed (Linehan, 1993).
Key Points – Adolescent Specific

1. Confidentiality limitations
   • Ethical obligation to inform, and the adolescent’s and parents’ right to know, about the limits of confidentiality prior to conducting any interviews.
   • Developing a strong therapeutic relationship may help reduce an adolescent’s underreporting and improve help seeking behaviors.

2. Strengthening interpersonal connections is a developmental marker of adolescence, thus their ability to talk about interpersonal experiences and to do so in an interpersonal context may be underdeveloped.

3. It can be helpful to talk about the adolescent’s fears of disclosing how he or she really feels.

4. Emphasize a team approach to managing the crisis.

5. Clinicians should always model hopefulness.

6. Do not be afraid to say the word “suicide”

6 Techniques to Generate Valid Data (Shea, 2002)

1. Behavioral Incident
   • Technique of asking about specific behavioral events or concrete trains of thought, not opinions.

2. Shame Attenuation
   • Meeting clients where they are emotionally, to help reduce shame in reporting.

3. Gentle Assumption
   • Designed to elicit sensitive material by gently making assumptions about the presence of some behaviors or thoughts.
   • For example, instead of asking an adolescent, “do you drink alcohol?” the clinician might begin with, “tell me about your alcohol use.” This suggests to the adolescent that the clinician is aware that alcohol use is a possible behavior and it is acceptable to discuss it.
6 Techniques to Generate Valid Data (Shea, 2002)

4. **Symptom Amplification**
   - Based on the assumption that patients often downplay the frequency or amount of their disturbing behavior.

5. **Denial of the Specific**
   - Denial of generic may not = denial of specific.
   - Do not combine more than one example into each question, or the clinician may find it necessary to then determine which example was being affirmed.

6. **Normalization**
   - Normalizing experiences, particularly for youth, may help generate an atmosphere where the individual's experience is not unique or that he or she is not the “only one” affected by something, and that this experience can be discussed.

Suicide Risk Assessment
Assess Suicidal Desire and Ideation

1. Have you been having thoughts or images of suicide?
2. Do you think about wanting to be dead?
3. Thwarted Belongingness
   *Do you feel connected to other people?*
   *Do you have someone you can talk to when you are feeling bad?*
4. Perceived Burdensomeness
   *Sometimes people think, “the people in my life would be better off if I were gone.” Do you ever think that?*

Joiner et al., 2009

Assess Resolved Plans and Preparations

5. When you have these thoughts, how long do they last (duration)?
6. How strong is your intent to kill yourself (0 = not intense at all; 10 = very intense)?
7. Past suicidal behavior:
   *Have you attempted suicide in the past?*
   *How many times?*
   *Methods used?*
   *What happened (e.g., hospitalization)?*
   *Feelings about past attempts?*
   *Non-suicidal self-injury?*
   *Family history of suicide?*

Joiner et al., 2009
Assess Resolved Plans and Preparations

8. Do you have a **specific plan** of how you would kill yourself?
   - Look for vividness and detail

9. Means and opportunity:
   - Do you have the pills (gun, etc.)?
   - Do you think you’ll have the opportunity to do this?

10. Have you made preparations for a suicide attempt (e.g., buying gun)?

11. Do you know when you expect to use your plan?

12. Fearlessness:
   - *Thinking about suicide, do you feel afraid (0 = very afraid; 10 = not at all afraid)*?

Joiner et al., 2009

Assess Other Significant Findings

13. Precipitant stressors:
   - *Has anything especially stressful happened to you recently?*

14. Do you feel **hopeless**?

15. Impulsivity:
   - *When you’re feeling bad, how do you cope?*
   - *Sometimes when people feel bad they do impulsive things to help them feel better. Has this ever happened to you?*

16. Presence of psychopathology
   - As indicated by psychiatric assessment

Joiner et al., 2009
Considerations with Children and Those with Cognitive Impairment

Special Considerations with Children

- Age – at what age should we recommend universal screening for suicide risk?
  - 6-10 year old self-poison 2x that of 4-year-olds
- Parents
  - Importance of private screening
    - Parent frequently underreport or unaware of suicidal ideation
  - Cultural factors that may interfere with parents leaving the exam room
  - Parent education significant in limiting access to lethal means
- Who conducts the screening?
  - Younger children may be more responsive to screening by women

Simplicity of Questions

- NOT “Are you having thoughts of suicide?”
- Some data on Reasons for Suicide Questionnaire in children as young as 8 years old, but not enough to demonstrate solid psychometrics

- Rather “Do you ever think about hurting yourself?"¹
  - “What do you imagine doing?”
  - “What do you imagine would happen to you if you did that?”
  - For younger kids, “what happens to you when you die?”
- “Do you ever feel sad enough it makes you want to go away and not come back?”
- “Have you ever done anything to hurt yourself on purpose?”
  - “What happened?”
  - “Who knows about it?”
- “Do you feel like crying a lot?”

¹ Tishler et al., 2007

Safety Planning
Major Challenges

1. How can a youth manage a suicidal crisis in the moment that it happens?
2. How can a clinician/counseling help the youth to do this?

Suicide Risk Assessment

Mental Health Referral/Treatment
Not a “No-Suicide Contract”

- No-suicide contracts ask youth to promise to stay alive without telling them **how** to do so
- No-suicide contracts may provide a false sense of assurance to the clinician

What is a Safety Plan?

- Prioritized written list of **coping strategies and resources** for use during a suicidal crisis
- Provides a sense of control/framework
- Brief process
- Accomplished via an easy-to-read format using the patient’s own words
- Involves a **commitment to the treatment process** (and staying alive)
Available at: http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

Safety Planning – Adaptation for Autism
Step 1: Warning signs

1. Difficulty sleeping  
2. Biting my nails more  
3. Stomachache


Step 2: Internal coping strategies – Things I can do to take my mind off of my problems without contacting another person.

1. Listen to music  
2. Go for a walk  
3. Draw

Step 3: People and social settings that provide distraction

1. Gabby: 123-4567
2. Liz: 456-4567
3. Java Café
4. Bookwork Books


Step 4: People whom I can ask for help:

1. Mom
2. Coach Smith
3. Mrs. Romano

If I go through the steps above and my suicidal thoughts continue or get worse, I will call one of the following emergency contacts:

1. Mr. Matt: 222-3333
2. Ms. Sherry: 222-333-4444

Local Emergency Service: 777-7777 (county crisis) OR 911
Emergency Services Address: 123 Any St, Any Town, Any State 12345

Youth signature  date
Caregiver signature  date
Provider signature  date


Resources
Crisis Supports for the Autism Community

Written and Developed by Lisa Morgan
In Collaboration with AAS'S Autism and Suicide Committee & Common Ground

Steps in Supporting Callers/Texters on the Autism Spectrum

- Ask clear, direct questions - use fewer words and be straight to the point
- Allow extra time to process thoughts and formulate words
- Help shift the thoughts - ask about any interests or passions
- Avoid using metaphors, social nuances, allegories, or slang
- Speak using logical words - not emotional words
- Explain positive coping skills and how they are helpful
- Facilitate a safety plan - help make connections to people or resources
Prevent Suicide PA Online Learning Center
www.preventsuicidepalearning.com

Homepage

Page for youth

www.youthsuicidewarningsigns.org
Pages for Professionals, Parents and Caregivers, Gatekeepers

Youth Suicide Warning Signs
1. Talking about or making plans for suicide
2. Expressing hopelessness about the future
3. Displaying new or worsening mood or behavior changes
4. Showing increased or decreased social or activity involvement
5. Withdrawing from or changing in social settings
6. Change in sleep patterns
7. Change in appetite or eating
8. Changes in school performance
9. Changes in verbal behavior
10. Suicidal ideation
11. Drug or alcohol use

How to Respond
1. Notice any of these warning signs in anyone, you can help!
2. Ask if they are feeling suicidal.
3. Avoid minimizing a person’s thoughts of suicide.
4. Let them know you care about them.
5. Listen attentively and non-judgmentally.
6. Stand what they need and let them know they have the right to be heard.

Respond
1. Let them know they have the right to be heard.
2. Let them know what they need and let them know they have been heard.
3. Let them know there are treatment available that can help.

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
www.suicidepreventionlifeline.org

Crisis Text Line
Text “PA” to 741741
For more information or to learn how you can prevent youth suicide, please go to:

www.preventsuicidepa.org

For more information, contact:

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