Suicide Assessment across the Life Span

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1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

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4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

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About the Author

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Introduction

> "It is beyond argument that the predication of an individual suicide is, and will remain, beyond our grasp (Murphy, 1984). It may nevertheless be possible to sharpen our recognition of those…at substantially elevated risk of self-destruction by judicious application of new knowledge concerning the interrelationship of just these "factors…of little specificity" and several others." (Murphy, 1992)

Suicide is a major, preventable public health problem. In 2004, it was the eleventh leading cause of death in the U.S., accounting for 32,439 deaths (CDC, 2004). Every day, on average, more than 80 Americans take their own lives, and an estimated 1,500 more attempt suicide. Although rates for teens and young adults appear to be declining, deaths from suicide in these age groups are still more frequent than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined. Americans 65 years and older have higher rates of suicide than any other age group. It is the third leading cause of death in all three age groups of children and young adults (10-14 years old, 15-19 years old, and 20-24 years old). In 1999, there were twice as many suicides as homicides. The psychological and social impact of suicide on the family and society is immeasurable. On average, a single suicide intimately affects at least six other people. If a suicide occurs in a school or workplace it has an impact on hundreds of people. Understanding how to recognize the signs of depression and suicidal behavior is vital to all healthcare professionals. Being comfortable asking the tough questions is a learned skill that requires practice and continued learning.

Objectives

Upon completion of this course, the learner will be able to:

- Identify the twelve myths of suicide.
- Describe the different prevalence rates among age, gender, and race.
- Identify how to assess suicide ideation.

Twelve Must Know Myths about Suicidal Clients

Suicide is a topic very few people understand or feel comfortable discussing. It is an event many fear that talking about it will encourage another person to try it. Shame or blame is often felt by friends and family members who have experienced a suicide event. *Counselor*, an online magazine for addiction professionals, shares the following myths and facts about suicide (Rosenthal, 2003). This can also be accessed from: http://www.counselormagazine.com/content/view/400/55/.

Myth 1: Suicidal people don't give warning signs.

> **Fact:** Nearly everybody who attempts or successfully commits suicide communicates his or her intent. The person may talk about suicide, repeatedly joke about it, write about it, place messages on Internet chat rooms, or even draw pictures related to death. Others give away prized possessions. Experts now believe that 75%-80% of all people give warning signs.

Myth 2: Suicide occurs around the holidays.

> **Fact:** To be sure, if a suicide occurs on a holiday, it is more likely to get media attention. Nevertheless, December generally checks in as the lowest month for suicide in the United States. In fact, some suicidologists have noted that all major holidays have a lower rate of suicide than other days of the year.

Myth 3: Suicide occurs more frequently in the dark, dreary days of winter.

> **Fact:** Totally false! Most suicides occur in the spring. May rates are generally the highest.

Myth 4: Suicide is primarily a teenage problem.

> **Fact:** Indeed, teen suicide is a problem. The rate of teen suicide is about three times what it was in the 1960s. However, the suicide rate in women continues to rise until it peaks at about age 51 and then it plateaus. In men, the suicide rate keeps increasing with age. A 60-year-old-man is more apt to take his own life than is a 50-year-old man and so on. The rate of geriatric suicide (ages 65 and older) is nearly three times the rate of the general population.

Myth 5: Most people leave a suicide note that explains the nature of their act.

> **Fact:** Only 15%-25% of those who commit suicide leave a note. Moreover, these documents often tell us little about why the person decided to take his or her own life.

Myth 6: Clients who live in big cities are under more stress and are more likely to kill themselves.

> **Fact:** Surprise! The suicide rate is clearly higher in sparsely populated rural areas. Densely populated states such as New Jersey or Washington DC have rates that are much lower than those of states such as Wyoming or Nevada that have fewer people per square mile.

Myth 7: Media stories about suicide and the economy do not affect the suicide rate.

> **Fact:** Researchers have known for a long time that the suicide rate goes down during extended newspaper strikes. When a famous person commits suicide the rate increases at a statistically significant rate. Suicide is a good barometer of the economy. In troubled times, such as the Great Depression of 1929, the suicide rate skyrocketed.

Myth 8: The grief surrounding a suicide is just like any other grief.

> **Fact:** In most cases survivors (i.e. those who have lost a friend or loved one to suicide) have a tougher time coping with grief. When an individual commits suicide, the survivors cannot blame a

virus or a drunk driver. Suicide prevention centers often provide special survivors of suicide groups to help those who are grieving deal with the loss.

Myth 9: Never ask a person if he or she is suicidal as you could put the idea in his or her head.

Fact: This is one of the most deadly myths of all time! Make it a point to ask each of your clients if he or she is suicidal. 75% of suicidal clients have visited a physician within three months of the suicide.

Myth 10: Once a person's depression lifts, the situation isn't as dangerous.

Fact: The greatest danger of suicide is the first three months after a deep depression. The happiness and peace of mind exhibited by some persons as they come out of a depression actually results from the fact that they finally "resolved" their crisis by deciding to take their lives and now have the energy to follow through.

Myth 11: Don't bother giving the suicidal individual the number of the local suicide prevention hotline if the client insists he or she won't call it.

Fact: Don't buy it! Many people who insist they would never call a hotline do decide to make the call after all. Make it a point to give all your suicidal clients the number of a suicide prevention hotline.

Myth 12: The tendency towards suicide is inherited and passed on from generation to generation.

Fact: There is no firm evidence that the propensity toward suicide is passed down genetically. The phenomenon sometimes seen of suicide "running in the family" seems to be due to learned behavior rather than inherited tendencies. There is however, a familial tendency towards depression and other mental illnesses that may contribute to suicidality.

The Suicide Lexicon

There are several terms that professionals use when discussing and documenting suicide ideation or attempts. Below are definitions of some of the most common vocabulary used to describe suicidal behavior:

- *Suicidal ideation* - vague, fleeting thoughts about wanting to die.
- *Suicidal intent* - thoughts about a concrete plan to commit suicide.
- *Suicidal threat* - expression of a person's desire to end his or her life.
- *Parasuicide* – Suicidal activities that do not result in death.
- *Suicidal gesture* - intentional self-destructive behavior that is clearly not life threatening but does resemble an attempted suicide.
- *Suicidal attempt* - self-destructive behavior by which an individual responds to ambivalent feelings about living.
- *Suicide completion* – suicidal activities resulting in death.

Distinguishing between a suicidal attempt and a suicidal gesture may be difficult. Those with a history of such attempts are almost 23 times more likely to eventually end their own lives than those who don't participate in such activities**.** It is not always easy to distinguish between intent and motivation. Many people who are contemplating suicide are truly conflicted over whether they wish to end their lives. All suicide-like acts should generally be treated as seriously as possible because if there is an insufficiently strong reaction from loved ones from a suicidal gesture, this may motivate future, and ultimately more committed attempts.

Prevalence

Here are some notable statistics on suicide in the United States (CDC, 2004):

- Suicide took the lives of 34,484 people in 2003.
- Suicide rates are generally higher than the national average in the western states and lower in the eastern and Midwestern states.
- New York = 6.1/100,000
- National average = 10.7/100,000
- In 2003, 438,000 individuals were treated in emergency rooms for self-inflicted injuries.
- In 2003, 54% of suicides were committed with a firearm, 21% through suffocation, and 17% through poisoning.

Risk Factors

Gender

Males

- Suicide is the 8th leading cause of death for all US men (Anderson & Smith, 2003).
- Males are 4 times more likely to die from suicide than females (CDC, 2004).

Females

- Women report attempting suicide during their lifetime about 3 times more often than men (Krug et al., 2002).

Age

School age children

- In 2002, 264 children and adolescents ages 5-14 died by suicide in the United States, the fifth leading cause of death. Of these suicides, 260 were in the 10-14 year age group, making suicide the third largest cause of death behind accidents and malignancy (Gibbons et al., 2006).

Teens

- The rate increases from 1.3/100,000 at ages 10-14 to 8.2/100,000 at ages 15-19 (CDC, 2004).
- Female adolescents were twice as likely to report a suicide attempt in the past year as their male counterparts.

For more information on adolescent and young adult suicide, view the "2006 Fact Sheet on Suicide: Adolescents and Young Adults" at http://nahic.ucsf.edu/downloads/Suicide.pdf.

Adults

- In 2004, suicide rates among young adults (20-24 years old) were 12.5/100,000 (CDC, 2004). This is a ten-fold increase from adolescents aged 10-14.
- Suicide rates continue to increase throughout adulthood until age 49, then decline from age 50-74.

Elderly

- At age 75 the rates of suicide again begin to increase.
- In the U.S. males over 70 commit suicide more often than younger males (CDC, 2006). There is no such trend for females over 70.
- Older white males are nearly 2.5 times more likely to kill themselves than older men or women of any other group.

Race and Ethnicity

- At least in the USA, Caucasians commit suicide more often than African Americans do. This is true for both genders.
- Non-Hispanic Caucasians are nearly 2.5 times more likely to kill themselves than are African Americans or Hispanics.
- Suicide rates are highest among Whites and second highest among American Indian and Native Alaskan men (CDC, 2004).
- American Indian and Alaska Native adolescents have the highest rate of suicide of all ethnic groups (more than twice the rate of any other group; males are at four times the risk). The age distribution of suicide rates for Native Americans is quite unlike that for the general population, because of the high rates among young adults and lower rates among the elderly (SMHAI, 2007).

Suicide, Alcohol and other Addictions

Overlying all these groups at risk is the risk of alcoholism and other addictions:

"A man may drown his sorrows in alcohol for years before he decides to drown himself."

- Alcoholism can cause loss of friends, family, and job, leading to social isolation.
- Drug and alcohol problems generate other circumstances in a person's life, which may worsen depression.
- Divorce, loss of job, legal trouble, and financial difficulties often grow from a dependence on alcohol or drugs and can bring about thoughts of suicide.
- Alcohol and suicide may both be attempts to deal with depression and misery.
- Alcohol will increase the effects of other sedative drugs, frequently used in suicide attempts.
- Alcohol may increase impulsive actions.

The significance of the last two points is emphasized by findings that alcoholic suicide attempters who used highly lethal methods scored relatively low on suicidal-intent test. The correlation between lethal intent and method was found only among non-alcoholics. Thus, to claim that alcoholism "causes" suicide is simplistic; while the association of alcohol excess with suicide is clear, a causal relationship is not. Both alcoholism and suicide may be responses to the same pain.

Another complicating factor with suicide is gambling. The National Council on Problem Gambling reports that one in five compulsive gamblers have attempted suicide, a rate higher than any other addiction. Because compulsive gambling is so hidden, gamblers are able to stay in "action" for longer periods of time without anyone knowing, increasing debt and hopelessness. Compulsive gamblers often see an "accidental death" as a way out of financial debt if they have a life insurance policy.

Other Risk Factors for Suicide

- Recent interpersonal loss (or belief that they may suffer a loss).
- History of suicidal ideation/attempts.
- Suicidal threats or communication.
- Psychiatric disease - depression and other mental health disorders including schizophrenia, anxiety disorders and personality disorders, especially borderline and anti-social, increase the risk of suicide.
- Family history of mental illness or substance abuse.
- Family violence, including physical or sexual abuse.
- Unemployment.
- Poor Social Support.
- Serious Health Problems.
- Living Alone.
- Firearms in the home, the method used in more than half of suicides.
- Incarceration.
- Exposure to the suicidal behavior of others, such as family members, peers, or media figures.

Research also shows that the risk for suicide is associated with changes in brain chemicals called neurotransmitters, including serotonin. Decreased levels of serotonin have been found in people with depression, impulsive disorders, and a history of suicide attempts, and in the brains of suicide victims. A person suffering from **Major Depressive Disorder** may present as depressed, irritable and with a sad mood. They often express a diminished interest or pleasure in all activities. They may show a weight gain or loss and an appetite gain or loss. Persons who are depressed are often characterized as unable to get out of bed with chronic fatigue but many actually experience insomnia. In addition, many exhibit psychomotor agitation. Both of these symptoms lead to the characteristic fatigue or loss of energy. A depressed person may verbalize their feelings of worthlessness or excessive guilt. They exhibit decreased concentration, thinking and decisiveness. They may seem inattentive, and their performance

at work or school may suffer. They seem unable to experience any feelings of happiness, even when participating in activities they normally enjoy. Depressed people are often burdened with a tremendous sense of guilt. To an outside observer, this guilt often seems unwarranted, but to the depressed person, it seems deserved. People who are depressed often speak of feeling hopeless or helpless and may have recurrent thoughts of death, suicidal ideation or a suicide plan.

Risk Factors are Cumulative

None of the factors in and of themselves may lead to a suicide. The lack of interpersonal support is a more potent factor than having a co-existing psychiatric disease in determining the response to interpersonal loss. Many people who attempt suicide are reactive to external cues. As the number of risk factors increase, particularly in the absence of protective factors, suicide risk increases and should be questioned.

> A prior history of suicide attempt entails a lifetime risk of subsequent suicide, around 12%. Apparently a willingness to imperil one's life in that particular way may persist. In assessing suicidal risk, the clinician would be very well advised not only to ask about current and past ideation and family history, but also about the patient's attitude toward suicide, the circumstances under which he/she would consider it, the basis for that thinking, and reasons not to do it. It is my clinical impression that citing negative impact on others shows connectedness and is strongly protective. The low level of connectedness in the present sample of suicides is keeping with that view. (Murphy, 1992, p. 215)

Case I. – Practice Question Numbers 1 through 3

Doug – *20-year-old male is admitted to critical care following a motorcycle accident in which he ran head on into an oncoming car. The patient is being treated for medical injuries. His family has informed the RN the patient has a history of depression and a previous suicide attempt.*

1. Doug is exhibiting which of the following risk factors for suicide?
   a. Unemployment
   b. Lives alone
   c. Previous suicide attempt
   d. All of the above

2. Which of the following pieces of information may <u>not</u> be helpful in determining if Doug's accident was truly a suicide attempt?
   a. What was Doug's Blood Alcohol Content (BAC) at the time of the accident?
   b. What were the details of Doug's previous suicide attempt?
   c. What does Doug do for a living?
   d. Did Doug recently break up with a significant other or lose a job?

3. It would also be important to determine if Doug was currently being treated for:
   a. Depression
   b. GERD
   c. Any STD's
   d. All of the above

Turn to page 25 for the answers.

Behavioral Changes

There is no "typical suicidal person." However, there are several behaviors that can indicate that a person is seriously considering suicide. These include:

- Talking about committing suicide and preoccupation with death and dying.
- Trouble eating or sleeping and noticeable change in personal appearance.
- Loss of interest in work, school, or hobbies and withdrawal from social activities, friends, and family.
- Drastic change in behavior, often taking unnecessary risks as if they didn't care what happened.
- Increased use of alcohol and drugs.
- Signs of preparing for death—making funeral arrangements or giving away prized possessions.

Any combination of these actions might alert both family and friends that a person is struggling with life and considering suicide as an option. The "IS PATH WARM?" acronym from the American Association for Suicidology may help you remember some of the most common warning signs of suicide:

I	**Ideation**
S	**Substance Abuse**
P	**Purposelessness**
A	**Anxiety**
T	**Trapped**
H	**Hopelessness**
W	**Withdrawal**
A	**Anger**
R	**Recklessness**
M	**Mood Change**

Ideation is expressed as signs of acute risk. The person may be threatening to kill him or herself, or talking of wanting to hurt or kill him/herself. They may be looking for ways to kill themselves by seeking access to firearms, pills, or other means. They may also talk or write about death, dying or suicide. If these behaviors are observed, seek help as soon as possible.

Additional warning signs are:

- Increased **substance abuse** (alcohol or drugs).
- No reason for living; no sense of **purpose** in life.
- **Anxiety, agitation,** unable to sleep or sleeping all the time.
- Feeling **trapped** – like there's no other way out.
- **Hopelessness.**
- **Withdrawing** from friends, family and society.
- Rage, uncontrolled **anger,** seeking revenge.
- Acting **reckless** or engaging in risky activities, seemingly without thinking.
- Dramatic **mood** changes.

If any of these behaviors are observed, seek help as soon as possible. There may also be some risk factors that are more common among some age groups than others.

<u>Children</u>

While it is much easier to believe that suicidal thoughts or behaviors displayed by a child are trivial or are ploys to get attention, studies have shown a high rate of nonfatal suicidal behaviors and ideations among

children, especially those that are psychiatric patients (Greene, 1994). Children's suicidal behaviors are rarely impulsive and their motives can be similar to adults. A child's suicide is often precipitated by:

- An attempt to gain control in their lives.
- Retaliation or revenge against real or perceived wrongs.
- Reunion fantasies.
- Relief or escape from unbearable pain.
- They see themselves as the family scapegoat.
- To distract the family from other issues, e.g. divorce.
- Acting out a covert or overt desire of the parent to be rid of the child.

Teens

Many of the warning signs of possible suicidal feelings are also symptoms of depression. Observations of the following behaviors by parents and care givers may be helpful in identifying adolescents who may be at risk of attempting suicide:

- Changes in eating and sleep habits.
- Loss of interest in usual activities.
- Withdrawal from friends and family members.
- Acting out behaviors and running away.
- Alcohol and drug use.
- Neglect of personal appearance.
- Unnecessary risk-taking.
- Preoccupation with death and dying.
- Increased physical complaints frequently associated with emotional distress such as stomach aches, headaches, and fatigue.
- Loss of interest in school or schoolwork.
- Feelings of boredom.
- Difficulty concentrating.
- Feelings of wanting to die.
- Lack of response to praise.
- Indicates plans or efforts toward plans to commit suicide, including the following:
    - Verbalizes "I want to kill myself," or "I'm going to commit suicide."
    - Gives verbal hints such as "I won't be a problem much longer," or "If anything happens to me, I want you to know ...."
    - Gives away favorite possessions; throws away important belongings.
    - Becomes suddenly cheerful after a period of depression.
    - May express bizarre thoughts.
    - Writes one or more suicide notes.

Threats of suicide communicate desperation and a cry for help. Always take statements of suicidal feelings, thoughts, behaviors, or plans very seriously. Any child or adolescent who expresses thoughts of suicide should be evaluated immediately.

Elderly

Substance abuse plays a much smaller role in elderly suicides than in their younger counterparts. Suicide in the elderly is most commonly associated with undiagnosed and/or untreated depression. Common risk factors in the elderly include:

- A recent death of a loved one.
- Physical illness, uncontrolled pain, or the fear of a prolonged illness.
- Perceived poor health.

- Social isolation and loneliness.
- Major changes in social roles (e.g., retirement).

Case II. – Practice Question Numbers 4 through 6

John – *75-year-old male hospitalized with a diagnosis of congestive heart failure. Patient is widowed and has no children. He lives in a senior apartment building. He was independent with ADL's prior to admission. He drinks daily. Patient reports some problems with memory and depression.*

4. Which of the following are risk factors for suicide for John?
   a. Lives alone
   b. Depression
   c. Drinks daily
   d. All of the above

5. What might be the next piece of information you would want to find out about John?
   a. How long has he lived alone?
   b. How much does he drink each day?
   c. Is his depression currently being treated?
   d. All of the above

6. What other risk factors may be important to explore when taking John's psychosocial history?
   a. How long has he been widowed?
   b. Does he have any social supports within his building?
   c. Mini mental status exam to determine his cognitive ability.
   d. A and B

Turn to page 25 for the answers.

Protective Factors

Protective Factors are the biological, psychological, and social factors that may reduce the likelihood of suicide activity. They are thought to enhance resiliency and may serve to counteract risk factors. Understanding the interaction of risk and protective factors in preventing suicide has still not been scientifically demonstrated. There are some that are easily proven. If a person is suffering from substance abuse or a mental health illness then receiving treatment and remaining abstinent can greatly reduce the risk factors for suicide. There are also some risk factors that cannot be changed, such as a family history or previous suicide attempt. Some of the most important protective factors are listed below:

- Effective treatment for mental illness or substance abuse
- Restricted access to lethal means of suicide (guns, pills, etc)
- Sense of responsibility to and strong connection with family
- Children in the home (except those with postpartum psychosis or mood disorder)
- Strong connection to community supports
- Pregnancy
- Religiosity – especially if beliefs discourage suicide and support self preservation
- Life satisfaction
- Reality testing ability
- Positive coping skills and non-violent handling of stressors
- Positive problem-solving skills and conflict resolution
- Positive social support
- Positive therapeutic relationship with a medical or mental health provider

For additional information on prevalence and risk factors, go to www.suicidology.org to visit the American Association of Suicidology.

Suicide Assessment

A suicide assessment must be comprehensive and multi-axial. A good assessment allows the clinician to identify specific factors and features that may generally increase or decrease risk for suicide, address the patient's immediate safety and develop an immediate plan as well as guide long term treatment planning. A biopsychosocial assessment should include:

- Presenting Problem
- Mental Health/Substance Abuse History
- Social History
- Suicide/Homicide History
- Mental Status Exam
- Risk Assessment
- Patient Strengths
- Patient Needs
- Provisional Diagnosis and Plan

In order to thoroughly assess a patient who may be suicidal, many difficult questions must be asked. For an example of which questions to ask, please see **Appendix A.**

There are many situations in which a suicide assessment may be warranted. Listed below are a few of the most common in a hospital setting:

- Abrupt change in clinical presentation (both negative and positive)
- Anticipation or experience of significant interpersonal loss
- Onset of physical illness (life threatening, disfiguring, severe pain, loss of executive functioning)
- Emergency Department or Crisis Evaluation
- Intake evaluation
- Before a change in suicide precautions/observation status
- Lack of improvement or gradual worsening despite treatment

Case III. – Practice Question Number 7

Mrs. A *- 29-year-old married female with five children and a history of two depressive episodes. The first took place postpartum 5 years ago, and the second 2 years ago, with a possible link to a change in occupation. Both episodes were treated with Celexa 60 mg/day, resulting in full remission. Neither of these depressive episodes was accompanied by suicidal ideation. She is now on the postpartum unit following the delivery of her fifth child.*

7. What would you need to assess for?

    a. Flat affect
    b. Bonding with her child
    c. Ability to perform ADL's
    d. All of the above

Turn to page 25 for answer.

Next Steps

It is very important to know the Crisis Management Policy of the agency at which you are employed. This policy may direct your next steps. However, there are some generalized things that a nurse can do:

1. Assess – if suicide precautions can be initiated by the RN without MD orders, do so.
2. Institute one-to-one constant observation.
3. Remove harmful objects from the environment.
4. Immediately request a Psychiatric Consultation.
5. Implement a Safety Plan based on the Psychiatric Emergency Protocol.

Case IV. – Practice Question Number 8

Kelly - *16-year-old female is brought to the Emergency Room by her mother. She states that her daughter has not eaten or gotten out of bed in 2 days. The daughter is very lethargic and withdrawn. She is oriented to person, place and time but has a flat affect and answers your questions in monosyllables. When asking the patient about any recent changes in her life she starts crying softly and states, "My boyfriend said he never wants to see me again. I don't want to live, he was my whole life."*

8. What is the nurse's next step?

    a. Determine if Kelly has a plan.
    b. Request a psych consult.
    c. Tell the mother that you think her daughter is crazy and needs to be committed to a psychiatric hospital, not your ER.
    d. Institute one-to-one observation.

Turn to page 25 for answer.

If, upon further questioning, Kelly continues to cry and says, "I don't know what to do", request a Psych consult.

However, if Kelly tells you that she is going to take her mother's entire bottle of Xanax, institute immediate one-to-one observation and request a psychiatric consultation. Establish a safety plan based on your agency's policy.

Proactive Treatment Planning is achieved by understanding suicide and being able to assess for signs and symptoms of depression. All nurses should be able to complete an assessment of suicidal behavior and implement the psychiatric emergency protocol. There should be crisis numbers (for staff and patients) available on all units, home care vehicles, or wherever a nurse is working. The patient will need to have their support system contacted and possibly have follow-up appointments with a psychiatrist, counselor, or social worker.

Lastly, be sure to document what was done and said. Be sure to keep it fact-based, symptom based and history based. The use of patient quotes is encouraged.

Unintentional Suicides

There are times when a patient may present to you as a result of a suicide attempt. However, if you look closely, the patient may have not had any suicidal ideation and accidentally harmed themselves in a manner that appears to be suicidal.

Erotic asphyxiation, asphyxiophilia, breath control play, or scarfing, is the potentially lethal practice of intentionally reducing the amount of oxygen to the brain during sexual stimulation in order to heighten the received pleasure from orgasm. A sexual partner may or may not be involved in the act, however, if one is excluded the practice can be referred to as autoerotic asphyxiation, or AEA. Various methods are used to achieve the level of oxygen depletion needed such as a plastic bag over the head or self-strangulation, typically by the use of a ligature (scarfing). The body produces more endorphins as it approaches the state of asphyxia, resulting in increased pleasure. The process is extremely dangerous and has resulted in many accidental deaths. Deaths often occur when the loss of consciousness caused by partial asphyxia leads to loss of control over the means of strangulation, resulting in continued asphyxia and death. Victims are often found to have rigged some sort of "rescue mechanism" which has not worked in the way they anticipated as they lost consciousness. Michael Hutchence, lead singer for INXS is likely to have died from autoerotic asphyxiation in 1997, although suicide was the official cause of death (The Daily Telegraph, 2007).

Even more frightening, teens around the country are playing a game called ***"the choking game."*** People playing the choking game tie something — a belt, a scarf, a rope, or even a chain bicycle lock — around their neck, then to another object. The choking cuts of the flow of oxygen to the brain, producing a brief "rush" or "high," explains pediatrician Thomas Andrew, M.D., New Hampshire's chief medical examiner (Kuzma, 2006). Many teens have died playing the game by themselves, when the rope or tie around their necks wouldn't loosen, choking them to death. They can lose consciousness one minute after putting something around their neck, and if the belt or rope tightens, they can die within two to four minutes, Dr. Andrew says. But the game is dangerous even when people play with friends. They might get brain damage from depriving their brain of oxygen, or accidentally touch on certain nerves, which can hurt or kill them. On March 28, 2007, the New York Times had a front-page story on a teenager who had suffered a heart attack and spent three days in a coma after hanging himself for a "rush" (Johnson, 2007).

To learn more about how to stop this deadly game, go to http://www.stop-the-choking-game.com/en/home.asp.

To add to a surviving family members' grief, recent court cases have come to varied results as to whether the unintentional death resulting from autoerotic asphyxiation or "the choking game" falls under the "self-induced injury" clause of standard life insurance policies, which prevents payouts for suicide. In June of 2003, one US court said the intent was not death and therefore the case was an accident, while another in August 2003 said it does technically fall within the terms since death is the logical result of asphyxiation.

Another unintentional suicide that a healthcare professional may encounter is an ***accidental overdose***. Many overdoses are not intentional, especially when street drugs are used. A scenario that is seen far too often in behavioral health is a patient who recently completed detox or inpatient treatment who then relapses. After 5 to 30 days (or more) away from their drug of choice, the patient's tolerance has decreased. If they use the same amount of drug, especially opiates, which they used when they went into treatment, an overdose may occur. However, if the patient does not survive, it is almost impossible to determine if this was a suicidal gesture or an accidental overdose.

In any of these situations, the families may be questioning themselves. They often are angry at their loved one who killed themselves. They may feel guilt over not "noticing the signs." The healthcare provider can help the family begin to accept the death of their loved one if they are able to reiterate that this may not have been intentional. There may not have been any "signs." Being aware of these practices may help the healthcare professional provide better care to the surviving family members.

Homicide-suicide acts are infrequent and are different in psychopathology from that of a single suicide. However, precipitating factors for homicide-suicide acts are similar to those found in single suicide. Depression, borderline disturbances, and narcissistic neuroses in combination with stressors such as physical illness, isolation, and social losses can lead to homicide-suicide. These are most often seen in child custody cases, acts of revenge against perceived wrongs and among the elderly. For more information on elderly homicide-suicide acts, go to: http://eldercare.uniontrib.com/news/marsha/marsha_suicide.cfm.

A suicide attack is an attack in which the attacker (*attacker* being either an individual or a group) intends to kill others and intends to die in the process of doing so. In a suicide attack in the strict sense the attacker dies by the attack itself, for example in an explosion or crash caused by the attacker. The term is sometimes loosely applied to an incident in which the intention of the attacker is not clear though he is almost sure to die by the defense or retaliation of the attacked party. Such attacks are typically motivated by religious or political ideologies and have been carried out using numerous methods such as truck bombs, “kamikaze” pilots, and mass poisonings. Others are motivated by perceived wrongs and isolation. In the recent massacre at Virginia Tech, the shooter fit the profile of other school shooters. They are often isolated, may have made remarks regarding suicide, but very rarely threaten anyone directly. Because of this, they are rarely reported to the authorities. In a landmark study in 2002 by the U.S. Secret Service, researchers looked at 37 school shootings and interviewed 10 of the shooters themselves. In more than 3 out of 4 school shootings, the attacker had made no threat against the schoolteachers or students. But most attackers engaged in some behavior prior to the incident that caused others concern or indicated a need for help. The attackers posed a threat even though they hadn't made a threat. For more information on school shooters, go to: http://www.secretservice.gov/ntac_ssi.shtml.

Clinical Self-Care

Anytime a healthcare provider comes into contact with one of these situations, it can leave one questioning themselves. Did I do enough? What if I had recognized the signs earlier? Is there anything I could have said or done to prevent this? Did I help the survivors cope? Guilt and self-doubt can color your professional practice. If a provider has a history of suicide gestures or attempts, or a loved one who has attempted or completed a suicide, losing a patient to suicide can re-traumatize them. It may bring up feelings from one's past that can cloud their judgment and their interaction with the patient's family. A healthcare provider may also have strong religious or cultural biases against suicide. They need to be cautious that their personal issues do not carry over into their professional behavior.

When a patient is lost to suicide, there are supports that you can reach out to. Many health care agencies have a Crisis Response Team or a Critical Incident Stress Debriefing Team. If these are not available, try contacting the Employee Assistance Program (EAP). They can offer counseling and referrals for professional self-care.

The Survivors Left Behind

At hospice, patients are taught five simple truths to tell their loved ones before they die: I'll miss you. I love you. I forgive you. I'm sorry. Goodbye. However, those left behind after a suicide are not able to hear these truths. Instead, they are left with a legacy of shame, fear, rejection, anger, and guilt. Edwin Shneidman, considered to be the father of the suicide prevention movement in the United States, has said:

> I believe that the person who commits suicide puts his psychological skeleton in the survivors emotional closet – he sentences the survivors to deal with many negative feelings and, more, to become obsessed with thoughts regarding their own actual or possible role in having precipitated the suicidal act or having failed to abort it. It can be a heavy load. (Worden, 2002, p. 119)

Nearly 750,000 people a year are left to grieve the completed suicide of a family member or loved one. This is one of the most difficult bereavement processes for someone to face and resolve in an effective manner. Those left behind often experience shame, stigma, guilt, anger, and low self-esteem. In our society there is still a stigma attached to suicide. The survivors are the ones who have to experience the stigma and the associated **shame**. They cannot grieve as others grieve for their loved ones without facing possible alienation from society.

This shame also must be faced for those who survive a suicide attempt. Worden (2002) describes a woman who survived a jump from a 155-foot bridge. But after her jump she experienced such shame and negative reactions from those around her that she repeated the attempt. This time she was successful.

Guilt is another common feeling among survivors of suicide victims. They believe there is something they could have done or said to prevent this. If the suicide happened in the context of some interpersonal conflict, the guilt is particularly difficult. Guilt can also manifest itself as blame. Some people project their own guilt onto others and blame them for the death.

Anger is another intense feeling often experienced by survivors. They think, “Why?” but they really mean “Why did he/she do this to me?” They interpret that to mean the deceased did not think enough of them or they would not have committed suicide. They experience the death as the ultimate rejection, leading to **low self-esteem** and intense grief reactions. Counseling is especially helpful in this type of situation.

Fear is another common response after a suicide. Survivors experience higher levels of anxiety than among survivors of natural deaths (Worden, 2002). However, a fear of their own destructive tendencies also occurs. This is especially true for sons of suicide victims. They may feel that suicide will be their fate as well. If there has been more than one suicide in a family, surviving members often are afraid that this may be passed down to the next generation.

Children often experience **distorted thinking** after a family member’s suicide. They need to believe that it was an accidental death. The family may create a myth regarding the actual death and anyone who challenges this will feel the anger of the family. While this may be helpful short term, it is not productive for working through the anger, shame and guilt long term.

How Can We Help a Survivor Heal?

Healthcare professionals can help survivors begin the healing process by letting them know that it is OK to grieve, to cry, to laugh, even though they lost their loved one to suicide. The grief reaction may be especially intense and a non-judgmental attitude can help a survivor talk about their feelings and their anger. *Survivors of Suicide* (SOS) is an independently owned and operated web site that is not associated with any specific group, organization or religious affiliation. Their purpose is to help those who have lost a loved one to suicide resolve their grief and pain in their own personal way. They offer the following suggestions to those who would like to help survivors heal:

- Accept the intensity of the grief
- Listen with your heart
- Avoid simplistic explanations and clichés
- Be compassionate
- Respect the need to grieve
- Understand the uniqueness of suicide grief
- Be aware of holidays and anniversaries
- Be aware of support groups
- Respect faith and spirituality
- Work together as helpers

To experience grief is the result of having loved. Suicide survivors must be guaranteed this ability to grieve. It is important to recognize that helping a suicide survivor heal will not be an easy task. You may have to give more concern, time and love than you ever knew you had. But this effort will be more than worth it. For more information, go to: http://www.survivorsofsuicide.com/index.html.

Answers for Case Practice Questions

1. **C**

2. **C**
   Rationale: Most subsequent suicide attempts are triggered by the same stressors that caused the previous attempts. If Doug's previous attempt was due to a break up and occurred while under the influence of alcohol, it would be important to determine if those same circumstances presented themselves before this accident.

3. **A**
   Rationale: Untreated depression is one of the most common causes of suicide ideation.

4. **D**

5. **C**
   Rationale: Suicide in the elderly is most closely correlated with untreated depression rather than substance abuse.

6. **D**
   Rationale: Recent interpersonal loss is a significant factor in elderly suicide as is social isolation. While a mini mental status exam would be helpful in determining what services John may need, it may not immediately help determine his suicide risk.

7. **D**

8. **A**

Appendix A

SUICIDAL BEHAVIORS

Questions That May Be Helpful in Inquiring About Specific Aspects of Suicidal Thoughts, Plans, and Behaviors

Begin with questions that address the patient's feelings about living:

- Have you ever felt that life was not worth living?
- Did you ever wish you could go to sleep and just not wake up?

Follow up with specific questions that ask about thoughts of death, self-harm, or suicide:

- Is death something you've thought about recently?
- Have things ever reached the point that you've thought of harming yourself?

For individuals who have thoughts of self-harm or suicide:

- When did you first notice such thoughts?
- What led up to the thoughts (e.g., interpersonal and psychosocial precipitants, including real or imagined losses; specific symptoms such as mood changes, anhedonia, hopelessness, anxiety, agitation, psychosis)?
- How often have those thoughts occurred (including frequency, obsessional quality, controllability)?
- How close have you come to acting on those thoughts?
- How likely do you think it is that you will act on them in the future?
- Have you ever started to harm (or kill) yourself but stopped before doing something (e.g., holding knife or gun to your body but stopping before acting, going to edge of bridge but not jumping)?
- What do you envision happening if you actually killed yourself (e.g., escape, reunion with significant other, rebirth, reactions of others)?
- Have you made a specific plan to harm or kill yourself? (If so, what does the plan include)?
- Do you have guns or other weapons available to you?
- Have you made any particular preparations (e.g., purchasing specific items, writing a note or a will, making financial arrangements, taking step to avoid discovery, rehearsing the plan)?
- Have you spoken to anyone about your plans?
- How does the future look like to you?
- What things would lead you to feel more (or less) hopeful about the future (e.g., treatment, reconciliation of relationship, resolution of stressors)?
- What things would make it more (or less) likely that you would try to kill yourself?
- What things in your life would lead you to want to escape from life or be dead?
- What things in your life make you want to go on living?
- If you began to have thoughts of harming or killing yourself again, what would you do?

For individuals who have attempted suicide or engaged in self-damaging action(s), parallel questions to those in the previous section can address the prior attempt(s). Additional questions can be asked in general terms or can refer to the specific method used and may include:

- Can you describe what happened (e.g., circumstances, precipitants, view of future, use of alcohol or other substances, method, intent, seriousness of injury)?
- What thoughts were you having beforehand that led up to the attempt?
- What did you think would happen (e.g., going to sleep versus injury versus dying, getting a reaction out of a particular person)?
- Were other people present at the time?
- Did you seek help afterward yourself, or did someone get help for you?
- Have you planned to be discovered, or were you found accidentally?

- How did you feel afterward (e.g., relief versus regret at being alive)?
- Did you receive treatment afterward (e.g., medical versus psychiatric, emergency department versus inpatient versus outpatient)?
- Has your view of things changed, or is anything different for you since the attempt?
- Are there other times in the past when you've tried to harm (or kill) yourself?

For individuals with repeated suicidal thoughts or attempts:

- About how often have you tried to harm (or kill) yourself?
- When was the most recent time?
- Can you describe your thoughts at the time that you were thinking most seriously about suicide?
- When was your most serious attempt at harming or killing yourself?
- What led up to it, and what happened afterward?

For individuals with psychosis, ask specifically about hallucinations and delusions:

- Can you describe the voices (e.g., single versus multiple, male versus female, internal versus external, recognizable versus unrecognizable)?
- What do the voices say (e.g., positive remarks versus negative remarks versus threats)? (If the remarks are commands, determine if they are for harmless versus harmful acts; ask for examples.)
- How do you cope with (or respond to) to voices?
- Have you ever done what the voices ask you to do? (What led you to obey the voices? If you tried to resist them, what made it difficult?)
- Have there been times when the voices told you to hurt or kill yourself? (How often? What happened?)
- Are you worried about having a serious illness or that your body is rotting?
- Are you concerned about your financial situation even when others tell you there's nothing to worry about?
- Are there things that you've been feeling guilty about or blaming yourself for?

Consider assessing the patient's potential to harm others in addition to him or herself:

- Are there others who you think may be responsible for what you're experiencing (e.g., persecutory ideas, passivity experiences)?
- Are you having any thoughts of harming them?
- Are there other people you want to die with you?
- Are there others who think would be unable to go on without you?

Resources

American Association of Suicidology (AAS)
5221 Wisconsin Avenue, NW
Washington, DC 20015
www.suicidology.org

AAS is an education and resource organization dedicated to understanding and preventing suicide. They do not provide direct services.

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

Twenty four hour, toll-free suicide prevention service available to anyone in suicidal crisis.

Survivors of Suicide
www.survivorsofsuicide.com

An independent organization dedicated to helping those who have lost a loved one to suicide resolve their grief and pain in their own personal way.

Teenwire.com
www.teenwire.com

Teenwire.com is a sexual health Web site for teens owned by the Planned Parenthood Federation of America. The Web site is staffed by professionals who are dedicated to providing health information. The site contains content about self-esteem, body image, drugs and alcohol, communication, and relationship advice. Important information is also available in Spanish through the "En Español" section of the site.

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Suicide Assessment across the Life Span

Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the course exam.

1. Every day, approximately how many suicides are completed in the United States?

    a. 15
    b. 80
    c. 250
    d. 1500

2. On average, a single suicide affects how many people?

    a. 1
    b. 4
    c. 6
    d. 20

3. Which of the following statements is not true?

    a. Most suicides occur in May.
    b. Most people who attempt suicide leave a note.
    c. Suicide is more common in rural areas than in urban.
    d. Teens and the elderly have the highest rates of suicide.

4. Which of the following statements is true?

    a. Once the person's depression lifts, the risk for suicide is over.
    b. The grief surrounding suicide is just like any other grief.
    c. 75% of suicide attempters have visited a physician within the last 3 months.
    d. The tendency towards suicide is inherited.

5. An intentional self-destructive behavior that is clearly not life threatening but does resemble an attempted suicide is called:

    a. Suicide ideation
    b. Suicide gesture
    c. Suicidal threat
    d. Suicide attempt

6. All suicide-like acts should generally be treated as seriously as possible because if there is an insufficiently strong reaction from loved ones from a suicidal gesture, this may motivate future, and ultimately more committed attempts.

    a. True
    b. False

7. The prevalence of suicide in New York State is:

    a. Higher than the national average
    b. Lower than the national average
    c. The same as the national average
    d. Not comparable to the national average

8. Which gender is more likely to attempt suicide?

    a. Males
    b. Females

9. Which gender is more likely to die from a suicide attempt?

    a. Males
    b. Females

10. Suicide is ranked _____ among the leading causes of death of children aged 5-14.

    a. First
    b. Third
    c. Fifth
    d. Tenth

11. Suicide rates continue to increase throughout young adulthood but level off at about what age?

    a. 29
    b. 39
    c. 49
    d. 59

12. An elderly male is more likely to die from suicide than a teenage male.

    a. True
    b. False

13. Which ethnicity is more likely to commit suicide than any other?

    a. Caucasian
    b. African-American
    c. Native American
    d. Hispanic

14. Which addiction is most likely to be associated with suicide?

    a. Alcoholism
    b. Cocaine Dependency
    c. Compulsive Gambling
    d. Marijuana Dependency

15. Which of the following is NOT a risk factor for suicide?

    a. Recent interpersonal loss
    b. History of suicide attempts
    c. Unemployment
    d. Reality Testing Ability

16. Which of these is NOT a protective factor for suicide?

    a. Children in the home
    b. Living Alone
    c. Life Satisfaction
    d. Strong connection to the community

17. A suicide assessment should include the following aspects:

    a. Biological information
    b. Psychological information
    c. Social context of suicide
    d. All of the above

18. **John -** *75 year old male hospitalized with a diagnosis of congestive heart failure. Patient is widowed and has no children. He lives in a senior apartment building. He was independent with ADL's prior to admission. He drinks daily. Patient reports some problems with memory and depression.*

    John is exhibiting which of the following risk factors for suicide?

    a. Lives alone
    b. Depression
    c. Drinks daily
    d. All of the above

19. **Doug -** *A 20 year old male is admitted to critical care following a motorcycle accident in which he ran head on into an oncoming car. The patient is being treated for medical injuries. His family has informed the RN the patient has a history of depression and a previous suicide attempt.*

    Doug is exhibiting which of the following risk factors for suicide?

    a. Unemployment
    b. Lives alone
    c. Previous suicide attempt
    d. All of the above

20. Documentation of suicidal ideation should be:

    a. Fact based
    b. Symptom based
    c. Conclusion based
    d. Both A and B