16 Suicide Prevention

CORE CONCEPTS

Suicide

Suicide Risk Assessment

Suicide Prevention

CHAPTER OUTLINE

KEY TERMS

altruistic suicide
anomic suicide
collaborative safety plan
egoistic suicide
suicide risk factors
suicide warning signs

OBJECTIVES

After reading this chapter, the student will be able to:

1. Discuss epidemiological statistics and risk factors related to suicide.
2. Describe predisposing factors implicated in the etiology of suicide.
3. Differentiate between facts and myths regarding suicide.
4. Apply the nursing process to individuals exhibiting suicidal behavior.

HOMEWORK ASSIGNMENT

Please read the chapter and answer the following questions:

1. How are age, race, and sex associated with suicide risk? Describe the difference between risk factors and warning signs of suicide.
2. Your neighbor tells you he is going to visit his sister-in-law in the hospital. The sister-in-law has been hospitalized after attempting suicide. Your neighbor asks, “What should I say when I go to visit Jane?” What suggestions might you give him?
3. John’s father died by suicide when John was a teenager. John’s wife, Mary, tells the mental health nurse that she is afraid John “inherited” that predisposition from his father. How should the nurse respond to Mary?
4. The nurse notes that the mood of a patient being treated for depression and suicidal ideation suddenly brightens, and the patient states, “I feel fine now. I don’t feel depressed anymore.” Why would this statement alert the nurse of a potential problem?
5. Write a one- to two-page journal reflecting on your previous experiences with suicide, examining your thoughts and feelings and their potential impact on your nursing practice. (Note: Self-awareness on the issue of suicide is identified as an essential competency for psychiatric nurses [American Psychiatric Nurses Association (APNA), 2018] and is relevant to all nurses in developing skills necessary for this aspect of nursing assessment and intervention).

Suicide is not a diagnosis or a disorder; it is a behavior. Specifically, it is the act of taking one’s own life and is derived from the Latin words for “one’s own killing.” Many religions hold that suicide is a sin that is strictly forbidden. Cultural norms and attitudes also influence an individual’s beliefs about suicide. Yet, although some populations are considered at higher risk for suicide (such as American Indians and Alaska Natives; active and veteran military members; lesbian,

gay, bisexual, or transgender individuals; and people in prison or child welfare settings), suicide touches the lives of all ages, ethnic, and racial groups in all parts of the country. A complex interaction of factors such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation are all influential in increasing these risks (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

In the past decade, many state legislatures have debated the acceptability of physician-assisted suicide. Although it is legal in all of the United States for an individual or the individual's power of attorney to refuse life-preserving medical treatment, the majority have not legalized physician-assisted suicide. In 2008 Oregon was the only state in which physician-assisted suicide was legal. Since then, six more states (Montana, Vermont, Washington, California, Hawaii, and Colorado) have adopted similar laws. New Mexico did so as well, but it was overturned on appeal in August 2015. Can suicide be a rational act? Most people in our society do not yet believe that it can.

In the field of psychiatry, suicide is considered an irrational act associated with mental illness and most commonly, but not exclusively, with depression or bipolar disorder. However, not everyone who takes their own life has a mental illness. Individuals in the community and in nonpsychiatric health-care settings may also be at risk. This chapter explores suicide from an epidemiological and etiological perspective. Care of the suicidal patient is presented in the context of the nursing process.

Historical Perspectives

In ancient Greece, individuals were said to have "committed" suicide because it was an offense against the state, and individuals who committed suicide were denied burial in community sites (Minois, 2001). In the culture of ancient Rome, individuals sometimes resorted to suicide to escape humiliation or abuse. In the Middle Ages, suicide was viewed as a selfish or criminal act (Minois, 2001).

Individuals who “committed” suicide were often denied cemetery burial, and their property was confiscated and shared by the crown and the courts (MacDonald & Murphy, 1991). The issue of suicide changed during the Renaissance period. Although condemnation was still expected, the view became philosophical, allowing intellectuals to discuss the issue more freely. Most philosophers of the 17th and 18th centuries condemned suicide, but some writers recognized a connection between suicide and melancholy or other severe mental disturbances (Minois, 2001). Suicide was illegal in England until 1961, and only in 1993 was it decriminalized in Ireland. With the decriminalization of suicide, many have advanced the idea that the term “committed suicide” should be removed from our vocabulary because it is inaccurate and potentially maintains a stigmatizing attitude toward this population.

Most religions consider suicide a sin against God. Judaism, Christianity, Islam, Hinduism, and Buddhism all condemn suicide. The Catholic church today still teaches that suicide is wrong, it is in opposition to proper love of self and love of God, and it wrongs others through the experience of loss and grief (Byron, 2016). But as Byron (2016) points out, some of the church’s condemnation may have been rooted in a “denial of the responsibility to understand the pain that produces such an act,” and he stresses the importance of encouraging those who “are hurting to open up,” which, it is hoped, will remove some of the taboos of discussing suicide within the church. Likewise, replacing the term *committed* suicide (which has persisted in use long since its decriminalization) may also reduce the stigma and taboo that has historically been associated with discussing suicide.

Epidemiological Factors

In 2018, the most recent year for which statistics have been recorded, 48,344 people died by suicide in the United States (American Foundation for Suicide Prevention [AFSP], 2020). The numbers continue to climb despite nationwide attention to suicide

prevention. This is the highest rate of suicide in more than 15 years. These statistics have established suicide as the second-leading cause of death (behind unintentional injuries) among young Americans ages 10 to 34 years, the fourth-leading cause of death for individuals ages 35 to 54, the eighth-leading cause of death for individuals ages 55 to 64, and the tenth-leading cause of death overall (Centers for Disease Control and Prevention [CDC], 2019). Many more people attempt suicide than die by suicide (about 12:1), and even more people seriously contemplate the act without carrying it out. Because statistics about numbers of suicide attempts reflect only those who have entered a treatment setting, the numbers could be much higher. With a steady increase in suicide rates from 2000 to 2018, suicide has become a major healthcare problem in the United States.

Not only is the number of suicides increasing, but the demographics have changed. Historically, the highest rates of suicide were among the elderly. However, the current highest rates of suicide are among individuals ages 45 to 54 years, and second highest are those ages 85 years and older (AFSP, 2019). In addition, the suicide rate has been lower among military personnel than among the general population. However, in some time periods since the Iraq War began—including in 2010 and 2011—more soldiers died by suicide than died in combat (Nock et al., 2013). See Chapter 37, “Military Families,” for further discussion.

Research is being conducted into the best strategies for prevention and assessment of suicide risk, how to differentiate between those with suicidal ideation and those who attempt suicide, and evidence-based treatments and interventions. The federal government, through the Substance Abuse and Mental Health Services Administration, has endorsed the Zero Suicide movement (Suicide Prevention Resource Center [SPRC], 2018), an effort to identify evidence-based strategies for suicide prevention. Within the next several years, our understanding of and approaches to treatment may dramatically change. We are certainly beginning to recognize that, with suicide rates on the rise, that conventional

interventions have not adequately addressed the complex needs of this population.

Confusion exists over the reality of various notions regarding suicide. Some currently accepted facts and myths relating to suicide are presented in Table 16–1.

Risk Factors

Suicide risk factors are identified as factors that have statistically been correlated with a higher incidence of suicide. They should be differentiated from **suicide warning signs,** which are identified as factors suggesting a more immediate concern. Both are included as part of a comprehensive assessment of overall risk for suicide.

Marital Status

Some evidence has suggested that the suicide rate for single, never-married persons is twice that for married persons and that divorce increases risk for suicide particularly among men, who are three times more likely than divorced women to take their own lives (Sadock, Sadock, & Ruiz, 2015). Widows and widowers have also been identified at higher risk, but a longitudinal study (Kposowa, 2000) found that being single or widowed had no effect on suicide rates. However, the evidence did support that divorced men are twice as likely as married men to die by suicide. Among women, the study showed no significant difference in the risk of suicide by marital categories. The authors highlight that the evidence is difficult to sort out and can be misleading if data are not stratified over several variables, including age, socioeconomic status, and other factors.

For those who are divorced and widowed, the stresses associated with major life changes and loss are influential. Evidence has demonstrated that a *change* in marital status increases the risk for suicidal behavior, particularly in the first year after the change and particularly among older people (Roškar et al., 2011; Yamauchi et al., 2013). Again, it should be noted that demographics such as marital

status, age, and sex may inform about populations that are statistically at higher risk, but none of these factors are predictive of immediate risk. A thorough assessment of variables, including risk factors, warning signs, and a host of other data, is essential to identifying individuals at acute risk for attempting suicide.

Sex

More women than men attempt suicide, but men more often die by suicide (about 70% for men and 30% for women). These rates reflect the lethality of the means. Women tend to overdose; men use more reliably lethal means, such as firearms. These differences between men and women may also reflect differing societal expectations; women are more likely than men to seek and accept help from friends or professionals.

Transgender individuals are also a high-risk population for suicide with an alarming 41% lifetime prevalence (Stroumsa, 2014). Further research is needed to better understand whether this increased risk is associated with gender dysphoria versus environmental variables.

Age

Suicide risk and age are, in general, positively correlated, particularly with men. Although rates among women remain fairly constant throughout life, rates among men increase with age. The most recent statistics, according to the AFSP (2020), reveal that in 2017 the highest rates of suicide occurred in the 45- to 54-year-old age-group and among those 85 or older.

Although adolescents may statistically have a lower rate of suicide than some other age-groups, it is still important to note that suicide has been the third-leading cause of death in this population over several years, and in 2013 became the second-leading cause of death where it remained in 2017. It has become the second-leading cause of death in children ages 10 to 14 years as well (CDC, 2019). Several factors put adolescents at risk for suicide, including impulsive and high-risk behaviors, untreated mood disorders (e.g., major depression and bipolar disorder), access to lethal means (e.g., firearms), and substance abuse. One recent study (Reyes et al.,

2015) found a link between some modes of anger expression in adolescents and suicide risk; in particular, hopelessness and hostility modes of anger expression were associated with an increase in suicidal tendency. Among children younger than age 10, the statistics have historically demonstrated a low number of suicides, and some have argued that younger children are unable to intentionally consider and follow through with a suicide attempt. Anecdotal evidence has shown this is not always the case, with some therapists identifying 5- to 9-year-old children actively talking about suicide (Jobes, 2015). Research is beginning to emerge that supports real risk in young children (Duran & McGuinness, 2016). Bridge and associates (2015) studied a large sample of children ages 5 to 11 and found that, on average, 33 children per year die by suicide within this age-group in the United States, predominately from suffocation and hanging. These researchers also noted that suicide was never coded as a cause of death for children younger than 5 years of age. However, when Whalen and associates (2015) studied children in the 3- to 7-year-old age-group, they found about 11% with suicidal ideation. Increased risk was correlated with male sex, psychiatric illness in their mothers, and psychiatric illness in the child. In young girls ages 10 to 14 years, the incidence of self-inflicted injury has risen 18.8% every year between 2008 and 2015, and self-inflicted injury is one of the strongest risk factors for suicide (Mercado et al., 2017). Duran and McGuinness (2016) stress that the implications for nursing are clear; direct inquiry about suicide ideas is a “necessary component in healthcare encounters with children,” including those in primary care, in emergency departments, and with the school nurse.

TABLE 16–1 **Facts and Myths About Suicide**

MYTHS	FACTS
People who talk about suicide do not act on their ideas. Suicide happens without warning.	Eight out of 10 people who kill themselves have given definite clues and warnings about their suicidal intentions. Very subtle clues may be ignored or disregarded by others.
You cannot stop a suicidal person. He or she is fully intent on dying.	Most suicidal people are very ambivalent about their feelings regarding living or dying. Most are “gambling with death” and see it as a cry for someone to save them.
Once a person is suicidal, he or she is suicidal forever.	Suicidal ideation and risk fluctuate over time and may be time-limited. If provided adequate support and resources, a suicidal person can go on to lead a normal life. However, multiple suicide attempts may reflect greater chronicity of suicidal ideation. Reassessment over time is important to identify current risks.
Improvement after severe depression means that a person is no longer at risk of suicide.	Most suicides occur within about 3 months after the beginning of “improvement,” when the individual has the energy to carry out suicidal intentions.
Suicide is inherited, or “runs in families.”	Suicide is not inherited. However, suicide by a close family member increases an individual’s risk factor for suicide.
All suicidal individuals are mentally ill, and suicide is the act of a psychotic person.	Although a majority of people who attempt suicide are extremely unhappy or clinically depressed, they are not necessarily psychotic. They are unable at that point in time to see an alternative solution to what they consider an unbearable problem.
Suicidal thoughts and attempts should be considered manipulative or attention-seeking behavior and should not be taken seriously.	All suicidal behavior must be approached with the gravity of the potential act in mind. Attention should be given to the possibility that the individual is issuing a cry for help.
People usually take their own lives by overdosing on drugs.	Gunshot wounds are the leading cause of death among suicide victims.
If an individual has attempted	Between 50% and 80% of all people who

suicide, he or she will not do it again.	ultimately kill themselves have at least one previous attempt.
Suicide always happens in an impulsive moment.	People often contemplate, imagine, plan strategies, write notes, post things on the Web. In-depth exploration and assessment may reveal these plans.
Young children (ages 5–12) cannot be suicidal.	Each year, 30 to 35 children younger than age 12 years take their own lives, and not all are clinically depressed.

Sources: Cardoza, K. (2016). 6 myths about suicide that every parent and educator should know. Retrieved from www.npr.org/sections/ed/2016/09/02/478835539; National Alliance on Mental Illness. (2019). Risks of suicide. Retrieved from www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Risk-of-Suicide; The Samaritans. (2019). Suicide myths and misconceptions. Retrieved from http://samaritansnyc.org/myths-about-suicide.

The American Association of Suicidology (2019a) reports that across all age, sex, and racial groups, suicide rates in the United States have risen, but the groups most likely to die by suicide are middle-aged and elderly white men. It cannot be overstated, however, that although statistics reveal degrees of risk in certain age-groups, screening for risk of suicide should be conducted for all individuals regardless of demographic characteristics.

Religion

Historically, suicide rates among Protestants and Jews have been higher than among Roman Catholic or Muslim populations, but the degree of orthodoxy and affiliation with one's religion may be an important variable (Sadock et al., 2015). A systematic review of the research on religion and suicide risk (Lawrence, Oquendo, & Stanley, 2016) found that although religious affiliation is not protective against suicide ideation, it is protective against suicide attempts, and that religious service attendance is possibly protective against suicide. The authors of one study (Rasic, 2009) found that religious affiliation is associated with a decreased risk of suicide attempts in both the general population and in those with a mental illness, independent of the availability of social support systems.

Socioeconomic Influences

Individuals in the very highest and lowest social classes have higher suicide rates than those in the middle classes (Sadock et al., 2015). Suicide rates are higher in rural areas and with a twofold greater use of firearms as the means (Ivey-Stephenson et al., 2017). Kim and associates (2016) studied the factors influencing a move from suicide ideation to suicide attempts and found that low education and unemployment significantly increased the prevalence of *attempts* among young adult men and women with suicide *ideation.* Because previous attempts are a leading risk factor for eventual suicide, assessing for suicide ideation in high-risk socioeconomic groups may be an important preventive measure.

Ethnicity

In 2017 the highest U.S. age-adjusted suicide rate was among whites (15.85), and the second-highest rate was among American Indians and Alaska Natives (13.42). Much lower and roughly similar rates were found among black or African Americans (6.61) and Asians and Pacific Islanders (6.59) (AFSP, 2020). Recent research has highlighted two trends that illuminate issues of concern within specific groups. First, although suicide rates among whites are higher in adults and the elderly, within the American Indian community, young adults have a higher risk for suicide than in any other ethnic group, and the rate is higher than that of the general population (Almendrala, 2015). Almendrala relays the story of a psychiatrist called to a reservation where there had been 17 suicides in the previous 8 months, and the community members described themselves as “grieved out.” The second trend of concern, as Almendrala reports, is that the rates of suicide may be underestimated in this population because death certificates do not always report accurately regarding ethnicity.

Another recent study examined suicide trends among school-age children younger than 12 (Bridge et al., 2015). A significant finding was that suicide rates for black children 5 to 11 years of age nearly doubled over the period from 1993 to 2012, whereas the overall

suicide rate in this age-group remained relatively stable during the same time period. The use of hanging or suffocation as a means of taking one's own life also significantly increased in this population. The contributing factors to these recent trends are not well understood and will require further research, including a review of the impact of health-care disparities for select communities and populations.

Other Risk Factors

The majority of people who die by suicide have a diagnosable mental illness, most commonly depression, bipolar disorder, or substance use disorder. Individuals who have been *hospitalized* for a psychiatric illness have a 5 to 10 times greater suicide risk than those with psychiatric illness in the general population (Sadock et al., 2015). This higher risk may be a reflection of the severity of their mental illness. Other recent research supports an increased risk of suicide in the period following discharge from psychiatric hospitalization, especially for those not connected to a system of care (Olfson et al., 2016). Suicide risk may increase early in treatment with antidepressants. One possible reason is that as an individual's energy returns, he or she may have an increased ability to act out self-destructive wishes. Although suicide is often linked to depression, there is also a recognized risk of suicide among people with schizophrenia, bipolar disorders, personality disorders, eating disorders, anxiety disorders, and substance use disorders. A thorough suicide risk assessment should be conducted for anyone seeking mental health services.

Other major physical conditions have also been identified as contributing to increased risk for suicide (Ahmedani et al., 2017), with three conditions (traumatic brain injury, sleep disorders, and HIV/AIDS) conferring a twofold increase in risk. Severe insomnia is associated with increased suicide risk even in the absence of depression. Use of alcohol, and particularly a combination of alcohol and barbiturates, increases the risk of suicide. Withdrawal from stimulants increases suicide risk as the person begins to "crash." Psychosis, especially with command hallucinations (hearing voices

telling one to harm or kill oneself), increases risk, as does having a chronic, painful, or disabling illness.

Several studies have indicated a higher risk factor for suicide among gay men, lesbians, and transgender individuals (Cassels, 2011; Cochran & Mays, 2000; Eisenberg & Resnick, 2006; King et al., 2008; Plöderl, 2013). This increased risk may be a function of the social stigma and discrimination associated with being part of a marginalized group. Additional personal stressors, including isolation, victimization, and stressful interpersonal relationships with family, peers, and community, are not uncommon. A report from the CDC (2016) identified that in a study of youth in grades 7 to 12, lesbian, gay, and bisexual youth were twice as likely as their heterosexual peers to attempt suicide (this study did not address the risk for transgender individuals). Another study, however, found that transgender individuals are also a high-risk population for suicide, with an alarming 41% lifetime prevalence (Stroumsa, 2014). See online Chapter 42, “Issues Related to Human Sexuality and Gender Dysphoria,” for further discussion on this topic.

Higher risk is also associated with a family history of suicide, especially in a same-gender parent, and with individuals who have made previous suicide attempts. About one-half of individuals who kill themselves have previously attempted suicide. Because roughly equal numbers die by suicide on their first attempt, all individuals with suicide ideation should be assessed carefully for risk factors and warning signs. Loss of a loved one through death or separation and lack of employment or increased financial burden also increase risk.

In recent years, several suicides have been reported in the media among young people who are the victims of bullying. Zweig and Dank (2013) reported that 41% of youth are victims of physical bullying (most often boys), 17% are victims of *cyberbullying* (being bullied via the internet or e-mail), and girls are more likely to be victims of psychological bullying. Clearly, bullying is a prevalent concern among youth. Klomek, Sourander, and Gould (2011) report:

> Studies among middle school and high school students show an increased risk of suicidal behavior among bullies and victims. Both perpetrators and victims are at the highest risk for suicidal ideation.

Cyberbullying has also been associated with an increased risk of depression and suicidal behavior among young people. Researchers found that both perpetrators and victims of cyberbullying had more suicidal ideation and were more likely to attempt suicide than those who had not experienced such forms of peer aggression (Bauman, Toomey, & Walker, 2013; Hinduja & Patchin, 2010). Edgerton and Limber (2013), in a research brief on suicide and bullying, caution that although research does show that those who are bullied have high levels of suicidal thoughts and attempts, there is not enough research to identify a cause-and-effect relationship. Other risk factors, such as mental health problems, appear to play a larger role.

Predisposing Factors: Theories of Suicide

Psychological Theories

Anger Turned Inward

Freud (1957) believed that suicide was a response to intense self-hatred. The anger originates toward a love object but is ultimately turned inward against the self. In other words, Freud thought that suicide occurred as a result of an earlier repressed desire to kill someone else.

Hopelessness and Other Symptoms of Depression

Hopelessness has long been identified as a symptom of depression and an underlying factor in the predisposition to suicide. Although the many symptoms identified in suicide assessment tools attempt to assess for the seriousness of suicide ideation, current research is attempting to glean which symptoms might be more predictive of the move from ideation to attempts. In addition to hopelessness, the strength of the person's intention to die and the amount of suicide-

specific rumination about suicide have also been identified as significant (Jobes, 2015; Rogers & Jobes, 2017).

History of Aggression and Violence

A history of violent behavior or impulsive acts has been associated with an increased risk for suicide (Sadock et al., 2015), although recent evidence suggests that impulsive traits are higher in individuals with suicide ideation but not necessarily associated with more attempts (Klonsky & May, 2015b).

Shame and Humiliation

Some individuals have viewed suicide as a "face-saving" mechanism —a way to prevent public humiliation following a social defeat such as a sudden loss of status or income. Both shame and humiliation may also interrupt one's sense of connectedness with others, and a sense of belonging and connectedness is considered protective against suicide. Evidence supports that the experience of shame is pronounced in trauma survivors (Taylor, 2015) and in females with borderline personality disorder (Wiklander et al., 2012). This research helps us understand some of the influencing factors for increased risk of suicide in these populations.

Sociological Theories

Durkheim's Theory

Durkheim's classic work (1951) studied the individual's interaction with the society in which he or she lived. He believed that the more cohesive the society and the more that the individual felt an integrated part of society, the less likely he or she was to carry out suicide. Durkheim described three social categories of suicide:

1. **Egoistic suicide** is the response of the individual who feels separate from the mainstream of society. Integration is lacking, and the individual does not feel a part of any cohesive group (such as a family or a church).
2. **Altruistic suicide** is the opposite of egoistic suicide. The individual who is prone to altruistic suicide is excessively

integrated into the group. The group is often governed by cultural, religious, or political ties, and allegiance is so strong that the individual will sacrifice his or her life for the group.

3. **Anomic suicide** occurs in response to changes in an individual's life (e.g., divorce, loss of job) that disrupt feelings of relatedness to the group. An interruption in the customary norms of behavior instills feelings of separateness and fears of being without support from the formerly cohesive group.

Connectedness continues to be identified as an important protective factor for suicide prevention and may include a sense of closeness with individuals, groups, families, schools, faith communities, community organizations, or cultural group (Suicide Prevention Resource Center, 2019).

Interpersonal Theory of Suicide

Thomas Joiner's (2005) interpersonal theory of suicide supports some of the same principles advanced by Durkheim that associates lack of a feeling of belonging with suicide risk. But Joiner's theory introduces the concept that suicide ideation and suicide attempts need to be understood as distinct processes. He proposed that low connectedness and a high sense of burden interact with each other to increase suicidal thoughts and desires, but those features in the presence of high capability for suicide are strongly associated with the move from ideation to lethal attempts.

The Three-Step Theory

Inspired by Joiner's theory, Klonsky and May (2015a) found that impulsivity is elevated in people who have made suicide attempts as well as in those who have suicidal thoughts and have never made an attempt. These researchers therefore sought to identify the factors other than impulsivity that elevate suicide ideation to an active risk for attempts. Their research supported the following three-step trajectory:

1. Pain (usually psychological pain), when combined with hopelessness, significantly increases suicide ideation (for both

men and women and across age-groups).

2. Connectedness prevents suicide ideation from escalating in those at risk, but when pain and hopelessness exceed one's sense of connectedness to others, suicide ideation becomes active.
3. When strong, active suicide ideation is present, it leads to an attempt only if one has the capacity to make an attempt.

Biological Theories

Genetics

Twin studies have shown a much higher concordance rate for suicide risks in monozygotic twins than in dizygotic twins. Some studies of people who have attempted suicide have focused on the genotypic variations in the gene for tryptophan hydroxylase, with results indicating a significant association with suicidality (Sadock et al., 2015). Tryptophan hydroxylase is an enzyme associated with the synthesis of serotonin, and diminished serotonin has implications for both depression and suicidal behavior. Additional research has identified a genetic variation in prefrontal cortex tissue that may be a biomarker for suicide risk when vulnerable individuals are exposed to a significant stressor (Sudak, 2017). These findings suggest the potential for a genetic predisposition toward suicidal behavior, but more research is needed to clarify this possible genetic link.

Neurochemical Factors

Some studies have revealed a deficiency of serotonin (measured as a decrease in the levels of 5-hydroxyindole acetic acid [5-HIAA] in the cerebrospinal fluid) in depressed clients who attempted suicide (Sadock et al., 2015). These studies, as well as postmortem studies, have supported the hypothesis that deficiencies in central nervous system serotonin are associated with suicide.

However, a recent meta-analysis examining biological factors found that they are, in general, weak predictors of a future suicide attempt or death by suicide (Chang et al., 2016). The only two biological factors that had statistical significance in this analysis were

cytokines (anti-inflammatory response chemicals) and low levels of fish oil nutrients (including omega-3).

Application of the Nursing Process With the Suicidal Patient

Many research studies are being conducted that explore suicide from different vantage points to identify demographics, risk factors, predictors of risk for suicide attempts, and strategies for prevention. This research can help nurses become more aware of the phenomenon of suicide and understand the limitations of research in making a clinical judgment about a patient's actual risks versus statistical risks.

Influential organizations across the nation are also advancing the importance of improving the quality of care, documentation, and reporting of details around sentinel events related to acts of or deaths by suicide. In addition to government-initiated national strategies for suicide prevention, The Joint Commission (2016) has advanced standards that include requiring hospitals to conduct risk assessments "identifying specific patient characteristics and environmental features that may increase or decrease the risk of suicide." The American Psychiatric Nurses Association (APNA, 2018; Puntil et al., 2013) has taken a leadership role in identifying psychiatric-mental health nurse essential competencies for assessment and management of individuals at risk for suicide. The CDC (2011) has advanced strategies for uniform definition and reporting about acts of self-directed violence to improve data collection and ultimately improve our understanding and prevention of suicide. At the heart of this wealth of information is the necessity for accurate, comprehensive suicide risk assessment that includes collaboration with the patient and other clinicians and is rooted in strategies to form a therapeutic relationship of trust and open communication.

Assessment

When nurses assess a patient's suicide ideation, it is important to identify and distinguish ideas (thoughts), plans (intentions), and attempts (behavior). Each of these assessment factors can provide information about a patient's level of risk. When the patient has attempted self-injury, it is important to distinguish between *suicidal self-injury* and *nonsuicidal self-injury.* The latter injury is often used as a method to release emotions, but it may also be a way of communicating the severity of distress that the patient is experiencing (Nock et al., 2013).

The following basic items should be considered when conducting a suicidal assessment: demographics; medical-psychiatric diagnoses; suicidal ideas or acts; interpersonal support system; analysis of the suicidal crisis; psychiatric, medical, and family history; and coping strategies. Dr. David Satcher, as Surgeon General of the United States (1998–2002), spoke of risk factors and protective factors in his "Call to Action to Prevent Suicide" (U.S. Public Health Service, 1999). This report initiated a national movement toward research designed to better understand predictors of suicide risk and develop more effective evidence-based interventions. Current models have clarified risk factors as different from warning signs that are associated with a greater potential for suicide and suicidal behavior. Protective factors have been identified that are associated with reduced potential for suicide. Examples of protective factors are outlined in Box 16-1. Figure 16-1 presents a model for differentiating low, high, and imminent suicide risk. The goal of such models is not to predict a suicide attempt but to identify the level of intervention needed to prevent an attempt.

BOX 16–1 **Examples of Protective Factors**

Resilient temperament
Social competency
Skills in problem-solving, coping, and conflict resolution
Perception of social support from adults and peers
Positive expectations, optimism for the future; identification of future goals
Connectedness to family, school, community
Presence and involvement of caring adults (for adolescents)
Integration in social networks
Cultural and religious beliefs that discourage suicide and encourage preservation of life
Access to quality social services and clinical health care for mental, physical, and substance use disorders
Support through ongoing medical and mental health-care relationships
Restricted access to highly lethal means of suicide

Source: Crosby, A.E., Ortega, L., & Melanson, C. (2011). Self-directed Violence Surveillance: Uniform definitions and recommended data elements, Version 1.0. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Retrieved from www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf

FIGURE 16–1 Risk factors and warning signs for suicide. Reprinted with permission from the Ontario Hospital Association.

Demographics

The following demographics should be identified when evaluating a patient for suicide risk. Although demographics alone do not directly translate into an individual's risk, they provide information as part of a comprehensive assessment of proximal or potentiating risk factors.

- **Age:** Adolescents and the elderly have been generally identified as high-risk groups, but recent statistics demonstrating the highest incidence in the 45- to 54-years age-group and evidence of suicide among children suggests that nurses should assess for suicide risk in all age-groups.

- **Gender:** Males are at higher risk for death by suicide than females, but females attempt suicide more frequently.
- **Ethnicity/race:** The CDC reports that the highest rates of suicide are among Caucasians followed by American Indians and Alaska Natives (CDC, 2018).
- **Marital status:** Single, divorced, and widowed individuals are at higher risk for suicide than are married people, particularly during periods of change in status.
- **Socioeconomic status:** Individuals in the highest and lowest socioeconomic classes are at higher risk than those in the middle classes.
- **Occupation:** Health-care professionals (especially physicians), law enforcement officers, dentists, artists, mechanics, lawyers, and insurance agents have all been identified as occupational groups incurring greater risks for suicide (Sadock et al., 2015). Potential contributing factors include occupations that involve high stress, isolation, lack of access to health-care resources, and repeated exposure to painful or violent stimuli.
- **Religion:** People with close religious affiliations may be at lower risk for attempting suicide if they believe, for example, that suicide is an unforgivable sin that is strictly forbidden within the religion. Conversely, people without close affiliations that impose restrictions about suicide may be at greater risk.
- **Family history:** A family history of suicide increases an individual's risk for suicide.
- **Military history:** Military personnel, both active duty and veterans, are a high-risk group for suicide. The most common method is firearms, which accounts for over 60% of all suicides among military members (Center for Deployment Psychology, 2019).

Medical-Psychiatric Diagnosis

Assessment data must be gathered regarding any psychiatric or physical condition for which a patient is being treated. Mood disorders (major depression and bipolar disorders) are the disorders most commonly associated with suicide. Substance use disorders

are also associated with an increased risk for suicide attempts. Other psychiatric disorders in which suicide risks have been identified include anxiety disorders, schizophrenia, anorexia nervosa, and borderline and antisocial personality disorders. Chronic and terminal physical illnesses have also been identified as potentiating risk factors.

Suicidal Ideas or Acts

An important part of the assessment of a patient's suicide risk is to determine the seriousness of the patient's intent to die. How serious is the patient's intent to die by suicide? How frequent are the patient's thoughts about suicide? Does the person have a plan? If so, does he or she have the means? How lethal are the means? Does he or she intend to carry out this plan? Has the individual ever attempted suicide before? These questions must be asked by the person conducting the assessment of the patient who is expressing suicidal ideation.

Individuals may provide both behavioral and verbal clues about their intention to act. Examples of behavioral clues that may indicate a decision to carry out suicidal intent include giving away prized possessions, getting financial affairs in order, writing suicide notes, and a sudden lift in mood.

Verbal clues may be both direct and indirect. Examples of direct statements include "I want to die" or "I'm going to kill myself." Examples of indirect statements include "This is the last time you'll see me," "I won't be around much longer for the doctor to worry about," or "I don't have anything worth living for anymore."

Recent research (Rogers & Joiner, 2017) provides evidence that suicide-specific rumination, that is, fixation on one's thoughts, intentions, and plans, may be an important predictor of suicidal behavior. Asking how frequently the patient is thinking about suicide ideas, intentions, and plans helps to discern this level of risk.

The lethality of the method identified by an individual with suicide ideation or by one who has already made an attempt provides meaningful information about the patient's intent to die. Use of

firearms, hanging, and suffocation, for example, are considered highly lethal methods.

Other assessments include determining whether the individual has a plan, and if so, whether he or she has the means to carry out that plan. If the person states the suicide will be carried out with a gun, does he or she have access to a gun? Bullets? If pills are planned, what kind of pills? Are they accessible? Asking the patient, "How likely are you to carry out this plan?" may provide verbal confirmation of their level of intent.

Interpersonal Support System

Does the individual have support persons on whom he or she can rely during a crisis situation? Lack of a meaningful network of satisfactory relationships may implicate an individual as a high risk for suicide during an emotional crisis.

Analysis of the Suicidal Crisis

Three aspects of assessment that enhance understanding of the patient's current suicidal crisis are evaluation of the patient's precipitating stressors, relevant history, and life-stage issues.

- **The precipitating stressor:** Adverse life events in combination with other risk factors, such as depression, may lead to suicide. Life stresses accompanied by an increase in emotional disturbance include the loss of a loved one either by death or by divorce, problems in major relationships, changes in social or occupational roles, or serious physical illness.
- **Relevant history:** Has the individual experienced numerous failures or rejections that would increase his or her vulnerability for a dysfunctional response to the current situation? Has the individual attempted suicide in the past? How recently? What was the method used in previous attempts?
- **Life-stage issues:** The ability to tolerate loss and disappointment is often compromised if those losses and disappointments occur during stages of life in which the individual struggles with developmental issues (e.g., adolescence, midlife).

Psychiatric, Medical, and Family History

The individual should be assessed for previous psychiatric treatment for depression, substance use disorder, or previous suicide attempts. A medical history should be obtained to determine the presence of chronic, debilitating, or terminal illness. Is there a history of depressive disorder in the family, and has a close relative died by suicide in the past?

Coping Strategies

How has the individual handled previous crisis situations? How does this situation differ from previous ones?

Presenting Symptoms

Several acronyms have been developed as mnemonic devices to summarize important factors that may increase a person's risk for suicidal behavior. One is the acronym IS PATH WARM? (American Association of Suicidology, 2019b; Juhnke, Granello, & Lebrón-Striker, 2007). The assessment items and patient descriptors for each letter are as follows:

Ideation: Has suicide ideas that are current and active, especially with an identified plan

Substance abuse: Has current or excessive use of alcohol or other mood-altering drugs

Purposelessness: Expresses thoughts that there is no reason to continue living

Anger: Expresses uncontrolled anger or feelings of rage

Trapped: Expresses the belief that there is no way out of the current situation

Hopelessness: Expresses a lack of hope and perceives little chance of positive change

Withdrawal: Expresses desire to withdraw from others or has begun withdrawing

Anxiety: Expresses anxiety, agitation, and/or changes in sleep patterns

Recklessness: Engages in reckless or risky activities with little thought of consequences

Mood: Expresses dramatic mood shifts

Although mnemonic devices such as IS PATH WARM? can be helpful in remembering what types of presenting symptoms to assess for, the overall assessment and management of suicidal behavior is far more complex and must consider available support systems, the client's willingness to accept support, and the client's ability to establish a trusting therapeutic alliance with health-care professionals intervening on his or her behalf. Ultimately, a clinical judgment must be made about the patient's degree of risk so that appropriate measures can be taken to prevent an attempt. The Columbia Suicide Severity Rating Scale (Posner et al., 2011) is an evidence-based tool that assists in this process (Figure 16-2).

Columbia-Suicide Severity Rating Scale
Screen Version - Recent

	Past Month		Lifetime (Worst Point)	
Ask questions that are bolded and underlined.	**Yes**	**No**	**Yes**	**No**
Ask Questions 1 and 2				
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***				
2) ***Have you actually had any thought of killing yourself?***				
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.				
3) ***Have you been thinking about how you might do this?*** E.g. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."*				
4) ***Have you had these thoughts and had some intention of acting on them?*** *As opposed to "I have the thought but I definitely will not do anything about them."*				
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***				

How long ago did the Worst Point Ideation occur? _____

	Yes	No
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc...		
If YES, ask: ***Was this within the past three months?***		

Low risk Moderate risk High risk

FIGURE 16-2 Columbia-Suicide Severity Rating Scale (C-SSRS). Reprinted with Permission from The Columbia Lighthouse Project.

 The Collaborative Assessment and Management of Suicidality (CAMS) model is an evidence-based approach that focuses on the importance of patient-centered, problem-focused intervention to build an alliance with patients for collaboration in reducing risk for suicidal behavior (Jobes, 2012). This model focuses on assessment, which necessarily includes asking the patient to identify what is driving the desire to take his or her own life so that alternatives (identifying and capitalizing on motivations to live) can be explored. For all health-care professionals, this work begins with developing skills in asking basic and direct questions, such as “Are you having thoughts of hurting or killing yourself?”

Beyond the basic questions of whether or not a person has suicidal ideas, a plan, and access to means, there must be a recognition that patients are not always forthcoming or truthful in their answers to such questions. Several strategies for enhancing a collaborative, therapeutic relationship and communication about suicide assessment have been elaborated. Because nurses are often at the front line of this assessment in medical-surgical, emergency department, outpatient care, schools, and other health-care settings, they must be thoughtful, comprehensive, and conscientious in this pursuit regardless of the practice setting and whether or not the patient has been identified as having mental health issues. Shea (2009) states that nurses need to assess not only what the patient is directly stating about his or her suicidal intent (stated intent), but also the amount of thinking, planning, and behaviors associated with suicide ideation (reflected intent) and the suicide intent that is withheld from the nurse (withheld intent). A summary of guiding principles in suicide risk assessment is included in Table 16–2.

One model for enhancing communication in suicide assessment is the Chronological Assessment of Suicide Events (CASE) approach. It is described as a flexible guide for interviewing that includes communication techniques designed to elicit and enhance detailed, valid feedback from patients about sensitive topics such as suicide. Several examples, as elaborated by Shea (2009), follow:

- ***Normalizing*** communicates that the patient is not the only one who experiences suicidal ideation.

> **Example**
>
> "Sometimes when people are in a lot of emotional pain, they have thoughts of killing themselves. Have you had any thoughts like that?"

- ***Asking about behavioral events*** rather than the patient's opinions may elicit more concrete information.

> **Example**
>
> "What did you do when you had those thoughts?" "How many pills did you take?" "What happened next?"

- ***Gentle assumptions*** encourage further discussion by assuming there is more to tell.

> **Example**
>
> "What other times have you attempted suicide?"

- ***Denial of the specific*** is helpful when a patient generally denies suicidal ideation. This strategy encourages more in-depth thought and response by asking questions that might trigger memories of specific events.

> **Example**
>
> After the patient denies suicidal ideation in response to a general question, the nurse asks more specifically, "Have you ever had thoughts of overdosing?" "Have you ever had thoughts about shooting yourself?"

- ***Chronologically exploring*** the presenting suicide event, recent suicide events, past suicide events, and immediate suicide events can broaden the nurse's understanding of the patient's immediate suicidal intent in the context of his or her behavior over time.

Diagnosis and Outcome Identification

Nursing diagnoses for the suicidal patient may include the following:

- Risk for suicide related to feelings of hopelessness and desperation
- Hopelessness related to absence of support systems and perception of worthlessness
- Ineffective coping related to extreme stress, crisis, feeling trapped, poorly developed coping skills, impulsivity

Outcome Criteria

Outcome criteria include short- and long-term goals. Timelines are individually determined. The criteria that follow may be used for measurement of outcomes in the care of the suicidal patient.

The patient:

1. Has experienced no physical harm to self
2. Develops a safety plan and sets realistic goals for self
3. Expresses optimism and hope for the future

Planning and Implementation

Table 16–3 provides a plan of care for the hospitalized patient who is suicidal. Nursing diagnoses are presented, along with outcome criteria, appropriate nursing interventions, and rationales for each.

TABLE 16–2 **Guiding Principles for Suicide Risk Assessment**

PRINCIPLES	EXPLANATION
Screening for suicide risk should be conducted as an essential component of health assessment, and risk factors, warning signs, and threats should be taken seriously.	Screening includes identifying through detailed assessment the individual's unique situation to discern additional resources, consultations, and interventions needed to ensure client safety.
Establishment of a therapeutic relationship is foundational to effective suicide risk assessment.	Establishing trust through empathy and respect provides a safe environment for the client to tell his or her story.
Suicide risk assessment is complex and challenges the nurse to use many different communication strategies.	Assessment includes exploring the client's thoughts, feelings, and behaviors from a variety of perspectives.
Suicide risk assessment is an ongoing process, and the level of risk can increase or decrease over time.	Assessment should take place over time to look for fluctuations in risk factors and changes in stress level, intensity of ideation, intention to act on suicide ideation, and support systems.
Collaboration with the client and other sources of information facilitates confidence in clinical judgments.	Collaboration entails using information provided by other people who are familiar with the client from home, work, or school and other clinical team members. Collaboration also implies that all those involved in the client's care are working together.
Suicide risk assessment uses direct rather than indirect language.	Terminology such as "suicide" and "death" should be used rather than "not happy with living" or other indirect statements. Use of direct language also communicates to the client that these are acceptable topics to discuss.
Suicide risk assessment attempts to discern the underlying message.	It is important to discern when the client is communicating unbearable distress, feeling trapped, feeling hopeless, or feeling driven to avoid additional emotional or physical pain.

Suicide risk assessment considers cultural context.	Anyone, regardless of race, religion, or culture, may be at risk for suicide. Some cultural or religious prohibitions may influence someone's willingness to openly discuss personal feelings.
Suicide risk assessment is documented in detail.	Documentation includes risk factors, warning signs, underlying themes, level of risk, clinical judgments, and recommended interventions.

Source: Adapted from Perlman, C.M., Neufeld, E., Martin, L., Goy, M., & Hirdes, J.P. (2011). *Risk Assessment Inventory: A resource guide for Canadian healthcare organizations.* Toronto: Ontario Hospital Association and Canadian Patient Safety Institute.

Table 16–3 | CARE PLAN FOR THE SUICIDAL PATIENT

NURSING DIAGNOSIS: RISK FOR SUICIDE

RELATED TO: Feelings of hopelessness and desperation

OUTCOME CRITERIA	NURSING INTERVENTIONS	RATIONALES
Patient will not harm self.	1. Ask the patient directly: "Have you thought about harming yourself in any way? If so, what do you plan to do? Do you have the means to carry out this plan? How strong are your intentions to die?" "How often do you think about suicide?"	1. The risk of suicide is greatly increased if the patient has developed a plan with lethal means and particularly if means are accessible for patient to execute the plan. Suicide-specific rumination is associated with suicide attempts.
	2. Create a safe environment for the patient. Remove all potentially harmful objects from patient's access (sharp objects, straps, belts, ties, glass items, alcohol). Supervise closely during meals and medication administration. Perform room searches as deemed necessary.	2. Patient safety is a nursing priority.
	3. Maintain close observation of the patient. Depending on level of suicide precaution, provide one-to-one contact, constant visual observation, or every-15-minute checks at irregular intervals. Place the patient in a room close to nurse's station; do not assign to private room. Accompany to off-unit activities if attendance is indicated. May need to accompany to bathroom.	3. Close observation is necessary to ensure that the patient does not harm self in any way. Being alert for suicidal and escape attempts facilitates prevention or interruption of harmful behavior.
	4. Maintain special care in administration of	4. Prevents saving up to overdose or discarding

	medications.	and not taking.
	5. Make rounds at frequent, *irregular* intervals (especially at night, toward early morning, at change of shift, or other predictably busy times for staff).	5. Prevents staff surveillance from becoming predictable. Being aware of the patient's location is important, especially when staff is busy and least available and observable.
	6. Encourage the patient to express honest feelings, including anger. Provide hostility release if needed.	6. Depression and suicidal behaviors may be viewed as anger turned inward on the self. If this anger can be verbalized in a nonthreatening environment, the patient may be able to eventually resolve these feelings.
Patient develops a safety plan for management of suicidal thoughts and urges.	1. Establish a trusting, therapeutic relationship to encourage open discussion of suicide.	1. Establishing trust and open communications encourages the patient to share thoughts and feelings.
	2. Collaborate with the patient to develop a safety plan that includes recognition of warning signs, coping strategies, supportive people and places, resources and contact information for crisis management, and plans to restrict access to lethal means.	2. Development of a comprehensive collaborative safety plan concretizes resources and management strategies. Actively engaging the patient in collaboration on the development of a safety plan promotes patient ownership and investment in the process.
	3. Assess verbal and nonverbal clues to identify the likelihood that the patient intends to follow through with the established safety plan and evaluate the patient's follow-through with safety plan measures while still hospitalized.	3. Assessment of patient safety includes analyzing congruence of verbal communication, nonverbal communication, and behavior.

NURSING DIAGNOSIS: HOPELESSNESS

RELATED TO: Absence of support systems and perception of worthlessness

EVIDENCED BY: Verbal cues (despondent content, "I can't"); flat affect; lack of initiative; suicidal ideas or attempts

OUTCOME CRITERIA	NURSING INTERVENTIONS	RATIONALES
Patient expresses hope and acceptance of life and situations over which he or she has no control.	1. Identify stressors in the patient's life that precipitated current crisis. Include assessing degree of emotional pain and hopelessness in relationship to feelings of connectedness or lack of connectedness with others.	1. It is important to identify contributing factors to assist the patient with stress management. Meaningful connections with others promotes hope and is identified as a protective factor against suicide.
	2. Determine coping behaviors previously used and the patient's perception of effectiveness then and now.	2. Identifying the patient's strengths encourages their use in the current crisis.
	3. Encourage the patient to explore and verbalize feelings and perceptions related to reasons for wanting to die as well as reasons for wanting to live.	3. Identification of feelings underlying behaviors helps the patient to begin the process of taking control of own life and enables the nurse to help the patient focus on maximizing his or her reasons for wanting to live.
	4. Provide expressions of hope to the patient in a positive, low-key manner (e.g., "I know you feel you cannot go on, but I believe that things can get better for you. What you are feeling is temporary. It is okay if you don't see it just now.").	4. Although the patient feels hopeless, it is helpful to hear positive expressions from others. The patient's current state of mind may prevent him or her from identifying anything positive in life. It is important to accept the patient's feelings nonjudgmentally and to affirm his or her personal worth and value.
	5. Help the patient identify areas of life situation that	5. The patient's emotional condition may interfere with the ability to problem-

	are under his or her control.	solve. Assistance may be required to perceive benefits and consequences of available alternatives accurately.
	6. Identify sources that the patient may use after discharge when crises occur or feelings of hopelessness and possible suicidal ideation prevail. This includes local suicide hotlines and other available support services.	6. A collaboratively developed, concrete plan promotes hope in the face of a crisis.
	7. Assist the patient to explore and identify future-oriented goals.	7. Identifying goals encourages the patient to focus on hopefulness for the future.

NURSING DIAGNOSIS: INEFFECTIVE COPING

RELATED TO: Extreme stress, crisis, altered mental status, poorly developed coping skills, feeling trapped or hopeless, impulsivity

EVIDENCED BY: Verbal cues (despondent content, "I can't"); decreased affect; lack of initiative; suicidal ideas or attempts

OUTCOME CRITERIA	NURSING INTERVENTIONS	RATIONALES
Patient identifies coping strategies and expresses commitment to incorporate these as part of a plan to maintain personal safety.	1. Assist the patient to identify stressors and other warning signs that are associated with thoughts and plans for suicide.	1. Patient's awareness of triggers for increases in suicidal thinking, plans, and intentions promotes an understanding of situations requiring the implementation of the safety plan.
	2. Explore past coping skills that the patient identifies as effective.	2. Exploring the patient's perception of effective coping skills promotes active engagement in the process of identifying and carrying out a safety plan.
	3. Maintain a nonjudgmental attitude when discussing the patient's suicide ideas, plans, and intentions.	3. A nonjudgmental attitude promotes open communication and collaboration.

	4. Assist the patient to identify internal coping strategies for immediate response to a trigger event.	4. This promotes the patient's ability to develop a sense of personal control in response to suicide ideas.
	5. Assist the patient in identifying support systems, resources, and social activities that the patient can use to support ongoing personal safety.	5. External coping strategies, such as eliciting support from a family member or friend, community resources, and social activities that may help the patient minimize rumination about suicide, are all positive coping skills essential to a comprehensive safety plan.

Intervention With the Client Who Is Suicidal Following Discharge or in an Outpatient Setting

In some instances, it may be determined that suicidal intent is low and that hospitalization is not required. Instead, the client with suicidal ideation may be treated in an outpatient setting. Guidelines for treatment of such clients on an outpatient basis include the following:

- The person should have immediate access to support systems and be connected to a system of care, as the term following hospital discharge is a high-risk period. Arrangements must be made for the client to stay with family or friends. If this is not possible, hospitalization should be reconsidered.
- A detailed safety plan should be developed that is an outgrowth of a comprehensive risk assessment and a collaborative, problem-solving discussion with the client. This intervention explores with the client what he or she will do to stay safe if there is a repeat of or increase in suicidal thoughts or urges. See Box 16-2 for more on the essential components of a safety plan.
- A safety plan should not be confused with a no-suicide contract. See Box 16-3 to learn about the critical issues associated with this

type of document.

- Enlist the help of family or friends to ensure that the home environment does not contain dangerous items, such as firearms or stockpiled drugs. Give support persons the telephone number of the counselor or an emergency contact person if the counselor is not available.
- Appointments may need to be scheduled daily or every other day at first until the immediate suicidal crisis has subsided.
- Establish rapport and promote a trusting relationship. It is important for the suicide counselor to become a key person in the client's support system at this time.
- Accept the client's feelings in a nonjudgmental manner.

BOX 16–2 **Essential Components of a Safety Plan**

According to Stanley and Brown (2008, pp. 3–4), the essential components of a safety plan include nursing support and assistance for the following:

1. Recognizing warning signs that precede suicide crises
2. Identifying and employing internal coping strategies that the client can implement without needing to contact additional support people
3. Identifying supportive family members and friends with whom he or she can discuss suicide and who may help resolve a potential crisis
4. Identifying people and healthy social settings that he or she can use for general support and distraction from suicidal thoughts and urges
5. Identifying resources and contact information for mental health professionals and agencies when needed in an escalating crisis situation
6. Problem-solving with the client ways to reduce the potential for access to and use of lethal means

Once the safety plan is elaborated with the client, an evaluation of the appropriateness of the plan and a collaborative assessment of the likelihood that the client will implement this plan should be conducted.

Assessment for suicidal risk and responsive intervention must be ongoing, as suicidal ideas and intent may change over hours, days, or longer time periods. The need for revision of the safety plan may become evident. Critical times for reassessment of risk and reevaluation of the safety plan (Hoffman, 2013) include the following:

1. When there is a change in the client's clinical presentation or worsening of symptoms
2. When medications or treatments are changed
3. When significant others identify an increase in concern
4. When a client stops treatment

BOX 16–3 **The Issue of No-Suicide Contracts**

A critical issue that needs to be understood is that of no-suicide contracts, sometimes called *safety contracts,* a strategy used by some clinicians in the context of a long-term, therapeutic relationship in which the client "promises" to contact the clinician before acting on suicidal ideation. No-suicide contracts are not the same as the development of a thorough safety plan. Contracting with a client is a controversial and often misused strategy (Hoffman, 2013; Shea, 2009). Evidence has not supported the efficacy of this method as a primary intervention (Drew, 2001; Freedenthal, 2013; Rudd, Mandrusiak, & Joiner, 2006). In fact, it may even be counterproductive in clients with borderline or passive-aggressive pathology (Shea, 2009). Such contracts should *never* be used in short-term encounters with clients, such as in emergency departments or during brief hospital stays, or with clients who are unknown, agitated, psychotic, impulsive, or under the influence of drugs and alcohol (Hoffman, 2013). They should never be used with the presumption that they will deter a client from attempting suicide. Shea adds that if clinicians use a safety contract with the belief that it will be a deterrent to suicide, they should understand that it not only "guarantees nothing [but also] may yield a false sense of security" among clinicians (2009, p. 21). The consequential danger is that clinicians may become less watchful or feel less need to reassess the client, thus missing critical signs of increasing suicide risk. Outside of practicing therapy in an advanced practice role, nurses should avoid no-suicide contracting altogether. Even in the conduct of therapy, it should be used with great caution and for limited, specific assessment purposes.

In general, it is important to recognize that not all suicidal individuals are alike, so interventions should be multifaceted, and suicide prevention plans should be comprehensive. Many models and tools for suicide assessment have been developed. One such model, SAFE-T (Suicide Assessment Five-step Evaluation and Triage), summarizes the key elements in suicide assessment (see Box 16-4).

CLINICAL PEARL Be direct. Talk openly and matter-of-factly about suicide. Listen actively and encourage the patient to express feelings, including anger.

- Discuss the current crisis in the client's life using the problem-solving approach. Offer alternatives to suicide while at the same time empathizing with the client's pain that led to viewing suicide as an option (Jobes, 2012). An example of this kind of communication might be:
  - "I understand how this emotional pain you've been experiencing led you to consider suicide, but I'd like to explore with you some alternative ways to decrease your pain and to identify some reasons for continuing to live."
- Help the client identify areas of life that are within his or her control and those that cannot be controlled. Discuss feelings associated with these control issues. It is important for the client to feel some control over his or her life situation in order to perceive a measure of self-worth.
- The physician or nurse practitioner may prescribe antidepressants for an individual who is experiencing suicidal depression. It is wise to prescribe no more than a 3-day supply of the medication with no refills. The prescription can then be renewed at the client's next counseling session.

  NOTE: Sadock and associates (2015) have stated:

  Patients with depressive disorders are at increased risk of suicide as they begin to improve and regain the energy needed to plan and carry out a plan of suicide (paradoxical suicide). It is usually unwise to give a depressed patient a prescription for a large number of antidepressants, especially tricyclic drugs, at the time of their discharge from the hospital. (p. 366)

- Taking an overdose of antidepressants can be fatal. Psychological interventions that have demonstrated effectiveness in reducing

suicidal behavior include dialectical behavior therapy, cognitive behavior therapy, and CAMS (Jobes, 2015).

Single interventions, including hospitalization, medication alone, and no-suicide contracts, are not supported by evidence as effective in reducing suicides (Jobes, 2015). Clients need to be actively engaged as partners in each step of the assessment and intervention process. Evidence does support that early follow up phone calls with patients who have been treated for a suicide attempt is an effective strategy for reducing suicide risk (Exbrayat et al., 2017; Stanley et al., 2018).

Information for Family and Friends of the Suicidal Client

The following suggestions are recommended for family and friends of an individual who is suicidal:

- Take any hint of suicide seriously. Anyone expressing suicidal feelings needs immediate attention.
- Do not keep secrets. If a suicidal person says, “Promise you won’t tell anyone,” do not make that promise. Suicidal individuals are ambivalent about dying, and suicidal behavior is a cry for help. It is that ambivalence that leads the person to confide to you the suicidal thoughts. Get help for the person and for yourself. 1-800-SUICIDE is a national hotline that is available 24 hours a day.
- Be a good listener. If a person expresses suicidal thoughts or feels depressed, hopeless, or worthless, be supportive. Let the person know you are there for him or her and are willing to help the person seek professional help.
- Many people find it awkward to put into words how another person’s life is important for their own well-being, but it is important to stress that the person’s life is important to you and to others. Emphasize in specific terms the ways in which the person’s suicide would be devastating to you and others.
- Express concern for an individual who expresses thoughts about suicide. The individual may make veiled comments or comments that sound as if he or she is joking, or the person may be withdrawn and reluctant to discuss his or her thoughts and

feelings. In each case, ask questions, acknowledge the person's pain and feelings of hopelessness, and encourage the individual to talk to someone else if he or she does not feel comfortable talking with you.

- Familiarize yourself with suicide intervention resources, such as mental health centers and suicide hotlines.
- Ensure that access to firearms or other means of self-harm is restricted.
- Communicate caring and commitment to providing support. Fleener (2013) offers the following specific suggestions for families and friends when interacting with someone who is suicidal:
  - Acknowledge and accept the person's feelings, and be an active listener.
  - Try to give the person hope, and remind the person that what he or she is feeling is temporary.
  - Stay with the person. Do not leave the person alone. Go to where he or she is, if necessary.
  - Show love and encouragement. Hold, hug, and touch the person. Allow the person to cry and express anger.
  - Help the person seek professional help.
  - Remove any items from the home with which the person may harm himself or herself.
  - If there are children present, try to remove them from the home. Perhaps a friend or relative can assist by taking the children to their home. This type of situation can be extremely traumatic for children.
  - Do *not judge* suicidal people, show anger toward them, provoke guilt in them, discount their feelings, or tell them to "snap out of it." This is a very real and serious situation to individuals experiencing suicidal ideation. They are in real pain. They feel the situation is hopeless and that there is no other way to resolve it aside from suicide.

Intervention With Families and Friends of Suicide Victims

The suicide of a family member can induce a whole gamut of feelings in the survivors. It has long been recognized that the bereavement process for families in which a member has taken his or her own life is complicated and requires an understanding by health-care providers of the unique burdens of this type of loss. Macnab (1993) identified the following symptoms that may be evident after the suicide of a loved one:

- A sense of guilt and responsibility
- Anger, resentment, and rage that can never find its "object"
- A heightened sense of emotionality, helplessness, failure, and despair
- A recurring self-searching: "If only I had done something," "If only I had not done something."
- A sense of confusion and search for an explanation: "Why did this happen?" "What does it mean?" "What could have stopped it?" "What will people think?"
- A sense of inner injury; the family feels wounded and does not know how they will ever get over it and get on with life
- A severe strain placed on relationships; a sense of impatience, irritability, and anger among family members
- A heightened feeling of vulnerability to illness and disease with this added burden of emotional stress

BOX 16–4 **SAFE-T: Suicide Assessment Five-Step Evaluation and Triage**

1. Identify risk factors
   Note those that can be modified to reduce risk.
2. Identify protective factors
   Note those that can be enhanced.
3. Conduct suicide inquiry
   Evaluate suicidal thoughts, plans, behavior, and intent.
4. Determine risk level and intervention
   Choose appropriate intervention to address and reduce level of risk.
5. Document
   Record assessment of risk, rationale, intervention, and follow-up.

Source: Reprinted from U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, www.samhsa.gov.

Read "Real People, Real Stories" for a better understanding of one person's lived experience of losing a child to suicide. Strategies for assisting survivors of suicide victims include the following:

- Encourage the survivors to talk to each other about the suicide and respond to each others' viewpoints and reconstructing of events. Share memories.
- Be aware of any blaming or scapegoating of specific family members. Discuss how each person fits into the family situation, both before and after the suicide.
- Listen to feelings of guilt and self-persecution. Gently move the individuals toward the reality of the situation.
- Encourage the family members to discuss individual relationships with the lost loved one. Focus on both positive and negative aspects of the relationships. Gradually point out the irrationality of any idealized concepts of the deceased person. The family must be able to recognize both positive and negative aspects about the person before grief can be resolved.
- No two people grieve in the same way. It may appear that some family members are overcoming the grief faster than others. All family members must be made to understand that if this occurs, it is not because those family members care less—it is just that they

grieve differently. Variables that enter into this phenomenon include individual past experiences, personal relationship with the deceased person, and individual temperament and coping abilities.

- Recognize how the suicide has caused disorganization in family coping. Reassess interpersonal relationships in the context of the event. Discuss coping strategies that have been successful in times of stress in the past, and work to reestablish these strategies within the family. Identify new adaptive coping strategies that can be incorporated.
- Identify resources that provide support: religious beliefs and spiritual counselors, close friends and relatives, support groups for survivors of suicide. One online connection that puts individuals in contact with survivors' groups specific to each state is the American Foundation for Suicide Prevention at www.afsp.org. A list of resources that provide information and help for issues regarding suicide is presented in Box 16-5.

Real People, Real Stories: Surviving the Loss of a Loved One to Suicide

Losing a loved one to suicide results in a grief process often complicated by stigma, misinformation, lack of information, and sometimes a sense of alienation from others. Emmy's story describes her ongoing journey to grapple with the loss of her son to suicide.

Karyn: We've talked before, but tell me more about your journey since Paul's death.

Emmy: My son Paul died in 1986 at age 17. The thing I remember most is that no one was talking about it. There were 10 students who died in his high school. Two others were known to be suicides.

Karyn: Do you mean no one was talking about it in the school system?

Emmy: Well, the students in Paul's class took up a collection that was for Paul, but the school couldn't decide how to use it, so it just sat there for the longest time. My other son heard they were going to use the money for supplies, so I went and talked to them to make sure that didn't happen.

The school eventually built a memorial garden that became dedicated to all of the students who had died.

Paul died in June, and in August, when all the other students were returning to school, I got a call from a community suicide survivors counselor who told me she was holding a high school assembly to discuss suicide. I wanted her to talk to the ninth and tenth graders, but they wouldn't permit it. I thought the younger kids needed to talk about and learn about this too—they had been my younger son's classmates, and they were affected by it as well. When the suicide counselor intervened, the teachers were told to watch Paul's friends for any evidence of "copycat" behavior, but that was all. I felt the school administration thought there was a stigma in talking about the cause of his death. I found out later that the seniors were talking about and memorializing Paul in their study halls. They were remembering him as a friend who was missed.

Karyn: How has your family coped with Paul's death?

Emmy: We didn't talk about Paul for the longest time; it was as if he didn't exist. We were very separate; we all went in our own directions. My husband started taking long bicycle trips, and he worked on a suicide hotline. I got very involved with offering a program for high school students called Listening POST (people offering students time), which allowed students to talk about anything they wanted to.

Karyn: I know you've told me that you're still close to several of Paul's peers.

Emmy: Oh yes, and their children too. But our family just became very separate. I don't even know how my other son got through his freshman year of high school. We went to a suicide survivors group as a family, and it was important to me as an outlet to talk, but we didn't talk as a family … and then we just stopped going, and the people who knew Paul didn't talk to us. I *so* wanted to talk to people who knew Paul.

After we stopped going to the survivors group, I started going to CoDA [Co-Dependents Anonymous] meetings, even though I don't think I'm codependent. It was more because I needed to

talk … to understand how this happened. I felt like I wasn't there for him…. I was busy with my job and maybe I wasn't tuned in to his moods. I was always taught that boys don't like to talk about feelings.

Karyn: Yes, I guess I've been taught that, too.

Emmy: I just remember that night he told his dad and I that he loved us, he went to bed, and the next morning we found him. I just couldn't make sense of it. Years later, one of Paul's peers, who now has a teenage son, said he could finally tell me what he remembered. And there were signs. Apparently, he had said to some friends (while they were drinking alcohol), "Have you ever thought of killing yourself?" and they all laughed about it and nothing more was said. I also found out that he told an older peer, whom he had met at church camp, that he didn't want to live. The peer smacked him and told him if he ever had thoughts like that again that he [Paul] needed to come talk to him first. But they never told anyone else; they kept it among their peers. They thought they were all-knowing and never told an adult. He was hysterical when he found out what happened.

On that last weekend, he had been partying with his friends … there was alcohol involved … and the friend that was with him told me that someday he would tell me what went down that day. But it's 30 years later, and I still don't know. I know he was at the party with a girl, but I've never been able to find her or talk with her. She went to a different school.

Karyn: And much of this information that you do know came 10 or more years after his death?

Emmy: Yes.

Karyn: What a long journey you've been on trying to put all the pieces together.

Emmy: (tearful) That's exactly it. Trying to put the pieces together, sort it out … but it never gets solved…. It's like being in a maze and you can't get out, and I had a lot of guilt…. Now I recognize that he just made some tragic bad choices.

Karyn: Appreciating that we don't "get over" such tremendous loss but rather amend our lives with some different understanding of

love and loss, what has been most helpful in your healing?

Emmy: Yes, I think there was a point when I realized it was okay to feel some happiness. Being with people who don't know me makes it easier. My faith and fellowship group has been an important part of healing. CoDA was helpful because we talked about how different people process things, and I could understand better how people can get stuck. I used to say that my other son had lost his brother. I couldn't say that I had lost a son. When I had to fill out a health assessment at one point, and I had to respond to the question of how many pregnancies I'd had, that was the most difficult question … because I had to acknowledge … the reality. And I involved myself with all the boys who were on the track team with Paul and the Listening POST and just talked about everything.

Karyn: What is the most important thing that nurses need to know?

Emmy: By the time we would have had any contact with nurses, it was too late. There were no ER, medical, or mental health visits prior to that. If they were to have an impact, it would have been in prevention in the schools. For example, I didn't know at that time to ask questions like, "Are you having thoughts of hurting yourself?" and "Do you have a plan in mind?" And Paul put on a different face for me. He wasn't solitary; he had lots of friends; he was active on the track team….

Karyn: I think you're not alone with not having been taught about things like suicide assessment. Because, as you've said, historically people haven't talked about it. There is an organization called Red Flags National that promotes mental health education for students, parents, and teachers as a standard part of health education in schools.

Emmy: Yes. It needs to be talked about. It's been helpful for me to talk about it even now. I've never had to try to explain the story before. To learn more about Red Flags National, go to www.redflags.org.

BOX 16–5 **Resources Related to Suicide Prevention**

National Suicide Hotline
1-800-SUICIDE (24/7)
National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
1-800-273-TALK (24/7)
American Association of Suicidology
www.suicidology.org
Depression and Bipolar Support Alliance (DBSA)
www.dbsalliance.org
American Foundation for Suicide Prevention
www.afsp.org
National Institute of Mental Health
www.nimh.nih.gov
National Alliance on Mental Illness
www.nami.org
American Psychiatric Association
www.psych.org
Mental Health America
www.nmha.org
American Psychological Association
www.apa.org
Screening for Mental Health Stop a Suicide Today!
www.stopasuicide.org
Boys Town
www.boystown.org
1-800-448-3000 (24/7 national hotline)
Centre for Suicide Prevention (Canada)
www.suicideinfo.ca
1-833-456-4566 (24/7 helpline)
Samaritans (U.K. and Republic of Ireland)
www.samaritans.org
116-123 (24/7 helpline)
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention

www.cdc.gov/injury/index.html
SAVE (Suicide Awareness Voices of Education)
www.save.org
Alliance of Hope: For Suicide Loss Survivors
www.allianceofhope.org

Evaluation

Evaluation of the client who is suicidal is an ongoing process accomplished through continuous reassessment and determination of goal achievement. Once the immediate crisis has been resolved, extended psychotherapy may be indicated. The long-term goals of individual or group psychotherapy for the client would be for him or her to:

- Develop and maintain a more positive self-concept and a sense of hopefulness
- Learn more effective ways to express feelings to others.
- Achieve successful interpersonal relationships.
- Feel accepted by others and achieve a sense of belonging.

A person contemplating suicide feels worthless and hopeless. These goals serve to instill a sense of self-worth while offering a measure of hope and a meaning for living.

Summary and Key Points

- The majority of all persons who attempt or die by suicide have a diagnosed mental disorder.
- Suicide is the second-leading cause of death among young Americans ages 15 to 34 years, the fourth-leading cause of death for those ages 35 to 44, and the fifth-leading cause of death for individuals ages 45 to 54. Based on recent statistics, the highest rates of suicide among all age-groups occurred among those 45 to 54 years of age, followed by those 85 years of age and older.
- Single (never married), divorced, and widowed people may be at greater risk for suicide than married people, but evidence supports

that recent change in status is a proximal risk factor.

- More women than men attempt suicide, but men succeed more often.
- Depressed men and women who consider themselves affiliated with a religion are less likely than their nonreligious counterparts to attempt suicide.
- Individuals in the highest and lowest social classes have higher suicide rates than those in the middle classes.
- Whites are at highest risk for suicide, followed by American Indians and Alaska Natives, Hispanic Americans, Asian Americans, and African Americans.
- Psychiatric disorders that predispose individuals to suicide include mood disorders (depression and bipolar disorders), substance use disorders, schizophrenia, anorexia nervosa, borderline and antisocial personality disorders, and anxiety disorders.
- Predisposing factors include internalized anger, hopelessness and other symptoms of severe depression, history of aggression and violence, shame and humiliation, developmental stressors, sociological influences, genetics, and neurochemical factors.
- Suicide risk assessment should be a patient-centered, collaborative process in the context of a therapeutic relationship and should chronologically explore presenting suicide events, recent events, past events, and immediate intentions.
- Assessment of the level of intervention needed includes identifying the number of proximal or potentiating risks as well as the number of warning signs.
- It is important for the nurse to determine the seriousness of the patient's suicidal intentions, the existence of a plan, and the availability and lethality of the method.
- Many tools exist to screen for risk factors and warning signs for suicide. The Columbia Suicide Severity Rating Scale is an evidence-based tool for assessing the degree of risk and making clinical judgments about what level of treatment is needed to help the patient remain free from self-injury or death by suicide.
- The suicidal person should not be left alone.

- A safety plan is developed with the patient following a comprehensive suicide risk assessment. A safety plan includes assisting the patient to recognize warning signs, identify and employ internal coping strategies, engage family members and friends as available support persons, identify people and social settings that can be used to distract from suicidal thoughts or urges, identify resources and contact information for crisis intervention, and problem-solve ways to restrict access to lethal means.
- Once the crisis intervention is complete, the individual may require long-term psychotherapy, during which he or she works to:
  - Develop and maintain a more positive self-concept.
  - Learn more effective ways to express feelings.
  - Improve interpersonal relationships.
  - Achieve a sense of belonging and a measure of hope for living.
- Evidence-based psychological interventions include dialectical behavior therapy, cognitive behavior therapy, and the CAMS approach.

For additional resources, please visit
www.fadavis.com

Review Questions

1. Which of the following individuals is at highest risk for a suicide attempt?
   a. A client who reports he is in deep emotional pain, feels hopeless, and says “No one is there for me.”
   b. A client who has been seeing a doctor for chronic, intractable pain and is taking pain medication.
   c. An American Indian client who just graduated from high school with honors.
   d. A physician who reports feeling “burnt out” and is considering retirement.

2. The nurse in the emergency department encounters a client who is expressing suicide ideation. The nurse recognizes that which of the following considerations are important to good suicide risk assessment? (Select all that apply.)

a. Collaborating with the patient
b. Asking specific questions about leisure activities
c. Establishing trust and open communication with the patient
d. Asking the patient specific questions about the strength of his intention to die
e. Identifying whether the patient has thought about a plan for trying to kill himself

3. A client is hospitalized following a suicide attempt after breaking up with her boyfriend. Freudian psychoanalytic theory would explain the client's suicide attempt in which of the following ways?

a. She feels hopeless about her future without her boyfriend.
b. Without her boyfriend, she feels like an outsider with her peers.
c. She is feeling intense guilt because her boyfriend broke up with her.
d. She is angry at her boyfriend for breaking up with her and has turned the anger inward on herself.

4. Which of the following interventions are appropriate for a client on suicide precautions? (Select all that apply)

a. Remove all sharp objects, belts, and other potentially dangerous articles from the client's environment.
b. Accompany the client to off-unit activities.
c. Reassess intensity of suicidal thoughts and urges on a regular basis.
d. Put all of the client's possessions in storage and explain to her that she may have them back when she is off suicide precautions.

5. Success of long-term psychotherapy with a client (who attempted suicide following a break-up with her boyfriend) could be measured by which of the following behaviors?

a. The client has a new boyfriend.

b. The client has an increased sense of self-worth.
c. The client does not take antidepressants anymore.
d. The client told her old boyfriend how angry she was with him for breaking up with her.

Clinical Judgment Questions

6. A 27-year-old female client was admitted to the psychiatric unit from the medical intensive care unit where she was treated for taking a deliberate overdose of her antidepressant medication, trazodone (Desyrel). She says to the nurse, “My boyfriend broke up with me. We had been together for 6 years. I love him so much. I know I’ll never get over him.” Which is the best response by the nurse?
a. “You’ll get over him in time.”
b. “Forget him. There are other fish in the sea.”
c. “You must be feeling very sad about your loss.”
d. “Why do you think he broke up with you?”

7. The nurse identifies the primary nursing diagnosis for a client as Risk for suicide related to feelings of hopelessness from loss of relationship. Which is the outcome criterion that would be most appropriate for this diagnosis?
a. The client has experienced no self-harm.
b. The client sets realistic goals.
c. The client expresses some optimism and hope for the future.
d. The client has reached a stage of acceptance in the loss of the relationship.

8. A client is hospitalized following a suicide attempt after breaking up with her boyfriend. She says to the nurse, “When I get out of here, I’m going to try this again, and next time I’ll choose a no-fail method.” Which is the best response by the nurse?
a. “You are safe here. We will make sure nothing happens to you.”
b. “You’re just lucky your roommate came home when she did.”
c. “What exactly do you plan to do?”

d. “I don’t understand. You have so much to live for.”

9. In determining the degree of suicidal risk with a client, the nurse assesses the following behavioral manifestations: severely depressed, withdrawn, statements of worthlessness, difficulty accomplishing activities of daily living, no close support systems. The nurse identifies the client’s risk for suicide as which of the following?

a. Low risk
b. High risk
c. Imminent risk
d. Unable to be determined

10. A client who has been hospitalized following a suicide attempt is placed on suicide precautions on the psychiatric unit. She admits that she is still feeling suicidal. Which of the following interventions are most appropriate in this instance? (Select all that apply.)

a. Restrict access to any item that might be harmful by placing the client in a seclusion room.
b. Check on the client every 15 minutes at irregular intervals, or assign a staff person to stay with her on a one-to-one basis.
c. Obtain an order from the physician to give the client a sedative to calm her and reduce suicide ideas.
d. Do not allow the client to participate in any unit activities while she is on suicide precautions.
e. Ask the client specific questions about her thoughts, plans, and intentions related to suicide.

Communication Exercises

1. Mr. J. was brought to the emergency department by his brother, who is concerned about Mr. J.'s worsening depression. During the assessment, Mr. J. tells the nurse, "None of this matters. There's nothing that can make this any better." What would be an appropriate response by the nurse?
2. Mr. J. admits to the nurse that he has had suicidal ideas for the last couple of weeks. How would the nurse intervene with Mr. J. at this point?
3. Mr. J. tells the nurse that ever since his wife died 3 months ago, he does not want to go on living. What would be an example of empathic communication in response to this statement by Mr. J.?

MOVIE CONNECTIONS

Dead Poet's Society • *It's Kind of a Funny Story* • *The Perks of Being a Wallflower* • *Girl, Interrupted* • *Cyberbully*

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