

The CURE for Suicide.

Dr David Hart 7.11.08 Draft Version

Suicide whether in the West or the East is a common and tragic event.. Fatal or completed suicide is obviously when a patient has been successful; parasuicide refers to when a person has attempted suicide in a non life threatening fashion – for example taken an overdose of nonfatal medication. This is often seen as a “cry for help” – listening to these people may indeed prevent them completing a successful attempt. Some people including the chronically ill take major risks with health; for example diabetics who don't care well for their illness; or people struggling with alcohol or drug addiction. In one sense this could be seen as suicide in slow motion.

Everyone working within the people helping arena whether a lay counselor, health worker, pastor, university lecturer or counseling professional, needs to have an awareness and understanding of the dynamics of suicide, and have thought through a management plan should they be faced with a client or friend who is found to be so afflicted. Many people do CardioPulmonaryResuscitation Training to be able to deal with a cardiac arrest. In fact, during a lifetime, one is probably more likely to see a suicidal person, and more likely to be able to successfully help save a life, than both see and be able to help someone in cardiac arrest. Being prepared (for both!) is the best way forward!

Mental Illness and Fatal Suicide.

The following conditions have been shown to carry an increased risk of fatal suicide. In fact 95% of all fatal suicide patients have at least one mental disorder, and for 80% this is depression. The following figures are for the US.

Depression- Major Depressive Disorder (MDD) and it's related illnesses for example chronic dysthymia, anxious depression, Seasonal Affective Disorder, and so on. Depressive illness carries a lifetime risk to the patient of 10-15% of fatal suicide. That means that 10-15% of all people who suffer from depression may actually die of suicide. Depressed patients who have suicidal thoughts generally would be classified as having severe MDD and as such require medication to improve. Not taking medication significantly exposes them to this elevated risk of 10-15% of death from suicide. Not a good statistic for say a 28 year old with simple treatable but severe depression. Many of us know at least one person who has died from depression related suicide – a preventable condition.

Bipolar Disorder carries a life long risk of between 20-60% of death from suicide - 20% for slow cycling and up to 60% for rapid cycling bipolar illness, the highest figure for all mental illness. This event can occur both in the manic phase perhaps when the patient has strong grandiose feelings, but particularly in the depressed phase when all seems bleak and despairing.

Eating Disorders, more common in young women, but also occurring in men, actually carry a 10% lifelong risk of fatal suicide.

Schizophrenia is often accompanied by depression- up to 50% of cases at diagnosis. The overall fatal suicide risk is 10% in the first 5 years from diagnosis. This may be higher if the depression is not adequately treated.

Alcohol Dependence 15% of alcoholics die from suicide, but note that many will also have co existing mental illness.

Relationship Issues account for many para-suicide attempts and fatal suicide amongst teenagers. More females than males attempt suicide, but males tend to be more successful than women. In the west 1 % of teen suicide attempts are fatal. Some 15% of teen girls and 8% of boys describe suicidal thoughts during their teens. These figures are higher if the teen also has a specific mental condition.

Special Note: Rural Women living in China have suicide as the most common cause of death for those in the 20-40 year old ie childbearing and mothering years. They tend to choose very lethal methods so a woman voicing these thoughts needs to be taken seriously.

Always explore thinking about suicide in your assessment of clients known to suffer from any of these conditions -especially if the condition is as yet not under control. People do not always tell you their suicidal thoughts unless you ask, but generally deeply appreciate the opportunity to talk about this when asked.

The CURE for Suicide

Pivotal to effective management of suicide are the CURE five steps.

Connect with them and stay connected- connection is like throwing a life support ring to a drowning person. It's the initial and ongoing connection that will assist you save a life! It has been shown that contrary to what people expect, talking with the person about their suicidal thoughts and maybe plans, and feelings, is not going to make them do it but in fact is usually an immense relief- that they may be able to find another way forward. Allow the client to talk out not act out their thoughts. Good connecting as always involves empathy, non judgmental listening, and establishing an accepting respectful relationship. Keeping connection with at least one person over time has been shown to significantly reduce risk of fatal suicide. Connective empathy coupled with wisdom will save lives!

Understand. Developing a clear understanding of this person, what drives them, what is happening for them across the sectors is paramount and can be done well by a lay worker as well as a professional. Both an understanding of the person themselves, and an understanding of the issues of suicide are important. A one hour conversation with the client will generally help locate issues in the sectors well. Understanding does not mean you agree with a person and their decisions- in fact reflectively mirroring back to the client “ So what I am hearing you say is that life is tough, so tough that you want to kill yourself ” can really help some one understand them selves and face them with what they are really thinking.

Respond A thorough assessment, drawn from understanding the person, will assist in the development of an effective response or management plan. This will usually take the form of a short, medium and long term plan, and be congruent with the underlying issues, the degree of risk the person has of self harm, and available resources.

Engage Help For lay people helpers and also for junior counselors it is highly recommended that the opinion of a specialist/ professional person be sought. Presenting the case to someone else is often an effective strategy for added wisdom and safety. If hospital admission is not required in the first instance, assisting the person to be cared for within the context of a reliable loving care pyramid provides another aspect of connection- so assist them to build this pyramid.

Evaluate both how the process is going for the client, and importantly how you are going in managing this case. Are you working in safety? The management plan should be reviewed each time you see the client- is it up to date with their current issues? Just because last week the client didn't need admission to hospital doesn't mean that they are still fine- keep the management in tune with the current situation.

The excellent helper would also be asking themselves- What is the learning opportunity for me here?

Understanding: Going Deeper

It should always be a goal of the helper, as they listen to the client, that they form a robust understanding of what level of risk of fatal suicide this person currently has. This can be done as the helper explores the following areas, looking for preventive or higher risk factors, in order to formulate a risk assessment of how serious this person really is about committing suicide. Add the sum of all the factors both protective and higher risk to estimate the total overall risk. These factors listed below are well documented in the suicide research literature.

First a note regarding medication: patients recently commenced on SSRI treatment: (In the first two weeks of treatment with an SSRI (Prozac, Zoloft and others) the medication sometimes helps improve the patient's psychomotor function faster than it improves mind function- thought and mood. Hence at times their ability to move physically precedes their ability to make wise decisions, so the suicide fatality rate actually may increase until the drug has benefited their mood and thinking and control. A 2 week careful observation period recommended. However the benefit of the drug- treating potentially lethal depression - out weighs the adverse aspects overall.

Understanding Risk: Preventive Factors

Aspects that tend to be preventive in people contemplating or experiencing suicidal thoughts are mentioned circle by circle.

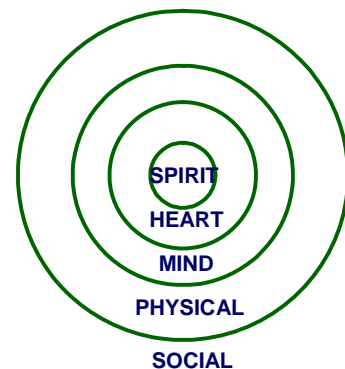
Brushes Female and younger age, in most cultures are protective factors. This is variable within cultures.

Social Circle

- Strong relationships with others or at least one person.
- Responsible for another child person or pet

Physical Circle

- No chronic medical or psychiatric illness
- Able to talk openly about problems, and easily solvable problems



- No previous attempts

Mind Circle

- Mild or occasional thoughts of suicide
- No specific plan or preparation
- Relief to find there may be other options than ending life

Heart Circle

- Robust sense of self and strong sense of self worth

Spirit Circle

- Active faith or belief in God.

Understanding Risk: Higher Risk Factors.

The risk of successful suicide is higher the greater the number of these factors present.

Brushes

- Male, older age, and variably within different cultural contexts- for example in Chinese rural communities being aged 15-40 years and female gender are in fact high risk factors.
- Older age – risk increases with age especially over 45 years old.
- Male - men successfully commit suicide four times as frequently as women

Social Circle

- Family history of successful suicide – siblings/parent or parents especially.
- Isolated/ lonely / living alone

Physical Circle

- One or more psychiatric illness or other chronic illness especially if a previous psychiatric hospital admission.
- Using drugs/alcohol – commonly these people also have underlying mental illness especially simple depression. The suicide rate in alcoholics is fifty times higher than non alcoholics
- Serious plan and materials for an attempt
- Previous unsuccessful attempt/s especially if in the last three months

Mind Circle

- Angry if plans are discovered, unkeen to discuss the issue.

Heart Circle

- Existential crisis - whether a crisis of love, identity, meaning, shame, guilt, or hopelessness.
- Seemingly unsolvable problems including unemployment causing hopelessness
- Deep Despair is a very significant risk factor and should be explored and evaluated as such.

Spirit Circle

- No particular faith in God

Goals of understanding the client: During the interaction with the client it will be helpful to try and establish a number of issues. Key areas include

- Identify the person on the circles and if possible the sectors- what is happening for them in each sector. This is a systematic and thorough way of knowing what is happening for them. Include exploration of recent events- “what has been happening in your life recently?” Particularly work with the client to together locate issues in the social circle, physical and behavior sectors, perception (in touch with reality or not?) volition, mood, thought, conflict, cope, centeredness, control, truth, love and spirit sectors. Explore their sense of identity, shame, and control or lack of it. Despair and hopelessness is very often a predictor of suicidal attempts. Is there a mood or other mental disorder?
- Understand the client’s current pyramid of support so that the best management plan can be developed. How could their pyramid be expanded?
- Clearly understand what are the client’s protective factors- what has stopped them committing suicide in the past and does this still hold? What would help them to cope better with life at present?
- How would they feel if they were to successfully commit suicide? And to be not successful?
- Understand and make an assessment of degree of risk- by assessing where they are at with regard to the above protective and high risk factors. What actual plans have been made or begun. Have they written a note? Do they have lethal items available to them? Guns knives medicine pesticide ropes?

Responding, Engaging Help, and Evaluating the Process.

Having spent some time connecting and staying well connected with the person, and having developed a sound understanding of them in their current situation, and having a clear assessment of degree of risk of fatal suicide, an effective management plan that will work in practice, keep the person safe, and plans for immediate, medium and long term management needs to be developed.

Counsellors may find it a very helpful exercise to write up a formulation or summary of key issues. They should also actively assess the degree of risk this person currently has of fatal suicide- mild moderate or high risk.

Below are some management tips for mild-moderate risk and high risk patients. Generally speaking mild or medium risk patients will be thinking about suicide but not have a definite plan, means, and maybe have prepared a note, as a higher risk person would have.

Management of Mild-Moderate Risk Patients

Bearing in mind that the counselor will have established good connection or rapport with the patient, and has a good understanding of them and their situation the following are important aspects of a management plan. It is always helpful to develop this using the circles as a guide- how can you work with the client to manage issues within each circle, and how can you add stability and value in each circle, assisting the client with safety and containment. As always the excellent helper looks at the client through the circles as spectacles – keeping these as guidelines for understanding as well as responding and evaluating.

Social Circle How can you assist with relational, work, education, or social circle issues and how can you assist the client in building their pyramid of support.

Physical Circle What physical /behavioural issues are there- communication issues, guns knives ropes that need dealing with, what mental illness issues is there, medications to add, sleep to obtain, unhealthy behaviours that can become healthier – for example drinking less alcohol.

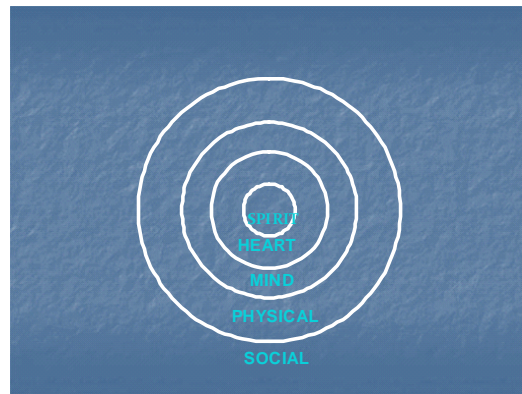
Mind Circle issues- what emotions need expression and managing, what thoughts are making life difficult and how can these best be contained, particularly what alterations to the perceptive senses are occurring and how can this best be managed- delusions, hallucinations and so on.

Heart Circle issues- meaning, purpose, despair, hopelessness, blame, shame, guilt issues- are these heart issues causing inner turmoil and how can these best be worked through?

Spirit Circle also begs exploration- connection with or distance from God, possibly transference issues from an abandoning earthly father transferred onto God, possible demonic oppression/possession, faith in other religious systems, and how to best work within the parameters the client gives consent to.

Immediate

Ensure the person is physically safe. This may mean engaging a pyramid of care- friends family or other designated responsible person into whose care the patient will remain until settled. Safety also means removing possibly items for suicide- ropes knives guns medication chemicals and so on. Best if these belong to the person that they somehow symbolically hand these over. Remember even seemingly low risk cases can surprise.



A contract is helpful- get the person to agree not to take any dangerous action, and if they feel tempted to call/notify the people (best if three in case one or two don't answer) whose phone numbers they can call any time 24 hours a day. Make sure these people know they are on that list, and are prepared to be with or talk with the patient if needed. While research into this idea of contracts has shown no increase in protection it nevertheless can be a useful tool.

Consider giving the person a sleeping tablet to buy time and ease the intensity of the situation- its hard to kill yourself if you are asleep! Don't give them a whole box though!

Discuss the case with a supervisor colleague or other person. Engage the wisdom of another professional. Suicidal cases always override the boundaries of confidentiality normally accepted as paramount in counseling.

Medium term

Monitoring and frequent contact /connection over the first week or two is important so the person feels cared for. Contact 2-3 times a week may be needed to fast track conflict resolution, problem solving, and close monitoring.

Assisting with problem solving using a Structured Problem Solving technique is very effective in those first few days to weeks. Looking at options, exploring solutions, working at relational conflict resolution is vital.

Remember to re evaluate frequently, ensure you keep connection, continue to view the client with in the circles framework, while also keeping the pyramid, triologue, the cross as valuable adjuncts.

Long Term

Assisting the client to deal with significant heart or other issues is vital for real cure. This may need ongoing counseling sessions. As mentioned locating issues within the sectors, then exploring links with past and present issues, lingering if client is comfortable in triologue, and assisting them to develop positive life skills that enable them to face issues and move forward -rather than taking it out on themselves by suicide, are very briefly some of the aspects that would be important here. Particularly worth mentioning is checking what coping strategies they have, and have they had in the past- are these helpful now, or would they like to work on updating these to more effective and healthy coping strategies.

Formal assessment and possibly medication via a doctor may be needed for any significant mental conditions especially depression or mood disorder, bipolar disorder, eating disorder, schizophrenia, and so on. Asking advice from a doctor is always worthwhile- there may be various ways they can help including but also beyond medication.

High Risk Patients

For cases where it seems the patient is quite intent on significant self harm, it may be best to have them admitted to hospital, or if expatriate, consider repatriating them to a home or stable third country base. If the latter is decided as the best course of action, clearly they would need someone to accompany them, and a definite connection option at the other end. Admission for patients should be discussed with a psychiatrist.

Medication will almost always be indicated- again discuss this with the doctor. At times electroconvulsive therapy will be life saving as it treats depression so much faster than any medication does. Medication for assisting sleep can be enormously helpful- even to get some clearer thinking and body routine functioning.

Otherwise the management plan should include similar aspects to that above- immediate safety, medium and longer term aspects. Note that for high risk patients a doctor should always be consulted. It's better to ask advice and be safe than wonder if you should have and then see a disaster.

Engaging Help This can mean mobilizing the help of others in the pyramid, or that of a colleague as part of your own professional pyramid. It may mean referral to another professional so you no longer have any connection with the case, or it may mean accessing advice or supervision, with you maintaining the connection with the client as key helper. Get to know professionals you trust and can refer to so you have options when you need them!

Evaluation It can be very instructive to evaluate how you went with the client, what went well, where you could have helped more effectively- both as you progress with the case, and when the case is finished. Continually also evaluate where the client is at- this is especially for those clients who are chronically suicidal- it is possible to become blasé and somehow slacken off with monitoring, but it is important to check at least briefly where they are at each time you meet.

Summary: Curing Suicide

In summary then remember the key steps to saving a life from suicide:

Connect well and in an ongoing way.

Understand the person well, and let them know that you understand and want to help them. Forming an assessment of risk level is part of this step.

Respond with a wise well thought out management plan addressing the short term safety needs, as well as medium and longer term issues.

Engage the help of others- both to assist building a pyramid of care for the client, and in accessing case discussion/supervision, and possibly medical advice as to what is needed regarding medication and other assistance.

Evaluate both how the process is going for the client, and importantly how you are going in managing this case. Is there a learning opportunity for you here?

Case Example

Bill Brown is a 56 year old man of English descent, who works as a railways engineer. He has been drinking alcohol daily, probably a liter of wine each day, since his wife left him six months ago. She left him for another man who she felt was bright, interesting and listened well to her emotions. He was stunned and hasn't really gotten over it at all. In fact he is very angry and often fantasizes about the other man getting run over by a train. Bill has not been sleeping or eating well lately, often he is awake in the early morning, and he has begun planning on how he can end this horrible life he is living. His mood is constantly low, and he is loathe to talk with friends. Lately he has been having 1-2 days off work a week especially Mondays and Fridays, and thinks they won't notice, and anyway he is due lots of sick days off. He lives alone. His dad committed suicide at age of 61 after many years of depression. Sometimes Bill thinks that would be a great way to go, so he has been

stockpiling medication from his doctor, and also bought some hose so he can connect up to the exhaust of his car if it gets really bad and end it peacefully with a cocktail of medication and gas. Recently he updated his will so that not a cent will go to his ex wife. He is quite defended as you speak with him, and somewhat upset that his son, who visited him yesterday and found the hose in the house, has contacted you, his local pastor. Bill used to come to church with his wife most weeks but you haven't seen him since the breakup. When Bills son, who loves Bill a lot, insisted he talk with someone Bill suggested you may be best, as he feels you won't give him too much trouble.

Questions Work out you own answers first before reading what one management plan could be.

1. What risk factors for suicide does Bill exhibit?
2. What risk category would you consider he is in?
3. Are you worried about his mental health?
4. What would be your management plan for Bill?
5. How do the CURE steps outlined above help you with this case?

Answers

1. Bill's protective factors seem to be no previous attempt described, possible faith in God, and has a son who has checked in on him. However on the down side he is now living alone, is over 45, male, has alcohol addiction and probable depression, there are unresolved relationship issues, and his father committed suicide at 61 years old. He is angry that his serious plans were discovered. Probably most important though is his alcohol use, making his chance of fatal suicide some 50 times higher.
2. Clearly Bill is at high risk of fatal suicide.
3. Mental health problems would include alcoholism, likely underlying clinical depression, (Major depressive disorder -severe) possible genetic elements as well as circumstantial; and probably some deep grief, and unresolved issues re his wife leaving him.
4. Management here needs to consider short, medium, and long term issues.

Initially safety would be the most important. Widening the pyramid- asking for help would be essential. You in fact call Bills family doctor who is willing to see Bill later that day. His son is agreeable to take him there. In fact Bills doctor advises time off work, full supervision 24 hours a day by Bill's son, daily review by the doctor, sleeping tablets, assistance with alcohol withdrawal, vitamin supplements for Bills nutritional state, proper diet, removal of tempting medication stockpile and hose, as well as knives, and to continue seeing, you, the pastor twice weekly as the initial management plan, with the provision that if things get worse he will have to go into hospital.

After a week Bill is significantly more hopeful, and has come off the alcohol, is sleeping well, and enjoying his sons company. **Medium term management** would involve grief counseling, working through his anger re the new man, and putting a behavioral program together for positive daily activities.

Bill rejoins his church men's group who embrace him. Bill mentions one day that one of the things that helped most in his recovery was that he and his son have a good relationship- it was for his son that he went through the pain of detoxing off alcohol. This demonstrates the power of a single well connecting relationship, no doubt which has saved Bills life. A few days later, he also tells you that the doctor he has is a believer, and really helped him when after he had listened to his story, then just by sitting with him as he poured out his story to Jesus, spent time seeing what Jesus would say to him. In fact Jesus told him how much he was precious to Him, how He is the one who can give him a fresh start, and He understands Bills grief and loss regarding his wife. He is after all the Man of sorrows. He knows sadness pain and rejection first hand. Bill says he felt better connected with Jesus than all those years sitting in (your!) church.

Long Term. Bill is taking antidepressant medication for a year, seeing you, the pastor weekly still at 2 months, involved in the men's group who often go fishing and camping, and sometimes also takes his son with him. He is back at work, where everyone to his surprise is accepting of him, and even asks him how he did it!

5. Clearly connecting with Bill, as this pastor has been regularly, being with him rather than rejecting him when he was at his worst, and Bills connection with his son are strong factors in his recovery. Bill felt understood by the doctor and his son, as well as the pastor. Although they did work through a structured initial response plan, including medication, and spent time in triologue at times, there has not been a great deal of specific directive therapy- its been more a walking with, sharing of the journey, and bringing the pain, grief, anger and so on to Jesus in triologue. Bills pastor wisely engaged help when he needed it from the doctor. At times he would ask Bill to evaluate how the healing journey was going. Bills pastor also helped make links with the men's group so Bill could widen his pyramid a bit more. Bills pastor swears by the CURE, it has helped him help so many people.....

References

Kaplan and Saddocks' Synopsis of Psychiatry Saddock and Saddock 10th Edition 2007.

ISBN 978-0-7817-7327-0

Management of Mental Disorders 3rd Edition 2000 Treatment protocol Project

World health Organization ISBN 0 9587052 67