E-kursuse "Suicidology " materjalid

Tartu Ülikoolis õpetatava aine " **Suicidology"** " juurde

Aine maht 4 EAP

Karmel Tall (Tartu Ülikool), 2010

SUICIDOLOGY

I Defining suicide

Suicidology is a science dedicated to the study of suicide and suicide prevention. Many fields of study overlap in suicidology including psychology, psychiatry, physiology and sociology. Suicidology includes not only completed suicide and nonfatal attempted suicide but also partial self-destruction, suicidal gestures and ideation, parasuicide, deliberate self-harm, self-mutilation, and a panorama of related self-destructive behaviors and attitudes. Because suicide is not one thing but many related overlapping phenomena, it does not have one cause or etiology. An absolutely fundamental distinction is between completed suicides and nonfatal suicide attempts. By definition "suicide" implies a death whereas a suicide attempt does not necessarily. Suicide attempters and completers are overlapping populations, but it is important not to forget that about 85 percent of suicide attempters eventually die a natural death.

On the most fundamental, existential level we pay attention to suicide because it is there, has kind of riveting compulsion to it, and is an unavoidable, sometimes devastating, life issue. The French philosopher/novelist Albert Camus has written eloquently about this essential, compelling aspects of suicides. Whether one can live or chooses to live is the only truly serious philosophical problem, according to Camus. He claims that man invented God in order to be able to live without killing himself and that only human liberty is to come to terms with death. "Suicide", Camus writes, "is prepared within the silence of the heart, as is a great work of art".

Sigmund Freud as well saw life-and-death wishes as inextricably intertwined. According to him, "Life is impoverished; it loses its interest, when the highest stake in the game of living, life itself, cannot be risked". Early on Freud saw aggression as a product of frustration of sexual impulses and tended to see all life energy as sexual energy. However, after witnessing the carnage of World War I Freud decided there were two opposing basic instincts: life (eros) and death (thanatos) drives. All instincts sought tension reduction, libido sought to reduce sexual tension, whereas the death instinct sought the elimination of the tension of life itself. Basically, life sought the peace of death or, as Freud put it, the universal goal of all living substances was to "return to the quiesence of the inorganic world." Freud contended that much external aggression against others was necessary to avoid self-destruction. In discussing melancholia (depression) he felt that people did not find the energy to kill oneself unless they were first killing an internalized object previously identified with and then turned this prior external death wish against a fragment of their own ego. Freud also believed that suicide is more likely in advanced civilizations requiring grater repression of sexual and aggressive energy.

There is no universal definition of suicide. By Erwin Stengel's widely used definition suicide is the fatal act of self-injury, undertaken with more or less conscious self-destructive intent, however vague or ambiguous. WHO's (World Health Organization) Working Group on Preventive Practices in Suicide and Attempted Suicide defined suicide as "an act with fatal outcome, which was deliberately initiated and performed by the deceased, in the knowledge or expectation of its fatal outcome, and through which the deceased aimed at realizing changes he/she desired". Table 1 provides several basic definitions of "suicide" from different theoretical perspectives or disciplinary perspectives.

Table 1. Definitions of Suicide

Definitions	Source	Year
Suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself,	Emile Durkheim	1897

which he knows will produce this result (Sociological definition)		
Currently in the Western world suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution (Psychological definition)	Edwin S. Shneidman	1985
The definition of suicide has four elements: (1) a suicide has taken place only if a death occurs; (2) it must be of one's own doing, (3) the agency of suicide can be active or passive, and (4) implies intentionally ending one's own life. (Philosophical definition)	David J. Mayo	1992
Suicide is (1) a murder *(selbstmord)* (involving hatred or the wish-to-kill), (2) a murder by the self (often involving guilt or the wish-to-be-killed), and (3) the wish-to-die (involving hopelessness). (Psychiatric/Psychoanalytic definition)	Karl Menninger	1938
Suicide denotes all behavior that seeks and finds the solution to an existential problem by making an attempt on the life of the subject. (Existential definition))	Jean Barchler	1975
A suicide is a fatal willful self-inflicted life-threatening act without apparent desire to live; implicit are two basic components lethality and intent	Joseph H. Davis	1988

Today researchers consider that suicide is a multidimensional and complex phenomenon with psychological, social, biological, cultural and environmental factors involved. No simple explanation of the phenomenon exists. Recent recognition that suicide risk factors are often multidimensional has resulted in massive expansion in research, which has occurred in all fronts, including psychiatry, psychology, social sciences, biology, genetics etc.

Suicides have been registered in Europe and in North America since the beginning of the nineteenth century, and for even longer in some countries. To compare their incidence in different periods and places it is necessary to calculate the suicide death rates for a certain proportion of the population, which is per 100 000.

Epidemiology

Epidemiologic research and clinical research work in complementary fashion to increase our understanding of disease. Epidemiology is the basic science of prevention. It is the study of patterns of diseases and disorders in groups. There are no worldwide, standardized criteria or the classification of suicide deaths. Recording of a death as a suicide varies with the country, culture, reporting practice, vital statistics system, and version of the International Classification of Diseases used. Because of these and other factors, suicide rates range widely among countries.

Every year, almost one million people die from suicide; a "global" mortality rate of 16 per 100 000, or one death every 40 seconds. So while you are reading this text, many people somewhere in the world die by their own hand.

In the last 45 years suicide rates have increased by 60% worldwide. Suicide is among the three leading causes of death among those aged 15-44 years in some countries, and the second leading cause of death in the 10-24 years age group; these figures do not include suicide attempts which are up to 20 times more frequent than completed suicide. Suicide worldwide is estimated to represent 1.8% of the total global burden of disease in 1998, and 2.4% in countries with market and former socialist economies in 2020. Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries. Mental disorders (particularly depression and alcohol use disorders) are a major risk factor for suicide in Europe and North America; however, in Asian countries impulsiveness plays an important role. Figure 1 shows suicide rates (suicides per 100 000) worldwide according to most recent data available as of year 2009.

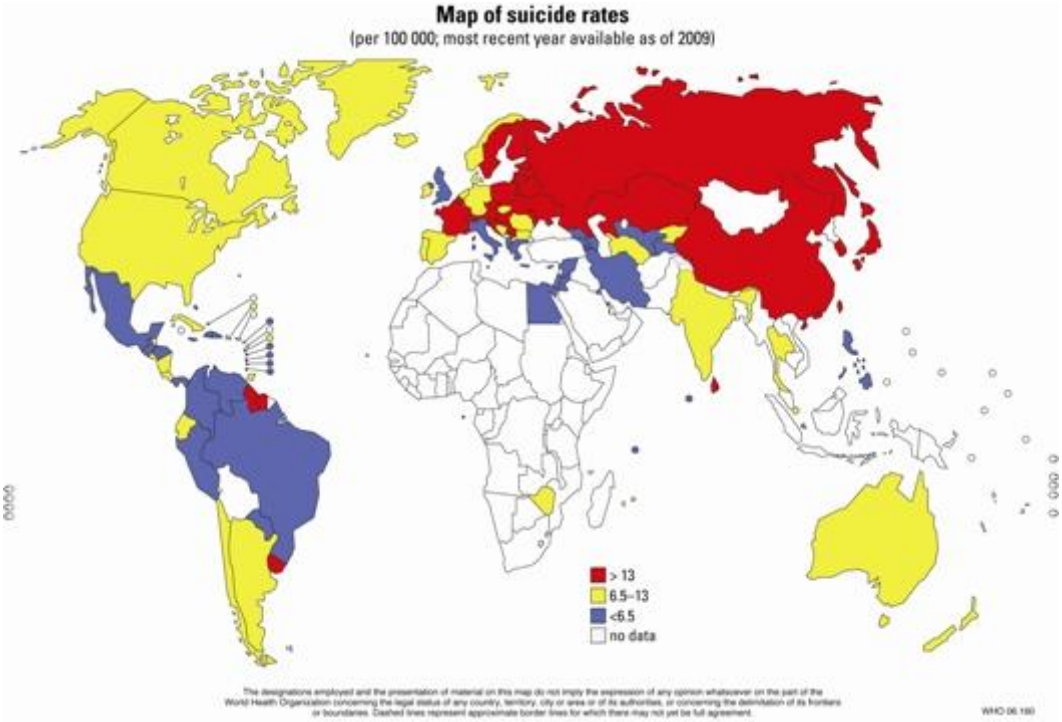


Figure 1. Map of suicide rates in the world (red=suicide rate over 13 per 100 000, yellow=6,5-13, blue=under 6,5, white=no data available)

In Europe one person dies by suicide in every 4 minutes. In many European countries suicidal behavior constitutes a major public and mental health problem and a considerable drain on resources in both primary and secondary health care settings. In numerous countries, the number of suicides is significantly higher than the number of deaths due to traffic accidents. In some countries suicides among youngsters are among the top three causes of death. Due to the changing age pyramids in some countries (increasing percentage of older persons) the problem of suicidal behavior among the elderly is also increasing.

Despite the common burden, the suicide situation in Europe differs between the various countries. In recent years, especially in East-Europe, the rank order of suicide rates among the various countries has changed dramatically. This is partially due to the splitting up of countries. On the other hand, some countries have published official suicide rates for the first time in their history. In some of the countries very high suicide figures can be found, even within some countries the rates for different regions vary significantly. In some countries the suicide figures are decreasing, covarying with a stable social situation and a good economic status. In other countries suicidality is increasing covarying with social changes and instability, unemployment and an increasing prevalence of psychiatric illnesses.

Since the beginning of the official registration, Hungary has been the country with the highest suicide rates in Europe, if not in the World. However, Hungary is now surpassed by some of the new Russian and Baltic states. The highest male rates are found for Lithuania, the Russian Federation, Belarus, Estonia, Latvia, Hungary, and Ukraine. The highest female rates are also found for Lithuania, Hungary, and Slovenia.

Nordic and Eastern European countries also have somewhat higher suicide rates, while the southern parts of Europe have comparatively low suicide rates. In comparison America and Asia generally have lower rates than most of the European countries. In all European countries, even those countries with very low rates, male suicide rates are higher than the female rates. Differences in suicide rates between the countries are not equally distributed for all age groups. Most differences (even for the states or areas within one country) are only significant for the older age groups.

Suicides in Estonia

During Soviet Union time, figures on suicide were kept secret by the state Statistical Committees of the former Soviet Union. If on some rare occasion the phenomenon of suicide was referred to in the press, the official line was always that suicide, alcoholism and other personal problems were manifestations of the western capitalist system, and almost nonexistent in the Soviet Union. Soviet ideology tried to make people believe in an illusion of well-being and happiness. At the same time psychology was considered to be a pseudoscience, psychoanalysis was forbidden, and psychotherapy was not developed. Due to Gorbachev's reforms, the Bureaus of Statistics were opened in 1988 and access to researchers was made possible.

Before World War I the suicide rates in Estonia ranged from 5 to 12 per 100 000. During World War I the figures dropped considerably to around 5 per 100 000, but they increased dramatically during the period of economic depression to a level of around 30 per 100 000 in 1931. At that time Estonia was still independent. During World War II suicide rates are believed to have decreased considerably, but data from this period are scarce.

The stagnation period (1970–1984) was characterized by the isolation of the entire Soviet Union from the rest of the world, as well as by strict censorship regarding freedom of expression and freedom to publish, by suspicion, double standards and identity crises. The integration of individuals was overregulated, resulting in reactions of passive resistance, alcoholism and suicides. Any utilization of psychiatric assistance was unpopular. It was taught that suicidal behaviour was a symptom of mental disease, whereas the psychological and social reasons for suicide were considered irrelevant. Suicidal patients were forcibly incarcerated in psychiatric hospitals under strict medical surveillance.

The period of reforms started after Gorbachev came to power in 1985. Hope-inspiring political reforms occurred in Estonia, including a congress of representatives from creative associations, the events of Hirvepark and the Singing Revolution, which created a close and emotional bond amongst Estonians and democratically-minded non-ethnic Estonians. The very strict alcohol policy which was implemented during the first years of perestroika can also be considered significant. Against the background of those events, the suicide index dropped by a quarter both in Estonia and the other Baltic countries. Suicidologists call the events which occurred within the Soviet Union the most effective prevention of suicides during the past century.

The radical social and political changes, which accompanied the dissolution of the Soviet Union, have turned Eastern Europe into an area of extensive social experimentation. This is turn means that we can assess the impact of environmental factors on human behaviour, including those related to health and death rates. The social aspect of suicide has been convincingly demonstrated in the trends of suicide deaths in the former Soviet Union republics, since they are measured in a population of nearly 300 million. Figure 2 shows a very high suicide death rate in the male population but a drop of nearly 40% during the first three years of *perestroika*. The suicide index for females is 4 to 5 times lower and the *perestroika*-related drop is not particularly marked (18%).

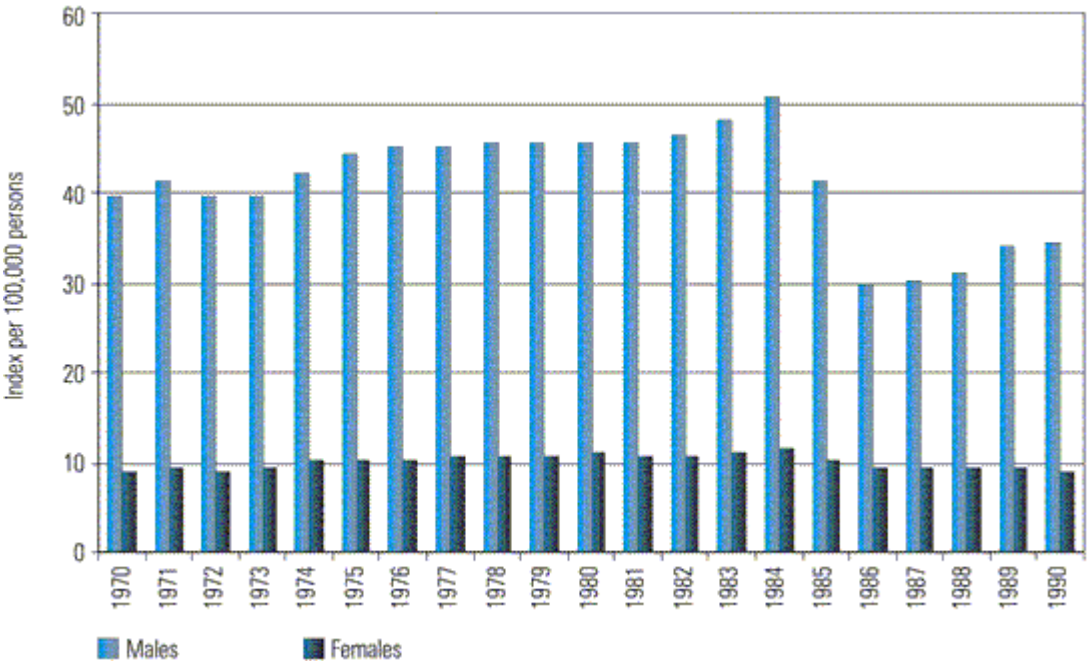


Figure 2. Suicide rate in the former Soviet Union

The suicide curve in Estonia, 1979–2007 may, due to its shape, be conditionally divided into two (Figure 3), corresponding to different socio-economic and political periods. During the first fifteen years of the period under observation, the so-called stagnation era, the index of suicides was permanently high and showed a slightly increasing tendency. During the last, i.e. the period of reforms, which was a series of radical historical events, the suicide curve has taken an S-shape. At the same time the average suicide indices of the two periods are almost identical.

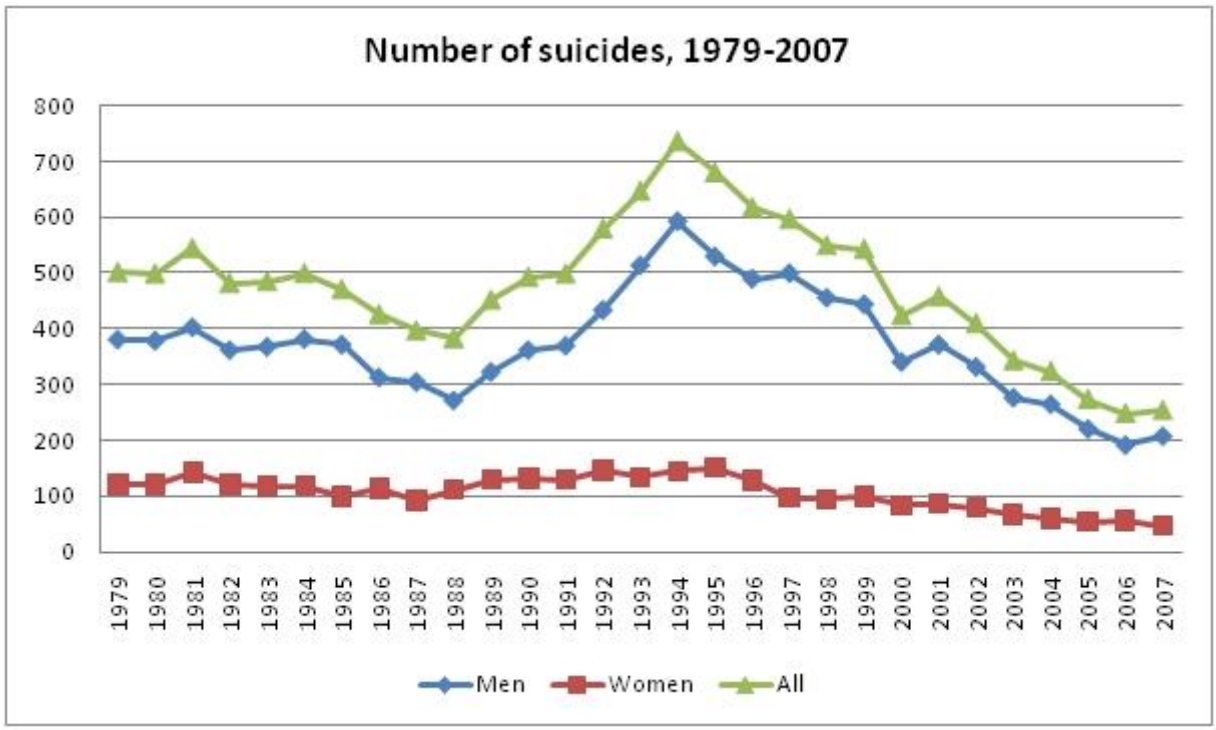


Figure 3. The suicide curve in Estonia, 1979-2007

The extensive economic reforms which followed these events required the ability to quickly adapt as well to reassess past values and lifestyles. The suicide curve shows that

many people could not cope with these requirements. Since 1989, the number of suicides significantly increased, and reached the highest level of the 20th century in 1994, when 614 suicides were registered in Estonia (41 deaths per 100,000 inhabitants). On the basis of existing observations it may be suggested that the stagnation period pushed to suicide those who felt trapped by restrictions to their freedom and by fake moral standards. However, in Estonia after the re-establishment of independence, there are other categories of people who are unable to cope. These are mainly people in the extreme categories – those who learned to be helpless in the Soviet Union, where relations between individuals and the state were overregulated, or those who became alcoholics. The other extreme category includes people who take unreasonably large risks, as well as those whose expectations of a free Estonia have been disappointed. During recent years, the suicide curve in Estonia has shown a steady trend downwards. 42% of the males committing suicide in Estonia belong to the age groups between 35 and 54. For women, those aged 65 and over make up more than a third of female suicides. It is difficult to explain the high number of male suicides. From the aspect of social integration, job loss or separation from spouse or partner often becomes fatal for this age group – all this often being related to alcohol abuse. At the same time, alcoholism and suicidal trends have somewhat similar roots. Apparently, one of the reasons is also the fact that in our traditional society men who experience internal crises does not consider the seeking of help to be suitable behavior. It could be said that Estonian men prefer to suffocate in their silence.

History of suicide

The history of suicide reflects the history of mankind. Suicide has existed as a form of behavior since the dawn of civilization. No one knows who the first was to slash his throat with a piece of flint, take a handful of poison berries, or intentionally drop his spear to the ground in battle. Nor do we know who first jumped impulsively, or after thought, from a great cliff; walked without food into an ice storm; or stepped into the sea with no intention of coming back. Death has always been close at hand; yet it is a mystery why the first to kill himself did: Was it a sudden impulse, or prolonged disease? An inner voice, commanding death? Perhaps shame or the threat of capture by an enemy tribe? Despair? Exhaustion? Pressure from others to spare common resources of food and land?

Cultures have varied in their notions of self-inflicted death. Several— for example, the Eskimo, Norse, Samoan, and Crow Indian— accepted, and even encouraged, "altruistic" selfsacrifice among the elderly and sick. Among the Yuit Eskimos of St. Lawrence Island, if an individual requested suicide three times, relatives were obligated to assist in the killing. The person seeking suicide dressed in ritual death garb and then was killed in a "destroying place" set aside specifically for that purpose. To save commonly held resources of food or to allow a nomadic society to move on unhindered by the physically ill or elderly, some societies gave tacit if not explicit approval to suicide. No early cultural or religious sanctions were attached to the suicides recorded in the Old Testament or to the only one, that of Judas Iscariot, described in the New (attitudes toward suicide hardened during the early years of Christianity). Most of these deaths, like those of the ancient Greeks portrayed by Homer, were seen as matters of honor, actions taken to avoid falling into the hands of a military enemy, to atone for wrongdoing, or to uphold a religious or philosophical principle. Hannibal, for example, took poison rather than be captured or dishonored, as did Demosthenes, Cassius, Brutus, Cato, and scores of others. Socrates, who refused to renounce his teachings and beliefs, drank hemlock. Gladiators thrust wooden sticks or spears down their throats or forced their heads into the spokes of moving carts in order that they might choose their own, rather than another's, time and way of dying. Beliefs about suicide varied considerably in ancient Greece. The Stoics and Epicureans believed strongly in the individual's right to choose the means and time of his death. Others were less accepting of the idea. In Thebes and Athens, suicide was not against the law, but those who killed themselves were denied funeral rites and the hand that had been used for the act was severed from the arm. Aristotle regarded suicide as an act of cowardice, as well as an act against the state; so,

too, did Pythagoras (Although, according to Heracleitus, Pythagoras starved himself to death).
Roman law actively prohibited suicide and further prohibited the passing on to heirs of the suicide's possessions and estates. The Catholic Church from its earliest days opposed suicide and, during the sixth and seventh centuries, codified its opposition by excommunicating and denying funeral rites to those who died by their own hand. Suicide was never justifiable, wrote St. Augustine in an authoritative argument for the Church, because it violated the sixth commandment of God, "Thou shalt not kill."
Jewish custom forbade funeral orations for anyone who committed suicide; mourners' clothes were not encouraged, and burial was generally limited to an isolated section of the cemetery, so as "not to bury the wicked next to the righteous." The Semachot, the rabbinic text on death and mourning, states that "He who destroys himself consciously ('la-daat'), we do not engage ourselves with his funeral in any way. We do not tear the garments and we do not bare the shoulder in mourning and we do not say eulogies for him." Over time, a greater latitude and compassion was extended to suicides committed while of an unsound mind. "The general rule," states one scholar of Jewish tradition, "is that on the death of the suicide you do everything in honor of the surviving, such as visit and comfort and console them, but you do nothing in honor of the dead apart from burying them." In Islamic law, suicide is a crime as grave as, or even graver than, homicide.
Strong religious and legal sanctions against suicide are scarcely surprising; it would be odd indeed if society had no reaction to such a dramatic, seemingly inexplicable, frightening, frequently violent, and potentially infectious form of death. Dante, writing almost seven hundred years ago in The Inferno, assigned a particularly grim fate to those who committed suicide. Condemned to the seventh circle of Hell and transformed into bleeding trees, the damned and eternally restless souls of the suicides were subject to continuous agony and fed upon mercilessly by the Harpies. They who in "mad violence" killed themselves were, unlike all others who resided in Hell, also denied the use of their earthly human forms.
The civil desecration of the corpses of suicides was common, as were attempts to prevent untoward influence upon the living by physically isolating and constraining the body and its potentially dangerous spirit. The bodies of those who killed themselves were, in many countries, buried at night and at a crossroads. The greater traffic over such crossroads was thought to "keep the corpses down," and the intersection of paths, it was believed, would make it more difficult for the spirit to find its way home. In early Massachusetts, cartloads of stones were unloaded at the crossroads where a suicide had been buried. Not uncommonly, a stake was driven through a suicide's heart, a practice that has suggested to at least one scholar its similarity to the fate of a fourteenth-century murderer whose body was discovered years ago in the peat bogs of Sweden. The murderer's captors, in order to stop the dead man from "walking," drove birch stakes through his back, side, and heart; they then sank his body into a fen, at the meeting point of four parishes, in the not altogether unreasonable belief that he would be unlikely to escape.
The Finns believed that because the act of suicide was a sudden one, it was impossible for the living to make peace with the dead, and the soul of the suicide was therefore "particularly restless and spooky." The body of a suicide victim was handled with dispatch and wariness: The deceased was washed as soon as possible after the death and clad in graveclothes. The male deceased were washed by men while the female ones by women. Epileptics, lunatics and suicides were not washed; on the contrary, they were buried prone on their stomach in the clothes they wore when they died. They were lifted into the coffin with pokers, never with bare hands, since it was feared that diseases and curse would catch hold of the family. Up to the early 1900's the one who had committed suicide was buried without any funeral services. The grave was located beyond the fence of the churchyard, often even far away in the woods. It was a general opinion that the corpse of the suicide was heavy. Among the common people there were plenty of stories afloat that the coffin of the suicide had been too heavy even for a horse to haul.

In France, the body of a suicide was dragged through the streets, head downward, and then hanged on a gallows. French criminal law in the late seventeenth century also required that the body thereafter be thrown into a sewer or onto the city dump. Clergy did not attend the burial of a suicide, and corpses could not be buried in consecrated ground. In parts of Germany, the corpses of suicides were put in barrels and floated down the rivers so that they would not be able to return to their home territories. Early Norwegian laws dictated that the bodies of suicides were to be buried in the forest with those of other criminals, or "in the tide, where the sea and the green turf meet." Suicide was, strongly and simply put, "an irreparable deed."

Gradually, both religious and legal sanctions against suicide lessened. Although many theologians continued to assert that suicide was among the more unforgivable of sins— Martin Luther, for example, wrote that suicide was the work of the Devil; the Puritan religious leaders deemed it abhorrent, despicable, and an "individual submission to Satan"; John Wesley declared that the bodies of those who killed themselves should be "gibbeted and . . . left to rot"; and philosophers such as Locke, Rousseau, and, more recently, Kirkegaard railed vociferously against any kind of social or religious acceptance of suicide— judicial systems and the public increasingly considered suicide to be an act of an unbalanced mind, rather than the result of weakness or personal sin. Corpses were no longer buried at crossroads; gradually, instead, they were buried on the north sides of churchyards. Rather than suffering damnation in isolation, the bodies of suicides now kept the geographic company of society's other disreputables and non-Christians: excommunicants, unbaptized infants, and executed felons.

Robert Burton's widely read and influential The Anatomy of Melancholy, which depicted with compassion the bonds between madness, melancholy, and suicide and argued for mercy for those who were in such despair and agitation as to kill themselves, was published in 1621. Twenty-five years later, Biathanatos, a landmark treatise about suicide, was published. Its author, poet John Donne, was also the prominent dean of St. Paul's Cathedral in London. In Biathanatos, Donne declared that suicide was, on occasion, justified; certainly, he argued, it ought to be humanly understandable. It was, for him, personal. "Whensoever any affliction assails me," he confessed in the preface to his work, "methinks I have the keys of my prison in mine own hand, and no remedy presents itself so soon to my heart as mine own sword."

Two recent authors of excellent accounts of suicide trace similar patterns in the changing attitudes and laws in England and the United States. Mark Williams, in Cry of Pain, reports that in mid-seventeenth-century England fewer than one in ten suicide verdicts was judged to be non compos mentis, or due to insanity. By the 1690s that figure had climbed to 30 percent; in 1710 it was 40. By 1800, essentially all cases of suicide were regarded as being due to insanity.

The Massachusetts Puritans and other early American colonists generally treated those who killed themselves not only as sinners but also as criminals; over time, however, public attitudes and laws changed. In the seven decades from 1730 to 1800, as Howard Kushner has documented in American Suicide, the Boston Coroners' Juries made one non compos mentis determination for every two or three felonious ones. By 1801– 1828, the ratio had flipped: there were two insanity decisions for every one felony suicide; at century's end, as in England, non compos mentis was the usual verdict in suicide.

Most European countries formally decriminalized suicide in the eighteenth and nineteenth centuries, although it remained a crime in England and Wales until 1961 and in Ireland until 1993. Certainly, public understanding of suicide has increased over recent years, although not to a degree commensurate with what has been learned from medical and psychological research. The harshness of centuries-old views of suicide still touches the present, both in social policy and in more personal ways. In my copy of the Book of Common Prayer, for instance, in the small print that precedes the burial rites— a service that is at once of such consolation and ancient familiarity: "I am the resurrection and the life. . . . O death, where is thy sting?"—there is a damning reminder of archaic taboos and exclusions: the Order for the Burial of the Dead, the prayer book clearly states, "is not to be used for any that die unbaptized, or excommunicate, or have laid violent hands upon themselves."

Psychological Autopsy

The term psychological autopsy refers to the reconstruction of a deceased biographical and psychological state preceding death when suicide is suspected. The procedure is used in clinical settings and within the scientific field, as well as in the development of suicide prevention and therapy programs. A psychological autopsy is conducted when the circumstances of death are uncertain. In this case investigators collect oral and written information from the environment of the deceased, such as in interviews with survivors (e.g., family, friends, and medical personnel) and documents (e.g., letters, diaries, police reports, and coroner's records). The main questions a psychological autopsy should reveal answers to are (a) How did the person die? (b) Why did the person (possibly) commit suicide? and (c) What was the exact nature of death?

In the late 1950s the term psychological autopsy appeared for the first time in the work of suicidologist Edwin Shneidman and his colleagues at the Los Angeles Suicide Prevention Center and the Los Angeles Medical Examiner's Office. After the investigation of a great number of unsolved death cases, Shneidman and his coresearchers developed this procedure to rebuild a person's history and to reveal the victim's motivation to commit suicide. In the first place, the psychological autopsy focuses on the last days before death, although Shneidman emphasizes that the investigation must range further than that. Survivors are asked about the personality, lifestyle, and relationships of the deceased. A brief outline of the personal history must also be provided, and questions regarding psychological stress can go back to about a year before death.

The traditional use of a psychological autopsy had been in coroners' reports in addition to the regular physical autopsy, because rather than focusing on the cause of death it focuses on its context. Furthermore, the procedure had been used in research for defining risk factors of suicide in adults. Later the research had been expanded to the investigation of suicidal children and adolescents. From the 1970s the focus shifted increasingly toward examination of risk factors, and the psychological autopsy became an important instrument for the treatment of potential suicides and failed suicide attempts. Another function had been recognized in the interviews with survivors. If the investigator is working with much accuracy and empathy, the interviews can have a therapeutic value for the bereaved. By talking about and confronting their feelings and thoughts, the survivors are able to deal with this difficult experience. The psychological autopsy can thus be used for pre-and postvention of suicidal acts.

In the investigation of suicide, data can be divided into two sets: prospective and retrospective. The retrospective data are collected during a psychological autopsy, whereas prospective data refer to clues before death (e.g., the person talking about suicide, previous suicide attempts, feelings of depression and hopelessness). This division is important in the study of suicide because there are different clues, which therapists and doctors should be aware of. Psychological autopsies reveal that when suicide is certain as the mode of death (e.g., when a goodbye letter or a weapon in the hand of the victim is found), prospective clues can be found in almost all cases. Suicidal people are aware of the fact that they want to die, and they also think of how they will be remembered after death. Shneidman refers to the imagination of how a person wants to be remembered as the "postself." The psychological autopsy is in fact a way of measuring the postself by collecting information from the environment of the deceased. The suicide note is the most direct measure of the postself in the case of suicide. The person leaves his or her last words to the world, words that will be remembered. In other personal documents, such as diaries or notes, the postself becomes visible when the victim fantasizes how the world would be without him or her. In the analysis of retrospective data in a psychological autopsy, the postself is represented in the memory of the survivors.

To conclude, there is not a standard way of conducting a psychological autopsy. Researchers use different methods: semistructured interviews, standardized questionnaires, and written data. The multidisciplinary character and the specific study of every case separately can reveal more background information about the exact mode of death. Additionally, in the scientific field, researchers strive for standardization of the

procedure so as to compare different cases more accurately. The methodological difficulties lie mainly in the diverse informants who provide different information about the deceased. Nevertheless, the psychological autopsy is a significant instrument in the investigation of death because it reaches further than the classic taxonomy of death modes (natural, accidental, suicidal, and homicidal death). Today's researchers try to combine the "classic" psychological autopsy with other methods, such as the narrative approach, by, for example, the use of life charts. The use and methods of the psychological autopsy are still under development.

II The suicidal process and related concepts

The term ***suicidality*** describes cognitive and behavioural characteristics, which may become manifest as ***suicidal ideation*** or ***suicidal behaviour***.

The term *suicidal ideation* refers to the occurrence of any thoughts about self-destructive behaviour, whether or not death is intended. Such thoughts may range from vague ideas about the possibility of ending one's life at some point of time in the future to very concrete plans to commit suicide.

In a similar way, the term *suicidal behaviour* may cover a wide range of self-destructive behaviours with a non-fatal or fatal outcome, described by the terms ***attempted suicide*** and ***suicide***, respectively.

The term *attempted suicide* is used to describe any forms of self-destructive behaviour which do not follow a typical pattern of habitual reactions to adverse life events, as is the case in self-mutilation.

The term attempted suicide has been criticized because it is used to describe a behaviour which, probably more often than not, lacks any serious suicidal intention. However, alternatives to replace this term, such as parasuicide or deliberate self-harm have their drawbacks too: parasuicide because it equally implies suicidal intentions, and deliberate self-harm because of the implication that physical harm always occurs.

O'Carroll and colleagues (1998) have proposed a comprehensive nomenclature for self-injurious thoughts and behaviours in which a distinction is made between risk-taking thoughts and behaviours and suicide-related thoughts and behaviours.

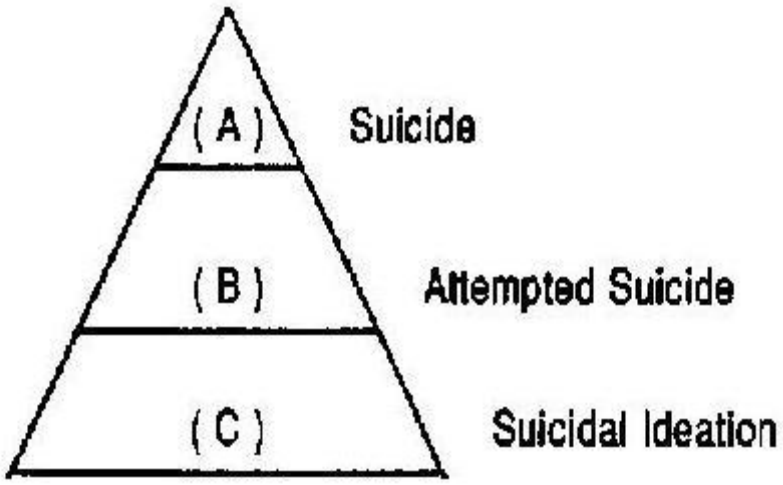
In this nomenclature the term suicide attempt is used to describe potentially self-injurious behaviours with a non-fatal outcome for which there is evidence (either explicit or implicit) that the person intended at some (non-zero) level to kill himself/herself. Suicidal intent is included in the definition of attempted suicide in this nomenclature. This nomenclature can be of particular relevance for the study and understanding of the suicidal process (e.g. as a result of inclusion of risk-taking thoughts and behaviours in the range of phenomena that may occur in the course of the process). For example, a significant association between smoking and suicidal behaviours has been found, which is independent of any association between smoking and psychiatric illness. The early recognition of specific risk-taking behaviours as related to suicide may contribute substantially to its prediction and prevention.

Table 1.1 Proposed nomenclature for suicide and self-injurious thoughts and behaviours (O'Carroll et al, 1998)

A. Risk-taking thoughts and behaviours
   1. with immediate risk (e.g. motocross, skydiving)
   2. with remote risk (e.g. smoking, sexual promiscuity)

B. Suicide-related thoughts and behaviours
   1. Suicidal ideation
      a. casual ideation
      b. serious ideation
         (1) persistent
         (2) transient
   2. Suicide-related behaviours
      a. Instrumental suicide-related behaviours
         (1) Suicide threat
            (a) passive (e.g. ledge sitting)
            (b) active (e.g. verbal threat, note writing)
         (2) Other instrumental suicide-related behaviours
         (3) Accidental death associated with instrumental suicide-related behaviours
      b. Suicidal acts
         (1) Suicide attempt
            (a) with no injuries (e.g. gun fired, missed)
            (b) with injuries
         (2) Suicide (completed suicide)

The suicide pyramid



The suicide pyramid concept is used to organize findings from cross-sectional and longitudinal epidemiological studies in the general population and in groups of attempted-suicide patients, respectively. The different layers of the pyramid describe the occurrence of suicidal (Heeringen 6)ideation and of non-fatal and fatal suicidal behaviour. The lowest layer describes the proportion of the general population that reports to have experienced suicidal ideation at one or more occasions. There is considerable evidence that, especially among adolescents, suicidal ideation is extremely common and may even be considered as a rather normal and in any case common way of reacting to adverse events.

The lowest layer of the pyramid may thus consist of the (nearly) total general population. Epidemiological surveys among adults have revealed a lower lifetime prevalence of suicidal ideation than those among adolescents.
The pyramid's second layer from below may consist of individuals among whom suicidal ideation is recurrent, or may take the form of concrete plans for suicidal behaviour.
The third layer of the pyramid is constituted of individuals who engage in non-fatal suicidal behaviour at one or more points in their lives. Differences in the definitions of these behaviours create problems in determining the exact prevalence rates. Moreover, these rates appear to vary according to the age of the population under study.
The review of recent large-scale general-population surveys in Europe and the USA shows the increasing possibilities to estimate the lifetime prevalence of non-fatal suicidal behaviour. This third layer of the pyramid may in fact consist of two or more sub-layers, each composed by individuals who show non-fatal suicidal behaviours, but which are defined by the lethality or suicidal intent of the behaviour, or by the fact whether individuals are so-called first-evers or repeated attempters.
Indications have been found that lethality and suicidal intent increase in individuals who repeatedly attempt suicide. Moreover, there is a 32 per cent increase in the relative risk of suicide with each prior attempt. It thus seems that repeating attempters constitute a sub-layer of the pyramid, which is more closely linked to the layer of completed suicides.
The top layer of the pyramid consists of individuals who commit suicide. Although substantial differences between countries exist with regard to the proportion of individuals who commit suicide recent epidemiological studies suggest that rates of suicide and those of attempted suicide covary, at least among the young, indicating that a more or less consistent proportion of individuals who have engaged in non-fatal self-destructive behaviour will die as a result of suicide.

The suicidal career

The suicidal career concept is used to describe the pathway that individuals may follow through the layers of the pyramid. For clinicians, researchers and policymakers it is of utmost importance to gain insight in the factors which determine the course of such a career. It seems reasonable to assume that a delicate balance of risk and protective factors determines the course of such a career, and, while knowledge is increasing, the identification of such factors and of the ways in which they can be changed clearly needs further research.
Answers have to be found to questions addressing the reasons why many people may experience suicidal ideation but do not proceed to engage in suicidal behaviour, or why only a proportion of suicide attempters will eventually commit suicide. Another important question concerns the reasons or mechanisms regarding the suicide of individuals who have shown no overt signs of suicidality before committing suicide (i.e. who apparently did not proceed through the layers of the pyramid towards the upper layer). The suicidal process approach as it will be described below may offer an answer to questions like these.
There is thus a major drawback associated with the use of the suicide pyramid concept. The most important limitation is the basic assumption of a stepwise progression of suicidality from suicidal ideation, through (whether or not recurrent) non-fatal suicidal behaviour, to suicide. Epidemiological research has shown that this, to say the least, is not always the case. For example, psychological autopsy studies have shown that a suicide is commonly preceded by one or more suicide attempts. However, up to 60 per cent of individuals who commit suicide do not have a history of suicide attempts. Moreover, studies of failed suicides have shown the existence of suicidal behaviour, which is carried out with high suicidal intent, but impulsively without preceding ideation or planning.

Pathways to suicide

Based on review of epidemiological data at least four different pathways to suicide can be described. These pathways reflect differences in the expression of the vulnerability to suicidal behaviour.

Pathway 1: Suicide after many years of persistent suicidal ideation, planning and non-fatal suicidal behaviour This is a relatively frequent pathway to suicide, which may occur in individuals with long-term mental illnesses such as severe depression, schizophrenia, alcohol and drug abuse, and severe personality disorders. The history of these individuals is commonly characterized by traumatization, long-term relational problems, psychiatric treatment, lifelong adversity and one or more suicide attempts. This pathway reflects the most outspoken and permanent vulnerability to suicide. Mental-health care can have a preventive effect on this pathway by providing adequate treatment according to good clinical practice. This mental-health care should be provided continuously and should be prolonged even when the patient is recovering and/or discharged from hospital. Intensive management is needed in these cases. The majority of individuals with this extreme vulnerability to suicide, with many recurrent periods of intense suicidality, will, however, probably not commit suicide but die because of another reason. This depends, among others, upon the quality of the mental- health-care system. It should be noted, however, that these individuals have an increased risk of death as a result of other causes.
Pathway 2: Suicide following periods of recurrent suicidal ideation, planning and non-fatal suicidal behaviour A second, relatively frequent pathway consists of episodic expressions of the underlying vulnerability, followed by periods in which people are mildly or not at all suicidal. Thus, when not confronted with adversities the vulnerability becomes latent and lies beneath a threshold, which reflects a satisfactory quality of life. This pathway illustrates the on-and-off character of many suicidal careers. Recurrent suicidal planning and suicide attempts are being elicited by life events which may be part of a normal life, such as the death of a spouse, becoming unemployed or by the absence of a therapist. Crisis- intervention facilities are needed in this type of suicidal career in combination with aftercare services for patients admitted to a general hospital following a suicide attempt. General practitioners may be helpful in monitoring the mood changes of these vulnerable patients.
Pathway 3: Suicide following only one period of suicidal ideation and planning Less prevalent, but no less shocking, are suicides which occur after one period of life adversity, inducing sudden suicidal ideation and/or planning. This may occur in individuals who most of their lives did not express their latent vulnerability to suicide, who had a happy and productive life, but who suddenly collapsed after a major threat to their wellbeing. Prototypical cases include individuals who lose a spouse, lose their job, become retired or develop an invalidating disease. Although such adverse events may precipitate psychiatric disorders, which need to be treated, it can be argued that, in the case of incurable diseases for example, assisted suicide may find its place in this pathway; however, here suicide attempts are rare.
Pathway 4: Suicide not preceded by suicidal ideation or planning Probably much less commonly, individuals may commit suicide without any apparent suicidal ideation or planning. Such cases have been described in studies of failed suicides in which individuals tried to kill themselves without any apparent suicidal ideation or preparation, other than in the very last moments. The urge to commit suicide was felt suddenly and irresistibly, and the impulse to kill oneself could not be controlled. These suicides can be precipitated by events which severely threaten self-esteem (e.g. by a severe humiliation or financial loss). The probability of suicide may be influenced by situational factors, including the availability of means such as guns, medication, pesticides or the vicinity of high places or a railway. The restriction of means may thus have a preventive effect.
The course of these pathways may be influenced by many factors. These may include cultural and socio-economical factors as has become apparent in the nations that were formerly part of the Soviet Union. Suicide rates have increased dramatically in these countries. The economic prospects in the Baltic countries, for example, are very unfavourable. Lithuania has the highest suicide rate in the world. The rate of attempted suicide, however, is much lower than in western European countries (Ivanova et al, submitted). Among suicide attempters in Lithuania there are few repeaters. This seems to indicate that persons at high risk of suicide in Lithuania commonly follow pathway 3 and die as a result of their first attempt. The mental-health-care system is not very developed in Lithuania in sharp contrast to the situation in western European countries,

in which many people who commit suicide have a history of attempted suicide and thus commonly follow pathway 1. In The Netherlands, for example, there are many repeaters among suicide attempters. This may reflect improved health care, which offers patients the possibility of expressing their vulnerability in a less fatal way.

III Children and adolescents

HOW TO IDENTIFY STUDENTS IN DISTRESS AND AT POSSIBLE RISK OF SUICIDE?

Identification of distress

Any sudden or dramatic change affecting a child's or adolescent's performance, attendance or behaviour should be taken seriously, such as:

- lack of interest in usual activities;
- an overall decline in grades;
- decrease in effort;
- misconduct in the classroom;
- unexplained or repeated absence or truancy;
- excessive tobacco smoking or drinking, or drug (including cannabis) misuse;
- incidents leading to police involvement and student violence.

These factors help to identify school students at risk of mental and social distress who may have thoughts of suicide that ultimately lead to suicidal behaviour. If any of these signs are identified by a teacher or school counsellor, the school team should be alerted and arrangements should be made to carry out a thorough valuation of the student, since they usually indicate severe distress and the outcome may, in some cases, be suicidal behaviour.

Assessment of suicide risk

When assessing suicide risk, school staff should be aware that problems are always multidimensional.

Previous suicide attempts

A history of previous suicide attempts is one of the most significant risk factors. Young people in distress tend to repeat their acts.

Depression

Another major risk factor is depression. The diagnosis of depression should be made by a physician or child/adolescent psychiatrist, but teachers and other school staff should be aware of the variety of symptoms that form part of depressive illness. The difficulty of assessing depression is linked to the fact that the natural transitional stages of adolescence share some features with depression.

Adolescence is a normal state, and during its course such features as low self-esteem, despondency, concentration problems, fatigue and sleep disturbances are common. These are also common features of depressive illness, but there is no cause for alarm unless they are lasting and increasingly severe. Compared with depressed adults, the young tend to act out, eat and sleep more.

Depressive thoughts may be present normally in adolescence and reflect the normal development process, when the young person is preoccupied with existential issues. The intensity of suicidal thoughts, their depth and duration, the context in which they arise and the impossibility of distracting a child or adolescent from these thoughts (i.e. their persistence) are what distinguishes a healthy young person from one in the throes of a suicidal crisis.

Risk situations

Another important task is to identify environmental situations and negative life events, as outlined previously, that activate suicidal thoughts and thus increase suicide risk.

HOW SHOULD SUICIDAL STUDENTS BE MANAGED AT SCHOOL?

Recognizing a young person in distress, who needs help, is not usually much of a problem. Knowing how to react and respond to suicidal children and adolescents is much more difficult. Some school staff have learnt how to treat distressed and suicidal students with sensitivity and respect, while others do not. The latter group's skills should be improved.

The balance that must be struck in the contact with a suicidal student is one between distance and closeness, and between empathy and respect. The recognition and management of suicidal crises in students may give rise to conflict in teachers and other school staff since they lack the specific skills required, are short of time, or fear facing their own psychological problems.

General prevention: before any suicidal act takes place

The most important aspect of any suicide prevention is early recognition of children and adolescents in distress and/or at increased risk of suicide. To achieve this goal, particular emphasis should be laid on the situation of the school staff and students concerned, by the means described below. Many experts share the view that it is unwise to teach young people about suicide explicitly. Rather, they recommend that issues relating to suicide are replaced by a positive mental health approach.

Strengthening the mental health of schoolteachers and other school staff

First of all, it is essential to secure the well-being and balance of teachers and other school staff. For them, the workplace may be rejecting, aggressive and sometimes even violent. Therefore they need information material that enhances their understanding and proposes adequate reactions to their own, students' and colleagues' mental strain and possible mental illness. They should also have access to support and, if necessary, treatment.

Strengthening students' self-esteem

Positive self-esteem protects children and adolescents against mental distress and despondency, and enables them to cope adequately with difficult and stressful life situations. To foster positive self-esteem in children and adolescents a variety of techniques can be used. Some recommended approaches follow:

- Positive life experiences that will help to forge a positive identity in the young should be accentuated. Positive past experiences increase young people‛s chances of greater future self-confidence.

- Children and adolescents should not be constantly pressured to do more and better. It is not enough for adults to say they love the child; the child must feel loved. There is a big difference between being loved and feeling loved.

- Children should not only be accepted, but also cherished, as they are. They must feel special just because they exist.

Whereas sympathy impedes self-esteem, empathy fosters it, because judgement is set aside. Autonomy and mastery are building-blocks in the development of positive self-esteem in early childhood. Children's and adolescents' achievement of self-esteem is dependent on their development of physical, social and vocational skills. For high self-esteem, the teenager needs to establish final independence from family and age mates; be able to relate to the opposite sex; prepare for an occupation for self-support; and establish a workable and meaningful philosophy of life.

Introducing training in life skills, first by visiting experts and later as part of the regular curriculum, is an effective strategy. The programme should convey knowledge to peers

on how to be supportive and, if necessary, seek adult help. The education system should also enhance the development and consolidation of every student's sense of identity. Promoting the stability and continuity of students' schooling is another important aim.

Promoting emotional expression

Children and adolescents should be taught to take their own feelings seriously and encouraged to confide in parents and other adults, such as teachers, school doctors or nurses, friends, sport coaches, and religious advisers.

Preventing bullying and violence at school

Specific skills should be available in the education system to prevent bullying and violence in and around the school premises in order to create a safe environment free of intolerance.

Providing information about care services

The availability of specific services should be ensured by widely publicizing the telephone numbers of, for example, crisis and emergency helplines and psychiatric emergency numbers, and making them accessible to young people.

Intervention: when a suicide risk is identified

In most cases, children and adolescents in distress and/or at risk of suicidal behaviour also experience communication problems. Consequently, it is important to establish a dialogue with a distressed and/or suicidal young person.

Communication

The first step in suicide prevention is invariably a trustful communication. During the development of the suicidal process, mutual communication between suicidal young people and those around them is crucially important. Lack of communication and the broken network that ensues result in:

- Silence and increased tension in the relationship. The adult's fear of provoking the child or adolescent into committing a suicidal act by discussing his or her suicidal thoughts and messages is often the reason for the silence and absence of dialogue.

- Obvious ambivalence. Understandably, adults' confrontation with a child or adolescent suicidal communication brings their own psychic conflicts to the fore. The psychological strain of an encounter with a distressed and/or suicidal child or adolescent is usually very heavy, and involves a wide range of emotional reactions. In some cases, the unsolved emotional problems of adults who are in contact with suicidal children and adolescents may come to the surface. Such problems may be accentuated among school staff, whose ambivalence - wanting, but simultaneously being unwilling or unable, to help the suicidal student - may result in avoidance of dialogue.

- Direct or indirect aggression. Adults' discomfort is sometimes so great that their ultimate reaction to the child or adolescent who is in distress or suicidal is one of verbal or nonverbal aggression.

It is important to understand that the teacher is not alone in this communication process, and learning how to achieve good communication is therefore fundamental. The dialogue should be created in and adapted to each situation. Dialogue implies, first and foremost, recognition of children's and adolescents' identity and also their need for help. Children and adolescents in distress or at risk of suicide are often hypersensitive to other people's style of communication most of the time. This is because they have often lacked trustful relationships with their families and peers during their upbringing, and so have experienced an absence of interest, respect or even love. The suicidal student's hypersensitivity is apparent in verbal and non-verbal communication alike. Here, body language plays as large a role as verbal communication.

However, adults should not be discouraged by distressed and/or suicidal children's or adolescents' reluctance to speak to them. Instead, they should remember that this attitude of avoidance is often a sign of distrust of adults. Suicidal children and adolescents also display marked ambivalence about whether to accept or reject help that is offered, and about whether to live or die. This ambivalence has evident repercussions on the suicidal young person's behaviour, which can show rapid changes from help-seeking to rejection and may easily be misinterpreted by others.

Improving school staff's skills

This may be done by means of special training courses aimed at improving cmmunication between distressed and/or suicidal students and their teachers, and enhancing awareness and understanding of suicide risk. Training all school staff in the capacity to talk among themselves and with the students about life and death issues, improving their skills in identifying distress, depression and suicidal behaviour, and increasing their knowledge about available support are crucial means of suicide prevention. Clear goals and precise limits as defined in manuals on suicide prevention are important tools in this work.

Referral to professionals

A prompt, authoritative and decisive intervention, i.e. taking the suicidal young person to a general practitioner, a child psychiatrist or an emergency department, can be life-saving. To be effective, youth health services need to be perceived as approachable, attractive and non-stigmatizing. Distressed and/or suicidal students should be actively and personally referred by school staff, and received by a team composed of doctors, nurses, social workers and legal representatives whose task is to protect the child's rights. This active transfer of the student to the health care system prevents her or him from dropping out during the referral process, which might happen if the referral is conducted only by correspondence.

Removing means of suicide from distressed and suicidal children's and adolescents' proximity

Various forms of supervision and removal or locking-up of dangerous medicines, guns, firearms, pesticides, explosives, knives, and so forth in schools, parental homes and other premises are very important life-saving measures. Since these measures alone are not enough to prevent suicide in the long run, psychological support should be offered at the same time.

When suicide has been attempted or committed

Informing school staff and schoolmates

Schools need to have emergency plans on how to inform school staff, especially teachers, and also fellow pupils and parents, when suicide has been attempted or committed at school, the aim being to prevent a cluster of suicides. The contagion effect results from suicidal children's and adolescents' tendency to identify with destructive solutions adopted by people who have attempted or committed suicide. Recommendations on how to manage and prevent suicide clusters, developed and promulgated by the US Centers for Disease Control in 1994 are now in wide use.

It is important to identify all suicidal students, both in the same class and in others. A suicide cluster, however, may involve not just children or adolescents who know one another: even young people who are far removed from or entirely unknown to suicide victims may identify with their behaviour and resort to suicide as a result.

Schoolmates, school staff and parents should be properly informed about a student's suicide or attempted suicide and the distress caused by such an act should be worked through.

SUMMARY OF RECOMMENDATIONS

Suicide is not an incomprehensible bolt from the blue: suicidal students give people around them enough warnings and scope to intervene. In suicide prevention work, teachers and other school staff face a challenge of great strategic importance, in which it is fundamental:

- to identify students with personality disturbances and offer them psychological support;
- to forge closer bonds with young people by talking to them and trying to understand and help;
- to alleviate mental distress;
- to be observant of and trained in the early recognition of suicidal communication whether through verbal statements and/or behavioural changes;
- to help less skilful students with their school work;
- to be observant of truancy;
- to destigmatize mental illness and help to eliminate misuse of alcohol and drugs;
- to refer students for treatment of psychiatric disorders and alcohol and drug abuse;
- to restrict students' access to means of suicide - toxic and lethal drugs, pesticides, firearms and other weapons, etc.;
- to give teachers and other school personnel on-the-spot access to means of alleviating their stress at work.

IV Assessing suicide risk

According to Cooper and Kapur (2001), assessing risk is part of everyday practice. For example, professionals working in mental health often need to assess the risk of harm to others, risk of harm to self, or the relative risks and benefits of a particular form of treatment (Kapur 2000).

Suicide risk assessment is an inexact science. The problems in applying risk factors to identify suicide are formidable. Known characteristics describe vulnerable groups rather than individuals. The features of risk vary between groups, while circumstances in an individual can change over time, making them more or less vulnerable. Further, the known characteris- tics identified for suicides from previous research are largely based on vari- ous groups of individuals who have died by suicide, irrespective of what psychiatric treatment they may have received (Hawton 1987). Prediction models of suicidality have consistently demonstrated high false positives, that is, patients identified as high risk who do not subsequently commit sui- cide (NHS Centre for Reviews and Dissemination 1998). High false nega- tives (patients identified as low risk who subsequently commit suicide) would be unacceptable in clinical practice. As clinicians the aim should not necessarily be to predict suicide but simply to assess risk in a reliable and consistent way.

Even though we cannot always predict suicide with certainty, important risk factors have been identified that increase the likelihood of suicide. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that nearly one quarter of people who died by suicide in England and Wales had been in contact with mental health services in the year before death (Appleby etal. 2001).

Strategies for Suicide Assessment

By Michelle E. Toth, MA; Robert C. Schwartz, PhD; and Sandy T. Kurka, MA

Despite the fact that several useful surveys and questionnaires are available to help clinicians evaluate suicide risk, a face-to-face clinician/client interview is thought to be both preferential and necessary to the assessment process (Reeves, Bowl, Wheeler, &

Guthrie, 2004). Whether this interview is done from a crisis intervention framework, a cognitive framework, an existential-constructionist framework, or a collaborative framework, a face-to-face thorough assessment remains the only valid method for determining risk (O'Connor, Warby, Raphael, and Vassallo, 2004). The psychotherapy relationship therefore becomes the pivotal pathway for clinicians to access clients' lethality. In order to accomplish this task, it is the responsibility of the psychotherapist to maintain an awareness of current information on suicide risk assessment practices (Westfeld et al., 2000). In this regard, the crisis interview method utilizing Shea's validity techniques (2002), the Collaborative Assessment and Management of Suicidality (CAMS) model (Jobes, 2006), and the Aeschi Group's Guidelines for Clinicians will be examined below.

One of the first things a clinician must be willing to participate in is a self-inventory for the identification of biases regarding suicide as an act. This self-reflection can determine whether an intervention will be a success or a failure (Shea, 2002). Self-exploration is not a static awareness, but on ongoing process (Shea, 2002). Attitudes can range vastly from "suicide is wrong" to "suicide has intrinsic positive worth" (Shea, 2002). Suicide is a difficult topic for discussion, even for the experienced therapist. It is for this reason that the therapist should be aware and keep track of his or her values and ongoing emotional experiences. Counter-transference is one phenomenon the psychotherapist should be continually checking in with, as this can create a power struggle between client and therapist. For example, Maris, Berman, and Silverman posit that suicidal clients can actually be "help-rejecting" as well as engaging in a wide variety of "interpersonally alienating behaviors" (p. 513), which may create negative counter-transference.

There are many schools of thought on how to assess a suicidal individual. One such assessment is the crisis interview wherein the psychotherapist directly asks questions regarding suicidality (e.g., ideation, intent, plan, means of completion). During this process, a helpful hint is to use very specific and concrete wording such as "kill yourself" or "commit suicide" versus general "softer" words such as "stop the pain" (Shea, 2002). The client needs to know that the psychotherapist can handle their thoughts surrounding taking their own life, as many clients do not have anyone else with whom to discuss these confusing thoughts.

Shea (2002) offers several other points to keep in mind when assessing a client's lethality. First, the slightest hesitancy in a client's response may suggest that he or she has thought about suicidal ideation (even if they deny it). Next, answers such as "no, not really" when clients are questioned about suicidal ideation usually means there have been at least some suicidal thinking. Clinicians should also try to be as present with the client as possible to pick up on any non-verbal cues he or she may be sending. For this reason, it may be beneficial for clinicians not to take notes (or to do so sparingly) during the suicide assessment, so they may be 100% available to the client during the process. Clinicians should routinely check themselves during the interview, asking "What am I feeling right now?" and "Is there any part of me that doesn't want to hear the truth right now?" These simple preparations can help guide the techniques the clinician will use when eliciting suicidal intent.

In The Practical Art of Suicide Assessment, Shea (2002) discusses six validity techniques that clinicians can utilize to explore sensitive material with a client. These can be used with a variety of sensitive topics, such as domestic violence, substance abuse, antisocial behavior, sexual abuse, and suicide. The first validity technique, the behavioral incident, is when the clinician asks about concrete behavioral facts. Questions like, "Exactly how many pills did you take?" provide the facts of the incident. The next technique is shame attenuation, which relates to the therapists' ability to inquire about information without making the client feel shame or guilt. Instead of asking the client, "Do you have a bad temper and tend to pick fights?" the clinician could ask, "Do you find people tend to pick fights with you when you are out trying to have a good time?" Or, "Some people have

told me that when they get angry they tend to pick fights, has that happened with you?"

The next technique is designed to help increase the chances the client will be open with sensitive information. Gentle assumption is a technique that proposes that the behavior is already happening. Instead of asking, "Do you drink?" The therapist can ask, "How much do you drink?" In the case of potential suicidality, if the client is severely depressed the clinician may ask, "During the past two weeks how difficult has it been to not think about taking your own life?" This technique helps clients bypass the psychological hurdle of admitting to problem behaviors in the first place.

The technique symptom amplification uses the client's natural tendency to minimize or downplay quantitative information about problem behaviors. By setting the upper limits of the quantity higher than average during questioning, the client has "room to move" while being more truthful about the actual number. For example, rather than asking, "Have you had thoughts of suicide during the past week?" the therapist could ask, "How many times has the thought of suicide entered your mind during the past week, fifteen or twenty?" This allows the client to ease his or her natural defense mechanisms and avoid confrontation. The question may be particularly effective after a gentle assumption (see above) has already exposed suicidality.

The technique denial of the specific involves asking the client specific questions versus generic or global questions. The rationale is that it is easier to deny a generic question than a specific one. If trying to assess the use of drugs a clinician might ask, "Have you ever tried cocaine?" or, "Have you ever smoked crack?" or, "Have you ever used crystal meth?" or, "Have you ever dropped acid?" rather than, "Do you use illegal drugs?" Regarding suicidality, when assessing a plan after suicidal ideation and/or intent has been revealed, the clinician may ask, "Have you thought about overdosing on your medication?" and, "Have you thought about taking your life by hanging?" and, "Have you considered using a gun to take your life?"

The last validity technique Shea (2002) offers is normalization. By normalizing their problem behavior, the client may not feel as embarrassed or anxious when discussing it. For example, regarding depressive symptoms, the therapist may ask, "Sometimes when people are depressed they will have a decrease in their sex drive . . . has this happened to you?" When assessing suicidality, a therapist might ask, "Many times when people are sad and 'in the dumps' as you have described yourself, they say the thought of wanting to die comes into their minds . . . has this thought surfaced for you?" Letting people know they aren't the only ones to experience the behavior allows them to feel less anxious about it and free to share it with the interviewer.

When completing an assessment of a potentially suicidal client, the clinician must be aware of the most important information needed from the client: mainly, the client's current level of suicidal ideation, suicidal intentions, whether a plan for action has been considered, and what access the client has for the means of completion (O'Connor et al., 2004; Packman et al., 2004; Schwartz & Rogers, 2004; Shea, 2002; Wingate et al., 2004). As the amount of information from these four areas increases, so does the probability that the client may be truly at risk. For example, if suicidal ideation is present, the clinician should evaluate how often these thoughts are occurring, how long the thoughts have been present, whether or not the thoughts have become more intense over time, and how difficult is it for the client to keep from acting upon these thoughts (Schwartz & Rogers, 2004). Another clinically important area would be to determine whether or not the client has a specific plan to harm him or herself. If a plan exists, the clinician would need to determine how well developed the plan is and whether the client has the means accessible to complete the plan. Not only will this exploration of ideation help to determine the lethality of the client, but it will also provide direct suggestions for setting up a safety plan.

Lethality is a function not only of risk factors, but also of whether or not protective factors are present (Maris et al., 2000). Below are some general guidelines provided by Schwartz and Rogers (2004) that may be helpful in determining the lethality of a client who acknowledges suicidal ideation:

* Low lethality—suicidal ideation is present but intent is denied, client does not have a concrete plan, and has never attempted suicide in the past.
* Moderate lethality—more than one general risk factor for suicide is present, suicidal ideation and intent are present but a clear plan is denied, and the client is motivated to improve his/her psychological state if possible.
* High lethality—several general risk factors for suicide are present, client has verbalized suicidal ideation and intent, has a coherent plan to harm him or herself, and reports access to resources needed to complete the plan.
* Very high lethality—client verbalizes suicidal ideation and intent, he or she has communicated a well thought out plan with immediate access to resources needed to complete the plan, demonstrates cognitive rigidity and hopelessness for the future, denies any available social support, and has made previous suicide attempts in the past.

Although suicide involves a complex range of behaviors, thoughts, and affective states, the evaluation of concrete suicide markers (i.e., ideation, intent, planning, and means) may increase a clinician's success in predicting a client's overall lethality (Schwartz & Rogers, 2004; Shea, 2002). However, as O'Connor et al. (2004) state, it is important to realize that "every clinician lives with the knowledge that even with our best efforts and exemplary care, there will still be some suicide deaths" (p. 359).

Another assessment approach that has been gaining popularity is an inclusive or "team-building" approach called the Collaborative Assessment and Management of Suicidality (CAMS), created from the research of David Jobes and associates. The main focus and uniqueness of this assessment model is that it targets the client's subjective suicidality as the central clinical problem, independent of objective diagnosis (Jobes, 2006). In addition, by utilizing the Suicide Status Form (SSF), both the clinician and client develop a shared understanding of the client's suicidality by rating the client's current psychological pain, press (stress), perturbation (agitation), hopelessness, and poor self-regard (self-hate) (Jobes, 2006; Jobes & Drozd, 2004). With the CAMS model, even the traditional face-to-face seating is changed once suicide is mentioned. The clinician asks for permission to sit side-by-side the client while filling out the SSF in order to facilitate a more collaborative feeling (Jobes, 2006; Jobes & Drozd, 2004).

In addition to ranking risk-related characteristics, the CAMS model also helps the client to identify reasons for living as well as reasons for dying. In doing this, the clinician receives a glimpse at some of the protective factors that have kept the client from taking his or her life up to this point. As Jobes & Drozd (2004) profess, it is our job as clinicians to help suicidal individuals find alternative ways of coping with the unbearable pain and stress in their lives in order to alleviate suicide as a viable option. Finding a common ground and being able to agree on mutual goals increases collaboration immensely (Ellis, 2004).

The CAMS model incorporates its own documentation throughout each of the stages. In this model, the SSF has 4 sections:

Section A: This initial section is completed collaboratively in order to extract a true understanding of the meaning the world has for the client currently.

Section B: This section is completed by the clinician who asks specific questions regarding plan, preparation, rehearsal, history of suicidality, and so on.

Section C: This section is completed collaboratively and explicitly states what the

outpatient treatment plan will be.

Section D: This section is completed by the clinician post-session and includes a mental status exam, preliminary diagnosis, and the client's overall suicide risk level. Also, this section provides a place for the clinicians to jot down any additional information not otherwise covered in sections A-D.

There is a place at the bottom of each section for the client and clinician's signature and date. This aspect of the model also reinforces collaboration during the assessment process, because the information collected is reviewed and agreed to by both clinician and client. This same process would be completed each session until there were three consecutive sessions without suicidal ideations (Jobes, 2006). As Jobes (2006) states, "I truly believe that through collaboration all things are possible, not the least of which is coaxing a life to be meaningfully lived back from the jaws of suicidal death" (p. 137)

V Postvention

Postvention includes procedures to alleviate the distress of suicidally bereaved individuals, reduce the risk of imitative suicidal behavior, and promote the healthy recovery of the affected community (Hazell, 1991). Postvention can take various forms, depending on the situation and context in which the suicide or suicide attempt takes place. For example, postvention could focus on students in a school where a suicide or suicide attempt occurred. Also, postvention could focus on a counselor or therapist whose client committed suicide, helping this individual to process feelings associated with the loss. Alternatively, postvention efforts could focus on the bereaved family and friends. Therapeutic strategies include helping survivors to process feelings of remorse and guilt and initiating steps that will permit them to engage in a healthy grieving process.
Suicides rarely occur in an interpersonal vacuum; in the wake of most suicides there are often survivors who may be deeply affected by the death. Typically, survivors are family, friends, and coworkers of the deceased. Nevertheless, others who may not have even known the deceased personally can also be profoundly affected by a suicide.The aftermath of suicide poses distinct challenges for suicide survivors and even puts some individuals at risk who may be especially affected by the suicide of another person.
Who are survivors? Edwin S. Shneidman has estimated that each suicide intimately affects at least six other people. Common assumption about survivors of suicide is that they are somehow explicitly or implicitly to blame for the death. The survivor is often perceived to have either directly caused the person to kill him- or herself or alternatively as having done nothing to prevent the death. Such social perceptions are unfair and deeply wounding and can potentially generate tremendously destructive shame in people who are already deeply grieved and guilt-ridden.
The contemporary suicide survivor movement has done much to educate and combat social stigma and stereotypes connected to losing someone to suicide. But ignorance and stigmatization still surround suicide survivorship. We should perhaps not be surprised; the stigma of surviving suicide has a distinct and extensive cross-cultural history.

References

Begley M, Quayle E (2007). The Lived Experience of Adults Bereaved by Suicide: A Phenomenological Study. Crisis 28: 26-34.
Conwell Y (1991). Suicide in Later Life: Psychological Autopsy Findings. *International Psychogeriatrics.* 3: 59-66.
Cooper J, Kapur N (2004). Assessing suicide risk. In: New Approaches to Preventing Suicide : A Manual for Practitioners by Duffy D (Editor), Ryan T (Editor). Jessica Kingsley Publishers.
Jamison KR (1999). Night Falls Fast: Understanding Suicide. Westminster, MD, USA: Alfred A. Knopf Incorporated.
Kerkhof JFM & Arensman E (2001) Pathways to Suicide: the epidemiology of the suicidal process. In: Understanding Suicidal Behaviour: The Suicidal Process Approach to

Research, Treatment, and Prevention. Contributors: Kees Van Heeringen - editor. John Wiley & Sons, New York.
Kõlves K (2006). Estonians' and Russian Minority's Suicides and Suicide Risk Factors: Studies on Aggregate and Individual Level. Dissertationes Sociologicae Universitatis Tartuensis.
Maris RW, Berman AL, Silverman MM (2000). Comprehensive Textbook of Suicidology. Guilford Press, New York.
MoScicki EK (1995). Epidemiology of Suicide. International Psychogeriatrics, Vol. 7, No. 2
Preventing Suicide: A Resource for Teachers and Other School Stuff, WHO, 2000.
Sourander A, Brunstein Klomek A, Niemelä S, Haavisto A, Gyllenberg D, Helenius H, Sillanmäki L, Ristkari T, Kumpulainen K, Tamminen T, Moilanen M, Piha J, Almqvist F, Gould MS (2009). Childhood Predictors of Suicide and Attempted Suicide. *Arch Gen Psychiatry.* 4: 398-406.
Toth ME, Schwartz RC, Kurka ST (2008). Strategies for Understanding and Assessing Suicide Risk in Psychotherapy. *Articlesbase.*
Värnik A (2001). Estonian Human Development Report. Suicides in Estonia, 1970–2000.
Van Heeringen K (2001) The Suicidal Process and Related Concepts. In: Understanding Suicidal Behaviour: The Suicidal Process Approach to Research, Treatment, and Prevention. Contributors: Kees Van Heeringen - editor. John Wiley & Sons, New York.
Wekstein L (1979). Handbook of Suicidology: Principles, Problems and Practice. Brunner/Mazel: New York.
Wojtkowiak J (2009). Psychological Autopsy. Encyclopedia of Death and the Human Experience. SAGE Publications
Westefeld JS, Range LM, Rogers JR, Maples MR, Bromley JL, Alcorn J (2000). Suicide: An Overview. The Counseling Psychologist 28: 445.