Suicidal and Non-Suicidal Self Directed Violence
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Objectives

This session will help participants:
1. Understand the term “suicide” and be able to differentiate it from “non-suicidal self directed violence”
2. Identify protective and risk factors, and warning signs, of self injury.
3. Identify the elements of a suicide risk assessment, and increase the ability to determine the risk of a suicidal behavior.
4. Improve their school’s suicide prevention and risk assessment procedures.

Definitions

• Self-Directed Violence (SDV)
  - “Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.”
  - Includes Non-Suicidal and Suicidal behaviors

• Non-Suicidal SDV (aka self-mutilation, cutting, self-injury)
  - “Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent.”

• Suicidal SDV
  - “Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.”

Crosby, Ortega, & Melanson (2011, p. 21)

Suicide & NSSI: Differences

<table>
<thead>
<tr>
<th>NSNI</th>
<th>Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressed Intent</td>
<td>relieve pain (feel better)</td>
</tr>
<tr>
<td>Method</td>
<td>damage to body</td>
</tr>
<tr>
<td>Frequency</td>
<td>more frequent</td>
</tr>
<tr>
<td>Level of psychological pain</td>
<td>psychological distress is lower</td>
</tr>
<tr>
<td>Cognitive Constriction</td>
<td>less severe</td>
</tr>
<tr>
<td>Aftermath</td>
<td>short-term improvement (death is rare)</td>
</tr>
</tbody>
</table>


Non suicidal SDV Myths

• Only females and/or teen-agers self-injure
• Self-injury is a suicide attempt
• Those who self-injure are
  - crazy
  - just seeking attention
  - manipulative
  - only cut themselves
• NSSI is untreatable
• There’s nothing I can do to help

Anyone who self-injures:
  - has Borderline PD
  - Is part of a “Gothic” or “Emo” subgroup
  - enjoys the pain or can’t feel it
  - are a danger to others
  - have been abused
  - can stop if really want to

Caicedo & Whitlock (2016)
**Non-Suicidal SDV Risk Assessment**

**PROTOCOL**

1. **Identification**
2. **Assessment**
3. Designated individuals to help manage NSSI cases
4. Determine when parents should be contacted
5. Manage active NSSI student
6. Determine when and how to refer
7. Identify external resources
8. Educate students and staff about NSSI

**Non-Suicidal SDV: Risk Factors**

- Variables that Increase the Odds of Behavior
  - Far from perfect predictors
  - Non-suicidal and suicidal SDV are idiosyncratic
  - Non-suicidal SDV serves many different functions
  - There are likely as many paths to suicide as there are suicide victims

**Cycle of Self-Injury**

1. Trigger
2. High emotion intensity
3. Poor distress tolerance
4. Urges to avoid the emotional response
5. Guilt and Shame
6. Difficulty Regulating Emotions
7. Temporary Relief
8. Self-Injury (self-harm)

**Non-Suicidal SDV: Risk Factors**

- Variables Signal the Presence of Non-Suicidal SDV
  - Personality Traits
    - Negative affect
    - Low impulse control
    - Hostility
    - Anxiousness
  - Biological/Genetic
    - Serotonin imbalances
    - Puberty: typical age of onset
    - Neurodevelopmental vulnerability increases emotional stability
    - Risk-taking behaviors
    - Impulsivity
    - More susceptible to negative social cues and respond poorly to emotional distress
    - Problem solving skills still developing/limited coping skills
  - Interpersonal Conflicts
    - Rejection, isolation, criticism

**Non-Suicidal SDV: Risk Factors**

- Variables that Increase the Odds of Non-Suicidal SDV
  - Demographics
  - Child Abuse
  - Self-Directed Violence History
  - Family Dynamics
  - Peer Modeling
  - Mental Disorder
  - Psychological

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Miller & Brock (2010), DSM-5 (2013)

Non-Suicidal SDV: Warning Signs

Variables Signal the Presence of Non-Suicidal SDV
- Behavioral
  - Other forms of self-destructive behavior (e.g., substance abuse)
  - Running into traffic
  - Jumping from high places
  - Possession of objects that could be used for cutting (e.g., razors, broken glass, thumb tacks)
  - Sudden change in peer group and/or withdrawal from prior relationships (or social isolation)
  - Sacrifice behaviors (e.g., spending atypical amounts of time in the restroom or isolated areas in school)
  - Males: tend to engage in self-battery
  - Females: tend to cut, burn, skin-pick
- Many learn from a recommendation or observation of others

Miller & Brok (2011; Hawold, Sakamono, & O'Connor (2012); Whitlock (2015))

Non-Suicidal SDV: Physical
- Cuts, scratches or burns that do not appear to be accidental
- Reports of frequent "accidents" that have caused physical injury
- Frequently bandaged wrists and/or arms
- Reluctance to take part in activities (e.g., physical exercise) that require a change of clothing
- Constant wearing of pants and long sleeved shirts, even in hot weather
- Direct observation of self-injurious behaviors (e.g., self-punching or scratching, needle sticking, head banging, eye pressing, finger or arm biting, pulling out hair, or picking at skin).

Miller & Brok (2011)

Non-Suicidal SDV Risk Assessment
- Non-Suicidal SDV
  - Assess the behavior
    - How I Deal With Stress (Heath & Nixon, 2009)
    - Self-Harm Behavior Questionnaire (Gutierrez et al., 2001)
    - Non-suicidal Self-Injury Assessment Tool (NSSI-AT; Whitlock 2014)
    - Functional Assessment of Self-Mutilation (FASM; Neck & Prinstein, 2004)
    - Self-Injurious Thoughts & Behaviors Interview (SITBI; Nock, Holmberg & Michel, 2007)
  - Are they refocusing attention from a stimulus that is causing psychological pain to a physical external pain they can control?
  - Help to identify alternatives
  - In some cases can be a rehearsal for suicide so always inquire about thoughts of death


Non-Suicidal SDV: Negative Reinforcement
- Experience a temporary relief and reduction of unpleasant emotions
  - Opioids released during self-injury mediate affect and decrease negative emotions

Kansier et al (2012); Bresin & Gordon (2013)

Non-Suicidal SDV: Positive Reinforcement
- Gain attention and concern from peers
  - Social rewards
- Use to influence social relationships (get attention, thus decreases isolation)
- Learn about it via social media/online forums
  - Encourages behavior, describes relief, shapes norms

Whitlock (2010)
Non-Suicidal SDV & Suicide: Common Risk Factors

• History trauma, abuse, chronic stress
• High emotional perception and sensitivity
• Few effective mechanisms for dealing with emotional stress
• Feeling of isolation (consider their perception)
• History alcohol/substance abuse
• Depression or anxiety
• Feelings of worthlessness

*Presence of NSSI can be a risk factor for suicide
*No evidence NSSI causes suicidal thoughts/behaviors but it lowers inhibition to suicidal behaviors

Protective Factors

Protective factors are variables which, when present, make it less likely that individuals will consider, attempt, or die by suicide.

• Protective factors can include genetic or neurobiological makeup, attitudinal and behavioral characteristics, and/or environmental attributes
• Protective factors in individuals and communities provide targets for intervention

Protective Factors

• Effective Medical and Mental Health Care
  – Clinical care for mental, physical, and substance abuse disorders
  – Support from ongoing medical and mental health care relationships
• Connectedness (family, school, and community support)
  – Contacts with caregivers
  – Family cohesion and stability
  – Seeks adult help when needed
  – Good relationships with other youth
  – Positive connections with school and extracurricular partition
• School environment that encourages help seeking and promotes health

Learned skills

• Skills in problem solving, conflict resolution, anger management and nonviolent ways of handling disputes
• Positive self-worth and impulse control
• Hopefulness

Cultural and religious beliefs

• Beliefs that discourage suicide and support instincts for self-preservation
• Religiosity

Restricted access to lethal means (including firearms)
Suicide Risk Factors

- Risk factors are variables, which when present, simply increase the odds of suicidal ideation and behavior
  - Risk factors are far from perfect predictors of the presence of suicidal thoughts, suicide attempts, or suicide deaths
- Pathways to suicidal ideation and behavior are idiosyncratic
  - Suicidal ideation and behaviors are typically the result of interactions among a number of different factors
  - Generally speaking these factors can be categorized as personal, familial, social, and historical

Suicide Risk Factors: Children

- Suicide is rare among children under age 13 years
- Suicide is practically unheard of under the age of 9 years
- Thus, childhood can be considered a protective factor
  - Very young children have difficulty cognitively understanding death
  - Psychopathology is more common in later adolescence
  - Alcohol and substance abuse less common
  - Less access to guns

However...

- Most children have an understanding of death and the concept of suicide by age 8 years
- Many are capable of planning, attempting, and dying by suicide
- Suicide is a leading cause of death among children age 10 to 12 years (N= 114 deaths in 2014, 7th among children age 10 years, 3rd among children age 11 to 12 years)
- Each year a small number of under age 10 years to die by suicide (N= 3 deaths in 2014, all were 9 year olds, no suicides among children 8 and under in 2014)
- In community samples rates of suicidal ideation among children range from 6% to 15%
- Consequently, even though it is rare it is important to attend to risk factors for childhood suicidality

Suicide Risk Factors: Children

- Personal
  - Psychopathology
    - Depression, ADHD and other disruptive behavior disorders
    - Relative to adults and adolescents lower rates of such
  - Negative emotional states
    - Worthlessness and negative automatic thought processes
  - Hopelessness
  - May be specific to ideation and not behavior
  - Low self-esteem
  - in the context of high depression

- Familial

- Social

- Historical

Suicide Risk Factors: Children

- Personal
  - Strong emotional states
  - Anger, sadness, expectations of loss/abandonment
  - Aggression, Irritability
  - A symptom of depression in children
  - Sleep disturbance
  - Bed-wetting
  - Impulsivity
  - Sensation seeking
  - Somatic complaints

Ridge Anderson et al. (2016); Soole et al. (2015). NOTE: Gender not a factor until after 11 to 12 years

Johnson et al. (2006); Pfeffer (1987); Shaffer et al. (1996); Soole et al. (2015)
Suicide Risk Factors: Children

- **Familial**
  - Family conflict
    - 22% of hospitalized children with ideation had experienced family conflict in their home prior to hospitalization
    - Discord, divorce
    - Parent-child conflict, poor communication
      - Often a precipitating factor
    - Attachment difficulties
  - Parental psychopathology
    - 36.8% of hospitalized children with ideation had a family history of depression

- **Social**
  - Suicidal children were more likely to have been bullied than suicidal adolescents
  - Negative peer pressure
  - Perceived or real school performance problems

Suicide Risk Factors: Adolescents

- **Personal**
  - Hopelessness
  - Psychopathology
    - Depression severity
    - PTSD
      - Differentiates attempters from ideators
      - Greater psychological distress increases risk
    - Dissatisfaction with one's weight

- **Familial**
  - Quality of the relationship with each parent predicts attempts
  - Conversely parent connected is a protective factor

- **Historical**
  - Prior suicide attempts
    - Children who die by suicide are more likely than other children to have previously attempted suicide
  - Prior suicidal thinking
    - More likely to think/dream about death
    - Preoccupation with death significantly correlates with the degree of lethality in subsequent suicidal behavior
  - Prior suicidal behavior within the family
    - "6-fold increased risk for suicide attempt, relative to offspring of non-attempters"
    - Child abuse, neglect, exploitation

- **Social**
  - While childhood might be considered a protective factor, increasing age is associated with increased risk of suicide.
  - Suicide is the 2nd leading cause of death among adolescents age 13-18 years
    - N = 1,669 in 2014
    - 2015 YRBS data suggests...
      - 17.7% of 9-12 graders have thoughts of suicide
        - 13.8% in 2009
        - 14.6% of 9-12 graders have made a suicide plan
        - 10.0% in 2009
        - 8.6% of 9-12 graders have attempted suicide
        - 7.3% in 1991
        - 2.8% of 9-12 graders have made a suicide attempt serious enough to require medical attention
        - 1.7% in 1991

Suicide Risk Factors: Adolescents

- **Familial**
  - Quality of the relationship with each parent predicts attempts
  - Conversely parent connected is a protective factor
Suicide Risk Factors: Adolescents

• Social
  - Interpersonal conflict the most frequent precipitating event
  - Conversely, connectedness to others is a protective factor

Conversely, having caring friends and reporting feeling safe at school are protective factors.

Burón et al. (2016); Taliaferro & Muehlenkamp (2013).

Suicidality

Personal
Familial
Social
Historical

Suicide Risk Factors: Adolescents

• Social
  - Compared with adolescents who were not involved in bullying, all pure victims, pure perpetrators and victim-perpetrators had a higher risk of reporting suicidal ideation and attempt. The results indicated that no matter what kind of involvement they have in bullying, adolescents who are involved in bullying are at risk of suicide.
  - Conversely, having caring friends and reporting feeling safe at school are protective factors.

Taliaferro & Muehlenkamp (2013); Yen et al. (2015, pp. 445-446).

Suicide Risk Factors: Adolescents

• Historical
  - Prior suicide attempt
  - Violent attempts associated with a clearly elevated risk among males.

Repeated Attempt Within One Year

Burón et al. (2016); Stenbacka & Jokinen (2015).

Suicide Risk Factors: Adolescents

• Historical
  - Nonsuicidal self injury
  - Differentiates ideators from attempters
  - Prior suicidal behavior among peers and family members
  - Prior substance use
  - Running away from home
  - Sexual abuse

Cwik et al. (2015); Taliaferro & Muehlenkamp (2013).

Suicide Risk Factors: Adolescents, Weighing the Risk

Risk Factors Differentiating Male Adolescents With Only Suicide Thoughts From Those With No Suicidality

<table>
<thead>
<tr>
<th>Rank</th>
<th>Risk Factor</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hopelessness</td>
<td>3.30</td>
</tr>
<tr>
<td>2</td>
<td>Self Injury</td>
<td>1.21</td>
</tr>
<tr>
<td>3</td>
<td>Depressive symptoms</td>
<td>1.18</td>
</tr>
<tr>
<td>4</td>
<td>Physical Abuse</td>
<td>0.34</td>
</tr>
<tr>
<td>5</td>
<td>Mental health problem</td>
<td>0.34</td>
</tr>
<tr>
<td>6</td>
<td>Skipped school because felt unsafe</td>
<td>0.28</td>
</tr>
<tr>
<td>7</td>
<td>Alcohol use</td>
<td>0.24</td>
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Taliaferro & Muehlenkamp (2013).

Suicide Risk Factors: Adolescents, Weighing the Risk

Risk Factors Differentiating Female Adolescents With Only Suicide Thoughts From Those With No Suicidality

<table>
<thead>
<tr>
<th>Rank</th>
<th>Risk Factor</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hopelessness</td>
<td>3.29</td>
</tr>
<tr>
<td>2</td>
<td>Self Injury</td>
<td>1.12</td>
</tr>
<tr>
<td>3</td>
<td>Depressive symptoms</td>
<td>0.95</td>
</tr>
<tr>
<td>4</td>
<td>Perceived over weight/maladaptive dieting</td>
<td>0.36</td>
</tr>
<tr>
<td>5</td>
<td>Mental health problem</td>
<td>0.28</td>
</tr>
<tr>
<td>6</td>
<td>Ran away from home</td>
<td>0.28</td>
</tr>
<tr>
<td>7</td>
<td>Sexual abuse</td>
<td>0.28</td>
</tr>
</tbody>
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Taliaferro & Muehlenkamp (2013).
Suicide Risk Factors: Adolescents, Weighing the Risk

Risk Factors Differentiating Male Adolescents With Suicide Attempts From Those With No Suicidality

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<tr>
<th>Rank</th>
<th>Risk Factor</th>
<th>Effect Size</th>
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<tbody>
<tr>
<td>1</td>
<td>Self Injury</td>
<td>3.72</td>
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<tr>
<td>2</td>
<td>Hopelessness</td>
<td>2.82</td>
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<tr>
<td>3</td>
<td>Depressive symptoms</td>
<td>1.09</td>
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<tr>
<td>4</td>
<td>Mental health problem</td>
<td>0.95</td>
</tr>
<tr>
<td>5</td>
<td>Ran away from home</td>
<td>0.75</td>
</tr>
<tr>
<td>6</td>
<td>Sexual abuse</td>
<td>0.51</td>
</tr>
</tbody>
</table>

Taliafero & Muehlenkamp (2013)

Suicide Risk Factors: Adolescents, Weighing the Risk

Risk Factors Differentiating Female Adolescents With Suicide Attempts From Those With No Suicidality

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<th>Effect Size</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Hopelessness</td>
<td>3.44</td>
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<tr>
<td>2</td>
<td>Self Injury</td>
<td>2.63</td>
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<tr>
<td>3</td>
<td>Mental health problem</td>
<td>1.00</td>
</tr>
<tr>
<td>4</td>
<td>Ran away from home</td>
<td>0.86</td>
</tr>
<tr>
<td>5</td>
<td>Depressive symptoms</td>
<td>0.74</td>
</tr>
<tr>
<td>6</td>
<td>Stress or anxiety</td>
<td>0.66</td>
</tr>
</tbody>
</table>

Taliafero & Muehlenkamp (2013)

Suicide Risk Assessment

WARNING SIGNS

Suicide Warning Signs

- Imminent Warnings
  - Talking about wanting to kill oneself or having the desire to die
  - Increased feelings of hopelessness, life is meaningless, or having no reason to live
  - Researching methods to commit suicide and/or getting a gun
  - Isolating oneself from social connections such as family and friends
  - Having a detailed plan of how, when and where

Suicide Warning Signs

- Verbalizations
  - Direct statements/threats about killing or hurt themselves, e.g.:
    - “I wish I were dead.”
    - “I am going end it all.”

Erbacher et al. (2015); Miller (2011)

Erbacher et al. (2015); Suicide Prevention Resource Center (2007)
Suicide Warning Signs

- Verbalizations
  - Indirect/vague statements, e.g.:
    - “You won’t have to worry about me anymore.”
    - “I want to take a permanent nap.”
    - “I wish I could fall asleep and never wake up”
    - “Everybody would be better off if I just wasn’t around”
    - “I’m not going to bug you much longer”
    - “I hate my life. I hate everyone and everything”
    - “I’m the cause of all of my family/friend’s troubles”
    - “I’ve tried everything but nothing seems to help”
    - “Nobody can help me”

- Common Behavioral, Emotional, and Physical Warning Signs
  - Refusing help and/or believing that there is not help for them
  - Giving away prized possession
  - Withdrawing from activities
  - Aggressive behaviors (e.g., fighting, arguing)
  - Decline in appearance and hygiene
  - Sudden positive change in mood
  - Expressing death/suicide themes in writings and art

Key Elements of Suicide Risk Assessment

- IS PATH WARM
  - I: Ideation (suicidal thoughts)
  - S: Substance abuse
  - P: Purposelessness
  - A: Anxiety
  - T: Trapped
  - H: Hopelessness
  - W: Withdrawal
  - A: Anger
  - R: Recklessness
  - M: Mood changes (including unexpected happiness)

- Levels of Suicide Risk
  - High
  - Moderate
  - Low
  - No thoughts of suicide

Adapted from Juhnke et al. (2011) and American Association of Suicidology (2016)
Suicide Risk Assessment

• Purpose
  – Is the student suicidal and to what extent?
    • No, Low, Moderate, or High Risk?
  – Connect to interventions and supports that address the needs of the student.
    • Is the situation a psychiatric emergency (i.e., is a 911 call indicated)?
    • How to address immediate and longer term needs?

Elements of Suicide Risk Assessment

• The presence of suicide risk factors and warning signs generates the need for a suicide risk assessment.
• Risk assessment begins by identifying the presence of suicidal thoughts
  • If suicidal thoughts are not present, then the suicide risk assessment is complete and other helping models are employed to address the risk factors and warning signs that lead to concern about suicide.

Elements of a Suicide Risk Assessment

• Risk Factors, Warning Signs, and Protective Factors
  – What are the factors and signs that increase or decrease the likelihood of suicide?
• Suicidal Ideation
  – Does the student want to die?
  – Is the student thinking about suicide?
  • Frequency
  • Duration
  • Intensity

Suicide Risk Assessment: Ask Questions

• Be direct when asking the “S” question.
  – BAD
    • You’re not thinking of hurting yourself, are you?
  – Better
    • Are you thinking of harming yourself?
  – BEST
    • Sometimes when people have had your experiences and feelings they have thoughts of suicide. Is this something that you’re thinking about?

Elements of a Suicide Risk Assessment

• Sample questions to assess suicidal ideation:
  – When did you begin having suicidal thoughts?
  – Did any event (stressor) precipitate the suicidal thoughts?
  – On a 10 point scale, with 1 being rarely and 10 being all the time, how often do you have thoughts of suicide?
    • How long do these thoughts last?
    • How strong are they?
    • What is the worst they have ever been?
  – What do you do when you have suicidal thoughts?
  – What did you do when they were the strongest ever?
Elements of Suicide Risk Assessment

- **Intent** (are there thoughts of suicide?)
  - Expressed and Observed Intent

- **History Self-Injury** (the more significant the history the greater the risk)
  - Prior behavior is the best predictor of future behavior
  - Prior suicide attempts = the greatest risk, but nonsuicidal self-injury is also increases the danger presented by suicidal thoughts

- **Plan** (the greater the planning the greater the risk)
  - How? Is there a plan? Is it specific?
  - How soon? Is there a time frame for suicidal behavior
  - How prepared? Method, means, has the student been preparing?

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Risk Levels

- From information collected is the student at No, Low, Moderate, or High Risk for suicide?
- **No risk** is assigned to the student who does not have suicidal thoughts.
- **Low risk** is assigned to the student with suicidal thoughts, but who has no plan to engage in a suicidal behavior.
- **Moderate to high risk** is assigned to the student who has suicidal thoughts and at least some hint of a suicide plan.
- **The highest risk** is reserved for the student with suicidal thoughts, a history of prior self-injury, who is in unbearable pain that they are desperate to end, and is unable to identify life sustaining resources.

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Suicide Risk Assessment: Absolutes

- **Must Keep** the student safe and supervised
  - Work as a team to assist with the student’s safety
  - Monitor, supervise, and escort
  - Don’t leave an at risk student alone

- **For any reason**
  - Don’t allow an at risk student leave the school unattended

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Suicide Risk Assessment: Absolutes

- **Parent Contact**
  - Should be done regardless of the level of risk
  - To inform, educate, and assist with connecting parents and student to appropriate levels of support
  - Lists of resources and outside providers
  - Release of information to facilitate ongoing support within the school
  - Educate and advise regarding the presence of lethal means within the home and the importance of their removal

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Suicide Risk Assessment: Absolutes

- **Parent Contact**
  - Identify who you are and that their child is safe
  - Link to your state legal requirements as part of your justification
  - Discuss the concerns and importance of seeking treatment
  - Assess the parents’ intent and willingness to help their child
  - Should not be done if the threat is associated with parental abuse
  - Child protective services
  - Document the contact
Suicide Risk Assessment: Additional Elements

- Documentation of the assessment
  - MUST BE DONE REGARDLESS OF THE RISK
  - Record keeping
  - Be aware of local and state requirements
    - How long must the records be maintained?
    - Where must they be stored?

Suicide Risk Assessment: Absolutes

- Follow up intervention/Safety Plan
  - What supports do you need to put into place once the student returns to school?
- Monitoring
  - Once the student returns to school with supports and interventions, how are you going to track safety and progress?
  - Information for connecting student and families to outside resources.

Suicide Risk Assessment: Training & Maintenance

- Core Training
  - Assessment Team
  - Document who went through the training and when
- Set up regular refreshers
  - Case studies/tabletops
  - Document who attended and when
- Review Cases for Lessons Learned

MODELS OF RISK ASSESSMENT

Suicide Risk Assessment

- Predicting Suicidal Behavior (CPR++)
  - Current plan (greater planning = greater risk).
    - How (method of attempt)?
    - How soon (timing of attempt)?
    - How prepared (access to means of attempt)?
  - Pain (unbearable pain = greater risk)
    - How desperate to ease the pain?
      - Person-at-risk’s perceptions are key
        - On a 10-point scale (just a little to unbearable) how great is the psychic pain?
  - Resources (more alone = greater risk)
    - Reasons for living/dying?
      - Can be very idiosyncratic
        - Person-at-risk’s perceptions are key

Ramsay et al. (2004)
Suicide Risk Assessment: Children

Guideline
1. Ask about suicidal ideation

Examples
Do things ever get so bad you think about hurting yourself? Have you ever wished you were dead? Have you ever tried to kill yourself?

Ask child to draw a picture of what they think about when they are at their most sad, angry or scared.

Suicide Risk Assessment: Children

Guideline
2. Assess child’s developmental understanding of death, including past experiences with death and anticipated outcome of suicide plan

Can someone return to life after they die? Have you ever known a person or pet who has died? Do you think death is pleasant or unpleasant? What do you think will happen when you die?

If you [describe child’s plan, e.g., stab yourself in the stomach], what do you think would happen next?

Suicide Risk Assessment: Children

Guideline
3. Ask about precipitating event(s)

What was happening right before you tried to kill yourself? (or, last thought about killing yourself?) Ask child to draw a picture of what happened.

Suicide Risk Assessment: Children

Guideline
4. Assess parent attitudes

Do parents/caregivers believe the child is at risk? Are they willing to implement safety plans?

Suicide Risk Assessment: Children

Guideline
5. Use a multi-method, multi-informant approach

Observe parent-child interactions; observe child’s play behavior; ask parents about relevant history and risk factors, to reduce interview burden on child.

Suicide Risk Assessment: Children

Guideline
6. Use structured assessment tools to supplement clinical interview

1. Suicidal Behavior Questionnaire for Children (Range & Knott, 1997)
2. Scale for Suicidal Ideation (Allan, Kashani, Dahmeier, Taghizadeh, & Dahlmeier, 1997)

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