# Suicide Risk Assessment
## of Rural and Urban Adolescents

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# Why should I be concerned about adolescent suicide?

- ***Suicide*** is a significant public health problem.
- ***Suicide*** is complex, but can be prevented in many cases by early recognition & treatment.
  - Professionals & gatekeepers must intervene.

(U.S. Department of Health and Human Services, Public Health Service, 2001)

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**Table 1.** ***Comparison of Suicide Rates in the United States and Pennsylvania***

| | Suicide Rates per 100,000 Youth* | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 15 – 19 Years of Age | | | | | | | |
| **Location** | **1999** | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** |
| United States | 8.04 | 8.02 (↓) | 7.93 (↓) | 7.43 (↓) | 7.26 (↓) | **8.20 (↑)** | 6.85 (↓) | N/A |
| Pennsylvania | 7.60 | 7.10 (↓) | **7.50 (↑)** | **8.10 (↑)** | 8.00 (↓) | 7.30 (↓) | 6.20 (↓) | 5.40 (↓) |

Note. Arrows indicate an increase or decrease compared to the previous year.
N/A – national rate for 2006 is not available at this time.
* 95% confidence interval.

(Centers for Disease Control and Prevention, 2005; Pennsylvania Department of Health, n.d.)

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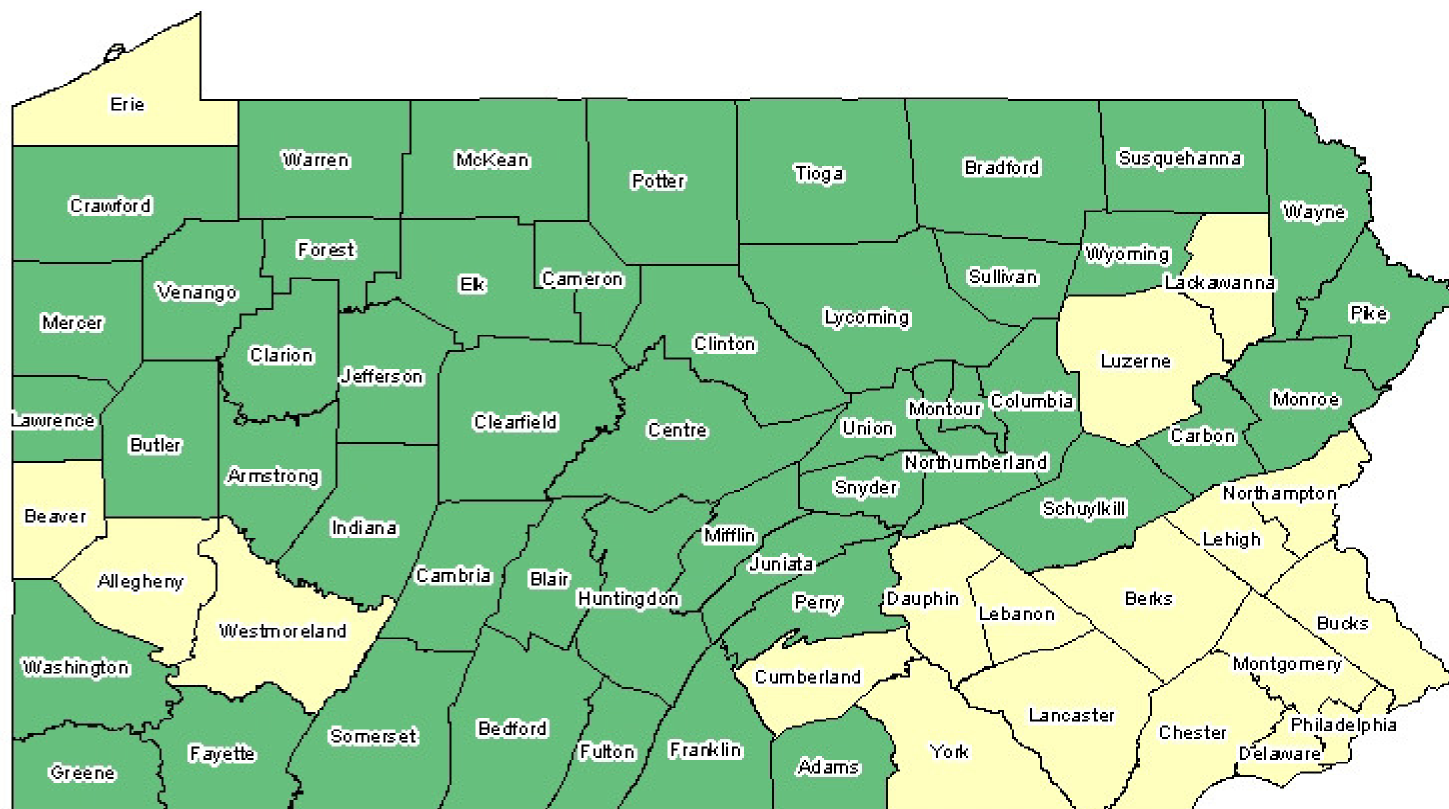


NOTE: REPRODUCED WITH PERMISSION OF THE CENTER FOR RURAL PENNSYLVANIA (CENTER FOR RURAL PENNSYLVANIA, N.D.A).

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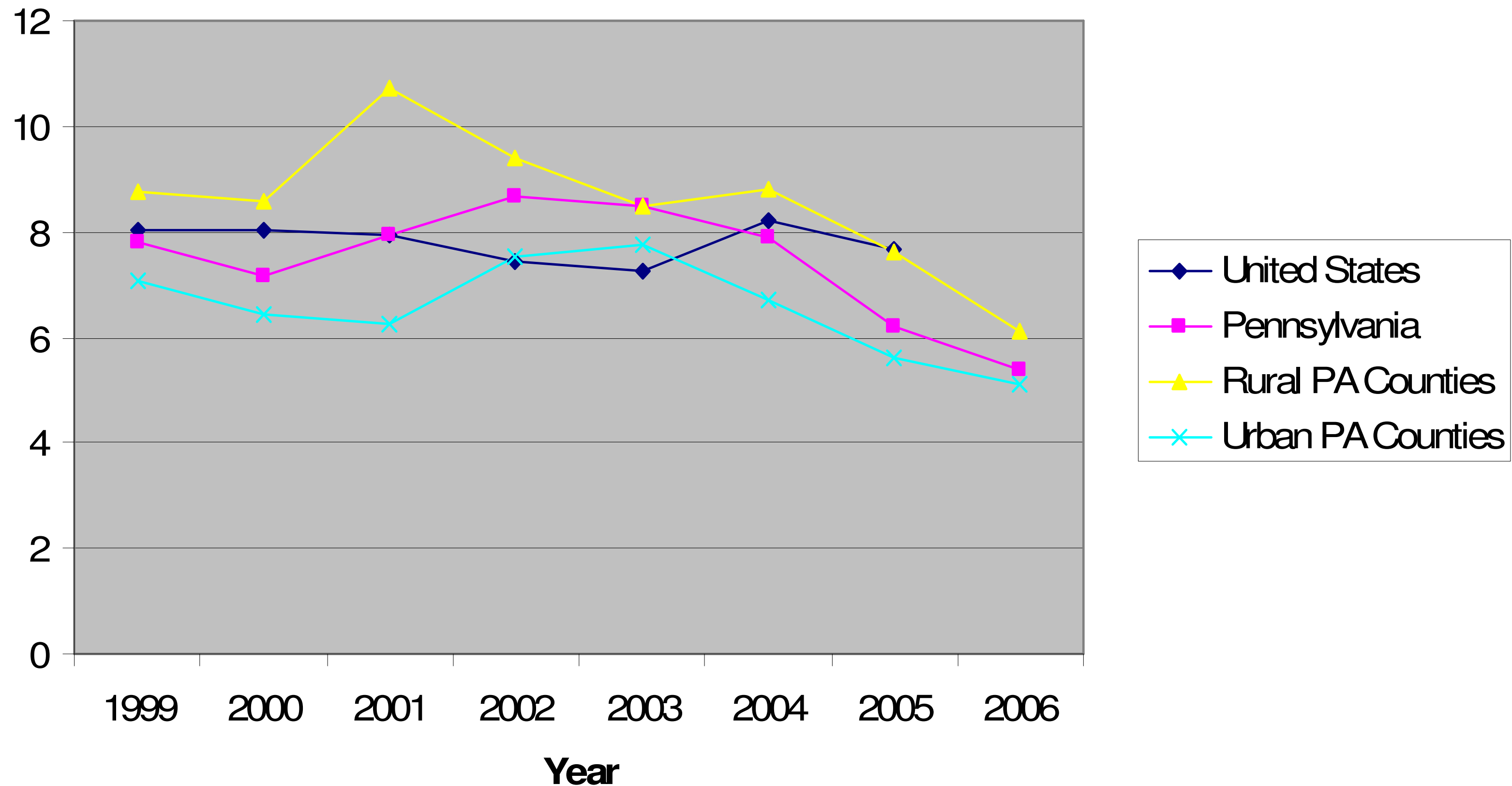


Note. Rates for counties were calculated using data from the Pennsylvania Department of Health (n.d.a). Additional content was obtained from the National Center for Injury Prevention and Control (2004). National rate for 2006 is not yet available.

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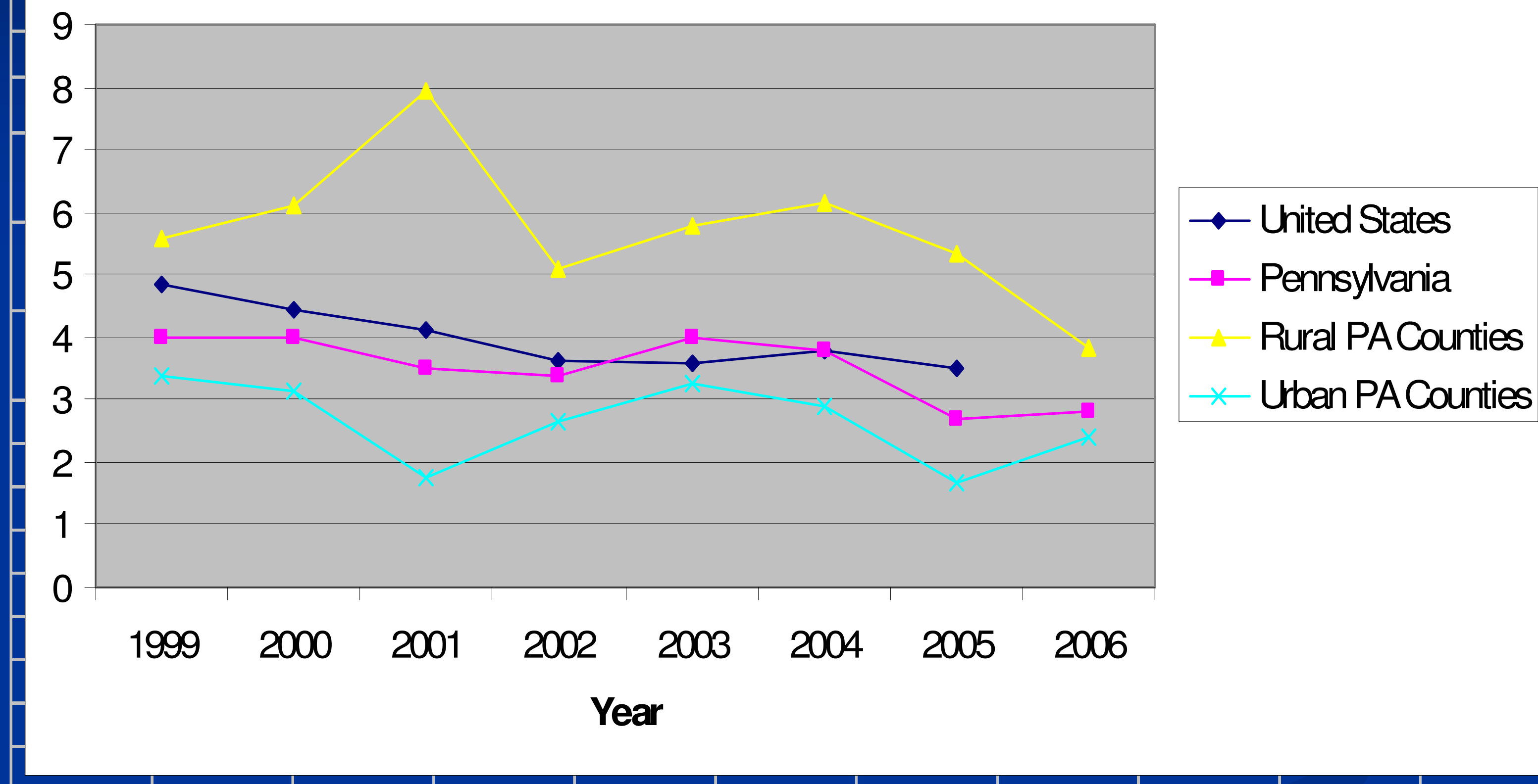


Note. Rates for counties were calculated using data from the Pennsylvania Department of Health (n.d.a). Additional content was obtained from the National Center for Injury Prevention and Control (2004). National rate for 2006 is not yet available.

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# Rural America. Safe & secure?

- Information superhighway
  - Harmful information & substances
- Fewer job opportunities
- Fewer resources in school
- Poverty

(Heck et. al., 2004; Robertson & Husenits, 2007)

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# In Rural Pennsylvania…

- Greater percentage of residents do not have health insurance or are insured through Medicaid.
- 22% live in areas that have too few health care providers or are medically under-served (Pa Rural Health Association, 2003).
- Fewer rural Pennsylvanians have high school diplomas.

(Center for Rural Pennsylvania, 2005; Pennsylvania Rural Health Association, 2003)

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# In Rural Pennsylvania cont.…

- Childhood obesity is more common in rural than urban regions.
- More of PA's rural children:
  - Live in households with incomes below the poverty level.
  - More are eligible for the Free and Reduced School Lunch Program.

(Center for Rural Pennsylvania, 2005)

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# Rural Dangers

- Recreational activities
  - Snowmobiles
  - All terrain vehicles
  - Hunting
- Occupations
  - Pesticides

* Guns and pesticides can be used for killing oneself.

(Department of Conservation and National Resources, 2004; Hirsch, 2006)

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# Psychosocial Problems of Rural Southeastern PA Youth

- Stressors
  - School (exams, tests, and grades)
  - Family issues such as fighting with one or both parents
  - Loss of a family member (half reported the death of a grandmother)
  - Friendship/social concerns (girlfriends, boyfriends, and dating)

(Puskar & Martsolf, 1993; Puskar, Tusaie-Mumford, Sereika, & Lamb, J. , 1999a)

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# Psychosocial Problems of Rural PA Youth

- Confusion about the future
- Depression
- Feeling lonely
- Trouble at home
- Suicidal thoughts
- Lack of a best friend
- Use of tobacco and alcohol
- History of sexual abuse
- General health concerns of both a physiological and psychosocial nature (feeling tired, being overweight, and headaches)

(Puskar & Martsolf, 1993; Puskar et al., 1999a)

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# Psychosocial Problems of Rural PA Youth

- Depressive symptoms significantly related to:
  - Death of a family member
  - An increase in the number of arguments with parents
  - Losing a close friend
  - Trouble with the police (including illegal drug use and violence)
  - Trouble with classmates, and higher levels of perceived negative life events
  - Anxiety was significantly and positively correlated with depressive symptoms and somatic complaints.

(Puskar et al., 1999b, Puskar et al., 2003)

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# Problems & Concerns of PA Rural Youth in Their Own Words

- Results of a qualitative study that was discussed at the conference will be included after they are published.

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# What about urban youth?

- Studies concern:
  - Interpersonal callousness among inner city males (from childhood through adolescence) (Obradovic et al., 2007)
  - Substance use progression among Blacks and Whites in Pittsburgh (White, Jarrett, Valencia, Loeber, & Wei, 2007)
    - Marijuana was the common end stage drug for Blacks
    - Tobacco and alcohol were the common end-stage drugs for Whites
    - Whites were more likely than Blacks to begin and become regular hard drug users

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# What about urban youth cont.

- Adolescents were diagnosed in a Pittsburgh children's ER with higher rates of drug and alcohol use disorders, together with major depression, compared to community controls (Kelly et al., 2003)

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# What about urban youth cont.

- Urban primary health care providers under-treat childhood obesity (O'Brien, Holubkov, & Reis, 2004)
- Child maltreatment of urban boys leads to the progression of disruptive and delinquent behavior (Stouthamer-Loeber, Loeber, Homish, & Wei, 2001)

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# What about urban youth cont.

- Increase in the incident of gunshot wounds among urban youth, especially adolescent Black males (Nance, Stafford, & Schwab, 1997)
- Long-guns were associated with youth suicide in rural areas while handguns were associated with youth suicides in urban areas
  - Recommended that firearms to be removed from the home (Brent, Perper, Moritz, Baugher, Schweers et al., 1993)

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# PA Community Health Assessment Resources

- Inquiries can be made concerning:
  - "Healthy People 2010 Statistics"
  - "Behavioral Risk Data"
  - "Injuries in Pennsylvania"
- Pennsylvania's Bureau of Health Statistics and Research Web site:
  - EpiQMS (Epidemiologic Query and Mapping System)

(Clark & Buell, 2004; Pennsylvania Department of Health, 2005)

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# PA Community Health Assessment Resources cont.

- Center for Rural Pennsylvania
- Center for Urban Health Policy and Research, Albert Einstein Healthcare Network in Philadelphia
- Child Death Review Team (CDRT)

(Clark & Buell, 2004; Pennsylvania Department of Health, 2005)

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# National Community Health Assessment Resources

- Census Bureau's American FactFinder
  - "American Community Survey"
- The National Center for Health Statistics

(Clark & Buell, 2004; Pennsylvania Department of Health, 2005)

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# Methods for Suicide

- During 2006 in Pennsylvania:
  - Firearms, falls, and poisoning (rates of 3.71, 3.14, 0.34, and 0.22 per 100,000 respectively) (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2008).
  - No youth drowned.
  - Only firearms and non-firearms can be identified on EPIQMS.
    - Rural/urban methods cannot be determined based on available information.

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# What is being done at the national level?

- *The Surgeon General's Call To Action To Prevent Suicide* (U.S. Department of Health and Human Services, Public Health Service, 1999)
- *Healthy People 2010* (U.S. Department of Health & Human Services, 2000)
- *Preventing Youth Suicide in Rural America: Recommendations to States* (State and Territorial Injury Directors Association, 2008)

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# Why does adolescent suicide occur?

- Because the adolescent is in emotional pain and believes that no one can help.
- Because he or she sees death as the only way out of the pain.
- Because death may be less real and suicide may be more acceptable.
- Because adolescents may fantasize that they can return to life after death, just as they can return from a drug-induced escape. Most do not want the finality that death by suicide brings.

(Allen, 1987; Becker-Fritz & Barbee, 1993)

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# Kral & Sakinofsky's Model

- Tier I: Assessment of Background Risk Factors
- Tier II:  Assessment of Subjective Risk Factors

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model

- Those of us who are aware of the background factors and subjective states of people who die by suicide, and who also promote an atmosphere conducive to communication and understanding of a client's subjective state, will likely be as close as possible to an optimal position for assessing suicide risk.

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model

- **Tier I: Assessment of Background Risk Factors**
  - Includes sociodemographic and related indices that have been correlated with increased risk of suicide.
  - Based on different populations, cultures, and cohorts.  Together, they inform clinicians about a client's general level of risk, and many of the indices change over time.

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model

- **Tier I: Assessment of Background Risk Factors cont.**
  - One background factor alone may not be very meaningful in determining suicide risk, but, as background factors accumulate, the risk for suicide increases.
  - Can provide the means for assessing subjective factors (e.g. recent loss and alcohol abuse).

(Kral & Sakinofsky, 1994)

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# Risk Factors for Suicide

- Common risk factors include:
  1) Negative personal history (including personal and interpersonal skills deficits, negative coping models, narcissistic injuries, parental psychopathology, a family history of suicide, and genetic-biochemical vulnerability),
  2) Significant negative personality attributes and psychopathology, including anxiety disorders and mood disorders, especially early-onset major depressive disorder,
  3) Stress,

(American Academy of Child and Adolescent Psychiatry; 2001; Berman & Jobes, 1994)

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# Risk Factors for Suicide

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(American Academy of Child and Adolescent Psychiatry; 2001; Berman & Jobes, 1994)

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# Risk Factors for Suicide cont.

4) Behavior and affect dysregulation and breakdown of defenses (including irrationality, cognitive rigidity, loss of reality testing, thought disturbance, and acute behavioral change),
5) Interpersonal and social alienation and isolation,
6) Dysphoria, self-deprecatory ideation, and hopelessness,

(American Academy of Child and Adolescent Psychiatry; 2001; Berman & Jobes, 1994)

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# Risk Factors for Suicide cont.

7) Runaway behavior,
8) Bisexuality and homosexuality, and
9) Accessibility, availability, and knowledgeability of a method for completing suicide

(American Academy of Child and Adolescent Psychiatry; 2001; Berman & Jobes, 1994)

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# Risk Factors for Suicide cont.

NOTE. Specific risk factors that have been studied for rural and urban youth are found on the following slides. The table that was discussed at Pennsylvania's second annual suicide prevention conference will be included once it is published.

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# Risk Factors for Suicide for Rural and Urban Youth

- Specific risk factors for suicide that have been identified for rural youth include the following:
  - Trouble getting along with parents/step-parents (Albers & Evans, 1994)
  - Family conflict (Evans, Smith, Hill, Albers, & Neufeld, 1996)
  - Family using drugs/alcohol (Albers & Evans, 1994)
  - Injuries by firearm in children & adolescents predominate in rural areas of Pennsylvania (Nance et al., 2002)

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# Risk Factors for Suicide for Rural and Urban Youth

- Specific risk factors for suicide that have been identified for rural youth include the following:
  - White youth were at a much greater risk for suicide by gun than homicide by gun compared to urban youth (Svenson et al., 1996)
  - Concern over family bills (Albers & Evans, 1994)
  - High-achieving rural students reported *higher* levels of suicidal ideation compared to low-achieving rural students (may be more affected by lack of educational & cultural opportunities, isolation, few extracurricular activities & lack of social support) (Albers & Evans, 1994)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for rural youth cont.:
  - What to do after high school (Albers & Evans, 1994)
  - Quality of school (Albers & Evans, 1994)
  - Paying for education after high school (Albers & Evans, 1994)
  - Evidence of criminal or legal issues (Shen et al., 2006).
  - Obtaining a satisfying job (Albers & Evans, 1994)
  - Friends using drugs/alcohol (Albers & Evans, 1994)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for rural youth cont.:
  - Alcohol abuse or dependence (reservation-reared American Indian youth) (Freedenthal & Stiffman, 2004).
  - Cigarette smoking & family history of substance abuse (reservation-reared American Indian youth) (Freedenthal & Stiffman, 2004).
  - Alcohol/substance abuse (Evans et al., 1996)
  - Sexual abuse (reservation-reared American Indian youth) (Freedenthal & Stiffman, 2004)
  - Family history of abuse (Albers & Evans, 1994)
  - Pregnancy (Albers & Evans, 1994; Evans et al., 1996)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for rural youth cont.:
  - More reservation- than urban-reared American Indian youth thought of dying by suicide (33% compared to 21%) (Freedenthal & Stiffman, 2004).
  - Suicide as a concern (rural Southwestern Pennsylvania) (K. R. Puskar, K. Tusaie-Mumford, S. Sereika, & J. Lamb, 1999) (West Virginia) (Heavner, Swinker, & Arbogast, 1991)
  - High rates of suicidal ideation (rural students of color) (Albers & Evans, 1994)
  - Depression, conduct disorder, & perceived discrimination (reservation-reared American Indian youth) (Freedenthal & Stiffman, 2004)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for rural youth cont.:
  - Psychological/emotional problems (Evans et al., 1996)
  - Physical & sexual abuse (Evans et al., 1996)
  - Relationship issues (Evans et al., 1996)
  - Lack a close, supportive family & feel disenfranchised from peers (Evans et al., 1996)
  - Making decisions (Albers & Evans, 1994)
  - AIDS (Albers & Evans, 1994)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for suicide that have been identified for urban youth include the following:
  - Fewer confiding relationships with their parents, & less affectionate & active relationships with mother figures (King, Raskin, Gdowski, Butkus, & al., 1990).
  - Trouble getting along with parents/step-parents (Albers & Evans, 1994)Chronic fighting with parents (Weinberger, Sreenivasan, Sathyavagiswaran, & Markowitz, 2001).

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Family using drugs/alcohol (Albers & Evans, 1994)
  - Fewer support persons (King et al., 1990)
  - Would not talk to family members about a problem & low levels of support or no one to count on (O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004; O'Donnell, Stueve, Wardlaw, & O'Donnell, 2003)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Less likely to have accessed formal network of contacts (teacher, minister/priest, medical doctor/nurse, mental health professional) (O'Donnell et al., 2003)
  - Higher levels of delinquent behavior compared to non-attempters (King et al., 1990)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Families did not have appropriate levels of cohesion (affect & warmth) balanced with the ability to adapt (respond to stress in a developmentally sensitive way); family dysfunction (concerning cohesiveness); & disengaged as far as their adaptability (chaotic, flexible, rigid, or structured) (Summerville, Kaslow, Abbate, & Cronan, 1994)
  - Less likely to be living with mothers (King et al., 1990)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Divorce of parents (Weinberger et al., 2001)
  - Having to leave family & live elsewhere (Weinberger et al., 2001).
  - Assaultive injuries in children & adolescents predominate in urban areas of Pennsylvania (Nance et al., 2002).

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Much greater risk for homicide than suicide by gun compared to rural youth (Svenson, Spurlock, & Nypaver, 1996)
  - Concern over family bills (Albers & Evans, 1994)Spent fewer afternoons/evenings doing homework (Mazza & Eggert, 2001)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Failing classes (Weinberger et al., 2001)
  - What to do after high school (Albers & Evans, 1994)
  - Quality of school (Albers & Evans, 1994)
  - Other school difficulties (Weinberger et al., 2001)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Paying for education after high school (Albers & Evans, 1994)
  - Higher levels of delinquent behavior (King et al., 1990)
  - Females who displayed physical aggression in middle school were at risk for suicidal ideation & behavior during 11th grade (O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Obtaining a satisfying job (Albers & Evans, 1994)
  - Friends using drugs/alcohol (Albers & Evans, 1994)
  - Alcohol abuse or dependence (urban-reared American Indian youth) (Freedenthal & Stiffman, 2004)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Direct relationship between substance use & depressive symptoms in early adolescence & later suicidal thoughts, attempts, or plans (O'Donnell et al., 2005)
  - Engaging in same-gender sex (O'Donnell, O'Donnell, Wardlaw, Stueve et al., 2004)
  - Sexual abuse (urban-reared American Indian youth) (Freedenthal & Stiffman, 2004)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Family history of abuse (Albers & Evans, 1994)Pregnancy (Albers & Evans, 1994)
  - Fewer urban-reared than reservation reared American Indian youth thought of dying by suicide (21% compared to 33%) (Freedenthal & Stiffman, 2004)
  - Having a family member who attempted or died by suicide (American Indian urban-reared youth) (Freedenthal & Stiffman, 2004)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Higher levels of depressed mood  (King et al., 1990).Mental health condition & a history of psychiatric disorder (Los Angeles County) (Weinberger et al., 2001)
  - Depression  (O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004; O'Donnell et al., 2003)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - A direct relationship was found between substance use & depressive symptoms in early adolescence & later suicidal thoughts, attempts, or plans (O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004; O'Donnell et al., 2003)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Depressive symptoms & maladaptive attributional style (O'Donnell et al., 2005; Summerville et al., 1994).
  - Breakup with a girlfriend or boyfriend (Weinberger et al., 2001)

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# Risk Factors for Suicide for Rural and Urban Youth cont.

- Specific risk factors for urban youth cont.:
  - Undesirable life stressors (King et al., 1990)
  - Basic needs not being met (O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004)
  - Making decisions (Albers & Evans, 1994)
  - AIDS (Albers & Evans, 1994)

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# Suicidality

- *What step should be taken first?*

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# Suicidality

- *What step should be taken first?*

Set the stage for the interview.

**(Clark & Ginsburg, 1995)**

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# Set the Stage for the Interview

- "Ensure privacy by having the parent leave the room."
  a) "Establish trust."
     i. Ensure confidentiality and explain situations in which confidentiality cannot be maintained.

(Clark & Ginsburg, 1995)

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# Kral & Sakinofsky's Model cont. *HEADSSS* for Tier I

- ***H***ome
- ***E***ducation
- ***A***ctivities
- ***D***rugs and Substances
- ***S***exuality
- ***S***afety
- ***S***uicidality, Depression, and Other Mental Illnesses

(Cohen, Mackenzie, & Yates, 1991)

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# Kral & Sakinofsky's Model cont. *HEADSSS* for Tier I

- *The version of* HEADSSS that was discussed at the conference will be included once it is published.

(Cohen, Mackenzie, & Yates, 1991)

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# Steps in Assessing the *HEADSS Domain of* Suicidality, Depression, and Other Mental Illnesses

a) First, understand emotions, including the signs and symptoms of depression and low self-esteem in adolescents.
b) Assess depression/self-image (Clark & Ginsburg, 1995).
c) Assess for traumatic events and loss.

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# Suicidality, Depression, and Other Mental Illnesses cont.

d) Observe for statements that indicate possible thoughts of suicide.
e) Assess for impulsiveness.
f) Assess for changes in behavior patterns, especially risky behaviors.

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# Physical Health

- Chronic medical illness
  - Depression:
    - Diabetes
    - Epilepsy
    - IBD
  - Treatment that destabilizes affect:
    - Phenobarbitol for epilepsy
    - Steroids for IBD

(Brent & Poling, 1997)

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# Physical Health cont.

- Life is ruined because my life span is shortened or because I have limitations (cannot drive, special diet, etc.)
- Chronic illness may result in a sense of hopelessness & lack of control generalized to other spheres outside of the illness.

(Brent & Poling, 1997)

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# Kral & Sakinofsky's Model

- **Tier II: Assessment of Subjective Risk Factors**
  - ***Perturbation***
  - ***Lethality***
  - ***Cognitive Constriction***

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model cont.

- **Tier II: Assessment of Subjective Risk Factors**
  - ***Perturbation***
    - "The degree of upset, disturbance, tension, anguish, turmoil, discomfort, dread, hopelessness, or other excessive psychological pain."
    - It can reach a point at which it is no longer tolerable. At this point, an adolescent becomes motivated to do something about it.
      - "How bad is the hurt?"
      - "Is it bearable?"

(Kral & Sakinofsky, 1994)

# Kral & Sakinofsky's Model cont.

- **Tier II cont.**
  - ***Cognitive Constriction***
    - "Can be defined generally as dichotomous thinking, tunnel vision, or a narrowing of the range of options to two and ultimately one."
    - Determine:
      1) if suicide is an option, and
      2) if suicide is the only option

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model cont.

- **Tier II cont.**
  - ***Cognitive Constriction* cont.**
    - "Sometimes when people feel this way, they think about hurting themselves or killing themselves. Have you ever thought about hurting yourself or killing yourself?"
    - "Are you thinking about hurting or killing yourself?
    - "Is this your only option?"

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model cont.

- **Tier II cont.**
  - ***Lethality***
    - "The conscious selection of suicide as a viable option. It is based on the person's considering suicide as a specific, and eventually the only option in alleviating perturbation."
    - Lethality includes both of the following:
      1) The insight or thought that cessation of consciousness is the solution for unbearable psychological pain, and
      2) The decision for action. Lethality leads to death.

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model cont.

- **Tier II cont.**
  - ***Lethality* cont.**
    - Most people who commit suicide deliberately plan to do so.
      - In the case of adolescents, however, a suicide plan is a less important sign of risk if the adolescent has a history of impulsive behavior.

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model cont.

- **Tier II. cont.**
  - ***Lethality* cont.**
    - **I. Specificity of the Plan**
    - A person who has a well thought out suicide plan, including time, place, and circumstances, as well as a high-lethal method, is at very high risk.
      - "Do you have a plan worked out for killing yourself?"
    - Determine if it includes any rescue possibilities. This can be determined by asking the following:
      - "What time of day do you plan to do this?"
      - "Is there anyone else around at that time?"

(Kral & Sakinofsky, 1994)

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# Kral & Sakinofsky's Model cont.

- Tier II cont.
  - *Lethality* cont.
    - **I. Specificity of the Plan cont.**
      - What truly matters is the person's ***intent***, and intent must be analyzed.
        - "What do you intend to accomplish?"
        - This is likely the most important thing that you will determine.

(Kral & Sakinofsky, 1994)

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# Understand the Motivation

- Reason or reasons given for an act of suicide.
  - Which of the following has the highest suicidal intent?
    - A wish to die
    - Desire to escape
    - Gain attention
    - Express hostility
    - Induce guilt

(Brent & Poling, 1997)

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# Understand the Motivation

- Reason or reasons given for an act of suicide.
  - Which of the following has the highest suicidal intent?
    - A wish to die – highest suicidal intent
    - Desire to escape – a close second
    - Gain attention.
    - Express hostility.
    - Induce guilt.

(Brent & Poling, 1997)

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# Kral & Sakinofsky's Model

- **Tier II cont.**
  - ***Lethality* cont.**
    - **II. Method**
      - **"What are you thinking of doing?"**
    - **III. Availability and accessibility of means**
      - "Do you have pills?" or "How do you plan to get the pills?"
      - "Do you have a gun?", or "How do you plan to get the gun?"
      - "Do you know how to use a gun?", and "Do you have ammunition?"

(Kral & Sakinofsky, 1994)

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# Assessing Suicidality, Depression, and Other Mental Illnesses

g) Observe for sudden cheerfulness after depression.

h) Assess for prior suicide attempts.

i) If an adolescent admits to depression or suicidal feelings, tell the adolescent that his or her parents need to know, as you agreed upon when discussing confidentiality (Clark & Ginsburg, 1995).

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# Assessing Suicidality, Depression, and Other Mental Illnesses cont.

j) Make a suicide contract with the adolescent if he or she is suicidal (Clark & Ginsburg, 1995; Weiss, 2001).
   - Controversial, but can also be useful.
   - Develop & record an emergency plan.

k) Complete the Tier II assessment of subjective risk factors.

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# No-Suicide Contract

- One of the most critical parts of assessment of suicidality.
- Test the patient's resolve by asking what he or she would do if the precipitant should recur.
- Write down the steps that the patient & family would take on a business card.
  - Also include alternatives.

(Brent & Poling, 1997)

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# Family Systems Approach to Suicide

- Disturbances in family structure promote suicidal acting out in the family system.
  - Blurring of role boundaries and role conflicts
  - Failure and secretiveness of communication
  - Dysfunctional alliances across boundaries
  - Rigidity with the inability to tolerate crisis or accept change.

(Thompson et al., 1994)

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# Family Systems Approach to Suicide

- Serious conflicts or problems of parents, as individuals or together, may interfere with the adolescent’s drive for growth and autonomy (Berman & Jobes, 1994).
  - The parental system, in particular, is one of the most studied variables related to adolescent suicide.
  - Parents, as models, are caretakers and nurturers, sources of reinforcement and praise, and have obvious roles in the development of healthy, autonomous children.

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# Family Systems Approach

- Assess 3 areas:
  1) Needs of the family
  2) Strengths of the family (include resiliency factors)
  3) Resources and supports of the family.

(MacPhee, 1995)

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# Family Systems Approach

1. **Determine family needs and prioritize them.**

- "A need is defined as the family's perception of what is important for them to acquire" (MacPhee, 1995).
  - Often related to other family problems or needs.
  - Explore concerns or problems connected to the presenting need or problem (Wright & Leahey, 1994).
    - You may ask: *"What do you think is the problem?" (Sideleau, 1992)*

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# Family Systems Approach

- You may use self-report standardized tools:
  - *Family Needs Survey*
  - *Parents Needs Inventory* (Fewell, Meyer, & Schell, 1981; Goldfarb, Brotherson, Summers, & Turnbull, 1986).
- Concludes by prioritizing the needs and their accompanying sources of support.
  - *Needs by Sources of Support and Resources Matrix* (Dunst, Jenkins, & Trivette, 1984).

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# Treatment

- The higher the judged risk for suicide, the more intensive the treatment that is recommended.
- When is the risk of suicidal behavior and suicide greatest?

(Brent & Poling, 1997)

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# Treatment

- The higher the judged risk for suicide, the more intensive the treatment that is recommended.
- When is the risk of suicidal behavior and suicide greatest?
  - Immediately after discharge from the hospital.

(Brent & Poling, 1997)

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# Levels of Risk & Referral

| Level of Risk | Indicators of Risk |
|---|---|
| ***No Predictable Risk*** <br><br> (Hoff, 1995) | ▪ No history of a suicide attempt <br> ▪ No suicidal ideation <br> ▪ Close contact with significant others <br> ▪ Social support system is satisfactory |

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# Levels of Risk & Referral cont.

| Level of Risk | Indicators of Risk |
| --- | --- |
| **Low *Risk*** <br><br> (Hoff, 1995) | ▪ Suicidal ideation<br>▪ Low lethal suicide methods<br>▪ No history of suicide attempts<br>▪ No recent serious loss<br>▪ Personal or social resources are present but problematic<br>▪ Risk of an attempt, repeat attempt, and eventual suicide is high, depending on what occurs after the threat or attempt<br>▪ Risk is increased if drugs or alcohol are abused |

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# Levels of Risk & Referral cont.

| Level of Risk | Indicators of Risk |
|---|---|
| ***Moderate Risk***<br><br>(Hoff, 1995) | ▪ suicidal ideation<br>▪ high lethal suicide method with no specific threats or plan<br>-OR-<br>▪ low lethal suicide method with a suicide plan<br>▪ includes attempts in which the chance of rescue is precarious<br>▪ ambivalence is strong—life and death are seen as equally favorable<br>▪ risk for a repeat attempt and eventual suicide is higher than low risk if no life changes occur |

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# Levels of Risk & Referral cont.

| Level of Risk | Indicators of Risk |
| --- | --- |
| ***High Risk***<br><br>(Hoff, 1995) | ▪ current high lethal suicide plan<br>▪ obtainable means to complete suicide<br>▪ history of previous suicide attempts<br>▪ not able to communicate with a significant other<br>▪ lean more in the direction of death than life<br>▪ immediate and long-range risk of suicide is very high<br>▪ attempt would probably be fatal without rescue unless help is available and accepted immediately<br>▪ chronic self-destructive behavior increases risk even further |

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# Levels of Risk & Referral cont.

| Level of Risk | Indicators of Risk |
|---|---|
| ***Very High Risk***<br><br>(Hoff, 1995) | ▪ current high lethal suicide plan<br>▪ available means to complete suicide<br>▪ history of previous suicide attempts<br>▪ cut off from resources<br>▪ attempt would probably be fatal without rescue<br>▪ lean more in the direction of death than life<br>▪ immediate and long-range risk of suicide is very high unless help is available and accepted immediately<br>▪ chronic self destructive behavior increases risk even further |

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# Successful Treatment = Social Competency for Adolescents

- Is the ultimate harbinger of success.
  - School (behavioral & academic)
    - Are expectations appropriate?
    - Trouble concentrating.
  - Peers
    - Poor negotiating skills
    - Rejection resulting from poor self-esteem, unrealistic expectations, and overpersonalizing
      - Distortions about ability vs. actual skills deficits
  - Family

(Brent & Poling, 1997)

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