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Suicide “How To” Tips on Intervention

*Prepared by Susan Kelley Bancroft of
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Remember: Always respond in an open, non-judgmental manner. Be supportive and straight forward in your questions and responses.

Remember: Your listening skills, validation, support, feedback, reflection, crisis intervention skills, warmth and concern will be the foundation to work with suicidal individuals.

Remember: React/respond to the individual, their feelings and not to the possibility of the suicide.

Remember: You are RESPONSIVE to, not RESPONSIBLE for, the people you work with. You are there to offer HOPE, CARING, and ALTERNATIVES. Having done this, it is up to the suicidal individual to choose.



Some Common Characteristics of Suicidal People:

- A.** A feeling of hopelessness – sees the situation as intolerable and feels helpless to change it.
- B.** Feelings of hopelessness – sees the situation as having no solution, therefore, is unable to change it.
- C.** The individual experiences ambivalence – feels like dying but likes living at the same time. Ambivalence is the key in the intervention process. You must offer hope and strength to the side that wants to live, but also hear and understand the part seeking relief in the form of death. NEVER deny or ignore the side that wants to die. This will make the individual defensive and he/she will withdraw.
- D.** Suicide is rarely a spontaneous activity. It is usually a long drawn out process of depression and loss of ability to cope with stress, disappointment, etc.

Some Verbal and Behavioral Clues to Suicide Risk:

Remember: Any one clue does not equate suicide BUT a cluster of clues definitely warrants caution and intervention.

Suicidal individuals give clues of their intent. These are verbal, blatant or coded, and behavioral messages we, as helpers, can listen for or be aware of.

VERBAL:

- A. I'm going to kill myself
- B. My family would be better off without me.
- C. I can't go on any longer.
- D. I'm going on a trip\going to leave.
- E. Please tell my family good-bye.
- F. I wish I'd never been born.
- G. You're going to be sorry when I'm gone.
- H. I want to go to sleep and never wake up.

BEHAVIORAL:

- A. Some abrupt behavior change, in appearance, socialization, use\non-use of alcohol\drugs, use of money, lessening of caution in dangerous situations.
 - B. A previous suicide attempt.
 - C. Giving away prized possessions.
 - D. Putting business affairs in order.
 - E. Quick, unexpected recovery from deep depression.
 - F. A suicide note (some are written way before the attempt), death related poems\stories\essays\journal entries.
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ASSESSMENT OF LETHALITY

Most suicidal individuals have plan of action. The more developed the plan the more immediate the danger.

- A. You need to know the individual's plan of action – need to know how detailed this plan is.
- B. You need to know if the method is immediately available. The more available the method, the more danger there is. If the method is easily accessible, work on having the individual rid themselves of the means at hand. Example – flush pills down the toilet, unload a gun, lock knives in a safe place, etc.
- C. You need to know how lethal the method is. The more lethal the less rescue time available.
- D. You need to assess if the individual is aware of the lethality risk involved. This will help gauge the intent and knowledge of the danger.
 - 1. Does the individual expect the pills to kill him\her (higher risk), know the pills won't complete the attempt, or is leaving it all up to chance (lower risk)?

2. Is there a possibility of someone intervening and is this known to the client? If they aid in their own rescue, the risk is lower.
- E.** If a previous suicide attempt has occurred you will need to know all the information listed above in addition to how long ago the attempt took place.
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ALTERNATIVES – HOPE\ACTION:

- A.** You will, in most cases, get to know the persons pretty well. What you learn about their life and their lethality risk will help you look at alternatives.
- B.** Look at and give support to the individual's strengths. Re-vitalize their own inner resources (prior successful coping strategies, etc.).
- C.** The individual's support system is important. Find out the people who make-up this system (friends, relatives, co-workers, therapists, psychiatrist, doctor, minister). If appropriate, get this system involved.
 1. This support system can provide further support: emotional, spiritual, medical, therapeutic.
 2. This support system can provide physical contact.
 3. This support system can help the individual when they need to be involved in the medical\mental health system – transportation\support to the doctor's office, to mental health outpatient agencies etc.
- D.** You as a support system. Make yourself available. This is usually in the form of a suicidal contract, which can be loosely structured or very specific. The higher the lethality, the more specific the contract needs to be.
 1. Contract to see how they are doing.
 2. Contract to see how the medical\mental health appointment came out.
 3. The contract gives the individual time to trust someone again.
 4. The contract gives the individual extra support while they are in therapy.
 5. The contract gives the individual time to think over other alternatives besides suicide.
 6. The contract gives the individual help through some time span until their usual support system is available again.
 7. REMEMBER YOU ARE NOT ALONE!

THE MYTHOLOGY OF SUICIDE

Prepared by Mary Miller – Center for Information on Suicide

MYTH–People who talk about killing themselves rarely commit suicide.

FACT–Most people who commit suicide have given some clue or warning of their intent; therefore, suicidal threats and attempts should always be treated seriously.

MYTH–The tendency toward suicide is inherited and passed from generation to generation.

FACT–Although suicide does tend to “run in families,” it appears that it is not transmitted genetically.

MYTH–The suicidal person wants to die and feels that there is no turning back. FACT–Suicidal people are often ambivalent about dying and frequently will call for help immediately following an attempted suicide.

MYTH–All suicidal people are deeply depressed.

FACT–Although depression is often associated with suicidal feelings, not all people who kill themselves are obviously depressed. In fact, some suicidal people appear to be happier than they’ve been in quite a while because they have decided to “resolve” all of their problems at the same time.

MYTH–There is a very low correlation between alcoholism and suicide.

FACT–Alcoholism and suicide often go hand in hand. Alcoholics are prone to suicide and even people who don’t normally drink will often drink shortly before killing themselves.

MYTH–Suicidal people are mentally ill.

FACT – Although many suicidal people are depressed and distraught, most of them couldn’t be diagnosed as mentally ill.

MYTH–If someone attempts suicide, he will always entertain thoughts of suicide.

FACT–Most people who are suicidal are so for only a very brief period in their lives. If the attempter receives the proper assistance and support, he will probably never be suicidal again. About ten percent of attempters later complete the act.

MYTH–If you ask a person about his suicidal intentions, you’ll encourage the person to kill himself.

FACT–Actually, the opposite is true. Asking someone directly about suicidal intent will often lower the anxiety level and act as a deterrent to suicidal behavior by encouraging the ventilation of pent-up emotions.

MYTH – Suicide is quite common among the lower classes. FACT – Suicide crosses all socioeconomic groups and no one class is more susceptible to it than another.

MYTH–Suicidal people rarely seek medical attention.

FACT – Research has consistently shown that about 75% of suicidal people will visit a physician.

MYTH–Suicide is basically a problem that is limited to young people.

FACT–Suicide rates rise with age and reach their peak among older white males.

MYTH-Professional people don't kill themselves.

FACT-Physicians, lawyers, dentists, and pharmacists appear to have high suicide rates.

MYTH-When a depression lifts, there is no longer any danger of suicide.

FACT-The greatest danger of suicide exists during the first three months after a person recovers from a deep depression.

MYTH-Suicide is a spontaneous activity that occurs without warning.

FACT-Most suicidal people plan their self-destruction in advance and then present clues indicating that they have become suicidal.

MYTH-Because it includes the Christmas season, December has a high suicide rate.

FACT-There is not a rash of suicides at Christmas and December has the lowest suicide rate of any month.

Survivors Reactions and Feelings to a Suicide

1. Strong feelings of loss, accompanied by sorrow and mourning.
2. Strong feelings of anger for:
 - a. Being made to feel responsible for
 - b. Being rejected (e.g., what was offered was refused).
3. Guilt, shame or embarrassment with feelings of responsibility for the death.
4. Feelings of failure or inadequacy that what was needed could not be supplied.
5. Feelings of relief that the nagging, consistent demands have ceased.
6. Feelings of having been deserted, especially true for children.
7. Ambivalence with a mixture of all of the above.
8. Reactions of doubt and self-questioning whether enough was attempted.
9. Denial that a suicide has occurred, with possibility of conspiracy of silence among all concerned.
10. Arousal of one's own impulses toward suicide.

It is not necessary for the officer to respond to all of these feelings, but he/she should be aware of their existence and be sensitive to them. This will allow him/her to complete his/her responsibilities more quickly, and avoid any unnecessary confrontation with family members whom he/she view as obstructing his/her investigation.