

ABCT.ORG
BRIEFING BOOKS

SUICIDE

ACROSS THE LIFESPAN



Edited by

RITA HITCHIING

ABOUT ABCT

ABCT is dedicated to bridging communication between scientific and clinical members and the media as well as the public.

We do that in a few ways by

- respond to media inquiries about CBT-related topics by connecting interested journalists, writers, and producers with relevant ABCT experts.
 - develop initiatives to assist ABCT members in communicating with the public about science and evidence-based practice. Possible video.
 - develop resources to help communicate with the media for ABCT members, journalists, and the public at large if we offered compendiums of relevant resources ("Briefing Books") that provide information about the current science presented in layman's terms.
-



SUICIDE ACROSS THE LIFESPAN





ABCT MISSION

The Association for Behavioral and Cognitive Therapies (ABCT) is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based

principles. ABCT is committed to a policy of equal opportunity in all of its activities, including employment. ABCT does not discriminate on the basis of race, color, creed, religion, national or ethnic origin, sex, sexual orientation, gender identity or expression, age, disability, or veteran status.

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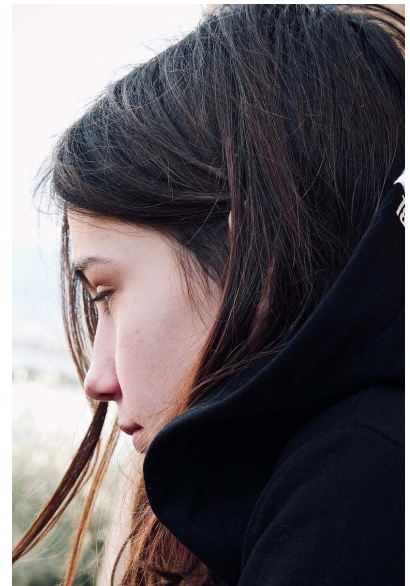
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CONTRIBUTORS

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Our organization is strengthened by your contribution and commitment to supporting our mission and vision. The wider community benefits daily from your efforts to support evidence based research and your commitment to those in your care.

in gratitude

YOUTH 5 TO 24 YEARS



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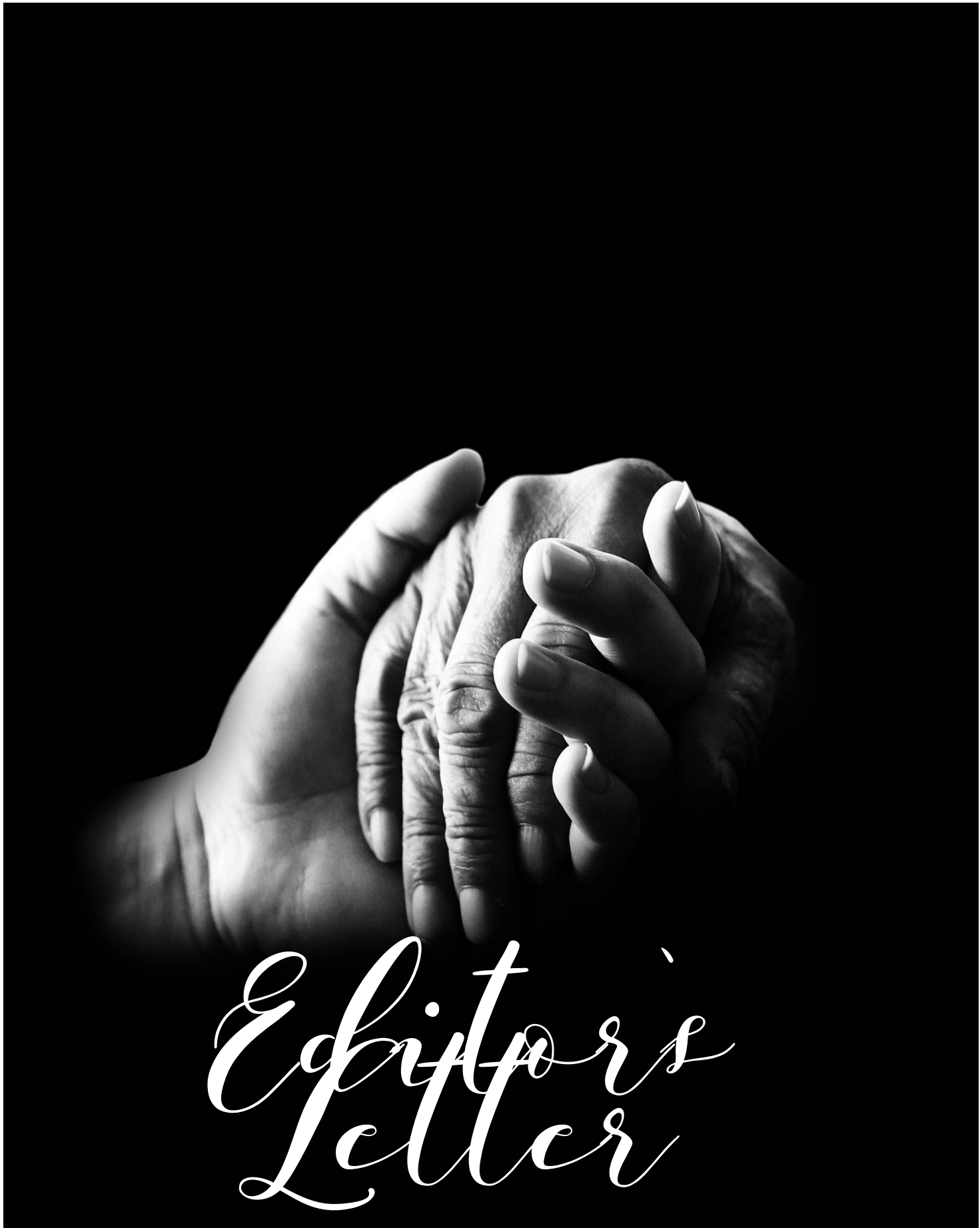
Rita Hitching, M.Sc.

WELCOME

Welcome to inaugural Briefing Books (BB) initiative. The BB initiative is an effort by the Association for Behavioral and Cognitive Therapies (ABCT) to provide easily accessible information on a range of temporally sensitive topics that affect everyone. This year we are including the coronavirus pandemic and its possible impact in the wellbeing of our community. In future, ABCT will look to add additional topics in the coming months and years.

WHY SUICIDE

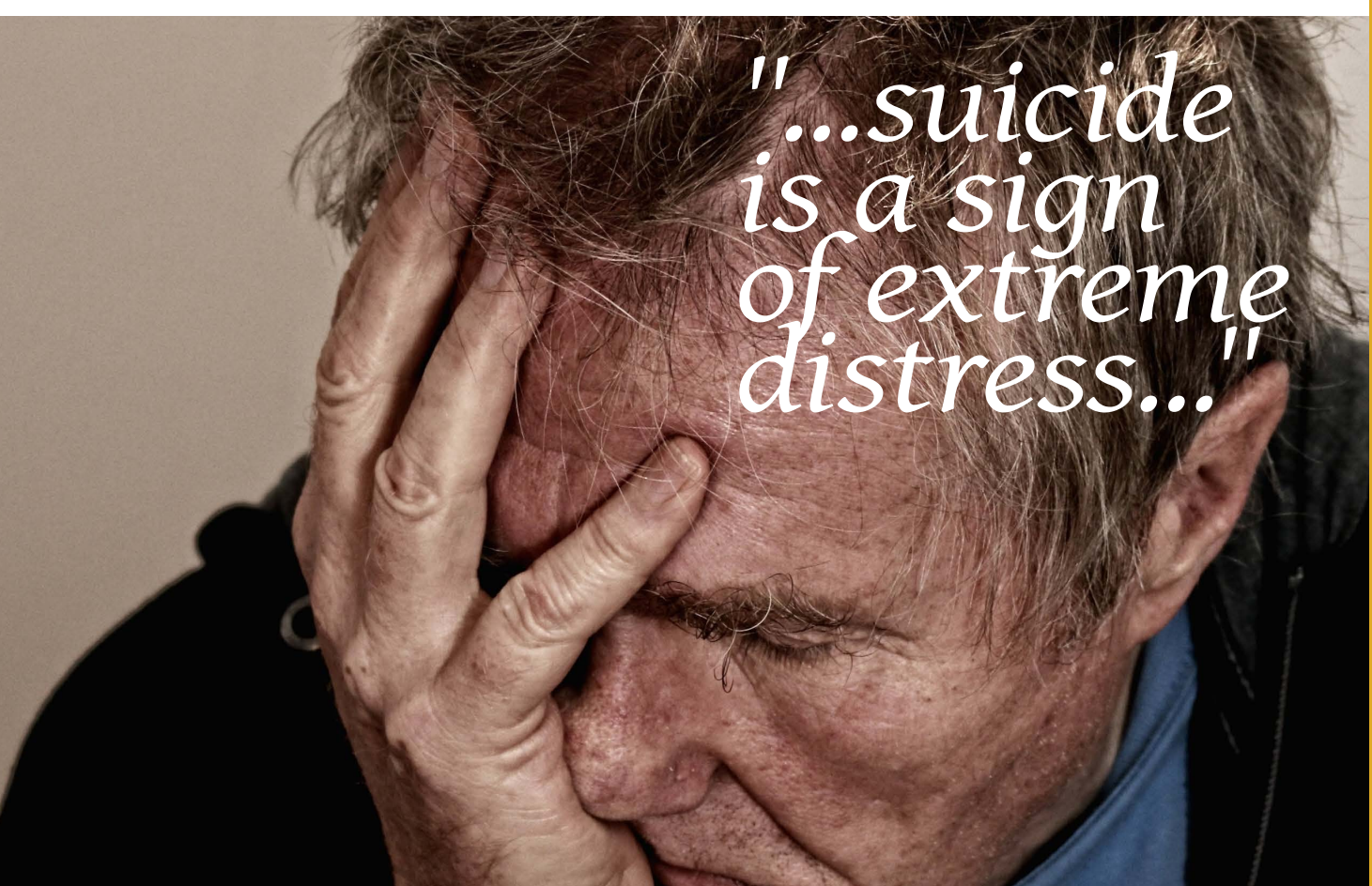
Our first Briefing Books (BB) issue is being released at a time when our society is experiencing an unprecedented level of stress. The global coronavirus pandemic has led to a substantial increase in the number of people experiencing anxiety and depression; in addition, 2020 has highlighted many social injustices and inequities. Emotionally demanding circumstances, persistent stress, and depression are strong risk factors for suicide. Consequently, we decided to focus our first BB initiative on death by suicide. When someone ends their own life, the impact is felt by family, friends, and the entire community, and often, long after the event.



SUICIDE
OVERVIEW

The suicide rate in the U.S. has been steadily increasing over the past 2 decades, 31% since 2001. In 2018 alone, more than 48,000 Americans died by suicide. For every suicide that is completed, 25 other individuals will make a suicide attempt. That means that there are more than a million suicide attempts annually. Suicide is a leading cause of mortality, and its impact is wide-reaching. Serious physical or brain injuries may occur as a consequence of a suicide attempt, and it may precipitate or exacerbate mental health concerns. The National Institute of Mental Health (NIMH)

defines suicide as an intent to die as a result of self-injurious behavior; and a suicide attempt as self-injurious behavior, with the intention to die, but that was not -fatal. Suicidal ideation and intent refers to the thought processes associated with the desire to die by suicide and any planned behavior to that end. In the US, on a typical day, 93 people end their lives through suicide, with 20 of those being Veterans. Suicide is the 2nd leading cause of death among those aged 10-34, and the 4th leading cause in those aged 35-54 years.



*"...suicide
is a sign
of extreme
distress..."*

Across all age groups, suicide is the 10th leading cause of death. The National Institute of Mental Health (NIMH) in conjunction with the National Action Alliance for Suicide Prevention (NAASP) have pledged to reduce the US suicide rate by 20% by 2025. The NIMH and NAASP are hoping to meet their target reduction by recommending frequent screening and assessment of risk of death by suicide across all age groups, even in cases of minimally suspected risk. It is estimated that 75% of all Americans who attempt suicide visit their healthcare professional in the preceding month, and increasing screening

seems like an important step in suicide prevention. Research shows that the addition of suicide screening at all emergency care settings as part of standard care has led to a twofold increase in risk detection. Suicide is a complex behavior. Some sections of the populations are at higher risks than others, and no single cause or explanation is currently available for why people attempt suicide.

*"...suicide
occurs
in every
country in
the world..."*





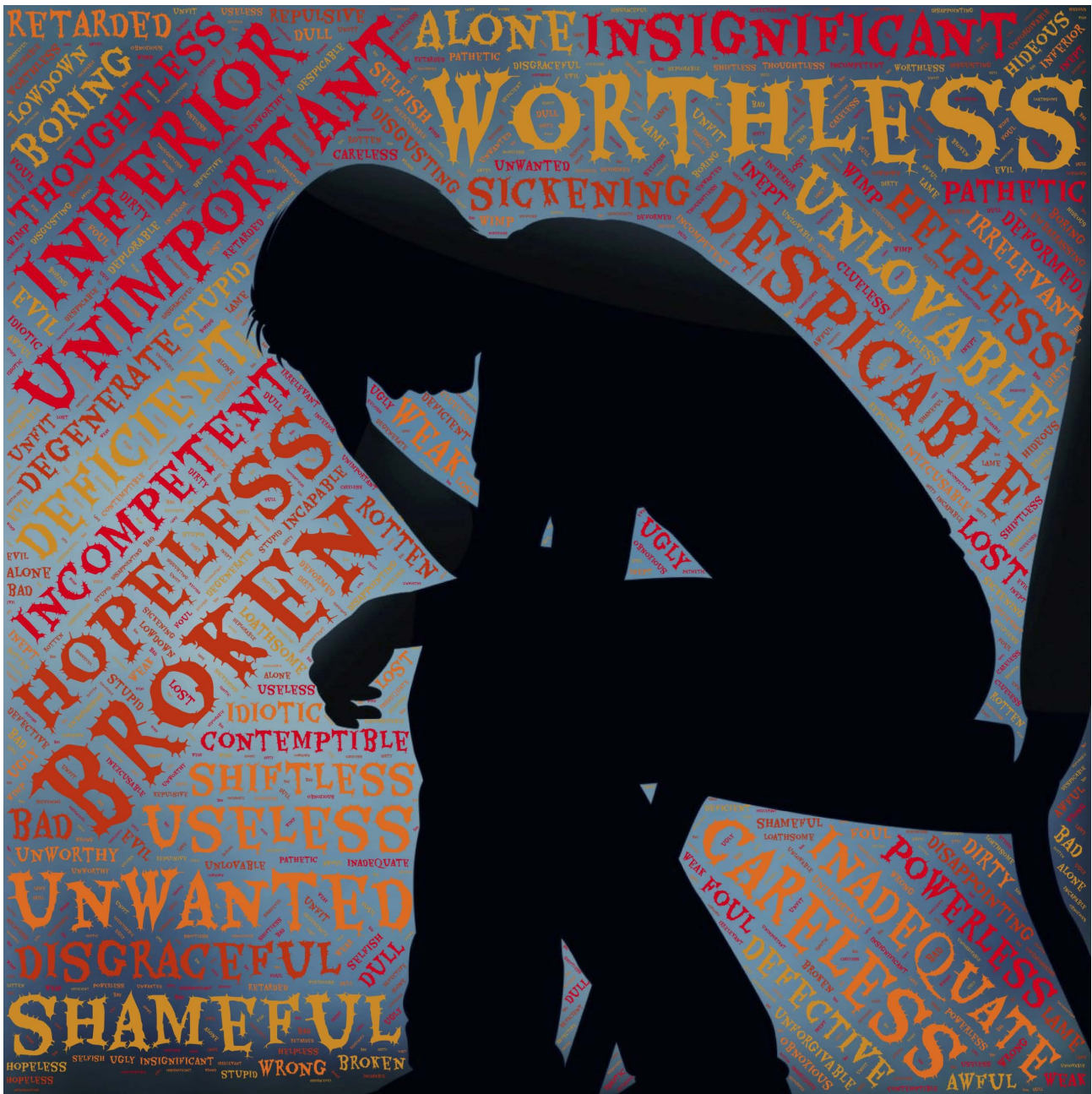
SUICIDE MULTIPLE RISK FACTORS

Research suggests that there are many risk factors for death by suicide, including:

- A psychiatric disorder, such as depression, substance abuse or family history of those conditions;
- Prior suicide attempt or family history of suicide;
- Exposure to suicidal behavior by peers and celebrities;
- History of family violence, trauma, including physical and sexual abuse;
- Chronic pain and certain medical conditions;
- Recent release from prison;
- Access to lethal means, including firearms in the home.

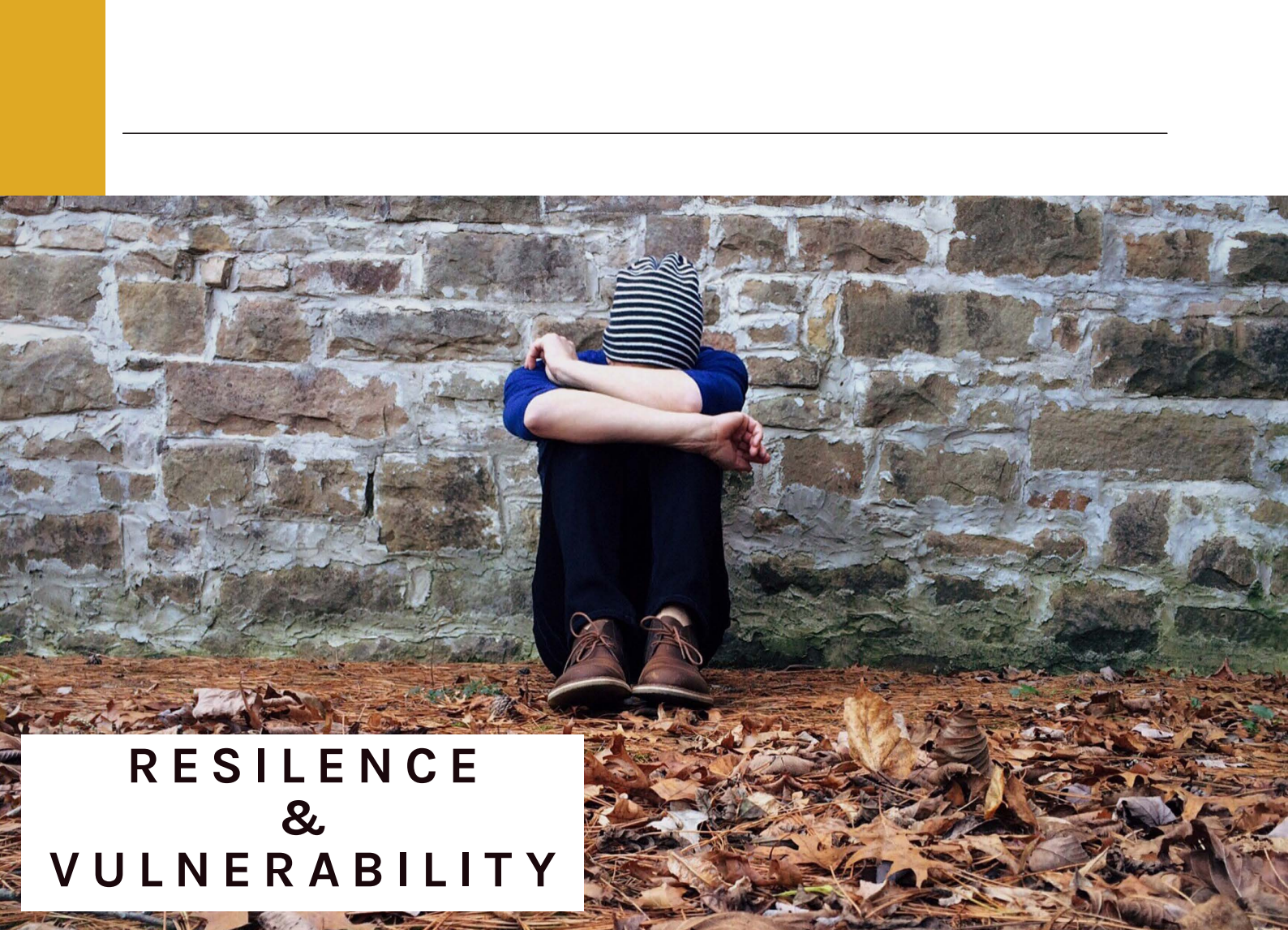
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stressful events, individual resilience and vulnerability differences, personal history, potential trigger events, such as loss or exposure to other's suicide, can further increase someone's risk for suicide. Suicide most often occurs when stressors outweigh a person's ability to cope, particularly in individuals with a mental health condition. Approximately 90% of people who died by suicide have a co-occurring mental disorder; such as depression, substance abuse, and PTSD. Suicide



risk and prevention is complex, and varies across the lifespan; thus, we present on the risks, assessment, and treatment options across several different developmental age-bands. The difference in the incidence of suicide between adolescents (17.2%), young adults aged 18-25 (11%), and adults has influenced our decision to present the information in age cohorts. The suicide rate in pre-teens, those aged 10 to 14

years is on the rise, and is the 2nd leading cause of death of cause in that age group, surpassing road traffic accidents as the main cause of death. The highest rates of suicide are in adults between the ages of 45 and 64 (19.3%) and among those 85 years or older (19.2%). Gender plays a significant role in suicide with 10.2% of females aged 45 to 64 years and 39.9% of males aged 85 years and older dying by suicide.



RESILIENCE & VULNERABILITY

Suicide rates are 3.5 times more common in men than in women, and white males make up approximately 70% of suicide deaths. Overall, males are more likely to die by suicide; however, females attempt suicide more often than men. The typically more lethal means, such as suffocation and firearms, used by males (compared to the use of poisoning by females) likely accounts for the greater incidence of suicide deaths among men. While white, older males have the highest rate of death by suicide, among minority ethnic groups American

Indians and Alaskan Natives tend to have the highest rate of suicide. African Americans and Hispanics tend to have the lowest rates. The most frequent method of completed suicide is by firearms, which account for almost half of suicides. In the geriatric population, the estimate is 4 suicide attempts for every 1 death by suicide. Given the high rate of lethality of suicide attempts among this population, and the high prevalence in older males, informed our decision to include a section for older adults. Between 2005 and 2017, the rate of suicide by

firearm increased by 33% for Veterans and 23% for non-veterans. In 2017, 69.4% of Veterans who died by suicide used a firearm. In addition we have incorporated special populations, such as those with a history of trauma, or chronic/ life threatening illness. Research has shown that lesbian, gay, and bisexual youth are 47% more likely to attempt suicide than straight identifying youth. Transgender adults have a 12-fold increase in suicide attempts, compared to other adults. In order to accommodate for the unique experiences of this population we have included a section on sexual and gender minorities. We have a section devoted to Veterans due to their unique experiences. The

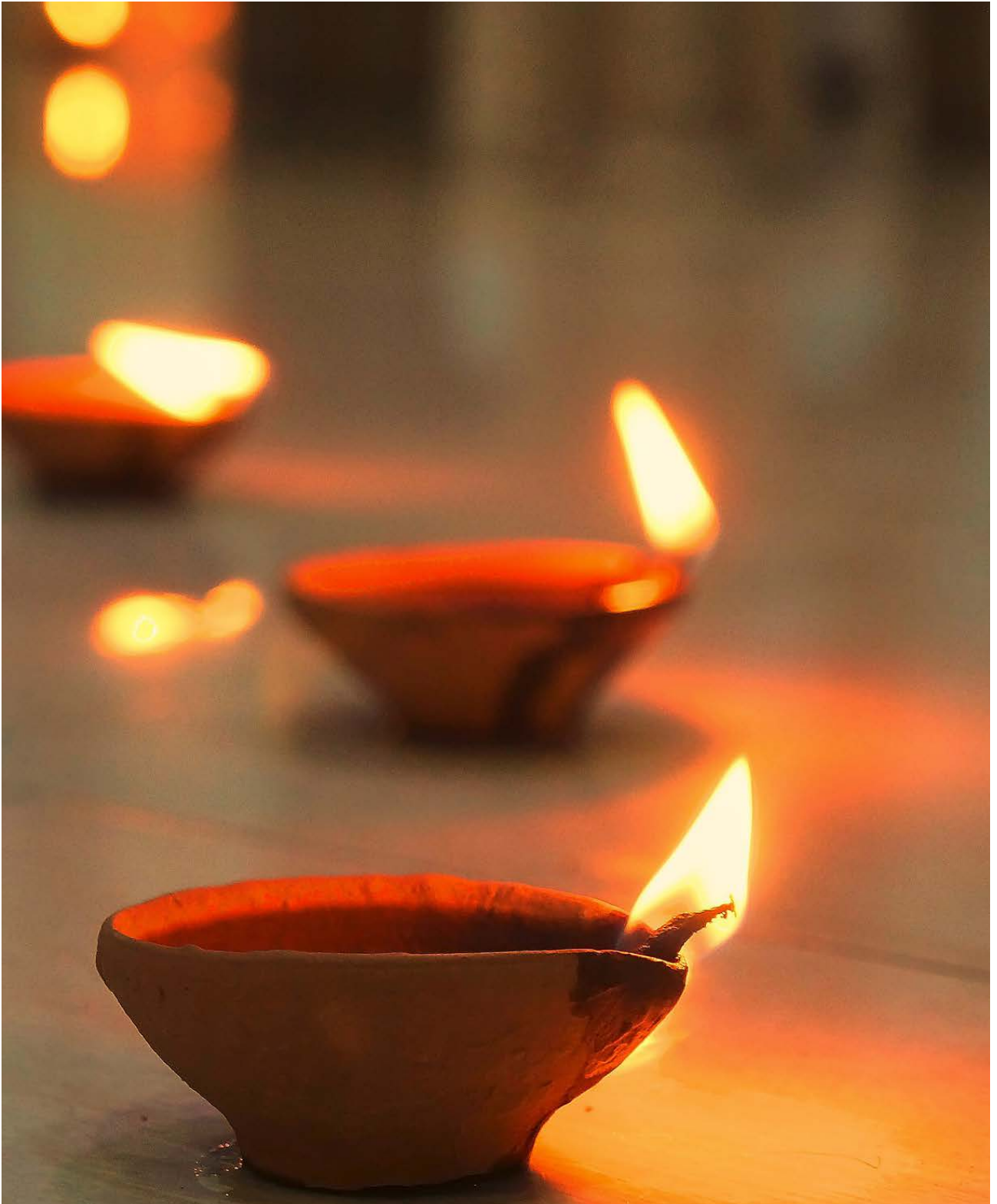
inclusion of non-suicidal self-injury is intended to round off the consideration of risk factors that are not suicidal per se, but may be precursors to suicide. Not everyone who attempts suicide has known risk factors, and suicidal thoughts and behavior should not be ignored. Suicide is a sign of extreme distress, and not a normal response to stress. There is no evidence that discussing or asking about suicidal ideation cause an increase in suicidal risk. Research shows that asking about suicidal ideation decreases the risk of suicidal behavior, and has been shown to contribute towards improvements in mental health in those seeking treatment.



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Rita Hitching



*only in darkness can
you see the stars*

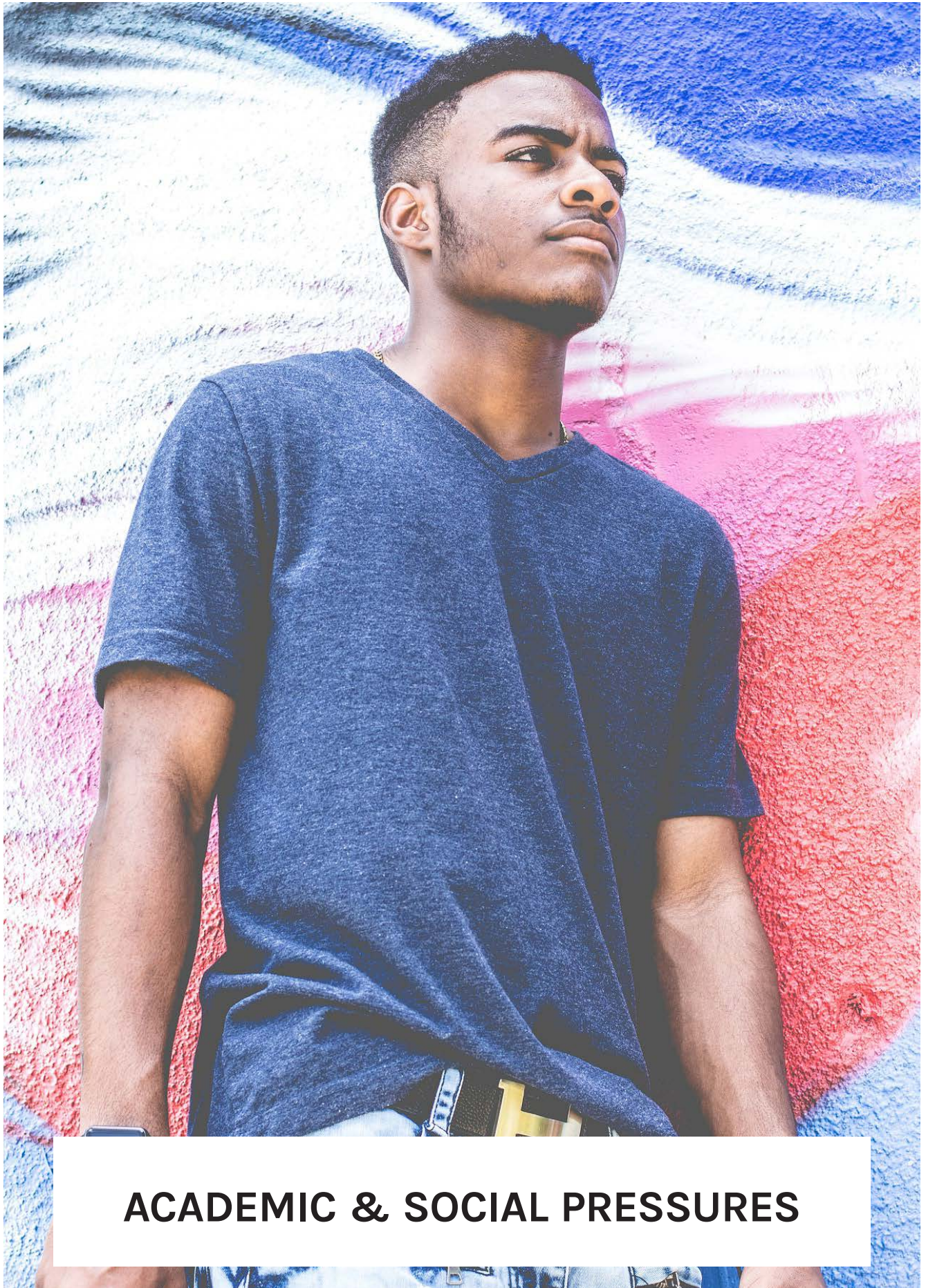
YOUTH SUICIDE

Adolescence is a developmental period characterized by key emotional, social, and biological changes. Adolescents exhibit increased sensitivity to their environment, which assists them in gaining the necessary skills to transition to adulthood, but it may also lead to increased vulnerability to stressors, as is reflected in the increased rates of self-injurious thoughts and behaviors during

this time. Indeed, suicide is the second leading cause of death among US adolescents with rates steeply increasing from late childhood through early adulthood. Research indicates large increases in thoughts of suicide (i.e., suicidal ideation) and self-harm during this time. Cumulatively, suicidal thoughts and behaviors are associated with immense suffering as well as substantial healthcare costs estimated to exceed \$40 billion annually in the U.S.



**ADOLESCENCE A TIME OF ENORMOUS
BIOLOGICAL & EMOTIONAL CHANGE THAT
INCREASES VULNERABILITY TO STRESSORS**



ACADEMIC & SOCIAL PRESSURES



PREVALENCE

Adolescence is a vulnerable period for suicide risk. During this developmental stage, youth experience significant social, environmental, and physical changes. As adolescents strive to become more independent, they spend less time with parents and more time developing peer and romantic relationships. Adolescents often experience more peer-related stressors, such as break-ups and bullying. Academic pressures, including increased workload and focus on

grades, also rise during the transition to adolescence. These added stressors can increase risk for mental health concerns, including depression and suicide. In addition, adolescence is characterized by rapid changes in the brain and body, affecting how teens respond to stress. Compared to younger children and adults, adolescents are more sensitive and reactive to social and emotional cues, due in part to neurobiological changes in puberty.

RISK ASSESSMENT

1. Risk and protective factors

Prior history of suicidal thoughts and behaviors

2. Current passive suicidal ideation

“How often have you thought about wanting to die?”

3. Current active suicidal ideation

“How often have you thought about killing yourself?”

4. Thoughts of methods

“How often have you thought about how you would kill yourself?”

What methods have you thought of using?”

5. Thoughts of methods

“What plans have you made for killing yourself?”

"What steps have you taken to prepare?"

"Have you thought about when and where you would kill yourself?"

6. Suicide plans or preparatory behaviors

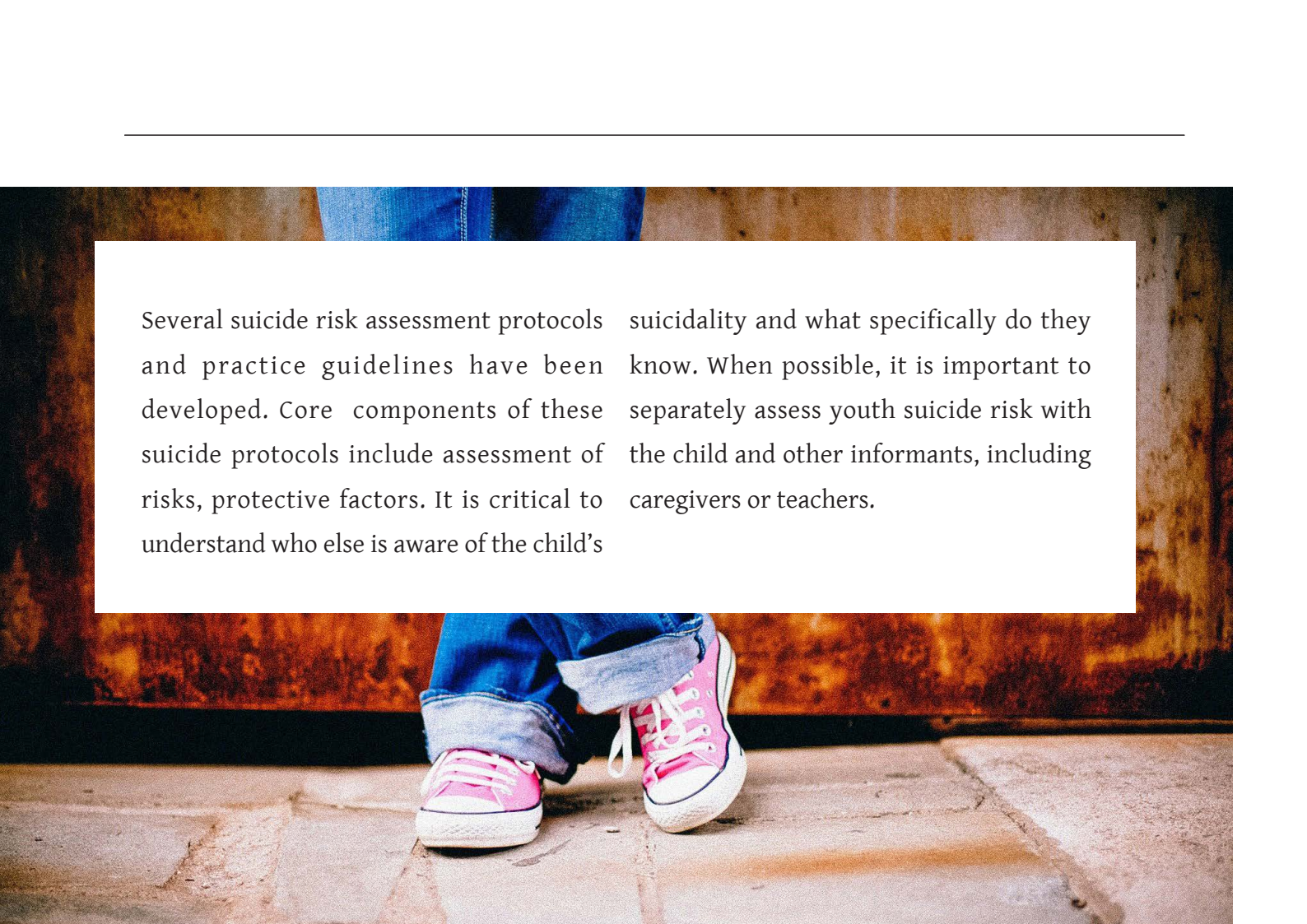
“How likely are you to act on thoughts of killing yourself?”

7. Intent

Do you have access to e.g., guns, pills, razors, etc.?”

UNDERSTAND WHO
ELSE IS AWARE OF
SUICIDAL PLAN OR
INTENT





Several suicide risk assessment protocols and practice guidelines have been developed. Core components of these suicide protocols include assessment of risks, protective factors. It is critical to understand who else is aware of the child's

suicidality and what specifically do they know. When possible, it is important to separately assess youth suicide risk with the child and other informants, including caregivers or teachers.

RISK & PROTECTIVE FACTORS

However, the brain regions responsible for self-regulation (i.e., the prefrontal cortex) do not fully mature until early adulthood. Therefore, some adolescents have a harder time exerting control in distressing situations, increasing risk for suicide. It is important to note that risk for suicidal behaviors are not uniformly distributed across US youth. In terms of age, the prevalence of completed suicide increases 17-fold between

pre-adolescence (ages 10-14) and adolescence (ages 15-24) with females having higher rates of suicidal thoughts, self-injurious behavior, and suicide attempts as compared to males, but males having higher rates of completed suicide as they tend to use more lethal means. In young people aged 10 to 24 years, suicide is the 2nd leading cause of death.



Friends Circle

Friends' suicidal ideation and behavior can also increase risk, due to contagion effects. A number of factors are protective for youth suicide, including access to treatment, individual assets (e.g., problem-solving ability, emotion regulation), and social support from family, peers, school and community.



Mental Health

Mental health conditions are known to increase risk, especially mood and depressive disorders, anxiety, substance abuse, and eating disorders, in addition to trauma (e.g., physical or sexual abuse). Stress is associated with a higher risk of suicidality in adolescents.



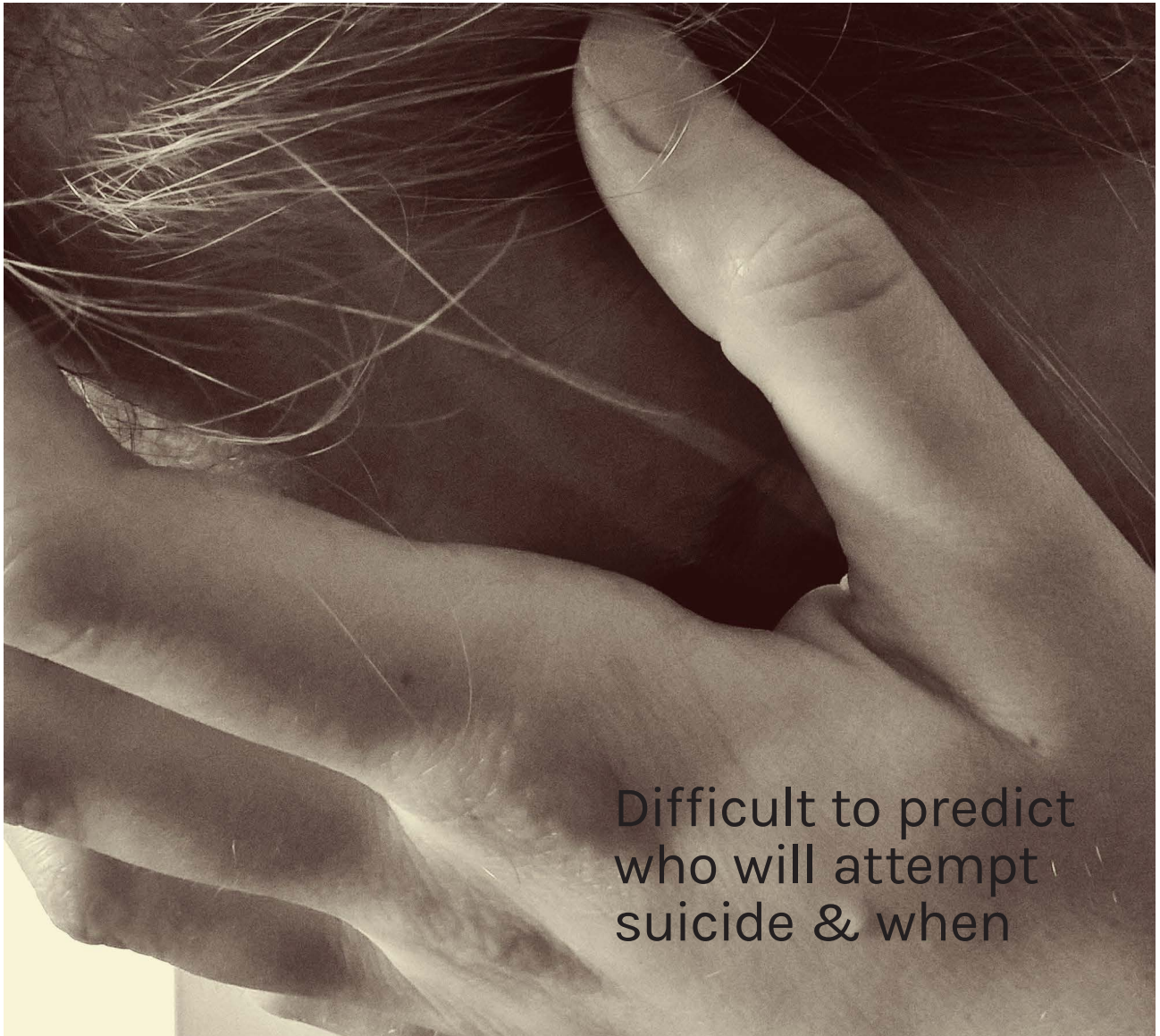
Life Events

For instance, negative life events, such as loss (e.g., death of a loved one, romantic relationship break-up, friendship termination), recent moves or relocations, and disciplinary crisis, are often linked to suicide risk in youth.



Family Issues

Family stressors, caregiver mental health, parent-child conflict, low family support, also increase risk for suicidal thoughts and behaviors. Further, peer- and school-related stress, social isolation, bullying, and academic difficulties, are particularly important for youth.



Difficult to predict
who will attempt
suicide & when

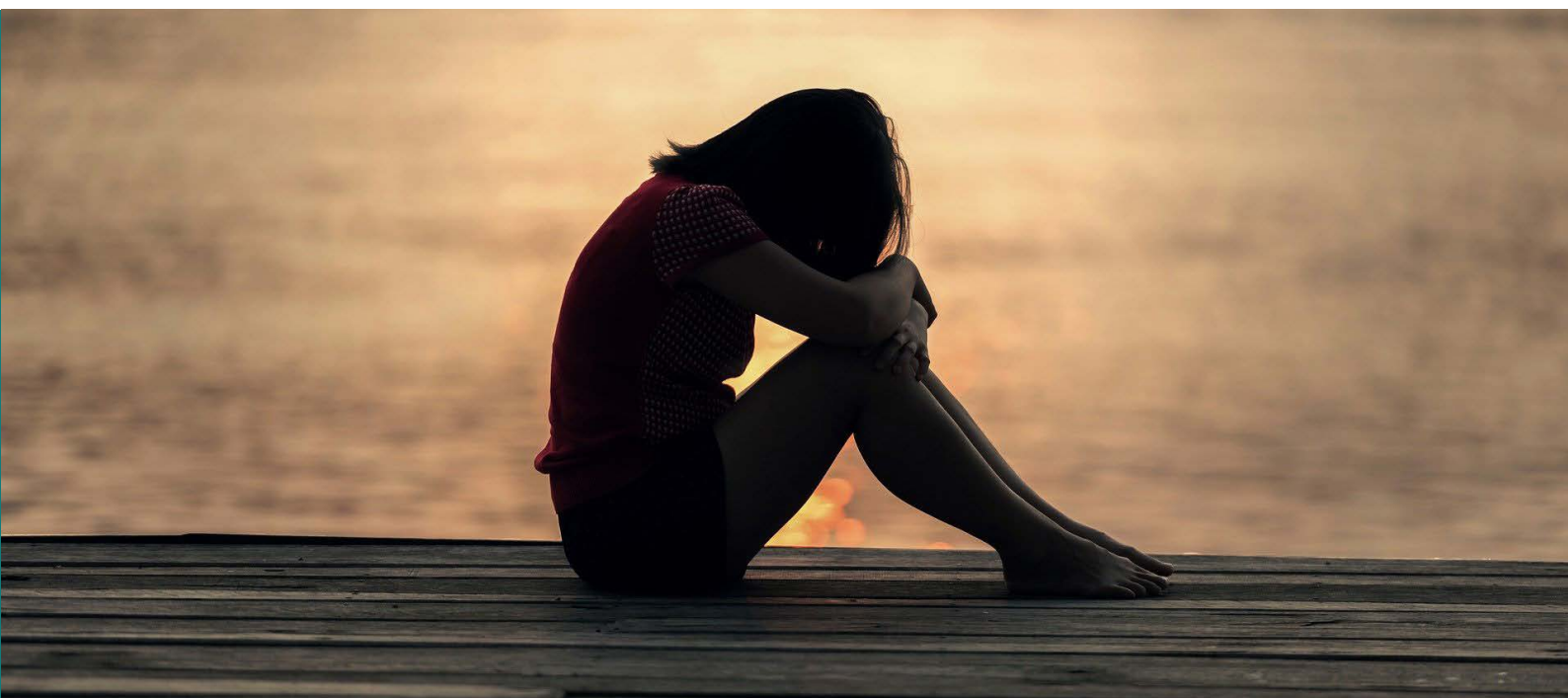
ASSESSMENT

Compelling data show that suicide risk screening or assessment does not increase risk in youth, and may even protect youth who are having thoughts of suicide. A number of evidenced based tools are available for psychologists engaging in suicide risk assessments with youth. Many professional

organizations, including the American Association of Suicidology, American Foundation for Suicide Prevention, and Suicide Prevention Resource Center, provide resources for clinicians and families. A variety of tools have also been validated for screening and measuring suicide.



**Prior suicidal
behavior or
non-suicidal
self-injury
are the best
predictors of
youth suicide**



TREATMENT

When youth report suicidal thoughts or behaviors, it is essential to develop a safety plan. Typically, plans include strategies that aim to prevent and manage youth's suicidal thoughts and urges. With younger children, safety plans are developed with the child in conjunction with family and other caregivers. With older adolescents, safety plans may be created only with the adolescent. The plans are then

reviewed with family and other caregivers to discuss ways to support the teen. A variety of empirically validated safety planning protocols are available. Youth experiencing acute suicidal thoughts and behaviors are encouraged to call 911 or go to the nearest emergency department. Once seen in the emergency room, youth are assessed and triaged to the appropriate level of care. Inpatient hospitalization may be required when there is a concern about a youth's immediate safety.

Core components of safety plans include:

Warning signs: A safety plan includes a list of youth's personal warning signals, including thoughts, behaviors, situations, or emotions, that often precede a suicidal crisis.

Coping skills: A set of coping strategies that youth find helpful, such as specific music, TV shows, sports, or hobbies.

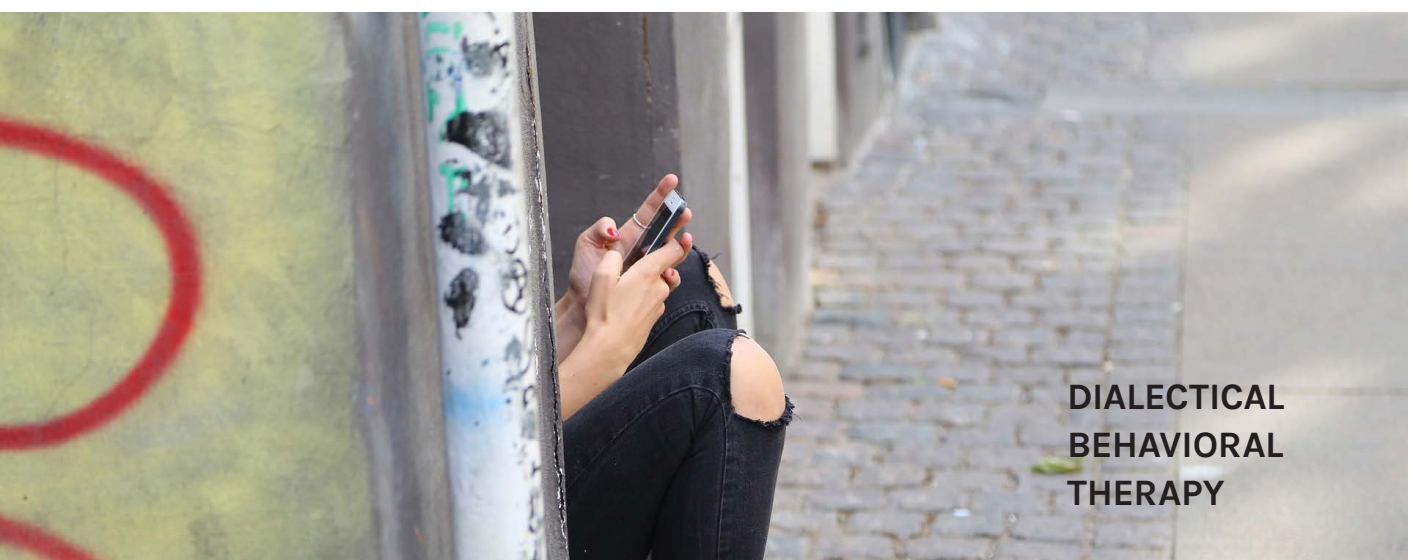
People and places: A list of people or places that can help distract from suicidal crises and help youth feel better.

Adult youth help list: Create a list of trusted adults to ask for help during a suicidal crisis, such as family members, school personnel, or religious leaders.

Mental health services: Services for mental health youth can contact during a crisis. May include youth's therapists, psychiatrists, the National Suicide Prevention Lifeline or text-based crisis intervention services. The Trevor Project also offers phone and text-based crisis services for LGBTQ youth.

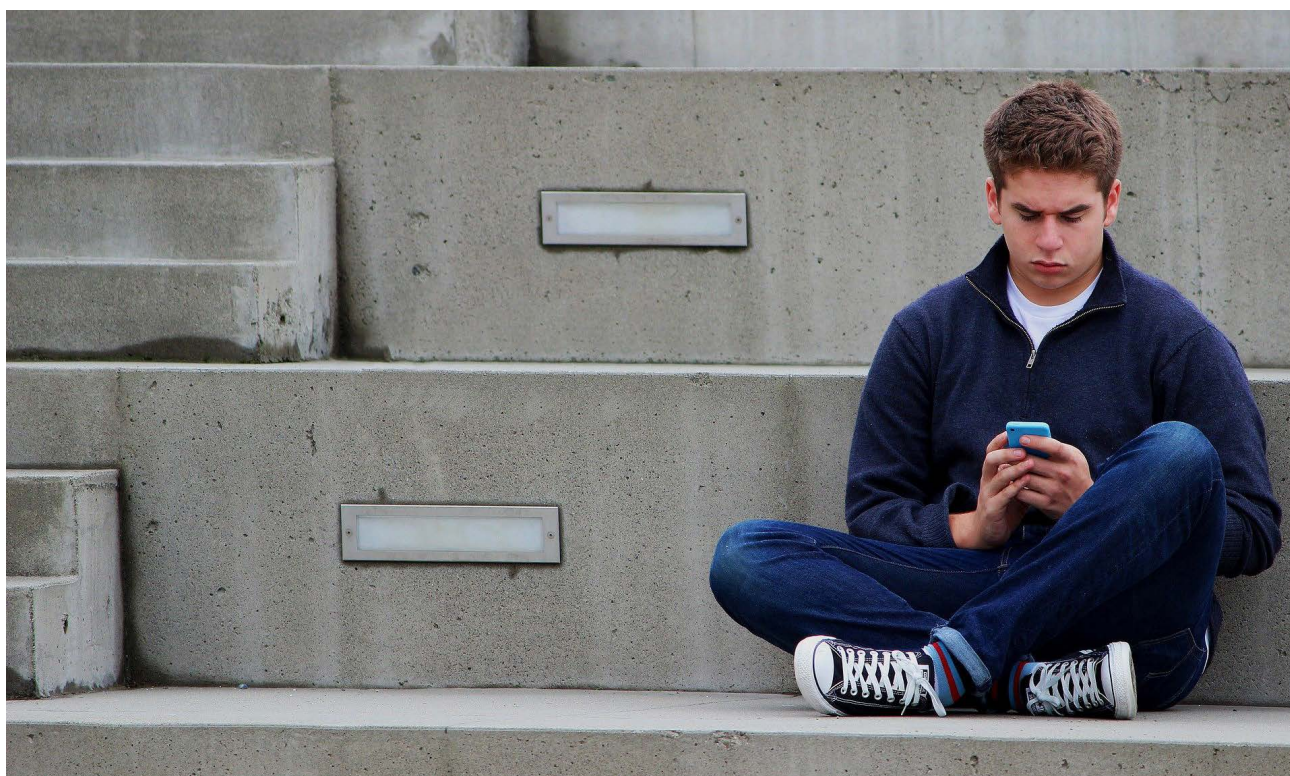
Limiting Access to means: Discuss how to make the environment safe by removing youth's access to means, particularly those associated with any specific suicide plans (e.g., removing firearms, storing sharp objects or medications in a locked box). Include caregivers, who can be coached on how to implement means restriction and monitor their child.

Reasons for living: Youth may also add a list of reasons for living, including people, pets, or future events that make life worth living.



Depending on symptom acuity, partial hospitalization, residential treatment, intensive outpatient services, or outpatient therapy may also be considered. Across treatment settings, cognitive-behavioral therapy (CBT) is considered the most efficacious treatment for youth experiencing suicidal thoughts and behaviors. One third-wave cognitive-behavioral treatment, Dialectical Behavioral Therapy for Adolescents (DBT-A), has shown promising results in treating suicidality in adolescents (ages 12-18). DBT-A includes weekly individual therapy, multi-family skills groups, in-the-moment phone coaching and therapist consultation. Treatment focuses on

decreasing self-harm behaviors, treatment and quality of life-interfering behaviors, and increasing behavioral skills across five domains: mindfulness, interpersonal effectiveness, emotion regulation, distress tolerance, and middle path skills. The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based treatment approach providing an interactive suicide-specific assessment and treatment between provider and patient to assess patient's current suicide risk.



YOUTH SUICIDE FAQs

Do teens attempt suicide as a way of getting attention?

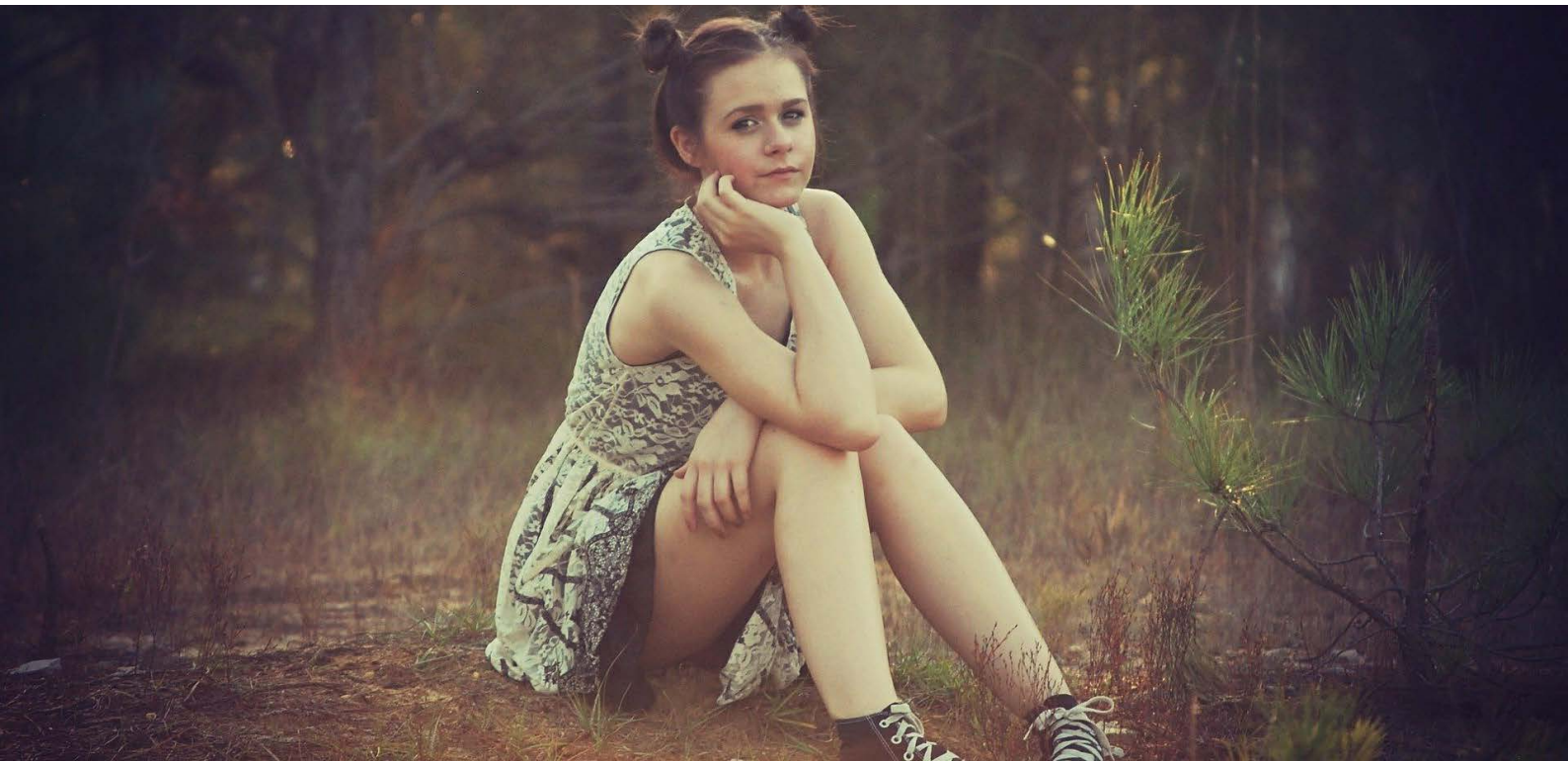
A person that considers death by suicide, irrespective of their age, are feeling deeply distressed and asking for help, not seeking attention. For many teens, stress, pressure to succeed, disappointment, loss, and self-doubt may seem unresolvable and suicide may seem like a solution to problems they cannot conceive of how to solve.

Are teens taking antidepressants at risk of suicide?

For children struggling with depression, or other type of psychiatric disorder, treatments are available. Antidepressants may be of type of effective treatment. It is not typically a first course of action but depending on the severity and the level of distress, antidepressants may be necessary. Antidepressants have not consistently shown to increase the risk of suicidal behavior or to more children dying from suicide.

Is mental illness the reasons why teens die by suicide?

Psychiatric disorders are common in adolescents that die by suicide or engage in suicidal behavior. Depression is the most common, with bipolar disorder and schizophrenia to a much lesser degree. Substance use is associated with psychiatric disorders, and children with a substance use disorder are at a greater risk of death by suicide. In younger children, suicidal behavior is often impulsive, and associated with sadness, anger, and confusion; in some cases ADHD and impulse control disorders are present.



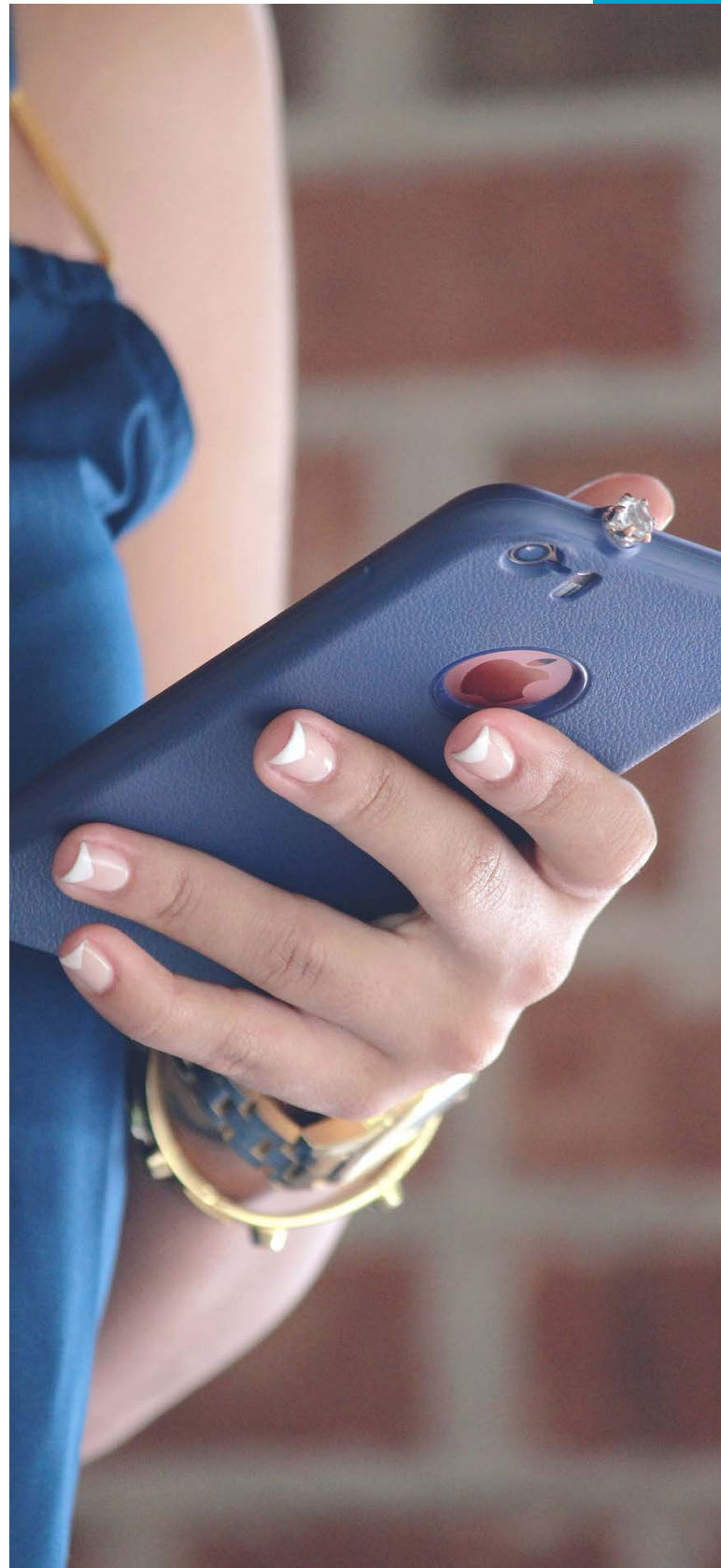
What roles does sexual orientation play in adolescent suicide?

Lesbian, gay, bisexual, and questioning youth are at an especially elevated risk for suicide compared to their heterosexual peers. The “coming out” experience is associated with an 8x increased risk when they experience negative family reactions or rejection. Transgender and non-binary youth are at greater risk than their cisgender peers. In terms of race and ethnicity, Native-American, Latinx, and White youth have higher rates of suicidal

thoughts and behaviors compared to other races, while Non-Hispanic youth tend to have higher rates of suicidal ideation and suicide attempts. Lastly, adolescence suicide risk begins to diverge during adolescence between youth living in urban and rural environments with this heightened suicide risk persisting across the lifespan for those living in rural areas. See more in details in the Sexual & Gender Minority Groups section.

Does technology play a role in suicide risk in adolescents?

In the last decade there has been massive public and scientific interest in the possible connection between technology use and youth mental health. While there were a number of initial high-profile studies depicting a strong association between technology use and adverse mental health outcomes amongst youth, more recent rigorous data indicate that the connection between technology use and youth mental health is more nuanced and likely determined by a multitude of factors including why and how youth are engaging with technology. Interestingly, the trend towards catastrophizing youth mental health during the introduction of new technologies is not a new phenomenon and has been repeated throughout history (e.g., introduction of the radio). While it may be tempting to cast a wide net and conclude that technology use negatively impacts youth mental health, current data does not support this view, and rather indicates that the how and why of technology use may be a more important indicator of risk as compared to general exposure to technology.



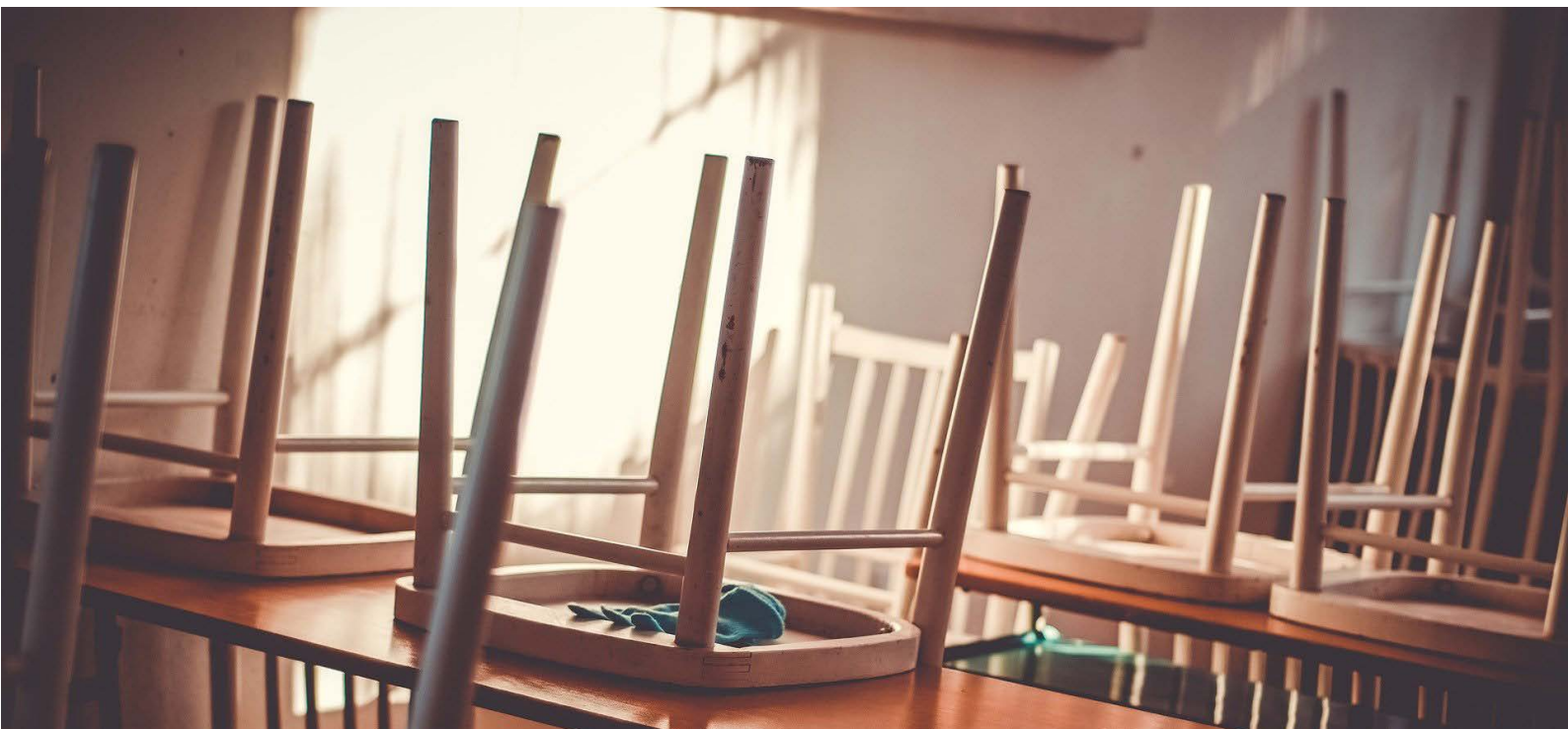


**SOCIAL MEDIA
& SUICIDE RISK**

Is cyberbullying linked to suicide in adolescents?

The advent of cyberbullying is one particular area of concern related to adolescent technology use that has been consistently shown to have negative impacts on adolescent mental health. Cyberbullying may be particularly deleterious, because unlike traditional bullying that is limited to school hours, technology use and the constant interaction with digital devices amongst adolescents (e.g., up to 9 hours per day on average) indicates that bullying is no longer limited to school hours and instead can occur at any time during the day and from the safety of one's own home. Recent meta-analysis findings in this area indicate that cyberbullying increases risk for self-harm, suicidal behaviors, suicide attempts, and suicidal thoughts by for those that were victims of cyberbullying. Perhaps surprising to some, those that perpetrated cyberbullying experience increase risk for suicidal behaviors and increase suicidal ideation as compared to those that did not perpetuate cyberbullying, which may be due to the fact that perpetrators of bullying tend to experience lower parental warmth, teasing, harsh discipline, violent conflict, and domestic violence in the home. In addition to cyberbullying, while the internet can be used

in beneficial ways as a means to receive social support and learn coping strategies, it can also lead to exposure to information related to suicide and self-harm that has the potential to normalize and trigger self-harm and suicidal behaviors, introduce new methods for self-harm and suicide, and discourage seeking professional help and discussing suicide-related thoughts. Furthermore, exposure to suicide-related materials has been associated with contagion effects during which there may be increased risk for suicidal behaviors. One well-known example can be found in popular television shows, such as Netflix's 13 Reasons Why, which was temporally associated with increased rates of youth hospital admissions for suicide above those that would be expected.



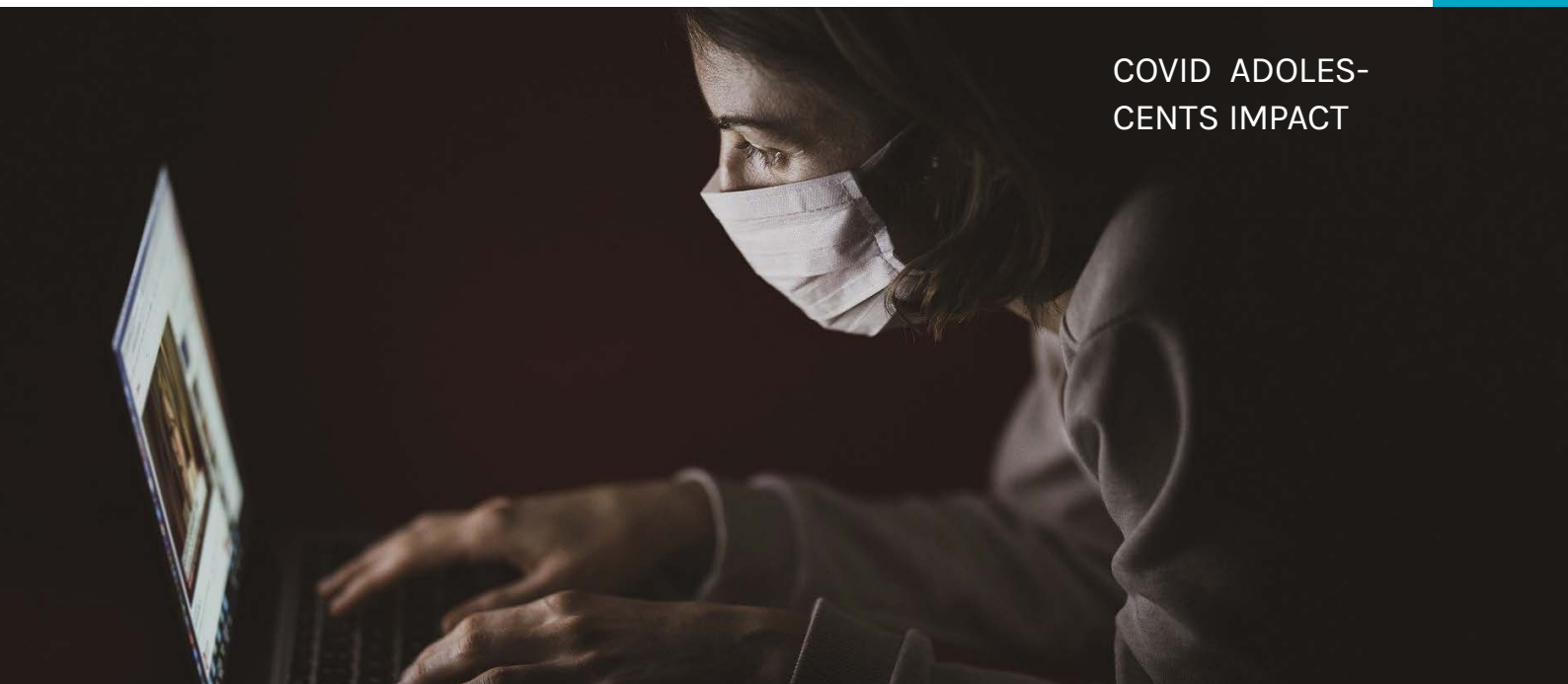
IMPACT OF COVID

COVID-19 has not only resulted in widespread medical complications and loss of life, with an associated reshaping of global economies; it has also transformed daily life, leading to mental health challenges that may be particularly potent among youth. As mentioned above, adolescence is a developmental period characterized by key emotional, social, and biological changes, during which adolescents exhibit increased sensitivity to environmental inputs that can act as a double-edged sword. On the one hand, increased sensitivity assists in adaptive learning as adolescents experience

reorientation from parents to peers in order to increase independence and autonomy and develop a sense of self that allows them to successfully transition to adult life. On the other hand, increased environmental sensitivity can be particularly damaging in the context of stressors, such as COVID-19, as is reflected in the increased rates of self-injurious thoughts and behaviors during this time. COVID-19 has essentially derailed many of the normative socioemotional developmental contexts of adolescence, which has reshaped

some of the most salient and important emotional elements that have known associations with mental health and suicidality. For example, COVID-19 has likely led to increased fear of dying, anxieties around contagion and infection and increased irritability and wide mood swings being common. In addition, vitally important public health initiatives to increase physical distancing including formal and personal event cancellations (e.g., graduation, birthday), loss of outdoor activities, and a shift to online schooling, which has greatly reduced or eliminated the indispensable peer relationships that are particularly important during the adolescent years. Furthermore, social distancing efforts have disrupted home routines, including activity, sleep, and diet,

while also altering family relationships, leading to increased frustrations with siblings and caregivers. Lastly, since COVID-19 stay-at-home orders began, there has been a large increase in child abuse as families spend more time together and adults deal with an onset of severe stressors. Overall, while most research into the impact of COVID-19 on youth mental health is currently in the collection phase, each of the altered domains listed above have well-known associations with mental health and suicide, which is reflected in recent CDC data indicating that 25% of young adults have considered suicide between July and August. These data highlight the vital importance of youth access to treatment during this pandemic.

A photograph of a person wearing a white surgical mask, looking down at a laptop screen. The person is wearing a dark long-sleeved shirt. The background is dark, and the laptop screen is lit up, showing some content. The overall mood is somber and focused.

COVID ADOLESCENTS IMPACT



SUMMARY

Suicidal ideation and suicidal behavior is relatively common in adolescents, and death by suicide relatively rare; however it remains the second leading cause of death in adolescents aged 15 to 19 years. It is impossible to predict which teens are likely to die by suicide, and every effort is being made to identify children at risk, and perusing treatment aggressively. Several risk

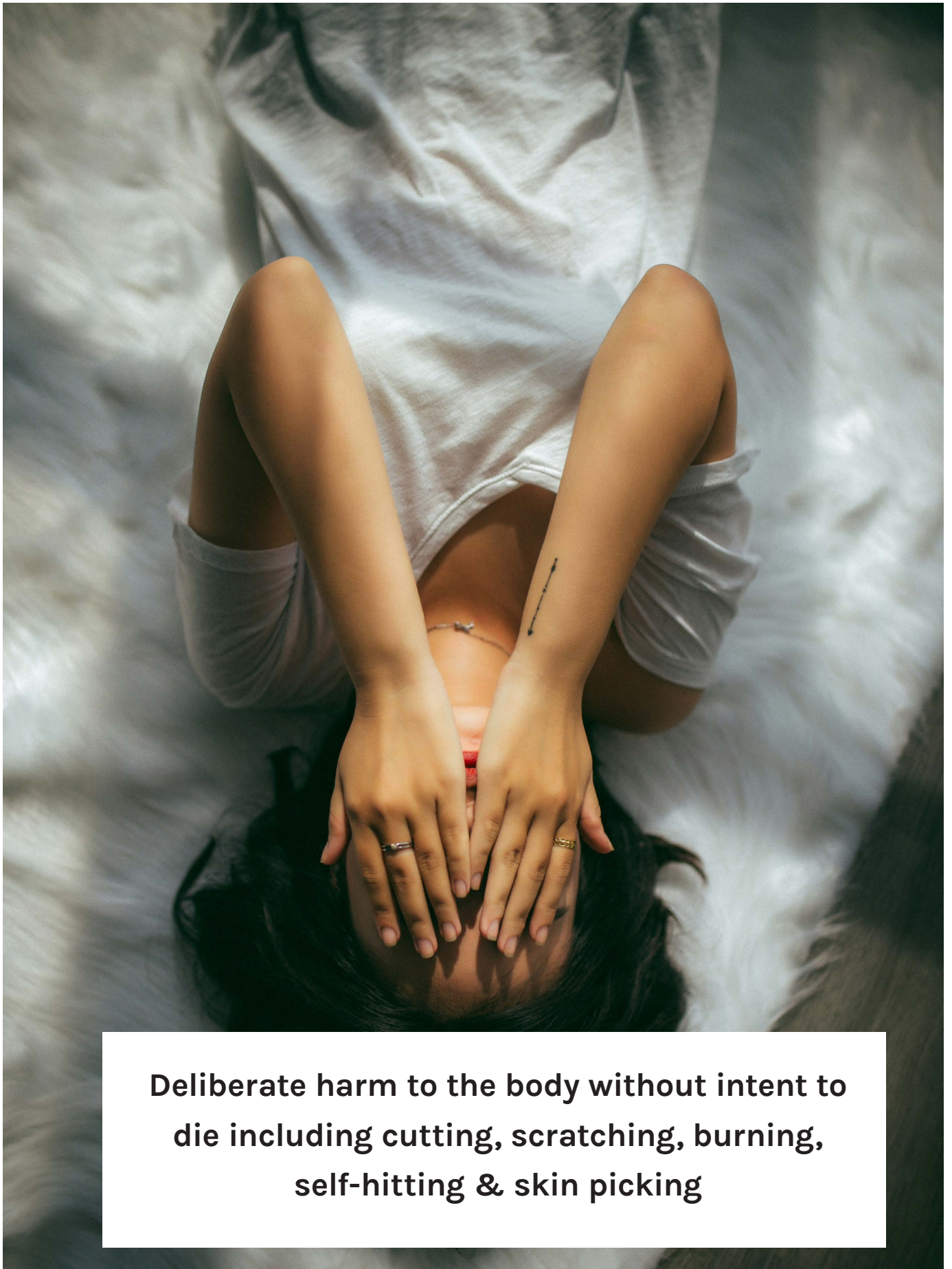
factors play a primary role in suicide, psychiatric disorders, primarily depression, psychotic disorders and substance use. A family history of suicide behavior, prior suicide attempt, or a history of physical and sexual abuse are substantial risk factors. Sexual, gender identity, and /or orientation is an additional risk factor for suicidal ideation and behavior.

Don't Be Afraid to Ask



NON-SUICIDAL SELF-INJURY

Non-suicidal self-injury (NSSI) involves deliberate harm to the body resulting in tissue damage that is performed without intent to die; common methods include cutting, scratching, burning, self-hitting, and skin picking. Although it is most often reported by adolescents and young adults, children and older adults also engage in the behavior. NSSI is commonly reported among both clinical and non-clinical community samples. The overwhelming majority of people who engage in NSSI do so in order to relieve and regulate negative emotional experiences, such as anxiety, sadness, and anger. For many, NSSI may be best understood as a maladaptive coping strategy.



NON-SUICIDAL
SELF-INJURY



PREVALENCE

NSSI is commonly reported among adolescents and young adults, with rates ranging from 5.5% to nearly 40% in community samples. Among clinical samples, reported rates are even higher, nearing 50%. People often report beginning to engage in NSSI between 12-14 years of age, but NSSI is also reported among children. Most people with a history of NSSI have engaged in the behavior multiple times; up to 37% of young adults with an NSSI history report a clinically significant frequency of the behavior. Both men and women are equally likely to engage in NSSI, although there may be gender differences in the method of NSSI. For example, women may be more likely to self-injure by cutting, while men may be more likely to burn themselves.



RISK & PROTECTIVE FACTORS

Given the prevalence of NSSI, the physical harm inherent in the behavior, and the increased risk for suicide, it is important to understand the factors that put people at increased risk for the behavior. Researchers have investigated factors that are associated with increased frequency or likelihood of NSSI, as well as with new onset of NSSI. Given the prevalence of NSSI, the physical harm inherent in the behavior, and the increased risk for suicide, it is important to understand the factors that put people at increased risk for the behavior. Researchers have investigated factors that are associated with increased frequency or likelihood of NSSI, as well as with new onset of NSSI. As with suicide, a strong predictor of

engaging in NSSI in the future is a history of the behavior, as are specific characteristics of past NSSI, such as the recency of the behavior and number of NSSI methods used, and self-reported likelihood of engaging in NSSI in the future. While NSSI is associated with increased risk of suicidality, suicidal thoughts and behaviors at baseline are also associated with later NSSI, again highlighting the relationship between these two distinct types of self-injury. NSSI is reported by individuals with a range of diagnoses, such as mood disorders, anxiety disorders, post-traumatic stress disorder, substance abuse, eating disorders, and borderline personality disorder (BPD).

In addition, NSSI is associated with increased symptoms of psychological disorders, such as depressive and anxious symptoms and symptoms of BPD, in the absence of a diagnosis. NSSI Disorder was included in DSM-5 as a disorder requiring further research, further highlighting the clinical significance of the behavior outside the context of other psychopathology. In addition to risk factors for NSSI behavior and onset in

general, researchers have investigated factors associated with proximal—or immediate—risk of NSSI. Increases in negative affect and stress relative to an individual’s typical levels are associated with increased risk of NSSI in the short-term, suggesting that these momentary fluctuations may be more important than an individual’s usual negative affect and stress in increasing risk for immediate NSSI.

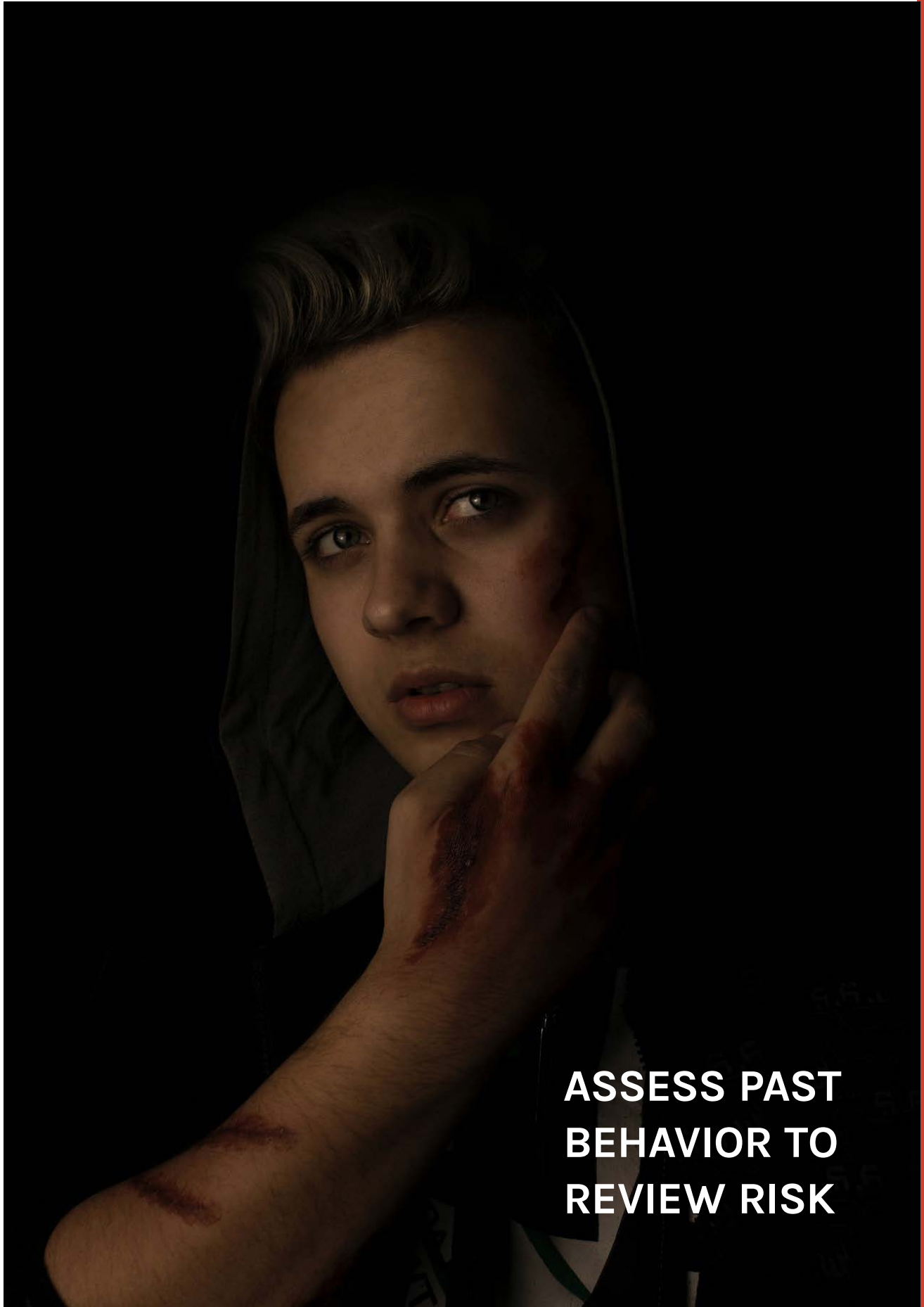


**FLUCTUATING
EMOTIONS**

ASSESSMENT

Assessment of NSSI often includes history, frequency, different methods of NSSI used, age of onset, duration, and function of the behavior. It is important to ask about NSSI in general rather than with regards to a specific behavior, such as cutting, as the methods used for NSSI vary. Asking about intent to die can also be critical in differentiating NSSI from suicidal behavior. When assessing NSSI, one should use a non-judgmental tone that does not reinforce, scold, or reflect discomfort or alarm at the disclosure. Several self-report and structured interview

measures have been developed to assess NSSI; although most measures were developed for research purposes, they can be helpful in guiding a clinical interview. It is important to note that these measures assess past behavior and are not intended to assess future NSSI. However, self-reported likelihood of future NSSI is associated with increased risk of the behavior, so asking how likely one is to engage in NSSI in the future may give a meaningful index of NSSI risk.



**ASSESS PAST
BEHAVIOR TO
REVIEW RISK**



*"...Dialectical
Behavioral
Therapy
Shows
Efficacy..."*

TREATMENT

The negative consequences associated with NSSI, including increased risk for attempted suicide, highlights the need to treat the behavior. Few interventions have been developed specifically to treat NSSI, but some researchers have also investigated the application of interventions focused on treating self-injury with and without suicidal intent to NSSI specifically. Dialectical behavior

therapy, developed for the treatment of BPD, has been found to decrease NSSI among adults and adolescents; it has been identified as a “probably efficacious” intervention for NSSI in adolescents, reflecting the strength of the research comparing DBT to a control condition. Consistent with research indicating increased emotion dysregulation among individuals who self-injure, emotion

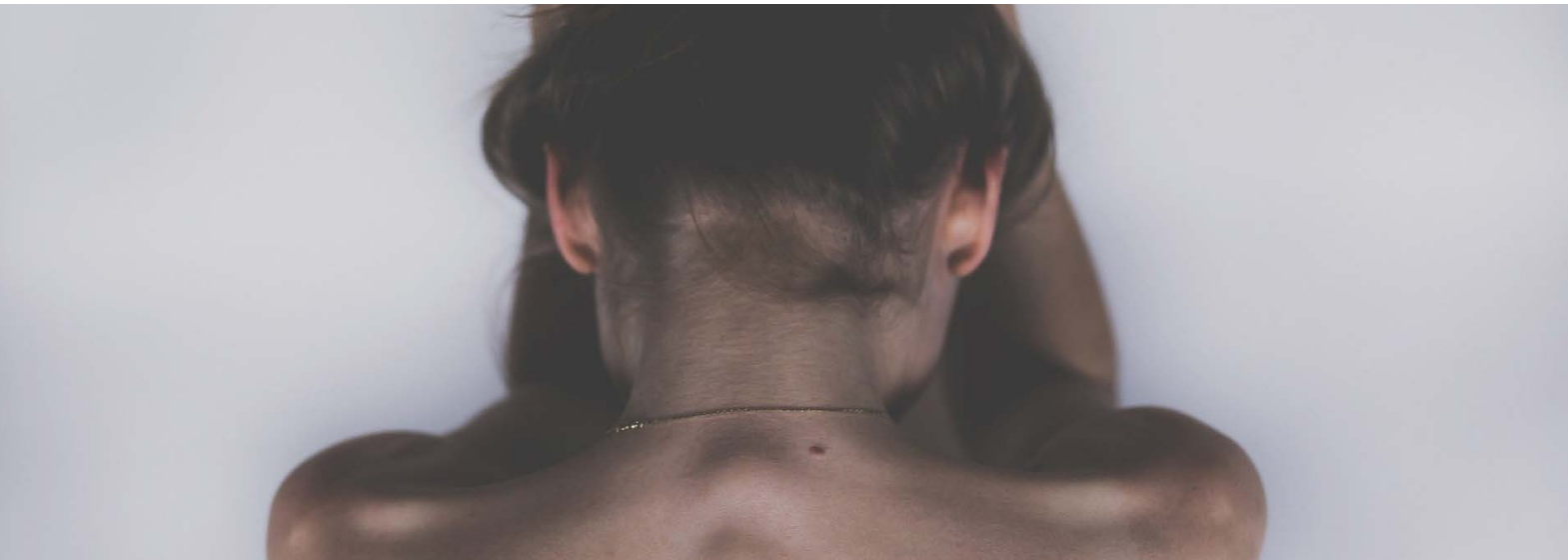
NON-SUICIDAL SELF INJURY



regulation group therapy (EGRT) was developed to treat NSSI among women with a BPD diagnosis or subthreshold symptoms; research has shown a decrease in NSSI behaviors among those receiving EGRT. Reductions in NSSI have also been found with cognitive, behavioral, and cognitive-behavioral interventions. More recently, digital interventions, such as online interventions or mobile apps, have been

developed and tested for the treatment of NSSI. Results have been encouraging for those digital interventions used in conjunction with or based on face-to-face psychotherapy, and further research is necessary. Treatment of NSSI can be challenging; however, it is important to note that the behavior does respond to intervention, and treatment is available.

NSSI SUICIDE FAQs



What psychological factors are associated with NSSI?

Difficulties regulating emotional experiences are a robust predictor of NSSI behavior, which in turn often serves to regulate negative affect. Other factors that have been identified to increase risk for NSSI include hopelessness, a history of childhood maltreatment, and sleep difficulties. Psychological distress is also

an important predictor of NSSI. Depressive symptoms and negative cognitive style have been found to be associated with new-onset of NSSI among early adolescents, and negative urgency, the tendency to act impulsively when distressed, is associated with the onset of NSSI in late adolescence.

How are NSSI and suicide behaviors related?

Is NSSI as a risk factor for attempted suicide?

Are some groups at greater risk for NSSI than others?

Although NSSI and suicide both involve intentional harm to the body and a significant number of people report engaging in both behaviors, NSSI and suicide attempts differ in function, lethality, method, and frequency. Importantly, NSSI is always performed in the absence of suicidal intent. Understanding the difference between the behaviors will improve assessment, treatment, and the development of treatment alliance.

Despite the distinctions between the behaviors, NSSI has been identified as a critical risk factor for attempted suicide. Assessment of NSSI, including history, frequency, recency, and a number of NSSI methods used, should be included when evaluating suicide risk.

Sexual and gender minority individuals, are at increased risk for NSSI. Although there is considerable overlap with risk factors for NSSI among heterosexual and cisgender samples, including a history of NSSI and suicidal behaviors, self-criticism, and family support, factors specific to sexual and gender identity, such as discrimination, are important predictors of NSSI among sexual and gender minority individuals. See more in details in the Sexual & Gender Minority Groups section.

PSYCHOLOGICAL DISTRESS

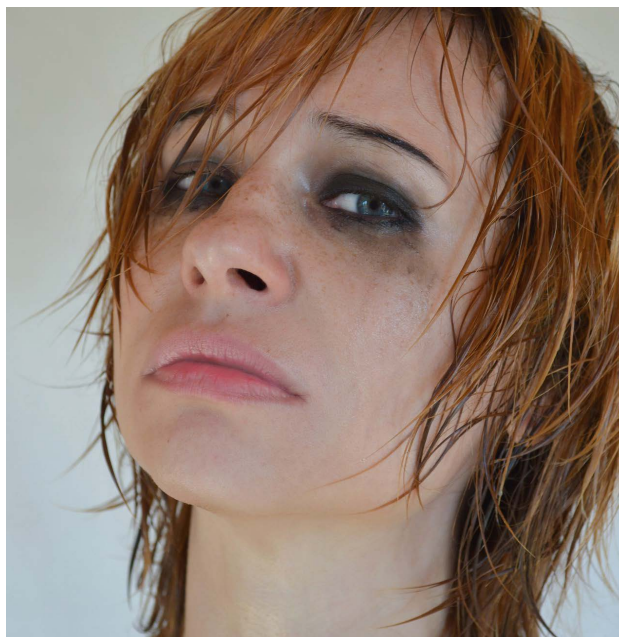


How does the social environment play a role in NSSI?

Studies have also investigated family and peer factors associated with onset of NSSI behaviors. Among adolescents, an increased likelihood of starting to engage in NSSI is associated with parental factors such as harsh punishment, low parental monitoring, poor attachment with parents, and a maternal depressive episode. Peer factors, such as peer victimization, negative perceptions of peers, poor social self-worth, and self-competence are also associated with an increased likelihood of new NSSI. When parental and peer factors were investigated together, peer victimization and decreased social self-worth emerged as unique predictors of new-onset NSSI over parental punishment, monitoring, and attachment. Also highlighting the importance of peer factors in NSSI, exposure to peer NSSI has been shown to predict NSSI risk in different samples, and lack of social support is associated with increased risk of NSSI onset among early adolescents.

Is sexual or gender identity associated with NSSI?

There is limited research in this area, but NSSI is less prevalent in heterosexual population or those gender identity and expression matches the biological sex they were assigned at birth. Young people that identify as LGBTQ approximately account for between 50% to 70% of all NSSI cases. See more in details in the Sexual & Gender Minority Groups section.

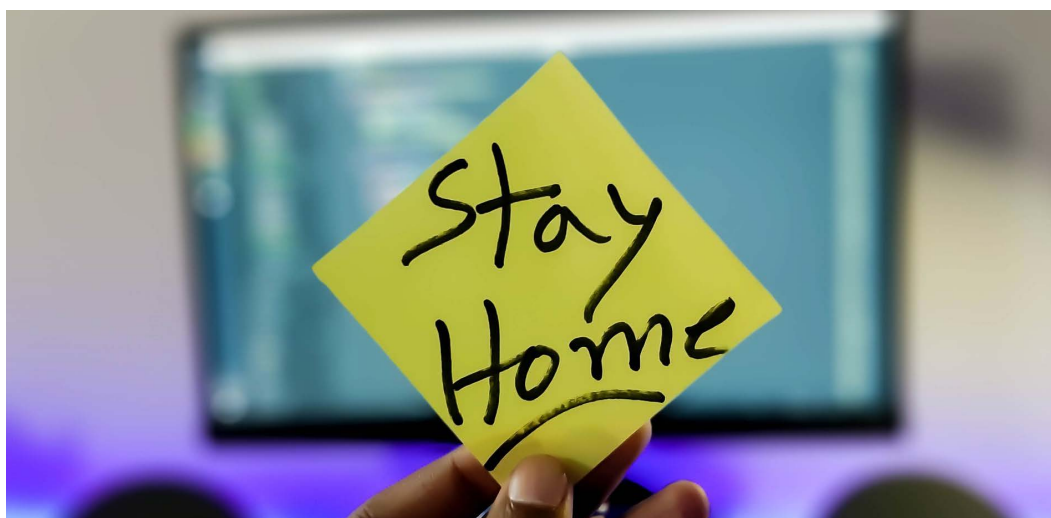




IMPACT OF COVID

The COVID-19 pandemic has had a profound and far-reaching effect, and research on the effect of the COVID-19 pandemic on NSSI specifically is in the very early stages. At this time, only two published studies have reported on NSSI thoughts or behaviors during the pandemic.

University students assessed during May 2019 and again in May 2020 did not report increased NSSI at the second time point; however, the researchers noted that individuals without pre-existing mental health concerns reported increases in several measures of psychological



distress from the previous year, while individuals with pre-existing mental health concerns reported decreased distress. This may be attributed to increased social isolation and loneliness reported by those without pre-existing mental health concerns, as increased social isolation and loneliness are associated with increased psychological distress during this time period. Similarly, other researchers found that individuals who were quarantined reported increased self-injury ideation (a composite reflecting both suicidal ideation and thoughts of NSSI) compared with those who were not quarantined. Social isolation and its effects on mental health in general and NSSI specifically is a significant concern during the COVID-19 pandemic, as many of the measures

taken to prevent the spread of the disease (e.g., quarantine, lockdown, social distancing) may also increase social isolation and decrease social support. Although changes in NSSI were not reported among university students in the one study published to date, we must still be vigilant for the potential onset of or worsening NSSI during this time, as the pandemic may impact factors associated with increased risk for the behavior. For example, lack of social support, psychological distress, negative life events, insomnia, and higher-than-typical stress levels may increase as a result of the pandemic, resulting in an increased risk of NSSI. While NSSI is clinically significant in its own right, the associated increased risk for suicide is especially critical during this time.

SUMMARY

NSSI involves deliberate injury to the body that is performed without intent to die. Associated with significant negative consequences, such as psychological distress, social isolation, and physical injury ranging in medical severity and potentially resulting in infections and scarring. Most people who engage in NSSI do

so to regulate negative emotional experiences. Despite the distinctions between NSSI and suicidal behaviors, NSSI is a significant risk factor for suicide attempts and ideation, and professionals should include NSSI as part of their assessment of suicide risk.



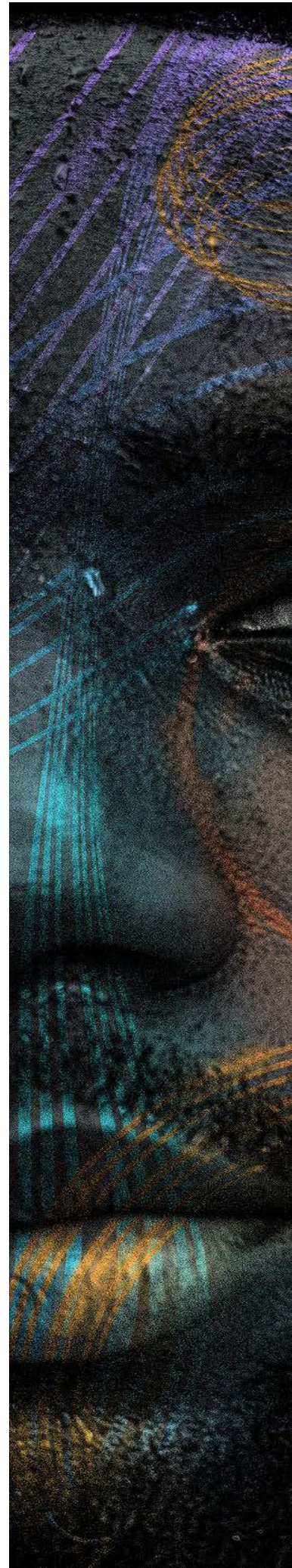
SEXUAL & GENDER MINORITIES

Approximately 4.5% of the US population identifies as a sexual and/or gender minority (SGM). SGM people include those who do not identify as straight (or heterosexual) — e.g., lesbians, gay men, bisexuals, pansexual folks — as well as those who do not identify as cisgender (or as the gender they were assigned at birth) — e.g., transgender men and women, nonbinary individuals, genderfluid/genderqueer folks. Often the term LGBTQ+ — Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other related identities — is used to describe this population. As younger people increasingly use different terms to define their sexuality and gender, researchers have taken to using SGM to capture the vast and ever-changing range of identities included in these communities.



PREVALENCE

Because death records do not identify a person's sexual orientation or gender identity, we do not know for sure how many SGM people die by suicide in the United States. However, there is a large body of literature suggesting that SGM people make or consider making suicide attempts at significantly higher rates than their non-SGM peers.







RISK FACTORS

Research has linked SGM with a higher likelihood of suicide attempts to the unique stress these individuals face as a result of their sexual orientation and/or gender identity. Minority stress theory delineates two different types of SGM related stress (outlined below). Other, non-minority stress-related risk factors

for suicide in SGM people largely overlap with risk factors in the general population. These include: co-occurring anxiety, depression, and/or alcohol and substance use disorders history of physical and sexual abuse; prior suicide attempt.

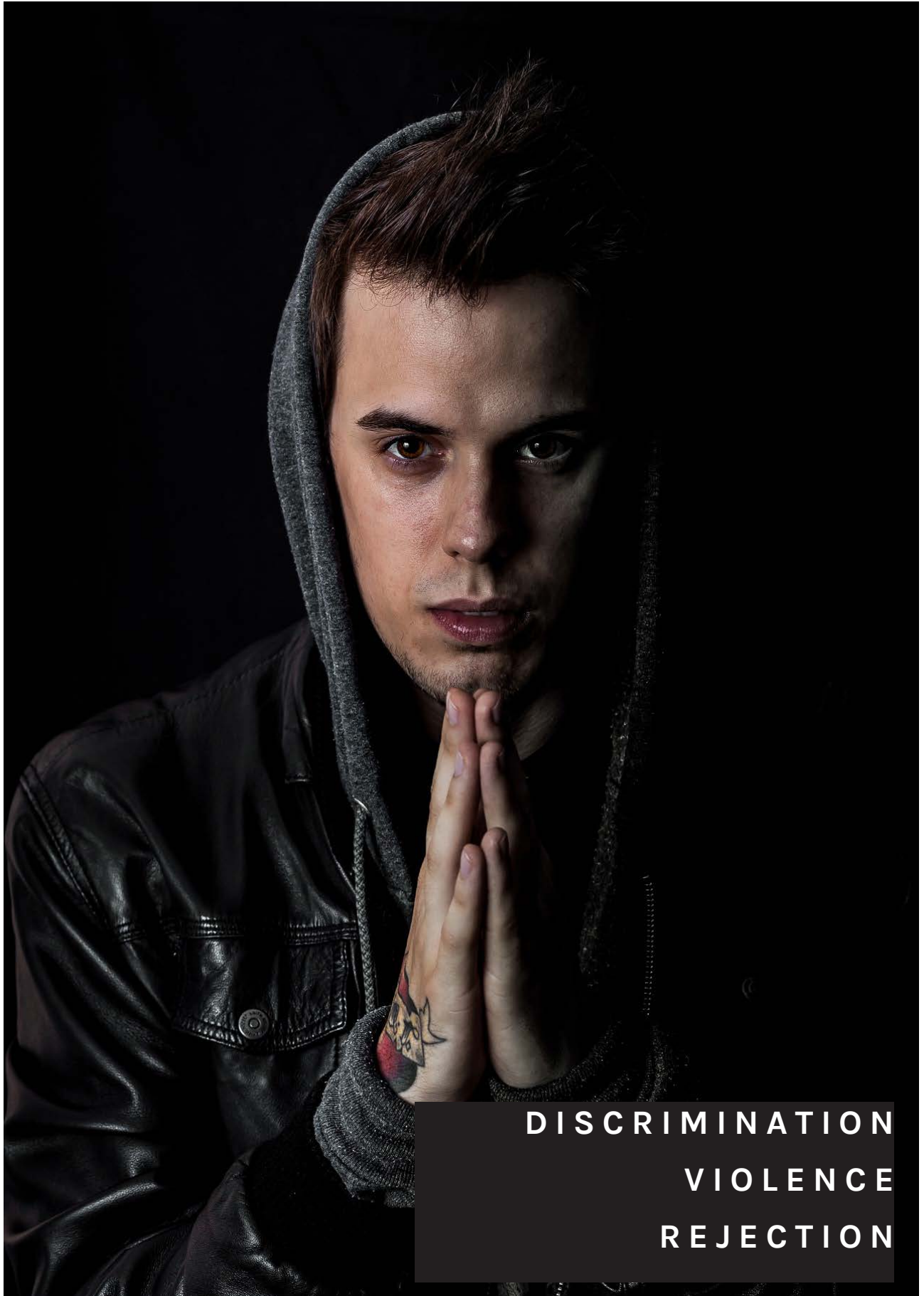
Distal (or external) stressors are experiences like discrimination, violence, and rejection that SGM people face as a result of their identity/ies. This includes both interpersonal experiences — like being called names by a stranger on the street or being rejected by one's family due to one's SGM identity — as well as more structural stressors — like institutional policies that discriminate against SGM people. In fact, research shows that more sexual minority youth attempt suicide in counties with fewer indices of support (e.g., schools with anti-bullying policies that include sexual orientation) compared to those who

live in supportive areas. Low family support for SGM identity (including being thrown out of the family home) is also a predictor of suicide attempts in this population as are conflicts between SGM identity and religious beliefs. Despite increasing acceptance of SGM people in recent years, 29% of SGM youth have experienced homelessness, been kicked out, or run away from home, a third of SGM youth reported being physically threatened or harmed because of their identity, and 10% of SGM youth reported undergoing so-called “conversion therapy”.

PROTECTIVE FACTORS

As in general populations, effective coping and emotion regulation strategies can be protective against suicide in SGM individuals. Minority stress theory also identifies a number of important protective factors that may reduce the likelihood of suicidality in SGM people. Social support is one such example. Research shows that peer and family support can help

buffer SGM people against the negative effects of SGM discrimination and victimization. In fact, SGM youth who report having at least one adult in their life who is accepting of their SGM status are 40% less likely to report a suicide attempt in the past year compared to youth without a supportive adult.



DISCRIMINATION
VIOLENCE
REJECTION



The Trevor Project

ASSESSMENT

While no suicide risk assessment tools have been specifically created for use with SGM populations, many suicide prevention experts recommend including a person's sexual orientation and gender identity in their risk formulation, given the higher risk of suicide attempts in this population. New research shows that SGM individuals may be less likely to

disclose their suicidality to family and friends if they have experienced a high level of SGM-related stress in their life so careful assessment of suicidality in this population is needed. One resource highlights the unique issues relevant to SGM suicide risk assessment and provides clinicians with guidance on suggested questions to use with patients.



TREATMENT

For SGM youth, The Trevor Project is currently the national leader in SGM-affirming suicide risk assessment, and their website also provides a number of resources. Research shows that SGM individuals are more likely to disclose their suicidality to other SGM people or to SGM affirming counselors. Despite this, little research has been conducted to develop evidence-based suicide-related treatments specifically for SGM populations. Attachment-Based Family Therapy (ABFT) is the only treatment that has been adapted specifically for suicidal sexual minority youth. ABFT is a

family-based therapy that reduces suicide by improving the parent-child relationship, and has a focus on emotion-related techniques. Although the sexual minority adaptation of ABFT has yet to be tested in a randomized control trial (the gold standard for treatment development), an open trial of 10 sexual minority youth found a significant reduction in youth-reported suicidal ideation and depressive symptoms over the course of the 12-week treatment. Other studies provide guidance for future treatment development in this area.

For instance, a qualitative study identified four considerations for efforts to reduce suicide in SGM populations:

1

Recognizing minority stress and mental illness stigma

2

Providing low-barrier, long-term SGM affirming counselling

3

Encouraging peer support and community connection

4

Recognizing minority stress and mental illness stigma

SGM GROUPS





SGM SUICIDE FAQS

Do more SGM people engage in suicidal be- haviors?

Evidence shows that SGM youth make suicide attempts at four times the rate of their straight, cisgender peers. A recent survey of 40,001 SGM youth aged 13-24 years found that 40% of all LGBTQ respondents, and more than half of all transgender and nonbinary youth, seriously considered attempting suicide in the past 12 months. This disparity continues throughout

the lifespan — 39% of SGM older adults report having seriously considered suicide during their life, and transgender adults continue to report higher rates of suicide attempts than their cisgender peers.



Is mental illness the reason why SGM died by suicide?

The stressors that SGM groups experience may explain why they are more predisposed to depression, anxiety, and substance use. Psychiatric disorders, depression in particular, is a strong risk factor for suicidal behavior and death by suicide, and may explain the higher incidence suicide in the SGM population.

Stressors associated with being a sexual or gender minority

Is mental illness the reason why SGM died by suicide?

Internal stressors often occur when SGM people internalize some of these negative environmental messages. These stressors include internalized homophobia/biphobia/transphobia — feeling negatively towards one’s own SGM identity as a result of taking on board negative societal views of SGM people — as well as identity concealment — stress associated with “staying in the closet” and appearing straight and/or cisgender — and rejection sensitivity — the learned tendency to anxiously expect, readily perceive, and intensely react to rejection because of one’s SGM identity. All of these internal factors have been linked with increased suicidality in SGM folks.

What environmental factors increase the likelihood of suicidality in SGM people?

SGM are more likely to experience physical and verbal violence, rejection, and discrimination than other population groups. Many struggle with community and family disdain, homelessness, financial strain due to limited employment and promotion opportunities that lead to significant stress. Rates of suicidal behavior in SGM youth are higher in locations with less community support.

What role does the internet play in suicide in SGM people?

Social connection, online or otherwise is a strong protective factor for suicide in SGM groups. For those living in isolated communities, or in communities where homophobia/biphobia/transphobia is common, the internet can provide a place to connect with others, without fear of reprisal. Everyone, benefits from knowing that they are not alone, and the online community for SGM can provide enormous support for some.



How should SGM people be addressed or written about?

SGM folks are often discussed using discriminatory terms in the media, and there is evidence showing that this can be tied to poor mental health outcomes — and sometimes ultimately suicide — for SGM people. As such, it is important to use appropriate language in speaking to or referring to SGM people. The GLAAD Media Reference Guide contains a

plethora of regularly updated guidance about reporting on SGM individuals and communities, with dedicated sections devoted to bisexual and transgender people. Similarly, Reporting on Suicide is a helpful resource for journalists writing about suicide.

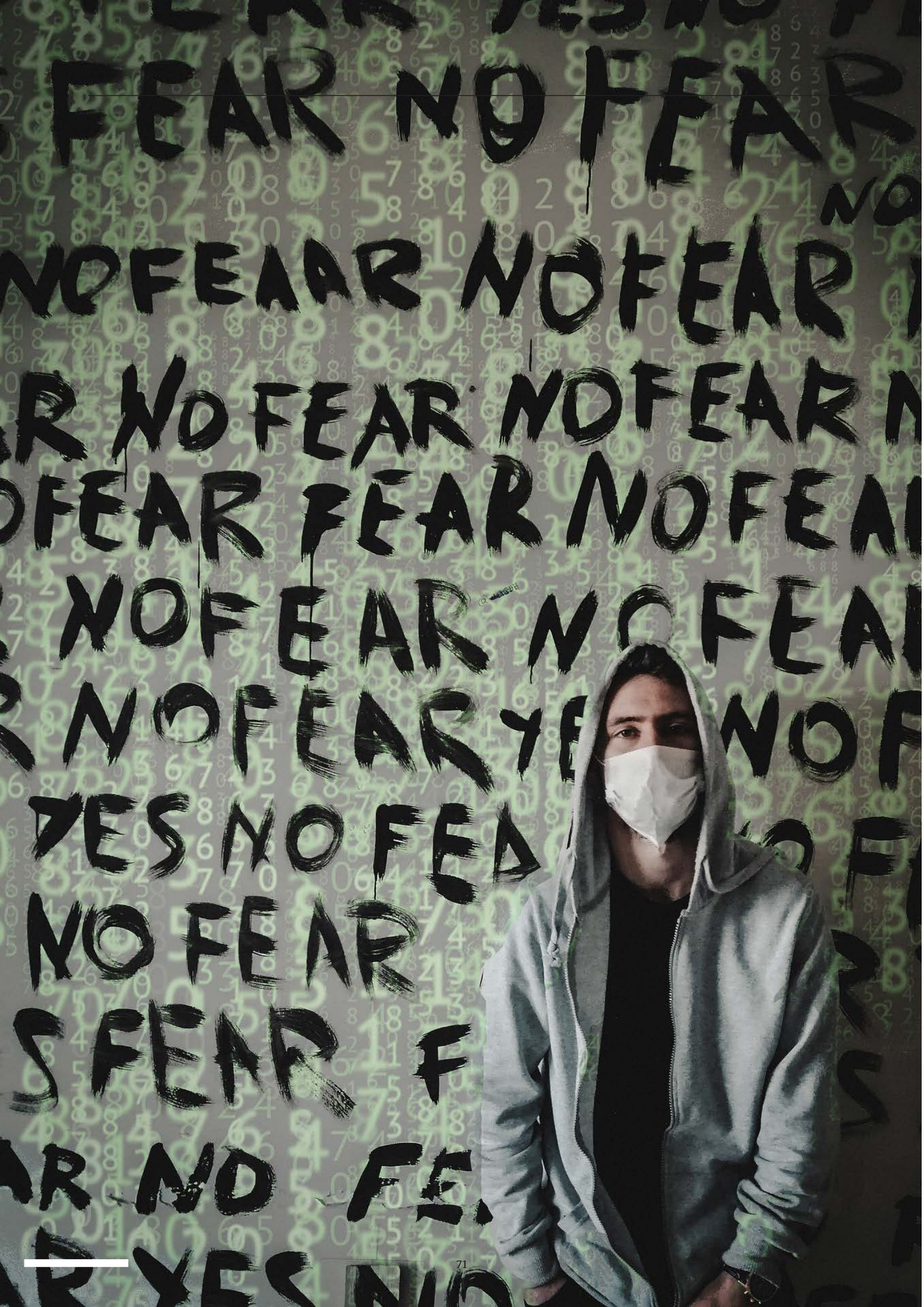


COMMUNICATION TIPS

- use the name the individual prefers (not necessarily their legal name);
- refer to individuals using the pronouns of their authentic gender (which may be different from their birth sex);
- don't be afraid to use singular 'they' pronouns — the AP style guide approves!
- identify individuals and couples accurately (don't use "straight/gay couple" if one of the partners identifies as bisexual); and
- avoid language that perpetuates stigma.

SGM
GROUPS





IMPACT OF COVID

Marginalized communities are particularly at risk for poor health outcomes during the COVID-19 pandemic, including SGM individuals. Even before the COVID-19 pandemic, SGM folks reported worse physical health than their straight, cisgender peers, and many SGM individuals in the United States do not have healthcare coverage. In addition to the health risks associated with the pandemic, COVID-19 has brought about mass loss of employment and financial stress. These two factors are associated with increased risk for suicide, and researchers have suggested that suicide rates worldwide may increase as a result as the pandemic progresses. At the time of writing, there were no studies explicitly examining suicidality in SGM populations during the pandemic. However, three studies highlighted the broader mental health challenges faced by SGM individuals during the pandemic. A survey

of nearly 500 SGM college students aged 18-25 and found that almost half of SGM college students have immediate families who do not support or know about their SGM identity. Further, they found that more than 60% of the sample were experiencing frequent mental distress, anxiety or depression. SGM students were more likely to experience these negative mental health symptoms when 1) their families were unsupportive of their LGBT identity, 2) they were unable to access mental health care because of stay-at-home orders, 3) their lives were disrupted “a great deal” by the pandemic, and 4) they were extremely concerned about COVID-19. A different study found that SGM youth were less likely than their cisgender/heterosexual peers to have access to mental health care during the pandemic, with one in four SGM youth unable to access care.

Research has shown that SGM youth have also struggled with increased mental health challenges as a result of the pandemic, which they related to sleep disturbance, feeling “stir-crazy”, and having more time to ruminate about their sexuality and/or gender. Youth expressed concern about being “stuck at home with unsupportive parents”, and others expressed sadness about the loss of “safe spaces” during the pandemic. In fact, one survey of 600 SGM youth found that 41% of respondents stated that COVID-19 impacted their ability to express their SGM identity, including 56% of gender minority youth. On the other hand, some youth described being

able to escape homophobic and transphobic individuals outside their home as a result of the pandemic. The study highlighted the utility of online support for LGBT youth during periods of COVID-19 related social distancing. While more research needs to be conducted explicitly on the topic of suicide and SGM individuals, it is clear from these studies that SGM folks are experiencing significant stress during the COVID-19 pandemic. Moreover, the pandemic is bringing to the forefront some of the existing risk factors SGM folks already have for suicide — like unstable housing, economic instability, and health care disparities.





SUMMARY

SGM individuals face a number of unique challenges that place them at higher risk for suicide than their non-SGM peers, especially during the COVID-19 pandemic. As research advances, we increasingly understand the factors that lead SGM individuals to consider suicide, as well as the positive aspects of

their lives and communities that can serve as protective factors. Although in their nascence, new SGM-specific suicide prevention efforts appear promising, and will hopefully begin to remove the disproportionate mental health burden that SGM folks carry.

ADULTS & MID-LIFE

Adulthood and mid-life are defined here as individuals aged 25-64. Suicide rates are the highest for this group, compared to all other age bands, and appear to be increasing. In 2017, 31,826 adults (ages 25-64) died by suicide, which accounted for 67.5% of all suicide deaths, and suicide is among the top 5 leading causes of death for US adults, ages 25-54. However, US adults comprise a very heterogeneous group, and suicide rates vary across a number of different populations and characteristics. Suicide rates differ greatly by sex. Males are approximately 3.5 times more likely to die by suicide.

However, females are much more likely to attempt suicide, indicating that males are much more likely to use lethal means when attempting suicide. Rates of fatal suicide attempts also differ by racial and ethnic groups. Non-Hispanic American Indians/Alaska Natives and non-Hispanic Whites have the highest rates of death by suicide. Non-Hispanic Black Americans, Non-Hispanic Asian or Pacific Islanders and Hispanic Americans are all approximately half as likely to die by suicide as compared to the highest risk group. Within these racial and ethnic groups, the sex disparity remains, with males being at least 3 times as likely to die by suicide as females.



RISK & PROTECTIVE FACTORS

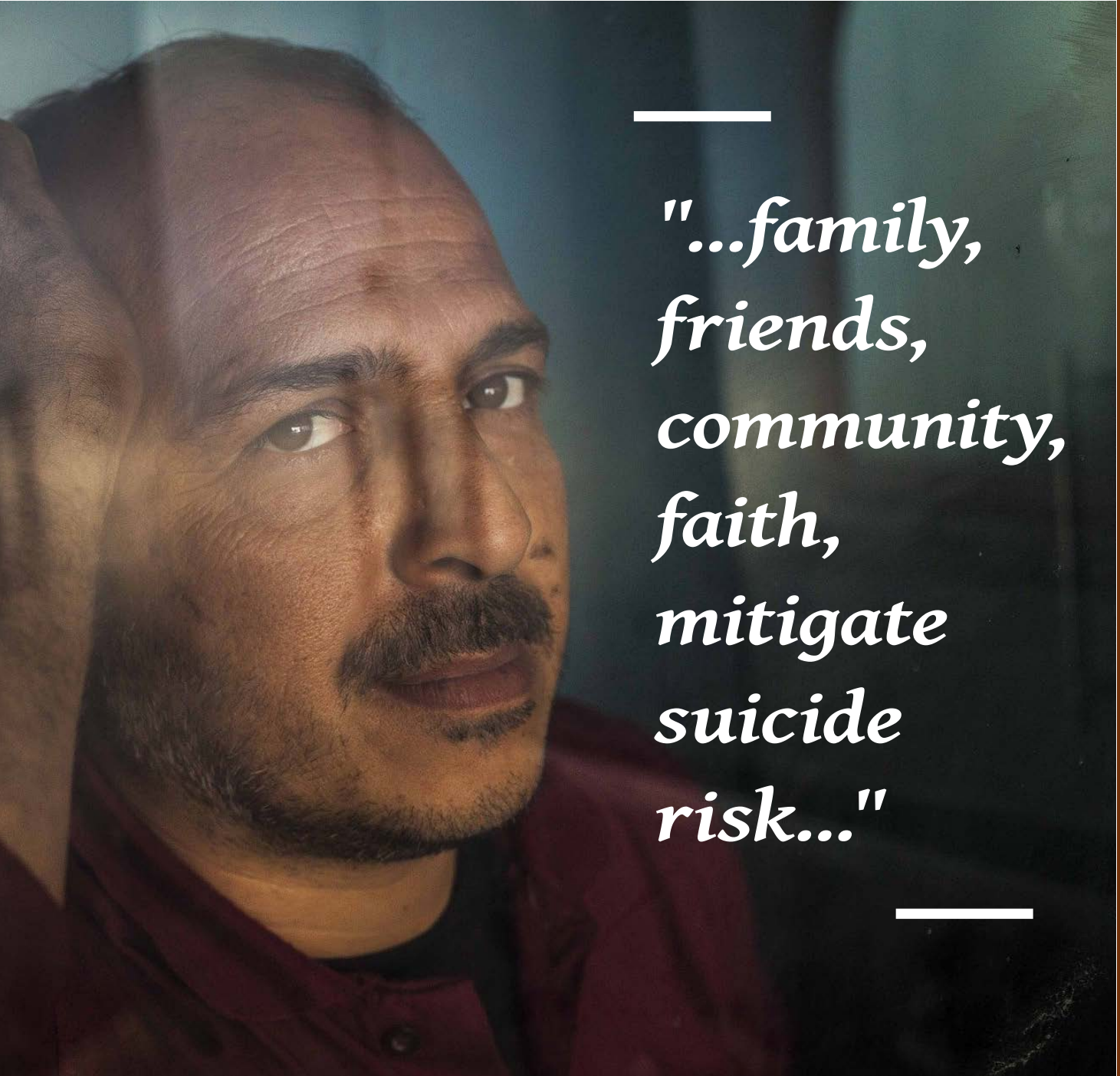
There are many known risk factors for suicide. These risk factors have been reported by the Centers for Disease Control, World Health Organization, and the American Association for Suicidology, along with many other organizations and research teams (e.g. CDC.gov, WHO.int, suicidology.org, afsp.org, sprc.org, etc.) and include factors such as: history of trauma or abuse, previous suicide attempts, family history of suicide, chronic pain, discrimination, environmental stressors, and mental illness and substance abuse. Marital status is associated with suicide, with individuals who are widowed being most likely to die by suicide, followed by individuals who are married, followed by those who are divorced or separated; individuals who were never married have the lowest rates of suicide. More

acute risk factors for suicide have also been well examined. The American Association of Suicidology reports a range of warning signs for increased risk for suicide attempts, including behavioral risk factors such as increased substance use, withdrawal from friends, anger/aggression, and impulsivity; and internal (cognitive or emotional) risk factors, such as purposelessness, anxiety/agitation, feeling trapped, and hopelessness. Additional proximal risk factors also include relationship conflict or loss, job loss or financial hardship, threatening to kill oneself or talking about wanting to kill oneself, and attempting to gain access to lethal methods (e.g. firearms). Protective factors reduce the risk of suicide, even among individuals with other risk factors.



Many protective factors are relational and related to community or interpersonal support, including strong supportive relationships with family, friends, or community, and access to effective mental health care.

Additional protective factors include: effective skills related to problem solving, communication, or coping; cultural, religious, or moral objections to suicide; and restricting access to lethal methods.

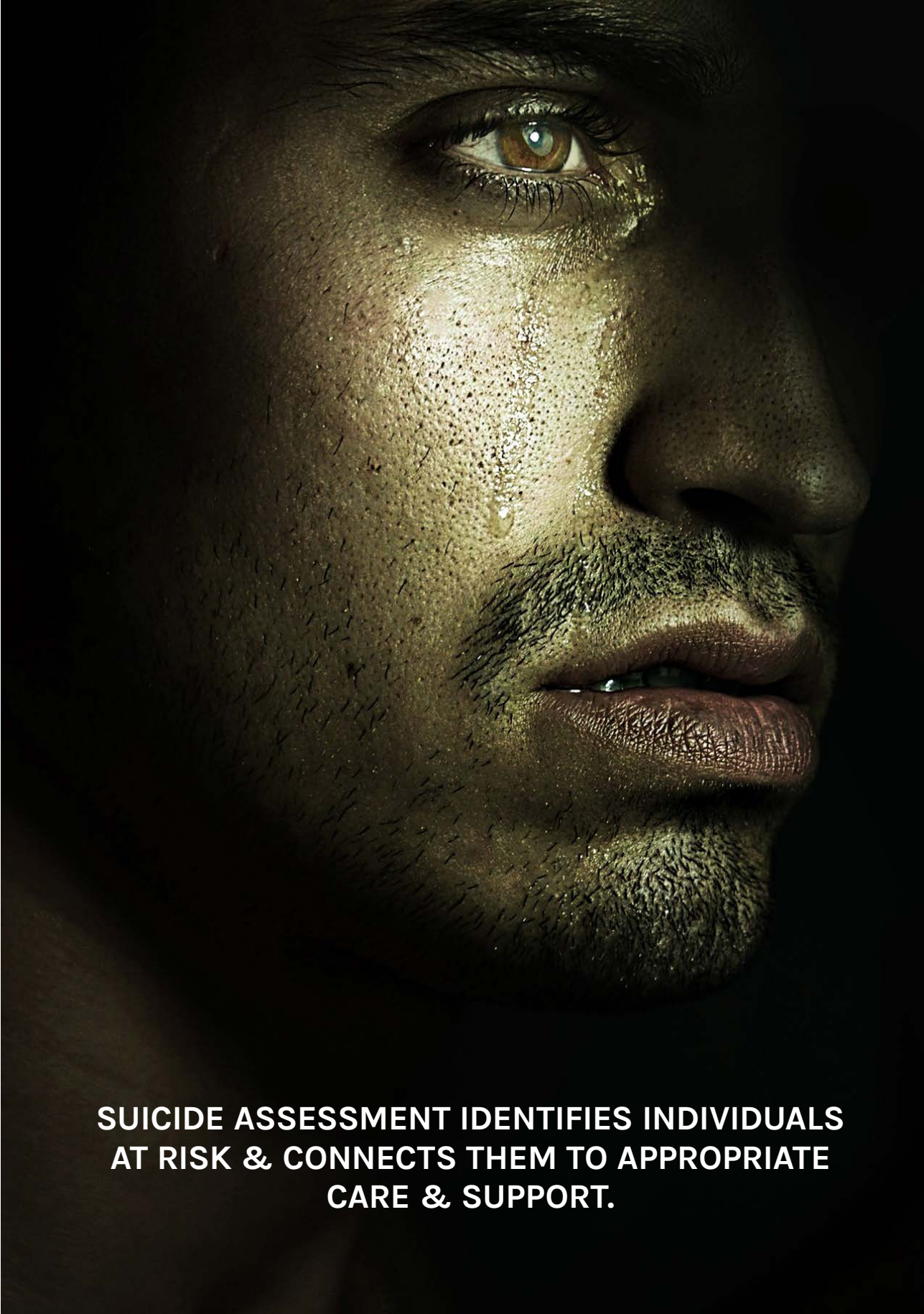


*"...family,
friends,
community,
faith,
mitigate
suicide
risk..."*

RISK ASSESSMENT

Suicide assessment is a critical tool to help identify individuals at risk for suicide, to accurately place individuals into different categories of risk (e.g. low, medium, high), and to appropriately connect these individuals to appropriate care and support. Suicide risk assessment can be completed through paper and pencil self-report scales, such as the Beck Scale for Suicide Ideation, the Suicide Behaviors Questionnaire, or the Depressive Symptom Index-Suicidality Subscale (DSI-SS). While self-report measures have several advantages, including being pragmatic to use, and potentially reducing pressure associated with answering questions in person, they should be completed in conjunction with clinical interviews. Clinical interviews allow mental health professionals to provide clarification about nomenclature, and to follow up immediately with a standardized

risk assessment protocol, if needed. Several clinical tools of this nature, including the Columbia Suicide Severity Rating Scale (C-SSRS), are available. The C-SSRS is a widely used and publicly available measure that offers clinician-administered risk assessment, as well as community and family measurement, for individuals concerned about loved ones who may be at risk (see The Columbia Lighthouse Project for additional details). More recently, a suicide risk assessment tool, The Suicide Risk Assessment and Management Decision Tree (DT), was developed as a brief tool to bridge the gap between assessment and suicide risk management. Research on the DT has demonstrated its potential to provide accurate risk assessments and support suicide risk management in outpatient care.



**SUICIDE ASSESSMENT IDENTIFIES INDIVIDUALS
AT RISK & CONNECTS THEM TO APPROPRIATE
CARE & SUPPORT.**

**SAFETY PLANNING
LIMITING ACCESS
TO LETHAL MEANS**



TREATMENT

Given the high and growing rates of suicide among adult and middle aged populations, it is critical to identify not only tools for accurately identifying and assessing individuals who are at risk for suicide attempts, but also strategies for treating and preventing suicide among these individuals. Suicide prevention efforts have grown in recent years. Many universal prevention efforts focus on reducing stigma of mental illness, increasing awareness of suicidal symptoms, increasing access to care, and reducing risk factors. For example, a recent CDC technical package was published outlining several evidence-based strategies for preventing suicide, including strengthening economic supports, strengthening access of suicide care, creating protective environments, promoting connectedness, teaching

coping/problem-solving skills, identifying individuals at risk, providing support, lessening harm, and preventing future risk. Multilevel prevention efforts can assist by engaging policy makers, communities, and individuals, among others. The organization #BeThe1To is encouraging everyone to support suicide prevention efforts by: learning to identify suicide warning signs, being available to support individuals in need, feeling empowered to ask friends or family about suicidal thoughts without fear that asking these questions will increase risk or suicidal ideation, learning how to reduce lethal risk, knowing how to refer at-risk individuals to a suicide prevention hotline or emergency services, as needed, and following up to provide additional support.



TREATMENT

Evidence-based treatments for patients at risk for suicide typically include strategies to address both the suicide risk as well as any underlying mental health concerns. Addressing the suicidal risk typically involves safety planning, which includes reducing access to lethal means, and identifying specific strategies that an individual will use in the context of current or future

suicidal urges. Additional treatment strategies for suicide include cognitive behavioral (CBT) and dialectical behavioral (DBT) approaches to improve coping, problem-solving, and distress-tolerance skills. Treatment for and prevention of suicide may also include psychopharmacological interventions, as well as a focus on increasing social support and connectedness.



**EVIDENCE BASED TREATMENTS
COGNITIVE & DIALECTICAL
BEHAVIORAL THERAPY**



What role does mental illness play in suicidal behavior?

Mental illness and psychiatric history are well-known risk factors for suicide. Specifically, affective disorders (especially for females), substance use disorders (especially for males), and multiple diagnoses are all associated with elevated risk for suicide. That said, mental illness is only one of many risk factors, and many suicides and suicide attempts are made by people with no known mental illness or psychiatric history.

**A HISTORY OF
SUICIDAL BEHAVIOR
IS ASSOCIATED WITH
MORE PRONOUNCED
EMOTIONAL REACTIONS**

ADULTS & MID-LIFE SUICIDE FAQs

What are the warning signs to of suicidal behavior in adults?

In similar situations why does one person want to die & another not?

Is it dangerous to ask someone if they are thinking of suicide?

Some research indicates that these “warning signs” may not differentially predict acute risk. One study found that the only warning sign that differentially predicted suicide attempts (over ideation alone), was anger/aggression. Deaths by suicide are not reliably preceded by changes in AAS warning signs in the seven days leading up to the death. That said, the known warning signs can provide guidance in identifying individuals at risk for suicidal ideation and/or attempts.

The risk and protective factors associated with suicide are not the same for everyone, even if their respective circumstances may appear identical. Everyone sees and experiences situations differently, thoughts and emotions associated with what appears to be the exact same stressor are felt and interpreted differently by everyone. Emotional reactions to events in people with a history of suicide attempts differs from those that have not considered ending their own life.

There is no evidence that asking about someone’s thoughts and feelings, including any intention or plan about dying increases the risk of death by suicide or encourages the person to act on their suicidal thoughts. Research suggests, that asking someone about how they are feeling and any possible plans of suicide can help identify someone at risk and encourage steps to get help.



**RURAL RESIDENTS
HIGHER RISK FOR
SUICIDAL BEHAVIOR**



Is suicide more likely in people with less education?

Education has also been shown to be related to suicide, with individuals who have not completed high school at higher risk than those who have received additional education. With college educated men and women over the age of 25 years, the least likely to die by suicide. However, lower levels of education are associated with many risk factors for suicide, such as substance use, financial difficulties, homelessness, and psychiatric disorders, that make it difficult to attribute lower education as an explanation for the observable higher suicide rates for those that did not complete high school.

Does where you live contribute to suicidal behavior or risk?

Geographical location has also been examined, and significant research supports that living in rural locations is associated with approximately 1.6 times higher suicide rates as compared to urban locations. In recent years, research has indicated that living in mountain regions and in western parts of the united states is associated with higher rates of suicide; however, this finding may be conflated with the fact that rural geographic location is associated with higher suicide rates.

IMPACT OF COVID

COVID-19 has led to significant upheaval and disruption to daily life for individuals across the globe. Individuals in the adult and mid-life age-group may be experiencing unique and particularly challenging stressors. Public health guidelines aimed at containment include social distancing policies which limit prolonged interactions with other people, impacting economic, professional, and personal endeavors. As a result, the pandemic has greatly impacted financial and job security for many, with unemployment rates rising to 10.2% in the United States as of July, 2020 (for comparison, the unemployment rate in July, 2019 was 3.7%). In addition to job loss and financial strain, the pandemic has placed interpersonal strains on families, as many working parents attempt to provide full-time childcare and continue working. Due to the differential impact of the coronavirus on older adults, adult-age parents may also have less

access to childcare and interpersonal support from extended family. Social connectedness has also been interrupted, with individuals experiencing increased isolation due to social distancing and intermittent shelter-at-home recommendations. Concerns about physical health for individuals and their loved ones are also heightened, increasing symptoms of anxiety and stress. Although research on the mental health impact of COVID-19 is still emerging, some initial evidence demonstrates that “the prevalence of anxiety and depression among U.S. adults was three times higher during the pandemic than a year earlier.” Clearly risk factors for suicide are increasing during the pandemic. Suicide prevention organizations have been responsive to this growing need, with additional resources on coping during COVID-19 emerging on websites dedicated to suicide prevention (e.g. #BeThe1To).



SUMMARY

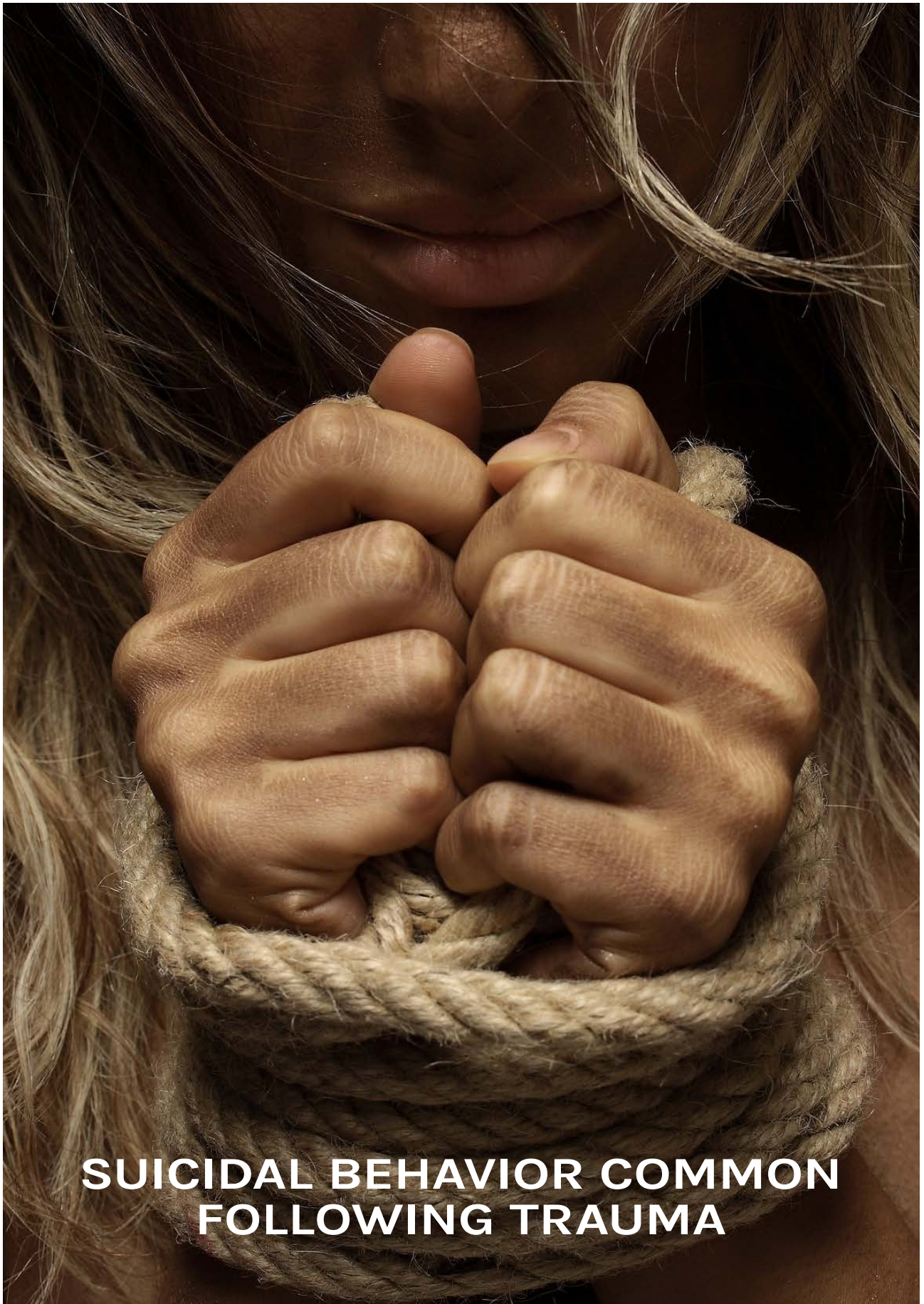
Suicide rates among adults are high and increasing; however, this risk is not spread evenly across the population. In order to reduce the overall prevalence of suicide, it will require a coordinated and comprehensive approach. However, individuals are also encouraged to address suicide risk by learning the suicide warning signs, asking

individuals about their suicidal thoughts , reducing access to lethal means, helping individuals access care, and following up. Now, more than ever, we must prioritize the identification and treatment of individuals at risk for suicide.

TRAUMA, HIV & CHRONIC OR TERMINAL ILLNESS

The American Psychiatric Association describe a history of trauma to include experiencing, witnessing, or learning about an actual or threatened physical injury, sexual violation, death, or repeated exposure to learning about the details of trauma through an occupation. In some cases, receiving a diagnosis of a chronic illness, including human immunodeficiency virus (HIV), cancer, or other serious medical condition, may be experienced as an index trauma that precipitates psychological distress. Given that chronic medical conditions can lead to PTSD and the development of suicide thoughts and attempts, special examples

of medical conditions that increase risk for suicide will be reviewed. The psychological consequences of exposure to trauma are numerous, including a variety of medical and psychiatric comorbidities. Posttraumatic stress disorder (PTSD) is one example of psychological consequence of trauma exposure; PTSD is diagnosed when a participant has been exposed to a trauma and develops symptoms across four symptom clusters, namely: alterations in arousal and reactivity, intrusions, avoidance, and negative alterations in cognitions and mood. Another common reflection of psychological distress following trauma exposure is suicidal ideation and behavior.



**SUICIDAL BEHAVIOR COMMON
FOLLOWING TRAUMA**



**40% OF PEOPLE WITH PTSD
REPORT SUICIDAL IDEATION**

PREVALENCE

Approximately 8% of individuals in the United States will meet criteria for PTSD at some point in their lifetime. Among individuals who meet criteria for PTSD,

approximately 40% will report suicidal ideation, and about 10% will have a lifetime history of a suicide attempt.

RISK & PROTECTIVE FACTORS

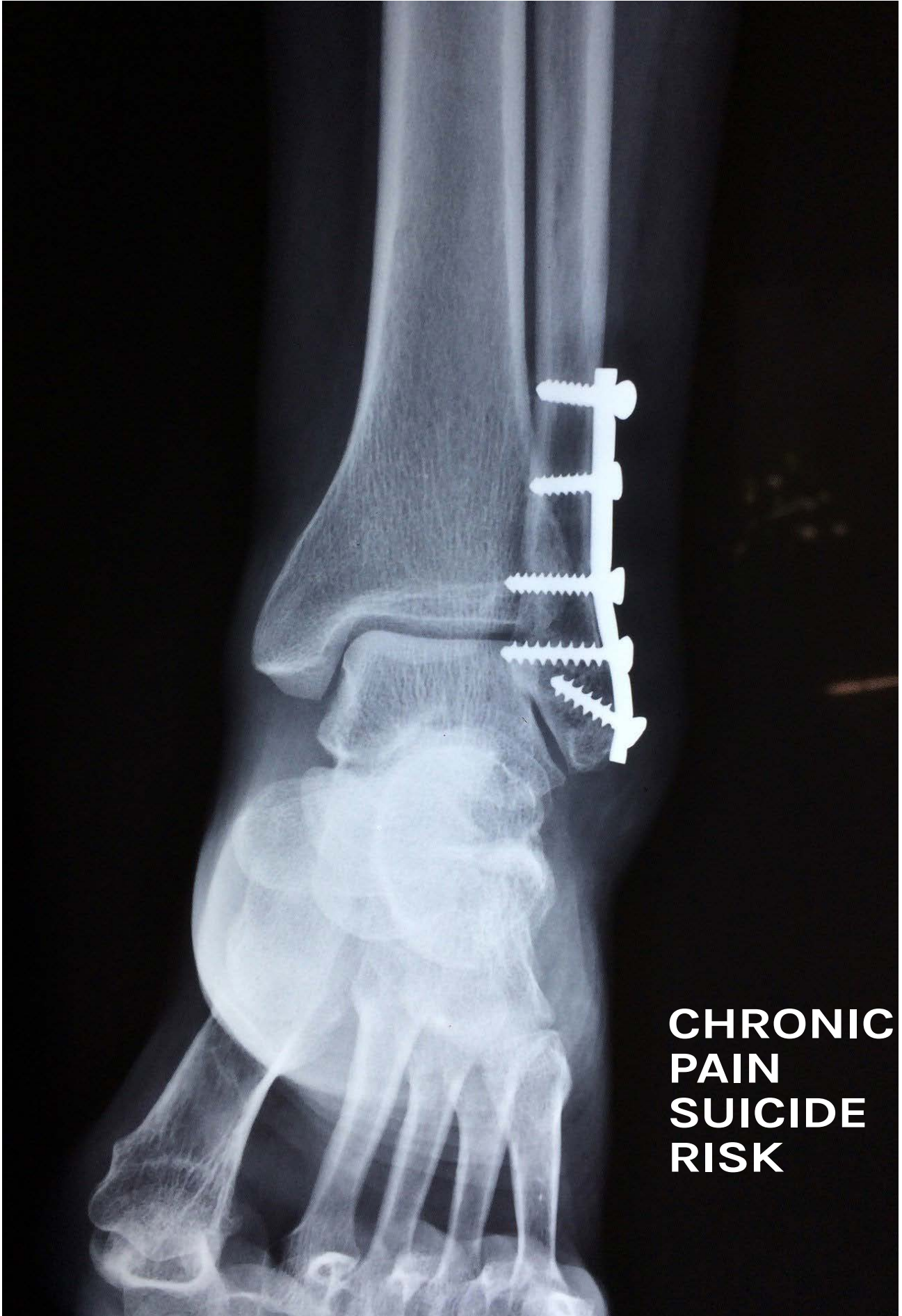
Risk for suicide is particularly elevated among individuals who develop PTSD. Civilians, veterans, and active duty military personnel with a diagnosis of PTSD are significantly more likely to experience thoughts about suicide, sometimes referred to as suicidal ideation. In addition, individuals with PTSD are more likely to make suicide attempts. Some studies suggest that PTSD confers a greater risk of dying by suicide, though the evidence on this topic mixed. PTSD is one of only a few

psychiatric conditions that is associated with the transition from thinking about suicide to engaging in suicidal behavior. Once an individual has PTSD, subsequent exposure to future traumatic experiences (e.g., natural disaster exposure) further increases risk for suicide. A number of possible mechanisms of the association between PTSD and suicide may explain their connection, including social disconnection, trauma-related cognitions, and alterations in arousal.



ASSESSMENT

Clinician interview assessments for PTSD include the Clinician Administered PTSD Scale for DSM-5 (CAPS-5) and the PTSD Symptom Scale-Interview (PSSI-5). Self-report measures include the PTSD Checklist for DSM-5 (PCL-5) and the Posttraumatic Diagnostic Scale (PDS-5).



**CHRONIC
PAIN
SUICIDE
RISK**





TREATMENT

Evidence-based treatments for PTSD, including prolonged exposure therapy (PE) and cognitive processing therapy (CPT), are each associated with significant reductions in suicidal ideation. Reductions in suicidal ideation during PTSD treatment appear to be driven by reductions in PTSD symptoms, which result in reductions in depression, which ultimately reduces suicidal

ideation. However, the majority of clinical trials for PTSD exclude participants who are at high-risk for suicide. This limitation to existing studies prevents an understanding of the impact of evidence-based PTSD treatments on suicidal behavior in high risk individuals.

Why is a chronic illness a risk for suicide?

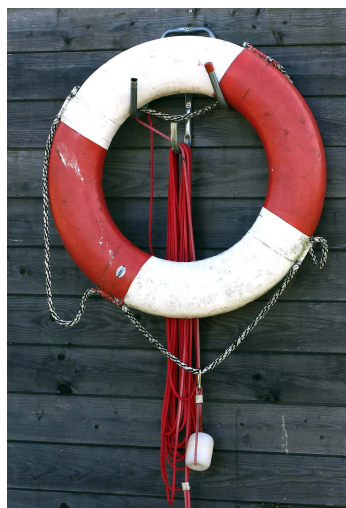
Some commonalities across chronic medical conditions may contribute to their influence on suicide risk. These conditions often negatively impact sleep, and disordered sleep is a known risk factor for suicidal ideation. Persistent pain is common in chronic illness, and catastrophizing about pain, predicts suicidal ideation and attempts. Hopelessness is a known risk factor for suicide that may be more common among patients with chronic medical illnesses. Depression is a common consequence of chronic medical conditions, and known to contribute to suicide risk.

Is asthma associated with death by suicide?

Respiratory diseases, such as asthma, significantly increase risk for suicide. Even after adjusting for mood disorders, asthma increases the risk of suicidal ideation and attempts. Individuals with asthma have twice the risk of suicide death. One possible reason for the increased risk of suicide among individuals with asthma may be panic disorder comorbidity, which is also independently associated with increased risk for suicide attempts.

Do people diagnosed with cancer consider suicide?

Individuals with cancer have nearly twice the rate of suicide compared to the general population. Risk factors for suicide among individuals with cancer include male sex, older age of diagnosis and white race, and being within 5 years of the cancer diagnosis. Risk for suicide decreases rapidly after the first year of cancer diagnosis. Individuals with prostate, lung, pancreatic, and head and neck cancers are at highest risk. Depression may be a critical underlying mechanism of this association in men, but less so in women.



Does having diabetes increase suicidal behavior?

Individuals with diabetes are also at increased risk for suicidal thoughts and attempts. Compared to controls in primary care without diabetes, individuals with diabetes report increased risk for suicidal ideation. In addition, individuals with diabetes are significantly more likely to have a history of suicide attempts. Poor quality of life and depression may drive the association between diabetes and suicidal ideation. Among individuals with diabetes who make suicide attempts, insulin is a common method. As with cardiovascular disease, diabetes does not appear to increase suicide risk in the elderly.

Is HIV a risk factor for suicidal thoughts? suicide?

Anti-retroviral therapies (ART), individuals who contract HIV can live long and healthy lives. Nevertheless, individuals who are living with HIV remain at significantly elevated risk for suicide. Among persons living with HIV who achieved viral suppression but died, suicide is the second leading cause of death. Among people living with HIV is under 50 years old, suicide was the leading cause of death (17% men, 25% women). One type of ART (efavirenz) is independently associated with increased risk for suicidal thoughts and behaviors.

Persons living with HIV are 4.7-7.6 times more likely to report suicidal ideation and

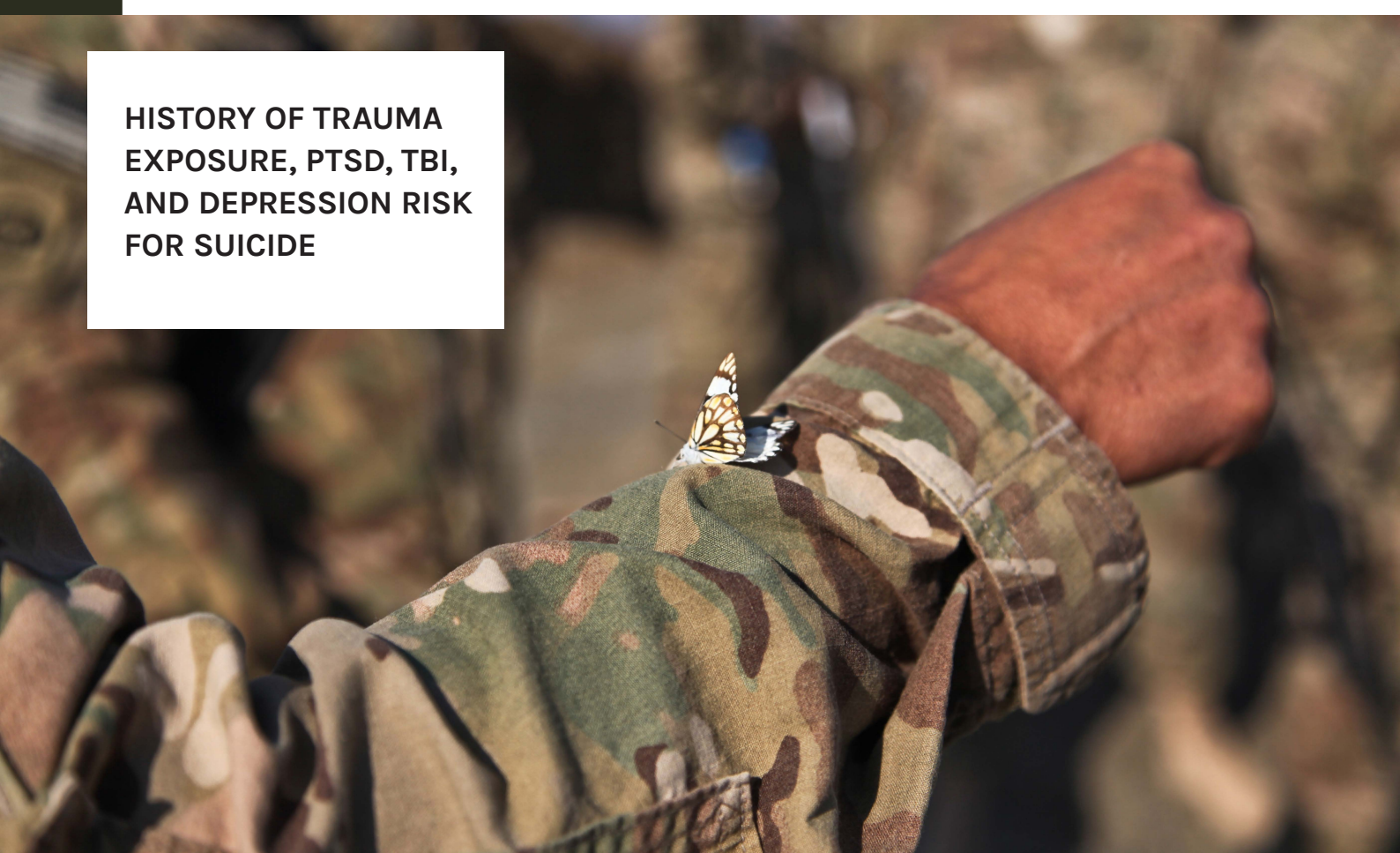
suicide attempts if they have trauma-related disorders. Each additional trauma exposure is associated with a 19% increase in the risk of suicidal ideation. Other risk factors for suicidal thoughts and attempts among persons living with HIV include substance use, social disconnection, cognitive decline, and sleep disorder symptoms.



VETERANS

Suicides among military personnel have been steadily rising during the past ten years, with suicide now being the second-leading cause of death among military personnel. In recent years, more military personnel have died by suicide than died in combat. This is

partly because of rising suicides in the military, but also because of decreased combat deaths due to the recent withdrawal of military personnel from Iraq and Afghanistan. Service members and their families are living with and exposed to significant stressors that are likely to contribute to the risk of suicide.



**HISTORY OF TRAUMA
EXPOSURE, PTSD, TBI,
AND DEPRESSION RISK
FOR SUICIDE**

PREVALENCE

The statistics on Veteran suicide are high, with 20 Veterans taking their lives every day. In 69.4% of cases, firearms are the cause of death. The rate of Veteran suicide has been on the increase since records first started in 2005, from 16.2% to 21.5% in 2017. Between 2005 and 2017, a total of 53,230 died by suicide,

a number 13x greater than service members killed in action in Syria, Afghanistan, and Iraq (4,076). The overwhelming majority of military suicides (greater than 90%) are by male personnel who are typically younger than 35 years of age.



RISK & PROTECTIVE FACTORS

Suicide is complex, and many different factors contribute to it. Suicide is therefore very hard to accurately predict. Like other populations, Veteran suicide is associated with risk factors such as a (i) mental health condition, (ii) stressful life events, such as job loss, death of a loved

one, marital issues and divorce, (iii) history of a prior suicide attempt, and (iv) access to lethal means. Intuitively, it would seem to make sense that the number and length of deployments would contribute towards suicide risk, but the evidence is inconclusive.



MILITARY SEXUAL TRAUMA

There are several factors that may offset the risk of suicidal behavior in Veterans, including (i) feeling connected to others, (ii) having a sense of purpose or meaning in their lives, (iii) access to mental health care, and (iv) positive coping skills. The sense of belonging to a unit provides many Veterans with a strong coping mechanism in times of adversity. The high incidence of military sexual trauma and a history of intimate partner violence (IPV) contributes to the suicide risk, in some instances doubling the risk, and the expansion of targeted mental health services for women Veterans, is one of the approaches to reduce the incidence of suicide in this population. The expansion of telehealth

services, mobile apps, Veteran peer mentors, and heavy investment into research on the reasons and possible treatments to prevent suicide are some of the additional efforts the VA is making to reverse the suicide trend. The Army's Study to Assess Risk and Resilience in Service members (STARRS) program is shedding some light on the risk factors for Veterans. For instance, frequency of deployment does not seem to be associated with greater incidence of suicide, but the absence of deployment or the earliest months of service do seem to increase the risk, in addition to the increased risk of suicide for any service member if member of their unit dies by suicide.



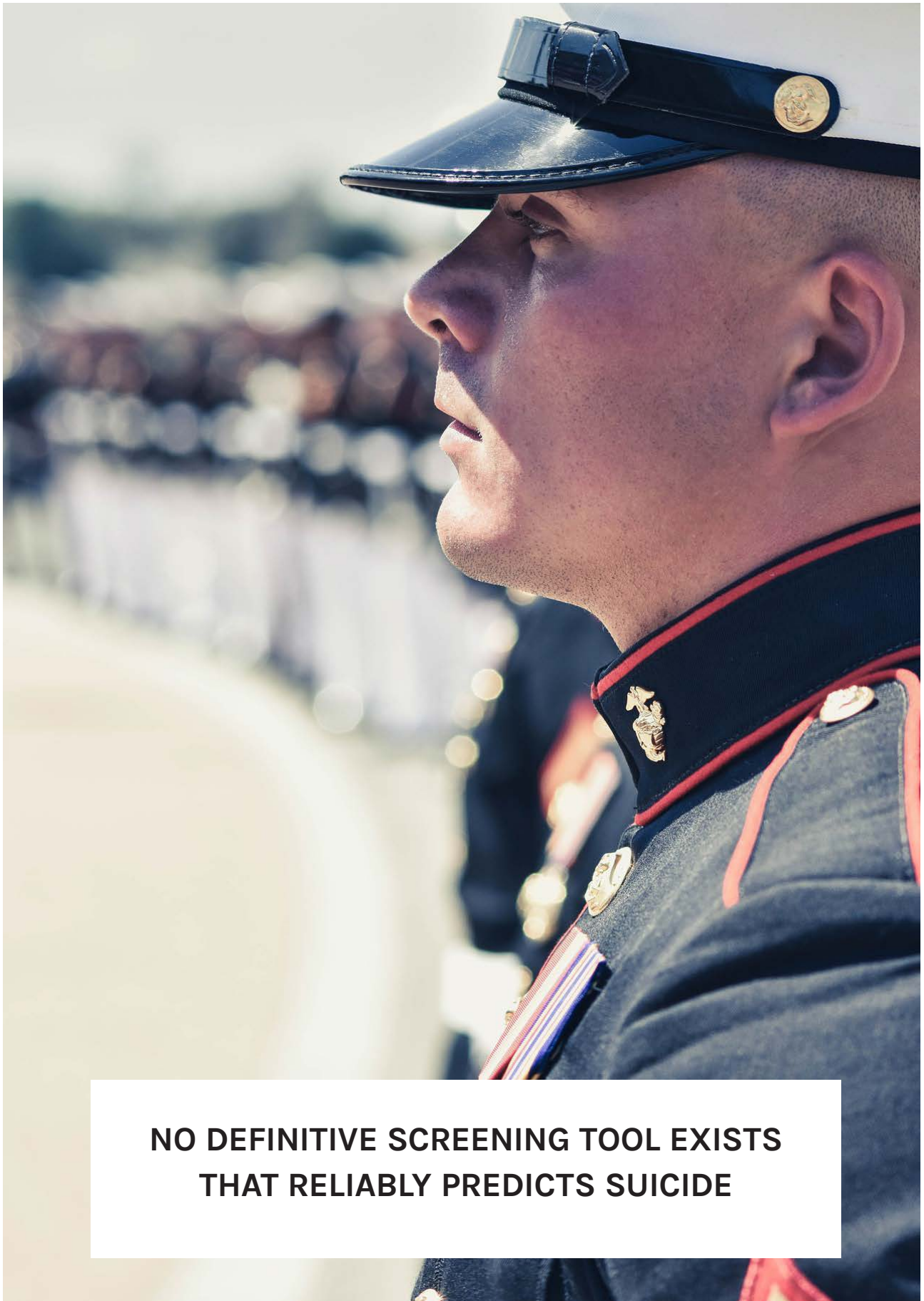
**VETERAN & ACTIVE DUTY SERVICE
MEMBERS SUICIDE BY MALES UNDER 35 YEARS**



RISK ASSESSMENT

The VA has made great efforts to reduce Veteran suicide amongst the 9 million plus Veterans they serve annually. The addition of a risk predictive model (REACHVET) is part of the electronic health record of any Veteran at elevated risk for suicide, hospitalization, illness, or other adverse outcomes. The VA encourages its clinicians to routinely screen for suicidality, and has invested heavily in public information on the issue of Veteran suicide, with a focus on seeking assistance and eliminating the stigma associated with suicidal behavior. Due to the unique risk and protective factors for Veteran suicide, there currently is no definitive screening tool that accurately assesses suicide risk.

The VA has developed tailored screening tools for clinicians to assess suicide risk in Veteran populations, but they are imperfect. The Community Provider Toolkit has a list of recommended screening and diagnostic tools for suicide that clinicians can use. The available screening tools have low positive predictive value and generate a high number of false negatives (50%) and false positives. Clinicians regularly attend training on suicide screening as research findings emerge that indicate more effective approaches. Suicide prevention is a core feature of VA health care, and an integral part of a Veteran's electronic health record.



**NO DEFINITIVE SCREENING TOOL EXISTS
THAT RELIABLY PREDICTS SUICIDE**

TREATMENT

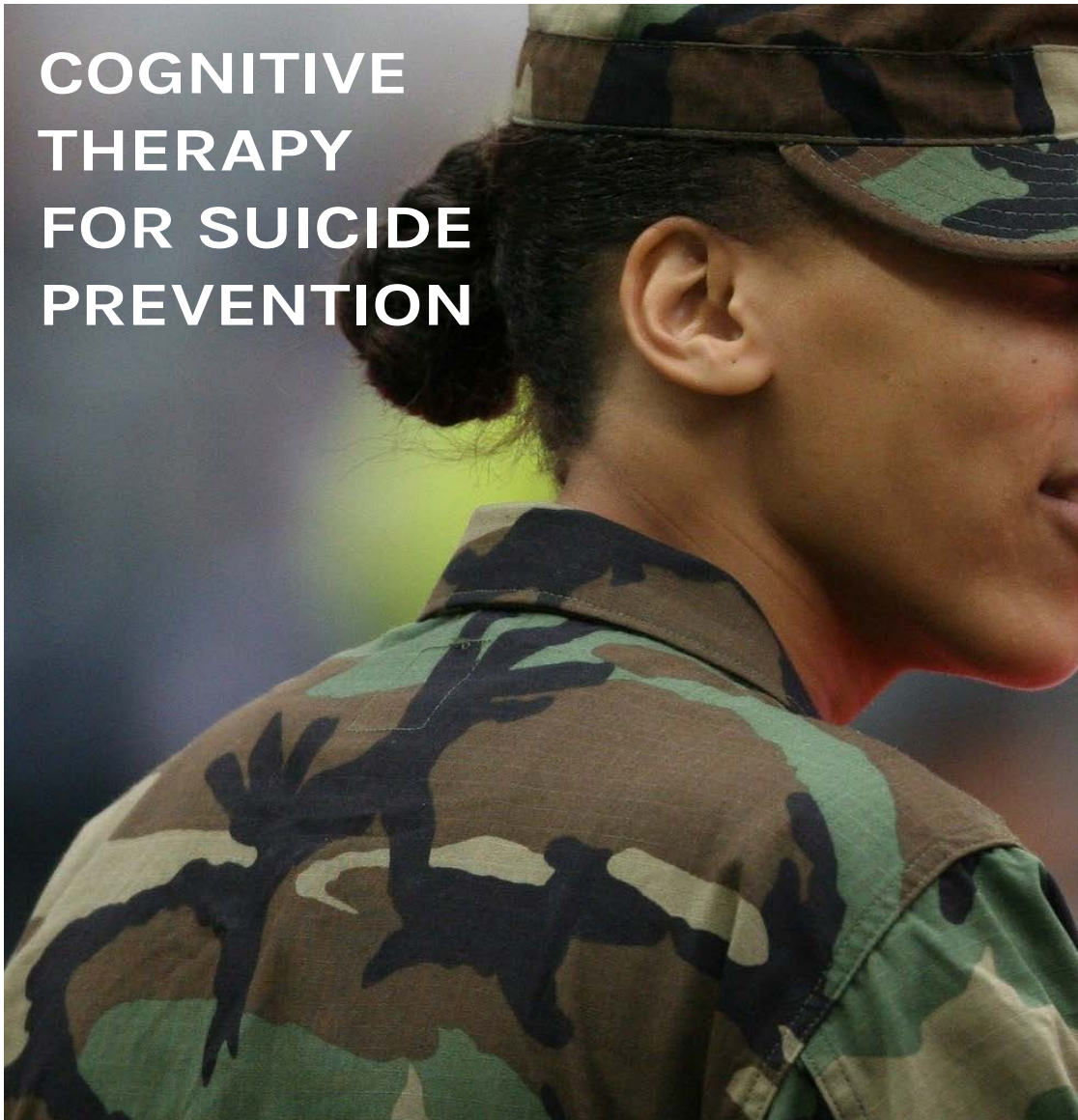
Research is indicating that an approach that incorporates a strong focus on prevention and awareness is a critical first step. Just as the cause of suicide is not attributable to one single factor, a multi-factorial approach to prevent repeated suicide is the only available treatment at present. In suicidal Veterans with depression pharmacological treatments are available, depending on whether treatment is happening following a hospital admission or

as an outpatient. Cognitive Behavioral Therapy (CBT) and an adapted version targeted at suicide, Cognitive Therapy for Suicide Prevention (CT-SP), both focus on teaching patients to identify problematic behavior and thought patterns, and to understand the subsequent impact they have on emotional wellbeing. Both approaches have shown promise in the reduction of repeat suicidal behavior, by as much as 60%.



**AWARENESS
& PREVENTION
CRITICAL FIRST
STEP**

COGNITIVE THERAPY FOR SUICIDE PREVENTION

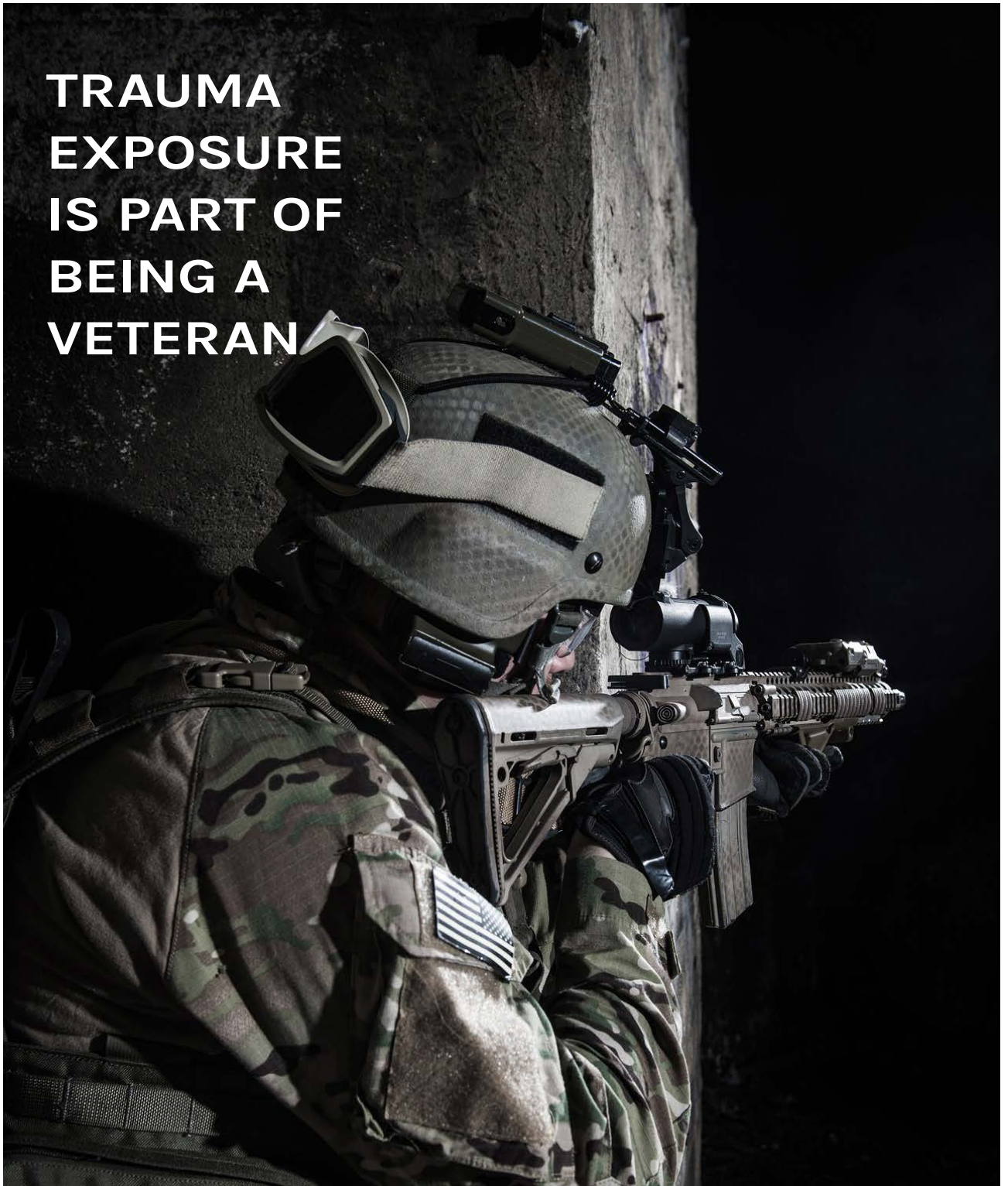


An approach initially developed for those with borderline personality, Dialectical Behavior Therapy (DBT) has been used in the reduction of suicidal thoughts and behavior. DBT aims to offer some of the thought and behavioral training of CBT with mindfulness techniques that support health emotion regulation, tolerance, and interpersonal relationships. Problem-Solving Therapy

(PST) and Interpersonal Therapy (IPT) are other approaches focused on solving problem behavior and addressing life events that may interfere with the coping skills of Veterans; both aim to increase-effectiveness and decrease emotional volatility. The efficacy of CBT, CT-SP, DBT, PST, or IPT at reducing suicide is inconclusive.

VETERAN SUICIDE FAQS

TRAUMA
EXPOSURE
IS PART OF
BEING A
VETERAN



Do Veterans die by suicide more than civilians?

The suicide rate among veterans is estimated at about 30% (30 per 100,000) in comparison the civilian rate is 14% (14 per 100,000 population). The suicide rate is highest amongst younger Veterans aged 18 to 29 years, and lowest in those aged 60 years and older. Looking at the number of annual deaths from suicide, it is the highest in those aged 60 and over, but is in part explained by the larger number of Veterans in this subgroup of all Veterans. The rate of death by suicide is lowest in middle-aged Veterans. The overall number of deaths is greatest in Veterans above 50 years

What Causes Military Personnel to Attempt Suicide?

Suicide is rarely caused by a single problem or issue, but rather seems to be due to a combination of stressors and problems that often occur at the same time. Relationship problems, financial stress, and legal or disciplinary problems are the life events that occur most often in the time before military personnel die by suicide. These situations can cause military personnel to become emotionally overwhelmed. If military personnel start to think that they cannot handle the stress and feel like their problems will never get any better, they may consider suicide

and make a suicide attempt. Relieving emotional pain and/or stopping bad feelings are the most common reasons that military personnel make suicide attempts. Veterans are at increased risk of trauma, and may develop mental health issues as a consequence. For others the transition from military life can result in significant stress that may make a Veteran feel unable to cope.

**TRAUMA IS A
RISK FACTOR FOR
DEPRESSION**

What role does depression play in suicide in Veterans?

Exposure to trauma is a risk factor for depression, and many Veterans are exposed to trauma and death in combat and outside. By itself, depression is a known risk factor for suicide, and approximately 14% of all Veterans develop depression post deployment. It is likely that this is an underestimate of the prevalence of depression. Veterans with living with depression and other psychiatric disorders have close to a 6 fold increase in suicidal ideation. It is important to note, that not all Veterans who are living with depression or PTSD have suicidal thoughts or end their life by suicide.

Is the risk of suicide higher after multiple tours?

Combat exposure can increase the risk and intensity of psychological and behavioral disorders, such as posttraumatic stress disorder, depression, and substance abuse. These conditions increase the risk for suicide. This has led many to conclude that deployments and combat are directly causing the recent increase in military suicides. However, less than half of military personnel who die by suicide have ever been deployed or been in combat, meaning that for the majority of military suicides,

deployment and combat could not be a causes. For those military personnel who have been deployed, combat appears to have a small relationship with increased suicidal thoughts over time. Military personnel who have deployed and who also have posttraumatic stress and depression are more likely to be suicidal, especially if they feel isolated or disconnected from others. Combat veterans who feel like they do not “belong” or “fit in” with others are at greatest risk for suicide.



Is brain injury linked to suicide in Veterans?

Researching the relationship between TBI and suicide is challenging. Veterans with TBI often experience depression and post-traumatic-stress disorder (PTSD), in addition to substance use, that contribute to suicide risk. The incidence of PTSD is greater in Veterans with a history of TBI. PTSD has been shown to contribute to risk of suicide, and having a TBI doubles the risk of having PTSD, and in some by as much as 6x.

Are firearms the reason for suicide in Veterans?

The most common way for military personnel to die by suicide is by firearms. Military personnel are more likely than civilians to use firearms when making a suicide attempt, meaning they are much more likely to die due to how lethal gunshot wounds can be. In general, military personnel seem to make more lethal suicide attempts than civilians, even when using other methods for suicide (e.g., overdose), meaning that they are more likely to die than civilians when they make a suicide attempt. Gun ownership is common in Veterans, with 45% reporting owning a gun, compared to 20% of non-Veterans, with ownership of 6 firearms

on average non-Veterans, with ownership of 6 firearms on average. Male veterans are more likely to use a firearm as a method of suicide, 70.7%, compared to females 43.2%. Although death by firearm has increased for female veterans from 2005 through 2017 by 26%, (from 34.3% to 43.2%), in comparison the increase in males is 2.8% (from 68.8% to 70.7%). In females Veterans, poisoning is the leading means of suicide, including the ingestion of drug and non-drug substances, such as industrial cleaners, pesticides, or prescription and nonprescription medications in conjunction with alcohol.







IMPACT OF COVID

Since 2019 military suicides have increased by 20%, with a 30% increase in active duty suicides (88 death in 2019 and 114 in 2020) and 10% increase (78 death in 2019 and 86 in 2020) likely attributable to the stress associated with COVID-19, as deaths by suicide were showing a decline between January and March 2020. Veterans that have sustained injuries are feeling greater levels of stress and isolation, and have not been able to attend support groups, to prevent the spread of the virus, or any possible worsening of their pre-existing medical condition(s)

in the event of an infection. All personnel, active or not have been seeking more mental health services with an increase in 10% of call to mental health providers or virtual support organizations that prior to the pandemic. The longer term consequences of COVID on suicide remain to be seen, but is likely to follow the current trend of higher number of Veterans dying by suicide.

SUMMARY

Suicide is the second-leading cause of death in Veterans, and in recent years, more military personnel have died by suicide than died in combat. The incidence of death by suicide is greater in male personnel under 35 years of age. Suicide is complex in all populations, and Veterans are no different. The higher

incidence of access to and ownership of guns may explain the high fatality rate of suicidal behavior. Significant efforts by the Veterans Administration have been made to increase awareness, screening, and treatment for those at risk of suicide.





**LATE LIFE SUICIDE OFTEN FATAL, DIMINISHED
PHYSICAL RESERVES & USE OF FATAL MEANS**

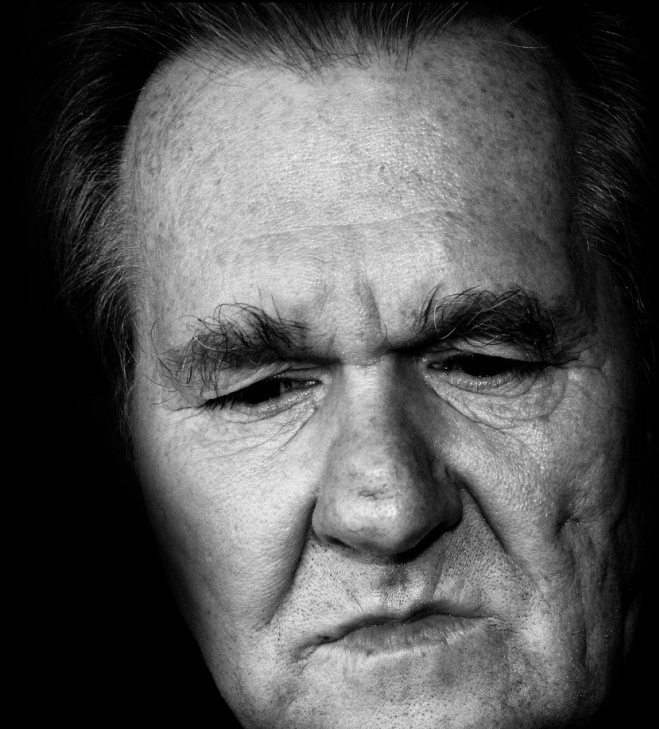
OLDER ADULTS

Attempted suicides are less common in the geriatric population in comparison to younger cohorts. However, the proportion of suicide attempts that are fatal are more substantial, and among a burgeoning geriatric population is an issue of growing public concern.

PREVALENCE

According to World Health Organization (2014), individuals who are age 70 years and older have the highest rates of death by suicide in most areas in the world. In the US suicide rates among all age groups have increased between 2000-2011, deaths from suicide for those aged 50-74 years have almost doubled. The prevalence of suicide increases with age, especially for males. In 2011, white males 85 years or older had a suicide rate of 47.3/100,000 per year. Suicide rates in the elderly have decreased in the last few decades, but the fatality rate in older adults is the highest across all age groups. It is estimated

that in the general population, 10 to 20 suicide attempts occur for every one death. In the geriatric population, the estimate is 4 suicide attempts for every 1 death by suicide. The high fatality rate has been associated with methodical planning of suicide attempts, paired with systemic medical conditions, and limited physiological reserve that makes older adults less likely to survive a suicide attempt. The Interpersonal Theory of Suicide suggests 2 main reasons for suicidal ideation or behavior in older adults - thwarted belongingness and perceived burdensomeness.



50% DEVELOP
DEPRESSION FOR
THE FIRST TIME
AFTER AGE 65



Factors such as living alone, loneliness, and social isolation resulting in limited social support contribute to a sense of thwarted belongingness is a psychologically painful mental state that results when the fundamental need for connectedness are un-met. People that experience are loss of belonging are more likely to engage in suicidal behaviors,

use more immediate lethal means and are more likely to re-attempt death by suicide. In addition perceived burdensomeness a mental state characterized by thoughts that others would be better off if the person is dead are common in situations of physical impairment, family discord, and unemployment

REDUCE RISK

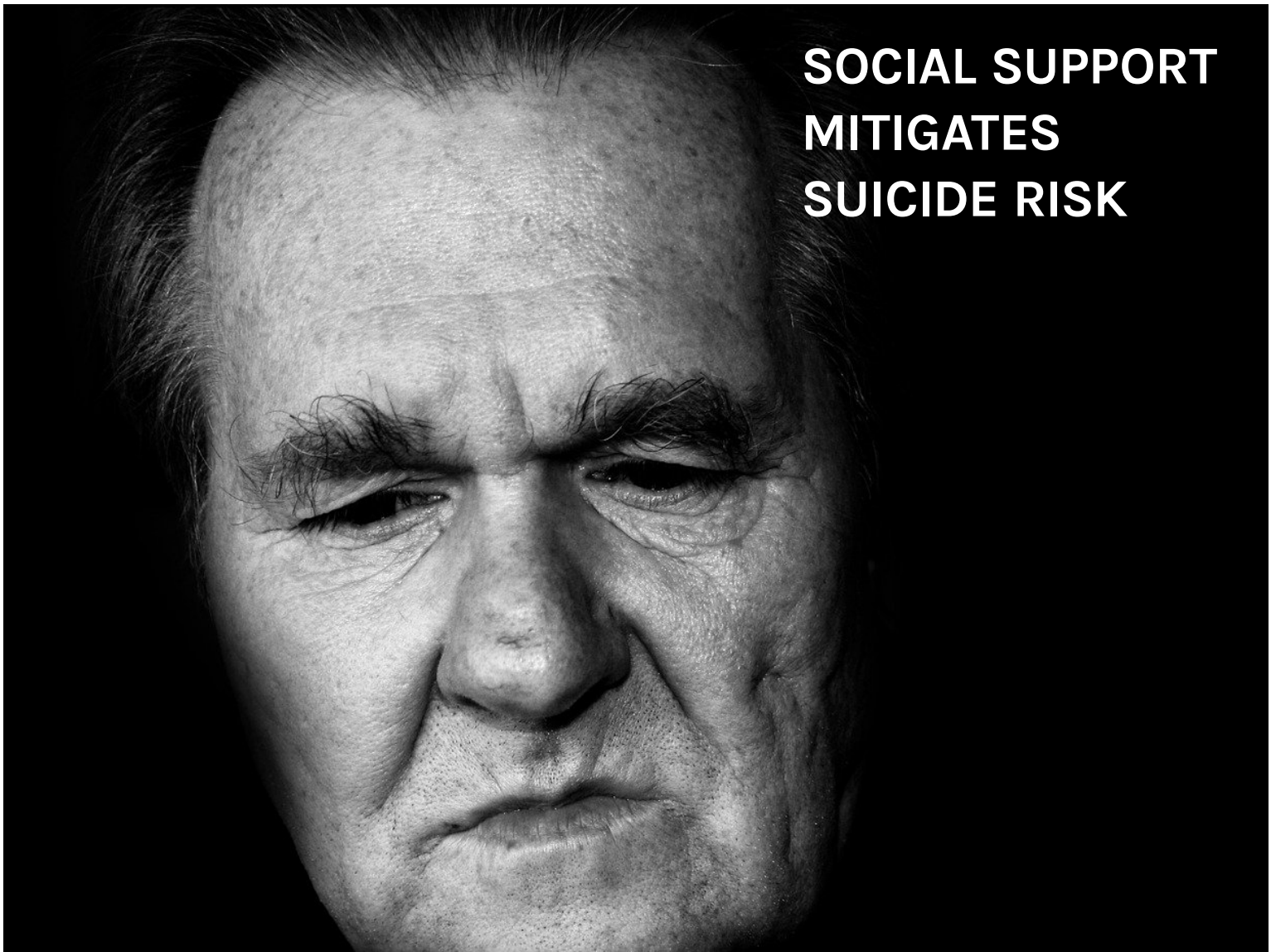
Medical illnesses, pain, disability, hopelessness, and decreased social connectedness have been noted to contribute to suicidality among older adults. A prior history of suicide attempts is a less relevant factor in older adults, as approximately 75% of aging adults who commit suicide have never made a prior attempt. The prevalence of psychiatric disorders is high among geriatric patients who die by suicide. Up to 97% of suicide attempts have been linked to a psychiatric illness. Major psychiatric illnesses were found in 71%-95% of suicides, with depressive disorders the most common conditions, seen in 54% to 87% of suicides. The absence of a psychiatric history does not necessarily moderate the risk of suicide in the aging individual, as many aging adults who commit suicide never sought mental health treatment. Moreover, about 50% of older adults develop depression for the first time after the age of 65 years. Recognition of the various methods of suicide and their

prevalence among seniors can help alert caregivers and family of available dangers in the environment. Firearms, hanging, and poisoning, are the most common ways older die by suicide. Awareness of recent purchase of guns or potentially poisonous substances, stock piling of medications or 'getting affairs in order' are important warning signs.

**50% DEVELOP
DEPRESSION FOR
THE FIRST TIME
AFTER AGE 65**

CTIVE FACTORS

**SOCIAL SUPPORT
MITIGATES
SUICIDE RISK**



ASSESSMENT

In light of the high prevalence of completed suicides in a burgeoning geriatric population, screening for suicide risk may need to be given a higher priority. Because aging adults often do not report suicidal thoughts spontaneously, it is helpful to use a screening instrument as a first step. A suicide risk assessment involves more than informal surveillance or structured screening. A comprehensive, three-stage process typically includes: 1) evaluation of risk and protective factors as well as warning signs, 2) an in-depth clinical interview to elicit suicidal ideation, behavior, planning and intent, and 3) a clinical risk formulation. Nature and extent of the patient's suicidal thoughts, feelings, and specific plans.

- Presenting suicide events (past 48 hours)
- Recent suicide events (preceding 2 months)
- Past suicide events (2 months prior to present)
- Immediate suicide events (feelings, ideation, intent)

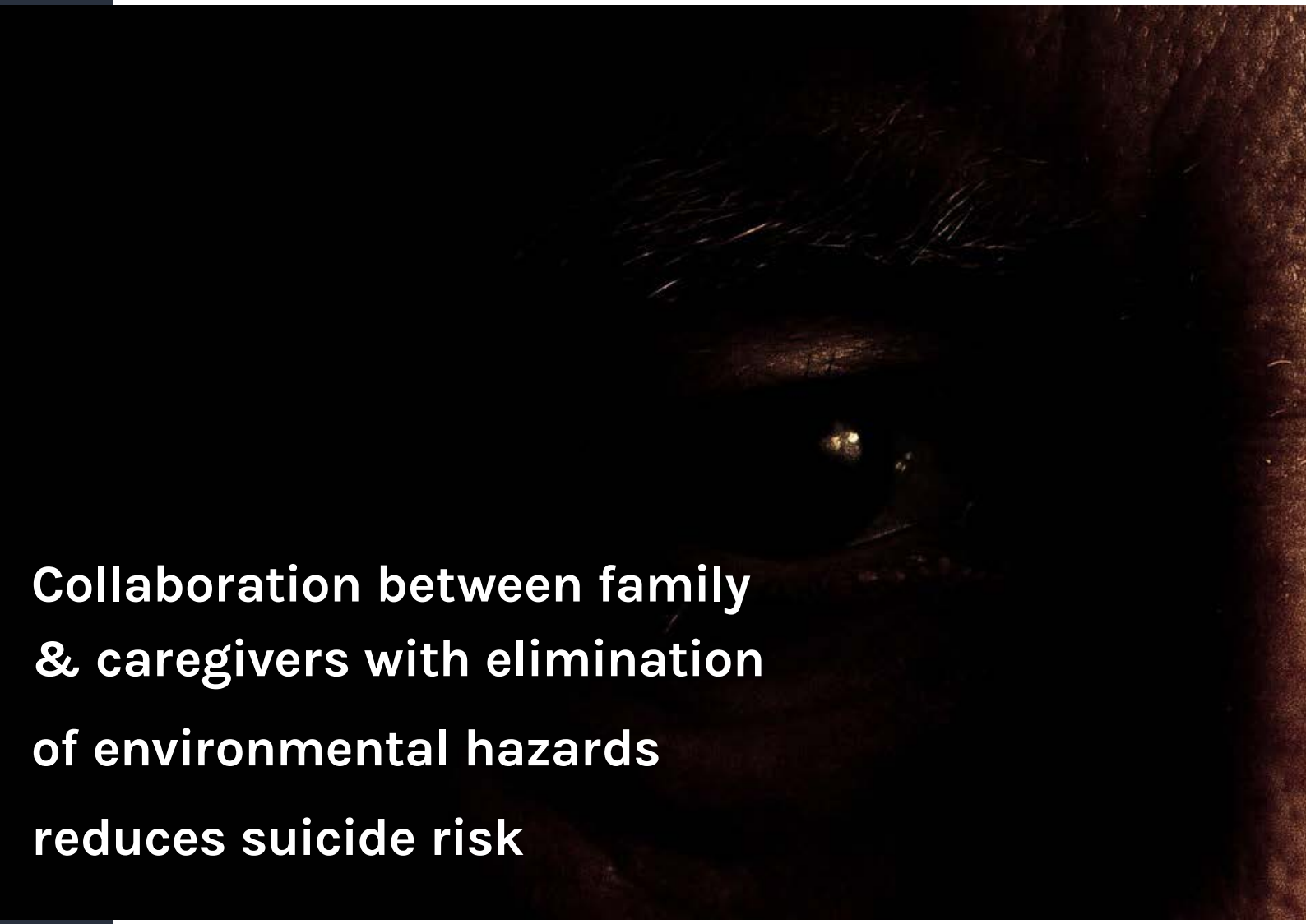


**GETTING "AFFAIRS IN ORDER"
STRONG INDICATOR OF RISK**

PREVENTION

Careful follow up of older adults at potentially increased risk of suicidal behavior, is critical in the prevention of suicidal behavior.

Older Americans living with depression and substance use, both known risk factors for suicide, should be followed closely to reduce the number that die from suicide.



**Collaboration between family
& caregivers with elimination
of environmental hazards
reduces suicide risk**

Under-diagnosed and undertreated alcohol abuse and dependence is a key risk factor for suicide in older adults and an important aspect to prevent suicidal behavior. Elimination of

environmental hazards, and collaboration with family and caregivers with older adults at risk is also important.



TREATMENT

Effective suicide prevention in the elderly should not only focus on mitigating risk factors, but also enhancing protective factors. Understanding what the factors are and what they can and cannot do. Significant others and caregivers may be asked to participate in the development of suicide prevention plans. The plans vary, depending upon the patient's condition, stressors, living environment, resources, and risks. With the suicidal person's permission, the risk of self-harm and death by suicide should be conveyed to caregivers, family, and allied healthcare providers. Safety contracts have sadly not consistently demonstrated prevention of suicidal behavior or death. Identification of support groups, and development of social networks can help mitigate suicide risk in older adults.





The potential efficacy of any treatment plan in older adults with suicidal behavior needs to be considered against the risk of possible adverse effects. Effective pharmacological treatments are available for older adults with suicidal ideation associated with depression or substance use. With antidepressant medication and lithium associated with a reduced risk of suicide compared with placebo. In cases of severe suicidal ideation and intent, paired with a long-history of recurrent episodes of depression Electroconvulsive Treatment (ECT) has shown efficacy, and is safe. Older adults with first occurrence of depression associated with suicidal behavior or whose depression is recent, the difference benefit of medication is less robust.

*"...effective
treatment
is available
for suicidal
behavior
associated with
depression..."*



OLDER ADULTS SUICIDE FAQs

Is the death of a spouse a sign of possible suicide?

Is dementia the reason for suicide in older people?

Are older people wanting to die by suicide depressed?

Suicidal thoughts and behaviors may pose a risk factor for the development of major neurocognitive disorders. Older adults who attempted suicide had an increased risk of developing major neurocognitive disorders later in life. The risk was independent of major depressive disorder and medical comorbidities (e.g. such as fronto temporal dementia).

Among depressive disorders, major depressive disorder has been associated with the highest likelihood of suicide. Depression is the most common psychiatric illness among older adults who die by suicide.

Bereavement most common precipitating life event associated with suicide/ Loss of spouse is a risk factor for suicidal behavior.

Are opioids the reason for suicide in older adults?

Opioids such as fentanyl, hydromorphone, and morphine, show some correlation with suicide, people with severe pain were found to be at increased risk of suicide. Prior prescriptions of these drugs, even at the right doses correlated with subsequent suicide. Medication regimens which have adverse effects on memory, mood, energy, and level of arousal can contribute to suicidality. Non-recommended use of benzodiazepines have shown a correlation with death by suicide, even after controlling poisoning-related suicides. Possibly because the effect of drugs lasts longer, and benzodiazepines contributes to sedation exacerbating the impact of suicidal behavior.

Is chronic illness why older people try to end their life?

Suicidal behavior after age 65 is associated with functional disability and specific medical conditions. Particularly malignant disease, neurological disorder, pain, COPD, liver disease, male genital disorders, and arthritis/arthrosis. Serious systemic illness in any organ is an independent risk factor for suicide. The medical illnesses found highly associated with greater risk of suicide are (i) visual impairment, (ii) neurological disorders, and (iii) malignant disease. The relative suicide risk is increased 5 fold in older adults with 5 or more illness or more illnesses.

Why are more older males dying by suicide than females?

Among elderly males, significant differences are found between the young-old (65-74), middle-old (75-85) and oldest-old (85+), respectively with increasing incidence with greater age. The incidence is significantly greater in older males than older females, across all geriatric age groups. Suicide and serious illness or disability has been found to be more common in men than in women (65% v 44%, $P=0.05$), physical illness was associated with a fourfold increase in the suicide rate in men. Studies suggest that physical illness may be a stronger risk factor for suicide in men than in women.



Awareness of risk factors & routine assessment
essential to decrease suicide rates in older people

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David Teisler, CAE

Director of Communications & Deputy Director

Media Finding Experts

ABCT has a list of speakers and subject matter experts on topics such as PTSD, anxiety, suicide, and more. Details available on the website or by contacting the ABC Press Office.

Media Guidelines for the Responsible Reporting & Depicting of Nonsuicidal Self-Injury (NSSI)



Avoid use of NSSI-related images and details within text, especially of NSSI wounds and methods/tools.



Highlight efforts to seek treatment, stories of recovery, adaptive coping strategies as alternatives to NSSI, and updated treatment and crisis resources.



Avoid misinformation about NSSI by communicating peer-reviewed and empirically supported material, including distinguishing NSSI from suicide.



Present information neutrally; avoid exaggerated descriptions of NSSI prevalence and sensational headlines that include NSSI, especially the method of NSSI.



Use non-stigmatising language and avoid terms that conflate person and behaviour (e.g., cutter, self-injured).

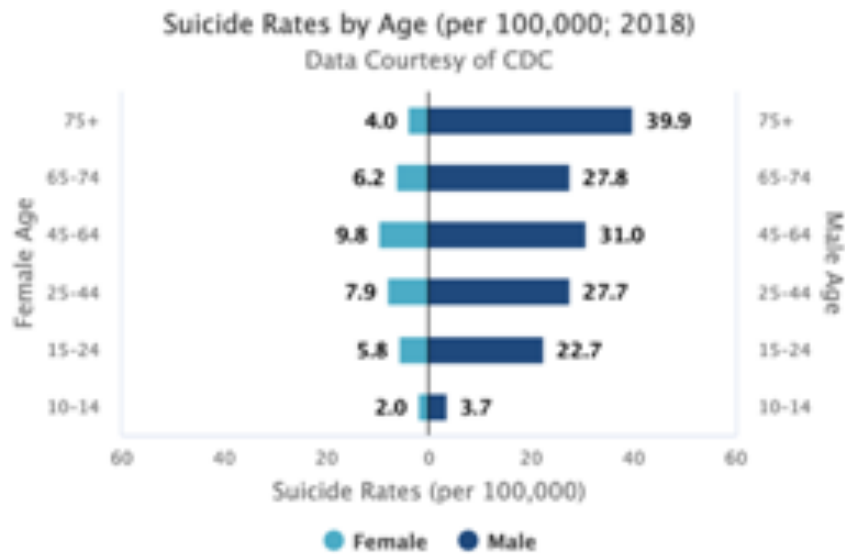


Assure that online article comments are responsibly moderated.

SUICIDE STATISTICS

Leading Cause of Death in the United States (2018) Data Courtesy of CDC							
	Select Age Groups						
Rank	10-14	15-24	25-34	35-44	45-54	55-64	All Ages
1	Unintentional Injury 692	Unintentional Injury 12,044	Unintentional Injury 24,614	Unintentional Injury 22,667	Malignant Neoplasms 37,301	Malignant Neoplasms 113,947	Heart Disease 655,381
2	Suicide 596	Suicide 6,211	Suicide 8,020	Malignant Neoplasms 10,640	Heart Disease 32,220	Heart Disease 81,042	Malignant Neoplasms 599,274
3	Malignant Neoplasms 450	Homicide 4,607	Homicide 5,234	Heart Disease 10,532	Unintentional Injury 23,056	Unintentional Injury 23,693	Unintentional Injury 167,127
4	Congenital Abnormalities 172	Malignant Neoplasms 1,371	Malignant Neoplasms 3,684	Suicide 7,521	Suicide 8,345	CLRD 18,804	CLRD 159,486
5	Homicide 168	Heart Disease 905	Heart Disease 3,561	Homicide 3,304	Liver Disease 8,157	Diabetes Mellitus 14,941	Cerebro-vascular 147,810
6	Heart Disease 101	Congenital Anomalies 354	Liver Disease 1,008	Liver Disease 3,108	Diabetes Mellitus 6,414	Liver Disease 13,945	Alzheimer's Disease 122,019
7	CLRD 64	Diabetes Mellitus 246	Diabetes Mellitus 837	Diabetes Mellitus 2,282	Cerebro-vascular 5,128	Cerebro-vascular 12,789	Diabetes Mellitus 84,946
8	Cerebro-vascular 54	Influenza & Pneumonia 200	Cerebro-vascular 567	Cerebro-vascular 1,704	CLRD 3,807	Suicide 8,540	Influenza & Pneumonia 59,120
9	Influenza & Pneumonia 51	CLRD 165	HIV 482	Influenza & Pneumonia 956	Septicemia 2,380	Septicemia 5,956	Nephritis 51,386
10	Benign Neoplasms 30	Complicated Pregnancy 151	Influenza & Pneumonia 457	Septicemia 829	Influenza & Pneumonia 2,339	Influenza & Pneumonia 5,858	Suicide 48,344

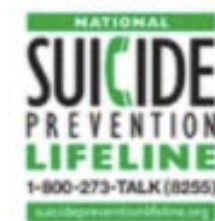
CLRD: Chronic Lower Respiratory Disease



USEFUL RESOURCES



www.veteranscrisisline.net



www.suicidepreventionlifeline.org



www.afsp.org



www.theactionalliance.org

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BRIEFING BOOKS