Additional Literature to Consider (Suicidal Ideation)

BOOKS:

Facing Suicide: Understanding Why People Kill Themselves and How We Can Stop Them by James Barrat

Suicidal: Why We Kill Ourselves by Jesse Bering

Reasons to Stay Alive by Matt Haig

Night Falls Fast: Understanding Suicide by Kay Redfield Jamison

Why People Die by Suicide by Thomas Joiner

How Not to Kill Yourself: A Portrait of the Suicidal Mind by Clancy Martin

Autopsy of the Suicidal Mind by Edwin S. Shneidman

The Suicide Myth by Michael Yapko

The Tennis Partner by Abraham Verghese

I Want to Escape: Reaching for Hope When Life Is Too Much by Rush Witt

ARTICLES OR MINIBOOKS:

"Making Sense of the Suicide of a Christian" by Jeffrey Black (JBC and MB)

"Evaluating A Person with Suicidal Desires" by Aaron Sironi and Mike Emlet (JBC)

"Teens and Suicide: Recognizing the Signs and Sharing Hope" by Julie Lowe (JBC)

I Just Want to Die: Replacing Suicidal Thoughts with Hope by David Powlison (MB)

Approaching the Intervention: Examine the Suicidal Desires
By: Shauna Van Dyke

1. Examine the degree of intention. Ask direct and clarifying questions to help them get safe, Right Now.

What are their thoughts…

- Are you thinking of killing yourself today?
- Have you had thoughts of taking your own life?
- Have you tried to hurt yourself recently?
- Have you thought about ways to kill yourself?
- Are you having those thoughts right now?
- How often do you think about taking your life – several times a day, once a day/week?

*A person who has a plan is much more likely to actually commit suicide than someone who is merely thinking about it, though both should be taken seriously. The lethality of their method of choice also raises the degree of action to be taken[1].

How would they do it…

- Do you already have a plan for how you would take your life?
- Do you have pills/weapons in the house?
- What ways have you thought about doing it?
- Do you currently have the resources to do it?

*When the person speaks of a specific means ("with the gun in my dresser drawer" or "jump off 'x' bridge", or "take all the pills in my medicine cabinet") their threat should be treated as an absolute fact. This means contacting emergency contact, ensuring 24-hour-a-day supervision, and alerting law enforcement (if necessary).

When would they do it…

- When do you plan to do it?
- Is this something you plan to do soon?
- How long have you been having these thoughts or planning this?

[1] First aid counsel for a suicidal friend by Brad Hambrick. You can find several resources on his website at www.bradhambrick.com

Why have they not done it yet…

- Why have you not taken your life already? *kids, animals, job, fear, etc.
- What has kept you from taking your own life?
- What are your reasons to live?
- How could your situation look different in a month or year from now?
- What does suicide solve for you? What other solutions might be options?
- What things in life would you still like to do/experience/achieve?
- What purpose would your death serve (to punish someone, relief from pain, get attention)?
- What obstacle would you need to overcome in order for life to be worth living?

Who knows of your struggle…

- Have you shared this with anyone else?
- Have you begun saying good-byes, written a farewell letter, or given things away?
    - **A more cheerful attitude is not necessarily a sign of improvement. Often after the person has finalized their plan to kill themselves, they are relieved that a decision has been made. Again, the best procedure is to ask direct questions and maintain supervision.*
    - Who have you tried getting help before? ○ Who else would you feel comfortable telling?
- What fears do you have in telling other people?
- Has a close family member or friend committed suicide?
    - **Having a close family member or friend who has committed suicide removes much of the taboo from the act. A person who has been through the process before may not be as frightened by the idea of suicide.*
- When are you going to be alone in the coming days/weeks?
- Who in your life could provide you support, be a prayer partner, offer accountability or give encouragement?
- Is there someone in your family who can manage your medication for you?
- Is there someone in your family who could hold your guns for now?
    - *Note: once a person is identified, call them together to include them in the safety plan.

*Most of the questions are open-ended questions so you avoid 'yes or no' answers and encourage an in depth response.

2.Examine the history of suicide attempts.

Details of past attempts…

- How many times in the past have you tried taking your own life?
    - **look for similarities & differences between attempts*
- Can you share with me the details of those moments leading up to that attempt?

- *any significant events happen, what were their dominating thoughts, etc.*
- Do you find yourself drinking a lot or doing any type of drugs?
  - *ask them to share past history and any current usage*
- When those attempts happened, who was your support system? Who helped you afterwards? *gather the names and numbers ○ *are they still in relationship with these people and could they support them now?*
- What did you appreciate or not appreciate in the way they helped you?
  - *let this help determine the type of support to put in place moving forward.*
- Have you ever been admitted to a hospital or care facility? If so, when and how many times?
- Do you think you need to be voluntarily admitted to a care facility to help you stabilize your emotional state right now? Why or Why not? ○ *note even if they don't think so, doesn't mean you still don't proceed with getting them the help needed. It's just a way to see how willing they are to get the help needed.*

3.Examine their relationship with the Lord

What is their spiritual maturity…

- How are you (or not) currently going to the Lord with your thoughts?
- What is your view of God, Jesus, and the Holy Spirit in this situation?
- Are you mad at God? Do you trust Him?
- Do you read the Word? Do you currently find this helpful?
- How is your prayer life?
- Are you involved within your church community?

*If someone has said Yes to wanting to take their life, your primary goal is to get them safe right now. You normally won't spend a long time in this section for 'examining,' but you can use some of these answers to help you prepare for your next session with them. You will, however, spend the next part of your time – sharing hope and encouraging them in scripture.

Personal Safety Plan

What are possible warning signs that a crisis is developing? Triggers, internal thoughts or feelings, behavior changes, certain time of day, etc.

_____
_____
_____

How can you make your home safe, right now, before a crisis? What do you need to remove? What things do you need to add?

_____
_____
_____

When I'm in a crisis, what are some healthy actions I can take?

_____
_____
_____

What are things that are important to me?

_____
_____
_____

Who can I call daily for encouragement?

_____
_____
_____

Who can I call in the moment of crisis to help me? Hotline: 1-800-273-8255 (TALK)

_____
_____
_____

What things have I agreed with my counselor to implement this week?

_____
_____
_____

I agree to… ○ Schedule and attend another counseling session ○ Not place myself in situations where I will be alone ○ Remove objects with which I could harm myself

from my direct access ○ Refrain from alcohol, drugs, or other mood-altering substances ○ Distance myself from situations/people that tend to trigger my despair

○ If at any time I should feel unable to resist suicidal thoughts or impulses, I agree to call the people I listed above or the Hotline immediately.

Organizing the Postvention

By Josh Weidmann

We must not underestimate the profound responsibility and privilege we have in ministering to those affected by suicide. In their darkest hours, they need hope and healing that only Jesus can provide. Let us commit to give them *"C.H.R.I.S.T."*

I. ***C*OMMIT to Reflecting Christ's Heart of Compassion** (Matthew 9:36)**.**

II. ***H*ELP the Community Grasp the Impact of Suicide** (1 Corinthians 12:26)**.**

III. ***R*OOT Your Efforts in Biblical Truth** (Psalm 119:105).

IV. ***I*MPLEMENT Practical Steps to Minister Effectively** (1 John 3:18).

V. ***S*TRENGTHEN a Healing Church Community** (Colossians 3:12-14).

VI. ***T*EACH Leaders to Keep Watch Effectively** (Hebrews 10:24-25).

Books

A Quiet Mind to Suffer With: Mental Illness, Trauma, and the Death of Christ by John Andrew Bryant

Conduct Gospel-Centered Funerals: Applying the Gospel at the Unique Challenges of Death by Brian Croft and Phil Newton

Dark Clouds, Deep Mercy: Discovering the Grace of Lament by Mark Vroegop

Preaching Hope in Darkness: Help for Pastors in Addressing Suicide from the Pulpit by Scott M. Gibson and Karen Mason

Suicide: Understanding and Intervening by Jeffrey S. Black

Online Resources

20 Recommended Resources Related to Suicide Prevention and Grieving a Suicide - BCC book list by Paul Tautges

Alive to Thrive - Focus on the Family training on preventing teen suicide

Counseling after a Suicide - IBCD lecture by Jim Newheiser

Evaluating a Person with Suicidal Desires - JBC article by Aaron Sironi and Mike Emlet

Hope & Help for Teens and Suicide - IBCD podcast with Julie Lowe

Nine Guidelines for Counseling Suicidal People - BCC article by Robert Jones

Why Pastors Are Committing Suicide - TGC article by Sarah Eekhoff Zylstra

Secular Resources

New Research Shows Alarming Number of Suicidal Thoughts Among Young Children with Autism Spectrum Disorder - Overview of JAMA Article

No Time to Say Goodbye: Surviving The Suicide Of A Loved One - Book by Carla Fina

Suicides Have Increased. Is This an Existential Crisis? - NY Times article by Clay Routledge

The Collaborative Assessment and Management of Suicidality (CAMS) - Book by David A. Jobes

The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors - Book by Shawn Christopher Shea

Suicide Screening Tools

ASQ Toolkit Summary - NIMH Toolkit

Suicide Risk Screening Tool - NIMH Toolkit

Brief Suicide Safety Assessment - NIMH Toolkit: Youth Outpatient

Patient Health Questionnaire- Adolescents - NIMH

Columbia-Suicide Severity Rating Scale - Columbia Lighthouse Project (instructions here)

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) - Substance Abuse and Mental Health Services Administration Guidelines

Evaluating a Person with Suicidal Desires

by Aaron Sironi and Michael R. Emlet

If you have done much counseling, you already know that you need to be prepared to assess whether or not someone is suicidal. Scripture tells us, and our experience confirms, "The purposes of a person's heart are deep waters…" The very counsel in a person's heart is inaccessible, unfathomable, and possibly dangerous (like deep waters). But God does not leave us in fearful paralysis or ignorance with one another, for "…one who has insight draws them out" (Pro 20:5). An understanding and wise person is skillfully able to draw out the hidden thoughts and intentions of the heart. Suicidal thoughts, desires, and motives often lie concealed beneath the surface of what a person is able and willing to verbalize. However, these purposes are accessible as we grow in our ability to speak with people in constructive and intentional ways—and always with good, saving purposes.

What is the basis for drawing out a troubled person's heart? We serve a gracious God who deeply cares about the hidden intentions, troubles, and cares of our hearts. He searches and examines our souls as a token of his love for us. Compassionately, he discerns our secret thoughts and purposes. This is one way he mercifully loves us. A Christian's call, therefore, is also to love others in this way.

This article will lay the groundwork for how to do this in the very specific area of suicide assessment. It will help you to determine where a person who may be considering suicide fits on a spectrum of suicidality, while guiding you wisely and confidently to intervene in a crisis. This article does not construct a theological explanation of suicide, nor will it discuss all the features of an ongoing counseling relationship with someone who struggles with suicidal desires. Although these are important discussions, they are beyond the scope of this article.

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Overcome Your Own Hesitancies and Confidently Inquire

Asking someone about suicidal thinking is challenging because it *is* such a personal question. It is a weighty matter: life and death. Your own experience, feelings, and beliefs about suicide come into play. Exploring the details of someone's specific plans for self-harm is not an easy or comfortable conversation for either the counselee or counselor. Counselees often feel guilt and shame. They may not raise the issue unless directly asked. Even when asked, they may avoid implicating themselves. Further, caring wisely for a person who intensely wants to die stirs up your own thoughts, feelings, and questions:

ow what I'm looking for. s If I ask the questions, will counselee be honest with me? And will I know to do with the answers?

ese are natural fears and uncertainties. But coming your own internal barriers to assessment prerequisite for moving toward signs (i.e., risk

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suicidal thoughts will plant ideas of self
mind. Do not be afraid

rs) in someone, it gives us good reason to wonder s person might be struggling with a desire to die. ng these signs should trigger an intuitive sense that

s Will I humiliate or offend my counselee by raising this question?

s I'm not sure I have time to bring up this issue right now.

s I get anxious just thinking about doing this assessment. s Will I ask the right questions? I'm not sure

this desperate person in wisdom and love. it is a myth to think that asking someone about suicidal thoughts will plant ideas of self-harm in that person's mind. Do not be afraid to ask. *Not* asking or *not* following up on a passing suicidal comment is a greater danger. Invariably, counselees who think suicidal thoughts are grateful and relieved that the issue has been raised. It gives a person permission to talk about these feelings and desires. Because suicide is a shameful and taboo subject, discussing it directly invites a person to open up to you. So put the clipboard down. Move out from behind the desk. Eliminate all other distractions. The counselor's attentiveness and willingness to speak frankly about suicide communicates constructive kindness and courage. This may be the first sign of hope for the counselee that someone is willing and competent to help.

ead to asking a few thoughtful questions. It is like ng at dusk through a wooded area. When you see rning sign for deer crossing, it does not mean you see a deer. But what it does mean is that there may eer in these woods. Keep your eyes open, slow n and drive carefully. Suicide risk factors are the ing signs that alert us to the possibility that this on may be struggling with suicidal desires.

Recognize Risk Factors for Suicide

More than seventy-five risk factors have been correlated to suicide. Counselors are often tempted to try to gauge a person's level of danger based on the number of risk factors that are present. But assessing a person's lethality is not a science. Not a single piece of research can point to a certain blend of risk factors that invariably predicts suicide. So why is it crucial to be familiar with the most common risk factors?

Because when we see some of these warning One way to learn and remember the most common risk factors is to use acronyms. The two that we think are the most useful are: SAD PERSONS[1] and NO HOPE.[2] First we will review the SAD PERSONS acronym.

Sex: 7 out of every 10 completed suicides are male. Yet females attempt to kill themselves three times as often. The methods men use tend to be more lethal. Generally, a suicidal man is more dangerous than a suicidal woman. **A**ge: Two age groups present the highest risk— adolescents and elderly facing chronic illness. **D**epression: Any serious psychiatric diagnosis (e.g., depression, bipolar disorder, anorexia, post-traumatic stress disorder, or a personality disorder) increases concern.

Previous attempt: Once a person makes a suicide attempt, the risk is much higher. **E**thanol (alcohol) or drug abuse: Almost half of suicides involve substance abuse. **R**ational thought loss: This describes someone suffering from psychosis or delusional hyperreligiosity. Such persons may experience command hallucinations from an outside power (including Satan) that badger them to kill themselves, or they may fixate on a passage of Scripture regarding martyrdom or human sacrifice. The loss of the ability to think clearly due to delusions or hallucinations can remove the final obstacle to a person committing suicide.

Social supports lacking: This describes a person who is isolated and has little supportive community, or who has suffered a recent interpersonal loss. Be cautious if you perceive that this person lacks a sense of belonging to others. Does this person have even a few individuals who care and connect in a meaningful way? **O**rganized plan: The degree of planning and the lethality of the plan are the most significant factors to assess. (We'll address this later.)

No Spouse: Divorced, widowed, separated, or single people are at higher risk. A deep sense of being disconnected and isolated is correlated with greater risk.

Sickness: The presence of a severe, chronic or debilitating illness increases the risk. The second acronym, NO HOPE, was developed to add more depth to the SAD PERSONS acronym.

No framework for meaning: A person sees current suffering as meaningless and unbearable, and is hopeless that it will ever end or improve. Some researchers identify this hopelessness as the common thread in lethal suicide attempts.

Overt change in physical or emotional condition: A sudden change in a medical condition (e.g., head trauma, cancer, thyroid irregularities) or mental status (e.g., a normally calm person becomes increasingly agitated, or a generally anxious person has an unexplained calmness or sudden drop in anxiety) may be associated with suicidal resolve.

Hostile interpersonal environment: This might include the presence of destructive conflict, abuse, or humiliation in an important area of a person's life, like at home, work, school or church.

Out of hospital recently: This refers to a recent discharge from a psychiatric hospital. There are two main reasons for psychiatric hospitalizations: serious suicidal intentions and/or being unable to care for oneself because of a loss of rational thought ability.

Pvolatile individuals (e.g., those who would meet redisposing personality factors: Emotionally diagnostic criteria for borderline personality, histrionic personality, etc.) present a higher risk.

Excuses or reasons for dying are present and strongly believed: A person may feel incompetent, ineffective and deficient. These perceived inadequacies both affect others and are seen by them. Not only does this person have a deep perception of being a burden, but starts to believe that others would be better off if the person were no longer around. Here you sense a twisted benevolence.

These two acronyms help the counselor cue into the possibility that a person may be struggling with a desire to die. It is important to understand that a person may possess many risk factors, but not be imminently dangerous. Conversely, a person who has just a few risk factors may be highly dangerous. With this said, four risk factors require more attention than the rest:

- a previous suicide attempt,
- rational thought loss (psychosis) that indicates lethality,
- hopelessness (no framework for meaning), and/or
- an organized plan.

Possibly the most crucial of these is the presence of an organized plan to die. Danger lies in a person's concrete suicide plans. It's here we find the clearest indication of whether or not a person is about to act on the desire to die. Think of it this way: one man may spend time fantasizing about a Hawaiian holiday. Another man does extensive research online, has sufficient funds in the bank, secures vacation time from work, reserves a condo, and books the flight. Which of these two people is more likely to act on the desire for a Hawaiian getaway? In the same way, a person who has concrete plans to die is very dangerous. Planning a Hawaiian vacation is rarely done in secret, but planning suicide is almost always latent and hidden deep in a person's inner world. So how do we invite a person to open this inner world to us?

Be thoughtful, calm and matter-of-fact when starting the conversation. It may seem awkward and uncomfortable for you because you may not live with a nagging desire to die. But to the person who does, having someone sincerely and calmly open up the topic is a blessing. You may be the first person to care enough to ask. And your asking may be the first hope that this person does not have to bear these thoughts alone any longer.

The first question is always the most difficult. Be careful not to communicate fearfulness, judgment, self-righteousness or irritation. If you do, the person may not trust you enough to let you in.

Likewise, do not "spring" the suicide question on a person. Instead, gently lead into this discussion as you find natural entry gates. For example:

- "Sometimes when a person is feeling sad and hopeless, he might think about escaping or killing himself. Have you ever had these thoughts and feelings?"
- "I know you have strong beliefs about suicide, but with all that's happened, I'm wondering if you've had some desires to kill yourself, even if they're just fleeting?"
- "Some people who struggle with chronic pain, day in and day out, feel so weary that they start to long for an end. Have you ever yearned for an end to your life or wished that you were dead?" If the person answers yes, you could follow up with, "So you long for death. Have you had any thoughts, even in passing, about killing yourself to end that pain?"

Often people deny suicidal thoughts on the first general inquiry. If a person denies thoughts of suicide or answers with a vague "not really," try and enter through a side door by asking at least one more specific question. Being ready to ask the question in different ways will increase the likelihood that you will help the counselee become comfortable talking to you about this difficult topic. Approaching a person with a gentle assumption that there is a struggle works against the taboo nature of suicide. Even expressing mild surprise after a person denies any suicidal feelings may give the person yet another chance to open up these desires without losing face.

Evaluate Degree of Suicidal Intention

Once a counselee has acknowledged suicidal thoughts, the next goal is to assess the intensity of suicidal thoughts (frequency and duration) and the extent of planning through

a series of progressively probing questions. Here are two rules of thumb:

- The longer, more frequent, and more intense the thoughts of dying have been, the more concerned you should be.
- The more concrete and thorough the planning, the greater the danger.

Killing yourself is not easy. It takes much forethought, inner wrestling and planning. So you must evaluate how much time and planning have been put into these thoughts.

Shawn Shea developed an engaging and dependable approach to eliciting suicidal ideation that is easy to learn and remember. He calls his approach the Chronological Assessment of Suicide Events (CASE).[3] In the CASE method, you explore four distinct time periods in a person's life that are important to evaluating suicidality. Although we will maintain his four time periods, we rearranged the sequence to better suit a pastoral or counseling office setting (though note that the components of any assessment may vary based on the unique circumstance).

1. Last 6-8 weeks: For many people, suicidal desires wax and wane. Choosing the last two months is strategic in capturing enough time to see this movement. If you ask for less, you may catch a person in the midst of a "good week," and miss the information you are seeking. Start by assessing the intensity of the suicidal feelings and thoughts. How often and how much time does this person spend thinking about dying? It's a good habit to aim high when you ask questions here. Ask something like this:

- "Over the last six to eight weeks, how much time would you say you've thought about killing yourself? Every day? Every other day?"
- "How much of the day would you say you think about dying? All day? 90% of the day? 50% of the day?"

Remember, the more prolonged, the more recurrent, and the more acute the thoughts of dying have been, the more concerned you should be.

Next, inquire about this person's specific plans during the same time period. Start by asking a general question like, "In the last six to eight weeks, what are the ways you've thought of to kill yourself? "If the person denies a detailed suicide plan, do not stop there. Ask distinct questions about every method that might be accessible. A good habit to form is to follow a general denial of suicidal plans with more specific questions. You might follow up an outright denial with:

- "Have you ever thought about overdosing on pills?"

s “What about hanging yourself?” s “In the last two months, have you thought about jumping off a bridge?”

s “Have you ever thought of shooting yourself?”

Do not be surprised when a person acknowledges suicidal ideas when you ask precise questions, even after having denied your initial inquiry; it is harder to deny a specific question than a general one. When a person confesses a specific method of suicide, the next logical question is whether or not this person has the resources and competency to do it. Let’s say a man confesses that he has thought about shooting himself. Some follow up questions would be: s “Do you own or have access to a gun?” s “Have you ever shot it?” s “Have you purchased ammunition?” s “Have you ever taken the gun out and placed the gun (loaded or unloaded) up to your body or head?”

What are we doing here? We are assessing this person’s resources, the know-how, and how much groundwork this man has laid to carry out the plan. Continue to search out other suicidal means until you have exhausted all reasonable methods. Bookend this inquiry with another general question: “In the last two months, what other ways have you thought of to end your life?” Or, “Is there any other way that I have missed?”

Remember, as you evaluate the last six to eight weeks, you are seeking to understand the frequency and intensity of these feelings, to uncover every possible concrete method, and to judge if this person has the know-how and means to kill himself.

Think of this using a diving board metaphor. For a child to go from learning to swim to jumping off the high dive is a process that takes time and repeated practice. Children learn to swim, jump into a pool from the edge, and then give the low diving board a try. After they have safely and successfully conquered the low dive, they start to consider the high dive. Even then, it may take several harrowing trips up and down the ladder before a child is ready to walk the plank. Eventually, a child is able to walk the length of the high diving board and leap into the pool. In the same way, killing oneself is usually a process that takes repeated practice and exposure for a person to actually complete it.

Keeping with this metaphor, learning to swim and jumping in from the side of the pool might be a person longing for a “way out” or an escape from a particularly painful struggle. Here you might sense a transient desire for death or a disquiet yearning for heaven. Proceeding to the low dive might be fantasizing about ending life or playing a mental video of how to die. Climbing the ladder to the high dive would be researching, obtaining the means, and then rehearsing a suicide plan. Walking out onto the high diving board might be a dry run at suicide. Jumping from the high dive would be an actual suicide attempt. In assessing suicidal intensity and the degree of suicidal planning, we are trying to locate a person on the spectrum from desiring to die to being ready and able to commit suicide.

As you evaluate a person, you may discover that this person has actually attempted suicide or has aborted an attempt at the last moment in the last two months. If this is the case, the task before you is to assess the seriousness of the attempt or suicidal gesture.

2. Recent suicide attempt: The best way to gauge the seriousness of a suicide attempt is to enter a person’s world at the time it occurred. Ask your counselee to describe the most recent suicidal attempt from beginning to end without leaving out a single detail. Get the play-by-play unfolding (verbal video tape) of the person’s experience. Here are some questions:

s “Pretend I am watching a tape of the night you attempted suicide. What would I see and hear, from beginning to end?”

s “Pretend I am inside your head that night. I really want to know what you were thinking and feeling at every step.”

s “What led up to this incident?” s “What happened next? Walk me through yesterday step by step.”

s “When you say you got angry at your wife, what exactly did you do?”

s “How many pills did you stockpile?... Did you put the 15 pills in your mouth?”

- s "Where did you make the cut on your body?... Did it require stitches?... May I see the scar?"

Encourage the person to go slowly and not leave out a single detail. Asking precise questions often gains access to a person's inner conflict, ambivalence and rationalization. Your aim is to gauge the seriousness of the suicide attempt while looking for reasons the person chooses to remain alive. In other words, did this person really want to die? Are there any bottom-line reasons to stay alive? It is crucial to uncover why the suicide attempt failed or was interrupted and how the person feels about this. Ask questions like:

- s "Why didn't you pull the trigger?" s "Why did you spit out the pills?" s "What kept you from using the razor blade?"
- s "How were you found, and who found you?"
- s "Did you hint to anyone before you locked yourself in the bedroom?"
- s "How do you feel about the fact that you're still alive?"

Throughout this process, there should be one single question running in the back of your mind: "What are this person's reasons to live?" This is important. A person can have several risk factors and even desire death. But if this person has meaningful reasons to live, suicide is less likely. These might include concern for loved ones, belief that suicide is sin and is not an option for Christians, fear of actually doing it, or a faint hope that things will improve. When you uncover the things that moor a person to life, do not miss the opportunity to affirm these. This does not mean a person will not develop an overriding justification in the future for proceeding to suicide, but the presence of current risk mitigators is a good sign that suicide risk may not be imminent. Keep in mind you are balancing many factors, and ongoing assessment is essential.

After you have evaluated a person's recent (last six to eight weeks) struggle with suicidal desires (frequency and intensity) and the most recent plan or attempt, now it is time to place this current struggle in a broader context.

3. Previous history of serious suicide attempts: A person's past history of suicide attempts and ideation will contextualize the present struggle. Here you assess the number of times a person has been suicidal and identify the most serious attempts before two months ago. What are the similarities and differences between past attempts and this present attempt? Unfortunately, practice can be lethal. If a person has a long history of multiple suicide attempts, it could indicate a pattern of manipulation, or it could indicate an exhaustion of hope. Be sure not to spend too much time in this category and avoid getting bogged down with distant details. Here are some possible questions:

- s "Before two months ago, what was the most serious attempt to kill yourself?"
- s "How many times would you say that you've tried to kill yourself?"
- s "Has there ever been a season in your life when a part of you wanted to die?"
- s "Have you ever done something—taking a few pills, let's say—thinking maybe that it would hurt or kill you…or something like that?"

Getting a more distant history helps you to assess if a person is practiced, chronically despairing and hopeless, or has begun to use suicidal actions as a way to communicate to others. If a person downplays a recent incident but has a history of a serious suicide attempt, be skeptical and aware that this person may be minimizing the seriousness of this last attempt. Remember, practice is deadly. Be very cautious if a person has a history of suicide attempts that mirror a recent attempt. If a person denies any past history of suicidal attempts, make sure and ask a second or third question (try the side door by asking about specific ways this person may have considered). After you understand how the person's history of suicidal attempts impacts recent suicidal desires, finish by assessing the present. This may be the most important time period for predicting a person's level of danger.

4. Right now and the immediate future: As you speak with your counselee in your office, what is this person's current intent to die? Directly ask,

"Right now are you having thoughts or feelings of killing yourself?" If the person denies suicidal thoughts ask, "What will happen when you return home and tomorrow night you start to think about killing yourself?" You will derive important information about a person's commitment to safety (or lack thereof) with these "right now" and "tomorrow" questions. At the same time, it gives you a good opportunity to talk about what to do if and when the suicidal feelings return.

One final tool is to ask the person to make a safety contract with you. This acts as one closing cue of where a counselee is at. When you ask a person to do this, the response (both verbal and nonverbal) may be the final assurance you need to make a wise decision for this person's care. With good eye contact and a solid handshake ask: "Will you contract with me that you absolutely will talk to me or to an

Communicate to this person that you take this very seriously. If the person becomes gamy, hesitates, avoids eye contact, or shows signs of ambivalence or discomfort, your work is not done. Find out why it is hard for this person to commit to safety.

No research has shown a safety contract to be a deterrent for suicide. But it can be an excellent tool to assess danger. Remember that your exploration of the past 6-8 weeks may uncover information that still makes protective hospitalization wise, even if the person denies suicidal thinking at this moment (e.g., if you've assessed that the person has assembled the means to commit suicide and you are worried that a resurgence of suicidal thinking may be unbearable). If the person had frequent suicidal thinking and planning over the last 6-8 weeks, but denies it in the present, you need to understand the reasons for the change. Why has the perspective changed? Has this person truly descended the high dive ladder? Or is this person so committed to dying that the denials are lies to throw you off? Further questioning will help sort this out.

In summary, the CASE approach to evaluating suicidality looks at four time periods: (1) the last 6-8 weeks, (2) the most recent suicide attempt, (3) previous history of serious

in your church (for example) before you do ıing to hurt yourself? And if you can't reach us, will :ell your spouse and call the crisis hotline before ; anything to harm yourself?" Or, "Will you agree ɔ harm yourself until we meet again in two days?" to develop a safety plan.

Make a Safety Plan with the Person

"I will seek out my sheep, and I will rescue them from all places where they have been scattered on a day of clouds and thick darkness" (Ezek 34:12). Our God pursues and rescues wayward people in danger. Our call is to embody this love to hurting people. Therefore, to the extent we are able, we work to ensure that the suicidal person remains safe. So, after evaluating a person's risk factors and level of suicidal thinking/behavior, it is time to make a safety plan.

Our God pursues and rescues waywa
Our call is to embody this love to

suicide attempts (prior to two months ago), and (4) right now and into the immediate future. If you have faithfully and adequately assessed each of these with a person, you are now ready Ask God to help you make wise decisions that protect your counselee's life. A suicidal person starkly reminds you of your desperate need for God's power and wisdom in the moment. Although we have stressed particular tools and approaches to equip you to assess someone for suicidality, this planning requires wisdom and direction from the Spirit. So call out to him. A spiritual battle is in progress. Your temptation will be either to over-react or underreact. Only God has the power ultimately to prevent someone's suicide, but there *are* several practical steps you can take to help:

1. Start by answering this question: is the counselee imminently suicidal? In other words, in light of risk factors, current or recent level of suicidal thinking, extent of planning, presence/absence of risk mitigators, and willingness/unwillingness to contract for safety, do you believe the person is in danger? Do you think

the person will remain at high risk for suicide after leaving your presence? If yes, an evaluation for hospitalization is necessary. If the person is willing, go together to the nearest emergency room—have a friend, spouse, or other person drive you both there. A voluntary admission to the hospital is the best scenario for all involved when you believe that the counselee is not safe. If, however, the person is unwilling to go for such an evaluation, you will have to call 911 to transport the counselee involuntarily. You cannot provide 24-7 care for someone

who seems determined to die, nor should that responsibility fall exclusively to family and friends. On rare occasions you will need to proceed, with the involvement of hospital personnel, to an involuntary admission for a counselee whom you judge to be persistently unstable.

While it is true that hospitalization will not provide your counselee with a biblical framework, it does provide time to stabilize the person emotionally and ensure safety. You will continue the hard work of bringing the gospel to bear during and following hospitalization. Your goal in this moment is to preserve life

has no plan, and can articulate multiple reasons to stay alive. If loved ones do not know about the presence of suicidal thinking, have the counselee call a spouse and/or good friend while in your office to share about the struggle. Often, sharing this emotional burden with others is helpful in itself to diminish active thoughts of suicide. It also alerts loved ones to be more vigilant in their interactions with the person. If the counselee is reluctant to tell anyone else it may be a marker of greater risk. Engage in further assessment and discussion to ensure safety.

At the end of the assessment, if you remain

Bring other family members and friends into the process to create a safety net of relationships

so that you can have those discussions in the future.

2. Consult confidentially with a trusted and more experienced counselor, supervisor or pastor. This is especially important if you believe hospitalization is necessary, or if you are considering sending a higher risk (but not imminently suicidal) person home. Do this before the person leaves your office or home. Although it may feel awkward to excuse yourself for this conversation it ensures a plurality of wisdom (Pro 15:22; 24:6). You may say to your counselee, "I am concerned for your safety and in situations like this I always seek the input of another experienced counselor. Would you excuse me for a few minutes while I speak with _____ and then I'll be back to talk further with you?" This may be unnecessary with a lower risk person with fleeting suicidal thoughts, but, a higher risk person should not leave your presence until you have discussed the case and your plan with another counselor, pastor, or supervisor.

3. Bring other family members and friends into the process to create a safety net of relationships. This is critical even if you judge the person to be at lower risk for suicide. Often, family and friends are already aware of the problem, and their active involvement and support is essential. Make certain someone will be with the person over the next several days. This constant presence may not be necessary if someone has only fleeting suicidal thoughts, concerned about the danger the person is in, this trumps concern for confidentiality. You are balancing a concern for safety with a concern for honoring the private nature of your relationship with the counselee. A concern that suicide may be imminent takes priority, although you never take the breach of confidentiality lightly.

4. Remove the means of committing suicide to make it more difficult to execute a suicide plan. Such actions might include removing firearms, locking up medications (including non-prescription drugs such as acetaminophen), having all medications monitored and dispensed by a spouse or parent, or taking away car keys. Ideally these actions are done in cooperation with the counselee. Reluctance may prompt a series of further questions to judge the current level of suicidal thinking and planning. Of course, you cannot eliminate all danger around a person, but removing access to available lethal objects and substances can be a matter of life and death.

5. If you believe this person to be at lower risk for suicide, and therefore not needing hospitalization, secure involvement of family, friends, and church leaders and set up a safety contract as previously described. Also, brainstorm actions to take, in addition to contacting you, should intense suicidal thinking and planning occur in future days. The idea is to build as many practical barriers to suicidal behavior as possible. These actions might include prayer, listening to favorite music or hymns, going for a walk, reading certain Scripture passages, calling additional friends, writing in a journal, etc. As noted above, run your plans by a colleague prior to the counselee leaving your office.

6. Make plans for a follow up visit or phone call within a day or two. Realize that ongoing assessment for suicidal thinking/ behavior is important as you seek to bring a biblical framework to bear upon this person's life struggles. In future weeks, it may be helpful to ask, "On a scale of 1-10, with 10 being 'I'm determined to end my life right now,' what is the highest you've been since we've met? Where are you today?" This does not preclude the need for additional assessment as outlined in this article, but it does give you a basic feel for how the counselee has been doing.

7. Here is the bottom line: you should not let the person leave unless you are convinced that suicide is not imminent and that your safety plan has addressed what to do if suicidal thinking becomes worse in the near future.

Be Faithful and Trust: A Final Word

It is common to feel apprehensive while caring for a suicidal counselee, even when you have taken the proper steps of assessment. You may have a nagging sense that you need to do more. But if you have been faithful in your evaluation and care, rest in the truth that this person is in God's hands. "Many are the plans in a person's heart, but it is the LORD's purpose that prevails" (Pro 19:21).

Suicide assessment is a learned skill, but a necessary one for the biblical counselor or pastor. We trust that this article has further equipped you in the methods of suicide assessment, knowing that we carry out such assessments depending upon our Father's wisdom, mercy, and power—for ourselves and for our counselees.

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1 J. Bird, H.H. Dohn, G. Patterson, W.M. Patterson, "Evaluation of Suicidal Patients: The SAD PERSONS Scale," *Psychosomatics* 24: 4 (1983): 343-349.

2 S.C.Shea, *Psychiatric Interviewing: The Art of Understanding, 2nd Edition* (Philadelphia: W. B. Saunders Company, 1998), 463

3 S.C.Shea, *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors* (Hoboken: John Wiley & Sons, Inc., 2002), 152.

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Letter written to a church family after a church member took their own life

Christian believers are called to share their lives in community – to '*rejoice with those who rejoice and mourn with those who mourn'* (Romans 15:16). At this point in the life of our church God has given us a particular responsibility to do that.

Today we remember again the promises of the gospel as we baptise David and rejoice with his parents that God has given them a child. However, as many already know, we also have reason to mourn. On Friday afternoon Claire Smith's struggle with profound depression ended when she took her own life. Claire has been at the very heart of things here ever since her arrival eight years ago and it was a day of great joy when she and Chris were married here five years ago.

Claire's death will produce shock, sadness, regret and bewilderment. Those who knew Claire will struggle to understand how someone so richly gifted could become so consumed by depression that she could no longer see a way to go on. It feels so senseless, so unnecessary – and we are bound to feel that somehow this should have been prevented. Claire's warmth and love, her thoughtful and perceptive care of others and her passion for Christ were all exceptional. How can it be right for her to die like this?

It's too early to try and make sense of what has happened and there are no simple answers to give. Cautiously, though, I want to highlight some things we should be clear about.

1. **The gospel message doesn't protect us from suffering**. Christians get cancer just like everyone else. They suffer in accidents and natural disasters just like everyone else. God doesn't promise Christian believers that they will be spared from trouble and that includes the experience of depression. Claire's struggles with depression go back many years and I have often had cause to thank God for the example she set of courageous perseverance in the face of difficulty. This recent episode was both abrupt and severe.
2. **It is so very hard to understand the experience of profound depression**. Even those of us who have been depressed find it incredibly difficult to convey the feelings to someone else. That someone as strong as Claire could reach a place where taking her own life seemed the only option tells us something of the awful agonies she was feeling.
3. **The manner of Claire's death is no barrier to her salvation in Christ.** I cannot imagine the despair that brought Claire to this point. It moves me to tears just to think about it. But even in the worst of her depression Claire spoke of the Saviour she knew and loved. She trusted in one who suffered in her place – one who shouldered a still more ultimate despair when he was cut off from his Father on the cross. He is able to save. Even the worst of our depressions is not beyond the reach of the love realised in Christ's sacrifice on the cross.
4. **We need the gospel for times like this**. The Bible describes death as the final enemy (1 Corinthians 15:26) and all our struggles with sin, sadness, depression and despair belong to this broken world – a world that Christ came to make new. And '*in keeping with his promise we are looking forward to a new heaven and a new earth'* (2 Peter 3:13) where *'there will be no more death or mourning or crying or pain'* and where he will wipe every tear from our eyes (Rev 21: 4). This isn't make believe. It is rooted in the historical death and resurrection of Jesus Christ. We need the gospel for times like this.

No date has been set for Claire's funeral service – we will make the details known as soon as possible. Please pray for Chris that he will know all the comfort of Christ and the support of church family and friends. Pray also for Claire's immediate family – especially her parents, sister and brother. Pray too for Claire's close friends who will miss her badly – *mourn with those who mourn*.

Today is a day both for rejoicing and mourning. May God enable us to help one another to do that. With

love in Christ

Lighthouse

Caring for the Suicidal

1Kings 19 begins with Elijah receiving a death threat from Queen Jezebel, so he runs for his life into the wilderness. Then in his hopelessness and despair he cries out to God in verse 4 saying, "It is enough; now, O Lord, take away my life, for I am no better than my fathers."

Elijah is not the only believer who experienced hopelessness to the point of despairing of life itself. C.H. Spurgeon notes his own suicidal thinking when he wrote, "I could say with Job, 'My soul chooseth strangling rather than life' [Job 7:15]. I could readily enough have laid violent hands upon myself, to escape from my misery of spirit." [1]

To help counselors care for individuals dealing with hopelessness and suicidal thoughts, we've prepared the following questions:

1. Does hopelessness ever take you to the desire to be dead? Do you ever go to sleep not wanting to wake up in the morning?

2. Does it take you to thoughts of ending your life?

   - What do you think death would solve?
   - If that's something we could solve in a different way, would you still want to die? If the answer is yes, then there is still something else there, so you keep going with questions until you clarify intent (*e.g. "if we could solve ____ in a different way, would you still want to die?"*)

     If yes:

     - Have you been thinking about how you might end your life? The more specific the plan the higher the risk. Illustration: A man dreaming of a Hawaiian Vacation versus a man who's paid for the vacation, who is more likely to go. A person who says he would use a gun but has no access to one, versus one who does.

     If yes:

     - Do you have some intention of acting on your thoughts and plan to end your life?

     If yes:

     - Do you have the ability to carry out the plan? (If they have a clear plan, intent, and a means of carrying out the plan we call 911 or 988).

     Have you attempted suicide in the past?

     - What did you do?
     - What brought on the attempt? (What was the precipitant)
     - What ended up happening? (How is it that they are still alive?)

[1] C. H. Spurgeon, The Metropolitan Tabernacle Pulpit Sermons, 63 vols. (London: Passmore & Alabaster, 1855–1917),* vol. 36, 200

- Has anyone in your life committed suicide? (e.g. family member, friend) Please note that the line of questions above is if they are saying "yes" to the questions, but if they start to say "no" then we keep asking questions and seek to reinforce the grace they are clinging to for hope. Below are the types of questions to help a counselee consider their reasons for persevering in life.

3. Where do you turn for hope to persevere? Explore their reasons for wantingto live. Have them write those things down, perhaps on cards that they always carry with them. Slowly help them see the importance of writing down the unfading realities we have in Christ that anchor us in this life. They might start by writing down more temporal ones like: "I have my health" or "I need to stay alive for my family", and we don't need to negate or correct those. But slowly we can help them consider more enduring and Christ-centered purposes for why we live.

4. Help them write one or two purpose statements for their life using different passages of Scripture (see examples below)

- Hosea 6:3 – my purpose is to press on to know the Lord who promises to care for my soul.
- Isaiah 43:6-7 – my purpose is to bring glory to God as his dearly loved child
- Ephesians 1:6, 12 – my purpose is to praise God for his glorious grace revealed most abundantly to me in Christ

5. Help them create a "life" plan. Ask questions like:

- *"What would it look like to move toward God in the face of the temptation toward suicide?"*
  This could include things like texting someone for prayer, going for a walk outside to meditate on creation, singing along with worship music, offering transparent prayers about what has robbed your heart of hope.

- *"What are some specific ways you would like to structure your day to stay in the pathways of grace?"*
  Wake up at 7am ⟶ pray, read Psalm, exercise, practice guitar, go to work ⟶ at work take pleasure in honoring God with your gifts and seeking to love others ⟶ Sleep better. (Can you see the positive spiral?) For a more a detailed view of this, go through the "Christ-centered scheduling" heartwork with them)

- *"What is the schedule that hopelessness or despair wants us to write for tomorrow?"*
  (e.g. Sleep until noon everyday ⟶ miss breakfast, no time to pray, no time to exercise, not time to look for job, no time for other responsibilities ⟶ increased stress, guilt, reduced energy ⟶ Stay in bed longer...etc.
  (Can you see the negative spiral?)

- *"What are some specific ways you can be a pathway of grace by demonstrating Christ to others?"*
  Who can you thank tomorrow? Who can you greet? Who can you pray for or ask for their prayer requests? Who can you listen to? Can you give your spouse and/or children a hug and kiss?

These small steps toward loving God and loving others help them live out their God designed purpose and as they take these steps we want to celebrate with them. These steps are also powerful sources of hope because each step, each choice they are making to do what is right is a seed they areplanting, and it will make a difference.

Grieving a suicide

It was in the summer of 2021 that I lost my brother to suicide. This had always been a risk - he had attempted to take his life on a few occasions before. He had suffered with bipolar disorder for 14 years and although he was escape and fall to his death.in a secure hospital, he wasn't as safe as we thought. He managed to

Joe was 34, a talented artist and musician and follower of Jesus. He had planned it and had left a note for us all saying he wanted to go to heaven now. He was tired of suffering. My heart broke the day that happened, and I cried out to God in pain. He carried me through it all especially in the lead up to the funeral and in enabling me to give a fitting tribute.

Suicide is a family's worst nightmare. So many questions surround a suicide. Why? How? What, if anything, could have prevented this? Guilt can begin to invade hearts too.

Although I shed tears as I write this, I can share some things that have helped me during the first few years of grieving Joe.

1. I am not responsible

The first instinct for most of us is to think we may bear some responsibility for the death somehow.' If only I had..', 'if only we had... then he would still be here'.

Sadly when someone has made up their mind to take their life it can be difficult to stop them. You doing one extra kindness or having just one more conversation or being in a different place would not have saved them. Desperation in suffering can cause one to take desperate measures.

It is not a cowardly act - it is a desperate choice driven by what feels like unbearable, unending suffering with no way out. Sadly, sometimes the sufferer truly believes that the family is better off without them - they believe they are a burden to them.

We cannot be responsible for someone's suicide as ultimately, they alone make that decision. There are of course factors that can incline them toward suicidal ideations but the ultimate responsibility for the desperate act lies with them.

2. **Bring it to God**

The Psalms are exemplary in bringing our questions and pain to God. He can handle it all - the shouting, the tears, the frustration. Why didn't God keep my brother from escaping? Why did his suffering have to be so acute that he felt there was no way out? Why did the many prayers for his healing go unanswered?

Psalm 42 speaks of endless tears, day and night, and raw questions to God like, 'Why have you forgotten me?' There are words for our pain and distress as the Psalmist has already been there.

You may want to meditate on and pray just a verse or two in the Psalms for a while especially if you are struggling to read the God's word.

3. **Talk about it**

Find a 'safe place' to talk about your loved one and your experience of losing them. I found a local church-run 'griefshare' group helpful a year or so after I lost Joe. It was a place where the bereaved could learn together about grief and share their stories of loss with each other.

I also spoke to a Christian counsellor and a mother who had lost her daughter to suicide. It was so good to be able to talk openly about all the thoughts that troubled me and realise my response was so 'normal'. Though you never 'get over' loss like this the pain of it will lessen as time goes on. It will likely take years to grieve fully so we need not be surprised if grief is a long journey.

4. Remember and celebrate your loved one

I am soon to choose a bench with a plaque in memory of Joe to place in a spot with a stunning view across the channel, not far from my house, where I walk my dog regularly. I had wanted to do this as his grave is a bit of a drive away, so with this bench Ialso bless others with a good rest stop and expansive view. Joe was a blessing to others can visit whenever I want. It will , so this is a fitting memorial.

I think many of us like to do something special in memory of our loved ones and sometimes having a special place to remember them and pray can help. I would encourage you to be creative in remembering them. The way they ended their life was just one small lives - there will surely be much good in their lives to celebrate. I am proud of my brother's part of their

humility in his creative skills, the way he faithfully led worship online, volunteered for the church and cared for the homeless.

What makes you feel more connected to your loved one? A certain activity? A song? Maybe you will want to write a poem about them or just a few special memories. It helps to have something to read over when you feel sad or want to reflect.

What can the church body do?

Aside from practical care like meals, the best thing you can do is be present. Visit the grieving person -Trust God to give you don't be scared to feel uncomfortable or worry about what to say.words if appropriate but it is most comforting to simply cry with them. When others enter your grief with tears there is a silent understanding that what has happened is truly awful and truly devastating.

A warm hug shows love. A phone call on receiving the news also speaks of love better than a text can. Prayer is always the right response for believers in grief so offer to pray with your friend. Perhaps note down the date of the anniversary of the death and let your friend know you are praying for them on that day especially. Do ask how the grieving process is going or what they miss about their loved one. Give them a chance to name them and to share a memory or a photo.

In loss, there is an awareness that you carry a deep wound, but the world quickly moves on and forgets. Just knowing that people haven't forgotten your loss, is precious - even years down the line.

Loss by Suicide

Note: These are brief comments about a very complex and difficult subject. This is certainly not a comprehensive response to the agonizing experience of losing someone to suicide, but only some initial pointers to know where to start.

This help sheet doesn't engage the important topic of assessing risk of suicide or how to respond in an emergency. If you are reading this because you are concerned about someone's safety, please seek out urgent help via your GP, the emergency services or the Samaritans (116 123).

When we lose someone to death by suicide, the impact is always deep and long-lasting. If you have experienced such a loss, or are supporting someone who has, then know that the situation you are facing is one of the very hardest to speak about.

Losing a loved one is itself a terrible experience. You experience loss and sadness, loneliness and pain. You are bereaved. Someone you loved is no longer there. You can't talk to them or hold them – they are lost to you and that is so very hard to bear.

But where that loss arises because your loved one took their own life, all sorts of other emotions may also be present. You may be feeling one or more of the following:

Confused and disorientated

That the person you loved could have died this way may seem incomprehensible to you. You cannot understand how it came to this or how they finally reached this point. The despair that must have brought them to such a point seems bewildering, even agonising, to you. What can it possibly have been like for them to feel so desperate? Feelings of confusion and disorientation may be especially prominent where there had been no warning of suicide being a possibility.

Angry and betrayed

Experiencing feelings of anger in response to death isn't unusual – but people often find it hard to

talk of such feelings. It is particularly difficult if any of the anger feels to be directed toward the person who died. In suicide the likelihood of such feelings of anger increases greatly. You may feel

horribly let down. Many people will ask: ‘how could they do this to me? Didn’t they care how this would affect me?’ When feelings of anger intersect with agony at the torment your loved one must have felt, it becomes hard to know what you really feel.

Anger may also be directed at those who have been involved in caring for the person who died. When death by suicide comes after previous attempts, anger may be directed at professionals because of a sense that they didn't provide the help that was needed.

Guilty and ashamed

Many, in the aftermath of a suicide, feel guilty. Some inevitably ask themselves: ‘what did I miss? How did I fail to see just how bad it was getting?’ There may be feelings of regret: ‘if only I’d listened more carefully. If only I’d not left them alone. If only I’d forced them to get help.’ There may be a sense of shame – ‘will others think I didn’t love them enough?’ Some feel ashamed because of what they are going to have to say about their loved one’s death.

Frightened and alone

That someone can reach a level of despair so deep that bringing life to an end seems the only way out can feel frightening and disturbing. You may find yourself imagining what they might have been thinking or feeling at the end, but then stop yourself because it is simply too awful to contemplate.

You may not know who you can talk to or about what. Which of your feelings are reasonable and which are too awful to mention?

For all these reasons (and more) losing someone we love to suicide may seem unbearable. Unbearable to contemplate their depth of their pain, an unbearable measure of guilt and unbearable to think of all the lives that will never be the same again.

Much support and care will be needed by anyone who has lost a loved one in this way. And that support will need to last a long time. What follows aren’t quick fixes and we must avoid offering comfort that feels either thin or trite. But as we slowly seek to find a way toward comfort from the Lord, here are some pointers.

Talk

There can be something very isolating about losing someone to death by suicide. People may not be sure how to talk to you. You may not be sure how to talk to them. Instead of isolation, we should

seek to connect – muddled emotions and unformed thoughts are to be expected. Talking will be one of the ways that, very gradually, thoughts and feelings begin to take shape.

Pray

The scriptures contain many examples of believers crying out to God in their distress. Often with emotions that are raw and thoughts that are confused.

- From the ends of the earth I call to you, I call as my heart grows faint… (Psalm 61.2)
- Why do you hide your face and forget our misery and oppression? (Psalm 44:24) Why, Lord, do you reject me and hide your face from me? (Psalm 88:14)
- I have borne your terrors and am in despair (Psalm 88:15)

God has included such raw and honest prayers in the Bible to teach us that they are a legitimate expression of faith. God wants his children to cry to him, even in their bewilderment. He hears our prayers even if all we have are the wordless groans by which the Spirit intercedes for us (Romans 8:26).

Remember the depth of grace

God alone can judge the thoughts and attitudes of our hearts. We may well fear for the soul of the loved one who has died. Ideas that suicide is some kind of unforgiveable sin may come to us. But if

our loved one died in faith then even if their final act was wrong (for taking our own life can never be God's will for us), Christ's forgiveness covers every sin – those we consciously confess as well as those we don't. We would all be lost if that weren't the case.

Accept the limits of our knowing

Why hard things come into our lives is often unclear and much suffering is mysterious. The idea that all suffering has a reason, and that God brings suffering to teach us a lesson is an unhelpful halftruth. God is sovereign – even the hardest of things are not beyond his control. And he can indeed use suffering – even doing so in the suffering of Christ on the cross. But it simply isn't helpful (or true) to imagine that the way to make suffering manageable is to pick out some kind of 'lesson' that

God must be trying to teach us. Job never knew why he suffered as he did. He went to his grave not

knowing how the terrible suffering he had endured was connected with events in the heavenly realms. The dark threads that come into our lives (and loss by suicide is one of the darkest) may, likewise, never 'make sense' to us.

Accept the limits of our capacity

We considered above how feelings of guilt, shame, and perhaps regret, are often prominent following a death by suicide. In this regard, one of the things we often need to accept is the limits of

our own capacity. We are all finite. And none of us are as wise as we wish we were. It is almost certain that there will be things we wish we had said and done, because there are invariably things we wish we had said and done. That's what it's like living with all the limitations of our human nature. We can speak to God about our regrets knowing that he knows and loves us in our weaknesses (2 Corinthians 12:10).

Cling to the character of God

What we can be certain of, because God has made it known, is that Christ came to set suffering aside. Indeed, the removal of suffering matters so much to him that he was willing to have Christ bear it in our place. So, whatever we say about God's part in our suffering, it cannot be that he doesn't care. He cared enough to give us Christ crucified. Christ became a man of suffering in our place and through his death suffering will, one day, be set aside forever. Our final comfort is found in the promise that Christ will return and bring with him a kingdom in which there is no more death or mourning or crying or pain (Revelation 21:4).

Ask Suicide-Screening uestions

The ASQ toolkit is organized by the medical setting in which it will be used: **emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics**.

While the toolkit materials are mostly the same for all ages, there are **Youth** and **Adult versions** of some of the tools: Brief Suicide Safety Assessments (Guides and Worksheets), Nursing Scripts, Suicide Risk Screening Clinical Pathways and Training Videos.

All toolkit materials are available on the NIMH website at **www.nimh.nih.gov/asq.** Questions about the materials or how to implement suicide risk screening can be directed to Lisa Horowitz, PhD, MPH at horowitzl@mail.nih.gov or Debbie Snyder, MSW at DeborahSnyder@mail.nih.gov.

ASQ Tools for all Ages and Medical Settings

- Information Sheet
- Screening Tool
- Screening Tool (foreign languages)
- Toolkit Summary
- Patient Resource List
- Training/Educational Videos

7RROV6SHFLÀFWR0HGLFDO6HWWLQJV

Emergency Department, Inpatient/surgical, Outpatient/specialty clinics

Ask

Youth

versions can be used for individuals ages 8 to 24 years, and Adult versions can be used for ages 18 years and older. There is overlap and that is left to the discretion of the clinician using the tools.

- Brief Suicide Safety Assessment Guide
- Brief Suicide Safety Assessment Worksheet
- Nursing Scripts
- Parent/Guardian Flyers
- 6XLFLGH5LVN6FUHHQLQJ3DWKZD\VÁRZFKDUWV
- &RYLG6XLFLGH5LVN6FUHHQLQJ3DWKZD\VÁRZFKDUWV

as

Suicide-Screening

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ①Yes ①No

2. **In the past few weeks, have you felt that you or your family**

   ™ ‘– †„‡„‡–– ‡” ‘ơ’‹ ˆ › ‘–™‡”‡†‡ƒ†Ǫ ①Yes ①No

3. **In the past week, have you been having thoughts about killing yourself?** ①Yes ①No

Ask Questions

4. Have you ever tried to kill yourself? ①Yes ①No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ①Yes ①No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*

- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**

† **"Yes"** • **Patient requires a** to question #5 = **acute positive screenSTAT safety/full mental health evaluation.**
î‹ ‹ ‡ –"‹ ‹†‡ –‹Ƥ‡†Ò

Patient cannot leave until evaluated for safety.

• Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

† **"No"** • to question #5 = **Patient requires a non-acute positive screenbrief suicide safety assessment to determine if a** î ‘–‡ –‹ƒ "‹ ‹†‡ –‹Ƥ‡†Ò**full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated**

- **as an "against medical advice" (AMA) discharge.** Alert physician or clinician responsible for patient care.

Assessment

Ask

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741741

2/6/2024

as

- Use after a patient **(8 - 24 years)** screens positive for suicide

risk on the asQ **Suicide-Screening uestions**

- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

What to do when a pediatric patient screens positive for suicide risk:

WORKSHEET

Patient name: _____ **DOB:**

_____ **Interviewer name:**

_____ **Assessment date:** _____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

Assess the patient

Review patient's responses from the asQ

_____

_____

Ask 

⑨ Frequency of suicidal thoughts

(If possible, assess patient alone depending on developmental considerations and parent willingness.) Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"

If yes, ask: "When was the last time you had these thoughts?" _____"How often?"_____(once or twice a day, several times a day, a couple times a week, etc.)

⑨ "Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

⑨ Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:**

"What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerningdetail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater than if they haven't thought it through in great concern and removing or securing dangerous items (medications, guns, ropes, etc.).

⑨ Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

If yes, ask: Ask the patient:"How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

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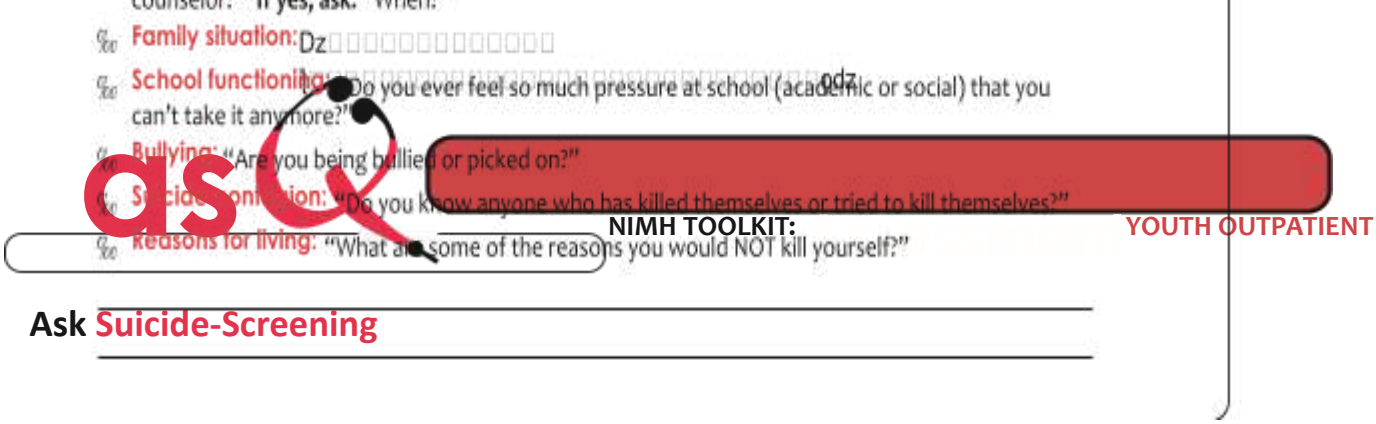

Ask Suicide-Screening

uestions

WORKSHEET page 3 of 4

Interview patient & parent/guardian together

"After speaking with your

about. We would now like to get your perspective."

"Your child said… (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."

"Does your child seem:

- Sad or depressed?" ⑨ Anxious?" ⑨ Impulsive? ⑨ Reckless?" ⑨ Hopeless?" ⑨ Irritable?"
- Unable to enjoy the things that usually bring him/her pleasure?"
- Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: ⑨ Sleeping pattern?" ⑨ Appetite?"

"Does your child use drugs or alcohol?" ⑨ Yes ⑨ No

"Has anyone in your family/close friend network ever tried to kill themselves?" ⑨ Yes ⑨ No

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)

_____

"Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents) ⑨ Yes ⑨ No

"Are you comfortable keeping your child safe at home?" ⑨ Yes ⑨ No

as

Ask Suicide-Screening

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient

Include the parent/guardian, if possible.

"‡ƒ-‡ƒ ƒˆ‡-›' ƒ ˆ "' ƒ ƒ‰‹ ‰' '-‡ -‹ƒ ˆ——"‡ –‹…‹†ƒ -Š '–‰Š- G ƒˆ‡-›' ƒ ‹ †‹ơ‡"‡ --Šƒ ƒ ‹ ‰ƒ Dz ƒˆ‡-›… ' -"ƒ…-dzÆƒ ‹ ‰-Š‡' ƒ-‹‡ -- '… ' -"ƒ…-ˆ "' ƒˆ‡-›‹ ‡ơ‡…-‹˜‡ƒ † ƒ›„‡†ƒ ‰‡" '– "'‰‹˜‡ƒˆƒ ‡ sense of security. **Say to patient:** Dz–"Ƥ" -' "‹ "'‹-›‹ ‡‡' ‹ ‰› '– ƒˆ‡G‡-ž ™ "' - ‰‡-Š‡"- '†‡˜‡ "ƒ ƒˆ‡-› plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call_____."

⑨ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

⑨ **Discuss means restriction** (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

⑨ **Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

Comments

as

Ask

Brief Suicide Safety Suicide-Screening Questions

WORKSHEET page 4 of 4

5 Determine disposition

For all positive screens, follow up with patient at next appointment.

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- **Emergency psychiatric evaluation:** **Patient is at imminent risk for suicide (current suicidal thoughts).**
  Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- **Further evaluation of risk is necessary:**
  Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- **3DWLHQWPLJKWEHQHÀWIURPRQXUJHQWPHQWDOKHDOWKIROORZXS**
  Review the safety plan and send home with a mental health referral.
- **No further intervention is necessary at this time.**

Comments _____

_____

_____

_____

_____

_____

_____

_____

_____

6 Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline ĞĞĞĭÖ□□□□ó□□æĞĞĞ˜
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PHQ-9 modified for Adolescents (PHQ-A)

Name: ______________________ **Clinician:** ____________________ **Date:** _______

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Office use only: **Severity score:** _________

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Ask Suicide-Screening Questions (asQ)

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? ______________________________________ When? ________________

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: ____

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Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Lifetime**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.		**High Risk**

If yes, was this within the past 3 months?		

If YES to 2 or 3, seek behavioral healthcare for further evaluation.

4, 5 or 6 is YES, get immediate help: all 911 or go to the emergency room.

ntil they can be evaluated.

988 SUICIDE & CRISIS LIFELINE

Download
Columbia
Protocol app

About the Protocol

A UNIQUE SUICIDE RISK SCREENING TOOL

The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk screening through a series of simple, plain language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, determine the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the tool ask people:

- Whether and when they have thought about suicide (ideation)
- What actions they have taken — and when — to prepare for suicide
- Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition

ASKING QUESTIONS

Protocol administrators ask a series of questions about suicidal thoughts and behaviors. The number and choice of questions they ask depend on each person's answers. The questioner marks "yes" or "no," as well as how recently the thought or behavior occurred and a scoring of its severity. The shortest screeners are condensed to a minimum of two and a maximum of six questions, depending on the answers, to most quickly and simply identify whether a person is at risk and needs assistance. For a more thorough risk screening, Columbia Protocol askers should use the standard scale.

The Columbia Protocol questions use plain and direct language, which is most effective in eliciting honest and clear responses. For example, the questioner may ask:

- "Have you wished you were dead or wished you could go to sleep and not wake up?"
- "Have you been thinking about how you might kill yourself?"
- "Have you taken any steps toward making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away, or writing a suicide note)?"

DETERMINING NEXT STEPS

To use the Columbia Protocol most effectively and efficiently, an organization can establish criteria or thresholds that determine what to do next for each person screened. Decisions about hospitalization, counseling, referrals, and other actions are informed by the "yes" or "no" answers and other factors, such as the recency of suicidal thoughts and behaviors.

The Columbia Lighthouse Project provides many examples of triage documents that Columbia Protocol users in hospitals, primary care practices, behavioral health care facilities, military services, prisons, and other settings employ to make these decisions. The Project also provides assistance to any organization that is thinking through its policy and establishing a care plan.

RESOURCES

- Download this card and additional resources at http://www.sprc.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide http://www.sprc.org/library/jcsafetygoals.pdf
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193

Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)

  Co-morbidity and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change

Access to firearms

2. PROTECTIVE FACTORS Protective factors, even if present, may not counteract significant acute risk

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External** : responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY Specific questioning about thoughts, plans, behaviors, intent

- **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live

  * For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

  * Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- **Assessment of risk** level is based on clinical judgment, after completing steps 1-3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
	Psychiatric diagnoses with severe symptoms or acute precipitating event; risk. Suicide precautions	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal protective factors not relevant	Admission generally indicated unless a significant change reduces
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.