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# Suicide Dynamics

The basic dynamics of the suicidal state include the following:

1. **Irecipitating Condition:**
   The suicidal person is temporarily overwhelmed. The failure of the ability to cope and function normally leaves the person with feelings of hopelessness and helplessness.

2. **Purpose:**
   To seek a solution, solve a problem.

3. **Goal:**
   The goal of the suicide attempt is to cease the flow of consciousness, so that the pain will stop.

4. **Stimulus:**
   Unendurable psychological pain or unendurable levels of stress.

5. **Psychological Need:**
   There is a major "stressor". A psychological need is being frustrated or thwarted that is of paramount importance to the person.

6. **Fear:**
   The common fear is of something worse than death - the continued pain or degradation if one continues to live in the present situation or emotional condition.

7. **Emotional Condition:**
   The person is feeling hopeless and helpless, because problem solving coping mechanisms are not working.

8. **Cognitive State:**
   The person commonly thinks that there are no options other than suicide or a magical resolution. Thinking is constricted and the person has tunnel vision.

9. **Internal Conflict:**
   Survival vs. unbearable stress

10. **Action:**
    The common action is escape. The need to escape form the pain is overwhelming.

11. **Communication of Intent:**
    90% of suicide victims give clues and warning of the suicide intent. The myth that people who talk about suicide seldom do it is erroneous and dangerous.

12. **Time:**
    The "active" suicide period when a person is prepared and capable to carrying out the suicide act is time limited. A person may be potentially suicidal for long periods of time, but is actively suicidal for a matter of hours.

13. **Internal Attitude:**
    The internal attitude of a suicidal person is ambivalence. This attitude is always present.

14. **Build-Up:**
    Suicide does not occur "out of the blue", but always has a history. The decision to attempt suicide builds up slowly over a period of time as all other problem solving efforts fail. The suicide build-up period provides time for identification and intervention.

# Suicide – Ten Basic Assumptions

1. We will try to stop all suicidal persons.

2. A suicidal person will put you in crisis.

3. Every person has final responsibility for his/her life.

4. All suicidal situations are volatile.

5. All suicide threats are serious.

6. No social, sexual, religious, ethnic or economic group is immune from suicide.

7. You cannot implant the idea of suicide in the mind of a person.

8. Every suicidal person has some ambivalence.

9. Judgments have no place in suicide intervention.

10. Empathy is the basic, unalterable foundation on which to use suicide skills.

## Suicide is...

1. A form of behavior designed to deal with and solve a problem.

2. A goal-oriented coping method.

3. A way to take control.

4. The ultimate revenge.

# Why do People Commit Suicide?

I. PRIMARY REASONS
   A. Hopelessness
   B. Helplessness

II. PRE-SUICIDAL SITUATIONS
   A. Sudden loss
   B. Social isolation
   C. Deep loneliness
   D. Illness and pain
   E. Changes in life style
   F. Burden to others
   G. Unfulfilled, unrealistic expectations

# Feighner Criteria for a Diagnosis of Major Depressive Illness

*(Feighner, Robins, Cruze, Woodruff, Winokur, Munoz, 1972)*

**At least five of the following eight symptoms for "definite" and four for "probable":**

1. Poor appetite or weight loss (two pounds per week or ten pounds or more the past year when not dieting) or increased appetite or weight gain.

2. Sleep difficulty or sleeping too much.

3. Loss of energy, fatigability or tiredness.

4. Psychomotor agitation or retardation.

5. Loss of interest in usual activities, or decrease in sexual drive.

6. Feelings of self-reproach or excessive or inappropriate guilt (either may be delusional).

7. Complaints of, or evidence of, diminished ability to think or concentrate, such as slow thinking or mixed up thoughts.

8. Recurrent thoughts of death or suicide, including thoughts of wishing to be dead.

# Mental Status Examination Findings of Depressed Persons

Most persons who are potentially suicidal reveal their distress in terms of mental status examination (MSE) findings. For that reason, it is important for you to be thoroughly familiar with MSE findings typical to depressed persons. Keep in mind that depressive symptoms may vary in type and intensity from person to person, and that depression may occur in association with a variety of psychological disorders, for example, schizophrenia, organic brain disorders, manic-depressive illness and others. Some combinations of the following MSE findings are likely to be present in most depressed patients.

**Appearance:** A patient's attention to individual grooming and appearance often depends on their emotional state. Indications of self-neglect which represent a change from usual grooming habits may be diagnostically significant. Accordingly, individuals who are depressed and preoccupied may show signs of personal neglect, perhaps in the form of disheveled hair, lack of makeup, un-kept clothing, or unshaven. However, some depressed patients may demonstrate no significant change in their appearance.

**Behavior:** Depressed individuals typically behave in ways which convey the feelings that they are emotionally and physically overburdened, fatigued and apathetic. Facial expression is blank or suggests sadness. Their movements are slowed, posture is usually slumped and use of gestures decreased. Speech is likely to be decreased in quantity, or low amplitude and either depressed or monotone in quality to the degree that they are able, depressed patients. They are usually cooperative and compliant with respect to your questions. However, profoundly depressed persons may be unresponsive to questions asked. Signs of restlessness and agitation associated with depression are often indications of serious psychopathology and signify an increased suicidal risk.

**Feeling (Mood and Affect):** Although individuals who are mildly depressed may show variation in feeling, the effect of those who are more severely disturbed show symptoms of unchanging sadness, hopelessness and helplessness. Feeling responses may be noticeably dulled or of marked depression. Some patients describe feeling "empty" and devoid of any feeling. The feelings of depressed persons are usually contagious and may evoke similar, but transient, feelings in you.

**Perception:** Illusions may occur, but depressed individuals rarely experience hallucinations. When hallucinations occur, they are typically auditory in nature and indicate the presence of psychosis and an increased risk for suicidal behavior.

**Thinking:** As you might expect, a person's thinking and intellectual functioning are affected roughly in proportion to the intensity of their mental pain and self-preoccupation. In most non-psychotic depression, mental responses may be slowed but usually there is no significant impairment of alertness, intellectual functioning, orientation, memory or judgment. Depressed patients typically describe feeling apathic about activities or work which they formerly enjoyed. Their thought content may reveal a sense of hopelessness, helplessness, guilt, sadness or self-doubt. Ideas of self-harm may be present.

In profound depression and/or when psychosis is present, intellectual functions may show considerable impairment. Alertness, abstract thinking, orientation, memory and judgment all may be disordered. At such times the impairment may be so great that it is difficult to

distinguish symptoms of a marked expression from those of an organic brain disorder. The impairment is not caused by an actual disorder of the brain functioning, but rather intense self-preoccupation, decreased concentration and a loss of interest in their surroundings. If the person is able to verbalize, he likely will mention feelings of profound hopelessness, despair and helplessness. Delusions about bodily functions, personal wrong doing and nihilistic ideas about the "end of the world" may be described. Associational disturbances then are characterized by marked slowing of speech, thought patterns and mid-sentence interruptions of thinking (blocking).

## Suicide – *How To* Tips on Intervention

**REMEMBER:** Always respond in an open, non-judgmental manner. Be supportive and straight forward in your questions and responses.

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

**REMEMBER:** React/respond to the individual/their feelings and not to the possibility of the suicide.

**REMEMBER:** You are RESPONSIVE BUT NOT RESPONSIBLE FOR the people you work with. Your are there to offer HOPE, CARING AND ALTERNATIVES. Having done this, it is up to the suicidal individual to choose.

# Some Common Characteristics of Suicidal People

A. Feelings of helplessness-sees the situation as intolerable and feels helpless to change it.

B. Feeling of hopelessness-sees the situation as having no solution therefore is unable to change it.

C. The individual experiences ambivalence-feels like dying but likes living at the same time. Ambivalence is the key in the intervention process. You must offer hope and strength to the side that wants to live, but also hear and understand the part seeking relief in the form of death. NEVER deny or ignore the side that wants to die. This will make the individual defensive and he/she will withdraw.

D. Suicide is rarely a spontaneous activity. It is usually a long drawn out process of depression and loss of ability to cope with stress, disappointment, etc.

# Some Verbal and Behavioral Clues to Suicide Risk

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

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

**VERBAL:**

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

**BEHAVIORAL:**

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

**ASSESSMENT OF LETHALITY:**

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

A. You need to know the individual's plan of action and how detailed this plan is.

B. You need to know if the method is immediately available. The more available the method, the more danger there is. If the method is easily accessible, work on having the individual rid themselves of the means at hand. In example, flush pills down the toilet, unload a gun, lock knives in a safe place, etc.

C. You need to know how lethal the method is. The more lethal, the less rescue time there is available.

D. You need to assess if the individual is aware of the lethality risk involved. This will help gauge the intent and knowledge of the danger.

1. Does the individual expect the pills to kill him/her (higher risk), know the pills won't complete the attempt, or is leaving it all up to chance (lower risk)?

2. Is there a possibility of someone intervening and is this known to the individual? If they aid in their own rescue, the risk is lower.

E. If a previous suicide attempt has occurred you will need to know all the information listed above in addition to how long ago the attempt took place.

# Alternate – Hope/Action:

A. You will, in most cases, get to know this individual pretty well. What you learn about their life and their lethality risk will help you look at alternatives.

B. Look at and give support to the individual's strengths. Re-vitalize their own inner resources (prior successful coping strategies, etc.).

C. The individual's support system is important. Find out the people who make up this system (friends, relatives, co-workers, therapist, psychiatrist, doctor, minister).

If appropriate, get this system involved. This support system can:

1. Provide further support: emotional, spiritual, medical, therapeutic.

2. Provide physical contact.

3. Help the individual when they need to be involved in the medical/mental health system-transportation/support to the doctor's office, to mental health out-patient or in-patient agencies, etc.

D. You as a support system. Make yourself available. This is usually in the form of a suicidal contract which can be loosely structured or very specific. The higher the lethality the more specific the contract needs to be.

1. Contract to see how they are doing.
2. Contract to see how the medical/mental health appointment came out.
3. The contract gives the individual time to trust someone again.
4. The contract gives the individual extra support while they are in therapy.
5. The contract gives the individual time to think over other alternatives besides suicide.
6. The contract gives the individual help through some time span until their usual support system is available again.
7. **REMEMBER YOU ARE NOT ALONE!!!**

# Suicide Clues

## SITUATION REFERENCES

1. I can't put my family through all the suffering and expense of these last few months.
2. The doctor says there is no treatment for it.
3. I don't know how I got into this mess, there's no way out.
4. I've tried every drug program available, I've really tried, there's nowhere else to turn.
5. I never thought I'd get caught. I can't face anyone after this.
6. Nothing is going to make it any better.
7. How can I be sure that my cats will be taken care of when I'm not there to do it?
8. How does one leave their body to a medical school?
9. Take care of my children.
10. I've really tried but nothing works for me, nothing makes it right.
11. I just can't do the things I use to be able to do.
12. I'd like to crawl into a hole and never come out.
13. Sometimes I think I'd be better off dead.
14. I just want out of the whole mess.
15. That's one problem I'll never have to worry about again.
16. I want out.
17. I'm tired of trying.
18. I have nothing to live for.
19. The doctor says it's just a matter of time anyway.
20. Everyone I ever loved is gone.
21. I want you to tell my family good-bye for me.

## RELATIONSHIP REFERENCES

1. He/she will be better off without me.

2. Nobody cares.

3. He/she will be sorry when they find me.

4. He/she will be sorry when they find out what I did.

5. I can't wait to see his/her face when they find me dead.

6. My mother is so angry with me because I won't have anything to do with her now. She thinks she has done something wrong but it just makes it easier this way.

7. He deserves what I'm going to do to him.

8. I've never been good enough for him it'll be better this way.

9. Everything will be all right when my husband finds me.

10. I'm going to make him suffer like I have.

11. My children don't need me anymore-they'll be O.K.

**TIME REFERENCES**

1. It won't matter after today.

2. That doesn't matter now.

3. I just can't go on like this anymore.

4. I just called to say goodbye.

5. You're the last person that will hear from me.

6. That is one problem I am taking care of right now.

7. I just want to sleep forever.

8. I won't be around much longer anyway.

9. I'm leaving.

10. I've decided now… (pause)… it's time to do it.

11. I can't take this any longer.

12. Tomorrow … there won't be a tomorrow.

13. That was a problem, a big problem, but it can't bother me now.

14. I talked to all my family last night so everything is taken care of.

15. About three months ago I went through a rough time and took an overdose, but I couldn't even pull that off.

16. You can't help me now, nobody can.

17. My sister killed herself a year ago today.

18. I won't have any problems tomorrow.

19. I don't have to worry about that anymore.

20. You won't be hearing form me again.

21. I can't live this way another day.

**EFFECTIVE TECHNIQUES**

1. Explore the person's feelings continuously.

2. Focus on getting person to express feelings.

3. Let person get angry at you.

4. Focus on the cause of suicidal feelings.

5. Talk openly about finality of death.

6. Focus on specific situation that caused person to feel suicidal.

7. Have person describe suicide as fantasized.

8. Explore what is meaningful to person.

9. Bid for time.

10. Put actions in perspective.

11. Stress that suicide is only one of many alternatives.

12. Express personal concern and empathy.