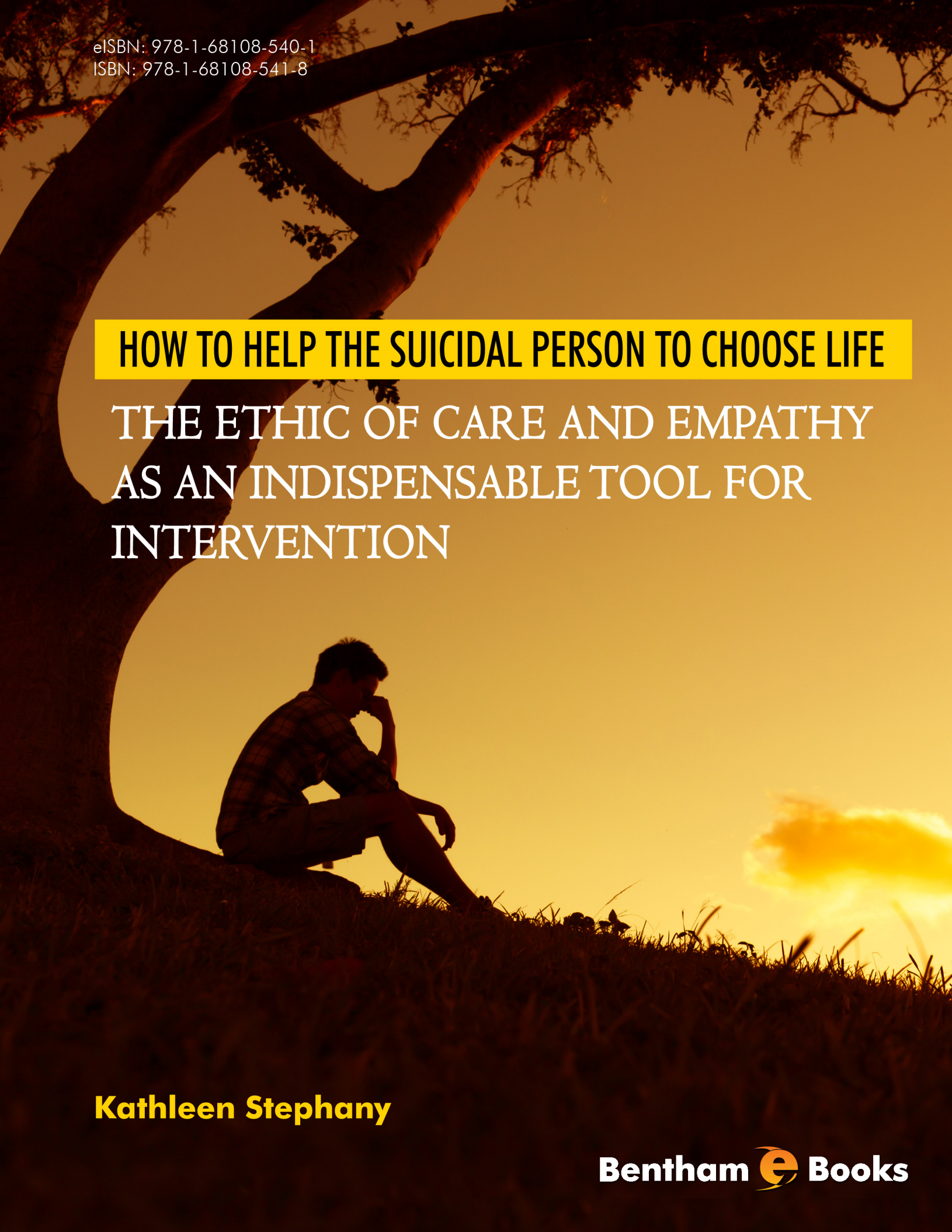
eISBN: 978-1-68108-540-1
ISBN: 978-1-68108-541-8

HOW TO HELP THE SUICIDAL PERSON TO CHOOSE LIFE

THE ETHIC OF CARE AND EMPATHY AS AN INDISPENSABLE TOOL FOR INTERVENTION



Kathleen Stephany

Bentham e Books

How to Help the Suicidal Person to Choose Life: The Ethic of Care and Empathy as an Indispensable Tool for Intervention

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eISBN (Online): 978-1-68108-540-1

ISBN (Print): 978-1-68108-541-8

First published in 2017.

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FOREWORD

I believe we are all, in one way or another, affected by suicide, be it the suicide of a patient, a client, or a loved one. I am constantly looking for resources and research that can provide an answer to how we can deliver better care to people who are at risk for suicide. As a practitioner educated, trained and practiced in three different continents, I am keenly aware that suicide is a worldwide phenomenon, affecting people from all cultures and countries. This knowledge underlies healthcare providers' search to mitigate the alarming increase in suicide and its disastrous toll on societies across the globe. At this time, awareness of mental health is increasing and there is an opportunity to re-focus and commit more resources towards stemming this terrible epidemic.

Healthcare has evolved steadily over the years and with the rise of modern technology we have the ability to diagnose and treat individuals, even when the symptoms are many and varied. However, when it comes to caring for people at risk of suicide, our progress is limited.

This book, *How to Help the Suicidal Person to Choose Life: The Ethic of Care and Empathy as an Indispensable Tool for Intervention* by Dr. Kathleen Stephany, provides unequivocal, current, evidence-based considerations on ways we can care for people at risk of suicide. It provides comprehensive and practical strategies for healthcare practitioners, mental health professionals, parents, and other family members who are striving to make a difference in the life of a person who may be at risk for suicide.

For each reader, the goal of reading this book may be different. Whether it is to prevent the death of a loved one, improve patient outcomes and experience or provide the best possible professional care, I believe that anyone who reads this book will be equipped with strategies that could ultimately save a life.

Kofi Bonnie
Clinical Nurse Specialist
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Canada

PREFACE

"What is suicide anyway? How can we understand it and prevent it?"
Shneidman, Suicidologist

The Ethic of Care & Empathy

This book is the third book, or trilogy, in a series of textbooks published by Bentham Science that I have written that features the ethic of care as the theoretical premise (Stephany, 2012; Stephany, 2015). The ethic of care emphasizes the interconnectedness of all of life and values lived experience with specific emphasis on the important relationship between the caregiver and patient. The ethic of care involves the action of caring for and about others, demonstrating compassion and doing what we can to end human suffering (Stephany, 2012; Stephany, 2015). This current book is also the second book that features empathy as an important therapeutic tool (Stephany, 2015). Empathy is closely aligned with the ethic of care (Stephany, 2015). Empathy is the capacity to understand and to identify with the experiences felt by another person (Shafir, 2008; Stephany, 2015). In this current textbook, the ethic of care in conjunction with empathetic responses coming from caregivers are presented as a tool for suicide intervention.

Where My Interest in Suicide Prevention Began?

My interest in the important topic of suicide prevention began when I was working as a Coroner in charge of Special Investigations for the Office of the Chief Coroner in the province of British Columbia (BC). A Coroner is a death investigator. A Coroner's job is to identify the deceased and their cause of death (BC Coroner's Service (BCCS), 2015). However, another integral role of the Coroner is to make recommendations to prevent death under similar circumstances based on the evidence gathered during the investigation (BCCS, 2015). One of my roles in this position as a Coroner was to lead investigations into deaths due to suicide. Over the course of time what became evident in my research was that many adults reached out to a health care professional shortly before taking their life, often within 72 hours prior to death (Stephany, 2007). As a result I began my journey to find out, what if anything, could the health professional have done differently, to help to change the suicidal person's mind about wanting to die. The beginning of my inquiry came up with a surprising result. Many of these individuals (68 % of 118 cases over the course of a decade) had admitted to someone close to them, prior to taking their life, that they did not feel cared for by the professional they reached out to for help (Stephany, 2007). Some of these suicidal people also disclosed that they felt judged by the care provider (Stephany, 2007). This finding was consistent with the findings of other researchers (Bailey, 1994; Gairin *et al*., 2003; Pompili *et al*., 2005; Betz *et al*., 2013). Therefore, I decided to conduct further research into what health professionals were doing well and what they could do better to prevent death by suicide. What I discovered was that, even though people who are suicidal often reach out to health professionals for help before taking their life, there is evidence that we often do not adequately train practitioners in how to intervene in these situations (Feldman & Freedenthal, 2006; Schmitz, *et al*., 2012; Motto & Bostrom, 2014). In fact there are gaps in the curriculum for many health professionals in the area of suicide prevention (WHO, 2012). This book has been written to address some of those gaps in information and the application of knowledge. The content is aimed at teaching everyone who cares for suicidal people to better understand the mindset of the suicidal person and how to help them to choose life.

Why this Book was Written?

Why did I write this book? I wrote this book because what it proposes is important information for caregivers to know, especially if they want to help prevent some people from ending their lives through suicide. Traditionally there has been a greater focus in the literature on risk factors for suicide with less emphasis on strategies of intervention (Gairin *et al*., 2003; Betz *et al*., 2013; Pompili, 2015). We now know that the essential component of the suicidal person's state of crisis is psychological and emotional. Therefore, we need to acknowledge and address those aspects of their experience especially if we want to gain their trust and help them (Shneidman, 1998; Pompili, 2015). In fact, approaches that focus on suicide prevention that do not address the despairing emotional mind set of the suicidal person, may not be as helpful as ones that do (Shneidman, 1998; Pompili, 2015).

Learning from Other People's Experiences

Throughout this book, I share heart felt stories. What these people had to tell me was extremely informative and can assist us in doing a better job of helping others to climb out of their psychological dungeon of despair. Useful information was derived from narrative case studies and psychological autopsies. Practice exercises and simulation were also included to help the care provider to practice how to be more empathetic. (Note that all the names of the people in this book and many details of the cases have been altered to preserve confidentiality).

Who Should Read this Book?

This book is ideal for any student or practicing professional who is confronted with trying to help people who are suicidal. Family members and others who have lost someone close to them due to suicide may also experience a sense of solace in some of the contents of this book. The recommended readership for this book may include students or actual practitioners in the following disciplines and vocations.

- Medicine
- Psychiatry
- Nursing
- Psychiatric Nursing
- Psychology
- Counselling
- Teaching
- Social Work
- The Military
- The Police Force
- Paramedics
- Other first responders (*e.g*., Fire Fighters)
- Volunteers
- Outreach Workers

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About the Author

Dr. Kathleen Stephany PhD is a practicing registered nurse (RN) with the College of Registered Nurses in BC (CRNBC) and a Psychologist who is certified with the Canadian Counselling & Psychotherapy Association (CCPA). She is also a nurse educator, published author, ethicist, ethic of care theorist and suicidologist. Kathleen has conducted both quantitative and qualitative research on suicide. As a psychiatric nurse, clinician and Psychologist she has experience assessing persons for suicide risk. Kathleen also teaches suicide risk assessment and prevention to nursing students. She is a member of the International Association for Suicide Prevention (IASP) and a member of the Canadian Association for Suicide Prevention (CASP). Kathleen speaks publicly in both academic and non-academic venues about the important subject of suicide prevention. Kathleen obtained her doctorate in Counselling Psychology from Breyer State University in Alabama. The topic of her doctoral Dissertation was entitled, Suicide Intervention: The Importance of Care as a Therapeutic Imperative. She also previously earned a MA in Counselling Psychology from Simon Fraser University (SFU), a BA in Psychology from SFU, a BSN from the University of Victoria and a Diploma in Nursing from the British Columbia Institute of Technology (BCIT). In addition to being a member of IASP and CASP, Kathleen is a member of other professional associations. For example, Kathleen is a member of The Canadian Mental Health Association (CMHA), BC Branch, and a member of the Xia Eta Chapter of Sigma Theta Tau International, Honor Society of Nursing, and an associate member of the Western Northern Region of the Canadian Association of Schools of Nursing (WNRCASN). Kathleen Stephany is employed full-time as a Nurse Educator in the Bachelor of Science in Nursing (BSN) Program at Douglas College in Coquitlam, BC. She is also a motivational and inspirational speaker and a passionate gardener.

ACKNOWLEDGEMENTS

I would like to acknowledge all of the people who work with people suffering from suicidal ideation. Thank-you for your compassion, devotion and care. Your work is not easy but extremely important. I also want to thank all of the people who so willingly shared their experiences with me. Thank-you for helping me to better understand what it feels like to lose all hope and to not feel understood by others, but also sharing how important it is for us to acknowledge your pain and offer you hope. You have enlightened me and have made me a better practitioner. This book could not have been written without you.

I want to extend a special thank-you to my husband, Dr. Harold Stephany for encouraging me to write this book even though the topic is not very uplifting. You constantly reminded me that this message was important and that it needed to be shared. I am grateful for your unending patience as you watched and waited while I hid away in my office for countless hours working on this project. Thank-you Bentham Science for publishing this book. I also wish to extend my sincere gratitude to those who made helpful suggestions on how to make this book even better.

CONFLICT OF INTEREST

The author (editor) declares no conflict of interest, financial or otherwise.

CHAPTER 1

The Importance of Teaching Suicidal Prevention Strategies to Gatekeepers

Abstract: The purpose of this current book was to add to what is already scientifically and experientially known, about the important role that gatekeepers play in suicide prevention. A gatekeeper is defined as a person, who due to the type of work they are involved in, may come into contact with persons who are at risk of suicide. The therapeutic relationship between the gatekeeper and suicidal person was presented as key to helping the suicidal person. Instillation of hope was also promoted because, while persons who are suicidal are in the midst of their despair they cannot see clearly. They may therefore, benefit from a gatekeeper helping them to re-discover their hope. Some hard facts about suicide on a global level were reviewed. It was pointed out that suicide is a complex issue and never occurs in isolation. Therefore, taking into consideration relevant issues that either contribute to, or are associated with suicide were discussed, such as social stressors and cultural issues. Religion was identified as a potential protective factor against suicide. Reasons were given in support of doing more to train gatekeepers. The ethic of care was presented as the theoretical premise for this book and both the ethic of care and empathy were introduced as a tool for suicide prevention. Quantitative and qualitative research were acknowledged as important in enhancing what we know about suicide prevention. This current manuscript draws quite significantly from evidence based data that is quantitative and qualitative. Two modes of qualitative methodologies were utilized to specifically analyze the case studies presented in this book, the narrative case study approach and the psychological autopsy. In this current Chapter, key themes were identified from the narrative case study of a suicidal person who was admitted to the Emergency Room (ER). Placing a suicidal person is a secure room for a lengthy period of time may increase their sense of being alone, and perceived neglect from a gatekeeper may be interpreted by the suicidal person as a lack of care. It was advised that when caregivers do not act in empathetic ways, instead of being self-critical, they must strive to be more self-compassionate. We were made aware of some of the ethical issues associated with caring for the suicidal person. For example, it was established that there is a risk of clinicians experiencing a violation of their moral agency, or their ability to act on their own moral beliefs.

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Keywords: Adverse life experiences, Autonomy, Beneficence, Culture, Emergency room, Empathy, Ethical dilemma, Ethic of care, Ethic of justice, Ethnicity, Ethics, Gatekeeper, Hope, Methodology, Moral agency, Moral dis-engagement, Moral residue, Narrative case study, Non-maleficence, Occupation, Philosophy, Psychological autopsy, Qualitative research, Quantitative study, Recovery models, Religion, Resiliency, Secure room, Self-compassion, Sexual prejudice, Social stressors, Spirituality, Suicide, Suicidology, Suicidologist, Transgender.

LEARNING GUIDE

After Completing this Chapter, the Reader Should be Able to:

- Define the terms suicide, suicidology and the role of the suicidologist.
- Explain how suicide differs from many other disease processes.
- Describe the function of a gatekeeper.
- Understand why conveying hope is important when trying to help a suicidal person.
- Be aware that suicide is still a leading cause of death in the developed world.
- Gain an understanding of some of the relevant issues that either contribute to, or are associated with suicide, such as the role that specific social stressors play in suicide.
- Be able to identify the 25 countries that have the highest suicide rates in the world along with some of the social factors that contribute to high suicide numbers.
- Discuss cultural aspects associated with suicide.
- Understand how religion sometimes acts as a protective factor against suicide.
- Describe the four key premises that support better training of gatekeepers.
- Appreciate that the ethic of care is the theoretical premise for this book.
- Explain why the ethic of care and empathy are an important tool for suicide prevention.
- Recognize the importance of both quantitative and qualitative research in enhancing what we know about suicide prevention.
- Gain an understanding of the qualitative methodologies utilized in this book, the narrative case study approach and the psychological autopsy.
- Explore themes from the Narrative Case Study: Admission to a Secure Room.
- Understand the importance of being more self-compassionate.
- Be aware of ethical issues associated with caring for the suicidal person.
- Understand that an ethical violation of a clinician's moral agency may occur when caring for a suicidal person and may cause moral residue and moral disengagement.

INTRODUCTION

> *"Sorrow comes in great waves but it rolls over us and though it may almost smother us it leaves us on the spot and we know that if it is strong, we are stronger inasmuch as it passes and we remain."*
> *Henry James, American Writer*

This book is concerned with the topic of preventing suicide. **Suicide** is the act of a person choosing to end his/her life voluntarily and intentionally (Merriam-Webster Dictionary, 2016). The subject matter of this textbook draws quite significantly from suicidology. **Suicidology** is the study of suicide, suicidal behavior and suicide prevention, and a **suicidologist** is someone who researches the subject of suicide (The Free Dictionary, 2016). It is important to note that suicide differs from many other disease processes in that its causes are multi-dimensional. Gunnell (2015), a suicidologist, asserts that there is a wide-range of factors that contribute to suicide. For example, suicide is the fatal outcome of a behavior, rather than a single disease process" (p. 155). Gunnell points out that, "suicidal behavior occurs in vulnerable individuals in the context of a range of different mental illnesses and social stresses and may be influenced by help-seeking behaviors and cultural attitudes" (p.155). Gunnell, therefore, subsequently recommends that prevention strategies focus on a wide range of areas.

The purpose of this current book is to add to what is already scientifically and experientially known, about the important role that gatekeepers play in suicide prevention. A **gatekeeper** is a person, who due to the type of work they are involved in may come into contact with persons who are at risk of suicide (Ghoncheh, Koot & Kerkhof, 2014). The therapeutic relationship between the gatekeeper and suicidal person is presented as key to helping the suicidal person. Subsequently, this book teaches practical, therapeutic and hopeful prevention strategies for gatekeepers to implement.

Overview of Chapter 1

This introductory Chapter introduces the notion of instillation of hope, followed by a brief overview of some of the hard facts about suicide. The multi-dimensional issues that either contribute to, or are associated with suicide are reviewed. For example, two specific social stressors are identified in relationship to suicide. The 25 countries that have the highest suicide rates in the world are presented along with some of the social factors that contribute to high suicide numbers. Cultural aspects associated with suicide are explored. Attitudes of various world religions toward suicide are presented and religion was identified as a potential protective factor against suicide. A comprehensive explanation is made as to why we need to be doing more to train gatekeepers. The ethic of care is

CHAPTER 2

Changing Stigma, Dispelling Myths and Assessing Risk

Abstract: Chapter two pointed out how stigma negatively impacts people who suffer from mental illness and/or suicidal ideation. Stigma can actually prevent patients from seeking the help that they need. What is alarming is that some of the most distressing stigma that people experience is perpetrated by health professionals. Health professionals who do engage in acts of stigmatization breach the very essence of what the ethic of care stands for. Educational endeavors need to be pursued in order to stop all discrimination. The lived experiences of two patients who presented to the emergency Room (ER) after a serious suicide attempt, was reviewed. Analysis revealed that their suicide attempts were not considered serious by staff and stigma likely played a role. No care plan or follow-up was arranged upon their discharge from the ER. Yet, research has demonstrated that the strongest indicator of a completed suicide is a previous attempt. Subsequently, caregivers were admonished to learn how to differentiate between a deliberate suicide attempt and other forms of self-harm. Dispelling preconceived assumptions about suicide that are not true was presented as another way to help to prevent suicide. It was also pointed out that some suicide risk assessment tools and/or frameworks are limited, and because the causes of suicide are multi-dimensional assessing suicide risk is not always a precise predictor of future outcomes. The warning signs of suicide were highlighted followed by a detailed 11 step process on how to conduct a thorough and focused suicide risk assessment. Key components of a Safety Plan was underscored. A narrative case study was presented as told by a Psychiatrist who was admitted to hospital after being diagnosed with depression, suicidal ideation and plan. Two key themes surfaced. There was a degree of personal shame experienced by the Psychiatrist associated with the notion of becoming depressed and suicidal. A patient's experience of shame associated with having a mental illness can also be made worse when they feel judged by their caregivers. In short, a few simple strategies to increase gatekeepers' self-awareness were highlighted as a means to dispel stigma.

Keywords: Access to means, Borderline personality disorder, Care plan, Compassion, Discrimination, Emergency room, Empathy, Ethic of care, Gatekeeper, Gesture, Journal, Lived experiences, Open-ended question, Parasuicidal gesture, Preconceived assumption, Protective factors, Rapport, Risk factors for suicide, Safety plan, Self-awareness, Stigma, Suicidal ideation, Suicidal plan, Suicidal thoughts, Suicide risk assessment, Suicide risk assessment tool, Warning signs of suicide.

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LEARNING GUIDE

After Completing this Chapter, the Reader Should be Able to:

- Describe what stigma is.
- Become aware how stigma by the general public and health professionals toward the mentally ill and the suicidal person, negatively affects them.
- Recognize that stigma from health professionals goes against empathy and the ethic of care.
- Understand how stigma also impedes suicide prevention.
- Be cognizant of the ways in which education can be used to end discrimination.
- Explore the lived experiences of two suicidal patients who experienced stigma from their caregivers.
- Differentiate between a deliberate suicide attempt and other forms of self-harm.
- Understand that the strongest risk for suicide is a previous attempt.
- Describe the four key preconceived assumptions about suicide that are not true.
- Become mindful of the limitations of some suicide risk assessment tools or frameworks.
- Become familiar with the warning signs of suicide.
- Learn how to conduct all of the 11 steps of a thorough and focused suicide risk assessment.
- Be able to describe the key components of a safety plan and when to use it.
- Explore themes from the Narrative Case Study: When a Psychiatrist Experiences Stigma.
- Learn some simple strategies to increase self-awareness.

Overview of Chapter 2

Chapter two begins by addressing the issue of stigma, how it negatively impacts people who suffer from mental illness and/or suicidal ideation, and how to change negative stereotypes through education. The lived experiences, as shared by two patients who felt judged after a suicide attempt, are presented and analyzed. Some common preconceived myths about suicide are dispelled. The warning signs of suicide are presented. Some of the problems associated with suicide risk assessment tools or frameworks are pointed out, followed by a step by step process of how to best conduct a thorough and focused suicide risk assessment. The importance of creating a safety plan is emphasized along with an overview of its key components. A narrative case study explores a Psychiatrist's experience of stigma when he is admitted to hospital for depression and suicidal tendencies. In closing, a few simple strategies are suggested to help gatekeepers enhance self-awareness.

STIGMA & HOW IT NEGATIVELY IMPACTS PEOPLE WHO SUFFER FROM MENTAL ILLNESS & SUICIDAL IDEATION

Stigma is defined as an association of disgrace or public disapproval of something such as a behavior or condition (The Free Dictionary, 2016). The term, stigma also conveys a deep, shameful mark or fault related to being a member of a group that is devalued by societal norms (Hinshaw, 2009). People who suffer from mental illness are stigmatized by "members of the public, from friends, family and co-workers" (MHCC, 2012, p. 16). In a report written by the Surgeon General for the United States, stigma was declared the "most formidable obstacle to future progress in the area of mental illness and mental health" (Hinshaw, 2009, p. x). As Fig. (**2.1**) points out, we need to do more to stop the stigma.

Fig. (2.1). Image: Stop the Stigma. Source: www.pixabay.com.

People living with mental illness "often report that the experience of being stigmatized has a more devastating impact on them than the illness itself" (MHCC, 2012, p. 16). The fact is that people who suffer from mental illness face additional discrimination when they also exhibit suicidal ideation (Betz *et al*., 2013). The judgment and stigmatization of people who suffer from mental illness has also been noted to be an impediment to suicide prevention in society in general (WHO 2012; WHO, 2014). For example, "stigma may prevent people from seeking help and can become a barrier to accessing suicide prevention services including counselling" and post-intervention support (WHO, 2012, p. 11).

Langille (2014 points out that in her opinion, "We've all grown up in a society that has taught us to stigmatize mental illness. Even though we don't want to

CHAPTER 3

Preventing and Treating Mental Illness & Understanding the Mindset of the Suicidal Person

Abstract: Chapter three pointed out that there is a significant connection between suicide and a diagnosis of mental illness and/or addictions. In fact the risk of suicide in people who are suffering from a mental disorder is five to 15 times higher than for people without a co-existing mental disorder. The degree of suicide risk associated with some specific diagnoses was presented first, followed by strategies to address early diagnosis and treatment. We are made aware of the fact that the WHO recommends that every country develop a national strategy for suicide prevention that includes provisions for early diagnosis and treatment of persons suffering from mental illness. Six specific strategies were recommended to address the global shortfall in mental health and addictions services. Psychache, or a mindset of unbearable emotional pain was determined to be a necessary condition for suicide to happen. Constriction of thought often accompanies psychache. The Strain Theory of Suicide was used to explain how psychache is preceded by specific types of psychological stressors. These stressors actually pull a person in conflicting directions that contribute to their hopeless despair. The lived experience of a suicidal person was examined in order to gain a clearer appreciation of the degree of their psychological pain. The following three specific ways were proposed to help the suicidal person to move past a death focused mindset. Attempting to understand their psychological pain fosters connection through empathy. Challenging their constricted thought patterns may help them to choose a coping mechanism other than death, and so will assist them to change the ending of their story from death to life. As an aspect of a psychological autopsy, the contents of a suicide note was examined and two key premises surfaced. The suicide note left clues to the person's experience of psychache. It also revealed their plea for understanding. In short, fostering resiliency was proposed as another way to help prevent suicide.

Keywords: Addictions, Affective disorders, Anxiety disorders, Behavior disorders, Constriction of thought, Empathy, Mental illness, Mental wellness, Narrative Action Theoretical Approach, Personality disorders, Psychache, Psychological autopsy, Psychological pain, Resiliency, Schizophrenia, Strain Theory of Suicide, Substance-related disorders, Suicide note, Understanding.

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LEARNING GUIDE

After Completing this Chapter, the Reader Should be Able to:

- Be cognizant of the fact that there is a significant connection between suicide and a diagnosis of mental illness and/or addictions.
- Be able to identify the suicide risk associated with certain types of mental disorders.
- Be aware that the WHO recommends that every country develop a national strategy for suicide prevention that includes provisions for early diagnosis and treatment of persons suffering from mental illness.
- Realize that mental health is more than the absence of illness.
- Describe six strategies that are recommended to address the global shortfall in services for mental health and addictions.
- Define psychache.
- Be aware that psychache is a necessary condition for suicide.
- Describe what is meant by constriction of thought.
- Explain what the Strain Theory of Suicide proposes.
- Explore themes from the lived emotional experience of a person who is despondent.
- Become aware of three specific ways to help the suicidal person to move past a death focused mindset.
- Review the contents of an actual suicide note in order to identify themes.
- Give reasons why fostering resiliency can help prevent suicide.

Overview of Chapter 3

Fig. (**3.1**), is a word conundrum. It is meant to create a sense of curiosity about what lurks in the mind of the suicidal person. Chapter three attempts to address this important query. Is it depression? Is it hopelessness, a lack of joy in life, emotional angst or something else?

The chapter begins by pointing out that there is a significant connection between suicide and a diagnosis of mental illness and addictions (Shneidman, 1998; Troister & Holden, 2010; Klott, 2012). The degree of suicide risk associated with some specific diagnoses is presented. Specific strategies are proposed to address early diagnosis and treatment of mental illness and addictions, and to promote increased mental wellness. Supportive rationale for these suggested policies is included (WHO, 2012; MHCC, 2012).

Fig. (3.1). Image: Word Conundrum & suicide mindset. Source: www.pixabay.com.

Although the factors that contribute to someone having suicidal thoughts is multi-dimensional, in almost every case of suicidal ideation, with or without a diagnosis of mental illness or addictions, emotional pain or distorted psychological needs are paramount (Shneidman, 1993; Shneidman, 1998). Therefore, chapter three also explores the mindset of the suicidal person and identifies specific ways to help them.

THE IMPORTANCE OF EARLY DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS & ADDICTIONS

Suicidal thoughts can happen to anyone, and suicide is more highly correlated with hopelessness than with depression (Shneidman, 1998 as cited in Stephany, 2007). However, there is a significant connection between suicide and a diagnosis of mental illness (Shneidman, 1998). In fact, the risk of suicide in people who are suffering from a mental disorder, is five to 15 times higher than for people without a co-existing mental disorder (PatientPlus, 2016). "It is estimated that 90% of people who die by suicide experience depression, another mental health illness, or a substance use disorder, all of which are potentially treatable" (Institute of Marriage and Family Canada, 2009 as cited in Moore & Melrose, 2014, pp. 509 – 510). "In Canada, in 2009 – 2010, approximately seven in ten hospitalizations for self-harm included a mental health diagnosis" (Moore & Melrose, 2014, p. 510). Therefore, prevention strategies need to focus on better management of underlying mental illnesses, especially early diagnosis and treatment (Shneidman, 1998; MHCC, 2012; Klott, 2012; Troister & Holden, 2010; Gunnell, 2015). The list that ensues breaks down the percentages of

CHAPTER 4

The Ethic of Care & Empathy as a Tool for Helping the Suicidal Person

Abstract: In chapter four we became aware that people who are experiencing suicidal thoughts feel especially alone in their experience. If we can help them to know that we genuinely care about them and their situation, we may be able to convince them that their life matters. This is the essence of the ethic of care in action. Empathic responses, in the form of validating another's experience, can also save lives. Specifically, in the hopeless patient, increased hope is instilled if they feel understood and cared for by their physician or nurse. Explicit aspects of the ethic of care and empathy were identified as a means to help the suicidal person to choose life. These strategies include: establishing connection, fostering a therapeutic alliance, offering unconditional positive regard, heartfelt listening, presencing and compassion. It was pointed out that trust can sometimes be severed in the emergency room (ER) when someone presents with a suicide attempt. For example, suicidal persons are often not even considered as real patients because they are not injured or ill. Key aspects of The Guidelines for Clinicians developed by The Aeschi Working Group of suicidologists were reviewed. These guidelines emphasized the significance of the therapeutic alliance between the clinician and patient. They highlighted the importance of offering empathy and of being non-judgmental and placed the patient's story as a priority over clinical expertise. We also learned that after a suicide attempt has occurred there is often a window where a patient can be reached. A touching narrative case study was reviewed where we discovered how a total stranger helped a suicidal youth through an act of compassion. A psychological autopsy followed this story and assisted us in gaining a retrospective view of what went wrong in the ER and why. Key themes emerged. The patient experienced the narrow constriction of thought associated with psychache. The ER physician admitted that she did not receive adequate training in suicide risk assessment. The patient reported that he did not feel cared for by the professionals in the ER, and prior to the patient being discharged no care plan was put in place to ensure that they would be safe. We learned that after the initial suicidal crisis has subsided, Cognitive Therapy may help the person to find a sense of purpose and meaning in their life. A dynamic simulation exercise was recommended to help gatekeepers practice being empathetic with a suicidal patient. The role play encouraged the use of both non-verbal and verbal empathic communication skills. At the end of the chapter, caregivers were encouraged to make empathy a habit through the act of journaling to increase self-awareness.

Keywords: Care plan, Clarification, Cognitive Therapy, Cognitive Behavioral Therapy, Cognitive re-structuring, Compassion, Connecting, Constriction of

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thought, Coping cards, Empathy, Exquisite empathy, Journaling, Listening, Listening stoppers, Mindful listening, Non-verbal communication skills, Open-ended question, Para-phrasing, Presencing, Psychache, Role play, Safety Plan, Self-awareness, Simulation, The Aeschi Working Group, The ethic of care, The International Association for Suicide Prevention (IASP), Therapeutic alliance, Trust, Unconditional positive regard, Validation, Verbal communication skills.

LEARNING GUIDE

After completing this Chapter, the Reader Should be Able to:

- Learn how the ethic of care and empathy can help the suicidal person.
- How the ethic of care promotes a web of connection.
- Define exquisite empathy.
- Explain how empathy helps a suicidal person to choose life.
- Compare helpful verbal responses with ones that are not helpful.
- Become familiar with specific components of the ethic of care and empathy that are beneficial to utilize when trying to help the suicidal person.
- Explain what often happens in the Emergency Room (ER) after a patient attempts suicide.
- Be able to summarize key aspects of The Aeschi Working Group of suicidologists' Guidelines for Clinicians.
- Be aware that after suicide attempt there is often a window where patients can be reached.
- Explore themes from the Narrative Case Study: An Act of Compassion.
- Review the results of a psychological autopsy in order to learn what could have been done differently.
- Understand the importance of referring a patient to Cognitive Therapy after a suicidal crisis has subsided.
- Practice utilizing both non-verbal and verbal empathetic communication skills in a simulation role play.
- Make empathy a habit through journaling to increase self-awareness.

Overview of Chapter 4

All human beings, may experience vulnerabilities at some time during the course of their journey through life (Klitzman, 2008). When the trials and tribulations hit, many people will likely require a caring person or professional to assist them during such trying times. The suicidal person as one such individual in crisis, is especially in need of our care (Stephany, 2015). In Chapter Four the ethic of care and empathy are presented as the means to communicate to the suicidal person that we genuinely care for them and want to help them out of their place of hopeless despair. (See Fig. **4.1**).

All human beings may experience vulnerabilities at some time during the course of their journey through life. When the trials and tribulations hit, many people will likely require a caring person or professional to assist them during such trying times. The suicidal person as one such individual in crisis, is especially in need of our care

Fig. (4.1). Caring for the suicidal person. Source: Klitzman, 2008; Stephany, 2015).

In this current chapter, specific components of the ethic of care and empathy are presented as an actual tool for suicide intervention. These include, establishing connection, fostering a therapeutic alliance, offering unconditional positive regard, heartfelt listening, presencing and compassion. Key aspects of The Aeschi Working Group of suicidologists' Guidelines for Clinicians will be reviewed. A touching narrative case study is presented where we learn how a total stranger helped a suicidal girl through an act of compassion. A psychological autopsy follows this story and assists us in gaining a retrospective view of what went wrong in the emergency room (ER) and why. Near the end of the Chapter, Cognitive Therapy is recommended once a suicidal person's initial crisis has subsided. A dynamic simulation exercise is then presented in two parts to help gatekeepers practice being empathetic with a suicidal patient. In closing, caregivers are encouraged to practice empathy in their daily round through the act of journaling to increase self-awareness.

THE ETHIC OF CARE AS THE WEB OF CONNECTION

The ethic of care is multi-dimensional and values our relationships to others, context, a sense of community and our interconnectedness (Gilligan, 1982; Noddings; 1984; Watson, 2008). The ethic of care also admonishes us to attend to the needs of all other persons, including those in our direct care as well as everyone else, even those we do not know (Noddings, 1984; Slote, 2007). In fact, caring for one another is not depicted as a nicety, it is portrayed as a necessity for the survival of all humans. For example, if we do not care about everyone we will not take moral action to help those who are in need, or to preserve life (Noddings, 1984; Slote, 2007). In fact the ethic of care promotes a web of connection that is inclusive of everyone and excludes no one (Gilligan, 1982; Stephany, 2012).

In Fig. (**4.2**), a pair of caring hands embraces a mosaic globe that is symbolic of how the ethic of care in inclusive of everyone. It does not matter whether or not our belief system aligns with that of other people, or what their status is in life, or whether or not they have made good life choices. Everyone is worthy of our care because they are fellow human beings (Stephany, 2007). We know that people

CHAPTER 5

Strategies that Promote the Emotional Well-being of Gatekeepers

Abstract: Chapter five begins by pointing out that suicide can be an occupational hazard in the caring professions. For example, physicians are twice as likely to commit suicide when compared to members of the general population. Contributing factors to physician suicide include but are not limited to: heavy work-loads, bullying, unreasonable expectations, stigma and perfectionism. Stigma associated with a diagnosis of mental illness, the dread of being judged, or fear of losing one's license to practice, all play a role in doctors refusing to get the help that they need. Studies have also demonstrated that there is high prevalence of suicide among nurses, higher than that of the general public. Ready access to means, mental illness, substance abuse, work related stress and even work place bullying were cited as some of the contributing factors to nurse suicide. Stigma toward mental illness was identified as a key factor in nurses not seeking professional help. It was pointed out that due to the fact that caring for the suicidal person can be stressful there is a real risk of gatekeepers developing compassion fatigue. Compassion fatigue was defined followed by an overview of some of the causal factors and symptoms associated with it. If compassion fatigue is to be prevented or effectively treated when it does occur, additional coping strategies need to be adopted and utilized. Therefore, the following approaches were recommended: encouraging gatekeepers to reach out for professional help; fostering self-compassion; and implementing strategies that promote self-care. In conclusion, some take away points from the book were highlighted.

Keywords: doctor suicide, mental illness, depression, substance misuse, stress, nurse suicide, Neonatal Intensive Care Unit (NICU), burn out, stigma, compassion fatigue, vicarious traumatization, critical incident de-briefing (CID), post-traumatic stress disorder (PTSD), depression, self-care, self-compassion, self-awareness, journaling, physical health, emotional health, work-life balance, gratitude.

Kathleen Stephany

LEARNING GUIDE

After Completing this Chapter, the Reader Should be Able to:

- Be cognizant of the fact that people who work in the caring professions are themselves at risk of suicide especially doctors and nurses.
- Be able to identify some of the key contributing factors to physician and nurse suicides.
- Describe some of the reasons why doctors and nurses are reluctant to reach out for help.
- Be aware that gatekeepers are at risk of developing compassion fatigue.
- Define compassion fatigue and vicarious traumatization and describe the similarities and differences between the two.
- List some of the key symptoms associated with compassion fatigue.
- Identify strategies that promote self-care.
- Summarize a few key take away points from the book.

Overview of Chapter 5

As Fig. (**5.1**) demonstrates, it is not selfish to love and take care of yourself, it is a priority, especially if you are a caregiver. As Schmidt (2002) points out, "Helpful persons sometimes spend so much time and energy caring for others that they risk neglecting themselves" (p. 83). Yet a helper who does not take care of themselves first over time will become too tired to care for others (Florio, 2010). Therefore, chapter five is concerned with promoting the well-being of gatekeepers. The discussion begins by pointing out a difficult truth that many people in the caring professions are themselves at risk of suicide, especially doctors and nurses. Key contributing factors to physician and nurse suicides and obstacles that impede their willingness to get help, are explored.

Due to the fact that caring for the suicidal person can be stressful there is also a real risk of gatekeepers developing compassion fatigue. Compassion fatigue is defined followed by an overview of some causal factors that may lead to its development. A list of some of the actual symptoms associated with compassion fatigue are also included in the discussion. In order to prevent compassion fatigue or to treat it when it does occur, strategies are recommended. These approaches include: encouraging gatekeepers to reach out for professional help, fostering self-compassion and suggesting specific ways to encourage self-care. The chapter ends with take-away points highlighted from the book.

Fig. (5.1). Taking care of yourself is a priority. Source: www.recoveryexperts.com.

ADMITTING THE UNTHINKABLE: SUICIDE AS AN OCCUPATIONAL HAZARD

Although it is a difficult topic to talk about, those in the caring professions are themselves at risk of suicide. For instance, suicide in the medically related professions such as: medicine, nursing, pharmacy and dentistry are on the increase when compared with data from the general population (Keith *et al*., 2011). There is also evidence that stress, depression and suicide are common among physicians and nurses (Rakatansky, 2016; Alderson, Parent-Rocheleau & Mishara, 2015). Although, it is beyond the scope of this chapter to explore the contributing factors related to all health professionals and suicide, some key contributing factors to physician and nurse suicides will be reviewed.

SUICIDE & DOCTORS

Doctors are people first, they are therefore, as susceptible to emotional difficulties like anyone else. Furthermore, being a physician is itself a stressful occupation and can sometimes lead to substance misuse, mental illness and suicide (Klitzman, 2007; Vogel, 2016; Rakatansky, 2016). In fact, "suicide is now considered an occupational hazard for physicians. About 400 doctors take their own life in the United States annually" (Picard, 2015, p. A15). Physicians are also twice as likely to commit suicide when compared to members of the general population (Milne, 2001). There is also a higher incidence of suicide among

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GLOSSARY

adverse life experiences are traumatic life experiences that may include early separation from parents, childhood physical, sexual and emotional abuse, and physical and sexual abuse in adult life.

autonomy is an ethical principle which respects a person's right to make decisions about their life.

beneficence is an ethical principle that is concerned with doing what will be beneficial to a patient.

borderline personality disorder is characterized as a marked instability in emotion regulation, unstable interpersonal relationships, impulsivity, identity or self-image distortions, and unstable mood.

clarification is a communication technique that involves the process of making clearer what may appear vague. It may consist of directly asking the other person to explain what they meant.

Cognitive Therapy, also referred to as **Cognitive Behavioral Therapy**, is a form of treatment that consists of helping a person to change the way that they think. It is based on the premise that the way that we think about events in our life profoundly influences the way that we feel about them. If we can change the way that we think, this will in turn, change the way that we feel.

cognitive re-structuring consists of a process of having a helping professional challenge negative automatic thought processes that are not necessarily true with actual facts.

compassion is closely aligned with empathy and is concerned with identifying with the suffering of others.

compassion fatigue occurs when people are exposed to suffering on a regular basis, suffering such as trauma, death, loss and emotional pain. Over time exposure to constant suffering can result in helping professionals disconnecting emotionally from those in their care as a means to cope. This is the essence of compassion fatigue.

connecting is a term that is used in communication that refers to the ability to meet another person on a human level and to relate to them as individuals. It helps someone to feel understood.

constriction of thought refers to the narrowing or tunneling of the focus of attention on death by the suicidal person as the only way out of their psychological pain.

coping cards are developed when a person is no longer in a crisis and contain adaptive coping statements that patients can consult during a time of future distress.

Coroner is the title given to certain death investigators. In addition to identifying the deceased and a cause of death, an integral role of the Coroner is to gather facts concerning the circumstances leading up to an unexpected sudden and unnatural death. An additional purpose of a Coroner is to make recommendations when appropriate to prevent a death under similar circumstances.

critical incident de-briefing (CID) is a formal process where a trained counsellor debriefs workers who have been exposed to traumatic situations that are outside of the normal realm of human experience.

culture represents the beliefs and customs of particular groups in society and consists of much more than ethnicity. Culture includes ethnicity but also encompasses age, socio-economic status, gender, and religion.
depression is characterized by some of the following symptoms: depressed mood, low energy, loss of interest in activities normally enjoyed, change of appetite, sleep disturbances, and negative thought processes including thoughts of suicide.
empathy is the ability to be able to identify with and to understand, the experiences of another person and includes both positive and negative experiences.
ethnicity traditionally is associated with a particular social group that shares a common culture, religion and language.
ethics is derived from philosophy and is concerned with the study of ideal conduct.
ethic of care is associated with the caring relationships between people and their interconnectedness. It is concerned with the action of caring for others and doing what we can to end human suffering and discrimination against all minorities.
ethic of justice is concerned with fairness and treating everyone equally.
ethical dilemma is said to occur when there are two or more ethically defensible courses of action that can be taken but only one can play out in practice.
exquisite empathy is a type of empathy that encourages professional boundaries. The practitioner identifies with the patient's feelings but is also able to stay separate from their suffering by choosing to remain in the present moment.
gatekeeper is a person who because of their specific line of work may come into contact with people who are suffering from suicide ideation.
gesture refers to an action performed for show and not necessarily for effect.
gratitude is the positive experience of being purposely thankful for the benefits in one's life.
hope is about having goals for the future and a belief that life can get better than it presently is.
hopelessness is associated with having no hope, feeling despair and resignation that nothing will change.
hope instillation is a process of helping others to re-discover their sense of hope. It is of particular importance for people who are suicidal because they often have lost all hope.
listening stoppers are hindrances that interfere with our ability to connect with the other person. Interrupting the other person is an example of a listening stopper.
mindful listening is concerned with making time stand still. It entails actively listening without anything distracting you from being in that very moment with the other person.
moral agency is one's ability to act on one's personal moral beliefs.
moral disengagement happens when a clinician who is experiencing moral residue, distances themselves from all relational aspects of care and resorts to only performing tasks.
moral residue is the feeling of on-going remorse and guilt that may occur when nurses are unable to act on their moral beliefs.
Narrative Action Theoretical Approach is a type of therapeutic technique where the therapist encourages the person who is suicidal to tell the story of why it is they have decided to end their life. They are then encouraged to change the ending to their story and to choose life instead of death.

narrative case study is a form of qualitative research. It consists of systematically gathering data by analyzing a person's story as told by them in order to identify themes and trends.

non-maleficence is an aspect of the ethical principle of beneficence and is about our duty to do no harm, either intentionally or unintentionally.

open-ended question is one that cannot be answered with one word, such as "Fine," Yes," or No." It is the type of question that helps the person to tell you their story.

para-phrasing is a communication technique that consists of re-stating the person's basic message in your own words. The purpose of para-phrasing is for the helper to see if they actually do understand what the intended message was.

parasuicidal gesture refers to an action of self-harm by a person. Equating an actual suicide attempt to a mere gesture may result in a dismissive response and actually diminish the gravity of the suicide attempt.

philosophy is the study of ideas concerning knowledge and what is true and the overall nature and meaning of life.

post-traumatic stress disorder (PTSD) occurs after exposure to an event that is outside the realm of normal human experience. Some of the symptoms of PTSD include hyperarousal, re-experiencing of the trauma, avoidance of anything associated with the disturbing memory, trouble in relationships, mood swings and even symptoms of depression.

presencing is the act of being fully present and in the moment with a person and offering them your full attention. It also entails sending the person kind and caring thoughts and is best done in silence.

protective factors are socio-cultural, environmental and individual factors which may reduce a person's vulnerability to suicidal behavior.

psychache is a term that refers to a person's unbearable emotional pain. It was a term developed by a world re-known 20th century suicidologist, Edwin Shneidman.

psychological autopsy consists of a retrospective investigation after a death has occurred. The goal is to try and re-trace the events that happened to the deceased prior to death. The process may consist of gathering physical evidence, review of medical records and interviewing people who were involved with the person prior to death.

qualitative study is a method of scientific inquiry that is utilized to gain increased understanding of the experience of humans and to describe the essence of that experience. Qualitative research aims to discover meaning and understanding rather than to verify truth or predict outcomes.

quantitative research consists of the measuring and quantification of identified objective reality. The goal is to draw inferences about the whole from the analysis of its parts and quantitative studies are concerned with causes and effects. In quantitative research the researcher stands outside the phenomenon that is being studied.

recovery models in mental health treatment do not necessarily focus on full recovery from illness but emphasize ways that people with mental illness can lead productive lives. Recovery models are strength based and encourage patient empowerment.

resiliency refers to a person's optimistic set of assumptions about themselves that in turn influence their mindset, their responses to life's stressors and their ability to cope in an affirmative manner to those stressors.

Safety Plan is a prevention tool that is designed to help those who struggle with their suicidal thoughts. It promotes healthy coping, assists the person in establishing reasons for living and to specifically identify people to call when they are in crisis.
self-awareness is the ability to recognize your emotions, beliefs, values and attitudes and to know your strengths and weaknesses. It also entails being aware of strong feelings without reacting to those feelings.
self-compassion consists of telling ourselves that because we are human we sometimes make errors in judgment and we must be more self-forgiving.
sexual prejudice consists of negative attitudes toward sexual preferences that differ from heterosexuality.
social stressors collectively represent factors and/or situations that occur in society that have an impact on a person's stress levels and ability to cope.
stigma is defined as an association of disgrace or public disapproval of something such as a behavior or condition.
Strain Theory of Suicide explains how psychache and ensuing suicide is usually preceded by specific types of psychological strains. These stressors usually consist of two or more variables that pulls or pushes an individual in different directions.
suicidal ideation refers to a person experiencing thoughts of suicide.
suicide is the act of a person choosing to end their life voluntarily and intentionally.
suicide note is a vehicle by which the decedent can have the last word.
suicide risk assessment tools are designed to assess the presence of particular symptoms or circumstances that places a person on a scale of categorized risk for a completed suicide (e.g., high risk, moderate risk, low risk).
suicidology is the study of suicide, suicidal behavior and suicide prevention.
suicidologist is someone who studies suicide.
The Aeschi Working Group is a group of suicidologists who are based in Switzerland and associated with the International Association for Suicide Prevention (IASP). This group of highly qualified professionals focuses on the therapeutic approach and offers new helpful strategies for health professionals to adopt to prevent suicide.
therapeutic alliance is the basis of a therapeutic process where the patient and care giver become collaborators in helping to heal mental illness and emotional distress. It is like a partnership.
transgender refers to a person whose gender identity does not correspond to that person's biological sex assigned at birth.
unconditional positive regard in practice consists of there being no conditions or obstacles to your ability to care for another person. Everyone is deserving of being cared for regardless of their behavior.
validation is a communication technique that consists of identifying with the feeling that the other person is experiencing. It may be in the form of offering reassurance that you understand the essence of their experience.
vicarious traumatization is very similar to compassion fatigue. It occurs due to the cumulative transformative effects upon therapists from empathic engagement with traumatized clients.
warning signs of suicide are somewhat elusive or sometimes overt messages that a person is in trouble. Many warning signs may not appear to be concerning to the

observer but when taken together they become quite concerning. You must also be aware that sometimes there are no warning signs of suicide.

APPENDIX A: Sample: Confidentiality Agreement for Simulation

Faculty of Health Sciences(as adapted from Douglas College Simulations Lab)

Welcome to our Faculty of Health Sciences Simulation Centre. The simulation lab is a learning environment whereby students and faculty actively engage in simulated clinical scenarios to enhance psychomotor, assessment, communication and critical thinking skills pertinent to clinical practice.

The simulation lab is a learning environment which promotes professionalism and an expectation that all students and faculty adhere to professional practice. This includes treating everyone with respect, valuing the opinions of others, and fostering a collegial and supportive learning environment. It is also an expectation that all simulation experiences be kept confidential with respect to scenario information, student performance, and debriefing discussions. All students are to adhere to confidentiality by ensuring that no discussions of students actions are to take place outside the simulation lab, this includes any information shared during debriefing sessions. This confidentiality agreement is in keeping with our school of Nursing's Policy, which expects academic integrity, honesty and ethical conduct of all students.

As a student participating within the simulation lab, I understand that the information and shared experiences of all students be kept confidential and that any violation of confidentiality is unethical and may result in disciplinary action according to our school's Academic Honesty policy.

Student Signature: _____ Month____ Day____ Year____

APPENDIX B: Further Recommended Readings

Colucci, E., & Lester, D. (Eds.), (2013). *Suicide and culture: Understanding the context.* UK: Hogrefe Publishing.

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Stephany, K. (2015). *Cultivating empathy: Inspiring health professionals to communicate more effectively*. United Arab Emirates: Bentham Science Publishing.

Simon Fraser University (SFU) Centre for Applied Research in Mental Health & Addiction (CARMHA). (2016). *Hope & healing: A practical guide for survivors of suicide.* The complete booklet can be downloaded from: www.health.gov.bc.ca/mhd or www.carmha.ca

Van Bergan, D. D., Montesinos, A. H., & Schouler-Ocak, M. (2015). *Suicidal behavior of*

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APPENDIX C: Information & Resources for Suicide & Crisis Intervention

International Association for Suicide Prevention (IASP)
Email: membership@iasp.info
www.isap.info

IASP Resources & Crisis Centres
To find a Crisis Centre in your area of the World please visit the link below and select your continent and/or region
www.iasp.info/resources/Crisis_Centres/

Some Additional Resources:

Canadian Association for Suicide Prevention/Association canadienne pour la prevention du suicide (CASP/ACPS) Winnipeg, Manitoba, Canada
Telephone: (204) 784-4073
www.suicideprevention.ca

Crisis Intervention & Suicide Prevention Centre of British Columbia (Canada)
https://crisiscentre.bc.ca
24 Hour Crisis Help Anywhere in BC: 1-800-SUICIDE or 1-800-784-2433
(In different languages)
Vancouver: 604-872-3311
Sunshine Coast/Sea to Sky: 1-866-661-3311
Mental Health Support Line: 604-872-1234
Seniors Direct Line: 604-872-1234
On-Line Chat Service for Youth: www.YouthInBC.com (noon – 1 AM)
Online Chat Service for Adults: www.CrisisCentreChat.ca (noon – 1 AM)

Centre for Suicide Prevention (CSP) (Alberta, Canada)
Telephone: 1-(403) 245-3900
Email: info@suicideinfo.ca
www.suicideinfo.ca

Reason to Live Manitoba, Canada
Linked with Manitoba's Suicide Line
www.reasontolive.ca

National Centre for Suicide Research and Prevention (NSSF) (Oslo, Norway)
Telephone: +47 22 92 34 73
Email: nssf-post (at) medisin.uio.no
www.med.uio.no/ipsy/ssff

Suicide Prevention Resource Center (SPRC) Washington, DC & Waltham, MA, USA
Telephone: 877-438-7772
Email: info@sprc.org
www.sprc.org

American Association of Suicidology (AAS) Washington, DC, USA
Telephone: +1 (202) 237-2280
Email: info@suicidology.org
www.suicidology.org

Irish Association of Suicidology (IAS) Dublin, Ireland
Telephone: +01 667 4900
Email: infor@ias.ie
www.ias.ie

Suicide Prevention Australia (SPA) Sydney, NSW
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APPENDIX D: Commonly Used Suicide Risk Assessment Tools

The following is a list of a few commonly used suicide risk assessments tools that assess either symptoms (e.g., hopelessness) or resilience factors (e.g., reasons for living), or both (Perlman *et al*., 2011). This is by no means an exhaustive list. However, these tools, and others, have been recommended by Perlman *et al*. (2011) after a review of the literature and interviews with experts. A brief statement as to what the scale measures is included. **Perlman *et al*. (2011) strongly advises training prior to utilizing any scales for suicide assessment.**

Beck Hopelessness Scale (BHS) (Beck & Steer, 1988)

Measures "negative attitudes about one's future and perceived inability to avert negative life occurrences" (Perlman *et al*., 2011, p. 39).

Beck Scale for Suicide Ideation (BSS) (Beck, Kovacs & Weissman, 1979)

Measures "the current and immediate intensity of attitudes, behaviors and plans for suicide related behavior with the intent to end life among psychiatric patients" (Perlman *et al*., 2011, p. 40).

Geriatric Suicide Ideation Scale (GSS) (Heisel & Flett, 2006)

"(I)s a multidimensional measure of suicide-related ideation developed for use with older adults" (Perlman *et al*., 2011, p. 42).

Nurses' Global Assessment of Suicide Risk (NGASR) (Cutcliffe & Barker, 2004)

The NGASR "is a nursing assessment tool used to identify psychological stressors that are reported to be strongly linked with suicide" (Perlman *et al*., 2011, p. 47).

Reasons for Living Inventory (RFL) (Linehan, Goodstien, Nielson & Chiles, 1983)

The RFL "assesses potential protective factors among persons who report ideation of suicide. It may be used to explore differences in the reasons for living among individuals who engage in suicide-related behaviours and those who do not" (Perlman *et al*., 2011, p. 48).

SAD PERSONS and Sad PERSONAS Scales (Patterson, Dohn & Bird, 1983)

This scale "is a simple mnemonic to assess major suicide-related risk factors" (Perlman *et al*., 2011, p. 49).

Scale for Impact of Suicidality – Management, Assessment and Planning of Care (SIS-MAP) (Nelson, Johnston & Shrivastava, 2010)

This scale "Is a comprehensive suicide assessment tool to aid in the prediction of suicide risk, as well as the development of a care and management plan" (Perlman *et al*., 2011, p. 51).

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> This humane book usefully applies the ethics of care and empathy to practical issues about suicide
>
> *Michael Slote*
> *University of Miami, Department of Philosophy*
> *United States*

Kathleen Stephany

Dr. Kathleen Stephany PhD is a practicing registered nurse (RN) with the College of Registered Nurses in BC (CRNBC) and a Psychologist who is certified with the Canadian Counselling & Psychotherapy Association (CCPA). She is also a nurse educator, published author, ethicist, ethic of care theorist and suicidologist. Kathleen has conducted both quantitative and qualitative research into suicide. As a psychiatric nurse clinician and Psychologist she has experience assessing persons for suicide risk. Kathleen also teaches suicide risk assessment and prevention to nursing students. She is a member of the International Association for Suicide Prevention (IASP) and a member of the Canadian Association for Suicide Prevention (CASP). Kathleen speaks publicly in both academic and non-academic venues about the important subject of suicide prevention. Kathleen obtained her doctorate in Counselling Psychology from Breyer State University in Alabama. The topic of her doctoral Dissertation was entitled, Suicide Intervention: The Importance of Care as a Therapeutic Imperative. She also previously earned a MA in Counselling Psychology from Simon Fraser University (SFU), a BA in Psychology from SFU, a BSN from the University of Victoria and a Diploma in Nursing from the British Columbia Institute of Technology (BCIT). In addition to being a member of IASP and CASP, Kathleen is a member of other professional associations. For example, Kathleen is a member of The Canadian Mental Health Association (CMHA), BC Branch, and a member of the Xia Eta Chapter of Sigma Theta Tau International, Honor Society of Nursing, and an associate member of the Western Northern Region of the Canadian Association of Schools of Nursing (WNRCASN). Kathleen Stephany is employed full-time as a Nurse Educator in the Bachelor of Science in Nursing (BSN) Program at Douglas College in Coquitlam, BC. She is also a motivational and inspirational speaker and a passionate gardener.