

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  Books**

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

**Authored by**

**Kathleen Stephany**

*Faculty of Health Sciences, Douglas College, BC, Canada*

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

Author: Kathleen Stephany

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

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

© 2017, Bentham eBooks imprint.

Published by Bentham Science Publishers – Sharjah, UAE. All Rights Reserved.

First published in 2017.

## **BENTHAM SCIENCE PUBLISHERS LTD.**

### **End User License Agreement (for non-institutional, personal use)**

This is an agreement between you and Bentham Science Publishers Ltd. Please read this License Agreement carefully before using the ebook/echapter/ejournal (“**Work**”). Your use of the Work constitutes your agreement to the terms and conditions set forth in this License Agreement. If you do not agree to these terms and conditions then you should not use the Work.

Bentham Science Publishers agrees to grant you a non-exclusive, non-transferable limited license to use the Work subject to and in accordance with the following terms and conditions. This License Agreement is for non-library, personal use only. For a library / institutional / multi user license in respect of the Work, please contact: [permission@benthamscience.org](mailto:permission@benthamscience.org).

### **Usage Rules:**

1. All rights reserved: The Work is the subject of copyright and Bentham Science Publishers either owns the Work (and the copyright in it) or is licensed to distribute the Work. You shall not copy, reproduce, modify, remove, delete, augment, add to, publish, transmit, sell, resell, create derivative works from, or in any way exploit the Work or make the Work available for others to do any of the same, in any form or by any means, in whole or in part, in each case without the prior written permission of Bentham Science Publishers, unless stated otherwise in this License Agreement.
2. You may download a copy of the Work on one occasion to one personal computer (including tablet, laptop, desktop, or other such devices). You may make one back-up copy of the Work to avoid losing it. The following DRM (Digital Rights Management) policy may also be applicable to the Work at Bentham Science Publishers’ election, acting in its sole discretion:
  - 25 ‘copy’ commands can be executed every 7 days in respect of the Work. The text selected for copying cannot extend to more than a single page. Each time a text ‘copy’ command is executed, irrespective of whether the text selection is made from within one page or from separate pages, it will be considered as a separate / individual ‘copy’ command.
  - 25 pages only from the Work can be printed every 7 days.
3. The unauthorised use or distribution of copyrighted or other proprietary content is illegal and could subject you to liability for substantial money damages. You will be liable for any damage resulting from your misuse of the Work or any violation of this License Agreement, including any infringement by you of copyrights or proprietary rights.

### ***Disclaimer:***

Bentham Science Publishers does not guarantee that the information in the Work is error-free, or warrant that it will meet your requirements or that access to the Work will be uninterrupted or error-free. The Work is provided “as is” without warranty of any kind, either express or implied or statutory, including, without limitation, implied warranties of merchantability and fitness for a particular purpose. The entire risk as to the results and performance of the Work is assumed by you. No responsibility is assumed by Bentham Science Publishers, its staff, editors and/or authors for any injury and/or damage to persons or property as a matter of products liability, negligence or otherwise, or from any use or operation of any methods, products instruction, advertisements or ideas contained in the Work.

### ***Limitation of Liability:***

In no event will Bentham Science Publishers, its staff, editors and/or authors, be liable for any damages, including, without limitation, special, incidental and/or consequential damages and/or damages for lost data and/or profits arising out of (whether directly or indirectly) the use or inability to use the Work. The entire liability of Bentham Science Publishers shall be limited to the amount actually paid by you for the Work.

## General:

1. Any dispute or claim arising out of or in connection with this License Agreement or the Work (including non-contractual disputes or claims) will be governed by and construed in accordance with the laws of the U.A.E. as applied in the Emirate of Dubai. Each party agrees that the courts of the Emirate of Dubai shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this License Agreement or the Work (including non-contractual disputes or claims).
2. Your rights under this License Agreement will automatically terminate without notice and without the need for a court order if at any point you breach any terms of this License Agreement. In no event will any delay or failure by Bentham Science Publishers in enforcing your compliance with this License Agreement constitute a waiver of any of its rights.
3. You acknowledge that you have read this License Agreement, and agree to be bound by its terms and conditions. To the extent that any other terms and conditions presented on any website of Bentham Science Publishers conflict with, or are inconsistent with, the terms and conditions set out in this License Agreement, you acknowledge that the terms and conditions set out in this License Agreement shall prevail.

### **Bentham Science Publishers Ltd.**

Executive Suite Y - 2

PO Box 7917, Saif Zone

Sharjah, U.A.E.

Email: [subscriptions@benthamscience.org](mailto:subscriptions@benthamscience.org)



## CONTENTS

<b>FOREWORD</b> .....	i
<b>PREFACE</b> .....	ii
The Ethic of Care & Empathy .....	ii
Where My Interest in Suicide Prevention Began? .....	ii
Why this Book was Written? .....	iii
Learning from Other People's Experiences .....	iii
Who Should Read this Book? .....	iii
<b>ABOUT THE AUTHOR</b> .....	iv
<b>ACKNOWLEDGEMENTS</b> .....	v
<b>CONFLICT OF INTEREST</b> .....	v
<b>CHAPTER 1 THE IMPORTANCE OF TEACHING SUICIDAL PREVENTION STRATEGIES TO GATEKEEPERS</b> .....	1
<b>LEARNING GUIDE</b> .....	2
After Completing this Chapter, the Reader Should be Able to: .....	2
<b>INTRODUCTION</b> .....	3
Overview of Chapter 1 .....	3
<b>INSTILLATION OF HOPE</b> .....	4
<b>SOME HARD FACTS ABOUT SUICIDE</b> .....	5
<b>THE MULTI-DIMENSIONAL FACTORS ASSOCIATED WITH SUICIDE</b> .....	6
<b>SOCIAL STRESSORS &amp; SUICIDE</b> .....	7
Social Stressors & Adverse Life Experiences .....	7
Social Stressors & Loss .....	7
<b>CULTURAL ISSUES &amp; SUICIDE</b> .....	9
Suicide & Socio-economic Status: .....	9
<b>25 COUNTRIES WITH THE HIGHEST RATES OF SUICIDE (AS ADAPTED FROM PETR, 2015)</b> .....	9
25. POLAND (16.6 per 100,000 people) .....	9
24. UKRAINE (16.8 per 100,000 people) .....	9
23. COMOROS (16.9 per 100,000 people) .....	10
22. SUDAN (17.2 per 100,000 people) .....	10
21. BHUTAN (17.8 per 100,000 people) .....	10
20. ZIMBABWE (18.1 per 100,000 people) .....	10
19. BELARUS (18.3 per 100,000 people) .....	10
18. JAPAN (18.5 per 100,000 people) .....	10
17. HUNGARY (19.1 per 100,000 people) .....	10
16. UGANDA (19.5 per 100,000 people) .....	11
15. RUSSIA FEDERATION (19.5 per 100,000 people) .....	11
14. TURKMENISTAN (19.6 per 100,000 people) .....	11
13. SOUTH SUDAN (19.8 per 100,000 people) .....	11
12. INDIA (21.1 per 100,000 people) .....	11
11. BURUNDI (23.1 per 100,000 people) .....	11
10. KAZAKHSTAN (23.8 per 100,000 people) .....	11
9. NEPAL (24.9 per 100,000 people) .....	12
8. UNITED REPUBLIC OF TANZANIA (24.9 per 100,000 people) .....	12
7. MOZAMBIQUE (27.4 per 100,000 people) .....	12
6. SURINAME (27.8 per 100,000 people) .....	12

5. LITHUANIA (28.2 per 100,000 people) .....	12
4. SRI LANKA (28.8 per 100,000 people) .....	12
3. SOUTH KOREA (28.9 per 100,000 people) .....	12
2. DEMOCRATIC PEOPLE’S REPUBLIC OF KOREA (38.5 per 100,000 people) .....	13
1. GUYANA (44.2 per 100,000 people) .....	13
Suicide & Age .....	13
Suicide & Gender .....	13
Suicide & Aboriginals .....	14
<b>RELIGION &amp; SUICIDE</b> .....	14
<b>THE IMPORTANCE OF TRAINING GATEKEEPERS</b> .....	15
Premise 1: The Training of Health Professionals in Suicide Risk & Therapeutic Intervention is Often Limited .....	16
Premise 2: We Need to Do a Better Job of Teaching Suicide Prevention to Health Professionals .....	16
Premise 3: People who are Feeling Suicidal Do Reach Out to Health Professionals for Help .....	18
Premise 4: Teaching Gatekeepers How to Establish Therapeutic Rapport & to Offer Empathy May Help to Save Some Lives .....	18
<b>THE ETHIC OF CARE AS THE THEORETICAL FOUNDATION</b> .....	21
<b>THE ETHIC OF CARE AND EMPATHY AS A TOOL FOR SUICIDE PREVENTION</b> .....	21
The Importance of Training Gatekeepers in How to Care .....	21
<b>METHODOLOGY</b> .....	23
<b>NARRATIVE CASE STUDY: ADMISSION TO A SECURE ROOM</b> .....	24
Analysis of the Case Study .....	26
Theme Analysis .....	27
Suggested Questions for Group Discussion .....	27
<b>SOMETHING TO PONDER: THE IMPORTANCE OF SELF-COMPASSION</b> .....	28
<b>ETHICAL ISSUES THAT MAY ARISE WHEN CARING FOR THE SUICIDAL PERSON</b> .....	29
Suggested Question for Group Discussion .....	29
<b>REFLECTING BACK</b> .....	30
Summary of Key Points Covered in Chapter 1 .....	30
<b>CHAPTER 2 CHANGING STIGMA, DIPELLING MYTHS AND ASSESSING RISK</b> .....	32
<b>LEARNING GUIDE</b> .....	33
After Completing this Chapter, the Reader Should be Able to: .....	33
Overview of Chapter 2 .....	33
<b>STIGMA &amp; HOW IT NEGATIVELY IMPACTS PEOPLE WHO SUFFER FROM     MENTAL ILLNESS &amp; SUICIDAL IDEATION</b> .....	34
<b>EDUCATION IS THE KEY TO CHANGING STIGMA</b> .....	36
<b>LEARNING FROM THE LIVED EXPERIENCES OF BEING STIGMITIZED</b> .....	37
Analysis of Their Lived Experiences .....	38
Theme Analysis .....	39
Questions .....	41
<b>EDUCATING OTHERS BY DIPELLING PRECONCEIVED ASSUMPTIONS</b> .....	41
Presumed Assumption 1: You can’t stop a person from committing suicide once their mind is made up .....	41
Presumed Assumption 2: Only depressed people kill themselves and other people are not at risk .....	42
Presumed Assumption 3: If you talk about suicide with someone who is thinking about it, you will push them over the edge and make them do it .....	42
<i>The following four questions are also useful when you suspect that someone is             suicidal (as adapted from SAVE, 2015)</i> .....	42

Presumed Assumption 4: If a person denies an intention of acting on their suicidal thoughts or plan, no further intervention is needed .....	43
<b>THE LIMITATIONS OF SOME SUICIDE RISK ASSESSMENT TOOLS OR FRAMEWORKS .....</b>	<b>43</b>
<b>INITIAL SCREENING: BECOME AWARE OF THE WARNING SIGNS OF SUICIDE ...</b>	<b>44</b>
Warning Signs: (as adapted from Fowler, 2011; Rudd et al., 2006) .....	45
<b>LEARN HOW TO CONDUCT A THOROUGH &amp; FOCUSED SUICIDE RISK ASSESSMENT .....</b>	<b>45</b>
Eleven Steps to a Focused Suicide Risk Assessment (as adapted from SuicideLine, 2016; PatientPlus, 2016; Perlman et al., 2011; Barker & Buchanan-Barker, 2005; Stephany, 2015) .....	45
Step 1: Establish Rapport by Conveying Empathy .....	46
Step 2: Ask Open-ended Questions .....	46
<i>Examples of Open-Ended Questions to Ask (as adapted from SuicideLine, 2016) .....</i>	<i>47</i>
Step 3: Assess for Risk Factors .....	47
<i>Individual Risk Factors .....</i>	<i>47</i>
<i>Socio-cultural Risk Factors .....</i>	<i>48</i>
<i>Situational Risk Factors .....</i>	<i>48</i>
Step 4: Assess for Protective Factors .....	48
<i>Personal Protective Factors (as adapted from SuicideLine, 2016) .....</i>	<i>48</i>
<i>Work Protective Factors (as adapted from SuicideLine, 2016) .....</i>	<i>49</i>
<i>Family Protective Factors (as adapted from SuicideLine, 2016) .....</i>	<i>49</i>
<i>Community Protective Factors (as adapted from SuicideLine, 2016) .....</i>	<i>49</i>
Step 5: Assess for Current Suicidal Thoughts .....	49
<i>Useful Questions to ask to inquire about Suicidal Thoughts (as adapted from SuicideLine, 2016) .....</i>	<i>49</i>
Step 6: Is There a Suicidal Plan? .....	49
<i>Questions that Assess for a Plan (as adapted from SuicideLine, 2016) .....</i>	<i>49</i>
Step 7: Is There Access to Means? .....	50
<i>Questions that Explore Access to Means (as adapted from SuicideLine, 2016) .....</i>	<i>50</i>
Step 8: Is There Any Prior History of Suicidal Behavior? .....	50
Step 9: Document all Findings .....	50
<i>Sample of Recommended Suicide Risk Assessment Documentation Topics (as adapted from Perlman et al., 2011) .....</i>	<i>51</i>
Step 10: Develop and Implement a Care Plan .....	51
Step 11: Engage in On-going Monitoring & Re-Assessment .....	52
Key Components of the Safety Plan (as adapted from Stanley and Brown, 2016; The National Suicide Prevention Line, 2013) .....	52
<b>NARRATIVE CASE STUDY: WHEN A PSYCHIATRIST EXPERIENCES STIGMA .....</b>	<b>53</b>
Analysis of the Case Study .....	54
Theme Analysis .....	54
Questions .....	55
<b>SOMETHING TO PONDER: INCREASING SELF-AWARENESS TO REDUCE STIGMA .....</b>	<b>55</b>
Simple Ways to Increase Self-Awareness (as adapted from Change Management Coach, 2016) .....	56
<b>REFLECTING BACK .....</b>	<b>57</b>
Summary of Key Points Covered in Chapter 2 .....	57
<b>CHAPTER 3 PREVENTING AND TREATING MENTAL ILLNESS &amp; UNDERSTANDING THE MINDSET OF THE SUICIDAL PERSON .....</b>	<b>60</b>
<b>LEARNING GUIDE .....</b>	<b>61</b>
After Completing this Chapter, the Reader Should be Able to: .....	61

Overview of Chapter 3 .....	61
<b>THE IMPORTANCE OF EARLY DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS &amp; ADDICTIONS</b> .....	62
Percentage of Hospital Admissions For Self-Harm (as adapted from the Canadian Institute for Health Information, 2011 as cited in Moore & Melrose, 2014, p. 511) .....	63
Strategies to Address the Global Shortfall in Mental Health & Addiction Services: (as adapted from WHO, 2012; MHCC, 2012; Schmitz, et al., 2012) .....	64
<b>PSYCHACHE AS A NECESSARY CONDITION FOR SUICIDE</b> .....	65
<b>PSYCHACHE &amp; CONSTRICTION OF THOUGHT</b> .....	66
<b>THE STRAIN THEORY AND PSYCHACHE</b> .....	66
<b>THE LIVED EXPERIENCE OF PSYCHACHE</b> .....	67
Analysis of Peter’s Experience .....	68
Theme Analysis .....	68
<b>MOVING THE SUICIDAL PERSON BEYOND A DEATH FOCUSED MIND SET</b> .....	68
Empathy as Means to Foster Connection .....	68
Challenging a Patient’s Constricted Thought Patterns .....	69
Helping The Suicidal Person to Change the Ending of Their Story: .....	71
<b>A PSYCHOLOGICAL AUTOPSY: WHAT A SUICIDE NOTE CAN TEACH US ABOUT THE EXPERIENCE OF PSYCHACHE</b> .....	71
Analysis of Howard’s Suicide Note .....	72
Theme Analysis .....	72
<b>SOMETHING TO PONDER: FOSTERING RESILIENCY</b> .....	72
<b>REFLECTING BACK</b> .....	73
Summary of Key Points Covered in Chapter 3 .....	73
<b>CHAPTER 4 THE ETHIC OF CARE &amp; EMPATHY AS A TOOL FOR HELPING THE SUICIDAL PERSON</b> .....	76
<b>LEARNING GUIDE</b> .....	77
After completing this Chapter, the Reader Should be Able to: .....	77
Overview of Chapter 4 .....	77
<b>THE ETHIC OF CARE AS THE WEB OF CONNECTION</b> .....	78
<b>EMPATHY AS A KEY COMPONENT OF THE ETHIC OF CARE</b> .....	79
Offering Empathy as a Means to Help the Suicidal Person to Choose Life .....	80
<b>ENCOURAGING THE SUICIDAL PERSON TO CHOOSE LIFE BY UTILIZING COMPONENTS ASSOCIATED WITH THE ETHIC OF CARE &amp; EMPATHY</b> .....	82
The Ethic of Care & Empathy: The Importance of Establishing a Connection .....	82
<i>Advice from Suicidal Patients</i> .....	83
The Ethic of Care & Empathy: Fostering a Therapeutic Alliance & Trust .....	83
<i>When Trust is Sometimes Severed</i> .....	84
<i>Establishing Trust Must be the Foundation for Everything Else that Occurs</i> .....	84
<b>THE AESCHI WORKING GROUP: GUIDELINES FOR CLINICIANS (SOURCE: MICHEL, 2011, PP. 9 – 10). (NOTE THAT THE FOLLOWING POINTS HAVE BEEN SUMMARIZED)</b> .....	85
The Ethic of Care & Empathy: Offering Unconditional Positive Regard .....	86
<i>Strategies for Learning How to Practice Unconditional Positive Regard</i> .....	87
The Ethic of Care & Empathy: Listening With Your Heart .....	88
<i>Learn to Avoid Listening Stoppers</i> .....	88
<i>Qualities Demonstrated by Good Listeners (as adapted from Shafir, 2008)</i> .....	89
The Ethic of Care & Empathy: Making Use of Presencing .....	90
<i>Qualities of a Fully Present Person (as adapted from Walker, 2010, p. 80; Shafir, 2008; Stephany, 2015)</i> .....	90

<i>Presencing &amp; Silence: Knowing When Not to Speak (as adapted from Shafir, 2008, p. 229)</i> .....	91
The Ethic of Care & Empathy: Learning how to be Compassionate .....	91
<b>NARRATIVE CASE STUDY: AN ACT OF COMPASSION</b> .....	92
Analysis of the Case Study .....	93
Theme Analysis .....	93
Question .....	94
<b>A PSYCHOLOGICAL AUTOPSY: REVIEWING WHAT WENT WRONG IN ORDER TO LEARN HOW TO DO IT DIFFERENTLY (AS ADAPTED FROM STEPHANY, 2007)</b> .....	94
Analysis of the Case Study .....	96
Theme Analysis .....	96
<b>MOVING BEYOND THE INITIAL SUICIDE CRISIS: THE ROLE OF COGNITIVE THERAPY</b> .....	97
Cognitive Therapy: Moving the Patient Beyond their Initial Crisis .....	98
<b>SIMULATION: MAKING USE OF EMPATHY TO HELP A SUICIDAL PATIENT</b> .....	100
Objective One: Establish a Therapeutic Alliance .....	100
Objective Two: Practice Skills that Covey Empathy .....	101
Objective Three: Develop a Safety Plan .....	101
Summary of Safety Plan Goals: (as adapted from Stanley & Brown, 2016; The National Suicide Prevention Line, 2013) .....	101
Simulation Confidentiality .....	101
Preparation for the Simulation .....	102
<i>Non-Verbal Communication Skills: (as adapted from Rosenberg, 2003; Walker, 2010)</i> .....	102
<i>Verbal Communication Skills (as adapted from Brammer &amp; MacDonald, 1999; Walker, 2010)</i> .....	102
<i>Scenario:</i> .....	103
<i>Setting the Scene:</i> .....	103
Role Play Part I: The Assessment Interview .....	103
Role Play Part II: Creating a Safety Plan .....	106
Simulation Suggestion .....	108
De-Brief & Learn .....	108
<i>De-Briefing Strategies for Consideration</i> .....	108
<b>SOMETHING TO PONDER: MAKE EMPATHETIC RESPONSES A HABIT IN YOUR LIFE</b> .....	109
Key Points on How to Journal to Evaluate Your Empathy Skills: (as adapted by Goldstein & Brooks, 2004; Stephany, 2006; Stephany, 2015) .....	110
<b>REFLECTING BACK</b> .....	110
Summary of Key Points Covered in Chapter 4 .....	110
<b>CHAPTER 5 STRATEGIES THAT PROMOTE THE EMOTIONAL WELL-BEING OF GATEKEEPERS</b> .....	112
<b>LEARNING GUIDE</b> .....	113
After Completing this Chapter, the Reader Should be Able to: .....	113
Overview of Chapter 5 .....	113
<b>ADMITTING THE UNTHINKABLE: SUICIDE AS AN OCCUPATIONAL HAZARD</b> .....	114
<b>SUICIDE &amp; DOCTORS</b> .....	114
Contributing Factors to Physician Suicide .....	115
Obstacles to Treatment .....	116
Change the Stigma That Exits Within the Medical Community .....	116
<b>SUICIDE &amp; NURSES</b> .....	117
Nurse Suicide & The Role of Work Stress .....	117

Stigma Prevents Nurses from Getting Help .....	118
<b>CARING FOR THE SUICIDAL PERSON &amp; COMPASSION FATIGUE .....</b>	<b>118</b>
<b>STRATEGIES THAT ENHANCE EMOTIONAL WELL-BEING .....</b>	<b>120</b>
<b>STRATEGY 1: REACH OUT FOR PROFESSIONAL HELP IF NEEDED .....</b>	<b>120</b>
Normalize the Experience of Getting Help .....	120
Access Critical Incident De-Briefing (CID) .....	122
<b>STRATEGY 2: FOSTER SELF-COMPASSION .....</b>	<b>122</b>
Reflective Journaling & Self-awareness .....	123
<b>STRATEGY 3: MAKE CARE FOR THE CAREGIVER A PRIORITY .....</b>	<b>124</b>
Self-Care Plan A: Adopt ways that Enhance your Physical & Emotional Health .....	125
<i>Begin by Conducting an Evaluation of Your Wellness</i> .....	125
<i>Set Realistic Goals for Yourself</i> .....	125
<i>Have Someone Make you Accountable</i> .....	125
Self-Care Plan B: Strive for Work-Life Balance .....	126
Self-Care Plan C: Foster Supportive Relationships with Others at Work .....	127
Self-Care Plan D: Cultivate Gratitude .....	127
<b>CONCLUSION &amp; TAKE AWAY POINTS .....</b>	<b>128</b>
<b>REFLECTING BACK .....</b>	<b>130</b>
Summary of Key Points Covered in Chapter 5 .....	130
<b>REFERENCES .....</b>	<b>132</b>
<b>GLOSSARY .....</b>	<b>143</b>
<b>APPENDIX A: SAMPLE: CONFIDENTIALITY AGREEMENT FOR SIMULATION .....</b>	<b>148</b>
<b>APPENDIX B: FURTHER RECOMMENDED READINGS .....</b>	<b>149</b>
<b>APPENDIX C: INFORMATION &amp; RESOURCES FOR SUICIDE &amp; CRISIS INTERVENTION .....</b>	<b>151</b>
<b>APPENDIX D: COMMONLY USED SUICIDE RISK ASSESSMENT TOOLS .....</b>	<b>153</b>
<b>SUBJECT INDEX .....</b>	<b>154</b>

## 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  
St. Paul's Hospital, Vancouver  
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

**Kathleen Stephany**

Full Time Nurse Educator in Faculty of Health Sciences  
Douglas College, BC  
Canada

E-mail: [stephanyk@douglascollege.ca](mailto:stephanyk@douglascollege.ca)

## **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 (WNRCSN). 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 in 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.

Kathleen Stephany

All rights reserved-© 2017 Bentham Science Publishers

**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

---

## **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.

Kathleen Stephany

All rights reserved-© 2017 Bentham Science Publishers

## **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](http://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

---

## **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.

**Kathleen Stephany**

All rights reserved-© 2017 Bentham Science Publishers

**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).



## **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

Kathleen Stephany

All rights reserved-© 2017 Bentham Science Publishers

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 is 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

---

## **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.

## 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](http://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

## REFERENCES

- Aboriginal Healing Foundation. (2007). *Suicide among Aboriginal people in Canada*. Ottawa.
- Allen, J.G. (2011). Mentalizing suicidal states. *Building a therapeutic alliance with the suicidal patient*. Washington, DC: American Psychological Association. 81-107.  
[<http://dx.doi.org/10.1037/12303-005>]
- Alderson, M., Parent-Rocheleau, X., Mishara, B. (2015). Critical review on suicide among nurses: What about work related factors? *Crisis*, 36(2), 91-101.  
[<http://dx.doi.org/10.1027/0227-5910/a000305>]
- Andrews, B., Brewin, C.R., Rose, S., Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: the role of shame, anger, and childhood abuse. *J. Abnorm. Psychol.*, 109(1), 69-73.  
[<http://dx.doi.org/10.1037/0021-843X.109.1.69>] [PMID: 10740937]
- Anees, M.A. (2006). Salvation and suicide: What does Islamic theology say? *Dialog*, 45, 275-279.  
[<http://dx.doi.org/10.1111/j.1540-6385.2006.00277.x>]
- Arnold, E.C. (2011). Developing therapeutic communication skills. *Interpersonal relationships: Professional communication skills for nurses*. (6th ed.) USA: Elsevier. 175-196.
- Baca-Garcia, E., Parra, C. P., Perez-Rodriguez, M. M., Sastre, C. D., Torres, R. R., Saiz-Ruiz, J. (2007). Psychological stressors may be strongly associated with suicide attempts. *Stress Health*, 23, 191-198.  
[<http://dx.doi.org/10.1002/smi.1137>]
- Bailey, S. (1994). Critical care nurses' and doctors' attitudes to parasuicide patients. *Aust. J. Adv. Nurs.*, 11(3), 11-17.  
[PMID: 7980877]
- Bajaj, P., Borreani, E., Ghosh, P., Methuen, C., Patel, M., Joseph, M. (2008). Screening for suicidal thoughts in primary care: the views of patients and general practitioners. *Ment. Health Fam. Med.*, 5(4), 229-235.  
[PMID: 22477874]
- Barker, P., Buchanan-Barker, P. (2005). *The tidal model: A guide for mental health professionals*. New York, New York: Routledge.  
[<http://dx.doi.org/10.4324/9780203340172>]
- Beck, A.T., Kovacs, M., Weissman, A. (1979). Assessment of suicidal intention: The scale for suicide ideation. *J. Consult. Clin. Psychol.*, 47(2), 343-352.  
[<http://dx.doi.org/10.1037/0022-006X.47.2.343>] [PMID: 469082]
- Beck, A.T., Steer, R.A. (1988). *Manual for the Beck Hopelessness Scale*. San Antonio, Texas: Psychological Corporation.
- Betz, M.E., Sullivan, A.F., Manton, A.P., Espinola, J.A., Miller, I., Camargo, C.A., Jr, Boudreaux, E.D. (2013). Knowledge, attitudes, and practices of emergency department providers in the care of suicidal patients. *Depress. Anxiety*, 30(10), 1005-1012.  
[<http://dx.doi.org/10.1002/da.22071>] [PMID: 23426881]
- Bhugra, D. (2005). Sati: a type of nonpsychiatric suicide. *Crisis*, 26(2), 73-77.

[<http://dx.doi.org/10.1027/0227-5910.26.2.73>] [PMID: 16138743]

Bien, T. (2008). The four immeasurable minds. *Mindfulness and the therapeutic relationship*, New York: The Guildford Press. 37-71.

Brammer, L.M., MacDonald, G. (1999). *The helping relationship: Process & skills*. Toronto: Allyn and Bacon.

British Columbia (BC) Coroners Service. (2015). In *BC: Ministry of Justice: BC Coroners Service*. [www.pssg.gov.bc.ca/coroners/](http://www.pssg.gov.bc.ca/coroners/)

Brooks, R., Goldstein, S. (2003). *The power of resiliency: Achieving balance, confidence, and personal strength in your life*. London: McGraw-Hills Books.

Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. USA: Gotham Books.

Brown, B. (2013). *Shame versus guilt*. [www.brenebrown.com/2013/01/14/2013114shame-v-guilt-html/](http://www.brenebrown.com/2013/01/14/2013114shame-v-guilt-html/)

Brown, G.K., Wenzel, A., Rudd, M.D. (2011). Cognitive therapy for suicidal patients. *Building a therapeutic alliance with the suicidal patient*, DC: American Psychological Association .273-291 . <https://www.suicideinfo.ca/resource/workplace-suicide-prevention/Washington> [<http://dx.doi.org/10.1037/12303-015>]

Canadian Association for Suicide Prevention (CASP). (2017). *Suicide risk in the aging Population*. <http://suicideprevention.ca/suicide-risk-in-the-aging-population/>

Canadian Institute for Health Information. (2011). *Health indicators*. Ottawa: Author.

Centre for Suicide Prevention. (2015). *The workplace and suicide prevention*. <https://www.suicideinfo.ca/resource/workplace-suicide-prevention/>

Centre for Suicide Prevention. (2017). *Trends in youth suicide*. <https://www.suicideinfo.ca/resource/youthatrisk/>

Cerel, J., Singleton, M.D., Brown, M.M., Brown, S.V., Bush, H.M., Brancado, C.J. (2016). Emergency department visits prior to suicide and homicide. *Crisis*, 37(1), 5-12. [<http://dx.doi.org/10.1027/0227-5910/a000354>] [PMID: 26620917]

Chopra, D. (2005). *Peace is the way*. USA: Three Rivers Press.

Cramer, R.J., Burks, A.C., Stroud, C.H., Bryson, C.N., Graham, J. (2015). A modernized mediation analysis of suicide proneness among lesbian, gay, and bisexual community members. *J. Soc. Clin. Psychol.*, 34(7), 622-642. [<http://dx.doi.org/10.1521/jscp.2015.34.7.622>]

Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience*. New York: HarperCollins Publishers.

Cutcliffe, J.R., Barker, P. (2004). The Nurses' Global Assessment of Suicide Risk (NGASR): developing a tool for clinical practice. *J. Psychiatr. Ment. Health Nurs.*, 11(4), 393-400. [<http://dx.doi.org/10.1111/j.1365-2850.2003.00721.x>] [PMID: 15255912]

Cutcliffe, J.R., Stevenson, C. (2007). *Care of the suicidal person*. USA: Churchill Livingstone Elsevier.

Etherington, K. (2016). *Narrative approaches to case studies*. <https://www.keele.ac.uk/media/keele-university/facnatsci/schpsych/documents/counselling/conference/5thannual/NarrativeApproachestoCaseStudies.pdf>

Ethnicity. *Merriam-Webster Dictionary*. <https://www.merriam-webster.com/dictionary/ethnicity>

Feldman, B.N., Freedenthal, S. (2006). Social work education in suicide intervention and prevention: an unmet need? *Suicide Life Threat. Behav.*, 36(4), 467-480. [http://dx.doi.org/10.1521/suli.2006.36.4.467] [PMID: 16978100]

Ferrucci, P. (2006). *The power of kindness: The unexpected benefits of leading a compassionate life*. New York: Jeremy P. Tarcher/Penguin.

Figley, C.R. (2002). *Treating compassion fatigue*. New York: Brunner-Mazel.

Fleischmann, A., De Leo, D. (2014). The World Health Organization's report on suicide: a fundamental step in worldwide suicide prevention. *Crisis*, 35(5), 289-291. [http://dx.doi.org/10.1027/0227-5910/a000293] [PMID: 25297514]

Fogarty, S. (2016). *ABC News: In Australia, suicide rates for indigenous men is the highest in the world*. <http://www.abc.net.au/news/2016-08-12/indigenous-youth-suicide-rate-highest-in-world-report-shows/7722112>

Fowler, J.C. (2012). Suicide risk assessment in clinical practice: pragmatic guidelines for imperfect assessments. *Psychotherapy (Chic)*, 49(1), 81-90. [http://dx.doi.org/10.1037/a0026148] [PMID: 22369082]

Freedenthal, S. (2014). *What is a suicide gesture? Speaking of Suicide: A Site for suicidal individuals and their loved ones, survivors, mental health professionals and the merely curious*. [www.speakingofsuicide.com/2014/04/16/What-is-a-suicide-gesture/](http://www.speakingofsuicide.com/2014/04/16/What-is-a-suicide-gesture/)

Fergusson, D.M., Beautrais, A.L., Horwood, L.J. (2003). Vulnerability and resiliency to suicidal behaviours in young people. *Psychol. Med.*, 33(1), 61-73. [http://dx.doi.org/10.1017/S0033291702006748] [PMID: 12537037]

Gairin, I., House, A., Owens, D. (2003). Attendance at the accident and emergency department in the year before suicide: retrospective study. *Br. J. Psychiatry*, 183, 28-33. [http://dx.doi.org/10.1192/bjp.183.1.28] [PMID: 12835240]

Gesture *Oxford Dictionary*. <https://en.oxforddictionaries.com/>

Ghio, L., Zanelli, E., Gotelli, S., Rossi, P., Natta, W., Gabrielli, F. (2011). Involving patients who attempt suicide in suicide prevention: a focus groups study. *J. Psychiatr. Ment. Health Nurs.*, 18(6), 510-518. [http://dx.doi.org/10.1111/j.1365-2850.2011.01697.x] [PMID: 21749557]

Ghoncheh, R., Koot, H.M., Kerkhof, A.J. (2014). Suicide prevention e-learning modules designed for gatekeepers: a descriptive review. *Crisis*, 35(3), 176-185. [http://dx.doi.org/10.1027/0227-5910/a000249] [PMID: 24901058]

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Gimmer, A. (2015). Personal therapy for therapists. *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists.*, London: Routledge.256-267.

- Goldacre, M., Seagroatt, V., Hawton, K. (1993). Suicide after discharge from psychiatric inpatient care. *Lancet*, 342(8866), 283-286. [http://dx.doi.org/10.1016/0140-6736(93)91822-4] [PMID: 8101307]
- Goldstein, S., Brooks, R. (2004). *The power of resilience: Achieving balance, confidence and personal strength in your life*. Toronto: McGraw Hill.
- Goleman, D. (2005). *Emotional intelligence: Why it can matter more than IQ*. Toronto, Canada: Bantam Books.
- Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Centre for Transgender Equality and National Gay and Lesbian Task Force.
- Gunnell, D. (2015). A population health perspective on suicide research and prevention: What we know, what we need to know and policy priorities. *Crisis*, 36(3), 155-160. [http://dx.doi.org/10.1027/0227-5910/a000317] [PMID: 26266821]
- Hawton, K., Agerbo, E., Simkin, S., Platt, B., Mellanby, R.J. (2011). Risk of suicide in medical and related occupational groups: a national study based on Danish case population-based registers. *J. Affect. Disord.*, 134(1-3), 320-326. [http://dx.doi.org/10.1016/j.jad.2011.05.044] [PMID: 21676470]
- Heisel, M.J., Flett, G.L. (2006). The development and initial validation of the geriatric suicide ideation scale. *Am. J. Geriatr. Psychiatry*, 14(9), 742-751. [http://dx.doi.org/10.1097/01.JGP.0000218699.27899.f9] [PMID: 16943171]
- Held, V. (2006). *The ethic of care: Personal, political, and Global*. UK: Oxford University Press.
- Hinshaw, S.P. (2009). *The mark of shame: Stigma of mental illness and an agenda for change*. United Kingdom: Oxford University Press.
- Hope. *The Free Dictionary*. www.thefreedictionary.com/hope
- Hopelessness. *The Free Dictionary*. www.thefreedictionary.com/hoplessness
- Institute of Marriage and Family Canada. (2009). *Canadian suicide statistics*. http://www.imfcanada.org/
- International Association for Suicide Prevention (IASP). (2016). *The Aeschi Working Group: Meet the Suicidal Person*. http://www.aeschiconference.unibe.ch/
- Jarvis, T. (2009). *Do you have compassion fatigue?*. http://www.oprah.com/spirit/ Recognizing-Compassion-Fatigue-When-Caregivers-Need-Care
- Joiner, T.E., Jr, Van Orden, K.A., Witte, T.K., Rudd, M.D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients*. Washington, DC, USA: American Psychological Association. [http://dx.doi.org/10.1037/11869-000]
- Jobs, D.A., Rudd, M.D., Overholser, J.C., Joiner, T.E., Jr (2008). Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice. *Prof. Psychol. Res. Pr.*, 39(4), 405-413. [http://dx.doi.org/10.1037/a0012896]
- Jobs, D.A. (2011). Summary, next steps, and conclusion. *Building a therapeutic alliance with the suicidal*

- patient., Washington, DC: American Psychological Association.379-393.  
[<http://dx.doi.org/10.1037/12303-020>]
- Jobes, D.A., Ballard, E. (2011). The therapist and the suicidal patient.*Building a therapeutic alliance with the suicidal patient.*, Washington, DC: American Psychological Association.51-61.  
[<http://dx.doi.org/10.1037/12303-003>]
- Kashdan, T.B., Uswatte, G., Julian, T. (2006). Gratitude and hedonic and eudaimonic well-being in Vietnam war veterans. *Behav. Res. Ther.*, 44(2), 177-199.  
[<http://dx.doi.org/10.1016/j.brat.2005.01.005>] [PMID: 16389060]
- Kearney, M., Weininger, R. (2011). Whole person self-care from the inside out.*Whole person care: A new paradigm for the 21<sup>st</sup> century.*, New York: Springer.109-125.  
[[http://dx.doi.org/10.1007/978-1-4419-9440-0\\_10](http://dx.doi.org/10.1007/978-1-4419-9440-0_10)]
- Khan, S. (2008). <http://www.heretohelp.bc.ca/visions/aboriginal-people-vol5/aboriginal-mental-health-the-statistical-reality>
- Klitzman, R. (2008). *When doctors become patients.*New York: Oxford University Press.
- Klott, J. (2012). *Suicide & psychological pain: Prevention that works.*USA: PESI Publishing & Media.
- Korenblum, M. (2015). Letter to the Editor: Doctor's suicides. *The Globe and Mail.*
- Kozy, M., Varcarolis, E.M. (2014). Depressive disorders.*Canadian psychiatric mental health nursing: A clinical approach.*, (First Canadian edition.) Toronto: Elsevier Sanders.231-259.
- Kuhl, D. (2003). *What dying people want: Practical wisdom for the end of life.*Canada: Anchor Canada.
- Kuosmanen, L., Makkonen, P., Lehtila, H., Salminen, H. (2015). Seclusion experienced by mental health professionals. *J. Psychiatr. Ment. Health Nurs.*, 22(5), 333-336.  
[<http://dx.doi.org/10.1111/jpm.12224>] [PMID: 26014830]
- Lambert, M.T., Simon, W. (2008). The therapeutic relationship.*Mindfulness and the therapeutic relationship.*, New York: The Guildford Press.19-33.
- Langille, J. (2014). Reducing stigma in health-care settings. *Can. Nurse*, 110(1), 34-36.  
[PMID: 24645385]
- Larson, E.B., Yao, X. (2005). Clinical empathy as emotional labor in the patient-physician relationship. *JAMA*, 293(9), 1100-1106.  
[<http://dx.doi.org/10.1001/jama.293.9.1100>] [PMID: 15741532]
- Leymann, H., Gustafsson, A. (2014). *Why nurses commit suicide: Mobbing in health care institutions.*New York: Edwin Mellen Press.
- Linehan, M.M., Goodstein, J.L., Nielsen, S.L., Chiles, J.A. (1983). Reasons for staying alive when you are thinking of killing yourself: the reasons for living inventory. *J. Consult. Clin. Psychol.*, 51(2), 276-286.  
[<http://dx.doi.org/10.1037/0022-006X.51.2.276>] [PMID: 6841772]
- Living Works Education. (2015). *SafeTALK: Suicide Awareness for everyone.* <https://www.livingworks.net/programs/safetalk/>
- Luoma, J.B., Martin, C.E., Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *Am. J. Psychiatry*, 159(6), 909-916.

[<http://dx.doi.org/10.1176/appi.ajp.159.6.909>] [PMID: 12042175]

Macran, S., Shapiro, D.A. (1998). The role of personal therapy for therapists: a review. *Br. J. Med. Psychol.*, 71(Pt 1), 13-25.

[<http://dx.doi.org/10.1111/j.2044-8341.1998.tb01364.x>] [PMID: 9561303]

Maltsberger, J.T., Buie, D. (1989). Common errors in the management of suicidal patients. *Suicide: Understanding and responding.*, Madison, Connecticut: International Universities Press.285-294.

Mandell, D.J. (2009). Symposium Report/ General comments and discussion: Social issues of suicide. *Leg. Med.*, 11, 5581-5583.

[<http://dx.doi.org/10.1016/j.legalmed.2009.01.115>]

Mathieu, F. (2012). *The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization.*New York: Routledge.

Maxwell, J.C. (2007). *The 21 irrefutable laws of leadership: Follow them and people will follow you. (10<sup>th</sup> Anniversary Edition).*Nashville: Thomas Nelson.

McCann, I.L., Perlman, L.A. (1990). Vicarious traumatization: A contextual model for understanding the effects of helpers. *J. Trauma. Stress*, 3, 134.

[<http://dx.doi.org/10.1007/BF00975140>]

Melton, B.B., Coverdale, J.H. (2009). What do we teach psychiatric residents about suicide? A national survey of chief residents. *Acad. Psychiatry*, 33(1), 47-50.

[<http://dx.doi.org/10.1176/appi.ap.33.1.47>] [PMID: 19349444]

Mental Health Commission of Canada (MHCC). (2012). *Changing directions, changing lives: The mental health strategy for Canada.*Calgary, Alberta: Author.

Mental Health Commission of Canada (MHCC). (2016). *Improving mental health outcomes for all Canadians: Reducing Stigma.* www.mentalhealthcommission.ca/English/focus-areas/stigma

Michel, M. (2011). General aspects of therapeutic alliance. *Building a therapeutic alliance with the suicidal patient.*, Washington, DC: American Psychological Association.13-28.

[<http://dx.doi.org/10.1037/12303-001>]

Michel, M. (2011). Introduction. *Building a therapeutic alliance with the suicidal patient.*, Washington, DC: American Psychological Association.3-10. a

[<http://dx.doi.org/10.1037/12303-000>]

Milne, C. (2001). Doctors and suicide: Physicians are twice as likely as the general populations to commit suicide. *Medical Post*, 37(6), 17.

Moore, S.L., Melrose, S. (2014). Suicide. *Varcarolis's Canadian psychiatric mental health nursing: A clinical approach.*, (First Canadian edition.) Toronto, Canada: Elsevier.509-525.

Motto, J.A., Bostrom, A.G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatr. Serv.*, 52(6), 828-833.

[<http://dx.doi.org/10.1176/appi.ps.52.6.828>] [PMID: 11376235]

Myers, M. (2000). Qualitative research and the generalizability question: Standing Firm with Proteus. *Qual. Rep.*, 4(1/2), 1-10.

Neenan, M., Dryden, W. (2002). *Coaching: A Cognitive-Behavioral approach.*New York: Brunner-

Routledge.

[<http://dx.doi.org/10.4324/9780203362853>]

Nelson, C., Johnston, M., Shrivastava, A. (2010). Improving risk assessment with suicidal patients: a preliminary evaluation of the clinical utility of the Scale for Impact of Suicidality--Management, Assessment and Planning of Care (SIS-MAP). *Crisis*, 31(5), 231-237.

[<http://dx.doi.org/10.1027/0227-5910/a000034>] [PMID: 21134842]

Noddings, N. (1984). *A feminine approach to ethics and moral education*. Berkeley, California: University of California Press.

Norko, M.A., Freeman, D., Phillips, J., Hunter, W., Lewis, R., Viswanathan, R. (2017). Can religion protect against suicide? *J. Nerv. Ment. Dis.*, 205(1), 9-14.

[<http://dx.doi.org/10.1097/NMD.0000000000000615>] [PMID: 27805983]

North Sydney Department of Health. (2004). Framework for suicide risk assessment and management (policy Guidelines). *North Sydney Department of Health*.

Oberle, K., Bouchal, S.R. (2009). *Ethics in Canadian nursing practice: Navigating the journey*. Toronto: Prentice Hall.

Orbach, I. (2011). Taking the inside view: Stories of pain. *Building a therapeutic alliance with the suicidal patient.*, Washington, DC: American Psychological Association. 111-128.

[<http://dx.doi.org/10.1037/12303-007>]

Pagnano, M., Greiner, P.A. (2009). Enhancing communication skills through simulations. *Simulation scenarios for nurse educators: Making it real.*, New York: Springer Publishing Company. 43-51.

Parents and Families, and Friends of Lesbians and Gays (PFLAG). (2015). Suicide and LGBT People: How to talk about it. <http://www.glaad.org/files/talking-about-suicide-and-lgbt-populations.pdf>

PatientPlus. (2016). *Suicide risk assessment and threats of suicide*. <http://patient.info/doctor/suicide-risk-assessment-and-threats-of-suicide>

Patterson, W. M., Dohn, H. H., Bird, J. (1983). Evaluation of suicidal patients: The SAD PERSONS scale. *Psychometrics*, 244(4), 343-349.

Paulson, B.L., Everal, R.D. (2003). Suicidal adolescents: Helpful aspects of psychotherapy. *Archive of Suicidal Research*, 7(4), 309-321.

[<http://dx.doi.org/10.1080/713848939>]

Perlman, C.M., Neufeld, E., Martin, L., Goy, M., Hirdes, J.P. (2011). *Suicide risk assessment inventory: A resource guide for Canadian health care organizations*. Canada: Ontario Hospital Association & Canadian Safety Institute.

Petr, H. (2015). <http://list25.com/25-countries-with-the-highest-suicide-rates-in-the-world/>

Philosophy. *Merriam-Webster Dictionary*. <https://www.merriam-webster.com/dictionary/philosophy>

Picard, A. (2015). Suicide shouldn't be an occupational hazard for doctors. *The Globe and Mail*.

Pollard, C.L., Ray, S.L., Haase, M. (2014). *Canadian psychiatric mental health nursing: A clinical approach*. (First Canadian Edition.), Canada: Elsevier Canada.

Pompili, M., Girardi, P., Ruberto, A., Kotzalidis, G.D., Tatarelli, R. (2005). Emergency staff reactions to

- suicidal and self-harming patients. *Eur. J. Emerg. Med.*, 12(4), 169-178.  
[<http://dx.doi.org/10.1097/00063110-200508000-00005>] [PMID: 16034262]
- Pompili, M. (2015). Our empathic brain and suicidal individuals. *Crisis*, 36(4), 227-230.  
[<http://dx.doi.org/10.1027/0227-5910/a000327>] [PMID: 26440618]
- Psychological autopsy*. [www.thefreedictionary.com/psychologicalautopsy](http://www.thefreedictionary.com/psychologicalautopsy)
- Schmitz, W.M., Jr, Allen, M.H., Feldman, B.N., Gutin, N.J., Jahn, D.R., Kleespies, P.M., Quinnett, P., Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training. *Suicide Life Threat. Behav.*, 42(3), 292-304.  
[<http://dx.doi.org/10.1111/j.1943-278X.2012.00090.x>] [PMID: 22494118]
- Rakatansky, H. (2016). [www.rimed.org](http://www.rimed.org)
- Riess, H. (2010). Empathy in medicine--a neurobiological perspective. *JAMA*, 304(14), 1604-1605.  
[<http://dx.doi.org/10.1001/jama.2010.1455>] [PMID: 20940387]
- Rockett, I.R. (2010). Counting suicides and making suicide count as a public health problem. *Crisis*, 31(5), 227-230.  
[<http://dx.doi.org/10.1027/0227-5910/a000071>] [PMID: 21134841]
- Rogers, C.R. (1959). Koch, S. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. *Psychology: A study of science (Vol. 3, Formulations of the person and the social context)*New-York: McGraw-Hill.
- Ross, C.A., Goldner, E.M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. *J. Psychiatr. Ment. Health Nurs.*, 16(6), 558-567.  
[<http://dx.doi.org/10.1111/j.1365-2850.2009.01399.x>] [PMID: 19594679]
- Rudd, M.D. (2006). *The assessment and management of suicidality*.Sorasota, Florida: Professional Resource Press.
- Rudd, M.D., Berman, A.L., Joiner, T.E., Jr, Nock, M.K., Silverman, M.M., Mandrusiak, M., Van Orden, K., Witte, T. (2006). Warning signs for suicide: theory, research, and clinical applications. *Suicide Life Threat. Behav.*, 36(3), 255-262.  
[<http://dx.doi.org/10.1521/suli.2006.36.3.255>] [PMID: 16805653]
- Ruth, B.J., Muroff, J., Giannino, M., Feldman, B.N., McLaughlin, D., Ross, A. (2009). Suicide prevention education in social work education: What do MSW deans, directors and faculty have to say? *meeting of the American Public Health Association*.Philadelphia, PA
- Safety Plan. (2013). *In The National Suicide Prevention Lifeline*. [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)
- Salzberg, S. (2004). *Lovingkindness: The revolutionary art of happiness*.Boston, Massachusetts: Shambhala Publications Inc..
- Schmidt, J.J. (2002). *Intentional helping: A philosophy for proficient caring relationships*.Columbus, Ohio: Merrill Prentice Hall.
- Schmitz, W.M., Jr, Allen, M.H., Feldman, B.N., Gutin, N.J., Jahn, D.R., Kleespies, P.M., Quinnett, P., Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: an American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training. *Suicide Life Threat. Behav.*, 42(3), 292-304.

[<http://dx.doi.org/10.1111/j.1943-278X.2012.00090.x>] [PMID: 22494118]

Schulze, B. (2007). Stigma and mental health professionals: a review of the evidence on an intricate relationship. *Int. Rev. Psychiatry*, 19(2), 137-155.  
[<http://dx.doi.org/10.1080/09540260701278929>] [PMID: 17464792]

Self-awareness. (2016). *In Change Management Coach*. [www.change-management-coach.com/self-awareness.html](http://www.change-management-coach.com/self-awareness.html)

Shafir, R.Z. (2008). Mindful listening for better outcomes. *Mindfulness and the therapeutic relationship*, New York: The Guildford Press. 219-230.

Shneidman, E.S. (1993). *Suicide as psychache*. UK: Oxford University Press.

Shneidman, E.S. (1998). *The suicidal mind*. UK: Oxford University Press.

Shneidman, E.S. (2004). *Autopsy of a suicidal mind*. UK: Oxford University Press.

Siegel, B. (2001). *How to live between office visits: A guide to life, love and health*. Toronto: Harper Collins Books.

Simon, R.I. (2002). Suicide risk assessment: what is the standard of care? *J. Am. Acad. Psychiatry Law*, 30(3), 340-344.  
[PMID: 12380411]

Skegg, K., Firth, H., Gray, A., Cox, B. (2010). Suicide by occupation: does access to means increase the risk? *Aust. N. Z. J. Psychiatry*, 44(5), 429-434.  
[<http://dx.doi.org/10.3109/00048670903487191>] [PMID: 20397784]

Slote, M. (2007). *The ethics of care and empathy*. New York: Routledge Taylor & Francis Group.

Stanley, B., Brown, G.K. (2016). *Safety Plan*. <http://www.suicidesafetyplan.com/>

Social Stressor. (2017). *In the Urban Dictionary*. <http://www.urbandictionary.com/define.php?term=social%20stressors>

Statistics Canada. (2011). *Ranking and number of deaths for the 10 leading causes, Canada 2000 and 2007*. <http://www5.statcan.gc.ca/cansim/a05?id=1020561&pattern=&stBYVal=3&paSer=&lang=eng>

Stephany, K. (2002). Preventing suicide by increasing understanding of the commonalities of suicide risk, learning from past miscalculations and instilling hope. *Life Notes*, 6(4), 6-7.

Stephany, K. (2006). *Honour yourself: Inspiring lessons to enrich your life*. Ontario: Volumes Publishing.

Stephany, K. (2007). Suicide intervention: The importance of care as a therapeutic imperative (unpublished doctoral dissertation). *Breyer State University, Alabama, USA*.

Stephany, K. (2012). *The ethic of care: A moral compass for Canadian nursing practice*. United Arab Emirates: Bentham Science Publishing.

Stephany, K. (2012). *Each day is a new creation: Guidelines on living a life of purpose*. Bloomington, Indiana: Balboa Press. a

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

Stigma. *Free Dictionary*. <http://medical-dictionary.thefreedictionary.com/stigma>

Suicide Awareness Voices of Education (SAVE). (2015). *Common Misconceptions*. <http://www.wayzata.k12.mn.us/cms/lib/MN01001540/Centricity/Domain/1467/Personal%20Counseling/Suicide/Common%20Misconceptions%20About%20Suicide.pdf>

SuicideLine. (2016). <https://www.suicideline.org.au/health-professionals/estimating-the-risk-of-suicide/>

Suicidology & Suicidologist. (2016). *In the Free Dictionary*. [www.thefreedictionary.com/suicidologist](http://www.thefreedictionary.com/suicidologist)

The National Suicide Prevention Lifeline. (2013). *The Safety Plan*. [http://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown\\_St StanleySafetyPlanTemplate.pdf](http://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_St StanleySafetyPlanTemplate.pdf)

Transgender. *The Dictionary.com*. <http://www.dictionary.com/browse/transgender>

Trister, T., Holden, R.R. (2010). Comparing psychache, depression, and hopelessness in their associations with suicidality: A test for Shneidman's theory of suicide. *Pers. Individ. Dif.*, 49, 689-693. [<http://dx.doi.org/10.1016/j.paid.2010.06.006>]

United Kingdom's Royal College of Psychiatrists. (2010). Helping those who self-harm. *Lancet*, 376(9736), 141. [[http://dx.doi.org/10.1016/S0140-6736\(10\)61092-6](http://dx.doi.org/10.1016/S0140-6736(10)61092-6)] [PMID: 20638550]

Valach, L., Young, R.A., Lynam, J. (2002). *Action theory: A primer for applied research in the social sciences*. Westport, CT: Praeger.

Vijayakumar, L. (2003). *Suicide prevention: Meeting the challenge together*. India: Novena Offset Print Company.

Vogel, L. (2016). Physician suicide still shrouded in secrecy. *Canadian Medical Association Journal (CMAJ)*, 188(17-18), 1213.

Walker, V. (2010). *The art of comforting: What to say and do for people in distress*. New York: Penguin Group Inc..

Walsh, R.A. (2008). Mindfulness & empathy: A hermeneutic circle. *Mindfulness and the therapeutic relationship*. New York: The Guildford Press. 72-86.

*Warning signs of suicide*. [www.merriam-webster.com/dictionary/suicide](http://www.merriam-webster.com/dictionary/suicide)

Watson, J. (2008). *Nursing: The philosophy and science of caring*. (Revised Edition.), USA: University Press of Colorado.

Wegela, K. (2011). *What really helps: Using mindfulness & compassionate presence to help, support, and encourage others*. London: Shambhala.

Wezel, A., Brown, G.K., Beck, A.T. (2000). *Cognitive therapy for suicidal patients: Scientific and clinical applications*. Washington, DC: American Psychological Association.

Williams, J., Stickley, T. (2010). Empathy and nurse education. *Nurse Educ. Today*, 30(8), 752-755. [<http://dx.doi.org/10.1016/j.nedt.2010.01.018>] [PMID: 20381220]

Wingate, L.R., Joiner, T.E., Jr, Walker, R.L., Rudd, M.D., Jobes, D.A. (2004). Empirically informed approaches to topics in suicide risk assessment. *Behav. Sci. Law*, 22(5), 651-

665. www.interscience.wiley.com

[<http://dx.doi.org/10.1002/bsl.612>] [PMID: 15378593]

Wood, A., Joseph, S., Linley, A. (2007). Gratitude – parent of all virtues. *Psychologist*, 20(1), 18-21.

World Health Organization (WHO). (2004). *Media centre: Suicide huge but preventable public health problem*. <http://www.who.int/mediacentre/news/releases/2004/pr61/en/>

World Health Organization (WHO). (2012). *Public health action for the prevention of suicide: A framework*. [http://www.who.int/mental\\_health/publications/prevention\\_suicide\\_2012/en/](http://www.who.int/mental_health/publications/prevention_suicide_2012/en/)

World Health Organization (WHO). (2014). *Preventing suicide: A global imperative*. [http://www.who.int/mental\\_health/prevention/suicide/suicideprevent/en/](http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/)

World Health Organization (WHO). (2015). *Mental health: Suicide stats*. [www.who.int/mental\\_health/prevention/suicide/suicideprevent/en](http://www.who.int/mental_health/prevention/suicide/suicideprevent/en)

World Health Organization (WHO). (2015). *WHO suicide fact sheet*. [https://www.cdc.gov/violenceprevention/pdf/suicide\\_factsheet-a.pdf](https://www.cdc.gov/violenceprevention/pdf/suicide_factsheet-a.pdf)

Worth, R.F. (2011). [http://www.nytimes.com/2011/01/23/weekinreview/23worth.html?\\_r=0](http://www.nytimes.com/2011/01/23/weekinreview/23worth.html?_r=0)

Wright, L.M., Leahey, M. (2005). *Nurses and families: A guide to family assessment and intervention*. (4th ed.), Philadelphia: F. A. Davis Company.

Wright, K. (2010). Employing spirituality and faith as a protective factor against suicide. *Ment. Health Nurs.*, 30(6), 14-15.

Wyman, P. A., Brown, C.H., Inman, J., Cross, W., Schmeelk-Core, K., Guo, J. (2008). Randomized trial of gatekeepers program for suicide prevention: One-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology*, 76(1), 104-115.

Zhang, J. (2016). From psychological strain to disconnectedness: A two-factor model of suicide. *Crisis*, 37(3), 169-175.

[<http://dx.doi.org/10.1027/0227-5910/a000420>] [PMID: 27427540]

## 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 20<sup>th</sup> 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.

Cutcliffe, J. R., & Stevenson, C. (2007). *Care of the suicidal person*. USA: Churchill Livingstone Elsevier.

De Leo, D., Cimitan, A., Dyregrov, K., Grad, O., & Andriessen, K. (Eds.), (2014). *Bereavement after traumatic death: Helping survivors*. UK: Hogrefe Publishing.

Gorski, T. T. (2010). *Straight talk about suicide: Finding a compelling reason to live*. USA: Herald House/Independence Press.

Hawton, K., & van Herringer, K. (Eds.), (2002). *The international handbook of suicide and attempted suicide*. UK: Wiley.

Henden, J. (2008). *Preventing suicide: The solution focused approach*. UK: Wiley.

Klott, J. (2012). *Suicide & psychological pain: Prevention that works*. USA: Publishing Media.

Kolf, J. C. (2002). *Standing in the shadows: Help and encouragement for suicide survivors*. USA: Baker Book House.

Michel, K., & Jobes, D. A. (Eds). *Building a therapeutic alliance with the suicidal patient*. Washington DC: American Psychological Association.

Perlman, C.M., Neufeld, E., Martin, L., Goy, M., & Hirdes, J. P. (2011). *Suicide risk assessment inventory: A resource guide for Canadian health care organizations*. Canada: Ontario Hospital Association & Canadian Safety Institute.

Michel, K., & Maillart, A. G. (2015). *ASSIP – Attempted suicide short intervention program*. UK: Hogrefe Publishing.

Shneidman, E. S. (2004). *Autopsy of a suicidal mind*. UK: Oxford University Press.

Slote, M. (2007). *The ethics of care and empathy*. New York: Routledge Taylor & Francis Group.

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](http://www.health.gov.bc.ca/mhd) or [www.carmha.ca](http://www.carmha.ca)

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

150 *How to Help the Suicidal Person to Choose Life*

*Kathleen Stephany*

*immigrants and Ethnic minorities*. UK: Hegrefe Publishing.

World Health Organization (WHO) (2012) *Public health for action for the prevention of suicide: A framework*. Geneva Switzerland: WHO Library Cataloguing-in-Publication Data.

## **APPENDIX C: Information & Resources for Suicide & Crisis Intervention**

### **International Association for Suicide Prevention (IASP)**

Email: [membership@iasp.info](mailto:membership@iasp.info)

[www.iasp.info](http://www.iasp.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/](http://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](http://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](http://www.YouthInBC.com) (noon – 1 AM)

Online Chat Service for Adults: [www.CrisisCentreChat.ca](http://www.CrisisCentreChat.ca) (noon – 1 AM)

**Centre for Suicide Prevention (CSP) (Alberta, Canada)**

Telephone: 1-(403) 245-3900

Email: [info@suicideinfo.ca](mailto:info@suicideinfo.ca)

[www.suicideinfo.ca](http://www.suicideinfo.ca)

**Reason to Live Manitoba, Canada**

Linked with Manitoba's Suicide Line

[www.reasontolive.ca](http://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](mailto:nssf-post(at)medisin.uio.no)

[www.med.uio.no/ipsy/ssff](http://www.med.uio.no/ipsy/ssff)

**Suicide Prevention Resource Center (SPRC) Washington, DC & Waltham, MA, USA**

Telephone: 877-438-7772

Email: [info@sprc.org](mailto:info@sprc.org)

[www.sprc.org](http://www.sprc.org)

**American Association of Suicidology (AAS) Washington, DC, USA**

Telephone: +1 (202) 237-2280

Email: [info@suicidology.org](mailto:info@suicidology.org)

[www.suicidology.org](http://www.suicidology.org)

**Irish Association of Suicidology (IAS) Dublin, Ireland**

Telephone: +01 667 4900

Email: [infor@ias.ie](mailto:infor@ias.ie)

[www.ias.ie](http://www.ias.ie)

**Suicide Prevention Australia (SPA) Sydney, NSW**

Telephone: +61 2 9223 3333

Email: [infor@suicidepreventionaust.org](mailto:infor@suicidepreventionaust.org)

[www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)

**Suicide Prevention Information New Zealand (SPINZ)**

Telephone: (09) 623 4813

Email: [info@spinz.org.nz](mailto:info@spinz.org.nz)

[www.spinz.org.nz](http://www.spinz.org.nz)

## **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).

**SUBJECT INDEX****A**

Aboriginal healing foundation 14  
 Addictions 54, 60, 61, 62, 63, 65, 74, 128  
 Addressing suicide 84  
 Address suicidality 16  
 Adolescents 7, 8, 9, 13  
 Aeschi working group 76, 77, 78, 83, 85, 86  
   of suicidologists 76, 85  
   guidelines for clinicians 85, 86  
 Affective disorders 60, 63  
 Alcoholics anonymous (AA) 70  
 Analysis of howard's suicide note 72  
 Angry outbursts 119, 130  
 Anxiety disorders 60, 63  
 Approaches 27, 79, 88, 94, 112, 113, 120, 121  
   empathetic 79  
   therapeutic 84, 85  
 Assumptions 15, 41, 42, 72, 75, 89  
   preconceived 32, 33, 41, 57  
 Australia suicide rates for indigenous 14

**B**

Behavior disorders 60  
 Beliefs 4, 9, 29, 31, 35, 36, 40, 48, 56, 99, 100, 125  
   patient's 29, 31  
   religious 48  
   suicide core 100  
 Borderline personality disorder 32, 39  
   portrays 39  
 Burn out 112

**C**

Canada statistics on actual physician suicides 115  
 Canadian association for suicide prevention 13  
 Care 19, 20, 21, 27, 29, 31, 76, 80, 82, 83, 84, 86, 88, 90, 91  
   & empathy 76, 82, 83, 86, 88, 90, 91  
   giver 20, 21, 27, 29, 31, 83  
   giver dehumanizes patients 80

  role 21  
   theorist 21  
 Care provider 19, 21, 84  
   gatekeepers 19  
   practice 21  
 Career 72, 86  
   issues 86  
   success 72  
 Caring 77, 78, 91, 112, 113, 114, 130  
   ethical 91  
   person 77, 78  
   professions 112, 113, 114, 130  
 Cause of death 2, 5, 10, 13, 30, 95  
 Clinician distances 29, 31  
 Cognitive 76, 98, 99  
   behavioral therapy 98  
   re-structuring 76, 99  
 Cognitive therapy (CT) 76, 77, 78, 97, 98, 99, 100, 111, 129  
 Cognitive therapy in relation 98  
 Cognizant 33, 46, 58, 61, 113, 123  
 Collateral information 51  
 Committing suicide 16, 31, 41, 52, 57, 58, 96  
 Compassion 20, 32, 36, 55, 57, 76, 77, 78, 91, 92, 111, 123, 124  
   act of 76, 77, 78, 92, 111  
 Compassion and understanding 20  
 Compassion fatigue 112, 113, 119, 120, 123, 124, 125, 130, 131  
   developing 112, 113, 119, 125, 130  
   symptoms of 119, 120  
 Component, essential 129  
 Connection 22, 60, 61, 62, 68, 73, 75, 76, 77, 78, 82, 83, 88, 110, 111  
   establishing 76, 78, 82, 111  
   significant 60, 61, 62, 73  
 Conscious choices 87  
 Constriction 60, 61, 66, 68, 72, 74, 93, 96, 111  
   narrow 76, 93, 96, 111  
   of thought 60, 61, 66, 68, 72, 74, 93, 96  
 Contact, eye 46, 102, 103, 106  
 Contributing factors 10, 11, 12, 13, 112, 113, 114, 115, 117, 130  
   to physician suicide 112, 115, 130

Contribution, human 6  
Convey empathy 101, 109  
Coping cards 77, 99, 100  
Coping strategies 40, 52, 58, 101, 112, 131  
  healthy 120  
Crisis 20, 51, 52, 53, 67, 68, 74, 77, 78, 85, 86,  
  97, 100, 101, 111, 119, 127, 129, 131  
  emotional 20, 85, 86, 119  
  initial 78, 98, 111, 129, 131  
  suicidal person's 129, 131  
Critical incident debriefing (CID) 112, 122,  
  131  
CT clinicians 100  
Cultural 9, 67, 74  
  issues & suicide 9  
  values 67, 74  
Current suicidal thoughts 49

**D**

Death, physician 115  
Decedent 71, 75  
Depth interview 51  
Diagnostic procedures 43, 44, 58  
Direction of learning 123, 124  
Disability pension 94  
  personnel 94  
Disease processes 2, 3, 30  
Disorders of personality and behavior 63

**E**

Early diagnosis and treatment 60, 61, 62, 63,  
  116, 130  
  of mental illness 62, 116  
Economic consequences 6  
Educating members 41  
Emergency, initial suicidal 1, 2, 24, 31, 32, 76,  
  77, 78, 94, 97, 111  
  room 1, 2, 24, 31, 32, 76, 77, 78, 94, 111  
Emotional 7, 119, 130  
  abuse 7  
  withdrawal 119, 130  
Empathetic 80, 100, 103, 109  
  practitioners 109  
  responses 80, 100, 103, 109  
  identified 80

Empathic 76, 80, 110, 119, 130  
  action 80, 110  
  engagement 119, 130  
  responses 76  
Empathy 77, 80, 111  
  exquisite 77, 80, 111  
  making 109  
  practice 78  
Empathy acts 68, 69  
Empathy Skills 110  
Empathy strategies 102  
Empathy value 82  
Establish rapport by conveying empathy 45,  
  46, 58  
Etherington 24  
Ethical challenges 4  
Ethical dilemmas 2, 29, 31  
Ethical issues 1, 2, 29  
Ethical principles 29  
Ethical violation 2  
Ethnicity 2, 9  
Expectations 110, 118, 122, 131  
  unreasonable 112, 115, 130  
Experience 7, 8, 9, 14, 22, 23, 27, 29, 31, 32,  
  34, 35, 37, 40, 42, 54, 55, 57, 66, 67, 72,  
  76, 79, 80, 82, 84, 85, 86, 89, 91, 92,  
  100, 102, 106, 109, 110, 120, 121, 122,  
  123, 127, 131  
  human 122, 131  
  negative 27, 37, 40  
Experience hopelessness 42  
Experience of psychache 71  
Experience vulnerabilities 77, 78  
Expert's diagnoses 85

**F**

Factors 2, 3, 7, 9, 12, 30, 47, 48, 62, 66, 112,  
  113, 117  
  causal 112, 113  
  individual 47, 48  
  social 2, 3, 30  
Family history of suicide 48  
Feeling hopeless 8, 119, 130  
Feeling suicidal 18  
Free dictionary 3, 4, 24, 34  
Fully present person 90

**G**

General population 14, 55, 112, 114, 130  
 Gestures 32, 39, 40  
   parasuicidal 32, 39  
 Goal, person's 67, 74  
 Good listeners 89  
 Group 6, 9, 13, 15, 34, 54, 57, 85, 89, 108  
   formal religious 15  
 Growth, personal 123

**H**

Health 7, 8, 15, 18, 20, 25, 30, 41, 64, 69, 81,  
   95, 103, 106, 112, 124, 125, 126, 131  
   emotional 112, 124, 125, 131  
 Health care 11, 12, 29, 31, 40, 48, 64, 65  
   accessing 48  
   advanced 12  
   poor 11  
   primary 65  
 Health-care 35  
   professionals 35  
   front-line 35  
 Health care 53, 64  
   services 64  
   system 53  
 Health outcomes, better 37, 57  
 Health professional(s) (HP) 15, 16, 17, 18, 24,  
   25, 30, 32, 33, 35, 36, 37, 38, 43, 45, 53,  
   55, 57, 63, 69, 70, 85, 88, 94, 95, 96,  
   103, 104, 105, 106, 107, 108, 114, 120,  
   123, 125  
   in suicide risk 16  
   stigmatize 57  
 Helpful 17, 21, 22, 36, 37, 45, 55, 56, 97, 113,  
   119, 124, 127, 130  
   persons 113  
   gatekeeper 97  
   professional chances 127  
   professionals 17, 36, 45, 55, 124  
   professionals disconnecting 119, 130  
   professions 21, 22, 37, 55, 56  
   work environment 127  
 Heterosexuals 14  
 Highest suicide rates 2, 3, 9, 10, 12, 13, 30  
 High risk 41, 52, 58, 95, 96  
   of committing suicide 41, 52, 58

  of suicide 95, 96  
 High suicide numbers 2, 3  
 Hospital 40, 63  
   admissions 63  
   care, poor 40  
 Hospitalizations 62, 63  
 Howard's 72  
   experience of psychache 72  
   suicide note 72

**I**

Illnesses, chronic 8, 48  
 Information and resource centres for suicide  
   help 43  
 Initial suicide crisis 97  
 International association for suicide prevention  
   (IASP) 77, 85  
 Interpersonal and social circumstances 44  
 Interpersonal communication 82  
 Interpersonal relationships 39, 73  
   unstable 39  
 Intervention 15, 16, 17, 18, 24, 30, 43, 45, 48,  
   51, 85, 96, 97, 98  
   therapeutic 15, 16, 17, 96, 97  
 Intrusive thoughts 119, 130  
 Inuit suicide rates 14

**J**

Journaling 28, 76, 77, 78, 109, 111, 112, 123,  
 131

**K**

Key 1, 22, 26, 31, 32, 33, 38, 45, 52, 54, 58,  
 68, 72, 76, 85, 86, 93, 96, 108, 111  
   actors 108  
   components 22, 32, 33, 52, 79  
   goal 45, 85, 86  
   themes 1, 26, 31, 32, 38, 54, 58, 68, 72, 76,  
   93, 96, 111

**L**

Lesbian, gay, bisexual, transgender and queer  
 (LGBTQ) 14

Life experiences, adverse 2, 7, 30  
Lifespan 13, 30, 64, 65  
Limitations 33, 43, 58  
Listening stoppers 77, 88  
Lithuania 12  
Lived 24, 32, 33, 37, 38, 53, 60, 61, 70, 74  
    emotional experiences 24, 61  
    experiences 32, 33, 37, 38, 53, 60, 70, 74  
Living works education 42, 43  
Loss 6, 7, 8  
    of health 7, 8  
    of life 6  
    of occupation 7, 8  
    of primary relationship 7, 8  
    of years 6

**M**

Males committing suicide 9  
Medical  
    community 115, 116  
    model 85  
    problem 35  
    school 19, 53, 95, 115  
Medication errors 53  
Mental disorder 18, 19, 26, 37, 47, 57, 60, 62, 63, 74  
Mental health 16, 17, 18, 27, 34, 35, 37, 43, 45, 48, 51, 53, 55, 57, 61, 62, 63, 64, 65, 74  
    care providers 16  
    commission of Canada (MHCC) 27, 34, 35, 37, 61, 62, 63, 64  
    gatekeepers 64  
    professionals 17, 18, 53, 55, 63  
    services 18, 26, 51, 57, 64, 65, 74  
    stigma 55  
    worker 26, 39, 40, 57  
Mental illness 3, 4, 6, 10, 14, 15, 18, 27, 32, 33, 34, 35, 36, 37, 42, 54, 55, 57, 60, 61, 62, 63, 64, 73, 74, 83, 94, 112, 114, 115, 116, 117, 118, 119, 129, 130, 131  
    & addictions 62  
    & suicidal ideation 34  
    elicit 55

    judge 118  
Mental wellness 60, 61, 63, 64, 74  
    increased 61, 63, 64  
Mindful listening 77, 90  
Moral 1, 2, 29, 30, 31  
    agency 1, 2, 29, 31  
    beliefs, personal 29  
    disengagement 2, 29, 30, 31  
    dis-engagement 2  
    residue 2, 29, 30, 31  
Mozambique 12  
Multiple studies 127, 128

**N**

Narrative 2, 24, 26, 32, 33, 53, 54, 60, 71, 76, 77, 78, 92, 93, 111  
    action theoretical approach 60, 71  
    case study 2, 24, 26, 32, 33, 53, 54, 76, 77, 78, 92, 93, 111  
National 52, 60, 63, 74, 101  
    strategy 60, 63, 74  
    suicide prevention line 52, 101  
Necessary empathetic qualities 20  
Negative scripts 73  
Neonatal Intensive Care Unit (NICU) 112, 117  
Non-maleficence 2, 29  
Non-verbal communication skills 77, 102  
Nurse(s) 16, 17, 20, 25, 26, 27, 38, 41, 54, 55, 76, 80, 81, 95, 103, 110, 112, 113, 114, 117, 118, 120, 121, 122, 130  
    caring 117  
    stigmatizes 118  
    student 121, 122  
    suicides 112, 113, 114, 117, 118, 130  
Nursing students 87, 88, 120, 121, 128

**O**

Occupational hazard 112, 114, 130  
Offer empathy may help 18  
Offering empathetic responses 22  
Offering unconditional positive regard 76, 78, 82, 86, 87, 88, 111

**P**

Parvinder's suicide 39

- Personal 68, 120  
   hell 68  
   issues 120  
 Personality 60, 63, 127, 128  
   disorders 60, 63  
   trait 127, 128  
 Personal 32, 48, 54, 119, 121, 122, 130  
   plan 122  
   protective factors 48  
   relationships 119, 130  
   shame, degree of 32, 54  
   therapy 121  
   therapy for therapists 121  
 Person 7, 8, 20, 21, 22, 24, 38, 39, 41, 43, 47,  
   48, 51, 57, 58, 65, 72, 75, 87, 88, 89, 90,  
   91, 92, 97, 102, 108  
   denies 43, 58  
   playing 108  
   ability 7  
   actions 87  
   demeanor, young 92  
   family doctor 51  
   feelings 51, 89  
   inclination 65  
   levels 51, 102  
   life 39, 47  
   optimistic set 72, 75  
   problems 88  
   safety 51  
   space 22  
   story 24, 88, 91  
   strengths 90  
   suicidal 38, 57  
   suicidal ideation 20  
   suicidal risk 41  
   suicidal story 97  
   vulnerability 7, 8, 48, 92  
   wholeness 21  
   wanting 39  
 Perspective 79, 123, 124  
   fresh 123, 124  
   patient's 79  
 Peter's 68  
   experience 68  
   experience of psychache 68  
 Physical health 112  
 Physician(s) 16, 17, 76, 80, 84, 91, 95, 110,  
   111, 112, 113, 114, 115, 116, 130  
   population 130  
   suicide 112, 115, 116, 130  
 Post-traumatic stress disorder (PTSD) 112,  
   122  
 Preconceived assumption 32, 33, 41, 57  
 Presumed assumption 41, 42, 43  
 Preventative care 65  
 Prevention strategies 3, 62, 74  
 Primary 7, 8, 18, 64, 65, 74  
   care providers 18  
   health providers 64, 65, 74  
   relationship 7, 8  
 Professional gatekeepers 25, 41  
 Protective factors 2, 32, 45, 48, 51, 52, 58, 97  
 Psychache 60, 61, 65, 66, 67, 68, 69, 70, 71,  
   72, 74, 75, 76, 77, 93, 96, 111  
   experienced 68  
   lived experience of 67, 70  
   person's 66  
   person's experience of 60, 75  
 Psychiatrist 33, 53  
   experiences Stigma 33, 53  
   experience of stigma 33  
 Psychological 1, 2, 4, 24, 31, 60, 66, 68, 69,  
   71, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96,  
   111  
   autopsy 1, 2, 4, 24, 31, 60, 71, 76, 77, 78,  
   94, 95, 111  
   pain 60, 66, 68, 69, 74, 75, 79, 93, 96  
 Psychologists 65, 120, 121  
  
**Q**  
 Qualitative 1, 2, 4, 23, 24, 31  
   methodologies 1, 2, 4, 24, 31  
   methods 23, 24  
   research 1, 2, 23, 31  
   study 23, 24  
 Qualities, empathetic 20  
 Quantitative study 2  
  
**R**  
 Recommended suicide risk assessment  
   documentation topics 51

Recovery models 2, 27  
Religion & suicide 14  
Resiliency, fostering 60, 61, 72  
Resources, medical 35, 40  
Risk 1, 3, 9, 24, 40, 41, 42, 44, 45, 46, 47, 48, 49, 51, 52, 60, 62, 64, 74, 81, 95, 96, 97, 112, 113, 114, 115, 117, 119, 130  
  person's 49  
  real 112, 113, 130  
Risk assessment 19, 30, 44, 46  
  comprehensive 46  
  frameworks 44  
Risk factors 32, 40, 45, 47, 58, 63, 115  
  strongest 40  
Role play 76, 77, 100, 103, 106, 111

**S**

Safety Plan 32, 33, 40, 52, 54, 58, 77, 95, 96, 97, 100, 101, 106, 108, 111  
Sample of recommended suicide risk assessment documentation topics 51  
Sarah 38, 39, 41  
Sarcasm 84  
Schizophrenia 60, 63  
Seclusion 4, 26, 27  
Secure room 1, 2, 24, 25, 26, 27, 31  
Security guard 25, 26  
Self-awareness 32, 33, 56, 59, 76, 77, 78, 109, 111, 112, 123, 125, 131  
Self-blame 123  
Self-care 112, 113, 122, 124, 125, 126, 127  
  plan 125, 126, 127  
Self-compassion 2, 28, 112, 113, 120, 122, 123, 131  
  fostering 112, 113, 120, 131  
Self-forgiveness frees 123, 124  
Self-harm 20, 24, 27, 29, 32, 33, 39, 40, 51, 52, 57, 62, 63, 86, 101, 107  
  action of 39, 40  
  previous episode of 40  
Separation, early 7  
Services 34, 64, 65, 74  
  accessing suicide prevention 34  
  right combination of 64, 65, 74  
Sexual abuse 7  
Shneidman's work 65

Shortfall, global 60, 61, 64  
Simulation exercises 22, 76, 78, 100, 111  
  dynamic 76, 78, 111  
Skills 16, 17, 19, 76, 77, 89, 100, 102, 109, 111  
  important 100  
  teach empathy 19  
  verbal communication 77, 102, 111  
  verbal empathetic communication 77  
  verbal empathic communication 76  
Sleep, disturbed 119, 130  
Social networking 15  
Social stressors 1, 2, 3, 6, 7, 30  
Social stressors & adverse life experiences 7  
Social stressors & suicide 7  
Social support 15, 47  
Social worker 16, 94, 95, 103  
Stigma 16, 32, 33, 34, 35, 36, 37, 38, 41, 48, 54, 55, 56, 57, 59, 112, 115, 116, 118, 130  
  distressing 32  
  experienced 33, 54  
  hurts 37, 57  
  prevents nurses 118  
Stigmatization 32, 34  
Stopped playing 127  
Strain(s) 60, 61, 67, 68, 74  
  psychological 67, 74  
  theory of suicide 60, 61, 67, 68, 74  
Stranger, total 76, 78, 92, 94  
Strategies 85, 100  
  empathetic 100  
  helpful 85  
Street 94, 95  
Stress 7, 8, 11, 13, 28, 29, 47, 48, 53, 64, 67, 72, 91, 112, 114, 116, 117, 120, 121, 123, 124, 125, 128, 130  
  considerable 116  
Stressors 44, 60, 67, 72, 74, 75, 115  
  life's 72, 75  
Substance 62, 63, 112, 114  
  misuse 112, 114  
  -related disorders 60, 63  
  use disorders 62, 63  
Suicidal 4, 6, 19, 24, 27, 32, 33, 35, 36, 41, 42, 43, 45, 49, 50, 52, 58, 62, 65, 74, 76, 79, 81, 82, 83, 85, 86, 91, 96, 97, 99, 101, 105, 110, 111

- act 6, 85, 86, 111
  - plan 32, 45, 49, 50, 58, 95, 105
  - state 83
  - tendencies 27, 33, 81, 96, 99
  - thoughts 4, 19, 32, 35, 36, 41, 42, 43, 45, 49, 52, 58, 62, 65, 74, 76, 79, 81, 82, 83, 91, 97, 101, 110, 111
  - experienced 24
  - youth 76, 111
  - Suicidal behavior 3, 39, 46, 48, 50, 51, 58
    - distinguishing 39
    - prior history of 46, 50, 58
  - Suicidal crisis 76, 77, 86, 99, 100
    - initial 76
  - Suicidal ideation 17, 20, 22, 32, 33, 34, 37, 42, 50, 52, 53, 58, 62, 65, 69, 87, 109
  - Suicidality 9, 46, 66, 85
    - increased 7, 8, 86
    - patient's 86
  - Suicidal patient 97, 99, 119
    - shares 119
    - journey 99
    - story 97
  - Suicidal person 4, 22, 23, 31, 66, 68, 84, 85, 88, 121, 129, 131
    - & compassion fatigue 118
    - move past 68
    - experience 4, 22, 23, 31
    - life 66
    - story 85, 88, 121, 129, 131
    - trusts 84
  - Suicide 2, 3, 6, 9, 13, 14, 15, 16, 18, 32, 33, 39, 43, 44, 86, 39, 40, 41, 44, 47, 50, 57, 58, 63, 96, 112, 114, 117
  - Suicide deaths 5, 10, 118
    - recorded 5
  - Suicide experience depression 62
  - Suicide help 43
  - Suicide ideation 66
  - Suicide intent 51
  - Suicide intervention 78
  - Suicide mindset 62
  - Suicide motivation 66
  - Suicide note 38, 60, 61, 71, 72, 75
    - actual 61, 75
  - Suicide plan 45
  - Suicide preparation 66
  - Suicide prevention 1, 2, 3, 4, 6, 13, 15, 16, 17, 21, 22, 23, 24, 30, 31, 33, 34, 35, 36, 41, 57, 60, 61, 63, 64, 65, 74, 85
    - key components of 64, 65, 74
    - teach 15, 17
    - teaching 16, 30
  - Suicide rates 5, 9, 10, 11, 12, 13, 14, 30
    - high 9, 10, 12, 13
  - Suicide rates for children 13
  - Suicide risk 15, 16, 17, 18, 20, 24, 32, 33, 40, 43, 44, 45, 46, 47, 48, 50, 52, 58, 60, 61, 76, 95, 96, 97, 99, 111
    - degree of 43, 58, 60, 61
    - increased awareness of 17
    - mitigate 99
    - reducing 52, 58
    - & Therapeutic Intervention 16
    - assessment 16, 17, 18, 32, 33, 43, 45, 46, 47, 58, 76, 95, 96, 97, 111
    - assessment process 52
    - assessment tools 32, 33, 43, 44, 47, 58
    - documentation 50
  - Suicide training 16
  - Suicidologist & member 83
  - Suicidologists 2, 3, 76, 77, 78, 85, 129, 131
  - Suicidology 2, 3
- T**
- Teaching 16, 18, 19, 30, 31
    - empathy 19
    - gatekeepers 16, 18, 19, 30, 31
  - Theoretical premise 1, 2, 4, 21, 31
  - Therapeutic 1, 3, 16, 19, 20, 76, 77, 78, 80, 83, 84, 85, 86, 88, 97, 100, 111, 129, 131
    - alliance 76, 77, 78, 83, 84, 85, 88, 100, 111
    - alliance of trust 129, 131
    - rapport, establishing 19, 20, 97
    - relationship 1, 3, 16, 19, 20, 84, 86, 97
    - strategy 20, 80, 111
  - Thought patterns, constricted 60, 68, 69, 75
  - Time 1, 9, 11, 12, 13, 14, 15, 26, 27, 31, 38, 47, 54, 60, 62, 69, 74, 77, 78, 85, 86, 88, 89, 90, 91, 92, 97, 99, 100, 105, 108, 110, 111, 113, 117, 119, 120, 122, 123, 124, 125, 126, 127, 128, 130
    - caring 124

*Subject Index*

coaching 100  
exposure 119, 130  
suicide rates 12  
Total reliance 50, 51  
Train 1, 3, 17, 18  
  gatekeepers 1, 3  
Training 2, 15, 16, 17, 18, 21, 22, 30, 54, 64,  
  76, 95, 96, 97, 111, 120  
  better 2, 18  
  gatekeepers 15, 21, 22  
  health care gatekeepers 97  
  of health professionals in suicide risk 16  
Transgender 2, 14  
Trauma 27, 48, 119, 120, 122, 131  
Tribulations 77, 78, 128  
Trust 19, 20, 21, 28, 46, 56, 70, 76, 77, 82, 84,  
  85, 100, 106, 111, 125, 129, 131  
  establishing 20, 84, 85  
  patient's 70

**U**

Unconditional positive regard 77, 86, 87, 104,  
  110

*How to Help the Suicidal Person to Choose Life 161*

Understanding 21, 22, 23, 71, 81  
  empathetic 71, 81  
  increased 21, 22, 23  
Unemployment insurance (UI) 70

**V**

Verbal responses, helpful 77  
Vicarious traumatization 112, 113, 119, 120,  
  130

**W**

Warning signs 32, 33, 44, 45, 51, 52, 58, 101  
  of suicide 32, 33, 44  
Work 112, 115, 117, 124, 126, 131  
  -life balance 112, 124, 126, 131  
  -loads, heavy 112, 115, 117  
Worthlessness 8, 27, 35, 40, 55, 72

“

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 (WNRCSN). 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.