Diego De Leo
Vita Poštuvan
(Editors)

Reducing the Toll of Suicide

Resources for Communities, Groups, and Individuals

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Reducing the Toll of Suicide

About the Editors

Diego De Leo, Doctor of Science and Emeritus Professor of Psychiatry, Griffith University, Australia, is the Head of the Slovene Centre for Suicide Research (UP IAM), a world-leading researcher in suicide research and prevention over several decades, he has designed and advised suicide prevention activities, projects, and programs around the world, including his contribution to the World Health Organization.

Vita Poštuvan, PhD, EuroPsy, Associate Professor of Psychology, is the Deputy Head of the Slovene Centre for Suicide Research (UP IAM). She is involved in research, public-health work and interventions related to suicidal behavior, bereavement, and mental health. She also works in crisis situations and provides therapy for people in distress. She is an active member of several international and national associations in the fields of suicidology and psychology and has worked professionally in Austria, Japan, China, and India.

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Contents

Foreword

The Slovene Centre for Suicide Research has been working with honour for a number of years now. The University of Primorska is particularly proud to have it among its institutions. Over the last few years, many activities and projects have been undertaken by the Centre which have benefited community members, students, and scholars around the world.

This volume results from one of the traditional initiatives of the Centre: the TRIPLE i conferences on intuition, imagination, and innovation in suicidology. Each year, under the wise guidance of Prof. Diego De Leo and Dr. Vita Postuvan, a number of master classes are run by world leaders from the field of suicide research and prevention in the beautiful city of Piran. This volume collects some of the most significant lectures and is essential reading for all those who have made suicide prevention a mission in their lives.

This book is the second volume of its kind, and the University hopes further volumes will continue to be published, not only as a tradition but also as a true enrichment for the community of suicide research scholars and practitioners.

Prof. Dragan Marusic
Past Rector Magnificus
The University of Primorska

Prof. Klavdija Kutnar
Rector Magnificus
The University of Primorska

Preface

Through the lenses of different disciplines and perspectives, understanding suicide has preoccupied humans throughout history. It is a highly value-laden topic that not only relates to the questions of life and death but also of freedom, choices, ethics, and religion, and it captures all the essential explorations of existence.

Today, science can explain several factors contributing to the development of suicidal behaviour, which usually consists of a combination of factors at the social, community, group, and individual levels. However, how these factors are intertwined in the personal story of an individual still constitutes a big challenge for the scientific community.

This book represents an attempt to shed light on the many complexities of suicidality. Distinguished authors from various disciplines have contributed to this volume by offering their expert perspectives on the subject. Thus, the chapters are packed with the latest knowledge and reflections from the field, and we hope that this content may help to increase the probability that more lives can be saved, helping to reduce the unbearable toll of suicide. This is a central mission of the Slovene Centre for Suicide Research (Andrej Marusic Institute, University of Primorska), which holds the TRIPLE i in Suicidology conferences, as it is for other similar institutions around the world. Fighting suicide is a very difficult task; besides knowledge, a determined stance is required at every level of society to enter the battlefield and to not passively surrender to the supposed inevitability of suicidal behaviour. We hope that this collection of master class lectures might also help improve this determination.

Diego De Leo and *Vita Poštuvan*

Slovene Centre for Suicide Research
Andrej Marušič Institute
University of Primorska, Slovenia

Acknowledgments

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Chapter 1

Assessing Suicide Risk in Older Adults

Diego De Leo

Slovene Centre for Suicide Research, Andrej Marušič Institute, University of Primorska, Koper, Slovenia

Australian Institute for Suicide Research and Prevention, Griffith University, M. Gravatt, QLD, Australia

De Leo Fund, Italy

Introduction

Although suicide late in life is not among the first causes of death, as it is for young people, it is sadly a common occurrence. Knowing how to assess the risk of suicide in an older adult can be a particularly challenging task for many health professionals. Recently, the latter have faced a growing level of external control over the validity of the diagnoses attributed to their patients and the effectiveness of the treatment strategies implemented.

The threat of litigation has greatly influenced the way clinicians cope with patient interactions. As a result, being able to manage the countless issues related to the assessment and management of people who present with a potential risk of suicide is one of the fundamental skills that clinicians need to develop and preserve throughout their professional life.

Epidemiological Considerations

The World Health Organization (WHO) *Global Health Estimates* provide a comprehensive assessment of mortality due to diseases and injuries in all regions of the

world. In 2015, it is estimated that 788,000 people died because of suicide; a much larger number of individuals attempted suicide without a fatal outcome (WHO, 2017).

In the same year, suicide accounted for about 1.5% of all deaths worldwide, making it one of the top 20 leading causes of death (WHO, 2017). Despite the decline in suicide in many countries over the past three decades (Bertolote & De Leo, 2012), suicide rates among individuals aged 65 and over are still the highest for both men and women in almost all regions of the world, as indicated by the WHO report *Preventing Suicide: A Global Imperative* (WHO, 2014). Furthermore, with the increase in life expectancy and the decrease in mortality due to causes of death other than suicide, it is expected that the absolute number of suicides among older adults could further increase.

Using data from 17 countries, Shah and colleagues (2014) identified that suicide rates continue to grow in very advanced ages (i.e. even in centenarians), with a curve of the steepest trend-line much more pronounced in men than in women. However, older adults seem to have benefited more than other age groups from the improvements in overall health care and quality of life that have been observed in many countries in recent years (WHO, 2014), as evidenced by the fact that suicide rates in older people have decreased more than in young people (Bertolote & De Leo, 2012; WHO, 2014).

Compared with suicide, non-fatal suicidal behaviours (suicide attempts) decrease proportionally with increasing age (De Leo & Scocco, 2000). This was clearly demonstrated by the results of the WHO/EURO Multi-Centre Study on Suicidal Behaviour (a very large cooperative effort), which found that only 9% of 22,665 episodes of *parasuicides* (episodes recorded in hospitals) were carried out by older people (65+ years) compared with 50% of episodes involving individuals in the 15–34 age group (De Leo et al., 2001). Compared with younger individuals (in particular adolescents and young adults), where the number of non-fatal behaviours is extremely high, the ratio between fatal and non-fatal suicidal behaviour can be very small among older adults, ranging from 1:2 to 1:4 (McIntosh et al., 1994); among young people, if we consider episodes of non-suicidal self-harm, it can reach a ratio of 1:5,000 (Shaffer & Jacobson, 2009). While non-fatal behaviour is particularly common in women of younger age, the prevalence tends to be the same in old age (Shah et al., 1998). The *gender paradox* in suicide rates (the difference in behaviour between the sexes, with rates in men much higher than those of their female counterparts) is often explained by the better help-seeking behaviour of women and the use of more violent methods by men (such as use of firearms or hanging; Karch, 2011; Kolves, Potts, & De Leo, 2015; Schriivers, Bollen, & Sabbe, 2012).

Contrary to common belief, the approach to the natural end of life is not accompanied by an increased frequency of suicidal ideation or death wishes: Both types of thoughts are more common in adolescents and young adults, as demonstrated by a community survey conducted in Australia in the context of the WHO/SUPRE-MISS Study (De Leo, Cerin, Spathonis, & Burgis, 2005).

Chapter 2
Psychotherapy With Suicidal Patients

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Introduction

Treatment of patients with suicidal behaviour is challenging. Some principles of treatment are:

1. Assess suicide risk – repeatedly;
2. Initiate measures to get control – (a) admission to inpatient treatment, (b) immediate outpatient follow-up, (c) support from family and others;
3. Evaluate problems and assess psychiatric, somatic, social problems and precipitating factors;
4. Address main points of intervention;
5. Intervene accordingly; and
6. Follow-up until the main problems are solved.

Various cognitive behavioural methods have been promising. Most of the interventions have been short-term. Many patients, however, have problems with their self-esteem, shame, guilt and relationship with others that call for long-term treatment with the use of psychodynamic approaches. In general, patients with suicidal behaviour have experienced many years of adverse experiences during their upbringing, which may adversely influence their understanding of themselves and others.

Two patient stories are presented. One illustrates how assessment of family dynamics during hospital stay after a suicide attempt may influence the intervention, and may get the family closer and avoid compulsory admission to a psychiatric ward. The other illustrates that the patient's understanding of herself and the

Chapter 3

Long-Term Perspectives on Suicide Risk of Youth

Lessons and Illustrations From Longitudinal Studies

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Oregon Social Learning Center, Eugene, OR, USA

Introduction

In the United States and many other countries, suicide is a leading cause of death among young people. Too many other adolescents and young adults also fall to homicides and accidents, the other leading causes of death in this age group. There are several important themes that are common to these premature deaths.

First, all three causes are much more common among males; specifically, in the United States in 2016 approximately four times as many males as females died by suicide and homicide, and males also are much more likely to die by unintentional injury (National Center for Health Statistics, 2018). Thus, additional attention to risk factors and processes for young males is needed.

Second, similar psychological states, traits and pathologies can increase risk for these different kinds of deaths. Such characteristics may play long-term roles in leading up to the events that result in death – for example, the behaviours and lifestyles of highly impulsive sensation-seeking individuals may put them at elevated risk for physically, psychologically or interpersonally dangerous experiences (e.g. arrest, violence, injury, relationship loss). Some of these characteristics also play critical proximal roles during the final moments of a crisis. For example, substance abuse contributes to impulsivity and poor judgement that can escalate or facilitate self- or other-directed violence, and substance intoxication is to blame for many

Chapter 4

The Continuing Problem of Suicide in Prisons

Key Issues for Prevention and Further Research

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Introduction

Suicides in prison are a major public health problem. Although data on the health and mortality of prisoners in low- and middle-income countries are sparse, research in high-income countries has repeatedly shown suicide to be the first or second leading cause of death in custodial settings, including in England and Wales (Fazel & Benning, 2009; Fazel, Benning, & Danesh, 2005), Finland (Joukamaa, 1998), Germany (Opitz-Welke, Bennefeld-Kersten, Konrad, & Welke, 2013), Italy (Cinosi, Martinotti, De Risio, & Di Giannantonio, 2013), the United States (Stoliker, 2018) and Belgium (Favril, Wittouck, Audenaert, & Vander Laenen, 2018). For example, suicide accounted for more than 35% of all deaths in European prisons between 1997 and 2008, with high fluctuations between countries, and only Malta and Cyprus registered no inmate suicides during this period (Rabe, 2012).

It is also well-established that rates of suicide in correctional settings are substantially higher than in the general population (World Health Organization [WHO], 2007), even though certain aspects of prison life should make suicide more easily preventable than in the community (e.g. by allowing greater monitoring of those at risk, and limiting access to means of suicide). A recent study of 24 high-income

Chapter 5

Understanding Male Suicide

A Qualitative Perspective

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Introduction

Men represent the majority of those who die by suicide worldwide, with the cross-national aggregate age-standardized ratio of male-to-female suicide of 3.5:1. However, there is scant research examining men's experiences of mental health problems, how attitudes towards suicide and help-seeking affect their behaviour and what the signs of depression and suicidality are among them. In addition, within the male population, prisoners are an extremely vulnerable group, with a consistently higher prevalence of suicide when compared with the general population, due to specific and various factors that may increase the risk of suicide. The main goals of our research were, therefore, to examine the characteristics and risk signs of suicidal behaviour in men, how masculine roles and attitudes influence this behaviour among male suicide attempters and male prisoners and what the age-specific trends of suicidal behaviour are in this population.

Chapter 6

Predicting Suicidal Behaviour in Patients With Mood Disorders

The Role of Underlying Bipolarity

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Introduction

Suicidal behaviour is one of the most alarming signs in psychiatry and it is the hardest end-point and most visible treatment outcome in patients with psychiatric disorders. Suicidal behaviour is a very complex, multicausal phenomenon, involving several medical–biologic, psychosocial and cultural components. However, a history of untreated major mood disorders (particularly in the presence of a previous suicide attempt) is the most important risk factor. On the other hand, because the majority of patients with mood disorder do not end their lives (and around 50% of them never attempt it), other familial–genetic, personality, psychosocial and demographic risk factors should also play a significant contributory role (Hawton & van Heeringen, 2000; Pompili et al., 2009; Rihmer, 2007).

Psychological autopsy studies consistently show that around 90% of consecutive suicide dead have one or more Axis I (mostly untreated) major psychiatric disorders at the time of their death, with major mood disorders (59–87%) schizophrenia/

Chapter 7
Papageno Effect
Its Progress in Media Research

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Introduction

Over the past few decades, researchers from across the globe have compiled a significant corpus of research about the effects of media on suicidality (Pirkis & Blood, 2010). With the ongoing groundswell of support internationally for suicide awareness campaigns to tackle the stigma surrounding suicidality and to prevent suicide, the task to complement research on harmful media effects (i.e. suicide contagion) with research on potential benefits of media discourse on suicidality has become a priority on the suicide research agenda (Niederkrotenthaler, Reidenberg, Till, & Gould, 2014).

Of particular importance for research on protective media effects is the so-called Papageno effect, which denominates suicide-protective effects of media, in contrast to harmful Werther effects (Niederkrotenthaler et al., 2010; Phillips, 1974). A synthesis of these two sides of media effects research can considerably contribute towards deepening our understanding of media roles in suicide, and may help identify novel lines of interventions using media as a tool to raise awareness and prevent suicide. Because research on harmful media effects provides a rich and relevant basis for the analysis of potential protective media effects, findings on harmful impacts should always be taken into account when planning and evaluating potentials of protective media effects. Therefore, this chapter includes selected findings on a broad range of media effects as they relate to suicidality, including both harmful and protective media effects.

Chapter 8

Ethical Guidelines for Technology-Based Suicide Prevention Programmes

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Introduction

Suicide is a serious public health problem worldwide. In the European Union, the standardized suicide rate is 10.9 per 100,000 population (Eurostat, 2018). Recently, new technologies have become available for the prevention of suicide. Technology-based suicide prevention (TBSP) programmes offer many opportunities because of the minimization of the prohibitive role of time and distance, and because of the perceived anonymity, reducing psychological barriers to seek help. Thanks to their high accessibility and anonymity, TBSP programmes are apparently successful in reaching out to various populations including persons who feel suicidal. Many people may avoid conventional psychiatric or psychological services, and as such, TBSP programmes can provide much-needed professional interventions (Barak, 2007; Hom, Stanley, & Joiner, 2015; Recupero, Harms, & Noble, 2008).

However, in trying to prevent suicide using various new technologies, the *Internet paradox* must be taken into account (Durkee, Hadlaczky, Westerlund, & Carli, 2011; Kraut et al., 1998). The Internet may be very helpful in preventing suicide in different ways, but it may also have a negative effect and even provoke suicidal behaviour (Lester, 2008). Providers of TBSP programmes need to know which elements have to be considered when developing and offering a TBSP programme, and users need to know which TBSP programmes are trustworthy (Alao,

The Ethical Guidelines for TBSP Programmes for Different TBSP Programmes

TBSP programmes can be divided into three different forms: passive, active, and interactive. One TBSP programme can include elements of one or more forms.

Passive forms of TBSP programmes (e.g. statistical information, advice, and frequently asked questions [FAQs]) allow a user only to read or look at the contents of the programme. Passive forms of TBSP programmes do not request active involvement from the user, require little effort, and since no personal information is left behind, the security risk is low (Schalken, 2010).

Active forms of TBSP programmes, for example, self-tests, chatbots, and serious games, expect active involvement from the user, and therefore require more effort than passive forms. When personal information of the user is stored, the security risk is higher than in passive forms (Schalken, 2010).

Interactive forms of TBSP programmes, for example, forums, one-to-one chats, group chats, and online treatment, are characterized by interactions between users (and caregivers). Interactive forms have the highest threshold for users since they require substantial effort from the user, and security risks may be high (Schalken, 2010).

In summary, the more active the forms of a TBSP programme, the higher the threshold for using it (see Figure 8.1: The programme becomes more complex and the security risk increases. This also has an influence on which ethical guidelines

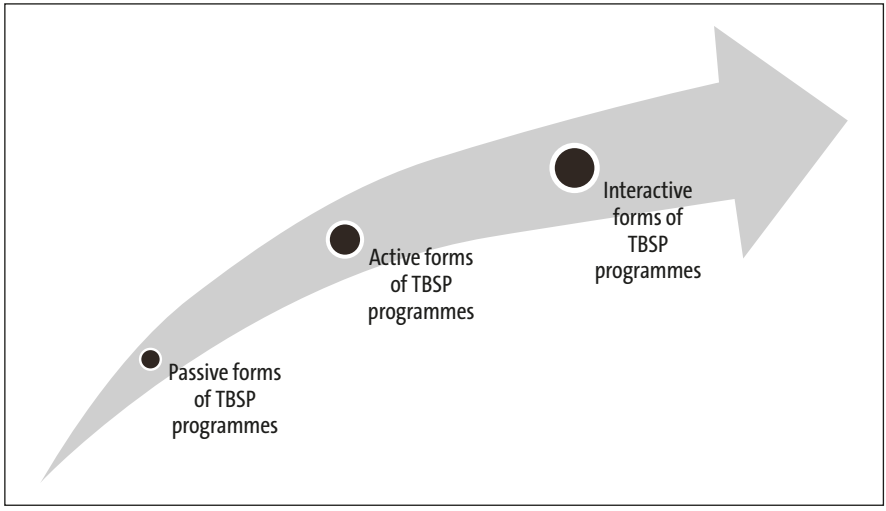

Figure 8.1. Different forms of technology-based suicide prevention (TBSP) programmes.

should be adhered to: The more active the forms of a TBSP programme, the more ethical guidelines the developer of a TBSP programme should take into account. Table 8.1 gives an overview of which ethical guidelines should be respected when developing a certain form of TBSP programme.

Table 8.1 Overview of Ethical Guidelines for TBSP Programmes According to the Different Forms of TBSP Programmes

Ethical Guidelines for TBSP Programmes	Passive	Active	Interactive
1. Crisis intervention		X	X
2. Transparency	X	X	X
3. Privacy & data protection	X	X	X
4. Accessibility	X	X	X
5. Accountability	X	X	X
6. Quality criteria	X	X	X
• Information on suicidal behaviour	X	X	X
• Links	X	X	X
• No propaganda	X	X	X
• Tailored TBSP programmes	X	X	X
• Evidence-based programmes		X	X
• Supervision by a moderator		X	X
• Suicide alert reporting system		X	X
• Qualified caregivers			X
7. Informed consent		X	X
8. Professionalism		X	X
9. Appropriateness		X	X

Note. TBSP = technology-based suicide prevention.

Chapter 9
Community Intervention

Collaborative Approaches to Suicide Prevention

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Introduction

A number of global initiatives have shown that a multifaceted approach to preventing suicide can result in greater awareness of, and commitment to, addressing the issues of suicide in our communities, whether that community is a village, a nation or global. This chapter will look briefly at community initiatives at three levels of intervention: district/village, nationally, and globally.

As with devising a strategy for suicide prevention at a national or global level, the fundamental requirements for a comprehensive community intervention are also formulated and structured with many of the same components. In both situations, first there requires to be acceptance of a clear multisectorial strategy to reduce suicides, followed closely with the development of a consortium that will provide the forum on which to focus evidenced-based research and implementation. Reaching a balance between perfecting a seamless system of delivering an intervention consisting of rigorous science that can be translated into best suicide prevention practice is ideal but frequently is time consuming and also disheartening where records indicate a continuum of suicides and, in some age groups and countries, an increase. As in the high-income countries (HIC), the use of a multifaceted approach to formulate comprehensive suicide prevention strategies is equally relevant to lower- and middle-income countries (LMIC) (Fleischmann et al., 2016)

Availability of psychiatrists and mental health professionals in LMIC is limited and other health professionals and community leaders take an increased role in suicide prevention (Vijayakumar, Phillips, Silverman, Gunnell, & Carli, 2014).

Chapter 10

Community Responses and Reactions to Bereaved

Suicide Survivors' Perceptions

Vita Poštuvan
Slovene Centre for Suicide Research, Andrej Marušič Institute, University of Primorska, Koper, Slovenia

Introduction

Bereavement after the suicide of a close person is usually a painful process and the bereaved are the ones carrying the biggest burden of suicide. There is no consensus about how many people are affected by each suicide death, but the numbers vary from 4 to 135 – depending on the definitions and methods used in different studies (Cerel et al., 2018). Nonetheless, not all of the people exposed to suicide share the same closeness or attachment to the deceased person and recent studies have confirmed that the loss of a first-degree relative had a significantly higher impact on the bereaved compared with being exposed to other relatives' suicide (Cerel et al., 2017, Poštuvan, 2017a). We refer to these first-degree relatives as *suicide survivors* in this chapter, as they often face many psychological, physical and social changes after a suicide in their everyday life (Andriessen, 2009).

The growing flower model of suicide survivors' bereavement and reintegration (Poštuvan, 2017a, Poštuvan, 2017b) distinguishes three levels of interactions that play a role in the bereavement process of suicide survivors. Firstly, these are interactions with their closest family members and friends; secondly, with people from the broader social network or community, such as acquaintances, colleagues, neighbours; and thirdly, with societal systems, for example, help systems, health care, police, social care, funeral services etc. The three identified levels are at the same time exposed to suicide and also influential in the support, attention and actions

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Chapter 11

Status of the Integrated Motivational–Volitional Model of Suicidal Behaviour

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Introduction

Suicide remains a major public health concern, with around 804,000 deaths per annum worldwide (World Health Organization, 2014), yet our knowledge of the specific markers of risk is still relatively limited (Franklin et al., 2017). There is growing recognition that psychiatric disorders alone are insufficient to predict suicide risk, and therefore there is a need to move beyond mental disorders and adopt more sophisticated explanatory models of suicide; highlighting the complex interplay of risk and protective factors (O'Connor & Nock, 2014). In line with this, the integrated motivational–volitional (IMV) model of suicidal behaviour incorporates major components from psychopathology, suicide research and the health psychology literature to delineate the final common pathway to suicidal ideation and suicidal behaviour (Figure 11.1; O'Connor, 2011; O'Connor, Cleare, Eschle, Wetherall, & Kirtley, 2016; O'Connor & Kirtley, 2018). Specifically, the IMV model is a tri-partite (pre-motivational, motivational and volitional phases) diathesis–stress model that endeavours to understand the emergence of suicidal ideation and the transition from ideation to suicide attempt. In the present chapter, we provide a brief overview of the IMV model, its core premises and empirical status.

Chapter 12

Understanding Suicide From Survivors' Perspective – Psychological Autopsy Outcomes

The Model of a Hot Air Balloon

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Introduction

Psychological autopsy (PA) is a method that provides a platform for a more thorough exploration of underlying psychological and contextual circumstances of suicide, resulting in a deeper understanding of the phenomenon and determining risk factors for suicide (Conner et al., 2011; Hawton et al., 1998; Pouliot & De Leo, 2006). PA studies include different research designs, from quantitative case-control studies with an appropriate non-suicidal comparison group to determine possible risk factors, to more qualitative-based research, focussing on a homogeneous group of suicide cases and investigating more thoroughly specific aspects of the deceased's life. PA studies involve interviews with one or more proxy informants who knew the deceased well and had been in contact with him or her in the last few months before death. The areas of the interviews often include psychopathology, adverse life events, previous suicide attempt, communication of intent, access to

The proxy informants in our study used the following metaphors when describing what was going on with their loved one: spiralling down, things falling apart, crumbling down, things piling up, the deceased not getting a break, being overwhelmed by life, losing their spark, losing energy, and that there was no turning back at a certain point. The dynamic properties of certain metaphors – such as falling, no turning back, and some others describing spark and energy – contributed to the idea of a hot air balloon model of suicide risk.

The main parts of the hot air balloon (HAB) that are important in our model are: an envelope, a possible hole in the envelope, cables connecting the envelope and the basket or gondola, a burner that provides heat, a pilot of the HAB, weights that are placed on the rim and inside the basket, and weather conditions.

The crucial concepts derived from the narrative of proxy informants are presented in Figure 12.1. We describe the different parts of the HAB in connection with the risk factors and events surrounding suicide. We invite the readers to keep in mind that the whole HAB, not only the pilot, represents a person. Also, some particularities in the metaphor might deviate from the actual HAB; nevertheless, we hope that the description suffices for the understanding of the idea.

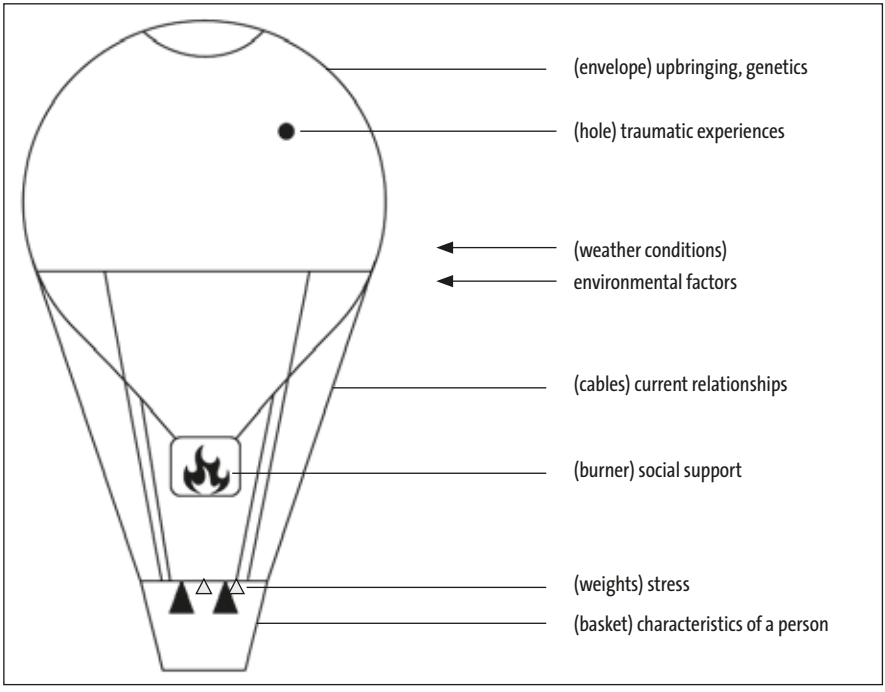

Figure 12.1. Metaphoric model of a hot air balloon.

Chapter 13

What Is Different About Suicidology?

Ethical and Methodological Issues Unique to Research on Suicidal Behaviour

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Introduction

Every 40 seconds, a person dies by suicide (World Health Organization [WHO], 2014). The scale of the problem of suicide, as well as its innumerable causes and consequences, is daunting. However, researchers have worked for decades to identify and overcome some of the most pressing ethical and methodological issues associated with researching and preventing suicidal behaviour.

Today, suicide research focusses on identifying risk and protective factors for suicidal behaviour and intervening to reduce risk factors. These interventions include: feasible and effective screening and assessment; interventions for those with suicidal ideation and suicide attempts to prevent future suicidal behaviour; biological treatments to prevent suicidal behaviour; interventions to increase help-seeking and referrals for at-risk individuals; population-based prevention programmes to build resilience; and reducing access to lethal means to suicide (Pearson et al., 2014). This range of efforts occurs at different levels and scales, from universal prevention to selective and indicated prevention, to suicide-specific treatment for those who are already experiencing suicidal thoughts or behaviour. In seeking to ameliorate the burden of suicide, researchers encounter many unique challenges.

This chapter will focus on several broad methodological and ethical challenges in conducting suicide research. These include the fact that a suicide decedent cannot

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