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Identifying and Preventing Suicide in Post-Sexual Assault Care

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Youth Suicide Prevention Program

Introduction



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Youth Suicide Prevention Program

Mission

- *Support and advocate for youth through mental health promotion, community solutions, and suicide prevention.*

Vision

- *YSPP envisions healthy communities where youth suicide does not occur.*



Youth suicide: the facts



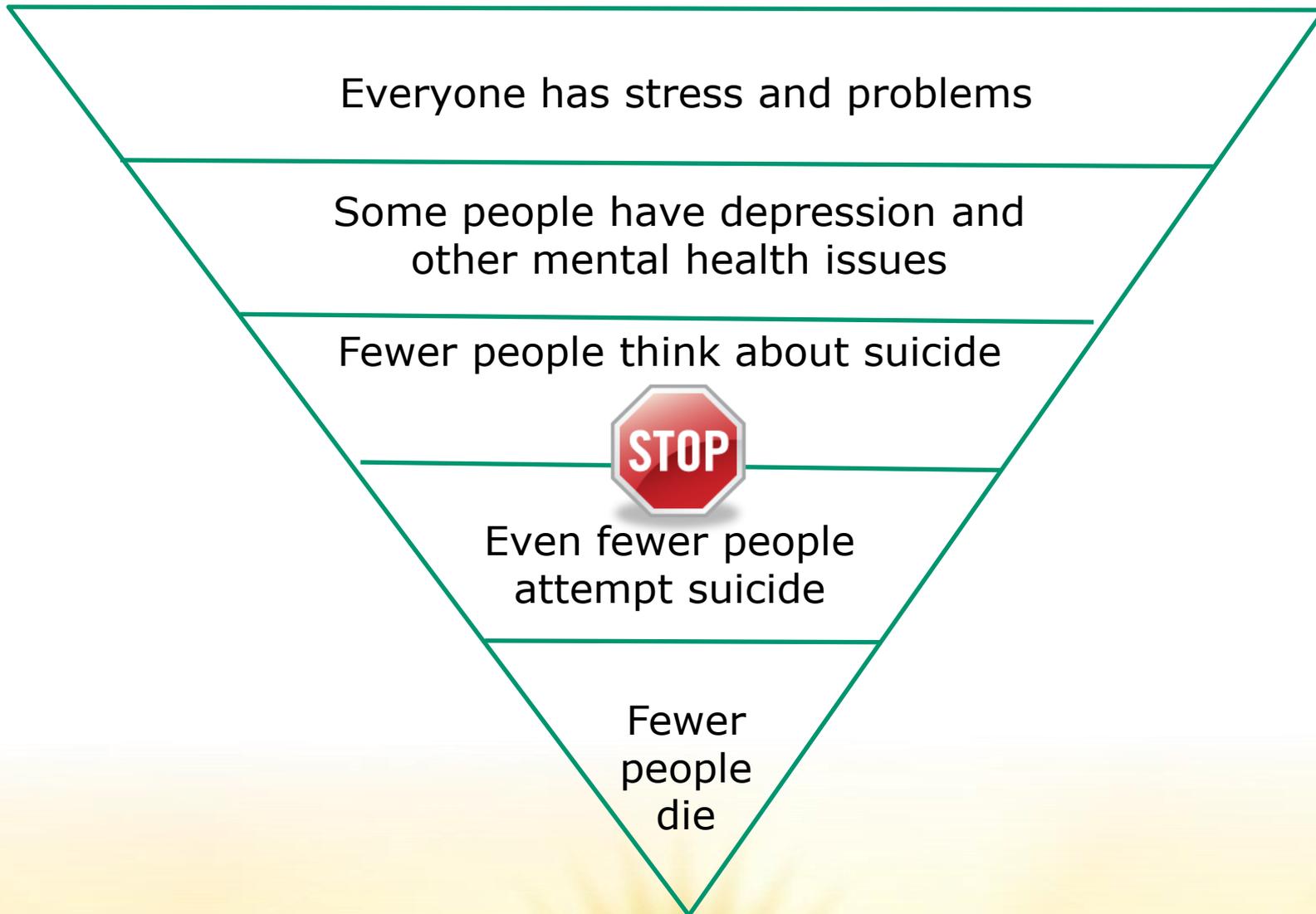
- An average of 2 youth between the ages of 10 and 24 die by suicide each week in Washington State.
- 15% of WA 6th graders, 17% of 8th graders, 19% of 10th graders and 17% of seniors reported seriously considering suicide in the last year.
- Suicide is the second leading cause of death for WA youth & young adults.
- Sexual violence is tied to depression and suicide risk.
- Suicide risk is reduced by increasing protective factors and working to change risk factors.



Suicide & sexual violence: the facts

- People who have been sexually assaulted often experience behavioral and emotional issues that are risk factors for suicide.
- People who have been raped are 3 times more likely to suffer a major depressive episode due to the trauma of sexual assault
- In one national study (female participants only):
 - (33%) of rape survivors said they had contemplated suicide.
 - Those who had been raped were 4.1 times more likely than non-crime victims to have contemplated suicide.
 - Those who had been raped were 13 times more likely than non-crime victims to have attempted suicide (13% vs. 1%).





Prevention: Knowing the issue



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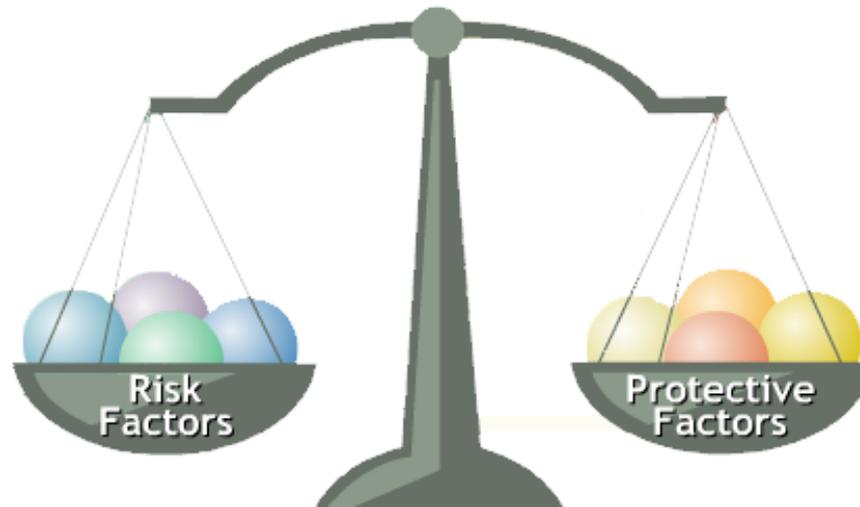
Typical adolescent behavior

- Testing rules and limits
- Touchy if asked too many questions
- Moody at times
- Easily embarrassed
- Amplified emotions and reactions
- Moving away from family – peer-oriented and motivated by peers' approval

How does typical behavior differ for those who have experienced trauma?



Risk and protective factors



- **Risk factors** increase the risk of a negative outcome like suicide.
- **Protective factors** reduce the impact of risk factors.



Some common risk factors

Personal Characteristics	Experiences	Health and Mental Health	Personality and Outlook
<p>Member of a vulnerable identity group (gender, race, disability, location)</p> <p>Sexual orientation</p> <p>Family history of mental health problems, psychiatric hospitalization, substance abuse</p>	<p>ACEs</p> <p>Loss (death, breakup)</p> <p>Humiliation (bullying, public failure)</p> <p>Sudden stress (violence, unplanned pregnancy, arrest, failing a test)</p> <p>Instability (frequent moving, unstable family)</p> <p>Social isolation</p> <p>Exposure to suicide</p> <p>History of attempts</p>	<p>Depression</p> <p>Substance use</p> <p>Other mental health disorders (anxiety, schizophrenia, bipolar disorder, eating disorders)</p> <p>Personality disorders</p> <p>Physical disability or chronic illness</p> <p>Cognitive impairment</p> <p>Traumatic brain injury</p> <p>Psychological pain or distress</p>	<p>Hopelessness</p> <p>Feeling like a burden</p> <p>Perfectionism (especially combined with depression)</p> <p>Black and white thinking</p> <p>Poor problem solving</p> <p>Feeling trapped</p>



Sexual Assault and Risk Factors for Suicide

- Sexual assault often exacerbates or results in mental health issues related to suicide risk, including:
 - PTSD
 - Major Depressive Episodes
 - Substance abuse
 - Delinquency
 - Eating disorders
- People who have been sexually assaulted report more numerous suicide attempts and are more likely to be medically treated for an injury related to a suicide attempt
- One set of statistics says people who have been sexually assaulted are 4 times more likely to contemplate suicide



Sexual Assault and Risk Factors for Suicide

- Underage males who are abused by a same-sex perpetrator are 5 times more likely to attempt suicide than males who were not sexually victimized
- Teenage females who have recently (last 12 months) experienced dating violence have a higher number of suicide attempts than females who have not experienced dating violence
- Those who attempt suicide more often show higher levels of Post-Traumatic Stress Disorder (PTSD) when following a traumatic event, such as sexual victimization

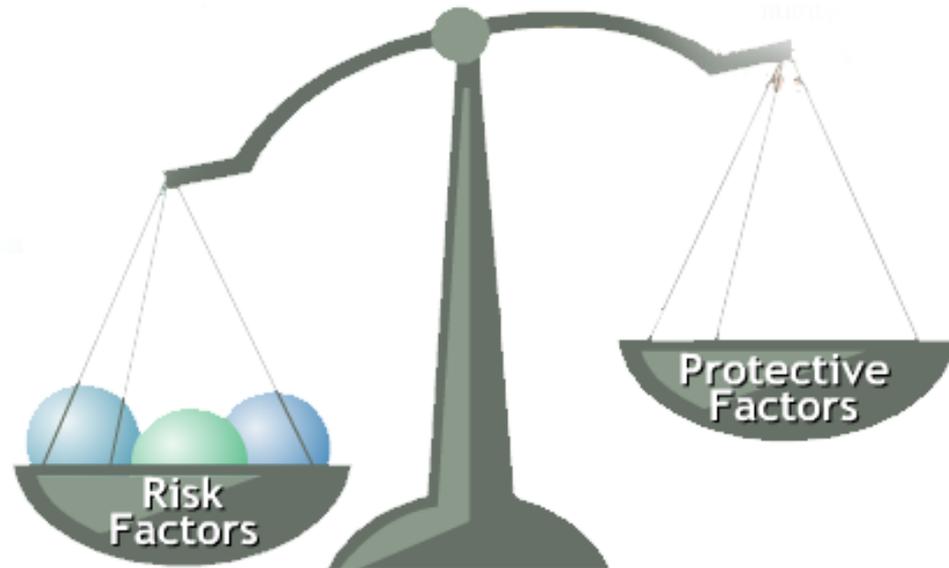


Some common protective factors

Individual	Family	Agency or Organization	Community
Good physical and mental health	Supportive adults	Supportive adults	Adequate and accessible health and mental health care
Willingness to seek help	Safe and stable home environment	Access to peer support	Safe spaces
Problem-solving skills	Restricted access to means in the home	Connection to a network of resources	Opportunities for youth to contribute positively
Self-soothing and coping skills	Responsibilities (pets, for example)	Responsibility and future orientation	Sense of belonging
Self-esteem and self-worth	Strong family connections	Opportunities for participation and skill building	
Risk avoidance	Family support of identity	Safe place, supported by policies and culture	
Belief system that discourages suicide	Reasonable expectations		



The more risk factors and fewer protective factors...



- The higher a person's risk of depression and other mental health issues
- The higher the person's risk of suicide



Youth depression: some facts



- One in every 8 adolescents may have depression. Major depression is more common in higher-risk groups.
- The majority of children and adolescents with depression do not get help they need
- Depression is a treatable illness that is not the person's fault.
- Treatment for depression could include counseling, medication, or both.



Youth depression: some signs

- **Irritability**

- Anxiety and/or persistent feelings of sadness
- A drop in school performance
- Problems with authority
- Indecision, lack of concentration
- Overreaction to criticism
- Frequent physical complaints

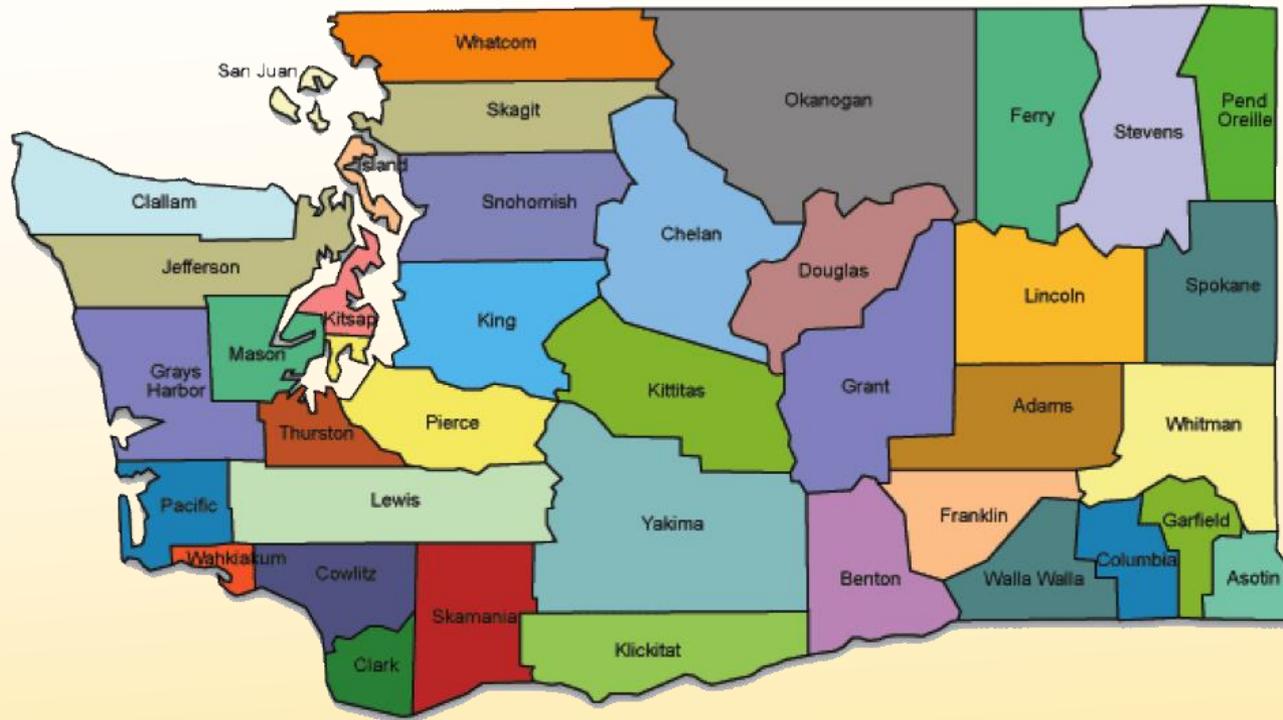


Sexual violence and depression

- Sexual violence may trigger a depressive episode or exacerbate existing depression
- People who have been sexually assaulted are three times more likely to experience depression
- Depression is strongly linked to suicide



III. Youth Suicide: The Numbers

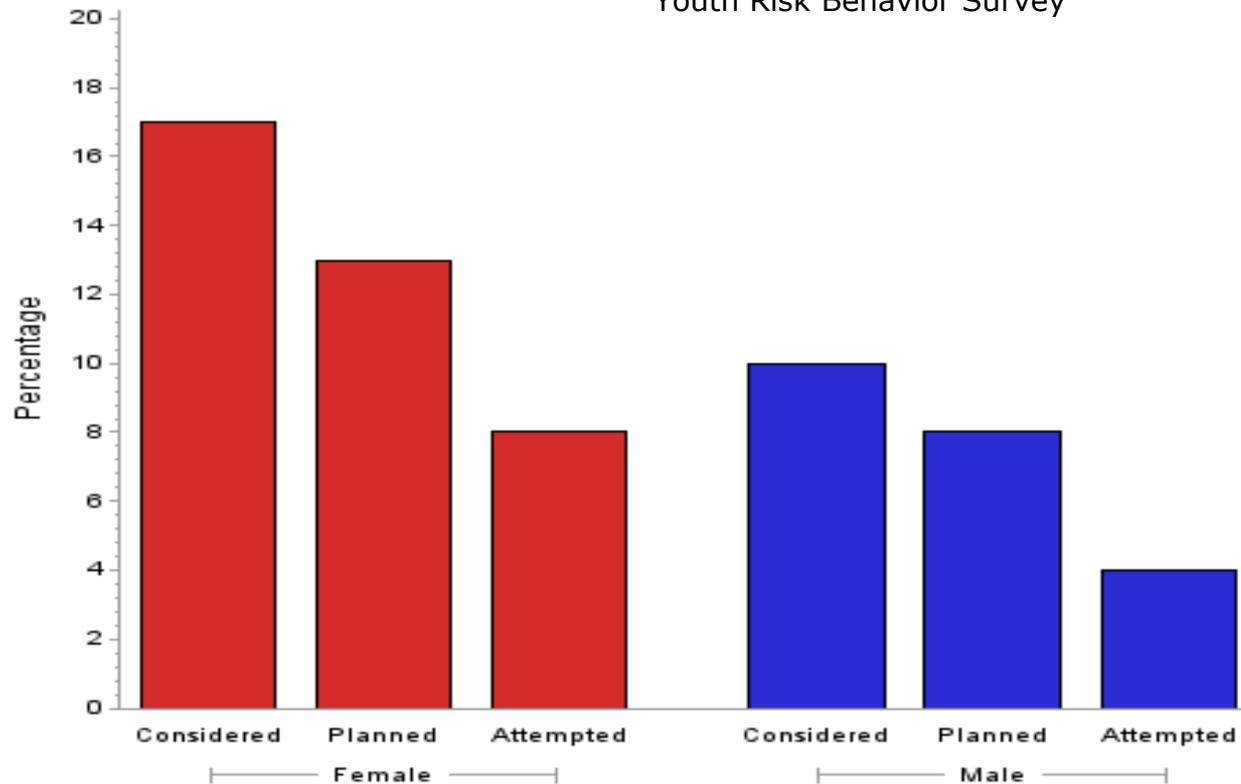


The following slides show some patterns and statistics.



Suicidal thoughts and behaviors

Percentage* of U.S. High School Students Reporting Considering, Planning, or Attempting Suicide in the Past 12 Months, by Sex, United States, 2009
Youth Risk Behavior Survey



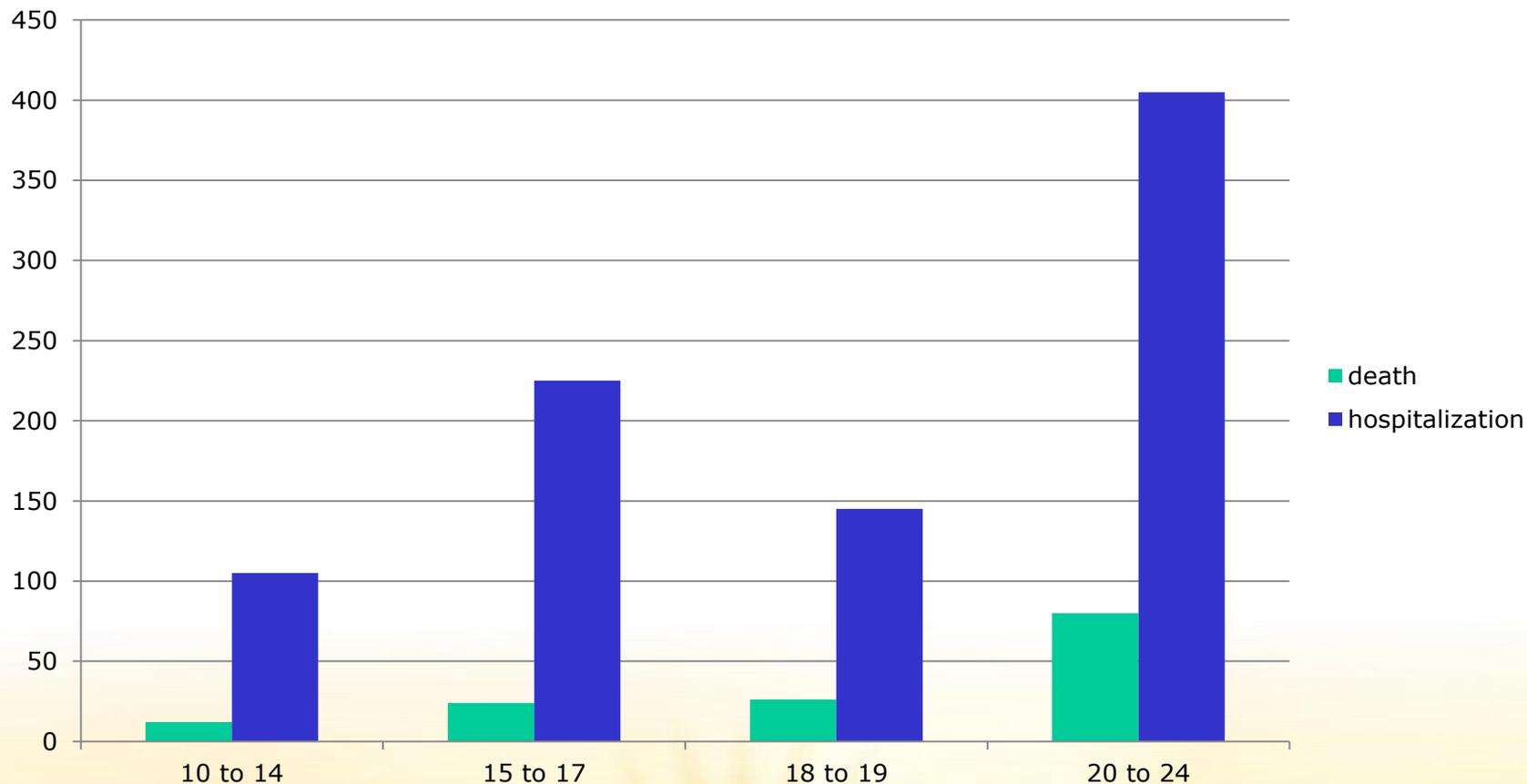
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Most youth who attempt suicide survive

(Washington State youth 2008-2012)



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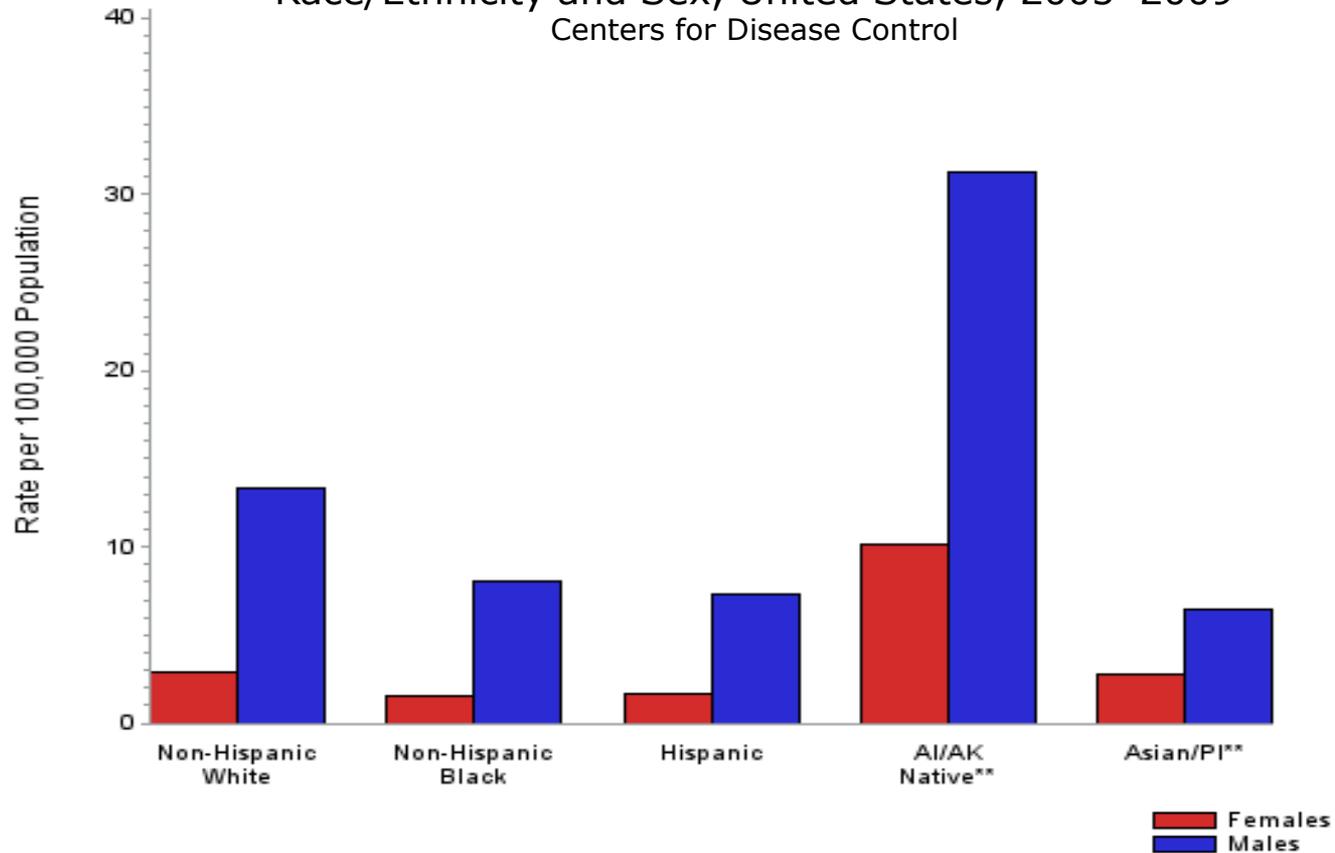
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Demographic differences in youth suicide rates

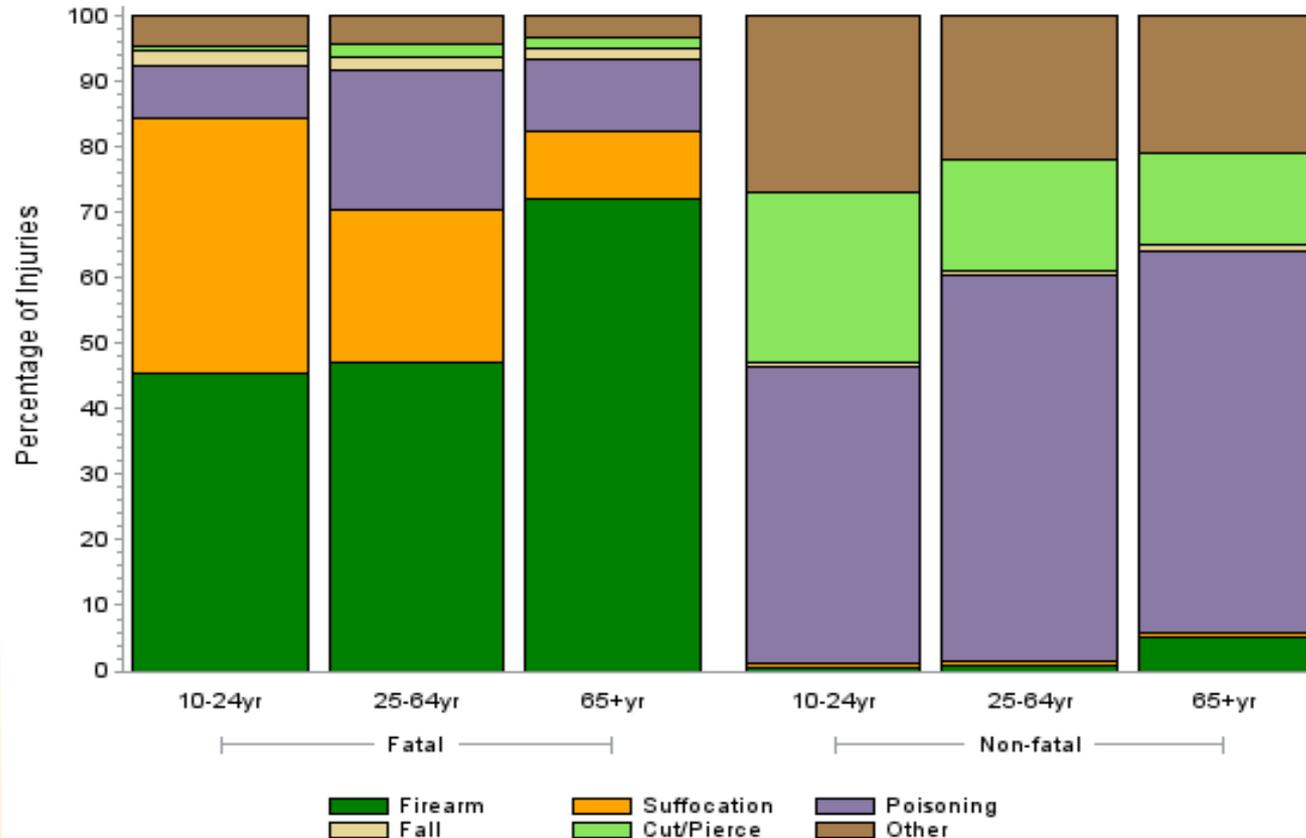
Suicide Rates* Among Persons Ages 10–24 Years, by Race/Ethnicity and Sex, United States, 2005–2009
Centers for Disease Control



Means matter: Fatal and nonfatal injuries

Percentage of Self-Harm Injuries, by Age Group, Disposition, and Mechanism, United States, 2005-2009

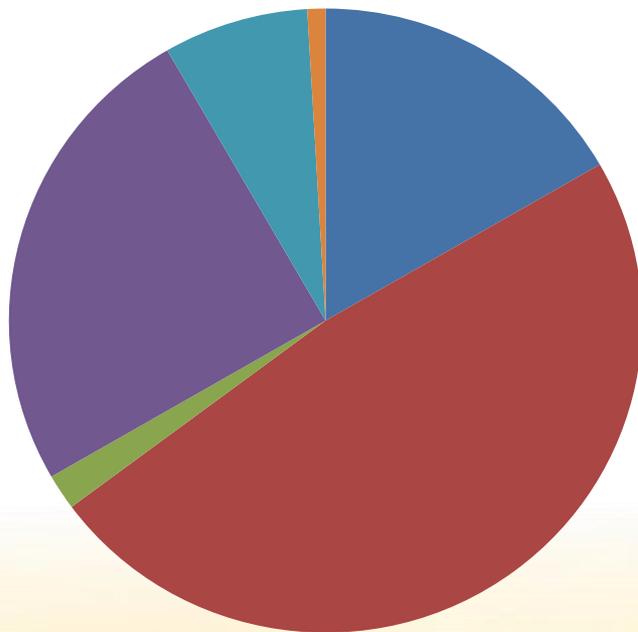
Centers for Disease Control



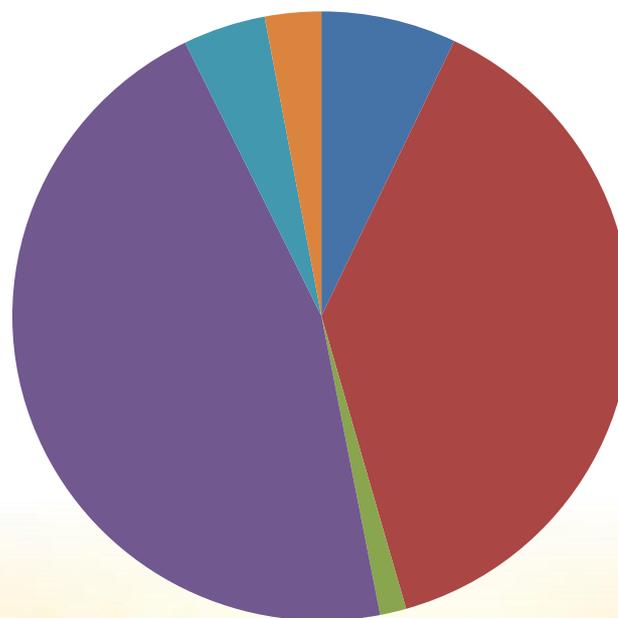
Fatal suicide means and gender

(Washington State youth 2008-2012)

Female youth
ages 10-24
n=108



Male youth
ages 10-24
n=509



- Poisoning
- Suffocation
- Drowning
- Firearms
- Jump/fall
- Other



Intervention: When to step in



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Populations at higher risk

- Youth with mental health issues
- Youth experiencing stresses (current or past) like poverty, abuse, violence, racism or living in low-resource communities
- Youth in vulnerable identity groups, including:
 - LGBTQ youth (worse with family rejection)
 - Native American youth
 - Latina adolescent girls
 - Foster care youth and alumni
 - Homeless youth
- Youth who abuse alcohol or other substances
- Youth who have attempted suicide before



Experiences that may increase risk

- The death or illness of a family member, friend or community member, including another teen suicide in the community
- A loss or sudden change in circumstances
- A problem with peers, like a breakup, bullying or conflict with friends
- A major stress like failing a test, changing foster placement, sexual violence, family conflict or being arrested
- Being abused
- Being or feeling socially isolated
- Having access to firearms or other lethal weapons



Red flags for suicidal thinking after sexual violence

- Shame
 - Males display more shame if sexually victimized by another male and, due to gender stereotypes, this can lead to difficulties with disclosure
- Guilt
- Isolation/social avoidance
- Preoccupation with the sexual assault
- Feelings of inadequacy
- Interpersonal relationship problems



Signs of suicidal thinking: The FACTS

Feelings

Sad, lonely, hopeless, in pain, moody, irritable, increased depression

Actions

Pushing away friends and family, giving away important possessions, using alcohol or drugs, making unsafe decisions, making or researching suicide plans, making art or writing about death, saying goodbye

Changes

Changes in school/work performance, changes in appearance or hygiene, changes in personality or attitude, just not seeming like themselves

Threats

Saying they're going to kill themselves, saying goodbye

Situations

Has the person had a crisis or trigger situation, especially in the last couple of weeks?



Scenario for review

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Kyla is in her first year at a college out of state. Feeling isolated and homesick, she came home for a weekend visit with friends and family. Tonight she was spending time with an ex-boyfriend from high school and began to feel uncomfortable with his behavior. She excused herself and tried to leave, and he blocked her exit and sexually assaulted her.

Kyla comes to the hospital with a friend and tells the advocate she feels dirty and ashamed. She isn't interested in making a police report or taking legal action against her assailant because her family is close with his and she fears they would all blame her. She says she would do anything to stop thinking about the assault and forget it ever happened. When asked about her safety plan for the future, Kyla says that isn't a concern because she has no future.



What are the **FACTS**?

Feelings

Actions

Changes

Threats

Situations

Are you concerned Kyla may be at risk of suicide?



Youth Suicide: Intervention Steps



- Show you care



- Ask the question



- Call for help



Show you care

- “I have noticed that _____, and I feel concerned about you because _____.”
- “I want to help. Tell me more about what you’re thinking.”
- “I can connect you with help when we understand what you need.”



Ask the question

- “Sometimes when ____ happens to people, they think about suicide. Are you thinking about it?”
- “When you said ____, it made me wonder if you were thinking about ending your life. Are you?”
- “Have you thought about how you would do it?”
- “What thoughts or plans do you have?”

Remember: Asking the question does not cause suicide



Choosing the question

- Many people want to ask, “Are you thinking about hurting yourself?” instead.
- “Are you thinking about hurting yourself?” is a valid and important question, BUT
- It is not a question about suicide.
- Ask this *also*, not *instead*.



Hesitation to answer the question

Why might someone who has experienced sexual violence be hesitant to answer the question honestly?

- Adding stigma to stigma
- Shame
- Trauma and mistrust
- Past negative experiences with mental health care or crisis services
- Fear of not being allowed to leave the hospital or other negative consequences



Call for help

- “You were very brave to tell me. We’re going to need more help.”
- “I know where we can get some help.”
(Mention specific resource people.)
- “You’re not alone. Let’s contact this resource together.”
- “Who are the 3 people in your life that you trust the most?”
- “Together we can figure out how to make you feel better.”



Suicide risk and confidentiality



- Suicide risk is a confidentiality exception even for those legally or ethically bound by confidentiality.
- Never promise that a client's writing or what they tell you will be confidential in all cases.
- If you need to break confidentiality to protect the client or comply with laws or rules, explain why.



Tailoring referrals to needs

Selection of appropriate referral determined by:

- Resources available in the community
- Level of risk
- Intensity of stressors
- Family's culture and language
- Client's identity
- Client's age and ability to consent/guardian availability
- Mental health and treatment history



Where to get information & help

- The person's existing positive connections: therapist, psychiatrist, case manager, family, wraparound team or trusted service provider
- Internal crisis resources (supervisor, on-call mental health clinician, hospital social worker, etc.)
- Your county crisis line
- Your Regional Support Network
- 211
- A crisis phone hotline (1-800-273-TALK, or for LGBTQ focus, 1-866-4U TREVOR)
- Resources available through the appropriate community center, religious institution or school



Scenario for review

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How would you:



- Show you care



- Ask the question



- Call for help
 - **Where would you refer?**
 - **How?**



At discharge, be mindful of...

- Is it actually safe for this person to leave, or is further suicide risk assessment needed?
- What is the person's support system and do they have a plan to access it? Are the people they live with part of the support system?
- Has a safety plan the person finds useful and can comply with been created?



At discharge, be mindful of...

- What are the person's formal resources (therapist, mental health referral, college counseling center, etc.)?
- Has the person been given a backup resource they can use starting immediately (24 hour crisis line, for example)?
- What kind of follow-up will be done (a scheduled follow-up appointment, a phone call for safety check, etc.)?



Safety planning

- Why a safety plan vs. no self harm contract
- Tool for the youth to stay safe
- Reviewed and modified regularly
- Goal is NOT liability reduction or reassuring the provider



Mental health safety planning

Adapted from the Suicide Prevention Resource Center's sample safety plan template:

1. What are signs that a crisis is coming?
2. What coping strategies can you use first?
3. Where can go or who can you be with to distract yourself?
4. Who are your support people who you can tell about the crisis and ask for help?
5. What are the available professional resources? (Therapists, hotlines, etc.)
6. What can you do to remove risks from your environment? Who can help?
7. How long can you keep safe before we discuss the plan again?





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