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Suicide risk assessment and implications for counselors

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Abstract

Beginning counselors may not be thoroughly knowledgeable in the art of suicide assessment. It is the purpose of this paper to review the current statistics of suicidality, known risk factors of attempting and completing suicide, crisis intervention techniques, how to carefully conduct a mental status exam, models of suicide assessment, and implications for counselors. The models surveyed in this paper were Leenaar's (1994) five step model which is considered the most common model in crisis intervention, the second model comes from Frierson, Melikian, and Wadman (2002), and the third model is the Chronological Assessment of Suicide Events (CASE approach) by Shawn Christopher Shea (2002). This information is designed to facilitate counselors' awareness and knowledge of suicide risk and assessments.

SUICIDE RISK ASSESSMENT AND IMPLICATIONS FOR COUNSELORS

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Suicide Risk Assessment and Implications for Counselors

Suicide assessment is an extremely important skill for counselors to master. It is not only a skill, but an art. To effectively evaluate a client for suicidality, a counselor has to have an artful approach to elicit important information. The information a counselor will need to gather is plentiful. It is also very time consuming. Oftentimes, counselors have very limited time which makes being accurate and competent difficult. So how do we evaluate lethality effectively in time-constraining times? It is the purpose of this paper to explain where society is now in relation to suicide. There is still a stigma attached to suicide which makes it a topic most people do not like to discuss. Counselors should be well-aware of their own biases and work through them in order to effectively elicit pertinent suicidal information from clients. The more the counselor is comfortable when talking about suicide, the easier it is for the client to open up and talk about their feelings without being ashamed. "Suicide intervention is an area of concern for counselors in all settings" (Nugent, 2000). This paper will review the current statistics about suicide, risk factors for suicidality, how to handle and evaluate crises, and models of suicide assessment. Concluding the paper will be implications for counselors.

Suicide Facts

According to the National Institute of Mental Health, suicide was the 11th leading cause of death in the United States in 2000 (National Institution of Mental

Health (NIMH), 2003). According to NIMH (2003), suicide was the 8th leading cause of death for males and the 19th leading cause of death for females. It is well-known that males commit suicide more often than females, though counselors should use caution when using gender as a sole means of assessment. Men commit suicide more than women in a ratio 4 to 1. “Seventy-three percent of all suicide deaths are white male and 80% of all firearm suicide deaths are white males” (NIMH, 2003). The total number of suicides in the United States was more than 30,000, the approximate equivalent of more than 80 suicides a day or one every 20 minutes (Frierson, Melikian, & Wadman, 2002). This does not take into account deaths not ruled a suicide on the death certificate. This number is alarming and should be a strong signal to counselors that suicide is a real problem. Although Shea (2002) reports “roughly less than one percent of people who have had suicidal ideation go on to kill themselves”. This number seems to be more reassuring. Whatever the numbers say, counselors must heed the numerous warning signs of suicide. Counselors must be educated and cognizant enough to conduct appropriate assessments of lethality among their clients.

“Suicide outnumbered homicides (16,765) by a 5 to 3 ratio” (NIMH, 2003). NIMH (2003) also reports that suicide by firearms was the most common method for both men and women, accounting for 57% of all suicides. Among the highest rates (when categorized by gender and race) are suicide deaths for white men over 85, who had a rate of 59/100,000. NIMH (2003) reports suicide was the

3rd leading cause of death among young people 15 to 24 years of age, following unintentional injuries and homicide. The rate was 10.4/100,000. Unbelievably, the suicide rate among children ages 10-14 was 1.5/100,000. It is a staggering statistic to think that children even know what suicide is. For 15-19 year olds it is 8.2/100,000 and for 20-24 year olds it is 12.8/100,000 with a gender ratio of 7:1 (males: females).

There is no annual national data on all attempted suicides, but NIMH (2003) indicates that there are an estimated 8-25 attempted suicides to one completion; the ratio is higher in women and youth and lower in men and the elderly. More women than men report a history of attempted suicide, with a gender ratio of 3:1. “Approximately 90 percent of the people who commit suicide have some psychological or psychiatric disorder. Some 45 to 70 percent of those people have a mood disorder, often with another disorder” (Wilson, O’Leary, Nathan, & Clark, 1996). With all of these statistics, health care and mental health professionals should be distressed. It is health care professionals that are on the front lines of detecting suicidal behavior. Counselors are also on the front lines, but only if the client reaches out for help in some way. Not only are counselors and other mental health professionals responsible for accurate suicide assessments, but for prevention measures as well.

Risk Factors

The contents of risk factors are generally divided into 4 arenas: epidemiologic factors, psychiatric disorders, past history, and medical disorders. First, our attention is directed at epidemiologic factors. There are five epidemiologic factors that counselors need to take into consideration when conducting a suicide assessment according to Gliatto & Rai (1999). The first factor is being a male, white, and being older than 65 years old. Second, a person who is widowed or divorced. Third, a person who lives alone. The fourth factor is presence of stressful life events, which can be a variety of events unique to each individual. The last factor to consider is whether the person has access to firearms. Gliatto and Rai (1999) do not list any other means of committing suicide, but one could argue that counselors need to find out if the person has access to a variety of weapons used for committing suicide. Niolon (1999) suggested a few more factors to be aware of. Niolon (1999) suggests persons over 45 years old are at a higher risk. Unmarried people are at the lowest risk, never married, divorced, widowed, and recently separated are at the highest risk. Recent job loss increases suicide risk, as well as the recent loss of a loved one, the anniversary of the loss and fantasies of reuniting with the deceased. Gay and lesbian youth may be at 3 to 5 times the risk for suicide as heterosexual youth. Finally, persons who have a history of suicide in their family and/or a history of impulsive or reckless behavior.

The next category of risk factors to include in an assessment is psychiatric disorders. According to Kaplan and Sadock (1996), highly significant psychiatric factors in suicide include substance abuse, depressive disorders, schizophrenia, and other mental disorders. Almost 95% of all patients who commit or attempt suicide have a diagnosed mental disorder. “The most common psychiatric disorders associated with completed suicide are major depression and alcohol abuse. The risk for suicide in patients with mood disorders (major depressive disorders and bipolar disorders) is 15%, and the risk is highest in the early stages of the illness” (Gliatto & Rai, 1999).

The third category is past history of suicidal behavior. “A past suicide attempt is perhaps the best indicator that a patient is at increased risk for suicide” (Kaplan & Sadock, 1996). “Studies show that about 40% of depressed patients who commit suicide have made a previous attempt. The risk of a second suicide attempt is highest within 3 months of the first attempt” (Kaplan & Sadock, 1998).

The final risk factor category is medical disorders. The relationship between physical health and illness to suicide is significant. According to Kaplan and Sadock (1998), postmortem studies show that a physical illness is present in some 25 to 75 percent of all suicide victims; in each instance the percentage increases with age. Seven diseases of the central nervous system increase the risk of suicide: epilepsy, multiple sclerosis, head injury, cardiovascular disease, Huntington’s disease, dementia, and acquired immune deficiency syndrome. All

of these illnesses are related with mood disorders. Kaplan and Sadock (1998) also found the following:

Factors associated with illness and contributing to both suicides and suicide attempts are: loss of mobility, especially when physical activity is important to occupation or recreation; disfigurement, particularly among women; and chronic, intractable pain. In addition to the direct effects of the illness, the secondary effects—for example, disruption of relationships and loss of occupational status—are prognostic factors. (p.866)

Obviously there are a plethora of medical problems and illnesses that can lead to pondering the taking of one's own life. As we grow older or become ill, we lose certain abilities. Some people cannot stand the thought of not being able to take care of themselves and thus turn to suicide as a way to end the pain and also lessen the burden for the caretaker.

Crisis Intervention

Crisis intervention and suicide assessment requires diligence and structure. In order to better understand how to conduct an assessment and intervention, it is important to first define what suicidal ideation, lethality, and perturbation are. "Lethality refers to the probability of a person's killing him-or herself, as assessed quantitatively from low to moderate to high. Perturbation refers to the person's subjective distress (disturbed, agitated) and can also be rated from low, to moderate, to high" (Leenaars, 1994). Lethality is what kills people, not

perturbation. Plenty of people are perturbed but do not turn to suicide. Perturbation and other risk factors may render a person more vulnerable to accepting the idea of suicide as a means of escape and release and more vulnerable to lethality. “People with suicidal thoughts often feel totally overwhelmed, that they have too many problems all at once, that others are expecting more from them than they can possibly accomplish. Sometimes suicide appears to be the only way out” (Copeland, 2001). Suicidal ideation can arise from three main factors: situational, psychological, and biological. It is important to remember that suicidal ideation more than not, has multiple causes. Clinicians must remember that each person has unique thoughts and emotions. This does not mean that we should not look for similarities between suicidal people, but to not fall into following stereotypes. Suicidal ideation is often triggered by three main categories: “external stressors (death, rejection, job loss, humiliation, and illness), internal conflict (psychological impasses, cognitive distortions), neurobiological dysfunction (exogenous toxins such as alcohol, or endogenous pathophysiology as evidenced during spontaneously arising biologic depressions)” (Shea, 2002). Other behaviors to pay close attention to are recurrent thoughts of or preoccupation with death, recurrent or ongoing suicidal ideation without any plans, positive family history of depression, bleak and hopeless attitude regarding life, social withdrawal, lethargy, and apathy, and engaging in self-destructive or dangerous behaviors (Jongsma & Peterson, 2003). It is important to remember

that mixtures of these categories are at work when suicidal ideation is developing.

Mental Status Exam

When assessing for suicide, every clinician must complete a mental status checklist. When performing a mental status exam, the following are extremely important to focus on. (Exam taken from Truman Medical Centers, Behavioral Health Network intake assessment).

- *Appearance*: Is the client appropriately groomed and dressed? Is the client disheveled or have poor hygiene?
- *Speech*: Is speech normal, delayed, slurred, excessive, loud, soft, incoherent?
- *Thought Processes*: Is client's thought processes obsessive, intact, circumstantial, tangential, or concrete? Does the client have loose associations or a flight of ideas?
- *Judgment*: Is the client's judgment intact or impaired?
- *Attitude*: Is client cooperative, guarded, suspicious, uncooperative, or belligerent?
- *Orientation*: Is the client oriented to person, place, time and situation?
- *Thought Content*: Is there no disturbance, depersonalization, delusions, paranoia, or grandiose?
- *Concentration*: Impaired or intact?

- *Motor Activity:* Is it normal, hyperactive, calm, agitated, or slowed?
- *Mood:* Is it normal, dysphoric, anxious, euphoric, or euthymic?
- *Self Perception:* Derealization or normal?
- *Hallucinations:* None, auditory, or visual?
- *Physical Issues:* Sleep problems, sexual issues, or weight and appetite changes?
- *Alertness:* Is it good, fair, or poor?
- *Affect:* Is it appropriate, labile, expansive, constricted, blunted, or flat?
- *Intellect:* Above average, average, or below average?
- *Memory:* Intact, impaired, immediate, recent, or remote?
- *Insight:* Good, fair, or poor?

Finally, you must ask the hard question directly, “Are you or have you ever been suicidal? Do you want to die?” (Kaplan & Sadock, 1998). “Eight out of ten people who eventually kill themselves give warnings of their intent. Fifty percent say openly that they want to die” (Kaplan & Sadock, 1998). It is the job and responsibility of the counselor to listen closely to what is said and not said by the client. In order to elicit information the counselor must structure the interview in a way that allows for exploration into many areas for potential abnormalities as well as an in-depth exploration of evident symptoms or signs (Trzepacz & Baker,

1993). The counselor's interview technique is important in eliciting information during the mental status exam. The counselor should strive for a therapeutic alliance with the client, so that the client can feel comfortable expressing themselves and sharing personal information. This can be achieved by asking open-ended questions. Some clients might need a gentle push into talking about certain topics, such as violent thoughts or suicidal ideation (Trzepacz & Baker, 1993). Empathic statements used by the counselor throughout the interview will communicate to the client that the counselor can understand what they have been dealing with and that the counselor is interested in what they are saying. Finally, certain topics, such as suicidality and "crazy" thoughts or ideas, may be ignored by the counselor out of awkwardness. This is vital information that the counselor may miss out on if one feels uneasy with the topics. The counselor should attempt to be calm, comfortable and objective in order to pose the hard questions and to communicate to the client that every aspect of his or her life is important (Trzepacz & Baker, 1993). "Asking about suicidal thoughts will not encourage your client to commit suicide. Most of the time, clients are relieved to be asked, because they have ambivalent feelings and thoughts about suicide, and want to be helped to feel better" (Faiver, Eisengart, & Colonna, 2004). The skilled counselor should attend both to the content and the process of the interview in order to accurately assess for suicidality.

Models of Suicide Assessment

Antoon A. Leenaars

The first model of suicide assessment comes from Antoon A. Leenaars. Leenaars (1994) believes that if you have a planned and structured model, the counselor or clinician will be able to approach a crisis situation rationally and will also be able to reduce their own inherent anxiety as well. Leenaar's (1994) model consists of five steps: 1) Establish rapport, 2) Explore, 3) Focus, 4) Develop options and a plan of action, and 5) Terminate. Leenaar's framework is one of the most common models in crisis intervention.

Establishing rapport is the first building block in intervention. In order to have the client open up to the counselor, an active and nonjudgmental rapport must be developed (Leenaars, 1994). Counselors should already have this skill refined, but in a crisis situation, the rapport must be built more quickly than in a typical therapeutic situation. Leenaars (1994) believes that the key to working with suicidal people is the relationship. A special relationship must ensue between a counselor and a suicidal client that is surrounded in caring, authenticity, and a nonjudgmental response. The goal of this encounter differs from traditional therapy in that the goal is to keep the person alive. In order to keep a suicidal client alive, a counselor must lower the lethality level. Leenaars (1994) points out that the way to decrease lethality is to dramatically decrease the perturbation, a process in which the relationship is the key. The clinician must

work diligently to give the suicidal client enough realistic hope until the intensity of the pain can be reduced to a tolerable level for the client.

The second stage of this model is to explore the client's perception into his or her problems. It is the counselor's responsibility to help translate the client's perception into a wider adaptive view of the world. Leenaars (1994) says that counselors must widen the patient's blinders. As the counselor explores more, the trauma becomes redefined as painful, but tolerable to the client.

The third stage is to focus on and to understand how the client defines the trauma. Questions to facilitate this process are: "What is the problem? What were you hoping to accomplish? What would be most helpful?" (Leenaars, 1994). This process allows both counselor and client to focus so that things become clearer for both parties. The client needs to vent and make sure that the feelings are lightening. Leenaars (1994) points out that it is not wise to react to a suicidal client with punishment, moral persuasion, or confrontation. The most effective way to help is to reduce the perturbation. Once the level of perturbation is decreased, lethality will decrease as well.

The fourth stage of Leenaars' model is to develop options and constructive action. The purpose, according to Leenaars (1994), is to help the client with problem resolution, not personality change. The client that attempts or thinks strongly about suicide is a person who wants some unbearable pain to cease. This is the goal of this stage, the person wants relief. This means that the counselor

must do something to assist the client in finding some relief from the pain. When developing options and constructive action, Leenaars (1994) believes the counselor should keep in mind three things:

First, a key to intermediate and long-range effectiveness with the suicidal person is to increase the options of actions available, to increase awareness of adjustment processes, to widen the blinders, and to increase the number of people available to help. Second, when the patient is no longer highly suicidal, the usual methods of psychotherapy can be used. Finally, given all that, the therapist should remember that work in suicide prevention is risky and dangerous, and there are casualties. (p. 350)

The primary goal is to develop options for the clients to reduce the trauma. Ultimately, the client will have to face the trauma head on. The counselor's task, according to Leenaars (1994), is to increase the options, to reframe the person's thoughts, and to widen the range of thoughts and fantasies. The counselor will want to increase the client's individual sense of possible choices and the sense of being supported.

Finally, the last stage is termination. "Before terminating the treatment, the therapist summarizes, rehearses, and develops the patient's planning skills; identifies resources; makes referrals; identifies emergency procedures; and establishes follow-up, to identify but a few essential steps before ending contact with a patient in crisis" (Leenaars, 1994). It is essential to bear in mind that this

crisis intervention did not fix the client. Counselors should encourage and gently suggest that the client may benefit from more traditional therapy. According to Leenaars (1994), the therapist should always affirm the client in the process of termination. The therapist should ask the client if he or she got what she wanted from the encounter. If the answer is no, then the therapist must go back to step two. Finally, the therapist should “leave the door open”, even if the counselor is referring the client for treatment elsewhere.

Frierson, Melikian, and Wadman

The second model of suicide risk assessment comes from Frierson, Melikian, and Wadman (2002). These authors contend that in order to elicit clients' suicidal thoughts, clinicians must use open-ended and non-judgmental interview style. This is consistent with other models of suicide risk assessment. The topic of suicide can be approached by asking the client about feelings of hopelessness and despair. If the answers are negative, then it will be necessary to move on to more direct questions about suicidal thoughts and intent. Clients who indicate active suicidal ideation or passive thoughts of suicide require a formal suicide risk assessment.

The authors start the formal risk assessment by encouraging the client to spontaneously elaborate on suicidal thoughts. The counselor may elicit this elaboration by being empathic and using open-ended questions. It is also useful to probe the client's reasons for not having attempted suicide or committed

suicide. This information may prove to be beneficial in developing a treatment plan at a later date. It is crucial to obtain a history of suicide attempts next. This material should include the circumstances in which the attempt occurred, whether the client sought help before an attempt, and the potential lethality of the method. The more serious the attempt, the higher the risk of a future attempt (Frierson, Melikian, &Wadman, 2002). At this time, an examination of the circumstances surrounding the previous attempts will be helpful. Suicide is more common among first-degree relatives of suicide victims, so this is another portion of information that can prove helpful.

Reviewing the client's current symptoms is next in the assessment. Pay close attention to feelings of hopelessness, helplessness, and excessive or inappropriate guilt. Listen for such statements as "My family would be better off without me" or "I would be better off dead". Inquire about the client's attitude toward treatment. Explore any current psychosocial stressors as they may provide clues to the source of suicidal thoughts (Frierson, Melikian, &Wadman, 2002).

Clients with altered perceptions of reality, such as those caused by intoxication or psychosis, are at increased risk of suicide (Frierson, Melikian, &Wadman, 2002). There is a link between suicide and alcohol dependence, so it is important to obtain a complete history of alcohol and drug use. The presence of psychotic symptoms in a depressed client with suicidal ideation is an ominous sign and should be taken very seriously (Frierson, Melikian, &Wadman, 2002).

There are three types of psychotic symptoms which are particularly troublesome and could push a client to commit suicide: 1) auditory hallucinations commanding suicidal acts, 2) thoughts of external control, and 3) religious preoccupation (Frierson, Melikian, & Wadman, 2002). These authors suggest collateral interviews with family members who can help confirm psychosis.

These authors also contend that the evaluation of the client's environment is as important as evaluation of the client. Counselors need to inquire about social supports, as they may be an integral piece in the treatment plan to keep the client safe. An assessment of the client's access to firearms and other weapons is also a crucial piece of information. At this point, the client will be evaluated to determine whether he or she would be safer in the hospital or treated as an outpatient with social supports to assist the client in his or her natural environment.

Shawn Christopher Shea

The Chronological Assessment of Suicide Events (CASE approach) is the final suicide risk assessment model that will be discussed in this paper. The CASE approach comes from Shawn Christopher Shea (2002). Shea (2002) uses the term "suicide events" to include death wishes, suicidal thoughts or feelings, and actual suicide gestures and attempts. Shea (2002) believes it is important to explore four regions that range from the distant past to the present. Each of these regions are to be thoroughly explored for suicidal ideation and actions that were

present during that specific time frame. The four regions should be explored in the following order:

- 1) The presenting suicidal ideation and behaviors
- 2) Any recent suicidal ideation and behaviors (over the preceding eight weeks)
- 3) Past suicidal ideation and behaviors
- 4) Immediate suicidal ideation and future plans for its implementation

This order seems to be the natural flow of conversation for most suicidal clients. Shea (2002) has found that exploring the recent and the distant past improves the engagement of the client and the client learns that it's okay to talk about suicidal ideation. When trust is built up, the client's immediate plans for suicide must be explored more fully and directly.

Region One is the exploration of presenting suicide events. First, it is crucial to uncover the extent of the concrete planning. Once the severity is discovered, the counselor can determine the number of sessions needed or if hospitalization is needed. There is specific information that the counselor needs to determine the seriousness of the gesture or attempt. We need to know how the client tried to kill him or herself, as well as how serious was the action taken. We need to find out to what degree did the client intend to die. How does the client feel about the fact that the attempt was not successful? Find out how well-

planned out the attempt was. Did alcohol or drugs play a role? Did interpersonal factors have a major role? Did a specific stressor prompt the attempt? Finally, why did the attempt fail? Shea (2002) contends that answers to these questions can provide a clear window into the internal world of the client at the time of the attempt.

In Region Two Shea (2002) explains the exploration of recent suicidal events:

In this region, the clinician will elicit the types of suicidal thoughts and actions that the patient has had during the previous two months, hoping to gain insights into the degree of the patient's suicidal planning and intent. The more concrete and thorough the planning, and the more frequent and intense the ideation, the more concerned the clinician should be about acute suicide risk. (p. 163)

Counselors should know that suicide is not a simple act on a whim. Suicide takes careful planning, so this past two month period can provide critical insight into the client's frame of mind, ideation and plans. A counselor can gain wonderful insight into the client's pros and cons of suicide, which can then provide insight into the client's immediate risk. A counselor can also find out what types of plans for suicide the client has had and how far the client has acted on them (Shea, 2002). In this region, the process unfolds best by determining the following according to Shea (2002):

- 1) The specific plans that have been contemplated
- 2) How far the client took actions on these plans
- 3) How much of the client's time has been spent on these plans

The goal for the counselor is to gather the most reliable “information that will allow for the best educated guess—about the client's lethality potential” (Shea, 2002). The approach used in gathering information according to Shea (2002) is to be straightforward. “After the counselor finishes exploring the region of the presenting event, a gentle assumption (“What other ways have you thought of killing yourself?”) is used to delineate the next method of suicide being considered by the patient” (Shea, 2002). The counselor can continue with a series of gentle assumptions, always following up to clarify the extent of action taken on the specific method.

Region Three is exploration of past suicidal events. As stated at the beginning of this paper, time is in short supply. So spending too much time on this section may prove to be time ill-spent. Shea (2002) recommends gathering only the information that could potentially change the decision on the safe disposition of a client. The counselor, according to Shea (2002), should explore key points including the following:

- What was the most serious past suicide attempt?
- What is the approximate number of past attempts?

- Going back beyond the previous two months, when was the most recent attempt and how serious was it? (p. 177-178)

After exploring the region of past events, it is now time to turn to the single most important time frame with regard to predicting imminent dangerousness, the present (Shea, 2002).

Region Four is exploration of immediate events. This region focuses on the client's present suicidal intent, as well as inquiring into whether the client anticipates thoughts of suicide after he or she leaves the office. Shea (2002) considers this region to be Now/Next. At this point, if there are continuing concerns about the safety of the client, corroborative sources are crucial. It is important to evaluate existing support structures, and possibly implement specific interventions and plans for their use.

In this region of the CASE approach, "the task of "cementing" crisis plans is frequently facilitated by asking questions such as, "What would you do later tonight or tomorrow if you began to have suicidal thoughts again?" From the patient's answer, one can often surmise how serious the patient is about ensuring his or her own safety" (Shea, 2002). This always provides a chance to discuss and brainstorm plans for such an occurrence. Oftentimes, this kind of questioning can lead the counselor into the semi-controversial world of "safety contracting". In the CASE approach, the counselor is asked to use his or her clinical judgment to determine whether the safety contract is appropriate for that particular client. It

is important to note that safety contracts are in no way legally binding. These contracts may prove beneficial for some clients, but may prove very counterproductive for other clients. If the counselor has a relationship with the client, the contract might carry more weight, while if the counselor and client have just met; the power of the contract might be markedly less. In Shea's (2002) opinion, deterrence is not the main reason for using a safety contract. He believes that the process of negotiating a contract is better utilized as a sensitive assessment tool. When talking with the client about a contract, the counselor can pay attention to the client's face, body, and tone of voice for any signs of deceit or ambivalence. Clients' responses might be hesitancy to contract, avoidance of eye contact, or other signs of deceit or ambivalence.

Finally, in this region it is worth exploring the client's current level of hopelessness and to note whether the client is making productive plans for the future or is agreeable to making concrete plans for dealing with current problems (Shea, 2002). This is yet another way of gaining insight into the present state of dangerousness the client may or may not be in. The CASE approach is a very matter-of-fact approach. This approach helps the client to feel safe enough to talk about his or her secretive world of suicidal thought. Not only has the counselor gathered a plethora of valuable information, the counselor has also helped the client to share painful information. With the counselor's thoughtfulness and thoroughness, he or she has also conveyed the message to the client that a human

being cares. To a suicidal client, this caring person may be the first realization of hope (Shea, 2002).

Conclusion and Implications for Counselors

What do all of these statistics, risk factors, and models mean to mental health professionals? The information presented in this paper is to enlighten those professionals who are not in touch with the risk of suicide and how to deal with suicidal clients. The statistics presented are staggering. It is helping professionals who are supposed to be able to recognize and help those people suffering from hopelessness and depression. Counselors need to be very aware of the main risk factors involved in suicide attempts. It can be a life-saving measure to be able to quickly recognize that a client is at high risk for suicide, then move quickly into assessing for the risk with a more formal model.

The models presented in this paper are just three of many models out there. Most suicide risk assessment models are very similar. The purpose of the formal assessment is to help the clinician complete a structured assessment, to be more diligent and effective in assessing risk. As clinicians, it is our mission to help uncover possibly reversible suicidal ideation. It is not our job to offer reasons for why the client has landed where he or she has, but to help them realize hope. Despite counselor's best efforts, some clients may ultimately decide to end their lives and thus release themselves from the pain. But there are many other clients who want, need, and accept the help of a professional. These clients who

were once self-destructing will remember those counselors who helped them with their compassion.

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