Suicide Awareness and Occupational Therapy for Suicide Survivors

Sharon D. Novalis, PhD, OTR/L
Assistant Professor of Occupational Therapy
Chatham University
Pittsburgh, PA

This CE article was developed in collaboration with AOTA’s Mental Health Special Interest Section.

ABSTRACT
Suicide is a public health crisis. In 2015, within the United States, 44,193 individuals completed suicide, and an additional 1.4 million individuals attempted suicide (Centers for Disease Control and Prevention, 2017a).

Although much remains unknown about the underlying cause of suicidal ideation, behaviors, attempts, and completions, research has indicated contributory (not causal) risk factors and associated warning signs. Because of the multiple complexities associated with treating those at risk (including those who have lost someone to suicide), a holistic approach that recognizes the complexities of the individual, such as the approach of occupational therapy, is crucial.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Identify known risk factors associated with suicide
2. Describe appropriate steps to take in addressing suicidal behaviors
3. Differentiate grief experienced by suicide survivors from other types of grief
4. Identify appropriate clinical considerations and resources to enhance the occupational therapy approach when working with individuals at risk for suicide (including suicide survivors)

INTRODUCTION
Suicide is defined as “the act or an instance of taking one’s own life voluntarily and intentionally” (Suicide, 2017). Medical examiners or designees report their findings associated with the cause of death and record these findings on the death certificate. This means that the medical examiner or designee, to whatever degree possible, may be involved in determining the “intentionality” of the act that resulted in death. Therefore, not all deaths that are directly because of the deceased’s actions are considered suicide. An opioid overdose, for example, that unintentionally results in death might not be considered suicide. The cause of death noted by a medical examiner or designee is also noted by other entities and compiled for reporting and research purposes (for example, by the Centers for Disease Control and Prevention [CDC]).

Throughout this article, the terms completed suicide or death by suicide are used instead of committed suicide. The word committed in this sense may imply judgment of the person or act. Therefore, the words are purposefully and thoughtfully chosen, particularly in view of the stigma associated with suicide. The term suicide survivor refers to an individual who has lost someone to suicide.

The statistical data that follows has primary application to the United States; however, suicide is also a global health issue. The World Health Organization (WHO; 2017) reported that in 2015, approximately 800,000 deaths by suicide were reported worldwide. In 2015, within the United States, a reported 44,193 suicides occurred (CDC, 2017a), making suicide the country’s 10th leading cause of death. In addition, 505,507 individuals received medical care for self-inflicted injuries in 2015 (CDC, 2017a). Researchers estimate that for every person who has completed suicide, approximately 11 to 25 individuals have attempted suicide (CDC, 2017a; National Institute of Mental Health [NIMH], 2016). Data from the Substance Abuse and Mental Health Services Administration’s 2015 National Survey on Drug Use and Health found that within the previous year, “9.8 million adults (18 years of age and older) seriously contemplated completing suicide, 2.7 million actually made plans, and 1.4 [million] had an actual attempt” (NIMH, 2016).

A more specific, brief summary by the CDC (2017a), based on data from 2015, found suicide to be the second leading cause of death among 15 to 34 year olds, after death caused...
by unintentional injury. Suicide is the third leading cause of death among 10 to 14 year olds, the fourth among 15 to 18 year olds, the fifth among 19 to 24 year olds, and the sixth among 25 to 30 year olds. Statistical data are also available regarding the prevalence of suicide among various ethnicities and races, the means and methods used in the completed suicides of 2015, and the economic burden associated with suicide (CDC, 2017a).

**Risk Factors**

Through research, risk factors have been identified that are associated with completed suicide. The presence of any of these risk factors does not imply absolutely that a suicide would be attempted. The factors do, however, indicate where caution needs to be used. Wherever possible, steps should be taken to reduce the number and/or intensity of risk factors.

The CDC (2017b) notes that risks factors include but are not limited to:

- Family history of suicide; family history of child maltreatment; previous suicide attempt(s); history of mental disorders, particularly clinical depression; history of alcohol and substance abuse; feelings of hopelessness; impulsive or aggressive tendencies; cultural and religious beliefs (e.g., belief that suicide is a noble resolution of a personal dilemma); local epidemics of suicide; isolation; a feeling of being cut off from other people; barriers to accessing mental health treatment; loss (relational, social, work, or financial); physical illness; easy access to lethal methods; and/or an unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts.

Again, these risk factors are considered to be contributory, not causal.

Suicidal ideation, suicidal behaviors, and suicide attempts are considered to be psychiatric emergencies. However, occupational therapy practitioners need to be aware of these contributory risk factors potentially present in clients, regardless of practice setting and area (i.e., not only in mental health practice settings). Research findings associated with an increase in the prevalence of suicidal ideation, suicide attempts, and completions among those who experience physical illness, disease, or trauma, further underscore the importance of occupational therapy practitioners' awareness of contributory risk factors. Kashiwa, Sweetman, and Helgeson (2017) addressed the high rate of suicide among veterans, as well as the contributing risk factors experienced by veterans. Individuals who have experienced bullying have also been identified as being at risk for suicide (American Occupational Therapy Association [AOTA], 2011; CDC, 2014). McIntosh and colleagues (2016) provided information on suicide rates as grouped by identified occupation and also offered interesting commentary as to potential contributing factors, including, in some instances, the exposure to various environmental pathogens. Research has also examined associated increased prevalence of suicide and chronic pain (Wilson, Kowal, Henderson, McWilliams, & Péloquin, 2013), lupus (Tang, Lin, Chen, Chen, & Chen, 2016), stroke (Pompili et al., 2012), traumatic brain injury (Fisher et al., 2016), spinal cord injury (Cao, Massaro, Krause, Chen, & Devivo, 2014), Parkinson's disease (Lee et al., 2016), amputation (Jammillo, 2015), Type I diabetes (Siddharth & Yatan, 2014), posttraumatic stress disorder (Selaman, Chartrand, Bolton, & Sareen, 2014), and rheumatic disease (Shim et al., 2017). This is by no means an exhaustive list. Whether contributing factors (e.g., mental illness) might be present before the onset of the client's condition, risk factors are consequential to the client's condition, or a traumatic life event or accident occurs (e.g., a life experience resulting in posttraumatic stress disorder, a disabling car accident), occupational therapy practitioners need to be aware of contributing factors to suicide and be able to provide an appropriate response.

A few comments need to be made regarding suicide survivors—those who have experienced the loss of someone to suicide. Suicide survivors are also sometimes referred to as suicide bereaved.

Research estimates regarding the number of survivors for every individual death by suicide vary, ranging from an average of six (Berman, 2011) to 115 (Spinno, Kameg, Cline, Terhorst, & Mitchell, 2016). The severity of the impact may be influenced by the relationship to the deceased (e.g., spouse, sibling, child, friend, co-worker, client), the circumstances surrounding the suicide, and the aftermath of the suicide (Cerel, Jordan, & Duberstein, 2008; Cerel, Maple, Aldrich, & van de Venne, 2013; Erlich, 2016; Grad, Clark, Dyregrov, & Andriessen, 2004; Mitchell, Sakraida, Kim, Bullian, & Chiappetta, 2009; Rostila, Saarela, & Kawachi, 2014). Suicide survivors may experience the stigma associated with suicide, resulting in isolation (Grad et al., 2004; Hansschmidt, Lehnig, Riedel-Heller, & Kersting, 2016). There may be a sudden change or end of a life role secondary to the loss (e.g., loss of the role of spouse, parent, sibling, child, client). Survivors may experience psychological and somatic declines that affect psychological, cognitive, and physical health status as well as a decline in the ability to carry out responsibilities (e.g., family, employment) (Rostila et al., 2014; Terhorst...
More specifically, Rostila et al. (2014) discussed “adverse health effects” associated with being a suicide survivor, including increased risk for suicide, cardiovascular disease, and “pathophysiological changes in the sympathetic nervous system, the hypothalamic-pituitary-adrenal (HPA) axis, and the immune system” (p. 920). Research also indicates that survivors of suicide grieve differently than survivors of death by other means and are at risk for complicated grief, which may persist for years, including shame, guilt, feelings of responsibility for the suicide, and feelings of rejection (Bailley, Kral, & Dunham, 1999; Brower, 2017; Gall, Henneberry, & Eyre, 2014). Mitchell, Kim, Prigerson, and Mortimer-Stephens (2004) further indicated that suicide survivors’ complicated grief may be associated with cardiovascular issues, cancer, immune disorders, and unhealthy behaviors (e.g., increase in smoking, negative change in eating habits). Given the range of potential health complications associated with being a suicide survivor, occupational therapy practitioners need to be alert to the possibility that a client will present with a primary condition of a cardiovascular disorder, for example, and potentially with underlying issues resulting from complicated grief.

The information discussed in the preceding paragraphs indicates the complex nature of suicide as well as the complexities involved in being a suicide survivor. Although medical research continues to explore pathophysiology, genetics, brain structure, and function, there are no definitive diagnostics to determine risk or provide a prognosis related to suicide. Short of an obvious suicide attempt, clinical observations and honest self-report (such as during a depression screening) are the primary methods of determining an individual’s level of risk for suicide or for suicide survivors’ psychological or physical functional status. Occupational therapy could be one of several qualified, responsive health care services received by an individual. Research indicates that a combination of medication and psychotherapy is the most effective treatment, particularly for individuals with mental health conditions that put them at risk for suicidal ideation (American Foundation for Suicide Prevention [AFSP], 2017). It is beyond the scope of occupational therapy to address every component of the client’s condition (i.e., occupational therapists do not provide diagnoses, prescribe medications, provide psychotherapy). Occupational therapy does, however, have a valuable role in working with those at risk for suicide and with those identified as suicide survivors.

Treatment for individuals who have suicidal ideation and/or behaviors is obviously linked to the identifiable underlying contributing factors. However, beyond an awareness of contributing risk factors, occupational therapy practitioners need to be aware of other potential indicators that an individual may be suicidal. The AFSP (2017) has provided information regarding warning signs that an individual might be contemplating suicide, namely:

Changes in behavior (such as increased use of alcohol or drugs, recklessness, withdrawal and/or isolation, looking for ways to complete suicide, giving away possessions), changes in mood (displays of depression, anxiety, loss of interest, rage, irritability, humiliation), and what a person says (talking about killing oneself, being a burden to others, feeling trapped, having no reason to live, being in unbearable pain).

Occupational therapy practitioners should be aware of any of these indicators that are expressed by clients and immediately follow the protocol as established by the employer or facility for such an emergency. Typically, the protocol will include steps to keep the client, one’s self, and others safe; how to summon emergency support if necessary; and how to ensure the treatment includes communication with one another (and emergency personnel, if necessary). Documenting the client’s words or actions and the occupational therapy practitioner’s response will likely occur within the occupational therapy note or through another method (such as an incident report, or client concern report). These documents are typically part of the client record and should be considered legal documents, with the hallmarks of accuracy, clarity, and factual relevance. Occupational therapy assistants should immediately report any concern or change in client status to the occupational therapist in the event that further evaluation or modification of the treatment plan is warranted. Methods of communication to part-time and/or per diem employees should also be established so that they are aware of the client’s status.

**Role of OT in Suicide Awareness and Working With Survivors**

As seen in the information presented thus far, occupational therapy practitioners may be treating individuals at risk, including survivors, regardless of setting or area of practice. Kashiwa et al. (2017) presented a compelling discussion regarding the need for occupational therapy practitioners to examine their professional roles and responsibilities in addressing suicide awareness and prevention with the veteran population (and others). Although Hewitt and Boniface (2014) indicated that many occupational therapy practitioners think they are “ill-prepared to address suicide-related issues” (p. 13), they have many professional tools available and need to consider their therapeutic approaches, both in assessments and interventions, based, at minimum,
on models of practice, frames of reference, and the Occupational Therapy Practice Framework: Domain and Process (3rd ed.; Framework; AOTA, 2014). The Framework and other models of practice can help practitioners develop a clinical approach that sustains the holistic views of occupational therapy. Additionally, although frames of reference assist practitioners in specific focuses of practice, the Framework and various models of practice provide a greater perspective that will many times include the dynamic interactions of environment, culture, occupation, and personal life roles of the client. In connection with this, Gutman (2005) provided several occupational therapy treatment suggestions, with a primary focus on client and family education. She highlighted the importance of client and family awareness of symptoms related to psychiatric conditions, exacerbations of those conditions (including the negative effects of drugs and alcohol), and understanding the importance of compliance with medication management. She also discussed the value of “contingency plans,” which outline steps to take if the client has an exacerbation of symptoms. Contingency plans are particularly useful if the client can participate in creating the plan, as a means, in some sense, to self-direct appropriate action in the event of a relapse. The Framework defines prevention as “education or health promotion efforts designed to identify, reduce, or prevent the onset and reduce the incidence of unhealthy conditions, risk factors, diseases, or injuries” (AOTA, 2014, p. S44). Gutman’s suggestions are certainly in alignment with this definition.

Addressing the occupational needs of the client is a core characteristic of occupational therapy (Lamb, 2016). To that end, occupational therapy practitioners need to apply all their knowledge of human condition and activity analysis within a therapeutic environment and through the therapeutic use of self to most effectively address the client’s engagement/re-engagement. Although occupational therapy interventions might involve various functional activities (e.g., dressing, bathing, cooking, managing medications), occupational therapy practitioners must look deeper than the client’s performance of the activity (i.e., functional status or components that affect functional status, such as decreased range of motion or strength, or attention span) to understand what meaning the activity has to the client and the client’s consequent level of engagement. Functional status and/or performance components offer important information regarding the client’s ability and potential; however, the client’s interpretation of meaning is critical to sustained engagement.

Velde and Fidler (2002) asserted that:

An activity encompasses a number of elements that contribute to defining the nature and characteristics of the activity. These include form and structure, action processes, properties, discernable outcome, and real and symbolic meaning. It is important to distinguish activity from occupation. While occupation is defined and understood as the dynamic, complex process of being engaged in “doing,” it is not a synonym for activity; rather, it connotes the dynamic process of doing. It is the phenomenon of mind and body being occupied. (p. 5)

This is relevant because individuals who contemplate suicide are literally contemplating, if not already experiencing, a dis-engagement. Even for those clients who are seeking physical rehabilitation through the occupational therapy process, practitioners need to take into account the effects of reduction in the client’s ability to engage in meaningful occupation when full rehabilitation may not take place. Fine (1999) described the ability to find meaning in “one’s self, one’s activities, [and in] the broader world of people and things around us, [as an invaluable ‘gift’ that allows for] adaptation and growth for both the individual and society” (p. 12). Fidler and Velde (1999) also placed value on the symbolic importance of purposeful activity and occupation, and the importance, as occupational therapy practitioners, of assisting the client in sustaining the engagement, or the “doing” of those activities (Fidler & Velde, 1999; Velde & Fidler, 2002). In such instances, when a client no longer views themselves as able to meaningfully engage, occupational therapy practitioners need to be able to navigate through the symbolic meaning of the occupation and assist the client in adapting and renegotiating either the manner or level of engagement or the meaning of that engagement. To provide the appropriate occupational therapy intervention, practitioners must understand the relevance of various activities to the client’s personal sense of meaning and interests, and more broadly, the relevance to the client’s personal and societal relationships.

Through therapeutic use of self, thorough client-centered activity analysis, and applying occupational therapy models of practice, the occupational therapist can address the client’s strengths and risk factors as well as physical, cognitive, and psychological components that might interfere with or facilitate engagement in meaningful activity and occupational performance. By applying these tools and approaches, occupational therapists can determine whether the goal is “health promotion, rehabilitation/restoration, remediation, health maintenance, adaptation, or prevention” (AOTA, 2014, p. S33). Educating the client to actively participate in identifying this overall goal as well as establishing
the appropriate steps is critical to successful intervention. Assisting the client in developing awareness of self (e.g., personal signs and symptoms of exacerbation of depression or the awareness of low self-esteem); knowledge (e.g., identifying coping strategies and resources); and perhaps even a health and wellness plan (e.g., self-care, exercise and diet, community engagement) are all preparatory activities. The occupational therapy process for clients should also include having the client actually perform the tasks or activities associated with the plan that has been developed. In so doing, practitioners are better positioned to respond to the client’s level of engagement and the perceptions of the client on the larger relevance and meaning of their engagement as part of “health promotion, rehabilitation/restoration, remediation, health maintenance, adaptation, or prevention” (AOTA, 2014, p. S33).

These concepts associated with the occupational therapy process apply to suicide survivors as well because of the identified potential complexities of physical and mental health challenges experienced by survivors following a loss as well as the survivor’s own risk for suicide.

ADVOCACY

Occupational therapy practitioners can advocate for methods that support suicide prevention awareness, research, and services. Many avenues are available for participation, such as supporting state and national occupational therapy political action committees; participating in lobbying efforts and town hall meetings; and participating in various volunteer organizations, such as the AFSP. Occupational therapy practitioners can also be leaders by developing and maintaining professional competencies; providing advocacy through documentation and reporting; and addressing third-party requests (e.g., medical review) in a thorough, accurate, and compelling manner. Such efforts can also provide a powerful example to clients of relevant methods of advocacy while discussing the need for services and appropriate resources. Given the number of risk factors and warning signs, as well as the potential for an extended, complicated grief process, occupational therapy practitioners should consider the benefits of advocating for occupational therapy services to be made available as part of the primary care process as well as potential for providing follow-up services.

Occupational therapy practitioners can advocate for required education on the topic of suicide awareness and prevention, as has occurred in several states (including Washington and Kentucky) to maintain state licensure for occupational therapy practice.

Occupational therapy practitioners can also be advocates by engaging in evidence-based practice and research. Searching for evidence and discussing the evidence with colleagues and other health care professionals can help establish the clinical basis and rationale for services. Participating in qualitative and quantitative research through compiling assessment and outcomes data and providing case studies (in accordance with facility research protocols and requirements) will further develop the body of knowledge and potentially help substantiate the need for and value of occupational therapy services.

AOTA (2017) provides strategies and tools to support practitioners in addressing and advocacy for mental health services. These tools include resources that assist practitioners in developing their own evidence-based practice as well as tools that can be used to educate others on the value of occupational therapy in addressing mental health.

CLINICIAN AS SURVIVOR

What would happen if an occupational therapist or occupational therapy assistant at some point in their career or personal life became a suicide survivor? The statistical information presented at the beginning of this article, as well as the information related to contributory risk factors, gives evidence that a great number of people are at risk. Whether occupational therapy practitioners work in the mental health practice area, or pediatrics, or physical rehabilitation, there will be clients who are at risk. Even if an individual is receiving treatment, they may still go on to complete suicide.

It is vital that occupational therapy practitioners take the necessary steps to address the effects of a suicide professionally and personally. Occupational therapy practitioners are not immune to the effects of a traumatic loss, such as suicide. Although blame, guilt, and anger might be a part of the “normal” grieving process associated with loss to suicide, prolonged and unresolved grief carries its own risks of psychological and physical harm. Seeking support is a crucial step professionally and personally. Attending to personal health and wellness to maintain an appropriate sense of balance through traumatic loss is also important. Through the grieving process, this balance is challenged. As Fielden (2003) noted, the transformation through grief related to a loss by suicide may include “ebb and flows” and “spirals inward and outward” (p. 83) until the survivor reaches a point of renegotiation and understanding, where new beginnings can occur.

Fine (1999) also stated that “there is a unique human need to understand and give meaning to our experiences” (p. 12). Occupational therapy practitioners will also likely seek understanding and meaning in experiencing a loss by suicide. Of course, many aspects of occupational therapy concepts...
and the Framework can also be personally applied. However, practitioners should not hesitate to seek out help from others who are trusted and qualified (e.g., physicians, family members, friends, religious/spiritual leaders, mental health professionals).

CONCLUSION

Statistical data and the known risk factors indicate that occupational therapy practitioners will likely encounter those who are at risk of suicide and those who are suicide survivors. They need to be aware of the identified risk factors and warning signs to respond appropriately.

Occupational therapy has a role in addressing the needs of those who are at risk for suicide or are suicide survivors. Applying models of practice, frames of reference, activity analysis, and the Framework can facilitate evaluation and treatment approaches that focus on the re-engagement of the client by addressing the factors that interfere with engagement, and potentially adapting to facilitate engagement in other ways or in other activities that are equally meaningful and purposeful to the client.

Although much research is still needed to understand the complexities and mechanisms that lead to suicide, occupational therapy practitioners need to continue to examine and enhance approaches to occupational therapy services for those at risk and for those who are survivors as well. Occupational therapy can have a positive effect in assisting clients to find ways to sustain their engagement and find meaning in their lives.

REFERENCES


Earn .1 AOTA CEU (one contact hour and 1.25 NBCOT PDU). See below for details.


---

How to Apply for Continuing Education Credit

A. To get pricing information and to register to take the exam online for the article Suicide Awareness and Occupational Therapy for Suicide Survivors, go to http://store.aota.org, or call toll-free 800-729-2682.

B. Once registered and payment received, you will receive instant email confirmation, with password and access information to take the exam online immediately or at a later time.

C. Answer the questions to the final exam found on pages CE-7 and CE-8 by November 30, 2019.

D. On successful completion of the exam (a score of 75% or more), you will immediately receive your printable certificate.

---

Final Exam

Article Code CEA1117

Suicide Awareness and Occupational Therapy for Suicide Survivors

November 27, 2017

To receive CE credit, exam must be completed by November 30, 2019

Learning Level:  Intermediate

Target Audience:  Occupational therapists and occupational therapy assistants

Content Focus:  Professional Issues and Process of OT

1. In 2015, the number of reported deaths by suicide within the United States was:
   A. 800,000
   B. 44,193
   C. 21,000
   D. 50,000

2. In 2015, approximately how many people in the United States made a suicide attempt?
   A. 15,000
   B. 3 million
   C. 1.4 million
   D. 800,000
3. Suicide is the second leading cause of death among 15 to 35 year olds, second only to:
   A. Homicide
   B. Traumatic brain injury
   C. Unintentional injury
   D. Cancer

4. As identified through research, risk factors for suicide include all the following except:
   A. History of suicide attempt
   B. Family history of suicide
   C. Presence of mental illness
   D. Active community engagement

5. If an individual exhibits suicidal behaviors during a treatment session, the first course of action would be:
   A. Provide an occupational therapy assessment to identify the underlying causes of the behaviors
   B. Provide the client with alone time so they can process their feelings and/or behaviors
   C. Remove the client from any object or means that potentially could be used to inflict self-harm (or could be used to harm others) and seek emergency support personnel
   D. Document the behaviors and provide a report at the upcoming weekly staff meeting

6. Current research indicates that an individual’s attempt to complete suicide is:
   A. Likely a response to multiple factors that need to be addressed
   B. Because of a single isolated life event
   C. Can always be known
   D. Not serious if the person did not actually complete the suicide

7. The cause of an individual’s intention to complete suicide:
   A. Can be determined through a blood test
   B. Can be determined through a brain scan
   C. Can be pre-determined through genetic testing
   D. Cannot yet be determined, in that no definitive diagnostic methods are available

8. Currently, research indicates that the most effective method(s) of treating individuals with mental health conditions that put them at risk for suicide is/are:
   A. Electroconvulsive therapy
   B. Long-term institutionalization
   C. A combination of medication and psychotherapy
   D. Medications only

9. Occupational therapy practitioners will encounter individuals who have suicidal ideation, made an attempt to complete suicide, or are an identified suicide survivor:
   A. In the mental health practice setting only
   B. In the pediatric practice setting only
   C. In physical rehabilitation only
   D. In any and all practice settings

10. The individual who will determine the meaning of an activity to a client is:
    A. A significant other or spouse
    B. Other immediate family member (parent, sibling, child)
    C. The client
    D. The occupational therapist or occupational therapy assistant

11. An occupational therapist who uses a holistic approach in working with clients will consider:
    A. Dressing, bathing, and functional mobility only
    B. Paper-and-pencil activities to address self-esteem issues only
    C. Components of activity and occupational performance as well as the larger context of meaning to or for the client and the effect on the client’s “world”
    D. Only the components listed on the evaluation or treatment plan form

12. Occupational therapy practitioners who use a holistic approach will consider:
    A. Applying activity analysis, models of practice, frames of reference, and the Occupational Therapy Practice Framework: Domain and Process
    B. Only what is required by the client’s insurance or payer
    C. Only what is required on the evaluation or treatment plan form
    D. Only aspects of client care that are specific to the setting