The British Psychological Society
Promoting excellence in psychology

Position Statement:

Understanding and preventing suicide: A psychological perspective

Introduction

Early identification of suicidal thoughts and behaviour, and effective care for those of us at risk, are crucial in ensuring people receive the care they need and deserve.

Suicide is preventable and it is unacceptable that 6188 people died by suicide in the UK in 2015 (Office of National Statistics, Suicide in the UK, 2015 registrations). Men, particularly those aged 20–29 years and those aged 40–49 years, are most at risk of suicide, but the rising rates of suicide by women and those in the criminal justice system are extremely worrying (Office of National Statistics, Suicide in the UK, 2015 registrations).

No civilised and caring society should tolerate this level of despair, hopelessness and avoidable tragedy. The early identification of suicidal thoughts and behaviour, and effective care for those of us at risk, are crucial in ensuring people receive the care they need and deserve. Action at an early stage is core to any strategy for suicide prevention.

Although the causes of suicide are many, understanding the psychological processes underlying suicidal thinking and the factors that lead to people acting on their thoughts of suicide is vital to enabling the development and implementation of effective prevention and intervention techniques. This includes understanding the social factors and health inequalities that lead to a sense of hopelessness and despair, and understanding how we as individuals make sense of and respond to challenges in our lives. Psychologists have made significant contributions to our understanding of the interconnected nature of the causes of suicidal behaviour.

'Every 40 seconds a person dies by suicide somewhere in the world and many more attempt suicide.'
(WHO, 2014, p.3)

Suicide and non-fatal suicidal behaviour are major public health concerns. Suicide is the 14th leading cause of death worldwide, responsible for 1.5 per cent of all mortality (O'Connor & Nock, 2014) and it is the leading cause of death among young and middle-aged men in the UK (ONS, 2015). However, despite the prevalence of suicide, it '…has remained a low public health priority. Suicide prevention and research on suicide have not received the financial or human investment they desperately need.' (WHO, 2014, p.13)

Suicidal behaviour refers to thoughts and behaviours related to suicide and self-harm that don't have a fatal outcome. These thoughts include the more specific outcomes of suicidal ideation (an individual having thoughts about intentionally taking their own life); suicide plan (the formulation of a specific action by a person to end their own life) and suicide attempt (engagement in a potentially self-injurious behaviour in which there is at least some intention of dying as a result of the behaviour).

Although suicide usually occurs in the context of mental health conditions (e.g. depression) there are many risk factors for suicide (Turecki & Brent, 2015; Hawton et al., 2012). Indeed, a past history of suicidal behaviour or self-harm is one of the strongest predictors of death by suicide (Carroll et al., 2014). Self-harm is defined as intentional self-poisoning or self-injury, irrespective of motive (NICE, 2011). As a result, much research and clinical attention has focused on those who self-harm as the latter is an important predictor of suicide irrespective of whether the previous self-harm had a suicidal motive or not (Cooper et al., 2005).

Whilst much research has been conducted to determine the causes of suicidal behaviour, what lies behind the decision to end one's life is not fully understood. Nevertheless, it is well recognised that a range of complex factors influence this behaviour. Identifying the mechanisms by which various factors are associated with an increase in suicidal behaviour is a way of working towards effective prevention and intervention. 'Suicide is perhaps the cause of death most directly affected by psychological factors because a person makes a conscious decision to end his or her own life.' (O'Connor & Nock, 2014). Thus, psychology is central to understanding and preventing suicide.

The challenge

In 2015 the suicide rate across the UK reached 10.9 deaths per 100,000 population. Men, particularly those under the age of 49, were most at risk of suicide, but the female suicide rates were the highest they have been in a decade. Three-quarters of all suicides are men. There continue to be variations in the suicide rates across the constituent countries of the UK. Northern Ireland had the highest suicide rate in the UK at 19.3 deaths per 100,000 population whilst Scotland and Wales had rates of 13.9 and 13.0 deaths per 100,000 population, respectively. England had the lowest rate at 10.1 deaths per 100,000 (ONS, Suicide in the UK, 2015).

Approximately one third of people who die by suicide are under the care of specialist mental health services, one third are in contact with their GP but not receiving special mental health treatment, and one third have not been in contact with health services 12 months before their death (NCIS, 2014, 2016). Over half of the patients who die by suicide in UK have a history of alcohol or drug misuse. (NCIS, 2016). Economic factors are becoming more common as antecedents in patient suicides. Unemployment and homelessness have increased and 13 per cent of patients who died by suicide had experienced serious financial difficulties in the previous three months (NCIS, 2016). Evidence from in-depth studies of the history of suicidal behaviour prior to suicide suggests that there is evidence of a mental health disorder in 90 per cent of suicides (Cavanagh et al., 2003). However, given that less than 5 per cent of people treated for depression kill themselves (Bostwick & Pankratz, 2000) and that our ability to predict suicide has not advanced markedly in recent decades (Franklin et al., 2017), the challenge is to identify more specific markers of suicide risk (O'Connor & Nock, 2014). To this end, there has been renewed focus on psychological factors and novel approaches to understanding suicide and self-harm.

The psychological risk and protective factors

In addition to the established role of psychiatric disorders/mental health conditions in suicide risk (Turecki & Brent, 2015; Hawton et al., 2012), personality and individual differences, cognitive factors, social factors and negative life events are all associated with suicide risk. The key psychological risk/protective factors for suicidal ideation and suicidal behaviour are indicated in Table 1 **(right)** and the evidence for these factors is summarised in O'Connor & Nock (2014).

In recent decades a number of theoretical models have been developed to describe the pathways to suicide (Joiner, 2005; Johnson et al., 2008; O'Connor, 2011; Klonsky & May, 2014). A commonalty across most of these models is that they are grounded within the ideation to action framework (Klonsky, 2014); namely that the factors leading to suicidal thinking are distinct from those that govern the transition from thinking about suicide to attempting suicide (O'Connor, 2011; O'Connor & Nock, 2014). One of these models, the integrated motivational-volitional (IMV) model of suicidal behaviour (IMV; O'Connor, 2011), maps the final common pathway to suicidal behaviour. In brief, the IMV model suggests that suicidal ideation emerges from feelings of defeat or humiliation from where there is no escape (O'Connor, 2011; O'Connor et al., 2013). Whether someone acts on their thoughts of suicide is governed by a range of factors, labelled *volitional moderators* (e.g. impulsivity, exposure to suicide, acquired capability, planning, access to the means of suicide), the presence of which increases the likelihood that suicide attempts/death by suicide will occur. For example, if someone has thoughts of suicide and is impulsive or knows someone close to them who has died by suicide, they are more likely to act on their thoughts of suicide. Theories such as the IMV model are important not only to advance our understanding of suicide risk but also because they form the basis for intervention development. However, the complexity of suicide risk should not be underestimated.

The complexity of suicide risk

Biopsychosocial models attempt to integrate the understanding of biological, psychological and

Table 1: Psychological risk and protective factors for suicidal ideation and behaviour.

Personality and individual differences	**Cognitive factors**
Hopelessness	Cognitive rigidity
Impulsivity	Rumination
Perfectionism	Thought suppression
Neuroticism and extroversion	Autobiographical memory biases
Optimism	Belongingness and burdensomeness
Resilience	Fearlessness about injury and death
	Pain insensitivity
	Problem solving and coping
	Agitation
	Implicit associations
	Attentional biases
	Future thinking
	Goal adjustment
	Reasons for living
	Defeat and entrapment
Social factors	**Negative life events**
Social transmission	Childhood adversities
Modelling	Traumatic life events during adulthood
Contagion	Physical illness
Assortative homophily	Other interpersonal stressors
Exposure to deaths by suicide of others	Psychophysiological stress response
Social insolation	

Adapted from O'Connor & Nock (2014).

sociocultural factors associated with an increased risk of suicidal behaviour and death by suicide. They recognise that these behaviours cannot be understood from any one perspective alone. Instead suicidality is best explained as a complex interplay between risk factors across domains. As an illustration, consider the association between unemployment and suicide. Exposure to high rates of unemployment can affect an individual's feelings of hopelessness or entrapment – to increase risk of suicidality. However, not everyone who is unemployed will feel suicidal. Risk factors are likely to interact with one another in complex ways to determine vulnerability. It is valuable to consider the contribution of biological, psychological and social factors at every point in the suicidal process. Psychological processes can be described as the biological and social factors which act to increase the risk that a person will end their life. However, even at this point, environmental factors such as the availability of means of suicide, and psychological factors, such as an individual's propensity to select between these means, will influence the likelihood of death. Thus understanding the complex interplay between the various biological, psychological and social risk factors that contribute to risk of suicidality is critical to the development of comprehensive and effective suicide prevention and treatment approaches.

Risk assessment

Although risk factors that increase the propensity to engage in suicidal behaviour have been identified, suicide remains a rare event and most risk factors have little positive predictive value in determining likelihood of eventual death by suicide (Turecki & Brent, 2015; Hawton et al., 2012; Franklin et al., 2017). Likewise, as reviewed by Bolton et al., (2015), although a number of risk assessment scales for suicide exist none to date provide enough robust evidence to justify their routine use in clinical settings and the vast majority are limited by their reliance on patient self-report (see also, Quinlivan et al., 2017; Chan et al., 2016). Novel, evidence-based methods of suicide risk assessment are being developed, but these are still at an early stage. The National Institute for Health and Care Excellence supports the importance of conducting an assessment of patient risk and needs, but does not support the use of specific risk assessment tools (www.nice.org.uk/donotdo/do-not-use-risk-assessment-tools-and-scales-to-predict-future-suicide-or-repetition-of-selfharm). All individuals who present to hospital following self-harm should receive a caring

assessment, which takes into account individual, social and behavioural influences. Such an assessment should address an individual's clinical history and current condition, their previous suicidal behaviour, and their current suicidal thoughts and plans. It should also address their social context, help them to keep themselves safe when in crisis and support them in obtaining ongoing clinical treatment, as required.
A compassionate psychosocial assessment plays an important role in establishing a positive therapeutic relationship between a clinician and patient in distress. It is important to ask about suicide in a direct but sensitive manner. Although clinicians can be concerned about exploring suicidal thoughts, there is no evidence to suggest that talking about suicidal thoughts and plans increases risk of suicidal ideation or self-harm, and some evidence that it is beneficial for those at higher risk (Dazzi et al., 2014).

Prevention

'Early identification and effective management are key to ensuring that people receive the care they need' (WHO, 2014, p.9). There are two important aspects to prevention, as noted above: (i) understanding the factors associated with suicidal thinking/ideation with a view to reducing distress; and (ii) reducing the likelihood that an individual makes a suicide attempt or dies by suicide. It is important to understand the psychological processes underlying each aspect as interventions must be tailored to each; for example, intervention at the suicide ideation stage would be specifically targeted at preventing progression to suicidal attempt.

National suicide prevention strategies tend to adopt a dual track approach of implementing large-scale public health interventions, such as restricting access to lethal means of suicide as well as intervening with those at high risk (WHO, 2014). High risk groups may include those who have self-harmed in the past; they are important group to target given the established relationship between self-harm and future death by suicide.

Restricting access to means

Restricting access to means involves implementation of measures to reduce availability of and access to frequently used means of suicide (e.g. drugs, fire arms, enhancing safety of bridges). Internationally, there is consistent evidence that restricting access to lethal means is associated with a decrease in suicide and that substitution to other methods is limited (Zalsman et al., 2016).

Education

Educating health care and community-based professionals to recognise depression and early signs of suicidal behaviour is important for determining level of care and referral for treatment, and subsequent prevention of suicidal behaviour (Wasserman et al., 2012; Coppens et al., 2014). Sustainability and capacity building of trainers and benefits in terms of knowledge, attitudes and confidence can be achieved via a Train-The-Trainer model (Coppens et al., 2014; Isaac et al., 2009). There are some indications for a link between improvements in intermediate outcomes (e.g. improved knowledge, attitudes and confidence) among health care and community-based professionals and primary outcomes (e.g. reduced suicide and self-harm rates; Mann et al., 2005; Hegerl et al., 2011; Zalsman et al., 2016).

Public information campaigns

There is emerging evidence for increasing awareness via public information campaigns to improve the care for people diagnosed with depression and simultaneously address awareness and skills in early identification of suicide risk among healthcare and community-based professionals (Szekely et al., 2013; Hegerl et al., 2013), with proven synergistic effects of simultaneously implementing evidence-based interventions (Harris et al., 2016).

Responsible media reporting

The importance of responsible media reporting of suicide in print, broadcast, internet, and social media is underlined by Niederkrotenthaler et al. (2014). The role of mass media has been shown to be effective in reducing stigma and increasing help seeking behaviour. There are also indications of promising results based on multi-level suicide prevention programmes (Niederkrotenthaler et al., 2014).
A systematic review covering 30 studies on social media sites for suicide prevention (Robinson et al., 2016) showed that social media platforms can reach large numbers of individuals and may allow others to intervene following expression of suicidal behaviour. However, reported challenges include lack of control over user behaviour, possibility of suicide contagion, limitations in accurately assessing suicide risk, and issues relating to privacy and confidentiality.

Intervention – How effective are psychosocial interventions?

Preventing repeat self-harm is a crucial part of suicide prevention efforts since, as noted earlier, many who die by suicide have previously engaged in such behaviour (NCIS, 2016). The gold-standard method for assessing the effectiveness of interventions is a randomised controlled trial (RCT).

Adults

Recently, two systematic reviews have synthesised the worldwide RCT evidence on the effectiveness of interventions for self-harm (Hawton et al., 2015; Hawton et al., 2016a). These reviews demonstrate that there is now strong evidence that psychological therapies such as problem solving behaviour, dialectical behaviour therapy (DBT) and cognitive behavioural therapy (CBT) (so called 'talking therapies') can effectively prevent the repetition of self-harm in adults (people aged 18 years old and over) (Hawton et al., 2016a, 2016b). They have also been shown to reduce the psychological distress associated with such behaviours (Townsend et al., 2001, Hawton et al., 2016a, 2016b).

Under 18s

For younger people (those aged under 18 years old) the evidence is very limited – with only eleven trials uncovered that have tested an intervention to prevent repeated self-harm in young people (Hawton et al., 2015). Moreover, the evidence is more equivocal for psychological interventions in this age group (Townsend 2014; Hawton et al., 2015). So, for DBT (2 RCTs) and group-based psychotherapy (3 RCTs) meta-analysis revealed no significant effect in terms of reducing the number of people repeating self-harm (group therapy) or the frequency of self-harm (DBT). However, there is some evidence (from one trial) that mentalisation-based therapy, an integrative form of psychotherapy, may be helpful in preventing repeated self-harm (Rossouw et al., 2012).

Vulnerable groups

A wider issue is whether those who are particularly vulnerable receive the support or treatment that they need. Bruffaerts et al. (2011) found that roughly 60 per cent of people with suicidal thoughts and behaviour do not receive treatment. For those who do, there are very few evidence-based treatments (such as prevention programmes, pharmacological interventions and psychological treatments) that are available. Thus it is important that there are tailored services to target specific groups, including: men, pregnant women and new mothers, people in the criminal justice system, children and young people, people leaving the care of mental health services, and people who self-harm. Another challenge is that despite 75 per cent of the world's suicides occurring in low and middle income countries (Vijayakumar & Phillips, 2016), the vast majority of research and evidence is gathered in high income countries.

Self-harm

Some recent encouraging evidence suggests that a very brief intervention based on implementation intentions (a volitional help sheet) may reduce repeated self-harm in patients admitted to hospital via emergency departments) (O'Connor et al., 2017), however this was only helpful for those with a history of repeated self-harm. Results suggested that the help sheet might actually increase self-harm in those who had not previously been hospitalised for self-harm (i.e., it was their first ever hospital-treated episode), though this increase was not statistically significant. These findings now require replication.

Electronic mental health interventions

Electronic mental health (e-mental health) interventions represent a promising means of increasing the capacity for patients' self-management of depression (Arensman et al., 2015). Using the internet to deliver treatment for affective disorders has been shown to be an effective option for reaching patients who were not able to receive face-to-face treatment due to geographical or other situational barriers (Vallury et al., 2015) or to augment face-to-face therapy (Hoifodt et al., 2013).

Electronic mental health interventions for mental health problems and mood disorders in particular have increased rapidly over the past decade. In recent years, an increasing number of e-mental health interventions have been delivered in the form of apps that are delivered via smartphones (Dogan et al., 2017). Available research underlines the value of smartphone-based approaches for gathering long-term objective data to predict changes in clinical states. However, the current evidence base does not provide conclusive information on the effectiveness and the risks of these

approaches. Methodological limitations in this area include small sample sizes, variations in the number of observations or monitoring duration, lack of RCTs, and heterogeneity of methods (Dogan et al., 2017).

Postvention: Providing support after suicide

There has been increased recognition of the importance of supporting vulnerable populations, such as bereaved families and friends, following suicides (WHO, 2014). The research demonstrates that people who are exposed to suicide deaths are at increased risk of complicated grief, traumatic grief and PTSD (Melhelm et al., 2004). Furthermore, the relatives and friends of the deceased may be particularly vulnerable to suicidal thoughts and behaviour (Joiner, 2005). Psychologists have a key role in providing support and interventions to those affected by the death and psychological models may be applied to understand how individuals manage grief and adjustment following a death by suicide.

There is emerging evidence supporting beneficial effects of a number of interventions, including counselling postvention for survivors and outreach at the scene of suicide (Szumilas & Kutcher, 2011). In addition, evidence-based guidelines for responding to suicide in a secondary school setting have been published recently (Cox et al., 2016). However, further research is required into the effectiveness of postvention services and interventions on reducing suicide and attempted suicide/self-harm.

Suicide deaths are often incredibly traumatic, the method of death is frequently violent and survivors are often plagued with the 're-experiencing' symptoms of trauma, such as flashbacks, nightmares and intrusive thoughts. These can occur even if the survivor did not witness the death scene. Re-experiencing, when accompanied with avoidance and hypervigilance symptoms, is characteristic of PTSD, and therefore counsellors need to be equipped to recognise and manage these symptoms or refer the person for trauma-focused cognitive therapy or another recognised PTSD treatment (NICE, 2005).

Suicide survivors may also be at risk of comorbid alcohol and other substance disorders, which may require treatment. Suicide has a huge impact on social relationships; there can be feelings of rejection and abandonment in addition to the burden of the loss. The death can also have a detrimental impact on social relationships and isolation due to the stigma surrounding the death and others' beliefs about causes and blame. Individuals who are bereaved by suicide can feel unable to accept support and those close to suicide survivors often have difficulty responding appropriately and may even withdraw from the survivor (Grad, 2011). Therapeutic interventions should include helping the survivor manage and navigate social interactions, harness support networks and foster connectedness. Group support from other suicide survivors, or programmes which link survivors to others who have had a similar loss may be particularly useful for this reason (Jordan, 2011).

Organisational postvention

The planned interventions with individuals and groups affected by a suicide death in a school or workplace are known as *organisational postvention*. Organisational postvention is a significant challenge and it is recommended that plans and protocols are put in place prior to a death. The goal of this type of postvention is in providing support to the bereaved, respecting their wish to honour the life of the deceased, without glamourising the death in a way that increases the risk of further suicidal acts. It is also important to do this in a way that respects the community's cultural and religious beliefs, does not further contribute to the stigma of suicide or leave the bereaved feeling that the deceased has been demonised or punished (Berkowitz et al., 2011).

Response plans

Postvention response plans typically include the coordination of resources, dissemination of information and the provision of support for those most affected by the death, or at risk of contagion. Psychoeducation regarding grief, depression and PTSD is an important component of postvention for those affected by the death. Organisational postvention should also include screening and case finding to detect people who are at higher risk of suicide, who may not come forward. Several screening and case finding tools are available for use in educational settings; however the identification of suicide risk based on screening tools is fraught with difficulties and many high risk individuals do not screen positive using such instruments (O'Connor et al., 2013). It is therefore important to foster an ethos of help seeking and compassionate peer support so that people can identify when others may be at risk and help them to seek support through clear support and referral structures. In the longer term, postvention should include the provision of opportunities for safe commemoration. It is advised that whilst commemoration should be no different for individuals

who have died by any cause, permanent memorials, or events/awards in the memory of the deceased should be avoided, again to prevent contagion (Berkowitz et al., 2011). Broader mental health and resilience programmes may also be helpful in group settings such as schools, however these need to be selected carefully and implemented alongside effective referral pathways (Hawton, et al., 2015; Wasserman et al., 2012).

Risk of contagion

Numerous international studies have shown that there is a risk of contagion following a suicide death. Known as the 'Werther effect', the reporting of suicide can increase suicide risk for those exposed to the death. Social learning and modelling may provide an explanation for this copycat behaviour. The type of language used to describe the death, information about the circumstances surrounding the death, and the use of prominent photos of the deceased may serve to 'glamourise' the death, lead to identification with the deceased and increase the risk of those who may already be vulnerable. Information about the method of suicide is said to increase capability to enact suicidal behaviour. Young people and adolescents are believed to be particularly vulnerable to contagion. In the light of this evidence organisations such as the International Association for Suicide Prevention, the World Health Organization and Samaritans have produced guidance for the reporting of suicide and for dealing with the aftermath of suicides in organisations such as schools, workplaces and sports clubs. More recently, the 'Papageneo effect' has also been described in the literature; this is the finding that the portrayal of alternatives to suicide and social modelling of recovery can increase a person's capacity to seek help when faced with suicidal thoughts (Neiderkrotenthaler et al., 2010). The guidelines for the reporting and management of suicides emphasise that the cause of the suicide should not be over-simplified, and that the links with mental illness, the importance of help-seeking and the efficacy of treatments and interventions should be highlighted. Details of the method of death and the circumstances surrounding the death (location, recent life events, etc.) should not be reported (World Health Organization & International Association for Suicide Prevention, 2008).

Future psychological research

Further research needs to be undertaken in the areas of understanding and prediction, and interventions and prevention.

Understanding and prediction

- Reach a consensus about terminology and phenomenology in respect of all self-injurious behaviours
- More large scale studies that test psychological models and risk factors to predict suicide attempt and death.
- Incorporation of psychological factors into national, linkage databases and psychological autopsy studies.
- Improved understanding of factors that distinguish those who attempt suicide from those who think seriously about it and those who repeatedly attempt suicide.
- Integration of experimental, naturalist, clinical and non-clinical research findings.
- Comprehensive testing of psychological models of suicidal behaviour.
- Focus on psychological factors that protect against suicide.
- Better understanding of the psychology of method selection.
- More psychological science research in participants from across the lifespan, from different ethnic backgrounds and countries.

Interventions and prevention

- More large and sufficiently powered clinical trials of psychological treatments to reduce suicidal ideation, attempts, and suicide.
- Development of more innovative brief psychosocial interventions (employing a range of delivery modalities) to reduce suicidal ideation, attempts and suicide.
- Better understanding of how different types of media representation of suicide and self-harm increase risk of suicidal behaviour and suicide clusters.
- Improved understanding of the barriers to help-seeking.
- Integrating advances in psychological science into suicide prevention and intervention programmes
- Development of public health interventions to promote resilience.
- Development of interventions which can be delivered in low-income and middle-income countries.

Recommendations

Prevention and early intervention is fundamental to suicide prevention. The Society calls upon the government and other agencies and organisations to act upon the following recommendations:

- The government must ensure investment in research into public mental health interventions and research into innovative brief psychosocial interventions (employing a range of delivery methods and modalities) to reduce suicidal ideation, suicidal behaviours and deaths by suicide.
- Whilst there has been some progress made in tackling stigma and discrimination there is still considerable work to be done. Improved training and education in health, social care and educational settings are needed to understand better the barriers in asking for help. This requires increased government investment to support it and expert psychological input to ensure it is appropriately designed and delivered.
- The Department of Health should ensure those discharged from hospital should receive a follow-up appointment within three days
- The Department of Health should ensure that enhanced support is provided for people bereaved by suicide, as outlined in *Hand is at Hand* (PHE & NSPA, 2015)
- OfCOM in conjunction with the Society and the Samaritans should strengthen the guidelines for the media on the reporting of suicide.
- The Royal College of General Practitioners should consider the development and introduction of mandatory GP training on identifying signs and symptoms of suicide ideation/behaviour; and appropriate referrals/immediate support.
- The Department of Health should ensure that the NICE guidelines on risk assessment following self-harm need are implemented consistently across the country.
- The Department of Education should develop appropriate psychologically informed curricula content for children and young people via personal, social, health and economic (PHSE) education in schools.
- UK Research and Innovation should establish increased funding for research into the causes of suicide and trials into suicide prevention, especially in vulnerable groups.
- NICE should develop guidelines for stepped intervention and postvention support.
- The Department for Business, Energy and Industrial Strategy should fund the development of appropriate technological intervention techniques for use on Smartphones, etc.

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