Suicide:

What you need to know

A Guide for Clinicians

Part of an on-going Behavioral Health series to support Firefighter Life Safety Initiative 13: Firefighters and their families must have access to counseling and psychological support.

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What Clinicians Working With Fire□ghters Need To Know About Suicide

Introduction

This guide is intended for counselors, social workers, psychologists, physicians and other professional caregivers who provide behavioral health services to a fire department or treat firefighters and EMS responders in their practice. It will also be useful to behavioral health professionals who have never worked with members of the fire service but are seeking information about doing so in the future. The purpose of this guide is to lend some perspective on the fire service culture specific to risk factors related to suicide. Information regarding an understanding of current knowledge about suicide, prevention and resources is also included.

Firefighters and EMS responders ***probably*** die by suicide at about the same rate as the general population but are exposed to suicide attempts and completed suicides at a significantly higher rate than most other occupations. Contrary to common belief, we do not really know the scope of firefighter/EMS suicide, because suicide data as related to occupation has previously not been systematically recorded or reported. Since many firefighters (upwards of 75%) are volunteers, the relationship between occupational stress and suicide becomes even cloudier. The National Fallen Firefighters Foundation (NFFF) and other fire service organizations are supporting efforts to collect data for analysis, but until that information becomes available it is imperative that firefighters and EMS responders receive the best care available.

For clinicians, the first step to learning more about providing behavioral health services to firefighters and EMS personnel is to take the free online course, *Helping Heroes*. This course was developed for the NFFF by the Medical University of South Carolina's National Crime Victims Research and Treatment Center. It offers behavioral health professionals easy access to instruction that will enable them to apply the very best evidence-based approaches to the issues presented by their fire service clients. *Helping Heroes* is a web-based training package designed to run on all popular software and hardware platforms. Each of the 10 training modules requires approximately one hour to complete, and an additional component serves as a session-by-session toolkit guide. Additional information about *Helping Heroes* is provided later in this guide.

The National Fallen Firefighters Foundation is committed to continuing an honest and forthright dialogue about suicide within our profession, and we recognize the importance of feedback from the clinical behavioral health

Glossary

a) **Suicide** refers to a death due to suicide, meaning that the person who died intentionally killed him/herself.

b) A **suicide attempt** occurs when someone intended to kill him/herself but does not die.

c) **Suicide ideation** is defined as thoughts about killing oneself, and may also involve thoughts about methods, planning, preparations and mental rehearsal.

d) **Death ideation** (also called **passive suicide ideation**) involves wishes for one's own death and/or thoughts that one would be better off dead, but does not necessarily include suicide as the means.

community. Since specific data on firefighters is currently limited, it is imperative that we fill the gap with real-world knowledge. If you have particular experience, lessons learned, or other relevant information that may assist us in helping your peers, please write to us and share these observations at the address listed at the end of this guide.

What is suicide and how often does it occur?

Suicide is currently the 10th leading cause of death in the United States. Approximately 30,000 people die by suicide each year in the U.S—more than are killed by homicides. At the same time, suicide is relatively rare, accounting for approximately 1.5% of total deaths in the general population. Regardless of its relative frequency, suicide is most often a preventable tragedy that is devastating to those who are left behind. Clearly, any suicide is simply one suicide too many.

We do not currently know how many firefighters each year die by suicide. This lack of information is not unique to the fire service, because data on suicide as it relates to occupations is very limited. It is rare enough that most fire chiefs will never experience the loss of a firefighter or other responder to suicide. By comparison, because of the inherent risk of firefighting the potential death of a department member is an omnipresent reality, and fire chiefs are strongly invested in measures to prevent unnecessary losses. Between 80-100 line-of-duty deaths typically occur nationally in any given year, and chiefs are well aware that these losses reverberate throughout closely-knit fire service organizations. So in their leadership role, chiefs need to not only worry about a member dying by suicide but also the impact this exposure presents. Despite all this, there has been relatively little suicide prevention education in the fire service to date, making an appropriate response when a suicide does occur all the more difficult to mount.

Suicide ideation is much more common than suicide attempts, which are more common than suicide deaths. In other words, many more people think about and attempt suicide than will ultimately die that way. The vast majority of firefighters who think about suicide will not die by suicide. However, it is important to recognize that making a specific plan for suicide is a very significant risk factor for dying by suicide; those who think about suicide and plan for it are much more likely to attempt suicide. Some attempts are unplanned or impulsive. However, the highest risk period for an attempt is during the year after thoughts about suicide begin to develop.

More men than women die by suicide in the United States. White men in particular are at greatest risk. The risk of suicide increases for white men in their early twenties, the age at which most firefighters begin working or volunteering for the fire service. Older white men (aged 65 or older) are at greatest risk for dying by suicide, an age at which many firefighters separate from the fire service. One reason suicide may appear to occur more often among firefighters is that white men, an already high-risk population, represent the predominant demographic group in the fire service and the current cohort of "baby boomers" is aging, increasing their vulnerability. These factors, in addition to the nature of emergency response work and the exposures it brings, mean that ***the majority of firefighters and EMS responders are members of an at-risk population for death by suicide from their first days on the job***.

Most suicide deaths are caused by gunshots. Hanging and suffocation are also common methods among men.

If a firefighter is having thoughts about suicide, he/she should be asked about access to a firearm. If the firefighter has access to a firearm, safety planning should be done. This could involve locking the ammunition and having someone else hold the key until the

crisis resolves. If the firefighter will not agree to this, any actions that can be taken to "slow down" the process of accessing a loaded gun should be used. This gives the firefighter more time to potentially choose to live and to be discovered by others. Many fire chiefs have implemented zero tolerance policies of **NO GUNS IN THE FIREHOUSE.**

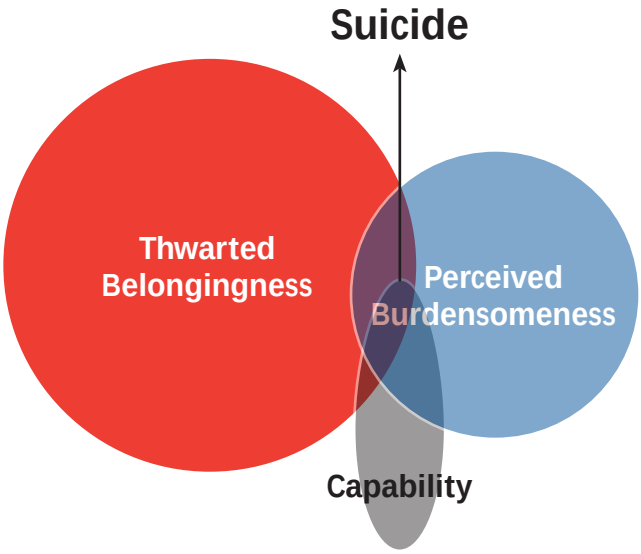
People with mental disorders, including depression, anxiety and substance abuse are more likely to have thoughts about suicide, to attempt suicide and to die by suicide. Acting on suicidal thoughts is more common among people with:

1. Certain types of anxiety problems, including PTSD;
2. Alcohol or substance abuse problems; and/or
3. Problems controlling their impulses.

Firefighters demonstrating signs of depression, anxiety, and substance abuse should be referred for appropriate treatment and helped to engage in that treatment. The NFFF recommends that screening for PTSD and depression be a part of every firefighter and EMS responder physical exam.

Why do people die by suicide?

People die by suicide because they *want to* and because they are *able to.* In other words, these people have the desire for suicide and the capability to engage in such a frightening and painful act. The ***Interpersonal Theory of Suicide*** proposes that suicide results from the intersection of three mental states: 1) low (or thwarted) belongingness; 2) perceived burdensomeness; and 3) capability to engage in suicidal behavior *(see the figure above)*. The sizes of the shapes represent how common the states are estimated to be in the population, and the area of overlap of the three shapes represents the highest risk of suicide.



This theory was developed to explain why people die by suicide. It has been tested by scientists around the world and received a great deal of support. The following brief description of this theory is also included in our corresponding guide for fire chiefs, to help them understand why firefighters might think about and attempt suicide. It can also be useful for helping co-workers and family survivors understand the reasons behind a suicide.

Desire for suicide is caused by mental pain and anguish, accompanied by loss of hope that the pain will go away. People who are suicidal are typically in pain because they are experiencing low belongingness and/or perceived burdensomeness.

1. **Low belongingness occurs when someone's fundamental need to belong is unmet, or thwarted**. Low belongingness involves the belief that one is not connected to and cared about by others, including friends, family, and coworkers. People experiencing low belongingness may feel they have no one to turn to, they are alone in the world, or they don't fit in. **Firefighters may be protected from low belongingness because of the strong sense of connectedness in the fire service. However, if a firefighter begins to feel disconnected,**

perhaps because of depression, alcohol problems, injury, or retirement, the feeling of low belongingness may be even more painful because it is such a profound loss. Department-sponsored organizations and events, such as regular retiree lunches, can go a long way in combatting this phenomenon.

2. **Perceived burdensomeness is the belief that one is a burden on others, so much so that others "would be better off if I were gone."** This is almost always a misperception but is believed strongly by the person who is suicidal. This belief often involves a mental calculation of sorts in which a suicidal person believes that his death is worth more than his life to the people around him. People may openly share thoughts such as "I'm a burden" or "I'm no good to anyone around here." **Firefighters may be protected from perceived burdensomeness because of the contributions they make to society through firefighting and EMS work, and the strong value they place on service to others. However, if a firefighter is unable to work or volunteer and contribute (as with retirement, injury, or disability) he or she may see him/herself as a burden because his or her most valuable avenue of contribution is suddenly gone.**

3. **Capability to engage in suicidal behavior.** Dying by suicide is not an easy thing to do. Nature has seen to it that humans are afraid of things that are physically painful or threaten our survival. In order to overcome the survival instinct and die by suicide, people have to get used to the pain and fear involved in suicidal behavior. One way this can happen is through planning, preparing for, or rehearsing suicidal behavior, or by actually making an attempt.

Evidence from numerous studies suggests that the capability for suicide can be acquired in other ways. Note the use of the term "acquired"—none of us were born with this capacity. It develops over time and with repeated practice. Exposure to situations that are physically painful and make people think about—and even face—their own deaths, is one pathway to acquiring the capability for suicide.

The inherent dangers of firefighting make the loss of one's own life a real and tangible risk which can cause them to become used to physical pain. It is essential to point out, however, that capability for suicide will only increase risk for suicide death if a firefighter *wants* to die by suicide. We noted earlier that firefighters might be protected from suicidal desire because the sense of connectedness may protect against low belongingness and the sense of contributing to the well-being of others may protect against perceived burdensomeness. But if suicidal desire does develop, this acquired capability can increase the likelihood that someone will act on—and die from—suicidal behavior. We don't fully understand the relationship between suicide and exposure to those who are engaging in pre-suicidal behavior or who have died by suicide, but this should certainly be a red flag when dealing with depression and other clinically diagnosable conditions in firefighters.

How can clinicians help to prevent suicide?

All clinicians should share with clients the number for the National Suicide Prevention Hotline, and teach clients when to use this number.

Clinicians should be aware of the warning signs for suicide. The American Association for Suicidology devised the mnemonic, IS PATH WARM, to help people remember certain warning signs for suicide:

Ideation
Substance abuse

Purposelessness
Anxiety/agitation
Trapped
Hopeless

Withdrawal
Anger
Recklessness
Mood changes

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Ideation refers to suicide or death ideation—thinking about killing oneself or wishing for death.

Substance abuse is a significant risk factor for suicidal behavior.

Purposelessness is the feeling of being without purpose or meaning.

Anxiety/agitation, or feeling like you are "crawling out of your skin," is also seen in people at acute risk for suicide.

Feeling **trapped** and/or **hopeless** is often reported by people at risk for suicide.

Withdrawal from family, friends, and co-workers is noted prior to many suicide attempts.

Significant **anger** and rage can be precursors to suicide attempts.

Reckless behavior and significant **mood changes** are also signs of risk for suicide.

Sleep disturbances are also associated with suicidal behavior. Because the shift work schedules of firefighters often result in disturbed sleep schedules, clinicians should assess sleep quality, including any recent changes in sleep patterns.

A person in acute risk for suicidal behavior will most often show these warning signs:

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself;
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or
- Talking or writing about death, dying, or suicide.

If you observe these signs, conduct a thorough suicide risk assessment, including establishing the presence/absence of a resolved plan, intent, and willingness to engage in safety planning. If risk is imminent, use emergency services. Do not leave the firefighter alone.

Asking someone if they are having thoughts of suicide will not cause them to have these thoughts or act on them. **If a clinician is concerned about the safety of a firefighter, he/she should ask if the firefighter is having thoughts of suicide and whether he/she has access to a gun.** It is a myth that people who talk about suicide do not go on to die by suicide. If a firefighter is expressing suicidal thoughts and states with resolve that he is going to kill himself, do not leave the person alone, and conduct a thorough risk assessment immediately. Use the Emergency Department if risk is imminent.

Clinicians should be knowledgeable about fire service culture and how different aspects of this culture function as a context for assessing suicide risk. The National Fallen Firefighters Foundation and the National Crime Victims Research and Treatment Center at the Medical University of South Carolina have created ***Helping Heroes***, an online training program to assist behavioral health clinicians working with firefighters dealing with depression and PTSD symptoms. The site is free and offers CEU credit. The first module provides an introduction to the fire service culture. However, clinicians are urged to complete the

full course. **This resource is available on this site.**

Key points from this training course that are especially relevant to suicide risk are summarized below:

Firefighters are survivors. Working or volunteering as a firefighter regularly exposes individuals to potentially traumatic events. At the same time, firefighters demonstrate remarkable resiliency in the face of these stressors, and use various coping strategies such as distancing themselves from the event, and even humor.

Firefighters are problem solvers. If a firefighter is contemplating suicide, he sees suicide as a solution to a problem he perceives as having no other solutions. Sharing with someone else that he is unable to solve a problem may be viewed as a sign of weakness and/or a sign that he cannot do his job. Both scenarios might conjure up fears of losing the support of fellow firefighters, which would be a significant loss of belongingness that may increase suicide risk. When working with firefighters, establishing trust will be an important foundational step. Providing information about confidentiality and rationale for assessment and treatment procedures are integral to establishing that trust.

Firefighters are helpers. In the worst of situations, firefighters take charge and save lives. Central to their self-identity is that they are helpers. Asking for help themselves may therefore be difficult for firefighters. They may feel that sharing suicidal thoughts will make others perceive them as not "duty-ready," and weak**. Clinicians should convey a genuine expression of the courage it takes to share suicidal thoughts and the strength it takes to fight to save one's own life.**

Restricting access to lethal means for suicide is an effective intervention. If a firefighter shares suicidal thoughts, a clinician can ask "What ways have you thought about killing yourself?" The clinician can then urge the firefighter to remove the means from the home, or to store the means safely with a friend or a relative. **It is essential to restrict access to firearms while a firefighter is experiencing suicidal thoughts.** The firefighter could be encouraged to enlist his/her fellow firefighters as sources of support and for assistance in means removal.

There are effective treatments for suicidal thoughts and behavior that can save lives.

- **Cognitive Behavioral Therapy (CBT)** is the most effective psychotherapy to prevent suicidal behavior. Clinicians working with firefighters who report current or recent suicidal thoughts should provide—or help firefighters find access to—a cognitive behavioral therapist.
- **Psychopharmacological treatment** is also effective. Clinicians should help firefighters find access to a physician/psychiatrist to evaluate for the suitability of medication that may help.
- **Dialectical Behavior Therapy (DBT)** has significant research supporting its use to prevent suicide attempts. However, much of this evidence has been with women with Borderline Personality Disorder. Clinicians working with a firefighter who demonstrates symptoms of Borderline Personality Disorder, including significant impulsivity and anger, should consider referring the client to a therapist who can provide DBT if the clinician is not intensively trained in DBT. Information on referrals for DBT therapists can be found here.
- **Cognitive Therapy (CT)** has also been shown to help suicidal clients. If clinicians have training in Cognitive Therapy, there is a treatment manual for using CT with suicidal clients: A.T. Beck, Gregory K. Brown, and Amy Wenzel *Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications*.

- **Problem Solving Therapy (PST)** has also been shown to help suicidal clients. This is a brief structured form of CBT that uses a primarily behavioral approach. Clients are taught a step-by-step process for solving problems that has been demonstrated to reduce depression and suicidal thinking. While many firefighters may already pride themselves on their problem-solving skills, this does not mean that PST will not be useful. In fact, treatments for depression have been shown to work best by capitalizing on client strengths. Because problems that are linked to feelings of low belongingness and perceived burdensomeness can be targeted using PST, this therapy may be an especially useful approach for clinicians working with firefighters. PST is relatively easy to learn, and there is an excellent free online training program for learning PST here.

All clinicians working with firefighters who report suicidal thoughts (including a history of suicidal thoughts) should engage the firefighter in safety planning. This is considered part of best practices by the Suicide Prevention Resource Center. Safety planning involves creating a written plan for clients to use when they are distressed and/or thinking of suicide. It involves a prioritized list of coping strategies, sources of social support, and emergency mental health resources that should be used in a crisis. Safety planning should include ways the client can increase belongingness and reduce perceived burdensomeness. These might include engaging sources of social support, volunteering to help others, calling 1-800-273-TALK, looking at photographs of family and friends, or thinking about times/ways the firefighter has helped others. There is a free, brief guide to safety planning available online through the Suicide Prevention Resource Center, as well as a printable template for creating a safety plan with a client.

How can clinicians help the survivors of suicide?

Sometimes suicide deaths cluster together in time and space. It is not known if suicidal thinking is "contagious" but it is known that clusters occur. If a firefighter dies by suicide, the death should be discussed openly to reduce stigma and promote help-seeking among survivors. However, the discussion should not describe or emphasize the means or methods of the death, or other aspects of the death that could facilitate acquired capability for suicide in others.

Both family and co-worker survivors should be offered support and given information about suicide, such as the information contained here, as well as access to behavioral health resources should they choose to seek them out. Information for clinicians working with survivors that was developed by the National Suicide Prevention Lifeline Consumer-Survivor Subcommittee is available here.

Clinicians working with firefighters should make themselves aware of the information on behavioral health issues relevant to firefighters and their family members on the National Fallen Firefighters Foundation's *Everyone Goes Home*® website. If you would like to share your material and/or observations about working with firefighters and EMS responders on this topic, please contact the National Fallen Firefighters Foundation through Dr. JoEllen Kelly.

Additional Resources

The American Association for Suicidology (AAS) serves as a national clearing house for information on suicide. The AAS has many resources and publications available to you and your clients. If you are working with a fire department that has experienced a suicide, the AAS had booklets and resource catalogs for survivors, as well as a state-by-state list of support groups.

The Suicide Prevention Resource Center (SPRC) has materials that can be applicable to working with fire departments. Two fact sheets *The Role of Emergency Medical Services Providers in Preventing Suicide* and *The Role of Co-workers in Preventing Suicide* will be particularly helpful. These can be copied and freely distributed and may be useful as handouts to firefighter and EMS clients.

There are other organizations that can also provide material:

The American Foundation for Suicide Prevention (AFSP)
Survivors of Suicide
The Link National Resource Center

Reports, Books & Articles:

There are many reports, books and articles that can help you prepare for this topic. Here are a few which should be helpful:

Joiner, T.E. *Why People Die by Suicide.* Harvard University Press. 2005.

World Health Organization (WHO) *Preventing Suicide: A Resource for Police, Firefighters, and Other First Line Responders* (2009)

US Forest Service, *Learning from a Traumatic Event—Suicide*. 2013.

Attached Resources:

Trauma Screening Questionnaire
NFFF Suicide Prevention Lifeline Flyer

NFFF Resources:

All NFFF information pertaining to suicide prevention and intervention will be posted on the Firefighter Life Safety Initiative 13 website.

The *Helping Heroes* site can be accessed here.

To learn more about **Stress First Aid for Fire and EMS Personnel**, **After Action Review**, and other NFFF behavioral health programs, please visit the Firefighter Life Safety Initiative 13 website.

NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255) suicidepreventionlifeline.org

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suicidepreventionlifeline.org

This guide was prepared by Kimberly A. Van Orden, Ph.D., University of Rochester (NY) Medical Center. She is the co-author of *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients* (American Psychological Association, 2009).

Assistance was provided by Vickie Taylor, LCSW, Tricia Sanborn Hurlbutt and JoEllen L. Kelly, Ph.D.—National Fallen Firefighters Foundation.

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Recommended Protocol for Exposure to Occupational Stress

The stress to re ghters that is created by exposure to traumatic events is very real. These kinds of experiences happen with unfortunate regularity because they are an essential part of what the re service does. No matter the size or type of the organization, it is important that re ghters be prepared to deal with the impacts of these exposures, and that re departments provide access to resources that can make a difference.

The actions recommended in the model shown in the owchart (on Page 1) re ect best practices based on current research, and should t easily into the operations and support systems that most re departments have in place. The key elements of this model include:

Determination of a Potentially Traumatic Event (PTE): A trauma for one responder may be a routine event for another. Reaction to a trauma is subjective, driven by an individual s experience, sensibilities and personal situation. After exposure to a PTE, members should be asked if they require assistance. If so what type? If not, expression of support may be all that is required.

Time out/hot wash: This concept is borrowed from the military as an element of After Action Review (AAR). It is a mechanism that allows those affected by an event to review what happened, what was successful, what could have gone better and how they might improve the next time they respond to a similar situation. This post-incident assessment will often help re ghters put the event into perspective. After a brief time out, they may elect to return to service.

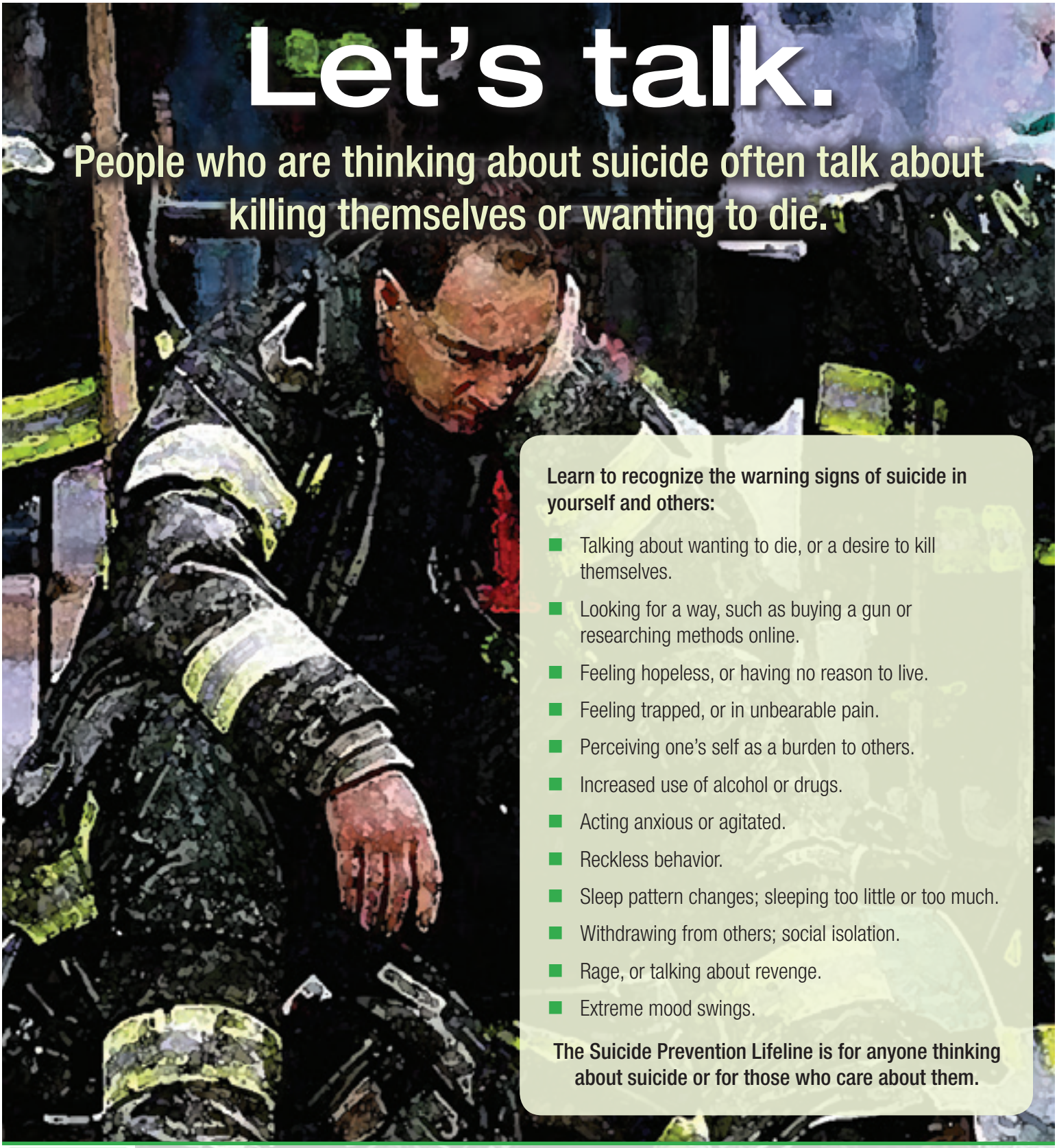
TSQ screening: The *Trauma Screening Questionnaire (TSQ)* is a straightforward and easily scored instrument to identify who is progressing well, and who may need additional help down the road. Used 3-4 weeks after the PTE, it consists of ten simple questions about recent symptoms. More than six positive responses suggest that a more complete screening by a competent behavioral health professional may be warranted.

Complete assessment: This can typically be accomplished by a referral to a department or jurisdiction s Behavioral Health Assistance Program (BHAP) or other competent behavioral health professional. BHAP counselors can often help with managing speci c symptoms and dealing with other non-event related stressors of daily living (such as marital problems, nancial issues, etc.) that might be interfering with a member s recovery from exposure to a traumatic event.

Treatment by specialty clinician: If more intensive care is needed, it should be provided by a specialist (psychiatrist, doctoral-level psychologist, licensed clinical social worker or licensed professional counselor) with advanced training and supervised clinical experience in speci c evidence-based treatment for PTSD, anxiety disorders and depression.

Firefighter Life Safety Initiative #13:
Firefighters and their families must have access to counseling and psychological support.

To learn more about the National Fallen Fire ghters Foundation s FLSI #13 Behavioral Health Protocol and for information regarding training in its use, visit http://www.everyonegoeshome.com.



Let's talk.

People who are thinking about suicide often talk about killing themselves or wanting to die.

Learn to recognize the warning signs of suicide in yourself and others:

- Talking about wanting to die, or a desire to kill themselves.
- Looking for a way, such as buying a gun or researching methods online.
- Feeling hopeless, or having no reason to live.
- Feeling trapped, or in unbearable pain.
- Perceiving one's self as a burden to others.
- Increased use of alcohol or drugs.
- Acting anxious or agitated.
- Reckless behavior.
- Sleep pattern changes; sleeping too little or too much.
- Withdrawing from others; social isolation.
- Rage, or talking about revenge.
- Extreme mood swings.

The Suicide Prevention Lifeline is for anyone thinking about suicide or for those who care about them.

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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