



THE
LAY COUNSELOR
ACADEMY

Suicide, Thoughts of Suicide, and How to Help

Brief Splash

The Mayo Clinic's [article](#) on helping with suicide (always appropriate for patient education) too.

Deep Dive

The [Substance Abuse Mental Health Administration](#) has a wealth of education, fact sheets, reports and research on this topic.

Language Tips

Avoid the term “committed suicide” or “commit suicide” as it tends to stigmatize this. “Died by suicide” or “suicided” are alternatives.

Nationwide, free suicide helplines

988 (call or text) 741741 (text HOME to this number)

NOTE: Always consult with a clinical supervisor or clinical support person, when a client discloses any level of suicidal thoughts or suicide attempts, whether in the past or present. Consultation helps us clarify steps taken, determine potential next steps as needed, and provides us with our own support to debrief and process our experience as counselors.



Overview

Suicide, suicide attempts and suicidal thoughts are scary for many of us. We may have had family members or friends who died by suicide, a parent or partner who had or has suicidal thoughts, or our own thoughts and even attempts to suicide. In a counseling role, we might be scared we will hear suicidal thoughts from a client, that we might not know what to do, or even that we could make a mistake and cause harm. Often our very worst fear is that somehow we will cause someone, or not stop someone, from dying by suicide.

These fears are normal and common—both for people in general and for helping professionals. Suicide has a heavy stigma surrounding it; we can see in obituaries how common it is to see a cause of death as cancer and how incredibly rare it is to see a cause of death being suicide. In addition, the mental health field has often approached suicide and suicidal thoughts from a legalistic, risk-oriented perspective, instituting rules for asking clients about suicidal thoughts at every visit, even with no clinical justification.

Our clients, too, have their own experiences, stigma, and fears around suicide. They may have had friends or family die by suicide. They may have had poor experiences disclosing suicidal thoughts in the past, perhaps with friends or family members, who judged their thoughts as “selfish,” or dismissed suicide attempts as “attention-seeking.” Often clients who struggle with suicidal thoughts have had poor experiences disclosing to helping professionals, including having the police being called. Many clients fear if they disclose to us, they will be involuntarily institutionalized

Our job is to increase our awareness of our own fears or stigma around suicide and suicidal thoughts, so we can ask and talk with clients about this in a relaxed, confident manner. We want to demonstrate to clients that we are not frightened by anything they share: we can hear all they have to say, and remain in our home stance, and maintain unconditional positive regard for them.



Asking:

Asking is very important. It is a myth that asking someone about suicidal thoughts increases suicidal ideation. In fact, research suggests that acknowledging and talking about suicide may reduce, rather than increase, suicidal ideation and may lead to improvements in mental health in general. Many people have had suicidal thoughts for years, sometimes since childhood. Remember that they have been dealing with this before they disclosed it to us.

When do we ask about suicidal thoughts?

- Any time a client shares **depressive** symptoms (such as hopeless thinking, depressed mood, difficulty finding pleasure in things they used to enjoy, low energy, feeling like a burden to others, changes in sleeping/eating patterns) we can ask about their thoughts around suicide, or not wanting to be alive.
- When a client shares that they have someone in the family who died by suicide, attempted suicide, or the client themselves shares that they've attempted or considered suicide, we can ask about their current thoughts around not wanting to be alive, of harming themselves, or ending their life.
- If a client describes distressing shame, humiliation, or profound loss, combined with any of the risk factors (at the end of this document), we can ask them about their thoughts around suicide, or not wanting to be alive.

How do we ask?

First and foremost, we create a safe space for the client to share their experiences. This is through foundational empathic communication, building trust, and demonstrating deep respect and kindness to clients. Sometimes clients will share about thoughts of wanting to die or of suicide without us asking!

As stated above, some clients worry that sharing suicidal ideation with us may result in being taken directly to a psychiatric facility. We can acknowledge the worry/fear, or even predict it ("I wonder if you have fears about sharing this with me?") and explain that disclosing suicidal ideation rarely leads directly to hospitalization. We can share how severe it would have to be, to lead to us having to recommend hospitalization, or take actions toward this (a firm intention to attempt suicide and die at this time or in the near future, the means to do this, and a plan about when and how to do it).



Exploring Suicidal Thoughts With Clients

Initial questions:

"Many people with depression also have thoughts of wanting to die, or of suicide. I'm wondering what your experience of this might be?"

"I really appreciate you sharing with me, about your father's suicide. Sometimes when we have a family member who has died by suicide, we have thoughts of suicide at some time in our lives. Could you tell me a bit about this, in your life?"

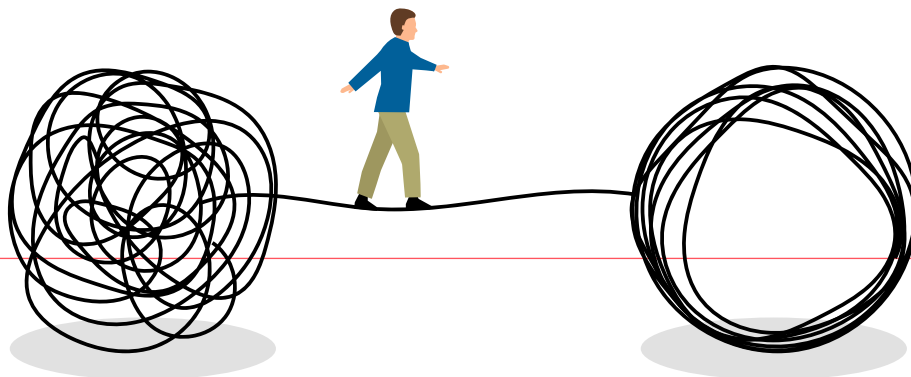
Asking about their relationship to these thoughts:

Many people have had suicidal thoughts for years, sometimes since childhood. They may not be deeply troubled by them, have found effective coping mechanisms to manage them, or may even be comforted by them. Others may be deeply troubled by these thoughts—they may be in conflict with their value system or similar thoughts may have led to attempts in the past. We want to understand:

What this means to them:

"Everyone has a different relationship to thoughts of death or suicide. Tell me a bit about how troubling these thoughts are to you?"

"I'm wondering about your relationship to these thoughts—how do they affect you....can you tell me more about that?"



Strengths, Resilience, Protective Factors:

"Considering how difficult things have been for you, what has kept you from acting on these things so far (or trying again)?"

"It sounds like your faith is part of what keeps you from acting on these thoughts— can you share more about this?"

"How do you normally manage these thoughts/feelings?"

"There is a part of you that really wants to be alive. Can you share more about this part of you?"

As with all strengths, reflecting back to the client what you hear, highlighting, amplifying, and generally validating and valuing these, are powerful ways to help clients.



Safety & Risk

When someone shares that they have had suicidal thoughts, or thoughts of wanting to die, we want to also find out how severe these thoughts are—how at-risk they are for attempting this. We do this by asking if they have had thoughts about how they would complete a suicide.

"Often people think of ways they might hurt themselves. If you were to act on these thoughts and feelings, how might you do that?"

"I'm asking this because it helps me understand better how far your thoughts go... can you share with me if you have thought of plans, about how you might suicide?"

ACTION: No matter what someone shares, we can return to Home Stance; we can ask more open-ended questions, reflect, counter shame, affirm strengths, acknowledge feelings:

- **Countering Shame:** *"It sounds like it really troubles you that you do think about taking pills to die. Thank you for sharing this with me. It isn't uncommon when people have thoughts of wanting to die, that ways to do that also come to mind."*
- **Affirming strengths:** *"It sounds like there is a part of you that thinks through how to die. I really appreciate your vulnerability in sharing this with me. It also is so striking to me, the part of you that is determined to keep you on this planet."*
- **Open-ended questions:** *"Tell me more about that part of you."*
- **Acknowledging feelings:** *"I can hear how desperate you feel sometimes," or "It seems like you feel embarrassed, or ashamed about this—is that right?"*
- **Empathic Reflection:** *"You have some thoughts of wanting to die, no thoughts of hurting yourself though, and no thoughts of ways you would do this. Did I get that right?"*

ACTION: If a client has thoughts of wanting to die, or die by suicide with no plan and no intent to do so, we discuss with a clinical support person or supervisor as soon as possible after the session.

If someone does share that they think of ways to die, we ask another, deeper question about if they have the ability (access to the means they described and the intention of doing this:

- *"I have another question for you. I know it might feel a bit hard. I'm wondering if you do have access to pills/gun, and if you do intend to die by suicide now, or in the near future"*
- *"So sometimes you do think of driving off the cliff near your house. Can I ask: how strong is your intent to do this, in the near future?"*



ACTION: If clients endorse access to the means to die, and an intention to do this immediately or in the near future, counselors should stay with the client (in the room, on the phone, or on the video call), let the client know that we are concerned for them, that we want to help, and that we are going to call a supportive supervisor to assist. Counselors should call or text for a clinical support person right away.

Avoid

- Dismissing or ignoring the disclosure (“Glad that was in the past...”)
- Trying to find a solution or “fix” the thoughts (e.g. “What do you think about medication?”)
- Trying to cheer them up, or change the subject
- Trying to persuade or convince them they shouldn’t feel this way
- Listing the things they have, or should be grateful for
- Any shaming statements (“You should think about your kids”)
- Self-disclosing anything about our own suicidal thoughts or attempts in the past—this isn’t an area where self-disclosures are useful.

Do

- Listen closely for a client’s sense of ambivalence—these mixed or contradictory feelings about living or dying are important to explore with clients. Reflect back to the client both parts of themselves, to encourage “perspective-taking,” for the client, on their own thoughts.
- Without dismissing the thoughts of wanting to die, or of suicidal thoughts, highlight and dig into the statements that lean towards wanting to live.
- Intentionally expand the initial discussion of this, into an agreement to have an open dialogue about these thoughts, for example, at the end of the session:

“I really appreciate your willingness to share today about the suicide attempt you had when you were a teenager, and the suicidal thoughts you sometimes have now. I know telling me felt scary to you, as you were afraid about me having to call the police, or that you’d end up in a hospital. I’m wondering if you feel comfortable considering this an open conversation, something you can continue to talk with me about, especially if the thoughts get more frequent or more intense. I’d like to be able to ask you about this periodically, too. What are your thoughts about that?”



Suicide and Suicidal Thoughts, Facts and Figures

- Suicide rates have increased over the last 20 years. They increased a phenomenal 30% between 2000-2018.
- Suicide affects all ages. In 2020, suicide was among the top 9 leading causes of death for people ages 10-64. Suicide was the second leading cause of death for people ages 10-14 and 25-34.
- The number of people who think about or attempt suicide is very high. In 2020, an estimated 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide.
- Some groups have higher suicide rates than others. Race/ethnicities with the highest rates were non-Hispanic American Indian/Alaska Native and non-Hispanic White populations.
- Others who have higher rates of suicide are: men, veterans, those who live in rural areas, and young people in the LGBTQ+ community.

Prevalence Of Suicidal Thoughts

Many people have some form of suicidal thoughts. Research indicates about 4% of us have some form of suicidal thought at any given time. This number is likely much higher as often people do not share these thoughts with others.

Risk factors include:

- Depression or other mood disorders
- Impulsive and/or aggressive tendencies
- Alcohol and other substance use disorders
- History of trauma or abuse
- Previous suicide attempt(s)
- Previous suicide attempt
- Family history of suicide
- Triggering events that cause shame or humiliation
- Legal issues
- Male (77% of all suicide deaths are by males)
- Loss of relationship(s) or job
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of healthcare, esp. mental health
- Sense of shame, self-hate

The most lethal risk combination is a male, with alcohol use disorder, depression and access to firearms.

