

Assessing Protective Factors Against Suicide: Questioning Assumptions

by Robert I. Simon, MD

Suicide risk assessment identifies counterbalancing treatable and modifiable risk and protective factors that inform the clinician's care of the at-risk patient. Systematic assessment of protective factors supports the patient's life instincts.¹ Much less is written about protective factors than risk factors.

Protective factors require the same careful assessment as risk factors. A commonly occurring flaw afflicting suicide risk assessments is the omission of protective factors. Suicide risk assessment forms often neglect protective factors.² When only risk factors are assessed, the clinician is uninformed about the patient's actual suicide

risk. The patient's suicide risk may be rated too high, creating counter-therapeutic restrictions on autonomy and freedom of movement. Conversely, the clinician will likely underestimate the patient's suicide risk if he or she is unaware that the patient has few or no viable protective factors. Thus, the opportunity to identify and mobilize protective factors is compromised.

PROTECTIVE FACTORS

Both internal and external protective factors require assessment.³ Internal protective factors refer to the patient's characterological and psychological strengths (eg, coping skills, resilience). External protective factors identify the patient's current life circumstances and relationships (eg, family support, occupational security).

The patient's internal protective factors improve with treatment. In contrast, external protective factors can often be mobilized and managed expeditiously, reducing the patient's overall suicide risk. Protective factors play an increasingly important role in the patient's recovery as suicide risk is treated and reduced. Protective factors vary with age, sex, race, ethnicity, culture, and demographic factors.^{4,5}

Suicide risk and protective factors are sometimes confused. The absence of a specific suicide risk factor can be mistakenly construed as a protective factor, as for example, when a patient reports no prior suicide attempts. Protective factors cannot be the mere absence of risk factors. The real-time presence of risk and protective factors is the clinician's immediate focus for assessment



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FACULTY

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FACULTY DISCLOSURES

Dr Simon has no relationships to disclose relating to the subject matter of this article.

Applicable CME LLC staff have no relationships to disclose relating to the subject matter of this activity.

This activity has been independently reviewed for balance.

TARGET AUDIENCE

This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

GOAL STATEMENT

This activity will provide participants with a better understanding of protective factors in systematic suicide risk assessment.

ESTIMATED TIME TO COMPLETE

The activity in its entirety should take approximately 90 minutes to complete.

LEARNING OBJECTIVES

After completing this activity, participants should be able to:

- Understand the importance of protective factors in suicide risk assessment
- Recognize internal and external protective factors

COMPLIANCE STATEMENT

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and treatment.

Some patients emphasize protective factors while they minimize suicide risk for a variety of reasons (eg, denial, guardedness, early hospital discharge). Protective factors are easier for patients to discuss, and they tend to be overvalued by both the patient and the clinician. Patients determined to commit suicide will inflate protective factors to hide their intent.

TRUST BUT VERIFY

Protective factors are not always what they appear to be. Presumed protective factors may not be protective or, may even be risk factors on further assessment. Identifying potential protective factors is the necessary first step; however, further assessment is required.

Protective factors are varied, and clinicians may only learn of them by asking the patient about, for example, pets, pictures of loved ones, and grandchildren. A child at home under age 18 is an evidence-based protective factor.⁶ But, an acting-out, impulsive, substance abusing adolescent under 18 years can be a suicide risk factor for a depressed parent. Thus, even evidence-based protective factors cannot be accepted at face value. Assumption must be questioned by evaluation of the individual patient.

Family

Family refers to a patient's immediate family (eg, spouse, partner, parents, siblings). Families aggregate along a continuum from supportive to destructive. Some families are divided in their support. For example, some family members who support the patient's treatment encourage the patient to take prescribed medications, while other members who deny the patient's mental illness discourage treatment. A divided family is an indication for psychoeducation.

Families are often tasked to oversee the patient's medications, to keep car keys out of reach until it is safe for the patient to drive, or to safely secure guns. A family member should be designated as spokesperson for the entire family to avoid miscommunication and multiple phone calls. It is important to first determine whether the designated family member is willing to fully cooperate.

Close collaboration between the clinician and the designated family member is essential to gun safety management. Before a patient is discharged, the clinician and the designated family member agree on a plan for safe gun and ammunition removal.⁷ Once the plan is implemented, the designated family member calls the clinician or associate and confirms that the gun safety plan has been implemented—a good example of *trust but verify*. Without the confirmatory callback, family members may not remove guns to a secure place *outside* the home. Denial of risk often leads to incomplete measures that leave guns accessible to the suicidal patient.

If the patient needs 24-hour supervision, he or she should not be discharged from the hospital. Asking family members to supervise a suicidal patient for 24 hours a day is unrealistic. Family members invariably fall asleep, do not accompany the patient into the bathroom, and make other exceptions that seem necessary for family

functioning. Family members can become fatigued or even resentful. Thus, the realistic support that the family can provide is eroded, and the family's role as an important protective factor is undermined.

The suicidal patient may feel that he is an intolerable burden on the family. The patient decides that the family, after a period of mourning, will be better off with his death. Burdensomeness is a pernicious suicide risk factor that can nullify family support.⁸ Counterintuitively, the patient's feelings of burden can be more intense toward devoted or overly protective family members.

Therapeutic alliance

Clinical consensus holds that the therapeutic alliance or working relationship between clinician and patient is a mainstay protective factor against suicide. However, no evidence-based research supports or refutes this widely held belief among clinicians.

Many factors influence the therapeutic alliance—eg, the clinician's training and experience, the type of treatment, the patient's psychiatric diagnosis. The therapeutic alliance may not develop in hospital stays of short duration; in a limited number of outpatient sessions; or in brief, infrequent medication management visits. Variations in the severity of the patient's mental illness and adverse situational factors also affect the stability of the therapeutic alliance.

For example, a depressed, borderline patient commits suicide between weekly outpatient sessions. The clinician feels that a stable, therapeutic alliance existed with the patient. The patient did not call for help. The clinician is shocked and bewildered. Subsequently, it is learned that the breakup of a romantic relationship exacerbated the patient's depression and triggered the patient's suicide.

Patients who develop a stable therapeutic alliance are likely to have other meaningful relationships. Rather than assume this to be true, the clinician must inquire further. For some patients, the only stable, supportive relationship is with the clinician.

A strong, positive therapeutic alliance is no guarantee against a patient suicide. The therapeutic alliance must be assessed along with other risk and protective factors. There is no absolute protective factor.

Suicide prevention contracts

A suicide prevention contract, also known as a "no harm contract," when unaided by systematic suicide risk assessment, is a potential risk factor. A suicide prevention contract cannot be a substitute for comprehensive suicide risk assessment. The suicide prevention contract creates the illusion of protection against patient suicide. When the suicide prevention contract is used, the clinician is on notice to do more.

In a study by Robins,⁹ 25% of suicidal patients denied suicidal ideation to the clinician but did tell their families. Use of the suicide prevention contract is based on the assumption that the patient is truthful and wants to be helped. Although this is true for many suicidal patients, it is a false assumption for the suicidal patient who is determined to commit suicide. For these patients, the

clinician or staff is their enemy.¹⁰ Moreover, studies show that suicide prevention contracts do not prevent suicide.^{11,12} The road to suicide is strewn with broken suicide prevention contracts.

Religious affiliation

Dervic and colleagues¹³ evaluated 371 depressed inpatients according to their religious or nonreligious affiliation. Patients who had no religious affiliation made significantly more suicide attempts, had more suicides among first-degree relatives, were younger, were less frequently married, less often had children, and had fewer contacts with family members.

Religious affiliation, like other presumed general protective factors, requires further clinical scrutiny. For example, a severely depressed, devoutly religious patient cursed God for abandoning him. Another patient with bipolar disorder believed that God would forgive her for committing suicide.

The Abrahamic religions, ie, Judaism, Christianity, and Islam, prohibit suicide, considering it as a grave and unpardonable sin. Suicide in Islamic countries is very rare. In contrast, Eastern religions with traditions of reincarnation generally do not vigorously condemn suicide.¹⁴ For many psychiatric patients, religious affiliations and beliefs are protective factors against suicide. Nonetheless, severe mental illness can overcome even the strongest religious prohibitions against suicide, including the fear of eternal damnation.

Coping skills

Linehan and colleagues¹⁵ developed the Reasons for Living Inventory, a self-report instrument that identifies 6 subscales: (1) survival and coping beliefs; (2) responsibility to family; (3) child-related concerns; (4) fear of suicide; (5) fear of social disapproval; and (6) moral objections to suicide. Survival and coping beliefs, responsibility to family, and child-related concerns were useful in differentiating between suicidal and nonsuicidal groups.

Malone and colleagues¹⁶ studied 84 inpatients with major depression. Forty-five had attempted suicide. The 84 depressed patients were administered the Reasons for Living Inventory. The depressed patients who had not attempted suicide demonstrated more a sense of responsibility toward family, more fear of social disapproval, more moral objections to suicide, greater survival and coping skills, and greater fear of suicide than did patients who attempted suicide. The authors recommended that the Reasons for Living Inventory be part of the assessment of patients at risk for suicide.

A first time mental illness in a previously high-functioning individual can be a severe narcissistic injury. Because the patient is often highly intelligent and accomplished, it may be mistakenly assumed that these qualities are protective factors against suicide. Clinician countertransference issues can minimize the patient's suicide risk, especially when the patient is a mental health professional. Mentally ill professionals and other "VIPs" who are treated "special" may not receive necessary assessment and treatment,

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increasing the risk of “executive” suicide.¹⁷ Unaccustomed to mental illness and highly defined by professional success, the patient may deny suicidal ideation to minimize his illness or to obtain early release from the hospital.

Careful assessment of coping skills coupled with information from collateral sources is essential in determining the strengths and weaknesses of the patient’s coping repertoire, both past and present. A patient’s coping skills are multifaceted, requiring differentiation of intact from impaired skills. Examples of core coping skills are the abilities to maintain interpersonal relationships and to manage conflict and stress without significant regression in functioning.

Pregnancy

Marzuk and colleagues¹⁸ determined the risk of suicide during pregnancy by analyzing autopsy reports of all female residents of New York City between the ages of 10 to 44 who completed suicide between 1990 and 1993. The race-adjusted standard mortality ratio for suicide was 0.33, or one-third the expected rate. The authors concluded that pregnant women have a significantly

lower risk of suicide than women of childbearing age who are not pregnant.

Pregnancy, however, should not be assumed to be an unqualified protective factor against suicide. The Marzuk study shows that pregnant women did commit suicide. An unwanted pregnancy in a young, mentally ill patient who has little or no support can negate the protective effect of pregnancy against suicide.

CONCLUSION

Protective factors against suicide are an integral part of systematic suicide risk assessment, but they are frequently omitted from the assessment. No suicide risk assessment can be considered comprehensive without inclusion of protective factors. Assumptions about protective factors must be questioned. Trust but verify is the operative principle.

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1. Which of the following should not be considered a protective factor?
 - A. Resilience
 - B. No prior suicide attempt(s)
 - C. Family support
 - D. Coping skills
2. Having a child at home, under the age of 18, should be an assumed protective factor.
 - A. True
 - B. False
3. A family member designated as being responsible for a suicidal patient’s safety is tasked with:
 - A. Instructing the patient not to drive
 - B. 24/7 supervision of the patient
 - C. Finding a secure place within the home for any guns or ammunition
 - D. All of the above
 - E. None of the above
4. Devoted and protective family members can reduce the patient’s feeling of burdensomeness, thus reducing the risk for suicide.
 - A. True
 - B. False
5. Which of the following are factors that may contribute to diminish the therapeutic alliance as a nonprotective factor for suicidal patients?
 - A. The severity of the illness
 - B. Brief or infrequent patient appointments
 - C. Unforeseen circumstances in the patient’s life
 - D. All of the above
 - E. None of the above
6. A suicide prevention contract is a potential risk factor.
 - A. True
 - B. False
7. One study found that _____ of patients denied suicidal ideation to the clinician but did tell their families.
 - A. 15%
 - B. 20%
 - C. 25%
 - D. 30%
8. All major religions have an absolute prohibition against suicide.
 - A. True
 - B. False
9. Which of following in the Reason for Living Inventory were found to be useful in differentiating between nonsuicidal and suicidal patients?
 - A. Survival and coping beliefs, fear of suicide, moral objections to suicide
 - B. Fear of suicide, responsibility to family, fear of social disapproval
 - C. Child-related concerns, fear of social disapproval, survival and coping skills
 - D. Responsibility to family, child-related concerns, survival and coping skills
10. High intelligence and professional success are considered to be protective factors for suicidal patients.
 - A. True
 - B. False