2023

Group Ideation Treatment (GRIT)-A Group Approach to the Treatment of Suicidal Ideation and Relapse into a Maladaptive Coping Skill

Hogan J. Gagle
Eastern Kentucky University, hogan_gagle@mymail.eku.edu

GROUP IDEATION TREATMENT (GRIT): A GROUP APPROACH TO THE TREATMENT OF SUICIDAL IDEATION AND RELAPSE INTO A MALADAPTIVE COPING SKILL

By

HOGAN J. GAGLE

Master of Science

Eastern Kentucky University

Richmond, Kentucky

2022

Bachelor of Science

Eastern Kentucky University

Richmond, Kentucky

2018

Submitted to the Faculty of the Graduate School of
Eastern Kentucky University

In partial fulfillment of the requirements for the
degree of

DOCTOR OF PSYCHOLOGY

May 2023

GROUP IDEATION TREATMENT (GRIT): A GROUP APPROACH TO THE TREATMENT OF SUICIDAL IDEATION AND RELAPSE INTO A MALADAPTIVE COPING SKILL

By

HOGAN J. GAGLE

DSP Approved:

Chair, Advisory Committee

Member, Advisory Committee

Member, Advisory Committee

Dean, Graduate School

ACKNOWLEDGMENT

I first would like to thank my family and friends for their support, encouragement, and always being available to listen to me talk about this project. This process is a marathon and I know that is something I could not have done on my own. A special thank you to Dr. Melinda Moore for her never-ending patience and for always pushing me to the next level. The inspiration for this project all started when I first met you in 2015. I will never forget tracking down your office hours to find the time to start a conversation with you. It is amazing to think how much that meeting has changed me as a student, clinician, and as a person.

I would also like to thank the faculty of the Eastern Kentucky University Psychology department. Starting my higher education journey began here in 2014 and has turned into becoming a part of a family that encourages, listens, and push one another. Thank you to Dr. Dustin Wygant, Dr. Michael McClellan, and Dr. Theresa Botts for your continued support with this project. The time and effort you have given to me in this endeavor and in my clinical training is something that I can never repay. I would also like to thank the other supervisors that have helped develop me as a clinician. This work is a passion of mine and something that I am honored to be a part of. The direction and room that you provided me to grow has always been exactly what I needed to progress in this journey.

Finally, thank you to Dr. Lora Johnson and Stacy Hagman for providing consult on the CAMS-G project. A great deal of this project is founded on the groundwork that you all provided. The stigma of suicide and its treatment is something that is contributed to by the views of the public, as well as those who treat it. It has been great to work with others who support greater normalization and openness on this topic.

ABSTRACT

Suicidal ideation is experienced across both acute presentations and chronic conditions of suicidality. For some, the ideation may be the only symptom that is present while others who have undergone treatment for suicidality may find a relapse into suicidal ideation. With the prevalence and potential relapse back to this maladaptive coping skill, the development of an intervention is needed that directly targets this case presentation. Ideation acts just as any other maladaptive coping skill, and just as with those, there is support for the use of group intervention. The individual's family or friends may become apprehensive towards being supportive if they hear of a resurgence or onset of suicidal ideation. Providing a peer-based support system in the context of a controlled therapeutic environment, where risk is being consistently monitored, could provide this individual with the situation that best fits their treatment needs.

TABLE OF CONTENTS

Section I: What is Suicidal Ideation

Description of Suicidal Ideation

When discussing suicide, there has been an increase in effort to standardize the language that is used amongst health professionals. As suicide is not classified under the Diagnostic and Statistics Manual of Mental Disorders (DSM-5) as a mental disorder, health professionals' reference to what suicide and other related features includes can often vary. This variance can create confusion in discussion of treatment theoretically, but also per clinical application. This confusion can ultimately negatively impact client care as their symptoms may be misdiagnosed or not identified at all.

Though there are still issues of language in place, in 1980 the Centers for Disease Control developed a task force to create a working definition for suicide. The Operational Criteria for the Determination of Suicide (OCDS) is (1) A death arising from (2) an act inflicted upon oneself (3) with the intent to kill oneself (O'Carrol et al., 1996). From these three core components a modified definition presented is "suicide is an act with a fatal outcome which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes: (O'Carrol et al., 1996, p. 33).

Other important components that are considered are intent and potentiality. Intent was initially brought up by Stengel (1964). This is to encapsulate instances of suicide or suicidal behaviors that are self-damaging, but may be vague or ambiguous. Potentiality, later brought up by De Leo et al., (2004), contributes the consideration that though perceived or voiced intent by the individual may not be present, that the potential for the engaged actions to cause life threatening harm may be to the point in which intent, and such suicide, can be determined.

In terms of suicidal ideation, the formal unifying definition by the American Psychological Association is “thoughts about or a preoccupation with killing oneself, often as a symptom of a major depressive episode. Most instances of suicidal ideation do not progress to attempted suicide” (American Psychological Association, 2007). As ideation can commonly be interchanged with other language of suicide, for the purposes of this project these include thoughts, ideas, wishes, and preoccupations with death and acts of suicide (Harmer et al., 2021). This definition focuses on a core trait of an individual’s thoughts about taking their own life. These can be of varying degrees of severity and intensity but does not include once an individual begins to take actions towards causing their own death (Andriessen, 2006).

The focus of suicidal ideation is often an initial question in suicide screeners and assessments. Commonly used measures that lead with ideation or thoughts of suicide include the Patient Health Questionnaire (PHQ-9) (Na et al., 2018), Suicide Assessment Five-Step Evaluation and Triage for Clinicians (SAFE-T) (Fulfer et al., 2007), Columbia-Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2011), and Ask Suicide-Screening Questions (ASQ) (Aguinaldo et al., 2021). These measures focus on asking if the individual had a wish to no longer be alive, then followed by asking more directly if they have had thoughts of ending their own life. These questions work to assess for suicide risk and also provide rationale for further questioning the client about suicide in their life (Na et al., 2018). This initial focus on ideation works as a gateway into further questioning for history and behaviors as thinking about suicide can often proceed suicidal actions (Fulfer et al., 2007). It should be noted that suicidal ideation does not necessarily have to precede suicidal behaviors. As such, those behaviors should also be inquired about in initial screening efforts (Na et al., 2018).

Aims of Project

The objective of this doctoral specialty project (DSP) is to propose a group-based intervention for the treatment of suicidal ideation. In developing this group, a review of the current interventions for suicide will be reviewed, as well as both individual and group-based interventions which treat disorders that often overlap with suicide. Treatment considerations will be derived from interventions that address maladaptive coping skills. The significance of screening for suicide and measures used will be included to address the risk concern of group effects on a high-risk population. Though suicide is present throughout all age groups the primary population considered in the literature review in the development of this group is adults. Suicide is a problem that occurs outside of the United States, but as the clinical presentations that underly the evidenced based practices reviewed in this project are predominately based on people from the United States, people outside of that population may not be directly accounted for. Sources and data on populations from diverse backgrounds are included and considered, but generalizing this review to those outside populations should be considered with caution. Despite this, effort to maintain cultural influence and considerations are included in this review.

Prevalence of Suicide and Ideation

Deaths by suicide have been a steadily increasing rate despite an increase in intervention and awareness efforts in recent years (Omary, 2021). However, there has been a recent notable decrease in 2019. Approximately 47,500 deaths were attributed to suicide in 2019 (Centers for Disease Control & Prevention, 2019), which is an instance rate of 13.9 suicides per 100,000 people. Outside of this year, instance rates of death by suicide have gone from 10.5 suicides per 100,000 people in 2014 to 14.5 per 100,000 people in 2019 (Drapeau & McIntosh, 2020). Focus

on addressing this crisis has shifted from being a responsibility of solely mental health professionals to also being recognized as a public health problem in 2019 (Knox, 2015).

A consideration that must be taken into account when considering these rates is how the data is recorded. This information is taken from reports on the death certificate, and as such is a reflection of the determination made by the medical provider or other individual who examines the body (Nielsen et al., 1991). Despite the CDC standardization for determining suicide as the cause of death (CDC, 1988) these reports can be influenced by multiple factors surrounding the individual's passing. The training of the examiner, stigma or views on the area, or methods involved in the person's death can contribute to different biases when making the determination (CDC, 1988). This does not indicate that the reported data is incorrect, but should be considered upon review.

Though the severity and concern of bodily harm or the loss of life by suicide is significant, the presence of suicidal ideation is also of concern. For adults 18 years of age and older, in 2015, approximately 9.8 million people had serious thoughts of killing themselves (Piscopo et al., 2016). Of those who had thoughts of suicide, 2.7 million made a plan and 1.4 million made a suicide attempt. This rate is up from 2014 in which 9.4 million adults indicated serious thoughts of killing themselves. Overall, suicide attempts occur at a rate 8 to 25 times higher than death by suicide (Moscicki, 2001).

Other factors that impact suicidality can serve as indicators of focus. Suicide risk and occurrence rate increases in the presence of mental illness (Chesney, et al., 2014). Dome et al., (2019) found that of those with bipolar disorder, up to 19% will ultimately end their life by suicide and up to 60% will attempt suicide at some point in their life. Of all the deaths by suicide

each year, bipolar disorder is diagnosed in up to 14% of those individuals. For those with anorexia nervosa, up to 24.9% will have a suicide attempt in their lifetime (Udo et al., 2019). In comparison, borderline personality disorder has a death by suicide rate of up to 10% (Paris, 2019). A common trait amongst these conditions is their known risk of suicide, but also that the maladaptive coping skills they present with to address their symptom burden (Wadsworth, 2015). Actions such as self-harm, controlled eating, and substance abuse are high occurrence maladaptive coping skills in mental health conditions discussed.

Section II: Literature Review

Method of Literature Search

Academic research was primarily obtained through utilizing the Eastern Kentucky university online library connections with academic search engines. Search engines such as PsycINFO, PubMed, Google Scholar and EBSCO Host. Journals referenced included General Hospital Psychiatry, Psychiatry research, The Journal of Crisis Intervention and Suicide Prevention, Journal of Interpersonal Violence, American Journal of Public Health, Journal of Affective Disorders, Suicide and Life-Threatening Behavior, Journal of Nervous and Mental Disease, Journal of Clinical Psychology. Other sources such as the Center for Disease Control and Prevention website was also utilized. Meeting with library staff at Eastern Kentucky University aided in identifying additional search terms and methods for locating and identifying target sources of literature. Key words searched included: suicide, suicidality, ideation, behavior, military, civilian, culture, mental health, disorder, depression, PTSD, NSSI, attachment, group treatment, DBT, CAMS, CBT, Mindfulness, borderline personality disorder, severe mental illness. In searching the online literature, databases were restricted to more recent literature when applicable. The time or release was expanded when reviewing history and previous methods to provide additional foundational information for the current approaches that were reviewed.

Risk Factors

Risk factors are important to consider when addressing suicide as these are traits that a person may have or experiences, they may have gone through that may make it more likely that they will think about, attempt, or end their own life (Halford et al., 2020). By better being able to identify risk factors, both prevention and intervention efforts can by increased to aid in

decreasing the likelihood of suicide (McDonnell, 2020). A review of a few different models will be further explored to provide a breadth of consideration for areas to identify and respond to. This list is not exhaustive as the degree and significance of an individual risk factor can vary even by the person. This is to identify common considerations to be made in approaching suicide risk. It should be noted that risk factors alone do not indicate that a person is suicidal or will die by suicide, rather they are traits that can place someone at increased risk (Institute of Medicine, Board on Neuroscience and Behavioral Health, & Goldsmith, 2001). Warning signs, which are more likely indicators that someone is thinking about or is engaged in some form of suicide, will be discussed in the next section (Rudd et al., 2013).

The Center for Disease Control (CDC, 2021) identifies four domains in which risk factors may present that increase the likelihood for suicide. These include individual, relationship, community, and societal. Traits for the individual that may increase suicide risk include previous suicide attempt, presence of mental illness, social isolation, criminal problems, financial problems, impulsiveness, job problems, and substance use disorders. Traits from a relationship that may contribute to risk include adverse childhood experiences, bullying, family or someone close to them having experienced suicide, significant relationship problems, and sexual violence. Traits from an individual's community includes barriers to accessing or utilizing health care, cultural or religious beliefs, and suicide clusters. Traits from society include stigma towards mental health or seeking help, easy access to lethal means, and media portrayals of suicide.

Another approach to suicidal risk factors comes from the American Foundation for Suicide Prevention (AFSP, 2021). The AFSP provides a similar definition for risk factors, as they are characteristics that increase the chance that someone will take their own life. The domains that are presented include health, environmental, and historical. From the health domain

specific areas of mental illness, serious health conditions, including pain, and a traumatic brain injury are all considered. Of the mental illness, conditions such as depression, substance use, bipolar disorder, schizophrenia, conduct disorder, and anxiety disorders are of concern. Environmental factors include access to lethal means, prolonged stress, stressful life events, and exposure to another suicide. The historical considerations include previous suicide attempts, family history of suicide, and child abuse, neglect or trauma.

Though the domains identified across these two sources differ, it can be seen that the traits to monitor have a great deal of overlap. When looking across these two sources key characteristics that are shared include the presence of a mental health condition, serious health concerns, past exposure to suicide, a past suicide attempt, access to lethal means, and some form of current or past significant stressor, such as an adverse childhood experience. Although identifying these factors can aid in prevention and intervention (McDonnell, 2020), understanding the prevalence and impact they have is equally as important for these efforts.

Of these risk factors, one of the strongest predictors of someone going on to attempt suicide is having a previous attempt (Goñi-Sarriés et al., 2018). However, those who attempt suicide, nine out of ten will not go on to die by suicide later in life (Owens et al., 2002). Of those who attempt suicide about 7% go on to die by suicide, 23% have a nonfatal reattempt, and 70% had no further attempts. In comparison to the general population, .01% of people die by suicide.

Warning Signs

Warning signs provide a direct indication of traits that may be currently present or being exhibited that would indicate an individual is either engaging in suicidal behaviors or is thinking about taking their life (Rudd et al., 2006). Though suicide can occur without a direct indication,

50%-75% of people who are suicidal exhibit warning signs (Erbacher et al., 2015). Some of these warning signs may include feelings of burdensomeness, withdrawing from family, depression, fatigue, not knowing reasons for living, writing about suicide or no longer being alive, referencing their own death or not being around, suicidal threats, suicidal notes or plans, feeling helpless, deteriorated self-care, changes in sleeping or eating habits, self-harm behaviors, and an increase in risk taking behaviors (Tucker et al., 2015).

Identifying the present warning signs can be an indication for both acute and chronic levels of suicide (Hall et al., 1999). By identifying chronic instances of suicidality, developing an intervention of care and following up with that individual can assist in how they manage those feelings. Though both presentations can be viewed by identifying the presence of suicide warning signs, often of more concern is acute instances of suicide as they can be indicative of an increased risk of someone acting of their suicidality (Tucker et al., 2015). Specific acute warning sings include suicidal ideation, loss of interest, anxiety, psychomotor agitation, and high-risk behavior (Ballard et al., 2016). Of these both suicidal ideation and loss of interest in activities they had once enjoyed both show a significant increase within five months of a suicide attempt.

In suicide treatment and prevention developing methods to adequate screen for these warning sings can support earlier intervention. Standardized screeners and forms, such as the Columbia-Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2011), directly ask the individual about domains including behaviors, thoughts, and intent (Aguinaldo et al., 2021). Though formal screeners provide a systematic guide for inquiring about an individual's current state, those who will interact with the individual may not be someone who is trained in those instruments (Dilillo et al., 2015). More public based prevention efforts, such as Question, Persuade, and Refer (QPR) Gatekeeper Training for Suicide Prevention, provides education in

assessing for desire or intent (Matthieu et al., 2008). Both of these measures, and those like it, incorporate screening and questions that provide focus towards identifying these warning signs as cues for follow up and additional care.

Protective Factors

Protective factors for suicide are characteristics that make it less likely that an individual will think about, attempt, or go on to die by suicide (Parekh, 2018). Knowing the risk factors and being able to identify when warning signs are present are major contributors to effective suicide prevention. Additionally, it is important to both promote the protective factors that are present to aid the general public, but also aid those who are at risk of suicide to increase resiliency (Sher, 2019). In a literature review of the supported protective factors against suicide by McLean (2008), 10 distinct characteristics were identified across the viewed literature. These protective factors include the presence of coping skills, having identifiable reasons for living, good health and being physically active, connection to family, supportive schools, social supports, participation in religion, being employed, presence of traditional social values, and access to health care.

An 11th characteristic was also identified as exposure to suicidal behavior. This was found in one study by Mercy et al (2001), in which exposure to suicidal behavior of a friend, acquaintance, or accounts in the media was associated with a lower risk of lethal suicide attempts. In contrast to the same study's findings, that exposure to suicidal behavior from a parent or a non-parent relative, was not associated with a lower risk of lethal suicide. This finding differs from prior research that indicates that increased exposure to suicide can lead to increased suicidality (Swanson & Colman, 2013).

There are three separate categories that suicide protective factors fall under. These include individual, psychosocial, and positive reasons for living (McLean, 2008). Appendix A outlines these factors and some characteristics within each. Within the individual level factor, several key areas outline characteristics that show to be correlated against risk of suicide. Individuals who show to be strong problem solvers, or those who use problem focused coping strategies are negatively associated with suicide attempts, even with individuals who score highly on hopelessness (Elliott & Frude, 2001). Showing self-control over behavior, thoughts, and emotions has shown to be protective in reducing risk of suicide (Everall et al., 2006). In defining self-control for children and adolescents, this was operationalized as demonstrating traits of cognitive processing, purposeful and goal-directed action, and being able to effectively process emotions. Characteristics of hopefulness, optimism, and being able to identify reasons for living has shown a positive correlation with reducing suicide risk (Malone et al., 2000; Hirsch et al., 2006). An individual's own perception of having good health has also shown to be associated with a decreased risk of attempting suicide (Chandy et al., 1996).

Within the psychosocial level, having connected and perceived supportive family relationships has been associated with decreased suicide risk (Flouri & Buchanan, 2002). Key traits found in a supportive family that contributed to this decreased risk include emotional support, family engagement, support of responsibility and parental engagement in their life. In addition to their parents and supports from childhood, positive marriage and romantic partnership commitments are also found to decrease the risk of suicide (Kraut & Walld, 2003). Outside of family relationships, social relationships and connection, specifically school connections, are associated with lower risk of suicide (Svetaz et al., 2000; Chandy, 1997). Specific supports do tend to rely on authority figures in the school system, such as having

involved nurses or teaching staff. An individual's own spiritual or religious connection is also associated with decreased suicide rates (Tubergen et al., 2005). In addition to the connection from participation in a spiritual group, an individual's own moral objection to suicide has also been linked to a decrease in suicide rates. Another study found that a greater presence of a moral objection to suicide is also linked with a decreased lethality of means for those who do have a suicide attempt (Malone et al., 2000).

Other factors that are protective against suicide risk are connected with the individual's orientation with life. Kraut and Walld (2003) found that those who are unemployed, as compared to those who work either part-time or full-time, show an increase in suicide attempts. One study by Cooperman and Simoni (2005), did find opposite evidence, specifically for women who were HIV-positive, in which employment had a positive correlated with suicide attempts. Cultural values, such as an individualistic versus a collective family-oriented view shows mixed results. It is found that for adolescent girls, having collective family-oriented views is protective against suicide attempts, but more individualistic values shows to be more protective for adolescent boys (Lam et al., 2004). This study was conducted in Hong Kong, which often holds a more traditional collective view on values when compared to the United States which is more often described as being more individualistic. Due to this, generalizing these findings to other populations, should be interpreted with caution.

Resiliency

A characteristic that has gained increased attention in the field of trauma and suicide is resiliency. To be resilient, from the view of positive psychology, is someone's ability to work through challenges by use of resources, strengths, or psychological traits (Tugade & Fredrickson,

2004). This is seen when a person is functioning as well as, or better than, they were prior to a challenging or stressful event (Srivastava, 2011). For example, these individuals may encounter a traumatic event, and instead of displaying a response pattern similar to those who develop PTSD, will go on to better themselves or support and aid those around them. An adage developed around resiliency is that the resilient individual will "bounce back" from adverse events. This idea of bouncing back in the face of adverse events has become so widely adopted that it is even used in developing and promoting resiliency traits for children to aid prevention efforts (Moss, 2016).

Just as resiliency aids someone in moving forward after experiencing adverse events, the development of suicidality is also found to be reduced when greater resiliency is present (Sher, 2019). As resiliency is supported by a wide range of characteristics, it is a combination of present traits that create this strong protective factor. Those who have these traits tend to be at a decreased risk of becoming suicidal, or developing other stress related disorders. As resiliency is something that can be developed, treatments that incorporate a focus on building resiliency skills find a reduction in a patient's suicidality.

Though identified as a single concept of being resilient, resiliency exists across a variety of individual traits (Levine, 2003). A person's sense of control can impact the way in which they view their own actions and their ability to make changes based on those actions (Munoz et al., 2017; Sher, 2019). Known specifically as internal locus of control, this person believes that their actions are responsible for outcomes that occur, rather than some external force being the determining factor. This trait allows a person to still find impact and purpose in their own actions, despite the loss of control that can often occur for individuals who experience a

traumatic or aversive event. These events are still impactful to the person, but their actions in response to these impacts are more often driven towards what they want to do.

Having strong social supports has also been found to enhance resiliency (Sher, 2019; Alizadeh et al., 2018). Though not explicitly determined by the number of people the person is connected with, having multiple strong connections across several life domains can improve the person's resiliency. In developing strong relationships, this is found when the individual feels able to connect with the other person by open communication or by being able to express their emotions with the other person. This creates a sense of belongingness and trust, as well as creating a network for the person to be able to turn to in a time of need. Having strong connections across multiple life areas allows for more chances of interaction with others and increases the likelihood that they will reach out to this support system.

Developing the ability to effectively problem solve, or cope is supportive of resiliency (de Almeida & Benevides, 2018). Aversive events can cause significant negative emotions and lead to symptoms of mental health conditions such as depression or anxiety (Wadsworth, 2015). The pressure of these emotions or conditions then leads to the person looking for some form of relief. The way in which they obtain this relief is called coping. Someone who is engaging in maladaptive coping will do things that make them feel better in that moment, but may result in direct or indirect long term negative consequences. Working adaptively strives to meet the needs of the moment, but not at the cost of potential longer term harm or difficulties. Effective coping strives to alleviate the present negative state, but does not include methods that can harm the individual. At times, effective coping may not make the person feel better in the moment, but rather aids them in getting through the moment until it passes. The goal is not to always feel good, but to manage the present.

Another factor connected to developed resiliency is a person's ability to engage in self compassion (Alizadeh et al., 2018). Self-compassion is a strategy of emotional regulation in which someone is accepting and understanding of the difficulties they are going through, and looking for ways to care for themselves in that moment. Self-compassion is made up of three elements that are identified by how they compare to a contrasting element. These include self-kindness versus self-judgement, common humanity versus isolation, and mindfulness versus over-identification. As a person is kinder to themselves, accepts the difficulty of being human, and takes a more balanced view towards their approach on their negative feelings, they become more self-compassionate. By demonstrating this trait, the individual builds an internal ability to approach difficult emotions in a non-polarizing manner, but rather in a way that is balanced to their own experiences and promotes actions to get through those moment's demands. In engaging in this action, the person becomes more resilient to the negative events that occur both internally and externally in their life.

Impacts of Suicide

The impact of an individual's mental illness on their families is a pervasive issue that can exacerbate the condition of the individual, and also create problems within the family (Barbeito et al., 2020). According to the National Institute of Mental Health, 25% of adults and 13% of children diagnosed with a mental disorder each year, the likelihood of this problem being present is quite high (US Department of Health and Human Services, 2020). Due to this prevalence across all members of the family, the person's mental illness may become a primary focus (Ketokivi, 2015). This can be due to the problems associated with the illness, access or adherence to treatment, and cost of treatment. As mental illness is linked to a combination of genetic and environmental factors, the likelihood that these problems may compound and occur

across generations is much greater (van der Sanden et al., 2013). As mental illness has profound effects within the family, suicide also shows to impact not only the immediate family, but also the community at large (Sveticic & De Leo, 2012).

When looking at the impacts of suicide, 64% of people living in the United States indicate that they know someone who has attempted or died by suicide (Cerel et al., 2013). In the same study, it was found that 40% of the sample had been exposed to suicide during their lifetime. Of these individuals, 20% of indicate that exposure to suicide has had a significant impact on their lives. Another study by Cerel et al (2018), examines the long-standing evidence that when someone dies by suicide, six people are left impacted. This number 6 has been referenced and used in discussing suicide intervention and prevention for over 30 years. However, in the updated study it was found that per suicide, 135 people were exposed. In this study, exposure was defined as individuals who reported knowing the person who had died by suicide.

Suicide not only impacts the individual, but also affects the family, community, and those close to the individual. To better understand the degree of impact that suicide has, the continuum model has been developed (Cerel et al., 2014). The continuum model follows a similar premise presented by Kenneth Norton, the director of the National Alliance of Mental Illness (NAMI) in New Hampshire. Mr. Norton describes the impact of suicide as when pebble is dropped into a pond (Sandler, 2018). The initial wave that is created by the pebble is large and continues to ripple wave after wave. Though each wave gets smaller in size the farther away that it spreads from the pebble, the reach that the pebble has is much greater than the size of the pebble itself. The continuum model works in a similar manner, and Appendix B resembles this ripple effect.

Cerel et al., (2014) conceptualizes the continuum model for the effects of suicide exposure across four tiers. These tiers are based on perceived closeness to the individual who has died by suicide. This idea around perception accounts for possible variability in the impact for individuals who may be considered traditionally closer or more distant to the person who has passed, such as family or a teacher. From most impacted to least impacted the tiers are listed as follows: suicide-bereaved long-term, suicide-bereaved short-term, suicide affected, and suicide exposed.

Those who are suicide-bereaved (long-term), experience significant difficulty during their grief process. They are likely to be in intense bereavement for a year or more. These individuals are also more likely to require assistance from a counselor or therapist to process the loss. Next, suicide-bereaved (short-term), are individuals who are close with the deceased and are experiencing grief from the loss. They will perceive their relationship with the person who has passed as close and will likely process the loss in the same amount of time that they would process other losses in their life. This processing may require professional assistance, but may also only require aid from a support system. Those who are suicide affected, experience a reaction to the loss that may require some form of assistance due to it causing grief or triggering some other response from personal history. These triggers could be connected to a mental health condition, personal struggles with suicide, or personal connections to suicide. Finally, those who are suicide exposed are anyone who is connected or experiences the loss of the person who has died by suicide. The Appendix C from Cerel et al., (2014) shows the types of individuals who might be more commonly associated with each of the four tiers.

History of Suicide Theory

Much of the history of suicide research has focused on etiology and behaviors associated with suicide (Goldney, 1982). In examining suicide, the perspective of different theories have developed to examine the presenting problem from difference etiologies. The origin of these different theories of suicide expanded from the ideas of founders such as Durkheim (Rosen, 1971). As Durkheim came from a background of sociology rather than psychology (Stark, Doyle, & Rushing, 1983), his views on the cause of suicide derive from the involvement of society and the social group. Durkheim presents four types of suicide that include Egoistic, Altruistic, Anomic, and Fatalistic (Pickerin & Walford, 2014).

Egoistic Suicide is, at its core, a feeling of not belonging to a community. Those not connected to a form of social groups are believed to be at an increased risk of suicide, as they do not abide by this social standard that provides a structure of support and guidance. Altruistic Suicide covers death as a result of feeling that one is overwhelmed by the needs of someone's society. The person may not feel able to provide for what is asked of them, or their own needs are outweighed by the needs of the many. Anomic Suicide is characterized when a person is not in touch with their own wants and desires and, as a result, are in a frequent state of disappointment. This person could be someone who possesses much, however their mental state is not in line with the reality of expectations. Because of this, they find themselves in a situation where they frequently feel a lack of life fulfillment. Fatalistic Suicide is a theoretical state in which their future is stopped, and they experience significant oppression. Durkheim believed that this was solely theoretical in nature and could not be present in reality. It is also found the be the opposite eyepiece of Anomic Suicide. Despite coming from opposite experiences and conditions, the impacts of a wish to die remain constant.

Initial development of suicide research has expanded and branched into the predominate theoretical views of suicide that include the biological theory, psychodynamic theory, cognitive-behavioral theory, and the interpersonal theory (Lester & Gunn, 2014). How each of these presents suicidality and its incorporation into treatment will be included in this review. Though other theories have been developed, the theories of suicide covered in this review provide background to unique domains of how suicide is developed. Each theory of suicide reviewed here includes unique components from the others presented or is founded in a well-regarded theory of psychopathology.

Psychodynamic Theory of Suicide

The psychodynamic perspective is founded on several contributing ideas that date back to work from Durkheim, Menninger, and Shneidman (Rose, 2017; Werth, 1996; Menninger, 1938). Though each provides different focus of the psychodynamic approach, each contributing idea predominantly emphasizes unconscious meanings and connections to death, such as reunion to a loved one, rebirth, retaliation, revenge, or atonement (Hendin, 1991). In understanding the psychodynamic approach to suicide treatment, the focus is on the client's unconscious process and possible motivations (Draper & Margolis, 1976; Yakeley & Burbridge-James, 2018). The client's unconscious reactions to past events or their interpretation of the events may guide their actions and, as a result, may end in acts of self-harm or suicide. The client may not recognize that their engagement in suicidal behaviors is a result of these internal reactions and may perceive them as another manifestation.

To reduce this risk of harm or death, the therapist works with the client to identify the mental framework that is operating (Schechter et al., 2019). The view of the self and others is

compared against the framework that has been developed by past experiences. The therapy processes allow for exploration that provides a therapeutic relationship and can promote an emotional release or connection. This creates a space that aids the client in beginning to manage the unmanageable feelings and confront the thoughts that they have pushed away.

The use of a psychodynamic approach to the treatment of suicidality has shown to provide similar treatment outcomes to that of using Cognitive Behavioral Therapy (Hawton et al. 2016). As using evidence-based treatments should be a foundation to selecting a treatment approach for any case presentation, due to the high-risk nature of suicide, having empirical support is necessary. In a metanalysis by Briggs et al., (2019) it was found that incorporating psychodynamic therapy into treatment with individuals who are suicidal and engaging in self-harm behaviors yielded a reduction in overall suicide attempts as compared to the studies' control group (OR=0.469). A statistically significant reduction in self-harm behaviors were also found during the 6-month follow up, but not during the 12-month follow up.

Biological Theory of Suicide

The Biological theory of suicide is underlined by the idea of a diathesis stress model. This model presents that an individual's suicidal behaviors are driven by an underlying biological predisposition that is triggered by a psychosocial stressor event (Aydın et al., 2019). Specific behavioral traits, such as impulsivity and aggression, act as indicators for possible suicidal behaviors under the biological model (Swogger et al., 2014). The research on the biological indicators and their connection to suicide has increased focus, towards neurobiology.

In a study conducted by Coon et al., (2018), risk of suicide was found to be correlated to 4% of genes. Gene variants such as APH1B, AGBL2, SP110, and SUCLA2 were some of the

markers that were noticeably associated with suicide risk. The study reports that 45% to 50% of suicide risk can be accounted for by this genetic component. The serotonergic system, and the impacts on serotonin, is one of the primary neurological systems focused on in regards to suicide (Mann, 2003).

The serotonergic system includes neurons that provide communication between various neural pathways that are frequently required for cognitive functions (Švob Štrac et al., 2016). There is an increase in the neurons involved in this system within the hippocampus and the prefrontal cortex, which are often involved with functions of learning and memory. An increase of serotonin receptors is also found in the amygdala, which is the integrative center for emotional, behavior, and motivation (Sadkowski et al., 2013). This results in great effects to an individual's overall mood regulation. The compounds involved with serotonin, including protein receptor, genetic polymorphic, and hormone metabolite differences have been found contribute to impulsivity and stress response, specifically in those who are suicidal (Stanley & Mann, 1983; Stanley et al., 1982).

Another system that is believed to have a significant influence in the cause of suicidality is the 5-hydroxytryptamine (5-HT) receptors (Underwood et al., 2018). The 5HT receptor acts as a serotonin receptor that modulates the release of neurotransmitters, including glutamate, GABA, dopamine, epinephrine/ norepinephrine, and acetylcholine. Impairment to the 5-HT receptor and SERT, another serotonin receptor, is found to be present in those who have attempted suicide, as well as those with diagnosed major depressive disorder and alcohol use disorder. Specifically, serotonin is found to bind to receptor cells at a lower rate for those who have made a suicide attempt, as compared to those who have not. This further highlights the significance of the role of serotonin for those who are suicidal.

Despite the connection between serotonin and suicide, some mental health conditions classified as severe mental illness, such as schizophrenia, often present with higher rates of suicide (Schmutte et al., 2021), but do not show an association between the condition and serotonin (Lin et al., 2014).Conditions such as major depressive disorder and generalized anxiety disorder show to be greatly impacted by dysregulation to serotonin and the serotonergic system (Owens, & Nemeroff, 1994; Ressler, & Nemeroff, 2000). As such this can place individuals with those mental health conditions at a greater genetic risk of suicidality.

Psychiatric conditions classified as severe mental illness are found to have the highest absolute risk of suicide (Nordentoft et al., 2011). Severe mental illness inflicts a significant impairment in functioning for the individual, and are long term conditions (Drake & Whitley, 2014). After their first psychiatric admission, individuals with bipolar disorder had an absolute risk of dying by suicide of 7.77%, while those with schizophrenia were at 6.55% (Nordentoft et al., 2011). These psychiatric conditions, as compared to the study's control group of those who did not have a diagnosed psychiatric condition, held an absolute risk of suicide of .72%. From this study, it can be shown that the absolute risk of suicide for those with bipolar disorder is 10 times higher than those without a psychiatric condition.

Cognitive-Behavioral Theory of Suicide

The cognitive-behavioral view, in line with Aaron Beck's cognitive-behavioral model, includes the interaction between the biopsychosocial component of the individual and how their thoughts interact (Wenzel & Jager-Hyman, 2012). From this, the resulting behaviors result in a tendency to engage in suicidal acts. The use of cognitive behavioral therapy (CBT) to address mental illness has not been shown to reduce suicidal thoughts or behaviors (Mewton & Andrews,

2016). When CBT is directed towards addressing the suicidal thoughts and behaviors, instead of just addressing mental illness, there does show to be a reduction in a person's suicidality.

CBT often serves as an umbrella term to capture various approaches to challenging and restructuring thoughts and behaviors. The use of CBT is often a preferred method of intervention due to its manualized and empirically based intervention (Hofmann et al., 2012). Suicide focused treatments of CBT include Cognitive Therapy for Suicidal Patients (CT-SP) and Cognitive Behavior Therapy-Suicide Prevention (CBT-SP) (Bryan, 2019; Stanley, 2009). Both of these programs follow a manualized 12-week approach. These include risk and means reduction while also focusing challenging distortions and behaviors that are directly connected to their suicidality. Additional focus in sessions can also be placed on specific problem areas that may be contributing to increased risk for the client.

Aaron Beck indicates that a person who is suicidal is attached to a core belief that they are worthless and undesirable (Beck et al., 1979). This can lead to feelings of hopelessness due to a belief that they cannot recruit help, nor solve their problems themselves. As the problems begin to overwhelm the individual, paired with a lack of perceived support, they view their situation as unsolvable and that there is no future (Mathews, 2013). This feeling of hopelessness is found to occur at a statistically significant rate for individuals who report experiencing suicidal ideation (Britton et al., 2008).

In the treatment of suicidality with CBT, a focus is placed on teaching the suicidal individual to recognize when thoughts occur, and how those thoughts influence our behaviors that follow (Brown et al., 2005). An important first step is to plan for safety to ensure that the individual is not at immediate risk, and is prepared to address moments of crisis between

sessions. Another important step of treatment is working to identify and reduce the present risk factors that could be contributing to their suicide, or those that may be putting them at greater immediate risk. Due to the lack of maladaptive coping mechanisms that may have developed for the individual, identifying effective coping mechanisms to address times of crisis and their risk factors can provide the individual with direct tools to begin to manage their feelings. Supportive factors to reduce risk and promote the effects of treatment include strengthening social supports and involvement (Czyz et al., 2012). Finally, depending on the presence of a mental health condition, adequate medical consultation for needed medication, or focus on medication adherence can support treatment (Asarnow et al., 2017; Brown et al., 2005).

Interpersonal Theory of Suicide

Thomas Joiner presents in his book, *Why People Die by Suicide* (2005) the interpersonal theory of suicide. This theory is based on three factors that account for an individual's desire for suicide and enacting a lethal, or near lethal, suicide attempt (Van Orden et al., 2010). The three factors include thwarted belongingness, perceived burdensomeness, and capacity for suicide. When thwarted belongingness and perceived burdensomeness are present, it can result in the individual developing a desire for suicide. If the capacity for suicide develops, while the desire for suicide is present, then the individual becomes at risk for dying by suicide. This is further outlined in Appendix D (Van Orden et al., 2010).

Thwarted belongingness is when a fundamental sense of connection is not present and causes a painful psychological state (Van Orden et al., 2012). Not feeling connected with others or feeling as though they do not have a place in the world can lead to negative effects on an individual's emotional patterns and their cognition (Baumeister & Leary, 1995). Different risk

factors can place individuals at a higher chance of experiencing feeling as though they do not belong. If patterns of social isolation occur, then that may place the individual at greater risk (Cacioppo & Patrick, 2018). High risk instances include living alone, lack or low social supports, or prolonged feelings of loneliness (Van Orden et al., 2012). The individual's level of attachment may also influence their level of perceived connection to others (Venta et al., 2014). Attachment is based in attachment theory, which states that the way that an individual connects with their caregiver during early development will influence how they perceive and interact with relationships in their future (Cassidy, 2013). Attachment has been found to interact with other life domains as well. It was found that those with an insecure attachment style also reported feeling as though they do not belong at a statistically significant rate (Venta et al., 2014). As the individual perceives connection with others under an insecure model, they are both less likely to understand how they relate to their relationships and will form relationships following the model of an insecure attachment. This can lead to relationships that are not fulfilling, are disconnected, or are harmful for them as an individual.

Perceived burdensomeness is experienced by an individual when they perceive themselves as adding additional peruse or work onto others at a greater amount than they help alleviate (Ryan & Deci, 2000). This can lead a person to feel as though others would be better off if they were not around anymore. Just as with thwarted belongingness, there are additional risk factors that are specific to increased chance of developing a feeling of perceived burdensomeness. In better understanding these risk factors, self-determination theory provides additional insight. The theory proposes that motivation is driven by three psychological needs (Patrick & Williams, 2012). These needs include competence, connection, and autonomy. When people are fulfilled in these areas, they then have a capacity to develop change in their life. When

these areas are not fulfilled there is a lack of motivation to engage in change. As such the individual may feel inadequate, disconnected, or unable to make change in their life (Brown, et al., 2000). These instances of feeling like a burden may occur when a person is unemployed, or has some form of functional impairment, either physically or mentally induced (Van Orden et al., 2012). Though this feeling may occur given any situation where a person is in need of assistance, individuals who more frequently need assistance, regardless of their level of control over that factor, may also view themselves as a burden.

Assessing thwarted belongingness and perceived burdensomeness can provide insight into an individual's desire for suicide (Van Orden et al., 2012). The Interpersonal Needs Questionnaire (INQ) provides additional data to be further reviewed for research, but also by clinicians in assessing risk for the suicidal individual. The INQ is shown a statistically significant effectiveness in measuring thwarted belongingness, perceived burdensomeness, and their interaction (Ma et al., 2016). Though this does not determine if this is a person who is going to go on to attempt suicide, it does provide more information on the severity to which the individual wishes to die. The INQ is not the only measure for measuring a person's social connection, but the factors that it specifies at are the closest to what is modeled in the interpersonal theory of suicide, and as such will be what is reviewed.

Capacity for suicide is a theoretical concept composed of three factors, including acquired capability, predisposition, and access to lethal means, (Bayliss et al., 2021). Models that include capacity within their framework include the interpersonal theory of suicide (Joiner, 2015), the integrated motivational-volitional model (IMV; O'Connor & Kirtley, 2018), and the three-step theory of suicide (3ST; Klonsky & May, 2015). Within each of these theories, capability is a common factor of capacity that is included. Each factor provided by Bayliss et al

(2021) will be reviewed here, but due to the wide adoption of the importance of capability across different theories, that will be the primary focus.

Disposition, uniquely a part of the 3ST, refers to individual differences that are often genetically based (Bayliss et al., 2021; Klonsky & May, 2015). These factors can include pain sensitivity or a phobia to blood (hemophobia). If an individual is born or has an increased level of pain tolerance, then they are at a higher risk of having the capacity to lethally harm themselves, as increased levels of physical damage will not be perceived as harmful by the individual. If they have a decreased level of pain tolerance, then they will be at a decreased risk of inflicting lethal harm due to the increased deterrence caused by pain and less than lethal physical damage. In regards to hemophobia, if the individual fears blood then they will be less likely to witness or themselves experience actions that result in blood being drawn. This avoidance will act as a greater deterrent from enacting lethal self-harm as the person will not have seen or engaged in harmful actions. As such, engaging in something that could cause lethal damage to themselves is a much more difficult task, and much less likely to occur.

Access to lethal means is a factor that is referenced across all three theories as a part of another factor within their theory, but is specifically focused on in its importance by the IMV (O'Conner & Kirtley, 2018). Not only does immediate access to lethal means puts the individual at greater risk, but prolonged exposure and knowledge of handling different lethal items, such as a firearm, greatly increases the risk of an individual dying by suicide. As the person becomes more accustomed to handling the lethal object, the fear response of the possible danger it can inflict diminishes. In addition to this, the greater their exposure to the lethal item, the greater knowledge they will possess to use it in a way that will be lethal. This can be seen both by service members who use firearms to end their life, and with doctors who may use means such as

medications. Individuals from these populations not only possess the knowledge and history of using the items, but are also more likely to possess access to them in the time of being actively suicidal.

Acquired capability is developed when an individual goes through painful experiences, both physical and mental, that habituates them to the fear of pain that is associated with attempting suicide. According to the interpersonal theory of suicide this is the factor needed to develop the capacity to enact lethal self-harm (Joiner, 2005). The development of this can occur from a variety of experiences, such as self-harm behaviors, military or first responders where being witness to death or pain of others is more frequent, athletes where physical pain is endured as part of training and within the sport itself, and substance use where the individual is not only putting themselves in life threatening situations, but are also more likely to experience loss of others due to the involved danger of using substances.

Overall, developing this capability can involve a prolonged exposure to these pain inducing events (Joiner, 2005). This develops an ability to overcome evolutionary programming for self-preservation, a trait that is fundamental to humans and nearly all life (Öhman & Mineka, 2001). The individuals' experiences increase their fearlessness and decrease their sensitivity to pain (Joiner, 2005). This combination makes the idea of enacting suicide, and the pain associated, no longer something that is a deterrent. Once this capacity is developed, then the individual is at much greater risk of being able to engage in acts that can cause death. This does not mean that the individual will enact on suicidal actions if they develop this capacity, but if they have developed the desire for suicide, then they are then someone who may make a suicide attempt.

Current Methods of Suicide Treatment

Though suicidality is not formally classified as a mental health condition, specific treatment methods have been developed and empirically validated as effective forms of intervention. Suicidal ideation and behaviors are also commonly present as symptoms, or in addition with mental health conditions (Brådvik, 2018). Because 90% of people who die by suicide also have a mental health disorder there are treatment methods not specifically aimed towards the treatment of suicide that do incorporate suicide focused parts to treatment (Arsenault-Lapierre et al., 2004). These methods of intervention have sparked several different variations to fit sub populations and treatment settings, but for the purposes of this review two common approaches to suicide treatment will be discussed: Collaborative Assessment and Management of Suicidality (CAMS) and Dialectical Behavioral Therapy (DBT).

Collaborative Assessment and Management of Suicidality (CAMS)

The Collaborative Assessment and Management of Suicidality, commonly known as CAMS, is a therapeutic atheoretical framework in which the provider and the patient work together to assess present risk and build a treatment focused on specific drivers behind their suicidality (Ryberg et al., 2016). Included in CAMS is an initial assessment that leads every session, known as the SSF. The overall framework of CAMS is based on four pillars including empathy, collaboration, honesty, and suicide focused (Jobes, 2016). Within CAMS, developing empathy with the client is a primary focus due to the history of shame and blame that is put on the suicidal individual. As discussed by Orbach (2001), empathizing with a patent's suicidal wish serves to validate that their experiences have led them to feel that it would be easier to no longer be alive. This is not to encourage or endorse that they should kill themselves, but rather to

build a therapeutic alliance by not diminishing their feelings or the difficulty of what they have been through. This idea leads into the next pillar of collaboration.

In promoting collaboration, CAMS is designed to not only partner with the client in developing a treatment that they feel works best for them, but also goes a step further by having the clinician pass the forms to the client for them to write themselves. This is done across all sessions in filling out their weekly assessment ratings. CAMS clinicians are instructed that the seating arrangement with the client should be side to side rather than the typical face to face that is most frequently used in psychotherapy. The treatment plan is developed collaboratively in the initial session, but is also checked in with each week to see if any updates need to be made. The client and clinician will discuss and collaborate on what could be done to best address any feedback about treatment. This same step is also followed with the stabilization plan. Collaboration is used to create a treatment that is agreed to by the client and aids in adherence to treatment.

The CAMS approach takes a view of critical and direct honesty with the client. This is consistent throughout informed consent, to the agreement that the clinician is asking of the client in participating in CAMS. CAMS does not use a no suicide contract as a method of prevention, as that method has shown evidence discrediting its efficacy (McMyler & Pryjmachuk, 2008). Rather, CAMS addresses the client's ambivalence to suicide and asks them to agree to engage in treatment for the determined amount of time while attempting to refrain from suicide. In second edition of Managing Suicidal Risk by Joiner (2016, p. 5) a sample text of establishing honesty with a client specifically says "The research shows that most suicidal people respond to this treatment within 3 months. So why not give it a try? You have everything to gain and really nothing to lose. You can of course kill yourself later, when you are no longer in treatment. It is

your life to live or not as you see fit. But then, what is the hurry?". A core theme to this approach to honesty is that the client can always choose to end their own life if that is what they truly want, but if they are coming into treatment, or even if they are forced into treatment, what is making them want to die? If that can be improved or made better in some way, do they still wish to die? You can always kill yourself, why not try this first to see if things can get better? Presenting these questions and options to the client provides true honesty to their condition that they likely have not experienced in the past and can promote positive connections towards continuing treatment.

CAMS describes itself as not being a new form of psychotherapy, but rather a therapeutic framework with a focus on the treatment of suicide. This allows the clinician the capacity to adapt and include specific treatment methods for intervention based on their own competency and the needs of the client. In treatment planning, the main focus of intervention are the individual drivers for suicide, and the methods of intervention which are proposed and decided on collaboratively between the clinician and the client. The overarching guidance to this is the Suicide Status Form (SSF; Jobes, 2012).

The CAMS approach is primary driven by the SSF, which provides a standardized method for assessment, treatment planning, tracking progress, and identifying clinical outcomes. In all sessions the SSF core assessment is completed. This includes six variables of assessment all rated on a scale of one to five, with one being a low indication of that variable and five being high. The first three variables, psychological pain, stress, and agitation, are based on the Shneidman cubic model of suicide (Shneidman, 1988). Psychological pain is based on the idea of psychache, which refers to the pain of the mind, but not stress. Under this theory, suicide occurs when their capacity to handle an amount of psychological pain is exceeded. In treatment,

working to reduce the occurrence of instances that provoke this pain, but also building their own tolerance to this pain are key elements to reducing risk for suicide. Stress, identified by Shneidman as press, refers to demands that impact the individual and cause significant distress. These can be rooted in both internal and external drivers. Agitation or perturbation is an individual's drive or impulsive desire to do something in that moment. This is described to the client as feeling a need to act now. This factors rating is helpful in indicating the individual's risk of taking suicidal action in an acute moment of distress.

The fourth variable measured on the SSF assessment is hopelessness. This is derived from Aaron Beck's concept of hopelessness, looking into the feeling that a person's situation will not get better no matter what they do to change it. The person feels powerless to improving what is bothering them and will stop trying to do anything about what is bothering them. They may feel helpless about themselves, others, or their future. Of all the risk factors for suicide, hopelessness is found to be correlated the highest (Beck et al., 1985 & Brown et al., 2000). The fifth variable, self-hate, comes from Roy Baumeister's conceptualization of self-regard. In this idea, an individual is driven to avoid and a negative perception of themselves. When an individual begins to develop negative self-views on their own, or provoked by others, this experience can become intolerable to the point in which suicide is the only from of escape. The final variable is the individual's overall risk of suicide. The scores indicated on this, in addition to clinical judgment, are used for determining the level care needed for the individual at that time, and it is used for determining resolution from CAMS. Although promoting clients' rights and autonomy is important, their safety is the top priority. If it is determined that the client is at immediate risk of suicide and that they are likely to leave session and go on to engage in acts that can end their life, and there is not confidence in an established plan to intervene with their

actions, additional more restrictive forms of care such as hospitalization may be necessary to ensure safety. From the CAMS treatment perspective, it is a primary goal to do everything that can be done to avoid hospitalization, but if risk cannot be mitigated, responsibility to the client's safety is prioritized. When scores on the sixth variable are less than a three across three consecutive sessions, then resolution from CAMS may be appropriate.

In the initial session other metrics are collected, such as how much suicide relates to thoughts of themselves versus others, their wish to live, and their wish to die. Specific reasons for dying and reasons for living are also outlined and ranked. It is not uncommon for something on the client reasons for dying list to also be present in some form on their reasons for living. The client is also asked a question like that of the miracle question. The miracle question asks, that if tomorrow the problem is gone, what does the world look like (Searight, 2010)? For the person who is suicidal it is asked what would be one thing that would help them no longer feel suicidal. In essence these questions ask what the client feels would make things better for them. From that answer, intervention can focus on tacking backwards towards what can be done to support that, or a version, of what the client is wanting. This is just one more step in addition to the specific treatment plan that is next outlined with the client.

The next section is filled by the clinician and incorporates several standardized risk areas. This provides a directed history for suicide risk. Though a greater history can be helpful, having a basis for these factors is supportive for identifying specific areas to address in the treatment. In developing the treatment plan with the client, a problem is identified, goals to address to work on that problem, and specific interventions to reach those goals. The timeline for treatment is typically 12 weeks. The number one problem is standardized as being the potential for self-harm. Due to the risk involved, and the inability to work on any other problems if the client dies by

suicide, that is prioritized. The client and clinician work together to identify areas of treatment for the remainder.

A critical component to the CAMS initial session is the stabilization plan. This is a form of a safety plan for the patient to use in moments of stress or crisis. In this plan, working how to restrict access to lethal means, things to do in moments of crisis, people to call in moments of crisis, and solutions to address barriers to continue to treatment are all completed collaboratively. The stabilization plan is revisited each session to identify any changes that should be made to better aid the client in practical use in their life. Having an effective and customized stabilization plan is a key element to the CAMS framework that allows for high-risk treatment to be conducted on an outpatient basis. The CAMS framework has been adapted to several different treatment populations and environments. In response to the COVID-19 pandemic, a digital telehealth from has even been piloted. The CAMS treatment approach is designed to work in conjuncture with the clinician and has been adapted to fit different approaches to treatment.

In the most recent meta-analysis by Swift et al., (2021), nine articles, including 749 participants, were examined for patient outcome data from the treatment of CAMS. To measure suicidal ideation, the included studies used one or more suicide screeners. These included the Beck Scale for Suicide Ideation (BSSI), Columbia Suicide Severity Rating Scale (CSSRS), Counseling Center Assessment of Psychological Symptoms (CCAPS-34), Patient Health Questionnaire 9 (PHQ9), and the Scale for Suicidal Ideation (SSI). Based on these findings the use of CAMS, as compared to another active intervention, suicidal ideation was significantly lower (d = 0.25). Though ideation was significantly reduced, no significant decrease was found for other suicide markers, including attempts or self-harm. In addition to reduced ideation, the meta-analysis also found that general distress was significantly reduced (d = 0.29). Hope, and

specifically hopelessness is a strong indicator for suicidal ideation, and is directly tracked on the CAMS SSF. Higher ratings of hope and lower ratings of helplessness were tracked and found to be strongly significant after CAMS intervention (d = 0.88). As another key feature of CAMS is its collaborative and client centered focus for structuring treatment, positive factors such as treatment acceptability were also tracked. Treatment acceptability was defined as patient rated satisfaction at the end of treatment and the amount of retention or dropout from treatment. Treatment acceptability was found to be significantly positively correlated with administration of CAMS as compared to other treatment methods (d = 0.42).

Dialectical Behavioral Therapy (DBT)

Dialectical Behavioral Therapy (DBT), initially developed for the treatment of those with borderline personality disorder (BPD), has gone on to be adapted for the treatment of other conditions that benefit from focus on emotional regulation or the reduction of harmful behaviors (May et al., 2016). The Mayo Clinic describes the characteristics of BPD as impacting the way a person feels about themselves and others, effects a person's ability to solve problems, issues with self-image, difficulty managing emotions and behaviors, and continued problems with having unstable relationships (Mayo Foundation for Medical Education and Research, 2019). DBT focuses on building life skills to address these problem areas that are found in BPD, but in other mental health conditions as well. Skills are broken up into modules that include distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness (Linehan, 2015). These skills are base level concepts that are built upon using a wide range of intervention skills

Though DBT focuses on teaching skills to alleviate the negative impact of symptoms and create new patterns of behavior, a specific four stage approach is taken as a view for addressing

treatment needs (Koons, 2021). This approach looks at the symptoms, thoughts, and behaviors of the individual rather than grouping based on mental health conditions. Stage one is primarily used for patients who are suicidal, engage in non-suicidal self-injury, or engage in heavily harmful behaviors that could limit their ability to engage in treatment or may put their life at serious risk. Treatment here focuses on reducing risk to harm and death so that the client will be safe and able to engage in further treatment to address other problem areas. Stage two focuses on treatment of those with patterns of emotional avoidance or numbness along with those who are experiencing symptoms of posttraumatic stress, but are guarded and reserved from their symptom expression. Treatment in stage two begins to approach skills to aid in life satisfaction, such as their ability to emotionally regulate, tolerate stress, and be able to communicate and interact with others effectively. Stage three clients often have an ability to regulate their behavior, but still present with difficulties with interpersonal relationship, limited self-care, and pervasive problems in several life domains. Treatment for those with stage three conditions are able to focus on improving the established relationships, enhancing skills in developing new relationships, and building the individuals positive self-esteem practices. Stage four cases tend to be lingering problems for the patient who struggle with personal meaning, feel empty, or lack a sense of joy in their life. Treatment in stage four works to support the client in satisfaction with the life they build and promoting positive self-esteem practices.

DBT is a structured practice that can require certification to be able to effectively practice. As DBT is an empirically supported treatment, adherence to the model is important for promoting consistent and care that follows best practices. Traditional DBT from the clinician's perspective includes a skills training group for the patient, individual psychotherapy for the patient, telephone consultations from the patient to the clinician, and the therapist talking with a

therapist consolation team weekly. In treatment of BPD, DBT has shown to reduce the need for medications and medical care by up to 90% (May et al., 2016). DBT, as a method of treatment for other conditions, such as bipolar disorder, restrictive eating disorders, PTSD, and substance abuse has also shown positive effects (Goldstein, 2007; Peterson et al., 2020; Steil et al., 2018; Kienast et al., 2014). In treating eating disorders, specifically those that involve restrictions of consumption like anorexia nervosa, there was a significant effect in symptom reduction (d = 0.40) (Peterson et al., 2020). For those with diagnosed PTSD, treatment with DBT resulted in a 79% remission in parent ratings of symptoms (Steil et al., 2018). Treatment of substance related disorders using DBT resulted in increasing both negative drug screens and number of day's abstinent form alcohol or drug (AOD) use.

Due to the skills and module system of DBT, specific pieces can be pulled from even when using a different form of treatment. While following DBT by the stages and model system, known as comprehensive DBT, support for incorporating skills into practice by a different treatment intervention is supported and known as informed DBT. In an initial study done by Marsha Linehan (1993), she examines the skills of DBT, without the additional methods used in comprehensive DBT, is effective at treating BPD. Those selected for treatment were BPD outpatient's client with chronic suicidality. Clients either were assigned to receive DBT skills intervention, without any other factors of comprehensive DBT, or to be assigned to a control waitlist while they continued to receive non-DBT related intervention. Results indicated that there was no significant differences detected between the two conditions. This was across suicidal injury, non-suicidal self-injury, suicide attempts, emergency room admissions, and hospitalizations at an inpatient psychiatric hospital. This indicates that DBT skills as an intervention is comparable to other forms on individual psychotherapy. Though this is promising

for use of integrating DBT skills into treatment, it has been shown that comprehensive DBT, as compared to non DBT adherent therapists, resulted in better patient outcomes (Linehan et al., 2002). Better patient outcomes in this study references reduction in positive urinalyses for opioids for those with an opioid use disorder.

A common condition found with those with BPD is suicidality and non-suicidal self-injury with up to 10% of BPD patient dying by suicide (Paris, 2019). For those with BPD, an inability to regulate emotions can lead to impulsivity. This places the individual at a higher risk of engaging in self-harm or other risky behaviors that can build a desensitization or capacity for suicide (Joiner, 2005). Unstable social relationships and lack of support systems is also a key trait found in those with BPD, as a result this individual lacks an ability to connect and address their needs for help (Pairs, 2019). Treatment of BPD focuses on helping the client step aside from the wave of their emotions, take time to self-reflect, break their impulsive reaction to engage in past behaviors or acting on emotions directly, and then to develop a better understanding of how to interact independently and with others. As the focus of DBT for these individuals starts with stage one, this method of intervention matches with aims of suicide specific intervention. This includes a focus on safety, building supports, and effective coping.

Maladaptive Coping Skills

Aversive events can cause significant negative emotions and lead to symptoms of mental health conditions such as depression or anxiety (Wadsworth, 2015). Maladaptive coping can be the result of experiencing overwhelming stress, poor treatment, and emotional validation. Though these are often pressures that occur during childhood they are also responses to adult

trauma, abuse, or severe loneliness. The pressure of emotions can lead to the person looking for some form of relief. The way in which they obtain this relief is coping. Someone who is engaging in maladaptive coping will do things that make them feel better in that moment, but may result in direct or indirect long term negative consequences. This person may not always be aware of this relationship, but even when they are, they may accept the negative consequences as they perceive the burden they are going through in the moment as worse. The use of substances, avoidance, or self-harm are all examples of maladaptive coping. Someone who has developed adaptive coping skills will be able to manage their current feelings or situation in a way that does not cause them harm later. Some adaptive coping skills include, deep breathing, talking with others, and reframing thoughts. Effectively using adaptive coping skills allows the person to alleviate their current stress or other events and manage difficulties long term.

As stated by Virginia Satir (1984) "Problems are not the problem, coping is the problem." Coping in itself is what is the focus of dealing with the issue is. In focusing on treatment, the reasons that drive the problem are often not the focus of what will make a person feel better. The things that a person does to alleviate this problem, or the negative feeling can, and often do, drive greater negative feelings and problems. This is demonstrated in the self-destructive patterns of addiction. An individual experiences aversive events or negative emotions that are driven externally or internally. Their initial use of substances or process addictive behaviors may be driven to alleviate the negative feelings to cope. The initial use can also be driven by factors unrelated to the negative feelings, but as relief is experienced after use or engagement in the behavior, a reinforced pattern emerges. Though addiction is a common maladaptive form of coping, engagement in rumination, emotional numbing, escape, intrusive thoughts,

procrastination, self-harm, binge eating or restrictive eating, isolation, and risk-taking behaviors are just some of the other copings skills that are typically considered maladaptive (Sutton, 2021).

In examining suicide and maladaptive coping, there is a positive relationship between increased suicidality and engagement in coping behaviors that can have impacts similar to those that are maladaptive (Liang et al., 2020). Substance abuse, isolation, venting, self-blame, and avoidance were all positively associated with higher scores on suicide screeners. In addition to there being more maladaptive and aversive behaviors that were engaged in by those who are at greater risk of suicide, there was a negative association with adaptive coping skills.

Suicide, in itself, can develop to be a coping mechanism (Webb, 2019). Though it is maladaptive, suicidal thoughts and ideation can provide a sense of relief or control in moments of despair, hopelessness, or pain. Those who use suicide as a method of coping may derive from different functions. They may romanticize the idea of suicide or parts that go along with it. In doing this they may leave out the pain, consequences, and irreversible nature of the action. These people may use this fantasy as a method of coping, but are unaware of the immediate and long term damages that continuous thoughts of suicide can cause.

Group Treatment

Group based interventions have become increasingly utilized due to the unique advantages that they provide both to the clients, and in the logistics of operating services (Holas et al., 2016). The unique environment of group therapy provides diverse views of modeling, social learning, and exposure to others experiences. Group support allows for clients with a connecting background to provide insight or challenges that could not traditionally be done effectively by their clinician. This ability to share and challenge one another, in itself, can be

therapeutic. From a practice view, this method also allows for more individuals to be seen at a time with often similar, if not better treatment outcomes for certain conditions. As access to healthcare can be challenging, providing group services works to aid more people.

In conducting effective group intervention, Yalom (1995) presents that reported ideology for group treatment is not an effective indicator of a successful treatment group. Findings indicated that adherence to ideology and stated approaches varied by facilitator, but effectiveness of treatment was associated with the intervention provided by the facilitator. This meaning that ideology is important, but the way in which a facilitator enacts that practice is what results in the best treatment outcomes. Four basic leadership functions were identified, including emotional stimulation, caring, meaning attribution, and executive functioning. Both caring and meaning attribution show to have a positive liner relationship with treatment outcomes, meaning that the more of these traits that are present, the greater the positive outcomes for treatment. Emotional stimulation and executive functioning showed a curvilinear relationship. This indicated that too little of these factors showed poor outcomes, but too much would also result in poor patient outcomes. Finding a balance point of moderate inclusions of these traits.

Group Treatment for Suicidality

Treatment groups encounter clients who express outwardly or are internally holding back their own experiences with suicide (Combstock & McDermott, 1975). These groups often don't focus on the treatment of suicide despite group intervention being an appropriate format for treating problems commonly associated with suicide, such as impulse control, lack of future orientation, low self-esteem, depression, and difficulties with accepting their own personal responsibility. For the group in the presented study, patients included those who had a suicide

attempt and had been hospitalized. Treatment was done on a weekly outpatient basis with rolling enrollment. The group was continued over the course of 2 years and in total had 105 patients. The median treatment stay was 6 weekly sessions, but 20% of participants were involved for at least 3 months of treatment and as much as an entire year. After intervention it was reported that the reattempt rate was four percent and one person went on to die by suicide, which was noted as being less than expected with patients who followed treatment as usual. These results indicate initial support for group-based treatment for those who are at high risk of suicide.

A primary deterrent and concern for suicide focused group intervention is the potential for suicide contagion (Spears et al., 2019). With several people being in the group who are at risk of suicide, the concern of if someone will be triggering to another and lead them to be at greater risk of dying by suicide is a major risk concern. In addition to this concern, Fournier (2005) reports that suicidal individuals can disrupt the group process and divert attention of the group. In response to these concerns, primary data on contagion effects is found amongst adolescents (Kaminer, 1986). In incidents in which contagion effects have been reported, populations often consisted of inpatient hospitals where severe mental illness becomes a compounding factor to the overall risk of the individual (Seeman, 2015). Though concerns are present for a group intervention for suicide, specific caution to these key problem areas can facilitate for a safe intervention that promotes positive characteristics of having group intervention.

A treatment for the group intervention of suicidality developed by the department of veteran affairs (VA) is the Project Life Force (PLF; Marin et al., 2019). PLF is a novel suicide safety planning group that focuses on providing intervention over several weeks to aid veterans in revising and developing their safety plans. Over 10 sessions the group utilizes methods of CBT, DBT skills, and psychoeducation to develop coping skills, emotional regulation abilities,

and interpersonal skills. Due to the novel nature of the intervention a randomized clinical trial has not yet been conducted, but a proposal for the format of intervention and evaluation of intervention has been published by Goodman et al., (2020).

In another development for group suicide treatment, the suicide status form (SSF) from the CAMS approach of individual suicide intervention had been adapted (Johnson et al., 2018). In the initial study that implemented this approach, veterans that were recently discharged from an inpatient psychiatric setting were followed up with participation in a treatment as usual group or a group that incorporated the SSF. There was not a significant difference recorded in group attendance or client rated satisfaction. Participants in both groups reported significant positive outcomes from treatment. Results after the three-month scheduled weekly sessions indicated that treatment as usual resulted in greater reduction in overall symptom distress. Factors that did show to correlate with positive outcomes for clients were attendance, working alliance with facilitators, and positive group cohesion. Thought treatment as usual showed to be more effective, both groups showed to have a positive effect, and both focused on a group intervention for those who were suicidal.

CAMS-G.

In addition to adopting the SSF to group suicide focused treatment, CAMS itself has been adapted to group intervention. Termed as CAMS-G, this method of intervention serves to integrate the collaborative assessment nature of CAMS and broadened it to a group format (Gutierrez et al., 2021). The basis for the group is that a group setting provides opportunity to

develop relationships and a sense of belongingness. As the interpersonal theory of suicide (Joiner, 2005) includes a sense of burdensomeness and thwarted belongingness as a primary driver behind suicidality, providing intervention that promotes integrated connection could assist in addressing this problem.

In an initial study examining the effectiveness of adapting CAMS to group intervention, patients who were recently discharged from a hospital following admission due to their suicidality were recruited to participate in an after-care therapy group (Johnson et al., 2014). Results from the study found that adaptation of CAMS to a group setting was feasible for providers previously trained in CAMS and was well accepted by the patients receiving care.

In the pilot study of CAMS-G, patient outcomes indicated a decrease in symptom distress, a positive sense of group cohesion, and overall satisfaction with the treatment they received (Gutierrez et al., 2021). Treatment outcomes for CAMS-G patients as compared to the control group, who received treatment as usual, resulted in no statistically significant difference, but did both result in positive outcomes for patients. Patient drop out from treatment was also comparable between both conditions.

Risk Assessment and Screening

According to the National Institute for Mental Health (NIMH, n.d.), the assessment of suicide before intervention serves to decrease the risk of harm to the client, but also aid the practitioner in determining the level of care needed to be provided for the client. For therapeutic intervention assessing risk and screening can serve both to determine risk, but can also aid in

tracking current severity so that it can be tracked over time. This is a function that is foundational to the CAMS SSF. The Columbia-Suicide Severity Rating Scale (C-SSRS) provides data on suicidal ideation and behaviors. The C-SSRS has been adapted to fit many different settings and treatment needs. The C-SSRS asks about thoughts and behaviors separately. Form this view it strives to catch more instances of suicidal and non-suicidal self-injury that could be putting the client at risk. The ideation questions build on one another and if certain discontinue criteria are met then further questions are not asked. This format aids in making the screener brief, but also thorough for the client's specific needs and to reduce chances of lost data.

Another measure includes the Patient Health Questionnaire (PHQ-9) which also provides a brief screening into the clients current functioning and possible suicidality (Na et al., 2018). Results are geared towards an indicator to the severity of depression, but symptom questions overlap with suicidality, including direct questions about thoughts of being better off dead. As the PHQ-9 is brief it can provide a snapshot into the clients functioning in minutes and can be used to track mental state in the past 2 weeks.

As hopelessness is a factor that is strongly associated with suicide risk, the Beck Hopelessness Scale (BHS) can also serve to provide future or present suicide risk (Balsamo et al., 2020). In providing thorough screening, potential risk can be adequately determined an aid in effective referrals for treatment that best suits the clients present needs. Regardless of indication of suicide, having results on an individual's hopelessness can be influential in treatment recommendations due to the specific impact that it may have on them.

As discussed by Joiner (2005), in the interpersonal theory of suicide, promoting positive connection and social support can aid in decreasing feelings of thwarted belonginess and

perceived burdensomeness. As these two factors are attributed to the development of suicidality, intervening in treatment to address connection issues with a client can aid in reducing their risk of suicide. As such, monitoring an individual's current state and progress for their interpersonal development can be an indicator for this risk. The Interpersonal Needs Questionnaire-15 (INQ-15) is a self-report measure to examine both a person's perceived burdensomeness and belonginess (Van Orden et al., 2012). As this measure has undergone several revisions, the 15 item questionnaire narrows down criteria to be a brief device to provide clients to identify current functioning and connection with others from their perspective.

Section III: Program Overview and Development

Dying by suicide is of growing concern and impacts not only the individual, but those around them. Despite treatment and outreach becoming more involved, the annual rate of deaths by suicide has been consistently increasing, this is a problem that is only growing in severity. Due to the risk of harm or death from suicide, treatment of this condition is a major focus. Screening efforts and engagement of both health professional across all fields have begun to incorporate a greater focus on identifying suicide to aid in early intervention. Though the overall risk of someone who endorse suicidal ideation going on to die by suicide being small, a major focus is striving for the goal of zero suicide.

Due to the risk of those who endorse suicidal behaviors or thoughts, concerns for implementing best practices arise. Proper screening and assessment methods are critical for promoting a safe environment for the client and that they obtain an appropriate level of care. Thought autonomy and maintain trust with a client are important, if screening efforts paired with clinical judgment indicate that the client is at an immediate risk that can't be mitigated, or cannot reasonable be treated on an outpatient basis, hospitalization becomes a necessary form of treatment. Though it can be necessary to save the life of a client, hospitalization can exacerbate the condition and place the client at an elevated risk of suicide upon discharge.

Ideology behind suicide has been adapting over time to include more empirical basis to the understanding. As research has incorporated greater focus on a whole focus on biology, mental illness, and environmental influences a better understanding of the etiology of suicide has emerged. Though these theories are still developing as more evidence is produced. Impactful methods of treatment and assessment have been developed to create effective forms of

intervention. The majority of these interventions have been focused on individual intervention and are geared towards those at risk of suicidal behaviors or attempts. As these are the greatest risk for harm this focus is needed, but additional focus on a far more pervasive issue of suicidal ideation is also needed. Most methods of intervention are also applicable for the treatment of those with suicidal ideation, but few if any focus on the relapse effect that can occur with persistent or chronic suicidal ideation that is present in absence of suicidal behaviors. As ideation is a precursor for developing behaviors, and as the numbers of those who endorse ideation is far greater than those who ever make an attempt, development for intervention that focuses on this specific problem area is needed.

Group methods of intervention are an increasing common method of treatment as group retention and engagement shows to be significantly greater as compared to individual treatment (Clough et al., 2022). Group methods of intervention of commonly used in the treatment of maladaptive behaviors, such as eating disorders and addiction, as well as with severe mental illness like borderline personality disorder (Adams et al., 2021; Courbasson & Nishikawa, 2010; Heerebrand et al., 2021). Though group intervention is not commonly used in the treatment of suicide, and the research on a manualized method is limited, traits of suicidality are often present with these maladaptive and sever cases of mental illness. Often these case presentations also include suicidality and responded well as a result of the group intervention. As such, a formal group intervention focused on suicide is of increased need.

The proposed group known as group ideation treatment (GRIT), serves to focus on providing a group intervention for those with suicidal ideation. Those with past suicidal behaviors and attempts are still appropriate candidates for this group, but the primary focus is that the individual is currently dealing with persistent thoughts of suicide. The view of this group

is that of suicidal ideation as a maladaptive coping skill that the client pervasively uses or struggles with relapsing back into use. Other group interventions for suicide treatment have been developed, but are primarily novel and used locally. Treatments such as project life force (PLF) are in development to obtain a randomized clinical trial, but primary focus on safety planning and for more severe and behavioral conditions of suicide. A treatment focus that uses a group intervention just for those who have persistent ideation is a current gap in the treatment field. Other methods such as CAMS for groups (CAMS-G), have been adopted for use, but just as with every other method of group suicide intervention, this has been established by adapting an individual treatment and has not been examined critically or made available for adoption.

This proposal of GRIT is to establish an initial outline of client recruitment, assessment for goodness of fit, and provide a manualized outline for a session-by-session guide. It is intended that this intervention be directly researched for outcome data and then compared towards a comparable form of intervention to assess for efficacy. GRIT focuses on the treatment of those with suicidal ideation. In developing screening for the group, those with active suicidal behaviors may be considered to be recommended for individual therapy, due to the group primarily focusing on suicidal thoughts. As safety planning is a key component of GRIT, suicidal and self-harm behaviors are not an immediate indicator of a poor fit, but it will mark for further review to aid in providing the client with the best services as well as to maintain the focus of the group on suicidal thoughts. Settings in which GRIT may be a good fit to implement would include outpatient community mental health centers, veteran affairs hospitals, college, or university counseling centers. Providing GRIT requires a stable structured environment and patients who will be able to attend and engage in treatment for the full terms of sessions.

As treatment for those who are suicidal comes with an increased risk of safety and liability for the group, thorough emphasis is placed on regular screening, individual check ins, group check ins, and safety planning. Through this effort, patients will be identified if their individual immediate risk for suicide would be better handled in a different treatment setting or if hospitalization is necessary to keep them safe. This method is followed every session along with additional safety planning and direct treatment to increase the patient's individual ability to cope and manage their suicidal thoughts. This does not eliminate risk, but rather creates an environment that is supportive of effective treatment while also prioritizing their individual safety.

In screening for GRIT, the CSSR-S Lifetime will be used. If within the last month the client indicates suicidal behaviors, this will indicate a need for additional review to determine if placement in the group is best for the client's level of needed care. While in sessions a weekly screening using the CSSR-S Since Last Contact for Corrections will be used. Though designed for corrections settings, the brief format of this form is a good fit for the setting it will be used I and is a supported indicator of if additional risk has been created that needs additional care or treatment outside the scope of the group. Indicators of additional care would be if there is a yes response to items five or six. If there is a yes response to item four, which is another immediate risk item, then additional one on one interview is needed. In addition to the CSSR-S the PHQ-9 and the BHS will be given to aid in initial screening.

Sessions one and two of GRIT are focused on establishing group connection and building a useful and effective safety plan. Sessions three and four are focused on building the individual's social support system through practice and feedback from the other group members. Sessions five, six, seven, eight, and nine are focused on disrupting and challenging suicidal

ideation as a primary method of coping. Session 10, 11, and 12 process the conclusion of group, recovery planning, and relapse into suicidal thoughts. Further details into the screening process and specific methods of intervention are included in the manual.

As GRIT utilizes a group approach and only two primary facilitators, reduced cost and greater accessibility of services is able to be promoted. The outside screeners used in this treatment are open for public use and have also been given direct permission for use in this treatment program. Standard costs of treatment will vary depending on the setting, but could include the cost of two licensed therapists for providing initial screening and interviews of potential patients, along with the cost of providing 12 core group sessions. Materials in session are limited in expense and are only planned to include the paper handouts, but flexibility is provided to the facilitators to incorporate additional reference sources as they see fit. Evaluation of the group after services are provided is an additional cost that should be budgeted as time would need to be spent reviewing and reporting the post treatment forms.

Group Ideation Treatment Program Evaluation

The presented program requires empirical research to determine the effectiveness of this method. The basis of the program is based on founded concepts from other interventions that have gained empirical support, but research into the application of this proposal is needed to determine efficacy. The GRIT program includes patient evaluation forms provided every session for the purposes of risk assessment for suicide and if other forms of treatment would be more appropriate. To aid in evaluation the responses on these forms could be tracked to indicate changes and improvement across different sections of treatment. For purposes of program evaluation, the Suicidal Behaviors Questionnaire-Revised (SBQ-R) should be used at the onset

of treatment and at the conclusion of treatment to track symptom changes and program effectiveness.

The SBQ-R is a 4 item self-report assessment that examines lifetime suicidal ideation and attempts, frequency of suicidal ideation over the past 12 months, future threat for a suicide attempt, and likelihood of future suicidal behaviors. When examined for internal consistency, test items one and the total score were found to effectively predict overall suicide risk (Osman et al., 2001). These results were found to be consistent across clinical populations.

In addition to empirical validation of this treatment proposal, the evaluation of the intervention and getting feedback from clients on their experience can serve as a helpful tool to identify areas of change needed for the treatment design. Providing participants an opportunity to complete an anonymous survey about their experience in the group can identify areas that they felt were helpful, areas they feel could be improved, and if they felt that they left treatment better off than when they started. To allow for this, both a pre and post treatment evaluation form will be provided to the participants, found in the materials section of the manual in Appendix E. By reviewing this outcome data, positive changes can be made to the group so that it may better aid those in future groups.

In addition to the pre and post evaluation and additional Treatment Feedback Form is provided to the participants to further evaluate the program. This evaluation focuses more on the design and implementation rather than the specific outcome data form the clients. An example of the Treatment Feedback Form is provided in the materials section of the manual in Appendix E.

References

Adams, G., Turner, H., Hoskins, J., Robinson, A., & Waller, G. (2021). Effectiveness of a brief form of group dialectical behavior therapy for binge-eating disorder: Case series in a routine clinical setting. *International Journal of Eating Disorders, 54*(4), 615–620. https://doi-org.libproxy.eku.edu/10.1002/eat.23470

Aguinaldo, L. D., Sullivant, S., Lanzillo, E. C., Ross, A., He, J.-P., Bradley-Ewing, A., Bridge, J. A., Horowitz, L. M., & Wharff, E. A. (2021). Validation of the ask suicide-screening questions (ASQ) with youth in outpatient specialty and primary care clinics. *General Hospital Psychiatry, 68,* 52–58. https://doi.org/10.1016/j.genhosppsych.2020.11.006

Alizadeh, S., Khanahmadi, S., Vedadhir, A., & Barjasteh, S. (2018). The Relationship between Resilience with Self- Compassion, Social Support and Sense of Belonging in Women with Breast Cancer. *Asian Pacific journal of cancer prevention: APJCP, 19*(9), 2469–2474. https://doi.org/10.22034/APJCP.2018.19.9.2469

American Psychological Association (2007). Dictionary of psychology. Washington, D.C.: American Psychological Association

American Foundation for Suicide Prevention. (2021, September 9). *Risk factors and warning signs*. American Foundation for Suicide Prevention. Retrieved November 10, 2021, from https://afsp.org/risk-factors-protective-factors-and-warning-signs.

Andriessen, K. (2006). On "Intention" in the Definition of Suicide. *Suicide and Life-Threatening Behavior, 36*(5), 533–538. https://doi.org/10.1521/suli.2006.36.5.533

Arsenault-Lapierre, G., Kim, C., & Turecki, G. (2004). Psychiatric diagnoses in 3275 suicides: A meta-analysis. *BMC Psychiatry, 4*(1). https://doi.org/10.1186/1471-244x-4-37

Asarnow, J. R., Rozenman, M. S., & Carlson, G. A. (2017). Medication and Cognitive Behavioral Therapy for Pediatric Anxiety Disorders: No Need for Anxiety in Treating Anxiety. *JAMA pediatrics, 171*(11), 1038–1039. https://doi.org/10.1001/jamapediatrics.2017.3017

Aydın, M., Hacımusalar, Y., & Hocaoğlu, Ç. (2019). Neurobiology of suicidal behavior. *Psikiyatride Güncel Yaklaşımlar, 11*(1), 1–23. https://doi-org.libproxy.eku.edu/10.18863/pgy.382119

Ballard, E. D., Vande Voort, J. L., Luckenbaugh, D. A., Machado-Vieira, R., Tohen, M., & Zarate, C. A. (2016). Acute risk factors for suicide attempts and death: prospective findings from the STEP-BD study. Bipolar disorders, 18(4), 363–372. https://doi.org/10.1111/bdi.12397

Barbeito, S., Sánchez-Gutiérrez, T., Becerra-García, J. A., Pinto, A. G., Caletti, E., & Calvo, A. (2020). A systematic review of online interventions for families of patients with severe mental disorders. *Journal of Affective Disorders, 263*, 147–154. https://doi-org.libproxy.eku.edu/10.1016/j.jad.2019.11.106

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117*(3), 497–529. https://doi.org/10.1037/0033-2909.117.3.497

Bayliss, L. T., Lamont-Mills, A., du Plessis, C., & Morgan, T. (2021). Suicide capacity within the ideation-to-action framework: A scoping review protocol. *BMJ Open, 11*(2). https://doi.org/10.1136/bmjopen-2020-043649

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. The Guilford Press.

Beck, A. T., Steer, R. A., Kovas, M., & Garrison, B. (1985). Hopelessness and eventual suicide: A 10-year prospective study of patients hospitalized with suicidal ideation. *American Journal of Psychiatry, 142*, 559-563. https://doi.org/10.1176/ajp.142.5.559

Brådvik L. (2018). Suicide Risk and Mental Disorders. *International journal of environmental research and public health, 15*(9), 2028. https://doi.org/10.3390/ijerph15092028

Braquehais, M. D., González-Irizar, O., Nieva, G., Mozo, X., Llavayol, E., Pujol, T., Cruz, C. M., Heredia, M., Valero, S., Casas, M., & Bruguera, E. (2020). Assessing high risk of suicide amongst physicians and nurses in treatment. *Psychiatry Research, 291*. https://doi.org/10.1016/j.psychres.2020.113237

Briggs, S., Netuveli, G., Gould, N., Gkaravella, A., Gluckman, N. S., Kangogyere, P., Lindner, R. (2019). The effectiveness of psychoanalytic/psychodynamic psychotherapy for reducing suicide attempts and self-harm: systematic review and meta-analysis. *The British Journal of Psychiatry, 214*(06), 320–328. doi:10.1192/bjp.2019.33

Britton, P. C., Duberstein, P. R., Conner, K. R., Heisel, M. J., Hirsch, J. K., & Conwell, Y. (2008). Reasons for living, hopelessness, and suicide ideation among depressed adults 50 years or older. *The American journal of geriatric psychiatry: official journal of the*

American Association for Geriatric Psychiatry, 16(9), 736–741. https://doi.org/10.1097/JGP.0b013e31817b609a

Brown, G. K., Beck, A. T., Steer, R. A., & Grisham, J. R. (2000). Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. *Journal of Consulting and Clinical Psychology, 68*(3), 371–377. https://doi.org/10.1037/0022-006x.68.3.371

Brown G., Ten Have T., Henriques G., Xie S., Hollander J., & Beck A. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA, 294*(5), 563-70. https://doi.org/10.1001/jama.294.5.563

Bryan, C. J. (2015). Cognitive behavioral therapy for preventing suicide attempts: A guide to brief treatments across clinical settings (C. J. Bryan (Ed.)). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9780203798515

Bryan, C. J. (2019). Cognitive behavioral therapy for suicide prevention (CBT-SP): Implications for meeting standard of care expectations with suicidal patients. *Behavioral Sciences & the Law, 37*(3), 247–258. https://doi-org.libproxy.eku.edu/10.1002/bsl.2411

Cacioppo, J. T., & Patrick, W. (2009). Loneliness: Human nature and the need for social connection. Norton. https://doi.org/10.1176/appi.ajp.2008.08091320

Cassidy, J., Jones, J. D., & Shaver, P. R. (2013). Contributions of attachment theory and research: a framework for future research, translation, and policy. *Development and psychopathology, 25*(4 Pt 2), 1415–1434. https://doi.org/10.1017/S0954579413000692

Centers for Disease Control and Prevention. (1988). *Operational criteria for determining suicide. Centers for Disease Control and Prevention*. Retrieved November 10, 2021, from https://wonder.cdc.gov/wonder/prevguid/p0000164/p0000164.asp.

Centers for Disease Control and Prevention. (1988). Operational criteria for determining suicide. Centers for Disease Control and Prevention. Retrieved November 10, 2021, from https://wonder.cdc.gov/wonder/prevguid/p0000164/p0000164.asp.

Centers for Disease Control and Prevention. (2019). WISQARS: Web-based injury statistics query and reporting system. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

Cerel, J., Brown, M. M., Maple, M., Singleton, M., Venne, J., Moore, M., & Flaherty, C. (2018). How many people are exposed to suicide? not Six. *Suicide and Life-Threatening Behavior, 49*(2), 529–534. https://doi.org/10.1111/sltb.12450

Cerel, J., Maple, M., Aldrich, R., & van de Venne, J. (2013). Exposure to suicide and identification as survivor. *Crisis, 34*(6), 413–419. https://doi.org/10.1027/0227-5910/a000220

Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of "survivorship": Definitional issues in the aftermath of suicide. *Suicide and Life-Threatening Behavior, 44*(6), 591–600. https://doi.org/10.1111/sltb.12093

Chandy, J. M., Blum, R. W., & Resnick, M. D. (1996). Female adolescents with a history of sexual abuse: risk outcome and protective factors. *Journal of Interpersonal Violence*, 503-518. https://doi.org/10.1177/088626096011004004

Chandy, J. M., Blum, R. W., & Resnick, M. D. (1997). Sexually abused male adolescents: how vulnerable are they? *Journal of Child Sexual Abuse, 6*(2), 1-16. https://doi.org/10.1300/j070v06n02_01

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World psychiatry: official journal of the World Psychiatric Association (WPA), 13*(2), 153–160. https://doi.org/10.1002/wps.20128Clough, B., Spriggens, L., Stainer, M., & Casey, L. (2022). Working together: An investigation of the impact of working alliance and cohesion on group psychotherapy attendance. *Psychology and Psychotherapy: Theory, Research and Practice, 95*(1), 79–97. https://doi-org.libproxy.eku.edu/10.1111/papt.12364

Comstock, B. S., McDermott, M. (1975). Group therapy for patients who attempt suicide. *International Journal of Group Psychotherapy, 25*(1), 44–49. https://doi.org/10.1080/00207284.1975.11491866

Coon, H., Darlington, T. M., DiBlasi, E., Callor, W. B., Ferris, E., Fraser, A., Yu, Z., William, N., Das, S. C., Crowell, S. E., Chen, D., Anderson, J. S., Klein, M., Jerominski, L., Cannon, D., Shabalin, A., Docherty, A., Williams, M., Smith, K. R., … Gray, D. (2018). Genome-wide significant regions in 43 Utah high-risk families implicate multiple genes involved in risk for completed suicide. *Molecular Psychiatry, 25*(11), 3077–3090. https://doi.org/10.1038/s41380-018-0282-3

Cooperman, N.A., & Simoni, J.M. (2005). Suicidal ideation and attempted suicide among women living with HIV/AIDS. *Journal of Behavioral Medicine, 28*(2), 149-156. https://doi.org/10.1007/s10865-005-3664-3

Courbasson, C. M., & Nishikawa, Y. (2010). Cognitive behavioral group therapy for patients with co-existing social anxiety disorder and substance use disorders: A pilot study. *Cognitive Therapy and Research, 34*(1), 82–91. https://doi-org.libproxy.eku.edu/10.1007/s10608-008-9216-8

Czyz, E. K., Liu, Z., & King, C. A. (2012). Social connectedness and one-year trajectories among suicidal adolescents following psychiatric hospitalization. *Journal of clinical child and adolescent psychology: the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53, 41*(2), 214–226. https://doi.org/10.1080/15374416.2012.651998

de Almeida, Z., & Benevides, A. (2018). Social skills, coping, resilience and problem-solving in psychology university students. *Liberabit, 24*(2), 265-276. https://doi.org/10.24265/liberabit.2018.v24n2.07

De Leo, D., Burgis, S., Bertolote, J. M., Kerkhof, A. J. F. M., & Bille-Brahe, U. (2006). Definitions of Suicidal Behavior. *Crisis, 27*(1), 4–15. doi:10.1027/0227-5910.27.1.4

Dilillo, D., Mauri, S., Mantegazza, C., Fabiano, V., Mameli, C., & Zuccotti, G. V. (2015). Suicide in pediatrics: epidemiology, risk factors, warning signs and the role of the pediatrician in detecting them. *Italian journal of pediatrics, 41*, 49. https://doi.org/10.1186/s13052-015-0153-3

Dimeff, L. A., & Linehan, M. M. (2008). Dialectical behavior therapy for substance abusers. *Addiction science & clinical practice, 4*(2), 39–47. https://doi.org/10.1151/ascp084239

Drake, R. E., & Whitley, R. (2014). Recovery and severe mental illness: description and analysis. Canadian journal of psychiatry. *Revue canadienne de psychiatrie, 59*(5), 236–242. https://doi.org/10.1177/070674371405900502

Draper, E., & Margolis, P. (1976). A psychodynamic approach to suicide prevention. *Community Mental Health Journal, 12*(4), 376–382. https://doi.org/10.1007/bf01411076

Dome, P., Rihmer, Z., & Gonda, X. (2019). Suicide Risk in Bipolar Disorder: A Brief Review. *Medicina (Kaunas, Lithuania), 55*(8), 403. https://doi.org/10.3390/medicina55080403

Drapeau, C., & McIntosh, J. (2020). *U.S.A. suicide: 2019 Official final data* [Data set]. Washington, DC: American Association of Suicidology. https://doi.org/10.1093/med/9780198834441.003.0092

Elliott, J. L., & Frude, N. (2001). Stress, coping styles, and hopelessness in self-poisoners. *Crisis: Journal of Crisis Intervention & Suicide Prevention., 22*(1), 20-26. https://doi.org/10.1027//0227-5910.22.1.20

Erbacher, T. A., Singer, J. B., & Poland, S. (2015). In *Suicide in schools: A practitioner's guide to multi-level prevention, assessment, intervention, and postvention* (pp. 13). essay, Routledge. https://doi.org/10.1080/03069885.2016.1146230

Everall, R. D., Altrows, K. J., & Paulson, B. L. (2006). Creating a Future: A Study of Resilience in Suicidal Female Adolescents. *Journal of Counseling & Development, 84*(4), 461-471. https://doi.org/10.1002/j.1556-6678.2006.tb00430.x

Flouri, E., & Buchanan, A. (2002). The protective role of parental involvement in adolescent suicide. *Crisis: Journal of Crisis Intervention & Suicide., 23*(1), 17-22. https://doi.org/10.1027//0227-5910.23.1.17

Fournier, R. R. (2005). Group Therapy and Suicide. In R. I. Yufit & D. Lester (Eds.), *Assessment, treatment, and prevention of suicidal behavior*. (pp. 313–333). John Wiley & Sons Inc. https://doi.org/10.1080/15434610600683882

Fulfer, J. L., Tyler, J. J., Choi, N. J. S., Young, J. A., Verhulst, S. J., Kovach, R., & Dorsey, J. K. (2007). Using Indirect Questions to Detect Intimate Partner Violence: *The SAFE-T Questionnaire. Journal of Interpersonal Violence, 22*(2), 238–249. https://doi.org/10.1177/0886260506295814

Goldney, R. D. (1982). Locus of control in young women who have attempted suicide. *Journal of Nervous and Mental Disease, 170*(4), 198-201. https://doi.org/10.1097/00005053-198204000-00003

Goldstein, T. R., Axelson, D. A., Birmaher, B., & Brent, D. A. (2007). Dialectical behavior therapy for adolescents with bipolar disorder: a 1-year open trial. *J Am Acad Child Adolesc Psychiatry, 46*(7):820–30. https://doi. org/10.1097/chi.0b013e31805c1613.

Goñi-Sarriés, A., Blanco, M., Azcárate, L., Peinado, R., & López-Goñi, J. J. (2018). Are previous suicide attempts a risk factor for completed suicide? Psicothema, 30(1), 33–38.

Goodman, M., Brown, G. K., Galfalvy, H. C., Spears, A. P., Sullivan, S. R., Kapil-Pair, K. N., Jager-Hyman, S., Dixon, L., Thase, M. E., & Stanley, B. (2020). Group ("Project life force") versus individual suicide safety planning: A randomized clinical trial.

Contemporary Clinical Trials Communications, 17, 100520. https://doi.org/10.1016/j.conctc.2020.100520

Gutierrez, P. M., Johnson, L., Podlogar, M. C., Hagman, S., Muehler, T. A., Hanson, J., Pierson, J. T., Brown, A. A., & O'Connor, S. (2021). Pilot study of the collaborative assessment and management of suicidality—group. *Suicide and Life-Threatening Behavior*. https://doi.org/10.1111/sltb.12817

Halford, E. A., Lake, A. M., & Gould, M. S. (2020). Google searches for suicide and suicide risk factors in the early stages of the COVID-19 pandemic. *PLoS ONE, 15*(7). https://doi.org/10.1371/journal.pone.0236777

Hall RC, Platt DE, Hall RC. Suicide risk assessment: a review of risk factors for suicide in 100 patients who made severe suicide attempts. Evaluation of suicide risk in a time of managed care. Psychosomatics. 1999 Jan-Feb;40(1):18-27. doi: 10.1016/S0033-3182(99)71267-3. PMID: 9989117.

Hawton, K, Witt, KG, Taylor Salisbury, TL, et al. (2016) Psychosocial interventions for self-harm in adults. Cochrane Database of Systematic Reviews, 5: CD012189 https://doi.org/10.1002/14651858.cd013668

Heerebrand, S. L., Bray, J., Ulbrich, C., Roberts, R. M., & Edwards, S. (2021). Effectiveness of dialectical behavior therapy skills training group for adults with borderline personality disorder. *Journal of Clinical Psychology, 77*(7), 1573–1590. https://doi-org.libproxy.eku.edu/10.1002/jclp.23134

Hendin, H. (1991). Psychodynamics of suicide, with particular reference to the young. *The American Journal of Psychiatry, 148*(9), 1150–1158. https://doi-org.libproxy.eku.edu/10.1176/ajp.148.9.1150

Hirsch, J. K., Duberstein, P. R., Conner, K. R., Heisel, M. J., Beckman, A., Franus, N., & Conwell, Y. (2006). Future Orientation and Suicide Ideation and Attempts in Depressed Adults Ages 50 and Over. *American Journal of Geriatric Psychiatry, 14*(9), 752-757. https://doi.org/10.1097/01.jgp.0000209219.06017.62

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognitive therapy and research, 36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Holas, P., Suszek, H., Szaniawska, M., & Kokoszka, A. (2016). Group cognitive-behavioral therapy for anxiety disorders with personality disorders in day clinic setting. *Perspectives in Psychiatric Care, 52*(3), 186–193. https://doi-org.libproxy.eku.edu/10.1111/ppc.12115

Institute of Medicine, Board on Neuroscience and Behavioral Health, & Sara K. Goldsmith. (2001). *Risk Factors for Suicide: Summary of a Workshop*. National Academies Press.

Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach*. Guilford Press.

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior, 42*(6), 640–653. https://doi-org.libproxy.eku.edu/10.1111/j.1943-278X.2012.00119.x

Johnson, L. L., O'Connor, S. S., Kaminer, B., Jobes, D. A., & Gutierrez, P. M. (2014). Suicide-focused group therapy for Veterans. *Military Behavioral Health, 2*(4), 327–336. https://doi.org/10.1080/21635781.2014.963762

Johnson, L. L., O'Connor, S. S., Kaminer, B., Gutierrez, P. M., Carney, E., Groh, B., & Jobes, D. A. (2018). Evaluation of Structured Assessment and mediating factors of suicide-focused group therapy for veterans recently discharged from Inpatient Psychiatry. *Archives of Suicide Research, 23*(1), 15–33. https://doi.org/10.1080/13811118.2017.1402722

Kaminer, Y. (1986). Suicidal behavior and contagion among hospitalized adolescents. *New England Journal of Medicine, 315*(16), 1030–1030. https://doi.org/10.1056/nejm198610163151614

Ketokivi, K. (2015). Mental illness, stigma and belonging in family relationships. *Families, Relationships and Societies, 4*(3), 349–363. https://doi.org/10.1332/204674314x14151979019318

Kienast, T., Stoffers, J., Bermpohl, F., & Lieb, K. (2014). Borderline personality disorder and comorbid addiction. *Deutsches Ärzteblatt International, 111*(16), 280–286. https://doi.org/10.3238/arztebl.2014.0280

Kline, P. (1989). Objective tests of Freud's theories. *Psychology Survey, 7*, 127-45.

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy, 8*(2), 114–129. https://doi.org/10.1521/ijct.2015.8.2.114

Knox, Kelly (2015). "If Suicide Is a Public Health Problem, What Are We Doing to Prevent It?". *American Journal of Public Health. 94*(1): 37–45. https://doi.org/10.2105/ajph.94.1.37

Koons, C. R. (2021). DBT beyond Stage 1: An overview of Stages 2, 3, and 4. In L. A. Dimeff, S. L. Rizvi, & K. Koerner (Eds.), *Dialectical behavior therapy in clinical practice: Applications across disorders and settings., 2nd ed.* (pp. 306–326). The Guilford Press.

Kraut, A., & Walld, R. (2003). Influence of lack of full-time employment on attempted suicide in Manitoba, Canada. *Scandinavian Journal of Work, Environment & Health., 29*(1), 15-21. https://doi.org/10.5271/sjweh.699

Lam, T.H., Stewart, S.M., Yip, P. S. F., Leung, G. M., Ho, L. M., Ho, S. Y., & Lee, P.W. H. (2004). Suicidality and cultural values among Hong Kong adolescents. *Social Science & Medicine, 58*(3), 487-498. https://doi.org/10.1016/s0277-9536(03)00242-9

Liang, J., Kõlves, K., Lew, B., de Leo, D., Yuan, L., Abu Talib, M., & Jia, C. X. (2020). Coping Strategies and Suicidality: A Cross-Sectional Study From China. *Frontiers in psychiatry, 11*, 129. https://doi.org/10.3389/fpsyt.2020.00129

Lin, S. H., Lee, L. T., & Yang, Y. K. (2014). Serotonin and mental disorders: a concise review on molecular neuroimaging evidence. *Clinical psychopharmacology and neuroscience: the official scientific journal of the Korean College of Neuropsychopharmacology, 12*(3), 196–202. https://doi.org/10.9758/cpn.2014.12.3.196

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press. https://doi.org/10.1177/002076409504100211

Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Welch, S. S., Heagerty, P., & Kivlahan, D. R. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence*, *67*(1), 13–26. https://doi.org/10.1016/s0376-8716(02)00011-x

Linehan, M. M. (2015). *Dbt skills training manual*. The Guilford Press. https://doi.org/10.1097/nmd.0000000000000387

Lester, D., & Gunn, J. F. (2014). *Theories of suicide: Past, present and future*. Charles C. Thomas.

Levine S. (2003). Psychological and social aspects of resilience: a synthesis of risks and resources. *Dialogues in clinical neuroscience, 5*(3), 273–280. https://doi.org/10.31887/DCNS.2003.5.3/slevine

Ma, J., Batterham, P. J., Calear, A. L., & Han, J. (2016). A systematic review of the predictions of the interpersonal–psychological theory of suicidal behavior. *Clinical Psychology Review, 46,* 34–45. https://doi.org/10.1016/j.cpr.2016.04.008

Malone, K. M., Oquendo, M. A., Haas, G. L., Ellis, S. P., Li, S., & Mann, J. J. (2000). Protective factors against suicidal acts in major depression: reasons for living. *American Journal of Psychiatry, 157*(7), 1084-1088. https://doi.org/10.1176/appi.ajp.157.7.1084

Mann, J. J. (2003). Neurobiology of Suicidal Behaviour. *Nature Reviews Neuroscience, 4*(10), 819–828. https://doi-org.libproxy.eku.edu/10.1038/nrn1220

Marin, L., Sullivan, S., Spears, A. P., & Goodman, M. (2019). “Project life force-geriatric”: A novel suicide safety planning group treatment. *The American Journal of Geriatric Psychiatry, 27*(3). https://doi.org/10.1016/j.jagp.2019.01.127

Matthews, J. (2013). Cognitive behavioral therapy approach for suicidal thinking and behaviors in depression. *Mental Disorders - Theoretical and Empirical Perspectives*. https://doi.org/10.5772/52418

Matthieu, M. M., Cross, W., Batress, A. R., Flora. C. M., & Knox, K. L. (2008). Evaluation of gatekeeper training for suicide prevention in veterans. *Archives of Suicide Research, 12*(2), 148-154. https://doi.org/10.1080/13811110701857491

May, J. M., Richardi, T. M., & Barth, K. S. (2016). Dialectical behavior therapy as treatment for borderline personality disorder. *Mental Health Clinician, 6*(2), 62–67. https://doi.org/10.9740/mhc.2016.03.62

Mayo Foundation for Medical Education and Research. (2019, July 17). *Borderline personality disorder*. Mayo Clinic. Retrieved November 8, 2021, from https://www.mayoclinic.org/diseases-conditions/borderline-personality-disorder/symptoms-causes/syc-20370237.

McDonnell, C. G., DeLucia, E. A., Hayden, E. P., Anagnostou, E., Nicolson, R., Kelley, E., Georgiades, S., Liu, X., & Stevenson, R. A. (2020). An exploratory analysis of predictors of youth suicide-related behaviors in autism spectrum disorder: Implications for prevention science. *Journal of Autism and Developmental Disorders, 50*(10), 3531–3544. https://doi.org/10.1007/s10803-019-04320-6

McLean, J. (2008). *Risk and protective factors for suicide and suicidal behaviour: A literature review.* Social Research.

McMyler, C., & Pryjmachuk, S. (2008). Do no-suicide contracts work? *Journal of Psychiatric and Mental Health Nursing, 15*(6), 512–522. https://doi.org/10.1111/j.1365-2850.2008.01286.x

Menninger, K. A. (1938). *Man against himself*. Harcourt, Brace. https://doi.org/10.2307/2084080

Mercy, J. A., Kresnow, M., O'Carroll, P. W., Lee, R. K., Powell, K. E., Potter, L. B., Swann, A. C., Frankowski, R. F., & Bayer, T. L. (2001). Is suicide contagious? A study of the relation between exposure to the suicidal behavior of others and nearly lethal suicide attempts. *American Journal of Epidemiology, 154*(2), 120-127. https://doi.org/10.1093/aje/154.2.120

Mewton, L., & Andrews, G. (2016). Cognitive behavioral therapy for suicidal behaviors: improving patient outcomes. *Psychology research and behavior management, 9*, 21–29. https://doi.org/10.2147/PRBM.S84589

Moscicki EK. 2001. Epidemiology of completed and attempted suicide: toward a framework for prevention. *Clinical Neuroscience Research* 1. 310-23. https://doi.org/10.1016/s1566-2772(01)00032-9

Moss, W. (2016). *Bounce back: How to be a resilient kid*. Magination Press.

Munoz, R. T., Brady, S., & Brown, V. (2017). The psychology of resilience: A model of the relationship of locus of control to hope among survivors of intimate partner violence. *Traumatology, 23*(1), 102–111. https://doi-org.libproxy.eku.edu/10.1037/trm0000102

Na, P. J., Yaramala, S. R., Kim, J. A., Kim, H., Goes, F. S., Zandi, P. P., Vande Voort, J. L., Sutor, B., Croarkin, P., & Bobo, W. V. (2018). The PHQ-9 Item 9 based screening for suicide risk: a validation study of the Patient Health Questionnaire (PHQ)−9 Item 9 with the Columbia Suicide Severity Rating Scale (C-SSRS). *Journal of Affective Disorders, 232*, 34–40. https://doi.org/10.1016/j.jad.2018.02.045

Nielsen, G.P., Björnsson, J. & Jonasson, J.G. The accuracy of death certificates. *Vichows Archiv A Pathol Anat 419*, 143–146 (1991). https://doi.org/10.1007/bf01600228

Nordentoft, M., Mortensen, P. B., & Pedersen, C. B. (2011). Absolute risk of suicide after first hospital contact in mental disorder. *Archives of General Psychiatry, 68*(10), 1058–1064. https://doi-org.libproxy.eku.edu/10.1001/archgenpsychiatry.2011.113

O'Carrol, P., Berman, A., Maris, M., Moscicki, E., Tanney, B., & Silverman, M. (1996). Beyond the tower of Babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behavior, 26*, 237–252. https://doi.org/10.1111/j.1943-278x.1996.tb00609.x

O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational-volitional model of suicidal behaviour. *Philosophical transactions of the Royal Society of London. Series B, Biological sciences, 373*(1754), 20170268. https://doi.org/10.1098/rstb.2017.0268

Öhman, A., & Mineka, S. (2001). Fears, phobias, and preparedness: Toward an evolved module of fear and Fear Learning. Psychological Review, 108(3), 483–522. https://doi.org/10.1037/0033-295x.108.3.483

Omary, A. (2021). National prevalence rates of suicidal ideation and suicide attempts among adults with and without depression. *Journal of Nervous and Mental Disease, 209*(5), 378–385. https://doi.org/10.1097/nmd.0000000000001309

Orbach, I. (2001). Therapeutic empathy with the suicidal wish: Principles of therapy with suicidal individuals. *American Journal of Psychotherapy, 55*(2), 166–184. https://doi.org/10.1176/appi.psychotherapy.2001.55.2.166

Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A., & Barrios, F. X. (2001). The suicidal behaviors questionnaire-revised (SBQ-R):Validation with clinical and nonclinical samples. *Assessment, 8*(4), 443–454. doi:10.1177/107319110100800409

Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: Systematic review. *The British Journal of Psychiatry, 181*(3), 193–199. https://doi.org/10.1192/bjp.181.3.193

Owens, M. J., & Nemeroff, C. B. (1994). Role of serotonin in the pathophysiology of depression: Focus on the serotonin transporter. *Clinical Chemistry, 40*(2), 288–295. https://doi.org/10.1093/clinchem/40.2.288

Parekh, R. (2018, June). *Suicide Prevention*. Suicide prevention. Retrieved November 1, 2021, from https://www.psychiatry.org/patients-families/suicide-prevention.

Paris J. (2019). Suicidality in Borderline Personality Disorder. Medicina (Kaunas, Lithuania), *55*(6), 223. https://doi.org/10.3390/medicina55060223

Patrick, H., & Williams, G. C. (2012). Self-determination theory: Its application to health behavior and complementarity with motivational interviewing. *International Journal of Behavioral Nutrition and Physical Activity, 9*(1), 18. https://doi.org/10.1186/1479-5868-9-18

Peterson, C. M., Van Diest, A. M. K., Mara, C. A., & Matthews, A. (2020). Dialectical behavioral therapy skills group as an adjunct to family-based therapy in adolescents with restrictive eating disorders. *Eating Disorders: The Journal of Treatment & Prevention, 28*(1), 67–79. https://doi-org.libproxy.eku.edu/10.1080/10640266.2019.1568101

Pickerin, F., & Walford, G. (2014). *Durkheim's suicide: A century of research and debate*. Routledge. https://doi.org/10.2307/3090084

Pirkis, J. (2020). Strengthening the evidence base in suicide prevention: Systematic reviews and registered reports. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 41*(2), 77–81. https://doi.org/10.1027/0227-5910/a000693

Piscopo, K., Lipari, R. N., Cooney, J., & Glasheen, C. (2016, September). *Suicidal thoughts and behavior among adults: Results from the 2015 National Survey on Drug Use and Health*. NSDUH Data Review. Retrieved from https://www.samhsa.gov/data/

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The columbia-suicide severity rating scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *The American journal of psychiatry, 168*(12), 1266–1277. https://doi.org/10.1176/appi.ajp.2011.10111704

Ressler, K. J., Nemeroff, C. B. (2000). Role of serotonergic and noradrenergic systems in the pathophysiology of depression and anxiety disorders. *Depression and Anxiety, 12*(S1), 2–19. https://doi.org/10.1002/1520-6394(2000)12:1+<2::aid-da2>3.0.co;2-4

Rozek, D. C., & Bryan, C. J. (2020). Integrating crisis response planning for suicide prevention into trauma-focused treatments: A military case example. *Journal of Clinical Psychology, 76*(5), 852–864. https://doi.org/10.1002/jclp.22920

Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning Signs for Suicide: Theory, Research, and Clinical Applications. *Suicide and Life-Threatening Behavior, 36*(3), 255–262. https://doi.org/10.1521/suli.2006.36.3.255

Rudd, M. D., Goulding, J. M., & Carlisle, C. J. (2013). Stigma and suicide warning signs. *Archives of Suicide Research, 17*(3), 313–318. https://doi.org/10.1080/13811118.2013.777000

Ryan, R. M., & Deci, E. L. (2000). The darker and brighter sides of human existence: Basic psychological needs as a unifying concept. *Psychological Inquiry, 11*(4), 319–338. https://doi.org/10.1207/s15327965pli1104_03

Ryberg, W., Fosse, R., Zahl, P. H., Brorson, I., Møller, P., Landrø, N. I., & Jobes, D. (2016). Collaborative Assessment and Management of Suicidality (CAMS) compared to treatment as usual (TAU) for suicidal patients: study protocol for a randomized controlled trial. *Trials, 17*(1), 481. https://doi.org/10.1186/s13063-016-1602-z

Sadkowski, M., Dennis, B., Clayden, R. C., Elsheikh, W., Rangarajan, S., Dejesus, J., & Samaan, Z. (2013). The role of the serotonergic system in suicidal behavior. *Neuropsychiatric disease and treatment, 9*, 1699–1716. https://doi.org/10.2147/NDT.S50300

Sandler, E. P. (2018, September 10). *The ripple effect of suicide*. NAMI. Retrieved October 31, 2021, from https://www.nami.org/Blogs/NAMI-Blog/September-2018/The-Ripple-Effect-of-Suicide.

Santel, M., Beblo, T., Neuner, F., Berg, M., Hennig-Fast, K., Jobes, D. A., & Driessen, M. (2020). Collaborative assessment and management of suicidality ((CAMS) compared to enhanced treatment as usual (E-TAU) for suicidal patients in an inpatient setting: Study protocol for a randomized controlled trial. *BMC Psychiatry, 20.* https://doi.org/10.1186/s12888-020-02589-x

Satir, V. (1984). *Satir step by step: A guide to creating change in families.* Science and Behavior Books.

Schechter, M., Ronningstam, E., Herbstman, B., & Goldblatt, M. J. (2019). Psychotherapy with Suicidal Patients: The Integrative Psychodynamic Approach of the Boston Suicide Study Group. *Medicina (Kaunas, Lithuania), 55*(6), 303. https://doi.org/10.3390/medicina55060303

Schmutte, T., Costa, M., Hammer, P., & Davidson, L. (2021). Comparisons between suicide in persons with serious mental illness, other mental disorders, or no known mental illness: Results from 37 U.S. states, 2003–2017. *Schizophrenia Research, 228*, 74–82. https://doi.org/10.1016/j.schres.2020.11.058

Searight R. (2010). "Suppose that Tonight, While You're Asleep, a Miracle Happens:" Pragmatic Solution-Focused Therapy for Substance Abuse. *Frontiers in Psychology, 1*, 149. https://doi.org/10.3389/fpsyg.2010.00149

Seeman, M. V. (2015). The impact of suicide on co-patients. *Psychiatric Quarterly*, *86*(4), 449–457. https://doi.org/10.1007/s11126-015-9346-6

Sher, L. (2019). Resilience as a focus of Suicide Research and Prevention. *Acta Psychiatrica Scandinavica*, *140*(2), 169–180. https://doi.org/10.1111/acps.13059

Shneidman, E. S. (1988). Some reflections of a Founder. *Suicide and Life-Threatening Behavior*, *18*(1), 1–12. https://doi.org/10.1111/j.1943-278x.1988.tb00136.x

Spears, A., R. Sullivan, S., & Goodman, M. (2019). The efficacy of groups in preventing suicide: Is contagion a concern of the past? *Integrative Clinical Medicine*, *3*(3). https://doi.org/10.15761/icm.1000153

Srivastava K. (2011). Positive mental health and its relationship with resilience. Industrial psychiatry journal, 20(2), 75–76. https://doi.org/10.4103/0972-6748.102469

Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., Kennard, B. D., Wagner, A., Cwik, M. F., Klomek, A. B., Goldstein, T., Vitiello, B., Barnett, S., Daniel, S., & Hughes, J. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *Journal of the American Academy of Child and Adolescent Psychiatry*, *48*(10), 1005–1013. https://doi.org/10.1097/CHI.0b013e3181b5dbfe

Stanley, M., & Mann, J. J. (1983). Increased serotonin-2 binding sites in frontal cortex of suicide victims. *The Lancet*, *321*(8318), 214–216. https://doi.org/10.1016/s0140-6736(83)92590-4

Stanley, M., Virgilio, J., Gershon, S. (1982). Tritiated imipramine binding sites are decreased in the frontal cortex of suicides. *Science, 216*(4552), 1337–1339. https://doi.org/10.1126/science.7079769

Stark, R., Doyle, D. P., & Rushing, J. L. (1983). Beyond Durkheim: Religion and Suicide. *Journal for the Scientific Study of Religion, 22*(2), 120–131. https://doi.org/10.2307/1385672

Stengel, E. (1964). *Suicide and attempted suicide*. Baltimore: Penguin Books.

Harmer B., Lee S., Duong TVH., Saadabadi, A. (2021). *Suicidal ideation*. StatPearls Publishing.

Steil, R., Dittmann, C., Müller-Engelmann, M., Dyer, A., Maasch, A. M., & Priebe, K. (2018). Dialectical behaviour therapy for posttraumatic stress disorder related to childhood sexual abuse: a pilot study in an outpatient treatment setting. *European journal of psychotraumatology*, *9*(1), 1423832. https://doi.org/10.1080/20008198.2018.1423832

Sutton, J. (2021, August 25). *Maladaptive coping: 15 examples & how to break the cycle.* PositivePsychology.com. Retrieved November 9, 2021, from https://positivepsychology.com/maladaptive-coping/.

Svetaz, M. V., Ireland, M., & Blum, R. (2000). Adolescents with learning disabilities: risk and protective factors associated with emotional well-being: findings from the National Longitudinal Study of Adolescent Health. *Journal of Adolescent Health, 27*(5), 340-348. https://doi.org/10.1016/s1054-139x(00)00170-1

Sveticic, J., & De Leo, D. (2012). The hypothesis of a continuum in suicidality: a discussion on its validity and practical implications. *Mental illness, 4*(2), e15. https://doi.org/10.4081/mi.2012.e15

Švob Štrac, D., Pivac, N., & Mück-Šeler, D. (2016). The serotonergic system and cognitive function. *Translational neuroscience, 7*(1), 35–49. https://doi.org/10.1515/tnsci-2016-0007

Swanson, S. A., & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. CMAJ : *Canadian Medical Association journal = journal de l'Association medicale canadienne, 185*(10), 870–877. https://doi.org/10.1503/cmaj.121377

Swift, J. K., Trusty, W. T., & Penix, E. A. (2021). The effectiveness of the collaborative assessment and management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis. *Suicide and Life-Threatening Behavior, 51*(5), 882–896. https://doi.org/10.1111/sltb.12765

Swogger, M. T., Van Orden, K. A., & Conner, K. R. (2014). The relationship of outwardly-directed aggression to suicidal ideation and suicide attempts across two high-risk samples. *Psychology of violence, 4*(2), 184–195. https://doi.org/10.1037/a0033212

Ubergen, F., Grotenhuis, M., & Ultee, W. (2005). Denomination, religious context, and suicide: neo-Durkheimian multilevel explanations tested with individual and contextual data. *American Journal of Sociology.111*(3), 797-823. https://doi.org/10.1086/497307

Tucker, R. P., Crowley, K. J., Davidson, C. L., & Gutierrez, P. M. (2015). Risk factors, warning signs, and drivers of suicide: What are they, how do they differ, and why does it matter?

Suicide and Life-Threatening Behavior, 45(6), 679–689. https://doi-org.libproxy.eku.edu/10.1111/sltb.12161

Tugade, M. M., & Fredrickson, B. L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of personality and social psychology*, *86*(2), 320–333. https://doi.org/10.1037/0022-3514.86.2.320

Udo, T., Bitley, S., & Grilo, C. M. (2019). Suicide attempts in U.S. adults with lifetime DSM-5 eating disorders. *BMC Medicine, 17*(120). https://doi.org/10.1186/s12916-019-1352-3

Underwood, M. D., Kassir, S. A., Bakalian, M. J., Galfalvy, H., Dwork, A. J., Mann, J. J., & Arango, V. (2018). Serotonin receptors and suicide, major depression, alcohol use disorder and reported early life adversity. *Translational psychiatry, 8*(1), 279. https://doi.org/10.1038/s41398-018-0309-1

U.S. Department of Health and Human Services. (n.d.). NIMH *" ask suicide-screening questions (ASQ) toolkit*. National Institute of Mental Health. Retrieved November 9, 2021, from https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials.

U.S. Department of Health and Human Services. (n.d.). *NIMH " suicide*. National Institute of Mental Health. Retrieved November 10, 2021, from https://www.nimh.nih.gov/health/statistics/suicide.

U.S. Department of Health and Human Services. (2020). *NIMH " mental illness*. National Institute of Mental Health. Retrieved November 10, 2021, from https://www.nimh.nih.gov/health/statistics/mental-illness.

van der Sanden, R. L., Bos, A. E., Stutterheim, S. E., Pryor, J. B., & Kok, G. (2013). Experiences of stigma by association among family members of people with mental illness. *Rehabilitation Psychology, 58*(1), 73–80. https://doi.org/10.1037/a0031752

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner, T. E. (2012). Thwarted belongingness and perceived burdensomeness: construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological assessment, 24*(1), 197–215. https://doi.org/10.1037/a0025358

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr (2010). The interpersonal theory of suicide. *Psychological review, 117*(2), 575–600. https://doi.org/10.1037/a0018697

Venta, A., Mellick, W., Schatte, D., & Sharp, C. (2014). Preliminary evidence that thoughts of thwarted belongingness mediate the relations between level of attachment insecurity and depression and suicide-related thoughts in inpatient adolescents. *Journal of Social and Clinical Psychology, 33*(5), 428–447. https://doi.org/10.1521/jscp.2014.33.5.428

Wadsworth M. E. (2015). Development of Maladaptive Coping: A Functional Adaptation to Chronic, Uncontrollable Stress. *Child development perspectives, 9*(2), 96–100. https://doi.org/10.1111/cdep.12112

Webb, J. (2019, June 26). *How suicidal thoughts can become a coping mechanism.* Psych Central. Retrieved November 9, 2021, from https://psychcentral.com/blog/childhood-neglect/2019/06/how-suicidal-thoughts-can-become-your-number-1-coping-mechanism#5.

Wenzel, A., & Jager-Hyman, S. (2012). Cognitive Therapy for Suicidal Patients: Current Status. *The Behavior therapist, 35*(7), 121–130.

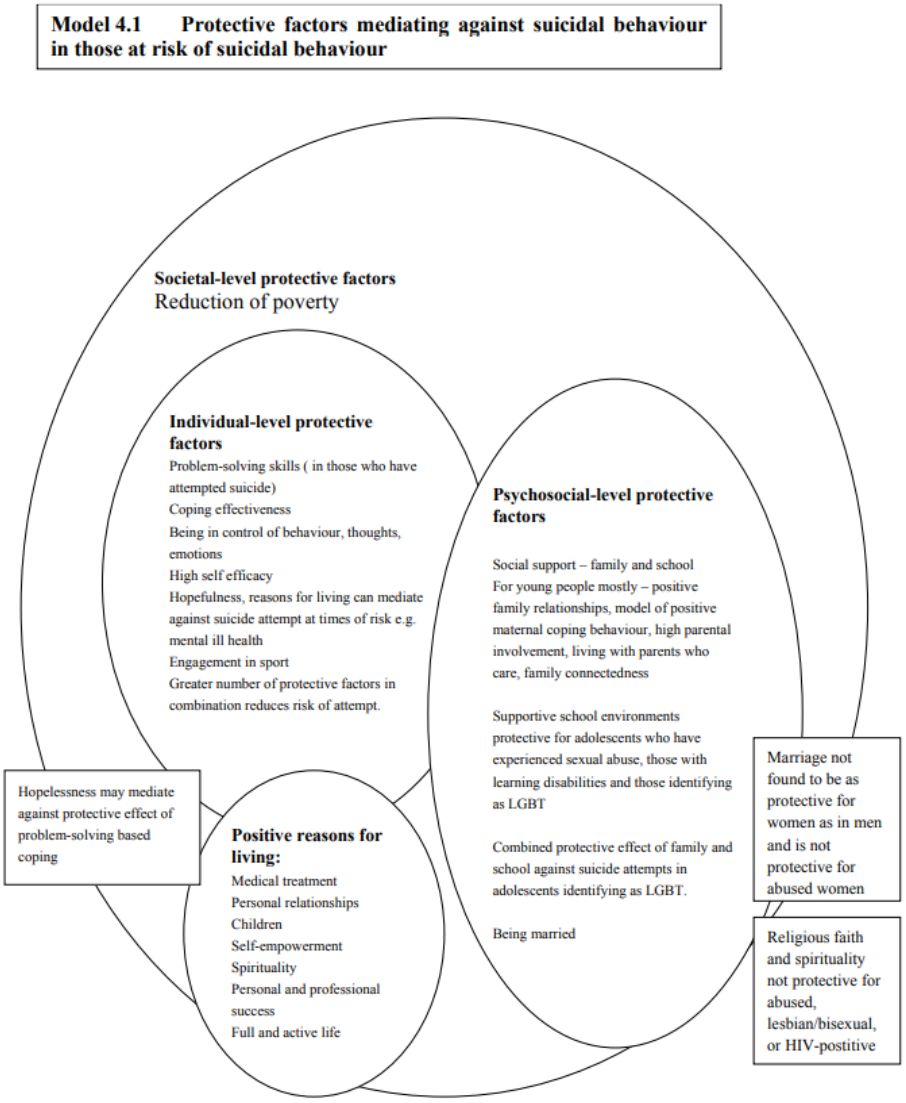
Werth, J. L. (1996). Can Shneidman's "Ten Commonalities of Suicide" accommodate rational suicide? *Suicide and Life-Threatening Behavior, 26*(3), 292–299. https://doi.org/10.1111/sltb.1996.26.issue-3

Yakeley, J., & Burbridge-James, W. (2018). Psychodynamic approaches to suicide and self-harm. *BJPsych Advances, 24*(1), 37-45. doi:10.1192/bja.2017.6

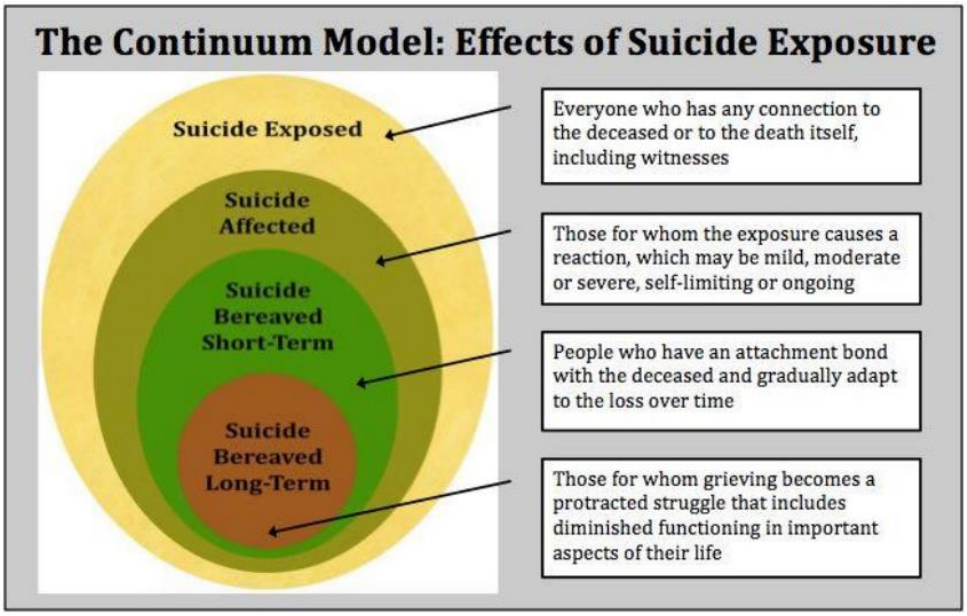
Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). Basic Books.

Appendices

Appendix A: Protective Factors Mediating Against Suicidal Behavior



Appendix B: The Continuum Model: Effects of Suicide Exposure

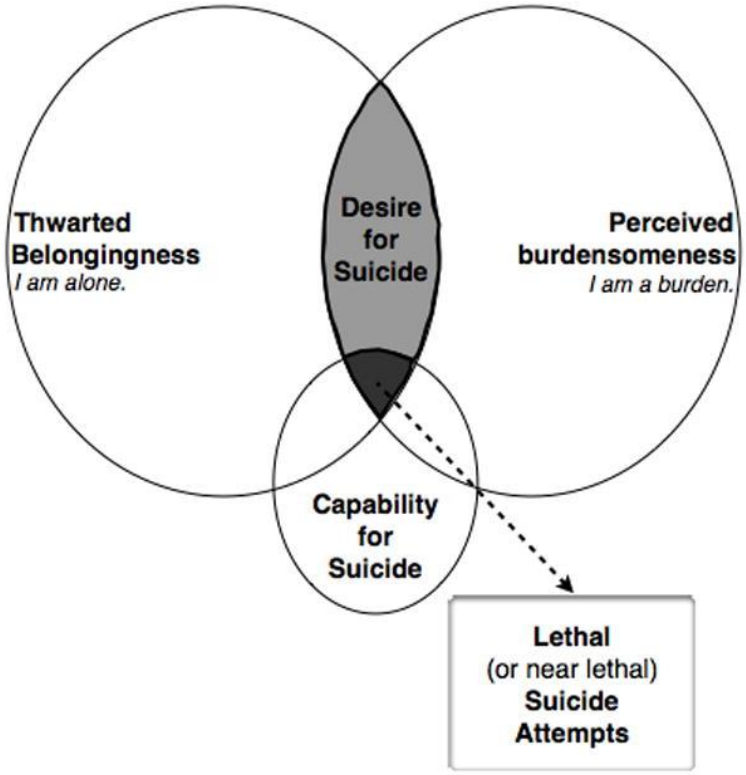


Appendix C: Effects on the Different Exposures to Suicide

TABLE 1
Potential Types of Individuals in Categories of Suicide Exposed, Affected, Bereaved Short-Term, and Bereaved Long-Term

Exposed	Affected	Suicide-Bereaved, Short-Term	Suicide-Bereaved, Long-Term
• First responders • Anyone who discovers the decedent • Family members • Therapists • Close friends • Health-care workers • Community members • School communities • Workplace acquaintances • Fans of celebrities • Community groups (e.g., sporting clubs) • Rural or close knit communities	• First responders • Anyone who discovers the decedent • Family members • Therapists • Close friends • Classmates • Co workers • Team members • Neighbors	• Family members • Therapists • Friends • Close work colleagues	• Family members • Therapists • Close friends

Appendix D: Interpersonal Theory of Suicide



Appendix E: Group Ideation Treatment (GRIT) Manual

Group Ideation Treatment (GRIT) Manual

Structure of Manual

The following manual provides details on the basis of the group design and methods for administration. Specific methods for safe and effective delivery of the group are provided, but clinical judgment should always act as the initial consideration for treatment. The following manual is currently a proposal and has not yet been implemented in a practical setting. Though thorough screening and risk assessment from empirically based methods are built into the treatment, use should be determined with caution. In addition to the session guide, specific materials for the group are included in the session materials section.

TABLE OF CONTENTS

GRIT Description and Recommendations

Focus and Intent for Group

Group Ideation Treatment (GRIT) is intended to provide therapeutic services, in a group setting, to those individuals who are currently (or have in the past) had difficulty with suicidal thoughts. This is an initial framework to the group and the procedures involved in recruiting and screening members, providing intervention, and assessing for treatment outcomes. Though based on the current literature intended for the treatment of suicide and suicide-connected conditions, this is not a prescriptive intervention and the clinicians involved in providing treatment should use their own clinical training and judgment in making final treatment decisions.

Number of Sessions

GRIT is provided over the course of 12 weekly sessions lasting 90 minutes each. The group should be created and provided on a cohort model and should not accept new group members after the group has already begun. Members should also be able to commit to attending all sessions. Due to the social connection and support model that underlies GRIT, this contingency is highly important to delivering care.

General Structure of GRIT

Sessions 1 and 2 of GRIT are focused on establishing group connection and building a useful and effective safety plan. Sessions 3 and 4 are focused on building the individual's social support system through practice and feedback from the other group members. Sessions 5, 6, 7, 8, and 9 are focused on disrupting and challenging suicidal ideation as a primary method of coping. Session 10, 11, and 12 process the conclusion of group, recovery planning, and relapse into suicidal thoughts.

Recommended Requirements for Group Facilitators

GRIT should be provided by two co-facilitators. Facilitators should be licensed professional clinicians (or are operating in training under the direct supervision of a licensed clinician) who have had formal training and supervised experience in providing treatment for patients with varying levels of suicide severity. Facilitators should be competent and comfortable with treating and talking about suicide not only with the patient, but also be able to communicate and work well with another professional in providing treatment collaboratively.

Recommended Requirements for Group Members

GRIT should be provided to between four to eight participants. Due to the high-risk nature of the condition being treated, ample amounts of screening for current suicide and harm risk are required. As such, groups that include more than eight members may lead to insufficient attention and check ins. Ideally, co-facilitators will work together, but will also individually check the wellbeing and current condition of the patients to aid in reducing missed warning signs or possibilities of screenings indicating a false negative. Caution should be taken when considering providing a group to less than four participants. One of the main focuses of GRIT is providing a social connection and framework for belonging. Groups that include less than four participants may not provide enough stability and opportunity for the group to connect. Ultimately group size should account for these considerations but

should also be determined by the clinical judgment of the co-facilitator's assessment of the needs of their service area, and of the goodness of fit applied to the group members.

What constitutes a "good fit" for GRIT can vary depending on the competency and training of the individual providers, as well as the needs of the community provided. The treatment is designed to aid individuals who are currently having, or have had a history of, suicidal ideation. A patient's history of treatment does not constitute a lesser goodness of fit for the services provided in the group. Those who have made a suicide attempt within the past three months may be considered for the group, but ample screening and individual determinations should be made to see if the individual may benefit more from individual treatment at that time. This consideration should be applied to all potential group members, but should be of significant focus in determining if someone with a recent (within the past three months) suicide attempt should be included in the group.

Group Screening and Admission

Standardized assessment measures included in the initial screening for admission to GRIT should include the Columbia Suicide Severity Rating Scale (CSSR-S Lifetime), Patient Health Questionnaire (PHQ-9), Beck Hopelessness Scale (BHS), and the Interpersonal Needs Questionnaire-15 (INQ-15).

If within the last month the client indicates suicidal behaviors, this will indicate a need for additional review to determine if placement in the group is best for the client's level of needed care. While in sessions, a weekly screening using the CSSR-S Since Last Contact for Corrections will be used. Though designed for corrections settings, this version of the CSSR-S provides a brief indicator for recent changes. If a new significant level of risk is indicated, then identifying additional care or treatment outside the scope of the group should be recommended. Indicators of additional care would be if there is a yes response to items five or six. If there is a yes response to item 4, which is another immediate risk item, then additional one-on-one interview is needed.

The PHQ-9 should provide additional data points for presence of suicidality and other problem areas the patient is currently having. Though no formal cut off is recommended for this measure, results should be compared with the CSSR-S to ensure accurate data. In cases of inconsistencies, direct questioning and further interviewing with the patient is required.

The PHQ-9 and CSSR-S are brief forms that should be filled out for every patient prior to the start of each group. The BHS and INQ-15 will provide additional baseline scores that will be followed up on after conclusion of treatment. Administration of the BHS and INQ-15 should occur before the first session and after the last session.

In addition to these assessment measures, clinicians should use their clinical judgment in determining if more information needs to be collected from the individual to determine their immediate level of risk, and if they would most benefit from group treatment as opposed to individual care. Facilitators should arrange for a follow up interview if needed to make this determination. If someone does not appear to be a good fit for GRIT due to the severity of their risk, facilitators should work in collaboration with the individual to connect them with the level of care that would best fit their treatment needs.

Adherence to GRIT Manual and Sessions

The layout and structure of sessions provided serves as an outline for facilitators and the group members. The major points provided in the session outline should be included in each session. Minor components of each session can, and is encouraged to, be directed by the indicated needs of the clients. Facilitators should promote a timely conduction of the group and ensure that the primary content is provided. Facilitators are also responsible for promoting clients to input and direct how the group can be provided to meet their needs. Facilitators should also encourage client collaboration in determining how different or similar needs can be addressed as a group.

Recommendations for Establishing Group Norms

Group norms are the guidelines and rules agreed upon to aid in effective and supportive work during the group session. Group norms should be discussed during the first session and should be tailored to fit the needs of the individual group. Some considerations should be:

- Contact between group members and discussion about the group outside of group
- Addressing conflict during session
- Acute suicidal risk during or outside of session
- Reasons for removal from the group
- Expectations for participation and communication

Establishing Safety

Group member safety is the number one priority. Group members should be informed during the individual pre-session screening of safety procedures involved in treatment. This includes their rights as a patient and the limits to confidentiality. This should be matched to fit the local laws and procedures for the governing organization.

If, during the initial screening that occurs at the start of every session, a patient indicates that they are actively suicidal or at immediate risk of suicide then they should be asked if they wish to discuss this further outside of the group. At this time, one facilitator should accompany the patient for an individual discussion to assess their safety and current risk. This time will be spent creating a safety plan, addressing any immediate needs that can be, and determining what the least restrictive form of care is needed to ensure their safety and treatment. If safety can be established and it is believed that the patient is not at immediate risk of suicide, then they can return to the group. If the patient is deemed to be at immediate risk of suicide, and safety planning and addressing their current suicidality shows that they are still actively suicidal, then hospitalization may be required for the wellbeing of the patient.

Grounds for Referring a Group Member Out of GRIT After Treatment has Started

Facilitators should determine and organize time during the initial session with patients to set ground rules for the group. As the group should form collaboration and serve as an opportunity to facilitate a connection between group members, letting patients decide how they wish to handle the norms and boundaries of the group should be promoted. General ground rules for promoting confidentiality and safety of individuals should be provided in the informed consent by the clinicians and is not open to modification by the group members.

Session Guide

Individual Pre-Session Screening

1. **Description of Group, what is a Good Fit, and Limits to Confidentiality**

   Provide a verbal overview of the services provided in GRIT and explain what treatment can be provided. An example of this may include: "Group ideation treatment focuses on addressing current, or concerns about, suicidal thoughts. As a group, work is done to provide a connection for a weekly processing of difficulties you may be experiencing with suicidal thoughts. The group also includes methods for safety planning, mindfulness relaxation, psychoeducation of suicidality, promoting healthy supports, and intervening with suicidal thoughts as a maladaptive source of coping. It is our hope that during your time in the group, you can identify areas that you wish to address, and practice working with peers to gain support for finding ways to manage and cope without using suicidal thoughts. From the view of this group, suicidal thoughts are a coping skill that you have found helps you get through difficult times or other problems. However, it is a maladaptive coping skill that causes you to engage in harmful thoughts and behaviors that ultimately lead to greater problems than what they initially addressed. By working as a group, we hope you can practice communication about your suicidality and how to approach others in times of need."

   In addressing goodness of fit an example may include: "A good fit for GRIT is important due to how much positive social interaction and work is involved in the group. GRIT focuses primarily on addressing current suicidal thoughts or worries about future relapse into suicidal tendencies. GRIT can still be a good fit for those who engage in self harm or have a history of suicidal behaviors, but individual and group safety is our number one priority. If someone is at immediate risk of suicide, actively engaging in significant self-harm behaviors, or are making suicide attempts then this group may not be a good fit as more intensive treatment might be a better method of intervention. If this is the case, then a warm hand off will be followed through. We hope to do everything in our power to promote safe, but also enjoyable treatment. Decisions on treatment alternatives are made collaboratively and are reserved for cases in which group participation and the individual's safety cannot be provided. Safety is our number one priority and ensuring that each group member is in a safe place before the group begins is essential. Questions about your current suicidality will be asked at the start of each group. You will see what those forms look like today. In the event that you report active suicidality, we will ask to talk with you one-on-one to ensure that safety can be established. Hospitalization or providing a new level of care is a last resort option and will only be used if no other method of safety planning or discussion can result in the assurance of safety."

   The facilitator should provide an overview of limits to confidentiality and any other policies of the practice. Group norms and rules should be discussed. Group norms will

be created as a group, but general confidentiality requirements should be discussed at this time. A list of recommended discussion points is found in the manual. The individual may also be asked what norms they feel should be included. These can be written down and addressed again during the first session of the group.

2. **Initial assessment of CSSR-S, PHQ-9, BHS, INQ-15**

All group candidates who agree to attend all scheduled group sessions, who have a current or past struggle with suicidal thoughts and wish to participate in a group aimed towards treatment of their suicidality should be offered an initial assessment and intake interview.

The CSSR-S Since Last Contact for Corrections will be used. Though designed for corrections settings, this version of the CSSR-S provides a brief indicator for recent changes. If a new significant level of risk is indicated, then identifying additional care or treatment outside the scope of the group should be recommended. Indicators of additional care would be if there is a yes response to items five ("Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?") or six ("Have you done anything, started to do anything, or prepared to do anything to end your life?"). If there is a yes response to item four ("Have you had these thoughts and had some intention of acting on them?"), which is another immediate risk item, then that should be addressed with additional questioning to determine if the level of risk is outside the scope of the services provided in the group.

The Patient Health Questionnaire-9 (PHQ-9) provides a screening for depressive symptoms, severity, and duration. The PHQ-9 also provides assessment of suicidality present in an individual's life. As indicated on the PHQ-9, if a person scores 5 or more responses in the shaded boxes (a rating of 2 or 3), then a Major Depressive Disorder should be considered. If that is the case, then this should be addressed with additional questioning to determine if the level of risk is outside the scope of the services provided in the group.

Scores on the BHS and INQ-15 provide additional data on the individual's functioning prior to group treatment. As hopelessness and social involvement are strong correlators with suicide risk, these factors will be tracked in addition to a pre and post questionnaire to evaluate patient outcomes and perception about the group.

As indicated in the previous section a pretreatment survey should be administered at this time and a post treatment survey will be administered at the end of the 12 weekly sessions.

3. **Intake Interview**

In addition to the structured assessment, facilitators should provide an intake interview to identify present risk factors and warning signs for suicidality. Each facilitator should develop their own list of questions to obtain this information based on what is already known about the applicant. Some recommended areas to ask about include:

- History of suicide attempts
- Any suicide related hospitalizations (reason, duration, and resolution)
- Any diagnosed mental illnesses
- Have they known anyone who has died by suicide
- Family or social supports present
- How the individual utilizes or engages with family or social supports
- History and current alcohol and drug use
- History and current self-harm behavior
- Frequency, duration, and content of suicidal ideation
- Triggers for engaging in suicidal thoughts
- Feeling supported by their support network in addressing their suicidality
- Feeling open to going to their support network in times of crisis
- Reasons for living
- Reasons for dying
- Wish to live
- Wish to die

This time can also be spent clarifying results on the assessment measures in the case that the data does not provide a clear indication for the individual's fit for the group.

Session 1 (90 Minutes): Developing Safety

1. **Administer CSSR-S and PHQ-9 (10 Minutes)**

   As participants come into the group, facilitators should make rounds to each person individually to administer the CSSR-S and PHQ-9. For the CSSR-S, if the individual reports yes to items 4 ("Have you had these thoughts and had some intention of acting on them?"), 5 ("Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?"), or 6 ("Have you done anything, started to do anything, or prepared to do anything to end your life?") then they should be pulled from the group for additional screening, risk assessment, and safety planning. Depending on level of risk, the patient may be able to remain in the group for the remainder of session and receive follow up safety planning after session. If they are actively suicidal, they should be pulled from the group immediately to address their suicidality and determine what the least restrictive form of care is needed to ensure their safety and treatment. If safety is established, then they may return to the group. If safety cannot be established, then hospitalization may need to be acted upon.

2. **Introduction to GRIT (Confidentiality, Group Norms, and Expectations) (10 Minutes)**

   Though it should be provided during the individual pre-session, confidentiality should be covered as a group. Next, introduction of group members and a discussion of group norms and expectations should be established by the group. Facilitators should ensure major points are addressed, such as discussing others outside of group and how groups will promote inclusion and safety. Recommendations for areas to address are found in the materials section of the manual. Group members should be the primary contributors to developing norms and facilitators should help promote a positive first interaction for the creation of this group's dynamic.

3. **Opening Session Check-in (20 Minutes)**

   Session discussion should begin with an open floor to discuss any reactions or thoughts about their rating scores, or anything else that they may wish to openly cover in group. Facilitators should directly ask each patient if they would like to share something, but all patients are not required to speak during this time. The length and depth of the responses should be monitored by the facilitators to ensure that comments remain on task and that everyone gets time to check-in.

   This time should be heavily group member driven and facilitators should work to facilitate sharing and discussion between group members.

4. **Safety Planning (40 Minutes)**

   To ensure the safety of group members throughout treatment, a specific safety plan should be outlined for each member at the start of treatment. A safety plan is provided in the materials for this session. Additions and changes to what is included in the safety plan can be made to fit the needs of the patient or group. This plan should be practiced outside of session as homework and adjusted as needed during treatment.

   A blank copy of the safety plan should be given to each group member. Collectively, the group will walk through each step and support one another in identifying triggers, ways to reduce access to lethal means, coping strategies to manage or distract from their suicidality (it should be noted that these strategies should be primarily internally based as contacting others for support is done in the next section), and people to call or talk to for distraction. These people do not necessarily have to know about the patient's suicidality or be required to talk about the patient's struggles. This contact is for when they are needing a distraction or someone to help pull them away from feeling suicidal. For those people who the patient does feel comfortable talking about their suicidality, the patient should communicate with the contact directly before putting them on their list. This contact should be told what the patient feels they may need in a time of crisis, and what they may need if it to distract them from that moment.

5. **Guided Mindfulness Meditation (10 Minutes)**

   Provide a brief introduction to mindfulness, meditation, and guide a short meditation. Meditation can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   Discuss the purpose of intention and the ability to develop the skill to be present. Discuss how to allow thoughts to be thoughts and how to let them pass without fixation of pushing them away.

   An example mediation may include: "Take a moment to adjust your body and sit comfortably in your chair. Sit with your feet flat on the floor, sit upright in your chair, and place your hands in your lap or wherever they feel most comfortable. Let's start by taking a deep breath in through our nose and out through our mouth. In through our nose and out through our mouth. If you feel comfortable doing so, allow your eyes to close. If you do not feel comfortable closing your eyes that is okay, just let your eyes focus on a point in the room an let yourself ease into your chair. Deep breath in and let it all out (continue deep breathing for 1-2 minutes). You may notice that thoughts are starting to pop into your mind. That is okay. Think of your thoughts like clouds in the sky. We don't control the clouds, the wind brings them in. There is no need to fixate on them or try to push them away. Just as easily as they came, the wind will take them away. Your thoughts will pass. No need to fixate on them or to push them away. Just let

them be and let them go in their own time. Now we will take this last minute to breath and sit in silence".

After mediation do a short check in to make sure that everyone feels okay and is ready for session to end.

6. **Homework**

Practice using the safety plan during a stable time in which the patient is not thinking about suicide or is actively suicidal. The patient should take the physical copy of the safety plan out and practice each step of the plan. The patient should make written notes of what they did, how they felt, and any challenges or difficulties they noticed. This will be reviewed in the next session as a group and adjustments to the plans will be worked on collaboratively.

If a group member has suicidal thoughts outside of group, they should still use their safety plan to address these thoughts to manage their suicidality.

The number of times to intentionally practice this skill during a stable, non-crisis, moment should be agreed upon by the group.

Session 2 (90 Minutes): Learning to Maintain Safety

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   Discuss the purpose of intention and the ability to develop the skill to be present. To allow thoughts to be thoughts and to let them pass without fixation of pushing them away.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. Patients may discuss their homework, but time will be allotted primarily to review and address this area next. It may be best to encourage discussion and reflection outside of their homework.

4. **Discuss Homework from Session 1, Discuss Safety Plan, and Adjust Safety Plan if Needed (45 Minutes)**

   Patients should share their experiences with practicing their safety plans, and review what corrections they feel will best support it being useful so they can effectively use it in times of crisis or suicidal thoughts. Group members should address specific moments in which they used their safety plan. This can be a time in which they were experiencing suicidal thoughts and/or a time in which they practiced without having suicidal thoughts. Group members are encouraged to share both experiences if applicable.

   Group members should be encouraged to cover their experience in depth and begin to practice being intentional in using and reflecting on adjusting their safety plan. This is to promote a skill to be able to create a safety plan that can support themselves now, but also in the future in times of relapse to suicidality.

   Group members should be informed that this is a practice that they need to continue, but that next session will begin to focus on building social support systems and how to use those to manage their suicidality.

It should be highlighted that patient should work to implement their safety plan not only during times of crisis, but also any point they find themselves engaging in suicidal ideation. The group members should be practicing initial steps in breaking the cycle of automatically turning to suicidal thoughts and being more conscientious of stopping that thought pattern. In sessions 5, 6, 7, 8, and 9 the group will receive an introduction to the cognitive model and CBT to help support the initial behavioral steps they have begun.

5. **Homework**

Practice using safety plan during a stable time in which the patient is not thinking about suicide nor is actively suicidal. The patient should take the updated physical copy of the safety plan out and practice each step of the plan. The patient should make written notes of what they did, how they felt, and any challenges or difficulties they noticed. This will be reviewed in the next session as a group and adjustments to the plans will be worked on collaboratively.

If a group member has suicidal thoughts outside of group, they should still use their safety plan to address these thoughts to manage their suicidality.

The number of times to intentionally practice this skill during a stable, non-crisis, moment should be agreed upon by the group.

Session 3 (90 Minutes): Examining Current Social Supports and Creating New Ones

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   Introduce the purpose of practicing mindfulness regularly and the benefits. As part of the homework, ask group members to engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on usage of the plan should be included in this check in.

4. **Current Supports and Creating New Ones (45 Minutes)**

   Group members should discuss their current support systems that they have included in their safety plan and how those people have been able to support them. Group members are encouraged to examine these relationships and how they feel others react to their suicidality. It is possible that group members may feel guilt or shame during this time. This feeling should be validated and addressed as it arises. Session should work to move the discussion towards identifying what makes for a positive and supportive relationship of someone in their support system.

   Group members may feel that they have lost people form their support system or that they can no longer turn to someone for multiple reasons. Examine these experiences to identify what the patient has learned they need for support and what those relationships look like. Reflect on if there is anyone who is currently in their lives who they feel they could ask or connect with to provide this support.

   In creating supports it is important to discuss with patients that the purpose of building new relationships is to expand their social and support system. This growth is positive for providing a sense of connection and belongingness. The degree to which they reach out to these new supports for help, especially regarding their suicidality, is something that should be tailored depending on the person and context of the relationship.

5. **Homework**

For homework patients should practice promoting or creating connection with another person. This is a flexible assignment and can vary from case to case. An example may be: calling a friend or family member they have not spoken to in some time, asking a friend to do something they both may enjoy, going to a social event at an activity the patient normally enjoys and talking with others at the event. Anything that connects them to others they may not feel very close with at this current moment in time.

As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 4 (90 Minutes): Asking for Help

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   As part of the homework, ask group members to engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

   Patients should report on their homework of practicing creating connection with another person.

4. **Asking for Help (45 Minutes)**

   Open discussion by having group members talk about how they would ask for help with an everyday task. Have them talk about their comfort level with asking for that help. Contrast this by having them talk about a time in which they remember asking for help to manage their suicidality, either directly or indirectly. Have them talk about their comfort level with this. Promote the strength and courage of asking for help.

   Group members may focus on how their suicidality has negatively impacted the relationship. Though there is the possibility that this has happened, the focus here is on identifying people in the patient's life who they feel can be a part of their support system, and most importantly how is the patient asking for help when needed.

   Discuss meta-communication skills, specifically how to talk about approaching conversations about help from the people they will go to for help. Provide time to discuss concerns and practice this skill. Identify a practice topic for something manageable and non-crisis related, that the patients can do for homework with someone in their support system.

5. **Homework**

Practice meta-communication skills for asking for help. Patients should discuss with someone in their support system how they can come to them for help on a certain topic. How this discussion went, and any challenges should be noted.

As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 5 (90 Minutes): What is Maladaptive Coping

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   As part of the homework, ask group members to engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

   Patients should check-in with their homework of practice meta-communication skills of asking for help. Discuss how this discussion went and note any challenges. Encourage patients to continue to practice this skill across different help areas or with different people in their life.

4. **Maladaptive Coping (45 Minutes)**

   Patients should be introduced to maladaptive coping and the ways in which it may present (thoughts, behaviors, relationships, avoidance, substances, etc.). The discussion should lead to difference between maladaptive and adaptive coping. It is important to validate the reason maladaptive coping is maintained. Highlighting the perceived immediate relief that maladaptive coping can provide from a stressor, even if in itself, the maladaptive coping induces another form of stress. Maladaptive coping may also provide relief in the moment without an immediate stressor or negative consequence, but may result in greater harm later on.

   This can be a time to discuss acceptance and how the tendency for trading long term suffering in place of immediate pain is a common behavior. Acceptance works towards tolerating and managing the stress and discomfort of the immediate pain to end the long-term suffering that someone experiences.

Discuss how suicidal behaviors and thoughts become a source of coping. Open discussion to how the patients may feel this has developed for them. Highlight reasons such as the relief of not being around anymore allowing them to escape stressors or problems they may face. Discuss how the intense feelings that suicidality provides may feel better than a lack of emotions or overpower another negative emotion they have with something more comfortable.

This session should be educating and allowing the patient to better understand the purpose of their suicidal thoughts in their life. For homework, they should continue to identify when and how their suicidal thoughts arise. Using an ABC sheet will be introduced in the next session for tracking the occurrences.

5. **Homework**

For homework patients should work to identify when and how their suicidal thoughts arise. Patients should take note of any triggers they may notice or their feelings before and after having suicidal thoughts.

As part of the mindfulness practice group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 6 (90 Minutes): Tracking Maladaptive Coping

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   As part of the homework, ask group members to engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

   Patients should check in with their homework of triggers and feelings they are noticing that occur with their suicidal thoughts.

4. **CBT for Maladaptive Coping (45 Minutes)**

   Introduce CBT and the cognitive model (thoughts effecting feelings and resulting in behaviors). Provide the Cognitive Model introduction paper which is found in the materials section of the manual. Discuss the implicit effect that automatic thoughts can have on how we feel and act. Provide encouragement that thoughts can be identified and changed. By practicing identifying when these thoughts occur (triggers and antecedents), and knowing the feelings that they may elicit, patients can develop the skill of intervening with these thoughts. After the patient becomes well practiced at identifying the thoughts that lead to their suicidality, disrupting this pattern can occur.

   Work with patients to identify an example of when this occurs and walk through the trigger of the situation to the thought, to the feeling, and to the suicidal thought/ behavior that it incurs.

5. **Homework**

   For homework patients should work to track the onset of their suicidal thoughts following the cognitive model handout provided. At least 3 examples should be written to follow the model.

   As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 7 (90 Minutes): Disrupting and Understanding Maladaptive Coping

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   As part of the homework, ask group members to engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

   Patients should check in with their homework of tracking the onset of suicidal thoughts and behaviors and what thoughts are proceeding them.

4. **Continuing CBT for Maladaptive Coping and Examining what Causes Maladaptive Behavior (45 Minutes)**

   Continuing to track and identify thought patterns should be discussed as a group. Methods of starting to engage with these negative thought patterns should be explored some example questions that can be explored include:

   1. Do I have experiences that this thought is not true all the time?
   2. If I felt differently right now, how would I think about this situation?
   3. Am I discounting any alternative explanations?
   4. If a friend told me they were experiencing what I am right now, what would I say to them?
   5. What happened the last time I was struggling with this, or something that felt like this?
   6. Is this thought true, or do I only feel that the thought is true?
   7. Is there another way that this can be thought about that I am not considering?

In addition to challenging the thoughts that are leading to their suicidal thinking, it can be important to offer some reflection into causes for their maladaptive behavior. The group working together to provide insight into what keeps them tied to suicidal tendencies can promote their own understanding and aid in talking with close support systems.

5. **Homework**

For homework patients should continue to track the onset of their suicidal thoughts following the cognitive model handout provided. At least 3 examples should be written to follow the model. They should also begin to challenge their thoughts they have identified that lead to their suicidal thinking.

As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 8 (90 Minutes): Disrupting Maladaptive Coping

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   As part of the homework, ask group members to engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

   Patients should check in with their homework of intervening the onset of suicidal thinking and the thought patterns that lead to them to their suicidality.

4. **Continuing CBT for Maladaptive Coping and Examining what Causes Maladaptive Behavior (45 Minutes)**

   Methods of interrupting negative thought patterns that lead to suicidal thinking should continue to be the primary focus of session. Meet patients where they are in this new process. Promote patient interaction and supporting one another in identifying and intervening with negative thought patters that lead to suicidal thinking

5. **Homework**

   For homework patients should continue to track the onset of their suicidal thoughts following the cognitive model handout provided. At least 3 examples should be written to follow the model. They should also begin to challenge their thoughts they have identified that lead to their suicidal thinking. Patient should focus on building consistency and target one area at a time, rather than applying a broad focus to this practice.

As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 9 (90 Minutes): Disrupting Maladaptive Coping cont.

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   As part of the homework, ask group members to engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

   Patients should check in with their homework of intervening with the onset of suicidal thinking and the thought patterns that lead to them to their suicidality.

4. **Continuing CBT for Maladaptive Coping and Examining what Causes Maladaptive Behavior (45 Minutes)**

   Methods of interrupting negative thought patterns that lead to suicidal thinking should continue to be the primary focus of session. Meet patients where they are in this new process. Promote patient interaction and supporting one another in identifying and intervening with these negative thought patters that lead to suicidal thinking.

   At this point in treatment the facilitators should be helping promote client interaction in addressing progress, while offering additional techniques and methods for disrupting their suicidal thought patterns.

5. **Homework**

   For homework, patients should continue to track the onset of their suicidal thoughts following the cognitive model handout provided. At least 3 examples should be written to follow the model. They should also begin to challenge their thoughts that they have identified that lead to their suicidal thinking. Patients should focus on building

consistency and target one area at a time rather than applying a broad focus to this practice.

As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session

Session 10 (90 Minutes): Challenging Relapse into Suicidal Thinking

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

   Patients should check in with their homework of intervening with the onset of suicidal thinking and the thought patterns that lead to them to their suicidality.

4. **Processing Conclusion to Group and Planning Next Steps**

   Open the discussion to how patients are feeling about the group coming to an end. What concerns do they have? When possible, validate their feelings and point out growth areas where they have made improvements during their treatment. Encourage group members to support one another as well in changes they have noticed or made.

   Ask patients to reflect on areas of growth they feel they should be focusing on next. Address if they feel they need to continue therapy and discuss if they prefer to find a group service or be involved in individual services.

   How do they feel about managing suicidal thoughts? How do they feel about continuing to challenge suicidal thoughts and the patterns that lead to their suicidality? Facilitators should dispel the idea that coming to the end of the group means patients should no longer be having suicidal thoughts, or that these thoughts will never occur again. This is not reasonable and not a likely outcome from the group. Allowing this misconception could create negative feelings towards their progress and decrease their openness to discussing relapse into suicidal thinking.

   Focus should be placed on frequency and duration of suicidal thoughts, if any, and management of them when they arise. Finally, if their suicidal thoughts stop for some time but then come back later, discuss how they think they will feel about it and what they will do. This last question is a main point of these last three sessions. Promote a

plan to get the patient to problem solve and try known methods that they have learned to address their suicidal thoughts. Whom to reach out to and how, as well as how to know when to get professional help should also be discussed.

To facilitate this, the Suicidal Thoughts Relapse Plan handout should be provided. For homework, the patients should work on filling out their plan. This will be reviewed in the next session.

5. **Homework**

For homework, patients should continue to track the onset of their suicidal thoughts following the cognitive model handout provided.

Patients should fill out the Suicidal Thoughts Relapse Plan and be ready to discuss in the next session.

As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 11 (90 Minutes): Post Group Preparation

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

4. **Processing Conclusion to Group and Planning Next Steps (45 Minutes)**

   Open the discussion to how patients are feeling about the group coming to an end. What concerns do they have? When possible, validate their feelings and point out growth areas where they have made improvements during their treatment. Encourage group members to support one another as well in changes they have noticed or made.

   Check in with patients' comments on last session regarding areas of growth they should focus on next. Prepare any appropriate recommendations or referrals that can be made to fulfill these needs.

   Check in with Suicidal Thoughts Relapse Plan. Discuss the people that they identified, the coping skills they have listed, and their thoughts on what actions they should take depending on the severity of their relapse. In this discussion, ensure that safety first is the primary focus. After establishing an effective method of promoting safety, discuss how much they feel they can continue to manage their thoughts versus when they should return to therapy or group for treatment.

5. **Homework**

   As part of the mindfulness practice, group members should engage in either self-led mindfulness or find a video or app that can help lead them through a mindfulness session at least 3 times by the next group session.

Session 12 (90 Minutes): Conclusion

1. **Administer CSSR-S and PHQ-9 (5 Minutes)**

   See session 1 for details.

2. **Guided Mindfulness Mediation (10 Minutes)**

   Provide a guided meditation. This can include deep breathing, an imagined safe space, guided imagery, or any that seem appropriate for the group.

   Example in session 1.

3. **Opening Session Check in (30 Minutes)**

   See session 1 for details. As the safety plan is not a primary focus for this session, a brief check-in on use of the plan should be included in this check in.

4. **Processing Conclusion to Group (45 Minutes)**

   Continue to review relapse planning and fielding next steps for group members in treatment.

   Help group members process their changes and strengths that were developed or built on during group. Promote group members in providing feedback to one another. Discuss what feelings they may have next week when they would normally be coming to group together, and what they can do instead to help address any negative feelings that may occur.

   Give group members remaining Post-Treatment Survey, Treatment Feedback Form, and INQ-15 (These documents can be found in the manual handouts). Facilitators will need to acquire an approved copy of the BHS. At the end of session, group members should be encouraged to stay after to talk with either of the facilitators individually if needed. If facilitators feel that any patient may need to talk or a facilitator has a concern about a patient, they should be pulled aside discreetly for a brief check-in.

Materials

The following section provides copies of group assessment and administration materials. Outside materials, including the Columbia SSRS, PHQ-9, PHQ-9 for Depression, and INQ have gained written permission for limited use in providing GRIT. Other materials have been created specifically for providing and assessing GRIT. Though the written protocol should be followed, when possible, it is understood that different settings or populations may require slight adjustments to the assessment, treatment, and evaluation. If such an instance occurs, group providers should make careful considerations to possible adjustments that could be made to accommodate the specific needs of the patients that are being served. Examples of such situations could include, but are not limited to, patients who are deaf or hard of hearing, have vision impairments, or have a neurological or cognitive impairment that limits their ability to properly use the provided materials.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Contact for Corrections

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Contact	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		
6) *Have you done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

Possible Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Referral
Item 4 Immediate Suicide Precautions
Item 5 Immediate Suicide Precautions
Item 6 Immediate Suicide Precautions

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

INQ

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

		Not at all true for me			Somewhat true for me			Very true for me
1.	These days, the people in my life would be better off if I were gone	1	2	3	4	5	6	7
2.	These days, the people in my life would be happier without me	1	2	3	4	5	6	7
3.	These days, I think I am a burden on society	1	2	3	4	5	6	7
4.	These days, I think my death would be a relief to the people in my life	1	2	3	4	5	6	7
5.	These days, I think the people in my life wish they could be rid of me	1	2	3	4	5	6	7
6.	These days, I think I make things worse for the people in my life	1	2	3	4	5	6	7
7.	These days, other people care about me	1	2	3	4	5	6	7
8.	These days, I feel like I belong	1	2	3	4	5	6	7
9.	These days, I rarely interact with people who care about me	1	2	3	4	5	6	7
10.	These days, I am fortunate to have many caring and supportive friends	1	2	3	4	5	6	7
11.	These days, I feel disconnected from other people	1	2	3	4	5	6	7
12.	These days, I often feel like an outsider in social gatherings	1	2	3	4	5	6	7
13.	These days, I feel that there are people I can turn to in times of need	1	2	3	4	5	6	7
14.	These days, I am close to other people	1	2	3	4	5	6	7
15.	These days, I have at least one satisfying interaction every day	1	2	3	4	5	6	7

Note: Items 7, 8, 10, 13, 14, and 15 are reverse coded.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner, T. E. (2012). Thwarted belongingness and perceived burdensomeness: Construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment, 24*(1), 197-215.

Safety Plan

A. Triggers For Suicidal Thoughts. Events, People, Avtivities, and Situations that Cause you to Feel Suicidal:

_____

_____

_____

B. Ways to Reduce Access to Lethal or Harmful Means:

_____

_____

_____

C. Coping Stratigies to Help Manage or Distract from Curent Suicidality:

_____

_____

_____

_____

Emergency Contact: _____

D. People I can Call or talk to for Distraction:

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

E. People I can Call or talk to for Help:

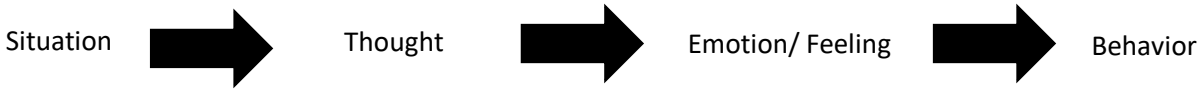
Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

If your life is at risk and you are feeling suicidal and are unable to manage your feelings using your safety plan, call 911 or have yourself checked into the hospital.

Introduction to the Cognitive Model



Situations are anything that is happening around or directly to you.

Thoughts are often triggered by how we interpret the situation we are in. Thoughts are not always direclty connected to the situation we are in, but the sitaution may spark an association or memory that we have connected in the past. The way our thoughts are impacted by the situation is often due to how we are percieving the situation, rather than how the situation may truly be. We may often not be aware of our thoughts, as they are happening all the time and can frequently occur automattically.

Emotions are caused by, and a reaction to, our thoughts. How we think about something will directly realate to how we feel about it as well. We typically notice our emotional response to events more than we do our thoughts. In working to improve and change how we feel, it can be more helpful to work backwards and start by addressing our situaitons and how we think about them. Changing our thoughts by addressing how we interpret events can, in turn, change how we feel.

Behaviors are the things we do in response to our emotions. It can be difficult at times to recognize what behaivors we are engaging in, as a lack of doing something in itsef can be a behavioral reaction.

Suicide and the Cogntive Model

When addressing suicidal thoughts and what leads to the suicidal thoughts, you need to backtrack to what situation and thought/interpretaiton lead you there. Addressing negative thought patterns at this point in the process can be a significant influence on improving how you feel and decreasing engagment in suicidality.

Suicidal Thoughts Relaspe Plan

It is possible that suicidal thoughts will return at some point in your life. These thoughts may be severe or they may be passing thoughts. As engaging in these thoughts can be promoting a previous maladapive form of coping, it is important we first keep you safe and second help intervene in this thought pattern. Just as we develop a safety plan to help you get through moments of crisis, this will serve as a plan in case suicidal thoughts return. It is best to look back at this plan every month even if you are not having suicidal thoughts, so you can make updates as changes occur in your life.

Am I safe?: If you feel that you are unsafe and your thoughts are turning into actions to take your own life then contact 911 and a trusted member of your support system to help you stay safe until you are able to get help. You should let these people know that you are including them on this list and let them know what you may need if you call for support. If you do not feel comfortable asking someone from your support system for help, contact the suicide hotline at 1-800-273-8255.

Support system contact: Name_____ Number_____

Name_____ Number_____

Coping Stratigies to Help Manage or Distract from Curent Suicidality:

1. _____

2. _____

3. _____

4. _____

I need to talk with: Who you need to talk with may change depending on the severity of your suicidal thoughts. Bellow include people you feel you can call depending on your need in that moment.

Name_____ Number_____

Name_____ Number_____

Name_____ Number_____

Name_____ Number_____

How to handle a relapse into suicidal thoughts: After you are safe and have done what you can to manage your suicidal thinking in the moment, it can be helpful to evaluate what was happening when your suicidal thoughts returned. You may be out of practice of using the cognitive model and the work done in group to help identify triggers for suicidal thinking and the thought patterns that promote them in your life. If your suicidal thinking seems to be returning and you are feeling concerned about the impact it is having on you, this can be a good time to check in with yourself to see if you should get individual or group help in the form of therapy. Returning back to therapy is a common and normal part of the recovery process for suicide and does not mean that you are failing or have done something wrong.

Pre-Treatment Survey

Thank you for joining the Group Ideation Treatment (GRIT)! We appreciate you taking time to commit towards taking steps to address your own mental health. Before starting GRIT we ask that you complete the following pre-treatment survey to help establish a baseline for how you are feeling now, and also provide you a section to write in areas of focus for you. In your responses, please consider how you have been feeling over the past four (4) weeks. In addition to this survey, you will also have two other questionnaires that we would ask that you complete before _____.

Please use the number key below to answer the following questions.

1 – Not at All 2 – Slightly 3 – Moderately 4 – Very 5 – Extremely

I feel connected with others. ____

My problems are more than I can handle. _____

Not being alive is something that scares me. _____

When I am stressed, thinking about not being alive calms me down. ____

Talking about suicide with someone I trust is something I feel okay doing. _____

I feel alone in my struggle with suicide. _____

In the space below, please describe what you are thinking about or doing before your suicidal thoughts occur. You may also use the back of this sheet, if needed.

Post-Treatment Survey

Thank you for being a part of Group Ideation Treatment (GRIT)! We appreciate you taking time to commit towards taking steps to address your own mental health. As we are ending GRIT we ask that you complete the following post-treatment survey. In your responses, please consider how you have been feeling over the past four (4) weeks. In addition to this survey, you will also have two other questionnaires.

Please use the number key below to answer the following questions.

1 – Not at All 2 – Slightly 3 – Moderately 4 – Very 5 – Extremely

I feel connected with others. ____

My problems are more than I can handle. _____

Not being alive is something that scares me. _____

When I am stressed, thinking about not being alive calms me down. ____

Talking about suicide with someone I trust is something I feel okay doing. _____

I feel alone in my struggle with suicide. _____

In the space below, please describe your feelings about having a relapse of suicidal thoughts. You may also use the back of this sheet, if needed.

Treatment Feedback Form (Side A)

Please complete the following feedback form (both sides A and B). Your feedback is voluntary and anonymous. Your support is greatly appreciated and will be used to assess the quality and help make improvements to the Group Ideation Treatment (GRIT). Thank you.

Please us the number key below to answer the following questions.

1 – Not at All 2 – Slightly 3 – Moderately 4 – Very 5 – Extremely

1. Content covered while in GRIT was helpful for me in learning new, or further utilizing, coping skills that are helpful for me. _____
2. I felt connected and supported by my fellow peers while in GRIT. _____
3. GRIT facilitators were considerate and inclusive of my cultural background. _____
4. The structure of sessions for GRIT was helpful for me. _____
5. The content covered in GRIT was helpful for me. _____
6. GRIT facilitators were respectful and worked with me to try to accommodate my concerns that I had about the group. _____
7. GRIT facilitators provided a supportive group that focused on coping skills, processing, and education about difficulties I have related to suicidal ideation. _____

Treatment Feedback Form (Side B)

For Items 8 – 11 please provide written feedback.

8. What was most helpful about GRIT?

9. What would you like to see changed about GRIT?

10. Would you recommend GRIT to someone who may also struggle with ideation?

11. Please provide any additional comments you would like.