



Maurizio Pompili · Roberto Tatarelli (Eds.)



# Evidence-Based Practice in Suicidology

A Source Book

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Maurizio Pompili  
Roberto Tatarelli  
(Editors)



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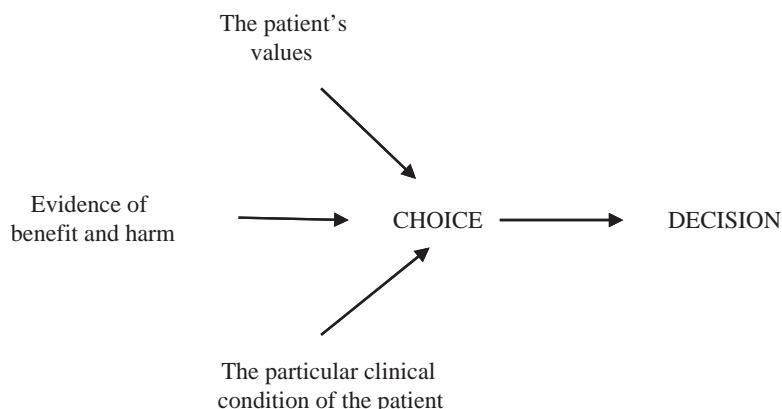
# Foreword

The most widely cited definition of evidence-based medicine is:

... the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice.

The term “evidence,” in English, means the type of knowledge derived from research, and although the term does not translate particularly well into Italian, French, or German, the term “evidence-based decision-making” has stuck and has become popular. The propositions made by professionals can be divided into those that are based on research evidence, evidence-based propositions, and those that are based on experience or opinion or on values. The former are not morally superior to the latter, but are less personal and less subjective, and there is fairly general agreement that decisions for both individuals and for populations or groups of patients should be based on research evidence.

“Evidence-based” is a term, of course, which includes not only the word “evidence” but also the word “based,” and decisions that are based on evidence do need to take into account the particular needs of the individual patient or group of patients, as shown in the diagram below:



Relating the evidence to the individual’s clinical condition, their other diagnoses, or risk factors, for example, sometimes called personalized medicine, requires the skills of a clinician. Even then values have to be taken into account, and not all clinicians or policy-makers are equally adept at managing values.

Evidence-based decision-making is most difficult when the evidence is scanty and when the values are strong, and in the prevention of suicide both these criteria hold true. Nevertheless, for both individuals and for populations it is essential that an evidence-based approach be taken. When resources are scarce, the best use has to be made of those resources. It is also important for those who are skilled in the management of evidence

to appreciate that evidence-based decision-making is evidence-based, and that values may drive a decision more than evidence. If public values demand that something be done, then the values may be deemed more important than the evidence if the evidence is that the type of action being proposed is ineffective.

In a democracy, values are more important than evidence. To the policy-maker, the official, the presentation of evidence is a core responsibility. If the decision goes against them, then they have to consider whether they can accept this value-based decision or whether they should resign.

In both the prevention of suicide in the individual and in the population, evidence and values need to be brought together; what is required then is good judgment, and that is sometimes even scarcer than good evidence.

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# The Framework



# Evidence-Based Practice in Suicidology

## What We Need and What We Need to Know

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Suicide prevention has become a national imperative in most countries worldwide, and a huge amount of resources has been invested to reduce the tragic loss of human lives that we witness each day. Despite great efforts in suicide prevention, the reduction of suicide rates does not parallel the ever-increasing investments both in economic and in human resources terms.

One of the most important obstacles in the prevention of suicide is the lack of solid evidence-based practices for delivering a sound intervention. Yet, suicidology proposes many interventions that have turned out to be effective. To some extent, in the health care domain, many practices are believed to be more or less a matter of one's own intuition, as if suicide prevention were a kind of art that some people may be able to master better.

Can we talk of "the art" of suicide prevention? Yes and no. The former because you must be really close to certain aspects of human suffering to deal with suicidal individuals and the latter because we must rely on shared principles that derive from evidence. With Hippocrates, medicine became a science and he was the one who stated "Where there is love for mankind, there is the love for the art of healing," David Sackett – one of evidence-based medicine's best proponents – once famously said that, when it comes to medicine, "Art kills" (Zuger, 1997). Whenever suicide prevention is based on our own intuition, we run the risk of not providing the best available care for an individual and, even worse, run the risk of losing that individual by suicide. In fact, relying on our scheme of reasoning or learned behavior may turn out to be extremely dangerous when dealing with suicidal subjects.

Prevention must be based on the most sound and best evidence available. Suicide prevention must begin with identifying prevention strategies, followed by conducting research to determine if these strategies work. Whenever we believe that we have an effective strategy, we should explore the impact and cost of that strategy in a community setting and then work for improving the strategy and its delivery.

The term *evidence-based programs* generally refers to interventions that have been evaluated and found to produce the desired results – in this case, reductions in suicidal behaviors or risk. The term *evidence-based prevention* can refer to those programs and also to effective *processes* for developing prevention programs, such as assessing local needs and assets, basing program content on up-to-date research and theory, tailoring programs to specific target audiences, designing multiple program components to work synergistically, and conducting evaluations. Choosing evidence-based *programs* and using effective *processes* are both important for effective prevention.

Recently, Berman (2008) raised the issue stating that we need scientific evidence “or at least a strong, logical argument based on the premise ‘it is more likely than not . . .’” He challenged the audience by asking for credible responses worthy of consideration for the following issues:

1. Is there evidence that suicide prevention public awareness programs or strategies save lives? (If not, why do organizations continue to spend limited available monies on these?)
2. Is there evidence that universal prevention programs are more cost effective and efficacious than indicated prevention programs? (If not, why are these so much more often put into effect?)
3. Is there evidence that the level of activity of suicidal thoughts (vague or passive ideation compared to detailed or active ideation) is directly related to suicidal behavior; that is, is there evidence that the more active and detailed the ideation, the greater risk of behavior (suicide attempt or death) and/or the more vague or passive the ideation the less risk behavior?
4. Is there evidence, other than anecdotal, to support the idea that giving away the prized possessions should be considered a warning sign (acute risk factor) for suicide? (If not, why is this so frequently mentioned as a warning by so many organizations educating the public about suicide’s warning signs?)

Rodgers, Sudak, Silverman, and Litts (2007) reported that expert-based review systems rely primarily on the experience of experts to determine what is evidence-based. These systems are used by experts to evaluate program effectiveness. While some prevention fields could boast of multiple registries of evidence-based programs and formidable arrays of published studies summarized in quantitative reviews, suicide prevention has relatively little to show in the way of evidence-based programs. Little is known about the effectiveness of many of these programs. The Suicide Prevention Action Network USA (SPAN USA Inc., 2001) reported that the “The single greatest obstacle to the effective prevention of suicide is the lack of evaluation research” (p. 19).

Pouliot and De Leo (2006) stated that:

The current emphasis on psychiatric disorders in published research needs to be balanced by a better study of the socioenvironmental contributors to suicide, particularly by stimulating the attention on conceiving and adopting standardized instruments and/or structured interviews that may favor the appropriate weighting of these variables. Efforts in this direction promote a truly ecological approach for understanding suicide and assist in the development of better preventive strategies.

In describing a practice as evidence-based, we mean that a body of research evidence supports the practice's effectiveness. According to the Institute of Medicine:

Effectiveness refers to the care that is based on the use of systematically acquired evidence to determine whether an intervention produces better outcome than alternatives – including the alternative of doing nothing.

Expert-based review systems rely primarily on the experience of experts to determine what is evidence-based. Such systems are used by experts to evaluate program effectiveness.

According to Sackett, Rosenberg, Gray, Haynes, and Richardson (1996):

Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice.

By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research, to the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. Without clinical expertise, practice risks becoming tyrannized by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient.

The best external clinical evidence can be obtained only if a hierarchy of evidence is taken into account. This hierarchy is usually provided as follows, the evidence at the top of the list being the most reliable:

- Systematic reviews and meta-analyses (discussion of validity and confidence intervals)
- Randomized controlled trials (discussion of validity, magnitude, and clinical significance of results)
- Cohort studies
- Case-control studies
- Cross-sectional surveys
- Case reports.

Evidence-based medicine is not restricted to randomized trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions. To consider an evidence-based approach, we should rely on the four-step approach:

- Formulate a clinical question
- Search for relevant information
- Evaluate the evidence for validity and usefulness
- Apply the evidence to the particular clinical situation/individual patient.

Last but not the least the evidence-based professional should filter the evidence, that is he or she should perform a critical appraisal of what is found.

## The Example of the Suicide Prevention Resource Center

The US Suicide Prevention Resource Center (SPRC) ([www.sprc.org](http://www.sprc.org)) promotes the implementation of the National Strategy for Suicide Prevention and enhances the nation's mental health infrastructure by providing states, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide.

The organization has established *the Best Practices Registry (BPR) for Suicide Prevention* whose purpose is to identify, review, and disseminate information about best practices that address specific objectives of the *National Strategy for Suicide Prevention*. The registry has three sections: Section I: Evidence-Based Programs; Section II: Expert and Consensus Statements; and Section III: Adherence to Standards. The three sections are not intended to represent "levels" of effectiveness, but rather include different types of programs and practices reviewed according to specific criteria for that section. BPR listings include only materials submitted and reviewed according to the designated criteria and do not represent a comprehensive inventory of all suicide prevention initiatives.

### Section I: Evidence-Based Programs

This section contains interventions that have undergone rigorous evaluation and have demonstrated positive outcomes. Section I includes listings from two sources: (1) interventions reviewed and rated by Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices, and (2) programs reviewed as part of the SPRC/American Foundation for Suicide Prevention Evidence-Based Practices Project.

### Section II: Expert and Consensus Statements

This section lists statements that summarize the current knowledge in the field and provide "best practice" recommendations to guide program and policy development.

### Section III: Adherence to Standards

This section contains suicide prevention programs and practices, including awareness materials, educational and training programs, protocols, and policies, that have been implemented in specific settings (as opposed to Section II statements that offer general

guidance to the field). These programs address specific objectives of the *National Strategy for Suicide Prevention* and their content has been reviewed for accuracy, likelihood of meeting objectives, and adherence to program design standards. Being listed in this section means that the program content meets the stated criteria; inclusion does not mean that the practice has been proven effective through evaluation (those programs are listed in Section I). While this section does not include treatments, it does contain practices that support treatment such as case-finding, compliance, and aftercare.

The BPR is designed to support program planners in creating effective suicide prevention programs. This section explains briefly how the BPR fits into the concept of evidence-based prevention and provides suggestions for using the BPR as part of a data-driven planning process.

## Principles of Suicide Prevention Effectiveness

According to Suicide Prevention Action Network USA (SPAN USA Inc., 2001), the following principles should be taken into account when designing prevention actions:

- Prevention programs should be designed to enhance protective factors. They should also work toward reversing or reducing known risk factors. Risk for negative health outcomes can be reduced or eliminated for some or all of a population.
- Prevention programs should be long term, with repeat interventions to reinforce the original prevention goals.
- Family-focused prevention efforts may have a greater impact than strategies that focus only on individuals.
- Community programs that include media campaigns and policy changes are more effective when individual and family interventions accompany them.
- Community programs need to strengthen norms that support help-seeking behavior in all settings, including family, work, school, and community.
- Prevention programming should be adapted to address the specific nature of the problem in the local community or population group.
- The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.
- Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.
- Prevention programs should be implemented with no or minimal differences from how they were designed and tested.

## Toward a Definition of Suicidology

Suicidology can be defined as the scientific study of suicide and suicide prevention. The term (and the concept) was first used by Shneidman (1964) and has since then been used in a number of ways such as to describe a new training scheme (Fellowship in

Suicidology, 1967); as part of a new journal (Bulletin of Suicidology, 1967); and to label a new association (The American Association of Suicidology, 1968). Suicidology is unlike other behavioral sciences in that it has usually included not just the study of suicide but also its prevention, in other words it incorporates appropriate clinical interventions to prevent suicide, a feature not always taken into consideration in the many contributions towards understanding suicide. The focus of suicidology is not necessarily completed suicide but above all the treatment of suicidal individuals. Suicides die with their unique life histories and dealing with pooled data or statistics would appear inappropriate for understanding the human misery of these individuals. Maris, Berman, and Silverman (2000) stated that:

While suicidologists give lip service to the multidisciplinary study of suicide, in actual fact most of us have very narrow and specialized domain assumption – usually those related to our professional training and subdisciplinary paradigms.

It is perhaps received wisdom in suicidology that suicidal individuals are experiencing unbearable psychological pain or suffering and that suicide may be, at least in part, an attempt to escape from this suffering.

As reported by Maris and colleagues (2000), the building blocks of a systematic theory of suicide include definition, basic concepts (lethality, motive, suicidal career, etc.), hypothesis, models, and research results. Regardless of such items, some concepts are so basic to suicide that they can be thought of as the commonalities of suicide. Shneidman (1985) listed some practical measures for helping highly suicidal persons:

1. Stimulus (unbearable pain): reduce the pain
2. Stressor (frustrated needs): fill the frustrated needs
3. Purpose (to seek a solution): provide a different answer
4. Goal (cessation of consciousness): indicate alternatives
5. Emotion (hopelessness-helplessness): give transfusion of hope
6. Internal attitude (ambivalence): play for time
7. Cognitive state (constriction): increase the options
8. Interpersonal act (communication of intention): listen to the cry, involve others
9. Action (egression): block the exit
10. Consistency (with lifelong patterns): invoke previous positive pattern of successful coping.

## The 1950s: Los Angeles Suicide Prevention Center

This book was in the final stages of preparation when Edwin Shneidman passed away. He was no doubt the person who fathered suicidology and who gave me some insight for this book during our long and regular chats on the telephone. The discipline was born under the star of searching for evidence related to suicide. Shneidman's search for evidence was a breakthrough in understanding suicide. He proposed the first experiment in the field and this was an effort to understand it scientifically.

As in most important developments in science, serendipity played a big role. It was not a particular interest in the topic that first moved Shneidman to get involved with suicide research, but rather his normal duties. In the last period of his life, he recalled the following event in 1949:

I was 31 and a clinical psychologist at Brentwood Veterans Administration Neuropsychiatric Hospital, and the superintendent asked me to prepare letters for his signature to two new widows whose husbands had recently committed suicide. On my own I went to the county coroner's office to find relevant background material and discovered a vault with hundreds of suicide notes. My contribution was to recognize their enormous potential, behavioral science potential. My further contributions were not to read them (so as to remain blind) and to invent, on the spot, a new genre of document, namely the elicited suicide note from non-suicidal persons so as to be able to compare genuine suicide notes in a real double-blind experiment. The day I went to the Coroner's office was somewhat an epiphany of my life. I then called Norman Farberow, who had recently completed a dissertation on suicidal patients using my Make a Picture Story test. Norman and I blindly analyzed each genuine and simulated suicide note. We published the results in a paper entitled "Clues to Suicide" (Shneidman & Farberow, 1956) and the following year we published another short paper entitled "Some comparisons between genuine and simulated suicide notes" (Shneidman & Farberow, 1957). In 1957 we co-edited *Clues to Suicide* (Shneidman & Farberow, 1957). That was the birth of Suicidology.

Obviously, only a few decades later, the new discipline became known as a major field of science.

## Psychological Autopsy Studies

During the development of suicidology, psychological autopsy became a major tool to understand suicide. This procedure introduced the psychological element into the study of suicide. Hitherto, suicide was studied anecdotally, statistically, sociologically but hardly psychologically. The psychological autopsy develops relevant information where the mode of death is unclear. Obviously one can write a biography without knowing the chief character directly, but by depending on people who knew the decedent as the informants. The psychological autopsy method involves a retrospective investigation of the deceased person and uses psychological information gathered from personal documents; police, medical, and coroner records; and interviews with family members, friends, coworkers, school associates, and health care providers to clarify equivocal deaths. The aim of the procedure is to achieve a clear picture of the personality preceding the event. Much credit for the success of the psychological autopsy belongs to Dr. Theodore Curphey, the Los Angeles coroner, who recognized the real benefits of that procedure. Shneidman had prophetically used the term for the first time in a book on Thematic Test Analysis, stating something that was going to become relevant afterwards (Shneidman, 1951):

... To present a study in which the emphasis is on the prediction of behavior rather than the validation of the technique; i.e., to hold a "psychological autopsy" on one case (p. 4)... Dr. James G. Miller has indicated rather succinctly that "Diagnosis is irrelevant and unproductive unless it is also prediction at the same time." He has also, in the same context, pointed out the need for clinico-pathologic conferences in psychology similar in function

to those held in medicine. This book, then, is a sort of “psychological autopsy,” wherein the postmortem is performed not on the patient but on the test interpretations. This is made possible by the availability of the clinical and psychiatric data... (p. 6).

## The Problem With Psychological Autopsy Studies

Over the past decades, psychological autopsies have provided important elements for understanding suicide. Most of the data that come from psychological autopsy studies support the idea that individuals who die by suicide were suffering from a psychiatric disorder. Studies labeled as psychological autopsies report little information on the psychology of the deceased.

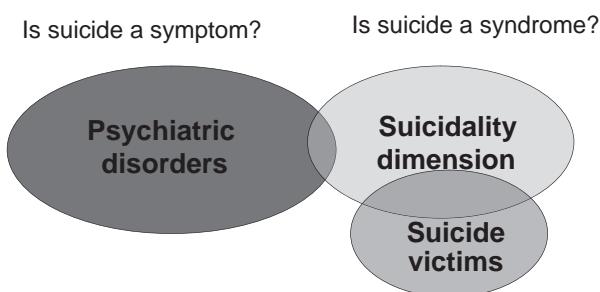
The assumption derived from psychological autopsy studies that the vast majority of individuals who die by suicide suffered from a mental disorder at the time of their death has, however, several biases. First, scholars worldwide use the term psychological autopsy for any retrospective investigation and such studies lack the comprehensive data gathering obtained from interviewing key persons. It is rather easy to classify a subject as depressed when in fact he or she was understandably sad for what was a mess in his or her life. Most of the data obtained from psychological autopsy studies are derived from a forensic environment, physicians, or death registries and much less often from family members or friends who could make sense of the depressive features that are distinguishable from clinical depression. Suicide is a problem of the human condition or, as Shneidman points out, “it is a dissatisfaction of the status quo.”

Pouliot and De Leo (2006) have highlighted many issues related to psychological autopsies, concluding that the medical model often fails to provide sufficient evidence that a disorder could lead to suicide. In most psychological studies conducted so far, suicide is almost exclusively researched under single paradigmatic umbrella of medicine. Pouliot and De Leo proposed that, according to the medical model, suicide is the consequence of biologically based alterations of the brain, where psychiatric symptoms are expressions of the disease caused by the alterations. Data reported by Cavanagh, Carson, Sharpe, and Lawrie (2003) support the notion that between 88% and 95% of suicides were suffering from a psychiatric disorder. These data contrast with evidence from prospective case studies which show that, at 10 to 20-year follow-up, the risk of suicide in adolescents suffering from major depression is 7.7% (Weissman et al., 1999), 3.4% for alcoholics (Murphy & Wetzel, 1990), and 3.8% in depressed patients (Gladstone et al., 2001).

As a psychiatrist, my model for depicting suicide refers to the two distinct dimensions that often overlap: the one comprising psychiatric disorders and the other referring to suicidality. When substantial overlapping exists, there is a major risk of suicide as the patient is “attacked” in two ways. However, suicide can occur with no psychiatric disorder when profound distress and psychological pain become unbearable and when suicide is seen as the perfect solution. In suicidal individuals, psychological pain affects the very core of their human condition and threatens life, which cannot be accepted in its present condition. This is precisely the aspect that characterizes suicide deaths and is absent in vast majority of psychiatric patients. A psychiatric disorder alone is, therefore, not sufficient for

precipitating suicide. There must be the suicidality dimension that carries some variant of negative emotions, such as heightened inimicality (acting against the individual's best interest); exacerbation of perturbation (refers to how disturbed the individual is); increased constriction of intellectual focus; tunneling or narrowing of the mind's content (dichotomous thinking); and the idea of cessation – the idea the insight that it is possible to stop consciousness and put an end to suffering (Pompili, in press).

In other words, the motives for suicide can be traced in the variables surrounding the individual viewed as a unique human being whose personality contains the real reasons for wishing suicide (Figure 1).



**Figure 1.** Suicide is better understood as the result of variables traceable in the suicidality dimension. This dimension generally includes: heightened inimicality (acting against the individual's best interest); exacerbation of perturbation (refers to how disturbed the individual is); increased constriction of intellectual focus and tunneling or narrowing of the mind's content (dichotomous thinking); the idea of cessation (the insight that it is possible to stop consciousness and put an end to suffering).

In medicine and psychology, the term syndrome refers to a group of several clinically recognizable features, signs (as observed by a physician), symptoms (as reported by the patient), phenomena, or characteristics that often occur together, so that the presence of one feature alerts the physician to the presence of the others. In suicidology, we have many features that are associated with suicide risk, but no single factor has been demonstrated to be necessary or sufficient to cause suicide.

Choron (1972) cites Gaupp's work (1910) as the milestone for understanding suicide from the biopsychological point of view; that is, there are forces that do not rise to the consciousness of individuals and thus cannot constitute motives, and forces that are related to race, age, sex, work, and social status. This perspective has been challenged by psychiatry that relates individuals who die by suicide to abnormal mental states. Ringel (1953) considered suicide as "the conclusion of a pathological psychic development." Weisman (1971) wondered whether suicide was a disease and proposed that "Suicide is neither a moral dilemma nor a mental disease but a form of life-threatening behavior resembling a declaration of war or a petition for bankruptcy." There is "suicidal sickness," but no

evidence of an organic “disease” to explain it. However, the concept of “disease” is a cultural abstraction that excludes other dimensions of sickness, such as conflict and crisis.

Esquirol (1838) said that suicide was a symptom of insanity and, therefore, those who commit suicide are psychiatrically disturbed. Esquirol developed the perspective that suicide is a psychiatric problem and wrote:

All that I have said up to now, the facts which I have reported, proves that suicide presents all the characteristics of insanity of which it is but a symptom; that there is no point for a unique source of suicide, since one observes it in the most contradictory circumstances, and because it is symptomatic or secondary, be it in acute delirium, or chronic, besides, the autopsy of suicides made so far did not throw much light on the subject of pathological changes (p. 639).

Considering suicide risk as a symptom impairs the opportunity to fully investigate and understand this aspect. If a patient has fever or headache, and if this ailment were thought to be part of pneumonia or cancer, clinicians would treat the disease as a whole rather than each symptom separately.

This phenomenological approach promises to aid our understanding of suicide, helping us understand rather than explain the behavior. Jaspers' (1959) assumption that we can explain a phenomena without understanding it at all is of particular interest here. Jaspers separated the study of subjective phenomena as experienced by the patients from the study of other psychological data. He introduced the difference between explanation and understanding and focused on the latter. Jaspers distinguished two types of psychiatric entities: developments that we can come to understand and processes that can be explained, even though they are not understandable. For instance, reactive depression is understood insofar as we can put ourselves in the place of the sufferer; most often, this is also true for suicidal behavior. On the other hand, we owe our emphasis to Kraepelin (1921) on documenting the longitudinal course of psychiatric disorders. As for suicide, he stated that: “The patients, therefore, often try to starve themselves, to hang themselves, to cut their arteries, they beg that they may be burned, buried alive, driven out into the woods and there allowed to die”; however, he did not emphasize on what was happening in their tormented mind, a feature often neglected when only DSM-Kraepelinian diagnostic criteria are taken into account.

The lack of association between suicide and psychiatric disorders has been dealt with in various studies (e.g., De Leo, 2004), and scholars have come to believe that alternative solutions must be found because the vast majority of depressed, schizophrenic, alcoholic, or organically psychotic patients do not commit or even attempt suicide (Leenaars, 2004; Lester, 1987, 1989). Hopelessness as a psychological construct has been reported to be a more important mediator of suicide risk than depression. Studies involving the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974) found that the extent of negative attitudes about the future (pessimism) was a better predictor of suicidal intent than depression (Beck & Steer, 1988). This indicates that it is not necessarily important how you feel right now, for example, being depressed, but it is important to trust whether the future would bring changes in your condition. This is particularly true for suicidal individuals experiencing the uniqueness of their suffering that, for them, has no escape and no future solution. It was suggested that: