Risk and Protective Factors for Suicide and Suicidal Behavior

The Nature of Risk and Protective Factors

A suicide risk factor is a variable (characteristic, attribute …) that is associated with an increased risk of morbidity (e.g., suicide attempt) or mortality (death by suicide). The association is correlational, hence not necessarily causal. Risk factors for suicide can be demographic, biological, psychological, social, and cultural. They also can be chronic (associated with elevated lifetime risk) or acute (associated with near-term risk). Many chronic risk factors are static or unchangeable (e.g., a history of a suicide attempt or a history of violence), but others may be modifiable or dynamic (e.g., a mental disorder that can be treated effectively or limitations in coping ability that can be improved with intervention). Acute risk factors are most often dynamic and changeable.

A protective factor is a variable that is associated with a decreased risk of morbidity or mortality. Protective factors may provide a counterweight to risk factors, but how risk factors and protective factors may interact is not always clear. No evidence-based system exists that informs clinicians about how much weight to assign any given risk or protective factor or any given combination of risk or protective factors. The co-occurrence of certain risk factors may be additive (i.e., equal to the sum of the risk associated with each factor), sub-additive (i.e., equal to a risk greater than that with one factor, but not equal to the sum of the two), or synergistic (i.e., the combined risk may be greater than the simple sum of the risk associated with each factor).

The Uses of Risk and Protective Factors in Suicide Risk Assessment

A listing of risk factors and protective factors for suicide (such as that provided below) should be regarded as an *aide-memoire* for the clinician; i.e., it is a listing of factors that can be reviewed in a particular case as the clinician attempts to arrive at a formulation or judgment about the level or degree of risk of suicide or suicidal behavior for the individual in question. In other words, a review of risk and protective factors should never be mistaken for a risk assessment in which these factors may be reviewed as part of a more complete case formulation. Moreover, it should be noted that, although the clinician should make all efforts to arrive at an evidence-based or

evidence informed risk formulation, the clinical formulation of suicide risk is ultimately a clinical judgment.

In assessing for acute or short-term risk for suicide, chronic or static risk factors may provide a foundation for the risk evaluation, but particular attention should be given to acute risk factors and protective factors. In the violence risk assessment literature, research has suggested that acute and dynamic risk factors contribute appreciably to assessments of short-term risk (McNiel, Gregory, Lam, Sullivan, & Binder, 2003). It seems plausible that the case may be similar with the assessment of short-term risk for suicide.

The listing of factors below is not exhaustive since there have been literally hundreds of identified risk factors for suicide. It is a listing of factors that are individually evidence-based and regarded as important factors to consider by the Section VII/Division 12 Working Group when a clinician evaluates a potentially suicidal individual. For the most part, the factors apply to all age groups.

The presence of risk factors for suicide should alert the clinician to the possibility that the individual is at risk. It should be noted, however, that the presence of one or more risk factors does not necessarily mean that a patient or client is actively suicidal. Alternatively, the presence of one or two very serious risk factors (e.g., a recent, near lethal suicide attempt with strong intent to die) can elevate the estimate of risk. Again, and as mentioned above, the clinician's decision about suicide risk should be based on a review of risk and protective factors in the context of a more complete clinical evaluation and a carefully considered case formulation. In considering the dynamic balance of risk and protective factors, it should be borne in mind that, in the face of overwhelming acute and chronic risk factors, protective factors are unlikely to be effective in preventing suicidal behavior.

Plans for management or treatment of a suicidal individual may benefit from a review of those dynamic and acute risk factors that can be modified through intervention and those protective factors that might be introduced or strengthened. In arriving at a case formulation for suicide risk, it is wise, if possible, to seek a consultation with a peer who is not necessarily a friend or close colleague. In addition, it is important to document your formulation of the level of risk, the observations that inform that formulation, your rationale for your formulation, your treatment plan based on your formulation, and the risks and benefits of your plan for management.

Selected Chronic Risk Factors, Acute Risk Factors, and Protective Factors

Chronic Risk Factors

Demographic factors

Male gender

White or Native American race/ethnicity

Divorced, widowed (particularly at a young age), separated, single

Age (35-64; 75-85+) (based on 2009 official U.S. suicide data)

Past Self-Injurious and Suicidal Behavior

Past suicidal ideation/plans*

Past suicide attempts*

Past self-injurious behavior

Past Impulsive or Violent Behavior

Past impulsive behavior

Past reckless and self-endangering behaviors

Past violent behavior

Cognitive/Psychological Features or Traits

Absolutistic thinking

Tunnel vision

Limited coping/problem solving ability

Limited capacity for self-soothing

Perfectionism

Family/Peer Group Factors

History of sexual or physical abuse/trauma as child/adolescent

Family history of suicide or suicide attempts

Family history of violence, substance abuse, or psychiatric disorders requiring hospitalization

Family/Self rejection of sexual orientation

Parental Divorce as a young child

Socioeconomic factors

Barriers to accessing mental health care

Stigma related to accessing mental health care

Easy access to lethal methods (particularly firearms)

Guns in the home

Hoarding of medications

Mental Disorders

Mood Disorders (including Major Depressive Disorder and Bipolar Disorder, Depressed)

Substance Use Disorder (particularly Alcohol Abuse/Dependence, Cocaine Abuse, and Nicotine dependence/smoking)

Schizophrenia

PTSD (particularly combat-related PTSD)

Anxiety Disorder

Personality Disorder (particularly Borderline or Antisocial)

Eating Disorders

Body Dysmorphic Disorder

Conduct Disorder (in adolescents)

Co-Morbid Disorders (e.g., Depression and Anxiety; Alcohol Abuse and Depression; Schizophrenia and Depression; PTSD and Alcohol Abuse; Borderline Personality Disorder and Depression)

Medical Illness

Cancer (risk greater in first year after diagnosis)

HIV/AIDS (risk greater with progression of disease)

End Stage Renal Disease (risk greater when age > 60)

Spinal Cord Injury/Disease (risk greater in first 2-5 yrs after injury)

Neurological Disorders

Traumatic Brain Injury (risk greater with cerebral contusions)

Epilepsy (risk greater for women)

Stroke (risk greater when age < 50)

Multiple Sclerosis (risk greater in first year after diagnosis)

Huntington's Disease (risk greater just prior to diagnosis and with decreased functioning)

Co-Morbid Axis III and Axis I Disorders (e.g., Axis III Disorder and Depression or Alcohol Abuse)

Acute Risk Factors

Suicide ideation/behavior

Current suicidal ideation**

Current suicidal plan**

Current suicidal plan includes very lethal means

Preparation for suicide (e.g., giving away valued possessions; rehearsal behaviors)

Recent suicide attempt (with no wish to be saved or expressed regret that death did not occur)

Acute symptoms of mental disorder

Acute depression

Active abuse of alcohol (particularly an increased use relative to historical pattern)

Depression following cocaine use

Rapid mood cycling in bipolar disorder

Command hallucinations (to commit suicide or harm self)

Insomnia; persistent nightmares

Acute co-morbid mental disorders

Acute depression and anxiety or panic symptoms

Acute depression and agitation

Alcohol abuse and acute depression

Schizophrenia and depressed mood

PTSD and active alcohol abuse

Borderline Personality Disorder and depressed mood

Physical Illness and Acute Emotional Distress

Physical illness (particularly as noted in Section I.I.) and depression

Burdensomeness of multiple physical illnesses

Unremitting and disabling pain

Cognitive/Psychological features

Feelings of hopelessness

Severe anhedonia and depressed mood

Global insomnia and depressed mood

Decreased self-esteem

Feelings of shame or humiliation

Feelings of intolerabl*e* aloneness

Few or no reasons for living; feeling loss of purpose or meaning

Feelings of being trapped

Behavioral features

Increased impulsive behavior or recklessness

Increased anger and/or aggression; seeking revenge

Recent violent behavior

Final act behaviors (e.g., making last will, giving possessions away)

Evidence of stalking and/or preparations for murder-suicide

Non-suicidal self-injury

Psychosocial issues

Recent loss or disruption of a relationship (separation, divorce)

Lack of social support

Recent discharge from psychiatric hospitalization

Unemployment

Financial Strain

Loss of socioeconomic status

Suicide cluster (contagion) (particularly with adolescents)

Pending legal issues or criminal charges

Exposure to suicide of a peer or of someone admired

Dramatic media coverage of a suicide

Victim of bullying (particularly in children and adolescents)

Protective Factors for Suicide

Good (available, accessible, and responsive) social support (including a positive therapeutic alliance)

Family cohesion and involvement (for adolescents)

Involvement in school activities (for adolescents)

Easy access to mental health care and substance abuse treatment

Good problem solving skills/ability to consider options

Children under 18 in the home

Pregnancy

Multiple reasons for living

Cultural and religious beliefs that provide meaning and discourage suicide

Restriction of access to highly lethal weapons/methods of suicide

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* The absence of past suicidal ideation/attempts cannot be taken as an indicator of lower risk. It is estimated that > 60% of suicides occur on the first attempt.

** An individual's denial of current suicide ideation or plan should not be taken to mean that there is no suicide risk. Also, both active suicide ideation and passive suicide ideation (e.g., wish to die without thoughts of killing oneself) confer increased risk.

Document prepared by the Section on Clinical Emergencies and Crises (Section VII) of the Society of Clinical Psychology, American Psychological Association Working Group on Suicide Risk Assessment Resources: Phillip Kleespies (Co-Chair), Marc Hillbrand (Co-Chair), Lanny Berman, David Drummond, and Lisa Firestone.