Suicide: What we Need to Know

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Case A

He went for therapy in search of assistance. He was only 17.

Client: May I come in?
Therapist: Yes, you may. Karibu.
Client: Thank you.
Therapist: How May I help you?
Client: I am here because I feel very low (starts crying) … I do not want to live any more.
Therapist: You are saying that you feel low and do not want to live anymore?
Client: Yes. I cannot continue to live. It is not possible.
Therapist: What has led to this?
Client: My father hates me. He does not want to see or hear of me. He does not want anything to do with me.
Therapist: How did you arrive at that?
Client: He thinks I am a failure.
Therapist: What happened for him to reach at that?
Client: I was living with my cousin. In a way I feel I messed myself up. I was stealing from him. My dad has tried several things on me but I have failed him. I really want to die. I have no more reason to live.

Case B

He looked at the bridge, under which he was meant to have died 10 years prior, and thanked God, thanked therapy and all that had contributed to him re-looking at life differently. Certainly, he would have died and forgotten, over ten years ago.

He had generally been a good boy. He did not struggle in school and so had managed grades to take him to the university. He even had gone through it and got a job. After working for two years, he had married and the two had been blessed with children. In all standards, he was a successful man.

He sat in his room and shed tears. He was feeling so low and valueless. Life had no meaning. He did not know his purpose. He did not feel like waking up or even going to work. He had noticeably gone low on matters grooming. He did not want to live.

Introduction

"Suicide is a serious global public health issue. It is among the top twenty leading causes of death worldwide, with more deaths due to suicide than to malaria, breast cancer, or war and homicide. Close to 800 000 people die by suicide every year" (WHO, 2019, p.7). In the U.S. suicide is the "second leading cause of death in people aged 10–34 and the fifth leading cause in people aged 35–54, [...thus being] a major contributor to premature mortality" (National Center for Health Statistics, 2021; Garnett, Curtin, Stone, 2022). In Europe, "over 56,000 of 5.2 million deaths in the European Union (EU) in 2015 were due to intentional self-harm…Just over 56,000 persons in the EU committed suicide" (Eurostat, 2018; Łyszczarz, 2021). In Asia, a study factoring in 2017-2019, by Lew et al., (2022) shows that the average suicide rates of ASEAN countries (Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Vietnam- those included in this study), is between 8.2 (Singapore) to 2.6 per 100,000 population for Indonesia and

the Philippines. The factors linked to these are economic development, religion, ethnicity, and history. These statistics though still high, are lower than those in North America, Europe and Japan: USA-22.5, Japan-19.4, Canada-17.6, France-16.4, Germany-12.9, U.K.- 11.1, and Italy-7.7 (WHO, 2021). In Australia, over 3,046 lost their lives to suicide in 2018 (Australian Bureau of Statistics (ABS) 2019), and the case is also no different in Latin America

In Africa, "suicide rate in the African Region is the highest in the world, estimated at 11.2 per 100,000 population in 2019, compared to the Global average of 9.0 per 100,000 population.... The WHO African Region male suicide rate is the highest of all Regions at 18 per 100,000 population, compared to the global average of 12.4 per 100,000 population" (IAHO, 2022, p. 1). As noted in the study, the leading countries are "Lesotho, Eswatini, Zimbabwe, South Africa, Mozambique, Central African Republic, Botswana, Eritrea, Cameroon, and Côte d'Ivoire. All have rates above 15 per 100,000 population, with peaks of 87.5 and 40.5 per 100,000 population respectively for Lesotho and Eswatini" (p. 1). These statistics confirm what is noted on suicide in East Africa (Kaggwa et al., 2021; Kaggwa et al., 2021b) and Kenya (Ongeri, L., Larsen, D.A., Jenkins, R. *et al*, 2022). In all these studies, the rate of male suicide is higher than that of females. Based on the reality that suicide is a negatively significant aspect of the human person, this current study seeks to review studies on suicide, exploring contributory causes to suicide, its effects as well as possible interventions.

What is Suicide?

For a clear understanding of the definitions, four terms namely suicide, suicide attempts, self-harm, and suicidal ideation, need to be clarified.

Term	**Definition**
Suicide	"a death caused by self-directed injurious behavior with any intent to die as a result of the behavior" (SAMHSA, 2020, p. 4)
Suicide attempt	"a non-fatal, self-directed, and potentially injurious behavior with any intent to die as a result of the behavior" (SAMHSA, 2020, p. 4)
Self-harm/ self-directed violence	"behavior that is self-directed and deliberately results in injury or the potential for injury to oneself" (SAMHSA, 2020, p. 4). It includes both suicidal and non-suicidal self-injury (NSSI), as well as self-harm with unclear intent.
Suicidal ideation/ Suicidal thoughts	- thinking about or planning suicide, ranging from once in a life time to daily or even in short intervals (M.D.H., 2019). - "thoughts lie on a continuum of severity from a wish to die with no method, plan, intent, or behavior, to active suicidal ideation with a specific plan and intent" (SAMHSA, 2020, p. 4; also cf Posner et al., 2011).

Who is Prone to Suicide? (region, gender, age)

In general, persons from all regions are affected by suicide, the average being 10.5 per 100,000, though Africa is rated the highest (IAHO, 2022, p. 1). Globally, the lowest rates are at 5 deaths by suicide per 100 000, to over 30 per 100 000 (WHO, 2018). The same document notes that suicide rates are higher in males (13.7 per 100 000) than in females (7.5 per 100 000). Additional statistics point towards majority of deaths by suicide occurring in low-and-middle-income countries (79%), where most of the world's population lives (84%) (WHO, 2019, Figure 5). Also, it notes that "more than half (52.1%) of global suicides occurred before the age of 45 years. Most adolescents who died by suicide (90%) were from low- and middle-income countries where nearly 90% of the world's adolescents live" (p. 11). All in all, "all ages, sexes, and regions of the world are affected" (WHO, 2019, p. 16), rendering suicide a global concern. The two cases presented at the start of the review, indicate clients prone to suicide, and ways in which they may seek interventions.

Contributory Factors to Suicide

According to M.D.H (2019, p. 4), the following risk factors are associated with suicide.

	Factor	Explanation
1.	Trauma	Current and past physical, sexual, or emotional abuse and/or trauma. Cf also SAMHSA, (2020).
2.	Triggering Events	Factors, stressors, or interpersonal triggers, especially those leading to humiliation, shame, despair, or loss.
3.	Ideation	Presence, duration, and severity of thinking about death or ending life. These could be current or from the past.
4.	Medical Health	Current and past medical health concerns or diagnosis, especially a new diagnosis or worsening symptoms.
5.	Mental Health	Current and past mental health concerns or diagnosis, especially with recent discharge from mental health treatment or hospitalization.
6.	Chemical Health	Current and past substance use disorders, especially with recent discharge from substance use disorder treatment or substance-related hospitalization.
7.	Substance Use	Any significant change in pattern of use, or current/past use.
8.	Past Suicidal Behavior	Past suicidal thoughts, attempts, failed attempts, or a family history of suicide. Cf also SAMHSA, (2020).
9.	Self-Injurious Behavior	Current or past injury to self.
10.	Trapped	Feeling of inability to escape current situation. Examples could include domestic violence, financial debt, health condition that feels inescapable, etc.
11.	Purposelessness	Presence, duration and severity of feelings of no reason for living or no sense of purpose.
12.	Hopelessness	Presence, duration, and severity of hopeless feelings.
13.	Withdrawal	Removal from friends, family, and society, isolation, or living alone.
14.	Anger	Rage, uncontrolled anger, or seeking revenge.
15.	Recklessness	Engaging in risky behavior, seemingly without thinking.
16.	Mood:	Any significant change from baseline, especially when demonstrating increased anxiety, agitation, lack of self-control, or impulsivity.

Additional contributory factors towards suicide include “bullying, social isolation, increase in technology and social media, increase in mental illnesses, and economic recession” (SAMHSA, 2020, p. 5). The same study notes high levels of suicide in LGBTQ+ adolescents, compared to those in hetero-sexual relationships. This may be a pointer that sex orientations may also be a contributory factor (Ivey-Stephenson, et al., 2020), relating to identity related stressors, including discrimination, violence, trauma, expectations of rejection, concealment of their identity, and internalized homo- and trans-negativity, thus increasing the risk for mental disorders and suicide (Johns, et al., 2019). An additional factor contributing to suicide is poverty (Leavitt, et al., 2018). Finally, in relation to adolescents, physical, hormonal, and social changes may make them more prone to anxiety or depression, leading to suicide (Lindsey, Sheftall, Xiao, & Joe, 2019).

SAMHSA, (2020. p. 6) also includes the following “ Childhood trauma, such as physical, sexual, and emotional abuse, being in the child welfare system, being a victim or perpetrator of bullying, experiencing a stressful event, consistent low-level or toxic stress, dysregulated sleep,

hopelessness, a sense of losing control, emotional reactivity or pattern of aggressive or aggressive-impulsive behavior, access to non-secure firearms, access to lethal means of suicide, including medications" These points are also supported by Sullivan, Annest, Simon, Luo & Dahlberg (2015); Cha et al., (2018); and also Liu et al., (2019).

The numerous natures of these contributory factors, point to the severity of the suicide problem; almost all are prone to suicide, and to its ideations at various times in one's life. It is therefore, all the more why there is need to discuss on it. Also, the vulnerability of the growing minds to challenging societal factors, sheds light on why young minds become increasingly prone to suicide and suicide ideations. The two cases presented at the start of this review, show some ways in which clients may communicate on issues of suicide. How then do we identify one that is at risk?

Identifying Who is at Risk of Suicide?

The process of identifying who is at risk of suicide starts with an awareness on warning signs. These are observable dispositions that persons who interact with one that is prone to suicide, may pick up. This awareness is aimed at enhancing preventive measures once the signs are noted. These signs include: (i) Talking about or making plans for suicide; (ii) Expressing hopelessness about the future; (iii) Displaying severe/overwhelming emotional pain or distress; (iv) Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the mentioned warning signs; (v) Withdrawal from or change in social connections/situations (vi) Changes in sleep (increased or decreased); (vii) Anger or hostility that seems out of character or context; and (viii) Recent increased agitation or irritability (SAMHSA, (2020. p. 7), also refer to. American Association of Suicidology, National Center for the Prevention of Youth Suicide, & Substance Abuse and Mental Health Services Administration (n.d.).

Together with these signs, it is important to carry out a risk assessment. According to the Risk Assessment tool by M.D.H (2019), the given template or a suicide inventory kit sheds more light in relation to persons having tendencies towards suicide:

Template of a suicide inquiry/inventory adopted from M.D. H (2019, p. 6-7)

Category	**Inquest**	**Very Much**	**Much**	**Moderate**	**Little**	**Very Little**
1. Ideation (i)	To what degree (intensity) do you have thoughts of hurting yourself or others?					
	To what degree (intensity) have you had thoughts of hurting yourself or others in the past?					
	To what degree (frequency) do you have thoughts of hurting yourself or others?					
	To what degree (frequency) have you had thoughts of hurting yourself or others in the past?					
	To what degree (duration) do you have thoughts of hurting yourself or others?					
	To what degree (duration) have you had thoughts of hurting yourself or others in the past?					
Ideation (ii)	To what degree (intensity) do you have thoughts of ending your life?					
	To what degree (intensity) have you had thoughts of of ending your life in the past?					
	To what degree (frequency) do you have thoughts of of ending your life?					
	To what degree (frequency) have you had					

	thoughts of of ending your life in the past?					
	To what degree (duration) do you have thoughts of of ending your life?					
	To what degree (duration) have you had thoughts of of ending your life in the past?					
2. Plan (i)	When you think about killing yourself or ending your life, how much do you imagine when you can/will do it?					
	When you think about killing yourself or ending your life, how much do you imagine where you can/will do it?					
	When you think about killing yourself or ending your life, how much do you imagine how you can/will do it?					
	When you think about killing yourself or ending your life, how much do you imagine the availability of the means (ways) you can/will use to do it?					
Plan (ii) Preparatory	To what degree have you taken steps to prepare to kill yourself, if any?					
	What steps have you taken? NB: The clearer and the more actual the steps, the higher the intensity. The assessor can put the intensity in the next column					
	Clarity & actuality of steps					
3. Behaviour	To what degree do you have thoughts about or tried to kill yourself?					
	To what degree have you ever thought about or tried to kill yourself in the past?					
	To what degree have you had aborted suicidal attempts?					
	To what degree have you carried out suicidal rehearsals e.g., tying noose, loading gun, measuring substance)?					
4. Non-suicidal self-injurious behavior	To what degree are you having paranoid thoughts?					
	To what degree have you had paranoid thoughts?					
	To what degree are you having hallucinations?					
	To what degree have you had hallucinations?					
	To what degree are you doing things to hurt yourself (e.g., cutting, burning or mutilation)?					
	To what degree have done things to hurt yourself (e.g., cutting, burning or mutilation)?					
5. Intent	To what extent do you expect to carry out the suicidal plan and believe that the plan will be lethal?					

	To what extent do you expect to carry out the suicidal plan and believe that the plan will be harmful?					
6. Information	What will happen when you act? To what degree are you aware of what will happen when the act is carried out?					
	What things put you at risk of ending your life or killing yourself (reasons to die)? To what degree are you aware of the things that put you at risk of ending life or killing yourself?					
	What things prevent you from killing yourself and keep you safe (reasons to live)? To what degree are you aware of the things that prevent you from killing yourself and keeping you safe?					
7. Notes	How much information do I have from parent, guardian or service provider, on the individual's suicidal thoughts, plans, behaviours, and changes in mood, behaviour or disposition?					
	How much information do I have from parent, guardian or service provider, on the individual's suicidal thoughts, plans, behaviours, and changes in mood, behaviour or disposition?					
	How much information do I have from parent, guardian or service provider, on the individual's thoughts, plans, behaviours, and changes in mood, behaviour or disposition in relation to desiring to hurt or kill another?					
NB: The higher the entries are towards "very much", the higher the risk of suicide or even homicide where relevant. This is so except on questions on degrees of information (7. Notes); the more the information, the better the intervention. This is also true on matters of the amount of information the individual has on things that can keep him/her safe.						

NB: Note the following statements of self-description and their intensities in pointing towards the severity of the suicidal tendency:

Statement	**Intensity of Suicidal Tendency**
"I'm dead, it's over."	high risk of suicide death.
"I think I'd end up in the hospital."	moderate risk of suicide death.
"I don't want to die; I want my suffering to end."	lower risk of suicide death.

Additional information on assessing the risk, is given in the following table adopted from M.D.H (2022, p.7).

Risk Level	**Risk Factors**	**Protective Factors**	**Suicide Inquiry**	**Intervention**
High	Multiple risk factors	Protective factors are not present or not relevant at this time	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Hospital admission generally indicated, suicide precautions (e.g., observation, means reduction)
Moderate	Multiple risk	Few protective factors	Suicidal ideation with a plan, but not intent or	Hospital admission may be necessary, develop crisis plan and

	factors		behavior	suicide precautions, give emergency/crisis numbers
Low	Few and/or modifiable risk factors	Strong protective factors	Thoughts of death with no plan, intent or behavior	Outpatient referral, symptom reduction, give emergency/ crisis numbers

(M.D.H., 2022, p. 7)

Interventions

M.D.H (2019) and SAHMSA (2020) refer to the interventions as protective factors that are either *internal or intrapersonal* (coping & stress management, spiritual beliefs, frustration tolerance, comfort with ambiguity or change, life satisfaction, and having goals & dreams) or *external* (also referred to as interpersonal) (pets, loved ones, positive therapeutic relationships, and resources for healing) (p. 5). Additional information on these factors is seen in O'Connor et al., (2014), and Taylor, et al., (2018).

These factors are singled out and further discussed by the National Center for Injury Prevention and Control, Division of Violence Prevention. They include (i) effective clinical care for mental, medical, and chemical health; (ii) access to a variety of interventions and support, at the least restrictive environment; (iii) positive connectedness to other people such as family, neighbors, community, and even culture (Centers for Disease Control and Prevention, 2019; SAMHSA, 2020, p. 7); (iv) support from ongoing medical, mental and chemical health care relationships; (v) skills in problem solving, conflict resolution, coping, and healing (awareness also falls under this category (SAMHSA, 2020. p. 7); and finally (vi) cultural and religious beliefs that discourage suicide and support instincts for self- preservation (in MDH, 2019, p. 5). Factors 1-4 are majorly external while the remaining two are internal. In addition to these interventions, continued gate-keeping trainings, relevant to the different participants (age, professionalism, social-economic status and ethnicity) need to be built and effected (Burnette, Ramchand, & Ayer, 2015).

Through the assistance of psychiatrists, and authorized and qualified medical personnel, pharmacological interventions may also be considered to treat depressive conditions that may be propelling the individual towards suicide. Some of the suggested treatment include Clomipramine (Anafranil)- for Obsessive- compulsive disorder (OCD) (10 & older); Duloxetine (Cymbalta)- for Generalized anxiety disorder (7 & older); Escitalopram (Lexapro)- for Major depressive disorder (12 & older); Fluoxetine (Prozac)- for Major depressive disorder (8 & older); Fluoxetine (Prozac)- for OCD (7 & older); Fluvoxamine- for OCD (8 & older); Olanzapine and fluoxetine, combination drug (Symbyax)- for Bipolar depression (10 & older); and Sertraline (Zoloft)- for OCD (6 & older) (Heiber, 2013; Mayo Clinic Staff, 2019). While using anti-depressants, caution should be taken and proper monitoring done for some may have heightened suicidal tendencies (Milosevic, Levy, Alcolado, & Radomsky, 2015). In this case, medical personnel, family members and other close persons should be aware of the changes happening to the patient. When the clients presented in the initial cases shared (one with a therapist, and the other with a friend), they were seeking assistance. This review wishes to create further information so that more persons should become aware and involved in the interventions as a way of reducing suicide cases.

Conclusion

Suicide, and other related terms suicide attempts, self-harm, and suicidal ideation, pose a risk to persons of all ages, and from all regions of the world. Statistics associated with suicide, rendering it among the top five causes of death, reveal the challenge that it poses. Its effect on young persons below 45 years, threatens both current and future generations. From literature, studies show a multiplicity of factors contributing to suicide, thus showing the vulnerability of almost each individual. Awareness of what it entails, of the factors contributing to its prevalence, and the myriads of possible psycho-social interventions, illuminates the future; with clarity of thought, of both intrapersonal (internal) and interpersonal (external) dispositions, that one can

embrace individually and/or in togetherness, in order to improve their wellness, thus reducing the threat to suicide. In addition, families and communities, Civil Society (including Faith Based Organizations) and governments, continue to be obliged to work on policies and on programmes, informing the preventive mechanisms geared at reducing the threat posed by suicide. Only then can the two and similar like individuals presented at the start of the review, can be assisted.

References

American Association of Suicidology, National Center for the Prevention of Youth Suicide, & Substance Abuse and Mental Health Services Administration. (n.d.). Youth Suicide Warning Signs. https://www.youthsuicidewarningsigns.org/.

Australian Bureau of Statistics (ABS). (2019). Causes of death Australia: 2018, *Australian Government*, Canberra

Burnette, C., Ramchand, R., & Ayer, L. (2015). Gatekeeper training for suicide prevention: A theoretical model and review of the empirical literature. RAND Health Quarterly, 5(1), 16. https://pubmed.ncbi.nlm.nih.gov/28083369/

Centers for Disease Control and Prevention. (2019). Risk and protective factors. https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html.

Cha, C. B., Franz, P. J., Guzmán, E. M., Glenn, C. R., Kleiman, E. M., & Nock, M. K. (2018). Annual research review: Suicide among youth-Epidemiology, (potential) etiology, and treatment. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 59(4), 460-482. https://doi.org/10.1111/jcpp.12831

Eurostat. (2018). Available at: https://ec.europa.eu/eurostat/web/products-eurostat-news/-/DDN20180716-1?inheritRedirect=true&redirect=%2Feurostat%2F.

Garnett, M. F., Curtin, S. C., Stone, D. M. (2022). Suicide mortality in the United States, 2000–2020. NCHS Data Brief, no 433. Hyattsville, MD: *National Center for Health Statistics*. DOI: https://dx.doi.org/10.15620/cdc:114217

Heiber, R. (2013). Toolbox: Psychotropic medications approved in children and adolescents. Mental Health Clinician, 2(11), 344-346. https://doi.org/10.9740/mhc.n145473.

Integrated African Health Observatory (IAHO), (2022). Suicide in Africa; A Neglected Reality. Available at https://aho.afro.who.int/country-profiles/af.

Ivey-Stephenson, A. Z., Demissie, Z., Crosby, A. E., Stone, D. M., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020). Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019. *Morbidity and Mortality Weekly Report*, 68(Suppl 1), 47-55. https://www.cdc.gov/mmwr/volumes/69/su/su6901a6.htm.

Johns, M. M., Lowry, R., Andrzejewski, J., Barrios, L. C., Demissie, Z., McManus, T., Rasberry, C. N., Robin, L., & Underwood, J. M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students - 19 states and large urban school districts, 2017. Morbidity and Mortality Weekly Report, 68(3), 67-71. https://doi.org/10.15585/mmwr.mm6803a3

Kaggwa, M. M., Nuwamanya, S., Ashaba, S., Rukundo, G. Z., Harms, S. (2021a). An adolescent's use of veterinary medicines: a case report exploring addiction. *J Psychoactive Drugs* [Epub ahead of print] 12 Jan 2021. Available from: https://doi.org/10.1080/02791072.2021.1873466.CrossRefGoogle ScholarPubMed

Kaggwa, M., Muwanguzi, M., Nduhuura, E., Kajjimu, J., Arinaitwe, I., Kule, M., . . . Rukundo, G. (2021b). Suicide among Ugandan university students: Evidence from media reports for 2010–2020. *BJPsych International*, 18(3), 63-67. doi:10.1192/bji.2021.13

Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides among American Indian/Alaska Natives — National Violent Death Reporting System, 18 states, 2003–2014. Morbidity and Mortality Weekly Report, 68(8),237–242. https://doi.org/10.15585/mmwr.mm6708a1

Lew, B., Kõlves, K., Lester, D., Chen, W. S., Ibrahim, N. B., Khamal, N. R. B., Mustapha, F., Chan, C. M. H., Ibrahim, N., Siau, C. S., Chan, L. F. (2022). Looking Into Recent Suicide Rates

and Trends in Malaysia: A Comparative Analysis. *Front Psychiatry*. 5(12), 770252. doi: 10.3389/fpsyt.2021.770252. PMID: 35069279; PMCID: PMC8766712.

Lindsey, M. A., Sheftall, A. H., Xiao, Y., & Joe, S. (2019). Trends of suicidal behaviors among high school students in the United States: 1991–2017. *Pediatrics*, 144(5), e20191187. https://doi.org/10.1542/peds.2019-1187

Liu, C. H., Stevens, C., Wong, S. H. M., Yasui, M., & Chen, J. A. (2019). The prevalence and predictors of mental health diagnoses and suicide among U.S. college students: Implications for addressing disparities in service use. *Depression and Anxiety*, 36(1), 8-17. https://doi.org/10.1002/da.22830

Łyszczarz, B. (2021). Production losses attributable to suicide deaths in European Union. *BMC Public Health* **21**, 950 (2021). https://doi.org/10.1186/s12889-021-11010-5

Mayo Clinic Staff. (2019, June 25). Antidepressants for children and teens. https://www.mayoclinic.org/diseases-conditions/teen-depression/in-depth/antidepressants/art-20047502.

Mental Department of Health (M.D.H). (2019). Suicidal Ideation Risk Management. Available at www.health.state.mn.us/syringe.

Milosevic, I., Levy, H. C., Alcolado, G. M., & Radomsky, A. S. (2015). The Treatment Acceptability/Adherence Scale: Moving beyond the assessment of treatment effectiveness. *Cognitive Behaviour Therapy*, 44(6), 456-469. https://doi.org/10.1080/16506073.2015.1053407.

National Center for Health Statistics. (2021). About multiple cause of death, 1999–2020. *CDC WONDER* online database.

O'Connor, S., Brausch, A., Ridge Anderson, A., & Jobes, D. (2014). Applying the collaborative assessment and management of suicidality (CAMS) to suicidal adolescents. *International Journal of Behavioral Consultation and Therapy*, 9, 53-58. https://doi.org/10.1037/h0101641.

Ongeri, L., Larsen, D.A., Jenkins, R. *et al.* Community suicide rates and related factors within a surveillance platform in Western Kenya. *BMC Psychiatry* 22, 7 (2022). https://doi.org/10.1186/s12888-021-03649-6.

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. *American Journal of Psychiatry*, 168(12), 1266-1277. https://doi.org/10.1176/appi.ajp.2011.10111704.

Substance Abuse and Mental Health Services Administration (SAMHSA), (2020). Treatment for Suicidal Ideation, Self-harm, and Suicide Attempts Among Youth. SAMHSA Publication No. PEP20-06-01-002 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration.

Sullivan, E. M., Annest, J. L., Simon, T. R., Luo, F., & Dahlberg, L. L. (2015). Suicide trends among persons aged 10-24 years--United States, 1994-2012. *Morbidity and Mortality Weekly Report*, 64(8), 201-205. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm.

Taylor, P. J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J. M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. *Journal of Affective Disorders*, 227, 759-769. https://doi.org/10.1016/j.jad.2017.11.073.

World Health Organization (2018). Global Health Estimates 2016: Deaths by cause, age, sex, by country and by region, 2000-2016. World Health Organization, Geneva.

World Health Organization (WHO). (2019). Suicide in the World. Global Health Estimates. https://apps.who.int/iris.

World Health Organization (WHO). (2021). *Global Health Estimates. USA, United States of America.*