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From tragedy to triumph: Raising awareness and reducing the stigma of suicide

A PEER-REVIEWED ARTICLE | by Diane Mullins, MS, RDH, CDIPC

ABSTRACT

Since suicide is considered a public health concern, bringing awareness can be imperative. As dental health-care providers, we have contact with thousands of patients a year, not to mention coworkers who may be struggling with life. By educating ourselves through terminology, techniques, and suicide prevention training, dental professionals could potentially help reduce suicide statistics. Understanding suicidal behaviors and being aware of available resources creates positive conversations to save lives.

EDUCATIONAL OBJECTIVES

At the conclusion of this course, the oral health-care provider will be able to:

1. Identify the language of safety when discussing suicide
2. Explain the most common co-occurring disorders associated with suicidal thoughts
3. Identify three psychological states associated with suicide
4. Recognize the role of dental health-care providers in suicide prevention

Public health extends beyond the dental office. It encompasses populations from neighborhoods to entire countries. Because of human and economic costs related to suicidal behaviors, the Centers for Disease Control and Prevention (CDC) recognizes suicide as a public health concern worldwide.[1] Preventing suicide from a public health perspective encompasses a variety of other factors and not just mental health alone. A population approach where the focus tends to be on populations or groups rather than individual treatment, primary prevention before suicidal behaviors occur, a strong sense to increasing understanding through science, and heightened collaboration among multiple disciplines are parts of the public health comprehensive view for suicide prevention.[1]

Whether researching suicide or suicide attempts statewide, nationwide, or globally, the statistics are rather alarming. The CDC states

suicide is one of the leading causes of death in the United States among young people.[1] In 2022, more than 49,000 people in the US died by suicide. That is roughly one death every 11 minutes.[2] Suicidal thoughts and attempts were higher. The CDC states a suicide attempt occurs roughly every 26 seconds.[1] According to the World Health Organization (WHO), over 700,000 people globally die from suicide every year, making it the fourth leading cause of death among 15- to 29-year-olds.[3] Non-Hispanic American Indian/Alaska Native people had the highest rate followed by non-Hispanic whites.[3] Statistically, veterans, people in rural areas, and industries such as mining and construction also have higher than average suicide rates.[3] Gay, lesbian, and bisexually identified young people have a preponderance of suicidal thoughts compared to their heterosexual peers.[3]

Figure 1 is adapted from the CDC, which in 2021 reported the number of Americans who have seriously thought about suicide was roughly 12.3 million. Those who made a plan for suicide registered at 3.5 million, and 1.7 million attempted suicide.[2]

Accessibility and quality of data related to suicide, including attempts, are mediocre at best, which is not unique to suicide. Because of the sensitive nature of suicide, the associated negative stigma, legal components, misclassification, and under-reporting alter the data. Most data are derived from hospital-based registries and national surveys that collect information regarding suicide attempts that are self-reported.[3] Reducing negative stigma could help authenticate future data.

Figure 2 reveals the 2022 mortality rates determined by the number of deaths per 100,000 total population, adapted from the CDC,[4] which depicts Montana having the highest suicidal mortality rate at 28.7, Wyoming the second highest at 25.6, and New Jersey reporting the lowest rate at 7.7.[4]

Suicide terminology

Understanding suicide data can be rather complicated due to the excessive number of statistics and variety of sources, not to mention the language related to suicide. The term "suicide behaviors" encompasses suicide ideation, suicide attempts, and suicide. Suicide ideation is the actual thought of ending one's life. An attempt is a nonfatal suicidal behavior, and suicide is ending one's life.[1] Deciphering the terminology relating to suicide is necessary for dental providers to effectively communicate with those at risk and to be able to collaborate with other healthcare providers.

Since language is important to any aspect of communication, when discussing the issues around suicide, using trauma-informed, nonstigmatizing language is preferred. The words chosen will either engage in or suppress effective conversation. Creating a safe, comfortable space will encourage those in crisis to pursue help.

Stay away from words such as "committed suicide," "successful attempt," or "completed suicide." Olson reports the word "committed" might imply that the act was criminal in nature; therefore, saying "committed

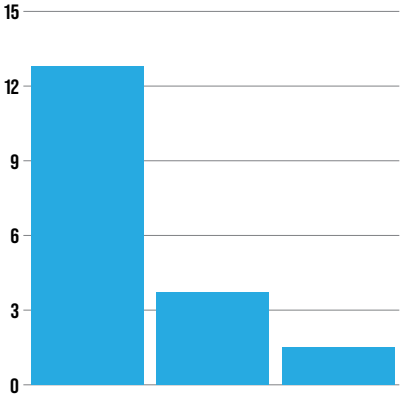

FIGURE 1: 2021 suicide thoughts, plans, and attempts. Numbers referenced in millions.[2]

State	Mortality Rate
Alabama	16.3
Alaska	27.6
Arizona	20.6
Arkansas	18
California	10.4
Colorado	21.1
Connecticut	10.6
Delaware	11.4
District Of Columbia	6.1
Florida	14.1
Georgia	14.6
Hawaii	16.6
Idaho	22.2
Illinois	11.7
Indiana	16.4
Iowa	18.5
Kansas	20.5
Kentucky	18
Louisiana	15.6
Maine	17.7
Maryland	9.5
Massachusetts	8.3
Michigan	14.7
Minnesota	14.8
Mississippi	14
Missouri	19.1
Montana	28.7
Nebraska	15.6
Nevada	21
New Hampshire	16.6
New Jersey	7.7
New Mexico	24.7
New York	8.5
North Carolina	14.4
North Dakota	22.5
Ohio	15
Oklahoma	21.4
Oregon	19.3
Pennsylvania	14.2
Rhode Island	10.6
South Carolina	15.4
South Dakota	21.6
Tennessee	16.7
Texas	14.4
Utah	22.1
Vermont	18
Virginia	13.3
Washington	14.9
West Virginia	18.3
Wisconsin	15.1
Wyoming	25.6

FIGURE 2: 2022 mortality rate per state[4]

suicide" leads one to believe there is an association of criminality or sinfulness to those who have died by suicide.[5] Use neutral language without assumptions or insinuations with judgment-free words such as "died by suicide." Prior terminology of "successful attempt" and "unsuccessful attempt" should be replaced with factual "suicide attempt."[5]

Olson encourages creating an environment where thoughts and feelings are safe so productive conversations may take place.[5] Keep in mind the person in crisis is vulnerable and any judgmental, aggressive language will not be supportive or helpful. Active listening is a skill that is also necessary for helping people in distress. Many patients confide in staff during dental care, especially those who have long-standing relationships. Being able to freely communicate could create a safe, positive environment; therefore, seeking education in suicide awareness/prevention for all dental health-care providers could be pivotal to saving lives.

Although suicide is an extremely sensitive subject and one that is frequently avoided, it is time to educate dental personnel on how to tackle the topic. Suicide prevention training will help ease the uncertainties and allow us to initiate the necessary conversations. This training should include all office personnel.

Psychological theory of suicidal behavior

What causes the desire for suicide? Research can help bring understanding to an inconceivable behavior. Although there are many theories as to how one gets to the stage of ideation, or displays suicidal behaviors, Joiner proposes three distinct psychological states must happen simultaneously over a certain period for people to develop the impulse for death.[6] These three psychological states are perceived burdensomeness, low sense of belongingness, and acquired capacity for suicide.[6]

Burdensomeness is a perception that one's mere existence is a burden to family, friends, or even society. Emphasizing the word "perception" is significant because frequently those feelings or thoughts of being a burden are distortions of the truth related to depression or other mental health disorders.[6] Research has found that this perceived burdensomeness was associated with the ideation of suicide among high suicide risk groups.[6] People in this psychological state feel their death is worth more to the family than their existence.

Not feeling an essential part of family, friends, or other important groups, along with alienation, creates a low sense of belongingness. Allen states that an inadequate sense of belongingness influences the risk for not just physical dysfunction, but psychological dysfunction as well.[7] Connecting to other human beings begins in-utero and continues throughout life; however, a disorganized attachment contributes to poor social and coping skills along with increased risk of mental health deficiencies.[7] Connection is deeply ingrained into our biological makeup.[7] Research indicates this defeated sense of belongingness is a predictor of suicide attempts.[6] The correlation between suicidality and the absence of belongingness has been determined among various demographics including adolescents, college students, and seniors.[6]

Even though the desire for suicide is instilled by burdensomeness and low belongingness, it does not necessarily confirm that the inclination will lead to an actual attempt. Joiner proposes a third component must present itself: "an acquired ability for lethal self-injury."[6,8] This theory suggests people acquire the ability to hurt oneself. Joiner has studied the capacity for suicide-predisposing factors, such as repeated provocative

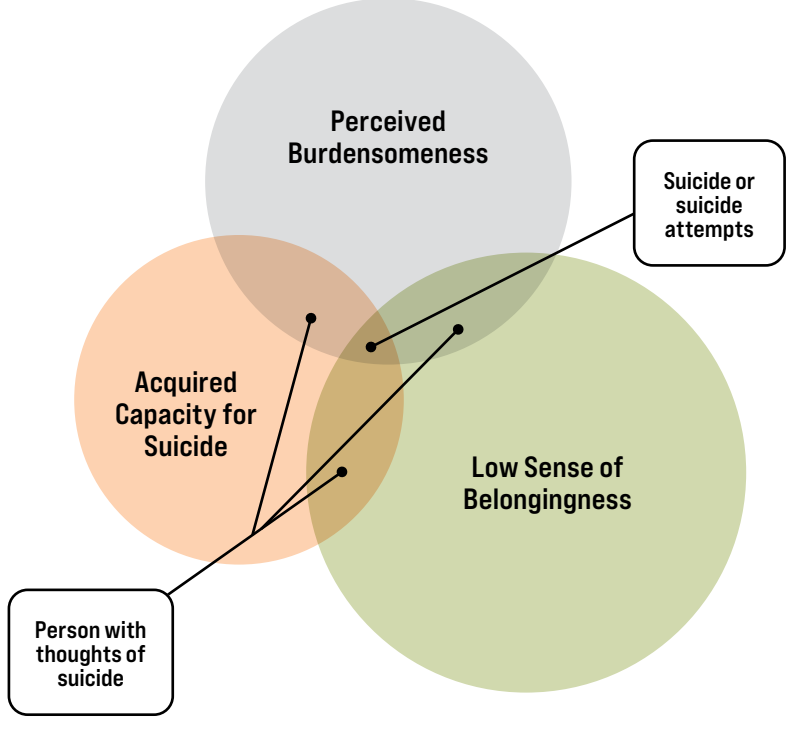

FIGURE 3: Psychological theories of suicidal behavior[8]

exposures, past suicidal behaviors, lowered fearfulness to pain, injury, or death, and a history of self-injury among a variety of demographics to offer insight on the significance of risk assessment. Risk assessment systems can be implemented among health-care providers, scientists, and clinicians to help determine individuals' risk levels.[8]

Figure 3,[8] adapted from Joiner, reveals the intersection of the three suicidal impulse components that can affect individuals' inclination for a suicide attempt. Dental health-care providers should become familiar with the interpersonal psychological theories of suicide and cognizant of Joiner's psychological suicidal behaviors.

Warning signs of suicide

Suicide is a complex health concern that does not follow an exact path. Educating dental professionals to recognize warning signs as well as how to respond to these signs is crucial to suicide prevention. Warning signs of suicide can vary from feelings of extreme sadness, agitation, and emotional pain, to expressing wanting to die or being a burden to others.[9] Statistically, family members or friends are first to diagnose suicide warning signs and can initiate the first steps for treatment. Electronic health-care records are beginning to use data that will aid in identification of suicidal risks.[9]

People contemplating suicide may convey their message directly or indirectly. Direct verbal clues are straightforward, blunt statements such as "I am thinking about killing myself" or "I'm going to end it all." Indirect expressions may be a little more subtle and not quite as candid, including "Things will be better when I'm gone" or "The pain will never stop unless I do something."[10] Whether the verbal remarks are spoken directly or indirectly, any remarks pertaining to suicide or burdensomeness should be taken seriously.

Nonverbal changes in a person's behavior should also raise a concern. Such actions include withdrawing from normal activities, family, or friends; giving away personal possessions; displaying risky behaviors; unusual conduct; extreme mood swings; buying a gun; stockpiling pills; increased use of alcohol; and radical changes in eating or sleeping habits.[9]

Typically, dental health-care providers can recognize emotions transmitted from their patients. If any of these warning signs surface, seek help immediately. As suicide prevention training suggests, persuade your patient to get help whether it be from local support groups, counseling, the American Association for Suicidology (www.suicidology.org), or the American Foundation for Suicide Prevention (www.afsp.org). The three-digit dialing code 988 is available to connect callers to the 988 Suicide and Crisis Lifeline. Having preprinted brochures with these resources on hand can help people in crisis.

Whether the clues are direct or indirect, every clue should be taken seriously. Never assume someone is joking around or crying wolf.

Understanding individuals at risk

Suicide does not discriminate against age, race, gender, or socioeconomic status; all demographics can be at risk. While there is not one single cause of suicide, there are certain risk factors that include: depression (major and bipolar); previous suicide attempts; financial problems; childhood trauma; alcohol use disorders; chronic pain or illness; presence of guns or pills at home; direct or indirect exposure to others' suicidal behaviors; and a sense of isolation.[2,3,9]

Determining who is at risk may be difficult. The WHO states those with a previous suicide attempt have the strongest risk factor by far.[3] Patients who have recently experienced a stressful life event (personal, legal, or financial) along with interpersonal triggers such as harassment, bullying, embarrassment, and discrimination may raise the suicide risk.[3] Do not assume that every patient or family member who is having difficulties, temporary setbacks, or moments of distress is suicidal; however, awareness is imperative.

Co-occurring conditions

Research shows suicidality has a close relationship to mental illness.[11] While most people who have a mental illness do not die by suicide, more than 90% of those who do take their own lives have experienced some sort of mental illness.[11] The agony of mental illness combined with devastating life situations is more likely to result in suicidal behaviors.[11]

Song et al. report psychiatric patients have a suicide rate five times higher than the general population.[12] Studies reveal psychotic disorder has the highest standardized mortality rate, followed by bipolar disorder, and then substance abuse disorders. Although anxiety, trauma-related disorders, and personality disorders contribute to suicidal risk factors, psychiatric disease with depression, psychosis, and substance use disorder are the most relevant risk.[13] Dental practitioners will treat many patients with mental illness throughout their careers; therefore, being conscious of these suicidal co-occurring conditions is critical.

Adverse childhood experiences

Traumatic childhood events, or adverse childhood experiences (ACE), occur between the ages of 0-17 years.[14] These unfavorable experiences may disrupt an individual's

health and interfere with stability throughout the duration of life. The prenatal period through later adolescence strongly influences adult relationships, health, and social outcomes.[15] Years of research has determined a link between the toxic stress of adverse childhood experiences and an elevated risk for development of diseases, behavioral difficulties, alcoholism, depression, obesity, and suicide.[14]

The latest data from the National Survey of Children's Health estimates 30% of children witnessed one ACE, and approximately 14% of children experienced two or more ACEs with no economic hardship association.[15] An estimated 45% of children with economic hardship experienced at least one ACE.[15] Financial instabilities and parental separation were found to be the most common cause of ACEs.[15] The CDC reports approximately 62% of adults in 23 states experienced at least one ACE during childhood years, and roughly 25% state they encountered three or more adverse effects.[16]

Understanding the risk factors for adverse childhood experiences along with protective factors can help end the trauma.[16] Evidence-based prevention strategies assist communities to help reduce events that have lifelong consequences.

Sustaining safe, positive relationships that are nurturing can help prevent ACEs and help children achieve a potentially healthy life.[16] Promoting economic support for families and protecting against violence are well-proven prevention strategies.

Stressors in dentistry

There is no doubt that the dental profession is demanding, which can lead to stress, anxiety, depression, impaired productivity, dissatisfaction with the job, and eventually health issues.[17] Chronic stress disrupts life in a negative manner, and since stress is correlated with mental illness, which contributes to suicide, it must be taken seriously.[12] According to Malcolm et al.,[17] more emphasis should be placed on the stressors of dentistry. Developing stress reduction methods to alleviate burnout and enhance job satisfaction is essential for maintaining mental and physical health.

Burger reports that dentists diagnosed with anxiety has more than tripled from 2003 to 2021.[18] Many dental professionals are plagued with burnout and other stress-related conditions that could potentially impair their ability to function at a competent level. According to Burger, the stigma associated with having a mental issue needs to be addressed.[18]

Stressors in the dental office include interpersonal friction between staff; patients in pain or who are fearful or unhappy; trying to stay on schedule; little to no time for lunch, bathroom breaks, or processing of instruments; phones ringing nonstop; overbooked schedules; and emergencies.

Physical, emotional, and mental self-care for dental professionals is crucial. Stress management or reduction activities should be practiced on a daily basis with exercise, meditation, proper sleep, a healthy diet, and connections with positive support groups. Not only will practicing self-care promote longevity of our dental careers, but it is also beneficial for overall well-being.

Prevention

Suicides are preventable; however, in order for the efficacy of prevention methods to improve, a great deal of coordination needs to happen. Interdisciplinary sectors including health, law, education, business, media, and politics must integrate their efforts to have a positive impact on understanding the complexity of suicide and prevention.[2] Even though dental offices may be a small part in the mass interdisciplinary components, every little bit helps.

Hogan states health-care employees who interact with patients should be cognizant of suicidal behavior signs and take appropriate steps if needed.[19] Health-care employees exposed to suicidal patients typically refer to behavioral health, mental health, and emergency departments. Since dental practitioners are classified as health-care providers, implementing formal suicide prevention training into patient care is important in the effort to reduce suicide statistics. Formal training can be completed online or in person through various organizations.

Other prevention strategies include reducing access to lethal means and screening for mental health conditions. Through education and learning how to reduce lethal means, such as locking up pills and guns, lives can be saved. Dental medical questionnaires should include screening questions.

As research continues, training for risk identification will continue to improve. Awareness is key. The National Institute of Mental Health (NIMH) advocates for research on the reduction of suicide in the United States and the implementation of suicide prevention and intervention programs. According to the World Health Organization Mental Health Action Plan, the aim is to reduce suicide rates by one third by 2030.[2]

Conclusion

Breaking the stigma of suicide and discussing this sensitive topic will help bring awareness to a significant public health concern. Preventing suicide is an ongoing collaborative project that needs all health-care providers' attention. There are a number of evidence-based suicide prevention

methods available for dental professionals along with training. Training should include recognizing suicidal thoughts, behaviors, risk factors, and prevention. Although change does not happen overnight, being aware of suicidality risks and signs will stimulate positive conversations among those in crisis. Hopefully, dental health-care providers can help reduce this tragic, preventable form of death.

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1. What type of language is recommended when discussing suicide?
   - A. Nonstigmatizing
   - B. Trauma-informed
   - C. Nonjudgmental
   - D. All of the above

2. What does burdensomeness mean?
   - A. The ability to hurt oneself
   - B. Not feeling essential to family or friends
   - C. The perception that one's existence is a burden to family or friends
   - D. A mental health disorder

3. People contemplating suicide may convey their message either directly or indirectly. What is an example of an indirect message?
   - A. I am thinking about killing myself.
   - B. I don't want to live anymore.
   - C. My family would be better off without me.
   - D. I am going to end it all.

4. Research shows anxiety has tripled among dentists during what time frame?
   - A. 1980–1998
   - B. 1998–2003
   - C. 2003–2021
   - D. 2021–2023

5. According to the World Health Organization, how many people die from suicide every year?
   - A. 300,000
   - B. 400,000
   - C. 500,000
   - D. 700,000

6. The National Institute of Mental Health approximates ___ people die every hour from suicide in the United States.
   - A. 10
   - B. 11
   - C. 12
   - D. 13

7. Research shows a suicide is attempted every ___ seconds.
   - A. 26
   - B. 20
   - C. 15
   - D. 5

8. According to the CDC, how many Americans have seriously thought about suicide?
   - A. 5.4 million
   - B. 6.7 million
   - C. 8.2 million
   - D. 12.3 million

9. What state had the highest mortality rate in 2022?
   - A. Alaska
   - B. Montana
   - C. Nevada
   - D. Wyoming

10. What psychological behavior has research shown to be a predictor of suicide attempts?
   - A. Defeated sense of belongingness
   - B. Imposing hardship
   - C. Lowered fearfulness to death
   - D. All of the above

11. Examples of unusual conduct one may exhibit when contemplating suicide include:
   - A. Routine schedule
   - B. Extreme mood swings
   - C. Meal planning
   - D. Enrolling in a new class

12. What is the three-digit code one can call or text for immediate help for someone in crisis?
   - A. 988
   - B. 989
   - C. 889
   - D. 898

13. What does the World Health Organization consider a strong risk factor for a suicide attempt?
   - A. Grandiose lifestyle
   - B. Religion
   - C. Previous suicide attempt
   - D. Smoking

14. Song et al. found psychiatric patients have a suicide rate that is ___ times higher than the general population.
   - A. 3
   - B. 4
   - C. 5
   - D. 6

15. Co-occurring conditions typically consist of a mental illness and:
   - A. Heart disorders
   - B. Substance abuse disorders
   - C. Kidney disorders
   - D. Periodontal diseases

16. The World Health Organization Mental Health Action Plan's goal is to reduce suicide rates by ___ by 2030.
   - A. One third
   - B. One half
   - C. One quarter
   - D. One fifth

17. As a dental health-care provider, where could we refer a patient in crisis?
   - A. Behavioral health facility
   - B. Mental health facility
   - C. Emergency department
   - D. All of the above

18. Which is a strategy of suicide prevention?
   - A. Screening for mental health conditions
   - B. Taking vitals
   - C. Reducing access to lethal means
   - D. A and C

19. What is an example of self-care that dental health-care providers can implement to reduce stress?
   - A. Immaculate oral hygiene
   - B. Meditation
   - C. Positive support groups
   - D. B and C

20. Adverse childhood experiences are best described as unfavorable experiences between what ages?
   - A. 0–17 years
   - B. 0–5 years
   - C. 5–12 years
   - D. 12–16 years

21. Adverse childhood experiences are linked to an increased risk of:
   - A. Depression
   - B. Alcoholism
   - C. Behavioral difficulties
   - D. All of the above

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22. What are the most common causes of adverse childhood experiences?
- A. Financial instability and alcoholism
- B. Alcoholism and parental separation
- C. Financial instability and parental separation
- D. Parental separation and depression

23. What percentage of adults have experienced at least one adverse childhood event?
- A. 56%
- B. 62%
- C. 73%
- D. 81%

24. How many Americans have encountered three or more childhood adverse effects?
- A. 25%
- B. 30%
- C. 35%
- D. 40%

25. Research reveals more than ___ of people who died by suicide have experienced some sort of mental illness.
- A. 70%
- B. 80%
- C. 90%
- D. 95%

26. A referral resource for someone in crisis is:
- A. Association for Suicide Prevention
- B. American Foundation for Suicide Prevention
- C. American Fundamentals for Suicide Prevention
- D. Association Founded for Suicide Prevention

27. Withdrawing from normal activities could be considered:
- A. A direct verbal clue
- B. An indirect verbal clue
- C. A nonverbal clue
- D. Not a clue

28. Acquired ability for lethal self-injury refers to people who:
- A. Do not feel an important part of the family
- B. Do not feel they belong in society
- C. Alienate themselves
- D. Have the ability to hurt themselves

29. Studies show estrangement affects physical dysfunction as well as ___ function.
- A. Psychological
- B. Physiological
- C. Psychosocial
- D. Psychophysiological

30. Language that should be avoided when discussing suicide includes:
- A. Committed suicide
- B. Successful attempt
- C. Completed suicide
- D. All of the above

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From tragedy to triumph: Raising awareness and reducing the stigma of suicide

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EDUCATIONAL OBJECTIVES

1. Identify the language of safety when discussing suicide
2. Explain the most common co-occurring disorders associated with suicidal thoughts
3. Identify three psychological states associated with suicide
4. Recognize the role of dental health-care providers in suicide prevention

COURSE EVALUATION

1. Were the individual course objectives met?
   Objective #1: Yes No Objective #3: Yes No
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Please evaluate this course by responding to the following statements, using a scale of Excellent = 5 to Poor = 0.

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10.	Ⓐ	Ⓑ	Ⓒ	Ⓓ	25.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
11.	Ⓐ	Ⓑ	Ⓒ	Ⓓ	26.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
12.	Ⓐ	Ⓑ	Ⓒ	Ⓓ	27.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
13.	Ⓐ	Ⓑ	Ⓒ	Ⓓ	28.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
14.	Ⓐ	Ⓑ	Ⓒ	Ⓓ	29.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
15.	Ⓐ	Ⓑ	Ⓒ	Ⓓ	30.	Ⓐ	Ⓑ	Ⓒ	Ⓓ

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