



IS PATH WARM?

A Suicide Assessment Mnemonic for Counselors

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Suicide is the 11th leading cause of death among all Americans (Anderson and Smith, 2003), the second leading cause of death among Americans ages 25-34, and the third leading cause of death among Americans ages 10 and 14 and 15 to 24 (Centers for Disease Controls, 2005). Annual death certificates in the US suggest that over 30,000 persons commit suicide each year (National Center for Health Statistics, 2006). This includes 2004, the most recent year of fully collected suicide data, when 32,439 persons took their lives via suicide (American Association of Suicidology, 2006). The numbers are staggering. Approximately 89 persons in the US commit suicide every day (McIntosh, 2006). This equates to nearly four suicides each hour, one suicide every 16 minutes (McIntosh, 2006).

Unfortunately, the robust suicide numbers depicted above may inaccurately reflect the true significance of US suicides (Granello & Granello, 2007; Granello & Juhnke, in press). This is because suicide data are based on causes of death reported on death certificates. Given that many suicides are likely misreported not as suicides but as vehicular accidents, hunting accidents, swimming accidents, or accidental alcohol or drug overdoses, the true suicide number is most likely significantly higher.

Concomitantly, the current suicide rates fail to address the number of failed suicide attempts. No governmental agency collects data related to suicide attempts, and there is no nationally standardized data collection among physicians or hospitals related to suicide attempts. Despite this lack of data collection, the American Association of Suicidology (2006) estimates that 25 suicide attempts occur for each completed suicide. Based on this estimate, McIntosh (2006) suggested that approximately 811,000 persons in the US made unsuccessful suicide attempts in 2004. This equates to one suicide attempt every 39 seconds (McIntosh, 2006). McIntosh (2006) further suggests that the number of suicide survivors in the US (e.g., parents, partners, children, etc.) is approximately 4.5 million persons and rapidly growing.

Discussion

Given the frequency and extent of suicide, counselors should understand how to assess clients and students for immediate suicide risk. Although acronyms based on literature identified risk factors such as the SAD PERSONS Scale (Patterson, Dohn, Bird, & Patterson, 1983) and the Adapted-SAD PERSONS Scale (Juhnke, 1996) have been utilized for years, an updated and more thorough mnemonic has been created to help assess

individuals for immediate suicide risk (American Association of Suicidology, 2006; Berman, 2006). The mnemonic is an easily memorized question, "IS PATH WARM?" Each letter corresponds with a risk factor noted as frequently experienced or reported within the last few months before suicide. The specific risk factors are:

Suicide Ideation: Does the client report active suicidal ideation or has she written about her suicide or death? Does the client report the desire to kill herself? Does she voice a desire to purchase a gun with the intention of using the gun to kill herself? Does she voice the intention to kill herself with a gun, weapon, or car that she currently has in possession or can gain access to?

Substance Abuse: Does the client excessively use alcohol or other drugs, or has she begun using alcohol or other drugs?

Purposelessness: Does the client voice a lack or loss of purpose in life? Does she see little or no sense or reason for continued living?

Anger: Does the client express feelings of rage or uncontrolled anger? Does she seek revenge against others whom she perceives have wronged her or are at fault for her current concerns or problems?

Trapped: Does the client feel trapped? Does she believe there is no way out of her current situation? Does the client believe death is preferable to a pained life? Does the client believe that no other choices exist except living the pained life or death?

Hopelessness: Does the client have a negative sense of self, others, and her future? Does the future appear hopeless with little chance for positive change?

Withdrawing: Does the client indicate a desire to withdraw from significant others, family, friends, and society? Has she already begun withdrawing?

Anxiety: Does the client feel anxious, agitated, or unable to sleep? Does the client report an inability to relax? Just as important, does the client report sleeping all the time? Either can suggest increased risk of suicide or self-harm.

Recklessness: Does the client act recklessly or engage in risky activities, seemingly without thinking or considering potential consequences?

Mood Change: Does the client report experiencing dramatic mood shifts or states?

Counselors conducting a suicide risk assessment should investigate each of the above noted risk factors both with the client and, when appropriate releases of information are

provided, the client's significant others to best determine immediate suicide risk. The presence of any of the above noted risk factors should serve as a warning and drive a thorough clinical intervention that will insure the client's safety. For example, should a client report the risk factor "Suicide Ideation," it is imperative that the counselor create a therapeutically responsible clinical intervention using the least restrictive environment necessary to insure the client's safety. This may mean hospitalization or close daily monitoring of the client, depending on the perceived severity, frequency, duration and extent of the client's suicidal ideation. In other words, if the client reported infrequent suicidal ideation (e.g., "I thought about suicide one time about six months ago") and the duration of the suicidal thought was fleeting with little consideration of how to end her life, hospitalization likely would not be required. However, if the suicidal ideation was frequent (e.g., "I think about killing myself every day"), and the duration of the suicidal thoughts were prolonged (e.g., "From the time I awake in the morning until the time I go to bed at night, I ruminate on how I want to kill myself"), hospitalization certainly would be strongly considered.

As is the case with all mnemonic suicide aids and scales, their purposes are to augment the counselor's clinical judgment. In other words, no matter the outcome or prescribed intervention noted by any suicide assessment aid, it is up to the counselor to insure her client's safety. Hence, if the suicide aid used to assess suicide risk fails to suggest necessary intervention and the counselor continues to believe the client is suicidal, the counselor must insure an adequate level of care is provided to keep the client safe. Additionally, all counselors should participate in regularly scheduled clinical supervision and have access to advanced mental health consultation opportunities should they encounter clients who may be at increased suicide risk.

Conclusion

IS PATH WARM? is an easily memorized suicide assessment mnemonic. It has significant potential to help counselors conduct a thorough and intensive suicide risk assessment. Each of the mnemonic's factors has been linked to frequently present risk factors in persons who have committed suicide. IS PATH WARM? should be used with every client

who presents as potentially at risk for suicide. Clearly, it is a suicide assessment mnemonic that should be taught to counselors-in-training and utilized by all who encounter those who may be potentially at risk.

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