

Responding to Suicidal Ideation in Play Therapy



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Suicide rates increased 33% between 2010 and 2019 (Centers for Disease Control and Prevention [CDC], 2021b). Although suicide completion is rare among young children, suicidal ideation is a more common symptom of distress. According to the CDC (2021a), suicide is listed as the eighth leading cause of death for children ages 5-11 years. There are particular concerns about increasing suicide rates of diverse youth, as suicide rates for Black children ages 5-12 years are twice as high as their White peers (CDC, 2021a), and LGBT youth account for a quarter of youth ages 12-14 years who completed suicide (Ream, 2019). Additionally, one in five adolescents reported thinking seriously about attempting or completing suicide (Lindsey et al., 2019). Therefore, play therapists need to be ready to respond to crises involving suicidal ideation and intent.

Available data about young children (ages 5-11 years) who have completed suicide reveals several differences in characteristics and circumstances when compared to early adolescents (ages 12-14 years; Sheftall et al., 2016). First, young children more often have experienced relationship problems with family or friends (e.g., arguments) prior to suicide than early adolescents. For children with known mental health problems,

young children were more likely than early adolescents to have attention-deficit/hyperactivity disorder (ADHD; 59.3% vs. 29%) and less likely to experience depression (33.3% vs. 65.5%). Suicide methods differed, as more young children died by hanging, strangulation, or suffocation than early adolescents (80.5% vs. 64.1%), with firearms as the second leading suicide method for both age groups. Finally, young children who died by suicide were more commonly male, Black, and died at home than early adolescents. These findings suggest careful attention is needed for suicide prevention and intervention with young children, particularly for those exhibiting impulsivity. Play therapists should be aware of these differences to provide targeted suicide screening, assessment, and intervention.

Guidelines for Suicide Screening and Assessment

Play therapists use their mental health training in suicide risk assessment and intervention to ensure the safety of all clients. Throughout the process, play therapists should be conscious of how culture affects the expression of suicidal thoughts, intent, and plans (Chu et al., 2010). Play therapists can use the following guidelines when addressing suicidal ideation.

CLINICAL EDITOR'S COMMENTS:

The author offers practical and ethical responses to suicidal ideation.

Do Not Ignore and Do Ask

Play therapists should not be afraid to ask about suicidal feelings or intentions, particularly when aware of verbal and nonverbal warning signs and risk factors. Death and destruction are common play behaviors for children (Ray, 2011). However, play therapists cannot ignore play behaviors conveying suicide. For example, if a child takes the toy gun and puts it in their mouth and pulls the trigger, the play therapist should set a limit that “guns are not for pointing at people,” and also stop and ask about this play behavior, regardless of theoretical orientation. Risk must be assessed.

Asking directly about suicidal ideation or behaviors has not been found to introduce suicide as a solution; rather, asking may reduce distress and potentially benefit mental health (DeCou & Schumann, 2018). Play therapists cannot ignore statements about suicide, even if it seems this was an expression of anger and not a verbal clue that the child is thinking of killing themselves. Many children can learn the seriousness of saying, “I wish I was dead,” when what they meant was, “I am so overwhelmed and frustrated that I can’t imagine another way to deal with this.” Play therapists must stop and talk about the suicidal statement in the moment.

Empathically Assess for Risk

Play therapists are able to validate emotional pain, sit patiently with suffering, and calmly respond to children’s play behaviors and words. This also means play therapists should not overreact to statements or play indicating suicidal ideation. As play therapists help children understand the seriousness of their words, they are allowing children’s emotional pain to take space in the playroom. When faced with these situations in my own playroom, I fully use Landreth’s (2012) “be with” attitudes: I’m here with them, I’m listening, I care, and I want to understand.

Play therapists may use the SLAP mnemonic (Morris, 1998) to assess for suicide by asking about the specifics, lethality, access, and prior attempts. After a child tells me, “I wish I was dead,” I ask if she has thought about what it means to be dead or how she would become dead to gather *specifics* on her plan. I ask the child what would happen to her if she was dead or if she could do anything else if she was dead to assess her understanding of death and the *lethality* of her plan. If she has a plan for how she would die, I ask about *access* to weapons or means. Finally, I ask about *prior attempts* (which would also mean a higher level of suicide risk), and I explore the dangerousness and timing of these previous attempts, if relevant.

When children are feeling despair and expressing suicidal ideation, it is important to learn more about their risk factors and resources. Play therapists may ask questions about what else is happening in the child’s life to screen for risk factors (e.g., bullying, abuse, other relationship problems) and to explore available supports and resources. Play therapists can empathically assess suicide risk by remaining calm and curious throughout the conversation and open to the child’s perspective.

Provide Hope

Clients who are suicidal believe suicide is their only solution to end their suffering. Depending on the age of the child, play therapists may be able to have a conversation about how the child views suicide as a solution. Even for our youngest clients, play therapists convey their care and concern and empathetically state a value for life. Play therapists can help identify and connect children and caregivers with wrap-around services, including referring to crisis lines or to psychiatric care, to provide other solutions and to prevent suicide, thereby rendering their valuing of life actionable. Play therapists should remind children and parents that breaking confidentiality in this situation helps keep them safe. Involving others in care provides hope as children experience additional support and focus on life.

Create a Safety Plan

Safety plans are a best practice in suicide prevention and should be completed in the same session when risk is assessed. Safety plans include warning signs, coping strategies, and resources, including names and numbers of crisis hotlines and adults who can help (Grant & Lusk, 2015). Play therapists may need to offer suggestions for coping strategies based on the client’s interests and resources. For young children, the safety plan may include statements such as, “When I am thinking about killing myself, I will tell my mom,” or “When I have thoughts of suicide, I can color.” Young children may need a version of this plan in picture format with visual cues for coping strategies. The play therapist, child, and family all need a copy of the safety plan, and parents are responsible for removing access to means as a part of this plan. Play therapists will revisit the plan in future sessions, recognizing that coping strategies and resources can change over time.

Guidelines for Suicide Intervention

Play therapists support children experiencing suicidal ideation beyond the initial crisis assessment. To help prevent suicide, play therapists provide suicide intervention by addressing mental health concerns, increasing coping strategies, and fostering resiliency. Play therapists can use the following guidelines for suicide intervention.

Teach New Coping Skills

Play therapists should specifically ask about suicidal thoughts and statements in subsequent sessions. Play therapists use developmentally appropriate questioning to follow up on suicidal ideation, such as “Last week you told me wanted to die with a knife. Have you been thinking about this again since you saw me last week?” Additionally, monitoring can occur through observation of play behaviors and themes, such as instability, anxiety, or hopelessness. Ray (2011) suggested the play theme of hopelessness can convey the internal message, “I have given up. Nothing will get better for me or others” (p. 115). When children express suicidal ideation, play therapists focus on teaching new coping skills so that suicide is no longer the solution for problems.

“***As play therapists learn about children’s experiences through play, they provide hope in the face of despair through relationship, presence, and bearing witness to emotional pain.***”

Suicidality is connected to emotional distress, and children in crisis may experience feelings of anger, depression, anxiety, sadness, and numbness. In a study of children aged 7-12 years admitted to a psychiatric inpatient facility for suicidality, children who attempted suicide had higher levels of anger, depression, and dissociation and greater difficulty with emotion regulation skills than children with suicidal ideation but no suicide attempts (Bodzy et al., 2016). Therefore, play therapists should help children experiencing suicidal ideation develop emotional regulation skills (i.e., stress management, expressing and communicating feelings, understanding the feelings of others, adapting to change) through nondirective or directive approaches. For example, play therapists may facilitate emotional expression through sandtray prompts, such as “Create a scene about your anger” or through games like emotional charades.

Coping skills that help children communicate feelings may be especially needed for children who say, “I wish I was dead,” but screen at low risk for suicide. As a school counselor, I frequently worked with children who made such statements. I remained open and curious when screening for suicide, and I was able to teach them new skills for expressing their emotional pain. In such cases, I reminded them of my role: “When you say, ‘I wish I was dead,’ I will always stop and ask you what you mean by that because I want to help make sure you stay alive.” I helped children

gain perspective by reframing their statements: “You’re saying, ‘I wish I was dead,’ but it seems you don’t really want to die forever. Instead, I think you’re trying to say that you’re so angry and sad right now. Is that right?” I used puppets and role play to introduce new skills: “I think there are other ways you could let your teachers, parents, and me know how angry and sad you’re feeling. Let’s practice some of those.” I always reminded children of the importance of letting adults know about suicidal thoughts that occur again.

Collaborate With Parents

Parents and caregivers are vital partners for preventing childhood suicide. Parents should be provided with resources from suicide prevention organizations to better recognize warning signs and risk factors. Play therapists can teach filial skills to help parents appropriately respond to suicidal ideation. This is important, because parents may feel scared, shocked, or confused when they hear suicidal statements and respond with statements, such as, “Don’t think about it,” or “You’ll feel better soon.” Filial therapy can help parents increase empathy and understanding of children’s emotional pain and reduce parental stress (Landreth & Bratton, 2019). Skills, such as reflective responding, may help parents respond to suicidal ideation in ways that encourage open communication, such as, “You’re worried right now. How can I help?” Filial therapy’s emphasis on the parent-child relationship and connection can help parents better attune to their children and enjoy special time together. Parents can learn skills for setting limits around issues of safety: “You’re feeling so upset, but hurting yourself isn’t safe. You can choose to do one of the ideas from your safety plan, like talking to me or coloring. I love you, and I’m worried about you.” Filial therapy principles can help parents learn to regulate their response, extend patience to themselves, and develop stronger resources for supporting the serious needs of their children in crisis.

Parents are partners throughout the process of treatment. Play therapists offer hope to parents of children experiencing suicidal ideation that children can learn new solutions for their problems and live. One way to offer hope for parents is to share the therapeutic powers of play and help parents understand that play therapy can increase resilience and resources as children better communicate, gain emotional wellness, experience social relationships, and increase personal strengths (Schaefer & Drewes, 2014).

Follow Setting-Specific Guidelines

Play therapists in school or community settings may encounter setting-specific policies dictating suicide assessment and response procedures given the seriousness of suicidality. As mandated reporters, play therapists adhere to ethical codes and legal mandates as well as workplace guidelines designed to ensure safety and communication with various stakeholders.

School-based play therapists can facilitate home-school communication about a child’s suicidality and progress through consistent contact with caregivers. School-based play therapists should detail how the child will navigate through the school building to ensure safety and supervision. For example, a child may need to be accompanied at all times if there is a

high risk for suicide. Although it is beyond the scope of the current article to detail here, teachers and school staff can be trained to help recognize warning signs of suicide and make timely referrals for play therapy. School-based play therapists can be advocates for children experiencing suicidal ideation by revisiting absence policies and encouraging academic accommodations and extensions, when appropriate. Finally, professional advocacy for more time and attention to mental health services in schools can support the needs of children in crisis.

Play therapists in community settings may be more likely to provide family treatment around issues of suicidality. Community-based play therapists may provide long-term play therapy to diagnose and treat underlying mental health problems that may be risk factors for suicidality, including attention-deficit hyperactivity disorder (ADHD), depression, or anxiety disorders. Given the aforementioned connection between ADHD and suicide completion for young children, play therapists need to help children and caregivers develop strategies for impulsivity for children with suicidal ideation. Evidence-based therapeutic interventions for young children's ADHD symptoms focus on building executive functioning and improving parent-child interactions (Halperin & Marks, 2019). Play therapists working with children with suicidal ideation and impulsivity may specifically focus on skills for making decisions and managing emotions.

More broadly, play therapists should be mindful of how trauma impacts children's development, emotional regulation, and impulsivity, as child abuse is a risk factor for suicidal behavior (Braquehais et al., 2010). Play therapists working in community settings should include strategies for safety monitoring in various contexts in the safety plan. Community-based play therapists can also offer to consult with school personnel if needed about the child's safety or treatment plans.

Conclusion

Caring and supportive adults serve as a protective factor against suicide. As play therapists learn about children's experiences through play, they provide hope in the face of despair through relationship, presence, and bearing witness to emotional pain. Play therapists need to be ready to ask about suicide, assess for risk, provide hope, and create safety plans to ethically provide urgent services for children in crisis and to save lives. They may partner with school personnel, other community mental health actors, and parents to effectively respond to suicidal ideation in their clients.

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