

# Suicide in the Middle Years

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## Abstract

This article presents an overview of adult suicide in the United States and Alabama. This includes the latest available information on the prevalence of suicide in the US and Alabama, demographic characteristics of suicide victims, trends in suicide, and known reasons behind adult suicide. With respect to adult suicide in Alabama, it focuses on economic issues and the recent occurrences of natural disasters. Also provided are risk factors and early, acute warning signs for potentially suicidal adults as well as selected strategies for preventing individual suicides.

## Suicide in the Middle Years

### The U.S. and Alabama

Alabama's rate of suicide for 2010 is 14.1 per 100,000. Although the U.S. rate will not be available for 2-4 years, provisional rates have been released by the Centers for Disease Control and Prevention (CDC) for 2008 and 2009. These rates are 11.7 and 11.9 per 100,000 respectively, and lower than the Alabama rates for the same period. Figure 1 shows a comparison of U.S. and Alabama suicide rates from 1960 until present. During the first two decades of this chart, the Alabama rates were lower than the U.S. rates, then Alabama exceeded the U.S. rates forming an elongated X pattern that still exists. No logical explanation for this crossover of rates has been found, although researchers suggest that the upsurge that began in 2006 may have been caused by a series of natural disasters combined with the economic downturn (e.g., Goldstein, Osofsky, & Lichtveld, 2011; Luo, Florence, Quispe-Agnoli, Ouyang, & Crosby, 2011; Phillips, Robin, Nugent, & Idler, 2010).

### Alabama's Demographic Profile

Like many rural states, Alabama's population is not widely diverse. Although the large urban centers may have racial and ethnic diversity, in most of the 67 counties in Alabama 95% of the state's population is either Black/African American or White. The official publications of Alabama's Center for Health Statistics display all demographic data as either "White" or "Black and Other" due to the extremely small populations of other racial groups. Although this may appear archaic, it is actually to preserve anonymity according to the World Health Organization guidelines regarding suppressing small population numbers in specific locations. Figure 2 illustrates the actual proportions of other populations in the state as a whole. All of the other demographic groups

account for 5.3% of the total population and people of Hispanic or Latino ethnicity, which may include Blacks and Whites, account for 3.9% of the population (U.S. Census Bureau, 2011).

### **Alabama Suicides by Age Group**

In Alabama, the total number of suicides for 2010 was 477, only slightly higher than 2009 (471), although the rate shows a small decrease (14.1 – 14.2). Figure 3 is a chart showing the actual number of suicides by age group in 2010, overlaid with a line showing 2009 suicides for comparison. There was little change between 2009 and 2010, with the number increasing slightly (2009-667; 2010-676) and the rate decreasing by 0.10%.

Some researchers posit that suicide rates in middle age, when rates historically decline before rising again in the elderly, are rising as baby boomers grow older (e.g. Phillips et al., 2010; Luo et al., 2011). Publications that are not research-based, cite statistics relating to rising rates in middle age, particularly the large cohort of those who are considered Baby Boomers—those born between 1946 and 1964 (Fields, 2010; Pew Research Center, 2010; Dubin, 2011). “The middle years may be times of disillusionment and regret about stalled careers and stale marriages. This time of life can also be filled with anxieties about mounting debt, while putting kids through school and caring for aging parents. Plus, men at midlife discover that their own bodies aren’t what they used to be.” Dan Fields states in a 2010 article entitled Middle-Age Suicide. The aging of such a large birth cohort creates “a so-called period effect” (Phillips et al., 2010) when competition for limited resources continues throughout the lifespan. This trend, too, is slightly higher in Alabama than the most recent U.S. rates as shown in Figure 4.

### **Racial and Gender Disparities**

Indisputably, white males at all ages have the highest rates of suicides. As shown in Table 1, in Alabama, white females aged 25-64, have the second highest rates. Black and Other males in Alabama have lower rates, with females in that category having extremely low rates. White women’s rates have risen during late middle age (e.g. Reinberg, 2008; Dubin, 2011) in recent years. During adolescence and young adulthood, White women’s suicide rates are generally slightly lower than Black and Other males. Table 1 shows that, in Alabama for ages 25-44, their suicide rate is only slightly higher than Black and Other males, but in ages 45-64 their rate is almost double that of Black and Other males. Black and Other females have extremely low rates during ages 25-64 in Alabama, indeed have the lowest suicide rates of any group, whether delineated by age or race.

Among suicide researchers, it is common knowledge that the number of suicide deaths “by demographic characteristics is unavoidably an undercount due to misclassification of some suicides as accidental or as undetermined in official mortality data” (Phillips et al., 2010). In Alabama, deaths of undetermined intent from 2007 through 2009 averaged 85.67 per year.

Suicide by cop (SBC) is another phenomenon that may add to the actual number of suicides. There is a body of literature that supports the hypothesis that many deaths by legal intervention are actually subject precipitated homicides (e.g. Kennedy, Homant, and Hupp, 1998; Mohandie, Meloy, and Collins, 2009; Lord and Sloop, 2010) in which the subject does not lose perceived self-esteem by appearing to be a suicide. Kennedy et al. (1998) in an examination of 240 police shootings between 1980 and 1995 found that 16% had probable suicidal intentions and 46% contained some evidence of suicidal intent. Although the demographic profile of SBC is very difficult to determine,

generally the proportion of African-Americans and Hispanic/Latinos is higher than that proportion of the population (Mohandie et al., 2009). Risk factors are a high degree of impulsivity, aggression, often alcohol or substance abuse is involved. Deindustrialization, racism, and discrimination leading to unemployment or underemployment may be a factor, as well as cultural stigmas attached to vulnerability. Clinical indicators may include internalization of feelings, bravado, limited social support, low self-concept, hopelessness, frustration, and anger.

### **Methods Used in Alabama**

According to the American Association of Suicidology (AAS), the most recent available data (2007), show that in the U.S. firearms account for 50% of all suicides, 25% are by suffocation, which includes hanging, and the third leading method is poisoning, which includes both legal and illegal drugs, as well as substances such as pesticides, drain cleaners, and other caustic or poisonous substances. In Alabama, 71% of all known suicides are by firearms, 15% by suffocation, and 9% by poisoning, with the remaining 5% accounting for all other possible methods (see Figure 5).

Obviously, firearms are the most used method, almost 22% higher than the national percentage. Males use firearms in 75% of known suicides and females a surprising 56% as shown in Table 2. The percentage of women using firearms has increased greatly; the national rate for women using firearms is 32%. During the latter half of the 20<sup>th</sup> century, women generally used poison or cut their wrists. It was commonly believed that they did not want to damage their faces. Poisoning does account for 24% of known female suicides in Alabama, but cutting or piercing only accounts for 1% of Alabama suicides.

Suffocation has greatly increased as a method for suicide in the U.S. during this century, but it remains at 15% for males and 14% for females in Alabama, which is about 10% less than the national statistics. One note regarding suffocation—there is often confusion regarding the Choking Game. This is not to be confused with autoerotic asphyxiation, but a method often used by adolescents and young adults to get high without using alcohol or illegal drugs. The National Center for Health Statistics considers a death by the choking game an accidental death because the intent was not to die, but many coroners disregard those instructions since it was a voluntary act and deem it suicide.

### **Trends in the US and Alabama**

Why have suicide rates among adults increased in the United States and Alabama since the 1990s? Many reasons are at work. First of all, they involve macro-level changes at the societal and community levels that affect individuals by producing feelings of helplessness, hopelessness, and despair that may ultimately lead to suicide unless timely and effective help is forthcoming. A major economic downturn causes increasing numbers of individuals to lose their jobs, income, and homes, and perhaps their marriages and families. All these events are often accompanied by a perceived loss of face among family and friends and a gradual decline in self esteem leading to anxiety and depression and, for some, despair, hopelessness, and a tunnel vision that can see no remedy but death.

## The Economy

Although many researchers have believed that the economy and job markets have a distinct effect upon suicide rates, there was little to support those beliefs. With the present economic conditions and unemployment at high levels, there is new evidence to support these beliefs (e.g., Phillips et al., 2010; Luo et al., 2011; AAS, 2011; SAMHSA, 2010). The National Survey on Drug Use and Health (SAMHSA, 2010) reported that combined averages of adults during 2008 and 2009 indicated that 8.4 million adults had seriously thought about committing suicide. The report further stated that employment status was a major risk factor with 6.5 of the unemployed having suicidal thoughts and behaviors, as well as 4.5 of those employed part time, and 3.9 in the “other” category, which includes retired, disabled, homemakers, students, or other persons not in the labor force.

The AAS (2011) issued a position statement on the economy and suicide stating “there is a clear and direct relationship between rates of unemployment and suicide...economic strain and personal financial crises have been well documented as precipitating events in individual deaths by suicide”. In 2009, Alabama was one of only five states where foreclosure rates doubled in one year (Gray, 2010) and the state’s homeless population grew by 13%. Other studies have reported that business cycles and economic hardships have a direct association among groups with other risk factors for suicide (e.g. Luo et al., 2011); higher rates of bankruptcy, personal financial losses, and high unemployment and underemployment have caused an increase in suicide in all age groups, but “is impacting those aged 50-64 years most severely, with respondents in this age range more likely to have incurred substantial investment losses and to report that they will have difficulty affording retirement” (e.g. Phillips et al., 2010). Luo et.al, (2011) state that “these people were breadwinners in their homes, and their jobs supported mortgage payments, health insurance, children’s education and other expenses”. They urge preventive efforts in settings where vulnerable individuals are found, such as workplace and employee assistance programs. Yet many will have already lost employment. Thus, settings where the unemployed gather should be the highest priority. These include employment agencies and programs, churches, colleges, and support groups.

Philips, Robin, Nugent, Idler, (2010) speculated that the rise in suicide rates after 1999 was possibly due to baby-boomers (who have had higher suicide rates since adolescence) passing into middle-age. They found that the increase in suicide rates after 1999 is especially pronounced for white men aged 50 to 59, the unmarried, and the less educated. Although the baby-boomer “effect” was present it was far outweighed by what they called “period effects” or circumstances occurring after 1999 such as higher unemployment and increasingly unstable economic conditions of all kinds including a rise in bankruptcy, a decline in permanent, full-time employment in favor of temporary, lower paid jobs without benefits, and losses of investment assets—homes, stocks, etc. More evidence for period effects was derived from the fact that the largest increases in economic problems occurred among boomers without a college education. A college degree and graduate studies have been a major protective factor for the cohort. Finally, a Pew poll quoted in the New York Times (May 15, 2009) indicated these events, along with the loss or downsizing of pensions, have combined to seriously threaten affordable retirement for increasing numbers of those in middle age.

Now, as in the past, less skilled or technical jobs are the most vulnerable to downsizing and movement off-shore. The less-skilled experience not only a loss of income but also the loss of health care and education opportunities. Sadly, these are the people with the fewest resources of any kind to deal with job loss or salary decreases. They have the least access to psychological

support, professional or otherwise, to deal with significantly declining self-esteem, family issues and depression. In the state of Alabama all of these macro-level factors are at work. Job gains in the auto sector have been more than offset by losses in textile industries and in the service sector (Richard Burlison, Personal Communication, 2010). And in this state, resources to cope with these problems are in short supply whether mental health counseling, unemployment benefits, and public assistance of all kinds.

Finally a longer-term secular trend is at play in the United States. Sally Spencer-Thomas also suspected that fraying social ties may play a role (2006). She noted that Americans' circle of confidants shrank by one-third in the previous two decades. And the number of people who said they have no one with whom to discuss important matters more than doubled in that time, to nearly twenty-five percent.

### **Natural Disasters**

Compounding the difficulties with the current economic situation, are the proliferation of natural disasters affecting Alabama in recent years. In Figure 6, a three year examination of the National Suicide Prevention Lifeline calls from Alabama show a 41% increase since 2008. In a personal conversation, Chandra Brown, the director of a major crisis center with 5 locations in Gulf Coast counties stated that their call volume had more than doubled by mid-year 2011 over 2010 rates (June, 2011). These include some of the National Suicide Lifeline calls, but the majority was local calls made directly to the crisis center.

Alabama's Gulf Coast has been hard hit—Hurricanes Ivan, Katrina, and Rita, followed by the mortgage bust, then in 2010 the BP Gulf Oil Spill. Figure 7 shows a timeline of these natural and financial disasters, and the impact on the number of suicides in the region. It appears clear that after one hurricane, Ivan, residents began to work together to overcome adversity, then when Hurricane Katrina hit the region, followed quickly by Rita, suicides rose as the devastation to families and businesses became clear. The rate dropped in 2008, until the financial crisis began.

The Gulf Oil Spill struck a region already under financial stress, with widespread loss of employment, homes, and still living with psychological distress. "Although many problems in the immediate aftermath of the hurricane had been resolved, others—remained....many residents met the criteria for partial and complete PTSD" (Goldstein et al., 2011). We are likely to see more repercussions as time progresses. A Gallup survey in September 2010 of 2,600 coastal residents showed that depression cases were up more than 25% since the oil spill (Reeves, 2010). The survey further described sleeplessness, anxiety, depression, anger, substance abuse, and domestic violence being reported at higher rates by mental health agencies—all symptoms of PTSD (2010). The Alabama Department of Public Health with the Department of Mental Health and the CDC conducted a survey of households in Mobile and Baldwin Counties during August 2011. CDC Epidemic Intelligence Service Officer Dr. Danielle Buttke said, "...the economic impacts of the oil spill have had lasting mental health effects on the community members whose household incomes were directly affected" (ADPH, 2011). The report further states that it may be several years before mental health returns to normal for these individuals.

This is representative of expectations for the state as a whole, after tornadoes struck dozens of cities in Alabama on April 25, 2011. There were 239 deaths due directly to the storms with several fatalities during the search and rescue, and clean-up initiatives. Some power outages lasted as long

as eight days, causing difficulties with water treatment, as well as shortages of food and gasoline. Typically, during natural disasters, the first issues are immediate safety, finding shelter and food, then grieving losses, whether human losses or financial losses. Once those immanent needs are met, there is an increase in depression, and in disasters, often PTSD, which may be followed by an increase in the suicide rate.

### **Suicide Prevention**

First know who's at risk of suicide. Understanding who's at a higher risk can help prevent a tragedy. While you don't necessarily need to constantly monitor someone at higher risk, you may be more alert for serious problems. Factors that increase the risk of suicide are below.

### **Environmental Reasons for Adult Suicidal Behaviors**

1. Unemployment, underemployment and economic problems such as foreclosures or threats of home foreclosures. In 2009, Alabama was one of only 5 states where foreclosure rates doubled in one year (Gray, 2011). High levels of joblessness or unemployment motivate depression and suicidal behaviors at all levels.
2. A decline in life circumstances is closely related to the above. These include the loss or downsizing of pensions, retirement programs, and health care coverage.
3. A lack of mental health treatment resources results in a decline in mental health treatment. One of the unresolved community problems in suicide prevention is lack of access to and availability of health care and mental health care. There is also the problem of locating available resources—many people don't know where to go to get help.
4. A decline in religiosity or spirituality removes a strong protective factor against suicide as Emile Durkheim showed in perhaps the greatest analysis of suicide yet done (1899; 1950).
5. Cohort characteristics. It has been hypothesized, but not verified, that the passage of the baby boomers into middle age has raised adult suicide rates since that cohort manifested high rates throughout adolescence and young adulthood.
6. Changes in social norms include the increasing acceptability of suicide as shown in polls and access to internet support for suicide in the form of chat groups, on-line suicide pacts, recipes for suicide, and dose information such as that found on the website Final Exit.
7. Increasing PTSD in vets who are victims of the wars in Iraq and Afghanistan.
8. Access to more lethal means—e.g. oxycontin instead of aspirin—other prescription medications, internet information on painless methods, and, above all, easy access to guns. Guns are readily available almost anywhere in the United States. Use of a gun almost always guarantees a fatal outcome. Impulsivity and easy access to a gun is particularly bad for a depressed person with substance abuse issues. In Alabama accidental deaths by firearms in Alabama are 4 times the US average. Gun owners say they keep a gun at home for self-defense or protection. States with stricter gun control laws have lower rates of suicide. The reverse is true for states with loose gun laws like Alabama. Scientists said that women generally used poison or cut their wrists, so as not to damage their faces. The percentage of



women using firearms has increased greatly, the national rate for women using firearms is 32%—it is 56% in Alabama. It is also noteworthy that 80% of gun-related deaths in American homes were suicides and 85% of all youth suicides under 18 used a parent's gun. Meaningful gun control in Alabama is unlikely. Focus now is on gun safety programs like:

- a. Means Matter from the Harvard School of Public Health,
- b. Lok-It-Up (trigger locks and guns kept under lock and key), and
- c. Child Access Protection (CAP) laws holding adults responsible for keeping guns away from kids. These laws have been passed in 18 states. (<http://Washington.Post.com/wp-srv/health/interactives/guns/gunsafety.html>)

The good news is a decline in overall rates of gun suicides since 1991 in all regions. Polling data show decline in self-reported gun ownership during same period.

### **Individual Reasons for Suicidal Behaviors.**

1. Chronic unemployment and loss of earnings, particularly for men, who invest their identity in their jobs.
2. Major Depression and other mental illness. The most frequent mental illness diagnosis for suicidal behaviors is depression—85.2%; next is bipolar disorder—7.4%; then schizophrenia—3.3%. Mental Illness in adolescence leads to compromised functioning in adulthood, psychopathology, suicidal behaviors, and poor overall functioning. Major depression left untreated leads to increasingly negative self perceptions of one's coping ability, low self-esteem, impoverished social skills, and bad interpersonal relations along with increasing social isolation. (Reinherz, Tanner, Berger, Beardslee, Fitzmaurice, 2006). A family history of depression is also a red flag.
3. A Previous suicide attempt is the best single predictor of suicide.
4. Substance abuse is often co-morbid with mental illness. When substance abuse and depression are co-morbid—the risk of suicide is much higher.
5. Family history of suicide increases risk of suicide pointing to possible genetic reasons.
6. Chronic Interpersonal Conflict. Frequent violence including physical and sexual abuse between significant others and within families increases risk. This broad category includes Intimate Partner Violence (IPM). A study of 662 racially and ethnically diverse sample of physically abused adult women found that 20% had threatened or attempted suicide during their lifetimes. The greater the severity or potential lethality of the violence the more likely PTSD, depression, anxiety and suicidal behaviors especially among white women, younger women and women who were chronically ill or disabled. Being chronically ill or disabled was associated with IPM irrespective of its severity implying an independent effect on suicidality. (Cavanaugh, Theresa-Messing, Del-Colle, O'Sullivan, Campbell, 2011).

Another facet is childhood and adolescent trauma or abuse, as well as, neglect and rejection. These exacerbate depression and anxiety through behavioral, emotional, and cognitive pathways, and increase the risk of substance abuse, and subsequent violent behavior of all kinds including suicidal

(Ilgen, Burnette, Connor, Czyz., Murray, Chermack, 2010) along with psychiatric diseases in adulthood and impulsivity ( Braquehais, Oquendo, Baca-Garcia, 2010; Clements-Noelle, Wolden, Bargmann-Losche 2009). The risk for suicidal behaviors in adults after childhood sexual abuse significantly elevates the risk for depression, PTSD, and persistent suicidal behaviors in both men and women with women at higher risk overall and earlier onset—by age 13 in many cases (Bedi, Nelson, Lynskey, McCutcheon, Heath, Madden, Martin, 2011).

7. Functional impairment in daily living (Freidman, Conwell, Delavan, Wamsley, Eggert, 2005).  
Persons who are permanently impaired, physically or mentally, are at high risk for suicide especially if social support is absent.

8. Marital status. Despite interpersonal conflict in family life, marriage is a protective factor for men but not women; divorced or widowed men have the highest rates of suicide. The presence of children is also a protective factor for both men and women.

9. Age. Immaturity and lack of impulse control especially in younger adults is a cause of suicidal behaviors for men and women who are depressed, substance abusers and involved in interpersonal conflict. This is especially so for men.

10. Gender. Males have more risk-taking behaviors, and the lack of impulse control often plays a part. Men are less likely to seek medical help, and gender role issues may emerge. Females tend to ruminate. Rumination is a psychological term for when you focus your thoughts on one thing to an unhealthy degree, that is, you turn it over and over in your head. Women also indulge in more dramatic behaviors. But women rarely invest their total identity in careers as do most American men—for men failure at work = failure in life and as a human being.

Women also have more social roles as wives, mothers, and daughters to express their identity. They usually still feel needed and loved by others whatever happens in their careers.

Women are less likely to be socially isolated and have stronger social support at all ages. They are more likely to seek help, professional or otherwise. Women use less lethal means such as overdoses and thus are more likely to be rescued. Women report greater religiosity. Child-rearing responsibilities are a deterrent. Women often have a less intense wish to die.

11. Incarceration. Suicide rates in city or county jails are higher than in state or Federal prisons. This may be due to intense feelings of despair and guilt by newly incarcerated persons. About 32% of all jail deaths are suicides (2% are homicides). Six percent of all prison deaths are suicides (1.5% are homicides). The risk is highest within first 24 hours of incarceration. Hanging is the usual method.

12. Social Isolation/Lack of Social Support. This refers directly to connectedness, social engagement, and feeling useful or wanted. Joiner (2001) calls this “thwarted belongingness” or wanting human contact and connection but being unable to develop or sustain these for a variety of reasons. This broad but crucial issue is indicated by numbers of friends, frequency of social contacts, low levels of isolation and loneliness. Connectedness works well for all age groups (CDC, 2011).



13. Feelings of burdensomeness or feeling that one is a useless and heavy burden on others. Joiner (2001) believes that this factor plus thwarted belongingness and availability of lethal means put one at serious risk for suicide.
14. Procurement of means to commit suicide including buying or borrowing a gun, obtaining a supply of lethal medications.

Demographically speaking, the person at highest risk is white or American Indian male over 60 years, unemployed, living alone without significant social support or social life. When you add psychosocial risk factors—substance abuse, depression and chronic illness—the probability of suicide is much higher. Yet they are least likely to ask for help. Below is information on how they might be helped.

### **How Do You Personally Help Someone Who Is Suicidal?**

#### **Learn The Warning Signs And Symptoms of Acute Suicidal Ideation.**

Warning signs, unlike risk/protective factors, imply immediate or acute risk. They are more episodic and variable—e.g. threatening to kill oneself or checking the internet for methods. They can vary from day to day. They are linked to so-called precipitating factors like losing a job, recent discharge from mental health treatment, a traumatic break-up or chronic rejection.

Here are typical warning signs:

1. Talking about suicide, including such statements as "I'm going to kill myself," "I wish I were dead" or "I wish I hadn't been born". Statements that seem to be self-deprecating or jokes often are deadly serious.
2. Obtaining the means to commit suicide, such as getting a gun or stockpiling pills, checking the internet for methods.
3. Withdrawing from social contact and wanting to be left alone resulting in disruption of social networks, social life, family discord, termination of close relationships (Duberstein PR, Conwell Y, Conner KR, Eberly S, Evinger JS, Caine ED 2004; Beautrais, AL, 2002).
4. Expressions of burdensomeness and social isolation, (Joiner, T.E., 2005)—felt these two in combination with acquiring the means to kill oneself are three primary risk factors, each of which is necessary but not sufficient to contribute to the overall risk of suicidal behavior. A review of empirical research found that social disengagement or social disconnection or rejection were one of the 5 most consistent predictors of suicide, independent of depression. (Conner KR, Duberstein PR, Conwell Y, Seidlitz L, Caine ED, 2001). Perceived burdensomeness is the perception, right or wrong that one's existence is a burden on others, that one is incompetent or ineffective. This is especially dangerous when the person can foresee no change and thus believes his/her burdensomeness is permanent (Joiner, 2001).
6. Dramatic mood swings, such as being emotionally high one day and deeply discouraged the next.

7. Being preoccupied with death, dying, or violence.
8. Feeling trapped or hopeless about a situation.
9. Increasing use of alcohol or drugs.
10. Changing normal routine, including eating or sleeping patterns.
11. Engaging in risky or self-destructive behavior, such as using drugs or driving recklessly.
12. Giving away belongings or getting affairs in order.
13. Saying goodbye to people as if they won't be seen again.
14. Radical personality changes, such as becoming very outgoing after being shy.

Don't always expect to see warning signs of suicide. Some people keep thoughts of suicide secret or deny having suicidal intentions even when directly asked. And many who consider or attempt suicide do so when you thought they should be feeling better — during what may seem like a recovery from depression, for instance. That's because they may finally muster the emotional energy to take action on suicidal thoughts.

Warning signs do not necessarily indicate one is imminently or truly suicidal. Many are depressed, experience losses or changes in behavior without suicidal tendencies. However, if a number of these signs occur simultaneously or in quick succession, help is needed. Intervene immediately by talking to the person at-risk, inquiring about suicidal feelings and behaviors, and obtaining any resources needed to prevent a suicide attempt.

### **Ask Questions When Someone Seems Suicidal**

#### **Mayo Clinic Strategies For Asking About Suicidal Thinking**

The best way to find out if someone is considering suicide is to directly but gently ask. Asking them won't give them the idea or push them into doing something self-destructive. To the contrary, your willingness to ask can decrease the risk of suicide by giving them an opportunity to talk about their feelings. If someone denies having suicidal intentions but you're still worried, continue to gently raise the issue. You can ask open-ended questions about their feelings or specific questions about suicide. Here are examples of questions you can ask someone you're concerned about:

- Are you thinking about dying?
- Are you thinking about hurting yourself?
- Are you thinking about suicide?
- Have you thought about how you would do it?
- Do you know when you would do it?

- Do you have the means to do it?
- How are you coping with what's been happening in your life?
- Do you ever feel like just giving up?

If a friend or loved one is considering suicide, he or she needs professional help. Don't tell him or her that you promise not to tell anyone. The safety of your friend or loved one is of the utmost importance. Don't worry about losing a friendship when someone's life is at stake. Signs to monitor after treatment begins include worsening depression and anxiety, new or worsening symptoms of anger, agitation or irritability, and unusual behavior of any kind.

### **Challenges in Helping Suicidal Adults**

Many suicidal persons, especially adults, will not respond to public health messages to seek help, take a free depression screening, or call a crisis center. These will likely be: working males and high profile females; those who fear being stigmatized; those suffering from serious mental illness or dementia; already too hopeless to believe they can be helped; using substances which a counselor will ask them to give up.

### **Men**

Men of all ages have gender role conflicts—they try to suppress emotionality and depression, they are less likely to seek help for mental problems because they have negative or ambivalent attitudes toward help-seeking. When help is sought they may present physical problems.

*"Women seek help—men die."* This quote from a 1990 medical journal article is an overgeneralization, of course. There are plenty of women who do not seek help for their emotional distress. After all, women in the United States are three times more likely to *attempt* suicide than men. But "men tend to hold their own counsel," says psychiatrist Yeates Conwell, co-director of the Center for the Study and Prevention of Suicide at the University of Rochester. "They often don't build supportive networks that allow them to share their concerns with others."

Men are also more likely to drink heavily when feeling distraught, and to reach for guns in order to kill themselves. Nearly sixty percent of suicides among males occur by firearms. Guns are almost invariably lethal and this helps explain why there are four male suicides for every female suicide. There's evidence that men are more likely than women to feel there is a stigma attached to a "failed" suicide attempt. Men may use more lethal methods to avoid being seen as unmanly—even as they're planning their own death.

### **How do we find and help suicidal persons, especially men, who will not self-refer?**

Paul Quinnett (2010) recommends the following: a. worksite depression screenings; b. open and advertise new anonymous places to get help—texting to trained crisis volunteers/mental health professionals; c. train community-base gatekeepers to recognize suicide warning signs and intervene to bring about a referral. (QPR); d. follow-up is vital, especially after treatment.

## Community-Based Suicide Prevention

### CASE FINDING

One basic approach to community-based suicide prevention links public health and mental health—CASE FINDING. Case finding is synonymous with “early detection and referral”.

It is accomplished by:

- .....school-based suicide awareness programs,
- .....gatekeeper training programs,
- .....screening programs by primary care or mental health providers and
- .....crisis centers or hotlines.

Early detection and referral is the cornerstone of prevention for most diseases. Public health messages about warning signs for heart disease, diabetes, cancer—you name it—are well known. They are designed for case finding—identifying those at risk and motivating the at-risk to get help from qualified care-givers.

Equally important to case finding is referral to accessible and competent care-givers. If not, terrible frustration occurs.

Most suicidal people send detectable warning signs. These are usually sent to intimate others already known to the suicidal person—family, friends, co-workers, fellow students, bartenders, hairdressers, bank loan officers, bus drivers, almost anyone in their immediate surroundings.

1. Make gatekeeper training—on line or otherwise—for the identification and assessment of potentially suicidal persons available to health, mental health, substance abuse and human service professionals as well as to natural community helpers such as: coaches; hairdressers; bartenders; faith leaders; primary care physicians; police and fire protection first responders; clergy; teachers; correctional workers; school counselors; adult and child protective service social workers; and other social workers.

Establish state-wide access to an evidence-based, low-cost source for on-line gatekeeper training for a nominal fee.

Develop a state-wide cadre of licensed trainers to conduct training.

Maintain and update gatekeeper training/education for first responders on a continuing basis.

2. Make gatekeeper training—on-line or face-to-face—for the identification and assessment of suicidal behaviors also available to family members of persons at risk.

3. Collaborate with primary care providers to help at-risk patients acknowledge and seek treatment for depression, substance abuse, and other major mental illnesses. Emphasize suicidal assessment training for primary care physicians.

4. Gun Control at Home. With respect to our most used method—guns—there are programs that provide “means restriction” methods to gun owners in order to make a household gun difficult to

access or use. These include trigger locks and gun boxes or safes that can be locked. They are especially important when there is a depressed or suicidal person in the household and, for whatever reason, guns cannot be removed. They can be obtained at almost any gun store.

5. Community-wide publicizing of Crisis or Suicide Prevention Centers. These prevent suicide among the acutely suicidal. The depressed and suicidal DO CALL these agencies.

6. Social Media. These include all manner of internet websites that provide information on suicide and suicide prevention. Notable ones are listed on the ALABAMA SUICIDE PREVENTION AND RESOURCE CENTER website.

An emerging social media approach is "Entertainment Education" (EE) or the use of entertainment media to educate people on health and social issues. In developing countries this approach is widely used to promote women's development, reproductive health and more recently HIV/AIDS and chronic disease prevention (Galavotti C, Pappas-DeLuca KA, Lansky A, 2001). EE is based on social cognitive theory (Bandura A, 2004) and uses modeling to demonstrate the consequences of pro-social and pro-health behaviors along with the consequences of anti-health and antisocial behaviors. It has also been effective in changing social norms (Singhal A, Cody MJ, Rogers E, Sabido M, 2004). The Hollywood, Health and Society program is a partnership between the CDC and the Norman Lear Institute, through which mainstream media program writers are advised on health issues that need to be addressed and how to appropriately and accurately address them (<http://www.learcenter.org/html/projects/?cm=hhs>). More localized approaches have been implemented in which original radio and TV dramas are written and broadcast in response to specific, local health issues. In Alabama, the BodyLove radio drama was broadcast in 16 communities across the state to promote chronic disease prevention among African American adults (Chen N, Kohler C, Schoenberger Y, Suzuki-Crumly J, Davis K, Powell J, 2009). Through the radio series listeners learned about behavioral risk factors for diabetes and hypertension and for secondary complications of the diseases as they affected the characters in the drama (Kawamura Y, Ivankova N, Permunean-Chaney S, Kohler CL, 2009).

EE is a potentially effective way to increase knowledge about suicide-related issues and to change negative attitudes by de-stigmatizing mental health issues. In one BodyLove program a storyline featured a young woman who became depressed, attempted suicide and subsequently participated in mental health counseling with her family. The consequences of not recognizing the young woman's depression and responding appropriately were modeled in a series of episodes in which a "well meaning" friend introduced her to the local bar scene to "get her out and feel better". Following this story line presentation, there was a 30% increase in the percentage of listeners surveyed who reported talking to friends and family about depression either often or very often (27.5% to 36.5%).

The national suicide hotline is 1-800-273-TALK. It functions as a national hotline that links callers to certified crisis centers or hotlines within each state.

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