September 4 - 10, 2005

Suicide Prevention Week
Information & Media Kit

"Partnerships for Change: Advancing Suicide Prevention Services & Practice"

Sponsored by

American Association of Suicidology

American Association of Suicidology
5221 Wisconsin Avenue, N.W.
Second Floor
Washington, D.C. 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
www.suicidology.org
info@suicidology.org

Prepared by Kristin E. Bergeron

American Association of Suicidology

Suicide Prevention Week
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Table of Contents

Part A. Introduction

American Association of Suicidology

To Understand and Prevent Suicide as a Means of Promoting Human Well-being

Central Office:
5221 Wisconsin Avenue, N.W.
Washington, DC 20015
202-237-2280
Fax: 202-237-2282
info@suicidology.org
Executive Director
Alan L. Berman, Ph.D., ABPP
Deputy Director
Amy Kulp, M.S.

Dear Suicide Prevention Week Participants,

This year, National Suicide Prevention Week, sponsored by the American Association of Suicidology (AAS), will occur on September 4th through September 10th. The theme is "Partnerships for Change: Advancing Suicide Prevention Services & Practice". This year's theme celebrates the amazing diversity of people working together as partners to help our fellow human beings, and it challenges us all to continue our assiduous efforts to advance suicide prevention and practice as we increase our evidence based foundations. Since suicide is such a complex and multi-dimensional problem, collaboration is the key in this endeavor. With collaborative partnership, compassion, solid research, hard work and cooperation, we can and will indeed save lives.

As introduced to you in 2004, National Suicide Prevention Week will take place in September of each year in order to synchronize with World Suicide Prevention Day (September 10th) hosted by the International Association for Suicide Prevention (IASP) in collaboration with the World Health Organization (WHO). World Suicide Prevention Day is intended to promote and expand international awareness for the need to increase suicide prevention efforts, appropriate research, and effective intervention since nearly one million suicides a year are completed world wide. AAS is pleased to be able to acknowledge and support this effort by collaborating with IASP and WHO to present a united effort towards preventing suicide in all nations.

This information kit includes materials for your use, such as information on how to interact with and educate the media, as well as facts regarding the issue of suicide. Also in this packet are up-to-date journal article references and recent developments in research about suicide prevention. Please feel free to use these materials for your media campaigns or in-house information sessions.

Suicide Prevention Week is an annual public health campaign sponsored by AAS. If you are not yet an AAS member agency, or know of individuals who are interested in this cause, we encourage you to join our association and help us make a significant difference (see enclosed membership information). Also, we are happy to provide organizations and crisis centers with this information kit should you know of any who wish to receive it.

We are interested in what your organization will be doing for Suicide Prevention Week. Please send us an e-mail and let us know, and we may be able to use your ideas to improve future AAS information kits.

For more information about AAS and for the latest information on suicide and prevention efforts, please visit the AAS website (www.suicidology.org) or contact us at (202) 237-2280.

With your efforts in raising awareness, we can help prevent suicide. Our partnership in this process will make a difference in people's lives. Count on it!

Sincerely,

Bernie Jesiolowski, Ph.D. PCC-S
Chair, AAS Publications Committee
Executive Director of Crisis Intervention Center of Stark County
Adjunct Faculty University of Akron

American Association of Suicidology

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Dear Friends,

The goal of Suicide Prevention Week is to highlight the significant mental health problem of suicide and to work collaboratively as one global society to promote awareness and advocacy about suicide prevention for all age groups. This year's theme, "Partnerships for Change: Advancing Suicide Prevention Services & Practices", recognizes suicide as a global problem and one of great complexity that requires collaborative and coordinated efforts to help reduce suicide worldwide. This coordinated effort also recognizes that many individuals at risk for suicide have already engaged in other suicidal behaviors such as making a suicide attempt or having suicidal thoughts. Essential to this effort is working together to form partnerships across different expertise while utilizing experiences from those who have lost loves due to suicide. This type of cooperation and collaboration will lead to the development and implementation of evidence-based suicide prevention programs. Although these steps are currently being taken in this regard, fostering partnerships with mental health professionals, volunteers, survivors, and researchers will help accelerate the results.

I hope that each and every one of you takes time during this week to develop a new partnership in your efforts to help prevent suicide. Utilizing these new partnerships in combination with ones that have already been established will help us advance our worldwide effort in suicide prevention. Yes, you *can* make a difference and I hope by choosing to participate in one of the many national and international events during Suicide Prevention Week that you *will* make a difference and save lives.

James J. Mazza, Ph.D.
AAS President

Who Can Participate in Suicide Prevention Week?

Suicide prevention is everyone's business and anyone can participate in Suicide Prevention Week. Here are some examples of organizations and institutions that might be involved with this national event:

Crisis Centers

Educational Institutions

Community Mental Health Centers

Hospitals

Private Treatment Facilities

Churches

Corporations and Businesses

Individuals

How can they help?

High schools, colleges and universities can create their own activities for Suicide Prevention Week. These locations are ideal to promote public awareness of the goals of suicide prevention, educate the public about the prevalence of suicide, as well as involve young adults in prevention activities.

Community mental health centers, hospitals, private treatment facilities and churches have a wide range of access to members of the community and are therefore in an ideal position to host Suicide Prevention Week in their locality.

Corporations and businesses can participate not only by hosting events for Suicide Prevention Week, but by sponsoring local or state events and providing services or materials. This collaboration between businesses and the community shows a willingness to work together towards the important cause of suicide awareness and prevention.

How can you help?

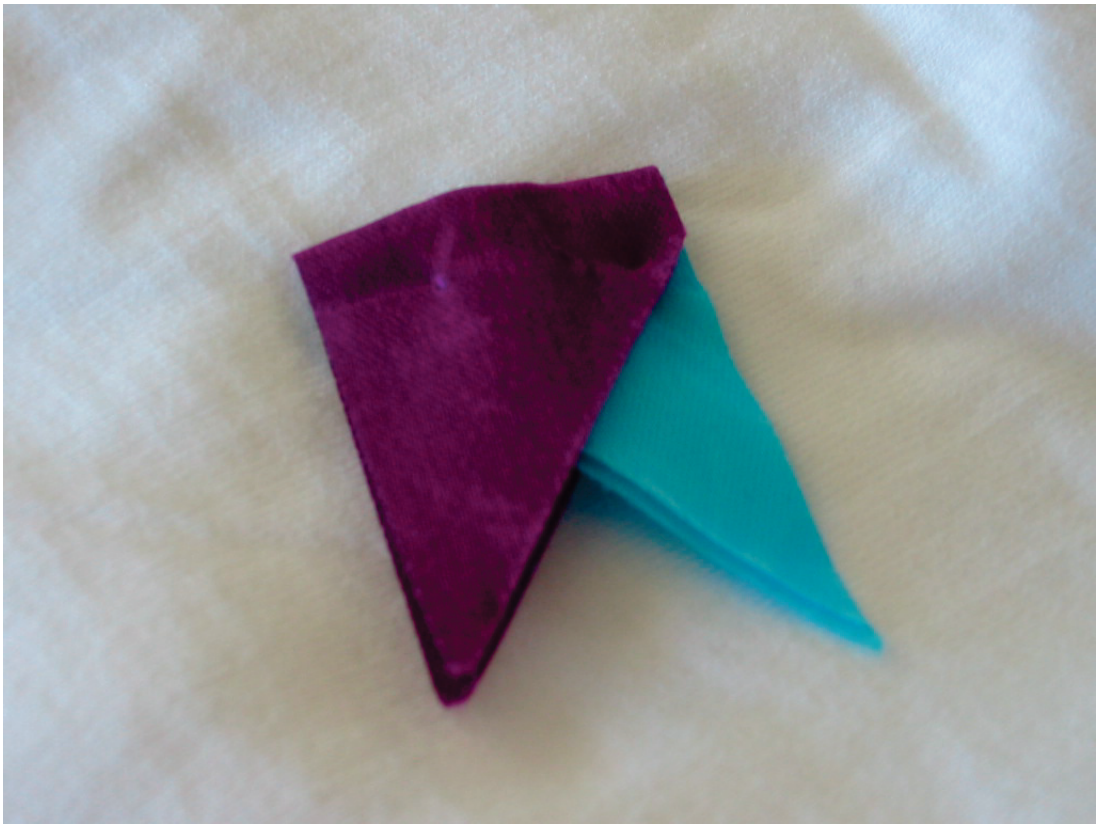
If you are an individual interested in becoming involved in Suicide Prevention Week or with other suicide-related activities, please contact your local mental health provider. For all other questions, please contact AAS.

Suicide Prevention Ribbon

The purple and turquoise Suicide Prevention Ribbon symbolizes suicide awareness and prevention.

The idea of using purple and turquoise stems from conversations between Sandy Martin, founder of the *Lifekeeper Quilts*, and Michelle Linn-Gust, editor of *Surviving Suicide*. Ms. Martin pointed out that every cause had a colored ribbon except suicide prevention. Because many causes already have a color, the decision was made to go with two. Purple and turquoise are both healing colors. The color combination stands for survivors of suicide and suicide itself. The ribbon serves as a reminder that suicide is an issue we need to talk about.

The Suicide Prevention Ribbon's first appearance was at the AAS Annual Conference in Santa Fe in 2003, and has been used in various conferences and suicide events since.



If you would like more information regarding the Suicide Prevention Ribbon, please contact Ms. Sandy Martin (lifekeeper@aol.com or (678) 937-9297).

World Suicide Prevention Day

The International Association for Suicide Prevention (IASP), in collaboration with the World Health Organization (WHO), is hosting its second World Suicide Prevention Day. World Suicide Prevention Day for 2005 is set for Saturday, September 10th.

The International Association for Suicide Prevention (IASP) was founded in Vienna in 1960 as a working fellowship of researchers, clinicians, practitioners, volunteers and organizations of many kinds. IASP wishes to contribute to suicide prevention through the resources of its members and in collaboration with other major organizations in the field of prevention. AAS is proud to be a member and supporter of IASP (www.med.uio.no/iasp/).

The World Health Organization (WHO) is a United Nations health agency founded in April 1948. Its primary objective is to help all people attain the highest possible level of health (physical, mental and social well-being). This organization carries out this objective through advocacy, education, research, medical and technological development as well as the implementation of health standards and norms (www.who.int/en/).

Suicide as an International Problem

Suicide is an international problem and a major public health concern. Suicide claims approximately 1 million lives worldwide each year, resulting in one suicide every 40 seconds.

Suicide and suicidal behavior affects all individuals of all ages, genders, races and religions across the planet. Suicide affects more men than women in all countries but China.

Risk factors remain essentially the same from country to country. Mental illness, substance abuse, previous suicide attempts, hopelessness, access to lethal means, recent loss of loved ones, unemployment and vulnerability to self-harm are just a few examples of risk factors. Protective factors are also the same in all corners of the world. High self-esteem, social connectedness, supportive family and friends, problem-solving skills, are all examples of factors that buffer against suicide and suicidal behaviors.

World Suicide Prevention Day represents a call for action and involvement by all governments and organizations worldwide to contribute to the cause of suicide awareness and prevention through activities, events, conferences and campaigns in their country. By collaborating together in this endeavor, we can indeed save lives.

Part B. Media Materials

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

General Guidelines

This section includes sample materials as well as suggestions and tips for communicating with the media, including a proclamation, a press release, a public service announcement (PSA), an op-ed and a flyer. Also included is a suggested timeline, publicity ideas and media guidelines. The document *Reporting on Suicide: Recommendations for the Media* follows next and explains how to report stories about suicide. This document can also be found on the American Foundation for Suicide Prevention website (www.afsp.org).

General Tips:
The content of your media materials should reflect your targeted audience. For example, if your targeted is teenagers, statistics will not hold their attention. Instead, focus their attention on breaking the stigma surrounding reaching out for help or receiving treatment for mental health care.

Assume the reader is new to this topic; explain any terminology and concepts. Keep in mind that you are trying to reach the general public regarding your opinions and issues.

Use plain language. Be brief, clear and to the point.

There should always be a positive angle included in your message. For example, despite the high rate of suicide in male youths, you can relay information about the effectiveness of treatment and the preventability of suicide.

There should always be information included about where to go to get help (1-800-273-TALK (8255), contact information for local crisis centers, etc.).

Remember:
The PURPOSE of contact and communication with the media is to get the word out.

The GOAL you want to portray is that by working together through awareness, promotion and education, we can reduce the incidence of suicides and prevent individuals from becoming suicidal.

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

Timeline

As you embark on engaging the media to promote your organization for Suicide Prevention Week, consider the following timeline to guide your efforts:

Week of	Activity
7/25	MEDIA LIST: Develop or update your database of local journalists, TV and radio reporters who cover health, science, lifestyle or features, or who have covered suicide or mental health issues in the past. Identify how many radio and TV outlets you will reach out to in each category – newspaper, radio and television. REAL STORIES: Identify local people who have experienced suicide and who would be willing to go "on record" with the media to tell their story in an attempt to help others. Have these sources available for the media to talk to on an as-requested basis. PSAs: Contact newspapers, radio or television station to determine their interest in running public service announcements. Work with a local audio-visual technician to create or modify PSAs for dissemination in August. SPEAKING ENGAGEMENTS: Contact local organizations to schedule speaking engagements by your staff to occur during Suicide Prevention Week.
8/1	ACTIVITIES: Finalize any open house, visitors' day, event, training session or other special activity associated with Suicide Prevention Week. Create promotional materials your activities. PRESS RELEASE: Draft a press release and highlight your organization, and add local statistics regarding suicide in your state, county or region of the country. LEGISLATIVE OUTREACH: Begin a dialogue with your mayor's and governor's offices to pitch the idea of a signed proclamation noting Suicide Prevention Week. OP-ED: Prepare and finalize an op-ed for dissemination to print media the following week.

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

Governor's (or Mayor's) Proclamation

Instructions:
The goal of a proclamation is to promote your activities to the general public.

Add your organization's information in the allotted areas.

Change the items to suit your community's needs, or the specific theme of your event, should it differ. For example, include statistics or facts from your state or to suit your demographic criteria. For recent statistics, please consult the WISQARS database run by the National Center for Injury Prevention and Control (NCIPC) (http://www.cdc.gov/ncipc/).

Public officials willing to sign your proclamation increase attention to your efforts. Typically, the Governor or Mayor signs the proclamation. Try to find a public official who already has some interest in suicide prevention.

Make the signing a public event. Organize a press conference for the occasion. Send copies of the proclamation to newspapers and health reporters in your metropolitan area, and publicize it on your website.

Sample Proclamation

Governor's (or Mayor's) Proclamation

This Governor's (or Mayor's) Proclamation recognizes suicide as a [statewide] public health problem, and suicide prevention as a [statewide] responsibility, and designates September 4th through 10th as "Suicide Prevention Week in [your state]." This week overlaps World Suicide Prevention Day that is recognized internationally and supported by the World Health Organization. The 2005 National Suicide Prevention Week is September 4th through September 10th.

WHEREAS, suicide is the 11th leading cause of all deaths in the United States and the 3rd leading cause of death among individuals between the ages of 15 to 24;

WHEREAS, suicide is now the [rank] leading cause of all deaths in the state of [your state], and the [rank] leading cause of death among people from the age 15 to 24 in [your state];

WHEREAS, in the United States, one person completes suicide every 17 minutes;

WHEREAS, it is estimated that 4.47 million people in the United States are survivors of suicide (those who have lost a loved one to suicide);

WHEREAS, 54% of people who die by suicide use a firearm, and guns stored in the house are used for suicide 40 times more often than for self-protection;

WHEREAS, the overall suicide rate in our country has only slightly declined from record highs in recent years, the suicide rate for those 15-24 years old has more than doubled since the mid-1950s; and the suicide rate remains highest for adults 75 years of age and older;

WHEREAS, the stigma associated with mental illness and suicidality works against suicide prevention by discouraging persons at risk for suicide from seeking life-saving help and further traumatizes survivors of suicide;

WHEREAS, statewide suicide prevention efforts should be developed and encouraged to the maximum extent possible;

WHEREAS, organizations such as the American Association of Suicidology and [list state organizations] which are dedicated to reducing the frequency of suicide attempts and deaths, and the pain of survivors affected by suicides of loved ones, through educational programs, research projects, intervention services, and bereavement services urge that we:

1. Recognize suicide as a national and state public health problem and declare suicide prevention to be a statewide priority;
2. Acknowledge that no single suicide prevention program or effort will be appropriate for all populations or communities;

3. Encourage initiatives based on the goals contained in the *National Strategy for Suicide Prevention:*
   A. Promote awareness that suicide is a public health problem that is preventable.
   B. Develop broad-based support for suicide prevention.
   C. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.
   D. Develop and implement community-based suicide prevention programs.
   E. Develop and implement community-based suicide bereavement support services.
   F. Promote efforts to reduce access to lethal means and methods of self-harm.
   G. Implement training for the recognition of at-risk behavior and for the delivery of effective treatment.
   H. Develop and promote effective clinical and professional practices.
   I. Increase access to, and community linkages with, mental health and substance abuse services.
   J. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
   K. Promote and support research on suicide and suicide prevention.
   L. Improve and expand surveillance systems for suicide behavior.

WHEREAS, a great many suicides are preventable;

THEREFORE IT BE RESOLVED that, I, _____, Governor (or Mayor) of [you city or state], do hereby designate September 4th through September 10th, 2005, as "Suicide Prevention Week" in the state (or city) of [your state or city].

(SEAL) _____

Signature and Date

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

Press Release

Helpful Hints:
The purpose of a press release is to convey information to the media. It serves as the first contact between you and the media.

Use your organization's letterhead. Your press release should not surpass two pages (type "more" or "over" at the bottom right for any subsequent pages).

Be precise and direct. Use plain language and explain any terms. This is an information sheet; no opinions, no fluff.

Your audience is journalists, and their audience is the general public. You want to peak the journalist's interest into writing an article or contacting you for an interview.

If you have a program of events already established, include a copy with the press release.

Send your press release to newspapers or radio stations that are most likely to use it. Check out different papers to determine which ones print articles and advertisements with similar topics.

There are three ways to disseminate a press release: mail, fax or e-mail. If you are not sure which one to use, call the newspaper or the journalist in question and ask them for their preferred method of communication.

Develop or update your database of local journalists. Include TV and radio reporters who regularly cover health, science, lifestyle or features or who have covered suicide or mental health issues in the past. If you are not sure who to write to, check your local library; they generally have a listing of media contacts.

You can send your press release to more than one media outlet; for example, you can send the same press release to many different local newspapers. However, it is generally not recommended to send the same media piece to newspapers/radio stations in the same 'market'. For example, do not send the same press release to two national newspapers or radio stations.

Content:
At the top left hand corner, the words "for immediate release" appear in bold, capital letters.

If you have an eye-catching headline, insert it in bold and centered. If not, insert the words "notification to the press" in bold, capital letters.

Your contact information should follow and include:

- Name*
- Title
- Organization name
- Address
- Phone and fax numbers
- E-mail address
- Website address

*The name of your contact person will be the person most knowledgeable concerning the event in question.

Then proceed to the big five questions: who, what, when, where and why. Order the information by importance. Also, include specific information relevant to your community or state, as well as national statistics.

Emphasize new points (first time event, new activity, special appearance). If your event has an angle, use it. The media likes innovative and unique ideas.

You can either display the information in a statement format (see Sample Press Release) or in a text format (no longer than two pages double spaced).

Include a Letter:

With your press release, include a letter (on agency letterhead) explaining who you are and why you are promoting your events. Include your contact information (address, phone numbers, fax and email address) in case reporters wish to follow-up on your information.

If you have volunteers who are willing to share their personal stories, mention such a possibility in your letter. Oftentimes, the media will include real life stories; it personalizes the article.

If the event you are trying to promote is time sensitive, include such information in the letter. For example, "This article was written partially in light of the upcoming Suicide Prevention Week from September 4th to 10th." This will help the editor as to when to put it to print.

Sample Press Release

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To Understand and Prevent Suicide as a Means of Promoting Human Well-being

FOR IMMEDIATE PRESS RELEASE

CONTACT:
[Your Contact Person's Name]
[Your Organization's Name]
[Your Organization's Address]
[Your Telephone Number]

NOTIFICATION TO THE PRESS

WHAT: Suicide Prevention Week for 2005 is set for September 4 through 10. [Your state] ranks [rank] in the nation in its rate of suicidal deaths.

Suicide is the 11th leading cause of death in the United States with one suicide occurring on average every 17 minutes.

Suicide is the 3rd leading cause of death among 15- to 24-year-olds.

The elderly make up 12.3% of the population, but comprise 17.5% of all suicides.

Approximately 800,000 Americans attempt suicide each year.

It is estimated that five million living Americans have attempted to kill themselves.

Every year in the United States, more than 17,000 men and women kill themselves with a gun; two-thirds more than the number who use a gun to kill another person.

An estimated 4.47 million Americans are survivors of the suicide of a friend, family member, or loved one.

[Your staff person] is available to discuss these and other facts surrounding suicide.

WHO: Suicide specialist, [your contact person], [position at your agency], is an expert in the areas of suicide assessment and intervention. [Include other information about the person's skills, expertise, and services available at your agency.]

WHEN: Suicide Prevention Week, September 4th through September 10th. This year's theme is "Partnerships for Change: Advancing Suicide Prevention Services & Practice".

HOW: To arrange an interview or for further information, please contact [your contact person] at [phone number].

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

Public Service Announcement

Tips:
Try to find a public figure to read the Public Service Announcement (PSA) or a prominent figure in the area of suicide prevention. Perhaps there is already an advocate for suicide awareness and prevention in your community.

PSAs can be done for radio, television or the print media. The three samples that follow are radio PSAs.

The goal of a PSA is to raise awareness and to educate people on a specific issue.

PSAs are generally developed for one of three reasons: to prevent a behavior, to stop a behavior and/or to encourage the adoption of a new behavior.

Include your complete contact information with your submission. Also, mention the timeframe for the announcements. For example, you may want a radio station to broadcast your PSA starting one month prior to September 10th or have a newspaper print your PSA every day during the week of September 4th.

For more information and more examples, please visit the Suicide Awareness Voices of Education (SAVE) website (www.save.org).

Sample PSA

Public Service Announcement
Suicide Prevention (20 Seconds)

Did you know that, in the United States, more people die by suicide (50% more!) each year than by homicide?

Experts believe that most suicidal individuals do not want to die. They just want to end the pain they are experiencing.

When suicidal intent or risk is detected early, lives can be saved.

September 4 through September 10 is Suicide Prevention Week. Please join [your organization] in supporting suicide prevention. Please join us for Suicide Prevention Week and together we can reduce the number of suicides in the U.S. by promoting suicide prevention and awareness.

Sample PSA

Public Service Announcement
Suicide Prevention (30 Seconds)

Did you know that, in the United States, one person completes suicide every 17 minutes? Or that it's estimated that more than 4.47 million people in the United States have been directly affected by a suicide?

Experts believe that most suicidal individuals do not want to die. They just want to end the pain they are experiencing.

Experts also know that suicidal crises tend to be brief. When suicidal behaviors are detected early, lives can be saved.

September 4 through September 10 is Suicide Prevention Week. Please join [your organization] in supporting suicide prevention. Please join us for Suicide Prevention Week and together we can reduce the number of suicides in the U.S. by promoting suicide prevention and awareness.

Sample PSA

Public Service Announcement
Suicide Prevention (45 Seconds)

Did you know that, in the United States, one person completes suicide every 17 minutes? Or that it's estimated that more than 4.47 million people in the United States have been directly affected by a suicide? Or that 54% of all persons who die by suicide use a firearm, kept in the home allegedly for safety, to kill themselves?

Experts believe that most suicidal individuals do not want to die. They just want to end the pain they are experiencing.

Experts also know that suicidal crises tend to be brief. When suicidal behaviors are detected early, lives can be saved. There are services available in our community for the assessment and treatment of suicidal behaviors and their underlying causes.

September 4 through September 10 is Suicide Prevention Week. This year's theme is "Partnerships for Change: Advancing Suicide Prevention Services & Practice". Please join [your agency] in supporting suicide prevention. Please join us for Suicide Prevention Week and together we can reduce the number of suicides in the U.S. by promoting suicide prevention and awareness.

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Suicide Prevention Week
September 4 - 10, 2005

Op-Ed

Getting Ready:
An op-ed is short for opinion-editorial. Some are written by journalists and some are submitted by the general public.

An op-ed is a journalism tool used by the general public to express an opinion or share ideas about a timely and specific issue. The goal of an op-ed is to get people interested in your issue in the hopes that they might become involved in your cause.

It always a good idea to contact the newspaper you are aiming for in advance. Call or email the editor of the op-ed section, introduce yourself and pitch your idea for an op-ed. Be receptive to any advice; this person is an expert on op-eds.

You can send a submission to more than one newspaper, but not in the same 'market'. That is, do not send the same article to two national newspapers. It is however acceptable to submit your article to several local newspapers that circulate in different areas.

Send your submission at least ten to fourteen days before you would like it to appear in the media.

Ask your organization if you can sign the article on behalf of your organization. This will add credibility and strength to your message.

Writing the Article:
Assume the reader is new to this topic; explain any terminology and concepts. Keep in mind that you are trying to reach the general public regarding your opinions and issues.

Be brief, clear and to the point. Be professional, yet maintain a conversational style.

Don't say things just to say them; be clear and unequivocal. For example, if you need to explain the previous sentence, rework that sentence to avoid the explanation entirely.

Use a simple structure; express your opinion, use facts and an example or statistics to back it up, mention the event in question and conclude. The article should flow easily.

The text should be no longer than two pages, single spaced. The average is typically from 600 to 800 words, but newspapers have different requirements. Submissions may be edited for length. A rule of thumb is that the less there is to take out, the less the editor will want to take out.

Your submission should focus on one specific area.

The title of the op-ed must catch the reader's attention. A good title will make the reader want to read the entire article; a bad title will make them move on to the next article.

Your first paragraph is the most important. This is where the reader will decide to read the whole thing or move on. Therefore, emphasizes your main point here; the reader is more likely to read the entire article if you hook them in the beginning. You should be able to do so in two sentences.

As much as you can, support your ideas with facts and statistics. Remember to cite your sources.

Your last paragraph sums your point and leaves room for the reader to remain interested in your issues. Make the reader want more information from your organization and cause.

Include a paragraph at the end on who you are (your title and role in your organization) and your contact information (e-mail and phone).

Include a Letter:
With your submission, include a letter (on agency letterhead) explaining who you are and why you are submitting an article. Include your complete contact information (address, phone numbers, fax and email address).

If the event you are trying to promote is time sensitive, include such information in the letter. For example, "This article was written partially in light of the upcoming Suicide Prevention Week from September 4th to 10th." This will help the editor as to when to put it to print.

If true, emphasize the point that their newspaper is the only one of that market that has received such a submission. If you have sent the same submission to more than one newspaper, simply state that this article was also submitted to such and such newspapers.

Be open to the fact that the editor might send your article back in order for you to shorten or revise it then resubmit it. The editor can also edit your article or title at his/her wish. Do not be surprised if there are changes. A simple and clear submission will avoid such editing.

Sample Op-Ed

SSRIs and Suicidal Behaviors

By Morton M. Silverman, M.D.

A recent controversy in the field of suicidology focuses on the relationship between selective serotonin reuptake inhibitors (SSRIs) and suicidal behaviors. The two key opposing questions that are being asked are: "Do SSRIs cause suicidal behaviors?" and "Are SSRIs responsible for the decline in national youth suicide rates over the last few years?"

THE FDA HEARINGS (SEPTEMBER, 2004)

As a result of the international publicity following the publication of some review articles suggesting the possible link between SSRIs and increased suicidal behaviors, and the action taken in Britain to limit the administration of SSRIs to children and adolescents, the U.S. Food and Drug Administration (FDA) conducted a joint public hearings session of two committees to address the controversy. A number of professional organizations were represented (American Association of Suicidology (AAS)), American Foundation for Suicide Prevention (AFSP), American Psychological Association (APA), American Association of Child and Adolescent Psychiatry (AACAP), American Medical Association (AMA), American College of Nurse Practitioners (ACNP), Suicide Prevention Action Network USA (SPAN USA)) as well as parents who lost loved ones to suicide. Many clinicians urged the FDA to consider all aspects of this complex issue and to understand that untreated depression, not antidepressant medication, is a greater threat to life.

As a result of the hearings, and after weighing all the available evidence and testimony, the FDA directed manufacturers of antidepressant medications to revise the labeling on their products to include a "black-box" warning that notifies healthcare providers and consumers about an increased risk of suicidal thoughts and behaviors in children and adolescents being treated with these medications. According to some studies reviewed by the FDA, children and adolescents who take antidepressants are twice as likely as those given placebos (4% vs. 2%) to become suicidal, i.e. to report suicidal thoughts or attempts. However there were no reported completed suicides among any of the children and adolescents enrolled in any of the clinical trials.

In adults, there is no clear relationship between SSRIs and suicide. There is clear evidence of efficacy of treatment with antidepressants in the pharmacological management of moderate to severe unipolar depression. However, patients and physicians should always be aware that suicidal ideation and suicide attempts may be present during the early phases of treatment (before the medications begin to be therapeutically effective), possibly because they induce agitation or activation early in the treatment process before they affect mood.

The "black box" warning states that "antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders." In addition the FDA developed a patient medication guide that must be dispensed with each prescription. Only fluoxetine (Prozac) is currently approved by the FDA to treat major depression in children.

Many professional organizations felt that the FDA arrived at a premature conclusion and possibly over-reacted to the public debate. While they expressed concerns that such labeling might decrease the use of these medications, they supported the call for better monitoring of patients taking these medications and better education of family members and caregivers as to the benefits of treatment, as well as how to identify any possible adverse effects should they arise.

The positions of most professional organizations and suicide prevention organizations is that caution, additional research, and full disclosure of the results of large-scale public clinical trials are needed to answer conclusively the questions about potential risk, and that, at this time, the potential benefits of these medications for treating child and adolescent depression far outweighs the risk (based on all the available research studies and case reports).

DIRECT BENEFITS OF THE FDA RULING:

Despite mounting evidence that there is no direct connection between SSRIs and the emergence of suicidal behaviors, the FDA "black box" ruling remains in effect. As a result, some direct benefits in the prescribing of SSRIs to children and adolescents are:

1. The FDA specified that there needs to be regular contact between the patient and the physician, leading to increased monitoring by the physician and increased adherence to the medication regimen by the patient.

2. There will be more involvement of family and support networks in the overall treatment plan.

3. Physicians will be expected to discuss potential side effects and benefits of medication prior to onset (informed consent) with the patient and his/her family and support network.

4. There will be more public access to data from clinical trials as well as unpublished research (leading to the establishment of a national clinical trials registry).

5. A coalition of major medical journals have implemented a new policy whereby studies that are sponsored by drug companies will only be published if the study has been registered with a public database.

6. There will be an intensification of research into the safety and efficacy of SSRIs through additional large-scale systematic studies, especially for children and adolescents.

Morton M. Silverman, MD, is Senior Advisor to the Suicide Prevention Resource Center (SPRC) and Editor-in-Chief of *Suicide & Life-Threatening Behavior*, the official publication of the American Association of Suicidology.

Sample Op-Ed

Unrecognized Depression is Lethal

By Donna Cohen, Ph.D.

Depression is a serious public mental health challenge for our aging population. Depression goes unrecognized in half of the general population and in 80% of the older population (ages 65 and older). The lack of detection, diagnosis, and treatment of depression in Americans of all ages, but especially older Americans, is unacceptable, since depressive disorders are treatable.

Depression, coupled with other risk factors, can be lethal. Older persons, both in the United States and around the world have the highest suicide rates of any other age group, and the rates increase with advancing age. In the United States, older men complete 80% of all suicides in their age group. In other countries, older men and women appear to be equally likely to complete suicide.

Older adults show a greater degree of planning and are more intent on killing themselves than younger persons. Over 70% of older suicides involve firearms compared to 54% for the general population. The elderly are less likely to attempt suicide, with an average of 4 attempts for every completed suicide compared to an estimated 100-200 attempts for every completed suicide in younger age groups. Careful planning, increased vulnerability, decreased reserve capacity to recover, and relative social isolation contribute to increased lethality in the aged. Older persons are less likely to be discovered after a suicide attempt, and they are less communicative about their ideation than younger persons.

Suicides are acts mediated by mental health problems, hopelessness, perceived burdensomeness, and desperation. Suicide pacts are very rare, but the suicide pact of an older couple in South Florida illustrates the quiet desperation and emotional bankruptcy of elderly suicides. The method of death is unusual, but the antecedent circumstances—incapacitating illness, depression, and a suicide note—are not.

> MS, age 85, and ES, age 80, had planned to die on New Year's Eve. They asked the condominium maintenance man to remove their bedroom window screens, complaining that they blocked the ocean breeze. He removed them, and several hours later the couple completed suicide. The results of the medical examiner's investigation showed that MS and ES had crawled across the bedroom floor to the window and fell 17 floors to their death. Both relied on walkers to get around their home. ES appeared to have helped her husband, who was weak and frail from emphysema, by pushing him out the window first before she followed. A note was taped to the telephone; ES had a note in her blouse pocket.

This tragedy illustrates many of the characteristics of the victims and circumstances of suicide pacts. Most couples have been married a long time and have enjoyed what appears to have been a successful marriage. However, disabling chronic or terminal illness accompanied by depression and other late life stressors, intervene and begin to limit their control and independence. The decision to complete suicide together is made reflectively, and typically the event is carefully planned. Often, the double suicide occurs on a date significant for the couple or at a time shortly after one or both experience a significant deterioration in health.

Physicians need to be alert to the warning signs. Most older patients who complete suicide have had a longstanding relationship with a primary care physician and have seen the doctor shortly before the suicide. Seventy percent have visited their physician within one month before killing themselves, 20% saw her/his physician the day they completed suicide, and 40% did so within one week.

Family members, friends, and neighbors need to be vigilant about risk factors for suicide. They may include advancing age, being male, chronic health problems, use of many medications, changes in health status,

a previous suicide attempt, being unmarried, multiple losses, and firearms in the home. If you see signs, there are several things you can do:

- Do not be afraid to ask if the older person has thought about suicide. You will not be giving them new ideas.
- Do not act surprised or shocked. This will make them withdraw from you.
- Continue talking and ask how you can help.
- Offer hope that alternatives are available. Do not offer glib reassurance. It may make the person believe that you do not understand.
- Get involved. Become available. Show interest and support. If you cannot do this, find someone who can, such as a neighbor or a minister, priest, or rabbi.
- Ask whether there are guns in the house. Ask the person what plans they have to die. The more detailed the plan, the higher the risk.
- Remove guns and other methods of death.
- Do not be sworn to secrecy. Get help from persons or agencies that specialize in crisis intervention.
- Call a crisis hotline in your area or 1-800-273-TALK or seek the help of a geriatric specialist. Do not try to do things by yourself.

There is help in the community. If you believe there is a risk for suicide, contact a professional immediately. Call a suicide crisis center, a crisis hotline, a family physician, a psychiatric, a medical emergency room, or a community mental health center listed in the yellow pages. Not all suicides can be prevented, but we can be vigilant for the signs of this silent killer.

Donna Cohen, Ph.D., is a professor in the Department of Aging and Mental Health and Head of the Violence and Injury Prevention Program at the University of South Florida in Tampa, Florida (E-mail: cohen@fmhi.usf.edu).

Sample Op-Ed

Depression isn't part of growing older

It's a serious disease with physical causes and can attack at any age, but treatment is available.

DONNA COHEN

Published January 27, 2004

Depression has many forms, from brief feelings of sadness to a serious medical condition. Most people feel sad and worried at some time in their life. These feelings are normal reactions to disappointments, illness or death. It is also normal to be moody, lose interest in people or favorite activities, have sleep problems and feel tired. These are all common expressions of what is known as normal reactive depression.

The circumstances that cause reactive depression may or may not go away, but you find ways to deal with your problems. In other words, you bounce back and feel better in a short time.

But when sadness persists and habits, such as eating, sleeping, working and enjoying life, continue to be difficult, you are dealing with something more serious than just "feeling down." You are facing a clinical depression, an illness that requires treatment. Many people believe that depression is normal in older adults. It is not. Most people also believe that depression in adults with chronic illness is normal. It is not. Clinical depression is a medical disorder, and it is caused by biological and psychosocial factors.

Fortunately, most depressive disorders are treatable with psychotherapy, drugs and other interventions. But if undetected and untreated, clinical depression can destroy quality of life and exacerbate health problems. It can lead to personal suffering, withdrawal from others, family disruption and sometimes suicide. Because it brings the potential for suicide, depression is a life-threatening illness.

Signs of depression

Clinical depression affects the body and the mind, causing changes in thinking, mood, behavior and body functions. If you recognize the following changes in yourself or someone you know, seek help from a physician or mental health professional.

Thinking: Depressed individuals often feel inadequate or overwhelmed. Even easy tasks seem impossible. Concentration is difficult and decisionmaking is burdensome. The world appears bleak, and pessimism colors perceptions of self-worth. Even successes are interpreted as failures. Thoughts of suicide may occur when the depression is severe.

Mood: Depressed individuals feel empty, helpless, hopeless and worthless, and they may report feeling pain and despair. Individuals may cry a great deal, often for little or no reason. Many, especially older men, become agitated and worry about everything. It is common to feel anger or even rage, as well as irritation, frustration and anxiety. Depressed moods are pervasive and persistent and do not lift even when good things happen.

Behavior: Depressed individuals often show such behavior as restlessness, hand-wringing, pacing, the inability to meet deadlines, withdrawal from friends, staying in bed most of the day, and decreased interest in sex. Many drink alcohol excessively or take sedatives to try to make the depression go away.

Body functions: Depression is a disease that affects the entire body. Individuals report physical pains such as headaches, backaches, joint pain, stomach problems, chest pain and gastrointestinal distress.

Getting help

It is not a sign of weakness to see a doctor when you are depressed. Unfortunately, the very nature of depression drains the desire and energy to talk with family members or seek professional help. Because depressed people often believe they are failures, many feel they are not worthy of help. The most courageous thing you can do is to get help.

Both men and women get depression. There is a widespread myth that depression is a woman's disease. It is not unmanly or wimpy to admit feeling depressed. Unfortunately, men are reluctant to seek treatment and instead become irritable, angry, drink or use drugs, and withdraw from loved ones.

It is not unusual to resist getting help, but telling someone how bad you feel is the first step to feeling better. A physician is the best person to contact; they need to know your medical history.

To be clinically depressed is to have a medical illness. Treatment is needed. Depressive disorders are diseases of the brain, just as cardiovascular diseases are diseases of the heart and circulatory system. Depressive disorders are not the result of character flaws, bad parenting, divine punishment, or personal weaknesses. They are not anything to be ashamed of.

Learning to spot the signs of depression is like learning to spot signs of cancer. It can save your life. Learning to detect the signs of depression and then getting help are essential steps to good health.

Donna Cohen, Ph.D, is a professor in the Department of Aging and Mental Health at the University of South Florida and also head of the Violence and Injury Prevention Project.

Sample Op-Ed

June 14, 2002

Letters to the *Journal*
Albuquerque Journal
PO Drawer J
Albuquerque, NM 87103

Dear Letters to the *Journal*:

Nine years ago, when my sister Denise took her life by walking in front of a train, everything changed for me. Suddenly, I was thrust into the world of suicide survivorship, one of which I wanted no part. However, I couldn't bring my sister back and was forced to cope with the fact that she chose to end her life.

Unfortunately, part of being a suicide survivor means one struggle through the insensitivity of others, including the *Albuquerque Journal*. Twice in this past week, the *Journal* has used the phrase "commit suicide" (see Monday, June 10, Health Section, New Mexico vital fact "Who are most likely to commit suicide: Men or women?" and Thursday, June 13, Front Section, "Priest Victims Speak" photo caption). To survivors, who had no say in their loved ones' deaths, this phrase connotates murder. It also leaves the survivor in the closet, afraid to tell others what they are going through, thus complicating grief and leading to other emotional and physical difficulties.

In this county, a person takes his or her life approximately every 17 minutes, leaving behind at least six survivors per death. New Mexico has the fourth highest suicide rate in the United States with 18.3 suicide deaths per 100,000 people (see www.iusb.edu/~jmcintos/ for verification).

The *Journal's* job is to educate the public, not hinder the grieving process of those left behind. Help us by using "died by suicide."

Sincerely,

Michelle Linn-Gust, M.S.
Author, *Do They Have Bad Days in Heaven? Surviving the Suicide Loss of a Sibling*

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

Flyer

Consider a flyer as a short information session. Only the most important and relevant information and statistics should appear.

Use the front page or flap as the introduction to your cause. Include titles and dates. The back of the flyer is a good place to display your contact information and website address so that participants can easily reach you after the event. Include a logo if you have one.

On the 'inside' of the flyer, use some space to list the activities that you are hosting, including the title of the activity, the date and time, as well as a location where the activity will take place or start from.

Also on the 'inside' on the flyer, include information and statistics on suicide. Edit the sample flyer to suit your needs. For example, if you are a youth organization, include more youth information from the Fact Sheets and omit less relevant material.

Sample Flyer (see next two pages)

[On this flap, insert resources and phone numbers that can help your participants seek information and help.]

[Include future events from your organization's calendar.]

[If you have a sponsor, include their logo, contact info and your appreciation.]

[Insert your contact information & logo here]

American Association of Suicidology
5221 Wisconsin Avenue, N.W.
Second Floor
Washington, D.C. 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
www.suicidology.org
info@suicidology.org

Suicide Prevention Week

September 4 - 10, 2005

"Partnerships for Change: Advancing Suicide Prevention Services & Practice"

Sponsored by

American Association of Suicidology

[Insert your list of activities for the week, with date and time as well as location of the activity.]

Example:

Suicide Prevention Week Opening Ceremony
Sunday, September 4th Noon
Convene at Central Library Park

Suicide Prevention Fund-raiser Walk
Saturday, September 10th 10 AM
Walk will begin in front of Springfield Community Center

Some Facts About Suicide

In 2002, the latest year for which we have data, in the U.S.:

More than 31,000 people die by suicide.

An average of 87 individuals per day (one per 17 minutes) will die by suicide.

Suicide is the 11th leading cause of death, with a rate of 11.0 per 100,000.

Males complete suicide at a rate four times that of females; however, females attempt suicide three times more often than males.
The suicide rates for Whites are approximately twice those of non-Whites.

Mental health diagnoses are generally associated with a higher rate of suicide. The risk for suicide is increased in depressed and alcoholic individuals.

Feelings of hopelessness are found to be more predictive of suicide risk than depression per se.

The vast majority of individuals who are suicidal often display clues and warning signs.

Youth (ages 15-24):

Suicide is the third leading cause of death; only accidents and homicides are more frequent.

The 2002 rate was 9.9 suicides per 100,000 (a total of 4,010).

One youth completes suicide every 2 hours and 11 minutes, which is about 11 each day.

Males between the ages of 20 and 24 were 6.6 times more likely than females to complete suicide. Males between 15 and 19 were 5 times more likely than females to complete suicide.

For every completed suicide by youth, it is estimated that 100 to 200 attempts are made.

Elderly (over 65):

The elderly make up 12.3% of the population but account for 17.5% of all suicides.

In 2001, there were 5,548 elderly suicides (about 15 per day).

Elderly white men are at the highest risk with a rate of approximately 35 suicides per 100,000 each year.

The rate of suicide for women declines after age 60 (after peaking in middle adulthood, ages 40-54).

Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate. Over the age of 65, there is 1 suicide for every 4 attempts.

Warning Signs:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – as if there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, inability to sleep or sleeping all the time
- Dramatic mood changes
- Expressing no reason for living; no sense of purpose in life

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

Publicity Ideas

- Send out the Public Service Announcements (PSAs) to the radio and television stations in your community. Send a 15 second and 45 second PSA. Insert your organization's name.

- Contact the Mayor's office and/or Governor's office and request that September 4-10 be proclaimed as [your city's] Suicide Prevention Week; arrange press coverage.

- Send the Press Release (with inserts such as fact sheets, the events program, etc.) to all your local papers, to the attention of Health and Science Reporters.

- Contact local organizations to schedule speaking engagements.

- Invite public officials to your events (Mayor, City Council Member, State Senator, Head of the School Board, etc.).

- Have an open house or visitors' day to promote your services and expertise.

- Write an open letter to the editor of your local newspaper emphasizing the importance of early detection of suicidal behavior.

- Invite a "Features" reporter to do a newspaper article about suicide prevention and services for suicidal persons.

- Ask a local radio or television station to broadcast an editorial regarding suicide prevention and services for suicidal persons.

- Offer a training session on suicide assessment, intervention, and resources available in your community.

American Association of Suicidology

Suicide Prevention Week
September 4 - 10, 2005

Media Guidelines

The following list of suggestions can help increase your education and prevention efforts in your area through the use of television, newspaper, radio or magazine stories and help you to minimize the potential dangers.

Utilizing the media for awareness, education and prevention:

- Become pro-active with the media. Establish a relationship beforehand. Initiate a contact with a phone call or press release and establish yourself or your agency as a contact on the issue of suicide prevention.

- Emphasize the warning signs of suicide, how to respond to someone who is at risk for suicide, and where to go for help in your community. Whenever possible, present examples of positive outcomes of people in suicidal crises.

- Using personal experiences and case studies can make a point more real and understandable, but be cautious not to reveal information which breaks client confidentiality.

- Review statistics so you will not dispense erroneous information. Make it a point to be aware of local or regional statistics, as well as the state and national figures prepared by the American Association of Suicidology. The most current statistics for your state can be obtained from http://webapp.cdc.gov/sasweb/ncipc/mortrate10.html.

- Use clear, simple terminology that layman readers or viewers will understand.

- Refer to the AAS website (www.suicidology.org) for media recommendations.

Reporting on Suicide:
Recommendations for the Media

Centers for Disease Control and Prevention
National Institute of Mental Health
Office of the Surgeon General
Substance Abuse and Mental Health Services Administration
American Foundation for Suicide Prevention
American Association of Suicidology
Annenberg Public Policy Center

Developed in collaboration with

World Health Organization • National Swedish Centre for Suicide Research • New Zealand Youth Suicide Prevention Strategy

Suicide Contagion is Real

.....between 1984 and 1987, journalists in Vienna covered the deaths of individuals who jumped in front of trains in the subway system. The coverage was extensive and dramatic. In 1987, a campaign alerted reporters to the possible negative effects of such reporting, and suggested alternate strategies for coverage. In the first six months after the campaign began, subway suicides and non-fatal attempts dropped by more than eighty percent. The total number of suicides in Vienna declined as well.[1-2]

Research finds an increase in suicide by readers or viewers when:

- The number of stories about individual suicides increases[3,4]
- A particular death is reported at length or in many stories[3,5]
- The story of an individual death by suicide is placed on the front page or at the beginning of a broadcast[3,4]
- The headlines about specific suicide deaths are dramatic[3] (A recent example: "Boy, 10, Kills Himself Over Poor Grades")

RECOMMENDATIONS

The media can play a powerful role in educating the public about suicide prevention. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy and need to be covered, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates.[1,2]

- Certain ways of describing suicide in the news contribute to what behavioral scientists call "suicide contagion" or "copycat" suicides.[7,9]
- Research suggests that inadvertently romanticizing suicide or idealizing those who take their own lives by portraying suicide as a heroic or romantic act may encourage others to identify with the victim.[6]
- Exposure to suicide method through media reports can encourage vulnerable individuals to imitate it.[10] Clinicians believe the danger is even greater if there is a detailed description of the method. Research indicates that detailed descriptions or pictures of the location or site of a suicide encourage imitation.[1]

Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.[6]

SUICIDE AND MENTAL ILLNESS

Did you know?

- Over 90 percent of suicide victims have a significant psychiatric illness at the time of their death. These are often undiagnosed, untreated, or both. Mood disorders and substance abuse are the two most common.[11-15]
- When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.[14,15]
- Research has shown that when open aggression, anxiety or agitation is present in individuals who are depressed, the risk for suicide increases significantly.[16-18]

The cause of an individual suicide is invariably more complicated than a recent painful event such as the break-up of a relationship or the loss of a job. An individual suicide cannot be adequately explained as the understandable response to an individual's stressful occupation, or an individual's membership in a group encountering discrimination. Social conditions alone do not explain a suicide.[19-20] People who appear to become suicidal in response to such events, or in response to a physical illness, generally have significant underlying mental problems, though they may be well-hidden.[12]

Questions to ask:

- Had the victim ever received treatment for depression or any other mental disorder?
- Did the victim have a problem with substance abuse?

Angles to pursue:

- Conveying that effective treatments for most of these conditions are available (but underutilized) may encourage those with such problems to seek help.
- Acknowledging the deceased person's problems and struggles as well as the positive aspects of his/her life or character contributes to a more balanced picture.

INTERVIEWING SURVIVING RELATIVES AND FRIENDS

Research shows that, during the period immediately after a death by suicide, grieving family members or friends have difficulty understanding what happened. Responses may be extreme, problems may be minimized, and motives may be complicated.[21]

Studies of suicide based on in-depth interviews with those close to the victim indicate that, in their first, shocked reaction, friends and family members may find a loved one's death by suicide inexplicable or they may deny that there were warning signs.[22,23] Accounts based on these initial reactions are often unreliable.

Angles to Pursue:

- Thorough investigation generally reveals underlying problems unrecognized even by close friends and family members. Most victims do however give warning signs of their risk for suicide (see Resources).
- Some informants are inclined to suggest that a particular individual, for instance a family member, a school, or a health service provider, in some way played a role in the victim's death by suicide. Thorough investigation almost always finds multiple causes for suicide and fails to corroborate a simple attribution of responsibility.

Concerns:

- Dramatizing the impact of suicide through descriptions and pictures of grieving relatives, teachers or classmates or community expressions of grief may encourage potential victims to see suicide as a way of getting attention or as a form of retaliation against others.
- Using adolescents on TV or in print media to tell the stories of their suicide attempts may be harmful to the adolescents themselves or may encourage other vulnerable young people to seek attention in this way.

LANGUAGE

Referring to a "rise" in suicide rates is usually more accurate than calling such a rise an "epidemic," which implies a more dramatic and sudden increase than what we generally find in suicide rates.

Research has shown that the use in headlines of the word suicide or referring to the cause of death as self-inflicted increases the likelihood of contagion.[3]

Recommendations for language:

- Whenever possible, it is preferable to avoid referring to suicide in the headline. Unless the suicide death took place in public, the cause of death should be reported in the body of the story and not in the headline.
- In deaths that will be covered nationally, such as of celebrities, or those apt to be covered locally, such as persons living in small towns, consider phrasing for headlines such as: "Marilyn Monroe dead at 36," or "John Smith dead at 48." Consideration of how they died could be reported in the body of the article.
- In the body of the story, it is preferable to describe the deceased as "having died by suicide," rather than as "a suicide," or having "committed suicide." The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.
- Contrasting "suicide deaths" with "non-fatal attempts" is preferable to using terms such as "successful," "unsuccessful" or "failed."

SPECIAL SITUATIONS

Celebrity Deaths

Celebrity deaths by suicide are more likely than non-celebrity deaths to produce imitation.[24] Although suicides by celebrities will receive prominent coverage, it is important not to let the glamour of the individual obscure any mental health problems or use of drugs.

Homicide-Suicides

In covering murder-suicides be aware that the tragedy of the homicide can mask the suicidal aspect of the act. Feelings of depression and hopelessness present before the homicide and suicide are often the impetus for both.[25,26]

Suicide Pacts

Suicide pacts are mutual arrangements between two people who kill themselves at the same time, and are rare. They are not simply the act of loving individuals who do not wish to be separated. Research shows that most pacts involve an individual who is coercive and another who is extremely dependent.[27]

STORIES TO CONSIDER COVERING

- Trends in suicide rates
- Recent treatment advances
- Individual stories of how treatment was life-saving
- Stories of people who overcame despair without attempting suicide
- Myths about suicide
- Warning signs of suicide
- Actions that individuals can take to prevent suicide by others

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These recommendations were produced in the spirit of the public-private partnership recommended by the Surgeon General's National Strategy for Suicide Prevention.

We would like to thank the many journalists and news editors who assisted us in this project.

The Annenberg Public Policy Center's involvement was funded by The Robert Wood Johnson Foundation.

Resources

United States

- Centers for Disease Control and Prevention
  Phone: 1-800-311-3435
  www.cdc.gov
- National Institute of Mental Health
  Phone: 301-443-4513
  www.nimh.nih.gov
- Substance Abuse and Mental Health Services Administration
  Phone: 1-800-487-4890
  www.samhsa.gov
- Office of the Surgeon General
  National Strategy for Suicide Prevention
  www.mentalhealth.org/suicideprevention
- American Association of Suicidology
  Phone: 202-237-2280
  www.suicidology.org

International

M0 M Canterbury Suicide Project (New Zealand)
Phone: 64 3 364 0530
www.chmeds.ac.nz/RESEARCH/SUICIDE/Suicide.htm

M0 M National Swedish Centre for Suicide Research
Phone: +46 08/728 70 26
www.ki.se/ipm/enheter/engSui.html

M0 M National Youth Suicide Prevention Project (Australia)
Phone: 61 3 9214 7888
www.aifs.org.au/ysp

M0 M Suicide Information and Education Centre
Phone: 403 245-3900
www.suicideinfo.ca

M0 M World Health Organization
Phone: +00 41 22 791 21 11
www.who.int

American Foundation for Suicide Prevention
Phone: 1-888-333-AFSP
Phone: 212-363-3500
Web: www.afsp.org

Part C. Information about Suicide

The Fact Sheets in this section are also on our website. These information sheets are put together by AAS and are available for public use. Please make as many copies as you need.

U.S.A. SUICIDE: 2002 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths	Group (Number of Suicides)	Rate
Nation	31,655	86.7	11.0	1.3	White Male (22,328)	19.9
Males	25,409	69.6	17.9	2.1	White Female (5,382)	4.8
Females	6,246	17.1	4.3	0.5	Nonwhite Male (2,344)	9.2
Whites	28,731	78.7	12.2	1.4	Nonwhite Female (568)	2.0
Nonwhites	2,924	8.0	5.5	0.9	Black Male (1,627)	9.1
Blacks	1,939	5.3	5.1	0.7	Black Female (330)	1.5
Elderly (65+ yrs.)	5,548	15.2	15.6	0.3	Hispanic (1850)	5.0
Young (15-24 yrs.)	4,010	11.0	9.9	12.1		

Completions:

Suicide rate increased slightly in both 2002 and 2001 after declines for six consecutive years and a steady 2000 rate.

- Average of 1 person every 16.6 minutes killed themselves.
- Average of 1 old person every 1 hour 34.7 minutes killed themselves.
- Average of 1 young person every 2 hours 11 minutes killed themselves. (If the 264 suicides below age 15 are included, 1 young person every 2 hours 3 minutes)
- 11th ranking cause of death in U.S. — 3rd for young

Cause	Number	Rate	Ages	Number	Rate
All Causes	33,046	81.4	10-14	260	1.2
1-Accidents	15,412	38.0	15-19	1513	7.4
2-Homicide	5,219	12.9	20-24	2497	12.2
3-Suicide	4,010	9.9			

- 4.1 male deaths by suicide for each female death by suicide.
- Suicide ranks 11th as a cause of death; homicide ranks 14th.

Attempts:

(figures are estimates; no official U.S. national data are compiled)

- 790,000 annual attempts in U.S. (using 25:1 ratio)
- 25 attempts for every death by suicide for nation. 100-200:1 for young; 4:1 for elderly.
- 5 million living Americans (estimate) have attempted to kill themselves.
- 3 female attempts for each male attempt.

Survivors:

(i.e., family members and friends of a loved one who died by suicide)

- *Each suicide intimately affects at least 6 other people.* (Estimate- Shneidman, 1969, *On the Nature of Suicide*)
- Based on the over 745,000 suicides from 1978 through 2002, estimated that the number of survivors of suicides in the U.S. is 4.47 million (1 of every 64 Americans in 2002); number grew by nearly 190,000 in 2002.
- If there is a suicide every 16.6 minutes, then there are 6 new survivors every 16.6 minutes as well.

Suicide Methods:

Suicide Methods		Number		Rate	Percent of Total
Firearm suicides		17,108	5.9	54.0%	
Suffocation/Hanging	6,462	2.2	20.4%		
Falls	740	0.3	2.3%		
Drowning	368	0.1	1.2%		
Poisoning	5,486	1.9	17.3%		
Cut/pierce	566	0.2	1.8%		
Fire/flame	150	0.1	0.5%		
All but Firearms	14,547	5.1	46.0%		

Old made up 12.3% of 2002 population but represented 17.5% of the suicides.
Young were 14.1% of 2002 population and comprised 12.7% of the suicides.

U.S.A. Suicide Rates 1993-2002

(Rates per 100,000 population)

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Age										
5-14	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7	0.6
15-24	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9	9.9
25-34	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8	12.6
35-44	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7	15.3
45-54	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2	15.7
55-64	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1	13.6
65-74	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3	13.5
75-84	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4	17.7
85+	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5	18.0
65+	19.0	18.1	18.1	17.3	16.8	16.9	15.9	15.3	15.3	15.6
Total	12.1	12.0	11.9	11.6	11.4	11.3	10.7	10.7	10.8	11.0
Gender										
Men	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9
Women	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3
Race										
White	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9	12.2
Nonwh	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6	5.5
Black	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3	5.1

15 Leading Causes of Death in the U.S.A., 2002

(total of 2,443,387 deaths; 847.3 rate)

Rank	Cause of Death	Rate	Deaths
	Total	847.3	2,443,387
1	Diseases of heart (heart disease)	241.7	696,947
2	Malignant neoplasms (cancer)	193.2	557,271
3	Cerebrovascular diseases (stroke)	56.4	162,672
4	Chronic lower respiratory diseases	43.3	124,816
5	Accidents (unintentional injuries)	37.0	106,742
6	Diabetes mellitus (diabetes)	25.4	73,249
7	Influenza & pneumonia	22.8	65,681
8	Alzheimer's disease	20.4	58,866
9	Nephritis, nephrosis (kidney disease)	14.2	40,974
10	Septicemia	11.7	33,865
11	**Suicide [Intentional Self-Harm]**	**11.0**	**31,655**
12	Chronic liver disease and cirrhosis	9.5	27,257
13	Homicide [Assault]	7.0	20,261
14	Essential hypertension and renal disease	6.1	17,638
15	Pneumonitis due to solids and liquids	6.1	17,593
	All other causes (Residual)	141.5	407,900

Official data source: Kochanek, K. D., Murphy, S. L., Anderson, R. N., & Scott, C. (2004). Deaths: Final data for 2002. National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120.

Population figures source: Table I, p. 108, of the National Center for Health Statistics (Kochanek et al., 2004) publication above.

$$\text{suicide rate} = \frac{\text{number of suicides by group}}{\text{population of group}} \times 100{,}000$$

Suicide Data Page: 2002
16 October 2004
Prepared for AAS by John L. McIntosh, Ph.D.

Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2002

Rank-State [Region] ('00 rank)	Rate	Number
01 Wyoming (04)	21.1	105
02 Alaska (06)	20.5	132
03 Montana (02)	20.2	184
04 Nevada (03)	19.5	423
05 New Mexico (01)	18.8	349
06 Arizona (10T)	16.2	886
07 Colorado (05)	16.1	727
08 West Virginia (07T)	15.3	276
09 Idaho (07T)	15.1	202
10 Vermont (26T)	14.9	92
11 Oregon (10T)	14.7	518
12 Utah (13T)	14.7	340
13 North Dakota (20T)	14.4	91
14 Oklahoma (09)	14.3	501
15 Florida (13T)	14.0	2,338
16 Arkansas (12)	13.9	377
17 Tennessee (20T)	13.4	778
18 Washington (24)	13.4	811
19 Kentucky (22)	13.2	540
20 Maine (19)	12.8	166
21 Kansas (36)	12.7	345
22 South Dakota (15)	12.4	94
23 Missouri (18)	12.2	693
24 Indiana (26T)	12.1	743
25 Mississippi (28T)	11.9	343
25 North Carolina (23)	11.9	986
27 Nebraska (35)	11.6	201
28 Alabama (28T)	11.5	514
28 Wisconsin (25)	11.5	627
30 Ohio (37)	11.3	1,287
31 Louisiana (34)	11.1	499
United States	**11.0**	**31,655**
32 Michigan (38)	11.0	1,106
32 Virginia (31T)	11.0	799
34 Pennsylvania (39T)	10.9	1,341
35 Iowa (39T)	10.7	314
35 South Carolina (28T)	10.7	440
37 Georgia (31T)	10.6	909
37 Texas (39T)	10.6	2,311
39 New Hampshire (17)	10.4	132
40 Minnesota (42)	9.9	497
41 Hawaii (31T)	9.6	120
42 California (46T)	9.2	3,228
42 Delaware (16)	9.2	74
44 Illinois (43)	9.1	1,145
45 Maryland (44)	8.7	477
46 Rhode Island (45)	8.0	86
47 Connecticut (46T)	7.5	260
48 Massachusetts (50)	6.8	436
49 New Jersey (49)	6.4	553
49 New York (51)	6.4	1,228
51 District of Columbia (48)	5.4	31

Caution: *Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single year alone*

Region [Abbreviation]	Rate	Number
Mountain [M]	16.9	3,216
East South Central [ESC]	12.6	2,175
South Atlantic [SA]	11.8	6,330
West North Central [WNC]	11.5	2,235
West South Central [WSC]	11.4	3,688
Nation	**11.0**	**31,655**
East North Central [ENC]	10.7	4,763
Pacific [P]	10.3	4,809
New England [NE]	8.3	1,172
Middle Atlantic [MA]	7.8	3,122

Source: Kochanek, K. D., Murphy, S. L., Anderson, R. N., & Scott, C. (2004). Deaths: Final data for 2002. National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120. (p. 92, Table 29).
[data are by place of residence]
[Suicide = ICD-10 Codes X60-X84, Y87.0]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2002
26 September 2004

Prepared by John L. McIntosh, Ph.D. for

American Association of Suicidology
5221 Wisconsin Avenue, N.W.
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2282

"to understand and prevent suicide as a means of promoting human well-being"

Visit the AAS website at:
http://www.suicidology.org

For other suicide data, and an archive of state data, visit the website below and click on the "Recent Suicide Statistics" link:
http://mypage.iusb.edu/~jmcintos/

AMERICAN ASSOCIATION OF SUICIDOLOGY
Dedicated to the Understanding and Prevention of Suicide

Suicide in the U.S.A.

Based on Current (2002) Statistics

1. In 2002 (the latest year for which we have national statistics), there were 31,655 suicides in the U.S. (87 suicides per day; 1 suicide every 17 minutes), with 11.0 of every 100,000 Americans killing themselves.

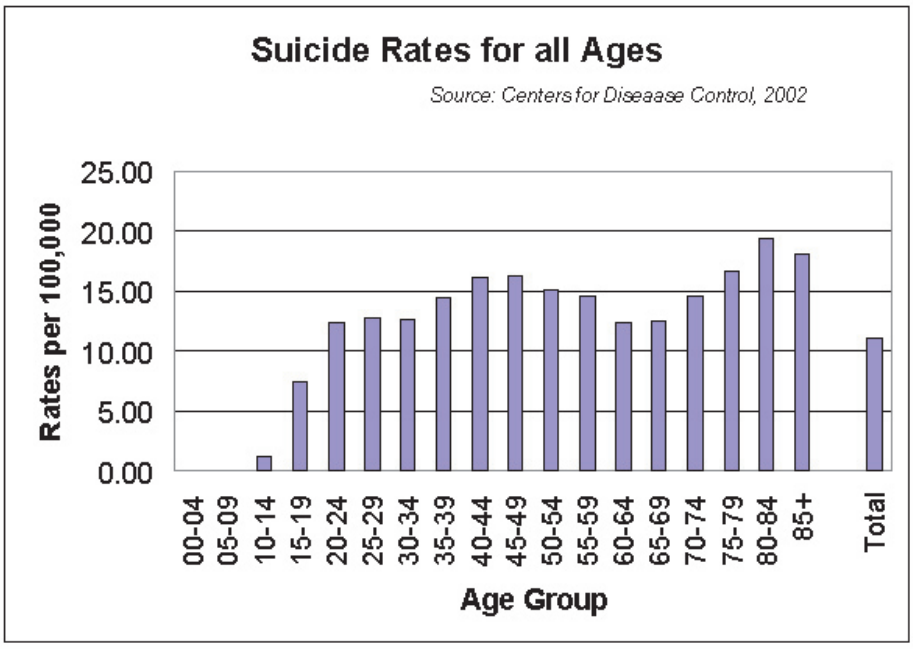
2. Suicide is the eleventh leading cause of death.

3. Suicide rates in the U.S. can best be characterized as mostly stable over time with a slight tendency toward a decrease. After six consecutive years of decrease (from 12.1 in 1993 to 10.7 in 2000), there was an insignificant increase in 2001 (10.8) and in 2002 (11.0).

4. Rates of suicide are highest in the Mountain States.

5. Males complete suicide at a rate four times that of females. However, females attempt suicide three times more often than males.

6. Relative to those younger, rates of completed suicide are highest among the elderly (age 65 and over).



7. Elderly adults have rates of suicide close to 50% higher than that of the nation as a whole (all ages).

1 December 2004

8. Youth (ages 15-24) suicide rates increased more than 200% from the 1950's to the late 1970's. From the late 1970's to the mid 1990's, suicide rates for youth remained stable and, more recently, have slightly decreased.

9. Suicide ranks third as a cause of death among young (15-24) Americans behind accidents and homicides.

10. Firearms remain the most commonly utilized method of completing suicide by essentially all groups. More than half (54%) of the individuals who took their own lives in 2002 used this method. Both African American and Caucasian males used it more often than their female counterparts.

11. Although firearms were the most frequently used method of suicide by African American females, the most common method of suicide for all females was poisoning, In fact, poisoning has surpassed firearms for female suicides since 2001.

12. The Caucasian population (12.3 per 100,000) has higher rates of completed suicides than the African American population (5.2 per 100,000).

13. Native Americans (American Indians) are the racial/ethnic group with the highest overall suicide rate, but large variations exist among tribal groups.

14. Suicide rates have traditionally decreased in times of war and increased in times of economic crises.

15. Suicide rates are the highest among the divorced, separated, and widowed and lowest among the married.

Research Findings

- Although there are no official statistics on attempted suicide (e.g., non-fatal actions) it is generally estimated that there is 25 attempts for each death by suicide.

- Risk of attempted (nonfatal) suicide is greatest among females and the young.

- Females have generally been found to make 3 times as many attempts as males.

- Ratios of attempted to completed suicides for youth are estimated to range between 100 to 1 and 200 to 1.

- Mental health diagnoses are generally associated with a higher rate of suicide. Psychological autopsy studies reflect that more than 90% of completed suicides had one or more mental disorders.

- Diagnosis groups are at particular risk include: depression, schizophrenia, drug and/or chemical dependency and conduct disorders (in adolescence).

- There is a relationship between depression and suicide; the risk of suicide is increased to more than 50 percent in depressed individuals. On average about 60 percent of suicides were depressed.

- There is a relationship between alcoholism and suicide; the risk of suicide in alcoholics is 50 to 70 percent higher than the general population.

- Feelings of hopelessness (e.g., there is no solution to my problem) are found to be more predictive of suicide risk than a diagnoses of depression per se.

- Socially isolated individuals are generally found to be at a higher risk for suicide.

- The vast majority of individuals who are suicidal often display clues and warning signs.

- Individuals may display one or more of the problems or "signs" detailed below. The following list describes some potential factors of risk for suicide. If observed, a professional evaluation is strongly recommended:

    - Presence of a psychiatric disorder (e.g., depression, drug or alcohol, behavior disorders, conduct disorder [e.g., runs away or has been incarcerated]).

    - The expression/communication of thoughts of suicide, death, dying or afterlife (in a context of sadness, boredom, hopelessness or negative feelings).

    - Impulsive and aggressive behavior; frequent expressions of rage.

    - Increase use of alcohol or drugs.

    - Recent severe stressor (e.g., difficulties in dealing with sexual orientation; unplanned pregnancy, significant real or anticipated loss; etc.).

    - Family instability; significant family conflict.

Other Issues

- The designation of "survivor of suicide" refers to the family members and friends who remain alive following the death of their loved one by suicide.

- Although the number of survivors is difficult to calculate, conservative estimates indicate that there are six survivors for every completed suicide. Based on data from 1977 to 2002, we can estimate that the number of survivors in the U.S. is approximately 4.64 million; close to 190,000 survivors of suicide were included in 2002.

Sources

The information for this fact sheet was gathered from the National Vital Statistics Reports on the National Center for Health Statistics website (http://www.cdc.gov/nchs/Default.htm) run by the Center for Disease Control and Prevention. Unless specified otherwise, information presented refers to the latest available data (i.e. 2002).

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

American Association for Suicidology
5221 Wisconsin Avenue, N. W.
Washington, D.C. 20015
Phone: (202) 237-2280
Fax: *(202) 237-2282*
Email: info@suicidology.org
Website: www.suicidology.org

AMERICAN ASSOCIATION OF SUICIDOLOGY

Dedicated to the Understanding and Prevention of Suicide

Understanding and Helping the Suicidal Individual

BE AWARE OF THE WARNING SIGNS

Are you or someone you love at risk of suicide? Get the facts and take appropriate action.

Get help immediately by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral should you witness, hear, or see anyone exhibiting any one or more of the following:

- Someone threatening to hurt or kill him/herself, or taking of wanting to hurt or kill him/herself.
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means.
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person.

Seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral should you witness, hear, or see anyone exhibiting any one or more of the following:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

BE AWARE OF THE FACTS

1. Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems.
2. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them.
3. Talking about suicide does not cause someone to be suicidal.
4. Approximately 32,000 Americans kill themselves every year. The number of suicide attempts is much greater and often results in serious injury.
5. Suicide is the third leading cause of heath among young people ages 15-24, and it is the eighth leading cause of death among all persons.
6. Youth (15-24) suicide rates increased more than 200% from the 1950's to the late 1970's. Following the late 1970's, the rates for youth suicide have remained stable.

7. The suicide rate is higher among the elderly (over 65) than any other age group.
8. Four times as many men kill themselves as compared to women, yet three times as many women attempt suicide as compared to men.
9. Suicide cuts across all age, economic, social, and ethnic boundaries.
10. Firearms are currently the most utilized method of suicide by essentially all groups (male, female, young, old, white, non-white).
11. Surviving family members not only suffer the trauma of losing a loved one to suicide, and may themselves be at higher risk for suicide and emotional problems.

WAYS TO BE HELPFUL TO SOMEONE WHO IS THREATENING SUICIDE

1. Be aware. Learn the warning signs.
2. Get involved. Become available. Show interest and support.
3. Ask if he/she is thinking about suicide.
4. Be direct. Talk openly and freely about suicide.
5. Be willing to listen. Allow for expression of feelings. Accept the feelings.
6. Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life.
7. Don't dare him/her to do it.
8. Don't give advice by making decisions for someone else to tell them to behave differently.
9. Don't ask 'why'. This encourages defensiveness.
10. Offer empathy, not sympathy.
11. Don't act shocked. This creates distance.
12. Don't be sworn to secrecy. Seek support.
13. Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don't understand.
14. Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

BE AWARE OF FEELINGS, THOUGHTS, AND BEHAVIORS

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work
- Can't get out of the depression
- Can't make the sadness of away
- Can't see the possibility of change
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't see to get control

TALK TO SOMEONE – YOU ARE NOT ALONE

CONTACT:

- A community mental health agency
- A school counselor or psychologist
- A suicide prevention/crisis intervention center
- A private therapist
- A family physician
- A religious/spiritual leader

American Association of Suicidology
5521 Wisconsin Avenue, NW
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2280
Email: info@suicidology.org
Website: www.suicidology.org

AMERICAN ASSOCIATION OF SUICIDOLOGY
Dedicated to the Understanding and Prevention of Suicide

Youth[1] Suicide Fact Sheet

- In 2002, suicide ranked as the third leading cause of death for young people (ages 15-19 and 15-24); only accidents and homicides occurred more frequently.

- Whereas suicides accounted for 1.3% of all deaths in the U.S. annually, they comprised 12.7% of all deaths among 15-24 year olds.

  Each year, there are approximately 10 youth suicides for every 100,000 youth.

  Each day, there are approximately 11 youth suicides.

  Every 2 hours and 11 minutes, a person under the age of 25 completes suicide.

- In 2002, 31,655 people completed suicide. Of these, 4,010 were completed by people between the ages of 15 and 24.

- Suicide rates, for 15-24 year olds, have more than doubled since the 1950's, and remained largely stable at these higher levels between the late 1970's and the mid 1990's. They have declined 25.6% since 1995.

- In the past 60 years, the suicide rate has quadrupled for males 15 to 24 years old, and has doubled for females of the same age (CDC, 2002).

- Suicide rates for those 15-19 years old increased 19% between 1980 and 1994. Since the peak in 1994 with 11.0 suicides per 100,000, there has been a 33% decrease. In 2002, the rate was 7.4 per 100,000.

- Males between the ages of 20 and 24 were 6 times more likely than females to complete suicide. Males between 15 and 19 were 5 times more likely than females to complete suicide (2002 data).

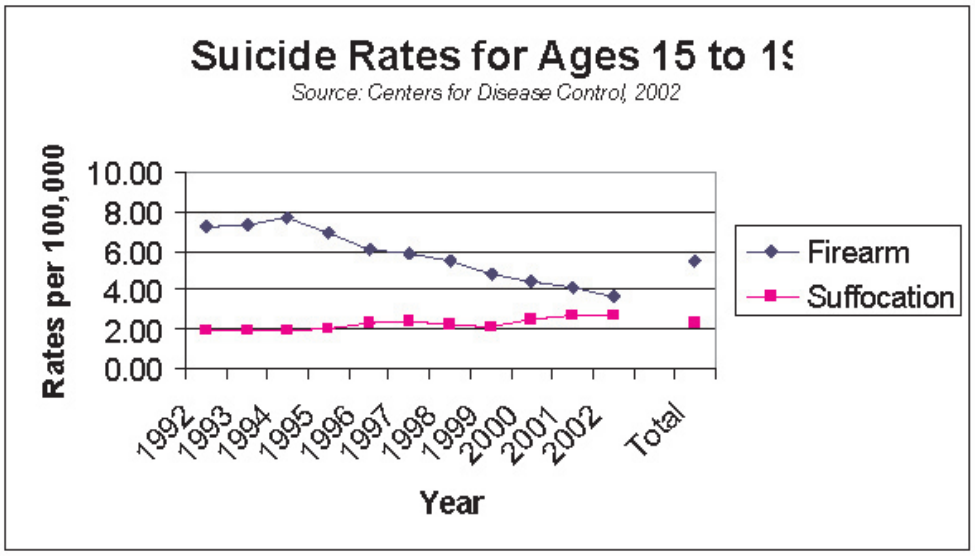
	Males	Females	Both genders
Ages 15 to 19	12.2	2.4	7.44
Ages 20 to 24	20.6	3.5	12.28

- Firearms remain the most commonly used suicide method among youth, accounting for 52% of all completed suicides.

[1] In this fact sheet, youth refers to the age groups of 15 to 19 and 20 to 24. Unless otherwise specified, information presented refers to the latest available data (i.e., 2002).

2 December 2004

- In the last decade, for youths aged 15 to 19, the suicide rate by firearm decreased (from 7.3 in 1992 to 3.7 in 2002); correspondingly, suicide rates by suffocation increased (from 1.9 in 1992 to 2.7 in 2002). Firearms remain the most commonly used method.



- Research has shown that the access to and the availability of firearms is a significant factor in observed increases in rates of youth suicide. Guns in the home are deadly to its occupants!

- For every completed suicide by youth, it is estimated that 100 to 200 attempts are made. Based on the 2003 Youth Risk Behavior Surveillance Survey, 8.5% of students in grades 9 through 12 reported making an attempt at suicide in the previous 12 months (11.5% female and 5.4% male). These percentages decreased from grades 9 (10.1%) to 12 (6.1%). A prior suicide attempt is an important risk factor for an eventual completion. In fact, according to the YRBSS, 16.9% of students seriously considered attempting suicide in the previous 12 months and 16.5% of students made plans for an attempt (2003).

Suicide Among Children

- In 2002, 260 children ages 10 to 14 completed suicide in the U.S.

- Suicide rates for those between the ages of 10-14 increased 99% between 1980 and 1997. This age group has shown a 21% decrease since 1997. For 2002, the rate is 1.2 per 100,000.

- Although their rates are lower than for Caucasian youth, African American youth (ages 10-14) showed the largest increase in suicide rates between 1980 and 1995 (233%). The rate for African American males ages 10-14 was 1.6 per 100,000 in 2002.

- In the 10 to 14 age group, Caucasian youths (ranked 3rd leading cause of death) were far more likely to complete suicide than African American youths (ranked 7th leading cause of death). Caucasian males between 10 and 14 years of age were three times more likely to complete suicide than Caucasian females of the same age.

- The trend of methods used by children has followed a similar pattern to that of youths 15 to 19 years old. Since 1992, suicide by firearm decreased and suicide by suffocation increased. Suicides by suffocation among 10 to 14 year olds have occurred more frequently than those by firearms since 1999.

Other factors

- Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- Although rates vary somewhat by geographic location, within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- The typical profile of an adolescent nonfatal suicide attempter is a female who ingests pills, while the profile of the typical completer suicide is a male who dies from a gunshot wound.
- Not all adolescent attempters may admit their intent. Therefore, any deliberate self-harming behaviors should be considered serious and in need of further evaluation.
- *Most* adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- Repeat attempters (those making more than one nonfatal attempt) generally use their behavior as a means of coping with stress and tend to exhibit more chronic symptomology, poorer coping histories, and a higher presence of suicidal and substance abusive behaviors in their family histories.
- Many teenagers may display one or more of the problems or "signs" detailed below. The following list describes some potential factors of risk for suicide among youth. If observed, a professional evaluation is strongly recommended:

Presence of a psychiatric disorder (e.g., depression, drug or alcohol, behavior disorders, conduct disorder [e.g., runs away or has been incarcerated]).

The expression/communication of thoughts of suicide, death, dying or the afterlife (in a context of sadness, boredom, hopelessness or negative feelings).

Impulsive and aggressive behavior; frequent expressions of rage.

Increasing use of alcohol or drugs.

Exposure to another's suicidal behavior.

Recent severe stressor (e.g., difficulties in dealing with sexual orientation; unplanned pregnancy, significant real or anticipated loss, etc.).

Family instability; significant family conflict.

Sources

The information for this portion of the fact sheet was gathered from the National Center for Injury Prevention and Control (NCIPC) website (www.cdc.gov/ncipc/wisqars/default.htm), a division of the Center for Disease Control and Prevention (CDC), and the Morbidity and Mortality Weekly Reports (May 21, 2004, 53 (SS-2); June 11, 2004, 53(4), p. 471-474).

Suicide Among College Students

- The rate of completed suicide for college students, according to a major study of suicides on Big Ten college campuses (1997) was 7.5 per 100,000.

- It is estimated that there are more than 1,000 suicides on college campuses per year.

- One in 12 college students have made a suicide plan.

- In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.

    - 9.5% of students had seriously contemplated suicide.
    - 1.5% have made a suicide attempt.
    - In the twelve month period prior to the survey, half of the sample reported feeling very sad, one third reported feeling hopeless and 22% reported feeling so depressed as to not be able to function.
    - Of the 16,000 students surveyed, only 6.2% of males and 12.8% of females reported a diagnosis of depression. Therefore, there are a large number of students who are not receiving adequate treatment and/or who remain undiagnosed.

- Of the students who had seriously considered suicide, 94.8% reported feeling so sad to the point of not functioning at least once in the past year, and 94.4% reported feelings of hopelessness.

- Two groups of students might be at higher risk for suicide:
  - Students with a pre-existing (before college) mental health condition, and
  - Students who develop a mental health condition while in college.
  Within these groups, students who are male, Asian and Hispanic, under the age of 21 are more likely to experience suicide ideation and attempts.

- Reasons attributed to the appearance or increase of symptoms/disorders:

    - New and unfamiliar environment;
    - Academic and social pressures;
    - Feelings of failure or decreased performance;
    - Alienation;
    - Family history of mental illness;
    - Lack adequate coping skills;
    - Difficulties adjusting to new demands and different work loads.

- Risk factors for suicide in college students include depression, sadness, hopelessness, and stress.

- As with the general population, depression plays a large role in suicide. “Ten percent of college students have been diagnosed with depression” (NMHA, 2001). “The vast majority of young adults aged 18 and older who are diagnosed with depression do not receive appropriate or even any treatment at all”.

Sources

The information for this portion of the fact sheet was gathered from:

Safeguarding your Students Against Suicide - Expanding the Safety Net: Proceedings from an Expert panel an Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses (2002), a report co-sponsored by the National Mental Health Association (NMHA) and the Jed Foundation.

Suicide Prevention Resource Center. (2004). *Promoting Mental Health and Preventing Suicide in College and University Settings*. Newton, MA: Education Development Center, Inc.

The Jed Foundation and the National Mental Health Association websites.

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

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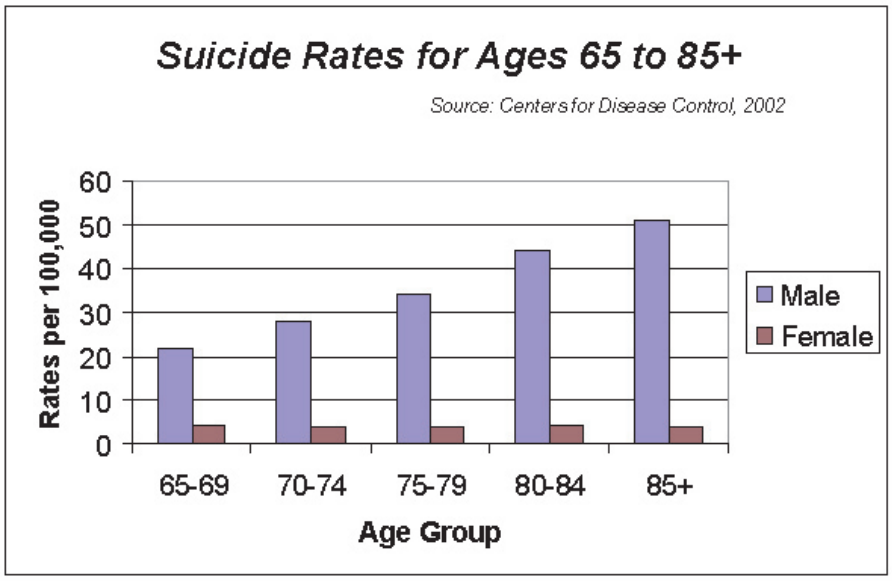
Elderly[1] Suicide Fact Sheet

- The elderly made up 12.3% of the population; they accounted for almost 17.5% of all suicides.
- The rate of suicide for the elderly for 2002 was 15.6 per 100,000.
- There was one elderly suicide every 95 minutes. There were about 15 elderly suicides each day, resulting in 5,548 suicides in 2002 among those 65 and older.
- Elderly white men were at the highest risk with a rate of approximately 35 suicides per 100,000 each year.
- White men over the age of 85, who are "old-old", were at the greatest risk of all age-gender-race groups. In 2002, the suicide rate for these men was 51.1 per 100,000. That was 4.6 times the current rate for all ages (11.0 per 100,000).
- 85% of elderly suicides were male; the number of male suicides in late life was 5.5 times greater than for female suicides.



- The rate of suicide for women declined after age 60 (after peaking in middle adulthood, ages 45-49).

[1] In this fact sheet, elderly refers to persons over the age of 65. Unless otherwise specified, information presented refers to the latest available data (i.e., 2002 data).

1 December 2004

- The suicide rate for the elderly reached a peak in 1987 at 21.8 per 100,000 people. Since 1987, the rate of elderly suicides has declined 28% (down to 15.6 in 2002). This is the largest decline in suicide rates among the elderly since the 1930's.

- Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate. For all ages combined, there is an estimated 1 suicide for every 25 attempts. Among the young (15-24 years) there is an estimated 1 suicide for every 100-200 attempts. Over the age of 65, there is one estimated suicide for every 4 attempts.

- In 2002, suicide rates ranged from 13.5 per 100,000 among persons aged 65 to 74, to 17.7 per 100,000 persons aged 75 to 84.

- Firearms were the most common means (72%) used for completing suicide among the elderly. Men (79%) use firearms more than twice as often as women (33%).

- Alcohol or substance abuse plays a diminishing role in later life suicides compared to younger suicides.

- One of the leading causes of suicide among the elderly is depression, often undiagnosed and/or untreated.

- The act of completing suicide is rarely preceded by only one cause or one reason. In the elderly, common risk factors include:

    - The recent death of a loved one;
    - Physical illness, uncontrollable pain or the fear of a prolonged illness;
    - Perceived poor health;
    - Social isolation and loneliness;
    - Major changes in social roles (e.g. retirement).

Sources

The information for this fact sheet was gathered from the National Center for Injury Prevention and Control (NCIPC) website (http://www.cdc.gov/ncipc/wisqars/default.htm) run by the Center for Disease Control and Prevention (CDC).

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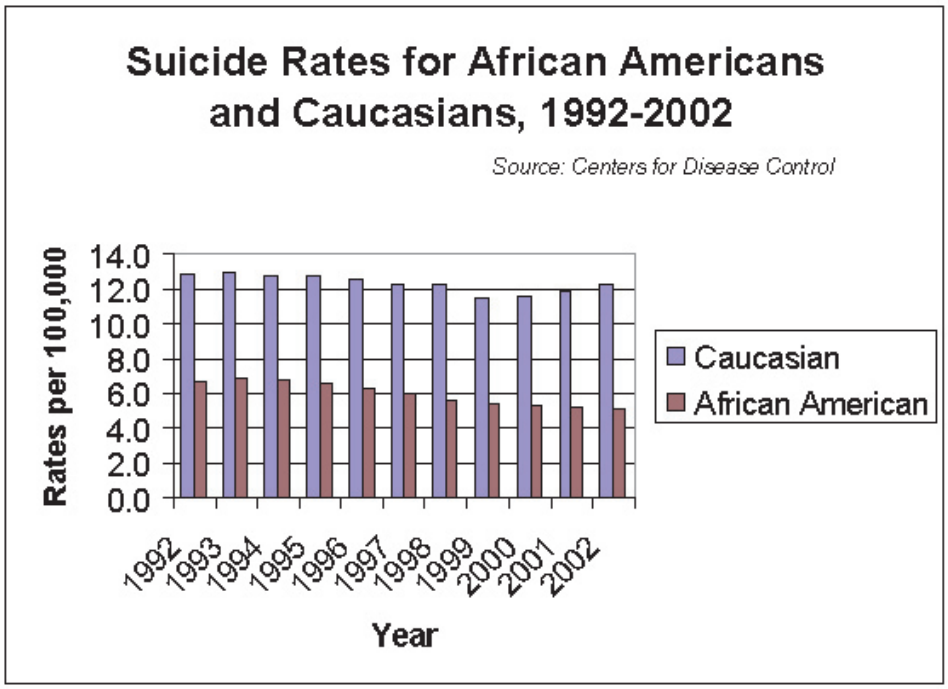
African American Suicide Fact Sheet[1]

- In 2002, 1,939 African Americans completed suicide in the U.S. Of these, 1,633 (84%) were males (rate of 9.1 per 100,000). The suicide rate for females was 1.6 per 100,000.

- In 2002, there were only 306 African American female suicides. The ratio of African American male to female was 5.34 to 1. The suicide rate among African American females was the lowest of all racial/ gender groups.

- As with all racial groups, African American females were more likely than males to attempt suicide and African American males were more likely to complete suicide.

- From 1993 to 2002, the rate of suicide for African Americans (all ages) showed a small but steady decline (from 6.9 in 1993 to 5.2 in 2002). For Caucasians, the rate declined until 1999 (from 13.0 in 1993 to 11.5 in 2009), and then increased slightly since 2000 (see graph below).



- Suicide was the third leading cause of death among African American youth, after homicides and accidents. The suicide rate for young African American youth was 6.5 per 100,000 (n = 403).

- For African American youth[2], the rate of male suicide (11.3 per 100,000) was 6.6 times higher than that of females (1.7 per 100,000).

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[2] In this fact sheet, unless otherwise specified, the information presented refers to the latest available data (i.e., 2002 data).

[2] The term 'youth' refers to individuals 15 to 24 years of age.

December 7, 2004

- African American youth suicide rates were generally low until the beginning of the 1980's when rates started to increase radically. Between 1981 and 1994, the rate increased 78%. Since then, the rate has decreased 43%, from 11.48 in 1994 to 6.5 in 2002.

- Although Caucasian youth are twice as likely as African American youth to complete suicide, the rate of suicide grew faster in this time period among African American youth than among Caucasian youth.

- From 1981-1994, the suicide rate increased 83% for 15-24 year old African American males and 10% for African American females. Since 1994, the rates for males have decreased 45%.

- Males accounted for 86.5% of African American elderly (65 and older) suicides.

- Firearms were the predominant method of suicide among African Americans regardless of gender and age; among 15 to 24 year olds, 63% of all suicides were by firearm, among 24 to 35 year olds, 54% of all suicides were by firearm, and among those 65 and older, 74% of all suicides were by firearm.

Proportion of African American Suicides by Firearm, 2002

	Both genders	Males	Females
All ages	55%	59%	38%
15-24	63%	67%	40%
25-34	54%	58%	36%
65 and older	74%	79%	38%

Things We Can Do to Help:

- Help remove the stigma and myths that suicide contradicts gender and cultural role expectations:
  - Religious stigma of suicide as the "unforgivable sin";
  - African American men are macho and do not take their own lives;
  - African American women are always strong and resilient and never crack under pressure.
- Remove barriers to treatment.
- Improve access to mental health treatment.
- Remove stigma associated with mental health treatment.
- Increase awareness in cultural differences in the expression of suicidal behaviors:
  - African American are less likely to use drugs during a suicide crisis;
  - Behavioral component of depression in African Americans is more pronounced;
  - Some African Americans express little suicide intent or depressive symptoms during suicidal crises;

- Develop liaisons with the faith community.
- Recognize warning signs and help a friend or family member get professional help.

Warning Signs of a Suicidal Person:

A suicidal person may:

- Threaten to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself;
- Look for ways to kill him/herself by seeking access to firearms, pills or other means;
- Talk or write about death, dying or suicide when these actions are out of the ordinary for that person;
- Express a sense of hopelessness;
- Experience rage, uncontrolled anger, and seek revenge

- Act reckless or engage in risky behavior and activities, seemingly without thinking;
- Feel trapped, that there's no way out;
- Increase alcohol or drug use;
- Withdraw from friends, family and society;
- Feel anxious, agitated, and experience an increase or decrease in the amount of sleep;
- Experience dramatic mood changes;
- Feel that there is no reason to live, that live no longer has a sense of purpose.

If you or someone you know is suicidal,
please contact a mental health professional
or call 1-800-273-TALK (8255).

For More Information:

American Association of Suicidology
www.suicidology.org
National Organization for People for Color Against Suicide
www.nopcas.com
National Center for Injury Prevention and Control
www.cdc.gov/ncipc/wisqars

Sources

The information for this fact sheet was gathered from the National Center for Injury Prevention and Control (NCIPC) website (www.cdc.gov/ncipc/wisqars/default.htm) run by the Center for Disease Control and Prevention (CDC), the National Institute of Mental Health website (www.nimh.nih.gov/) as well as the National Organization for People of Color Against Suicide (NOPCAS) website (www.nopcas.com).

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FACTS ABOUT SUICIDE

In 2002, suicide was the eleventh leading cause of death in the U.S., claiming 31,655 lives. Suicide rates among youth (ages 15-24) have increased more than 200% in the last fifty years. The suicide rate is highest for the elderly (ages 65+) than for any other age group.

Four times more men than women complete suicide, but three times more women than men attempt suicide.

Suicide occurs across all ethnic, economic, social and age boundaries.

Many suicides are preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems. Most suicidal people give definite warning signals of their suicidal intentions, but those in close contact are often unaware of the significance of these warnings or unsure what to do about them.

Talking about suicide does not cause someone to become suicidal.

Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk for suicide and emotional problems.

WHAT IS DEPRESSION?

Major Depressive Disorder (MDD) is the most prevalent mental health disorder. In the U.S., the lifetime risk for MDD is 16.6% according to a recent study (Kessler et al., 2005). According to the National Institute of Mental Health (NIMH), 9.5-% or 18.8 million American adults suffer from a depressive illness in any given year.

The symptoms of depression (listed below) interfere with one's ability to function in all areas of life (work, family, sleep, etc).

Common symptoms of depression, reoccurring almost every day for a period of two weeks or more:

- Depressed mood (e.g. feeling sad or empty)
- Lack of interest in previously enjoyable activities
- Significant weight loss or gain, or decrease or increase in appetite
- Insomnia or hypersomnia
- Agitation, restlessness, irritability
- Fatigue or loss of energy
- Feelings of worthlessness, hopelessness, guilt
- Inability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or plan for completing suicide

A family history of depression (e.g., a parent) increases the chances (11-fold) that a child in that family will also have depression.

The treatment of depression is effective 60 to 80% of the time. However, according to the World Health Organization (WHO), less than 25% of individuals with depression receive adequate treatment.

Depression often is accompanied by co-morbid (co-occurring) mental disorders (such as alcohol or substance abuse) and, if left untreated, can lead to higher rates of recurrent episodes and higher rates of suicide.

THE LINK BETWEEN DEPRESSION AND SUICIDE

Suicide is the major life-threatening complication of depression.

Major Depressive Disorder (MDD) is the psychiatric diagnosis most commonly associated with completed suicide. Lifetime risk of suicide among patients with untreated MDD is nearly 20% (Gotlib & Hammen, 2002).

About 2/3 of people who complete suicide are depressed at the time of their deaths.

In a study conducted in Finland, of 71 individuals who completed suicide and who had Major Depressive Disorder, only 45% were receiving treatment at the time of death and only a third of these were taking antidepressants (Isometsa et al., 1994).

About 7 out of every 100 men and 1 out of every 100 women who have been diagnosed with depression at some time in their lifetime will go on to complete suicide.

The risk of suicide in people with Major Depressive Disorder is about 20 times that of the general population.

Individuals who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.

People who have a dependence on alcohol or drugs in addition to being depressed are at greater risk for suicide.

Individuals who are depressed and exhibit the following symptoms are at particular risk for suicide:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – as if there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, inability to sleep or sleeping all the time
- Dramatic mood changes
- Expressing no reason for living; no sense of purpose in life

TREATMENT

The most commonly used treatments for depression are:

- Pharmacology (i.e. antidepressants)
- Psychotherapy
- Electroconvulsive Therapy (ECT)

The best treatment for depression is the combination of antidepressants and psychotherapy. A meta-analysis of 16 studies (Pampallona et al., 2004) demonstrated the advantages of combined treatment versus pharmaceutical treatment alone. One hypothesis is that therapy increases adherence to the antidepressant treatment.

Treatments are effective 60 to 80% of the time. The Collaborative Depression Study indicates that after a first episode, 70% recovered within 5 years (National Institute of Mental Health).

In summary…

- Risk benefit ratio clearly resides on the side of treatment as opposed to no treatment for depression.
- The best treatment is combined pharmacology and psychotherapy.
- Most suicides in individuals with Major Depressive Disorder are among those who do not receive treatment.
- We still know too little about those who don't improve despite adequate treatment.
- More clinical research is needed.

ANTIDEPRESSANTS and SUICIDE RISK

In short-term studies, there has been some evidence that children and adolescents taking antidepressants exhibit a risk of increased suicidal ideation and/or suicidal behaviors (suicidality). Given this, the concern is that antidepressants could potentially lead to completed suicides.

The U.S. Food and Drug Administration (FDA) analyzed 24 trials that included over 4400 patients and concluded that the risk of suicidality in children and adolescents who were prescribed antidepressants was 4%, twice the placebo risk of 2% (www.fda.gov).

As with any new prescription in children and adolescents, careful monitoring of symptoms and side-effects should be observed by an adult. Any changes in symptomatology should be reported to the prescribing physician.

More research is required to determine if antidepressants are related to suicidality in children, adolescents and adults.

FDA 'BLACK BOX' WARNINGS

The Food and Drug Administration (FDA) is now requiring manufacturers of antidepressants to add a 'black box' warning label describing the potential risks of suicidality and the need for close monitoring of anyone prescribed this type of pharmacotherapy.

As well, the FDA developed a Patient Medication Guide (MedGuide), a user-friendly guide intended to educate patients and their caregivers about their prescription.
A joint meeting of the Psychopharmacologic Drugs Advisory Committee and the Pediatric Drugs Advisory Committee in September 2004 analyzed the short-term placebo-controlled trials of nine antidepressant drugs. The results demonstrated "a greater risk of suicidality during the first few months of treatment of those receiving antidepressants, the average risk of such events on drug was 4%, twice the placebo risk of 2%. No suicides occurred in these trials" (www.fda.gov). Based on these findings, the FDA issued the following warnings (the 'black box' warnings) regarding antidepressants:

- ☐ Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with MDD (Major Depressive Disorder) and other psychiatric disorders.
- ☐ Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with the clinical need.
- ☐ Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.
- ☐ Families and caregivers should be advised to closely observe the patient and to communicate with the prescriber.

All patients being treated with antidepressants should be closely monitored for any changes in symptoms especially at the beginning of treatment or when the dose is adjusted up or down.

For more information on the FDA warnings, please visit their website (http://www.fda.gov/).

BE AWARE OF FEELINGS, THOUGHTS, AND BEHAVIORS

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis they are experiencing is temporary, but death in not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

Can't stop the pain
Can't think clearly
Can't make decisions
Can't see any way out
Can't sleep, eat, or work
Can't get out of the depression
Can't make the sadness go away
Can't see the possibility of change
Can't see themselves as worthwhile
Can't get someone's attention
Can't seem to get control

If you experience any of these feelings, get help!

If you know someone who exhibits these feelings, offer help!

TALK TO SOMEONE -- YOU ARE NOT ALONE. CONTACT:

- A community mental health agency
- A school counselor or psychologist
- A suicide prevention/crisis intervention center
- A private therapist
- A family physician
- A religious/spiritual leader

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References:

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Isometsa, E. T., Aro, H. M., Henriksson, M. M., Heikkinen, M. E., & Lonnquist, J. K. (1994). Suicide in major depression in different treatment settings. *Journal of Clinical Psychiatry, 55* (12), p. 523-527.

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Pampallona, S., Bollini, P., Tibaldi, G., Kupelnick, B., & Munizza, C. (2004). Combined pharmacotherapy and psychological treatment for depression: A systematic review. *Archives of General Psychiatry, 61* (7), p. 714-719.

Websites:

National Institute of Mental Health (http://www.nimh.nih.gov/)
U.S. Food & Drug Administration (http://www.fda.gov/)

AMERICAN ASSOCIATION OF SUICIDOLOGY
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Survivors of Suicide Fact Sheet

A survivor of suicide is a family member or friend of a person who died by suicide.

Some Facts…

Survivors of suicide represent "the largest mental health casualties related to suicide" (Edwin Shneidman, Ph.D., AAS Founding President).

There are currently almost 32,000 suicides annually in the USA. It is estimated that for every suicide there are at least 6 survivors. Some suicidologists believe this to be a very conservative estimate.

Based on this estimate, approximately 5 million American became survivors of suicide in the last 25 years.

About Suicidal Grief

The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex, and long term. Grief work is an extremely individual and unique process; each person will experience it in their own way and at their own pace.

Grief does not follow a linear path. Furthermore, grief doesn't always move in a forward direction.

There is no time frame for grief. Survivors should not expect that their lives will return to their prior state. Survivors aim to adjust to life without their loved one.

Common emotions experienced in grief are:

Shock	Denial	Pain
Guilt	Anger	Shame
Despair	Disbelief	Hopelessness
Stress	Sadness	Numbness
Rejection	Loneliness	Abandonment
Confusion	Self-blame	Anxiety
Helplessness	Depression	

These feelings are normal reactions and the expression of them is a natural part or grieving. At first, and periodically during the following days/months of grieving, survivors may feel overwhelmed by their emotions. It is important to take things one day at a time.

Crying is the expression of sadness; it is therefore a natural reaction after the loss of a loved one.

Survivors often struggle with the reasons why the suicide occurred and whether they could have done something to prevent the suicide or help their loved one. Feelings of guilt typically ensue if the survivor believes their loved one's suicide could have been prevented.

At times, especially if the loved one had a mental disorder, the survivor may experience relief.

There is a stigma attached to suicide, partly due to the misunderstanding surrounding it. As such, family members and friends of the survivor may not know what to say or how and when to provide assistance. They may rely on the survivor's initiative to talk about the loved one or to ask for help.

Shame or embarrassment might prevent the survivor from reaching out for help. Stigma, ignorance and uncertainty might prevent family and friends from giving the necessary support and understanding. Ongoing support remains important to maintain family and friendship relations during the grieving process.

Survivors sometimes feel that others are blaming them for the suicide. Survivors may feel the need to deny what happened or hide their feelings. This will most likely exacerbate and complicate the grieving process.

When the time is right, survivors will begin to enjoy life again. Healing does occur.

Many survivors find that the best help comes from attending a support group for survivors of suicide where they can openly share their own story and their feelings with fellow survivors without pressure or fear of judgment and shame. Support groups can be a helpful source of guidance and understanding as well as a support in the healing process.

Children as Survivors

It is a myth that children don't grieve. Children may experience the same range of feelings as do adults; the expression of that grief might be different as children have fewer tools for communicating their feelings.

Children are especially vulnerable to feelings of guilt and abandonment. It is important for them to know that the death was not their fault and that someone is there to take care of them.

Secrecy about the suicide in the hopes of protecting children may cause further complications. Explain the situation and answer children's questions honestly and with age-appropriate responses.

American Association of Suicidology

The American Association of Suicidology (AAS) offers a variety of resources and programs to survivors in an attempt to lessen the pain as they travel their special path of grief. These include:

- Survivors of Suicide Kit: an information kit consisting of fact sheets, a bibliography and sample literature.
- *Survivors of Suicide: Coping with the Suicide of a Loved One* booklet and *A Handbook for Survivors of Suicide*.
- *Surviving Suicide*, a quarterly newsletter for survivors and survivor support groups.
- "Healing After Suicide", an annual conference held every April, for and about survivors.
- Suicide Prevention and Survivors of Suicide Resource Catalog: a listing of books, pamphlets, etc. which can be ordered from AAS. Includes resources for children and those who care for them.
- Directory of Survivors of Suicide Support Groups – print version available for purchase and an online version available at www.suicidology.org.
- Guidelines for Survivors of Suicide Support Groups: a how-to booklet on starting a support group.

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Email: info@suicidology.org
Website: www.suicidology.org

Additional Resources

- American Foundation for Suicide Prevention (AFSP) (www.afsp.org).
- Survivors of Suicide (www.survivorsofsuicide.com).
- The Link National Resource Center (www.thelink.org).

AMERICAN ASSOCIATION OF SUICIDOLOGY
Dedicated to the Understanding and Prevention of Suicide

Helping Survivors of Suicide: What Can You Do?

The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex and long term. Grief and bereavement are an extremely individual and unique process.

There is no given duration to being bereaved by suicide. Survivors of suicide are not looking for their lives to return to their prior state because things can never go back to how they were. Survivors aim to adjust to live without their loved one.

Common emotions experienced with grief are:

Shock	Denial
Pain	Numbness
Anger	Shame
Dispair	Disbelief
Depression	Stress
Sadness	Guilt
Rejection	Loneliness
Abandonment	Anxiety

The single most important and helpful thing you can do as a friend is listen. Actively listen, without judgment, criticism, or prejudice, to what the survivor is telling you. Because of the stigma surrounding suicide, survivors are often hesitant to openly share their story and express their feelings. In order to help, you must overcome any preconceptions you have about suicide and the suicide victim. This is best accomplished by educating yourself about suicide. While you may feel uncomfortable discussing suicide and its aftermath, survivor loved ones are in great pain and in need of your compassion.

Ask the survivor if and how you can help. They may not be ready to share and may want to grief privately before accepting help.

Let them talk at their own pace; they will share with you when (and what) they are ready to.

Be patient. Repetition is a part of healing, and as such you may hear the same story multiple times. Repetition is part of the healing process and survivors need to tell their story as many times as is necessary.

Use the loved one's name instead of 'he' or 'she'. This humanizes the decedent; the use of the decedent's name will be comforting.

You may not know what to say, and that's okay. Your presence and unconditional listening is what a survivor is looking for.

August 20, 2004

You cannot lead someone through their grief. The journey is personal and unique to the individual. Do not tell them how they should act, what they should feel, or that they should feel better "by now".

Avoid statements like "I know how you feel"; unless you are a survivor, you can only empathize with how they feel.

Survivors of suicide support groups are helpful to survivors to express their feelings, tell their story, and share with others who have experienced a similar event. These groups are good resources for the healing process and many survivors find them helpful. Please consult our website (www.suicidology.org) for a listing of support groups in or near your community.

The American Association of Suicidology (AAS) offers a variety of resources and programs to survivors in an attempt to lessen the pain as they travel their special path of grief. These include:

- Survivors of Suicide Kit: an information kit consisting of fact sheets, a bibliography, and sample literature.
- *Survivors of Suicide: Coping with the Suicide of a Loved One* booklet and *A Handbook for Survivors of Suicide*.
- *Surviving Suicide*, a quarterly newsletter for survivors and survivor support groups.
- "Healing After Suicide", an annual conference held every April, for and about survivors.
- Suicide Prevention and Survivors of Suicide Resource Catalog: a listing of books, pamphlets, etc. which can be ordered from AAS. Includes resources for children and those who care for them.
- Directory of Survivors of Suicide Support Groups – print version available for purchase and an online version available at www.suicidology.org.
- Guidelines for Survivors of Suicide Support Groups: a how-to booklet on starting a support group.

Additional Resources

- Survivors of Suicide (www.survivorsofsuicide.com).
- Suicide Awareness: Voices of Education (SAVE) (www.save.org).
- American Foundation for Suicide Prevention (AFSP) (www.afsp.org).

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

American Association of Suicidology
5221 Wisconsin Avenue, N. W.
Second Floor
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
Email: info@suicidology.org
Website: www.suicidology.org

Part D. American Association of Suicidology

General Information

What is the American Association of Suicidology?

- Edwin S. Shneidman, Ph.D. in Los Angeles, founded AAS in 1968.
- AAS is a non-profit organization devoted to suicide research, education, clinical practice, suicide prevention programming, and services for those who have survived the loss of a loved one.
- AAS is comprised of some 1,200 individual and organizational members.
- Alan L. Berman, Ph.D., Executive Director of AAS, has more than 25 years experience as a suicidologist-clinician, researcher, and educator. He has published widely and serves as a national spokesperson and advocate for suicide prevention, especially focused on youth.
- AAS' Annual Conference is the only annual, national forum for the presentation of state-of-the-art research and professional training in suicidology. Similarly, AAS' Healing After Suicide Conference annually provides support and resources for hundreds of survivors of suicide.
- Over 85% of AAS' annual funding goes directly to program support and development; administrative expenses are less than 15%.

AAS Exists to Promote:

- Early detection and treatment for those in suicidal despair.
- Prevention programs to forestall the potential for suicidal despair.
- Research to better understand those at risk for suicidal despair.
- Better service delivery by crisis services and professionals positioned to intervene and help those in suicidal despair.
- Support services for those left to suffer a most painful survival after the death of those who complete suicide because we were not there in time to help.

How Your Support Can Help Save Lives:

- Promote programs to restrict access to lethal means by youth.
- Support development of new clinical interventions.
- Provide staffing and resources to increase public awareness.
- Develop programs to build resiliency and coping skills among at-risk youth.
- Increase services to families bereaved by suicide.
- Better educate professionals to recognize and respond to at-risk individuals.

American Association of Suicidology

Membership Information

Suicide Prevention is *Everyone's Business*

The American Association of Suicidology's mission is to understand and prevent suicide as a possible means of promoting human well-being.

Who are we?

We are your peers and colleagues. We are researchers and survivors, crisis workers, clinical and public health program professionals. We are crisis and suicide prevention centers, mental health emergency services, and school districts. We are members of the American Association of Suicidology (AAS). AAS is the only national organization to embrace all of us as members.

What is the AAS?

The AAS is a not-for-profit membership association founded in 1968. AAS's mission is to understand and prevent suicide as a means of promoting human well-being. AAS promotes research, public and media awareness, professional education and gatekeeper training, and suicide prevention programs.

Why are we AAS?

Because approximately 29,000 Americans and more than 750,000 people world-wide annually take their own lives.
Because a much larger number of people make non-fatal suicide attempts each year, often resulting in serious injuries, trauma, and economic loss to society.
Because suicide is a leading cause of death in the United States, typically the third among our young.
Because suicide knows no boundaries; it occurs among the old and the young, the rich and the poor, and people of all cultures, races, and religions.
Because surviving family members and peers suffer great trauma and pain.
Because many suicides are preventable.
Because in partnership and associations, we can make a difference.

What does AAS do?

Since 1968, AAS has sponsored a major annual conference every spring at which state-of-the-art research presentations, training workshops, and networking opportunities are offered. Since 1990, AAS has sponsored a second annual conference, "Healing After Suicide", for and by survivors of a suicide of a family member or other loved one.
AAS publishes the oldest and internationally respected peer-reviewed quarterly journal S*uicide and Life-Threatening Behavior*.
AAS produces and disseminates two quarterly newsletters, a resources guide, fact sheets and current statistics, directories of crisis centers and survivor support groups, standards and guidelines for caregivers and services. AAS serves as both a resource center and clearinghouse of information for those with a need to know.
AAS annually sponsors Suicide Prevention Week.
AAS annually presents awards to outstanding contributors in suicidology, both early career and lifetime contributions; student-conducted research; research in schizophrenia and suicide; for services to the field as a whole; to survivors and to crisis centers; and, for public policy leadership.
Since 1976, AAS has certified crisis services that meet established standards for service delivery. AAS certified centers are actively involved in the National Suicide Prevention Lifeline (1-800-273-TALK (8255)).
AAS educates and trains professionals and care givers to better assess and treat individuals at-risk for suicide.
AAS considers education and training as significant to our mission.

AAS develops and supports committees and task forces to work on special topics in suicidology. Over the years, these have included such diverse topics as: Assisted Suicide and Euthanasia, School Suicide Prevention Guidelines, Suicide and Religion, Clinician Survivors of Suicide, and Hospital Discharge Planning Recommendations.
AAS advocates for public policy and effective suicide prevention. AAS publishes a Consensus Statement on Youth Suicide by Firearms, co-signed by more than 40 national organizations.
AAS contracts with federal agencies, state and community groups to provide services and expertise to meet individual, organizational, and community needs.
AAS mentors young researchers in suicidology.
AAS has had both federal and foundation grants to certify and network more than 250 crisis centers and to evaluate the effectiveness of crisis centers, help develop suicide prevention programs for both the Department of the Navy and the US Army, collaborate in the nation's only Suicide Prevention Research Center in Nevada, create a web-based resource center for prevention program evaluation, and provide training in early onset bipolar disorder and suicide.
AAS supports school and community prevention programs and state suicide prevention planning teams.
AAS publishes *School Suicide Postvention Guidelines*, *Guidelines for Survivor Support Groups*, *Guidelines for Suicide Research*, and *Recommendations for Media Reporting of Suicide*.

Why join AAS?

AAS membership gives you opportunities to be part of the solution.

AAS membership offers you:

☐ Our quarterly journal *Suicide and Life-Threatening Behavior*, featuring current research, case studies, and applied prevention articles.
☐ Our quarterly newsletter *Newslink*, featuring current national and international events and news and intra-association information.
☐ Our quarterly newsletter *Surviving Suicide*, written for and by survivors.
☐ Annual statistical updates.
☐ Suicide Prevention Week Information & Media Kit (organizations only).
☐ Directory of Suicide Prevention and Crisis Centers.

AAS offers you deep discounts to our:

☐ Annual conferences and training workshops.
☐ Publications and resources.
☐ Multiple annual uses of the Suicide Information and Education Center's database.
☐ Individual and organizational certification programs.
☐ Directory of Survivor Suicide Groups.

AAS offers you access to:

☐ A *Member's Only* website page.
☐ Our Listservs.
☐ Network with colleagues.
☐ Collaborate on projects of mutual interest.
☐ Participate on committees, Task Forces, and grant-funded projects.

For any additional information about AAS membership, please contact AAS.

American Association of Suicidology

How do I join AAS?

For Individuals

1. Tell us about you.

I am in the following profession:

☐ clergy ☐ corrections ☐ counseling
☐ education ☐ nursing ☐ psychology
☐ psychiatry ☐ public health ☐ social work
☐ other _____

or a:

☐ volunteer (*Name of Center*) _____
☐ student (*School Attending*) _____
(*Please provide copy of valid student ID*)
☐ survivor _____
(*Please specify nature of loss, e.g., spouse, son…*)

I am most interested in the following interest area(s) (Membership divisions):

☐ clinical ☐ crisis centers
☐ research ☐ survivors
☐ prevention programs (*school, community, state, etc.*)

_____
I learned of AAS from

_____
Your name

_____
Highest Degree

_____
Mailing Address ☐ work ☐ home

_____
Street

_____
City

_____
State/Province, Zip/Postal Code

_____
Country, if not US

_____
Daytime Phone: Evening Phone:

_____
Fax: E-mail:

Your Membership Category and Annual Dues:

☐ Regular (*US and Canada*)	$140.00 US
☐ Fixed Income/Retired	$100.00 US
☐ Student/Volunteer (*includes journal and Surviving Suicide*)	$85.00 US
☐ Student/Volunteer (*includes journal*)	$70.00 US
☐ Student/Volunteer (*without journal*)	$35.00 US
☐ International *Add $10.00 US to relevant fee*	

**All members receive Newslink, the Association newsletter.*

2. Submit Application

☐ Check enclosed (*payable to AAS*) for $_____
☐ Charge $_____ to my: ☐ VISA ☐ MC
Card Number_____
Exp. Date_____
Name on Card_____
Signature_____

3. Return Application

Mail:
AAS
5221 Wisconsin Avenue, NW
Second Floor
Washington, DC 20015
Fax: (*credit card payment only*) (202) 237-2282

Please add $_____ to my dues as a tax-deductible contribution to help AAS continue its work in suicidology and suicide prevention.
This contribution is ☐ in memory or ☐ in honor of _____.

American Association of Suicidology

How do I join AAS?

For Organizations

1. Tell us about you.

_____
Organization Name

_____
Street

_____
City

_____
State/Province, Zip/Postal Code

_____
Country, if not US

_____
Business Phone: Emergency Phone:

_____
Fax: Director's E-mail:

_____
Contact Person's Name and Title

If your organization is a suicide prevention or crisis intervention agency, *please tell us:*
Hours service is available:_____ Days/Week service is available:_____
Services provided: ☐ survivor support groups ☐ attempter support groups
☐ school programs ☐ other:_____

We are most interested in the following area(s) (*membership divisions*):
☐ clinical ☐ crisis centers
☐ research ☐ survivors
☐ prevention programs (*school, community, state, etc.*)

Your Membership Dues (*based on annual organizational revenues*):

Revenues: (In $US)		Dues:	
	< $100,000		$200.00 US
	$100,000 - $199,999		$250.00 US
	$200,000 - $499,999		$350.00 US
	$500,000 - $749,999		$450.00 US
	$750,000 - $999,999		$550.00 US
	$1,000,000 +		$650.00 US

☐ International *Add $10.00 US to relevant fee*

☐ We would like to receive *Surviving Suicide* (*not included in organizational membership dues*). Add $15.00 US to fee above.

2. Submit Application
☐ Check enclosed (*payable to AAS*) for $_____
☐ Charge $_____ to my: ☐ VISA ☐ MC
Card Number_____
Exp. Date_____
Name on Card_____
Signature_____

3. Return Application
Mail:
AAS
5221 Wisconsin Avenue, NW
Second Floor
Washington, DC 20015
Fax: (*credit card payment only*) (202) 237-2282

Please add $_____ to my dues as a tax-deductible contribution to help AAS continue its work in suicidology and suicide prevention.
This contribution is ☐ in memory or ☐ in honor of _____.

Additional Resources

American Foundation for Suicide Prevention (AFSP)
www.afsp.org

Centers for Disease Control and Prevention (CDC)
www.cdc.gov

The Jason Foundation
www.jasonfoundation.com

The Jed Foundation
www.jedfoundation.org

The Links National Resource Center for Suicide Prevention and Aftercare
www.thelink.org

National Center for Injury Prevention and Control (NCIPC)
www.cdc.gov/ncipc/default.htm

National Institute of Health (NIH)
www.nih.gov

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

National Organization for People of Color Against Suicide (NOPCAS)
www.nopcas.com

National Strategy for Suicide Prevention (NSSP)
http://www.mentalhealth.org/suicideprevention/

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org

Office of the Surgeon General
www.surgeongeneral.gov

Organization for Attempters and Survivors of Suicide and Interfaith Services (OASSIS)
www.oassis.org

Samaritans USA
www.samaritansnyc.org

Suicide Awareness Voices of Education (SAVE)
www.save.org

Centre for Suicide Prevention
www.suicideinfo.ca

Suicide Prevention Action Network (SPAN USA)
www.spanusa.org

Suicide Prevention and Research Center (SPRC)
www.sprc.org

Yellow Ribbon Suicide Prevention Program
www.yellowribbon.org

Part E. Articles

Articles

Books:

National strategy for suicide prevention: Goals and objectives for action. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001. (Also available on the web at http://www.mentalhealth.org/suicideprevetion.)

Reducing suicide: A national imperative. Washington, D.C.: Institute of Medicine of the National Academies, 2002.

Articles:

Centers for Disease Control and Prevention (CDC). (2005). Homicide and suicide rates—national violent death reporting system, six states, 2003. *Morbidity and Mortality Weekly Report, 54,* (15), p. 377-380.
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Evans, E., Hawton, K., & Rodham, K. (2004). Factors associated with suicidal phenomena in adolescents: A systematic review of population-based studies. *Clinical Psychological Review, 24* (8), p. 957-79.
Abstract at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15533280

Gibbons, R.D., Hur, K., Bhaumik, D. K., & Mann, J.J. (2005). The relationship between antidepressant medication use and rate of suicide. *Archives of General Psychiatry, 62* (2), p. 165-172.
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Gould, M.S., Velting, D., Kleinman, M., Lucas, C., Thomas, J. G., & Chung, M. (2004). Teenagers' attitudes about coping strategies and help-seeking behavior for suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry, 43* (9), p. 1124-1133.
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Grossman, D. C., Mueller, B. A., Riedy, C., Dowd, M.D., Villaveces, A., Prodzinski, J., Nakagawara, J., Howard, J., Thiersch, N., & Harruff, R. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. *Journal of the American Medical Association, 293*, p. 707-714.
Abstract at: http://jama.ama-assn.org/cgi/content/abstract/293/6/707?etoc

Hennen, J., & Baldessarini, R.J. (2005). Suicidal risk during treatment with clozapine: A meta-analysis. *Schizophrenia Research, 73* (2-3), p. 139-145.
Abstract at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15653256

Isacsson, G., Holmgren, P., & Ahlner, J. (2005). Selective serotonin reuptake inhibitor antidepressants and the risk of suicide: a controlled forensic database study of 14,857 suicides. *Acta Psychiatrica Scandinavica, 111*(4), p. 286-290.
Abstract at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15740464

Jick, H., Kaye, J. A., & Jick, S. S. (2004). Antidepressants and the risk of suicidal behaviors. *Journal of the American Medical Association, 292* (3), p. 338-343.
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Kessler, R. C., Berglund, P., Borges, G., Nock, M., & Wang, P.S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *Journal of the American Medical Association,* 293, p. 2487-2495.
Abstract at: http://jama.ama-assn.org/cgi/content/abstract/293/20/2487

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Abstract at: http://jama.ama-assn.org/cgi/content/abstract/292/7/807

Mittendorfer Rutz, E., & Wasserman, D. (2004). Trends in adolescent suicide mortality in the WHO European Region. *European Child Adolescent Psychiatry, 13* (5), p. 321-331.
Abstract at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15490280&itool=iconabstr

Oquendo, M. A., Lizardi, D., Greenwald, S., Weissman, M. M., & Mann, J. J. (2004). Rates of lifetime suicide attempt and rates of lifetime major depression in different ethnic groups in the United States. *Acta Psychiatrica Scandinavica, 110* (6), p. 446-451.
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Palmer, B. A., Pankratz, V. S., & Bostwick, J. M. (2005). The lifetime risk of suicide in schizophrenia: A reexamination. *Archives of General Psychiatry, 62* (3), p. 247-253.
Abstract at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15753237

Royal Australian and New Zealand College of Psychiatrists. (2004). Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm. *Australian and New Zealand Journal of Psychiatry, 38* (11-12), p. 868-884.
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Schulberg, H. C., Bruce, M. L., Lee, P. W., Williams, J. W., & Dietrich, A, J. (2004). Preventing suicide in primary care patients: the primary care physician's role. *General Hospital Psychiatry, 26* (5), p. 337-345.
Abstract at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15474633&itool=iconabstr

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Stein, D., Lilenfeld, L. R., Wildman, P. C., & Marcus, M. D. (2004). Attempted suicide and self-injury in patients diagnosed with eating disorders. *Comprehensive Psychiatry,* 45 (6), p. 447-451.
Abstract at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15526255&itool=iconabstr

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Full-text at: http://www.aafp.org/afp/20041201/us.html

Special thanks to Lori Bradshaw, Librarian at the Suicide Prevention Resource Center (SPRC), for the articles in this section.

If you or someone you know is suicidal,
please contact a mental health professional
or call the National Suicide Prevention Lifeline
at 1-800-273-TALK (8255).

Mark your Calendar!

Plan to join us in Seattle, Washington

Grand Hyatt Seattle

for

the 39th Annual AAS Conference

Science and Practice in Suicidology: Promoting Collaboration, Integration, and Understanding

Friday, April 28th to Monday, May 1st, 2006

Look for the Call for Papers on the AAS website in June 2005

For more information:

AAS Central Office
5221 Wisconsin Avenue, N. W.
Second Floor
Washington, DC 20015
Phone: (202) 237-2280
Website: www.suicidology.org
Email: info@suicidology.org