

September 5 - 11, 2010

National Suicide Prevention Week  
Information & Media Kit

“Families, Community Systems and Suicide”

Sponsored by

American Association of Suicidology



American Association of Suicidology

5221 Wisconsin Avenue, N.W.

Washington, D.C. 20015

Phone: (202) 237-2280

Fax: (202) 237-2282

[www.suicidology.org](http://www.suicidology.org)

[info@suicidology.org](mailto:info@suicidology.org)

# American Association of Suicidology

## National Suicide Prevention Week

September 5 - 11, 2010

### Table of Contents

#### Part A. Introduction

Who Can Participate in Suicide Prevention Week?  
Suicide Prevention Ribbon  
World Suicide Prevention Day

#### Part B. Media Materials\*

General Guidelines  
Timeline  
Tips for Governor's or Mayor's Proclamation  
**Sample Governor's or Mayor's Proclamation**  
Tips for a Press Release  
**Sample Press Release**  
Tips for a Public Service Announcement  
**Sample Public Service Announcement (20 seconds)**  
**Sample Public Service Announcement (30 seconds)**  
**Sample Public Service Announcement (45 seconds)**  
Tips for an Op-Ed  
**Sample Op-Eds**  
Tips for a Flyer  
**Sample Flyer**  
Publicity Ideas  
Media Guidelines  
*Reporting on Suicide: Recommendations for the Media*

\* Bold items are samples of  
media materials.

#### Part C. Suicide Fact Sheets

2007 Official Final Data  
Suicide in the U.S.A.  
Mnemonic: IS PATH WARM?  
Understanding and Helping the Suicidal Person  
Youth Suicide Fact Sheet  
Elderly Suicide Fact Sheet  
African American Suicide Fact Sheet  
Facts about Suicide and Depression  
Survivors of Suicide Fact Sheet  
Helping Survivors of Suicide: What Can You Do?

#### Part D. American Association of Suicidology

General Information  
Membership Information  
Additional Resources

## Part A. Introduction

## Who Can Participate in National Suicide Prevention Week?

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

**Crisis Centers**

**Schools and Colleges**

**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 National 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 National Suicide Prevention Week in their locality.

Corporations and businesses can participate not only by hosting events for National 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 National 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, President-Elect of AAS. 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.



Along with the purple and turquoise ribbons, purple and turquoise wristbands are also available to show support for anyone whose life has been touched by suicide. Please go to [www.chelleheadworks.com](http://www.chelleheadworks.com) to order the ribbons, wristbands, or other support materials.

## World Suicide Prevention Day

The International Association for Suicide Prevention (IASP), in collaboration with the World Health Organization (WHO) and the World Federation for Mental Health, is hosting World Suicide Prevention Week on September 5th - 11th, 2010. This year's theme is "Families, Community Systems and Suicide" and will focus on raising awareness that suicide is a major preventable cause of premature death on a global level. Governments need to develop policy frameworks for national suicide prevention strategies. At the local level, policy statements and research outcomes need to be translated into prevention programmes and activities in communities.

The International Association for Suicide Prevention (IASP) was founded in Vienna, Austria 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/](http://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/](http://www.who.int/en/)).

The World Federation for Mental Health's mission is to promote the highest possible level of mental health in all aspects (biological, medical, educational and social) for all people and nations. Their goals are to heighten public awareness, promote mental health, prevent mental disorders and improve the care and treatment of those with mental disorders ([www.wfhm.org](http://www.wfhm.org)).

### 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. There is an estimated 10 to 20 suicide attempts per each completed suicide, resulting in several million suicide attempts each year.

Suicide and suicidal behavior affects 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, problem-solving skills, supportive family and friends are all examples of factors that buffer against suicide and suicidal behaviors.

World Suicide Prevention Week 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

## National Suicide Prevention Week

September 5 - 11, 2010

### 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* is incorporated in this Kit on pages 36 to 42 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](http://www.afsp.org)).

#### General Tips:

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

Assume the reader is new to this topic; explain 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

## National Suicide Prevention Week

September 5 - 11, 2010

### Timeline

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

<b>Week of</b>	<b>Activity</b>
8/15	<p><b>MEDIA LIST:</b> 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 television outlets you will reach out to in each category – newspaper, radio and television.</p> <p><b>REAL STORIES:</b> 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.</p> <p><b>PSAs:</b> Contact newspapers, radio or television stations 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 and the first week of September.</p> <p><b>SPEAKING ENGAGEMENTS:</b> Contact local organizations to schedule speaking engagements by their staff to occur during Suicide Prevention Week.</p>
8/22	<p><b>ACTIVITIES:</b> Finalize any open house, visitors’ day, events, training sessions or other special activity associated with Suicide Prevention Week. Create promotional materials for your activities.</p> <p><b>PRESS RELEASE:</b> Draft a press release and highlight your organization. Add local statistics regarding suicide in your state, county or region of the country.</p> <p><b>LEGISLATIVE OUTREACH:</b> Begin a dialogue with your mayor’s and governor’s offices to pitch the idea of a signed proclamation noting Suicide Prevention Week.</p> <p><b>OP-ED:</b> Prepare and finalize an op-ed for dissemination to print media the following week.</p>

# **American Association of Suicidology**

## **National Suicide Prevention Week**

**September 5 - 11, 2010**

### **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 the issue of 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 5<sup>th</sup> through 11<sup>th</sup> 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 2010 National Suicide Prevention Week is September 5<sup>th</sup> through September 11<sup>th</sup>.

WHEREAS, suicide is the 11<sup>th</sup> leading cause of all deaths in the United States and the 3<sup>rd</sup> 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 15.2 minutes;

WHEREAS, it is estimated that 4.6 million people in the United States are survivors of suicide (those who have lost a loved one to suicide);

WHEREAS, 50.2% 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, an increase in the overall suicide rate in our country was seen in 2007, representing a change in the recent pattern of stability or slight declines, 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 5<sup>h</sup> through September 11<sup>th</sup>, 2010 as “National Suicide Prevention Week” in the state (or city) of [your state or city].

(SEAL) \_\_\_\_\_  
Signature and Date

# American Association of Suicidology

## National Suicide Prevention Week

September 5 - 11, 2010

### 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 television 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 National Suicide Prevention Week from September 5<sup>th</sup> to 11<sup>th</sup>." This will help the editor determine when to put it to print.

## Sample Press Release (on your company's letterhead)

### 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 2010 is set for September 5 through 11. [Your state] ranks [rank] in the nation in its rate of suicide deaths.

Suicide is the 11th leading cause of death in the United States with one suicide occurring on average every 15.2 minutes.

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

The elderly make up 12.6% of the population, but comprise 15.7% of all suicides.

Approximately 864,950 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 4.6 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:** National Suicide Prevention Week, September 5<sup>th</sup> through 11<sup>th</sup>. This year's theme is "Families, Community Systems and Suicide."

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



# **American Association of Suicidology**

## **National Suicide Prevention Week**

**September 5 - 11, 2010**

### **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 11<sup>th</sup> or have a newspaper print your PSA every day during the week of September 5<sup>th</sup>.

## 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 5 through September 11 is National Suicide Prevention Week. Please join [your organization] in supporting suicide prevention. Together we can reduce the number of lives shaken by a needless and tragic death.

## Sample PSA

### **Public Service Announcement Suicide Prevention (30 Seconds)**

Did you know that, in the United States, one person completes suicide every 15 minutes? Or that it's estimated that more than 5 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 5 through September 11 is National Suicide Prevention Week. Please join [your organization] in supporting suicide prevention. Together we can reduce the number of lives shaken by a needless and tragic death.

## Sample PSA

### **Public Service Announcement Suicide Prevention (45 Seconds)**

Did you know that, in the United States, one person completes suicide every 15 minutes? Or that it's estimated that more than 5 million people in the United States have been directly affected by a suicide? Or that 50% 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 5th through September 11th is National Suicide Prevention Week. This year's theme is "Families, Community Systems and Suicide". Please join [your agency] in supporting suicide prevention. Together we can reduce the number of lives shaken by a needless and tragic death.

# American Association of Suicidology

## National Suicide Prevention Week

September 5 - 11, 2010

### 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 is 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 op-ed ranges 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, emphasize 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 summarizes 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 5<sup>th</sup> to 11<sup>th</sup>." This will help the editor determine when to put it to print.

If you are sending your submission to only one newspaper, emphasize the point theirs is the only one in 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 as such and to other newspapers.

Be open to the fact that the editor might send your article back in order for you to shorten or revise it and 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, especially in children and adolescents?” and “Are the increase in the prescription of SSRIs responsible for the decline in national youth suicide rates over the last few years?”

In 2004, as a result of public hearings, and after weighing all the available evidence and testimony, the U.S. Food and Drug Administration (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. However there were no reported suicides among any of the children and adolescents enrolled in any of the clinical trials.

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. This may be due to the possibility that the medications have yet to be therapeutically effective, or possibly because the SSRIs induce agitation or activation early in the treatment process.

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 is currently approved by the FDA to treat major depression in children.

In May, 2006 the FDA and GlaxoSmithKline warned healthcare professionals regarding the potential increased risk for suicidal behavior associated with the use of paroxetine HCL tablets/oral solution or paroxetine extended-release tablets. Such monitoring may be of particular importance in young adults and those whose depression is improving. Recent study results show that paroxetine therapy compared to placebo was linked to an increased frequency of suicidal behavior in young adults aged 18 to 24 years. Although not statistically significant, the increase occurred in patients with depressive and non-depressive conditions.

Although many professional organizations have 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 major depressive disorders 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 death by suicide, 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 former 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 psychiatrist, 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](mailto: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 decision-making 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 behaviors 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.**

© Copyright 2003 *St. Petersburg Times* . All rights reserved.

## 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 struggles 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 connotes 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/](http://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*

© Copyright 2002 *Albuquerque Journal*. All rights reserved.

# **American Association of Suicidology**

## **National Suicide Prevention Week September 5 - 11, 2010**

### **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 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 5<sup>th</sup> Noon  
Convene at Central Library Park

Suicide Prevention Fund-raiser Walk  
Saturday, September 11<sup>th</sup> 10 AM  
Walk will begin in front of the Springfield Community Center.

## National Suicide Prevention Week

September 5 - 11, 2010

“Families,  
Community Systems  
and Suicide”



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

Sponsored by

American Association of  
Suicidology

## Some Facts About Suicide

In 2007, the latest year for which we have data, in the U.S.:

[Insert your contact information & logo here]

More than 34,000 people died by suicide.

An average of 94.8 individuals per day (one per 15.2 minutes) will die by suicide.

Suicide is the 11<sup>th</sup> leading cause of death, with a rate of 11.5 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 2007 rate was 10 suicides per 100,000 (a total of 4,189).

One youth completes suicide every 2 hours and 7 minutes, which is about 11.3 each day.

Males between the ages of 20 and 24 were 5.3 times more likely than females to complete suicide. Males between 15 and 19 were 4.5 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 12.5% of the population but account for 15.7% of all suicides.

In 2007, there were 5,421 elderly suicides (14.9 per day).

Elderly white men are at the highest risk with a rate of approximately 31.1 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:

Mnemonic IS PATH WARM?

- I • Ideation
- S • Substance Abuse
- P • Purposelessness
- A • Anxiety
- T • Trapped
- H • Hopelessness
- W • Withdrawal
- A • Anger
- R • Recklessness
- M • Mood Change



## **National Suicide Prevention Week September 5 - 11, 2010**

### **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 5-11 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 5 - 11, 2010

### 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 lay readers or viewers will understand.
- Refer to the AAS website ([www.suicidology.org](http://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.<sup>1-2</sup>

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

- The number of stories about individual suicides increases<sup>3,4</sup>
- A particular death is reported at length or in many stories<sup>3,5</sup>
- The story of an individual death by suicide is placed on the front page or at the beginning of a broadcast<sup>3,4</sup>
- The headlines about specific suicide deaths are dramatic<sup>3</sup> (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.<sup>1,2</sup>

- Certain ways of describing suicide in the news contribute to what behavioral scientists call “suicide contagion” or “copycat” suicides.<sup>7,9</sup>
- 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.<sup>6</sup>
- Exposure to suicide method through media reports can encourage vulnerable individuals to imitate it.<sup>10</sup> 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.<sup>1</sup>

Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.<sup>6</sup>

# 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.<sup>11-15</sup>
- When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.<sup>14,15</sup>
- Research has shown that when open aggression, anxiety or agitation is present in individuals who are depressed, the risk for suicide increases significantly.<sup>16-18</sup>

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.<sup>19-20</sup> 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.<sup>12</sup>

## 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.<sup>21</sup>

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.<sup>22,23</sup> 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.<sup>3</sup>

## **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.<sup>24</sup> 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.<sup>25,26</sup>

## **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.<sup>27</sup>

# **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

# References

1. Sonneck, G., Etzersdorfer, E., & Nagel-Kuess, S. (1994). Imitative suicide on the Viennese subway. *Social Science and Medicine*, 38, 453- 457.
2. Etzersdorfer, E., & Sonneck, G. (1998). Preventing suicide by influencing mass-media reporting. The Viennese experience 1980-1996. *Archives of Suicide Research*, 4, 67-74.
3. Phillips, D.P., Lesyna, K., & Paight, D.J. (1992). Suicide and the media. In R.W. Maris, A.L. Berman, J.T. Maltzberger et al. (Eds.), *Assessment and prediction of suicide* (pp. 499-519). New York: The Guilford Press.
4. Hassan, R. (1995). Effects of newspaper stories on the incidence of suicide in Australia: A research note. *Australian and New Zealand Journal of Psychiatry*, 29, 480-483.
5. Stack, S. (1991). Social correlates of suicide by age: Media impacts. In A. Leenaars (Ed.), *Life span perspectives of suicide: Timelines in the suicide process* (pp. 187-213). New York: Plenum Press.
6. Fekete, S., & A. Schmidtke. (1995) The impact of mass media reports on suicide and attitudes toward self-destruction: Previous studies and some new data from Hungary and Germany. In B. L. Mishara (Ed.), *The impact of suicide*. (pp. 142-155). New York: Springer.
7. Schmidtke, A., & Häfner, H. (1988). The Werther effect after television films: New evidence for an old hypothesis. *Psychological Medicine* 18, 665-676.
8. Gould, M.S., & Davidson, L. (1988). Suicide contagion among adolescents. In A.R. Stiffman, & R.A. Feldman (Eds.), *Advances in adolescent mental health* (pp. 29-59). Greenwich, CT: JAI Press.
9. Gould, M.S. (2001). Suicide and the media. In H. Hendin, & J.J. Mann (Eds.), *The clinical science of suicide prevention* (pp. 200-224). New York: Annals of the New York Academy of Sciences.
10. Fekete, S., & Macsai, E. (1990). Hungarian suicide models, past and present. In G. Ferrari (Ed.), *Suicidal behavior and risk factors* (pp. 149- 156). Bologna: Monduzzi Editore.
11. Robins, E. (1981). *The final months: A study of the lives of 134 persons*. NY: Oxford University Press.
12. Barraclough, B., & Hughes, J. (1987). *Suicide: Clinical and epidemiological studies*. London: Croom Helm.
13. Conwell Y., Duberstein P. R., Cox C., Herrmann J.H., Forbes N. T., & Caine E. D. (1996). Relationships of age and axis I diagnoses in victims of completed suicide: a psychological autopsy study. *American Journal of Psychiatry*, 153, 1001-1008.
14. Brent, D.A., Perper, J.A., Moritz, G., Allman, C., Friend, A., Roth, C., Schweers, J., Balach, L., & Baugher, M. (1993). Psychiatric risk factors for adolescent suicide: a case-control study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32 (3), 521-529.
15. Shaffer, D., Gould, M.S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, 53 (4), 339-348.
16. Mann, J.J., Wateraux, C., Haas, G.L., & Malone, K.M. (1999). Toward a clinical model of suicidal behavior in psychiatric patients. *American Journal of Psychiatry*, 156 (2), 181-189.
17. Soloff, P.H., Lynch, K.G., Kelly, T.M., Malone, K.M., & Mann, J.J. (2000). Characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder: a comparative study. *American Journal of Psychiatry*, 157 (4), 601-608.
18. Fawcett, J. (1990). Targeting treatment in patients with mixed symptoms of anxiety and depression. *Journal of Clinical Psychiatry*, 51 (Suppl.), 40-43.
19. Gould, M.S., Fisher, P., Parides, M., Flory, M., & Shaffer, D. (1996). Psychosocial risk factors of child and adolescent completed suicide. *Archives of General Psychiatry*, 53, 1155-1162.
20. Moscicki, E.K. (1999). Epidemiology of suicide. In D.G. Jacobs (Ed.), *The Harvard Medical School Guide to suicide assessment and intervention* (pp. 40-51). San Francisco: Jossey-Bass.
21. Ness, D.E., & Pfeffer, C.R. (1990). Sequelae of bereavement resulting from suicide. *American Journal of Psychiatry*, 147, 279-285.
22. Barraclough, B., Bunch, J., Nelson, B., & Sainsbury, P. (1974). A hundred cases of suicide: clinical aspects. *British Journal of Psychiatry*, 125, 355-373.
23. Brent, D.A., Perper, J.A., Kolko, D.J., & Zelenak, J.P. (1988). The psychological autopsy:



- methodological considerations for the study of adolescent suicide. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27 (3), 362-366.
24. Wasserman, I. M. (1984). Imitation and suicide: A re-examination of the Werther effect. *American Sociological Review*, 49, 427-436.
25. Rosenbaum, M. (1990). The role of depression in couples involved in murder-suicide and homicide. *American Journal of Psychiatry*, 47 (8), 1036-1039.
26. Nock, M.K., & Marzuk, P.M. (1999). Murder-suicide: Phenomenology and clinical implications. In D.G. Jacobs (Ed.) *The Harvard Medical School guide to suicide assessment and intervention* (pp. 188-209). San Francisco: Jossey-Bass.
27. Fishbain, D.A., D'Achille, L., Barsky, S., & Aldrich, T.E. (1984). A controlled study of suicide pacts. *Journal of Clinical Psychiatry*, 45, 154-157.

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

American Association of Suicidology  
Phone: 202-237-2280  
[www.suicidology.org](http://www.suicidology.org)

American Foundation for Suicide Prevention  
Phone: 1-888-333-AFSP  
Phone: 212-363-3500  
Web: [www.afsp.org](http://www.afsp.org)

Centers for Disease Control  
and Prevention  
Phone: 1-800-311-3435  
[www.cdc.gov](http://www.cdc.gov)

National Institute of Mental Health  
Phone: 301-443-4513  
[www.nimh.nih.gov](http://www.nimh.nih.gov)

Substance Abuse and Mental Health  
Services Administration  
Phone: 1-800-487-4890  
[www.samhsa.gov](http://www.samhsa.gov)

Office of the Surgeon General  
National Strategy for Suicide Prevention  
[www.mentalhealth.org/suicideprevention](http://www.mentalhealth.org/suicideprevention)

### International

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

National Swedish Centre for Suicide Research  
Phone: +46 08/728 70 26  
[www.ki.se/ipm/enheter/engSui.html](http://www.ki.se/ipm/enheter/engSui.html)

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

Suicide Information and Education Centre  
Phone: 403 245-3900  
[www.suicideinfo.ca](http://www.suicideinfo.ca)

World Health Organization  
Phone: +00 41 22 791 21 11  
[www.who.int](http://www.who.int)

## Part C. Information about Suicide

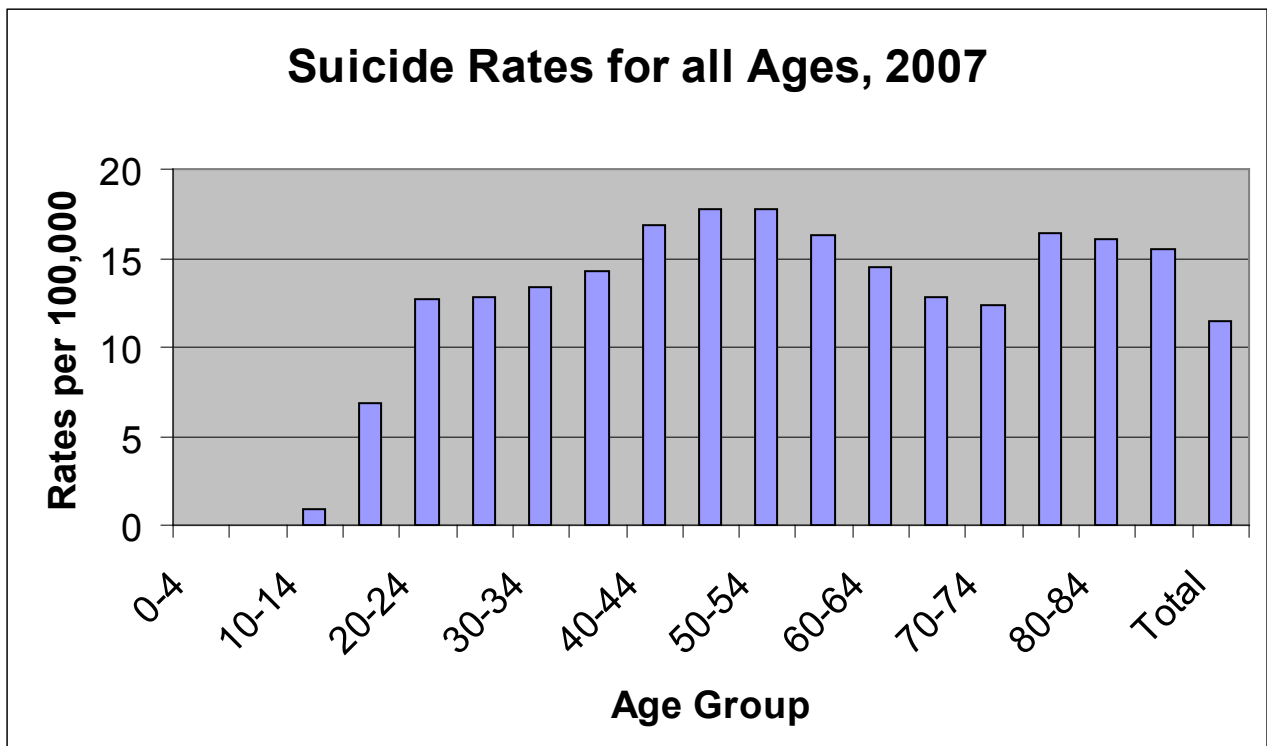
The Fact Sheets in this section are also available on our website. These information sheets are compiled by AAS and are available for public use. Make as many copies as you need.



AMERICAN ASSOCIATION OF SUICIDOLOGY

## Suicide in the U.S.A. Based on Current (2007) Statistics

1. In 2007 (the latest year for which we have national statistics), there were 34,598 suicides in the U.S. (94.8 suicides per day; 1 suicide every 15.2 minutes). This translates to an annual suicide rate of 11.5 per 100,000.
2. Suicide is the eleventh leading cause of death.
3. A rate increase was seen in 2007, representing a change in the recent pattern of stability or slight decline. Since 1990, rates have ranged between 12.4 and 10.7 per 100,000.
4. Rates of suicide are highest in the intermountain states. Six of the top 10 states suicide rates are from those states.
5. Males complete suicide at a rate 3.6 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 80 and over).



7. Elderly adults have rates of suicide close to 50% higher than that of the nation as a whole (all ages).
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, since then, 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 (50.2%) of the individuals who took their own lives in 2007 used this method. Males used it more often than their female counterparts.
11. The most common method of suicide for all females was poisoning. In fact, poisoning has surpassed firearms for female suicides since 2001.
12. Caucasians (12.9 per 100,000) have higher rates of completed suicides than African Americans (4.9 per 100,000).
13. Suicide rates have traditionally decreased in times of war and increased in times of economic crises.
14. Suicide rates are the highest among the divorced, separated, and widowed and lowest among the married.

## Research Findings

- Although there are no official national statistics on attempted suicide (e.g., non-fatal actions) it is generally estimated that there are 25 attempts for each death by suicide.
- Risk of attempted (nonfatal) suicide is greatest among females and the young.
- 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.
- Those with the following diagnoses are at particular risk: 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 by more than 50 percent in depressed individuals. Aggregated research findings suggest that 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 diagnosis 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 cues and warning signs.

## Warning Signs

Here's an Easy to Remember Mnemonic for the Warning Signs of Suicide: IS PATH WARM?

A person at risk for suicidal behavior most often will exhibit warning signs:

- |   |                 |  |
|---|-----------------|--|
| I | Ideation        | <input type="checkbox"/> Expressed or communicated ideation  |
|   |                 | <input type="checkbox"/> Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or          |
|   |                 | <input type="checkbox"/> Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or |
|   |                 | <input type="checkbox"/> Talking or writing about death, dying or suicide, when these actions are out of the ordinary.               |
| S | Substance Abuse | <input type="checkbox"/> Increased substance (alcohol or drug) use   |
| P | Purposelessness | <input type="checkbox"/> No reason for living; no sense of purpose in life   |
| A | Anxiety         | <input type="checkbox"/> Anxiety, agitation, unable to sleep or sleeping all the time  |
| T | Trapped         | <input type="checkbox"/> Feeling trapped (like there's no way out)   |
| H | Hopelessness    | <input type="checkbox"/> Hopelessness  |
| W | Withdrawal      | <input type="checkbox"/> Withdrawal from friends, family and society   |
| A | Anger           | <input type="checkbox"/> Rage, uncontrolled anger, seeking revenge   |
| R | Recklessness    | <input type="checkbox"/> Acting reckless or engaging in risk activities, seemingly without thinking                                  |
| M | Mood Change     | <input type="checkbox"/> Dramatic mood changes   |

These warning signs were derived as a consensus from a meeting of internationally-renowned clinical researchers held under the auspices of the AAS in Wellesley, MA in November 2003.

## Other Issues

- The designation of “survivor of suicide” refers to the family members and friends who are impacted by 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 1983 to 2007, we can estimate that the number of survivors in the U.S. is approximately 4.6 million. An estimated 207,588 survivors of suicide were added in 2007.

## **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 Centers for Disease Control and Prevention (CDC). Unless specified otherwise, information presented refers to the latest available data (i.e., 2007).

## **American Association of Suicidology**

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. For membership information, please contact:

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



## AMERICAN ASSOCIATION OF SUICIDOLOGY

### 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 1-800-273-8255 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 talking 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 1-800-273-8255 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 death 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 occurs 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](mailto:info@suicidology.org)  
Website: [www.suicidology.org](http://www.suicidology.org)



## Youth<sup>1</sup> Suicide Fact Sheet

- In 2007, 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 1.4% of all deaths in the U.S. annually, they comprised 12.2% 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 11.3 youth suicides.
- Every 2 hours and 7 minutes, a person under the age of 25 completes suicide.

- In 2007, 34,598 people completed suicide. Of these, 4,140 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 almost 30% since 1994.
- 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.
- 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 34% decrease. In 2004, the rate was 8.2 per 100,000.
- Males between the ages of 20 and 24 were 5.32 times more likely than females to complete suicide. Males between 15 and 19 were 4.46 times more likely than females to complete suicide (2007 data).

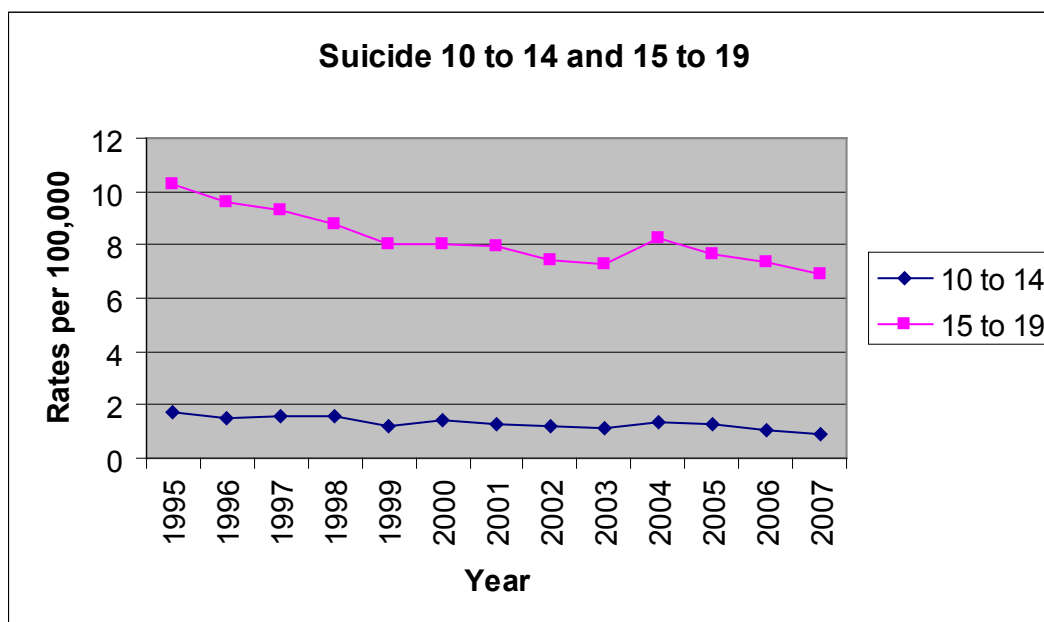
	Males	Females	Both genders
Ages 15 to 19	11.11	2.49	6.91
Ages 20 to 24	20.91	3.93	12.68

- 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 (YRBSS), 8.5% of students in grades 9 through 12

<sup>1</sup>“Youth” refers to ages 15-24. Information presented refers to the latest available national data (2007).

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).

- Firearms remain the most commonly used suicide method among youth, accounting for 45.9% of all completed suicides (2007).
- In the last decade, for youths aged 15 to 19, the suicide rate by firearm decreased (from 7.3 in 1992 to 2.94 in 2007); correspondingly, suicide rates by suffocation increased (from 1.9 in 1992 to 2.88 in 2007). 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!

## Suicide Among Children

- In 2007, 119 children ages 10 to 14 completed suicide in the U.S.
- Suicide rates for those between the ages of 10-14 increased over 50% between 1981 and 2007.
- Although their rates are lower than for Caucasian children, African American children (ages 10-14) showed the largest increase in suicide rates between 1980 and 1995. In 2007, the rate for African American males ages 10-14 was 1.12 per 100,000 (the rate for Caucasian males was .63 per 100,000).
- In the 10 to 14 age group, Caucasian children (ranked 3<sup>rd</sup> leading cause of death) were far more likely to complete suicide than African American children (ranked 5<sup>th</sup> leading cause of death). Caucasian males

between 10 and 14 years of age were 2.21 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 1993, 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 suicide completer 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 abuse 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.); and/or

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](http://www.cdc.gov/ncipc/wisqars/default.htm)), a division of the Centers for Disease Control and Prevention (CDC), and the Morbidity and Mortality Weekly Reports.

### 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 on 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

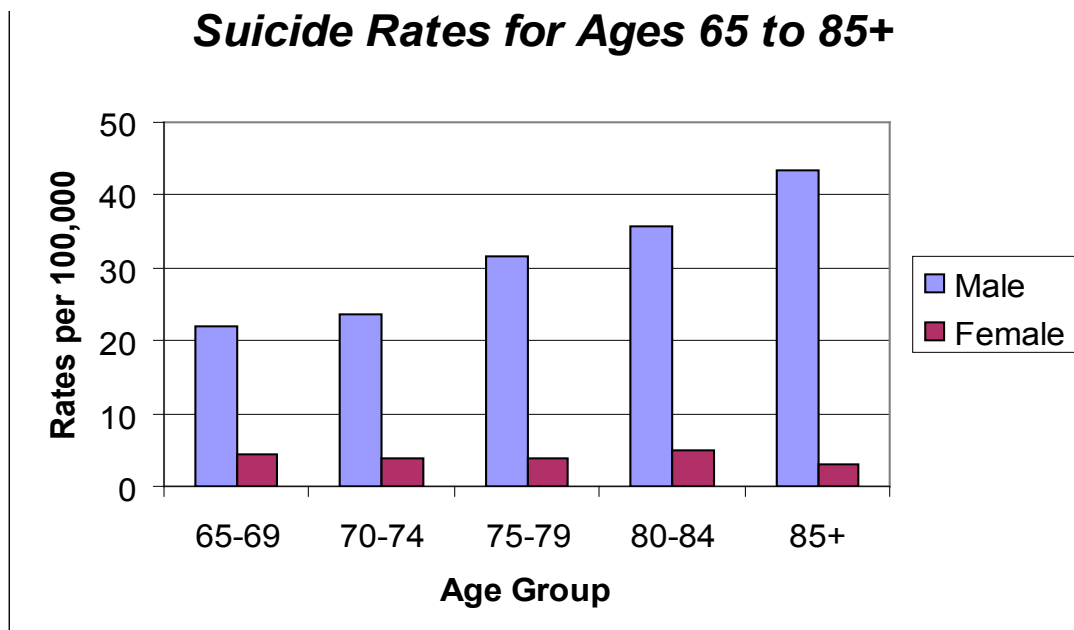
AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. For membership information, please contact:

*American Association of Suicidology*  
5221 Wisconsin Avenue, N. W.  
Washington, DC 20015  
(202) 237-2280  
(202) 237-2282 (Fax)  
[info@suicidology.org](mailto:info@suicidology.org)  
[www.suicidology.org](http://www.suicidology.org)



## Elderly<sup>1</sup> Suicide Fact Sheet

- The elderly made up 12.5% of the population; they accounted for almost 15.7% of all suicides.
- The rate of suicide for the elderly for 2007 was 14.3 per 100,000.
- There was one elderly suicide every 97 minutes. There were about 14.9 elderly suicides each day, resulting in 5,421 suicides in among those 65 and older.
- Elderly white men were at the highest risk with a rate of approximately 31.1 suicides per 100,000 each year.
- White men over the age of 85, who are labeled “old-old”, were at the greatest risk of all age-gender-race groups. In 2007, the suicide rate for these men was 45.42 per 100,000. That was 2.5 times the current rate for men of all ages (18.3 per 100,000).
- 84.4% of elderly suicides were male; the rate of male suicides in late life was 7.3 times greater than for female suicides.



<sup>1</sup> “Elderly” refers to persons over the age of 65. Information presented refers to the latest national data (2007).

- 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 14.3 in 2007). This is the largest decline in suicide rates among the elderly since the 1930's.
- The rate of suicide for women typically declines after age 60 (after peaking in middle adulthood, ages 45-49).
- 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 attempted suicides. 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 attempted suicides.
- Firearms were the most common means (71.9%) used for completing suicide among the elderly. Men use firearms far more often than women.
- 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>) operated by the Centers for Disease Control and Prevention (CDC).

#### **American Association of Suicidology**

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. For membership information, please contact:

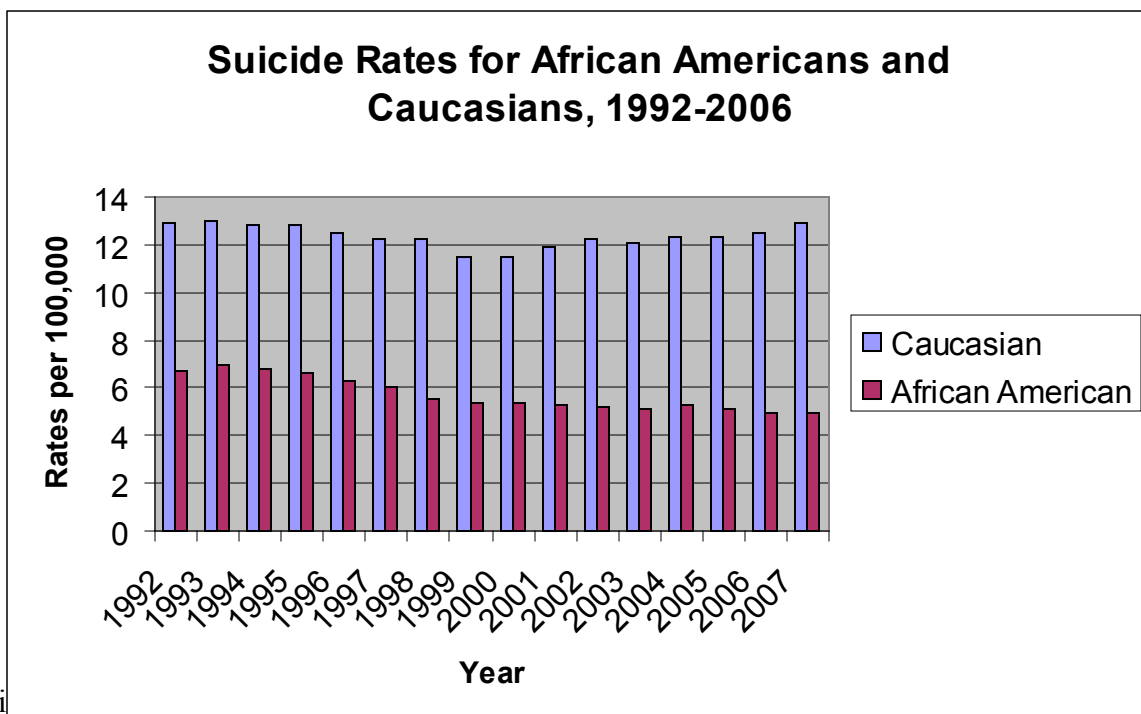
*American Association of Suicidology  
5221 Wisconsin Avenue, N.W.  
Washington, DC 20015  
(202) 237-2280  
(202) 237-2282 (Fax)  
[info@suicidology.org](mailto:info@suicidology.org)  
[www.suicidology.org](http://www.suicidology.org)*





**African American Suicide Fact Sheet<sup>1</sup>**

- In 2007, 1,958 African Americans completed suicide in the U.S. Of these, 1,606 (82%) were males (rate of 8.4 per 100,000). The suicide rate for females was 1.7 per 100,000.
- In 2007, there were 352 African American female suicides. The ratio of African American male to female was 4.56 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 2007, the rate of suicide for African Americans (all ages) showed a small but steady decline, before increasing slightly since 2003.



- Suicid... homicides and accidents. The suicide rate for young African American youth was 2.68 per 100,000 (n = 184).

<sup>1</sup> In this fact sheet, unless otherwise specified, the information presented refers to the latest available data (i.e., 2007 data).

- For African American youth, the rate of male suicide (4.3 per 100,000) was 4.3 times higher than that of females (1.0 per 100,000).
- 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 significantly.
- 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 67% for males and 23% for females.
- Males accounted for 87.2% of African American elderly (65 and older) suicides.
- Firearms were the predominant method of suicide among African Americans regardless of gender and age, accounting for roughly 50.4% of all suicides.

### **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.

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](http://www.suicidology.org)

National Organization for People for Color Against Suicide

[www.nopcas.com](http://www.nopcas.com)

National Center for Injury Prevention and Control

[www.cdc.gov/ncipc/wisqars](http://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](http://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/](http://www.nimh.nih.gov/)) as well as the National Organization for People of Color Against Suicide (NOPCAS) website ([www.nopcas.com](http://www.nopcas.com)).

## **American Association of Suicidology**

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. For membership information, please contact:

*American Association of Suicidology*

*5221 Wisconsin Avenue, NW*

*Washington, DC 20015*

*Phone: (202) 237-2280*

*Fax: (202) 237-2282*

*Email: [info@suicidology.org](mailto:info@suicidology.org)*

*Website: [www.suicidology.org](http://www.suicidology.org)*

## Warning Signs of Suicide

The mnemonic IS PATH WARM? can be used to remember the warning signs of suicide:

I	Ideation
S	Substance Abuse
P	Purposelessness
A	Anxiety
T	Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood Change

A person in acute risk for suicidal behavior most often will show:

### Warning Signs of Acute Risk:

Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him or herself; and/or,  
Looking for ways to kill him or herself by seeking access to firearms, available pills, or other means; and/or,  
Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

These might be remembered as expressed or communicated **IDEATION**. If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

### Additional Warning Signs:

Increased **SUBSTANCE** (alcohol or drug) use  
No reason for living; no sense of **PURPOSE** in life  
**ANXIETY**, agitation, unable to sleep or sleeping all the time  
Feeling **TRAPPED** – like there's no way out  
**HOPELESSNESS**  
**WITHDRAWING** from friends, family and society  
Rage, uncontrolled **ANGER**, seeking revenge  
Acting **RECKLESS** or engaging in risky activities, seemingly without thinking  
Dramatic **MOOD** change

If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273 TALK (8255) for a referral.



## Some Facts About Suicide and Depression

### WHAT IS DEPRESSION?

Depression is the most prevalent mental health disorder. The lifetime risk for depression is 6 to 25%. According to the National Institute of Mental Health (NIMH), 9.5% or 20.9 million American adults suffer from a depressive illness in any given year.

There are two types of depression. In major depression, the symptoms listed below interfere with one's ability to function in all areas of life (work, family, sleep, etc). In dysthymia, the symptoms are not as severe but still impede one's ability to function at normal levels.

Common symptoms of depression, reoccurring almost every day:

- 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 (i.e., a parent) increases the chances (by 11 times) than a child will also have depression.

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

If left untreated, depression can lead to co-morbid (occurring at the same time) mental disorders such as alcohol and substance abuse, higher rates of recurrent episodes and higher rates of suicide.

## **FACTS ABOUT SUICIDE**

In 2007, suicide was the eleventh leading cause of death in the U.S., claiming 34,598 lives. Suicide rates among youth (ages 15-24) have increased more than 200% in the last fifty years. The suicide rate is also very high for the elderly (age 85+).

Four times more men than women kill themselves; but three times more women than men attempt suicide.

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

Suicide is 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 others 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 of suicide and emotional problems.

### **THE LINKS BETWEEN DEPRESSION AND SUICIDE**

Major depression is the psychiatric diagnosis most commonly associated with suicide. Lifetime risk of suicide among patients with untreated depressive disorder is nearly 20% (Gotlib & Hammen, 2002). The suicide risk among treated patients is 141/100,000 (Isacsson et al, 2000).

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

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

The risk of suicide in people with major depression 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:

- Extreme hopelessness
- A lack of interest in activities that were previously pleasurable
- Heightened anxiety and/or panic attacks
- Insomnia
- Talk about suicide or have a prior history of attempts
- Irritability and agitation

## ANTIDEPRESSANTS

There is no evidence to date that the prescription of antidepressants for the treatment of depression increases suicidality in children, adolescents or adults.

### BE AWARE OF THE WARNING SIGNS

*A suicidal person may:*

- Talk about suicide, death, and/or no reason to live.
- Be preoccupied with death and dying.
- Withdraw from friends and/or social activities.
- Have a recent severe loss (esp. relationship) or threat of a significant loss.
- Experience drastic changes in behavior.
- Lose interest in hobbies, work, school, etc.
- Prepare for death by making out a will (unexpectedly) and final arrangements.
- Give away prized possessions.
- Have attempted suicide before.
- Take unnecessary risks; be reckless, and/or impulsive.
- Lose interest in their personal appearance.
- Increase their use of alcohol or drugs.
- Express a sense of hopelessness.
- Be faced with a situation of humiliation or failure.
- Have a history of violence or hostility.
- Have been unwilling to “connect” with potential helpers.

### 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                      *If you experience any of these feelings, get help!*
- Can't think clearly
- Can't make decisions                      *If you know someone who exhibits these feelings, offer help!*
- 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

## **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**

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

For membership information, please contact:

*American Association for Suicidology*  
*5221 Wisconsin Avenue*  
*Washington, D.C. 20015*  
*(202) 237.2280*  
*(202) 237.2282 (Fax)*  
*[www.suicidology.org](http://www.suicidology.org)*





## AMERICAN ASSOCIATION OF SUICIDOLOGY

### 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 over 33,000 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 6 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 of 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 others 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](http://www.suicidology.org).
- Guidelines for Survivors of Suicide Support Groups: a how-to booklet on starting a support group.

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. For membership information, please contact:

*American Association of Suicidology*  
5221 Wisconsin Ave. N. W.  
Washington, DC 20015  
(202) 237-2280  
(202) 237-2282 (Fax)  
[info@suicidology.org](mailto:info@suicidology.org)  
[www.suicidology.org](http://www.suicidology.org)

## Additional Resources

- o American Foundation for Suicide Prevention (AFSP) ([www.afsp.org](http://www.afsp.org)).
- o Survivors of Suicide ([www.survivorsofsuicide.com](http://www.survivorsofsuicide.com)).
- o The Link National Resource Center ([www.thelink.org](http://www.thelink.org)).



## AMERICAN ASSOCIATION OF SUICIDOLOGY

### **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 life without their loved one.

Common emotions experienced with grief are:

Shock	Denial
Pain	Numbness
Anger	Shame
Despair	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 grieve 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.

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](http://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](http://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](http://www.survivorsofsuicide.com)).
- Suicide Awareness: Voices of Education (SAVE) ([www.save.org](http://www.save.org)).
- American Foundation for Suicide Prevention (AFSP) ([www.afsp.org](http://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 Ave. N. W.  
Washington, DC 20015  
(202) 237-2280  
(202) 237-2282 (Fax)  
Email: [info@suicidology.org](mailto:info@suicidology.org)  
Website: [www.suicidology.org](http://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 1,000 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.
- ❑ The AAS Annual Conference is the only annual, national forum for the presentation of state-of-the-art research and professional training in suicidology. Similarly, the 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*

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

#### *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 33,000 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 *Suicide 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 National 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.

### **AAS offers you access to:**

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.
- Directory of Suicide Prevention and Crisis Centers.
- Access to the members-only section of [suicidology.org](http://suicidology.org), for community forums and division content.

### **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.

### **AAS offers you access to:**

- 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.

Apply Online!  
[www.suicidology.org](http://www.suicidology.org)

# 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, must be verified -- see attached form on how to do this):

Revenues: (In \$US)	< \$100,000	Dues:	\$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 \$20.00 US to fee above.

#### 2. Submit Application

Check enclosed (payable to AAS) for \$ \_\_\_\_\_  
 VISA  MC  AMEX \$ \_\_\_\_\_  
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 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:

- |  |             |
|--|-------------|
| <input type="checkbox"/> Regular ( <i>US and Canada</i> )                                    | \$150.00 US |
| <input type="checkbox"/> Fixed Income/Retired  | \$107.00 US |
| <input type="checkbox"/> Student/Volunteer ( <i>includes journal and Surviving Suicide</i> ) | \$91.00 US  |
| <input type="checkbox"/> Student/Volunteer ( <i>includes journal</i> )                       | \$75.00 US  |
| <input type="checkbox"/> Student/Volunteer ( <i>without journal</i> )                        | \$38.00 US  |
| <input type="checkbox"/> International <i>Add \$10.00 US to relevant fee</i>                 |             |

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

#### 2. Submit Application

- Check enclosed (*payable to AAS*) for \$ \_\_\_\_\_  
 Charge \$ \_\_\_\_\_  VISA  MC  AMEX  
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

All organizations must provide documentation supporting the membership dues level indicated on the membership application or renewal form.

An organization may either submit the form below or provide a copy of the organization's current budget. The documentation must be submitted within 30 days of sending in the membership application or renewal.

The form below may be submitted in lieu of a current budget. The signature of the Board Chair or Treasurer is required.

I, \_\_\_\_\_ the \_\_\_\_\_ of  
(position)  
\_\_\_\_\_ hereby  
(organization)

affirm that the current annual operating budget for our organization is  
\$ \_\_\_\_\_.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

## Additional Resources

American Foundation for Suicide Prevention  
(AFSP)  
[www.afsp.org](http://www.afsp.org)

Centers for Disease Control and Prevention  
(CDC)  
[www.cdc.gov](http://www.cdc.gov)

The Jason Foundation  
[www.jasonfoundation.com](http://www.jasonfoundation.com)

The Jed Foundation  
[www.jedfoundation.org](http://www.jedfoundation.org)

The Links National Resource Center for  
Suicide Prevention and Aftercare  
[www.thelink.org](http://www.thelink.org)

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

National Institute of Health (NIH)  
[www.nih.gov](http://www.nih.gov)

National Institute of Mental Health (NIMH)  
[www.nimh.nih.gov](http://www.nimh.nih.gov)

National Organization for People of Color  
Against Suicide (NOPCAS)  
[www.nopcas.com](http://www.nopcas.com)

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

National Suicide Prevention Lifeline  
[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

Office of the Surgeon General  
[www.surgeongeneral.gov](http://www.surgeongeneral.gov)

Organization for Attempters and Survivors of  
Suicide and Interfaith Services (OASSIS)  
[www.oassis.org](http://www.oassis.org)

Samaritans USA  
[www.samaritansnyc.org](http://www.samaritansnyc.org)

Suicide Awareness Voices of Education  
(SAVE)  
[www.save.org](http://www.save.org)

Centre for Suicide Prevention  
[www.suicideinfo.ca](http://www.suicideinfo.ca)

Suicide Prevention Action Network  
(SPAN USA)  
[www.spanusa.org](http://www.spanusa.org)

Suicide Prevention Resource Center  
(SPRC)  
[www.sprc.org](http://www.sprc.org)

Yellow Ribbon Suicide Prevention Program  
[www.yellowribbon.org](http://www.yellowribbon.org)

# Do You Know the Warning Signs of Acute Suicide Risk?

The American Association of Suicidology (AAS) offers the empirically-based IS PATH WARM? Posters and Wallet Cards to keep this vital information where you need it, when you need it. These Warning Signs were developed by an international task force assembled by AAS, and are recognized as a Best Practice by the U.S. Department of Health and Human Services. A grant from the Charles E. Kubly Foundation, Wisconsin, provided the design of these materials.

## POSTER:

24 x 30 inches, unframed

\$4 Each\*

Orders of 10 or more shipped to same address

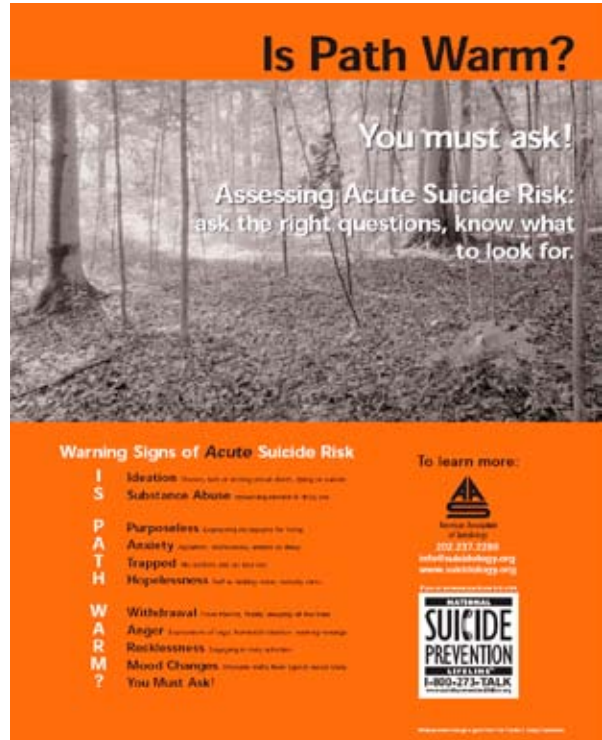
\$3 Each\*

## WALLET CARDS:

Unfolded, 200 count

\$25

\*Shipping costs will be added to cost of total order.



## ORDER FORM

Bill to:  
Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
(City, State, Zip)

Phone (\_\_\_\_) \_\_\_\_\_

Ship to: (if different from above)

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
(City, State, Zip)

Quantities:

Posters \_\_\_\_\_ x \$ \_\_\_\_\_ = \$ \_\_\_\_\_

Cards \_\_\_\_\_ x \$ \_\_\_\_\_ = \$ \_\_\_\_\_

Total = \$ \_\_\_\_\_

Shipping additional \_\_\_\_\_

Paid by: \_\_\_\_\_ Cash \_\_\_\_\_ Check  
(Payable to AAS)

Credit Card # \_\_\_\_\_

(Visa, MasterCard, AmEx)

Name on card: \_\_\_\_\_

Expiration date: \_\_\_\_\_

Signature: \_\_\_\_\_

Please return form to AAS at  
5221 Wisconsin Ave., Washington, D.C., 20015,  
or fax to (202) 237-2282.

**Skip the pen and ink - Order Online!**  
<http://www.suicidology.org/web/guest/store>

# Why not mark Suicide Prevention Week with an AAS training or certification?

## **AAS Crisis Call Center Accreditation**

Be competent and confident in crisis intervention with AAS Accreditation. For crisis centers and individual workers.

<http://www.suicidology.org/web/guest/certification-programs/crisis-centers>



## **AAS's School Suicide Prevention Accreditation Program**

For school psychologists, social workers, counselors, nurses, and all others dedicated to or responsible for reducing the incidence of suicide and suicidal behaviors among today's school-age youth.

<http://www.suicidology.org/web/guest/certification-programs/school-professionals>

## **The Forensic Suicidology Certification Program**

A board-certification program for those with exemplary credentials in suicidology and courtroom testimony.

<http://www.suicidology.org/web/guest/certification-programs/forensics>



## **Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians (RRSR)**

An advanced, interactive training based on established core competencies that mental health professionals need in order to effectively assess and manage suicide risk.

<http://www.suicidology.org/web/guest/education-and-training/rrsr>



## **Recognizing and Responding to Suicide Risk: Essential Skills in Primary Care (RRSR-PC)**

The RRSR-PC was developed to provide Physicians (PCPs), Nurses/Nurse Practitioners, and Physicians Assistants with the knowledge they need in order to include suicide risk assessments in routine office visits, to elicit risk, and work with patients to create treatment plans. The RRSR-PC can be delivered in person or by webinar.

<http://www.suicidology.org/web/guest/education-and-training/rrsr->

There are some things you do **not** want to learn by experience...



One of them is recognizing suicide risk in one of your clients.

We can teach you how.

### **RRSR- PC: The Webinar**



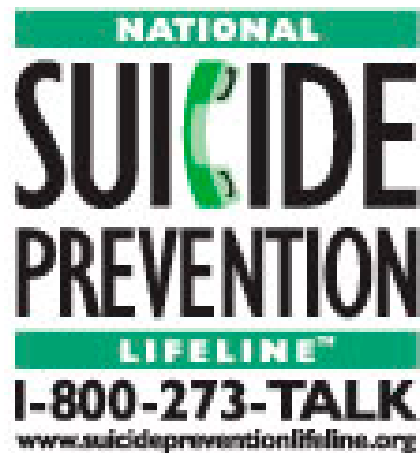
The American Association of Suicidology, the experts in suicide prevention training for health care professionals, is pleased to announce 4 webinar presentations of Recognizing and Responding to Suicide Risk in Primary Care. This 90-minute program, utilizing clinical video vignettes, provides the learner with an interactive approach to recognizing the signs of depression and determining suicide risk. But it's more than just a webinar. You will come away with tools you can take back to your practice to put into use immediately.

<http://www.suicidology.org/web/guest/education-and-train/rrsr-pc-webinar>

**Check out our website for more information!**

<http://www.suicidology.org/web/guest/education-and-training>

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).





AMERICAN ASSOCIATION OF SUICIDOLOGY

## **Mark your Calendar!**

Plan to join us in Portland, OR  
at the  
Hilton Portland & Executive Towers  
for the

44th AAS Annual Conference  
*Changing the Legacy of Suicide*

April 13th to 16th, 2011

Call for papers at  
[www.suicidology.org](http://www.suicidology.org)

For more information:

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