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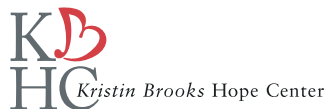
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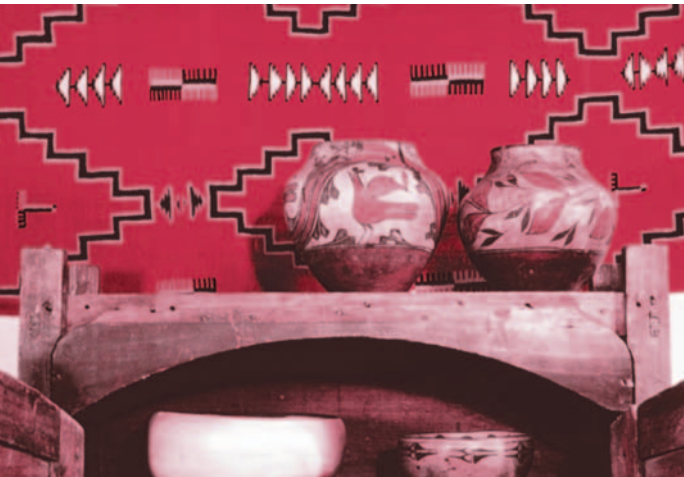
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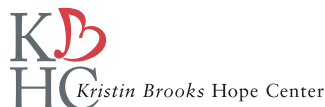
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Part II  
Understanding Suicide  
In the 21st Century

March/April 2003

# PREVENTING SUICIDE

The National Journal

volume two • number two

## Understanding Suicide in the 21st Century

### First in a Two-Part Series

*Featuring:*

**Richard Balon, M.D.**

**Lanny Berman, Ph.D.**

**David Lester, Ph.D.**

**Edwin Shneidman, Ph.D.**

**The Emerging Problem of Internet Tragedies—A Call to Action**

# From the Desk of the Editor

## Understanding Suicide in the 21st Century: Why We Created This Portfolio

In the August 30, 1902 issue of the Journal of the American Medical Association (JAMA) there was an article that referred to a 1901 analysis of suicides in 50 American cities, finding a suicide rate of 16.6 per 100,000 population. However, using 1900 census figures, the estimated suicide rate for the nation in 1901, including both rural and urban environments, was 11.8 per 100,000 population. In the year 2000, the overall suicide rate was reported as 10.6 per 100,000 population.

If we accept both these rates as accurate, we can conclude that it took 99 years to decrease the suicide rate by 1.2 per 100,000. That gives me pause. What happened in the last century?

We know that we know more about suicidology and suicidal ideation, intent, gestures, attempts and completions today than we knew in 1901. We know that we have a much more refined understanding of the interactions between these thoughts, emotions and behaviors. So why isn't the suicide rate reflective of the work done, the observations made and the lessons learned in the 20th century? Is it because we haven't figured out how to translate scientific findings and clinical interventions into meaningful suicide prevention programs? Is it because fundamental pieces of the suicide puzzle have eluded us? Is it because we don't know what to look for or what to ask? The unchanging suicide rates raise many questions.

In an attempt to better understand what we have learned and what we have yet to learn, we posed the following four questions:

1. What do you feel is needed to move forward in our understanding and prevention of suicide in the 21st century?
2. How would you measure success in the field of suicide prevention?
3. Given the multidimensional nature of suicide, which dimension most needs to be developed for more effective suicide prevention—and what dimension do you feel holds the most promise if further developed for producing the greatest positive effect?
4. What are your thoughts on pharmacology and genetics in relation to suicide and suicide prevention?

Having posed these questions, we looked for people to answer them. We identified some (but certainly not all) of the American men and women who have advanced suicidology and suicide prevention in the last century, and asked them to help answer these questions. By asking these four questions we had hoped to get a snapshot of our field, in part to serve as a benchmark for the future. We thought of this exercise as a one-time glimpse of the "state-of-the-art" at the dawn of the 21st century. We also hoped that answers to these four questions would generate more sophisticated questions and probes. Well, we got much more than we had envisioned. In the process of looking for answers, other questions were raised and other ideas and perspectives emerged.

Diana Jones, our managing editor, volunteered for the task of interviewing these experts. We thought we could call each of these experts, ask them the four questions, transcribe their answers and be off the phone in half an hour. We thought we could get our answers quickly and, because there would be so much consensus, we would only have to ask a few of the better-known experts and leaders in the field. Much to our delight, all of the experts used this opportunity to passionately share with us their perspectives, insights, thoughts and personal feelings that went far beyond our four questions—so much so, that we have expanded this feature into a series.

Once we started listening to the experts, it became evident that it would be difficult to try to categorize them and their responses. There was unexpected divergence in response to some questions and surprising convergence to others, making it very difficult to categorize responses and experts. What I came away with is the reaffirmation that the field of suicidology is alive and well, filled with men and women of different philosophical, psychological and scientific persuasions. Controversy exists and this is, indeed, a good thing, because this is how a scientific field advances—not in a linear path, but through fits and starts.

It is my hope that out of this varying array of viewpoints will come some new thinking and new approaches to the study of suicidology and suicide prevention. It is my hope that in the year 2100 (if not a lot sooner!) we can say conclusively that the 21st century, advancing on the accomplishments of the 20th century, brought an end to suicides in this nation.

One final note: Out of respect for these experts, we are presenting their interviews in alphabetical order in each of the two journal features.

I would like to take this opportunity to thank each one for his or her time, energy and commitment to the field of suicidology. Collectively, through this process, I believe that they have contributed to the advancement of suicide prevention in the 21st century.

Morton M. Silverman, M.D.

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### Reaching Those in Trouble: A Plea for Improved Technology

**To the Editor:** On Monday, Feb. 24, I received an e-mail addressed to the American Foundation for Suicide Prevention (AFSP), Midwest Chapter. The writer, who gave his name only as "Matt," was clearly depressed. He had lost his job and his family, had been denied unemployment insurance and social security and was talking of ending his life, to "make room for the rest" of us.

Twenty-one months ago I lost my 25-year-old son to suicide. I didn't have it in me to ignore Matt's plea for help. To be able to help him, however, I needed to locate him. Time was of the essence. I called 9-1-1 and reached the Chicago police. I asked them to trace his e-mail address. I was transferred eight times to eight different officers, all of whom were actually very concerned. None of them could help me, however. Eventually I was given a telephone number for the Illinois State Police. I called it and was transferred six more times to six different concerned officers. From one I obtained the pager number of the officer in charge of computer crimes. I was told he had the technology that could help me. I left emergency pages for him three times. Four days later, as I sat down to write this letter, I had yet to hear back from him.

Realizing the importance of timing in relation to Matt's call, I then telephoned the national headquarters of AFSP to see if anyone there had experience in tracking calls. I spoke with Bob Gebbia, our executive director. He suggested that I call KBHC, which manages the 1.800.SUICIDE Hopeline network, in the hope of finding the necessary technology. I contacted Melinda Moore, the executive director. She was very understanding. She suggested I call Matt's internet company.

Using a search engine, I located it in St. Louis, Mo., and obtained from the internet the name and telephone number of its chief executive officer. I called him. I felt in this case that a deviation from the company's normal privacy policies was in order.

I was directed to a customer service representative, who, upon hearing the word "suicide," immediately transferred my call to his supervisor, Lori Jo. She was a winner. She worked with me for 30 minutes to try to locate Matt. She eventually sent me back home to my computer and had me send her a copy of the original e-mail, so she could try and locate Matt through the IP address on it.

About an hour after I got her the information, I received a call from Jason, who worked with Lori Jo. According to him, the provider had located Matt and planned to notify the police. The only information the company would release to me was that Matt lived somewhere in Wisconsin.

By this time, I had also received a response to my e-mail from Matt. His note, I thought, was a good sign, even though he still sounded quite depressed.

That night I sent Matt two or three more messages. I got little sleep because I was so concerned about him. All through the night I checked my e-mail. There was no word from Matt. When I arrived at work the following morning, however, I found a message from Matt, saying he would call me by 11 a.m. He kept his word and we spoke. He gave me his phone number and address in Wisconsin.

Yesterday, there was a meeting with Matt to begin to get him the help he needs. We have yet to see where all this will lead.

The point of my sharing this story with you now is to make you aware of how difficult it is to locate someone in real trouble, someone who will not, or cannot, disclose his or her actual location. The anonymity of the internet is today a major challenge for those of us who wish to help those who are calling out.

This letter is a plea for help: WE NEED A BETTER SYSTEM. WE NEED BETTER LAWS. WE NEED TO BE ABLE TO TRACK DOWN PEOPLE IN DESPERATE NEED OF HELP. FINDING THEM IS A HUGE PROBLEM.

**Stan Lewy**  
**President AFSP, Midwest Chapter**  
**Chicago, Ill.**

*Publisher's Note: What Stan outlines in this internet intervention account highlights the need for a call to action. (See page 12 for details.) There are many crisis centers that will take internet e-mail pleas for help. One is Community Crisis Center in Maryland. It can be accessed by going to: info@communitycrisis.org. The hotline there is 24-7. However the e-mail responses are periodic and not instantaneous. KBHC's policy on internet interventions, until the task force makes its rulings, is to "at first do no harm," and sending an e-mail or having a crisis center send an e-mail before contacting the police or ISP is the first point of contact. In the first e-mail make sure you always include 1.800.SUICIDE (784-2433) as a point of contact for the person in crisis. Also include helpful web sites, many of which are linked from www.hopeline.com. Offering referrals for mental health assessment and simultaneously making the point that depression is treatable is a staple of all our e-mail interventions.*

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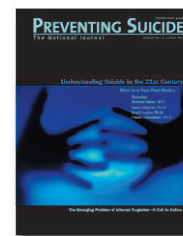
- Wellstone Mental Health Parity Act of 2003 presented in D.C.
- Upcoming Events Nationwide

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##### Part I of a Series

Leading experts in the field of suicidology offer views for the future. Featured this month are interviews with:	
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**About this cover:**  
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## Choosing against life

By Thomas Curwen

**A Sorrow Beyond Dreams** by Peter Handke. Translated from the German by Ralph Manheim, (New York Review of Books: 80 pp., \$10.95 paper)

**The Angel and the Dragon: A Father's Search for Answers to his Son's Mental Illness and Suicide** by Jonathan Aurthur. (Health Communications: 362 pp., \$12.95 paper)

Judging whether life is worth living or not is, as Camus famously wrote, the fundamental question of philosophy. Yet he clearly understates the problem. For those who kill themselves, there can be no second-guessing. That decision is merely the surcease of pain. Hardly an answer, it is the beginning of the anger, the sorrow, the guilt, disbelief and shame for those left behind. But the real legacy of suicide is a story, a reiteration of Camus' question tied onto every memory and every memory recast, reshaped and re-imagined to provide an explanation for an event that has none. Perhaps no two authors could be more dissimilar in their ventures into this territory than Peter Handke and Jonathan Aurthur, and it is precisely their differences that make their stories important today.

"A Sorrow Beyond Dreams," first published in 1975, is Handke's account of his mother's life and death. Prosaic, poetic, elliptical and self-conscious, it is an exacting picture of the shock and grief that await those who have inherited the ruins of a suicide. "The Angel and the Dragon" is messier and more desperate. The story of Charley Aurthur's life and his death in 1996, told by his father, lacks literary concision but gains momentum in its inconsolable grappling with the meaning of mental illness.

Charley Aurthur was by all accounts a talented and precocious child. He was born in 1973 of activist (and soon to be divorced) parents, grew up in Southern California, played the piano with obvious aptitude and wrote. By the time he turned 15, however, a shadow, tinged by insomnia and abrupt mood swings, had begun to dim his talent. Then, the summer between his freshman and sophomore years at college, he took a trip to Yosemite and, while driving home, totaled the family car. A week later, he was sitting with his parents and a psychiatrist, who recommended that he be hospitalized. It is every parent's nightmare: Aurthur and his ex-wife learned that the accident and Charley's subsequent behavior—jittery, dazed, anxious and weeping—were most easily understood as the symptoms of a psychotic break.

The Aurthurs' introduction to the world of mental illness was precipitous. For his part, Charley experienced disorienting extremes of delusion and despair, reconstructed here through his letters, poetry and journal entries. His doctors debated whether he suffered from manic depression or schizophrenia. (Their diagnoses were often guided by the effectiveness of specific medications, which after one suicide attempt became a cocktail of Navane, Cogentin, Klonopin, lithium and Wellbutrin, cut by an occasional session of psychotherapy.) Aurthur was no better prepared emotionally—or financially—than Charley and found himself searching the past and the present for why his once seemingly balanced child had changed and what could be done to set his life right. He ranged broadly through the written landscape—from Michel Foucault to A. Alvarez, from Kay Redfield Jamison to Kate Millett—scrutinizing biomedical and psychosocial treatments and confronting his own powerlessness in the face of Charley's rapid decline.

Mental illness is a phrase you won't find in Handke's account of his mother's death, yet it surely waits in the wings. While attempting a factual account of his mother's life, told with a journalist's precision ("The Sunday edition of the *Karntner Volkszeitung*," his story begins, "carried the following item under 'Local News': 'In the village of A. (G. township), a housewife, aged 51, committed suicide on Friday night...'", Handke can't help but fall through the occasional trap door. "This story," he concedes, "... is really about the nameless, about speechless moments of terror."

Born in a small Austrian village in the 1920s, Handke's mother—he keeps her nameless—lived in a world constrained by history and convention. Pregnant by her first love—a married man who disappeared from her life as quickly as he appeared—she married a German army sergeant, and, after World War II, they settled in Berlin, where he worked as a streetcar motorman and drank, worked as a baker and drank, and finally just drank. She had a second child, aborted a third and grew old before her time. In 1948, they fled the eastern sector of the city and returned to Austria, to the house where she

was born. "Squalid misery can be described in concrete terms," Handke writes; "poverty can only be intimated in symbols." And poverty abounded. Given the fact of her death, the mystery is how she survived these years, but it is not uncommon to find purpose in great hardship. She swaddled herself with the illusion of progress, the chimera of change, and, in truth, her husband, now in middle age, was becoming less of a bully, and she—we are told rather cryptically—"was gradually becoming an individual."

But suicide is not the result of one moment or one wound. It is a slow accumulation of pain, often triggered by a physical malady. She began having bad headaches. Her doctor thought it was a strangulated nerve, and what first incapacitated her ("She dropped everything she picked up, and would gladly have followed it in its fall. Doors got in her way; the mold seemed to rain from the walls as she passed...") became a chronic condition. She visited a neurologist, whose diagnosis, "nervous breakdown," provided a strange comfort. "He knew what was wrong with her; at least he had a name for her condition. And she wasn't the only one; there were others in the waiting room." And so she endured, traveling to Yugoslavia, putting up fruit and vegetables for the winter and talking of adopting a child, until the world closed in on her. When her husband, who had been sent to a sanatorium with tuberculosis, started getting well, she grew desperate again. She stopped seeing people. She shut herself up in her house. She went to a pharmacist for 100 sleeping pills.

The final pages of Handke's story are a wrenching litany of real and imagined moments, of syncopated flights of mostly single-sentence paragraphs—heart-wrenching associations and chasms of silence between each thought—and when he recounts the flight home for the funeral, he confesses: "I was beside myself with pride that she had committed suicide," as if she had finally availed herself of the only freedom remaining to her. It is a stunning line. Could Jonathan Aurthur make this claim? Perhaps. Eleven days after Charley leaped from Lincoln Boulevard into the morning rush hour on the Santa Monica Freeway, Aurthur visited the overpass, stared into the flow of traffic and walked away feeling suddenly, perhaps inexplicably, liberated. "[Charley's] terrible affliction and suffering had imprisoned him but it had also imprisoned me," he writes, "and now both of us were free."

During his last three years, Charley had been buffeted among five hospitals, a process that Aurthur equates with the life of a soldier "repeatedly wounded, repeatedly sprayed with sulfa drugs and patched up and sent back to the trenches, a little weaker each time." At the end of each treatment, Aurthur was left with no greater certainty about what could be done to restore his son, and, indeed, questioned whether the cure might be worse than the disease.

Thirty years may be an instant and an eternity when comparing the world between "A Sorrow Beyond Dreams" and "The Angel and the Dragon," but the before and after of a suicide has changed little. The statistics are stark. In this country today, a person completes a suicide every 15 minutes, and almost as often someone is left behind to try to make sense of it. It may be a father remembering his son; it may be a son remembering his mother. In either case, it is less a philosophical question than a profoundly social problem.

While the pleasure, if this is the word, of reading Handke comes from the existential assumptions of his story, it is important to realize that suicide — the reality, as opposed to the idea (which Camus seemed to savor) — is not an existential dilemma. It is the final, tragic outcome of a psychiatric illness. Yet how prepared are we for this knowledge?

There is no more a prescribed course for treating mental illness than there is a prescribed course for being human, and as Aurthur looks at what we now know—and don't know—about mental illness, it becomes clear that the model we have today for understanding the diseases of the mind and suicide is inadequate. Beyond the brain-mind dichotomy that has of late polarized our understanding of human behavior must lie a paradigm that will break the icy rivers of vested interests, professional bias and brazen certainty and encompass the complex social and emotional roots of these diseases. Certainly, Handke's and Aurthur's books suggest this need. ■

Thomas Curwen is the deputy editor of the Los Angeles Times Book Review, where this essay first appeared.

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# Understanding Suicide in the 21st Century

*America's leading suicidologists discuss what is needed to help prevent suicide in the future.*

Each of our experts was asked the four questions presented in bold face. Their answers are as varied as their disciplines.



**Richard Balon, M.D.**

*Associate Director of Residency Training & Director of Master of Science in Psychiatry Program at Wayne State University Specialist in clinical psychopharmacology, anxiety and mood disorders and sexual dysfunction*

**Question: What do you feel is needed to move forward in our understanding and prevention of suicide in the 21st century?**

We need large studies. We need also some solid epidemiological data such as we have seen, for instance, in Sweden, where they have a birth registry and they can really get the feel of what's happening across the country. In this country, we get some statistics from different places, which are not representative of the way things are across the board. In Sweden, I saw an article that compared the use of antidepressants in relation to the rates of suicide there. I don't think we have been able to do that kind of thing in this country.

To move forward in our understanding and prevention of suicide in this country, we need more statistical studies, such as what is done in some European countries, in particular the Scandinavian countries, where they can get data across the country and a better representative sample.

As far as the prevention of suicide goes, the primary concern is getting more research data. The other important things, I think, are education and being able to detect, at least in some populations, some signs that things are not going well and to have the public be aware of the fact that there is help, that we can do something about it. I still have the feeling that that's not the case.

The public must be made aware. There is a manuscript I recently reviewed that talks about some similarity to a cardiac prevention model. Using something like this will help people better recognize that there is a problem, that suicide is a possibility, in addition to the warning signs. I don't know if we have enough data for that. Certainly there are some warning signs, but people don't always pay attention to them so that they can recognize them. Then, if that is the case, whom should they notify and how should they do it, and who is the first professional contact and what happens after that? It's the stuff, which, as I said, exists in the manuscript that draws some parallels between prevention of cardiac disease and the prevention of suicide. I don't think we have done anything like this. That's why this article is so interesting—because we don't have anything in that sense. For the prevention of suicide that would be a wonderful thing.

Another thing is that each state is different, and this is a huge country. We don't have anything unifying the country so we can compare one or two places to see if a new approach or technique would work. We have no way to compare one state to another to see if something like this works in regard to, say, education, the way people are responding to something, what to do quickly, etc. If we had this, we could do a longitudinal study to tell us if these rates were going down or not. We don't have anything like that. In many states we don't have anything at all that functions in a reasonable way. The American Association of Suicidology is doing a great job, but it's not up to the association to establish what I'm talking about. I can assure you that in Michigan there is not much happening in this area.

**Question: How would you measure success in the field of suicide prevention?**

The ultimate measure would be the completed-suicide rates would go down. Again, how accurate and how good it is across the country and different states, I don't know. It's probably the ultimate scientific dream that the suicide rates would go down. If you can do an ideal study where you could take the population and measure suicidology in that population, it would be even better; but I don't think that is possible. I think the ultimate scientific thing would be to see that the suicide rates go down. I don't know how low they can go since we cannot prevent every suicide, but I would like to see the numbers going down.

**Question: Given the multidimensional nature of suicide, which dimension most needs to be developed for more effective suicide prevention—and what dimension do you feel holds the most promise if further developed for producing the greatest positive effect?**

I don't think it's biology right now. I don't think we have a good answer in the area of biology in terms of the research. It certainly is psychology, and spirituality also is an important issue for people. At the present time, I think those areas might be the most important. We sometimes talk about 'the Age of Anxiety.' I don't think we have a full understanding of certain things, such as suicide going on with young people out of desperation. As regards the dimensions that hold the most promise, I would say they are understanding the psychology, together with the giving of hope, and certainly psychiatry, too, if the suicide is a part of some mental illness—because not every suicide is necessarily a part of mental illness.

I don't think there is any one area in particular that holds the most promise. For me, probably the psychological aspects of what is going on would come first. I don't think we have a full understanding of what is going on. We almost go from one extreme to the other and try to do a lot, but I don't think, as I said, right now we have a great understanding or that we are progressing in this area. Contrary to my orientation, I'd probably advocate more for psychology.

**Question: What are your thoughts on pharmacology and genetics in relation to suicide and suicide prevention?**

I think it is possible for pharmacology to play a significant role in reducing suicide, but I think we have to look at it realistically. It doesn't mean that everybody should be medicated, certainly. There are some data. The recent study on the use of Clozapine in schizophrenic patients showed some decrease in suicidality. For medical reasons, the study couldn't have suicide as an outcome measuring it. We cannot say that Clozapine is really

preventing suicide, per se. The article showed that there is a decrease of suicidality. Actually there are some mistakes in the article, and I'm going to write a letter about it. That certainly may help in schizophrenia and in some other mental disorders, because we know that in these diseases or disorders there is a propensity to higher rates of suicidality and completed suicide; but if we can properly treat people, it looks hopeful.

There are also data that show the decrease of suicide with the increased use of serotonergic antidepressants in Sweden. We can properly treat depression. We properly treat schizophrenia with some drugs that we know can prevent suicidality. Lithium now is decreasing the suicidality in people with bipolar disorder. There is a wonderful study, which was done in Sardinia by Drs. Tondo and Baldessarini on the use of lithium. I think if people get properly treated, then we can see how we can get help in the area of mental illness. That, again, does not address the area of people who might commit suicide for other reasons.

In psychiatry, we tended to feel that suicide is necessarily just a part of mental illness, but the original thinking of Durkheim and other people showed other kinds of suicide, not just those that are part of mental illness. That's the hardest part to address in the future because that's the one we know least about. And then there are tons of different factors, which point at people of this age or sex or disease or whatever, but we cannot put a definite finger on it or put them in certain groups. While with, let's say, people with major depression or bipolar disorder or with schizophrenia, we know that these people have a higher chance of trying to commit suicide or feeling suicidal. So with those, we know that if we can really get them stable with good treatment, then we can be successful with the remaining segment of people who I'd say are chronically ill or desperate about some other situation.

I think pharmacology doesn't answer problems in the area of mental illnesses that have higher rates of suicidality, suicidal attempts or completed suicides. If these illnesses get properly treated, we can decrease a rate of suicide in them. But as for the rest of suicide, that's a hard thing, as I said.

I don't think that genetics at the present time could give us an answer. I think it's a very complicated issue. We know from clinical practice that if somebody has a family history of suicide, there's a higher chance the person is going to try and kill himself or herself. I don't think we're going to be able to analyze a gene or combination of genes in the near future. I remember once I was watching Francis Collins talking on Charlie Rose at night, and he said it himself, the area of mental illness is the most complicated one as far as identifying anything in genetics. I think we have to be very careful because we have been through these fantastic discoveries that we have a gene for this and that, and six months later it totally disappeared. For a

complicated phenomenon of many factors in the possible etiology, genetics at the present time cannot give us many answers to this question.

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*a member of the editorial board of several psychiatric journals, including Suicide & Life-Threatening Behavior. He is a member of numerous professional organizations, such as the American Psychiatric Association (Distinguished Fellow), American Association of Suicidology, American College of Psychiatrists (Fellow), Society of Biological Psychiatry, AACT and CINP.*



## **Lanny Berman, Ph.D.**

*Executive Director, American Association of Suicidology*

**Question: What do you feel is needed to move forward in our understanding and prevention of suicide in the 21st century?**

What comes to mind first is the need for infrastructure support. We're not going to advance our understanding without significant funding of research and evaluated pilot/demonstration programs to assess what works in regard to suicide prevention. Embedded in that statement is the need for empirical evaluation. The time has come, I believe, to move away from testimonials and, potentially, idols of false belief based on good feeling approaches and toward models which we can truly demonstrate make changes that matter. That's no small task; which goes back to the notion of needing serious funding to make that happen. Embedded, as well, I believe, is the need for cooperation between and among organizations and individuals who are involved in the process, because it is highly unlikely that any one organization or one research center is going to be able to significantly move us ahead without having the involvement of a variety of perspectives.

Given the complexity of suicide and therefore of suicide prevention, it is no surprise that we have taken a buckshot approach, hoping that one pellet will hit the target, only then to realize that this is, indeed, a very complex phenomenon and that we are only impacting a very small piece of what has to be impacted. So what also is needed is a truly integrative model of suicide prevention.

We could, for example, do something about decreasing the incidence or severity of depression; however, without some correlated decreases in other aspects of the problem this may not significantly impact the rate of suicide. In the same vein, there are needs for very serious work to occur in subpopulations that, because of their higher incidence of suicide or suicidal behaviors, have to be targeted for specific focus. As an example, when we think about reducing the rate of suicide, we have to note the significant gender difference in completed suicide. So it is imperative to develop models of suicide prevention that will specifically better understand and implement

interventions that we can evaluate with regard to males, who do not generally seek help for their problems; and subgroup populations such as blacks or Native Americans, etc., who may require culturally specific interventions to impact their suicidality. There is, at present, little to no funded research that is subgroup focused in understanding risk among subpopulations and, therefore, developing prevention programs in those populations.

**Question: How would you measure success in the field of suicide prevention?**

That's a very good and terribly complex question. Success could be measured on several levels. One is demonstrating short-term success in reducing known risk factors for suicide or its correlate, that is, increasing factors that protect against suicidality. If we can demonstrate that we can do that, that's one step toward success; but, again, it may be a very small part of the overall package of success that has to be demonstrated.

The second level of success would be to demonstrate that we can, indeed, increase the level of professional knowledge and understanding of suicidal individuals such that we can dramatically increase the quality or effectiveness of treatment of suicidal individuals who are recognized and referred for treatment. Thirdly, we can measure success on a broader scale through intervention models that accomplish simply desired objectives. These may involve an increase in knowledge, although increased knowledge has to be paired with consequent behaviors. The bottom line, obviously, is measuring success over the long term, in reducing rates of suicide; but that requires a long period of study to measure the impact of any intervention or prevention effort. Therein lies a very significant problem that has to change in the 21st century, and that is having funded programs that can be evaluated over the long term; thus, they need to be funded over the long term. That's a whole shift in philosophy regarding how things are generally funded.

**Question: Given the multidimensional nature of suicide, which dimension most needs to be developed for more effective prevention—and what dimension do you feel holds the most**

## promise if further developed for producing the greatest positive effect?

The heart of suicide prevention clearly has moved to the arena of public health. That is appropriate. The view of suicide as a significant public health problem is an effective way to mobilize resources to deal with this on a par with other major public health problems. That being said, suicide still has to be thought of as an untoward and tragic outcome from what is primarily a mental health problem. We know, for example, from psychological autopsy studies that 90-plus percent of all suicides can be retrospectively diagnosed as having one or more mental disorders. If we ignore, for the moment, the less than 10 percent that do not show sufficient symptom clusters to be diagnosed and assume that for the most part all suicides stem from a psychological-psychiatric vulnerability, then we have a clear focus for what has to be done to make a difference if we could only impact one area. That is, we have to improve upon the recognition, referral, assessment and effective treatment of those who have suicide risk. That begins with those who have mental disorders. To accomplish this, we clearly need a multifaceted approach. At the heart of that approach, however, has to be a better-trained, professional, care-giving community, which, at present, is ill-trained, under-trained and ineffectively trained to understand the suicidal character, to understand suicide risk, to understand the evaluation of that risk, and to understand and implement multifaceted treatment approaches that we, again, need to evaluate as effective.

## Question: What are your thoughts on pharmacology and genetics in relation to suicide and suicide prevention?

I assume we're talking about pharmacotherapeutic intervention. There is no question from the research literature that the most effective treatment of depression, no less perhaps than many other mental disorders, is a combination of pharmacotherapy and psychotherapy. Therefore pharmacology is an integral part of the recipe that defines a significant intervention for people at risk. At the same time we have a fair way to go to better understand and develop medications that more effectively work.

We need to better understand what there is about those individuals for whom medication does not appear to work, and we need to have a better appreciation of the iatrogenic effects of pharmacotherapy, particularly when multiple medications have not worked in any one individual over time; the down side risk in these cases—thankfully there are few relative to the majority—has to do with inducing hopelessness. That is obviously not what we want to do. So I'm a firm supporter of pharmacotherapeutic intervention in combination with psychotherapy and I believe that we have yet a considerable amount of study to do better at both.

With regard to genetics, I think our understanding of genetic influences in suicide is important. There is no doubt that a suicidal vulnerability runs in families and that one significant reason for that is a genetic vulnerability to

predisposing conditions. Genetics clearly has the most importance if and when we are able to develop genetic markers for suicide, for suicidality, and correspondingly, therefore, prevention and treatment models that will be responsive.

*Dr. Berman is Executive Director of the American Association of Suicidology (AAS). He is a past president of the AAS (1984-1985) and its 1982 Shneidman Award recipient (for Outstanding Contributions in Research in Suicidology). He holds a B.A. degree from the Johns Hopkins University and a Ph.D. from the Catholic University of America. From 1969 to 1991 he taught at the American University, where he attained the rank of tenured full professor. In 1991 Dr. Berman's appointment was changed to that of Distinguished Adjunct Professor, when he was named director of the newly established National Center for the Study and Prevention of Suicide at the Washington School of Psychiatry, a position he held until accepting his current role with the AAS in January, 1995.*

*A Diplomate in Clinical Psychology (American Board of Professional Psychology) and a Fellow of the American Psychological Association, Dr. Berman maintains a full-time private practice of psychotherapy and psychological consultation at the Washington (D.C.) Psychological Center. He has published over 90 professional articles and book chapters. From 1990-1994, he served as case consultation editor of the journal, Suicide and Life Threatening Behavior (SLTB). In 1994 Dr. Berman was elected editor of SLTB; however, he resigned this position when he was chosen as the AAS's executive director. He remains a consulting editor to SLTB and three other journals. He is a Fellow of the International Academy of Suicide Research. In 1999 Dr. Berman was elected first vice president of the International Association for Suicide Prevention. He currently (2002—2003) is president-elect of Section (VII) of Behavioral Emergencies of the Division of Clinical Psychology (Div. 12) of the American Psychological Association.*

*Dr. Berman appears frequently on both national and local media. He has appeared on "The Today Show," "Good Morning America," "Hour Magazine," and "The Larry King Show." He has testified three times on Capitol Hill: on suicide among Vietnam combat veterans, on teenage suicide, and on the U.S.S. Iowa explosion. In 1996 he was appointed Consultant to the Office of Independent Counsel to investigate and finalize the report on the 1993 death of White House Counsel Vincent Foster, Jr.*

*He served on the HHS Federal Task Force on Youth Suicide Prevention (1985-6) and was an initiating member of the Centers for Disease Control sponsored "Working Group" on the operational criteria for the classification of suicide and the NIMH sponsored conference on developing a nomenclature for suicide morbidity. He frequently is asked to serve as an expert witness in legal cases involving suicide malpractice and wrongful death and has a national reputation as a teacher and professional workshop leader on the topics of suicide and youth suicide (assessment and intervention).*

*Dr. Berman has edited "Suicide Prevention: Case Consultations" (1990, N.Y.: Springer; is the senior author of "Adolescent Suicide: Assessment and Intervention" (1991), Wash., D.C.: American Psychological Association (David Jobes, co-author); and co-edited: (with Drs. Ronald Maris, John Maltsberger and Robert Yufit) "Assessment and Prediction of Suicide" (1992, N.Y.: Guilford Press), "Suicidology: Essays in Honor of Edwin S. Shneidman" (1995: with Drs. Antoon Leenaars, Pamela Cantor, Ronald Maris and Robert Litman), "Risk Management with Suicidal Patients" (1998: N.Y.: Guilford; with Drs. Bruce Bongar, Ronald Maris, Morton Silverman, Erik Harris and Wendy Packman); is co-author of "The Comprehensive Textbook of Suicidology and Suicide Prevention" (2000: N.Y.: Guilford; with Drs. Ronald Maris and Morton Silverman), and "The Encyclopedia of Suicide," 2nd Edition (In Press, N.Y.: Facts on File; with Carol Turkington).*



**David Lester, Ph.D.**

*Past President of the International Association for Suicide Prevention*

**Question: What do you feel is needed to move forward in our understanding and prevention of suicide in the 21st century?**

That is a very difficult question to answer because I think that the field has ground to a halt. I wrote a little piece a few years ago called “The End of Suicidology” in which I said that there have been no new theories, no new ideas and the research that’s getting published is the same kind of study—sometimes even exactly the same study—that has been done many, many times in the past. I feel that the field has come to a stop.

What is to be done in the 21st Century? Those of us who are in the field have run out of ideas. I don’t see many new people coming into the field. There are not many young people at the conferences or writing in the journals. We need some new ideas. We need some new, young scholars, who would not think along the same lines that we have and who maybe would come up with some bright new ideas. I’m much too old to do it. Most of us are getting too old to do it, and that’s true both for the research, the theory and for prevention.

Scholars—those of us in psychology and sociology—like to complain that suicide is still not a respectable topic. It’s not that there’s a stigma attached to it. It’s that to be successful in academic psychology, you have to be an experimental psychologist. You have to do laboratory research. If you are doing research into suicide, you cannot bring it into the laboratory. You cannot do experiments. Academic psychologists love experiments where you can manipulate the independent variable. You cannot manipulate suicidal behavior. Sociologists have a field called deviant behavior. You would think that suicide would fit there, but sociologists also say that research on suicide is not considered a mainstream topic. So it’s hard to see how we’re going to attract new scholars into the field.

I reckon that I’m going to sound very pessimistic throughout this interview. I have no ideas on how to attract new Ph.D.s to choose suicidology. Jim Rogers and I have been talking for years about doing a book called something like “The Anatomy of Suicidology,” in which we tear the field apart and then propose new ideas or new directions for it. The book is still on hold. We think about it from time to time, and maybe we will finish it.

**Question: How would you measure success in the field of suicide prevention?**

The four ideas that are around now are the same four ideas that have been around for a long time: psychiatric treatment and psychotherapy, suicide prevention centers, restricting access to lethal methods and school educational programs. And that’s it. We’ve known this for 30 or 40 years. Those are the four major tactics. In most of them,

we’ve done as much as we can. America is saturated with suicide prevention centers. The idea of a national toll-free hotline is new; but we’ve had suicide prevention centers, more than 250 now, for a long time. There is not much more we can do there.

Regarding school education programs, a lot of people think that they’re not that good. I’ve just worked with Antoon Leenaars on an article reviewing the evaluation studies, and there are no good evaluation studies.

Similarly, there aren’t many researchers trying to evaluate the success of suicide prevention centers. I did a major analysis a few years ago, but I doubt if there have been any new studies since then. People have given up evaluating whether these tactics work.

As for restricting access to lethal methods, America is never going to have strict, really strict, gun control. Domestic gas is already detoxified. Car exhaust is already cleaned up. Again, we’ve done as much as we can there.

As for psychiatric treatment—as a psychologist, it’s the tactic I’m least interested in—at least when more and more people are prescribed antidepressants then maybe the suicide rate will decrease. The suicide rate has dropped maybe a point, from 12 per 100,000 per year to 11 in the last decade. It may be that more people are taking Prozac and the other serotonin reuptake inhibitors [SRIs]. The only alternative there is to put them in the water supply so we would all get them. We have fluoride in the water. Maybe we should put Prozac in the water. People are speculating about the effect of antidepressants on suicide, but, again, it’s hard to do good research on the issue, and people have attacked the couple of papers that have been published, arguing that they do not provide conclusive evidence.

So there’s very little evaluation work being done. I’ll use an example from the school education programs. The research looks at whether the kids learn more about suicide and about whether they might respond differently to a suicidal peer. However, completed suicide is so rare that there are no studies seeing whether they actually have an impact on the suicide rate, and it’s not clear whether you would detect it even if it did have an impact. Most schools do not have a suicide every year, let alone 10 or 20 so that you could detect a decrease. Suicidologists are not working on a sound evaluation of this tactic, and the previous papers that have come out are inconclusive in their results.

How could we measure whether the tactics have had an impact? People are going to have to look at the gross suicide rate. But there are all kinds of factors that could affect that rate. I have a theory that suicide rates are higher when the quality of life is better. So maybe the fact that suicide rates are coming down in America means that life is getting worse. There could be all kinds of other social factors that affect the suicide rate, factors such as the unemployment rate and social integration.

As far as the American health care system is concerned,

mental health services were more extensive several years ago, and people were better covered for psychotherapy by their health care plans. Nowadays, the HMO that I belong to will only cover acute psychiatric care, with a limited amount per lifetime. Twenty years ago, my health care plan covered several years of psychotherapy. When my students ask what to do, whom to talk to, luckily we have a campus counseling center, a small one, but to use the resources in the community means that you are going to have to pay—find money out of your pocket or your parents' pockets and pay a lot for psychotherapy.

Ideally, I'd advocate taking a look at the American health care system as it pertains to mental illness, depression and suicide prevention—a total re-evaluation. However, England has a national health service, and there are a lot of complaints about it. My cousin, two years ago, had surgery for a cancer and fell apart. She went to the appropriate people and said "I need to talk to someone." They said, "Great, we'll get you an appointment with a therapist, maybe in a year." After a year, she felt better, and she didn't go for counseling. To have a really good health care system in this country would cost so much that it is not affordable. One can mouth these nice platitudes—yes, it would be nice to have better health care, better provisions for mental health services, educate doctors to detect depression and prescribe appropriately, etc. They are great ideas. One can mouth them and put them in 10-year plans, but I don't have any confidence that they will happen.

Think about the program in Gotland (Sweden) to educate physicians about detecting depression and prescribing antidepressants. The study claimed that it worked, that it cut the suicide rate—although people have argued with that—but the interesting thing is the program ended. They stopped educating the physicians. I don't know why. They implied that many of the physicians had moved away and that new physicians had come to the island so that, after three years, many of the physicians in Gotland had not been through the training. That implied that they stopped it. I've never read that the program was extended to educate physicians across Sweden. It was just a demonstration project. Perhaps the cost was too expensive or other priorities came up.

**Question: Given the multidimensional nature of suicide, which dimension most needs to be developed for more effective suicide prevention—and what dimension do you feel holds the most promise if further developed for producing the greatest positive effect?**

Psychotherapeutic and psychiatric treatment is probably going to be most important in the future. Psychologists (academics and researchers) and sociologists have had their chance, and they've done as much as they can. The advent of better antidepressants and their availability—the dissemination of information through

advertising on TV, etc.—means that more and more people will take them. The short-term cognitive therapies are good, effective, brief treatments so that more people can get short-term therapy and crisis intervention if it's necessary. That's where we have to focus. They are tactics that have existed for 10, 20 years, and they show great promise. I don't think that psychologists and sociologists and those in other disciplines are going to produce any new knowledge that will suggest new avenues for understanding or preventing suicide.

Psychological theories of suicide have been the weakest in the past. Very few mainstream psychologists have paid attention to the problem. None of the great theories of personality or the systems of psychotherapy have ever addressed the problem. Psychologists have a list of risk-factors for suicide that they simply add up. If you have depression, loss, low self-esteem and poor problem-solving skills, let's add up all these risk-factors and see what we can predict.

We do not have a good psychological classification of types of suicide. We simply use the psychiatric classification of disorders—schizophrenic suicides, borderline personality suicide, etc. We don't have a good psychological classification such as the one Durkheim proposed for the sociological study of suicide. Psychological research is the worst, and psychological theorizing is the worst. That's why there might be some room for advances there. But I'm a psychologist. Why don't I come up with them? I'm too old!

**Question: What are your thoughts on pharmacology and genetics in relation to suicide and suicide prevention?**

Psychiatrists try to discover the physiological and genetic bases for the different psychiatric disorders. Suicide is usually an afterthought. Most of the physiological research that was done on suicide was really an afterthought of their research on depression. They wanted to find out the physiological and genetic causes of depression and, since a lot of depressed people complete suicide, they could generate an article on suicide too. To focus on suicide rather than a classic psychiatric syndrome has not been done too much. Obviously the government has a lot of hope in the physiological approach to mental illness because a great deal of federal funding goes to physiological research.

The field, however, is getting confusing. To give you an example, it used to be that the serotonin reuptake inhibitors, the SRIs, were prescribed for depression. Then they gave SRIs to obsessive compulsives and to those with eating disorders, and next they discovered there were serotonin deficits in murderers and arsonists. Now they're giving SRIs for social anxiety.

It's a matter of faith whether you think that physiological and genetic research will advance our knowledge. But despite the fact that the theoretical basis

for this tactic is still weak, it's a cheap, quick and easy method for treating people, and Americans love drugs. They love pills. It seems odd to me that there are some drugs that are labelled illegal and you are persecuted if you sell or use them, like heroin or cocaine or marijuana, while there are others that are legal. We should let people take any kind of drug. Americans are horrified at this thought and support the war on illegal drugs while they happily take medications. Children and adolescents must see their parents as complete hypocrites. They get punished for using marijuana, but they see their parents taking legal drugs. Remember 'Mother's Little Helpers?' So many people were taking amphetamines 30 years ago that the Rolling Stones wrote a song about it.

There is no stigma attached to taking pills. It won't be hard to persuade Americans to take 'the good pills' if you can develop them and market them well. Ten years ago, I remember reading about towns in America where 80 percent of the people were on Prozac. On the one hand that was horrifying, but on the other hand at least everybody there was medicated. Researchers never checked on the suicide rate.

It is sad that we prosecute so many people for the illegal

drugs. Life is hard. Life is stressful. We have to acknowledge that, and if some people want to opt out mentally, numb their minds a little bit, or maybe a lot, and they don't harm other people, then that is fine. I don't really see much difference between somebody who is on Prozac and somebody who smokes marijuana each day. To me, they're both trying to reduce the psychological stress of living.

Given the American penchant for medications, pharmacology probably is the best approach for the future—developing better, safer, more targeted medications that will work for particular disorders.

*David Lester teaches at Richard Stockton College in Pomona, N.J. He has doctoral degrees in psychology (Brandeis University, U.S.A.) and social and political science (Cambridge University, England). He has served as President of the International Association for Suicide Prevention and has received the Dublin Award from the American Association of Suicidology.*



### **Edwin Shneidman, Ph.D.**

*Founder of the American Association of Suicidology.*

*Founding Editor of Suicide and Life Threatening Behavior*

#### **Question: What do you feel is needed to move forward in our understanding and prevention of suicide in the 21st century?**

In my personal opinion, what is needed is a new look at old catholicities. What we see now at the end of the 20th century is a narrowing of focus. We have biologized suicide far too much. In the circle of etiology, in the pie of causality, there are many elements including genetical, constitutional, biological but also including sociocultural, psychodynamic and strictly psychological. In my own personal opinion, we have short-shrified the phenomenological aspect of suicide, the psychological pain that I call "Psychache" and the crying need to scientize and quantify psychological pain and then to address that pain.

#### **Question: How would you measure success in the field of suicide prevention?**

That's a complicated question. It's more than simply looking at statistics. In fact, it's larger than saving lives. One would measure it in terms of a reduction—a global or community reduction of psychic pain. Just as there is psychic pain in each individual, one can measure psychic pain in a community. For example in the United States, the psychic pain has gone up in the last several months. One

needn't be too bright to point fingers there. I'm not sure. It's a moot and serious question meriting the most focused thought of our brightest scholars as to what need goals of suicide prevention are. For example, is it too iconoclastic to ask if the goal is to prevent suicide in every case? Is that a realistic goal? Certainly the goal is to have as few people suffer from intense, internal crushing pain, a kind of malaise of the spirit, as few as possible.

#### **Question: Given the multidimensional nature of suicide, which dimension most needs to be developed for more effective suicide prevention—and what dimension do you feel holds the most promise if further developed for producing the greatest positive effect?**

My response to that is redundant. I've answered that earlier in the interview. I believe that there is a great deal of psychological pain in the world without suicide, but that there is no suicide without a great deal of psychological pain. And what we have done, to use this phrase again, we have short-shrified the essence of suicide. It is a damp and dismal November in the mind. What we need to do is to go back to introspection. Wundt and Titchener gave introspection a bad name. They made it speciously accurate, dealing with trivial dimensions. But the life of the mind cannot be gainsaid. When Watson threw out the mind, that was a howling, enormous philosophical blunder, so big that it was accepted and called behaviorism. The most interesting part of the human experience is what goes on in the mind. The mind

has a mind of its own. The main purpose of the mind is to mind its own business. Suicide may have concomitants in the brain, but it is a function of the mind.

**Question: What are your thoughts on pharmacology and genetics in relation to suicide and suicide prevention?**

Pharmacology has its place. By that I mean that it's a two-edged sword. It has an enormous, contributing positive place, but it has a limited place. It's essentially, if one uses it philosophically, reductionistic. There's always a biochemical, bioelectrical symphony in the brain. No brain—no mind. But that doesn't mean that we shouldn't attempt to mind functions, and that's primarily what they are. The basis of this is: Is suicide a disease? My answer is no. It's a malaise. There's a world of difference. I'm one who does not quickly convert suicide into depression and then say what we need are antidepressants.

I'm not sure of my thoughts on genetics. I think there may be genetical dispositions as to mood. I think that in the dictionary sense of the word there are people who in utero and as infants and as children and as adolescents and young adults have a proclivity toward an optimistic view of the universe and themselves. And, furthermore, there are people who have a pessimistic view. They are dour. They are naysayers. It's a drag to be born on the dark side of life, on the dour side of life. Much of the interest in literature is on the dour side of life. Is not Melville more interesting as an author than Louisa May Alcott?

*Edwin Shneidman, Ph.D., was born in 1918 in York, Pa. He is Professor of Thanatology Emeritus at UCLA. During World War II he served from private to captain. In the 1950's he was co-founder and co-director of the Los Angeles Suicide Prevention Center. In the 1960's he was the charter chief of the Center for Study of Suicide Prevention at the National Institute of Mental Health in Bethesda, Md. He has been Visiting Professor at Harvard and at the Ben-Gurion University of the Negev in Beersheba. He has been research associate at the Karolinska Hospital in Stockholm and fellow at the Center for Advanced Study in the Behavioral Sciences at Stanford.*



*In 1968, he founded the American Association of Suicidology. He is the founding editor of the quarterly journal, "Suicide and Life-Threatening Behavior." He is the author of "Deaths of Man" (nominated for a National Book Award), "Voices of Death," "Definition of Suicide," "The Suicidal Mind and Comprehending Suicide" (winner of a CHOICE Award). He is a member of the Melville Society. He is a widower with four sons (all health professionals) and six grandchildren.* ■

Help is just a phone call away—that's the beauty of the National Hopeline Network's easy-to-remember 1-800-SUICIDE (784-2433) number. The way we see it, the more certified crisis centers in our network, the more effective our services will be. That's why we're issuing a blanket invitation to crisis centers across the nation to join us, free of charge.

The National Hopeline Network is the nation's only suicide prevention crisis hotline network linking American Association of Suicidology (AAS) and CONTACT USA certified crisis centers under one toll-free number. A simple call to our toll-free number puts a person in crisis (or someone close to that person) in immediate touch with help at the nearest AAS- or CONTACT USA-certified crisis center. The line is staffed 24 hours a day.

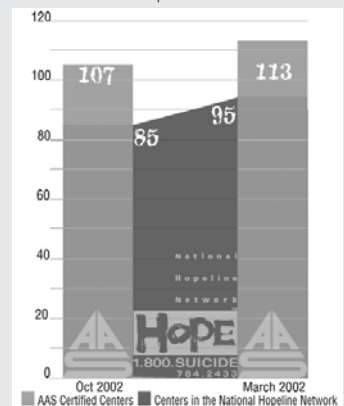
The fact that your crisis center may not be certified is not a problem. Free of charge, we will help you obtain national certification, thanks to a three-year Substance Abuse Mental Health Services Administration (SAMHSA) grant, awarded jointly to the American Association of Suicidology (AAS) and the Kristin Brooks Hope Center.

The grant is for the expansion and support of national crisis-center services and subsequent research to evaluate their effectiveness. Even charges for telephone calls received via 1-800-SUICIDE are paid for by the SAMHSA grant.

For information about joining, contact G. Lee Judy, AAS certification coordinator, or H. Reese Butler II, founder and president of the National Hopeline Network. Lee Judy can be reached at (202) 237-2280 or e-mailed at [leejudy@suicidology.org](mailto:leejudy@suicidology.org). To reach Reese Butler, call (540) 338-5756 or e-mail him at [reese@hopeline.com](mailto:reese@hopeline.com).

The AAS website is [www.suicidology.org](http://www.suicidology.org). The website for the Kristin Brooks Hope Center is [www.hopeline.com](http://www.hopeline.com). ■

**Next Month:**  
Second Installment of  
**"Understanding Suicide in the 21st Century"**  
Interviews on the future of suicidology  
with  
Donna Barnes, Ph.D.  
Sherry Davis Mollock  
Herbert Hendin, Ph.D.  
David A. Jobes, Ph.D.  
Ronald W. Maris, Ph.D.  
James R. Rogers, Ph.D.  
M. David Rudd, Ph.D.  
Steven Stack, Ph.D.





# Frontline

## “I told u I was hardcore”

By H. Reese Butler II

These were the last coherent words Brandon Veda, 21, typed into his computer. It was Jan. 12, and he was in the bedroom of his Phoenix, Ariz. residence when he entered the sentence on his p.c. Then, in front of a web cam, he overdosed on prescription drugs before a national audience.

His unfortunate death was not the first internet-related suicide. It was the first, however, to be documented by the media, and until the crisis center community learns how to deal more effectively with such internet-related suicide, there will probably be many more deaths like his.

The ability for internet intervention exists, but it is still in its infancy. When asked to help find someone in serious crisis, some internet service providers (ISPs), like the one mentioned by Stan Lewy in our “Letters to the Editor” column, will actually do a trace and notify police. Others, however, will not.

In the last four years, the Kristin Brooks Hope Center and its Hopeline member agencies have performed numerous successful internet interventions. *Keep in mind that such interventions are always risky business and must be performed with great care.*

What desperately needs to be in place is a system with the mechanics and the protocols, the lethality assessment tools and the levels of supervision for handling a suicidal person. To create this we must have a task force made up of internet service provider security people, crisis center directors, advocates, lawyers and clinicians. We at KBHC have started the process of creating such a task force, and we welcome your suggestions.

KBHC's first encounter with online intervention began soon after the Hope Center was created. Our outreach before the creation of the 1.800.SUICIDE (784-2433) hotline was done on [www.livewithdepression.org](http://www.livewithdepression.org).

KBHC officially began doing internet interventions in mid-September, 1998. At that time, I met a woman online whom I shall refer to as Jane Doe. She was suicidal and wanted to know why she should not kill herself. Immediate intervention proved successful. Jane agreed to get mental health treatment, read books and basically live to fight another day.

After months of e-mailing back and forth and chatting online, I got to know her, and we developed a bond via the internet. Jane, it turned out, was in touch with several other suicidal young people. She introduced me to them and to the work of KBHC. These youths, who hung out in the same chat rooms she did, had found each other as they searched for common interests. Suicide was one of them.

After 10 months of communicating with Jane and her friends, I received, in mid-May of 1999, a panic-stricken “Instant Message” (I.M.) from a young woman I shall call Mary Brown. Mary had already begun the process of suiciding. She was cutting herself and told me she planned on bleeding to death. Jane gave me Mary's I.M. handle and history, and I immediately sent her an I.M. based on information Jane had provided.

After engaging Mary in a long internet intervention I was able to glean from the two young women what Mary's last name was and the town and state where she lived. I notified a female co-worker, online, of this development and she, in turn, notified Mary's mother about what was transpiring in her daughter's life and room. Mary's mother responded first with disbelief and denial. Then my co-worker told her where the knife was that her daughter planned to use and suggested she check out both her child and her child's room. Mary was hospitalized soon after this and agreed to mental health treatment. The latter resulted in her eventually completing high school and graduating with honors. She later enrolled in one of the nation's top colleges.

Mary and Jane referred many of their suicidal online pen pals to the newly created 1.800.SUICIDE (784-2433) hotline for online interventions.

Not all stories have such happy outcomes. There is a list serve, [alt.suicide.holiday](http://alt.suicide.holiday), often referred to as ASH, which can be viewed on the internet as a website. It combines an unmoderated discussion board and provides detailed guidelines on how to commit suicide. It has been linked

to 10 confirmed suicides and 14 other suicides. The site's FAQ defines the forum as a place where visitors can “talk openly about suicide in a culture that regards suicide as a taboo.”

The critics of ASH include the relatives of some ASH regulars who died by their own hands. These survivors say the site encourages people to kill themselves. For more on this, go to (“No One Asked Why He Wanted to Die” by Julia Scheeres of Source: Wired 02:00 AM Feb. 04, 2003 PT) (<http://www.wired.com/news/business/0,1367,57480,00.html>). What follows is an excerpt from the second installment of a three-part series.

*A month to the day before he killed himself, Michael Benjamins posted the following message on the internet: “PLEASE help me,” wrote Benjamins, a 24-year-old computer programmer from Ohio. “I am looking for a fast, reliable way to kill myself. I don't want to screw it up.” The message, posted on ASH Sept. 17, 2000, also stated that Benjamins had spent time in a mental institution and feared he might not pass the background check needed to purchase a gun in his home state.*

*Responses to this posting ranged from instructions on how to slit his wrists to a suggestion that he drive his car into a brick wall at high speed. No one asked him why he wanted to die or sought to change his mind. His subsequent posts on the internet narrated his trajectory toward death. He wrote about his fear of being in large groups of people, of the eight years he spent in therapy and his fear that he might not find an end to his mental turmoil.*

*He also wrote a posting when he learned that his having been institutionalized would not prevent him from legally owning a gun. Soon after this, he bought a .410-gauge shotgun at Wal-Mart and posted online that he was “looking forward to death.” When Michael Benjamins placed a shotgun in his mouth and pulled the trigger Oct. 17, many ASHers—as they call themselves—had known of his plans for weeks. None, however, had tried to prevent his death by contacting his family or law enforcement officials.*

*His father, Gerry Benjamins, a 55-year-old electrical engineer, said after his son's death that depression ran in both sides of the family and that Michael had had a long history of suicide attempts. His son's first serious attempt reportedly occurred when Michael was six years old and was hospitalized for stabbing himself in the chest. In the next eight years, Michael Benjamins made dozens of other suicide attempts.*

*According to Gerry Benjamins, his son tried taking antidepressants but stopped because of their side effects. Soon after, he began hurting himself again. “What we saw was that he was going to get so bad that he'd have to be institutionalized or he'd eventually succeed at killing himself,” his father said.*

*Unlike many parents, Gerry Benjamins doesn't blame ASH for his son's death. “The reason he [Michael Benjamins] got on that website was because of his desperation to find someone else who felt the same way he did,” the elder Benjamins said. “If it wasn't this group, it would be another group. Sooner or later, people with this tendency are going to find each other. I think there is a real positive in that you can find someone who understands where you come from.”*

*Over the years, Michael Benjamins reportedly tried many strategies to fight his depression. He exercised, read self-help books, kept a journal, drew and took various medications, according to Matt Vanek, a friend since middle school. According to Vanek, nothing seemed to work long for his friend, who often complained his mind was “reeling, in a state of chaos.”*

*“[Depression] was pretty much a constant state of being [for Mike],” Vanek said. “That being said, he was able to hide it well. He could still laugh and have some amount of fun, at least externally. He was very, very good at hiding what he felt from the rest of the world.”*

*These tragic stories speak to why we must work now to create online intervention procedures and counseling. Please join me and KBHC in calling for a task force to put together the tools and resources needed to save lives. ■*

**H. Reese Butler II is publisher of this journal and president of the Kristin Brooks Hope Center. Julia Scheeres is a reporter with Wired News. <http://www.wired.com/news/>. Portions of this article are reprinted with permission from Wired News.**

## The Recent Past |

# happenings

## Upcoming Events

### Kennedy and Domenici Introduce Wellstone Mental Health Parity Act of 2003

By Melinda Moore

Washington, D.C.—Speaking before a packed house of mental health lobbyists, activists, media and congressional staff, United States Senators Ted Kennedy and Pete Domenici recently introduced the Wellstone Mental Health Parity Act of 2003. The legislation honors the late U.S. Senator Paul Wellstone, a champion of mental health parity until his death last October in a plane crash. The bill was presented Feb. 27 in a stirring press conference in the Dirksen Building on Capitol Hill.

“While I feel a profound sense of sadness, I also have a renewed determination to win parity for millions of Americans affected by these dreaded diseases of the brain,” said Senator Domenici. “Health care policies are not keeping pace. Too often, families face financial ruin and shattered relations because mental health benefits are limited.”

The Wellstone bill is modeled after the mental health benefits package provided Federal employees and seeks to prohibit group health insurers from treating mental health benefits differently than medical and surgical benefits. It seeks to provide full coverage for all categories of mental health conditions, with coverage contingent on a particular mental health condition being included in an authorized treatment plan. The legislation does not mandate coverage of mental health benefits and, if adopted, would apply to plans already providing coverage.

“Equal treatment of the mentally ill is not just an insurance issue, it is a civil rights issue,” Senator Kennedy told those assembled. “It defines our humanity as a society.” His son, Patrick, a U.S. representative from Rhode Island, and U.S. Representative Jim Ramstad of Minnesota co-sponsored the bill in the House of Representatives.

The group stood beside more than 30,000 petitions signed by young people nationwide, urging Congress to pass this legislation. The petitions were collected by *Preventing Suicide* Associate Publisher Arielle Bielak during the Plea for Peace/Take Action Tour, America’s premiere punk rock music tour that traveled to 38 U.S. cities between late September and the end of October, 2002, and benefited the Kristin Brooks Hope Center, program manager for the National Hopeline Network/1.800.SUICIDE (784-2433) and publisher of *Preventing Suicide*.

One in five Americans will suffer some form of mental illness, but only one third of them will receive treatment. At least four million children suffer with a major mental illness and force parents to

We invite readers to contribute suicide prevention events for inclusion in our calendar. Send your submissions to: [calendar@hopeline.com](mailto:calendar@hopeline.com). Please include the official title of the event, its date and a brief description, along with the name of a contact, and a way to reach that person.

**March 21-25, 2003**—American Counseling Association Annual Convention, Anaheim, Calif. [www.counseling.org/convention/convention.htm](http://www.counseling.org/convention/convention.htm). Features several programs on suicide prevention, assessment and treatment.

**April 11-13, 2003**—27th Annual Convening of Crisis Intervention, Chicago, Ill. [www.uic.edu/orgs/convening/](http://www.uic.edu/orgs/convening/). For further information, contact Dr. Barry Greenwald at: [bsgreenw@uic.edu](mailto:bsgreenw@uic.edu).

**April 21-26, 2003**—First Ever Collaborative Crisis Center Conference, co-sponsored by AAS, CONTACT USA, and the Kristin Brooks Hope Center; Program Manager for the National Hopeline Network 1.800.SUICIDE, Santa Fe, N.M. [www.suicidology.org/](http://www.suicidology.org/). For further information, go to: [info@suicidology.org](mailto:info@suicidology.org).

**May 4-10, 2003**—National Suicide Prevention Week. For more information, e-mail: [suicidology.org](mailto:suicidology.org).

**May 7, 2003**—“Lifesavers Dinner” Sponsor: AFSP, Cipriani, 110 East Forty-second Street, New York, N.Y. “Honoring those who have made a significant contribution to raising public awareness about depression and suicide.” For more information, contact: Darrell Tucci (212) 363-3500 Extension 18.

**May 17-22, 2003**—American Psychiatric Association Annual Meeting, San Francisco, Calif. Featuring 24 scientific sessions on the topic of suicide. For more information, go to: [www.psych.org/sched\\_events/ann\\_mtg\\_03/index.cfm](http://www.psych.org/sched_events/ann_mtg_03/index.cfm).

**May 13-14, 2003**—Survivor Research Workshop. Sponsors: AFSP and NIMH. Washington, D.C. “Bringing together leading researchers to develop agenda for survivor issues.”

**June 2, 2003**—Harmony for Mental Health Dinner, Waldorf Astoria New York City, N.Y. For more information call The Jed Foundation at (212) 343-0016 or e-mail: [pmsatow@jedfoundation.org](mailto:pmsatow@jedfoundation.org) or [pharringtonusa@netscape.net](mailto:pharringtonusa@netscape.net).

choose between care their child needs and the other financial needs of the family. If passed into law, the Wellstone Mental Health Parity Act of 2003 would help end insurance discrimination.

*Melinda Moore is interim executive director of the Kristin Brooks Hope Center.*

You are invited to become a subscriber to *Preventing Suicide: The National Journal*. Through September 2004, subscription costs are covered by a grant as part of the educational awareness component of the SAMHSA suicide prevention initiative. Please complete and return the enclosed card with your name and mailing address to the KBHC Journal Subscription Department, 201 North 23rd Street, Purcellville, Va. 20132. If you prefer, you may enter your subscription electronically at [subscriptions@hopeline.com](mailto:subscriptions@hopeline.com). Please feel free to duplicate this subscription form for colleagues and other people interested in preventing suicide.

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