

Chapter 7 SUICIDE AND ALCOHOLISM

SUICIDE - LET'S TALK ABOUT IT

Suicide is an increasingly serious problem – in our communities, our families, and our police forces. Suicide is more common than most of us realize. It now ranks among the ten leading causes of death in North America. As reported by the Center for Disease Control (CDC), suicide took the lives of 30,622 people in 2001. In 2002, 132,353 individuals were hospitalized following a suicide attempt and 116,639 were treated in emergency departments and released.¹ Since many suicides are not reported as such, experts believe the true number is considerably higher. For every successful suicide there are several unsuccessful attempts.

- Suicide rates are generally higher than the national average in the western United States and lower in the eastern and Midwestern United States (CDC 1997)
- In 2001, 55% of suicides were committed with a firearm²

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Who tries to commit suicide? Why? What are the danger signals? How can we help? Despite the seriousness of the problem, surprisingly little research has been carried out. However, a number of facts are now known; a number of myths can be laid to rest.

Suicidal Myths

True or False *People who talk about suicide rarely commit suicide within the six months preceding the suicide.*

False: Talk of suicide may be a clue or warning. Out of ten people who kill themselves, eight have given definite clues about their intentions. Suicide threats **MUST** be taken seriously.

True or False *The suicidal person really wants to die.*

False: Most suicidal people are ambivalent and want help. They are undecided about living or dying. They “gamble with death”, leaving it to others to save them. Almost no one commits suicide without letting others know how they feel. Often this “cry for help” is given in code.

¹ Department of Health and Human Services, Center for Disease Control and Prevention (CDC), 2004. For Additional information, visit CDC's website at www.cdc.gov/ncipc/factsheets/suifacts.htm.

² Anderson RN, Smith BL. Deaths: leading causes for 2001. National Vital Statistics Report 2003; 52(9):1-86.

- True or False* *There is no correlation between alcoholism and suicide.*
False: A person who commits suicide is often also an alcoholic.
- True or False* *Once someone attempts suicide they will always be suicidal.*
False: Happily, individuals who want to kill themselves are "suicidal" for only a limited time. If saved from self-destruction, they can go on to lead productive lives. New ways of coping with stress can be learned.
- True or False* *Asking directly about suicide could encourage an attempt.*
False: Asking directly can minimize anxiety and act as a deterrent.
- True or False* *A person who tries to kill him/herself is mentally ill; suicide always the act of a psychotic or crazy person.*
False: Stories of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, they are not necessarily mentally ill. Their overpowering unhappiness may result from a temporary emotional upset, a long and painful illness, or a complete loss of hope.
- True or False* *Improvement following a suicidal crisis means that the suicidal risk is over.*
False: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put their morbid thoughts and feelings into action. Relatives and physicians should be especially vigilant during this period.
- True or False* *Suicide strikes more often among the rich, or conversely, occurs more frequently among the poor.*
False: Suicide is neither a rich man's disease nor a poor man's curse. It is common through all levels of society.
- True or False:* *Suicide is inherited and "runs in a family".*
False: Suicide does NOT run in families. It is an individual matter and can be prevented. However, the suicide of a family member can have a profound influence on others in the family.

A Cry for Help

Someone who is seriously thinking of suicide is undergoing a crisis in which they are not their normal self. They need help just as surely as if they were fighting a severe physical illness.

Even a "mild" suicide attempt indicates a desperate need for sympathy and understanding. If help isn't forthcoming, a more serious attempt may follow. Every effort should be made to get at the cause of the unhappiness, and the individual should be watched carefully for at least 90 days after the suicidal period.

Prevention of Suicide

A question sometimes thoughtlessly asked is, "If a person finds life so intolerable that they want to commit suicide, why not let them?" Evidence shows that if a person is prevented from committing suicide, they are very thankful afterwards.

Every human life is precious. Our culture's humanitarian and religious beliefs place a high value on human life. This is reflected in the great effort we put into the control of disease, accident prevention, rescue operations, etc.

Suicide leaves a trail of tragedy. Sorrow over a death is always difficult to bear, but suicide places an unusually heavy burden on the survivors. Our society attaches a stigma to suicide which the victim's family must bear. This can be particularly difficult for children.

Then, too, those left behind may identify with the victim and become preoccupied with the fear that they too may resort to suicide if life becomes very difficult.

Clues for Preventing a Suicide

Very often a suicide could have been prevented if the family had been able to recognize clues in the victim's behavior shortly before death. Here are some of the more common clues:

- Repeated talk of death or suicide threats.
- The following remarks were made by people who later killed themselves:
 - ♦ Bullet and indent
 - ♦ "My whole family would be better off without me."
 - ♦ "I'm going to end it all; I can't stand it any more."
 - ♦ "I won't be around much longer for you to put up with me."
 - ♦ "I don't want to be a burden."
 - ♦ "This is the last straw; this is all I needed."
 - ♦ "I can't stand it any longer. I want to die."
- It's a mistake to take such remarks lightly. If a person has been ill, unhappy or depressed for some time, it's important to seek prompt professional help.
- Planning for death or absence
 - ♦ Many suicides are carefully planned so that affairs will be left in order for surviving family members. Making a will, discussing insurance policies and organizing affairs can be warning signs if these actions are accompanied by suicidal talk and general unhappiness. Of course it is foolish to think that anyone who makes a will or discusses insurance is suicidal.

Other clues

Other warning signs are important if they occur along with any of the above symptoms. These may include chronic sleeplessness, loss of weight (through loss of appetite), withdrawal from social contacts, loss of sexual desire, and loss of interest in hobbies. In short, any change in behavior which makes a person seem quite different.

What to Do For the Suicidal Person

Family, loved ones and friends are in the best position to give emergency assistance. The first step is frank recognition that the person - no matter how healthy or stable he has been in the past - is now very unhappy and potentially suicidal.

It is a dangerous mistake to play "ostrich" or to delay in the hope that "things will get better". There is no substitute for professional assistance in the treatment of a suicidal crisis. If in doubt, call in expert help.

Where to Look For Help

The Family Doctor. In most communities, the first source of emergency help is the family physician. If there is no family doctor, the local medical society may be called for suggestions and help. In larger centers, the general hospital usually maintains an emergency out-patient service.

Crisis Intervention Distress Center. There are now telephone distress centers across the United States and Canada; they have proven themselves to be a reliable suicide prevention resource.

The name given to this method is "Befriending". In many cases the telephone lines are open 24 hours a day with trained lay people working in shifts. Most of the callers respond positively to a friendly voice at the other end of the line, and the workers have been trained to cope with referral or emergency situation.

The Psychiatrist. A psychiatrist is a medical doctor who has specialized in treating mental and emotional illnesses. Suicidal behavior is usually considered to be a symptom of pathological disturbance of emotions - in other words a mental illness.

Psychiatric Facilities. In addition to the family doctor and the practicing psychiatrist, there may be special mental health clinics and treatment facilities available in the community. These can be called on for special help, in many cities the general hospital provides 24-hour psychiatric emergency services.

Religious Counselors. Surveys have shown that people concerned with personal or health problems go first to their minister, priest or rabbi - even more frequently than to their family doctor. Today many clergymen have had professional training as counselors, so they're able to assist with problems or at least locate other sources of help.

Social Agencies. In most communities there is a network of family case workers and social welfare agencies. They can be found in the telephone directory under such listings as United Way, Social Planning Council, Community Information Center, and Social Service Organizations.

Remember, that "Cry for Help" should always be taken seriously. The best response is fast, professional help. Keep the following things in mind if you hear a "cry for help" that indicates a person might be suicidal:

- How to Assist the Person – Suicide Prevention
 - ♦ Ask them open ended questions
 - What are you feeling now?
 - What's going on in your life? Look for these commonalities:
 - ♦ Unbearable Physical Pain
 - ♦ Desire to cease pain
 - ♦ Tunnel Thinking
 - ♦ Unfulfilled Needs
 - ♦ Hopelessness
 - ♦ Trying to Communicate, Intent

- ♦ Unsolved Problems
- ♦ Ambivalence
- ♦ Difficulty with Coping Pattern
- Are you depressed?
- What are your goals (dreams)?
- Are you thinking about killing yourself? (*This can be very “releasing” to the person*)
- Have you ever tried suicide before or given it serious thought?
- Has anyone in your family ever committed died by suicide?
- Are you on any medication?
- Are you under a doctor’s care? (medical, physical, or psychological)
- How do you want to do it?
- Do you have the means to do it? How? (Available Now!)
- Look for the following clues in their answers to the above
 - ♦ Previous suicide attempts (family or self)
 - ♦ Recent Losses (relationships, job, etc.)
 - ♦ Loss of face among peers (rejected)
 - ♦ Isolation
 - ♦ Appetite loss
 - ♦ Verbal Cues
 - ♦ Behavioral Clues (giving things away)
 - ♦ Philosophy on Death
 - ♦ Failures (i.e., school)
 - ♦ Intolerance for Crisis
 - ♦ Moving
 - ♦ Moodiness – Changes
 - ♦ Alcohol / Drugs
 - ♦ Poor Physical Health
 - ♦ Stress
 - ♦ Lack of Resources
 - ♦ Low Communication
 - ♦ Apathy
 - ♦ Disturbed Family Structure
- Look for clues...do they have a DESIRE to live
- Look for Self Revealing Techniques. “ A person who is suicidal will drop verbal clues that say “I really want to talk”. These clues are an invitation for the helping person to probe deeper and ask more questions. Some clues might be: I don’t know what’s happening with me!” , “I’m confused.”
- Keep them in the RIGHT NOW!
- It’s between you and them.
- Be aware of your surroundings and what’s going on around you. Sometimes a suicidal person may decide to take someone with them, or do something spontaneous such as jump off a bridge. Remove anything that may prove to be a danger to you or to the person you are helping.
- Be Warm – Be Direct – Be Confrontive

How can Chaplains Help?

Chaplains are a buffer between the survivors and the police. If it is appropriate, Chaplains will often be used to assist the survivor in seeing the victim. Assist the survivors in obtaining the facts and direct them towards support group information when

the timing is appropriate. This referral, if acted upon, may be one of the most important things they will do after the event.

Other areas where a Chaplain may find him/herself asked to assist include working with the family and mortuary/chapel as a liaison for funeral preparations. Of all the victim/survivor scene events, police tend to get over protective for survivors in suicide-related deaths. This is especially true when the person is a law enforcement victim. Just keep in mind, "If you can't improve on silence, don't".

What should a Chaplain bring to a suicide attempt? Bring yours "best" self. Offer hope and honesty. Have and show a caring attitude through touch and being touched. Have patience and be empathetic to the conditions. Keep these in mind:

DO

- Listen – Establish a relationship (obtain information)
- Identify and clarify the problem – talk about it.
- Share hope
- An extended family (significant others) – Reach out to them as well
- Talk about suicide
- Speak slowly but softly (be calm)
- Take your time
- Know your limits
- Clarify concept of death
- Reassurance in a positive way
- Alternatives – what else can be done (formulate a plan)

DON'T

- Promote guilt
- Physically reveal a weapon
- Promise confidentiality
- Argue
- Give choices they can't make
- Leave them alone
- Get over involved
- Be shocked at anytime

SUICIDE LETHALITY SCALE

Risk Level	Details	Mental Health	Precipitating Event	Person's Disposition	Action
Low	<ul style="list-style-type: none"> ▪ Person states he/she is feeling suicidal ▪ No suicide plan ▪ Person not in immediate danger (e.g. the means to carry out the plan are not present, intent is not immediate.) 	<ul style="list-style-type: none"> ▪ May or may not have received counseling in the past ▪ May or may not have received mental illness diagnosis/treatment. 	<ul style="list-style-type: none"> ▪ Recent crisis or string of crises. 	<ul style="list-style-type: none"> ▪ Primary need seems to be someone to talk to who will listen ▪ Person is open to and active in developing a positive plan of action. ▪ Person has a basic support system available. 	<ul style="list-style-type: none"> ▪ Explore primary issues. ▪ Discuss short and long term plans of actions. ▪ Contract with person to fulfill positive plan of action. ▪ Contract with person to reach out for help again if the suicidal feelings return.
Medium	<ul style="list-style-type: none"> ▪ Person states s/he is feeling suicidal. ▪ They have a plan. ▪ Means to carry out the plan are readily accessible ▪ Means are available but not immediately lethal. ▪ Intent is not immediate. 	<ul style="list-style-type: none"> ▪ May have family history of suicide and/or mental illness. ▪ May have chronic mental illness diagnosis. 	<ul style="list-style-type: none"> ▪ Likely feels that negative life events have been ongoing for years. ▪ May resist idea of "here and now" 	<ul style="list-style-type: none"> ▪ Person may seem uncertain about prospect of future happiness/wellness. ▪ Person still willing to reach for help and develop a positive action plan. 	<ul style="list-style-type: none"> ▪ Explore primary issue. ▪ Discuss short and long term plans of action, including the possibility of mental health assessment. ▪ Contract with person to fulfill a positive plan of action. ▪ Contract with person to reach out for help again if the suicidal feelings return.
High	<ul style="list-style-type: none"> ▪ Person states s/he is feeling suicidal. ▪ Plan developed. ▪ Intent is immediate or within near future ▪ Means are lethal and accessible. ▪ Likely to have attempted before and has probably felt suicidal for a long period of time. 	<ul style="list-style-type: none"> ▪ Presence of chronic mental illness is likely, whether or not it's been diagnosed. ▪ Likely has family history of mental illness/suicide. 	<ul style="list-style-type: none"> ▪ Recent crisis likely in addition to ongoing crisis/distress. 	<ul style="list-style-type: none"> ▪ Person stated intent to die. ▪ Resistance to open communication/alternatives. ▪ Disillusioned with helping system, strong feelings of hopelessness and diminished fear in the face of death. ▪ You believe the person will harm themselves. 	<ul style="list-style-type: none"> ▪ If suicide is in progress, call 9-1-1 to dispatch emergency services. ▪ Contract with person to seek immediate ▪ Assistance from a mental health professional – follow up to make sure this was done. ▪ Contract with person to reach out for help again if suicidal feelings return.

Table 3: www.crisiscallcenter.org/crisisweb/suicide_lethality_scale.htm

LETHALITY ASSESSMENT SCALE FOR SUICIDE POTENTIAL

How likely is it that this person will be dead in 2 hours? From the above table, you can see that many factors contribute to the suicide lethality scale. When dealing with the assessment of whether or not someone has a high potential for suicide or not, the following facts should be taken into account:

1. Age and Gender
 - a. Females attempt suicide most often
 - b. Males accomplish suicide the most
 - c. Young men and men over the age of 60 are higher risks than males of other age groups.
 - d. Race is not a critical factor
2. Self Destructive Behavior
 - a. Is this the first time they have felt suicidal tendencies versus feeling suicidal feelings a number of times.
 - b. First feelings are “scored” as a low lethality where multiple feelings are “scored” as a high lethality.
3. Method and Availability
 - a. The less violent the method, the lower the lethality. Pills are an example of a low lethality.
 - b. The more violent the method, the higher the lethality. Guns are an example of a high lethality. So too, is hanging or jumping.
4. Major Losses:
 - a. Have they lost someone/something close to them?
 - i. A friend moved away
 - ii. Loss of a pet
 - iii. Something minor, like they broke something or “spilled the milk”
 - iv. The degree of loss depends on their perspective not ours. We will never know what their perspective is unless we ask.
5. Medical Conditions tend to be high on the lethality scale.
 - a. Have they been battling ill health or serious medical conditions?
 - b. Do they have psychological conditions or depression?
 - c. What is the “last straw” for them?
6. Resources
 - a. If they have a supportive family, feel needed at their job or enjoy their job, if they have an “okay” home life, if people listen to them – their lethality level is low.
 - b. If they have been sloughed-off by people who have dealt with their previous attempts, have missed their “cries for help”, or they have “worn out” the people around them – their lethality level is high.
7. Communication Quality
 - a. If you can engage them in meaningful conversation and they can express their feelings – low lethality
 - b. If they are isolated, are having trouble communicating, or holding things in – high lethality
8. Self Worth (Self Worth used instead of “Personality Status”)
 - a. Does the person have any self worth? Do they have a family status? Do other people depend on them (in a positive way)?
 - b. Low self worth and family status – higher lethality.

When a person has a high lethality score, they may be admitted to an observation ward for safe keeping. Under a 5150, the physician can keep a person under observation for 24 hours. If the person is not a threat to themselves, you can apologize the next day for your concern. If the

physician or professional feels the person has a moderate level of lethality, they will work with the person on their mixed or conflicting feelings and help them work out any ambivalent feelings they have. If the person has a low level of lethality, the basic assessment will most likely recommend that the person work out their issues with the guidance of a licensed counselor.

If you are dealing with a person that appears to be low to moderate on the lethality scale, ask them to make a "contract" with you – not to do anything in the next 24 hours. Ask them to meet with you again – and force them, if you have to, for a decision on where to meet and at what time. Think about where God fits in all this?

WORKING WITH SUICIDE BEREAVEMENT

Be Honest. No one is comfortable with the facts and feelings that surround a suicide. However, the temptation to be dishonest to avoid facing some of these facts or feelings should be avoided. Any attempt will undermine your effectiveness with the bereaved.

Be Willing to Hear and Accept Feelings. Grief brings a variety of feelings to a person. The grief that follows a suicide can bring so many conflicting feelings that the bereaved feels unable to accept them. Often, this takes the form of guilt over the various feelings being experienced. They need to know that it is "OK" and even "normal" to experience conflicting and confusing feelings.

Take a Non Judgmental Stance. It is not our place to judge the deceased or the bereaved. We need to be very cautious about any judgmental messages that might inadvertently come across. This is true even when the bereaved seeks a judgment from you.

Recognize Their Need for Acceptance. The person who has lost a loved one to suicide has experienced the ultimate rejection. In their mind, their loved one chose death over life with them. This can lead to the feeling that they themselves are unlovable and unacceptable. As a person representing God, the church, and the community, your willingness to accept them as people carries great meaning.

Disregard Taboos. Each culture has its own taboos regarding suicide, such as "Don't talk about it," "Don't say anything negative about the dead," and so on. The bereaved needs help understanding what is acceptable and what is not. Any "taboo" about suicide that stands in the way of the bereaved person's pain being healed should be ignored or consciously denied.

Lead the Bereaved to Forgiveness. The bereaved may have legitimate reason for feeling guilty. If so, they should be recognized and the bereaved should be helped to find forgiveness.

Remember Who You Are. When you go to a bereaved person, you represent God and humanity. Your actions will in some ways illustrate for the bereaved what the reality of life is. If you teach that God forgives, yet they sense that you don't, they will not believe what you have said about God.

Make Appropriate Referrals. Often you will only be able to help with the immediate crisis. If you are not going to be offering ongoing assistance, or if you feel the bereaved needs help you cannot provide, help them to someone who can.

False Statements	True Facts
1. People who talk about suicide rarely commit suicide.	1. People who commit suicide have given some clue or warning of intent. Suicide threats and attempts must be taken seriously.
2. The tendency toward suicide is inherited and passed on from one generation to another.	2. Suicide does not “run in families”. It has no characteristic genetic quality.
3. The suicidal person wants to die and feels there is no turning back.	3. Suicidal persons most often reveal ambivalence about living versus dying and frequently call for help immediately following the suicide attempt.
4. Everyone who commits suicide is depressed.	4. Although depression is often associated with suicidal feelings, not all people who kill themselves are obviously depressed. Some are anxious, agitated, psychotic, organically impaired or wish to escape their life situation.
5. There is very little correlation between alcoholism and suicide.	5. Alcoholism and suicide often go hand in hand; that is, a person who commits suicide is often also an alcoholic.
6. A person who commits suicide is mentally ill.	6. Although persons who commit suicide were often distraught, upset or depressed, many of them would not have been medically diagnosed as mentally ill.

7. A suicide attempt means that the attempter will always entertain suicide.	7. Often a suicide attempt is made during a particularly stressful period. If thoughts during the remainder of the period can be appropriately managed, then the attempter can do on with life.
8. If you ask a client directly, "Do you feel like killing yourself?" This will lead them to make a suicide attempt.	8. Asking a client directly about suicidal intent to kill often minimizes the anxiety surrounding the feeling and acts as a deterrent to the suicidal behavior.
9. Suicide is more common among lower socioeconomic groups than anywhere in our society.	9. Suicide crosses all the socio-economic groups and no one group is more susceptible than another.
10. Suicidal persons rarely seek medical help.	10. In retrospective studies of committed suicide, more than half had sought medical help within the six months preceding the suicide.

STAGES OF SUICIDE

Behavioral Clues

1. Stressful Events: A series of upsetting situations may lead persons to considering suicide. These situations may include things such as:

- Loss of job
- Breakup of a relationship
- Death of a loved one
- Rape or assault
- Illness
- Other significant changes in lifestyle

What you can do:

- Encourage them to talk about feelings.
- Be willing to listen without passing judgment.
- Suggest finding supportive help that will offer new ways of coping with stress.
- Encourage them to call the local Suicide Prevention center and speak with a counselor.

2. Suicidal Thoughts: Sometimes these thoughts may be expressed silently through behaviors such as alcohol or drug abuse, depression or sadness. Sometimes they are expressed in words like:

- "No one understands."
- "You'd be better off without me."
- "There's no hope; it'll always be this way."

What you can do

- Recommend that they get help for specific issues of concern.

- Encourage them to reduce stress through physical exercise, eating regularly, getting adequate sleep, and avoiding coffee and alcohol.
 - Don't be afraid to ask, "Are you thinking about suicide?"
 - Call the Suicide Prevention center to discuss your concerns.
3. Suicidal Plan: Look for unexpected changes in behavior or disruption in sleeping or eating patterns. The person may also begin getting ready by:
- Buying a gun
 - Collecting pills
 - Giving away valued possessions
 - Making or changing a will
 - Saying "good-byes"

What you can do:

- Strongly encourage them to seek professional help.
 - Ask directly about suicidal feelings and find out about specific plans.
 - Take away pills or gun
 - Help them to see other alternatives.
 - Get them to agree not to attempt anything without first consulting a professional counselor.
4. Suicidal Action: Persons who up until now have been agitated and upset often appear unusually calm or emotionally withdrawn just before a suicide attempt. Plans may be acted out by:
- Driving reckless
 - Going off to be alone
 - Taking dangerous chances

What you can do:

- This is a Life and Death situation. Take whatever action is necessary to save a life.
 - Contact the police, sheriff or Suicide Prevention center.
 - Let the person know you are worried and that you care.
 - Enlist the help of family members and close friends.
5. After An Attempt: The first three months after a suicide attempt is a critical period of adjustment. People often feel embarrassed, ashamed or angry, and they may be gathering strength for another attempt. They may view their unsuccessful suicide attempt as just another personal failure.

What you can do:

- Be honest and open about your concerns.
- Let them know that their survival matters and that you have confidence in their ability to work things out.
- Encourage them to get professional help to find better ways of dealing with crisis.

Remember: Ultimately you cannot stop someone who is intent on suicide but you can encourage them to seek professional help.

SIGNS OF DEPRESSION AND SUICIDE RISK

- Sad, withdrawn
- Lack of interest in activities previously enjoyed
- Apathy and fatigue
- Pessimistic, irritable
- Loss of appetite and weight
- Loss of sexual interest (married relationships)
- Sleep disturbance -- insomnia, sometime early waking nightmares
- Difficulty in making conversation and carrying out routine tasks
- Sense of futility
- Indecisiveness
- Feeling worthless
- Loss of religious faith
- Feelings of guilt and self-blame
- Preoccupation with illness, real or imaginary
- Financial worries
- Drug or alcohol dependence
- Preoccupation with or talk about suicide
- A definite plan for committing suicide
- Suicidal impulses
- Previous suicide attempts
- Social isolation
- Recent loss
- No hope for future
- Unsympathetic relatives, feeling that "nobody cares"
- Tidying up affairs, giving away possessions
- Suicides in the family or among close friends
- Fear of losing control, going crazy, harming self or others
- Feeling of helplessness
- Low energy
- Anxiety
- Stress

Many times people are most at risk when they seem to be improving. Sometimes when a person has carried around with them for a long time the idea of suicide, even a seemingly trivial mental stress can set off a tragedy.

If a person seems depressed, do not be afraid to ask "Do you feel bad enough to kill yourself?" It can be a great relief to them if you bring up the subject and let them talk freely about their suicidal thoughts, feelings, impulses, plans and/or fantasies. Talking about it to someone who accepts them, without showing shock or disapproval, can clear the air and reduce the tension. Nearly everyone can be helped to overcome almost any kind of situation which might destroy their self-confidence; if they have someone who will listen to them, take them seriously, and show that they care about them.

BEFRIENDING SUICIDAL OR DESPAIRING PEOPLE

1. All befriending is played by ear. There are no formulas, just some safe guidelines.
2. You must be yourself. Anything else feels phony and won't be natural to you or the person who is talking with you.

3. Your job is to make a relationship with the other person so that they feel they can trust you enough to tell you what is really on their mind. You want them to be able to level with you as they would to their friend.
4. What you say or don't say is not as important as how you say it. If you can't find the right words, but feel genuinely concerned, your voice and manner will convey this.
5. Deal with the person; not just the problem. Talk as an equal; if you try to act as a counselor or an expert, or try to solve problems, it will probably be resented.
6. Give your full attention. Listen for feeling as well as facts and for what is not said as well as what is said. Allow the person to unburden without interruption.
7. Don't feel you have to say something every time there is a pause. Silence gives you each time to think.
8. Show interest, and invite the person to continue without giving him the third degree. Simple, direct questions ("What happened?" or "What's the matter?") are less threatening than complicated, probing ones.
9. Steer toward the pain, not away from it. The person wants to tell you about the private, painful things that most other people don't want to hear. Sometimes you have to provide an opening, and give them permission to begin talking. ("You sound depressed. What's the matter?")
10. Try to see and feel things from the other person's point of view. Be on their side; don't side with the people they may be hurting or the people who are hurting them.
11. Let the person find their own answers, even if you think you see an obvious solution.
12. Many times there are no answers and your role is to bear witness, to listen, to be with the person in his pain. Giving your time, attention, and concern may not seem like "doing enough". People in distress, in seemingly hopeless situations can make you feel helpless and inadequate. Happily, you do not have to come up with solutions or change people's lives, or even save their lives. They will save themselves, make their own changes, etc. Trust them.

When you don't know what to say, say nothing!

Article~

Suicide affects the lives of so many

By: Penne Usher, The Journal (Gold Country Media – Auburn, CA)

Wednesday, June 28, 2006 11:07 PM PDT

I cried Tuesday for a young man I never met.

As six deputies carried the body of a man who fell to his death from the 730-foot Foresthill Bridge Tuesday afternoon, they looked like uniformed pallbearers. It was at that moment when I thought in just a few days well-dressed friends and family members of the young victim will be carrying his casket to its final resting place.

For reasons no one will ever know, this man made a decision to end his life. I cannot fathom

what pushed him to the brink where he felt death was his only option.

I've covered many tragic stories involving deaths, but this one hit me - hard.

On my way home from work I thought about the latest victim of the bridge. I thought about his family and that they were about to receive a knock at the door.

A uniformed officer and a chaplain would be standing on the other side.

A mother, a father, would hear the horrific news that their son had died.

I learned Wednesday that the young man had not yet been identified. He was found without identification. There was no vehicle in the area that could be traced to the victim. No one has come forward looking for him. No one has missed him yet.

Seeing his body lying on the Clementine Trail is an image I cannot erase from my mind. I spoke to my friend, Officer Dale Hutchins of the Auburn Police Department. He understood what I was feeling.

Hutchins told me I needed to talk to someone. I thought that's what I was doing.

I spoke Wednesday to Chaplain Terry Morgan with the Placer County Law Enforcement Chaplaincy. As my emotions bubbled at the surface we recounted what had occurred on the banks of the American River.

As we sat in his office, I went through what he called Critical Incident Debriefing. He said that what I saw was abnormal, but what I was feeling was normal.

Author Victor Frankle once wrote, "An abnormal reaction to an abnormal situation is normal behavior."

Morgan and I talked. I cried.

The Center for Disease Control and Prevention reports that suicide is the third leading cause of death among young people age 15 to 24.

Adolescents and young adults often experience stress, confusion, and depression from situations occurring in their families, schools and communities. Such feelings can overwhelm young people and lead them to consider suicide as a "solution," the CDC reports.

Coping with the tragic and sudden loss of a loved one is something many have endured - myself included.

At 6:15 a.m. on April 1, 2004, I received a phone call from my mother. She told me my 41-year-old brother had drowned. I fell to my knees, cried and kept denying her words. He left behind a wife, and two daughters.

In the two years since his death, I have come to terms with the loss. My brother, Dale, taught me in his death, to be a more compassionate writer.

There's a lesson in this latest tragedy as well. I just don't know what it is yet.

As I drove home Wednesday I prayed for the family the young man left behind.

The Journal's Penne Usher can be reached at penneu@goldcountrymedia.com.

Article~

POLICE SUICIDE

by Gilles Sussant

Psychologist, Institute de police du Quebec, Nicolet, Quebec

Fiction: Suicidal people are fully intent on dying.

Fact:

Most suicidal people are undecided about living or dying, leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling. Often this "cry for help" is given in code.

Fiction: Suicide strikes more often among the rich, or conversely, occurs more frequently among the poor.

Fact

Suicide is neither a rich man's disease nor a poor man's curse. It is common through all levels of society.

Fiction: Suicide is inherited and "runs in a family".

Fact

Suicide does not run in families. It is an individual matter and can be prevented. However, the suicide of a family member can have a profound influence on others in the family.

Fiction: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

Fact:

Although extremely unhappy, he is not necessarily mentally ill. His overpowering unhappiness may result from a temporary emotional upset, a long and painful illness, or a complete loss of hope.

Fiction: People who talk about suicide don't do it.

Fact:

Out of 10 people who kill themselves, 8 have given definite clues to their intentions. Suicide threats must be taken seriously.

Fiction: Once a person is suicidal he is suicidal forever.

Fact:

Happily, individuals who want to kill themselves are "suicidal" for only a limited time. If saved from self-destruction, they can go on to lead useful lives.

Fiction: Suicide happens without warning.

Fact:

Research shows that the suicidal person gives many clues and warnings. Recognize these cries for help can save a life.

Fiction: Improvement following a suicidal crisis means that the suicidal risk is over.

Fact

Most suicides occur within 3 months following the beginning of "improvement" - when the individual has the energy to put his morbid thoughts and feelings into action. Relatives and physicians should be especially vigilant during this period.

PORTRAIT OF A SUICIDAL INDIVIDUAL

Psychologist Jean-Louis Campagna, founder of the Quebec Suicide Prevention Center, claims that we cannot stereotype suicidal individuals; however, they do share certain characteristics. In his opinion, a distinction must be made between two categories; those who have chronic suicidal tendencies and those who contemplate suicide because of a given situation.

One specialist, Marie-Josée Filtear, describes these two categories in a short document entitled "Suicidal people and how to deal with them". Her document also deals with topics such as: the warning signs of suicide, people's reaction to someone threatening suicide and, finally, how to assist the person in distress.

1. People with chronic suicidal tendencies:

Serious lack of affection during childhood, battered or sexually abused during childhood, academic failure, dropout, inter-personal relations almost always fail, intense and chronic depression, inability to keep a job, alcoholic, addicted to drugs, repeated tries to commit suicide before making a clear and resolute decision to go through with it.

At one point, they choose to die and decide when, how and where they will do it. They might draw up a will and settle their affairs, or make peace with those around them. Even at this moment, all is not lost - there is still a chance that the person will be able to find a glimmer of hope, a new reason for carrying on with life. This is what we must help them discover.

2. People contemplating suicide because of a given situation:

This applies to a person who has led a normal life until the day they suffer a major loss. This could be the loss of a loved one through death or divorce, the loss of prestige or social status, the loss of a job, a financial loss or a loss of self respect.

For a variety of reasons, the loss may upset the person's psychological balance and cause a crisis. No longer able to think as before, they become increasingly depressed and negative towards others and themselves. This is when their thoughts turn to suicide. The time between the thought and the act may be very short and therefore, prompt action is imperative.

It is therefore extremely important to know and recognize the warning signs of suicide, so that immediate intervention is possible. What are these signs? A tendency to withdraw, settle their affairs, take an interest in medication, talk about a trip. There may be psychosomatic changes such as: loss of appetite, insomnia, headaches, a tendency to give away things that they value, etc.

Attention: Care must be taken because certain signs may be deceptive. Often the individual with chronic suicidal tendencies may appear to be at peace with themselves once they have made an irrevocable decision to commit suicide. They will appear to be relaxed, happy, and even euphoric. It might therefore be easier for those around them to mistakenly believe that things are going better, that the crisis has passed.

It must be remembered that sudden fluctuations in mood from deep depression to happiness may be a sign that the person is contemplating suicide. In case of doubt, it is better to talk to the person directly and see how they react.

THE CLOSED WORLD OF THE POLICE OFFICER

Not much research has been done on police officers, as their domain is relatively inaccessible to those who are not part of a police organization or a legal institution.

In 1978, in his article entitled "Suicide in police officers", David Lester criticized the lack of recent research into suicide in police officers. He attributed this fact to the desire of police forces to protect the image of the police officer.

He argued that this attitude was unfortunate, because this image was being protected at the expense of police officers whose suicides could be prevented, if enough data were available. Lester did, however, do some valuable work in this area, which we will now investigate.

HEIMAN'S STUDY

In his article "The police suicide" Heiman explores a few of the psychological aspects likely to explain the high rate of suicide amongst police officers. He comments on the suicides that have taken place in both the New York and London police departments.

In his opinion, it is the relatively infrequent use of guns in London and the public's acceptance of the police officers' role in their city that explains the low rate of police suicide in London compared with New York. The police here are under less stress, at least as far as their morale is concerned, and this facilitates their social integration.

Heiman also points out that police officers often suffer from anxiety and an inability to confide in their colleagues. He suggests that greater use should be made of psychological services and techniques, to protect the mental health of the police officers.

Listed below are the psychological and sociological hypotheses of various experts as related by Heiman.

1. *Friedman: Suicide represents the displacement of a drive to kill, turned against oneself. Friedman's hypothesis is inspired by Stekel: no one would ever kill himself, if he had never wished to kill someone else, or desired someone else's death. The subconscious convicts the self under the lex talionis: and eye for an eye, a tooth for a tooth. He finds himself guilty of the wish to kill and so condemns himself to death. Police work involves "legitimate" aggressive behavior, but this behavior must be controlled. Such behavior is not always well accepted, leading to tension in the police officer.*
2. *Hendin: Suicide can be viewed as:*
 - a. *an act of desertion (vengeance)*
 - b. *a way of exercising power, omnipotent mastery*
 - c. *a homicide directed at oneself*
 - d. *a meeting*
 - e. *a rebirth*
 - f. *a punishment*
 - g. *a process with an emotional purpose, i.e. the individual sees himself as already dead (cancer)*
3. *Menninger: Basing himself on Freud's "desire to live", the author elaborates on the following three desires: desire to kill, desire to be killed, desire to die (these desires are unique to man).*

4. *Nelson and Smith: According to these two authors, the suicide rate is high when the following two characteristics are weak: social integration and social regulation. A study conducted in Wyoming revealed that the following six factors could serve to explain the situation:*
 - a. *Police work is a male-dominated profession, and men have the higher suicide rate.*
 - b. *The fact that police officers are familiar with guns and know how to use them may explain the small number of unsuccessful suicide attempts.*
 - c. *Constant exposure to death has psychological repercussions.*
 - d. *The long and irregular hours of work strain family relations and do not encourage police officers to strengthen friendships.*
 - e. *They are always exposed to public criticism and hostility.*
 - f. *Contradictions by judges, irregularities and illogical decisions tend to negate the value of police work.*

5. *Henry and Short: These authors claim that aggressive behavior results not so much from the individual's internal drives as from social frustrations. Suicide is a manifestation of this phenomenon.*

6. *Gibbs and Martin: The suicide rate of a population is inversely proportional to its "status integration". The authors try to relate the degree of social integration to the durability and stability of social relations and to the absence of conflict in the individual.*

GASKA'S RESEARCH

According to research done by Cass Gaska, a police instructor at the Henry Ford College in Dearborn, Michigan, the suicide rate amongst retired police officers is ten times greater than the national average. This study concentrated on the deaths of 4,000 retired police officers between 1944 and 1978.

Gaska was a Southfield police lieutenant. He affirmed that, out of these 4,000 police officers, those who had committed suicide had held positions with high stress levels or had been forced to retire while still young because of physical or emotional problems.

Another reason why the suicide rate is so high amongst police officers is that a police officer almost never misses, because of his familiarity with guns. Two-thirds of these suicides had been reported as accidental or natural deaths, so as not to traumatize the families.

FURTHER RESEARCH BY DANTO

While doing further research on the Detroit police, psychiatrist Bruce Danto focused on twelve active police officers who had committed suicide between 1968 and 1976. It was reported that these officers had been caught in a major "police-family" dilemma, and that they had chosen suicide as the final solution.

They had all been relatively young, with little seniority, and they had had marital problems.

POLICE OFFICER'S SUICIDE

Stress is taking its toll on police officers throughout the nation. It is a problem that many departments do not want to talk about, according to an article written by Claude Lewis of the Philadelphia Inquirer.

It is difficult to confront the situation when various departments in our United States refuse to talk about the problem. Everyone knows this is a serious business. It needs to be addressed and people need to deal with it.

Most officers will not admit they have a problem and often decline into depression from which they are unable to help themselves. Often they turn to suicidal thoughts.

A recent study revealed that New York City officers kill themselves at a rate of 29 per 100,000 a year. The rate of suicide in the general population is 12 per 100,000. Most of the victims are young with no history of having problems that shoot themselves while off duty.

Nationally, twice as many cops – about 300 annually-- commit suicide as are killed in the line of duty. This is according to a study by the National Association of Police Chiefs.

It is difficult to determine just why an officer will take his or her life. There are many factors to be considered because of a state's confidentiality law and possibly the police will not admit to keeping such statistics.

Michael Broader, a clinical psychologist, has been working with the EPA since July of this year. He states that "The dynamics of the job" sometimes lead officers to take their own lives. One must keep in mind they always have a weapon with them, on or off the clock.

Captain Gus Carre, the commanding officer at EAP, did say stress among police officers is not unusual. "It's a difficult job made by more difficult by the individuals that officers must deal with on a daily basis." Many officers are on a steady diet of bad situations dealing with the undesirable sides of life which most people rarely see.

Many officers all over the country refuse to seek needed assistance because the fear it will result in them being labeled as "weak". They also fear that their careers will be destroyed if their supervisors find out. There may be an occasion where an individual will feel betrayed by those fellow officers and the officer may commit suicide because he or she may feel abandoned. They often make the mistake of trying to solve their own problems quietly which often leads to alcohol or substance abuse. There may also be some departments that place a different label on an officer who committed suicide, such as "an accidental discharge of a weapon." It may be anything but accidental. Many departments do not want to share with the public when an officer commits suicide. They feel this is a personal matter that should not be divulged to the public.

The California High Way Patrol is developing a training program for suicide awareness and prevention after eight troopers killed themselves in eight months last year, for a total of thirteen since September 2003 as stated by John Ritter, USA TODAY. The CHP is "the largest cluster I've seen for a department that size," says Robert Douglas, executive director of the National Police Suicide Foundation.

The International Association of Chiefs of Police is circulating a proposal to make suicide prevention tools available to all of the nations nearly 18,000 state and local police agencies. Current police culture tends to be avoidant of the issue leaving suicidal officers with "no place to turn.", a draft of the proposal says.

The suicide foundation says it has verified an average of 450 law enforcement suicides in each of the last three years, compared with about 150 officers who died annually in the line of duty, it is believed there are no more than 2% of the nations law enforcement agencies that have prevention programs.

Most large departments across the nation have comprehensive programs which include, tapes, videos, brochures, posters, training classes, peer-support, and coaching about warning signs of a possible suicide potential. The Los Angeles sheriff's program started in 2001. Since 2002 the force has had two suicides among 9,000 officers. The personnel are receptive to getting assistance when they need it.

People are to remember that police bear the same stress from work, and family illness that civilians do. What is different is the stress of the street. It is a different kind of stress and it is an every day occurrence dealing with a negative environment continually. Remember, the street officer has to wear a bullet proof vest to work.

OFFICER SUICIDE

The following section is information taken from an article entitled "Every Police Department's Nightmare: Officer Suicide", by Sgt. Monroe Dugdale. It was originally published on 1 August 1999 (source unknown) and reprinted here by permission.

There were more than twice as many police officers committing suicide than were killed in the line of duty in 1994 [ourworld.compuservu,1999]. The growing problem is not only in the United States, but also places like France who experienced 50 per cent more than the average rate of suicide for the last decade. Paris had a rate in 1995 of almost twice the rate for New York City Police Department [Simons, 1996].

There are many preconceived ideas of what goes on with a police officer, such as the pain and suffering police experience and witness as a direct result of their job. Police suicides, corruption, and misconduct, high rates of alcoholism, divorce and mental breakdowns among officers offer a grim conformation that police work is grueling and stressful. How can policemen be happy when they must deal with more emergencies, tragedies and criminals in a violent society than ever before, while vowing to serve and protect? In a study of 1995 reports a rate of 29 suicides per 100,000 for the New York Police Department, versus 12 per 100,000 for the general population [McNamara, 1996].

The nation's largest organization, the Fraternal Order of Police, studied suicides among 38,800 of its 270,000 members in 1995 by looking at insurance records in 92 local chapters in 24 states. They found a suicide rate of 22 deaths per 100,000 officers [Fields and Jones, 1999].

Robert Douglas, executive director of the National P.O.L.I.C.E. Suicide Foundation states, "We are losing about 300 officers a Year to suicide." Forensic psychologists are now paying more attention to police suicide and to what is referred to as a hidden epidemic [Loh, 1994]. One forensic psychologist in New York profiles a typical suicide potential as being 35 years old abusing alcohol, separated or seeking a divorce, experiencing a recent loss or disappointment. Typically domestic abuse is involved. [Loh, 1994] Cops are generally controlling individuals. When the officer loses control in their own home, they can not handle it. When that point is reached, they may be suicidal for at least the next 24 to 36 hours.

Drugs, alcohol, and relationships continue to surface among officers suicides. Suicides among officers rise when they bring their job home. Many deny such and offer excuses to compensate for their actions. Most officers witness some most horrific scenes and get catapulted into moments of terror and danger and close-ups of human degradation and death "[McNamara, 1996]. These things could trigger stress which can be labeled as Post Traumatic Stress Disorder [PTSD].

Departments must stop ignoring the problem before the problem becomes a nightmare. Many police officers have ended their life needlessly when perhaps help is just a phone call away.

CAUSES OF SUICIDE AMONG POLICE OFFICERS

Generally speaking, the authors and researchers who deal with the field of police work agree that several factors contribute to the suicide of a police officer:

1. Firstly, the stressing agents inherent in police work
2. Physical or emotional inadequacies
3. Marital problems
4. 4. Conflicts between police and family
5. Abuse of alcohol
6. Use of tranquilizers

7. Use of drugs
8. Certain difficult political situations
9. Certain environments that are hostile to the police
10. Badly organized police department
11. Poor partner
12. Poor team (negative) (bad elements)
13. Personal financial problems
14. Inadequate training (resulting in professional shortcomings)
15. Poor selection (the individual is not at home in the police and does not demonstrate the qualities, aptitudes or attitudes required for the job)

SUICIDAL SYMPTOMS IN POLICE OFFICERS

Early Warning Signs

Previous studies refer to several symptoms detected (after the fact) in police officers who had committed suicide. A psychological autopsy of the suicides almost always pointed to the following behavioral signs:

1. A clear and obvious threat to commit suicide (which must always be taken very seriously)
2. Cries for help, but not necessarily clearly expressed, verbal pleas; sometimes distress signals were simply in the form of indications of impotence, despair, implicit and camouflaged pleas for help
3. Abrupt changes in behavior unexplained, weird behavior
4. Bad mood, aggression, irritability, violent temper
5. Confusion, illogical speech
6. Morbid fear
7. Feelings of persecution
8. Anxiety
9. Insomnia, loss of appetite, shaky hands
10. Isolation, an attempt to withdraw or seek solitude, introversion
11. Friendships dropped
12. Appearance neglected
13. Lethargy
14. Sudden preoccupation with death and what happens after
15. Tendency to give away property, particularly things of value

Pay close attention to someone who appears to get his energy back after going through a period of depression or withdrawal, or after simply talking about suicide. The change in behavior might be due to the fact that the decision to commit suicide has been made.

Symptoms or Early Warning Signs of Suicide

Pay close attention to severe psychiatric, psychological or physical problems: 13 had lengthy psychiatric and/or psychological files; 7 had voluminous medical files.

Hence we can see that we must be very careful with such cases. It is not a question of discrimination; on the contrary, we should ensure that these people receive preventive care and follow-up tailored to their needs. For the sake of their own welfare, we must not be afraid to take away their guns and take them off the job, if necessary. We must ensure that they are psychologically ready before they assume their former duties, or assign them to new duties better suited to them.

Let us now take a look at the 28 symptoms or early warning signs that the 27 police officers showed, which we will now use to help others: these signs are visible to superiors, peers or colleagues, subordinates, family members (spouses, children) and, most often, to their partners. (See Table 2)

Early Warning Signs (listed in order of importance)	% of signs
1. For some time or for a few days, they have been depressed, not themselves; they do not have any energy, "pep" or motivation. [19/27]	70%
2. They are no longer involved in sports and pay no attention to their physical fitness. [14/27]	52%
3. They are introverted, withdrawn, solitary, shy and even awkward; they do not say much any more, or say nothing at all, they do not confide in anyone [13/27]	48%
4. They are an alcoholic or are turning more and more to alcohol. [10/27]	37%
5. They are given to having accidents with their personal car and their service vehicle (one, two, or more accidents) [10/27]	37%
6. They are anxious, anguished. [9/27]	33%
7. They look very tired or are suffering from overwork [9/27]	33%
8. They have told others about their thoughts of suicide [8/28]	30%
9. They use tranquilizers [8/27]	30%
10. They are emotionally unstable [7/27]	26%
11. They are having trouble concentrating and often hurt themselves (unlucky) [7/27]	26%
12. They have a discipline file (often very lengthy) [7/27]	26%
13. They are arrogant, aggressive, impulsive, violent [7/27]	26%
14. They are very proud and unable to deal with frustration [7/27]	26%
15. They often cry [6/27]	22%
16. They are nervous, or more nervous than before [6/27]	22%
17. They have talked about killing somebody. Under influence of alcohol or on an empty stomach. They have talked about using a gun. They have started to take out their gun (for no reason) [5/27]	19%
18. They are an insomniac [5/27]	19%
19. They appear to be very pensive [5/27]	19%
20. They have complexes (physical or other) 5/27]	19%
21. They are jealous [5/27]	19%
22. They are disillusioned [4/27]	15%
23. They suffer from high blood pressure [4/27]	15%
24. They have tried to commit suicide [3/27]	11%
25. They use tranquilizers combined with alcohol (very dangerous) [3/27]	11%
26. They have written one or more strange letters to those close to them, in which they talked about life, death, the purpose of life, or they have made their last wishes known, in case something were to happen to them on of these days. [3/27]	11%
27. They have written or rewritten their will and talked about it in a weird and unusual way. [2/27]	7%
28. They have let it be known, in a mysterious way, that they had something important to do (or something like that) [2/27]	7%
Table 2	

Here we have a list of the 28 symptoms, warning signs or signals that constitute a major police suicide syndrome.

It goes without saying, however, that the appearance of one of these symptoms does not automatically mean that a police officer is contemplating suicide!

However, it should be noted that, if the manifestation of one of these signs is sufficiently severe, or if several of these symptoms are evident in the same police officer, his family, social or professional milieu should take note, so that competent, trained specialists can intervene.

Preventing Police Suicides

Jerry Dash and Martin Riser, in an article entitled "Suicide among police urban law enforcement agencies", explain why the suicide rate in the Los Angeles Police Department is low in comparison with other police forces.

The authors claim that it is the result of the rigorous screening and evolution of police personnel. Even their emotional stability is examined. Aspiring police officers who do not pass the psychological, physical, written and oral tests are eliminated.

The low suicide rate over the past few years is also attributed to the fact that a general program has been implemented to prevent mental health problems. Psychologists involved in the program provide training, organize group meetings and seminars and do personal and family counseling.

Los Angeles' example appears to answer the question of how to prevent police suicides. To be sure, if someone is dealing with the causes and symptoms mentioned previously, the prevention of suicide is almost automatically ensured.

Such prevention is beneficial not only to the suicidal police officers, but also to the police department, family and society as a whole.

This is why we strongly encourage the creation of a psychological services section of police officers by ensuring that applicants have the necessary psychological profile. Also, prevention counseling and treatment could be provided.

Thought should also be given to creating a special police suicide prevention service; a department that would be independent of police organizations and therefore absolutely impartial. This department should be run by competent individuals who are familiar with the police environment and related problems. We are therefore looking at a skilled and highly confidential service, a provincial service available to all police officers, whenever necessary.

Helping a Suicidal Person

It is recommended that the following steps be taken:

1. Establish an atmosphere of confidentiality.
2. Try to understand what the person is going through (the easiest way to do this is to simply ask the person directly) and have them talk about the problem; in other words, what hurts them so much that they want to stop living.
3. Assess the risk of the person committing suicide in the near future: talk to them about their desire for death; ask them when and how they plan to kill themselves. If the method they have chosen is easily accessible at any time, the danger of their carrying out their plan is greater.
4. Try to find the best approach to talk with the person: should you be direct, tread lightly or be calm? Should you be authoritarian, tell them what to do or simply provide advice?

5. Avoid sermonizing: do not tell them to banish all thoughts of death from their mind; rather, talk about the issue, so that they realize all of the implications of their act. Do not tell them that committing suicide would be bad or that they are crazy. Such comments serve no purpose and will not help them.
6. Do not give your recipes for happiness to the suicidal person, because everyone has their own way of living and being happy depending on their background, personality, etc. Instead, try to see what they think would make them happy, try to find other solutions (aside from suicide) that would enable them to get through their crisis.
7. Try to pinpoint what activity the person likes or liked before things started deteriorating. Encourage them to pursue activities, to meet people, but at a rate that is in keeping with their current abilities.
8. Do not try to help the suicidal person by doing everything for them. They will then think that they are no longer able to take action, that you no longer trust them.
9. Explain to the individual that they do not have to make threats or attempt to commit suicide to make sure that you will understand how they feel and be willing to help. This is sometimes how a suicidal person expresses their despair. Explain that it is not necessary to resort to these techniques, that you are there, you understand and want to help.
10. Once again, if you fear that the person is really going to commit suicide, put the question to them directly, finding out when and how they plan to do it. In an emergency, contact your nearest suicide prevention center.
11. Do not forget to respect your limitations in what you can and cannot do as far as helping the suicidal person is concerned.
12. Remember that you are not responsible for what they do. They are the one who decides to kill themselves, not you, regardless of what they may say.

These notions apply to any suicidal person in general and, therefore, to the police officer in particular. I am not advocating that you assume the role of a trained specialist, but I am saying that everyone can do something.

TEENAGE SUICIDES IN THE UNITED STATES

According to the National Institute of Mental Health, scientific evidence has shown that almost all people between the ages of 15 and 24 years old that suicide has become the subject of much recent focus. In 1999, U.S. Surgeon General David Satcher recently announced his call to action to prevent suicide, an initiative intended to increase awareness, promote intervention strategies, and enhance research. Suicide among our nation's youth has drawn the attention across our country. Teenage suicide seems to be most tragic – lives lost before they have really started. The question is, "Why must we lose so many lives unnecessarily?"

Some Basic Facts

- Suicide is the third leading cause of death among young people ages 15 to 24. In 2001, 3,971 suicides were reported in this age group.³

³ Anderson RN, Smith BL. Deaths: Leading causes for 2001. National Vital Statistics Report 2003; 52(9):1-86

- Of the total number of suicides among ages 15 to 24 in 2001, 86% (n=3,409) were male and 14% (n=562) were female.⁴
- American Indian and Alaskan Natives have the highest rate of suicide in the 15 to 24 age group.⁵
- In 2001, firearms were used in 54% of youth suicides. (Anderson and Smith 2003).

⁴ Anderson and Smith, 2003

⁵ Center for Disease Control, 2004.

What Kids Are At Risk For Suicide? (*KidsHealth.org*)

Teenage years are a time where they get caught up in that gray area between childhood and becoming an adult. It is a time of responsibilities which can become a period of confusion and anxiety. There are the pressures of fitting into society, to perform academically, and act responsibly. Then there is the awakening of sexual feelings, self-identity, and a need for autonomy which conflicts with the rules and expectations set by others.

Teens with adequate support of friends, family, religious affiliations, peer groups or extracurricular activities may have an outlet to deal with their frustrations. If they do not have that support, they may feel disconnected and isolated from family and friends. These teens are at an increased risk for suicide.

Factors that increase the risk of teenage suicide:

- The presence of a psychological disorder, depression, bipolar disorder, and alcohol and substance use. [Approximately 95 per cent of people die by suicide have a psychological disorder at the time of death.]
- Feelings of distress, irritability, or agitation
- Feelings of hopelessness and worthlessness that often accompany depression
- Previous suicide attempt
- Having suffered physical abuse or sexual abuse
- Lack of support network, poor relationships with peers or parents, or hostile school environment

Suicide Signs (*National Alliance on Mental Health, 2007*)

There are many behavioral indicators that can help parents and friends to recognize the threat of suicide of a loved one. Many of the clues to watch for include:

- Extreme personality changes
- Loss of interest in activities that use to be enjoyable
- Significant loss or gain in appetite
- Difficulty falling asleep or wanting to sleep all day
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Withdrawal from family or friends
- Neglect of personal appearance or hygiene
- Sadness, irritability or indifference
- Having trouble concentrating
- Extreme anxiety or panic
- Drug or alcohol use or abuse
- Aggressive, destructive or defiant behavior
- Poor school performance
- Hallucinations or unusual beliefs
- Rejection from peers

Many times these signs go unnoticed while the person suffers from one off these symptoms. It is always best to communicate openly with a person who has one or more of these behaviors when they are unusual for that person. Watch and listen to those who are having concerns as they are expressing themselves and what is going on inside as they try to deal with their understandings and emotions. What may not be a big deal to a parent or friend, it is to the person expressing them self. Don't be afraid of asking questions, especially the question about if they are thinking of committing suicide. GET THEM HELP!

SUICIDE HOT LINES

National Suicide Hot Line	800-273-TALK
Auburn, CA	530-885-2300
Lincoln, CA	916-645-8866
Roseville, CA	916-773-3111
Sacramento, CA	916-368-3111

SURVIVORS OF SUICIDE

This is not dealing with victims of suicide, because they are already dead. This deals with the survivors, the families of a suicide victim, those who have suffered a death.

In talking to these families we must remember to remove them to a safe place because the media and officer activity can distract and keep them in a state of unsettledness.

Follow-up is necessary in the actual dealing with these families. If possible, a chaplain could be assigned to the family to carry them through the funeral if they do not have a minister available.

Suicide is epidemic. It is the eighth cause of death. In ages 15-20 it is the third cause. One-third of homicides involve suicide.

Find the prevention center closest to you and work with them if possible. To have it in place is extremely important before the fact.

Helping to recognize signs is also important. Learn all we can about it. Coordinate with other agencies. The caregivers must be trained. The training, however, is general enough to work with all ages. Caregivers are those who may be turned to in times of crisis from bus drivers at school to ministers, to teachers, to cops. We don't have to be professionals to take this intervention training. It is a model that can be carried with us in memory which may be able to save lives.

JACK CLAYTON is with the California Highway Patrol. His son died by suicide on May 12, 1984. He was asked, "How does suicide affect your life and those around you?" The following is his story (source unknown):

His son died by suicide May 12, 1984. Saturday morning his son came in to the store distraught. He had wrecked the truck. He wasn't satisfied that they could fix the truck. Jack was working and went to the back room where the son said, "I must talk to you." Jack didn't have time to talk at that moment so he went on to the front to deal with customers. The son left the store, got into the truck and drove off.

About 15 minutes later, the daughter called and asked, "What is the matter with Brad? He walked in, slammed the door, and I heard a bang. The door is locked and I can't get in." The mom went home and found her son in the room dead with a gunshot wound. 911 was called and they responded. Jack went home and was met in the yard by an officer who said, "Mr. Clayton, your son blew his brains out and it is all over the room." (Even today, five years later, the event is so tragic that Jack cannot talk without breaking up.)

People who experience a suicide have gone through something very traumatic and they need sensitivity and caring. It hurts as bad today as it did then. The problems were that they took the body to the Medical Examiner who sent it to the funeral home. The family went to see the body. The director would not let them see the boy because of the wound. Being an officer, he had seen mangled bodies and forced the mortician to allow him to see the son. The director refused in spite of all the insistence. Jack still has doubts as all of the furniture, even the personal effects, in the room were removed. It is like he has just vanished from the face of the earth. The worse cycle of grief is almost never-ending. The events continue to return in vivid memory

Prior to the event, Jack's memory was keen and effective. He had no trouble in memory but today there are total lapses of memory. This event drastically changes the individual. The feelings and losses are tremendous.

When asked, during a question/answer period, Jack was gracious to talk about his experience. The following are his answers to several questions raised:

Question: In this period of time, what has given you the most help?

Answer: "My faith in God #1." The final step taken by the suicide is FINAL. There is no turning back. There are many who are insensitive to suicide. Neighbors may still believe that suicide is a mortal sin. The families don't need that type of thing because there is no scriptural basis for it.

Question: "Are you in some way feeling responsible for the death?"

Answer: "Yes, I didn't stop to talk to him when he needed help. It may not have made any difference, but the gnawing guilt is there."

Question: "Were there signs leading to this?"

Answer: "Yes, he stared off into space a lot. Became disoriented and paid little attention to the details of business. His customers noticed it as well as the family, but they didn't do anything that would help him." He didn't give away personal items, he didn't say good-bye. This was more of a spontaneous event rather than a planned event.



Brad had a girlfriend who married and came back and attempted to contact him but he refused her advances. He did leave a note that said "I love you all. Pray for me. Brad."



When a certain wife killed herself, insensitive people asked the husband, "Did you cheat on her, or she on you? Is that what caused this?" They were not able to accept the failure of anyone who would take their lives. On the other hand there is a train of thought that says "They did it, I can do it and be free of these problems."

Friends quite often pull back from the families of suicide. This is where the chaplains can come into play with such a tremendous part of aid and help and caring. Getting people to listen to the facts of survivors and suicide is difficult because they feel if you talk about it they will do it. Lots of questions are usually discovered in open discussions about suicides.

Marilyn Koenig of Friends for Survival, Inc.

1977 there were no signs that her son, 18, was going to kill himself. He was one of seven children, obedient, and about to graduate high school. Their friends were supportive through their tragedy. The church gave great help and support. He had a girl friend and things seemed well. *It is scary because you feel like there will not be the support.*

Most of the time the person who kills themselves doesn't want to die, they just want to stop the pain. They feel their only option is suicide. There are alternatives of which we must make them aware.

Grief can last as much as 10 years, even normal people grieve 5 years. It takes so long to overcome this type of death. The trauma is extensive. It may not be public grieving, but the personal hurt is when the darkness is thickest.

Life must go on so the human spirit carries on. The truth is, however, there may be lasting symptoms. Even 12 years later, my memory is not what it used to be prior to the event.

People who have been affected by suicide may not function very well. To expect them to function as they used to function is unrealistic.

Every year, more police officers die by suicide than are killed by criminals. Their families are particularly affected. There are more suicides in the nation than there are homicides. If we can get people to admit they have had a suicidal thought then they can be helped. Without saying the word, they can't be helped.

Unique aspects of survivors

The Shock that is There

Disbelief, denial, questions like could it be an accident, or even murder. There are usually months that pass before the family can accept that this is a suicide. They need something to blame.

Searching for Why is the Ultimate Goal

The bottom line is when they come to the point that no matter the "Why" they accept the fact that it is the decision of the one killed, not anyone else's fault. There are always options and even the most professional of situations cannot prevent someone who makes up their mind to kill themselves. 8 to 9% of the time there are subtle signs. Families need to know the signs.

Honesty Helps

Teach kids to be up front about their feelings. They must be honest as to how they got through bad times.

Anger Builds Up in Survivors

This person leaves you without so much as an explanation. They may then feel guilty because the problem child is now gone. We can never feel good as anger builds up.

They Face the Stigma of Being involved in Suicide

There are many reasons, but fear, ignorance, immaturity...all cause withdrawal of friends, even churches. Many families feel that they should have been the ones to be affected and guilt builds up so they withdraw rather than face their guilt. Being uncomfortable is often the reason friends don't come around anymore. It is best to deal with survivors as if they had been victims of someone dying with a heart attack or cancer. We must program our minds to think this is like an accident. The loss is real, regardless of circumstances.

Depression will often Follow the Suicide

This is natural and normal and a good help is for them to realize this is normal.

Survivors will Spend Time Assessing Responsibility

Survivors will spend time assessing their own responsibility and the responsibility of others; school, civic, churches, etc. They want to blame others but they will not do it verbally. We can help them do this verbally. They can blame other family members. Some subtle remark is made that kids catch on that means nothing to adults. Those kids then have great guilt heaped upon them and they will never verbalize that guilt. It festers, they then become candidates for suicide.

We may say: "No one is to blame. That person made that decision themselves. You could not have helped."

Suicide is often Considered by the Survivors Themselves

They fail to realize the added burden it may add to the family. Some get into a cycle where there are a series of suicides in the same family group.

Recovery Takes Time!

Often longer time is required than is published. Productivity can be resumed but some of the pain may last forever.

Non-Judgmental Attitudes are Helpful

Survivors need places where they can go to where others have been through suicide and can tell them that it is normal to feel they way they do.

Scripture and Pious Platitudes Usually Fail!

Discovered revelation is better than proclaimed revelation from some "well-meaning" clergy. You can't heal them, you can't fix them. That is the task of the Holy Spirit and if they don't have that resource then you may be able to impart it to them in time. "If only..." is a futile statement.

Marilyn Never Goes to the Cemetery: "I don't have time." (I try to go since it is part of the follow-up – Assigning chaplains to these families would preclude complete follow-up).

Jack: There are some strange things that have happened. Son used .3030 deer rifle. They could not find the bullet. They finally discovered it in the closet where it had ricocheted off the son's head. Jack then walked in one day many weeks later and noticed the closet opened a bit. No one could have opened it. Strange thing. They closed the door, and about two weeks later the door was opened again. No one could explain how the door was opened, or who opened it.

Wife was folding clothes one day and felt a hand touch her on the shoulder. There was nothing there. Daughter and husband moved to Monterey and one Saturday walked in the house and into the family room where pictures were hanging of both kids. She walked to Brad's picture and noticed that the picture had something wrong with it. The bullet was in the forehead.

(My observations of the picture are eerie. The photograph showed a red hue around the hair line of the boy. It did simulate blood running down the head. Also, there was a spot just under the hairline that represented a bullet hole. No conclusion drawn, just observation.)

Many strange things happen and other folks think they are crazy. The picture had red streaks all over the face. Almost an outline. The people are not craze. Some things happen that cannot be explained.

Having Friends Who will Assure and Not Blame are Important

Circumstances will run every moment in the minds of the families. Their thoughts cannot be changed, they can respond, however.

The Families may be Suicidal and Need to Talk about those Feelings

There are organizations which can help if they are approached. This must be something that is done. Over 1000 people in 7 years called Marilyn. Talking can be effective, one doesn't have to be a therapist from a formal agency to assist (do know your boundaries). Just simple caring referrals will help.

QUESTION: How would you define "Survivors"?

ANSWER: Anyone who has been affected by the suicide death of another. This includes many other groups or organizations, not simply family.

Teach folks coping skills. They must find alternatives to dealing with the pain. They cannot take a permanent solution to temporary problems.

There are other options to suicide. There are no perfect people and no perfect solutions, but there are helping people and alternatives. Each must be explored and those ideas must be revealed.

Bill Blackburn wrote a book, "What you should know about suicide". He talks about a family contract against suicide. In our family suicide is not the answer to the problem. We must share with each other and talk about all the options with each other. Then the family is in on the solutions and there is an instant support group.

ALCOHOLISM

According to the United States National Library of Medicine and the National Institutes of Health (www.nlm.nih.gov/medlineplus/ency/article/000944.htm) alcoholism is defined as:

An illness marked by drinking alcoholic beverages at a level that interferes with physical health, mental health, and social, family, or occupational responsibilities.

There are those who can not deal with every day life situations and believe they must depend upon some substance for support. This often becomes alcohol abuse. Alcoholism is an illness by drinking alcoholic beverages at a level that interferes with physical health, mental health, and social, family, or occupational responsibilities.

Alcoholism is divided into categories: dependence and abuse.

People with alcohol dependence, the most severe alcohol disorder, usually experience tolerance and withdrawal. Tolerance is a need for increased amounts of alcohol to achieve intoxication or the desired effect. Withdrawal occurs when alcohol is discontinued or the intake is decreased. Alcohol dependents spend a great deal of time drinking alcohol, and obtaining it. Those with dependence have more severe problems and a greater compulsion to drink.

Alcohol abusers may experience legal problems such as drinking and driving. They could also have other problems such as binge drinking [drinking 6 or more drinks at one sitting].

Alcohol is an addictive type of drug. There is both physical and psychological dependence with this addiction. The physical evidence reveals itself by withdrawal symptoms when the intake is interrupted. Alcohol affects the central nervous system as a depressant, resulting in a decrease of activities, anxiety, tension, and inhibitions. A few drinks can result in behavioral changes, slowing down motor skills, and decrease the ability to think clearly. Concentration and judgment become impaired

Alcohol also affects other body systems. Irritation of the gastrointestinal tract can occur with erosion of the lining of the esophagus and stomach causing nausea and vomiting, and possibly bleeding. Other things can happen such as vitamins are not absorbed properly, which can lead to nutritional deficiencies with long term use of alcohol. Liver diseases may also develop and

can cause cirrhosis. The heart muscle may be affected. Sexual dysfunction may also occur causing problems for both male and female.

Alcohol can also affect the nervous system and can result in nerve damage and severe memory loss. Chronic alcohol use also increases the risk of cancer of the larynx, esophagus, liver, and colon. Alcohol intake during pregnancy can cause birth defects. The most serious defect is fetal alcohol syndrome which could result in mental retardation and behavioral problems. A milder form of the condition could result in a lifelong impairment called fetal alcohol affects.

The development of dependence on alcohol may take several years following a consistent pattern. A tolerance of alcohol develops, then black-outs may occur relating to the drinking, people may lose control of their drinking and will find it difficult or impossible to stop. The most severe drinking problem includes prolonged binges of drinking with associated mental or physical complications.

Withdrawal occurs because the brain has physically adapted to the presence of alcohol and cannot function without the drug. Symptoms of withdrawal may include elevated temperature, increased blood pressure, rapid heart rate, anxiety, psychosis, seizures, and can cause death.

There is no common cause of alcoholism, but there are some factors which may play a role in its development. People who have or had alcoholic parents, genes may have an influence, unresolved conflict with relationships, low self-esteem, a need for anxiety relief, peer pressure, and a stressful lifestyle.

Symptoms

Men who consume 15 or more drinks a week, women who consume 12 or more drinks a week, or anyone who consumes 5 or more drinks per occasion at least a week are all at risk for developing alcoholism. [One drink is defined as a 12-ounce bottle of beer, a 5-ounce glass of wine, or a 1 1/2-ounce of liquor.]

The above information was taken from the United States National Library of Medicine (NLM) and the National Institutes of Health (NIH). For more information, please refer to the NLM/NIH website at (www.nlm.nih.gov/medlineplus/ency/article/000944.htm) Medline Encyclopedia, 2007.

SUPPORT GROUPS - Websites / Contact Numbers

FamilyDoctor.org

Alcoholics Anonymous (Sacramento) 916-454-1100
One of most popular support groups, with members available 24/7 – support is through peer groups, learning to participate in social functions without drinking; given a model of recovery.

AL-Anon/Alateen (for those who live with someone who drinks) 800-344-2666

Adult Children of Alcoholics 310-534-1815

Celebrate Recovery 916-791-1244
Jeff Redmond
email contact: jeffr@baysideonline.com

Center for Abuse Treatment 800-662-HELP

Women for Sobriety	800-333-1606
SMART RECOVERY	440-951-5357
Alcohol Anonymous (National Number)	212-870-3400
National Association for Children of Alcoholics www.nacoa.org	
National Institute on Alcohol Abuse and Alcoholism	301-443-3860
National Clearinghouse for Alcohol and Drug Information	800-729-6686

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being, the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry the message to alcoholics, and to practice these principles in all our affairs.