
Suicide and Violence Prevention Newsletters

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OFFICE OF SUICIDE & VIOLENCE PREVENTION

NOVA SOUTHEASTERN UNIVERSITY

Newsletter – Winter 2020

Dr. Scott Poland & Dr. Douglas Flemons, Directors

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ADOLESCENT SUICIDE PREVENTION IN THE CONTEXT OF SOCIAL MEDIA: PART ONE

Marina Niznik, Scott Poland & Richard Lieberman

Social media has enabled far-reaching connections among adolescents, thereby increasing exposure to an individual adolescent's suicide. Among individuals ages 15 to 19, suicide is now the second leading cause of death (Heron, 2016). Social media use is ubiquitous among this age group, with 95% of youth engaging in daily use (Burns et al., 2013). As vulnerable youth find each other through social media (Joiner, 2010), this trend can conceivably impact a large number of adolescents. School mental health professionals should be aware of this in order to mitigate the potential effects. This is the first of a two-part series on the context of social media in adolescent suicide prevention. Part 1 provides an overview of these issues. Part 2, which will be published in the December issue of *Communiqué*, continues with suggestions for harnessing the reach of social media to enhance suicide prevention, intervention, and postvention.

Adolescent Suicide Contagion

The linkages formulated across technology platforms make identification of students who are at risk after an adolescent suicide, and the task of preventing additional suicides (i.e., contagion), vastly more difficult. Two main types of suicide clusters are identified. Mass clusters are temporary increases in suicides during a time period

UPCOMING EVENTS:

"Educators Making the Difference for Students in a Challenging World"
Keynote address, Florida Council of Independent Schools Winter Symposium hosted by Pine Crest School, 2/7/20, Dr. Scott Poland.

"#MSDSTRONG Two years Later: Lessons from the Road to Recovery."
2/8/20, 9:00 am-2:00 PM
Nova Southeastern University, Dr. Scott Poland

NSUnited Event
2/13/20, SVP Crew

"Assessing Suicide Risk"
Undergraduate Case Competition Workshop
3/11/20, Dr. Scott Poland & Dr. Elizabeth Hilsman

"Stress Management & Test Prep" for Physical Therapy Grads,
5/6/20, Dr. Elizabeth Hilsman

—irrespective of location—and are often associated with the influence that media reports may have, such as the reporting of suicide of a celebrity. Point clusters are an increase in suicides that are close in time or space and occur in communities (Poland, Lieberman, & Niznik, 2019). The effects of “social-media contagion” on adolescents are not yet clear (Luxton, June, & Fairall, 2012).

Individuals ages 15 to 19 are up to four times more prone to suicide contagion than people in other age groups (Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990). Factors that increase vulnerability to imitating suicidal behavior include: being an adolescent, having mental health issues, and exposure to or bereavement over someone else's suicide (WHO, 2017). The effects are even more pronounced when an individual identifies with the person who died by suicide.

Though previously held that each death by suicide typically has a profound impact on six people, it is now estimated to impact 135 people, one-third of whom will experience a severe life disruption (Cerel et al., 2018). Adolescents were not sampled as part of that study; however, it was found that the younger the person who was exposed, the greater the risk of suicidal thoughts (Cerel et al., 2018). As social media connections have enabled social proximity to transcend physical geography, adolescent deaths by suicide are no longer isolated, resulting in an adolescent's suicide impacting other students beyond their geographic community. In fact, one study found that 59% of individuals ages 14 to 24 were exposed to suicide-related content through Internet sources (Dunlop, More, & Romer, 2011).

Exposure to the suicide of a peer can magnify preexisting negative life experiences as well as a desire and capacity for suicide (Gould et al., 2018; Woodford, 2017). However, a single exposure to the suicidal behavior of another person does not result in imitative behavior in the absence of vulnerability factors (e.g., previous attempts, mental health issues, substance abuse, access to lethal means; Gould et al., 2018).

Friendship with an adolescent who died by suicide is associated with an increased suicidal risk; however, it has been found that it is the less close friends that knew the student who died that have the highest rates of suicidal ideation or behavior as a result (Gould et al., 2018). This vulnerable group may include teens in an individual's social network community. Even over a decade ago, 45% of the nation's teens (aged 13 to 17) reported that they knew a teenager personally who attempted suicide (McMurray, 2004), which can be assumed to have grown significantly with the sharing of such information over social media. Focusing solely on

those students closest to the teen who died by suicide likely results in many exposed, at-risk students being unidentified.

Contagion via social networks has been established. Exposure to a suicidal peer via messages posted on social media may affect a variety of offline behaviors (Gould et al., 2018). Furthermore, emotions can be spread on social media just like real life, leading people to experience the same emotions without their awareness, without direct interaction between individuals, and in the absence of nonverbal cues (Kramer, Guillory, & Hancock, 2013).

Perhaps rather than remaining distinct categories, in the age of social media, point clusters and mass clusters might be better conceived as co-occurring in many situations, due to the broadening of the concept of communities that are not defined by geographical constraints. This change from categorical descriptions to more of a continuum of impact can have significant implications for prevention, intervention, and postvention with regard to adolescent suicide.

Adolescent Use of Social Media

The overwhelming majority of teens have smartphones (Pew Research Center, 2018) and the ability to distribute information almost instantly to potentially hundreds of people simultaneously. According to the Pew Research Center, 92% of teens use the Internet daily with 45% of them reporting “almost constant” online usage (Anderson, 2018).

The vast majority of teens (71%) report that they use more than one social media site (U.S. Department of Health & Human Services, 2019). Currently, the most often used social media platforms among teens are: YouTube (85%), Instagram (72%), Snapchat (62%), Facebook (51%), and Twitter (32%; Pew Research Center, 2018). The universal popularity of social media platforms among young people presents a unique set of opportunities and challenges for suicide prevention (Cox et al., 2012).

Social Media: Mental Health Resource or Risk?

Emerging data suggest that social media is a valuable resource for youth at risk of suicide who are in need of support, primarily serving to decrease feelings of isolation leading to reduced suicidal thoughts (WHO, 2017). Mental health benefits of digital communities may include the opportunity to engage otherwise disengaged individuals; a forum to share experiences and emotions; an avenue for friends to intervene and provide support to each other, particularly at times of imminent risk; the reduction of social stigma; and the increased availability of trained providers

(Robinson, Bailey, Browne, Cox, Hooper, 2016; Robinson, Rodrigues, Fisher, Bailey, & Herrman, 2015; WHO, 2017). Participation in online communities may also support well-being among teens via increased engagement with causes that are important to them, enhanced learning experiences, access to a plethora of information and resources, involvement in civic issues and causes, opportunities for cross-cultural communication, and a forum for self-expression and creativity (U.S. Department of Health & Human Services, 2019).

However, there are potential risks associated with digital media use for teens, as well. Nationwide, 14.9% of students report that they have been electronically bullied through texting or social media sites (CDC, 2018). Other negative effects may include access to suicidal images or methods that may normalize suicidal behavior and increase contagion, exposure to or sharing of inappropriate or illegal content, and the propensity for inaccurate information to circulate and be viewed (U.S. Department of Health & Human Services, 2019). The need for adult involvement is clear, because “ultimately, social media becomes a tool or risk for teens’ health based on how they use it, which is in turn shaped by the guidance they get from caring adults” (U.S. Department of Health & Human Services, 2019).

Recommendations for parents and professionals to guide healthy social media use are provided by the Government Office of Adolescent Health. These include: (a) help teens protect their online information; (b) teach teens how to be responsible digital citizens and prevent or manage cyberbullying and sexting; (c) set healthy boundaries for social media use; (d) access reliable sources about adolescent health; and (e) guide teens toward sites that can assist them directly (U.S. Department of Health & Human Services, 2019).

Safe Messaging: Traditional Media

Individuals with a recent suicide attempt or those with severe depression are more likely to attempt suicide as a result of a media report (Gould & Lake, 2013). Therefore, to prevent further deaths by suicide, professionals in both the news and entertainment media have been encouraged to adhere to safe messaging guidelines when reporting stories about suicide. These recommendations include: **(a) refrain from using sensational language or normalizing suicide, (b) avoid unnecessary repetition of the story, (c) use neutral rather than emotionally charged photos, (d) refrain from detailing the method of death, and (e) take particular care when the suicide involves a celebrity** (CDC, 2017; WHO, 2017). The World Health Organization (WHO) noted that collaborating with

media on safe messaging of suicide is an evidence-based suicide prevention strategy (Robinson et al., 2017).

Safe Messaging: Digital and Social Media

As a natural extension, safe messaging guidelines regarding reporting content relating to suicide via digital media (news, blogs, networks over the Internet) have also been recommended. They include: **(a) avoid hyperlinking of suicidal material, such as video or audio footage (e.g., emergency calls) or links to the scene of a suicide, especially if the location or method is clearly presented; (b) avoid using pictures of a person who has died by suicide; (c) avoid harmful wording in headlines; and (d) avoid data visualizations or sensationalizing statistics about suicide** (WHO, 2017).

Social media platforms commonly used by teens, such as Instagram, Snapchat, and Facebook, involve the sharing of content that is created by the users (in this case, adolescents) rather than media professionals, highlighting the need to expand safe messaging guidelines to incorporate creators of content on social media. Complicated by the ephemeral and fleeting nature of some posts on platforms that enable messages to disappear within a short time period, safe messaging on social media can be hard to track.

Adolescents play a lead role in the dissemination of information when a suicide of a peer occurs, effectively becoming “citizen journalists,” (public citizens who are actively collecting, reporting, and disseminating information). Though traditional media outlets are increasingly following established safe reporting guidelines for deaths by suicides, social media posts by individual users are not, as there are few accepted guidelines about safe messaging for the active users of social networks (Cox et al., 2012).

Guidelines are beginning to be developed for social media platforms to modify the way in which suicide is discussed online (Robinson et al., 2017), however these efforts are limited and not yet well-tested. A recent exploratory study demonstrated that educating young people regarding safe ways to communicate about suicide and then supporting them to develop their own media messages appears to be promising, affecting participants’ perceived ability to communicate safely about suicide as well as their perceived ability to support others expressing emotional concerns, both on- and off-line (Robinson et al., 2017). Increasingly, the vast majority of adolescents receive news from social media rather than traditional media (Pew Research Center, 2018). Therefore, mediating the reporting of teen suicide

by traditional media is likely insufficient; increased education about safe messaging in social media exchanges is now warranted to decrease the impact on vulnerable adolescents.

Suicide Prevention Response Among Major Social Media Platforms

Social media networking companies are seemingly aware of the ways in which youth use their services to manage their mental health, and have responded to the need to provide options to keep their platforms safe (Robinson, Bailey, Browne, Cox, & Hooper, 2016) and provide increased support and resources for mental health issues (Rice et al., 2016). Facebook, for example, recognizes that they are “well-positioned and resourced to build suicide prevention tools” which “... makes suicide prevention work an ethical imperative for Facebook” (Nuno Gomes d Andrade, Pawson, Muriello, Donahue, & Guadagno, 2018).

In an effort to provide guidelines for social media companies, a tool has been created by industry and leading mental health experts for users who are concerned about someone who may be suicidal (Reidenberg, Wolens, & James, 2013). It outlines three degrees of response from *basic* (e.g., help center policies, referrals), to *mid-level* (e.g., guidelines, user reporting, partnerships, contextual messaging, education), to *advanced* (e.g., timely response, outreach, cultural competency). Presently, Facebook, Google, YouTube, and Twitter participate in using this framework. In addition to other resources, most major platforms minimally include referral information to both the National Suicide Prevention Lifeline and the Crisis Text Line on their safety pages.

Worldwide, every 40 seconds, someone dies by suicide, which totals about 800,000 people per year (WHO, 2019). Simultaneously (on one social media site—Facebook), worldwide, every 60 seconds, users make 510,000 posts, update 293,000 statuses, react to 4 million posts, and upload 136,000 photos (Osman, 2019). Though critics argue that the use of artificial intelligence and machine learning to review suicidal content to keep users safe is inadequate, it appears that the practicality of an alternative approach, such as solely using content moderators, is not always sufficiently considered. In fact, machine learning has been found to be more accurate than a user's ability to determine posts of a concerning nature due to the ability of expert-derived algorithms to detect patterns in content (Card, 2018). For justifiable reasons, decision-

makers leading social media platforms must strike a balance between efficacy (detecting suicidal ideation at all costs) and respecting user privacy. To address their role in suicide prevention directly, Facebook, for one has stated:

“Even with the introduction of these AI-fueled detection efforts, people are still core to Facebook's success around suicide prevention. That's why anyone who flags a potential cry for help is shown support options, including resources for help and ways to connect with loved ones. And whether a post is reported by a concerned friend or family member or identified via machine learning, the next steps in the process remain the same. A trained member of Facebook's Community Operations team reviews it to determine if the person is at risk—and if so, the original poster is shown support options, such as prompts to reach out to a friend and help-line phone numbers. In serious cases, when it's determined that there may be imminent danger of self-harm, Facebook may contact local authorities. Since these efforts began last year, we've worked with first responders on over 1,000 wellness checks based on reports we've received from our proactive detection efforts.” “We're not doctors, and we're not trying to make a mental health diagnosis,” says Muriello. “We're trying to get information to the right people quickly.” (Card, 2018)

It is unclear if and how the future calls for privacy regulations may impact social media and the platform moderators' abilities to review posts from vulnerable youth at imminent risk for suicide, because increased data privacy may result in reduced visibility within the platforms of all posts, including those with concerning suicidal content. Such a change might put the onus of first-line suicide intervention squarely on the user's friends and social connections with whom the post was shared, to make a determination of how to best respond, thereby increasing the need for all users, particularly teens, to be educated and skilled on what to do when faced with a potentially suicidal friend to whom they are connected on social media. As we know, suicide prevention is up to everyone. With regard to adolescent suicide prevention in the context of social media, school psychologists and other school mental health providers need to be ready to support students to respond to this emerging challenge.

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Social Media Guidelines

By Kirsten Vadelund

- 1. Help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.**
Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- 2. Social interactions with people living with mental illness are the most effective way to reduce public stigma.**
Using social media to matter-of-factly talk about your own experience can help online friends and followers gain a better understanding of mental illness.
- 3. Consider sharing positive stories about recovery**
Rather than only posting mental health-related content when there is a negative incident.
- 4. Avoid sharing stories that imply that mental illness often causes violence.**
The vast majority of people who are living with mental illness are never violent, and are in fact more likely to be victims than perpetrators of violence.
- 5. When you see someone else posting stigmatizing or disparaging content, say something!**
You have the power to influence how someone thinks about people living with mental illness. Rather than attacking them, explain why what they posted is hurtful.
- 6. Write conversationally.**
Don't sound like a textbook or a press release. People are more receptive when they feel like they are connecting with a real person behind the account.
- 7. Avoid stigmatizing or derogatory language.**
This includes words like "crazy," "psycho," "nuts," "lunatic," "deranged," etc. Also avoid "committed suicide" (associated with crimes) and "successful/failed suicide." Instead, use "suicide attempt," "suicide death," or "attempted/died by suicide."
- 8. Use people-first language rather than labels.**
This means describing, for example, someone as "living with schizophrenia" rather than "a schizophrenic."
- 9. Avoid posting stereotypical imagery of people looking disheveled or threatening, or clutching their head.**
Most people living with mental illness show no outward signs of distress.

INTERVIEW WITH DR. ALAN (LANNY) BERMAN

By Dr. Scott Poland and Dr. Douglas Flemons

Dr. Alan (Lanny) Berman, Adjunct Professor of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine, was interviewed by NSU's Office of Suicide and Violence Prevention Co-Directors Dr. Scott Poland (SP) and Dr. Douglas Flemons (DF). Dr. Berman is an international expert in suicide prevention who has received numerous awards, has served as past President and Executive Director of the American Association of Suicidology (AAS), and has authored well over 100 publications since he began helping to form the field of suicide prevention in the U.S.

What got you interested in suicide prevention? (SP)

I was a new Ph.D. back in 1970, when my first job was an instructor and then, a year later, an Assistant Professor at American University. The second year I was there, some undergraduate students approached me and a colleague and asked if we would help them build a university-wide crisis service. We got academic approval to build a 500-level course for undergraduate and graduate students in something we called "Behavioral Crisis Intervention," which allowed us to teach about crises, crisis intervention, helpline support, and other forms of intervention.

I read the literature and worked up a lecture or two at the time. This was an innovative program. One of the students in that first class was the son of Berkeley Hathorne, the second-in-command to Edwin Shneidman at the National Institutes of Health (NIH) when he was there to run a Center for Suicide. I was invited to be on a panel to describe the program we had built at the 1971 annual meeting of the American Association of Suicidology (AAS) in D.C. On that panel were clinicians and researchers whose work I had been teaching about, Norman Farberow, Jerome Motto, and some others. I realized I had fallen into a small but very deep pond. So, I got excited and therein was born another 50 years of working in that small pond.

I got to know Ed Shneidman rather well, Norman Farberow, and Bob Litman, the guys who had started and run the mecca of suicide prevention at that time, the Los Angeles Suicide Prevention

Center. I spent some time in LA pouring through their files, reading the psychological autopsies they were doing and had long discussions with them about these. It was a tremendous opportunity to sit at the feet of the biggies in the field at that time, to recognize how much work needed to be done, how much research needed to be done, and how much we didn't know. That was a tremendous impetus to a young researcher and clinician.

When did you go to work for AAS? (SP)

Well, I joined the AAS at that meeting and ended up getting elected to the Board within the first 10 years. I was Treasurer at one point, so I had been actively involved in the organization, which in the 70's was really quite small. I think there were between 200 and 400 members throughout most of the 70's. I was asked to run for President in '83-'84 and was President in '84-'85. So, within 14 years or so, I went from knowing nothing about the field to becoming the President of a national organization dealing with the study and prevention of suicide.

You've made a splash in the field as Executive Director and President of the AAS and as a researcher and a clinician. You've done a lot of writing, with over one hundred publications, you've had such a wide range of influence. Is there any particular part of that legacy that has been most satisfying for you? (DF)

There's so much of it that has been satisfying. As a researcher, clinician, or someone who has been in the field for a good while, anytime you get feedback that you've positively influenced somebody or something, nothing could be more fulfilling. My wife was having her nails done the other day, and she sat next to a woman who, once she gave her name, asked if she was my wife, and then went on at length about how I did whatever I did to save her son's life 20 years ago. So clinically, things like that are the most satisfying aspects of being in a field like this. You're moving the needle in one way or another for patients or getting the research done that's needed to influence policy or preventive interventions. Most importantly, you're mentoring the next generations of Ed Shneidmans.

What do you see as the biggest challenges today in suicide prevention? (SP)

Money, money, money. Research doesn't get done unless it's funded, and there's still way too little funding. The funding that is there tends to go to significant projects that don't tend to have significant impact. What I mean by that is that they're not focused on sustainable, large-scale, long term, developmental kinds of projects that are going to give us the data we need. There is almost no data, only three studies in the literature, relative to acute risk or near-term risk of people who die by suicide. So we need far more data on the last days of these individuals' lives in order to better improve assessment, no less intervention. There's just so much that needs to be done, but I started off with money because nothing happens without that.

I think the excitement I see now is in the depth and breadth of the field and several very bright new Ph.D. and M.D. scholars that are coming in and recognizing this is a worthwhile area in which to spend their energies. But they're going to be similarly constrained by their ability to get funding. There's always a danger that, if the federal government doesn't pony up or the private sector doesn't get more involved, 50 years from now we're not going to have gotten very far.

You gave a talk a few years ago where you mentioned the figment called "imminent risk." Can you talk a little more about that? (DF)

Yes, we talked a lot about the issue of imminent risk. If you're a clinician, your primary responsibility is assessing the feasibility that your patient may die by suicide and developing effective interventions to prevent that from happening. As was said before, we know practically nothing related to the last 48 to 72 hours of the lives of those who die by suicide. If you're going to be charged with a serious safety event risk in the very near term and held legally accountable if you blow it, then we need much more informative data as to what causes the shifts from ideation to action and what behavioral signs are more indicative of the potential to act. We can't just rely solely on patients telling us that they're thinking about acting, because the majority of patients who die by suicide deny it when last asked before taking their lives.

We just don't have much of that data, which is crucial to inform clinical intervention and to limit potential malpractice suits when deaths occur. In

thinking about upstream prevention, it's crucial to note that there's a distinction between those who are chronically suicidal versus acutely suicidal. We need to be able to differentiate those individuals who may be chronically suicidal all their lives but still die of natural causes such as cancer, compared to those who make that shift from being in a suicidal zone, being chronically at risk or vulnerable, to a point where they actually then take action.

In one of your publications, I was really impressed by you acknowledging that there has been a lot of research at the sociological level about risks, but when you actually have somebody sitting in front of you and need to be paying attention to the idiosyncratic nuances of their experience, that those overarching risk factors may not be incredibly helpful in guiding your decision making. (DF)

Oh, absolutely. I'm not a big fan of epidemiological research. It's important and helpful for social and cultural perspectives, but not so much for clinicians. For example, the epidemiology of suicide in the U.S. would tell us that Black females are at very little risk for suicide. But a clinician sitting with a Black female client is informed very little by this data, because that Black female client may very well be at significant risk for suicide. So again, the focus of our research is overwhelmingly epidemiological and needs to be shifted much more toward understanding the dynamic that the individual presents, no less the characteristics of the interactions that occur between clinician and patient that may influence an increase or decrease in that risk. Dave Jobes and I used to have discussions about this very issue, trying to really take on the client's perspective in order to understand how someone can go from feelings of despair, anguish, or pain to a plan or behavioral intention to end their pain by taking their life.

It's an incredibly difficult process to understand how that happens and why it would happen for any individual. Trying to imagine what they may not have gotten developmentally that would have given them the coping abilities to understand that they will get through this. Specifically, what is it about their context that is so overwhelming that even though they have been resilient in the past, now those coping skills or strengths simply aren't present? That kind of information doesn't come from epidemiological research but from truly understanding a patient or an individual.

You've mentioned a lot of important things there. Douglas and I are both currently training graduate students. What do you think are the most important things they can focus on when working with suicidal clients? (SP)

I'm going to take a legal perspective on this. The duty to care imposed upon the clinician when dealing with a patient relative to suicide is to address the potential that that patient has for taking their life, especially those who are self-harming, and based on that assessment, designing and implementing a treatment plan to reduce that level of risk. We're not very good, however, at accurately assessing a patient's level of risk. In fact, the research data says that there are basically equal proportions of people who die by suicide coming from those assessed to be low risk as there are coming from those assessed to be high risk. Therefore, we're not very good at this. So the focus has to be, again, on truly gaining a sense of what drives the patient to cope, to take care of themselves, and to strive towards the future under difficult circumstances, either intra- or interpersonal, versus what happens that makes that determination and capacity break down. Is it pathology? Is it unremitting external or potential threats? What is it that drives a lack of will to sustain one's life?

There are lots of questions, so the clinician has to be as curious as a private detective in seeing the world through their patient's eyes and not applying an external frame to the patient, but letting that patient's phenomenology dictate an understanding of, "If I were in this person's shoes, might I indeed consider that nothing will change to solve my problems?" Take as much time as necessary to get to know your patient inside and out and the world in which they live and then be a consultant, adviser, teacher, clinician, and help that patient move toward a better place. Obviously, you also need to know something about what research tells us are evidence-based interventions and what tools we have to make that movement possible. But for the most part, we don't have a lot of those either.

When you are consulting to hospitals about what happens when patients are involuntarily hospitalized, what exactly do you usually advise them? (DF)

First, I tell them it's not a great idea. I'm not a fan of involuntary hospitalization. Committing a patient

doesn't prevent their potential to suicide and may actually foster that potential. But, if indeed someone is under your watch and is hospitalized in this way, the focus has to be not on the 72 hours of hospitalization but on the next 72 hours after that. The purpose of the hospitalization is to get the patient calmed down, maybe start them on medication, and maybe give them some various forms of supportive, mostly group, therapy. Hospitalizations don't do a lot to turn people around.

The issue is that after 72 hours, unless the patient is grossly psychotic, they're going to be discharged back to the community from which they came and in which they were suicidal or at least in need of involuntary hospitalization according to somebody. So the focus really needs to be on integrating what we can do in the next 72 hours that's going to make a difference in this patient's life over the hours and days following. The focus has to be on continuity of care and developing a treatment plan that reduces future risk.

I wanted to ask you about safety plans. I'm continually amazed that some people are still using "no suicide contracts." Do you have any words of wisdom or thoughts on safety planning? (SP)

I find safety planning an intriguing movement in our field. It is perfectly sound to include critical advice and direction to a patient, giving them resources and support, and reminding them of what to do if and when. There is some initial data that says that they have some impact. It's not overwhelming data, and it's not long-term data. So, in that sense, I don't think that we're at the stage of development where we can say these are the be-all end-all in what needs to be done, but they're a tool. They're a tool that you can hand patients and use to help them through the next couple days and weeks where they may cycle through experiences that brought them to a suicidal state to begin with. So, it is helpful. But it's not a sustainable intervention. It's simply a crutch that hopefully patients will use and recognize has value in the information, contacts for support, and interventions when necessary.

Could you comment about the importance of removing lethal means? (SP)

Without question, the data here are probably the best we have. If you make inaccessible any lethal means to suicide, the individual has to then

be creative in their problem solving to find another accessible method. So, with a certain proportion of suicides being impulsive, removing immediate access to a lethal weapon, most often a firearm, means they would have to go to a secondary choice. They would have to be creative problem solvers, and if they're suicidal, they're not likely to be. If they were, they'd probably not be suicidal. Even if they do come up with an alternative means, it's likely going to have a lower fatality rate than a firearm does and therefore their chance of survival, followed by changing their mind or receiving an intervention, is that much greater. So, we have a lot of good data relative to the impact of restricting firearm accessibility, building bridge barriers, lowering the toxicity of pesticides, etc.

The problem that remains, which we've always argued is minimal, is that new data is beginning to make us question the finding that restrictions of lethal means such as firearms is the answer. Indeed, there are some means to suicide that we can't restrict. We have no reasonable method to keep ligatures away from people. We have no reasonable way to keep knives away from people. You can only cleanse the house of potentially lethal means so much. We've seen rising rates of suicide by hanging as we've seen some rates of suicide by firearms go down. So the point I was making is that means substitution has always been seen as an unlikely possibility, but I think increasingly, that is not necessarily true. We have a long way to go relative to restricting access to lethal means, but clearly in this country, firearms are key. To the extent that one can accomplish limiting the immediate accessibility of a lethal weapon, you could save some lives.

We have some good data on bridge barriers as well. I have some local data relative to what would be an obvious immediate second choice of a bridge perpendicular to our number one bridge here in D.C. Interestingly, when a barrier was built on the one bridge, there was no uptake in suicides from the perpendicular bridge. So there's data like that that's very encouraging, but not sufficient on a large scale. Again, we're talking about firearms in the United States. It's very questionable the amount of opposition we will have to constraining access to a firearm. The only exception to that is the ERPO (Extreme Risk Protection Order) laws that are now increasingly on the books in a number of states, red-flagging people who are domestic abusers and/or suicidal and removing firearms from their possession. The difficulty in all this is sustainability over the long-term, because aggression and/or

suicidality wax and wane in people who aren't otherwise treated over the long run. So we can intervene today and prevent something from happening in the next few days, but eventually they're going to get the gun back and then what?

Great point. In your work, what have you found to be most helpful for suicide survivors? (SP)

I think it's terrific when survivors get active in prevention organizations, because clearly their intent is to make something good come out of something tragic and horrible. I think survivors have a role in what we build preventatively. They can teach us about their own experiences. But overall, those experiences are pretty idiosyncratic, and we will need to aggregate a lot of that idiosyncrasy into something normative that allows programs to be developed based on those experiences. In many cases, survivors may have reasonable biases and blind spots in aspects of their interactions with their loved one that may not give us the kind of valid data we would need. It's been an interesting movement, one that is very exciting to the field. However, I'm a little concerned as a clinician, a researcher, and a professor that there's been maybe too much of a scientific embrace of survivors and those with experience, in lieu of more solid research, which I feel, is more crucial for advancing the field. Survivors aren't teaching us an awful lot about what clinicians need to do better. Those with lived experience can likely help us, but even there, you've got to take what they have to say through a lens of whatever pathology they had. So it's mixed, but overall, I think it's important to the field to include everybody who has got some skin in this game.

You've done a marvelous job of talking about what we have left to do to improve the field. Can you reflect for a moment on the progress we have made since the '70's? Where are we now? (DF)

I have mixed responses to that question. The NIH-sponsored "Suicide Prevention in the 70's" report came out around 1973 listing many recommendations, very few of which have ever truly been enacted or followed up on in significant ways. The Department of Defense (DOD) Task Force that I was on over a decade ago produced around 70 to 80 best practice recommendations, and yet military suicides are higher now than they were then, because many of these recommendations were not enacted. Policies have been proposed, and state and national prevention agendas have

been established. That has all been very significant and helpful. However, they don't sufficiently get translated into programs, they don't get funding, and they aren't sustained over time.

The U.S. Air Force Suicide Prevention Program is a great example of this. This program had some promising initial positive results, but the program wasn't sustained, and suicide rates that had declined came back up again. The Garret Lee Smith grants funded by SAMHSA showed some promising results that weren't sustained when funding stopped. Take away the funding, take away leadership support, and the program ceases. So, what's to be gained?

My point is that there has been tremendous growth on many levels, much more energy in the field, many more people in the field, and more significant researchers focusing on these important problems, but there are so many obstacles that still haven't been overcome. It's a bit distressing to me that after give or take 50 years, we're still struggling with many of the same issues: sustainability, fundability, leadership, and public-private partnership never really developing in a significant way. States are doing lots of feel-good, look-good kinds of things, but rates are still not going down and in many cases are going up. If I can frame this in another context, if we were the CEO's of a major corporation, we'd all be fired by now, because we are failing at our task. So, I think the bottom line is that we have a lot more potential now than we had 50 years ago to use this data in a significant way, but we are still not there. We have to be much more self-critical in what we are not doing right and how we can get it right.

Do you have any other final thoughts or things you'd like to share with us? (SP)

I think the only other thing comes out of what I've been doing the last three years now at Hopkins. I have an adjunct appointment in the Department of Psychiatry, but in truth, I spend more of my time in the School of Public Health, because that's where the people I'm associating with are, for the most part. I'm now affiliated with a major medical institution in which there are approximately 30 to 40 people I could identify that, in one way or another, have an interest in suicide and suicide prevention. However, they're all in different silos, and I've been doing yeoman's effort in my biweekly visits to Baltimore to argue that we need to develop a center, a critical mass, to get these people talking to each other, collaborating, and working together to pool skillsets and resources. That means the psychiatric side of the institution as well as the public health side have to work in tandem if we're going to make a difference. That's what's been missing. There are still too many silos, too many individual projects, and too many individual research centers or studies that aren't looking at the bigger picture. I would argue very strongly that the future, if we're going to get this right, is to really demand much more out-of-the-box thinking by people and encouraging them to work in interdisciplinary teams or with a collaborative emphasis.

Very important. You might be interested to know that Douglas and I are in different NSU Colleges, but we've been collaborating now for about 12 years. I absolutely agree, partnership and collaboration are key. (SP)

“We have to be much more self-critical in what we are not doing right and how we can get it right.”

Dr. Lanny Berman

What Made Maddy Run?

By Samantha Vance

The tragic loss of Madison Holleran shook the nation when she died by suicide on January 17, 2014 at the age of 19. Maddy was a student athlete for the University of Pennsylvania's track and field team. The book *What Made Maddy Run?* is a heart-wrenching narrative that explored Maddy's life, her struggles, and the tragedy behind her death. It lends readers a closer look into her journey as a young, all-American, competitive athlete. In this story, Maddy is survived by her parents James and Stacy, along with her siblings Ashley, Mackenzie, Brendan, and Carli.

Maddy played competitive soccer throughout her life and began competing in track during her sophomore year in high school. She excelled athletically, academically, and socially. She was described as a happy, fun, high-achieving, and perfectionistic young girl. During her senior year of high school, she committed to play collegiate soccer at Lehigh University after being offered an athletic scholarship. Soon after, the University of Pennsylvania (Penn) reached out to offer her an athletic scholarship to run track and field. With this conflicting decision, she decided to pursue her academic and athletic career at Penn. Her father indicated in an interview conducted by espnW that he believes her reasoning behind this decision was that "she was enamored with the Ivy League" and that it was due to the "prestige" (Fagan, 2015). In this same interview, her sister revealed, "Once she was shown that she could get that, that it was in her reach, she wanted it" (Fagan, 2015).

The transition from high school in New Jersey to a prestigious Ivy League university in Pennsylvania was quite difficult for Maddy. She became less social with her friends, lost a significant amount of weight, and had difficulty sleeping. Her friends noticed that her behavior seemed out of

character, however they attributed it to her adjusting into this new chapter in her life. When Maddy returned home for a visit from college, her family recognized that her mental health issues were more severe than they initially believed. She expressed hating her life at school and still being unhappy at home. In a conversation with her sister, Ashley, Maddy said that she "is not happy anywhere" and that "this is not normal," coming to the conclusion that her unhappiness was not solely due to her environment. Maddy's father indicated that "she was losing the balance there, between being perfect, or trying to be perfect, and trying to be happy" and that "she wasn't feeling like she was achieving at her perfectionistic level that she had become accustomed to" (Fagan, 2015). Her sister expressed, "She was putting a lot of pressure on herself" (Fagan, 2015). Close friends and family of hers also indicated that she had trouble asking for help, which poses a great threat to someone who may be struggling emotionally.

A passage from the family and friends' recollections included a time that Maddy spent the day at her friend Emma's house with Emma and Emma's mother, Lorraine. Their conversation involved the topic of college and how Maddy had been disappointed in her experience. It was obvious to Lorraine that Maddy had lost quite a bit of weight. Maddy also mentioned she was having difficulties sleeping and "[did] not know what exactly [was] wrong." Significant weight loss or weight gain and sleeping issues such as hypersomnia or insomnia are symptoms of depression and/or anxiety, both of which Madison seemed to struggle with (American Psychiatric Association, 2013). Lorraine conveyed that she thought about asking Maddy if she was having any thoughts about killing herself but refrained,

because she thought it was an extreme response. One of the most common misconceptions about suicide is that by asking about suicidal ideation, we will “put the thought into one's head” (Joiner, 2011). On the contrary, evidence proves that inquiring about suicidal ideation will not make people “suicidal” but will make them feel comfortable expressing their emotions and can lead to keeping them safe (Joiner, 2011). Research also suggests that someone who is suicidal is desperate for human connection, which was something Madison seemed to previously value in high school but then lost in her freshman year of college (Van Orden, et al., 2010).

Upon realizing the distress that Madison was experiencing, over Thanksgiving break her parents found her a therapist whom she continued to see through her winter break (Fagan, 2015). After speaking with the therapist and her parents, Madison contemplated transferring to Vanderbilt University but was terrified. She even began discussing the idea of transferring with her friends Emma and Ashley, who was also her track teammate at Penn. Maddy was overwhelmed with this decision, as she did not want this to reflect her giving up. It has always been a dream of hers to be a student athlete at an Ivy League university. Madison's father was present in the final session with her therapist, the day prior to her return to college. During this session Madison admitted to having suicidal thoughts. Her therapist asked Madison to agree that if she had thoughts about suicide that she would not act on them and would call the therapist or someone in her family. Her father expressed that when he later reflected on this conversation, he could tell that Madison might not have been “sincere enough” in her response to the therapist.

Approximately a week after returning to college, Madison ended her life on January 17, 2014. Sadly, Madison was in so much pain from her present situation that she was unable to see hope for her future. Someone who struggles with suicidality can benefit from continued therapy or hospitalization, depending on the severity of the situation. In therapy, it would be beneficial for the client and therapist to collaboratively create a written, individualized safety plan. A safety plan is a customized crisis plan that is used to prevent the client from dangerous situations and typically includes the following content: identified triggers and warning signs, coping techniques, strategies to restrict access to means, sources of support, professional help, emergency services, and protective factors. The safety plan should be handy for the client to access whenever they feel they are in danger. If a person is considered a danger to themselves, it is imperative that they receive intensive treatment at an appropriate facility (e.g., crisis stabilization unit or hospitalization), with the goal of stabilizing the individual to prevent suicidal behavior.

In efforts to contribute to the prevention of suicide, soon after the tragedy, Maddy's family created a charity organization called The Madison Holleran Foundation, whose primary mission is to prevent suicides and assist individuals in crisis situations by providing relevant resources. They focus their efforts on providing information to high school seniors and college freshman to help them with the trying transition into college. Their website is <http://www.madisonholleranfoundation.org/>. According to Fagan (2015), “The Hollerans's are trying now to deliver a new message: ‘It's okay to not be okay; It's okay to show people you're not okay.’”

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Emergency Dispatcher Vulnerabilities

By J.R Soria

Emergency dispatchers are the personnel providing a lifeline to the United States' 911 system. Across the U.S., there are more than 6,000 public safety answering points, all staffed with professionals who are trained in emergency communications (911 Dispatcher, 2019). Their responsibilities include answering inquiries, referring phone calls to law enforcement or fire rescue, prioritizing simultaneous situations occurring at the same time, and dispatching units to their selected emergency situation. Their primary objective is to keep the caller calm enough to gather information and even instruct cardiopulmonary resuscitation if need be while other emergency medical professionals are on their way.

Due to the nature of their professional responsibilities, emergency dispatchers are subjected to high-stress situations that may impact both their physical and psychological health. For example, it is well documented that dispatch involves constant emergencies that causes an increase in the sympathetic nervous system's responses. Adrenaline, cortisol, and other hormones are pushed through the system to prepare the body and mind for the challenge, known as fight or flight response. Dispatchers may experience what is referred to "auditory exclusion" to receive the most vital information to ensure a successful dispatch call. Their auditory senses are heightened while they keenly listen. Over time, their body is full of adrenaline and cortisol while responding at their desk. Ultimately, they have limited ability to shake off all these nerves. These hormones take time to reduce. If left unchecked, the accumulation of these hormones in the body increases stress levels

that affect both heart and mind.

Thus, emergency dispatch personnel endure higher levels of psychological stress compared to the general population. This high level of psychological distress is shown in increased rates of depression and anxiety among emergency dispatchers. While research is abundant and ongoing in both police and firefighter populations, research is limited with emergency dispatch personnel, despite their similar stressors. The continuation of research in emergency dispatch personnel is important to understand better and more effective strategies to cope with common concerns in this population. Like other first responder groups, suicidality is a significant concern.

Studies show that salivary samples of the stress hormone cortisol taken from emergency dispatchers showed distinct stress patterns related to specific aspects of their profession (Weibel, Gabrion, Aussedat, & Kreutz, 2003; Bedini, Braun, Weibel, Aussedat, Pereira, & Dutheil, 2017). For example, the unpredictable volume of calls was one indicated stressor for dispatchers. The intensity and severity of the call situations was another factor that influenced stress. Other factors were the inability to provide more support because of their limitation at the call-center and the inability to gather more information, unlike responders at the scene. Some common concerns in job-related stress was the lack of administrative support and/or recognition from superiors. Moreover, often times emergency dispatchers were not recognized as true first responders amongst police or firefighter individuals.

Second, the most commonly found psychiatric disorders for first responders were PTSD, major depression disorder, anxiety, and substance abuse, all of which have been significantly correlated with suicidality (Steinkopf, Reddin, Black, Van Hasselt, & Couwels, 2018). Despite dispatchers' absence in experiencing first-hand exposure to trauma, the secondary trauma they endure has been found to lead to PTSD. In addition, depression due to PTSD and other job-related stressors are significantly correlated. One common difficulty amongst all studies that examined psychiatric disorders in emergency dispatchers was the difficulty in isolating dispatchers from police and from firefighters (Klimley, Van Hasselt, & Stripling, 2018).

Critical incident stress management and specific interventions such as critical incident stress debriefings have been found to be helpful in reducing mental health concerns for first responder populations (Burque, Baker, Van Hasselt, & Couwels, 2015). One concern with critical incident stress debriefings are the parameters of what a critical incident may look like for emergency dispatchers. A critical incident recognized by police officers and/or firefighters may not be the same as emergency dispatchers taking in phone

calls. In addition, these interventions are generally held for all first responders, but their personal experiences may differ and thus may add challenges to the intervention approach. For police officers and firefighters, personnel are obligated to attend the critical incident stress debriefings. They are also almost done immediately and routinely; however, for emergency dispatchers, they are generally invited to these debriefings and not required to attend, despite the similarities in mental health concerns.

Ultimately, emergency dispatchers share many similarities in both mental health concerns and job-related stress. Unfortunately, dispatchers do not receive the administrative support and attention they deserve. Research in this population is limited. However, there is enough supporting literature which suggests that dispatchers are also vulnerable to suicide just like the police and firefighter populations. Additional research should be done with emergency dispatchers as a stand-alone population not to be generalized with all first responders. Emergency dispatchers exhibit the same psychiatric symptoms, including suicidality, as do other first responders due to the nature of their professional responsibilities.

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POVERTY AND YOUTH SUICIDE

By Catherine Ivey

Established risk factors for suicide include a current mental health disorder, exposure to suicide, stress, and a previous suicide attempt. Poverty, however, has not received as much attention as a risk factor (American Foundation for Suicide Prevention, 2019), although the association between poverty and suicide is a growing area of research.

Worldwide, suicide ideation and behaviors are associated with relative diminished wealth and unemployment (Thompson et al., 2017). Specifically, 79% of suicides occur in low- to middle-income countries (World Health Organization, 2019). In the United States, however, varying definitions of poverty have complicated researchers' ability to compare or generalize results in the literature (Thompson et al., 2017). Traditionally in the U.S., poverty has been understood as socioeconomic status or income and has been examined through the scope of education, employment status, and relative income (2017). Despite this difficulty, there are some notable points made across both the adult and adolescent literature that may be beneficial to practice and future research.

The majority of U.S. poverty-related suicides are seen to affect adults. A few researchers have found an association between high social economic status and suicide (Page et al., 2006), hypothesizing that increased wealth deceives individuals into thinking they are self-reliant, while poverty encourages a more community-reliant frame of mind that protects individuals from suicide (Augustine, 2012). However, most research has validated the findings that impoverished individuals are 35% more likely to experience suicidal ideation and attempts compared to non-impoverished individuals.

Trying to understand this association has been difficult.

In 2017, Kerr and colleagues found that poverty mediated the relationship between employment status and suicide rates. That means that the relationship between suicide and employment status disappeared when poverty was included as a factor. The researchers suggest that the increased rates of suicide in impoverished areas may be linked to a lack of resources available to individuals to receive help. Additionally, many studies have shown a significant increase in suicide ideation and attempts in disadvantaged neighborhoods, compared to more economically advantaged neighborhoods, independent of family factors and income (Cubbin et al., 2000; Middleton et al., 2006).

It is also important to note that a study in Europe found that it was not absolute income that was associated with suicidal thoughts and attempts, but it was income ranking. The study found that when perceived income rank was a factor, there was no relationship between actual income and suicide. This suggests that aspects of the relationship may be psychosocial in nature, which can in turn influence actual poverty level.

Social rank theory explains that individuals with low income may perceive themselves to be of low social rank compared to others, which activates the acceptance of self-defeat, inferiority, and insecurity, which are all feelings related to suicidality. In the United States, this may explain the impact that low SES has on physical and mental health, as well as mortality (DeBastian, 2019). Because suicide is preventable, investigating the relationship

between socioeconomic status, perceived social status, access to resources, and suicide may be beneficial.

As the research on adult poverty and suicide expands, the same holds true for research with adolescents. Dupere, Leventhal, and Lacourse (2009) sought to examine the association between poverty and suicidality for adolescents and found that poverty for adolescents is best understood through neighborhood income, as opposed to individual income. Specifically, impoverished neighborhoods expose children to a variety of risk factors including delinquent activity, drug abuse, stressful life events, reduced social support, depression, and suicide. Taking into account many of these vulnerabilities, the authors found that compared to non-impoverished neighborhoods, suicidal thoughts and attempts were significantly associated with neighborhood poverty independent of the vulnerabilities examined. Suicidal ideation in youth occurred twice as often compared to youth in non-impoverished neighborhoods, while suicide attempts occurred four times as

often, all of which were found to be independent of the previously mentioned risk-factors.

Low-income adolescents are also more likely to attend impoverished schools. A previous study by Fang (2018) found that adolescents attending impoverished schools are exposed to more environmental stressors, leading to poorer mental health outcomes. When taking gender into consideration, the researcher found that adolescent boys attending impoverished schools were significantly more likely to attempt suicide than their male counterparts attending middle and high income schools. No significant differences were found for adolescent girls.

Overall, for adults, the research has suggested that understanding how poverty is related to suicide risk may be beneficial. Social rank theory suggests that this relationship may be because low status of individual leads to self-defeated thinking, which may reinforce low income. While the literature is mixed for adolescents, it is important to study the impact that poverty can take on mental health.

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FL Psychoanalytic Center Discusses Mark Rothko's Suicide Risk Factors

By Karly Hauser & Elizabeth Hilsman

John Hartman, Ph.D. presented at a recent scientific meeting of the Florida Psychoanalytic Center in Coral Gables on "Risk Factors in Suicide: Mark Rothko and His Art." Dr. Hartman is a Clinical Psychologist, a Training and Supervising Analyst at the Florida Psychoanalytic Center, and an Affiliate Professor in the Department of Psychiatry at the University of South Florida. Previously, he taught at UCLA and the University of Michigan and is the author of several publications.

Looking beyond epidemiological studies of suicide is necessary to provide clinicians with information about the proximal processes that lead chronically suicidal individuals to finally attempt and complete suicide, as noted by Dr. Lanny Berman in this publication. Clinicians assessing and monitoring suicidality in patients with chronic depression and hopelessness need more information about this dynamic process to improve the difficult task of suicide risk assessment and intervention.

Similar in some ways to a psychological autopsy (Shneidman, 2004), researchers like John Hartman (2018) are conducting qualitative retrospective biographical studies of public figures who died by suicide in order to identify and illustrate risk factors in the assessment of lethal suicide potential. Hartman studied risk factors in the life and work of well-known twentieth century artist Mark Rothko to evaluate his presenting risk factors that may have contributed to his ultimate suicide. He reviewed biographical information, published writings, and themes present in his art, looking at convergence with other known risk factors and with established psychological theories from the field of psychoanalysis.

The general risk factors identified within the life of Mark Rothko that may have contributed to his

ultimate death by suicide include early separation from and loss of his parents, recurrent episodes of major depression, relationship disruptions, and substance abuse. After losing his father in childhood, Rothko divorced and also suffered greatly following the news of his mother's death in 1948, becoming seriously depressed for the second time. Hartman (2018) speculated that the intense pain Rothko felt following the loss of his mother may have been compounded by his earlier traumatic experiences and relationship losses.

Rothko's suicidal crisis began following the discovery of a dissecting aortic aneurysm in 1968, which appears to be the triggering event for his completed suicide. His illness left him clinically depressed, sexually impotent, and angry. The anguish Rothko felt following this resulted in major relational disruptions, another identified risk factor for his suicide. His illness resulted in him ultimately isolating himself from his friends, family, and the world. While living alone in his studio, Rothko was said to be indulging in the final risk factor for his death, drinking heavy amounts of alcohol.

From Hartman's psychoanalytic perspective, Rothko's intrapsychic risk factors are thought to include affective flooding, self and object splitting, boundary disturbances, narcissistic vulnerability, and unconscious fantasies of surviving the suicidal assault and fusing with his dead parents. These processes may have contributed to his lethal self-attack. Further supporting evidence for the speculated intrapsychic risk factors presented were examined through elements of Rothko's art, his extensive use of color shading, transparency, and

translucency that have been shown in projective testing to predict lethal suicidal intent.

Overall, Hartman (2018) posed plausible risk factors that can be used in the assessment of lethal suicidal intent. By examining the general and intrapsychic risk factors that may have driven the famous artist Mark Rothko to end his own life, it is the hope that doing so will assist clinicians in their assessments of suicidal intent in their own clients. The innovation from which this work was loosely based, psychological autopsies, can be a valuable source to utilize in further understanding the risk factors, thought processes, and behaviors of those who go on to die by suicide.

Hartman, J. J. (2018). *Risk factors in suicide: Mark Rothko and his art*. *Journal of Psychiatry and Mental Health*, 3(2), dx.doi.org/10.16966/2474-7769.127.

Shneidman, E.S. (2004). *Autopsy of a suicidal mind*. Oxford University Press, New York, NY, US.

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SVP Presentations

The office of Suicide and Violence Prevention has provided 300+ presentations to various departments at NSU.

SVP has presented to over 6,000 NSU faculty, staff, and students, on a variety of topics related to suicide and violence training, management, and mental health struggles.

To request a presentation,
email svp@nova.edu or
use the form at our website
www.nova.edu/suicideprevention.

Suicide & Violence Prevention Resources

Henderson Student Counseling

954-424-6911 (available 24/7)

nova.edu/healthcare/student-services/student-counseling.html

NSU Wellness

(mental health services for NSU employees)

1-877-398-5816; TTY: 800-338-2039

nova.edu/hr/index.html

National Suicide Prevention Lifeline

1-800-273-TALK (8255) or 1-800-SUICIDE

suicidepreventionlifeline.org

Veterans: Press "1" or Text 838255

Chat: suicidepreventionlifeline.org/chat

TTY: 1-800-799-4889

Crisis Text Line

Text: "Home" to 741741

Mobile Crisis Response Teams

(for on-site crisis assessment)

Broward (Henderson):

954-463-0911

Palm Beach:

North: 561-383-5777

South: 561-637-2102

Miami-Dade (Miami Behavioral):

305-774-3627

Broward 2-1-1 Help Line

2-1-1 or 954-537-0211

211-broward.org

Chat: <https://secure5.revation.com/211-broward/contact.html>

Palm Beach 2-1-1 Help Line

2-1-1 or 561-383-1111

211palmbeach.org

Jewish Community Services of South Florida

305-358-HELP (4357); 305-644-9449 (TTY)

jcsfl.org/programs/contact-center/

Substance Abuse and Mental Health Services

Administration (SAMHSA) Treatment Locators

samhsa.gov/find-help

The Jed Foundation (JED)

jedfoundation.org

Suicide Prevention Resource Center

sprc.org

Suicide Awareness Voices of Education

save.org

The Depression Center

depressioncenter.net

Yellow Ribbon International

yellowribbon.org

Florida Initiative for Suicide Prevention

fisponline.org

Florida Suicide Prevention Coalition

floridasuicideprevention.org

National Center for Injury Prevention and Control

cdc.gov/ncipc/dvp/suicide

American Association of Suicidology

suicidology.org

American Association for Suicide Prevention

afsp.org

Florida Department of Children and Families Suicide Prevention

myflfamilies.com/service-programs/mental-health/suicide-prevention