Suicide

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1

Learning Objectives

- Discuss the history of suicide as well as current social and cultural beliefs and constructs
- Review data on the incidence of suicide and examine trends among certain populations, including those of differing gender, race, age, and socioeconomic status
- Recognize indicators predictive of increased suicide risk, and how to best assess mental health status and risk factors
- Describe interventional protocols for individuals who have suicidal ideation or have attempted suicide
- Identify how to best address suicide-associated risk factors and how a team approach in cooperation with other health care providers and social service professionals can improve outcomes

2

"Lo, my name is abhorred,
Lo, more than the odor of carrion
On summer days when the sky is hot."

-*"The Dispute With His Soul Of One Who Is Tired Of Life"*[1]

3

Definition

- **Suicide** is defined by the Centers for Disease Control and Prevention (CDC) as "death caused by injuring oneself with the intent to die".[2]
- **Suicidal ideation** is "a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide," and has no actual consistent definition that is universally accepted. This leads to difficulties with being able to compare findings across studies and causes limitations with meta-analyses.[3]

4

Suicide in Antiquity

- Some time after the emergence of Homo sapiens roughly 300,000 years ago,[4] human suicidality also emerged.
- Recorded history essentially began with the invention of cuneiform writing by the Sumerians in Mesopotamia around 3500 BC.[5]
- There does not appear to be any clear reference to suicide in recorded history until the first suicide note in existence, written on papyrus during the time of the Middle Kingdom in Egypt (1991 to 1786 BC) and titled by its translator Erman as "*The Dispute With His Soul Of One Who Is Tired Of Life*".[1]
- In 600 BC the citizens of the Greek colony Massalia could apply to their Senate for the right to commit suicide, and if granted would even be given hemlock to carry it out, for no charge.[6]

5

Suicide in Antiquity (2)

- Pythagoras (c.570 - c.495 BC) and Aristotle (384–322 BC) were against suicide though for different reasons.
- Pythagoras believed a finite number of souls existed and the sudden and unexpected exit of one from the world would upset a delicate balance.
- Aristotle felt that suicide was essentially robbing society of the service by one of its members.
- In ancient Rome, suicide was only illegal for those accused of capital crime, for soldiers and for slaves.
- Otherwise it could be viewed as a guarantee of personal freedom and virtue.[7]

6

Suicide in the Middle Ages

- In the Middle Ages (5th century – late 15th century) the Christian church viewed suicide as an unpardonable sin that went against the fifth commandment 'Thou shalt not kill,' with those completing suicide having their individual properties confiscated, their bodies desecrated and finally not allowed a Christian burial.[8]
- In 1670, Louis XIV of France ordered that those that completed suicide would have their personal property confiscated and their body drawn through the streets face down then either hung or simply thrown on a garbage heap.[7]

7

Suicide in the Renaissance

- During the Renaissance (15th–16th century) Christian sentiment of the Middle Ages was echoed, with some possible exceptions.
- Thomas More's *Utopia* (1516) wrote in favor of assisted suicide for those suffering from terminal disease, though he still considered it a crime if occurring for other reasons, with punishment being denial of funeral rites.
- Some question his support of suicide given the fantastical and satirical tone of the writing.[8]

8

Suicide in the Age of Enlightenment

- During the Age of Enlightenment (17th–18th century) suicide began to be examined through the lens of science.
- Psychology and the social circumstance of the individual were scrutinized.
- Traditional views were felt to be "muddled and superstitious" per the unpublished essay, "Of Suicide" written by David Hume in 1783.
- In his writing he referenced that suicide did not violate duties toward God, others and ourselves.[8]

9

Suicide in the 19th to early 20th Centuries

- Suicide was being romanticized in novels as an inevitable response by a soul anguished from being rejected by love or society.
- Psychiatry also emerged to diagnose and treat the underlying causes of suicide including but not limited to melancholy and hysteria.
- Suicide became a focus of sociology and was viewed as a byproduct of alienation from ongoing modernization.
- Suicide rates were found to be increasing in European nations as well.
- Suicide prevention then became both a bureaucratic and medical preoccupation which led to suicidal patients being institutionalized in large numbers.
- All these factors led to the suggestion that impersonal social or psychological forces caused suicide instead of the agency of individuals.[8]

10

Contemporary Western Religions and Cultures

Generally, there is still stigma attached to suicide with Western religions and much of Western culture, and Western religions generally still tend to forbid it.[9]

There is less stigma in Western culture concerning assisted suicide:

- In the US, there are 9 states, beginning with Oregon in 1994, that made it legal, 5 of which did so in the last 5 years.
- Other states in which it is legal now include:
  - Washington (2008); Montana (2009); Vermont (2013); California (2015); Colorado (2016); Hawaii (2018); and both New Jersey and Maine in 2019.[10]

11

Contemporary Western Religions and Culture (2)

Regarding assisted suicide via prescription medication in the United States, legality under state laws require its use for patients with terminal illness and the following conditions:

- The patient must be a “mentally competent” adult.
- The patient must have been given six months or less to live because of a terminal illness.
- Two physicians must confirm the patient's residency, diagnosis, prognosis, mental competence, and “voluntariness” of the request.
- There are two required waiting periods: one between the oral requests and the second between receiving and filling the prescription.[10]

12

Contemporary Western Religions and Culture (3)

Western countries outside of the United States where assisted suicide is legal include:

- Switzerland, the Netherlands, Belgium, Luxembourg, Canada and Australia.
- New Zealand is awaiting a third and final reading in parliament, and it is not clear if it will end up succeeding.
- Colombia allows for voluntary euthanasia.
- France allows for "palliative sedation" where one can ask for sedation until they die, but "assisted dying" is not actually legal.[11]

13

Contemporary Eastern Religions and Cultures

Contemporary Eastern religions and culture tend to be more accepting of suicide:

- Buddhist monks can view self sacrifice for religious reasons as honorable, and they were known to set themselves on fire during and in protest of the Vietnam War.
- In Japan, attitudes toward suicide are mixed, but some find it acceptable and even glorify it when done to control one's own destiny and/or as a response to disgrace.
- A Chinese widow without children can commit suicide upon her husband's death to show her faithfulness.
- Hindi culture condones suicide for either incurable disease or "great misfortune."
- In the Pacific region, suicide can be a culturally recognized means of responding to domestic violence.[9]

14

Global Statistics

- According to the World Health Organization (WHO), 77% of global suicides occur in low- and middle-income countries.
- According to the WHO, the intentional ingestion of pesticide (in rural/agricultural areas and low-/middle- income countries), hanging and firearms are among the most common methods of suicide globally.[12]
- Each year, nearly 800,000 people die by suicide in the world, roughly one death every 40 seconds.
- For ages 15-24 years, suicide is the 2nd leading cause of death in the world.
- Depression is the leading cause of disability globally. [13]

15

Global Statistics (2)

Top ten countries with highest suicide rates in 2019 (suicides per 100k)[14]

1. Lesotho	72.4
2. Guyana	40.3
3. Eswatini	29.4
4. South Korea	28.6
5. Kiribati	28.3
6. Micronesia	28.2
7. Lithuania	26.1
8. Suriname	25.4
9. Russia	25.1
10. South Africa	23.5

16

Global Statistics (3)

Top 10 countries with lowest suicide rates in 2019 (suicides per 100k)[14]

1. Antigua and Barbuda	0.4
2. Barbados	0.6
3. Grenada	0.7
4. St Vincent & the Grenadines	1.0
5. Sao Tome & Principe	1.5
6. Jordan	1.6
7. Syria	2.0
8. Venezuela	2.1
9. Honduras	2.1
10. Philippines	2.2

17

United States Statistics

- Every day, roughly 130 Americans die by suicide and an estimated 285,000 each year become suicide survivors.
- There is one suicide for every estimated 25 suicide attempts for all ages, and one suicide for every estimated 4 suicide attempts in the elderly.
- Suicide takes the lives of over 48,500 Americans every year which is roughly one death every 11 minutes.
- The highest suicide rates in the US appear to be among Whites, American Indians and Alaska Natives.
- Depression affects 20–25% of Americans aged ≥18 years in a given year.
- Only half of all Americans experiencing an episode of major depression receive treatment.[13]

18

United States Statistics (2)

- Suicide is a major contributor to premature mortality and in 2018 ranked as the second leading cause of death for ages 10–34 and the fourth leading cause for ages 35–54.[15]
- The suicide rate increased from 10.5 per 100,000 to 14.2, from 1999 through 2018 (around a 35% increase)[15] but decreased to 13.9 per 100,000 in 2019 (around a 2% decrease).[16]
- It increased roughly 1% per year from 1999 to 2006, then increased roughly 2% per year from 2006 through 2018, and then decreased by roughly 2% in 2019 as referenced above.[15]
- From 1999–2018, among females it was highest in the 45–64 year old age group, and among males highest for ≥75 year old age group.[15]
- The 2018 rate for males was 3.7 times the rate for females (22.8 and 6.2, respectively).[15]

19

United States Statistics (3)

- The 2018 and 2019 rate for females was similar for all age groups except 25–44, where the 2019 rate was significantly lower than the 2018 rate.[15]
- The 2019 rate for males was significantly lower than the 2018 rate for ages 10–14, 45–64, and 65–74.[16]
- The 2019 rates for female suicide by suffocation (1.8) and by firearm (1.8) were higher than the rate for suicide by poisoning (1.7),[16] similar to 2018.
- From 1999–2019, the rate for male suicide by firearm was highest, while the rate of male suicide by suffocation increased the most, doubling from 3.3% in 1999 to 6.6% in 2019.[16]
- The 2018 rate for both males and females was higher in the most rural of counties compared with the most urban of counties.[15]

20

United States Statistics (4)

- In 2020, the suicide rate apparently decreased for a 2nd consecutive year with a decline from 47,511 reported suicide deaths in 2019 down to 44,834 in 2020, a roughly 5.6% drop per provisional data from the National Center for Health Statistics (NCHS) National Vital Statistics System (NVSS).[17]
- In 2020, COVID-19 was the 3rd leading cause of death in the US , pushing suicide down to the 11th leading cause of death[17].
- It is not currently known if some suicides are being masked by COVID-19 deaths in 2020, meaning would some have died by suicide but instead died from COVID-19 or had COVID-19 at the time of death and cause of death attributed to COVID-19.[17]
- Also note that the rate of death due to overdose also increased in 2020 and there can be difficulty in distinguishing some overdose deaths from suicide, which could have masked the true number of suicide deaths as well.[18]

21

United States Statistics (5)

Between 2/21/20–3/20/21: ER visits due to suspected suicide attempts in the 12–17-year-old age group were 50.6% higher among females and 3.7% higher among males as compared the to same period in 2019.[19]

May 2020: ER visits began to increase for suspected suicide attempts in the 12–17-year age group, especially females.[19]

Evidence may suggest further caution interpreting suicide data due to:

- **Possible misclassification** of suicide in unintentional/accidental deaths (the rate of which has been increasing from 2015–2020)
- **Possible undercounting** of suicide deaths in areas of the US that rely on elected coroners for death investigation
- **Apparent undercounting** of suicides in:
  - Certain demographic groups (such as Blacks, Hispanics and women)
  - Certain types of injuries (poisoning/overdoses, drowning, singular motor vehicle fatalities)
- **Unclear explanation** as to why there has been an increase in risk factors for suicide during the pandemic but with this having unexpectedly led to a decrease in suicides[18]

22

Additional Race and Ethnicity Statistics

- Between 2018 and 2019, age-adjusted suicide rates *decreased* for White and American Indian or Alaska Native individuals, reflecting the decrease in total deaths.
- The age-adjusted suicide rate *increased* for Black and Asian or Pacific Islander individuals beginning in 2014 then through 2019
  - 30% increase for Black individuals (from 5.7 to 7.4 per 100 000 individuals)
  - 16% increase for Asian or Pacific Islander individuals (from 6.1 to 7.1)
- Based on the 2014–2017 trend, the change between 2018–2019 was:
  - In the expected range for:
    - Black individuals (2019 actual: 7.4; expected: 7.3-8.0)
    - Asian or Pacific Islander individuals (2019 actual: 7.1; expected: 7.0-7.5)
    - Hispanic individuals (2019 actual: 7.3; expected: 7.3-8.0)
  - But the change was outside of the expected range for:
    - White individuals (2019 actual: 17.6; expected: 18.0-18.9),
    - American Indian or Alaskan Native individuals (2019 actual: 22.2; expected: 22.5-24.6)
    - The total population (2019 actual: 13.9, expected: 14.3-14.7)

23

Additional Race and Ethnicity Statistics (2)

- For both male and female youth aged 15 to 24 years, suicide rates were higher among American Indian or Alaskan Native youth
  - E.g., 2019 rate among female youth (23.0) and White youth (6.1) relative to Black youth (4.3), Asian or Pacific Islander youth (5.1), and Hispanic youth (4.4) for all years.
- Suicide rate increased for:
  - Black male youths aged 15 to 24 years by 47% (from 12.2 in 2013 to 17.9 in 2019)
  - Asian or Pacific Islander male youth by 40% (from 12.0 in 2013 to 16.8 in 2019)
- The rates from 2018 to 2019:
  - Increased among Black and Asian or Pacific Islander male youths aged 15 to 24 within the expected range given the 2013 to 2017 trend (Black, 2019 actual: 17.9; expected: 17.5-19.0; Asian or Pacific Islander, 2019 actual: 16.8; expected: 16.5-17.9)
  - Decreased among White youth in this age group, which fell outside of the expected range (2019 actual: 25.4; expected: 27.7-29.0)
- Similar increases were found among female youth aged 15 to 24 years:
  - 2013–2019: the rate increased by 59% among Black female youth in this age group (from 2.7 to 4.3) and 42% among Asian or Pacific Islander female youth in this age group (from 3.6 to 5.1).[19]

24

Additional Gender Statistics

- Males:
  - Die by suicide 4 times as much as females
  - Represent 79% of all US suicide deaths from 1999 to 2018
  - Firearms are the most common means of suicide for males (51%) in the US
- Females:
  - Poison is the most common means of suicide
  - More likely than males to have had suicidal thoughts
  - Experience depression at roughly twice the rate of men
  - Attempt suicide 3 times as often as males [13]

25

Sexual Orientation and Sexual Identity Statistics

- High school students identifying as lesbian, gay, and bisexual (LGB) are 4 times more likely than their heterosexual peers to attempt suicide based upon CDC data from 2017.[21]
- 42% of lesbian, gay, bisexual, transgender and queer (LGBTQ) youth seriously considered attempting suicide in the past year, including more than half of transgender and nonbinary youth.[22]
- 62% of LGBTQ youth reported symptoms of major depressive disorder in the past two weeks, including more than 2 in 3 transgender and nonbinary youth. [22]
- LGBTQ youth are 4 times more likely to make a medically serious suicide attempt as compared to other youths.[23]
- LGB youths that are either rejected or not accepted by their families are more than 8 times more likely to attempt suicide as compared to those that were accepted by their families.[23]
- With each incident of an LGBTQ person being exposed to physical or verbal abuse or harassment they become 2 and ½ times more likely to engage in self injury.[23]

26

Additional Age Group Statistics

- Most recent data from 2019 showed the following ranking of suicide as cause of death out of the top 10 causes, per age group[24]:
  - 10-14 age group ranked as 2nd
  - 15-24 age group ranked as 2nd
  - 25-34 age group ranked as 2nd
  - 35-44 age group ranked as 4th
  - 45-54 age group ranked as 5th
  - 55-64 age group ranked as 8th
  - 65+ age group not ranked in top 10

27

Mental Health Comorbidity Statistics

Case control study — 2674 patients in 8 health care systems in the Mental Health Research Network, from 2000–2013, matched against 267,400 general population patients, showed the following risk of suicide mortality after adjustment for age and sociodemographic characteristics[27]:

- Schizophrenia spectrum disorder: adjusted odds ratio (AOR) = 15.0
- Bipolar disorder: AOR = 13.2 (note that in this group, the risk of suicide death was actually higher in women than men)
- Depressive disorders: AOR = 7.2
- Anxiety disorders: AOR = 5.8
- ADHD: AOR = 2.4

28

Additional Risk Factors

Risk factors for suicide include having:

- A history of prior suicide attempt, the single most important risk factor for suicide in the general population[12]
- A mental health condition, with prior estimates that 46% of those dying by suicide having a known condition[26] but a more recent study has shown this figure to be 51.3%[27]
- Family history of suicide[26]
- Active substance use as well as intoxication, with over 1 out of 3 being under the influence of alcohol when they complete suicide[26]
- Access to firearms[26]
- A serious or chronic medical illness[26]
- History of trauma[26]
- Prolonged stress[26]
- A recent tragedy or loss[26]
- Note that data suggest that 90% of those that survive a suicide attempt do not end up killing themselves later[2] which may reflect the degree of impulsivity with suicide attempts

29

Additional Risk Factors (2)

National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

- Face-to-face longitudinal survey conducted with a national representative sample of noninstitutionalized civilian population ≥18 years old in the US
- Data from wave 1 (2001–2002) and wave 2 (2004–2005) was analyzed in a study using machine learning
- Involved 34,653 adults in a large national survey database and analysis of 2805 survey questions

Findings:

The 3 most important risk factors for those age 18 and over that predicted subsequent suicide attempts were:

- History of suicidal behaviors or ideation
- Functional impairment from mental health disorder
- Socioeconomic disadvantage

Also important:

- Younger age (18-35 years); Lower educational achievement; Recent financial crisis
- Women, Whites and those of lower income had higher risk

Study limitations:

- A lack of inclusion for those under age 18 considering suicide risk being highest among the 15-to-25-year age group
- Potential misclassifications of suicide attempts.
- Since the study goal was not to study suicide, there was also lack of data on stress, adjustment disorders, and other important variables.
- More studies may help further validate the findings.[28]

30

Prevention and Interventions

- Asking about past suicide attempts or self harm, not just in mental health care but primary care settings, considering that *half* of those that die by suicide have a had a primary care visit in the preceding month.[15]
- Funding for suicide prevention at a national, regional and local level. This would hopefully improve the underdeveloped and undersupported systems for gathering suicidality data to allow researchers to better understand what is going on to help determine appropriate response.[17]
- As compared to existing self-report tools, prediction models based upon large scale EHR data appear to be more accurate.[29]

31

Prevention and Interventions (2)

The CDC advises a multi-pronged community driven approach to the prevention of suicide[25]

- Give temporary financial assistance to individuals in need at a state level to ease unemployment and housing stress.
- Improve access to and delivery of healthcare such as offering treatment by phone or online where services are not widely available (note from the presenter; there has been so much progress with this during the pandemic).
- Have employers create a healthy and protective work environment and reduce stigma about seeking help.
- Connect people in their own communities to increase a sense of belonging via community programs and events.
- Have schools teach coping and problem-solving skills to manage challenges such as relationship and school problems.
- Have the media help prevent future risk by describing helpful resources in lieu of headlines or details that increase risk.
- Identify and support those at risk by promoting everyone to learn the warning signs of suicide, how to respond, and where to get help.

32

Prevention and Interventions (3)

Per the National Alliance on Mental Illness (NAMI), warning signs for suicide include[26]:

- Increased alcohol and drug use
- Aggressive behavior
- Withdrawal from friends, family and community
- Dramatic mood swings
- Impulsive or reckless behavior

The behaviors associated with suicidal planning may be a psychiatric emergency and if seen in others or self, seek immediate help:

- Collecting and saving pills or buying a weapon
- Giving away possessions
- Tying up loose ends, like organizing personal papers or paying off debts
- Saying goodbye to friends and family

33

Prevention and Interventions (4)

NAMI has suggestions how friends and family can provider support in a suicide-related crisis[26]:

- Talk openly and honestly. Don't be afraid to ask questions like: "Do you have a plan for how you would kill yourself?"
- Remove means such as guns, knives or stockpiled pills
- Calmly ask simple and direct questions, like "Can I help you call your psychiatrist?"
- If there are multiple people around, have one person speak at a time
- Express support and concern
- Don't argue, threaten or raise your voice
- Don't debate whether suicide is right or wrong
- If you're nervous, try not to fidget or pace
- Be patient

34

Prevention and Interventions (5)

- On an individual basis, after having identified suicidal risk address safety concerns;
  - Psychiatrically hospitalize if imminent danger (possibly involuntarily)
  - Address means (family or caregiver should remove weapons and medication that could be used)
  - Care could occur outside of the hospital with suicidal ideation if there is no plan or means and if the individual has good support in the community and if not being hospitalized does not contribute to a sense of helplessness or hopelessness.[30]
- Address impactable causes/risk factors:
  - Psychiatrically evaluate including risk assessment
  - Treat mental health/SUD concerns
  - Procure assistance for financial/housing stress
  - Pull in family/friend support if available
  - Pull in other community support if available
  - Promote continued follow through with mental health care
- Note that suicide prevention contracts have not been shown to reduce the likelihood of suicide attempts and should not be relied upon as actually being binding if an individual contracts to not commit suicide.[30]

35

Prevent and Interventions (6)

- Specific psychotherapies:
  - Dialectical Behavioral Therapy (DBT) can have impact on suicidality and non-suicidal self-injury[31]
  - Cognitive Behavior Therapy for Suicide Prevention (CBT-SP), where suicidal behavior is viewed as the primary problem and a problematic coping behavior, rather than a symptom of a disorder, may be of benefit[32].
- Pharmacotherapy:
  - Lithium is likely to have a substantial and clinically important anti-suicidal effect[29]
  - Clozapine/Clozaril has been shown to be superior to olanzapine/Zyprexa in preventing suicide attempts in those with schizophrenia and schizoaffective disorder[34]

36

The Aftermath of Completed Suicide

- Completed suicide burdens loved ones, caretakers and treatment providers, with stressors including personal and legal ramifications.
- Bereavement is complicated by survivors feeling shame and blame upon themselves.
- Treatment providers need to be prepared to support the suicided individuals loved one's and understand that needs may vary.
- Support could include more formal support from a trained and licensed therapist.
- It could also include informal social support from family, friends and/or support groups (see next slide).[30]

37

Resources for Suicide Prevention/Survivors

- American Foundation for Suicide Prevention
  - Web site: http://www.afsp.org
- National Suicide Prevention Lifeline
  - Telephone: 800-273-TALK (8255)
  - Web site: http://www.suicidepreventionlifeline.org
- Suicide Prevention Resource Center
  - Web site: http://www.sprc.org [30]

38

David Foster Wallace
Author of Infinite Jest
(2/21/1962 – 9/12/2008)

"The so-called 'psychotically depressed' person who tries to kill herself doesn't do so out of quote 'hopelessness' or any abstract conviction that life's assets and debits do not square. And surely not because death seems suddenly appealing. The person in whom Its invisible agony reaches a certain unendurable level will kill herself the same way a trapped person will eventually jump from the window of a burning high-rise. Make no mistake about people who leap from burning windows. Their terror of falling from a great height is still just as great as it would be for you or me standing speculatively at the same window just checking out the view; i.e., the fear of falling remains a constant. The variable here is the other terror, the fire's flames: when the flames get close enough, falling to death becomes the slightly less terrible of two terrors. It's not desiring the fall; it's terror of the flames. And yet nobody down on the sidewalk, looking up and yelling 'Don't!' and 'Hang on!', can understand the jump. Not really. You'd have to have personally been trapped and felt flames to really understand a terror way beyond falling."[35]

39

"Death is before me today
As a man longs to see his house
When he has spent years in captivity."

-"The Dispute With His Soul Of One Who Is Tired Of Life"[1]

40

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41

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42