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Suicide

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This chapter provides an overview of suicide and reviews suicidal behavior, suicide attempts, and suicide completions within the African American population. There are more than 30,000 suicides a year in the United States and more than 1 million worldwide. The prevalence of suicide among African Americans has been of concern only recently. Suicide was thought to be a "White thing" for so long that it was difficult within the African American community to accept suicide as a serious concern by Black institutions, families, death certifiers, and the larger public. In fact, suicides were more likely to be misclassified for Blacks than for any other ethnic group (Crosby & Molock, 2006; Phillips & Ruth, 1993).

In 1938, Charles Prudhomme, a Black psychoanalyst, published an article in the *Psychoanalytic Review* entitled "The Problem of Suicide in the American Negro." He observed that suicide among African Americans increased as the Black population moved from rural communities to urban areas. He saw the close interpersonal ties among Blacks in rural areas as a protective factor that helped to explain the low rates of suicide among this population.

More recently, Alvin Poussaint, a Black psychiatrist at Harvard Medical School, has maintained that suicide has been an issue within Black society (Poussaint & Alexander, 2000). The difference is that suicide was never mentioned or admitted. It was classified as an accident by funeral directors and other death certifiers to protect families and often disguised as homicide or drug overdose. Today, Blacks have higher rates of homicides and drug-induced deaths than Whites (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, & National Center for Health Statistics, 2007). It is suggested that many

of those homicides and drug overdoses are actually suicides (Poussaint & Alexander, 2000).

The rise in reported rates of suicide among Blacks in the 1980s and 1990s is attributed to a variety of factors, including internalization of failures, disrupted families and relationships, assimilation and acculturation issues into White lifestyles, feelings of discrimination and oppression, and loss of a belief system, mainly religious, or lack of religiosity (Lester, 1998; Poussaint & Alexander, 2000; Walker, Lester, & Joe 2006).

These explanations can be grouped within three broad theoretical constructs: sociological, psychological, and medical or psychiatric. The sociological construct interprets the suicidal act as emerging from the individual's relationship with others (i.e., society). Thus, difficulties arising from being a member of a minority and its treatment by the majority drive the suicidal ideation or acts (Cantor, 1999; Maris, Berman, & Silverman, 2000). The psychological framework uses negative internalization—internal drives found in low self-esteem and an internal negative locus of control—to explain suicidal thoughts and attempts. It is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who perceives suicide as the best solution (Maris et al., 2000) to psychological or emotional pain brought on by unhappiness and hopelessness (Cantor, 1999). The medical or psychiatric model equates suicidal ideation or acts with mental illness (Cantor, 1999). Increasingly, this last model incorporates genetic or other biological factors into explanations for suicidal behavior.

Collectively, these constructs suggest that suicide is a multifaceted phenomenon and necessitates a multidimensional approach for prevention and for treatment of those who have attempted it (Jacobs, Brewer, & Klein-Benheim, 1999).

DEFINITIONS

Suicide is a self-inflicted death with evidence that the person intended to die (American Psychiatric Association, 2003). A *suicide attempt* is a self-injurious behavior with a nonfatal outcome accompanied by evidence that the person intended to die. *Suicide ideations* are thoughts of serving as the agent of one's own death. Ideations may vary in seriousness depending on the specificity of suicide plans and degree of intent (American Psychiatric Association, 2003).

INCIDENCE

The rate of suicide among African Americans has increased significantly during the 1980s and 1990s: For Black males between the ages of 15 and 24, it is the third leading cause of death after homicide and unintentional injuries, and for

Black females between the ages of 15 and 24, it is the fifth leading cause of death. It appears that Blacks attempt suicide at an earlier age than Whites (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, & National Center for Health Statistics, 2007).

The growth in the Black male suicide rate was first evident in 1993, when it jumped more than 8 points over the previous year (see Table 19.1).

Suicide rates are significantly lower for Black females compared with Black males (see Table 19.1). The large disparity prompts two questions: What prevents Black females from completing suicide? Do they even engage in suicidal behavior? Many theorists argue that Black females have a substantial amount of resiliency, which keeps them from spiraling to the level of hopelessness that drives people to suicide, and are more likely to defer their problems to God. Furthermore, often Black females have children to care for, serving as a protective factor against suicide. Friendship, kinship, social networks, and religion have been seen to be strong supports for African American females and, therefore, protective factors against hopelessness (Cook, 2002; Nisbet, 1996).

However, these low rates should not be misunderstood to indicate that Black females do not kill themselves or do not engage in suicidal behavior. They have high rates of attempts, comparable to those for White females, and their risk factors include partner abuse, family dysfunction, psychological and interpersonal issues, and childhood maltreatment (Kaslow et al., 1998, 2000; Twomey, Kaslow, & Croft, 2000).

TABLE 19.1. Suicide Rates per 100,000 for Young (Ages 15–24) Black Males and Females

Year	Males	Females
1990	14.53	2.37
1991	16.80	1.72
1992	18.40	2.18
1993	20.40	2.65
1994	20.89	2.65
1999	14.77	1.96
2000	14.59	2.26
2001	13.42	1.28
2002	11.56	1.69
2003	12.49	2.03
2004	12.36	2.23
2005	11.91	1.72
2006	10.94	1.79

Note. Data from Centers for Disease Control and Prevention.

BIOLOGICAL/GENETIC FACTORS

Mental health scholars report that 90% or more of suicides are due to some form of mental disorder believed to have strong genetic components, such as bipolar and unipolar disorders or schizophrenia (Institute of Medicine, 2002). Neurobiological changes can occur when personality traits such as impulsivity and aggressive behavior interact with trauma, substance abuse, and chronic stress (Mann & Arango, 1999).

Studies suggest that impulsive and aggressive behaviors are related in part to lower levels of reduced central nervous system serotonergic function (Oquendo & Mann, 2000). Serotonin (5-hydroxytryptamine) is one of several neurotransmitters found in the brain influence brain functions such as appetite, sleep, and mood. Decreased levels of serotonin in the brain have been linked to depression. Increasing serotonin levels, often with medications such as selective serotonin reuptake inhibitors (SSRIs), can reverse this effect. Individuals who suffer from serotonin-related clinical depression that goes untreated have a 15% risk of suicide (Institute of Medicine, 2002).

To date, no one gene or genetic element has been identified as predisposing a person to suicide or suicidal behavior. Rather, it appears that an interaction between a critical mass of stress-producing life events and depression or another illness with a genetic component may trigger the event (Jamison, 1999). Vulnerability factors that influence the predisposition to complete or attempt suicide include a family history of low serotonergic functioning in the brain, aggressiveness, impulsivity, and chronic substance abuse (Mann, Waternaux, Haas, & Malone, 1999). More specifically, a clinical phenotype of suicidality shows genetic liability from two sources: (1) a genetic liability to mental illness and (2) a genetic liability to impulsive aggression. When both come together, the risk for suicide is high (Institute of Medicine, 2002).

INDIVIDUAL FACTORS INFLUENCING RISK AND RESILIENCY

Several factors can increase a person's risk of suicide: emotional disorders, substance abuse, childhood and adult trauma, social isolation, economic hardships, relationship loss, previous suicide attempts, and psychological traits such as hopelessness.

Mental Illness

As noted earlier, there is strong evidence linking mental illness to many but not all suicides (National Strategy of Suicide Prevention, 2001).

- An estimated 2–15% of persons who have been diagnosed with major depression die by suicide. Suicide risk is highest in depressed individuals

who feel hopeless about the future, those who have just been discharged from the hospital, those who have a family history of suicide, and those who have attempted suicide in the past.

- An estimated 3–20% of persons who have been diagnosed with bipolar disorder die by suicide. Hopelessness, recent hospital discharge, family history, and prior suicide attempts all raise the risk of suicide in these individuals.
- An estimated 6–15% of persons diagnosed with schizophrenia die by suicide. In fact, suicide is the leading cause of premature death in this population. Between 75 and 95% of these individuals are male.
- Also at higher risk are individuals who suffer from depression and a comorbid mental illness, specifically substance abuse disorder, anxiety disorder, schizophrenia, and bipolar disorder.
- People with personality disorders are approximately three times as likely to die by suicide than those without. Between 25 and 50% of these individuals also have a substance abuse disorder or major depressive disorder.

Adult and Childhood Trauma

Evidence shows that traumatic events such as sexual abuse, military combat, sexual assault, and domestic violence increase a person's risk for suicide (Goldman, Silverman, & Alpert, 1998; Tedeschi, 1999; Thompson et al., 1999). This risk may be due to the actual experience of the trauma or a related psychiatric condition that is expressed following the trauma (National Center for PTSD, 2007). Recent work with returning armed forces personnel suggests that an interaction among a variety of factors places veterans at risk, among them:

- Gender
- Alcohol abuse
- Family history of suicide
- Older age
- Poor social-environment support (homelessness and unmarried status)
- Familiarity with firearms and other weapons

The trauma of childhood abuse has been linked to suicidal behavior when depression is present. Several studies suggest that childhood sexual abuse may produce lasting alterations in the brain that can lead to increased risk of suicide (Perroud et al., 2007; Roy, Hu, Janal, & Goldman, 2007). Continual exposure to violence can have negative psychological effects, including depression, posttraumatic stress, anger, aggression, violent behavior, and suicidal behavior (Garbarino, Bradshaw, & Vorrasi, 2002; Gorman-Smith & Tolan, 1998).

Studies at the Grady Health System, Emory University, with African American women who had attempted suicide reported that childhood maltreatment had

short- and long-term consequences on mental health. This included a strong correlation between childhood abuse and suicidality (Anderson, Trio, Price, Bender, & Kaslow, 2002; Thompson, Kaslow, Lane, & Kingree, 2000).

Economic Hardship, Social Isolation, and Relationship Loss

Stressors, whether acute like sudden unemployment or the unexpected loss of a loved one, or chronic, like social alienation, discrimination, and oppression, can increase the risk of suicidality. When acute or chronic stressors accumulate and reach an individual's critical mass for handling them, the risk of suicide increases. For instance, when one loses a job unexpectedly, it can become more than just a lost job. It can generate economic hardship, relationship discord, and unstructured time, which can lead to risky behavior and social isolation.

It is important to be aware that life events affect individuals differently. While some can become stronger and more faith based because of the hardships, others can become fearful and depressed, particularly if their typical coping mechanisms prove inadequate to handle stressful events.

Previous Suicide Attempts

Of those who have attempted suicide, 10–15% will go on to complete suicide (Jamison, 1999). Any attempt must be taken seriously because predicting who will eventually succeed is impossible. Individuals who present with a history of attempts should be considered to be at risk for suicide. Some individuals are relieved to have survived while others regret having not been able to complete the act and become more depressed (Taylor, 2002).

Hopelessness

When life loses its meaning and one cannot see beyond the present moment, people experience overwhelming hopelessness and see no reason for life. Studies indicate that hopelessness mediates the relation between suicidal ideation and depression, increasing the likelihood of a suicide attempt (Beck, Kovacs, & Weissman, 1975; Chioqueta & Stiles, 2007; Cole, 1988; Hendin, Maltsberger, & Szanto, 2007; Minkoff, Bergman, Beck, & Beck, 1973). This psychological pain is accompanied by severe anxiety, shame or humiliation, psychological turmoil, decreased self-esteem, or agitation (American Psychiatric Association, 2003). Feelings of sadness, desperation, guilt, worthlessness, loneliness, and helplessness contribute to feelings of hopelessness.

Factors That Decrease Suicidality (Protective Factors)

The flipside of hopelessness is resiliency, a protective factor. Resiliency can come from within, when individuals develop positive attitudes with high expectations

about their life. Resilient individuals generally have high tolerance levels, tenacity, and a sense of humor; are self-reliant and independent (Werner & Smith, 2001); and possess good coping skills. These coping skills are honed and strengthened by a strong social support system that can be found in the family, the community, and schools, or at work.

The more individuals are involved with their surroundings, attached to family, committed to work or school, and possess a strong belief system, the more likely it is that they will be resilient. Just as social isolation is a risk factor, social integration is a protective factor.

FAMILY FACTORS INFLUENCING RISK AND RESILIENCY

Family factors that increase suicidal risk include aggressive and delinquent family members, suicide attempts or completion by another family member, a family environment marked by physical violence and with few resources, and emotionally unsupportive family members in the household (Centers for Disease Control and Prevention, 2007). The following case report from a state mental health center in Maryland serves as an example of this last point: A 17-year-old African American boy was referred to a psychiatrist by his teacher. The psychiatrist diagnosed him with schizophrenia and prescribed medication. When the young man came home with medication, his father poured the pills down the sink and told his son he didn't want him taking that "crap." The young boy ended his life 2 weeks later. As another example, based on police reports at the state of Maryland's coroner's office, a young Black 15-year-old boy was called for dinner. When he did not respond, his brother went to his room to get him, but instead found him hanging by a belt. The suicide victim left a note cursing the whole family.

Race is not the issue in either of these examples. Rather, in the first instance, a father rejected his son's medical needs, and in the second case there was a disconnection between the suicide victim and his family. I observe that too often African American families are afraid to take suggestions from the dominant culture regarding their children's well-being if it appears to be of a negative nature. Too often African Americans mistrust the system, and professional recommendations are seen as little more than glorified attempts to keep "the brother down," or, worse, to dupe them into engaging in a "Tuskegee" scheme.

Black males especially have a tendency to not seek mental health treatment. If they do seek treatment, they are unlikely to comply with or complete treatment (Poussaint & Alexander, 2000), increasing their risk for suicide. Family support is needed to encourage compliance. Toward this end, two factors are critical: (1) education for families regarding the diagnosis, treatment, and support, and, more importantly, (2) the cultivation of trust in a system whose history has engendered African American skepticism for decades.

While genetic factors can influence suicide attempts or completions, suicide thoughts and behavior can be influenced by other family members who have attempted or completed a suicide, particularly if no explanatory note was left behind. A relative's suicide can serve as a model, making imitation more likely (Institute of Medicine, 2002). Often the pain of losing a loved one to suicide engenders guilt, shame, and blame among surviving family members, especially if he or she did not leave a note explaining why. Among those who complete suicide, no more than 10% leave a note. Families left without notes are often in turmoil as they try to figure out why the suicide occurred and whether they may have contributed to the life-ending decision. Their despair can increase their own risk for suicidal ideation. As a case in point, in a support group for families who have lost loved ones to suicide, one parent shared that, although her 27-year-old son's suicide was devastating, she was spared guilt and its resulting turmoil because he left a note that was full of love and compassion for her.

Several studies suggest that positive expectations for children can encourage the development of their own strong sense of resiliency (Masten & Gewirtz, 2006; Werner, 1995). Some children appear to be born with resilient characteristics, while others need help to develop them (Masten & Gewirtz, 2006). According to Frey (1998), boys and girls have different needs at different times in their life cycles. Because of their physical immaturity, boys are more at risk for suicidal ideation earlier in life and girls are more at risk during their second decade because of their emerging sexuality and gender-culture expectations. Resiliency cultivated early in life serves as a protective factor.

SOCIAL AND COMMUNITY FACTORS INFLUENCING RISK AND RESILIENCY

Numerous societal factors increase suicidal risk, among them poverty; norms that support sexual violence, especially male superiority and sexual entitlement; norms that maintain women's inferiority and sexual submissiveness; neighborhoods with high crime and drug misuse; and poor schools. Simply put, environments that harbor negative activities and support deviant behavior exercise a strong influence that can contribute to a decision to end one's life.

Such environments encourage fatalism, hopelessness, and helplessness, which can lead to risky, life-jeopardizing behavior, for example, waving a gun at a police officer, starting a fight with someone who has already threatened your life, or joining a violent gang that is known for homicidal behavior. Not surprisingly, rates of homicide and drug-related death are high within these neighborhoods. Poussaint and Alexander (2000) argue that many of these homicides are more accurately identified intentional suicides, that is, people have purposely placed themselves in harm's way.

Countering this exposure to harm is the reality that healthy elements within a community can provide a degree of protection. As noted earlier, a truly car-

ing family is protective. A truly caring extended family is protective. A strong caring faith community is protective. Possessing characteristics like a sense of humor, intelligence, and attractiveness increases the likelihood that individuals will gain inclusion, respect, and recognition in even suboptimal school environments (Hammack, Richards, Luo, Edlynn, & Roy, 2004). This sense of well-being is protective.

EVIDENCE-BASED TREATMENT INTERVENTIONS

What Works

The objective of treatment intervention programs is to prevent the suicide from happening. However, where suicide is not predictable, the solutions are just as complex as the problem. Evidence-based treatments for suicide are inconclusive. There are standard practices, such as hospitalization or medication, but no scientific evidence that they prevent immediate or eventual suicide (Kalafat, 2003; Zemetkin, Alter, & Yemini, 2001).

What Might Work

Treatment efforts generally start by reducing risk factors and promoting protective factors as much as possible. Ideally, the intervention should address factors at all levels of influence: individual, relationship, community, and society. Although many of the promising approaches to reducing suicide have not been tested at least three times successfully and certainly not tested on African Americans, efforts that reduce risk factors and promote protective factors should work with any population. The clinician needs to understand that what are considered risk factors and protective factors can vary depending on the culture. Assessment is key: Asking all the right questions, knowing when to stop, and letting the client know that you do not understand and you need further explanation.

Many times treating a suicidal client will mean short-term hospitalization. Generally, with hospitalization, the admitting physician needs to determine whether or not to take progressive or regressive therapeutic measures. With regressive therapeutic measures, the client is kept free of any responsibility: generally, no visits or phone calls home, no discussion of family conflicts, and no contact with his or her work environment. With progressive therapeutic measures, the client is given independence gradually as the suicidal ideations and depression wane. The client has complete independence throughout the hospitalization and normal contact with family, and his or her social problems are discussed. Generally, regressive measures are next to impossible for the impoverished client who is the head of household and has an ample amount of responsibility that cannot go without attention. In these cases, it is good practice to ask the client to collaborate with the therapist in an effort to minimize stress and to enhance the protective factors.

Counseling Approaches for Survivors of Attempts

The overall process for managing a suicidal client includes assessment, treatment planning, and management of risk. According to Jobes (2006), a clinical approach strives to keep clients out of inpatient hospital settings and works toward developing clients' inner strength to take responsibility for their feelings. Jobes builds a client collaboration system that includes a treatment plan set up by the clinician that is time limited. A treatment plan with a suicidal client needs to be comprehensive because it is developed based on the fact that the client considers death to be an option. These thoughts are generally temporary, so the treatment plan can also be temporary because its focus is on the client thinking of suicide. Plus, the time limitation gives the client a feeling that he or she is working toward a final goal and not something that has to go on indefinitely. Once a time limit is established, the therapist develops the following:

1. A comprehensive assessment that measures the status of the client's suicidal thinking.
2. A contract between the client and the clinician whereby the client agrees to certain conditions such as not abusing alcohol or drugs if he or she is prone to do so or agreeing to restrict the means to suicide (e.g., by getting rid of a gun in the house).
3. A list of activities the client enjoys and that make him or her feel good, such as walking, bowling, knitting, drawing, or working in the yard. The client is encouraged to keep this list handy and to engage in these behaviors when feeling depressed. If the depression worsens, the client is encouraged to seek help.

In clinicians' assessments of African Americans, the incorporation of cultural considerations is essential for accurate diagnoses and effective care. According to the American Psychiatric Association, clinicians should always be cognizant of the following:

- Cultural identity of the individual
- Cultural explanations of the individual's illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician

As Primm (2000) explains in her presentation and video *Black & Blue*, African American women will often refer to mental illness, ranging from depression to schizophrenia, as "bad nerves." It is a polite and socially acceptable code word and is less stigmatizing than the actual diagnosis.

Therapy after an Attempt

One promising intervention developed by Guthrie and colleagues (2001) provides four sessions of psychotherapy for adults who have attempted suicide by poisoning. The unique aspect of this intervention is that it is home based and provided by a nurse therapist. Results achieved with this intervention were statistically significant when compared with treatment as usual. At the 6-month follow-up, only 9% of clients in the home-based model had harmed themselves compared with 28% who received treatment as usual.

Another promising approach involves the use of cognitive therapy. In a study at the University of Pennsylvania, 120 adult participants underwent a 10-session cognitive therapy intervention to prevent repeat suicide attempts. After 18 months only 13 patients who received cognitive therapy attempted again compared with 24 who received standard treatment (Brown et al., 2005).

What Does Not Work

Techniques such as tough love that are based on withholding of empathy are ineffective for managing people in suicidal crisis. Most people in suicidal crisis do not want to die and are ambivalent right up to the last moment. Sneiden (1978) at the University of California at Berkeley interviewed survivors of a jump from the Golden Gate Bridge and found that the majority were glad to be alive and recalled thinking on their return from the bridge or during the jump that they wanted to live. In essence, suicidal individuals generally want only to kill the emotional pain that has become too difficult to manage. Self-destructive behavior among young adults is becoming a monumental problem. They don't want to kill themselves; rather, they want to murder the sadness. Being tough or providing tough love does not always work.

PSYCHOPHARMACOLOGY AND SUICIDE

As mentioned, several researchers have linked low levels of the brain chemical serotonin to suicidal behavior. In unipolar depression, evidence suggests that medications (particularly SSRIs) can have a positive impact on reducing the chemical imbalance that partially explains the depression and improve the client's affect. Likewise, the use of medication has been helpful with individuals with bipolar disorders (Borne, 1994). In both instances, medication alone does not appear to be as effective as medication in combination with counseling.

PREVENTION OF SUICIDE

Suicide is the most preventable cause of death if signs are properly recognized and caution prevails. If an individual is suffering from major depression, goes

on a drinking binge, and has a gun available, think suicide. If an individual has borderline personality traits, relationship discord with the family, is on the verge of losing a job, and just got into a car accident, think suicide. If an individual just suffered the death of a close parent, is doing poorly in school, feels socially unacceptable, think suicide. It is never harmful to present individuals with your feelings of concern and ask them directly whether they are thinking of killing themselves. Asking the question will not put the idea in their head: Asking the question will make them feel that you are concerned and will give them relief in that they can now discuss their internal frustration or emotional pain. Ask the question in a manner that is sympathetic. Do not pass judgment. Do not ask the question as if to suggest it is a *stupid* or *crazy* idea. Ask the question with great understanding and compassion.

What Works

A search of the literature did not identify a program that met the criteria for inclusion in this section.

What Might Work

In general, school-based programs appear to be excellent prevention initiatives because they reach kids at early stages in their lives (Weissberg & Greenburg, 1997). The *Columbia University TeenScreen Program* is designed to identify youth who are at risk for suicide and potentially suffering from mental illness. Youth who are found to be suffering from a mental illness or in a suicidal crisis receive a complete evaluation generally after parental consent. Screening programs can take place anywhere as long as they are conducted by qualified practitioners, for example, churches, conventions, juvenile justice facilities, shelters, anywhere where people are seen on a daily basis or clustered.

The SOS Program: Signs of Suicide incorporates two prominent suicide prevention strategies into a single program: a curriculum that aims to raise awareness of suicidal signs and related issues and a brief screening for depression and other risk factors associated with suicidal behavior. It promotes the concept that suicide is directly related to mental illness, typically depression, and that it is not a normal reaction to stress or emotional states. The goal of this program is to teach students how to recognize the signs of suicide among their peers and respond to the signs as an emergency, just as one would do with cardiopulmonary resuscitation for a heart attack.

The Reconnecting Youth Class targets young people in grades 9–12 who show signs of poor school achievement, potential for school dropout, and other at-risk behaviors, including suicide risk behaviors. This program teaches skills to build resiliency with respect to risk factors and to moderate early signs of substance abuse and depression/aggression. The program includes social support and life skills training. It has been recognized by several governmental agencies as an

effective, model program for reducing substance abuse and similar at-risk behaviors among youth.

The *Prevention of Suicide in Primary Care Elderly: Collaborative Trial* (PROSPECT; *www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=113*) aims to prevent suicide among older primary care patients by reducing suicidal ideation and depression. The intervention components are (1) recognition of depression and suicide ideation by primary care physicians; (2) application of a treatment algorithm for geriatric depression, which assists primary care physicians in making appropriate care choices during the acute, continuation, and maintenance phases of treatment; and (3) treatment management by health specialists (e.g., nurses, social workers, and psychologists), who collaborate with physicians to monitor patients and encourage patient adherence to recommended treatments. Patients are treated and monitored for 24 months.

Implementation of the program relies on educating primary care physicians to recognize symptoms and apply a clinical algorithm based on depression treatment guidelines for older patients from the American Psychiatric Association, the Agency for Healthcare Research and Quality, and the Texas Department of Mental Health. The recommended first-line treatment is citalopram (Celexa), an SSRI. If citalopram does not achieve the desired result, other medications may be added or substituted. Interpersonal psychotherapy may also be used in addition to or instead of pharmacological treatment.

Randomized primary care trials concluded that suicidal ideation resolved more quickly in patients who were randomly assigned to receive the intervention compared with those receiving standard usual care. "The impact of the intervention on depressive symptoms was greater among patients with major depression than for patients with mild depression unless suicidal ideation was also present" (Bruce et al., 2004).

RECOMMENDED BEST PRACTICES

One approach for developing treatment and prevention interventions is to examine the profiles of individuals who committed suicide. In such a study, I examined coroner reports on 46 suicides by African American males younger than age 25 (Barnes, 2006). I found that the major issues in their life at the time of their suicide were disruptive families, relationship discord, and unemployment. These conditions, if lining up like lucky 7 on a slot machine, can cause desperation, hopelessness, rage, anxiety, feelings of abandonment, loneliness, guilt, humiliation, and on and on.

Although some suicides are the result of a mental disorder, others are not. For the former group, the National Institute of Mental Health (Rice et al., 1989) reported four major profiles:

1. Agitation, severe anxiety, associated with psychosis
2. Symptoms of anxiety and undiagnosed depression

3. Suicidal acting out in borderline disorder associated with anxiety and anticipated loss
4. Interpersonal loss in depression, associated with a history of drug or alcohol abuse and impulsive behavior

When delivered in a culturally appropriate manner and setting, the treatment interventions described earlier and the appropriate use of medication represent current best practice for African Americans.

The prevention of suicide, in my opinion, is less focused on intrapsychic factors and more on interpersonal factors and the environment. From an interpersonal perspective, what do we need to do? Not fire anyone, not divorce anyone, not cause anyone to get upset or anxious? How, in the world that we live in today, do we stop suicide? Many of these conditions can be caused by a lack of understanding, a lack of insurance, and a lack of assistance. Can we change the conditions of society overnight? The only thing we can do to decrease suicidal behavior is very simple: Recognize the risk factors and help to alleviate them.

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