

SUICIDE

41,000 people kill themselves every year. For every suicide that is completed, 25 other individuals will make a suicide attempt. That means that there are more than a million suicide attempts annually.

Suicide completion is 3.5 times more common in men than in women, and white males make up approximately 70% of completed suicides. The highest rates of suicide are in adults between the ages of 45 and 64 (19.3%) and among those 85 years or older (19.2%).

While men are more likely to die by suicide, women are more likely to attempt suicide. Men are more likely to use deadly methods, such as firearms, while women are more likely to attempt suicide by poisoning. While white, older males have the highest rate of suicide completion, among minority ethnic groups American Indians and Alaskan Natives tend to have the highest rate of suicide. African Americans and Hispanics tend to have the lowest rates. The most frequent method of completed suicide is by firearms, which account for almost half of suicides.

Risk Factors

Understanding who is at risk for suicide involves understanding the complex factors among individual differences, long-term risk factors, and short-term risk factors. Individuals who complete suicide demonstrate individual differences in processing emotion, thinking, planning, problem solving, and decision making. They may have long-term risk factors, such as childhood violence or ongoing mental disorders. The interplay between these individual differences, long-term factors, and triggering events, such as loss or exposure to suicide, helps researchers and clinicians understand who is at risk. Suicide most often occurs when stressors outweigh a person's ability to cope, particularly in individuals with a mental health condition. Approximately 90% of people who complete suicide have a co-occurring mental disorder; however, there are many risk factors for suicide and a mental disorder alone does not necessarily make one at risk for suicide. Documented risk factors for suicide include co-occurring mental health problems, chronic physical pain, terminal illness, acute loss, family history of suicide and/or mental disorders, and situational factors, such as having access to guns or being incarcerated.

The interpersonal-psychological theory of suicidal behavior developed by Thomas Joiner proposes that an individual will not die by suicide unless she or he has both the desire to die by suicide and the ability to do so. The desire to die by suicide is thought to be a combination of psychological states called perceived burdensomeness and low sense of belonging. The ability to die by suicide is proposed to be an acquired capability for suicide developed over time by exposure to painful experiences that results in a fearlessness of pain, injury, and death. While not conclusive, this theory has substantial evidence to support it and gives clinicians a structured theory to understand suicide.

Depression

Depression is the mental disorder most commonly associated with suicide, and is present in 50% of suicides. Individuals with depression are at 25 times greater risk for suicide than individuals without depression, and an estimated 2% to 9% of individuals with depression will complete suicide. Untreated depression increases this estimated range to 2% to 15%.

What Is Cognitive Behavior Therapy?

Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or goals might involve:

- A way of acting, like confronting our feared thoughts
- A way of feeling, like helping a person be less scared, less depressed, or less anxious
- A way of thinking, like evaluating the probability of an event occurring
- A way of dealing with physical or medical problems, like lessening back pain or helping a person stick to a doctor's suggestions.

Behavior Therapists and Cognitive Behavior Therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well with ways of living that work, and giving people more control over their lives, are common goals of behavior and cognitive behavior therapy.

HOW TO GET HELP: If you are looking for help, either for yourself or someone else, you may be tempted to call someone who advertises in a local publication or who comes up from a search of the Internet. You may, or may not, find a competent therapist in this manner. It is wise to check on the credentials of a psychotherapist. It is expected that competent therapists hold advanced academic degrees and training. They should be listed as members of professional organizations, such as the Association for Behavioral and Cognitive Therapies or the American Psychological Association. Of course, they should be licensed to practice in your state. You can find competent specialists who are affiliated with local universities or mental health facilities or who are listed on the websites of professional organizations. You may, of course, visit our website (www.abct.org) and click on "Find a CBT Therapist."

The Association for Behavioral and Cognitive Therapies (ABCT) is an interdisciplinary organization committed to the advancement of a scientific approach to the understanding and amelioration of problems of the human condition. These aims are achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment.

Bipolar Disorder

An estimated 3% to 20% of people diagnosed with bipolar disorder die by suicide, and approximately half of individuals with bipolar disorder have made a suicide attempt. Onset of the disorder, hopelessness, recent hospital discharge, family history, and prior suicide attempts all raise the risk of suicide in these individuals. The reasons for the seemingly higher rate of suicide in persons with bipolar disorder compared with those who are only diagnosed with depression are largely unknown; however, there is evidence to support that comorbid anxiety disorders confer additional risk for suicide in this population. Lifetime anxiety disorders were associated with more than a doubling of the risk of a suicide attempt. Moreover, the more anxiety disorders one has, the greater the risk for attempted suicide.

Schizophrenia

Among people diagnosed with schizophrenia, an estimated 20% to 40% attempt suicide. Between 5% and 13% actually complete the act of suicide. Compared to the general population, people with schizophrenia have a more than eight-fold increased risk of suicide. Depression is one of the major risk factors for suicide among individuals with schizophrenia. In one trial, suicidal thoughts and plans, previous suicide attempts, and depressive symptoms are among the strongest predictors of suicidality in patients presenting with first-episode psychosis. A history of prior suicide attempts, drug misuse, alcohol misuse, poor adherence to treatment, all increase risk for suicide in patients with schizophrenia. Additionally, the presence of auditory hallucinations and delusions increases risk of suicide among patients with schizophrenia.

Personality Disorders

People with personality disorders are approximately three times as likely to die by suicide as those without. Between 25% and 50% of these individuals also have a substance abuse disorder or major depressive disorder. Personality disorders confer risk for suicide above and beyond other risk factors, meaning that individuals with both a psychiatric disorder, such as anxiety or depression, and a personality disorder are at increased risk for suicide attempts and completed suicide. Borderline personality disorder (BPD) is highly associated with suicidality, with rates as high as 10% of sufferers. Because suicidal behavior is a symptom of BPD, the estimated rate of suicide attempts is between 40% to 85% in this group.

Anxiety Disorders

Anxiety disorders, especially panic disorder and PTSD, are independently associated with suicide attempts. More than 70% of individuals who reported making a suicide attempt had an anxiety disorder. Even after adjusting for sociodemographic factors and other types of psychiatric disorders, the presence of an anxiety disorder was significantly associated with suicide attempts. Panic disorder and PTSD, when comorbid with personality disorders, demonstrated much stronger associations with suicide attempts over either disorder alone.

Chronic Pain

Compared with the general population, individuals with chronic pain have higher levels of depression, PTSD, and any anxiety disorder. Patients with chronic pain are twice as likely to commit suicide as individuals without. Pain-specific risk factors include location (low back and widespread pain), intensity (high), duration, and concomitant insomnia. Catastrophizing and feelings of being a burden also are associated with suicidal ideation in the pain population. Studies of patients with complex regional pain syndrome (CRPS) or fibromyalgia have shown particularly high rates of suicidal

ideation (74% and 48%, respectively).

Warning Signs

There are many warning signs for suicide, including changes in behavior, talking about being a burden, statements about feeling hopeless, physical pain, having no reason to live, and insomnia. Specific behavioral changes may include increased alcohol or drug use, looking or researching ways to commit suicide, withdrawing from people, friends and activities, giving things away, and increased aggressive and impulsive behaviors.

Protective Factors

Protective factors buffer individuals from suicidal thoughts and behavior. Although protective factors have not received as much research as risk factors, there are some identified factors that help reduce risk. A strong therapeutic relationship with a provider, access to clinical interventions, family and community support, good problem-solving skills, and religious or spiritual beliefs that discourage suicide are all thought to reduce risk for suicide.

Prevention

Treatment for specific risk factors is the number-one prevention strategy for suicide. Treatment for individuals who are at risk for suicide is multifaceted and may involve both medication and psychotherapy to address the underlying mental health disorder. Social support may also reduce the risk, particularly for individuals who have had a recent significant loss. Cognitive behavioral therapy for suicide attempters and dialectical behavior therapy have been shown to reduce the rates of suicide.

There are many medications available to treat depression, anxiety disorders, and substance use. At this time, clozapine is the only medication approved by the FDA to treat suicide risk in patients with schizophrenia. Antidepressant medications may increase anxiety, agitation, restlessness, and irritability, which may increase risk for suicide when the medication is started or the dosage is changed. These medications come with a black-box warning, and symptoms should be closely monitored with the prescribing doctor.

Resources

American Foundation for Suicide Prevention

www.afsp.org

Suicide.org

www.suicide.org

National Suicide Prevention Lifeline

www.suicidepreventionlifeline.org

NIMH

<http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>

Suicide Prevention Resource Center

<http://www.sprc.org/>

Suicide Prevention in Veterans

<http://www.hsrd.research.va.gov/publications/esp/Suicide-Prevention-2009.pdf>

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For more information or to find a therapist:

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