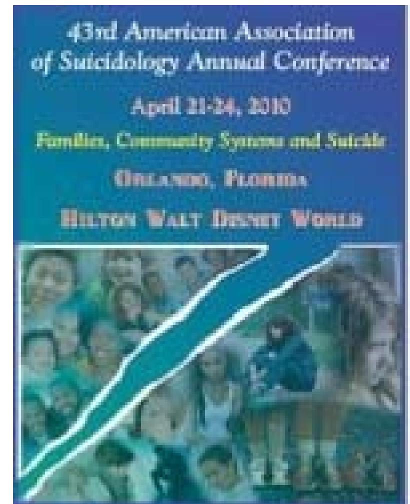
Don't Miss Out on the Opportunity to Share Your Knowledge and Research



In order to streamline the process of finalizing the best program possible for the 2010 Annual Conference, taking place April 21 - 24 in Orlando, FL, the conference committee and Central Office staff are working with a set of new deadlines. Thanks to everyone who submitted an abstract.

The theme for the 43rd AAS Annual Conference is "Family, Community Systems and Suicide."

Monica McGoldrick is slated as a keynoter at the 43rd Annual Conference.

Monica McGoldrick to Address AAS Annual Conference in Orlando

McGoldrick

Monica McGoldrick, M.A., LCSW, Ph.D., has agreed to be a keynote speaker at the upcoming AAS Annual Conference in Orlando, FL. Her theme will be, "Exploring the Ripples of Suicide in Families through Time."

She is a fourth generation Irish American, married to a Greek immigrant, and raised in a family in which her closest emotional connection was to her African American caretaker, Margaret Bush. As a result, she grew up knowing very little about her roots, but came through her family therapy work to believe deeply in the importance of connections to family and cultural history.

Dr. McGoldrick is known internationally for her writings and teaching on topics including culture, class, gender, the family life cycle, loss, family patterns (genograms), remarried families, and sibling relationships. Her videotape of clinical work with a multicultural family around issues of loss is one of the most widely respected in the field.

Several of her books have become best selling classics of their publishers, including:

* Ethnicity and Family Therapy, now in its 3rd edition, co-edited with Joe Giordano and Nydia Garcia Preto;
* The Expanded Family Life Cycle, 2005, soon going into a 4th edition, co-edited with Betty Carter and Nydia Garcia Preto;
* Genograms: Assessment and Intervention, in a 3rd edition, co-edited with Sueli Petry;
* Women in Families, Living Beyond Loss: Death in the Family, 2nd edition, co-edited with Froma Walsh, and
* Revisioning Family Therapy: Race, Culture, and Gender in Clinical Practice, recently published in a 2nd edition, co-edited with Ken Hardy.

Her book You Can Go Home Again: Understanding Family Relationships translates her ideas about family relationships for a popular audience, using examples such as Beethoven, Groucho Marx, Sigmund Freud and the Kennedy family.

Her work and writings fit ideally into the conference theme, "Family, Community Systems and Suicide."

Dr. McGoldrick is the Director of the Multicultural Family Institute in Highland Park, New Jersey, and on the faculty of UMDNJ, Robert Wood Johnson Medical school. She has a B.A. from Brown University, a M.A. in Russian Studies from Yale University, a M.S.W and Honorary Doctorate from Smith College School for Social Work.

Lanny Berman Elected President of the IASP

AAS Executive Director Dr. Lanny Berman has been elected President of the International Association of Suicide Prevention.

His term begins during the IASP Conference at the end of October.

From the Executive Director...

Two police officers, on routine patrol at 5:40 a.m., happen upon a car parked in a remote area. Approaching the vehicle, the officers observe a vacuum hose extending from the exhaust pipe through the rear window of the car, and the driver's side window open. The engine is off; the radiator cold to their touch; and there is no smell of fumes.

The driver appears to be writing a note. When asked what he is doing, he says he is recording his private thoughts and refuses to give them the note. When asked about the vacuum hose, the driver states that he had been thinking about doing "something stupid" and that he is in a "loveless" marriage and is writing his thoughts to his mother.

He then says he realizes that he has other options and is going to return home to talk with his wife.

To the officers, he appears rational, cooperative, reasonable, and absent any signs of mental illness. Running a check on the driver, the officers find that he had not been reported as missing or wanted. While they did this, the driver removes the vacuum hose from the exhaust pipe and places it in the back seat of his car. The officers offer to contact the driver's doctor or his family, but he refuses and states that he would see his doctor later. The

driver then left and...

As the iconic radio newsman Paul Harvey used to say, "in a minute...the rest of the story."

In the U.S., the power to detain a person and commit him or her for involuntary inpatient treatment is defined by individual state standards for assisted treatment. With but a few exceptions, detaining an individual at potential danger to self (risk of suicide) requires, as the first condition that must be met, that the person suffers from a mental illness, mental disorder, or psychiatric disturbance, i.e. that the individual's risk of suicide is a result of mental illness or serious psychiatric impairment.

Other countries have enacted similar legislation, e.g. Australia's Mental Health Act which provides for discretionary power of detention, as a common law duty to protect against the risk of suicide by someone who appears to be mentally ill or mentally disturbed.

One of the most elementary rights protected by common law is that of personal autonomy. Limits to this right, however, are often imposed by the state in the public interest.

When there appears a risk of suicide in the context of psychiatric disturbance, the state can attempt to enforce treatment; but in cases where there is no clear evidence of mental illness, treatment cannot be forced upon the individual against his or her will. The contemporary approach to suicide prevention relies primarily on the principle of active intervention and, if necessary, involuntary commitment of the suicidal individual.

While there is general acceptance of society's right, even its moral obligation, to intervene to prevent a suicide, there is much less agreement concerning the conditions under which such an action should proceed.

This issue was hotly debated by AAS's founding president Ed Shneidman and the psychiatric maverick, Thomas Szasz, at the University of California, San Francisco, in 1974. Shneidman, at his peak of eloquence, argued that society has a duty to intervene, given that suicidality was an expression of an individual's unendurable mental pain, which he viewed as treatable.

Szasz, described by one reviewer as "one of the most disliked names in contemporary psychiatry," and the author of The Myth of Mental Illness (1960), argued that suicide was a civil right and that to intervene uninvited was to violate the individual's civil rights. That a psychiatrist had taken this position was, in the same reviewer's mind, akin to "an atheist teaching comparative religion."

AAS has recaptured this now famous UCSF debate in a set of 6 DVDs and is making these available to members at a most affordable price. For academics, crisis center directors, and clinical supervisors, this is a great pedagogical tool that will spark considerable discussion among students and trainees alike. I urge you to visit AAS's website and to take advantage of this opportunity.

Now for the rest of the story.

The driver leaves and...returns home. His wife awakens at 9 a.m. and finds her husband lying on a sofa. She had plans to attend a dog show and, as he had expressed no interest in joining her, she soon leaves to go by herself.

Returning home at 2:30 pm, she finds her father and a police officer in the family garage attempting (unsuccessfully) to revive her husband who had connected a hose from his car's exhaust pipe to the inside of the vehicle and started the engine while he sat inside the car.

His wife brought suit against the police officers and the state, alleging a breach of duty to apprehend and detain him for treatment. The question for the court was whether the officers owed the decedent a duty to intervene, not whether they were morally or ethically obligated to intervene.

The court determined that

* the decedent showed no signs of mental illness in the officers' considered judgment,
* common law does not presume that evidence of preparation to suicide is evidence that the person is mentally ill, and
* the objective evidence was consistent with his voluntary withdrawal from his plan.

Thus the state owed no duty of care to the decedent.

The case, Kirkland-Veenstra v Stuart, after an appeal, was ultimately decided this past April by the High Court of Australia in favor of the state (and the police officers). As noted above, putting the legal issues aside, the case poses a number of significant questions for Suicidologists.

Here are just a few:

* definition (What is the threshold at which preparing to make a suicide attempt equates to making a suicide attempt?),
* risk assessment (Was Mr. Veenstra at imminent risk for suicide, in spite of denying his intent?),
* how to define imminent risk (Can one be imminently at risk for suicide without clear signs of mental illness or acute psychiatric symptoms?),
* whether or not active intervention was called for (If a layman happened upon Mr. Veenstra in his car, as was observed by the police, and had called in to a crisis center to describe what he saw, would the crisis center have initiated active intervention?).

One further complicating fact. The reason the police officer was at Mr. Veenstra's residence when the wife returned home was not because he had been called by her father after finding Mr. Veenstra in his car. Rather, the police officer himself had happened upon Mr. Veenstra, having come to his house that afternoon to serve him papers relating to allegations of fraudulent business transactions arising out of his former employment as an accountant with a car dealership.

Were this fact known to the police officers at the time they did a background check on him (it was not) or by a crisis center at the time a 3rd party caller called in, would this change the assessment of his suicide risk or a decision to intervene?

We look forward to publishing readers' responses to these questions.

Clinical Division

Considering Mental Health Medications

By Bill Schmitz Jr., Psy.D., Director

Stigma, as it relates to mental illness, mental health care, and suicide is an entrenched and ongoing challenge confronted by mental health professionals. All too frequently, while in the process of checking in with my clients, they will report that they are not taking their medications as prescribed.

While many of these people are quick to report vigilant adherence to blood pressure medications, cholesterol medications, heart medications, and a litany of other "physical" health medications, they choose to neglect "mental health" medications because they are not deemed "important." When and how did this perception of psychopharmacological medications, some of which are used to treat conditions known to be associated with death [suicide], as "optional" "tertiary," or "unimportant" evolve?

The reality is that some of the people who seek out mental health treatment will die by suicide. There is ample empirical data to attest to this sad, yet expected, reality. As noted by Joiner (2008), mental health providers "should understand that suicidal behavior is a complication of mental disorders."

We know, based upon the empirical literature, that most people who are diagnosed with Major Depressive Disorder, Schizophrenia, Bipolar Disorder, or any of the other mental health diagnoses will not die by suicide. However, complications arising from many of these disorders do, on occasion, result in death by suicide. This reality is often left out of discussions with mental health consumers.

For many mental health providers, this leads to the difficult and delicate balance of providing hope and optimism yet not minimizing the potentially deleterious sequelae of mental illness.

Nevertheless, if these conversations do not occur, we risk perpetuating the false belief that these mental health conditions are "just" mental health concerns, and not serious, potentially life-threatening illnesses or conditions that can have vast and negative consequences.

I would have to concur with the noted Pulitzer Prize novelist William Styron who wrote poignantly in his 1990 memoir Darkness Visible that the word "depression" falls exceedingly short in describing the despair and bleakness of soul which is the essence of melancholia (Major Depressive Disorder in DSM-IV-TR lexicon) and psychache.

As clinicians, we should consider how we broach the topic of mental illness, ensuring that mental health consumers receive fully informed and accurate information, not only the diagnosis and prognosis, but of the sequelae of the illness and stress the parity with comorbid medical problems.

So hopefully, the next time I do a check on a patient, besides hoping the patient is better, that the litany of medications which they are taking regularly and as prescribed will also include those "mental health" medications.

These are just some thoughts to consider for those clinicians who continually interact with people who

may believe they “just have .... [fill in the DSM diagnosis].”

As with previous columns, I am again including a potential resource that clinician [and general] members may find useful in their various practice settings.

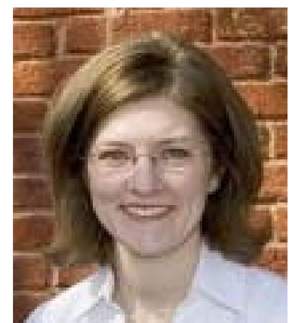
This month’s resource is our own AAS website that is launching the Member’s Section. This is an extremely exciting development that will allow AAS members to engage in a new level of collaboration, collegiality, and information dissemination.

Please check out the website, give it a “test drive,” create your profile, visit the various group pages and read the content on the message boards. AAS envisions the member’s portal as a wonderful resource to help keep up to date and connected to the most recent developments in the suicidology community.

As always, if you have any questions, comments, or suggestions please don’t hesitate to contact me at William.schmitzjr@va.gov, or through the website.

Research Division

Exciting New Changes to the AAS Website!



By Kelly Cukrowicz, Ph.D., Director

As many of you know, AAS launched a redesigned web page during the winter. The website is now much easier to navigate and contains lots of great information for the public and AAS members.

During the last few months, AAS leadership has been working hard to launch the Members Only community of the website. I encourage you to log into this section and familiarize yourself with all of the wonderful benefits it offers.

After you log into the Members Only community, you will see that you have access to message boards, groups (e.g., clinical division, research division), announcements, and ongoing discussions/threads. This page also has a calendar where major events will be posted that may be of interest to members.

The message board includes categories for different topics that readers may be interested in hearing about. For example, the research division message board currently has postings designed to stimulate your thinking about things you do to keep yourself going when working with suicidal patients takes a toll, as well as a post about terminal illness and suicide.

I encourage you to respond to these posts and contribute additional posts on topics you are interested in. We hope that this forum will be a way for members to communicate with each other and share ideas about topics of common interest.

You will also notice that there are groups that you can join. These groups include the various divisions of AAS,

and you are welcome to join more than one. The group pages will serve as a great place for division members to find out about current events and common interests for the division, as well as to gain access to helpful resources.

The main page for the Research Division currently contains several announcements regarding research, as well as information about the 2010 Annual Conference. You will also notice that there is a separate message board here for Group members where messages of interest to the Research Division will be posted.

You will see folders at the bottom of the Research Division group page that will contain documents and resources for group members. As you will notice when you log into the Members Only community, there are several messages encouraging submissions for the Annual Conference.

I'd like to echo that encouragement here. The Call for Papers has been released and can be found at http://www.suicidology.org/web/guest/education-and-training/annual-conference. The 2010 conference will be April 21 through 24 at the Hilton Walt Disney World in Orlando, Florida.

The research division typically receives a large number of high quality submissions and we hope to continue that trend this year. For many the conference serves as a wonderful opportunity to gain information spanning the range of topics within our field.

Prevention Division

Prevention A Major Focus at AAS Annual Conference

By Scott Poland, Psy.D., Director

The U.S. city with the most suicide deaths from a single location, San Francisco, home of the Golden Gate Bridge, hosted this year's AAS Conference.

Although the Prevention Division maintained a strong presence at the conference, this member headed home to Florida wondering, "What more can be done to promote suicide prevention in San Francisco?"

I was stunned during a tour of the Golden Gate Bridge when the tour guide remarked, "with a suicide off the bridge every two weeks, maybe you'll be lucky enough to witness a suicide today!" Walking across the majestic bridge, one may have noticed signs warning against jumping. The signs stated "There is hope, make the call, results of jumping can be fatal and tragic."

However, are signs enough, considering the enormous number of suicides off the Golden Gate Bridge? The number of suicide deaths from the opening of the bridge until May of 2008 was listed as 1,269.

The debate about more prevention efforts and erecting a barrier has gone on a long time, beginning with a study by Richard H. Seiden, Ph.D., MPH, in 1978 testing the notion that, if a person is prevented from jumping from the Golden Gate Bridge, they will just go somewhere else to die by suicide. Seiden found that

suicidal individuals will not just go someplace else!

The debate over installing a barrier on the Golden Gate Bridge was one of many issues raised by a riveting documentary by Eric Steel entitled The Bridge. Steel and his film crew monitored the bridge all during the year of 2004 and taped 23 of the 24 suicides that occurred that year. The film has been both praised and criticized, but it certainly raised again the question of creating a barrier to make it more difficult to jump from the bridge.

There has also been much publicity this year about the high number of suicides by soldiers and military veterans and there have also been a number of youth suicide clusters around the nation. In addition, high-profile suicides by financial managers have raised concern about increased suicide deaths due to the national financial crisis. As a result, education and prevention programs were a very important topic at the conference.

Education programs were one of the agenda items discussed by members of the Prevention Division while meeting at the conference. AAS now has an accreditation program in place to provide certification to educators and gatekeepers working in schools. For more information on the accreditation program for schools, go to http://www.suicidology.org/web/guest/certification-programs/school-professionals.

Another important topic discussed during the Prevention Division meeting was videos recommended for suicide education. With the leadership of Sue Eastgard, members of AAS have been reviewing videos to make recommendations about their appropriateness for use in educational settings. To find the list of recommended videos, along with a description of each video and the reasons it is or is not recommended, go to http://www.suicidology.org/web/guest/stats-and-tools/videos. Also, if you would like to assist in this very important cause, please contact Sue Eastgard.

I wish that it were possible to highlight all the presentations at the conference that focused on prevention and there may have been a record number of proposals for the division to review. For example: Michelle Moorehead, M.S., LCPC, and Nickki Kontz, MSW, discussed the creation and implementation of suicide prevention week strategies for those working with adolescents. This workshop emphasized the necessity of "buy in" from other community agencies in creating this event and how to get these agencies to buy in. Sandra Black, MSW, S. Todd Stolp, M.D., and Christa Thompson, B.A. discussed the state and local suicide prevention techniques utilized in California. Furthermore, Gale Jaffe, MSW, MPH, Amanda Lehner, B.A., Richard Low, Ph.D., and Kenneth Norton, MSW, LICSW discussed implications for suicide prevention when dealing with the Internet. This workshop focused on benefits and challenges of suicide prevention programs and newer technologies.

All presenters did a fantastic job of promoting suicide prevention at the conference. The efforts of all presenters and division members certainly make a difference in their respective communities. This was further evidenced by the volume of this year's high quality presentations.

As the conference moves to Orlando, FL next April, the members of the Prevention Division are urged to continue their efforts. If you would like more information on becoming an active member of the division, please contact Scott Poland at spoland@nova.edu

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Crisis Center Division

TEEN LINE, Crisis Center Excellence Award Winner

By Tim Jansen, LCSW, Director

Greetings! My predecessor, Mary Drexler, created a tradition in Newslink during her tenure by highlighting the winner of the annual Crisis Center Excellence Award. I whole-heartedly endorse this tradition. This year the award was presented to TEEN LINE in Los Angeles, California.

Executive Director Elaine Leader accepted the award at the Conference. The following is taken from the center's nomination letter.

In 1996, in addition to our ongoing Teen Suicide Prevention Outreaches to schools and youth groups, TEEN LINE, the Los Angeles-based teen-to-teen hotline, inaugurated a community policing alliance with local law enforcement to prevent teen suicide. The goal of TEEN LINE's Los Angeles Police Department Teen Suicide Training Project was to improve police handling of teen suicide victims and their families, and to sensitize police officers to the needs of suicidal adolescents.

This was to be accomplished by the development of a training approach that incorporated didactic, audio visual and experiential components. A key element was the utilization of suicide survivors as panelists who relate their personal experience of suicide, thus putting a face to teen suicide.

The distribution of materials including TEEN LINE's Youth Yellow Pages, a resource handbook for youth, and educational brochures on teen suicide prevention, as well as a brochure from Compassionate Friends is part of the educational effort.

TEEN LINE's first efforts involved instructing officers who attend the Los Angeles Police Department's Juvenile Procedures School and this continues to be a mainstay of our community policing teen suicide prevention project.

The Juvenile Procedures School is mandatory continuing education for juvenile officers within the LAPD. Officers attend four days of seminars, all of which, except two, are taught by law enforcement personnel. The School is offered eight times a year, with each class consisting of between 25 and 40 experienced officers.

In addition to participation as Instructors at the LAPD Juvenile Procedures School, the Team has developed customized, specialized training to meet the specific needs of varied law enforcement settings, ranging from Police Explorers, to D.A.R.E officers to SWAT team members, the Los Angeles Unified School District Police Officers, the California Hostage Negotiators, the Sheriff's Department, and other local Police Departments.

Some of the most important classes are those attended by young Police Explorers who themselves may be experiencing some of the warning signs of depression and suicide being discussed.

Despite the difficult material encountered in discussing teen suicide, the TEEN LINE Team has been inspiring and inspired by the contacts made through its community policing alliance.

Our research documents that our training model is an effective tool for teen suicide prevention within the con-

text of a community policing effort.

We hope other communities will follow our example - to the benefit of all involved - youth, officers, and the community at large.

I want to once again congratulate the TEEN LINE and hope that you are able to get a sense of the great work they are doing. I had the opportunity to meet many of you in San Francisco and I hope that I will see you at the next Annual Suicide Conference in Orlando - start planning now! If you would like to get in touch with me you can reach me easiest by email tjansen@communitycrisis.org.

Thank you all for all the continuing work you are doing to help those in crisis!

Call for Increased Student Involvement

By Stephen O'Connor, Student Representative

As many students may have learned at the AAS conference in San Francisco, the merger between the Council of Delegates (CoD) and Board of Directors (BoD) resulted in the termination of several elected positions, including the Student Representative.

While this may at first seem like a blow to student involvement with AAS, it seems to me to also provide an opportunity to increase and improve opportunities for student leadership in our association.

Now that the Student Representative will no longer formally exist, we have the chance to start with a clean slate and consider different ways to channel student involvement.

Thus far, there have been initial discussions with the current BoD to create a student group with leadership elected by student members of AAS. Leadership of the student group would communicate directly with a designated member of the BoD, such as the President or Executive Director. The student group would be open to any member of AAS who is currently enrolled in either a graduate or undergraduate program.

What functions would this group serve? Two ideas come to mind.

1. Student programming at the annual conference. This would include events such as a student social, pre-conference workshop, and symposia on relevant topics. The annual conference presents the opportunity to try out new ideas to address student needs. During the past four years, topics covered include career development, tips on publishing, and the history of suicidality. We need to continue to think of new ways to engage students and make their conference worthwhile. There is no doubt in my mind that having more people involved with planning would lead to a greater number of student events.
2. Course in Suicidality. Creating a curriculum for students enrolled in graduate programs to receive credit hours for a mini-course taught by AAS. Lanny Berman has been talking about this for years. Unless students

are fortunate enough to have a professor who specializes in suicide-related research, it is unlikely that they will come across a course that prepares them to work with suicidal individuals in treatment. In fact, current research suggests that over 50% of mental health professionals did not receive suicide-specific training while in graduate school. Student input would be crucial in making this endeavor a success.

I have only listed two possibilities for student participation; yet, based on my own experience with the BoD, AAS would appreciate increased involvement from students in a variety of areas. We need only to take the initiative of brainstorming ideas and presenting them to elected leadership.

My term as student representative will expire after the Orlando conference in April. We need to have a student group assembled by this time to ensure a smooth transition. I am urging those student members interested in taking a leadership role with AAS to email me personally at oconnor7@uw.edu so that we can get rolling.

I am already planning events for next year's conference and would love to hear ideas from my peers on ways to improve student content, as well as those experiences you feel are crucial to student members.

Support AAS Through Your Annual Campaign!

If you are part of an employer's Combined Federal Campaign, please designate the American Association of Suicidology as the beneficiary of your contributions. AAS's CFC number is #10605.

"Suicide Highest on Wednesday!" Really?!

By John L. McIntosh, Ph.D.

Perhaps you saw the news coverage.

On July 8 (other stories appeared later, including on the SPRC Weekly Spark of July 15) at least seven news sites (and likely their syndication) and one blog site reported on a study that will appear soon in the journal Social Psychiatry and Psychiatric Epidemiology and has already appeared online.

This study, as reported in the news stories, found that (for the years 2000-2004) suicides were now highest on Wednesdays and in warm months.

As many of you know, I have worked with the annual mortality data for suicide from the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) for nearly three decades.

When I read the news story I was astounded. I could not recall a single year in which the day of the week observation noted in this study was true. Based on the details of the study published in the news articles

(some of which I later discovered were not fully accurate, though they did not affect the ultimate findings), I decided to investigate.

With what I found, I wrote a letter to the editor of the journal. AAS Executive Director, Dr. Lanny Berman, provided me with a copy of the upcoming article and I was able to have more details about the study methodology and its data.

The conclusions this study has regarding the accuracy of the timing of suicide death records is the first issue I would like to address. The second is the general issue of the information on death certificates regarding day of death (official data are derived from death certificate information) as well as possible implications of day of the week for suicide prevention and/or intervention.

Over the years, I have discovered that the general public has a great curiosity about the statistics on suicide, including in particular such factors as geographic distribution, age and gender differences, and the cycles of suicide associated with season of the year and day of the week. While the first three of these factors may well provide information about high risk that could lead to prevention or intervention measures, the latter, cycle issues, it seems to me are more curiosity than clinically useful.

In reading the journal article, it is first important to realize that not all suicides in the years studied were to be included in the analyses. As described in the journal article, data were excluded for those under age 18 and for any deaths in which the decedent's state of residence differed from the state where the death occurred.

These exclusions already lessen the application of the study's results to portray the overall national patterns of suicide by temporal factors (i.e., its generalizability to the entire population). Further, because I suspected that the proportion of suicides attributed to Wednesdays (reported to be 25 percent of the total) still could not be accounted for by these two exclusionary criteria (and would by itself call into question the headline "Suicide Highest on Wednesday," as will be demonstrated below), I ran analyses of the same data files (which I have received annually from personnel from the NCHS and which are now posted online), first including all deaths and then excluding deaths by the age and state of residence-occurrence criteria described by Kposowa and D'Auria in the article.

In short, I could not replicate any portion of their basic analyses for suicide by day of the week, and more confusing, the number of deaths by suicide once the age and state exclusions were employed that I found, did not agree with the number included by Kposowa and D'Auria. Kposowa and D'Auria excluded 23,906 suicides from their analysis (from among the 155,542 for which day of the week was known; 15.36 percent) whereas my own application of their exclusionary criteria excluded only 10,511 suicides, a difference of 13,395 cases.

Several conclusions or possibilities could explain these discrepancies, including additional exclusionary criteria applied but not described in the article's methodology, perhaps some error in the selection of cases, or some other data error that could be associated with the changing location in the data files of pertinent variables (e.g., age, state of residence or occurrence, weekday of death) across the years under study.

Specifically, the exclusion of data for those under 18 and to include only those who died by suicide in the same state in which they reside had no effect on the resulting pattern by day of the week (see Table 1 and Table 2). As has always been the case, Monday is the highest day of the week for suicides, just as I discovered when I collected these data for a paper presented at the 2001 AAS Annual Conference (McIntosh, 2001/2004) for the years 1992-1998 (and in subsequent analyses annually through 2006).

Next highest was Tuesday, followed then by Wednesday. Contrary to Kposowa and D'Auria's results, even with exclusions applied, Wednesday never accounted for more than 15.0 percent of the suicides for any single year

and not for the entire five-year period combined.

Thursday was not lowest, but rather, again in keeping with consistent past patterns, the lowest levels were observed on Saturday and then Sunday. The only data consistent with Kposowa and D'Auria's stated results were for women in the year 2000 only, when Wednesday exceeded Tuesday by two suicides and Monday by four suicides.

In every other data year, overall as well as by gender, Wednesday ranked below both Monday and Tuesday. Monday had the highest number of suicides overall and for men for each year as well as for the mean five-year period 2000-2004.

Data for the years 2005 and 2006 show the same patterns as observed in the current analysis.The seasonal patterns reported by Kposowa and D'Auria, with suicide highest during the warm seasons (spring and summer) are consistent with past patterns in the USA (and in fact was observed by Durkheim, 1897/1951, in the late 1800's as well).

While it may well be true that the public believes that winter and cold months would be highest for suicide, data have never supported that belief.

The present analysis did not investigate this component of Kposowa and D'Auria's paper, and thus the possibility of data problems associated with exclusionary methodology cannot be addressed here (but warrants investigation before utilization of specific results).

It might be noted that while the findings for ranking of days of the week for suicide are consistent (and have been over time), there are only relatively small differences between the highest (Monday, 15.67 percent) and lowest (Saturday, 13.2 percent) days of the week.

This leads to some brief comments about the real-life significance and meaningfulness of variables such as days of the week with respect to suicide risk and suicide prevention.

While we could speculate about what might lead individuals to take their lives on Monday as opposed to some other day of the week, it seems unlikely that a person would kill him/herself because it was Monday, for instance. This fact seems quite minimal among factors that would be associated with elevated suicide risk.

We could speculate the likely truth of this, but imagine a scenario where the day of the week becomes the proverbial "straw that broke the camel's back," or a factor that exacerbates momentary feelings of hopelessness. Even if these ideas were accurate in some cases, it is not clear what could be done to prevent the suicide with respect to day of the week.

We could urge people to be more diligent and mindful on Mondays perhaps, but again, the risk is not so much greater on Monday that this urging should be focused so precisely. What measures are warranted to prevent suicides given the slightly higher (though consistent) proportions occurring on Mondays and Tuesdays (or if it were on Wednesdays)? I see little practical usefulness to this variable in suicide prevention.

Another problem with dwelling on day of the week as a variable in suicide is that the reliability of the data has been questioned for many years. More specifically, it has been argued that the day of the week registered on the death certificate (which is the source from which official statistics are derived) may well reflect the day of discovery of the deceased person's body more than it does the actual time/day of the death. That would call into question the actual validity of the day of the week in perhaps a large number of the deaths by suicide. Therefore, while determining which day of the week suicides are highest or lowest may be of interest to the lay public, the

information may be more of a curiosity than important prevention information. (Oh, and just because it is in the news doesn't mean all that you read and/or hear is true.)

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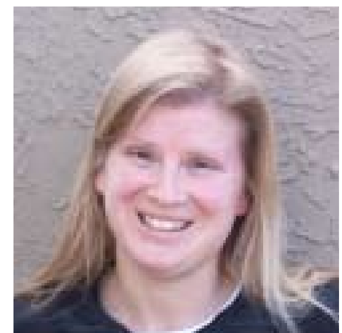
Reflections on a Memorial Service for Ed Shneidman

By Michelle Linn-Gust, Ph.D.



I never met Ed Shneidman in person.

I have this vague memory of seeing him at the podium at the 2000 AAS conference in Los Angeles. Since it was my first AAS conference, I knew no one the first day I attended.

Several years later, I made a phone call to him to settle where he came up with the concept that, on average, six survivors are left behind after a suicide. I was writing an article for Surviving Suicide at the time and both Frank Campbell and John McIntosh suggested I call Ed.

While Ed had told Frank the six survivors theory came from a plane crash settlement, he told me it was about a cemetery double-burying bodies (as Frank still says, "That's Ed"). Ed told me to call him anytime. It wasn't until I found out I'd become the president-elect of AAS in late March of this year that I felt the need to call him again. Something told me that it was important I do so, and the assignment he gave me that day, six weeks before his death, will appear in the fall issue of Surviving Suicide.

There was a small part of me that was nervous about attending Ed's memorial in July in Los Angeles. Who would I know? Surely everyone there would have a much more personal connection than I did. I thought it would be a room full of people who all knew Ed and had a personal relationship with him.

I knew Lanny (Berman) would be there and, as the event drew closer, I found out several people I knew from Didi Hirsch Suicide Prevention Center (Los Angeles, CA) would be there as well.

While the room was full, it consisted of a diverse group of people each having different, yet unique, experiences of how Ed touched their lives through his knowledge, and simply through who he was and what he shared with the world. It was an opportunity to see all sides of a man who many only know through his work. A photo slide show allowed us to see Ed with his family, Ed rowing a boat, and a whole side of his life that existed beyond offices and conferences. But we also saw the offices and conferences, shown for the benefit of his neighbors and the hospice workers who look care of him at the end of his life.

His four sons each spoke of their unique relationship with their father. One son's childhood friend even added his memories of time spent at the Shneidman home.

Some people who shared stories of Ed came from more expected places, as they had worked with him in the Suicidology field. They remembered how important it was to Ed to unlock the mystery of suicide and to understand how it related to the mystery of the mind. But they also recalled a man who had a quick wit about him. It seemed that nothing went unnoticed by Ed.

The Los Angeles Times reporter Thomas Curwen, who wrote several articles about Ed, relished the time he spent with him and recalled how Ed would be waiting for him to arrive, barely giving Thomas time to get his laptop set up before he began talking. At least one former student spoke of taking Ed's class. A survivor recounted her letter to Ed after reading one of his books, asking him to help her understand her brother's suicide. A fellow psychiatrist in the community recalled lessons learned from Ed about how to help suicidal patients. All the stories were different; they showed a man who touched the lives of many although he did not appear to realize it.

One person summed it up best when he said, "There's a little of Ed in all of us."

President's Column

Looking Ahead...

By Jim Rogers, Ph.D., AAS President

I have to admit that I have approached writing this, my first NewsLink column as President of AAS, with mixed feelings.

On one hand, we are coming off of our most successful conference in the history of the Association! By all accounts, the 42nd Annual Conference was an overwhelming success and bodes well for the continued presence of AAS as a leader in the advancement of scientific and programmatic efforts in suicide prevention.

Of course, credit for the success of the conference goes to the Program Committee members under the leadership of Dr. Sean Joe as Program Chair, our Deputy Director, Amy Kulp, Central Office staff and the terrific programs offered by the conference presenters! Thus, I extend a heart-felt thanks to all who contributed to this outstanding conference.

Looking forward, AAS's 43rd Annual Conference will be in Orlando in 2010 from April 21st through the 24th. The theme for the conference is Family, Community Systems and Suicide. Under the leadership of President-Elect Dr. Michelle Linn-Gust and 2010 Program Chair Dr. Phillip Rutter, I expect that we will be offered an equally provocative and informative slate of keynote speakers, panels, papers, and other programs.

In fact, Michelle, Phillip, and Amy got off to a running start with an early release of the Call for Papers http://www.suicidology.org/web/guest/education-and-training/annual-conference with a deadline for submissions of September 30th, 2009. I encourage you to consider submitting a response to the Call for Papers and reserve the dates for the 2010 Conference.

Before leaving this topic, I must admit to having a sense of relief about passing the responsibility for the Annual Conference to Michelle and Phil. Having served as Program Chair for the Seattle conference in 2006 during Peter Gutierrez's first year as President-Elect and then having responsibility for the Boston and San Francisco conferences as President-Elect, it was clearly time to move on! Thank goodness that I had Doreen Marshall and Sean Joe as program chairs for those conferences, respectively, to insure their successes!

On the other hand, against the backdrop of this year's successful conference, we have had the passing of Dr. Edwin Shneidman on May 15th, 2009. As the Founding President of the Association and the father of American Suicidology, his passing represents a significant loss to the field and to the many folks who have had personal and professional relationships with him.

Dr. Shneidman's death was particularly poignant to me as I had recently become the 39th President of the Association. As I reflected on Dr. Shneidman's legacy related to Suicidology, the AAS, and my new presidency, I began to think chronologically about the leadership of the organization.

Although some may be aware of this, others may not know that Dr. John McIntosh, a Past President of the AAS himself (1993-1994), has put together a pictorial chronology of the presidents of AAS that can be found at http://mypage.iusb.edu/~jmcintos/AAS.Presidents.html. I would like to publicly thank John for putting this page together as part of the historical record of the Association.

Viewing the photographs of the Past Presidents gave me a clear sense not only of Dr. Shneidman's impact on the field in general and AAS in particular, but also heightened my awareness of the influence that many of these folks have had on me personally. For example, my first real connection with the field of Suicidology came as I stumbled upon copies of Suicide and Life Threatening Behavior edited by Shneidman and later by Dr. Ron Maris, also a Past President of AAS. Through their editorial efforts and the later work of Dr. Mort Silverman in the role of Editor in Chief, I became connected with and influenced by the work of many of the individuals listed on John's AAS Presidents page. Clearly, the important role of SLTB in influencing the next generation of Suicidologists will continue under the watchful eye of Dr. Thomas Joiner as the journal's new Editor in Chief.

In addition to influencing my academic career, a number of past presidents directly encouraged my involvement in AAS leadership positions. To name a few, these have included Dr. Frank Campbell, Dr. David Jobes, Dr. David Rudd, Dr. Jim Mazza, and last, but nowhere the least, Dr. Pete Gutierrez. In my reflective mood, I would like to thank them (now, since I don't yet know what lies ahead for my presidency!) for their encouragement and support in this regard.

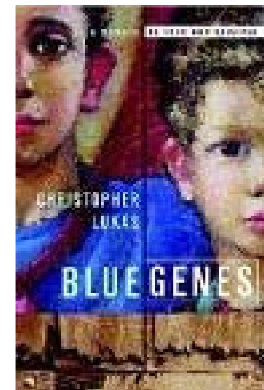
My intent is to use future columns to highlight important activities and events both inside and outside the Association. At this time, however, I want to recognize the incredible work of Board Member Jill Nyhus and the Web site development committee over the past few months and I encourage everyone to visit the site (www.suicidology.org) and look for future information about the rollout of the Members Page as a forum to facilitate communication and networking.

I would also like to acknowledge Drs. Frank Campbell, John McIntosh, and Bob Yufit for their willingness to serve the Association as members of the initial Forensic Suicidology Certification Board formed earlier this year. Finally, I would like to personally thank Dr. Cheryl King for agreeing to chair a newly-formed task force to review a proposal from Executive Director Lanny Berman for the creation of a National Center for the Study and Prevention of Youth Suicide. Dr. King has pulled together an outstanding group of folks for the task force that includes Drs. Joan Asarnow (UCLA), David Goldston (Duke), Sean Joe (University of Michigan), Anthony Spirito (Brown), and Dr. Berman as ex officio.

Clearly it is through the work of these and all of our members that keeps the AAS at the forefront of the field of Suicidology!

To conclude, this has been a bittersweet beginning to my tenure as President of the Association. A terrifically successful conference in San Francisco juxtaposed with the passing of a giant in our field and the founder of our Association, Dr. Edwin Shneidman. In some ways, it seems like just the kind of existential irony that he would understand.

Book Review



Blue Genes: A Memoir of Loss and Survival
By Christopher Lukas
Reviewed by: Judy Raphael Kletter

Christopher Lukas authored this book 11 years after the suicide of his brother, Tony, a two-time Pulitzer-winner.

Tony, who was being treated for depression, ended his life in 1997.
Christopher Lukas, himself a writer-producer-director in television, wrote this book in the hope of coming to an understanding of his relationship with his brother, with whom he had difficulty finding “common ground.” Lukas writes:

“Still two things pain me: Am I -- should I have been - my brother’s keeper? And after all is said and done, should I be able to forgive him for killing himself? In the end I have decided no -- on both counts.” (p. 243)

Christopher was six and his brother Tony was eight when their mother, Elizabeth, died by suicide on the property of her psychoanalyst following an appointment with him. She had made two prior attempts to end her life.

Lukas writes about the turbulent relationships that existed within his family, touching on his parents’ unhappy marriage, the tension between his father and maternal grandmother (who fought over the proper medical/mental health treatment for Lukas’ mother), his fear of his father, and the feelings of disconnect with Tony.

The family history is saturated with emotional turmoil and despair caused by depression and bipolar disorder. This is evidenced in the numerous suicides within his family: maternal grandmother, uncle, uncle's wife, and father who died from alcoholism which Lukas views as a form of suicide. The reverberations of these suicides have impacted his entire life.

Throughout their lives neither brother was pleased with his accomplishments. They were always striving for more; looking for the approval, love, gratitude and applause they received at a young age from their mother, instead of the abandonment Christopher felt throughout his life. He recalls his happiest childhood memory:

"The most important part of our early life was the little dramas Tony and I staged on the window seat in the dining room. There at the ages of six and four, my brother and I began to play out our feelings, making up plays to express ourselves through mime or dialogue. This was at the urging of Mother, the actress and budding educational psychologist. Mother applauded, encouraged, critiqued and supported our little theater company. It was a result, I later realized, not of our mother's desire to have us express ourselves but of her inability to ask us directly how we felt about things - to connect with us." (p. 69)

Lukas is "concerned about life," and authoring this book is his attempt to integrate his past with the present. While his writing is, at times, a bit disjointed, this appears to reflect the honest outpouring of thought and feeling from the author. In his daily battle, working through his depression, he finds hope in the midst of despair. As he states in the epilogue:

"The question then becomes: If Tony was only the latest in a long line of family members who killed themselves, will I be the next? Hard as it may be to believe, in my adult life I have not had a single day when I felt wholly well--physically or emotionally. Still, with full confidence, I know that I will never go into a room at the end of a day and kill myself. For I am a perennial survivor. I have managed to live in the shadow of my legacy of suicide through connectivity and family and psychotherapy, among other blessings." (p. 245)

An emotionally touching outpouring on the part of Christopher Lukas, Blue Genes is a poignant and touching memoir of loss and survival that is powerful and insightful in its naked truth about the impact of suicide and to those who persevere through the abyss of suicidal desire.

Meeting IRL to Save Lives Online

Suicide Prevention in the Age of New Media

Contributed by Christopher Gandin Le, Emotion Technology

On May 6 of this year, the Substance Abuse, Mental Health Services Administration (SAMHSA), the Suicide Prevention Action Network (SPAN USA), and Gallup invited 35 people to a meeting called "Suicide and New Media: an Action Planning Summit to Save Lives." The summit's intention was to develop a set of goals for using new media in suicide prevention, intervention, and postvention.

It brought together suicide prevention stakeholders (including AAS Executive Director Lanny Berman) and new media industry leaders (like representatives from Facebook and MySpace) to collaborate toward the shared aim of using new media to prevent suicide.

This meeting evolved from a forthcoming white paper on suicide and new media, funded by SAMHSA and

written by Jennifer Dusenberry, Christopher Gandin Le, and Irene Saunders Goldstein.

One of the paper's findings was that "many lives have already been saved by the pioneering collaborations between suicide prevention organizations, social networking sites, and individual users. However, no unified strategy or common practices exist at present to guide the most effective future use of new media in suicide prevention."

With this in mind, Mary Yakatis and Jennifer Dusenberry (Gallup) and Christopher Gandin Le (Emotion Technology) launched the meeting by presenting some of the key findings about social media use, the language used to discuss suicide online, and some examples of suicide prevention organizations using social media, like the National Suicide Prevention Lifeline and the Jed Foundation.

Industry leaders have taken notice of the issue of suicide online. YouTube recently added "suicide" to the list of potential safety issues on their site. (http://help.youtube.com/support/youtube/bin/request.py?contact_type=abuse). At that link, users can report many specific suicide-related themes, including "Someone on YouTube is at possible suicide risk," and "A video (or video comment) demonstrates the act of suicide or expresses suicidal thoughts."

With social media at the center of the summit, the meeting didn't stay small or private for very long. Attendees created a Twitter "hash tag" to post rolling updates about the meeting, which allowed attendees in the room to share their thoughts and discoveries with Twitter users. Those remote users then contributed to the discussion by asking questions and posting their own ideas.

This new type of meeting - where using a mobile phone is necessary rather than rude -- thrilled participant Susan Keys, Executive Director of Inspire USA Foundation. Keys, whose organization will launch Reachout.com during September, said, "I thought it was a good opportunity to have a broader audience participate in what was a very exciting interchange inside the meeting."

Keys said she didn't find the interactivity distracting; instead, she found it an "interesting juxtaposition between a formal meeting and cutting edge technology."

At the heart of the meeting was small group working sessions, in which participants developed goals and objectives (to be published with the white paper) for using new media in suicide prevention, intervention, and postvention.

Exciting new connections formed from these small groups, networks that will share ideas and move the suicide prevention field even further into the future.

Amanda Lehner, Online Communications Manager for Lifeline 1-800-273-TALK (8255), was "excited that SAMHSA and SPAN took the opportunity to support efforts in new media and suicide prevention, because we've long seen that as a need." For her, the meeting was an important step to "prepare for the future of suicide prevention as social media continues to reshape marketing and communications."

To access social networking sites from major suicide prevention organizations, visit their websites for a link.

Editor's Note: The federally-funded Suicide Prevention Resource Center provides information and resources about specific topics in each issue of Newslink.

SPRC and WICHE Release Suicide Prevention Toolkit for Rural Primary Care

At any given time, between two and four percent of primary care patients are having thoughts of suicide. They may come to exam rooms presenting with many different concerns, but the one they may not be telling their physician about could be the one that will kill them - unless primary care physicians and members of their staff are prepared.

The Suicide Prevention Toolkit for Rural Primary Care, a new product from the Suicide Prevention Resource Center (SPRC) and the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, contains the information and tools needed to implement state-of-the-art suicide prevention practices in primary care settings. The Toolkit offers the support necessary to establish the primary care provider as a member of a care team that is fully equipped to reduce suicide risk among patients.

Consider the following statistics:

* Primary care is often a patient's only source for mental health treatment of any kind, especially in rural areas
* Up to 88 percent of individuals who die by suicide have visited their primary care provider within the previous year; up to 66 percent have visited within one month of their death
* In the weeks or months prior to their deaths, people who die by suicide are more than twice as likely to have visited a primary care provider than a mental health provider

It's clear that primary care physicians can play an important role in suicide prevention, especially in rural areas where access to mental health services may be limited. The Toolkit provides everything needed to walk physicians step-by-step through the process of integrating suicide prevention into their practice. This includes teaching staff about suicide prevention; developing an office protocol for potentially suicidal patients; developing a referral network; and ordering community and patient education tools such as brochures and posters. Although the tools in the Toolkit are designed with the rural practice in mind, most are quite suitable for use in non-rural settings as well.

The Toolkit

The Toolkit is available in both hard copy and electronic formats (for more information, see Accessing the Toolkit, below.) It includes six sections:

1. Getting started
2. Educating clinicians and office staff (a five-part primer)
3. Developing mental health partnerships
4. Patient management tools
5. Patient education tools
6. Resources

Educating clinicians and office staff (a five-part primer)

The primer is the heart of the educational section of the Toolkit. It includes five brief learning modules on:

1. prevalence and co-morbidity;
2. epidemiology;
3. effective prevention practice
4. suicide risk assessment; and
5. intervention.

The first two modules present background material that is useful for the entire staff.

* Module 1, Prevalence and comorbidity, summarizes the magnitude of the suicide problem in the U.S. and describes the relationship between suicide and mental health and substance abuse problems.
* Module 2, Epidemiology, lists demographic groups that are at relatively greater risk for suicide.

Modules 3 and 4 present information and practices to put into effect in the primary care office.

* Module 3, Prevention practices, discusses general practices, such as screening, that can be incorporated into primary care settings to lower the risk of suicide across the entire patient population. This module should be read and discussed by the entire primary care staff.
* Module 4, Suicide risk assessment, provides a methodology for gathering information about a patients' suicidal thoughts and plans and an approach for assessing the level of suicidal intent.

Module 5, Intervention, discusses a range of patient management approaches that can be implemented in the primary care setting according to the patient's level of risk. These include:

* Referral or co-management when mental health assessment and treatment are available
* In-office treatment for depression and other psychiatric symptoms
* Encouraging social support networks
* Planning collaboratively with the patient for his or her future safety
* Documentation and follow-up care

Developing mental health partnerships

The strong association between behavioral health problems and suicide suggests that the majority of patients primary care providers evaluate for suicide risk are also in need of mental health care. Ongoing communication between the primary care provider and mental health clinicians is a key to achieving treatment success. Time and time again, research has shown that the combination of medication plus psychotherapy produces the best results. When comprehensive treatment is delivered to patients, recovery becomes an achievable goal in most situations.

To assist primary care offices in developing mental health partnerships, the Toolkit includes a mental health outreach letter template to help build strong, collaborate partnerships between primary care and mental health practices. This letter of introduction extends an invitation to meet to share perspectives and develop a model for collaborative patient management.

Other resources listed in this section of the Toolkit include the SAFE-T Pocket Card, designed by mental health experts to guide assessment and intervention (may be included with outreach letter to mental health practices); online tools to help locate treatment for mental health or substance abuse problems; and a web-based guide to walk communities through the steps necessary for developing a tele-mental health service.

Patient management tools

The Patient Management Tools section of the Toolkit includes tools primary care offices can use to:

1. Create an office protocol for handling potentially suicidal patients
2. Develop a safety plan and a crisis support plan for use with patients at risk for suicide and their loved ones

3. Create a patient tracking log to protect patients at heightened risk
4. Screen for depression and substance abuse

Patient education tools

Patient education tools included in the Toolkit include brochures, posters, and wallet cards for posting in the primary care office or making available to patients and their loved ones.

Accessing the Toolkit

The Toolkit was developed collaboratively by the Suicide Prevention Resource Center and the Western Interstate Commission for Higher Education Mental Health Program, with funding from the Health Resources Services Administration and the Substance Abuse and Mental Health Services Administration.

The toolkit is available free through a web-based portal at http://www.sprc.org/pctoolkit/index.asp. Hard copies of the toolkit are available for $25.00 (plus shipping and handling) through WICHE Mental Health Program.

For more information, please contact Jenny Shaw at jshaw@wiche.edu.

Current References

Editor's Note: As a service to our readers each issue, Newslink publishes selected references of recent publications, culled from Current Contents, relating to suicide and of broadest interest to our readers. Only the first author and the first page of each reference are listed. References from Suicide and Life-Threatening Behavior, Archives of Suicide Research, and Crisis are not listed below, as entire issues of these journals are devoted to Suicidology. The following references appeared between May 1 and July 31, 2009.

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